The Medical Society of Virginia (“MSV”) is a professional association of more than 6,500 Virginia physicians. Originally founded in December 1820, and incorporated in 1824, MSV is the only association in Virginia representing all medical doctors and doctors of osteopathy, regardless of specialty or type of practice setting.

Dedicated to Virginia’s physicians and their patients, the Medical Society of Virginia provides administrative, legislative and legal services to its members, and produces a monthly publication. MSV sponsors and accredits continuing medical education for physicians and serves as the liaison between local, national and specialty medical organizations.

The Medical Society of Virginia has been responsible for the creation of the State Board of Health, the State Board of Medical Examiners, the Board of Medicine, the MSV Review Organization known today as the Virginia Health Quality Center, and the Virginians Physician Network, a 100% physician-owned HMO network. Each of these now independent entities had their beginnings within the Medical Society of Virginia.

The Medical Society of Virginia also created a Physicians Health and Effectiveness Committee, which was responsible for investigating impaired physicians, referring impaired physicians to appropriate treatment and monitoring their recovery progress. This committee was the basis for the development of the Virginia Health Practitioners Intervention Program.

Today, the Medical Society of Virginia leads the way in advocating for patient protection in the current managed care environment, access to health care for all Virginians, and ensuring the highest standards of quality for health care for Virginia’s citizens.

The Future of the Medical Society of Virginia

The Medical Society has refocused itself. We have added a Health Policy and Medical Economics Department and restructured every department to meet the changing needs of Virginia’s physicians.
We see the Society as the most credible advocate of health care quality in Virginia, as well as the foremost initiator and facilitator of dialogue between the political and healthcare communities throughout the Commonwealth.

We also see the Society providing programs and services enabling Virginia physicians to thrive in the changing healthcare environment.

The Medical Society can be reached at the following places:

Medical Society of Virginia
4205 Dover Road
Richmond, Virginia 23221
(804) 353-2721 phone
(804) 355-6189 fax
www.msv.org

Key Contacts:

Paul Kitchen- Executive Vice President
Marni Eisner, Esquire- Legislative Affairs
Bill Cimino- Communications
Mike Jurgensen- Health Policy and Medical Economics
Wendy McCollough- Membership
The Virginia Academy of Family Physicians is a state-wide organization of 1300 actively practicing family physicians.

The organization was founded in 1948 and their mission is to:

- Improve the health care of patients, their families and the citizens of Virginia.
- Serve the unique needs of members with professionalism, leadership and creativity.
- Advance and represent the specialty of family practice.

The Virginia Academy of Family Physicians Headquarters office is located at 1301 North Hamilton Street, Suite 312, Richmond, Virginia 23230. Phone: (804) 358-1721 Fax: (804) 359-4184. The official website for the VAFP is www.vafp.org.
Virginia Association of Durable Medical Equipment Companies
(as of November 1, 1998)
Sam Clay, President
c/o Clay Home Medical
518 S. Sycamore Street
Petersburg, Virginia 23803
Phone: 804-733-5888
Fax: 804-862-1254

Rebecca P. Snead, R.Ph., Executive Director
c/o Virginia Pharmacists Association
5501 Patterson Avenue, Suite 200
Richmond, Virginia 23230
Phone: (804)285-4145
Fax: (804)285-4227
E-mail: vphanow@erols.com
Website: http://pharmacy.su.edu/vpha

MISSION STATEMENT

The Virginia Association of Durable Medical Equipment Companies (VADMEC) is an association of privately owned and publicly held home medical equipment and service organizations. VADMEC promotes quality of service to consumers and the viability of its members through ethical standards, education, advocacy, and communication.

The purpose of VADMEC is to represent and strongly support the interests of the membership by:

1. Promoting compliance with accepted standards of practice and ethics for the industry.
2. Effecting positive change through regulation and legislation.
3. Promoting the financial viability of the membership.
4. Assuring that quality DME is an integral part of health care policy in the future.
5. Promoting appropriateness and quality of care.
6. Educating members, consumers, legislators, allied health care professionals, manufacturers and third party payors.
7. Serving as liaison between governing agencies, third party payors, and the membership.
8. Being politically pro-active.
9. Serving as a clearinghouse for the distribution of information.
10. Assuring the continuation of a market driven DME industry.
11. Demonstrating leadership and sound management principle.

The current VADMEC Board of Directors and lobbyist are identified below:

Sam Clay, President
Clay Home Medical
518 S. Sycamore Street
Petersburg, Virginia 23803
Phone: 804-733-5888
Fax: 804-862-1254

April Stover, Program Director
Clay Home Medical
518 S. Sycamore Street
Petersburg, Virginia 23803
Phone: 804-733-5888
Fax: 804-862-1254

Jamie Copenhaver, Treasurer
Community Health Care
190 W. Main Street
Wytheville, Virginia 24382
Phone: 540-228-3081
Fax: 540-228-8636

Brian Wilson, Past President
Community Home Health Care
479 Piney Forest Road
Danville, Virginia 24540
Phone: 804-797-2332
Fax: 804-783-3916

Marcia Pruner, Secretary
ARGO Medical Services
P.O. Box 1621
Lebanon, Virginia 24266
Phone: 540-889-3108
Fax: 540-889-3119

Rick Baldridge
Choice Medical
P.O. Box 6235
Bluefield, WV 24701
Phone: 304-325-0476
Fax: 304-325-0478

Lori Edmonds, Regulatory Chair
Advance Health-Care Services
58 N. Washington Avenue
Pulaski, Virginia 24301
Phone: 540-980-0505
Fax: 540-980-0757

Bob Evans
Roberts Home Medical
3917 Deep Rock Road
Richmond, Virginia 23233
Phone: 804-270-1511
Fax: 804-270-2328

Doug Ellis, Legislative Chair
Ellis Pharmacy & Home Health
217 W. Main Street
Abingdon, Virginia 24210
Phone: 540-628-8181
Fax: 540-628-6116

Helen Farrell
Med-Emporium
2322 E. Little Creek Road
Norfolk, Virginia 23505
Phone: 757-480-0351
Fax: 757-588-6430
Kevin Knable
Invacare Corp.
2329 Stony Brook Road
Powhatan, Virginia 23139
Phone: 804-598-8190
Fax: 804-598-8190

Nancy Martin
Friendship Home Health, Inc.
560 W. Main Street
Abingdon, Virginia 24210
Phone: 540-628-4554
Fax: 540-628-4570

Glenn Perry
Regional Home Care
P.O. Box 69
Clifton Forge, Virginia 24422
Phone: 540-862-1810
Fax: 540-862-3449

Ms. Cynthia L.W. Warriner, Registered Lobbyist
5601 Ecoff Avenue
Chester, VA 23831
Phone: 804-748-8181
Fax: 804-768-4772
Virginia Association of Health Plans
(as of November 1, 1998)
Executive Director - Mark C. Pratt
118 N. 8th Street
Richmond, Virginia 23219
Phone: 804-648-8466
Fax: 804-648-8036
vahp@pipeline.com
Visit our website at www.vahp.org.

Our Mission

The Virginia Association of Health Plans (VAHP) is a non-profit organization committed to enhancing the acceptance and understanding of managed care organizations as high quality, cost-effective options for providing comprehensive health care to Virginia citizens. Established in 1988 as the Virginia Association of Health Maintenance Organizations, the Association broadened its mission and changed its name to VAHP in 1998. The association assures that Virginia’s managed care health insurance plans have a voice in promoting quality and affordable care through advocacy, education, and research services. The Association is committed to cultivating a regulatory and marketplace environment that facilitates private sector health care solutions.

Our Philosophy

The Association and its members promote a philosophy of care that emphasizes active partnerships between patients and their physicians. We believe that comprehensive health care is best provided by networks of health care professionals who are willing to be held accountable for the quality of their services and the satisfaction of their patients. We are committed to high standards of quality and professional ethics, and to the principle that patients come first.

Our Scope

Currently, the Association represents 14 managed care organizations which, through their HMOs, PPOs and other managed care health insurance plans, provide health care benefits for nearly 2.2 million Virginians. Our affiliation with the American Association of Health Plans provides us with an expansive national resource which tracks the managed care industry state by state and issue by issue.

Our Services

Representation and Advocacy
VAHP develops and promotes a legislative and regulatory agenda that advances the successful operation of health plans in the Commonwealth. We are actively involved in policy development and issues analysis before, during and after the General Assembly sessions each year. The Association issues position statements, educates legislators on health issues and organizes involvement of the health plan community in the legislative process. The Association also facilitates political involvement through a political action committee (PAC) to support candidates who are committed to the mission and policy positions espoused by the Association.

Communications

VAHP generates a number of health information resources to assist stakeholders in understanding the latest issues and the current marketplace in which managed health insurance plans work.

A sample of current resources includes:

*Viewpoint* - A quarterly newsletter which covers business and health trends, association news and managed care education information.

*Annual Directory of Health Plans* - A comprehensive reference guide to health plans operating in Virginia which includes overall managed care information regarding national, regional and state trends in enrollment and utilization as well as individual profiles on Virginia health plans.

*Annual Report Of Legislation* - This post-session report summarizes the legislation tracked by the Association and describes how health plans fared on laws passed, bills killed and issues tabled for study.

*Website: www.vahp.org* - Our website posts our newsletter, information from our directory, and policy statements and positions from the organization. It also offers industry links and more detailed information about staff and Association membership.

Partnerships

VAHP collaborates with other health organizations to foster progressive partnerships which will help accomplish our mission. We pursue constructive dialogue and joint efforts with medical societies, health associations, employer groups, and state regulatory agencies to promote comprehensive and fair discussion of current health policy issues.

VAHP contributes to charitable causes that demonstrate the commitment of the Association to the community through its Charitable Fund. One ongoing example of a partnership in action is the joint sponsorship of scholarships for minority medical students. VAHP co-sponsors these scholarships with the Old Dominion Medical Society and the Virginia Health Care Foundation.
Our Membership

Full Members

Every managed care health insurance plan licensee in Virginia is asked to join the association as a full voting member.

Associate Members

Plans pursuing licensure in Virginia can join as associate members. Associate members enjoy all the benefits of full membership except for committee and executive voting privileges, which are activated upon licensure.

Corporate Affiliate Members

Because many types of organizations are interested in promoting market acceptance and consumer support for managed health insurance plans, the Association also offers non-voting levels of membership to other types of organizations interested in health issues. These affiliate members support the philosophy and goals of the Association and want to benefit from the activities and programs developed to further the Association's mission.

Corporate affiliate members may be managed care entities, provider organizations, large and small businesses, pharmaceutical companies, medical groups, health care information management firms, or other entities involved in the health care system.

1998 VAHP Members

Blue Cross & Blue Shield of the National Capital Area
CIGNA Corporation, Inc.
John Deere Health Care/Heritage National Health Plan
George Washington University Health Plan, Inc.
INOVA Health System
Kaiser Foundation Health Plan of the Mid-Atlantic
Mid-Atlantic Medical Services, Inc. (MAMSI)
NYLCare Health Plans of the Mid-Atlantic, Inc.
PARTNERS National Health Plans of North Carolina, Inc.
QualChoice of Virginia Health Plan, Inc.
Sentara Health System
Trigon Blue Cross Blue Shield
United HealthCare of Virginia
Virginia Chartered Health Plan, Inc.
VAHP 1998-99 Officers/Executive Committee

Chairman of the Board - Michael M. Dudley, Sentara Health Management
President - Greg Bowman, CIGNA HealthCare Corp.
Vice President - Thomas P. Barbera, MAMSI
Secretary - Kathleen McNalty, Kaiser Foundation Health Plan of the Mid-Atlantic
Treasurer - Thomas B. Jones, John Deere Health Care/Heritage National Health Plan
At-Large - Ellen C. Harrison, Trigon Blue Cross Blue Shield
At-Large - Gail M. Thompson, Blue Cross Blue Shield of the National Capital Area

Staff

Executive Director - Mark C. Pratt, MBA
Director of Policy - Lynn M. Warren, RN, MPH
Executive Assistant - Melissa Throckmorton

For More Information

Phone: 804-648-8466
Fax: 804-648-8036
E-Mail: vahp@pipeline.com
Website: www.vahp.org
Mission Statement

We advocate for and improve home care in Virginia.

The Virginia Association for Home Care is a 501(c)(6) not-for-profit organization chartered in 1983. The Association has a separate Foundation, a 501(c)(3) that provides educational support for the members. An eighteen member Board of Directors establishes policy for the association. Standing committees include the Executive Committee, Legislative Committee, Finance Committee, Quality Assurance and Improvement Committee, Membership Committee, and Nominating Committee. The Association also sponsors two caucuses, the Proprietary Caucus and the Institutional-Based Caucus.

The philosophy of the Virginia Association for Home Care (VAHC) is unity of purpose with regard to the promotion and delivery of quality home care in the Commonwealth. Furthermore, VAHC believes that home care is the best possible way to care for people who are sick and disabled and to promote wellness and independence in matters related to health care.

In representing the home care industry in Virginia, the Association’s goals are to increase and maintain a unified membership representing the full spectrum of provider services, strengthen the image and value of home care, represent effectively the needs and requirements of home care in the legislative and regulatory processes, promote member ownership and involvement in VAHC, and strengthen the image and value of VAHC.

VAHC supports state legislative efforts to increase Medicaid reimbursement for Personal Care services, an essential means of helping Virginians who need assistance to remain at home and are otherwise at risk of nursing home placement. Medicaid reimbursement for this service has not kept pace with the cost of proving the care. A recent study ordered by the General Assembly resulted in an audit of thirty providers, each of whose costs exceeded Medicaid reimbursement.

VAHC represents more than 200 home care organizations, or provider members, and associate members that provide goods and supportive services to home care organizations. VAHC has members from the full spectrum of home care including home health, private duty, personal care (including Medicaid-waivered services), infusion therapy, home medical equipment, and hospice.
Home health care organizations are heavily regulated and monitored by a number of entities, some required and others voluntary. State licensure is required by the Code of Virginia except for entities that are exempted because they are 1) certified by Medicare; 2) accredited by the Joint Commission on Accreditation for Healthcare Organizations or the National League of Nursing’s Community Health Accreditation program; or 3) providing services under Title XIX, including Medicaid-waivered services. Staff from the Health Care Financing Administration, the Virginia Department of Health, the Virginia Department of Medical Assistance Services, and other entities provide regular inspections, and the providers are also subject to rules of the Occupational Safety and Health Administration, the Ombudsman Program, Adult Protective Services, and the Fair Labor and Standards Administration. In recent years, providers have been required to obtain a criminal records check on all employees at the time of hiring. Providers must also ensure the training and competency of all staff who are responsible for patient care.

To assist its members in ensuring the highest quality of care, VAHC has adopted a Code of Ethics for providers of home care services. Additionally, the Association has produced a pamphlet with Virginia-specific information, entitled “How to Choose a Home Care Agency.” This material is available both to the VAHC membership and to the public.

In serving its members, VAHC is a member of the Prospective Payment System Work Group, the National Association for Home Care, the Home Health Services and Staffing Association, the National Association of Medical Equipment Services, the Society for Ambulatory Care Professionals, the National Hospice Organization, and the Health Industry Distributors Association.

The Association has had a full-time Executive Director since 1991.

Currently it has four staff members: the Executive Director, a Director of Regulatory Affairs, an Administrative Director/Meeting Planner, and an Office Assistant.

For more information, call (800) 755-8636 or (804) 285-8636, or write to:

Virginia Association for Home Care
5407 Patterson Avenue, Suite 200-B
Richmond, VA 23226
Virginia Association of Nonprofit Homes for the Aging
(as of November 1, 1998)
Sandra Levin, President
Website: Vanha.org
E-mail: Vanha@erols.com
Phone: 804-965-5500
Fax: 804-965-9089

Overview

The Virginia Association of Nonprofit Homes for the Aging (VANHA) is a statewide association that represents the interests of not-for-profit continuing care retirement communities, nursing facilities, adult care residences, and retirement housing. VANHA advocates for and educates its members through ongoing development of an effective association.

History

VANHA was founded in 1973 by a group of nursing home administrators who believed that nonprofit homes were unique in their needs and they wanted their own organization to help assure that these needs were met. As nonprofit organizations, their primary goal is to provide the highest quality of care for residents in the most cost effective manner.

Joint Membership

VANHA is affiliated with the American Association of Homes and Services for the Aging (AAHSA) through a joint membership agreement. AAHSA represents over 5,000 facilities nationwide.

Current Membership

VANHA represents almost 100 nonprofit facilities with over 100 businesses, community service providers, and individuals in fields related to caring for the elderly.

Benefits for Membership

- Opportunity for information sharing with other members
• Informative publications, including a monthly newsletter, weekly legislative reports during the General Assembly session, and an annual VANHA Voice

• Networks for Activity Directors, Development Directors, Food Service Directors, Directors of Human Resources, Marketing Directors, Directors of Nursing Social Workers, and Volunteer Directors

Council meetings that focus on specific issues for: Nursing Homes, Continuing Care Retirement Communities, Adult Care Residences and Retirement Housing

VANHA Education

VANHA offers its members a wide variety of educational seminars with topics ranging from care of Alzheimer’s patients, marketing strategies and exploring new ideas in the health care industry like the "Eden Alternative." In the last year, VANHA provided 68 continuing education credits for Nursing Home Administrators, Food Service Directors, Activity Directors, and CPAs. VANHA brought nationally respected speakers to the Virginia area. Members enjoy a reduced rate for VANHA sponsored programs.

VANHA Legislation

Representing the Commonwealth of Virginia’s nonprofit homes at state and national levels for the last 25 years, VANHA has brought about changes in state legislature to include the signing of HB 2870, the "Return to Home" legislation, in 1997. During the General Assembly, VANHA members receive up-to-the-minute reports on legislative issues. This allows VANHA members not only to follow legislation but to become engaged in the process.

VANHA Shared Services

VANHA’s Group Purchasing and Services Program provides members the opportunity to save substantially on all types of purchasing decisions. Preferred Vendors offer a wide array of products and services. Through use of this program, members realize a cost savings for their facilities, lowering the bottom line. VANHA receives an administrative fee from the Preferred Vendors which helps to keep annual dues from increasing, benefiting all involved.
Every year a small number of babies are born with serious birth-related neurological injuries.

Virginia has a program to help parents take care of these babies for life.

The program covers what insurance and other programs do not -- necessary medical expenses, hospital expenses, rehabilitation expenses, residential and custodial care and service expenses, special equipment or facilities expenses, and related travel expenses for eligible babies -- through infancy, through childhood, through adulthood, for a lifetime, it pays compensation for lost earnings between ages 18 and 65, reimburses costs of filing a claim, including reasonable attorneys’ fees, works quickly, privately, confidentially. It's an exclusive remedy and it's no-fault. We hope your family never needs this program. But we also hope you'll find it reassuring to know that, if you ever should, it's there.

The Virginia Birth-Related Neurological Injury Compensation Fund is an example of a private-public partnership endeavor that is working. Known as the Birth Injury Fund, the Program provides a wide range of benefits to a child who is in need of permanent assistance in all activities of daily living, and who has sustained a brain or spinal cord injury caused by oxygen deprivation or mechanical injury during labor, delivery, or in the immediate post-delivery period in a hospital which renders the child permanently (1) motorically disabled, and (2) developmentally disabled or cognitively disabled.

The First Injury Fund was initiated for two principal reasons: (1) to provide benefits to eligible children over their lifetime without having to resort to the tort law system for recovery and (2) to insure that the medical community would be able to continue to provide obstetric services within the Commonwealth.

The benefits of the Birth Injury Fund are limited to “medically necessary and reasonable expenses” of medical and hospital, rehabilitative, residential and custodial care and service, special equipment and facilities. The Birth Injury Fund is a payer of last resort; that is, the Fund pays after available insurance or governmental programs have paid. A unique feature of the Program provides
for payments as “loss of earnings” to the child when he or she reaches the age of eighteen years based upon a formula set by law.

The Birth Injury Fund is financed by assessments, in varying amounts, upon hospitals that have obstetric units, licensed physicians who practice obstetrics or perform obstetrical services, including licensed nurse-midwives, all other licensed physicians, and the insurance industry within the Commonwealth.

A seven member Board of Directors manages the Fund, and they employ an Executive Director. They are assisted by a number of professionals to provide eligible children with medically necessary services. The Board meets regularly, and all meetings are open to the public.

Claims for compensation under the Fund are made to and awarded by the Virginia Workers’ Compensation Commission. Once a claim has been awarded, the Program will communicate with the parents or caregivers of the child. A home visit will be made to determine the needs of the child and the family.

Counseling can be provided, initially and ongoing, and the Board strongly urges members of the family to avail themselves to this benefit. If the situation warrants, individual counseling will be considered.

The Program at A Glance

Repays Necessary

- Medical expenses
- Hospital expenses
- Rehabilitation expenses
- Residential and custodial care and service expenses
- Compensation for lost earnings, ages 18 to 65
- Special equipment or facilities expenses
- Reasonable claim-filing expenses
- Reasonable attorneys' fees
- Related travel expenses
- For all awarded claims

Does Not Repay

- Expenses covered by other government programs
- Expenses covered by prepaid health plans or HMOs
- Expenses covered by private insurance
- Maternal substance abuse
Eligibility

- Babies delivered by a participating doctor
- And/or at a participating hospital
- With serious birth-related neurological injury, as defined by Virginia law

Procedure

- Quick
- Private
- Confidential
- Exclusive remedy
- No-fault

For More Information

Elinor J. Pyles, R.N.
Executive Director
Virginia Birth-Related Neurological Injury Compensation Program
7400 Beaufont Springs Drive, Suite 425
Richmond, Virginia 23225
1-800-260-5352

Additional Information

Virginia law, §38-2-5001 et. seq., defines a birth-related neurological injury as:

- an injury to the brain or spinal cord of an infant caused by the deprivation of oxygen or mechanical injury,
- occurring in the course of labor, delivery or the immediate post-delivery period,
- in a hospital,
- which renders the infant permanently motorically disabled and
  (i) developmentally disabled or
  (ii) for infants sufficiently developed to be cognitively evaluated, cognitively disabled

In order to constitute a “birth-related neurological injury”, such disability shall cause the infant to be permanently in need of assistance in all activities of daily living.
Virginia College of Emergency Physicians
(as of November 1, 1998)
Gwen E. Messler Harry, Executive Director
Phone: (757) 220-4911
Fax: (757) 258-3042
E-mail: vacep@erols.com

Virginia College of Emergency Physicians (VACEP) is the medical specialty society for physicians who practice Emergency Medicine. We are not a trade association. We are in the process of updating our mission statement. Briefly, we seek to promote and protect the interests of emergency physicians and the patients they serve. We currently have 430 members. Our 16 member Board meets quarterly. We have the usual committees all medical associations have. Melanie Gerheart is our lobbyist. Anyone with an issue that they feel directly or indirectly impacts emergency medical care is welcome to contact the Executive Director.
Virginia Chapter of the American Academy of Pediatrics and The Virginia Pediatric Society
(as of November 1, 1998)
9291 Laurel Grove Road, Suite 10
Mechanicsville, Virginia 23116
Phone: (804) 730-6851
Fax: (804) 730-6853
E-mail: vapedsoc@erols.com
Website: http://www.virginiapediatrics.org

Vision

To be the leading authority, advocate and voice for the health of Virginia’s children and for
the profession of pediatrics.

Mission

The mission of the Virginia Chapter, American Academy of Pediatrics and The Virginia
Pediatric Society is the attainment of optimal health, safety and well-being of Virginia’s children and
promotion of pediatricians as the best qualified of all health professionals to provide child health
care.

NOTE: Use of the term “children” refers to infants, children,
adolescents, and young adults; use of the term “pediatrician” refers to
the primary care pediatrician, pediatric medical subspecialist, and
pediatric surgical specialist.

Membership

The association is comprised of over 900 pediatricians and allied health professionals in
private practice, academia and public health.

Structure

The association is governed by a 16-member Executive Committee and programs are carried
out by the following committees:

| ADOLESCENCE | HEMATOLOGY/ONCOLOGY |
| BREASTFEEDING COORDINATORS | HOSPITAL CARE |
| CATCH COORDINATOR | IMMUNIZATIONS AND INFECTIOUS DISEASES |
| CHILD ABUSE & DEPENDENT CARE | MEMBERSHIP |
| CHILD HEALTH FINANCING | PROS COORDINATOR |
| CHILDREN WITH DISABILITIES | PUBLIC RELATIONS |
Mission Statement

The Virginia Dental Association:

Representing and Serving Member Dentists By Fostering Quality Oral Health Care and Education.

Goals

To improve and expand membership services.

To promote the policy of the Association through proactive legislative and regulatory advocacy on behalf of the public and the members of the Association.

To increase membership recruitment and retention.

To enhance membership communications.

To increase access to quality oral health care.
The Virginia Health Care Association ("VHCA") is a statewide, voluntary, not-for-profit association of long-term care providers. VHCA is comprised of licensed nursing facilities, adult care residences, continuing care retirement communities, individual professionals and students, and the suppliers of products and services that support the goal of dedicated service to the elderly and disabled in Virginia.

Advocacy

VHCA provides for its members legislative and regulatory advocacy, accredited quality education, an annual convention and trade show, and a full array of communications services. In addition, the VHCA strives to aid the general public in understanding the different levels of long-term care and the unique benefits and services provided by each.

As an advocacy group for the long-term care industry and its residents, VHCA concentrates on assuring the delivery of quality care, reasonable government regulations and adequate Medicaid and Medicare funding for long-term care. In addition, VHCA actively promotes the development of a stable alternative private source for the funding of long-term care, such as long-term care insurance.

Education

Educational programs provided by VHCA are another valuable service to our members. Nursing Home Administrators are required by state law to renew their licenses each year with a minimum of 20 hours of continuing education through sponsors approved by the Virginia Board of Nursing Home Administrators or the National Association of Boards of Examiners of Nursing Home Administrators. VHCA also provides educational opportunities for other long-term care staff through workshops and conferences specifically designed to bring up-to-date information on best standards of practice and regulatory changes to nurses, social workers, activity professionals, reimbursement specialists, human resources personnel, dietary managers, and rehabilitation personnel.
Networking

VHCA’s annual convention and trade show offers members not only an opportunity for educational seminars, but also an opportunity to preview a wide array of new products and services that are available and which contribute to the delivery of quality care for their residents. In addition, it offers an excellent opportunity for members to network with other professionals in the field.

Public Policy

VHCA’s management demonstrates leadership by identifying and communicating good practice models in the field and representing industry interests by shaping public policy aimed at optimum care and quality of life. The VHCA’s efforts are spurred by a commitment to stability, self regulation, and public confidence. VHCA encourages an exchange of information that benefits both those within the industry and the public by working closely with advocacy groups, regulatory agencies, and other health care organizations on long-term care issues, especially quality of care, quality of life, and funding. Medicaid funding is a particularly important issue in this industry.

Medicaid and Medicare

Approximately two out of three Virginia nursing facility patients depend on Medicaid to fund their care. It is a common misconception among the American public that Medicare will take care of their long-term care needs when they become elderly. Unfortunately, a majority of the elderly and disabled who need nursing facility care find that they must “spend down” their assets and apply for Medicaid. These elderly Medicaid patients typically are people who have simply “outlived” their savings.

Because of budget concerns at both the federal and the state level, Medicaid funding has come under great scrutiny and pressure. At the federal level, the current goal is to severely constrain the growth of Medicaid funding. The Commonwealth of Virginia is recognized for having operated a very efficient, low-cost Medicaid program, as compared to other states, and is constantly looking for ways to slow the growth of Medicaid funding. In fact, Virginia is among the lowest states in spending on Medicaid for long term care.

Regulatory Issues

Congress has recently made, and is further considering, many changes to the Medicare program to control its spending growth. Needless to say, VHCA is carefully monitoring and participating in the Congressional debate as decisions are being made about the future of Medicaid and Medicare and any resulting reform legislation that could affect the federal regulations under which nursing homes are regulated. Proposed changes to these two programs could result in unprecedented changes for the elderly, the disabled, and those providers of their care.
Other legislative and regulatory issues facing the long-term care industry include state revisions to the nursing facility Medicaid reimbursement payment system, consolidation of state agencies providing services to the aged and disabled, and state certificate of need laws and regulations. Nursing homes are among the most heavily regulated industries, being monitored by multiple state and federal regulatory agencies, such as the Departments of Medical Assistance Services, Social Services, Health, Labor, Aging, as well as the Ombudsman Program and Health Care Financing Administration. The list of rules and regulations requiring compliance range from licensing inspections and surveys for Medicaid and Medicare, and life safety surveys by fire officials, to OSHA inspections and abuse and neglect investigations by Adult Protective Service workers. Surveys of nursing homes are conducted at least annually by the Virginia Department of Health to ensure that standards for quality of life, quality of care, and facility practices are met.

**Assisted Living**

VHCA has also been a major stakeholder in the evolving assisted-living industry in developing standards for Adult Care Residences, which are licensed and regulated by the Department of Social Services. This emerging part of the long-term care system offers care and services to an increasingly older and frail population who want to remain in these settings as they “age in place”. VHCA’s advocacy role in all of these areas requires frequent interaction with the regulatory agencies.

Changes that are foreseen for the long-term care field include an increasing number of residents in nursing facilities other than the traditional elderly, chronically ill or disabled individual. A growing number of far younger residents are benefiting from nursing home care. The 20-year-old accident victim with traumatic brain injury, the 48-year-old stroke or heart attack victim, and the post surgical rehabilitation patient are treated in nursing facilities as effectively as the elderly. Insurers no longer allow extended hospital stays to ensure optimum recovery and rehabilitation. Many short-term residents, young and old alike, receive the necessary health care, 24-hour per day nursing supervision, and rehabilitation services at a nursing facility at a fraction of hospital costs. This expanding environment will permit nursing facilities to link readily with other community health providers as part of an integrated health care system.

**Staff**

VHCA’s nine member staff is divided into two groups: an advocacy group and a member services group. The advocacy staff lobbies Virginia’s Congressional Delegation and the Virginia General Assembly and works with state and federal agencies in the development of proposed legislation and regulations. The member services staff concentrates on education, membership development, and numerous services to the industry. The offices are located at 2112 W. Laburnum Avenue, Suite 206, Richmond, Virginia 23227. The telephone number is (804) 353-9101 and the fax number is (804)353-3098. The Association’s web page may be accessed at www.vhca.org.
The Virginia Hospital & Healthcare Association (VHHA) was created in 1926 as a trade association of Virginia hospitals. It was called the Virginia Hospital Association until 1995, when members voted to change the name to reflect its changing membership, which now includes not only rural and urban acute care and specialty hospitals, but also integrated health care delivery systems and their long-term care facilities and services, ambulatory care sites, home health services, insurance subsidiaries and other health system-related entities.

The VHHA's mission is "to help its members as they strive to improve the health status of communities they serve by offering comprehensive, accessible, quality, cost-effective health services...." Its activities in this endeavor focus on representation and advocacy, education, communication and health care data, as summarized below.

**Representation and Advocacy**

- Develop overall goals for state health policies and promote initiatives to help achieve these goals.
- Work with state and federal legislative, regulatory and policy-setting entities on issues affecting the delivery, quality, accessibility, and cost-effectiveness of health care.

**Education**

- Educate members about changes in health care delivery and regulation.
- Help members evolve into effective health delivery systems.

**Communication**

- Communicate with media representatives and the public about important health care issues in which hospitals and health systems are involved.
- Form partnerships and coalitions with other community and business groups to achieve common goals.
Data

- Act as a data resource for members, policy-makers, state and national organizations and agencies, and purchaser groups.

- Work to define and measure quality standards in health care.

Key VHHA Staff

<table>
<thead>
<tr>
<th>Position</th>
<th>Name</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>President</td>
<td>Laurens Sartoris</td>
<td>(804) 965-1216</td>
</tr>
<tr>
<td>Senior Vice President</td>
<td>Christopher Bailey</td>
<td>(804) 965-1207</td>
</tr>
<tr>
<td>Senior Vice President</td>
<td>Katharine Webb</td>
<td>(804) 965-1215</td>
</tr>
<tr>
<td>Vice President</td>
<td>Susan Ward</td>
<td>(804) 965-1249</td>
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<tr>
<td>Vice President</td>
<td>Catherine Hammond</td>
<td>(804) 965-1213</td>
</tr>
<tr>
<td>Director of Policy</td>
<td>Vacant</td>
<td>(804) 965-1221</td>
</tr>
</tbody>
</table>

The e-mail address for each staff person is his first initial and last name @vhha.com.
The Virginia Medical Group Management Association (VMGMA) is a professional association of medical practice managers and administrators. Founded in 1974, VMGMA has grown to more than 240 members from all sections of the Commonwealth. VMGMA has formal affiliations with the national Medical Group Management Association, the oldest and largest medical practice management, and the Medical Society of Virginia, the largest physician organization in the Commonwealth.

VMGMA’s mission is to advance medical practice management in order to improve the delivery of healthcare. Educational conferences are held twice a year at rotating sites across Virginia, providing informative sessions and networking opportunities. VMGMA also provides a quarterly newsletter for its membership.

VMGMA is active from an advocacy perspective, working with the Medical Society of Virginia in the legislative arena on behalf of the patients and medical practices of Virginia. Recent areas of focus include fair business practices, patient protection, and the medical malpractice cap.

VMGMA membership is open to medical practice managers and to persons interested in this field. Its diverse membership includes managers of practices ranging in size from one physician to one hundred physicians, healthcare attorneys, practice consultants, and vendors with an interest in medical practices.

**VMGMA 1998-99 Board of Directors**
President - Cindy C. Soueidan, MBA, CMPE
President Elect - Cheryl C. Ange, FACMPE
Vice President - Lucien W. Roberts, III, MHA, CMPE
Secretary - Glenda Q. Hampton
Treasurer - Robin E. Moore, MSA
Past President - James M. Palazzo, MHA, CMPE
At-Large - Judy S. Berryman
At-Large - Leslie Stasio
At-Large - Ronald R. Eagle, MBA, CMPE
Virginia Optometric Association, Inc.
(as of November 1, 1998)
Bruce B. Keeney, Sr., Executive Director
Virginia Optometric Association, Inc.
118 North Eighth Street
Richmond, VA 23219
Phone: 804-643-0309
Fax: 804-643-0311

Organization

The Virginia Optometric Association (VOA) is Virginia's only statewide professional membership organization representing the Commonwealth's actively practicing doctors of optometry. Founded in 1912 and incorporated in 1918, the VOA presently represents over 80% of all actively practicing optometrists in Virginia.

The VOA has ten local optometric societies (representing geographic regions) which are affiliated with the state professional society. The VOA is also affiliated with the Southern Council of Optometrists (Atlanta, GA) and the American Optometric Association (St. Louis, MO).

Membership

Active membership in the VOA requires the doctor of optometry to be engaged in active clinical practice in Virginia. Associate membership is restricted to those Virginia licensed optometrists whose principal practice is in a neighboring state but who also maintain a practice in Virginia. Student members are those persons enrolled in an accredited school or college of optometry. Associate Retire members are those Virginia licensed optometrists no longer actively practicing.

Active members must maintain membership in their VOA affiliated local optometric society, the VOA, the Southern Council of Optometrists and the American Optometric Association.

Mission

The objects of the VOA are to assist in improving the vision care and general health care of the public and to promote the art and science of the profession of optometry; to promote the welfare of VOA members; to support the laws and regulations of Virginia governing the profession; to assist the Virginia Board of Optometry in the proper discharge of their duties; to advance the theory and practice of the profession and to improve the delivery of quality vision care services; to coordinate national, regional, state and local activities within the profession; to encourage the development and innovations in health care delivery systems; and to promote conduct by Virginia doctors of optometry in their practices which exhibit the highest standards and competency and integrity.
Association Activities

In addition to normal activities provided by a state professional membership association, the VOA is the major sponsor of continuing education programs for Virginia optometrists. The VOA publishes an award-winning newsletter, is extremely active in the legislative process, and provides assistance to members as they face changes in the third-party health care reimbursement system, including managed care. The VOA maintains a subsidiary organization, Virginia Eyesite, which provides a statewide network of vision care specialists to market eye and vision care services to third party insurance carriers, HMOs, PPOs and self funded businesses.

Resource Services For Attorneys

Attorneys often contact the VOA as a resource in the attorney's representation of an optometrist. Examples of resource information are: establishing values related to the sale or purchase of a practice; employment, associate or partnership agreements; disciplinary proceedings by the Virginia Board of Optometry; corporate practice prohibitions; sales and use tax exemptions; discrimination against an optometrist seeking to participate in a third-party health insurance plan; arranging for expert witnesses; and professional conduct issues.

Optometry - The Primary Vision Care Provider

Upon completing their undergraduate education, the optometrists must successfully complete a four year doctoral degree program at an accredited school or college of optometry (earning the O.D. or doctor of optometry degree). To obtain a license to practice in Virginia, the doctor of optometry must successfully complete all portions of the national boards and a jurisprudence section of the Virginia Board of Optometry. Applicants for licensure must meet educational and clinical training requirements for certification in diagnostic pharmaceutical agents. Further, separate examination and certification by the Virginia Board of Optometry is then required for the optometrist to administer and prescribe pharmaceutical agents to treat abnormal conditions and diseases of the human eye and vision system.

Doctors of optometry serve approximately 70% of the nation's population. The optometrist examines and evaluates the human vision system to ascertain refractive error and, when necessary, prescribes and dispenses eyeglasses and contact lenses. The comprehensive eye health examination evaluates and diagnoses the presence of any disease or abnormalities such as cataracts, glaucoma, macular degeneration, foreign body, detached retina, visual dysfunction, etc. The optometrist also administers and prescribes medications to treat eye diseases such as pink eye, conjunctivitis, corneal abrasions, infections, glaucoma, and removes foreign bodies from the eye. When medically appropriate, the optometrist will refer patients to specialists for surgical treatment of certain conditions. Often the optometrist will provide the pre-surgical evaluation and render post-operative care for conditions such as cataracts.
Optometrists possess far greater specialized clinical training in the diagnosis and non-surgical treatment of eye disease. With their extensive training of the human eye and vision system, doctors of optometry are recognized as the primary vision care provider.

For Information Contact:

Virginia Optometric Association, Inc.
118 North Eighth Street
Richmond, VA 23219
office: 804/643-0309
call: 804/643-0311
The Virginia Organization of Nurse Executives (VONE) established in 1974 to give nursing administrators an opportunity for closer interaction with their peers. The group was formed with 12 members representing all areas of Virginia. Membership grew as more nurse executives found that this organization met their unique interests, problems, and needs. In 1976, the Virginia group became the ninth chapter admitted to the American Society of Nursing Service Administrators. The VONE was incorporated October 31, 1983 as the Virginia Society for Nursing Service Administrators, Inc. The name was changed to the Virginia Organization of Nurse Executives on December 12, 1985. In 1995, the VONE merged with the Virginia Council of Nurse Managers. The VONE is closely aligned with the American Organization of Nurse Executives.

The purpose of the VONE is to advance the development of effective administration and management of the nursing practice in health care institutions and agencies in Virginia by:

1. Providing a medium for the interchange of ideas and dissemination of information and materials relative to nurse executives/managers.

2. Providing a platform within the healthcare field from which nurse executives/managers may speak on nursing and health care issues.

3. Identifying and defining health care issues that affect nursing and establishing position statements on these issues.

4. Promoting educational programs and activities to strengthen nursing executive/manager practice.

5. Providing consultation for nursing education programs.

6. Influencing legislative and public policy pertaining to nursing and health care issues.

Full membership is awarded to RN’s holding an organizational role of administration/management who are accountable for strategic, operational, and performance outcomes, as well as designing, facilitating and managing care in sites where health care is delivered;
faculty in graduate nursing administration programs, including deans and directors; and consultants in the nursing administration/management practice. Associate Members are RN’s whose role supports the purpose and objectives of VONE, including nurses employed by the JCAHO; editors of professional nursing journals; retired VONE members; and students enrolled in a relevant degree program with a career path in nursing administration/management.

The VONE meets three times a year to include the Legislative Meeting, Spring Conference, and Annual (Fall) Meeting. Two Sara Tatem Scholarships, in honor of one of the founding members, are awarded annually to VONE members pursuing postgraduate education in administrative fields.
The Virginia Pharmacists Association
(as of November 1, 1998)
Rebecca P. Snead, R.Ph.,
Executive Director
5501 Patterson Avenue, Suite 200
Richmond, Virginia 23230
Phone: (804)285-4145
Fax: (804)285-4227
E-mail: vphanow@erols.com
Website: http://pharmacy.su.edu/vpha

The Virginia Pharmacists Association founded in 1881, is the professional association representing the pharmacists of Virginia. Its 1700 members represent pharmacists in metropolitan and rural areas across the Commonwealth practicing in community pharmacies, hospital pharmacies, mail-order pharmacies, industry and education.

The purpose of the Association is to assure the viability and vitality of the profession of pharmacy by maximizing its contribution to patient care, promoting the competency of its practitioners, and increasing an awareness of these contributions and capabilities and their value.

Monthly Publication:

The Virginia Pharmacists

Annual Publication:

Virginia Pharmacy Directory

For more information:

5501 Patterson Avenue, Suite 200
Richmond, Virginia 23230
Phone: (804)285-4145
Fax: (804)285-4227
E-mail: vphanow@erols.com
Web site: http://pharmacy.su.edu/vpha
Mission Statement

The mission of the VSHP is to represent its members and to provide leadership that will enable pharmacists in organized health-care settings (1) to provide high quality pharmaceutical care that fosters the efficacy, safety, and cost-effectiveness of drug use; (2) to contribute to programs and services that emphasize the health needs of the public and the prevention of disease; and (3) to promote pharmacy as an essential component of the health-care team. VSHP endeavors to create an environment in which pharmacists are expected to focus the full potential of their knowledge and expertise on patient care.

In support of the mission statement, VSHP has established the following goals:

1. To advance rational patient-oriented drug therapy.

2. To promote pharmacists as integral members of the health-care team in order to allow full utilization of their clinical and drug-use control functions that would be beneficial in each health-care setting.

3. To serve as a primary advocate for advancing professional practice, increasing the cost-effectiveness of pharmaceutical care, and improving the quality of patient care.

4. To advocate the pharmacist's value to patients in ensuring that appropriate clinical services and drug-use control processes are applied to their benefit.

5. To foster the optimal and responsible use of drugs, including prevention of improper or uncontrolled use of drugs.

6. To assure sufficient, competent manpower in the profession by offering continuing education and training programs.
7. To provide leadership in the identification, analysis, and evaluation of pharmacy trends and in the development of policy statements, and to address legislative and regulatory initiatives of concern to pharmacy.

8. To facilitate information exchange between the members, health-care professions, and consumers.

9. To maintain lines of communication between the organization and its membership so that needs are accurately represented and to provide a full complement of services and products of the membership.

Goals and Objectives

1. Establish proactive stances on issues affecting the profession at the state level in order to develop a system to provide timely responses to public professional concerns and inquiries.

2. Remove barriers to the use of technical support in the safe and efficient distribution of medications in organized health-care organizations.

3. Support increased and standardized education of pharmacy technicians to meet current and future responsibilities.

4. Expand public information activities (designed to communicate the positions and actions of the VSHP) to members, health-care practitioners, policy makers, and consumers.

5. Provide timely and accessible continuing education that addresses the needs and interests of the members.

6. Assure that professional service and dedications to safe/effective drug use are afforded high visibility to persons considering pharmacy as a career path.

7. Provide the VSHP membership with a unified voice on professional practice issues which are the subject of legislative/regulatory actions.

8. Build effective liaisons and associations which will allow VSHP to access to input into the decision making process for pertinent legislative and regulatory actions.

9. Provide opportunities for VSHP members to "network" ideas related to pharmacy practice issues.

10. Perpetuate high quality membership service and representation through effective leadership promotion within VSHP.
11. Accurately represent and advance the interest of the membership.

12. Determine and develop guidelines to maximize VSHP investment income and determine acceptable levels of risk.

13. Maintain a reserve fund for contingency purposes.

**Constitution**

**Article I. Name, Objectives, and Definitions**

(a) This organization shall be known as the “Virginia Society of Health-System Pharmacists,” hereinafter referred to as the State Society.

(b) Objectives

The objectives of the State Society shall be:

(1) To advance public health by promoting the professional interests of pharmacists practicing in health systems through:

   a. Fostering pharmaceutical services aimed at drug-use control and rational therapy.

   b. Developing professional standards for pharmaceutical services.

   c. Fostering an adequate supply of well-trained competent pharmacists and associated personnel.

   d. Developing and conducting programs for maintaining and improving the competence of pharmacists and associated personnel.

   e. Disseminating information about pharmaceutical services and rational drug use.

   f. Improving communication among pharmacists, other members of the health-care industry, and the public.

   g. Promoting research in the health and pharmaceutical sciences and in pharmaceutical services.

   h. Promoting the economic welfare of pharmacists and associated personnel.
(2) To foster rational drug use in society such as through advocating appropriate public policies toward that end.

(3) To pursue any other lawful activities that may be authorized by the Board of Directors.

Article II. Membership

The membership of the State Society shall consist of active, associate, and honorary members as provided in the Bylaws. Active members shall be licensed pharmacists who have paid dues as established by the State Society and support the purposes of the Virginia Society of Health-System Pharmacists as stated in Article I of the Constitution. Other Requirements for active membership shall be stated in the Bylaws.

Article III. Officers

The officers of the State Society shall be a President, an Immediate Past President, a President-Elect, a Secretary, and a Treasurer. The President-Elect shall be elected annually for a term of one year and shall ascend successfully to the office of President and Past President, serving one year in each position. The Secretary and the Treasurer shall be elected on alternate years for two-year terms of office.

Article IV. Affiliated Regional Chapters

There shall be geographic regions with each region having a chapter and officers as defined in the Bylaws.

Article V. Affiliated Student Chapter

There shall be an affiliated student chapter or chapters as defined in the Bylaws.

Article VI. Board of Directors

There shall be a Board of Directors of the State Society consisting of Officers, Regional Vice-Presidents, and Ex-Officio members as provided in the Bylaws.

Article VII. Amendments

Every proposition to alter or amend this Constitution shall be submitted in writing by two or more voting members at any Board of Directors business meeting and shall be approved by a majority of votes cast. A copy shall be submitted to the American Society of Hospital Pharmacists before it is submitted to the active membership for vote by mail ballot, in the same manner as in the balloting for officers as provided in the Bylaws, and shall be sent out as part of the ballot for officers.
Current Board of Directors

Janet A. Silvester, VSHP President
Martha Jefferson Hospital Pharmacy
459 Locust Avenue
Charlottesville, VA 22902
Work: 804-982-7055
Home: 804-973-7094
FAX: 804-982-7060
E-Mail: jasilvester@mjh.org

Thomas E. Hughes, VSHP President-Elect
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FAX: 804-982-1682
E-Mail: teh2j@virginia.edu

Gill B. Abernathy, VSHP Past President
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Home: 703-824-8186
FAX: 701-698-3015
E-Mail: aberngi@erols.com

Bobby J. Ison, VSHP Secretary
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FAX: 757-482-6125
E-Mail: bison@exis.net

Michael M. Hayter, VSHP Treasurer
Johnston Memorial Hospital Pharmacy
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Abingdon, VA 24210
Work: 540-676-7102
Home: 540-944-4509
FAX: 540-676-7241
E-Mail: mhayter@naxs.com
Virginia Society of Radiologic Technologists  
(as of November 1, 1998)  
Lloyd E. Bittinger, Executive Secretary  
P.O. Box 547  
Alexandria, Virginia 22313-0547  
(800) 929-8778  
(800) 929-8778 (press * for fax)

The Virginia Society of Radiologic Technologists was formed in 1948. Active membership is open to individuals who are certified by the American Registry of Radiologic Technologists, the Registry of Diagnostic Medical Sonographers, or the Nuclear Medicine Technology Certification Board. There are also student and associate member categories. The primary purposes of the organization are to advance the science of radiologic technology to support high standards of education, to elevate the quality of care, and to improve the welfare of technologists.

Current Officers are:

Jane O. Carpenter, R.T. (R)  
Chair of the Board of Directors  
804-295-3872

Ferrell Justice, B.S., R.T.(R)  
Chair-Elect Board of Directors  
804-329-7417

Kevin Murray, R.T.(R)  
President

Angie Dopkowski, R.T. (R), (CT)  
President-Elect

David Gilmore, R.T.(R), (CT)  
Vice-President

Lora Bryant Gilmore, R.T.(R) (CT)  
Recording Secretary

Radiologic technologists is a general term applied to individuals who are qualified to use x-rays (radiographers) or radioactive substances (nuclear medicine technologists) to produce images of internal body parts for interpretation by a physician. It also applies to those who use x-rays or
radioactive substances in the treatment of disease (radiation therapists) and those who use sound waves for imaging (sonographers). Radiography encompasses diagnostic x-ray as well as computed tomography (CT) and magnetic resonance imaging (MRI). According to the American Registry of Radiologic Technologists, the primary certifying agency for radiologic technology, as of 3-16-98, there were 5,454 registered technologists. The Virginia Society has a membership of 1,633 technologists, of whom 132 are student members.

The VSRT's primary legislative issue for the last twenty plus years has been the enactment of some form of regulation of medical radiation workers, a measure VSRT has always felt necessary to protect Virginia's citizens from exposure to unnecessary ionizing radiation. This goal was realized in a limited way in 1994 with the passage of House Bill 1300 which makes it "unlawful for a person to practice or hold himself out as a radiologic technologist or radiologic technologist, limited, unless he holds a license as such issued by the Board". The law, which became effective on January 1, 1997, unfortunately does not apply to employees or independent contractors of licensed hospitals. Efforts by the VSRT will continue to effect an amendment to the Bill to eliminate the hospital exemption. As the largest employer or radiologic technologists, it is important that the assurance of minimum standards is met in these facilities as well as in small clinics and in physician offices.

The primary concerns relative to the proposed regulations that need to be addressed are the lack of restrictions on the examinations and procedures, which can be performed by limited licensees, and the lack of any assessment of learning or competence for them. The regulations permit acquiring a license in one of two ways: (a) after a minimum of two years of education and passing of a national certification exam (radiologic technologist) or (b) after approximately 50 hours of education with no examination of any kind (radiologic technologist, limited). Regulations as implemented create a two-tiered system; holders of both restricted and unrestricted licenses will be performing the same studies. When the individual is reasonably well-educated in the radiologic sciences, an exam is required. If the individual is minimally educated, there is no requirement for documentation or assurance of that knowledge or competence prior to achieving licensure, and there are virtually no restrictions on practice. The VSRT believes these inadequacies need to be addressed.

The VSRT is firmly committed to quality patient care, to providing continuing education for its members and the radiologic technology community in general, and to increasing awareness of radiologic technology among the general public. Any questions or concerns may be directed to a member of the Board of Directors or to the Executive Secretary.
Joint Commission on Health Care  
(as of January 18, 1998)  
Patrick W. Finnerty, Executive Director  
William L. Murray, Ph.D. and Joseph J. Hilbert  
Senior Health Policy Analysts  
1001 E. Broad Street, Suite 115  
Old City Hall Building  
Richmond, Virginia 23219  
804-786-5445 Phone  
804-786-5538 Fax  
http://legis.state.va.us/jchc/jchchome.htm -website

The Joint Commission on Health Care was created by the 1992 Session of the Virginia General Assembly to study, report and make recommendations on a wide range of health care issues. Each year, the Joint Commission has an extensive agenda of health care studies, policy analyses and reviews that it conducts throughout the year. At the conclusion of the year, the Joint Commission develops a legislative package of bills and resolutions that it presents to the General Assembly during its annual legislative session.

The Joint Commission is composed of 16 legislative members, several of whom are from the Tidewater area. The Secretary of Health and Human Resources serves in an *ex officio* capacity. The current members of the Joint Commission are:

Delegate Kenneth R. Melvin (Chairman)  
Senator Jane H. Woods (Vice-Chairman)  
  Senator William T. Bolling  
  Senator Joseph V. Gartlan, Jr.  
  Senator Benjamin J. Lambert, III  
  Senator Stephen H. Martin  
  Senator Edward L. Schrock  
  Senator Stanley C. Walker  
Delegate Thomas G. Baker, Jr.  
  Delegate Robert H. Brink  
  Delegate John J. Davies, III  
  Delegate Jay W. DeBoer  
Delegate Alan A. Diamonstein  
  Delegate Franklin P. Hall  
Delegate Phillip A. Hamilton  
Delegate Harvey B. Morgan  
The Honorable Claude A. Allen (ex-officio)
The work of the joint Commission falls primarily into five major areas: (i) health insurance/access for uninsured, (ii) medical education, (iii) health care cost and quality, (iv) health workforce issues, and (v) long-term care.

During 1998, the Joint Commission conducted numerous studies, including: (i) a study of quality of care and reimbursement issues related to telemedicine; (ii) a review of the need for a centralized planning and funding mechanism for health workforce initiatives; (iii) a review of licensing and financing issues involving long-term care; (iv) a study of whether there is a need for an external appeals mechanism or ombudsman program for managed care enrollees; (v) a study of pooled purchasing arrangements for small employers, community health centers and free clinics; (vi) a review of the feasibility of establishing a high risk insurance pool in Virginia; (vii) a study of academic health centers’ participation in managed care provider networks; (viii) a review of health care coverage for eating disorders; (ix) a review of regulation and laws relating to midwifery; (x) a review of organ transplant issues; and (xi) a review of the health status and conditions of African-Americans in the Commonwealth.

The Joint Commission’s full-time staff is headed by its Executive Director, Patrick W. Finnerty. William L. Murray, Ph.D. and Joseph J. Hilbert serve as Senior Health Policy Analysts. Mr. Murray is the primary contact for long-term care issues.

The staff may be contacted at (804) 786-5445. The mailing address for the Joint Commission is: Suite 115, Old City Hall, 1001 E. Broad Street, Richmond, Virginia 23219. You may also visit the Joint Commission web site at http://legis.state.va.us/jchc/jchchome.htm.

Once the 1999 General Assembly Session is completed, the Joint Commission will resume its monthly meetings which are generally held in Senate Room A of the General Assembly Building in Richmond. For additional information you may contact the Joint Commission directly or visit its web site.
The Attorney General provides all legal service in civil matters for the Commonwealth, the Governor, and every state official, agency, and board, as well as the courts and judges. (Va. Code § 2.1-118.) The Commonwealth’s ubiquity as regulatory overseer in almost every matter with which the health care community is involved increases the chances that health care attorneys may eventually have reason to deal with the Office of the Attorney General. Knowing the organization and players works to everyone’s advantage.

Under Attorney General Mark L. Earley and his Chief Deputy Randolph A. Beales are five Deputy Attorneys General, each directing a major division within the Office. Deputy Attorneys General Ashley L. Taylor, Jr., Stephen J. Telfeyan, Judith W. Jagdmann, E. Montgomery Tucker, and Francis Ferguson respectively head the Divisions of Health, Education, and Social Services, Government Operations, Civil Litigation, Criminal Law, and Local and Intergovernmental Affairs. In addition, major litigation and special projects are handled by Senior Counsel William H. Hurd, Counsel David E. Johnson, and Counsel Robert C. Metcalf.

The Division most involved with health matters is the Division of Health, Education, and Social Services, which provides counsel to the following agencies: the Departments of Medical Assistance Services, Health Professions and its professional boards, Mental Health, Mental Retardation, and Substance Abuse Services, Health, Rehabilitative Services and the Woodrow Wilson Rehabilitation Center, Deaf and Hard of Hearing, Visually Handicapped and Aging. The Department of Social Services, its Division of Child Support Enforcement, and the state’s public school system, community colleges, and institutions of higher learning are also advised by counsel in the Division of Health, Education and Social Services. The Division’s three sections are Mental Health and Health Services headed by Section Chief Jane D. Hickey, Medicaid and Social Services headed by Section Chief Siran S. Faulders, and Education headed by Section Chief Ronald C. Forehand.

Attorneys representing the Department of Mental Health, Mental Retardation, and Substance Abuse Services are Jane D. Hickey, Garland L. Bigley, Evelyn R. (“Lynne”) Fleming, Roscoe C. Roberts, and Rita R. Woltz.

The Board of Medicine, the Board of Psychology, the Board of Social Work, and the Board of Licensed Professional Counselors, receive counsel from Lynne Fleming, who is also legal counsel to the Intervention Committee for the Health Practitioners Intervention Program.
Howard Casway represents the Board of Dentistry, Joint Boards of Medicine and Nursing, Joint Boards of Nursing, Board of Examiners in Optometry, Board of Pharmacy, Board of Veterinary Medicine, Board of Health Professions, and the Virginia Voluntary Formulary Board. Advisory opinions with respect to physician self-referrals fall within the responsibilities of the Board of Health Professions, advised by Howard Casway.

The Boards of Audiology and Speech-Language Pathology, Nursing Home Administrators, and Funeral Directors and Embalmers fall under the legal oversight of Roscoe Roberts.

All activities of the Department of Health, except for environmental services, and of the Board of Health and the Advisory Board of Emergency Medical Services are assigned to Carol Nance. Those activities include epidemiology, vital records and health statistics, the Office of the Chief Medical Examiner, the local health districts and local health departments, emergency medical services, family health services, public health nutrition and WIC, healthcare facilities licensure and certification, certificate of public need, and certification of quality assurance of managed care health insurance plans.

Among smaller departments, Rita Woltz provides legal advice to the Department of Rehabilitative Services, including the Woodrow Wilson Rehabilitation Center, the Department for the Deaf and Hard of Hearing, the Department for the Visually Handicapped, the Rehabilitation Center for the Blind, the Board for People with Disabilities, and the Virginia Assistive Technology Loan Authority. Rita Woltz additionally serves as legal counsel for the Comprehensive Services Act. Carol Nance advises the Department for the Aging and the Governor’s Employment and Training Department.

Section Chief Siran Faulders, Paige Fitzgerald, Brian McCormick, and Kim Piner represent Medicaid matters within the ambit of the Department of Medical Assistance Services. Daniel Poynor, also in the Medicaid and Social Services Section, represents the licensing services of the Department of Social Services, including adult care residences with assisted living.

Of related interest, Francis Ferguson represents the Birth-Related Neurological Injuries Board. Occupational Safety and Health is advised by Stewart Leeth. The Medical College of Virginia Hospitals Authority is advised by Jean Reed and the University of Virginia by Paul Forch and Beth Hodsdon.

Environmental programs and agencies, including the Department of Environmental Quality, the Air Board, the Department of Health’s water programs, air quality, septic systems and sewage handling, wells, restaurants, swimming pools, campgrounds, shellfish sanitation, are assigned to the Government Operations Division’s Natural Resources Section, with counsel from Section Chief Roger Chaffe, John Butcher, Deborah Love-Feild, MaryJo Leugers, Karen Lebo, Stewart Leeth, Carl Josephson, and Fred Fisher.
Health-related **Professions and Occupations** include asbestos and lead contractors and workers, barbers, cosmetologists, hearing aid specialists, opticians, soil scientists, waste management facility operators, waterworks and waste water works operators, and fall under the Government Operations Division, Commerce and Trade Section, headed by Richard Zorn and served by Bill Diamond, Lisa Rowley, John Purcell, Sandra Riggs, and J. C. “Max” Wilkinson. John Purcell advises the **Department of Agriculture and Consumer Services**.

To assure complete dissociation of prosecutorial counsel from advisory counsel to the health professional boards, attorneys in the separate Division of Criminal Law prosecute licensees of those boards. Criminal violations of the basic statutes and regulations are referred to the Commonwealth’s Attorney for the jurisdiction in which the violation took place. Rhonda McGarvey is the Chief of this Section of Investigative Enforcement, and prosecuting counsel are Frank Pedrotty, Trish Munro, and Steve Baer. In the case of Medicaid Fraud, the Commonwealth’s Attorneys often refer the cases back to the **Medicaid Fraud Unit** for prosecution after indictment. At the present time, legal counsel for the unit is provided by John Moriarty, who will soon be joined by two other assistant attorneys general.

A new area of review of **asset disposition by not-for-profit healthcare facilities** has been assigned to Deputy Attorney General Judy Jagdman, who has designated Natalie Harris of the Division of Civil Litigation’s Antitrust and Consumer Affairs Section, Donald Ferguson of the Government Operations Division’s Section Finance and Taxation, and Carol Nance of the Health, Education, and Social Services’ Mental Health and Health Services Section to the review team. David Irvin is Senior Chief of the Antitrust and Consumer Affairs Section and oversees all **antitrust** issues.

The **Administrative Process Act Committee** is composed of Roger Chaffe, Section Chief of the Natural Resources Section in the Government Operations Division, Richard Zorn, Section Chief of the Section for Commerce and Trade in the Government Operations Division, Terri Manning serving the Racing Commission, the Charitable Gaming Commission, and the Lottery in the Government Operations Division, Deputy Attorney General Francis Ferguson, and Howard Casway and Carol Nance in the Mental Health and Health Services Section of the Division of Health, Education, and Social Services.

The Division of Civil Litigation customarily handles claims under the Virginia Tort Claims Act and EEO claims (including disability, workers’ compensation, grievances, and other employment issues). The Attorney General has established contracts with a number of pre-eminent medical malpractice attorneys across the state who may be requested or appointed to defend medical malpractice claims against officers, agents, and institutions of the Commonwealth.
In Virginia, regulatory functions normally associated with a state's department of insurance are the responsibility of the State Corporation Commission (SCC). The SCC was created by Article IX of the Virginia State Constitution, which empowers the "Commission" to administer laws concerning the regulation and control of corporations transacting business in the Commonwealth. Three Commissioners who are appointed to six-year terms by the General Assembly direct the SCC. In addition to setting policy for the SCC, the three Commissioners hear regulatory cases that come before them. The SCC is sometimes described as a fourth branch of government because it has legislative, administrative, and judicial powers. It is a court of record, and the decisions made by the Commissioners may only be appealed to the Virginia Supreme Court.

By statute, the SCC is responsible for registering corporations and monitoring the activities of those providing financial services, public utilities and transportation. Insurance concerns fall within the general category of "financial services." The SCC's regulatory responsibilities in the area of insurance are handled primarily through the Bureau of Insurance.

The Bureau of Insurance is the largest division of the SCC. It is headed by a "Commissioner of Insurance" who is appointed pursuant to § 12.1-12 of the Code of Virginia and charged generally with the administration of the insurance laws of the Commonwealth, most of which may be found in Title 38.2 of the Code. Alfred W. Gross is the current Commissioner of Insurance.

Approximately 185 people are employed in the SCC's Bureau of Insurance. From the SCC's offices in Richmond, the Bureau regulates all companies transacting the business of insurance in Virginia; conducts financial condition and market conduct examinations of domestic companies; issues licenses to agents and agencies; reviews life and health and property and casualty policy forms and rates; and helps consumers resolve disputes with insurance companies. In terms of health insurance matters alone, this activity involves over 880 insurers and approximately 54,000 agents or agencies that are authorized to underwrite or sell health insurance in Virginia. Some are classified as “life and health” insurers or agents; others are classified as “property and casualty” insurers or agents; all are authorized specifically to offer “accident and sickness” insurance in Virginia. But
these numbers are only part of the picture. In addition to overseeing the activities of traditional health insurers, the Bureau has regulatory responsibility for:

- 31 health maintenance organizations (HMOs);
- 9 pre-paid health services plans, including plans which offer health services generally or which specialize in dental or optometric services;
- 51 continuing care retirement communities (CCRCs);
- 238 multiple employer welfare associations and trusts (MEWAs);
- 17 workers' compensation group self-insurers plus 489 licensed insurers which also offer workers’ compensation insurance coverages; and
- 49 property and casualty insurers, including reciprocal insurers, which offer medical liability and medical malpractice insurance.

The nature and extent of regulatory activities varies depending on the type of health insurance entity being regulated. Generally speaking, provisions applicable to traditional life and health insurance companies may be found throughout Title 38.2 of the Code of Virginia. Special chapters in Title 38.2 may address unique types of operations or forms of organization; e.g., Chapter 18 for agents, Chapter 43 for HMOs, Chapters 42 and 45 for prepaid health services plans, Chapter 49 for CCRCs. However, each of these entities is subject also to many of the more general statutes that comprise much of Title 38.2, including for instance, licensing provisions in Chapter 10, provisions in Chapter 34 concerning accident and sickness insurance, and the MCHIP statutes in Chapter 58 affecting health carriers operating managed care health insurance plans.

Administration of the insurance statutes is aided frequently by rules and regulations, which are promulgated and adopted by order of the SCC after publication and notice of hearing. The SCC's "Rules Governing Multiple Employer Welfare Arrangements" (14 VAC 5-410-10 et seq.) and the "Rules Governing Health Maintenance Organizations" (14 VAC 5-210-10 et seq.) are particularly relevant for MEWAs and HMOs. The SCC has adopted additional regulations with broader application in matters such as insurance rates, policy forms and mandated benefits, reserving methodology and market conduct expectations. All of these regulations are filed in the Clerk's Office at the SCC in Richmond. Commission regulations are published in the Virginia Administrative Code, a compilation of agency rules and regulations of the Commonwealth published by West Group Publishing. The NILS Publishing Company, a private publishing company located in Chatsworth, California, also publishes most of the insurance rules and regulations, as well as administrative letters issued by the Bureau. Proposed regulations, orders adopting new regulations and administrative letters are published also in the Virginia Register of Regulations, a monthly publication of the Commonwealth. Current regulatory material is available also through the SCC’s
Although Title 38.2 and the Bureau play significant roles in the regulation of insurance matters in Virginia, other portions of the Code of Virginia and other regulatory agencies can be significant. For example, the SCC's licensing responsibilities with respect to workers' compensation group self-insurance associations (GSIAs) are set forth in § 65.2-802 of Chapter 8 of Title 65.2 of the Code. Related provisions in this chapter make it clear both the SCC and the Workers' Compensation Commission shall exercise regulatory oversight over these GSIAs. Other entities may also come under the regulatory umbrella of multiple agencies. CCRCs subject to Chapter 49 in Title 38.2 must be registered with the Bureau; however, they can be affected by provisions in Title 32.1 that are administered primarily by the Department of Medical Assistance Services or the Commissioner of Health. As discussed in the following paragraph, the State Health Commissioner can play a role in the regulation of HMOs and other health carriers as well. The federal government, as a consequence of ERISA, can be involved in the regulation of MEWAs, but it does not obviate the need for state regulation via the Bureau in matters of solvency.

Legislation enacted during the 1998 session of the Virginia General Assembly has significantly increased the role of the Virginia Department of Health (VDH) in the regulation of health insurance. The State Health Commissioner now has the authority to regulate private review agents, oversee utilization review and certify the quality of care provided through managed care health insurance-service plans (MCHIPS). This authority will impact licensed health insurers and health services plans as well as HMOs. The VDH, acting primarily through its Center for Quality Health Care Services and Consumer Protection, will handle complaints involving quality of care issues for covered persons while the Bureau will continue its regulation of health carriers as to issues of solvency and market regulation. The Bureau of Insurance will continue to handle complaints dealing with policy coverage issues, and also shall ensure that each health carrier has lived up to the representations and disclosures it has made to enrollees concerning the availability of a complaint system. It is anticipated that this restructuring of existing laws involving the regulatory oversight of health carriers and managed care health insurance plans will provide for a more consistent and coordinated regulatory oversight of HMOs and other health carriers offering health care services to Virginia’s citizens.

The Bureau is structured into three large divisions and one smaller division. Those divisions are Property and Casualty Market Regulation, Life and Health Market Regulation, Financial Regulation, and Administration.

The Financial Regulation division is responsible for company licensing, ongoing financial analysis and monitoring, and financial condition field examinations. The division processes company applications for licensing, annual financial statement filings, holding company and other material transaction disclosures and approvals, and the preparation and filing of financial condition examination reports of companies domiciled in Virginia. The mission of the Financial Regulation division is to identify troubled companies as quickly as possible and to take steps to resolve
problems before a company becomes insolvent. The deputy commissioner in charge of the division is Douglas C. Stolte. The division's offices are located on the 6th floor of the Tyler Building at 13th and Main Streets in Richmond. Primary contact numbers are:

- Questions concerning company licensing (804) 371-9637
- Questions concerning domestic L&H insurance companies (804) 371-9637
- Questions concerning foreign L&H insurance companies (804) 371-9636
- Appointments to copy or inspect filings (804) 371-9546
- Questions concerning HMOs, health service plans, MEWAs and CCRCs (804) 371-9637
- Questions concerning GSIs (workers' compensation groups) (804) 371-9063
- Financial examination matters (804) 371-9061
- Financial Regulation Division Fax (804) 371-9511

The **Life and Health (L&H) Market Regulation division** reviews and approves most health policy forms prior to their use in Virginia, and also reviews and approves rates for individual health insurance policies. Market conduct examiners assigned to the division conduct on-site examinations of health insurers and others licensed in Virginia. In addition, the L&H division administers the qualification, licensing and appointment of insurance agents and consultants in Virginia. It also assists consumers in resolving problems with insurers and agents and provides information about insurance to the general public. Its activities include the publication of various consumer guides, including a Health Insurance Consumer's Guide and a Senior Citizen's Guide to Insurance. Gerald A. Milsky is the deputy commissioner in charge of the L&H Market Regulation division. The division's offices are located on the 5th floor of the Tyler Building at 13th and Main Streets in Richmond. Primary contact numbers are:

- Requests for Consumer Guides (804) 371-9691
- Agents, brokers and consultants (804) 371-9631
  (Fax (804) 371-9349)
- Life and health forms, rates and policy approval (804) 371-9110
- Market conduct matters (804) 371-9691
  (Fax (804) 371-9944)
In Virginia, a life insurer may be authorized to write accident and sickness insurance but not a class of property and casualty insurance. A property and casualty insurer may be licensed to write accident and sickness insurance, but not life insurance. Also, only non-life insurers may be licensed to write the related coverages for workers' compensation insurance and medical malpractice insurance. As a consequence, those inquiring about health insurance matters will usually find themselves talking with employees in either the Financial Regulation or L&H Market Regulation divisions of the SCC's Bureau of Insurance. However, if the question involves a P&C insurer or a line of property, casualty or liability insurance, calls should be placed to the Bureau's **Property and Casualty Market Regulation division**. Deputy Commissioner Mary M. Bannister heads the division. The division's offices are located on the 5th floor of the Tyler Building at 13th and Main Streets in Richmond. Primary contact numbers are:

- **P&C consumer services and market conduct matters**
  - (804) 371-9185
  - (Fax) (804) 371-9349

- **P&C policy approval and rates**
  - (804) 371-9965
  - (Fax) (804) 371-9396

**Administration**, the fourth and smallest division, handles administrative matters for the Bureau and also processes premium tax filings and the reports due from surplus lines brokers. Brian P. Gaudiose manages administrative services and tax matters. His office is located on the 6th floor of the Tyler Building at 13th and Main Streets in Richmond. Primary contact numbers are:

- **Insurance company premium taxes**
  - (804) 371-9096

- **Surplus lines broker filings**
  - (804) 371-9192

- **Tax and surplus lines fax**
  - (804) 371-9821

The Bureau welcomes inquiries, and has a "hotline" and automated directory service which may be reached by an in-state toll free number (1-800-552-7945). TDD (telecommunications device for the deaf and hard of hearing) may be reached on the toll-free number or (804) 371-9206. Callers should remember, however, that many questions and problems cannot be adequately addressed until inquiries and specific concerns are submitted in writing. Written inquiries may be directed to the attention of a specific division or employee and should be addressed to the SCC Bureau of Insurance at either 1300 East Main Street, Richmond VA 23219 or P. O. Box 1157, Richmond, VA 23218.
Mission Statement

To reduce death and disability resulting from sudden or serious injury and illness in the Commonwealth through planning and development of a comprehensive, coordinated statewide emergency medical services (EMS) system; and provision of other technical assistance and support to enable the EMS community to provide the highest quality emergency medical care possible to those in need.

Emergency Medical Services At A Glance
(July 1, 1996 to June 30, 1997)

- 720 Licensed EMS agencies serve Virginia
- 269 Volunteer Rescue Squads
- 133 Volunteer Fire Departments
- 64 Volunteer Fire & Rescue
- 145 Commercial
- 58 Government/Municipal
- 13 Hospital
- 11 Air Ambulance
- 13 Industrial
- 5 Correctional
- 9 Non-Profit

- 36,577 EMS providers
- 4,555 First Responders
- 25,139 Emergency Medical Technicians
- 1,578 Shock Trauma Technicians,
- 2,661 Cardiac Technicians
- 2,099 Paramedics
- 545 Certified EMS instructors
- 472 EMT courses taught (322 basic, 140 refresher).
- 9,153 Candidates tested for certification as a First Responder, EMT-B, EMT-Shock Trauma, Cardiac Technician or Paramedic.
- 120 Emergency Vehicle Operators courses taught.
<table>
<thead>
<tr>
<th>Number</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>64,348</td>
<td>Continuing education credit hours awarded through 2,222 EMS training programs.</td>
</tr>
<tr>
<td>11</td>
<td>Virginia hospitals are certified as trauma centers for providing specialized care to severely injured patients.</td>
</tr>
<tr>
<td>195</td>
<td>VDH Rescue Squad Assistance Fund grants totaling $3,097,924.59 were awarded to non-profit EMS agencies/organizations to buy ambulances and EMS equipment.</td>
</tr>
<tr>
<td>54</td>
<td>VDH grants totaling $100,000 awarded to EMS agencies for recruitment, retention and public awareness programs.</td>
</tr>
<tr>
<td>339</td>
<td>Prospective EMS providers referred to volunteer and/or career EMS agencies</td>
</tr>
</tbody>
</table>

$2,548,900 Two for Life Funds returned to localities for EMS activities.

$1,000,000 Two for Life Funds awarded for regional EMS operations.

$385,750 Two for Life Funds awarded for training programs:

$105,750 Regional training grants

$280,000 ALS training
Mission

The mission of the Department of Environmental Quality is to protect the environment of Virginia in order to promote the health and well-being of the citizens of the Commonwealth. To accomplish this, DEQ administers state and federal environmental programs; issues environmental permits and ensures compliance with regulations; and coordinates planning among the Commonwealth's environmental programs.

Citizen Boards

Three citizen regulatory boards are responsible for adopting Virginia's environmental regulations: the Waste Management Board, the Air Pollution Control Board and the State Water Control Board. The DEQ staff administers the regulations as approved by the boards.

Environmental Permits and Regulations

Water Quality

DEQ administers the federal Clean Water Act and enforces state laws to improve the quality of Virginia's streams, rivers, bays and groundwater for aquatic life, human health and other water uses. Permits take into account physical, chemical and biological standards for water quality. Water programs address:

Pollution Discharges

Permits set limits for pollutant discharges from point sources, such as ditches or pipes (including discharges from storm water systems), by businesses, governments and individuals.

Groundwater

DEQ oversees the withdrawal of large amounts of groundwater within designated groundwater management areas.
Surface water

Withdrawals of large amounts of water in designated surface water management areas are issued permits to ensure adequate stream flows during droughts.

Land application of treated waste

The treatment, storage and spreading on land of industrial and sewage sludge, animal waste and treated wastewater are regulated. Permits typically are issued to industry and large animal feeding operations.

Dredged material

Permits are issued for discharges of dredged material into waterways or wetlands, and for other in stream activities.

Air Quality

DEQ administers the requirements of the federal Clean Air Act, and enforces state law and regulations to improve Virginia's air quality. Programs include:

Issuing permits to new and modified sources of air emissions.

An enhanced vehicle emissions inspection and maintenance program for Northern Virginia.

Voluntary ozone reduction efforts in Northern Virginia, Richmond and Hampton Roads, through ozone forecasts and advisories.

The Small Business Assistance Program, which provides technical assistance to help small businesses understand and comply with the Clean Air Act and state air regulations. The Small Business Assistance Program Compliance Advisory Panel provides oversight and advice to the Small Business Assistance Program.

Waste Management

DEQ administers waste management programs created by legislation such as the federal Resource Conservation and Recovery Act and the Virginia Waste Management Act. DEQ's activities are coordinated with the U.S. Environmental Protection Agency.
Solid waste management
Regulations establish standards for the siting, design, construction, operation, closure and post-closure care of solid waste management facilities. A permit is required by all public and private facilities that operate a waste management facility. These permits follow federal and state standards to protect the land, water and air from pollutants.

The state has regulations for solid waste landfills, transfer stations, incinerators, composting, medical waste, material recovery facilities, and managing solid waste from industrial, construction and demolition activities. In addition, there are state regulations for developing and implementing local and regional solid waste management plans.

Hazardous waste management

State regulations follow federal standards established under RCRA and require a permit for storage, treatment and disposal of hazardous waste. Regulations also govern the issuance of transportation permits for hazardous waste and the siting of hazardous waste management facilities. There currently are no permitted hazardous waste disposal sites in Virginia.

Petroleum storage tanks

DEQ ensures that aboveground and underground storage tanks are registered, inspected and maintained, and have leak and spill detectors. Tank owners are responsible for developing spill contingency plans, and demonstrating sufficient financial capability to handle cleanups and remediation.

DEQ sponsors voluntary remediation and cleanups at federal facilities and Superfund sites. The Voluntary Remediation Program encourages hazardous substance cleanups that might not otherwise take place, enabling site owners or operators to voluntarily enter into an agreement with DEQ to clean up the property and restore it to productive use. DEQ also works with the federal government to ensure proper cleanup of hazardous wastes at federal facilities, including military bases. EPA administers the Superfund program in Virginia, and DEQ performs necessary activities mandated by the Superfund law. DEQ is not involved in day-to-day activities.

Management of regulated medical waste

DEQ establishes standards for the storage, transportation and treatment of regulated medical waste. Regulated medical waste may be stored, steam sterilized or incinerated only at a permitted facility. Alternative treatment technology may be allowed if the effectiveness of the treatment can be demonstrated.
Coal ash

Regulations establish standards for the use, storage and disposal of coal combustion byproducts, known as coal ash. Alternative uses and reuses of the ash are allowed under the regulations.

Waste tires

DEQ is responsible for developing and implementing a plan to properly manage waste tires. The plan will include short-term and long-term recommendations for addressing tire stockpiles. The Waste Tire Trust Fund administered by DEQ provides money to several regions to help them manage the current flow of waste tires. Virginia also has regulations to provide for cost reimbursements to waste tire end-users.

Litter prevention and recycling

DEQ administers an annual grant program that provides funding to local litter prevention and recycling program efforts.

Monitoring and Inspection

DEQ conducts extensive monitoring to ensure that state and federal standards for water quality, air quality and waste management are met. DEQ also oversees monitoring by permit holders and conducts inspections of permitted sites to ensure that sources such as water discharges, air emissions and waste management facilities meet permit requirements. Activities include:

- Monitoring water quality in rivers, lakes and estuaries at some 1,100 locations to detect pollutants and to assess pollution prevention efforts. In addition, a stream gauging network provides important flow data for streams throughout Virginia.

- A network of air monitors throughout the state to measure for specific pollutants in the atmosphere. DEQ analyzes air quality data and maintains an inventory of stationary air emission sources.

- Monitoring landfills to ensure that groundwater is not contaminated. Permitted hazardous waste storage sites also are monitored to ensure permit compliance.

Chesapeake Bay and Coastal Programs

DEQ participates in numerous state and federal programs aimed at restoring the Chesapeake Bay and improving Virginia's coastal resources.
DEQ works with other state agencies, other state governments and the federal government as part of the Chesapeake Bay Program. Among other initiatives, the Bay program is working to reduce the amount of nutrient pollution in the Bay and its tributaries, and to reduce the amounts of toxic substances entering the Bay.

DEQ monitors Virginia's coastal regulatory programs and administers federally funded grants for projects to preserve coastal resources.

**Pollution Prevention and Compliance Assistance**

DEQ promotes technological innovation and science-based approaches to preventing pollution and better managing Virginia's natural resources. Citizens and business are encouraged to develop efficient ways to reduce or eliminate waste materials before they are released to the air, water or land. DEQ is helping accomplish this through technical assistance, and partnerships with industry and local governments.

**Environmental Impact Review**

DEQ coordinates recommendations to the Governor to ensure that new state facilities are constructed in an environmentally sound manner. DEQ also coordinates review of new airport construction proposals, oil and gas drilling in Tidewater, state agency farmland preservation plans, and the environmental impacts of federal projects.

**Regional Operations**

DEQ has consolidated operations at the agency's regional offices in Abingdon, Harrisonburg, Richmond, Roanoke, Woodbridge and Virginia Beach. Satellite offices in Fredericksburg, Kilmarnock and Lynchburg support the regional operations. In addition, there is a stream flow monitoring office in Charlottesville and an air monitoring office in Richmond.

Each regional office houses DEQ's air, water and waste programs, provides permit assistance and emergency response, and ensures compliance with regulations.

**Environmental Education**

DEQ sponsors an annual education conference, produces printed resource materials, promotes a statewide network of teachers and other environmental educators, and coordinates teacher training on environmental subjects.

**Online Communications And Media Relations**

DEQ maintains an extensive information site on the World Wide Web (http://www.deq.state.va.us), covering all major program areas of the agency and providing...
opportunities for public involvement in environmental issues. Information on special DEQ activities also is made available to the news media and the general public.
Overview of Regulatory Programs

The State Board of Health and the State Health Commissioner, assisted by the State Department of Health, are authorized to administer and provide a comprehensive program of preventive, curative, restorative and environmental health services; educate the citizenry in health and environmental matters; develop and implement health resource plans; collect and preserve vital records and health statistics; provide medicolegal investigation of deaths that occur suddenly, unexpectedly, violently, or in an otherwise suspicious manner; assist in research; investigate outbreaks of disease; and abate hazards and nuisances to the public health and to the environment. Code of Virginia, Title 32.1, Chapters 1, 2 and 8. Regulatory activities are noted below as vested in the department, without distinction among those vested in the State Board of Health or the State Health Commissioner. In furtherance of its mission to protect public health, the department administers numerous programs and engages in many regulatory activities. These regulatory activities include:

(i) Establishing standards and requirements for research on human participants conducted or authorized by the department, or any facility or other entity operated, funded, or licensed by the department;

(ii) Establishing a statewide and unified emergency medical care system, composed of various facilities and resources; establishing a statewide poison control system; licensing emergency medical services agencies, vehicles and personnel in order to improve the delivery of emergency medical services and reduce morbidity, hospitalization, disability and mortality;

(iii) Compiling a list of human diseases required to be reported to the department; prescribing the manner and time of such reporting; maintaining a confidential statewide cancer registry; issuing orders to combat epidemics and communicable disease and to address other public health emergencies so that disease may be controlled and investigated epidemiologically; and requiring the immunization of children in order to prevent certain diseases;
(iv) Establishing and maintaining a system of screening tests for newborn infants that detects various inborn errors of metabolism in order to prevent disability and death and establishing and maintaining a system to identify hearing loss at the earliest possible age among newborns; monitoring infants identified as having hearing impairment so that they may receive appropriate early intervention through treatment, therapy, training and education;

(v) Prescribing standards, examinations and analyses governing the taking and marketing of crustacea, finfish, and shellfish; conducting inspections of shellfish planting grounds and seafood packing houses; and establishing the boundaries of and condemning growing areas in which crustacea, finfish or shellfish are unfit for market;

(vi) Establishing a methodology for the review and measurement of the efficiency and productivity of health care institutions; administering a patient level data system for consumers, employers, providers and purchasers of health care to improve the quality, appropriateness, and accessibility of health care; and providing information useful in making decisions relating to health care;

(vii) Establishing procedures and policies for soliciting and receiving applications for grants from the Commonwealth Neurotrauma Initiative Trust Fund and criteria for reviewing and ranking such applications in order to prevent traumatic spinal cord and brain injuries and to improve the treatment and care of persons with such injuries;

(viii) Defining the income limitations within which a person shall be deemed to be medically indigent so that such persons may receive the medical care services of the department without charge; and prescribing a scale of charges, based on ability to pay, for departmental patients who are not deemed to be medically indigent;

(ix) Establishing procedures and fees for the review of applications for certificates of public need; and, upon finding public need for the construction of or specified modifications to medical care facilities, issuing such certificates, conditioned upon an agreement to provide medical care to indigents where warranted, as well as providing for limitations on the time for completion and on capital expenditures;

(x) Licensing, prescribing minimal standards of construction, maintenance and operation for, and inspecting hospitals, nursing facilities, hospices, and other medical care facilities; and licensing and prescribing minimal standards governing the activities and services provided by home care organizations;
(xi) Prescribing requirements for permitting the practice of midwifery by persons who are not registered nurses and who were permitted pursuant to the Board’s standards before January 1, 1977;

(xii) Prescribing standards that ensure the quality of managed health care insurance plans offered by entities that are licensed by the State Corporation Commission; and issuing certificates of quality assurance to such licensees;

(xiii) Licensing restaurants, hotels and other lodging facilities, summer camps, campgrounds and migrant labor camps; inspecting these establishments, along with public swimming pools, for compliance with sanitary requirements;

(xiv) Regulating and controlling sources of radiation; licensing the use, production and possession of radioactive materials; and requiring the registration, inspection and certification of diagnostic therapeutic x-ray machines used in the healing arts;

(xv) Granting conditional scholarships for the training of certain physicians, nurses, dentists and dental hygienists; defining the obligations scholarship recipients must fulfill, including their practice in areas undeserved by medical and dental professionals, as such areas are delineated by the department;

(xvi) Uniformly administering the statewide system for maintaining vital records, i.e., birth, adoption, marriage, divorce, death, and fetal death records; and allowing access and necessary changes to these records;

(xvii) Issuing permits for and regulating the design and operation of public water systems; and establishing standards for protecting the quality and safety of the drinking water produced by such systems;

(xviii) Prescribing standards for the location, construction and abandonment of residential wells used for drinking and domestic purposes; and

(xix) Supervising the collection, transportation, treatment and disposal of sewage; regulating the construction and operation of sewage disposal and treatment facilities; setting standards for and approving residential sewage disposal systems; and prescribing requirements for the disposal of sewage at marinas and for the application of bestialities to agricultural lands.

The department operates under the supervision of the Secretary of Health and Human Resources. All regulations adopted by the State Board of Health appear in Title 12 of the Virginia Administrative Code.
There are numerous agencies within the Department of Health, some of which are listed below. For further information on the following agencies, please refer to headings listed alphabetically in this compendium:

Center for Quality Health Care Services and Consumer Protection
Virginia Department of Health - Division of Certificate of Public Need
Virginia Department of Health - Office of the Chief Medical Examiner
Virginia Department of Health - Office of Water Programs
Virginia Department of Health - Women, Infants and Children (WIC) Program
Mission

The Center for Quality Health Care Services and Consumer Protection (the Center) performs the following functions:

- Determines and certifies the public need (COPN) for new construction and renovations and new health care services in acute and long term care medical facilities.

- Promotes the delivery of quality health care services and protects health care consumers through the conduct of routine onsite inspections and complaint investigation.

- Enforces state licensure regulations related to (5) medical care provider categories.

- Promotes state quality of care standards governing insurers and providers which offer health care benefits through managed care health insurance plans (MCHIPS). Also enforces quality of care standards for Professional Utilization Review Agents (PRAs).
- Certifies (23) medical care provider categories for federal financial participation in the Medicare, Medicaid, and the Clinical Laboratory Improvement Programs.

- Provides training and education programs for the health care provider community, consumers and Center staff.

**Functional Areas**

The Center has a main office located at Suite 216, 3600 West Broad Street in Richmond, Virginia and (50) home based, surveyor offices located around the state. The CQHCCP consists of the following functional areas: Licensing and Certification/MCHIPS, Policy, Education and Administration:

<table>
<thead>
<tr>
<th>FUNCTIONAL AREAS</th>
<th>STAFFING</th>
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<tbody>
<tr>
<td>LICENSING/CERTIFICATION</td>
<td>67</td>
</tr>
<tr>
<td>COPN/ POLICY DIVISION</td>
<td>12</td>
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<tr>
<td>EDUCATION</td>
<td>5</td>
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<tr>
<td>ADMINISTRATION</td>
<td>4</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>88</strong></td>
</tr>
</tbody>
</table>

Licensing/Certification/MCHIPS

**Acute Care/Complaint Division (AC)**

Consists of Medical Facilities Inspectors and Supervisor/Management staff. Conducts onsite inspections and complaint investigations in acute medical care facilities throughout Virginia. Inspects general hospitals, managed care organizations and acute medical care facilities throughout Virginia. Inspects general hospitals, outpatient hospitals, home care organizations and hospices comprising about 250 providers for compliance with state licensing quality of care standards. Enforces quality of care licensing regulations governing approximately 400 managed care plans and 75 private utilization review agents.

Certifies and enforces federal Medicare/Medicaid regulations governing 23 medical provider types in Virginia comprising over 2000 medical care providers. Also investigates fraudulent practices in home health, nursing homes and homes for the aged under the federal Operation Restore Trust Program. The cost of an average acute care onsite inspection is $3000.

Oversees complaint handling for the CQHCCP. Processes all complaints and investigates those complaints falling outside of the Divisions' routine onsite inspection schedules. Processes over 1400 complaints and facility reported incidents annually.
**Long Term Care Services Division (LTC)**

Consists of Medical Facilities Inspectors and Supervisor/Management Staff. Conducts onsite inspections and complaint investigations in long term care facilities throughout Virginia. Licenses nursing homes and enforces federal Medicare/Medicaid regulations governing four (4) LTC federal provider categories, as well as the nursing home components of general hospitals, mental hospitals and institutions for the mentally retarded.

The inspection workload comprises onsite inspections and complaint investigations at approximately 360 providers locations. The average cost of inspecting and licensing a nursing home is $2,000 per provider. The average cost of surveying and federally certifying a nursing home is approximately $3,000 per provider. The combined cost of licensing and federally surveying a nursing home is approximately $5,000.

**COPN/Policy Division**

Consists of the COPN Division’s Project Review Analysts, an Architect and a Policy Analyst. Reviews certificate of public need (COPN) applications and makes recommendations to the Commissioner of Health. Decisions by the Commissioner of Health are made on approximately 60 COPN applications annually. Reviews the architectural drawings of new construction and renovations in general hospitals, outpatient hospitals and nursing homes for compliance with state licensure regulations. Architectural plans on over 50 projects are reviewed and approved annually. Includes promulgation and review of twenty six (26) sets of state regulations.

**Education**

Consists of a Training Coordinator, Agency Management Analyst, MDS/RAI Coordinator, Computer Engineer and Help Desk Technician. Provides statewide training and educational programs to health care provider community, consumers and staff. Furnishes routine technical support and assistance to nursing homes and home health agencies, as well as interested public and private entities related to the MDS/RAI and OASIS statewide patient data base systems.

**Administration**

Consists of the Office Director, the Fiscal Unit, and an Executive Secretary. Provides overall direction, guidance and interpretation of the state/federal licensure/federal certification/COPN programs in Virginia.
**Program Costs**

Total annual expenditures are $5.8 million dollars. The combined state licensure costs for hospitals, nursing homes, home care, hospice, and the Medicaid state match expenditures ($1,570,000) account for approximately 32% of the total cost of the State Licensure/Federal Certification Program ($4,975,000). The federal certification program consists of Medicare/Medicaid/State Match/CLIA programs annually. Excluding COPN, all state programs, including the licensing and the MCOs and PRAs programs (1.8 million dollars), comprise 35% of the total CQHCCP Licensing/certification expenditures (5.2 million dollars).

**The State Licensing Programs**

The state licensing programs cover the following categories:

- Inpatient hospitals licensure
- Outpatient hospitals licensure
- Nursing homes licensure
- Home care Organizations (HCO) licensure
- Hospice licensure
- MCHIP’s Certification
- Private Utilization Review Agents (PRA) Certification

Regulations governing quality of care in hospitals, nursing homes, home care and hospice providers are promulgated by the VDH Board of Health. CQHCCP issues licenses to these providers based upon an onsite inspection process. Hospital and nursing home providers are inspected for licensure biennially. Home Care and Hospice providers are inspected annually.

Regulations governing licensure for MCHIPS and PRAs are promulgated by Bureau of Insurance, State Corporation Commission. The Center is developing regulations for promulgation by the VDH Board of Health by December 1999 which will establish quality of care regulatory standards for all MCHIPS in Virginia.

State regulatory authority for hospitals, nursing homes, home care organizations and hospices is found in Section 32 of the Code of Virginia and in the following state regulations:

- Rules and Regulations For The Licensure of Hospice, April 11, 1990
- Rules and Regulations For The Licensure of Home Health Organizations, April 11, 1990
- Rules and Regulations For The Licensure of Nursing Homes, October 15, 1980.
The Federal Survey and Certification Programs

Under an interagency agreement with the federal Health Care Financing Administration (HCFA), Department of Health and Human Services, CQHCCP administers the following federal programs. Regulatory authority for these programs is found in the Code of Federal Regulations (42 CFR) and in the State Operations Manual (SOM) issued by HCFA to state survey agencies.

1. MEDICARE (TITLE 18 OF THE SOCIAL SECURITY ACT)
2. MEDICAID CERTIFICATION (TITLE 19 OF THE SOCIAL SECURITY ACT
3. MEDICAID INSPECTION OF CARE (IOC)
4. CLINICAL LABORATORY IMPROVEMENT ACT OF 1988
5. MDS/RAI DATA BASE
6. OPERATION RESTORE TRUST

The federal survey programs expenditures account for approximately 68% of the total cost of the licensure/federal survey programs annually.

Medicare and Medicaid Certification

The Medicare and Medicaid certification programs have different and distinct revenue sources. The governing regulations which prescribe the conditions of participation and define the quality of medical care services which must be furnished in order for a medical care provider to obtain certification and reimbursement as a Medicare/Medicaid provider are the same. The purpose of the Medicare/Medicaid certification programs is to protect the health and safety of citizens receiving medical treatment in participating medical care facilities in Virginia.

Medicare/Medicaid regulations currently govern the provision of medical services in twenty three (23) medical provider categories. Through onsite inspections, the CQHCCP certifies non-accredited providers for Medicare/Medicaid participation, validates accredited providers and investigates complaints.

Federal program expenditures are reported based upon a federal fiscal year, which begins October 1 and ends September 30. Medicare funding for certification is obtained from HCFA and is based upon an approved annual budget. There is no state fund matching requirement for Medicare. Federal Medicaid funding for certification activities is obtained from HCFA and is available based on the level of CQHCCP's actual expenditures in the federal fiscal year. A negotiated and approved indirect cost rate of 4.5% is charged to both Medicare and Medicaid against salaries.

Medicaid State Match for Certification

There is 75/25% state matching requirement for all Medicaid certification fixed and variable costs. The Medicaid State Match for Certification is approximately $345,000 annually.
Medicare/Medicaid Certification Categories

<table>
<thead>
<tr>
<th>Provider Category</th>
<th># of Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Hospitals</td>
<td>104</td>
</tr>
<tr>
<td>Long term care including ICF/MR</td>
<td>336</td>
</tr>
<tr>
<td>Home Health</td>
<td>171</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>93</td>
</tr>
<tr>
<td>ESRD</td>
<td>78</td>
</tr>
<tr>
<td>Rehabilitation agencies</td>
<td>80</td>
</tr>
<tr>
<td>Ambulatory surgery centers</td>
<td>23</td>
</tr>
<tr>
<td>Psychiatric excluded units</td>
<td>21</td>
</tr>
<tr>
<td>Rehabilitation excluded units</td>
<td>16</td>
</tr>
<tr>
<td>Hospice</td>
<td>14</td>
</tr>
<tr>
<td>Other</td>
<td>215</td>
</tr>
<tr>
<td>Total</td>
<td>1,437</td>
</tr>
</tbody>
</table>

Clinical Laboratory Inspection Program

The purpose of the Clinical Laboratory Improvement Act of 1967 and 1988 Amendments (CLIA) is to assure that all laboratories performing tests of human specimens for the prevention, diagnosis and treatment of human disease meet strict federal standards and have a CLIA license in order to operate. The program is funded entirely by the collection of inspection fees by the Health Care Financing Administration. The CQHCCP is required to conduct onsite surveys on a two year cycle. A negotiated and approved indirect cost rate of 4.5% is charged to Medicaid against salaries.

<table>
<thead>
<tr>
<th>Provider Category</th>
<th># of Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laboratories</td>
<td>1034</td>
</tr>
</tbody>
</table>

Interagency Agreements

1. Office of Environmental Health Services - OEHS
   The CQHCCP and OEHS have agreed to share information and to cooperate with respect to mutual responsibilities related to the inspection of the kitchen and dining areas in health care facilities.

2. Virginia Health Information - VHI
   VHI agrees to collect and provide hospital survey data.

3. Department of Health and Human Services (DHHS)
VDH agrees with the Secretary, DHHS to administer the federal survey and certification programs for the Medicare and the CLIA programs.

4. **Department of Medical Assistance Services (DMAS)**
   VDH agrees to administer the Medicaid survey and certification programs. DMAS shares MDS patient data.

5. **Department of Health Professions (DHP)**
   DHP agrees with VDH and DMAS to administer the federal Nurse Aide Registry and Training Program. VDH and DMAS transfer state licensure, Medicare and Medicaid funds to DHP to support the program quarterly.

6. **Virginia Department for the Aging (VDA)**
   VDH agrees to share complaint information and cooperate with respect to mutual responsibilities related to onsite complaint investigations in long-term care facilities.

7. **Virginia Health Quality Center (VHQC)**
   VHQC agrees to review quality of care issues and share relevant data related to care and services received by Medicare beneficiaries in Virginia.

8. **Virginia Health Systems Agencies**
   Agreement to review and make recommendations on Certificate of Public Need applications.

9. **MCHIPs & PRA Agreement with the State Corporation Commission**
   Agreement allows the Center to examine and review quality of care issues, credentialing policies, quality assurance plans and the handling of complaints.

10. **Department of Social Services (DSS)**
    The DSS agrees to allow the Center to conduct fraud and abuse investigations in homes for adults.

**Publications**

Copies of state regulations governing inpatient hospitals, outpatient hospitals, nursing homes, home care and hospice providers, the Certificate of Public Need Program, as well as Directories with the names, addresses and phone numbers of licensed providers may be obtained by calling 804/367-2102. The cost is $10.00 a copy.

Copies of federal regulations must be obtained from the Superintendent of Public Documents in Washington, D.C.
Copies of survey reports, complaint investigation reports and COPN applications may be obtained for .20 cents a page under the Freedom of Information Act. All patient identifiers and complainant names will be blocked out in accordance with state/federal requirements governing patient confidentiality.

**Fees**

There is an annual state licensure fee charged and collected for hospitals, nursing homes, home care providers and hospice providers. Licensure fees total approximately $103,000 annually. There is no fee involved to become federally certified for participation in the Medicare/Medicaid programs. There is an inspection fee charged and collected by HCFA to clinical providers, which CQHCCP certifies for compliance with the federal Clinical Laboratory Improvement Act. There is a state application fee charged to COPN applicants based upon the dollar amount of the proposed project. COPN application fees total approximately $600,000 annually. The state fee structures can be found in the regulations governing the medical provider category in question. A copy of the regulations can be obtained by writing or calling CQHCCP.
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(as of November 1, 1998)  
The VDH Division of Certificate of Public Need  
The Virginia Medical Care Facilities  
Certificate of Public Need Program  
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The Virginia Department of Health (VDH) regulates capital spending for certain categories of medical care facilities and medical facility projects. Before any person can initiate such projects, they must apply for and obtain a certificate of public need (“COPN”) from the Commissioner of Health (“Commissioner”).

The COPN program was established at Va. Code Section 32.1-102.3 et seq. in 1973 to “encourage, foster, and promote the planned and coordinated development of necessary and adequate... medical care facilities... in a manner which is coordinated, orderly, timely, economical and without unnecessary duplication of services and facilities.” The program’s objectives are to “promote comprehensive health planning, assist in promoting the highest quality of health care at the lowest possible cost, avoid unnecessary duplication of medical care facilities, and provide an orderly administrative procedure for resolving questions concerning the necessity of construction or modification of medical care facilities.”

The Commissioner approves or denies a request for a COPN after an application review process, aimed at determining whether there is a public need for the project based on standards of need developed by VDH and required considerations in the law. There are always two levels of application review and sometimes, three levels of review which occur before a final decision is made by the Commissioner.

First, the application is considered by a regional health planning agency (“RHPA”). There are five RHPAs in Virginia, organized as not-for-profit corporations. They receive state funding through VDH and review and advise the Commissioner on COPN requests in their regions. Each has a voluntary Board of Directors which includes consumer and provider representation. These Boards recommend approval or denial of COPN requests after a public hearing on the requests has been convened.

Secondly, the application is considered by VDH staff of the Division of Certificate of Public Need. Department staff consider the RHPA recommendation and also perform their own evaluation of the project’s compliance with the project review standards established for COPN. These
standards are embodied in a regulation known as the State Medical Facilities Plan (12 VAC 5-230 through 5-360).

A potential third level of review is adjudication. If a project receives a negative recommendation from the RHPA or Department staff or if a request is made for adjudication by an opponent of the project who can demonstrate “good cause” the project will be reviewed by a VDH Adjudication Officer. An informal fact-finding conference is convened at which all present their respective positions to the Adjudication Officer. The Adjudication Officer makes his own findings on the need for the project and a recommendation to the Commissioner.

The categories of medical care facility currently regulated under the Virginia COPN program are:

- general hospitals;
- sanitariums;
- nursing homes;
- intermediate care facilities;
- extended care facilities;
- mental hospitals;
- mental retardation facilities;
- psychiatric hospitals;
- intermediate care facilities established primarily for the medical, psychiatric or psychological treatment and rehabilitation of alcoholics or drug addicts;
- specialized centers, clinics, or physician offices developed for outpatient surgery and nine other designated diagnostic or treatment services;
- rehabilitation hospitals;
- any facility licensed as a hospital.

The types of projects which require COPN authorization are:

- establishment of a medical care facility (see list above);
• an increase in the total number of beds or operating rooms in an existing or authorized medical care facility;

• relocation at the same site of ten beds or ten percent of the beds, whichever is less, from one existing physical facility to another in any two year period;

• the introduction into any existing medical care facility of seventeen designated diagnostic or treatment services;

• the conversion of beds in an existing medical care facility to medical rehabilitation or psychiatric beds;

• the addition by an existing medical care facility of equipment for the provision of nine types of diagnostic or treatment service;

• the replacement by an existing medical care facility of equipment for the provision of eight types of diagnostic or treatment service;

• any capital expenditure by or in behalf of an existing medical care facility of $5 million or more.

In the past two fiscal years, the Department has reviewed an average of 61 COPN requests per year. In the most recent fiscal year which ended June 30, 1998, the Commissioner issued 63 decisions, authorizing 54 projects with total authorized costs of $168,474,718 and denying 9 projects with estimated capital costs of $9,370,319.

COPN program expenses, at the VDH level, are solely funded from COPN application fees, authorized in state law and established by regulation.

Regional health planning agencies, which participate in the COPN regulatory process, are authorized to receive state general funds, under Va Code Section 32.1-122.06. They also receive excess COPN application fee revenue. This funding is administered by the Department and distributed to RHPAs in the form of grants. RHPAs can also obtain funding from local government and other sources.
The Virginia Department of Health  
Office of the Chief Medical Examiner  
(as of November 1, 1998)  
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The Office of the Chief Medical Examiner offers statewide investigation of the deaths of persons who die a sudden, unexpected, suspicious, or violent death. The Medical Examiner System is staffed by 400 plus physicians in the cities and counties of Virginia who serve voluntarily part-time (fee-for-service city and county medical examiners). City and county medical examiners, appointed by the Chief Medical Examiner, receive notices of deaths falling under the jurisdiction of the Medical Examiner as outlined by § 32.1-277 of the Code of Virginia. Following guidelines promulgated by the Chief Medical Examiner, local medical examiners refer cases for medicolegal autopsy to one of four regional medical examiner offices. The regional offices are staffed by board certified forensic pathologists who perform autopsies, determine the cause and manner of death, collect medical evidence and reconstruct mechanisms of injuries.

The four missions of the Medical Examiner System are mandated by the Virginia Code. The missions are:

1. To investigate deaths of public interest;
2. To provide instruction in legal medicine to the institutions of higher learning in Virginia;
3. To administer the State Anatomical Program; and
4. To chair and coordinate the State Child Fatality Review Team.

Virginia’s Medical Examiner System was created in 1947 by the General Assembly at the urging of the Medical Society of Virginia and the Virginia Bar Association. The purpose was to bring medical expertise to the investigation to all sudden, unexpected and violent deaths to all cities and counties in Virginia regardless of the population, budget or indigenous level of violence. The Medical Examiner System archives reports of all death investigations and provides medical expertise to the criminal and civil courts of the Commonwealth, law enforcement agencies, families, insurers, and to others who have a legitimate need to know information relating to cause and manner of citizens’ deaths. The office continually serves the public health by identifying trends in causes of death, providing statistical information to epidemiologic researchers and by cooperating with other agencies seeking to develop strategies to reduce violent death and promote the public health.
The Medical Examiner System, in cooperation with the Department of Legal Medicine of the Medical College of Virginia, Virginia Commonwealth University, trains graduate pathologist fellows in forensic pathology and pathology residents in one of the oldest accredited training programs in the country. The office is certified by the National Association of Medical Examiners. The pathologists in the Medical Examiner System provide more than 1,500 hours a year of direct teaching to physicians, lawyers, medical and law students, law enforcement, health professionals and citizens.

The licensed embalmers of the State Anatomical Program receive bodies donated by citizens and provide more than 400 donations for scientific research to the schools of medicine and the institutions of higher learning throughout the Commonwealth.

The Child Fatality Review Team coordinator and the Chief Medical Examiner are responsible for administering the Child Fatality Review Team, which provides epidemiologic review of over 1200 child fatalities each year and develops recommendations for prevention of child deaths in Virginia.

The statistical data derived from death investigation on causes and manner of death is utilized by local, regional, state and federal agencies for program planning and outcome studies. The system operates at a cost of 49 cents per capita.

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Mission

The Office of Water Programs (OWP) is dedicated to protect the public health and promote the public welfare by ensuring that drinking water from public drinking water systems (waterworks) is pure water and all molluscan shellfish and crustacea offered for wholesale are sanitary and fit for market.

In addition, OWP implements the project evaluation program of the Division of Wastewater Engineering (DWE), Office of Environmental Health Services, to ensure that all municipal sewage systems and sewage treatment works are designed and constructed in conformance with applicable regulations.

Organization

OWP consists of the Central Office (CO), the Division of Water Supply Engineering (DWSE), the Division of Shellfish Sanitation (DSS), six engineering field offices, and three shellfish field offices.

OWP has a staff of 146 employees. The OWP CO staff consists of six employees, who provide general support to the two divisions and are budgeted through DWSE. DWSE is the larger division with 115 employees. DSS has a staff of 31.

Of the 115 employees of the DWSE, an equivalent of nine engineers are utilized in support of the sewage project evaluation program of DWE, Office of Environmental Health Services. Implementation of the majority of DWSE programs and the sewage project evaluation program of DWE is through OWP staff located in six environmental engineering field offices. These field offices are located in Abingdon (Abingdon Field Office or AFO), Lexington (Lexington Field Office or LFO), Culpeper (Culpeper Field Office or CFO), Danville (Danville Field Office or DFO), Chesterfield County (East Central Field Office or ECFO), and the City of Virginia Beach, (South East Field Office or SEFO).

DSS operates three field offices, one each located in White Stone, Norfolk, and Accomac.

Central Office
The Central Office provides management, administrative (personnel, budget, and fiscal), and training support for OWP. The CO develops, establishes, and approves OWP policy, procedures and standards. The CO coordinates the activities of its various units.

The CO provides general supervision of the six engineering field offices, which implement the drinking water program and the project evaluation program for municipal sewerage systems and sewage treatment works, and coordinates any conflicting program demands.

**Division of Water Supply Engineering**

DWSE is responsible for protecting the health of consumers of drinking water provided by public drinking water systems (waterworks) by ensuring that the drinking water is pure water. This function is authorized by Public Water Supplies, § 32.1-167 et seq. of the *Code of Virginia* and is implemented via the Waterworks Regulations. The DWSE is the primary agency for implementation and enforcement of the federal Safe Drinking Water Act and the National Primary Drinking Water Regulations.

The *1996 Amendments to the Safe Drinking Water Act* established the Drinking Water State Revolving Fund (DWSRF) Program. The purpose of the DWSRF Program is (i) to provide low cost loans to waterworks owners in need of making infrastructure improvements to protect public health; and, (ii) to provide financial and technical assistance to waterworks owners to ensure the long term provision of safe drinking water to their customers.

The division’s 14 central office employees, including the six employees utilized in the DWSRF Program, support the 95 employees in the field offices, including three DWSRF Program staff, in the six engineering field offices.

**Engineering Field Offices**

The staff in the field offices provide direct service and are organized to provide one-stop-shopping to owners, operators and designers of waterworks, sewerage systems, sewage treatment works and biosolids use contractors, and the general public. The organization focuses upon the District as the unit, which provides the service delivery. Districts are coterminous with the state planning districts. Districts 12, 15, and 20 are subdivided into A and B because of the heavy workload. A typical district is managed by a District Engineer who may lead a team consisting of one or more Assistant District Engineers or Inspectors. The District Engineer is responsible for implementation of the Waterworks Regulations, Sewerage Regulations, and Biosolids Use Regulations in the District. The District Engineer’s responsibilities include but are not limited to: (i) evaluation of applications, reports, plans, specifications and other engineering documents for the design, construction, and operation of waterworks, sewerage systems, sewage treatment works, and biosolids use facilities; (ii) approving development and utilization of new water sources; (iii) conducting sanitary surveys of waterworks; (iv) providing technical assistance; (v) investigating complaints; (vi) assessing compliance; and, (vii) when necessary, initiating enforcement actions.
Division of Shellfish Sanitation

DSS is responsible for protecting the health of the consumers of molluscan shellfish and crustacea by ensuring: (i) that shellfish growing waters are properly classified for harvesting; (ii) that molluscan shellfish and crustacea processing facilities meet sanitation standards; and that all facilities have developed hazard Analysis Critical Control Point (HACCP) plans. These functions are authorized by Fish, Oysters, Shellfish and Other Marine Life, Health and Sanitation Provisions, § 28.2-800 et seq. of the Code of Virginia and are implemented via Rules and Regulations Governing the Sanitary Control of Oyster, Clams and Other Shellfish, and the Rules and Regulations for the Sanitary Control of the Picking, Packing and Marketing of Crab Meat for Human Consumption. In addition, for the Virginia molluscan shellfish industry to engage in interstate commerce, Virginia must conform to the National Shellfish Sanitation Program (NSSP) administered by the United States Food and Drug Administration.

The central office staff of the DSS consists of nine employees. The DSS central office staff supports the field operations consisting of 22 employees and determines the classification of shellfish growing waters. Shoreline surveys to support the classification of growing waters are coordinated from the central office. Both central office staff and field office staff participate in shoreline surveys. Most data gathering and program implementation is through its three field offices (Norfolk, White Stone, and Accomac).

Shellfish Field Offices

The staff in the shellfish field offices have two major categories of customers: (i) the owners and operators of shellfish and crustacea processing facilities and lease holders of shellfish growing areas; and, (ii) the central office staff of the division responsible for the classification of shellfish growing areas.

The field office staff, under the leadership of the Shellfish Field Director: (i) conduct sanitary and HACCP inspections of molluscan shellfish and crustacea processing facilities; (ii) conduct shoreline surveys to identify pollution sources which may affect shellfish growing area water quality; (iii) collect seawater samples for microbiological analysis; (iv) collect hydrologic data to be utilized in the classification of growing waters; (v) analyze seawater and meat (oyster, clam, scallop, crab) samples; and, (vi) collect oyster, clam and seawater samples for heavy metal, toxic substances and radiological analysis by the Division of Consolidated Laboratory Services, Department of General Services. Each field office includes a microbiological laboratory which provides timely data to support the classification of shellfish growing waters and the sanitation in processing facilities.

Contacts

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Women, Infants and Children (WIC) Program
(as of November 1, 1998)
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mtate@vhd.state.va.us Email

Mission

The Virginia Department of Health’s (VDH) Division of Chronic Disease Prevention and Nutrition administers the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). The Virginia WIC Program is funded through the U.S. Department of Agriculture (USDA) and is operated through local health departments as well as satellite and mobile clinics.

The mission of the Virginia WIC Program is to provide high-quality nutritional care and food to low-income pregnant, lactating, and postpartum women and children up to age five. The program provides milk, cheese, eggs, juice, cereal, dried beans or peas, peanut butter and iron-fortified formula that supply crucial nutrients such as protein, iron, calcium, and vitamins A and C essential to this population.

The WIC Program is unique in that it mandates ongoing nutrition education by specially trained personnel for all participants and/or their caretakers.

Program Description

The Virginia WIC Program is administered by nearly 550 employees in approximately 170 sites available. WIC personnel are multi-disciplinary, drawing from the fields of nutrition, nursing, health education, and public health.

Currently, 75 percent of the funding for Virginia’s WIC Program is received from a grant from the USDA. The remaining funds are received from a rebate program offered through Ross Laboratories, the Virginia WIC Program’s supplier of infant formula.

Within the scope of the WIC Program, there are two primary areas of responsibility: (1) program services for eligible participants; and, (2) vendor account services for participating retailers.
WIC Program Services

There are currently more than 137,000 Virginians participating in the WIC Program. Eligibility is established based on program specific residential, categorical, and income (less than or equal to 185 percent of the poverty level) requirements, as well as nutritional need based on a medical/nutritional assessment.

Each year, the Virginia WIC Program releases a WIC Approved Food List that is effective October 1st. This is a listing of WIC-approved foods that participants can choose from when shopping at participating retailers. All foods listed must meet established Federal guidelines as well as state-specific criteria. Food companies and manufacturers can apply to have food items added to the list. To do so, important product information such as nutrient analysis, product availability, and product labels must be submitted to the WIC Program Manager by February 1st of each year.

Program participants receive vouchers for WIC-approved foods. These vouchers may be redeemed at one of 1,100 authorized retailers.

WIC Vendor Account Services

Through the Virginia WIC Program, training and support is provided to the 1,100 retail stores currently authorized to participate in the program. Participating retailers are predominantly located in Virginia. However, there are a few located in other states who serve the needs of participants living in border areas of Virginia.

There are a variety of retail stores participating in the Virginia WIC Program including: small independent stores; full service grocery stores; commissaries; and pharmacies. Authorized retailers are eligible to accept checks issued by the Virginia WIC Program from program participants. These checks reimburse retailers for WIC-approved foods prescribed for participants by WIC personnel. In 1997, retailers received more than $72 million from the Virginia WIC Program.

Authorized retailers are selected based on a competitive process that is dependent upon the service needs of the program. Each authorized store signs a contractual agreement that specifies both the VDH’s and retailer’s responsibilities. In addition, a Vendor (Retailer) Manual for the Virginia WIC Program is distributed to all authorized stores. This manual contains the VDH’s policies and procedures for administering and managing the WIC Program. Additionally, it outlines the retailer’s responsibilities and requirements. Retail stores have a ‘right to appeal’ the VDH’s decisions, which affect their authorization status, including any disqualification actions. Based upon past experience, some retail stores elect to seek legal counsel regarding the following areas:

- Transfer and change of store ownership;
- Retailer selection and authorization;
• Program compliance (i.e. sanction points, civil monetary penalty fines, etc.); and,

• Disqualification.

Contacts

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The mission of the Virginia Department of Health Professions is to assure the safe and competent delivery of health care to citizens of the Commonwealth by providing support for the following activities of the health regulatory boards:

- Licensing applicants who meet minimum qualifications as determined by law and regulation.
- Taking appropriate action to enforce compliance with legal requirements.
- Issuing licenses or permits to certain health related businesses and inspecting for compliance with applicable laws and regulations.
- Studying and recommending the appropriate degree of regulation of health related professions and occupations.
- Enforcing standards to assure safety and integrity of drugs and medical devices.

**Board of Audiology and Speech-Language Pathology**

Elizabeth Y. Tisdale  
Executive Director  
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Regulations are available from the Board’s office at 6606 West Broad Street, 4th Floor, Richmond, Virginia 23230-1717. The Board is an agency within the Department of Health Professions. Title 54.1, Ch. 25.

The Board is authorized to license the practice of audiology and speech-language pathology, to fix standards for licensure and professional conduct, and to make regulations to carry out the licensing act. See Title 54.1, Chs. 25 and 26.
Board of Dentistry

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Regulations are available from the Board’s office at 6606 West Broad Street, 4th Floor, Richmond, Virginia 23230-1717. Also available is Dental Statutes of Virginia, reprinted from the Code of Virginia.

The Board is an agency within the Department of Health Professions. Title 54.1, Ch. 25. It is authorized to license and promulgate regulations governing the practice and teaching of dentistry and dental hygiene. See Title 54.1, Ch. 27. For reports required to be made to the Board by hospitals, other health care institutions, and practitioners of the healing arts respecting drug addiction, alcoholism, psychiatric illness, incompetence, or improper conduct of Board licensees, see Title 54.1, Ch. 29.

Board of Funeral Directors and Embalmers

Elizabeth Y. Tisdale
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Regulations are available from the Board’s office at 6606 West Broad Street, 4th Floor, Richmond, Virginia 23230-1717.

The Board is an agency within the Department of Health Professions. See Title 54.1, Ch. 25. It is authorized to license individuals and establishments providing funeral and embalming services, to register surface transportation and removal service companies, and to supervise programs for resident trainees, to regulate pre-need funeral contracts and pre-need funeral trust accounts, and to make regulations to improve and promote standards of service and practice and otherwise to carry out the licensing act. The Board is also directed to enforce applicable regulations of the State Board of Health and of local governments. See Title 54.1, Ch. 28.
Board of Health Professions

Robert A. Nebiker
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Statutes governing the Board and Regulations of the Board are available at the Board’s office at 6606 West Broad Street, 4th Floor, Richmond, Virginia 23230-1717.

The Board is an agency within the Department of Health Professions. See Title 54.1, Ch. 24 and 25. The Board’s advisory authority includes evaluation of the need for coordination among health professional regulatory boards within the Department; review of the need to regulate or deregulate health occupations and professions; monitoring of the activities of the Department and providing a forum for the resolution of conflicts among the boards within the agency and between the boards and the agency; review and comment on the agency’s budget; providing a means for public access to the Department and publicizing the policies and programs of the agency; comment on all regulations proposed or promulgated by the boards; development of standards for evaluating the competency of regulated health occupations and professions; review of enforcement and discipline activities of the boards and the Department; and examination and comment on scope of practice conflicts. The Board advises the Governor, the General Assembly and the Director of the Department on all matters regarding the regulation or deregulation of health occupations and professions.

In addition, the Board administers the Practitioner Self-Referral Act, Ch. 24.1 (§54.1-2410 et seq.). The Act establishes the framework for determining the legality of investment, referral and other activities of licensed, certified and unregulated health care practitioners and entities in the Commonwealth. The Board’s authority includes establishment of standards, procedures and criteria for administration of the Act, for determining compliance with, exceptions to and violations of the Act and for advising practitioners and entities of the applicability of the Act; levying and collecting fees related to exceptions from the Act and authorization to make referrals; granting exceptions and issuing advisory opinions, determining violations of the Act by entities other than practitioners as defined in §54.1-2510 and taking appropriate actions against these entities; and overseeing the adjudication of complaints and reports alleging violation of the Act by practitioners regulated by health professional boards within the Department.

The Board is comprised of seventeen members appointed by the Governor. One member each is appointed from among the members of the twelve health professional regulatory boards within the agency, and five members from the Commonwealth at large (§54.1-2507).
**Board of Medicine**

Warren W. Koontz  
Executive Director  
Phone: (804) 662-9960  

Ola Powers  
Deputy Executive Director, Licensure  
Phone: (804) 662-9073  

Karen Perrine  
Deputy Executive Director, Discipline  
Phone: (804) 662-7693  

Fax: (804) 662-9517  
E-mail: www.medbd@dhp.state.va.us  

Regulations are available from the Board’s office at 6606 West Broad Street, 4th Floor, Richmond, Virginia 23230-1717.

The Board is an agency within the Department of Health Professions. See Title 54.1, Ch. 25. It is authorized to license the practice of acupuncture, medicine, osteopathy, chiropractic, podiatry, physical therapy, radiologic technologists, radiologic technicians, occupational therapy, respiratory therapy, and physician assistants. The Board also makes regulations to carry out the licensing act and jointly with the Board of Nursing, to make regulations respecting services and prescriptive authority of the nurse practitioner. See Title 54.1, Ch. 29. For reports required to be made to the Board by hospitals, other health care institutions, medical societies, and physicians respecting drug addiction, alcoholism, psychiatric illness, incompetence or improper conduct of Board licensees, see Title 54.1, Ch. 29, Art. 1.

**Board of Nursing**

Nancy K. Durrett  
Executive Director  
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Regulations are available from the Board’s office at 6606 West Broad Street, 4th Floor, Richmond, Virginia 23230-1717. Copies are also distributed to Virginia schools of nursing, hospitals, nursing homes, and related health agencies and organizations. Board actions, including disciplinary actions, are distributed quarterly to these entities. The Board’s Newsletter is distributed to all licensees one time a year.
The Board is an agency within the Department of Health Professions. See Title 54.1, Ch. 25. It is authorized to license registered and practical nurses, to register clinical nurse specialists, to certify nurse aides and massage therapists, to approve and prescribe minimum standards for nursing education programs, to approve curricula therefor, and to make regulations to carry out the act. See id. at Ch. 30. It is also authorized, jointly with the Board of Medicine, to make regulations respecting medical or health services that nurse practitioners (including nurse midwives and nurse anesthetists) may render under the supervision of physicians, and regulations governing prescriptive authority for nurse practitioners. See id. at Ch. 29. For reports required to be made to the Board by hospitals, other health care institutions, and practitioners of the healing arts respecting drug addiction, alcoholism, psychiatric illness, incompetence, or improper conduct of Board licensees, see Title 54.1, Ch. 29, Art. 1.

Board of Nursing Home Administrators

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Regulations are available from the Board’s office at 6606 West Broad Street, 4th Floor, Richmond, VA 23230. The Board is a separate agency within the Department of Health Professions. Code of Virginia, Title 54.1, Ch. 25.

The Board is authorized to license nursing home administrators, to prescribe standards for licensure and professional conducts, and to make regulations to carry out the licensing act. Code of Virginia, Title 54.1, Chs. 25 and 31.

Board of Optometry

Elizabeth A. Carter
Executive Director
(804) 662-9910
(804) 662-7098
E-mail: cstamey@dhp.state.va.us

Regulations are available from the Board’s office at 6606 West Broad Street, 4th Floor, Richmond, Virginia 23230-1717.

The Board is a regulatory board within the Department of Health Professions. See Title 54.1, Ch. 25. It is authorized to license optometrists, to make regulations fixing standards for admission and governing practice, and to approve courses of continuing education required for annual license renewal. The Board has the authority to take disciplinary actions against licenses who are found in
violation of the laws or regulations governing the practice of optometry in the Commonwealth. See id. at Ch. 32.

Board of Pharmacy

Elizabeth Scott Russell  
Executive Director  
Phone: (804) 662-9911  
Fax: (804) 662-9313  
E-mail: pharmbd@dhp.state.va.us

Regulations are available from the Board’s office at 6606 West Broad Street, 4th Floor, Richmond, Virginia 23230-1717 and are also on the Board’s website at www.dhp.state.va.us.

The Board is an agency within the Department of Health Professions. See Title 54.1, Ch. 25. It is authorized to license pharmacists, pharmacies, and those persons engaged in the manufacture, distribution, and dispensing of drugs and devices, and to register persons prescribing or doing research in controlled drugs; to modify the statutory classifications of controlled drugs; to prescribe standards for special packaging; and to make regulations respecting equipment, sanitation, quality control, and safeguards against diversion, and otherwise to carry out the drug control statutes. See id. at Ch. 33. The Board is authorized to license and regulate the sale of controlled substances by practitioners of the healing arts. The storage, handling, and distribution of prescription drugs by wholesale distributors, medical equipment suppliers, and warehousers, to assure the integrity of and to prevent the diversion of prescription drugs, are regulated by the Board. See Title 54.1, Chs. 33 and 34.

It may also embargo products and impose a monetary penalty for violations not prosecuted. See id. at Ch. 34 and Title 18.2, Ch. 7.

Board of Licensed Professional Counselors, Marriage and Family Therapists and Substance Abuse Professions

Evelyn Brown  
Executive Director  
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E-mail: EBROWN@dhp.state.va.us

Regulations are available from the Board’s office at 6606 West Broad Street, 4th Floor, Richmond, Virginia 23230-1717.

The Board of Licensed Professional Counselors, Marriage and Family Therapists and Substance Abuse Professionals is the professional board authorized to license and regulate the
practice of professional counselors, marriage and family therapists and substance abuse treatment practitioners and the certification of substance abuse counselors and rehabilitation providers. See Title 54.1, Chs. 24 and 35.

Legislation enacted by the 1994 General Assembly creates an Advisory Board on Rehabilitation Providers to this Board and authorizes the Advisory Board to recommend standards for the voluntary certification of rehabilitation providers to the Boards of Medicine, Nursing, Professional counselors, Psychology, and Social Work for licensees of these boards, and to recommend standards to the Board of Professional Counselors for the mandatory certification of persons who provide rehabilitative services but are exempt from licensure as professional counselors under subdivision 1 of §54.1-3501. (H.B. 733).

Board of Psychology

Evelyn Brown
Executive Director
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Regulations are available from the Board’s office at 6606 West Broad Street, 4th Floor, Richmond, Virginia 23230-1717.

The Board of Psychology is the professional board concerned with the practice of psychology and school psychology, and with recommendations to the Board of Medicine concerning applicants for licensure as clinical psychologists. See Title 54.1, Chs. 24 and 36.

Legislation enacted by the 1994 General assembly creates an Advisory Committee on Certified Practices to this Board and authorizes the Committee to recommend standards for the voluntary certification of sex offender treatment providers to the Boards of Medicine, Nursing, Professional Counselors, Psychology, and Social Work for licensees of these boards, and to recommend standards for the mandatory certification of sex offender treatment providers by the Board of Psychology for professionals who are otherwise exempt from licensure under subdivision 4 of §§54.1-3501, 54.1-3601 or 54.1-3701. Unless reenacted, these provisions expire on July 1, 1999.

Board of Social Work

Evelyn Brown
Executive Director
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E-mail: EBROWN@dhp.state.va.us
Regulations are available from the Board’s office at 6606 West Broad Street, 4th Floor, Richmond, Virginia 23230-1717.

The Board of Social Work is an agency within the Department of Health Professions. See Title 54.1, Chs. 34 and 37. The Board is the professional board concerned with the practice of social work. See id. at Ch. 37.

**Board of Veterinary Medicine**

Elizabeth Carter  
Executive Director  
Phone: (804) 662-9915  
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Regulations are available at the office of the Executive Director of the Board, 6606 West Broad Street, 4th Floor, Richmond, VA 23230. The Board is an agency within the Department of Health Professions. Code of Virginia, Title 54.1, Ch. 25.

The Board is authorized to license veterinarians and veterinary technicians, and to approve veterinary school and college programs and programs of practical training. It may establish standards for licensure and professional conduct, and make regulations governing the conduct of veterinary medicine and animal facilities, and otherwise to carry out the statute; and it may inspect premises and issue subpoenas. The Board may promulgate any necessary regulations for the issuance of temporary licenses to graduates of Board-approved veterinary medicine programs or persons who have completed certain testing and certification requirements. Code of Virginia, Title 54.1, Ch. 38.
The Statute

Chapter 10 of Title 37.1 of the *Code of Virginia* governs the delivery of community mental health, mental retardation, and substance abuse services. The 1998 General Assembly session passed House Bill 428, the first significant revision of Chapter 10 since the original legislation was enacted in 1968. HB 428 introduced fundamental changes in the structure and delivery of community services. While many provisions took effect July 1, 1998, others related to outcome and performance measures will not take effect until 2000. This article discusses the major changes enacted with the passage of HB 428.

Overview of Community Services

Community mental health, mental retardation, and substance abuse services are provided through 40 community services boards (CSBs) that cover the whole state. CSBs are established by cities and counties, singly or in combination. CSBs serve 20,000 Virginians annually; their total budgets exceed $430 million. CSBs are governed by boards of directors, volunteers who are appointed by their local governments. More than 500 citizens serve as board members.

Boards are legally considered agents of the local governments that established them. However, the structural relationships of CSBs to their local governments vary significantly. Eight CSBs are city or county departments. Three CSBs are staffed by city or county employees, but there is no department. The other 29 CSBs employ their own staff, are not local government departments, and operate relatively autonomously. Until now, these structural differences were not reflected in Chapter 10. This situation led to ambiguous situations where accountability was not clear.

HJR 240 Joint Subcommittee

The General Assembly established the HJR 240 Joint Subcommittee to Evaluate the Future Delivery of Publicly Funded Mental Health, Mental Retardation and Substance Abuse Services in
1996. HB 428 is one of the Joint Subcommittee’s major products. An underlying theme of HB 428 is increased accountability. This will be achieved through:

1. clearer relationships between CSBs and the local governments that established them and between CSBs and the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services (the Department);

2. greater involvement and participation of consumers and family members in policy and decision making and services planning, delivery, and evaluation; and

3. an enhanced and expanded performance contract that will include consumer outcome, provider performance, and consumer satisfaction measures and comparable and consistent information about costs, services, and consumers.

Types of Community Services Boards

HB 428 clarifies relationships and increases accountability by defining three types of community services boards (CSBs).

Operating CSB: Powers and duties are enumerated in § 37.1-197.A of the Code of Virginia. The CSB employs its own staff and provides services directly or through contracts with other providers. The CSB is not a city or county government department.

Administrative Policy CSB: Powers and duties are enumerated in § 37.1-197.B of the Code. The CSB does not employ its own staff. The CSB’s executive director is hired by local government with the board’s participation. Services are provided by city or county employees or through contracts with other providers.

Policy-Advisory CSB: Powers and duties are enumerated in § 37.1-197.C of the Code. The CSB has no operational powers or duties; it is an advisory board to a local government department that provides services directly or through contracts with other providers. The powers and duties of the local department are enumerated in § 37.1-197.A of the Code of Virginia.

Section 37.1-194 of the Code requires every city and county that has established or joined a CSB (all 135 localities had done so by 1982) to designate the type of CSB it has by July 1, 1998. Local Governments can change their designation at any time by ordinance. In the case of CSBs established by more than one city or county, such a change must be unanimous among all of the jurisdictions.

While not all CSBs had been designated at the time this article was written, it appears that there will probably be 29 operating boards, 10 administrative policy CSBs, and one policy-advisory board. While most administrative policy CSBs serve one city or county, several serve more than one locality.
CSB Appointments

Section 37.1-195 of the Code requires that one third of the appointments to every CSB be identified consumers of services or family members of consumers, at least one of whom must be a consumer currently receiving services. Section 37.1-195 also increases the number of local government officials who can be appointed from one jurisdiction to a CSB from one to two and, for the first time, allows appointed officials to serve on CSBs. Finally, this section allows the appointment of one or more non-governmental service providers, as long as the board members and staff of such an organization do not receive any funds from any CSB.

New CSB Responsibilities

Operating and administrative policy CSBs and local government departments have several new duties as a result of the passage of HB 428. In the rest of this article, references to CSBs should be understood to include local government departments that receive advice from policy-advisory CSBs.

1. Take all necessary and appropriate actions to maximize the involvement and participation of consumers and family members in policy formulation and services planning, delivery, and evaluation.

2. Institute a consumer dispute resolution mechanism approved by the Department of Mental Health, Mental Retardation and Substance Abuse Services. This mechanism must enable consumers and family members of consumers to resolve concerns, issues, or disagreements about services without adversely affecting their access to or receipt of appropriate types and amounts of current or future services from the board. This mechanism would not deal with allegations of violations of a consumer’s human rights, which are dealt with through the existing human rights regulations.

3. Serve as the single point of entry into the publicly funded mental health, mental retardation and substance abuse services system.

4. Develop and submit to the Department the necessary information for the comprehensive state plan required by § 37.1-48.1 of the Code.

5. Provide, in consultation with the appropriate state mental health facility or training center, predischarge planning for any person who, prior to admission, resided in the locality served by the CSB. Until now, state facilities had the lead responsibility for predischarge planning, and CSBs merely cooperated with state facilities. HB 428 fundamentally reverses this relationship.
Predischarge Planning

HB 428 strengthens and elaborates Code provisions related to predischarge planning. Section 37.1-197.1 now states that no person shall be discharged from a state facility without completion of a predischarge plan by the CSB.

The plan must be prepared with the involvement and participation of the consumer or his or her representative. It must reflect the consumer’s preferences to the greatest extent possible. Finally, the plan must include the mental health, mental retardation, substance abuse, social education, medical, employment, housing, legal, advocacy, transportation, and other services that the consumer will need upon discharge, and it must identify the public or private agencies that have agreed to provide these services.

Section 37.1-197.1 also establishes a process for dealing with disagreements between state facilities and CSBs about a patient’s readiness for discharge. If state facility staff identify a person as ready for discharge and the CSB disagrees, the CSB must document its reasons in the person’s treatment plan within 30 days. If the state facility disagrees with the CSB’s position and the CSB refuses to develop a predischarge plan, the state facility or CSB must ask the Commissioner of the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services to review the state facility’s identification of the person as ready for discharge.

If the Commissioner determines that the person is ready for discharge, the Department will develop a plan. The Commissioner will also determine if sufficient state-controlled funds have been allocated to the CSB to implement the plan. If sufficient funds have been allocated, the Commissioner may contract with a private provider or another CSB to deliver the services in the plan and withhold funds from the CSB originally responsible for the person’s care.

CSB Performance Contract

Original language in Chapter 10 of Title 37.1 of the Code addressed financial and service accountability by requiring CSBs to submit plans and budgets for approval by their local governments and the Department. HB 428 replaces this plan and budget with the performance contract as the accountability and funding mechanism for community services.

Section 37.1-198.A of the Code requires the Department to develop and negotiate the performance contracts through which it funds CSBs. It also requires the Department to make the standard contract form (the language in the contract body) available to the public six months before the start of the fiscal year and to solicit public comments for a period of 60 days.

Section 37.1-198.B requires the CSB to make its proposed performance contract available for public review and to solicit public comments for a period of 30 days before it is acted upon by the CSB’s board of directors. This section also requires the governing body of each local
government that established the CSB to approve the performance contract by formal vote before September 15 of each year.

Section 37.1-198.C of the Code states that the performance contract shall:

1. delineate responsibilities of the Department and the CSB;
2. specify conditions that must be met for the receipt of state controlled funds by the CSB (state controlled funds include state general funds and federal funds appropriated by the General Assembly and Medicaid fees received by CSBs);
3. identify the groups of consumers to be served with state-controlled funds;
4. beginning on July 1, 2000, contain specific consumer outcome, provider performance, consumer satisfaction, and consumer and family member participation and involvement measures and state facility bed utilization targets that have been negotiated with the CSB;
5. establish an enforcement mechanism should a CSB fail to comply with any provisions of its contract that includes a notice and appeal process and provisions for remediation, the withholding of funds, repayment of funds, and the Department’s termination of the contract; and
6. include reporting requirements and revenue, cost, service, and consumer information displayed in a consistent, comparable format determined by the Department.

This section also authorizes the Department to contract with an administrative services organization to determine whether CSBs are performing in accordance with the requirements of their performance contracts.

Section 37.1-198.D of the Code states that no CSB shall be eligible to receive state-controlled funds after September 15 of each year unless:

1. its performance contract has been approved by the governing body of each local government that established the CSB;
2. it provides service, cost, revenue, and aggregate and individual consumer data and information to the Department in a format prescribed by the Department; and
3. starting on July 1, 2000, it uses standardized cost accounting and financial management systems approved by the Department.

Section 37.1-198.E authorizes the Department to terminate all or a portion of a CSB’s performance contract, after unsuccessful use of a remediation process described in the contract and affording the CSB an adequate opportunity to use the appeal process in the contract, if the CSB
remains in substantial noncompliance with its contract. After termination, the Department may use the state-controlled funds in that contract, after consulting with the local governing body of each local government that established the CSB, to negotiate a contract with another CSB or a private organization to obtain services that were the subject of the terminated contract.

**Allocation and Withdrawal of Funds**

HB 428 revised § 37.1-199 of the *Code of Virginia* to require the Department to disburse state-controlled funds to the CSB in accordance with its performance contract.

The original legislation listed three circumstances in which the Department could withdraw state controlled funds from a CSB. HB 428 added a new criteria for the withdrawal of funds: failure to meet the provider performance, consumer outcome, consumer satisfaction, or consumer and family member involvement and participation measures in the CSB’s performance contract.

Section 37.1-199 of the *Code* also lists six criteria for allocation of state-controlled funds to a CSB. HB 428 added a new criteria for the allocation of funds to a CSB: the board’s performance as measured by provider performance, consumer outcomes, consumer satisfaction, and consumer and family member involvement standards and criteria promulgated by the State Mental Health, Mental Retardation and Substance Abuse Services Board.

**Unchanged Provisions in Chapter 10**

While HB 428 rewrote almost all of Chapter 10 in Title 37.1 of the *Code*, several sections remained unchanged. Section 37.1-197.2 deals with criminal background checks on new staff. Section 37.1-200 addresses withdrawal of a member locality from a CSB. The locality which desires to withdraw must give a two year notice unless all of the other localities consent to an earlier withdrawal. Section 37.1-202.1 of the *Code* establishes the liability of the consumer or responsible party for the costs of services.

**Behavioral Health Authorities**

HB 428 incorporates the statutory authorization for behavioral health authorities (BHAs), which was in Title 15.1 of the *Code of Virginia*, into Title 37.1 of the *Code*, as Chapter 15. BHAs are established to provide the same services that are offered by CSBs. Most provisions applicable to BHAs closely resemble the powers and duties of operating CSBs in Chapter 10.

Only three localities are authorized to establish BHAs: Chesterfield County, Richmond City, and Virginia Beach. Only Richmond has actually created a BHA at this point.
Conclusion

The 1998 General Assembly enacted House Bill 428, developed by the Joint Subcommittee to Evaluate the Future Delivery of Publicly Funded Mental Health, Mental Retardation and Substance Abuse Services. This bill rewrote almost all of Chapter 10 in Title 37.1, the statute governing delivery of community mental health, mental retardation, and substance abuse services.

The major changes made by HB 428 in the structure and delivery of these services will increase accountability at local and state levels through clearer relationships, greater consumer and family member involvement, and a strengthened performance contract mechanism.

Contact Information

Local community services boards: consult local telephone directories or call (804) 786-6148.
Overview of Social Services System

Virginia is among the minority of states with a locally administered, state supervised social services system. The Virginia Department of Social Services directly administers some funding programs, such as Neighborhood Assistance and Family Violence Prevention grants and delivers two major services: child support enforcement and facility regulation of non-medical day and residential programs for children and adults. The Department and its five regional offices supervise 122 local departments of social services that administer many familiar services such as: Child Protective Services, Adult Protective Services, Foster Care and Adoption Services, Temporary Assistance to Needy Families, Food Stamps, Auxiliary Grants, and casework services.

This article will focus on the activities most likely to be of interest to health attorneys: the regulation of adult care facilities and services to consumers in these facilities. Key contact information appears at the end of the article.

The Department’s Division of Licensing Programs regulates about 7,000 facilities, most of which offer child day care. On June 30, 1998, there were 599 licensed Adult Care Residences (ACR) with a capacity to serve 29,398 adults who are elderly or who have disabilities, as well as 54 licensed Adult Day Care Centers (ADCC) able to serve 1,669 such adults while their families work.

Statutory Base for Programmatic Regulation of Adult Care

Chapter 9, Title 63.1 establishes both the general contours for programmatic regulation of adult care facilities and some specific requirements, e.g., resident rights and criminal clearance requirements and "barrier crimes" that apply to the hiring of facility staff. Additionally, § 54.1-3408 requires the Board of Nursing to approve training methods and curriculum for facility staff who administer medications but who are not licensed health care professionals.

The law requires only for-profit Adult Day Care Centers to be licensed. Although the vast majority of ADCC’s are non-profit organizations, nearly all are voluntarily licensed. Some licensed centers qualify for Medicaid waivers, designed to offer an alternative to nursing home placement,
administered by the Virginia Department of Medical Assistance Services and/or Child and Adult Care Food Program nutrition funds administered by the U.S. Department of Agriculture.

All ACR’s providing care, maintenance, protection, and supervision to a total of four or more aged or disabled adults in one or more locations are required to be licensed, however, regardless of sponsorship or business type. The only exception is when all adults in care are relatives of the provider. A number of ACRs also voluntarily license portions of their facilities offering "independent living" quarters in order to offer convenient continuity of care when these consumers need higher levels of care.

Law does not require licensure of independent living facilities or "boarding homes" unless the operator assumes responsibility for the care and well-being of four or more tenants. If tenants appear to need care and oversight which the operator cannot or does not provide, referral to the local department of social services’ Adult Protective Services unit is appropriate. Housing developments for elderly and disabled tenants may “drift” into subjectivity to licensure as adult care residences if they begin to assume responsibility for aging tenants whose abilities to maintain independent living status have deteriorated. Licensing staff can assist housing operators either to achieve licensure, if that is their goal, or to design services so as to remain exempt from licensure.

Overview of the ACR Industry’s Development

The ACR Industry has been regulated since the 1950's. Facilities were often called “rest homes” or “retirement homes.” They offered personal care and the security of congregate living for elderly persons who did not need nursing home care. Virginia law formerly defined these facilities as “homes for adults.”

The first significant changes came in the 1970's. Additional funding, including the “Auxiliary Grant program,” came into existence to help elderly and disabled persons. State mental health facilities began the process of “deinstitutionalization.” (The Joint Legislative Audit and Review Commission, which has made several studies of ACRs over the years, conducted a study of the adult care industry in 1997, focusing on the adequacy of care and services to ACR residents with mental illnesses and disabilities. The Department was directed by 1998 legislation to continue and expand that study and report on implementation to future Assemblies.)

During the 1980's, the industry broadened its market base again. Several converging trends contributed to the use of the ACRs for more seriously health-impaired residents and to an increase in facilities catering to more affluent residents seeking greater continuity in residential services. These trends included: growing customer preference for social rather than medical models of care; expanded longevity and reduction in serious debilitation as the medical sciences made advances in the prevention and treatment of illnesses; similar advances in medical technology that led to proportionately less reliance on acute care and skilled-care long term facilities as well as the greater use of out-patient treatment and in-home health care; attempts by families, insurance carriers and
public agencies to reduce health care costs by delaying or averting admissions to nursing facilities; and, the rise of the home-health care industry, which can provide services in ACRs.

Accordingly, the current ACR industry is diverse by any measure: characteristics of sponsors; facility size range; price range and income status of residents; whether the facility accepts auxiliary grants; caregiving services and amenities offered; types and severity ranges of disabilities admitted/retained; homogeneity or heterogeneity of residents; levels of care offered, including some that offer progression from independent living to skilled nursing on the same site; and quality of care and services provided.

Licensing standards are designed to prevent or reduce ordinary risks to health, safety and general well-being in group care but do not assure quality beyond that minimal level. Quality care is encouraged through such strategies as training, consultation, and recognition of achievement via differential licensure techniques.

Recent Statutory Changes Affecting the ACR Industry

A 1990-1991 Joint Legislative Audit and Review Commission study recommended altering the regulatory framework to address problems and accommodate changes in the industry. Statutory amendments enacted between 1991-1995 established a two-tiered level of licensure — residential living and assisted living levels, with the later including some overlap in the usual nursing facility admission criteria. The goal of the legislation was to allow more latitude for residents to “age in place” and to choose an alternative to nursing home care, provided they do not have certain prohibited conditions spelled out in §63.1-174.001. (During approximately the same time period, the Assembly considered consolidation of long term care and aging services currently provided by several state agencies and their local affiliates but took no action.)

Regulations to implement the two-tiered licensing system were implemented in 1996. The regulations attempt to offer protections commensurate with the needs of residents with more serious mental and physical disabilities now served in many ACRs without disrupting operations in ACRs opting to offer the more traditional services.

Roles of the Department’s Division of Licensing Programs

Staffs of the central office of the Division of Licensing Programs develop regulations under the promulgation authority of the State Board of Social Services, oversee operations in eight licensing offices, and develop provider and consumer support services.

Different regulations establish the unique programmatic requirements for ACRs and ADCCs. A second applicable regulation implements statutory requirements for criminal records screening of adult care facility employees. A third applicable regulation covers all facilities, including child day and residential care facilities, and implements general licensing procedures. The general procedures regulation provides licensing information and establishes variance and enforcement procedures,
including immediate sanctions, as well as problem-solving and administrative appeal procedures, which follow the requirements of the Administrative Process Act. (The 1998 Assembly enacted legislation that streamlines and expedites the use of available intermediate sanctions.)

Licensed facilities are also subject to applicable regulations developed through other agencies, such as building, fire safety, health and food service requirements, and, if applicable, vendor requirements. They are also subject to local zoning ordinances. Licensing staffs coordinate with relevant agencies at the state and local levels in the development and implementation of programmatic regulations.

Licensing staffs in the eight service offices: process applications; offer on-site consultation and assistance to comply with requirements; act on requests for precededented waivers or variances; monitor continued compliance, usually unannounced; investigate and resolve complaints, in coordination with Adult Protective Services and/or Ombudsmen as appropriate; and recommend action in non-routine matters such as action on unprecedented variance requests, application of intermediate sanctions, and denial or revocation of licenses. Staff may issue licenses for periods up to three years. License duration and assigned inspection frequency are geared to a facility’s compliance history and profile. Licensing staffs also help facilities to coordinate with local or area authorities or services, including mental health services since many ACR residents have been diverted or deinstitutionalized from acute care facilities within the Department of Mental Health, Mental Retardation and Substance Abuse Services.

Staffs in licensing field offices are responsible for suppression of illegal operations. Allegations of illegal operations are investigated and resolved in one of three ways: persuading the facility to cease or reduce the scope of its operation to conform to law; assisting the facility to achieve timely licensure; or preparing the case for approval to seek court action with the assistance of the Office of the Attorney General.

Staffs in field offices also respond to Freedom of Information Act requests concerning licensed facilities. Prospective consumers and their families often seek directories of licensed facilities as well as specific information about the licensing and complaint histories of particular facilities they may be considering. Licensing rules require that facilities post or otherwise make available their most recent inspection reports as a means to keep residents and their families informed. Facilities are also required to post resident rights information, including complaint reporting methods.

Provider support services available through the Division of Licensing Programs’ central office include: statewide provider training workshops and development and dissemination of technical assistance information and newsletters. The Division contracts with the Virginia Geriatric Education Center to maintain a medication management training system in accordance with requirements for facility staffs who are not personally licensed to administer medication. Provider support activities are funded primarily through a statutory provision that licensing fees be expended for training purposes.
Locally Administered Services

Local departments of social services administer a number of relevant programs for their adult populations. These include eligibility determination and payments, within limits established by the General Assembly in the Appropriations Act, for Auxiliary Grants to help eligible ACR residents afford residential living care as provided in §63.1-25.1, A. The previously mentioned tiered licensing system provides the basis for an additional per capita payment, administered through the Department of Medical Assistance Services (DMAS), for Auxiliary Grant-supported residents at the regular assisted living level of care. Moreover, Medicaid waivers approved for this program provide an additional per capita supplement for eligible residents who are determined to require more intensive care with the assisted living level of care.

State law directs the use of the Uniform Assessment Instrument (UAI) by all public health and human resources agencies for consumers accessing publicly funded long-term care services. In ACRs, private-pay residents are assessed with an abbreviated UAI to assure proper placement within the two-tiered licensure structure while public assistance residents receive an assessment to determine placement in the correct level of care (See §63.1-25.1,D). These assessments also permit community level assessment and case management services to determine if publicly funded consumers would more appropriately be directed into non-residential service options. Staff of the Department’s Division of Family Services is responsible for developing and overseeing the case management and Auxiliary Grants regulations.

Local departments of social services investigate all reports of adult abuse, neglect or exploitation, regardless of the individual’s income or place of residence. They also provide or refer to appropriate available services for adults. The Virginia Department of Social Services maintains a 24-hour toll-free hotline for both Child and Adult Protective Services. The number for the Adult Protective Services Hotline is: 1-888-83-ADULT (1-888-832-3858).

Some Area Agencies on Aging provide the Ombudsman service through a contract with the State Ombudsman’s Office. Adult Protective Services (APS), Licensing and Ombudsman Programs have fundamentally different but complementary missions and legal mandates which require coordination in order to effectively serve consumers. APS is required by §63.1-55.1 to receive and investigate reports of suspected abuse, neglect, and exploitation. The Ombudsman Program assists residents of long-term care services in dispute resolution and resolving complaints. If complaints allege abuse, neglect, or exploitation, Ombudsmen report to APS and in some situations participate in a joint investigation. In complaints against ACRs, Licensing staff will also be involved in a coordinated investigation in all APS complaints and most Ombudsman complaints (unless the dispute clearly does not involve a licensing rule). Licensing staff’s role in coordinated investigations is to determine whether licensing rules were violated, whether the entire group of residents is adequately protected and whether the licensure of the facility should continue. By policy APS and Licensing staff report to one another as required to carry out their mandates within regulated facilities.
By local option, social services departments approve adult foster family care homes serving fewer than four residents and regulated under programmatic standards promulgated by the State Board. Eligible adult foster family care residents may also access Auxiliary Grant funds. The provision of adult foster family care is authorized by §63.1-55.1:1. In addition, §63.1-55.01 authorizes local boards of social services to provide home-based companion, store and homemaker services to support clients and give them the ability and choice to remain in their homes.

**Contact Information**

To report suspected abuse, neglect or exploitation of an adult: 1-888-83-ADULT (1-888-832-3858)

Local Departments of Welfare/Social Services and Area Agencies on Aging: Consult local telephone directories.

Division of Family Services, Adult Services Unit: 804-692-1208

Virginia Department of Social Services: General Information: 804-692-1900

Western Region Licensing Office (Abingdon): 540-676-5490

Piedmont Region Licensing Office (Roanoke): 540-857-7971

Verona Licensing Office: 540-248-9345

Northern Regional Licensing Office (Warrenton): 540-347-6345

Fairfax Licensing Office: 703-934-1535

Central Region Licensing Office (Richmond): 804-662-9743

Peninsula Licensing Office (Newport News): 757-594-7594

Eastern Region Licensing Office (Virginia Beach): 757-491-3990

Division of Licensing Programs, central offices: 804-692-1776
Virginia Department for the Visually Handicapped
Department for the Visually Handicapped
(as of November 1, 1998)
W. Roy Grizzard, Jr., Commissioner
397 Azalea Avenue
Richmond, Virginia 23227
(804) 371-3145
(804) 371-3157 Fax

The department was established by an act of the General Assembly in 1922, and its board is composed of seven members who are appointed by the Governor. Four of the seven members must be blind.

The mission of the department is to enable Virginians with visual disabilities to achieve their maximum level of independence and participation in society.

Strategic Plan 1998-2000

Critical Issue 1: Assist customers to obtain jobs that pay well.

Goal 1: Create better opportunities for job placement and retention in lucrative jobs.

Objective 1

Develop and provide local, state-of-the-art computer training for customers by 2001.

Strategies

* Funds will be made available to provide adaptive technology training for service providers in localities where there is a serious unmet need for adaptive technology support identified by the regional manager beginning in 1/1/98. (Requiring reallocation of Federal dollars with no net change.)

* Internet access will become a component of the adaptive technology evaluation/training program at VRCB for customers who are blind beginning in 3/1/98. (No impact on budgets or positions.)

* Determine availability of VR funds to provide equipment and training to enhance braille captioning and Internet access for deaf or blind customers by 7/1/98. (No impact on budget or positions.)
* Additional providers of adaptive technology services will be identified from the private sector in each region to meet hardware/software installation and training needs by 10/1/98. (No impact on budget or positions.)

* The adaptive technology tutoring network will be expanded to all areas of the State by 10/1/99. (No impact on budget or positions.)

* Computer equipment and software in regional office computer labs will be updated and standardized by 10/1/99. (Requiring reallocation of Federal dollars with no net change.)

**Objective 2**

Establish formalized job preparation program for customers who do not have a work history by 2001.

**Strategies**

* Survey all regional offices to identify those programs/resources that have been utilized in the past and proven to be successful by 3/1/98. (No impact on budget or positions.)

* The successful resource information will be distributed to counselors and the VR manual will be updated with guidelines to enable counselors to utilize those resources by 6/1/98. (No impact on budget or positions.)

**Objective 3**

Expand opportunities for challenging jobs for Virginia Industries for the Blind (VIB) "excepted employees" in administrative and general office support services statewide.

**Strategies**

* Develop a focused segment in VIB's business plan detailing actions (which will be implemented as identified where feasible), responsibilities and timing to achieve statewide skilled job growth by July, 1998. (No impact on budget or positions.)

**Objective 4**

Participate with the GETD's job clearinghouse program.

**Strategies**

* DVH regional managers and VR counselors will attend meetings being conducted by GETD for input and participation with the new 1-Stop employment grant to be implemented by December, 1998. (No impact on budget or positions.)
* DVH will provide online access to VR counselors to the job information clearing house being developed by GETD by December, 1999. (No impact on budget or positions.)

* DVH will inform all VR customers of the option of using the online 1-Stop as a source for independently assisting in securing their own employment opportunities by July, 2001. (No impact on budget or positions.)

**Objective 5**

Establish four Rehabilitation Engineers assigned to Western, Northern, Tidewater, and Central Va. areas by 2001.

**Strategies**

* Consider each agency position vacancy during the 1998-2000 biennium for reallocation as Rehabilitation Engineer. (No impact on budget or positions.)

* Convert positions identified and approved by Commissioner for reallocation as Rehabilitation Engineers where Vocational Rehabilitation funds are available during the 1998-2000 biennium. (Requires reallocation of resources with no net change.)

**Objective 6**

Increase the number of vendors and vending facilities by 15% by 2002.

**Strategies**

* Monthly, identify potential opportunities for developing new facilities through the exploration of publications such as the Commerce Business Daily on the Internet. (No impact on budget or positions.)

* Quarterly, maintain contact with the traditional sources of vending opportunities such as the Federal entities of General Services Administration, Department of Defense, United States Postal Service, and State entities such as the Department of General Services, State Purchase and Supply as well as the Department of Corrections and the Community College System. (No impact on budget or positions.)

* Continue to access the primary sources of referral, the vocational rehabilitation counselor, to ensure that adequate numbers of candidates for the position of licensed vendor are provided. (No impact on budget or positions.)

* Train at least 6 blind customers per year with the objective of licensing 4 trainees per year to maintain satisfactory staffing levels in the Vending Program. (No impact on budget or positions.)
Goal 2: Develop and implement a program to enhance the customer's skills and abilities to be competitive in the job market.

Objective 1

Assist customers with understanding and enhancing their pre-vocational and vocational skills required for success.

Strategies

* Collect and distribute to counselors and work evaluators current labor market information to be used as a tool in vocational planning with customers by 6/1/98. (No impact on budget or positions.)

* Develop and use checklist of skills that are needed for success on the job by 7/1/98. (No impact on budget or positions.)

* Train staff to enable them to utilize information from sources such as "Virginia View" regarding skills required by employers by 12/1/98. (No impact on budget or positions.)

* Identify and develop resources to help customers fully access adult basic education programs by 10/1/99. (Reallocation of dollars or positions with no net change.)

* Direct service staff and supervisors to be trained regarding the "importance of blindness skills" by 7/1/00. (Requiring a reallocation of resources.)

Critical Issue 2: Increasing elderly blind population. The incidence of blindness and deterioration of vision increases with age, and Virginia has a rapidly growing population of non-working citizens age 55 and older with visual impairments.

Goal 1: Maximize the independent living skills and functioning levels of older blind citizens so they may adjust to blindness and vision loss by becoming more autonomous in caring for their personal needs, live more unconstrained in their homes and communities, and avoid inappropriate institutionalization.

Objective 1

To supplement, expand, and enhance the local options for service delivery to DVH customers by the end of the 1998-2000 biennium.

Strategies
* Establish a means for the 25 Area Agencies on Aging, in cooperation with the DVH, to screen customers for early signs of vision loss by 1/1/99. (No budget impact.)

* Provide a simple vision screening questionnaire to AAA case managers to use as part of their intake process so they can appropriately refer to DVH or other vision professionals by 6/30/99. (No budget impact.)

**Objective 2**

Maintain the number of customers age 55 and older who achieve a majority of their independent living goals at closure at 85%.

**Strategies**

* Increase cooperation and coordination with local senior centers so DVH customers will learn of and use their services and facilities early in the rehabilitation process and with greater frequency by 10/1/98. (No budget impact.)

* Create more efficient operations by implementing STARBASE and electronic case file recording techniques that will reduce staff time spent on paperwork by 10/01/99. (No budget impact.)

* DVH RT/IL staff will develop and implement local senior support groups for older blind customers who have achieved their IL goals and need ongoing contact by 1/1/00. (No budget impact.)

**Critical Issue 3:** Special education services for blind children and students.

**Goal 1:** Insure that the agency meets the expectations of blind students, their parents and school personnel in providing effective educational services in a timely manner within its resources.

**Objective 1**

To establish one joint educational or recreational program with the Virginia Schools for the Deaf and the Blind (VSDB) in each year of the 1998-2000 biennium.

**Strategies**

* Meet with appropriate staff from VSDB to establish the training that will be presented during the first year of the biennium by 3/31/98. (No impact on budget or positions.)
* Meet with appropriate staff from VSDB to establish the program that will be presented during the second year of the biennium by 3/31/99. (No impact on budget or positions.)

* Present the first year program by 6/30/99. (No impact on budget or positions.)

* Present the second year program by 6/30/00. (No impact on budget or positions.)

**Objective 2**

To present training programs for teachers of the visually handicapped and other school personnel during each year of the 1998-2000 biennium.

**Strategies**

* Determine if a non-DVH group is willing and able to offer a statewide training workshop for teachers of the visually handicapped, other school personnel and parents by 8/31/98. (No impact on budget or positions.)

* Establish a teacher-to-teacher support network by 6/30/99. (No impact on budget or positions.)

* In each year of the biennium offer two one-day training programs for teachers of the visually handicapped in each of the agency's regional offices. (No impact on budget or positions.)

**Objective 3**

To increase the number of blind youth who have the skills they need to successfully transfer from school to post secondary education or work.

**Strategies**

* Review the draft transition process that has been developed by DVH staff by 12/31/98. (No impact on budget or positions.)

* Redefine the agency's transition process to empower blind youth to prepare for work or post-secondary education with emphasis on developing pre-vocational and adjustment skill by 11/30/99. (No impact on budget or positions.)

**Objective 4**

To transfer both the responsibility for providing public school basic aid for visually handicapped children and the basic aid appropriation to the Department of Education for the 2000-2001 school year.
Strategies

* Work with Department of Education staff to develop information about both state and national teacher-pupil ratios for teachers of the visually handicapped by 6/30/98. (No impact on budget or positions.)

* Work with Department of Education staff to establish a pupil-teacher ratio for Virginia's teachers of the visually handicapped by 4/30/99. (No impact on budget or positions.)

* Develop a state budget proposal to transfer the public school basic aid appropriation for visually handicapped children to the Department of Education for the 2000-2002 biennium by 8/31/99. (No impact on budget or positions.)

Critical Issue 4: Efficient use of the Library and Resource Center

Goal 1: Increase customer access to Library and Resource Center services.

Objective 1

Implement an on-line access to LRC collections by 9/30/00.

Strategies

* Identify automated system with on-line capability for textbooks and adaptive equipment by 2/1/98. (No impact on budget or positions.)

* Determine features that will be accessible for textbooks and adaptive equipment by 4/1/98. (No impact on budget or positions.)

* Purchase and install new automated system for textbooks and adaptive equipment by 5/1/98. (No impact on budget or positions.)

* Evaluate READS 2 Library system for on-line access and replacement of existing READS system by 1/1/00. (No impact on budget or positions.)

* Plan to install READS 2, or modify existing system for on-line access by 7/1/00. (No impact on budget or positions.)

* Install READS 2 or modify existing system for on-line access by 1/1/01. (No impact on budget or positions.)
**Objective 2**

Investigate the feasibility of implementing a dial-in access to Library collections.

**Strategies**

* Incorporate into evaluation of READS 2 an assessment of establishing a dial-in access to the Library collection by 1/1/00. (No impact on budget or positions.)

* Determine cost and benefit of providing a dial-in access to Library collections by 1/1/01. (No impact on budget or positions.)

**Objective 3**

Establish a receptionist/services consultant part-time position.

**Strategies**

* Develop position description for a 30 hour per week receptionist/services consultant position by 3/1/98. (No impact on budget or positions.)

* Request permission to establish a WE-14 position by 4/1/98. (No impact on budget or positions.)

**Objective 4**

Implement an LRC web page with newsletter updates.

**Strategies**

* Develop text for web page by 2/1/98. (No impact on budget or positions.)

* Work with DRS designee to establish web page by 5/1/98. (No impact on budget or positions.)

**Objective 5**

Pursue implementation of dial-in newsletter and information update access.

**Strategies**

* Evaluate feasibility of dial-in information service by 1/1/01. (No impact on budget or positions.)
* Assess cost of establishing dial-in information service by 5/1/01. (No impact on budget or positions.)

**Objective 6**

Establish evening and weekend hours and special programming.

**Strategies**

* Review and update position descriptions of existing vacancies, and submit for permission to hire by 3/1/98. (No impact on budget or positions.)

* Survey library users in Richmond metropolitan area regarding interest in extended hour usage by 6/1/98. (No impact on budget or positions.)

* Develop staffing plan that allows for adequate coverage of all LRC functions and frees up some staff for extended hour coverage by 9/1/98. (No impact on budget or positions.)

* Develop special adult programs for implementation by 1/1/99. (No impact on budget or positions.)

* Develop special children's programs for implementation by 6/15/99. (No impact on budget or positions.)

**Critical Issue 5**: Capital Projects.

**Goal**: To provide for high quality, acceptable and secure facilities for customers and staff.

**Objective 1**

Provide for high quality and acceptable DVH facilities statewide.

**Strategies**

* Review for continuation, the Memorandum of Understanding the agency has with the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) for technical assistance for Capital Outlay planning, development and administration, and for the use of open-end contracts awarded by DMHMRSAS for professional services and minor maintenance and construction by April 1 of each year. (No impact on budget or positions.)

* Review and identify office furnishings and equipment that are obsolete and need replacing during the summer of 1998. (No impact on budget or positions.)
* Update facility master plan every two years beginning in fiscal year 1999. (No impact on budget or positions.)

* Access agency owned buildings to identify items for inclusion in the agency's Maintenance Reserve budget by September of each year. (No impact on budget or positions.)

* Prepare and submit every two years a Capital Outlay Budget for the agency. (No impact on budget or positions.)

**Objective 2**

Provide security for staff, customers and clients at the Azalea Avenue Complex.

**Strategies**

* Identify security measures to safeguard staff, customers and clients at the Azalea Avenue Complex by April 1998. (No impact on budget or positions.)

* Cost out security measures identified by May 1998. (No impact on budget or positions.)

* Implement critical security measures that can be funded from operational budgets during fiscal year 1999. (No impact on budget or positions.)

* Include as part of the 2000 - 2002 Capital Outlay Budget a request for the remaining security measures. (No impact on budget or positions.)

**Objective 3**

Repair and Renovate the Rehabilitation Center for the Blind's Dorm building and Virginia Industries for the Blind facility in Charlottesville.

**Strategies**

* Complete all requests for information associated with the Capital Outlay requests for the two projects by Oct 24, 1997. (No impact on budget or positions.)

* Proceed on implementation of the projects upon receipt of written approval. (No impact on budget or positions.)

**Critical Issue 6: Automation and Communication**

**Goal:** Implement a fully automated data collection and information management system.
Objective 1

Implement the system for tracking and reporting client information database (STARBASE) by 6/30/98.

Strategies

* DVH and DRS commissioners will assign top priority to STARBASE by January 1, 1998. (No impact on budget or positions.)

* DRS IS department will have appropriate staff assigned to write code for STARBASE by January 1, 1998. (No impact on budget or positions.)

Objective 2

Implement a DVH Intranet for data warehousing and dissemination of information.

Strategies

* Determine staff hardware and software requirements to access the internet by 7/1/98. (No impact on budget or positions.)

* Identify the types of data to be available via the internet by 10/1/98. (No impact on budget or positions.)

* Procure needed hardware and software by 1/1/99. (No impact on budget or positions.)

* Compete construction of and test the internet by 1/1/99. (No impact on budget or positions.)

* Employees have access to the internet by 4/1/99. (No impact on budget or positions.)

Critical Issue 7:  Human resource structure and staffing requirements

Goal:  Refinement of positions and functions.

Objective 1

Maximize Agency Staff Resources.
Strategies

* Personnel Office will review position descriptions of all classified non-exempt DVH positions as part of the annual performance review process to ensure proper classification and qualifications. (No impact on budget or positions.)

* Personnel Office in conjunction with DVH administrative and program staff will review program staffing levels to determine if programs are appropriately staffed by 6/30/98. (No impact on budget or positions.)

* Develop and implement an agency Staff Recognition Program by 9/1/98. (No impact on budget or positions.)

* Update performance plans annually to include measures to achieve agency goals. (No impact on budget or positions.)

* Develop and Implement staff training program by December 1999. (No impact on budget or positions.)

* Expand recruitment efforts to the Internet, University programs and consumer organizations by July 2001. (No impact on budget or positions.)
Virginia’s Business Health Coalitions  
(as of November 1, 1998)

HAMPTON ROADS HEALTH COALITION  
Barbara Wallace, EdD, Executive Director  
287 Independence Boulevard  
Pembroke II, Suite 218  
Virginia Beach, Virginia 23462  
Phone: 757-552-0913  
Fax: 757-497-5191  
email: hrhealthc@aol.com  
website: www.hrhc.org

PURPOSE: Founded in 1983, the Hampton Roads Health Coalition (HRHC) is a non-profit organization consisting of 80 member businesses committed to improving the value and quality of health care in the 16 cities and counties which represent the Hampton Roads community.

BLUE RIDGE HEALTH CARE COALITION  
(Vacant), Executive Director  
2727 Electric Road, Suite 200  
Roanoke, Virginia 24018  
Phone: 540-776-3240  
Fax: 540-776-1058

PURPOSE: The Blue Ridge Regional Health Care Coalition (BRRHCC) was incorporated in 1984 as a not-for-profit organization when a group of Roanoke, Virginia employers joined together to create change in localized pricing and delivery of health care services. This local grassroots organization has grown and matured to become a regionally known force in health care reform using the concept of health care value based group purchasing (highest quality, delivered in the most cost-effective setting, at the lowest cost).

NORTHERN VIRGINIA GROUP HEALTH ALLIANCE  
Jay Jarvis, Executive Director  
4330M Evergreen Lane  
Annandale, Virginia 22003  
Phone: 703-916-1100  
Fax: 703-916-0001  
email: info@t-pdi.com  
website: www.t-pdi.com/novaalliance  
website: www.washingtonpost.com/yp/pdi
PURPOSE: The Northern Virginia Group Health Alliance (the Alliance) is a non-profit organization that works to provide the best, most cost-effective, health care for employees of member employers of Chambers of Commerce in Northern Virginia. The NOVA Alliance was begun in 1993 as the Arlington Small Business Health Plan when 35 Arlington Chamber of Commerce members joined together to pool their buying power for group health insurance. By August of the same year the group expanded to cover members of all chambers in Northern Virginia, and they adopted a formal charter in the form of a legal trust named the Northern Virginia Group Health Alliance.
Virginia Monitoring, Inc.
(as of November 1, 1998)
William E. McAllister, President
2101 Executive Drive
Tower Box 88
Hampton, Virginia 23666
(757) 827-6600
1-888-827-7559
(757) 827-8864 Fax

Goals
- To increase identification, treatment and recovery.
- To increase appropriate involvement of employers and colleagues and peers.
- To improve the level and quality of services provided by treatment providers, including treatment and monitoring.
- To increase earlier identification and intervention.
- To provide comprehensive, timely and effective monitoring.

In its 1997 session, the Virginia General Assembly passed legislation creating a Health Practitioners’ Intervention Program (“HPIP”). Under the authority of this legislation, the Virginia Department of Health Professions entered into a contract with Virginia Monitoring, Inc. to provide comprehensive services which may offer to "impaired" (defined as "any physical or mental disability which substantially alters the ability of a practitioner to practice his or her profession with safety to his/her patients and the public," ) health care professionals an alternative to disciplinary action by health regulatory boards.

Purposes
- To provide investigation, intervention, assessment, evaluation, referral to treatment and continuous monitoring to impaired professionals.
- To encourage concerned practitioners to seek assistance.
- To establish a non-punitive alternative for impaired practitioners who are eligible.
- To enhance public safety.
- To provide service to practitioners who previously had no peer assistance program to help them.
- To provide statewide mental health and substance abuse education within the professions.

A network of qualified providers has been established throughout the state of Virginia and surrounding areas.
The highly qualified staff of Virginia Monitoring will also be providing outreach efforts to facilitate the identification and participation of impaired professionals.

Ongoing projects will include informational and training presentations on chemical dependency to:

- professional teaching facilities;
- peer assistance groups;
- health care organizations; and
- educational programs.

Who Are Our Clients?

The Health Practitioners’ Intervention Program is open to any person who is or was licensed, certified, registered, or an applicant who is otherwise fully eligible for licensure, certification, or registration, by a health regulatory board within the Virginia Department of Health Professions.

Participation open to any person regulated by the Virginia Board of:

- Audiology & Speech Pathology
- Dentistry
- Funeral Directors & Embalmers
- Medicine
- Nursing
- Nursing Home Administrators
- Optometry
- Pharmacy
- Professional Counselors
- Psychology
- Social Work
- Veterinary Medicine

Services Available

- Assessment
- Evaluation
- Referral
- Monitoring
- Intervention Coordination
- Collaboration with Peer Assistance Groups
- Advocacy for Board Issues
- Urine Drug Screens
Eligibility

All health practitioners regulated by any of the health regulatory boards within the Department of Health Professions (240,000), including applicants and practitioners whose credentials have been suspended or revoked.

Operation

The seven-member Health Practitioners’ Intervention Committee comprised of licensed health care providers who are not Board members, is appointed by the Director of the Department of Health Professions to oversee the program.

As required by law, Virginia Monitoring, Inc. was awarded the contract to provide the services available through the Impaired Practitioners’ Intervention Program and report to the Committee.

The Committee is authorized by law to approve a request for stay of disciplinary action that meets the eligibility requirements when submitted by the contractor on behalf of a participant.

Each of the twelve Boards within the Department of Health Professions has named a liaison for consultation and coordination between the Boards, the Department and the Committee.
Vision

An environment where credible, unbiased, and timely information is readily available to consumers and purchasers to make informed health care decisions.

Mission

To create and disseminate health care information to promote informed decision making by Virginia consumers and purchasers and enhance the quality of health care delivery.

Strategy

Virginia Health Information's (VHI's) strategy is to bring order out of the mass of health care data. VHI endeavors to convert this data into useful information considering the priorities of our stakeholders and the needs of our customers. VHI will produce and publish this information in the format and media that is designed for the target audience.

VHI subcontracts and works through partnerships for the development of new products. This approach is reflected in our subcontracting of data processing, statistical analysis, services survey, and publication design. Further, an appraisal of our ongoing initiatives must take place to remain relevant and effective. Market surveys and consumer focus groups are part of VHI's development activities. Through use of competitive negotiations and bidding, we intend to ensure that VHI is a good steward of public and private funds.

History

February 1991

Senate Joint Resolution (SJR) Number 178 passed to study all aspects of the possible establishment of a patient level data base in Virginia.

April 1991
In response to the Secretary of Health and Human Resources request for comments, over fifty individuals and organizations overwhelmingly supported the concept of a patient level database.

**June 1991**

The Virginia Health Planning Board adopted a number of recommendations including the establishment of a patient level data base.

**December 1991**

The patient level data base feasibility study, as requested by SJR 178, was presented to the Commission on Health Care for All Virginians.

**March 1992**

Senate Joint Resolution (SJR) Number 139 was enacted by the 1992 Session of the Virginia General Assembly which requested the Secretary of Health and Human Resources to develop a detailed, systematic plan for establishment of a patient level data base in Virginia.

**June 1992**

The Joint Commission on Health Care identifies a Virginia patient level data base as a priority project with an intent to recommend legislation for such to be considered in the 1993 Session of the General Assembly.

**February 1993**

A certificate of incorporation was filed by Virginia Health Information and granted by the State Corporation Commission on February 12, 1993.

**July 1993**


**February 1994**

First data received by Virginia Health Information.

**April 1994**

Legislation signed which requires state agencies providing coverage for outpatient services to submit patient level data regarding paid outpatient claims and which allows individual employers, insurers, and other organizations to voluntarily provide VHI with outpatient data.

**March 1995**

First data tapes containing one year of patient level data released.

**April 1996**
Governor George Allen signed House Bill 1307 (HB1307) which eliminated the Virginia Health Services Cost Review Council (VHSCRC) and transferred the efficiency and productivity methodology to VHI.

May 1996
VHI Articles of Incorporation and Bylaws revised to reflect inclusion of nursing home representatives on the Board while maintaining provider parity as stipulated in HB1307. VHI's first consumer publication, Guide to Obstetrical Services, was printed.

July 1996
VHI contracts with the Virginia Department of Health to provide patient level data and efficiency and productivity services.

October 1996
VHI's Strategic Plan was presented to the Board of Health, Governor, and the General Assembly.

December 1996
VHI's Board of Directors resolved to include physician identifiers on data tapes and reports for discharges occurring on and after April 1, 1996.

January 1997
Revisions to fee amounts, refunds and collections approved by the Virginia Department of Health.

June 1997
House Joint Resolution (HJR) Number 637 passed for Emergency Medical Services Advisory Board to contract with VHI to conduct a pilot study linking pre-hospital care data to VHI's inpatient discharge database.

July 1997
Virginia Department of Health renews contract with VHI and includes additional funding for outpatient pilot study.

October 1997
VHI presents Annual Report and Strategic Plan Update to Board of Health, Governor and General Assembly.

March 1998
Senate Joint Resolution (SJR) Number 109 passed for VHI to research and propose a managed health insurance plan information set.

April 1998
Senate Bill 660 passed and approved to collect health employer data information set (HEDIS) from Virginia Health Maintenance Organizations and to collect healthcare practitioner information to be reported to the public.

**May 1998**
Senate Bill 712 passed and approved for the Virginia Department of Health to identify and certify managed care health insurance plans (MCHIPs).

**November 1998**
VHI presents Annual Report and Strategic Plan update to Board of Health, Governor and General Assembly.

**Industry Report**

Virginia hospitals and nursing homes are ranked in Virginia Health Information's *Hospitals and Nursing Homes: 1997 Virginia Industry Report*. Providers are ranked by comparing revenues, operating costs, productivity and utilization of services, financial viability, and the level of community support activities. A * (star) indicates which providers ranked in the top quartile for each of the indicators.

Economists, providers, and state representatives designed the Industry Report as a market-based approach to cost containment. Healthcare consultants and providers report they use this information to help facilities reduce costs and improve the quality of care. When first developed by the Virginia Health Services Cost Review Council (VHSCRC), a former state agency, the first year's publication was over 1,000 pages long. In 1996 VHI was awarded a contract with the Virginia Department of Health to produce the report. Now in its fifth year of publication, VHI revamped the tables, simplified the charts, made the explanations easier to understand, and provided the data on its website, www.whi.org. The data is also provided on computer disks with the publication.

VHI is continually evaluating all indicators for their relevance and is researching quality of care and outcomes information for future reports. The Industry Report is available from VHI for $20. Previous years' reports may also be obtained. For more information on this and other VHI publications and products, contact VHI at (804) 643-5573.

**Consumer Guides Overview**

A series of general Consumer Guides were envisioned to produce general information for the consumer and employer on health plans/health insurance companies, hospitals, nursing homes, and physicians. These publications are intended to provide the reader with a general understanding of the issues, questions, and choices available to them when choosing each type of product or service. Background of each subject is provided along with lists of questions to ask when making decisions as to which health insurance product, hospital, physician, or long-term care service to choose. Lists of resources including other publications and Internet web sites is also provided.
Health Insurance Options: A Consumer’s Guide

This guide, printed in 1998, is VHI’s second consumer publication. It explains the differences between types of health insurance plans and provides a work sheet to compare plans. It has been widely distributed to employers and consumers and is now in its second printing.

Obstetrical Services: A Consumer’s Guide

VHI printed its first obstetrical service guide in 1996. It included delivery rate information and service offerings on Virginia Hospitals. In 1998, VHI enhanced this guide by adding physician-specific information including delivery rates, office location, credentials and education.

VHI is working on three other consumer guides. A Consumer’s Guide to Hospitals will explain the different types of hospitals and provide data on each licensed Virginia hospital. Long-term Care Options: A Consumer’s Guide will describe the types of long-term care services and provide a directory of nursing facilities and other long-term care organizations. Both guides are expected to be published in 1999. VHI is also developing a Consumer’s Guide to Physicians.

Guides will be provided to libraries, state agencies, public resource centers, news media, and other public distribution sites. Health insurance companies, hospitals, employers, physicians, nursing homes, and other long-term care providers will be contacted as distribution points.

Historical Publications

As part of VHI's contract with Virginia Department of Health, we make the publications described below publicly available. Please contact VHI for more information.

Annual Report


Annual Survey of Charges


Buyer's Guide to Efficient and Productive Hospitals and Nursing Homes
Efficiency and Productivity facility and regional rankings published in 1995 by VHSCRC and in 1996 by Virginia Health Information (VHI). In 1997, VHI changed the name to Hospitals and Nursing Homes: Virginia Industry Report. Copies are available from VHI at a cost of $20 each.

Commercial Diversification Survey


Consumer Guides

In 1995 the VHSCRC published the results of the Annual Survey of Charges in a series of regional publications that were small enough to be offered to the public at no charge. All are available from VHI at no charge. (Please refer to specific guides for regional availability.)

- Hospital Inpatient made use of VHI's Patient Level Database System to report charges in effect for selected DRGs over a six-month period. Inpatient guides are available in the following regions: Central, Eastern, Northern, Northwestern, and Southwestern.

- Hospital Outpatient reported the result of a survey on the charges in effect on a given day for selected outpatient procedures. Outpatient guides are available in the following regions: Eastern, Northern, Northwestern, and Southwestern.

- The Nursing Home Guides reported the result of a survey on the charges in effect on a given day for selected outpatient procedures. Nursing Home guides are available in the following regions: Central, Eastern, Northern, and Northwestern.

Hospital and Nursing Home Industry Trends

This was the trends data published as a separate book in 1995. In previous years the VHSCRC combined this data in its Annual Reports. Copies are available from VHI at a cost of $10 each.

Hospital Financial Extracts

This booklet contains selected financial fields taken from the data collected for the Efficiency and Productivity Methodology. This includes some raw financial data from hospitals more typical of the earlier Annual Reports. Limited copies are available from VHI at a cost of $5 each.
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Stakeholders
The following organizations are named in VHI's Bylaws to nominate Board Members and play very active and supportive roles in VHI's projects and accomplishments.

Business
Commonwealth Coalitions on Health
The Virginia Chamber of Commerce
Virginia Business Council
Virginia Manufacturers Association

Hospital
Virginia Hospital and Healthcare Association

Insurance
Trigon Blue Cross and Blue Shield of Virginia
The Virginia Association of Health Plans

Nursing Home
Virginia Association of Nonprofit Homes for The Aging
Virginia Health Care Association

Physician
Medical Society of Virginia
Old Dominion Medical Society
Introduction

The Virginia Health Quality Center (VHQC) was created in 1984 with a specific purpose: to serve as the Medicare Peer Review Organization (PRO) for Virginia. Its first three Medicare contracts, awarded and administered through the Health Care Financing Administration (HCFA), emphasized retrospective medical record review of inpatient care for quality, utilization and accuracy of coding. Due to a welcome paradigm shift at HCFA, Medicare PRO contracts nationwide now emphasize quality measurement and improvement. Today, the VHQC seeks to work with a variety of customers who want to improve health care for the populations they serve.

This positive, new focus is reflected in the VHQC's mission statement, which charts the course for the VHQC to promote health care quality evaluation and improvement by (1) working collaboratively with patients, physicians, providers and others, including government groups; (2) collecting, analyzing and communicating data about access to care, appropriate health care practices and costs; and (3) educating all participants in the health care system to enable them to make informed, responsible decisions about their care.

The cornerstone of the VHQC's current work for Medicare is the Health Care Quality Improvement Program (HCQIP). The aims of the HCQIP are to identify patterns of care and outcomes that can lead to system-wide improvement, implement interventions that will help practitioners adopt new practice patterns and motivate patients to change health behaviors, and finally, to produce measurable improvements in care for large numbers of Medicare beneficiaries.

To carry out the HCQIP, the VHQC profiles and analyzes data from Medicare claims databases, enrollment and provider files and other sources of clinical information to identify patterns in care and outcomes for the entire state and for individual facilities, practices or HMOs. To isolate meaningful trends, the VHQC analyzes the distribution of significant events (e.g., admissions, readmissions, transfers) by provider, diagnosis and procedure code and/or by major diagnostic categories.

Local improvement projects are developed by multidisciplinary VHQC teams that include a physician epidemiologist, nurse manager or other administrative leader, biostatistician, programmer/analyst, professional health educator or communicator, and nurse abstractors. The
participating hospitals, physician practices or HMOs also are involved in project development, and are supported throughout the improvement process by the VHQC team.

Since the beginning of its fifth Medicare PRO contract in September 1996, the VHQC has developed, initiated or completed projects on a wide range of clinical and health promotional topics, including:

- ACE inhibitor use for diabetic nephropathy
- Acute myocardial infarction (2 projects)
- Advance directives
- Cardiac catheterization (2 projects)
- Carotid endarterectomy
- Congestive heart failure (2 projects)
- Diabetic retinal examination
- Diabetic management (2 projects)
- Influenza immunization
- Mammography (2 projects)
- Peptic ulcer disease
- Stroke/atrial fibrillation
- Vancomycin utilization (2 projects)

At the direction of HCFA, which has challenged PROs to set and achieve "bold goals" for measurable improvement in care for as many Medicare beneficiaries as possible, the VHQC currently is concentrating its resources on four large projects addressing acute myocardial infarction (The Cooperative Cardiovascular Project), congestive heart failure, diabetic eye examination and vancomycin use. Together, these projects will reach 158,250 Virginia seniors - nearly 20% of the Commonwealth's Medicare population - either directly or through health care providers.

Project results are disseminated to the medical community through facility visits, regional workshops, publications and other appropriate means. Press releases, coordination with beneficiary organizations and other outreach strategies are used to keep the public informed.
Additional Projects

In addition to holding its Medicare contract for nearly 14 years, the VHQC has served a wide range of clients who are interested in assessing quality, managing utilization and ensuring the integrity of their health care programs:

- Since 1988, the VHQC has served as a review agent for the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) under contract with the U.S. Department of Defense. The VHQC’s competitively awarded contract, which began in July 1995 and ended most recently this September, has covered as many as 3.5 million beneficiaries and 1,938 hospitals in a 12-state area.

- From 1989 to 1994, the VHQC performed quality review at Virginia Department of Corrections facilities, helping health administrators identify areas for improvement. The VHQC also conducted a project in which it audited outpatient medical bills to identify inappropriate billing practices.

- In 1993-1994, the VHQC performed medical analytical services to support HCFA's PRO program in Department of Health and Human Services Region II. This included re-reviews of some work performed by other PROs.

- In 1996-1997, the VHQC served as the Virginia Department of Medical Assistance Services' External Quality Review Organization. In this role, the VHQC oversaw the quality of HMO services provided under the Medallion II program. The VHQC also conducted two special studies: an evaluation of the first six months of Medallion II operations, and a survey of disenrollees from Medicaid HMOs.

- In addition, the VHQC has provided utilization management for case management companies, third-party payors, small insurers and medium-sized businesses. These services have included physician specialist (third-level) review of denied care and telephonic review of proposed admissions or surgical procedures.

New Business

The VHQC’s recently updated strategic plan calls for increasing business with nongovernmental customers. To support business development goals, the VHQC is seeking strategic alliances and other partnerships with organizations that have complementary interests, strengths and capabilities, the VHQC's inventory of skills and experience especially suits the organization for work involving:

- Complex statistical analysis
• Database manipulation and management
• Medical record auditing and screening
• Patient education and health promotion
• Peer review by expert physicians
• Performance profiling
• Program evaluation
• Quality improvement
• Survey design and interpretation

Organization and Capabilities

The VHQC (formerly known as the Medical Society of Virginia Review Organization) was incorporated as a not-for-profit 501(c)(3) organization in early 1984. The law firm of Hofheimer Nusbaum, P.C., currently serves as its general counsel.

The VHQC is governed by a 25-member board of directors, which includes 13 physician members, up to 4 representatives of institutional health care providers, and up to 8 representatives of consumers, insurers, business and the public sector. The president of the board of directors is Hawes Campbell III, M.D., a family physician who practices in Yorktown, Va. The VHQC's headquarters are in Richmond.

Currently, the VHQC has a staff of more than 40, many of whom hold advanced degrees: 3 doctoral degrees (medicine, biostatistics and health services research) and 17 master's degrees in a variety of disciplines, including business, public health, mathematics, health education and social work. The staff also includes 8 registered nurses, most of whom hold a bachelor's degree in nursing. In addition to its more than 600 credentialed physician reviewers, the VHQC has developed relationships with additional physician specialists - many of them state and national "opinion leaders" who volunteer their time to serve on cooperative project study groups and other committees.

The VHQC's Medicare contract is supported by HCFA's Standard Data Processing System (SDPS). This system is hardware-independent and capable of managing multiple, networked programmable platforms. Through the SDPS, the VHQC is connected to HCFA, the rest of the nation's PROs and the Internet via a wide-area network. In addition, the SDPS supports videoteleconferencing.
At this time, the VHQC is upgrading the administrative local-area network (LAN) that it uses for its non-Medicare business. The VHQC LAN, once upgraded, will be a Y2K-compliant system, capable of meeting not only the company's current technology needs, but also its strategic expansion plans. It will allow the VHQC to possess corporate computing capabilities similar to those provided for its Medicare work by the SDPS.

The VHQC is one of three PROs nationally that enjoys a strong institutional commitment from its state medical society to work with the PRO to improve medical quality. Unlike many other PROs, the VHQC and its state hospital association (The Virginia Hospital and Healthcare Association) also have a long and positive working relationship. The VHQC's Medicare contract has been renewed noncompetitively since it was first awarded in 1984, providing a solid base from which the organization can offer its services to other governmental and private customers.
Introduction

This Compendium is designed to identify the relevant trade associations, societies, regulatory agencies and commissions and other public and private sector contractors which focus on health care issues in the Commonwealth and to summarize their respective missions and jurisdiction. This Compendium is intended to serve as a convenient mechanism for Virginia State Bar members throughout the Commonwealth to identify and access those entities which may have relevance to particular client needs. The Compendium is also being made available to the contributing entities in order that they may make the information available to their membership, constituents and the general public, as appropriate.

This initial February 17, 1999 Compendium includes summaries of, and identifies relevant contact persons for, more than 35 of the most important of these health care regulatory agencies, associations and contractors. It is expected that the Compendium will be updated periodically and that additional trade associations, regulatory agencies and contractors will be identified and included in the Compendium on an on-going basis.

If you are aware of additional entities which you would like to see included, or if you have other suggestions as to how to improve the Compendium, please communicate with any member of the Board of Governors of the Virginia State Bar’s Health Law Section or the Editors identified on the cover page of the Compendium.

Hard copies of the Compendium are available from the Virginia State Bar at a charge designed to defray the copying cost by calling Elizabeth L. Keller at the Virginia State Bar at 804-775-0516.
# INDEX

## Health Care Trade Associations and Societies

<table>
<thead>
<tr>
<th>Organization</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Society of Virginia</td>
<td>1</td>
</tr>
<tr>
<td>Virginia Academy of Family Physicians</td>
<td>3</td>
</tr>
<tr>
<td>Virginia Association of Durable Medical Equipment Companies</td>
<td>4</td>
</tr>
<tr>
<td>Virginia Association of Health Plans</td>
<td>7</td>
</tr>
<tr>
<td>Virginia Association for Home Care</td>
<td>11</td>
</tr>
<tr>
<td>Virginia Association of Nonprofit Homes for the Aging</td>
<td>13</td>
</tr>
<tr>
<td>Virginia Birth-Related Neurological Injury Compensation Program</td>
<td>15</td>
</tr>
<tr>
<td>Virginia College of Emergency Physicians</td>
<td>18</td>
</tr>
<tr>
<td>Virginia Chapter of the American Academy of Pediatrics and The Virginia Pediatric Society</td>
<td>19</td>
</tr>
<tr>
<td>Virginia Dental Association</td>
<td>21</td>
</tr>
<tr>
<td>Virginia Health Care Association</td>
<td>22</td>
</tr>
<tr>
<td>Virginia Hospital and Healthcare Association</td>
<td>25</td>
</tr>
<tr>
<td>Virginia Medical Group Management Association</td>
<td>27</td>
</tr>
<tr>
<td>Virginia Optometric Association, Inc.</td>
<td>28</td>
</tr>
<tr>
<td>Virginia Organization of Nurse Executives</td>
<td>31</td>
</tr>
<tr>
<td>The Virginia Pharmacists Association</td>
<td>33</td>
</tr>
<tr>
<td>Virginia Society of Health-System Pharmacists</td>
<td>34</td>
</tr>
<tr>
<td>Virginia Society of Radiologic Technologists</td>
<td>39</td>
</tr>
</tbody>
</table>

## Health Care Regulatory Agencies, Commissions and Contractors

<table>
<thead>
<tr>
<th>Organization</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint Commission on Health Care</td>
<td>41</td>
</tr>
<tr>
<td>Virginia Attorney General’s Office</td>
<td>43</td>
</tr>
<tr>
<td>Virginia Bureau of Insurance</td>
<td>46</td>
</tr>
<tr>
<td>Virginia Department of Emergency Medical Services</td>
<td>51</td>
</tr>
<tr>
<td>Virginia Department of Environmental Quality (Medical Wastes)</td>
<td>53</td>
</tr>
<tr>
<td>Virginia Department of Health</td>
<td>59</td>
</tr>
<tr>
<td>Virginia Department of Health - Center for Quality Health Care Services and Consumer Protection</td>
<td>63</td>
</tr>
<tr>
<td>The Virginia Department of Health- Division of Certificate of Public Need</td>
<td></td>
</tr>
<tr>
<td>The Virginia Medical Care Facilities Certificate of Public Need Program</td>
<td>71</td>
</tr>
<tr>
<td>The Virginia Department of Health-Office of the Chief Medical Examiner</td>
<td>74</td>
</tr>
<tr>
<td>The Virginia Department of Health-Office of Water Programs</td>
<td>77</td>
</tr>
<tr>
<td>Virginia Department of Health-Women, Infants and Children (WIC) Program</td>
<td>81</td>
</tr>
<tr>
<td>Virginia Department of Health Professions</td>
<td>84</td>
</tr>
<tr>
<td>*Virginia Department of Medical Assistance Services</td>
<td>92</td>
</tr>
<tr>
<td>Virginia Department of Mental Health, Mental Retardation &amp; Substance Abuse Services</td>
<td>93</td>
</tr>
<tr>
<td>Virginia Department of Social Services: Adult Care Residences</td>
<td>100</td>
</tr>
<tr>
<td>and Adult Day Care Centers</td>
<td></td>
</tr>
<tr>
<td>Virginia Department for the Visually Handicapped</td>
<td>106</td>
</tr>
</tbody>
</table>
Other Non-Provider Health Care Players
Virginia’s Business Health Coalitions ............................................. 118
Virginia Monitoring, Inc. ............................................................. 120
Virginia Health Information ....................................................... 123
Virginia Health Quality Center .................................................. 132

* To be submitted
Compendium of Virginia Health Care Trade Associations and Regulatory Agencies

Prepared by Health Law Section of Virginia State Bar

February 17, 1999

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