December 7, 2022
Study packet contents

Local Health Department Structure and Financing

- Report in brief
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Local Health Department Structure and Financing

POLICY OPTIONS IN BRIEF

There are 11 policy options in the report for Member consideration. Below are highlighted options.

Option: Amend Code of Virginia to include all core public health Program Areas.
(Option 1, page 12)

Option: Direct VDH to design a state performance management process for all local health departments.
(Option 2 page 21)

Option: Direct VDH to develop and submit a plan for a centralized LHD data infrastructure.
(Option 3, page 26)

Option: Fund and direct a loan repayment program as a retention incentive, and provide targeted salary increases to local health department staff.
(Options 4-5, page 33)

Option: Direct health districts to participate in regular community health assessments and determine funding necessary to ensure sufficient communications capacity at the local level.
(Options 7-8, pages 38-39)

FINDINGS IN BRIEF

State Code does not require all core, public health program areas and some are lacking at local health departments
Two of the five foundational public health Program Areas identified as national best practice are not required of local health departments in Virginia. These are the ability to ensure access to necessary services and link individuals to those services, and a focus on chronic disease and injury prevention. Neither of these areas are explicitly required in state Code, and only a few local health departments currently focus on them.

There are no systems for accountability or performance management across local health departments
Monitoring performance for local health departments is challenging, but improvements are needed to ensure VDH can assess effectiveness across the state. Current data focuses on process metrics, such as the number of health inspections or clinical encounters, with no data on quality of services or outcomes. Other states have implemented performance management models that could serve as a framework for Virginia.

Local health departments need additional support for information technology and workforce
The IT systems that local health departments use for their core functions are siloed and outdated. Additionally, recruiting and retaining qualified staff are persistent challenges, due primarily to low salaries. Improving both of these administrative capabilities will improve local health department performance.

Funding allocations do not account for true service costs or need
Local health department budgets are primarily based on historical funding levels. This results in drastic variation across localities and means that budgets are not accounting for changes in need over time. Without a better understanding of the cost of core services and local performance, it is not possible to determine whether major funding changes are necessary. However, targeted investments to address identified shortcomings are necessary.

November 2022

JCHC Analyst: Kyu Kang

Policy Options

Joint Commission on Health Care
Local Health Department Structure and Financing

OPTION 1
The JCHC could introduce legislation to amend the Code of Virginia to require LHDs to ensure the availability of clinical services, either by the LHD or by other providers, facilitate access to and linkage with clinical care, as well as address chronic disease and injury prevention. The legislation should include an enactment clause directing VDH to update the Local Government Agreements to reflect these changes. (Page 12)

OPTION 2
The JCHC could introduce a Section 1 bill directing VDH to design a state performance management process for each LHD, with the goals of assessing the ability of each LHD to meet minimum capacity requirements, assisting in continuous quality improvement, and providing a transparent accountability mechanism to ensure public health functions are being met. (Page 21)

OPTION 3
The JCHC could introduce a Section 1 bill directing VDH to develop and submit a plan by November 1, 2023 for the development of a centralized data system that will enable VDH to access necessary data from all LHDs across departments to support LHD assessment and performance management, as well as enable greater data sharing with stakeholders and the public. (Page 26)

OPTION 4
The JCHC could introduce a budget amendment to provide additional funding to VDH for loan repayment programs for LHD staff. (Page 33)

OPTION 5
The JCHC could introduce a budget amendment to fund targeted increases for LHD staff base salaries to align with current industry salary benchmarks. (Page 33)

OPTION 6
The JCHC could introduce a budget amendment directing VDH to create regional operations and facilities management positions to assist LHDs, and providing funding for these staff. (Page 35)

OPTION 7
The JCHC could introduce a Section 1 bill directing VDH to require all health districts to participate in the CHA/CHIP process, in coordination with the state health assessment process and local health system Community Health Needs Assessments. The legislation should include an enactment clause directing VDH to update the Local Government Agreements to reflect these changes. (Page 38)

OPTION 8
The JCHC could introduce a Section 1 bill directing VDH to determine the funding necessary to provide sufficient communications capacity across all health districts. VDH should submit the funding estimate to the Chairs of the House Appropriations Committee and Senate Finance and Appropriations Committee by August 1, 2023. (Page 39)

OPTION 9
The JCHC could introduce a Section 1 bill directing that VDH track cooperative budget funding per capita, compare that funding to the identified needs of each LHD, and make appropriate adjustments as additional funding is made available. (Page 50)

OPTION 10
The JCHC could introduce a Section 1 bill directing VDH to update state regulations for environmental health services to increase inspection fees and adjust them based on the type of establishment being inspected, to account for the typical time it takes to conduct the inspection. (Page 52)

OPTION 11
The JCHC could introduce a Section 1 bill directing VDH to adopt regulations to implement a system of civil monetary penalties on facilities in violation of state environmental health regulations. (Page 52)

JOINT COMMISSION ON HEALTH CARE

Senator George L. Barker, Chair *Delegate Robert D. Orrock, Sr., Vice Chair*

TO: JCHC Members
FROM: Kyu Kang, JCHC Associate Health Policy Analyst
DATE: December 7, 2022
RE: Local Health Department Structure and Financing Study – Response to Briefing Questions

During the November 3, 2022 Joint Commission on Health Care (JCHC) briefing, staff shared findings and policy options from the JCHC study on *Local health department structure and financing in Virginia*. In response to Policy Options 10 and 11 in the report, Members requested additional information about several aspects of how other states design environmental health inspection fees and fines:

- How do other states' environmental health inspection fees compare to Virginia's?
- Do other states allow greater flexibility in the frequency of inspections if an establishment has a track record of good performance?
- If we establish civil monetary penalties for health inspection violations, is there any way to account for the severity of the risk involved with a violation when setting the penalties (i.e., distinguishing between violations that are minor and technical vs. those with major health implications)?
- Is there a way to incentivize businesses to meet health inspection standards, rather than punish the ones who don't? For example, could restaurants who require fewer inspections have lower fees?

Members also requested additional information about local health department staff who receive salary supplements from their localities, in response to findings about low staff salaries leading to workforce challenges.

Environmental Health Fees and Penalties

Implementing Option 10 or Option 11 would require decisions about specific environmental health fees and penalty structures. These could be made in statute, or VDH could be directed to develop the details through the regulatory process. There are three main levers the state may consider when designing a system for environmental health inspections and enforcement:

- **Annual license cost**: The majority of facilities regulated by the Virginia Department of Health (VDH) must pay for an environmental health permit every year. This includes all restaurants, hotels, motels, campgrounds, and summer camps, which pay a flat rate of $40, regardless of facility size or type.

- **Frequency of inspections**: Every facility regulated by VDH must receive an environmental health inspection, though the frequency of routine inspections varies by establishment type and risk category, as described below. VDH may also conduct follow-up inspections after identifying a violation during a routine inspection, or additional inspections after receiving a complaint.

- **Penalties for violations**: Establishments found to be in violation of environmental health regulations during routine inspections may face some form of penalty. For food establishments in Virginia, environmental health specialists may suspend or revoke an establishment's permit, or under orders from the Commissioner, VDH may pursue criminal penalties or charge a civil fee up to $25,000 per violation for severe public health threats. However, inspectors will most often provide corrective education and conduct as many follow-up inspections as needed to ensure the violation has been corrected.

Jeff Lunardi, Executive Director
Joint Commission on Health Care
P.O. Box 1322/Richmond, VA 23218

Other states have taken different approaches to managing environmental health fees and fines. Careful consideration of these three factors allow states to create enforcement systems that are best suited to their specific needs and goals.

Annual Licensing Fees

Twelve of the 13 other states or localities that JCHC staff reviewed vary the annual fee for food establishments. Most of these states vary the fee based on the size of the establishment, by measuring seating capacity, square footage, or another proxy for size. Two of the states vary the fee based on the health risk of the establishment (TABLE 1). The range of fees in other states can be large, with the smallest fees typically being for temporary establishments (e.g., food vendors at events) and not traditional brick and mortar restaurants. JCHC staff did not find any examples of states or localities that varied annual fees for food establishments based on a history of good performance.

TABLE 1: Examples of annual food establishment environmental health inspection fees in other states

State	Annual license Fee	Fee variability factors
District of Columbia	$300-475	Seating capacity
Kentucky	$160-510	Seating capacity
Maryland	$200-500	Risk
Massachusetts	$100-300	Type of establishment (e.g., sit-down dining or take-out) Square footage
New Mexico	$25-200	Type of establishment (e.g., temporary food establishments, home-based processing operations, food establishment) Waived for food establishments under specific conditions (e.g., provide food at no charge)
New York	$280	Plus $25 if establishment manufactures frozen dessert
North Carolina	$50-200	Seating capacity Square footage
Oregon	$159-824	Gross annual sales
Pennsylvania	$75-240	Seating capacity Square footage Liquor permit
San Antonio, Texas	$412-1,240.12	Number of employees $259.56 for establishments that sell only prepackaged, non-potentially hazardous foods or drinks
Tennessee	$40-350	Seating capacity
Vermont	$105-1,000	Seating capacity $125 for fair stand food vendor; $230 if operating 4+ days a year
West Virginia	$0-500	Seating capacity

SOURCE: JCHC staff analysis of other state laws and regulations.

A 2017 report by VDH to the General Assembly found that an establishment's health risk was the primary driver of how long a health inspection takes, and in turn how much it costs the state to perform.[1] The size of the establishment also impacted the time required for the inspection, but the difference between small and large establishments was relatively small (1 hour and 10 minutes on average for large establishments versus 1 hour and 2 minutes on average for small ones). The report calculated that the $40 annual fee covered only 6% of the total cost of administering the food program in 2017, which is likely an even smaller percentage in 2022. The VDH report proposed raising the average, annual fee to $238 per establishment, which would have constituted about one-third of the total revenue required to administer and implement the food program at the time.

[1] Virginia Department of Health, Office of Environmental Health Services. Cost Recovery Analysis of "Larger" Food Establishments, 2017. https://rga.lis.virginia.gov/Published/2017/RD589/PDF.

Virginia could structure its annual fees a few different ways:

- Set a higher, flat annual fee
- Vary annual fees based on an establishment's designated risk category
- Vary annual fees based on the number of inspections required in the previous year (this option would be a more performance-based annual fee, in lieu of civil monetary penalties or inspection fees)

The same model could be used for assessing annual fees for other types of establishments that also have a flat $40 fee, like hotels and campgrounds.

Inspection Frequency

VDH determines the frequency of food establishment inspections based on risk and prior performance, using an algorithm developed from U.S. Food and Drug Administration recommendations. For example, establishments selling prepackaged foods that require minimal to no handling (e.g., most convenience stores or coffee shops) are considered lower risk than establishments cooking and serving food to susceptible populations (e.g., hospitals or nursing homes). Food establishments that are considered a Risk Category 1 typically receive one routine inspection per year, while establishments that are considered a Risk Category 4 receive three to four routine inspections. Similarly, establishments with a history of compliance and good performance may receive fewer routine inspections than establishments with a history of violations or complaints (TABLE 2).

TABLE 2: Food establishments' inspection frequency is determined by risk category and other factors

Risk Category	Food Establishment Type	Annual Routine Inspection Frequency
Category 1	Serve, sell, or prepare only pre-packaged, non-time/temperature control for safety foods (e.g., convenience store operations, hot dog carts, coffee shops)	Typically 1, may range from 1-2 depending on whether they have a history of risk management
Category 2	Have a limited menu and most products are prepared/cooked and served immediately; complex preparation is limited to only a few foods (e.g., retail food store, quick service operations)	Typically 2, may range from 1-3 depending on whether the establishment is new, or has a history of successful risk management
Category 3	Have an extensive menu and handle raw ingredients with complex preparation including cooking, cooling, and reheating (e.g., full-service restaurant)	Typically 3, may receive only 2 if the establishment has a history of managing foodborne illness risks successfully
Category 4	Serve a highly susceptible population (e.g., preschools, hospitals, nursing homes) Conduct specialized processes (e.g., smoking and curing, reduced oxygen packaging for extended shelf-life)	Typically 4, may receive only 3 if the establishment has a history of managing foodborne illness risks successfully

SOURCE: Virginia Department of Health, Office of Environmental Health Services. Cost Recovery Analysis of "Larger" Food Establishments, 2017. https://rga.lis.virginia.gov/Published/2017/RD589/PDF.
NOTE: This table is currently under a routine review and potential update by VDH.

Classification of Penalties

Some states, including Virginia, have an annual license fee but do not issue civil monetary penalties for violations identified during inspections. Many states have both an annual license fee, as well as an established system of civil monetary penalties for violations and repeat inspections. States may vary civil monetary penalties depending on the severity, type, or frequency of the violation and subsequent follow-up needed (TABLE 3). For example, New York sets a detailed schedule of penalties with fines that range from $250 to $600 depending on the type and

severity of the violation (FIGURE 1). Other states charge a flat fine, regardless of the violation type or severity, or vary the fine based on the number of repeat offenses upon follow-up or how many re-inspections are needed.

TABLE 3: Examples of environmental health inspection civil monetary penalties in other states

State	Penalties
District of Columbia	Ranges from $250-4,000 depending on severity and number of repeat violations
Massachusetts	First offense = $100; Second offense = $250; Subsequent offenses = $500
New Mexico	Re-inspection fee: $100
New York	Ranges from $200-600, depending on severity and type of violation
Oregon	Written notice informing restaurant of the violation – restaurant may avoid a civil penalty by curing the violation within 60 days, otherwise penalty ranges from $250-1,000.
Pennsylvania	Ranges from $100-300 for a first or second offense Re-inspection fees: 2nd = $150; 3rd or subsequent = $300
Texas	Up to $500 per day based on severity, history of previous violations, amount necessary to deter future violation, efforts to correct the violation, and any other matter that "justice may require". San Antonio also has re-inspection fees: 1st = $103.00; 2nd = $118.45; 3rd = $128.75; 4th = $154.50
Vermont	First offense = up to $300; Repeat offense = up to $500
West Virginia	Notice of violation within certain time frame, after which there is a fine of $5 per day for every day establishment fails or refuses to comply

SOURCE: JCHC staff analysis of other state laws and regulations.

FIGURE 1: New York has a schedule of penalties based on violation type and severity

CHAPTER 23 – APPENDIX 23-C FOOD SERVICE ESTABLISHMENT AND NON RETAIL FOOD SERVICE ESTABLISHMENT PENALTY SCHEDULE

SCORED VIOLATIONS

VIOLATION CODE	CITATION	CATEGORY	VIOLATION DESCRIPTION	VIOLATION PENALTY CONDITION I*	VIOLATION PENALTY CONDITION II*	VIOLATION PENALTY CONDITION III*	VIOLATION PENALTY CONDITION IV*	VIOLATION PENALTY CONDITION V*
02G	NYCHC 81.12(d)(4)	Public Health Hazard	Reduced oxygen packaged foods not held at proper temperatures	$250	$300	$350	$400	$600
02H	NYCHC 81.09(e)	Public Health Hazard	Potentially hazardous food not cooled by approved method	$250	$300	$350	$400	$600
02I	NYCHC 81.09(e)(2)	CRITICAL	Potentially hazardous food not cooled to 41°F when prepared from ambient temperature ingredients within 4 hours	$200	$200	$250	$300	
02J	NYCHC 81.12(d)(4)	Public Health Hazard	Reduced oxygen packaged foods not properly cooled	$250	$300	$350	$400	$600
03A	NYCHC 81.04	Public Health Hazard	Food not from an approved source				$400	$600
03A	NYCHC 81.12(c)	Public Health Hazard	Reduced oxygen packaged foods not from an approved source				$400	$600
03A	NYCHC 81.12(e)	Public Health Hazard	Reduced oxygen packaging fish not frozen before processing				$400	$600

SOURCE: NYC Health, Chapter 23 – Appendix 23-C Food Service Establishment and Non Retail Food Service Establishment Penalty Schedule, https://www1.nyc.gov/assets/doh/downloads/pdf/rii/ri-violation-penalty.pdf

Virginia could introduce a penalty structure a few different ways:

- Civil monetary penalties based on the frequency of the establishment's offenses
- Civil monetary penalties based on the type and severity of the violation
- Re-inspection fees for any necessary non-routine inspections

With any of these options, Virginia could build in grace periods to give facilities the opportunity to correct violations quickly without facing a fine. Any civil monetary penalties would need to be sufficient to cover the agency resources and staff time required to pursue collection via the Attorney General's office. For example, in the onsite sewage program, while VDH has the authority to seek imposition of civil monetary penalties for violations, the agency has not implemented any because the low fees established during the rulemaking process and administrative barriers to collecting fees through the courts mean the costs of implementation outweigh the potential benefits.

Locality supplements for local health department staff salaries

Some localities use local funds to supplement the state salaries of all or some of their local health department staff, but the practice is not widely used. Localities must receive permission from the General Assembly before supplementing state public health employee salaries with local dollars.

There are currently four localities that provide salary supplements to some of their local health department staff, with three of the four being in Northern Virginia. As of January 31, 2022, there were a total of 157 classified, full-time public health employees that received salary supplements from their localities (7% of total local health department employees statewide).

- Alexandria – 72 employees (out of 74 total employees)
- Prince William – 70 employees (out of 70 total employees)
- Loudoun – 14 employees (out of 46 total employees)
- Lord Fairfax – 1 employee (out of 61 total employees)

Non-state salary supplements averaged $14,754 across all 157 positions, or about 20% of employees' total salaries (TABLE 4).

TABLE 4: Non-state supplements averaged about 20% of employees' total salaries

	Average	Median
State Salary	$60,308	$53,857
Non-State Supplement	$14,754	$12,000
Total Salary	$75,062	$66,778

SOURCE: Department of Human Resource Management, VDH Population data, 2022.
NOTE: Data do not account for state employee raises of 5% effective July 2022.

Of all of the employees receiving supplements, a majority (60%) are environmental health services specialists, public health nurses, or office services specialists (TABLE 5). Other positions receiving salary supplements include business managers, health directors, clinicians, health care technicians, program specialists, and outreach workers.

TABLE 5: Three position types receive the majority of non-state supplements

State	Number of Staff	Average State Salary	Average Non-State Supplement	Average Total Salary	Supplements as Percent of Total Salary
Public Health Nurses	35	$68,151	$19,488	$87,640	22%
Environmental Health	32	$59,472	$14,212	$73,684	19%
Office Services	26	$45,507	$10,236	$55,744	18%

SOURCE: Department of Human Resource Management, VDH Population data, 2022.
NOTE: Data do not account for state employee raises of 5% effective July 2022.

HAMPTON VA
CITY MANAGER'S OFFICE

November 18, 2022

Joint Commission on HealthCare
Commonwealth of Virginia
411 E. Franklin Street, Suite 505
Richmond, Virginia 23219
jchcpubliccomments@jchc.virginia.gov

Re: Public Comments
Local Health Department Structure and Financing Commission Draft Report

To Whom it May Concern:

The City of Hampton (the "City") has hosted the Hampton Health District (the "District") within its borders continuously since at least 1977. The District provides services to the citizens of Hampton, and in cooperation with the Peninsula Health District, also to the citizens of Newport News, Poquoson, York County, James City County, and Williamsburg. We are pleased to have the opportunity to submit comments for your consideration.

We are in full agreement that additional supports and resources are needed to improve the efficiency and effectiveness of all local health districts, and support all the options suggested for improvement set forth in the draft report. In addition, the City has the following specific concerns for your consideration:

- While the Joint Commission ranks greater support for facilities and operations low in their priorities, the City views it as a high priority. Further, it is indisputable that inadequate facilities are a material contributing factor to management and service deficiencies outlined in the report. The City has been working with the District since 2020, and more recently also with the Department of General Services, in an effort to obtain funding to improve the facility in which the District operates. A bit of context so you can better understand the significance of this issue to the City:
    - Rent paid for the use of the facility within the City has been substantially below market value, and for many years nothing more than a mere token as compared to the costs to adequately maintain the facility. From 1978 to 2014, annual rent received by the City was $20,778.67, which equates to approximately $1.30 per square foot. That rent was increased to $7.00 per square foot in 2015 ($111,727 annually); and $7.50 in 2017 ($119,708 annually), an amount which continues to be paid today. Today's market rent is approximately $12.00 per square foot. Compounding this issue is the fact that the District has used more square footage at the facility than was contemplated in the lease.

OFFICE OF THE CITY MANAGER

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- In addition to paying its required allocation of rent to support the facility, the City is also responsible for upkeep, maintenance, and utilities at the facility. On top of that, the District annually (and sometimes more frequently) has and continues to request improvements, janitorial services, and capital investment – all expected to be accomplished at the sole cost of the City. Those circumstances have reached a point of extreme (and untenable) inequity in the delineation between the City and State support the District.

- The Committee analysis on the fees charged for health inspections is much the same analysis that the City goes through when analyzing fees charged for similar services. When making those decisions, the City also considers the impact on the users that ultimately pay those fees. Accordingly, we recommend that any changes to fees and penalties should not result in discouraging small businesses and entrepreneurs by creating higher barriers of entry through the structure of the permitting process. Additional support should be considered to assist small business entrepreneurs through the process of establishing new businesses to proactively mitigate the need for multiple VDH inspections in the future.

- VDH's current structure has a direct impact on the City's emergency preparedness.

  - Due to the structure of the Peninsula Health District, the City has experienced inconsistencies in leadership support over the past few years. In addition, the members share administrative staff, such as the Emergency Planner, which extends the amount of time our emergency planning efforts may take. Because of this, the City suggests a dedicated Hampton Health Director to provide sustainable leadership support to the region.

  - The City agrees that community partnership and development capacity in LHD is low in regards to the development of shared response plans.

  - Future dedicated funding from the State's general fund would support emergency preparedness and provide consistency and stability that is normally challenging with the typical reliance on federal funding.

- A local health district should choose to be centralized or decentralized. The current hybrid version of those options creates confusion within the locality which may ultimately impact service delivery. The City's preference is a decentralized system as the LHD proved to be ineffective in meeting the needs of the communities it served during the COVID-19 pandemic.

  - The City also advocates that as a component of decentralization, VDH and its client communities may be best served if coverage of a single location is reduced to only one to two localities (i.e., a single office to serve Hampton, or only Hampton and Newport News).

- The City specifically supports the efforts to enhance technology and improve recruitment and retention of staff.

- The City believes that specific legislation requiring the LHD to address chronic health issues such as hypertension and diabetes has the potential to improve the health and overall well-being of communities such as ours with a high African-American population.

Thank you again for providing the opportunity to submit our comments for your consideration. Should you have any questions, please feel free to contact our office at (757) 727-6392.

Respectfully,

Brian D. DeProfio
Assistant City Manager
City of Hampton, Virginia

November 15, 2022

Virginia Joint Commission on Health Care
Attn: Jeff Lunardi
Executive Director
411 E. Franklin Street
Suite 505
Richmond, VA 23219

RE: Virginia JCHC Draft Report on Local Health Department Structure and Financing

Mr. Lunardi:

On behalf of the Virginia Restaurant, Lodging & Travel Association, Roanoke Regional Chamber of Commerce, Virginia Food Industry Association, Northern Virginia Chamber of Commerce, Virginia Asian American Store Owners Association, Hampton Roads Chamber of Commerce, and Virginia Petroleum & Convenience Marketers Association, we want to take this opportunity to share our organization's joint feedback regarding some of the proposed recommendations included in the Virginia Joint Commission on Health Care Draft Report on Local Health Department Structure and Financing. Our organizations represent a variety of businesses that are subject to inspections and fees from the Virginia Department of Health (VDH).

After reviewing the draft report issued by your commission related to Local Health Department Structure and Financing, we have developed concerns with some of the suggested proposals related to the financing of local health departments and the impacts it will have on regulated businesses in Virginia.

According to data from the National Restaurant Association, approximately 20 percent of restaurants closed permanently as a result of the public health mitigation measures that were implemented to prevent the spread of COVID-19. These businesses along with many other industries continue to struggle as a result of pandemic induced deficits that hamper our ability to fully recover. That problem coupled with the challenges the business community continues to face from inflation, supply chains issues, increasing energy prices, rising labor costs, and workforce shortages, leave these establishments struggling to break-even.

In addition, we continue to see many state agencies moving towards implementing and increasing fees on businesses around Virginia. All these suggested increases for fees, permits, fines, etc shouldn't be viewed in isolation, rather they should be viewed cumulatively as all sectors of Virginia's economy face "death by a thousand cuts." Unfortunately, the draft report includes several porposals that would increase costs for businesses in Virginia.

As noted in the draft report, Option 10 recommends increasing fees based on the number of visits to an business or it's size. We have concerns that this could significantly increase costs on businesses, especially when VDH is working with a business to try and remedy a problem and could discourage the collaborative relationship that currently exists between the operator and VDH.

Besides the financial challenges facing our industry, we have concerns about how some of the recommendations could undermine public health and place greater strain on local health departments and the Virginia Department of Health (VDH). Option 11 in the report suggests imposing fines and monetary penalties on businesses for violations. We believe this could place greater demands on VDH staff as it could lead to

inspectors having to take time away from conducting inspections to make court appearances related to violations. Further, it would also likely require that the Virginia Attorney General's office would need to show up to court for each violation to represent the Commonwealth, which itself would be very costly for Virginia.

Therefore, we believe it's deeply misguided to consider increasing inspection fees and imposing fines on regulated businesses and we are opposed to Options 10 and 11 in the draft report. Rather, we encourage the Commission to consider alternatives such as increasing general fund allocations to local health departments.

We are strongly opposed to increasing fees and imposing fines on industry as a means to increase funding revenues for local health departments. We urge you to consider alternatives such as utilizing general fund revenues. Thank you for your time and consideration of our feedback and request.

We are happy to discuss these issues with you should you have any questions or concerns related to them.

Sincerely,

Virginia Restaurant, Lodging & Travel Association
Virginia Food Industry Association
Roanoke Regional Chamber of Commerce
Virginia Asian American Store Owners Association
Northern Virginia Chamber of Commerce
Hampton Roads Chamber of Commerce
Virginia Petroleum & Convenience Marketers Association

Cc: The Honorable Senator George Barker, Chairman of the Virginia Joint Commission on Health Care
The Honorable Robert Orrock, Sr., Vice Chairman of the Virginia Joint Commission on Health Care
The Honorable John Little, Virginia Secretary of Health and Human Resources

COMMONWEALTH of VIRGINIA

Department of Health
P O BOX 2448
RICHMOND, VA 23218

Colin M. Greene, MD, MPH
State Health Commissioner

TTY 7-1-1 OR
1-800-828-1120

November 21, 2022

Mr. Jeff Lunardi, Executive Director
Joint Commission on Health Care
411 East Franklin Street, Ste. 505
Richmond, Virginia 23219

Dear Mr. Lunardi:

I would like to express my appreciation to the Joint Commission on Health Care for the report titled "Local Health Department Structure and Financing." The amount of time that you and your staff spent over the past six months working closely with staff throughout the Virginia Department of Health (VDH), and traveling to many of our local health departments, is clearly reflected in a very thorough, detailed, and thoughtful report.

My staff and I have reviewed and discussed the 11 policy options contained in the report. VDH offers the following comments with respect to policy options 1 and 2:

- Option 1: The JCHC could introduce legislation to amend the Code of Virginia to require LHDs to ensure the availability of clinical services, either by the LHD or by other providers, facilitate access to and linkage with clinical care, as well as address chronic disease and injury prevention. The legislation should include an enactment clause directing VDH to update the Local Government Agreements to reflect these changes.

- Option 2: The JCHC could introduce a Section 1 bill directing VDH to design a state performance management process for each LHD, with the goals of assessing the ability of each LHD to meet minimum capacity requirements, assisting in continuous quality improvement, and providing a transparent accountability mechanism to ensure public health functions are being met.

From the perspective of VDH either of these policy options, and especially option 1, could have a substantial fiscal impact on the agency. For that reason, VDH suggests that the JCHC consider amending both policy options to include – in addition to legislation - submission of an appropriate budget amendment request.

Thank you again for all of the courtesy that the JCHC staff extended to VDH throughout the course of the study. Please let me know if you require anything further.

Sincerely,

Colin M. Greene, MD, MPH
State Health Commissioner

VDH VIRGINIA DEPARTMENT OF HEALTH
To protect the health and promote the well-being of all people in Virginia.

VIRGINIA PUBLIC HEALTH ASSOCIATION

www.virginiapublichealth.org

Sent Via Email

November 18, 2022

Jeffrey Lunardi
Executive Director
Joint Commission on Health Care
411 East Franklin Street, Suite 505
Richmond, Virginia 23219

RE: Local Health Department Structure and Financing

Dear Mr. Lunardi,

The Virginia Public Health Association (VPHA) is a 501(c)(3) non-profit organization dedicated to strengthening public health practice, fostering health equity, and promoting sound public health policy. On behalf of its 300+ members, I appreciate the opportunity to comment on the Joint Commission on Health Care's draft report, "Local Health Department Structure and Financing." We thank Ms. Kang and the Commission for drafting the report and proposing policy options to strengthen Virginia's public health.

In lieu of commenting on individual policy options, **VPHA urges the Joint Commission on Health Care to recommend that the General Assembly establish a workgroup of key stakeholders to study these recommendation and other potential reforms in more detail and to share their findings with legislators by October 1, 2023.**

It is crucial that Virginia policymakers adequately fund local health departments (LHDs) so they can adequately provide effective, evidence-based public health services to all Virginians. It is also essential that LHDs provide these services equitably, transparently, and sustainably. While several of these policy options could strengthen LHDs' finances and performance, many are far reaching and require further inspection to ensure they satisfy these three principles.

This is not an endorsement of the status quo. Rather, it is crucial that policymakers and stakeholders, especially the individuals and communities served by local health departments, have adequate time to analyze these proposals in more detail.

While we are calling for more study of potential legislative action, VDH can take two immediate actions to strengthen Virginia's public health system:

1. **The Virginia Department of Health should make all current Local Government Agreements (LGAs) and local match rate methodology and data for each locality publicly available on its website.**

2. **The Virginia Department of Health should ensure that all job postings for local health department director positions make clear that public health professionals that meet SB 192's criteria can apply.**

The remainder of this letter explores these requests in more detail.

Equity

The funding formula for local health departments is inequitable. The Commission report notes that funding allocations do not account for true services or need. Instead, they are based on historical funding levels and localities' ability to pay.

This latter point is especially important. Localities must match between 18 percent and 45 percent of the state's contribution. If they cannot do so, the state reduces its contribution until the locality can afford its match. This methodology penalizes poorer localities, as those that cannot afford their match or contribute beyond it cannot offer optional public health services that their wealthy counterparts can provide.

Policy option nine, "track cooperative funding per capita, identify needs and differences, and adjust as appropriate," is necessary but insufficient. The word "adjust" presumes that fundamental changes to the cooperative health budget funding formula are unnecessary. VPHA is unconvinced. While tracking cooperative funding per capita and identifying needs and differences is critical, we believe fundamental reforms to the funding methodology may be necessary.

Finally, the report states that current requirements hinder LHDs' ability to pursue federal grant funds, putting at risk their ability to deliver public health services effectively and equitably. It is our understanding that under the current system, federal grant dollars sometimes go unspent instead of being strategically and equitably deployed to LHDs. Identifying better ways to coordinate the pursuit of grant funds should a key goal of a potential workgroup.

Transparency

A key theme of the Commission's report is that foundational public health program areas and capabilities are not standardized across the Commonwealth. While all local health departments are responsible for ensuring communicable disease control, environmental

public health, and maternal child and family health, the range of services they provide within these categories varies significantly.

There is also significant variation among optional services. The report notes that some local health departments operate chronic disease programs. Some still provide direct clinical services while others refer individuals to community providers. As stated earlier, the services provided by local health departments are unrelated to the true needs of the communities they serve.

Ensuring that every community can access the public health services they need is impossible until we understand what services are currently available and how they are financed. **VDH can accelerate this understanding by making all current Local Government Agreements (LGAs) and local match rate methodology and data for each locality publicly available on its website.** This data should be aggregated into a machine-readable spreadsheet so policymakers and the public can easily compare what services each local health departments provide and how they are financed.

Sustainability

Too often, public health funding runs on a boom-and-bust cycle. Virginia's biennial budget includes significant public health investments. However, these investments are largely funded by one-time federal COVID-19 relief dollars. Virginia must sustain these investments before these dollars run dry. VDH has already warned that these investments may be at risk without sustained funding, recently cautioning the General Assembly that it will not be able to afford the monthly fees for upgraded broadband equipment without a long-term funding source.[1]

The report's policy options to strengthen accountability and performance management, information technology systems, and the public health workforce are all thoughtful, but they will fail unless the General Assembly adequately and sustainably supports them with general fund dollars.

A robust public health workforce is also necessary to sustainably strengthen Virginia's local health departments. The General Assembly took an important step forward this year by approving SB 192, which allows qualified public health professionals to lead local health departments. The Commission's report noted "the constant churn of health directors in recent years had created an environment where priorities and expectations

[1] Virginia Department of Health, "American Rescue Plan Act (ARPA) State and Local Fiscal Recovery Fund (SLFRF)," June 2022.

changed like 'flavors of the month.'" Expanding the pool of qualified candidates to include qualified public health professionals can reduce this churn.

Despite SB 192's passage, recent job postings for local health department director positions do not make clear that qualified public health professionals may apply. **VPHA urges the Department of Health to ensure that all job postings for local health department director positions make clear that public health professionals who meet SB 192's criteria can apply.**

Conclusion

VPHA is committed to working with the Joint Commission on Health Care, the Department of Health, policymakers and the public to build a public health system that gives every Virginian the opportunity to be healthy. This report is an important step toward that goal.

Thank you again for the opportunity to comment, and please do not hesitate to contact Ben Barber at president-elect@virginiapublichealth.org should you have any questions.

Sincerely,

Benjamin Ford Barber

Ben Barber
President-Elect
Virginia Public Health Association