COVID-19 GOVERNMENT + POLITICS

As Virginia struggles to boost vaccination rates, state officials face calls for more coordination

BY: **KATE MASTERS** - JANUARY 21, 2021 12:01 AM

(NBC12)

The Lord Fairfax Health District vaccinated more than 2,000 people last week at two walk-up clinics in Clarke County. The first, on Monday, was open to anyone 75 and older. The second, on Friday, covered anyone 65 and up – as well as most of the county's educators.

In the neighboring Blue Ridge Health District, officials are still working to finish immunizing the health care providers prioritized in the first phase of Virginia's COVID-19 vaccine campaign.

It's not that they don't have plans for the same large-scale clinics. Earlier this month, the Blue Ridge Health District opened a large vaccination site with help from Riverbend Development – a private company in Charlottesville that owns a former Gold's Gym and Kmart space near a bus stop and the convergence of two main roads. Riverbend, along with a few other private

partners, helped the district navigate the city's permitting process to erect a 10,000-square-foot tent outside the former retail space.

Without the tent, the district would have been left cobbling together a list of potential vaccination sites in Charlottesville and Albemarle County, said Ryan McKay, the director of policy and planning for the district, which provides health services to more than 250,000 people in Albemarle, Charlottesville, Fluvanna, Greene, Louisa and Nelson. But the district hasn't staged the same sort of walk-up events – in part because it hasn't had the time or the staff.

"For us, I think that wasn't going to be the best use of our resources if we're trying to take on 75 and older and also wrap up 1a," McKay said. "Because we're moving so quickly – and sooner than we wanted to, to be honest – we're dovetailing 1a and 1b. And I think it's going to be more effective if we can be more surgical, so to speak."

Across Virginia, there have been major differences in how much help local health departments have received from hospitals and other private partners as well as the degree of coordination. Vaccination in Lord Fairfax, which includes Clarke, Frederick, Shenandoah, Page and Warren counties and the city of Winchester, has been heavily aided by its local hospital system, Valley Health, which immunized its own employees along with unaffiliated providers in the community. District Director Dr. Colin Greene said the system has also stepped up for Phase 1b, organizing large-scale vaccination clinics at Shenandoah University's athletics center.

"They just started it up last week and it can knock out more than a thousand doses a day," Greene said. In Blue Ridge, there's been collaboration with UVA Health, which has volunteered to vaccinate some independent providers and – starting Tuesday – send some of its own employees to work as vaccinators at the health district's primary site in Charlottesville.

A worker with UVA Health moves doses of the Pfizer COVID-19 vaccine into ultra-cold storage. (Courtesy of UVA Health)

But for the past few weeks, Blue Ridge has largely been managing vaccines in Phase 1a and 1b on its own – something Greene, the Lord Fairfax director, said would be a significant challenge.

"I can imagine what it would be like if the hospital system maybe vaccinated all its own people but didn't want to do anything more," he said. "I'd have some 230,000 people to vaccinate and only 73 people to do it with. It just wouldn't work."

How extensively each of Virginia's 35 local health districts can rely on outside assistance is one of many lingering questions as the state implements its COVID-19 vaccination plan. Dr. Laurie Forlano, deputy commissioner for population health at the Virginia Department of Health, said Tuesday that the central office holds several calls a week with community health districts, where plans are "built upon years of experience in vaccine planning and execution."

But VDH hasn't developed a uniform playbook or guidance that local health departments can follow when it comes to COVID-19 vaccination – a campaign that's logistically unprecedented. Some hospitals and local health systems have taken large roles in vaccinating their communities, but there's no state directive or requirement that they offer assistance or coordinate with their local health departments.

Virginia, like most of the country, has struggled to quickly administer the shots amid inconsistent messaging from the federal government and shipments that arrive a week at a

time – making it difficult to consistently plan how many doses VDH can redistribute. At a news briefing on Saturday, Dr. Danny Avula, who was named the state's vaccine coordinator on Jan. 6, weeks after Virginia's first doses arrived in mid-December, said the department got 300,000 dose requests this week but received only 106,000 doses from the federal government. That number also changed for the state mid-week – federal officials had initially told Virginia to expect up to 80,000 shots.

But data from the Centers for Disease Control and Prevention also indicate that Virginia is falling behind many other states in administering doses, which are all facing the same federal problems. As of Wednesday afternoon, Virginia was ranked 42nd out of 50 states and Washington, D.C. when it came to shots administered per 100,000 residents. And while the average number of daily new doses in Virginia has been steadily increasing (18,740 as of Wednesday morning) VDH's public vaccine dashboard still shows a total of 360,051 shots administered out of 943,400 distributed across the state – a gap of more than half a million doses.

Accounting for that gap has become enormously complicated. After initially telling the Mercury that the state's dashboard did not include doses reserved for long-term care facilities through a federal partnership with CVS and Walgreens, VDH said Monday that those shots are in fact included in the state's tally of doses distributed and administered. According to Avula, that equates to roughly 226,000 shots over which Virginia has little direct control.

As the Roanoke Times reported Tuesday, there are other discrepancies with the state's data. Currently, VDH is showing it's distributed more doses than the CDC reports allocating to Virginia. Health systems also say they've given out more doses than reflected on the state's dashboard.

As of Wednesday, VDH reported that 175,978 shots had been administered at hospitals across the state. But the Virginia Hospital and Healthcare Association reported 234,389 on its own public database.

Avula and other state officials have said that up to 200,000 doses may simply not have made it into the state's database yet – making Virginia look farther behind that it actually is. VDH recently hired 10 new staff members specifically to work with vaccination sites and ensure data on administered vaccines is making its way to the state.

It's more than an optics issue, though. If shots aren't uploaded into the Virginia Immunization Information System, or VIIS, which reports to the CDC, the federal government could cut Virginia's shipments – a threat it's recently made to all states.

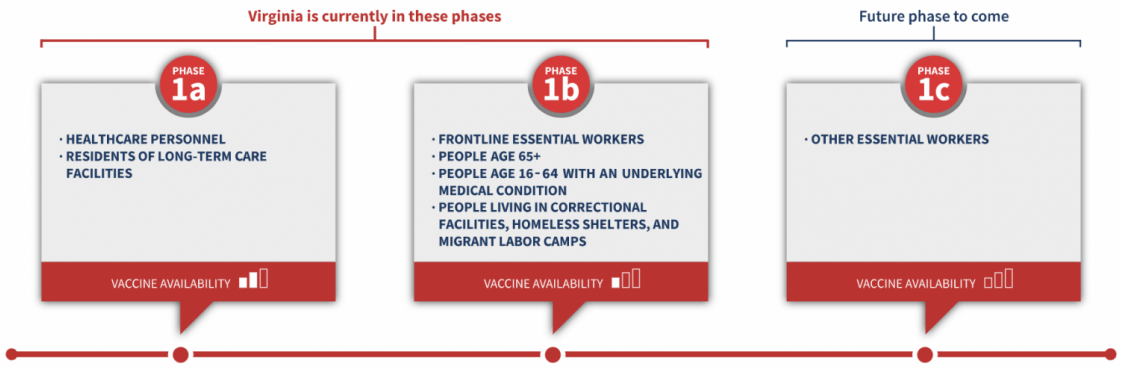
"What I'm telling all of our providers is that I see them doing a great job, but if those shots don't get into the system, it's going to screw you and it's going to screw us," Avula said in an interview on Saturday. "Because our federal allocation is dependent on our ability to get that vaccine out."

Dr. Danny Avula speaks at an event in 2018 during which he was named director of both the Richmond and Henrico County health departments. (Katie O'Connor/Virginia Mercury)

Escalating frustration

The vaccination effort has become increasingly politicized since the start of the General Assembly session, with Republicans criticizing Gov. Ralph Northam for the state's response and Democrats casting the blame on an erratic federal rollout orchestrated in the waning days of the Trump presidency. Those arguments have spilled out into the House and Senate floors sessions as the General Assembly begins the 2021 session.

Behind the scenes, though, the state is fielding complaints on numerous fronts. Seventeen city managers and county administrators in the Hampton Roads region sent a letter to Avula and state Health Commissioner Dr. Norman Oliver on Jan. 12 outlining concerns with the vaccination process. Those ranged from a request for more local data on vaccination rates and the number of vaccinators in each health district – "there appear to be major differences across the state," the letter reads – to clarification on how the state planned to manage mass registration for the roughly half of all Virginians who fall into the recently expanded 1b priority group.



The Virginia Department of Health has outlined prioritized groups for the first three phases of the state's vaccination campaign.

Hospitals have also been asking questions. In a call with the governor and other key administrators late last week, VHHA executives asked for more transparency on vaccine allocation, saying that hospitals ordered more than 50,000 vaccines the week before and only received about 22,000 – a 60 percent reduction from what they were expecting.

In a later email, VDH spokeswoman Melissa Gordon wrote "there was no 'reduction' in amount expected vs received, because as all providers know, supply is extremely limited and allocations change frequently to reflect that.

"It is safe to say that all Americans – hospitals, private providers, pharmacies and local health departments – want more doses than are currently available," she added.

But with little public transparency on where the state is shipping vaccines – or how it's determining its allocations to different providers – health systems aren't the only ones with concerns. On Tuesday, Chesterfield County Public Schools Superintendent Mervin Daugherty sent an email to staff notifying them that the school system, which is planning to bring some students back for in-person instruction next month, had received far fewer doses than anticipated.

As a result, the district had to cancel planned vaccination clinics for "Cohort 1" employees as well as elementary school staff.

"I regret that I have to share the supply chain outside of CCPS has not delivered," Daugherty wrote. "The first shipment of shots for Chesterfield County arrived yesterday and only contained 1,000 doses. The county government is providing the school division with 750 of those doses for use with our staff."

That 1,000-dose shipment arrived after the Chesterfield Health District put in an order for roughly 8,000 first shots (county officials anticipated receiving "at least 50 percent of that order this week," Daugherty wrote).

It's not clear why the county's allocation was so much lower than anticipated. But it's not just affecting the school system, which has "no plans to delay the re-entry of elementary students for in-person learning" despite the shortage of vaccines, Daugherty wrote.

Some private medical providers in Chesterfield – who ostensibly should have been vaccinated in the first phase of the state's campaign – have also been unable to schedule shots through the health district. Many of the practices that have struggled to schedule shots are smaller providers without ties to nearby hospital systems or satellite offices in adjoining health districts, which have been more successful in administering doses.

"Richmond, Henrico and Chickahominy seem to have had greater success at distributing the vaccine, all things considered," said Jim Beckner, the executive director of the Richmond Academy of Medicine. "Chesterfield is still struggling."

It's a stark contrast compared to other health districts– some of which were able to move into Phase 1b by the second week of January. That includes Fairfax, which has administered more than three times more vaccines than Chesterfield, according to state data.

Efforts in Fairfax County have been bolstered by Inova, one of the wealthiest hospital systems in Virginia. After a rocky start – one that left many primary care doctors in the dark about when they'd be eligible for a vaccine – the health system began opening appointments to unaffiliated providers in early January (Claudia Téllez, executive director of the Medical Society of Northern Virginia, said Inova notified her of the change on Jan. 4).

The health system has provided more than 38,000 vaccinations since opening its clinic in December, according to a recent staff email from CEO Dr. J. Stephen Jones. In the same message, he notified employees that the procedures for appointments has changed.

"Now that we are expanding our vaccination efforts into larger populations, we want to streamline the process for all of our team members," Jones wrote on Friday. Starting "immediately," all Inova employees – in addition to volunteers and contractors – could receive their vaccines without an appointment at one of the health system's two clinics.

"Walk-ins are encouraged," Jones wrote.

But as the health system expanded slots for its own workers, some residents in Fairfax County were notified the health district didn't have enough vaccines available to schedule their appointments. Many of the messages went to older residents with high-risk medical conditions who were told they were eligible to register for the vaccine under Phase 1b – including a Mercury reader who forwarded a Jan. 16 email from the health district.

"We want to thank you for registering to receive a COVID-19 vaccine," it reads. "Unfortunately, we do not have enough vaccine supply availability to schedule your appointment right now."

Inconsistent messaging on when and how the vaccines will become available has led to widespread frustration, both for residents and local officials across the state. Chesterfield's county administrator and board of supervisors recently released a letter "empathiz[ing] with citizens who are concerned and frustrated with the state's vaccine rollout," the Chesterfield Observer reported.

"We have also encouraged the state to expand the roles of local government in the vaccine campaign to further expedite the process, but to no avail," they wrote.

State Health Commissioner Dr. Norman Oliver speaks at a press conference in August. (Ned Oliver/Virginia Mercury)

'It is imperative to have greater coordination'

An apparent lack of local coordination has become a theme of Virginia's vaccine rollout. In talking points drafted before a VHHA call with Northam last week, hospital executives appear surprised by VDH plans to establish mass vaccination clinics at several locations across the state ("We also understand that there have been conversations about contracting with hospitals and health systems to help support these clinics," one point reads.)

But with some hospitals already planning clinics of their own, executives on the call wondered if a "collaborative approach" would be more efficient to avoid duplicating efforts.

"Moving forward, it is imperative to have greater coordination between VDH, local health districts, and hospitals/health systems to plan and execute vaccine clinics in communities across the Commonwealth," another talking point read. "We all, to varying degrees, have resources that could support these efforts."

Hospitals aren't alone in asking for more collaboration. In their letter to Oliver and Avula, Hampton Roads leaders included multiple questions on how officials intended to bridge the gap between state-level plans and local operations.

One asked if funding would be available to localities to offset costs for assisting in vaccination efforts. Another wondered if the state was anticipating any medical supply shortages – a major problem earlier in the pandemic as Virginia worked to expand access to testing.

“Are there any supply chain issues that local governments will have to work to solve for the vaccination plan to work?” local leaders asked. “Can localities assist with the procurement of these supplies?”

Staff at VCU Medical Center in Richmond receive 4,000 doses of the Pfizer COVID-19 vaccine. (VCU)

One of the most pressing requests, from hospitals and local health districts, has been for help with staffing. Mass vaccination efforts are largely dependent on having a large pool of vaccinators to help administer the shots. But the state’s post-holiday case surge has widely overwhelmed the health care workforce.

For hospitals, the spike in admissions has forced many providers to isolate or quarantine and kept others busy with patient care. At local health departments, high case counts have dramatically expanded the need for testing and contact tracing – overwhelming already strained workforces.

McKay, the director of policy and planning for Blue Ridge Health District, said environmental health staff would normally handle many of the logistics for vaccination clinics – including packing and transporting supplies. But since local health departments have also been tasked

with administering the governor's emergency orders, he said those same workers have been too busy with enforcement.

National Guard members stepped in to help with logistics last week after a request from the district, according to McKay. But finding vaccinators has been another challenge. While Northam and other state officials have touted the Medical Reserve Corps – a volunteer group established to respond to public health emergencies – the reality is that many members have full-time jobs and can't commit to fully staffing a vaccine clinic.

"It can be difficult to get volunteers to commit to the number of hours we need," McKay said. While the district has no shortage of volunteers, onboarding is also a challenge. Even experienced providers currently have to go through at least six to 10 hours of training, including a skills test with a public health nurse. Hospitals and localities have also complained that the current prerequisites make it difficult to quickly expand the state's vaccination workforce.

"We are seeking a temporary waiver for the non-essential requirements to more quickly facilitate the registration of additional vaccinators," Hampton Roads leaders wrote to Avula and Oliver. "Another possibility would be for VDH to allow nurses or other qualified healthcare professionals to certify and work under our hospital systems' emergency credentialing."

Hospital executives have also asked the administration to ease some of those requirements through an executive order. Avula said Saturday that the state is in the process of drafting that language.

"I understand that people are frustrated, but this is a massively complex logistical challenge," he added. "So while I understand the frustration, I think we need a lot more grace and collaboration. And I think in the coming two weeks we're going to shift from, 'Where are those missing doses?' to 'Okay, they're getting out – how do we get more?'"

Most localities and health systems readily acknowledge the barriers presented by a chaotic federal rollout. But McKay said the lack of coordinated state messaging has also been a challenge as many local districts struggle to scale up their vaccination efforts.

One key example is the state's transition to Phase 1b. After what state Health Secretary Dr. Dan Carey described as "strong guidance" from the federal government, Virginia expanded eligibility to include residents 65 and older and all adults with underlying health conditions. As a result, nearly half the state's population has been told they'll qualify for a vaccine once their local districts enter that next phase (for some, that's already happened, but officials say the entire state is expected to move onto 1b by the end of January).

Exhausted vaccine reserve could unravel plans for Phase 1b expansion in Virginia

News that the federal government has already exhausted its supply of "reserve" COVID-19 vaccines sent Virginia officials scrambling on Friday — less than 24 hours after Gov. Ralph Northam outlined plans to expand vaccine eligibility. The Washington Post reported Friday that there was no federal stockpile of additional vaccines, despite an announcement earlier this week … Continue reading

The problem is that, as of now, federal vaccine shipments aren't expected to increase until at least March, which means Virginia's allocation will remain at roughly 110,000 a week. And beyond the limited supply, not all health districts are getting the same level of assistance. As a result, availability will likely continue to vary widely across the state.

"Just to say we're moving into Phase 1b doesn't mean all those people in 1b are going to get quick access," McKay said. "So that creates some challenges in terms of messaging. And not all districts are on the same timeline. So managing all that becomes very, very difficult."

KATE MASTERS

An award-winning reporter, Kate grew up in Northern Virginia before moving to the Midwest, earning her degree in journalism from the University of Missouri. She spent a year covering gun violence and public health for The Trace in Boston before joining The Frederick News-Post in Frederick County, Md. While at the News-Post, she won first place in feature writing and breaking news from the Maryland-Delaware-DC Press Association, and Best in Show for her coverage of the local opioid epidemic. Before joining the Mercury in 2020, she covered state and county politics for the Bethesda Beat in Montgomery County, Md.

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Two Hampton Roads health systems' legal battle reignites old debate over state's medical facility policy

BY: **KATE MASTERS** - MAY 18, 2021 12:01 AM

Sentara Heart Hospital in Norfolk. (Ned Oliver/Virginia Mercury)

For years, a battle between two competing hospital systems in Hampton Roads has spilled into the halls of the Virginia Capitol and the hands of sometimes reluctant legislators.

Now, it's spilled into the court system. In late April, Chesapeake Regional Medical Center sued Sentara, the region's dominant health system, claiming Sentara worked deliberately to "cripple" Chesapeake's cardiology program. Among the heated allegations are that Sentara

worked secretly to poach doctors that formed the backbone of Chesapeake's program, persuading them to break their contracts and join the much-larger system.

At the root of the business dispute, though, lies a nearly 50-year-old Virginia policy – one that's become the center of countless debates in the state's General Assembly. Since 2017, Chesapeake has sought to establish its own open-heart surgery program, a service offered by Sentara and multiple other hospitals in the region. But to do so, it has to go through Virginia's Certificate of Public Need Program, a bureaucratic process that governs medical services and facilities across the state.

Virginia isn't the only state with COPN laws. But its program is known for being uniquely granular. Approval is needed not only for major projects, like building a new hospital, but for purchases as small as a new MRI machine or CT scanner. Even adding licensed beds to an existing facility requires going through the application cycle.

The process also allows competitors to oppose projects they view as a threat to their existing services. It's done routinely and frequently. When Chesapeake first applied for an open-heart surgery program, the application was derailed when Sentara requested what's known as an "informal fact finding conference" – a chance for it to contest the merits of the project.

Eleven months later, Chesapeake's application was denied by State Health Commissioner Dr. Norman Oliver, despite initially being recommended for approval by staff at the Virginia Department of Health. That background factors heavily into the hospital's lawsuit against Sentara, which – not content with its majority hold on local cardiology services, Chesapeake alleges – "seeks to eliminate competitors who attempt to encroach on its monopoly service lines."

Virginia Health Commissioner Dr. Norm Oliver spoke at a press conference in March 2020 on Capitol Square. (Ned Oliver/Virginia Mercury)

It's far from the first clash between the two health systems. In Virginia, it's common for providers to fight over the COPN process and appeal to the General Assembly for legislative solutions. But long-time observers say it's unusual for the matters to end up in court.

"This probably represents a new level, in some respects, of controversy between health systems," said Don Harris, who spent more than four decades in government relations for Inova Health System before joining Del. Mark Sickles, D-Fairfax, as his senior policy adviser. COPN applicants sometimes file litigation against the state health commissioner to contest a decision — a step that was also taken by Chesapeake. Of more than half a dozen experts interviewed by the Mercury, though, none could think of another instance where one health system sued another and cited COPN-related activity.

At stake is more than $20 million in damages that Chesapeake is seeking for Sentara's "malicious" interference in its business, according to the filing, first reported by the Checks & Balances Project, which describes itself as an investigative blog and has set its sights on Sentara's power and influence. But the litigation could also force COPN laws, which faded in prominence at the start of the COVID-19 pandemic, back to the forefront for Virginia legislators.

In the 1980s and '90s, Harris said disputes tended to be between hospitals and physician groups, who were becoming increasingly interested in establishing their own outpatient

surgery centers. But as most health systems have moved to acquire medical practices and establish their own outpatient services, opposition to COPN applications more frequently comes from competing hospitals.

If that results in more lawsuits – or more legislation designed to benefit a particular health system – Harris thinks lawmakers could begin to reconsider the COPN program. Because at the end of the day, experts say, the Virginia legislature doesn't like to choose between competing business interests.

"When you put legislators in the middle of these disputes, it does provide a lot of ammunition for them to say, 'Well, why don't we just get rid of the law altogether?'" Harris said. "It puts them in an unwinnable situation."

'Chesapeake, especially, is pretty frustrated'

Over the years, providers have often looked for legislative intervention in the form of what lobbyists refer to as "carve-outs." In bills addressing the COPN process, a frustrated applicant – often a health system – will slip in a clause meant to ensure their success in the process.

One recent example was a failed amendment in a 2020 bill from Sen. George Barker, D-Fairfax, which aimed to streamline the application process. At one point, the legislation would have exempted HCA Healthcare from going through the COPN process for a new neonatal care unit in the Roanoke region. The system has long been embroiled in a fight with Carilion, which opposes HCA's efforts to establish a new NICU. VDH has sided with Carilion, arguing the area has enough services to meet the existing need.

Physicians with the Carilion Clinic in Roanoke wear enhanced personal protective equipment inside the health system's facilities (Photo courtesy of the Carilion Clinic).

But Chesapeake, especially, has a history of inspiring specific legislation to protect it from Sentara. The same year that HCA sought a carveout in Barker's bill, Sen. Louise Lucas, D-Portsmouth, sponsored narrowly tailored legislation that would have added a COPN requirement to any freestanding emergency department owned by an affiliated hospital located within 35 miles specifically within Planning District 20 (which covers much of the Hampton Roads region).

The bill was a direct response to freestanding emergency departments established by Sentara, which Chesapeake – and its supporters – argued were deliberately siphoning well-resourced patients to Sentara hospitals.

The previous year, Chesapeake and Sentara were the focus of yet another legislative fight when Sen. J. Chapman Petersen, D-Fairfax City, sponsored a bill that would have required vertically integrated health carriers – insurance plans that also own hospitals – to allow public hospitals to participate in their networks. This time, the dispute focused on the Sentara-owned health plan, Optima, which Chesapeake argued didn't accept all the services it offered in-network.

"They felt that Optima was favoring Sentara hospitals and services and not giving them an equal opportunity," said Del. Terry Kilgore, R-Scott, who served as chair of the House Commerce and Labor committee at the time. Chesapeake has frequently served as a

convenient proxy in the COPN war, both for its local lawmakers and for legislators who more generally oppose the process. The hospital is one of the few independent facilities left in Virginia – one that's not owned by a large corporation with multiple hospitals across the state. And it's controlled locally through the Chesapeake Hospital Authority, a governing body with members appointed by the Chesapeake City Council.

It was conceived more than 50 years ago by local residents and community leaders, who led the drive to fundraise and build the hospital. Those hometown ties have inspired fierce loyalty among residents and the local legislators who represent them. But other lawmakers, including Petersen, have argued that smaller players like Chesapeake need protection from entities like Sentara, a multi-billion dollar company with 12 hospitals across Virginia and northeastern North Carolina.

"Honestly, I feel like it was inevitable it was going to come to this point," said Lauren Schmitt, a lobbyist who's worked on COPN bills for the Virginia Orthopaedic Society, which is part of a loose coalition focused on reforming the process. "We've seen a lot of the larger health systems dominate the process. And I think Chesapeake, especially, is pretty frustrated with the process that they've been going through over the last few years."

A hallway in the Capitol crowded with citizen and corporate lobbyists during the legislature's 2019 session. (Ned Oliver/Virginia Mercury)

'These events caused a lot of damage'

That frustration is palpable in the lawsuit, in which Chesapeake points out that Sentara holds about 70 percent of the market share for cardiology services in the Hampton Roads region. Chesapeake is "the only one of three systems without an open-heart surgery program," said Johan Conrod, the attorney representing the hospital in its suit.

But what forced the hospital to litigate, he said, was Sentara's successful poaching of seven cardiologists from Bayview Physician Services. The private medical group was contracted by Chesapeake to provide the bulk of its existing cardiology services, and losing those doctors nearly upended the program. It was only through "significant additional cost" that the hospital was able to continue providing those services to its patients, Chesapeake claims in its suit.

"There can be no debate that if your interventional cardiologists walk out the door, you as a community hospital have to scramble to make sure people are served," Conrod said. "It massively impacted Chesapeake, and you can't get around that. This wasn't one of those car accidents that happened at 2 miles per hour. These events caused a lot of damage."

Whether Sentara stole those doctors is the subject of separate litigation filed in Virginia Beach. Chesapeake alleges that Sentara began meeting secretly with the cardiologists in early 2019, "not long after taking steps to block CRMC's open heart application," according to its lawsuit. Gary Bryant, an attorney for Sentara, counters it was the doctors who approached the system for employment after deciding to end their contract with Bayview.

But neither system is arguing against the COPN system itself. Both parties frame it as a contract dispute — despite Chesapeake claiming that "undermining" its COPN application was "part of Sentara's plan to cripple CRMC's cardiology services program."

"While it makes a number of COPN-related allegations, none of the claims relate to COPN," wrote Jamie Martin, an outside counsel to Sentara who represents the system in matters involving the process. Sentara, too, said the litigation revolved around the question of whether the cardiologists had broken their contract with Bayview when they went to work for Sentara.

"We are focused on our patients and not-for-profit mission to improve health every day by providing safe and quality care to the communities we serve," Dale Gauding, a spokesman for the system, said in a statement. "It is unfortunate that Chesapeake Regional Medical Center chose to file a lawsuit involving a contract dispute, not a Certificate of Public Need, instead of continuing to focus on the communities we serve – especially as we continue to face the COVID-19 pandemic together."

That's because hospitals remain one of the most enthusiastic supporters of Virginia's COPN program, despite sometimes falling victim to it. Health systems, which are required to accept all patients regardless of insurance status, argue that protecting local monopolies on profitable services such as knee replacement and imaging subsidizes loss generators like NICUs and psychiatric beds.

"COPN proved its worth and proved its value as a foundational block of the health care delivery system during the pandemic," said Julian Walker, the vice president of

communications for the Virginia Hospital and Healthcare Association. He pointed to facilities that served on the frontlines despite losing millions during a pause in elective surgery and surges of often-costly COVID patients. If any provider was able to expand without input from the state, health systems argue it could undercut their own services to the point where they'd have to close, leaving communities without a vital health resource.

State data highlights the extent to which all hospitals participate in the COPN process. In May 2020, Chesapeake wrote its own letter of concern when Sentara submitted an application to open a new operating room at Virginia Beach General Hospital. A few months later, both systems opposed Bon Secours' effort to significantly expand its services at Harbour View in Suffolk, arguing the competing health system was trying to transfer more care to a higher-income area.

There have even been deals struck between the two. During the 2019 fight over vertically integrated health carriers, Kilgore said he brokered a handshake deal between Chesapeake and Sentara. Sentara wanted the bill to go away. Chesapeake agreed on the condition Sentara wouldn't oppose its new COPN application for an open-heart surgery program.

Del. Terry Kilgore, R-Scott.

"We've always said the focus should be on providing care to patients where it's more convenient and less expensive," Schmitt said. And when hospitals can influence the system, she argued, it's patients who suffer from inflated costs and less access to services.

"If someone lives 15 minutes from a hospital, they should be able to go to that hospital for whatever care they need," she said. Chesapeake's second open-heart application ended in a recommendation for denial, and city residents still can't receive the surgery at their local hospital. Sentara, too, has been blocked from adding specialty level NICU services to its medical center in Harrisonburg. That's despite support from the Mennonite community, who said it would be more accessible for them than traveling to the next-nearest specialty center at UVA.

But repealing the law, or supporting substantial reforms, is still a tricky subject for legislators. Some lawmakers have long been opposed to the program, arguing it stifles competition. But as a representative of a rural district, Kilgore said the issue wasn't as straightforward.

"It's a tough call," he said. "Someone coming in with an MRI machine and taking away paying patients could really hurt a small, rural hospital."

Medicaid expansion was expected to significantly shift arguments surrounding COPN, and Sickles, who's submitted numerous bills on the program, said it has — to some extent. With more insured patients, it's harder for hospitals to argue that they need protection from the burden of providing charity care. But many have shifted to arguing that Medicaid reimbursements still don't fully cover the cost of services.

"The problem is, we need another way to finance hospitals," Sickles said. "Because if you take away their highest payers and they're living on Medicare and Medicaid patients, we're going to have a problem."

KATE MASTERS

An award-winning reporter, Kate grew up in Northern Virginia before moving to the Midwest, earning her degree in journalism from the University of Missouri. She spent a year covering gun violence and public health for The Trace in Boston before joining The Frederick News-Post in Frederick County, Md. While at the News-Post, she won first place in feature writing and breaking news from the Maryland-Delaware-DC Press Association, and Best in Show for her coverage of the local opioid epidemic. Before joining the Mercury in 2020, she covered state and county politics for the Bethesda Beat in Montgomery County, Md.

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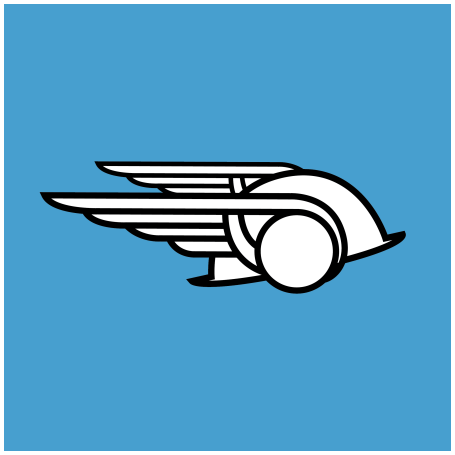

From the push to remove Confederate statues to big shifts in healthcare and energy policy, the Old Dominion is changing; fair and tough reporting on the policy and politics that affect all of us as Virginians is more important than ever. The Mercury aims to bring a fresh perspective to coverage of the state's biggest issues.

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GENERAL ASSEMBLY 2021 HEALTH

Virginia's naturopathic doctors are continuing a 15-year fight for licensure

BY: **KATE MASTERS** - JANUARY 5, 2021 12:03 AM

(Getty Images.

For the past 15 years, Virginia's naturopathic doctors have been on a quest for licensure by the state's Department of Health Professions – a step that's been taken by 23 other states and would allow them to diagnose and treat patients like many other medical providers.

That goal has brought the debate around the field of naturopathic medicine – widely defined by practitioners as a system that emphasizes prevention and self-healing through natural

therapies — to the state's General Assembly. Most recently, both the House and Senate considered bills during the 2020 legislative session that would have mandated the Board of Medicine to develop regulations for licensing naturopathic doctors in Virginia.

While both bills failed in committee, the Senate instructed the Board of Health Professions to conduct a study on regulating naturopathic doctors — one that concluded with a unanimous recommendation for licensure by the board's Regulatory Research Committee during a meeting in August. But the effort ran into another dead end less than two hours later, when the full board met and voted narrowly — 5-6 — against licensing.

"It was a little disappointing," said Sarah Giardenelli, a naturopathic doctor and licensed acupuncturist in Leesburg who serves as president of the Virginia Association of Naturopathic Physicians. "I've never seen another profession go through this — where the research committee recommended licensing and the full board voted against it. It certainly didn't feel right to us at all."

Amid an ongoing global pandemic that's led to significant revenue losses for many primary care providers, Virginia's naturopathic doctors plan to carry their fight for licensure into 2021, arguing they could play a critical role in expanding access to care for patients.

Del. Sam Rasoul, D-Roanoke, who sponsored the House version of the legislation in 2020, said a new bill would be filed in the upcoming General Assembly session. It's likely to share similarities to previous versions, which proposed a significantly expanded scope of practice for NDs, allowing them to examine and diagnose patients, order clinical laboratory tests, and administer intravenous medication, among other treatments.

Del. Sam Rasoul, D-Roanoke. (Ned Oliver/ Virginia Mercury)

“It’s sad to see that politics is what drove this decision, rather than the sound, objective information that was presented by the committee,” he added. Rasoul was referring specifically to objections from physicians’ groups like the Medical Society of Virginia, state chapter of the American Academy of Pediatrics and seven other medical associations that signed a letter opposing licensure for NDs. The medical society, in particular, has long said licensing would give naturopathic practitioners a level of credibility that the profession doesn’t deserve.

“Licensure connotes a level of training that has some scientifically and medically backed substance to it,” said Clark Barrineau, assistant vice president of government affairs for the Medical Society of Virginia. “And for better or worse, that substance in naturopathy isn’t out there for anyone to evaluate right now.”

‘We’re a glorified health consultant’

It’s a view that naturopathic doctors – most spread among the roughly 18 practices listed in Virginia – are fighting against as they work towards licensure.

Virginia did license providers until 1972, when, according to the state’s most recent study, an ND member of the Board of Medicine recommended deregulating the industry. More than 30 years later, in 2005, the state’s Board of Health Professions first re-examined the issue, with NDs arguing that their title comes with a specific level of education and experience.

The board's 2020 study points out that every other state to license NDs– including neighboring Maryland and D.C. – requires practitioners to hold a degree from a four-year program certified by the Council on Naturopathic Medical Education, an accrediting agency that's recognized by the U.S. Department of Education.

They also have to pass the NPLEX, or Naturopathic Physicians Licensing Examinations – a two-part exam that includes questions on basic biomedical subjects such as anatomy, physiology and genetics. A second section involves diagnosing patients, interpreting lab results and administering treatments, including plant-based medicines and supplements. Some states also require NDs with certain specialties to pass additional clinical exams in areas such as acupuncture, minor surgery and pharmacology.

"The main point is that we have the training and education and breadth of experience that's needed," said Maria Rodriguez, a naturopathic doctor who lives in Northern Virginia but practices in D.C., where she's licensed.

With her practice in D.C., Rodriguez said she can examine and diagnose patients, which includes ordering and interpreting her own clinical lab tests. The city's regulations define naturopathic medicine as treatments using "air, water, heat, cold, sound and light," along with more specific therapies ranging from exercise and ultraviolet light to diathermy – a therapy for joint and muscle conditions that uses high-frequency electric currents to "deep heat" tissue, according to the FDA.

"I actually have a pretty limited scope," Rodriguez added. "I'm allowed to prescribe natural hormones, so I will do that, but otherwise we have fairly limited prescriptive privileges." In Virginia, on the other hand, the lack of licensure means she can't legally perform even routine physical exams.

"I think the healthiest way to put it is that we're a glorified health consultant," added Leah Hollon, a naturopathic doctor who also graduated with a masters of public health from Virginia Commonwealth University and opened her own clinic in Richmond eight years ago. It's frustrating for many in the industry, who say the lack of regulation creates unnecessary barriers for both patients and providers.

Naturopathic doctors and patients continue to advocate for full licensure in Virginia. From left to right: Peter Ross, the co-owner of Richmond Natural Medicine; Dr. Peyton Taylor, MD, a supportive physician; April Garnett, a supportive patient; ND Desta Golden, a member of the Virginia Association of Naturopathic Physicians; ND Marie Rodriguez, VAANP Vice President; ND Leah Hollon, a VAANP board member; ND Sarah Giardenelli, VAANP president; ND Theresa Collier, a member of VAANP.

“Right now, without licensing, I’m not even able to use basic evaluation and management insurance codes so patients can try to submit their claims for reimbursement,” Giardenelli said. In written testimony to the Regulatory Research Committee, multiple NDs pointed out that they had to ask their patient’s licensed physician to order diagnostic tests they were recommending – a process that, at best, forced patients to schedule multiple appointments with different providers, and, at worst, ended in outright refusal.

“I do not always have established relationships with all of their providers, and sometimes these providers are not willing to order the labs or to consider other ideas I may have suggested for our shared patients,” Giardenelli added in her written testimony. “I cannot blame them; it is truly odd for me to ask another provider to basically do my job for me.”

‘It suggests a level of backing that we think, candidly, could cause some harm’

Opponents of licensing, though, often bristle at the idea that NDs in Virginia have the expertise to practice autonomously and refer to themselves as doctors or physicians. While NDs often note that the Council on Naturopathic Medical Education is recognized by the federal government, Barrineau pointed out that recognition as an accreditation agency by the DOE doesn't mean that the government has approved or endorsed the curricula of programs it oversees.

One frequent criticism is that naturopathic education is accredited almost exclusively by other naturopathic doctors, without the extensive and multidisciplinary third-party oversight required for most medical and nursing education. In 2014, the American Medical Association developed a module aimed at "assist[ing] physicians in countering the advocacy efforts of naturopaths seeking licensure and/or expansion of their current scope of practice." It highlighted findings from other state studies of the industry, including a Colorado report that found the NPLEX Part II, the licensing exam, "does not adequately measure clinical competence."

Barrineau said that results in programs that focus heavily on things like homeopathy — a treatment involving tiny doses of natural substances that has little scientific evidence to back up its effectiveness, according to the National Center for Complementary and Integrative Health.

Naturopathic medicine can involve a host of treatments depending on the practitioner and the scope of practice allowed in different states, from clinical nutrition to botanical supplements to massage. But the American Medical Association has harshly criticized many of the therapies common within the industry, writing that "the lack of randomized controlled trials and other forms of rigorous scientific inquiry into naturopathic treatments has not gone unnoticed by the medical and scientific communities."

"The reason we oppose the effort is that if they can say 'I am licensed by the Commonwealth of Virginia,' it suggests a level of backing that we think, candidly, could cause some harm," Barrineau said.

Much of the opposition to licensure in Virginia has also come from other naturopathic practitioners — ones who haven't gone through a CNME-accredited program or, in some cases, received any form of third-party training. Often called "lay" or "traditional" naturopaths, many oppose licensure on the grounds that it would restrict their ability to practice. But many also say NDs blend natural remedies with conventional medical treatments in a way that can be harmful to patients.

"Allowing them to practice medicine without going to medical school is essentially giving them a license to kill," Julie Coombs, a member of the American Naturopathic Medical Association — which opposes licensure — said in public testimony to the committee in August. "They think that putting a natural substance such as turmeric in an IV makes it naturopathy, when in fact it does not."

Coombs was referring specifically to a case of naturopathic medicine gone wrong — a patient who died after receiving a turmeric infusion from a licensed ND in California.

It's the kind of example that makes many NDs in Virginia cringe. Giardenelli pointed out that one major advantage of licensure would be the establishment of a regulatory board that could discipline and even de-license providers who harmed patients or ventured outside their scope of practice.

The BHP's study found that in licensed states, the number of disciplinary proceedings for NDs were generally equivalent with other medical providers. In some cases, they involved providers advertising themselves as NDs without the necessary credentials. Giardenelli said licensing would help prevent that by reserving the title for providers who graduated from an accredited program — a step she said would also help patients distinguish between NDs and traditional naturopaths.

The issue remains a significant point of contention between NDs and many licensed medical groups. Another frequent criticism is that licensure would enable NDs to treat children or patients with specialized needs — groups that require a different level of care than healthy adults. The Virginia chapter of the American Academy of Pediatrics testified against licensing on the same grounds, calling training for NDs "considerably less rigorous than the training for pediatricians in allopathic and osteopathic medicine."

"We are concerned that children would instead be taken by their parents to naturopathic providers who are not trained to provide this care and potentially serious medical issues could be overlooked," added Dr. Barbara Boardman, chair of the Virginia AAP's advocacy committee.

But Hollon said the goal of responsible NDs is to work collaboratively with other providers, including referrals to specialists and emergency care if a patient came in with a serious condition.

"I would never work with a cancer patient who didn't have an oncologist, for example," she added. "It's extremely unethical and irresponsible. Even if I was in a licensed state, it would be unethical because with oncologists — that is their specialty. They often know about drug trials that are available that I don't know about."

The temporary General Assembly Building, seen from Capitol Square. (Ned Oliver/Virginia Mercury)

‘I think there is a lot of room for providers like us to come in and serve as these frontline practitioners’

Many NDs worry that misinformation, including a tendency to pit naturopathic practitioners against doctors and other conventional providers, is one of the biggest barriers to state regulation. In a letter ordering the licensure study, Sen. Louise Lucas, D-Portsmouth — the chamber’s president pro tempore — pointed to the “confused information related to the stance of NDs on certain care health care practices.”

“One particularly relevant and concrete example: a [Department of Health Professions] representative mistakenly mentioned in one of our conversations after committee that medically trained NDs have an ‘anti-vaccination standpoint,’” she wrote, “which is inaccurate as in states where vaccines are included in their scope of practice, NDs are administering them as outlined and in keeping with basic healthcare practices.”

And while many of Virginia’s biggest medical groups are united in their opposition to licensure, the same view isn’t held universally. More than a dozen licensed providers, including cardiologists, registered nurses, pharmacists and physical therapists, also testified in favor of licensure for NDs. Dr. Cliff Morris, a cardiologist based in Chester, said he had worked collaboratively with them for more than 10 years and been impressed not only by the

amount of time NDs devoted to each patient, but the preventive health services they were able to provide.

"They treat and see the entire person holistically," he said, adding that "more specifically, I wish that I had received instruction in therapeutic nutritional counseling during my conventional medical training, but it was not in my curriculum.

Like many NDs in Virginia, Morris also said licensing the industry could help address the "social and economic burden" in communities with shortages of primary care providers – a common thread in testimony from patients and other practitioners. More than a dozen counties across Virginia are labeled as "health professional shortage areas" in primary care, with some of the most acute need among low-income communities in rural counties such as Northampton on the Eastern Shore and Tazewell in the far southwestern corner of the state.

Giardenelli pointed to Oregon, where naturopathic doctors are licensed as primary care practitioners and covered by most major insurance plans. While not every ND wants to practice primary medicine, even the AMA acknowledged that some naturopathic programs studied important and multidisciplinary topics such as the effect of diet on managing blood sugar levels – an important aspect of preventive care.

"We focus a lot on prevention and spend a lot of time on individual visits, so I think our skill set is more suited to things like chronic illness," Rodriguez said. "But honestly, with the way the health care system is headed, as we get more and more licensed and as the shortage of primary care doctors continues to grow, I think there is a lot of room for providers like us to come in and serve as these frontline practitioners."

Of course, it will largely depend on whether Virginia ends up adopting licensure for NDs – and how the state defines their scope of practice. Some states, like Rhode Island, license the industry but specifically stipulate that NDs are not recognized as primary care providers and are "not responsible for the overall medical care of any patient," according to the BHP study. Medicare and many state insurance plans still don't cover naturopathic medicine, though that could change if providers became more ubiquitous across Virginia.

Rasoul's original bill, after several committee amendments, would have precluded NDs in Virginia from practicing obstetrics or osteopathy – a field reserved for fully licensed doctors, or DOs, whose treatments sometimes involve musculoskeletal manipulation to treat injuries or illnesses. But it would have opened the door for them to perform physical exams, order labs, and prescribe supplements and other non-prescription drugs.

It's still not clear whether lawmakers will push for the same scope of practice in the 2021 session. After the full Board of Health Professions defeated licensure in August, several NDs suggested they might opt for a more pared-down approach, which could include allowing them to practice under a collaborating agreement with a licensed physician – similar to nurse practitioners in Virginia with less than five years of clinical experience.

"I anticipate given what's happened in other states, it will probably be a gradual licensure," Hollon said. "And I think that's a safe way to prove oneself and prove one's profession." But Rasoul also tied the COVID-19 pandemic — and his own experience with the virus — to the role that NDs could play within Virginia's medical system.

"My body is still recovering," he said. "And I wish there was more of a proliferation of naturopathic doctors who could sit here and talk to me about how I can manage the inflammation, make sure I am rebuilding my immune system, and focusing on that more holistic model."

"At the time, we didn't have much or any real medication to help," he added. "So, COVID has taught us the need for expanding our horizons."

KATE MASTERS

An award-winning reporter, Kate grew up in Northern Virginia before moving to the Midwest, earning her degree in journalism from the University of Missouri. She spent a year covering gun violence and public health for The Trace in Boston before joining The Frederick News-Post in Frederick County, Md. While at the News-Post, she won first place in feature writing and breaking news from the Maryland-Delaware-DC Press Association, and Best in Show for her coverage of the local opioid epidemic. Before joining the Mercury in 2020, she covered state and county politics for the Bethesda Beat in Montgomery County, Md.

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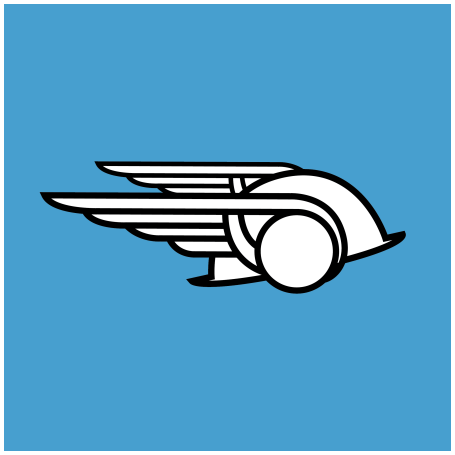

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