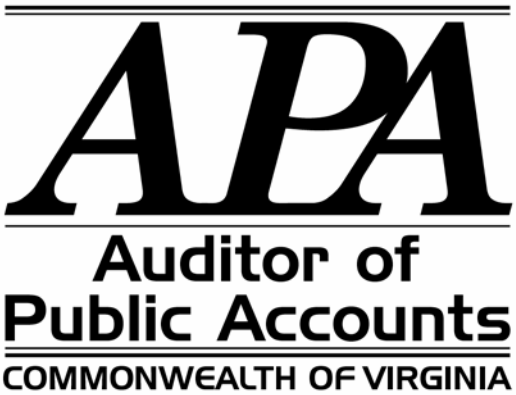
VIRGINIA DEPARTMENT OF HEALTH

RICHMOND, VIRGINIA

REPORT ON AUDIT

FOR THE YEAR ENDED

JUNE 30, 2003



AUDIT SUMMARY

Our audit of the Department of Health for the year ended June 30, 2003, found:

- amounts reported in the Commonwealth Accounting and Reporting System were fairly stated;

- internal control matters that we consider reportable conditions, however, we do not consider these matters to be material weaknesses;

- instances of noncompliance with selected provisions of applicable laws and regulations; and

- adequate implementation of corrective action with respect to the audit findings reported in the prior year.

- T A B L E O F C O N T E N T S -

AGENCY OVERVIEW

The Virginia Department of Health (Health) seeks to achieve and maintain personal and community health by emphasizing health promotion, disease prevention, bioterrorism preparedness, and environmental protection. Health administers the state's system of public health.

The state Board of Health appointed by the Governor provides planning and policy development for Health to implement a coordinated, prevention-oriented program that promotes and protects the health of the citizens. In addition, the Board serves as the advocate and representative of citizens in health issues.

Health operates through a central office and 35 health districts that operate 119 local health departments. During fiscal year 2003, patient visits to local health departments totaled 391,644. These patients received services in various areas such as child health; maternal health; the Women, Infants, and Children (WIC) nutritional program; and immunization clinics.

Local health departments work with Health through agreements between the state and the participating local governments. These agreements define the health services funded by the localities in the health districts. Programs offered include communicable disease control, prevention, and health education. In addition to patient visits, local health departments are responsible for inspecting restaurants and drinking water and issuing permits for sewage systems, wells, and waterworks operations. Additionally, most local health departments provide a variety of nonmandated health care services for persons who cannot otherwise afford them.

FINANCIAL OPERATIONS

Overview

Health received over $437 million in funding during fiscal year 2003 with federal funds representing the largest funding source. In addition to expenses of $404 million, Health passed through $9,507,915 to other agencies. The following tables summarize Health's budgeted revenues and expenses compared to actual results for fiscal year 2003.

Analysis of Budgeted and Actual Funding

	Original Budget	Adjusted Budget	Actual Funding
General Fund appropriations	$146,964,557	$130,785,554	$130,785,554
Special revenues	101,275,994	107,743,377	105,862,103
Special dedicated revenue	5,777,815	23,499,859	23,374,646
Federal grants	167,460,055	183,166,077	177,621,731
Total	$421,478,421	$445,194,867	$437,644,034

Analysis of Budgeted and Actual Expenses by Program

Program	Program Expenses Original Budget	Adjusted Budget	Actual Expenses
Community Health Services	$162,372,571	$159,969,519	$151,089,526
Nutritional Services	80,300,818	80,300,818	70,440,562
Communicable and Chronic Disease Prevention	48,999,157	61,573,757	61,395,881
State Heath Services	32,328,583	33,544,801	33,514,228
Environmental Resources Management	34,616,085	46,547,626	31,268,392
Emergency Medical Services	15,818,943	16,222,286	14,708,850
Support Services	13,981,441	12,446,115	11,261,650
Regulation of Food, Products, Public Facilities, and Services	11,522,726	11,018,722	10,262,559
Special Health Improvement and Demonstration Services	5,914,682	7,322,169	5,687,535
Medical Examiner	5,360,735	5,562,396	5,314,351
Vital Records and Health Statistics	4,578,223	5,034,251	4,443,686
Health Research, Planning, and Coordination	2,840,398	3,036,017	2,932,115
Higher Education Student Financial Assistance	2,844,059	2,616,390	2,463,704
Total	$421,478,421	$445,194,867	$404,783,039

Analysis of Budgeted and Actual Expenses by Program Funding Source

Program	Funding Sources (Expenses) General Fund	Special Revenues	Dedicated Special Revenues	Federal Grants
Community Health Services	$ 78,587,960	$72,254,239	$ -	$ 247,327
Nutritional Services	-	894	-	70,439,668
Communicable and Chronic Disease Prevention	12,060,090	477,338	-	48,858,453
State Heath Services	8,719,899	2,250,156	-	22,544,173
Environmental Resources Management	2,966,572	3,283,949	4,125,808	20,892,064
Emergency Medical Services	2,336,601	7,718,180	4,293,762	360,307
Support Services	9,957,919	1,303,731	-	-
Regulation of Food, Products, Public Facilities, and Services	4,061,801	738,695	384,520	5,077,542
Special Health Improvement and Demonstration Services	2,054,700	2,449,112	732,819	450,903
Medical Examiner	4,864,707	151,178	-	298,467
Vital Records and Health Statistics	895,444	3,548,242	-	-
Health Research, Planning, and Coordination	1,232,629	1,109,958	-	589,528
Higher Education Student Financial Assistance	1,780,822	-	663,041	19,841
Total	$129,519,144	$95,285,672	$10,199,950	$169,778,273

Health adjusted its original general and federal fund budgets primarily due to general fund budget reductions and increased federal funding for Communicable and Chronic Disease prevention programs. Health also adjusted its original special and dedicated special revenue budgets due to additional revenue

collections in community health services, vital records, medical examiner's office, and disease control programs, as well as reappropriations of fiscal year ending 2002 cash balances.

The resulting decrease in actual federal revenue and expenses was due to a decline in the Nutritional Program for Women, Infants, and Children (WIC). The WIC program is Health's largest federal program and represents 41 percent of total federal revenue. Health develops its non-general fund budgets primarily on a three-year historical trend cycle. While activity in this program has historically increased, actual program participants decreased for the first time in several years. Contributing to the decline in program expenses is the USDA's implementation of cost containment strategies such as consolidating participating vendors in an effort to obtain lower food prices. The section later in the report entitled "Nutritional Program for Women, Infants, and Children (WIC)" describes this program.

Increases in the dedicated special revenues budget occurred in the Drinking Water State Revolving Loan Program (DWSRF) related to the use of the cash balance carry over of $12.5 million. Health earmarked these funds for program initiatives including its state matching requirements. DWSRF is a federal program and the U.S. Environmental Protection Agency requires states to deposit matching funds on or before the award of the federal grant. The variance between the Environmental Resources Management Program's adjusted budget and actual expenses, which includes the DWSRF program, arises from the delay in spending the state match. Health uses the state match to reimburse localities for construction projects, which requires applicants to spend their own funds before receiving reimbursement. The application, loan closing process, and the actual construction takes about two years to complete. No disbursements occur until construction begins. The section entitled, "Capitalization Grants for Drinking Water State Revolving Loan Fund" describes this program.

AGENCY HIGHLIGHTS

General Fund Budget Reductions

As with all state agencies, Health has undergone recent budget reductions in its general fund appropriations. Budget cuts for fiscal year 2003 amounted to about $9.4 million. Approximately $3.9 million of the cuts was associated with savings strategies, which included management and renegotiation of contractual services, deferral of nonessential equipment purchases, and turnover/vacancy management savings. Approximately $4.6 million of the reduction was due to the elimination of some of Health's service programs such as the Emergency Medical Services medal of life, telemedicine study, pfisteria, and organ tissue –transplant council funding. The remaining reduction of $.9 million was associated with pass-through appropriation reductions. Health also reverted $1,266,411 at fiscal year end.

For fiscal year 2004, Health anticipates further budget reductions of $7.8 million. Of the $7.8 million, approximately $4.9 million of the reduction is associated with reduced services and programs. $2.9 million is related to pass-through funding to various health care providers. In addition to reducing program funding, Health continues to evaluate the impact of decreased funding through eliminating and maintaining vacant positions throughout the agency.

Nutritional Program for Women, Infants, and Children (WIC)

The Supplemental Nutrition Program for Women, Infants, and Children provides supplemental foods and nutritional education to eligible persons through local health departments. Eligible persons include pregnant, postpartum, and breast-feeding women, infants, and children up to their fifth birthday. The program serves as an adjunct to good health care during critical times of growth and development in order to prevent the occurrence of health problems and improve the health status of those persons. The number of WIC participant visits in fiscal year 2003 was 1,498,199.

Health administers the WIC program through local health departments who determine qualifying criteria for participation in the program. In November 2001, Health began to implement the new information technology application, WIC-Net, at local health departments. As of August 2002, Health had fully implemented WIC-Net at all local health departments. WIC-Net provides for automated record keeping, as well as the issuance of computerized WIC checks that include the participant's food package. During fiscal year 2003, Health automated eligibility determination for the Women, Infants, and Children (WIC) program through the utilization of WIC-Net. Our evaluation of the administration of the WIC program at various local health departments identified the following way Health can enhance its internal controls over the administration of the WIC program.

Improve WIC Policies and Procedures

Medicaid recipients are automatically eligible for WIC benefits, but Health does not require local health districts to validate a participant's Medicaid eligibility using Medicall. Medicall is the Department of Medical Assistance Service's automated real-time recipient Medicaid eligibility verification system. It is Health's policy to review the Medicaid card to validate Medicaid eligibility. The Medicaid card only displays the recipient's name and identification number. Since the card does not indicate a period of eligibility, a recipient could obtain WIC benefits using an expired or invalid card. Therefore, merely reviewing the Medicaid card is not sufficient.

Health should require local health departments to validate participant's Medicaid eligibility using Medicall. This control will help limit benefits to only eligible recipients.

Agency Response: *See pages 9-13.*

Ryan White CARE Act Title II Grant Program

The Ryan White Care Formula Grant enables states to improve the quality, availability, and organization of health care and support services for low income individuals and families with Human Immunodeficiency Virus (HIV) disease. This comprehensive care grant provides drugs under the Virginia AIDS Drug Assistance Program (ADAP) and also provides other services such as essential medical and support services.

Health's Division of HIV/STD provides support to local health districts in the prevention and treatment of HIV, including its complications, through provision of education, information, and health care services. Health also contracts with five regional health consortiums to provide AIDS-related services, other than AIDS drugs. In addition, Health has contracted with an outside entity to maintain its ADAP database, which provides utilization and demographic data used for program reporting requirements.

Comply with Eligibility Requirements

For 5 of the 15 participants tested, the local health district never followed up to determine Medicaid eligibility, but continued to provide ADAP benefits. Health also overrode one person's ineligibility and granted benefits. As a result, we identified questioned costs of $42,232 for these six individuals.

To be eligible, an individual must have a medical diagnosis of HIV disease and be a low income individual, as defined by the state (42 USC 300 ff-26(b)). According to state policy, eligibility is limited to persons who do not have insurance, do not qualify for Medicaid, and meet low income requirements. In addition, the patient is to bring evidence of Medicaid approval or denial to continue in the program because eligibility for Medicaid disallows eligibility for the ADAP program.

Health should comply with program requirements and not grant benefits to ineligible persons. Local health districts should adhere to established procedures and require the patient to provide evidence of Medicaid denial or approval to ensure only eligible persons receive ADAP benefits.

Agency Response: *See pages 9-13.*

Improve Controls over the ADAP Program

Health's division of HIV/STD did not monitor the administration of the AIDS Drug Assistance Program by local health districts. Program objectives and procedures consist of central office performing site reviews for each local health district at least once a year; however, central office did not perform any local health district site visits during the fiscal year. Site visits determine if providers understand program regulations and is important to ensure only eligible participants receive program benefits. The performance of site visits may have identified the lack of verification for Medicaid eligibility.

Health should improve its controls over ADAP by developing and adhering to a quality control program that includes local health district site visits. Health should continue to provide training and communicate the expectations and program requirements to the appropriate district personnel.

Agency Response: *See pages 9-13.*

Capitalization Grants for Drinking Water State Revolving Loan Fund

The federal Safe Drinking Water Act Amendments of 1996 (SDWA) established a Drinking Water State Revolving Loan Fund (DWSRF) program where eligible states receive funds through a capitalization grant. Virginia received its first award of federal funds for the administration of the DWSRF program in fiscal year 1998. The Drinking Water Revolving Loan Fund, administered by Health's Division of Drinking Water, provides qualified communities, local agencies, and private entities with loans and other types of financial assistance needed to achieve or maintain compliance with SDWA requirements.

Health classifies Drinking Water funds into two uses: project funds and non-project funds. Project funds (construction funds) provide financial assistance to waterworks to address public health problems and to ensure compliance with the provisions of the SDWA, while non-project funds provide the technical and managerial training to owners of waterworks. Since the inception of the program, Health has closed loans on 88 projects totaling $105.4 million, 19 of which totaled $19.9 million during this fiscal year. Additionally, Health closed one project totaling $1,226,781 funded from loan repayments. Health anticipates closing an additional 22 loans totaling $13.7 million during fiscal year 2004.

OTHER INTERNAL CONTROL FINDING AND RECOMMENDATION

Request Payment for Unallowed Health Planning Agency Expenses

Health contracts with five Health Planning Agencies (HPAs) and pays them over $1 million annually. HPAs support the health planning system of the Commonwealth and must spend these funds in accordance with state rules and regulations. In addition, HPAs provide Health quarterly financial reports and certifications that they have spent funds in accordance with state regulations.

We performed reviews of two HPAs and identified improper payroll activities at Eastern Virginia Health Planning Agency (EVHPA). EVHPA employees received cash payments representing 20 percent of their salary for fringe benefits, cash payments for retirement benefits, and advance payment of leave balances.

These activities do not comply with state laws and regulations and did not have HPA Board approval. We estimate the improper transactions to be approximately $53,843.

Health should request payment from the HPA for all improper transactions.

***Agency Response**: See pages 9-13.*

Commonwealth of Virginia

Walter J. Kucharski, Auditor

Auditor of Public Accounts
P.O. Box 1295
Richmond, Virginia 23218

February 23, 2004

The Honorable Mark R. Warner
Governor of Virginia
State Capitol
Richmond, Virginia

The Honorable Lacey E. Putney
Vice Chairman, Joint Legislative Audit
and Review Commission
General Assembly Building
Richmond, Virginia

INDEPENDENT AUDITOR'S REPORT

We have audited the financial records and operations of the **Virginia Department of Health** (Health) for the year ended June 30, 2003. We conducted our audit in accordance with Government Auditing Standards, issued by the Comptroller General of the United States.

Audit Objectives, Scope, and Methodology

Our audit's primary objectives were to evaluate the accuracy of recording financial transactions on the Commonwealth Accounting and Reporting System, review the adequacy of Health's internal control, and test compliance with applicable laws and regulations. We also reviewed Health's corrective action of audit findings from the prior year report.

Our audit procedures included inquiries of appropriate personnel, inspection of documents and records, and observations of Health's operations. We also tested transactions and performed such other auditing procedures as we considered necessary to achieve our objectives. We reviewed the overall internal accounting controls, including controls for administering compliance with applicable laws and regulations. Our review encompassed controls over the following significant cycles, classes of transactions, and account balances:

Information Systems	Payroll
Expenses	Accounts Receivable
Grant Management	Revenues

We obtained an understanding of the relevant internal control components sufficient to plan the audit. We considered materiality and control risk in determining the nature and extent of our audit procedures. We performed audit tests to determine whether Health's controls were adequate, had been placed in operation, and were being followed. Our audit also included tests of compliance with provisions of applicable laws and regulations.

Health's management has responsibility for establishing and maintaining internal controls and complying with applicable laws and regulations. Internal control is a process designed to provide reasonable, but not absolute, assurance regarding the reliability of financial reporting, effectiveness and efficiency of operations, and compliance with applicable laws and regulations.

Our audit was more limited than would be necessary to provide assurance on internal control or to provide an opinion on overall compliance with laws and regulations. Because of inherent limitations in internal control, errors, irregularities, or noncompliance may nevertheless occur and not be detected. Also, projecting the evaluation of internal control to future periods is subject to the risk that the controls may become inadequate because of changes in conditions or that the effectiveness of the design and operation of controls may deteriorate.

Audit Conclusions

We found that Health properly stated, in all material respects, the amounts recorded and reported in the Commonwealth Accounting and Reporting System. Health records its financial transactions on the cash basis of accounting, which is a comprehensive basis of accounting other than generally accepted accounting principles. The financial information presented in this report came directly from the Commonwealth Accounting and Reporting System.

We noted certain matters involving internal controls and its operation that we considered to be reportable conditions. Reportable conditions involve matters coming to our attention relating to significant deficiencies in the design or operation of internal control that, in our judgment, could adversely affect Health's ability to record, process, summarize, and report financial data consistent with the assertions of management in the financial records. Reportable conditions are discussed in the sections entitled "Nutritional Program for Women, Infants, and Children (WIC)," "Human Immunodeficiency Virus (HIV) Care Formula Grant Program," and "Other Internal Control Finding and Recommendation." We believe that none of the reportable conditions are material weaknesses.

The results of our tests of compliance with applicable laws and regulations disclosed instances of noncompliance that are required to be reported under Government Auditing Standards, which is discussed in sections entitled "Human Immunodeficiency Virus (HIV) Care Formula Grant Program" and "Other Internal Control Finding and Recommendation."

Health has taken corrective action with respect to audit findings reported in the prior year.

This report is intended for the information and use of the Governor and General Assembly, management, and the citizens of the Commonwealth of Virginia and is a public record.

EXIT CONFERENCE

We discussed this report with management on March 9, 2004.

AUDITOR OF PUBLIC ACCOUNTS

MAM/kva
kva:

COMMONWEALTH of VIRGINIA

Department of Health

ROBERT B. STROUBE, M.D., M.P.H.
STATE HEALTH COMMISSIONER

P O BOX 2448
RICHMOND, VA 23218

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

March 9, 2004

The Auditor of Public Accounts
P. O. Box 1295
Richmond, Virginia 23218

Dear Sir:

We are providing this letter in response to your report on audit of the financial records of the Virginia Department of Health for the fiscal year ended June 30, 2003.

We confirm that we have reviewed the findings, conclusions and recommendations and have prepared a response and corrective action plan which is attached.

We would like to take this opportunity to thank the Audit Director, Mona Morris for the professionalism exhibited by her and the audit staff assigned to our audit this past year.

Sincerely,

Robert B. Stroube, M.D., M.P.H.
State Health Commissioner

Helen Tarantino , Deputy
Commissioner for Administration

CC: Department of Accounts

Virginia Department of Health
Management response and corrective action plan for findings, conclusions and recommendations in the APA report for the year ended June 30, 2003.

Improve WIC Policies and Procedures

Medicaid recipients are automatically eligible for WIC benefits but Health does not require local health districts to validate a participant's Medicaid eligibility using Medicall. Medicall is the Department of Medical Assistance Service's automated real-time recipient Medicaid eligibility verification system. It is Health's policy to review the Medicaid card to validate Medicaid eligibility. The Medicaid card only displays the recipient's name and identification number. Since the card does not indicate a period of eligibility, a recipient could obtain WIC benefits using an expired or invalid card. Therefore, merely reviewing the Medicaid card is not sufficient.

The Department should require local health departments to validate participant's Medicaid eligibility using Medicall. This control will help limit benefits to only eligible recipients.

Agency Response:
The Division of WIC & Community Nutrition Services is unable to utilize the Department of Medical Assistance Service's Medicall system to validate Medicaid eligibility as the disruption to clinic flow and interference with in-coming phone calls would be too great. The Division recognizes the need to ensure that Medicaid eligibility is current, and has already begun to take the necessary steps to put a system in place. The Division is implementing a computerized system of checking Medicaid eligibility through our WICNet system, and will have this system in place by June 2004. Responsible person: Donna Seward – Director of WIC and Community Nutrition Services.

HIV Care Formula Grant Program/ADAP

Comply with Eligibility Requirements

For 5 of the 15 participants tested, the local health district never followed up to determine Medicaid eligibility but continued to provide ADAP benefits. Health also overrode one person's ineligibility and granted benefits anyway. As a result, we identified questioned costs of $42,232 for these 6 individuals.

To be eligible, an individual must have a medical diagnosis of HIV disease and be a low income individual, as defined by the State (42 USC 300 ff-26(b)). According to State Policy, eligibility is limited to persons who do not have insurance, do not qualify for Medicaid, and meet low income requirements. In addition, the patient is to bring back evidence of Medicaid approval or denial to continue on the program because eligibility for Medicaid disallows eligibility for ADAP program.

Health should comply with program requirements and not grant benefits to ineligible persons. Local health districts should adhere to established procedures and require the patient to provide evidence of Medicaid denial or approval to ensure only eligible persons receive ADAP benefits.

Agency Response:
This recommendation, while fully supported, can be difficult to ensure with 35 health districts handling ADAP eligibility. Program criteria are updated as needed and distributed to the health districts throughout the year. In addition, the Division of HIV/STD will send a written reminder to all health directors reminding them of the importance of following ADAP program policy and procedures. The necessity of following up on Medicaid applications will be emphasized.

For ADAP clients, Web-VISION offers some limited benefit for verifying Medicaid eligibility. Since ADAP is not available for Medicaid clients, very few clients are already approved for Medicaid at the time of application at the local health department. The system does not indicate whether someone has applied or whether that person has been denied, only that the person is currently approved to receive Medicaid services. We are advising local health departments to develop a tickler system to verify Medicaid eligibility within sixty days to see if clients have been approved.

Faye Bates, ADAP Coordinator, is also pursuing access to the Medicaid database electronically. For back billing purposes, this would decrease the time it takes to verify Medicaid eligibility.

The decision to allow ADAP benefits for a person who does not meet the criteria has been made in rare instances. A policy has been drafted and forwarded for senior management review and approval that would delegate the authority for granting exceptions to Casey Riley, Director of the Division of HIV/STD. In those instances, only state ADAP funding would be used for medications for those patients. No Ryan White funding will be used to support ADAP benefits for ineligible persons.
Responsible person for ADAP control implementations – Casey Riley, HIV-STD Division Director.

Improve Controls over the ADAP Program

Health's division of HIV/STD did not monitor the administration of the AIDS Drug Assistance Program by local health districts. Program objectives and procedures consist of central office performing site reviews for each local health district at least once a year; however, central office did not perform any local health district site visits during the fiscal year. Site visits determine if providers understand program regulations and is important to ensure only eligible participants receive program benefits. The performance of site visits may have identified the lack of verification for Medicaid eligibility.

Health should improve its controls over ADAP by developing and adhering to a quality control program that includes local health district site visits. Health should continue to provide training and communicate the expectations and program requirements to the appropriate district personnel.

Agency Response:
Site visits (explained in more detail below) are being conducted in all health districts to ensure understanding and compliance with ADAP program policy and procedures. As a component of these visits, the ADAP Coordinator reviews patient's records for appropriate documentation of evidence that ADAP patients were ineligible for Medicaid.

Although no site visits were conducted within the 2003 state fiscal year, the Department of Health operates on the grant year when implementing federal programs. During that grant fiscal year, there were three site visits that were documented in written summaries. In addition, during the 2003 state fiscal year, another site visit was conducted to the Roanoke Health District, although the formal summary was not prepared.

Staff shortages prevented the health department from conducting additional site visits. The current ADAP Coordinator has made site visits a priority. Since she was hired in August 2003, she has completed eight district reviews. In addition, one of the health departments cited for in Medicaid eligibility follow up received a second technical assistance visit from the ADAP Coordinator.

The ADAP Coordinator participates in monthly national technical assistance conference calls sponsored by the federal funding agency, the Health Resources and Services Administration. These calls offer suggestions for improving quality assurance program controls. The ADAP Coordinator is also planning to conduct training for staff that conducts eligibility screening at local health departments. This training will include program policy and procedures as well as suggestions for effectively monitoring Medicaid status.
Responsible person for ADAP control implementations – Casey Riley, HIV-STD Division Director.

Request Payment for Unallowed Health Planning Agency expenses

Health contracts with five Health Planning Agencies (HPAs) and pays them over $1 million annually. HPAs support the health planning system of the Commonwealth and must spend these funds in accordance with state rules and regulations. In addition, HPAs provide Health quarterly financial reports and certifications that they have spent funds in accordance with state regulations.

We performed reviews of two HPAs and identified improper payroll activities at Eastern Virginia Health Planning Agency (EVHSA). EVHPA employees received cash payments of 20% of their salary for fringe benefits, cash payments for retirement benefits and advance payment of leave balances. These activities do not comply with state laws and regulations and did not have the HPA Board approval. We estimate the improper transactions to be approximately $53,843.

Health should request payment from the HPA for all improper transactions.

Agency Response:
A letter was sent from the Center Director, Nancy Hofheimer, to the EVHSA Board President on February 5, 2004 which addresses the audit concerns and requests repayment of the disallowed expenditures. A response from the EVHSA Board President has been received by the Center Director and is being reviewed with agency management.
Responsible Person – Nancy Hofheimer, Center Director

VIRGINIA DEPARTMENT OF HEALTH
Richmond, Virginia

Robert B. Stroube, MD, MPH
Health Commissioner

BOARD OF HEALTH
As of June 30, 2003

Charles W. Hickey, DVM, Chairman

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Julia Beales, MD
Jack Lanier, Ph.D.
Shirley Kelly

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