

1 **VIRGINIA TOBACCO INDEMNIFICATION**
2 **AND COMMUNITY REVITALIZATION COMMISSION**

3 701 East Franklin Street, Suite 501
4 Richmond, Virginia 23219

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9 **Special Projects Committee Meeting**

10 Tuesday, June 19, 2012

11 10:30 a.m.

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13 The Hotel Roanoke & Conference Center
14 Roanoke, Virginia

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1 **APPEARANCES:**

2 The Honorable Daniel W. Marshall, III, Chairman

3 Ms. Connie Greene Nyholm, Vice-Chairman

4 The Honorable Kathy J. Byron

5 Mr. John R. Cannon

6 The Honorable Mary Rae Carter

7 Deputy Secretary of Commerce & Trade

8 Ms. Sandra F. Moss

9 The Honorable Israel O'Quinn

10 Dr. David Redwine, DVM

11 The Honorable Ralph Smith

12 Mr. Gary D. Walker

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14 COMMISSION STAFF:

15 Mr. Neal Noyes, Executive Director

16 Mr. Ned Stephenson, Deputy Executive Director

17 Mr. Timothy J. Pfohl, Grants Program Director

18 Ms. Sara G. Williams - Grants Coordinator, Southwest Virginia

19 Ms. Sarah K. Capps - Grants Coordinator, Southside Virginia

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1 DELEGATE MARSHALL: Good morning
2 ladies and gentleman, welcome, I'll call this meeting of the
3 Special Projects Committee to order. Neal, would you please
4 call the roll?

5 MR. NOYES: Mr. Barnard?

6 MR. BARNARD: (No response.)

7 MR. NOYES: Delegate Byron?

8 DELEGATE BYRON: Here.

9 MR. NOYES: Mr. Cannon?

10 MR. CANNON: Here.

11 MR. NOYES: Senator Carrico?

12 SENATOR CARRICO: (No response.)

13 MR. NOYES: Deputy Secretary Carter?

14 MS. CARTER: Here.

15 MR. NOYES: Delegate Marshall?

16 DELEGATE MARSHALL: Here.

17 MR. NOYES: Mr. Moss?

18 MS. MOSS: Here.

19 MR. NOYES: Ms. Nyholm?

20 MS. NYHOLM: Here.

21 MR. NOYES: Mr. O'Quinn is on his way.

22 Dr. Redwine?

23 DR. REDWINE: Here.

24 MR. NOYES: Senator Smith?

25 SENATOR SMITH: Here.

1 MR. NOYES: Mr. Spiers?

2 MR. SPIERS: (No response.)

3 MR. NOYES: Mr. Walker?

4 MR. WALKER: Here.

5 MR. NOYES: You have a quorum, Mr.

6 Chairman.

7 DELEGATE MARSHALL: Thank you.

8 The minutes are on the website, do I have a motion for their
9 approval. I've got a motion and a second, all those in favor
10 say aye (Ayes) all right, thank you. The minutes are approved.

11 All right, let's get down to the fun stuff. Neal, I'm going to ask
12 you to kind of give us a kind of a thirty thousand feet why
13 we're here today.

14 MR. NOYES: Thank you, Mr. Chairman.
15 When we met in Danville, I went down the list and the further
16 I went down the list Gary's eyes got bigger and everyone's eyes
17 got bigger and what in the world is this fellow talking about. It
18 was not a recommendation to do all these things. It was
19 simply alerting you as a Committee to those things which we
20 could expect to hear about in applications. Today the
21 objective is for this Committee to establish some priorities for
22 what it is that you wish to hear about in applications in terms
23 of access to healthcare. Those things are published on our
24 website, a guide to the staff as we evaluate applications that
25 come in if you don't decide a particular subject is a priority it

1 won't get a lot of credit by staff. There are some of them that
2 very clearly we are expected to do in terms of access to
3 healthcare. One of those is cancer research and that's the
4 central thing.

5 I think what we need to say today is going to be an
6 eligible activity for applications for fiscal year '13. I don't
7 think that's avoidable and it doesn't mean you have to fund
8 everything that comes in in an application that involves cancer
9 research and we'll go through those when they come in. That
10 is a priority.

11 I can go down the list and try to answer your
12 questions about each of the bullet points. We also need to
13 establish a date for submission of the application. We list
14 projects for cancer research, for example, and I'm not
15 recommending that but that's the decision this Committee
16 comes up with and I don't think there is any reason why we
17 can't continue on the path of having a final decision at the
18 September board meeting. There's not going to be forty or fifty
19 applications for cancer research.

20 Mr. Chairman, is it the will of the Committee that I
21 go through this list?

22 DELEGATE MARSHALL: Let me just
23 clarify something. You all received a copy from the staff of this
24 information from staff, that's a spreadsheet of some of the
25 applications that we have. We've already gotten something

1 like 25 million. Our budget this year is \$4 million. So that's
2 pretty thin. The purpose of what we want to do today, first of
3 all Mary Rae made a good point. We need to go through and
4 decide what this Committee wants to do as far as healthcare.
5 But then what are our priorities for healthcare in fiscal '13?
6 Anytime you have a question, please raise your hand and
7 speak out, jump in and we can get everybody's opinion on
8 this.

9 So, Neal, the answer is yes.

10 MR. NOYES: I mentioned cancer
11 research and July 1st the state law that applications come to
12 us that may be used outside of the footprint, the Governor has
13 signed that legislation.

14 So, the first bullet point deals with cancer research.
15 The second one deals with access to prescription medicines, a
16 proven program that affects a large number of individuals
17 saving them money on prescription medicines. If that's not
18 something you want to entertain this fiscal year '13 now is the
19 time to send that message.

20 MS. CARTER: I have two questions. The
21 first one is cancer research. Was there a dollar figure?

22 MR. NOYES: No, ma'am, no dollar figure.

23 MS. CARTER: Is there any particular
24 criteria for the cancer research?

25 MR. NOYES: Yes, applications are

1 eligible from Virginia Commonwealth to designated cancer
2 centers, Massey and VCU, Cancer Center at UVA. There can
3 be other applications that have to do with cancer research
4 from other entities but those are specifically mentioned in the
5 legislation that was passed.

6 MS. CARTER: Money will be specifically
7 for cancer research, is that the clinical trials?

8 MR. NOYES: It could be, yes.

9 MS. CARTER: So we've got a total of four
10 million dollars?

11 MR. NOYES: Yes, competitive.

12 MS. CARTER: The four million, does this
13 requirement fall under the four million or is that separate from
14 the matter, does it come out of the four million?

15 DELEGATE MARSHALL: Do you
16 remember we reauthorized money for Massey, we did it at our
17 last meeting.

18 MR. CANNON: How much money was
19 that?

20 MR. NOYES: \$2.3 million, what I seem to
21 remember and it was provided a time extension and a
22 repurpose.

23 MS. CARTER: That was for which
24 number?

25 MR. NOYES: There are a number of

1 elements in that application, which includes an education
2 program.

3 MS. CARTER: I remember now, I'm
4 sorry, I remember what you're talking about.

5 SENATOR SMITH: Clarification, was the
6 legislation you spoke about, does that direct us to spend a
7 certain amount of money?

8 MR. NOYES: No, sir.

9 SENATOR SMITH: Or was it the fact that
10 it could be included there wasn't any legislation –

11 MR. NOYES: - the issue that was
12 addressed in that legislation was whether Commission funds
13 might be spent outside the footprint. We've had a relationship
14 with UVA and a relationship with Massey going back several
15 years. Prior to the legislation it's been our policy, the
16 Commission's policy that our funds, an amount equivalent to
17 our funds be spent inside the Tobacco Commission footprint
18 and the new legislation removes that policy for that piece.

19 SENATOR SMITH: The legislation didn't
20 say specifically anything about cancer research?

21 MR. NOYES: It was very specific that
22 Massey and UVA could apply for funds for cancer research to
23 be used outside the footprint.

24 DELEGATE MARSHALL: Delegate Kirk
25 Cox, it was his bill, no dollar amount.

1 MR. NOYES: The specific change is that
2 our funds could be used in Richmond or Charlottesville,
3 previously we had been unwilling to do.

4 DELEGATE MARSHALL: We saw what
5 they were doing in Danville and we got a report of what they're
6 doing in other parts of the footprint, also in your area also.

7 MR. NOYES: They're doing many things
8 in many places throughout southern Virginia, moving over a
9 little bit over in Southwest, Southeast and my understanding
10 based on telephone conversations that the University, Massey
11 and UVA Cancer Centers are coordinating the work that
12 they're doing, a built in efficiency will come in, if not with joint
13 applications, with applications that complement each other.
14 That is their stated intention but we haven't seen anything
15 yet.

16 MR. CANNON: Mr. Chairman, I just have
17 a question as to how in the world the Tobacco Commission
18 could start down this path of funding these medical things in
19 all these different areas at the same time, how much money
20 would be used. I would suggest we kind of stick to one area,
21 whether it's telemedicine and work on the assets that are
22 already available that are in place and serve places like
23 Southside and Southwest that don't have large populations to
24 try to provide some kind of or help to provide some kind of
25 quality healthcare so that these people, they don't have

1 facilities for medical care close to their house. There was a
2 presentation put on by the Alliance Group I think it was and
3 that was pretty effective. I just think we're going down this
4 road, we're going to be spread out too much and we're limiting
5 ourselves. I know that the cancer aspect but certainly
6 telemedicine that can serve a lot of people.

7 MR. NOYES: It's just one bullet point on
8 the list.

9 MR. CANNON: Yes, I saw that. How can
10 we serve all these things? How can we do it?

11 MR. NOYES: I don't think we can.

12 MR. WALKER: Just to refresh my
13 memory, the total budget for the Committee is \$4 million?

14 DELEGATE MARSHALL: Yes.

15 MR. WALKER: Not just cancer research,
16 if we don't do any other projects working with \$4 million.

17 DELEGATE MARSHALL: Yes, that's the
18 budget.

19 MR. WALKER: That leaves us –

20 MR. NOYES: For the record, Mr.
21 Chairman, the Committee's budget that was approved was for
22 12.5, 8.5 of that was the second phase of the Liberty
23 University Medical School Program. It was agreed to last year
24 because we couldn't fund it all.

25 DELEGATE MARSHALL: As we go down

1 this list like the second bullet point, we can address these and
2 get an up or down as we go or do you want to hear more? So
3 expanded access to prescription medicines, any discussion on
4 that?

5 MS. CARTER: I don't know if we have the
6 budget for this. And second of all the programs that are state
7 programs and I know it's one of the bullet points but probably
8 cancer and telemedicine, I don't think we can do this.

9 DELEGATE MARSHALL: Any objection to
10 taking this one off the list, expanded access to prescription
11 medicines, all right. We'll talk it off the list.

12 MR. NOYES: Expanded access to
13 medical professionals where our funds are used as some
14 portion of multi-year services contract that may include
15 relocation expenses. This may involve replacement of medical
16 professionals that may no longer serve in the footprint or it
17 may involve support for new or augmented specialty services
18 where demand is clearly demonstrated. Staff recommends
19 that such support be limited to not more than three calendar
20 years.

21 DELEGATE BYRON: A lot of what I'm
22 reading here reminds me of the federal act that's in question
23 right now. Some of these seem a little premature in light of
24 waiting for a ruling from the Supreme Court on the healthcare
25 act. Access to medical professionals seems like a big stretch

1 when you're thinking that a lot of the coverage by other
2 programs, so I'm not sure without all the details what's not
3 covered or that's questionable.

4 DELEGATE MARSHALL: What we're
5 looking for today is direction for the staff for the applications
6 for fiscal year 2013. Next year, after the Supreme Court
7 makes its decision, we could always readdress if we need to.
8 Addressing doctors and other healthcare professionals and
9 members of the Commission raised this in discussion, that's
10 why you see it.

11 MS. CARTER: Weighing in on what
12 Delegate Byron said, I was telling Delegate Marshall about
13 Liberty University is coming out with a journal and that came
14 out and the thing that caught my eye was that the dean of the
15 new medical school said that 67% of the health professional
16 shortage area is out of the southside region or underserved
17 and these are areas that need health specialists. I think the
18 figure was less than one position for every 3500 patients. In
19 Virginia, forty percent of its medical school graduates remain
20 in the state. Here we have Virginia Tech producing
21 physicians, we've got Liberty ready to come on board and
22 you're talking about King College. If we're investing already in
23 these programs and we cannot get quality physicians in our
24 rural areas, all the telemedicine in the world, considering that
25 so I think if we can challenge these doctors wherever they

1 come from to come to rural areas and stay there for a period of
2 time, maybe it involves helping them with loans or something
3 if they don't stay for a certain period of time, they have to pay
4 it back. I was telling the Chairman, I've lived in my current
5 location since 2005, if any of you have been to Pinhook,
6 Virginia, you know it's very rural. My position has always
7 been carillion, since I've lived there I've had five interns, now
8 there's three new ones. It's very difficult to have quality care
9 when that happens. I don't know why that is, but whether it's
10 money, I don't know. If there's some way that we can
11 convince people that will be trained in areas near the
12 footprint, we could try to convince them, I just hope we'll look
13 at things like that for this profession.

14 DELEGATE BYRON: Mary Rae brings up
15 some great points. The thing about these positions, but we
16 haven't really identified specific needs, we don't know what
17 those incentives may be yet but I'm not aware of what some of
18 the incentives are to keep people, barriers that are keeping
19 people from coming and staying. Maybe those are some of the
20 things we need to address. The things that we can do going
21 forward in 2013 to find out those answers.

22 MS. CARTER: I think that makes sense.

23 DELEGATE MARSHALL: Do you want to
24 take this off the list?

25 DELEGATE BYRON: I think it's

1 premature. I think we need to research that further, identify
2 that need and look at some of the things that we would be
3 able to invest in.

4 MS. CARTER: I would think that we
5 might be interested in contacting some of these medical
6 schools to find out where their doctors go after school and how
7 long they stay.

8 DELEGATE BYRON: I know of one
9 example, she's going to be a pediatrician and we might follow
10 up on things like that, that's a good idea.

11 MR. NOYES: The Virginia Healthcare
12 Foundation, an element of their programs where they've used
13 foundation resources for the most part, this is one of the
14 activities they have supported in rural areas. At the end of the
15 day it comes down to money because people have substantial
16 debt. The typical way of recruiting somebody is to do things
17 over time but I'm not saying we need to do it this year, at the
18 end of the day I think you'll find that money is always
19 involved.

20 DELEGATE BYRON: I went to an
21 anniversary in the Franklin County area at the clinic. A large
22 part of that is funded by the state and they continue to do
23 their work and they rely on state money. It's not a one-time
24 investment but it's a continuing investment, sustain what
25 you're investing in.

1 DELEGATE MARSHALL: What I'm
2 hearing is that you think it's a good idea but do we want to
3 take it off the table in 2013 and try to get more information for
4 2014? All right.

5 MR. NOYES: Acquisition of medical and
6 essential communications equipment necessary to support
7 expanded services, to include both hospitals and satellite
8 clinics. When we get into the issue of supplies or
9 consumables, if we go with this we're also likely to and we'll
10 probably hear from applicants who want a newer piece of
11 equipment that accomplishes the same thing, you're not really
12 getting any net new acquisition, you're getting improved
13 technology. Is that something the Committee feels is
14 important?

15 DELEGATE MARSHALL: The wildcard
16 for us and just because a clinic or a hospital, it doesn't
17 necessarily mean they can go out and buy it. And they have
18 to go through certain like a certificate of public need, it's a
19 whole other story. A lot of that's based on competition. I
20 think that's a wildcard in all of this. They might come to us
21 for funding but they might need a certificate of public need
22 before they can get that equipment. That's known as a COPN.

23 MR. NOYES: It can be the policy of the
24 Committee to pass by applications where there is not at point
25 of application a certificate of public need. That would

1 eliminate that problem. If that's something you want to do in
2 the first place, that would be a way to approach it.

3 SENATOR SMITH: What we're dealing
4 with here is not just a certificate of public need project but
5 this can be quite a challenge. I know there might be a good
6 one but I think maybe we're too thin and maybe one or two.

7 DELEGATE BYRON: I was going to say
8 the cost factor and just to bring somebody up to standards.
9 Not only the ins and outs of all that certificate of public need
10 requirements but there's been many debates between the
11 private sector and the hospital concerning say an imaging
12 center. I don't think we need to be getting into the middle of
13 that.

14 DELEGATE MARSHALL: Do you want to
15 take that one off the table?

16 MR. NOYES: Mr. Cannon was referring
17 to the telemedicine initiative, personnel and transport costs,
18 telemedicine initiatives to include fixed assets, personnel and
19 transport costs. And staff recommends that such support be
20 limited to not more than three calendar years per fiscal year,
21 which is 36 months.

22 DELEGATE BYRON: Do we have an
23 update on, or what have we done with that?

24 MR. PFOHL: Several years ago, UVA
25 offered a telehealth and they came to the Commission seeking

1 matching funds for a federal grant. The federal grant was held
2 up to a variety of changes in the regulations. That project,
3 even though we committed 750,000, UVA never accessed
4 those funds. They reapplied about a year ago in Southwest
5 and Southwest Economic Development for eight or nine
6 hundred thousand dollars to advance telemedicine capabilities
7 in the footprint. That proposal was not acted upon in
8 Southwest. And it was tabled. So, all in all, we have not
9 actually funded telemedicine or used that money.

10 DELEGATE BYRON: Was the transfer
11 because they didn't feel it fit the Committee or other reasons?

12 MR. PFOHL: It was tabled in Southwest
13 along with several other projects because we were beginning to
14 impart on our strategic plan update. The strategic plan that
15 you recently adopted now targets your Committee as the
16 healthcare Committee. That's why the UVA telehealth
17 proposal was sent to you, it's on your table right now.

18 DELEGATE BYRON: Was that a pilot
19 program that needed money for that?

20 MR. PFOHL: It was among other things
21 replacing aging equipment and bringing it up to standards or
22 state of the art and trying to utilize the broadband capabilities
23 at UVA. It would replace aging and inefficient equipment at a
24 number of hospitals and clinics across the Tobacco Region.

25 DELEGATE BYRON: So they can go into

1 that type of atmosphere –

2 MR. PFOHL: - yes, Halifax, allowing
3 patients and doctors in localities to confer with UVA
4 specialists.

5 DELEGATE BYRON: Mr. Chairman, I
6 think that you might be, it might be worth discussing a pilot
7 program, trying to outfit several hospitals in telemed we hear a
8 lot about and maybe when you consider rural areas that really
9 have a need and it might be beneficial for us to consider and
10 to start a pilot of some sort.

11 DELEGATE MARSHALL: Mr. Cannon,
12 you mentioned someone coming to –

13 MR. CANNON: She was out of state,
14 maybe Southwest. Doctors were needed in that area, certain
15 hospitals, we're speaking about a need area, of course, patient
16 needs come first. People would have to get their medical, I
17 just thought that with the certain amount of money that we're
18 talking about it might be an excellent pilot program. You've
19 got to always figure the need.

20 MS. NYHOLM: When you're working with
21 these rural hospitals, especially in Southwest, and when you
22 consider leveraging and what assets are already there if we
23 could just get these to a broader area to serve more people.

24 MR. PFOHL: Mr. Chairman, for a point of
25 information, we have received a pre-application from

1 Mountain State Health Alliance for \$6.5 million and
2 consolidate the ICU and patient at the Southwest Hospital.
3 We have some specific information on this.

4 MR. NOYES: Let's talk about this
5 particular project. Thirty-seven beds, consolidated, so is there
6 going to be 48 beds or 50 beds, the answer is no. This is
7 simply upgrading a single central location for the equipment
8 to do the same thing that's being done every day. Now you're
9 talking about access to healthcare, could telemedicine expand
10 this particular project?

11 MS. CARTER: This is not a pilot, it's
12 already there, it's upgrading.

13 DELEGATE MARSHALL: I think today we
14 need to stay at 30,000 feet. We need to talk about the concept
15 of telemedicine in this case. We might have a good project or
16 bad project if we decide to do telemedicine then I think that's
17 what we should do. We can always in this Committee once
18 the application comes to us, too much money not enough
19 results if we want to say that.

20 DELEGATE BYRON: When we were
21 talking about telemedicine, what was described to me in that
22 application you're referring to, I was envisioning a UVA or a
23 hospital like Massey or something where the doctors at that
24 hospital assist a particular patient in one of our regions, how
25 does that fit Neal?

1 MR. NOYES: That's telemedicine. That's
2 not what this particular application was interested in. My
3 understanding is the same as you described. Actually the
4 patient can be evaluated 24 hours a day because a doctor in
5 India or Japan could be doing the diagnostics technology.
6 What I put down here is, pilot or telemedicine initiatives would
7 be activities that this Committee could be prepared to do. Is
8 that correct?

9 DELEGATE BYRON: And the application
10 would hold the details and we could vote it up or down.

11 MR. NOYES: Vote it up and down in
12 terms of your recommendation.

13 DELEGATE MARSHALL: We have to
14 remember, we're only talking about four million.

15 DELEGATE BYRON: Can we go back to
16 that one, the idea of a pilot, was that for the pilot or was that
17 just telemedicine and broadband only?

18 MR. NOYES: What I said was pilot, that's
19 what I heard from this Committee, is that what you want to
20 do?

21 DELEGATE BYRON: Maybe I didn't hear
22 you.

23 DELEGATE MARSHALL: We're talking
24 about 2013, if we get an application if we decide that's the way
25 to go thereon we'll address that.

1 MR. WALKER: We've had cancer
2 research and now we're talking about telemedicine issues. I
3 think we need to stop right there and wait and look at the
4 applications that come in and look and see what the
5 applications look like then and then in another year if we want
6 to expand it into some other program, we can get into it. But
7 when you're talking about only \$4 million and you might have
8 applications that are overwhelming the staff and then there's
9 not enough money anyway.

10 DELEGATE MARSHALL: I think that's a
11 very good point. I would like to go through the rest of these
12 because there might be some we like and it might be a good
13 idea whether we do it now or later. If we can't do it this year,
14 we can always do it next year, 2014. Just like prescription
15 medicine. We did take it off the table without an objection.
16 Let's go on.

17 MR. NOYES: Continuous charges, to
18 include lease payments, utilities, facility insurance, et cetera.
19 Staff recommends that such support be limited to not more
20 than three calendar years. This would apply only to new
21 venues and would not replace any existing arrangements. The
22 idea here is that it's less expensive to lease the space than for
23 new construction space for example like a clinic.

24 MS. CARTER: I don't think this is
25 something we ought to look at all. If the doctor wants to go

1 into practice and he can practice in a hospital or something
2 else, they can do what they need to do. I don't think we
3 should do this.

4 DELEGATE MARSHALL: Without
5 objection, we'll take it off the table.

6 MR. NOYES: Capital projects and
7 equipment requests for more than a half million dollars,
8 250,000 in TICRC financing shall be required to provide
9 equivalent cash match that must be in place prior to the
10 disbursement of any TICRC funds. That gets to the issue of
11 leveraging what this Committee wishes to do in terms of a
12 matching requirement. You can see from the list that Tim and
13 Sara and Sarah compiled. There's a number of projects that
14 have very substantial requirements, applicable requests. As
15 far as exceeding what's going to be available this fiscal year
16 2013, but probably in fiscal 2014 as well.

17 MS. NYHOLM: Mr. Chairman, I'd like to
18 propose that we look for a dollar for dollar match in healthcare
19 projects.

20 DELEGATE MARSHALL: In reference to
21 this particular capital project or overall?

22 MS. NYHOLM: Certainly overall for
23 project and equipment. I'd like to say that would be part of a
24 broader request. I wouldn't be adverse to keeping this, as
25 long as it has dollar for dollar matching, is what I'm saying.

1 DELEGATE MARSHALL: Without
2 objection, a dollar for dollar match?

3 MR. STEPHENSON: Just a fine point.
4 Do you anticipate the match being in place before the
5 applicant approaches the Commission or that they would be
6 given time after the Commission approves it to find the
7 match?

8 MS. NYHOLM: That they have the match
9 in hand before the Commission approves it, that it's in hand
10 before we approve it and evaluate it.

11 DELEGATE MARSHALL: A half million or
12 250 for capital projects. That's pretty broad. We've got some
13 national healthcare companies in our footprint. Anywhere
14 from doctors to hospitals, that covers a large footprint and this
15 is pretty broad. How is the staff going to determine to bring
16 an application and then for the Committee to determine who
17 gets funded?

18 MR. WALKER: That goes back to what
19 Neal was saying whether expanding or replacing existing,
20 when you talk about existing needs, are you talking about
21 expanding?

22 MS. CARTER: I don't believe that fits into
23 access to healthcare. People have needs as far as professional
24 or telemedicine, communications. I think we have to be
25 careful about that part of this especially with limited funding.

1 MR. NOYES: We don't have to do capital
2 projects at all. If you are constructing a cancer clinic where
3 there is no community clinic, then that's expanding access to
4 healthcare. If you look at an application when it comes in and
5 if it's serving the same population base and the same service,
6 there's no expanded access because that service isn't
7 available. Somebody could make a case that it's expanding it.
8 When the application comes in, the larger question is to
9 consider capital projects.

10 MS. CARTER: I understand what you're
11 saying but I believe that if you're going to and if that's the case
12 nine out of ten or are you talking about funding it themselves
13 so if you take that off the table –

14 MR. CANNON: Any project you could call
15 capital in the southside especially.

16 MS. CARTER: I don't know that there's
17 enough money.

18 MS. NYHOLM: Mr. Chairman, I'm not
19 adverse to taking it off the table and just taking it off the table.

20 MR. PFOHL: Would the Committee still
21 be allowing, just on the equipment, I mean within cancer
22 research and telemedicine and any other bullet that you
23 endorse?

24 DELEGATE MARSHALL: The way I read
25 this, you wrote this, but bullet point number seven capital

1 projects and equipment and I would assume that that bullet
2 point refers to an application that's specific to doing capital
3 projects. If we're doing cancer research, that's pretty broad,
4 that's going to be people, equipment.

5 MR. NOYES: Mr. Cannon's point that
6 there will be a capital component and whatever the priorities
7 are, this Committee, the point here was that and this
8 discussion about what it is we're going to be doing about
9 capital projects. If we're going to do capital projects are we
10 going to require an equivalent match here, should it be 50/50
11 like Ms. Nyholm says? Or anything that we do to access
12 healthcare has an expectation of a dollar for dollar match?

13 DELEGATE BYRON: I think like what
14 Connie said and we've done this in many places before but
15 without the funding and if you go to this bullet point and
16 realizing that a lot of the projects, if you consider the
17 definition of capital and capital assets, I think you have to
18 define that. Are you talking about, what kind of match or
19 more so than getting what it encompasses, should the
20 application also have a match?

21 DELEGATE MARSHALL: This is two
22 different things. The first issue is do we want applications for
23 capital projects and not equipment. After that, are we going to
24 get applications from every community in the Tobacco
25 Commission, so am I hearing no, we don't want to do that?

1 DELEGATE BYRON: Telemedicine
2 coming into a specific pilot?

3 MS. NYHOLM: I think what you're both
4 saying is that if there is a capital need that's associated with
5 an approval such as cancer research or telemed that it would
6 be considered but not outside of the already approved. And
7 then the second part. My suggestion was a dollar for dollar
8 match.

9 MR. NOYES: The definition of capital, a
10 long-life fixed asset, a depreciable asset.

11 DELEGATE MARSHALL: So that bullet
12 point off the list as a capital project. Any objection? All right.

13 MR. WALKER: So, on thirteen that's a
14 50/50 match?

15 DELEGATE MARSHALL: Yes, without
16 objection. Does anybody have any objection to dollar for
17 dollar match? All right.

18 DR. REDWINE: Mr. Chairman, and just
19 so I can be clear and I'm in total agreement, when you look at
20 our bullet points and how many we have. Certainly my
21 experience has been that if we stick to mainly research there's
22 more money available for research than other funding areas in
23 our economy right now. We're at a small clinic and you put in
24 bricks and mortar, you might have a hard time finding money,
25 if we keep those things out today without an issue. So I think

1 if we see where we are when we get through all these points, a
2 50/50 match seems real palatable because, it's easier for the
3 research projects to find money.

4 DELEGATE MARSHALL: All right Neal.

5 MR. NOYES: Multi-year project requests,
6 particularly those involving personnel, shall be required to
7 show an escalating proportion of the total project cost to be
8 borne by the grantee during the years two and three and
9 there's an illustration of that. The expectation is that you're
10 going to fund these types of projects that will require a year or
11 so of wrap-up and then the second year and then the third
12 year or at least in the third year become self-sustained. I
13 expect there'll be a lot of interest in that approach to
14 expanding access to healthcare. So if you want to do that, it's
15 recommended that that approach that has been demonstrated
16 to Virginia Healthcare Foundation in the past and we can
17 piggyback on what they have learned or maybe you don't want
18 to do multi-year projects to begin with.

19 DELEGATE MARSHALL: We can take the
20 telemedicine and if we like the idea on bullet number eight or
21 if you want to do a multi-year project along the lines of the
22 25/75 percent. I guess the first question is do we want to
23 take applications for multi-year projects?

24 MR. NOYES: If I may, Mr. Chairman,
25 understanding that quarter by quarter benchmarking of where

1 they need to be in the application and we're not likely to
2 consider a second year of funding if milestones from year one
3 have not been met.

4 DELEGATE MARSHALL: Multiple year
5 projects, one time, single –

6 MR. CANNON: Mr. Chairman, you mean
7 telemedicine more than one year?

8 DELEGATE MARSHALL: I'm saying they
9 can come back.

10 MS. CARTER: When you talk about
11 multi-year, you mean the first year the applicant was sent to
12 the Tobacco Commission a report of what had been
13 accomplished, is that correct?

14 MR. NOYES: At point of application to
15 describe for the period that they're seeking funding of course,
16 three years, 36 months worth of accomplishments. We could
17 fund the first year of the project, if it's one you wish to proceed
18 with and then we would track on a quarterly basis their
19 milestones and then advise the Committee whether funding in
20 the second year would go forward.

21 MS. NYHOLM: Are you suggesting that
22 this be tied back to the bullet point or just –

23 MR. NOYES: I think that's a reasonable
24 way to do it. Not everything is not new initiatives to be
25 funded. We've got two so far that you have indicated

1 willingness and that's cancer research and telemedicine. As
2 Mr. Cannon points out, we can do these things and a lot of
3 them don't fit in a twelve month model. It's going to take six
4 months or eight months or ten months to get moving before
5 you start seeing some changes and some effects, in month
6 eleven and fifteen and twenty, you might start seeing
7 something.

8 MS. NYHOLM: If an application comes in
9 on a project or an approved bullet point and includes
10 personnel costs, then we would evaluate the personnel portion
11 according to the formula.

12 MR. NOYES: That's what this bullet
13 point suggests, the Commission front load the costs and
14 they've got to come up in year two dollar for dollar and year
15 three come up with the 75%.

16 MS. NYHOLM: That's the clarification on
17 capital expenditures but that match would have to be in hand
18 at the time of application. This multi-year match, the first
19 year would be in hand but then future years that would be the
20 claw-back if they don't do it.

21 MR. NOYES: Yes, I think so. That's what
22 I would like to see but it's up to the Committee to decide.

23 DELEGATE MARSHALL: Other questions
24 and thoughts?

25 MR. NOYES: The second and third year

1 awards should be performance based by using the milestones,
2 we've already dealt with that.

3 DELEGATE MARSHALL: All right, the
4 next one.

5 MR. NOYES: Tobacco Commission funds
6 can be made available to for-profit organizations in exactly the
7 same way that we do through the R&D and TROF programs.
8 The eligible applicants re-up with that private sector
9 beneficiary or we can say we're not going to do any access to
10 healthcare where the private sector is providing, which doesn't
11 make a lot of sense to me.

12 DELEGATE MARSHALL: A large hospital
13 is in our area that are not-for-profit. Any thoughts on this?

14 MR. CANNON: That's actually the
15 summation –

16 MR. NOYES: The end of the day private
17 beneficiaries can be eligible.

18 DR. REDWINE: When you say the same
19 amount in the TROF program, are you talking about goals?

20 MR. NOYES: When we get an application
21 from an eligible applicant, we know who is and who's not. But
22 the funds are being used by a private entity and that happens
23 all the time in the R&D program. It happens by design in the
24 TROF program. I'm saying we need to be able to do the same
25 thing and maybe it's pointing out the obvious but –

1 DR. REDWINE: You're not expecting
2 these people to reach certain investment goals –

3 MR. NOYES: I'm expecting them to do
4 what they say in the application this Committee hears. It
5 would be the responsibility of whoever that beneficiary is.

6 DELEGATE MARSHALL: Of the ones we
7 approve, telemedicine, it's either going to be a for-profit
8 company or limited to an amount.

9 DELEGATE BYRON: The only question
10 that we could award money to a for-profit or a not-for-profit –

11 MR. NOYES: They have to come through
12 an eligible application, the IDA or a county or something like
13 that, absolutely.

14 DELEGATE BYRON: I think it's a great
15 idea. There's a lot of competition and that's good in the
16 marketplace and some people are doing things and others are
17 not.

18 DELEGATE MARSHALL: Yea or nay on
19 this, (Yea).

20 MR. NOYES: The outcome measures will
21 include number of persons served net new. You spend some
22 money and you operate equipment and there's no new person
23 served. You have not expanded anything. You have improved
24 something but not expanded access to citizens in the
25 footprint, the healthcare. Currently, we're serving ten people

1 and you've helped us with this financing and we're going to
2 serve twenty people and the application comes in and it says
3 we're going to serve ten people and actually if you help us with
4 money we're still going to be serving ten people. There is no
5 expanding access to healthcare here. You have to have an
6 outcome measure that can be reported on.

7 DELEGATE MARSHALL: If you have two
8 pilot programs along the same line and one can serve four
9 people and get a higher check.

10 MR. NOYES: The staff would accord that
11 a higher priority.

12 MR. CANNON: Mr. Chairman, I
13 understand what you're saying. Someone comes in and sends
14 in an application for 1,000 people and comes back and says
15 we're going to do a good job and a 1,000 people are getting
16 more, we need more equipment to really expand that 1,000
17 people, you're going to expand the facilities, if you could
18 expand that, you'd be helping more people.

19 MR. NOYES: I would say that doesn't
20 really expand access.

21 MR. CANNON: Three or four hundred
22 people.

23 MS. NYHOLM: It's not the people in the
24 population, it's the people that you can serve. In telemedicine
25 if they're right now able to reach 500 people in the universe

1 there's 200,000 and through telemedicine they're reaching or
2 utilizing, they can have 100% increase in utilization. The
3 utilization not the demographic profile.

4 DR. REDWINE: You're talking about a
5 percentage. We know telemedicine is designed to reach people
6 in the nooks and crannies and now we're getting into a
7 guideline here that makes Danville more competitive for
8 money than Gretna because there's fewer people there. And
9 they're not going to compete well in the numbers game but
10 they may need it worse.

11 DELEGATE MARSHALL: I understand
12 what you're saying. Danville has a population of 45,000 and
13 Gretna probably has a population of, I don't know exactly
14 what it is.

15 DR. REDWINE: A round number of new
16 people can be larger than that.

17 MR. NOYES: The Committee needs to
18 hear what that raw number is, you're talking about the service
19 area but the Committee needs to hear both numbers.

20 DELEGATE BYRON: I think we need to
21 leave that bullet point in and I think we all agree expanding
22 access to healthcare is an important element of anything we
23 do but when we start getting applications, let the staff digest
24 things and how they're presented to us. We don't know yet.

25 MR. NOYES: There's a learning curve on

1 this. We need to have something to tell applicants that they
2 need to tell us this information in the application. What this
3 is suggesting is net new. They can tell us a percentage but
4 raw numbers.

5 DELEGATE MARSHALL: Maybe we need
6 to change our terminology here a little bit.

7 DR. REDWINE: I think that's the whole
8 point with telemedicine is that people in metropolitan areas
9 have access but out in the hollows and the valleys and rural
10 areas people don't. They need access to expanded medicine at
11 UVA more than someone that lives within 30 miles of Roanoke
12 does.

13 DELEGATE MARSHALL: When you talk
14 about telemedicine, that's the same argument just like cancer.
15 Folks in Danville probably get easier service than the people
16 in Gretna.

17 DR. REDWINE: I don't want to sound
18 like I'm just arguing. I just want to make sure that we don't
19 come up six months from now and say we set a guideline that
20 now keeps the very people we wanted to serve to be able to
21 compete and win at this funding level.

22 MR. NOYES: I understand Dr. Redwine's
23 position. Do you have a position on that Sara, Tim?

24 MR. PFOHL: Not at the moment.

25 MS. CARTER: I would agree with what

1 David is saying and I agree with the concept of looking at
2 numbers and percentages. I just want to make sure that we
3 as a Committee don't put so many people as numbers that we
4 forget the whole purpose of this and that is access. If you look
5 at rural Virginia population-wise, they're not increasing and
6 how do you put a number on that whether or not it's going to
7 be a good practice. I don't know. I just think we might or
8 there could be a chance to place too much emphasis just on
9 the numbers.

10 MR. NOYES: That's a point well taken
11 and a good point. At the end of the day we have to be able to
12 have a report on the outcome and that's one that seemed to
13 make sense to me, if there's a better argument, I'd like to hear
14 it about access.

15 MR. O'QUINN: It seems to me that if you
16 look on it as a raw number and a percentage base it would
17 take care of the problem. A thousand to 1300 in Danville,
18 good and then going from 200 to 700 in Gretna is good. So if
19 you look at a raw number, the final raw number may not be as
20 impressive in Gretna as it is in Danville. The percentage
21 increase is going to be better, so you have to look at both of
22 those.

23 MR. NOYES: I think we've just been
24 wordsmithed. Percentage increase, that's new and/or
25 percentage increase and that's presented to the Committee for

1 your consideration at the point of application.

2 DR. REDWINE: I'm satisfied with that.

3 MR. NOYES: I'm glad you made it on
4 time.

5 DELEGATE MARSHALL: The last bullet
6 point.

7 MR. NOYES: Expanded access to
8 screening for prevention shall be eligible. That's an eligible
9 activity.

10 DELEGATE MARSHALL: I assume it's
11 Southwest and Southside. I don't think we have enough
12 money to tackle that issue. Do you want to take that off? All
13 right, without objection we'll take it off.

14 MR. O'QUINN: There's an old saying and
15 I never thought I'd get to the age where I'd say this an ounce
16 of prevention is worth a pound of cure or something like that.
17 If it's something that fits into the monetary framework, it may
18 not be something that's quite right. It may not be something
19 entirely in the footprint but it may be something that would
20 help. I know in our company a huge prevention program
21 brought some of the overall insurance costs down.

22 DELEGATE MARSHALL: Certainly we've
23 already done some access. We're doing the cancer research
24 and telemedicine. We can certainly limit if it's the will of the
25 Committee, if we want to limit access to a particular field we

1 can do that.

2 DELEGATE BYRON: I would say that
3 there's a lot of preventative work. You have all sorts of things
4 that certainly affect whether it's mental health or alcoholism,
5 all sorts of things that can crop up once you start looking at
6 different things that are not good for our health. Maybe we
7 should stick with what we're starting with here, cancer
8 research and telemedicine. When you start with this one,
9 you're going to have just as many worthy programs. We're
10 going to make ourselves too thin.

11 DELEGATE MARSHALL: Well, we can
12 look into 2014.

13 MR. NOYES: The next page. Should
14 priority be given to projects that clearly serve both regions or
15 all of Southwest or Southside? It's the scale of the project
16 rather than local project or a one county project or a one city
17 project. The staff as it looks at applications gives priority to
18 those that deal with the whole footprint or Southside or
19 Southwest and that's the question for you.

20 DELEGATE MARSHALL: Telemedicine,
21 do we want to look at a project specifically to one locality,
22 Southwest or Southside or the whole footprint?

23 MS. CARTER: Under special projects, it
24 would come to special projects it was for the whole footprint.
25 When the project comes to special projects, we never really

1 said this is Southside or Southwest.

2 DELEGATE MARSHALL: We have
3 economic development projects in Southside and Southwest.

4 MS. CARTER: That was under special
5 projects. If an applicant comes to special projects, we never
6 say is this for the entire tobacco region or am I missing
7 something?

8 MR. PFOHL: We have required
9 participation by three localities to meet eligibility for special
10 projects for the last eight or nine years. It could be three or
11 41.

12 MS. CARTER: Would we want to change
13 that? Because there's two regions, different healthcare needs.

14 DELEGATE MARSHALL: Question one,
15 is it Southside or Southwest, are we taking an application just
16 for Danville or application for Southside?

17 MR. NOYES: We're not changing
18 anything, what we're saying is that in terms of priority do you
19 want more comprehensive approach to access to healthcare or
20 do you want local approaches?

21 DELEGATE BYRON: I think my
22 observation, my personal thoughts on the pilot program, I
23 think we should use the pilot in one of the areas when the
24 cost factor is there and we don't want to try to do both regions
25 if we can't do it correctly. As far as priorities go, we know that

1 in the past we had times we felt it was a little bit top heavy in
2 the Southwest region, even though we try to do regional
3 projects, when you start getting into the larger amounts that
4 while we don't want to turn away projects, maybe there's been
5 more activity in one region than the other and then we have by
6 quota tobacco production and that was the reason for the
7 economic development committees. My only thought would be
8 that we don't, we shouldn't give priority to one or the other
9 and we should be aware to make sure we try to cover both
10 areas.

11 MS. NYHOLM: I agree with the fact that
12 we should be aware and bring all the areas. What we don't
13 normally do is we have a minimum of participating localities, if
14 it turns out to be five or six or 41 they get more stars on the
15 application, maybe awarded for covering a broader area.

16 SENATOR SMITH: Serving my areas, I
17 would hate for us to not be able to afford because we can't
18 find an equivalent in another area, then I think we're going to
19 handicap ourselves.

20 MR. NOYES: We're still requiring
21 multiple jurisdictions as co-applicants or it can be a single
22 applicant serving multiple jurisdictions. The local project that
23 doesn't serve multiple jurisdictions would not be eligible for
24 special projects. That's the way it has been in the past.

25 MS. CARTER: Is that what you want to

1 do with healthcare?

2 DELEGATE BYRON: The cancer
3 research, what jurisdictions is that involved in?

4 MR. NOYES: The Massey project is doing
5 multiple jurisdictions in southern Virginia. And my
6 understanding is that the application that is expected from
7 UVA and Massey will be coordinated and we'll deal with both
8 Southside and Southwest. I haven't seen it so I don't know
9 how many jurisdictions are affected and what period of time.

10 DELEGATE MARSHALL: Let me get back
11 to Mr. O'Quinn's when he talked about the percentage
12 increase. That could apply here also.

13 MR. NOYES: To every application.

14 MS. CARTER: It can start that way and it
15 can change, is that what you're suggesting?

16 MR. NOYES: Yes.

17 DELEGATE MARSHALL: That's a good
18 idea. All right, next.

19 MR. NOYES: TICRC financing ought not
20 to be used to supplant services that healthcare providers
21 decide to reduce or eliminate. If you don't stop that policy,
22 somebody's going to say if I don't get the money we're going to
23 stop.

24 DELEGATE MARSHALL: Any objection to
25 that?

1 MR. NOYES: Does the Committee desire
2 to assign priority to particular groups? To workforce age
3 persons or uninsured persons or children? Or retirees, in
4 other situations, you have said you're trying to stand up for
5 the workforce, you're not going to do Pre-K but that's just an
6 example.

7 DELEGATE BYRON: When you talk
8 about workforce, they have children and elderly parents and if
9 there's issues dealing with them, it impacts their ability to be
10 in the workforce.

11 DR. REDWINE: I would also say that
12 given different communities, there's programs in place for one
13 or the other groups then you start putting an umbrella over it
14 and maybe duplicating.

15 MR. NOYES: I was just asking a
16 question.

17 DELEGATE MARSHALL: We're talking
18 about healthcare here but ultimately Southside and
19 Southwest is the number one issue we have and that's jobs.
20 The majority of things we do as this organization is trying to
21 create jobs and that last bullet point involving workforce age,
22 if we get a healthy worker and whatever the issue is out there,
23 then it might help the issue as far as getting people employed.

24 DELEGATE BYRON: Well, you can
25 always apply for employment.

1 MS. CARTER: I see what you're saying
2 but if we cater to a certain sector of people, I don't know if
3 that's really providing access to healthcare. You've also got to
4 consider you've got Medicare and Medicaid and there's all
5 kinds of things out there that can help.

6 SENATOR SMITH: Rather than aid those
7 that are in the workforce or who are seeking employment, you
8 might say because there's so many elderly for one thing.

9 MS. CARTER: Then how do we quantify
10 that?

11 DELEGATE BYRON: Mr. Chairman, if
12 you look at that we've got to relate to a broad spectrum.
13 You've got to remember we're dealing with access but if you
14 open it up to other things, then you're talking about for
15 instance pregnant women, babies that are born that have a
16 specific need, you can just go all over the place. That opens
17 up a lot of areas. If it's associated only with those things that
18 we approve, you're looking at an entirely different need.

19 MR. NOYES: You're talking about point
20 of application?

21 DELEGATE MARSHALL: Or 2014. So
22 am I hearing no?

23 MR. WALKER: You're talking about being
24 at 30,000 feet, I think we're getting ready to let the air out
25 here.

1 DELEGATE MARSHALL: All right, do I
2 hear a no? That's it, no. Neal, do you want to summarize
3 what we've done?

4 MR. NOYES: Yes. In summary, the
5 initial bullet point cancer research and your dedicated cancer
6 centers outside the footprint, that that shall be a priority for
7 fiscal year '13. You have agreed that bullet point, which is the
8 telemedicine initiatives, which include the items mentioned
9 shall be eligible for fiscal year '13 and the applications can be
10 for envisioning multiple years to accomplish the objective but
11 they will be monitored on an annual basis, funded for a year
12 two and it will depend on having met the milestones across
13 year one.

14 You have agreed that the outcome figures will be
15 the number of persons in new measures will be the number of
16 not new or a percentage increase of persons served to
17 demonstrate expanded access. Pretty much the same
18 standard for special projects, must have multiple applicants
19 served and multiple jurisdictions, the same way the federal
20 projects work. We're not going to use TICRC financing to
21 reduce or eliminate. We're going to require a dollar for dollar
22 match on all the programs. You've got two focus areas, cancer
23 research and telemedicine for fiscal year '13 and then the
24 measures.

25 DELEGATE BYRON: That's for the

1 telemedicine.

2 MR. NOYES: Percentage increase.

3 DELEGATE MARSHALL: Is there anyone
4 on the Committee who don't agree with or we need to bring
5 up?

6 MS. CARTER: On bullet point three it
7 talks about, are we talking about bringing other people in, in
8 2014?

9 MR. NOYES: Yes. Two focus areas for
10 fiscal year '13, the parameters apply to those two focus areas.

11 DELEGATE MARSHALL: Any other ideas
12 at the table?

13 MR. NOYES: If I may, Mr. Chairman, the
14 dollar for dollar match is a minimum requirement. There are
15 some where an applicant will have more than a dollar for
16 dollar match, staff will react happily.

17 DELEGATE MARSHALL: Anyone else
18 have anything on this issue?

19 MR. CANNON: We've talked about a lot
20 of things here but I think we should have an attorney here
21 when you're dealing with guidelines.

22 MR. NOYES: We're in the process of
23 getting one. Delegate Kilgore is working on it probably as soon
24 as he wakes up today. Mr. Chairman, do we want to maintain
25 the July 13th deadline?

1 MR. PFOHL: Mr. Chairman, I was going
2 to suggest that probably the date of August 1st would be very
3 helpful.

4 MR. NOYES: Also the Committee will be
5 hearing an application from Liberty University and it will be
6 referred to this Committee, healthcare related.

7 DELEGATE MARSHALL: Our next board
8 meeting is then?

9 MR. NOYES: Yes.

10 DELEGATE MARSHALL: So probably
11 late August, early September?

12 MR. NOYES: Maybe the second.

13 DELEGATE MARSHALL: Anything else?

14 MR. PFOHL: Mr. Chairman, going back
15 to Secretary Carter's point about the type of projects, typically
16 inviting special projects. Is there an interest in taking on any
17 other regional projects, not healthcare special projects we
18 have over the years or are we making call for others now or at
19 some point in the future? The Crooked Road is one, Regional
20 Water and Sewer projects.

21 DELEGATE MARSHALL: Speaking out
22 loud, I think we're going to open up another Pandora's Box if
23 we do another park and if we put it out there then we're
24 asking for localities to bring us maybe a regional park, then
25 you get into issues of multiple jurisdictions, et cetera.

1 MR. NOYES: Let me remind the
2 Committee that you have responsibility for the Mega Site
3 program, doing that at the discretion of the Chairman, only
4 not this round, maybe not until the spring.

5 DELEGATE BYRON: I know monies are
6 limited but the main goal has always been job creation and
7 economic development. I'm wondering if there are projects
8 that don't fit that have come to this Committee in the past that
9 are regional and don't fit the parameters that Tim has talked
10 about that are economic development projects. In other
11 words, if there is a good job project and good healthcare
12 project, whichever project.

13 DELEGATE MARSHALL: Just like the
14 Mid-Atlantic Broadband. That's good for all areas.

15 MR. PFOHL: The Regional Rail to Trails,
16 a regional industrial facility or industrial park or water or
17 sewer system, any number of things that we've done in the
18 last decade or so. I suggest that if we throw open the doors to
19 something like that, we'll probably get \$20 million worth of
20 proposals in addition to healthcare.

21 MR. WALKER: I think that would be way
22 too broad. I think if somebody has a project that can be done
23 right away, I know I'm not saying anything against industrial
24 parks but something that would create jobs right away.

25 DELEGATE MARSHALL: That could go

1 straight to TROF and one of the other committees.

2 MS. CARTER: What are some of the
3 more successful projects you've had in Special Projects?

4 MR. PFOHL: The Crooked Road Music
5 Trail and eighteen communities are helping fund that, around
6 the mountain is another one. We had regional and industrial
7 parks.

8 MS. CARTER: Those funds are used for
9 construction? It's harder to get that money USDA or EDA on
10 the federal side. They don't necessarily produce jobs but you
11 have to have them in order to get jobs or projects that lead to
12 jobs.

13 MR. NOYES: One function of this
14 Committee has been in southern Virginia for those
15 jurisdictions that have a pressing need for economic
16 development projects but do not have sufficient allocation to
17 go forward with that project.

18 DELEGATE MARSHALL: The Henry
19 County allocation is one that comes to mind. I think we
20 should leave the door open for those game changers.

21 MR. NOYES: Are you interested in doing
22 the healthcare first and then depending on the balance of
23 funds available then make a decision to have other items or
24 projects come in with the Mega Site program?

25 MR. PFOHL: I'm just offering it as a

1 suggestion.

2 DELEGATE MARSHALL: You can give us
3 some feedback or outline of what you're thinking and we can
4 address it at the September meeting. We can also consider
5 2014, too.

6 MS. CARTER: Right now there's \$12
7 million in Special Projects, 12.5, over eight is going to one
8 project. Then in 2014, we'll have twelve million.

9 MR. NOYES: The budget is for four
10 million competitive funds for 2014 and then it opens up
11 beyond that with the Mega Site programs.

12 MS. CARTER: How much traditionally
13 has Special Projects had?

14 MR. NOYES: If you tried to chart it, it
15 would be all over the place. If there's a particular initiative,
16 the R&D Center, in terms of a purely competitive amount of
17 funds, it's not far off from \$4 million. It might have been forty
18 in one year, 26 in another.

19 MR. STEPHENSON: Mr. Chairman, for
20 clarity, the August 1 grant round is opened only to the
21 healthcare community and no one else, is that what I
22 understood?

23 DELEGATE MARSHALL: I didn't
24 understand that.

25 MR. NOYES: That is my understanding

1 in an attempt to learn about non-healthcare projects and then
2 a decision then to go forward with the application round in
3 conjunction with the Mega Site program at some point later in
4 the year.

5 MS. CARTER: Do you have applicants for
6 Special Projects that are not healthcare related?

7 MR. STEPHENSON: I don't know what's
8 in inventory but the community is looking for a signal from
9 this Committee as to whether they should apply or not. They
10 need to know how much money.

11 DELEGATE MARSHALL: What's the
12 thought of the Committee, do we just go healthcare for this
13 round? We'll just have to see how it turns out. If it's a good
14 project, I think that's our problem if we don't say no all the
15 time. I'd like to see what's out there. So without objection,
16 just healthcare?

17 MS. CARTER: I was just worried about
18 changing in mid-stream.

19 MR. PFOHL: Sara and Sarah are telling
20 me we are aware of a handful of prospective applications,
21 water and sewer project in Poplar Forest.

22 MS. CARTER: I'm worried about
23 changing in mid-stream. I agree with Gary, look at all the
24 applications and base it on that.

25 DELEGATE MARSHALL: Then without

1 objection.

2 DELEGATE BYRON: I think what I'm
3 also hearing is looking at them and based on merit and the
4 additional work for staff that there should be some priority for
5 a group being job creation, something that fits a parameter
6 that makes it better. A lot of projects may be merit based but
7 that doesn't mean the Committee is going to look favorably
8 upon them based on the budget. If there's some way we can
9 narrow that, maybe we can consider those in the future.

10 MR. NOYES: The strategic plan that you
11 approved emphasizes direct private sector jobs, private sector
12 capital investments and those are outcomes that we will be
13 looking at for the types of projects. We should be able to tell
14 from an application they are near term. If they are induced for
15 indirect jobs, which is the case a lot of times like the ATV trail,
16 the Poplar Forest project and that's tourism related and those
17 are not going to be as competitive to the terms of the new
18 strategic plan as they might have been previously because
19 they're not direct jobs.

20 DELEGATE MARSHALL: So folks might
21 go on the website and read our plan, we're just going to have
22 to tell them or the staff will tell them.

23 MR. NOYES: We can and Sara and Sarah
24 have meetings with potential applicants, but that won't stop
25 people from applying. The staff is now clear what we're

1 supposed to evaluate them on.

2 DELEGATE MARSHALL: All right, does
3 anyone else have anything? Thank you very much, it's been
4 very productive.

5 Now, do we have any public comments, is there
6 anyone in the audience that would like to come up and speak?
7 Hearing and seeing none, I declare the meeting adjourned.

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9 PROCEEDINGS CONCLUDED.

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1 CERTIFICATE OF THE COURT REPORTER

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3 I, Medford W. Howard, Registered
4 Professional Reporter and Notary Public for the State of
5 Virginia at large, do hereby certify that I was the court
6 reporter who took down and transcribed the proceedings of
7 the **Special Projects Committee of the Virginia Tobacco**
8 **Indemnification and Community Revitalization**
9 **Commission when held on Tuesday, June 19, 2012 at**
10 **10:30 a.m. at the Hotel Roanoke and Conference Center,**
11 **Roanoke, Virginia.**

12 I further certify this is a true and
13 accurate transcript to the best of my ability to hear and
14 understand the proceedings.

15 Given under my hand this 1st day of
16 July, 2012.

17
18 _____
19 Medford W. Howard

20 Registered Professional Reporter
21 Notary Public for the State of Virginia at Large

22
23 My Commission Expires: October 31, 2010.

24 Notary Registration Number: 224566