

Attendees

Task Force Members Present:

Christina Mullins; Danny Scalise; Chuck Thayer; Tim Hazelett; Linda Sanders (designee for Chad Bundy); Dr. David Didden; Vivian Parsons; Walt Ivey; Amy Atkins; Patricia Pope; Patti Hamilton; Anne Williams; Dr. Stephen Worden; and Dr. Gregory Hand

Participated via conference call:

Dr. Rahul Gupta, Chair; Melissa Kinnaird; Sandra Ball; Senate Finance Vice-Chair Chris Walters; and Jim Kranz

Task Force Members Absent:

Barb Taylor; Andy Skidmore; Jeff Johnson (representing Senate Health and Human Resources Chair Ryan Ferns); Charles Roskovensky (representing House of Delegates Health and Human Resources Chair Joe Ellington); Ted Cheatham; and House of Delegates Health and Human Resources Member Michael Pushkin

Community Members Present:

Sissy Price; Boyd VanHorn; Lloyd White; Ted Krafczyk; Karen Begg; Margaret Howe-White; William Ours; Candy Hurd; Stan Walls; Bill Kearns; Meike Schleiff; Cecil Pollard; Henry Taylor; Stephanie DeWees; Jon Welch; Robert White; John Taylor; Jackie Huff; Ted Gross; Lee Smith; Lillian Smith; Diana Gaviria; Karen McClain; Jamie Moore; Paris Charles; Jamie Summerlis; Andrew Sutterland; Michael Kilkenny; Sunah Hallie; Randy Williams; David Beard; Bobbi Sykes; Delegate Barbara Evans Fleischauer; Andrea Fisher; Linda Lipscomb and Brian Skinner

Agenda

Amy Atkins welcomed everyone to the meeting. Ms. Atkins acknowledged PHIT Chair, Dr. Rahul Gupta, was travelling, but participating via conference call. Ms. Atkins thanked the Monongalia County Health Department for hosting the PHIT meeting.

PHIT members participating by conference call were asked to identify themselves. Ms. Atkins informed PHIT members that the conference call dial-in number was mistakenly sent to local health department staff. As per the WV PHIT Operating Procedures and Guidelines, only PHIT member's participation by phone is permissible. Since some of the local health department staff opt to participate via conference call and did not travel to Morgantown to attend the PHIT meeting, accommodations were made this time (only) for participation by phone. Ms. Atkins informed the conference call participants that if they had a comment to share when the floor was opened for public comments to use the email address they were provided. Comments would be read aloud.

June 2, 2015 meeting minutes were presented for approval. Chuck Thayer motioned to approve the minutes. Danny Scalise seconded the motion. Vote was taken and all were in favor. **June 2, 2015 meeting minutes were approved.**

Amy Atkins introduced the presenters for the meeting - Cecil Pollard, Director, Office of Health Services Research, WVU School of Public Health; Dr. Henry Taylor, Acting Health Officer and Deputy Health Officer Carroll County, Clinical Deputy Health Officer Cecil County & Senior Associate Health Policy and Management of John Hopkins Bloomberg School of Public Health; and Meike Schleiff, Johns Hopkins University.

First presenter on the agenda was Cecil Pollard. Mr. Pollard has a long involvement with public health in West Virginia. In the past 10-15 years, his focus has been on chronic disease (mostly diabetes, hypertension and asthma) – implementing standards of care and best practices in primary care centers. The key to community prevention is local health departments. Per Mr. Pollard, appropriate technology is only as useful as the user. He started the concept of a distributed registry which has expanded over the years. He has assisted primary care centers in accurately tracking patient outcomes, benchmarking care against national standards, and modifying clinical policies and procedures for improved outcomes. His efforts include supporting the use of electronic health records and registries to monitor and target care; provide provider and staff training/education on chronic disease prevention and management; and assist in the use of clinical outcomes data for quality improvement. Mr. Pollard shared his vision as to what direction he would like to see public health take in West Virginia. He presented a map of a region in El Salvador; basically a county divided into divisions/communities. Each division is assigned a community health worker that visits the communities/households every month to perform an environmental scan. Every individual that needs obstetric care or observation is indicated on the map. Mr. Pollard believes West Virginia could do that. El Salvador has some public health characteristics similar to West Virginia. Mr. Pollard concluded his presentation by making his recommendations as to where the group needs to head – (1) urge to agree on one EHR system/site; (2) lobby for community health workers; (3) think in terms of population health (think locally); (4) start to enumerate your population; and (5) create/build regional health alliances.

Next presenter on the agenda was Dr. Henry Taylor. Dr. Taylor expressed that it is an exciting time for public health. There are tremendous changes taking place in health care today. He commends the PHIT for focusing on the “health” of public health – it’s a very tough job. Maryland is doing the same things. This is happening all over the country, all over the world. Dr. Taylor stated that it will take “storming” to get to the “norming”. Dr. Taylor is available as a resource. He shared the analogy - “Turtle on a Fence Post”. (1) The turtle didn’t get there by accident (we are here for a reason); and (2) it needs help getting down (we need to work together – use our strength and resources, identify the issues, and don’t slip into some of the pitfalls).

Dr. Taylor stated the notation of what is community-based primary health care is the big banner being addressed globally. It’s similar to what we are doing in West Virginia and similar to what we are doing in every small community. Per Dr. Taylor, primary health care is not primary care in terms of clinical work, it’s how do you care for groups of people as if they were a patient. Community-based public health is known globally and Dr. Taylor teaches five (5) different models of it.

Dr. Taylor distributed a handout of his 1994 presentation, “**Closing the Gap Between Clinical Care, Public Health and Community Needs**”. This presentation was based on his experience in 1994 when he was in Pendleton County working with the State Health Department on primary care centers. Dr. Taylor can offer multi-dimension perspectives. He recommends process the notion of functional analysis of needs and resources. There was a point in time when he was involved in the Transition Project. The key to the Transition Project was to differentiate basic public health services and the financial mechanisms for basic health services from the efforts that had been going on by a lot of people at the “tip of the pyramid” which was clinical services. At that time, you couldn’t use the word “regionalization”. It was a big controversy. Twenty years

before, West Virginia had systematically developed clinical care systems through FQHCs, free clinics, school-based wellness centers, etc. Tip of the pyramid was the clinical care aspect. Now with the ACA, we can afford to fund some of that at the tip of the pyramid.

Per Dr. Taylor, the challenge lies in the middle of the pyramid known as enhanced services. The question is – in enhanced services, what is population health? Dr. Taylor provided a short version of functional analysis – one function is clinical services for the sick, another function is total population/basic public health services, and the middle would be what are those things in each community that need to be tackled. Working together as a group with the same focus, success can be found. Dr. Taylor feels that health departments, primary care centers, other advocacy groups, etc. need to come together to make a difference in the community.

He states that the end of the point of functional analysis is to have an impact. Impact is driven by outcomes. Outputs are the wedges, i.e. CPT codes. Per Dr. Taylor, no one has defined the CPT codes for public health. The process in which the job is performed is to have a clear definite purpose, define your role in the system – what is your territorial control and lastly what are you accountable for. Part of the theory is relationships – everyone has a role. Working together as a team makes a difference and will make an impact.

To conclude his presentation, Dr. Taylor asked the questions, are we here to decide whether to have a centralized public health system in West Virginia? Are we here to decide whether we are going to have a 55 county health department (boards of health) system? Are we here to decide if we want a hybrid system? Dr. Taylor said that State of Maryland does have a hybrid system but is trying to move to population health. The real task is to make the decision about structure. Form must follow function. Until you have thought about the functions, it's hard to think about what form to take.

Last presenter on the agenda was Meike Schlieff. Ms. Schlieff provided a summary (handout) of the PHIT survey that was conducted. The survey was to provide feedback on how the process was going, reflect on what PHIT is trying to accomplish and what can be done to assure the ultimate goals of the PHIT will be met by the end of the series of meetings. Ms. Schlieff shared that out of 24 members, 21 completed the survey (88% response rate). The respondents were largely from the Bureau for Public Health followed by local health departments, and partners including county commissions, academia and others. The first question asked the respondents about the current level of fulfillment of the public health mission of West Virginia. On a scale of 1-5, 1 being not at all fulfilled and 5 being fully fulfilled, PHIT members' perception was "somewhat". Respondents were also asked what was the greatest challenge facing the PHIT process. PHIT members listed timeframe as the number one challenge, with lack of agreement coming in second. Finally, the survey asked the levels of confidence in the PHIT process on a scale of 1-10 (1 being no confidence and 10 being great/high levels of confidence). PHIT members fell in at 7 with the level of confidence in the process. Plans are to conduct a couple more rounds of the survey as PHIT progresses.

Per Ms. Schlieff, during the first couple of PHIT meetings, a theme of working with a "decentralized system with a centralized mission" surfaced a number of times as one of the challenges faced in the process. The survey provided respondents an open response field to provide their insights in the challenges and opportunities provided by this dynamic. Emerging themes included the need for local ownership and standards (leadership) as well as the essential nature of an upgrade to the system both in terms of the structure and performance metrics and goals of the system.

Lastly, the survey provided respondents a chance to provide ideas about how the PHIT process might be improved moving forward. The theme that emerged included substantial enthusiasm and optimism about the workgroups, the need to focus at a strategic level, and the aspiration to

develop by the end of the process strong recommendations for legislation. Additionally, several respondents felt the efforts of the PHIT should be focused on how to enable local health departments to enforce and uphold strong and relevant central mission.

Amy Atkins opened the floor for discussion/questions from the PHIT members on the speakers' presentations.

Vivian Parsons asked Dr. Taylor what were the four (4) points in the book he referenced during his presentation? Dr. Taylor replied that it is based on the notion of roles. (1) What is the role? (2) What is its purpose? (3) What is its turf (domain)? (4) What is its accountability?

Dr. Didden asked Cecil Pollard about the distributed registries and the potential those registries might have to be able to demonstrate cost savings for populations. Cecil replied his experience hasn't been based on the financial end of it – haven't connected to the cost savings/payment side. However, can demonstrate change in patient outcomes and utilization of services. Would not be difficult – just haven't combined the clinical data to the financial side.

Patti Hamilton asked about the timeframe of the PHIT. It was listed as the number one challenge on the survey. What is driving the timeframe? What constituted the timeframe? What is the deadline? Amy Atkins replied just the sense of urgency around the need to get the system aligned and functioning effectively and efficiently and also if there should be any needed legislative changes there would be recommendations developed to support that. Patti Hamilton asked if the timeframe is realistic. Amy Atkins replied the issue has been identified by the PHIT. This is a huge undertaking. PHIT has established workgroups to try to put more energy and time at the table in terms of thinking through these issues. Work will continue through PHIT and Dr. Gupta's leadership to help determine best way to improve upon that.

No other questions/comments from the PHIT were presented in regards to the speakers' presentations.

Amy Atkins opened the floor for discussion/questions from the public on the speakers' presentations.

Karen McClain from Brooke County Health Department wanted to publicly thank Cecil Pollard for his help with their health department with community needs assessment. She had a question regarding one system amongst the health departments. The obstacle and challenges are different between health departments. Wouldn't it be somewhat standardization to share data amongst the health departments, i.e. collect meaningful use data, West Virginia health information network, etc? Mr. Pollard agreed that what Ms. McClain was suggesting is what we want. We want common functionality.

Delegate Barbara Evans Fleischauer commented that she was intrigued by the timeframe question too. Delegate Fleischauer asked what the timeframe is. Amy Atkins replied that the schedule, meeting minutes, etc. are posted on the Center for Local Health's website. The PHIT was launched in April 2015 and meetings are scheduled through late October 2015.

No other questions/comments from the public were presented in regards to the speakers' presentations.

Amy Atkins stated at the last PHIT meeting, four (4) workgroups were established. The first charge for the workgroups was to assign a Chair. This charge has been completed. Each chair will give a brief report on their respective workgroup. Amy Atkins introduced the first workgroup – Better Health.

Danny Scalise is the Chair of the Better Health workgroup. Mr. Scalise stated the Better Health workgroup has started a working document which they consider public health responsibilities in West Virginia. They have broken it down into what the group considers state and community; in addition to breaking it out into topics. First topic was monitor health. Group used, as a basis, the 10 central public health services but modified those some to be a little more generic and broke out what the state and community do in those. Also included diagnosis and investigate health hazards; inform and educate; mobilize; policy development; and enforce regulations. Group had a section to look at gaps; ensure a competent public health workforce; research new ideas and discuss metrics for evaluating and reporting. Group has a draft document, but it is not ready to share/distribute at this time.

Amy Atkins introduced the workgroup Better Quality. Better Quality is chaired by Dr. Hand. Better Quality workgroup is working under the framework that accreditation is really establishing a minimum package of quality functions and services, providing for ongoing evaluation of quality improvement, and providing a framework for linking resources, expectations and priorities. Dr. Hand said first question addressed was do local health departments want accreditation. Is there an interest in providing statewide performance standards? The answer was, yes - there is a need and desire for performance standards across the State. The workgroup believes that West Virginia citizens should expect a standard package that promotes health from the local health departments. Some local health departments are interested and ready to seek accreditation through the Public Health Accreditation Board. But there remain other local health departments that do not feel they are ready at this time. They don't have a full understanding of accreditation to seek it at this time. Everyone feels there should be some set performance standards statewide. All are interested in enhancing quality improvement. Another question that arose was what kind of support (if any) is available from the Bureau for accreditation efforts.

The workgroup's next step is to provide an overview for the accreditation process that would be available to local health departments. Before moving forward, the workgroup wants to see what standards are currently being established and what is already completed – do not want to reinvent the wheel. The workgroup found there needs to be a broader discussion with the PHIT in terms of resources and building capacity to providing a central package of benefits across the State. Also need to address what (if any) coordination efforts with the Bureau's efforts for accreditation.

Next workgroup introduced was the Affordable Public Health, chaired by Amy Atkins. Workgroup's charge was affordable public health and focus specifically on the Bureau's statutes, codes and regulations. The workgroup discussed in more detail about the current code and rule and framework that established the state and local relationship. The workgroup thought it was important to think about it in terms of affordable public health - how do we want to start to explore that topic. The workgroup looked at it in terms of "buckets" – what are some of the buckets that need addressed. The buckets defined were (1) system requirements and guidelines; (2) capacity and infrastructure that takes to meet requirements; (3) accountability for public funds; and (4) oversight of the system (look at the system at an affordability stand point and develop processes on how we manage and support efficiencies throughout the system to continue to improve). Workgroup is still in its development stage – exploring how do we define and how do we explore moving forward.

The last workgroup introduced was Community Engagement chaired by Tim Hazelett (handout). The workgroup developed its operating definition – *“Community engagement refers to the process by which community benefit organizations with emphasis on public health and individuals build ongoing, permanent relationships for the purpose of applying a collective vision for the benefit of a community. Community engagement primarily deals with the practice of moving communities toward change and sustaining that process”*. The workgroup asked – what is community? The workgroup determined that community is a complex and fluid concept that

is defined by both an individual's perspective and the structures and values of others in the larger system. Community as the individual may belong by choice or innate personal characteristics, voluntary associations, common characteristics, etc. Community the system is made up of individuals and sectors that are connected through a role, function or activity. Success is dependent on each sector performing its function. Community the system also includes the dynamics of status and power. The task is not to own the status and power, the task is to initiate the change that impacts the health of the State. In looking at the definition of community, the workgroup starting observing the same point - working collaboratively with and through groups and mobilize and influence system to change relationships among partners. This engagement has to happen with the partnerships that are developed in public health. Engagement has to happen early for sustainable changes. The workgroup addressed what could be done for a successful community engagement. The findings included address the system; ensure initiative is appropriate for the community; explain relevance and benefits of initiative; empower the community within; and use core partnerships effectively from the beginning of the initiative to the end. In the 10 essential public health services, two essentials relate to community engagement – (1) inform, educate and empower people about health issues and (2) mobilize community partnerships to identify and solve health problems. In reviewing resources, the theme that kept coming up was engagement in the community.

Floor opened to PHIT members for questions/comments as related to the workgroups.

Dr. Didden wanted to make an observation and distinction between primary care and community-based primary health care. He believes that the latter is consistent with the mission of public health. Primary care itself is part of the reason there are escalating costs with poor outcomes because that system is designed to increase resource utilization. It is the nature of that system. What public health offers is the community-based primary health care (population-based), not resource intensive, non-hierarchy, a lateral distribution of information and skills at being able to navigate health challenges. Tim Hazelett replied that we either stay separate or come together and engage to find the solution to tackle community health problems. In reviewing available resources, all resources show you can't stay separate. Public health and primary care need to come together to make a great impact/change. Dr. Didden asked if different models were reviewed/discussed as to how this might look. Tim Hazelett replied they have discussed various models (on-going); Workgroup will look for feedback and suggestions. There are a lot of environmental factors involved. It will be challenging to try and engage primary care partners.

PHIT members had no other comments/questions as related to the workgroups.

At the last PHIT meeting, it was requested to entertain the notion of adding more membership representation. Four (4) additional members have been chosen to participate on the PHIT. These members include Lloyd White, Marion County Health Department; Bill Kearns, Berkeley County Health Department; Dr. Adam Breinig, President – WV State Medical Association and Terri Giles, Executive Director – WV for Affordable Healthcare. Amy Atkins presented members to the PHIT members for discussion. Danny Scalise motioned to accept their membership. Dr. Worden suggested each individual should be presented and accepted separately. Amy Atkins presented membership for Lloyd White – Danny Scalise motioned, Chuck seconded the motion, vote was taken and all were in favor; Bill Kearns – Danny Scalise motioned, Walt Ivey second the motion, vote was taken and all were in favor; Dr. Adam Breinig – Dr. Hand motioned, Dr. Didden seconded the motion, vote was taken and all were in favor; Teri Giles – Patricia Pope motioned, Christina Mullins seconded the motion, vote was taken and all were in favor. **The four (4) new additional PHIT members were approved.**

Amy Atkins opened the floor for public comments. Public comments received are below:

Todd Gross with Hampshire County Health Department agreed that the public needs to be involved. Mr. Gross is not against regionalization, he is just concerned with how we are going to do the regionalization; pulling of leadership in each county. Mr. Gross compared local health department staff positions to those in the military ranks. He is a firm believer that local leadership is needed. Mr. Gross referenced disasters, such as the 911 – the need the local response teams. Mr. Gross doesn't want to see localization destroyed; the pulling of local leadership such as the administrators and local health officers.

Bill Ours with Hardy County Health Department wanted the PHIT to keep in mind/consider that a lot of local health departments are in the county commission buildings and receive in-kind support. The regional concept will be hard to come in locally and get resources. As for accreditation, Mr. Ours is not against it, just can't afford it. There are only 75 health departments nationally that are currently accredited. He would like to see the locals and State come together and create our own performance base instead of having someone nationally come in and tell us we are doing a good job.

Dr. Steve Worden is a board member of the Mid-Ohio Valley Health Department (MOVHD). He wanted to encourage the PHIT to have the MOVHD Executive Director speak at an upcoming PHIT meeting. Mid-Ohio Valley is a six (6) county region, formed in 1992. Each county has a facility. The Executive Director visits each county and presents at the county commission meetings. Dr. Worden said regionalization is a reoccurring concern among everyone; he wanted to recommend the MOVHD Executive Director to give a presentation which may provide some insight. They haven't experienced any issues.

Robert White wanted to comment that health care is different across the State. Disparity across the State is PHIT problem. Dr. White believes we can't cookie-cut the solutions, it's going to have to be different across the State.

Lloyd White wanted to comment on the message he got was the value of local public health and the role it plays in society. He feels we need to look at expanding local health, not shrink it. We should take the foundation already established and build upon it. We need to start at local health level.

Delegate Barbara Evans Fleischauer wanted to comment on what Mr. Todd Gross said about disasters; West Virginia had its own – the water crisis. It is important to think of dual roles in health departments including public health responding to disasters. The centralized part of it didn't work very well. The local health department worked well in one county, but not (maybe) in the other eight, cause we didn't hear from them (maybe) due to the centralized focus. Somebody someday needs to study that response.

John Taylor with Grafton-Taylor Board of Health commented he can't see local support if regionalized.

Henry Taylor commented this is a cool discussion. He is observing local health advocacies, ability to customize for local implementation and local health authority. Dr. Taylor said that West Virginia is the only state that has a dual system with the same/common personnel system. The personnel system is already centralized. Federal grants have to be vetted through the State Health Department.

Bill Kearns wanted to comment that he believes in community engagement. Local health departments need guidance. He would like to see local health departments remain focused on standardization and protect their local health employees.

Amy Atkins asked for final comments from the public. None were received.

Patti Hamilton (PHIT member) wanted to share a couple of agenda suggestions. She likes the idea of having the Executive Director of MOVHD give a presentation. She stated that she has no sense as to the individuals that go to health departments. She would like to know who uses health departments, why do they use health departments, and who are health departments supposed to serve. She feels this is a part of community engagement. Also, she likes having the PHIT meetings around the State, but suggested that everyone know in advance to where specific meetings will be held.

PHIT meeting adjourned at 2:49PM.