

Attendees

Task Force Members Present:

Dr. Rahul Gupta, Chair; Amy Atkins; Sandra Ball; Chad Bundy; David Didden; Patti Hamilton; Tim Hazelett; Walt Ivey; Christina Mullins; Vivian Parsons; Danny Scalise; Barb Taylor; Lloyd White; and Anne Williams.

Participated via conference call:

Ted Cheatham; Gregory Hand; Honorable Joe Ellington; Jeff Johnson (representing Senate Health and Human Resources Chair Ryan Ferns); Bill Kearns; Melissa Kinnaird; and Jim Kranz.

Task Force Members Absent:

Dr. Adam Breinig; Terri Giles; Jack McClung; Patricia Pope; Honorable Michael Pushkin; Charles Roskovensky; Andy Skidmore; Chuck Thayer; Honorable Chris Walters; and Stephen Worden.

Community Members Present:

Tina Alvey; Karen Begg; Ashley Butler; Sandra Cochran; Fred Cox; Linda Miller Devine; Vicki Gallaher; Robert Hicks; Susan Hosaflook; Candy Hurd; Deb Koester; John Law; Linda Lipscomb; Drema Mace; Carol McCormick; Randy McCormick; Don McIntyre; Jamie Moore; Sissy Price; Rebecca Schmidt; Brian Skinner; Tom Susman; Stan Walls; Toby Wagoner; and Cindy Wilfong.

Agenda

PHIT Chair, Dr. Rahul Gupta, welcomed everyone to the meeting. All PHIT members introduced themselves.

October 14, 2015 meeting minutes were presented for approval. Danny Scalise motioned to approve the minutes. Anne Williams seconded the motion. Vote was taken and all were in favor. October 14, 2015 meeting minutes were approved.

Dr. Gupta introduced and welcomed the presenters on the agenda, Robert W. Hicks, Deputy Commissioner of Community Health Services and Jennifer L. Mayton, Operations Director for Community Health Services with Virginia Department of Health; and Dr. Charles Devine, Health Director for Lord Fairfax Health District. Mr. Hicks, Ms. Mayton and Dr. Devine presented "Virginia Department of Health: District Structure and Funding." The intent of this presentation was to provide participants with an overview of the Virginia Department of Health's (VDH) structure, communication methods and budget highlights. The mission of the VDH is to protect and promote the health of all people in Virginia and the Department's vision is for Virginia to become the healthiest state in the nation.

The Virginia Department of Health is codified in Section 32.1-2 of Virginia code, as follows: *“the General Assembly finds that the protection, improvement and preservation of the public health and of the environment are essential to the general welfare of the citizens of the Commonwealth. For this reason, the State Board of Health and the State Health Commissioner, assisted by the State Department of Health, shall administer and provide a comprehensive program of preventive, curative, restorative and environmental health services, educate the citizenry in health and environmental matters, develop and implement health resource plans, collect and preserve vital records and health statistics, assist in research, and abate hazards and nuisances to the health and to the environment, both emergency and otherwise, thereby improving the quality of life in the Commonwealth.”*

The Deputy Commissioner directly supervises 33 of 35 district directors and serves as reviewer for 300 district managers. Each district is led by a physician director and managed by a team that includes nursing, environmental, and business managers. District directors also supervise clinicians, pharmacists, dentists, and laboratorians where those services still exist.

The role of the district directors is to serve as a medical and public health resource for private sector, local government officials, and public utility operators; manage operations for Local Health Departments (LHDs) within their district; and carry out authority delegated by the Commissioner and Deputy Commissioner. 75% of directors have a Masters in Public Health (MPH) degree and 66% are board certified in preventive medicine.

The Virginia Department of Health communicates event notifications between the LHDs and the Central Office such as release of information, situations and/or problems, issues that have immediate impact or require immediate action, background information, discussions, recommendations for action, and conclusions. As situations change, the event notifications are updated so that senior leadership is always kept aware of what is happening. In some cases, there is confidential information, so it is limited on how this information is shared. They also use a polycom system, which is a phone and video system. This allows them to have face-to-face messaging without having travel expenses. Almost all of their health districts have at least one room that is equipped with a camera for this system.

For new grant applications, the review process is as follows: The office/district completes the event notification; notification is e-mailed to the Office of the Commissioner (OCOM); OCOM reviews e-mail within 2 business days and approves or denies application; the office/district completes the grant approval form and requests a grant meeting; the grants office sends an approval form to the operations director; the operations director reviews the approval form and approves or denies the application 5 days before the grant submission.

There are 134 cities and counties which are organized into 35 health districts for community health services. District boundaries usually follow planning districts and include as few as one and up to ten cities and/or counties. There is at least one service delivery site in every city and county. Services vary among localities within a district and between districts based on local needs, funding, and private sector capacity. Alternatives for LHD operation are that a locality may enter into a contract with VDH to operate (130 of 134 localities); administer their LHD under

contract to VDH (four of 134 localities); or operate an independent LHD with no state funding (no locality has chosen this option).

The philosophy behind LHDs in Virginia is that LHDs are a partnership between state and local governments; LHDs work closely with private sector health care providers and systems; there are an array of LHD services which vary based on local need; flexibility is preserved for LHDs on how to improve community health while assuring compliance with policy, regulation, and law; and partnership is the key.

The strengths of Virginia's public health system are local health districts in every city and county that provide basic public health services; joint state and local funding of local health districts; interdisciplinary management of districts; flexibility to adapt to local needs; and public-private partnerships to improve health.

Local health district services are provided in every LHD and include communicable disease control, family planning, inspection of public establishments that serve food, permitting of onsite sewage disposal and well construction, and emergency preparedness and response. There are a limited number of districts that provide pharmacy, lab, and general medical services.

Most districts have more than one of the following models depending on service and community capacity: LHD staff provides services directly to clients; LHD provides services with individual provider contracts or through agreements with non-profits; LHD provides initial service then hands-off to private sector; or, LHD collaborates with private sector to assure service.

Prior to the creation of the existing system, all parts of Virginia did not have access to basic public health services throughout the state, including control of communicable diseases and immunizations. Cities tended to have more established, better funded public health services. Rural areas had a limited tax base and could not afford to establish more comprehensive public health services. 88% of the VDH budget is spent in local communities. In fiscal year 2008, \$535,427,433 was spent on VDH funding & staffing whereas \$638,605,455 has been spent in fiscal year 2016.

LHD funding streams include state funds appropriated by the General Assembly; local matching funds appropriated by local governments based on an ability to pay formula developed by the Joint Legislative Audit and Review Committee (JLARC); 100% of local funds above the match requirement; revenue earned from services delivered; and federal grant funds that are primarily categorical in nature. The district average of cooperative budget percentage of shared cost between state and local funding, excluding self-generated revenue, is 58.237% state general fund share and 41.763% local government share. Self-generated revenue (revenue generated by charging patients for services), varies from 11.8% to 18.3% for the counties in the Lord Fairfax District. Dr. Devine said ten years ago, this revenue would not have been there but a large part of their budget in this district is money the District earns through services.

PHIT Chair, Dr. Rahul Gupta, opened the floor for discussion/questions from PHIT members on the Virginia Department of Health presentation (see Questions and Answers section at the end of the minutes).

No further questions/comments from the PHIT members were presented in regards to the presentation on the Virginia Department of Health.

PHIT Chair, Dr. Rahul Gupta, requested updates from the workgroups. For the Better Quality Workgroup, Dr. Gregory Hand said they are looking at different types of state accreditation and involuntary natural accreditation that came on in 2011. The Workgroup is looking at accreditation in terms of how to improve quality across the state, drive performance, how to get out of the box of current efforts. There are now 28 states that have some involuntary natural accreditation. Within those states, there are eight state health departments that are accredited and all of WV's bordering states now have accredited local health departments. The workgroup plans to begin working on a recommendation soon.

Dr. Gupta reminded the Task Force members that recommendations could be entertained today or at the next meeting on December 9th in Charleston and for workgroups to be aware of that timeline.

For the Community Engagement Workgroup, Tim Hazelett said they will be ready to present something on December 9th.

Dr. Gupta mentioned that the Bureau had been invited to meet with the West Virginia Association of Local Health Departments on November 5th to hear about key concepts from the Association related to public health systems change. The Bureau will also be reaching out between November 5th and December 9th to different workgroups with the intent that the proposal on December 9th will have been vetted by/discussed with the workgroups.

For the Better Health Workgroup, Danny Scalise handed out a document, created by his workgroup, which described a recommendation for a minimum package of health services. The minimum package included environmental health (including food and general sanitation, lodging, child care and facility inspections); chronic disease and prevention (including obesity, tobacco, substance abuse, alcohol abuse and diabetes prevention); communicable reportable disease; and emergency preparedness. Mr. Scalise also highlighted cross-cutting capabilities/capacity needs that span all services in the package including epidemiology/assessment, accreditation and data and reporting. Mr. Scalise stated that the document was purposefully broad and lacking in detail in order to promote discussion. Lloyd White, a member of the workgroup, stated that the group had discussed family planning services and that he supported the inclusion of family planning as a basic service. Anne Williams said that since the expansion of Medicaid in West Virginia there have been significant declines in Title 10 Family Planning Services. However, it is not certain where/to what extent these services are being accessed outside the public health system. Ms. Williams said her biggest concern is the confidentiality aspect for services for minors because without the Title 10 funding, that umbrella is not there. Christina Mullins said that the minor population is not decreasing as much as the older population. Anne Williams said the other piece is that historically family planning services have been considered an enhanced rather than an essential public health service in West Virginia. Anne Williams said that community health promotion needs to be added. Amy Atkins said that one of the things they have been doing in the Affordable Public Health Workgroup is talking and looking at the ways in which states are framing their minimum package and in terms of WV, health promotion is really about

mobilization and engagement. In terms of community health promotion, you see that in the prerequisite of assessment as part of the cross-cutting capabilities/capacity that must be in place to assure provision of the services. Dr. Gupta said we have been working on a State Improvement Method (SIM) and there are 3 buckets: obesity, tobacco and substance abuse/behavioral health. What is being presented in SIM through the Health Innovations Collaborative is the design of a state obesity and state tobacco plan. There is a lot of work that is going into that already and that is just leveraging what is part of public health. It is a cross-cutting measure.

Jeff Johnson stated that he wasn't given any notes or opportunities to participate in the workgroup and had not had an opportunity to review the handout. Mr. Scalise apologized.

For the Affordable Public Health Workgroup, Amy Atkins said that one of the things their workgroup has been doing is meeting to get their arms around what is the current code and rule and the current standards of a definition of basic public health services to make sure our group had a good sense of where there are opportunities and limitations. At the most recent meeting, the discussion shifted to learning where there are some opportunities in looking at the Institute of Medicine report related to minimum package, NACCHO's minimum package and looking at other states to compare how WV defines basic public health services and how West Virginia aligns with the national picture. Four areas were discussed in the most recent workgroup meeting:

1. West Virginia's need to align with national recommendations by developing a minimum package
2. The importance of all local health departments having access to the skills and tools necessary to deliver the minimum package (capacity).
3. The need to define capacity requirements – what skills and tools are needed?
4. General structure and how decisions of the structure of local public health should be based upon the ability to efficiently and effectively provide the minimum package of services. What factors should be considered? We have heard through some of the PHITF presentations that economies of scales and population might be factors as well as financial capacity. However, that is an important discussion to have and the workgroup recognizes there are a lot of intricacies in how you balance state and local agency's needs.

PHIT Chair Dr. Rahul Gupta asked for any other questions or comments from the Task Force members. None were received.

PHIT Chair, Dr. Rahul Gupta opened the floor to the public for comments.

Dr. Drema Mace, Director of the Mid-Ohio Valley Health Department, asked the Task Force to consider the following when looking at the Virginia model:

- 1) What the grant approval system in Virginia does to indirect costs and how it affects the local model.
- 2) Whether there are any problems with subrecipient awards when you are looking at local funding.
- 3) Concern that WV local governments could not match state funds.

- 4) How district employees work with other federally funded organizations that receive state funding like FQHC's and the free clinics.

Tom Susman with the WV Association of Local Health Departments said that it seems that local health departments in Virginia are getting a greater amount of federal funding than local health departments in West Virginia.

PHIT Chair, Dr. Rahul Gupta, asked for final comments from the public. None were received.

PHIT Chair, Dr. Rahul Gupta, informed everyone the next meeting will be held on December 9th and asked if we have a location yet. Amy Atkins stated that she believes it will be at the University of Charleston.

Meeting adjourned at 2:30pm.