

Attendees

Task Force Members Present:

Dr. Rahul Gupta, Chair; Ted Cheatham; House of Delegates Health and Human Resources Member Michael Pushkin; Christina Mullins; Melissa Kinnaird; Danny Scalise; Chuck Thayer; Sandra Ball; Tim Hazelett; Chad Bundy; Dr. David Didden; Nancy Cartmill (representing Vivian Parsons); Walt Ivey; Barbara Taylor; Amy Atkins; Patricia Pope; Carrie Hill (representing Patti Hamilton) and Anne Williams.

Participated via conference call:

Charles Roskovensky (representing House of Delegates Health and Human Resources Chair Joe Ellington); Jeff Johnson (representing Senate Health and Human Resources Chair Ryan Ferns); and Dr. Gregory Hand.

Task Force Members Absent:

Jim Kranz; Deputy Secretary Jeremiah Samples; Andy Skidmore; Senate Finance Vice-Chair Chris Walters; and Dr. Stephen Worden.

Community Members Present:

Wendy Casto; Susan Hosaflook; Margaret Howe; Sissy Price; Boyd VanHorn; Lloyd White; Jesse Rose, III; Fred Cox; Stanley Mills; Carol McCormick; Lolita Kirk; Dr. Arthur Rubin; John Law; Ashley Butler; Ron Forren; Genevieve Ruble; Rodney Boyce; Amanda McCarty; Drema Mace; Diana Riddle; Tracey Sebastian; Jackie Huff; Sandra Cochran; Stan Walls; Meike Schleiff; Lee Smith; Denise Knoebel; Tom Simms; Annette Santilli; Dr. Michael Kilkenny; Deb Koester; Toby Wagoner; Gloria Thompson; Andrea Fisher; and Brian Skinner.

Agenda

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

April 29, 2015 meeting minutes were presented for approval. Andrea Fisher reported a change was recommended by a Task Force member to add the legislative committee chair title to the Legislative members represented. Danny Scalise motioned to approve the April 29, 2015 minutes with the noted corrections. Christina Mullins seconded the motion. Vote was taken and all were in favor. **April 29, 2015 meeting minutes were approved.**

Chad Bundy, President of the WV Association of Local Health Departments/Executive Director, Harrison-Clarksburg Health Department provided a presentation on ***The Local Governmental Public Health System***. The presentation gave an overview of local health and the Association. Background of local health control and authority was discussed. Local health authority is formed on the statute of WV Code 16-2-3; 16-2-7; and 16-2-11. Presentation continued with the roles/responsibilities which include Community Health Promotion; Environmental Health Protection; and Communicable or Reportable Disease Prevention and Control. The local structure and staffing of local health departments was presented and the number of staff

depends on the individual health department and population. An overview of services provided by local health departments was provided. Complaints received in the local health departments must be investigated and the biggest portion is inspection of food establishments. Chad Bundy noted West Virginia now has labor camps. These are brought to us by the oil and gas industry. The projected budget and expenditures for FY2015 per chart in presentation was discussed. Budgets are approved by the Board of Local Health then sent to the Center for Local Health (CLH). Program plans are due on or around April 15th each year. With the Affordance Care Act (ACA), there is less and less grant funding. Chad Bundy continued presentation with the value of partnerships. Important to have personal relationships in the community – problems arise you can call the responsible individual directly. He encouraged the Task Force to keep local control and authority – keeps local health departments at the table.

Ted Cheatham asked if Boards of Health have to provide services by a doctor or nurse? Chad replied that Boards of Health are not required to provide services, however they need to make sure services are available. Ted Cheatham inquired about reserves or the other budget line item on the chart. Chad Bundy explained each local health department is different – some have a reserve, some operate on a month to month basis. Patricia Pope asked what source or category does the federal revenue come from? Chad replied that most revenue comes from threat preparedness grants.

After short recess, Chuck Thayer, Deputy Commissioner, Administration, Bureau for Public Health, presented ***The West Virginia Bureau for Public Health***. The presentation included the diverse scope, mission, vision and programs of the Bureau and how it links to communities and services. Chuck Thayer shared the Bureau's organizational chart. A copy of the org chart will be placed on the PHIT website. The Bureau has mandates that range from programmatic, legislative and federal to provide very specific services, regulations and work across an entire life span of a person's life and which touches each person at some point of their life. There are 130 independent programs at any given time in the Bureau. The Bureau's charge/challenge is to move those through the entire State of West Virginia consistently and effectively. The Bureau has a diverse workforce with a wide range of specialist.

Chuck Thayer discussed public health evolution. Systems are changing and the nature of partnerships is changing. Public health has changed and West Virginia needs to catch up. The ACA has forced us to relook at the way we look at the world. Federal funding requirements are shifting to performance and outcomes versus process. Almost 50% of the Bureau's funding comes from federal sources. The Bureau's goal is to reduce administration costs to get more of the dollars out to meet our goals. The Bureau has seen a decrease in funds for threat preparedness, tuberculosis (TB), chronic disease programs, and immunizations since 2010. The Bureau is expecting additional funding cuts in the Family Planning Program, Breast and Cervical Cancer Screening Program, TB, and vaccine programs. Requirements in federal funding is changing; driving towards accountability, rigorous monitoring of dollars going out to programs and increases in performance evaluations. The Bureau's administrative costs are about 20%. The goal is to reduce that number so more dollars go out to the communities. The goal is to drive administration cost down in the State which will translate locally as well.

Chuck Thayer discussed the importance of relying on partnerships. He discussed some of the services provided to West Virginia residents such as comprehensive laboratory services, protection from adverse environmental factors, chief medical examiner, support from maternal, child and family health, access to health care in rural communities, comprehensive statewide epidemiological services, emergency medical services, and reduction in the incidence of preventable diseases and death. Chuck Thayer gave a brief overview of the offices and centers within the Bureau.

Chuck Thayer spoke about the focus being on higher level systems and policy change, environment change, a health in all policies approach. Community coordinated care linkages are areas of focus with health care providers linked with public health programs and mutual referral systems back and forth between programs. Meaningful and regularly updated performance measures are required for all programs with the Bureau. Chuck Thayer concluded his presentation by stating that the Bureau must provide consistency to all counties and to have a system that is sustainable and is in context with these changes and expectations as well as adjust to future changes.

Dr. Didden asked about the service delivery of home visitation. He wanted to know if any of those services are provided by local health departments. Christina Mullins, Director of the Office of Maternal, Child and Family Health, which houses the WV Home Visitation Program, replied that services are typically provided by other local community agencies.

Amy Atkins, Director, Center for Local Health, explained the role of the Center for Local Health. CLH services as a liaison between the Bureau and the 49 boards of health/local health departments. Amy Atkins acknowledged there are system challenges and the information shared will illustrate one example. She reviewed the funding structure in response to an early question by a Task Force member. The State allocation is 16.6 million. There is a specific formula that guides the way the money is distributed; 15.7 million is distributed to local health departments. The Emergency Fund is up to 2% of the total. 4.7% provides for support to local health departments. Funds are distributed by a formula that includes a base and a weighted per capita allocation based on health need factors. CLH's duty is to monitor health department operations. We work with the agencies to communicate findings so that they can take appropriate action. We are a decentralized system w/ a centralized mission. We are as strong as our weakest link. The Center has seen trends in financial indicators that reveal disparities among the LHDs in terms of operations. Amy Atkins reported that 19 local health departments have published audits with operating deficits, eight of those have published audits with operating deficits from the past three years and eleven of those 19 have less than three months cash/cash equivalents on hand. These figures were similar even when estimates of OPEB liability were removed.

Ted Cheatham reported that the Governmental Accounting Standards Board (GASB) is changing the way retirement boards report out retirement liability. Next year it will be listed individually rather than carrying it currently. Correct to pull OPEB liability out. The picture will look much worse on paper next year.

Amy stated that we are one public health system. System is defined in three pieces in West Virginia; 1) governing body (oversight of local board of health and other function related to policy/partnership development; 2) administration (response for developing programs, implementing programs and ensuring compliance; 3) services (have to be delivered throughout state basic public health services).

The Bureau's role is to assure service delivery to all communities and to monitor and provide feedback to local health departments. The parameters under which we assure services are limited. We do not have a clear line of sight on the details of agency operations and this poses challenges.

Tim Hazelett requested the opportunity to look at the operating budgets of the 19 local health departments in the slide presentation to assess what is being looked at to compare budgets. Mr. Hazelett would like to see what the issues.

PHIT Chairman, Dr. Gupta, stated it would be no problem to provide these reports. These are publicly available audit reports. Copies will be sent to the PHIT members prior to the next meeting for review. Members can discuss at the next meeting.

Brian Skinner provided overview of the establishment of the state public health system. The Legislature established the public health system into two separate systems that work in conjunction with each other. A lot of overlap exists with each system's duties. Brian Skinner described the powers and duties of the Local Boards of Health and the State of West Virginia. He stated that the current structure has existed since the end of World War I. The State basically acts as the conduit for funding. Powers and duties are both governed by law. The State Education system has a similar model in terms of structure; there is a State Board of Education, then each county has a County Board of Education. There is a difference in terms of where that structure came from. It's a constitutional right to an education. There have been instances where the County Board of Education has been deficient and the State has had to step in. The public health code is not that explicit.

PHIT Chair, Dr. Gupta, opened floor for questions/comments by the PHIT members.

Ted Cheatham asked if the PHIT can recommend to the Bureau where it thinks the Bureau needs to go and commit resources and/or potentially where funding of ineffective use at the local level should stop? Brian Skinner replied, currently and per terms of statutory framework, the Bureau can only do what is authorized to do by the law. Chad Bundy asked who defines a public health emergency. Brian Skinner replied that Local Board of Health has a duty to work with the Commissioner/State Health Officer in a case of a public health emergency which can be defined by the State Health Officer or Governor. If it fails or refuses to enforce public health law, the State Health Officer can remove members of the Board and/or the Local Health Officer for failing or refusing. PHIT Chair, Dr. Gupta, asked a question in regards to the operational deficit of the 19 local health departments referred to in Amy Atkins' presentation. He wanted to know what would be the ability of the State Health Officer at that point (operational deficit) in the law to make changes happen. Brian Skinner replied that currently the ability in the law to make changes happen is very limited. The State Health Officer could remove local funds, but that would jeopardize the services provided to the constituents. There are no other options.

Tim Hazelett wanted to clarify the statement mentioned earlier by Chuck Thayer specific to the Community Transformation Grant in terms of the collaboration between the Bureau and local health. Chuck Thayer clarified that it was a difficult managing the federal requirements but the relationship with partners went well.

PHIT Chair, Dr. Gupta, stated that public health is a complex multitude of agencies and partnerships that collaborate, not just at local and state level. We are all part of the big system.

No other questions received from the PHIT members.

PHIT Chair, Dr. Gupta, opened floor for public comments. Public comments received are below:

Ashley Butler – Greenbrier County Health Department – stated that in-kind support wasn't considered when looking, in particular, at county funding/state funding. In-kind support that health departments receive is not being considered. A lot of counties receive their facilities thru their respective county; don't have to pay rent – given a place to operate. If that county support was removed, health departments (in particular Greenbrier County) would have to find their own place to operate. PHIT needs to consider in-kind support as well in addition to county dollars.

Boyd Vanhorn – Grafton-Taylor County Health Department requested clarification regarding whether the 9% of the funding to local health from the Bureau represented the total. Chuck stated that it did not include subrecipient agreements. Mr. Vanhorn stated that his health department is one of four that has a home health agency and has seen a 400% increase in growth and does not know the reason for that but it may be the county knows and trusts the health department. Local control authority anatomy allows us to provide this level of service. When he became Administrator he was charged with two things 1) save home health and 2) build a new health facility for the county. The autonomy has given them the opportunity to complete the charge. They have already bought property with local funding available for development.

Lloyd White – Marion County Health Department stated that all presentations were very informative. If there are a percentage of local health departments failing, how did we get there? If Director Atkins' office is tasked with monitoring finances of local health then how did we get here? As for emergency funding, as a member of the committee we have not received an application for emergency funding. If in fact the problem is as it's perceived, why hasn't an application been received requesting support? We need to look at operational budgets prior to making assessments and what data is being used to make assessments. Local health is not like the Board of Education, if they factor in liability, how many would be operating with a deficit?

PHIT Chair, Dr. Gupta, assured Mr. White that any info shared with Mr. Bundy will also be shared with him as well.

PHIT Chair, Dr. Gupta, shared the next steps. The PHIT members were asked for any feedback as to how the meetings are being conducted/venue, etc. Is there anything that could be done differently or changed? Are the members satisfied with things as is? No comments were received.

CLH will try to hold some meetings at different locations around the State. Members also have the option of participating via conference call. The first two meetings were to really talk about the public health system and to understand the state of public health in West Virginia. Everyone's attendance and participation is appreciated. All questions are welcomed.

Tim Hazelett noted that anything the PHIT members could receive for review prior to the scheduled meetings would be extremely helpful. He wants to research how much money is spent per capita per person in West Virginia on public health. How much does it cost us to be such a sick state? Part of our task is to understand the balance between the dollars we have and how sick we are. How much is it going to cost in five years? Need to look at the system, how much do we spend and the impact of what's spent. How do we ensure PHIT changes impact in a positive manner? PHIT Chair, Dr. Gupta, noted that CLH will get out the info as soon as possible.

PHIT Chair, Dr. Gupta, also wanted to be sure everyone was aware that meeting information and contents are available on the website. If individuals, agencies, institutions, etc. have ideas/proposals on the public health system (anything different), submit it to the website to be brought forth to PHIT for consideration. This is a very open process and we are looking to develop solutions. We know what's not working; we now need to know how to change. Ideas are encouraged.

PHIT Chair, Dr. Gupta, asked for any final comments. None were received.

Danny Scalise motioned to adjourn meeting; motion seconded by Ted Cheatham. PHIT meeting adjourned at 12:00pm (Noon).