

Attendees

Task Force Members Present:

Dr. Rahul Gupta, Chair; Christina Mullins; Danny Scalise; Chuck Thayer; Tim Hazelett; Chad Bundy; Dr. David Didden; Walt Ivey; Amy Atkins; Patricia Pope; Patti Hamilton; Anne Williams; Deputy Secretary Jeremiah Samples; Melissa Kinnaird; Barb Taylor; House of Delegates Health and Human Resources Member Michael Pushkin; Jim Kranz; Sandra Ball; Lloyd White; and Bill Kearns.

Participated via conference call:

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

Task Force Members Absent:

Ted Cheatham; Dr. Gregory Hand; Vivian Parsons; Andy Skidmore; Senate Finance Vice-Chair Chris Walters; Dr. Steve Worden; and Teri Giles.

Community Members Present:

Sissy Price; Karen Begg; Stan Walls; Meike Schleiff; Lee Smith; James Moore; Michael Kilkenny; Andrea Fisher; Linda Lipscomb; Brian Skinner; Toby Wagoner; Gloria Thompson; David Stone; Drema Mace; Casey Napier; John Law; Lolita Kirk; Michael Brumage; Nikki Dolan; Ashley Butler; Susan Hosaflook; Deb Koester; Rodney Boyce; Julie Mundell; and Sandra Begg.

Agenda

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

July 15, 2015 meeting minutes were presented for approval. Jim Kranz motioned to approve the minutes. Christina Mullins seconded the motion. Vote was taken and all were in favor. **July 15, 2015 meeting minutes were approved.**

PHIT Chair, Dr. Rahul Gupta, introduced the two presenters for the meeting – David Stone, Education Specialist, Public Health Accreditation Board and Brian Skinner, General Counsel/Director of Public Health Regulation, Bureau for Public Health. Presentation topic included National and State Public Health Agency Standards.

First presenter on the agenda was David Stone, Public Health Accreditation Board (PHAB). Mr. Stone's presentation was entitled "*Accreditation, What's It All About? - It's An Investment*". Mr. Stone provided background on accreditation. At one time, there were 23 states working on their own individual accreditation process. The Institute of Medicine created a steering committee to examine the benefits of accrediting governmental public health departments nationally. The goal was to determine if there was a desire and if it was feasible. The end results determined it was desirable and feasible to establish a national program; thus the PHAB was chartered in

2007. The process was launched in September 2011 with the first health departments being accredited in February 2013. To date, there are 79 accredited departments across the country with 250 in process.

The accreditation process is voluntary. Currently, the State of Ohio passed legislation that all their local health departments will have to be accredited by 2020.

PHAB's goal is to improve and protect the health of the public by advancing and ultimately transforming the quality and performance of state, local, tribal and territorial public health departments. An accreditation program looks at the following aspects: 1) set of developed standards; 2) some type of assessment against those standards; 3) independent board(s) award/decision based on how the assessment goes either gives accreditation or not; and 4) idea of quality improvement (QI) throughout the process. Accreditation looks at leadership, planning, community engagement, customer focus, workforce development, evaluation and QI and governance.

Mr. Stone referenced the PHAB logic map, *Public Health Agency Accreditation System* (handout). On the map, Mr. Stone wanted to focus on what health departments will benefit 1) public health agencies more effectively and efficiently use resources; 2) strengthened organizational capacity and workforce; and 3) improved responsiveness to community priorities.

There is a seven step process towards accreditation: 1) Pre-application; 2) Application; 3) Document Selection and Submission; 4) Site Visit; 5) Accreditation Decision; 6) Reports and 7) Reaccreditation. Documentation takes place in all steps. Applicants can be accredited or have an action plan. 40% of all applicants receive an action plan. Usually an action plan requires further work to do on documentation. Applicant names are kept confidential and action plans are **not** made public. At the end of the process, only information given out is if you were accredited or not. The top three pre-requisites are 1) must have a community health assessment and all documentation around that; 2) must have a community health improvement plan and all documentation around that; and 3) must have a departmental strategic plan and all documentation around that. All must be finished and in place when you apply. The QI plan must link to the strategic plan.

Within the standards and measures are three other plans, workforce development; risk communication; and emergency operations. Those submitted as well with all documentation around them.

Guide to accreditation is available – version 1.0. However, the guide was revised in June 2015 version 2.0 was passed by the Board. The accreditation process is entirely paperless; everything is performed online. PHAB's website is www.phaboard.org.

There are principals behind the standards and measures that guide the whole process of development and implementation and what to hope to receive through the standards and measures. The principals of standards are advance public health, moderate level, be clear, QI, apply to all health departments, establish same standards, reflective of emerging issues and promote partnerships.

Fees are based on size of jurisdiction. The process includes resources, time and fees. Fees have been the same since 2011. Fees are anticipated to increase in about two years. Fees cover an assigned accreditation specialist, site visit, applicant training, access to the information system, annual support and network of accredited health departments.

PHIT Chair, Dr. Rahul Gupta, opened the floor for discussion/questions from PHIT members on Mr. Stone's presentation on accreditation.

Danny Scalise asked since there is a lot associated with accreditation like man hours and cost involved with fees, are you finding smaller health departments are having an issue or are you finding a mix of smaller and larger? Mr. Stone replied, both. The largest department has a jurisdiction of 38 million and the smallest has a jurisdiction of 7,000. There is a mix; most in the system are mid-size between 50,000-150,000. PHAB is currently working on a set of standards for small departments.

Jeremiah Samples asked when the set of standards for the smaller departments are anticipated to be released. Mr. Stone replied that the body of work on these standards will begin in November. He doesn't know how long it will take; his best guess is we won't see anything before two years.

PHIT Chair, Dr. Rahul Gupta, mentioned about a year and a half ago the Institute of Medicine (IOM) came out with the minimum package of services. Can you explain the difference between a minimum package and accreditation? Per Mr. Stone, PHAB is performing a crosswalk to look at the foundational capabilities package that every health department has and should have and be funded for this based on line of services. The crosswalk finds this goes well together. Part of foundation is the administration aspect of running a quality department. It looks at the kind of package and how links; not having two bodies of work. Idea is that anything in one supports the other.

Lloyd White wanted to know when it makes a difference – benefits vs. cost. Mr. Stone replied that PHAB hopes to know more by the end of next year. PHAB's fiscal year runs July – June. PHAB should know more in June 2016 when it begins to see what departments are seeing since being accredited back in 2013.

Danny Scalise asked if PHAB was involved with State of Ohio policy makers in discussions to mandate accreditation by 2020. Mr. Stone replied – No. PHAB was not involved. Ohio did this all on its own.

Jeremiah Samples stated that Mr. Stone indicated over the next couple of years PHAB is developing standards for small local health departments, he asked if the fee schedule will change to reflect small health departments. Mr. Stone replied he wasn't for sure since it hasn't been developed, but his assumption is yes. The process shouldn't be that intensive, some costs will be the same, trainings, etc., others not expected to be. There will be a different fee schedule.

Dr. Didden asked if PHAB is considering any options for smaller departments to collaborate for the process and reduce the fees. Mr. Stone replied, Yes - It is currently available. It's called multi-jurisdictional. This is where departments that are not part of the same governmental unit, not district, work together and collaborate their services. Note for ones considering this to be sure to document relationship.

Bill Kearns asked if it would be better to have a combined board of health before venturing with that process. At least you would have same guidelines followed between the counties. Mr. Stone replied that it depends on what the relationship is governmentally. As far as multi-jurisdiction, you have still separate entities you would have to show documentation as it relates to all the combined boards of health and how they understand what their departments are doing. You could have a MOU in place. MOUs are acceptable.

Patti Hamilton asked how long accreditation was good for. Mr. Stone replied five years from the time you are assigned the status.

Mr. Stone shared with PHIT members that the accreditation approval committee is currently working on the reaccreditation process. He doesn't know a lot about that process yet. Mr. Stone said that departments will receive notice prior to their expiration and long as in process, still accredited until the process is complete.

Sandra Ball wanted to know what the fees were for reaccreditation. Mr. Stone said that this is part of the process and unclear at this time. The fee structure could change depending on the process. Currently whatever fee schedule is in place when you apply is what you will pay.

Mr. Stone added that for 2013, reaccreditation isn't necessary until 2018. There is still time.

No other questions/comments from the PHIT members were presented in regards to Mr. Stone's presentation on accreditation.

PHIT Chair, Dr. Rahul Gupta, opened the floor for discussion/questions from the public on Mr. Stone's presentation on accreditation.

Drema Mace asked about the payment process. Mr. Stone replied that there are three ways to pay – pay the entire amount at once, 3 year payment plan, or 5 year payment plan. Once you pay whatever the fee is, you are done until you apply for reaccredited. It takes 18 months to go thru the accreditation process and you are accredited for five years.

No further questions/comments from the public were presented in regards to Mr. Stone's presentation on accreditation.

PHIT Chair, Dr. Rahul Gupta, introduced BPH General Counsel Brian Skinner to discuss West Virginia performance standards. Mr. Skinner wanted to give a basic idea of what standards apply under law. (*Handout*)

Mr. Skinner's presentation provided an overview of West Virginia Public Policy and a description of the essential public health services which is in WV Code §16-1-1 (*State's responsibility to assist in the provision of essential public health services.*)

Mr. Skinner reviewed the powers and duties of the Commissioner.

Mr. Skinner noted that rule making authority is of the Secretary of DHHR (*The Secretary of DHHR is authorized to propose rules necessary and proper to effectuate the purposes of Chapter 16 – WV Code §16-1-4.*)

Mr. Skinner noted that the standards of the local boards of health predates to 1996. Chapter 16 established the uniform provisions. Prior to 2000, there are two articles that address how local boards of health could be organized; one actually goes back to the 1880's. In 1950's there was an article 2-A that set up an alternative method for organizing the board and in 2000 already organized and put together and is what we have now. Interesting is the standards of the boards of health predates the statute of change.

He reviewed the standards as related to local boards of health. Local boards of health are to provide the basic public health services and programs in accordance with State Code §16-2-11. Basic public health services are those services that are necessary to protect the health of the public and that a local board of health must provide. The three areas of basic public health services are communicable and reportable disease prevention and control; community health promotion; and environmental health protection.

He provided an overview of the requirements such as organization, health services and programs, reports and records, general administration, financial management, physical facilities, program plan, penalties for non-compliance, and distribution of state funds for support. Provisions exist such as how often local boards of health have to meet, requirements of bi-laws, maintain a case reserve equal to at least three months' operating expenditures of the local health department; building and grounds of the local health department shall have one or more outside signs which clearly identify the department and the board shall establish a policy prohibiting smoking or the use of smokeless tobacco in the local health department, etc. It also provided for the program plan requirements which have been around since 1996.

Mr. Skinner reviewed program plans. A general plan of operation must be submitted to the Commissioner for approval if it receives any state or federal money for health purposes. The program plan is submitted annually and must comply with the provisions of the local board of health standards administrative rule. The Commissioner may withhold all or any part of any funds until a local board of health submits an acceptable plan to correct deficiencies in the local board's program plan.

Prior to 2000, there was a reference in code that the operational plan had to be in place to receive state funds. Provisions have been around since 1996; content is general. Also director is referred to which actually is the Commissioner.

Mr. Skinner provided an overview of the distribution of state funds for support of local boards of health. There is a nine step process. Additionally, there are emergency funds to assist local boards to escape financial emergencies if needed.

Standards were adopted about the same time of reorganization of the code in 2000. There are 36 standards under communication and reportable disease, 3 standards under community health promotion, 26 under environmental health protection, 33 under administrative and 9 under financial. All have objective measures and are identified to provide guidance to local boards. Mr. Skinner provided a general overview of what is in the standards.

Mr. Skinner listed the requirements that entities which accept federal monies must meet.

In conclusion Mr. Skinner's goal was to provide an idea of requirements placed on the local boards and the Bureau. It all starts with Chapter 16 - article 1 sets out with the authority of the Bureau and 2 devoted to administration of local boards.

PHIT Chair, Dr. Rahul Gupta, opened the floor for discussion/questions from PHIT members on Mr. Skinner's presentation.

Danny Scalise asked, in Mr. Skinner's opinion, do the standards own up to the 21st Century with what public health has to deal with. Mr. Skinner replied that he feels he is not the best one to answer that, but standards were developed in 2000 which makes them at least 15 years old. Another interesting finding is it provides standards but not many measures.

PHIT Chair, Dr. Rahul Gupta, added that the standards and rules booklet is around 105 pages. In lieu of making copies of the booklet for each member, he will have a couple of booklets made to share at the next meeting.

Patti Hamilton referred to the word "monitor" which is used in the code. Does the State monitor the meeting of the standards? Mr. Skinner replied, yes. In a previous PHIT meeting, he reviewed what authority the Commissioner had as it related to local boards. It's not particularly robust, but provided monitoring of compliance. Commissioner can step in if boards are not

enforcing public health law. In terms of everyday operation, not a lot of authority but can look at program plans. If program plans are found not acceptable, Commissioner can hold funding.

Dr. Didden had a question about the formula for relocation of state funds. That incentive for consolidation – given weight of 15% in the formula – can you give an example of what that means in dollars? Amy replied, she ran examples and it came out to about \$10,000 but there are other factors to consider. When you combine jurisdictions, those other mean factors, depending on what they are, influence the amount as well.

Chad Bundy stated there was no clear definition of what an emergency is. He wanted to know if local health departments fail to meet some of the standards and public health services were not being delivered, can that be defined as an emergency. Mr. Skinner said at some point that may be true, but code is really looking at it in the situation where there is a public health emergency. Mr. Skinner added that if a local board was not providing basic public health services, the Commissioner could step in. PHIT Chair, Dr. Rahul Gupta, added that this is reactive in nature not proactive. It's not actually challenges that the boards face. It has to be where people are actually suffering when it comes to an emergency.

No other questions/comments from the PHIT members were presented in regards to Mr. Skinner's presentation.

PHIT Chair, Dr. Rahul Gupta, opened the floor for discussion/questions from the public on Mr. Skinner's presentation.

Drema Mace commented in community health assessments that are required, the Commissioner is empowered to ensure whether legislation is changed or not. She feels the current legislation empowers the Commissioner a lot.

No other questions/comments from the public were presented in regards to Mr. Skinner's presentation.

PHIT Chair, Dr. Rahul Gupta, requested to hear updates from the workgroups. Better Health, Better Quality, and Affordable Public Health workgroups did not have updates to share; will report at next meeting. Community Engagement reported the workgroup continues to meet regularly. The group was looking forward to hearing the PHAB presentation. The workgroup is currently reviewing models and will have more to report at the next meeting.

PHIT Chair, Dr. Rahul Gupta, commented that one of the results from the PHIT survey was the challenge of insufficient time for the process. Meike Schleiff is working on a second version of the survey. This survey should be able to get the timeline expected from the group. The survey will have questions related to the timeline. The survey will be released within the next week or so.

PHIT Chair, Dr. Rahul Gupta, introduced Meike Schleiff. Ms. Schleiff, Amy Atkins and Dr. Henry Taylor have been looking at possibilities to assist the PHIT with a common platform for collaboration and discussions between the working groups and members. The platform called Ningsite was introduced to the PHIT members. Ms. Schleiff showed a layout of the site on the projector. She explained the functions of the site (tabs include: home, calendar, learning communities, profiles, chat, managing groups, and manage). This site will be branded with the Center for Local Health website. Ms. Schleiff is opened for suggestions. This would only be opened to the PHIT members and individuals the members would like to add.

PHIT Chair, Dr. Rahul Gupta, opened the floor for discussion/questions from the PHIT for Meike Schleiff.

Chuck Thayer asked how many users it can support at a given time. Meike Schleiff replied that she wasn't sure of the exact number, but knows it's in the 100s. It would not max out.

Lloyd White wanted to verify that it would not be available to the public? Ms. Schleiff replied, yes you are correct. In order to access the site, you would have to log on. It would be only for PHIT members and individuals that the members would like to grant access. There could be a possible way to have a public front added as well. The Center for Local Health website should be used by the public to obtain information on PHIT.

Tim Hazelett wanted to know how this rolls into the open government meeting act. Brian Skinner commented there is no concern. It's just a platform for communications. It's just like the workgroup meetings.

Tim Hazelett wanted to express he feels the biggest challenge is the timeframe. PHIT Chair, Dr. Rahul Gupta, wanted to reiterate that this taskforce is everyone's taskforce. There is no rush. The follow-up survey will allow the opportunity to see what PHIT members feel the timeframe should be. We will move forward with the group consensus.

Lloyd White asked Dr. Gupta to identify the problem that we should be working on. What is the end result? Dr. Gupta suggested that all new members receive the link to the Center for Local Health website where every presentation, agenda, meeting minutes, etc. is located. By accessing the website/documents, the new members will be aware of the work/discussions to date. Dr. Gupta also suggested each new member receive a hard copy of all documents.

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 in Wheeling, WV on September 2, 2015 at the same time (12:30pm-2:30pm). Folks from the State of Ohio have been invited to present/speak.

Chuck Thayer motioned to adjourn meeting; motion seconded by Dr. Didden. PHIT meeting adjourned at 2:21pm.