

## **Attendees**

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### Task Force Members Present:

Dr. Rahul Gupta, Chair; Anne Williams; Christina Mullins; Dr. David Didden; Dr. Stephen Worden; Tim Hazelett; Chad Bundy; Lloyd White; Barb Taylor; Walt Ivey; Charles Roskovensky (representing House of Delegates Health and Human Resources Joe Ellington); Jeff Johnson (representing Senate Health and Human Resources Chair Ryan Ferns); Danny Scalise; Patti Hamilton; Dr. Gregory Hand; and Amy Atkins.

### Participated via conference call:

Dr. Adam Breinig; Sandra Ball; and Melissa Kinnaird

### Task Force Members Absent:

Ted Cheatham; Terri Giles; Jim Kranz; Vivian Parsons; Patricia Pope; Senate Vice-Chair Chris Walters

### Community Members Present:

Susan Hosaflook; Stan Walls; Candy Hurd; Karen Begg; Deb Koester; Michael Bolen; Jamie Moore; Lee Smith; John Law; Ryan Weld; Cheryl Wonderly; Drema Mace; Yudith Staskey; Toby Wagoner; Carolyn Baker; Rebecca Schmidt; Arielle Lippman; Meike Schleiff; Donna Gialluco; Jackie Huff; Howard Gamble; Sissy Price; Ronda Francis; Lisa Thompson; and Brian Skinner.

## **Agenda**

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

August 10, 2015 meeting minutes were presented for approval. Danny Scalise motioned to approve the minutes. Dr. David Didden seconded the motion. Vote was taken and all were in favor. August 10, 2015 meeting minutes were approved.

Opening remarks were made by Andy McKenzie, Mayor of Wheeling. Mr. McKenzie welcomed everyone to Wheeling. He indicated that Oglebay Park is the largest, independent free-standing city park in the United States. Last weekend, they had boat races on the Ohio river and there was a health issue due to the green algae; however, it was a great fundraiser. Wheeling is a very healthy community. They have approximately fifty 5K to half marathons in their community and are growing immensely, including the Color Me AU-Some, a challenge race for youth services systems and the Make a Wish Foundation race. The City of Wheeling employees will once again participate in the American Heart Association walk in October. A handful of

employees are also taking advantage of a new smoking cessation program offered by the City of Wheeling. The city contributes to public health wellness projects in community measures. They operate several playgrounds and run numerous camps through the city recreation department. They also have the first concrete skate park in the State of West Virginia. They are very proud of their Miracle Field which provides a specially designed playground for physically challenged kids to play baseball as an example. They most recently opened a JV Chambers Recreation Park in east Wheeling which cost \$4 million dollars. This is a great place that is free for the community to use and allows them to promote health. After several challenging years, they continue to invest in their community financially and put money into things that really help public health. Outside of downtown Wheeling, there are parks that offer a range of activities throughout the year including swimming, golfing, skiing and many other activities. Wheeling is very fortunate to be active in their community and to have these wonderful parks. Mr. McKenzie is very proud of the Wheeling-Ohio County Board of Health. The City of Wheeling appoints half the members and the Ohio County Commission appoint half the members of the Wheeling-Ohio County Board of Health. They do not always agree; however, they do a great job. Health is always forefront in every decision that they make. As a citizen in Wheeling, Mr. McKenzie thinks we are very fortunate to not only have the state organizations and the local organizations that care about the physical and mental wellbeing of our community but as the world changes on many fronts, we are tasked with some of the most challenging work there is. As a political person that is elected, at the end of the day, we must always do what we think is right and we must always do what we think is the best for the community. There is never a doubt in my mind that they have the best interest of the citizens of Wheeling at heart. Keep up the great work; continue to do things for the community and to keep the public healthy and to keep West Virginia moving in the right direction.

The next presenter on the agenda was John Hoornbeek, PhD, Director, Center for Public Policy and Health at Kent State University. Mr. Hoornbeek presented "Reforming Public Health Service Delivery: Insights from Ohio". The intent of this presentation was to provide participants with information about the Center's work, based on recent scholarly research; research and service work in Ohio and Ohio's "Public Health Futures" efforts as well as offer thoughts and lessons emerging from their work and research.

The Center for Public Policy & Health conducts research and provides assistance to improve public health. They possess expertise in public health policy, governance, and management. They have been funded by foundations, federal agencies, state agencies/organizations, and local governments. Their recent areas of focus include public health collaborations and local health department consolidation.

We have a public infrastructure that has been around for 100+ years and was built to address yesterday's problems. We need to adapt our public infrastructure to meet changing needs and circumstances: 1) enhancing focus on chronic diseases; 2) internationalization of public health; 3) constrained public sector budgets for public health; 4) calls for accountability and continuous improvement - Public Health Accreditation Board (PHAB); and 5) need for cross-jurisdictional perspectives and actions.

Recent research indicates local health department (LHD) consolidation may hold promise for improving the performance of essential services. This research included: 1) compiled

performance data from LHD's in seven states; 2) regression analyses to test the effects of LHD characteristics on public health system performance; and, 3) measures of LHD capacity – size, financial resources, and staffing levels which had positive impacts on various measures of performance. Economies of scale appear to apply to the delivery of public health services.

Communities are more likely to consolidate health departments if they perceive that economies of scale can be achieved through consolidation, and; their community is similar to the community with whom they are consolidating. Based on these findings, financial incentives may be needed to encourage creation of regional health districts.

Recent work in public health consolidation in Ohio includes: 1) facilitation of LHD consolidation in Portage County, Ohio; 2) assessment of the Impacts of LHD Consolidation, One Year Later: Summit County & cities of Akron & Barberton; and 3) statewide study of LHD consolidations in Ohio since the turn of the century.

In 2013, the city of Ravenna entered into an expanded contract for public health services with the county and the two LHD's fully consolidated in 2015. The City of Ravenna saved more than \$150k per year, and avoided future costs associated with LHD consolidation. Additionally, they also now receive expanded public health education and other services from the county.

In 2008 and 2009, local governments in Ohio were facing significant financial challenges, and this affected cities throughout Ohio including Akron. The Mayor of Akron, the County Executive, and other public health stakeholders in Summit County established a committee to assess the feasibility of LHD consolidation in the county. Feasibility was confirmed and the 3 LHD's in the county consolidated by January 2011.

One year later, the Kentucky State University – Center for Public Policy & Health conducted a follow-up study and found: 1) there were substantial savings, \$1.5 million; 2) mixed evidence on public health services which needs further research; 3) stakeholders and staff agreed that existing public health services were maintained during the year of consolidation and that it would likely yield future public health improvements; and 4) disruptions and difficulties were revealed which occurred during the transition to one consolidated agency.

In 2013 and 2014, the Center conducted a longitudinal analysis of LHD consolidations in Ohio from 2000 to 2012. Through this study, 20 LHD consolidations were identified to study using a mixed-methods research design. A quantitative analysis based on data reported annually by LHD's to the Ohio Department of Health was used. Additionally, interviews were held with the Health Commissioners associated with the health departments. Through this analysis, the Center sought to assess the impacts of consolidation on total and administrative public health expenditures. Key findings were released in a 2013 report, and additional analyses and refinements resulted in a 2015 article in the American Journal of Public Health. Other key results and impacts from LHD consolidation in Ohio include statistically significant reductions in total public health expenditures and improvements in public services. These findings will be presented at the American Public Health Association in Chicago this fall.

A major effort (Public Health Futures) to assess and re-think public health service provision in Ohio was initiated in 2011 by Local Health Commissioners through their Association of Ohio

Health Commissioners (AOHC). A report summarizing the state of public health in Ohio and offering recommendations was issued in 2012. The report illuminated significant disparities in funding and service capacities between health districts in Ohio, and in many ways reflects an unsustainable system in decline.

Key results from the Public Health Futures effort include: 1) a vision statement generated by Local Ohio Health Commissioners; 2) a definition of a set of minimum essential services for public health in Ohio, based on a set of foundational public health capacities; 3) multiple recommendations addressing public health capacities and services, jurisdictional structure, financing and implementation; and 4) establishment of a state legislative committee on public health futures, which made some of its own recommendations, based in part of the AOHC report.

Recommendations for jurisdictional structure should include the following: 1) decisions about jurisdictional structure of local public health in Ohio should be based upon LHD ability to efficiently and effectively provide the Minimum Package of Public Health Services; 2) all LHD's should assess their ability to provide the Minimum Package of Public Health Services, the potential impact of cross-jurisdictional sharing and the feasibility of and local conditions for consolidation; 3) Most LHD's, regardless of size, may benefit from cross-jurisdictional sharing; however, LHD's serving populations <100,000 in particular may benefit from consolidation to ensure adequate capacity to provide the Minimum Package; 4) LHD's in counties with multiple LHD's should consider the feasibility of voluntary consolidation; and 5) statutory barriers to voluntary multi-jurisdictional consolidation and cross-jurisdictional sharing should be removed such as allowing for multi-county levy authority, consolidation of non-contiguous cities or counties and addressing other barriers identified.

Mr. Hoornbeek provided the following final thoughts for consideration: 1) Everyone should be commended for "re-thinking" public health in our state; 2) LHD consolidation can yield cost savings and/or efficiencies; 3) consolidation may also yield improvements in capacities and services; 3) institutional re-design is challenging work and you are likely to encounter difficulties and frustrations; and 4) over the long term, you are likely to have opportunities to enhance your capabilities and services if you maintain your effort.

PHIT Chair, Dr. Rahul Gupta, opened the floor for discussion/questions from PHIT members on Dr. Hoornbeek's presentation on reforming public health service delivery.

Dr. Stephen Worden asked if there had been any counties consolidated in Ohio rather than just county and city consolidations. Dr. Hoornbeek replied that only county consolidations had occurred. Nineteen out of twenty consolidations were county to county consolidations and one was a city to city consolidation.

Chad Bundy asked what you would recommend for a consolidation plan given limited resources. Dr. Hoornbeek responded that to the extent you can ground it in objective measures you are going to be ahead. There are multiple points of view that will come into play in those kinds of discussions and multiple points of view that need to be heard in the process. If you establish measures and criteria that can reflect directions that you want to go and utilize mechanisms that are based on those criteria and measures, you will clarify dialogue. You may find as you go

through the process that your measures were not perfect and that you may need to adjust them. This can be a controversial exercise as I am sure you are well aware as people have different perspectives. If you can lift the dialogue out of personal antidote and into known criteria and objective measures that will keep a dialogue going at a higher level in this area that might otherwise have been. In terms of how you go through this process, engage with local folks and include some mechanism at the state level to move forward. There is a mandate in Ohio that says you have to apply for accreditation by 2018 and achieve it in 2020. The nature of that mandate was essentially an authority given to the Ohio Department of Health to remove state and federal aid to those local health departments. The City of Ravenna Health Department was never going to become accredited. This example has created some pressure in Ohio to think about this problem from a set of standards. Those standards are the standards that PHAB have created to evaluate accreditation. He does not know if that means you have to use those set of standards in WV; however, having that external criteria and a data driven process of some kind can elevate dialogue and produce productive insights. Chad Bundy then said he noticed they were able to see a financial statement for the short-term in Ohio and because we continue to be in a public health crisis in WV and dealing with public health disparities, when do you think data will be available where you can show the data in Ohio where public health service has also increased. Dr. Hoornbeek responded that you need to have measures in public health services that everyone is going to agree to. He isn't sure they have that in Ohio; however, one measure that is likely to be used is the number of PHAB accredited health departments. After a 5 to 7 year period, they are going to be looking at those health departments that have not achieved accreditation and rethinking; do they continue as they are or consider joining with someone else. No one is saying that you have to consolidate but he thinks that the PHAB standards are going to become a measuring rod. There could be other ways to measure service but I have not seen that done consistently in the State of Ohio across all health departments.

Lloyd White stated that it would not be safe for us to assume that whatever benefits that you achieved in Ohio with consolidation may be applicable to us. Mr. White asked what the driving force behind their consolidation was – financial, delivery of services, or was it both. Dr. Hoornbeek responded that the driving force in some cases in the consolidations were cities that were financially strapped. They reached the conclusion that they could not fully provide the services that were required by the state as the current environment existed. In many instances, it was the cities that initiated the conversations about consolidation in the State of Ohio. The other driving force has become the PHAB accreditation requirement at the state level. Commissioners doing their jobs were looking down the road and knowing they have to meet PHAB accreditation. They are looking at different ways to provide services, consolidation strategies, collaboration strategies, and methods to bring in greater funding sources from tax payers. You can try different strategies but at the end of the day, the idea is to build the tree that I have shared with you in every health department in the State of Ohio. The fiscal exigency and the top-down incentive that was established at the state level were drivers. In some cases, it was public health professionals that wanted to see if we could do this better and that was a motivation. In terms of the applicability to WV, the point is well taken that the data we looked at were city to county consolidations and I have reasonable confidence based on what we did and the people that we talked to that we are telling a pretty accurate story for the State of Ohio. I think the larger national data that I shared with you suggests similar dynamics are likely to play out in other states as well. Whether WV plays out exactly as Ohio does, I am not necessarily ready to make that association. There are places where they do consolidate county health

departments. The Center for Sharing Public Health Services was an initiative of the Robert Wood Johnson Foundation based out of Kansas which pulled together people looking for collaborative endeavors across health departments. I got to know some people in Minnesota through that process that had a number of multi-county consolidations because they were encountering problems that their leadership thought were somehow compared to the problems we have had in Ohio. The dynamics that I am referring to here are not limited to cities and counties and it doesn't mean that the results that I shared with you are directly applicative to WV.

Lloyd White stated that we understand that interviews produce results but we do not have any data that cost savings improved delivery of services? Dr. Hoornbeek responded that they have the suggested studies that he shared with everyone and the results of their interviews that gave multiple examples where that has occurred but the quantitative analysis that they did was focused on expenditures not services. Dr. Gupta stated that he wanted to mention that this is as it stands in Ohio because we are talking to Ohio and we can certainly take on other areas as well in future meetings, as the law stands currently, every health department is expected to be applying for national accreditation by 2018 and obtaining that accreditation by 2020 in order to continue to get public funds. The state and federal funds are contingent upon being accredited, so a lot of work with 120 some agencies is going on currently. Dr. Hoornbeek responded that there is the quantitative data that he shared from 2012 and he knows they are about to start a process with Jefferson County and the city of Steubenville with consolidation of their health departments, which is just across the river from Weirton, WV. There are conversations in other counties throughout the state as well. There are dialogues occurring around this concept and I think Dr. Gupta is correct; those conversations to some degree are being incentivized by limiting the state and federal aid to health departments that have not applied for accreditation. Dr. Gupta said he emphasizes that by 2020, we will have border counties at least in Ohio if not in other states, that will be fully accredited, and however their system is consolidated. Dr. Hoornbeek stated assuming that the Department of Health uses the authority that is provided to them in that legislation, yes that is correct.

Dr. David Didden asked what services became available and what kind of numbers did you see? Dr. Hoornbeek responded that the example closest to this would be the one with Ravenna. They had a public health educator trying to deal with chronic disease and health education issues and in a city that has a large low income population, that service was not happening prior to their consolidation. In this case, it was local leadership trying to get to the problem before people above them did.

Lloyd White wanted to know what the timeframe was from when the first consolidation process was started to when it was implemented. Dr. Hoornbeek responded that everyone who wants to do a consolidation thinks they can do it quickly. He said that he had sat in a room with the Mayor and a Health Commissioner in May of 2013 and they signed their consolidation agreement in March of 2015. This is something that should be done well and thoughtfully because that is how you are going to find where you can build better service. The balance is that you have that incentive built into your operation while also allowing the time for full benefits to flow from this kind of process.

Lloyd White said that when you look at the public health system, and based on one of our previous meetings, based on CDC's matrix of a public health system, we only hear about the local health system which is one component of the system. He asked what happened to the other component of that system. Dr. Hoornbeek responded that when they do facilitation work in this area, they have a set of 8 criteria with which we walk through the health department. One is what does the community stakeholders think of this process, how we can do this process productively and align with their activities. The idea behind public health in this country is increasingly not that the health department does everything all by themselves but to be an engager and facilitator of interventions that take place by other organizations and entities. Those relationships have to be taken into account in this process. The opposition to consolidation that he has seen has come more from some health departments than from the stakeholders in most cases. He has seen more opposition from the smaller health departments that believe they are doing positive things which may get lost in the process. I have seen less opposition from the stakeholders as long as they are brought into the dialogue. They are worried about enabling the services to be provided that they have invested time, research and energy to provide and the health departments are a key part of that.

Christina Mullins stated that Dr. Hoornbeek had mentioned economies of scale are about 100,000 per population. She asked was there any observations about the bigger the better or staying around 100,000? Dr. Hoornbeek responded that is the number that Dr. Santeria arrived at based on his quantitative analysis of health departments around the country. The reality is that most of the health departments in the country do not serve that many people. He said in his sample that 77% of the health departments serve less than that number. I do not have a better number than that but I think there are estimation processes that go there. I would preoccupy less about the number than about the process. There are limits to what very small health departments can do for themselves and if you bring capacities together across jurisdictions, sometimes you can do more for everybody than as island to yourself.

Tim Hazelett asked can you share or are you aware of the 5 to 7 objectives that were established to conduct this basic systems reengineering process. Dr. Hoornbeek responded that if you look at the report, the original thinking on the part of the people at the local Health Commissioner level of Ohio was that there were these disparities that they saw and they needed to address them. They started thinking about issues associated with collaboration and consolidation. As their dialogue unfolded, they came to the realization that we can't talk meaningfully about those concepts without establishing the goal. This is why they developed this minimum essential service framework and that became the central framework.

No further questions/comments from the PHIT members were presented in regards to Dr. Hoornbeek's presentation.

PHIT Chair, Dr. Rahul Gupta dismissed the meeting for a five minute break and stated this would give anyone in the public audience a chance to connect with Dr. Hoornbeek and ask any questions.

PHIT Chair, Dr. Rahul Gupta introduced Meike Schleiff with Johns Hopkins University of Public Health to provide an update on the PHIT survey and website development. Ms. Schleiff stated that she has been working on the survey with Dr. Gupta and Amy Atkins and that the survey

should be sent tomorrow. She said that Amy Atkins will let everyone know when the survey needs to be finished. The results will be used to steer the timeframe and work groups structuring needs and also to get some feedback from everyone about other information, priorities which will help inform the PHIT. She said the survey is still short but will give an opportunity to get perspective and allow comments for ideas. She stated that she and Amy Atkins have been working on some technical questions for the website and there have been some challenges. Ms. Schleiff then asked Amy Atkins to give an update on the website. Ms. Atkins stated they are looking at a different couple of platforms to ensure that both state and local and external partners would have access to the website and then we want to get information from the survey as well to provide some content, structure and support. As we get feedback from folks, we will be able to create something meaningful.

PHIT Chair, Dr. Rahul Gupta, requested to hear updates from the workgroups. For the Better Health workgroup, Danny Scalise reported that minimum standards should be set for health departments in WV but they could not agree if it should be accreditation and felt that was not their charge. Dr. Gupta stated that he hoped the presentation today helped and asked Dr. Hoornbeek to provide them with the slides to share with everyone and put on the website. He said it might be helpful to look at what the State of Ohio has done as a minimum service package. For the Better Quality workgroup, Dr. Gregory Hand said they met today at Oglebay and were reviewing the accreditation process, what the purpose is and how it would affect the ongoing work in WV. Lloyd White asked if we have looked at standards besides accreditation. Dr. Hand responded there was some discussion if there could be some kind of state accreditation or certification. He said this is actually the standards and measurements for the PHAB accreditation and it's based on the ten essential services and the organizational structure of the department. He said he did not see how you could have some kind of internal certification or accreditation for a health department that would not include these. He agrees there needs to be a common mission for the state. For the Affordable Public Health workgroup, Amy Atkins stated they do not have a report at this time. For the Community Engagement workgroup, Tim Hazelett stated they had a conference call with Rebecca Schmidt to discuss a presentation she had given on community engagement in the state. We have also reached out to two experts from NACCHO and CDC to join us on a conference call to establish what tools we should develop or use to enhance community engagement or what measures we should be using to measure community engagement.

Floor opened to PHIT members for questions/discussions from previous meetings.

Dr. David Didden put forth a motion to ask the Bureau to present a model for restructuring public health to consider and eventually take with a recommendation to the legislature to help improve the health of all West Virginians. He thinks with this model we can move this discussion into something more concrete, we can look at the data and consider pros and cons and we can address the concerns that people have in local health about some of those areas of friction or conflict that are going to come up. He said maybe we will decide there is no way to get there but as long as we look at it systematically, consider the balance of data and we do it somewhat more appropriately, I would be fine with that outcome. But until we have something in front of us that we can sink our teeth into, I don't feel like we have a strong sense of direction. Dr. Gupta asked if there was a second motion and Danny Scalise seconded the motion.



PHIT Chair, Dr. Rahul Gupta opened the floor to PHIT members for discussion about Dr. Didden's motion.

Dr. Gregory Hand asked if there was a timeline in mind for this. He said it sounds like you want the Bureau to give us a model before we give our input. Dr. Didden responded that after we get the results of the survey, he would be open to the experts setting that timeline.

Chad Bundy stated that he did not oppose any model around input; however, we need to see what current model we have and the requirements needed for it to be fully efficient. Dr. Didden responded that would be a natural first step for the Bureau to develop a model. Mr. Bundy responded that we can't develop a model unless we know the requirements. Dr. Didden said we are seeing examples injected into this discussion and doesn't feel we are really accessing those examples.

Dr. Gupta clarified that Mr. Bundy was asking that in this motion, we evaluate the current model before developing a new one. Mr. Bundy stated that he did not think we could take the next step before evaluating our current model and before we look at other models. Dr. Gupta asked Dr. Didden if this was something that he wanted to consider and add to his motion. Dr. Didden said that he would prefer to let the motion stand as it is and consider Mr. Bundy's suggestion as a subsequent motion.

Tim Hazelett stated that he does not oppose Dr. Didden's motion but he does not want to see us go there unless we do systems reengineering step by step. Dr. Didden stated that he did not think his motion precluded from having that and it certainly includes input from community members. We haven't set a timeframe yet when it will be presented so that can be included as part of the goal, a deliberation and contact with experts.

Dr. Hand said that two things need to be considered. Number one if a model gets put on the table, it becomes policy. Secondly, if you are going to start evaluating models, how are you going to evaluate them and what are the criteria. Do you use national standards or do you use something internal? Before we start talking about models, we need to do the work that we have been tasked with here. Until we have some vision to move forward, I don't know how you would assess models or how the Bureau could put a model together.

Lloyd White said that is what he said last week...what is our charge, what is the problem? If our goal is to simply change the health outcomes of our citizens, it will be pretty simple. But when we say public health systems, it is broad. Are we truly talking about restructuring the local health departments? If so, then let's focus on that and not the public health system. They are so different. Local health departments are just one very small component of a local health system. Dr. Didden said we have slipped into details of the product rather than the process. My motion is to put some additional emphasis behind this committee's work to give us a model to assess and to do that, we can apply all these questions in that process and address all of your concerns.

Mr. Bundy stated that he agreed with Dr. Hand in assessing the current model and then after looking at the positives and negatives, we develop measures so we can determine that the model meets up with the measures of this task force. Dr. Didden stated that his idea is to spur

that mission forward and to actually have some of these questions answered specifically because we are getting models presented. He said we had a model presented to the association before this committee had even met.

Dr. Gupta stated that he has already received a proposal from one of the task force members and a request to implement that proposal regardless of how we move forward; we have to consider the proposal. He said that this does not preclude anybody from submitting a proposal for this group.

Patti Hamilton stated that she thinks we are looking for something tangible to discuss. She said that maybe model is to final sounding; however, she would like to see a summary of ideas that we have discussed. She is on information overload and it needs organized. Dr. Didden stated that was a great capsulation of the motion. He said he did not see any other process that has been brought up in having a baseline assessment tool.

Danny Scalise said that the reason he seconded Dr. Didden's motion is that we have met six or seven times and we have seen nothing. Everybody here is taking important time out of their day and I feel like we are going to get to the last meeting and we are going to say we met ten times and have nothing to show for it. He wants to see a product. If we fail, we fail; but if we don't do anything, it is a miserable failure of wasting the tax payer's dollar.

Anne Williams stated that she is at the point in this process where she needs something more tangible and concrete. It would be a starting point to have a discussion about building something up or tearing down current models. We need to focus on what the strengths and weaknesses are in the current system.

Lloyd White wanted to know what our goal is. Dr. Gupta responded that we have provided him with a lot of detail and documents and suggested that he review those documents. Mr. White said he has reviewed those documents but no one has answered his questions. Dr. Gupta said he would be happy to have Amy Atkins sit down with him if that is the case.

PHIT Chair Dr. Rahul Gupta called a vote for Dr. Didden's proposal. All PHIT members with the exception of four (Chad Bundy, Lloyd White, Dr. Stephen Worden and Dr. Gregory Hand) approved the motion. With the majority of the vote, the motion passes.

PHIT Chair Dr. Rahul Gupta asked for any other questions or comments from the task force members.

Dr. Didden asked if we could get a timeframe for when his motion could be put into place. Amy Atkins responded that we can provide a report at the next meeting and go from there.

Dr. Hand stated that we are supposed to have recommendations from the work groups in six weeks and where does this leave those recommendations? Dr. Gupta stated that the survey that Ms. Schleiff has developed asks how much time the task force will need to complete its work and that is why it is important to complete the survey. He said this will dictate the work of the task force.

Tim Hazelett asked what the purpose of the survey is. Dr. Gupta asked Ms. Schleiff to explain the purpose of the survey. Ms. Schleiff stated that the original purpose of the survey was to provide an anonymous and selective space for the task force to provide input on a variety of issues and to ensure everyone has an equal voice.

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

Sissy Price asked the task force members when you were appointed to this committee, did you call your local health department in your county to know what they are doing and how this decision affects people. If you haven't done that, you need to do that because the impact that this committee has does not just affect the people at this table. There are 1.8 million residents in WV and if you do not know the faces of health departments, come see us at the health departments. We can show you the faces of people we see at the health departments and the things that we do. You need to get to know your nursing directors, your administrators, your sanitarians and let them tell you things that can make their agencies better because that is our goal. She said she has not heard at any of these meetings who or what these decisions will affect. Keep the citizens of WV in mind as you make decisions and talk to your counties.

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 October 5, 2015 from 12:30pm to 2:30pm.

Meeting adjourned at 2:38pm.