

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; Vivian Parsons; Walt Ivey; Barbara Taylor; Amy Atkins; Patricia Pope; Patti Hamilton; Anne Williams; Charles Roskovensky (representing House of Delegates Health and Human Resources Chair Joe Ellington); Jeff Johnson (representing Senate Health and Human Resources Chair Ryan Ferns); Jim Kranz; Senate Finance Vice-Chair Chris Walters; and Dr. Stephen Worden.

Participated via conference call:

Dr. Gregory Hand

Task Force Members Absent:

Deputy Secretary Jeremiah Samples and Andy Skidmore

Community Members Present:

Susan Hosaflook; Sissy Price; Boyd VanHorn; Lloyd White; Jesse Rose, III; Fred Cox; Carol McCormick; Lolita Kirk; John Law; Ashley Butler; Genevieve Ruble; Rodney Boyce; Diana Riddle; Jackie Huff; Sandra Cochran; Stan Walls; Meike Schleiff; Lee Smith; Tom Simms; Dr. Michael Kilkenny; Deb Koester; David "Bugs" Stover; Mike Vickers; Jim Workman; John Taylor; Jerry Rhodes; Jack Mease; J.K. Fife; Karen McClain; Candy Hurd; Jamie Moore; Elizabeth Ayers; Kathleen Napier; Lydia Nuzum; Nasandra Wright; Thomas Susman; Gloria Thompson; Andrea Fisher; Lisa Thompson; Linda Lipscomb and Brian Skinner.

Agenda

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

May 13, 2015 meeting minutes were presented for approval. Danny Scalise motioned to approve the minutes. Vivian Parsons seconded the motion. Vote was taken and all were in favor. **May 13, 2015 meeting minutes were approved.**

PHIT Chair, Dr. Rahul Gupta, introduced State Auditor, Glen Gainer, III, and Deputy State Auditor & Director of Chief Inspector's Office Stuart Stickel. Mr. Gainer and Mr. Stickel were invited guests from the West Virginia State Auditor's Office to present on local health department audits.

Glenn Gainer thanked the PHIT Chair, Dr. Gupta, for asking the Auditor's Office to participate in the meeting. The State Auditor's Office has the responsibility of over site or audit of most health departments. He understands the way audits are conducted may not be liked by all, but the audit process is never fun; strives to be partners and work together. The Office's core mission is to ensure public funds are being expended in accordance with the law and regulations of the

State of West Virginia and in guidance with the directive of the Legislature. The Inspection Division audits all municipalities and counties and all the funding units of those county governments in West Virginia. Conducts approximately 750 audits each year; of that, the Division conducts half of those audits with the other half contracted to local CPA firms. To make sure entities understand their responsibilities, various trainings are offered. It's encouraged that local boards/health departments take advantage of the trainings. It was determined, most board members inherit their financial problems. About 10 years ago, the Legislature determined the problem was a lack of training provided for board members. Chapter 30 (Professions and Occupations) requires board members to attend trainings that the Office is obligated to provide. Trainings offered by the Auditor's Office include rule-making review, ethics, Robert's Rules of Order, privacy issues, etc.

Currently the Auditor's Office is striving to standardized business processes in the State. By standardizing business processes across State Government, every agency will operate and conduct business the exact same way. The Office understands that some boards/health departments don't operate exactly the same; some business processes are unique. However, when those unique business processes are performed, its costs taxpayers money. By standardizing statewide, it will save the State \$300 million dollars. Business processes will be standardized to eliminate those exceptions. If all 49 local health departments operated under the same standardized business practices it would bring about savings.

After Mr. Gainer's speech, he turned it over to Stuart Stickel to provide the PHIT members with the presentation **Local Health Department Audits**. Mr. Stickel provided an overview of the Chief Inspector's Office. The Office works under statutory authority Chapter 6, Article 9. It audits such entities as primary governments, component units, jointly governed organizations and other stand-alone organizations. The Office audits 90% of the Local Boards of Health (BOH). Mr. Stickel explained the different types of public sector audits. The single audit performed in accordance with Circular A-133 will have a new threshold in 2016. The new threshold will be \$750,000. The Office also performs fraud investigations. The audit process in West Virginia was discussed. Mr. Stickel explained what a typical government audit contains, such as reports and statements. Financial Statements are the main item reviewed. Mr. Stickel's presentation contained a summary of BOH audits. Last year, his office conducted 34 audits and local CPA's conducted 15. Last audit year issued was 1 BOH in FYE 2012, 17 BOH in FYE 2013 and 31 BOH in FYE 2014. The majority were financial audits (41). As for compliance findings, 12 had findings and 37 had none; this is actually pretty good. Currently, 13 have negative fund balances and 18 had a deficiency of revenues over expenditures (net loss). The average OPEB liability of all is \$263,263. Additionally, Mr. Stickel shared upcoming items with PHIT members; which include, (1) SB469 OPEB reduction and (2) GASB 67 financial reporting for pension plans. GASB 67 establishes new standards for measuring pension liability for plans. Mr. Stickel concluded his presentation.

PHIT Chair, Dr. Gupta, opened the floor for discussion/questions from the PHIT members on what was presented by the State Auditor's Office.

Chad Bundy inquired how would the Auditor's Office characterize health departments, as a system, are doing on audits? Mr. Stickel replied like anything else, could be better, but overall looks pretty good; not a lot of findings. The Office doesn't necessary look at financial performance or operations, simply look at financial statements reported internally by control findings. So, in that regards looks good. Mr. Bundy asked if there were suggestions on how to improve? Mr. Stickel replied having a complete set of financial statements ready at time of audit would be helpful. It makes the audit process go much better and could also help with costs.

Tim Hazelett asked why are we seeing the varying timeframes in the audits? Mr. Stickel replied June 30, 2014 is as perfect as you can get; keeping in mind the end of year hasn't come yet.

They have 3 months after the end of year to get financial statements. 2015 audits won't start until September. Additionally some of those may have County Commissions audited as an A-133. This type of audit must be issued by March 31st within 9 months after the end of year per federal guidelines. These are scheduled first. If a BOH is associated with a County Commission audited as an A-133 they will schedule that audit at that time as well or, may schedule them in line when the Office thinks they are going to get the County Commission done. Reason is that some County Commissions have component units that require auditing. The Office tries to schedule the BOH audits in conjunction with the County Commission component unit audits to keep from showing a negative.

Chad Bundy inquired, since we have an audit structure being a couple of years in arrears, would a health department or BOH be able to hire their own audit? Would this be something you recommend? Mr. Stickel replied not recommended.

Tim Hazelett asked the question what has significant impact on the income statement that shows an operating loss but is uncontrollable from a BOH stand point? Mr. Stickel replied it might be difficult to tie it down to one, costs vary from BOH to BOH. Anything accrued on the balance sheet as an expense such as an increase in OPEB would affect the income statement. Costs vary from BOH, one big variance seen are personnel costs. The Auditor's Office doesn't perform a detail analysis. As an auditor, just test transactions to make sure their coded correctly and properly presented on the financial statement.

Dr. Didden asked how audit costs are determined and what is spent per year from local health on these costs? Mr. Stickel replied don't have this info at his fingertips but can obtain that information. Office's staff track estimated hours vs. actual hours. Generally audit is set up based on previous audit history. Audit is set for same amount of hours. Costs may go up – based on employee costs, etc. What costs more is the amount of work required by the standards. Audits are a flat cost; an engagement letter is sent with the calculated costs. If the audit goes over the estimated time, the Office doesn't charge for that.

Vivian Parsons wants to clarify, so she understands correctly, these new standards will show an even greater shortage of funds when looking at the bottom line. It's not really a reflection of performance, it's because of the new standards. Mr. Stickel said this is correct. It has always been there, now it has to be shown. Pension numbers just need to be report now.

No other questions received from PHIT members. Floor opened for public comment in regards to the presentation/discussion of the Auditor's Office.

Robert Toler asked if Mr. Stickel could explain what a "coin concern finding" is? Mr. Stickler replied that during every audit the auditor is required to analysis the coin concern of the entity their auditing; is the entity stable enough to continue financially for the next year. An auditor is required to have an explanatory paragraph in the audit report if there is a reasonable possibility of concern that the entity would not be able to operate the next year. Mr. Toler asked that of the 19 BOH that ran a deficit the last operating year was there a concern? Mr. Stickel replied no.

Jack Weese, Cabell-Huntington Health Department was seeking clarification. Mr. Weese said that Cabell-Huntington was listed as one of the health departments in trouble according to the newspaper. First of all, their budget was submitted out of balance to begin with. Cabell-Huntington has \$4 million in the bank that comes from surplus (but not listed as income). Their regular financial statement shows \$95,000 depreciation. When you look at the reconciliation and take out what needs to be taken out, they have a positive of \$73,000. Does that mean Cabell-Huntington is in financial trouble? Mr. Stickel replied that he didn't say anyone was in financial trouble. Also you can have \$4 million in the bank and still have a net loss so to speak. Mr. Weese questioned the 19 health departments listed as operating in a deficit. Mr. Stickel

informed Mr. Weese that all is based on pure numbers when looking at the financial statements; the 19 had more expenditures than revenue. Mr. Stickel added they are only going by their last audit report. Mr. Weese mentioned this was hard to understand, a little misleading.

Tom Susman asked if OPEB was considered an expense. Mr. Stickel replied - correct. Mr. Susman proceeded to ask if the average OPEB liability is \$263,263 would that not have a direct impact on the financial statements shown for these entities? Mr. Stickel replied – yes, the \$263,263 would be accumulation of the OPEB liability since implementation year of 2009; so if you are looking at the 2014 financial statement and had \$250,000 listed, it might be \$50,000 a year hitting the income statement. Mr. Susman asked if this is not an amount the entity would have to write a check for, that's an accrual that shows up on the financial statement. Mr. Stickel replied this continues to be long argument. The written law has a blurb that states if an entity fails to pay full amount of ARC, then it remains a liability of the entity. Based on a governmental accounting standard for interpretation that says anything billed on multi-cautionary plain that are not paid, but requires to be paid, must be a current liability. Mr. Susman then wanted to clarify that the upcoming pension liability effects all in the State, not just local health departments that it is an exposure that will show up on everyone's financial statements. Mr. Stickel replied correct.

David Stover – Wyoming County asked if you estimate a certain amount for an audit and it's not that actual amount is there a refund issued. Auditors Office doesn't actively seek refunds. Has been instances where the entity is concerned about costs and the engagement letter may state if audit is completed under the stated hours we may issue a refund in a specific amount.

Carol McCormick – Kanawha-Charleston Health Department stated she was interested in Mr. Gainers' comments about standardization methods to save. Ms. McCormick wanted to know if Mr. Gainer had any recommendations for the local BOHs to make to standardize processes in order to save money. Mr. Gainer replied his office would be glad to work with PHIT to come up with recommendations. He mentioned that one cost saving measure is the use of the State Purchasing Card (P-Card). This is used and successful at the state level and he knows that some health departments utilize the card as well. It's a cost savings that generates a rebate back to the health departments.

Lloyd White – Monroe County Health Department asked a question about the new standard practice regarding the pension liability showing a negative impact. Mr. Stickel said yes, it will affect the balance sheet and show some balances in the negative. Individuals behind the standards are aware of that when they look at the financial statements. It will be a matter of educating the public.

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

After a short recess, PHIT Chair, Dr. Gupta, introduced the ***Vital Signs – Core Metrics for Health and Health Care Progress*** (handout) to the PHIT. This document is an April 2015 report brief from the Institute of Medicine of the National Academies. The idea of the report is to change the way we do health in public health systems by recognition of developing core metrics. The report proposes 15 core measures across 4 domains. PHIT Chair, Dr. Gupta, listed the 15 core measures for the public audience. Report's view looks more like population health measures than health measures. This is where the focus is going within the next several years; transitioning from individual care to much more population care. When the complete report comes out soon, the core measures will be divided into 4 domains – (1) Better Health; (2) Better Quality; (3) Affordable Public Health; and (4) Community Engagement.

PHIT members will be divided into 4 workgroups matching the domains. Amy Atkins, Director – Center for Local Health, distributed a handout that identified the 4 workgroups and the

respective members. Individuals were matched to the best of ability to their domain. It is recommended that the first person listed in the group will take control and set up meetings, establish a chair, etc. Center of Local Health will provide support and technical assistance (phone calls, taking meeting minutes, etc.) as needed.

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

Vivian Parsons wanted to clarify what workgroups are actually focusing on. PHIT Chair, Dr. Gupta, responded by instructing the PHIT to keep in mind the measures/domains (which is the way we are headed nationally) but focus is more on the public health aspect such as (1) Enhancing public health services defining mission and scope of public health in West Virginia; (2) Using public health accreditation to drive performance and quality of services and programs; (3) Redefining the BPH statutory and regulatory authority; and (4) Integrating of community resources to improve public health and health care.

Dr. Didden asked what output should be accomplished and when? PHIT Chair, Dr. Gupta, replied that the workgroups are to focus on their respective areas and provide ongoing feedback. Status reports will help keep everyone engaged. The goal is to work towards making a recommendation to PHIT Chair, Dr. Gupta, based on the findings of the respective workgroups for moving forward.

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

PHIT Chair, Dr. Gupta, discussed the membership update. Numerous local health departments have contacted the Center for Local Health expressing their concern of being represented on the PHIT. Not feasible to allow all 49 to participate on the PHIT. The concern for the need to increase membership has been presented. To accommodate to the extent possible, additional members will be added 2 from local health agencies and 2 from others across the state that represent public health systems. The process going forward will charge Chad Bundy, President of the Local Health Association, to select and appoint the addition members. The members will be incorporated into the workgroups. PHIT Chair, Dr. Gupta, briefly stated the requirements for the appointment of these new members, but will send the requirements to Chad Bundy at his request.

Chad Bundy wanted to address old business. He was asked at a previous PHIT meeting by Ted Cheatham what was the combined amount of reserve from all of local health; \$25,215,908 in reserves accumulative.

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

John Taylor – Grafton-Taylor Board of Health – handed out a copy of a financial sheet used at their monthly board meetings. Grafton-Taylor Health Department was included in the 19 health departments with a deficit. Mr. Taylor wanted to inform the PHIT that their system is working. He wanted to bring attention that out of the 19 at least one had turned things around because of the governance of the local board. Additionally, he wanted to clarify the standard for case reserve. The standard for cash reserve has always been 3 months, but now (according to the paper) its 6 months. He is requesting a clear standard that all will be judged by and not something that changes daily. Mr. Taylor wanted to also address what is needed from the State. Clear expectations, evaluation, support and training are needed from the State. Mr. Taylor wanted to share that Grafton-Taylor is on the improving side.

Ted Cheatham asked Mr. Taylor what the 5th line item down – PPS MDCR HH – on his handout represented. Mr. Taylor replied has something to do with their home health.

Sissy Price – Braxton County Health Department – stated that problems she has encountered as a new Nurse Administrator is lack of guidance. It is hard to be a public health champion for the state and county if consistency of measures aren't presented to new administrators and given training as to what you want from them. She recommends to the PHIT as changes are being made to include trainings so individuals can be public health champions in the state and their county/community.

Fred Cox – Wyoming County Health Department – wanted to mention that Wyoming County Health Department was listed in the paper as one of the at-risk health departments. Mr. Cox doesn't agree with the assessment in the paper. Mr. Cox wanted to introduce Robert Toler (CPA helping Wyoming County) who can provide clarification as to why Wyoming County was on the list. Mr. Toler wanted to caution the PHIT into taking actions solely on the Auditor's reports. Their statements are grossly in error. In Wyoming County, they had support/clerical staff entering financial data; which didn't know what they were actually doing. The statements had a liability account and expense account over stated; posting error. The State Auditor's Office missed this simple posting mistake. Mr. Toler spoke with Mr. Gainer and it will be fixed. Wyoming County is simply on the list because of the Auditor's Office missing this simple posting mistake.

David Stover – citizen of Wyoming County – wanted to comment on the history of the country centralizing authority; sometimes it works – sometimes it doesn't. Mr. Stover wanted to inform the PHIT that centralizing authority (adding another layer) often doesn't work, but if this is the way the PHIT goes, please go with great caution.

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

PHIT member, Sandra Ball, wanted to clarify why Summers County was on the list. Ms. Ball wanted to share that improvements have been made. If OPEB liability was removed, it wouldn't show a deficit. Summers County has never had a large cash reserve; operates on a month-to-month basis.

PHIT Chair, Dr. Gupta, wanted to insure everyone there are no preconceived notions. PHIT is here to figure out best way to move forward. Wanted to emphasis that.

Dr. Didden shared it was helpful to discuss the audits, but fundamentally it's not about the money. It's about the health of the people we are responsible for taking of. As a country, we spend more money on mediocre outcomes overall. Dr. Didden stated he hopes to move on to more of those discussions. We have deeper issues to address, because the system is failing. He understands the disconnect between the financial assessment heard from the State and what is seen at local health. Dr. Didden stated we can improve communications and the process. Dr. Didden wants to energize the PHIT to address the needs of the patients.

PHIT Chair, Dr. Gupta, wanted to suggest changing the next meeting to July 13, 2015 so the workgroup can meet prior. That would be cancelling June 24, 2015 meeting and changing the regular scheduled July meeting to the 13th in lieu of the 15th. Dr. Didden suggested keeping the June 24, 2015 meeting for a workgroup meeting and also keeping the July 15, 2015 meeting as regularly scheduled. The Honorable Michael Pushkin motioned for that option; motion seconded by Dr. Didden. Vote was taken and all were in favor. **The PHIT June 24, 2015 meeting is cancelled. June 24, 2015 will be available for workgroups to meet. Next scheduled PHIT meeting is July 15, 2015 (as regularly scheduled).**

Ted Cheatham asked if each county could send in what they believe are the core public health deliverables in West Virginia. What do they think the core mission is? PHIT Chair, Dr. Gupta,

stated this can and will be done; will prepare a survey to distribute to the local health departments for completion. Additionally, there is another survey for PHIT members to complete. Dr. Gupta introduced Meike Schleiff of John Hopkins School of Public Health. Ms. Schleiff has prepared a survey for the PHIT members to gauge their views/perspective of public health. Survey link will be sent to members after meeting. Survey needs to be completed by close of business June 3, 2015. Results of both surveys will be compared and shared.

Tim Hazelett wanted to make a statement based on what Amy Atkins had stated in the last meeting. He referred back to the meeting minutes where Amy quoted "*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.*" Per Mr. Hazelett, PHIT's biggest challenge is to identify how to deliver services equally, adequately, and consistently in a standardized manner. This statement is spot on. How do we know we are delivering adequate public health services for every citizen in West Virginia equally and consistently? Currently it seems we are basing public health on finances, need to move away from that, put the financial piece behind us; public health is so much more. Focus needs to be on providing public health in a consistent manner across the State.

Danny Scalise motioned to adjourn meeting; motion seconded by Ted Cheatham. PHIT meeting adjourned at 2:30pm.