



West Virginia Public Health Impact Task Force

DRAFT FINAL REPORT

December 16, 2015

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Background

The West Virginia Department of Health and Human Resources (DHHR), Bureau for Public Health (BPH) has a responsibility to the citizens of West Virginia to assure public health services are delivered consistently, according to the same standards of care, in every community. Over the past hundred years, public health needs, service delivery, funding strategies and the conceptual frameworks that drive progress in health outcomes have changed dramatically. Chronic disease, rather than infectious disease, is now the primary cause of morbidity and mortality. Payment models under the Affordable Care Act are moving towards a focus on coordinated care and payment by outcome, rather than procedure or service. With the expansion of the insured population, public health agencies must evolve to adapt to this paradigm shift. Due to the availability and importance of data for effective decision making, access to powerful and integrated information technology is a necessity for the public health system. Finally, the cost of health care, and consequently the cost of failing to prevent the preventable, continues to increase.

According to the Behavioral Risk Factor Surveillance System (BRFSS), West Virginia ranks 46th nationally in key indicators of morbidity and risk behaviors, including arthritis, cardiovascular disease, disability, obesity and current smoking (WV Health Statistics Center, 2013). West Virginians are dying from preventable conditions, including deaths from accidents and drug overdoses, at twice the national rate (WV Health Statistics Center, 2013). The social and economic factors that drive health outcomes, such as income and education, remain significant challenges in West Virginia and require intersectoral partnerships and public health agencies that have the capacity to respond on multiple levels in a dynamic environment. While traditional preventive and clinical services are required for the protection of the public's health, community care coordination, (which links health systems with communities), and health in all policies, (which addresses the 80% of health factors that are unrelated to clinical services), are critical areas for the public health system to engage in, support and lead.

West Virginia's public health system, structured on a 100 year old model, is not positioned to respond effectively to these changes and challenges. The performance standards for local boards of health are outdated and do not refer to recent evidence on the relationship of economies of scale to public health system performance, the importance of market analysis to determine service provision, or the national accreditation standards for public health. Public health services in West Virginia are delivered through 49 local health agencies, governed by 49 local boards of health. The significant differences in administrative costs; collection, reporting and delivery of public health data and services; information technology capacity; and revenue generation among the 49 agencies suggest that services and funding are not being effectively targeted statewide, for the greatest impact on health outcomes, according to consistent standards. These challenges are reflected nationally and are not unique to West Virginia.

Nationally, leading agencies in public health and health care have laid a foundation for aligning public health and health care through the paradigm of population health. The Institute of Medicine's Roundtable on Population Health Improvement defines population health as, "the health outcomes of a group of individuals, including the distribution of such outcomes within the group" (Health Policy Institute of Ohio, 2014). At its core, population health recognizes that health outcomes are good or bad, or unevenly distributed in the population because of the presence of factors such as individual genetics and behaviors; social, familial, cultural, and economic factors; physical environment; and effectiveness of the public health and health care systems (Health Policy Institute of Ohio, 2014). The Institute of Medicine has also released four reports and a workshop summary calling for the modernization of the public health system including recommendations for the accreditation of public health agencies (Institute of Medicine, 2011); development of a minimum package of public health services (Institute of Medicine,

2012); a standard chart of accounts for public health work (Institute of Medicine, 2012); standardized measurement of health outcomes through a performance measurement system (Institute of Medicine, 2011); and strategic partnerships between public health agencies, primary care and other partners to improve population health (Institute of Medicine, 2012). These recommendations are being adopted by state and local health departments nationwide. Currently, more than 45% of the US population (nearly 138 million people) is being served by an accredited public health agency (Public Health Accreditation Board (PHAB), 2015) and multiple states have adopted minimum packages of public health services.

In order to achieve the shift to population health and incorporate recommendations from nationally recognized subject matter experts and health system research, stakeholder engagement around a common framework for progress is critical. Since 2013, public health's partner agencies in West Virginia, including hospitals, primary care centers, free clinics and payers, have met to align with the transition to population health through the West Virginia Health Innovation Collaborative (WVHIC). The WVHIC uses the Triple Aim framework (Institute for Healthcare Improvement, 2012) and has developed workgroups around **Better Care** (identify cost savings that can be achieved in the health care system and to promote the concept that higher cost does not always equal higher quality); **Better Value** (identifying inefficiencies in the health care delivery system in the state and strategies to help improve the health care system to better meet the needs of West Virginia citizens); and **Better Health** (identifying strategies that can help improve West Virginia's health statistics). Yet, due in part to the breadth of the WVHIC's charge, public health agencies have been on the periphery of this initiative in West Virginia.

In addition to the significant research emerging nationally concerning public health agency administration, performance and impact on health outcomes, there have also been fiscal changes that necessitate a change in the way public health does business. Nationally, funding streams from the Centers for Disease Control and Prevention (CDC) have been declining while Health Resources and Services Administration (HRSA) funds have increased (Trust for America's Health, 2015). Due to state fiscal crises and new opportunities for revenue generation through insurance billing, few states support local health departments with general revenue funds. Funding streams to public health are also increasingly integrated with other programs and providers require significant evidence of partnering with other community or state level organizations to maintain funding.

In West Virginia, state agencies have received cuts to their budgets annually over the last four years and the state's budget shortfall is forecast at \$250 million or more for FY2016. The 2-4 year projections for the state include significant revenue shortfalls and anticipated required reductions. In addition, federal funding to BPH for traditional public health programs has decreased significantly. For example, Public Health Emergency Preparedness (PHEP) funding has declined since 2002 resulting in a 47% reduction of funds for West Virginia. At the local level, primary care centers received a 44% reduction in funding and free clinics received a 32% reduction in funding in FY2015 in addition to a new funding formula. These funding changes and challenges require not just adaptation, but strategic reinvention of how the public health system in West Virginia targets public dollars for public goods and how the system can leverage the efficiencies and opportunities brought about by the shift to a population health focus.

Charge of the Public Health Impact Task Force (PHITF)

In recognition of these challenges, the BPH Commissioner and State Health Officer, Dr. Rahul Gupta, assembled a Public Health Impact Task Force (PHITF) in April 2015 that was charged with redefining the mission of public health in West Virginia for the 21st century. The PHITF is

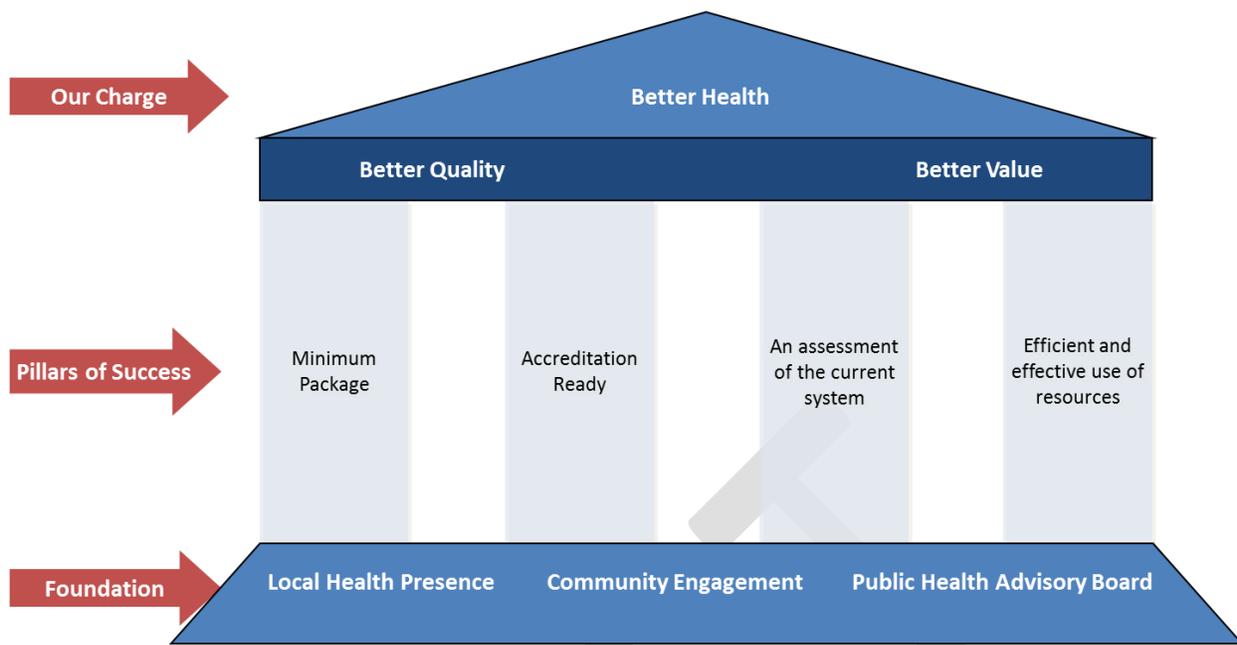
comprised of 28 members that include representatives from the BPH, local health departments, legislators, and the following partner organizations: Association of West Virginia County Commissioners; West Virginia Association of Counties; West Virginia Association of Free Clinics; West Virginia Hospital Association; West Virginia State Medical Association; West Virginia University School of Public Health; Public Employees Insurance Agency (PEIA); and West Virginians for Affordable Healthcare. The PHITF was formed to make recommendations to Dr. Gupta, which could include structural and organizational changes to modernize the state and local governmental public health system. The work of the PHITF will impact the lives of West Virginians by positioning the state's public health system to effectively and efficiently work with communities to improve health outcomes while addressing health concerns.

The PHITF worked in four focused workgroups that align with the Institute of Medicine's recently published report, *Vital Signs: Core Metrics for Health and Healthcare Progress*. The report identifies four interrelated domains of influence with the "greatest potential to have a positive effect on the health and well-being of the population and each individual within it, now and in the years to come" (Institute of Medicine, 2015). These four domains are "healthy people, care quality, care costs and people's engagement in health and health care" (Institute of Medicine, 2015). For public health to have an impact on improving health outcomes in the state, the system must be retooled with sustainable system level solutions. The PHITF was designed to ensure that solutions are collaboratively developed in a manner that will serve all citizens in West Virginia regardless of where you live, work or play.

Public Health Impact Task Force Recommendations: A Framework to Modernize West Virginia's Public Health System

At the PHITF meeting on December 9, 2015, the PHITF membership voted unanimously to adopt the following core concepts outlined by the BPH and aligned with key concepts presented by the West Virginia Association of Local Health Departments.

1. Maintain a local health presence and services in every county.
2. Partner with stakeholders to align West Virginia's public health system with national recommendations by developing a minimum package of public health services accessible to all West Virginians.
3. The State's public policy should support a public health system that is accreditation-ready.
4. Conduct an assessment of the current system (state and local) responsible for the provision of statewide basic public health services including funding and revenue sources.
5. The State's public policy should encourage the efficient and effective use of public resources that support statewide public health services.
6. A Public Health Advisory Board should be established to improve transparency, accountability, and efficiency and promote a statewide culture of health.



PHITF Process

Membership

In order to ensure both diverse perspectives and experience and to engage stakeholders critical to implementation of any recommendations for change, the Center for Local Health (CLH) developed a blended nomination and targeted invitation approach to member recruitment. For local health representation, a nomination process was developed to assure the diverse perspectives of local health were represented including local boards of health members, administrators, health officers, environmental health and public health nursing. More than 150 local leaders were contacted to submit nominations. Nominations were received initially through February 20, 2015 and members were selected based on criteria that resulted in diverse representation of local health in terms of geography, size of jurisdiction, expertise, etc. The nomination form included the individual's basic information, such as title, role and years of service, as well as questions regarding interest in serving on the PHITF and anticipated contributions to the process.

For other health system partners, the CLH collaborated with BPH and DHHR leadership to identify stakeholders from a wide range of public health system partners including those partners critical to fulfilling public health's mission through programmatic, funding or statutory authority requirements. For example, because assuring strong systems are in place to deliver quality and critical public health services to West Virginia citizens is a natural interest and obligation of the Legislature, several members of the West Virginia Senate and House were invited to participate, specifically members with a knowledge of fiscal and health related issues.

Stakeholder Engagement

In order to highlight the work of the PHITF and gain input from multiple perspectives, the CLH launched a communications initiative through multiple platforms. Given the impact any recommendations produced by the PHITF would have, not just on public health, but on our partners, it was critical to engage in dialogue around the process through as many venues as possible.

In addition to the PHITF meetings and membership, the CLH engaged national partners and conducted informational interviews with other states and research institutions. The CLH also worked with other state departments, including the State Auditor’s Office and State Division of Personnel, to collect information that would be valuable to the PHITF in terms of background around the status of local health department operations. Including the national and state level models that were discussed during the PHITF, West Virginia’s Mid-Ohio Valley Health Department regional model was presented and discussed as a possible resource for PHITF recommendations.

To engage public health partners within the BPH and in local health agencies, regular PHITF updates were provided through the CLH’s newsletter; Public Health Partnership Meetings (held between local health representatives and BPH leadership); site visits to local health departments and local boards of health in 2015; trainings provided to local health agencies, including a Local Board of Health Governance Forum held in April and May 2015; and individual meetings between local health department leaders and the BPH Commissioner and State Health Officer and/or the CLH Director. Internally, the CLH hosted meetings with BPH leadership to provide updates on the PHITF and address any concerns related to individual programs. Critically, the CLH engaged the West Virginia Association of Local Health Departments and requested the development of key concepts from the Association that should be incorporated into any recommendations for the public health system. These key concepts were presented to BPH leadership on November 5, 2015 and were essential to the framework of concepts presented by the BPH to the PHITF on December 9, 2015.

In addition to public health partners, the BPH Commissioner and State Health Officer presented on the PHITF process at several statewide conferences and association meetings including the West Virginia Rural Health Association, West Virginia Association of Counties, West Virginia Primary Care Association and the Try This Conference.

Public comment was also solicited, both from partners who were not members of the PHITF and the general public. From April 2015 through December 2015, representatives from 70% of local health departments attended PHITF meetings, many of whom offered feedback and questions during the open comment period. In order to make the process both transparent and accountable, the PHITF meetings were held under West Virginia’s Open Governmental Meetings Act and posted to the Secretary of State’s website accordingly. Media advisories were also circulated before every meeting and more than 20 articles were published on the process in more than 15 media publications. The CLH website was updated regularly throughout the process and includes membership, meeting agendas, meeting minutes and presentations to the PHITF.

PHITF Workgroups

The PHITF workgroups were organized in alignment with the four domains included in the Institute of Medicine’s report, *Vital Signs: Core Metrics for Health and Health Care Progress*: Better Health; Better Quality; Affordable Public Health; and Community Engagement.

Better Health		Better Quality	
Enhancing public health services by defining mission and scope of public health in WV.		Using public health accreditation to drive performance and quality of services and programs.	
*Danny Scalise	Anne Williams	*Gregory Hand	Chris Walters
David Didden	Jim Kranz	Chuck Thayer	Christina Mullins
Ted Cheatham	Lloyd White	Patti Hamilton	Adam Breinig
Ryan Ferns		Sandra Ball	

Affordable Public Health		Community Engagement	
Redefining the BPH statutory and regulatory authority.		Integrating of community resources to improve public health and health care.	
*Amy Atkins Vivian Parsons Walt Ivey Andy Skidmore	Teri Giles Stephen Worden Joe Ellington	*Tim Hazelett Chad Bundy Patricia Pope Barb Taylor	Melissa Kinnaird Michael Pushkin Bill Kearns

*Workgroup Chair

PHITF Workgroup Recommendations

The following workgroup recommendations, products and reports were used to inform the final PHITF Recommendations and distributed to PHITF membership at the December 9, 2015 meeting.

Better Health

The Better Health workgroup presented a draft document of a minimum package of public health services for West Virginia at the October 28, 2015 meeting. This draft document was used to generate discussion and highlight the need to work together to develop a minimum package that meets the critical needs of West Virginians in every community. To support the interest of the workgroup and provide context for the PHITF on the minimum package concept, a summary of how the minimum package concept had been adopted in other states was developed and distributed at the December 9, 2015 meeting.

Better Quality

The Better Quality workgroup presented the following recommendations to the PHITF at the December 9, 2015 meeting:

1. The WV Bureau for Public Health should pursue accreditation through PHAB.
2. The State of West Virginia should establish an expectation of meeting performance-based standards for local health departments by creating, implementing and assessing regularly, a standardized and comprehensive set of performance criteria aligned with PHAB standards. This assessment process should be designed to provide measurable feedback on strengths and areas targeted for improvement.
3. Accreditation by PHAB could be used to ensure quality performance in lieu of the state process.
4. The WV Bureau for Public Health should optimize every opportunity to provide financial incentives, provision of training/technical assistance, and other support for successful achievement of accreditation and ongoing quality improvement efforts.
5. Local health departments should develop an effective peer support network for meeting performance-based standards aligned with PHAB criteria.

Affordable Public Health

The Affordable Public Health workgroup presented the following recommendations to the PHITF at the December 9, 2015 meeting:

1. West Virginia should align with national recommendations by developing a minimum package of public health services that would be accessible to all West Virginians.
2. All local health departments should have access to the skills and resources necessary to deliver the minimum package of public health services.

3. Bureau support should align with the requirements of a minimum package of public health services.
4. Decisions about the jurisdictional structure of local public health should be based upon an ability to efficiently and effectively provide the Minimum Package of Public Health Services. Additional factors that should be considered include population size, and local geographic and financial conditions.

Community Engagement

The Community Engagement workgroup developed a summary on how community engagement is defined and resources to support community engagement efforts in public health. Community engagement is part of the foundation for the Bureau's recommendations to the PHITF and the resources identified by the workgroup, including a PowerPoint presentation, were distributed to PHITF members on December 9, 2015.

PHITF Meetings and Presentations

Meeting 1 - April 29, 2015

DHHR Cabinet Secretary Karen L. Bowling provided the keynote address, emphasizing the need to embrace change, highlighting the importance of this work, encouraging members to share ideas that would lead to measurable outcomes and improved health. Dr. Gupta presented the State of the State's Health which included a summary of key health indicators, trends in national funding to support public health and opportunities for public health in the future. Dr. Gupta's call to action was to redefine the mission of public health in West Virginia in the 21st century. For public health to have an impact, the system must be retooled to address the needs of West Virginians today. The vision of DHHR, "Better Health, Better Quality and Lower Cost", was presented as a platform upon which to build sustainable system solutions with a collaborative approach.

Meeting 2 – May 13, 2015

Chad Bundy, President of the WV Association of Local Health Departments/Executive Director, Harrison-Clarksburg Health Department, provided a presentation entitled, *The Local Governmental Public Health System*. The presentation gave an overview of local health and the Association, roles/responsibilities which include Community Health Promotion, Environmental Health Protection and Communicable and Reportable Disease Prevention and Control, local structure, staffing of local health departments and services provided by local health departments. Chuck Thayer, BPH Deputy Commissioner, provided a presentation entitled, *The West Virginia Bureau for Public Health*. The presentation included the scope, mission, vision and programs of the BPH and how it links to communities and services. The presentation described the requirements the BPH has to assure and/or provide consistent, quality services across the entire span of a person's life.

Meeting 3 – June 2, 2015

Glen Gainer III, West Virginia State Auditor, provided a presentation that described the core mission of the State Auditor's Office which is to ensure public funds are being expended in accordance with law and regulations of the State of West Virginia and in guidance with the directive of the Legislature. State Auditor Gainer's presentation included the work underway to standardized business processes in the state. Stuart Stickel, Deputy State Auditor, presented, *Local Health Department Audits, An Overview of the Chief Inspector's Office and the Audit process in West Virginia*. During this meeting, Dr. Gupta provided the Institute of Medicine Report Brief titled, *Vital Signs: Core Metrics for Health and Health Care Progress*, which proposes fifteen (15) core measures across four domains. The four domains are: Better Health; Better Quality; Affordable Public Health; and Community Engagement. The PHITF members were divided into four workgroups specific to those domains.

Meeting 4 – July 15, 2015

The meeting convened at the Monongalia County Health Department in Morgantown. Cecil Pollard, Director, Office of Health Services Research, WVU School of Public Health presented an overview of work related to primary care and public health partnerships and the use of technology to improve health. Mr. Pollard encouraged the PHITF to consider one electronic health record system; support for community health workers; to think in terms of population health (think locally) and start to enumerate your population and create/build regional health alliances. Dr. Henry Taylor, Acting Health Officer and Deputy Health Officer Carroll County, Clinical Deputy Health Officer Cecil County and Senior Associate Health Policy and Management of Johns Hopkins Bloomberg School of Public Health, provided an historical overview and introduced the concept of a functional analysis as a means for thinking through the work of PHITF. The PHITF welcomed four new members to the process.

Meeting 5 – August 10, 2015

David Stone, Education Specialist with the PHAB, provided an overview and status of the national public health accreditation activities. Brian Skinner, General Counsel for the BPH, provided an overview of the legal structure and public health performance standards for local boards of health.

Meeting 6 – September 2, 2015

Andy McKenzie, Mayor of Wheeling, West Virginia welcomed the PHITF members to Wheeling and provided an overview of the town/county public health initiatives. John Hoornbeek, PhD, Director, Center for Public Policy and Health for Kent State University presented, *Public Health Changes in Ohio: Lessons Learned*, and provided an overview of their experiences. The PHITF approved a motion requesting the BPH present a proposed model for review and consideration by the PHITF.

Meeting 7 – October 14, 2015

Pat White, former Director of Special Projects for the WV Health Systems Agency, and Drema Mace, PhD, Executive Director for the Mid-Ohio Valley Health Department presented, *Mid-Ohio Valley Health Department, A Regional Model of Public Health Service Delivery*. The presentation provided an overview of the development of this model and current services in place as well as an estimated 12 million in projected savings.

Meeting 8 – October 28, 2015

Robert Hicks, Deputy Commissioner of Community Health Services, Jennifer L. Mayton, Operations Director for Community Health Services, and Dr. Charles Devine, Health Director, Lord Fairfax Health District representing the Virginia State Department of Health provided an overview of the current structure of the public health system and operation for the State of Virginia, specifically discussing the interfaces between the central state office, district offices and the local health departments.

Meeting 9 – December 9, 2015

Amy Atkins, CLH Director, presented the BPH's core concepts for a framework to modernize the public health system in West Virginia. This presentation was in response to an approved PHITF motion on September 2, 2015 for the BPH to present a model for restructuring public health for consideration by the PHITF. The BPH's six core concepts and framework were unanimously approved by the PHITF.

PHITF Member Surveys

Recognizing the importance of the PHITF work, the opportunities for others to learn and the need to be responsive to partner feedback, three surveys were conducted throughout the PHITF process to obtain perspectives on the PHITF and its potential impact.

The surveys were conducted by Ms. Meike Schleiff, doctoral student at Johns Hopkins University School of Public Health in Baltimore, Maryland and Dr. Henry Taylor, founder of Pendleton Community Care in Franklin, WV, former West Virginia State Health Officer and Commissioner, and faculty member at John Hopkins University School of Public Health.

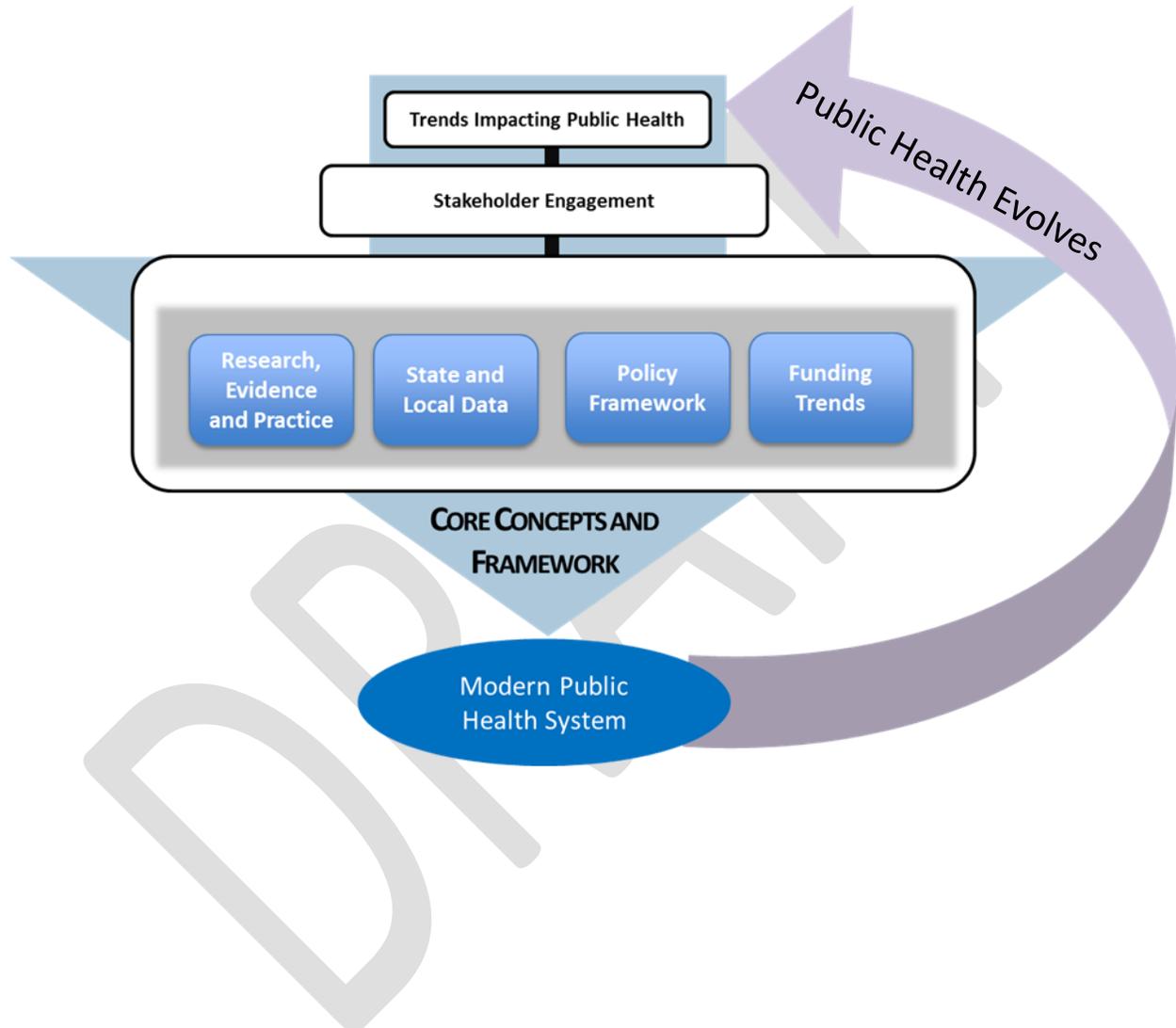
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Attachment 1

Bureau Approach to Developing Recommendations to the PHITF

In September 2015, the BPH was charged with creating a model through an approved motion by the PHITF. The CLH coordinated the development of this model for the BPH and engaged multiple partners to determine how the model should be created to ensure a platform upon which all partners could build.



Attachment 2

West Virginia PHITF Membership List, August 2015

Rahul Gupta, MD, MPH, FACP, Chair
Commissioner & State Health Officer
Bureau for Public Health

Amy Atkins, MPA
Director
Center for Local Health

Anne Williams, RN, BSN, MS-HCA
Deputy Commissioner for Health Improvement
Bureau for Public Health

Barb Taylor
Deputy Commissioner for Health Protection
Bureau for Public Health

Vivian Parsons
Executive Director
Association of West Virginia County Commissioners

Patricia Pope
Executive Director
West Virginia Association of Free Clinics

*Adam Breinig, DO, FAAFP
President
West Virginia State Medical Association

Ted Cheatham
Director
Public Employees Insurance Agency

Sandra Ball, RN, BSN
Administrator
Summers County Health Department

Tim Hazelett
Administrator
Cabell-Huntington Health Department

Danny Scalise, MBA
Administrator
Fayette County Health Department

Andy Skidmore
Board of Health Member & County Commissioner
Putnam County Board of Health

Chad Bundy, MPA
Administrator
Harrison-Clarksburg Health Department
President of WV Association of LHDs

Chuck Thayer
Deputy Commissioner for Administration
Bureau for Public Health

Christina Mullins
Director
Office of Maternal, Child & Family Health

Walt Ivey
Director
Office of Environmental Health Services

Melissa Kinnaird
Director
Office of Emergency Medical Services

Patti Hamilton
Executive Director
West Virginia Association of Counties

Jim Kranz
Vice President, Professional Activities
West Virginia Hospital Association

Gregory Hand, PhD, MPH, MS
Founding Dean
West Virginia University School of Public Health

*Terri Giles
Executive Director
West Virginians for Affordable Healthcare

David Didden, MD
Physician Director and Health Officer
Jefferson County Health Department

*Bill Kearns
Administrator
Berkeley County Health Department

*Lloyd White, RS, MPH
Administrator
Marion County Health Department

Stephen Worden, BS, DVM
Ritchie County Commissioner
Mid-Ohio Valley Board of Health

The Honorable Ryan Ferns
Ohio County
Chair, Health & Human Resources Committee
West Virginia State Senate

The Honorable Chris Walters
Putnam County
Vice Chair, Senate Government Organization & Finance
West Virginia State Senate

The Honorable Joe Ellington
Mercer County
Chair, Health & Human Resources Committee
West Virginia State House of Delegates

The Honorable Michael Pushkin
Kanawha County
Member, Health and Human Resources Committee
West Virginia State House of Delegates

(Revised) *New members voted in by Task Force – July 15, 2015

Updated August 25, 2015

DRAFT