DRAFT

Southwest Virginia Health Authority
Minutes of the
Board of Directors Meeting
April 3, 2024 at 5:00 PM

Southwest Virginia Higher Education Center, Room 240
Abingdon, Virginia

ZOOM ™ link was also provided to public

I. Call to Order

The Chairman initially started the meeting in transit to the meeting. He called the meeting to order at 5:11 p.m.

The Chairman stated that Delegate Rodney Willett was attending the meeting virtually. He wanted to thank Delegate Willett for attending the Authority meeting. The Chairman shared that Delegate Willett had been a leader in healthcare for the past three to four General Assembly sessions. He thanked Delegate Willett for joining.

The Chairman stated that to get the meeting started he would move to the presentation on the Blueprint.

A. Blueprint Update

The Chairman called on Dr. David Driscoll to make his presentation.

Dr. Driscoll thanked Chairman Kilgore and introduced Dr. Karen Rheuban as the principal investigator of the project. He shared that Dr. Rheuban helped support the Blueprint project.

Dr. Driscoll asked Dr. Rheuban if she would like to start the presentation.

Dr. Rheuban introduced herself as a member of the Authority representing the University of Virginia. She shared that she was a pediatrician and faculty member at the University of Virginia.

She shared that a Consortium was formed to apply for the USDA Rural Healthcare Emergency Grant (the "Grant"). Dr. Rheuban noted that the Grant was funded by COVID relief dollars.

She stated that the Consortium members currently included UVA Health, UVA Wise and the Healthy Appalachia Institute, the Authority, Ballad Health, Tri-Area Community Health Services, and the Health Wagon.

Dr. Rheuban expressed her gratitude toward Dr. Driscoll for accepting the role of updating the Blueprint. Dr. Rheuban made note that the Blueprint was distributed to the Authority members and the public ahead of the meeting so that they had ample time to review and prepare for a discussion.

Dr. Rheuban stated that if a quorum was established and the members felt confident in the Blueprint, she would like there to be a motion to approve the Blueprint so long as it met everyone's expectations.

Dr. Driscoll asked if there was a quorum. Mr. Mitchell stated that once the Chairman arrived, they would call roll.

Dr. Driscoll shared that when he and Dr. Rheuban spoke to the Authority in October 2023, they were midway through the Blueprint process.

The order of his presentation would be first to provide an overview of the Blueprint process, then discuss the programs up for consideration, and lastly, he would cover next steps.

Blueprint Overview

There were three phases to the Blueprint process:

> **Phase 1:** An assessment of the leading demographic and health issues among residents of the three regional health districts (January – February 2023);
>
> **Phase 2:** A scoping review of the health literature to understand the context, outcomes, and evidence-based programs promoting Appalachian population health (February – June 2023); and,
>
> **Phase 3:** Community outreach to assess local perceptions of community strengths and priorities related to health problems, contextual areas for improvement, and strategic plans (June – December 2023).

Dr. Driscoll visited all 13 counties and the three western-most health districts in the Commonwealth of Virginia. He spent significant time at county fairs, apple festivals, public libraries, and health departments where he and his team set up a table to talk with constituents and collect surveys.

Dr. Driscoll discussed the results of Phase 1. He referred to his PowerPoint presentation, Exhibit A, which displayed the data. The data used in his report was pulled from the CDC's Wonder Data Set[1] because it contained vital statistics data from across the state.

He stated that on the slide were listed the 10 leading causes of morbidity and mortality in their region and the order in which they occurred. Dr. Driscoll added that most of them were disparity outcomes. He explained that several of the residents in the region were dying at a much higher rate than the state average. For heart disease and for certain cancers, they were twice the rate for their region when compared to the state averages. For diseases of despair, they were close to three times the state average.

Dr. Driscoll shared that they were facing challenges as it related to trying to understand what was going on upstream. What were the drivers for this outcome? What were the reasons for this occurring?

Dr. Driscoll stated that another way to understand disparities was to look at Years of Potential Life Lost ("YPLL"). He explained that YPLL was basically premature mortality. He stated that this included people who were dying at an earlier age than one would anticipate. Dr. Driscoll stated that all three of the health districts in their region had much higher levels of YPLL compared to the state average. He added that this was where the higher rates of mortality were coming from.

[1] https://wonder.cdc.gov/ (March 2023)

Dr. Driscoll stated that in their Blueprint they had prepared a graphic to help explain this data. The graphic is included below as *Figure 1*.

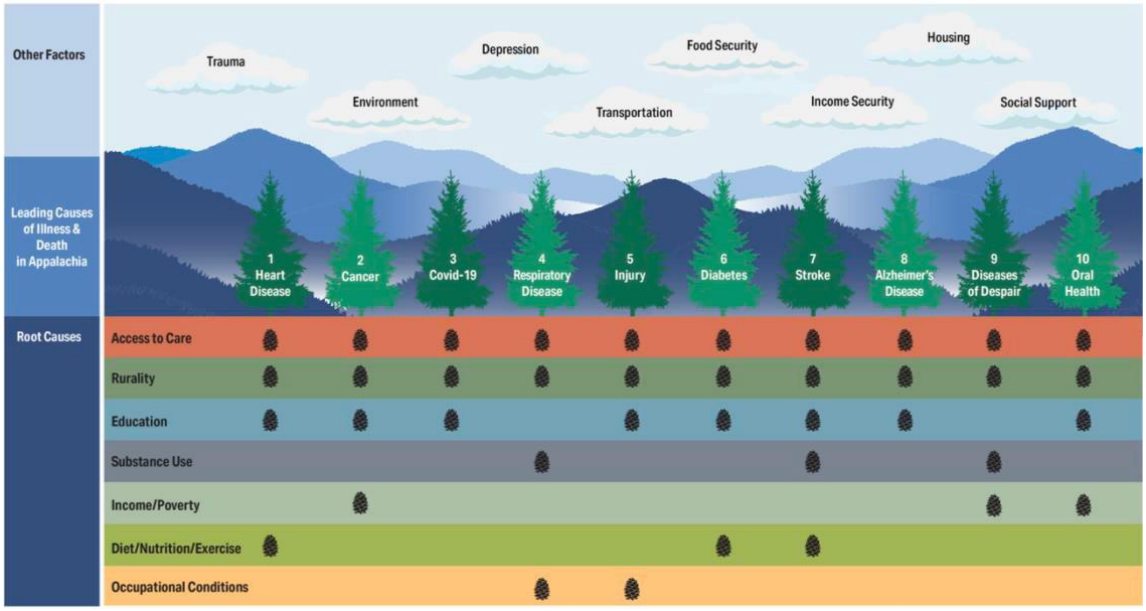

Figure 1. Seeing the Forest

He explained that the trees represented the leading causes of morbidity and mortality in the region. The pinecones were representative of areas where a significant number of articles demonstrated an association. For example, if there was a pinecone between heart disease and access to care, then that meant that there was a lot of evidence to suggest that higher rates of heart disease were associated with lower rates of access to care.

The clouds represented additional root causes or factors that arose during their community discussions. Dr. Driscoll stated that they made it a point to include the clouds in the graph when they surveyed constituents and asked for their feedback.

Dr. Driscoll moved to discuss the survey in more detail.

He stated that they used the same instrument that was used in the original Blueprint from 2009. They made a few modifications as they related to some of the specific outcomes and some of the specific drivers, but the general structure of the instrument remained the same, which allowed them to compare the results to the initial 2009 instrument.

Dr. Driscoll asked participants what the strengths and benefits were to living in the area. He shared that 26% of participants responded that their communities were friendly. Others similarly stated that the neighborhoods were safe, while some answered that a benefit to living in the area was the easy access to parks and recreational areas.

Dr. Driscoll stated that their responses were the same as what they had been hearing for over a decade. He stated that some of those attributes tended to lend themselves well to some of the programs that might be specifically focused on exercise and diet.

When surveying the participants, Dr. Driscoll and his team would ask participants what they thought some of the primary health problems were in the region after they had reviewed *Figure 1*.

The most common responses were diabetes, cancer, heart disease, and substance overdose. Dr. Driscoll referred members to the Blueprint for more details.

Even though *Figure 1* showed diabetes being the sixth leading cause of mortality, participants selected it as the number one health problem in the area, which suggested that the epidemiologic data that they had received from the Commonwealth really did not demonstrate the impact of diabetes on the lived experiences of the residents.

Dr. Driscoll then asked participants what the primary health related areas were where they could really improve and could make interventions or investments to try and improve those health outcomes. He emphasized that this was an important discussion, because in the literature review that they shared the academics who had done a lot of the work had identified several different root causes.

When they had talked to people in the communities, they saw that there were not so many root causes, because several were combined. For example, substance use, stress, and poverty. Dr. Driscoll explained that if they were to try to implement any kind of intervention or program that was intended to try and revise or modify one of those causes, then they would need to modify several other causes. Failing to focus on all of the upstream drivers simply ensured that they were sending people back into the same environment from which they came, and dealing with the same challenges they were dealing with before.

Dr. Driscoll stated that the best programs are the ones that are multi-level (a combination of those factors). That was one of the primary areas where people suggested that there was an opportunity for improvement.

Another area for improvement was in access to care. Dr. Driscoll cited a literature review that focused on access to care. He explained that a simple way to assess was to look at whether there was a healthcare facility in the county. But after talking with residents, Dr. Driscoll stated that simply evaluating whether a healthcare facility existed in a county did not demonstrate access to care, because there were other barriers that needed to be considered. Barriers could include but were not limited to transportation, willingness to seek care at that facility, or insurance status.

Dr. Driscoll reiterated that any efforts to try and implement programs that would reduce those challenges needed to modify *all* of the challenges.

Lastly, areas for improvement would include education, diet, nutrition, and exercise. Dr. Driscoll shared that education was a really important component of most health-related programs. He explained that there were multi-generational factors that led to several health problems reoccurring. The best strategy to try to intervene was through education. By promoting diet and exercise and by helping people to manage their diabetes or pre-diabetes. This was again an instance where Dr. Driscoll stated they were focused on trying to understand the larger assemblage of upstream factors.

Dr. Driscoll paused his report and presentation on the Blueprint to ask if there were any questions.

Delegate Williams agreed with Dr. Driscoll's perspective on education being a major factor when it came to rural healthcare. He shared that food was one of their social needs that had been explored in their rural communities. Delegate Williams referenced a program that the Kentucky Department of Health had been working on with the Department of Agriculture. The program was focused on supplying healthy foods to their communities. It was his hope that the Commonwealth could build on that program.

Dr. Driscoll stated that he completely agreed. He stated that the Kentucky model that Delegate Williams discussed was included in the literature review that they conducted. He shared that one of the things they were doing was creating cookbooks to show how people could prepare nutritional meals using relatively accessible sources of food from local grocery stores. He noted that sometimes that was all that was needed to provide a little bit of education on how to go about creating more healthy diets.

Dr. Driscoll thanked Delegate Williams for his input and continued to the next big discussion of the Blueprint, Programs for Consideration/Discussion.

He shared that when selecting the programs to include on the list, they focused on evidence-based programs. They looked at programs that had been implemented elsewhere, specifically in Appalachia. Dr. Driscoll also shared that they looked at programs that were multi-level, for the reasons discussed earlier.

Additionally, he shared that the programs they had investigated were either already in use by several of their partnering organizations or those partners were planning to start implementing the programs in the near future. Dr. Driscoll stated that their goal was to build onto something rather than start new. They wanted to support the processes already in place. He noted that improving access to care was more than providing a facility, but was also providing support to people who needed to benefit from the programs.

A program that was already in use by several partners was one that focused on high-risk patients and their providers by providing screening programs, telemedicine equipment, and at-home remote patient monitoring equipment and connectivity as needed. This was an evidence-based model that had already been tested elsewhere in Appalachia. Dr. Driscoll shared that they would like to provide protocols and provide support and training for people doing this, in a way that was consistent and integrated.

The second program that Dr. Driscoll discussed was one that looked at telehealth access points. It was also an evidence-based program that had been used across West Virginia and Kentucky. The goal of this program would be to make it so that residents did not have to drive more than 12 miles to reach a telehealth access point.

He suggested that they could place equipment in clinics, libraries, community centers, EMS units, senior centers, pharmacies, and other locations for all residents. By providing consistent equipment, they could ensure that people would be able to access healthcare regardless of their location.

The third program highlighted was an evidence-based program that Ballad Health was currently implementing. The program was a school-based integrated health service. Dr. Driscoll stated that schools were a potential telehealth access point because schools had access to broadband. In addition to broadband availability, the schools had a population of young people who could stand to benefit from many of the programs as well as the staff who worked there.

Dr. Driscoll voiced his support for this program and stated that the Tri-Area was also interested in implementing a similar program.

Dr. Rheuban added that they were looking forward to implementation of the Broadband Equity, Access, and Deployment (BEAD) funding that would bring more bandwidth to patients, homes, and other entities. She stated that it was amazing to have access points that were convenient and

noted that no one was trying to bypass existing providers in the region. Dr. Rheuban stated that they wanted to work with existing providers. She shared that everyone needed a medical home, and this was just another tool to be able to access that medical home and not necessarily have to travel long distances.

Dr. Rheuban stated that there were so many policy changes related to telemedicine that it was part of everyday care. She shared that telehealth was healthcare now.

An attendee at the meeting shared that in Galax, Virginia, they were implementing something similar to the third program discussed in Dr. Driscoll's presentation.

Dr. Mayhew added that there were several Community Support Programs (CSPs) in their region that had school-based behavioral health services. She shared that they could connect with other providers by telehealth from the schools if they need additional services.

Dr. Rheuban shared that there was a Medicaid program that spent a lot of money on the aged, the blind, and the disabled. She shared if they could prevent blindness by just doing a simple exam of the retina, which could be transmitted virtually, then they could get patients care. Dr. Rheuban stated that Diabetic Retinopathy was a silent illness. They had a number of partners across the Commonwealth and Dr. Rheuban added that this was another great opportunity to improve the quality of life and prevent expensive conditions that do not necessarily need to happen.

Senator Pillion stated that if they could get people to exercise, like was mentioned earlier as an example, or doing other things proactively, then they wouldn't need to spend so much money reactively. Dr. Driscoll added that the younger they were the better, because it would make a bigger impact for lifelong improvement.

Ms. O'Dell stated that a few years ago the Community Services Board started doing primary care screenings for all of their adults and children. Especially looking at diabetic screenings and then referring them to their providers. She stated that it was amazing how many people they had identified with diabetes that did not have a provider or have anyone providing any care for them.

Ms. Sloce shared that in LENOWISCO and the Cumberland Plateau, they had been providing preventive dental care in schools for quite some time. She stated that it was a wonderful thing. They also have been doing telehealth colposcopies, working with Every Woman's Life Program partnering with UVA Charlottesville. She stated that now they were actually doing these in-house. They were wonderful opportunities to provide access to care to both children and women who would be unable to travel and get those services.

Dr. Driscoll stated that what Ms. Sloce and the others shared was exactly what he was talking about. He shared that he thought there was a tremendous opportunity to find all of those "bright spots" that were currently taking place around the region and try to bring them together to integrate so that they could learn from each other's experiences.

Dr. Mayhew commented that it was not so much a "bright spot" and joked that it was more of a "dim spot." She stated that a great opportunity for intervention was in their public school systems and in their nutrition plans. She shared that she had a child in the Buchannon County school system. She shared that their food was highly processed, not healthy, most of the children did not eat them, and it was not cool for the kids to bring their own lunch to school. Dr. Mayhew stated that there was an opportunity to make educational interventions because it was the root cause of one of many

of their chronic diseases that they often see. She stated that many chronic diseases were caused by poor eating habits early in life.

Dr. Rheuban added that the UVA Cancer Center was one of the Commonwealth's two comprehensive NCI-designated cancer centers. She shared that they had a relationship with many of the federally qualified health centers ("FQHCs") to do screenings, education, and navigation. Dr. Rheuban stated that this was another opportunity to provide mammography equipment. She shared that they were looking to partner with Tri-Area Community Health about providing mammography equipment where mobile was not necessarily the full solution. Because of the delays in access for women in the area, there was an increase in mortality and morbidity. Dr. Rheuban stated if they could get early intervention and early screening programs, this would be an opportunity to save a life.

Dr. Driscoll shared that one of their meetings was in Grundy, Virginia. The Appalachian College of Pharmacy was a partner in that outreach. They brought a machine to the community meeting and a third of the residents who attended the meeting found out that they were either diabetic or pre-diabetic and had not previously been aware. Dr. Driscoll noted that more widespread screening would certainly make a big difference.

Dr. Rheuban stated that they had a discussion about maternity care, maternal mortality, and infant mortality, which according to the databases that they had searched, the mortality rates were not necessarily higher in their region. She stated that there were "mortality deserts" all along the spine of the Appalachian region. She shared that it was a state and federal priority and that they should look at ways they could improve maternal outcomes statewide using telemedicine. She noted that Medicaid was also looking into programs. This was another way to enhance outcomes longer term.

Dr. Driscoll noted that they would move to discuss the second of the broad categories mentioned earlier. He reminded the Authority that they discussed the need to try and integrate substance use and trauma informed care as well as other programs to try to respond to poverty.

He stated that there were three programs they had identified that were already in place. He shared that their goal was to assist and promote the integration of these programs.

The first program that was integrated was for primary and behavioral treatment, which included trauma-informed therapy and medication management with both in-person and outpatient capacity via telehealth.

CSPs were engaged in the first program as well as many of the existing partners on the project. Dr. Driscoll specifically wanted to point out the medication management. He noted that it was important and something that they should really get out ahead of and say that they approve and support medication management. Dr. Driscoll stated that some of their partners needed to recognize that this was an evidence-based model.

The second program was one that Dr. Driscoll shared he was particularly proud of and excited about. The program used community navigators, particularly peer recovery specialists in the area. Peer recovery specialists brought lived experiences to the table. Dr. Driscoll shared that they generally could help everyone who was going through this process, because they had navigated the process themselves. They could speak to it not just in general terms, but in real local terms.

Dr. Driscoll also stated that if they could create those roles, they could create a paying position for people who were attempting to work their way into a pathway for recovery. It created a model that

people could look to as a first step toward getting back into employment and getting back into the workforce.

He stated that they should really do everything in their power to try to reduce the barriers to this and reduce the stigma associated with it, as to ensure that those individuals were a part of any program that they saw in the area that specifically focused on long-term recovery.

Senator Pillion stated that he carried legislation in 2024 to reduce barrier problems and to get more peer counselors. He shared that it passed and they were now just waiting on the government side of it. Senator Pillion stated that it would put about 1,400 counselors back into the Commonwealth that could not be there otherwise because of the prime barrier.

Ms. Sloce shared that they had a peer recovery specialist in LENOWISCO and a full-time specialist in the Cumberland Plateau. She shared that it had been tremendously successful. Ms. Sloce stated that it had been a great program for them.

Ms. O'Dell shared that they had made great strides in using peers in services. She stated that one of the barriers that she thought that they should work on was the rates that Medicaid private insurance paid for those services. She shared that they had made some strides on this issue in Lee, Wise, and Scott County. Ms. O'Dell stated that they had 10 peers currently working and that they could add another five or six if they could get them through the barrier piece. She was hopeful that the barrier would be removed.

Dr. Driscoll asked if they could continue that conversation after the meeting. He was interested in learning more.

He moved to discuss the last program, which promoted evaluation and management of child abuse and neglect both in-person and through telehealth. He shared that adverse childhood experiences were tragically prevalent in the region. Dr. Driscoll stated that there was a whole host of literature that demonstrated the association between cases of childhood trauma and substance abuse later in life.

They would be interested in promoting multidisciplinary child protected teams, which would be able to identify and screen young people and intervene early to try to reduce cases in their communities.

Dr. Driscoll stated that they already had partners doing this, and that it was an evidence-based strategy. He took a minute to explain that evidence-based means that there is already a set of metrics, that someone had already put together a method of how to go about evaluating certain data.

Dr. Rheuban directed her comment to the two General Assembly members of the Authority and stated that she was disappointed that they did not make it into the final budget and added that they could use any help they could get. She pointed out that they only had two pediatricians left in the entire Commonwealth who were trained to lead child protection teams. She stated that there were originally three. Dr. Rheuban stated that they would do whatever was needed to help solve that challenge. She suggested that Delegate Willett and his select committee could help them as well going forward, because it was a problem across the Commonwealth of Virginia, but in particular, Southwest Virginia.

Dr. Driscoll stated that the last of the general domains was promoting healthy diet, nutrition, and exercise. He stated that this was the first and highest priority issue. He was interested in trying to

help provide nutrition management and physical activity across the region. There were programs already taking place across the region by partners on the project, but he would love to be able to help support those programs and integrate them and unify them.

Dr. Driscoll suggested coming up with a centralized protocol to help evaluate the programs.

He ended his presentation and handed the discussion over to Dr. Rheuban to discuss next steps.

The Chairman thanked Dr. Driscoll.

Delegate Kilgore asked to pause the presentation so he could call roll and declare a quorum.

II. Roll Call

When the Chairman arrived, he called roll. The following members were present: Ms. Helton, Ms. Brillhart, Mr. Flanary, Mr. Chapman, Ms. O'Dell, Mr. Prewitt, Ms. Gulley, Dr. Rheuban, Dr. Mayhew, Mr. Showalter, Mr. Block, Delegate Williams, Ms. Sloce, Senator Pillion, and Delegate Kilgore.

Mr. Barry, Mr. Eichorn, and Mr. Meyer attended the meeting virtually.

Mr. Mitchell attended the meeting in person as legal counsel to the Authority.

III. Declaration of Quorum

The Chairman declared a quorum existed at 5:52 p.m.

The Chairman asked Dr. Rheuban to continue her presentation.

Dr. Rheuban stated that after the robust discussion of the Blueprint, she wondered if the Authority would feel comfortable with a motion to approve the Blueprint.

The Chairman stated that he felt that they had done a great job on identifying the issues. He felt that most of the members who were involved in healthcare on a day-to-day basis realized that these were the issues that they had been working on for quite some time. He stated that telemedicine would play an important role. He reiterated that they had done a great job.

The Chairman asked if anyone had questions or comments. No questions or comments were heard.

The Chairman asked if there was a motion to approve the Blueprint. Senator Pillion motioned to approve the 2023–2024 Blueprint for Health Improvement and Health-Enabled Prosperity, and Dr. Mayhew seconded. The motion was approved unanimously.

IV. Approval of Minutes

Following the presentation, the Chairman returned to the agenda and asked for a motion to approve the meeting minutes from the June 26, 2023 meeting of the Authority Board of Directors and the October 16, 2023 Meeting of the Authority Board of Directors.

Ms. Brillhart made a motion to approve the minutes, and Ms. O'Dell seconded her motion. The motion passed unanimously.

V. Officers Report

A. Treasurer's Report

The Treasurer's Report was written into the meeting material since Dr. Henry was unable to attend the meeting.

The report stated that the current cash balance of the Authority's account was $70,822.50.

Last quarter, the Authority received their annual payment from the Cooperative Agreement with Ballad Health in the amount of $75,000.00.

Expenditures since the previous meeting were mainly catching up outstanding invoices to The Mitchell Law Firm, A Professional Corporation, for legal services, and to Dennis Barry for his salary for monitoring activities, along with the appropriate payroll taxes.

The Chairman asked for a motion to ratify the payments. Senator Pillion made a motion to ratify and approve the payments. Mr. Prewitt seconded the motion. The motion passed unanimously.

VI. New Business

B. Designation of Monitor

The Chairman stated that Mr. Barry transitioned from full-time status to part-time status in January 2024. The Chairman thanked Mr. Barry for all of his help and thanked him for staying on part-time.

The Chairman asked that the Authority ratify Mr. Barry's part-time employment offer.

Senator Pillion made a motion to ratify the employment offer and Dr. Rheuban seconded the motion. The motion passed unanimously.

Mr. Mitchell reminded the Board that Dr. Driscoll was serving as interim monitor alongside Mr. Barry until a more permanent replacement was found.

C. USDA Rural Healthcare Emergency Grant Update

Dr. Rheuban stated that the Blueprint was born of the region and needed to be implemented by the region and the regional stakeholders. She stated that she hoped they would consider a smaller working group that would prioritize where they would spend the dollars and what grants they could apply for collaboratively.

The Chairman stated that a draft Charter of the committee has been prepared, included as Exhibit B, that allowed up to seven members. He asked if anyone present at the meeting would be interested in serving on that committee. If there were no volunteers, then he would appoint members.

Mr. Mitchell informed the Chairman that they needed a motion to adopt the Charter for the Grant Committee and appoint the committee members.

Mr. Prewitt motioned to approve the Grant Committee and appoint the committee members. Ms.

Brillhart seconded the motion. The motion to approve the Charter of the Grant Committee passed unanimously.

Mr. Mitchell stated that one of the reasons that they prepared a Charter for the Grant Committee was because it was a public body. They would be responsible for acting as a public body.

Dr. Rheuban stated that they were looking for additional partners to join the consortium. She stated that in discovery and discussions, Mountain Empire Older Citizens played a huge role in the region and they would love to have them officially join the Consortium.

She stated that she did not want to appoint people to the Consortium without the approval of the Authority.

Dr. Rheuban suggested that the CSPs who serve the region should also be members of the Consortium. She asked if there were any thoughts on adding new members to the Consortium.

Mr. Showalter asked if they had any small rural health clinics that could join the Consortium. Dr. Rheuban stated that Tri-Area Community Health and the Health Wagon were members. She stated that they would take others if they wanted to join.

Dr. Rheuban stated that as they disseminated innovative projects and funding for innovative projects they wanted to include all. She stated that innovative models could be applied to anyone, to any of those groups.

Ms. O'Dell stated that there were four other CSP directors in their region that she was sure would be happy to participate.

Dr. Rheuban stated that they knew there were strategies to secure funding for those projects. She stated that there was already some funding as part of the USDA Grant. She stated that the Authority has some members of the General Assembly who could help with appropriations for the projects that meet the needs and have been identified.

The Chairman thanked Dr. Rheuban for her report.

The Chairman shared that he was on the Authority back when then-Delegate Phillips drafted the first Blueprint in 2016. He noted that Dr. Cantrell led a revision of the Blueprint goals in 2017. He pointed out that they were on the third iteration of the Blueprint and emphasized that it was great progress for the Authority.

He thanked everyone for their hard work and their commitment to Southwest Virginia.

VII. Announcements

The Chairman stated that there were no announcements.

VIII. Next Meeting of Authority

The next meeting of the Authority has not been determined. The Chairman stated that it will probably be sometime in the late summer or early fall.

He added that there would be a Cooperative Agreement Task Force meeting before then.

IX. Public Comment

Mr. Mitchell stated that no one had signed up to make a public comment.

X. Adjournment

The Chairman ended the meeting at 6:05 p.m.

Attached

Exhibit A – PowerPoint Presentation (Dr. Driscoll)

Exhibit B – Charter of Grant Committee