Blueprint for Health Improvement and Health-Enabled Prosperity

Southwest Virginia Health Authority 2009

Adopted May 13, 2009

by

Southwest Virginia Health Authority
c/o GMEC
One College Avenue
Wise, Virginia 24293
276-328-0249

2nd Printing - August 2009

MISSION:

The Southwest Virginia Health Authority seeks to improve quality of life in the region by enhancing, fostering and creating opportunities that advance health status and provide health-related economic benefits for people of all ages.

VISION:

The vision of the Southwest Virginia Health Authority is to achieve continuous improvement in the health and prosperity of the region.

COMMONWEALTH OF VIRGINIA
HOUSE OF DELEGATES
RICHMOND

BUD PHILLIPS
POST OFFICE BOX 36
CASTLEWOOD, VIRGINIA 24224

SECOND DISTRICT

COMMITTEE ASSIGNMENTS:
PRIVILEGES AND ELECTIONS
GENERAL LAWS
APPROPRIATIONS

June 10, 2009

Dear Reader:

This *Blueprint for Health Improvement and Health Enabled Prosperity* represents the work of many caring people who worked thoughtfully for over a year on its creation. Crucial input was gathered from key leaders and citizens from throughout far Southwest Virginia and the broader region who represented not only the healthcare sector but also business, education, and government. Crafted by the members of the Southwest Virginia Health Authority, this *Blueprint* is the first definitive strategic plan of its kind for our region – a region whose people have suffered from health disparities far too long.

In this *Blueprint* you will find a summary of our region's health challenges and gain a better understanding of why the seven counties and one city in our Coalfields have a premature mortality rate 26 percent higher than the state as a whole. More importantly, you will see a comprehensive plan developed by our region to improve our health and the quality of our lives. Because the problems are numerous and significant, priorities were delineated for the Authority to address first; however, we welcome your assistance in implementing any of the needed actions and recognize and applaud the work that is already ongoing in a number of these areas. All resources, both within and outside our region, must be garnered for Southwest Virginia to experience true and lasting progress.

Though by necessity this *Blueprint* is all business in structure and intent, it is grounded in and fueled by the heart and spirit of the people of our region, and by all of us who believe that in improving health we secure our future prosperity.

Our work has just begun.

Sincerely

Clarence "Bud" Phillips
Chairman, SW Virginia Health Authority

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I. INTRODUCTION

In 2007, the Virginia Legislature created a special state organization called the Southwest Virginia Health Facilities Authority (SVHA) for the LENOWISCO and Cumberland Plateau Planning Districts. (The word "Facilities" was dropped by the legislature in 2009.) The Authority is governed by a board of directors that include Virginia legislators, nominal members and one appointed member from each participating locality. Named officers include a chairman and vice chairman. The Authority has also determined to name a secretary/treasurer. Actions of the Authority require an affirmative vote by a majority of a quorum of its members.

The Authority has broad powers to conduct its affairs including receiving appropriations; the issuance and sale of bonds and provision to secure payment and provide for legal investment of bonds; exemption from foreclosure, execution sale or judgment lien; and eminent domain (see the Appendix for a more complete list of the Authority's powers/ responsibilities taken from the enacting legislation).

II. PLANNING PROCESS

The Authority's members concluded soon after its initial meetings in late 2007 that a formal strategic blueprint was needed to direct its future operations and projects. A special planning Retreat of available Authority members and health experts was therefore convened in late May 2008, by the Vice-chair, Dr. John Dreyzehner. They began the process of drafting this Blueprint for Health Improvement and Health-Enabled Prosperity for the LENOWISCO and Cumberland Plateau planning districts. The specific purposes of the Retreat were to:

- Review Healthy Appalachia's Analysis of Strengths, Weaknesses, Opportunities & Threats
- Create vision and mission statements for the Authority to review
- Discuss draft goals, objectives and potential measurable outcomes and
- Set a possible timeline for accomplishing the goals

The products actually generated at the Retreat (presented below) did not include completion of the above-mentioned objectives and outcomes, due to time constraints, but all other tasks were accomplished resulting in the first iteration of the blueprint.

This Blueprint was approved by the Authority and serves as the foundation for further strategic planning.

Among the documents reviewed at the Retreat were the results of the "Healthy Appalachia" analysis of the region's Strengths, Weaknesses, Opportunities and Threats (SWOT Analysis). Healthy Appalachia is a collaborative planning process funded through a grant from the Appalachian Regional Commission that calls for the development of a strategic plan for improving the health of people in the Cumberland Plateau and LENOWISCO planning districts of Virginia. Essential to the development of this regional strategic health plan is the engagement of local leaders from health care, education and public service in the planning process to develop a profile of the region's strengths, weaknesses, opportunities and threats.

The Healthy Appalachia SWOT planning process took place in early May 2008 and had the support of the Authority and the active participation of many of its members including the Chair, Vice Chair and Secretary. At the Retreat, Authority members and other local experts were provided the notes from the SWOT meetings (Appendix B) and offered a "30,000 foot" summary presentation of the overarching consensus points from the SWOT:

- The region has reached a strategic inflection point - a critical moment for change
- To effect substantial and lasting change, the improvement of health is interconnected with advances in education and business opportunities
- While there is increasing collaboration, the region is still fragmented in its approach to health planning and delivery
- There is a need to develop a truly regional solution for Central Appalachia
- There is an opportunity in our region to craft a model for all of Appalachia
- The region's topography has a significant impact on planning
- The region has significant strengths in its natural beauty and culture
- The gap in the health of the region when compared to the Commonwealth is widening (see below)
- The improvement of health and prosperity require a systematic approach to public health by its many stakeholders and providers including government, academia and the public and private sectors
- Significant resources will be required
- There is now a broadly held consensus among the region's leaders on strengths weaknesses, opportunities and threats
- Now is the time to think and act boldly

III. THE HEALTH STATUS OF LENOWISCO AND CUMBERLAND PLATEAU PLANNING DISTRICTS (PD I and II)

Prior to the Healthy Appalachia and Authority Retreat meetings, a report was circulated outlining the region's demographics and health status. A summary of that report is presented below.

Population

Approximately three (3) percent of Virginia's population of 7.6 million or about 200,000 individuals reside in these two planning districts. There was a decrease of 4.29 percent in total population for these counties according to the 2000 Census compared to an increase of 14.40 percent for Virginia for the same period. The rate of population loss is most acute for ages 20-39.

Race and Place of Birth

In this region, more than 95 percent of the population is white; the rate for the whole of the Commonwealth is 72 percent, a statistically significant difference. More than 72 percent of the residents of PD I and II were born in Virginia.

Education, Poverty and Income

According to the 2000 census, only 62 percent of the region's population completed high school and 11 percent college, compared with 82 percent and 30 percent respectively for Virginia. Over 20 percent of the residents of the two districts live below the poverty level compared to 10.2 percent for Virginia. Per-capita income levels in the region are a little more than half of the levels of the state for 2000. In 2005, the median household income was $26,780 versus $51,980 for the state (source: Virginia Atlas).

Employment and Health Insurance

The percentage of the working population is approximately 45 percent in these counties, almost 20 percent less than the overall percentage for the state. Unemployment is on average 5 percent compared to 3 percent for the state. The number of residents in the region not in the labor force is almost double that of the state. Many of these are so-called "discouraged workers" who have ceased attempts to find employment, or persons of working age who receive disability and are not counted in unemployment rates. Of these residents, 31,833 (or over 19 percent) did not have insurance coverage for the years 2003-2005 according to Virginia Department of Health (VDH).

Disease Risk Factors

These two planning districts have higher rates of health risks than the Commonwealth in obesity, blood pressure and cholesterol levels. There are statistically significant higher risk levels in the percent of adults who smoke and/or have exposure to secondhand smoke at home and work.

Mental Health Issues

Based on a Community Service Board (CSB) study in May 2007, more people in PD I and II who presented at a CSB displayed overt indication of danger to self than in Virginia (47.5 percent vs. 37.1 percent). This difference is statistically significant. The adjusted suicide rate for the region is over 20 per 100,000 residents, compared to 11 per 100,000 in the state. From the 2006 Virginia Coroner's Report, the adjusted death rate from fatal drug overdosing for these districts was 40 per 100,000 residents, compared to 8.3 for Virginia.

Leading Causes of Death

The leading causes of death in the region are heart disease, cancer, cerebrovascular disease, chronic lower respiratory disease, accidents and diabetes. The mortality rate for all causes in Virginia is 780 (±14) deaths per 100,000 residents. The corresponding rates for PD I and PD II are 1,246 (±34) and 1,182 (±73) per 100,000, respectively. This is approximately 26 percent higher when compared with the rest of the Commonwealth. An analysis of variance showed that the mortality rates are statistically significant.

Heart disease remains the number one cause of death in the region and the state. Each year there are approximately 14,700 deaths in Virginia which represent 203 (±11) deaths per 100,000. PD I and PD II account for approximately 5 percent of these cases each year. These districts have a death rate of 344 (±25) and 338 (±32) deaths per 100,000, respectively.

- In Virginia, the death rate for solid tumor cancers is 185 (±5) deaths per 100,000. In PD I and PD II the death rate is 267 (±39) and 239 (±23) per 100,000 respectively, approximately 4 percent of the total deaths in the state from these cancers.

- The probability of dying of CLRD (Chronic Lower Respiratory Disease) in this area is twice the probability of dying of the same cause elsewhere in Virginia. Each year there are 160 deaths in these districts, which represents 5.75 percent of the total number of deaths in the state due to CLRD. The average mortality rate of these counties from CLRD is statistically significant from the mortality rate of the state.

- The total number of deaths from unintentional injury is approximately 145 cases per year, which corresponds to 6.11 percent of the state total. The death rate due to unintentional injury in these counties is a statistically significant variance from the state rate.

- The fifth-leading cause of mortality in these planning districts is from diabetes. The mortality rate in the region is almost twice that of the state. Each year, nearly 80 people die from this disease, which represents about 5.15 percent of the deaths in the state from diabetes.

These health disparities as reflected in this health status analysis of Planning Districts I and II, and relative to these measures for the population of Virginia, are consistent with the trends seen in the Appalachian region as a whole, including the regions in the bordering states of Kentucky, Tennessee and West Virginia. "Place matters" and these geographic health disparities are a regional, state and national challenge.

They are shared across socio-economically disadvantaged populations, including inner cities and other rural areas.

IV. RESULTS OF THE PLANNING RETREAT: MISSION AND VISION STATEMENTS

Mission Statement: The SVHA seeks to improve quality of life in the region by enhancing, fostering and creating opportunities that advance health status and provide health-related economic benefits for people of all ages.

Vision Statement: To achieve continuous improvement in the health and prosperity of the region.

Values:

Collaborative
Flexible & Adaptable
Innovative
Data-driven & Evidence-based
Inclusive
Homegrown
Integrative
Accountable to Community
Having Integrity

V. RESULTS OF THE PLANNING RETREAT: FOUNDATIONAL RECOMMENDATIONS

1. There is a need to inventory existing regional resources, establishing a workgroup composed of ETSU/UVA Schools of Public Health, the Virginia Department of Health, the Southwest Virginia Area Health Education Center and other appropriate entities.

2. A multi-stakeholder inclusive approach is critical to achieve the desired continuous improvement in the health, the education and the prosperity of the region.

VI. RESULTS OF THE PLANNING RETREATS AND PUBLIC COMMENTS: GOAL STATEMENTS, OBJECTIVES AND RELATIVE TIMELINE

Starting with inputs from the community and a schematic diagram/logic model (see next page), Goals and Objectives were developed by the Authority with timeframes divided into three Timeline Categories: **Near** (N) meaning 0-2 years, **Intermediate** (I) meaning 3-9 years, and **Long-Term** (L) meaning 10+ years.

Also developed were some Strategic Goal Categories . . .

Overall Health
Health-related Economic Benefit
Health Workforce
Health Systems and Policies
Health Information
Health (in/and) Education

And some Organizational Goal Categories . . .

Development
Funding
Advocacy
Operations

Goal Statements: The main result of these efforts of the Authority and the stakeholders and community members who provided input to this document is the following list of Goals A to T, with more specific objectives under each (asterisks - * - denote priority objectives – see also Appendix #2):

A. Improve health status of the region – to include . . . [Overall Health]

- Oral Health

1. Increase the number of children that access dental care annually (N)
2. Increase to 90 percent the percentage of children who have dental sealants applied (I)
3. Enable dental hygienists to provide preventive care independently in the region (N)
4. Increase the permanent dentist workforce in the region [dentist to population ratio to become better than national and state rate] (N,I)*
5. Create a dental school in the region (I)*

- Medical And Behavioral Health

6. Decrease regional drug overdose deaths by half (N,I)*
7. Decrease regional suicide rate to below state rate (N,I)
8. Increase the permanent licensed behavioral health workforce in the region to parity with state ratios (I)*
9. Reduce the health disparities of premature mortality from heart disease, solid tumor cancers, chronic lower respiratory disease, unintentional injury and diabetes [to parity or better than state rates](L)
10. Increase permanent specialty medical care workforce, particularly in endocrinology, pulmonology, psychiatry, cardiology (preventive and noninvasive) and oncology (I)
11. Create a model collaborative permanent bricks and mortar medical specialist training center of excellence located in the region with a dual workforce development and care mission (I)*
12. Increase the permanent ancillary licensed care providers (PT, OT, ST, RD etc.) to at least parity with state ratios (I)
13. Expand the regional network of community health centers (including FQHCs – Federally Qualified Health Centers) (I)

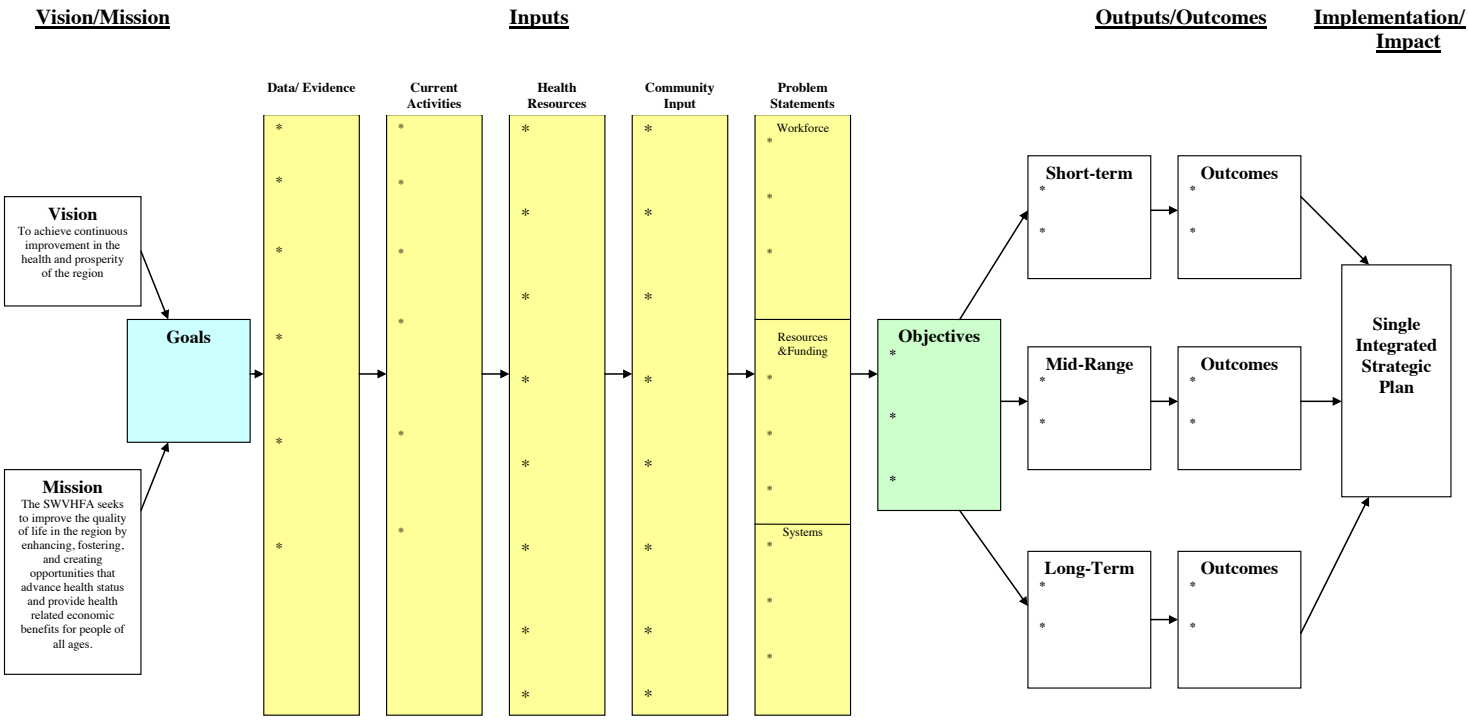
- Fitness And Wellness Opportunities

14. Decrease tobacco use rates to below state levels (N,I)
15. Enhance, foster or create (as needed) fitness centers in each county in the region (N,I)
16. Enhance, foster or create (as needed) outdoor sporting facilities in the region for people of all ages (N,I)
17. Enhance, foster or create connecting multi-use (non-motorized) trails in all of our communities (L)
18. Enhance, foster or create walkability and bikability in all of our regional communities (I,L)
19. Create or foster age appropriate school-based, after-school athletic and arts activities, targeted at elementary and middle school children that promote lifetime fitness and athletic confidence and/or artistic development and confidence (and ensure these activities can be and are utilized by high risk and disadvantaged children and measure the results in term of subsequent academic success and high school completion rates) (N,I)

B. Advocate for effective/inclusive care payment systems in the region [Systems and Policy]

1. Pilot cost-based reimbursement for primary care and targeted specialty care providers in the MUSAs (Medically Underserved Service Areas) in the region (I)

C. Advocate for payment parity for primary care



providers and nonprocedural specialists, including behavioral health [Systems and Policy; impacts Workforce]

1. Pilot parity for cognitive services (versus procedural) in MUSAs in the region (I)

D. Insure appropriate number of and access to providers [Workforce]

- *Cross-reference with objectives in A*

E. Improve health entity collaboration and encourage regional integration where appropriate. [Systems and Information]

1. Enhance the Collaboration of the Authority with the Healthy Appalachia Institute (N,I)
2. Complete Health Authority Organizational Goals (N,I)
3. Foster CareSpark's role in regional electronic health information sharing to include prescription information exchange (N,I)*

F. Improve workforce (care and academic) and development (and retention) related to health careers and foster educational collaboration between regional education and providers [improve workforce development related to health careers, improve retention of the health care worker, and improve healthcare work environment] [Workforce]

- *Cross-reference with objectives in A*

1. Foster the establishment of academic certificates in health areas (e.g., public health, health administration, others) geared toward "in career" adult learners with or without bachelor's degrees (N)*
2. Create an "Introduction to Public Health" course in the regional community colleges and universities to enhance awareness and understanding of health among ancillary health care workers and others (N)*
3. Expand and enhance Allied Health (AH) professional training, including establishing a new AH center at Mountain Empire Community College (I)*

G. Enhance academic engagement in regional health [Impacts all 5 strategic goals]

1. Establish a regional standard for community-based participatory research (N)
2. Establish a mechanism for operational collaboration among regional academic institutions (N)

H. Improve and enhance the quality of life for at-risk children and families [Overall Health, Economic Benefit, Systems and Policies, Education]

- *Cross-reference with objectives in A*

1. Decrease the percentage of children in foster care to parity with the state rate and increase the regional prevalence of "kin-care" (I)*
2. Increase the percentage of children with a medical home and SCHIP enrollment above state rates (I)
3. Increase the enrollment of eligible women and children in Women, Infants and Children (WIC) and the number of WIC retailers in the region to parity with state rates (N,I)
4. Decrease children's exposure to secondhand smoke in the region (N,I)
5. Create in place a regional residential care capacity for children (N,I)

I. Improve access and portability of patient health information, and encourage health information exchange and e-health services including telemedicine [Overall Health, Economic Benefit, Information]

1. Foster "last mile" of broadband infrastructure to enable connectivity among providers, health centers and patients to enable access to 90 percent of regional households and businesses (I)*
2. Advocate for mandated insurance coverage for telehealth services (N)*
3. Obtain resources to subsidize regional health provider adoption of electronic health records (N,I)*
4. Obtain resources to enable CareSpark to connect regional providers (N)*

J. Increase resources and services for mental health and substance abuse including nicotine addiction [System and Policies]

- *Cross-reference with objectives in A*

1. Support Appalachian Substance Abuse Coalition and OneCare Substance Abuse Consortium strategies and objectives for combating substance abuse in the region (N,I)*
2. Increase the in-place regional inpatient capacity for treatment of mental health and substance abuse diagnoses by 25 percent or more (N,I)*

K. Insure early health education interventions [Health in Education]

1. Pilot well-designed (in consultation with Healthy Appalachia) health literacy education initially targeted to at least 10 percent of all regional pre-K through elementary school children (N)

L. Advocate for economic incentives for job creation in[cluding] health care [Workforce impacts Economic Benefit]

1. Research and establish a model for expansion of the health care sector in the regional economy (N)*
2. Pilot an incentive program to attract health care sector small businesses using incentives based on direct economic impact rather than number of jobs created (N)*

M. Support regional efforts in education and economic development [Education, Economic Benefit impacts Overall Health]

- *Cross-reference with objectives A, K, L*

1. Engage regional economic development entities in recruitment of health care and education sector business recruitment, including incentives (I)

N. Advocate for environmental health quality that improves the health of the region [Overall Health]

1. Advocate for expanded resources for regional water and sewage solutions (N,I)*
2. Map non-compliant sewage systems (e.g., "straight pipes") to target for mitigation (N)

O. Empower individuals and communities to better maintain their own health [Overall Health]

- *Cross-reference with objectives in A*

P. Assure access to affordable healthcare [Overall Health]

- *Cross-reference with objectives in A, B, C, D, E*

Q. Coordination of Authority mission and goals with hospital healthcare delivery systems. [Systems and Policy]

- *Cross-reference with objectives in E, F, G*

R. Partner-collaborate with hospitals: Investment in new and enhance current services integration-continuity of care [Systems and Policy]

- *Cross-reference with objectives in E, I*

S. Advocate for COPN (Certificate of Public Need) continuation to ensure the orderly development of care in the region

T. Work to enhance the capacity of the Authority to affect the strategic plan [Organization goals]

1. Obtain funding for Authority operation (N,I)*
2. Develop the positions of Executive Director, Health Planner, Health Economist, Community Liaison, Administrative Assistant, and IT (N,I)*
3. Develop legislative agenda (N,I)*

VII. CONCLUSION

It is envisioned that this document will serve to concentrate the activities of the Authority for the foreseeable future. As that future unfolds, this Blueprint will, of course, need to be updated and made pertinent to new realities, but for the present it represents a succinct and cogent statement of the Authority's strategic direction. It is envisioned that this Blueprint's implementation, as the above mission statement makes explicit, will bring about significant improvements in the quality of life in the region.

Appendix 1

Functions/powers of the Southwest Virginia Health Authority as granted by the Virginia Legislature in 2007

1. Sue and be sued; adopt a seal and alter the same at pleasure; have perpetual succession; and to make and execute contracts and other instruments necessary or convenient to the exercise of its powers.

2. Employ such technical experts and such other officers, agents, and employees as it may require, to fix their qualifications, duties, and compensation, and to remove such employees at pleasure.

3. Acquire within the territorial limits of the participating localities embraced by it, by purchase, lease, gift, or otherwise, whatever lands, buildings, and structures as may be reasonably necessary for the purpose of establishing, constructing, enlarging, maintaining, and operating one or more hospitals or health centers.

4. Sell, lease, exchange, transfer, or assign any of its real or personal property or any portion thereof or interest therein to any person, firm, or corporation whenever the Authority finds such action to be in furtherance of the purposes for which the Authority was created.

5. Acquire, establish, construct, enlarge, improve, maintain, equip, and operate any hospital or health center and any other facility and service for the care and treatment of sick persons.

6. Make and enforce rules and regulations for the management and conduct of its business and affairs and for the use, maintenance and operation of its facilities and properties.

7. Accept gifts and grants, including real or personal property, from the Commonwealth or any political subdivision thereof and from the United States and any of its agencies; and accept donations of money, personal property, or real estate and take title thereto from any person.

8. Make rules and regulations governing the admission, care, and treatment of patients in such hospital or health center, classify patients as to charges to be paid by them, if any, and determine the nature and extent of the service to be rendered patients.

9. Comply with the provisions of the laws of the United States and the Commonwealth and any rules and regulations made thereunder for the expenditures of federal or state money in connection with hospitals or health centers and to accept, receive, and receipt for federal and state money granted the Authority or granted any of the participating localities embraced by it for hospital or health center purposes.

10. Borrow money upon its bonds, notes, debentures, or other evidences of indebtedness issued for the purpose only of acquiring, constructing, improving, furnishing, or equipping buildings or structures for use as a hospital or health center, and to secure the same by pledges of its revenues and property as hereafter provided. This power shall include the power to refinance all or any portion of such debt, to renegotiate the terms of all or any portion of such debt, and to retire all or any portion of such debt prior to its maturity date.

11. Execute all instruments necessary or convenient in connection with the borrowing of money and issuing bonds as herein authorized.

12. Enter into leases and agreements with persons for the construction or operation or both of a hospital or health center by such persons on land of the Authority.

13. Contract for the management and operation of any hospital or health center subject to the control of the Authority; however, the Authority may charge such rates for service as will enable it to make reasonable compensation for such management and operation.

14. Assist in or provide for the creation of domestic or foreign stock and nonstock corporations, limited liability companies, partnerships, limited partnerships, associations, foundations, or other supporting organizations or other entities and to purchase, receive, subscribe for, or otherwise acquire, own, hold, vote, use, employ, sell, mortgage, lend, pledge, or otherwise dispose of shares of or other interests in or obligations of any domestic or foreign stock and nonstock corporations, limited liability companies, partnerships, limited partnerships, associations, foundations, or other supporting organizations, joint ventures, or other entities organized for any purpose, or direct or indirect obligations of the United States, or of any other government, state, territory, governmental district or municipality or of any other obligations of any domestic or foreign stock or nonstock corporation, limited liability company, partnership, limited partnership, association, foundation, or other supporting organization, joint venture or other entity organized for any purpose or any individual. The investments of any entity wholly owned or controlled by the Authority that is an “institution,” as such term is defined in § 55-268.1, as amended, shall be governed by the Uniform Management of Institutional Funds Act (§ 55-268.1 et seq.) of the Code of Virginia.

15. Participate in joint ventures with individuals, domestic or foreign stock and nonstock corporations, limited liability companies, partnerships, limited partnerships, associations, foundations, or other supporting organizations or other entities for providing medical care or related services or other activities that the Authority may undertake to the extent that such undertakings assist the Authority in carrying out the purposes and intent of this chapter.

16. Provide domestic or foreign stock and nonstock corporations, limited liability companies, partnerships, limited partnerships, associations, foundations or other supporting organizations, joint ventures or other entities owned in whole or in part or controlled, directly or indirectly, in whole or in part, by the Authority with

appropriate assistance, including making loans and providing time of employees, in carrying out any activities authorized by this chapter.

17. Make loans and provide other assistance to domestic or foreign stock and nonstock corporations, limited liability companies, partnerships, limited partnerships, associations, foundations or other supporting organizations, joint ventures, or other entities.

18. Transact its business, locate its offices and control, directly or through domestic or foreign stock and nonstock corporations, limited liability companies, partnerships, limited partnerships, associations, foundations or other supporting organizations, joint ventures, or other entities, facilities that will assist or aid the Authority in carrying out the purposes and intent of this chapter.

19. Procure such insurance, participate in such insurance plans, or provide such self-insurance, or any combination thereof, as it deems necessary or convenient to carry out the purposes and provisions of this chapter. The purchase of insurance, participation in an insurance plan, or creation of a self-insurance plan by the Authority shall not be deemed a waiver or relinquishment of any sovereign immunity to which the Authority or its members, officers, directors, employees, or agents are otherwise entitled.

20. Exercise all other powers granted to nonstock corporations pursuant to § 13.1-826.

* * * *

Editor's Note: The Authority is also limited in that it remains subject to the Certificate of Public Need law, its powers and authorities do not apply to or affect any hospital as defined in § 32.1-123, nor to the facilities, equipment, or appropriations of any state agency including, but not limited to, the Virginia Department of Health and the Department of Mental Health, Mental Retardation, and Substances Abuse Services.

Appendix 2

Table of Authority Blueprint Goals and Objectives with Near, Intermediate, and Long-Term Time Frame Characteristics Summarized and with Adopted Priorities in BOLD and Green for Objectives and in BOLD and Blue for Corresponding Priority Goals

Goal	*Related Objectives*	*Brief Summary of Blueprint Wording*	*N*	*I*	*L*
A		**IMPROVE HEALTH STATUS OF THE REGION**			
	1	***Children that access dental care***	**X**		
	2	***Children who have dental sealants***		**X**	
	3	***Dental Hygienists to provide preventive care***	**X**		
	4	***PERMANENT DENTIST WORKFORCE***	**X**	**X**	
	5	***DENTAL SCHOOL***		**X**	
	6	***DRUG OVERDOSE DEATHS***	**X**	**X**	
	7	***Suicide rate***	**X**	**X**	
	8	***PERMANENT LICENSED BEHAVIORAL HEALTH WORKFORCE***		**X**	
	9	***Health disparities of premature mortality***			**X**
	10	***Permanent specialty medical care workforce***		**X**	
	11	***MEDICAL SPECIALIST TRAINING CENTER OF EXCELLENCE***		**X**	
	12	***Permanent ancillary licensed care providers (PT, etc.)***		**X**	
	13	***Community health centers***		**X**	
	14	***Tobacco use rates***	**X**	**X**	
	15	***Fitness centers in each county in the region***	**X**	**X**	
	16	***Outdoor sporting facilities***	**X**	**X**	
	17	***Multiuse (non-motorized) trails***			**X**
	18	***Walkability and bikability***		**X**	**X**
	19	***After school athletic and arts activities***	**X**	**X**	
B		**Effective/inclusive care payment systems**			
	1	***Pilot cost based reimbursement for … providers***		**X**	
C		**Advocate for payment parity**			
	1	***Parity for cognitive services***		**X**	
D		**Appropriate number of and access to providers**			
E		**HEALTH ENTITY COLLAB. AND REGIONAL INTEGRATION**			
	1	***Collaboration of the Authority with the Institute***	**X**	**X**	
	2	***Health authority organizational goals***	**X**	**X**	
	3	***CARESPARK***	**X**	**X**	
F		**WORKFORCE AND DEVELOPMENT**			
	1	***CERTIFICATES IN HEALTH AREAS***	**X**		
	2	***'INTRODUCTION TO PUBLIC HEALTH' COURSE***	**X**		
	3	***ALLIED HEALTH INITIATIVES INCLUDING AT MECC***		**X**	
G		**Academic engagement**			

Goal	Related Objectives	Brief Summary of Blueprint Wording	N	I	L
	1	Community-based participatory research	X		
	2	Collaboration among academic institutions	X		
H		QUALITY OF LIFE FOR AT-RISK CHILDREN AND FAMILIES			
	1	CHILDREN IN FOSTER CARE; "KIN-CARE"		X	
	2	Children with a medical home and SCHIP		X	
	3	Eligible women and children in WIC; more retailers	X	X	
	4	Children's exposure to secondhand smoke	X	X	
	5	Regional residential care capacity for children	X	X	
I		PATIENT INFORMATION, E-HEALTH SERVICES			
	1	BROADBAND INFRASTRUCTURE		X	
	2	INSURANCE COVERAGE FOR TELEHEALTH SERVICES	X		
	3	ELECTRONIC HEALTH RECORDS	X	X	
	4	CARESPARK CONNECTION RESOURCES	X		
J		MENTAL HEALTH/SUBSTANCE AB./INCLUDING NICOTINE			
	1	APPAL. SUB. ABUSE COAL./ONECARE SA CONSORTIUM	X	X	
	2	INPAT. CAPACITY MENTAL H. AND SUBSTANCE ABUSE	X	X	
K		Early health education interventions			
	1	Health literacy education	X		
L		ECONOMIC INCENTIVES FOR JOBS IN[CLUDING] HEALTH			
	1	MODEL FOR H. CARE SECTOR IN REGIONAL ECONOMY	X		
	2	INCENTIVES FOR HEALTH CARE SMALL BUSINESSES	X		
M		Education and economic development			
	1	Recruitment of h. Care and education sector business		X	
N		ENVIRONMENTAL HEALTH QUALITY			
	1	REGIONAL WATER AND SEWAGE SOLUTIONS	X	X	
	2	Noncompliant sewage systems	X		
O		Individuals and communities maintain their health			
p		Access to affordable healthcare			
Q		Coordination of Authority with hospital systems			
R		Hospital services integration-continuity of care			
S		COPN (Certificate of Public Need) continuation			
T		CAPACITY OF THE AUTHORITY			
	1	FUNDING FOR AUTHORITY	X	X	
	2	DEVELOP/HIRE POSITIONS FOR AUTHORITY	X	X	
	3	DEVELOP LEGISLATIVE AGENDA FOR AUTHORITY	X	X	

Appendix 3

This strategic planning effort and the Health Authority itself have received no direct funds from any source to produce this blueprint. This publication was produced with the generous in-kind funding assistance of the Healthy Appalachia Institute at the University of Virginia's College at Wise with the support of the Appalachian Regional Commission. The following members have given generously of their time and talents:

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Appendix 4

Inputs for this Blueprint were obtained during two community comment sessions held at Southwest Virginia Community College and at Mountain Empire Community College, at two SWOT (Strengths, Weaknesses, Opportunities, Threats) community expert planning sessions, at three Authority strategic planning conferences, and at many discussions with area health organizations. The Authority is thankful for all inputs received and the generous amount of time that so many people donated. The persons listed below were particularly generous in providing their time, talents and ideas to help the Authority develop this Blueprint. (The inclusion of their names and their organizational affiliations should not be taken to mean that they agree with the statements in this Blueprint.)

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HEALTHY APPALACHIA INSTITUTE

The University of Virginia's College at Wise

Ending poverty, advancing educational opportunity, encouraging prosperity and promoting health, including ensuring access to health care, are essential to improving health outcomes in Central Appalachia. This ambitious goal requires a vehicle to ensure regional collaboration across communities and organizations, to generate new ideas and to establish a process to engage the social, economic and scientific issues that exist at the interface of health and Appalachian culture. To serve as this vehicle, The University of Virginia's College at Wise Board formally recognized and named the Healthy Appalachia Institute (HAI) in October 2008.

HAI is a collaboration between critical thinkers, scholars, system planners and leaders at the College, the University of Virginia, the Southwest Virginia Graduate Medical Education Consortium, the Southwest Virginia Health Authority and key partners in government, education, business and health care. With support from the Appalachian Regional Commission, this coalition seeks to provide policy makers, health care systems, educators, the business community and the region's citizens the necessary tools, resources, ideas and strategies to foster a healthier population.

The goals of the Institute are to develop a common understanding of the health status of the region, to craft and implement a single, integrated strategic health plan and to operate an institute to conceive initiatives that ensure a healthier future for the residents of far Southwest Virginia and Central Appalachia. HAI is unique among university-based Appalachian studies programs in that it seeks to transform Central Appalachia into a leading model for health for rural communities throughout the world. This vision is moved forward through the mission of the Healthy Appalachia Institute to improve the health, education and prosperity for the residents of the region by:

- Listening to the needs of communities and their citizens;
- Ensuring a continuous assessment of the region's health status;
- Supporting ongoing strategic health partnerships and planning;
- Designing and implementing innovative models of health education, workforce development and health care delivery;
- Promoting service learning for undergraduate and graduate students on behalf of the residents;
- Advancing community-based participatory research opportunities;
- Providing evaluation expertise for health improvement projects in the region;
- Developing resources to support the work of HAI and its partners;
- Exploring the history of health in the mountains of Appalachia;
- Fostering intellectual, artistic and emotional expressions of understanding at the interface of Appalachian culture and health; and
- Serving as an incubator for new ideas to ensure an improved quality of life for all residents of Central Appalachia and beyond.

The issues of energy, education, work and health are at the center of our nation's most significant challenges. These same issues are at the heart of the Institute and its mission. While Central Appalachia has been often considered "the other America," this region is at the center of the most important national debates. To ignore the contradictions and challenges of Central Appalachia is to ignore the greatest issues facing the nation as a whole. The Healthy Appalachia Institute seeks to elevate the issues facing the region and the power of community-based solutions to a national level.

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