

1. Performance Standards and Accreditation

The Ohio Department of Health should implement a process to engage an independent review team to verify the data reported by local health departments related to the Ohio performance standards which “mirror” the Public Health Accreditation Board (PHAB) standards.

COMMENT: 8

Kimberly Moss: My question would be who will be paying for that? And, if a health district is accredited, would they have to endure yet another review process (since the standards are the same)? You see, being a government entity there is already more red tape to account for which takes us away from the business of public health. Those standards do not address if we are effective. They address the way things are done and assume that if we do things in this manner we will be effective.

Heidi Fought: It was noted during discussions that some type of peer review should be included. Is this too specific or getting too far into the weeds?

Tim Ingram: The PHAB standards will have an independent review team associated with the accreditation process. In the interim and since ODH is currently using the PHAB standards as its standards, an independent team could be established by ODH until the LHD applies for PHAB accreditation. This way there is no duplication and confusion between the two processes.

All local health departments should be required to apply for PHAB accreditation within 5 years (year 2018) or risk losing state program funding.

Frank Kellogg:

- 1) Independent peer review teams (which included ODH staff) for LHD's were first used in Ohio in the mid-1980's. The effort was largely a failure. All LHD's passed due to weak standards and too friendly review teams. Little improvements were made.
- 2) Suggest use of national, recognized PHAB standard only. No need to enact a separate, Ohioized, less credible, non-CDC recognized performance standard
- 3) If a separate standard is enacted, credit should be given for achieving PHAB accreditation
- 4) The ODH database tool should remain in place (if it is equivalent to PHAB) for comparative and tracking tool purposes
- 5) Legislation should specify attained PHAB accreditation within a specified time period (e.g. 5 to 10 years), coupled with adequate state funding or means to attain funding. If accreditation is not attained within the specified time period, then State further state grant, subsidy or other funding should be reduced/withheld.
- 6) Small Ohio LHD's need the time, funding and opportunity to prove that they have the capability, local backing and desire to attain standards

Nancy Shapiro: As with many of these recommendations, development of rules would require local public health representation and thorough review, including specifics as to what documentation would be acceptable to measure compliance with PHAB standards.

Anne Goon:

- I concur that there should be an external/independent review process for local health departments choosing not to pursue voluntary public health accreditation. The PHAB accreditation process would serve as the independent review process for those pursuing accreditation.
- Use of an independent review process would be most important if eligibility for funding was based upon local health departments' achievement of performance standards. I would advocate that ODH should not be the entity conducting the review process, since it would not be an independent third party. Just as a jury of peers determines guilt or innocence in a trial and then a judge determines the consequences, it would be best to have an independent review completed by peers (whether active or retired) and ODH determining the resulting grant eligibility.

I would also advocate that this recommendation should include a funding mechanism. Since ODH or the state of Ohio would be the entity requiring the external review, one could argue that they should be funding the process (in full or in part). Most LHDs choosing not to pursue accreditation are citing cost as the primary reason. Perhaps the costs could be split between the state of Ohio, ODH, and LHDs, where the LDH portion is no more than one-half of PHAB accreditation fees for a jurisdiction of their size (about \$1,000-1,200 for jurisdictions <50,000, \$1,900-\$2,000 for jurisdictions of 50,000-100,000, etc., annually)?

Gene Nixon: I support a minimum verifiable standard for LHDs. I believe that the PHAB standards represent the universally accepted standard that Ohio should strive to assure all LHD meet.

My concern with the draft recommendation is with the expectation that ODH will implement a process any more rigorous than what currently exists. ODH has always had the authority to assure LDH meet a minimum standard, yet has largely capitulated on that authority. My fear is that we are putting in place a more rigorous standard for LHD, meaning additional reporting requirements and significantly more work for locals without a robust verification process or without true accountability.

I believe we should aim for PHAB accreditation:

"The Ohio Department of Health should implement a process to train and facilitate local health district to gain the necessary skills and capacity to become accredited. All local health districts in Ohio should be eligible for PHAB accreditation within five years."

If a separate verification or standards process is adopted, local health districts that gain PHAB Accreditation should be given credit.

Ken Slenkovich:

This proposed language is too limited and is not fully supportive of the recommendations related to PHAB accreditation in the AOHCFutures report. The recommendations in the report are very explicit, "All LHDs should become eligible for accreditation through the Public Health Accreditation Board (PHAB), p.97." If this goal is to be achieved then it is important that the Committee clearly state its support for it based on the reasons cited in related recommendations in the Futures report, namely that: 1) "All Ohioans ... should have access to the Core Public Health Services", (p.97); 2) "All local health departments should have access to the skills and resources that make up the Foundational Capabilities to support these services", (p.97); and 3) "The Ohio Minimum Package of

Local Public Health Services should be used to guide any future changes in funding, governance, capacity building, and quality improvement,” (p.97). As described in the Futures report (Appendix E) the Minimum Package of Local Public Health Services, which includes the Core Services and Foundational Capabilities, addresses all of the PHAB domains.

The proposed language should state that the Committee supports these recommendations. It also does not urge the Ohio Department of Health to develop the rules and procedures necessary to ensure that LHDs will move in this direction. It addresses only one of a series of steps that should be taken to move the public health system toward the goal of having every local health department become accredited as envisioned by the Futures report. Limiting the Committee’s recommendation to this one step does not adequately create a sense of commitment to and urgency for establishing the mechanism by which PHAB accreditation of local health departments can occur.

An alternative to the proposed language would be to explicitly state the Committee’s support of recommendations #1-4 in the Futures report along with calling for the Ohio Department of Health to develop a plan with AOHC whose goal is for all local health departments in the state to be accredited within five years.

2. Outcomes and Data

The Ohio Department of Health and local health departments should work toward identifying a standardized process of specific data collection and identification of common public health data indicators.

COMMENT: 7

Kimberly Moss: Wonderful idea! Then set outcome goals and measure that! I saw this project last week and it looks very good. http://www.youtube.com/watch?v=eeFoh_x6DB4

Tim Ingram: Yes this should happen with a clearly defined implementation schedule. The outcomes should be associated with the leading causes of morbidity, disability, and mortality in our state.

Frank Kellogg: Yes, utilization of data such as from the Network of Care would be helpful. ODH should gain access to be able to share the data with all Ohio LHD’s as individual purchase is cost prohibitive

Nancy Shapiro: Would like to assure that data collection requirements are in alignment with State Health Improvement Plan and also include elements of local health improvement plans. For example if the majority of local plans include obesity as a community wide issue, then ODH should help collect and report statistically significant data to measure progress toward goals. Additionally, we would recommend that ODH access data from Health Insurance Plans specific to morbidity related to chronic diseases and childhood and adult injuries.

Anne Goon:

- I concur with this recommendation, but I would strengthen the wording (e.g. “ODH and LHDs should identify a standardized”..., rather than “should work toward identifying...”).
- Creating a “public health report card” would provide a convenient way of demonstrating accountability and return on investment to stakeholders and community members. The list of

common public health data indicators should be uniform for ODH and LHDs, since improving the health of Ohioans is a shared responsibility.

- There are significant technology and resource barriers to identifying a standardized process for data collection. Since electronic health record technology is still evolving, Ohio's health information exchange is not developed enough yet to allow ODH or LHDs to gather population-level health data from electronic health records of hospitals, private providers, FQHCs, and other providers. Due to lack of funding for this foundational capability, local health departments (and probably ODH as well) generally lack both the technology and the expertise to collect and assess population-level data from EHRs. With information technology and data assessment proposed as a foundation capability that all local health departments should have access to, it would make the most sense to make the investment at the state level to develop this capacity. (It could be at ODH, a state-level data center, a major university, or something similar.)
- Ideally, the list of common public health indicators should come from the State Health Improvement Plan (SHIP), since it should be focusing on the most critical health issues impacting Ohioans. Other launching points could be the Healthy People 2020 Leading Health Indicators or the County Health Rankings.
- There are two alternate types of tools to consider:
 1. A tool similar to the HCAPHS survey used to evaluate hospitals: This standardized national tool has both Core (clinical) and Patient Satisfaction Measures. I think it is important to include both service/client satisfaction and health outcome measures, since ODH and LHDs are public agencies.
 2. A balanced scorecard approach: This tool could include 2-4 measures related to health outcomes and access to care, 2 related to financial management, 2 related to workforce development, 2 related to quality, and 2 related to service.
- Funding would need to be allocated for the development of a list of common public health indicators. This could be accomplished by re-investing some of the cost savings being pursued (or achieved) through payment reform. After all, improving the health outcomes of Ohioans requires concerted and coordinated efforts on both a population-level (by Ohio Department of Health and local health departments) and the individual-level (by hospitals and personal healthcare providers).

Gene Nixon: As I understand this recommendation is intended to document and quantify the health status of Ohio by jurisdiction (LHD, counties, municipalities?) and measure health outcome improvements over time. This will provide a value measure to Ohio's investment in the public health infrastructure and help guide future legislative PH allocation decisions.

Ken Slenkovich:

This proposed language is a good start, however, it needs more specificity and scope. It is important that the set of indicators included go well beyond the traditional public health indicators typically tracked by health departments (e.g., communicable diseases, vital stats, etc.). It should also include a variety of chronic disease indicators (e.g., morbidity rates, behavioral risk factors, preventable hospital readmissions and complications), environmental conditions, social determinants, health care access and utilization measures. This data should also be available such that small area analysis can be done, community health improvement scorecards can be created, and geographically-targeted action plans can be developed and implemented. The recommendation should also specify that local health departments must play a critical role in overseeing the data collection, analysis, and action development as part of their community engagement core public health service function and foundational capability.

I would suggest adding some additional specificity to this recommendation along the lines above to provide clearer guidance to ODH and local health departments.

3. Boards of Health

Local health department board members should participate in continuing education requirements related to public health practice, ethics, and governance.

COMMENT: 9

Ned Baker: Committee Recommendation and Concept # 3: Local health department board members should participate in continuing education requirements related to public health practice, ethics and governance.

Kimberly Moss: continuing education is a good idea.

Heidi Fought: I support the concept of training but I do have to ask, who would pay for such training? Also, what is ODH's role in this training? Should ODH have a role in the training so that training is consistent across the state?

Suggested alternative to above: To enhance an appointee's background and working knowledge of public health, and the rules adopted by the Ohio Department of Health, the Director of Health shall hold education programs for persons appointed to local boards of health. The Director of Health shall determine the manner, content and length of the training programs after consultation with appropriate statewide organizations of public health officials.

Kim Edwards: Yes, however, we also need continuing ed requirements for DAC to understand their responsibilities. This could be accomplished with current technology, ie – webinar training in the local district so that it does not become cost prohibitive.

Tim Ingram: Yes, but just having continuing education requirements for Boards of Health does not reach far enough. Boards of Health should have term limits. Their composition should include representatives from the health care delivery system and not solely consumer representatives.

Frank Kellogg

- 1) In Lake County, every Board meeting includes a 15 to 20 minute segment on some aspect of public health.
- 2) CE requirements are worthwhile but ought to be able to accumulate such hours in-house without the added expense of NALBOH or OABH meetings.
- 3) All Lake County BOH members are also given membership into OABH and receive both OABH and NALBOH newsletters.
- 4) The 14 Lake County BOH members are critically engaged in public health topics and include a CPA, retired restaurant owner, veterinarian, PhD psychologist/social worker, MBA Nurse/LSW, 2 city administrators, environmental remediation expert, retired engineer, swimming pool manager and 2 MD's including the County Coroner.

Nancy Shapiro: Would structure similarly to continuing education requirements for medical directors.

Anne Goon:

- A reasonable amount would be four hours of orientation training during the first six-twelve months of appointment. Each board member could be required to complete an additional four hours of continuing education annually. This training could be provided through a variety of methods (in-person training sessions, annual conference, webinars, and other distance-learning methods). Topics should include board of health governance, the local public health system and health department services, board ethics, and statutes relating to public boards (e.g. open meetings), at a minimum.
- In addition, instituting term limits would make it easier to bring diversity and new perspectives to the board, create a built-in balance of continuity and turnover, and regularly rotate committee assignments. Term limits also present an opportunity for the board and the “retiring” board member to assess a mutual willingness to continue working together, creating the possibility of enlarging the circle of committed public health supporters by keeping retired board members involved. Similar to ADAMhs boards, a limit of two 5-year terms would seem appropriate, with a lapse of at least 3 years before a former board member could be reappointed.

Ken Slenkovich:

This is an important recommendation. Again, I would suggest adding additional specificity. Board of health members should be better informed about a number of relevant issues that impact their health department’s ability to perform effectively including such things as:

- PHAB accreditation, performance standards, 10 Essential Services framework
- Evidence-based prevention practices
- Social determinants of health
- Their community’s sociodemographic and health status profile and trends, health services and resource inventory, and service gaps
- Models of integration between public health and health care organizations

4. Multiple Agency Program Administration

Identify and refer programs currently administered by two agencies (Ohio Department of Agriculture and Ohio Department of Health) such as food safety and waterpark / swimming pools to the Common Sense Initiative (CSI) for further review and recommendations related to program efficiency.

COMMENT: 7

Kimberly Moss: Another good idea.

Tim Ingram: Yes, having two state departments oversee the same local programs is inefficient and presents confusion.

Frank Kellogg: Both pools and food inspection should be recognized as public health based programs and should be housed within ODH. Neither food or pool inspection should be housed in an agency (ODA) whose mission is (in part) to promote the industry

Nancy Shapiro: Would assure that programs retain their health focus.

Anne Goon:

- This recommendation makes sense. The Common Sense Initiative would need to gain a full understanding of each agency's philosophical approach, mission, and goals to try to develop a solution that is in the best interests of the health of Ohioans (rather than in the best interests of one agency or the other).

Gene Nixon: I have no objection to the recommendation, although I believe it falls outside the charge of the Futures Report.

Ken Slenkovich: Good idea as long as local health departments are involved in the review process.

5. **Multi-District Public Health Levy**

Revise Ohio Revised Code 3709.29 to allow for permissive multi-county levy authority for public health services.

COMMENT: 6

Kimberly Moss: Yes, but wouldn't do much good unless the health districts are merged or share governance.

Kim Edwards: WE need to be mindful of where the taxing authority lies. It should not rest with boards that are not accountable to the public. This needs a deeper discussion relating to taxing authority and the creation of multi-county districts in general. Currently districts can contract for services. Do we really need multi-county levies without the creation of multi-county districts?

Tim Ingram: I agree. If that were implemented, what would the governance structure of local boards of health look like in the future?

Frank Kellogg:

1) I do not support multi-district levy authority. Rational is that a) multi district levies are usually an impediment to consolidation as no one wants to take in the poorly funded LHD or the one where it is known that the voters will not support, b) levies (in general) are a poor basis for public health support, especially if we are all to have a minimum package of services. If your levy fails to pass does that mean that basic public health services should be withheld to a certain geographical segment of Ohio's population?

2) Levies for public health should only be permitted for programs above and beyond the minimum package (or PHAB). The state should ensure adequate LHD funding and funding methods for the core public health services that all Ohioans should receive.

Nancy Shapiro: Assure for both General and specific health programs (ie. TB, mosquito districts and preparedness districts).

Anne Goon:

- This recommendation is a “no-brainer.” If ODH or other state-level officials wish to push consolidations or mergers of health departments, then obvious (but very significant) barriers like this one should be removed.

6. Shared Services Resources

Encourage and enhance shared services at the local health department level by developing model contracts and memorandum of understanding (MOUs and/or qualifying Councils of Governments (COG)).

COMMENT: 8

Kimberly Moss: Yes but there are quite a lot of bugs to work that one out.

Heidi Fought: The Ohio Department of Health should encourage and enhance shared services by local health departments by developing model contracts and memorandums of understanding that are easily adaptable by local boards. (MOUs and/or qualifying Councils of Governments (COG)).

Kim Edwards: Strike wording after MOU. Should we really be creating more government? We say in #4 that we want to look at efficiency, but turn our back on it with creating a COG in this recommendation. A COG can create a lack of transparency in regard to levy dollars. Levy dollars may be spent anywhere within the COG regardless of where it was voted on.

Tim Ingram: Certainly MOUs and contracting should continue to occur. But this does not go far enough in respect to the future of local public health in a changing health care delivery system. The status quo of 125 health departments in 88 counties is neither effective nor efficient today. With 58% of the health departments in Ohio serving 50,000 people or less, it is difficult to improve efficiency, capacity, and find additional revenues in order to improve the future health of all Ohioans. There needs to be better service alignment between the health care delivery system (hospitals, providers, FQHC's, pharmacists,) and local health departments. This alignment includes governance representation, electronic technology connectivity, and shared community health goals.

Frank Kellogg:

- 1) Regional shared service centers should be funded by the State or identify and provide funds to LHD's that can/will provide specific foundational capabilities for the region
- 2) Do not believe that a formal COG-like structure is required to share services. ORC 3709.36 (as amended by HB 509) makes it very clear that LHD's have broad contracting authority

Anne Goon

- This recommendation could be strengthened by addressing a wider variety of the challenges faced by health districts that may be interested in pursuing shared services. These include 1) models for how to get to shared services (not just model contracts and MOUs), 2) technical assistance in developing a business case for shared services (i.e. what services it makes sense to share and which type of shared service arrangement might be appropriate for Service A vs. Service B); 3) legal assistance in developing shared services agreements (local prosecuting attorneys seem to lack this kind of legal expertise, as well as the time or interest to work with local health districts); 4) financial assistance to support the process of moving to shared services.

There are significant “transactional” costs associated with developing shared service arrangements. Before cost savings can possibly be realized, additional expenses must be incurred, creating one of many automatic barriers to pursuing shared services.

- Since the LGIF application submitted by the 6-Pact health districts in northwest Ohio (Defiance, Fulton, Henry, Paulding, Putnam, and Williams counties) addresses these barriers, it would make sense to encourage funding of this proposal as a way of helping shared public health services move from being a concept to being a reality.

Gene Nixon: *cross-jurisdictional* shared services. This should reference between health districts *and* between health districts and other local government agencies and non-profits organizations.

Ken Slenkovich: There are a number of additional steps that could be taken to encourage local health departments to explore resource sharing and/or consolidation that could be included in this recommendation. For example, setting aside some of the Local Government Innovation Fund specifically for local health departments; offering technical assistance (e.g., consultants) to health departments that choose to explore shared service/consolidation arrangements; streamline ODH grant administration requirements for health departments that successfully pursue resource sharing/consolidation.

7. Consolidation of Non-Contiguous Cities or Counties

Revise Ohio Revised Code sections 3709.051 and 3709.10 to allow city and county health districts to contract/consolidate/merge together within a “reasonable” geographic distance (consider AOHC regions).

COMMENT: 6

Kimberly Moss: Not the whole region. Waaaaay too big to accomplish local goals.

Heidi Fought: Revise Ohio Revised Code sections 3709.051 and 3709.10 to allow city and county health districts, whether contiguous or noncontiguous, to ~~contract/consolidate/merge together~~ within a “reasonable” geographic distance (consider AOHC regions). They already have the ability to contract pursuant to ORC Sect. 9482 and merge and consolidate are same thing. In discussions, we mentioned noncontiguous entities and I do believe it is important to add that word.

Time Ingram: Seems like it might be worth a demonstration project or two, but the real goal here should be re-structuring of local health departments to one per county, or for those counties with multiple health departments inside a county boundary, no city health department less than 25,000 in population size. Why? This would reduce citizen confusion over conflicting policies, fee structures, which LHD does what type of inspections, etc, and ultimately to improve communication among medical providers and local health departments. All of this can lead to a more efficient and effective local public health system. We need to make this recommendation in the Legislative Committee’s Report.

Please remember if we are serious about addressing the leading causes of death, disability, and injury today and tomorrow, for our children’s sake, we must improve and develop a stronger local public health system in Ohio.

Frank Kellogg: In Favor.

Nancy Shapiro: Contracting for services would be the most understood option with local residents, as that most likely would be seamless. With consolidations and mergers issues of District Advisory Councils, locations of client services, Board of Health composition are more difficult, but are appropriate for some areas of the State.

Anne Goon

- This recommendation is also a “no-brainer,” although the determination of a “reasonable” geographic distance should be left to the discretion of health districts. Using a pre-defined map of regions does not make sense, since this may unnecessarily restrict potential contracts, consolidations, or mergers. Economics alone may determine how great of a distance between “partnering” agencies would be feasible.

8. Reimbursable Services

Local health departments should work to enhance their ability to contract and credential with private payers and Medicaid managed care for clinical services such as immunizations and other public health and clinical services.

COMMENT: 7

Kimberly Moss: I think we are already doing this. The problem we run into is if there are already providers in the local area, the insurance companies will not take on LHDs. If people are being served, ok. But, if there are pockets of un or underserved, then we have a big problem.

Tim Ingram: What does “enhance their ability to contract “really mean? How will reimbursable services work efficiently under the current local public health system in an environment of a changing health care delivery system?

Frank Kellogg: ODH should sponsor and promote this effort

Nancy Shapiro: Very supportive of this recommendation. However, the recommendation needs to be strengthened to requirements for insurance plans to offer streamlined credentialing for universally provided local health department services, including immunization services, STI testing and treatment, HIV testing and other chronic disease screening services. More intense credentialing model should be utilized for more complex medical services including primary medical care services: family planning, prenatal, etc.

Anne Goon

- I concur that local health departments need to find a way to enhance their ability to contract and credential with private and public payers. However, there may be actions that the state, Ohio Department of Health, Ohio Department of Insurance, or Ohio Medicaid could take to facilitate this process. For example...
 - Could all public and private payers be required to accept local health departments as panel or in-network providers (if not in all counties, then at least in those counties where local physicians don't provide childhood immunizations or provide <20% of all immunizations given, since the payer won't be able to achieve target health outcomes without local access to immunizations for children or adults)?

- Could all public and private payers be required to have an abbreviated credentialing process for local health departments since they are not for-profit ventures (unlike private physician practices)?
- Could the Patient-Centered Medical Home pilot project require all participating practices that don't provide children's immunizations, to sub-contract with the local health department to provide immunizations in their office so it is a "one-stop" shop for their patients? In this case, would the local health department not need to be credentialed, since the PCMH would be doing the billing for the service they are providing in their office?
- Could local health departments receive the same level of increased reimbursement for services (Medicaid, I think) that private providers will be receiving in 2013?
- As safety net providers, could local health departments receive enhanced Medicaid and Medicare reimbursement comparable to FQHCs?
- Could ODH negotiate a rate for electronic health records or billing systems that local health departments could "opt in" to, similar to what it is doing with Environmental Health software?
- Could ODH partner with the Robert Wood Johnson Foundation or another private funder to provide a funding opportunity to create an integrated network of local health department providers for immunizations and other clinical services?

Gene Nixon: This recommendation doesn't move the needle. It continues to place the burden on individual LHD to maneuver the many confusing credentialing and billing networks. We need a more uniform reimbursement system.

I believe there should be direct and categorical language in Ohio's Medicaid reform which specifically enables LHDs as preferred providers of reimbursable services including billable preventive health care, integrated care management and health exchange management services.

Ken Slenkovich: This is an area where the state could be very helpful in providing funding for pilot projects to enable health departments and private providers and payers to design mechanisms and models for integrating public health services with health care services. There are some good models in Ohio and elsewhere that have not been widely implemented in Ohio but could/should be. Language could be added recommending state support for such efforts.

9. Chronic Disease Block Grant Funding

ODH initiate review of federal and state authorities for a "blended funding" approach that integrates all state/federal public health funding using block grants (when/where possible) to reduce fragmentation in public health funding.

COMMENT: 8

Kimberly Moss: Seems to me that this was done in the 90's and was eliminated due to inability to prove outcomes.

Kim Edwards: Don't remember much decision making on this issue. Would we recommend a formula and what would it be based on? Would the mere pittance that the state provides be removed and used for grants only? "Reduce fragmentation in public health funding" – What does this mean? Does everyone get \$X if you meet criteria A, \$XX if meeting criteria B, and so on?

Time Ingram: This seems like a reasonable, more efficient grant funding proposal than the current process ODH uses. I would add that ODH should eliminate or reduce the 30% indirect costs they currently take from local grants. This would allow for more monies available for programs at the local level.

Frank Kellogg

- 1) Since LHD's are responsible for the "Public Health System", all grants should be tied to outcomes in the State and Community Health Improvement Plans
- 2) ODH should provide 2-5% incentives on ODH grants that apply to multi-jurisdictional (>100,000 population) projects
- 3) Increase subsidies for counties with <=1 LHD

Nancy Shapiro: Very supportive if possible

Anne Goon

- Senator Burke asked a question at the Sept 11 committee meeting regarding the role of the state and local public health agencies. This recommendation really gets at the core of what I see as the state's role.
- The role of the state/ODH is to provide leadership, vision, and direction. Its role is to create the conditions that will allow local health districts to successfully do the work of improving the health of Ohioans. ODH can create these favorable conditions by 1) seeking more federal funding;, 2) advocating for policies that address statewide conditions that are harming the health of Ohioans (e.g. tobacco control, sugar-sweetened beverages, access to care and insurance coverage); 3) seeking adequate state funding to assure all Ohioans have access to core public health services (and state-delegated functions) provided by skilled public health professionals in health departments that have access to the proposed foundational capabilities .
- The role of the local health district is to 1) provide core public services that will result in the implementation of effective, evidence based strategies and the improvement of the local communities' health (i.e. do the work of public health); 2) engage traditional and non-traditional partners and build/sustain local partnerships that can implement the community 's health improvement plan and achieve measurable improvements in health outcomes. Since Ohio is a diverse state, health needs and priorities vary from county to county and from region to region. The availability of flexible funding (i.e. that is not tied to one sole health problem or issue) is critical to the local health district's ability to tackle local health needs. Improved health at the local level will result in improved health outcomes for the entire state, making Ohio a more attractive location for potential employers (healthier residents means a healthier workforce that costs less to insure).

Gene Nixon: This recommendation should be expanded to include and encourage more regional funding arrangements to multi- health district collaborations.

Ken Slenkovich: Good idea. Such funding should come with some requirements, e.g., implementation of evidence-based interventions that are tied to a state and/or local chronic disease prevention plan; establishment of effective chronic disease surveillance and program evaluation mechanisms; ongoing program review with performance metrics based on outcomes (e.g., reduction in disease rates, reduction in unnecessary hospital readmissions, etc.). Adding this kind of language might help sell the idea to the federal authorities.

SUGGESTED/ADDITIONAL TOPICS:

Alice Davis: As a Local Bd. of Health President and vice pres. of OABH (Ohio Ass'n of Local Bds. of Health). I feel it is very important for BOH members to receive ongoing education re; Public Health and their role as a bd. member. OABH has printed info re Roles and Responsibilities of BOH members. We also developed a Training Manual for new members. We are having a training session on Nov. 10 in Columbus

NALBOH (National Ass'n of Local Bds of Health also has info re; the role of bd. members. I personally have presented at some BOHs re; their role as BOH members as has NALBOH staff. Making education mandatory for BOH members would be very helpful and would certainly be a benefit for members and the communities they serve.

Kimberly Moss: Maybe we do not need 125 health districts, maybe small rural areas will be underserved if we don't. I cannot really answer this question. However, I do think though that every health district should have a full time health commissioner. The ones that have part-time HC's/medical directors are far less engaged than the ones that do. They require someone without authority to make decisions to be in charge. Are you really being more efficient/ effective in that system? Sure there are a very few exceptions to this but in the rural areas I believe it to be true.

Kim Edwards: Additional discussion on funding, Governance of district advisory council, Space for LHD – providing space and costs associated is actually a perk to not combine. I go back to Martin's suggestion that health departments should be stand alone, to not require space, \$\$s from General Fund for TB and BCMH, and costs be paid for through cost sharing or cost allocation plan. I believe this needs more discussion to have a true change in the function of health depts. After continued thoughts on the discussion from the last meeting as it relates to local health departments changing/impacting major health issues, that may be a function but is difficult to analyze and associate to changes that the legislature can make in a budget cycle. Just a thought.

Tim Ingram: Health Department Role, Function, and Scope of Services; Board of Health appointment process.

Frank Kellogg

- 1) Board of Health members should never be elected. The main guiding principal of public health is that it should be separate from direct political influences
- 2) County Commissioners should only be involved at the Board of health level if they bring funding to the table
- 3) Local levies should only be permitted to finance programs outside the minimum package/PHAB scope
- 4) Additional significant funding must be infused into the local public health system by the State or no significant changes, that result in population health improvement will occur

Anne Goon:

- Fund the creation of regional public health service centers to ensure all local health districts have access to the foundational capabilities needed to provide core public health services as outlined in the Ohio Minimum Package of Local Public Health Services. Similar to the educational service centers that receive state funding and provide services via contract to participating school districts, regional public health centers would provide community health assessment and improvement planning services; specialized legal support; quality assurance and quality improvement training and assistance; data analysis expertise; IT expertise; grant writing services and training; workforce development services; policy planning, development, and analysis services; and the like.
- Require the Office of Health Transformation, Ohio Department of Health, and local health districts to submit an integrated care model proposal to CMS that includes funding to build public health capacity for population-level health improvements or to create shared public health service opportunities.

Ken Slenkovich: The Center for Community Solutions is currently developing specific recommendations related to how the public health and private health care systems can work together to reduce rates of the major chronic diseases in Ohio. This will include an analysis of existing public health laws in Ohio as well as in other states that impact chronic diseases. It will also include recommendations related to the development of a chronic disease infrastructure to support population-level chronic disease prevention initiatives in terms of funding, organizational capacity building, and outcomes-based evaluation. We will work with state and local public health officials, health care providers and payers, and others who have an interest in this area. The contact for this work is Ken Slenkovich, (330) 672-6504, kslenkovich@communitysolutions.com, Associate Director at Community Solutions and Assistant Dean at the Kent State University College of Public Health