

Deposition Specialists, Inc.... (614) 221-4034

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APPEARANCES

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MEMBERS PRESENT:

- Dr. Ted Wymyslo, Director of Health
- Martin Tremmel
- Joe Mazzola
- Commissioner Jim Adams
- Greg Moody
- Steve Wermuth
- Jennifer Wentzel
- Dr. D.J. McFadden
- Christopher E. Press
- Lindsey English
- Kim Edwards
- Nancy Shapiro
- Representative Lynn Wachtman
- Representative Nickie Antonio
- Steve Wagner
- Walter Threlfall

Also Present:

- Annie Ryznar
- Brittany Boulton
- Monica Juenger
- Kate Philips
- Jessica Crews
- Zack Holzapfel
- Jason Orcena

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AGENDA

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- 1. Welcome
 - * Director of Health, Dr. Theodore Wymyslo
- 2. Presentation and Overview Futures Committee Report
 - * AOHC
- 3. Identification and Discussion of Legislative and Fiscal Policies
- 4. Selection of Committee Leadership
 - * Chair
 - * Vice-Chair
 - * Secretary
- 5. Review of Future Meeting Dates, Communication and other Considerations

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1 number of opportunities and a number of topics and
2 issues, this will be a lively discussion and we look
3 forward to all of it.

4 Just a couple of housekeeping items,
5 restrooms for everyone are just outside this door behind
6 me. You can take a right outside there in the corridor
7 for men's and women's restrooms; there's also the cafe,
8 Roger's is there for fill ups and refreshments. And let
9 me then speak to just a little bit of the process.

10 What we have today, folks, is a live
11 meeting. Mr. Mazzola, Rory, and other members of the
12 ODH team have set up a live meeting.

13 You have in front of you a camera, there
14 will be, or the opportunity for those to be, present
15 from around the state watching this live meeting.

16 We will not be able to necessarily allow
17 participants who are members on this committee to
18 express themselves or attend on live meetings, because
19 the legislation doesn't call for that.

20 So if folks do, however, feel that they
21 cannot be in Columbus for the meeting, but they want to
22 just view the meeting, we'll be able to save this,
23 right, Joe, they can view it later, that's the purpose.
24 We're really trying to be very thoughtful and very
25 complementary to folks to see this as well.

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1 Any attendees on the live meeting at home.

2 MR. MAZZOLA: There are two.

3 MR. TREMMEL: Two, okay, and they are?

4 MR. MAZZOLA: Greg Kesterman (Phonetically
5 Spelled), on behalf of Tim Ingram and Kirstin Hildreth
6 (Phonetically Spelled) is also present.

7 HEARING OFFICER: So, Greg, Kirstin,
8 welcome, if you can hear us on your end.

9 UNIDENTIFIED SPEAKER: Thank you.

10 MR. TREMMEL: Okay. We will try to give
11 some appropriate breaks, folks, and, please, keep me on
12 task of import when you need a break so that we can
13 continue to move things along accordingly, but take the
14 sufficient time.

15 In addition to the camera, we do have Teresa
16 Mantz with us. Teresa, good morning. Teresa is our
17 court stenographer, folks, she is going to do her level
18 best to be able to capture all of the thoughts and
19 issues here for members of the committee.

20 I would just ask two favors of you, if I
21 might; No. 1, until Teresa is to some degree a little
22 bit more familiar with all of us just let Teresa know
23 your name as you're giving your response, this is so and
24 so, just for the explanation; and, No. 2, as you know or
25 should know for court stenographers it does become a

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1 little difficult if we engage in some cross
2 conversation, if I interrupt you, et cetera, so let's
3 maybe just allow, as we can, and I know we're going to
4 get into some different issues here, but let's allow, if
5 we can, someone to finish a thought, and then state our
6 name and jump in, so we don't get this kind of
7 fragmented report back, Teresa throws up her hands, we
8 don't want that, at least not for the first meeting.

9 Okay. We have a couple of colleagues who
10 are sitting in for colleagues. I know Health
11 Commissioner Adams is here, again, welcome.

12 Commissioner Adams is going to review the
13 Futures Report for AOHC who's sitting in for Commission
14 Nixon who's out at some of the national meetings. I
15 believe Commissioner Ingram is at some national
16 meetings. We have a couple of other colleagues that are
17 sitting for their representative group.

18 So with that, let me stop and introduce to
19 all of you the Director for the Ohio Department of
20 Health, Dr. Ted Wymyslo, to introduce some of our very
21 special guests here as well, and then we'll turn right
22 to the Agenda, so Dr. Wymyslo, good morning.

23 DR. WYMYSLO: Thanks, Marty, and welcome to
24 the Ohio Department of Health, appreciate you being
25 here. I know everyone's got very busy schedules, but

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1 this is going to present itself as a tremendous
2 opportunity, I think, in Ohio to move health forward.

3 We're about transformation in Ohio, and
4 health, and public health fortunately is a large part of
5 the transformation that we're focused on.

6 With me today I have Greg Moody who many of
7 you know who leads the Office of Health Transformation
8 for the Governor's Office, and Greg and I, as we came
9 in, were assured that the expectation was we weren't
10 going to make subtle, minor changes in the way health is
11 delivered and the way health, public health that is, is
12 practiced in the state, but rather the changes we're
13 going to make would be transformative.

14 That's a significant change, which means it
15 always has with it a disruption built in, so if it feels
16 tense at times, that's part of the disruptive part of
17 this, because we want to get at issues, concerns,
18 positions that at times will be somewhat difficult, I
19 think, to express opinions on, but I hope people will,
20 so that we have the ability to be open and transparent
21 in our communications or we won't get to a better place
22 than we are today.

23 We've already been on that route, many of
24 you know, for instance, with the recent MBR work that we
25 had, you know, that the Public Health Council was

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1 abolished, but replaced by what we feel will be a
2 modernized way to give input about public health in
3 Ohio, and that's the Public Health -- help me with
4 the board --

5 MR. TREMMEL: Advisory.

6 MR. WYMYSLO: -- Advisory Board, that's what
7 it is, haven't met for the first meeting, but we're
8 getting there.

9 So the Ohio Public Health Advisory Board is
10 going to be a structured way to have all of the
11 different associations give input as we consider best
12 decisions and best directions for the future, and we'll
13 do it in a structured way that will allow us to have
14 coordination of decision making with the multiple
15 associations, and at large, members.

16 And it will go over and be exposed actually
17 to all rules that we're considering as the Public Health
18 Council, only worked with about half of them, and I have
19 been responsible for the other half, now they'll have
20 exposing for all rules and have the opportunity to give
21 input and help structure and design that.

22 So we're trying to modernize, because the
23 Public Health Council has been about 120 years in
24 existence, it was put in place at a different time and
25 we wanted to take advantage of the newly created

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1 associations and organizations that are involved in
2 public health.

3 Well, the national prevention strategy out
4 there tells us that their purpose and their goal for all
5 public health in the nation is to increase the number of
6 Americans who are healthy at every stage of life, and we
7 know our local health departments are a critical piece
8 of that.

9 We can think it and develop policy and
10 determine best direction from the state level, but the
11 boots on the ground activity happens at the public
12 health level in the community.

13 So local health departments are critically
14 important, we experienced that last week when we got our
15 statewide emergency. I was interfacing on a regular
16 basis with all the local health departments.

17 They were mobilizing volunteers; we
18 mobilized our medical reserve corp; we were mobilizing
19 other recourses at the local level to get out to the
20 community, to the people that were isolated, perhaps
21 separated, and because we were missing electric, you
22 know, we had difficulties in communication also.

23 But it was a great experience from my
24 perspective of multiple agencies working together at the
25 state level, but also a good interface with local

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1 health.

2 That's the way it's supposed to work
3 together, it's about safety, it's about preparedness,
4 it's about all the other pieces to public health.

5 But you know I come from a clinical medicine
6 background and didn't appreciate exactly the value of
7 population health and the importance of it. I
8 experienced it indirectly, but didn't have the direct
9 interface that I have now, but the beauty of what we're
10 doing right now is that it interfaces very nice with
11 clinical medicine.

12 Clinical medicine, folks, is a little more
13 individual health and public health is looking at
14 population health. But, interestingly, if you look at
15 what we're doing today it coincides nicely with the --
16 what the American College of Physicians just put out,
17 which is strengthening public health infrastructure.

18 Isn't that nice to know that the internists
19 around the nation are interested in public health and
20 how we can make it stronger, and then the Institute of
21 Medicine just put out, sorry, but that's a huge
22 document, but for the public health, Investing in a
23 Healthier Future.

24 So the Institute of Medicine also this year
25 put out a very hefty report, once, again, it's clinical

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1 medicine looking at public health saying, how important
2 it is and how critically important it is that we work
3 together.

4 So that's why it's nice with the Office of
5 Health Transformation, we have the opportunity to bring
6 all of these various disciplines in health together, so
7 we make good joint decisions that are coordinated
8 decisions, and instead of duplicating or having waste
9 happen we're overlapping in a nice way that's
10 streamlining the use of resources that we have now,
11 we're getting more done with less.

12 But, remember, our goal always is to have
13 the highest quality output we can have at the most
14 affordable cost.

15 I think we've shown success in that so far,
16 we've got lots more room for improvement, but I'm glad
17 to see local health is partnering with us.

18 We thought this was so important at the
19 Department of Health that we elevated Martin Tremmel and
20 also Joe Mazzola's office, which had been a combined
21 office with us with local health into a more robust
22 capability.

23 And so Marty is leading our efforts to
24 strengthen our relations with the associations, with the
25 local health departments, so that we're communicating

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1 effectively, we're working in lock step on the same
2 issues and programs that we're trying to achieve, and
3 we're helping the local health departments in their
4 leadership role at the local level to understand what
5 they could be in the community at the front lines
6 helping other resources come together, that's
7 businesses, schools, government leaders and others, and
8 coordinating that interface.

9 But local health has a lot to offer, and
10 they've got that leadership opportunity, I think, right
11 now, because people are looking at how do we best get at
12 issues like social determinative's of health; how do we
13 get at some of these health issues that are plaguing the
14 communities, and I still feel that the local level, that
15 is the best place for you to mobilize resources and use
16 them effectively.

17 It's much more cost effective at the local
18 level to mobilize available resources than it is for us
19 to at the state level, send information or people out,
20 and we saw this last week with our statewide emergency,
21 that local -- that local response was critically
22 important to saving lives.

23 So I appreciate what people have done in the
24 past at the local level, I really appreciate the
25 importance of our local health departments in having

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1 good health for eleven and a half million people in
2 Ohio, and it's going to be real important that we work
3 very well together as collaborators in getting to,
4 hopefully, a very good recommendation during this
5 process, during the next three short months.

6 So the beauty of this is we don't have
7 forever, I kind of like that. There's a little a bit of
8 a time crunch on us, and I apologize, I know that we did
9 miss Tim Ingram and a few others, I think they're at
10 H.O. meetings, because they had this large national
11 meeting, I love them staying connected that way.

12 But we thought we'd at least better have
13 that first interface today, get some structural
14 questions answered, get a little bit of an overview of
15 what Public Health Futures is doing from the AOHC
16 perspective, and then move us into a much stronger
17 conversation as we move forward.

18 So that's probably too much, but this is
19 exciting stuff. So I appreciate you all being here
20 today and looking forward to what we're able to achieve
21 together, thank you.

22 MR. TREMMEL: Thank you, Dr. Wymyslo. With
23 our guests here I think we'll proceed. Just two other
24 quick things, our apologies, No. 1, Dr. Threlfall,
25 Nancy, our apologies, apparently our directions are not

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1 accurate, so, Joe, if we can get on to the Fourth
2 Avenue, Fourth, something, our sincere apologies for
3 that. We have a left and should have been a right, or
4 vice versa.

5 Joining us also within the room and in the
6 audience as well are some on our subject matter experts
7 within the Department, members of the ODH team, and some
8 of our other colleagues have join us here.

9 We'll do a quick introduction, and I'm just
10 asking for a name and who you're with, so we can just
11 kind of know, because this is a very broad perspective
12 of folks, so maybe, Dr. Threlfall, if we can just
13 have --

14 DR. THRELFALL: Walt Threlfall, I'm with the
15 Delaware County General Health District representing
16 boards of health.

17 MS. SHAPIRO: Nancy Shapiro, I'm Assistant
18 Health Commissioner at the Delaware General Health
19 District and representing the Ohio Public Health
20 Association.

21 MS. FOUGHT: Heidi Fought with the Ohio
22 Township Association.

23 MS. WENTZEL: Jennifer Wentzel with Public
24 Health Dayton Montgomery County representing Ohio
25 Environmental Health Association.

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1 MR. PRESS: Chris Press, I'm with Blanchard
2 Valley Hospital representing OHA.

3 MR. WERMUTH: Steven Wermuth, ODH.

4 DR. WYMYSLO: Ted Wymyslo, again.

5 MR. TREMMEL: Martin Tremmel.

6 MR. MOODY: Greg Moody, Office of Health
7 Transformation.

8 DR. MCFADDEN: Jack McFadden, Health
9 Commissioner, Association of Ohio Commissioners.

10 REPRESENTATIVE WACHTMAN: Lynn Wachtman,
11 State Representative.

12 MS. EDWARDS: Kim Edwards, Ashland County
13 Commissioner representing County Commissioners
14 Association.

15 MS. ENGLISH: Lindsey English with Senator
16 Burke's office.

17 COMMISSIONER ADAMS: Jim Adams with the
18 Canton City Health Department. Actually sitting -- and
19 I'm with AOHC, I'm actually sitting in for Gene Nixon
20 who is the Health Commissioner at Summit who is the AOHC
21 representative.

22 MS. SCOFIELD: Good morning, Jennifer
23 Scofield, I'm with the Office of County Executive, Ed
24 Fitzgerald, Cuyahoga County.

25 MR. MAZZOLA: Good morning everyone, Joe

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1 Mazzola, ODH.

2 MR. TREMMEL: Great, thanks everyone. You
3 see we have a diverse group here and the Director talked
4 about relationships and I still say, you've often heard
5 me say this, these public health relationships with the
6 associations here represented I still maintain are some
7 of the strongest in all of Ohio.

8 We really -- when we pick up the phone, we
9 reach out to you, you respond, and we look very forward
10 to your efforts here going forward.

11 Having said all of that, HPIO and the
12 Association of Ohio Health Commissioners entered into an
13 agreement some number of weeks or months ago, Mr. Adams?

14 COMMISSIONER ADAMS: Months.

15 MR. TREMMEL: Months, and that contract
16 resulted in a Public Health Futures Report. Let me turn
17 it over to Commissioner Adam to walk us through the
18 Executive Summary. Jim said this would take the better
19 part of two and a half, three hours, right?

20 COMMISSIONER ADAMS: But I'll do my best.

21 MR. TREMMEL: If you can do your best in
22 some number of 40 some minutes, and we'll just maybe, if
23 necessary, take a quick walk around from there,
24 Commissioner.

25 COMMISSIONER ADAMS: Thank you, Mr. Tremmel.

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1 As Marty said, my name is Jim Adams and I'm not only
2 with the Canton City Health Department, but I'm also the
3 President -- current President of AOHC, the Association
4 of Ohio Health Commissioner.

5 Just by way of a couple of opening comments,
6 we have been trying to release this report in kind of a
7 purposeful way, making it first available to our
8 membership.

9 So they've seen this report for maybe about
10 two weeks now, and so this presents us with a really
11 nice opportunity to be able to re -- help leadership
12 within the State of Ohio, and kind of move forward with
13 some of the recommendations of the report.

14 So a couple of thoughts that I have just
15 before I get started is that most of our members
16 probably are on one side or the other of this report.

17 I would say that at least as many that like
18 the report probably don't like the report for the
19 recommendations that are in the report.

20 I had a conversation once with one of my
21 editors of the paper, and he said if we publish
22 something in the paper and half the people like it and
23 half the people don't, we know we've done a great job.

24 So if one of the purposes of the report is
25 to stimulate a lot of discussion a long way we can

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1 improve the delivery of local public health services, I
2 think we're well on the way with this successful report.

3 Following my preparation I would welcome any
4 kind of comments people might have, the best, most
5 efficient way to really distribute the full report, the
6 full report has a hundred and twenty some odd pages and
7 contains really a lot of detail, that'll take some time
8 to kind of read through it several times before you can
9 really absorb some of the information that in there, so
10 we could, you know, work out the best way that we can
11 make that available for everybody.

12 I -- the difficult thing for me is that we,
13 you know, as an organization that represents the
14 delivery of local public health services in Ohio, you
15 know, our members are kind of -- they don't quite know
16 where they want to be on this report yet, and -- but one
17 of the things that I think we can probably agree upon is
18 that we have a few common goals and interests.

19 For me it's really -- I think the common
20 goal for me is that I think we can do better for the
21 people in Ohio.

22 We think that everybody in Ohio deserves
23 quality public health services delivered close to where
24 they live by local departments, and if we can kind of
25 keep our eyes focused on the best way to deliver those

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1 services so that people can have successful health
2 outcomes no matter where they live.

3 You know, these disparities and health
4 outcomes that kind of show up just because of the place
5 we live, I think, are kind of unacceptable. So for me
6 that's one of the things I focus on as we move forward
7 in some of the differences and opinions we may have on
8 this.

9 So as Marty pointed out, I do have this
10 presentation that was actually developed by our two
11 co-chairs, who are Gene Nixon, who's the Commissioner of
12 Summit County Public Health, and Kathleen Meckstroth,
13 who is with the Washington County Health Department, and
14 they have put together a very nice preparation, and this
15 is their preparation, so I will attempt to muddle my way
16 through it.

17 If you ask me technical questions I would
18 probably have to either make something up or just defer
19 it for the group later.

20 My sense is that we're probably the experts
21 in the room, and if we don't know the answer immediately
22 from the presentation it's going to be up to us to try
23 to figure it out. So please be kind, I guess, with the
24 questions as we go through.

25 Probably one of the more efficient ways to

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1 do this is probably just have me blunder through the
2 presentation until we get to the end and maybe ask some
3 questions later, otherwise we might get a little
4 sidetracked. I know my attention span is a little bit
5 limited. In the past this has taken about 40 or 45
6 minutes, not two and a half hours.

7 MR. TREMMEL: We'll hold you to 35.

8 COMMISSIONER ADAMS: So I do appreciate the
9 opportunity to be able to be here, and, I guess, with
10 your permission I'll go ahead and get started.

11 This is the Executive Summary of our Public
12 Health Futures Report, and this is considerations for a
13 new framework for public health in Ohio.

14 This was started last September in great
15 earnest, we had had the beginnings of a Futures
16 Committee that was started by a previous president,
17 Wally Burton, who is from Pike County Health Department.

18 We had a presentation at our fall meeting in
19 September by Mr. Moody, and he had about two slides in
20 his very compelling presentation about health care
21 reform that talked about the number of local health
22 districts. So we did not really need much more prodding
23 beyond that.

24 We knew that we had to move forward with
25 this project that we already kind of had on the back

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1 burner, and we wanted to do a good job in describing
2 what we thought local public health might look like in
3 the future.

4 So the goals of the project are listed here,
5 we wanted to find out the current status of public
6 health, including structure, governance and funding;
7 look at the rules and policies and standards that are in
8 place, particularly as they might relate to the
9 Affordable Care Act.

10 Now, that the Supreme Court has upheld that
11 Act, I think that probably compels us to look at this in
12 a very significant way.

13 Look at any other stakeholders interest and
14 concerns to develop, particularly in the areas of
15 collaboration and consolidation.

16 A few other objectives were describe the
17 current status -- wait a minute, I thought I clicked
18 that, Joe.

19 MR. MAZZOLA. You did.

20 COMMISSIONER ADAMS: Okay. Is that a
21 repeat?

22 MR. MAZZOLA: Uh-huh.

23 COMMISSIONER ADAMS: The methods that we
24 wanted to look at is we engaged with a contractor,
25 Health Policy Institute of Ohio, we worked Amy

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1 Bush-Rohling (Phonetically Spelled) and a subcontractor,
2 Patrick Lanahan, who is an independent contract with
3 HPIO.

4 They worked with us to develop what I think
5 is a very comprehensive, a very honest and very straight
6 forward report that we can use to help guide our
7 discussions on how to structure public health in the
8 future.

9 We also had the very kind support of several
10 funding institutions and they are listed in the full
11 report. I won't list them, but AOHC put in some of
12 their own money, as well as we were able to get support
13 from several foundations throughout Ohio to help fund
14 this project, so with that, I think we've done a very,
15 very good job and have been very good stewards with
16 their money.

17 We did a regulatory scan, a couple of
18 structured surveys, as well as a conversation type
19 survey.

20 We did key informant reviews and a
21 literature review, and we held several all district and
22 all member meetings in order to gather information from
23 what's really happening in the field of local public
24 health in Ohio.

25 The road to consensus was a bit rocky and

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1 torturous, but we don't really have quite consensus yet
2 on what the report means and how it's going to be
3 implemented in Ohio, so this report is really just a
4 start, and so it's going to allow us to have some
5 structure around these some 18 recommendations that the
6 report makes for structuring local public health in the
7 future.

8 We initially started looking at cross
9 jurisdictional sharing and regionalization, and usually
10 when you see the word regionalization in the report,
11 that's kind of a code word for merging, so as we've had
12 -- as most people know, when you talk about collapsing
13 the number of local jurisdictions of anything, the word
14 merge or consolidation is a bit of a touchstone, so
15 that's always been a difficult thing to get by.

16 I think we've kind of got by that a little
17 bit. We can actually say consolidation without tripping
18 over it or being embarrassed, so I think we're making
19 some progress.

20 What happened is when we talked, we
21 initially started the report with looking at the
22 direction of how can we best describe a process for
23 consolidation in the future, and what quickly happened
24 is consolidation is one thing, but it's really only a
25 means to an end.

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1 What are we really looking for and what
2 we're looking for is the delivery of quality public
3 health services in the community for all of Ohio, and
4 how can we organize ourselves to be able to deliver
5 those services in a way that makes sense.

6 This is a little bit difficult to see, the
7 full -- the full chart is in the full report, but what
8 it's trying to talk about is that there's really a
9 continuum of shared services that are going on in Ohio
10 right now.

11 Many, many, informal arrangements, either
12 verbal or handshake agreements, some MLUs with different
13 grants and things like that, sharing information,
14 sharing equipment, sometimes sharing personnel on a very
15 informal level.

16 The next level up is formal contracts for
17 sharing of facilities, joint ownership, mutual aide
18 agreements and things like that, and that goes all the
19 way on up to full consolidation or even regionalization
20 across county lines.

21 We don't have -- as far as I know we don't
22 have any public health services, any public health
23 departments that are consolidated across the county
24 line, although we do have some that are consolidated
25 within the county, so that's kind of a range of

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1 services.

2 And the diagram kind of indicates, I don't
3 know if they can see this moving on my chart here, but
4 goes from simple to complex types of arrangements, and
5 from low risk types of arrangements, so, of course, the
6 easy ones we do first, but high risk and complex ones
7 are very difficult to do, so they come last, so that's
8 where we are at with that chart.

9 Three parts to the report. The first part
10 of the report talks about the general description of
11 what's going on in Ohio.

12 So we all know some of the obvious is that
13 in Ohio we have a local very centralized structure, the
14 local control. There is significant variability across
15 local health departments in terms of population, size
16 per capita, expenditures and capacity.

17 And the report later goes on to describe the
18 differences and the types of services that can be
19 provided based upon the population size and the amount
20 of funding that's available to that local department.

21 71 percent of local health departments are
22 combined or general districts, which in the report is
23 generally referred to as a county; 29 percent are city.
24 Right now I believe we have 125 local health districts.

25 When we started the report we had 127, so we

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1 did have a successful merger or union of three
2 departments into one, which actually turned out to be a
3 pretty good model. 74 percent of Ohio's counties have
4 one health district in the county.

5 This chart illustrates of a hundred twenty
6 five local health districts kind of the break down
7 between city and county health departments, 37 city, 88
8 county, and it also breaks down by color whether they
9 serve a small jurisdiction, a small population, which in
10 this case is less than 50,000 residents, medium, large
11 and very large districts.

12 So you'll see, it's pretty obvious that over
13 58 percent of local health districts serve a population
14 of 50,000 residents or less. So we have a lot of
15 smaller jurisdictions serving the people in our
16 community.

17 These numbers are not new to us, Ohio ranks
18 33rd in median per capita local health department
19 expenditures and 41st in state public health
20 expenditures, and that's been a trend that we've
21 observed for the last few years.

22 Of local funding about 75 percent of the
23 revenue that is provided locally, it varies widely by
24 jurisdiction, and is very vulnerable to local economic
25 conditions, so we have a very unsteady, at least,

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1 funding stream at the local level.

2 State generated revenue, right now Ohio
3 contributes about 6 percent of local health department
4 funding through general GRF dollars with the state.

5 Although, it is true and it is very
6 appreciated that about 22 percent of the revenue that
7 Ohio -- that local health departments receive is pass
8 through dollars that the state manages on our behalf,
9 and we appreciate that.

10 This chart is also a little small, but a
11 better chart is actually in the report. What it
12 attempts to break down is of the 2010 --

13 MR. TREMMEL: Page 7 in the report.

14 COMMISSIONER ADAMS: Pardon me?

15 MR. TREMMEL: Page 7.

16 COMMISSIONER ADAMS: Thank you. Page 7,
17 might be a little clearer there, 2010 local health
18 department revenue in Ohio a little over \$564 million.

19 The chart looks at the breakdown of the
20 sources of that local health department revenue. The
21 little break out circle shows that about 33 percent of
22 that local revenue coming from local government, and
23 then the little circle over here breaks down the local
24 government portion.

25 And you'll notice that in local government

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1 about 40 percent of the local share comes from local GRF
2 dollars, about 33 percent comes from levies, 19 percent
3 comes from inside millage, which is the current system
4 for townships to contribute to local health department
5 services, and then 19 percent is other local government
6 fees, and for the life of me I can't remember what that
7 is right now, so please don't ask me, but it's in the
8 report.

9 This chart also is in the full report, but
10 not in the summary. What this shows is that breakdown
11 between the annual local health department revenue
12 between the United States and Ohio.

13 The features to note on this chart is that,
14 as we said before, Ohio, about 38 percent of the revenue
15 comes from local, and also about 27 percent up here
16 comes from fees and other user generated fees, which is
17 also kind of like local dollars.

18 You'll see nationally local health
19 departments get about 16 percent of Medicaid and
20 Medicare funds, in Ohio we only get about 7 percent, so
21 this is a model that I think we can kind of look at.

22 Other things like other funding and federal
23 direct funding is pretty similar between Ohio and the
24 United States. The thing that's really different is the
25 amount of state, local dollars that funds local health

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1 department programs. Nationally about 21 percent comes
2 from state dollars, in Ohio only about 6 percent.

3 So the chart immediately shows that we drive
4 a lot of the costs for provision of local public health
5 services into local government.

6 Current collaboration, since 1919 we had
7 about 180 health departments, that collapsed down to
8 125.

9 If someone is a history buff I would love to
10 do a study about what happened after the flu pandemic of
11 1918 and why we had the law that changed into the
12 current structure we have now.

13 My feeling is we probably did a fairly lousy
14 job with the flu, and the legislature knew it, but that
15 would be a great study.

16 A lot of those were city, county mergers or
17 unions, and contract arrangements, so we had a number of
18 small cities that had local health departments and those
19 were collapsed into a more county structure.

20 Local health departments currently engage in
21 a great deal of collaboration and resource sharing,
22 which ODH will be able to show in the amount of grants
23 that we are able -- that we collaborate with and things
24 like that.

25 So 90 percent of local health districts

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1 reported contractual arrangements with each other; 66
2 percent reported shared services or pooling of services
3 and the provision of services; and 51 percent reported
4 more sharing over the past four years, rather than less,
5 so the trend is to get together and share more.

6 There also is a strong interest in future
7 sharing, so the areas that we looked at as far as future
8 sharing, as we saw a need for sharing for subject matter
9 experts, leadership development, policy development and
10 particularly accreditation guidance.

11 And I think there's a slide later on that
12 talks a bit about accreditation, so I'll have to spend a
13 minute on that for those who are unfamiliar with that.

14 Also, for administrative functions like
15 information technology, human services and technology,
16 there's ample opportunity for sharing to provide those
17 services to a number of departments.

18 Economic environment, according to a 19 --
19 2009 NACCHO, NACCHO stands for the National Association
20 of County and City Health Officials, survey, 72 percent
21 of local health departments reported a loss of staff;
22 85, cuts to at least one program.

23 That has stabilized a little bit in the last
24 year and a half, but they're still working with much
25 less staff than we did in 2008.

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1 Of course, we know about the issues for
2 leaner government at state and local levels, and we also
3 note that ODH has had significant staff reductions in
4 the past few years, which results in fewer services that
5 are available for local health departments. So we are
6 in an environment where we really have to do much with
7 less.

8 The policy environment that the report
9 outlined was that these issues of accreditation and
10 improvement -- performance improvement standards.

11 So for those of you that may not know, there
12 is a national recommended voluntary accreditation
13 standard for the provision of local health department
14 services in the community.

15 There's a set of standards that are centered
16 around 10 domains in the provision of local health
17 department services, there's a National Accreditation
18 Board, and that board is accepting applications for
19 accreditation.

20 So it's much like -- it's much like
21 hospitals would go through with JCARR or something like
22 that to be accredited.

23 It's a very expensive process, there's a lot
24 of documentation, so while we think many departments are
25 able to provide these services on a pretty routine

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1 basis, the process of actually documenting that
2 provision can be fairly onerous and time consuming.

3 But it does provide tools for really
4 measuring our performance to the community and making us
5 held accountable to the community for the services that
6 we are providing.

7 MR. MOODY: Is the contents of the
8 accreditation seem as legitimate from the local
9 perspective?

10 COMMISSIONER ADAMS: I would say, yes. Ohio
11 has recently changed the way that we report our
12 performance. As you know Ohio has a set of performance
13 standards, those standards recently were changed to
14 mirror the National Accreditation Standard virtually
15 word for word, and the reporting tool that ODH has
16 developed allows us to report on those exact same
17 performance standards, and those same domain areas that
18 the National Performance Standards have.

19 And I have a slide that illustrates how
20 we're already using that data to kind of highlight some
21 of these disparities in the provision of services.

22 MR. TREMMEL: We just rolled out that
23 technology in January, and it was in concert with the
24 Ohio General Assembly timeline in December.

25 COMMISSIONER ADAMS: I believe there is some

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1 push back from the departments, because of the fees for
2 accreditation, and really the amount of documentation
3 that has to be collected, but I think -- in general I
4 think most people are on -- would agree that it's a good
5 program, that it's really helping us define the
6 provision of services.

7 MR. TREMMEL: And on accreditation for just
8 a quick second, there are no health departments
9 accredited yet. Some local health departments are in
10 the process with Delaware being one.

11 MS. SHAPIRO: We have sent in our intent, I
12 believe Summit County has also sent in an intent, and
13 Mahoney.

14 MR. TREMMEL: And the Ohio Department of
15 Health, I want everyone to know.

16 COMMISSIONER ADAMS: And ODH, from the state
17 side, because as with local standards, there are also
18 standards that apply to provision of services from the
19 State Health Department.

20 MR. TREMMEL: Okay. Thank you.

21 COMMISSIONER ADAMS: The Ohio Department of
22 Health, as well as, was it one or two local health
23 departments in Ohio were beta test sites for the
24 standard.

25 MS. SHAPIRO: The Ohio Department and I

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1 think Mahoney was.

2 MR. TREMMEL: I think those were the two out
3 of eight or thirteen test sites, we had two in Ohio.

4 MS. SHAPIRO: Just a point of information,
5 the Ohio Public Health Association has received a grant
6 from the America Public Health Association to measure
7 the willingness of local health departments to proceed
8 with accreditation, and we're doing a project in
9 cooperation with AOHC and ODH, and just surveyed, about
10 66 percent have replied for survey, health departments,
11 and they'll be a series of three meetings to look at
12 moving folks from the ones that are really ready to go,
13 some that are kind of on the fence of whether they're
14 going to go, and then the other group.

15 So want to move these five health
16 departments over to moving in a direction seeking
17 accreditation, the project under way and completed by
18 the end of October, I believe.

19 MR. MOODY: Didn't mean to take you off
20 track.

21 COMMISSIONER ADAMS: Oh, no, that's fine.
22 It's a good discussion, especially for -- we use this
23 terminology pretty freely, because we're pretty familiar
24 with them, and I'm mindful that this might be the first
25 time that some of you may have heard about the

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1 accreditation process.

2 The other areas, of course, in the policy
3 environment are health care reform, and I think Mr.
4 Moody and his office could probably speak to this much
5 better than we can, but that clearly affects the
6 provision of local public health services and has the
7 ability I think to really improve the delivery of health
8 services in our community.

9 And we also have the completion of the State
10 Health Improvement Plan, or the impending completion,
11 I'm not quite sure where that is, but I think we're like
12 99 percent there, right?

13 DR. WYMYSLO: We're within a month or two,
14 we'll be totally complete.

15 COMMISSIONER ADAMS: So we'll see that as a
16 way to help drive, you know, what we need to do at our
17 local levels to provide those services to make those
18 improvements.

19 Some of the challenges we have, as I
20 mentioned before, there's a very complex and fragmented
21 funding scheme that local departments have cobbled
22 together to provide services in their community.

23 The funding streams are frequently not
24 aligned with what we are now recognizing our community
25 needs to help improve health cost in our community, so

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1 we need to try to realign that funding with what's
2 needed in our community.

3 This is a fairly complex chart, and I don't
4 believe it's in the Executive Summary, but it will be in
5 the full report.

6 I think this was an idea that was advanced
7 by Dr. Friedman who was Health Commissioner for the New
8 York City Department of Public Health and is now at CDC,
9 but the features of this chart is that we get the most
10 bang for our buck, if we spend money on things that are
11 lower in this triangle.

12 So if we spend money on socioeconomic
13 factors it affects health outcomes, poverty, education,
14 that we can spend a little bit of money in those areas
15 and get a larger impact in the community to those
16 investments in those foundational elements.

17 And as we move up the chart we spend more
18 and more money, but it affects less and less people, and
19 at the very tip of the diagram we spend maybe a lot of
20 money on individual counseling and education, but that
21 only really affects that one person.

22 So one of the things that Friedman would
23 advance is that we need to drive our funding to the
24 lower parts of the pyramid, because it affects a larger
25 number of people for a less amount of money.

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1 So what HPIO tried to do, and I think they
2 did a very nice job, as you read the report you'll have
3 to spend some time with the chart to get the full amount
4 with this, but what they tried to show is they tried to
5 show local health department expenditures relative to
6 where they were at on this diagram.

7 So you'll see that about 35 percent of the
8 funding that we have is really for long lasting
9 protective interventions, but it really only affects a
10 limited amount of people, and the interventions might be
11 a WIC program or smoking prevention, things like that.

12 So with the goal, I think, is really trying
13 to shift this diagram so that it looks more like we're
14 spending more money in the lower parts of this triangle.

15 It's a complicated chart. There's a lot of
16 information in there, and it's one that we'll have to
17 spend some time on the full report to get the full -- to
18 glean some of the information out of that.

19 MR. MOODY: Can you read the second one up?

20 COMMISSIONER ADAMS: This one here, Changing
21 the Context to Make Individual's Default Decisions
22 Healthy.

23 So a good example of that is Ohio's Smoke
24 Free Workplace Ban, you know, so it makes it -- you're
25 not allowed to smoke in a public place, and so, you

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1 know, that makes that default decision much easier for
2 people to do.

3 So some other examples, like in New York,
4 their bans on trans fats and things like that, starting
5 to make it easier for people to make a more healthy
6 decision, so that's kind of like the default with
7 society.

8 REPRESENTATIVE ANTONIO: Can I ask, are
9 there -- so when you talk about the cost, it's the cost
10 at the moment put into the program, does it also take
11 into consideration the long-range savings or is that not
12 a part of the equation?

13 COMMISSIONER ADAMS: It is part of the
14 equation, and I can't describe that in as much detail as
15 probably what you would like now.

16 But part of the equation, there are some
17 demonstrations in particularly New York where they have
18 done a lot of this thing where they're really looking at
19 the chart in these areas, because Dr. Friedman was from
20 New York, and so they have some recent journal articles,
21 I just saw one in the Lancet not too long ago that
22 really relates to economic impact for long-term chronic
23 care management related to things like smoking and that
24 kind of issue, yeah, so there is some data that's
25 beginning to be available. Does that help with your --

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1 REPRESENTATIVE ANTONIO: Yeah, I would just
2 think it's a consideration in the long-term that we
3 would at least have to consider.

4 COMMISSIONER ADAMS: Absolutely.

5 REPRESENTATIVE ANTONIO: Yeah, thank you.

6 COMMISSIONER ADAMS: So that's kind of the
7 first part of the report. The second part of the report
8 really talks about the interviews and the surveys that
9 were done to try to gather information and what lessons
10 were learned from literature reviews and shared service
11 examples.

12 So we interviewed about 25 stakeholders,
13 some of those interviewees are in this room, I believe,
14 and Patrick Lanahan who did those interviews did
15 summarize that in the full report.

16 Some of the key messages from the informants
17 were the time is right to develop a new model. We're
18 already doing a great deal of collaborating, but -- and
19 there is a high motivation to do more to figure out new
20 ways to share.

21 The next step should be empowering those
22 collaborations to be on a more formal basis and
23 initiated by local public health. No single strategy
24 emerged for future models for cross jurisdictional
25 sharing.

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1 We were unable to answer the question, how
2 many local health agencies should there be? I mean
3 that's a fairly common question, there's not really a
4 good answer to that, at least right now. If somebody
5 asked me today I'd probably say the number of local
6 health agencies or what we need to be to make sure that
7 we have efficient local public health services delivered
8 for everybody in Ohio, I don't know what that number is,
9 but that's the right number.

10 Consolidation is a way to get there, but
11 it's not a silver bullet, there's no one size that fits
12 all. One of the key things that came out of these
13 messages was a need to define a future model for local
14 public health.

15 They talked about a minimum standard of
16 public health protection should be available statewide.
17 So everybody should have public health services, quality
18 public health services delivered in their community,
19 local public health services.

20 A high priority was to find a way to
21 organize and fund the capacity to support a minimum
22 standard of local public health services.

23 We feel that there's probably not enough
24 funding in the system now, so I don't know whether we
25 can take the same amount of funding or reconfigure it or

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1 add new funding to the system, we're not really sure
2 where that's at right now.

3 We need to be able to truly identify local
4 needs, we need to prioritize what public health can do
5 that other systems cannot or will not do.

6 Frequently local public health becomes a
7 safety net provider in many, many communities, and we
8 need to become much more connected with the broader
9 health care system, so the two should not, like Dr.
10 Wymyslo pointed out at the beginning with his comments,
11 that the provision of personal public health service and
12 public health services should be much more connected
13 than they are now.

14 Lessons learned, just kind of briefly, these
15 are some experiences that we had in the past for
16 especially consolidations, if you have a past history of
17 mutual trust and a history of collaboration it's much
18 easier to move down that line into a more formal
19 collaborative model.

20 We need strong commitment from top level
21 leadership, really at all levels, state and local
22 government.

23 Partnerships begin with communities with
24 similar demographics, much harder to collaborate or
25 combine when you have a large urban county and a small

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1 rural county, you know, those two are just kind of a
2 difficult fit, because of the nature of the populations
3 this live in those particular communities, and they have
4 to be able to demonstrate current and maybe even past
5 successes at increasing efficiency or cost reduction.

6 People don't want to go through the process
7 of consolidating unless we can show some pretty quick
8 cost reductions and savings.

9 You need to -- lessons learned continued as
10 the ability to maintain services needed and expected by
11 the community, but no longer feasible for one local
12 health department to provide.

13 So it's very difficult to have this
14 conversation, people don't want to lose the feeling that
15 they have this local connection to the service provider
16 that they have. They want to have a -- they really want
17 to have a guarantee that those services will continue
18 even at a combined environment.

19 We need to make sure that we have a very
20 clear purpose about reasons for engaging in
21 collaboration, can't be just kind of out there, have to
22 be very specific about why you're collaborating.

23 And weighing the cost of collaboration and
24 participating varies, and that goes to your question, I
25 think, Representative, that you have to be able to

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1 demonstrate both short term and long term cost savings
2 within the system.

3 Key concepts, shared services, we talked
4 about that. There's this process of just informal
5 collaboration to full out merger.

6 Clarity of purpose, determine local health
7 department's performance. We want to make sure we have
8 quality health departments out there.

9 There's a minimum sufficient scale that's
10 described in the report, I'll talk about that on a chart
11 in just a minute.

12 I did mention the Public Health
13 Accreditation Standards, and how they're going to affect
14 the measurement of the quality of services, we're going
15 to use that as the standard for our quality.

16 We talked about the health impact pyramid
17 for a minute, and then the next chart that I think we're
18 going to talk about is this Minimum Package of Public
19 Health Services.

20 So through these key informant interviews
21 and the meetings that we had with our -- our district
22 meeting today at AOHC we struggled with how to come up
23 with what the local health department should be doing.

24 There's a chart that's on Page 13, I am
25 going to get to it in just a second, but it's on Page 13

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1 different lines. Along the lines of local health
2 department capacity, services and quality; some
3 recommendations on jurisdictional structures; some other
4 recommendations on financing; and there were a few
5 recommendations on implementation strategies. So those
6 are the groups of the recommendations that the report
7 came up with.

8 Some challenges and opportunities, we
9 thought that some of the key roles that public health
10 provided for the community that really nobody else can
11 provide is communicable disease prevention and
12 environmental health protection. I don't know of
13 anything else that can really do that in the community,
14 and so that's really critical for the health of the
15 people.

16 And as Dr. Wymyslo pointed out in this time
17 when we have power outages or disease outbreak, these
18 services are really delivered first and most efficiently
19 at the local level with support from the state later on.

20 The challenge -- another challenge we have
21 is to really serve public health's role in chronic
22 disease prevention and population health approach, and
23 this is an area that we have had in the past, we've kind
24 of lost it, now we need to kind of reassert that role.

25 We have a challenge in trying to rebalance

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1 our provision of clinical services within the role of
2 the new health care landscape.

3 So clinical services currently are being
4 provided by -- a lot by private providers and a lot of
5 local health offices do have clinical services. So how
6 is this going to fit as health care changes in the
7 future; how is that going to fit together?

8 And we think we need to lead health outcomes
9 and improvement using both the state and community
10 health improvement plans.

11 One of the features of an accreditation
12 process is that a local community has to go through,
13 much like the state has done, is go through a health
14 assessment process, and then develop a health
15 improvement plan for that community, and then help the
16 community follow that plan.

17 So if you're going to be even considered for
18 accreditation those are two of the basic things that you
19 have to do. You have to have a health assessment and
20 you have to have a health improvement plan that talks
21 about the goals and priorities of your community, and
22 then you align your services along that. So we think
23 that's a great role for local public health.

24 We need to strike a balance between local
25 control and statewide standardization. You know, as I

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1 drive through Ohio, I've lived in Ohio for 30 some
2 years, I wasn't born here, but it's an amazingly diverse
3 state.

4 We have Appalachia down in the southeast and
5 we have flat farmland, like I grew up in Indiana, up
6 around the northwest, and so just an amazingly diverse
7 state with different needs and different challenges.

8 We think there's opportunities to use cross
9 jurisdictional sharing and alternate consolidation, not
10 necessarily full consolidation, build capacity, improve
11 performance of local health districts.

12 So challenges for finance is building
13 political support for increasing or at least maintaining
14 funding to local public health. And some of the initial
15 steps that we think might address problems caused by
16 fragmented funding or lack of dedicated funding for
17 foundational capabilities.

18 I hope my chart is still in here, because I
19 want to go over that. Ability to make long-term
20 investments due to revenue instability.

21 I mentioned before that a lot of people are
22 dependent upon levies for some of their core funding and
23 things like that, and so as that funding goes up and
24 down it makes it very difficult to make those
25 investments in our foundational capabilities, we need to

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1 move our departments forward.

2 And a misaligning in the current funding
3 streams and services that local health departments are
4 mandated and expected to provide, either by the
5 community or through various state laws and expectations
6 from the state health agency.

7 Okay. So what I want you to do, I did take
8 this chart out of there, because it was too hard to read
9 on the screen, so if you could turn to Page 13, and I'll
10 just kind of highlight.

11 This chart has a lot of information in it
12 and we are going to -- you know, this group will have to
13 take a very serious look at it in order to get all of
14 the information out of here.

15 MR. TREMMEL: If I can interrupt just for
16 point of order, about how much time, maybe another five
17 or ten minutes?

18 COMMISSIONER ADAMS: I could make it 15; is
19 that all right?

20 MR. TREMMEL: Shorter, if you can.

21 COMMISSIONER ADAMS: I will. Let me
22 introduce just this Ohio minimum package of local public
23 health services. This chart tries to describe, on the
24 top left is the green box that talks about core public
25 health services that we think are the minimum things

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1 that local health departments need to be able to provide
2 in their communities.

3 There are, in the pink-ish box, it's on the
4 right-hand side, are other public health services that
5 local health departments frequently provide, and we get
6 actually categorical funding for many of those things.

7 But the bottom in the blue is the
8 foundational capabilities that local departments need to
9 have access to these services in order to support the
10 other two, which is why it's on the bottom.

11 So the foundational capabilities are the
12 part -- some of the parts where we think we're very,
13 very close to or very, very right for additional
14 sharing, particularly across jurisdictions to provide
15 that foundation.

16 All right. There are 18 recommendations,
17 and the recommendations are, one, that all Ohioans,
18 regardless where they live, should have access to this
19 minimum package of local public health services, and
20 there's the chart that I just went over.

21 Local health departments should have access
22 to skills and resources that make up the foundational
23 capabilities and to act as a support for its services.

24 Right now the purpose of this little tree
25 diagram is the leaves are the basic services that we

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1 provide; the trunk is the foundational capabilities.
2 And the situation we have right now is that the trunk is
3 very, very singly, and very few foundational
4 capabilities.

5 We're pretty good at providing all the leafy
6 part, but we're pretty unsteady in the trunk part, so we
7 need to increase those foundational capabilities.

8 If I could just take one second I'll
9 highlight how we're using the Ohio Department of Health
10 Standards Reporting Tool to look at some of this.

11 The orange bars are standards that talk
12 about quality improvement, evidence based practice,
13 workforce and policies and plans. Those are the lowest
14 scores in our reporting, those represent some of the
15 foundational capabilities.

16 The scores that we were highest in were
17 things like governance, investigation of communicable
18 diseases, some administration and management, there's
19 environmental health services here included in there.

20 So we're pretty good at doing some of the
21 core services, we're very weak in the foundational parts
22 is the purpose of that chart.

23 And this shows it, again, in another way, it
24 shows environmental health services that are provided
25 kind of by jurisdictional size, let's see, there's very

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1 little -- there's not a lot of difference between the
2 size of the jurisdiction and the ability to provide
3 environmental health services.

4 But in this quality improvement, which is
5 clearly one of the foundational capabilities, the
6 differences between small populations, less than 10,000
7 and larger populations is very dramatic.

8 So, you know, they're just not able to put
9 those resources into doing some of those foundational
10 capabilities, it's all used up, these are the things
11 they have to do.

12 I'm going to skip over this chart, but just
13 know, there's this very complicated chart that tried to
14 align the PHAB standards with the health impact pyramid,
15 and kind of where we're at with foundational
16 capabilities in the report, it's a very rich chart that
17 I hope we can get into later.

18 Minimum package of local services should
19 guide future changes. Is it okay if I -- per your
20 suggestion, I'll just rush through these, okay.

21 All local health departments should become
22 eligible for PHAB accreditation, note that's not the
23 same as being accredited, but we think we should get to
24 the place where we can possibly make an application, if
25 we desire to.

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1 Local health departments that meet the
2 minimum package should be prioritized for grant funding
3 within their jurisdictions. That goes to the fact that
4 we should prioritize funding for the local departments,
5 rather than other agencies within that jurisdiction.

6 We should use the biennial standards
7 reporting tool that Joe Mazzola and Marty now manage as
8 a reporting tool to -- to identify whether we're in
9 compliance with those standards or not.

10 A scan of current laws to make sure that we
11 can make changes within current -- the current laws that
12 really address these minimum standard -- minimum core
13 package services, are they aligning with what we really
14 need to do; do we need to make changes in state law that
15 define that in a better way.

16 Decisions about jurisdictional structure
17 should be based upon the ability to efficiently and
18 effectively provide that minimum package of local public
19 health services.

20 So some of those things to consider in that
21 are population size, the number of jurisdictions within
22 a county, and local geographic political and financial
23 conditions.

24 There's a chart in your report on Page 14
25 that talks about this, I don't want to take -- if I can

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1 take just a minute on this, because I think this is an
2 important point.

3 There is the -- the literature indicates
4 that if you have a local -- local jurisdictions that
5 serve populations of about a hundred thousand people or
6 better show a dramatic increase in their efficiencies in
7 being able to provide some of these foundational
8 services.

9 So one of the decision making trees that we
10 try to highlight in the report is, first of all, take a
11 look at whether you're able to provide these minimum
12 packages of services with adequate support, if you're
13 able to do that, you're great, continue to improve,
14 continue to move on, continue to serve the community
15 well.

16 If for some reason you're not really
17 providing these minimum services then you really need to
18 consider how you can develop systems to be able to have
19 the support to be able to do that.

20 And one of those things is to think about
21 the population size that your aggregated group is going
22 to serve, and so this will take some time, I think, of
23 this group to kind of figure all of that out.

24 But just know that the literature suggests
25 that population sizes of around a hundred thousand show

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1 this dramatic increase in efficiency of their provision
2 of services, which is not the same to say that you can
3 only have a hundred thousand or more in your health
4 jurisdiction.

5 There are recommendations in the report of
6 other ways that you can gain these foundational services
7 short of consolidation. It really becomes a local, the
8 report says, it should be a local kind of decision to
9 make.

10 The other part of this chart is that if you
11 have multiple jurisdictions within one county, of which
12 Stark County is a pretty good example of this, there are
13 four health care stations in Stark County, the county
14 itself serves about 240,000, Canton is about 80,000, and
15 then we have two smaller cities. We need to seriously,
16 seriously consider why we cannot combine our departments
17 into one.

18 So we've started to engage in that process,
19 and we'll kind of see where it goes, but that's the
20 other thing the report says, it's about multiple
21 jurisdictions within one county.

22 I am going to actually skip through the rest
23 of the recommendations, because they are in the report
24 and we are able to cover those in detail when we go
25 through there.

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1 I want to go to the very end, I just want to
2 click through them real quick, because I do have to do
3 the thank you.

4 I wanted to thank our chair, these are the
5 folks that actually worked on the report from HPIO, we
6 think they did an excellent job. I want to thank Gene
7 Nixon and Kathleen Meckstroth who were our co-chairs for
8 this process and they did a great job.

9 So with that, I'm sorry I had to rush
10 through the last part of the program, but I'd be glad to
11 entertain any questions or comments.

12 MR. TREMMEL: Thank you, Commissioner Adams.
13 As Commissioner Adams outlined for you, the
14 recommendations are on Page 11 and 12 of your Executive
15 Summary there for your reflections during the meeting
16 and after.

17 Commissioner, I really appreciate your
18 thoughtful presentation. It was very well done,
19 superbly outlined, and recognize that we have -- in this
20 audience here we have folks that are in different
21 places, and I think you can appreciate that,
22 Commissioner, there are folks that see this in one
23 framework, there are folks that are going to see this in
24 a totally different framework, but I appreciate starting
25 the conversation with this, and we applaud the

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1 association, and all the public health associations for
2 being participatory.

3 COMMISSIONER ADAMS: Thanks for the
4 opportunity.

5 MR. TREMMEL: Okay. Wonderful. Also wanted
6 to thank and welcome Representative Antonio, thank you
7 for being here, Representative, and help us with the
8 areas that you represent.

9 REPRESENTATIVE ANTONIO: Well, I'm in
10 Cuyahoga County, Lakewood and the west side of
11 Cleveland.

12 MR. TREMMEL: Welcome to ODH.

13 REPRESENTATIVE ANTONIO: Thank you.

14 MR. TREMMEL: Thank you for being here. And
15 I also want to recognize Mr. Mazzola will be driving the
16 car again today. Any additional participants, Mr.
17 Mazzola?

18 MR. MAZZOLA: No.

19 MR. TREMMEL: Okay. And one other point
20 that Commissioner Adams mentioned were the Public Health
21 Standards, and I do want to make this clear, is it still
22 true that Ohio is the only state health department in
23 the country with standards of this nature?

24 MR. MAZZOLA: No. There are other states
25 that have adopted the PHAB standards.

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1 MR. TREMMEL: But I mean, the mechanism we
2 have, the electronic mechanism for reporting?

3 MR. MAZZOLA: We may be the only state that
4 has a system that's set up in a way that captures the
5 self-assessment based on the PHAB standards, and the
6 ability to export data back out as far as quality
7 improvement scores, yes.

8 MR. TREMMEL: And we have some other states
9 that are interested in our software system that we
10 designed, so thank you for helping clarify that.

11 MR. MAZZOLA: Sure.

12 MR. TREMMEL: With that, folks, are we
13 agreeable to maybe a three or four minute walk about,
14 and let's reconvene, some of our colleagues here --

15 MR. MOODY: We're going to discuss this
16 more, right?

17 MR. TREMMEL: Yeah, we're going to come back
18 for a quick discussion, yes, Mr. Moody, we'll be able to
19 put some things up on the board, if we need to capture,
20 but just three or four minutes, if you'd be so kind to
21 get back timely.

22 (OFF THE RECORD.)

23 (BACK ON THE RECORD.)

24 MR. TREMMEL: Okay. So thanks all of you
25 for joining us, a couple of our colleagues will be

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1 joining us here, again, any movement.

2 In light of the report that Commissioner
3 Adams has outlined for us, some initial comments from
4 members here; things we like about the report; things
5 that we've identified that are some concerns; some
6 things that we find are on base or off base?

7 And, again, I appreciate, and I think
8 everyone recognizes that we're all coming from a
9 slightly different place.

10 MS. EDWARDS: Kim Edwards, Ashland County.
11 I have a question that more goes to the accreditation,
12 I've heard -- I understand that the accreditation
13 within, I don't know quite specifically what timeframe,
14 but I believe within a certain amount of years, four to
15 five years maybe, that health departments may be
16 required to be accredited to receive dollars, Medicaid,
17 Medicare dollars; am I correct on that or not?

18 COMMISSIONER ADAMS: I've heard stories
19 about that, I don't think that that's been determined.
20 I mean the PHAB Board has only been active for only one
21 year now and they're only now accepting applications.

22 MS. EDWARDS: Okay.

23 COMMISSIONER ADAMS: I know that I've heard
24 a presentation at least once by the Executive Director
25 where that is a concern that is expressed by many local

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1 health departments throughout the country and they're
2 trying to work to address that.

3 I don't think that was the original intent
4 of the accreditation standards, although the intent was
5 to clearly demonstrate accountable.

6 MS. EDWARDS: And I guess that goes more
7 towards any type of federal grant.

8 COMMISSIONER ADAMS: Well, yeah.

9 MR. TREMMEL: And maybe, Kim, from the state
10 side I can address this to some degree, and I'll defer
11 to my colleague, Mr. Wermuth, here. We have not had
12 that conversation. I think there have been a number of
13 rumors to the effect of what would accreditation mean
14 for any local health department.

15 But, surely, we will keep our eye on
16 accreditation as one of those benchmarks of high
17 performing health districts to which we would likely
18 have some discussions with our colleagues about funding.

19 So I don't think we are anywhere near a
20 place to say a local health department not accredited
21 today or tomorrow would not get funding, but it's
22 probably a conversation that a health department
23 tomorrow that would be funded or that would be
24 accredited is likely to be appropriately funded, or as
25 we can, align funding for higher performing health

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1 departments.

2 But I just put that out there, because we
3 haven't said that, talked about it, referenced it, but I
4 just wanted to put that out there for purposes of
5 discussion. Is there anything you want to add to that?

6 MR. WERMUTH: Yeah, I think as we move
7 forward with some of those discussions in learning what
8 -- you know, from the experiences in other areas within
9 the health care delivery system becomes somewhat
10 helpful.

11 In other words, hospitals are not required
12 to be JCHCO accredited, but a hospital is not going to
13 get a contract from a commercial payer unless they have
14 that JCHCO accreditation.

15 So, you know, you can look at some of those
16 models and say does that have any application to what
17 we're trying to do with restructuring or looking at the
18 public health infrastructure in Ohio.

19 MS. EDWARDS: Okay. Thank you.

20 MS. FOUGHT: Heidi Fought with the Township
21 Association. During the presentation you had mentioned
22 only a few that were seeking accreditation or might be
23 moving towards accreditation, so what is the drawback?
24 Why aren't all departments seeking accreditation? I
25 think that's a fair question.

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1 COMMISSIONER ADAMS: Well, I can answer
2 briefly for maybe my department, maybe D.J. you can
3 throw in your's too.

4 One is the complexity of the application
5 process and the amount of documentation involved really
6 demands that you have a full-time person assigned to
7 that project to be able to make that work, and we simply
8 don't have the resources to put to that effort to
9 develop and provide all that documentation.

10 Also, I don't think we could afford the, is
11 it \$5,000, I don't know what -

12 MS. SHAPIRO: Nancy Shapiro, it depends on
13 the size of the jurisdiction to the cost, and D.J. might
14 be able to speak, I believe it's around -- do you
15 remember?

16 The Board of Health in Delaware has
17 authorized the funding, and I think it was somewhere
18 between 25 and \$30,000.

19 COMMISSIONER ADAMS: Yeah, we would
20 definitely struggle.

21 MS. SHAPIRO: And that's for our size
22 jurisdiction, it goes up and down depending on the size.

23 DR. MCFADDEN: Our's, I think, would be
24 around 5,000, I believe, but it's based on
25 jurisdictional size. And it's an annual fee?

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1 MS. SHAPIRO: You can pay it over five years
2 or a single lump sum.

3 DR. MCFADDEN: And for us it ends up being
4 both of those, I mean the financial, you know, we sit
5 and we say, you know, there's a long tradition of us
6 being a member of the Chamber of Commerce, because of
7 what that allows us to do in the community, but do we
8 pay our \$100 fee to the Chamber of Commerce, is that
9 money well spent when things get so tight?

10 So when we are talking about a hundred
11 dollars, when we start talking thousands of dollars, is
12 that, you know, the other piece though would be, you
13 know, so we do issue health alerts to our community, we
14 send out faxes to all of our doctors when we have the
15 power outages, we have H1N1, but for me -- so one of the
16 things that I would need to do with the -- and this is
17 just a small example, I would need to save all of those
18 messages that we send out routinely, I mean it's just a
19 part of our life, something happens, you send out a
20 message.

21 Now, I need to have someone who's
22 responsible for maintaining all of those so that I have
23 documentation of everything that we did.

24 Again, it's not that it's hard, it's not
25 that it takes a lot of money to do that, it's just that

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1 we have to remember every little thing we do.

2 Every time a sanitarian goes and educates
3 someone about, you know, the septic system we need to
4 keep track of those pieces so that it meets one of the
5 other -- you know, our guys, sort of like nursing and
6 hospitals, nurses are, you know, they want to take care
7 of the patient, but now nurses in hospitals are being
8 asked to do the billing, do customer service, do
9 customer satisfaction, do protection and safety of their
10 patients, and the more things you add on the more
11 diluted that primary role becomes, and I think those are
12 some of the questions we struggle with when we are -- I
13 mean we are shrunk to being able to get the work done,
14 and I think that's a problem.

15 MS. SCOFIELD: Jennifer Scofield from
16 Cuyahoga County Executive's Office. For the actual
17 process of the application is there anyone who's
18 providing any kind of technical assistance?

19 I don't know if you've talked about it in
20 your shop, but just to even get that process started is
21 someone able to do that?

22 MR. TREMMEL: At this time the Department of
23 Health is proceeding along its own track. As
24 Commissioner Adam mentioned, there's a community
25 assessment piece, there's a community health improvement

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1 plan, there's a strategic plan, and then beyond that we
2 start -- we put the PHAB Board on notice we would like
3 to apply for accreditation.

4 So the Ohio Department of Health is going
5 through its own steps right now, but even if the
6 Department of Health doesn't have necessarily at this
7 time all of the resources to do exactly what you're
8 asked, but what we will have is lessons learned of our
9 path, and then Joe and I taking some of those lessons
10 learned and communicating that to local health
11 departments.

12 But remember, we have two or three forward
13 thinking health department's that are going through
14 their own PHAB, so I think it should be a combination,
15 kind of a collaborative approach and we -- the nice part
16 about the Department of Health and the team we have
17 assembled here is we use a lot of this technology, the
18 live meetings and cameras, so we can pull together
19 lessons learned and we can have our colleagues across
20 the state saying, well, this is how we dealt with the
21 domain, you know, this is how we dealt with -- well,
22 we're a small department, we're a medium size, so that
23 would be our approach, Jennifer, when we get to that
24 point, but we're not at that point.

25 MS. SCOFIELD: And then just a quick

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1 follow-up question to that, these are national
2 accreditation standards, is there anyone from the
3 national level who's providing any technical assistance,
4 or did it just say here you go, this is what we
5 recommend you do?

6 MR. TREMMEL: The -- at least my
7 understanding from the months ago that the Ohio
8 Department of Health had the experience, we were
9 considered a Beta test site across the nation, and we
10 had this sort of early preview review of what public
11 health accreditation might look like, and what the Apps
12 might be when they sent a team, and a team was assembled
13 nationally, I think there were a half a dozen folks from
14 across the country with accreditation backgrounds and/or
15 with the Public Health Accreditation Board.

16 They came here and did an initial preview
17 assessment, asked us the kinds of questions along the
18 kinds of domains to which we provided the documentation,
19 and the walk away was, there are some areas that the
20 Ohio Department of Health does well and has appropriate
21 bases covered and there are areas that the Ohio
22 Department of Health needs some further improvement in
23 the system.

24 Not that they would take a walk away and say
25 you would or wouldn't be accredited, it's just that

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1 these are areas you need to work on.

2 We were thankful to be one of the early
3 adopters in the country to even learn what the process
4 is. We're going to translate those lessons learned into
5 now going down our path towards accreditation.

6 DR. MCFADDEN: I think to your question, two
7 or three years ago, correct me if I'm wrong, when the
8 Ohio Voluntary Accreditation Team, or OVAT started, one
9 of their discussions that we had was around individuals
10 who go through the process and are on the front end
11 trying to have some coaching back, and these are
12 conversations that haven't -- I don't know where they're
13 at at this point in the association, but to, you know,
14 to raise all districts, you know, coach back to try and
15 give people help.

16 We've had other discussions about how do we
17 help to ensure that districts that are smaller or
18 without resources are able to receive or get the
19 resources they need so that they are able to go through
20 the process. So those are conversations that we've had,
21 I don't think there's anything official yet that's been
22 decided.

23 MS. SHAPIRO: One of the things that we're
24 hoping would be small grants that we just received from
25 the American Public Health Association that we will be

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1 able to have some groups get together, and then
2 hopefully provide some mentorship down the pike, so it's
3 a little bit of framework, it's a really small grant,
4 just a couple thousand dollars, but it's starting --
5 hopefully starting a discussion.

6 REPRESENTATIVE WACHTMAN: Lynn Wachtman,
7 State Representative, for my more rural district, I
8 think my largest county is 37,000, smallest 20,000. I
9 guess I really wonder how the smaller counties could get
10 accredited if they stay a small county versus share
11 resources in one way, shape or form, whether it's
12 mergers or whatever you want to call it; where do the
13 rural counties go from here?

14 Are they on their own as far as -- I guess
15 who's going to push to move this whole health care
16 system to be more efficient, productive?

17 One of the things that at least I'm always a
18 big believer, we're never as good as we can be, there's
19 always improvement we can all do.

20 Is there any vision about how we get from
21 here to there; is that the big million dollar question?

22 COMMISSIONER ADAMS: One of the suggestions
23 that was in the report, the full report, was this idea
24 of exploring something that's like a regional council of
25 government to provide a lot of these foundation

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1 capabilities.

2 So that idea has not been fully flushed out,
3 I'm sure that's one of the purposes of this group is to
4 look at how you can have several counties come together,
5 much like the developmental disabilities and mental
6 health people have done, and to provide things, common
7 things like maybe billing, some administrative services,
8 maybe H.R., accreditation services, you know, one person
9 maybe services five or six different departments working
10 towards accreditation and maintains that documentation.

11 So I think that's an interesting part of
12 that report, one that I don't think we've ever
13 considered before from a local standpoint, so I think
14 that bears a lot of development in how that can be
15 provided.

16 Because I think for most of us, if you ask
17 most local health departments they're really committed
18 to trying to provide their local public health services
19 in their local community, but we're trying to figure out
20 how we can support them in some of these other areas,
21 and maybe can we aggregate these services; can we
22 aggregate to larger groups?

23 MR. WERMUTH: So maybe from a different
24 perspective, Representative Wachtman, I think that this
25 group is charged with exactly what you're asking. It's

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1 coming up with recommendations to provide to the
2 legislature as to what policy considerations need to be
3 looked at as we get into the next budget process.

4 So I think that's what this group is
5 supposed to work on, but I would also venture to say, at
6 least once again from my perspective in the years I
7 spent in local public health, it's one thing to look at
8 what the structure -- what the infrastructure of a local
9 public health system needs to look like, in other words,
10 the number of health departments and what those
11 jurisdictions look like.

12 When we start talking about cross county,
13 cross political boundaries, then we get into the
14 discussion, I think, Jim, you briefly talked about is
15 the really tough spot that I've personally witnessed in
16 my career is getting local elected officials to agree
17 on, you know, how that funding mechanism is going to go.

18 So if you take three counties and want to
19 put them together, I mean, you might get the local
20 boards of health to say, yeah, this makes some sense,
21 but trying to get all of those townships, all of those,
22 you know, the county commissioners, and everybody to
23 agree on how that funding happens to make sure that the
24 infrastructure is there is a challenge in itself.

25 And so one of the things that I would hope

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1 this group would also look at is not just what is the
2 system going to look at, but then how can it be funded?

3 Because we can probably come up with some
4 pretty good recommendations going forward on what this
5 system should look like, but it can hit a really big
6 roadblock once we get into, you know, how it gets funded
7 based off of what the current funding mechanisms are.

8 So we might have to be challenging ourselves
9 to kind of look outside the box, and say, how are we
10 going to fund public health in Ohio, if we look at cross
11 jurisdictional health departments?

12 SENATOR WACHTMAN: I'm sorry, I think part
13 of that is rightfully so, elected officials wanting
14 accountability of tax balance. However, a lot of just
15 -- people don't like to change in general, it's very
16 easy to track money now days, do it all over the world
17 very quickly, very efficiently.

18 Well, I'm not sure where it's going there,
19 except for the fact I see more of the people, how do yo
20 feed them?

21 I just relate one example early in my
22 political career, we regionalized the county school --
23 the county school boards, you know, my way, one of the
24 directors became the director, one became the assistant
25 director, one became whatever, you know, it was like no

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1 efficiencies. The workers still only do work in their
2 little world, so there's some good ways not to do it.

3 MR. TREMMEL: Well taken.

4 MS. FOUGHT: Heidi Fought with the Township
5 Association. I actually appreciate what you just said
6 about funding, Steve, because given the fact that
7 townships inside millages get raped, and I'm gonna use
8 that word, get raped for the funding of public health,
9 right or wrong, I mean that's how we fund the system in
10 Ohio, but with given the budget cuts and everything
11 else, it's just one more thing that we have absolutely
12 no control over.

13 I mean it's basically, here you go public
14 health, you know, here's our share, but -- so I
15 appreciate at least having the discussion of how we fund
16 public health.

17 I want to touch on something else in the
18 report, you had mentioned about where you saw efficiency
19 with a hundred thousand people. My question to you is
20 it county -- was it only in a single county or was that
21 cross county lines?

22 Because when you start crossing county
23 lines, and I'm going to use the example that we just
24 talked about with Union, Delaware and Morrow County,
25 examining it in the past, Morrow is so different from

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1 Union and now Delaware.

2 I mean they talked about it a couple of
3 years -- many years ago, and the shift that Delaware had
4 in the last 20 years, there's no way Morrow could have
5 lived in that cross jurisdictional entity, so -- or
6 tried, they would have tried, but they just would have
7 had no voice.

8 So I guess I'm curious as to when you say a
9 hundred thousand people for efficiency, is that in a
10 single county where most people are alike, going back to
11 one of your very first comments about what you guys were
12 looking at or is that across county lines where the --
13 the standard of living might be lower or higher or
14 people expect more or less and how do you --

15 COMMISSIONER ADAMS: Sure.

16 MS. FOUGHT: Sorry.

17 COMMISSIONER ADAMS: No, no, that's fine.
18 I'm not an expert on that part of the report. I do know
19 that it was not specific to local health jurisdictions
20 and it was not specific to Ohio.

21 MS. FOUGHT: Okay.

22 COMMISSIONER ADAMS: But it was more of a
23 national -- it was more of a paper that was done by
24 several -- on a national basis.

25 So when they talk about they had surveyed a

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1 number of agencies that provide local government
2 services, not just public health services, and that's
3 where they talked about where they got these jump in
4 efficiency, because I think that the underlying
5 assumption was that there was sufficient support than
6 when you get a larger jurisdiction to do some of that
7 foundational type work.

8 A smaller jurisdiction is, as I think we're
9 all -- we have many departments that have a dozen people
10 or less in their health department, and so you're busy
11 doing those things you have to do either by state law or
12 about what your community demands that you do,
13 nuisances, food services inspections, things like that,
14 you have no time for anything else.

15 So I think that the underlying report --
16 that hundred thousand issue is one that we're going to
17 have to look at in a lot more detail, because I think it
18 has a lot of information in there that's going to be
19 useful in trying to figure out what a structure is going
20 to look like in the future.

21 I think that it does make assumptions that
22 it goes across county lines. You know there's no reason
23 -- I don't think there's anything in there that says
24 that you cannot aggregate some on this usage across
25 different county lines in order to provide some of these

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1 foundational services.

2 I think that was one of the parts of it in
3 short, and it doesn't necessarily say you have to
4 combine to get to a hundred thousand that we will
5 provide those services. It just suggests the fact that
6 you start seeing these real jumps in efficiencies once
7 you start serving populations of that size or more.

8 And I think the assumption is that resources
9 follow, because of the size.

10 MR. MOODY: I assume everybody's seen or
11 know about the Shared Services Report that the State of
12 Ohio recently put out.

13 You know, I really encourage folks to take a
14 look at that in parallel to this, because I think
15 there's a lot in parallel in how you put this together.

16 I'm actually impressed in terms of how far
17 you were able to go with the report, and I think it's
18 because by offering a framework for thinking things
19 through, but stopping short of saying you should do it
20 exactly this way, really, I think, is a constructive way
21 to think about this.

22 And, you know, the old way of thinking about
23 jurisdiction is that you have to draw a line, and then
24 within that line is the jurisdiction, but it is just not
25 working that way now.

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1 Where in Morrow County you may want to have
2 -- be totally in touch with your local community in
3 terms of that core central responsibility you have, but
4 why not outsource your H.R. to somebody who has the
5 capacity to do it.

6 So I think the inside of separating out
7 those foundational services as something that could be
8 shared is really the right insight in this, and it
9 matches very closely to -- because then you all may
10 become providers of a service for each other.

11 You know, a big county that has a really
12 sophisticated H.R. system, not that hard to add a couple
13 hundred people into your system, you know, so that loses
14 a lot of the distinction of jurisdiction, because the
15 decision is, do you pay for that service or not, but
16 it's out of your resources.

17 The other thing with this I would encourage
18 people to do is the temptation is going to be to go down
19 and try to define, okay, who's going to partner; how
20 many consolidations are we going to have?

21 I would really encourage, for this budget
22 process, to go the other direction. There's some really
23 basic issues here, like we fund things in these tiny
24 little pockets, but then lock up the money and make it
25 very difficult to provide a range of services.

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1 Can we, in this budget, do something to
2 break that up a little bit to create some flexibility in
3 how localities are able to address some of these issues?
4 That's a really big kind of idea, and it's embedded in
5 here, that's the kind of thing I think we need to take
6 on.

7 I think your pyramid where that bottom level
8 is, Improve Socioeconomic Conditions, well, we just
9 freed up \$500 million through Jobs Ohio to try to
10 stimulate job growth in Ohio.

11 I would think of that as a public health
12 initiative, you know. I mean, don't think of it as you
13 have to address all of those socioeconomic issues, think
14 of it as public health can benefit from that kind of
15 activity in other areas, because if you think about it
16 that way then suddenly, you know, \$20 million in the
17 Medicaid program, we should think of that as a resource
18 to achieve public health objectives.

19 You know, you're never going to get \$20
20 million in the public health system, but how can we use
21 leadership to transfer those principles. So, for
22 example, in that clinical world you're getting the
23 reporting back to you to be able to make public health
24 decisions.

25 I mean those are the kinds of things that I

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1 think we're organized to try to take on. The trick is
2 even in here, I could come up with a hundred things to
3 take on, so I think the next part of the process for
4 folks is going to be really zero in on those letters
5 that are really, really strong, that if we can take on
6 two or three or four things in the next budget maybe
7 where there's some common ground, can we really make a
8 step forward.

9 And it can't be a hundred things, it's going
10 to have to be -- we're going to have to pick some
11 things, so anyway, I see some very constructive starting
12 framework with a leverage, some sense of those
13 priorities.

14 I think it's a great opportunity, but, you
15 know, folks are going to be folks, and I think, I mean,
16 frankly our role as an administration is to make people
17 nervous.

18 I think we're going to have to push hard and
19 say inefficiency in the system is not acceptable, and I
20 get the state funding and there are things we can think
21 about trying to do, but there's not going to be a lot
22 more money.

23 So we're going to, in a sense, be the bad
24 guy in terms of having to push folks to really take
25 seriously this idea of what does efficiency mean, but

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1 what our goal in that would be to be as constructive as
2 possible, you know, and to make sure we're not pushing
3 too far to a breaking point, but really kind of
4 encouraging people to maybe go a little further than
5 they thought they could.

6 So, anyway, and I think this group is the
7 natural group to kind of carry on -- carry on that
8 conversation.

9 I don't know if that rings true or not, but
10 I think the timing is perfect that we have this now, and
11 that by November or December we're going to be
12 constructing a budget for the legislature to consider
13 this January or February, it's really good timing.

14 MS. SCOFIELD: Just a couple of things to
15 follow-up on Mr. Moody's comments from the shared
16 services perspective. We're doing a lot across Cuyahoga
17 County through regional collaboration, and really when
18 you add those kind of typical back office functions,
19 H.R., I.T., fiscal, and a couple quick examples, our
20 H.R. department is now working with political
21 subdivisions to provide H.R. specialists services maybe
22 one day a week, I think it's Brooklyn, Brooklyn Heights,
23 maybe who had asked for that service, so it's the first
24 one out of the gate that we're testing.

25 They're giving one of our H.R. staff one day

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1 a week to do all of their H.R. services, that frees up
2 their Law Director who had been doing it to do the
3 things that he needs to do from that perspective.

4 Another example is our new Chief Information
5 Officer is working with municipalities to do their
6 website design and to do some other things, so that's --
7 so we're taking that on, we're hosting it, we're doing
8 all that.

9 So there's real opportunities there to test
10 out some small shared services, capacities, and how does
11 that help, and -- and I think that's good. I think
12 there's some things perhaps that we're learning that can
13 be useful.

14 The other hat that I wear, not only am I the
15 health staffer for the county executive, but I also
16 manage his performance measurement strategy called Count
17 Stat, and the similarities in this conversation to what
18 I've working on there are very similar.

19 So how do we get to performance measurement;
20 how can it improve our public health services?

21 So I work with 20 agencies across the county
22 from the Sheriff's Office, the Medical Examiner and
23 Senior Adult Services and H.R., all of them to say, what
24 do you do; how do we collect that information; how do we
25 use that to make improvements to find efficiencies, to

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1 provide better service?

2 So I think there's probably some real good
3 opportunity through this group to really look at
4 performance measurements as part of how we improve
5 public health. And I worked for the Cleveland
6 Department of Public Health for a number of years, so I
7 come from that background, so I see both sides of this,
8 so --

9 MS. EDWARDS: If I could kind of tag on to
10 that as -- from a small county perspective. We're a
11 little bit over 50,000, we have shared services really
12 with many of the counties around us.

13 Richland County is the next one over,
14 they're the largest county pretty much within our area,
15 so they provide many services that we cannot, and we
16 have probably four counties around Richland County that
17 can do that.

18 One of the things I want to go back to, a
19 comment that you made, Greg, about making people
20 nervous, I don't mind doing that at all, because it does
21 make people accountable.

22 And one of the things that I'm interested in
23 is the governance, let's go to the head, to the
24 pinpoint, the governance of the local county board of
25 health, it -- who are they responsible to?

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1 Because they're not -- they're not voted in
2 like I am, they're not appointed. They're appointed by
3 a number of township trustees, village mayors, large
4 city and one commissioner, but I think to get to the
5 efficiency, to promote that, they need to be
6 accountable, and I -- is this the proper system that we
7 have; is it not? That's a question that I would like to
8 see answered.

9 DR. MCFADDEN: I think that if our civil
10 society was working, functional, functioning well, I
11 think that there is accountability there, and I can only
12 speak for Holmes County.

13 MS. EDWARDS: In theory, I mean, I would
14 agree.

15 DR. MCFADDEN: So in Holmes County, if a
16 member of the community doesn't like what I do, they
17 will go to -- we're pretty intentional on finding folks
18 from different regions of the county, if they're in
19 Berlin, they'll go to Paul and they say, Paul, we have a
20 problem with McFadden, you know, how are we going to
21 make this right? And, you know, Paul will typically
22 call me.

23 Now, if there's a problem with Paul they
24 will technically go to the Berlin Township or the Salt
25 Creek Township trustee or to the county commissioners,

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1 write letters to the editor, et cetera, and, you know,
2 eventually Paul won't be there.

3 Now, it may be five years, you know, our
4 county, because it's a cycle of where they are that they
5 aren't there anymore, but I don't know if that's any
6 different from how an elected official is whether you
7 have a problem two, four, six years in.

8 So if people in the community aren't taking
9 their responsibilities seriously they can raise their
10 voices and do that, I'm not sure it always happens.

11 I've never had anyone in our community come
12 to our meeting and say we have a problem with what
13 you're doing where they -- it was within their right to
14 do so.

15 MS. EDWARDS: I have, I have seen that, and
16 I have seen it stippled by the board. I've seen --
17 well, I'm just going to be quite honest, I've seen the
18 board with their head in the sand, and I don't know that
19 they're necessarily engaged, some boards are as engaged
20 as they should be.

21 I will say that I've seen some township
22 trustees and village mayors that we cannot get to the
23 meetings, you know, it's required by O.R.C. one time a
24 year in March to be at a meeting.

25 In my -- and prior to being a County

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1 Commissioner I was a Mayor, so over my 15 or so years I
2 have never seen everyone in a meeting.

3 MR. MOODY: Or even on a simple question
4 like efficiency, if you're in an area where, you know,
5 the city department is accountable, the city and the
6 county department accountability to the commissioners,
7 and you might have a couple of villages in there, well,
8 then -- as an area for the citizens in that area, how
9 are you accountable for efficiency in that situation?

10 I do think that's kind of a governance
11 question where, you know, who is accountable in a
12 situation where you might have multiple governance
13 jurisdictions, but, you know, your category up there,
14 you've got financing, you've got governance, and I think
15 you've laid out the framework for folks to hang those
16 concerns kind of into this process to pose these
17 questions.

18 COMMISSIONER ADAMS: Just if I could point
19 out some PHABs here, on some of the PHAB standards do
20 relate to governance issues, and they talk about the
21 interaction of the board and the interaction of the
22 board with the community, and so one of accountable
23 factors is that, you know, you really should not have a
24 board that has their head in the sand.

25 You know, they need to be out there and

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1 accountable for the funds that are being spent at
2 district, maybe approve a strategic plan, they need to
3 hold the staff accountable for following that plan,
4 that's all part of the standard care, PHAB standard.

5 So I would suggest that if you have a highly
6 functioning department you also have with that a highly
7 functioning board, you know, two really working
8 hand-in-hand together, Delaware might have that
9 experience, I would think.

10 MR. WERMUTH: This is interesting, I'm
11 trying not to say too much, but after 15 years at the
12 local level it's kind of hard, and what's going on now,
13 the accountability piece, it's interesting, because when
14 you say, you know, we need to have a stronger governance
15 making sure that people are doing the right things, one
16 observation that I made in the years I was at the local
17 level was in the two counties where I was the health
18 commissioner we worked on a levy.

19 Okay. And so I wasn't -- I wouldn't say I
20 was worried, but my major focus was on keeping my
21 customers happy, keeping the residents of Tuscarawas
22 County or Clark County, making sure that we were
23 providing the appropriate services, because I knew if I
24 didn't my next levy wasn't going to get passed.

25 So it was -- it almost -- in some ways I

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1 would equate it to almost a private market, you know,
2 type of structure, which says, you know, if you're not
3 keeping your customers happy you're not going to stay in
4 business too long.

5 So, you know, from our perspective it was
6 every time somebody walked in the front door of the
7 health department, you know, the service that you
8 provide them from the time they walk in until the time
9 they walk out will determine whether or not they go out
10 and tell five of their friends they had a good
11 relationship or a good interaction or if they had a bad
12 one.

13 And we all know the adage, you know, people
14 won't say anything good, but if you go into a bad
15 restaurant or something you'll tell ten of your friends
16 don't ever go there again.

17 I only bring that up, because as we're
18 moving forward is it an issue of, you know, so who's the
19 customer and how are we going to keep -- who are you
20 going to keep happy, more or less, because if it's
21 really about delivering services in a population base,
22 you know, is it making sure that the people that are
23 recipients of those services, whether it be food service
24 inspections, whether it be septic and water, whether it
25 would be immunizations, home visits, those things, are

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1 we keeping those folks happy and delivering those
2 services in such a way that we can be accountable back
3 to them, because from a public health perspective those
4 are the direct recipients of services.

5 So, you know, it gets to be kind of tough,
6 because you are accountable to a Board of Health, and
7 you are -- and the Board of Health is accountable to the
8 District Advisory Council.

9 So that gets -- you know, you have to keep
10 that in mind as well, but ultimately it's about serving
11 the people in your community.

12 REPRESENTATIVE ANTONIO: So it seems to me
13 that the accountability -- I'm interested in the
14 accountability standardization, but I'm also -- which it
15 sounds like what we're talking about, it seems to me
16 that somewhere in all of this incentives have to play a
17 role on why it is, whether it's the accreditation;
18 whether it's merging and figuring out that one size
19 doesn't fit all.

20 Clearly as my colleague has pointed out,
21 different parts of the state, as we all know, it is an
22 incredibly diverse state. So what works in one place
23 may not work in another as far as how the coordination
24 happens or the collaboration happens, but I think there
25 are best practices that will come out of that.

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1 I spent a lot of time as a direct service
2 provider running a drug and alcohol program, and we were
3 very, very small, but we were incentivized to go after
4 accreditation and seek the state standardizations and
5 licensing, because it was attached to some additional
6 funding that was possible.

7 But beyond the funding it was also bringing
8 us into that level and that standard of care that was
9 improved, because as we were then a part of that system
10 we also had access to some professional services,
11 continuing to train our staff, all kinds of other things
12 came to us, because we were now part of this system.

13 The funding was not a guarantee, it could
14 come, it could go, it was something we had to apply for,
15 but being a part of a bigger system was incredibly
16 important to us as a small provider, and so I keep
17 thinking about that.

18 And then ultimately the other thing I
19 thought as I was listening to everyone talk is that
20 there are some real consequences in public health, if
21 the services are not provided well, because -- and I do
22 think it's really important for us to keep that in mind
23 as we're looking at this as well, is efficiencies are
24 important, certainly, but there are some real
25 consequences that impact our communities and our state,

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1 if we don't have a model that works well for the
2 customers, the providing of services.

3 DR. MCFADDEN: One thing that I would like
4 to bring up sort of a triangle here of comments, you
5 know, if we look back to the original formation of
6 health districts, 1918, 1919, they were on the heels of
7 a devastating, you know, nationwide epidemic, and in the
8 State of Ohio they saw that in places where systems
9 worked and communities came together, they had a
10 functioning public health system, people did well, to
11 your point, and in these places where they didn't people
12 did poorly.

13 And so they set up a financial structure
14 that was designed to ensure, you know, we can say it was
15 right or wrong, but to ensure that that system had
16 funding, and even gave the incentive that if there's an
17 epidemic where you don't have enough money to address,
18 you determine what you need, and, you know, you go to
19 the townships through the Budgetary Commission, and you
20 say, we need a million dollars and the townships are
21 shackled, you know, to fund that.

22 So the structure was let's prevent some
23 catastrophic event from ever happening, and, you know,
24 let's have the structure, such that it is,
25 accountability that doesn't change with the weather, but

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1 also gives people an opportunity to come back, and,
2 again, a civil society is working as it should.

3 Now, we can have huge discussions now on
4 whether or not that's functioning, you know, 2012 in
5 Ohio, but I think if we look at why things happen, I
6 think the discussion here is great and I think the task
7 now as we're looking at this, how do we create something
8 that is able to withstand, you know, a 1918 or a 2013
9 obesity epidemic; how do we create funding streams,
10 governance streams; quality assurance streams?

11 I mean the time is right for doing this, and
12 I'm not saying that we don't need to change things, I do
13 think if we look back as to why we can start to
14 understand why things exist the way they are.

15 DR. THRELFALL: Several comments have been
16 brought up, first of all, when addressing our -- the
17 needs of the people we serve, we did a survey prior to
18 running our last levy to find out what our clients
19 thought about us.

20 Most of them had no idea who we are; what we
21 did, nothing, zippo. That was one of the best things we
22 did, because I think philosophically it helped, we were
23 in transition, but it really helped us change our
24 direction, so we started to educate. The staff did a
25 fantastic job, the board members did a great job, we got

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1 the word out, all the things we did, and it was
2 interesting hearing the clientele say we didn't know you
3 did that.

4 A lot of them didn't know we inspected
5 restaurants, sewage systems, nothing, that really helped
6 us.

7 As far as the board members, the thing that
8 I have liked the most, and I have not in real politics,
9 but I've run for offices and I've gotten elected, but
10 something I like about the Board of Health being
11 appointed is basically we're not holding to anybody.

12 I have no political aspirations of
13 attempting to get votes from the people I serve, so I
14 can really make decisions based on what I think is
15 right.

16 And Nancy will be the first to admit that
17 she may not have agreed with me all of the time, and I
18 haven't been right all of the time, but I really did it
19 because that was the reason.

20 It wasn't, because, gee, Joe Blow's got a
21 million dollars, two-million dollars, he'll put some
22 into my political campaign, whatever. There is no
23 perfect way to get a person on a Board of Health. Like
24 anything else, the point is, it's always going to boil
25 down to the person. You have people on the board or

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1 staff or washing cars or whatever they do that could
2 care less, I many times wonder why they do it. I've
3 never figure that out yet, I will probably die before I
4 do.

5 Then you have other people who do it for the
6 right reasons. It's not about fame, it's not about
7 glory, it's certainly not about money, they really want
8 to impact their community, and I think this comes back,
9 again, yes, you can outsource some of your things, you
10 can get people to come in, if it's more efficient
11 monetarily and production-wise I think that's fantastic.
12 There has to be a feeling, I think, of community,
13 especially, when we talk about funding.

14 We've got to have -- because if we would
15 have a dual county health department with Morrow County
16 we would lose southern Delaware County, because they're
17 going to say, why do I want to support financially
18 anything up there? They don't want to support northern
19 Delaware County. I didn't say that.

20 MR. TREMMEL: Strike that.

21 DR, THRELFALL: But seriously, there has to
22 be some community and we have a situation where they're
23 consolidating a school and it's been a horrible
24 situation for those people in that particular part of
25 the county.

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1 They're doing away with their's, they're
2 moving them, transporting them, whatever, it's -- I
3 think many times we really forget, especially in this
4 day and age of computers, cell phones, nobody talks to
5 anybody, that community feeling, whatever it is.

6 And maybe it will be dead in five or ten
7 years since we're now thinking about teaching courses
8 for people on how to verbally communicate; who would
9 have ever thought of that?

10 But I think it's important that when we look
11 at this, and I'm impressed with all of the things that
12 have been brought up. We look at it from the standpoint
13 of idealism, a big touch of realism, and the financing
14 of this, it's going to come from somewhere and that
15 somewhere is everybody that's paying taxes and have a
16 job, whether we call it government or whatever we call
17 it, it's coming from people, it's going to be how we
18 distribute it.

19 And we've been very fortunate in Delaware
20 County, we feel a strong bond with our DAC, they attend
21 our yearly meeting, they ask questions, we tell them how
22 badly they're going to be hit, and they are the greatest
23 group of supportive people we have.

24 County Commissioners, we have formed a bond
25 with those people, again, that bond could break with the

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1 next election, but they understand what we do, who we
2 are, and I think how much we care, and I think that's
3 monumental to getting the point across and getting
4 support.

5 But you have to have the staff, you have to
6 have the board that really buys into this, it's not just
7 something I go to once a month or whatever meeting, and
8 that's it. It's a bigger commitment than that, so it
9 comes back to the person. Sorry.

10 MR. TREMMEL: Thank you.

11 MS. SHAPIRO: I was just going to say that
12 when Steve was commenting on who you serve and keeping
13 your clients happy, it's very different when you're in
14 the clinical arena and you're serving a lot of clinical
15 patients.

16 And, again, those people are coming in, but
17 if we're looking at that bottom of that triangle or
18 pyramid where you're looking at population based
19 services, again, there's a potential there to engage
20 more people, to do things through coalitions, to make
21 some policy and some systems change that will impact
22 more people, and, again, get the word out differently,
23 so I think if we look at that pyramid and where we want
24 to put some more resources might be an issue.

25 MS. EDWARDS: Let me be clear, I don't

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1 necessarily think that someone needs to be elected to
2 this -- to a Board of Health, you know, as their board,
3 I don't necessarily think they need to be appointed.

4 What I think, to get to the crux of
5 everything that the boards are going to have to deal
6 with in the future, I think it's a good idea to look at
7 how they are structured, and how they are going to be
8 able to be flexible enough to move forward to the future
9 in health, but that's why I think it needs to be looked
10 at.

11 We have problems in Ashland County, there's
12 no question in my mind and in a number of individual's
13 minds within Ashland County, but what is the proper way
14 to go forward with a Board of Health, it's in O.R.C. how
15 it's created, this is a prime opportunity to look at how
16 that works. I don't know that there will be another
17 opportunity, so that's why I think it needs to be looked
18 at.

19 MR. TREMMEL: Just for a point of order,
20 maybe in the next seven, eight to nine minutes we'll try
21 to wrap up some conversation, we'll continue with the
22 Agenda, I might ask Joe if there's some purpose to what
23 you have up here.

24 Dr. Threlfall, let me get to your question.

25 DR. THRELFALL: Yeah, I think the board make

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1 up is extremely important, and I think, again, Delaware
2 County by some, I'm sure it was planning, most of it, on
3 our board we have physicians, we have registered nurses,
4 we have soil scientists, they are stuck with one
5 veterinarian.

6 But, you know, when we get together it's
7 amazing, even when we disagree we always are friends at
8 the end of the meeting, and each of us brings our own
9 special expertise to it, because, you know, a
10 veterinarian's education is all about population
11 medicine and clinical medicine, so we understand the
12 outbreaks like crypto and stuff like that, but, yeah, I
13 think that board make up is really good. I don't know
14 as I'd want it mandated.

15 I think local boards should be educated as
16 to who they ought to go out and look at to attract, to
17 come in, but I would hate for somebody to tell us you
18 have to be two MDs, three nurses, a veterinarian.

19 MS. EDWARDS: I totally agree.

20 DR. THRELFALL: But guidance, yeah, I think
21 guidance is great.

22 COMMISSIONER ADAMS: I just feel compelled
23 to follow-up just real briefly, but I often thought of
24 our Board of Health as a little bit like a non-profit
25 board of development, and I think it's leadership in the

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1 department that helps build that board into a body that
2 helps -- it's like a nice relationship together.

3 So I heard you mention the fact that your
4 commissioners kind of tell you things, and you can have
5 disagreements and things, seems like a healthy
6 relationship, because I think they've probably gone
7 through quite a bit of a process in developing that
8 board over time and educating you in your
9 responsibilities, and you take those responsibilities
10 very, very seriously, and the best guy on our board is
11 also a veterinarian.

12 DR. THRELFALL: I didn't say that, and Nancy
13 didn't either.

14 COMMISSIONER ADAMS: I'll say it though,
15 they're all about public health.

16 MR. TREMMEL: Others? I didn't mean to
17 interrupt, to cut off conversation, please take the next
18 couple of minutes.

19 MS. SCOFIELD: Just as a follow-up comment
20 to my own comment that I just remembered, the
21 opportunity to kind of merge what we're doing around
22 public health through our Health Alliance and County
23 Stat is that County Stat goes every Tuesday, Thursday
24 morning with a different agency coming forward to
25 present their data and their progress report.

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1 The Cuyahoga County Board of Health for the
2 first time is joining that presentation schedule, so
3 they -- we've added them, they've agreed to participate
4 and be a part of that strategy as we're trying to kind
5 of, in the spirit of performance measurement, engage
6 different parts of the county government, as you know
7 they're quasi governmental.

8 So they're joining that schedule as is our
9 Alcohol and Drug Abuse and Mental Health Services Board,
10 and our County Planning Commission, so we're folding
11 them in and trying to kind of bridge that process.

12 So just a follow-up to that, is that our
13 Board of Health and getting involved so hopefully we can
14 do that together and look at performance measurements
15 within public health.

16 MR. TREMMEL: Jennifer, would you mind
17 giving us a 60 second overview of just what County Stat
18 kind of looks like so we can get an idea, just is it
19 similar to other things suggested, is it a KOG or not a
20 KOG?

21 MS. SCOFIELD: No, county Stat is the county
22 executives strategy around performance measurements. So
23 how do we look at the data we collect and use it to
24 improve efficiencies and accountability and services.

25 He actually ran the same strategy when he

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1 was mayor of Lakewood, he called it City Stat, it's --

2 MS. ANTONIO: It's a national --

3 MS. SCOFIELD: Yeah, it started in New York
4 City with Com Stat, and then Martin O'Malley and Marilyn
5 did Baltimore City Stat, now he's doing State Stat as
6 governor of Maryland, so it's a performance measurement
7 strategy, there are a number of versions of it.

8 Our's is, you know, kind of specialized to
9 what we're trying to do in Cuyahoga County, but, again,
10 it's a schedule. I have just over 20 participating
11 agencies, we go every Tuesday, Thursday morning for an
12 hour, so it's a quarterly schedule, so the Sheriff's
13 Office, the Medical Examiner, Clerk of Court, Regional
14 Collaboration Development, all of the health and human
15 service agencies, operational ones, so H.R., I.T.,
16 fiscal, public works, all are on that schedule. We've
17 just added the three quasi governmental groups, so it's
18 all about data collection.

19 We're tracking universal measures,
20 especially around absent hours, so sick leave, overtime,
21 that type of -- FMLA, that type of information, but then
22 also measures that are very core to each of those
23 agency's mission.

24 So whether it's looking at the length of
25 time to close out a case on child abuse and neglect from

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1 the time we get the call until the time its closed; it's
2 the number of bridges that we inspect and what their
3 ratings are on an annual basis; the number of toxicology
4 reports that we do through the Medical Examiner; number
5 of autopsies; how quickly are they completed; that type
6 of information.

7 So we're using that as a gauge to how well
8 we're doing, and we also do a lot of benchmarking, so we
9 look to see kind of how we stack up against similar
10 counties providing similar services.

11 MR. TREMMEL: Do you suspect there might be
12 some ability to transfer this to the number of food
13 service inspections or the number of public health
14 visits or home visits?

15 MS. SCOFIELD: Yes.

16 MR. TREMMEL: And so what if I don't meet my
17 benchmark, so what or is there something more about --

18 MS, SCOFIELD: Well, that's what I'm hoping
19 and that's why we've invited the County Board of Health
20 to participate and they're actually doing some similar
21 organizational development performance metrics, tracking
22 of their own, so I'm curious to see that.

23 But I mean there's not like a huge
24 consequence, other than you've got this regular
25 reporting, and if you're not making your goals then you

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1 have to be accountable for that. Why aren't you
2 reaching what you said you're going to be doing?

3 So I would think there'd absolutely be an
4 opportunity to check that same kind of public health
5 performance measurement data and track it regularly.

6 Are we doing what we said we were going to
7 do? How well are we doing it? How do we stack up
8 against our peer counties or cities? What's working;
9 what's not; and what do we need to do to make it better?

10 MR. TREMMEL: Maybe between now and our next
11 meeting if you might provide some information to us here
12 on the e-mail, to myself or Mr. Mazzola, Representative
13 Antonio, that you might have something similar, but
14 we'll create a mechanism to push that to us and we'll
15 try to get out to folks here.

16 MS. SHAPIRO: Just one question, is any of
17 that -- the benchmarks, and I understand counting, is
18 anything linked to outcome?

19 So if we're doing 400 food inspections that
20 we say we are are we seeing a decrease in food borne
21 outbreaks? So is there that tie-in yet or --

22 MS. SCOFIELD: We -- some of the agencies
23 are able to do that right now. We were really -- it was
24 a pretty unique situation that we found ourselves in a
25 year and a half ago with the change in government and

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1 all of that.

2 So the last year or so has really kind of
3 taken all of these 20 plus agencies and kind of trying
4 to get them all together on the same page.

5 There was a continuum of capacity to be able
6 to do this, did they have analysts within their
7 department who could actually collect the information
8 and do analytical work around it.

9 I've got the sheriff talking about smart
10 objectives, I think that's a pretty big accomplishment
11 in a number of different ways. So I have coached this,
12 with my public health background I have coached
13 performance measurement across all these different
14 agencies trying to bridge some of that language. So now
15 we're starting to look at some of those longer term
16 outcomes.

17 And, you know, the Office of Re-Entry has
18 five employees, they're part of it, they're really
19 starting to look at performance base contracting. How
20 are they spending their money with providers across the
21 county through re-entry issues?

22 What does that mean about recidivism? How
23 are we defining that; how does the State define that?
24 So we're getting there; we're getting there. And that's
25 a very definitive goal of what we're trying to get those

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1 to do, so --

2 MR. TREMMEL: Thank you. Other comments,
3 before we turn our attention to another Agenda item?

4 SENATOR WACHTMAN: Just one, I appreciate
5 the measuring, you know, improving outcomes, I mean all
6 of those things are very important, but I would suggest
7 you remember that most, if not all, of these are still
8 monopolies, and, therefore, you really don't know what
9 it's like to have to be the best and the most efficient,
10 because most areas of government don't have the
11 privilege to go out of business.

12 So I would commend all of us here, in fact,
13 we're really talking about how to improve mediocrity,
14 that's not to be offensive to anybody, but it is true,
15 at least I think it's true in life when you don't have
16 the privilege of going out of business, when you have
17 archaic laws governing employment, things like that,
18 which we have in Ohio, you're generally governing for
19 the private sector, the mediocrity, and we need to
20 remember that, because the least that should come out of
21 this is huge improvements in mediocrity.

22 I think that's a reasonable goal when you
23 consider the taxpayers who are always footing the bill
24 at some level for all of these programs there should be
25 no less expectation.

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1 when you do that it will take that jurisdiction and map
2 it out for you, the jurisdiction line itself will come
3 up, so that's one way.

4 You can also select all of the health
5 jurisdictions at one time to get a sense as to how the
6 jurisdictions map out. So you give the server a minute
7 to come up, it will render all the health jurisdictions
8 all at one time.

9 You can, of course, take these pins off
10 here, if you like, and then this kind of gives you a
11 translucent appeal, and you can zoom in and zoom out as
12 well.

13 So it kind of outlines all of the health
14 jurisdictions here, and then one other way is you can
15 look by legislative district.

16 MR. TREMMEL: Let's see Representative
17 Wachtman, so we can see where these areas are.

18 MR. MAZZOLA: Absolutely, and I did that
19 earlier. So Representative Wachtman's district here,
20 we'll zoom out here.

21 REPRESENTATIVE WACHTMAN: Got to get to
22 Indiana.

23 MR. TREMMEL: You're moving.

24 Representative WACHTMAN: There's the state
25 line.

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1 REPRESENTATIVE ANTONIO: Covers a lot of
2 territory.

3 DR. MCFADDEN: Another piece of it, we could
4 be doing, it will look up the PHAB cost.

5 MR. MAZZOLA: We could do that, but there's
6 just several different ways to get a sense as to how the
7 jurisdictions are divided across the state, be it
8 political subdivision or by health jurisdiction itself,
9 and I apologize for the slowness of the server.

10 In fact, our I.T. guys are well aware of
11 this and they're trying really hard to fix that, and you
12 can also search by Senate district and U.S.
13 Congressional district as well, feel free to take a look
14 at that, and let us know.

15 MR. TREMMEL: That's available on the
16 website, Joe has outlined that for all of you for your
17 review. Any other closing comments as we move forward
18 with the Agenda?

19 All right. Thank you for the discussion.
20 My impressions were not to -- were to speak lightly as
21 to the variety of topics that we kind of put out here.
22 My next impression was not to dive too deep today. I
23 just don't know that our appetite is ready for it today,
24 but I'd like us to take back some of this information,
25 and be ready for a little bit deeper dive as we go

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1 forward.

2 As we've indicated previously, we have a
3 number of meetings that will be necessary, the good news
4 is this is time limited. We will need and we will
5 produce a report to the General Assembly, to the
6 administration and the Governor's Office on or about
7 October 31st.

8 There will be some necessary revisiting of
9 these meetings and they could be every other week, could
10 be every third week, but we will need some necessary
11 frequency, and we will get to that when we get to the
12 chair and let the chair and the group decide.

13 I just put that on your radar screen,
14 there's going to be some necessary time to meet, and if
15 for some reason you cannot meet we do have available the
16 live meeting for you, it's just the participatory part,
17 you'd be able to view and visualize and recognize the
18 issues, participatory type of concerns.

19 And Joe will give you the link where you can
20 revisit these meetings going forward. I'm not sure how
21 that was said or how that was interpreted.

22 So next in our -- next on our Agenda is to
23 look at the selection of committee leadership. It's
24 necessary for the committee here to nominate, recommend
25 and vote on a chairperson, a vice-chairperson and

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1 secretary.

2 Now, I know many of you are at this table,
3 because you'd like one or all of those things, so
4 knowing that there's some interest in, and we do need
5 some legitimate interest in leadership, and we do have a
6 number of folks representing just large backgrounds,
7 large jurisdictions on a county basis, local public
8 health.

9 We have folks that represent members of the
10 General Assembly, medium to small size counties; rural
11 county health; folks that are in a very progressive area
12 and have a lot of success in their health district; our
13 township folks and township leadership, county
14 leadership; public health association folks.

15 We even have a colleague of ours here who
16 represents the hospital systems. And this is very
17 important to note, the hospital system role in public
18 health, and I think with Mr. Press you have a background
19 not only in the hospital side, but you have a background
20 in public health as well, which wasn't mentioned in
21 academia; is that right?

22 MR. PRESS: That's right.

23 MR. TREMMEL: Okay. And then we have,
24 again, state representation from the General Assembly,
25 and then you have some administration or light

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1 administration, between Mr. Wermuth and myself from the
2 Department of Health, and Mr. Mazzola.

3 So, having said all of that, if I could just
4 turn to all of you and ask for your consideration at
5 this point who you would feel would be a necessary and
6 appropriate chairperson; who you would feel would be a
7 necessary and appropriate vice-chairperson and
8 secretary.

9 Secretarial skills will really be handled
10 for the most part by Mr. Mazzola and myself. We have
11 good expertise with Teresa who will deliver the
12 documents accordingly for your review, but -- and,
13 again, time limited.

14 So thoughts, and maybe I could turn to,
15 Steve, do yo have any other thoughts beyond some of my
16 comments as we're going forward into our process?

17 MR. WERMUTH: I think that as we're moving
18 forward with selecting the chair and everything look at,
19 you know, some individual that can move this committee
20 forward, maybe have some neutral position, and then
21 understands the health care delivery system, as well as
22 the public health system in Ohio, and so that's what
23 we're going to be looking at as we try to put our
24 reports forward, so let's think about that.

25 MR. TREMMEL: Okay. Great. So thoughts for

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1 members of the team here as far as who we would like to
2 be serving as chair going forward?

3 DR. MCFADDEN: The issues coming out of the
4 legislation for this body, specifically the Senate, and
5 experience within the health care system, I wonder if
6 Senator Burke would be, I haven't -- I haven't talked at
7 all to him, but that for me is a very -- -

8 MS. FOUGHT: Sure, he's not here.

9 REPRESENTATIVE WACHTMAN: And the work
10 always goes to the staff anyway.

11 DR. MCFADDEN: Mostly because with serving
12 the House and the Senate, having begun some of these
13 discussions, that comes to mind, but, again, not having
14 a relationship with Senator Burke, not having the
15 opportunity to talk with him, I'm hesitant to just throw
16 him under the bus, but those are thoughts that I do
17 have.

18 MR. TREMMEL: Well, and before we throw
19 someone under the bus, could you speak lightly to
20 Senator Burke's background or interest, because we'd
21 like to know if he has an interest in this, a legitimate
22 purpose and interest, because we really have a
23 legitimate purpose in moving this forward.

24 MS. ENGLISH: Oh, absolutely, and, you know,
25 I hope I can speak lightly for Senator Burke with him

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1 not being here, and, again, he apologizes he could not
2 make it to the meeting today, but looks forward to
3 working with everybody on this very important issue.

4 He and I did discuss this legislative
5 committee and in speaking with him I know that he does
6 have an interest in the outcome of this meeting, and I
7 do know that he has an interest in taking on a
8 leadership role.

9 I don't want to speak for him and go ahead
10 and commit to anything, but can say that he does have a
11 legitimate interest in moving forward on that, so if
12 that helps, can certainly get back with everyone. I
13 don't know how you want to proceed.

14 MR. TREMMEL: Well, with that comment let's
15 take some other comments and thoughts. So we have
16 opportunity for possibly Senator Burke, other
17 recommendations, other thoughts?

18 I know, Mr. Press, you have a background and
19 maybe if you could share with us, and would you have an
20 interest in serving as chair, and I know you have a
21 background, and then maybe we'll pose some other
22 questions.

23 MR. PRESS: Back to the benefit of the
24 group, the background is native Ohioan, spent about 20
25 years in Atlanta in a little bit different situation,

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1 operating hospitals down there, but during that time had
2 the privilege to serve on the faculty of the public
3 health school at Emory University for about ten years,
4 and, you know, the hospital association's interest in
5 this matter is probably partly the overlap of
6 responsibilities, that I've heard it well said today by
7 a number of folks, that there are intersecting interests
8 of different parties in this, whether that's public
9 health or that's clinical delivery of care at primary
10 care levels through immunization, medical homes or
11 visiting nurses.

12 But our own experience is that in Findley we
13 operate a very large 40,000 visit a year alcohol or
14 public health clinic, even though that's not what it is,
15 that's how it functionally operates, we support that,
16 and we're happy to do it.

17 We also play a key role in some of the
18 disaster activities that have taken place the last few
19 years, and, of course, we have two health departments,
20 so we kind of -- this isn't for the record, well, could
21 be, I've said it on the record, anyway, we kind of feel
22 like we have three health departments in town and it's
23 just -- it's probably just not prudent and it's not
24 sustainable going forward.

25 There just aren't the resources in the

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1 future to do what we're doing today, and giving people
2 the flexibility to make local choices about where they
3 want their redundancies or don't want their
4 redundancies, or where they want capabilities more
5 emphasized or less emphasized, the theme I felt was
6 brought out expertly in this report.

7 I commend the folks who actually came up
8 with the -- was it 17, 18 specific recommendations,
9 which is hard to do, you know, 19 specific
10 recommendations.

11 So I'm honored to be here and happy to help
12 in anyway I can, if that's a leadership role that would
13 be terrific, if that's --

14 MR. TREMMEL: Other thoughts and
15 recommendations for a chairperson for the group moving
16 forward?

17 We have a couple of candidates, and I'm sure
18 there won't be hard feelings either way, we're all big
19 kids here. We have a recommendation for Senator Burke,
20 and you have reason to believe, again, he would be
21 interested?

22 MS. ENGLISH: Yes.

23 MR. TREMMEL: So maybe with that being the
24 first recommendation is there a show of hands for
25 Senator Burke for the recommendation, and we will have a

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1 show of hands if it's okay for Mr. Press. Show of hands
2 for Senator --

3 SENATOR WACHTMAN: -- Or could one, you
4 know, is there a better way? Do we need to vote on this
5 or just ask one if they want to be chairman and the
6 other vice-chair or co-chair?

7 MR. TREMMEL: And my guess is either would
8 be willing to serve in the role.

9 COMMISSIONER ADAMS: I'd like to say just
10 for point of clarity, in the legislation it says that
11 we're supposed to appoint -- at that first meeting
12 they're supposed to select a chairperson and
13 vice-chairperson.

14 MR. TREMMEL: And would there be any
15 thoughts from Senator Burke to serve in either capacity?

16 MS. ENGLISH: I know, and, I, again,
17 speaking lightly for Senator Burke, because I don't want
18 to put words in his mouth, but I do know that he would
19 have an extreme keen interest in serving as chairman of
20 this committee.

21 MR. TREMMEL: Any interest in you serving as
22 chairman or vice-chairman?

23 MR. PRESS: Yeah, if he has a keen interest
24 I'd be happy to help in anyway I can.

25 MR. TREMMEL: Okay. Does that satisfy maybe

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1 where we're going, Representative, and for other
2 members, kind of hearing, if I'm getting the vibe right,
3 we have a chairman and a vice-chairman in a role; does
4 that sound fair and accurate? Any objection to that?

5 MS. EDWARDS: I go back to a comment that
6 you made about maybe a mutual, since this report is
7 going to the legislature I feel a little more
8 comfortable about having a non-legislature individual as
9 a chair, just my personal thoughts.

10 MR. TREMMEL: Okay. Feelings that way?
11 Take this in another direction, we have a chair in Mr.
12 Press.

13 MR. PRESS: Well, I'm a rookie here, but I
14 guess I would ask the elected folks, does it help to
15 have a legislator, I mean, eventually that's where this
16 work product goes, so I guess I'm just trying to
17 understand. I'm happy to do it either way, but I'm
18 trying to understand.

19 MS. EDWARDS: I would -- for me, I would
20 feel -- I want this committee to be driven by the state,
21 not the legislature, even though it's going there, we
22 understand that, but I think it's important to have the
23 drive from the committee, the emphasis from the
24 committee and not the legislature.

25 MS. FOUGHT: And I would say that given the

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1 fact that the majority of people that make up the
2 committee are not legislators, I think it will be
3 driven, and that's just my opinion. I think looking
4 around the table I just think that it wouldn't really
5 factor in.

6 MR. TREMMEL: Okay. Other thoughts?

7 REPRESENTATIVE WACHTMAN: I think there's a
8 lot more positive to having a chairman, frankly, you're
9 probably going to give a lot of these issues leadership
10 if a Senator were to be chair or vice-chair, if he wants
11 to be chair, I see a lot more positives. I don't see
12 this as a conflict of interest with him.

13 MR. TREMMEL: Okay.

14 REPRESENTATIVE WACHTMAN: As Heidi said, I
15 think the make up of this council is such that a lot of
16 the important players have all the appropriate input
17 they need to really go here.

18 MR. TREMMEL: Okay. Comments continue,
19 Commissioner?

20 COMMISSIONER ADAMS: If I might, first of
21 all I appreciate your comment in this. I think this
22 room has a good feel to it, it looks like you folks are
23 really willing to share.

24 I think the chairman's responsibility is to
25 be able to really kind of manage that conversation so

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1 that everybody's points get heard. I would think that
2 the Senator has some skill in that, being, you know,
3 skilled in legislature as far as at least managing
4 conversations, other people probably have different
5 opinions, which is why we have -- but I think it would
6 be -- I agree with the Representative that I think it
7 would serve us well if we had somebody that was part of
8 the legislature picked as a chairman, I don't think that
9 would be a real problem.

10 I do agree with you that there is that risk
11 of it being driven, and that we are not able to fully
12 express ourselves in the committee process. However, it
13 seems like we have some pretty good personalities here
14 that are able to express themselves, they're not
15 particularly quiet, so current example is noted too.

16 MR. TREMMEL: I think the chemistry as a
17 group is good. I think we're going to continue to agree
18 and disagree about some things between now and the end
19 of October, but I really like the chemistry of where
20 we're going.

21 REPRESENTATIVE ANTONIO: Thank you. So I
22 appreciate, Jim, your comments and concerns. Having
23 served with Senator Burke before he was a Senator I know
24 him also to be a very good listener and very balanced.

25 We worked on a number of issues on the House

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1 Committee, and so knowing that it's Senator Burke that
2 we're all talking about as the chair I have confidence
3 in him running a fair and balanced committee, and so I'm
4 very supportive of him, but I also understand and
5 appreciate your concerns.

6 MS. EDWARDS: I don't know him.

7 REPRESENTATIVE WACHTMAN: Not all
8 representatives get ruined when they go to the Senate.

9 REPRESENTATIVE ANTONIO: Or they come back.

10 MR. TREMMEL: Other comments?

11 DR. MCFADDEN: I guess I just want to -- to
12 your point, I totally understand where you're coming
13 from and my thoughts are more coming from the standpoint
14 of -- as a local public health person who was -- we were
15 walking down this path, so this group sort of, to me,
16 came out of -- somewhat out of the blue.

17 It's not that it couldn't be expected, but I
18 guess I was hoping to, you know, for those that were led
19 to this formation, I was hoping to at least have some
20 that understood better than maybe what I do now or did,
21 why we're here.

22 There are great opportunities in the need to
23 have this discussion, but I think that I was hoping to
24 have leadership that could, you know, frame it.

25 MS. EDWARDS: Do something with it?

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1 DR. MCFADDEN: Right.

2 MR. TREMMEL: Okay. So let me, kind of as
3 we're closing here for the question, Mr. Press, it would
4 appear that the committee has a lot of faith and a lot
5 of interest in you serving in that vice-chair role; is
6 that comfortable or uncomfortable? Would you feel more
7 inclined to want to be serving in the chair role?

8 MR. PRESS: I can do it, I think the group
9 senses they feel like they have a good choice for the
10 chairman.

11 MR. TREMMEL: I think the group finds good
12 leadership and good effect and looks forward to your
13 direction in the vice-chair role, if you're so inclined.

14 Okay. If you'll so communicate this to the
15 good Senator at your earliest convenience we will
16 convene the meeting. We also have the need to find
17 ourselves for purposes of a secretary.

18 Mr. Mazzola, I'm not certain exactly what
19 those secretarial duties might be, but I think you and I
20 will be putting most of this together.

21 We'll be using the necessary efforts from
22 Teresa, we'll run these through the secretary, and then
23 we'll just use our ODH e-mail system to communicate to
24 all of you, maybe a little more perfunctory than some of
25 these kinds of things can be, am I wrong about that

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1 assessment; do you think?

2 MR. MAZZOLA: No, I think that's exactly
3 right.

4 MR. TREMMEL: Interest in a secretary to
5 serve in such a role, anyone so inclined?

6 COMMISSIONER ADAMS: I would suggest, I'm
7 not sure, if I can vote or not, I would suggest that
8 maybe you be designated as secretary, and then hand it
9 off to your staff to do that.

10 MR. TREMMEL: I don't mind doing that, I
11 just don't want to be, and I'm very sensitive to what
12 Commissioner Edwards said, I wouldn't want the
13 Department to be seen, you know, taking this in a
14 certain direction back and forth, so if there's any
15 hesitance, any resistance you're not going to hurt my
16 feelings.

17 I think that the Department has yet to --
18 the Department will have a person represented, it may be
19 me or it may not be me, but the Department will have
20 someone from the administration represented on the
21 matter, but, again, if you're so inclined to select
22 another secretary I'm sure the Director and Mr. Wermuth
23 are fine with that.

24 Okay. Well, if we could have the record
25 reflect that, Teresa, accurately in all of the action

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1 forward here.

2 We will need to establish some future
3 meeting dates, we will establish a communication median,
4 and let's talk about meeting dates.

5 Is it -- so let me go with the kind of full
6 court press here, is it too inconvenient to do every
7 other week from here for a short period of time to see
8 what traction we get?

9 And currently we are on, what is today, a
10 Tuesday, 9:30, is it too inconvenient to do Tuesdays at
11 9:30? So not the following, but the following after
12 that, and we'll just schedule accordingly, we'll cancel
13 meetings if we need to or is that too aggressive a
14 timeline?

15 And, again, I can appreciate some of you
16 need to be home, but we will give you a venue.

17 COMMISSIONER ADAMS: We will need to check
18 with Senator Burke as well on his schedule; is there any
19 chance that Wednesday works?

20 MR. TREMMEL: It can, except that Mr.
21 Mazzola and I do a weekly Wednesday call for every local
22 health department at 11:00, so that does -- my guess is
23 that the meeting from 9:30 will butt up to that 11:00.

24 MR. PRESS: We could after.

25 MR. TREMMEL: Right. And we could, we could

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1 go after, we could do noon, 12:30 on Wednesdays.
2 Senator have a schedule day better than another?

3 MS. ENGLISH: Not to cause any
4 inconvenience, because obviously we will be flexible, I
5 do know that as of right now the Senator has been coming
6 in on Tuesdays, that's the day of the week he comes into
7 the office and we look to get things done.

8 However, if it's more -- if it's easier for
9 everyone to do Wednesdays we'll be more than flexible to
10 do that, however, just so everyone knows Tuesday is his
11 day in Columbus.

12 MR. PRESS: If we can even just have a
13 little flexibility for Tuesday afternoons, we have all
14 our executive council meetings on Tuesday mornings, so
15 I'm truant today.

16 REPRESENTATIVE ANTONIO: For me it just
17 depends on how late you push it, because I'm coming from
18 Cleveland.

19 MR. TREMMEL: Because that was a question I
20 was going to ask of the folks that are traveling, is it
21 easier to come in first thing in the morning?

22 I mean a 9:30 start means, for some of you
23 folks, you're on the road at 6:00 or something like
24 that, if you have a 1:00 start then you're leaving at
25 10:00 or 11:00, so I'm just trying to be mindful of

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1 those.

2 For those of us who are selfish, who don't
3 have to drive, can start any time we want, so I'm just
4 trying to --

5 MS. SCOFIELD: The Tuesday mornings, the
6 County Stat we go every Tuesday, Thursday morning from
7 9:30 to 10:30, so it would be an ongoing struggle for me
8 to participate at all on a Tuesday morning, if it's not
9 till a little bit later.

10 MR. WERMUTH: So from like 12:00 till 3:00.

11 COMMISSIONER ADAMS: What happens with
12 Monday? Just to throw something else out.

13 MR. TREMMEL: We could do Monday, generally
14 in the morning you have an executive meeting every
15 Monday, it's not good for us. Representative Wachtman,
16 Tuesday morning or Tuesday afternoon, is that an option
17 for you or is there a better day?

18 REPRESENTATIVE WACHTMAN: This is a priority
19 for me, so either one is fine, but the afternoon is
20 probably slightly better.

21 MR. TREMMEL: So I'm hearing more afternoon,
22 are you okay 1:00 to 3:00, or you want to go to 12:30,
23 maybe just catch lunch on the road, you want to start at
24 12:30 or 1:00?

25 Okay. So, Mr. Mazzola, if you'll schedule

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1 us at 1:00 every other Tuesday going forward.

2 MS. SHAPIRO: So the next one starts on the
3 24th?

4 MR. TREMMEL: Yes, so the 17th, 24th. Yes,
5 24th, 1:00 p.m., we're going to schedule these out that
6 way every other Tuesday, just kind of pencil in your
7 schedules lightly. Mr. Mazzola will get the list out.
8 Heidi, do you have a question?

9 MS. FOUGHT: I just want to say right now,
10 we hold regional meetings in the whole last part of
11 July, so just know the next meeting I won't be here, I
12 would love to, but that Tuesday we're out of town.

13 MS. EDWARDS: I won't be here either.

14 MS. SCOFIELD: Sorry.

15 MR. TREMMEL: Is it just that Tuesday?

16 MS. SCOFIELD: I'm on vacation that week.
17 Tuesday's at 1:00 would be fine.

18 MS. FOUGHT: And I'm good every other
19 Tuesday, every other Tuesday, but that 24th, I'm good.

20 DR. MCFADDEN: My only conflict, the second
21 and fourth Tuesday are much better than the first and
22 third, I can move everyone, if you really want to keep
23 it to every other week.

24 MR. TREMMEL: Anyone else have a conflict on
25 2/4 versus 1/3?

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1 MS. FOUGHT: That same 31st I will be in the
2 boat -- in the same boat as the 31st, if the 31st is a
3 Tuesday I'll be in the same boat only because of my
4 meeting, but other than that I'm good.

5 MR. TREMMEL: Will you be back by the 31st?
6 Do you all want to move to next week for our first one,
7 or you want to push back to the 31st, if we go to this
8 2/4?

9 MS. EDWARDS: I won't be able to do next
10 week, we can schedule however.

11 MR. TREMMEL: So we okay with the 31st?
12 Now, we're going to lose a little bit of traction here
13 folks, so you're going to need to stick with the
14 homework.

15 MS. FOUGHT: So the 31st, and then the 14th?

16 MR. TREMMEL: Yeah, I think that most folks
17 have the 24th as well, but we're trying to be
18 deferential to you, because we either put a gap or we
19 meet back to back. So if we go to 31, we'll just keep
20 the continuity of every other. So I think Steve
21 recommended we go 24, and then we maybe go 31, and then
22 go every other after that.

23 MS. FOUGHT: There will be three of us not
24 here on the 24th.

25 MR. TREMMEL: Okay. So back to schedules,

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1 24, 31, and then we will go every other after that.

2 MS. FOUGHT: So the 24th and 31st will be
3 the meeting?

4 MR. TREMMEL: Yes, 24 and 31. We have a
5 more complete report that Commissioner Adams is
6 providing or will be providing for us electronically,
7 Mr. Mazzola will getting to you the --

8 COMMISSIONER ADAMS: Should be able to get
9 it up at anytime today.

10 MR. MAZZOLA: It will be ready by the end of
11 the day.

12 MR. TREMMEL: Can you show folks how they
13 would access that full report, so when they get the
14 e-mail they'll know this is -- so go to the ODH home
15 page.

16 MR. MAZZOLA: So under the ODH home page,
17 click on Local Health Departments, you'll see a link on
18 the left-hand side where it says Legislative Community
19 and Public Health Futures, this is the page you're
20 seeing now with links to the legislation and some of our
21 member organizations.

22 We'll have our meeting minutes; we'll have
23 the reports here linked in; future meeting dates; so all
24 the public information will be here on the website.

25 As Mr. Tremmel mentioned we can do e-mail

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1 communication as well, but some of the more public
2 documents will be here on this website.

3 MR. TREMMEL: Great. Folks, please
4 familiarize yourself with that website and that area, so
5 that you'll be able to pull your information quickly, so
6 that you -- we wouldn't want you to spend the next two
7 weeks waiting for something when we're posting it up.

8 We may follow-up with e-mail to you
9 reminding you, but we'll post everything up. Mr. Press?

10 MR. PRESS: In the homework department could
11 we, for those of us who aren't familiar with some of
12 these documents that were referenced today, I think Mr.
13 Moody referenced a state shared service report?

14 MR. TREMMEL: We have that document, we'll
15 post it up.

16 MR. PRESS: And then if there's an expert in
17 the group or a resource to help us understand some of
18 the elementary requirements associated with
19 accreditation, because I think I heard a pretty long
20 discussion about that, some of us have no idea what that
21 implies, so if there's kind of a checklist around.

22 COMMISSIONER ADAMS: Actually they have a
23 very -- the PHAB Board, it's called, P-H-A-B, Board,
24 they have a pretty nice website that has resources
25 there.

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1 MR. TREMMEL: We'll put together --

2 MR. PRESS: And then if there's somebody
3 here at one of our meetings can take us through in a
4 definitive period of time what the highlights are, and
5 if that's something that's not a good use of everybody's
6 time we can do that in a subcommittee before the
7 meeting, and I hate to be sensitive, but there might be
8 some people in here that don't want to be here all the
9 time.

10 MR. TREMMEL: I think there's an audience
11 here that could use a light overview, not two meetings
12 full, but a light overview.

13 MR. MAZZOLA: We also have on our website a
14 link for the relevant laws related to local health
15 departments.

16 So on that same home page if you click on
17 Laws, Rules and Policies, you'll see at the top here
18 references to Administrative and Revised Codes relating
19 to local health departments, which you can take a look
20 at if you have questions.

21 MR. TREMMEL: Excellent. Joe, I really
22 appreciate your thorough review and just using this
23 resource here for folks to kind of guide and drive them
24 to this information.

25 MS. SHAPIRO: We can just do a search on the

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1 website to find --

2 COMMISSIONER ADAMS: If I could, Marty, just
3 for one second, you know, I know I wasn't able to get
4 into a lot of the meat of the report, but HPIO has done
5 actually a very nice job in providing a lot of resources
6 on overlapping rules, requirements, regulations, things
7 like that.

8 They've done a very nice scan of laws and
9 things that are very detailed in there, so it will take
10 a few reads, I think, to kind of pick out the
11 information that you think is most important in this
12 report.

13 REPRESENTATIVE ANTONIO: And just to
14 clarify, the meetings will be all in the same room?

15 MR. TREMMEL: Yes, our apologizes, we will
16 amend the directions, our apologies, again, folks, but
17 we will continue to meet here.

18 Please use the 35 building, please do not
19 use 246, 246 will put you in an elevator and unless
20 there's a department employee you won't have access out
21 of the elevator, because you need a badge for purposes
22 of security.

23 So please use the 35 entrance, take that
24 down to the basement area, get off, turn right at the
25 cafe, turn left or right into here, and we'll continue

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1 to meet right here, there will be a forum very similar
2 to this one.

3 Closing, other things that I'm forgetting or
4 other things I need to review with everyone?

5 REPRESENTATIVE ANTONIO: Do you validate
6 parking?

7 MR. TREMMEL: Talk to Steve about that.

8 Thank you so much for attending. I
9 apologize if we've taken more of your time, this is
10 going to be a great group.

11 (Thereupon the hearing was concluded at
12 12:28 p.m.)

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CERTIFICATE

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I, Teresa L. Mantz, Certified Professional Reporter, and Notary Public in and for the State of Ohio, do certify that the foregoing is a true and correct transcript of the proceedings taken by me in this matter on Tuesday, July 10, 2012, and carefully compared with my original stenographic notes.

That I am not an attorney for or relative of either party and have no interest whatsoever in the outcome of this litigation.

IN WITNESS WHEREOF, I have hereunto set my hand and official seal of office at Columbus, Ohio, this 18th day of July, 2012.

Teresa L. Mantz
Notary Public in and for
the State of Ohio
My commission expires 12/22/2014

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