

11 * Vice-Chair
 * Secretary

12 Review of Future Meeting Dates, Communication
 and other Considerations

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MR. TREMMEL:

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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.

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.

10

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.

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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.

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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.

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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 Commissioners.

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.

19

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.

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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.

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

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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.

25 The road to consensus was a bit rocky and

24

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.

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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.

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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.

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3 74 percent of Ohio's counties have
4 one health district in the county.

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.

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, 30

25 So 90 percent of local health districts 31

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.

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. 32

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.

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. 33

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.

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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.

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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.

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12 So we interviewed about 25 stakeholders,
13 some of those interviewees are in this room,

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.

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.

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.

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14 We envision a network of local health
15 departments that are rooted in strong engagement with
16 local communities; are supported by adequate resources
17 and capabilities that align with the community need and
18 with public health science and deliver high quality
19 services; demonstrate accountability and outcomes in
20 maximized efficiency, and look at those services; so
21 that's kind of where we would like to go.

25 We had recommendations really along four
1 different lines. Along the lines of local health 46
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.

25 We have a challenge in trying to rebalance
1 our provision of clinical services within the role of 47
2 the new health care landscape.

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.

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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.

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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 -- identify whether we're in
9 compliance with those standards or not.

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.

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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.

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.

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.

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
1 capabilities. 69

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.

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

1 coming up with recommendations to provide to the 70
2 legislature as to what policy considerations need to be
3 looked at as we get into the next budget process.

4 MS. FOUGHT:

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.

22 COMMISSIONER ADAMS:

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.

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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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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?

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.

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

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.

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

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.

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 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
81
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.

9 MS. EDWARDS: We're a
11 little bit over 50,000, we have shared services really
12 with many of the counties around us.

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.

15 DR. MCFADDEN:

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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.

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.

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3 MR. MOODY: Or even on a simple question
4 like efficiency..
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..

25 You know, they need to be out there and

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..

10 MR. WERMUTH:

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..

2 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..
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.

12 REPRESENTATIVE ANTONIO: So it seems to me
13 that the accountability -- I'm interested in the
14 accountability standardization..

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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3 but we were incentivized to go after

4 accreditation and seek the state standardizations..

7 But beyond the funding it was also bringing
8 us into that level and that standard of care that was
9 improved..

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:

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6 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?

15 DR. THRELFALL:

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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...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 92
10 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. 93
13 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. 94

5 But you have to have the staff, you have to
6 have the board that really buys into this...

11 MS. SHAPIRO:

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 95
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..
6 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...

13 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.

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

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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.

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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

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1 The Cuyahoga County Board of Health for the
2 first time is joining that presentation schedule...
5 in the spirit of performance measurement, engage
6 different parts of the county government

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.

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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.

7 So we're using that as a gauge to how well
8 we're doing.. 100

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. 101

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. 103

4 REPRESENTATIVE 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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7 MR. MAZZOLA: Just to...
10 highlight that we do have this on our website where
11 folks can search their local health department
12 jurisdiction in a couple of different ways.

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15 MR. TREMMEL:
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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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.

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

1 secretary.

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109

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.

110

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 --

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.

24 MS. ENGLISH: Oh, absolutely, and, you know,
25 I hope I can speak lightly for Senator Burke with him
111

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.

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:
112

7 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.

25 There just aren't the resources in the

113

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.

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 --

114

8 be willing to serve in the role.

119

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.

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...

120

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.

121

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.

123

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?

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

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.

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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 --

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 127
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.

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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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.

13 REPRESENTATIVE ANTONIO: And just to 129
14 clarify, the meetings will be all in the same room?

15 MR. TREMMEL:

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

7 MR. TREMMEL: Talk to Steve about that. 130

8 Thank you so much for attending.

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