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BEFORE THE OHIO DEPARTMENT OF HEALTH

- - -

Legislative Committee :
of Public Health Futures :
August 14, 2012 :

- - -

Ohio Department of Health
35 East Chestnut Street
Basement Training Room A
Columbus, Ohio 43215
August 14, 2012
1:13 p.m.

- - -

Deposition Specialists, Inc.
Professional Court Reporters
35 East Gay Street, Suite 300
Columbus, Ohio 43215
(614) 221-4034

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1 APPEARANCES

2 - - -

3 MEMBERS PRESENT:

4 Senator David Burke, Chairman
5 Christopher E. Press, Vice-Chairman
6 Martin Tremmel, Secretary
7 Kim Edwards
8 Heidi Fought
9 Luke Jacobs
10 Tim Ingram
11 Gene Nixon
12 Dr. D. J. McFadden
13 Jennifer Scofield
14 Nancy Shapiro

10

Also Present:

11

12 Joe Mazzola
13 Ken Plunkett, ODH OMIS
14 Aaron Ockerman
15 Terrence Allen
16 Duane Stansbury
17 Beth Bickford
18 W. Zackary Holzapfel
19 Lindsay English
20 Adrianna Pust
21 Jason Orcena
22 Kate Philips
23 Jessica Crews
24 Laura Abu-Absi

18

Present via audio link:

19

20 Jim Adams
21 Kim Cupp
22 Kristen Hildreth
23 Bridgett Harrison
24 Representative Nickie Antonio, Commission Member
25 Dr. Michael Thomas

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AGENDA

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- 1) Welcome
 - * Chair, Senator David Burke
 - * Vice-Chair, Christopher E. Press
- 2) Approval of July 24 and 31 Meeting Summary Notes
- 3) Survey of Committee
- 4) Presentation: Gene Nixon, Health Commissioner
Summit County Public Health
- 5) Discussion and Review of Recommendations
 - * Local Public Health Capacity, Services and Quality
 - * Jurisdictional Structure
- 6) Next Meeting August 28, 2012

- - -

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1 DR. MCFADDEN: I have a correction.

2 CHAIRMAN BURKE: Corrections.

3 DR. MCFADDEN: Section 100, Lines 24 and 25,
4 only because it's a clarification, it was OVAT, it
5 should be Ohio Voluntary Accreditation Board, and I
6 think because I mumbled it, it became Voluntary
7 Relations Fund, so that should be Ohio Voluntary
8 Accreditation Board, Lines 24 and 25, Section 100.

9 CHAIRMAN BURKE: You heard the corrections,
10 everybody understands what Dr. McFadden has pointed out
11 for the correction?

12 MR. TREMMEL: Yes.

13 CHAIRMAN BURKE: Any additional corrections?

14 COMMISSIONER SHAPIRO: I found some things
15 that I'm not sure whether they're corrections or not,
16 whether they're -- and I didn't get a chance to look at
17 the Summary versus the whole text, so if we can maybe
18 possibly approve them with -- as we have a better chance
19 to digest everything to make corrections to the record
20 in the future, I don't know if that's a possibility or
21 not.

22 CHAIRMAN BURKE: Well, once we approve the
23 Minutes, then the Minutes would stand as approved.

24 COMMISSIONER SHAPIRO: Yeah, I mean for --
25 it's Section 23 Line -- in the Summary, Line 16,

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1 multiple health departments spent about, it says, 521
2 per capita, and I think it's \$5.21 per capita, it looks
3 like it's \$521 per capita, so those are things I don't
4 know if they're correct or not.

5 MR. TREMMEL: You're on July 24?

6 COMMISSIONER SHAPIRO: Yes.

7 MR. TREMMEL: And you are on?

8 COMMISSIONER SHAPIRO: Section 00022.

9 MR. TREMMEL: 00022, Line?

10 COMMISSIONER SHAPIRO: Line -- I'm sorry,
11 it's 23, 23, Line 16.

12 MR. TREMMEL: Multiple health departments
13 spend about 521. Okay. So is it \$5.21?

14 COMMISSIONER SHAPIRO: I think so, that's
15 what I was thinking, but I wasn't sure.

16 MR. TREMMEL: And I would think, and so that
17 you know, the transcriber is going to type what the
18 transcriber hears, so we just need to be clearer. So,
19 yeah, we can make that adjustment.

20 COMMISSIONER SHAPIRO: Okay. And then one
21 other change, it's Section 00025, Line 11, it says,
22 increase local health findings, I don't know if that's
23 findings or funding, because it's referring to funding,
24 but I'm not sure.

25 MR. TREMMEL: I'm not sure there is funding,

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1 because it's talking about rates of preventable disease,
2 this was a quote coming from -- might just leave that
3 stand, because I don't know that it speaks to funding.

4 COMMISSIONER SHAPIRO: Okay. That's fine.

5 MR. TREMMEL: I'm sure that what the
6 reporter had was accurate.

7 CHAIRMAN BURKE: Any additional changes,
8 additions or deletions to the July 24th Minutes?

9 I guess without objection then the Minutes
10 will stand as approved.

11 On the July 31st meeting Minutes, any
12 changes, additions or deletions from those Minutes?

13 Without objection those Minutes will stand
14 as approved.

15 In the future I'll request that the Minutes
16 and the Agenda items and ancillary type material, if at
17 all possible can be posted 24 hours in advance to try to
18 give people time to digest this.

19 I know this has been kind of a learning
20 curve, but as we start to get into a little more of the
21 meat and potatoes, I think if we can give folks at least
22 24 hours to have that material in hand would be
23 beneficial to everybody, so set that as a bar, and if we
24 need to adjust it we can try to go from there, but we
25 will start with that.

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1 We have some folks on the phone with us as
2 well, if there's anybody that would like to state their
3 name and/or make a comment feel free. I know that your
4 names are on the screen, but just to open it up to you
5 all, is there anybody with any opening comments on the
6 phone?

7 REPRESENTATIVE ANTONIO: This is Rep.
8 Antonio, can you hear me?

9 CHAIRMAN BURKE: Yes, can you hear us? Can
10 you hear us?

11 REPRESENTATIVE ANTONIO: Yes, I can, loud
12 and clear. I'm so sorry I was not able to join you, but
13 I'm happy to be there at least live and in person
14 auditorily.

15 CHAIRMAN BURKE: Very good, thank you for
16 joining us, Representative, we appreciate your time.

17 REPRESENTATIVE ANTONIO: Thank you.

18 MR. THOMAS: This is Dr. Mike Thomas from
19 the University of Cincinnati, sorry I couldn't be there
20 as well, but I can see you guys, and everyone looks very
21 nice.

22 CHAIRMAN BURKE: Thank you, doctor.

23 MS. HARRISON: My name is Bridgett Harrison,
24 and I am the House Republican Healthy Staffer for the
25 Health and Aging Committee, and I'm looking forward to

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1 learning more.

2 CHAIRMAN BURKE: Excellent, well, thank you
3 for joining us.

4 And getting no more comments, we'll continue
5 on to the Agenda items. Next on the Agenda is a Survey
6 of the Committee, this is something that we have in hard
7 form for folks, as well as will be available
8 electronically for you.

9 What this is is basically a breakdown of the
10 recommendations that have been presented to the
11 committee to digest, and allows folks the ability to
12 rank their importance of each recommendation.

13 Now, this is merely a thermometer, this is
14 not going to drive what this Agenda will look like.
15 This data will be shared with the committee, and what it
16 will do is it will give folks a perspective on an issue
17 that you may or may not find important to you, but let
18 you know how other folks felt about that same issue.

19 So if you are passionate about it you know
20 you better get in there and fight, and if it's something
21 you're already in agreement with you can, I guess, push
22 that agenda, and hopefully this will be just one
23 component, or will be as we enter the implementation
24 phase of the items that we work on going forward.

25 So just merely a barometer, but obviously

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1 try to make sure we dedicate enough time to the
2 recommendations and this will help us after discussing
3 it, hopefully by the time we work through finance, which
4 by the way, Vice-Chair Press will chair the next
5 meeting, I will be out of town at the next meeting, so
6 if you could either electronically or by hard form get
7 those to the Vice-Chair at the next meeting we can
8 tabulate those.

9 And then as we enter the implementation part
10 on the process we'll all have an idea of where these
11 recommendations rest as a group, so that will save,
12 hopefully, some potential discussion.

13 We also have with us Mr. Ken Plunkett. Mr.
14 Plunkett is an I.T. person with the Department of
15 Health, and I know he has just real briefly a couple of
16 minutes here to show a brief presentation on some
17 mapping. So, Mr. Plunkett, feel free to proceed.

18 MR. PLUNKETT: Joe's going to proceed.

19 MR. MAZZOLA: Well, before I do that, I do
20 want to recognize Ken. Ken has worked over the last
21 week and a half to make some enhancements to our
22 website, which has a lot of mapping features to local
23 health departments, and in particular, the latest
24 enhancement is based on the AOHC report.

25 We are now able to look at health

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1 departments by the jurisdictional size that they serve,
2 so in terms of population, we can pull that information
3 by district.

4 And what Ken has done, what he's showing you
5 now is the Association for Ohio Health Commissioners,
6 looks at the state in five districts, and those
7 districts, we're now able to light those up, as Ken is
8 doing right now, to get a sense as to how the state is
9 broken down.

10 And then what we can do is -- maybe I could
11 take over from here, is that you can look at health
12 departments by the population that they serve, and so
13 when you filter it out you can look at either health
14 departments that serve between 5,000 and 25,000, 25 to
15 75, 75 to a hundred, and then 100 and greater.

16 And that really just gives the committee and
17 the general public an idea as far as how many health
18 departments there are that fall in those different
19 categories, so you can get a sense, just to look and see
20 how many health departments are there that serve over a
21 hundred thousand people; how many health departments are
22 there that serve between 5 and 25,000; and where are
23 they located throughout the state.

24 So this is just another enhancement that Ken
25 has done over the last several weeks and is available on

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1 ODH's home page, but we are making it available for the
2 presentation here today.

3 CHAIRMAN BURKE: But that is available on
4 the Ohio Department of Health home page?

5 MR. MAZZOLA: It is.

6 CHAIRMAN BURKE: It is an active link, folks
7 can connect to run whatever simulation they want to?

8 MR. MAZZOLA: Right. Right. It will be
9 available on the ODH web page probably within the next
10 couple of days, but right now we can make the link
11 available to the committee in the interim.

12 CHAIRMAN BURKE: Excellent.

13 MR. MAZZOLA: Of course, we do -- and Ken
14 would want to make sure that we mention that you can
15 also divvy up the health jurisdictions by political
16 subdivisions.

17 So in your case, Senator Burke, you can
18 highlight your legislative district, and see which
19 health departments are in your district based on these
20 different population groups.

21 CHAIRMAN BURKE: Any other things to go
22 through?

23 MR. MAZZOLA: No.

24 CHAIRMAN BURKE: Or if you care, does any
25 member of the committee have questions to ask; do you

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1 have any questions?

2 Excellent. All right. Mr. Plunkett, thanks
3 for putting that together, that will be a useful tool to
4 research and delve into and to move forward.

5 MR. PLUNKETT: Thank you.

6 MS. EDWARDS: Sorry, the pins, you've got
7 green pins and yellow pins, can you give me the quick --

8 MR. PLUNKETT: Yeah, up top you can --
9 there's a drop down, so you can fill -- we've got about
10 90 some sets of pins, hospitals, nursing homes, rest
11 homes, dialysis centers, so the pin senses wherever you
12 pick, so you can light up the core pins, so the green
13 pins are 5,000 to 24,999, and then the yellow pins are
14 the 50,000 to almost a hundred thousand pins.

15 And as you click on any one of the pins
16 itself it brings up the overlay information and that
17 total population, who the contact person is.

18 MS. EDWARD: Okay.

19 MR. MAZZOLA: You picked a good pin; how did
20 you know?

21 MR. PLUNKETT: Kept kicking me.

22 CHAIRMAN BURKE: Thank you very much. Next
23 on the Agenda we have Mr. Nixon. I know you have a
24 presentation for us, if you're ready to go go ahead and
25 get things started.

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1 MR. NIXON: All right. Thank you, Mr.
2 Chairman. I did a preparation recently, about a year
3 and a half ago, Summit County, there were three health
4 departments that came together under a consolidation, so
5 I thought I'd -- the best way to present this, I guess,
6 as I thought about it is talk a little bit about the
7 planning for that consolidation, or those
8 consolidations, the actual implementation, and then
9 finally a year later, how did it go, kind of a
10 retrospective sense of how it went.

11 So there is Summit County, just to kind of
12 give you a spatial perception of where we're at. Of
13 course, Ohio, there's about a hundred twenty-five --
14 there are a hundred and twenty-five health departments,
15 last I heard, second, I think, only to Massachusetts
16 maybe in the total number.

17 The next slide shows actually Summit County,
18 you can see prior to 2011 there were three health
19 departments, the city of Akron, the city of Barberton
20 and the balance of the county, and within Summit County,
21 of course, we have thirteen cities, we have nine
22 villages and ten townships.

23 As well Summit County was unique at the time
24 in being the only charter form of government in Ohio, so
25 that created some unique opportunities for us as we

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1 considered the consolidation, so this was some of the
2 district details.

3 At the time we entered into it, you can see,
4 Summit County itself, we have staff of over a hundred
5 and thirty people, \$13 million budget; Akron, as well
6 had a \$17 million budget, and about the same number of
7 people; Barberton, a little smaller with a \$2 million
8 budget and a staff of 29, so that's what we were working
9 with to bring this together.

10 As I talked about consolidation, you know,
11 the first thing I say out of the gate, it's not
12 necessarily for everyone. I'm not here to advocate that
13 everybody ought to consolidate, it worked for us, it
14 doesn't work for everybody, but I think this is
15 something that we learned along the way, is that maybe
16 15 years ago the three health departments barely
17 tolerated each other, we did communicate a little bit,
18 but we didn't work that well together.

19 Over the next 15 years we learned through
20 cooperation and in finding collaboration on some actual
21 programs where we shared resources, shared employees
22 under some programs, that that level of trust was
23 developed that we could actually consider moving forward
24 towards consolidation.

25 I think that was very important to have that

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1 level of trust between the agencies to be able to move
2 forward, so I think that's an important kind of model to
3 think about.

4 So how did we go about it? The first thing
5 we did is actually we met with some principal key
6 stakeholders in the community, talked about the idea of
7 consolidation, gained some perspective about their
8 thoughts on it and ultimately ended up with a
9 Feasibility Study Committee.

10 But before that I think it's important for
11 there to be a sort of internal assessment to assess the
12 agency's capacity for actually doing a consolidation.

13 It's not for the faint of heart. I think
14 there' a lot of work involved, and do you have the
15 administration, the fiscal management, the I.T.
16 management, the legal support and the personnel
17 management to do this, because that was critical for the
18 success, to have that administrative capacity.

19 The leadership capacity getting to weather
20 change, this is stressful on the staff and on the
21 leadership, and I think that was important as well.

22 You can go ahead and move, is there
23 sufficient board of health support, political support in
24 the community and so forth; are we fiscally strong
25 enough?

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1 I think one of the principal reasons for
2 considering consolidation, of course, increase
3 sufficiency and saving of moneys, but initially there is
4 an up front cost that has to be considered whenever
5 agencies are considering consolidation, the I.T., the
6 phones, the personnel cost and so forth.

7 And then finally those -- that broad arena
8 of internal conflict, the circumstances in the community
9 that may preclude the ability to move forward with
10 consolidation, so that was important.

11 I think secondly is to, of course,
12 understand why you want to consolidate.

13 Everybody has the assumption consolidation
14 is a good idea, but I think it's important to go through
15 the process of the -- the community process, to decide
16 whether this is important to your community and why you
17 want to do it in the first place.

18 Efficiency, of course, is important. The
19 ability to leverage additional resources at a larger
20 agency, the fact that we already come together on a
21 number of programs, and we're co-locating on some things
22 gave us, I think, confidence that we knew why we wanted
23 to do it.

24 It also allows you to come back later and
25 decide -- and to measure how well you did in meeting the

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1 objectives as you consider consolidation.

2 We brought together a Feasibility Study
3 Committee that was initially a bit of chaos as everybody
4 came together, but we did organize the process around
5 some key issues and we looked at each one of these
6 individually in subgroups or as a whole committee to
7 determine whether the facility capacity was there to
8 house a larger agency; whether the staffing could really
9 come together and was compatible; to take a look at the
10 financing, what would it cost the city to join with the
11 county health department; the governance structure,
12 would that change, would the governance structure change
13 under this new model; what community support, that was
14 important for our committee -- our inclusive Feasibility
15 Study Committee to know that the community people
16 supported this; as well as how programatically
17 compatible the two agencies or three agencies were.

18 So the Feasibility Study Committee came
19 forth and said, yes, it's very feasible. In fact,
20 looking at these factors it's desirable to move forward.

21 So that was all well and good, but now
22 really the work began, the actual implementation, and
23 that's where I think it's important to have that
24 organizational, administrative capacity to support this
25 kind of work.

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1 Personnel alignment was particularly
2 difficult when you had that many people under different
3 salary schedules and job definitions and job titles to
4 align those probably created one of the hard -- some of
5 the hardest work for us to do.

6 Grants and contracts, all the legal work
7 that went with that, it wasn't just the large ODH grants
8 and the federal grants, but it's also the contracts for
9 the copy machine, maintenance agreements, pop machines,
10 just innumerable contracts that had to be aligned.

11 Fiscal details, of course, to work out an
12 arrangement for the city to assure that their employees
13 had an opportunity to be hired, but we had the capacity
14 economically to support those employees.

15 What would that new organizational structure
16 look like? I think that it's not only the matter of
17 maintaining a robust management structure, but to move
18 forward in the spirit of a true merger in that there was
19 management capacity from all agencies.

20 It wasn't just Summit County Health District
21 managing all of these new employees, but there was
22 shared management responsibilities from all three
23 agencies.

24 It presented a unique opportunity to promote
25 public health in our community, to advance what we're

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1 all about, what we're moving forward, why we're doing
2 this to the larger community, and then finally training
3 to get everybody up to speed with the new personnel
4 standards and how we do business in the health
5 department.

6 And that created an opportunity to change
7 and reassess, and internally avail ourselves of the
8 opportunity to measure how well we did things, and so it
9 was a real opportunity, but that was the hardest part.

10 I think the lesson learned as we entered the
11 first year of consolidating the three health departments
12 was the willingness of all partners to support -- key
13 community leader support, the champions in the
14 community, the county executives, the mayors.

15 We had unanimous support from all of our
16 cities and townships and villages to move forward on
17 this. We had strong community support, which I think is
18 vital to have that willingness and -- and support for
19 the process.

20 The administrative capacity, I can't say
21 enough about the work that was done by all of the
22 administrators to make this a success.

23 There were -- there were road blocks. I
24 think we -- there were issues that came up that seemed
25 insurmountable. We kind of prefer to think of them as

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1 hurdles, not road blocks.

2 At times we had to lock ourselves in a room
3 and decide what are we going to do about this, we've got
4 to figure out a way to get around this, and those were
5 the main hurdles, but you can expect issues to come up
6 that seem to be insurmountable, but I think if the will
7 is there you can make it happen.

8 And then I think the, why, I think it's
9 important that you establish that, the savings, I think
10 you have to consider where everyone is sitting and what
11 their expectation for the consolidation may be.

12 I think elected officials want to see some
13 economic savings, I think public health officials want
14 to see an enhanced public health capacity, and all of
15 those need to be balanced, and you have to remember who
16 the audience is, but I think the why is important, don't
17 enter into this too lightly.

18 So a year later I think we felt -- our board
19 felt a responsibility to take a look at one year later,
20 how did we do; did we meet the challenges that we put
21 before ourselves?

22 So we hired some folks from Kent State
23 University, shared between their School of Public
24 Administration and School of Public Health to measure
25 that and to put together some -- a study for us on that.

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1 So they did focus groups with employees,
2 with key community leaders, as well as management and
3 boards of health to see the opinions; they surveyed
4 folks, as well as doing a fiscal analysis; and then to
5 take a look at some of those bench marks, what grants
6 did we lose; did we gain anything and so forth.

7 So they identified three strategic
8 challenges that faced us along the way.

9 A new strategic direction, we very
10 purposefully, after the first year, after we merged,
11 took a look at what health departments or what in Summit
12 County we should be doing in public health.

13 We did a very robust strategic plan, changed
14 the way we do a lot of our business, and I think that
15 that was -- we took that opportunity and tried to
16 capitalize on that, engaging key community stakeholders
17 to articulate what was going on; why we were doing it, I
18 think that was a challenge; and then I think assessing
19 the consolidation along the way to measure how we did in
20 that -- meeting our expectations of consolidation.

21 And then operationally adjusting the
22 personnel roles and working arrangements, you know,
23 little issues, like now you have to pay parking where
24 you didn't have to pay before, you have to move your
25 office, drive more, these became big issues for

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1 employees, of course.

2 Technologically we had two different
3 systems, three different systems, which created
4 challenges to get everybody on-line. That goes for
5 phones as well, who do you call now and how do those
6 calls get transferred; the facility arrangements, the
7 changing organizational cultures among staff; and then
8 finally, communicating and engaging staff.

9 I think that in retrospect there was always
10 the issue of communication, as much as we tried to keep
11 the process transparent, involve everybody in it, I
12 think there was always a sense that something else was
13 going on in the background, so we had to really work
14 very hard on that, but that came to the surface in their
15 evaluation, and so there's a couple of charts here, so
16 I'll try to go through them.

17 The first one talks about the financial
18 changes. Ultimately we've determined that we've saved
19 the City of Akron about \$1.3 million in general revenue
20 support from what was originally estimated, and that was
21 adjusted for some of the first year up front costs that
22 we incurred, so this is probably a sustainable dollar
23 amount.

24 The City of Barberton, we saved the City of
25 Barberton a hundred and eighty-six thousand dollars, and

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1 the costs were consistent for other communities.

2 So in total about a million and a half
3 dollars from what we estimated going into that first
4 year, so that was welcome news.

5 The next one --

6 VICE-CHAIRMAN PRESS: Are we going to hold
7 questions or how -- can we just go back to that --

8 MR. NIXON: Sure.

9 VICE-CHAIRMAN PRESS: Can we go back to that
10 slide, you said these are savings relative to your
11 expectations.

12 Did you forecast some savings and these were
13 the differences, or did these compare to the actual run
14 rates of the organizations before they existed?

15 MR. NIXON: Well, it's -- the answer is when
16 we knew we were going into consolidation a year earlier
17 the city had cut some of their budget, recognizing that
18 there were going to be some savings, they cut some staff
19 and so forth.

20 So when we estimated the cost for the City
21 of Akron we estimated a cost number, and one of the
22 criteria the city had was all employees had an
23 opportunity for employment. So when we took a look at
24 what that cost would be we could set an established
25 dollar amount.

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1 contribution today to Summit County?

2 MR. NIXON: The general revenue support?

3 MR. INGRAM: Uh-huh.

4 MR. NIXON: Oh, what's that number, I think
5 it right now is about \$4 million. Now, they're under
6 contract for 5 point something per year for three years
7 with the 10 percent savings each year.

8 So, in fact, they pay on a quarterly basis,
9 last year they didn't pay the fourth quarter, because we
10 had that much savings.

11 MR. INGRAM: Okay.

12 MR. NIXON: So we're re-evaluating going in
13 for our third year of the contract what that next
14 contract will look like, and so that would be reduced
15 significantly, I'm sure.

16 COMMISSIONER SHAPIRO: So you are -- the
17 contract, it wasn't in combination?

18 MR. NIXON: It is a -- they are part of the
19 health district, it's not a contract for services, no.
20 It's a contract to consolidate with the agencies. It's
21 a union with the county health district, not a contract
22 for services, but it still involves a contract.

23 COMMISSIONER SHAPIRO: Okay.

24 MR. NIXON: So then taking a look at some of
25 the outcomes, I think the next one demonstrates

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1 perception of overall services changed.

2 Most of the people felt that there had not
3 been a negative change, and most people felt that --
4 that services remained basically the same, 83 percent
5 thought services had been maintained at the existing
6 level.

7 Fewer people felt that services have
8 improved, but 95, or 87 percent of those that were
9 surveyed said that the consolidation will have a
10 positive impact on the public health services in the
11 future, and this is a total from all -- all people that
12 were interviewed, both outside and internal to the
13 organization.

14 In measuring the next one, public health
15 capabilities, you can see some difference here between
16 supervisors, non-supervisory staff. Most supervisors
17 felt that services, the capacity, has, in fact,
18 improved, 96 percent, where it was only about 70 percent
19 non-supervisory staff felt our capacities had improved.

20 The next one demonstrates a perceived aid to
21 progress in pursuing the goals of consolidation. Again,
22 the health district senior managers and external
23 stakeholders felt very -- that there had been quite a
24 bit of progress in the pace of pursuing our goals,
25 whereas non-supervisory staff showed the least sense of

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1 a very fast or fast pace of progress.

2 So these were good lessons learned as we
3 look forward to our next strategic plan, and then the
4 overall impact.

5 I think the main lesson here was that most
6 people felt that the consolidation was a good idea, and
7 ultimately then as the final result of the report can
8 offer three benefits that the consolidation of the
9 health district is providing an opportunity to rethink
10 public health in Summit County.

11 The consolidation of departments is yielding
12 potential increases in capacity can be multiplied over
13 time, and then finally while the transition has been
14 disruptive for persons involved, there has been public
15 health service improvement identified by our staff and
16 by participants in the process.

17 And I will say, some of the major events, we
18 were able to secure a -- a health transformation grant
19 from the federal government, one of just a handful that
20 were given out nationally.

21 We did apply for accreditation, and we lost
22 -- on the other hand we did lose a major federal lead
23 grant as part of that and we did lose some money in some
24 other grants, but I think that may have been more of a
25 reflection of the economy and what's going on in the

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1 federal government, than a reflection of the actual
2 consolidation.

3 And the report is available on the website,
4 and I think it's been provided to -- you should have a
5 copy of that report, that's available as well as the
6 feasibility study report is also available to the
7 committee. So, with that in a nutshell --

8 CHAIRMAN BURKE: Again, thank you, Mr.
9 Nixon, we'll get to some questions here in a minute.

10 This report will be posted -- is posted on
11 the Ohio Department of Health website for folks to
12 review.

13 Just a couple of questions, I guess, and I
14 think this is good that this is happening, can you talk
15 a little bit about the drivers that made this occur.

16 I don't -- do people just all of a sudden
17 lock arms and start singing Kumbaya, or what happened to
18 make this possible?

19 MR. NIXON: Well, I think the idea of
20 consolidating Summit County has been floating around for
21 probably 30 years.

22 You know, there's been some thought to it,
23 it's been visited a couple of times, the opportune time
24 for us has been when, quite honestly, when there's a
25 retirement of one of the health commissioners from one

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1 of the major systems that created an opening to consider
2 it.

3 I think it makes it a little easier during
4 those times, but at this time, I think, certainly the
5 economy threw us into that a little bit more
6 dramatically than might otherwise happen, and the
7 challenge, the City of Akron has had some financial
8 difficulties and this was one that presented itself.

9 The building departments and the city and
10 the county had consolidated, I think, a year earlier, so
11 that met with some success, so here was an opportunity
12 to take a look at the health department.

13 So it -- it started out with some, you know,
14 some discussions with some key leaders in the community,
15 it resonated with the hospitals, with the -- our
16 District Advisory Council, our ultimate governance
17 entity with the county health district, the mayor was
18 supportive in discussions with him, and the Feasibility
19 Study Committee, I think, kind of locked the community
20 support for moving forward.

21 CHAIRMAN BURKE: So what physically
22 happened, you had two separate health departments, two
23 separate buildings; what -- what happened? Did you
24 agree on the location; did you keep those buildings up;
25 did you convert to one?

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1 MR. NIXON: Yeah, right now we're in a
2 search for facilities, we have several that we're
3 looking at.

4 We've actually been in discussions with Job
5 and Family Services, with the Solid Waste Authority,
6 with the Drug and Alcohol Agency, and a couple of other
7 agencies about consolidating all of our locations in a
8 mega kind of county facility, which offers obviously for
9 additional efficiencies in Summit County, so we're
10 pursuing that.

11 Right now we are located in about 13
12 different buildings, we want to consolidate that. We're
13 looking for a main facility for most of the staff, and
14 that's been a difficulty having people, you know,
15 fragmented around the county. So we've been -- that's
16 our new adventure is finding a new location, a central
17 location for our staff.

18 But over the last year we've kind of drifted
19 into clusters where nurses are in one location,
20 environment health folks are in another, so, you know,
21 people kind of migrated into clusters of like purposeful
22 groups.

23 CHAIRMAN BURKE: You touched a little bit on
24 I.T., were both health districts running on the same
25 platform?

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1 MR. NIXON: No.

2 CHAIRMAN BURKE: It's not. Then how was
3 this data put together; has it been put together in some
4 singular fashion?

5 MR. NIXON: Yeah, we're under a single
6 system now completely in all locations, as well as the
7 single phone system in all locations.

8 But that was a significant challenge over
9 the first year, in that you had computers -- antiquated
10 computers from the city that were really, many of them,
11 ten years old, which is way beyond their life, so I
12 think we ended up buying about 130 lap -- or desktops
13 and laptops, and put them under a single system that the
14 back up and everything supported it.

15 But it was, you know, there were a lot of
16 wiring issues, it was an old building, and that's all
17 been aligned now, and we've been able to do that under
18 the -- under the cost savings -- with the cost savings
19 as well.

20 CHAIRMAN BURKE: Just my final question,
21 have you seen any changes in health outcome? Have you
22 seen a change in something that would be more acute,
23 like low birth weight babies or immunization rates, have
24 they gone up?

25 MR. NIXON: No, we've not seen any -- we've

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1 got a very robust community assessment process in the
2 county.

3 I think probably more dramatic is what we've
4 done is institute some quality assurances within the
5 organization to measure efficiencies and outcomes, and I
6 think question some of those outputs that we're doing.

7 I mean we've always kind of historically run
8 under kind of auto pilot, here's the programs we do, and
9 you do your job, and I think for the first time we have
10 really taken a hard look at some of those outputs and
11 outcomes to question why are we doing this and what
12 value does it bring to the organization, and realigned
13 some of our programs, because of the findings that we
14 found.

15 Our need for some of the clinical services
16 declined, whereas our role in assuring better access to
17 services through some other programs in the community,
18 like Adult Protective Services and so forth had provided
19 opportunities, so we're transitioning a number of the
20 programs.

21 But some of those definitive public health
22 measures, I can't say that in a year and a half we've
23 made any dramatic impacts.

24 CHAIRMAN BURKE: And just one follow-up,
25 when you talk about the savings that you procured out of

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1 this consolidation, what happened to those savings, did
2 you drive those back into the health department and
3 public health or were they absorbed into local
4 government and county health?

5 MR. NIXON: Absorbed into the city, the
6 city, so they weren't charged those fees, and so that
7 was a direct savings to those communities.

8 CHAIRMAN BURKE: Okay. Any additional
9 questions for Mr. Nixon from anybody on the committee?

10 MS. FOUGHT: So you said it was a direct
11 savings to the city, so the townships were still charged
12 what they would have normally been charged?

13 MR. NIXON: We have maintained the charges
14 to the township, villages and other cities for four
15 years, it's been a flat charge. We have not increased
16 the fees to the city, and I think we've had a lot of
17 efficiencies along the way to do that, so there was no
18 actual direct savings back to those communities.

19 I think next year it's something we're
20 actually looking at. There may be a decrease in actual
21 charges based on some savings, but, you know, that's all
22 balanced against some programs that we lost some
23 significant dollars on and we've lost a number of
24 employees, so that general revenue burden on the balance
25 of the city is now being looked at two years out, so

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1 there's potential for that.

2 MR. JACOBS: Gene, can you explain a little
3 bit about the stark differences between your -- prior to
4 the consolidation, between your department and the City
5 of Akron's department; were there any gaps in services
6 where Akron provided something and you hadn't
7 traditionally provided that; how did you help manage,
8 and what was the reaction to your citizens in Akron at
9 that point in regards to either loss or gain of a
10 program?

11 MR. NIXON: Well, again, I don't think we
12 lost any services. There were some programs -- actually
13 there was an air pollution program that they managed for
14 the EPA, they have an adult counseling program, which is
15 something behavioral health was -- which was not an area
16 that I had any experience with, but they have counselors
17 and they do some counseling services.

18 So there was a smattering of, as you know, I
19 mean, there's some core services we all do, the
20 environmental health, restaurant inspections, mosquito
21 control, some of these things that we all -- we did and
22 shared some of those services, communicable disease
23 investigation, which those folks worked together
24 already, so there were some programs on both sides that
25 -- that the others didn't do, but it also created new

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1 opportunities.

2 So there were some programs that those with
3 the county previously hadn't had access to working in
4 that now they could consider going to something else,
5 and it went both directions. So, you know, it really
6 kind of opened things up as a whole for the
7 organization.

8 I think your questions to the community, I
9 think there were some concerns, some angst by community
10 leaders that, you know, the county's going to come in,
11 they know nothing about public health services, to the
12 city and we're going to lose, and I think we had to deal
13 with that a lot. We had to be very visible in the
14 community.

15 There was also the risk that the townships
16 felt that the money from the township was going to flow
17 to the city, because that's where the needs are.

18 And, frankly, I heard from the mayor that he
19 was concerned that the money from the city was going to
20 flow out to the townships.

21 So we actually created a mechanism to track
22 those budgets independently, so we could demonstrate
23 that, and we sold that to the cities and to the
24 townships, and here's how we're going to measure some of
25 that, you know, in good faith, to show how we are acting

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1 and how we are spending the money, and that's remained
2 pretty consistent with where it was, but nobody's really
3 asked us for that.

4 So we had the mechanism in place to
5 demonstrate that, and I think it's been useful for us,
6 but outside there's really been -- I think there's been
7 good trust developed, and it's worked out pretty well.

8 MS. EDWARDS: One of the first things that
9 you did was your internal assessment, one of the things
10 I wrote down here, is there enough leadership? How long
11 did that take to gel; how did that gel; and where did
12 the leadership ultimately end up?

13 MR. NIXON: Well, again, I think to
14 demonstrate, the 250 staff members, that this wasn't a
15 take over by the county. I think we had to be very
16 purposeful in designing a management team that would
17 encompass members from all over the organization.

18 That was a challenge, because it didn't
19 always work exactly as we would have liked, but
20 nevertheless I think that we came together as a team,
21 the leaders from all of those agencies worked together
22 through this process, so it was really based on a lot of
23 trust, and I think that kind of evolved out of that.

24 And -- but I think going in I can't say
25 enough about, you know, kind of mentoring staff about

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1 what the expectations are, because a director of a team
2 of 30 people is going to be a different director when
3 he's got a hundred people to supervise and he has
4 assistant directors now and to kind of prepare folks for
5 what they can expect and to be ready for that change,
6 and then to mentor their staff about that was something
7 that we did very thoughtfully going in and I think
8 that's kind of lead to some of that, helped a lot of the
9 -- deadening of some of the anxiety and angst.

10 DR. MCFADDEN: You guys are out in front
11 with this, and this is a tough question, I know, but
12 it's relatively easy months, to quarters, to years, to
13 say how much money is saved, I think, you've already
14 reflected on how hard it is to show quality improving,
15 staying the same or worsening, have you gotten any -- do
16 you have any wisdom about how to -- looking back to the
17 process, how do we measure that; how do we go forward?

18 Because I think that's -- we had some
19 conversation, we want to do it efficiently, but we also
20 want to be effective and make sure that that service is
21 not jeopardized by --

22 MR. NIXON: Well, obviously, Kent State,
23 when they did this, they came out with some other
24 recommendations to others that are considering this,
25 what to think about going in.

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1 Because one of the challenges for them was
2 to measure how effective that change was, and was there
3 a change in the community health status because of that,
4 and so they put together some recommendations for folks
5 to think about in establishing some of those baseline
6 measures going in so when people come out the other side
7 saying this was the benefit.

8 So, you know, in retrospect we might have
9 done a lot more measures, collected a lot more measures
10 going in, but we're a whole different agency now. You
11 know, I mean we're not the same agency. I think in
12 retrospect what we expected coming out, we've got a
13 completely different animal now.

14 What we're doing; how we're approaching our
15 public health; how we're doing it has been -- has really
16 opened -- you know, the door's been opened for us, how
17 we can approach our job.

18 MS. FOUGHT: Two questions. One, going back
19 to your statement where you had said townships and
20 cities were worried, and the funding, you had put
21 something in place, well, have you gone back to them one
22 year later and asked their opinion as to whether the
23 services has been --

24 MR. NIXON: That was all part of this
25 survey.

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1 MS. FOUGHT: Okay. And so what -- what --
2 I'm sorry if I missed it, what was the overall reaction
3 from the elected officials?

4 MR. NIXON: Overall the community leaders
5 were very pleased.

6 MS. FOUGHT: And had they expressed a desire
7 to increase the services that are being offered, because
8 it's been so beneficial?

9 I don't know if there are opportunities for
10 increased services or anywhere -- like programs that
11 might not have been offered under this joint effort,
12 because maybe the city was doing it, but the county
13 wasn't; any availability of expanding services at all?

14 MR. NIXON: I mean they haven't come to us
15 and asked us to expand services. I think they, you
16 know, look to us for some leadership on where we think
17 some of those changes ought to be, and I think where
18 we've changed programs or we've changed services,
19 eliminated a program or eliminated an office or added an
20 office or a program, I think we had to go out to the
21 communities and explain that, I mean, I don't think any
22 of that's done in a vacuum.

23 I think if I'm closing an office in a city,
24 I'd better be able to explain why I'm closing that to
25 that community.

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1 I think the challenge to us is to be able to
2 articulate and communicate with elected officials in a
3 different way, and like you asked a question, the
4 economic impact of those communities, I think that's
5 where we've got to become more skilled in public health
6 in communicating that way.

7 We can talk about a \$15 savings for every
8 dollar invested in immunization, well, showing me the
9 \$15, you know, so we have to be able to do that a little
10 bit differently.

11 But directly I haven't been -- I don't know
12 that they've come and said, add services, but I don't
13 think they've said, as we presented the new definition
14 of public health in Summit County, that they've objected
15 either.

16 MS. FOUGHT: What about grant funding? You
17 had mentioned how you had lost some grants, but have you
18 found that you're also eligible for even more, because
19 you are now a bigger department and have you gone out
20 and gotten some grants?

21 MR. NIXON: Yes, I think that's, you know,
22 when we talked about one of our advantages or one of our
23 hopes coming out was that we'd be better able to
24 leverage some of those things, and I think we found
25 that.

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1 I think internal to the county where we
2 built that -- that program with Adult Protective
3 Services and partnerships with Job and Family Services,
4 aligning behavioral health programs with primary health,
5 with oral health care, with a pharmaceutical access
6 program, those are all things that we've done which we
7 potentially could have done fragmented, but, boy, it's a
8 lot easier when you're consolidated and speaking as
9 public health for Summit County.

10 The Health Transformation Grant from the
11 federal government, you had to have a population of a
12 half million people to be eligible, we didn't have that
13 prior to the consolidation, so that made us eligible for
14 that program.

15 So, so far we've realized, I think, funds
16 offset any of those losses and the losses that are
17 coming are coming anyway, so far we've been able to
18 balance those things pretty well.

19 MR. INGRAM: In retrospect, Gene, is there
20 anything, looking back, that the Department of Health or
21 the administration or the Ohio Legislature could have
22 done to have made this initiative, this effort go
23 easier?

24 MR. NIXON: I knew you were going to --
25 somebody was going to ask that question. I can say

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1 that, you know, it went pretty well for us.

2 I don't know, I spoke to Marty very early on
3 in the process, and I think I was -- we had some fears
4 with all of the grants between the agencies, shared
5 uniformly around Summit County between Akron, Barberton
6 and Summit County, to consolidate those all in one was
7 going to be difficult, because they're not on the -- on
8 the calendar year, and, to hand those over two months
9 before we consolidated or six months after when the
10 health department didn't exist, and they were very
11 helpful in facilitating that process and very helpful, I
12 must say, I really appreciated that.

13 In terms of laws, you know, we were able to
14 cough up the money for the feasibility study, and a lot
15 of the administrative work, but that was through the
16 generosity of a lot of our partners, and I don't know
17 that we could have done that without some of that
18 support from the hospitals, from the health department
19 and so forth.

20 That money doesn't come easy, and the
21 flexibility to spend it on that kind of work was -- kind
22 of helped make that process work, so absent that money
23 at the local level, I think it would be very difficult
24 to get some of that work done.

25 So, again, we were fortunate in a number of

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1 ways, it was kind of the perfect storm, but that's
2 probably where we could use some help.

3 VICE-CHAIRMAN PRESS: First of all, thank
4 you for your presentation, I kind of feel like you're
5 kind of in the hot seat, that's certainly not what it's
6 meant to be, I just have a lot of questions.

7 MR. NIXON: That's okay.

8 VICE-CHAIRMAN PRESS: I'm trying to recap
9 what I think I heard from your presentation. I think
10 what I heard you say was total spending is down; really
11 no compromise or reduction in programming, your
12 programming has stayed pretty well constant; no jobs
13 lost in the consolidation didn't sound like --

14 MR. NIXON: Everybody got an opportunity to
15 move.

16 VICE-CHAIRMAN PRESS: -- And you'd had
17 attrition to begin with, so didn't lose jobs; spent less
18 money; we haven't reduced programing; and the jury is
19 still out on quality outcomes, because that takes a
20 little bit more time.

21 MR. NIXON: Right.

22 VICE-CHAIRMAN PRESS: Let me ask a question
23 that we didn't really hit on, there were -- previously
24 there were three boards of health, right, Barberton, the
25 county, the city?

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1 MR. NIXON: Yes.

2 VICE-CHAIRMAN PRESS: Were there then three
3 -- you had three health departments, were there three
4 different boards of health?

5 MR. NIXON: Yes, Akron has a health
6 commission, but --

7 VICE-CHAIRMAN PRESS: Take us through, if
8 you would please, what happened to all those board of
9 health members? Do they all combine into a super board;
10 did they pick amongst each other; did they stand for
11 reappointment? Take us through the humanistics of that.

12 MR. NIXON: Well, that was a difficult
13 moment in the process, because Akron certainly with an
14 investment of 5 to 6 million dollars felt that they
15 needed more representation on the Board of Health.

16 And we have a board where every city has a
17 representative, and then there's four representing the
18 townships and villages, and one representing the
19 licensing council, we have a very big board.

20 VICE-CHAIRMAN PRESS: That was by -- excuse
21 me, that was by agreement in the course of the merger or
22 was that an arrangement that had to be hammered out
23 through the board?

24 MR. NIXON: Yeah, it had to get hammered out
25 with the City of Akron, so that, you know, the mayor

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1 certainly felt they needed more representation, to -- to
2 allow that I would have had to open up contracts with
3 all of my other cities, which created, you know, a
4 challenge I really didn't want to go into.

5 So we talked about the ability to do that,
6 but that would delay this consolidation significantly,
7 and I think that kind of moved us towards, let's allow
8 for one representative on the Board of Health with some
9 consideration in the future about maybe changing that
10 board structure.

11 So that was kind of a tense moment in the
12 whole thing, but the City of Akron has one seat on the
13 Board of Health, there's 17 board members, and they have
14 one seat, Barberton has one seat based on their
15 contract.

16 The City of Barberton and the City of Akron
17 still maintain a Health Commission and a Board of
18 Health. They don't have the authority for any of those
19 services, but -- and I think both of those entities
20 still struggle with their purpose, trying to understand,
21 absent a health department to manage, what's their
22 purpose, and we report to them on occasion about what's
23 going on, and they still struggle with that a little
24 bit, but --

25 VICE-CHAIRMAN PRESS: I'm going to piggyback

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1 Tim's question now, is that a hold over from the statute
2 that they have to do, those bodies have to be appointed,
3 even if there's really nothing important to do?

4 If they've been consolidated one might ask,
5 well, why not give some relief so they don't have to
6 proceed to appoint them?

7 MR. NIXON: Right, well, under both
8 charters, the City of Barberton and the City of Akron,
9 they have, in their charter, the city shall maintain a
10 Board of Health, and I think both cities sort of
11 interpreted that as, well, we have a county, probably
12 how you want to interpret that, but I think at the same
13 time rather than fight it, well, we have a Board of
14 Health, we don't have any statutory responsibility or
15 authority, but we still have a Board of Health.

16 And they've actually found some purposes in
17 the community, but it's just still unclear as far as in
18 a document this is what your role should be, because
19 they've taken on various tasks and so forth, but that's
20 part of it, and I think that they'll probably at some
21 point in the future, if we stay consolidated, there'll
22 be some charter amendment to the city that takes that
23 on.

24 VICE-CHAIRMAN PRESS: Then they've devised
25 each of their own way then to point to this, I think,

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1 you said the City of Akron has one person on this
2 committee appointed by the mayor, the city council, or
3 they've got some mechanism, again, that was a term that
4 you all agreed to in the --

5 MR. NIXON: Well, it's consistent with all
6 of our cities, the mayor appointments them.

7 VICE-CHAIRMAN PRESS: Just two more
8 questions, in response to some questions from Heidi, you
9 were saying that the townships had a certain funding
10 level, was that -- was that contractually committed to?
11 I mean did you just say that we promise you no increases
12 for four years or --

13 MR. NIXON: No.

14 VICE-CHAIRMAN PRESS: Okay. So that was
15 just everybody was aware?

16 MR. NIXON: Our budget -- we take our budget
17 proposal each year to our Board of Health, they
18 establish a budget. We take that proposed budget to the
19 Budget Commission, the County Budget Commission, and the
20 Budget Commission then approves it.

21 VICE-CHAIRMAN PRESS: And then sometimes
22 I've seen these arrangements where people sort of say,
23 well, they sort of do a pre-nump, where you say, well,
24 if this doesn't all work out this is how we're going to
25 unwind this. Did you have unwinding language in this or

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1 was this pretty much this is the way we're going to do
2 it?

3 MR. NIXON: The City of Barberton, they are
4 under contract with us, and sort of a boilerplate
5 contract by all of our other cities.

6 Akron is a little bit more detailed, it's a
7 three year contract and -- but there isn't an unwinding
8 clause in it. I mean at the end of the three years they
9 can, yeah, but I don't think anybody thinks that could
10 happen.

11 VICE-CHAIRMAN PRESS: So let me make sure I
12 understand, you merged the city and the county, and
13 there's a contract between those two legal entities to
14 perfect that; is that generally correct?

15 MR. NIXON: Yeah.

16 VICE-CHAIRMAN PRESS: And that party
17 contracts with Barberton to fulfill the services with
18 that community's obligations?

19 MR. NIXON: There's two models to
20 consolidate in Ohio, okay, I guess, the -- and this was
21 something I went through with the city -- the state law
22 department helped us do that, under one model you can
23 contract for services.

24 So we can assume all the public health
25 authority and responsibility for the City of Akron under

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1 our contract, and we charge them, here's what it cost
2 us, and they pay us for providing all those services.

3 Now, under that model they're not part of
4 our health district. Okay. They've remained an
5 independent health district by definition, and so under
6 that they wouldn't be entitled to a Board of Health
7 representation, and that was -- that was a detail that
8 was -- really is unclear in the law, but I think it was
9 interpreted that way by the state who preferred it then.

10 The other one is that they actually created
11 a union with the health district, and under that then
12 they, you know, become a part of the overall health
13 district, so you can either contract for services or you
14 can become a union with the health district.

15 MS. SCOFIELD: I'm with Cuyahoga County, so
16 interesting the similar form of government. You
17 mentioned building and housing had merged about a year
18 or so before you started this process, has anything else
19 changed that you know of where the county has kind of
20 taken on city services?

21 MR. NIXON: The sheriffs have taken on a
22 couple of communities, but no major programs like that,
23 and housing actually is still with the city.

24 MS. SCOFIELD: Okay.

25 MR. NIXON: It's the building part that's

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1 combined, so --

2 MS. SCOFIELD: Okay. When you went through
3 this process, when you were looking at the legal and
4 fiscal questions that -- that came up, was it your own
5 internal staff that did that; did you work with county
6 administration for any assistance in doing that analysis
7 or was it just your internal?

8 MR. NIXON: Well, that's interesting. We
9 actually did it two ways -- independent ways to come up
10 with the number.

11 We -- we, with the Feasibility Study
12 Committee, the Center FOR Community Solutions actually
13 was our consultant for that.

14 They had a fiscal analysis done to come up
15 with a number based on staffing and cost and so fourth,
16 internally our agency, to kind of protect our own
17 interest, did the same thing, and they came together and
18 the number was like a hundred thousand apart, so it was
19 very -- we had some assurance that we were pretty close
20 on that number.

21 So the county did not provide that, we did
22 that internally and with support from our consultant.

23 MS. SCOFIELD: Okay. I forgot about the
24 Center for Community Solutions' role. And then my third
25 question would be did you do any other kind of

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1 benchmarking or comparison to other mergers aside from
2 -- within public health?

3 Did you look at how other counties and
4 cities had merged and their process, and did that inform
5 your's at all or --

6 MR. NIXON: We did very early on before the
7 feasibility took a look around to see who had done what
8 and there wasn't a lot of information available, and I
9 think that's one of the -- if you look at that
10 nationally there's really not a lot of information
11 available on the process itself, on the measures or on,
12 you know, and so we did have -- this document was
13 shared.

14 I don't know that it gave us any huge
15 enlightenment on the process. No, we did research that,
16 but I can't say that there's a lot of information on the
17 process.

18 MS. SCOFIELD: Do you think it's improved
19 since you started; do you know?

20 MR. NIXON: Well, since we've come up with
21 this it certainly --

22 MS. SCOFIELD: You've certainly added to the
23 literature, right?

24 MR. NIXON: I think there's a lot of
25 attention being paid to it now at the state level and at

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1 the national level. So there are some mechanisms to
2 begin to gather that data right now.

3 MS. SCOFIELD: Okay.

4 CHAIRMAN BURKE: Any additional questions
5 for Mr. Nixon? I know he devoted a fair amount of time,
6 but I think it's an important case study, so we
7 appreciate you sharing that with us.

8 And I think we'll move on to the next Agenda
9 item. We have a little bit of clean up to do in the
10 recommendations in the first section of Local Public
11 Health Capacity, Services and Quality, in particular
12 Item Nos. 4, 6 and 7.

13 Just to give a reference of time here, it's
14 2:10, and we can try to move through these four items
15 just as quickly as we can.

16 So if we can start with Jurisdictional
17 Structural, which is a nice kind of lead in of what Mr.
18 Nixon shared with us.

19 And just also add a note here on the phone,
20 try to reiterate this at the beginning of meetings, but
21 somebody's placed their line on hold, so make sure that
22 people place us on mute in the future, rather than on
23 hold, so if we can all get by the wireless EKG we'll be
24 okay.

25 So with that being said, Nos. 4, 6 and 7 in

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1 the Recommendations. No. 4, of course, deals with an
2 accreditation issue; No. 6, is improvement standards
3 recorded through the Ohio Department of Health on a
4 profile performance database, which is a platform for
5 the minimum package and updating that capability from
6 time-to-time; and then No. 7 deals with the Ohio
7 Association of Health Commissioners, and their laws and
8 regulations dealing with mandates and other types of
9 items that don't align with the minimum package of
10 public health services.

11 I don't know if anybody has any discussion
12 on these. I know they're maturing issues and I
13 apologize about the delay in getting through them in the
14 previous meeting, but if there's anybody with any
15 comments, and, of course, we can always circle back as
16 well, there's a survey out there, and this will start to
17 gel up once we get through these sections in the future
18 meetings, so --

19 MS. EDWARDS: Senator Burke, if we can go to
20 4.

21 CHAIRMAN BURKE: Sure.

22 MS. EDWARDS: Now, as time goes on I kind of
23 think about some of this and some of the things that
24 have been said in maybe the first meeting and how
25 they've come out, should become eligible. I'm not sure

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1 what that means, should become eligible.

2 When I think about accreditation, and I
3 asked this question at the first meeting, does that mean
4 that if I'm not accredited, that if Ashland County is
5 not accredited that we have jeopardy of funding in the
6 future? I'm not sure, so what does that mean?

7 I'm not sure every county needs to be
8 accredited. I definitely believe the state needs to be
9 accredited, but unless that -- and this is something I
10 said before, unless that changes our outcomes, if it
11 makes our outcomes better within each community then why
12 do we need to spend the money to be accredited; can
13 somebody answer those questions?

14 MR. NIXON: I think just to speak for the
15 Futures Committee, we've debated the issue of
16 accreditation, whether every health department should be
17 accredited, and we didn't go there.

18 So we backed off that a little bit, and said
19 every health department ought to meet the standard of
20 accreditation, yet not necessarily have to be
21 accredited.

22 I think one of the limitations on every
23 health department becoming accredited is the cost to
24 apply for accreditation.

25 We applied for accreditation, and I think

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1 it's costing us \$30,000, which is a lot of money to pay
2 for accreditation.

3 So I think overall for the State of Ohio,
4 for all of the health departments to become accredited
5 we've estimated that it costs about two and a quarter
6 million dollars in Ohio for all of the health
7 departments to be accredited, and I think that's a
8 barrier that we ought to think about.

9 If that is the standard, how do we pay for
10 that accreditation in Ohio?

11 MS. EDWARDS: Well, then that leads to my
12 next question, then who -- if they should be eligible
13 who watches that; who covers that; who takes care, who
14 makes sure that Holmes County or Morrow County or any
15 county falls within those guidelines?

16 MR. NIXON: Well, there is an accreditation
17 process in Ohio, so there is a -- which mirrors the PHAB
18 standard, accreditation standard. So, you know, you
19 could suggest that that acts as a -- involves an
20 accreditation process, but I think it falls short.

21 I think that accreditation is what it is,
22 it's accreditation through PHAB, and I think at some
23 point as a state we need to get health departments
24 eligible, and not just eligible, but accredited.

25 MS. EDWARDS: How do we rank our health

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1 department now; is there a standard to rank them? I
2 just don't know.

3 MR. NIXON: No.

4 MS. EDWARDS: There's not?

5 MR. NIXON: No.

6 MS. EDWARDS: Okay. So I guess in my simple
7 mind here, I'm thinking right off the bat, wouldn't that
8 be better to have that first, and then work down the
9 road? I don't know.

10 MR. NIXON: I think it's a question of
11 capacity to be accredited, to even apply for
12 accreditation.

13 CHAIRMAN BURKE: I guess just to clarify, to
14 build on the Commissioner's point and to wrap this into
15 No. 7 where you're also advocating for elimination of
16 mandates, which is kind of a paradoxical as we move
17 forward, Joe, I think you had pulled up states parallel
18 performance type of standards.

19 To go back where the committee originally
20 talked about and when they formulated this
21 recommendation, are they looking for just a set of
22 standards, is that what the outcry is here, some kind of
23 universal state standard that health districts can be
24 judged by; is that --

25 MR. NIXON: Well, I think the accreditation

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1 process was vetted nationally. It took, I don't know
2 how many years, five, ten years maybe to get to this
3 accreditation standard, and it encompasses all of those
4 four foundational capabilities that health departments
5 ought to have to meet the public health requirements in
6 their community, and that would be epidemiology, the
7 assessment, the priority development, the information
8 systems and so forth, to be able to even begin to do
9 what we think is truly a fundamental responsibility.

10 So accreditation is the packaging of those
11 capabilities for everybody, and I think that if you're
12 going to have a standard and if you're going to say
13 health departments ought to be doing something, this
14 defines what that something is in the State of Ohio.

15 Absence of that, I think it's just you've
16 got a mishmash, which exists in Ohio now.

17 MR. JACOBS: Is that to say, Gene, or
18 anybody else in the group, that this accreditation
19 standard is meant to be a minimum standard?

20 Because I think that's kind of what the
21 struggle is, holding people to a minimum standard of
22 what local health should look like, versus a silver
23 standard, versus a gold standard, and so I think that
24 there's some -- a mix-up of what this accreditation
25 actually does and means as far as what kind of standard

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1 -- we want to hold local public health to a gold
2 standard.

3 However, I think we have to concede the fact
4 that not all local health departments or local
5 jurisdictions are going to be able to meet what a gold
6 standard -- like for funding, for lack of capacity, for
7 lack of people served, so I think that, you know, is
8 this accreditation truly meant to be a minimum standard,
9 and I don't know the answer, but I would argue that's
10 probably not in the way we see minimum standards. I
11 don't know.

12 MR. INGRAM: I would just -- the current
13 Ohio Department of Health local health district
14 performance standards that we certify at the end of the
15 year is a self-reporting mechanism. Okay. There is no
16 third party review, it's self-reporting today.

17 The national accreditation standards that
18 Gene was speaking about has been an evolution of trying
19 to create minimum standards, which would create -- in
20 which today some health districts could not meet,
21 because there's not adequate capacity in the system to
22 do so.

23 So by adopting the national standards would
24 help lead a funder, if you're funding an entity, why
25 would you want to fund someone who would not be

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1 accredited in the future, could not be accredited? I
2 mean why would you put your money in them, I guess, just
3 like in a hospital, or so forth, if they're not JCAHO
4 certified?

5 So I guess what I -- it's about creating
6 some consistency and some -- across the public health
7 system to eliminate some variability to improve and
8 enhance capacity, and I would say, you know,
9 professional capacity.

10 CHAIRMAN BURKE: And those standards are on
11 the website, is there a quick link so we don't have to
12 hunt for them that you can put them somewhere in an
13 e-mail that's just a click, that way I'm not delving
14 through a vicious site tree of mayhem?

15 MR. MAZZOLA: The link to the PHAB standards
16 is on the committee's website. This is the private
17 database that ODH administers for, as Mr. Ingram talked
18 about, when the health departments do submit their
19 reports, their self-assessments based on those PHAB
20 standards.

21 So we have this information available, I do
22 want to be sensitive. I don't want to just pull
23 information up, because there are individual reports
24 within this system.

25 I'm happy to demonstrate the system at the

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1 discretion of the committee, but this is the system that
2 houses it, but this is not on the public website.

3 DR. MCFADDEN: Is there a way to give access
4 to just one county? Like if I were to say that the
5 board can have access to Holmes County so they can see
6 what it looks like, would that be able to be distributed
7 to folks; could you distribute that just to the folks
8 that are --

9 MR. MAZZOLA: Yeah, and I could show that
10 right now, I could show a particular health department
11 right now, if that were the discretion of the committee,
12 but I could make that available.

13 DR. MCFADDEN: We're Holmes, we're not going
14 to be green in everything, I can tell you that right
15 now. I'd also be okay if you gave them access to our
16 data so they can go in and just see how that's done, I
17 would not have a problem with that.

18 CHAIRMAN BURKE: I don't want to bring it --

19 VICE-CHAIRMAN PRESS: So, Joe, you're
20 bringing that up, do I understand -- do I understand
21 this exchange to be that the health districts fill out
22 an annual certification of some kind, but then that's
23 not public information?

24 MR. NIXON: It is public information.

25 VICE-CHAIRMAN PRESS: It is public, it's

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1 just not on the website, right?

2 MR. MAZZOLA: Correct.

3 DR. MCFADDEN: I have some concerns about
4 the minimum standard, as we've stated, and I think I
5 would share the concerns of those that have the most
6 concerns about an accreditation board would be this
7 train is rolling out of the station, it's down the path,
8 we realize where things are going, and I think the
9 concern is that as we mandate, you know, if we mandate
10 accreditation, one, the cost isn't just the cost of the,
11 you know, \$2.5 million to apply, the cost is also, I
12 think, hasn't been fully understood here, the intense
13 person hours that it takes to get to that, and, of
14 course, you talked about capacity.

15 My concern continues to be that the
16 communities that stand to be penalized the most, if we
17 set up this, you know, you are funded if you're
18 accredited, you are not funded if you are not in our
19 rural communities, again, in my opinion, in my opinion.

20 And so I think that we are setting ourselves
21 up to have a system similar to our -- how we fund
22 schools in which poor rural communities have -- now are
23 looking to suffer, because they're not getting funded,
24 because of accreditation, and, you know, I think then
25 that people say that drives them then to join with other

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1 communities, but the problem comes when they're
2 surrounded by other poor rural communities, as some
3 sections in our state are.

4 We need to be a little bit cognizant of the
5 fact that we might be having a disparity of health in
6 our state that we are creating, if we're not cognizant.

7 CHAIRMAN BURKE: And I had the same thought,
8 I think this kind of came up in the last meeting, are
9 you identifying strengths and weaknesses, and is the
10 goal to reward strengths or to identify weaknesses as
11 hot spots and try to address those hot spots, and is
12 that actually a disadvantage to actually being
13 accredited or vice versa?

14 So, yeah, I understand exactly what you're
15 talking about, because the weak would get weaker, if
16 accreditation is going to be the formula for success.

17 MS. EDWARDS: It's kind of like going from a
18 Focus to a Cadillac. You know, I can afford to drive a
19 Focus, I can afford the maintenance, I can afford the
20 gas, I can afford all that now, but you're expecting me
21 to drive a Cadillac, and how am I going to be able to
22 afford that?

23 COMMISSIONER SHAPIRO: But if you use a
24 system of trying to improve quality, and by measuring
25 where you are and whether you have yellow, orange, red,

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1 whatever, you see where the deficiencies are, and then
2 maybe you can get those deficiencies up to where you're
3 no longer in a Focus, but you're in a Taurus.

4 MS. EDWARDS: Okay. And I would agree with
5 that.

6 COMMISSIONER SHAPIRO: And we all rise and
7 we all grow together, rather than a competition, and I
8 think that is some of the discussion here is who's
9 eligible now, but that doesn't mean that Holmes County,
10 well, they might have, frankly, Delaware does too,
11 because we have not focused on those areas.

12 Now, once we've found what they are we're
13 putting some resources and energy into making sure that
14 we do come into compliance.

15 And, again, for some communities, I'm not
16 going to pick one, but in Appalachia, their deficiencies
17 may be more significant, because they truly don't have
18 the resources, but, again, there could be a model to
19 help them.

20 I'm probably the only one who remembers,
21 maybe there's a few in here as old as me, but -- that
22 have been around, but where we did have it in the old
23 days with a system of peer review.

24 It only lasted for a couple of years, but it
25 was an opportunity for peer health commissioners and

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1 ancillary other staff, high level, to go into another
2 department, measure against standards that weren't that
3 good at the time, but they were still there, and see
4 whether or not -- and then offer suggestions, we shared
5 resources, we helped each other to boost up a little
6 bit.

7 It was more programmatic than the PHAB
8 standards are. I don't know if other systems have used
9 that, I'm sure in hospital systems where we have
10 collaboration and partnership and management contracts,
11 I'm sure there's a system so that you're -- for example,
12 Ohio Health, they're helping the Morrow County Hospital
13 meet those standards by having an Ohio Health expertise
14 in there.

15 VICE-CHAIRMAN PRESS: To be honest, that's
16 why I'm trying to listen very carefully to this
17 conversation, put my hospital hat on, we're licensed by
18 the Ohio Department of Health and subject to licensure,
19 inspections and violations and compliance, most folks
20 would probably be joint commission accredited, so we go
21 through that process, but then beyond that, you know,
22 some laboratories are licensed -- accredited by ISO,
23 pharmacies are subject to -- we ended up, all the
24 regulators one day it was 400 and something when you
25 counted the FDA, you counted -- so the idea that outside

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1 observation of the processes doesn't make you better, I
2 just can't get there, I mean we would be a much lesser
3 organization, a much lesser industry, if we didn't have
4 -- now, I would say maybe 400 is a little excessive.

5 But for those folks having expectations of
6 us, you know, I don't think we would be as good, so I
7 hear the quandary about, you know, searching for what's
8 -- where is the minimum standard?

9 What I'm trying to glean out of this
10 conversation, is there a minimum standard that exists
11 today in the groups trying to renegotiate where that
12 minimum is or is there no minimum standard today and
13 we're trying to assert accreditation or eligibility,
14 whether those boards are carefully chosen.

15 Eligibility for accreditation is some kind
16 of -- I don't know whether it's a minimum standard or
17 voluntary standard or what, that's why I'm trying to
18 kind of listen towards.

19 CHAIRMAN BURKE: If I could add to that, I
20 mean you've got two tracks. You could say that you want
21 a hundred and twenty-five health districts and we're
22 going to improve each one, or we're going to measure all
23 of our health districts and see where the best outcomes
24 or the weakest outcomes are at, focus on those weak
25 outcomes and figure out how we can improve them, which

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1 may mean you're not that capable of delivering public
2 health.

3 I think a mother who happens to live on one
4 side of the county line or another doesn't care who
5 those magic lines are that deliver those immunizations,
6 as long as they get delivered.

7 And if this side of the county line does it
8 better than this side of the county line in moving --
9 she doesn't care where that county line is at, her kids
10 just need immunized.

11 So, again, going back to just this
12 simplistic point of view, if you're going to use this to
13 measure how health is delivered in the State of Ohio
14 holistically, and then structure whatever those lines
15 are around those measurements, then I think there's some
16 value in looking at this, not with the intent of
17 improving a hundred and twenty-five health districts,
18 but improving the entire health care system, which may
19 mean the state needs to adapt how health districts look.

20 MS. SCOFIELD: I would say, if I could
21 quickly, I think you're right, I think it doesn't
22 necessarily matter which side of the county line the
23 services come from, and I don't know if having a
24 regional health department in Appalachia would be less
25 effective or not depending on how it -- where the

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1 facilities are and how it's set up.

2 I don't know, I don't know what kind of
3 analyses has been done or comparison has been done to
4 see if that kind of system works, but I think somewhere
5 in here we need to -- need to look at how we incentivize
6 accreditation, I think that's very important.

7 I think we should be looking at minimum
8 requirements for each public health department or
9 district in the state, that they need to meet within a
10 certain amount of time, and maybe that those incentives
11 come in training, in providing resources to help
12 departments do all of that very labor intensive work to
13 get that done.

14 And then I think, you know, as a result of
15 all of that, you know, can we provide some incentives
16 for mergers or regionalization where it makes sense?

17 And so instead of just saying we're not --
18 we're not going to look at that, I think it has to be
19 part of the conversation, and I think a lot of it comes
20 in providing that technical assistance, whether it's
21 from the state, whether it's from academia, you know,
22 however that looks.

23 VICE-CHAIRMAN PRESS: So I'm not trying to
24 put words in your mouth, Jen, so you're saying
25 incentivize certain behaviors or maybe said another way,

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1 create some minimum standards, and then give people ways
2 to waive out of them, if there's a real hardship.

3 Where I don't want to see us end up is,
4 because of Appalachia, and I went to school in
5 Appalachia, I went to OU, I know what it looks like down
6 there, it's a very different place, but to gear the
7 entire state around southeast Ohio, I'm not sure that's
8 going to work either anymore than it would work to
9 impose Cleveland on Athens.

10 So the question would be, can we design
11 something and let people check off, if they've really
12 demonstrated difficulty or sound basis to not meet the
13 minimum standard for accreditation?

14 MS. SCHOFIELD: And I understand that, I
15 guess my thought would be, I would want my local public
16 health agency to meet those minimum requirements.

17 So I have some concern with giving it out,
18 if you can't -- if you don't have the capacity to
19 provide those, that would be my concern, no matter where
20 I lived.

21 CHAIRMAN BURKE: Well, and I would want them
22 to meet that as well, but that may involve a
23 consolidation.

24 MS. SCOFIELD: Right, and that's -- I mean
25 if -- if that's where that -- this process of assessment

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1 leads a community then, yes, I think that needs to be a
2 viable solution.

3 MR. NIXON: If I could put a caveat in
4 there, I think the PHAB standards allow for some joint
5 application.

6 So while, you know, council of governments,
7 there's some across jurisdictional sharing arrangements,
8 you can still meet those standards short of
9 consolidation, so wouldn't have to mandate it, can be a
10 gap to consolidate it, and I think our flow chart kind
11 of allows for some of that.

12 So there's some ways to do it short of
13 consolidation to meet the accreditation standards.

14 CHAIRMAN BURKE: And I'm probably phasing
15 into the next subject area, but just to ask a question,
16 there's been a lot of talk about the number of health
17 districts here in the State of Ohio, and is that number
18 correct, and if you went down the path of accreditation
19 are you in essence solidifying the number of 125 as the
20 correct number?

21 DR. MCFADDEN: You could, if that's what you
22 said, it's possible that we could get there and end this
23 process and with 125.

24 MR. NIXON: I don't think that will happen.

25 MR. INGRAM: I would disagree with Dr.

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1 McFadden, I don't see that happening. I don't think we
2 can do this and end up at a hundred and twenty-five.

3 MR. NIXON: I think it's possible, I don't
4 think you can.

5 MR. INGRAM: I'm just looking with five
6 inside my own county knowing the varying capacities,
7 working in a rural county prior to an urban county,
8 understanding the dynamics and so forth, I think we're
9 just kidding ourselves.

10 The last thing I would hate to see come out
11 of this is that we waste more time and money.

12 MR. NIXON: But I think the process pushes
13 us towards consolidation, pushes us towards cross
14 jurisdictional sharing, our councils, governance or
15 other mechanisms.

16 I don't think it mandates -- this doesn't
17 mandate a hundred and twenty-five to 88 or to 50 or to a
18 hundred and ten, it says regardless of the size of the
19 health department or how you're recognized you will
20 provide the core services, okay, and measured by -- it
21 was measured by your eligibility for accreditation.

22 If we agree on that then health departments
23 are going to have to find some way to meet that. Right
24 now I don't think a lot of them will be able to meet it
25 independently, so something will have to change.

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1 CHAIRMAN BURKE: So what happens to the
2 health district that doesn't meet them?

3 MR. NIXON: If they don't meet the
4 standards, if they're eligible then I think that what
5 this suggests is that you take a look at -- you take a
6 look at consolidation, and consolidation may or may not
7 work, because of politics, geography, for a lot of
8 reasons, it may not work in a particular community.

9 If it's not going to work for any of those
10 kind of reasons, and this doesn't say, you shall
11 regardless, it says then you better take a look at some
12 of these other arrangements that we suggested, cross
13 jurisdictional sharing, you know, contracting for I.T.
14 or some of these other arrangements, and see if that
15 can't work, then you go back and see if you're eligible,
16 but you can't just say, well, we're not eligible, so
17 that's the way we're going to be.

18 We're saying you need to move towards the
19 eligibility.

20 CHAIRMAN BURKE: So what's the carrot and
21 the stick?

22 MR. NIXON: Well, that's where we get down
23 into some of these --

24 CHAIRMAN BURKE: I'm with you, I'm just
25 asking, tough question, if that is a health district,

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1 what are we in the long run going to do to force
2 improvement?

3 DR. MCFADDEN: Well, I just want to make
4 sure that I understand the record, what Commissioner
5 Ingram and Nixon, I think, are saying.

6 What I'm hearing both of you saying is that,
7 you know, we go with PHAB as a standard, and as a result
8 we are going to force those communities, that health
9 district that cannot meet to go away or consolidate,
10 that's from where I sit, and I think where some of the
11 others that have concerns across the state, that's what
12 they hear you saying.

13 So for me, it would be helpful to have a
14 little bit better clarification, because that's the
15 message that I'm hearing, is that we need PHAB to set
16 the standard, if you can't meet this, you're not a
17 health district until you do something different, that's
18 what I hear.

19 MR. INGRAM: Well, that's partially what I
20 said, the big piece that was not said that I assumed was
21 in that statement is financing. You can't -- PHAB is a
22 way of improving financing of local health departments
23 through accreditation.

24 Funders are going to look at this at some
25 point, I really believe this, that you will not be

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1 eligible for CDC grants or Robert Wood Johnson
2 Foundation grants or Kellogg Foundation grants and so
3 forth without being a PHAB certified health department,
4 you're going to be out of the game for funding.

5 So I am saying, that is the issue, if we
6 want to improve financing the health departments we have
7 to get PHAB certified. We can't go knocking on the
8 state, albeit the moneys are way too little today,
9 that's why we're kind of in this quandary we're in, I
10 believe, partially, partially.

11 So financing is the -- the verb, if you
12 will, or -- or maybe it's a noun, but whatever it is,
13 that should be in that statement, and I would agree with
14 you.

15 MS. EDWARDS: So if I've got a levy, the
16 county has a levy, and -- Ashland County, we've got a
17 levy for outside of the city, and then the city pays a
18 portion, they pay about half, and then I don't know how
19 much we get from the state, and if that money, the
20 funding meets what they want, what they need, then what
21 kind of carrot do you have? Am I not following?

22 MR. INGRAM: Well --

23 MS. EDWARDS: Who -- who holds that? I
24 don't understand.

25 COMMISSIONER INGRAM: I think what's been

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1 missing here, that I haven't heard and it's not really
2 in my -- I don't think it's my place to bring this on
3 the table, what is the current status of local public
4 health today in Ohio? That should come from our
5 Department of Health.

6 Are you satisfied? Do we have a great local
7 health system and we should just close our books and go
8 home, or is there something else that we need to talk
9 about?

10 That is not for me to discuss, because I'm
11 just one little microcosm in part of the state from what
12 I perceive and what I see happening, and I've already
13 talked about the changing in the health care system, and
14 how I feel we should be better aligned with that, but
15 that's separate, that will happen, I trust, in all good
16 time.

17 COMMISSIONER SHAPIRO: But I think the
18 mechanisms of the major issue is the disparities in
19 public health services in Ohio.

20 You have communities where you have
21 excellent public health services and that may be whether
22 it's a moderately funded health department or it just
23 depends on the staff, the qualifications of staff and
24 the capabilities that that group has, and a lot of it
25 depends -- but a lot of it depends on funding, Delaware

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1 County is very, very lucky that we have a supportive
2 levy.

3 If we didn't have that levy and that
4 funding, there are so many things we couldn't do. I can
5 go to my board of health and say for the benefit of our
6 community we really need to tackle chronic diseases, and
7 they say, go ahead, Nancy, go do that.

8 And we're building, I just had a call from
9 United Way today, wants us to lead the Hunger Discussion
10 Bill for the county and food pantry issues, distribution
11 of food in the community, because we have -- we're
12 beginning to get that reputation of somebody that's
13 saying, we're going to deal with these issues and tackle
14 them, but that's because we have local funding.

15 Our funding from the state non-categorical,
16 non-grant, non-pass through is minuscule, it doesn't
17 cover the salary of one of our secretaries. That is our
18 state subsidy money, doesn't do it. So if you're a
19 health deputy like I think -- do you have a levy?

20 MR. NIXON: No.

21 COMMISSIONER SHAPIRO: So he's working
22 totally on inside millage from the townships and what
23 the cities give him, and in our case the only inside
24 millage we receive from our township is to pay for our
25 building, because the county doesn't house us.

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1 So we need to first rent, and then we're
2 going to end up buying a building, and the township
3 supported us doing that. So that is the support that
4 they give us, and that's it.

5 The rest of it comes from voted millage, and
6 if the voters don't like what we're doing, because we're
7 regulating them, that money is in jeopardy.

8 So we have a very fragmented financing
9 system, and I think a lot of that has to do with the
10 disparity that's been created, that one side of
11 Cleveland has a 25 year life expectancy than the other
12 side, because of where you live, that shouldn't happen
13 in this state.

14 MS. FOUGHT: And I would tag on to that,
15 Nancy, because I think when the question was asked, Mr.
16 Chairman, about the carrot and the stick, really your
17 carrot and stick is money in today's age, I mean,
18 especially coming from the state.

19 Okay. But as was pointed out, it's
20 minuscule in certain areas, but in those more rural
21 areas it's huge to them, because they don't have the
22 levy, and if you're going -- I mean, I like what you
23 said, I mean, the fragmented system of financing,
24 because, you know, the haves and have nots, you know,
25 the levy funded counties, the non-levy funded counties,

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1 how are those non-levy funded counties supposed to pass
2 a levy, i.e., Monroe County, and I don't know if Monroe
3 County has one, so I shouldn't say that, but, you know,
4 the poorer counties, they don't have the millage, guys.

5 I mean they'd have to pass like a 5, 10 mill
6 levy just to get enough money, so that -- that is the
7 disparity, or you're going to go back and take more
8 money out of the general funds of those entities that
9 are supporting it, and then where does that leave those
10 entities who need that general fund to sustain their
11 other operations?

12 So I think that that question is the real
13 question that I don't know if we -- if we want to tackle
14 it, but I think that's really the question that needs to
15 be tackled before we talk about some of these other
16 things, but --

17 MS. SCOFIELD: I would say I think that does
18 beg the question of how public health -- it gets back to
19 the fundamental question of why we're here.

20 How is it organized and how is it supported
21 across the state, and it's not necessarily equitable,
22 because of the variance we have across the state.

23 So not only do we have to decide what local
24 public health agencies have to provide and at what level
25 and what quality, but where does the other support come

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1 from?

2 I mean that's a big part of this question,
3 what is the role of ODH and other state agencies to
4 support public health? How does that tie into federal
5 funding; what are we getting? I think we're what 49 out
6 of 50, the amount of money we get from --

7 MS. EDWARDS: CDC, 50.

8 MS. SCOFIELD: Yeah, so we don't bring in
9 the funds that we could and should be doing, so how does
10 that all play out? I think we have to look at those, you
11 know, ask and answer those questions as well.

12 COMMISSIONER SHAPIRO: Higher in HRSA
13 funding.

14 MR. TREMMEL: Let me get maybe a little bit
15 on the soapbox from the ODH side for just a moment here.

16 The beautiful thing about public health in
17 Ohio is that while we have a lot of disparity, public
18 health jurisdictional issues and problems, the beautiful
19 thing is that even some of the smaller health
20 departments, couple of staff, do the best they can with
21 what they have to get something done, could be just
22 vital statistics, could be just immunization.

23 On the other hand, today's day and age, and
24 I think many of us around this room, and within the
25 totality of this room agree, this dynamic has changed.

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1 There needs to be a better, more
2 comprehensive array, platform, core, minimum package,
3 you know, we're throwing a lot of words and phrases at
4 it, but there needs to be a more basic structured public
5 health set of deliverables at every place within the
6 State of Ohio at this -- at this point in our history of
7 public health and our history of governance. I think we
8 can all agree to that.

9 The disconnect we find in this patchwork
10 quilt of public health is that we have, again, some of
11 the larger health districts that do this remarkably
12 well, because of the funding, and we have some of these
13 others, based on geographic location of this state,
14 based on the lack of federal funds, possibly, and we can
15 argue and we have stated, the lack of the state
16 investment in public health.

17 These are all collisions along this process
18 that makes the public health system very disconnected
19 and very different in Ohio.

20 We couple this with some jurisdictions,
21 because we allow this under law, we allow small health
22 departments to exist based on the models you saw there,
23 you can look at your leisure, the pins and otherwise, if
24 you're a jurisdiction, a city of 5,000 or more, and you
25 decide for the betterment of your community that you

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1 want a local health department, you can have one, and we
2 have little to say about that, unless you were to ask us
3 today to form a local health department.

4 We would likely have some amount of
5 conversation, what would you do, because you need
6 mandated programs like the food, environmental programs,
7 schools, campgrounds, et cetera, inspection programs,
8 and by the statistics, so we would probably likely say,
9 the efficiencies are not worth the while for the state,
10 nor worthy, but we still have the grandfathering of the
11 number of these jurisdictions who have these.

12 It becomes a difficult conversation for the
13 state to say to the health districts based on size,
14 geography or whatever, you have these, now we're going
15 to take them way.

16 My suspicion is that if the state were to do
17 that the smaller jurisdiction that has a vital statistic
18 program that's supporting 60, 80, a hundred thousand in
19 their revenue, that does the best it can to support a
20 staffer or two, if the state were to come in and remove
21 that that would probably be the end of the jurisdiction
22 there.

23 For the same argument, the mandated programs
24 of environmental health that the state would come in and
25 say the mandated programs of inspections on all the

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1 eastside were to be taken away, because they belong to a
2 larger jurisdiction, that would probably answer the
3 question.

4 I don't know that in this journey we are at
5 that place, but that surely is a remedy. Accreditation
6 gets talked again and talked about, and those swear by
7 it and those swear at it. At the end of the day
8 accreditation does provide a measure.

9 It does provide that good housekeeping seal
10 of approval that you've come to a department for
11 services that meets this -- some could call it a
12 baseline, some could call it a ceiling, whether you're
13 talking the floor or the ceiling, it's immaterial, it
14 does give you assurances that the public health services
15 that you are about to receive have been reviewed by an
16 independent third party to have all value and
17 consideration to meet that whatever standard.

18 I don't know, and I don't suppose that that
19 means anything necessarily, back to your point,
20 Commissioner Edwards, that everyone must go through it,
21 because the state has available a mirrored image of
22 those standards that, as Commissioner Ingram mentioned,
23 are self-reporting. The problem with self-reporting is
24 it's self-reporting.

25 So to Nancy Shapiro's point, there was a

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1 time when the state engaged local health commissioners
2 to be a part of a peer review model to which you went
3 around to other parts of the state, or maybe you were in
4 your same district, as I'm recalling, so I think that
5 based on the five districts you kind of played in that
6 neighborhood and you encouraged and got -- so maybe
7 there's a mechanism to look at those same domains, those
8 same public health standards, but assurance, maybe more
9 assurance, maybe more oversight that we're getting and
10 achieving those based on a peer review.

11 And beyond a peer review model you can go
12 through PHAB accreditation, maybe you don't need to do
13 peer review at all, but self-reporting has its
14 limitations, because it's self-reporting.

15 Mr. Mazzola can show you any number of
16 examples of small health departments and large health
17 departments that say they're on the continuum of great
18 -- doing things, that I suppose if we went there today
19 or tomorrow may not necessarily legitimize -- be
20 legitimate.

21 Having said all of that, the things that we
22 will struggle with, and the thing that needs to be, and
23 I think we continue to dip our toe in the water, we jump
24 back out, we dip our toe in the water, we jump back out,
25 is what does this baseline look like? What are the core

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1 minimums that a health department must show and must
2 accomplish and must accommodate, if we cared?

3 And assuming we care and want to do
4 something about it that's one thing, but caring and
5 wanting to do something about it is only half the
6 equation; who is going to pay for it?

7 If my county, my jurisdiction, my whatever,
8 my community likes what we have very well, and thanks
9 very much, leave me alone, because you are not making
10 the investment in my county to do anything about it,
11 that's shown by the will.

12 On the other hand, this theory and logic of
13 these kinds of conversations gets us to a different
14 place you will and you shall and because you must, we
15 can have that conversation, the next part of it becomes,
16 so how many should there be, because as the pins will
17 show and the map shows, that Hamilton County, having
18 five health departments and one jurisdiction beg the
19 question, isn't that just too many?

20 And I'm not picking on my good colleagues
21 that are health commissioners and health departments in
22 Hamilton County, it's an excellent example as there are
23 many others in northeast Ohio faced with small staff,
24 less than a \$500,000 budget doing the best they can for
25 what they're trying to do and what does that equation

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1 look like?

2 We can do the division all day, we can do
3 the subtraction all day, but we do have, Mr. Chairman,
4 Mr. Vice-Chairman, we do have some difficulty, and I
5 think we're going to have to, as we can, drive through
6 this process or beg these questions, and tease out these
7 issues so we can come up with some rational perspective,
8 maybe somewhat irrational, but we need a perspective.
9 We need a three to five to seven year map to come to
10 some realignment, because it will at the end of the day.

11 The State of Ohio is a decentralized system,
12 we know that, it's a decentralized public health system.
13 There are other states that have more health departments
14 than us, not many -- who was it that knows; who knows,
15 Massachusetts has 350, but anyway just -- just to sum
16 this up, this is the difficulty we find ourselves and we
17 will make possibly a better opportunity for larger
18 funding, but that's not necessarily in local health,
19 right, that's largely dependent on the interaction
20 between local and state health.

21 DR. MCFADDEN: And I think you raise a
22 question about financial, we've talked about that too.
23 It's hard -- I think it's hard to say to, you know, a
24 county, Holmes County, for example, where we receive a
25 significant portion from the inside millage, we receive

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1 generous amounts from the commissioners for our housing
2 and we receive a significant amount of our budget from
3 our fees.

4 To say to Holmes County residents, this is
5 the funding structure, but, you know, local is paying
6 for public health in Holmes County, not in totality, but
7 the vast majority is from local, but the state is going
8 to change that to improve your standard of living, and,
9 you know, no more new money is coming to you.

10 You all still pay for the benefit to form a
11 council of government with Wayne County or to
12 consolidate with Tuscarawas County, thanks very much.

13 I mean I really, for me, I would love to
14 see, you know, this is pie in the sky, but I would love
15 to see the state have more skin in this game
16 financially, because in the report it's clear, I mean,
17 the locals -- the local citizens pay the bulk of what we
18 do.

19 MR. TREMMEL: Right.

20 DR. MCFADDEN: And I would have less of a
21 sense of angst about the whole thing, if I felt like
22 there's going to be, you know, the state's going to have
23 to hold us more accountable at local, and is also going
24 to say, and we're also spending more money, rather than
25 saying, we're holding you more accountable, and if you

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1 can't meet this, if you can't get a Cadillac, you can't
2 even buy gas. You know, your money is not good here.
3 We won't give you gas, because you don't have a
4 Cadillac.

5 I'd like to see, you know, another way of
6 looking at it, I mean, that I think is going to be the
7 hardest piece of what we do.

8 I understand why the accreditation is, you
9 know, set as a standard, I get that. I, me, personally,
10 I need assurances that communities are not going to be
11 required to foot the bill and be penalized when they
12 can't make that capacity.

13 MR. TREMMEL: Well said.

14 COMMISSIONER EDWARDS: Question, to go to
15 what you're saying also, I'm going to pay the same
16 amount, and if I'm -- if I own a restaurant, if I'm a
17 mom and I've got two kids, am I still going to go and
18 get my shots; am I still going to get my restaurant; is
19 the restaurant still going to get the inspection; is
20 that inspection going to change today, because I don't
21 have accreditation; is it going to be some new form or
22 something different two years from now when I do have
23 accreditation?

24 So from the local person, from the local
25 resident's perspective who cares whether you're

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1 accredited or not? I don't care, my kids still got
2 their shots, they're still going to school. I can eat
3 at Bob Evans, and it's fine. Who cares whether you're
4 accredited or not.

5 CHAIRMAN BURKE: We're approaching 3:00 and
6 I know that Vice-Chairman hopefully will stay on board
7 after this next meeting with the volume of things to be
8 continued, because there's still going to be obviously
9 governmental, jurisdictional, as well as financing,
10 which seems to be tying together, but I just want to, as
11 we look ahead, because hopefully towards the end of --
12 and prior to the next meeting you'll fill out the
13 survey, that will give you time to digest the financing,
14 so you'll hopefully at least be mentally through all
15 three sections, and then we can start a consolidation
16 process at the next meeting after finance is discussed.

17 But just remind folks that as we open this
18 process there's policy, there's legislation and there's
19 finance, and I ask you to think of those three things,
20 and also ask you to think as we move through this
21 process what that goal is and that goal might be
22 measured in years, and so what we roll out may just be
23 -- I mean just making this up, a system of measurement,
24 right, we would like less health districts, but we don't
25 know which health districts to get rid of to improve

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1 public health, so how do we go about doing that?

2 And we don't have to be overly prescriptive,
3 because this is going to be a recommendation to the
4 General Assembly who will draft legislation in concert
5 with the administration to achieve an outcome that will
6 end up in rules and go through another legislative
7 process called JCARR, so that this is -- you don't have
8 to be down to the infinitesimal clerical level, so
9 please think macro, think what your goal is.

10 We can, again, just lay a re-convenance of
11 this same body at some unknown date, and come back and
12 continue to move this ball forward.

13 We don't have to hit a home run, if we get
14 to first base, I think that's more than has been done in
15 decades, so just ask you to keep that in mind that the
16 world's problems will probably not get solved by this
17 committee, but if we can solve a couple of them, and
18 start a process that leads to an end goal, then, again,
19 I'd say we've done more than most others before us.

20 So in the interest of time, I know we're
21 approaching 3:00, if anyone wishes, we could continue
22 this discussion, or our Vice-Chair, if he is willing to
23 accommodate clean-up on this issue, and then, of course,
24 finance.

25 VICE-CHAIRMAN PRESS: If they have another

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1 15 minutes.

2 CHAIRMAN BURKE: D.J. does have an
3 engagement, but if somebody would -- is the group open
4 for another 15 minutes of conversation, you want to do a
5 little clean up here?

6 I promised I'd keep you till 3:00, so just
7 allocate another 15 minutes and continue this or
8 wherever anybody wishes to jump back in the
9 jurisdictional discussions, accreditation discussions.

10 MR. NIXON: I was going to say, I think,
11 Marty, you were really piquing some of my memories at
12 Futures Committees, because we struggled at times with
13 do we give a number of health departments, how do we
14 recommend where we want to end up?

15 And I think you really struggle with that
16 and finally came out with the eligibility for
17 accreditation as the bottom line standard.

18 Part of the struggle with the dollars and
19 how to pay for all of this, there was some assumption a
20 year ago, as we did this process, that there wasn't
21 going to be a lot of money flowing into local health
22 departments, and somehow local health departments had to
23 develop the strategies to at the same time meet the
24 standards, so how do we do this, and we felt that some
25 of these other models might help them join with their

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1 neighbors in making that happen.

2 But we weren't ones to dictate which
3 neighbors they should work with, because frankly as it
4 may look good on a map to cluster these health
5 departments, those don't get along, but these over here
6 do, so we wanted to leave some of that strategizing to
7 the local health departments in those particular regions
8 based on who they're comfortable with, who they work
9 well with, where their strengths are in that part of the
10 state.

11 I wanted to make a comment about
12 accreditation, because we're talking a lot about
13 accreditation as a standard.

14 You know to apply for accreditation health
15 departments have to, you know, have done a strategic
16 plan, you know, have done a community assessment, and to
17 do a community health improvement plan, you know,
18 fundamentally I think that's what health departments
19 should be doing.

20 But it's not all that you have the bells or
21 whistles or you don't, it's a lot of that, are you
22 sharing with the community; are you engaging the
23 community in the process and it's a hard process.

24 We went through it and it took us eight
25 months of intensive work, some 300 documents had to be

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1 submitted, which goes way beyond the state's
2 self-reporting, which you can do pretty much in a few
3 days.

4 You know, this is a really intensive
5 process, and when you've been through it, you've been
6 through it, but it's also truly a process that
7 identifies for you, as a health department, where you
8 need work, where you need to be better engaged in the
9 community, where you need to be doing some better
10 quality assessment within your agency and engaging
11 staff, communicating, and those weaknesses come out, and
12 you find those and you have to adjust to do that.

13 I can say that after going through the
14 process we're a better agency for it, okay, and we met
15 most of those standards, but we learned a lot, and I
16 think that's what it's all about.

17 It's not just do you meet it or do you not,
18 it's a process, and I stand behind the accreditation as
19 a standard, and I think we have to fundamentally decide
20 does Ohio need a standard or not? And if it needs a
21 standard, I think this meets that definition.

22 COMMISSIONER EDWARDS: Let me ask a question
23 of Chris, does any of this duplicate what the hospitals
24 do?

25 VICE-CHAIRMAN PRESS: Under the Affordable

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1 Care Act hospitals are required to do a Community Health
2 Assessment, and I think do what I hear referred to as a
3 Community Health Improvement Plan.

4 Now, the rules -- that's in the statute, the
5 rules have not been written around how you do that. You
6 have to do it every three years, if you don't do it
7 you're subject to a \$50,000 fine, but that's about all
8 we know right now.

9 There's no standard for -- there's no
10 regulation around, well, the assessment has to
11 contemplate this or the assessment has to contemplate
12 that.

13 Now, what's unclear to me, or what -- I can
14 tell you a little story, what we did in Hancock County,
15 not to burden everybody with that, but in our situation
16 we knew that the law required us to conduct a health
17 assessment.

18 We knew that we had conducted them in the
19 past, it's a variation of a strategic plan in its own
20 right. I mean as a strategic plan you'll be out looking
21 at what your constituents need, so that's kind of a part
22 of what the Community Health Assessment is.

23 But we also knew that the United Way was
24 thinking of doing one and the other community
25 foundation, and they were thinking of doing one, and

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1 then we knew that the health department, at least it
2 sort of kicked the tires on doing something like that.

3 So we're fortunate enough, we're a small
4 enough community, we all see each other often enough, if
5 we could sit down with each other and say that doesn't
6 make any sense, there's no way we're doing three or four
7 community health assessments, because that wouldn't be
8 -- first of all, it wouldn't be cost effective; second,
9 we would be debating the findings of the surveys, which
10 probably were going to be materially the same, but
11 different, right, so we'd be trying to reconcile all
12 those, well, how hungry are people; how fat are people?
13 Doesn't matter, you either have those problems or you
14 don't.

15 And now ultimately we have to decide what is
16 it that you want to do, and my strong bias was it was
17 blessed and we shared, you know, the problems that we
18 are confronted with are difficult problems, and the easy
19 ones have already been solved, so now we're left with
20 the hard ones.

21 Well, the hard ones are resilient,
22 resistant, and so fixing them takes focused energy for
23 each of us -- take just those four agencies.

24 Let's say we have a hundred thousand
25 dollars, which we don't, but let's just say that, well,

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1 if we spent \$25,000 on each of four different problems,
2 I don't think that's going to create any change in the
3 public health status or any change in community health,
4 but if we all could agree to focus on a couple of --
5 maybe one problem, and put a hundred thousand dollars
6 against that problem I think we'd tend to see that
7 you're going to get more of a change in the outcomes.

8 So we kind of joined forces, we did the
9 Community Health Assessment together, we sort of
10 narrowed our focus to some things around obesity, and a
11 couple of other problems, because those predict all
12 kinds of other problems, particularly around diabetes,
13 just all kinds of other things happening as a result of
14 that.

15 So it's a long answer to a short question,
16 your question was, do these things duplicate?

17 My answer is they could, but they don't have
18 to, because by having a community health department,
19 local health department being required to -- you have to
20 look at the verb, conduct or have, a Community Health
21 Needs Assessment, there's nothing that should stop them
22 from wanting to unite with other agencies in the
23 community to formulate that.

24 Whether they're the first author or the
25 hospital's the first author or a big medical practice in

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1 town is the first author or the school system is the
2 first author, to me makes no difference, the question is
3 do you have a Community Health Needs Assessment so that
4 the agencies that are accountable to the public have a
5 conversation with the public around what those needs
6 are, and they're trying to follow, at least as best they
7 can, some rational plan, some evidence based approach to
8 try to solve one or several problems that that community
9 agrees are important.

10 I wouldn't know what the problems are in
11 Summit County, and wouldn't expect them to know in
12 Hancock or Hamilton or Cuyahoga County.

13 So I see this as a way to get -- I don't see
14 this as duplication. I see it as trying to create an
15 alignment between different agencies in the community so
16 that they're all trying to drive to the same place.

17 And I'm going to agree with Commissioner
18 Nixon, I think from what I got so far, eligibility for
19 accreditation, not accreditation, but eligibility for
20 accreditation, three standards, you've got to have a
21 Community Health Assessment, an Improvement Plan and a
22 Strategic Plan.

23 I guess my question would be, why wouldn't a
24 health department, I wish D.J. were still here, why
25 wouldn't a health department want to have those things

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1 anyway?

2 I know they're not necessarily expensive
3 things to have, not necessarily, I see your head, Tim,
4 but, you know --

5 COMMISSIONER SHAPIRO: Depends how you do
6 it.

7 VICE-CHAIRMAN PRESS: Yeah, but you can get
8 the local university to help you with your Strategic
9 Plan, and there's people who do pro bono work, so I mean
10 it's not impossible, didn't say it's easy, but it's not
11 impossible, so that's kind of where I'm at.

12 CHAIRMAN BURKE: Topic point we'll have, as
13 this process matures, Mr. Nixon brought forward, I
14 didn't see any cattle prod hits on anybody, that seemed
15 to be a point of -- somewhat of agreement.

16 So if you went down that path, and go back
17 to the question in structure and governance, do you
18 reward success or do you identify weakness and try to
19 strengthen it?

20 And I liken this to schools, I'm going to
21 kind of work this into the funding, and do a punt to the
22 next meeting for you, if you had a community that had a
23 strong levy potential and you were going to keep state
24 funding the same, does the state still give you money or
25 does it address it to a weaker, lower millage potential

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1 county or health district in order to help address their
2 cause, if so, and that county is weak, what are we
3 paying for, and how do we assess then your inability to
4 reach that standard and when do we start removing your
5 justification to do inspections and to do these other
6 kinds of things, and start some kind of collaborative or
7 consolidated process on that county, because they've
8 gone, like a school, onto academic watch and eventually
9 it's a state takeover?

10 It's a wide door to walk through and it kind
11 of leaves us open to the next meeting. I mean I think
12 those are things to think about, if we're going to
13 develop a carrot and a stick, if we're going to talk
14 about hot spots and how to address them to move public
15 health up in the state --

16 MR. JACOBS: Well, if I can just talk about
17 the stick for a minute, because I think that one thing
18 that, you know, if we're going to use this PHAB standard
19 as this minimum standard that we're going to use for
20 local health districts to become eligible, if you will,
21 I guess my concern is if we have something different
22 than that, something different than PHAB, some sort of
23 where they had to meet the eligibility requirements, if
24 ODH is the fox, or, you know, if they're going to be
25 watching the hen house, I guess I have concerns about or

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1 worried about local health departments being consistent,
2 and that's part of the issue that's driving this, but
3 frankly I'm finding inconsistencies in how ODH is
4 applying their -- their already set in place standards
5 for environmental health programs.

6 I mean I've been to three different counties
7 and I've seen it done frankly three different ways. And
8 it's very subjective, and so even if there's criteria
9 that are set forth there's -- we have to be careful
10 about how we're -- how we're going to measure these
11 things, because unless there's somebody watching --
12 somebody needs to be watching ODH watching other people,
13 if that's going to be the case, because it's dangerous
14 to put all the cards, you're talking about employment,
15 you're talking about peoples' lives, peoples'
16 livelihood, ultimately health outcomes, are they
17 improving, but there's got to be some mechanism in
18 place, if we're not going to use PHAB, and I'm not
19 advocating one way or the other at this point, but if
20 we're not going to use PHAB some other sort of minimum
21 standard as far as eligibility goes.

22 There's got to be mechanisms in place to
23 account for accountability from the state's standpoint,
24 if they're going to be the ones that are going to be
25 making those determinations as to whether you're meeting

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1 it or not.

2 And, frankly, PHAB is kind of scary too,
3 because while they have everything set in stone, and we
4 haven't been through accreditation where I'm at right
5 now, we're in the process of doing it, but I wonder how
6 subjective is that, and just one sign of the pen could
7 lead to your demise, and that's kind of scary.

8 And maybe it's necessary as far as whether
9 the services and the outcomes are going to be improved,
10 but that's just -- it just seems a little scary to have
11 all of the power in one entity's hand as to whether or
12 not the health district is going to survive or not.

13 CHAIRMAN BURKE: Well, now a question on
14 accreditation, how long does this accreditation last; is
15 that an annual, biannual, tri-annual process?

16 COMMISSIONER NIXON: Once you pass
17 eligibility, once you get accredited, you're accredited
18 for five years, but each year you have to do an update
19 on how's your -- you know, improving some of those
20 quality assurance areas, if there's weaknesses and so
21 forth, so you update it each year, but you don't have to
22 go through the whole blown thing, but once every five
23 years.

24 CHAIRMAN BURKE: And if anybody isn't
25 accredited, what happens, they have to restart the whole

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1 process all over again?

2 COMMISSIONER NIXON: I think you can apply
3 within the year.

4 COMMISSIONER INGRAM: I think that's right,
5 you get an opportunity to reapply.

6 MR. NIXON: You can reapply.

7 MR. TREMMEL: Just let me add for the
8 purposes of your point, Mr. Chairman, and Lucas,
9 accreditation is a new conversation in public health.

10 The Mahoning County Health District that we
11 saw previously was the beta test, there were only a
12 handful in the nation. The Ohio Department of Health
13 was a beta test, only one of eight or twelve in the
14 nation, so this is a new conversation.

15 There aren't accredited public health
16 departments running around the country. It's new, it's
17 novel, it's unique, and some folk's argument, well
18 placed and needed.

19 Mr. Jacobs brings up an excellent point, the
20 Ohio Department of Health needs to be a part of the
21 conversation about consistency, because the Ohio
22 Department of Health is on its journey and path to
23 accreditation, the Health Assessment is complete, the
24 Health Improvement Plan is complete, we are now in the
25 final stages of this Strategic Plan.

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1 Now, imagine all of the documentation that
2 will be necessary for the Ohio Department of Health in
3 the coming weeks and months to go through the
4 accreditation, imagine ODH becomes accredited, we will
5 and we hope that we would become accredited, that does
6 not for one moment speak to the consistencies or the
7 inconsistencies about measures or opinions or decisions
8 that are going to affect the mandated program, it just
9 doesn't, those two don't -- those two aren't synonymous.

10 So one of the considerations of this group
11 might be, ought to be, what is the Ohio Department of
12 Health, which is a state mandated environmental health
13 program, what is the Ohio Department of Health going to
14 do to manage its consistent message, so its
15 applicability from the smallest to the largest and
16 anyone in between is measured similar?

17 It's going to be very difficult, because I
18 think Commissioner Ingram said this at one of the very
19 first meetings, and I think it bears repeating again and
20 again, capacity, small health districts just will not,
21 cannot have complete capacity, might do a great job in
22 immunization, best job in immunization maybe in all of
23 the state with the nurse and the process for which they
24 give that vaccine for that child, food borne outbreak
25 involving 50, 75, 200 folks, very difficult, very, very

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1 difficult, H1N1 events wrapping up large clinics, mass
2 vaccinations, probably not going to happen.

3 In fact, I can say that with some amount of
4 confidence, in that here, some of the health districts
5 here saw that first -- first blush and first impression,
6 because some of our colleagues could not set up mass
7 vaccination clinics, they relied upon you.

8 CHAIRMAN BURKE: Well, there's 15 minutes.
9 Mr. Vice-Chairman, I don't think we solved everything so
10 your next meeting should be engaging. We do appreciate
11 everybody's time.

12 The next meeting is August 28th, I'll make
13 sure and I'll request that the Minutes and other related
14 material be posted 24 hours, if not more, prior to that
15 meeting so that this body can digest that information.

16 I'll remind you again of your survey,
17 electronically, on paper, however, you get it to us, we
18 can condense that.

19 I believe Mr. Nixon is the last of our
20 presenters, so we're starting to enter the brass tack
21 phase as we work through this and try to stay focused on
22 what we believe achievable and appreciate the
23 Vice-Chair's willingness to take over in my absence and
24 the time that all of you have spent thus far. So with
25 that --

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1 COMMISSIONER INGRAM: Mr. Chairman, did you
2 want the survey sent back to Mr. Press or to you, sir?

3 CHAIRMAN BURKE: Either way, if you'd like
4 to send it to my Senate --

5 COMMISSIONER SHAPIRO: Do you want us to do
6 it on-line?

7 VICE-CHAIRMAN PRESS: I think you might want
8 to send it to the Secretary for tabulation; is that
9 okay?

10 MR. NIXON: You said that's going to be
11 on-line?

12 CHAIRMAN BURKE: It is going to be.

13 MR. TREMMEL: Well, it may be.

14 CHAIRMAN BURKE: We can do it by e-mail, and
15 you can respond by fax to my Senate office or to the
16 Director's office.

17 COMMISSIONER INGRAM: Just so we're clear
18 where we want to send them, so we don't have them all
19 over, and it's just the people at this table that are on
20 the committee, I should say.

21 CHAIRMAN BURKE: Just the members of this
22 committee, okay, and I just request it by the next
23 meeting. Now, you won't see these tabulations for the
24 next meeting, it'll be the following meeting, but either
25 way, my office or to Mr. Tremmel's office, we'll get

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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 August 14, 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 22nd day of August, 2012.

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

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