



Present via audio link:

19 Jim Adams  
20 Kim Cupp  
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21 Bridgett Harrison  
Representative Nickie Antonio, Commission Member  
22 Dr. Michael Thomas

3

1 AGENDA

3 Welcome

4 \* Chair, Senator David Burke

5 \* Vice-Chair, Christopher E. Press

6 Approval of July 24 and 31 Meeting Summary Notes

7 Survey of Committee

8 Presentation: Gene Nixon, Health Commissioner  
Summit County Public Health

9 Discussion and Review of Recommendations

10 \* Local Public Health Capacity, Services and  
11 Quality

12 \* Jurisdictional Structure

13 Next Meeting August 28, 2012

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4 CHAIRMAN BURKE: Okay. We'll go ahead and  
5 get this started with the August 14th meeting of the  
6 Legislative Committee of Public Health Futures.

20 Excellent, we'll roll judicially on with  
21 the business, as we mentioned in the last meeting,  
22 hopefully you folks have had time to digest a couple of  
23 Minutes here. First, the Minutes of the July 24th  
24 meeting, with that being said, do we have a motion to

25 approve those July 24th Minutes?

5

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?

24 MS. SHAPIRO:

25 it's page 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.

9 MR. TREMMEL: 00022, Line?

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

20 MS. SHAPIRO: Okay. And then one  
21 other change, it's page 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,

7

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.

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.

8

9

5 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 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.

10

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.

19 MR. MAZZOLA:

11

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 --  
11           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 100K 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.

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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.

14

1                   MR. NIXON: All right. Thank you, Mr.  
2           Chairman. 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.

15

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..

16

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



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 programmatically  
17 compatible the two agencies or three agencies were.

19

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

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 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.

21

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;

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.

22

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.

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.

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2 Technologically we had two different  
3 systems, three different systems, which created  
4 challenges to get everybody on-line.

18 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  
24  
1 the costs were consistent for other communities.

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.

25  
1 One year later it was -- the savings to them  
2 was 1.3 million less than that cost that we determined  
3 for the city.

5 MR. TREMMEL: Let me clarify, just in  
6 staffing or were there other overhead expenses?

7 MR. NIXON: Well, obviously mostly staff,  
8 there were some savings, and some of that I will say  
9 when we did the consolidation in numbers it was based on  
10 everybody coming over. A few people chose not to come  
11 over and retired at that point, or took a leave from the  
12 organization.

19 MR. INGRAM: Yeah, that -- the City of Akron  
20 was paying \$17 million a year previously when they had  
21 their own health department; is that the right number?

22 MR. NIXON: Yes. Now, that was 6 million or  
23 so in general revenue support, the 17 million included  
24 all the grants and all the fees and so forth.

25 MR. INGRAM: Okay. So what -- what's the

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1 contribution today to Summit County?

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.

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8 CHAIRMAN BURKE:

14 can you talk

15 a little bit about the drivers that made this occur.

17 what happened to

18 make this possible?

19 MR. NIXON:

13                   So 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?

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1                   MR. NIXON:  
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.

20                   CHAIRMAN BURKE:  Just my final question,  
21     have you seen any changes in health outcome?

25                   MR. NIXON:

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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.

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.

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.

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.

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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?

11                   MR. NIXON:

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.

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



17 we can approach our job.

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1 MS. FOUGHT:  
2 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?

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.

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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.

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.

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:

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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.

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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.

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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?

12 MR. NIXON:

16 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.

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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.

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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?

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:  
25 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?

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.

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23 MS. SCOFIELD:

25 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

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9 CHAIRMAN BURKE:

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

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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.

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

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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?

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:

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?

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.

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 --

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1 process was vetted nationally.

3 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.

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, 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: 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. 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.

60

5                   So I guess - 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.

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  
18 when the health departments do submit their  
19 reports, their self-assessments based on those PHAB  
20 standards.

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13 DR. MCFADDEN: We're Holmes, we're not going  
14 to be green in everything  
15 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.

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

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.

23 MS. 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,

1 whatever, you see where the deficiencies are, and then  
2 maybe you can get those deficiencies up

6 MS. 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

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

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

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6 bit.

7 It was more programmatic than the PHAB  
8 standards are.

15 VICE CHAIRMAN PRESS:

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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.

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?

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 any more 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. SCOFIELD: 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.

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

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,

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?

25                   COMMISSIONER INGRAM: I think what's been

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?



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 MS. 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.

14 MR. TREMMEL:

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.

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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.

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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.

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5 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.

19 , 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,  
6 -- 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.

25 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,

12 On the other hand,  
13 these kinds of conversations gets us to a different  
14 place 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?

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.

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.

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



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.

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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 3000 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.

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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 <sup>99</sup>  
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 - there 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.



24 CHAIRMAN BURKE: And if anybody isn't  
25 accredited, what happens, they have to restart the whole  
1 process all over again? 101

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

7 MR. TREMMEL: Just let me add for the  
8 purposes of your point, Mr. Chairman, and Luke,  
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.

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 has 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

1           difficult, H1N1 events wrapping up large clinics, mass

2 vaccinations, probably not going to happen.

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.

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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 --

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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1 these together then for the next meeting ahead of time,

2 so everybody can review them and get a sense of those  
3 recommendations.

4                   Okay. With that, I appreciate your time,  
5 again, and we are adjourned. Thank you.

6                   (Thereupon the Committee Meeting was  
7 adjourned at 3:21 p.m.)