

BEFORE THE LEGISLATIVE COMMITTEE  
ON PUBLIC HEALTH FUTURES

- - -

Tuesday, August 28, 2012  
1:03 p.m.

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Ohio Department of Health  
35 East Chestnut Street  
Lower Level, Training Room A  
Columbus, Ohio 43215

- - -

DEPOSITION SPECIALISTS, INC.  
35 East Gay Street, Suite 300  
Columbus, Ohio 43215  
(614) 221-4034

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## APPEARANCES:

Commissioner Martin Tremmel, Secretary

Commissioner Nancy Shapiro

Commissioner Jennifer Wentzel

Commissioner Christopher E. Press, Vice-Chair

Commissioner D.J. McFadden, M.D.

Commissioner Gene Nixon

Commissioner Tim Ingram

Commissioner Kim Edwards

Representative Lynn Wachtmann

Jennifer Scofield

Walter Threlfall

Joe Russell

Heidi Fought

Joe Mazzola, IT

Melissa Bacon

## VIA VIDEO TELECONFERENCE:

Kristen Hildreth  
Senator Capri Cafaro  
Michael Thomas  
Terry Allen  
Kathy Luhn  
Tim Tegge  
Stephanie Branco  
Kelly Smith

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1 Tuesday Afternoon Session  
2 August 28, 2012  
3 1:03 p.m.

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5 P R O C E E D I N G S

6 - - -

7 VICE CHAIR PRESS: Those of you on  
8 the phone my name is Chris Press. And  
9 Senator Burke has chosen to entrust this meeting  
10 to me. I believe he is hobnobbing with the  
11 Republicans in Florida, if I understand correctly.  
12 So we hope he is having a safe and reasonably dry  
13 trip. And we will welcome him back in two weeks.

14 I hope you all will be gentle with  
15 me in this capacity. We have a reasonably full  
16 agenda today. And we'll take some time to go  
17 through that.

18 Everybody have an agenda before  
19 them?

20 A couple housekeeping items. Of  
21 course we have the Cafe, which is closed  
22 momentarily. So if you need a bite to eat there  
23 is that. Restroom's nearby for those of you that  
24 need those.

25 I'm told Dr. Winslow is on his  
way.

1                   And Dr. Winslow is here. We  
2 welcome him.

3                   So today's discussion is going to  
4 be around three things, which are related. I've  
5 given this some thought. We are, of course, going  
6 to stick with our work product that comes from the  
7 Commissioners. Today try to look at three  
8 different areas, capacity, quality and services,  
9 jurisdictional structure, and financing. And all  
10 three of those things are related.

11                   By necessity we've tried to tackle  
12 these issues topically. We deal with one subject,  
13 and then we come try to come to a resolution on  
14 that. And we go to the next subject and try to  
15 come to some resolution on that.

16                   But really in a sense, that is --  
17 this is a mechanism that can be related -- all the  
18 issues are related. And it is not really possible  
19 to separate one from the other.

20                   If we're going to talk about  
21 capacity, or we're going to talk about minimum  
22 level of services, or we are going to talk about  
23 ways to gain efficiency out of the system, all  
24 three of those things are discrete subjects of  
25 themselves, but they're also inseparable from each

1 other, as well as from the subject of financing.  
2 So financing is probably going to be part of the  
3 heavy lifting we're going to have to give some  
4 consideration to. And we'll start that process.

5 Just bear in mind some of the  
6 facts and the things that we'll have to give  
7 warrant to our consideration with -- last  
8 biennium. And there are others here more expert  
9 than I.

10 Last biennium we had a State  
11 headed certificate that was a statement of facts.  
12 And that is just was it is, statement of facts.

13 And part of that remediation of  
14 that deficit came from one time Federal funds.  
15 And I'm not going to -- it's just a statement of  
16 facts. The availability of those one-time funds  
17 in the event of a second -- another biennium  
18 budget, we can't foretell.

19 So this is a difficult financial  
20 environment for all of us. So how we approach  
21 these problems and how we create flexibility in  
22 the system so that when people are trying to be  
23 good stewards of their scarce resources they have  
24 the flexibility to do that, just to local demands  
25 and needs. I think that is part of a challenge in

1 front of us.

2 So I'm glad everybody is here. We  
3 have a good group today. And I think we'll make  
4 some progress on those issues.

5 I'll ask if there is anybody on  
6 the telephone who needs to be introduced?

7 Joe, I believe you have a line-up  
8 for us there; do you not?

9 MR. MAZZOLA: We do. They may not  
10 be on the web, but we do have some folks on the  
11 line that can introduce themselves.

12 And folks are logged in to the  
13 web. I'll make sure that we tell you who that is,  
14 as well.

15 VICE CHAIR PRESS: That would be  
16 great.

17 On the telephone, who is with us  
18 today?

19 SENATOR CAFARO: This is  
20 Senator Cafaro.

21 DR. THOMAS: This is  
22 Dr. Mike Thomas, from the University of  
23 Cincinnati.

24 If you guys could just speak up  
25 just a little bit.

1 MR. ALLEN: This is Terry Allen,  
2 Cuyahoga County Board of Health.

3 MS. SMITH: Kelly Smith, with  
4 State Rep. Nickie Antonio's Office.

5 VICE CHAIR PRESS: Great.

6 MR. TEGGE: This is Tim Tegge,  
7 with NALBOH.

8 MS. BRANCO: This is Stephanie  
9 Branco, also with NALBOH.

10 MS. LUHN: Kathy Luhn, Allen  
11 County Health Department.

12 MR. MAZZOLA: And  
13 Kristen Hildreth, are you with us from Medina  
14 County?

15 MS. HILDRETH: I am, but I was  
16 eating my lunch at the same time. So I'm sorry.

17 MR. MAZZOLA: Thank you.

18 VICE CHAIR PRESS: A reminder to  
19 those of you on the telephone, evidently when you  
20 put us on hold we get some lovely music. We can't  
21 necessarily hear others on the phone. So as a  
22 reminder, if you have to excuse yourself from the  
23 phone, if you can set your handset down and mute  
24 it, that would be helpful for the rest of us.

25 Any other welcomes or

1 introductions that we have this morning?

2 Does that conclude it.

3 DR. WINSLOW: Well, I certainly  
4 would welcome the group here, and state that as  
5 has been quoted recently and multiple times,  
6 "these are the best of times, these are the worst  
7 of times." And we need to experience them  
8 together. Isn't that wonderful?

9 So I welcome you all here to try  
10 to go through what I perceive as opportunity, but  
11 it also challenges.

12 And we at the Ohio Department of  
13 Health, just like you at the local level, every  
14 day struggle with this, with how do we do the best  
15 job as possible with the resources we have  
16 available to us.

17 I just wanted to share with you a  
18 couple of tid bits of information you may want to  
19 know.

20 One is today we're happy to add to  
21 our rank Melissa Bacon, who is joining me as our  
22 Chief Policy Advisor here for the Ohio Department  
23 of Health. So Melissa comes to us through the  
24 Governor's Office with a wealth of experience in  
25 legislature and community, knows Ohio well, and

1 will serve, I think, well as a Policy Advisor. It  
2 was a position we didn't have filled, but needed  
3 to have in the past, and we've experience for  
4 about a year and-a-half a desire for that to  
5 occur. So she was kind enough to accept our  
6 invitation.

7 So thank you for coming and  
8 joining us here.

9 And you'll have interface with her  
10 as we move forward.

11 The second bit of information:  
12 Part of the best of times, the worst of times  
13 thing is that we're going to have change in  
14 leadership at the executive level. And that is  
15 that Steve Worman [phonetic] has announced that he  
16 will be resigning from the position as Chief  
17 Operating Officer effective September 7th. So he  
18 will be with us for the next two weeks.

19 Now, I gave him the weekend to  
20 reconsider. I've given him many other  
21 opportunities to reconsider. And I want to tell  
22 you that there's no one I'd rather work with  
23 day-in and day-out, Steve Worman, here at the Ohio  
24 Department of Health, and also all of you as a  
25 local health department, as well. And that

1 friendship and that relationship will continue  
2 strong as you move into the private sector to  
3 resume some activities out there in the private  
4 community that will relate to healthcare.

5 So we'll looking forward to those  
6 opportunities to interface with him more in a  
7 public and private manner in the future.

8 But I can assure you he lives,  
9 breathes, and walks public health every day of his  
10 life, caring for our needs, and the future changes  
11 that we need to carry that forward.

12 So it's been a very important part  
13 of my first year-and-a-half here as Director, I'm  
14 going to miss him dearly; but those things do  
15 happen, as you all know. They say if you say that  
16 it's innovation, you have to always say that it is  
17 also disruptive.

18 So I think we are innovating all  
19 over the place and I'm feeling disruptive right  
20 now. But I want to tell you we're moving into a  
21 very healthy direction with Steve's assistance.  
22 He has kindly agreed to help us in the transition  
23 so that we can all end up in as good a place as  
24 possible. But he will be sorely missed, I assure  
25 you.

1                   With that mixed information, I'll  
2                   turn it back over to our Chairperson.

3                   Thank you.

4                   VICE CHAIR PRESS: Thank you.

5                   Anything for you to say  
6                   (indicating)?

7                   SECRETARY TREMMEL: No, sir.

8                   VICE CHAIR PRESS: All right.  
9                   Everyone has had an opportunity to receive the  
10                  minutes of the summary notes, I guess minutes of  
11                  the August 14th meeting.

12                  I'd be happy to read them in their  
13                  entirety for the group or we can entertain a  
14                  motion to approve them or amend them.

15                  COMMISSIONER NIXON: Move to  
16                  approve.

17                  VICE CHAIR PRESS: We have a  
18                  motion to approve.

19                  Is there a second?

20                  COMMISSIONER WENTZEL: Second.

21                  VICE CHAIR PRESS: Is there any  
22                  discussion or corrections for the minutes?

23                  - - -

24                  Thereupon, no response was had at  
25                  approximately 1:13 p.m.

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VICE CHAIR PRESS: All in favor,  
sign by "aye."

- - -

Thereupon, responses were had at  
approximately 1:14 p.m.

- - -

VICE CHAIR PRESS: All opposed,  
like sign.

- - -

Thereupon, no response was had at  
approximately 1:14 p.m.

- - -

VICE CHAIR PRESS: All right.  
Everyone has had a copy of a  
survey sent to them from Senator Burke's office.  
And how many replies do we have,  
Lindsey?

MS. ENGLISH: I've got eight.

VICE CHAIR PRESS: Terrific.  
So we have eight responses to  
that.

And Senator Burke's hope was that  
we could use that today as an opportunity for  
folks to turn that in, if that's what they wished

1 to do, or they could e-mail them or fax them into  
2 Lindsey's office.

3 Lindsey, is there anything you  
4 want to make the group aware of so far?

5 MS. ENGLISH: I guess the only  
6 thing is -- and I apologize if this was not clear  
7 in the directions. But for those of you who have  
8 yet to turn them in or are re-doing some things, I  
9 would ask that you rank all of the  
10 recommendations.

11 I know some people did their top  
12 ten. And that is absolutely fine. You're more  
13 than welcome to leave it if that's what you wish.

14 But we did want you to rank all of  
15 the recommendations based on their importance to  
16 you, not necessarily if you agree with them or  
17 not.

18 Mr. Press, you and I talked about  
19 this.

20 VICE CHAIR PRESS: I just want to  
21 make sure everybody kind of answers them the same  
22 way.

23 But go ahead. Continue, please.

24 MS. ENGLISH: So if you could base  
25 those recommendations again on the report to you,

1 that would be wonderful.

2 But again, if you guys have any  
3 other questions, you know, feel free to grab me  
4 after the meeting today. I'm also available by  
5 phone or by e-mail.

6 But thank you for all of those who  
7 have turned them in. It's been very helpful.  
8 Appreciate it.

9 Thank you, Chair Press.

10 VICE CHAIR PRESS: You're welcome.

11 So just as a clarifying point, as  
12 you're looking at the responses, the ranking is  
13 around the importance of that particular issue to  
14 the discussion. Ten means you highly agree, and  
15 one means you highly disagree with whatever  
16 recommendation. We're trying to figure out which  
17 issues we want to get in the room that people feel  
18 strongly to work through.

19 Everyone good?

20 All right. And then your hope,  
21 Lindsey, is to get those all in and tabulated for  
22 us to bring next time?

23 MS. ENGLISH: That is correct.

24 VICE CHAIR PRESS: All right.

25 Mr. Tremmel, you have an interesting archival

1 historical note.

2 SECRETARY TREMMEL: We do.

3 In addition to the '60s version of  
4 the assessment of public health and the time, we  
5 also have the '93 version, more recent version.  
6 And Mr. Mazzola has this up on the website. He  
7 has it pulled up there for you (indicating).

8 So I do call your attention to the  
9 '93 version, as well.

10 I think I heard a number of folks  
11 that have read both versions. And one thing that  
12 has been suggested is we take two or three things  
13 from the '60s, two or three things from the '90s,  
14 and one or two from here. Then our work is pretty  
15 much done.

16 But the issues are the same. The  
17 issues on local funding, governance, structure,  
18 are rather consistent.

19 So I do encourage all of you to  
20 revisit the '90s's version, especially the middle  
21 sections. Some of that information is sort of  
22 detailed.

23 Thank you, Joe, and Tom, and  
24 others for pulling that up.

25 VICE CHAIR PRESS: And that's on

1 the website for this task force, right, for this?

2 MR. MAZZOLA: It is.

3 VICE CHAIR PRESS: And I believe  
4 it is Chairman Senator Burke's hope in the next  
5 meeting or so to begin to identify those areas  
6 where we're beginning to draft up some of the  
7 recommendations so that might go forward.

8 So I don't know the precise legal  
9 scope, whether we're bound to just the documents  
10 we were given, or whether it's tongue and cheek  
11 that we're given, or half serious.

12 SECRETARY TREMMEL: Half serious.

13 We have the opportunity to take  
14 the recommendations of the Association and its  
15 HPIO report. And we can modify that and really  
16 take a look at it.

17 I think 50 years of this  
18 conversation is sufficient. And I think there is  
19 a teaching point and opportunity to review and  
20 encourage maybe a couple of points, especially  
21 those that have been consistent for this period of  
22 time.

23 COMMISSIONER MCFADDEN: This is a  
24 point of information.

25 One of the items that led to the

1 discussion that ultimately I think brought us here  
2 today is a conversation that we have had Northeast  
3 about this document probably two years ago in just  
4 asking the question where we are today, why the  
5 recommendations that were in '93 we haven't done  
6 anything with.

7 And so that is just a point of  
8 information. I mean, that started as a small  
9 conversation, which got larger and is much bigger.  
10 But I would say that is one of the things I think  
11 has ultimately led us here today, I think.

12 SECRETARY TREMMEL: And I would  
13 say that a couple of issues that are in '93 have  
14 been addressed.

15 I do take, for example, the one  
16 that struck me square was the IT issue.

17 And from that we have the topic,  
18 which is the new version of the IT shared systems  
19 with local health departments.

20 Impact Assist is an excellent  
21 example, because the concerns in the '90s of how  
22 do we track. And this is very disjointed. So we  
23 have a structure and capacity to do that that has  
24 been developed over the last probably 10 or 12  
25 years, or so.

1 COMMISSIONER NIXON: That may have  
2 been from the Five Point Plan, the data.

3 SECRETARY TREMMEL: Okay. Well,  
4 it's in here, as well (indicating).

5 DR. WINSLOW: I saw Mo Momlet  
6 [phonetic] the other day. I said, this is 20  
7 years ahead of everybody. And so it may be that  
8 some of this is just coming around to actually  
9 being put in place.

10 SECRETARY TREMMEL: I think ODRS  
11 is another system that we use. I mentioned Impact  
12 Assist, that's where it came from. ODRS is  
13 tracking a lot of surveillance. I think there has  
14 been a couple of things. And there are things  
15 out -- it raises the question about are there  
16 other 10, 15 other things that could be, should be  
17 re-visited.

18 VICE CHAIR PRESS: Any other  
19 comments before we -- we have no presentation  
20 today, so we actually have to work on stuff. So  
21 shall we?

22 All right. Very good.

23 First up on the list is capacity,  
24 services and quality.

25 I'll just take everybody to our

1 recommendations sections and the associated  
2 documents. And I'll try to watch the clock so  
3 that we balance our time between these topics, but  
4 invite others to help in that cause.

5 So --

6 SECRETARY TREMMEL: I think we  
7 have remaining 4, 6, and 7.

8 I think what we had at our last  
9 meeting was a fairly robust conversation,  
10 especially on 4, some of 6.

11 And so, Mr. Vice Chairman, I do  
12 suggest with your consideration whether you want  
13 to revisit 6 or not.

14 And then I think 7 might be --

15 VICE CHAIR PRESS: Let's start  
16 with 7 and then if we slip back to 6 we can do  
17 that, but in the interest of time, trying to keep  
18 us moving forward.

19 SECRETARY TREMMEL: So this would  
20 be the unfunded mandate issue conversation.

21 COMMISSIONER INGRAM:  
22 Mr. Chairman?

23 VICE CHAIR PRESS: Please.

24 COMMISSIONER INGRAM: I believe  
25 all these points are in certa. And we have ranked

1           them individually, presuming we filled out our  
2           survey.

3                           Is there something that  
4           Senator Burke or you are looking for in addition  
5           to what the survey ranking will show when it's  
6           disclosed?

7                           VICE CHAIR PRESS: I think the  
8           goal would be to get some discussion today around  
9           these. Then when we get the survey results we'll  
10          know where to put the emphasis on the remaining  
11          time to really focus on driving toward more  
12          clarity.

13                          COMMISSIONER INGRAM: My only  
14          point is that if some of these come ranked low by  
15          the majority of the group, we probably would  
16          never -- I mean, we're spending that time now. We  
17          don't know actually where everybody is till we see  
18          the survey results.

19                          That is my opinion.

20                          VICE CHAIR PRESS: Timing risk, I  
21          guess.

22                          COMMISSIONER SHAPIRO: I just  
23          think this discussion has helped clarify some  
24          issues and some questions of those that are not in  
25          the public health system to help understand where

1 the basis for conversation, what the complexity of  
2 the issues are. So I think there is some value to  
3 discuss, with some brevity, maybe.

4 COMMISSIONER WENTZEL: And, folks,  
5 present some examples.

6 Obviously, the group that  
7 pre-empted this must have thought there were some  
8 things that would be prudent from, I'm supposing  
9 regulations or statutes.

10 Were there ideas that were  
11 discussed at the time from those who were part of  
12 this process?

13 COMMISSIONER NIXON: I think it is  
14 a general statement.

15 There has been work I think, that  
16 has gone on in the last year to take a look at  
17 some of the projects that are mandated for local  
18 health departments. Many of those revolve around  
19 environmental health, some data should be mandated  
20 appropriate for local health departments, or not.

21 I think as we assume that we're  
22 driven toward more efficiency and the best use of  
23 the hours that we have, we ought to assure that  
24 what is mandated is, aligned with those core  
25 performance standards and those programs that we

1 outlined.

2 So I think it is a general state  
3 to assure that what we do makes sense, that it  
4 fits with our core responsibilities, and we're not  
5 doing some things that by convenience health  
6 departments are doing just because there is nobody  
7 else really to put it with.

8 So I think some of that has begun.  
9 And I think there has been some movement in that  
10 direction in the last year, with the Mobile Home  
11 Park Program and some other things that we have  
12 taken a look at.

13 So I think that is the intent of  
14 doing what we should be doing, the burden with  
15 things, particularly for health departments.

16 COMMISSIONER EDWARDS: If I could  
17 comment and maybe look at another area.

18 As I look at the package, under  
19 public -- other public health services I see  
20 specific maternal and child health programs with  
21 Help Me Grow and BCMH.

22 Particularly BCMH, I'll point to  
23 that one first.

24 If this falls under other public  
25 health services, and I read that, it says, "varies

1 by community as needed," then why are counties  
2 continuing -- maybe this needs changed. Counties  
3 are -- now continue to have funds for BCMH.

4 If this isn't going to be a  
5 requirement under the core, and I don't think it  
6 should be a requirement under the core, then there  
7 may need to look at legislature not requiring  
8 BCMH.

9 SECRETARY TREMMEL: For just a  
10 slight perspective and background.

11 The Bureau for Children with  
12 Medical Handicaps Program is being referenced  
13 as -- for some number of years, as  
14 Commissioner Edwards is aware, and many of you  
15 other health experts, this has been a tenth of a  
16 mill set aside specific for a number of years in  
17 county budgets allowing the generally local public  
18 health system to provide a means or a mechanism to  
19 home visits, referrals, follow-ups, tracking and  
20 monitoring for families that have a child with  
21 special needs. And in some cases these are  
22 adults.

23 There has been in a number of  
24 counties this tenth of a mill is sufficient, for  
25 that BCMH funding.

1                   In some counties that tenth of a  
2 mill is not completely used. So that tenth of a  
3 mill can be redirected to other appropriate  
4 counties' decisions for funding.

5                   There are -- I don't know if I can  
6 think of many, but there can be occasions where --  
7 and somebody at BCMH can maybe answer for  
8 others -- where counties can max out. But again,  
9 I don't know if we see that often. But you have  
10 the State being able to pay and provide revenues.

11                   I think the concern here from --  
12 so long story short, I think the concern about the  
13 areas of BCMH is that there are some departments  
14 that don't have the capacity, the infrastructure,  
15 the nurses, the trained experts to do BCMH, and it  
16 is either -- or it's being considered by others,  
17 maybe some of the hospital systems or others.  
18 Some of you know.

19                   Would that be true?

20                   Or if it's not done, it's not  
21 done.

22                   COMMISSIONER SHAPIRO: I don't  
23 believe any hospital systems are doing it.

24                   I think that in Delaware County we  
25 applied for a waiver to allow us to get part of

1 that tenth of a mill to do some of the case  
2 management services.

3 But for the most part, and you  
4 guys can correct me if I'm wrong on other parts,  
5 that tenth of a mill is going to pay for treatment  
6 services for children that are enrolled in the  
7 program.

8 So for example, if I have a child  
9 that has a mental handicapping position and I need  
10 to have my diagnostic and treatment services,  
11 those bills, if they fall within the income  
12 guidelines, then part of that bill goes to the  
13 county to help pay for those services for those  
14 children that cannot afford to pay so that every  
15 child hopefully in the State of Ohio has access to  
16 medical care and the specialty services that they  
17 need to have to have as a quality of life as they  
18 can.

19 So as the local health department  
20 we may receive some money indirectly through the  
21 billing process, but that money does not come  
22 directly to the health department, as far as I'm  
23 aware.

24 COMMISSIONER MCFADDEN: I realize  
25 for the county commissioners that the financing

1 issue is probably the most acute when we speak  
2 about BCMH.

3 I think that given the trend that  
4 we in public health potentially are into more case  
5 management eliminating BCMH, maybe perceived by me  
6 and some as a step backwards, as the program -- as  
7 we talk more about not doing -- some of the  
8 conversation about not doing clinical care, but  
9 doing more case management.

10 I think that some of the ongoing  
11 discussions move the office of health  
12 transformation, and ODH center sectors are -- to  
13 me at least, I can't speak for them. But to me as  
14 outside from those agencies, but inside doing BCMH  
15 seem to be trying to -- some of the financing  
16 issues that they find a way to, you know, make  
17 things consistent.

18 I guess I say that only to say  
19 that to me there seems that there are some balls  
20 in place in regards to BCMH that I'm not sure that  
21 we need to hit that head on to acknowledge that  
22 it's county specific that is a significant concern  
23 for us, as far as local funding.

24 But I'm assuming here that if it  
25 is given zero financing between -- and you're

1 looking for -- as well as to continue to be  
2 viable?

3 COMMISSIONER EDWARDS: Right.

4 But I'm also looking at when I  
5 look at the core -- when I look at the core  
6 package to me it seems more of the umbrella and  
7 not necessarily the individual -- and maybe I'm  
8 wrong. Maybe I'm not looking at that properly --  
9 that as a state we provide the public those  
10 services that impact the most.

11 And I guess I'm not sure -- I  
12 don't believe that at this time it would be  
13 necessarily targeted.

14 COMMISSIONER NIXON: I was going  
15 to say I think some of those programs are State  
16 funded through grant funds that come through the  
17 Federal Government, or I'm not sure directly State  
18 funded. But they do represent programs like you  
19 say are sort of an umbrella for that group of  
20 people in the community.

21 But some of them are programs that  
22 are local funded, as well.

23 I think what these programs need,  
24 there is no attempt to say these are not as  
25 important as the foundational capability or the

1 public health services.

2 In each community with these  
3 foundational capabilities understanding where the  
4 gaps are, like in our community, oral health  
5 services. There is a real gap in dental health  
6 services. There is no State funding available to  
7 our community to fill that capacity. So we're  
8 partnering with others to build that capacity.  
9 And I think that is a missing element in our  
10 community.

11 And every community has specific  
12 needs that can be identified through the community  
13 health assessment and the community priority  
14 development and so forth.

15 So some of them you can cover  
16 through State funds and through pass through  
17 dollars from the Federal Government. Some of them  
18 you're kind of on your own to develop that  
19 capacity or partnership with other communities.

20 Some counties in Ohio have no  
21 healthcare capacity at all. No hospitals. And so  
22 they represent, I think -- you have a hospital in  
23 your community -- well, some counties don't.

24 COMMISSIONER EDWARDS: There is  
25 about ten. I went through the list last night and

1 there is about ten communities.

2 COMMISSIONER NIXON: And they are  
3 the only game in town for certain health care  
4 delivery systems. So that's where the variety is  
5 in Ohio.

6 COMMISSIONER EDWARDS: How -- the  
7 National Healthcare Act, it's up there -- throwing  
8 that up on the wall. It doesn't matter to me who  
9 is going to be -- it does matter.

10 But whoever is president, some of  
11 this is going to stick.

12 And how are we moving forward with  
13 what we're recommending to dovetail into what we  
14 already know about the National Healthcare Act?

15 And health changes in  
16 Medicare/Medicaid, the health exchanges, how are  
17 we working toward utilizing what we already know?

18 COMMISSIONER NIXON: I can answer  
19 it from our perspective.

20 I don't think there is a uniform  
21 answer to that. I think every community is trying  
22 to assess that individually on what they need to  
23 do.

24 We are transitioning out of  
25 clinical care toward care managed, care

1 coordination, which is difficult in itself to  
2 transfer staff in a new direction.

3 I don't know that we have a  
4 design -- a State-driven design on how to respond  
5 to the Care Act. I think a lot of that is being  
6 done at the local level and kind of hits and  
7 misses and trying to understand and guess how this  
8 is going to affect it.

9 The exchanges, will the local  
10 health department play a part in that? I'd like  
11 to think so. But I think there is a lot of  
12 elements in that.

13 So I don't know whether the  
14 State --

15 DR. WINSLOW: So we're looking at  
16 our teams playing this year toward finishing the  
17 ships process State Health Improvement Plan,  
18 finishing now our personal ODH strategic plan and  
19 ultimately approves accreditation from FAB.

20 What we're looking at are the  
21 documents you mentioned, as well as a national  
22 prevention strategy, the national quality  
23 strategy, helping people 20/20 and trying to keep  
24 all those in focus as we determine what our role  
25 is going to be in moving health in Ohio to a place

1 where it's more available, it's more affordable,  
2 and it's of higher quality.

3 Some of that is integrating public  
4 health with primary care, as it has in the past.  
5 And you all are doing that in the local community,  
6 too.

7 That doesn't mean you have to  
8 provide the care. We have to be sure it is  
9 available to people and it's high quality and it's  
10 affordable for people.

11 So we're very involved in looking  
12 at how the Affordable Care Act will play out in  
13 Ohio.

14 We're not necessarily following  
15 all those, all of the stages that we could in  
16 affordable care. We think that is a good model of  
17 care. We're going to do what we can to get this  
18 all over Ohio.

19 Other parts of it were moving  
20 along in a coordinated way with Government and  
21 other agencies to determine, especially for our  
22 office of health transformation, what's the best  
23 way to interface to get the most good for the  
24 people in Ohio so that we can use that act as a  
25 methodology for us to implement some good quality

1 care as possible, including prevention.

2 So the prevention side has been a  
3 missing piece in the puzzle that everyone  
4 struggles with. How do we afford that? How do we  
5 provide that? How do we integrate that? Most of  
6 our system has been focused on disease.

7 So we're in that transition that  
8 you're in, too, where we're going from sick care  
9 to health care as the focus and trying to use the  
10 Affordable Care Act where we can to get more of  
11 the health focus in our overall healthcare plan  
12 that we're putting together.

13 We're not done, but we will be in  
14 the next few weeks with out strategic plan. But  
15 as it is completed that will be put out to all the  
16 local health departments, and it was designed with  
17 much input from local health, from probably about  
18 60 associations around the State, at least as it  
19 moved through the process to say what they thought  
20 was important. We're translating that into what  
21 we can do, just like you at the local levels are  
22 translating what everybody would like to be done  
23 into what is possible with your local resources  
24 and what your local needs are that you're  
25 responding to what the community needs very quite

1 significantly across the State.

2 So a very similar process as to  
3 what you're doing at your local level, we're going  
4 through at the State level.

5 COMMISSIONER EDWARDS: I guess I  
6 personally think that might be important for this  
7 group to see where -- some of your stronger points  
8 so they see it measures in with what we're doing.

9 DR. WINSLOW: And, of course, the  
10 State Health Improvement Plan is available to  
11 everyone's eyes on looking to what we should be  
12 doing with health in Ohio.

13 I tell you what, we're going to do  
14 that translation. How about the Ohio Department  
15 of Health? What's our part of the responsibility  
16 for the balance needs of the State? That's what  
17 we're determining at this point.

18 But as soon as that is complete  
19 we'll make that available to everyone in this  
20 group, because it does need to be factored in  
21 toward what you're saying, for your targets.

22 COMMISSIONER EDWARDS: Right.

23 DR. WINSLOW: So timing is  
24 excellent for this. It will be done well ahead of  
25 when your report is going to be completed here.

1                   So you'll be able to factor our  
2                   perspective. And you're exactly right. You also  
3                   want to look at the other initial issues and be  
4                   sure that that's in your scope as it is for us.  
5                   So health, and helping people 20/20, and national  
6                   strategies, and others, we're making sure we fit  
7                   it into our process.

8                   But we do have a crosswalk now  
9                   across all of those, no two of which are exactly  
10                  the same, and seeing how do we put this together  
11                  for something that works for us.

12                  COMMISSIONER INGRAM: I would  
13                  agree with your perspective, Ms. Edwards.

14                  I would be remiss -- I agree with  
15                  Commissioner Edwards' comments regarding making  
16                  sure the governmental public health system is  
17                  aligned with the healthcare delivery system as it  
18                  is transforming under the Affordable Care Act.

19                  One could look at the BCMH  
20                  population as a special population, very similar  
21                  to what the hospitals are doing right now with the  
22                  Capital Hill Organization, that they are beginning  
23                  to take a group of people and say they're going to  
24                  manage their care to help improve their health,  
25                  that's really what we've been kind of doing under

1 the BCMH program already.

2 You have someone doing care  
3 coordination in the home, making sure the meds are  
4 being taken, making sure the appropriate care is  
5 being given, and referrals.

6 So going forward as this spans,  
7 the question becomes is if Ohio does do a Medicaid  
8 expansion whether that role comes with BCMH or  
9 not, that's an unknown.

10 Second thing is that clearly care  
11 coordination, either through, you know -- as  
12 Dr. Winslow was talking about, these position  
13 groups have become certified to be BCMH providers,  
14 one of the big things that they need to know how  
15 to do is link their patients with services,  
16 because they're being focused on how they're to  
17 manage that population of patients, relative to  
18 just not the individual.

19 So I think it is a real good  
20 point. And I think we would be remiss not to try  
21 to understand going forward where we should go.

22 VICE CHAIR PRESS: I think it gets  
23 to the issue of -- we're going to get to this a  
24 little later on. It gets to the issue of enabling  
25 flexibility in relationships, which may not exist

1 today, or we could improve upon.

2 I guess I'd like to maybe connect  
3 that thought back to our question on No. 7.

4 Help me, because I'm not familiar  
5 with it. Who were the folks that were on the  
6 original committee? Any of you were?

7 Just the two (indicating)?

8 Let me float an idea out and see  
9 if this works with the group or maybe doesn't work  
10 for the group.

11 What level of interest would there  
12 be in having a couple, three members of the group  
13 peel off and try to look at what I'll just call  
14 the "shall versus may issue" that may exist in the  
15 statute of regulations, come back to us in a  
16 couple of weeks to say there is a lot of shalls  
17 that could be reconsidered as may's and maybe  
18 eliminated.

19 Because I really don't look at  
20 archaic or outdated regulations as benign. It is  
21 there. It can be enforced. In fact, it creates  
22 difficulties for the agencies, because they have  
23 rules and they have the obligations to enforce  
24 them, even though they don't always make sense.  
25 And that's our focus in the communities.

1                   So I just kind of put that out  
2                   there as an idea and maybe get some votes.

3                   Ms. Scofield, if you maybe would  
4                   consider. You've got a big county. And maybe get  
5                   a small county, get somebody that was on the  
6                   original task force so we get some continuity.  
7                   And I'll float that idea and get reactions.

8                   Reactions, positive or negative?

9                   SECRETARY TREMMEL: Has the  
10                  Association done a review of some of the  
11                  statutorial rule issues for consideration of  
12                  unfunded mandating?

13                  COMMISSIONER NIXON: I think in  
14                  this section -- I'm not sure that we have done  
15                  that on this particular section.

16                  COMMISSIONER INGRAM: Well, there  
17                  was a review in the book. I mean, in the very  
18                  back of the book there is a listing of -- on Pages  
19                  120 through what I think -- excuse me -- it starts  
20                  118, I believe, and runs through --

21                  VICE CHAIR PRESS: This would be a  
22                  great committee to be on, because it's already  
23                  done.

24                  COMMISSIONER INGRAM: All this was  
25                  was basically a review of the Revised Code

1 relative to statutes that have -- effect the local  
2 public health system.

3 VICE CHAIR PRESS: So it does not  
4 make recommendations for what might be outdated or  
5 something like that?

6 COMMISSIONER INGRAM: Not that I  
7 remember.

8 COMMISSIONER EDWARDS: If I can  
9 just have another comment.

10 I think that could be really  
11 important. And I'd go back to what nationally we  
12 are seeing in healthcare.

13 And maybe I'm all wet.

14 But it seems that from what I'm  
15 hearing from my local doctors, the hospital  
16 personnel that in the future as -- I'm giving --

17 My local doctor, she's an O.D. --  
18 or D.O. Sorry. And she said I'm worried about  
19 what is going to happen with who I am in the  
20 future. If I'm not specialized how can I justify  
21 the cost?

22 And if some of the reimbursements  
23 are coming down, how can I justify the costs of  
24 being a doctor?

25 If I'm not captured in a larger

1 umbrella in a corporation I can't pay for the  
2 updates that I need to do in technology, in my  
3 office, all of those things that need to happen.

4 So her thought was, you know, I'm  
5 wondering if we're going to look at -- see more  
6 nurse practitioners coming through and having more  
7 responsibilities.

8 So I lay that out.

9 I thought about that. And I  
10 looked at that in comparison to what we have as  
11 the medical directors in our counties or local  
12 health departments.

13 We have a doctor has to be there.  
14 I understand that. But a nurse practitioner, from  
15 what I know, can write orders.

16 If you combine more than one or a  
17 couple from another county -- let's say D.J. and  
18 another county combined. Could we have a nurse  
19 practitioner?

20 So I think some of that language  
21 is going to need to be changed to allow some of  
22 those in that.

23 I don't know if that's going to be  
24 acceptable in the community. I don't know.

25 But I think to allow future

1 changes, unless you guys want to be back in here  
2 in about three or four years, you know, maybe  
3 that's a good thing that we should look at some of  
4 those changes that allow those things to happen.

5 DR. WINSLOW: I certainly have to  
6 respond to that.

7 People are now looking at the  
8 competence as being what determines what the  
9 person does and does not do. And that's not  
10 always obvious.

11 So what we want for a public  
12 health line is to understand the communities that  
13 can make good decisions about what is in the best  
14 interest of the community. If that is done by a  
15 nurse practitioner, a physician assistant, an  
16 M.D., a D.O., or others, that should be in this  
17 day and age allowed to be determined by those  
18 communities.

19 So there is much more open  
20 discussion about allowing people to work at the  
21 top of their license in a way that we used to look  
22 at that.

23 And I can tell you the primary  
24 care example is exactly what you're saying, is  
25 that we do not have enough primary care physicians

1 to cover the needs of the population of Ohio. So  
2 without practitioners, without P.A.'s, without  
3 other people participating in that, we are going  
4 to be in very bad shape when everyone  
5 has supposedly access to care, but really don't  
6 have access and are using the emergency  
7 departments instead.

8 But that becomes very expensive  
9 when you have an M.D. in charge of everything that  
10 goes on that you could replace them, when you  
11 could have other people doing that who can give  
12 you the outcome that you're looking for that is  
13 competent to make the similar decisions.

14 So, yeah. I think we are very  
15 open in 2012 to allowing people to demonstrate  
16 competence and be allowed to perform at a level of  
17 ability to which they are trained.

18 COMMISSIONER EDWARDS: But right  
19 now --

20 DR. WINSLOW: Yeah. I understand.

21 You're where we are in a number of  
22 areas. That's why when you look at our medical  
23 demonstration project around the state I allow  
24 nurse practitioner led practices to be included in  
25 that. And we do that and we built it into our

1           legislation on purpose, because everyone says they  
2           can't do this, they can't do that.

3                         We had all these statements being  
4           made from both sides about what was possible and  
5           what people are capable of doing. I said, let's  
6           see. Let's do these experiments and find that  
7           out.

8                         And we will be able to demonstrate  
9           differences, similarities, where you have to have  
10          one versus another.

11                        I think it will be much clearer  
12          after our two-year experiment is complete, which  
13          is starting in September.

14                        So I think many organizations are  
15          asking the same question, or what I'm saying is  
16          let's do things to demonstrate what is safe and  
17          what is possible, and maybe difficult from what  
18          we're doing right now.

19                        COMMISSIONER EDWARDS: And I think  
20          the comment before is different counties, when you  
21          have a very difficult time finding someone that  
22          you want to be county coroner, I think we are also  
23          going to have trouble to find someone that also  
24          wants to be a medical director in the future.

25                        DR. WINSLOW: Lots of very good

1 questions coming forward now about who has to do  
2 which functions in the healthcare delivery system.  
3 And those are being defined as we move forward.

4 I certainly have different  
5 perspectives of different people looking at this  
6 from various organizations.

7 And it is up to us, I think to  
8 raise those concerns to the surface for discussion  
9 to determine a time for change in 2012, because  
10 this train is different, the capabilities are  
11 different now than when those were written. So we  
12 should open that book.

13 REPRESENTATIVE WACHTMANN: Thank  
14 you.

15 Lynn Wachtmann.

16 So did ODH or local health  
17 departments restrict the scope of practice  
18 pursuant to Revised Code?

19 Is that what was just said here?

20 DR. WINSLOW: I will respond to  
21 that.

22 There are defined professional  
23 training requirements for certain functions. We  
24 talked about county corners. Those have been in  
25 the 88 counties in Ohio.

1                   So occasionally we'll have  
2 definitions that exist that have to be satisfied,  
3 because they're that specific.

4                   In other areas there may not be  
5 that much specificity, as far as what training has  
6 to happen for someone to be eligible to do that.

7                   As I understand it, at least  
8 corners, they have to be M.D.'s or D.O.'s.

9                   COMMISSIONER MCFADDEN: For  
10 medical directors with the local health commission  
11 there are for who can do what.

12                   REPRESENTATIVE WACHTMANN: But  
13 there is no restriction of scope of practice  
14 beyond what the Revised Code allows, is there?

15                   DR. WINSLOW: Not that I'm aware  
16 of.

17                   SECRETARY TREMMEL: I don't know,  
18 Representative Wachtmann, of a prohibition. I can  
19 give you a couple examples, others might have  
20 better.

21                   There are a number of health  
22 departments that are currently engaged in the  
23 primary care business, as you've outlined and I  
24 think Representative Wachtmann is suggesting.

25                   But we are in a conundrum as to

1           whether or not the model of public health in  
2           primary care is the appropriate focus. It would  
3           appear that the model has changed. And it's been  
4           in conversation for a number of years that maybe  
5           public health isn't the primary care network or  
6           system, that public health is a case manager  
7           performing ancillary services.

8                           And maybe the opportunities in the  
9           Affordable Care Act and Medicaid Managed Care  
10          gives public health a new opportunity to be  
11          involved in more and more case management for  
12          purposes of home visits, nursing, et cetera,  
13          specialists.

14                           Back to the issue in question.  
15          There are some health departments with a primary  
16          care focus, Representative Wachtmann, who use and  
17          have used nurse practitioners, but it would  
18          require, as I recall, necessarily a physician to  
19          help with collaborations.

20                           So I do know some departments that  
21          use nurse practitioners and P.A.'s. And the  
22          physician -- I don't know the rules, but it seems  
23          like there is something that the physician used to  
24          have to be outside. But I don't know if they need  
25          to right now. They could be at their office down

1 the street and using an NP or PA at the local  
2 office.

3 Does that answer the question?

4 REPRESENTATIVE WACHTMANN: I think  
5 I'm all set.

6 I dealt with all those issues the  
7 last 20 years. I'm hoping we won't restrict those  
8 scopes of practices.

9 DR. WINSLOW: I believe that is a  
10 concern that everyone is working on within the  
11 State.

12 COMMISSIONER SHAPIRO: I was just  
13 going to add that there is actually licensing  
14 requirements of what you can do under your license  
15 as a nurse. I can only do certain things as a  
16 nurse under my license. I need to have a  
17 physician. If I was a nurse practitioner I think  
18 having a position to be able to do those things,  
19 those are licensing requirements by the Board. So  
20 they are --

21 REPRESENTATIVE WACHTMANN: I  
22 understand. I heard something I wanted to make  
23 sure wasn't an issue. So I'm good.

24 I guess I would, Mr. Chairman,  
25 bring up one other bigger issue.

1                   If at least in the case of some  
2 health departments that were headed more toward  
3 case management and administrative services of the  
4 other districts, I guess it begs the question why  
5 don't we potentially allow -- and this comes from  
6 only me, nobody else -- why not allow the  
7 potential for a county hospital to become the  
8 delivery of services in Henry County, or a county  
9 hospital?

10                   Again, those don't come from those  
11 hospitals. I don't know if they want to have  
12 anything to do with it.

13                   But it seems to me that if we're  
14 going to allow the flexibility of this animal in  
15 the future of delivering public health services at  
16 least from my perspective of rural counties, I'm  
17 not sure the current system is the best. It could  
18 be. And maybe there are other alternatives.  
19 Maybe there is a large organizational group that  
20 we want to get into this business. I don't know  
21 who would want to get into it, but my guess is the  
22 market place with State statute, local government  
23 allowed for such things to be at least considered  
24 locally.

25                   SECRETARY TREMMEL: Maybe allow

1 Commissioner Nixon to respond.

2 COMMISSIONER NIXON: My comment on  
3 that is I think at least in my community and I  
4 think in posts that I'm familiar with, we're not  
5 competing with hospitals. When most of the  
6 services for the oral health or care management or  
7 whatever it may be would be in lieu of what the  
8 hospitals are willing and want to do.

9 These are gaps in the services in  
10 our communities and we identified that the  
11 hospitals typically don't want to do in  
12 partnership with Jobs and Family Services to  
13 provide some care management for those clients, or  
14 even with hospitals at times when they just  
15 contract with us for services.

16 So it's not that, you know, we're  
17 in competition with hospitals, it's more that the  
18 hospitals really aren't interested in providing  
19 those services and we are the stop-gap kind of  
20 provider that services may not exist at all unless  
21 we're providing it.

22 REPRESENTATIVE WACHTMANN: And I  
23 realize that. But again, that's under the current  
24 system. A new system, the structure could  
25 potentially flow differently.

1                   And again, I don't know how much  
2 interest would develop out there.

3                   I have a philosophy in life that  
4 what we currently do is not necessarily the best  
5 we can always do it, no matter what it is in life,  
6 and maybe there is a new better animal out there.

7                   VICE CHAIR PRESS: I think these  
8 are variations on a theme, though. So that's why  
9 to the extent that there are aspects of our  
10 current arrangement that limit that sort of  
11 corroboration where we can remove those barriers  
12 and enable folks to, if they can agree,  
13 voluntarily into those agreements. I guess that's  
14 the jurisdictional question on the table.

15                   So people need to be creative in  
16 those arrangements. And I don't know the answer  
17 to that, and I guess that's what I'm hoping for.

18                   COMMISSIONER MCFADDEN: I share an  
19 axiom of public health issues, what no one else  
20 wants to do, public health will do.

21                   And I think that gets to this  
22 point a little bit, because sometimes those things  
23 that no one else wants to do gets codified that  
24 public health shall do. And I share with you that  
25 I'm not sure that maybe we want to do some of

1 those things.

2 We have a primary health clinic in  
3 our health department where 68-percent of our  
4 clients are Medicaid. I guarantee to you that  
5 there is no programming that anybody has that I  
6 know of that can survive with 68-percent of their  
7 cases by Medicaid. 25-percent of our clients are  
8 no pay.

9 So there aren't a lot of places  
10 that can make that work. And our hospital is  
11 regularly asking why are we accepting the number  
12 of patients we're taking.

13 They want us to take more to free  
14 up the emergency room.

15 But I would say in our community  
16 the local doctors are taking care of private  
17 insurance. They are very happy to have a safety  
18 net that will take the primary care, the folks for  
19 Medicare. I'm not saying that's right, but in our  
20 situation that is what we want to do. So that's  
21 what we started to do.

22 I think that is case management  
23 based. One of the roles for me is that it used to  
24 make exceptions in public health, but it is  
25 currently the physician that could do that. But

1 case management seems to me to work better when we  
2 don't expect folks to come to us, but when we go  
3 to them.

4 Public health has been based on  
5 the belief that we can go to people where they're  
6 at, rather than expecting people to come to us,  
7 like a physician's office. Physicians used to go  
8 to patients, but then more physicians stayed home  
9 and in public health offices. Hospitals tend to  
10 stay put and people come to them.

11 I certainly think there are great  
12 opportunities for private physicians and hospitals  
13 to engage in case management. But I do think that  
14 the shift may be a little bit more difficult for  
15 them from requiring people to come to them, as  
16 opposed to going to where people are at.

17 I do think it is an opportunity  
18 for public health and clinical medicine to form  
19 better partnerships, because I think that the days  
20 are just waiting around for people to come to  
21 us -- I'm speaking as a physician now -- may be  
22 gone. I mean, really to give good care we're  
23 going to have to find ways as physicians to go to  
24 people -- so that I think is some of the -- when  
25 we talk about case management of the public

1 health, but I think anyone can do it.

2 DR. WINSLOW: Mr. Chairman,  
3 Representative Wachtmann, Ted Winslow.

4 And what I see public health doing  
5 is being the -- you are the eyes on population  
6 health and nobody else will look at them like you  
7 all do.

8 And so rather than seeing yourself  
9 as filling gaps that might exist in your health  
10 community, I would much rather see you driving  
11 where the health community is going. That is,  
12 first identifying how well you're doing in the key  
13 areas of public health that we measure. We do  
14 that with county health.

15 But then the next important part  
16 is to mobilize the resources in the community to  
17 address the needs. And it doesn't have to all be  
18 you, versus just making sure someone is addressing  
19 the needs in the community.

20 And many times multiple partners  
21 are doing that together. And if you can't do it  
22 or if you choose not to do it, just be sure  
23 someone is addressing that.

24 Well, that's that care  
25 coordination kind of role in giving some kind of

1 care to move all the health in the community  
2 forward in a positive way.

3 And so it is helping those  
4 relationships in the community be developed and  
5 move forward that get at the real health issues  
6 you have.

7 So whether it is, you know,  
8 related death or if it's infant mortality or  
9 whatever, I really trust public health more than  
10 anybody to watch what is going on with the whole  
11 population and then devise strategies in their  
12 community that is unique to your community.

13 And for some communities you're  
14 going to have drug care and for others you're  
15 going to go, no, it's better done over here to a  
16 better outcome. But it is having someone who is  
17 looking over the entire community and watching it  
18 from a population health perspective.

19 That's what I trust public health  
20 to do better than anybody does.

21 COMMISSIONER SHAPIRO: Just to  
22 add -- Nancy Shapiro -- is that when Marty and  
23 Dr. Winslow were talking about the State Health  
24 Improvement Plan, I think all of the health  
25 departments are developing, if they haven't

1 already, local health improvements funds. And I  
2 think that we should keep an eye on that.

3 Our goal, hopefully, is to assist  
4 the State as individual county departments or  
5 however we're structured to help the State reach  
6 their goals, but we also have our own goals within  
7 our community based on our community gap.

8 So I think that needs to be  
9 factored into that minimum package or what we call  
10 the other services. So for my county my local  
11 needs may be very different than Summit County's,  
12 but that we should all be helping move the State  
13 forward, too.

14 So I think we need to look at that  
15 big package when we take a look at the minimum  
16 package of core services, too.

17 COMMISSIONER EDWARDS: That brings  
18 a good point. I'll bring out another one of those  
19 specifics, WIC.

20 We have great Ohio State extension  
21 services and they have a family nutrition program.  
22 Wouldn't that dovetail really well for those two  
23 to work together maybe instead of -- I believe we  
24 contract with another county to provide our WIC  
25 services.

1                   But I think that those -- that  
2                   Ohio State extensions could really grow with that  
3                   extension program and work it together.

4                   Not everybody would have to do  
5                   that, but it would have the opportunity and could  
6                   promote that as a working tool. I think that  
7                   would be --

8                   VICE CHAIR PRESS: It would be  
9                   your understanding that wouldn't be permitted  
10                  under the current configuration of things?

11                  COMMISSIONER EDWARDS: Yes. It is  
12                  my understanding.

13                  And I might be all wrong on that,  
14                  too. I just don't know.

15                  COMMISSIONER SHAPIRO: WIC  
16                  services -- I know we utilize extensions in our  
17                  WIC programs to do a lot of the educational  
18                  services and other issues.

19                  And I don't know if you guys all  
20                  have WIC. So there is a collaboration.

21                  But the WIC program and dietary  
22                  requirements is they see -- they're Federal  
23                  requirements that require registered dietitians  
24                  and those kinds of things that I don't believe  
25                  that every county extension office has. That

1 doesn't mean that we shouldn't encourage the  
2 collaboration, which I know we haven't tried to  
3 get in the project and intend to do that.

4 COMMISSIONER NIXON: What D.J.  
5 suggested I don't think is limited to health  
6 departments.

7 MS. SCOFIELD: No. Isn't it Metro  
8 Health?

9 Cuyahoga County?

10 It's who has the brains.

11 COMMISSIONER INGRAM: So, you  
12 know, back to the healthcare system that is  
13 transforming, I know, because it is necessary  
14 because the businesses expect to have better value  
15 systems or looking at better care. And we as the  
16 population of health are looking for better health  
17 overall, because we're stagnating today and so are  
18 some of our big majors.

19 So one of the things that the  
20 healthcare systems and, you know, a/k/a the  
21 hospitals, are required to do and not-for-profit  
22 hospitals, is they shall conduct a community  
23 health assessment.

24 The IRS has ruled and would be  
25 upholding of the Affordable Care Act with the U.S.

1 Supreme Court that really memorialized that  
2 directive.

3 The other thing is that the IRS  
4 has told the not-for-profit healthcare delivery  
5 system that you should also develop a health  
6 improvement plan.

7 So we all have health needs that  
8 are different from perhaps where you're sitting in  
9 Columbus looking at the State, although those  
10 needs all mesh up.

11 So I continue to think that going  
12 forward as this system transforms and begins to  
13 change some of the outcomes we are stagnating on,  
14 we've got to roll the governmental public health  
15 system into that process.

16 And what I hear down in Hamilton  
17 County is if you look at the five major healthcare  
18 services, and I know that is much different in a  
19 lot of the other areas in Ohio, but very similar  
20 in the urban areas, is that, geez, Tim, we just  
21 can't write a health improvement plan just for  
22 Hamilton County. We are a market place model. We  
23 serve eight or nine counties. But what we can do  
24 is somehow work together. And perhaps we need to  
25 minimize that or perhaps push it a little bit

1 saying we're going to try to create a State Health  
2 Improvement Plan that the hospitals are going to  
3 buy into and what the community needs so that  
4 we'll have certain objectives that we will take  
5 care of, those gaps in services, whether it's  
6 dental needs, whether it's infant mortality,  
7 whether it's babies that are being born addicted  
8 to opiates, whatever it might be that the  
9 hospitals then will put community benefit dollars  
10 in to help fund.

11 And we need to be the driver of  
12 that. But we have a structure today that exists  
13 that will not allow us to move in that direction,  
14 in my opinion.

15 COMMISSIONER NIXON: I think that  
16 does lead us into the next area, which is  
17 jurisdictions, because I think that some of those  
18 questions are addressed in the comment No. 12,  
19 which is barriers to some of these sorts of  
20 arrangements.

21 VICE CHAIR PRESS: I've been  
22 making some notes. We've been nibbling around the  
23 questions of the jurisdictions in terms of how do  
24 we facilitate broader opportunity for  
25 relationships and your organizational cooperation.

1                   Before we go there I'd like to tie  
2 a bow around No. 7 here real quick.

3                   I floated an idea. The  
4 conversation drifted away from that. Maybe that  
5 wasn't -- but I do think that one of our  
6 obligations is to try to get some degree of  
7 specificity around some of recommendations that  
8 are in front of us. And right now I wouldn't know  
9 what specifically to do with that. It sounds like  
10 a good idea, but ultimately get to the specifics.

11                   Do we have an approach to add  
12 specificity to No. 7?

13                   How could we get it?

14                   COMMISSIONER NIXON: We have  
15 listed those shalls in the back.

16                   Perhaps to assign a group to look  
17 to those, we already have them.

18                   If there are areas that the  
19 committee by the next meeting see that we ought to  
20 consider, the maybes and shalls, we should bring  
21 it to the committee.

22                   VICE CHAIR PRESS: Any  
23 suggestions?

24                   Any comments.

25                   Those of you on the phone, if

1           you're playing along at home?

2                       Others?

3                               - - -

4                       Thereupon, no response was had at  
5           approximately 2:09 p.m.

6                               - - -

7                       COMMISSIONER MCFADDEN: For the  
8           sake of time would it be worthwhile to potentially  
9           e-mail as a group or e-mail it to Senator Burke  
10          what those items are, rather than just bring those  
11          next time?

12                       VICE CHAIR PRESS: I'm sure that  
13          would speed things along.

14                       Look at leadership here. That  
15          list that Commissioner Ingram called to our  
16          attention, does that serve us as something useful  
17          for desensitized -- is that a base --

18                       SECRETARY TREMMEL: It could be a  
19          complete list I think, if possibly the health  
20          commissioners would be so inclined.

21                       Would you or would the Association  
22          be willing to go through and make some notes,  
23          concerns, e-mail that back as a representation of  
24          the public health reaching out to your colleagues  
25          here, pushing that to Mr. Mazzola and myself,

1 it'll go through all of you, it will be posted up  
2 to all of you as our past practices?

3 Is that acceptable?

4 VICE CHAIR PRESS: That work for  
5 the group?

6 Do we need a formal motion, or can  
7 we just do it by head nod?

8 What is the procedure?

9 Okay. Consensus. Okay. All  
10 right.

11 Good. Let's return now to the  
12 jurisdiction question.

13 We have heard comments about  
14 according to the local health districts, according  
15 to the other providers in the community. That  
16 could be a hospital, a physician practice.

17 Commissioner Edwards, you raised  
18 earlier the question of BCMH and the question went  
19 to my mind, and I don't know where MRDD fits into  
20 that.

21 One thing that is going on out  
22 there is everyone is getting a case manager. So  
23 now we are going to have to have case managers and  
24 case managers.

25 And that is a positive thing, but

1 it does call the question how do we create  
2 cooperation.

3 COMMISSIONER EDWARDS: You know,  
4 that should fall under public health.

5 VICE CHAIR PRESS: And that's --  
6 and given again, I'm going to be drum.

7 Giving people the flexibility to  
8 go to Holmes County and not Cuyahoga County --

9 DR. WINSLOW: Mr. Chairman, I  
10 would like to say, you know, about that issue,  
11 giving those folks the opportunity to make those  
12 determinations within the community to communicate  
13 health teams, and community health teams are a  
14 common site where people go to keep with the  
15 service so that they can get oriented in the  
16 proper direction by a single team, rather than  
17 continually working with a number of different  
18 caseworkers that aren't talking with each other.

19 They still have been able to  
20 somehow make that work pretty effectively and  
21 found that the changes to getting to what they're  
22 supposed to get to move up very nicely if you've  
23 got those services coordinated through a central  
24 navigation process. And they call it the  
25 community health -- CHT in the blueprint. Those

1 type models are already out there.

2 The question is also do we want to  
3 pick up some of those that we're seeing being  
4 tried around the counties and try some of those in  
5 our own region.

6 That's why I'm encouraging people  
7 to think outside of what we've already done and  
8 say are there better ways to approach this and  
9 address that. And we'd like to have ODH be a part  
10 of that process, that is being a resource to the  
11 local level with what we're aware of, as far as a  
12 model for care and addressing public health issues  
13 that are being tried all around the country.

14 And some of this proves to be  
15 beneficial and some haven't, but we need to move  
16 to that next step together and combine our  
17 understand and our ability to bond with those  
18 things with proven best practices that are out  
19 there.

20 VICE CHAIR PRESS: Thank you.

21 Now that there's a bridge to focus  
22 on Nos. 8 and 10, I'd like to maybe set 9 aside a  
23 little bit, since 9 speaks to the minimum package.  
24 I'm really focused on jurisdiction and  
25 cooperation.

1                   Comments on either barriers today  
2                   to filling the objectives as they're stated here,  
3                   or comments (indicating)?

4                   COMMISSIONER INGRAM: I'll go  
5                   first. I guess somebody has to step into this.  
6                   Probably not going to be too much of a surprise  
7                   considering what I'm about to engage in.

8                   But, you know, I've read all three  
9                   reports, the 1960 report, the 1993 report, and  
10                  then, of course, the June 2012 report.

11                  There's been 60 years of reports  
12                  that have talked about the governmental public  
13                  health system. And someone said earlier, what  
14                  have we implemented over 60 years?

15                  There's been a few things.

16                  But the fundamental question that  
17                  came out of those reports was what is the  
18                  appropriate size of that a local governmental  
19                  health district should serve.

20                  And I would tell you that it's my  
21                  belief that there should be a -- probably a  
22                  minimum size, just because of the needs to be able  
23                  to deliver efficiently and effectively, to be able  
24                  to coordinate care, coordinate communication  
25                  relative to what disease is going around and the

1 population that you serve today.

2 And with the healthcare delivery  
3 system, I keep coming back to that, because I  
4 don't see us going forward separate. I see us  
5 going forward more integrated.

6 And again, I think this is pretty  
7 true throughout the State, in Southwest Ohio about  
8 80-percent of the primary care physicians are now  
9 employed by one of the five healthcare systems.

10 We're going to at some point have  
11 a hard time finding a medical director, unless we  
12 do a contract with the healthcare system for that  
13 service, perhaps. Perhaps. Perhaps. Perhaps,  
14 because the independent docs are either joining up  
15 or riding this storm out because of the cost that  
16 they're incurring relative to putting in  
17 electronic health records, keeping that software  
18 updated, and so forth. So they're making some  
19 decisions, you know, in that regard. That's what  
20 I see. That's what I am hearing and that's what I  
21 see down our way.

22 Given that, our responsibilities  
23 are changing and that we need to be tied into that  
24 electronic flow of information, too, in order to  
25 be able to understand what disease we need to be

1 chasing in order to prevent further spread into  
2 the community, because at the end of the day  
3 that's what we do. Just like the police on the  
4 street trying to chase down that criminal to  
5 prevent that next crime, or the fireman trying to  
6 prevent that block from burning down, public  
7 health workers chase the people that are caring or  
8 defectors or the animals that are carrying that  
9 contagious disease to make sure it does not cause  
10 an outbreak in the community or in your family.  
11 And we have to have enough capacity to do that in  
12 the future.

13 And I think we'd just be kidding  
14 ourselves and saying that right now, first of all,  
15 we have a sufficient capacity, or the appropriate  
16 sustainable funding stream to ensure that capacity  
17 going forward. I think something has to change.  
18 I don't know what the number is. The number in  
19 this book suggests it was 150,000. The '93 study  
20 said one per county. The 1960 study said 100,000,  
21 nothing less than 25, no jurisdiction smaller than  
22 25,000.

23 REPRESENTATIVE WACHTMANN: Okay.

24 Thank you, Mr. Chairman.

25 How did information flow, or does

1 it?

2 Let's say somebody from Deshler  
3 goes into a branch health care system and one of  
4 the doctors pinpoints XYZ disease. If the Henry  
5 County health department should know that for  
6 public health, do they know that?

7 Is there an automatic exchange of  
8 information intra-county, et cetera, et cetera?

9 VICE CHAIR PRESS: It depends  
10 where you are in the State.

11 I don't want to put you on the  
12 spot.

13 REPRESENTATIVE WACHTMANN: You  
14 talk about your service area much by a district is  
15 served by many different hospitals depending on  
16 which county. I'm just curious how information  
17 flows, or doesn't.

18 COMMISSIONER INGRAM: Well, right  
19 now, down our way, inside the systems they're all  
20 documenting electronic health records. And so  
21 there is pretty good intra-office ability inside  
22 the system.

23 The challenge has been for us, and  
24 we're probably further ahead than most areas, and  
25 that is to get sharing of data, healthcare

1 information across the systems, because of the  
2 concept and, you know, everything that goes with  
3 that.

4 We have an organization known as  
5 "Health Bridge" that's been the conduit for  
6 sending data across the system. So whether it is  
7 Trihealth going to the Mercies, or Christ going to  
8 the Mercies, or what-have-you, that's been kind of  
9 the conduit.

10 The way we get notified of  
11 information really comes several ways. Either  
12 directly from a lab, so down our way. Once upon a  
13 time -- and now it's changed. But once upon a  
14 time we were on the same communication feed when  
15 there was a contagious communicable disease  
16 reported by law, the same time that physician was  
17 getting that report the local public health  
18 authority would get the same report.

19 That's not happening now, because  
20 the greater Cincinnati area is becoming an epic  
21 town. So that's changed.

22 But so, you know, at the end of  
23 the day there is data flowing into the Ohio  
24 Department of Health, Ohio Reporting System for  
25 the labs, and we're all connected to that system.

1 Some of the hospitals are connected to that  
2 system, too, and use that system.

3 But it still takes that -- I  
4 always say it still takes that astute position  
5 that an ED, or in a doctor's office who receives  
6 something that comes in that looks like it's  
7 reportable to make that phone call to that local  
8 health department saying I think I've got this  
9 case, a meningococcal disease, and, you know, you  
10 guys have got to mobilize and prophylax people so  
11 that they don't get a bigger problem.

12 VICE CHAIR PRESS:

13 Commissioner Nixon.

14 COMMISSIONER NIXON: I think I  
15 understand what Tim says.

16 We have the same thing; the  
17 hospitals have to report disease. That's a law.  
18 The shall. It's one of the shall things.

19 When we had three health  
20 departments it was very complicated. So we  
21 consolidated those functions to a single office  
22 that streamlined it for hospitals.

23 The question though, between  
24 hospitals, that doesn't happen very often, case of  
25 communicable disease. I think that is a prime

1 responsibility.

2 When we get that call through an  
3 infectious control officer from a hospital, calls  
4 our communicable disease unit and says we've got  
5 something here, probably all the electronics -- it  
6 comes down to an individual or a personal  
7 relationship with the health department to say  
8 something is going on here.

9 The health department then gets on  
10 their horse and starts calling other hospitals, to  
11 other health departments and neighboring  
12 communities and saying, are you seeing anything  
13 like this. And then it could be picked up to the  
14 Ohio Department of Health, which will do something  
15 statewide, if necessary.

16 So I think that is a function that  
17 I don't think could happen independent of the  
18 public health system. And I think that's a  
19 perfect example.

20 VICE CHAIR PRESS: I'm going to  
21 borrow from Senator Burke who says consistently --  
22 I think I've got this right -- it's not so much  
23 establishing a size, it's as establishing a  
24 rational policy and letting size sort itself out.  
25 And I think there is wisdom in that; however, that

1 can also get a little circular.

2 So the question is if the  
3 committee stood by its earlier thoughts about the  
4 minimum standards -- let's just have a  
5 conversation -- let's say that that's policy.

6 Does Commissioner Ingram's premiss  
7 stand that we would need to have larger minimum  
8 sized product?

9 I mean, would that policy decision  
10 drive consolidation or encourage consolidation to  
11 larger units?

12 COMMISSIONER SHAPIRO:

13 Nancy Shapiro.

14 - - -

15 Thereupon, Melissa Bacon exited  
16 the room at approximately 2:22 p.m.

17 - - -

18 COMMISSIONER SHAPIRO: I think  
19 that what the drive is, is the flexibility for  
20 again, local communities to determine what's the  
21 best way of meeting those standards.

22 So whether that be a consolidation  
23 effort, that has happened in Summit County, or is  
24 a cooperative agreement with similar model to  
25 shared services with the educational services

1 centers, or it's partnerships that are more  
2 formalized with hospital systems. However, that  
3 can work.

4 I know when we talk about hospital  
5 systems -- in Delaware County we now own an Ohio  
6 Health Hospital. We used to have a local  
7 hospital. We're working right now on a community  
8 health needs assessment that we're helping them  
9 complete the end of theirs and they are helping us  
10 begin the beginning of ours. So we are working  
11 together as a group. We have facilitated that for  
12 helping us do that. But as we have discussions  
13 going forward, we hope to join resources to do  
14 some things.

15 So I think there is all different  
16 kinds of models. I don't think that any one size  
17 fits all as an ideal for the communities.

18 And I think that's C on No. 8,  
19 which is the political and financial  
20 considerations, the political considerations in --  
21 often times are huge in dealing with the issues of  
22 consolidation.

23 And the allowability, which you go  
24 down to No. 12, the multi-county levy authority,  
25 the other issues that are in statute that make it

1 very difficult if your are levy funded to be able  
2 to have those joint discussions.

3 I know that it must be in statute  
4 that the combined mental health boards can do some  
5 levying authority between the counties that they  
6 are serving in public health. I don't know if we  
7 have that.

8 VICE CHAIR PRESS: Here is my  
9 question. This -- maybe this will get us to --

10 It is true that there is going to  
11 be remarkable changes coming forward as a result  
12 of whatever national health reform survives.

13 If you believe that -- however  
14 much money there is today the likelihood that  
15 there would be more money going forward is less  
16 and less, and likely there will be less going  
17 forward than more and more.

18 The question I suppose I have is  
19 does policy and regulations provide folks the  
20 maximum opportunity to be creative in their  
21 relationships, as you just described, so that at  
22 the local level they can make their own choices,  
23 that so for Holmes County they don't want or can't  
24 agree with it -- if you can't agree, then okay.  
25 That's those folks. They made those decisions and

1 that pressure must not be great. And that's fine.  
2 But if somebody else wants to do something  
3 different -- what I see as our opportunity is to  
4 create, is to remove barriers to relationships  
5 where people want to have them.

6 COMMISSIONER MCFADDEN: That is  
7 there are the opportunities for us to move those  
8 barriers as we talk on No. 12 there.

9 What I like about this report is  
10 that to me it gives an opportunity, it says here  
11 are some standards that we think you should -- and  
12 it says here are some ways you can get to that if  
13 you're not able to get to that right now.

14 I would like to convey what you're  
15 suggesting, the flexibility for local  
16 jurisdictions, be it collaboration, be it  
17 consolidation, or if you could meet it on your  
18 own. I like the flexibility that is in here  
19 currently.

20 I think the question I hear is a  
21 number of health districts, you know, 100, 60, 88,  
22 whatever -- you know, the question I ask is can we  
23 form something as a collaboration.

24 Say I join with four or five other  
25 health districts and say, guys, we're going to

1 meet on a regular basis, we're going to see what  
2 resources we can share amongst ourselves, we're  
3 going to call ourselves whatever, Northern  
4 Apalachia, and this is what we're going to do.

5 Each of our boards could in that  
6 structure stay intact and have the local  
7 jurisdiction within the county.

8 So as ODH relates to us we're one  
9 group, we've decided that we will come to ODH as a  
10 unified body, but we still have our board.

11 So that's a question that I'm not  
12 sure when we talk about the collaboration, are we  
13 saying that each of us now has to have only one?  
14 Have we come down to 88 or 60, does that mean we  
15 have 88 or 60 boards of health, or can we come as  
16 units?

17 I think we have to have the  
18 creativity that respects the differences that we  
19 might have, you know, in different parts of the  
20 state, eliminate those things that keep us from  
21 coming together. But what I think we want is the  
22 ability to come together in a sense. And I think  
23 that holding up a standard, this is what we want  
24 you to meet, realizing that many can't meet that  
25 right now, I think that that really help us to get

1 to those places to remove those.

2 And I think that we also need  
3 folks that want to stick and also a carat -- I  
4 think that when we get to the financing there are  
5 carats in financing that I think really help us to  
6 continue down this path.

7 But, you know, again, when we look  
8 at that blue section on the foundation, those are  
9 areas that I say that are going to require a  
10 larger -- if we're going to really do those  
11 sections of the foundation, the trunk, many of us  
12 are going to have to join with other folks.

13 And I would like the flexibility  
14 to do that without having it stated you shall be  
15 100, you must collaborate if you're not. I would  
16 like it to be here are things we need it to be.  
17 That's why I like this graphic.

18 VICE CHAIR PRESS: The  
19 Commissioner made a comment. Let me just try to  
20 see if I hear what you're saying.

21 If there is an area for  
22 prescription you'd rather be a little more  
23 prescriptive around minimal requirements and less  
24 prescriptive around minimum size and let that sort  
25 itself out.

1                   Is that fair? I don't want to put  
2 words in your mouth.

3                   COMMISSIONER NIXON: Because of  
4 the political --

5                   COMMISSIONER INGRAM: Okay. I  
6 think that Dr. McFadden makes a really good point.

7                   And I would only say that somewhat  
8 in contrast to it is the fact that you have to  
9 have this discussion on this. If we are in  
10 agreement, and that is the question, that we don't  
11 have the adequate capacity today to change the  
12 health outcomes going forward. And that's the  
13 assumption I'm working under. And if people  
14 disagree with that, then that kind of falls apart.

15                   Then you have to ask yourself,  
16 okay, what do you need in order to increase that  
17 capacity, what services, and we've been talking  
18 about that a little bit, and what uniformity are  
19 we looking for so that when you go from one health  
20 district to another that you won't get a complete  
21 different set of services and service level as you  
22 go from one jurisdiction to another.

23                   You have more consistency of  
24 regulation. You have a similar fee structure.  
25 You have easier reporting from physicians and

1 hospitals into the public health system for our  
2 follow-up to make sure disease is not running  
3 rampid, and so forth.

4 - - -

5 Thereupon, Dr. Winslow entered the  
6 room at approximately 2:31 p.m.

7 - - -

8 COMMISSIONER INGRAM: So I think  
9 I'd really like to have a contact of funding,  
10 because, you know, there are perhaps some ways  
11 that we could create a more sustainable funding  
12 structure to change the system going forward so  
13 that we can start to address some of those  
14 outcomes that we know we're not making any  
15 progress with today.

16 This is really from my perspective  
17 about truly the future of the health of Ohio, the  
18 children that we are raising today and the  
19 children that we're not.

20 VICE CHAIR PRESS: Comments?

21 COMMISSIONER NIXON: I agree with  
22 both perceptions.

23 I think that, you know, if we  
24 simply keep this flexible, as long as you think  
25 you can reach these things and you can do it

1           however you want, I think we're not going to reach  
2           that point. I think we're at risk of not reaching  
3           the point of the capacity we're talking about  
4           here.

5                           I think this system in a lot of  
6           ways is broke. I can talk about the necessities  
7           and the Department of Health can talk about the  
8           great things that we see in the future.

9                           But right now, the fact is that  
10          most health departments can provide the mandated  
11          services, they can do the things that they have  
12          do, but beyond that they come up short.

13                          And I think if Ohio is serious  
14          about reducing costs across the board, healthcare  
15          costs, we have to have a prevention piece. I  
16          think that is lacking.

17                          I think by all measures, if you  
18          look at the Federal numbers, I think Ohio is not a  
19          very healthy State. And I think if we're going to  
20          commit ourselves to doing something about that we  
21          have to take a look at the population health  
22          strategies.

23                          And healthcare system -- we have a  
24          great healthcare system that deals with the  
25          individuals, but they're not focused on the

1 population based strategies that have to be  
2 imposed, that have to be in place in our State to  
3 make a difference in improving the health of Ohio.

4 So unless we commit ourselves to  
5 building a stronger system -- and I don't think a  
6 strong system consists of a county of 1,400 people  
7 in maintaining a system that can assess the needs  
8 to develop the strategies to build coordinations.  
9 And I just don't believe it can happen.

10 There has got to be a certain  
11 efficiency scale that we have to encourage,  
12 strongly encourage through some prescriptive --  
13 strong prescriptive means, or talk about size,  
14 because I don't think -- if we keep everything  
15 flexible we're back to where we were in 1993.

16 VICE CHAIR PRESS: Not as far as  
17 '63?

18 COMMISSIONER NIXON: '92.

19 MS. SCOFIELD: Gene just  
20 articulated it better than I was.

21 I was sitting here struggling a  
22 little bit of how I wanted to say a few words  
23 about this.

24 And I guess kind of my thought  
25 process on this is that this kind of change that

1 we're discussing is going to be very difficult.  
2 And I think we have to set some floors and we have  
3 to look at scales and use that as a determining  
4 factor as we move forward.

5 I agree with a number of the  
6 things that the three commissions have said, but  
7 if we really want to make some change and if we're  
8 taking the time and the effort to go through this  
9 process that we're engaged in right now, if we  
10 don't set some difficult criteria, if we don't  
11 really kind of nudge that change along, I agree, I  
12 don't think it's going to happen.

13 If we allow for so much  
14 flexibility at the local level that there is no  
15 attempt, that we can't bring anything to scale,  
16 that's going to be hard to measure, then I think  
17 we're doing the change the process a little  
18 disservice. If we don't set it out at the  
19 forefront and provide some incentives, or provide  
20 some assistance to make some of those efficiencies  
21 happen.

22 REPRESENTATIVE WACHTMANN: I think  
23 at the very first we have an example of a poor  
24 school board or a country school board combined.  
25 They made one director, one assistant director,

1 one something else, and one something else. And  
2 they had one -- now a large organization instead  
3 of something more efficient, but I thought it  
4 would maybe be expected.

5 I guess to begin, how much measure  
6 of capacity of services provided per dollar, or  
7 whatever other measurements that would be  
8 important do we have of districts by health  
9 district?

10 I mean, somehow we've got to build  
11 some framework. To me we've got to build some  
12 framework in this where -- the only thing I know  
13 that works in the private sector is competition,  
14 because I have the privilege of going out of  
15 business. If I'm not the best, and blah, blah,  
16 blah. And I'm not saying we go that far.

17 But at some point I guess I'm  
18 going to go back to what I said earlier.

19 No. 1, can we measure. And if we  
20 can measure technically to know what services  
21 we're getting for the bucks in various health  
22 districts, can we potentially offer some of those  
23 services potentially out to contractors, someone  
24 that maybe can do it better, more efficiently,  
25 better service skills, all the other things that

1 are important to providing good public health.

2 But again, I'm not saying we make  
3 anybody go there, but I don't know what else,  
4 other than some potential competition makes you  
5 become more efficient within the Government  
6 political -- other than the timing of the strong  
7 political leader or a strong director.

8 Inherently, that's not usually one  
9 of our positions in Government. It is for me,  
10 but --

11 MS. SCOFIELD: I just want to say  
12 something, too, is when we talk about public  
13 health, I mean, there are different components in  
14 a public health district.

15 There is governmental public  
16 health, which is a health department and others,  
17 hospitals have a role, businesses have a role, and  
18 so on.

19 So I want to make sure that we  
20 would not be mixing those up too much and that  
21 we're talking about just kind of the whole public  
22 health system, or are we talking about the  
23 governmental piece of the public health system as  
24 we go through this.

25 So I don't necessarily -- I think

1 we need to -- again, back to these core services,  
2 what does that local health department expect?

3 And the public local health  
4 department has been a top gap provider, because  
5 that's how the whole system has evolved over time.

6 Is it the right way? I don't know  
7 at this point.

8 But I don't know that those core  
9 services necessarily need to be put out for a bid  
10 or privatized, either.

11 So I think we're walking kind of a  
12 fine line in this discussion.

13 DR. WINSLOW: We weigh-in a bit on  
14 Representative Wachtmann's comments.

15 You know, one of the things we're  
16 dealing with as a State on some of our smaller  
17 hospitals is going to be OB capabilities, because  
18 they can't afford to keep it open.

19 What we see with data two and  
20 three years out the that is that half of the work  
21 in the county that surrounds it in the infant  
22 mortality actually improves, and the other half,  
23 it gets worse.

24 And so the logic is drawn to if  
25 you lose that capability your infant mortality

1 will worsen. Well, that ain't necessarily so,  
2 just because of exactly what  
3 Representative Wachtmann said, is that we're not  
4 always comparing all the things we need to do look  
5 at. We're not looking at efficiency. We're not  
6 looking at quality. So I don't assume anything  
7 anymore.

8 What I do is just look at it more  
9 freely at what is happening there, but I have to  
10 have a comparison to look at. So we have to have  
11 a comparison and challenge ourselves to look at  
12 where the best practice is and how do we relate to  
13 what are the best practices there.

14 And it may be the safety net  
15 services we're providing could be provided by a  
16 better hospital system, by a health department. I  
17 don't know. But I don't assume anything anymore.

18 And I think we need to ask those  
19 questions ourselves. Are we the best people to do  
20 this or is someone else better. Well, talking  
21 about salaries, talking about the needs, sometimes  
22 you'll find out they actually will be willing to  
23 do it.

24 And those are the kind of  
25 conversations that I think need to be happening at

1 the local level to get the highest quality of  
2 service for the most affordable price that we can  
3 out there, or we're not going to move any of this  
4 stuff into a better place than it is today.

5 Just to comment, I don't like to  
6 assume everything is true that I used think was,  
7 versus the higher concentration at the  
8 subspecialty in the community, the shorter the  
9 life span and the sicker people are at every stage  
10 of life. And that's proven true all over America.

11 So you tell me how that makes  
12 sense, I mean, from a logic standpoint.

13 I'll tell you how it makes sense.  
14 Just looking at -- you guys get this, right?

15 So we've got to keep challenging  
16 ourselves. Let's go into this with an open mind  
17 saying how could we improve this, are there better  
18 models, maybe I can achieve efficiency.

19 So I like to move the spectrum  
20 with that frame of mind, no assumptions.

21 - - -

22 Thereupon, Representative  
23 Wachtmann exited the room at approximately  
24 2:40 p.m.

25 - - -

1 MS. FOUGHT: And I would just like  
2 to touch on the flexibility issue.

3 And I appreciate the differing  
4 opinions; however, when you look at certain  
5 regions of this state there is no way you can put  
6 a population. Let's use the number of 100,000 and  
7 look at southeastern Ohio. And I'm sorry that I  
8 keep harping on the southeastern Ohio bit.

9 But I know how much my township  
10 struggled down there. And I'm sure all the other  
11 political subdivisions down there are struggling,  
12 as well.

13 And so if you put a 100,000  
14 population number on them, the people in Morgan  
15 County, if they can pass a levy or if they're  
16 willing to support it, but the people in Monroe  
17 County or Noble County -- and I'm so sorry if  
18 anybody's from those counties, because I don't  
19 want to offend you.

20 But if they're not willing to  
21 support it, then the people in Morgan County are  
22 going to feel like they're the ones propping up  
23 this health district all because of a population  
24 size.

25 So when you talk about

1 flexibility, I mean, I think it's a great point  
2 that we need standards. And if you want to put  
3 those standards in there, I think that is  
4 excellent. And let's strive for those standards.

5 But when you start putting a  
6 population threshold and tying it to funding or  
7 something else, you're going to lose a group of  
8 people in this state that cannot afford the  
9 services, and they're not going to be able to  
10 afford the services no matter what you put in  
11 place for them.

12 So the flexibility point of that  
13 will allow them -- because maybe Monroe, Morgan,  
14 and Noble don't want to join together, but maybe  
15 Morgan and Washington do. Now, there are counties  
16 separating each other, which I am not sure if it  
17 is true. If I look at a map I could tell you.

18 But, you know, maybe a county  
19 apart they are willing to work together. Why  
20 shouldn't they be allowed to do it?

21 And if that's the flexibility that  
22 we're looking for and those are the types of  
23 standards that maybe we should change, or at least  
24 recommend to the General Assembly to change, I  
25 think that should be the direction, as opposed

1 told setting forth certain population standards.

2 We should look at care, like  
3 mandated service levels or care levels, and then  
4 provide the flexibility needed to those  
5 departments.

6 And then again, it also goes to  
7 the whole financial piece of it. And I know  
8 they're not there yet, Mr. Chairman, but at the  
9 same time that is a the issue.

10 VICE CHAIR PRESS: But we are  
11 there.

12 We are talking in non-dollar  
13 terms, because that is absolutely a financial  
14 question.

15 COMMISSIONER EDWARDS: There is a  
16 number of things we could be talking about.

17 Are we talking about a combination  
18 of services of boots on the ground, or are we  
19 talking about a combination of administration?

20 Because I can guarantee you that  
21 my Amish community in the Northeast portion of  
22 Ashland, Ohio is not going to go to Holmes County  
23 to get their shots. And your Amish population --

24 COMMISSIONER MCFADDEN: They're  
25 not going to leave anywhere to get their shots.

1 We have to go out to them.

2 COMMISSIONER EDWARDS: Yeah.

3 So the boots on the ground, and  
4 it's very important in where they're at.

5 The administration portion,  
6 however, to me can be maybe another story.

7 VICE CHAIR PRESS: That's what I  
8 understand the scope of the conversation.

9 To say which pieces of this are  
10 more minimal consolidation, versus a combination  
11 of scale, right?

12 MS. SCOFIELD: Yeah.

13 I didn't mean to imply that the  
14 only criteria be population size, although I think  
15 that is an important one, because I think there  
16 are some small health departments surrounded by  
17 big ones that don't quite stand alone -- they are  
18 still stand alone health departments. That is  
19 kind of a question that I kind of talked --  
20 struggle a little bit.

21 But certainly even if there is not  
22 one, there's -- you know, we talked about it.  
23 There is things about the administration, the back  
24 office function that could be across the board in  
25 many situations. HR, IT, finance, those types of

1 things can, and there are a number of ways you can  
2 talk about the shared services or shared  
3 purchasing around that that could save a lot of  
4 money.

5 But I also think that scale of  
6 service in combination with quality of service has  
7 to be part of this, or there doesn't -- I really  
8 don't -- they don't move. They won't move and not  
9 in any meaningful way or time frame.

10 So I think that's that.

11 COMMISSIONER WENTZEL: I want to  
12 follow up on Heidi's comment.

13 So Heidi help us out.

14 In those areas with more sparse  
15 population, not dense, do I understand you  
16 correctly to say that you think there are  
17 opportunities to get scale?

18 Because the reason I have more  
19 people is to get scale, right? That's the proxy  
20 for the solution. Is that pretty much thinking  
21 the same way on that one? Okay. All right.

22 Do I understand you to say then,  
23 that the solution for scale in those cases is,  
24 what, if it's not combining districts into 100,000  
25 people there. You're saying let them sort it out

1 among themselves, or what?

2 MS. FOUGHT: Again, I go back to  
3 flexibility.

4 So yes. I mean, if it's not  
5 population based, but it's the willingness of  
6 certainly counties to combine back office work or  
7 whatever, I mean -- or putting certain levels in  
8 where they know they have to meet it so there  
9 would be some type of incentive for them to at  
10 least work together, I don't think population is  
11 the best way to do it, especially given the  
12 funding that have today of the health departments,  
13 population in southeastern Ohio is not going to  
14 get the job done.

15 VICE CHAIR PRESS: To the point,  
16 there are some things where proximity and adjacent  
17 to may be required, but you could have your  
18 payroll done by Cleveland, right?

19 MS. SCOFIELD: Sure.

20 MS. FOUGHT: Purchasing of  
21 supplies can be done by -- whatever. Exactly.

22 COMMISSIONER EDWARDS: You can  
23 contract anywhere.

24 MS. FOUGHT: That's available  
25 today. How widely used, I can't speak to that.

1                   COMMISSIONER EDWARDS: Don't mind  
2 if I tag on, we don't need anymore calls, though.  
3 I'm just saying.

4                   MS. FOUGHT: And I would take a  
5 different approach to that, however.

6                   But, yeah. There are  
7 opportunities today. And I just don't know enough  
8 about the opportunities you all are sharing today.  
9 I mean, I know I've heard a little bit about it.  
10 I just don't know enough personally about it.

11                  VICE CHAIR PRESS: Dr. McFadden.

12                  COMMISSIONER MCFADDEN: So one  
13 comment that I'd like to throw out for folks to  
14 throw darts at.

15                  So I have a little bit of  
16 difficulty with the concept of the jurisdiction of  
17 14,000 can't be a functioning health district.

18                  I think -- so if Holmes County --  
19 the residents of Holmes County won't do it, but if  
20 the residents of Holmes County were to say were to  
21 pay \$20 per capita to our local health district I  
22 can meet all of this. That's not going to be an  
23 issue.

24                  So the issue really is how much  
25 money are we willing to put in. But I just want

1 to separate the functionality of the health  
2 district is really based on the money that it can  
3 generate, I believe. I don't think it's based on  
4 the size of the population it serves or the size  
5 of the health district. If I have enough money I  
6 can buy enough people to get the work done.

7 That's the only comment that I  
8 want to raise.

9 So here is an issue I've been  
10 struggling with. I've been floating it sort of  
11 casually and cautiously with some folks and I'm  
12 just going to float it here.

13 I will share it is not unique to  
14 me. This has come from looking at other states  
15 and this is one of the things they're doing.

16 I wonder what it would look like  
17 if we said you can keep doing what you're doing  
18 right now. These are the standards we're going to  
19 hold up right now. You need to meet those  
20 standards. If you choose to stay the way that you  
21 are, you know, that's fine; but -- however, the  
22 State of Ohio is going to create block grants.  
23 And I'm going to throw out some numbers here. I  
24 would be doing \$5 per capita. Maybe that's too  
25 much.

1                   But the State of Ohio is going to  
2                   have \$55 million that we will distribute. We will  
3                   only distribute it to jurisdictions that come  
4                   together forming a collaborative relationship or a  
5                   consolidation, you guys decide, that have X number  
6                   of people and X number of counties.

7                   You're not eligible for this money  
8                   unless, one, you meet these standards, and two,  
9                   you meet this jurisdiction size.

10                  You do not have to play. You can  
11                  get your state subsidy of 0.01-percent of your  
12                  budget. We will give that to you. That \$6,000 to  
13                  Holmes County, we will give you that, but if you  
14                  want \$200,000 for Holmes County, you have to play  
15                  with some other counties and you have to  
16                  consistently meet these benchmarks to continue to  
17                  be able to play; otherwise, you're not eligible.

18                  So I don't know if that idea meets  
19                  folks' desire for changing jurisdiction, if it  
20                  needs the folks' desire for having accountability,  
21                  if it meets the folks' desire for having equality.  
22                  But fore me, that's been something that I've been  
23                  thinking about -- again, this is not my idea.  
24                  This is based on what some other folks are doing.

25                  And so I'm going to throw that out

1           there, because I've been talking with some folks  
2           who typically are not very favorable of this  
3           concept of increasing the size of jurisdiction.

4                         And it's been polling okay in  
5           those sections, but I don't expect that we're  
6           going to have some of the folks that I usually rub  
7           shoulders with jumping up and down congratulating  
8           me.

9                         So I put that out there.

10                        COMMISSIONER INGRAM: Great idea.  
11           Great idea.

12                        I think that is a discussion we  
13           really need to have on the funding.

14                        I will say to you, D.J., relative  
15           to there is efficiency to be gained by  
16           reconfiguration of the system. Okay?

17                        There is so much money going out  
18           per capita today and that's reconfigured. There  
19           should be efficiency gained due to consolidation  
20           of administrative functions and so forth, that  
21           that money could go back into the programming, for  
22           example.

23                        I'll say -- just say if you rig a  
24           bigger system, how much health commissioners do  
25           you need? How many banquet directors do you need?

1 How many accountants do you need? And so forth.  
2 Okay? Obviously, that goes without saying. It's  
3 what you're seeing with school districts in that  
4 discussion.

5 But I will tell you that I do  
6 think that it is interesting she landed on the  
7 \$55 million number, because that is the same  
8 number I actually wrote in on the survey at \$5 per  
9 capita, but the only difference was that I believe  
10 that we should look whether it is coming out  
11 through block grant, we should be looking for  
12 asking for redistribution of the existing excise  
13 tax that is on tobacco.

14 There is \$868 million that was  
15 collected in tobacco taxes in this state in 2010.  
16 And if you look at the chronic diseases that we  
17 are chasing today, most of them have some ties to  
18 tobacco or the effects of tobacco use.

19 And I know that asking for that  
20 excise tax to be increased by \$1.25 a pack to  
21 something is probably not as politically  
22 acceptable in today's environment if we go back  
23 and ask for redistribution of some of those monies  
24 up to 7-percent, to go into a reconfigure perhaps,  
25 block grant public health system that will allow

1 for health improvements to occur in the future.

2 There is another \$45 million of  
3 tobacco tax dollars that are being collected  
4 today, I think it was passed in '93, on smoke less  
5 tobacco products. Okay? And I think that was  
6 based on a percentage of 17-percent -- 17-percent  
7 type of a formula.

8 So I would suggest that much in --  
9 perhaps somewhat in agreement with what you're  
10 looking at, that -- how do you package it is the  
11 question. And do you make it flexible in order to  
12 be able to play with this new foundational  
13 funding. I'm talking about foundational funding.  
14 Okay? I'm not talking about if you could raise  
15 other monies in addition over and above that.  
16 That's that jurisdiction, whatever that may look  
17 like in future's opportunity to do.

18 So, uhm, that's starts to get to  
19 the heart of the matter, I think, of what that  
20 will do for the local public health system. Those  
21 are monies that are already currently coming into  
22 the State. I realize they're already being  
23 appropriated in different places. Asking for  
24 7-percent of 860 million I don't think is  
25 unreasonable for the job that is ahead of us.

1                   The other thing I would say and  
2 probably for more time, Mr. Chairman, is that at  
3 some point we have to talk about the governance.

4                   And I know we talked about the  
5 edge of that, because Mrs. Edward's added, and so  
6 forth.

7                   I really do think that this is all  
8 tied together. The capacity is tied to funding.  
9 Structure is tied to that. And governance is  
10 ultimately going forward, helps perhaps to deal  
11 with some of the issues that Mrs. Fought talked  
12 about, going forward.

13                   I know I would not expect one  
14 county to levy support another two counties's  
15 operation. That's just not feasible. That's not  
16 going to happen. That's not in the cards.

17                   Nor can you ask the townships and  
18 villages that are already supporting a certain  
19 percentage of the general health issue to all of a  
20 sudden anti up more to create that capacity.  
21 That's just not going to work. They're getting  
22 cut.

23                   So we have to look at where are  
24 the revenues today that allow us to go forward to  
25 building a better health system.

1 Thank you --

2 COMMISSIONER EDWARDS: A report in  
3 1993 says a numbers in the recommendation the  
4 State should assume a major responsibility or fund  
5 the profit -- providing the core public health  
6 functions in private practices.

7 Where is the State in all of this?

8 Because when I look at our county  
9 budget, the State subsidy for a total revenue of  
10 \$565,000, the State revenue subsidy is \$11,000.

11 So where are we with the State?

12 DR. WINSLOW: What I would say  
13 now, because of this conversation about futures  
14 and we're in a biennial budget process right now,  
15 this is an excellent time to look at where we are,  
16 where people think we should be, and to make  
17 recommendations that you all think we can float  
18 up.

19 So -- so -- because I really enjoy  
20 what I am doing now and I'd like to work with you  
21 all to get a common goal that we have.

22 So I'd like you to, if you would,  
23 be careful in your considerations, but don't  
24 hesitate to put some recommendations down, because  
25 this is the right time to put out recommendations

1 and it's the right time for us to be considering  
2 the issues right now. It will be two years before  
3 we get to this kind of conversation again.

4 So those are fair questions and  
5 they need then to be carefully considered by the  
6 group, because you guys know the history and  
7 landscape better than I do.

8 But give us things to work with  
9 that you feel you can support and we can move  
10 forward with great strength. Because I think it  
11 is interesting, you know, if we go after some  
12 tobacco money, well, that's an option always to  
13 consider. But I've always been very careful with  
14 what I put forward, because I really want to  
15 survive the process.

16 And so I like to put things  
17 forward that we think have a really good chance of  
18 making it and I have really good support of all of  
19 you to make that happen, too.

20 But ones I can't put forward, I'm  
21 not in a position to do that. That doesn't mean  
22 other people can't bring to the table  
23 recommendations that we all then can consider.

24 So I encourage you to think this  
25 with a lot of thought. We're in a different time

1 and I think the government is a little different  
2 than it was, but it's still got the same barriers  
3 that we always had.

4 What I hate is when people stop  
5 before we started anything, because they already  
6 assumed it wouldn't work. That I don't like too  
7 much.

8 So I think this is a healthy  
9 question to ask. It puts us on the spot. That's  
10 a good thing to do. It's a good question. Are we  
11 doing our job, are we doing what we're supposed to  
12 do?

13 For us to, you know -- my budget  
14 is about 12-percent CRS. Is that enough, or is  
15 that not enough for me to function as a State  
16 health department.

17 It's been a lot of State health  
18 departments. Is that a fair way to get at the  
19 issues that we as Ohio have as a state?

20 I tell you, I don't like being 36  
21 in the country in our state. That's not a point  
22 of pride for me. I'm used to being first.

23 So if you guys are willing to work  
24 with me toward those common goals, you reach with  
25 your health department to No. 1, I'm No. 1 with

1 you. That's a good place for us all to get.

2 I think we need to find better  
3 ways to work together toward that goal. I'm with  
4 you. And I'm willing to consider any and all  
5 possibilities. But if you would help me to make  
6 sure this is going forward, I'll stand behind, and  
7 hopefully have a good chance for being successful  
8 with.

9 With that, I've got to go to a  
10 webinar, guys. I hate to do that at this time,  
11 but I've got to get going.

12 I thank you all for what you're  
13 doing. I really appreciate this effort you're  
14 putting toward moving forward. And I really hope  
15 you'll look at the barrier and say how do we get  
16 past this, that doesn't stop us, and not let us  
17 stop now. And we'll work together towards those.  
18 Thank you all for --

19 VICE CHAIR PRESS: Thank you for  
20 being here.

21 I'm noticing that we are coming to  
22 the end of our scheduled time. I'm trying to take  
23 a minute and see if I can map out some things and  
24 see if the group agrees or disagrees.

25 It sounds like there is consensual

1 agreements around the concepts expressed here of  
2 allowing organizations to feel some latitude in  
3 their contracting in their relationships. So  
4 flexible in that.

5 - - -

6 Thereupon, Dr. Winslow exited the  
7 room at approximately 3:01 p.m.

8 - - -

9 VICE CHAIR PRESS: It sounds like  
10 there is less agreement around the minimum  
11 threshold size. It sounds like there are more  
12 folks that are more in support of that and some  
13 other folks less in support of that.

14 I don't hear anybody opposed to  
15 viewings -- correct me if I'm wrong. I don't hear  
16 anybody opposed to viewings scale as a mechanism  
17 for efficiency, but they don't necessarily want  
18 that scale to be based on population.

19 Is that a fair -- is that okay?

20 I'm hearing some discussion around  
21 how, but no consensus around the extension beyond  
22 the minimum services. You brought up some issues.  
23 I don't hear anybody say those things that are  
24 described as others should be moved into a column  
25 rather than part of the minimum packaging, even

1           though there was some discussion.

2                         COMMISSIONER SHAPIRO:   In my mind  
3           that whole thing is the minimum package.   The  
4           other package, the other services are based on  
5           individuals.

6                         And you're the author of the  
7           report so maybe you can -- is that what you had  
8           the information on?

9                         COMMISSIONER NIXON:   Right.

10                        COMMISSIONER SHAPIRO:   So in my  
11           situation I might be providing the MCH services.  
12           He might be doing prenatal care and family  
13           planning and other things.   So it's based on the  
14           needs of the community.

15                        One thing that isn't that you said  
16           in your endeavor now is dental health.   And it is  
17           just a huge issue statewide.   So it depends on the  
18           community.

19                        VICE CHAIR PRESS:   Got it.   Okay.

20                        And then I'm hearing we sort of  
21           got into the beginnings of some of the financing  
22           discussions.   We heard some discussion or  
23           suggestions, as well as I think some words of  
24           improvements.   So --

25                        COMMISSIONER EDWARDS:   Can I ask a

1 question about if we go back to the agreement  
2 on -- talk about the population and sizes?

3                   Could we potentially agree to a  
4 consolidation of health districts that use the  
5 same staff, but have two different boards?

6                   They are out there. We are one of  
7 them.

8                   COMMISSIONER NIXON: There's  
9 mechanisms for that now.

10                   COMMISSIONER EDWARDS: Yeah.

11                   So if you're using the same staff,  
12 if the administration is even the same, but you've  
13 got a couple -- two different boards, well, that's  
14 my question.

15                   MS. FOUGHT: Obviously, the  
16 communities, they want both of them. I mean, if  
17 they wanted to have a joint one they would have  
18 made that happen, correct?

19                   COMMISSIONER EDWARDS: Not  
20 necessarily.

21                   Because there is question, and  
22 maybe they don't understand.

23                   One's a city. Obviously, one is a  
24 city and one is a county. The city pays and that  
25 is in their Charter to have a health department.

1 They may. So that is what is in their Charter.  
2 So they deem that as they need a board and to do  
3 that.

4 So when you go to a health  
5 department meeting you've got the mayor and the  
6 city board sitting on this side of the table and  
7 the rest of the board sitting on this side of the  
8 table. And I know that we are not the only county  
9 that does this. But you've got those individuals  
10 and they're basically both stamping the same  
11 bills.

12 MS. FOUGHT: The only issue I see  
13 with that --

14 Mr. Chairman, I'm sorry for  
15 jumping in.

16 The only issue I see with that is  
17 that is a Home Rule decision. So that is  
18 something that that city chose to do. And the  
19 only way -- I mean, Home Rule is in the  
20 Constitution. So this body is not going to be  
21 able to tell a city that has Home Rule what not to  
22 do unless it's for, I think -- whatever. There is  
23 some provision in the Code.

24 But for the most part, the cities  
25 have the right to do that. So that wouldn't be

1 something legislatively we could change. It would  
2 have to be done via Constitution.

3 COMMISSIONER EDWARDS: Then we're  
4 really going to have a very big issue with  
5 consolidating cities with county cities.

6 MS. FOUGHT: No. They can choose  
7 to do it. The cities can choose, they just would  
8 have to go back and amend their Charters to take  
9 out that health board. But it's a city choice.  
10 They're choosing to keep that.

11 COMMISSIONER EDWARDS: I guess  
12 what I'm asking is could this group agree to  
13 encourage that.

14 COMMISSIONER NIXON: If I could?

15 I think the report offers several  
16 strategies for building better efficiency, council  
17 of Governments, cross jurisdiction sharing to  
18 consolidation.

19 You know, to your earlier  
20 question, Ohio ranks last in Federal support for  
21 public health. And they're the last in State  
22 support. With that said, we get strong local  
23 support -- when you look at the local support for  
24 public health, the general revenue support, we're  
25 not that far off of others states. We are very

1 close in terms of total support for public health.

2 So I think to suggest that we go  
3 to the State and "give us some more money and  
4 we'll do everything you ask," I think is  
5 short-sided. I think that that is not out of the  
6 question. But I think as a public health  
7 community we've got to demonstrate we did  
8 something up front, okay, and build better  
9 efficiencies before we do that. I don't think to  
10 go, "give us more money," and "hey, we'll do  
11 everything you ask of us," I think that is  
12 irresponsible and I don't think it meets what is  
13 expected of us.

14 I do think we can build  
15 efficiencies for a lot of strategies. Like I  
16 mentioned, counsel of Government, you could share  
17 administration, you can do all kind of things. So  
18 it doesn't have to be reducing the total number of  
19 health departments, but somehow we need to get it.

20 But there is money in the system.  
21 As Tim said, there is money in the system. It's  
22 just not very efficiently spent, I don't think, in  
23 a lot of ways.

24 So I think there is lots of  
25 opportunities, but we've got to take some of the

1 first steps to demonstrate that we're making some  
2 of the changes in the system to better meet the  
3 needs of the community.

4 COMMISSIONER INGRAM: -- you know,  
5 Heidi, that's interesting. And if you put Charter  
6 City aside, separate, because the Constitution  
7 question with that city, if you read -- if you get  
8 a chance and you haven't read the 1960 Service  
9 Commission Report, on Page 25 there is a 1921 Ohio  
10 Supreme Court decision that actually talked about  
11 that question. It's *Cuyahoga Heights versus*  
12 *Zangerelli* [phonetic].

13 And they actually said that since  
14 health districts are creatures of state statute  
15 that they actually -- in the nature of the public  
16 health being what it is, that they actually -- the  
17 Legislature has that authority, notwithstanding  
18 Charter 6.

19 MS. FOUGHT: Exactly.

20 Non-charter cities absolutely have  
21 the ability to do it, if the Charter cities that  
22 they don't.

23 COMMISSIONER INGRAM: And no one  
24 wants to put -- I certainly don't want --

25 I think there is a way to improve

1 the system and still allow for local control to be  
2 apart of the system. And that goes to the  
3 question of government plans, which I know we'll  
4 have to rest on.

5 VICE CHAIR PRESS: I'd like to  
6 suggest two things maybe to wrap up.

7 Mr. Tremmel could take us through  
8 the handouts that are at your seat. And maybe we  
9 can look at those between now and the next  
10 meeting.

11 And I have one other thought after  
12 that.

13 Do you want to real quickly orient  
14 everybody to what we're looking at.

15 SECRETARY TREMMEL: Mr. Mazzola  
16 will pull these up for us. Joe put together the  
17 reports that you see.

18 The conversations that Joe and I  
19 were having were in reference to our previous  
20 couple of three meetings.

21 First would be, let's look at  
22 revenue, Joe, by region.

23 So at your table you have the five  
24 districts, the Association of Health Commissioners  
25 has a traditional five district, north, east,

1 west, southeast, southwest, central region.

2 You can look at the disparity in  
3 population. This comes up quite often in our  
4 conversations. You can look at disparities being  
5 weighed, to the Northeast, more populous area, the  
6 southwest.

7 You can look at local revenues.  
8 Again, the disparities here of 130 million to 36,  
9 you're looking at about 4 to 1 disparity -- not  
10 quite 4 to 1 disparity.

11 But then if you take it the other  
12 way, as Joe referenced to me, you can look back at  
13 the population as a 4 to 1 disparity. So maybe  
14 things even themselves out in some strange way.

15 But here is what's striking: All  
16 of the rest aside, jump down to the bottom. Out  
17 of a \$564 million total revenue infrastructure for  
18 public health as we know it -- and this is data --  
19 let me qualify the data to suggest to you this is  
20 data that is reported to us through local health  
21 departments in their local in their annual  
22 financial reports. This isn't scrubbed clean  
23 data. This is data that's reported. So we take  
24 it for its advantages and caveats that are out of  
25 it.

1                   Out of \$564 million in the public  
2 health system, 430 of that are generated at the  
3 local level. So it comes back full circle is what  
4 we're seizing and grappling and grappling with.  
5 We want to change it. We want to change it. So  
6 we should at the -- let's change it, and then it  
7 begs the question "what's the investment on the  
8 state side." And it is referenced 49, 50, you  
9 know, 160 million, including Federal Pass Through  
10 monies.

11                   So while we could converse and  
12 have a number of different opinions, you know,  
13 there is one piece of the puzzle here for a  
14 moment. And maybe we open this up for  
15 conversation for a moment or two, but I'd like to  
16 come back to it at another opportunity.

17                   COMMISSIONER MCFADDEN: Well,  
18 that's one of the at least two opportunities I've  
19 said something that I think disagrees with what  
20 the Commission in this case said. And that is if  
21 at the State level we are going to be expecting  
22 more from local public health, I believe  
23 personally, D.J. McFadden here speaking, that the  
24 State has to have more skin in this game.

25                   I think it is very hard to demand

1 local public health to do more than the local  
2 population are paying for it, not to stay -- I  
3 don't have a problem with --

4 Maybe someone says, D.J. McFadden,  
5 you're not doing enough, you're not out working  
6 enough, you need to do more. But when it feels  
7 like the State is saying D.J. McFadden, you're an  
8 idiot, but we're only going to pay you this  
9 amount, that sticks in my craw a little bit.

10 And so that is the reason that as  
11 I propose it, I believe that there needs to be  
12 more skin in this game, and we at the local have  
13 to -- then have to produce more skin, then we are  
14 whole. But to have them be holding when I'm  
15 generating my money locally through relationships  
16 and going to my budgetary group and my township  
17 trustees and saying, guys, here is what we're  
18 going for, what you do you think, that is what I  
19 will share.

20 I've said it before, and I will  
21 say it again.

22 VICE CHAIR PRESS: Mr. Mazzola,  
23 could you or somebody maybe, I don't know, save  
24 us -- I'm guessing however man people are here  
25 that are starting to do the arithmetic, could you

1 maybe save us the trouble and get someone to do  
2 it?

3 SECRETARY TREMMEL: Do a per  
4 capita run.

5 COMMISSIONER SHAPIRO: One more  
6 question.

7 On the "Local Government Funds,"  
8 "Inside Millage," I understand, "Public Health  
9 Levy," I understand, "Local General Revenue," I  
10 don't understand.

11 I don't know what the "Local  
12 General Revenue" --

13 COMMISSIONER INGRAM: I would  
14 presume that's fees.

15 COMMISSIONER SHAPIRO: That's what  
16 I thought.

17 But we don't know?

18 What is it, Joe?

19 MR. MAZZOLA: General Revenue, I  
20 think mostly would be from those cities that  
21 contribute to General Revenue Funds.

22 COMMISSIONER SHAPIRO: So it's the  
23 city putting money into the city.

24 MR. MAZZOLA: Yes.

25 But fees are included in the

1 revenue for some reason that Mr. Tremmel was  
2 talking about. Fees are included in that revenue  
3 for the local. For the 430 million, that does  
4 include local fees and local, where folks go for  
5 services and they pay for it on the local level,  
6 individually. That includes that, as well.

7 MS. FOUGHT: Can I just ask a  
8 question for clarification?

9 VICE CHAIR PRESS: Sure.

10 MS. FOUGHT: "Inside Millage," is  
11 that the county inside millage portion that was  
12 referred to earlier in this discussion, or is that  
13 the inside millage that has been taken from  
14 townships or villages, or in some cases they are  
15 given general revenue funds.

16 So how would we know which  
17 category they're in?

18 I'm sorry. Does that make sense?

19 Because it could be in both, is  
20 what I'm trying to figure out.

21 Because, I mean, there are some,  
22 but there are other townships that have to give  
23 from their general revenue funds. So that's why I  
24 guess I'm --

25 MR. MAZZOLA: It could be both.

1 MS. FOUGHT: Okay.

2 SECRETARY TREMMEL: It could be  
3 referenced in other Local Government Funds. The  
4 title is at the top (indicating).

5 Do you have that one?

6 MS. FOUGHT: I'm sorry.

7 SECRETARY TREMMEL: It says "Local  
8 Government Fund" at the time.

9 MS. FOUGHT: Yeah.

10 SECRETARY TREMMEL: Okay. So in  
11 that you see -- you won't see -- take, for  
12 example, "Central," \$2.1 million of Inside Millage  
13 and an additional \$21 million in Local Government,  
14 Local General Revenue, 10 -- almost 11 million in  
15 a Levy.

16 I don't know if we could know  
17 necessarily know who that is, but we can see who  
18 that is. But it shows you the variety of  
19 combinations.

20 MS. FOUGHT: Yes.

21 SECRETARY TREMMEL: So the  
22 total -- so it shows you that there is some  
23 mixture in it.

24 But if you want to jump down to  
25 the answer quickly, 62 million in Local Public

1 Health Levies, versus 14 -- 13, 14 million.

2 That's one short equation, just over the Local  
3 Government Revenues.

4 MS. FOUGHT: Yeah.

5 SECRETARY TREMMEL: So back to the  
6 City, it's interesting here. City Funding is  
7 nearly -- hear the Public Health Levy.

8 MR. MAZZOLA: And we do have an  
9 individual local health department breakdown  
10 called "Fees" in categories to share with the  
11 committee at you're discretion.

12 It would be hard for us to say  
13 exactly what that breakdown looks like, just  
14 speaking on a local level without looking at those  
15 numbers.

16 MS. FOUGHT: Can I see that?

17 VICE CHAIR PRESS: Would you,  
18 please.

19 MR. MAZZOLA: Yeah we have that  
20 available.

21 MS. FOUGHT: Do you have the map  
22 that shows the breakdown real fast, if it's  
23 possible?

24 VICE CHAIR PRESS: Of the regions?

25 MS. FOUGHT: Yeah.

1 VICE CHAIR PRESS: If you could  
2 just get us the common definitions and maybe just  
3 the composition of each of the areas.

4 SECRETARY TREMMEL: And we can  
5 post this up on the website. It will show the  
6 lines of the five districts.

7 MS. FOUGHT: Thank you.

8 SECRETARY TREMMEL: So there is  
9 this information.

10 And then --

11 COMMISSIONER SHAPIRO: Excuse me.

12 Is someone going to be compiling  
13 the "shall" in this case.

14 COMMISSIONER NIXON: We'll do that  
15 specifically, but I think everyone else --

16 COMMISSIONER SHAPIRO: Needs to  
17 look at it, too.

18 VICE CHAIR PRESS: I guess the  
19 last thing -- thank you, Joe Mazzola.

20 This is just sort of personal  
21 observations and feelings.

22 This is the second time whereas  
23 our meeting progressed and I felt like we really  
24 started to have some good discussions, started to  
25 get into the real kind of meat of some of the

1 issues that are difficult, controversial, and our  
2 time expires.

3 So I guess what I would ask  
4 everybody to do -- the Chairman may come back and  
5 regret that he left.

6 But I guess what I would like to  
7 maybe do is would it be better, should we take one  
8 of our future dates, maybe schedule a little  
9 longer time, focus our energy a little longer so  
10 we can kind of maybe -- because eventually were  
11 are going to really have to make some  
12 recommendations here.

13 I feel like we get to the edge of  
14 some things and then we have got to get out of  
15 here. I guess I feel like if we took a little bit  
16 longer time we can really make a lot of progress,  
17 is one of our suggestions. I just invite we think  
18 a bit on that.

19 And, Lindsey, you can pass that  
20 word to the senator, or I'll take it to him.

21 Any thoughts on that?

22 COMMISSIONER INGRAM: I think  
23 you're right.

24 Are you thinking an extra hour?

25 VICE CHAIR PRESS: I would go with

1 whatever the group thinks would be best.

2 I mean, we've gone over 15 or 20  
3 minutes a couple weeks in a row here.

4 SECRETARY TREMMEL: And just as  
5 another point of clarity.

6 This is the end of August. We're  
7 staring at two opportunities in September. We  
8 were thinking a little collaboration in October  
9 and wrap up the report. So there is not a lot of  
10 sand left here in this hour glass to which we can  
11 pull together some good solid recommendations.

12 COMMISSIONER NIXON: Do we have an  
13 idea how we'll make those decisions?

14 I mean, are we going to ask some  
15 hard questions of ourselves and do a straw vote,  
16 or have we thought about that? Or should we think  
17 about that as an agenda item?

18 VICE CHAIR PRESS: I have not  
19 discussed it with the chairman. We should get  
20 some schematics on that.

21 But my thinking would be we should  
22 do something about that. And that's part of the  
23 reason you wanted this ranking, is to figure out  
24 where we should -- when time gets scarce where we  
25 should concentrate our efforts, put those around

1 the things that the group thinks are most  
2 important.

3 I mean, I guess that's kind of how  
4 you did it when you went through your nomination.

5 COMMISSIONER NIXON: Pretty much.

6 VICE CHAIR PRESS: Anything else  
7 for the good of the order, or a motion to recess  
8 till next time?

9 COMMISSIONER INGRAM: So moved.

10 VICE CHAIR PRESS: Second?

11 COMMISSIONER SHAPIRO: Second.

12 VICE CHAIR PRESS: Thank you,  
13 everyone. I really appreciate your time.

14 - - -

15 Thereupon, the meeting adjourned  
16 at approximately 3:21 p.m.

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C E R T I F I C A T E

- - -

THE STATE OF OHIO:

SS:

COUNTY OF FRANKLIN:

I, Heidi L. Funderburk, a Professional Reporter and Notary Public in and for the State of Ohio, do hereby certify that said meeting was taken in all respects pursuant to the stipulations; that the foregoing is the said meeting was given at the said time and place;

IN WITNESS WHEREOF, I have hereunto set my hand and official seal of office at Columbus, Ohio, this 6th day of September, 2012.

-----  
HEIDI L. FUNDERBURK  
Notary Public in and for  
Franklin County, Ohio  
My Commission Expires 7/27/15

- - -