

14 Aaron Ockerman
Lindsay English
Beth Bickford
15 Krista Wasowski
Karen Hughes

3

- 1 AGENDA
- 3 1. Welcome
- 4 * Senator David Burke, Chairman
* Christopher Press, Vice-Chairman
- 5
- 6 2. Approval of July 24 Meeting Summary Notes
- 7 * Martin Tremmel, Secretary
- 8 3. Review of Recommendations: Local Public Health
Capacity, Services and Quality
- 9 4. Review of Beyond Boundaries: A Shared Services
Action Plan
- 10 * Randy Cole, OBM
- 11 5. Next Meeting August 14, 2012
- 12

4

17 CHAIRMAN BURKE: Excellent. Next on the
18 Agenda is the approval of the July 24th meeting Summary
19 Notes and Minutes.

20 I know that those have just been posted,
21 some folks have just gotten those. In order to give you
22 time to review those we'll take the approval of the
23 Minutes and move it to the next meeting, if that's
24 acceptable for folks to give time to digest and make any
25 recommendations or corrections, should there need to be

5

1 any.

2 So with that being said, we'll start right

3 to work, Review of Recommendations. As we originally
4 had laid out, we're going to break this into components
5 in which we were handed, and in the recommendations on
6 Page 11 of the Public Health Futures Report you'll find
7 Recommendations 1 through 7 under Local Public Health
8 Capacity, Services and Quality.

6
7
8

4 MS. EDWARDS: If I could add on to your
5 comment, Nancy, an example would be access to birth and
6 death records.

7 Does every county need to have a vital
8 statistics? I mean obviously, we should have access,
9 but where is the access? So I think that's vital to
10 this conversation.

11 MR. TREMMEL: And your thought is meaning
12 that access is not necessarily needed in every county?

13 MS. EDWARDS: In this day and age, and in
14 the future, no, I don't think it is.

9

10

2 MR. TREMMEL: --

10 So a year and a half ago, or thereabouts,
11 you could now go into any county health department that
12 had an office, a vital statistics office, many do, there
13 are, I think, upwards of ninety or a hundred, not one in
14 every health department, now you can access, go into any
15 one of those points, the record for any county.

16 MS. EDWARDS: Okay.

17 MR. TREMMEL: But you can also access this
18 on-line, so you can go to the ODH site and you can pay a
19 fee, third party vendor, to secure the records, and
20 alternately you can go to the ODH Office of Vital
21 Statistics here in Columbus and access your records, so
22 there are a number of opportunities.

23 The efficiencies are built in, but I think
24 to your point, how many are necessary, and I guess
25 that's a good question, and I don't know that I can

11

1 answer, other than just layout for you the --

2 MS. EDWARDS: Okay.

4 MS. EDWARDS: And that is both, birth and
5 death records, or not?

6 MR. TREMMEL: Birth available now, death
7 coming on-line within maybe that's not the next number
8 of months, could be 6, could be 9 months.

9 MS. EDWARDS: Okay.

10 MS. SHAPIRO: The -- one of the things that
11 you have to do though, the vital -- the office not only
12 issues the death certificates, but they also do the
13 burial permits and other functions, so that if you're --
14 if you need someone buried you need to be able to file
15 those permits and those kind of things.

12

13

1 MR. INGRAM
9 So what the group did was say, we need a
10 set, we want -- perhaps every Ohioan is entitled to this
11 core package, they're not all receiving this today.
12 Okay. It varies depending on where you are and the
13 capacity of that local health district.

14 So this was truly perspective in nature, for
15 example, health promotion, education and prevention,
16 there's a lot of different variation across the State of
17 Ohio relative to how many local health districts
18 actually employ health educators, and so forth, and you
19 can go on and talk about other areas too.

20 On the vital statistic question, I think the
21 only thing I would add is that it's important to
22 remember that is where the birth or death occurred, the
23 registrar, that's defined in the Ohio Revised Code
24 today, which happens to be mostly assigned to all local
25 health departments, has the responsibility to issue that

1 birth or death certificate.

2 And up until two years ago or so those
3 places that had, you know, a lot of birthing hospitals
4 or large populations, they were issuing all the birth
5 and death certificates, regardless of where that person
6 lived, because it's based on where it occurred, and

7 that's a very important distinction to keep in the back
8 of your mind.

16 We issue, just out of Hamilton County,
17 there's 10,000 births a year in Hamilton County, 3,000
18 to 4,000 of them are issued out of Hamilton County, and
19 the other 6 are issued out of Cincinnati.

17

18

3 So back to the core functions, but those
4 three top ones, environment health, communicable disease
5 and epidemiology are all in rule or in the Ohio Revised
6 Code. The other ones are referenced in the
7 accreditation standards that everybody is filing at the
8 end of the year.

15 CHAIRMAN BURKE: And that is a reasonable
16 framework then for the committee to strive towards
17 those, there's no distention on that particular issue?
25 you mentioned, larger regions, as you look at other

19

10 DR. MCFADDEN:
And so I think that -- what are things that
11 are essential for folks to have access to the service in
12 their community, and I speak from, you know, a rural
13 community where I really feel like sometimes rural
14 communities don't have access to things that they need
15 and I want to make sure through this process that we
16 don't take away.

17 MS. EDWARDS: But that goes to the one size
18 does not fit all.

19 DR. MCFADDEN: Right. Right. So for me, I

20 think part of my concern is that as we go through this
21 process that we do consider, you know, Ohio's a unique
22 state, you don't have the rurality of Nebraska nor do we
23 have the urban nature of New Jersey.

20

1 -- I would hope that we would
2 not harm our rural, you know, southeast Ohio, some of
3 the rather rural places that I think could be harmed, if
4 we're not careful, the citizens. I just wanted to point
5 that --

6 CHAIRMAN BURKE: And that's kind of the way
7 that we thought about how to do this and how to
8 structure it, and then people come up with the magic
9 number of health districts.

10 I don't think it's the number of health
11 districts that drives the policy, I think it's the
12 policy that should drive how the health district works.

13 It could be a single person working in an
14 office in a small county that is an access point and
15 some services are provided somewhere else.

16 It could be 88, it could be 240, I don't
17 know, but as we work through this and we agree on what
18 these fundamental activities are, then we can work on
19 how we actually would deliver them.

21

CHAIRMAN BURKE:

1 So I guess if everybody's okay with what

2 those core public health services are, take that
3 recommendation and kind of make that a baseline of
4 services.

5 MS. SHAPIRO: I just think we need to be
6 cautious. Again, when I'm thinking about what D.J. is
7 saying and with the other services and access issues,
8 and access to health care in some rural and very low
9 income areas in Ohio without being in big city, but some
10 of those issues need to be looked at also.

11 So the other services I'm thinking are the
12 clinical, preventative and primary care services, again,
13 with BACA, I think may change a little bit, but I think
14 we can't throw that maybe out with the bath water yet.

15 I think we need to look at that to make sure
16 that -- that, again, every Ohioan has some access to
17 services that they need.

18 CHAIRMAN BURKE: Well, I'm going to thank
19 you, Nancy, because that's going to roll me into No. 2.

20 "All local health departments should have
21 access to the skills and resources that make up the
22 foundational capabilities", which is in -- I guess it's
23 like a blue-ish, purple-ish colored area, "in order to
24 effectively support the core services."

25 So we can discuss these additional

22

1 foundational capabilities, and I don't know, since we do
2 have some resources here on the thought process, beyond
3 the core public health services, Tim, can you share a

4 little bit about what the foundational capabilities
5 were.

6 MR. INGRAM:

13 For example, there needs to be quality
14 assurance inside the system, either providing it
15 directly or assuring it through another -- by another
16 entity, whether it would be a shared educational service
17 center, like there's a lot of discussion around school
18 districts today, or directly by that health department.

19 Clearly, electronic health records has taken
20 off, you know, train's left the station. You'll find, I
21 think, across the state that health departments that are
22 staying in clinical services, perhaps as an option are
23 at different degrees of implementing their own
24 electronic health records, others are probably trying to
25 partner with hospitals, they're obviously moving ahead

23

1 quickly and other doctors offices and so forth.

7 Policy development, again, you have to have
8 the capacity to be able to develop policy

24

1 But wouldn't it be nice to be able to have a
2 resource center just for public health that we could
3 work collectively in a way in which we are successful in
4 bringing grant dollars, just not to local health
5 departments, but to the State of Ohio.

6 We're not getting our fair share of grant
7 dollars out of Washington and other places inside this

8 state relative to public health.

13 Currently in Ohio law the prosecuting
14 attorney is required to provide us legal services. You
15 know, and I can tell you, as the health commissioner
16 that's been in Hamilton County for almost 20 years in
17 that position, if we did not have good legal counsel out
18 of that office we would not be successful.

19 That's a key, key position, relative to the
20 work that we have, relative that we have police powers,
21 and we're cleaning up messes at times, and every now and
22 then, often we have to go into court, you know, every
23 now and then.

25

5 Laboratory capacity, there's not much
6 laboratory capacity left for public health in the State
7 of Ohio. Cincinnati Health Department actually closed
8 their labs, I think, a year and a half ago and that was
9 -- that was the last one down our way.

10 Now, we still have, and thank goodness, the
11 Ohio Department of Health Laboratories that are now
12 combined out with Ag and some other ones out in
13 Reynoldsburg, and EPA and that stuff, and we need that.

19 And, you know, it takes trying to get
20 behavioral change, so that the incidents of chronic
21 disease will begin to reduce is -- it takes trained
22 professionals, and so I think that not only do you need

23 health educators and other people that are in that area,
24 but you also need somebody that has and knows how to
25 deal with the media.

26

9 So we feel, the committee, I believe, felt
10 that you had to have, this is the roots, this is the
11 trunk of the tree, and the core public health service,
12 if you remember that diagram in the book when you heard
13 in the report from the first meeting with kind of the
14 leaves and the branches and the fruit, essentially what
15 people were going to get, but you've got to have that
16 foundation before you can bear -- bear fruit.

17 CHAIRMAN BURKE:

24 Maybe our local health folks can jump in
25 here, if we could just discuss these points and see

27

1 what's available and what's not under quality assurance,
2 help me out; where are we headed and what else do we do?

3 DR. MCFADDEN: I guess, I feel like of the
4 document, these things in blue are perhaps some of the
5 more revolutionary, I mean, can really change public
6 health in Ohio to be sure, and I wasn't part of the
7 group that put this together, but I really think these
8 are good things.

9 I don't -- I don't know that these are
10 necessarily budget neutral, and so I see this, I mean, I
11 see this as an opportunity to improve public health, but
12 that's one thing that I personally applaud, that it's

13 not budget neutral, but that may be something that you
14 and the legislature do, but I think that these are
15 pieces that are perhaps the most prospective.

19 I like the language that -- the language in
20 point two, they should have access to, because some of
21 these pieces we definitely have in spades in our
22 district and some we don't.

28

13 I look to the northwest, the six pack that's
14 up there, Henry County, Williams County, those counties
15 have some really terrific things that they're doing
16 around small districts that lead to quality, but that I
17 think are really -- will help us in a small area, so
18 that's how --

29

NANCY SHAPIRO:

6 and one of the questions was, was the Ohio
7 Department Health thinking about taking over, doing that
8 role or not? Is that one of the goals of the department
9 to assist locals in building all our capacities and
10 strengths? I don't know if one of you has an answer to
11 that.

15 MR. TREMMEL: No, I don't have the answer,
16 and, no, I haven't heard that being the plan. I think
17 that with accreditation being novel, especially for the
18 test sites, and we were one of the fortunate ones to
19 become, we are still dipping our toes into
20 accreditation. The assessment is done, the shift is

21 done, the strategic plan is now complete, we need to put
22 all of those together and start putting together the
23 necessary documentation.

30

1 ...combine three or four thousand separate documents to
2 which he felt was appropriate to prove to the
3 Accreditation Board that he was ready to be reviewed,
4 that will be the next step for the Ohio Department of
5 Health in the coming weeks, then going to the PHAB,
6 paying the necessary fees, inviting them to make a visit
7 at the Ohio Department of Health and to do an in-depth,
8 complete assessment to determine whether the department
9 of health is to be accredited.

31

19 REPRESENTATIVE ANTONIO: Thank you. So when
20 I looked at this model, one of the things that strikes
21 me in having been in municipal government where all we
22 talked about was core versus everything else, is kind of
23 how it went.

24 MS. EDWARDS: Yes.

25 REPRESENTATIVE ANTONIO: And when we divided

32

1 up that way were we throwing out the baby with the bath
2 water, or were we saying we've identified core, but in
3 order to truly have a successful, functional core, we
4 have to have a foundation.

5 And when I look at this I see the

6 foundational capacities and the capabilities truly being
7 visually, as well as literally, as well as figuratively,
8 being the foundation on which to be able to successfully
9 have your core services, these things have to be there
10 as well, it's a complementary sort of model.

11 Having said that, then going back to what
12 D.J. was saying about the whole rural versus urban, or
13 not even versus, but just the fact, acknowledging we
14 have both, was that lens looked at or do we also look at
15 that lens through that lens as we're talking about
16 whether it's best practices, places for collaboration.

17 As I look at all these areas I'm thinking,
18 even -- even a grants program, and that conversation I
19 love, because having worked a lot with non-profit, the
20 organizations actually put some resources up front into
21 having a grant writer or having some -- putting some
22 resources into that area, reap the benefits, then of
23 being able to leverage those dollars for other dollars,
24 and I know that it's possible to share those resources
25 as well.

33

7 I'm just curious where those conversations
8 went and as we look at this where we might be mindful of
9 that.

10 MR. INGRAM: I -- to try to be as fair as I
11 can, based on the -- the committee was composed of quite
12 a cross section of urban, rural, large, small health
13 districts, so I'm not sure we got to that question.

19 And so it almost comes down to you can only
20 share, you do have the good fortune of having some
21 capacity of grant writers and public affairs folks and
22 epidemiologists, and so forth, but you can only share
23 that capacity so long until somebody has to pay for it,
24 you have to build it, somebody has to pay for it.

25 If you want to keep capacity, somebody has
34 to pay, otherwise they're going to go away, you know, so
1 I don't think we got to that point.
2
7 there's going to be always local
8 variation, everybody's got a little different, you know,
9 needs and so forth, and that was not to discount that at
10 all, that was brought in too, but still, you could go to
11 this health department and you would expect, whether you
12 were coming out of Hamilton County or coming out of
13 Athens County or what have you, you would still see some
14 similarity of what some of the services were with the
15 people.

23 See the grants, all these grants require
24 someone to be doing the evaluation, and in a lot of --
25 you know, sometimes you can do it internally, often
35
1 anyone who's -- who's funding you you've got to go
2 outside, and so you've got to hire somebody

6 So I just wanted to put that -- so that's --
7 -- not a lot of capacity
9 in the state throughout the 125 health districts for

10 program evaluations.

11 REPRESENTATIVE ANTONIO: So could I ask a
12 question, could that be a core part of something that's
13 shared then, as having -- having that as almost like
14 that center?

15 MR. INGRAM: I think it could be, yes, I
16 think it could be.

17 VICE-CHAIRMAN PRESS: Question similar to
18 the Representative, would you look at -- when I look at
19 the list of foundational capabilities, one thing to your
20 point, is there a measurement or outcomes or program
21 evaluations, so was that discussed by the working group
22 and rejected, or just never got there or would you
23 recommend that that be kind of a heading underneath this
24 group?

25 MR. INGRAM:

36

4 So I'm not sure I'm answering your question,
5 Chris, but -- maybe you ought to re-phrase it, perhaps
6 that would --

16 DR. MCFADDEN: I think it should fall under
17 quality assurance, because I think under quality
18 assurance it was identifying best practices, evidence
19 based practices.

37

4 VICE-CHAIRMAN PRESS: I agree with you, but
5 then I would ask the question, so how do we measure
6 support and expertise for engagement strategies or how
7 do we measure policy development and resources?

21 MS. SCOLFIELD: I mentioned this briefly at
22 the last meeting or the first meeting, actually, and I
23 forwarded a little bit of information to Joe about it,
24 but I think one thing that public health might benefit
25 from is looking at performance measurement or

39

1 performance management, not from necessarily a community
2 health assessment type of framework, but through some
3 kind of more specific performance management strategy.

4 I mentioned, County STAT, which is something
5 that we're doing, Terry Allen, who's our commissioner
6 from the Board of Health is -- has joined our strategy,

14 So I think there's a way to get to
15 efficiencies, I think there's a way to look at some
16 basic outputs, but then also get to some longer term
17 outcomes through a strategy such as that, or such as --
18 as what we're doing.

40

3 We can get down to the efficiencies, to the
4 number of -- to each sanitarian, if we wanted to, so I
5 think there's ways to do that that are not in a
6 traditional public health measurement strategy.

7 MS. SHAPIRO: But I also think that when you
15 decreasing quality of life.

16 And so when we're looking at those

17 strategies and there's policy issues regarding change
18 strategies and things that we're doing, I think long
19 term what you're going to look at, if you want to have
20 outcome, is decrease rates of obesity, decrease rates of
21 arthritis, cancer, heart disease, whatever, increasing

41

2 MR. INGRAM: I would agree that what
3 Jennifer is talking about is some short term agers, and
4 they vary across the hundred and twenty-five health
5 districts.

6 For example, response times and nuisance
7 complaints, okay, that can be measured as long as you've
8 got a system in place that's measuring and that
9 complaint comes in the door, it's either a filthy house
10 that needs, you know -- or it's trash in the backyard,
11 whatever it is, it's dealing with whatever we're
12 responsible for cleaning up.

42

43

4 And so I think there's a double -- there's
5 two questions here.

6 There's the one that deals with the short
7 term, like you're looking at with Cuyahoga County stats
8 and which -- for performance measures relative to
9 day-to-day performance and for stuff that's coming
10 through the door everyday and there's stuff that's a
11 little bit longer term relative to what I would get to
12 the effectiveness of this question that Nancy was

13 talking about.

14 Are we going to make a dent in maybe leading
15 causes of death today; are we going to lower, you know,
16 infant mortality even more and some of the other broad
17 measures that we actually collect data on? I think you
18 have to look at that measurement system from both sides
19 of that.

20 MS. SCOLFIELD: Uh-huh, and I would -- I
21 agree with you, and what we're trying to do is start at
22 our core function and make sure that we can do that, and
23 then, you know -- and simultaneously look at those
24 longer term outcomes, but another -- another aspect of
25 this that we're looking at as a county organization is

1 performance based contracting.

44

2 Most county governments, certainly in
3 Cuyahoga County, are the largest funders for human
4 services, and we tend to fund the same organizations all
5 the time without real regard in some cases, certainly
6 not all, but in some cases about their capacity to
7 really impact some of those disease rates and other
8 things.

16 MS. EDWARDS: I have a question, so does
17 accreditation, does that get me or are our departments
18 more efficient, or did it help us with the public to
19 control diseases?

20 I don't necessarily see where accreditation,
21 from what we're saying here, is going to help the cancer

22 and the high blood pressure, to some extent I see where
23 you're going..

45

5 I'm looking at accreditation the same way.
6 If we are accredited, if different departments are
7 accredited, are we going to have better results in our
8 health care?

9 MR. INGRAM: I -- I don't think we know. I
10 think the accreditation -- I mean public, as far as
11 health care goes, public health is probably the last of
12 the Mohicans, if you will, to go through accreditation.

17 I think that it will create some better
18 capacity, relative professional development, because
19 you're going to have either access to, or probably in
20 most cases, inside that entity, you know, trained by
21 epidemiologists, biostatisticians, program evaluators,
22 past policy development folks that are -- that are
23 dedicated, that aren't wearing two and three hats as
24 they're trying to, you know, switch, based on demands of
25 the day, should improve quality.

46

1 Because it is about quality improvement,
2 understanding how to do quality improvement methods, and
3 there should be a tie in a little bit more with the
4 local governing body and what the community sees as
5 their needs, because that's another big piece of that --
6 of the accreditation process.

47

3 REPRESENTATIVE ANTONIO: I have a question,

4 so the -- so the laboratory capacity in this, is that --
5 will that continue to be, I don't know how to ask this,
6 relevant with regard to -- so does it make sense to have
7 the capacity within -- within the actual structure and
8 framework of the public health department, or does it
9 make more sense to have an immediate direct pipeline to
10 the best research and labs within the area? Anybody who
11 wants to say answer.

12 MR. INGRAM

24 So it's really about when you have an
25 emergency in public health, we have a communicable

48

1 disease outbreak, like we've got right now, we're
2 working with that situation in Butler County.

3 Okay. You know you've got to have a place
4 to go to get those samples analyzed and you want them
5 analyzed in a relatively -- you want them prioritized to
6 get turned around pretty quick.

7 What -- it's expensive, labs are expensive.
8 So you can't be -- you know, it doesn't make any sense
9 to put one in, you know, every health department, of
10 course, but it does tell me that we've got to have
11 access to at least a few labs that are appropriately
12 placed across the State of Ohio that we would be able to
13 send samples.

23 DR. MCFADDEN: I do think -- I think that
24 the number, how many labs we need, that's the question

25 that maybe has to be, but I do think, one of the points

49

1 that I was making is, that laboratories are important
2 and we need to continue to fund the labs that we have,
3 either at ODH, you know, or regional labs.

4 Today on my way here I dropped off a horse
5 head and a bat to the ODH lab.

8 If I didn't have that ability
9 to do those tests for rabies I don't know what we would
10 do. You know, when I have a horse that bites eight
11 people, you know, yesterday, tonight I'm going to have
12 the answer if those folks need treatment.

13 And so that's something that is important,
14 and given that we're northwest Ohio means that's --
15 that's a significant concern for us.

16 So I think that we, as Holmes County, don't
17 need to have the ability to test for rabies or to --
18 classification of this H5N1 or basically N2, but I need
19 a place that I can do that.

25 MS. SCOLFIELD: I would say, as well, and I

50

1 know that at the next meeting we'll talk about the
2 shared services concept in that we try to keep some kind
3 of running tab on some issues or some services that
4 could be shared, that would make sense.

5 Whether it's regional labs or regional
6 resource centers for some of the blue box functions that
7 we kind of take a look at that and say what really makes

8 sense from an operational standpoint for local health
9 departments, the cost in those types of issues, because
10 I think there's some real benefit in some shared
11 services as we go through this.

12 CHAIRMAN BURKE:

16 We're going to go back and reflect on what
17 would you build on, which would move us into No. 3,
18 about "The Ohio Minimum Package of Local Health Services
19 should be used to guide any future changes in funding,
20 governance, capacity building and quality improvement."
21 And there's a diagram on Page 14 of the study that is
22 kind of a self presented thought pattern there.

51

1 Mr. Cole is with us, he'll have a presentation. I don't
2 want to slow him down, but also want to give him a
3 chance to kind of get in the groove here a little bit
4 with us.

5 But as we look at No. 3, and we look at this
6 diagram, what that thought process would be. Does
7 anybody have, and, again, this is kind of touching the
8 beehive here, depending on whether you have a yes or no
9 answer, but just at the 10,000 foot level to start
10 things, what are folks thoughts about this thought
11 methodology?

12 I mean this kind of touches that third rail
13 when you get down to population size, which may or may
14 not be the answer, I understand, but it brought us this

15 direction by begging the question and recommendation.

21 MS. EDWARDS: And I'm using our county, but
22 I have an issue, and I think many have an issue, with
23 the governance of county health departments.

24 By Ohio Revised Code you have a
25 representative from each township, the mayor or the

52

1 mayor's representative, and the president of the Board
2 of Commissioners to attend one meeting once a year in
3 March to decide who those representatives to the Board
4 of Health on the county side are.

5 And not only mine, but in many opinions,
6 where is the teeth to that; where is the accountability
7 to that?

8 In my many number of years of being in --
9 either a mayor or a county commissioner I've never seen
10 a time when the majority -- when a large group was at
11 that meeting. We have 15 townships, I don't even think
12 I've seen 10 townships there. I have an issue with
13 that.

19 MR. THRELFALL: Again, there's such
20 variation in the State of Ohio, Delaware County, the
21 majority of our trustees, the trustees from all the
22 townships show up at that annual meeting.

23 When I say a majority, 90 percent, sometimes
24 there may be one missing. We have an excellent

25 discussion, we have a presentation, we have questions,

53

1 and we have votes from them.

6 It's always going to come back on the
7 individuals that live in those communities and whether
8 they want to take part or 30 health districts do not
9 want to enforce or be -- well, turn it over to the state
10 for the smoking.

16 Because I don't know, but in our county
17 through education, involvement, we go to township
18 meetings, city meetings, village meetings, that's the
19 way it works, if you have staff and board members that
20 don't want to do that, get new ones.

54

14 When it gets back to core programs and the
15 individual variation, our core programs that we think
16 are necessary for Delaware County, I won't tell you
17 change every year, but in our reviews and our retreats,
18 they may change every three or four years.

19 What we thought was in the priority for
20 funding and to do is off the list and something else is
21 up there, but that would be different from county to
22 county.

55

11 CHAIRMAN BURKE: I just want to hear you
12 again, so you're telling me you're having problems
13 getting 50 plus 1 to even host a meeting, if you would
14 have any votes?

56

15 MS. EDWARDS: I would -- I would say there
16 have been times when there has been an issue, now
17 remember, this is once a year, it's not like the monthly
18 meeting.

22 VICE-CHAIRMAN PRESS: The District Advisory
23 Council's authorities go beyond -- and responsibilities
24 go beyond that one meeting.

25 MS. EDWARDS: Certainly.

57

58

59

60

24 CHAIRMAN BURKE: If I could just flip to
25 Page 14, again, real quick on the methodology, providing
61

1 the package itself, and probably not getting into a
2 discussion about size, that we'll probably save for the
3 next meeting.

10 MR. INGRAM:

14 They did a -- they looked for
15 evidence out there in their research, in the literature,
16 excuse me, that had been from a peer review article that
17 talked about what is the minimum size of a health
18 district in which you can get certain levels of
19 efficiency, as well as some effectiveness, and that's
20 where they landed.

62

10 MS. EDWARDS: I know in our county

11 specifically, we have Ashland City Health Department and
12 Ashland County Health Department, they work very well
13 together, but to change that the city is going to have
14 to change their charter.

19 DR. MCFADDEN: For this, what I like about
20 this is that it starts with capacity and quality, I
21 mean, if you can do these things, great, no worries; if
22 you can't do these things, here's two options.

23 One, you join formally with another
24 jurisdiction, you know, you look and see, is this
25 something we can do to join, whether they are forced to

63

1 join, evaluate it, does it make sense to join with
2 someone else, if it doesn't make sense, find ways to
3 meet them.

4 If that's not the capacity you're going to
5 find ways to meet things, it doesn't say you have to be
6 a hundred thousand for city, find ways to make this
7 happen, and that's what I like about this graphic is it
8 doesn't say you have to be a hundred thousand, it
9 doesn't say Nebraska is at 30,000, doesn't say you have
10 to be 30,000.

17 That's what I like about this, because it
18 allows the local system, as a state here, unless we
19 decide to do something different, this allows the locals
20 to sit back and say, okay, how are we going to make this
21 happen.

2 CHAIRMAN BURKE: Excellent. I know, Mr.
3 Cole, your time is valuable. I don't know if you're at
4 a point where, if it's the group's desire to start with
5 your Beyond Boundaries a Shared Service, Dr. McFadden
6 has given us a great role in here, how to combine and
7 talk about how to share things, to move ahead, if you're
8 ready, we welcome your presentation.

9 MR. COLE: Well, thank you, Mr. Chairman,
10 and if everybody's ready for it, I will make some
11 highlights and bring up some points.

15 But just to close a little bit of that point
16 you just talked about with governance, you know, I will
17 start my comments by saying, I hope everyone in this
18 room understands that with this issue, you are not
19 alone.

20 You guys are taking the right approach, it's
21 reasonable. Mr. Threlfall, I would say the message will
22 get out. You know, in this room, you can't -- you can't
23 fix everything, but you can lay a road map, you can lay
24 a course of action that local government officials can
25 lead, can follow things, recommendations to the

1 legislature, through that process can follow, and then
2 over time our citizens can understand.

24 This level of change is going to require an
25 awful lot of new thinking and education, courage,

1 leadership, and commitment to keep it moving.

2 That's an awful lot of preface for the
3 comments I want to make, but I just want you guys to
4 know, first, you're not alone, you are taking the right
5 approach, because the market will dictate this, right.

6 A reduction in resources will continue to
7 get the ability to deliver the services and/or the
8 change will happen without reason, right, and without --
9 it'll be a patchwork of quick fixes and/or places where
10 they get it right or places where they don't.

11 Our job here, your job, will be to help
12 guide that and create the road map, and I think you guys
13 are definitely on the way to doing that.

14 Related to governance, don't be afraid of
15 changing your governance. Again, in all those systems
16 we talked about there are going to be governance
17 changes, none of the models are right and/or we have
18 multiple ones.

71

11 it's about the leadership, it's about
12 creating the reasonable course of action, so that there
13 are options and local control to make the right choices
14 that will give them the sustainable functions to deliver
15 these supports and services, and the pressure is going
16 to be there.

17 So, you know, the quick comments I would
18 make are, the attack we do have here is not on the

19 officials who run these systems and the boards that
20 govern them, but it is on the status quo.

72

19 Going to the web, don't just look at
20 governance, you know, again, Mr. Chairman, I would
21 suggest it is time for us to look at our public meetings
22 law in this state, because some of those township
23 trustees are farmers, some of them work for a regional
24 or national corporation and they're in San Francisco
25 today.

73

10 Government spending has significantly
11 outpaced the economy in Ohio and the state's population.
12 I'll work backwards, I usually go with the big numbers.

13 The population in Ohio in 1993 was 11.1
14 million people; in 2009 it was 11.5. The 2010 consensus
15 didn't change that much.

16 Our gross state product almost doubled from
17 \$268 billion in '93, to \$462 billion in 2009.

18 Combined state and local government
19 spending, this does include welfare and education, but
20 it increased from \$47 billion in 1993, to \$107 billion
21 in 2009, more than doubled.

74

6 I do believe that shared services is one of
7 the pieces of the puzzle to move beyond that fragmented
8 system we've inherited to make the changes. It is
9 difficult with that level of 20,000 elected officials

10 though, it's hard to educate that many people.

19 A couple of members of this task force were
20 appointed by Representative Budish, and when he was
21 speaker he commissioned a study, the Compact with Ohio
22 Cities Task Force was established, it came up with a
23 report.

24 I'm just going to read you one quick quote,
25 "Ohio's individual cities and townships have taken on

75

1 expenses that are unsustainable and the state's ability
2 to assist them is limited. Regional approaches to
3 collaboration and coordination are necessary to preserve
4 services to Ohioans and achieve affordability."

76

6 There are
7 local government officials leading this cause and for
8 them we are finding out how we can change the law, which
9 we've done through the MBR, intergovernmental shared
10 service authority, universal authority in the last
11 budget, we made some changes for the health departments
12 in the MBR process.

13 We continue to find those barriers, if you
14 come up with those recommendations, the administration
15 will vet them and I'm sure with the timing of this
16 report they can be a part of the deliberations on the
17 next budget, our budget package or stand alone
18 legislation, that's where you go.

19 But we are looking for those ways to break
20 down those barriers and support the people who are
21 leading.

22 For those others we are trying to find the
23 examples, make heroes out of the people leading the
24 cause or reports like this one in help raising the
25 education, finding ways through Skinny Ohio on the

77

1 Auditor of State website.

2 We're doing a tour of 14 stops around the
3 state, the one next week on August 10th will be in
4 Summit County talking about that consolidated health
5 district. The Director of the Office of Health
6 Transformation, Greg Moody, will be joining me there.

7 Our purpose in all of those things is to
8 show how local leaders are making a difference; what's
9 happening; and how it fits into the bigger picture of
10 what we're trying to accomplish with this around the
11 state.

16 And then so the second part is tools,
17 information for those types of leaders to follow the
18 examples of the first group. So we're trying to find
19 leaders, find the followers for that...

78

21 Because as there's more understanding about
22 the cost of services, the right way things are
23 happening, the good stories are getting out there,
24 within a few years the public expect -- again, right now

25 the public doesn't care, they also don't know what the

79

1 options are.

2 As there's more accountability and
3 transparency, more of these stories about what's
4 working, more reports that come out that show the path,
5 eventually the public and/or candidates for office are
6 going to pick that up and the pressure will build and
7 the change will come.

8 I would suggest most of it can be done
9 today, and your report, your work will be a big part of
10 that.

11 The core of Beyond Boundaries is that shared
12 services should be simple. Again, there's so much that
13 can be done by contract without -- without touching
14 governance, and that's what I like about the model on
15 Page 14, you know, obtain meeting capabilities from
16 formal cross jurisdiction sharing.

17 Look at anybody, under the law a health
18 department can contract with other people to do any type
19 of back office things, and in those places the law
20 allows to direct find services, find those solutions,
21 and I would suggest it's not just health departments.

22 I know you highlight a few things there, but
23 I'll forward to Mr. Tremmel a little chart we put
24 together, it's like a heat map of high, medium and low
25 opportunities for shared services.

14 So for a long time health districts have
15 been looking at what they can share, or boards of
16 developmental disability have, but there's a geographic
17 focus to some things you provide that would be better
18 done with your neighbors.

2 We do believe that we should create a
3 network of regional shared service centers. Those are
4 not a new bureaucracy.

5 All we are talking about is working for
6 clearer integration of the education service centers and
7 the information technology centers around the state, 55
8 ESCs, there are 22 information technology centers, they
9 all support schools, almost all of the schools.

10 In some cases they have re-formed as a
11 council of government and provide services to local
12 governments, in some cases health districts in parts of
13 the state.

1 You don't have to create that or that
2 doesn't necessarily just have to be health department
3 training. You might be able to use training modules and
4 the training regiment by someone else, and then focus it
5 on the core curriculum you're trying to achieve.

12 We continue to believe, as an
13 administration, that there should be choice in this.

14 The market should dictate it, this should be an option
15 to what's happening, which, again, is part of the beauty
16 you guys have already reached in this.

17 It doesn't have to be forced consolidation,
18 in fact, this is a Randy Cole personal comment, but if
19 we rush to straight consolidation, again, in Summit
20 County where I live, I'm an Akron resident, we've seen
21 the benefit, right, that merged Health District of
22 Akron, Barberton and Summit County is working.

23 We use them as one of our examples in Beyond
24 Boundaries, because the information they provided to us,
25 including the national award they received for what

83

1 they're doing, they were able to control the number of
2 actual employees they have and maximize them to increase
3 the number of inspections from 170 to 300 per
4 sanitarian, and reduce the fees they charge the people
5 they're inspecting.

13 We're going to create a couple of tools to
14 help support this, and as we do that we'll work with the
15 Department of Health Office of Health Transformation,
16 your work may be done, but joint purchasing, you know,
17 again, you're looking at ways to save money on that.

18 We're creating, the Department of
19 Administrative Services is creating a joint purchasing
20 portal to show all of the known, existing, shared
21 purchasing programs from insurance to office supplies to

22 fleet maintenance to fuel for the vehicles, anything
23 government purchases, we're putting it all together on
24 one website, that should be up and running by the start
25 of the year.

84

1 The Auditor of State is putting examples of
2 how this is working at Skinny Ohio for any of you
3 associated with individual health districts and/or this
4 report should go up on that website and/or the examples
5 that back up what you're doing or how local health
6 departments are changing, all that information belongs
7 there, again, to help create public awareness of what's
8 happening or help local officials make -- make the
9 changes.

10 We're going to continue to work through
11 those things. The Local Government Innovation Fund, I
12 encourage -- there are bonus points for following Beyond
13 Boundaries' recommendations.

14 I would suggest that this report, when it's
15 done, should go to the 15 members of the Local
16 Government Innovation Council, so that they can be
17 aware, as we evaluate projects from counties or cities
18 or health districts that come before that fund for
19 funding to be aware of how it fits into a bigger picture
20 and helps accomplish that goal, but local health
21 departments are eligible for funding under that.

85

86

1 Real quickly, where does this go? The City
2 of Green is one of our favorite examples. In the City
3 of Green, 25,000 people there. They don't have a health
4 department, it's a city, they contract with the county;
5 they don't have a building department, they contract
6 with the county; they don't have a police department,
7 contract with the county.

23 Because you know what they did, they built
24 one space like this, that on Monday night's the City
25 Council and on Tuesday night's it's the school board,

87

1 because we didn't really need an empty space 314 days
2 out of the year, do we?

3 The ongoing savings are wonderful, once that
4 happened they said we've got some extra money in our
5 budget, they built a state of the art technology room,
6 video capability, again, thinking how they got their
7 information public, they broadcast everything, but it
8 created one I.T. director, because they started to merge
9 their systems. They merged their I.T. departments, they
10 bought better equipment, more public outreach, lower
11 overall cost.

12 They saved 7 to 8 percent of their \$25
13 million budget through shared services, that's their
14 reporting, their calculations.

88

20 Shared services with like minded partners

21 enables us to do something better, faster and cheaper
22 we're compelled to consider it. My guess is in some
23 cases we'll be buyers, in other cases we'll be sellers.
24 We don't have to own our own stuff, that's the point.

89

6 It's time to break some of the models and
7 move to new models that will work to sustain the core
8 service that everyone did get into this business to
9 support, which are education, core government services,
10 and in this case, public health, and have the resources
11 to deal with emergencies and ongoing needs of our
12 populations in this vital area of government operation.

90

18 CHAIRMAN BURKE: Just bring that up, because
19 I do think it is exciting what you're talking about, you
20 consolidated your thoughts in nearly an hour, which I
21 think is a very short period of time.

22 As we move into jurisdictional issues next
23 time I think there's good knowledge basis there that
24 will aid in our discussion. Any questions of Mr. Cole?

25 MS. SCOLFIELD:

91

4 We have a merger study going on out east, if
5 you will, but we're starting, as a county, we've gone
6 through huge reorganization over the last year and a
7 half, and we're starting to see some movement around,
8 truly some regional collaboration from anti-poaching
9 agreements to the county providing I.T. services to

10 municipalities or lending an H.R. specialist to
11 municipalities to do some of the work.

12 So it's slow progress, but I think we can --
13 I mean we can get there, and it's voluntary, you're
14 right, it's not mandated you have to do this, but it's
15 about the conversation that says, can we help you by
16 taking on some of this, and so I think it can work.

17 MR. COLE: Yeah, and, you know, I would
18 suggest, again, that if there was a rush to
19 consolidation or merger we're going to have a lot of
20 shotgun weddings that may not work.

21 And if we merge two departments, and part of
22 the goal is to keep things, you know, the first thought
23 would be, well, we'll bring them together, but they're
24 going to look a lot like they did yesterday, instead of
25 the way they should look tomorrow, would be a natural

92

1 movement.

2 If instead there's a dating period and we
3 worked through establishing trust, efficiencies, better
4 models and let those evolve, then we'll see if there are
5 mergers and consolidations down the road, but I think,
6 you know, in Summit County there wasn't a rush, there
7 was a careful course or path to get to where they got.

18 MR. INGRAM:

20 And so I

21 was real intrigued by your comment about marketplace

22 models, and it's something that I've been watching, as
23 the health care systems, there's five major health care
24 delivery systems that serve the greater Cincinnati area
25 and northern Kentucky, and they have -- they are

93

1 transforming at a very fast pace relative to providers
2 now becoming employees of those organizations and as
3 they put in data management systems and electronic
4 health records and so forth.

5 And since really in the end a lot of people
6 think about health departments like inspection services
7 and so forth, and, yeah, that's a big piece of what we
8 do on the environmental health side, but that's -- it's
9 all about really trying to prevent that next case of
10 contagious disease so it doesn't create an epidemic, and
11 then we all have this huge focus on chronic diseases,
12 which is where, you know, Medicare and Medicaid's taking
13 the quality aspect of the health care system too.

14 I would be interested in, I guess, your
15 thoughts on how does -- I see us as an integral part of
16 their success.

17 I'm not sure what that "sweet spot" is, that's
18 my term, of where we align with that, I'll been trying
19 to find it, but I'd be interested in seeing how you saw
20 jurisdictional boundaries changing relative to health
21 districts with a marketplace model that's improving
22 health care in that delivery system, because every

23 health care system has a certain delivery model.

94

5 MR. COLE:

9 I serve on the Program Management Office of
10 the Office of Health Transformation, and so we continue
11 to look at what's happening, you know, then they're
12 plugged in to, of course, Medicaid and transformation,
13 and what the private sector is doing with health care
14 delivery in the state and the quality measures.

15 We are trying to make sure that we are
16 dovetailing each of these efforts into that, and I would
17 just suggest that the first answer, that as those market
18 forces change we will integrate that into our thinking
19 and our process in how that aligns with what might come
20 out of the report you guys are working on or initial
21 recommendations or the future processes related to the
22 budgets and the state policy, we'll keep an eye to it.

23 The other way we're looking at that is with
24 health care pooling and supporting local consortia into
25 the development of regional health care pools, which

95

1 often align with those local health markets.

23 VICE-CHAIRMAN PRESS: Just a compliment, I
24 think you've actually framed it in an eloquent way, the
25 challenge before this group, because as we -- all the

96

1 experience I've observed in economic life says that when
2 resources are used, when there's a reduction in

3 resources, when that fate comes about, organizations are
4 forced to make more difficult choices, and they may end
5 up inevitably some form of specialization, they choose
6 things that they call their core capability or their
7 central capability.

8 So what I hear in your presentation that's
9 so hopeful is a description of ways to create
10 flexibility so that when that pressure comes, because it
11 inevitably is going to come, there's no mistake that
12 will happen.

97

1 MS. EDWARDS: Your presentation that you did
2 today, I know we have this entire document, but I know
3 you had to have notes of a short summary; is that
4 on-line or do you have that?

5 MR. COLE: I can forward that, and it is,
6 it's just a very short Power Point, it is all excerpts,
7 including the status of the recommendations, as far as
8 legislative changes, what the legislature has already
9 enacted from that report, or all of those things, yeah,
10 that's -- all that's included in that, including the
11 little bit of humor that I didn't share with you
12 earlier, but when you get the Power Point don't be
13 surprised, because so much of this is about change,
14 Director Moody uses the same thing, I think.

98

5 REPRESENTATIVE ANTONIO: I also appreciated

6 your presentation, and part of my willingness to serve
7 on this committee is how important I think the work that
8 we're doing in terms of looking at this report, but I
9 also appreciate the framing that it's in a very highly
10 politically charged climate, that this isn't an issue
11 for one side of the isle or the other, but really it is
12 ultimately how we deal with the change that is, you're
13 absolutely right, already here, but it's -- it's how we
14 take care of it.

99

14 CHAIRMAN BURKE: If I could, Mr. Cole,
15 you're welcome to stay, I don't know what your timeframe
16 is, my goal here is to try to wrap up, if I can, in the
17 next 10 to 15 minutes.

100

7 So I feel it's important to work through the
8 rest of those issues, if we can do that, so with that
9 being said, if we can try to keep a 10 minute
10 conversation, No. 5, which is, "Local health districts
11 that meet minimum local health package standards should
12 be prioritized for grant funding through their
13 jurisdiction."

14 If I could just pose a question on that real
15 quick, I know this current administration is focused on
16 hot spots, areas where maybe weakness have been seen in
17 trying to direct allocation to weakness, so that we can
18 build up that area.

19 If you were going to prioritize grant

20 funding would you prioritize it to somebody that's doing
21 well already or would you try to improve maybe somebody
22 who is in a weakness?

23 DR. MCFADDEN: That is exactly one of the
24 concerns I have about the PHAB process or the Ohio --
25 voluntary accreditation team in Ohio, that I felt if we
101

1 identify locations that are struggling, rather than
2 penalize them at the outset, we need to find a way to
3 try to lift them up, if they can't be lifted up, you
4 know, then there needs to be accountability and you fund
5 success.

6 But I think I feel like in public health we
7 have been starved -- public health has been starved for
8 so long that there are some areas that are on life
9 support that if they were given, you know, proper
10 nutrition, could do really well.

25 MS. SCOLFIELD: Okay. I would generally
102

1 concur with that, is to provide an opportunity for those
2 departments or districts that -- or areas that are
3 struggling for any number of reasons, give them a period
4 of time to make some improvements with proper investment
5 or other tools and resources, and then if they still
6 can't meet those requirements then you have the
7 consequences, I suppose.

13 MS. EDWARDS: And I agree with what you're
14 both saying, it will take some time, and it may be

15 changes in personnel, it may be changes in a number of
16 issues, but at some point you do have to come to a tough
17 love situation where you need to move forward or you're
18 going to have -- that department will have to figure out
19 another way, I guess, that's the way I would phrase it,
20 not necessarily cut you off, but you're going to have to
21 figure out another way, but it would take time, not
22 immediately by any stretch.

23 MR. INGRAM:

103

3 Because I would hope to think that everybody
4 wants to improve, I mean I think that's a natural
5 tendency for all of us to feel, but I just wonder, how
6 do you -- who becomes that timeline, there's already
7 only so many resources that are going to be available,
8 if you're going to put an investment of money into
9 struggling jurisdictions, and I'm not sure how you
10 define that, but that means there's going to be less
11 money for those somewhere else, I think, I'm going to go
12 under that supposition, so I just kind of wanted to
13 know, you know the old, the devil's in the details here
14 a little bit.

104

14 CHAIRMAN BURKE: Let me pose this question,
15 if there were -- a two part question, if there weren't
16 additional resources and you looked to improve the
17 system, how would you allocate them?

18 And I use an example, and, Walter, this is

19 not directed to you, this is just a carpet example, when
20 you look at county health rankings, Delaware's No. 1 in
21 the state, but if you drive five minutes up the road to
22 Morrow County, then I think it's No. 74, and I would ask
23 myself, why would I give any money, what little we get
24 to Delaware County, when it would appear as though
25 Morrow County needs the money?

105

1 But then the next questions would be, what's
2 Delaware County doing right, and if I was going to
3 allocate current resources to their committee or give
4 additional resources what would I be buying and what
5 would I be paying for that gets me close to Delaware
6 County?

7 What are they doing that the Department of
8 Health should be doing in some sense that moves that
9 county just to your north forward?

17 I'm not a -- I ask my colleagues here, I
18 guess, if you were to take ten most troubled health
19 districts in the State of Ohio and move them forward,
20 what does that do to help in the overall state?

21 Is it that kind of thing or do you move all
22 health districts forward?

23 MR. THRELFALL: I'll attempt to give my
24 opinion. The first thing I think we need to look at,
25 the accreditation, which was mentioned earlier, I think

1 that's absolutely fantastic.

106

11 It gave the board, the staff, everybody, a
12 complete picture of where we were. Okay. Where am I
13 going? If we can find a way to get to other health
14 departments to do that, give them help, give them a
15 grant, give them whatever it takes for them to see what
16 they have and what they don't have, and No. 2, if
17 there's a way, and we did this sort of for a while, for
18 Delaware and Morrow to work together, and what Delaware
19 has gained Morrow might be able to see, and then maybe
20 justify that they could get some funding.

107

11 DR. MCFADDEN: Sitting on the group, the
12 futures committee, the one way to read these that we
13 were interpreting here, and then I think another way to
14 interpret that statement would be that within a
15 jurisdiction the ones that should be -- ODH is giving
16 money for LHD or otherwise, that should be a local
17 health district, rather than a school or private entity
18 of that.

19 MR. INGRAM: There were discussions on that,
20 D.J., but I don't -- more opportunity for health
21 districts relative to those type of programs, I believe,
22 we had a discussion on that.

23 DR. MCFADDEN: This can be interpreted
24 different ways. I mean I certainly want to make sure
25 that we don't penalize the health districts that are

108

1 struggling, but I think other -- a flip way to interpret
2 this from the folks that prepared it could be we want
3 local health districts who meet the minimum standards to
4 be prioritized for funding from ODH, as opposed to other
5 non-public health entities who want to do the work, that
6 is another way to interpret it.

22 MS. WASOWSKI: Krista Wasowski, currently
23 the Medina County Health Commissioner, but until
24 recently, for the past eight years, the Morrow County
25 Health Commissioner.

109

1 I think one of the things I just need to say
2 coming from Morrow County for many years, is that county
3 health ranking certainly was a great discussion starter
4 about health and about community health, but I think the
5 danger in some of that is assuming that a low ranking
6 necessarily means that there's not good health or that a
7 health department is not functional, because as a health
8 department we come very -- we score very well when it
9 comes to the standards, when it comes to the process.

10 There are things that they do lack as a
11 health department and that is capacity, particularly for
12 some of those foundational pieces.

13 Do we have the ability there to do CQI, yes,
14 there's a skill, but there isn't the time.

22 As a health department we were the only
23 provider in childhood immunizations in the entire
24 county, with 11 doctors, none of them gave childhood

25 immunizations, so if you wanted to get them in the

110

1 county you came to the health department.

5 Is there a desire for accreditation in
6 Morrow, absolutely; would they benefit from having
7 pooled resources, someone at a regional level, someone
8 at the state level, and another organization,
9 absolutely. Always looking at shared service, always
10 looking at a way to increase that capacity.

11 CHAIRMAN BURKE: If the committee found
12 accreditation was something that we should move through
13 what kind of incentives or help could the state give to
14 a place like Morrow County to help achieve that goal?

15 MS. WASOWSKI: Well, it's really the time,
16 it's having someone that can pull all of the records
17 together, and I think, as some of the organizations
18 around the table have gone through accreditation know,
19 it's not necessarily that you're not doing the work,
20 it's having all the documentation together to prove all
21 the things that you're doing to obtain that
22 accreditation.

111

4 It's been, in Morrow County, almost seven
5 years since they did a Comprehensive Community Health
6 Assessment, and it's finances, it isn't desire.

19 MS. SHAPIRO:

112

2 The program evaluation components, we just

3 don't have the expertise on staff to be able to do that
4 research design you need up front when we're applying
5 for a grant or to measure the outcomes on the little
6 things that we do, that we have to do internally and our
7 strength in that is somewhat limited.

8 So I think that to me having a pool of
9 experts there, again, with some knowledge of the public
10 health, not -- doesn't have to be a lot, but to know
11 what we need would be highly beneficial.

12 MS. WASOWSKI: And that could come from
13 another system, it doesn't necessarily have to be public
14 health driven.

15 MR. TREMMEL:
16 You talk about money, could you put that in
17 perspective, because Morrow is unique, levied, funding,
18 so just put that in perspective, because the disconnect,
19 folks, in public health is large when you look at how
20 these departments are funded and the disparities really
21 between health departments.

113

2 MS. WASOWSKI: I don't feel that we're that
3 dissimilar really if you look per capita.

4 MS. SHAPIRO: Our millage for our levy,
5 which we've had since the 1950's is .7 mill rolled back.
6 That .7, because of the property values in Delaware
7 County generates -- I don't know what millage Morrow has
8 now.

9 MS. WASOWSKI: Half mill, it generates
10 \$320,000 a year, ballpark.

11 MS. SHAPIRO: And ours, I don't have it
12 right now, but --

13 MS. WASOWSKI: It's about 280,000.

14 MS. SHAPIRO: So the millage isn't that --
15 because our millage is probably reduced down to point --
16 I don't know what it is, but it's rolled back, so it's
17 not that much different, but it generates more, and that
18 is for Delaware County the significant portion of our --
19 of our funding.

114

12 MR. TREMMEL: So my second part of the
13 question is for the health departments here, and Joe's
14 reminding me of this, do some of you remember, Nancy,
15 you may, Tim, you might, Peer Review, is there a place
16 in this discussion -- can one of you describe Peer
17 Review in a short perspective in that the Peer Review
18 might be an opportunity to be revisited for purposes of
19 the kinds of things that we're seeing are some misses,
20 Peer Review helping us identify misses, but then put
21 together a mechanism, and we heard Mr. Cole and others
22 say, maybe there's a sharing service mechanism that
23 needs put in place, because Peer Review's identifying
24 them.

25 MS. SHAPIRO: I was around back in the day

115

1 when we had the early public health standards and that
2 we did the Peer Review. In that time we had the
3 agreements between Delaware, Morrow and Union counties,
4 and so what we did first was we tested each other.

5 Before we had the peer reviewers come in we
6 did our own, so we were able to go to the visitors and
7 visit kind of in an informal basis and find out where
8 the deficiency was, and in that way when we did, all
9 three counties, when they were at the Peer Review, I
10 think they all got good, they might not have, but the
11 results were very, very good, so it did provide an
12 opportunity.

21 CHAIRMAN BURKE: I'm going to just sound the
22 two minute mark here as we wrap up, because I know
23 traffic is going to start to build, and we have folks
24 that need to get home to out of town places, so two
25 minutes. Tim, comments, anybody?

116

3 MR. INGRAM: I think the financial
4 disparities are huge, just as much as some of the
5 service disparities across the state are too, and I
6 think there's a lot of probably connectivity to perhaps
7 one or the other, but I think it also comes down to what
8 the community understands, what's important, they're
9 willing to support, along with the leadership that's
10 running these entities, which includes governance.

11 CHAIRMAN BURKE: I think in our next meeting
12 then we'll go back and revisit, talk a little bit more

13 about accreditation, which is No. 4, No. 6 and No. 7 as
14 well that rolls into jurisdictional structure.

15 Mr. Cole has given us a good document to
16 review for jurisdictional structure. I'm not sure if we
17 have a presenter at the next meeting or was that the
18 following meeting?

21 CHAIRMAN BURKE:

24 Certainly a lot of ground to cover, we've
25 got a little bit of a buffer here in terms of an extra

117

1 meeting time or two, so we want to make sure that we
2 continue to do our due diligence.

3 With that being said, I don't know if
4 there's any closing comments by anybody here today, that
5 puts our next meeting on August 14th, 2012.

9 With that, the meeting is adjourned.

118
