

Deposition Specialists, Inc..... (614) 221-4034

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APPEARANCES

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MEMBERS PRESENT:

- Senator David Burke, Chairman
- Christopher E. Press, Vice-Chairman
- Martin Tremmel, Secretary
- Joe Mazzola
- Steve Wermuth
- Dr. D.J. McFadden
- Kim Edwards
- Nancy Shapiro
- Representative Nickie Antonio
- Walter Threlfall
- Joe Harrod
- Tim Ingram
- Jennifer Scolfield

Also Present:

- Jessica Crews
- Jason Orcena
- Aaron Ockerman
- Lindsay English
- Beth Bickford
- Krista Wasowski
- Karen Hughes

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AGENDA

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

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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.

9 And we can work right down that list as well
10 as additional points of conversation, which I believe
11 you may all have on your desk, a couple other items that
12 are always topics of discussion, if anybody wishes to
13 pursue that or in addition to what we're working on.

14 So I'll go ahead and get things started,
15 and, I guess, we'll just start in order with the first
16 recommendation that has been given this body, "All
17 Ohioans, regardless of where they live, should have
18 access to Core Public Health Services described in the
19 Ohio Minimum Package of Local Public Health Services."

20 And then there is a diagram of those
21 services on Page 13 of the Public Health Futures Book,
22 as well as on Page 89, for those of you that need a
23 point of reference.

24 Now, we can go down these individually, if
25 that meets the Committee's approval. Some of them

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1 sure that's --

2 CHAIRMAN BURKE: That's fine, that's my next
3 -- I guess, just as a point some of you who read these,
4 some of these recommendations, I would say are very
5 open, and, I think, that's why I just bring this up in a
6 discussion format, and, yay or nay, as we work through
7 each one of these, and, again, when we get through them,
8 we can come back and look at the whole thing kind of
9 forward.

10 So I'm assuming at this point that there is
11 no debate that all Ohioans should have access to these
12 core public health services, obviously these mandated by
13 law.

14 MS. SHAPIRO: I think that you have the core
15 public health services, and how you define them, and I
16 think that's one area that possibly the Futures -- what
17 the minimum standard should be for those services are
18 not defined, and someone, correct me if I'm wrong, I
19 think that that -- that this diagram kind of defines
20 some of those services.

21 But what exactly are the minimum -- the
22 minimum capabilities the local public health partnership
23 should have, I don't know if the core -- the minimum
24 level of core public health functions has been defined,
25 per se, that if you live in Akron you should have this

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1 level of service, which should be the same as if you
2 lived in Cincinnati. I don't know, that has been
3 truly --

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.

15 MR. TREMMEL: All right.

16 VICE-CHAIRMAN PRESS: So if you look up at
17 the top on Page 13, are there folks in the room who
18 participated in the authorship of this report?

19 MR. INGRAM: I did.

20 MR. TREMMEL: And a couple of folks in the
21 room as well so you can rely on their expertise.

22 VICE-CHAIRMAN PRESS: I'm impressed. How --
23 how precise were they being in the language at the top
24 where they said, "All LHDs should be responsible for
25 providing the following services in their district"?

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1 Does, they, mean make sure they are available in the
2 district or did they mean provide?

3 Because to Kim's point, making sure the
4 capability's available is to me something different than
5 delivery.

6 MS. SHAPIRO: It says at the top here,
7 "Director will write contracts at the local level," so I
8 think that's --

9 VICE-CHAIRMAN PRESS: I missed that part,
10 okay, good, so that would answer the question.

11 MS. SHAPIRO: I did too at first.

12 MR. TREMMEL: Okay.

13 VICE-CHAIRMAN PRESS: So that takes us back
14 to the question, does that answer your question, so that
15 you --

16 MS. EDWARDS: In a sense it does and in a
17 sense it doesn't, because we can just let it go as it
18 is, but this is our opportunity to make changes, so if
19 we're going to make changes we should make changes.

20 VICE-CHAIRMAN PRESS: Your question is, why
21 isn't there a data warehouse someplace?

22 MS. EDWARDS: Right, or if it were an
23 original concept or -- -

24 MR. TREMMEL: And there is, so let me maybe
25 explain a little bit of the vital statistics --

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1 MS. EDWARDS: Okay. That was an example.

2 MR. TREMMEL: -- Program. So a couple of
3 things, folks, two years ago or maybe slightly less than
4 that, you had the ability to access your vital records
5 in the county to which you were born.

6 The State of Ohio, through the fees
7 collected, the Ohio Department of Health put together a
8 significant infrastructure to be able to put this, and
9 make this available at the local health level.

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

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

2 MS. EDWARDS: Okay.

3 MR. TREMMEL: -- The domain as I know it.

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.

16 MR. TREMMEL: That is a local?

17 MS. SHAPIRO: Yeah, it is a local thing.

18 MS. EDWARDS: Right. I'm trying to think of
19 -- bare with me here, I'm trying to think of in our
20 small county how much the funeral director's do and the
21 townships do, and I know it's going to be different for
22 a city, more so than maybe --

23 MR. TREMMEL: All right. So let's review
24 this, just maybe that -- just take that next layer down
25 a strategy, and Dr. McFadden would be able to help, and

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1 some of the other colleagues here will be able to fill
2 in the blanks that I'll be missing.

3 But the vital statistics registrar at the
4 local level on the birth side will receive any number of
5 birth records, there could be missing information,
6 incomplete, need clarity, to which his or her role is to
7 work with that physician and work with the hospital, and
8 I think my colleagues here know this, to get that record
9 as correct and as true and valid as possible, and then
10 submitting that record and using hospital information,
11 because the information is collected at the hospital
12 level, they're inputting the data electronically, going
13 through, getting the proper sign-off signatures,
14 otherwise validating, cleaning it, getting it prepped,
15 ready and pushes to the state.

16 Now, contrary to that on the death side, as
17 Nancy points, now you have a different particular issue,
18 because the person deceases, family pairs information
19 with funeral home staff, to which funeral home staff
20 must work with a registrar, under law, to determine the
21 necessary paperwork for cause of death, burial, burial
22 prep, et cetera, et cetera, and the same kinds of things
23 -- and same kind of things, accuracy, valid records, et
24 cetera, and you get, on any number of days, occasions,
25 this needs to be done quickly, this happened, we need to

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1 do something on Friday, because it cannot wait until
2 Monday.

3 So there are any number of conversations and
4 opportunities in the system, I would probably frame it,
5 to where all of this needs to be cross referenced
6 down --

7 MS. EDWARDS: Okay.

8 MR. TREMMEL: -- Procedurally permitted,
9 because you're not under law to bury someone without
10 that.

11 MS. EDWARDS: Right. Could you also be
12 working -- some of that work goes through the coroner's
13 office and it's under duplication.

14 MR. TREMMEL: And it does -- and it does,
15 except that coroners by and large are involved in not
16 all deaths, but some deaths, so deaths of an unknown
17 origin, homicides, et cetera, accidents can warrant
18 further investigation.

19 My own opinion, and I'll need colleagues to
20 join me, my own opinion would be, if we were to presume
21 or assume that our colleagues, coroners, these are
22 physicians by and large, I don't know that there's
23 anyone who is a coroner, who's not a physician in Ohio,
24 but there might be.

25 MS. EDWARDS: No.

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1 MR. TREMMEL: But the interest level of a
2 coroner who's paid at the county level, and let's say
3 maybe not paid necessarily at the professional rate to
4 give them the opportunity to be validating death records
5 and burial permits, et cetera, probably not what they're
6 looking for in their, you know, routines and activities,
7 I'll stop short of that.

8 MS. EDWARDS: I guess I'm just, you know,
9 I'm looking for ideas to streamline the process.

10 CHAIRMAN BURKE: Well, just -- just to bring
11 something up, the next meeting, of course, is going to
12 be about jurisdictional structure.

13 There's going to be lots of overlap and when
14 I look at the core public health services and Chris'
15 point, it does say, services in their district directly
16 or by contracting with another health district, so not
17 using obviously in this wording an outside vendor, a
18 person, or third party, but only one health district or
19 one health district with another.

20 So I guess everybody is okay with that
21 concept on how these core functions in and of
22 themselves, core health services, this list, and the
23 fact that it's done by a health department and/or by
24 another health department makes sense; is that a true
25 statement?

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1 MR. INGRAM: Well, I just want to point out
2 a couple of -- I want to go to the vital statistics
3 question for a second, but if you look at this green
4 box, only the top three are mandated in the Ohio Revised
5 Code rules.

6 All right. The other items were brought in
7 as a part of the accreditation that's pending for
8 several probably local health departments in the future.

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

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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.

9 For example, in the health district that I
10 work in, Hamilton County Public Health, Hamilton County
11 is -- so we have two large health departments, both of
12 them -- actually there's five listed inside Hamilton
13 County and three of them have their registrar districts,
14 okay, Cincinnati, Hamilton County, and then the city of
15 Norwood.

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.

20 The deaths are about -- the deaths are about
21 equivalent to that, but with the deaths, you still would
22 have to -- if that person died inside the city limits,
23 they'd have to go inside Cincinnati to get the death
24 certificate, I couldn't issue it.

25 So one thing that happened was they opened

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1 -- the State Department of Health opened up the ability
2 to -- for each other to issue the birth certificates, it
3 was really a good -- it's really been a good model for
4 the customer, for the citizen.

5 So what has actually happened is it has
6 created some competition and you're seeing some price
7 variations occurring across the state relative to what's
8 the price for a birth certificate, because we're
9 competing with each other.

10 So now we're trying to hold our number of
11 birth certificates, because I've got to still issue
12 them, I've still got to have a staff to file them.

13 So the health department, which has the
14 hospitals still is responsible for holding that
15 infrastructure, although, Warren County or Butler County
16 or even Pickaway County could be, you know, Columbus
17 City, they could issue a birth certificate for a child
18 that was born in Hamilton County, but I still have to
19 process it.

20 MS. EDWARDS: Okay.

21 MR. INGRAM: So it's an interesting point,
22 because, you know, we're doing okay, because we got very
23 competitive, because we knew that we were still going to
24 have to keep the staff there, so we've done everything
25 we can to say come to Hamilton County to get your birth

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1 certificate, and that's a good thing, this is a good
2 thing.

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.

9 So I don't know, I mean, there may be
10 different pieces that are in the rule, but I don't think
11 it's a Carte Blanche, I could be wrong in that.

12 So we have to remember, this is a
13 perspective process, it was where we should -- where we
14 go in the future.

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?

18 DR. MCFADDEN: I would add, sort of to your
19 question, I think it gets to something I have a little
20 bit of concern about as we're discussing that. I think
21 that at the local level what folks have access to is
22 different.

23 I mean so as you're asking a question
24 specifically about vital statistics and some other, as
25 you mentioned, larger regions, as you look at other

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1 states like Idaho, you know, Nebraska, some of these
2 areas that have larger districts, access, I'm thinking
3 about my population, you have some too of Amish, you
4 know, who need a birth certificate, to send to Columbus
5 to get the birth certificate, you know, when they might
6 need it today or to travel, you know, to Ashland County
7 or to Wayne County to get the birth certificate is a
8 different experience than what they would have in our
9 county.

10 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.

24 I mean there's rural areas of New Jersey as
25 well, but we have really a unique mix here and I think

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1 that what we do, I think -- 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.

20 DR. MCFADDEN: And I actually have no
21 problem with No. 1.

22 CHAIRMAN BURKE: But I think the discussion
23 you're having is exactly, I think, where we need to go.
24 We just need to determine what are they trying to do,
25 and then help them shape what that role is.

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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

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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: Well, this was basically what
7 the committee was thinking as that dialogue was
8 beginning is that there is -- this is the foundation,
9 this is the building block for the future of the local
10 health department in order for these to be, you know,
11 functional, relative to providing those core public
12 health services we just discussed.

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

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1 quickly and other doctors offices and so forth.

2 And the truth of the matter is, this same
3 system is the system that we need to use to measure
4 performance by too, you know, so you need some type of a
5 performance based system inside, and that has to be
6 linked on today.

7 Policy development, again, you have to have
8 the capacity to be able to develop policy. You know,
9 the days of probably developing policy on the back of a
10 napkin are probably over, although maybe some of the
11 best ideas come from that.

12 But, nonetheless, it takes expertise to do
13 that and you have to have resources in order to be able
14 to pull a policy position together, and then go to the
15 people that are charged with making policy, whether
16 that's the legislature or a local board, presented in a
17 way in which you take the science of the public health
18 and move health forward in that -- in that environment,
19 and the rest of them kind of speak for themselves.

20 I mean, you know, if you look at that
21 funding formula that's in executive, there's a lot of
22 health departments that are dependent on grants, and I
23 can tell you, not everybody has grant writing
24 capabilities within their department, very few do, and
25 occasionally you can contract it out.

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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.

9 So that's something we want to keep in the
10 back of our mind, and how would that look going forward
11 relative to the infrastructure, in order to be more
12 competitive in that area.

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.

24 So I think the question becomes there, it's
25 just not to make sure that there's legal support across

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1 the state in that regard, but, you know, public health
2 law is really becoming more and more complicated,
3 especially now with the implementation of the Affordable
4 Care Act.

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.

14 So I talked a little bit about policy, you
15 know, a lot of things we do is really trying to change
16 behavior since chronic diseases are the leading cause of
17 death, and that's kind of where a lot of us have shifted
18 our resources.

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.

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1 The media is a key piece, they can eat your
2 lunch or they can help add something to the dish, if you
3 don't know how to engage them.

4 So I think the other piece of that, Senator,
5 was to just -- like in some of these other areas is
6 having a resource center, you can't afford your own
7 public relations people on staff, just being able to
8 have access to that.

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: So when you look at the
18 foundational capabilities and the question asked, having
19 access to the skills and resources that make those up,
20 you mentioned things like grant resource centers and
21 meeting and what not, so maybe, is it okay, do you
22 think, to just start with quality assurance, because the
23 first thing here is accreditation.

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

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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.

16 These are pieces that are the most, for me,
17 looking forward to what we're going to need to really
18 be, a highly functioning public health in Ohio.

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.

23 Because, again, you know, the quality piece,
24 we haven't always had the ability financially to be
25 really aggressive at improving every piece that we were

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1 doing.

2 We responded to do what code told us to do,
3 and we did it, but to be able to say what do we need in
4 customer service, were we responding in the proper
5 amount of time for an outbreak.

6 You know, those are things that we haven't
7 always had the resources or the power to do, and so I
8 look forward to being able to work with someone that can
9 do those things, but, you know, that would be the one
10 thing that I would raise, but I think as far as the
11 quality, there's some great work that's being done in
12 some of the smaller counties.

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 --

19 MS. SHAPIRO: I was at a meeting this
20 morning that talked about the accreditation issue and
21 talking about assistance, again, the accreditation
22 process is the first time doing it, it's a learning
23 experience for all health departments, and I don't -- in
24 our discussion it was who was -- we need something in
25 Ohio that will facilitate and provide the technical

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1 assistance to help either some of the larger or smaller
2 health districts in becoming accredited.

3 What are -- if you can't do it all yourself,
4 because you don't have the infrastructure in place, is
5 there somebody that's going to come, be available to
6 help you, 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.

12 MR. TREMMEL: No.

13 MS. SHAPIRO: You know the answer, but is
14 that the plan?

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.

24 You might recall Commissioner Stefani
25 (Phonetically Spelled) saying his example, thinking

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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.

10 And with all of that accreditation comes
11 some constructs or criticisms that suggest you're strong
12 in these areas, weak in others with opportunities for
13 improvement.

14 But there's an ongoing with -- and Mr. Press
15 and others, Commissioner Ingram, would be able to tell
16 you, Dr. McFadden, the ongoing effort of accreditation
17 is -- is -- it takes time and it takes resources, and
18 there is money involved, of course, there's expense to
19 all of this.

20 So, long story short, we see local health
21 departments in this place, the department of health in
22 this place, my guess is, and it's just my own personal
23 guess, my guess is the Ohio Department of Health needs
24 to find out where it's at in the progress of coming out
25 the other side, and then the discussions, I would think,

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1 should continue and should involve local health
2 departments, exactly as what you're saying, Nancy.

3 What support is there from the state and/or
4 alternately as mentioned for others, a health department
5 that's been through the accreditation process similar to
6 other models, and Commissioner Ingram mentioned ESCs and
7 others, some of what we might want to capture in these
8 meetings, and these attempts in looking at networking
9 and sharing, who's been through it and who can be the
10 oven spoke.

11 There's a number of folks that want to be in
12 that place, that are wanting to be the spokes, but
13 you'll need a hub to say this is how, we've been there,
14 and this is how we've done it.

15 So we'll need to look creatively at the
16 forward thinking with those health departments that have
17 put themselves in that place, like Mahoning, that say,
18 we can assist in this.

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

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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.

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1 So I wanted to ask you, Tim, through --
2 through this process, when you looked at things like
3 that, did it actually divert into saying, well, it would
4 work this way for rural, but a little bit different for
5 urban, or are there -- did you also talk about those
6 areas where it really doesn't matter?

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.

14 I think each of us were speaking in terms of
15 where we sat though, and so we are trying to come up,
16 realizing that even in large health districts, you know,
17 it's all a function of, there's not enough capacity
18 there, everything is stretched, you know.

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

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1 to pay, otherwise they're going to go away, you know, so
2 I don't think we got to that point.

3 I think we were looking, we just knew that
4 in order to be successful going forward in the future,
5 and to make sure these services are getting provided
6 somewhat consistently across the State of Ohio, with the
7 understanding that 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.

16 Because really, it was all about trying to
17 improve effectiveness, okay, and change some of the
18 outcomes, which appear to be not --we're not progressing
19 as well as we could be on it.

20 And I just wanted to add one thing on the
21 accreditation part, so one thing that -- when we're
22 talking about quality assurance was evaluation.

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

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1 anyone who's -- who's funding you you've got to go
2 outside, and so you've got to hire somebody, and a lot
3 of us will pull people out of the universities, you
4 know, we'll pay them to do that, to do the evaluation on
5 our grants.

6 So I just wanted to put that -- so that's --
7 that's an important part, and I can tell you that
8 there's -- that are not a lot -- 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: Well, I think the thought was

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1 that if you're doing -- in order to be able to train
2 disease outbreaks in your community, okay, you've got to
3 have people that are trained in that area.

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 --

7 VICE-CHAIRPERSON PRESS: Let's -- how --
8 where is the part where we could answer the question, we
9 know success, because it looks like this? To me that's
10 sort of a measurement category.

11 We did health education, because that's a
12 core service that we want to make sure that every Ohioan
13 has access to. How would we know when a district was
14 successful in that effort, or forget success, somehow we
15 could measure where they were.

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.

20 So when you say, what does this look like, I
21 think that that should fall under best practices or
22 evidence of base practices or quality assurance.

23 My whole, although it's not specifically,
24 you know, labeled here, but when you talk about quality
25 improvement, I would make that not just quality

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1 improvement, but more of a pocket sort of thing and
2 continuous quality assessment, quality improvement
3 process, that's what I would hope could happen.

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?

8 So to me, measurement, you know, could a
9 district's discretion, take a particular emphasis around
10 immunization, for instance, where we want to have a
11 hundred percent, whatever the number is.

12 MR. TREMMEL: And I think just to add to
13 that concern and legitimacy of that, Representative
14 Wachtmann is not with us today, but the Representative
15 has raised this similarly, and I would suggest to you
16 that you can point to a number of things, but we just
17 don't seem to get squared.

18 So those number of things could be community
19 health assessments. We've talked about that, right, and
20 you would make a pretty fair level argument that the
21 community health assessment has taken some of these into
22 consideration, you could say that your health
23 improvement plan alternatively has done some of this.
24 You might say that your strategic plan is dealing with
25 some of the rest of the remainder, you may alternately

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1 say, well, the health district is in a place and in a
2 process or in a strategy of accreditation, and
3 accreditation looks at some number of these.

4 You could also point to the necessary
5 reporting for the State of Ohio, and that's through the
6 performance standards, it's an on-line tool that's
7 available to all these health districts, and all of
8 these health districts are participatory every year to
9 -- for which they receive their state subsidy, or you
10 can look at their annual financial for reporting
11 purposes.

12 But it does not, to say that there are a
13 number of tools in a tool box does not mean necessarily,
14 and this still resonates with me, Representative, how is
15 it that you show efficiencies? How is it that you show
16 that improvement? How is it that you show that
17 capacity?

18 And I think we get all around it, but I
19 don't know that we can just really say, here's the grade
20 card, it's right here, checked it off.

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

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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,
7 he's actually presenting on Thursday morning, so he has
8 agreed to participate.

9 I know that they're doing some
10 organizational development work at -- at the board that
11 the Director of Organizational Development, which I
12 think gets to some of these -- these issues and these
13 items that we're discussing today.

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.

19 So I think it's interesting that we're
20 working not only with our fiscal offices and our fiscal
21 office and our cashiers as to their level of efficiency
22 in doing some comparison of work productivity down to
23 the employee.

24 We're doing that with the Sheriff's Office,
25 we're doing it with -- I think I mentioned, you know,

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1 we've got 20 some odd agencies that we're doing this
2 with, so the Board of Health is not any different.

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
8 look at what public health has done, and you talk about
9 immunization rates, because of those rates we've
10 increased life expectancy.

11 And I think now, as you mentioned, Tim, the
12 chronic disease epidemic that we're having, you're not
13 only talking about decreasing life expectancy, but
14 you're also talking about increasing disability and
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
22 quality and life expectancy.

23 So I think that is the long-term thing that
24 may be in addition to the efficiency, but also look at
25 what can we do to improve the quality of life for all

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1 Ohioans.

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.

13 You know, I would say that some
14 jurisdictions probably have 72 hours, you know, once it
15 comes in the door, we'll respond to it, others might be
16 five days, I don't know. So you can look at those short
17 term measures and try to level that perhaps, but that's
18 a capacity question too.

19 Okay. The second thing though is, and what
20 I was going at was like -- take Smoke-Free Ohio. Okay.
21 I mean we know that tobacco use is a leading cause of
22 chronic diseases, hearth disease, lung cancer and so
23 forth, everybody's convinced that tobacco use is not
24 beneficial to your health.

25 Okay. So the voters in this state in, what

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1 was it, 2007 asked the legislature, and they passed a
2 smoke-free state, a workplace smoke-free.

3 You would expect that although the
4 Department of Health is responsible by law to enforce
5 that, that's been delegated for the most part to local
6 health districts, and so like I've asked Marty to, you
7 know, chime in here, if I say something that's
8 incorrect.

9 So I believe of the hundred and twenty-five
10 health districts there are 30 some that are not -- have
11 decided locally not to enforce that law, perhaps a
12 little more than that, is that --

13 MR. TREMMEL: Not to administer that law
14 might be a fair way to say that.

15 MR. INGRAM: Okay. Not to administer the
16 law.

17 MR. TREMMEL: In that they're deferring the
18 program to the State of Ohio for the enforcement.

19 MR. INGRAM: Which we know there's -- so
20 that strains capacity from the Ohio Department of Health
21 for whatever number of counties it is, it's somewhere
22 around 30, I believe, maybe a little more.

23 So the point is, if we're going to try to
24 change some of these chronic diseases and we know
25 there's a relationship between secondhand tobacco smoke

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1 and workplace relative to disease causes, the longer
2 term outcome is why isn't that consistent, I mean,
3 across local health districts?

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

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1 performance based contracting.

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.

9 So we're looking at -- we're looking at it
10 in a number of different ways where we invest a lot of
11 resources across the county to make sure that we are --
12 we are setting up a capacity to get to some of those
13 longer term impacts, and it's hard to do. It's a
14 difficult process, but something we -- we have decided
15 we really need to tackle that.

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, Nancy, I see that look.

24 MS. SHAPIRO: I have a lot of those.

25 MS. EDWARDS: Okay. But I'm not so sure

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1 when we're continually talking it shows me efficiencies,
2 accreditation shows me efficiencies, but as you had
3 said, Tim, where does -- when Ohio voted for that
4 smoke-free, then why don't we have those results?

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.

13 Hospitals went through JCAHO for a long
14 time, and so we're one of the last -- and this piece of
15 the public health -- of the health equation to get
16 accredited.

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.

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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.

7 You've got to have the needs assessment,
8 you've got to have the improvement plan, and then you've
9 got to have a strategic plan.

10 You can't do the strategic plan without the
11 governing body being involved, which in this case, of
12 course, is the Board of Health, and perhaps other local
13 elected officials, so I don't know. I don't think it's
14 gonna -- the effectiveness, I don't know.

15 CHAIRMAN BURKE: And some of that will fall
16 into No. 4, which we're working our way towards, it's
17 good to work forward, that's a good thing.

18 I guess I'll ask this question on reverse,
19 on No. 2, is there anything on the fundamental --
20 foundational capabilities that a local health district
21 should not have access or skills for?

22 I know that sounds like an ignorant
23 question, but just to boil it down, is there something
24 that should be eliminated on this, if we were to use
25 this as a policy framework for how we were going to make

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1 choices in the future as this discussion matures; is
2 there anything on here that we should scratch off?

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: Well, I don't want to -- well,
13 I'm going to somewhat punt this question, because I
14 think there's already a model to see what's happening
15 with the hospital systems.

16 Okay. I mean for the longest period of time
17 every hospital had their own clinical -- clinical
18 laboratory, and now what you see, most of them went off
19 to the big ones that are out there, you know, the
20 LabCorps and so forth, contracted them out, you know,
21 and I don't know how well that's working, because I also
22 see a few of the systems down our way are looking like
23 they're going to go back into business.

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

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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.

14 I'm not going to answer your question
15 directly, but I would -- I'm going to move it to Chris.

16 VICE-CHAIRMAN PRESS: Well, it's kind of
17 like, maybe some of these counties, kind of like the way
18 a coroner works, autopsies are done.

19 You know, we don't do autopsies in Hancock
20 County, we send them all to Lima or to Toledo, and, you
21 know, I think there's five autopsy centers in the state
22 or something like that, so there are ways to do it.

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

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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.

6 REPRESENTATIVE ANTONIO: I'm glad I don't
7 ride with you.

8 DR. MCFADDEN: 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.

20 So I think that it's important, and for me
21 the more important piece is that we need to remember to
22 fund, you know, laboratories. For me it's important for
23 us that I have ODH, so that's what I would add.

24 REPRESENTATIVE ANTONIO: Thank you.

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

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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: So I don't hear anybody
13 descending from of any these capabilities, and we can
14 use this as kind of a framework, not that anything is
15 set in stone here.

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.

23 I don't know if anybody has -- and, again,
24 I'll try to keep this portion of the discussion, we may
25 have to break here in about five or ten minutes, Mr.

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1 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.

16 MS. EDWARDS: Senator, if you don't mind, I
17 will step out. I made this comment at the first meeting
18 and I'll continue to pound on this, if you don't mind
19 for a little while.

20 MR. COLE: I yield my time.

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

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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.

14 If this is the right way to go about that,
15 and if the group thinks that that's okay, then I'm fine
16 with that, but I do think that we have the opportunity
17 to look at how health departments, county health
18 departments are governed.

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,

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1 and we have votes from them.

2 How do we get to the people that don't go
3 and don't attend? How are we going to accomplish any of
4 these things that we sit in the room today and want to
5 do?

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.

11 I mean that's mind boggling, but how do you
12 get people to be accountable for themselves or if they
13 run for office to be accountable for people they serve?
14 If somebody has that magic pill, I would love to know
15 where we can get it.

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.

21 MS. EDWARDS: And who gets the new ones?

22 MR. THRELFALL: It depends on which level
23 we're talking about. I've never understood, and our
24 board has been very active with the people who put them
25 on the board, so, you know, if I would not do my job, I

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1 would anticipate the trustee would rip me off with a big
2 hook.

3 I mean I would hope that would happen,
4 because it would be time to get out of there, because we
5 need people on that board for the leadership, not the
6 micromanaging, for the leadership, for the goals, for
7 the future of health in Delaware County.

8 We've got that big objective, and then we
9 get to our staff who are all excellent, I mean I tell
10 them that, I think, just about every board meeting, to
11 implement, to find a way to make it work. We work
12 together to look at funding and how we can get funding
13 to make it work.

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.

23 MS. EDWARDS: Sure. I think just as your
24 experience is different from county to county.

25 MR. THRELFALL: Well, I don't know how you

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1 get -- I don't know why anybody runs for an office,
2 well, I do know, but we won't go there, runs for an
3 office that does not have the stakeholders at heart.

4 It's like they get elected and that's it,
5 and I wish you could tell beforehand, it would be so
6 good, but people have other motives.

7 MS. EDWARDS: I guess I could even take that
8 one step farther, if you don't mind, throughout the
9 State of Ohio, at least in looking at it from a
10 commissioner's standpoint and looking at the discussions
11 that we've had at CCAO with county coroners, there's a
12 number of counties that really have a difficulty in
13 getting someone to run for county coroner, you know
14 that.

15 MR. THRELFALL: I know that.

16 CHAIRMAN BURKE: Just a curiosity question,
17 those meetings, are votes taken by majority present --

18 MS. EDWARDS: -- Yes --

19 CHAIRMAN BURKE: -- Or majority appointed?

20 MS. EDWARDS: -- Majority present.

21 CHAIRMAN BURKE: Majority present. So even
22 if only three people showed up and two out of three
23 showed up and they decided that was the path, there goes
24 the lie.

25 MS. EDWARDS: Pretty much.

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1 DR. MCFADDEN: The Revised Code does allow,
2 I mean, there's language, if there's not a quorum of the
3 members of the body present that an executive -- you
4 know, it's a process that we go through in order to get
5 the measure past until a quorum could be reached, and
6 that's specifically spelled out.

7 CHAIRMAN BURKE: So the quorum amount is 50
8 plus 1 --

9 MS. EDWARDS: Right.

10 DR. MCFADDEN: -- Of the appointed members?

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?

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.

19 The individuals that come to the monthly
20 meeting, I believe, I don't attend those meetings every
21 time, so I couldn't say.

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.

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1 VICE-CHAIRMAN PRESS: Right. So -- okay.

2 DR. MCFADDEN: Senator, if I could, in our
3 county, the -- how it usually goes is as the Health
4 Commissioner I go to the township trustees meeting, sort
5 of months before, whichever is closest to when our
6 meeting is going to be, and I announce it, beg, cajole,
7 ask them to come, send out information, and if there are
8 problems I know that we're going to have the room
9 packed, if they're unhappy -- in our county if they're
10 unhappy with how things are going people are going to be
11 there.

12 During 2007 after the sewage rules, the
13 meetings were full, people were there, in H1N1, because
14 people were concerned about what was happening the
15 meetings were full.

16 Intervening years, where things are going,
17 you know, just no problem, I end up that evening calling
18 people and saying -- at their house, and saying, hey,
19 Mike, you know DAC is tonight, you know, we want to
20 start at 7:00, it's 7:15, can you be here, yeah, I'll be
21 there in 15 minutes, great.

22 You know, Joyce, I need you here, you know,
23 and we wait until we have a quorum, that's what I do to
24 get people there.

25 I don't think that necessarily people aren't

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1 interested or in my particular -- or public health is
2 not a concern, I think though it reflects, you know,
3 things are moving smoothly, they feel like things are
4 good.

5 When there are problems, they all come and
6 want to make sure, that's what I would share from our --
7 but it is difficult. I would share your frustration, it
8 is difficult, because I don't know that everyone always
9 understands how important that meeting is to the
10 functioning of my board.

11 MS. EDWARDS: I totally agree with that, and
12 I think, and I'm going to speak, because we're from a
13 rural county, when you've got township trustees that are
14 still farmers and they're out till -- you know, getting
15 soil ready, whatever, getting feed ready, they're not
16 thinking.

17 They're thinking about the roads they have
18 to maintain; they're thinking about the burial that they
19 had to have somebody do today; they're thinking about
20 getting their own roads and -- not necessarily bridges,
21 but roads and some other things done for their township.

22 They're not thinking about county health,
23 because that's not really on their agenda.

24 CHAIRMAN BURKE: Okay. Well --

25 MS. EDWARDS: I'm not saying that -- please,

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1 don't misunderstand, it's not that I want to see
2 townships out of it. I just think that -- how is there
3 a better way? I don't know that answer necessarily, but
4 I just continue to say we've got this good opportunity.

5 MR. INGRAM: I just, you know, governance is
6 a key question here. I always believe it's fundamental
7 to what we're talking about, and the OHC future report
8 did not -- did not tackle governance.

9 Okay. So just keep that in the back of your
10 mind, but I think it's -- and just like we heard from
11 the good doctor and others here, you know, there is that
12 much variation across the state.

13 I can tell you in Hamilton County, it's the
14 same thing, 49 units of government, 30 of -- 33 of them
15 are served by Hamilton County Public Health. Okay. So
16 that means I've got to have 17 or 16 to have a quorum.

17 Okay. And we've struggled at times and we
18 do exactly what Dr. McFadden said, we'll form this
19 executive committee, and then there will be a committee
20 of five, and they'll make their appointment.

21 But, you know, I've also said that boards of
22 health are appointed by elected officials, and a county
23 board of health in a single general health district, not
24 a combined, it's a five member board, one must be a
25 medical doctor, the other four are just consumers that

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1 represent some regard to geographical representation of
2 the district in which they serve.

3 Perhaps we shouldn't overlook that, although
4 the district advisory council has the majority
5 appointments, there is a regulatory body known as the
6 licensing council that gets one appointment too, and the
7 law was actually changed about 10 or 12 years ago,

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

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.

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

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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.

22 For equal assurance, let's form this

23 relationship with this group over here, for grant
24 writing, let's form a relationship with this group over
25 here. To me that makes sense, so that's what I would

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1 say in response to that.

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.

23 Now, I'd argue that this is a great room for
24 me to be in.

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2 Sometimes when I give these presentations
3 and I've done almost 50 of them to over 5,000 people
4 around the State of Ohio, talked about Beyond
5 Boundaries, what we need to do with shared services; how

6 we're going to sustain key services to local governments
7 around the state.

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

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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,

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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.

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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.

21 I've heard some numbers thrown out, let me
22 give you some big picture perspectives. There are 3,962
23 local political subdivisions in the State of Ohio.

24 A hundred and some are health districts
25 included in that number, but 3,962, they are governed,

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1 not appointed boards, but elected officials in the State
2 of Ohio, 20,232.

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.

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1 They may still want to fulfill their duty or
2 go to your meeting, find a way to let them with 21st
3 century terminology, and allow better public input by
4 opening those things up.

5 You can't all do that on your own, 3,962
6 political subdivisions can't, but through regional data
7 centers, regional shared service centers, going to the
8 county seat, having someone make that investment and
9 sharing it, you can make those things happen.

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.

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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

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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."

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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

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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.

12 And we're getting great editorials and
13 examples, and we'll continue to work on publicizing
14 those and finding ways to display what's happening to
15 continue to move it forward.

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...

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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

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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.

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.

14 We are continuing to work through the next
15 budget, through Department of Education policy, we
16 already changed the law to say those people can directly
17 provide services to you as a political subdivision,
18 anybody, they can provide those services, but we are
19 working on their capacity, their list of services in the
20 core areas of administration, technology and
21 instructional support or training.

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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.

6 You know what I mean, don't create the back
7 office support to create training networks, use someone
8 else's training network and say, but this is who we're
9 going to have provide the training and the subject
10 matter, right, don't create the rest of the bureaucracy

11 that supports it.

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

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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.

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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.

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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,

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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.

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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.

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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.

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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: I didn't really have any

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1 questions, but just some -- some comments. As an
2 example, in Cuyahoga County we've been doing a lot of
3 work around looking at shared services.

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

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: Thank you for your
19 presentation, Randy. Tim Ingram, I'm the Health
20 Commissioner in Hamilton County Public Health. 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

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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.

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5 MR. COLE: Okay. I don't have an immediate
6 answer to that, but, you know, Director Moody and I talk
7 frequently, OHT is following this and is plugged into
8 what you guys are doing.

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

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1 often align with those local health markets.

2 MR. INGRAM: Not to beat this up, but, you
3 know, everybody knows in those areas, you know, if
4 you're south of Lebanon you come into the greater
5 Cincinnati market, if you're north of Lebanon you go
6 into the Dayton market. I mean it's just -- I mean it's
7 really kind of well understood.

8 Now, that doesn't mean that, you know, some
9 people aren't going to run up to the Cleveland Clinic
10 and get health care, but as they're trying to move into
11 core coordination models and they're working outside the
12 walls and being actually incentivized to do that, and as
13 we've been struggling to do what we've got to do with
14 dwindling resources, I'm looking for that sweet spot
15 where we become a part of each other's success, with
16 ultimately improving the health of all Ohioans better
17 than it is today would be the ultimate outcome.

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

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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.

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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.

19 Again, when I'm in those audiences that may
20 be less receptive to a message about framing the big
21 picture, why we have to change and where this is going,
22 it's important to point out that the change is
23 happening, but what we have at stake is the ability to
24 provide the services people expect or credibility when
25 they see the rest of the world changing around them at

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1 their jobs, in their homes, and they see a rigid
2 structure or people unwilling to change or asking to
3 protect yesterday instead of moving forward, it's not
4 our choice to change, our choice is how we change.

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.

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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.

21 If I could, with the committee's approval
22 here, focus maybe just on No. 5 for maybe 10 minutes.

23 Save No. 4, we talked a little bit about
24 accreditation, No. 6, improvement standards and No. 7
25 Ohio health commissioners review of laws and

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1 regulations, see if we can take those strategies and
2 roll them into the next meeting, if we can, before we
3 discuss jurisdiction, and then I just feel it's
4 important that, as we move forward with how something is
5 going to look that the intent and the purpose of what it
6 looks like reflects the policy.

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 relation funds in Ohio, that I felt if we

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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.

11 And I feel like, because of geographical or
12 other problems that we could right now, with this No. 5,
13 we could end up, you know, terminating them, rather than
14 giving them a short bit of proper nutrition, and them
15 being able to succeed and be successful.

16 So for me, that's the concern I have with
17 that statement, so I would be a hundred percent with the
18 administration and with you, that I -- what I feel like
19 you're leading us to think about is I think we should
20 have a time period where struggling areas have an
21 opportunity to have an infusion, and then after that
22 have a cut off point, and say, okay, from now on we need
23 to have people from Ohio, that's my only -- that's been
24 my bias for the last three years.

25 MS. SCOLFIELD: Okay. I would generally

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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.

8 But even with that said, have -- have the
9 plan in place to make sure that those areas still have
10 access to services, so that the residents aren't --
11 don't suffer, but that perhaps there's, you know, merger
12 and collaboration, things that have to happen instead.

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: I certainly understand the
24 philosophy. I guess the question is how -- what if the
25 jurisdiction said we're not interested in improving

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1 ourselves? What if there are certain barriers that are
2 in place that are preventing that?

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.

15 I understand the importance of putting cash
16 infusion, I mean the emergency preparedness money that
17 came out after 911 has really been a good example of --
18 that's been the largest cash infusion into local public
19 health in, I think, recent memories, and so I happen to
20 sit on that committee with others, and, you know, we
21 ended up going -- based on -- doing a base amount of
22 money to every county or every jurisdiction, or actually
23 I think it was a county level, and then a per capita
24 basis.

25 So I just -- I just wonder, how you do this,

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1 in light of that we put a good bit of money, and that
2 emergency preparedness installment was just not for
3 emergency preparedness, but was for infrastructure
4 building.

5 So there's already an example out there of
6 which we've already went down this road, so I just still
7 want to make sure we're not going to, you know, repeat
8 perhaps something that we've already tried to do, and
9 I'm not suggesting that there's something, you know,
10 that some of this hasn't worked, because it has.

11 MS. SCOLFIELD: I was making the assumption
12 that would be additional resources.

13 MR. INGRAM: Additional moneys.

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?

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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?

10 How do I improve, add a year to somebody's
11 life, whatever it is, and I don't know how to get there,
12 just in a carpeted sense, would you do that through
13 rewarding people that are doing the right things or do
14 you turn your attention to folks that maybe aren't doing
15 the right things, help fix them, and then develop a
16 carrot stick approach?

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

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1 that's absolutely fantastic.

2 Nancy will vouch for the fact that when we
3 started doing this, I said, how many diseases are we
4 going to prevent? How much of our staff time is it
5 taking doing things that ought to really help?

6 Asking the question, not for or against, but
7 I certainly ask the question a lot, every board meeting,
8 but as I saw this unfold, it was great, because it not
9 only pointed out our weakness, it pointed out our
10 strengths.

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.

21 I'm not saying Delaware County would want to
22 fund them, because that wouldn't go over well, but if
23 there is a way for the boards to get together and talk
24 about what could be gained for the public health of
25 their citizens, and, again, I don't know if that's a

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1 pill that would work or might not even be swallowed, but
2 I think cooperation, and as Randy pointed out, you force
3 consolidation, I've seen that happen, that doesn't
4 always have a really nice turn out, but if we can get a
5 way of finding a cooperative effort, I think that's what
6 Delaware can offer, I think that's what Morrow can get.

7 But I would agree, to hand out money for one
8 that's non-functional now without accreditation and
9 knowing where they're non-functional and what -- I think
10 that would be a mistake.

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 LED 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

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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.

7 CHAIRMAN BURKE: I wonder with the
8 committee's, I guess, permission here, I just found out
9 that there's a former Morrow County health director
10 here; is that right?

11 And if I could build on your point, Walter,
12 Morrow County's obviously a small county, the metropolis
13 of Mr. Gilead located in its heart, how difficult would
14 it be or is it possible for this accreditation process
15 to occur in Morrow County and identify what those
16 strengths and weaknesses are; is that possible?

17 MS. WASOWSKI: It is possible, would you
18 like for me to come forward?

19 CHAIRMAN BURKE: Sure, yeah, I mean, you're
20 probably a good example, because it's an economically
21 depressed area, it's small.

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.

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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.

15 An the health commissioner there I was
16 registering home births, Amish families would come in,
17 answering telephones, doing all sorts of things that as
18 a health commissioner you -- you can't be looking at the
19 big picture when you're doing the day-to-day, and with a
20 health department with limited resources that's really
21 what the game is.

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

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1 county you came to the health department.

2 So keeping the doors open and keeping
3 staffing for that, that was a priority for our health
4 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.

23 And so, you know, I would say, a body. I
24 would say people or the ability to fund a person to not
25 do some of the other things that they were doing in the

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1 agency, but to really focus on documenting and
2 determining what needs to be done or what hasn't been
3 done, so -- and a community health assessment.

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.

7 It isn't that people sitting around the
8 table didn't know what the needs are in the community,
9 it's that we don't have a document to put on the table
10 that we can send to PHAB to say we can prove that we
11 know what it is, because we went through this process
12 and here it is.

13 So I hate to always say, money, but I would
14 say the ability to do some of that, and, I know ODH
15 really reached out to the community, the critical access
16 hospitals and looked at how to help the hospital code
17 that, but for community health assessment and the
18 improvement plan, it's really locally driven.

19 MS. SHAPIRO: I have a question, having
20 worked with Morrow County closely even before Krista,
21 the shared services concept, I think, could greatly
22 benefit, not only the Morrow Counties of the world, but
23 also the Delaware Counties of the world, because we
24 don't -- there's some functions that we don't do enough
25 of that we didn't have the capacity to do, and do it

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1 well.

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: Mr. Chairman, I have two
16 questions, the first one for Krista, and then the next
17 one for the larger group of folks here.

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

24 Delaware will be, continues to be, that
25 shining example of the health district that does so many

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1 things so well, and it's taking the opportunity.

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.

20 And the problem is that you're asking people
21 to vote for something when we also regulate a lot of it,
22 and so when you close the favorite restaurant in the
23 community, because it's hurting people, that doesn't
24 build friends and influence with people, and so those
25 controversial issues, and you were talking about it

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1 before, D.J., getting people to a room --

2 MS. WASOWSKI: The landfill.

3 MS. SHAPIRO: Yeah, the landfill.

4 CHAIRMAN BURKE: Church.

5 MS. SHAPIRO: And that, you couldn't stop
6 it, or you tried to stop it and it didn't work or
7 whatever.

8 MS. WASOWSKI: Or it's legally allowed, just
9 unpopular.

10 MS. SHAPIRO: Right, but the population
11 wanted it stopped.

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

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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.

13 And, again, we shared resources, it wasn't
14 just Morrow County standing alone trying to develop a
15 CQI plan.

16 We were able to -- in those days we were
17 able to -- we did it one place, we were able to take
18 that model and use it somewhere else, so with that --
19 and Walt will remember that too, those days were a long
20 time ago.

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?

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1 MS. SCOLFIELD: No, not really, just to
2 reinforce it.

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?

19 MR. MAZZOLA: I believe Representative Nixon
20 will be presenting at the next meeting.

21 CHAIRMAN BURKE: Mr. Nixon from Summit
22 County. Okay. And we'll try to get that done, if not
23 first, line up, and try to keep things rolling here.

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

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CERTIFICATE

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I, Teresa L. Mantz, Certified Professional Reporter, and Notary Public in and for the State of Ohio, do certify that the foregoing is a true and correct transcript of the proceedings taken by me in this matter on July 31, 2012, and carefully compared with my original stenographic notes.

That I am not an attorney for or relative of either party and have no interest whatsoever in the outcome of this litigation.

IN WITNESS WHEREOF, I have hereunto set my hand and official seal of office at Columbus, Ohio, this 9th day of August, 2012.

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

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