

BEFORE THE LEGISLATIVE COMMITTEE  
ON PUBLIC HEALTH FUTURES

- - -

Tuesday, July 24, 2012  
1:03 p.m.

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

- - -

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1 APPEARANCES:

2 Commissioner Martin Tremmel

3 Commissioner Nancy Shapiro

4 Commissioner Jennifer Wentzel

5 Commissioner Christopher E. Press

6 Commissioner D.J. McFadden, M.D.

7 Commissioner Gene Nixon

8 Senator David Burke

9 Commissioner Tim Ingram

10 Representative Lynn Wachtmann

11 Representative Nickie Antonio

12 Joe Mazzola, IT

13 Rory Hamlett, IT

14 VIA VIDEO TELECONFERENCE:

15 Kristen Hildreth

Monica Juenger

16 Commissioner Matthew Stefanak

Commissioner Jim Adams

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1 Tuesday Afternoon Session  
2 July 24, 2012  
3 1:03 p.m.

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

6 - - -

7 MR. TREMMEL: Let me just take  
8 care of a couple of housekeeping items and  
9 measures for everyone again, and then I'm going to  
10 quickly turn this over to a couple other folks to  
11 take care of the purposes of the meeting.

12 No. 1, Representative, good  
13 afternoon. Nice to have you.

14 Housekeeping Item No. 1, we have  
15 Heidi with us today.

16 Good afternoon, Heidi.

17 Heidi will be taking all of our  
18 reporting information. We want you to know  
19 purposefully we're trying LHD for the Future's  
20 information. We're trying to really push it  
21 electronically and kind of paperless.

22 I'll take any criticisms during  
23 the meeting if you think that it is too much or  
24 just not the right stride for all of you. But  
25 we're trying to reference you back to that point,  
with Heidi being here.

1                   Again, please maybe just speak  
2                   your name for her so that she can get the record  
3                   moving quickly. And we'll try not to do too much  
4                   interrupting back and forth.

5                   We have a couple new folks that  
6                   are new here and have arrived, Health Commissioner  
7                   D.J. McFadden, Senator Burke, of course.

8                   We have the facilities here. The  
9                   restrooms are behind us here. Just outside the  
10                  door the cafe is available. So at your leisure  
11                  take opportunities that way. That cafe has coffee  
12                  and water and refreshments.

13                  We've talked about some of the  
14                  e-capabilities. I'm pleased to announce Joe is  
15                  with is today driving the car again.

16                  Welcome, Joe.

17                  To his right is our colleague,  
18                  IT Rory.

19                  For all of you, any of you and  
20                  especially the Chair and the Vice Chair, if you  
21                  want to see certain things on the internet or  
22                  anything of a technology, we'll pull it for you.

23                  Thank you.

24                  The transcripts are available in  
25                  full version. And the transcript is available in

1 an abridged version. So I'll pass the transcripts  
2 out to the Vice Chair and to the Chair.

3 Folks, the way you read the  
4 transcript is through the service. On the  
5 left-hand side are the line numbers, and on the  
6 right-hand side are the page numbers. I think  
7 we've clarified that in an e-mail to you.

8 Joe and I are taking our best  
9 level efforts to make you an abridged version of  
10 130-some pages of transcript. And I know we can  
11 do a better job, because it is still pretty  
12 lengthy, but it reads rather quickly. So it does  
13 read a bit like a novel, very long. We're working  
14 on the best seller part. Maybe not there yet.

15 We also used video technologies  
16 and capabilities.

17 Joe, remind us who is on the call  
18 at this time and how many.

19 MR. MAZZOLA: Sure.

20 I think we have four guests with  
21 us today: Mr. Matt Stefanak, Commissioner Jim  
22 Adams, Kristen Hildreth, and Monica Juenger.

23 MR. TREMMEL: Wonderful.

24 Well, thank you for joining us on  
25 the call.

1                   Next is that you also have the  
2 agenda available to you. You have some  
3 information.

4                   One of these charts that has been  
5 available to you -- this is just the FAB  
6 accreditations fees that came up from the last  
7 meeting (indicating).

8                   And I'll share something else with  
9 you, just in some kind of minor sort of review.  
10 Joe brought to my attention a report. And it's  
11 rather interesting is where you're going through  
12 this, and just kind of my first read.

13                   I'm going to read just three  
14 excerpts on this to show you kind of how these  
15 respectively ebb and flow.

16                   The ideal population size of a  
17 local health district according to the national  
18 public health authorities are currently  
19 recommending a minimum population of 100,000 per  
20 local health district, recognizes the smaller  
21 units of 25 or 35,000 may be more desirable in  
22 sparsely populated areas. And this is referenced  
23 here, as well as the American Public Health  
24 Association.

25                   Two other excerpts, quickly: Over

1 one-half of all local health districts are now  
2 cooperating, contracting, or combined with other  
3 health districts, over two-thirds have such  
4 arrangements. The Department of Health, after  
5 this certain census was successful in persuading  
6 inner cities to cooperate in contract.

7 Let's see. The apparent  
8 successful record of consolidation of health  
9 districts in Ohio is blemished, of the 30 city  
10 health districts and 14 general, below 25,000,  
11 which continue to operate alone by the inherent  
12 shortcomings of the present methods of uniting  
13 them.

14 All city health districts are  
15 100,000, or some lesser figure, 50 required,  
16 combined with general health districts is  
17 predominate in rural areas. This issue of measure  
18 approached consolidation.

19 And then the last thing in this  
20 71-page report is the weakness of funding at the  
21 local health level, especially in areas of public  
22 health levies, state subsidies --

23 And it is sort of interesting:  
24 The present state subsidies failed for public  
25 health standards equalized financial burdens on

1 local health districts to help them with serious  
2 financial health and population problems.

3 And the annual authority went a  
4 long way back 40 years ago, went a long way to pay  
5 salaries of public health folks, health  
6 commissioners, nurses, et cetera.

7 So I read all of that to you  
8 because there is some similar themes in all of  
9 this, interestingly. But I wanted to reference  
10 you back to -- this is reported back from the LLC  
11 in December of 1960. 1960.

12 So interesting. Interesting. And  
13 even some of the same numbers. Isn't that  
14 unbelievable?

15 Anyway, with that, let me turn  
16 matters over to our good colleague and our  
17 director here of the Ohio Department of Health,  
18 Dr. Ted Winslow.

19 Dr. Winslow is briefly here. I  
20 know his schedule is very limited.

21 But we're glad to have you here.

22 DR. WINSLOW: It's a pleasure to  
23 be here. And welcome everyone who is here in  
24 person and also on the telephone.

25 This is a very important issue,

1 obviously, for the whole State of Ohio. And  
2 clearly we've got a history of having looked at  
3 this issue in the past and what we want to try to  
4 do to see if we can establish clear directions.  
5 And I have every confidence that we will with the  
6 leadership that we have in charge of this effort.

7 I wanted to just make some  
8 comments to you also, as I'm getting ready to go  
9 to Washington, D.C.

10 What I'll be doing later today and  
11 the next two days is representing the State of  
12 Ohio as we look at the efforts that are going on  
13 nationally to address the integration of public  
14 health and primary care.

15 And this is being led by the  
16 Institute of Medicine and also the Association of  
17 State and Territorial Health Officers, and the  
18 CDC.

19 So they're all behind this and  
20 they've invited us as a state, because they see us  
21 as the lead state with the capacity to move  
22 towards the greater integration of public health  
23 and clinical medicine. And specifically, this  
24 conference is about primary care.

25 But you all know that we have been

1 discussing this over this past year or so, as I've  
2 been in the leadership position. And I think  
3 that's a critical place where local health  
4 departments can have a tremendous participative  
5 role and leadership role, because you've got those  
6 connections at the local level with clinical  
7 patient care.

8                   Traditionally, public health and  
9 clinical medicine have been seen as separate  
10 entities. And one of our goals is to see how can  
11 we better integrate decision-making, patient care,  
12 and ultimately impact population health and  
13 well-being and not artificially separating those,  
14 but instead bringing them together in a  
15 coordinating care delivery model that has public  
16 health side-by-side with clinical medicine  
17 providing comprehensive care to the whole patient.

18                   So we have been invited to  
19 Washington to discuss our perspective from Ohio on  
20 that. You're integral in this process of  
21 converting our system in Ohio, in transforming it,  
22 actually, into one that allows those separate  
23 entities to function on a more integrated chain.

24                   So I just tell you, this is very  
25 important what you're doing today. It has a

1           tremendous future impact that I think we'll be  
2           able to realize.

3                       And I want to thank you all for  
4           putting the time and effort into this that you're  
5           putting in. It will be worth-while. And we'll  
6           come up with, I think, more than we did in 1960,  
7           as far as some outcome to show, because I think  
8           everyone is ready for action on this at this  
9           point.

10                      So thank you all, very much,  
11           again.

12                      Especially thanks to our  
13           leadership for taking on this responsibility.

14                      MR. TREMMEL: Thank you, very  
15           much, Dr. Winslow.

16                      We have a number of the ODH Team,  
17           SMEs, Program and Administration joining us, as  
18           well as the members of the Association. So thank  
19           you all for being here. We appreciate it.

20                      At this time let me introduce the  
21           Chairperson for the Committee going forward. And  
22           we visit Vice Chair and welcome Mr. Press.

23                      And I especially welcome  
24           Senator Burke. And thank you for assuming the  
25           responsibilities of the chairing of this effort

1 and this Committee, leading us forward to a  
2 strategy that we can develop a report out to the  
3 General Assembly by the end of October.

4 So welcome. Thank you.

5 CHAIRMAN SENATOR BURKE: Thank  
6 you.

7 MR. TREMMEL: Well, we could maybe  
8 go around and introduce ourself.

9 And I have a role for you, if you  
10 will like.

11 CHAIRMAN SENATOR BURKE: I'll call  
12 today's meeting officially to order, as Chairman.

13 I would like to thank the  
14 Committee for their trust and confidence they  
15 placed in me.

16 I guess the first lesson to learn  
17 is once again, don't miss a meeting or they'll  
18 make you the Chair.

19 But I do thank you, and it's good  
20 to see familiar faces. I look forward to working  
21 with everyone, especially with my Vice Chair,  
22 Mr. Press.

23 Showing, once again, it's a small  
24 world, I had the opportunity to intern for a  
25 quarter of a stint at Ohio Northern and Blanchard

1 Valley Hospital. So it is a small world.

2 And also speaking of connections,  
3 my wife also serves on the Board of Health in  
4 Union County. So I have a connection, as well,  
5 that way. So I'll hear probably from all sides.

6 But the most important thing is  
7 that I hear from you. We have a task before us on  
8 a report that's been handed to us that requires  
9 some type of action. And we bring a variety of  
10 backgrounds with us in an expectation to produce  
11 results.

12 And so I encourage people to  
13 interact on their own, through our office, through  
14 the Department of Health, to move an agenda  
15 forward that puts public health into this form.

16 I don't know what shape that is  
17 going to take. I don't know how that is going to  
18 look. But I do know that we bring town and people  
19 together. We do good things.

20 So with that being said, if you  
21 want to kind of start and discuss this a little  
22 bit.

23 I know that Marty introduced some  
24 people. But we can go ahead and just call out  
25 again and do our role.

1 MR. MAZZOLA: Good afternoon.

2 My name is Joe Mazzola. I'm the  
3 local Health Department liaison.

4 MR. HAMLETT: Rory Hamlett, also  
5 technical support.

6 COMMISSIONER MCFADDEN:  
7 D.J. McFadden, Health Commissioner in Holmes  
8 County, and serving on the Association of Health.

9 COMMISSIONER NIXON: Gene Nixon,  
10 Health Commissioner of Summit County Public  
11 Health, and also serving on the Association of  
12 Health.

13 REPRESENTATIVE WATCHMAN:  
14 Lynn Watchman, State Representative.

15 VICE CHAIR PRESS: Chris Press,  
16 I'm President at a hospital in Findlay, Ohio.

17 CHAIRMAN SENATOR BURKE:  
18 Dave Burke, State Senator.

19 MR. TREMMEL: Marty Tremmel, with  
20 the Ohio Department of Health.

21 DIRECTOR WINSLOW: Ted Winslow,  
22 Director of the Ohio Department of Health.

23 COMMISSIONER INGRAM: Tim Ingram,  
24 Health Commissioner, Hamilton County.

25 COMMISSIONER WENTZEL:

1 Jennifer Wentzel, President of Ohio Environmental  
2 Health Association.

3 COMMISSIONER SHAPIRO: I'm the  
4 Chair and Health Commissioner in Delaware, and  
5 representing ODHA.

6 COMMISSIONER ANTONIO:  
7 Nickie Antonio, State Representative.

8 Chairman SENATOR BURKE: We do  
9 have a quorum, so we can move forward.

10 There was available to you, as was  
11 mentioned earlier, a rendition of the minutes on  
12 the Department of Health web site.

13 There is also an abbreviated  
14 version of that. And as the secretary mentioned,  
15 it is abbreviated and referenced by page and line  
16 number on the entire document highlighting  
17 important things to make you aware of.

18 Do we have a motion to approve the  
19 minutes of July the 10th?

20 REPRESENTATIVE WATCHMAN: So  
21 moved.

22 REPRESENTATIVE ANTONIO: Second.

23 Chairman SENATOR BURKE: We have a  
24 motion and a second. Motioned by  
25 Representative Watchman, seconded by

1 Representative Antonio.

2 Do we have -- I guess anybody  
3 opposed to approval of the minutes?

4 - - -

5 Thereupon, no response was had at  
6 approximately 1:24 p.m.

7 - - -

8 CHAIRMAN SENATOR BURKE: Hearing  
9 no opposition, we'll go ahead and approve the  
10 minutes.

11 And just to read in again, I know  
12 we did it earlier, the folks that are on the phone  
13 could you repeat those names again, just for the  
14 record?

15 MR. MAZZOLA: We have Commissioner  
16 Jim Adams. We have Commissioner Matt Stefanak.  
17 We have Kristen Hildreth, and Monica Juenger.

18 CHAIRMAN SENATOR BURKE:  
19 Excellent.

20 I see next on the agenda we have  
21 Commissioner Matt Stefanak.

22 Matt, can you hear us okay?

23 COMMISSIONER STEFANAK: Hello,  
24 Mr. Chairman.

25 Yes. I just regained access. And

1 I think I am able to see you and you may be able  
2 to see me in the corner of your screen.  
3 Regardless, I have a voice connection here so that  
4 we can proceed, if you wish.

5 I asked Joe Mazzola to advance my  
6 slides as I go through.

7 I understand I have 20 minutes to  
8 talk; is that correct?

9 MR. TREMMEL: Or less.

10 CHAIRMAN SENATOR BURKE: We're  
11 very much --

12 COMMISSIONER STEFANAK: I'm going  
13 to start by addressing the first topic that I was  
14 asked to talk about. And that was the brief that  
15 we put together earlier this year for different  
16 stakeholders in Mahoning County who were then  
17 considering whether or not to start a discussion  
18 about the jurisdictional sharing or even an  
19 outright merger of the two health departments  
20 there.

21 I believe everyone has a copy of  
22 that; is that correct, Joe?

23 MR. MAZZOLA: That's correct.

24 It's been posted on the website.

25 COMMISSIONER STEFANAK: Great.

1 Okay.

2 And I'm just going to give you  
3 maybe a five minute overview of our findings  
4 there, and then transition to the slides that you  
5 see in front of you.

6 We put together this brief in the  
7 from of a series of frequently asked questions and  
8 answers in response to a question of the Mayor of  
9 Youngstown that we consider a discussion between  
10 the townships and the City for consolidation of  
11 public health services.

12 And we began by assembling all  
13 those questions or assertions that we have heard  
14 in recent years about cost and benefits of  
15 consolidating health departments in Mahoning  
16 County.

17 And the first few questions in the  
18 FAQ is to deal with the mechanics of how to  
19 execute a contract or a merger for public health  
20 services. And it's clearly spelled out in Revised  
21 Code Chapter 3709.

22 We also put together a cross block  
23 of how the health departments are currently  
24 sharing the services. And not surprisingly what  
25 we find in Mahoning County and public places

1 across the State of Ohio, there are many examples  
2 of jurisdictional sharing from a situation where  
3 one health department takes the lead of a grant  
4 opportunity and provides the service county-wide,  
5 like preparedness planning in Mahoning County.  
6 That's an example.

7 And others that two health  
8 departments will decide to split the labor, if you  
9 will, to divide the labor with one health part in  
10 the lead agent -- a physical agent and contracting  
11 with the other to provide some parts of the  
12 service, as Mahoning County, the remuneration  
13 action program, the outreach program between  
14 Youngstown and Mahoning County.

15 We've talked about the governance  
16 changes that would be allowed for in a merger.

17 We also tried to answer the  
18 question how would the quality of services be  
19 affected in the wake of a merger. And the only  
20 data we had available to share with the  
21 stakeholders at that time was our experience in  
22 the acquisition of two small city health districts  
23 in Mahoning County that I negotiated in the last  
24 ten years.

25 We have a performance system at

1 the Health Department. And one of the things we  
2 track closely is our response time to nuisance  
3 complaints, and our batting average of how much of  
4 them are being actually resolved.

5 We observed that after the  
6 acquisition of Strothers and Camel [phonetic], two  
7 health departments with a population of about  
8 20,000 people, there is no decline in our  
9 responsiveness to the nuisance complaints of  
10 county-wide or health district-wide. In fact, it  
11 was a steady improvement in our batting average,  
12 more nuisance complaints were getting resolved.

13 And this was even at a time in  
14 2008, 2009, when there were many housing  
15 constraints, especially in a very distressed and a  
16 lot of vacant, delapidated housing. And, in fact,  
17 the housing enforcement agency in that city and  
18 many rural townships, we were called upon and  
19 processed a lot of nuisance complaints and did so  
20 successfully.

21 To side-step the issue of the  
22 following questions that are in front of you, and  
23 in Question 5 we side-stepped the issue of where  
24 our health districts and services would be  
25 located, pointing out that different constituents,

1 different customers, and different health  
2 departments value their current location.

3 We tried to address the question  
4 of job loss, of the failure with respect of  
5 bargaining units in Health Departments and how to  
6 reconcile differences in pay and benefits and  
7 seniority.

8 And fees, they are levied by the  
9 Board of Health. And how the -- how regulations  
10 that have been adapted by the Board of Health  
11 would be enforced in a combined district.

12 There were questions for this  
13 discussion, of course, that the belief that there  
14 may be a cost savings available for health  
15 districts that are involved in a consolidation in  
16 Mahoning County.

17 To try to answer that question we  
18 turned to the annual financial report, which is a  
19 standard report of financial workforce data that  
20 every health district in Ohio submits to the Ohio  
21 Department of Health on an annual basis.

22 The most recent data we had  
23 available for financial review was 2010. And I  
24 went into that 2010 data and collected a group of  
25 counties of a lot of the similar size of Mahoning

1 County, excluding the extremely small and  
2 extremely large counties. Within those 11  
3 counties there were 22 health districts. Five of  
4 the counties had 16 health districts within their  
5 borders. And 16 counties had a similar combined  
6 health department.

7 With that, some of the costs or  
8 the expenditure data reported there we tried to  
9 answer the question about whether or not  
10 consolidated health departments had lower  
11 administrative or overhead cost.

12 We found that there really was not  
13 much difference in per capita administrative costs  
14 in the two groups of counties, those with multiple  
15 or those with a single health department. The  
16 Multiple Health Departments spent about 521 per  
17 capita, and counties with combined health  
18 departments spent about \$4.80 per capita. And  
19 that was 15- and 17-percent of total expenditures,  
20 respectively.

21 This was a cross-sectional  
22 analysis, so we hesitate to draw any conclusions  
23 from these observations or any of the follow-up.  
24 And they really do call for further exploration,  
25 and we will discuss it here momentarily.

1                   The other thing you hear very  
2 often is that larger health departments are more  
3 successful. So we looked at the AFR data to see  
4 if there were any differences in the total dollars  
5 per capita and the percentage of local health  
6 district revenues that came from State sources or  
7 Federal sources.

8                   We didn't find any difference  
9 there. But per capita revenues from those sources  
10 were exactly the same in both types of counties,  
11 \$10.73 per capita.

12                   The question is for both  
13 municipalities and townships -- the burning  
14 question is are combined health districts able to  
15 lower cost of public health services for those  
16 subdivisions.

17                   In our analysis we found that  
18 counties with multiple health districts were  
19 nearing \$5 more per capita in local government  
20 revenues than in counties with combined health  
21 districts.

22                   The percentage also of total  
23 health district revenues that came from the local  
24 sources in higher and multiple health district  
25 counties, 35.7-percent of their revenue, as

1           opposed to 33-percent of their total revenues in  
2           counties with a single health department.

3                         We also looked at the literature.  
4           And you've heard some of the literature references  
5           already, so I won't repeat them; however, I do  
6           want to draw your attention to Question 14.  
7           Because as we looked for economies through  
8           cross-jurisdictional sharing, contracting and  
9           merging, it is, I think, important to bear in mind  
10          that there at least have been observations that  
11          increase local health findings in a community that  
12          is associated with lower rates of preventable  
13          death. So the local investments of the public  
14          health structure does deal with benefits, in terms  
15          of lower rates expendable to us.

16                        You've heard the 100,000 threshold  
17          for per capita costs being sort of the magic  
18          number. That is more now per the literature, as  
19          well as other predictors of local public health  
20          simple forms, as measured against U.S. Centers for  
21          Control, National Public Health Forms standard.  
22          The size of the population served in local per  
23          capita public health standings continues to rise,  
24          the performance of health departments continue to  
25          rise until the health department reaches a

1 population served of about 500,000.

2 So in the appendix to the report  
3 is either sample counties as the counties reported  
4 in the handbook.

5 Also there is a range of a  
6 crosswalk of how services are provided in Mahoning  
7 County by the health departments.

8 And when this report was presented  
9 to our stockholders earlier in the spring both  
10 parties felt that it was worthwhile to continue  
11 this discussion. They formed a committee. That  
12 Committee has had several meetings and the  
13 discussion continues.

14 We decided, however, after looking  
15 at the data in this report that there was some  
16 value in looking at a larger, more extensive set  
17 of annual financial report data, and we are  
18 preparing to do that through an organization that  
19 I'm going to discuss now.

20 So, Joe, if you will cue up the  
21 slides.

22 MR. MAZZOLA: (Complied.)

23 COMMISSIONER STEFANAK: Do you see  
24 the slide in front of you?

25 MR. MAZZOLA: We do.

1 COMMISSIONER STEFANAK: Thank you.

2 Okay. You're driving.

3 Several years ago we created in  
4 Ohio an organization called the Ohio Research  
5 Association for Public Health Improvement. And it  
6 is it's an organized group of public health  
7 agencies that engaged in collaborations with  
8 public health research. This is rigorous, careful  
9 studies designed to ultimately improve the  
10 organization plans and delivery of public health  
11 services.

12 Next slide.

13 The Public Health Research Network  
14 mirrors -- of which mirrors its common place of  
15 research with the primary care research networks.

16 Ohio is one of 12 states that has  
17 a PBRM. It is intended to result in improved  
18 performance for public health services. And has  
19 been generously funded by the Robert Johnson  
20 Foundation.

21 Next slide.

22 Here is a model. And starting at  
23 1 o'clock on the circle.

24 The practice community and  
25 researchers in Ohio's public health academic

1 centers identify questions of interest by applied  
2 research methods for the questions, collect data,  
3 analyze data, and hopefully translate those  
4 findings into improvement in public health  
5 practices.

6 Next slide.

7 Here are the members of all of our  
8 public health -- public health programs, as well  
9 as the Ohio public health partnership of these  
10 professional organizations.

11 Next slide.

12 Here are the current research  
13 projects underway.

14 We have completed a study of the  
15 variations of the enforcement of the Ohio Smoke  
16 Free Workplace Act.

17 There is currently a large study  
18 underway called Direct Conservation of Local  
19 Public Health that is intended to do -- look at  
20 how health departments respond to and control  
21 outbreaks of foodborne illness and how will they  
22 measure up against national standards for  
23 foodborne outbreak response.

24 There are also smaller projects  
25 underway that look at public health nursing, and

1 the future of teaching roles of health  
2 departments.

3 Next slide.

4 There are pending projects that  
5 are underway. And mainly talked about here is  
6 changes in public health funding in Ohio health  
7 that have undergone -- follows the brief that I  
8 discussed.

9 Also are putting together a public  
10 health database with local public health  
11 regulations enacted by local forces of health so  
12 it could be easily shared among health districts  
13 that are trying to address merging public health  
14 issues through enactment of local regulations.

15 Next slide.

16 We submitted a proposal for and  
17 hope to hear back by the end of the month. It's a  
18 look at the changes in public health funding and  
19 work force proposition in numbers in Ohio  
20 communities that's undergoing consolidation.

21 So In the last 7 years, 12 health  
22 districts ranging from those of large, Lakewood,  
23 Ohio, to the smallest counties have undergone a  
24 merger or acquisition.

25 What one tends to look at is the

1 premium posting of consolidation differences in  
2 status and overall expenditures in those  
3 communities.

4 They also did a qualitative aspect  
5 of -- for key informant interviews with mayors and  
6 health commissioners, and other stakeholders who  
7 were involved in these 12 mergers and  
8 acquisitions. And depending on the timing, we  
9 hope to formulate some key findings and share  
10 lessons of learning with policymakers like  
11 yourselves to help inform you in your decisions in  
12 your recommendation.

13 The timetable for this is to  
14 launch it as soon as funding is received from the  
15 Foundation, as early as next month. And then have  
16 some perhaps recommendations ready by mid-October

17 Okay. I'm going to switch gears  
18 now, Joe, to the next slide.

19 I would ask that I talk briefly  
20 about accreditation. I understand the issue came  
21 up in your first meeting. And I'm perhaps in a  
22 unique position to share some observations about  
23 accreditation, because while serving as  
24 commissioner in Mahoning County I led the  
25 preparations for the beta test in national

1 accreditation standards and submitted the  
2 accreditation package to FAB or review -- ongoing  
3 review and accreditation hopefully this fall. I  
4 also served as a site visitor for them, for FAB,  
5 visiting health departments that have  
6 accreditation in other states.

7 So what is it and why pursue it?

8 Next slide, please.

9 The goal of this is to improve and  
10 protect the health of the public by advancing the  
11 quality and performance of health departments of  
12 all types, state, local, territorial.  
13 Accreditation is notice that public in the  
14 community help meet standards of quality set forth  
15 by a national accredited unit.

16 Now, what is it?

17 Next slide, please.

18 This is a public health  
19 accreditation board that you've heard about, newly  
20 created, funded by primarily the Robert Johnson  
21 Foundation and U.S. Center for Disease Control and  
22 Prevention.

23 Next slide, please.

24 CDC and the RWJ are only two, but  
25 are measured partners among many that are

1 supporting this national accreditation.

2 Next slide.

3 The benefits of accreditation are  
4 tallied as these are, primarily for promoting  
5 quality of improvement within the health  
6 department, evaluating the health performance in  
7 national standardized performance measures, and,  
8 uhm, delivering results. Ultimately a health  
9 department that is performing effectively should  
10 contribute to improvements in the health of its  
11 community.

12 Next slide.

13 Here are some of the current and  
14 professional sets for accreditation. Of course,  
15 national recognition is important.

16 Potential access to funding  
17 stream, potential streamlining of grant reporting,  
18 contributions to the evidence base for best public  
19 health practices in the community.

20 And this is important. I think  
21 it's assurance that if accredited you have some  
22 competency that you're doing the right things in  
23 the health department and doing things right.

24 Next slide.

25 There is a seven-step process to

1 accreditation beginning with pre-application.

2           There is a cost. I've inserted on  
3 the slides some sample fees from a population  
4 serving a health population of 100 to 200,000.  
5 Cost of about \$30,000 for that five-year period to  
6 get accredited.

7           There are training requirements of  
8 assembly of large documentation, site visits by  
9 peer reviewers, and also annual reports, as well  
10 as re-accreditation within a seven year period.

11           Next slide.

12           So how responsive is the public  
13 health community to the national accreditation  
14 initiative?

15           In 2010, they show the national  
16 accreditation of county and community health as a  
17 2,800 number for accreditation. The response was  
18 that 30-percent of health department candidacy of  
19 accreditation in the first two years after it's  
20 offered.

21           Early this spring I learned from  
22 the Chairman of that board that health departments  
23 representing 12-percent of the United State's  
24 population were somewhere in the accreditation  
25 process. Perhaps that is a statement of intent,

1 perhaps they had submitted an application for  
2 accreditation, that is that 50-percent of the U.S.  
3 population will be served by an accredited health  
4 department by 2015.

5 Next slide, please.

6 In order to even submit a letter  
7 of intent for recommendation a health department  
8 must show -- must have three prerequisites in  
9 hand:

10 They must have completed a  
11 community health assessment within the last three  
12 years;

13 Develop a community health  
14 improvement plan with measurable goals intended  
15 for community health; and

16 Must have an agency participate.

17 Next slide.

18 The accreditation packet was  
19 divided into domains, standards, and measures.

20 Here you see some of the numbers.  
21 There are 97 measures. For each of those 97  
22 measures the health department submits from 1 to 5  
23 or more documents proving that it -- or asserting  
24 that it meets those measures.

25 Next slide.

1                   As I mentioned before, we have  
2                   some early out-of-the-gate accreditation  
3                   movements. We were selected as one of 19 health  
4                   departments nationwide for a beta test for  
5                   accreditation standards in 2009.

6                   The report that we received  
7                   pointed out some weaknesses that I think are  
8                   common in any health department, mainly we didn't  
9                   have a community health assessment or improvement  
10                  plan. Our quality improvement plan was -- needed  
11                  work. We did not have a plan for developing our  
12                  work force in order to have a comprehensive  
13                  performance management system.

14                  We worked on those areas of  
15                  weakness in 2010 and 2011. And then went -- FAB  
16                  went live in 2011, and began to put together the  
17                  documentation needed for those 97 measures.

18                  We estimate that we have uploaded  
19                  between 3 and 400 documents to be an on-line  
20                  application portal. And many of those are  
21                  duplicates of some documents that would be used to  
22                  satisfy multiple measures.

23                  The final package was submitted  
24                  from the Mahoning County district March 5th. And  
25                  the Health Department awaits its site visit

1           sometime in September, I believe.

2                       Next slide.

3                       Just to give you an example of  
4 what some of these measures and documents are, I  
5 have given you a screen shot from the on-line  
6 application portal.

7                       For example, to meet the needs to  
8 investigate health problems and environmental  
9 public health hazards one of the measures show  
10 that you maintain protocol for containment and  
11 mitigation of public health problems and  
12 environmental public health hazards, as well as  
13 demonstrate the process for determining when your  
14 all hazards and emergency plan will be  
15 implemented.

16                      So -- next slide, please -- as I  
17 said, we submitted that package on March 5th. And  
18 I never concluded any talk about accreditation for  
19 the hard working public health workers who worked  
20 so hard to advance the quality of work in the  
21 health department and ultimately improve the  
22 health of their community. The credit goes to  
23 Jody Graham [phonetic], Julie Thompson [phonetic],  
24 the County Board of Health in this initiative.

25                      Thank you.

1                   CHAIRMAN SENATOR BURKE: Thank  
2 you, very much, for the presentation.

3                   Just a couple quick questions you  
4 kind of touched on.

5                   What was your time frame from your  
6 initial thoughts of starting the accreditation  
7 process to actually achieving accreditation; how  
8 long did that take?

9                   COMMISSIONER STEFANAK: Well, it  
10 would be wishful thinking for me to say that we've  
11 achieved accreditation. That determination won't  
12 be made till sometime this fall by FAB.

13                   The process for us consumed about  
14 430-person hours, or health department staff to  
15 learn -- be trained on the accreditation process  
16 and to assemble the documentation necessary to  
17 prove that we meet the accreditation measures.

18                   The cost fortunately for us in a  
19 dry run, the beta test was borne by a grant from  
20 the FAB Board. But in addition to the fees paid  
21 that -- for accreditation, there are man hours  
22 that haven't been figured into the process. Those  
23 430 hours were spread out over approximately ten  
24 months.

25                   CHAIRMAN SENATOR BURKE: Okay. I

1 know you've obviously looked at other places that  
2 have received accreditation, I would assume. Were  
3 there improvements in health outcomes within those  
4 districts that received accreditation?

5 COMMISSIONER STEFANAK: I think  
6 it's too soon to answer that question.

7 No health department has yet  
8 actually been accredited. Those accreditations  
9 won't be conferred until this fall.

10 So to say if that logic model  
11 holds, there is a linkage between performance of  
12 the health department as measured by accreditation  
13 and improvements of health measures of the  
14 community is something -- is a question we can't  
15 yet answer.

16 CHAIRMAN SENATOR BURKE: Anybody  
17 else have any questions for Mr. Stefanak?

18 MR. TREMMEL: Hi, Matt. It's  
19 Marty Tremmel.

20 COMMISSIONER STEFANAK: Hi, Marty.

21 MR. TREMMEL: If you could maybe  
22 just revisit the -- you're a very early adopter in  
23 all of this. And maybe we could revisit for  
24 purposes of Chairman Burke and members of the  
25 Committee, the FAB accreditation process, you were

1 made a test site. Explain that a little bit more.

2 And because you're a very early  
3 adopter, do you have any early initia of how many  
4 local and state health departments are in the  
5 queue now, and what stages they're in.

6 And then could you give us some  
7 perspectives, because you're not just unique in  
8 being an early adopter, you also mentioned you are  
9 a FAB reviewer. So I think we would be curious to  
10 know what it is that you have seen or what you're  
11 able to share with us around the country in some  
12 of this accreditation process.

13 And then can you -- I apologize.  
14 It's kind of a mumbled list of questions here.

15 But where do you see this going?

16 We often criticize the system,  
17 because accreditation ought to lead to something.  
18 And what does that something mean? Does that mean  
19 consolidation? Does that mean funding? What does  
20 that mean kind of from your perspective or where  
21 you're seeing the Board or CDC or HHS?

22 So do you have all of that?

23 COMMISSIONER STEFANAK: I'll try  
24 to recall all the questions.

25 Starting with -- I'm sorry if I

1           crossed over the process a little in the interest  
2           of time.

3                         But we actually began our interest  
4           in accreditation back in 2008. At that time FAB  
5           had called for nominations for health departments  
6           to test these draft accreditation standards by a  
7           beta test.

8                         The Board of Health and the  
9           leadership of the health department had thought  
10          that that was a great time to do that. This was  
11          in mid-2008. We had just lost about 15-percent of  
12          our work force, laying off, to attrition, as the  
13          downturn in the business cycle began in  
14          Youngstown.

15                        We thought that it was a great way  
16          to measure what the health department was doing at  
17          that time as it began the process of rebuilding  
18          itself, of making sure that it was doing the right  
19          things as it rebuilt. And we totally applied.

20                        We were selected. And over the  
21          next ten months, as I said, we examined ourselves.

22                        We looked at each of the  
23          standards. We tried to determine if we met them  
24          or not. And we produced -- did we prove it in the  
25          form of a document that we were doing these

1 things?

2 And we were one of the -- when the  
3 site visitors came they were pleased that we  
4 weren't doing many of the right things. We met  
5 more than 80-percent of the accreditation measures  
6 that satisfied the site visit. That self-  
7 assessment and review by site visitors was very  
8 encouraging and encouraged us to see what the  
9 accreditation was doing. And it was just late  
10 last fall.

11 So you have, as I mentioned, a lot  
12 of health departments from around the country that  
13 have jumped in. FAB did not disclose which health  
14 departments have applied for accreditation, So I  
15 don't know what other health departments in Ohio  
16 have also followed suit and submitted their  
17 application packages. But we know that many are  
18 in the process.

19 As I looked around the country, as  
20 I look at our experience, the largest weakness,  
21 the greatest weakness that the health departments  
22 face in preparing their package is not having  
23 participated in ongoing community health  
24 assessment and planning and having an  
25 organization-wide commitment for quality

1 improvement and work force development.

2 It is also very challenging for  
3 the Mahoning Health Department and others, I'm  
4 sure, to demonstrate that they have a  
5 comprehensive performance management system that  
6 provides performance measures, performance  
7 improvement, and quality improvement.

8 I got up as far as those two  
9 questions. Marty, I think the questions that  
10 followed you may have to repeat.

11 MR. TREMMEL: Then your  
12 experiences as a reviewer would be kind of the  
13 next. What you see in your --

14 And again, I'm making some  
15 assumptions that you have done some review, but  
16 maybe it is premature to say that you have.

17 And where does this drive us?  
18 Does this drive us to a different look and  
19 function and platform of public health, just kind  
20 of a regional kind of approach? Does this drive  
21 the issue of funding differently for local health?

22 COMMISSIONER STEFANAK: I don't  
23 have any experience to relate as a reviewer. I've  
24 not been on site visits yet, so I can't address  
25 that question.

1                   It's accreditation and emphasis  
2                   for more cross-jurisdictional sharing or  
3                   consolidation of perhaps if a health department is  
4                   unable to demonstrate compliance with certain  
5                   accreditation measures, then turning to or  
6                   developing a formal relationship with another  
7                   entity, another health department or some other  
8                   community provider to assure that those functions  
9                   are being met. Those services being provided is  
10                  something that a health department can do.

11                  There are also opportunities for  
12                  health departments to increase  
13                  cross-jurisdictional sharing overall, but  
14                  submitting an application for accreditations that  
15                  are multi-jurisdictional.

16                  I just happened to have the guide  
17                  in front of me here.

18                  The health department that wants  
19                  to partner with another to submit an accreditation  
20                  application has to prove that it is of -- that it  
21                  has a substantive relationship with those other  
22                  health departments.

23                  And I'm pulling here from the  
24                  guide of the National Public Health Accreditation.

25                  The relationship must be that of

1 the health departments working together to deliver  
2 services and/or perform functions over the  
3 combined jurisdiction. It cannot be simply an  
4 of-convenience or paper only relationship to apply  
5 for accreditation. The business and working  
6 relationship of multi-jurisdictional applicants  
7 must be well established and well defined.

8 So that gives applicant health  
9 departments a range or portfolio of different ways  
10 to approach to achieve accreditation that do  
11 encourage multi-jurisdictional or  
12 cross-jurisdiction sharing, or in some cases even  
13 outright merger.

14 CHAIRMAN SENATOR BURKE:

15 Dr. McFadden.

16 COMMISSIONER MCFADDEN: Hey, Matt.

17 This is D.J.

18 This is follow-up to  
19 Senator Burke's questions, maybe in a little bit  
20 of a different way.

21 Clearly FAB, when they were  
22 developing their talking points looked to other  
23 programs to make the claim that the plan was to  
24 improve quality by doing this process.

25 I am wondering if you were able to

1 speak to any of the other accreditation projects  
2 that they looked to to gain some of those  
3 thoughts?

4 And then if you have heard of any  
5 thoughts from FAB, if down the line, you know, 15,  
6 20 years they look at this and it shows there is  
7 not any difference between those that are FAB  
8 accredited and those that aren't, then what?

9 COMMISSIONER STEFANAK: That's a  
10 challenging question.

11 COMMISSIONER MCFADDEN: I'm a  
12 challenging person.

13 COMMISSIONER STEFANAK: And I wish  
14 I had a competent response to whether or not the  
15 logic model between accreditation, that -- the  
16 logical train of thought is that accreditation  
17 needs to improve performance and improve community  
18 health, it will alter them.

19 FAB borrowed heavily from the  
20 academic side of the house, from the education for  
21 public health in developing the accreditation  
22 process.

23 The standards themselves, of  
24 course, are the result of a consensus of expert  
25 opinions from around the country about what the

1 names, what measures, what the standards are that  
2 tell you that a health department is doing the  
3 right thing, that the things that will lead to  
4 community health improvement. It's an empirical  
5 question as far as I'm concerned, but time will  
6 tell.

7 I think that there are  
8 intermediate or process measures that will suggest  
9 that there is -- that the logic model is correct,  
10 that the health departments that are accredited  
11 should be better performers financially. They  
12 should be more successful in seeking funding, and  
13 will have a more stable funding source, a more  
14 broader source of funds. They should be, uhm,  
15 more successful in the community in regards to  
16 their performance.

17 So those interim process measures,  
18 I think, still need a lot of work in terms of  
19 getting them developed.

20 COMMISSIONER MCFADDEN: Thanks,  
21 Matt. Sorry to put you on the spot.

22 CHAIRMAN SENATOR BURKE:  
23 Representative Antonio.

24 REPRESENTATIVE ANTONIO: This is  
25 Representative Antonio. Thank you.

1                   So when you were talking about  
2 consolidation, I have a couple questions.

3                   First, is it my understanding  
4 that -- so your health departments did do a merger  
5 before starting into the accreditation process, or  
6 was it simultaneous?

7                   COMMISSIONER STEFANAK: These  
8 discussions between Mahoning County and Youngstown  
9 began after the Mahoning County District Court  
10 felt as -- that it was well into the accreditation  
11 process.

12                   As I mentioned before, I've been  
13 involved in the merger of well, three -- three  
14 health departments in Mahoning County over the  
15 last 25 years, Hamilton, Struthers [phonetic], and  
16 the City of Sebring [phonetic], when they  
17 converted to a village.

18                   Does that answer your question?

19                   REPRESENTATIVE ANTONIO: Yeah.

20                   So then the next part of where I'm  
21 going I guess in my head is, so, Joe, from your  
22 experience in looking forward, because you also  
23 mentioned the opportunity for mergers just in  
24 general -- so is it safe to say that the -- there  
25 is the accreditation process and there is the

1 opportunity for mergers and that they could happen  
2 almost at any point in the process of acquiring  
3 accreditation, or not?

4 COMMISSIONER STEFANAK: Yes. I  
5 would agree with that.

6 If negotiations continue in  
7 Youngstown, and they are in a lot of other  
8 communities, several other communities in Ohio,  
9 that both can proceed to parallel.

10 REPRESENTATIVE ANTONIO: Okay.

11 So I have a background in working  
12 with organizations as their -- and especially when  
13 they're looking at the possibility of  
14 strategicalizing and then actually merging.

15 So with the accreditation process,  
16 I guess where I'm going is trying to figure out  
17 whether there is a point that the purpose could be  
18 served where the accreditation process could  
19 actually serve to help clarify whether a merger is  
20 possible, or, you know, would that -- would the  
21 accreditation process actually help facilitate  
22 those potential merger discussions?

23 COMMISSIONER STEFANAK: That is a  
24 very interesting question that I'm not -- occurred  
25 to me before.

1                   And I don't know if there is a  
2                   role for accrediting organizations like FAB in  
3                   helping facilitate the discussions. I think there  
4                   is a need for an expert source of guidance like  
5                   that. It doesn't exist right now that I know of.  
6                   But I can't -- the State has been doing some work,  
7                   as well as the Center for Community Solutions in  
8                   Cleveland and health departments. And this dates  
9                   back many years to task -- for stakeholders and  
10                  health departments to ask the right questions  
11                  about consolidation, how it would benefit the  
12                  processes.

13                   I do believe we needed to enhance  
14                   centers of expert advice like that at Kent State  
15                   and Center for Community Solutions in Ohio to help  
16                   guide these kinds of conversations that are  
17                   underway in Youngstown and elsewhere.

18                   REPRESENTATIVE ANTONIO: Okay.  
19                   Thank you.

20                   COMMISSIONER NIXON: Matt, this is  
21                   Gene.

22                   Just to follow-up a little bit on  
23                   that.

24                   I think that the Senate Committee  
25                   struggled with that a little bit, about trying to

1 be descriptive and appropriate size of a health  
2 department, and use the FAB accreditation process  
3 as sort of a guiding principle that if a health  
4 department were eligible to apply for  
5 accreditation under FAB, then they're good.  
6 That's a good health department underneath these  
7 standards.

8 If a health department was not,  
9 then they ought to consider -- if they're smaller  
10 than 100,000 or more than one health department or  
11 district in a county they should consider  
12 consolidation.

13 And for a variety of reasons in  
14 many communities it won't work, geology, politics,  
15 whatever it might be. And if a consolidation  
16 wouldn't work, then to think about  
17 cross-jurisdictional sharing and other councils in  
18 government and other strategies.

19 But it all begins, I think, with  
20 the capacity of the local district to be able to  
21 meet those accreditation application standards.  
22 And that doesn't mean they've been accredited, but  
23 they are able to apply and be eligible for  
24 accreditation.

25 REPRESENTATIVE ANTONIO: Well,

1 thank you.

2 Because it occurred to me as I was  
3 listening that it could serve as almost like a  
4 checkpoint of being able to say are you ready or  
5 are you sustainable enough. So thank you.

6 COMMISSIONER STEFANAK: I see  
7 where you're going with this. Yes.

8 I would point out that this  
9 accreditation is a voluntary process right now.

10 Yes, there are incentives. And  
11 there will be more and more incentives and perhaps  
12 even disincentives not to get accreditation as  
13 time goes by.

14 Either incentives or disincentives  
15 that a health department applied that cannot meet  
16 accreditation standards, they will be forced to  
17 seek a memorandum of understanding and other  
18 methods into a cross-jurisdictional sharing with  
19 other health departments, including consideration  
20 of merger and acquisition.

21 CHAIRMAN SENATOR BURKE:  
22 Mr. Press.

23 COMMISSIONER PRESS: Mr. Stefanak,  
24 my name is Chris Press.

25 A couple of questions.

1                   You referenced in the  
2 accreditation discussion various alternatives for  
3 combination.

4                   One of the things that I think is  
5 in one of the draft reports is this notion of  
6 council of governments.

7                   Do I have that language right?  
8 Thank you.

9                   Would that kind of structure be  
10 consistent with the requirements of  
11 accreditation -- meets the requirements of  
12 accreditation?

13                   COMMISSIONER STEFANAK: I'm --  
14 this is my interpretation of the guides of  
15 language from FAB to the National Public Health  
16 Accreditation.

17                   But if the council of government  
18 can be the mechanism to demonstrate that there is  
19 a business and working relationship of  
20 multi-jurisdictional applicants, then it could be  
21 one mechanism to help those components of a  
22 multi-jurisdictional applicant meet accreditation.  
23 Yes.

24                   Then I would point out that there  
25 are mechanisms in Ohio right now to -- in

1 Chapter 3709 to -- that allows for the creation of  
2 those documented relationships to assure that  
3 services are being provided and functions are  
4 being met. And council of government, it's yet  
5 another mechanism to enable that.

6 COMMISSIONER PRESS: So is it a  
7 fair construction of your response that they have  
8 to meet the requirements of accreditation, but  
9 that structure alone would not be disqualifying?

10 COMMISSIONER STEFANAK: That -- I  
11 think I understand what you're saying.

12 COMMISSIONER PRESS: Well, it's  
13 not a trap question.

14 I'm trying to understand.

15 You have several means to an end  
16 and if the end is accreditation, I'm just trying  
17 to understand is this a blind alley for somebody,  
18 or assuming they could meet all the other  
19 requirements this would be okay?

20 COMMISSIONER STEFANAK: Okay.

21 COMMISSIONER PRESS: Second  
22 question: We have several folks involved in this  
23 process who have been through combinations of  
24 health districts you had mentioned and I think we  
25 had some others.

1                   At some point in the course of our  
2 work would it be possible to share with the  
3 Committee the things that facilitated that  
4 conversation, as well as things that might have  
5 impeded that process?

6                   I'm looking at your FAQ here. It  
7 kind of reads like a checklist of things that  
8 would have to be considered in the process  
9 (indicating).

10                   Would it be from your experience  
11 useful to advance that kind of thing to us so we  
12 can understand what some of the accelerants and  
13 decelerants are?

14                   COMMISSIONER STEFANAK: Yes.  
15 Absolutely.

16                   In fact, that is a decomponent of  
17 the study that we just submitted our proposal to  
18 RWJ for.

19                   We hope to have -- to develop this  
20 time to that checklist, if you will, what were the  
21 elements that contributed to the success of those  
22 12 mergers and consolidations that have taken  
23 place over the last seven years.

24                   And I -- our hope is that we have  
25 some analysis of those interviews with the mayors

1 and health commissioners and other key informants  
2 in those 12 health districts available to you,  
3 while you're still deliberating issues, before  
4 October.

5 COMMISSIONER PRESS: I think that  
6 would be helpful.

7 Somebody alluded, I think  
8 Commissioner Nixon mentioned that, you know, there  
9 is some place that is never going to have the  
10 opportunity due to local politics or local  
11 conditions or geography, or whatever it is. And I  
12 don't think we are ever going to reach those  
13 issues. But to the extent there are issues in  
14 policy or administration or statutes, if you could  
15 identify what those are and at least understand  
16 them, that's a departure point.

17 COMMISSIONER STEFANAK: I would  
18 agree.

19 The circumstances in Summit County  
20 may be unique to Summit County. Those conditions  
21 don't prevail in some of the states. But there  
22 must be some common -- we are wondering as to the  
23 research question if there are any common threads  
24 that contributed to the success of these 12  
25 consolidations around the state.

1 COMMISSIONER PRESS: Thank you.

2 COMMISSIONER SHAPIRO: Matt, this  
3 is Nancy Shapiro.

4 I have a question.

5 When I looked over your  
6 consolidation FAQs and some other issues, on the  
7 fiscal side of things, just I'm not fiscal person,  
8 so it's not my background, but it looks like you  
9 just have a 1.1 mil levy that deals with  
10 tuberculosis control.

11 And one of the things that may  
12 enter into the picture is the current funding. I  
13 hope you get the funding to do that, would  
14 demonstrate how levies either impede or impinge  
15 upon combination consolidation.

16 Uhm, having worked in a health  
17 district that relies on the levy for a majority of  
18 our funding, it's a sensitive issue of whether  
19 people can join in and whether that will affect  
20 the success or failure of that levy.

21 So I don't know of the  
22 combinations that have happened since 2005, but --

23 COMMISSIONER STEFANAK: Well, in  
24 the case of that particular levy in Mahoning  
25 County, the tuberculosis control on the 1/10th of

1 1 mil, that is a county-wide levy. It has always  
2 been so that the districts work -- two health  
3 departments were to consolidate, that levy would  
4 be unaffected.

5 Now, there are other communities,  
6 I know, that where the levy is levied by only one  
7 health district and in the wake of consolidation  
8 that the question of whether how to manage that  
9 levy is actually beyond my experience.

10 I do know, for example, in  
11 Columbiana County there is a cancer control levy  
12 that funds services through the Columbiana County  
13 Board of Health, Salem and Liverpool residents are  
14 not eligible for those services, because they are  
15 not part of that taxing district. So how would a  
16 combined health district in Columbiana County deal  
17 with that?

18 I'm not suggesting that they're --  
19 get consolidation of Columbiana County. I'm just  
20 giving you an example of how levies and health  
21 district boundaries don't necessarily coincide.

22 COMMISSIONER SHAPIRO: Okay.  
23 Thank you.

24 MR. TREMMEL: Matt, it's Marty.  
25 Just another quick question or

1 two.

2 On the RAPHI Quick-Strike Grant,  
3 in short you're looking at 12 health districts  
4 that have merged or consolidated over the recent  
5 how many years?

6 COMMISSIONER STEFANAK: Since  
7 2005.

8 MR. TREMMEL: Okay.

9 And you're seeking such funding  
10 through Robert Johnson in your Quick-Strike. So  
11 it has a turnaround that you wanted to pull this  
12 information out and get a report complete and  
13 published by when?

14 COMMISSIONER STEFANAK: Our  
15 timetable is to complete the analysis of the AFR  
16 data, financial report data, and the interviews of  
17 the key informants from the 12 communities within  
18 four months.

19 MR. TREMMEL: Okay.

20 And that AFR data, just so that  
21 everyone knows that associated collective data,  
22 Mr. Chair, Vice Chair, and members of the  
23 Committee, AFR data is annually collected data  
24 composite data from each local health district in  
25 Ohio that is built into a system and now on a more

1 complicated revised system here at ODH.

2 And then the last question, Matt,  
3 is the Youngstown City issue, are you at liberty  
4 to just give us a minute or a moment on how is  
5 that conversation going, what are the issues, so  
6 we can just kind of refamiliarize or maybe first  
7 impressions for folks here like how those  
8 discussions go?

9 And have you put together a little  
10 bit of research effort on that, as well, or am  
11 I -- have I misread that?

12 COMMISSIONER STEFANAK: Those  
13 discussions that are in Youngstown are not part of  
14 the scope of this study.

15 But I can tell you that in  
16 conversations with Patricia Sweeney [phonetic],  
17 who has succeeded me as Health Commissioner in  
18 Mahoning County, that the committee is composed of  
19 two or three township trustees, the City of  
20 Youngstown Law Director, the Youngstown Finance  
21 Director, as well as the acting Health  
22 Commissioner in Youngstown, and several boards of  
23 health members from both wards that has met  
24 several times.

25 Since May they have -- or

1 Ms. Sweeney is now thinking that they may want to  
2 reach out and get some facilitation help with an  
3 outside consultant. She is discussing with a  
4 private foundation in the Mahoning Valley Funding  
5 that consultants come in and help them on a  
6 short-term basis to help move the process along.

7 And it may begin with key  
8 informant interviews, people who have a stake in  
9 this who will need to talk about it with someone  
10 to make sure their expectations, their concerns  
11 about these discussions.

12 The committee has received a brief  
13 from Gene Nixon about the Summit County process.  
14 And there was much attention to the success in the  
15 Summit County merger in the last year in  
16 Youngstown from the news media, the Vindicator,  
17 which is a promoter of consolidation of the two  
18 health departments, calling it a "no-brainer." I  
19 beg to differ; it is not a no-brainer.

20 But the mayor is in need of the  
21 newspaper's support of this. Mayor Sam Merone  
22 [phonetic] is a lame duck by choice -- if he wants  
23 to return to City Council as Council Chair so he  
24 has a fast track agenda to move along with a lot  
25 of this unfinished business.

1 I don't know what that predicts  
2 for the timetable of these discussions, but they  
3 do continue.

4 CHAIRMAN SENATOR BURKE: Any  
5 additional questions for Mr. Stefanak?

6 COMMISSIONER MCFADDEN: I wonder,  
7 Mr. Chairman, if at some point it would be helpful  
8 to hear from other processes that have  
9 accreditation for specifically of a hospital. I  
10 don't know if OHA, or --

11 COMMISSIONER PRESS: Oh, it's a  
12 thrill a minute.

13 I figure if I can get down to \$430  
14 hours over ten months, I would cheer. That would  
15 be just awesome. We'd probably do that in a week.

16 COMMISSIONER MCFADDEN: I think  
17 just some -- on some of the questions on FAB is  
18 relatively new, but we're on the beginning and the  
19 hospitals have definitely had a much longer period  
20 of understanding in history with this.

21 And while it may not be directly  
22 applicable to public health, there may be some  
23 pieces or questions that we have as far quality  
24 and other questions that might be helpful at some  
25 point to hear from.

1 CHAIRMAN SENATOR BURKE:

2 Certainly.

3 I think that if this is something  
4 that the group is interested in -- and I think it  
5 was mentioned earlier, what is the end goal?  
6 Accreditation?

7 If we did it, what does it do?  
8 What does it mean?

9 I think those are all valid  
10 questions.

11 COMMISSIONER PRESS: I think the  
12 interpretation for the position, I think that  
13 echoes accreditation for hospitals, which, of  
14 course, it is a condition of payment for us.

15 Chairman SENATOR BURKE: I was  
16 just going to point out I think that it is in rule  
17 in Ohio that hospitals have to be accredited; they  
18 need to be accredited by the Ohio Department of  
19 Health, or they can shoot for the Commission. I  
20 think the vast majority wants the Commission. I  
21 think they pay hefty fees for that team to come in  
22 and do that survey. So this has been a process  
23 they've been going through for how many of years  
24 as the Joint Commission on-going survey?

25 COMMISSIONER PRESS: A long time.

1                   COMMISSIONER INGRAM: Unlike us,  
2 we are not in rule that we shall be accredited.  
3 This was voluntary. So there is a huge  
4 distinction here.

5                   COMMISSIONER MCFADDEN: No. I  
6 understand that, Tim.

7                   My sense is that from common  
8 senses that are out there that this may at some  
9 point no longer be voluntary, or that there could  
10 be interest to tie accreditation of public health  
11 to funding or to other items.

12                   So from that standpoint, for me it  
13 would be at least helpful to hear from others that  
14 have gone down the path where they're at, so we  
15 cannot step in the same stuff, be stepped on.

16                   COMMISSIONER INGRAM: I'm not sure  
17 if that would be beneficial, because the truth is  
18 hospitals are undergoing that change right now  
19 relative to I'm trying to do quality and lower  
20 cost outside their system as they start to look  
21 outside their doors to the population of health  
22 prevention model.

23                   So it would be interesting  
24 actually how the Joint Commission begins to morph  
25 in that area relative to be seen in times of the

1 healthcare system. I would prefer that we stay  
2 focused on the public health system.

3 COMMISSIONER NIXON: If I may,  
4 just real quick.

5 I think that that comment raises  
6 something that we are able to learn from this,  
7 which is where the Joint Commission has gone,  
8 hospitals have gone.

9 When the Joint Commission focused  
10 on pain, hospitals focused on pain. When the  
11 Joint Commission focused on accident and fall  
12 prevention, hospitals focused on fall prevention.

13 And I think that if we -- I mean,  
14 a bigger picture, once we have accreditation, if  
15 there are pieces that move away from the ten  
16 essentials of public health or something else from  
17 the accreditation board to focus on then public  
18 health starts to move that way.

19 And I'm not sure that for  
20 hospitals' perspective that it is always  
21 improvement of care then the Joint Commission  
22 moved in that direction.

23 So the question would be some on  
24 the learning we have from that, because, you know,  
25 our assumption if public health would be improved

1 by what standards -- what is measured is what  
2 changes.

3 COMMISSIONER INGRAM: I  
4 understand.

5 The only thing I would disagree  
6 with -- and I'm just trying -- because we run on  
7 such a short time frame, this would be a huge  
8 discussion.

9 I would just say that the results  
10 today where we are with the healthcare system kind  
11 of speaks for itself, relative to where -- there  
12 are funders and the people that manage the system  
13 are trying to take it, and providers.

14 I mean, we're clearly in a  
15 changing time with healthcare. I don't think  
16 anyone disagrees with that.

17 So I don't know what we could  
18 learn from it. I guess to study the path of how  
19 we got here, but we're here now at this point in  
20 time. The question is how do we fence a line with  
21 that changing healthcare delivery system going  
22 forward in the next hundred years or 20 or 10.

23 That's just my perspective.

24 MR. TREMMEL: Mr. Chairman, just a  
25 point of clarification with the variety of the

1 members that we have assembled here,  
2 Commissioner Nixon just is in recent mergers  
3 in western -- Commissioner Nixon, a recent merger  
4 in Summit County [phonetic],  
5 Commissioner McFadden, in Holmes County  
6 [phonetic], Commissioner Ingram, in Hamilton  
7 County, wherein you have four other health  
8 departments in Hamilton County.

9 So just a different kind of  
10 knowledge you get from relation issues, politics.

11 CHAIRMAN SENATOR BURKE: We still  
12 have -- Mr. Stefanak is still working through and  
13 hopefully finishing up his presentation.

14 Are there any additional questions  
15 on this presentation while we still have the Board  
16 here?

17 - - -

18 Thereupon, no response was had at  
19 approximately 2:23 p.m.

20 - - -

21 COMMISSIONER SHAPIRO: I think it  
22 has been interesting to hear what Youngstown is  
23 looking to doing, but it might be beneficial for  
24 us if we're talking about different forms and how  
25 consolidation goes, to hear a little bit about the

1 Summit County experience and what the -- again  
2 some of the checklist of what was positive.

3 I mean, it was -- I know from my  
4 history it was a very long process that has been  
5 discussed for I don't know how many years. Maybe  
6 it might be an interesting case study to look at  
7 either today or some other time when we're more  
8 prepared.

9 MR. TREMMEL: Thank you, Nancy.  
10 Aren't we looking at that as a  
11 possible meeting?

12 COMMISSIONER NIXON: I think we  
13 have discussed that possibility, but I don't know  
14 if we have made it an official invitation to  
15 Mr. Nixon. But I think that has certainly come up  
16 as a possible agenda just given the recent history  
17 there and the study of that merger, one or more  
18 larger mergers, if not the largest merger.  
19 Certainly, I think that would be an interesting  
20 discussion for the Committee.

21 CHAIRMAN SENATOR BURKE: I think  
22 that would be a good one to have in the year, if  
23 you're open to that?

24 COMMISSIONER NIXON: Sure.

25 COMMISSIONER SHAPIRO: Then also

1 maybe if there have been ones that haven't worked  
2 out so well.

3 I know Lorraine [phonetic] I think  
4 was in discussions.

5 COMMISSIONER NIXON: Orange County  
6 has been in the discussions. There has been a  
7 number of them. Number of dialogue goes on.

8 COMMISSIONER SHAPIRO: So it might  
9 be interesting to get a couple perspectives of  
10 what is working and what hasn't and what the  
11 barriers have been.

12 COMMISSIONER PRESS: I think the  
13 key is barriers, the things that are impeding  
14 possibilities to let people choose options that  
15 are more suitable to the local environment, if  
16 that's what they want to do and things that we are  
17 encouraging.

18 You know, hearing those -- because  
19 that is going to be a thing, because there is  
20 always going to be local conditions that are not  
21 going to be replicated anywhere else or relevant  
22 anywhere else, common things.

23 COMMISSIONER INGRAM:  
24 Mr. Chairman, I didn't really want to completely  
25 push back on Dr. McFadden's suggestions.

1 I do believe there is a benefit to  
2 hearing from the hospital systems on what they  
3 perceive as going forward how we best help them  
4 integrate or align in a healthcare delivery model  
5 that is moving outside the walls of the system.  
6 Because I believe we have a very important role to  
7 play, and I think that discussions would be of  
8 help.

9 And I certainly would agree on the  
10 subject of learning from other people relative to  
11 what we've already looked at this from a short  
12 term stand point.

13 I'm trying to think down the road  
14 a little bit about, you know, we know we have  
15 stagnating life expectancy in this country right  
16 now and in this state as far as at birth. We know  
17 we're at that point where you're hearing some  
18 reports that the generation that's being born  
19 today aren't going to live as long as the parents  
20 that created them. This is a serious problem.

21 Immortality has lowered  
22 tremendously over the last hundred years. But why  
23 can't we do better?

24 So I think that that's the thing I  
25 was hoping that we kind of the keep in mind as we

1 go forward to keep those two benchmarks in mind,  
2 so that child is born in 2030, or whatever, would  
3 actually have an opportunity to live longer than  
4 the parents that created them, or even longer and  
5 productively or beyond what we ever imagined.

6 So I just wanted to throw that on  
7 the table.

8 I know it's easy to, and I get  
9 that same way caught into this discussion of, you  
10 know, what do we do to, you know, build better  
11 capacity and more sustainable funding from a  
12 variety of sources to be able to prove some of the  
13 outcomes that are occurring in the public health  
14 system.

15 But I do want you to know that I  
16 think we have to keep that as the ultimate prize,  
17 if you will, for our society.

18 COMMISSIONER NIXON: I think we  
19 are beating this up, but I do want to add a little  
20 bit of --

21 And I think Matt has through his  
22 beta testing and the accreditation process has  
23 really been a trail blazer in Ohio and actually  
24 nationally in trying to develop some of the  
25 standards.

1                   But the end point to this, to go  
2 back to one of your original questions, what does  
3 this do to improve the health?

4                   And I think that is the point of a  
5 lot of standards that have to demonstrate that  
6 you're working with the community to develop a  
7 community improvement plan, that you have  
8 measurable standards in a time frame for getting  
9 those done. That all has to be in there. You  
10 have to have a robust management system that has  
11 to be demonstrated.

12                  And to be accredited is not an  
13 easy process, but I think it is a valid standard.  
14 I think it leads to continuous quality  
15 improvements. Once you receive your  
16 accreditation, every year you have to update how  
17 you've improved over the year. You identify the  
18 weaknesses within the health department and a plan  
19 for improving.

20                  So I think it is a standard, and  
21 if not this standard, what standard?

22                  I think this has been beat to  
23 death nationally and in Ohio, and I think it is a  
24 valid standard.

25                  And I think when we work around it

1 we have to begin somewhere. Where do we need to  
2 be as a local health department to provide a  
3 standard that measures it, that's been validated  
4 nationally and in Ohio?

5 So, you know, I think that's where  
6 we need to begin. If not that standard, what  
7 standard do we stand behind?

8 COMMISSIONER PRESS: If I may, let  
9 me frame the question in follow-up that will  
10 support your view and I'll pick on Findlay not  
11 Cincinnati, because that's my home town.

12 If the hospital is required under  
13 the Patient Protection Act to conduct the  
14 community health assessment and each health  
15 department is required under accreditation  
16 standards to come up with a health improvement  
17 plan, I'll just ask the question: Can we really  
18 afford to do that three times in a county of  
19 70,000 people.

20 COMMISSIONER NIXON: They do not.  
21 No.

22 COMMISSIONER PRESS: I think that  
23 will spend what little money we have.

24 I think those are the kinds of  
25 things that are going to create reasons around

1 some solutions today that don't look reasonable,  
2 because that's not the way the incentive reads.

3 CHAIRMAN SENATOR BURKE: If I  
4 could, Matt, thank you, very much for your  
5 presentation.

6 If we have additional questions we  
7 can circle back around.

8 In the interest of time I'd like  
9 to move on to Item No. 4, which has been kind of  
10 touched on, identification and discussion of  
11 legislative and fiscal policies.

12 And just make a few comments, if I  
13 could, and turn it over to our Vice Chair for some  
14 comments, as well.

15 I guess my goal as Chairman is to  
16 keep us on task, on target, and on time.

17 And certainly when you work with  
18 something that is kind of nebulous like this, that  
19 is going to be a herculean effort, especially with  
20 the legislative deadline to produce a document  
21 which hopefully will be greater in size than the  
22 posting. So I'll try to make sure we're  
23 productive with what we do.

24 With that being said, in my short  
25 experience in this process, we're going to be

1 dealing with three separate things: One is a  
2 policy of rule-making-type apparatus; the second  
3 is a legislative law-type apparatus; and the third  
4 is a fiscal-type apparatus.

5 And those can interact in varying  
6 ways. And I say that because in spending a few  
7 years here in the General Assembly, not everything  
8 has to be done in law; it can be done in rule. We  
9 don't have to debate the infatessimalness of an  
10 idea to have it implemented. So come in with an  
11 open mind. Think about what is possible, and  
12 think about what our corps mission is in this  
13 process.

14 And to that I bring up what was  
15 handed to us, completed on June 15th by the  
16 Committee, which has tasked us in essence with  
17 this process, which is outlined I think fairly  
18 well on the purpose on Page 5 of the public health  
19 futures framework.

20 So I would ask as we move forward  
21 that we look at exactly what the objectives are to  
22 which we have been tasked, and in the original  
23 statement.

24 And then moving on to Page 11, as  
25 you know, these folks went through a painful

1 process to get us their recommendations, all 19 of  
2 them, and have put value and time in that process.

3 So as we look at those  
4 recommendations, and they've been broken into  
5 sections, I would probably recommend to this body  
6 that we follow that framework with the time that  
7 we have.

8 So looking at that, we have  
9 recommendations of local healthcare capacity  
10 services equality, jurisdictional structure, we  
11 have financing, and then we have an implementation  
12 strategy.

13 At our meeting process maybe  
14 follow along that framework to give us some  
15 boundaries of discussion within each one of those  
16 meetings so that folks have time to go back and  
17 reflect, compare, know what those topics are going  
18 to be. And we can start to pencil out the things  
19 we used, the things we don't use, the things we  
20 could change, and how we could work within those  
21 three frameworks of policy, legislation, and  
22 fiscal ability to obtain those goals.

23 And then finally, once we work  
24 through those sections come back and think about  
25 what that final document would look like. I mean,

1 are we going to produce one legislative idea, two  
2 policy ideas, and fiscal. I don't know how that  
3 is going to look.

4 But I do think if we have a  
5 framework that follows that which has been laid  
6 before us that we get to where we need to be.

7 And, of course, on Page 13, those  
8 have been broken down into to components.

9 So I guess I am not one to give  
10 homework, because I never liked homework. But at  
11 least you know if we follow that path, which I see  
12 approval with head nods from the Committee, that  
13 we know next week what is going to be on the  
14 plate. Do we have time to prepare for it? Did we  
15 make copious notes on that process? And the  
16 following week we move on to the next section.  
17 And then we move on to the next section.

18 This will also allow us to be able  
19 to go back to relive meetings or if time is needed  
20 to go back and revisit and think about how to tie  
21 it all together.

22 So I think -- and we may end up  
23 using some of those days, we may not. But at  
24 least we know where we're going to be.

25 I would like to also using what

1 are called actions in here, within the two-hour  
2 time frame that we have for those meetings, keep  
3 us on track. Good to have the spirit, great. But  
4 definitely in health care we can get into a lot of  
5 consensual-type issues. So I think we need to  
6 reflect on what our corps mission is.

7 So with that being said, we can  
8 think about what our meeting dates would be going  
9 forward as prescribed.

10 We have July 31st, which would  
11 give us capacity services and quality and the  
12 opportunity for Mr. Nixon to explain, if that  
13 allows.

14 COMMISSIONER NIXON: I am not  
15 available.

16 Chairman SENATOR BURKE: Could we  
17 get you on another date?

18 COMMISSIONER NIXON: Yes.

19 CHAIRMAN SENATOR BURKE:  
20 Excellent.

21 We will get Mr. Nixon on the  
22 agenda sometime to talk about his experiences.

23 August 14th then, going every  
24 other Tuesday.

25 At this point we have

1 jurisdictional structure. And there is obviously  
2 an opportunity to have somebody speak to us in  
3 addition to.

4 August 28th we would be talking  
5 about the financing component.

6 And September 11th would give us  
7 implementation strategy.

8 And that also then would allow us  
9 an additional meeting in September, as well as the  
10 potential to have two additional meetings in  
11 October to try to tie things together.

12 Obviously, giving us hopefully at  
13 the beginning of October to have something  
14 finalized and to go that route. We can if we need  
15 to skip a week to allow folks to digest things.  
16 We can work with that.

17 But that schedule gives us some  
18 flexibility on next meeting dates.

19 Looking ahead, I imagine the  
20 Department of Health has an open door policy. The  
21 website is certainly a plethora of information,  
22 including our minutes, abridged and non-abridged,  
23 as well as a whole litany of resources going back  
24 to the original group that folks can dive into,  
25 and come in and form intelligent discussions. So

1 I encourage folks to use that.

2 We also have each others' e-mails  
3 for those who wish to correspond with each other,  
4 or on the phone. Whatever that may be, I  
5 encourage that.

6 My office is at your service, as  
7 well. Anything that you need, certainly I'd  
8 rather direct things to resources in the  
9 Department of Health to try to keep us tight and  
10 organized.

11 So with that being said, Mr. Vice  
12 Chair, I hope I've laid out a good action for  
13 framework.

14 COMMISSIONER PRESS: It's a great  
15 frame work.

16 I agree with you that we don't  
17 need to re-plow the field that's already been  
18 plowed.

19 I think it is excellent work that  
20 has been performed, to look at this body for  
21 further action and to go forward. I think the  
22 highest tribute to pay is to do something with the  
23 work that is well done.

24 CHAIRMAN SENATOR BURKE: So I  
25 guess with that being said then, I'm certainly

1 open for more discussion depending on folks' time.

2 That gives us a next meeting on  
3 July 31st to discuss capacity services and  
4 quality. And it will be, I imagine, in this same  
5 room, same time.

6 MR. TREMMEL: Yes.

7 Chairman SENATOR BURKE: I guess  
8 with that being said, if folks have additional  
9 things they'd like to discuss, if that's a  
10 reasonable call of action going forward --

11 REPRESENTATIVE ANTONIO: I just  
12 have a question for clarification.

13 So you had mentioned that we have  
14 everyone's e-mail. I know there was an original  
15 sheet, but that was not complete.

16 Do we have something additional on  
17 the website?

18 MR. TREMMEL: Yes.

19 We're going to keep deriving  
20 everyone as much as we can to the site.

21 MR. MAZZOLA: Just given this  
22 particular machine, we're not going to be able to  
23 pull that up. But right there at the top, where  
24 it says "Committee" and that is an updated version  
25 of the roster with contact information

1 (indicating).

2 REPRESENTATIVE ANTONIO: Thank  
3 you. Great.

4 And I think it is fine to  
5 organized our time, as well. So appreciate that.

6 CHAIRMAN SENATOR BURKE: Thank  
7 you.

8 Again, I enjoy open discussion,  
9 but in the interest of time, please don't think  
10 rude of me if I bring us back to center again and  
11 keep us routed in what we need to do.

12 Your time is extremely valuable  
13 and I don't want to waste it in non-productive  
14 discussion. So I'll try to keep us focused and  
15 produce what we need to produce.

16 With that being said, if there are  
17 additional items for discussion, we are certainly  
18 welcome to hear them.

19 I do have 20 minutes of time,  
20 personally.

21 MR. TREMMEL: Yes.

22 CHAIRMAN SENATOR BURKE: Or I  
23 could be approached as far as --

24 COMMISSIONER NIXON: Would you  
25 like something I could do in the first meeting in

1 September?

2 CHAIRMAN SENATOR BURKE:

3 September 11th?

4 COMMISSIONER NIXON: That would be  
5 fine.

6 CHAIRMAN SENATOR BURKE:

7 Excellent.

8 Pencil in Mr. Nixon on September  
9 the 11th.

10 REPRESENTATIVE WACHTMANN:

11 Mr. Chairman, will any of your discussion be on  
12 efficiencies that you gleaned, but is that part of  
13 what you'll focus on, quality, efficiency, and  
14 things like that, or --

15 COMMISSIONER NIXON: There are a  
16 couple documents I can distribute.

17 We did contact Kent to do a  
18 one-year retrospective review and surveyed the  
19 staff, key in performance and community about how  
20 to go and got their opinions and how they look at  
21 the future, how does it look into the future.

22 We also did a financial analysis  
23 about safety of costs, additional costs as well as  
24 an across-the-programs where the efficiency losses  
25 in grants. So that whole picture. So I can

1 distribute that.

2 As well as the process itself  
3 getting to the consolidation, that report should  
4 be out this week, I think. Harvard University did  
5 a case study and did this sometime in Akron and  
6 talked with the mayor and county executives about  
7 the process and did a case study on that. So it  
8 gives a good story line on actually what happens.

9 So as I think about it, I think  
10 what I would do in that short period is just to  
11 real quickly review about how we got there, how we  
12 actually implemented it, the feasibility of how we  
13 implemented it, one year later how did we do.  
14 Very briefly and outline it. And I think  
15 questions might be -- and, you know, just some  
16 types of questions. But that is generally when  
17 you get some of the best discussions.

18 MR. TREMMEL: And if I might add  
19 just to the Representative's point.

20 And for those of you, both on the  
21 Committee and Joe, as we look for others that will  
22 be participatory in other kinds of modeling, it's  
23 really important that we look at these  
24 efficiencies. I think we have heard this time and  
25 again, status quo is going to be part of this

1 issue, efficiency in raising the bar, what we've  
2 done for some efficiencies, whether it's  
3 accreditation or whether it's other partnership,  
4 or whether it is some other kinds of merging, some  
5 other kind of opportunities. But what is it that  
6 we're going to do?

7 And I think that Dr. McFadden's  
8 pointed to accreditation, could it be the end all  
9 to get this. I don't know that it is. But what  
10 do we do about efficiency? That is going to be  
11 our corps purpose, or at least one of our purposes  
12 of measure, how do we become more efficient?

13 And from that going forward, as  
14 the Chairman said, the other kinds of  
15 jurisdictional pieces, final implementation.

16 This will take -- could take a  
17 rule change, if you want to throw a bunch of that  
18 around. But it could take some mechanisms or  
19 instruments to get there.

20 And I think for those of you that  
21 are participatory know about these things, what  
22 are the hurdles? Because I think the  
23 administration and the General Assembly would  
24 appreciate knowing what it is about you that you  
25 can't become more efficient? A payroll? Is it

1 purchasing? Is it vouchers? What is that and how  
2 does that work?

3 REPRESENTATIVE WACHTMANN: I can't  
4 imagine accreditation is going to be much about  
5 efficiency verses quality delivery, although it  
6 may contain some efficiency.

7 We do a number of our  
8 accreditations in our private sector. You can  
9 make a strong argument that it makes it less  
10 efficient. But if the quality is the worth, that  
11 is a very important part of delivery service.  
12 So --

13 CHAIRMAN SENATOR BURKE: Well, as  
14 folks mature on that, too, tying us back to the  
15 administration or other folks that will be  
16 implementing and having a vested interest in what  
17 we do, if somebody wants to get somebody on the  
18 phone or here in person that helps us in the  
19 decision-making process, let us know ahead of time  
20 to see if we can pursue that.

21 As Representative Antonio knows,  
22 you can write any law you want, whether or not it  
23 gets done or not is another thing. And that, I  
24 think, is kind of where we need to be to make sure  
25 we are all lined up and where we need to be.

1                   REPRESENTATIVE ANTONIO:  And just  
2                   to the point of equality and accreditation and  
3                   where the connections are between them, I also  
4                   really believe having gone through a certification  
5                   process with programs that while there are parts  
6                   of it that certainly may show the wheels of  
7                   progress down in terms of efficiency at the end of  
8                   the day, quality, accountability, and then over  
9                   the long haul, I think efficiency plan.  Because  
10                  once things are standardized at some point going  
11                  forward, then I think there are some other  
12                  efficiencies that come along as the bar is being  
13                  raised.

14                         So those are the kinds of things  
15                         that are also very interesting to me as we go  
16                         forward.

17                                 And it's interesting to see that  
18                                 we're at the beginning of this with so many --  
19                                 with everyone, it sounds like.

20   So some of that is apt to be found  
21   out, but I think we can at least set the path.

22   COMMISSIONER MCFADDEN:  What I  
23   think I hear you saying is, for me, I don't want  
24   the effectiveness of our local public health  
25   systems to be hindered by the efficiencies that we

1 choose. Because, you know, there are times that  
2 we have to respond quickly to an outbreak, to a  
3 possible food, that we can't allow, you know,  
4 having a system that is economically efficient as  
5 possible but not allow us to quickly, rapidly  
6 address that to prevent, you know, weeks more of  
7 work of inefficiencies.

8 So I think I would interject that.

9 I hear what you're saying.

10 Thank you.

11 CHAIRMAN SENATOR BURKE: Anything  
12 additional?

13 - - -

14 Thereupon, no response was had at  
15 approximately 2:45 p.m.

16 - - -

17 CHAIRMAN SENATOR BURKE: With that  
18 being said, I'll again thank the Vice Chair for  
19 your time, and all your time is extremely  
20 valuable.

21 Mr. Mazzola, thank you for putting  
22 items together.

23 And Mr. Tremmel, thank you.

24 MR. TREMMEL: Yes.

25 CHAIRMAN SENATOR BURKE: I promise

1 to keep everybody on track and on target. We'll  
2 do the best we can to help public health in Ohio.

3 With that, do we need a motion to  
4 adjourn?

5 REPRESENTATIVE ANTONIO: Second.

6 CHAIRMAN SENATOR BURKE: At this  
7 point I'll call the meeting adjourned.

8 - - -

9 Thereupon, the meeting adjourned  
10 at approximately 2:46 p.m.

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C E R T I F I C A T E

- - -

THE STATE OF OHIO:

SS:

COUNTY OF FRANKLIN:

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

IN WITNESS WHEREOF, I have hereunto set my hand and official seal of office at Columbus, Ohio, this 27th day of July, 2012.

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

- - -

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