The following is a draft summary of the transcription taken at the July 24, 2012 Legislative Committee on Public Health Futures. For purposes of reference, on the right side of the page are the page numbers from the original transcription document. On the left side are line number references from the original transcript. Edits and summary comments were taken from the original transcript for purposes of providing the Committee and the public a more concise overview of the meeting.

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1 BEFORE THE LEGISLATIVE COMMITTEE

2 ON PUBLIC HEALTH FUTURES

3 Tuesday, July 24, 2012

4 1:03 p.m.

5 Ohio Department of Health

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1 AGENDA

3 Welcome

5 Approval of July 10 Meeting

6 Summary Notes

7 Presentation Matt Stefanak,

18 Identification and Discussion of

19 Legislative and Fiscal Policies

20 Next Meeting July 31, 2012

00003

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

13 Rory Hamlett

14 VIA VIDEO TELECONFERENCE:

15 Kristen Hildreth

Monica Juenger

16 Commissioner Matthew Stefanak

Commissioner Jim Adams

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4 P R O C E E D I N G S 6

23 MR. TREMMEL:

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4 One of these charts that has been 5 available to you -- this is just the PHAB

6 accreditations fees that came up from the last 7 meeting

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.

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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
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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.
19 Dr. Wymyslo is briefly here.
22 DR. WYMYSLO: 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,
00010
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.
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.
25 But you all know that we have been
00011
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.
00012
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.
14 MR. TREMMEL: Thank you, very
15 much, Dr. Wymyslo.

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.
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11 CHAIRMAN SENATOR BURKE: I'll call
12 today's meeting officially to order, as Chairman.
19 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.
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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.
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.
00015
1 MR. MAZZOLA: Good afternoon.
2 My name is Joe Mazzola. I'm the
3 local Health Department liaison.
4 MR. HAMLETT: Rory Hamlett,

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 WYMYSLO: Ted Wymyslo,

22 Director of the Ohio Department of Health.

23 COMMISSIONER INGRAM: Tim Ingram,

24 Health Commissioner, Hamilton County.

25 MS. WENTZEL:

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1 Jennifer Wentzel, President of Ohio Environmental

2 Health Association.

3 Ms. SHAPIRO: I'm the

4 Chair and Deputy Health Commissioner in Delaware, and

5 representing OPHA.

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
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1 Representative Antonio.
2 Do we have -- I guess anybody
3 opposed to approval of the minutes?
5 Thereupon, no response was had at
6 approximately 1:24 p.m.
8 CHAIRMAN SENATOR BURKE: Hearing
9 no opposition, we'll go ahead and approve the
10 minutes.
18 CHAIRMAN SENATOR BURKE:
20 I see next on the agenda we have
21 Commissioner Matt Stefanak.
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.
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 walk
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
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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
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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 Struthers and Campbell, 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.
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,
00022
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.
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
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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 $5.21 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.

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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
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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 funding 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

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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.

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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.
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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
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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

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

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1 accreditation standards and submitted the

2 accreditation package to PHAB or review -- ongoing

3 review and accreditation hopefully this fall.

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.

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.

24 CDC and the RWJ are only two, but

25 are measured partners among many that are

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1 supporting this national accreditation.

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.
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.
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.
13 Develop a community health
14 improvement plan with measurable goals intended
15 for community health; and
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1 CHAIRMAN SENATOR BURKE: Thank
2 you, very much, for the presentation.
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 PHAB.

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 PHAB accreditation process, you were
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1 made a test site. Explain that a little bit more.
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 PHAB 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.
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?
23 COMMISSIONER STEFANAK:
3 But we actually began our interest
4 in accreditation back in 2008. At that time PHAB
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.

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11 So you have, as I mentioned, a lot

12 of health departments from around the country that

13 have jumped in. PHAB 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.

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.

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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.

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.

25 The relationship must be that of

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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.

16 COMMISSIONER MCFADDEN:

18 This is follow-up to

19 Senator Burke's questions, maybe in a little bit

20 of a different way.

21 Clearly PHAB, 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

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1 speak to any of the other accreditation projects

2 that they looked to gain some of those

3 thoughts?

4 And then if you have heard of any

5 thoughts from PHAB, 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 PHAB

8 accredited and those that aren't, then what?

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 PHAB 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

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

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.

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1 And I don't know if there is a

2 role for accrediting organizations like PHAB 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.
20 COMMISSIONER NIXON:
24 I think that the Senate Committee
25 struggled with that a little bit, about trying to
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1 be descriptive and appropriate size of a health
2 department, and use the PHAB accreditation process
3 as sort of a guiding principle that if a health
4 department were eligible to apply for
5 accreditation under PHAB, 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:
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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.
23 MR. PRESS:
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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?

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 PHAB 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
00053
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 MR. 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.
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.
00054
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 decelerates are?
14 COMMISSIONER STEFANAK: Yes.
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
00055
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 MR. PRESS:
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.
00056
2 MS. SHAPIRO:
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.
23 COMMISSIONER STEFANAK: Well, in
24 the case of that particular levy in Mahoning
25 County, the tuberculosis control on the 1/10th of
00057
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.
00058
8 MR. TREMMEL: Okay.
9 And you're seeking such funding
10 through RWJF 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
00059
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 familiarize or maybe first
7 impressions for folks here like how those
8 discussions go?
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,
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
00060
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.
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.
00061
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 --

16 COMMISSIONER MCFADDEN: I think

17 just some -- on some of the questions on PHAB 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.

00062

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?

00063

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
00064
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
00065
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.
21 MS. 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

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.
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.

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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

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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.

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.
00072
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.
24 I think those are the kinds of
25 things that are going to create reasons around
00073
1 some solutions today that don't look reasonable,
2 because that's not the way the incentive reads.
3 CHAIRMAN SENATOR BURKE:
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.

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

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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 merits 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
00075
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.
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,

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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 components.

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.

25 I would like to also using what

00077

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 consentual-type issues. So I think we need to

6 reflect on what our corps mission is.

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.

21 We will get Mr. Nixon on the

22 agenda sometime to talk about his experiences.

25 At this point we have

00078

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.
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
00079
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.
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 --
6 CHAIRMAN SENATOR BURKE:
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.
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 State 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.
00085
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.
00086
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.
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
00087
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.
25 CHAIRMAN SENATOR BURKE:
00088
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.
9 Thereupon, the meeting adjourned
10 at approximately 2:46 p.m.