

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

1 APPEARANCES

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3 MEMBERS PRESENT:

4 Senator David Burke, Chairman
Christopher E. Press, Vice-Chairman
5 Martin Tremmel, Secretary
Kim Edwards
6 Heidi Fought
Tim Ingram
7 Gene Nixon
Dr. D. J. McFadden
8 Nancy Shapiro
Representative Nickie Antonio
9 Representative Lynn Wachtmann
Jennifer Wentzel
10 Anne Goon
Kim Bordenkircher

11 Also Present:

12 Duane Stansbury
13 Lindsay English
Pam Walker-Bauer
14 Jim Adams
Cammie Matrione
15 Charles Patterson
Bruce McCoy
16 Marjorie Eilerman
Steven Tostrick
17 Tracy Freeman
Joseph Goicochea
18 Socrates Tuch

19 Present via audio link:

20 Jennifer Scofield, Commission Member
Dr. Michael Thomas
21 James Watkins
Kimberly Moss
22 Stephanie Branco
Ned Baker

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AGENDA

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- 1) Welcome
 - * Chair, Senator David Burke
 - * Vice-Chair, Christopher E. Press
- 2) Approval of August 28 Meeting Summary Notes
- 3) Presentation Henry County Hospital and Henry County Health Department
- 4) Committee Recommendations Survey Review
- 5) Discussion and Review of Recommendations
 - * Capacity, Service and Quality
 - * Jurisdictional Structure
 - * Financing
 - * Implementation
- 6) Next Meeting September 25, 2012

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1 is the approval of the August 28th Meeting Summary
2 Notes. I don't know, are there any additions,
3 deletions, corrections to those Minutes?

4 COMMISSIONER NIXON: I'll move to approve.

5 CHAIRMAN BURKE: We have a motion to
6 approve.

7 COMMISSIONER WENTZEL: I'll second.

8 CHAIRMAN BURKE: Second, all those in favor
9 signify by saying aye.

10 (Thereupon all Commission Members voted
11 affirmatively.)

12 CHAIRMAN BURKE: Those opposed same sign.

13 Ayes carry, motion stands, these Minutes are
14 approved.

15 With that, the next Agenda item is a
16 presentation by the Henry County Hospital and Henry
17 County Health Department. I know we have Commissioner
18 Goon with us today, thank you for coming down today.

19 COMMISSIONER GOON: Glad to be here.

20 CHAIRMAN BURKE: It's an honor to have you,
21 we look forward to the information that you will give to
22 us, and the floor is yours, ma'am.

23 COMMISSIONER GOON: Thank you, and I have
24 Kim Bordenkircher CEO at Henry County Hospital, so we're
25 here to tell you about the strengths that we have in our

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1 public health system and how we've gotten to where we
2 are.

3 If we start with introductions, I have been
4 the Health Commissioner for three years in Henry County
5 and prior to that I was in Holmes County for almost
6 eleven years, and I also have nine years of hospital
7 experience.

8 And I have to admit that I have had some
9 connection with most of the people around this table
10 having lived and still have my home in Holmes County, my
11 family lives there.

12 I'm originally from Ashland County, so if
13 Commissioner Edwards was here she would know that by my
14 last name, obviously Representative Wachtmann
15 represented our district, and I served on the Public
16 Health Futures Committee with several of you.

17 Kim, you want to give them an introduction?

18 MS. BORDENKIRCHER: As Anne said, my name is
19 Kim Bordenkircher, CEO at Henry County Hospital, I've
20 been there for 15 years, I've been the CEO for 13. I've
21 been in health care for about 34 years.

22 I'm proud of the hospital in Henry County,
23 we're a 35 bed critical access hospital and over the
24 course of the last few years we have won quite a few
25 awards recognizing the quality across all six of the

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1 pillars that we operate under and specifically related
2 to patient perception of care and patient engagement.

3 And most recently we have worked real
4 aggressively in sharing the strengths that we have as a
5 hospital and the strengths of the health departments --
6 as a health department, so that we can work to improve
7 the health of the residents in our county, so I'm glad
8 to be here.

9 COMMISSIONER GOON: So that helps us cover
10 some of the information about who we are. Probably the
11 main things to know about our health department is while
12 we are in a small county, we're not a small health
13 department.

14 We have nearly 60 staff and have a wide
15 variety of services including home health, hospice and a
16 regional safety net dental clinic, as well as Help Me
17 Grow, so we have a wide variety of staff.

18 We are the primary source of immunizations
19 in our county, none of our local physicians give
20 immunizations. So that, for us, is a key piece of what
21 we do, and that really is supported by that health levy.

22 You see there, we have very generous local
23 support that we're very thankful for, it allows us to do
24 many things, but especially allows us to do that
25 immunization program for our local citizens.

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1 So with that, you can --

2 MR TREMMEL: -- If you just want to advise
3 Rory --

4 COMMISSIONER GOON: -- Move to the next
5 slide.

6 MR. TREMMEL: -- This is Rory, just advise
7 Rory for your next slide.

8 COMMISSIONER GOON: Sure. Rory, you can go
9 through that slide, we're on the next one after that
10 actually.

11 MR. HAMLETT: Okay.

12 COMMISSIONER GOON: Kim, is there anything
13 else you want to say about the hospital?

14 MS. BORDENKIRCHER: No, I think we're good.

15 COMMISSIONER GOON: If you don't know where
16 Henry County is, you can see we're northwest Ohio. And
17 then the next slide. We have created over time a very
18 intentional enter-connectedness between the health
19 department and the hospital and our local health
20 partners.

21 For example, with governance, I'm a
22 permanent member of the Hospital Board of Trustees. I
23 have two of Kim's staff on my Board of Health, and
24 that's intentional to help create that linkage between
25 the two.

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1 We do joint planning together, we just
2 completed our Community Health Improvement Plan. We do
3 our Community Health Assessment, and actually the IRS
4 ruling has had nothing to do with how we do it in Henry
5 County, it's been since 1998 when the first joint health
6 assessment was done.

7 So we've done three, we're getting ready to
8 embark on our fourth, so that's just a part of how we
9 operate.

10 And there are many people around the table,
11 as well, besides the hospital and the health department.

12 We do training. The hospital actually does
13 some training for us and allows us to take advantage of
14 that, so if you want to talk, feel free to share.

15 MS. BORDENKIRCHER: One of the things that's
16 pretty common in health care is we promote people that
17 have unbelievably great clinical skills into leadership
18 roles, and often times they're not trained to be good
19 leaders.

20 We know that the primary reason employees
21 leave their position is because of their relationship
22 with their most immediate manager. So we invest a lot
23 of time and energy into leadership development in our
24 organization.

25 We do eight training days a year where we

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1 teach them regarding everything from how to improve
2 patient perception of care to budgeting, finance,
3 operations, management, leadership, hiring, firing,
4 coaching, et cetera.

5 And we believe that it has been so
6 successful in positioning the hospital where it is that
7 we've opened it up to individuals in the community, so
8 Anne -- and Anne comes to almost all of our, what we
9 call LDIs, Leadership Development Institute, and we've
10 also presented LDIs for the leadership staff of the
11 health department.

12 And to have the hospital and the health
13 department operate their businesses from a similar
14 leadership platform in theory really does a wonderful
15 job to set us up for great collaboration and -- so that
16 we don't have redundancy.

17 We both have limited resources and we aren't
18 in a position where we can overdo one another, so to
19 speak. So it provides a wonderful opportunity for
20 everyone from staff to leadership, to governance, to
21 people to be able to network and work together so that
22 we can plan for the county.

23 COMMISSIONER GOON: And so our strategic
24 action, much of what we have in our Strategic Plan
25 reflects that, but it also reflects the Community Health

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1 Improvement Plan, which while we plan comprehensively,
2 we're not tackling it all at once and we actually don't
3 have any additional resources we're implementing our
4 Community Health Plan with.

5 We're doing it with what we're already --
6 we're starting with what we already have and we're just
7 improving these things and then looking for those
8 additional opportunities, but our plan is comprehensive
9 in nature so that, you know, we know what we want to
10 tackle, it's just a matter on when can we tackle it.

11 But we don't receive many of those
12 traditional funding sources that other people use for
13 Community Health Assessments or health improvement
14 implementation.

15 We also do very close shared services, if
16 you want to go to the next point on this one, shared
17 services and close collaboration, what we call the six
18 pack, which are the six counties in northwest Ohio.

19 We're known for working together closely, we
20 do already share services. We are actually looking at
21 how we can enhance that.

22 We just submitted an application last week
23 for a Local Government Innovation Fund Grant to be able
24 to develop a business case for shared services for the
25 six counties.

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1 So that's something we've actually been
2 talking about for a while, but just didn't have the
3 means of getting there, and so we're hopeful that this
4 will help us get there so that we've identified where
5 the very best places where we can share and how can we
6 most effectively do that across the six counties.

7 Next slide please. Why we do what we do,
8 the way that we do it. One is we both have a common
9 mission. Kim often says -- in different settings,
10 what's our business, our business is saving lives, and
11 that's true for both the health department and the
12 hospital, and it's in our Mission Statement that we're
13 here to improve the health of Henry County residents.

14 And actually it's broader than that, it's
15 the health of Henry County residents and the residents
16 of northwest Ohio, because we serve more than just our
17 county, so that's actually part of our mission.

18 We have a collaborative spirit, not just
19 between the hospital and the health department, but also
20 between our health department and the other health
21 departments in the area.

22 We like working together, and we know that
23 we achieve a lot more together than any of us could
24 separately. We just couldn't compete for things and we
25 couldn't do them as well either, if we were working on

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1 our own.

2 And then we have complementary services,
3 like Kim said, we do not duplicate each other. If I'm
4 providing a service, she's not or vice versa. So it
5 allows both of us to be viable and it also makes sure
6 that we're meeting local needs without wasting any of
7 our resources.

8 So if we can go to the next slide we talk
9 about how we do it. This gets back to what Kim was
10 mentioning about how we go about doing that in our area.

11 MS. BORDENKIRCHER: This is what we call the
12 healthcare flywheel, it actually comes out of Jim
13 Collins' book, From Good to Great, and there's something
14 about a picture's worth a thousand words.

15 So the three things that we concentrate on
16 whenever we're implementing anything from a small
17 program to a big initiative in the hospital, is if you
18 look at that slide over in the right corner, Pillar
19 Results, is we're very measurement focused in our
20 organization.

21 We have organizational goals, departmental
22 goals, supervisory goals, program related goals, and
23 they all cascade down through the organization.

24 So no one in our hospital can work on their
25 pet project or their pet little fun thing, we all have

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1 to work together to drive our goals.

2 We establish annual goals that we work
3 towards, and then every manager in the hospital,
4 including myself, has a 90 day plan and we have 90 day
5 goals that we have to achieve in order to achieve our
6 end goal.

7 The second one there is, Passion, and we
8 really hire for passion. I believe that we save lives
9 in our organization, and I'm not looking for somebody
10 that wants a job or a paycheck. My sisters are all
11 nurses and we used to say you don't want to hire a
12 refrigerator nurse, someone who's just getting a
13 paycheck to buy their next refrigerator.

14 I want to hire people who are really in the
15 business to save lives, whether they're a cook or a
16 housekeeper, they work in the maintenance department or
17 in billing, or they're a nurse, we're all in the
18 hospital environment to save lives, so we really hire
19 and maintain passion in our organization.

20 And then the last thing there is,
21 Principles, and we do have use for prescriptive to do's
22 in our organization, which Anne has adopted in the
23 health department.

24 Meaning that there are certain things that
25 are must-haves in our organization, which I'll talk

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1 about in a minute, but we only have prescriptive to do's
2 or must do's based on evidence.

3 So whether it's clinical initiative, we have
4 evidence based medicine strategies, but we also have
5 evidence based leadership practices. So managers and
6 supervisors in our organization don't do things the way
7 they've always done it. We only do things where we have
8 evidence to demonstrate that it's effective.

9 If you go to the next slide you'll see some
10 examples of what we consider evidence based leadership.
11 And this is a theory or philosophy of leadership that we
12 adopt, that the health department is also implementing
13 in their facility, where if you read this picture, if
14 you will, from left to right, and, again, whether I'm
15 implementing an out-patient diabetic education program
16 or looking at dental health in our county or
17 implementing hospitalists in our hospital, we work from
18 this graph from left to right.

19 And the first one there is what I just
20 mentioned, that's what we call a LEM, a Leadership
21 Evaluation Manager. Where we develop goals for all the
22 managers, regardless of the project, so they know
23 exactly what they must accomplish and what they need to
24 accomplish every 90 days in the hospital.

25 Then, in addition, we make sure that people

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1 know exactly what that looks like. So we don't make any
2 assumptions that people know what excellent looks like,
3 we draw or show them a picture of that, which takes us
4 to the next pillar there in Leadership Development.

5 We do very aggressive leadership development
6 and training in our organization. As I said before, we
7 do eight days of leadership training a year as a whole
8 group where we take them out of the hospital and do
9 training and development.

10 We do that according to what I consider the
11 most important must have is observation.

12 So for instance yesterday I spent three
13 hours observing different managers meeting with their
14 employees where I can give them feedback about what they
15 did well in their meeting and what they can do better.

16 I observe committee meetings, I observe
17 nurses taking care of patients, I observe nurses giving
18 reports, so that not only do I think that they know what
19 they're doing or I think they're doing what they're
20 supposed to be doing, but I can give them feedback that
21 they -- what they're doing well and what they need to do
22 to improve.

23 Then you see that Must-Have column in the
24 middle, and that just gives you a sampling of some of
25 the must-haves, or what I consider the evidence based

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1 strategies.

2 For instance, we do rounding, so all our
3 managers round in the whole building. We know it takes
4 all of the knowledge and expertise from everyone that
5 works in the hospital to execute perfectly with the
6 strategies we want to do.

7 So I have a certain number of hours per week
8 that I round on staff to ask them, do you have the tools
9 and the equipment that you need to do your job; are the
10 processes working the way they should be; who's
11 deserving of some special recognition; and what do you
12 know that you don't think that I know?

13 And it's amazing what I can harvest
14 throughout the building to move our organization
15 forward.

16 Another example of the must-haves, I'll just
17 touch on just briefly, is we do behavioral based
18 interviewing and peer interviewing for all our positions
19 in the hospital.

20 You don't get hired at Henry County Hospital
21 with at least -- without at least four interviews under
22 your belt, because, again, we're not hiring somebody
23 because they need a new job.

24 We're hiring people to save lives and that's
25 a real important job, and we want to make sure they have

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1 all the core characteristics based on behavior based
2 interviews and peer interviewing that we can. So we
3 have a very lengthy interview process.

4 That also decreases our turnover, which
5 decrease costs, because orientation and education is one
6 of the most expensive things that we do. Fifty percent
7 of our cost in the hospital are people related.

8 The next one there is Performance Cap, the
9 hospital -- health care in general and hospital
10 specifically, we have always put up with if you had
11 great clinical skills the rest of it didn't matter.

12 Well, in this day and age with accountable
13 care and us being reimbursed based on our ability to
14 deliver to goal, you have to have high performers.

15 So we assess all our staff as to whether
16 they're high, middle or low performers. Historically
17 when you first implement this about ten percent of your
18 staff are in the low performer category, we coach them
19 up or out of the organization.

20 Evidence demonstrates that one-third of
21 those people will select themselves out of your
22 organization, one-third will move up and one-third
23 you'll have to terminate. So that gives you the
24 opportunity then to work with high and middle performers
25 to be able to achieve the goals for the organization

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1 that you want.

2 Then the final pillar there is about
3 standardization. We are implementing lean in our
4 organization, so we are working aggressively to improve
5 performance while removing cost and increasing quality.

6 This year at Henry Hospital alone we have
7 hard green dollars of more than \$60,000 we've taken out
8 of our organization based on performance improvements
9 and quality improvement. You have to have both of those
10 in order to meet that goal, that matrix for our
11 department.

12 So that's an example of our evidence based
13 leadership structure.

14 COMMISSIONER GOON: So the next slide, so
15 many of these things are things that we've put in place
16 at the health department as well. We've been able to
17 see how it's executed, we've been able to see the
18 results and so very similar -- we're doing very similar
19 things.

20 They're three, four years ahead of us, so
21 we're much newer and we have not implemented all the
22 pieces yet, but, for example, we do have five pillars,
23 so a balanced work approach, if you wish, where we have
24 to perform well in all five of these areas to be a great
25 health department, and that's really what we're trying

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1 to do.

2 We're trying to move from being a good
3 health department to becoming a great health department,
4 and so we have those five pillars of people, service,
5 quality, growth and finance.

6 And you can see listed on your handout as
7 far as what are the specific strategic goals that we
8 have in those areas, but then we have priorities and we
9 do have cascading.

10 For example, this -- for my managers this is
11 our strategy, really cascading those goals down to each
12 individual. So our goal for People Pillar is to be the
13 public health employer of choice.

14 One of the ways we're measuring that is by
15 percentage of staff completing the employee satisfaction
16 survey, which we started three years ago, we -- I know
17 by which division do or don't complete that.

18 And so for like my dental director, their
19 goal was to increase the percentage of their staff
20 completing the survey from twelve and a half percent,
21 maybe one or two people, to fifty percent at least.

22 So each one of those division directors know
23 exactly what their goals are for each one of the
24 pillars. So those things all lead up to what we're
25 trying to achieve as an organization.

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1 If you want to go to the next slide.

2 What I've provided you are just with
3 background information. I'm not going to go through it
4 all, but I want you to see the type of strategy that
5 we're implementing or have implemented as a health
6 department to achieve higher quality in what we do.

7 So we've done a lot of work in the People
8 Pillar, quite honestly, that's where I needed to start.
9 There was not great morale when I started there three
10 years ago, and then we just headed right into H1N1, so
11 we started all of this after we got through H1N1.

12 But then if you go onto the next slide you
13 can see how we're measuring that, so we have specific
14 ways that we're measuring those achievements and we're
15 reporting that back out then to the staff and to the
16 board, so they both know, everybody knows where we are
17 with that.

18 So actually with the People Pillar you can
19 see that, yes, we've -- we achieved two of our goals, or
20 basically achieved two of our goals. One of those we
21 did not meet quite as well as far as satisfaction with
22 current positions.

23 And we don't look at strongly agree and
24 agree, we want the highest scores, so we look at
25 strongly agree only.

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1 If you go on to the next one, it's our
2 Service Pillar, and really our focus there is providing
3 excellent customer service, client service. So whether
4 they're there for environmental health services or
5 they're seeing us for a clinical service for them
6 individually, we care about how that service went for
7 them.

8 You know, how long did it take? What was
9 the quality they had? How did they perceive that?

10 So we have an ongoing client satisfaction
11 survey that we do all year round, and it's available to
12 all of our clients, so that we are constantly monitoring
13 that, and the next slide then actually shows where we
14 are with that.

15 We also use the H-Caps that are standard
16 national survey tools for our home health agency, so you
17 can see on the bottom that we actually look at a
18 particular question on there.

19 It's nice having H-Cap, it's great if you
20 don't have to develop your own tools, so we use that for
21 home health. We didn't have anything like that for
22 public health as a whole, so we basically took that tool
23 and modified it to be able to have something to work
24 from.

25 We have the Quality Pillar is our next

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1 pillar. And you can see there really, it was our goal
2 has been around developing a Strategic Plan for our
3 agency, and positioning us to be eligible to apply for
4 accreditation, but we also have other things there as
5 well, and these relate back to some of those must-haves.

6 The next slide just addresses how we're
7 doing with that; how do our clients rate the quality of
8 what we provide to them?

9 You can see in 2011 our goal was 86.4, we
10 achieved 86.4 of our clients saying our care was
11 excellent, the services were excellent, that's a high
12 score.

13 Our goal is to get to 90 percent this year,
14 we're not quite there, but we also know what some of the
15 things are that are impacting that.

16 For example, we've had to change how we do
17 some of our clinics. So it appears the same, but the
18 way we provide it is different, and it's making clients
19 wait a little bit longer, and so it's a trade off.

20 We want to be able to serve as many, if we
21 need to adjust the way we're doing it, but it also
22 allows us to see what's the impact to the change we've
23 made on the service that we're providing to them.

24 The next one is our Growth Pillar and that
25 one really -- well, actually here you can see what our

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1 quality scores have done since we started our survey in
2 2010.

3 And then the Growth Pillar is the next one
4 after that, as far as what we've been doing to, excuse
5 me, I'm losing my train of thought, to implement our
6 Strategic Plan, to achieve that accreditation, to
7 implement evidence based practices that will improve our
8 community's health, and so that really comes out of our
9 Community Health Improvement Plan as well.

10 So you can see on the next slide, the two
11 ways we're measuring that is through our preparations
12 for accreditation and our Strategic Plan. So we've met
13 almost all of those this year, it's been a big year for
14 us.

15 And then in Finance, our -- our goal there
16 is to have adequate funding to provide all of the
17 essential public health services. And so you can see
18 there's a variety of ways we're doing that.

19 And we're really trying to bring up our
20 skill set as well, so there's some training that you see
21 on there, but if you look at the ways we're measuring
22 that we're looking at our general fund balance.

23 We did not have defined previously what was
24 the minimum fund balance we had to have. So our board
25 members were really -- well, do we start getting

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1 nervous, do we not starting getting nervous; is this
2 okay, is this not okay?

3 So we've gone -- we've gone through the
4 preliminary work of coming up with some round number.

5 We actually have -- we want to be setting a
6 policy later this year, we have that in our Strategic
7 Plan to define that more fully, but then we do have
8 self-supporting programs. So for those self-supporting
9 programs we also have cash flow goals for them, and a
10 year-end fund balance for them.

11 And then our health levy is our final piece.
12 We're at the end of our ten year cycle and so our
13 finances, as far as our general fund dollars are at the
14 lowest it will be, and so our goal, we have a lot of
15 work that went into getting that next round of funding
16 so that we could continue to serve, and then actually
17 put some things in place that we don't currently have in
18 place that are really part of that foundational
19 capability set.

20 It all sort of flows together into the next
21 slide, which shows a strategic map, and that's why you
22 have a copy in your hand, if you can't see that one.

23 But really shows how we start from our
24 pillars; how that defines what we -- the results that we
25 achieve for our stakeholders and the results that our

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1 clients see; the results that we expect as an agency to
2 see, and those are what our strategic priorities are.

3 So this is what our Strategic Plan
4 addresses: The effective use of technology; strategic
5 funding decisions; effective communication, both
6 internally and externally; our pursuit of diverse
7 partnerships, and that's not only working with the
8 hospitals, that's also working with the other health
9 departments, that's working with other entities beyond
10 those two.

11 You know I was just talking yesterday
12 actually with our county auditor. I presented in our
13 Family Children First Council Meeting our Community
14 Health Improvement Plan, and we were talking about how
15 we could work together to address childhood and adult
16 obesity, and he had some ideas, well, you know, that
17 summer nutrition program you all do, and he said, well,
18 you know, I think my staff could volunteer one day a
19 week. I mean so it's those non-traditional kind of
20 partnerships too that help to get people on board.

21 And our City Manager said, you know, I
22 really need somebody to talk to City Council about why
23 we need to keep our pool open and why we don't charge
24 for our youth recreation program, and so I'm going to be
25 at the City Council meeting talking about that.

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1 And then the areas where we need to do our
2 work is really that blue line at the bottom. Where we
3 need learning and growth to get to those desired
4 results. And so you can see we have on there some very
5 intentional workforce development, not only of our staff
6 and our managers, but also of our board.

7 We have the type of peer interviewing we
8 were talking about, we've implemented that and in those
9 divisions that we've implemented that we see much better
10 hiring decisions than what we see happening in some of
11 the divisions that have not implemented that yet.

12 So we have very specific things that we're
13 doing to improve the quality of what we're seeking to
14 achieve.

15 And so I would like to end with just some
16 information, again, from Jim Collins, which is really
17 what this Studer Group Concepts are based on, is that it
18 doesn't necessarily depend on where you are or how big
19 you are or how small you are, it's more do you have the
20 will to get there and you're making a conscious
21 decision, the discipline to get to that point.

22 And so for us to be able to impact the
23 health of our Henry County residents, it takes very
24 intentional, not only on the hospital's part, but it
25 also takes that very same great intention on our part,

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1 so that we both get there together. So that's what we
2 wanted to share.

3 CHAIRMAN BURKE: Excellent, thank you. Just
4 a couple of quick questions for you. Henry County's
5 Health District is the only health district?

6 COMMISSIONER GOON: It is, uh-huh, we're a
7 combined health district.

8 CHAIRMAN BURKE: Just looking up here, you
9 have a population of about 29,000 people?

10 COMMISSIONER GOON: 28, yes.

11 CHAIRMAN BURKE: You touched on it briefly,
12 could you tell me what services you share with the
13 surrounding districts?

14 COMMISSIONER GOON: Sure, sure.

15 CHAIRMAN BURKE: If you want to share on
16 that.

17 COMMISSIONER GOON: We share one
18 epidemiologist for the six counties, and then we provide
19 services to Defiance County in reproductive health and
20 wellness, Fulton County shares those same services with
21 Williams County; we also share WIC services between
22 Fulton County and Henry County. I'm trying to think
23 what else, there are some other things too.

24 CHAIRMAN BURKE: And these are hardware,
25 software, people, resources or what's --

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1 COMMISSIONER GOON: Both.

2 CHAIRMAN BURKE: Both are being shared. So
3 if somebody in another county with a service that you
4 share, like WIC, for example, wanted to apply for WIC,
5 what's changed; where do they go; what do they do?

6 COMMISSIONER GOON: They are to be served in
7 their local county, but the staff are all out of one
8 unit. So, for example, in that case it's Fulton County
9 that receives the funding to do it for both counties, so
10 they provide the staff, we provide space.

11 CHAIRMAN BURKE: How long have you been
12 doing WIC, for example?

13 COMMISSIONER GOON: WIC has been combined
14 like that from the very beginning, it's been like that
15 for 30 years in Henry, Fulton County.

16 CHAIRMAN BURKE: And so you say they applied
17 for a Local Government Innovation Fund Grant, I assume?

18 COMMISSIONER GOON: Uh-huh, yeah.

19 CHAIRMAN BURKE: So you did send in
20 obviously for that grant application, surveys and things
21 along that line that was required for the grant and
22 stuff?

23 COMMISSIONER GOON: Uh-huh.

24 CHAIRMAN BURKE: What is the grant for; what
25 are you funding?

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1 COMMISSIONER GOON: It's for a planning
2 study to look at actually all of the services, the core
3 public health services, the foundational capabilities
4 and those other services to come up with a business plan
5 for what makes the most sense here economically to
6 share. So we're open, we're looking at all of them, all
7 agencies.

8 CHAIRMAN BURKE: So I assume then on the
9 prospectus that you sent in for the grant application
10 itself obviously showed cost savings, right, through
11 this kind of combination?

12 COMMISSIONER GOON: The challenge is showing
13 that when we don't know which services that'll end up
14 being combined, because we won't know until we go
15 through that business case analysis.

16 CHAIRMAN BURKE: Thank you.

17 COMMISSIONER EDWARDS: Website, do you have
18 a website that I can go to look at some of these things
19 to answer questions?

20 MR. TREMMEL: Rory, could you pull --

21 COMMISSIONER GOON: Our website is
22 www.HenryHCOHD, so it's that middle part there, dot org.

23 COMMISSIONER INGRAM: So -- thank you for
24 your preparation. It looks like that the health
25 district and -- actually has some of the hospital's

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1 goals.

2 COMMISSIONER GOON: Similar, uh-huh.

3 COMMISSIONER INGRAM: I noticed that the
4 readmission goal, that's interesting. So how did that
5 develop, because you've exchanged board members on your
6 representative boards or you think that would not have
7 happened, if that had not occurred?

8 Because your governance structure is a
9 little different in Henry County than in perhaps a lot
10 of other areas.

11 COMMISSIONER GOON: If I really take it back
12 to where it first occurred, I mean when I had my
13 orientation to the hospital board it followed those
14 guidelines as far as, you know, how the staff introduced
15 themselves, how I was oriented to the facility,
16 everything like that.

17 But for me it really started when I had an
18 employee I had to lay off, and she was a joint employee,
19 excuse me, and she suggested that we look at the
20 hospital, and so that was really when I started saying,
21 I'm gonna -- that comes to the LDI, let me see what it
22 is you have to do.

23 So that was really the first point where --
24 we need to have a better focus, we need to have a clear
25 vision of where we're going, we need -- we need to

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1 change how we're operating.

2 COMMISSIONER INGRAM: Just two quick
3 follow-ups, Mr. Chairman, if I may. Does the hospital,
4 does Henry County only serve Henry County; what's your
5 market area?

6 MS. BORDENKIRCHER: Primarily we serve Henry
7 County. We have an OB/GYN physician at our facility and
8 he does recruit ladies from all contiguous counties, but
9 primarily our market area is Henry County.

10 COMMISSIONER INGRAM: And you're a
11 not-for-profit or are you actually --

12 MS. BORDENKIRCHER: We're a not-for-profit
13 hospital, and although our name has county in it, we're
14 not a county --

15 COMMISSIONER INGRAM: Okay. Sure, you're
16 not-for-profit status, but solely owned through a
17 governance structure that deals with -- that Health
18 Commissioner Green sits on, as well as other members
19 from the community, any elected officials sit on your
20 board?

21 MS. BORDENKIRCHER: No.

22 COMMISSIONER INGRAM: The only other
23 question I had was, and kind of two questions, so you
24 have some community benefit dollars that you're
25 providing perhaps to Henry -- to Anne's district?

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1 MS. BORDENKIRCHER: Uh-huh.

2 COMMISSIONER INGRAM: Yeah, I thought so.
3 Okay. Last question, I heard you say, Anne, that you --
4 how you wanted to become a great health department, so
5 what barriers exist today to prevent that from
6 happening?

7 COMMISSIONER GOON: I think barriers that --
8 well, the areas where I see us needing to improve the
9 most yet, and, therefore, it's been challenging to
10 garner the resources to do that is really around the
11 health education, health promotion piece of it, because
12 we, just like many other health districts, supported
13 that solely out of grants.

14 And those that know me know that I've said
15 all along that this is a core function of public health.
16 This should be paid out of general fund dollars. And so
17 it's just taken me three years to get to the point where
18 we're ready to do that.

19 Where that's an obligation that we're doing
20 out of our general fund, because we can't move the
21 community forward, we can't move the health of our
22 community forward without having individuals who
23 specifically concentrate on that.

24 So -- so that's really the greatest
25 challenge that we have, is that, you know, we're used to

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1 doing immunizations, and while immunizations are still
2 very important, because nobody else is stepping up to do
3 those, we need to do other things as well.

4 And so it's being able to have the staff,
5 the right staff with the right skill set, with the
6 funding to be able to support them.

7 COMMISSIONER INGRAM: Thank you. Thank you
8 both. Thank you, Mr. Chairman.

9 CHAIRMAN BURKE: Vice-chair Press.

10 VICE-CHAIRMAN PRESS: Thank you. Two
11 questions briefly. You have six jurisdictions with
12 which you're sharing some resource, and each of those
13 jurisdictions has its own revenue stream, yes?

14 COMMISSIONER GOON: Uh-huh.

15 VICE-CHAIRMAN PRESS: So behind the scene
16 you all have just negotiated some contracts and
17 agreements to pay each other for the way those things go
18 back and forth?

19 COMMISSIONER GOON: Right. Some of those
20 are by the funding itself. For example, when the
21 application is submitted we submit -- with their
22 agreement, we will submit the grant for two counties,
23 but for others like the epidemiologist, we literally
24 negotiate how we do that.

25 Originally it was each county paid

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1 one-sixth, well, when the grant funding kept getting cut
2 it got to the point where for one of the counties it
3 meant they were going to have to eliminate their planner
4 or cut him down and he was one of their full-time staff,
5 and so we renegotiated how we do that cost allocation,
6 so it's now on a per capita basis.

7 So his price, his cost went down, others
8 went up, but that was agreeable to all of us, because we
9 saw the need to continue that service and we saw the
10 need to do it together.

11 VICE-CHAIRMAN PRESS: Last question from me,
12 this body is trying to consider future public health.
13 What could this committee recommend that would make what
14 you did easier for others to do?

15 If you want a week to think about it, not
16 trying to put you on the spot. I mean, you know, you
17 have a model of need in your community that you
18 organized yourselves around to address that need could
19 be different in different parts of the state, but the
20 underlying cooperation, I think, is admirable, so if we
21 can facilitate that kind of cooperation where folks want
22 to do that, Tim's question regarding impediments, but
23 the question is how could we -- how could we, by our
24 actions and recommendations, help that cause?

25 COMMISSIONER GOON: Kim, that's -- well, I

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1 think one piece of it is access to the resources. I
2 have access to a resource that most other counties do
3 not have.

4 VICE-CHAIRMAN PRESS: There's a hospital in
5 almost every county in the state.

6 COMMISSIONER GOON: Right, but they don't do
7 what Henry County Hospital does, and I think that's one
8 of the differences.

9 VICE-CHAIRMAN PRESS: I think that's what
10 I'm asking, what can we do to encourage that level of
11 cooperation?

12 COMMISSIONER GOON: Move to northwest Ohio.

13 VICE-CHAIRMAN PRESS: I'm already in
14 northwest Ohio.

15 CHAIRMAN BURKE: Not northwest enough, I
16 take it.

17 COMMISSIONER GOON: I think a piece of it is
18 making it -- for example, you can't do some shared
19 services -- I mean, to combine these six counties, for
20 example, we've talked about that.

21 I mean we talked about it before this ever
22 came about, you know, what would that look like and how
23 could that work and what would it take to get there?

24 Well, one thing, we can't do a levy. We
25 simply can't do a levy. We don't have the ability to do

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1 a six county levy.

2 We have a four county ADAMH's Board, they
3 have the authority to do that, we don't have the
4 authority to do that.

5 So that certainly is a barrier to us even
6 thinking about doing anything jointly, but that doesn't
7 mean that we necessarily want to be combined into one,
8 but it's really having, if we choose that that's the
9 best route that would be a barrier that would keep us
10 from being able to accomplish it.

11 VICE-CHAIRMAN PRESS: Good concrete example.

12 COMMISSIONER GOON: I think the other thing
13 is -- is that just like we talked about the goals
14 cascading and not focusing, we don't focus first on the
15 low performer, we focus first on the high performer.

16 I think a system that is created that allows
17 this state and local partnership, but the focus is first
18 on those high performing health departments and how do
19 we move them forward, and then you bring the middle
20 performers up a level, and then you address those low
21 performers that are dragging people down.

22 I mean that happens within your staff. We
23 have health departments that don't perform as well as
24 other health departments. Well, you either need to help
25 them move up or maybe that's where you go that route and

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1 say, sorry, we need to consolidate you or maybe you
2 decide you need to consolidate with somebody else, but I
3 think that focus on high, middle, low, and moving those
4 highs up, focusing on them first, then moving the
5 middles up, and then addressing those low performers
6 would be helpful.

7 REPRESENTATIVE ANTONIO: So -- and I
8 apologize, I didn't hear the beginning of the entire
9 presentation, but do you -- are you licensed at this
10 point?

11 COMMISSIONER GOON: Licensed, or accredited
12 you mean?

13 COMMISSIONER ANTONIO: Accredited, I'm
14 sorry.

15 COMMISSIONER GOON: No, we have not.

16 REPRESENTATIVE ANTONIO: Is that something
17 that you, having been this model -- having this model of
18 collaboration and cooperation, is that something that
19 you've looked at at all?

20 COMMISSIONER GOON: Well, that's something
21 we've been positioning ourselves to be able to do,
22 intentionally we've been positioning.

23 MR. TREMMEL: You might want to explain, you
24 went through all of it in your --

25 COMMISSIONER GOON: Right. We are basically

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1 -- I mean we identified what were the things that were
2 barriers for us. We didn't have our Community Health
3 Improvement Plan done yet; we didn't have our Community
4 Plan done yet. We've completed those things this year.

5 So we're basically at the point. I mean I
6 still have to do the on-line course, you have to do that
7 two hour thing, but I mean our accreditation coordinator
8 has done -- we have a team, with started gathering the
9 documents, all of that.

10 REPRESENTATIVE ANTONIO: So when you -- so
11 to position yourself, and let me get this straight, but
12 the Henry County Health Department, what about the other
13 folks that you are working in collaboration with, is
14 that something that's going to develop them as well or
15 will you be the front?

16 COMMISSIONER GOON: It sort of depends, but
17 that's actually one of the things that we're going to
18 look at with our -- if we're able to get that LGF
19 funding, because we want to look at would we qualify,
20 could we qualify as a multiple jurisdictional applicant,
21 because that's one way we certainly could save money,
22 but we could also save some time and bring everybody's
23 performance up a level.

24 I mean we currently already do do that with
25 Williams County. We do -- we have done our own core

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1 health department management team. We've started our
2 own LDI, Leadership Development Institute, and we do
3 that for employees, but it's not something where we've
4 said to everybody, well, you know, you need to do this.

5 It's more a matter of seeing it and becoming
6 convinced, yeah, this is important. Our managers can't
7 perform, if we don't train them how to perform.

8 REPRESENTATIVE ANTONIO: And the last
9 question I have for you, and, you know, certainly this
10 is a major public discussion, but have -- in all of the
11 collaboration that you do, I mean has the idea of
12 consolidation come up enough.

13 Because it seems like you're so -- from
14 everything I'm hearing you're so well positioned to be
15 able to have that as a consideration, those strategic
16 alliances that then move towards consolidation, has that
17 come up in your discussions with the other departments?

18 COMMISSIONER GOON: We've talked about it.
19 I don't think our boards are anywhere close to that
20 point yet. I don't know that our communities are close
21 to that point.

22 And we've also just even talked about the
23 geographic barriers. I mean from one side of my county
24 to the another it's an hour, let alone from the corner
25 of Williams County to the southeast corner of my county.

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1 I mean we're talking big distances and so I think that's
2 another one of those reasons we want to do that business
3 case analysis is because can you really do this and do
4 it across this big of a region and do it effectively?

5 REPRESENTATIVE ANTONIO: Thank you.

6 DR. MCFADDEN: When you guys started, Anne,
7 when you first started there where would you have said
8 -- when you did your tiles of poor, good, excellent,
9 where would you have thought that Henry County was and
10 where do you think you are positioned now, and which was
11 the piece that moved you the most?

12 COMMISSIONER GOON: I mean I would say my
13 board -- because this was something that came up during
14 my interview with the board, was that while we were in
15 -- we were in an okay position, so I don't know, maybe
16 that 50 percentile.

17 I mean we were doing well, but they didn't
18 want to just do well, they wanted us to lead, they
19 wanted my health department to lead. So as far as what
20 was that point where -- it's still happening.

21 I don't know, you know, we're not at that
22 tipping point yet. Actually, we didn't talk about it at
23 all, but you hit a wall where your high performers are
24 moving up and your middle performers are moving up, but
25 your low performers are just waiting for this initiative

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1 to disappear, you know, if we wait long enough they'll
2 go onto something else.

3 Well, we're basically at this point right
4 now, so actually the training we did with our management
5 team just last Friday was really about how to identify,
6 and we're starting to train them how to address that, so
7 that we don't just put up with that behavior, but that
8 we actually use disciplinary processes to either help
9 those people move up or help those people move out, so
10 that it doesn't hold everybody else back from moving on
11 up.

12 So we're not there yet. I mean I don't know
13 from the hospital perspective what was the time frame
14 where you really saw that.

15 MS. BORDENKIRCHER: Yeah, probably three
16 years, two and a half to three years.

17 COMMISSIONER GOON: So we're not there,
18 we're about two years in.

19 CHAIRMAN BURKE: Okay.

20 MR. TREMMEL: Just maybe a comment and a
21 question or two. Rory has the health department site up
22 there, is there anything you want to reference for the
23 group?

24 MR. HAMLETT: I'm sorry.

25 MR. TREMMEL: As he's doing that, maybe a

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1 comment. In a word, just from me, I would say, wow.
2 This is something we've heard about in public health,
3 this initiative between both a hospital and a health
4 department.

5 I'm very pleased that you were able to be
6 here and present it. It's obvious to me that you both
7 bring a lot of conviction, a lot of passion to what it
8 is you're doing, you use this pillar approach to get
9 there.

10 Having said all of that, and I noticed that
11 you do an extensive surveying of your clients, extensive
12 surveying and training of your staff.

13 One of the criticisms of the public health
14 system as we're looking forward tell us about
15 deficiencies; tell us about capacity; tell us about
16 redirects that are making some positive -- what are you
17 figuring just like the -- just like anyone in a business
18 have to do to reinvent themselves, to reinvest, to find
19 the best investment to figure out what works best for
20 them to get to the end product; the criticisms of
21 government, and if we just take a moment at the public
22 health system, some folks, we can collectively throw up
23 our hands and someone else can do it, doesn't
24 necessarily have to be the public system.

25 So are you looking at any measures; are you

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1 looking at any standards; are you looking at any data
2 that gets us to that place separate and kind of over and
3 above to all the other great things you're doing?

4 COMMISSIONER GOON: I'm not sure if I'm
5 totally equipped to answer that question. I can share
6 what it is that -- how we use that information to
7 improve.

8 For example, like with immunizations, we
9 were doing it one particular way, everybody walks in on
10 Wednesday. It was crazy, madhouse, clients waited
11 hours, our staff hated that day, but yet I couldn't move
12 a particular member of my management team to consider
13 some other way, and so that was one of the reasons we
14 started doing the client surveys, let's ask them what is
15 it that they want; what is it they expect from us?

16 And so we modified how we do it so that
17 we're now offering appointments in addition to walk-ins.
18 So we changed, we added additional days of service,
19 because that's what clients wanted.

20 Did we expand total number of hours,
21 actually, no, we did not. We expanded total number of
22 hours that children could come in, but we did not expand
23 our overall hours, we actually reduced them.

24 We changed how we did them and who we
25 offered them to, so that it made it more available to

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1 the largest majority of our clients, and then we monitor
2 that, what did they think of that after we made that
3 change.

4 And so we've very definitely saw increases
5 in the satisfaction of the clients, parents, because
6 we're measuring parents. Some of our 12 and 11 and 13
7 year olds do actually fill out the survey, because you
8 can sort of tell from the handwriting sometimes, but,
9 you know, the adults were much more satisfied and they
10 said the quality is much better.

11 I mean they always thought the quality was
12 good, but it was much better, so that's one of the
13 reasons we measure that length of time, service time.

14 Was it about what you expected? Meaning are
15 we communicating to you clearly about what -- about what
16 it will take to do this, but then also are we meeting
17 that or beating that expectation? It's much less than
18 what I expected, it really happened.

19 So I don't know that I answered your
20 question directly. We're not quite -- I don't think
21 we're quite to that point yet being able to tackle
22 those. Do you have anything?

23 MS. BORDENKIRCHER: Yeah, our Community
24 Health Assessment work we can measure outcomes through
25 the county that way and I think we've seen some success

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1 with some of those measures.

2 You know, as Anne was talking what came to
3 my mind, not directly related to the health department,
4 but how the hospital looks at things.

5 We use a -- we outsource our pathology work,
6 and so we were getting complaints from our physicians
7 that it wasn't timely.

8 So the company that we use said, well, we'll
9 add another route. But we actually did our own analysis
10 at the hospital and found out that actually another
11 route would not be helpful, it would only add cost.
12 What we needed to do was change the pick-up time from
13 8:00 p.m. to 4:00 p.m.

14 So while it didn't directly affect our cost
15 directly it certainly impacted our vendor and the
16 hospital looks at collaboration and optimizing all our
17 vendors regardless of how it would directly impact us.

18 So we actually countered with them and said,
19 no, don't add another route, would it be possible to
20 move your 8:00 p.m. pick-up to 4:00. I mean they were
21 overwhelmed that, you know, saved a lot of cost for
22 them. Doesn't directly save cost for us, but it
23 improved our service without adding cost.

24 COMMISSIONER SHAPIRO: Question on sharing
25 data and resources. One of the issues with the health

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1 assessment process is the ability to get some hospital
2 data, and are you guys merging EMRs or anything else,
3 electronic medical record or anything else to help
4 really measure the health of the community as a whole
5 and also where you see some improvements or
6 deficiencies?

7 MS. BORDENKIRCHER: You know, I'll start,
8 we're not -- we've talked about merging EMRs. To be
9 honest the health care EMR is not actually where it
10 needs to be and before we start talking about merging
11 our systems with other places we need to right -- you
12 know, we need to get our system working well, but an
13 example of that is the dental clinic that Representative
14 Wachtmann mentioned earlier.

15 One of the reasons that all came about is we
16 were doing some analysis of our emergency room and
17 identified that one of our frequent returns to the
18 emergency room was dental issues.

19 Well, that's way beyond our area of
20 expertise, and so we, because I have such a close
21 relationship with Anne it's very easy for me to take my
22 emergency room data and pop it to her and say look at
23 all this, look at all this dental issue we have in our
24 ER, our doctors are going crazy with this.

25 And because we have a good relationship and

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1 we're really trusting, I mean I'll give her any data or
2 information she needs to demonstrate the need for that
3 dental clinic, and that has been unbelievably helpful in
4 our emergency room, because my emergency room docs do
5 not like to deal with dental pain. All we -- all
6 they're going to do in the ER is give them a bunch of
7 narcotics, which we don't want to do.

8 So that has dramatically improved the health
9 of those people.

10 COMMISSIONER SHAPIRO: Did you help fund the
11 dental clinic?

12 MS. BORDENKIRCHER: No, we do not.

13 COMMISSIONER GOON: No, currently the dental
14 plan is not supported. I mean there were ODH funds that
15 helped initiate it, get it going, capital funds, and we
16 do use a Safety Net Dental Clinic as a portion of it,
17 but it's self-supporting.

18 CHAIRMAN BURKE: I'm going to move on in the
19 interest of time, if I could. First, again, thank you
20 very much for taking time to come down here today. I
21 know that's a drive from Henry County and sharing your
22 experience with us.

23 You have a good state representative who
24 I've had the honor of working with, and he drives a hard
25 bargain, but he brings good people to the table, and I

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1 appreciate you being here, so thank you very much.

2 REPRESENTATIVE WACHTMANN: Just one food for
3 thought as to how maybe we encourage more of these type
4 of relationships, which I think are important, and I'm
5 not -- necessarily think we start at the top, but I
6 don't know if the Ohio Hospital Association, I mean is
7 Phil Inman (Phonetically Spelled) the current president
8 or incoming president?

9 MS. BORDENKIRCHER: Incoming, I believe.

10 REPRESENTATIVE WACHTMANN: And so, you know,
11 he has, I think, probably a good working relationship
12 with the Wayne County Health Department, and we have a
13 leader or an incoming leader at the Ohio Hospital
14 Association and I don't know if the Association of
15 Health Councils, if they would care to meet and talk at
16 that level about maybe working together, because in the
17 end it takes local people wanting to make things happen,
18 working together, but maybe those discussions could be
19 thought about and maybe had, and see if there's anything
20 to be gained there.

21 MS. BORDENKIRCHER: I can bring that up.

22 CHAIRMAN BURKE: Thank you, again, I
23 appreciate your -- I mean you're welcome to stay for the
24 duration, if you can, that's all right.

25 With that being said, we'll move on to the

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1 regular Agenda. And I will, again, try to keep us on
2 task here and on target. But a few things, I know we
3 have some folks on the phone, if you wish to participate
4 please do, if not, if you could mute your phone,
5 sometimes every once in a while we get background, but
6 have not heard anything at this time, but appreciate you
7 folks being on the phone and don't be bashful.

8 We have a list of who you are on the phone?

9 MR. HAMLETT: Yeah, we have James Watkins;
10 are you on the phone, James?

11 MR. WATKINS: I'm here.

12 MR. HAMLETT: And Kimberly Moss.

13 MS. MOSS: Yes, I'm here as well.

14 MR. HAMLETT: Michael Thomas, M.D.

15 DR. THOMAS: I'm here.

16 MR. HAMLETT: And Stephanie Bronco
17 (Phonetically Spelled).

18 MS. BRONCO: I'm here.

19 CHAIRMAN BURKE: Excellent. Well, thank you
20 folks for joining us, please don't be shy, just because
21 you're not here physically, you're definitely here on
22 the phone, so I appreciate that.

23 MS. SCOFIELD: Hello, one more, this is
24 Jennifer Scofield also on the phone.

25 CHAIRMAN BURKE: Thank you.

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1 MR. BAKER: This is Ned Baker, and I'm also
2 on the phone.

3 CHAIRMAN BURKE: Excellent, thank you,
4 folks. I know just looking ahead, our next meeting
5 hopefully we'll start driving some brass tacks, this was
6 our last presentation of the Committee or to the
7 Committee, so, again, I appreciate the folks from Henry
8 County coming up.

9 Looking at our next meeting, as we work
10 through this before we get to the end today, if there is
11 a desire to extend or add to the meeting time when we
12 get to the end of today we'll have that discussion
13 depending on where folks are at and how they feel, as
14 long as there's -- or in addition to any thoughts on
15 correspondence with ideas as we start working through
16 ideas, has to be some kind of open dialogue in the
17 background that occurs between meetings, that's
18 something that we can also discuss one on one, or, you
19 know, obviously we can't have a group meeting, a quorum,
20 but if anything comes up in your mind to improve
21 correspondence, please let me know.

22 One of the documents that you all filled
23 out, and I appreciate that, was a Health Futures Survey.
24 We have accumulated the results on those surveys that we
25 got back and that was a vast majority of our members.

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1 You've been given those results just in
2 terms of rank, and, again, the idea was just to give
3 folks a thermometer on where -- if there was something
4 you were passionate about, where it fell, and if not
5 where it fell.

6 There's a mediate of each recommendation
7 document that you might have, as well as a chart in the
8 back that shows you where folks that responded rated
9 each recommendation, and I think you can tell the top
10 recommendations that were on people's minds were No. 1,
11 No. 12, No. 13 and No. 14, as presented by the
12 recommendations to us for the considerations of a new
13 framework. So I'll toss that out there just to keep
14 that on the forefront.

15 And I'm going to go ahead and just start the
16 conversation here, because I kind of want to work
17 towards a roundtable idea kind of thing.

18 So I'll just reiterate some of the things
19 that I've heard over the last few meetings just, again,
20 fire up the machine, as it were.

21 One of the main things that some folks have
22 brought to us initially in conversation was an magic
23 number, what the size of a health district should be.

24 That magic number would eliminate Henry
25 County, so if you like that presentation say goodbye.

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1 Oh, the irony, right, but that's why they call me
2 Chairman, I guess, right.

3 So I ask myself, as I brought up before,
4 what is the role of public health at the state level;
5 what is the role of public health at the local level;
6 can we measure it today; is there even a standardization
7 in place to measure it?

8 Because if you're going to pick a number
9 like a hundred thousand or you think a hundred
10 twenty-five or a hundred and twenty-six is too big show
11 me why, and as a legislature, and I don't know if my
12 colleagues feel the same way, I like to make decisions
13 on facts, not just because it sounds good.

14 So you all, folks, bring that to the table
15 with your experience here, is there a measurement
16 process in place; is there a standardization process in
17 place, so that I can say that Henry County is doing a
18 great job, we should leave those folks alone, but, boy,
19 those folks in Scioto County they need to be combined
20 with somebody else because they're not meeting X,
21 whatever X is.

22 It would be in the public's best interest if
23 we combined this health district with this health
24 district or had a regional health district, it would
25 strengthen what?

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1 I don't know. I ask myself those questions,
2 and then it gets to the next level even below that is,
3 if we were to put more money into health what are we
4 paying for; what am I buying; what kind of outcomes do I
5 have; and are they measurable outcomes?

6 Obesity, smoking, right, influenza, TB,
7 rabies, right, food borne allergies, all these other
8 kinds of things that you do at a superficial level, I
9 think, that's kind of worth discussing here.

10 Some of the things I've heard people talk
11 about, board makeup and term limits on those boards;
12 central government -- or central grant writing, all
13 right, and how to work with grants; the size of the
14 health district in regions; I.T. consolidation; the need
15 for measurement; accreditation; standardization of fees;
16 and as we talked about today, legislative changes to
17 allow for cross-jurisdictional revenue sharing and how
18 that would look.

19 Those are just a few things, but I'll go
20 back to my first point, if you're going to do anything
21 can you measure it today; is it standardized to measure
22 it; whatever that change may be; and what is the role of
23 the state in the local government?

24 I go back, again, these can be broad, we
25 don't have to be really proscriptive. I would say

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1 you've got folks like Henry County that do a great job
2 with delivering it. How do we as a state then, based on
3 those goals, incentivize that kind of behavior? Not
4 being mandated in legislation, but how do we incentivize
5 outcomes like what you're doing and some of the
6 questions that you were asked drove to that, right?

7 How does the state, LGIF is a good example
8 of that, that's really not what we're doing in health.
9 So I'm just going to kick that out and keep the ball
10 rolling as we move through this process.

11 We're going to have to have some producibles
12 and I want to know, what are we going to bring our
13 colleagues in the administration of the General Assembly
14 in terms of these are the goals? So I'll start it off
15 right there.

16 Does anybody have any thoughts? This is
17 open forum for the next three meetings, and eventually
18 by the way, we're going to have to vote on something,
19 FYI, and it can be Dave's and Chris' magic list or it
20 can be a committee that gets the job done, so --

21 COMMISSIONER NIXON: Well, I would say I
22 agree with you on all points. I think that to assign a
23 number, a flat number of a hundred thousand, probably
24 wouldn't work for a lot of health departments that are
25 already exceeding, you know, the minimum standards.

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1 I think there's really three issues that are
2 facing the committee is No. 1 is that standard -- what
3 is the standard in Ohio for local health departments?

4 And, you know, health departments have
5 always have a standard only it hasn't worked very well.
6 There's been a standard, we've all had to report to
7 receive our state subsidy, and it's been non-enforceable
8 and non-followed up on.

9 The accreditation process, I think, is the
10 appropriate standard that's been vetted nationally. I
11 think it's a work in progress though. I think something
12 like that is probably you need to look for health
13 departments to be eligible for accreditation say in five
14 years or so.

15 I think it's a target we ought to aim for.
16 There's no accredited health departments right now in
17 Ohio. The State is working towards, several local
18 health departments are close to being accredited, but
19 it's still a work in progress. But I think it is the
20 standard and I think Ohio, it'd behoove us to look
21 forward to accreditation as the standard.

22 I think the idea of consolidation, I think
23 setting a number is probably not appropriate, but like
24 you, I agree, we ought to be encouraging it.

25 I think health departments that aren't able

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1 to reach that accreditation eligibility ought to be
2 encouraged to look at consolidation or look at some
3 cross jurisdictional arrangements, and whether it be
4 informational exchanges, whether it be grant writing,
5 whether it be a governance, whatever it may be, that
6 flexibility ought to be there.

7 The levy issue, we ought to deal with that
8 and have some ability to have some levies across
9 jurisdictions, and then I think the third leg of the
10 issue is you've got accreditation, you've got
11 encouraging cross jurisdictional sharing, including but
12 not exclusive to consolidation, and the third leg is the
13 funding.

14 I think local health departments are sorely
15 funded and the majority of the funding is at the local
16 level.

17 There ought to be some strengthening of that
18 funding and there's been several ways to do that, either
19 through tobacco subsidy or pop subsidy or through health
20 care, whatever it might be, but I think that's another
21 issue that we ought to begin to transfer some of that
22 cost and that revenue to a state mechanism.

23 So I think those are the three issues really
24 facing the committee.

25 COMMISSIONER SHAPIRO: I was gonna agree

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1 with Gene on the accreditation standards as being a
2 point of getting everyone up to that level to be able to
3 do that, and, again, sharing resources as we can.

4 The levy issue is huge, but it also, again,
5 focuses on local funding. So the ability to do cross
6 jurisdictional levies would be helpful, but having a
7 solid basis of some kind of money, whether that be state
8 or leverage in grants that ODH gets to have a different
9 mechanism for distributing those not as categorical as
10 they are now.

11 So, for example, if I want to do dental
12 services and I want to apply for funding from the Ohio
13 Department of Health it'd have to be in a dental grant
14 that meets these specific criteria. I can't use
15 maternal and child health funds, for example, to do
16 that.

17 So figure out ways of funding and
18 distributing that money a little differently might be
19 helpful, I don't know if that's feasible, but --

20 CHAIRMAN BURKE: How does someone tell if
21 one health district is doing a better job than another?

22 COMMISSIONER NIXON: Well, it's subjective
23 now. Local health departments need to say they're doing
24 things and they need to say they're working towards
25 things, but nobody really measures that, you know, in an

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1 effective way.

2 I think -- that's where I think the
3 accreditation standard provides that solid benchmark
4 that we can assess ourselves, not only in Ohio, how we
5 do against each other, but how we do nationally against
6 other health departments in other states.

7 CHAIRMAN BURKE: Yeah, that is a five year
8 accreditation?

9 COMMISSIONER NIXON: No, the five years I
10 would suggest -- it's five years, yeah, you are
11 accredited, you need to reapply after five years, but
12 you are accredited with five years with regular reports
13 submitted during that five years to demonstrate how
14 there's continuous quality improvement during that time.

15 DR. MCFADDEN: I guess it comes to no
16 surprise I'm still leery of accreditation for a host of
17 reasons.

18 And what I'm hearing Gene say is that there
19 needs to be something, other than subjective, us
20 reporting as locals, and I really prefer to look to
21 increase the quality, certainly us as locals just saying
22 that we're doing a good job isn't enough.

23 I'm not sure that it takes, you know, 50.5
24 million or whatever you said it would take to actually
25 pay for accreditation fees for all of us that that is

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1 what we need to do.

2 When the first step it seems we could do is
3 take our current annual report, which is based on the
4 PHAB standards that currently self-report on and
5 manipulate that as a state to something where
6 individuals are seeing that we actually -- I don't think
7 that we have the resources across the state to do that
8 every year, but if PHAB is doing that every five years,
9 seems like that's something.

10 I still -- I still have concerns, when we
11 look across the state, there's some locations across the
12 nation that were targeted to -- you know, some of the
13 early in line to do PHAB accreditation and now
14 struggling saying we're not going to be able to do it
15 for financial, for staffing, for the whole -- looking at
16 other states, not just Ohio.

17 I'm, you know, I have now heard two good
18 things about PHAB and I'm continuing to hold on to those
19 two good things, but I'm not sure that I yet am
20 converted. I might be in the pew, but I'm not yet ready
21 to be baptized, so that's where I'm at.

22 COMMISSIONER WENTZEL: I agree with Dr.
23 McFadden. Do we know of any health departments that
24 have been accredited that shows -- outside of Ohio that
25 have shown a better product to their community; has it

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1 been demonstrated that their community is healthier and
2 better than those that are non-accredited?

3 COMMISSIONER SHAPIRO: There's no one in the
4 nation yet accredited, so until they're -- there are 90
5 in the queue waiting, like Gene's agency is, and I don't
6 think they've set their visit date with you yet, have
7 they?

8 COMMISSIONER NIXON: Huh-uh.

9 COMMISSIONER SHAPIRO: So there's no one in
10 the nation yet. So there were, I think, 40 or 45 at the
11 first training that happened, about 40 to 45 the second
12 training, two counties in Ohio have actually sent all of
13 the documentation to the accreditation board, two
14 counties are loading their documents and ready to hit
15 the send button in the next couple of months, and then
16 they're waiting on the site visit.

17 So no one in the nation is accredited. So
18 we don't have outcome information whatsoever and won't
19 for a number years. You're going to have reports of
20 who's accredited. I'm sure they're going to be sharing
21 information across the system of -- that PHAB has set
22 up, but I don't think we're going to be able to -- the
23 same as when JCAHO started.

24 There was no way to measure outcomes until
25 after you got your initial process, got your

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1 infrastructure up and running, and then showed
2 gradually, as the standards changed and lifted a little
3 bit to try to measure some outcomes.

4 COMMISSIONER EDWARDS: I've said this
5 before, this entire document, all the recommendations
6 are based on this, and right here is Quality Assurance
7 Accreditation.

8 So we're basing something on this pie -- no,
9 not pie in the sky, but it's out there, we don't even
10 have it yet. I've always had a problem with that.

11 CHAIRMAN BURKE: The health department has a
12 reporting process.

13 COMMISSIONER EDWARDS: Right, but it's
14 self-reporting.

15 CHAIRMAN BURKE: So let's talk about this
16 for a minute, I'm going to pick on my friend from the
17 health department as well for a minute. How does the
18 state tell who is a good performing health district and
19 who's not?

20 And how do you, when you as Health
21 Commissioners fill out this form know -- I mean I'm just
22 curious, I've never seen this form, I've not gotten into
23 it. How do you report what your obesity rate is or your
24 TB rate or premature death rate?

25 COMMISSIONER GOON: You don't report any of

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1 that.

2 CHAIRMAN BURKE: So what are we measuring on
3 this form just feel good, subjective, I think I have a
4 great county, I'll send it in form?

5 MR. TREMMEL: Well.

6 DR. MCFADDEN: Well.

7 COMMISSIONER GOON: I can tell you from my
8 experience in completing this, because I know if you
9 look at my score --

10 MR. TREMMEL: Are you okay if we pull up
11 your county?

12 COMMISSIONER GOON: Sure, yeah.

13 MR. TREMMEL: So Henry County, Rory.

14 COMMISSIONER GOON: If you look at our
15 score, it's probably lower than other counties for
16 several reasons. When we went through those standards
17 we looked at the details of the standards, not just what
18 was the overall statement, but what was the detail.

19 So if it had five components, if we couldn't
20 meet all five, we said, no. But there probably were
21 others who might have said -- they might have read the
22 app and said, yeah, we do that, we do that.

23 I mean so it depends on how much -- how much
24 you put into reading it and critically looking at what
25 you're doing would determine how you would score

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1 yourself on some things.

2 That's the benefit of having an outside
3 entity verify that, which is what PHAB would do. So
4 unless the state would verify that, unless an outsider
5 comes in and verifies that you don't have a great way of
6 saying, yeah, they're definitely 73 percent and they're
7 definitely 53 percent.

8 CHAIRMAN BURKE: I'm not -- just one of the
9 things that I look at on a regular basis is County
10 Health Rankings and Roadmaps, and I look at Henry County
11 and your health outcomes, you're 24th out of 88. This
12 lists your premature death rates, morbidity, your health
13 factors, your smoking, your obesity, your drinking,
14 clinical care, socioeconomic factors, all rank you in
15 relationship to the State of Ohio.

16 Where else do I find this data? Are we
17 supposed to use an outside source to find out where
18 you're at? The premature death rate in your county is
19 less than the state, I think that's an important
20 measurement though.

21 When you get into smoking and obesity and
22 other kinds of disease states, I think those are
23 important measurements. You're telling me that you, as
24 a health district, have no ability to report that to the
25 State of Ohio itself?

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1 COMMISSIONER GOON: (Shakes head.)

2 CHAIRMAN BURKE: We have to rely on an
3 outside entity to tell us how we're doing?

4 COMMISSIONER GOON: There's no comprehensive
5 look at that data to report -- for me to report that to
6 the state or for them to report that to me, I mean that
7 would work both ways, but, no.

8 I mean, and maybe that's one of the
9 deficiencies of this entire system, if the state doesn't
10 have particular goals they're trying to meet like
11 obesity or premature birth or whatever then it would be
12 easier for us to fall in line with, okay, here's what
13 our goal is, here's where we are, if we're way off that
14 we're more likely to be able to make a big jump in
15 improvement.

16 If you're a county that's pretty high up
17 there you make smaller incremental changes, but if we
18 all knew and had a specific standard set, okay, your
19 county has to get to this for the state to achieve this,
20 then we might have a place of measuring this all.

21 COMMISSIONER ANTONIO: So my question was
22 when you complete this form, do you use it then as any
23 kind of outcome information and go back and say, now
24 taking a look at this here's where we are; do you do
25 that now?

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1 COMMISSIONER GOON: We do, that fed right
2 into our Strategic Plan.

3 COMMISSIONER ANTONIO: Okay. So in what
4 you're saying though it's kind of self-determined
5 whether or not a health department actually does meet --
6 takes it to the point of we've measured the outcomes,
7 now we're going to set a bar, a goal, and we're going to
8 make some changes to improve.

9 CHAIRMAN BURKE: So I'm just going to throw
10 out this straw poll then just where we are at, work
11 through this, I'll ask the same question many times.
12 Straw poll, then who here thinks it's important to have
13 some kind of standardization in reporting?

14 And then just ask the same question, who
15 here thinks that that exists today?

16 COMMISSIONER NIXON: Could I clarify,
17 because I think the question of accreditation and put on
18 the table about whether PHAB should be the standard or
19 not. I don't think anybody in public health today says
20 that is an appropriate standard.

21 The question is whether you need to go
22 through the application process, and the report itself,
23 the future report was very careful in not saying you
24 have to be accredited, and I think what I'm suggesting
25 is that you be eligible.

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1 The measures that you talk about are part of
2 that process of being eligible that you do a Community
3 Health Assessment, if there's a Community Health
4 Improvement Plan and if the health department has done a
5 Strategic Plan.

6 And I think those begin to give the
7 community measures they need to check the health of the
8 community and to track it. And that simply, those are
9 the pieces that make you eligible to become accredited.

10 Now, the full accreditation process goes way
11 beyond that and I think it's valuable. We've gone
12 through it and I think as an agency we're better for
13 going through it and we'll improve because of it, but I
14 think that eligibility is what we're saying, not that
15 everybody should become accredited.

16 I'd like to say everybody should be
17 accredited, but I think that's premature, but I think
18 those standards are without a doubt pretty much agreed
19 upon by everybody in public health as the appropriate
20 standard.

21 CHAIRMAN BURKE: Does being accredited
22 though improve public health?

23 COMMISSIONER NIXON: I think going through
24 the process, I think becoming eligible, yes, I would say
25 it does. I think the question of the eligibility,

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1 there's a cost associated -- or to become accredited
2 there's a significant cost to that both in time, as well
3 as direct fees to be accredited.

4 I think it's a difficult process that's
5 still being vetted, but, you know, again, it's something
6 that's been agreed upon across the board nationally,
7 and, you know, I don't see how we can ignore those
8 standards.

9 CHAIRMAN BURKE: So if you went down that
10 path then how do you measure accreditation; did it work;
11 it worked because?

12 COMMISSIONER NIXON: Because of those
13 measures that you're doing in the community, you're
14 going a Community Health Assessment, which I don't think
15 everybody does, you're doing a Community Health
16 Improvement Plan, I'd say the majority of health
17 departments are not doing that.

18 And I think the Strategic Plan internally,
19 many do that, probably most do that, but I think in
20 combination with the community partners, as it calls
21 for, then create that baseline within your community,
22 and every community in Ohio is unique, the issues that
23 are going on in Henry County, I'm sure are a lot
24 different than in mine, but nevertheless we have a road
25 map for moving forward within the community, with our

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1 community partners, which, you know, wasn't as robust as
2 it was before the application process.

3 CHAIRMAN BURKE: Jump over here real quick.

4 COMMISSIONER FOUGHT: I was just going to
5 ask then based on what you just said where it's the
6 eligibility to be accredited versus actually being
7 accredited, does that change your position then, because
8 -- you know, versus being accredited and being eligible?

9 DR. MCFADDEN: I think that it does, but if
10 we're looking for how you compare, you know, Holmes to
11 Stark or Summit or Henry to make me eligible to be
12 accredited, you know, what I'm hearing is that unless I
13 go through that process and they say I'm accredited that
14 still we can't be compared, because they'll have the
15 accreditation and we wouldn't, if we didn't go through
16 the process.

17 So I think if we're looking for ways to
18 compare county A to county B, if we use accreditation as
19 that standard just being eligible for it isn't going to
20 still allow us to compare, but I think that -- I'm not
21 in disagreement of us having a standard that we can
22 compare each other to.

23 I just -- I mean some of the questions that
24 you're asking, so if a county goes through the
25 accreditation process today, they have a thriving

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1 economic situation, et cetera, tomorrow -- you know, we
2 were accredited, tomorrow a major employer of, you know,
3 a thousand people closes, the health of the community is
4 impacted.

5 When I go to be reaccredited in five years
6 there is a significant chance that my -- that my -- any
7 of those things that you would want to measure, infant
8 mortality, obesity, smoking rates are going to be worse.

9 Accreditation just helps me to identify what
10 systems I need to have in place to impact the community,
11 but it does -- you know, there are all kinds of things
12 that happen in our community that accreditation isn't
13 going to affect.

14 And so now I'm accredited, and so if you
15 want to say because I'm accredited I should always see
16 my numbers improving, well that's a case where the
17 numbers are not going to improve, and the next time I go
18 to -- and the accreditation board, in my sense, doesn't
19 even care if my infant mortality rate is 7.6 or if it's
20 6.4 in my community, that's not something they care
21 about.

22 What they care about is do I have a method
23 to meet with people in my community; do an assessment in
24 my community; form a plan with my community; and address
25 the problems that we identify. If infant mortality

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1 isn't one of those problems that we, as a community,
2 identify, it's not going to be addressed, and so that's
3 the reason that I say, yes, accreditation, you know,
4 going through the process does build the system that we
5 can, you know, problem solve, but if you're looking at
6 those specific things, you know, I don't know we're
7 going to de facto see infant mortality change or obesity
8 change, I think that there's a very good chance.

9 But Holmes County, if you look at our
10 ranking, it's because, you know, people don't smoke,
11 they walk, they ride bikes, it's the culture of our
12 community that makes us healthy and I could be an awful
13 health district, I could be an excellent health
14 district, my community would still be in the top ten
15 percent. I mean that's just because of who's there.

16 CHAIRMAN BURKE: I want to just go ahead and
17 make a comment, you touched on this a little bit. If
18 accreditation is a five year block of time, the state
19 runs a budget on a two year cycle, and I would like to
20 know if each budget cycle either I'm going to help my
21 best performers or I'm going to turn to hot spots and
22 hit my weak performers, because factory X left and your
23 numbers all of a sudden took a nose-dive, I'd like to
24 know how we allocate resources, if you're going to
25 allocate resources to help that.

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1 I can't do that in a five year block of
2 time. All right. I need to know every two years on an
3 ongoing basis how things are looking.

4 COMMISSIONER EDWARDS: Nancy, didn't you say
5 that no one through the nation has been accredited?

6 COMMISSIONER SHAPIRO: No, it's a new
7 process.

8 COMMISSIONER EDWARDS: Okay. So we don't
9 know. We don't know what this is going to look like for
10 anybody across the nation.

11 COMMISSIONER SHAPIRO: We know that the
12 standards have been thoroughly, thoroughly vetted
13 through the entire nation. All the national
14 associations, locals have had an input, everyone has had
15 input in how to set up the standards.

16 COMMISSIONER EDWARDS: Where is the carrot?
17 The carrot is not out there for the individuals, for me
18 as a property owner, as a resident of Ashland County,
19 because we still have individual choice, and where that
20 there may be some carrot and stick is in the taxation of
21 cigarettes, alcohol, beer, whatever.

22 REPRESENTATIVE WACHTMANN: Beer's a health
23 food.

24 COMMISSIONER SHAPIRO: Ketchup.

25 COMMISSIONER EDWARDS: If you want that you

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1 have to pay for it, your individual choices make a
2 difference, but that doesn't mean that you're going to
3 be healthy or not be healthy.

4 I mean I can be healthy and still drink a
5 lot of pop just because of my make up, and I think it's
6 going to take longer than five years down the road to
7 see the impact, as D.J. is saying, of a company closing
8 or a major catastrophe, that's an ongoing -- that's a
9 longer process.

10 I don't see that accreditation is going to
11 boom right now, we're going to see a difference, it just
12 doesn't make sense to me.

13 REPRESENTATIVE WACHTMANN: Thank you, Mr.
14 Chairman, I guess a couple of things, a question for Kim
15 and Anne.

16 For instance, my perception is Henry County
17 Board, Defiance County has one of the strongest dental
18 clinics in the state, but I don't know that, that's my
19 perception.

20 But, Kim, I mean, do you have data that
21 shows a dramatic climb or decline in your emergency room
22 needs, the cost to hospital, the cost to Medicaid, less
23 use of narcotics, I mean, does that --

24 MS. BORDENKIRCHER: Regarding dental issues,
25 sure.

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1 REPRESENTATIVE WACHTMANN: -- Flow with what
2 Anne has done at the dental clinic? And, again, Mr.
3 Chairman, I don't know whether accreditation is good or
4 bad, but I do know having criteria that's set, which I
5 presume this accreditation has all that information that
6 we can probably pick out of it for reporting purposes
7 and having reporting that matters, that's accurate and
8 means something with the health district is critical.

9 I don't know that we should even promote
10 accreditation, because I'm not sure we need to, there's
11 a lot of cost, there's a lot of things, but then some
12 health departments probably would never put the
13 processes in place unless they would have to become
14 accredited.

15 So it's a quagmire, it's hard to figure out,
16 but in the end we need to come up with or require a set
17 of data that's reportable in an accurate fashion to mean
18 something.

19 And even if you're worse today you should
20 always be improving to be better, and maybe that's just
21 -- I don't care who you are or what you are, you can
22 always be better.

23 And so we shouldn't get hung up on if my
24 county ranks the 88th, the worst health measure by
25 whatever measurement we have, our goal is to make it

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1 better, better health for the county or whatever the
2 health district is.

3 COMMISSIONER FOUGHT: Something was said,
4 and I was just talking to Nancy --

5 COMMISSIONER SCOFIELD: Jennifer Scofield on
6 the phone, could people identify themselves, because I'm
7 having a hard time kind of following the conversation,
8 because obviously I can't place voices with names, so if
9 people wouldn't mind doing that.

10 And I was not able to log in on-line, so I
11 apologize for the interruption.

12 CHAIRMAN BURKE: No problem. Okay.

13 COMMISSIONER SCOFIELD: I don't know who
14 just provided that last comment.

15 REPRESENTATIVE WACHTMANN: Lynn Wachtmann,
16 State Rep.

17 COMMISSIONER SCOFIELD: Oh, okay. Thank
18 you.

19 COMMISSIONER FOUGHT: I was just talking to
20 Nancy as Representative Wachtmann was speaking as well,
21 because something was said in your guy's preparation,
22 where you said you guys are very fortunate, because you
23 share data and that's a great relationship and I asked
24 Nancy if that's common and obviously it isn't common in
25 all of the health districts.

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1 I mean is there some way that -- I mean,
2 what would be the downfall of requiring the hospital to
3 share that data with the health districts?

4 CHAIRMAN BURKE: Well, I don't disagree, but
5 I asked about incentivizing behavior, because, again,
6 you've got places like Franklin County where we're
7 currently at, there's almost a half dozen hospitals that
8 you could ride your bike to from where we're at in one
9 health district.

10 So what's in a small county with 29,000
11 people might be different than a county like this one
12 that has a million. See, I mean I'm not that sure how
13 proscriptive to get.

14 But I would say -- I would say though that
15 maybe that's not our job. Our job is to task them with
16 the ability to achieve whatever outcome we drive, not
17 necessarily how you get there, and that may be a
18 consolidation of hospital and health on certain issues,
19 but I don't want to be that proscriptive, here's what
20 you need to do; here's how we're going to measure it.

21 And I want to go back to what Representative
22 Wachtmann was saying about standardization that Gene
23 kind of brought up.

24 I think two things here, I think goals and
25 measurement, right, what you're going to be doing and

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1 how we're going to measure it, and then how that
2 measurement gets back in some kind of comparable way,
3 and I think I.T. on that, because it's my understanding
4 we have a hundred and twenty-six districts reporting
5 things a hundred and twenty-six ways. Well, I can't
6 make -- a hundred and twenty-five, I'm sorry, somebody
7 combined, Marion combined, I apologize.

8 But I'm just throwing those two things out
9 there that if you're going to move towards
10 standardization what are those goals; how do you measure
11 them; and then how are they reported in a universal
12 format in sort of a subjective form?

13 COMMISSIONER NIXON: There is a mechanism in
14 the report that talks to that. The performance standard
15 report that gets submitted to the Ohio Department of
16 Health can serve the very purpose that you suggest.

17 So we've got the accreditation process,
18 which is a national accreditation board, which measures
19 that, but then there is a performance standard report
20 that goes to the Ohio Department of Health that can talk
21 to some of those standardizations across Ohio between
22 health departments, and that can be, I think, serve that
23 purpose and modified to reflect those uniform standards.

24 VICE-CHAIRMAN PRESS: I want to go back and
25 share a question that sort of set us on this path of

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1 dialogue, which was how would we know a good health
2 department from a not as good a health department?

3 I suppose if we had the technology to take
4 that measurement, the answer to that would be those
5 departments that have the greatest impact on improving
6 underlying health status for the lowest dollar.

7 I mean I think that's where everybody would
8 say, well, people would make the greatest impact for the
9 least investment. So the underlying status, healthy
10 county, made it better, not so healthy county made it
11 better, make an adjustment.

12 The challenge that we have here is we don't
13 have the technology to measure that. So the folks who
14 want accreditation are saying, well, it's an imperfect
15 measure, because it's not a measure of outcomes, but it
16 is a process measure. It is measurable, we can say that
17 is done or it is not done.

18 So the belief structure, I'm guessing, of
19 those who favor accreditation is we think that that
20 process has to be tied to list the most, we believe
21 that, over time we have faith that that improvement in
22 process will yield improvements and outcomes later.

23 But it still remains true that you could be
24 accredited, you could -- I'll pick immunizations as an
25 example, we could get a thousand vials for immunizations

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1 and we could take delivery of all thousand, we could
2 have none of those perish, we could administer a
3 thousand of them, but we didn't really have any impact
4 on influenza outcomes in the county and still had a lot
5 of people sick and hospitalized with the flu.

6 That could happen with or without
7 accreditation, and that's DJ's point. D.J. is saying,
8 well, accreditation, but did I get the flu influenza
9 vaccine to the people or didn't I, and then did that
10 make their health better?

11 So the search for the resolution to kind of
12 try to find the outcomes and the measures, I'm not so
13 sure that both folks aren't right, if we could
14 standardize the reporting then we begin to understand
15 what exactly is it we should be measuring, and in the
16 meantime maybe we have to accept process improvement,
17 process measures in the meantime.

18 And I try not to talk about hospitals, but
19 Joint Commission for the longest time was nothing, but
20 process measurements, did you have policies; did you say
21 you did this; did you say you did that? But they didn't
22 ask us if we gave aspirin on arrival; they didn't ask us
23 if we had pressure sores; they didn't ask us if we were
24 infecting people with nosocomial infections.

25 Now, now, we have the technology to measure

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1 those things. We didn't have that capability 20 years
2 ago. So this just might be a gate we have to go through
3 to get to the other end.

4 All I would say is if we stop at the gate of
5 accreditation we haven't gone far enough, eventually
6 we've got to get to is underlying health status better
7 or not?

8 And obesity is an example, it's not a
9 communicable disease, I don't know what you do with
10 obesity, I mean, as an example, it's just not.

11 And so to hold somebody accountable for
12 something that is not communicable, I don't know where
13 you go with that one.

14 Influenza, on the other hand, you know, we
15 should all be able to sit around the table and say, you
16 know what, if we prevent flu, we prevent costs in the
17 system and we save money and lives doing that, that
18 should be something that everybody can say, yeah, we
19 should be able to do that.

20 So I'm trying to kind of dissect what I
21 think I'm hearing, because today's the first time I
22 understood anything anybody was talking about. It was
23 great to have you guys here, thank you.

24 MR. TREMMEL: So we'll continue to struggle
25 with the conversation back to 1960 that they had. We

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1 continue to struggle with size, composition of local
2 health -- we continue to struggle with size, structure,
3 shape, deliverables, et cetera.

4 Our colleague on the phone, Mr. Ned Baker,
5 that all of the public health folks in the room would
6 know well, Ned Baker with OABH and NALBOH in Bowling
7 Green, Ohio would say the same thing, in '93 they
8 struggled with the same kind of things.

9 The good news is from '60 to '93 to today we
10 have put some things in place, like the performance
11 standards, like the accreditation kind of conversations.

12 What I struggle with on accreditation, and
13 we spend -- it seems to me we spend an inordinate amount
14 of time discussing accreditation, and I think it's a --
15 in some cases folks it's a little bit of a red herring.

16 I'm not saying it needs to be dealt with
17 directly here and now, because there are different kinds
18 of measures.

19 For example, the county health rankings,
20 that is a model between the University of Wisconsin and
21 the Robert Wood Johnson Foundation, it took years of
22 expertise and took years of different data sets at the
23 national level and put together what they thought was a
24 comprehensive measure of the community's health.

25 We can agree with it or disagree with it.

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1 One of the faults of it, for those of you who don't have
2 the kinds of health ranking numbers you would like, one
3 of the faults is it's heavily, heavily blended and
4 dependent on the education of your community and the
5 number of industry and jobs.

6 And if you happen to fall into that
7 Appalachian corridor, your public health system, no
8 matter, and we have some excellent public health
9 systems, no matter, your county health rankings are
10 poor.

11 So that's a real -- for me that's a
12 criticism of that model, that matrix, that assumption,
13 so on first blush you look at it and say, oh, well, this
14 is terrible. It's not a terrible situation, their
15 health departments do remarkably well.

16 Accreditation will get us to a conversation
17 and what we're trying to do in Ohio is -- on this
18 database, and I don't know that Rory's able to click
19 on -- did you try clicking on Henry County?

20 MR. HAMLETT: It's not susceptible.

21 MR. TREMMEL: So you may not have access to
22 it, but in short we do see that there is some progress
23 being made. So you have a listing of counties and
24 there's different progressions along the line as to what
25 they have for the domains of public health and the

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1 deliverables and initiatives, et cetera.

2 The interesting part of this system in Ohio
3 is, we've said this before, maybe the only state in the
4 country that has something like this, but it really is a
5 model of accreditation.

6 We've taken the accreditation standards, the
7 ten essential services, we've taken some of those '60s
8 and '90s considerations and recommendations from Baker
9 and others, from health commissioners, from legislators,
10 blended them into this system, into this reporting
11 system, but the criticisms, like anything else are many.

12 The first fundamental criticism is it's
13 self-reporting. We need to look at a strategy beyond
14 self-reporting. If we leave it alone as self-reporting
15 and say that it's okay, it's well enough, there needs to
16 be two or three other things complimentary to this to
17 drive -- to really drive and drill down into the core
18 public health theories.

19 What is your Health Improvement Plan; have
20 you done a health assessment, what does that look like;
21 what's your Health Improvement Plan; what is your
22 Strategic Plan?

23 Because I would suggest to members of this
24 committee and all around Ohio with all their
25 differences, county by county, obesity is going to be

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1 different, drug and alcohol issues are going to be
2 different, teenage pregnancy is going to be different,
3 infant mortality is going to be different.

4 We must get local health departments to
5 drill down and figure out what those are, figure your
6 unique set of whatever that is about you, make that your
7 strategic plan and drive the system.

8 If it's obesity, we have to be able to find
9 a way to drive your results. You need to find a way to
10 drive your results, and once we get you to a point of
11 driving your results, we have to have some
12 accountability, this is the hard part, which should come
13 with funding, to give to local health departments that
14 isn't there now.

15 The State of Ohio, we have some difficulties
16 in this area, I won't go into the details, but you know
17 what those are. We have strong difficulty in being able
18 to take very categorical grants, genital, prenatal, a
19 little bit of TB funding, some WIC, and we have, as you
20 can imagine, if you were a business and someone gave you
21 money for 4 things, but they said we want you to
22 accomplish 8 or 12, I don't have the parts for that. I
23 can't build it. That is the problem with the public
24 health system.

25 They don't have the parts, they don't have

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1 the components to build whatever this widget needs to
2 looks like.

3 If there were a large block grant of dollars
4 available to the public health system to which you used
5 a tool like this or modified accordingly and said what
6 does your Strategic Plan identify, what are the unique
7 characteristics of your community, and, for example,
8 let's go back to obesity, we're going to give you --
9 through a block granting mechanism of dollars we're
10 going to give you this money and you will move that
11 needle, you must move the needle for your core, if you
12 do not move the needle you lose funding, and then other
13 conversations need to happen about the efficiency and
14 efficacy of your public health system, big, large,
15 small, wouldn't matter.

16 So anyway, that's a long lecture, we go on
17 and on about accreditation, I think we need to put
18 accreditation in a proper perspective, because I think
19 we get there, I just think that's two or three exits
20 down the turnpike.

21 CHAIRMAN BURKE: I just want to build a
22 little bit and reflects, as we move onward with
23 recommendations, they don't have to be overly
24 proscriptive, right, advising the administration and
25 General Assembly that a process of standardization

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1 should be developed and it should reflect these types of
2 standards, that's all you have to say.

3 You don't have to put down what they need to
4 measure, that's going to go through the bureaucratic
5 process and the legislative process and the joint rule
6 review process, that will all get ferreted out, but just
7 think in that sense, and I know Marty rode into the
8 funding, and that's another topic that we're going to
9 get to here.

10 I'm going to transition to the second step,
11 and the three steps that Gene brought up, but I just ask
12 we think in that, don't think too far into the we's,
13 everybody thinks this is something we should do. The
14 process will help us figure it out, just give it a sense
15 of direction where it needs to go.

16 REPRESENTATIVE ANTONIO: So I'm going to
17 just reenforce what you just said, as I was listening,
18 this idea that there's some attachment of the funding
19 that is attached to some on the being able to report in
20 a standardized way in my brain connects incentive in
21 some way, because we've talked about those incentives.

22 For a long time I was a director in a
23 chemical dependency program and when we worked towards
24 being certified at the state level in order to have
25 other pots of money available to us, it forced us into

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1 -- into not only the standardization and some
2 accountability, but also put us on that next level of
3 being able to make those kinds of evaluations leading
4 towards improvement.

5 So to me I am 100 percent convinced that
6 there has to be some sort of standardization. I think
7 -- I'm hearing people say that we don't know for sure
8 about accreditation, where it leads. It's almost like
9 it's too big and too new to say that we would require
10 this of everyone, however, it seems to me that there are
11 steps that some of the health departments are taking
12 already in moving towards this that may have the
13 components to be able to -- of which to be able to get a
14 baseline of that standardization, and, again, it lifts
15 everybody up then.

16 So I think it's something for us to
17 consider. I also really think it's important to at some
18 point have funding, some sort of funds be available to
19 those folks that are making that move up.

20 CHAIRMAN BURKE: I'm going to build
21 hopefully talking points here for folks to reflect on as
22 we work through this process we can continue this
23 dialogue at the next meeting and mature these thoughts.

24 The second thing that Gene brought up, and
25 hope you're in agreement with this second topic here was

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1 consolidation and I would even throw in collaboration
2 and how that looks.

3 We talked about encouraging it, right,
4 incentives, or whatever method that takes; cross
5 jurisdictional sharing, how that looks that we can do;
6 levy issues that need to be resolved.

7 And I'll throw in a couple of other things I
8 heard people talk about, board make up, if that fits
9 into this, and we also talked at one of the first
10 meetings about grant writing centralization for smaller
11 counties, the ability to do something with grants that
12 would lead to some kind of collaboration.

13 I'm just going to throw that out as the
14 second area of interest to see what folks have to say.

15 COMMISSIONER SHAPIRO: I think that the
16 issues of I.T., grant writing, we've talked about H.R.
17 functions, those things -- similar to, and I think when
18 we -- the Beyond Boundaries person was here, we talked
19 about the shared services, similar things to educational
20 service centers having some kind of organization serve
21 in that regard and to help in those processes.

22 Again, they're very, very costly. I.T. is
23 huge, standardization of things is huge, so I think if
24 you put all of those things together it comes to
25 administrative components and having some experts being

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1 able to -- I don't know how that works and how that gets
2 paid for, but having that to be shared would be helpful
3 in some jurisdictions.

4 DR. MCFADDEN: I would think back on that,
5 you know, I would like to see and encourage, as far as,
6 how we work together, so I would think back on some of
7 the things, if there were a mechanism for enhanced
8 funding of health districts, I think there would be a
9 possibility to incentivize that by saying if you have a
10 population -- either proscriptive, you must have a
11 population of this to receive this, or if you have a
12 population of whatever it is, 60,000, you get X dollars
13 per capita, if you have a population of a hundred
14 thousand or more you get X plus 1 per capita, if you
15 have a population of a hundred and fifty you get X plus
16 2, and say to folks you find a way to form arrangements
17 and agreements with other folks to make this happen, you
18 know.

19 Again, you can be proscriptive, you have to
20 collaborate with someone in a formal way in order to
21 come together and be a part of what we're offering, but
22 you can also tier it to say the more that you -- the
23 more that you, you know, leverage the resources that are
24 in your region the more opportunity you have for, you
25 know, those are some things that I think that we can do.

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1 I -- just going back to -- these are the
2 questions that we're -- some of the examples, some of
3 the process type questions that we're asked, you know,
4 do you have evidence of the types of supporting
5 documentation that your participation represents various
6 sectors of the tribunal or local community, and they
7 have regular meetings that their proscripton and
8 process is to identify health issues and assets.

9 Those are the types of questions that we're
10 currently asked, which I don't know how different those
11 are from PHAB, as far as process, but I think that, you
12 know, one of the things that we could do, I mean if
13 we're talking about -- if talking about encouraging
14 people, I think there are some incentives that we can
15 use to get them there.

16 And if the questions really is are we doing
17 Community Health Assessments, are we forming Strategic
18 Community Health Improvement Plans, I mean certainly,
19 Marty, we can encourage the legislature to include that
20 as part of the standards, rather than just to -- and
21 your local report, but that you also submit every X
22 number of years your Community Health Assessment, you
23 also submit your Community Health -- I mean, that's
24 something that could be done in the rule or legislation
25 to get there.

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1 VICE-CHAIRMAN PRESS: D.J., while I
2 appreciate you're interested in incentive, and I agree
3 with that, I guess what I would have to say is when
4 people aren't motivated by the incentive nor motivated
5 by the stick, the system to make delivery, and so what we
6 have is people who won't consolidate, not feeling that
7 there's enough of an incentive for them to go through
8 that process, but frankly not feeling that the hardships
9 of not consolidating are so harsh as to motivate them to
10 do it.

11 So I know that sounds really cold and I
12 don't mean for it to, but we can't solve every problem
13 by putting money in it, and eventually people have to
14 figure with a half a million dollars a year maybe they
15 can spend that half a million dollars better, if they
16 consolidate without additional money to throw in the
17 bucket.

18 DR. MCFADDEN: I guess from being within it,
19 I would say that there is pressure and extremists on
20 some of us, even when we're losing staff, when we're not
21 able to meet the needs of our community.

22 So you're right in that there may be some
23 places that say, we don't care, 16 cents per capita is
24 good enough for us, but there are some of us that feel
25 an acute need that are looking -- as has already been

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1 done in other regions, looking to find ways to make
2 ourselves better.

3 VICE-CHAIRMAN PRESS: And so we're moving
4 impediments to that, it's an incentive of another
5 nature, meaning it's not a monetary incentive, it's an
6 ease of work or a reduction of difficulty incentive. I
7 think if we can do those, that's terrific.

8 COMMISSIONER EDWARDS: I think we may have a
9 little bit of all of that already not to reinvent
10 something, but we kind of have that in the LGIF, in the
11 grant that you're going for, some of those questions and
12 reform it a little bit, but I think we already have that
13 out there so we can utilize that.

14 Our county, I can pretty much tell you that
15 they're not going to be accredited. They're happy with
16 the dollars that they have, I shouldn't say they're
17 happy, they're satisfied at this point with the dollars
18 that they have.

19 The state subsidy isn't nearly enough nor is
20 the township share nearly enough to make up for the
21 amount that they get out of fees and levy dollars,
22 that's the majority, that's over 90 percent of their
23 budget.

24 So they're going to be okay just with what
25 Chris is saying, but I do think the LGIF process is

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1 something that we already have available that could be
2 utilized.

3 REPRESENTATIVE ANTONIO: So I just have a
4 question, for things like immunizations is that
5 purchased at that -- and then in a central location and
6 then everyone, because as we're talking about all of
7 this, and, you know, the cost savings and this and that,
8 flu vaccine, things like that, are those things
9 purchased at the central level, and then the department
10 -- the health department accesses them somehow or is
11 that even something that's possible if it doesn't
12 happen?

13 MR. TREMMEL: I can try to answer some of
14 that. It depends.

15 REPRESENTATIVE ANTONIO: Good answer.

16 MR. TREMMEL: It depends in that the Centers
17 for Disease Control spends billions of dollars for
18 childhood vaccinations to which they provide those
19 through a conduit that the State of Ohio is eligible
20 through the Ohio Department of Health based on
21 population need and otherwise, to which we make those
22 available to local health departments.

23 That is on the cusp of changing right now.
24 The Centers for Disease Control have figured out that
25 vaccinations are given in the probably hundreds of

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1 millions of dollars, and may be larger numbers than
2 that, to children and families who because of previous
3 insurance issues and the Affordable Care Act are
4 eligible for insurance coverage for that vaccine.

5 So hence less the rationale in the priority
6 to provide vaccination for your child who may need to be
7 immunized, let's use that vaccine for this child and
8 family who isn't covered by insurance or otherwise.

9 So that is in a state of transition, the
10 State of Ohio is assisting all of these health
11 departments in that transition over the coming weeks and
12 months to where the public health system, this would be
13 under the challenge of public health systems on another
14 day and another conversation, they will need to develop
15 a network or strategy to figure out how they can bill
16 for, because they're not in the billing business, like
17 our colleagues in the hospitals, they're not billing
18 animals, but they will need to get into the billing
19 business or place, so they offer these vaccines to
20 children or alternatively they'll have to go, local
21 health departments will have to make a business decision
22 to go buy this vaccine somewhere through a broker, put
23 that vaccine in their refrigerator and charge the
24 insurance family for that.

25 The same or -- a different conversation

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1 could be said for flu vaccine. The amount of flu
2 vaccine that the state used to have based on its
3 internal dollars was -- is in a much different and
4 lower, lesser place today than it was.

5 Today flu vaccine at the state level is --
6 there are a number of health departments here who do
7 still receive ODH flu vaccine, but our availability to
8 purchase it is on a precipitous decline.

9 So these folks have figured out through
10 their own brokering arrangements to buy through a vendor
11 a large cache of flu vaccine at the right price and
12 split that cost and dole those doses to each local
13 health department for whatever that dose or congregate.

14 COMMISSIONER SHAPIRO: With the issue of
15 flu, and now with the ability for people, and access is
16 huge and very, very important and something that I think
17 the public health district should encourage, you can go
18 to Kroger, you can go to Walgreens, you can go Meijer to
19 get flu shots, everyone can get flu shots wherever they
20 want to, however, no one knows the coverage.

21 We can't get the data out of Kroger and
22 Walgreens to know whether we're increasing the
23 immunization rate in the state or not.

24 We know we're giving less, which is, okay,
25 but we don't know that people are out there really

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1 getting them, and so it begins, information that is
2 really hurting us and there's surveillance.

3 So when you say are we preventing flu and
4 are we preventing hospitalizations we used to know,
5 because we were the player in town that provided it, but
6 now we can't say that anymore, because you might say I'm
7 going to get it, and then you never go to Kroger, you
8 never go, and we don't know that.

9 REPRESENTATIVE WACHTMANN: Do you know at
10 the other end though how many cases of flu we have in
11 each county? Again, I guess my question, what are the
12 reports available through doctors to who, hospital, et
13 cetera, because outcomes are what matter more than
14 anything, I mean, I think, good outcomes.

15 COMMISSIONER NIXON: Yeah, we do
16 surveillance. We did surveillance in our community with
17 a certain number of doctors report to us, hospitals
18 report to us flu cases or flu like symptoms. We also
19 track in drug stores how much Pepto-Bismol sales and
20 medicine that comes off the shelf that support the flu,
21 so we have some measures, but it's not an exact.

22 REPRESENTATIVE WACHTMANN: But I guess it's
23 hard for me to believe that the number of flu shots we
24 give hasn't increased though, everybody goes to
25 Wal-Mart, K-Mart, or, well, don't go to Kmart anymore,

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1 but Walgreens, anyway almost everybody goes shopping
2 somewhere and the availability and part of the
3 challenge --

4 REPRESENTATIVE ANTONIO: They don't report
5 it?

6 REPRESENTATIVE WACHTMANN: Go ahead.

7 COMMISSIONER INGRAM: I was just going to
8 say, at the end of the day what matters is there's more
9 people being vaccinated, it doesn't matter who's doing
10 it from my perspective.

11 COMMISSIONER SHAPIRO: We don't know.

12 COMMISSIONER INGRAM: Well, yes, we do, in
13 Hamilton County we do and we know that's a complete game
14 changer for us. We're almost out of the influenza
15 vaccination business, because of Kroger and CVS and
16 Walgreens and all the competitors.

17 I mean there's literally thousands of
18 vaccinations being given by these groups and we know
19 that, Nancy, because we've asked them to report the
20 data. We may have the benefit of having Kroger's
21 corporate headquarters in Cincinnati, but nonetheless --

22 COMMISSIONER SHAPIRO: They won't share it
23 with us.

24 COMMISSIONER INGRAM: -- We've called down
25 there, we know that they're giving hundreds of

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1 thousands, and perhaps something the state would be able
2 to do, they could probably get that data for Ohio.

3 The only other thing that I was going to say
4 is that at some point, and this is kind of, you know,
5 haven't said a whole lot today, so I guess now is my
6 time.

7 You know, there is a very important role for
8 local health districts in this state. And we can talk
9 about process until we're blue in the face and until our
10 stomach can't take it anymore, but the truth of the
11 matter is there's two issues here that you expect us,
12 the citizens expect us to do.

13 One is, there's no one else that's going to
14 do this, and that is when we have a communicable disease
15 or infectious disease outbreak it is the local health
16 district that goes out and has that executive authority
17 to chase down those folks who are carrying that disease
18 or that animal or that vet, and we've got a perfect
19 example of West Nile Virus.

20 So what I would ask us is how are we doing
21 in that area? That's the first piece of that. What are
22 the main infectious diseases in Ohio; what are the top
23 three; what group are they in?

24 I can tell you, there's sexually transmitted
25 diseases. Okay. And the question is why; and are they

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1 trending up or are they trending down; and why is there
2 a difference in communities?

3 Well, there's a lot of cultural differences,
4 but the bottom line is we're looking at the health of
5 all Ohioans and we know it takes by community, by
6 community, by community to do that. And if we don't
7 prevent that one case of congenital syphilis and that
8 baby survives, that's a multi-million dollar baby that's
9 going to be in the system for the rest of its entire
10 years.

11 These are the questions I think we should be
12 asking ourselves. I mean how do we get to that end, and
13 the other piece of that equation is, chronic disease,
14 which a lot of us are focused on, and we know that the
15 child being born today, the data's saying that it may
16 not live as long as the parents that created them.
17 There's that -- that data is coming out of CDC.

18 So if you're a white male and you're born
19 today, average life expectancy in Ohio is around 75
20 years of age, if you're a black male you just lost 7
21 years, because of that issue, of the disparities that go
22 with that.

23 If you're a white female you may live to be
24 80 years of age, if you're born today, if you're a black
25 female it's less, and so it goes.

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1 And what I think we should be doing is
2 saying that's unacceptable, as it probably was for
3 somebody in the early 1900s, and say we can do better
4 than that over the next hundred years, and we should try
5 to think about how do we build a system, a health care
6 system, hospital system, and I applaud Henry County, I
7 had no idea they were that far along with their
8 hospital, but that model is really an interesting model
9 that we ought to be trying to engage in, because they're
10 sharing goals on readmissions, because you know why, the
11 largest insurer in the world, Medicaid, Medicare, CMS,
12 is saying we're going to disincentive you, unless you do
13 this, unless you keep these people outside your walls
14 for 30 days or more depending on the disease.

15 That's where I think we've got to come
16 together, because, you know, who's giving these
17 services, and I know it's about access to a certain
18 point depending on the community, I mean every community
19 is a little bit different, but the bottom line is are we
20 getting more people vaccinated; are we preventing more
21 epidemics and infectious diseases; and have we actually
22 started to change the outcome of chronic disease
23 delivery in this country and this state, so that that
24 child being born today in Ohio actually will have a
25 better chance of living longer than the parents that

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1 created it. That's where I want to go.

2 MR. TUCH: Hi, this is Socrates Tuch, and
3 I'm with the Ohio Department of Health's legal
4 department, and throughout my entire career here at ODH
5 one of the things I've dealt with is the laws related to
6 infectious disease.

7 And -- well, Commissioner Ingram is correct
8 in where I think public health is going, the question --
9 and where we maybe need to go, the question I think that
10 was posed, how do we know we're having an affect?

11 And in some ways we never really know if
12 we're having an affect, except to see the people are
13 walking around and surviving whatever the latest disease
14 happens to be.

15 Our information has always been in the past
16 based and our laws are based on a paper system that
17 requires providers to tell us what's going on.

18 What are they seeing walking through the
19 doors, whether is a doctor's office or a hospital, what
20 are you seeing coming through your doors, and then when
21 you tell us we can maybe put it together and try to
22 develop a picture, that's our infectious disease rate,
23 burden of disease.

24 We have always known that that information
25 is under reported. We have a severe gap between what is

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1 told to us and what is actually going on out there.

2 We are now moving into an electronic world
3 where some claim privacy is dead, but we're certainly at
4 a point where data is getting integrated to a stage
5 where maybe we, we being the collective society, need to
6 also integrate. What Henry County may be physically
7 doing is representative of what technologically is
8 happening anyway.

9 When you go to a person based health system
10 or data system where anyone and any provider in the
11 country can pull down a person's health information
12 through what will ultimately be a national interoperable
13 health exchange, what's -- there is no way for a person
14 to go somewhere and not have that information be
15 available.

16 That information then tells us on a scale
17 that we have never previously had access to. Public
18 health needs to get out of knowledge base, we need to
19 get out of the paper system in hoping that people tell
20 us the right things and tell us enough for us to know
21 what is going on.

22 We need to get to a stage where we can
23 actually reach out and see the data for ourselves,
24 that's a capacity issue. And this is where maybe some
25 investment comes in, because public health, we have

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1 enormous legacy systems that are based on this paper
2 system.

3 We are not prepared to move forward into
4 this new world of electronic data, our systems don't
5 have the capacity to reach out like that. We're working
6 on it, but it's a slow process for us. We just don't
7 have the dollars to invest that way.

8 The initial federal investment on this
9 health and commission exchange and this national
10 interoperable system was \$17 billion, the lion share of
11 that went to the private sector, public health saw very
12 little of it. We're now starting to see a little more
13 of it, but it's still not going to be enough.

14 We can get to that knowledge base and we can
15 get to that knowledge, and maybe it's part of that
16 integration that we're all talking about and this is a
17 good model. When people's information is seamless,
18 maybe we need to operate on that basis, maybe we need to
19 operate on that notion and our laws need to catch up
20 with that.

21 So that's my two cents worth, and I'm hoping
22 I'm answering your question about how do we know,
23 because the reality is we've got good guesses, we've got
24 educated guess, but we don't actually know.

25 CHAIRMAN BURKE: I just want to build on

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1 that point well quick then obviously on a hospital base
2 system every hospital has its own system, it reports
3 accordingly, the standardization of EMR, but that aside
4 every hospital has its own.

5 Health departments or local health
6 departments are really a function of the state, but yet
7 we have a hundred and twenty-five operating in a hundred
8 and twenty-five different ways in terms of how they
9 collect data and the software they use to do it.

10 If I were to use the BMV as an example
11 that's not the case at all. They can tell you how many
12 tags are issued that day; how many tractors; how many
13 trailers; how many motorcycles; how many license exams,
14 right? They can even send you a picture of the person.

15 I can't do that in health, so as you look
16 forward, right, as a vision to where that
17 standardization should go is that a BMV style data
18 reporting system or is it a hospital style
19 standardization, EMR, into, you know, yeah, you're using
20 a different software, but it interfaces with what we do.
21 How does that work?

22 MR. TOUCH: Probably the latter rather than
23 the former. DMV works the way it does or BMV works the
24 way it does, because they're the only show in town. You
25 can only get a tag from the BMV or from one of the local

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1 registrars, which are under contract with the BMV.

2 So if we follow that model health would have
3 to be the source, public health would have to be the
4 source of all things, and we're not. As you heard,
5 things are getting confused and decentralized and it's
6 reaching more people, but we've lost the ability to know
7 or measure how impactful those actions are being.

8 Now, to the extent we can build good
9 relationships with the private sector and the private
10 community doing that and Commissioner Ingram gave a good
11 example of it, we've got to have a little bit more
12 knowledge, but it's not systematic, it's not
13 comprehensive, and that's where we need to get to.

14 So we need to be able to, you know, operate
15 with those health providers, with those private systems,
16 with the Epics and the other health data systems that
17 are out there, the electronic health records, we need to
18 be able to interact with them, but we also need to be a
19 little forward and say that we're entitled to see that
20 information.

21 Right now we're entitled to receive the
22 information, does that necessarily translate to our
23 entitlement to see it, to reach out and get it? There
24 are going to be legal scholars who are going to disagree
25 on that back and forth.

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1 I'm not a legal scholar, I'm a practical
2 person, and I deal with practicalities of how the health
3 department and the health system operates on a daily
4 basis, and I have questions, I really wonder about that.

5 CHAIRMAN BURKE: Okay.

6 DR. MCFADDEN: I would say that I do think
7 that this ideal world is fast approaching where we do
8 have access to the information and hopefully we do the
9 changes or submit a list of items that we really feel
10 important public health have access to.

11 But I think short of that we have always
12 been able to take a temperature of our community, and
13 that's what the Community Health Assessments are
14 supposed to be. We're supposed to be asking our
15 community what's going on.

16 One of the pieces of the prospective
17 surveillance survey is have you had the flu shot? So we
18 do have access, and we can form our assessments in
19 whatever manner that we have. We have to encourage them
20 that we think it's important.

21 So short of what I think is going to be true
22 data, you know, you can always say, yes, I exercise, you
23 know, 30 hours a week to your practitioner and getting
24 that record or getting it on our survey, and you might
25 only exercise, you know, whatever, once every three

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1 months, so it's still what they say.

2 We right now rely on people filling out our
3 assessments, and that's why the assessments are so
4 important and why -- and I think when we look at the
5 stumbling blocks, the first steps of PHAB are, have you
6 done an assessment; have you gotten your Strategic
7 Health Improvement Plan?

8 So we do have access to some of that data if
9 we're asking the right questions, and maybe, maybe at
10 the state we start talking about how do we ask the right
11 questions in our communities.

12 That's something that we -- that's what I
13 would share as far as until we get to that point where
14 we have access.

15 CHAIRMAN BURKE: Again, that fits underneath
16 Collaboration and Consolidation. I guess to go on your
17 point here some, when I think about the money that we
18 have to spend with hospitals and in setting up Recs, I
19 believe it was, as far as, you know, to build this
20 network, millions and millions and millions and millions
21 of dollars, certainly more than the state ever pays
22 right now just in raw public health, more or less in
23 data, so that's why I'm not sure if it's a client/server
24 relationship.

25 And, again, this gets into the we's, I

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1 should probably shut up, but, again, the broad stroke of
2 it, having central format of data that allows for
3 integration into the EMR, or whatever that statement may
4 be, I'm not saying that's a statement that we're going
5 to agree on, I'm just throwing that out.

6 While we have Socrates here is there anybody
7 that has any questions real quick on data collection or
8 management?

9 COMMISSIONER INGRAM: You know, just from
10 experience of what I witness going on in the Greater
11 Cincinnati area with chronic health records and looking
12 for inter-collaboration, you know, the dilemma that's
13 starting to develop and we really -- we have an --
14 there's an opportunity still to change it, but down
15 there it's starting to get a little far down the road,
16 because they've already invested hundreds of millions of
17 dollars, but that is you'll never -- you still need a
18 physician, the astute physician or clinician that's in
19 that office that has an obligation under Ohio law to
20 report that communicable disease to a local health
21 authority, that's Ohio law today.

22 There's about a hundred communicable
23 diseases based on the type they are and the severity as
24 how often they have -- how quickly they have to report.

25 The other piece of this is case management,

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1 so let me just pick sexually transmitted diseases,
2 because it is the leading infectious disease in the
3 state.

4 In this state we only fund HIV and syphilis,
5 gonorrhea, chlamydia and all the rest, if the local
6 community can come you with those resources it will get
7 addressed, and you cannot address this just through
8 treatment.

9 That's the first big start, which means you
10 have to have access, it's partner notification, it's
11 case follow-up, and that's where the work's done, that's
12 where the public health workers are like the cops on the
13 street trying to prevent the next crime.

14 The public health workers are on the street
15 trying to prevent that disease from spreading further
16 into the community, and that's where we don't have
17 enough resources, because quite frankly we turn away
18 from those two diseases and they are not going away.

19 So gotta keep it all in perspective, because
20 at the end of the day that's how I know we're getting
21 healthier, because we're getting less infectious
22 diseases, which means there's more opportunity for those
23 childbearing folks to make sure their child has a full
24 opportunity to live a productive life down the road.

25 CHAIRMAN BURKE: I'm going to keep mixing it

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1 up. Who here is happy with the way the health boards
2 are made up? The make up of the health board is a
3 statute, is everybody happy with who sits on them? No
4 changes on that, keep it the same, don't touch it?

5 COMMISSIONER EDWARDS: No.

6 CHAIRMAN BURKE: You're not happy, Kim, why
7 aren't you happy? What's -- what could we do
8 differently if we were going to improve it? What's the
9 problem, No. 1?

10 COMMISSIONER EDWARDS: Well, one thing I
11 think is the situation of who gets to vote on a health
12 board; who appoints that health board? And it's by
13 District Advisory Council by Ohio Revised Code one time
14 a year that that board meets, it's required in March,
15 representative of the township, representative from each
16 village, representative village or mayor, the president
17 of the county commissioners, and those individuals get
18 to vote on who's going to be that health commissioner.

19 I just don't think it's a fair make up of
20 people when you have the -- when you have -- I'll give
21 our example.

22 There's fifteen townships, eight villages,
23 one county commissioner. First of all, it is difficult,
24 and we've had this conversation here at the beginning of
25 these meetings, about getting everyone to the table in

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1 March for that discussion. It can be very difficult to
2 get a quorum, that's one issue.

3 You have -- you have township trustees, but
4 that's really not their big focus, and I am not bashing
5 township trustees one iota.

6 COMMISSIONER FOUGHT: It's all right, go
7 ahead.

8 COMMISSIONER EDWARDS: Not one iota, trust
9 me, because we work very well together, but their --
10 their real focus is more on fire districts, on roads, on
11 culverts, cemeteries, that's where their focus is. It's
12 not necessarily on who's going to serve on the Board of
13 Health.

14 Quite frankly you've got, like I said, if we
15 had even all of them there, those township trustees, if
16 we had them all there, have a pretty high vote compared
17 to the other individuals that may give dollars. I mean
18 it's a -- they have a high vote, but they don't give all
19 the bucks.

20 I think -- I think that there's no
21 accountability, and I know that's been discussed here
22 before and I kind of got thrashed for that, and that's,
23 okay, I'll take that.

24 But I don't think there's any
25 accountability, because those folks all go home after

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1 they vote, and that's quite honestly, it's the last
2 thing on their mind in most townships or in most
3 counties.

4 COMMISSIONER FOUGHT: I just want to address
5 the vote situation, and the reason for that is each
6 township should have a vote just like each village or
7 whatever, however, they want to make that up, because
8 they're putting the money in.

9 However, if you want to use the -- you know,
10 give them a percentage of the vote based on the amount
11 of money that they're putting into a system, that's not
12 what's in play here.

13 It's if you give money you get a vote, and
14 isn't that similar to what we have in the State of Ohio,
15 I mean, if you own property you vote on that property
16 tax. Well, not even that, it's really anybody that
17 wants to vote, but you get my point. You're voting, you
18 get that right.

19 So those townships should have a right.
20 They have no other right to dictate that health board or
21 how that money is disseminated or what it's used for
22 than through that voting process.

23 They don't get to go to the health
24 commissioner and say, you know, this is exactly what I
25 want you to do or we're pulling our funding. They don't

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1 get that right. Instead it's that money is given to the
2 health board, no questions asked, they have to do it, so
3 this is their way of having at least a vote or a voice
4 in the process.

5 So whether it's township, villages, cities,
6 I don't care who it is, you know, everybody that is
7 required to fund that health district should get a say
8 in the process.

9 COMMISSIONER EDWARDS: So what if we weren't
10 required to fund it?

11 COMMISSIONER FOUGHT: That's a whole other
12 topic, and I'd love to have that conversation about
13 funding.

14 CHAIRMAN BURKE: That's Item No. 3.

15 COMMISSIONER FOUGHT: Yeah, and, well, I
16 think that's a fair question, but that's a funding as a
17 whole, and so I think that that's, you know, if we're
18 going to talk about how to fund health districts, and if
19 we're going to change the funding of health districts
20 away from the primary local source of revenue, which it
21 currently is today, then I think it's fair to open that
22 discussion of the appointing of the boards and whatever,
23 but until we change that -- that dominance of local
24 funding for these health boards those local officials
25 should have a say. That's my opinion.

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1 COMMISSIONER EDWARDS: I don't necessarily
2 think that they shouldn't have a say. I think it should
3 be in relationship to the rest of the individuals in the
4 county or in that district, let's say, because, you
5 know, there are different cities.

6 Well, city's are separate, because the mayor
7 appoints everyone on that board, but in county health
8 departments you've got, there again, 15 people making
9 that decision or 15 townships, why not break that up;
10 why do all 15 of those have -- why not the -- why not
11 three people or two people from the township association
12 in that county? I'm just think off the top, so bear
13 with me.

14 COMMISSIONER FOUGHT: Yeah, and in response
15 to that I would say, because each township is required
16 to give money and that -- that would be our rationale.
17 If each township is required to give money then by God
18 each township should have at least a voice in the
19 process.

20 And I'm not just saying townships, again,
21 that could apply to villages, cities, whoever is the
22 make up of that body. So if all townships, all villages
23 and all cities are all a part of that county health
24 district, well, then, fine, let them have their vote.

25 Is it difficult to get some of them there

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1 for the quorum, I won't disagree with that, even D.J.
2 has said that he has issues sometimes.

3 You know, could we have a better way of
4 getting them there, absolutely, but I think as long as
5 the local dollars are being taken from these entities to
6 be used for the public health system they should have
7 some vote or voice in the process.

8 COMMISSIONER EDWARDS: I would still go to
9 the issue of accountability, because there is no
10 accountability at this point with that group that is
11 voting.

12 COMMISSIONER FOUGHT: What's the
13 accountability? What exactly would you want out of them
14 besides putting them on that -- you know, voting those
15 people to serve on the health board; what are you
16 looking for for accountability?

17 COMMISSIONER EDWARDS: What I'm looking for
18 is the ability for those individuals to be educated in
19 health, if -- if that's their responsibility then they
20 should be educated in the process.

21 And, of course, well, one of the things I
22 would go to straight off is we all have the ability to
23 vote, but I would hazard to guess how many are really
24 educated in the process or -- about the issues before
25 the public goes to vote, that doesn't mean they

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1 shouldn't have that right.

2 So I'm going to kind of throw that right out
3 there, so nobody says it, I already know it.

4 But I think there should be some education
5 and I think it should be required more, if they should
6 be there at that table then they should be there more at
7 that table.

8 MR. TREMMEL: Maybe to reference what Kim is
9 saying, as I understand it, board of health members come
10 from a variety of backgrounds based on the appointment
11 system that's in place.

12 One of the criticisms, I'm not saying that
13 these are mine, but one of the criticisms, and there are
14 many, about the system and board membership, some board
15 members come in at a different understanding of the
16 public health system and process than others, and it
17 should be, ought to be incumbent upon the administration
18 of the public health system to get them in a different,
19 better place to recognize all those responsibilities.

20 I think Kim has found in experience of hers,
21 and others around the room, I think Representative
22 Wachtmann, if he were here would have similar kind of
23 feelings, there are times when board members aren't as
24 engaged, aren't as thoughtful, aren't as maybe critical
25 of the system or the administration as maybe they ought

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1 to be.

2 What we have learned in the public health
3 system for its appointed staff, environmental director,
4 director of nursing, the epi folks, health commissioner,
5 et cetera, is it's necessary for them to have required
6 training based on licensure, based on appointments, et
7 cetera, so maybe there's an opportunity, Mr. Chairman,
8 to address some of what Commissioner Edwards is really
9 suggesting here and that is required necessary training
10 of board membership, you do share responsibilities, some
11 folks wouldn't know health assessments from health
12 improvement plans to strategic, but those kinds of
13 things need to probably be discussed to see if there's a
14 strategy or a mechanism to which we can put those in
15 place one way or another.

16 COMMISSIONER EDWARDS: If I may add to that,
17 I think we've already had a study from 1960 and a study
18 from 1993 that shows, that has continually said that
19 that make up should change, and I would continue in that
20 vein.

21 CHAIRMAN BURKE: I've -- we've got a hot
22 topic, I'm going to finish this one up, so we can get to
23 the third one. Did you have a comment, Nancy?

24 COMMISSIONER SHAPIRO: I'm not sure I
25 understand whether you want accountability from the

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1 District Advisory Council or you want accountability
2 from the Board of Health?

3 COMMISSIONER EDWARDS: Both.

4 COMMISSIONER SHAPIRO: And the role of the
5 District Advisory Council, from my understanding, and
6 you guys can correct me if I'm wrong, is to basically --
7 one of the things is to approve the department's budget,
8 and if what they're selecting, what they're asking for
9 for townships and also to appoint board of health
10 members for the general health district, five members,
11 five year terms. In cases of combined health districts
12 you also have city representation, if you're combined.

13 So in the case of my health district, I have
14 five that the District Advisor Council appoints, I have
15 two from the City of Delaware, based on population, and
16 one from the City of Powell, then we also have a
17 District Advisory Committee, so we have a different
18 board make up and the county commissioners have a vote
19 on who's appointed from the DAC.

20 CHAIRMAN BURKE: I'm going to jump to
21 funding next, and, again, I want to try to keep on task
22 and on schedule here, it's almost 3:00. I'm only going
23 to give this topic about five to ten minutes. I know
24 that's a short time, and then we're going to talk about
25 the next meeting and time to go over just some

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1 housekeeping stuff real quick.

2 But the only reason why I think it's an
3 important topic just from a General Assembly standpoint,
4 how can you fund something when you don't know what
5 you're paying for?

6 And we can talk about different ways to do
7 it, I can tell you, and I'm sure Representative Antonio
8 has been down the same path before, trying to reallocate
9 funds is difficult; coming up with a new revenue stream
10 for an allocation is easier. I just draw that
11 distinction, because if I'm going to get my money from
12 that guy, that doesn't work, rarely.

13 Coming up with an innovative idea, we've
14 heard some concepts about how we would do that, I think
15 that's a good thing, how that then is allocated back out
16 is another, top performers, hot spots, right, per capita
17 based on need, block grant, single solution driven.

18 These are the kinds of things, I think, just
19 in terms of funding how you would do that. Just use,
20 for example, one of my passions, cigarillos, right,
21 you're all familiar with cigarillos, right, if you're
22 not well you should be, but that's an example that has
23 come before the General Assembly a couple of times that
24 could generate theoretically \$50 million, wow, you ever
25 seen an ant at a picnic, right, try to figure out how

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1 you're going to do that.

2 Just pretend that's something you wanted to
3 pursue, how would you delegate that; how does that look?
4 And I don't know if it's cigarillos, if it's levies, you
5 brought up some cross jurisdictional things here that
6 would allow for revenue sharing like ADAMH boards do. I
7 think these are important, but I think we need to know
8 what we're paying for before we do anything.

9 So I'm just going to start a funding
10 discussion very broad like that and just see what the
11 response is. I scare everyone?

12 DR. MCFADDEN: I've said it before, I have a
13 hard time having more expected with our dismal central
14 state funding, and so I guess I feel like a lot of this
15 is tied up, and I think some of the discussions that
16 CCAO might bring and townships might bring do come
17 around the issue of funding and I think that I don't
18 know many of us from the local public health world would
19 not say, how we're funded right now is very locally
20 driven.

21 I mean, it's lopsided as far as what the
22 state is providing compared to local, and so I think
23 that -- I can't speak for all, but I would think many do
24 -- would like to be able to have more state funding and
25 perhaps some of the other concerns that local government

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1 might have we can address in a different way.

2 I certainly feel like we're going to have
3 more responsibility being asked from the state as far as
4 meaning -- you know, drive this field this way. I
5 personally feel that it would be good to have, you know,
6 to have that ability to tell us what to do, that needs
7 to be among us. That's my opinion.

8 I think that we certainly do, we owe it to
9 whoever, you know, whoever pays the piper picks the
10 team, and I think if the state is in this game, then
11 certainly we have to meet whatever the state says we
12 have to meet.

13 I mean I have no problem with that, and if
14 the state says that we have to be PHAB, and, oh, by the
15 way we're going to give you more money, that's -- we'll
16 do PHAB, but I do -- I personally would like to see a
17 diverse -- diverse group of funding sources that are
18 consistent with the Commission of Public Health, that's
19 the reason why I do support looking at soda pop, looking
20 at cigarettes, looking at cigarillos, looking at chewing
21 tobacco, things that I think -- you know, tobacco is the
22 No. 1 killer in our state, it's probably the No. 1 cost
23 to the Medicaid system, we're all paying for tobacco, we
24 just don't know it.

25 And so why -- why can't we help to drive

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1 better, you know, health outcomes by having people,
2 young people especially, who can't afford increased
3 taxes, drive the young people from not starting, because
4 now cigarettes or cigarillos cost X.

5 You know, still legal, people can smoke, if
6 they want to, have to pay full share. So I --
7 personally I think there should be local funding, there
8 should be fees, I think that if there's excise taxes
9 that it needs to be diverse, rather than putting all of
10 our eggs in one basket and trying to use what we think
11 public health should look like to try and have a double
12 impact, try to drive people away from unhealthy
13 behaviors.

14 In another five years we're going to have
15 the benefit of the state spending the most per capita on
16 obesity, because we're going to have the most obesity,
17 we're going to have that benefit in a short time.

18 Great, we're No. 1 in something. You know,
19 we need to be able to use every force at our power to
20 drive the state of health care and I think public policy
21 is one of them, taxation could be another way.

22 CHAIRMAN BURKE: And, again, I'm not
23 shortchanging funding, I just think as we work through
24 these issues that funding will probably take a larger
25 portion of the discussion in the next go around.

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1 COMMISSIONER INGRAM: I agree with D.J. on
2 the tobacco question, so I won't say anymore about that,
3 but I do think that it's interesting as Commissioner
4 Edwards and Heidi were talking about assessment dollars
5 and how that's calculated and so forth and how actually
6 antiquated the whole system is based on how it's funded.

7 Now, I'm going to depart, and aside local
8 levies, so this is not talking about local levies, so
9 this would be without local levies coming to the table,
10 so now we're moving to where hospitals are required, in
11 order to maintain their IRS not-for-profit status, to do
12 Community Health Assessments, which is sort of a great
13 example of two systems working together on that.

14 They've got to do a Community Health
15 Improvement Plan in order to get accreditation, which
16 really the two should be driving that together, because
17 they have an obligation to address those health
18 assessment needs.

19 Today the funding from townships and
20 villages and counties and cities is really quite frankly
21 in most cases based on property valuation.

22 It has no rhyme or reason based on where the
23 services are necessarily, regardless of what the
24 community health assessment says, because those
25 townships that have less industrial base or less housing

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1 developments will be paying less money into the health
2 district's general fund versus those that have more jobs
3 and more industrial base.

4 And as we know jobs are a key component as a
5 social determinative health -- of improving health
6 status, so we'll spend, in Hamilton County, more time in
7 those townships and villages and cities who have less
8 property valuation and give us less money for those
9 purposes, because of the fact -- the way it has been
10 crafted originally back in the '50s, I believe is when
11 that law was actually created.

12 So in light of that we're moving to a new
13 era of health care reform and focusing on community need
14 and plugging those gaps and utilizing other resources
15 assistive there, I think it's time to take a look at
16 that.

17 And there's no question on the chronic
18 disease guide, tobacco and sugar are where we're
19 spending a lot of time right now trying to ameliorate
20 the causes of the uses of those types of products. A
21 lot on disease is being created from that.

22 COMMISSIONER EDWARDS: Senator, I just want
23 to ask, add one more thing, honestly.

24 CHAIRMAN BURKE: Five minutes.

25 COMMISSIONER EDWARDS: Less than that, I

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1 promise.

2 CHAIRMAN BURKE: I hope so, it'll be the end
3 of the meeting.

4 COMMISSIONER EDWARDS: When we talk about
5 funding I would like to also keep everyone mindful that
6 county commissioners do have a dollar in this and that's
7 in TB funding. That's required by law and BCMH, and for
8 those general health districts we also have to provide
9 building space and maintenance, and utilities that go
10 along with that.

11 So that is a part of funding that I would
12 really hope to add to that -- to that funding
13 discussion.

14 CHAIRMAN BURKE: I think I just -- funding
15 health I look at it a lot like funding education. The
16 answer is never enough and I need more.

17 So as you look globally to like townships,
18 for example, to talk about Tim's point, look at the
19 results in education, that doesn't make much sense,
20 somewhere along the line I might have to take money from
21 your township and send it to another township in another
22 county, if that's what we're going to call it, health
23 care equality, right.

24 If we're going to look at hot spots and
25 we're going to move the health needle forward as a state

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1 that might mean you only get \$4 of every \$5 that you can
2 give me, or, however, that funding is going to look,
3 right, but it just becomes a very perpetuitous thing
4 where it's never enough and everybody wants to pay their
5 fair share and get their fair share back, and that's --
6 fair is a very nasty word when it comes to those kind of
7 topics, because fair is an I issue, it's not a we issue
8 and that is a -- that's problem.

9 So as we think about different streams I
10 just ask folks to keep that in mind.

11 All right. I've got some great points here
12 that you have brought me -- brought before, I'll
13 summarize these. I will have these expeditiously
14 returned to you via e-mail so that you can discuss them.

15 Don't forget about the survey that you have
16 that highlights some other points that were brought to
17 us here. Again, we're building around these, but I
18 still think it's important to look back at the original
19 mission and vision to which we were tasked.

20 Let's see, a couple of things that I would
21 like to see the health department send us or at least
22 have readily available at our fingertips is a copy of
23 the survey that we looked at.

24 We discussed the standardized reporting, I
25 think it's good for at least us non-health department

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1 people to see what that survey is, what questions were
2 asked.

3 I think, Kim, I know you have a passion
4 about this and some other folks do too, a copy of the
5 code, at least the link to it that summarizes what board
6 structure is, and if we're not talking about board
7 structure I heard somebody else talk about term limits,
8 I don't know if that was to me, whatever, is that an
9 option?

10 I don't know, I'm just throwing things out
11 there, because, again, as we mature on things these are
12 topics that we're going to hash through next time.

13 I asked folks to review the current material
14 that we have, because at the next meeting, I'm just
15 going to throw this out, usually scheduled 1:00 to 3:00,
16 who would be in favor of expanding that meeting time so
17 that we can really get into some difficult stuff?

18 All right. If we were going that way, the
19 maximum amount of time in my mind, correct me if I'm
20 wrong, noon to 4:00. My goal would like to be to have
21 people out of here by 4:00, because the traffic really
22 starts to build at about 4:30 for those that come from
23 outside of 270.

24 COMMISSIONER INGRAM: Would there be any
25 change to move it up?

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1 CHAIRMAN BURKE: We can start at 11:00, this
2 is a consensus of the group.

3 COMMISSIONER INGRAM: Yeah, I was just
4 wondering if we could start earlier than later or go
5 later.

6 COMMISSIONER EDWARDS: I know Ms. Scofield
7 had an issue before, because we had talked about that.
8 Do you have an issue? Somebody else had an issue with
9 an early morning.

10 DR. MCFADDEN: First and third are what I
11 have an issue with.

12 CHAIRMAN BURKE: And, again, we have a
13 cafeteria, and on the phone, I'll throw you folks here
14 on the phone, and I know this doesn't concern you, but
15 we do have a cafeteria out to the side here, we can
16 break for 15, 20 minutes, so folks can get food, we can
17 continue to work and eat, so that's not an issue of
18 convenience.

19 Any folks on the phone have an issue with
20 some of the meeting times we've talked about? Jen, are
21 you okay with like an 11:00 to 4:00, for example, if we
22 were to expand something that long?

23 COMMISSIONER SCOFIELD: No, I'm fine with
24 that, I have standing Tuesday morning meetings, but I
25 can work around that.

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1 COMMISSIONER SHAPIRO: It would be
2 difficult.

3 CHAIRMAN BURKE: Does 11:00 work in general
4 with you folks, if I were to throw out a time period to
5 start by 11:00 and just crank through difficult issues
6 and take straw votes on things that are important,
7 because the way I see us working together is summarizing
8 what's important.

9 Folks, please add to the e-mail that you
10 will get, all right, we'll continue to hash through
11 this, produce sentences and lines and structure, send it
12 back out to you again, meet again, right, make sure
13 we're not missing anything, look at the document in its
14 entirety and that will be actually the final document
15 then that we'll vote on and support as a group. That's
16 how I see this coming forward.

17 So I would like to really devote a lot of
18 time on the next meeting to really hit some key points.
19 Does 11:00 to 4:00, no pitchforks, no torches if I say
20 11:00 to 4:00?

21 All right. Then the next meeting we'll meet
22 at 11:00 in the morning and we'll run till 4:00 or less
23 time, if it works that way. With that being said, if
24 there's no additional business before the committee I
25 will call the committee adjourned. Thank you for your

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1 time and travel again.

2 (Thereupon the meeting was adjourned at 3:15
3 p.m.)

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CERTIFICATE

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I, Teresa L. Mantz, Certified Professional Reporter, and Notary Public in and for the State of Ohio, do certify that the foregoing is a true and correct transcript of the proceedings taken by me in this matter on September 11, 2012, and carefully compared with my original stenographic notes.

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

IN WITNESS WHEREOF, I have hereunto set my hand and official seal of office at Columbus, Ohio, this 20th day of September, 2012.

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

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