

16 Bruce McCoy
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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1 AGENDA

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

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4 CHAIRMAN BURKE: Let's go ahead and call the
5 September 11th Legislative Committee on Public Health
6 Futures to order

24 CHAIRMAN BURKE: So thank you very, very
25 much. With that being said, the next item on the Agenda

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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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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.

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.

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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.

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15 COMMISSIONER GOON:

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.

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.

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.

23 COMMISSIONER GOON

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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.

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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.

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.

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

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7 The second one there is, Passion, and we
8 really hire for passion.

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.

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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.

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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.

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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.

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.

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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.

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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.

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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.

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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, 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?

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.

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2 COMMISSIONER INGRAM:
3 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.

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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?

16 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

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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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17 COMMISSIONER GOON:

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.

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.

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7 REPRESENTATIVE ANTONIO:
9 are you...
13 Accredited,

15 COMMISSIONER GOON: No, we have not.

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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.

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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.

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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20 MR. TREMMEL:

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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.

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.

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18 CHAIRMAN BURKE:

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,
14 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.

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3 CHAIRMAN BURKE:
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.

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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?

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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?

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.

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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?

9 The accreditation process, I think, is the
10 appropriate standard that's been vetted nationally

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.

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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.

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:

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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 --

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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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.

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22 MS. 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 SHAPIRO: So there's no one in
9 the nation yet.
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11 COMMISSIONER EDWARDS: I've said this
12 before, this entire document, all the recommendations
13 are based on this, and right here is Quality Assurance
14 Accreditation.

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

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18 CHAIRMAN BURKE: I'm not -- just one of the
19 things that I look at on a regular basis is County
20 Health Rankings and Roadmaps, and I look at Henry County
21 and your health outcomes, you're 24th out of 88. This
22 lists your premature death rates, morbidity, your health
23 factors, your smoking, your obesity, your drinking,
24 clinical care, socioeconomic factors, all rank you in

15 relationship to the State of Ohio.

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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.

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16 COMMISSIONER NIXON:
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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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.

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.

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.

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9 DR. MCFADDEN:

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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.

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25 COMMISSIONER EDWARDS: If you want that you

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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.

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1 REPRESENTATIVE WACHTMANN:

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.

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24 VICE-CHAIRMAN PRESS

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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.

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21 MR. TREMMEL: 83
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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.

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16 REPRESENTATIVE ANTONIO:

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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.

20 CHAIRMAN BURKE:

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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.

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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.

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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 sytem 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.

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24 COMMISSIONER INGRAM:

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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.

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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

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.

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.

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.

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.

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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.

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2 CHAIRMAN BURKE: 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?

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

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?

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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:

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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.

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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.

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.)