

1 BEFORE THE OHIO DEPARTMENT OF HEALTH

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3 Legislative Committee :
4 of Public Health Futures :
5 October 9, 2012 :

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10 Ohio Department of Health
11 35 East Chestnut Street
12 Basement Training Room A
13 Columbus, Ohio 43215
14 October 9, 2012
15 11:13 a.m.

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1 APPEARANCES

2 - - -

3 MEMBERS PRESENT:

4 Senator David Burke, Chairman
Martin Tremmel, Secretary
5 Kim Edwards
Heidi Fought
6 Tim Ingram
Gene Nixon
7 Dr. D. J. McFadden
Nancy Shapiro
8 Representative Nickie Antonio
Jennifer Wentzel
9 Jennifer Scofield
Anita Scott-Jones

10

Also Present:

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Joseph Mazzola
12 Bruce McCoy
Jessica Crews
13 Kate Philips
Lyndon Jones
14 Beth Bickford
Maggie Greiner
15 Charles Patterson
Aaron Ockerman
16 Jason Orcena

17 Present via audio link:

18 Christopher E. Press, Vice-Chairman
James Watkins
19 Kimberly Moss
Gillian Solem
20 Kristen Hildreth
Karen Butler
21 Krista Wasowski
Anne Goon
22 Jim Adams
Tim Tegge
23 T. Freeman
Terry Allan

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AGENDA

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- 1) Welcome
 - * Chair, Senator David Burke
 - * Vice-Chair, Christopher E. Press
- 2) Approval September 25, 2012 Meeting Summary Notes
- 3) Review Mapping LHD Jurisdictions by Population
- 4) Discuss Draft Recommendations as Discussed September 25
- 5) Review 1993 and 1960 Boards of Health Recommendations
- 6) Discuss and Review of Recommendations:
 - * Capacity, Service and Quality
 - * Jurisdictional Structure
 - * Financing
 - * Implementation
- 6) Next Meeting October 23, 2012

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1 With that being said, we do have and have
2 been given a copy of the September 25th Meeting Summary
3 Notes, everyone should have received a copy of that.

4 Are there any additions or corrections to
5 the September 25th meeting notes?

6 COMMISSIONER NIXON: Move to accept.

7 CHAIRMAN BURKE: We have a motion, and a
8 second, all those in favor signify by saying aye.

9 (Thereupon all Commission Members voted
10 affirmatively.)

11 CHAIRMAN BURKE: Opposed nay.

12 The meeting notes from September 25th are
13 approved.

14 We do have a brief, just a couple minutes, I
15 think Joe has a mapping of local health districts by
16 population to show us. So when you're ready, Joe, feel
17 free to go ahead and we'll do a real quick run through
18 on that, only take a minute here.

19 MR. MAZZOLA: And hopefully folks who have
20 logged on can see this as well. There's been some
21 enhancements, we've shown this website in previous
22 meetings.

23 There have been some enhancements made just
24 recently and the Committee might want to take a look,
25 when you go to this website, which is off of the ODH

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1 home page, go down to the bottom, click on health care
2 provider and suppliers, you'll find this mapping feature
3 and one of the options you have is Local Health
4 Jurisdictions, and before the enhancement was made you
5 could select a local health department jurisdiction to
6 map out where that jurisdiction is on the map.

7 We made some enhancements, and as we looked
8 at health departments that serve different population
9 ranges you can now map all of those, there's four
10 different population ranges.

11 The first being zero to 24,999, the next one
12 being 25 to 50, next one being 50,000 to a hundred
13 thousand, and the last one being a hundred thousand and
14 above.

15 And what this does is, and I'll just select
16 one of them, it'll give you a geographic representation
17 of what that looks like for the State of Ohio in terms
18 of the population and the geographic representation of
19 those different health departments.

20 So, for example, here I've selected those
21 health jurisdictions that have populations between 50
22 and a hundred thousand people, so you can get a sense as
23 to how much of the state that actually covers.

24 So we select that one, we can move from that
25 one to say those who serve less than 25,000, again,

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1 gives you that representation, and then you can zoom in
2 all the way down, you know, literally to the street
3 level, if you'd like, to see where those boundaries are.

4 So you might just want to take a look, and
5 look at the map and get a sense as to what health
6 departments fall in those different categories, and, of
7 course, you can select those individual health
8 departments as well, but that's an enhancement that was
9 just made available last week.

10 CHAIRMAN BURKE: Any questions of Joe or how
11 to use the map, if anyone has any interest in it?
12 Seeing no one, Joe, thank you very much, it's good to
13 have improvement.

14 I know everybody was given a copy of the
15 draft recommendations with discussion points, and then
16 communicated back to us on each one of those
17 recommendations from the September 25th meeting.

18 I don't know if -- my concept was to maybe
19 just briefly work through these up until lunch, and
20 we'll again try to break at about 12:30, 12:45 for lunch
21 while the cafeteria is still open, allow people to get
22 food, a little bit of respite for lack of a better term
23 and try to get back into order by 1:00 at the latest,
24 if possible, and to churn through the rest of the day
25 until 4:00, and work on new items and more macro type

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1 issues.

2 With that being said, I assume everybody has
3 a copy of this document, at least was sent to you
4 electronically.

5 MR. MAZZOLA: Right. I'm sorry.

6 CHAIRMAN BURKE: No, go ahead, Joe.

7 MR. MAZZOLA: The compilation of all the
8 comments have not been sent to the committee, we could
9 do that. We do have it available for everyone to view,
10 and we could also make copies, if you'd like.

11 COMMISSIONER SHAPIRO: I need copies.

12 MR. TREMMEL: Need copies based on --

13 CHAIRMAN BURKE: Is that something we can
14 do?

15 MR. TREMMEL: Yeah, Joe will have pulled it.

16 MR. MAZZOLA: It is available in the live
17 media right now.

18 CHAIRMAN BURKE: We'll stand down for three
19 or four minutes to make some quick copies for folks, we
20 can work through them. So let's go into recess for
21 three to four minutes more or less.

22 (OFF THE RECORD.)

23 (BACK ON THE RECORD.)

24 CHAIRMAN BURKE: Everyone has a copy now of
25 the recommendations. They were the same ones that we

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1 spoke about in the previous meeting and we asked folks
2 for their feedback and this is just a reference
3 document.

4 This is not an official document, it's just
5 a reference document the refresh your memory to what you
6 responded to us, as well as, give you some oversight of
7 how other folks interacted with those same
8 recommendations.

9 So, if we could, just to finalize what we
10 had discussed in the previous meeting, we'll just kind
11 of roll right through these and see how much time it
12 takes to hopefully get this solidified.

13 The first recommendation was on Performance
14 Standards and Accreditation, and we talked about how we
15 would implement a process for engaging independent
16 review of data from a local health district, which would
17 mirror Public Health Accreditation Board standards, and
18 we can take just a moment to glance through folk's
19 thoughts.

20 And, again, this isn't the only time that
21 we'll look at these. These will also go into play as we
22 craft whatever that final document is when we get a
23 chance to review that, but I just wanted to share with
24 you, again, on this first topic, any input that you have
25 as well as what other people have brought back to us.

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1 So give you a moment to digest this, if
2 someone has a strong feeling either way feel free to
3 communicate it.

4 COMMISSIONER INGRAM: Mr. Chairman, just as
5 kind of a point of order, and it doesn't -- I'm okay
6 with it. I don't want to think it sounds like -- I just
7 want to understand the comments on here are from members
8 outside of the appointed group, that's fine for me. I
9 just wanted to make sure that everyone was aware of
10 that.

11 CHAIRMAN BURKE: Yes, and, again, it was an
12 open discussion, but the committee is obviously the one
13 that makes the final recommendation. So as we move into
14 drafting the actual document, of course, it's the
15 committee that's going to be in charge of that, but I
16 just want to give us some oversight into what the
17 feedback was thus far before we move into new soil, so
18 to say here after lunch.

19 COMMISSIONER INGRAM: Okay. Thank you.

20 CHAIRMAN BURKE: The next item, and then we
21 can go back and rehash these issues, had to do with
22 Outcomes and Data, it was the Ohio Department of Health
23 and the local health departments working to identify a
24 standardized process of data collection and
25 identification with the public health indicators.

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1 You can kind of see what the feedback was on
2 that.

3 REPRESENTATIVE WACHTMANN: Mr. Chairman,
4 that phraseology covers a lot of things, but I think
5 having not read through it I think we want to consider
6 putting some pointed criteria in there for the
7 legislature, quality and quantity, that would be two
8 that come to mind and the whole notion of efficiency,
9 comparable data would allow people to measure
10 efficiency, services, quality and quantity.

11 COMMISSIONER NIXON: That may be No. 2,
12 possibly, outcomes and data.

13 REPRESENTATIVE WACHTMANN: That might be
14 another way to say it or it might be addition to the
15 list.

16 CHAIRMAN BURKE: Is that, Representative
17 Wachtmann, again, I have quality, quantity, comparable
18 efficiency; is that specific enough?

19 REPRESENTATIVE WACHTMANN: Well, I think
20 it's additional, I just want to read here. I mean No.
21 2, you're right, Gene, is -- is, I guess, also good.

22 REPRESENTATIVE ANTONIO: It seems to me that
23 this is an area where we haven't gotten down into
24 exactly what is that criteria.

25 I mean what -- and I don't know, I think,

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1 we've also -- while we've talked about the need for some
2 kind of measurement, I don't know that this is a group
3 that would necessarily set what that is, so I'm not sure
4 -- or is it? I --

5 CHAIRMAN BURKE: It's a recommendation. I
6 mean, it can be a should, doesn't have to be a shall.

7 REPRESENTATIVE ANTONIO: A should, but I'm
8 also talking about the detail part of it, the actual
9 what that measurement tool is; what are those
10 parameters; what are the -- is that something that this
11 group -- is that part of our charge as well? It's a
12 question.

13 REPRESENTATIVE WACHTMANN: Mr. Chairman, I
14 guess I agree. I don't want to go into any further
15 detail, it wasn't my expectation anyway for this to go
16 into any further detail than what was here and what I
17 mentioned.

18 REPRESENTATIVE ANTONIO: Okay. That's good.

19 CHAIRMAN BURKE: That's fine, again, we'll
20 get into the weeds as the policy matures.

21 DR. MCFADDEN: I think that what we talked
22 about last time a little bit with potential for there's
23 to be priority identified at the state level from the
24 Ohio Department of Health, and what we measure is what
25 changes, and so by keeping it a little vague I believe

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1 it gives the opportunity to, you know, every two years
2 revisit or every year how -- whatever is determined, but
3 to have those priorities set, because certainly the
4 things that we track are going to be things that we
5 move.

6 So I think that, you know, certainly talk
7 about quality, those sort of things certainly are
8 important, but also give the flexibility to what I think
9 is going to be important.

10 COMMISSIONER NIXON: Mr. Chairman, you know,
11 I think you asked for a vote a couple of meetings ago or
12 maybe last meeting of whether or not we felt that local
13 health departments ought to have a standard, and I think
14 unanimously we agreed the accreditation standard is a
15 standard that's been a vetting process in Ohio, that has
16 basically adopted those same standards in Ohio.

17 I think it is the standard we should adopt
18 and I think we're dancing around whether the PHAB
19 standards ought to be what we aim for.

20 I think we ought to aim for it at some
21 point, whether it's five years out or some point in the
22 future and say very straight forward that local health
23 departments should be eligible for accreditation within
24 five years.

25 I don't think that that's something that we

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1 shouldn't aim for. I think it's appropriate, and
2 frankly the eligibility doesn't cost local health
3 departments.

4 I mean I think once you're eligible, I think
5 you'll find the means to become accredited, but I think
6 to say that we'll have some parallel mechanism for, you
7 know, that will mirror the accreditation is just silly.
8 I think we should aim for accreditation.

9 CHAIRMAN BURKE: Okay. Well, I could just
10 cut to the chase and do a little hand count here, who
11 think we should accredit health departments and who
12 thinks we shouldn't, I'm not asking that question. I'm
13 just saying that would be one way to make that
14 recommendation.

15 REPRESENTATIVE WACHTMANN: Mr. Chairman, I
16 guess a question I would have is I think we ought to
17 either move forward to forced accreditation, but my
18 question, if we don't do that can we also -- can we
19 abide by those accreditation standards without becoming
20 accredited? I mean the standards are there, right, we
21 know what the standards are?

22 COMMISSIONER SHAPIRO: Uh-huh, right.

23 REPRESENTATIVE WACHTMANN: So I'm just leery
24 of forcing accreditation frankly, but as long as we have
25 those standards and we can, you know, one way shape or

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1 form a health department would have to have them in
2 place at some date, even if they're not, I don't know if
3 we're going to get sued if we steal some association's
4 accreditation, I don't know those kinds of answers.

5 CHAIRMAN BURKE: Just for the folks on the
6 phone, they probably don't have a copy of this, we're
7 back to No. 1, Performance Standards and Accreditation
8 that reads, the Ohio Department of Health shall
9 implement a process to engage an independent review team
10 to verify the data reported by local health departments
11 related to the Ohio performance standards, which mirror
12 the Public Health Accreditation Board or PHAB standards.

13 That is No. 1. So two questions I'm
14 hearing, right, one is to mandate it through this
15 recommendation, the other is to mirror it and have some
16 kind of time line engaged in to -- for folks to come
17 into some mirrored compliance, for a lack of a better
18 term.

19 MR. TREMMEL: Sure. Just to re-qualify,
20 again, there is a subcommittee in the state called the
21 Ohio Voluntary Accreditation Team and they've met for
22 the last couple three years or so.

23 The efforts of the OVAT team was to put
24 forth these standards and they have been in discussions
25 with PHAB, that the Ohio standards, the Ohio-ized

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1 version of these PHAB standards are consistent with
2 PHAB, but they're not adverse.

3 The accrediting board is not taking umbrage
4 that Ohio's efforts are clear in mirroring that.

5 Currently the standards are self-reported,
6 we've talked about this. Joe has shown them on a number
7 of occasions and we can pull them up for you again.

8 So the qualifier of all of this is, I think,
9 back to the Representative's question, and Mr. Nixon's
10 question as well, Commissioner Nixon, that is should
11 they be mandated or should we be otherwise qualified to
12 roll out an accreditation timeline, x-number of years to
13 which you would follow those standards as a mirror of
14 PHAB, which you would over a given period of months or
15 years find yourself at this point to be accredited.

16 So I think those are the two issues, just to
17 qualify, if we're getting a little disconnected as to
18 what this particular is.

19 COMMISSIONER SHAPIRO: My question is the
20 verification issue. So to be eligible for accreditation
21 you're sending things off, which we just did to PHAB to
22 apply, they come back and say either you have enough or
23 you don't have enough or what you need to do.

24 If -- right now the Ohio system, which we do
25 every two years in compliance with the standards, is

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1 that we do a little self-check and say we're in
2 compliance.

3 So to me, doing that, with some verification
4 or having PHAB accreditation, which would then mean that
5 you don't need, you've already been verified, would take
6 care of the issue.

7 So I think there's a couple of things. One
8 is have a timeline for meeting those standards in
9 totality, and, two, setting up, because there are going
10 to be departments that cannot, or for one reason or
11 another afford, unless there's money supplied to help
12 them pay for that to have some kind of system where you
13 can verify accountability to meet the standards or they
14 are going for PHAB accreditation, that -- to me that's
15 -- is that --

16 REPRESENTATIVE ANTONIO: And so, you know,
17 one of the questions that I think this -- this committee
18 has overarching in all the discussions is whether or not
19 there are some departments that may need to figure out
20 Plan C.

21 COMMISSIONER SHAPIRO: Right, have a meets.

22 REPRESENTATIVE ANTONIO: And to me having
23 worked with organizations that have needed to ask those
24 tough questions and say maybe this is the time for us to
25 consolidate or elaborate.

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1 It seems to me like the process moving
2 forward towards this of being can we meet those criteria
3 or not would help determine who's going to be able to be
4 there for the long haul and who may need to partner;
5 does that make sense?

6 DR. MCFADDEN: I think certainly if -- if
7 the group that had put this document together were able
8 to find consensus among all the health districts that
9 the PHAB standards are clearly the standards for the
10 United States they would have said everyone should be
11 accredited with PHAB.

12 And so I guess I feel like this is a second
13 -- our committee is sort of round two of that
14 discussion, and round three will probably be the
15 legislature as to whether or not we should require
16 everyone to be PHAB accredited.

17 To my knowledge we would be the first state
18 to require PHAB accreditation. While other states do
19 have accreditation processes with their state, I don't
20 know if they've had PHAB accreditation.

21 It's also reading between the lines of some
22 of the stuff that's come up in medicine. I get a little
23 concerned there may be some that feel like, as a
24 country, we're still a little premature with the
25 requiring of these standards, and so I -- while Ohio's

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1 -- what we have in Ohio mirrored the PHAB standards I
2 have a little bit more -- I guess, I'm a little bit more
3 comfortable with the local sort of situation where --
4 and having us reporting and having peers come and
5 verify. I have a little bit -- I feel a little less
6 umbrage with that process than requiring that we follow
7 a federal, and say the expense that goes with that.

8 So for me those are some of the concerns
9 that I have about this process, and I would not be
10 adverse to putting it to a vote here, but I think that
11 -- understanding that this is round two.

12 I mean, this is -- I believe that they would
13 have put it clearly that everyone should be accredited
14 if they could have found consensus with that.

15 VICE-CHAIRMAN PRESS: Good morning everyone,
16 I'm sorry I'm unable to be present in Columbus today.

17 I'm trying to listen to the discussion, I'm
18 sure I'm missing a syllable here or there, feels like to
19 me we have four tiers here of sort of regulatory
20 changes.

21 One would be that the health departments
22 should be eligible, and that seems to me to be the
23 lowest level of a requirement, because above that it
24 would be, shall be eligible, which it doesn't say you
25 would be accredited, it says you shall be or should be

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1 accredited.

2 So you wouldn't have to pay the accreditor
3 any fees, you wouldn't have to necessarily file
4 conforming documentation with the accreditor, you would
5 just have to meet on the paper the standards and
6 demonstrate some level of eligibility.

7 Above that there are two other levels. One
8 would -- should be accredited, which, again, is
9 recommendation, not prescription. You don't have to
10 meet that standard, because it's a should be standard,
11 and then the highest one is you shall be accredited.

12 So I guess the concern I'm having as I
13 listen to this is the reluctance to accept the lowest
14 level of this requirement, and as Mr. Nixon has kind of
15 expressed, if I've heard him right, if the lowest level
16 is you should be eligible, so you can say, I don't want
17 to be eligible, you said I should be, but I don't want
18 to be, then you don't have to be, so it doesn't matter,
19 and others who think they want to advance to
20 accreditation can do so, and others who want to advance
21 to eligibility can do so or you can stand down and skip
22 the whole thing.

23 REPRESENTATIVE WACHTMANN: Well, I for one
24 didn't come here to do nothing, which is what you
25 proposed, and, you know, you can't manage unless you

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1 have good data to manage and if we're wanting to, on a
2 statewide basis, which is why I'm here, to be able to
3 manage better, to improve public health, then you need
4 good data.

5 And, again, restate, because maybe I was all
6 fumbling earlier, I do not want to force anyone to be
7 into the federal qualified certification, but they need
8 to have a look alike program in place at a certain point
9 so that we have statewide standards that are measurable
10 by health districts and that serves a lot of good
11 purposes.

12 For instance, in my business, one of my
13 businesses, I belong to a 20 group. We have 20 of us
14 business owners. We're all similar businesses, we
15 compare data on a quarterly basis of cost of doing
16 business and things like that, profit center, it's
17 extremely helpful to help you know where you're at with
18 the rest of the world, that's just one for instance.

19 But, again, if we want to improve public
20 health coming out of this working group I think we need
21 to be pretty clear that we expect all health districts
22 to be able to give out information and data that is
23 consistent health district by health district that we
24 can all measure by and feel confident that it is good
25 data.

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1 And if a small health district can't get
2 there then maybe two or three small health districts
3 need to go together to get there.

4 I mean this really is to me, Mr. Chairman,
5 kind of a fundamental question that we've always kind of
6 skirted around, you know, what do we do with people who
7 for whatever reason can't get wherever we want them to
8 go, and so if we are going to give on this issue we're
9 -- we're really not going to, in my opinion, move very
10 far ahead.

11 CHAIRMAN BURKE: Let me just reiterate here
12 real quick, we've got two recommendations we're kind of
13 merging into one, but I myself kind of feel they need to
14 be slightly separate.

15 The first is Performance Standard and
16 Accreditation, which we're actually going to
17 universalize the measures; the second, Outcomes and
18 Data, which is how we're actually going to measure it.
19 So what we're measuring and how we're going to measure
20 it.

21 So if I could, if it's comfortable with the
22 committee to kind of keep those separate, I do think
23 that's important not to blend these two things, if I
24 could ask that, which leads me back to our first
25 performance standard recommendation that currently

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1 reads, the Ohio Department of Health should implement a
2 process, just those starting words, if I'm hearing this
3 correctly, we should change that to Ohio Department of
4 Health shall implement a process, that is an option, if
5 that is your will.

6 We can discuss what that process means
7 momentarily, but is the group comfortable changing,
8 we'll re-read the whole thing, and then build this
9 statement, but are we comfortable changing that should
10 to shall?

11 All right. And then I continue to build
12 this statement, this isn't trapping anybody into
13 anything here.

14 So going to implement a process to engage
15 independent review teams to verify the data reported by
16 local health districts related to the Ohio Performance
17 Standard, now this is what we're going to measure it in,
18 which mirror the public health accreditation or its
19 standards.

20 So we're going to mirror PHAB in our
21 measure.

22 COMMISSIONER NIXON: Well, I would say that
23 this exists already. We're not changing anything beyond
24 the status quo, so I think that by -- talking about the
25 independent review team as the difference that is going

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1 to take a number of years to set up, we've tried that in
2 the past, we had peer review, that did not work very
3 well as far as I'm concerned, and so if we're talking in
4 the future, talking five years out, the health
5 departments will be eligible, then we have five years to
6 help health departments, facilitate them in building the
7 capacity and learning what the ropes are.

8 There's a number of health departments that
9 are applying, that capacity is being built faster than
10 we would imagine, the number of health departments that
11 are applying for accreditation right now, and I think
12 over the next five years you're going to see all health
13 departments become eligible for accreditation.

14 So looking forward, looking to the future,
15 we ought to say in five years health departments will be
16 eligible for accreditation, period, and then in the
17 meantime we spend five years working to get everybody up
18 to speed, if we build a verification process I think
19 we're just creating a machine that is unnecessary and
20 doesn't really built that capacity.

21 CHAIRMAN BURKE: So for those then to build
22 on Gene's point then, I would replace the word, mirror,
23 with the word, meet.

24 COMMISSIONER NIXON: Uh-huh.

25 CHAIRMAN BURKE: And then next we would have

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1 a timeline, Mr. Tremmel.

2 MR. TREMMEL: So here's where things get a
3 little disconnected. The standards can be met, if we
4 put some definition or some great angst to what meeting
5 means.

6 Joe, pull one up for me quickly. We won't
7 digress, but just a moment. If someone's in the 60th
8 percentile is that going to be acceptable or is 70 or
9 the 90th or 95th?

10 This will be the difficulty, and, again,
11 it's a self-reporting mechanism, so to both the Nixon
12 comment and Representative Wachtmann's comment, I'm not
13 sure just how we get there, if we're purposeful about
14 being specific and deliberate, because I'm all for the
15 recommendations, but I wouldn't want folks to leave that
16 are members of the public health system, the local
17 public health system leave the conversation.

18 I don't know what you mean, so I would like
19 a little bit more clarity. Would it be possible that we
20 can agree upon a number and maybe this is not for this
21 committee, but whatever that number ought to be or
22 status ought to be, there's X-number of indicators that
23 if you have an overall score of 70, or if you have
24 overall domain totalling up of whatever, if not, that's
25 fine.

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1 Alternatively, back to Commissioner Nixon's
2 comment, if it's five years, do you want to do this on a
3 rolling basis, so maybe the larger health departments
4 roll out in three to four years, the medium size health
5 departments, according to Joe's earlier venue of the
6 health departments that fall less than a hundred
7 thousand, 25 to a hundred thousand, 99,999, maybe those
8 roll out year four and five, and then the smallest of
9 the health districts below 25,000 roll out years five
10 and six.

11 Then alternatively, and I know I'm throwing
12 out a handful of issues on the table, but I'm just
13 struggling with how much specificity you want. I just
14 know what I think the expectations or the questions will
15 be and the responses from 125 health departments.

16 Do we feel comfortable with the limited
17 funds we have, and they are very limited, \$2.3 million
18 currently in the GRF of state subsidy; are we
19 comfortable reframing some of that 100,000, 150,000,
20 200,000, some such number, but are we comfortable taking
21 some amount of those dollars and putting that forward
22 for pilot projects, first for the large ones, roll out
23 20,000, 30,000, I don't know, but every year roll out
24 that subset of money to give folks, large ones, but
25 probably with some clauses in there that if you're going

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1 to roll out and be accredited you need to mentor someone
2 else within your subset, region, whatever, and go to the
3 next tier, middle and go to the smaller tier, the small
4 one.

5 So I've tossed out a lot of ideas, but I
6 just struggle with some specificity and guidance that we
7 can provide and offer to get this to where we'd like it
8 to be, instead of meeting again in some number of years
9 wondering what happened and why reports are
10 inconsistent.

11 REPRESENTATIVE WACHTMANN: I don't know why
12 we want to dictate which side does things first and
13 last. I think -- I don't know that the bigger are
14 always better than the smaller, I don't know. I have no
15 clue, because I don't have good data to base any of that
16 on so I would say I don't think we need to speak to
17 that.

18 Personally, I think you let the health
19 departments work it out. If there's small ones who are
20 most aggressive, want to make things happen sooner, let
21 them, you know, find a way to do that, some big ones
22 that want to do it sooner let them do it and first come
23 first serve on the money, which is pretty typical.

24 I mean if the health departments say you
25 need guidelines on that money, but I don't know that we

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1 should stymie the marketplace out there with health
2 departments with any time frame based on size or
3 anything else.

4 COMMISSIONER SCOFIELD: Good morning. I
5 would agree. I say we kind of put it at five years and
6 then they can roll -- local health departments can roll
7 out as it works for them, and perhaps some of the money
8 that is available, I know we talked about it before, ODH
9 kind of organizes some technical assistance or the
10 mentoring between those who have gone through the
11 process and are ready and have done it can help others
12 kind of build that capacity to lay out the work that
13 they need to do to meet the standards.

14 But I say just cap that five, let people do
15 what they need to do within that five years, and then,
16 you know, figure out, I suppose, what any consequence
17 might be if you can't do.

18 I know that's addressed in perhaps some of
19 the other areas, but just make it, you know, quick and
20 dirty, and make it clean in that regard.

21 COMMISSIONER EDWARDS: I do have a question
22 though. Martin, when you said, to meet the standards, I
23 think we do need to get in our heads what meeting the
24 standards mean; is that 50 percent; is that 60; is that
25 90? Because if you've got a small district and you have

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1 to meet 90 percent, you know, sometimes in certain areas
2 there's no way you're ever going to do it.

3 I mean I look at that, I see that all the
4 time in our JFS, with meeting the two income households.
5 We just -- one person goes out, we're never going to
6 meet that when we have to meet the 90 percent, that's
7 the concern.

8 MR. TREMMEL: Mr. Chairman, I just
9 struggling with if what we're saying is that you would
10 meet the standards, self-reported, that are voluntary
11 until whatever this language is or if what the committee
12 intends to see is within five years you will go through
13 the actual PHAB accreditation process and become
14 accredited. I don't know, I'm still disconnected from
15 what it is you're saying.

16 COMMISSIONER WENTZEL: Maybe Gene or Marty
17 or Nancy could answer this question, when you go through
18 the PHAB accreditation process do you have to meet each
19 criteria one hundred percent to become accredited or do
20 they give you some --

21 COMMISSIONER SHAPIRO: No one knows yet.

22 COMMISSIONER NIXON: I think it's -- it's --
23 the intent is some continuous quality improvement. So
24 you provide all the documents, and then those are looked
25 at as long as the date's right and so forth, and then

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1 they come out and visit and assess those.

2 And I think there are identified weaknesses
3 and strengths in the health department that are reported
4 back, again, you're right, we haven't been through that,
5 we're scheduled for a visit to have that done, but I
6 think to identify those strengths and weaknesses and
7 throughout the five years that you're accredited then
8 you report back on a yearly basis how you're doing in
9 those areas where, I assume, were your identified
10 weaknesses.

11 I don't think anybody is assumed to be a
12 hundred percent, you know, everybody gets a -- unless
13 you get a hundred on the report card you failed. So I
14 think there is some lead-way in there, but exactly how
15 that's assessed and measured is yet to be determined.

16 But we're all headed for accreditation, and
17 I think to deny that is -- is -- ignores the fact that
18 this is coming down the pike and I think what our job
19 should be is to prepare everybody for the process, get
20 them the skills, get them the knowledge and understand
21 the process.

22 And I think Marty talked to that a little
23 bit, how we can provide some money and provide some
24 mentoring as part of the availability of the dollars,
25 and I think that's beginning to hit on what that will

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1 look like.

2 REPRESENTATIVE ANTONIO: So then anyone's
3 free to answer this question, my understanding is that
4 one of the things we're really looking for, in addition
5 to the data collection, is having some common set
6 benchmark, criteria, you know, to go forward, so is that
7 accomplished through the accreditation or does the
8 accreditation create the framework for that to be
9 possible?

10 COMMISSIONER NIXON: I'm not sure I
11 completely understand.

12 REPRESENTATIVE ANTONIO: So the
13 accreditation process requires certain --

14 COMMISSIONER NIXON: -- Documents --

15 REPRESENTATIVE ANTONIO: -- Documentation
16 from the organization, from the department. Does --
17 does that in itself give the data that is missing right
18 now and the common language?

19 Because right now what I'm hearing is a lot
20 of self-reporting, and it's just out there, the
21 information is there, but how does this accreditation
22 process also get us to that common language, common data
23 available to be able to say then how are we doing.

24 COMMISSIONER NIXON: I'd say -- okay. As I
25 interpret them, as I see it, part of -- one of the

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1 documents that's required before you even apply is the
2 Community Health Assessment, which is a data collection
3 process that takes a look at the bottom, you know, all
4 of the immunization through social issues in their
5 community and develop some strategic plan, and it
6 develops a Community Health Improvement Plan, and so
7 forth, and that's all based on the Community Health
8 Assessment, and right now that's an independent process
9 that's developed at the local health department level.

10 Now, the opportunity does exist, and it's
11 basic where you're all working for the same set of data,
12 okay, we're interpreting it differently, but I think
13 that holds the opportunity for what you said, is to
14 begin to develop a common set of data indicators that
15 can be used throughout the state to measure the sort of
16 things that Representative Wachtmann talked about, but
17 at the Community Health Assessment everybody has to do
18 that under the accreditation process.

19 COMMISSIONER SCOTT-JONES: I think the
20 quandary in -- perhaps Commissioner Nixon just answered
21 it, but I didn't quite see the purpose of this
22 recommendation if we're not moving towards
23 accreditation, because, again, it just seems like a mute
24 point to have this recommendation and there's no goal
25 with which to reach, because it doesn't make sense.

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1 Am -- am I on the right track, because what
2 are the ramifications for not meeting the standard?

3 When I look at Recommendation No. 2 and
4 Representative Wachtmann talks about the data set, I
5 mean, that's what it leads back to with the same
6 recommendation as No. 1.

7 It talks about data collection, and then the
8 standardization of data, but if you don't have that and
9 you implement this recommendation, okay, then what are
10 the ramifications if none of them meet those standards,
11 if it's not going to lead towards accreditation and Ohio
12 is not accredited?

13 COMMISSIONER NIXON: Working on it.

14 COMMISSIONER SCOTT-JONES: That's what we're
15 working on, but it also would open up doors for other
16 avenues, for federal funding and everything else, am I
17 right?

18 MR. TREMMEL: Correct.

19 COMMISSIONER SCOTT-JONES: Just doesn't make
20 sense if that recommendation is there, but it's not
21 leading towards something more sustainable, something
22 more concrete, it doesn't make sense why it's there.

23 CHAIRMAN BURKE: If I can answer just from
24 perspective, I think that's exactly the answer. I can't
25 tell you if 125 health districts is too high or too low,

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1 is a hundred thousand the magic number, if 25 is too
2 little until you have some comparables.

3 And this allows the standardization of
4 comparables to make a fact based decision on where
5 health is best being delivered or not delivered, at
6 which time somebody else can come back and say these are
7 the changes that we need to make. The system isn't even
8 really comparable.

9 COMMISSIONER FOUGHT: And I agree that there
10 should be some standards, and I'm not opposed to using
11 the PHAB standards, my only concern is forcing health
12 districts that don't have the money.

13 If the Department of Health doesn't have
14 enough money today to help the health departments,
15 right, isn't it 17 cents per person, correct, okay, so
16 for -- to have that little amount of money today, yet --
17 and I think the fee is 2.5 million, is that fee to
18 apply; what's the fee to apply?

19 For all of you currently it's 2.5 million,
20 state-wide, though, correct, 2.5 million for everyone to
21 apply, but the state only has 2.3 million is what you
22 just said, where are all of these local health
23 departments going to get that money?

24 And I understand, bigger, sometimes you
25 might have the money, but even if you're forcing -- if

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1 you go back to the map and you force, you know, a couple
2 of jurisdictions to go together for a hundred thousand
3 people, there's no guarantee those hundred thousand
4 people are going to pass levies to pay for fees to get
5 accredited.

6 So, I mean, having the standard or having
7 them to have the ability to meet the standard is great,
8 but forcing them to pay to actually get accredited,
9 that's what I have a problem with, unless we're going to
10 find money to give them to get that accreditation, and
11 where the money?

12 That's a whole other discussion, I know, but
13 where are we going to get that money to pay for some of
14 these districts that can't afford to do that and yet
15 even if you force them to combine they probably still
16 wouldn't be able to get the money.

17 So I just -- we have to realize that we're
18 talking about multiple things, data, we've got to have
19 data, everyone there is standard, right.

20 Yet we have to have standards that everyone
21 meets, but don't we also need funding. I mean these are
22 all tying together, and can't -- unfortunately we can't
23 separate them out anymore. We have to have the
24 discussion, where is the money going to come from to
25 help those districts that can't pay for it.

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1 REPRESENTATIVE WACHTMANN: Look, again,
2 forgive me, but I come from the private sector where my
3 company has had to adapt to new rules. You know what,
4 the managers had to work more hours and I've got no
5 empathy for people who complain about I always need more
6 money to accomplish a new goal.

7 If people are going to be in the public
8 health business, and if they can't get it done in their
9 own county then they better find a way to do it. I mean
10 it's as simple as that.

11 This discussion about we can't do it,
12 because we don't have more money, it should not be part
13 of the discussion in my opinion from my perspective,
14 because they have to find a way to do it.

15 I mean, again, maybe my area, three or four
16 rural health districts, one of the people will take this
17 project on for the four districts, one of them will take
18 this project on, and you know what, if they have to work
19 an extra 200 hours next year I've got no problem with
20 that.

21 I mean that's my background, that's where I
22 come from, and I'm sick of government people saying I
23 can't do it unless you give me a new source of funding,
24 because the last time I checked we're not going to raise
25 taxes in the State of Ohio.

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1 And so if we're going to let this continued
2 threat of, we need more money stop this progress, then
3 I'm not sure what purpose we're here for, because with
4 the limited resources and people have to make it happen.

5 CHAIRMAN BURKE: I'll just build on
6 Representative Wachtmann's point. If you're going to
7 set a bar and everybody's going to meet that bar, why
8 are we even setting the bar.

9 I think if you're going to determine if 125
10 is the magic number for health districts, if a hundred
11 thousand's the right size, 25 is too small, we are going
12 to have to have some kind of vetting process, and I
13 would say that the inability to participate in the
14 process itself calls into question the ability to
15 actually deliver quality public health when we talk
16 about chronic disease, state management or new ventures
17 in partnering with entities, whether they're private or
18 public in delivering that public health.

19 So I would say that this bar to me sounds
20 like a reasonable request to determine, if you can, No.
21 1, even accommodate the standards, more or less meet
22 them.

23 Because I would say if you can't even
24 accommodate the ability to participate that you're
25 probably not going to meet them either, which calls in

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1 liability, the question was exactly the point that we're
2 trying to discuss.

3 Are there punitive actions in this
4 recommendation, no, but what to do with those outcomes
5 will be the topic of another committee at another time,
6 but, again, Heidi, I'm not being abrasive, I'm just
7 saying that is exactly what folks need to know when they
8 make a decision.

9 DR. MCFADDEN: I wish that Representative
10 Wachtmann were here, but I struggle with comparison to
11 the private, because so when I'm a physician with the
12 community and I have something that I have to address,
13 you know, my staff works overtime, and I raise my fees,
14 you know, I work harder, I see more people, I admit more
15 people or raise my fees. My output generates more
16 money.

17 I don't know how, in my district, to
18 generate more money when my cost methodologies for my
19 environmental health are set for those specific
20 programs.

21 So I tell all of my staff we're going to
22 work towards accreditation, here's the things you do, my
23 environmental staff are helping, but they're not
24 providing direct -- they're not inspecting restaurants,
25 they're not evaluating our parks. I can't include that

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1 in that cost methodology, so I can't raise those fees.

2 My birth certificate fees, is it fair for me
3 to raise my birth certificate fees, you know, more,
4 because I'm going through accreditation; is that fair?

5 You know when I'm in business I make more
6 widgets, I sell more widgets, I invest in advertising,
7 so I can get my product out there, so I can sell more,
8 so I can make more money.

9 When I'm in public health I inspect the
10 school for free; I get rid of that trash pile for free;
11 I go and investigate that complaint that their
12 neighbor's got, you know, dirty water, and you know
13 what, maybe they don't have dirty water and I do that
14 for free.

15 So I don't know how I generate more widgets.
16 I am -- I don't disagree the Representative that if we
17 have new regulations, it's the cost of doing business,
18 and in public health, you know, if this is the standard
19 that we set, you know, we will do it.

20 I just don't know how we generate more fees.

21 I mean we go to our budget commission and if
22 our budget commission says, no, this is your budget,
23 okay, that's what we live under.

24 There are still going to be trash heaps that
25 I have to take care of; there's dog bites that I have to

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1 address; there are still immunizations that we give.

2 And I don't, you know, we had -- so we've
3 had two entrepreneurial enterprises, both which did
4 generate money, but distracted us from the business of
5 public health.

6 So, you know, we do all these other things
7 to generate money so that we can do our primary mission,
8 but it distracts. You know, we spend so much time doing
9 these other things it distracts us from what we should
10 be doing. And that's a real struggle that I have is,
11 you know, there aren't ways for us to bill for the
12 things that we're asked to do.

13 And I'm not saying that's how it has to be,
14 but there aren't ways for us to bill for many of the
15 things that we are required to do that in some
16 communities there may be no trash heaps, in others there
17 may be lots of trash heaps, and those are the concerns
18 that I have.

19 I can't make more widgets, you know, there's
20 only so many hours in the day, and once I start paying
21 overtime the community starts saying, why are you paying
22 overtime to government workers.

23 CHAIRMAN BURKE: And I hear what you're
24 saying, but in terms of funding, I would certainly think
25 it would be much more prudent to fund a health district

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1 that can at least meet PHAB standards, rather than one
2 that can't for whatever reason.

3 I don't know what that reason is, but
4 that's, to be frank with you, not my problem, that's
5 exactly the problem I'm trying to fix.

6 DR. MCFADDEN: My only concern is I hope
7 five years down the road, ten years down the road, when
8 we have PHAB accredited health districts and other
9 districts that decide to merge, because they weren't
10 able to meet PHAB accreditation, I hope the things we
11 would really care about, which are, is our infant
12 mortality going down, is our obesity going down, are
13 vaccinations being delivered in our community, I hope
14 that the thing we really care about are able to be met
15 by, you know, the things that we're saying that PHAB is
16 going to do.

17 I struggle, because I think that, you know,
18 health districts are -- we haven't asked for the data on
19 the health districts being able to do those things.

20 What we're asking for is do we have a
21 structure in place that meets the gold standards for
22 what a structure should be, you know, everyone should
23 have the structure of Apple, you know, while some are
24 functioning at the structure of the corner, you know,
25 computer technology store.

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1 So we have this structure now, my concern is
2 down the road when I'm still in public health is my
3 population healthier than they are today and not less
4 healthy, and that's the question that I don't think any
5 of us can answer.

6 We can sit here and say, it is our hope, it
7 is our desire, we believe if you meet this accreditation
8 people will be healthier, but we're not asking any of
9 those questions.

10 We are asking with PHAB do you have the
11 structure in place? Get the structure in place and the
12 rest will follow, I'm -- I'm not convinced that that is
13 reality.

14 COMMISSIONER SCOFIELD: A couple of things.
15 I am -- I am more confident that if we push towards
16 eligibility for accreditation that we try to build
17 capacity in all of the health departments to do that.

18 That we at least put -- just like with
19 accreditation in any other discipline, whether it's
20 hospitals, whatever it might be, that we are at least
21 putting forward the opportunity to meet those longer
22 term goals and objectives and outcomes.

23 We are looking at a statewide system where I
24 think we need to find -- define that level, that
25 standard that should help us do that.

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1 We've got -- if we go this way we have five
2 years to work through that process. For the smaller
3 departments where they can do most of it maybe they need
4 to consolidate some of their epidemiologists and their
5 I.T. folks, or something like that, that does save
6 money, because unfortunately though you might see the
7 elimination of some positions and that kind of thing.
8 That is in many ways how shared services can work.

9 So I think we need -- it's tough, it's not
10 going to be easy, but at least five years, if we can get
11 five years it gives everyone an opportunity to work
12 towards that, and to build that capacity and if it's
13 such that departments or boards have to merge or they
14 consolidate at that level or they just go through shared
15 services either with other boards of health or other
16 health departments or with their commissioners or
17 whatever it might be, that will play itself out.

18 So I really think that we will find
19 ourselves behind -- behind the curve, if we don't push
20 towards this now.

21 The other thing that I just want to go back
22 a minute to, how we define how we meet the standards.

23 Correct me if I'm wrong, does PHAB already
24 have some kind of bar that they set that says if you do
25 this, you meet the standard?

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1 line, I just want to segue on that. Two of those
2 documents, the Community Health Assessment and the
3 Community Health Improvement Plan should be well aligned
4 with the health care delivery system.

5 That will allow for leverage of resources
6 and allow for shared and common goals and allow for us
7 to actually perhaps make an impact on population health
8 whether, it's chronic disease prevention, controlled
9 infant mortality, what have you, that's where we
10 leverage our resources together.

11 Because the hospitals have been told they
12 shall do a Community Health Assessment, all right, by
13 the IRS to maintain their not-for-profit status.

14 For PHAB accreditation we have to be able to
15 -- to be eligible we have to do a Community Health
16 Assessment, then once that's done then you can come
17 together and do a Community Health Improvement Plan.
18 That should be done in concert with the hospitals and
19 the other members of the health care delivery system to
20 set that common agenda.

21 Now, we've got shared resources, we put them
22 in each other's performance objectives, now you start to
23 move the needle with some real resources.

24 The third thing is the Strategic Plan, which
25 brings in the governance structure, just like a board of

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1 health to others.

2 But I just want to say that, you know, you
3 can obviously read my comment, I didn't mean to be so
4 standout-ish, I just happened to highlight them and
5 copied them over. So I firmly believe that we need to
6 accredit.

7 Accreditation, I think it has to be required
8 in five years, because I don't see how we move the bar,
9 based on where we are today, based on what the data is
10 showing, albeit kind of scattered, that life expectancy
11 is stagnating for the children that are being born today
12 and we are not moving the needle further in some
13 communities on infant mortality, which are the two big
14 benchmarks we're always measuring ourselves against.

15 I will leave with this one comment that a
16 very wise person told me a long time ago, and I just
17 want to share it with you, because I feel it's still
18 solid advice today.

19 I can remember as a young man I was whining
20 a little bit about working so hard and getting paid so
21 little, and this person said to me, well, you must not
22 be performing very well or you'd be getting paid more.
23 I looked at him and said, well, what do you mean, well,
24 what have you done.

25 And so the bottom line was don't chase the

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1 money, perform. Do the best you can do and the money
2 will follow and I really believe in that principle.

3 And I think that accreditation, there's a
4 little bit of a gamble here, it's a little bit of an
5 unknown, but I really believe that the foundations,
6 perhaps the federal government and the State of Ohio
7 will at some point say to local health districts, unless
8 you're accredited you're not eligible to apply for these
9 moneys.

10 And we'll see, and I understand what Dr.
11 McFadden is saying, time will tell whether or not we
12 have actually started to move the life expectancy needle
13 and to have some impact on some of these other concerns
14 that today are troublesome, and they should be to us,
15 they should be unacceptable.

16 But I don't know how else to do this, and we
17 have to have somebody to independently review us. You
18 know, when we got to grade ourselves in college or in
19 high school, sometimes we're our own worst critic, but
20 you know, you really need someone, you need that outside
21 advice.

22 You need someone to talk with you about have
23 you thought about this; have you thought about doing
24 that and so forth, so --

25 REPRESENTATIVE WACHTMANN: Just on Tim's

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1 last point, the State Auditor does a lot of performance
2 audits now on local government, but you have to, I
3 think, invite them in, but my understanding is the State
4 Auditor's Office now has a lot of capability either
5 through their own personnel or contractor to come in and
6 do performances.

7 I mean, maybe they should be the entity
8 potentially who decides who's following the rules and
9 who's doing a good job and who's not.

10 Now, that doesn't set the 70 percent and 90
11 percent, but, Martin, you spoke earlier about
12 percentages. I went to parochial school, unless you had
13 an 80 you had an F, so I'm more for a higher bar.

14 CHAIRMAN BURKE: So I hear a time-line then
15 of five years getting kicked around. I assume that most
16 people think that's an acceptable period of time. So if
17 I could read the statement that I have from what we've
18 discussed.

19 The Ohio Department of Health shall
20 implement a process to engage an independent review team
21 to verify the data reported by local health departments
22 related to the Ohio Performance Standards, which meet
23 the Public Health Accreditation Board, PHAB, standards,
24 which shall be completed in five years.

25 Now, a lot of whichs and comas in there, but

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1 does that capture the essence of what we're trying to
2 say?

3 COMMISSIONER SHAPIRO: Just as long as if
4 you meet the -- if you've already applied and performed
5 and become accredited, that you don't need another
6 review.

7 So if I'm -- so if Gene has passed his
8 accreditation and he's accredited by PHAB that's good
9 enough, so you don't need -- so we don't need to be
10 double reviewing people, we don't need to be spending
11 that kind of money to do that. I don't know how or
12 where you put that.

13 CHAIRMAN BURKE: I would assume just by
14 being accredited and --

15 COMMISSIONER SHAPIRO: -- You think that --

16 CHAIRMAN BURKE: -- You're not accrediting
17 yourself, I'll put it that way.

18 COMMISSIONER SHAPIRO: Yes, if you can
19 assume that, that's okay.

20 MR. TREMMEL: Maybe put that at the end, for
21 all departments that are not currently accredited.

22 CHAIRMAN BURKE: Okay. So then --

23 COMMISSIONER NIXON: I'm not sure the
24 independent review team -- are we talking about -- that
25 sounds like peer review, again, that sounds like -- I'm

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1 not sure what that means.

2 I think we want to move towards
3 accreditation and to create a parallel, we're still
4 talking about a mirrored process, some kind of review,
5 internal state review, I'm just not sure what we mean by
6 that.

7 CHAIRMAN BURKE: Does anybody else, I mean
8 I'm okay with it, I think I understand the intent, maybe
9 I'm the only one that feels that way, I don't know how
10 descriptive we want to be with that.

11 COMMISSIONER SCOFIELD: I'm sorry, Mr.
12 Chairman, you're -- what are you okay with; what's in
13 writing?

14 CHAIRMAN BURKE: The term, independent
15 review team, again, that's a process that can mature
16 legislatively into the rule, but to me I would interpret
17 that as being anybody, but somebody at the health
18 department, otherwise it wouldn't be independent by
19 definition.

20 VICE-CHAIRMAN PRESS: If we struck that
21 clause and engage an independent review team, does that
22 first of all eliminate the confusion that might arise
23 with, I'm guessing, when the accreditors come in they
24 have their own review team, it would eliminate that
25 confusion, does it not also give ODH the flexibility to

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1 use something, other than a team to verify the data
2 that's reported, because we're not interested in having
3 a team are we; we're interested in having the right
4 data?

5 COMMISSIONER SHAPIRO: Independent review.

6 CHAIRMAN BURKE: Well, I think if you struck
7 that it would probably pretty much gut the whole thing
8 then so you're back into the process of self-reporting.

9 COMMISSIONER NIXON: The process to verify.

10 CHAIRMAN BURKE: Well, one person could be a
11 team, I mean we starting to fall down the path of
12 word-smithing.

13 VICE-CHAIRMAN PRESS: Well, okay, maybe I'm
14 not reading it right then, so the language, independent
15 review team applies only to verification of the data?

16 CHAIRMAN BURKE: Correct.

17 VICE-CHAIRMAN PRESS: Thank you.

18 REPRESENTATIVE ANTONIO: But I think it's
19 important to know who, who is doing that and is the
20 capacity within the Ohio Department of Health currently
21 on its current budget to do that, to do what we're
22 asking?

23 MR. TREMMEL: I don't have a short answer
24 for that, probably not.

25 CHAIRMAN BURKE: It may be, no. To be frank

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1 with you, I am not overly concerned with financing as
2 much as I am about intent, because I can't finance
3 something that doesn't have intent.

4 REPRESENTATIVE ANTONIO: Well, even if I --
5 okay. So move the financing away for a minute, I hear
6 you. Are we adding a layer of work onto -- I mean, is
7 the capacity or are we adding a new -- a whole new part
8 of the job description and the responsibilities that
9 where we don't even talk about financing or is this a
10 peer review team; is this a team of folks from different
11 health departments?

12 I guess it -- I guess it does depend, I mean
13 it does make a difference, how we're suggesting this be
14 done.

15 I mean in theory and concept I'm here with
16 it, but I don't know, are we adding some kind of
17 responsibility onto everything that everybody goes --
18 points in different directions to who's responsible?

19 CHAIRMAN BURKE: Anybody from an outside
20 department or wherever they come from to verify that
21 data, I think, is what we're asking.

22 I don't know who it is, it could be the
23 Auditor's Office, it could be peer review. I don't know
24 how that's going to take shape once we make a
25 recommendation through policy or through law. I don't

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1 know how that's going to look, but I do know I'd rather
2 not be overly prescriptive on it.

3 COMMISSIONER SCOFIELD: Question.

4 CHAIRMAN BURKE: Then I'm going to call it
5 to a vote after your comments, and the baby will be
6 born.

7 COMMISSIONER SCOFIELD: I just want to
8 clarify between this one and Item No. 2. This first one
9 says we are undertaking a five year process to get
10 everyone eligible for accreditation.

11 No. 2 says how we -- how we set indicators
12 and we verify the accuracy of the data.

13 In No. 1 are we planning periodic reviews to
14 check progress of local health departments to meet the
15 standards or are we just saying we're giving everybody
16 five years to get there?

17 So that's kind of my question, whether or
18 not we need independent review teams around the
19 accreditation standards when we're giving them five
20 years to get it with hopefully some training or capacity
21 building to help local health departments complete
22 those.

23 CHAIRMAN BURKE: I'd say you have five years
24 to come into compliance, that could be next week, that
25 could be four years and 51 weeks from now.

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1 COMMISSIONER SCOFIELD: So my question is,
2 do we need some kind of independent review for that
3 process or are we just saying go?

4 So then No. 2 talks about how do we kind of
5 quantify the data that we're reporting, I don't know.
6 I'm sorry, maybe I'm getting a little confused on this.

7 REPRESENTATIVE WACHTMANN: Jennifer, I think
8 you make a good point, but my answer to a lot of those
9 issues are beyond us. I think now hopefully heading
10 towards a good direction, my opinion, let the
11 legislative process figure out all the details, and
12 beyond that at some point the Department of Health will
13 be given or will make the authority.

14 And a lot of these things have been
15 discussed here recently, I see them as a very important
16 part of the legislative process in hearings, how they
17 vote, the finance committee when it comes to funding
18 health, and in Health Committee, and House, wherever the
19 bill comes out of this meeting gets sent to it basically
20 will be worked out in the committee process, but they're
21 good questions.

22 CHAIRMAN BURKE: So the question is the Ohio
23 Department of Health shall implement a process to engage
24 independent review teams to vary the data reported by
25 local health departments related to the Ohio Performance

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1 Standards, which meet the Public Health Accreditation
2 Board, known as PHAB, standards, which shall be
3 completed in five years.

4 All those in favor say aye.

5 (Thereupon all Commission Members voted
6 affirmatively.)

7 All those opposed say nay.

8 The ayes have it.

9 No. 1 stands as read.

10 No. 2, Outcomes and Data, and it's getting
11 close to lunch time so this is going to tie in to some
12 discussions on No. 1.

13 Let's break right now for lunch. We'll go
14 into recess 15 minutes, more or less, return, key punch
15 here and work while we eat. The committee will into
16 recess.

17 (OFF THE RECORD.)

18 (BACK ON THE RECORD.)

19 CHAIRMAN BURKE: I appreciate everyone's
20 time and right off the bat, we're just going to clarify
21 our first recommendation. I think we knew what we
22 meant, but there was a question as to what it said is
23 what we meant.

24 It sounded like we were asking for the state
25 to be given a five year window to develop standards,

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1 rather than health departments to develop standards.

2 So the language that we kind of changed a
3 little bit reads, the Ohio Department of Health shall
4 implement a process to independently verify the data
5 reported by local health districts related to the Ohio
6 Performance Standards that meet the PHAB standards, so
7 that all local health districts meet PHAB eligibility
8 within five years. I'll read it one more time.

9 The Ohio Department of Health shall
10 implement a process to independently verify the data
11 reported by local health districts related to the Ohio
12 Performance Standards that meet PHAB standards, so that
13 all local health districts meet PHAB eligibility within
14 five years.

15 REPRESENTATIVE ANTONIO: I like that.

16 CHAIRMAN BURKE: And I can read it one more
17 time.

18 COMMISSIONER SCOFIELD: I just -- I just, as
19 you read that it strikes me that we're creating a second
20 process on top of local health departments doing the
21 work to meet the PHAB standards, that's the same
22 question I had before, seems like a duplicative process.

23 If we're saying local health departments
24 need to work to meet those PHAB accreditation standards
25 within five years then are we -- we're setting up a

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1 secondary process to check that along the way or are we
2 just saying go and figure it out within five years?

3 COMMISSIONER NIXON: So you could say all
4 local health districts shall meet PHAB eligibility
5 within five years, period.

6 COMMISSIONER SCOFIELD: Yes, and then we use
7 the PHAB process, and I know they're going to, you know,
8 I imagine they're going to work that out and have more
9 information over the course of the next five years as
10 well.

11 My concern is we're just creating a
12 secondary duplicative process.

13 DR. MCFADDEN: But there won't be any
14 verification, I mean, if you say that they'll -- that
15 they'll just meet PHAB eligibility there's no
16 verification there.

17 The only verification would be if they are
18 PHAB accredited or attempt to be PHAB accredited, they
19 have to go through the process. The only way to verify
20 it is to either have there be a verification process
21 that is in place in the state or to require everyone to
22 be PHAB accredited. Those are the only two options, if
23 you want to have accreditation.

24 You can't -- people cannot be PHAB eligible
25 and assume that somehow they're going to be verified.

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1 COMMISSIONER SCOFIELD: And that's my
2 question that goes to No. 2, then what does No. 2 mean,
3 recommendation, because that gets to the review and
4 verification of outcomes, measures and data that the
5 state is looking at.

6 DR. MCFADDEN: But I think some of the
7 disconnect is what's actually asked from PHAB may not be
8 what you want the state to be looking at.

9 What's asked from PHAB is a process, it is a
10 process. This is -- this is not what you expect,
11 because it is putting the structure in place, verifying
12 that you have the structure in place to carry out your
13 business.

14 COMMISSIONER SCOFIELD: Right, I understand
15 that.

16 DR. MCFADDEN: It has nothing to do with the
17 standards, specific data collection that you might be
18 looking for.

19 COMMISSIONER SCOFIELD: Right. I understand
20 that, and that's why I'm -- that's why I think we're
21 going to -- that verification belongs under No. 2 not
22 No. 1.

23 CHAIRMAN BURKE: Well, if I can -- when I
24 think of No. 2 I'm talking about or thinking about the
25 data that's currently being reported.

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1 DR. MCFADDEN: Do you mean like data in
2 regards to health outcomes, public health outcomes or do
3 you mean the data that we're reporting in regards to are
4 we able to report 24 hours a day, 7 days a week to the
5 state?

6 CHAIRMAN BURKE: I would think more, again,
7 this is the way I would interpret it, 125 health
8 districts, the standardization of that data coming into
9 Columbus for a comparable purpose.

10 I mean somebody could send me the number of
11 visits they have in for a well baby clinic and someone
12 doesn't, you know, how do you compare?

13 COMMISSIONER EDWARDS: It should all be
14 standardized.

15 CHAIRMAN BURKE: Yep.

16 COMMISSIONER EDWARDS: No question.

17 CHAIRMAN BURKE: And that is above and
18 beyond what PHAB accreditation actually is, so help me
19 word-smith this real quick, because I think we know what
20 we're looking for we just need to put it down.

21 The statement could be as simple as, all
22 local health districts shall meet the PHAB eligibility
23 within five years, such reporting or data shall be
24 independently verified.

25 COMMISSIONER INGRAM: That could be.

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1 COMMISSIONER NIXON: I think that's --

2 COMMISSIONER EDWARDS: Very simple.

3 CHAIRMAN BURKE: Write it down before --

4 COMMISSIONER SHAPIRO: Just for

5 clarification, sorry.

6 CHAIRMAN BURKE: Go ahead, Nancy.

7 COMMISSIONER SHAPIRO: Okay. Are we talking
8 eligibility, right now the way it reads it says
9 eligibility, which means you need three documents and
10 that's all we're talking about, those three documents?

11 CHAIRMAN BURKE: Uh-huh.

12 COMMISSIONER SHAPIRO: Okay, that's fine.

13 CHAIRMAN BURKE: And then I was just using
14 the word data, I can't remember what other word I used
15 in there, data or process.

16 So the statement starts, all local health
17 districts shall meet PHAB eligibility within five years.
18 Such data shall be independently verified; does that
19 work?

20 COMMISSIONER SHAPIRO: Documentation; is it
21 documents rather than data, I don't know.

22 CHAIRMAN BURKE: Such data and/or
23 documentation.

24 COMMISSIONER SHAPIRO: Is it data or is it
25 documentation, if you can produce the three documents --

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1 COMMISSIONER NIXON: Yeah, probably
2 documentation.

3 MR. TREMMEL: And should we qualified that
4 that this is the Health Assessment, Health Improvement
5 Plan and Strategic Plan; those are the three documents
6 you're referencing?

7 COMMISSIONER SHAPIRO: Right.

8 COMMISSIONER NIXON: Well, I think
9 eligibility.

10 COMMISSIONER SHAPIRO: I don't think you
11 need it.

12 CHAIRMAN BURKE: So then now it reads, all
13 local health districts shall meet PHAB eligibility
14 within five years, such documentation shall be
15 independently verified.

16 COMMISSIONER NIXON: I think that would
17 work.

18 CHAIRMAN BURKE: Does that work?

19 REPRESENTATIVE ANTONIO: Sounds good.

20 COMMISSIONER INGRAM: I mean what you're
21 saying, they have to have the three documents ready. I
22 guess are we saying they have to apply within five
23 years?

24 COMMISSIONER SHAPIRO: No.

25 COMMISSIONER INGRAM: Okay.

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1 CHAIRMAN BURKE: Okay. I'll make a motion
2 then to repeal and replace the prior language in
3 Recommendation No. 1, so that it reads, all local health
4 districts shall meet PHAB eligibility within five years,
5 such documentation shall be independently verified.

6 All those in favor signify by saying aye.

7 (Thereupon all Commission Members voted
8 affirmatively.)

9 All opposed nay.

10 All right. The language in No. 1 is
11 repealed and replaced.

12 Okay. Outcomes and Data, No. 2. Open
13 discussion here, because we kind of talked about a
14 couple of things.

15 Right now the Ohio Department of Health and
16 local health departments should work towards identifying
17 the standardized process of specific data collection and
18 identification of common public health data indicators.

19 Representative Wachtmann added in there
20 should include quality, quantity, comparables and
21 efficiency.

22 Any additional discussion on No. 2, even
23 though it kind of bleeds over from No. 1?

24 DR. MCFADDEN: Could be the Ohio Department
25 of Health and local health districts shall create a

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1 standardized process of data collection and public
2 health indicators.

3 I feel that's -- for me this is more
4 important than the first one, because I believe that
5 what we -- to reiterate, what we measure and follow will
6 change, and if we want to change quality measures or we
7 want to change outcomes of infant mortality we will have
8 to remeasure that in our community and be reporting that
9 on a regular basis.

10 Would it be very hard for communities to not
11 be concerned about the topic, if there's a listing on
12 ODH -- from ODH that says, last year Holmes County had
13 this rate of infant mortality, this year they're worse?
14 I'm not going to be able to sit back and not --

15 CHAIRMAN BURKE: Agreed. So then it would
16 read, the Ohio Department of Health and local health
17 districts shall create a standardized process of data
18 collection and identifying of public health data
19 indicators, this should include quality, quantity
20 comparables and efficiency.

21 COMMISSIONER SHAPIRO: In my comment one of
22 the things that we struggle with, at least I do, is, I
23 don't know if everyone does, is chronic disease
24 information.

25 You know what people die from, you know what

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1 they are born with, but we don't know what's happening
2 to them in between. Insurance plans have that
3 information, and it would be wonderful if the Ohio
4 Department of Health could access that information in
5 aggregate down to specific county levels.

6 So when I knew that we had 62 percent of my
7 adult population affected with hypertension, wow,
8 wouldn't that be wonderful to know, and then I could
9 intervention depending where that's happening, just --
10 so we need some tools to help gather some information.

11 The same with flu shot information. I don't
12 know what coverage we have in our community, because
13 they're giving it at Walgreens, and Walgreens isn't
14 reporting to me, and I can't get them to report to me.

15 So I think we need some language in there
16 that would give us, ODH, the authority to get that
17 information, and then get it out to us would be helpful.

18 CHAIRMAN BURKE: Okay. Is everyone in
19 consensus with that in general, just have to figure the
20 words and how you would --

21 COMMISSIONER SHAPIRO: I don't know.

22 MR. TREMMEL: Nancy, I think that's just an
23 excellent assessment. The trump here will be whether we
24 will be able to get the data.

25 COMMISSIONER SHAPIRO: Well, put in PHAB to

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1 give it to you that's a requirement from the Department
2 of Insurance, I don't know what kind of stick you have
3 over them.

4 COMMISSIONER INGRAM: I understand where
5 Nancy is wanting to go and I share the common
6 denominator of trying to have data at the level that is
7 actually meaningful, boy, this is a real -- real
8 difficult issue.

9 First of all, insurance companies see that
10 as their data. Okay. I mean, quite frankly as a
11 democracy we have not decided the question of who owns
12 their health records.

13 I would think it's my health records, but my
14 doctor actually thinks it's his record, and so this
15 really -- really when you get into this, you go -- you
16 have to start really getting down in the weeds on this.

17 So it has a lot of ramifications and the
18 only reason why I'm putting this on the table is because
19 in the greater Cincinnati area we're -- we have had some
20 opportunity to share data, and we were one of the
21 recipients of a Comprehensive Primary Care Initiative,
22 which is the Medicare reimbursement program. There's
23 only seven in the country and we're one of them.

24 And so the insurance companies have come to
25 the table to shared data, because, you know, you can't

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1 get the value without payment. Payment is seen as
2 proprietary, but, you know, if we could get above that
3 frag and just look at what you're talking about, better
4 health, not necessarily better care inside the
5 provider's office or the doctor's office, but just
6 better health, whether or not -- you know, where do we
7 need to go relative to making sure people are taking
8 their hypertension medication; where do we need to go
9 relative to these hot spots where there's a lapse
10 perhaps for immunization.

11 COMMISSIONER SHAPIRO: Yeah, and I don't
12 even know if we have to go into that. I think there's a
13 couple of big tickets of issues of what's causing the
14 majority of deaths, so that we -- there's a cancer
15 reporting system already, so we have some data on -- but
16 we don't have it on so many other conditions that affect
17 your health long-term.

18 COMMISSIONER INGRAM: Well, my only point --
19 I'm sorry, go ahead.

20 REPRESENTATIVE ANTONIO: And I was just,
21 Chair's busy writing. This information is one of the
22 take aways from this whole process that will stay with
23 me, is this whole discussion about the fact that when
24 another provider is doing something like giving flu
25 shots or whatever that it is not in the data set for

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1 public health departments and communities, that was big
2 a ah-ha for me.

3 It seems to me, I mean my thought on this
4 particular item is that as we work forward with this it
5 may actually come down to something that needs to be
6 done district-by-district or as communities develop
7 those relationships, but I don't know that we can
8 necessarily require, but what it seems to me if we're
9 working in this direction and we have much more
10 information now than we had on the other side, this
11 could be something that gets vetted during the
12 legislative process, that's my thought.

13 CHAIRMAN BURKE: Well, and I agree, and
14 there's two things you can think about here. No. 1, if
15 you're talking about the flu shot issue, talking about
16 receiving records from the Department of Health that I
17 received a flu shot or are you talking about anonymous
18 data?

19 COMMISSIONER SHAPIRO: Anonymous data.

20 CHAIRMAN BURKE: If I were to think about a
21 sentence I would use for that, just to let folks know
22 we're thinking about it underneath No. 2, I would add,
23 the sharing of anonymous health related data among
24 payers and providers is encouraged.

25 COMMISSIONER SHAPIRO: That's a start.

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1 COMMISSIONER NIXON: That's fantastic.

2 CHAIRMAN BURKE: I just --

3 COMMISSIONER SHAPIRO: Yeah, it's a start, I
4 mean, I just --

5 DR. MCFADDEN: And obviously if we're doing
6 assessments, it's not perfect, but it's what we do, we
7 just ask the person, on the FERPA data there's a
8 question, have you ever been diagnosed with
9 hypertension; have you ever been diagnosed with heart
10 disease; have you ever been diagnosed with arthritis;
11 did you get your flu shot?

12 Those are all there on the FERPA, now it's
13 not perfect, but when we don't have perfect data we get
14 what we can get.

15 COMMISSIONER SHAPIRO: But why shouldn't we
16 even try to get better data, if this is what this is
17 about we should try to go for as good as we can get.

18 DR. MCFADDEN: Understand the mind of
19 physicians, if data is going to be used different than
20 what I intend it to be used as a physician, which is
21 where we're at right now, I change my charting. I will
22 chart in a way that I think is best for my patients.

23 COMMISSIONER SHAPIRO: So you would not
24 report the fact that they have hypertension, even though
25 it could be and not code that?

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1 DR. MCFADDEN: That's not something that
2 maybe I will change, but there are other things I will
3 change, and if my patient comes back to me and says, you
4 know, why are people getting this data, I reported it
5 differently.

6 Rather than, you know, service side consider
7 chlamydia I might write, neupropyrllic discharge
8 (Phonetically Spelled), you know, something that people
9 don't understand.

10 COMMISSIONER SHAPIRO: Well, I'm going to
11 find out that they have chlamydia, because that's going
12 to be reported to me from the lab work, so I'm going to
13 know.

14 DR. MCFADDEN: Not if I don't test it.

15 COMMISSIONER SHAPIRO: So you're not going
16 to test it.

17 DR. MCFADDEN: So I say neupropyrllic
18 discharge, here's some Zithromax. All I'm saying is
19 that physicians have a service relationship with their
20 patient. They are a buyer, we re a seller, if I offend
21 my buyer I have nothing to sell, so I will do what will
22 encourage my buyer to keep coming back.

23 COMMISSIONER SHAPIRO: Regardless of whether
24 they're cured.

25 DR. MCFADDEN: Oh, no, no, I will cure them.

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1 COMMISSIONER SHAPIRO: And you're not going
2 to do the contact tracing, and you're not going to have
3 to engage the entire system.

4 DR. MCFADDEN: I think you misunderstand
5 that physicians have to have patients, in order to
6 practice medicine, and if we offend our patients we have
7 no one. So we are -- this issue about -- this issue
8 about whose data it is, we get really concerned if our
9 patients are getting upset with us.

10 So I think we have to, you know, we can get
11 perfect data, but I think as physicians some will change
12 how they do their charting, and I think that's just --

13 COMMISSIONER INGRAM: It's a crucial
14 question and I don't think we're going to resolve any of
15 this here, because it goes very deep, and as Dr.
16 McFadden has just touched on some of this, I just know
17 that, and I can only speak from where I've been sitting
18 down in southwest and watching some of these initiatives
19 take hold.

20 You know, we're targeting diabetes, because
21 we have a Type 2 diabetes epidemic, and so physicians
22 are being incentivized through dollars, public as well
23 as public, to make sure they're doing what's called a
24 D-5, they're collecting all that data, you know, every
25 time, every time, and then that's being put into a

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1 community, but protective proprietary, I don't want to
2 use the word proprietary, but protected registry that's
3 basically benchmarking.

4 And the trick to all of this is obviously
5 with multiple health care delivery systems is getting
6 everyone to play well in the sandbox along with the
7 insurance companies, and then there's public health,
8 then there's us, you know, who have actually always had
9 our eye on the population health so that we can send out
10 information to the physicians saying this is what's
11 going around town so when someone walks into Dr.
12 McFadden's office, you know, he's more altered, if he
13 wasn't already a public health doc that, you know, I'm
14 glad I know that, helping with his differential
15 diagnosis and so forth.

16 So where am I going with all this, it's
17 complicated, but you know, I do think that every
18 community is different and some of the needs are
19 different, but if you take a look at three areas, or
20 perhaps chronic disease, we just look at chronic disease
21 and we pick heart disease and everything that goes with
22 heart disease.

23 Okay. We know that that could become an
24 outcome that we all shoot for, we know it's a leading
25 cause of death, right, we know it's shortening lives and

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1 so forth, I like to say on the other side of that is
2 infectious disease, because that's what brought us to
3 where we are today.

4 It was infectious diseases from the 1900's
5 which are still around, not as many perhaps that were
6 there, diphtheria and stuff, we resolved this pretty
7 much, the point of the matter is we should be measuring
8 ourselves on how we're evading infectious diseases.

9 I don't understand why we don't measure
10 that, why are we not trending those type of diseases and
11 saying, what are we doing as a state to decrease them?

12 I understand chronic disease is more
13 complicated, because there's lifestyle factors involved
14 and so forth, but we still -- and we're spending a lot
15 of money working on that, a lot of policy questions.

16 I just like to go back to the infectious
17 disease questions, some of those, when we have an
18 outbreak, some of them will burn themselves out, you
19 know, and get back down to the background level, but
20 other times or through our own efforts, I shouldn't be
21 saying -- they don't burn out on their own, but through
22 our efforts, but for some of these other ones they
23 continue to be increasing, I don't know, what am I
24 missing here, someone help me out.

25 CHAIRMAN BURKE: We're merging a new concept

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1 into No. 2, and I don't know, of course, time is
2 valuable and I'm not sure who wants to go down this road
3 and how specific you want to be.

4 The sentence that I just read is sharing of
5 anonymous health related data among payers and providers
6 is encourage. That's pretty generic. I think if we try
7 to get even more specific we're going to spend a lot
8 more time on it.

9 So the first question is, I guess, who even
10 wants to have any style like statement like that in No.
11 2, does anybody?

12 DR. MCFADDEN: I think it's good where it
13 stands now.

14 COMMISSIONER EDWARDS: I like where it
15 stands.

16 MR. TREMMEL: Question, on anonymous, is the
17 proper term -- of the other members of the team, is the
18 proper term di-identify?

19 COMMISSIONER SHAPIRO: As a provider, is
20 public health considered a provider? I just want to
21 make sure, because really it's public health I want the
22 information for. I don't care if D.J. gets his own data
23 bank, I mean, I do, but I don't, it's with public
24 health, it's state health.

25 CHAIRMAN BURKE: All right. So that would

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1 read the sharing of de-identified health related data
2 among payers, providers and public health is encouraged.

3 COMMISSIONER EDWARDS: Senator, I have a
4 question, does -- so we are increasing the amount of
5 data? We're asking to increase the amount of data to
6 your provider?

7 CHAIRMAN BURKE: The new topic here, it's
8 beyond the standard reporting. We were talking about
9 standardizing normal reporting procedures in No. 2, and
10 we are adding, correct, another layer of new information
11 to do that.

12 COMMISSIONER EDWARDS: And who's going to
13 determine what those new identified data are?

14 CHAIRMAN BURKE: They just call me Chairman,
15 if you want to go down this road, this is a deep well.

16 COMMISSIONER EDWARDS: Well, I don't, and
17 that's why I'm asking the question.

18 COMMISSIONER NIXON: I don't think it's --
19 as I understand it, I don't think it's asking to collect
20 any more data. It's the ability for local health
21 departments to access what's already there.

22 COMMISSIONER EDWARDS: Okay.

23 COMMISSIONER SCOFIELD: And I would say,
24 part, some of this will occur over time as we continue
25 to improve electronic medical record systems and how

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1 that data is available.

2 So I think a lot of this will happen, you
3 know, as we progress through those types of things as
4 well.

5 But, yeah, just a quick example, in Cuyahoga
6 County we have finally pulled together local foundations
7 and a lot of interested parties to develop a community
8 health dashboard, which is essentially the same concept
9 where agreements are put in place where hospitals will
10 up-load their information, health departments, the
11 results of our community-wide assessment, you know, that
12 kind of thing, so it's a shared -- shared resource.

13 So we're -- I think you can take some
14 initiative like that locally, it just took a long time
15 to get major players like the hospitals and the hospital
16 systems to the table, but it can -- you know, it can be
17 done.

18 CHAIRMAN BURKE: So if I could -- go ahead.

19 REPRESENTATIVE ANTONIO: Just one small item
20 for explanation, I think it would be good to have a
21 definition of de-identify somewhere below it, or
22 whatever, so nobody is trying to figure out what that
23 means. I mean I think it could just be a footnote of
24 some sort.

25 COMMISSIONER SHAPIRO: Aggregate anonymous,

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1 yeah, so it's a lumping, so you can't tell it's me with
2 that blood pressure.

3 CHAIRMAN BURKE: So I can read No. 2 then,
4 the Ohio Department of Health and local health
5 departments shall create a standardized process of
6 specific data collection and identification of common
7 public health indicators. This should include quality,
8 quantity, comparables and efficiency. The sharing of
9 de-identified health related data among payers,
10 providers and public health is encouraged.

11 COMMISSIONER WENTZEL: Just a point of
12 clarification, what do you mean by efficiencies?

13 CHAIRMAN BURKE: That could be anything from
14 mergers, sharing of department equipment, people, I
15 would say some may take that --

16 COMMISSIONER WENTZEL: So doesn't count
17 outcome data, you'd be looking at business type data?

18 CHAIRMAN BURKE: Yes.

19 VICE-CHAIRMAN PRESS: Mr. Chairman, I think
20 the key word, if I heard you correctly, in that sentence
21 is among and not with?

22 CHAIRMAN BURKE: Correct.

23 VICE-CHAIRMAN PRESS: Thank you.

24 CHAIRMAN BURKE: Okay. So then, No. 2, then
25 I'll just read it, take a vote, comfortable with that,

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1 the Ohio Department of Health and local health
2 departments shall create a standardized process of
3 specific data collection and identification of common
4 public health data indicators. This should include
5 quality, quantity, comparables, efficiency, the sharing
6 of de-identified health related data among payers,
7 providers and public health is encouraged.

8 All of those in favor of No. 2 signify by
9 saying aye.

10 (Thereupon all Commission Members voted
11 affirmatively.)

12 All opposed nay.

13 There's No. 2.

14 No. 3, Boards of Health. Currently reads,
15 local health department board members should participate
16 in continuing education requirements related to public
17 health practice, ethics and governance.

18 COMMISSIONER SHAPIRO: And Dr. Threlfall
19 will not be here.

20 CHAIRMAN BURKE: Okay. This dealt back to
21 the issue of having the continuing education to boards
22 of health.

23 COMMISSIONER SHAPIRO: Which when I talked
24 to him he was in favor of.

25 CHAIRMAN BURKE: Again, the key word here

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1 is, should, so we're just making a request.

2 COMMISSIONER EDWARDS: I believe it should
3 be shall, and I believe it should include the District
4 Health Council, their District Advisory Council unless
5 you want to change it.

6 CHAIRMAN BURKE: So your recommendation is
7 that you should make this recommendation a mandate, from
8 should to shall. So I'm just going to cut right to the
9 heart of it and ask folks what they think with a verbal
10 vote, no offense, everyone loves everyone.

11 All those in favor of changing the word
12 should to shall participate in continuing education, so
13 all those who favor changing the word should to shall
14 signify by saying aye.

15 (Thereupon all Commission Members voted
16 affirmatively.)

17 All those opposed nay.

18 So the current recommendation will read,
19 local board -- local health department board members
20 shall participate in continuing education requirements
21 related to public health practice, ethics and
22 governance. Any additions, deletions?

23 COMMISSIONER EDWARDS: Yeah, District
24 Advisory Council.

25 DR. MCFADDEN: Just so I understand you

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1 correctly, if the process that through, you know, from
2 here on out determines that at every board meeting there
3 will be 15 minutes of continuing education or that there
4 are two conferences a year that every board member has
5 to attend, the county commissioners and representative
6 from every township are going to come and participate at
7 those?

8 COMMISSIONER EDWARDS: Uh-huh.

9 DR. MCFADDEN: Okay. I just want to make
10 sure.

11 COMMISSIONER FOUGHT: Why would the DAC have
12 the same requirements as the board of health?

13 COMMISSIONER EDWARDS: Because they're the
14 ones that are voting in the board of health.

15 COMMISSIONER FOUGHT: But they also don't
16 have the same medical requirements that those members of
17 the board of health have.

18 COMMISSIONER EDWARDS: Then that gets back
19 to changing what that DAC is and how the board of health
20 gets voted in.

21 COMMISSIONER FOUGHT: I disagree with her
22 proposal. I don't want the DAC included and if we're
23 going to include the DAC it's go to be something
24 different than what the board of health has. I just
25 think they're two different things.

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1 CHAIRMAN BURKE: I don't disagree.

2 COMMISSIONER NIXON: I agree, I think the
3 District Advisory Council meets one hour a year and has
4 very limited responsibility in appointing a small
5 percentage, at least in my district, of the board of
6 health representatives.

7 The board of health meets on a regular
8 basis, on a monthly basis, and really does need to know
9 what public health is all about, the governance, the
10 ethics and those other things, so I think there's a
11 distinct difference in responsibility.

12 And the District Advisory Council, as well,
13 those are elected officials, so I think they've got a
14 lot of those.

15 MR. TREMMEL: Is there a way, and, again,
16 I'm looking for a solution, and maybe I should just
17 leave it alone, but is there a way that the district
18 advisory members appointed, let's say that number is
19 three or four or five in any given health district, is
20 there a way that that particular board member, Mrs.
21 Smith, reports back to either the township or that DAC
22 itself.

23 And maybe that's too in depth in detail, but
24 there is -- so if I'm appointed to the Board of Health
25 there's -- the quid pro quo is I need to report back

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1 either to the DAC or alternatively to the township to
2 give an update annually or something like that.

3 COMMISSIONER SHAPIRO: My understanding,
4 correct me if I'm wrong, it is our legal requirement at
5 a health district to send out information to those --
6 that DAC on a quarterly basis?

7 We do that in the form of a newsletter. So
8 we send out on a quarterly basis, usually we get about
9 six out a year, if there's any kind of issue on fee
10 changes or rule regulation changes or whatever. Things
11 that are of interest to the township, mosquito spraying,
12 and those kind of things.

13 So they are getting that information. Now,
14 if they choose to read it or not that's another story,
15 but we're required to send that.

16 COMMISSIONER EDWARDS: That's a requirement?

17 COMMISSIONER SHAPIRO: Yes, currently in
18 law.

19 COMMISSIONER NIXON: Quarterly.

20 COMMISSIONER SHAPIRO: Quarterly.

21 DR. MCFADDEN: It's quarterly reported, but
22 it's actually quarterly infectious disease statistics,
23 but we are quarterly to report and many are interpreting
24 it as a broader.

25 We do it by providing them with all of our

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1 certificates and all of your board minutes every month,
2 but the requirement is that quarterly infectious
3 disease.

4 COMMISSIONER SHAPIRO: That's what I said,
5 correct me if I'm wrong, we do it as a form of
6 information.

7 COMMISSIONER EDWARDS: Okay. Could we beef
8 that up?

9 COMMISSIONER FOUGHT: To what though?

10 COMMISSIONER SHAPIRO: Well, to maybe make
11 it more substantial reporting, if it's just --

12 COMMISSIONER EDWARDS: Right.

13 COMMISSIONER SHAPIRO: I don't know what the
14 code -- we'd have to look up what the code says.

15 CHAIRMAN BURKE: Again, you're heading down
16 waters we haven't tread before, and that's your time,
17 approve this one before we go down a new road.

18 COMMISSIONER INGRAM: So, you know, I
19 understand what Commissioner Edwards is saying, but I
20 just think about the process over the years and we have
21 a large DAC, because we have multiple units of
22 government in Scioto County, I think it takes like 16 or
23 17 to have a quorum, so it's a big group and we
24 struggle, we have.

25 We just barely make it and when we don't,

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1 there's a section that allows us to form an executive
2 committee to be appointed.

3 At that District Advisory Council meeting,
4 which is like shall meet the first Monday of every
5 March, I always give a report on the status of the
6 district, and so that's kind of their continuing
7 education, I mean from my perspective, because I give a
8 report.

9 I don't know if everyone does, but that's
10 what we do. We do some type of presentation based on
11 what we've been seeing and where we are going, and
12 perhaps why we are asking them for more money, which
13 they're always interested in or not.

14 So I don't know. I mean I'm not sure, I
15 mean those folks, as you know, are composed of county
16 commissioners, township trustees and village mayors are
17 their delegated representative.

18 I'm not sure, I mean I would hope that we're
19 out in the community enough that they're already being
20 educated for us and we do send every board packet, just
21 like we had a board of health meeting last night, all
22 that's public published notice by law and they get
23 copies of all of our minutes and all our reports that
24 we're putting out.

25 And every now and then someone will show up,

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1 one of the trustees or mayor will show up if he or she
2 sees something of interest.

3 So with that being said, I just don't know
4 if this is allowed to be brought back in the table or
5 not, Mr. Chairman, but not only as I wrote it and a
6 couple of others wrote, and I've talked about with the
7 boards of health, because I really do believe going
8 forward that we ought to really consider having a
9 section of the board of health composed of executives
10 from the health care delivery system.

11 I know I wrote about term limits, I guess
12 some people feel ambivalent about it, some are stronger
13 about it. I guess I'm not -- that's okay.

14 I just take practical experience, I think
15 there's a time when you've got people that have been on
16 for four or five terms, I don't think that's uncommon,
17 which is 20 to 25 years.

18 One has to really scratch their head and ask
19 themselves is this the right thing to do relevant to
20 where we're trying to build, raise and better
21 development a more robust public health system.

22 But I've got to tell you, if
23 there's anything -- I agree with continuing education,
24 if there's anything we ought to do in a government
25 structure, I think we should somehow create -- we need

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1 to get the health care delivery system more involved
2 with us going forward and I don't see how we do that
3 without getting in at the governance level, perhaps a
4 situation where we would be also on their boards too
5 perhaps.

6 Just think about it, we heard an excellent
7 presentation by Health Commissioner Goon from Henry
8 County, in which that's already occurred and I realize
9 that's not necessarily always one size fits all relevant
10 to who that individual should be from the health care
11 delivery system, but I don't see how we move
12 successfully together what we've been talking about,
13 whether or not it's on a Community Health Assessment,
14 Community Health Improvement Plan, what have you, unless
15 we are in more consistent communication with each other.

16 I'll leave it at that, thank you.

17 COMMISSIONER SCOFIELD: I guess my take on
18 this is to not do this with the DAC but maybe there's
19 something, to just keep it kind of simple, but maybe
20 there's something through the Health Commissioner's
21 Association or others where that kind of information
22 sharing can be encouraged.

23 I imagine that kind of work varies across
24 the 125 different departments or districts, so I think
25 some good ideas were put forward as to how we can do

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1 that, but I don't know that we need to include it in
2 this at this time.

3 COMMISSIONER SHAPIRO: So are you suggesting
4 that, for example, that AOHC, and I'll speak to them,
5 but anyway, would development something, maybe get it
6 out to Heidi who would get it out to all township
7 trustees?

8 COMMISSIONER SCOFIELD: Yeah, or just
9 something through normal AOHC that would encourage other
10 commissioners and other directors to do something
11 similar. I don't know how formal -- or I don't know.

12 COMMISSIONER EDWARDS: My thought would be
13 going along those lines, and I'm conceding here quite a
14 bit, I admit, that if something were added to the tune
15 of that information or publication be presented at
16 annual conferences for township trustees, county
17 commissioners, because those are the ones that sit --
18 sit on that DAC.

19 COMMISSIONER FOUGHT: I'm sorry, say that
20 beginning part again, I must have missed it.

21 COMMISSIONER EDWARDS: That's where I'm
22 struggling, information or education or something to get
23 them involved in the process.

24 COMMISSIONER FOUGHT: Like to understand
25 what the role is; that type of thing?

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1 COMMISSIONER EDWARDS: To understand what
2 the role of the DAC is, to understand what their role
3 is, period.

4 COMMISSIONER WENTZEL: I'm one hundred
5 percent certain if one of those groups asked us to come
6 speak to their conference we would be there. I mean if
7 the invite is extended we're there, so I don't see where
8 that would be an issue or a problem.

9 COMMISSIONER FOUGHT: For example, I just
10 asked for an article from the health commissioners along
11 that line for running in our, Did You Know Section, so I
12 mean, I think, yeah, those opportunities are out there.

13 DR. MCFADDEN: This seems like more -- we
14 have executive folks from the CCAO, I think to me that
15 seems like an appropriate discussion that we have here,
16 but not to put it in our recommendations, but encourage
17 that at your guys conferences that folks come and
18 present, because I think that's valuable, and likewise,
19 you know, at our conferences it might be worthwhile
20 having folks from the township board or CCAO to come in
21 and talk to us, if we can do that, but I don't think
22 that impacts what we're doing here.

23 CHAIRMAN BURKE: Correct.

24 COMMISSIONER EDWARDS: I'm stepping back,
25 I'm not conceding, because every year I go to this

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1 meeting, every year, I've been doing this for a number
2 of years, and you've got township trustees that are
3 there, some, a lot of them don't come.

4 I think out of eight mayors the last time
5 there were only two. You've got a number of people that
6 are coming, they don't know why they're coming. They
7 know that they're supposed to be there, and if they've
8 got something else going on it's more important than
9 going to a doggone health -- health meeting.

10 And if they're not engaged I don't know how
11 to be engaged or how to educate, that's my struggle.

12 CHAIRMAN BURKE: If I could throw something
13 out, we talked about this originally and you're driving
14 to the point. It was about increasing the intelligence
15 level of people on the board, and C.E. was a way to do
16 that.

17 And I hear what Tim talks about when he
18 talks about trying to put folks together on that board,
19 so if I could just throw something out, if you had -- as
20 it reads, local health department board members shall
21 participate in continuing education requirements related
22 to public health practices, ethics and governance, you
23 can also put a comma and say unless X-members were on
24 the board.

25 So it's a carrot and a stick. You don't

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1 have to do continuing education, if you've got a
2 hospital and a doctor and whatever, if your board had --
3 otherwise you have to, otherwise we can leave this as
4 is.

5 I'm going to move on here in a minute, no
6 one is biting.

7 So this currently reads and without any, I
8 guess, additional things coming up here, local health
9 department board members shall participate in continuing
10 education requirements related to public health
11 practice, ethics and governance.

12 COMMISSIONER FOUGHT: I just would like to
13 ask a question, maybe this is getting too far into the
14 weeds, but who would be developing that education?

15 In other sections of the code you have the
16 Auditor of State or you have other folks doing it, and
17 I'm just wondering should we put in there that maybe
18 it's ODH with consultation of X organization.

19 I -- I'm just worried that we might need to
20 put a little bit more specificity in there.

21 CHAIRMAN BURKE: And I agree with you, and I
22 don't know who would do it, and second if you don't do
23 it, I don't know what the punishment would be.

24 COMMISSIONER SHAPIRO: Right now medical
25 directors are required to go for some continuing

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1 education, which they meet that by going to either the
2 combined conference, which is all the public health
3 entity or AOHC fall meeting.

4 So if you had something similar it would
5 require board of mental health members to attend either
6 one or both of those things, at least some of those
7 things, they don't go to the whole event, but some of
8 it, and I think that would take care of --

9 CHAIRMAN BURKE: And I hear what you're
10 saying, I don't know how long an appointment --

11 COMMISSIONER SHAPIRO: For DAC, appointed
12 five years.

13 CHAIRMAN BURKE: Okay. So then have
14 continuing education every year or can they meet that
15 requirement over a five year period?

16 COMMISSIONER SHAPIRO: Right now for medical
17 directors they have to attend every year at least one.

18 CHAIRMAN BURKE: I'm just asking, this is
19 how this is going to look, annualized continuing
20 education, then what's the quantity and what's the
21 action, if you don't get it?

22 COMMISSIONER SHAPIRO: I know what the
23 requirements are for the Medical Director and what the
24 costs are to receive that, so that is specified.

25 COMMISSIONER SCOFIELD: I worry a little bit

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1 about including specific conferences or other things to
2 go to.

3 I think a lot of this probably can and
4 should be provided locally or in some other form that
5 makes it as easy as possible for board members to get
6 their continuing education, or whatever this training
7 is, and let that be handled more locally than
8 centralized.

9 CHAIRMAN BURKE: I'm just talking out loud,
10 but I think when this ends up in whatever lap it ends up
11 in, somebody's going to t to do this, and I don't want
12 to be too specific.

13 I mean it's obviously not going to be the
14 back of a Captain Crunch box that's fill in, somebody is
15 going to have a standard here.

16 REPRESENTATIVE ANTONIO: So is any of this
17 addressed in the accreditation process?

18 VICE-CHAIRMAN PRESS: Yes, it is, might be a
19 question for Gene Nixon. There's a standard that says
20 assess staff competency and it speaks to requiring
21 continuing education of leadership and management staff.

22 So the question would be around what is the
23 definition of leadership.

24 COMMISSIONER NIXON: And if I could add the
25 Boards of Health Association is looking at some of these

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1 things right now and I think they're the entity that I
2 think is looking for a purpose and this falls right into
3 what they can do with it.

4 CHAIRMAN BURKE: So then No. 3, reads local
5 health department board members shall participate in
6 continuing education requirements related to public
7 health practice, ethics and governance.

8 All those in favor signify by saying aye.

9 (Thereupon all Commission Members voted
10 affirmatively with the exception of Commissioner
11 Edwards.)

12 Opposed nay.

13 COMMISSIONER EDWARDS: Nay.

14 CHAIRMAN BURKE: The ayes have it, no call
15 for a roll count, which means stands as read.

16 No. 4, Multiple Agency Program
17 Administration. Identify and refer programs currently
18 administered by two agencies, the Ohio Department of
19 Agriculture and the Ohio Department of Health, such as
20 food safety, water park/swimming pools to the Common
21 Sense Initiative, CSI, for further review and
22 recommendations related to program efficiency.

23 That seems pretty clear. I don't know, does
24 anybody have any --

25 COMMISSIONER INGRAM: Move to approve.

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1 MR. TREMMEL: Second.

2 CHAIRMAN BURKE: Any additional -- you did
3 make a motion, I'm sorry --

4 MR. TREMMEL: I have a question. So just a
5 point of clarification, does anyone know the role of the
6 Common Sense Initiative in this; is this something they
7 would take off; is this within their purview?

8 I'm familiar with the word and phrase Common
9 Sense Initiative, I just don't know if this is part of
10 their --

11 COMMISSIONER ANTONIO: They review the rules
12 of the agency.

13 CHAIRMAN BURKE: It would appear to me
14 duplicative type of recommendations on how to resolve
15 that duplicative action would fall right into their lap.

16 COMMISSIONER SHAPIRO: In addition to
17 program efficiency, can we put something in there that
18 relates to health?

19 I mean it's just we want to make sure the
20 food rules are not about cows, we want to make sure it's
21 keeping the food safe. It's not an industry issue, it's
22 a food safety and a health focus on pools. You think
23 it's in there.

24 CHAIRMAN BURKE: Well, what CSI would do if
25 this action got action was make recommendations. It

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1 would make recommendations either to administration or
2 to the General Assembly, and the particular things that
3 we're asking for would require action by the General
4 Assembly, because it's improved laws and other kinds of
5 laws.

6 COMMISSIONER SHAPIRO: I just want to make
7 sure that food safety and water safety, that you're not
8 going to make people sick. The purpose of us doing,
9 Jennifer can correct me if I'm wrong, is to make sure
10 that no one ends up with food poisoning, which is what I
11 thought happened to me yesterday when I ate lunch, so I
12 reported it, and it's being investigated, but that's
13 what I want to make sure happens, I don't -- and, again,
14 I think agriculture does other things, they count how
15 many cows are out there.

16 CHAIRMAN BURKE: I understand.

17 COMMISSIONER NIXON: I think the follow-up
18 on that, I'm not familiar with this group either, so I
19 would assume they would ask for some testimony
20 potentially from both the Department of Agriculture and
21 Department of Health.

22 Conceivably they could come out and say the
23 status quo is fine, there's a role that co-manages and
24 not necessarily driven to one or the other, so is that
25 -- that's my question?

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1 CHAIRMAN BURKE: That is correct. This is a
2 third party evaluating the relationship between two
3 other parties and trying to make a recommendation on how
4 to improve that relationship.

5 That still requires additional action. CSI
6 does not mean you have to make a recommendation.

7 COMMISSIONER WENTZEL: Nancy, are you
8 looking for the role and focus as preventable and not to
9 promote business?

10 COMMISSIONER SHAPIRO: Correct.

11 CHAIRMAN BURKE: Well, theoretically it
12 could be advantageous.

13 COMMISSIONER SHAPIRO: Well, it would be
14 both, I want to make sure there's a protecting health
15 focus, but then doing the review.

16 CHAIRMAN BURKE: Knowing the relationship
17 between these two bodies, I can't imagine either one of
18 them being quiet during that process, giving you CSI as
19 much intelligence as it may need to make a decision,
20 just my guess, but, no, point well taken.

21 So we do have a motion from Tim, do we have
22 a second on the motion?

23 COMMISSIONER FOUGHT: Second.

24 CHAIRMAN BURKE: All those in favor of
25 approving No. 4 as read, identify and refer programs

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1 currently administered by two agencies, the Ohio
2 Department of Agriculture and the Ohio Department of
3 Health, such as food safety and water park/swimming pool
4 to the Common Sense Initiative, CSI, for further review
5 and recommendations related to the program efficiency.

6 All those in favor signify by saying aye.

7 (Thereupon all Commission Members voted
8 affirmatively.)

9 Those opposed nay.

10 The ayes carry, No. 4 is approved as read.

11 No. 5, Multi-District Public Health Levy.

12 Revise Ohio Revised Code 3709.29 to allow for permissive
13 multi-county levy authority for public health services.

14 Any discussion on this recommendation?

15 COMMISSIONER NIXON: I support the
16 recommendation, although, I think the points been made
17 in some of what's been written is that levies are a poor
18 way to fund local health departments.

19 By enabling that I think it may send a wrong
20 message that, you know, we're saying that they shouldn't
21 be funded through levies when, in fact, most of the time
22 that's a difficult and poor way to support local health.

23 CHAIRMAN BURKE: I don't disagree.

24 COMMISSIONER EDWARDS: I really have an
25 issue with creating -- having a multi-county levy

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1 without having multi-county districts.

2 COMMISSIONER SHAPIRO: Just in the 1990s
3 Delaware, Morrow and Union county health departments
4 were all served by a single health commissioner and
5 administrative staff.

6 We met for six years about mergers, three
7 boards on health, talking about creating a single
8 multi-jurisdiction in Ohio, and one of the major
9 barriers, there were a few, but the major one was the
10 fact that we did not have authority, that all three have
11 levies, a way to combine those levies of running a levy
12 and having a district that could do that, so we
13 split-up, and now there's three health districts.

14 CHAIRMAN BURKE: Maybe this is more of a
15 barrier removal.

16 COMMISSIONER SHAPIRO: Right. It gives you
17 a tool to get to that consolidation merger issue that we
18 talked about earlier.

19 COMMISSIONER FOUGHT: And I would just like
20 to point out that there are other areas like this, for
21 example, like township fire districts where there are
22 multiple fire districts in one county, and, you know,
23 where it's not just one township being the taxing
24 district, I mean it is -- they are governing as a unit.

25 And so if these three counties, if the goal

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1 is that they have to meet these PHAB standards and the
2 only way to meet these standards is by possibly going
3 together, yet as Nancy adequately pointed out, it's a
4 barrier, because they don't want to join together if
5 they all three don't pass a levy, if all three don't
6 pass a levy one entity is not getting the services while
7 the other two are paying for them.

8 I mean it is truly a barrier in a
9 multi-jurisdictional levy it's just an options, folks,
10 this is not mandating that they go down this route. It
11 really is a smart way to handle it.

12 CHAIRMAN BURKE: Okay. We have a motion by
13 Dr. McFadden to approve.

14 COMMISSIONER FOUGHT: Second.

15 CHAIRMAN BURKE: Motion is to approve point
16 No. 5, reading, revised Ohio Revised Code 3709.29 for
17 allowing permissive multi-county levy authority for
18 public health services.

19 All those in favor signify by saying aye.

20 (Thereupon all Commission Members voted
21 affirmatively, with the exception of Commissioner
22 Edwards.)

23 Opposed nay.

24 COMMISSIONER EDWARDS: Nay.

25 CHAIRMAN BURKE: In the opinion of the Chair

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1 the ayes carry.

2 No. 5 passes as read.

3 No. 6, Shared Services Resource. Encourage
4 and enhance shared services in the local health
5 department by developing model contracts and memorandums
6 of understanding, MOUs, and/or qualifying Councils of
7 Government, COG.

8 COMMISSIONER FOUGHT: Mr. Chairman, I just
9 wanted to ask that a couple of words be added, and it's
10 in my recommendation if you read it.

11 It's the Ohio Department of Health should
12 encourage and enhance shared services by local health
13 departments by developing model contracts and
14 memorandums of understanding that are easily adaptable
15 by local boards.

16 I just think that that should to be the
17 goal. I mean we shouldn't just take somebody's contract
18 and pass it out, and if nobody understands what they're
19 doing, you know, then that becomes a model.

20 I think we really should be looking at all
21 those that would be easily adaptable.

22 MR. TREMMEL: When I read -- when I read
23 that back to myself, Heidi, it says the Ohio Department
24 of Health will develop the contract; is that what you're
25 suggesting?

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1 MS. FOUGHT: Not necessarily. I mean if
2 they're already there, like I'm just saying, if those
3 models are out there, the Department of Health is kind
4 of like the resource body, and is able to share those
5 with folks.

6 So you may have AOHC and other entities, but
7 also the Department of Health has those models.

8 MR. TREMMEL: And what we could do in
9 standards that we ought to include there's a way to
10 upload that document into the standards as a model
11 practice.

12 We could just use that same technology to do
13 that, we would just need to let folks know.

14 CHAIRMAN BURKE: So you're talking then
15 about developing or sharing?

16 MR. TREMMEL: Sharing, being it would be
17 developed at the local level, they would share it up,
18 and then it's available for everyone in the public
19 health system to view it.

20 COMMISSIONER FOUGHT: Yeah, I didn't even
21 think about that, Marty, I was just looking more so like
22 let ODH be the hub of info.

23 COMMISSIONER SHAPIRO: So that was the hub?

24 COMMISSIONER FOUGHT: Uh-huh.

25 CHAIRMAN BURKE: So if we were to consider

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1 Heidi's No. 6, improvement on our current No. 6, any
2 additional discussion to that recommendation?

3 It would read, the Ohio Department of Health
4 should encourage and enhance shared services by local
5 health departments by sharing model contracts and
6 memorandums of understandings that are easily adaptable
7 by local boards, (MOUs and/or all qualifying Councils of
8 Government (COG).

9 VICE-CHAIRMAN PRESS: Mr. Chairman, may I
10 ask Heidi a question?

11 CHAIRMAN BURKE: Yes.

12 VICE-CHAIRMAN PRESS: Thank you. Heidi,
13 would you accept a friendly amendment to change, by to
14 including or including -- in other words, I'm trying to
15 take out the limitation on the -- that limits ODH to
16 this specific thing?

17 COMMISSIONER FOUGHT: Which by, there are
18 two bys?

19 VICE-CHAIRMAN PRESS: Oh, okay. Probably
20 the first one.

21 DR. MCFADDEN: Second.

22 VICE-CHAIRMAN PRESS: ODH would encourage
23 and enhance shared -- second by.

24 COMMISSIONER FOUGHT: Okay.

25 VICE-CHAIRMAN PRESS: By such data as, or

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1 something like that.

2 COMMISSIONER FOUGHT: Yeah, I'm fine with
3 that, opening the door for other alternatives of sharing
4 of certain documents or whatever, yeah, absolutely.

5 VICE-CHAIRMAN PRESS: Right. Precisely,
6 other sharing arrangements, right.

7 COMMISSIONER SCOFIELD: Do we need to
8 include something as specific as Councils of
9 Governments?

10 CHAIRMAN BURKE: We can strike the
11 parentheses statement, is that what you're looking for?

12 COMMISSIONER SCOFIELD: Yeah, I just -- I
13 don't know. I'm not sure why -- I can't remember why we
14 specifically identified COGs as part of this, just as --

15 COMMISSIONER FOUGHT: It was an option.

16 COMMISSIONER NIXON: It came from the
17 report, the Future's Report actually provided some
18 option and that's where that came from.

19 COMMISSIONER SCOFIELD: Okay. It just seems
20 like this says it's either an MOU or Councils of
21 Government, and so that's -- I don't think --

22 COMMISSIONER FOUGHT: I guess I would see it
23 by intent should be more broad, not just limited to
24 those two, I would want it to be as broad as possible.

25 CHAIRMAN BURKE: So I can just insert e.x.

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1 for example?

2 COMMISSIONER SCOFIELD: Yeah, or such as,
3 just so we're not --

4 CHAIRMAN BURKE: I already used a such as
5 earlier.

6 COMMISSIONER SCOFIELD: Okay. Point taken.

7 COMMISSIONER NIXON: Just to expand on, I
8 think, Heidi's point and Anne Goon put some comments in
9 there that I think broaden this to include financial
10 issues and legal issues and technical assistance as
11 needed and necessary.

12 So I think it's not just a model, but also
13 a gamut of issues that you're facing, any kind of
14 cross-jurisdictional sharing or collaboration or
15 consolidation.

16 CHAIRMAN BURKE: For example, to --

17 COMMISSIONER NIXON: Right.

18 CHAIRMAN BURKE: -- Broaden it further.

19 COMMISSIONER NIXON: Well, to include
20 financial, legal and other technical assistance as
21 necessary. And I don't mean financial in terms of
22 provide the money to do it.

23 There's a lot of financial agreements that
24 come into this kind of program that can help provide
25 boiler plate models or what other communities have done.

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1 COMMISSIONER FOUGHT: And, again, yeah, I
2 know we have them at the Township Association for a lot
3 of -- a variety of shared services that we share with
4 folk when they contact us and I'm sure, again, that
5 other associations do as well, but I just think, again,
6 having a hub, and if we're going to have ODH work with
7 the standards and everything else they might as well
8 have some of this other data.

9 CHAIRMAN BURKE: Okay.

10 COMMISSIONER NIXON: And I would say they
11 wouldn't necessarily have to create that, someone need
12 not necessarily create it, but to share with all that's
13 done out there and kind of broker out --

14 COMMISSIONER EDWARDS: -- Just as
15 information.

16 COMMISSIONER FOUGHT: Absolutely.

17 CHAIRMAN BURKE: So if I could read it back,
18 the Ohio Department of Health should encourage and
19 enhance shared services by local health departments,
20 such as the sharing of model contracts and memorandums
21 of understanding that are easily adaptable by local
22 boards, (e.x. MOUs and/or qualifying Councils of
23 Government, financial and technical assistance.)

24 Is that what you're thinking? Nancy, you
25 look like you --

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1 COMMISSIONER SHAPIRO: If you could read it
2 one more time.

3 CHAIRMAN BURKE: Sure. The Ohio Department
4 of Health should encourage and enhance shared services
5 by local health departments, such as the sharing of
6 model contracts and memorandums of understanding that
7 are easily adaptable by local boards. Now, parentheses
8 e.x., now we do kind of restate MOU, and that's
9 duplicative, and other qualifying Councils of
10 Government, financial and technical assistance.

11 COMMISSIONER NIXON: And other technical
12 assistance.

13 CHAIRMAN BURKE: Okay.

14 COMMISSIONER SCOTT-JONES: Mr. Chairman,
15 point of clarification, the gentleman that was on-line,
16 where does his change of including come in?

17 CHAIRMAN BURKE: Such as the sharing of
18 model contracts.

19 COMMISSIONER SCOTT-JONES: Thank you.

20 CHAIRMAN BURKE: Yes, ma'am. Is MOU in that
21 final parentheses, is that duplicative? I think it is.

22 COMMISSIONER EDWARDS: Yeah, it is.

23 CHAIRMAN BURKE: I'll scratch that, okay.

24 COMMISSIONER EDWARDS: What if you change
25 that around and just put memorandums of understanding,

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1 financial and technical assistance?

2 COMMISSIONER NIXON: No example?

3 COMMISSIONER EDWARDS: Yeah, no example.

4 CHAIRMAN BURKE: That would work.

5 COMMISSIONER EDWARDS: Because then that
6 broadens it out better.

7 CHAIRMAN BURKE: Okay. So then help me out
8 here, that are easily adaptable by local boards, then
9 just want parentheses, financial and other technical
10 assistance?

11 COMMISSIONER NIXON: I don't have it, where
12 you have MOU at the top, and then include then after
13 that financial, legal and other technical assistance.

14 COMMISSIONER EDWARDS: Just take out your
15 example, your i.e.

16 MR. TREMMEL: So MOU and COG's language?

17 CHAIRMAN BURKE: Yes, so it would be, that
18 are easily adaptable by local boards, including
19 financial and other technical assistance.

20 COMMISSIONER FOUGHT: Or was it the thought
21 where it goes model contracts, memorandums of
22 understanding, financial, legal and other technical
23 assistance that are easily adaptable by local boards.
24 Is that what somebody was just saying, like to go back
25 up into that sentence?

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1 CHAIRMAN BURKE: Is that what you want, not
2 at the end?

3 COMMISSIONER FOUGHT: I think putting it all
4 up in the list above, Mr. Chairman, is what they were
5 saying.

6 So, model contracts, memorandums of
7 understanding, financial, legal and other technical
8 assistance that are easily adaptable by local boards.

9 CHAIRMAN BURKE: All right. Let me see if I
10 can give it a clean read then.

11 The Ohio Department of Health should
12 encourage and enhance shared services by local health
13 departments, such as the sharing of model contracts and
14 memorandums of understanding, financial and other
15 technical assistance that are easily adaptable by local
16 boards.

17 MR. TREMMEL: Just another point of clarity,
18 the COG language is absent; is there any objection to
19 that?

20 COMMISSIONER FOUGHT: That could still be
21 shared, right, because it's, such as, right?

22 MR. TREMMEL: Yes. I wrestle with sometimes
23 we get two impressions. What did the group mean, and
24 then you get to legal interpretation, if you did not
25 specify then it's not specific and explicit, and it's

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1 not applied or allowable, but it's okay.

2 DR. MCFADDEN: I would hope that our intent
3 would be that there would be no barriers, you know, to
4 shared services, so the COG is the intent of the group
5 to share, that should be allowed, so --

6 CHAIRMAN BURKE: I would assume silence
7 means approval.

8 COMMISSIONER NIXON: Just for simplicity, by
9 developing model contracts, and --

10 CHAIRMAN BURKE: -- Memorandums of
11 understanding, financial and technical -- other
12 technical assistance.

13 COMMISSIONER FOUGHT: Going back to the COG
14 point, Mr. Chairman, I think, again, as long as we're
15 all in agreement that when you say, such as sharing of,
16 it's not limited. I mean do we need -- maybe it's not
17 limited to.

18 I mean maybe that's something to add to
19 address your point, Marty, I'm just wondering, but,
20 again, the idea is that we're being inclusive we're not
21 being exclusive.

22 CHAIRMAN BURKE: Okay. Clean read then, the
23 Ohio Department of Health shall encourage and enhance
24 shared services by local health departments, such as,
25 but not limited to, the sharing of model contracts,

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1 memorandums of understanding, financial and other
2 technical assistance that are easily adaptable by local
3 boards.

4 COMMISSIONER NIXON: Move.

5 CHAIRMAN BURKE: Motion.

6 COMMISSIONER FOUGHT: Second.

7 CHAIRMAN BURKE: All those if favor signify
8 by saying aye.

9 (Thereupon all Commission Members voted
10 affirmatively.)

11 Opposed nay.

12 Ayes have it.

13 Recommendation 9 passes as read, correction
14 6, had it flipped over already.

15 No. 7, Consolidation of Non-Contiguous
16 Cities and Counties. Ohio Revised Code sections
17 3709.051 and 3709.10 to allow city and county health
18 districts to contract, consolidate, merge together
19 within a reasonable geographic distance, consider AOHC
20 regions.

21 COMMISSIONER FOUGHT: Mr. Chairman, I would
22 just ask that if we are specifically looking to address
23 the non-contiguous that that language just be included
24 in some way, you know, that example would be whether
25 contiguous or non-contiguous, that's just an example.

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1 It's just, I think you have to say the word
2 non-contiguous somewhere, that would just be my concern.

3 REPRESENTATIVE ANTONIO: May I ask why?

4 COMMISSIONER FOUGHT: Because all the other
5 sections of the code, I mean if they're only speaking to
6 contiguous or there are limitations with respect to the
7 contiguous, I mean you want to make sure that you're
8 saying that non-contiguous are permitted to go together
9 if they want to.

10 My understanding is the code speaks to
11 contiguous jurisdictions, correct, it doesn't speak to
12 non-contiguous. So without having the word
13 non-contiguous in the recommendation we're only granting
14 contiguous entities the right to do that.

15 The title may say one thing, but the
16 recommendation says -- the title says, consolidation,
17 but the example Ohio Revised Code blah, blah, blah, does
18 not ever say non-contiguous.

19 REPRESENTATIVE ANTONIO: So you want some
20 kind of language that says consideration may be given to
21 non-contiguous, even though it does say within a
22 reasonable geographic.

23 COMMISSIONER FOUGHT: I would just -- I just
24 think we want to be very clear two non-contiguous
25 entities have the ability to do it, and I know, for

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1 example, in township law, and, again, I can only speak
2 to what I know, in township law we had to explicitly say
3 in the Ohio Revised Code during the budget process last
4 year that non-contiguous entities could do something.

5 CHAIRMAN BURKE: So if we inserted the word
6 non-contiguous between the word reasonable and
7 geographic distance, it would read revised Ohio Revised
8 Code sections to allow city and county health districts
9 to contract, consolidate, merge together within a
10 reasonable non-contiguous geographic distance.

11 COMMISSIONER NIXON: I think it sounds
12 better after allow.

13 CHAIRMAN BURKE: To allow --

14 COMMISSIONER FOUGHT: -- Non-contiguous.

15 CHAIRMAN BURKE: All right. Then we will
16 now read, revise Ohio Revised Code section to allow
17 non-contiguous city and county districts to contract,
18 consolidate, that's what you're thinking?

19 COMMISSIONER FOUGHT: Uh-huh.

20 CHAIRMAN BURKE: Okay. Any other
21 recommendation on this recommendation?

22 COMMISSIONER SCOTT-JONES: May I just ask a
23 question for clarification, because if you -- we know
24 what the Ohio Revised Code currently reads and it allows
25 for contiguous, but by putting this statement here and

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1 saying non-contiguous, would someone read that as now we
2 don't allow contiguous?

3 COMMISSIONER NIXON: No, it's a good
4 question.

5 COMMISSIONER SCOTT-JONES: Could someone
6 read that though? How difficult would it be to say
7 contiguous or non-contiguous, that way it just clears up
8 all misunderstandings and you know in the law, if
9 someone can misread something they will.

10 COMMISSIONER FOUGHT: Yeah, I mean it's a
11 very good point, you're right. I mean I don't think
12 that -- we would not recommend changing what's currently
13 there and what's permissible today, it's adding another
14 option, but you're right.

15 COMMISSIONER SCOTT-JONES: That's my concern
16 though, because just based on what you said about you
17 all had to put very specific wording in there, because
18 if it's not there one could assume that it has replaced
19 the contiguous part.

20 CHAIRMAN BURKE: If this were to be written
21 into legislation it would not replace the current code,
22 but add to the current code and give permission for
23 non-contiguous entities to come together.

24 COMMISSIONER SCOTT-JONES: So my concern,
25 would there be a statement that says exactly that, Mr.

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1 Chairman?

2 CHAIRMAN BURKE: And, again, I have not
3 looked at the section of code, I'm going to guess that
4 the section of the code only allows for contiguous.

5 COMMISSIONER SCOTT-JONES: Right, and that's
6 what I'm saying though. There is nothing in this
7 wording that says it doesn't disallow it either.

8 CHAIRMAN BURKE: Yes, but you wouldn't
9 repealing contiguous, you would allow for contiguous and
10 non-contiguous.

11 REPRESENTATIVE ANTONIO: From a
12 non-legislative perspective I hear what -- -

13 CHAIRMAN BURKE: Yeah, I hear what she's
14 saying.

15 REPRESENTATIVE ANTONIO: So maybe because
16 these are our recommendations for here, to allow for
17 contiguous and non-contiguous maybe.

18 CHAIRMAN BURKE: Either way, all right.

19 REPRESENTATIVE ANTONIO: Then we haven't
20 changed, it's allowing both.

21 COMMISSIONER FOUGHT: Okay.

22 COMMISSIONER INGRAM: I was just reading the
23 section of the code that's referenced here, just for
24 everybody's information on 3709.10, which deals with
25 general health districts it says in there, what's

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1 proposed as two or more contiguous general health
2 districts not to exceed five, and unite in the formation
3 of one general health district a District Advisory
4 Council of each general health district shall meet and
5 vote on the question of the union.

6 So there's a limitation of how big you can
7 be, but it is clearly you have to be touching, two or
8 more have to be touching to change that.

9 For cities I don't think it's the same
10 requirement, but I did just want to bring up a relevant
11 question on number of health districts within one county
12 boundary and the size of those.

13 And so my comments are in my -- in the
14 draft, and I'd only ask the group to consider it.

15 With under formation of a city general
16 health district two or more contiguous districts,
17 reading the code there is no limitation on how far you
18 can go, that's all.

19 CHAIRMAN BURKE: Heidi.

20 COMMISSIONER FOUGHT: Sorry, it's not
21 relating to the very end of what Tim said, but going
22 back to where he was reading the code section, is there
23 a reason why we would want to or we would limit it to
24 five for those that are -- I mean is there a reason why
25 it's limited to five and should that number be suggested

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1 to be removed from the code?

2 I don't know. Does anybody know why five
3 was the limit?

4 COMMISSIONER INGRAM: I don't know.

5 MR. TREMMEL: They couldn't get three or
6 four.

7 CHAIRMAN BURKE: It's how many favors --

8 COMMISSIONER FOUGHT: I'm just curious, I
9 didn't know if maybe that would be something you'd want
10 to address.

11 REPRESENTATIVE ANTONIO: Geographic
12 consideration.

13 CHAIRMAN BURKE: I would hope we would have
14 that much consolidation that somebody looks forward and
15 adjusts that, I just --

16 REPRESENTATIVE ANTONIO: I would just like
17 unwielding of getting any larger.

18 COMMISSIONER SCOTT-JONES: Could I ask for a
19 point of clarification, could you read that again.

20 COMMISSIONER INGRAM: Which section, cities
21 or the general councils?

22 COMMISSIONER SCOTT-JONES: 3709.10.

23 COMMISSIONER INGRAM: .10 -- .01, so, union
24 of general health districts, when it's proposed that two
25 or more contiguous general health districts, not to

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1 succeed five, unite in a formation of one General Health
2 District the District Advisory Council of each General
3 Health District shall meet and vote on the question of
4 union an affirmative majority vote -- you want me to
5 read the entire section?

6 COMMISSIONER SCOTT-JONES: No, sir, I guess
7 my -- the general health district is considered what
8 then, a county district?

9 COMMISSIONER INGRAM: Most likely.

10 COMMISSIONER SCOTT-JONES: Most likely.
11 Because I mean if the title is cities or counties, I
12 just want to be sure.

13 COMMISSIONER INGRAM: Yeah, cities are
14 considered health districts too.

15 COMMISSIONER SCOTT-JONES: Right, and you
16 read there are no boundaries for how much you can have
17 in the city.

18 COMMISSIONER INGRAM: I didn't see it, and I
19 read it again.

20 COMMISSIONER SCOTT-JONES: I just wanted to
21 qualify what general health districts meant.

22 COMMISSIONER INGRAM: See, health districts,
23 being an attorney, districts have that connotation of
24 having significant law, it's its own unit of government.
25 We exist because the legislature allows us to be.

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1 COMMISSIONER SCOTT-JONES: But that's why I
2 just wanted to --

3 CHAIRMAN BURKE: So with that being said,
4 No. 7 reads, revise Ohio Revised Code 3709.051, 3709.10
5 to allow contiguous and non-contiguous city and county
6 health districts to consolidate, contract, merge
7 together within a reasonable geographic distance, which
8 we consider AOHC regions.

9 DR. MCFADDEN: Are those the correct codes?

10 CHAIRMAN BURKE: Yeah, I'm assuming and if
11 there are not, if you left something out don't worry
12 about it, LSC will make sure that the intent is
13 adjusted, it could be possibly more or less the code,
14 but it will happen. You know what I mean.

15 Second on the motion.

16 COMMISSIONER SCOFIELD: I just had a
17 question, and I don't even know, just the title of this
18 one, says consolidation of non, do we need to change
19 that too, because it's a little --

20 CHAIRMAN BURKE: Contiguous or
21 non-contiguous.

22 COMMISSIONER SCOFIELD: It says
23 consolidation, but then are we actually talking about
24 contracts, consolidation and mergers, so I just didn't
25 know if it should just say contiguous or U.S. cities and

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1 counties and break it out in the language.

2 CHAIRMAN BURKE: So that the title will read
3 consolidation of contiguous and non-contiguous cities or
4 counties.

5 COMMISSIONER SCOFIELD: No, actually I was
6 thinking strike the consolidation too, because we
7 actually talk about contracts, consolidations and
8 mergers in the -- so I was just thinking just put
9 contiguous and non-contiguous cities or counties as just
10 kind of a general heading for that one.

11 CHAIRMAN BURKE: Okay. Anybody opposed to
12 that change in the title in No. 7?

13 REPRESENTATIVE ANTONIO: I think just saying
14 contiguous or non-contiguous doesn't really give --

15 CHAIRMAN BURKE: -- Direction.

16 REPRESENTATIVE ANTONIO: Yeah, because it is
17 consolidation or mergers, or I mean without repeating
18 the entire part of it.

19 COMMISSIONER SHAPIRO: Is it joining or --

20 COMMISSIONER SCOTT-JONES: Could you not
21 just say contract, consolidate and merger of contiguous
22 or non-contiguous cities and counties in the title?

23 CHAIRMAN BURKE: That would be the simplest
24 way to --

25 COMMISSIONER SCOFIELD: Yeah, I guess my

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1 thought was the other ones establish things like shared
2 services, resources or multi-district public health
3 levy, that doesn't really get into --

4 CHAIRMAN BURKE: So the title for No. 7
5 would read, contract, consolidate and mergers of
6 contiguous and non-contiguous cities or counties, and
7 we've got a motion already on the floor, No. 7 as read.

8 We have a second by Heidi, any additional
9 discussion?

10 All those in favor signify by saying aye.

11 (Thereupon all Committee Members voted
12 affirmatively.)

13 All opposed nay.

14 No. 7 stands as read.

15 Now, we have two more to go before we get to
16 any new topics, No. 8 and No. 9. We'll go then until
17 2:30 before we break.

18 No. 8, Reimbursable Services. Local health
19 departments should work to enhance their ability to
20 contract and credential with private payers and Medicaid
21 Managed Care for clinical services such as immunization
22 and other public health and clinical services.

23 COMMISSIONER SHAPIRO: My comment here, and
24 what I had sort of intended is that there, again, be
25 some language that requires for some basic public health

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1 services, the credentialing of local health departments
2 by insurance plans, because right now I call Medical
3 Mutual and they don't call me back.

4 They are for base programs, I'm not talking
5 about primary care services, you know, doing prenatal
6 care, those type services, immunization services, maybe
7 STD testing, a couple of services that they must
8 contract with local public health to do, because that's
9 how we get more widgets, because we get more income, if
10 we do those services.

11 COMMISSIONER NIXON: I definitely agree. I
12 think the idea of helping local health departments to
13 become eligible with the funding of the insurers is just
14 a no win situation for locals.

15 It's a nightmare trying to get -- there are
16 so many insurers, and, you know, we don't provide that
17 much in terms of clinical services, it spends the money
18 to get that -- to build those relationships with
19 insurers.

20 We need some kind of authority, and I think
21 the Medicaid reform in Ohio is the opportunity to build
22 in some funding structures for local health departments,
23 there's an opportunity to fund local health departments.

24 Some of the things we do in preventive
25 health care services can be funded, some of the -- some

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1 of the other services, the integrated care management,
2 the opportunity for local health departments to bill for
3 that, if they choose, doesn't mandate that that is what
4 they'll do, but it's in their community, they're working
5 with hospitals and others to provide that integrated
6 care. We ought to be able to get funded for that.

7 So I think that here is where the real
8 opportunity to advance public health is, if you just
9 make it up to the local health department, isn't going
10 to move the needle.

11 COMMISSIONER INGRAM: I don't disagree with
12 what either of my colleagues are saying. My reality
13 check on this is we're not structured to be a force
14 enough to negotiate in this market place today. We're
15 not big enough.

16 We don't have the clout, and unless you give
17 us, the legislature all of a sudden gives us an upper
18 hand we've got to fix it another way, which we've kind
19 of passed over here, quite frankly, and that's okay, I
20 understand, but my point is the marketplace is changing.

21 And so we just have to be -- do kind of a
22 gut check here and understand for us to play in this new
23 transforming health care world and what's going on, size
24 does matter.

25 CHAIRMAN BURKE: Well, again, depending on

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1 what services you think you can bring to the table and
2 what value you add you can change the statement to make
3 it more enforceable and read something like, the
4 Department of Insurance should work to enhance the
5 ability of local health districts to contract and
6 credential provider, payers, da-da-da.

7 That's what you really say, if that's what
8 you want done, because I agree with you, the local
9 health department is not going to get anything done.

10 If that's the message you want to send in
11 this recommendation, I don't know, I'm just asking,
12 because then as these ACOs and MCOs and everybody else
13 rolls out and you think you're going to be a part of
14 that network, I don't know, you're all the directors,
15 right on this, if you're going to be plugged into it,
16 obviously they're not going to have to contract with
17 you, because you give away free services, while they're
18 contracted to do it.

19 If you're going to integrate with them in a
20 holistic fashion then the best way to do it is, if you
21 want to have an insurance contract with the State of
22 Ohio you have to acknowledge local health districts as
23 providers.

24 I'm not saying I agree with or disagree with
25 that, but that's what you can do is have a mandate or to

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1 sell your product in the state. I don't know if other
2 states do that or not.

3 COMMISSIONER SHAPIRO: I just know for
4 immunization services, the Delaware General Health
5 District spent three years getting one Medicaid Medicare
6 plan to get a contract that our prosecutor would agree
7 with them to allow us to sign. Three years. That's
8 crazy. One claim.

9 COMMISSIONER EDWARDS: Aren't we being
10 pushed as far as -- aren't local health departments
11 being pushed to contract or to do something by -- well,
12 here, it's, October, isn't it?

13 MR. TREMMEL: It was amended, well, it would
14 appear the CDC has softened their October mandate. The
15 Ohio Department of Health has vaccine funds available to
16 get us through probably February or March, and the CDC
17 mandate maybe stronger by then.

18 But the short of the CDC issue is the
19 vaccine will be used for children that are vaccine
20 eligible, not for children that are part of a family
21 with insurance, and this will be on the heels of the
22 Affordable Care Act, et cetera, et cetera.

23 DR. MCFADDEN: I think part of the reason,
24 we talked about how do we -- how we fund local public
25 health, I struggle a little bit, because part of me says

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1 that this is an association, and as an association we
2 should be making things happen, but I also agree that
3 there are barriers that exist in insurance.

4 I'm not -- I don't know, this statement
5 doesn't necessarily say what I would want it to say, but
6 I also don't know what the appropriate way to say that
7 local health districts should be a player, you know, we
8 should be able to provide services and be reimbursed by
9 insurance companies.

10 I don't know how -- how to make that happen
11 that doesn't force insurance companies to work with --
12 you know one says that they have to contract with
13 physician Y or Z, most of them want to participate,
14 because they're doing a service. So that's where I
15 struggle.

16 I do think, you know, to Tim's point, you
17 know, if an association or a region or a district in an
18 area, we get together and approach insurance companies,
19 it could be easier to get credentialed.

20 It also would be easier to get credentialed
21 if the medical directors were willing to be the person
22 that was going through the credentialing process for the
23 district.

24 You know, lots of things like that, there
25 are lots of little wrinkles in this along the way, but I

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1 feel like there needs to be something said, because
2 we're talking about financing, because it's an important
3 part of financing.

4 I struggle with what's the right way to do
5 it that will make the message, but it isn't -- I'm not
6 looking to say that -- I'm sorry, but I'm not looking to
7 say the insurance company has to contract with me,
8 because they're an insurance company, they're a private
9 entity, but on the other hand, I don't want them to over
10 look me.

11 CHAIRMAN BURKE: The statement would ask the
12 Department of Insurance -- The Department of Insurance
13 should work to enhance the ability of local health
14 departments to contract and credential with private
15 payers -- Department of Insurance should work to enhance
16 the ability of local health departments or districts,
17 whatever the right wording would be, to enhance their
18 ability to contract and credential with private payers
19 and Medicaid Managed Care for clinical services, et
20 cetera, et cetera.

21 Kind of asking the Department of Health to
22 almost be like a buying group, for a lack of a better
23 term, for contractual things under the Department of
24 Insurance and the ability to contract, if you wish, not
25 mandate, should.

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1 COMMISSIONER INGRAM: I think that's a --
2 are we ready to vote?

3 MS. SOLEM: Can I ask a question from the
4 phone?

5 CHAIRMAN BURKE: Sure.

6 MS. SOLEM: I think one of the things that
7 is a barrier for insurers is when they have to make
8 contracts with a lot of small places.

9 Do you feel that the language in some of the
10 other sections that we've looked at would allow
11 financial arrangements among health districts to
12 minimize the number of contracting entities an insurer
13 would have to negotiate with, and simplify the billing
14 process.

15 CHAIRMAN BURKE: Well, just off the top of
16 my head, you're talking a maximum, statewide, 125
17 contracts, and, of course, Ohio is broken up into a
18 three managed care regions depending on where you're at,
19 and it's going to be mirrored with eligibles and other
20 kinds of things.

21 When I think of a place like Marion, Ohio,
22 you probably have more than 125 contracts just in the
23 city of Marion more or less, a few dozen that you're
24 going to have in this MCO region, I don't know, does
25 anyone else, because statewide you're talking 125

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1 contracts and they're probably going to be universal in
2 payment and type.

3 COMMISSIONER NIXON: Should be.

4 CHAIRMAN BURKE: Depending on what you
5 negotiate, right?

6 COMMISSIONER INGRAM: Yes, it's negotiable,
7 and I think it's volume that you actually can bring to
8 the table, so obviously that gives you an opportunity to
9 negotiate for a better rate.

10 You know how this works, this is really a
11 private sector type of notion, just public sector doing
12 the work.

13 CHAIRMAN BURKE: Well, and you can do the
14 same thing again with soft billings on ambulance runs,
15 kind of a precedent, you're familiar with that, this
16 isn't new ground, so --

17 REPRESENTATIVE ANTONIO: And we're talking
18 about this from a local forward, but it occurs to me
19 that hopefully in discussions down the road that there's
20 a role in here, I don't think we can necessarily require
21 it from the health departments, but it seems like
22 there's a role from the health department to be able to
23 do some of these global kinds of contracting as well,
24 because wouldn't that have made, Nancy, your life
25 easier, if there was some kind of, you know, that the

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1 health department did negotiate to be able to be the
2 provider of vaccinations, I'll just use that as an
3 example. I don't know -- you know.

4 CHAIRMAN BURKE: Yeah, it could be one
5 contract.

6 REPRESENTATIVE ANTONIO: Exactly.

7 CHAIRMAN BURKE: Again, we leave that open,
8 we don't specify.

9 REPRESENTATIVE ANTONIO: Right.

10 CHAIRMAN BURKE: It just says to enhance the
11 ability of local health, that could be by coming
12 together with one contract.

13 REPRESENTATIVE ANTONIO: Right.

14 COMMISSIONER NIXON: I think that's fine, I
15 like that. I just -- I think this helps us enormously,
16 even if it's only enabling, even if it just mentions
17 local health departments, because so often we go to the
18 table and we're a second thought, and we have to begin
19 afresh with every new insurer on this issue.

20 And I think it should break open beyond just
21 a clinical immunization. I mean our opportunity to do
22 that integrated care management and some of these other
23 things, it hasn't occurred to a lot of people, a lot of
24 these insurers.

25 I think to say that helps us a lot to be

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1 able to go to them and have that as a recommendation, so
2 I'm strongly in support of it, even if it's only,
3 should.

4 COMMISSIONER INGRAM: Yeah, I think maybe
5 the Director of the Department of Insurance will say to
6 them, we want to see some of these health departments in
7 these contracts.

8 CHAIRMAN BURKE: No. 8, reimbursable
9 services would read, Department of Insurance shall work
10 to enhance the ability of local health districts to
11 contract and credential private payers Medicaid Managed
12 Care for the clinical services such as immunizations and
13 other public health and clinical services.

14 COMMISSIONER NIXON: Can we just expand
15 clinical to include integrated care management, even
16 exchange as health exchanges, because I think it does
17 preventative health care.

18 COMMISSIONER INGRAM: I'd put the word
19 preventative.

20 COMMISSIONER NIXON: Preventative health
21 care and integrated care management.

22 CHAIRMAN BURKE: How about if I add in
23 integrated health management and other care models?

24 COMMISSIONER SCOFIELD: I would just say
25 that within that you could include things like health

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1 education and certified diabetes educators and that type
2 of thing.

3 CHAIRMAN BURKE: So it would read, the
4 Department of Insurance should work to enhance the
5 ability of local health districts to contract and
6 credential in private payers and Medicaid Managed Care
7 clinical services such as immunizations and other public
8 health clinical services, integrated health management
9 and other care models.

10 COMMISSIONER TREMMEL: Ask one more, I'm
11 sorry, ask another clarity, maybe the association is
12 familiar, federally qualified health centers, is this
13 requirement under any Ohio rule or Ohio statute?

14 AUDIENCE MEMBER: I think there's some
15 language in the Ohio statute and rules specially where
16 the Medicaid program is concerned that would -- that
17 might be a model, some of that comes from federal
18 legislation, absolutely, but I do think there's a model,
19 and free clinics are the same way, whether you have
20 carve out or they have the specific mention that might
21 be used again as a model for some of the language that
22 we're talking about.

23 MR. TREMMEL: So the language is already
24 complete, we could just try to mirror, apologize for the
25 digression, but I didn't know, I wasn't aware that there

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1 was something already being done that would make sense,
2 because then everybody could be together having the same
3 opportunity.

4 CHAIRMAN BURKE: It's probable this may
5 change to mirror that new language is what you're
6 saying?

7 MR. TREMMEL: Correct. I'm not sure what
8 the statutory language is, maybe it could say something
9 to the effect that the Ohio Department of Insurance in
10 research of current Ohio statute and rules, while some
11 consistency --

12 CHAIRMAN BURKE: What we could do, if
13 somebody wanted to, we could make a motion on that as
14 read, with the understanding that it is subject to
15 change based some word-smithing on that.

16 And, again, I understand too people when
17 they get this draft document to you so that you can
18 comment on that so we can leave No. 8 open with the
19 intent of it shall be as read, how about --

20 MR. TREMMEL: That would be good.

21 CHAIRMAN BURKE: Do we have a motion then to
22 accept intent as read, No. 8.

23 COMMISSIONER NIXON: So moved.

24 COMMISSIONER SCOTT-JONES: Second.

25 CHAIRMAN BURKE: All those in favor signify

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1 by saying aye.

2 (Thereupon all Commission Members voted
3 affirmatively.)

4 All those opposed nay.

5 No. 8 passes as read. Leaves us just number
6 nine. We'll take a ten minute recess.

7 (OFF THE RECORD.)

8 (BACK ON THE RECORD.)

9 CHAIRMAN BURKE: Call the committee back to
10 order. We have one other recommendation to look at that
11 we have under No. 9, Chronic Disease Block Grant
12 Funding.

13 It reads, the Ohio Department of Health to
14 initiate review of federal and state authorities for a
15 blended funding approach that integrates all state,
16 federal, public health funding using block grants
17 when/where possible to reduce fragmentation in public
18 health funding. Any thoughts?

19 REPRESENTATIVE ANTONIO: I have a question.

20 CHAIRMAN BURKE: Representative.

21 REPRESENTATIVE ANTONIO: Can we have an
22 example of what this -- some kind of a concrete example
23 of what this looks like or what this would look like.

24 DR. MCFADDEN: So the example that I would
25 provide that exists currently is one that I've given

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1 before, which was Nebraska, which uses a block grant
2 approach.

3 They are funding from a set pool of money,
4 rather than mixing funds, but set pool of money that
5 comes from their tobacco settlement, which is a little
6 different than what we're describing here.

7 But they have a list of what they expect
8 local health to be doing, they provide the block grant
9 and they say, these are what you are to accomplish.

10 The locals have to accomplish that, but also
11 annually they have to report back to the state in a
12 report that then is consolidated and made available to
13 everyone, the state comments back, I believe it's to the
14 legislature, but it might be just to the health -- State
15 Health Department and that's how they do it.

16 I think that what the consideration here is
17 to try and find ways that these silo streams of funds
18 that come to ODH, and then go out, could somehow come
19 out of the silo be somehow consolidated and pushed out
20 as consolidation with expectations of outcomes.

21 So we send this money to you so that, you
22 know, if the money runs out for X, but there's still a
23 need there, how does that need get met, or if there's
24 not as much need there at X, does that money all go back
25 to the state or a new need happens in this time period,

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1 there's money for this, there's money for this, there's
2 money for this, but a new problem develops that the
3 state doesn't send -- the state or the feds don't send
4 money for.

5 For example, if during H1N1 the feds had
6 said we have vaccine available, make it happen, and we
7 were to find ways to do what they were asking us to do
8 without the fund of how would we do that.

9 Well, we couldn't pull from this here,
10 because we have specific, couldn't pull from this grant,
11 we could pull it from our general fund, as long as we
12 have general funds and rainy day, but then there comes a
13 point in time where we can't pay salaries to carrying
14 out all these things, so how do you do that. I think
15 that's some of what's being asked.

16 I think the part of the piece that's missing
17 here is, I think it's been mentioned earlier, but how do
18 we hold folks accountable for the money that's coming
19 down?

20 I think a block grant is -- I think we need
21 more flexibility that way, but then how do we report
22 back; how do we? I think that's where earlier No. 2, we
23 were talking about reporting, it's going to be
24 important, but I think there is some self-reporting back
25 to the state on how we do.

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1 REPRESENTATIVE ANTONIO: Thank you, that
2 helps me understand where the could be. What is it
3 we're changing; what does this change?

4 COMMISSIONER INGRAM: Right now it's all
5 categorical funding, so we're always -- you probably
6 know this, we're always chasing the next grant, at least
7 we are.

8 And so, you know, we follow the money. I
9 mean I think most people do, and so whoever is funding
10 and where we think there's a need, there's a service
11 that would benefit our community, and it may not be the
12 most pressing need, but it's something that we think
13 that we can -- we're all going to be doing it.

14 So the question becomes, as you -- you know,
15 that's how the federal government quite frankly
16 influences us at the local level, what they see as their
17 health priorities.

18 They put the money in the bucket and say, go
19 get it, and then they know you're going to, and then
20 they hold us accountable.

21 So the question becomes, I'm not just saying
22 we're not going to change that necessarily, but I think
23 that money comes through the state, the state does what
24 they do with it, and then, you know, we get it from them
25 more times than not.

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1 So I think what we're looking at is to
2 generalize that money for -- in other words, not --
3 instead of just saying we're going to go after
4 cardiovascular disease or cancer prevention control, or
5 what have you, it might be, as D.J. laid out in chronic
6 disease, it would include all of those; is that what
7 you're thinking?

8 DR. MCFADDEN: Yeah, absolutely.

9 COMMISSIONER INGRAM: I mean if it's an
10 infectious disease grant for like right now, five or six
11 regions get HIV and STD moneys, but they can only be
12 used -- quite frankly the STD money can only be used for
13 syphilis, and then you have HIV money.

14 So you've got to ask yourself, what about
15 the rest of them; who's going to take care of that?

16 And so, I mean, we really -- it's kind of
17 rethinking how we fund these programs, and we keep it as
18 specific as it is today, in which it is, it's
19 categorical, to virtually broadening it into more
20 general buckets.

21 COMMISSIONER SCOFIELD: If I might add, at
22 least this is how it worked when I was still at the
23 local health department, and it's been a few years, but
24 there might be a diabetes prevention grant and a
25 cardiovascular health promotion grant, but they were

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1 never able to intersect.

2 So we weren't really able to leverage, even
3 if they did come down in the silo you weren't able to
4 lever that, you had to come up with a different action
5 plan and different ways of spending the money, and you
6 couldn't leverage those two grants, so it made it, you
7 know, difficult to really --

8 COMMISSIONER SHAPIRO: Different staff
9 people, different coalitions, same people coming to two
10 different meetings, because they each have to have their
11 own.

12 COMMISSIONER SCOFIELD: Yeah.

13 DR. MCFADDEN: But one of the pieces though
14 that I think you point to, Tim, that I think we had
15 mentioned a little bit the last time was by having -- by
16 having this block grant, the state does have an
17 opportunity to try to direct some priorities for the
18 state.

19 I mean now how it's done, the state directs
20 that body which grants they apply for from the CDC, but
21 it's also what grants they can get, but with this sort
22 of approach there could be -- the state could say these
23 are the areas that we expect you will be addressing, not
24 that it's limited to these, but we have to see movement
25 in A to B and C to D, as we do this, and there certainly

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1 is the opportunity to say, and if there's not movement,
2 you know, this consequence happens, there's certainly
3 that.

4 COMMISSIONER INGRAM: Not to rain on it, I
5 actually like the idea, but then I just, practically
6 speaking, I think that if I'm in the state's seat, and
7 I'm not, they might have a problem trying to pull this
8 off, because the fact that the money they're getting
9 from the feds aren't categorical, and so I don't know
10 how we address that question for now, but it would be
11 interesting perhaps, Marty, looking at all the grants
12 that you guys have on your website that are available
13 through multiple organizations throughout the state, how
14 many of those could actually be blended and what would
15 not be allowed to be blended.

16 COMMISSIONER SCOFIELD: Or, again, even if
17 it's -- and I understand, because there's reporting,
18 there's financial reporting, and there's other things
19 that have to be kept separate, but I think if the
20 programs could be administered in a more integrative
21 fashion where we weren't so limited at the local level
22 as to how we -- how we use them to build a more robust
23 local program.

24 Like you said, there's multiple coalitions
25 that are talking about healthy eating and no smoking and

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1 physical activity, but they're not -- there's a diabetes
2 one and a cardiovascular health one and something else,
3 so even if, you know, there could be a more streamlined
4 way of actually administering the grants so there's not
5 so much duplication, that would be very helpful just in
6 that too.

7 REPRESENTATIVE ANTONIO: So that goes to
8 where my thought process was, is that so many times
9 these details are dictated at the federal level by
10 whatever the source of the grant is itself, so -- but I
11 guess why I'm curious from the group that there's enough
12 possibility of making these kinds of decisions at the
13 state level for the -- to be a part of this initiative,
14 because if people believe that's --

15 COMMISSIONER NIXON: I'm not convinced, I'm
16 not sure what headway we can make in this. I know the
17 state has tried that in the past with grants that came
18 to our community for locals to sign off on the direction
19 of some of the -- how those grants were administered,
20 and I don't know what impact that had, if any.

21 I'm not sure what kind of dent we can make,
22 but some of the issues go to the very funding from the
23 federal government to Ohio which grant's way at the
24 bottom.

25 You know, I think there ought to be a

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1 combined initiative to try to do something about this,
2 you know, use our joint leveraging capacity and work our
3 federal partners and try to address some of these
4 funding streams and the amount that we get, what they're
5 focused on and how we can weave them together a little
6 bit better, but, you know, there's not a lot of state
7 dollars that comes to local, so I don't know what dent
8 we can make.

9 So this is really the administration of
10 federal dollars, and it's not very good, and it's not
11 very integrated, it's not efficient at all, you heard, I
12 think, from Nancy about some of that, where we, you know
13 -- and so I think we ought to work to do something about
14 our federal funding of public health overall.

15 REPRESENTATIVE ANTONIO: So, if I might, so
16 then it sounds like not only are we doing this in an
17 effort to reduce the fragmentation, but also in an
18 effort to increase and leverage additional dollars being
19 able to come in.

20 COMMISSIONER NIXON: Sure.

21 REPRESENTATIVE ANTONIO: So I don't know if
22 that's a part of the thinking, a part of clarifying,
23 this. That helps me, because it's almost like we're
24 suggesting something that we may or may not have total
25 control over, but if we have this vision at the state

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1 level and are pushing that then it -- coordinating then
2 it's possible for us to bring more dollars in.

3 COMMISSIONER SHAPIRO: I might have missed
4 -- but are we still 50th in the nation for CDC?

5 COMMISSIONER SCOTT-JONES: 49th.

6 COMMISSIONER SHAPIRO: Either one,
7 Mississippi is better.

8 COMMISSIONER INGRAM: Do we know why we're
9 so low? Why -- why are we competing so poorly to bring
10 all these grants; why are the other states ahead of us?

11 MR. TREMMEL: Well, we don't know, that
12 would be one way of saying it. The short answer is that
13 Ohio is not alone.

14 It would appear that when we look an the
15 demographics across the country some or a number of the
16 states in the lower quartile of funding at the federal
17 level for states in the midwest, West Virginia,
18 Tennessee, Michigan, Pennsylvania, Indiana, but we don't
19 know why that disconnect exists.

20 And I think -- and I think we've been
21 asking, and I think the administration here is starting
22 to ask, more to HHS and HRSA and CDC, what is that;
23 there seems to be a disparit amount of per capita
24 funding to the midwest states, don't have any answer,
25 but I think there's opportunity.

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1 I think, you know, we could pontificate on
2 any number of issues and opportunities, but probably the
3 sooner we could have some discussion with the
4 administration of health and administration of public
5 health systems to the administration from the
6 administration up to the federal level, and using our
7 own, you know, our own congress folks here and your own
8 senators, I think the more this would be brought to the
9 attention of our congressional folks in Ohio.

10 I think they would be more likely, and I
11 think are maybe starting to do something of this up in
12 your area.

13 COMMISSIONER SCOFIELD: Another thing that
14 I've always thought was -- at least in my experience has
15 been missing is any kind of real relationship with the
16 staff in the regional office in Chicago, which is often
17 an opportunity to get to know what's coming down the
18 pike, to get to know some of those senior administration
19 officials, and that would be the same kind of approach.

20 But you've got all of those types of
21 agencies for the most part are in the regional office in
22 Chicago, so that's another opportunity, I don't think
23 we've taken advantage of in the past.

24 CHAIRMAN BURKE: Okay. Well, again, looking
25 at No. 9, have not heard any changes in wording, so,

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1 again, it still reads as read. I don't know, hearing
2 discussions, but I'm not hearing any recommendations
3 beyond what's already down.

4 REPRESENTATIVE ANTONIO: I guess I would
5 like to, in addition to reducing the fragmentation, I
6 would say also in order to leverage and increase
7 leverage.

8 COMMISSIONER SCOTT-JONES: In line with what
9 Ms. Scofield was saying, maybe some wording that
10 includes the regional aspect as collaboration with
11 federal, regional and state authorities.

12 CHAIRMAN BURKE: Does that fit? Looking for
13 -- okay.

14 COMMISSIONER NIXON: Can we possibly change
15 review to advocate or review and advocate or advocate,
16 I'm not sure where we are at.

17 CHAIRMAN BURKE: Okay. So ODH to review --
18 initiate, review and advocate?

19 COMMISSIONER SCOTT-JONES: I think that's
20 kind of what I was saying was instead of review was
21 either promote a collaboration with federal, regional
22 and state authorities for the blended funding.

23 COMMISSIONER NIXON: And increase.

24 COMMISSIONER SCOTT-JONES: Right.

25 CHAIRMAN BURKE: Okay. I see what you're

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1 saying. Trying to -- so you were talking, Anita, at the
2 beginning of the sentence.

3 COMMISSIONER SCOTT-JONES: ODH would promote
4 collaboration, rather than the word review or something,
5 with federal, regional and state authorities for a
6 blended funding approach, something like that.

7 CHAIRMAN BURKE: You said review and
8 advocate, review and advocate?

9 COMMISSIONER SCOTT-JONES: Either way.

10 CHAIRMAN BURKE: Does that -- okay. So then
11 if I read this as I understand it then, ODH initiate,
12 review, advocate federal and state authorities for a
13 blended funding approach that integrates all state,
14 federal, public health funding in block grants
15 when/where probable to reduce fragmentation of public
16 health in an effort to leverage and address funding.

17 COMMISSIONER SCOTT-JONES: The word regional
18 just to include the Chicago office, and other entities.

19 HEARING OFFICER: So state, federal and
20 regional public health.

21 COMMISSIONER SCOTT-JONES: Yes.

22 CHAIRMAN BURKE: Okay. I got you. You want
23 me to read this one more time from what I have, ODH
24 initiate, review and advocate federal, state and
25 regional authorities for a blended funding approach that

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1 integrates all state, federal, public health funding
2 using block grants when/where possible to reduce
3 fragmentation in public health funding in an effort to
4 leverage and increase funding.

5 This seems kind of choppy.

6 DR. MCFADDEN: I think that might need some
7 work, but I mean -- because we have the idea that we
8 want, but I'm not sure that we flow.

9 COMMISSIONER SCOTT-JONES: So you're saying
10 review, initiate, advocate, right?

11 CHAIRMAN BURKE: Well, I didn't say
12 initiate, ODH initiate --

13 COMMISSIONER SCOTT-JONES: -- Review and
14 advocate --

15 CHAIRMAN BURKE: Yeah, federal, state and
16 regional authorities for a blended funding approach that
17 integrates all state/federal, public health funding
18 using block grants when/where possible to reduce
19 fragmentation in public health funding and (sic) an
20 effort to leverage and increase funding.

21 COMMISSIONER SCOTT-JONES: Reduce,
22 leverage --

23 COMMISSIONER NIXON: In an effort, rather
24 than and an effort.

25 CHAIRMAN BURKE: So to read this one more

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1 time, to leverage and increase funding, so to read this
2 one more time.

3 REPRESENTATIVE ANTONIO: Can I make one
4 suggestion?

5 CHAIRMAN BURKE: Yes, ma'am.

6 REPRESENTATIVE ANTONIO: Okay. So where it
7 says, to reduce fragmentation, leverage and increase
8 public health funding, how about that? Leverage and/or
9 increase public health funding, that way we're not
10 saying public health funding, increase price.

11 CHAIRMAN BURKE: Okay. So then if I heard
12 you correctly, then it would be thinking up, to reduce
13 fragmentation in an effort to leverage and increase
14 public health funding.

15 REPRESENTATIVE ANTONIO: Great.

16 CHAIRMAN BURKE: So give it one read here
17 then, the Ohio Department of Health initiate, review,
18 advocate federal, state and regional authorities for a
19 blended funding approach that integrates all
20 state/public health funding using block grants
21 when/where possible to reduce fragmentation in an effort
22 to leverage and increase public health funding.

23 COMMISSIONER NIXON: I'll move to support
24 it.

25 REPRESENTATIVE ANTONIO: Second.

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1 CHAIRMAN BURKE: Okay. All those in favor
2 signify by saying aye.

3 (Thereupon all Commission Members voted
4 affirmatively.)

5 All those opposed nay.

6 The ayes have it. Recommendation 9 stands
7 as read.

8 That is the last of the recommendations that
9 we had left over to finalize from the previous meeting.

10 Just looking at our agenda before we move on
11 to the next topic, we have a review that you all were
12 sent 1993 and 1960 Boards of Health Recommendations just
13 to kind of spark interest in our next topic area.

14 One of the things that I did want to discuss
15 as we move into the next final part here, which is kind
16 of open season, I guess, to any other ideas that anybody
17 wants to work through that, that may take a little time.
18 We have about an hour here.

19 Is there any intent for a recommendation to
20 ask for any kind of reconvening of this body or another
21 body, two, three, four, five years down the road; is
22 that a reasonable recommendation to ask at least to have
23 out there whether or not it gets acted on or not?

24 COMMISSIONER WENTZEL: I think it's
25 reasonable. We have been going through the years, 20

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1 years before we look at things again, and maybe not wait
2 that long. We can re-evaluate where we're at today in
3 three years and maybe make changes quicker.

4 COMMISSIONER EDWARDS: If we're asking -- if
5 we're asking -- in the beginning we talked about five
6 years in our first recommendation.

7 CHAIRMAN BURKE: Correct.

8 COMMISSIONER EDWARDS: Six years, five, six
9 years down the road, we should be looking at what's
10 going on. This should not be a plan that's just
11 shelved, that would be a working suggestion.

12 DR. MCFADDEN: The concern, five years is --
13 I do feel that after the election and next year we may
14 very well see continued rapid changes in many of the
15 areas that affect public health.

16 So while I don't disagree with the logic of
17 five or six years, my concern with that is things may
18 have changed enough within three years that we need to
19 rethink. That's the only proviso that I would put out
20 there.

21 COMMISSIONER NIXON: You could say that the
22 director can reconvene this group at any time that may
23 be necessary, but no later than five years.

24 COMMISSIONER INGRAM: That's one way of
25 getting good compromise.

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1 COMMISSIONER EDWARDS: Yeah.

2 CHAIRMAN BURKE: The Director of Health?

3 COMMISSIONER SHAPIRO: The Director of
4 Health Or --

5 COMMISSIONER INGRAM: You prefer it to be
6 somebody else?

7 CHAIRMAN BURKE: No, I'm okay with that. I
8 just want to make sure that the Director of Health is
9 the advocate.

10 COMMISSIONER INGRAM: We will have a
11 Director of Health in the future, right?

12 CHAIRMAN BURKE: Yeah, but I see director,
13 but not act.

14 COMMISSIONER NIXON: No later than five.

15 CHAIRMAN BURKE: Shall be no later than.

16 COMMISSIONER NIXON: Maybe convene sooner,
17 if necessary, but no later than five years from the
18 date.

19 COMMISSIONER SCOTT-JONES: Mr. Chairman, for
20 consistency sake the legislature convened, this
21 committee, right, so I would think this legislature
22 would reconvene, just a thought.

23 CHAIRMAN BURKE: Well, this body dissolves
24 after it submits its recommendations.

25 COMMISSIONER SCOTT-JONES: But you're

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1 putting that caveat in there though, right?

2 CHAIRMAN BURKE: Well, the law, we don't
3 have the ability to change the law. We can only make
4 the request that this body be reinstated at another
5 date for review of this work, but technically it ceases
6 to exist by law once we submit our recommendations.

7 COMMISSIONER SCOTT-JONES: But aren't we
8 making a recommendation?

9 CHAIRMAN BURKE: We are making a
10 recommendation.

11 COMMISSIONER SCOTT-JONES: Could we not make
12 one for that?

13 CHAIRMAN BURKE: Yes, my point exactly, but
14 in order to be in the same capacity it would require a
15 law, otherwise, it could review. I mean the
16 recommendation could be for the Director of Health, but,
17 again, this body was formed under the power of law, and
18 the director doesn't have to reconvene it.

19 COMMISSIONER SCOTT-JONES: But I'm not
20 talking about the director reconvening. I'm talking
21 about legislature reconvening, because it was the
22 legislature that convened it, right, not the Director of
23 Health?

24 CHAIRMAN BURKE: Correct.

25 COMMISSIONER SCOTT-JONES: So I'm just

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1 saying the same entity, but put a recommendation in our
2 recommendations that it not be dissolved or that it be
3 continued.

4 CHAIRMAN BURKE: No, we wouldn't have time
5 to pass a bill for this.

6 COMMISSIONER SCOTT-JONES: To not dissolve
7 it?

8 CHAIRMAN BURKE: No.

9 COMMISSIONER SCOTT-JONES: But you could put
10 a caveat in there that we could possibly reconvene for a
11 review?

12 CHAIRMAN BURKE: You could, and that's the
13 route I was thinking about going, any thoughts? Is
14 that --

15 COMMISSIONER SHAPIRO: Reconvening, one
16 association that was left out of this whole discussion
17 was the health educator group, SOPHE, so maybe
18 reconvening, maybe not, that was the public health
19 association that was not included, so I know they wanted
20 to be, trying to be all inclusive.

21 CHAIRMAN BURKE: I'm okay with that. The
22 only thing is you're not just asking them to reconvene
23 this current body, you're asking to reconvene this
24 current body plus this person.

25 COMMISSIONER SHAPIRO: Well, yeah.

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1 CHAIRMAN BURKE: Then once you get into the
2 list of calling names, brother, look out.

3 COMMISSIONER SHAPIRO: All right.

4 CHAIRMAN BURKE: Sophie, she may be a
5 wonderful person.

6 COMMISSIONER SCOFIELD: I think we made a
7 compromise on that, because I'm a member of Sophie.

8 CHAIRMAN BURKE: I don't know who she is,
9 but God bless her.

10 REPRESENTATIVE ANTONIO: Jennifer, did you
11 say you're a member?

12 COMMISSIONER SCOFIELD: Society for Public
13 Health Education, yeah, so I'm kind --

14 COMMISSIONER SHAPIRO: That there's peace in
15 the --

16 COMMISSIONER SCOFIELD: Yeah.

17 CHAIRMAN BURKE: So, okay, if we were to
18 make a recommendation that this body were to reconvene
19 for review, what would that time period be, two years,
20 three years?

21 I mean appreciate the cognitive, some of
22 these things might take a while to get acted on, and
23 then reconvene in the end and there's no action on,
24 what's the point of having a meeting.

25 COMMISSIONER SCOFIELD: I think three is

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1 probably reasonable.

2 CHAIRMAN BURKE: Three years, okay. So then
3 just a straw vote, so then the recommendation would be
4 that this body reconvene for review purposes, I don't
5 know if I would say every three years or within three
6 years.

7 COMMISSIONER NIXON: Three years from the
8 date.

9 CHAIRMAN BURKE: Within three years from the
10 day of the report submission; does that make sense then?

11 Okay. Paraphrasing this, I guess just to
12 make sure that everybody's on board, so the body would
13 reconvene for review within three years of the date of
14 report submission. That kind of general wording, you
15 get the idea.

16 Is there anybody that's opposed to that, I
17 guess, would be the best way to phrase it?

18 MR. TREMMEL: With authority -- just under
19 the authority or preface of the senate of this or you
20 should the authority --

21 CHAIRMAN BURKE: Whoever, I mean it's
22 possible you could put this -- if somebody picked up
23 these recommendations, then could put it in a budget
24 bill or another bill, you know, then going to act an it.
25 I would hope if you're going to call to reconvene that

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1 you should do it because you're acting on something that
2 we've done, just thinking out loud.

3 Okay. With that being said, are there any
4 additional topics anybody else would like to work on for
5 recommendations.

6 DR. MCFADDEN: As I look at the survey that
7 we did, I think that Recommendation No. 1, we've tried
8 to address throughout so many of these, which is one of
9 our top.

10 No. 12, which was another one of the ones
11 that we identified as being important to us, I think
12 we've definitely addressed through a couple of these
13 recommendations.

14 No. 13 and 14 were others that we have -- we
15 identify as being important to us. I'm not sure that we
16 have necessarily addressed those in our list of nine,
17 and the other ones that we've addressed are 4, 6, 15,
18 and 16, as I see it, maybe others see it differently.

19 I guess, I feel like we've tried to say some
20 things around 13 and 14, and I would be interested to
21 put it to a vote.

22 I realize that there are difficulties
23 politically to make this happen, but I would feel like I
24 would have not done my job if I didn't suggest that we
25 make a recommendation for new mechanisms for funding

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1 public health, such as excise tax, be included in that.

2 So I would -- I understand the other forces
3 at work here, but I would feel like I wasn't doing my
4 job if I didn't at least make that recommendation.

5 CHAIRMAN BURKE: So you want me to write
6 that down there, talking about the investigation --

7 DR. MCFADDEN: Right.

8 CHAIRMAN BURKE: -- Of an excise tax as a
9 source of revenue --

10 DR. MCFADDEN: -- For the public health
11 system.

12 COMMISSIONER NIXON: Or other mechanism.

13 DR. MCFADDEN: Other mechanisms.

14 COMMISSIONER SHAPIRO: Are you talking
15 specific excise taxes or are you just leaving that
16 broad?

17 COMMISSIONER NIXON: Well, we've talked a
18 soda pop tax --

19 COMMISSIONER SHAPIRO: -- Like tobacco,
20 sugar sweetened beverages.

21 CHAIRMAN BURKE: So the investigation of
22 excise tax or other mechanisms as a source of revenue
23 for funding local health districts. Anybody else want
24 to add anything to that?

25 That sweet, that simple, okay.

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1 COMMISSIONER INGRAM: If we're going to get
2 tax is that just additional or redistribution of
3 existing.

4 DR. MCFADDEN: No.

5 COMMISSIONER SHAPIRO: No.

6 DR. MCFADDEN: My sense would be that we do
7 something that's additional, rather than redistribute.

8 CHAIRMAN BURKE: The investigation of excise
9 tax or other mechanisms as a source of additional
10 revenue for funding local health districts.

11 COMMISSIONER NIXON: Well, while we're at
12 the table we're currently funded at 17 cents per capita,
13 and we've identified \$5 per capita as necessary and
14 actually we're doing -- we have some funding to do some
15 studies to that effect, what does it cost to fund that
16 foundational capability in Ohio and that's our best
17 estimate, so I don't have hard data.

18 Do we want to say 17 cents to increase it
19 to, you know, a number, because just to increase the
20 amount without some target I think may not be doing our
21 job. I'd recommend \$5.

22 REPRESENTATIVE ANTONIO: Wow, 17 cents to
23 \$5, no problem.

24 COMMISSIONER SCOFIELD: Well, that gives you
25 room for negotiation as part of the process.

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1 CHAIRMAN BURKE: I don't know if I want to
2 name a number --

3 COMMISSIONER NIXON: Thought I'd throw it
4 out there, see --

5 COMMISSIONER INGRAM: Well, so I had to take
6 a call, are we actually on No. 6 or which number?

7 COMMISSIONER NIXON: A new number.

8 CHAIRMAN BURKE: We're just talking about
9 using excise taxes as a source of funding -- new excise
10 tax revenue or existing as a source of additional
11 funding.

12 COMMISSIONER INGRAM: You know, I guess it
13 will come as no surprise to the group by now, so I have
14 no -- there's no question, I would hope, to the group
15 that we're woefully under funded for the work that we
16 need to do, and that's expected of us to do.

17 And I can give a point in case of the fungal
18 meningitis situation over the weekend, because we had a
19 facility involved and we took time, brought 20 some
20 people in on Sunday and contact 200 patients and worked
21 with the other health districts for those that we
22 couldn't get ahold of that live in their homes so they
23 weren't laying on the floor suffering from a stroke or
24 something else.

25 Now that's what, you know, you need these

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1 boots on the ground, that's the important work that we
2 do.

3 I will also say to you being in a system for
4 a few decades that I don't believe we can just throw --
5 put more money in the system without looking at the
6 structure, and so I would just put that attachment to
7 it, I don't know what the answer is.

8 There's plenty of reports that have been
9 published over the years the '93 report suggested one
10 per county, the '60 report suggested something over
11 25,000.

12 I just know that there does -- this does not
13 have to be a win, loose, this can be a win, win, and
14 that's how we should approach it, but we should create a
15 structure that will allow us to be better funded while
16 we're building better efficiency and effectiveness, and
17 I know that's generalizing statements there, but I would
18 be the first one to go in front of the health committee
19 asking for money with a structural change in the system
20 that made sense.

21 COMMISSIONER SHAPIRO: One way, I'm in -- my
22 community is one that's growing in Ohio, so we have the
23 potential for additional cities.

24 Right now a city of -- that once you hit
25 that 5,000 people threshold you can do a whole bunch of

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1 stuff, and one of them is form your own health district.

2 One of the things we could do, I don't know
3 if it's easy or hard legislatively is say, instead of
4 5,000 you have to have a population for X before you can
5 do that, not saying old, new city, but that would maybe
6 stop a little bit of the increase in numbers in those
7 areas where you're having population growth.

8 You're a village now, do you really care
9 when you're at 5,000, I don't know if you care, because
10 you're getting health services from your health district
11 that's -- so it might be an easy way to contain in those
12 areas. So I'm thinking like Warren County --

13 COMMISSIONER FOUGHT: Medina.

14 COMMISSIONER SHAPIRO: Yeah, all of those
15 surrounding areas.

16 COMMISSIONER NIXON: Just to add to my, I
17 was just putting out that \$5. I agree with you, Tim, I
18 think we do have to demonstrate something back. We do
19 have to -- I don't think we can just throw money at the
20 problem in Ohio, but I do think it's worth noting the 17
21 cents, and the fact that Ohio really does not have state
22 support for a public health system, and, in fact, if
23 we're committed to changing the health of our state then
24 there needs to be investment in the public health system
25 and 17 cents does not step up and do that.

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1 So some language that acknowledges that,
2 maybe absent a dollar amount, but I think it's unfair
3 not to recognize -- we ran into that problem in some
4 discussion about redistribution of state dollars, so we
5 pointed out it's only 17 cents per capita, and there's
6 nothing there to redistribute.

7 So it is something that ought to be
8 acknowledged in the report, so whether or not we put an
9 amount to recognize that I think it's appropriate. But
10 as Tim says, there's also a burden on the public health
11 system to demonstrate the value of that, and I think
12 we've put together some things that should do that with
13 accountability and verification, and I think we put some
14 things in there that should demonstrate to legislators
15 and to the State of Ohio that some steps have been taken
16 in the right direction.

17 COMMISSIONER EDWARDS: To add on to what
18 Gene was saying, I think that should really come at the
19 beginning of the report, and really public health hand's
20 have been strapped, I think, in some areas about doing
21 that, changing things and doing things without
22 significant dollars to be able to do this. So I think
23 that should come at the beginning of the report.

24 REPRESENTATIVE ANTONIO: You know, it
25 occurred to me, when you went from the 17 cents to the

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1 \$5 the first thing that came into my head was, what are
2 we paying for now; what are we missing; what outcomes
3 are being affected or not affected, because of this
4 amount; and in order to even suggest an increase what
5 does that mean; what are those outcomes; what are we
6 moving towards; how is public health being impacted in a
7 positive way, if there is an increase?

8 And it seems like a lot of what we've been
9 talking about in the past several weeks and through this
10 process is how to document and even get that baseline,
11 really, on where we are right now to be able to even
12 articulate what additional funds or where -- I don't
13 even want to talk about it in terms of funds, but what
14 are the additional needs and expectations of this
15 department?

16 So that's what I thought of, I don't know
17 that I've --

18 CHAIRMAN BURKE: I'm just thinking more to
19 Kim's comment, and I appreciate what you're saying, but
20 if I opened up a report and the first thing to hit me in
21 the face was a request for money the next thing I'm
22 going to do is shut the report.

23 COMMISSIONER EDWARDS: I guess I'm not
24 necessarily asking for money, but I'm saying this should
25 be pointed out.

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1 CHAIRMAN BURKE: But I think you just built
2 a great cause for the things you're going to do, and
3 then if I were to take some of what I heard here and put
4 it into a sentence, it would be investigation of excise
5 tax and/or mechanisms as a source of additional revenue
6 for funding local health districts, noting that the
7 current 17 cents per capita per year is inadequate for
8 incentivizing compliance to outcomes at the local level.

9 COMMISSIONER FOUGHT: So moved.

10 COMMISSIONER EDWARDS: It's done.

11 CHAIRMAN BURKE: Really.

12 COMMISSIONER NIXON: No, I like that, but I
13 would just add and improve health for Ohioans.

14 CHAIRMAN BURKE: Well, but outcomes, that's
15 what we're looking for, because I just say that, because
16 it's hard for the state to ask you all to do something
17 when all you have to do is say only 17 cents, have a
18 nice day, you know what I mean.

19 I'm not going to pay 25 cents to get your 17
20 cents, use more of a carrot and a stick approach, right,
21 chronic disease partner with us and all those other
22 things that we stated up there on the list then help me
23 get there, that to me is what you say at the end. I can
24 do those things, but you have to help me get there.

25 COMMISSIONER SHAPIRO: I don't know, I like

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1 the word incentivize, I think those of us who are in
2 public health are there for the public's good and I
3 don't know, but that I understand.

4 CHAIRMAN BURKE: I think I can't pass a law
5 that says I want you to drop your health districts BMI
6 down to 22, but if I incentivize you and pay you for
7 every person that comes into your health department for
8 a BMI screening, I'll give you this, and if they go to
9 class and they attend that full course I'll give you
10 this, and if you partner with an employer on smoking
11 cessation, I'll give you this, you know what I mean,
12 work to do those kinds of things, right, that I can
13 measure, then I'll pay you to do those things on behalf
14 of the state to improve health in the health district.
15 That's what I think of when I think of incentivizing you
16 to do something.

17 COMMISSIONER INGRAM: To kind of add on to
18 that a little bit, I guess, there was a comment from a
19 health commissioner outside of our committee, I think it
20 was in the other comments -- additional comments.

21 It just struck me, and I forgot about this,
22 and I actually kind of ran into this over the weekend as
23 we were trying to figure out how we were going to get
24 visits made to the people that we couldn't talk with
25 that happened with the steroid that carried the fungal

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1 meningitis.

2 But, anyhow, that person said that it's hard
3 to build a system basically with part-time health
4 commissioners and, I think, part-time medical directors,
5 but I don't remember if that's -- you know, that's a
6 function of, you know, of obviously funding and how
7 community sees the value and all of that and everything
8 else, but somebody has to pick that up, okay.

9 When things don't -- when we get a call from
10 the Director of Health asking us to contact people, you
11 know, we do care, and most of us would say, yeah, we'll
12 do that, we'll figure out a way to do that, but we can't
13 do it alone, because there's always a function of how
14 much capacity you've got.

15 So you bring people in on Sunday, say, hey,
16 come on in, you're exempt employees, not paying you
17 overtime, we're going to do this, because we have to do
18 it, it's what we've got to do. That works sometimes,
19 sometimes it doesn't.

20 So the question becomes what should that
21 standard be across the state relative to people that are
22 employees of health commissioners and medical health
23 directors and so forth, should that -- I mean currently
24 today in Ohio, if you have a triad, Director of
25 Environmental Health, the Health Commissioner -- I'm

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1 sorry, Director of Nursing and the Medical Director,
2 you've got to have a Medical Director, and that can be
3 the Health Commissioner, by the way.

4 You are basically eligible for funding from
5 the State Department of Health to carry out programs,
6 and I just want to put that on the table, I'm not sure
7 if everyone is aware of that.

8 And I don't know how many of that scenario
9 actually exists in Ohio, I don't think it's as many as
10 it once upon a time was, but it is a limitation folks of
11 what you can expect relative to performance. It is a
12 limitation relative to what you can expect from
13 performance day in, day out.

14 COMMISSIONER NIXON: You have a suggestion.

15 COMMISSIONER INGRAM: Well, my thought is
16 there ought to be -- there ought to be a certain
17 full-time complement based on whatever number of health
18 districts there ought to be in Ohio. Right now there's
19 125, and should those not be full-time employees at the
20 leadership level at least.

21 COMMISSIONER EDWARDS: I wouldn't disagree
22 with you at all, Tim, but when you've got doctors, and
23 you well know, we have a hard enough time getting
24 coroners in the State of Ohio.

25 COMMISSIONER INGRAM: I understand.

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1 COMMISSIONER EDWARDS: Doctors want to be
2 doctors, and they're going to make more money on that
3 side of it, not in the public health side, I'm not sure.
4 I agree with you.

5 COMMISSIONER INGRAM: So let me take that,
6 because you kind of open the door, and I'm going to use
7 one of our own members and so why can we not share a
8 Medical Director, because doctors are hard to find.

9 I mean there is a level where there may be a
10 certain size that you need a full-time, and if you get
11 to a certain size you can probably afford a full-time
12 public health doctor, but that's another story perhaps
13 for another day.

14 COMMISSIONER EDWARDS: Okay. Since you
15 opened that door, I'm going to open the window now. I
16 believe in the legislature there's -- there's a bill
17 looking at not registered license -- practitioners and
18 what their abilities are, can that be expanded in the
19 public health sector? I don't know, I don't know what's
20 all there.

21 COMMISSIONER INGRAM: Well, one thing that,
22 I mean obviously in our business, at least my
23 experience, has been you need a Medical Director,
24 because you're going to have three -- you need someone
25 to help you with -- you need a doctor, because we're in

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1 the health care business, somebody has to write standing
2 orders to the department, that has to be a physician.

3 Do you need a physician to see every person
4 that's coming through the door, I'm not going to go
5 there, I think the marketplace sort of speaks for itself
6 in that regard, but I don't know.

7 I think you raise a good point, Kim, but I
8 know that this situation we just worked through over the
9 weekend was very complicated, and I was glad to have our
10 Medical Director right beside us in our group helping us
11 work those screening questions as we talked with these
12 patients who had multiple chronic problems, and perhaps
13 could have been exposed to another sickness, you need
14 that.

15 We never want to forget that health's in our
16 name for a reason, and we do do health every day,
17 whether it's a prevention or a care, so I don't know
18 where to go with this.

19 I just know that I have a sense of urgency
20 that we have to do something, and I've been trying to
21 stress that over and over again going forward with other
22 health districts.

23 Should we not have full-time leadership in
24 our health departments regardless of where they are or
25 size today, should we not? Perhaps a couple of

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1 positions that we think we could share.

2 CHAIRMAN BURKE: To me it just depends on
3 how it's structured.

4 COMMISSIONER INGRAM: I understand.

5 COMMISSIONER SCOTT-JONES: I don't think
6 what you're saying, Mr. Ingram, is mutually exclusive
7 from what the Chairperson was stating about
8 incentivizing, because I think until we get a handle on
9 what the parameters are going to be for these
10 recommendations, is it going to 25 -- population of
11 25,000 or 50,000 to a hundred thousand, I think that
12 dictates whether you need a full-time person or not.

13 But I think also the incentives broadly
14 could incorporate hiring people or hiring whoever you
15 need. I don't think they need to be exclusive at all.

16 DR. MCFADDEN: As you know, infectious
17 disease certainly doesn't wait until Monday as you found
18 out, and I'm not sure -- I'm not sure even having a
19 full-time person always means that, you know, they don't
20 say or wouldn't, couldn't say, you know, it's after
21 5:00.

22 So I think what's needed is that, you know,
23 folks, you know, regardless of how many hours they're
24 paid for that they realize that, you know, I'm -- I'm
25 going to be needed 24 hours a day, 7 days a week.

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1 In my situation in Holmes County or Carroll
2 County, because I serve as Medical Director for Carroll
3 County, and if they need me I have to be available or
4 provide another physician that can give them that level
5 of care that they need, because you're absolutely right
6 that infection doesn't wait for Monday, it doesn't stop
7 at Friday at 4:30 or 5:00, and that's the dilemma.

8 I would hope that all of our colleagues
9 would understand that when there's an emergency, you
10 know, I can't leave my hospital. I have to be within 30
11 minutes of my hospital at all times, unless I have
12 somebody else to cover it for me, that's my
13 responsibility.

14 I would hope that every health district
15 would have access to their Medical Director, you know,
16 no matter what. I think that's the important piece is
17 that they have to have access all the time, and people
18 have to be responsive.

19 COMMISSIONER INGRAM: I don't disagree, I
20 was just going off the comment that was made by one of
21 our colleagues.

22 DR. MCFADDEN: Sure.

23 COMMISSIONER INGRAM: And it actually kind
24 of struck a nerve, I actually had kind of forgotten
25 about that that still exists, and at times that's become

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1 an issue.

2 You're not -- you know, you've all been
3 around the block a couple of times. There's a
4 difference between people that are full-time employees
5 and part-time employees, it's just the way it is.

6 COMMISSIONER SCOTT-JONES: But does that
7 always mean -- that's just not pertinent to the
8 physician, so it's pertinent to the staff, because you
9 could have an over worked staff, and then, again, you
10 have to keep in mind why you're in this industry too and
11 it goes back to the incentives, because you can
12 incentivize someone and say it may not be a monetary
13 factor, it might be I need a day off, it might be I need
14 to come in late, that might be an incentive for someone
15 who has to work an extra 30 or 40 hours for that week.

16 COMMISSIONER INGRAM: If we could just set
17 aside the physician, the public health physician for a
18 moment. I mean I think what this person was saying was,
19 you know, Health Commissioner, Directors of Nursing,
20 Directors of Environmental Health, that complement
21 probably needs to be full-time if you're going to be a
22 health district.

23 COMMISSIONER NIXON: I'm not sure that's
24 true.

25 COMMISSIONER INGRAM: Okay.

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1 COMMISSIONER NIXON: I think that the whole
2 question is one we've avoided in the public health
3 community in Ohio. I think that we've transitioned from
4 the full-time Medical Director, most health
5 commissioners are now administrators, they're not
6 doctors any longer.

7 You know the full-time Nursing Director, a
8 lot of health departments have moved from a Nursing
9 Director clinical model to now community health with a
10 broader impact, and you have to assign somebody to
11 Nursing Director, because you need the triad.

12 You have to have a Medical Director now it
13 may be somebody on staff for an hour a week to meet that
14 requirement, so a lot of that is changing, and, you
15 know, frankly we haven't had that dialogue.

16 COMMISSIONER INGRAM: That opens the next
17 door, do we really need that, those positions in the
18 future?

19 COMMISSIONER NIXON: Right.

20 COMMISSIONER INGRAM: So I'm not going to go
21 there right now, because I think that's outside of the
22 purview here, but it does raise a lot of good questions,
23 kind of a dialogue.

24 CHAIRMAN BURKE: And I do think those are
25 good questions. I know that we did have a comment

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1 related to finance and I heard a motion on the
2 investigation of excise tax or other mechanisms --
3 additional revenue for funding local health districts
4 noting that the current 17 cents per capita per year is
5 inadequate for incentivizing compliance and outcomes at
6 the local levels. So D.J. you made a motion to approve.

7 COMMISSIONER SCOTT-JONES: Second.

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

10 (Thereupon all Commission Members voted
11 affirmatively, with the exception of Vice-Chairman
12 Press.)

13 All those opposed, nay.

14 CHAIRPERSON PRESS: Opposed.

15 CHAIRMAN BURKE: In the opinion of the Chair
16 the ayes have it, no request for roll call vote, that
17 will go into the record as Recommendation -- was that 10
18 or 11?

19 Reconvening was 10; 11 is finance.

20 Okay. That moves us towards Recommendations
21 11 -- 13 and 14 from our Health Future Survey on
22 September 7th, additional comments within 13 or 14, or
23 any other points. It's about quarter till 4:00, just to
24 throw a net out there on the clock.

25 Again, we'd like to consolidate down into a

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1 recommendation in the next 15 minutes, if you have
2 something that we could move forward with.

3 COMMISSIONER FOUGHT: What was the 13 and 14
4 that you referenced, I'm sorry, I might not have
5 everything.

6 CHAIRMAN BURKE: 13 and 14 have to do with
7 finance. We took a ranking of these questions. 13 and
8 14 were at the top of the list.

9 That recommendation kind of helped with the
10 financing part.

11 I suppose the dissilient in some degree was
12 a block grant.

13 COMMISSIONER FOUGHT: Yeah, so really it's
14 13; is that right?

15 COMMISSIONER SHAPIRO: If we just did that.

16 COMMISSIONER FOUGHT: I looked at 17.

17 CHAIRMAN BURKE: The excise tax was 13, the
18 block grant would have touched on 14.

19 COMMISSIONER FOUGHT: Okay.

20 COMMISSIONER EDWARDS: So am I correct that
21 like 17, we've kind of broken that down into a couple of
22 different ones, haven't we?

23 CHAIRMAN BURKE: Yeah.

24 COMMISSIONER FOUGHT: Yeah. May I ask --
25 I'm sorry, Mr. Chair, what was the -- I know this has

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1 come up with some of commissioners, but the
2 establishment of fees, like raising the fee level and
3 that -- I mean that's in 17, is that something that
4 needs to be addressed? It's not been addressed yet, is
5 that still something --

6 CHAIRMAN BURKE: Well, we kicked around
7 earlier like the standardization of fees and how that
8 would look and never seemed to get a whole lot of
9 movement on that.

10 COMMISSIONER FOUGHT: Yeah, that's just why
11 I just wanted to raise that. All right. Guess not,
12 move on. It was just in the report.

13 COMMISSIONER NIXON: It is a problem.

14 COMMISSIONER SHAPIRO: It costs different
15 things to do different services in different places.

16 COMMISSIONER INGRAM: There's a variability
17 of fee structure across the state for the services that
18 we carry out, the variability of public health delivery
19 throughout the state at the local public health level,
20 period. I don't know how to say it.

21 COMMISSIONER EDWARDS: Just for my
22 knowledge, let's say birth certificates and death
23 certificates, is that a standard fee; is everybody
24 charged the same fee?

25 COMMISSIONER INGRAM: No.

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1 process them regardless -- if you're a district with a
2 lot of birthing hospitals you've got to process that
3 regardless of whether you're selling them or not.

4 DR. MCFADDEN: So, for example, in Carroll
5 County they would not have to process any birth
6 certificates. They do not have to take in and answer,
7 you know, as far as creating them.

8 They would distribute them, but the piece
9 that you're talking about is you have five hospitals
10 that are making, you know, having deliveries in their
11 hospital, you have a gazillion birth certificates that
12 you have to process, and, you know, make I --

13 COMMISSIONER INGRAM: -- You have to
14 register them and file them obviously with the state,
15 regardless if we sell one of them.

16 So obviously our cost for that, because we
17 have three birthing centers is probably more, I would
18 suggest, than those, perhaps, I shouldn't say that,
19 perhaps those that don't have more.

20 COMMISSIONER EDWARDS: Okay. What about
21 death certificates, are they standard?

22 COMMISSIONER INGRAM: Death certificates are
23 currently issued on where the death occurs, unlike
24 births. Now, that's about to open up, I understand, so
25 we can all distribute each other's death certificates,

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1 but, again, we can charge our own fee above the state
2 minimum, there's a state bottom to it. I don't know
3 what that is.

4 COMMISSIONER NIXON: It's been equalized. I
5 think with what Tim says is where you can get them
6 anywhere now, you're going to see a leveling in some of
7 those costs. I don't know that that range is that great
8 anyway, the lowest and the highest, I think they're
9 pretty uniform anyway.

10 COMMISSIONER EDWARD: Okay.

11 COMMISSIONER INGRAM: I think the state base
12 is \$19; is that right?

13 COMMISSIONER NIXON: I thought it was 17.

14 MR. MAZZOLA: 17 sounds right.

15 COMMISSIONER EDWARDS: When I look at that,
16 I'm trying to think of other programs or other things
17 within the state, like building codes, or, you know,
18 electrical codes that have to be enforced and I think --

19 DR. MCFADDEN: But there is a state -- there
20 is a state fee, and then there is a local fee.

21 COMMISSIONER EDWARDS: Right.

22 DR. MCFADDEN: And I think in some of these
23 other fees there is a state and a local, and so the
24 state fee doesn't change.

25 You know, if you want to get your birth

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1 certificate at the state fee you can contact ODH and you
2 can get your birth certificate, if you want your birth
3 certificate.

4 If you want your birth certificate in 15
5 minutes you can walk in my door and you will have it.
6 If you want it mailed to you you can call the state or
7 you can call your local health district and see if they
8 will overnight it to you.

9 For an additional fee, if you want to pay
10 with a credit card, you know, same thing, so those are
11 the differences, there's a state fee and there's a local
12 fee for birth certificates.

13 COMMISSIONER INGRAM: D.J., can I just say,
14 there's one exception that you can get it in 15 minutes,
15 if it's coming out of a place that is recording those,
16 you're assuming that work has occurred.

17 DR. MCFADDEN: No, I'm saying --

18 COMMISSIONER INGRAM: So don't forgot that,
19 that's a big over look by a lot of people. If you've
20 got a jurisdiction that's slow to get those recorded,
21 they're not available as quickly as the next one that's
22 more efficient.

23 DR. MCFADDEN: Right, right, if you're an
24 adult, if you're an adult that walks in the office and
25 you need a birth certificate.

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1 COMMISSIONER EDWARDS: Similarities with
2 fees with other programs that are out there. Like
3 commercial electrical, I can come down to Columbus to
4 get that done, I can go to Richmond County, I can go to
5 Canton to get that done. There are certain places that
6 you can go to get those types of permits. I'm trying to
7 level that out between the two, and it's not working,
8 never mind.

9 REPRESENTATIVE ANTONIO: No standardization.

10 COMMISSIONER EDWARDS: Yeah, there's just no
11 standard.

12 CHAIRMAN BURKE: Just a topic, kick it out
13 there, if there's any other -- if we don't have a firm
14 recommendation on that, any other items that anybody
15 feels that we should address?

16 COMMISSIONER INGRAM: Structure.

17 CHAIRMAN BURKE: Well, I don't disagree with
18 you there, and I think to be honest with you, if there's
19 nothing else before us, I'll just say all your time is
20 very valuable taking you away from your communities to
21 come here to try to improve health, and the work that
22 we've done over the last -- what has it been, four
23 months now, I think has been actually fairly good, a lot
24 of open discussion on issues.

25 We took the recommendations and I think

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1 brought clarity to that and moved that forward into a
2 set of recommendations that actually set a path with
3 direction that I believe is fairly concise considering
4 what we had to start with, a good sense of the direction
5 and the legislative process and the administration and
6 start to act on those recommendations.

7 What we will do with these recommendations
8 is e-mail them to you, allow you to look at them, and
9 then if we don't have a problem, I hate to call us all
10 back here for one day to just vote on these
11 recommendations.

12 I mean some of you come a pretty far
13 distance just to vote on a recommendation, but I don't
14 know any other way to either approve these individually.

15 I don't know if anybody feels compelled to
16 approve them as a group, but we do have a little
17 word-smithing on No. 8, and I believe there was another
18 one that we just needed to work with one or two words on
19 depending on what the current law was on another issue.

20 So we can communicate those out to you, if I
21 don't hear any complaints from anybody, we don't have to
22 meet.

23 DR. MCFADDEN: Mr. Chairman, just a
24 question, how the report is actually coming. Is the
25 report then just a list of our recommendations or how

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1 does it -- in what form does the legislature --

2 CHAIRMAN BURKE: It will just basically be a
3 list of our recommendations. I tell you what I will do
4 then, until I get a definitive answer on what we're
5 going to produce, because I'm teaming up with the
6 Department of Health, using their clerical services to
7 do this drafting and other kind of work, we'll go ahead
8 and leave the meeting of October 23rd on the agenda. If
9 I can work around not having that meeting, we'll cancel
10 it.

11 But we have approved each and every
12 individual -- even the ones that we agreed to that
13 required word-smithing as long as there is no objection
14 to that then we will not meet again, but I won't know
15 that until I get that to you, and that will be the
16 actual document that we will submit.

17 COMMISSIONER SHAPIRO: So we're talking
18 start 1:00 to 3:00 time?

19 CHAIRMAN BURKE: If that's convenience.

20 COMMISSIONER FOUGHT: Instead of starting at
21 11:00 we would 1:00, correct?

22 CHAIRMAN BURKE: Yeah, and then talking
23 probably a ten minute meeting at that point.

24 COMMISSIONER FOUGHT: And we would get the
25 draft as a whole?

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1 CHAIRMAN BURKE: And I know that sounds
2 ridiculous, it's not even worth your parking, that's why
3 I wanted to verbally approve each and every one of these
4 recommendations, so that even when they're amassed
5 together it makes coming together fruitless, so unless I
6 hear a strong recommendation, oh, I didn't know you were
7 going to word it that way, and somebody takes offense to
8 it, we have to come together, if I don't see that then
9 I'm not going to come back.

10 COMMISSIONER SCOTT-JONES: Mr. Chairman, I'm
11 just going to put my in-put in for what it's worth. I
12 have almost a two hour drive here, but I would rather do
13 the two hour drive on the last meeting, make sure that
14 we have completely gotten to the point where we really
15 need to get to, just to give you an example, and not to
16 throw off on anyone who sent the information to us, but
17 if we don't get that until the weekend before the
18 meeting and you have work constraints or you have other
19 constraints that you have to do and usually you're maybe
20 reading it on the way down here, if someone's driving or
21 you're reading it the night before, I just think the
22 last meeting will offer opportunities for clarification
23 or questions or whatever most of us, not everyone, but
24 most everybody is in person, and then can really
25 solidify it, that's just my opinion.

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1 CHAIRMAN BURKE: And I don't disagree, I
2 hear what you're saying. My fear is that if we were to
3 do that and we didn't have a quorum then we wouldn't be
4 able to do anything.

5 COMMISSIONER SCOTT-JONES: But we knew the
6 meeting was going to be the 23rd of October anyway, I
7 mean it's on my calendar, it should be on everybody's
8 calendar.

9 CHAIRMAN BURKE: And I agree with you, if
10 you did disagree with anything that was in there and you
11 never bothered to show up, and then this body couldn't
12 act on it anyway and it would pass as it did on today's
13 dated.

14 COMMISSIONER SCOTT-JONES: I wouldn't give
15 the option of reading --

16 CHAIRMAN BURKE: -- I'm not giving anyone
17 legislative know how.

18 I hear what you're saying, but let's get it
19 together. I want to keep this meeting on the agenda,
20 get this out as soon as I can to you so that everybody
21 can review it. You may be completely satisfied and we
22 may find no reason, but I'll make sure we circle back
23 around and touch base with everybody.

24 I'm not just going the drop this, because,
25 again, I want to make sure it holistically is what we

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1 want. So with that being said --

2 REPRESENTATIVE ANTONIO: I would just say
3 from my specific, because we did go through them item by
4 item, and unless there's something that comes back that
5 I think really substantively changes the meaning or
6 intention of what we agreed on, I -- while I understand
7 certainly the interest in seeing the entire document and
8 all that, I feel that we have vetted this process so
9 well that while it's on my calendar too and I'm happy to
10 attend, at the same time if there's not substantive
11 changes I can think of, you know, that five and a half
12 hours would be better served somewhere else than my
13 transportation. So it almost -- it definitely seems
14 also redundant to me, if we've agreed point by point
15 today.

16 COMMISSIONER INGRAM: Or even if we
17 disagree, it's okay, it's all right. I would actually
18 take it in front of the Chair based on the feedback that
19 we have.

20 CHAIRMAN BURKE: That's what we'll do, we'll
21 solicit that from each of you in it's finalized form and
22 should there be strong need to come back and have a
23 meeting we will do that, Heidi.

24 COMMISSIONER FOUGHT: Mr. Chairman, can I
25 just ask that we maybe try to get it a week before, as

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1 opposed to weekend before, can I just try to emphasize
2 that? Joe, you're doing a great job, okay. I'm just
3 trying to think if we could try a week before, that
4 would be helpful.

5 CHAIRMAN BURKE: That would be?

6 COMMISSIONER FOUGHT: Next Tuesday.

7 CHAIRMAN BURKE: That would be what, the
8 15th, is that --

9 COMMISSIONER FOUGHT: 16th.

10 CHAIRMAN BURKE: Okay. We will have the
11 report in hand no later than the end of business on the
12 16th. We do then request your response no later than
13 end of business on the 18th, giving you 48 hours to
14 review the document. Oh, by the way, absence or no
15 reply equals consent.

16 COMMISSIONER SCOFIELD: So noted.

17 COMMISSIONER FOUGHT: Agreed. Thank you. I
18 think that would just help us immensely, if that was the
19 case, thank you.

20 CHAIRMAN BURKE: I appreciate everybody's
21 time, it's valuable, spend time away from your family
22 and business during the summer, and I think we actually
23 moved the ball forward.

24 I feel very positive about what we've done.
25 Representative Antonio and I personally will continue to

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1 drive that thought forward.

2 I hope I've served you well as the Chairman,
3 I appreciate your confidence in me allowing me to be
4 Chairman, but most of all I appreciate, again, your time
5 and input, and we look forward to having that document
6 to you next Tuesday, with your reply no later than the
7 end of business on Thursday, and then have that same
8 time frame to decide whether or not to have that
9 meeting. Thank you.

10 (Thereupon the Commission meeting was
11 adjourned at 4:03 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 October 9, 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 17th day of October, 2012.

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

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