
HEALTHY PEOPLE - HEALTHY COMMUNITIES
AN AGENDA FOR PUBLIC HEALTH REFORM

THE REPORT OF
THE OHIO PUBLIC HEALTH SERVICES STUDY COMMITTEE

October 13, 1993

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CHAIRMAN'S FOREWORD

"Healthy People in Healthy Communities" eloquently states the Ohio Public Health Services Study Committee's vision for the health of all Ohioans. People and communities have the greatest potential for being healthy when there is a seamless web of services among all providers that assures the availability of community preventive health services, access to appropriate primary health care, including clinical preventive services, secondary and tertiary care for illness and injury, and protection from environmental hazards to all people. Therefore, as Ohio's leaders discuss and plan a reformed personal health care delivery system, it is appropriate that the Committee's "Agenda for Public Health Reform" also be debated and acted upon.

The Institute of Medicine's report *The Future of Public Health* found America's public health system to be in "disarray." Such a statement is a disservice to the dedicated public health workforce in Ohio. In spite of inadequate financial resources, a lack of public understanding of the public health mission, and the weak support of state and local elected leaders, most local health departments continue to serve their communities well. This is more a tribute to the capability and dedication of local public health leaders and their staffs than a credit to the current organizational structure of local public health in Ohio.

There is ample evidence that the health status of Ohioans should and can be improved, that newly recognized and emerging public health problems are not being adequately addressed, and that all Ohioans are not uniformly served by local public health units providing the core public health functions and practices. Regardless of how the personal health care delivery system might be reformed, real improvement in the health of Ohioans is likely to depend on how the issues in the Committee's Agenda for Public Health Reform are addressed.

The Committee thanks each of the many individuals who volunteered to participate on subcommittees to draft options papers for the Committee's consideration. This volunteer effort was a rich addition to our staff. We express our appreciation to our staff for their hard work. We also thank each person who provided oral and/or written comments on the Committee's draft recommendations at the nine regional hearings held around the state. Those comments helped the Committee to refine and focus the recommendations.

I wish to thank Peter Somani, MD, PhD, Director of the Ohio Department of Health, for his strong support of the Committee's work and for the adequate budget provided to the Committee.

I wish to thank my colleagues on the Ohio Public Health Services Study Committee for working so efficiently together over the past year. I salute each of you for your dedication to developing and defining a new vision for local public health in Ohio. I believe we all share

the hope that others will join us as we start down a road leading to an even better public health system for the twenty-first century.

Maurice Mullet, MD
Chairman

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EXECUTIVE SUMMARY

The Ohio Public Health Services Study Committee was created with the enactment of Substitute House Bill 179 by the 119th Ohio General Assembly. The Committee concludes that significant restructuring of Ohio's public health system will be required to achieve the vision of "Healthy people in healthy communities." Under current law, dating back to the Hughes-Griswold Act of 1919, variations in the organization of local health districts result in differences in governance and authority between city and county health districts. Additionally, the Committee determined that local health departments are not funded in a consistent manner and rely on sources of revenue that are inadequate and unstable. Furthermore, recent data confirm that many local health departments are unable to offer a comprehensive range of public health services, including many direct services aimed at reducing the spread of communicable diseases.

The Committee's new vision for public health in Ohio recognizes that all levels of government have an increasing responsibility for the health of the public. As a guide to its recommendations, the Committee endorses the concept that Assessment, Policy Development, and Assurance constitute the core functions of the public health system. Assessment means the regular collection, analysis, and sharing of information about the health status of populations, risk factors for disease, and health systems resources. Policy development results in a course of action that integrates problem identification, technical knowledge of possible solutions, and societal values. Assurance means confirming that necessary services are provided and/or that necessary resources are available to reach agreed upon goals, either by encouraging private sector action, by requiring it, or by providing services directly.

Against the backdrop of a vision of public health based on core public health functions and the practices implied by those functions, the Ohio Public Health Services Study Committee developed a set of recommendations, which are summarized below.

- o Local public health departments should be restructured into new jurisdictions with the authority and responsibility to provide the core public health functions.
- o The geopolitical boundaries of the restructured jurisdictions should be coincident with county boundaries.

- o These jurisdictions should be governed by a Board of Health appointed by a District Public Health Council consisting of the jurisdiction's elected leadership.
- o The public health system will be strong when it has appropriate personnel, authority, and resources, and will be well-funded when its revenue base is adequate, certain, flexible, and stable.
- o The state should assume a major responsibility to fund the cost of providing core public health functions and practices. State funding for these efforts should come from a public health trust fund. Local funding should come from the inside millage, fees, and health levies.
- o Accountability and accreditation of the public health jurisdictions should be based on documented abilities to provide core public health functions and practices.
- o The public health jurisdictions should employ staff that demonstrates administrative and medical leadership, as well as competence in the public health disciplines of nursing, environmental health, health education, nutrition, and community assessment.
- o Public health jurisdictions should assure the provision of direct preventive and personal health services. These include primary care and clinical preventive services, as well as services for the management of communicable and chronic diseases and newly emerging public health problems. Priorities should emphasize population-based services.
- o Public health jurisdictions must have increased capacity to prevent and control communicable diseases through epidemiologic investigations, direct services, and timely and appropriate administrative responses.
- o Environmental health risks should be assessed within the public health jurisdiction. The jurisdiction should assure that adequate environmental health resources and services are available.
- o The public health jurisdiction should have a central role in the development of community health policy and in the allocation of resources in the community.

- o Any proposal to reform the health care delivery system must provide for a strong and well-funded public health system.
- o Public health jurisdictions should be encouraged to strengthen relationships with state agencies and with other local providers of health and human services.

To achieve a new vision of public health, the Committee has offered a set of recommendations specifically directed at improving the health status of the populations served. These recommendations address deficiencies in Ohio's current system and offer a model based on core public health functions and practices that will assist public officials in efforts to reform and enhance the public health system.

INTRODUCTION AND BACKGROUND

Public health activities stand historically as significant contributors to the reduction and near elimination of many infectious diseases. As longevity of the population has increased, public health professionals have had an ever increasing presence and impact on the control of chronic diseases and disabling conditions that may result from environmental hazards and individual behavioral choices. The complexities of the modern environment, economy, and private health care system call for a focused, organized, and sustained approach to maintain and improve the health status of populations.

The Hughes-Griswold Act of 1919 established the current organization of public health districts in Ohio. Since that time, several statewide task forces, committees, and associations have issued statements documenting financial, organizational, and service delivery problems within the public health system. These include:

- o "Organization and Financing of General Health Districts" Ohio Legislative Services Commission (1)
- o "A Proposed Act to Establish Regional Health Districts" Association of Ohio Health Commissioners, Ohio Public Health Association, Ohio State Medical Association (2)
- o "Organization of Health Care in Ohio" Governor's Task Force on Health Care (3)
- o "Platform Statement for the 1980's" Association of Ohio Health Commissioners (4)

None of these efforts, however, resulted in the enactment of legislation that significantly restructured Ohio's local public health system.

In recent years, there has been a growing recognition that continued successes in public health practice will require more capacity within the public health system. A landmark study of the public health system was published in 1988 by the Committee for the Study of the Future of Public Health. This Committee was convened by the National Academy of Science's Institute of Medicine (IOM) to respond to the concern that this nation has lost sight of its public health goals and that the public health system has fallen into disarray. The Committee's report, The Future of Public Health, speaks to a new vision of public health and underscores past achievements as the basis for believing that public health can continue to make a positive difference in the quality of life (5). To do so, however, this report concludes

that the public health system must recast itself within the framework of three core functions--assessment, policy development, and assurance--and that these functions must form the basis of a reformed public health system at all levels of government. The IOM Committee summarized its recommendations about the core functions in the following manner:

"The [IOM] committee recommends that every public health agency regularly and systematically collect, assemble, analyze, and make available information on the health of the community, including statistics on health status, community health needs, and epidemiologic and other studies of health problems."

"The [IOM] committee recommends that every public health agency exercise its responsibility to serve the public interest in the development of comprehensive public health policies by promoting use of the scientific knowledge base in decision-making about public health and by leading in developing public health policy. Agencies must take a strategic approach, developed on the basis of a positive appreciation for the democratic political process."

"The [IOM] committee recommends that public health agencies assure their constituents that services necessary to achieve agreed upon goals are provided, either by encouraging actions by other entities (private or public sector), by requiring such action through regulation, or by providing services directly."

Restoring an effective public health system is essential to continuing efforts to improve health status and reduce threats to health. Past successes in public health have been characterized by organized links between science and public policy. Future successes will require creative new methods to continue making these links and translating them into effective health programs for communities. The Institute of Medicine Committee has acknowledged that there is not a single way to achieve these goals, but rather urged communities to develop solutions that can result in effective responses and fulfill public sector responsibilities with respect to health.

Substitute House Bill 179

A significant step toward the goals espoused by the Institute of Medicine was taken in Ohio with the passage of Substitute House Bill Number 179. Passed by the 119th Ohio General Assembly on March 4, 1992, and signed into law by the Governor on March 24,

1992, its stated purpose was "To create the Ohio Public Health Services Study Committee to study the ability of Ohio's public health system to deliver needed public health services throughout the state."

The objectives of Sub. H.B. 179 closely parallel the objectives and recommendations of the Institute of Medicine report. The statute established the Ohio Public Health Services Study Committee (OPHSSC) and charged it to do the following tasks:

1. "Examine the ability of the state's public health system to deliver needed public health services to all Ohio residents through modern disease and environmental prevention and control measures that address contemporary public health problems."
2. "Clarify the basic authority and responsibility of the state and local public health agencies and their officials and the relationship between state and local public health agencies and recommend any statutory changes necessary to make this clarification."
3. "Assess the role of local health districts in conjunction with the private sector in providing primary health care, such as prenatal care and immunization, to the indigent and those who are medically uninsured or underinsured."
4. "Determine ways to ensure that the Ohio Department of Health and local health districts are sufficiently strong and well-funded to provide needed public health services."
5. "Recommend a system of review and accreditation of local health districts."

Furthermore, the Committee was directed to study the following:

1. "The structure and authority of local boards of health, including the boards' roles and relationships with state agencies."
2. "The financing of state and local public health services, including the relationship between the distribution of state health district subsidy funds under section 3701.342 of the Revised Code and the standards of performance of boards of health and local health departments."

3. "The role of the Ohio Department of Health and local health districts in implementing public health services and controlling disease at the local level."
4. "The organization of local health districts necessary to deliver local public health services efficiently."

Accomplishing these tasks will be a significant step in achieving the core public health functions described in the Institute of Medicine report. Today, Ohio's public health system is affected adversely by fragmentation, duplication, inadequate funding mechanisms, and competing service delivery systems. The public health statutes in Ohio are a combination of a system enacted into law in 1919 and a variety of single-purpose health statutes addressing a series of health problems identified over many decades. As a result, as modern public health problems demand attention, public health officials find that they are without the necessary statutory tools to address the problems, or are forced to use procedures and authorities that were designed for other problems or for practice now considered antiquated.

Current health problems call for coordinated approaches linking public health agencies with other providers, such as human service, law enforcement, hospital, and voluntary agencies, as well as the private sector. Ohio law must facilitate strong cooperative relationships, without diffusing the ultimate responsibility of public health officials to carry out the core functions of assessment, policy development, and assurance with respect to these problems. At present, it is simply not possible for each of Ohio's 150 local health departments to sustain the capacity to carry out these core functions of public health in a cost-effective or efficient manner.

THE CHALLENGE

Central to the Ohio Public Health Services Study Committee's vision for a new public health system is an understanding and implementation of the core public health functions, a restructuring of the system to integrate existing services into this model (where appropriate), and the systematic development of new programs and services to fulfill the mission of the public health system.

For many indicators of health status, Ohio ranks well in national comparisons. Even in those instances for which Ohio is not in the lowest portion of national rankings, the potential for

improved health status is great. In many significant areas, however, Ohio ranks below the national average. For example, the rate of infant mortality in Ohio is 9.9 deaths per 1,000 live births versus 7.6 nationally; only 51% of Ohio's children under two years of age receive the basic immunization series versus 70-80% nationally. The Children's Defense Fund ranked Ohio as showing inadequate progress in prenatal care and low birthweight infants.

Ohio's mortality rates for many leading causes of death exceed national averages. Ohio women have the ninth highest rate of death from breast cancer. Rates for Ohio also exceed national averages for deaths from lung cancer, coronary heart disease, and chronic obstructive pulmonary disease (6).

Other indicators or predictors of health in populations were reported by the American Public Health Association. Although Ohio scored well in the overall category of Medical Care Access, the state ranked 35 in the number of primary care physicians per capita. Overall, Ohio ranked in the third quartile for Healthy Neighborhoods. With respect to Healthy Behaviors, Ohio ranked 34 for smoking, and 18 for seat belt non-use (7).

A most striking conclusion from these data from a public health perspective is that these indicators represent problems that are amenable to community or population-based intervention, and in some cases, Ohio has witnessed the success of such interventions. For example, the immunization rate of two year olds in Children and Family Health Services programs is 82%, exceeding the overall state rate by 30%.

The Committee has identified issues that presently limit the capacity of the public health system in Ohio. These issues address questions about the organization and authority of local public health jurisdictions; about the funding, by state and local sources, of the public health system; and some observations about the current programs and activities of Ohio's local public health departments.

Organization of Ohio's Local Public Health System

Acclaimed nationally at the time as a major accomplishment in public health, the Hughes-Griswold Act required 2158 city, village, and township health units to combine into 88 general (county) health districts and 92 city health districts. The term "health district," therefore, does not reflect a governmental unit with universally recognized geopolitical boundaries, but a hybrid of combinations formed nearly 75 years ago.

Today, there are 150 operating health departments in Ohio -- 26 county (general), 62 city, and 62 combined health districts. An additional 172 Ohio cities meet the minimum population criterion of 5,000 to be a health district, and therefore could, under current law, operate a health department. In total, then, there are currently 322 health districts in Ohio.

The distinction between general and city health districts continues to exist today and is even more complicated by the existence of a "combined general health district," which is a combination of a general health district (county) with one or more city health districts within a specified geographic area. Contracts creating the combination may vary from one combined health district to another.

A "National Profile of Local Health Departments," published in 1990 by the National Association of County Health Officials, documents that Ohio is one of only seven states with 100 or more health departments (8). States with larger land mass and population--California, Texas, Florida, New York, and Pennsylvania--all have fewer health departments than Ohio.

Although the consolidation of health districts created in 1919 was deemed to be progressive at that time, the maintenance of that system today is arguably ineffective. Many health districts are not of sufficient size to attract, keep, and utilize appropriately trained personnel and to provide minimum services as well as core functions. Statutes creating health districts for all communities with populations greater than 5000 are outdated, yet there are many health departments in Ohio today serving populations of just 5,000-10,000 persons. As early as 1960, the American Public Health Association recommended a minimum population of 100,000 for local health districts. The Association of Ohio Health Commissioners (AOHC), in its platform statement for the 1980's, stated that "the existing number of health jurisdictions is not cost effective because it produces a duplication of services in some areas of the state and leaves other areas of the state with inadequate public health services. The AOHC supports legislation or administrative rules that will reduce the number of health districts to an ideal of no more than one per county" (4).

The variations in the organization of local health districts result in variances in governance and authority. The Ohio Revised Code and the Ohio Administrative Code do not treat general and city health districts equally, and the same law has been interpreted differently among County Auditors and

Prosecuting Attorneys. There are differences in the appointment process of Board of Health members, compensation for the services of Board members, and the qualifications of the Health Commissioner. Under current statute the Health Commissioner serves as secretary to the Board of Health, with certain administrative functions reserved for the Board. This causes cumbersome procedures to be implemented and results in inefficiencies in the management of local health districts.

Moreover, the authority of the Board of Health has been diluted over time with conflicting and unclear statutes. Interpretations of statutes have limited the power of the Board with limitations placed on the ability to contract, set fees, and own property.

The organization of local health districts in Ohio is viewed as cumbersome and outdated. This is because there are varying statutory mandates based on structure, a wide disparity in size, differences in governance, unclear policy and administrative functions between the Board and the Health Commissioner, and limitations on authority. To achieve the new vision for public health, these issues must be addressed and rectified to allow for the most effective and efficient use of personnel, property, money, and services.

Funding of Ohio's Local Public Health System

One of the intended outcomes of Sub. H.B. 179 is for the Committee to "determine ways to ensure that the Ohio Department of Health and local health districts are sufficiently strong and well-funded to provide needed public health services."

A review of the most current available data indicates that local health departments are not funded in a consistent manner, and they must rely heavily on sources of revenue that may result in inadequate and unstable funding. The recommendations of the Committee place a significant emphasis on the provision of core public health functions. However, only anecdotal information is available regarding the extent to which these functions are now being provided. The Committee also lacked information on the cost of providing these functions. Significant efforts will need to be made by the Ohio Department of Health and local health departments to begin collecting data related to the provision of core functions. This effort might begin with a survey to determine the extent to which core public health functions are now being performed.

Previous reviews of the financial status of local health departments have relied on traditional methods, which present

trends within major categories of revenue and expense and by calculation of a per capita cost for the provision of services. The Ohio Department of Health, on an annual basis, compiles a profile of the financial status of local health departments. The 1991 Financial Report of Ohio's Local Health Departments is the most recent of these reports (9). A review of the report does provide some basic information that may be helpful in understanding the current system of financing local public health departments.

The report categorizes revenues and expenditures for city and county districts. Overall, revenues increased from 1990 to 1991 by 6.62%. The most significant sources of revenue, by percentage, differed between city and county health districts, as summarized below.

<u>Source</u>	<u>County (%)</u>	<u>City (%)</u>
Local General Revenue	14%	54%
Public Health Levy	19%	<1%
Home Health Fees	11%	4%
Personal Health Services	5%	7%
Environmental Health Fees	17%	4%
Other Fees, Permits, Licenses	4%	5%
Local Funded Projects	6%	2%
State Subsidy	2%	1%
ODH Funded Grants/Projects	17%	15%
Other State Funded Projects	2%	3%
Federal Grants/Contracts	<1%	4%
All Other Sources	1%	<1%

County health districts experienced a 9.5% increase in total revenue from 1990 to 1991 (\$91,948,525 to \$100,705,784). Some shifts in percentage revenue from the previous year are worth noting. Other State Funded Projects/Grants decreased by 41% while various fees increased: Home Health by 32%, Environmental Health Fees by 21%, Personal Health by 16%, Local Funded Projects and Special Contracts by 21%. Between 1990 and 1991, there was a notable shift away from state funding for public health services and a greater reliance on fees and local sources.

City health districts experienced a 3.73% increase in total revenue from 1990 to 1991 (\$91,932,664 to \$95,364,292). Although the same sources generated the highest percentage revenue in the previous year as well, as with county health districts, there were some notable shifts. Decreases were noted in Other Fees (18%) and Other State Funded Projects/Grants (15%).

Sources reflecting increases included Public Health Levies (137%), Environmental Health Fees (45%), and Personal Health Services Fees (41%). City health districts also relied more heavily on local sources and fees for funding of services. A large portion of the increase in fees may be accounted for by new legislation enacted in 1990, which authorized local Boards of Health to recover the full cost of mandatory environmental health programs for the first time.

The erosion of state funding adds to this weak pattern of funding by not providing a consistent and adequate source for the provision of basic services or core functions. The state subsidy is not a major source of revenue for local health departments. Twenty-four county and 38 city health departments received less than \$10,000 in state subsidy in 1991. The total state subsidy decreased slightly from 1990 to 1991 (\$3,667,549 to \$3,633,680) and represented only approximately 2% of total revenue. The minimal amount of support received through the state subsidy, compounded by a decrease in funding from Other State Funded Projects/Grants and an increased dependence on local sources, supports the need for funding reform. A "stable and well-funded" public health system cannot be created when there is such heavy reliance on sources that are short-lived, user-driven, and revenue-limited.

A review of the per capita expenditures of the 63 city and 88 county health departments further emphasizes the disparity and inconsistencies in funding. County health departments averaged \$9.82 per capita, with 44 counties above the average and 44 below. City health departments averaged \$26.55 per capita. However, only six cities were above the average. These figures are presented as a point of illustration, since the data are not available to detail the reasons for these differences (particularly among the cities) or to ascertain the degree to which core public health functions are being performed.

The need for data that appropriately reflect the financial standing of local health departments is critical if progress is to be made toward a new vision of public health. Continuing study is called for to collect timely and relevant data that can form the basis for plans to ensure a strong and well-funded public health system.

Analysis of Current Programs and Activities

The activities and functions presently performed by Ohio's local health departments illustrate some of the inconsistencies and inadequacies in service that result from problems of

organization, authority, and funding. An Ohio Department of Health survey of compensation and services conducted in 1993 documents many of these issues (10). A prime example concerns the analysis of basic public health information, as summarized below.

<u>Type of Information</u>	<u>Analyzed by local health department</u>
Communicable diseases	51%
Reportable diseases	48%
Vital records and statistics	43%
Morbidity data	33%
Chronic diseases	25%
Behavioral risk assessment	17%

The ability to plan services for a community is significantly limited without strong bases of information about the extent of health problems in the community. Yet less than one-half of Ohio's local health departments analyzed reportable disease data in their jurisdictions. Only one in three analyzed morbidity data; only one in four analyzed chronic disease data; and less than one in five attempted to understand the eating, smoking, drinking, seat belt usage, etc. of their population. Moreover, only 70% of local health departments indicated that they would make use of birth and death records supplied by the Ohio Department of Health. Only 62% of departments wanted morbidity data, and only 59% desired mortality data.

The impact of problems within the public health system is further evidenced by reviewing the reported capabilities of local health departments. Deficiencies in several areas are demonstrated by the findings of the Ohio Department of Health survey, as described below.

- o 99% of local health departments conduct state-mandated inspections of food service and nuisances. However, services for non-mandated, but significant environmental problems such as lead poisoning, radon, and indoor air quality are provided by only 69%, 40%, and 24%, respectively, of local health departments.

- o Significant percentages of local health departments do not provide services for major public health concerns.

<u>Service</u>	<u>% not providing this service</u>
Tuberculosis	40%
STD testing and counseling	56%
Chronic diseases	71%
AIDS testing and counseling	71%
Family planning	76%

Note: It is not possible to determine from this survey whether the service is provided by other agencies in the community.

- o More than three out of four (76%) local health departments have never developed a strategic plan.
- o Two out of five local health departments admit to not advocating for any public health issue in the preceding three years.
- o Nearly one-half (47%) of Health Commissioners worked only part-time. Note: Full time was defined as 20 or more hours per week.
- o Despite the importance of grant funding to implement specific targeted programs, 63% of local health departments reported that they could not complete a grant application with existing departmental staff.

A NEW VISION FOR LOCAL PUBLIC HEALTH

The Ohio Public Health Services Study Committee recognizes that government at federal, state, and local levels has an increasing responsibility for the health of its people. In addition to the official public health agencies at the state and local levels, many others, including other state and local agencies, individual health care providers, voluntary associations, community-based organizations, etc., may also provide community health services. The Committee believes that people and communities have the greatest potential for being healthy when there is a seamless web of services among all providers that assures the availability of community and personal preventive health services, access to appropriate primary health care, including clinical preventive services, secondary and tertiary care, and protection from

environmental hazards.

The Committee envisions a public health system that can work efficiently and in concert with the private health care system; that can achieve major gains in health status through efforts that affect whole populations; and that maintains a strong defense against preventable disease and injury. The characteristics of the public health system should support the vision and mission that have been adopted by the Committee.

VISION: Healthy people in healthy communities

MISSION: The mission of Ohio's public health system is to assure the conditions in which all Ohioans can be healthy and live in healthy communities.

Population-Based Services

Implicit in the Committee's statements of vision and mission is the recognition that the public health system is responsible to populations and that, to be successful, its programs must be population-based. Population-based services have historically been the foundation of the public health system and must remain so under any reformed health care system. Services that focus on entire populations or on special populations defined by demographic characteristics and/or risk for disease will continue to be a major contributor to the overall improvement of health status. These services focus on health promotion, community and personal health protection, personal prevention, and assistance to individuals in gaining access to personal health care services. Focus is on the health needs of the community, and services may range from providing education about healthful lifestyles to taking action to assure a safe food supply. In addition, the public health system's responsibility in prevention extends to certain clinical preventive health services, which might involve screening of high risk individuals, providing immunizations against vaccine-preventable diseases, and providing health education to reduce the risk of disease. Population-based services provided by the public health system include:

- o Health surveillance activities, such as monitoring death certificates, following the incidence of communicable diseases, and establishing chronic disease registries.
- o Health promotion programs, such as education about nutrition, substance abuse, physical activity, sexuality.
- o Health protection programs, such as injury control,

environmental health (air, water, food, waste management), hazards, and nuisances.

- o Personal preventive services, such as immunizations, early detection, behavior change counseling.
- o Services to improve access to care, such as information and referral, transportation, case management, and outreach.

The capacity to provide comprehensive population-based public health services is related in several ways to the size of the health jurisdiction. Data from the National Association of County Health Officials' (NACHO) National Profile of Local Health Departments indicate that larger jurisdictions are, on average, more likely to employ staff capable of providing core functions. This trend is reflected in the Ohio data from the NACHO study (8). Districts with populations greater than 100,000 are more likely than smaller districts to employ physicians, epidemiologists, health educators, nutritionists, social workers, and toxicologists. For example, only 71% of county districts under 25,000 persons employ physicians, while 100% of districts over 100,000 do; sanitarians are employed by only 81% of county districts under 25,000 and 86% of combined districts of 25,000 to 49,999, while all larger districts uniformly employ sanitarians.

The presence or lack of certain professional disciplines in local health departments translates directly into the provision of services. Similar trends related to size of district are evident for the provision of services. Basic public health practices such as communicable disease surveillance and immunization are not uniformly performed by districts under 50,000 population. In general, larger districts are more likely to perform a wide range of inspection, environmental, and certain personal health services.

Regardless of staff capabilities, small districts face difficult challenges in attempting to evaluate the health status of their populations and to measure the impact of their services. The Committee recognizes that sound data are a requirement for planning and priority setting within a local health department. Yet the ability to collect and analyze sound data and to make justifiable policy decisions based on these data is severely limited in small districts. The successful application of epidemiologic methods in a community setting requires populations of sufficient size to conduct valid scientific investigation. To make appropriate programmatic decisions at the local level, it is desirable to determine what the problem is, who the problem is

affecting, where the problem is occurring, and what results have thus far been obtained from intervention efforts. Without answering these questions, there is potential for significant waste of human and fiscal resources and, most importantly, missed opportunities to prevent morbidity and mortality.

The desirability of making policy decisions on the basis of studying large populations can be demonstrated by example. Generally, when conducting basic population studies, data must be considered separately by gender, race, age, and location, since not all subgroups have the same risk for disease or injury. For example, consider deaths from cancer in a hypothetical health jurisdiction of 200,000 persons. The overall annual cancer mortality rate for Ohio in 1989 was 219.7 deaths per 100,000 population or about 439 deaths in a jurisdiction of 200,000 persons. If deaths were equally distributed between males and females (which they are not), there would be 219.7 deaths in this jurisdiction for each gender. If ten age groups were considered, there would be about 22 deaths per age group (temporarily disregarding the fact that cancer is more frequent in older age groups). If 20% of the jurisdiction's population was non-white, there would be about 4 deaths among non-whites and 18 deaths among whites. The numbers become even smaller when considering different types of cancer, which would be the more common analysis, or when evaluating data for different geographic locations within the jurisdiction. Based only on this information, it is clear that the expected numbers of deaths yield too little data to analyze and too little data on which to base scientifically sound public health policy decisions.

This example of evaluating cancer trends in a hypothetical jurisdiction of 200,000 confirms the desirability of conducting assessments of health status in large populations. The situation becomes even more critical when considering health outcomes that are less common than cancer. The mortality rates from many conditions far less common than cancer are also of major public health interest. In Ohio, the mortality rate from pneumonia and influenza is 29.8 per 100,000; from stroke is 63.5; and from injury is 32.6. Small health jurisdictions are significantly constrained in their ability to measure the impact of these conditions on their populations.

A similar conclusion can be reached with regard to the study of morbidity. In Ohio, the morbidity rate for tuberculosis is 3.3 cases per 100,000 population; for syphilis, about 11 per 100,000. Basing appropriate interventions for chronic conditions is also more difficult for small populations. For example, the estimated prevalence of hypertension in Ohio is 301.7 per 100,000. The

hypothetical jurisdiction of 200,000 described above would have about 600 cases, and may therefore have good opportunities to develop cost-effective programs to promote screening and education, focusing on those most at risk, and to assist with access to treatment. By contrast, a health jurisdiction of 20,000 persons may only have 60 cases. Provision of service to this population would require proportionally greater resources.

Conducting assessments of health status, reaching policy decisions about cost-effective public health services, and monitoring the effects of intervention programs is a difficult matter and one that requires a strong scientific base. These examples demonstrate that this critical task is facilitated by the presence of large populations, but often not feasible or not valid among small populations.

Core Public Health Functions

As a central guide to the development of its recommendations, the Committee has endorsed the statement that:

Assessment, Policy Development, and Assurance constitute the core functions of the state health agency and all local, official public health jurisdictions in Ohio.

Assessment

Assessment means the regular collection, analysis, and sharing of information about the health status of populations, risk factors known to affect people's health, and health system resources in a community. Assessment results are shared with the community, policy makers, and the health care provider community for the purpose of developing and utilizing resources and health policies to solve community health issues. The assessment function is intended to be broad in scope, addressing questions about major health problems; populations that are at risk; the availability, adequacy, and quality of services; concerns of consumers and providers.

Local health departments can provide leadership in collecting, interpreting, and communicating health status and health system information within their communities. Many types of community-based data are required to perform the assessment function. Among them are:

- o Personal health data, such as vital statistics, laboratory test data, hospital discharge data, surveys about behavioral and other risk factors;

- o Epidemiologic and surveillance data about communicable diseases, chronic diseases, perinatal conditions and infant mortality, substance abuse, and injury;
- o Environmental health data, collected from sanitary surveys, air and water monitoring, and facility inspections;
- o Data about the health care delivery system, such as selected treatment management reviews, consumer complaint follow-up information; facility and professional licensure data; availability and access to services; utilization and cost of services; and quality and outcome of service delivery.

Performing ongoing assessments will provide the basis for identifying new issues of local or statewide concern and for identifying target populations for whom new, enhanced, or special services might be required. Assessment results will have significance for many public and private entities within the community, and it is essential for the findings from assessment activities to be appropriately distributed. Local public health departments may choose to publish annual or more frequent reports and to engage in a variety of public communication efforts.

Policy Development

"Policy development is the means by which problem identification, technical knowledge of possible solutions, and societal values join to set a course of action" (5). Good public policy development includes a sound scientific foundation, information sharing, citizen participation, compromise, and consensus in a way that nurtures shared ownership of the policy decisions. In conducting policy development activities, public health departments will integrate data from assessment activities with information from consumers and providers. Successful policy development by local health departments acknowledges local community values and priorities, as well as the interests of other public agencies and private entities. The process of policy development:

- o Defines health needs;
- o Sets priority health issues by analyzing the outcome of assessment;
- o Develops policies and plans to address the most important

health needs by setting goals and measurable objectives;

- o Develops alternative strategies for implementing plans;
- o Identifies necessary and available resources.

Policy development at the local level can also be responsive to state and federal health initiatives and goals by customizing strategies that are expected to have positive outcomes at the local level.

Assurance

Assurance means that "Government has an inherent responsibility to take positive action to achieve goals that society agrees upon in the interest of individual justice or for the common good." Assurance means making sure that necessary services are provided and/or necessary resources are available to reach agreed upon goals, either by encouraging private sector action, by requiring it, or by providing services directly. Assurance activities are tied to assessment by the ongoing monitoring of the impact of public health and personal health care services on the health status of the population.

In the context of a new vision for public health, meeting the requirements of the assurance function will demand that the public health system enhance its population-based health protection and health promotion services, as well as its quality assurance activities. The public health system's responsibilities under the assurance function include:

- o Provision of environmental health services.
- o Provision of public health nursing services.
- o Encouragement, purchase, or provision of other population-based services, such as health promotion and education programs at worksites and for the general public; comprehensive school-based programs; clinical preventive services; improved access to care.
- o Maintenance of the capacity to respond to emergencies such as disease outbreaks, toxic spills, product recalls.
- o Administration of quality assurance programs, including licensing of facilities; enforcement of rules, regulations, and standards.

Performing public health services under the core public health function model has significant implications for reform of the public health system and for the emerging role of public health within health care reform. Public health agencies, at both the state and local levels, have substantial responsibility for the protection and promotion of health. The functions of assessment, policy development, and assurance provide a strong, feasible framework within which to offer a broader role for public health, while at the same time enhancing many traditional public health activities.

An operational approach to the performance of core public health functions has been offered by the Public Health Practice Program Office of the Centers for Disease Control and Prevention (11). This description of organizational practices provides a summary of the Committee's approach to implementing its vision of public health. The functions that define the role of local public health agencies are:

- o Assess the health needs of the community by establishing a systematic needs assessment process that periodically provides the agency with information on the health status and health needs of the community.
- o Investigate the occurrence of health effects and health hazards in the community by conducting timely epidemiologic investigations that identify the magnitude of health problems, duration, trends, location, and population at risk.
- o Analyze the determinants of identified health needs in order to identify etiologic and contributing factors that place certain segments of the population at risk for adverse health outcomes.
- o Advocate for public health, build constituencies, and identify resources in the community by generating supportive and collaborative relationships with public and private agencies and constituent groups for the effective planning, implementation, and management of public health activities.
- o Set priorities among health needs based on the size and seriousness of the problems, the acceptability, the economic feasibility, and effectiveness of interventions.
- o Develop plans and policies to address priority health needs by establishing goals and objectives to be achieved

within a systematic course of action that focus on local community needs and equitable distribution of resources, and involve the participation of constituents and other related governmental agencies.

- o **Manage resources and develop organizational structure** through the acquisition, allocation, and control of human, physical, and fiscal resources; and maximizing the operational functions of the local public health system through coordination of community agencies' efforts and avoidance of duplication of services.
- o **Implement programs** by taking actions that translate plans and policies into services.
- o **Evaluate programs and provide quality assurance** in accordance with applicable professional and regulatory standards to ensure that programs are consistent with plans and policies, and provide the agency with feedback on inadequacies and changes needed to redirect programs and resources.
- o **Inform and educate the public** on public health issues of concern in the community, promoting an awareness about public health services availability, and health education initiatives which contribute to individual and collective changes in health knowledge, attitudes, and practices towards a healthier community.

This vision, mission, and commitment to performing the core public health functions are the underpinnings to the recommendations submitted by this Committee. These recommendations are designed to result in a structure and financing system for public health in Ohio that will facilitate the performance of core functions and allow these functions to be integrated into a reformed health care system. Only under these circumstances will there be a continuous system of health services that can work efficiently and effectively. Public resources must be directed to population-based efforts that can maintain a strong defense against preventable disease and injury and thereby reduce morbidity and mortality.

Adoption of the core public health function model suggests that significant shifts in resources will be necessary. To the extent that increases in resources will be required, the Committee supports the identification of cost-effective and cost-efficient methods to support core functions. To fulfill the requirements of the assessment and policy development functions, the Committee

recognizes that health jurisdictions will need to have sufficient population base to support the areas of expertise and the activities that will be required.

A reformed public health system, in concert with a reformed personal health care system, will provide new opportunities for shared activities between all levels of government and with private entities. The public health system will continue to expand its population-based emphasis with respect to prevention and disease detection, but can also assume a unique and significant role with respect to monitoring access to care and developing and applying measures to ensure the quality of care provided within communities. Moreover, the public health system will be the entity with the greatest capability to respond to health emergencies, to enforce regulatory measures to protect personal and environmental health, and to promote community decision-making that enhances individual health.

The successes that can result from a new public health system will be measured by improved health status of the populations and by the reduction of the economic burden associated with premature morbidity and mortality from preventable disease and injury. The public health system's contribution can be significant. For each case of disease prevented, the savings in treatment alone will represent a large return on investment. For example, it is estimated that first year costs of treating heart disease by coronary bypass surgery are \$30,000 per patient; for angioplasty, \$15,000; for lead toxicity, \$13,000; for neonatal intensive care treatment of low birth weight babies, \$10,000; for cervical cancer treatment, \$15,000. The potential savings over a lifetime for many preventable conditions are staggering. The lifetime costs for managing HIV infection are estimated at \$100,000 per patient; for congenital rubella syndrome, \$354,000; and for treatment and rehabilitation of severe head injury, \$310,000. These figures speak loudly to the wisdom of investment of public and private resources in well-designed, well-implemented, and well-evaluated population-based prevention and early detection programs.

To meet a new vision of public health successfully, public health professionals must challenge themselves to view the system in new ways that will enhance the services provided and the health status of the populations served. The model of core functions proffered by the Institute of Medicine provides a strong conceptual approach within which the structure and operation of the public health system can be reformed. This model incorporates the services that are the traditional backbone of public health, yet casts them in a new context, emphasizing both

familiar services and new forward-looking objectives.

RECOMMENDATIONS

As a foundation for its work, the Committee committed to the following principles on which to base its decisions.

1. "No citizen from any community, no matter how small or remote, should be without identifiable and realistic access to the benefits of public health protection, which is possible only through a local component of the public health-delivery system." (5)
2. The state must be the central force in public health and bear the primary public sector responsibility for health.
3. The public health system must be constituted with a capacity to be "strong and well funded." (Sub. H.B. 179)
4. The local component of the public health system must have the capacity to deliver core public health services to its constituents.
5. The local component of the public health system must be accountable for the quality and quantity of core public health services provided within its jurisdiction.
6. "The existing number of health jurisdictions is not cost effective because it produces a duplication of services in some areas of the state and leaves other areas of the state with inadequate public health services." (4)
7. The number of local health departments currently existing is inconsistent with the capacity to be strong and well-funded and to deliver core public health services.
8. Change in the current number of local health departments should be accomplished through a series of incentives and/or disincentives (5).

The Committee believes there are certain responsibilities and functions that fall solely on government and that these functions cannot be delegated. Therefore, for the purposes of its recommendations, the Committee offers the following definition of the "public health system":

The public health system in Ohio is the Ohio Department of Health and those local, official public health units created by Ohio law to fulfill the state's public health mission and to achieve its vision of healthy people in healthy communities.

Under the Committee's recommendations for a restructured public health system, it will be advantageous to retain familiar terminology. The following definitions apply to the Committee's recommendations.

PUBLIC HEALTH DISTRICT -- The local public health jurisdiction whose boundaries are coincident with the county boundary or with multi-county boundaries.

HEALTH DEPARTMENT -- The operating unit(s) within the local public health jurisdiction.

BOARD OF HEALTH -- The governing authority of each local public health jurisdiction.

HEALTH COMMISSIONER -- The Chief Executive Officer of the governing authority in each public health jurisdiction. This officer shall be the Health Officer of the jurisdiction and shall have such authority and responsibility as specified in the Revised Code and as may be delegated by the governing authority.

FISCAL OFFICER -- The Chief Financial Officer of the local public health jurisdiction. The fiscal officer reports to the governing authority through the Chief Executive Officer.

DISTRICT PUBLIC HEALTH COUNCIL -- The appointing authority for Boards of Health. This replaces the District Advisory Council.

The name of the public health district should be taken from the county, from the combination of the most populous municipality and the county, or such other name as may be selected locally. Multi-county units might have an operating unit within each county, all under the same governance and management.

The following sections of this report present the recommendations of the Ohio Public Health Services Study Committee.

ORGANIZATION AND STRUCTURE

As discussed above, the organization of local public health districts in Ohio has not changed in 75 years. The demands of the public health system today are more complex and require districts to have the flexibility to react to issues quickly and efficiently. Public health professionals must respond to environmental hazards and disease outbreaks that affect the health of citizens across cities, counties, and even states.

The Committee studied several options in considering the most appropriate organizational structure for the delivery of public health services in local communities. These included: a unit of state government; a general purpose government unit; a regional system providing services to population bases of at least 200,000; and maintenance of the current system. Even though there was support among Committee members for a regional system, the Committee determined that county-based units offered the minimal base required to perform core public health functions, as well as to meet financial and staffing requirements.

To realize a new vision of public health and to implement a system that focuses on performance of core public health functions, the Committee recognizes the need for more comprehensive data systems that enable decision-makers in the public health system to use data effectively in developing policy.

The following section details the Committee's recommendations for the organization and structure required to meet a new vision of public health. Topics addressed include organizational structure, political boundaries, governance, administration, medical leadership, and data management systems.

1.0 Organizational Structure for Delivery of Public Health Services in Local Communities

- 1.1 To assure the delivery of public health services in local communities in Ohio, the state should be organized into separate, local political jurisdictions which have full authority and responsibility for providing the core public health functions. These distinct jurisdictions should have sufficient autonomy to reflect the unique characteristics and needs of the people in the jurisdiction, have adequate resources to fulfill their public health mission, and be accountable to the people served.

The organizational framework of public health encompasses both

activities undertaken within the formal structure of government and the associated efforts of private and voluntary agencies and individuals. Every locale and population is served by a unit of government at some level having responsibility for the public's health. The concept of "a governmental presence at the local level" (AGPALL) is important because government alone has the power to make binding decisions (12).

While local governments are clearly creatures of the state, "the strengths of local governments for the provision of public health are: (1) to serve as a governmental presence at the local level, ensuring each citizen's access to the security, protection, and authority of government; (2) to provide a mechanism for implementation and integration of a complex array of needed services; (3) to perform these functions on the basis of both professional and community-specific knowledge and in line with the maintenance of individual rights; and (4) to convey information on local needs, priorities, and program effects to the state and national levels."

2.0 Political Boundaries of Restructured Public Health Jurisdictions

- 2.1** The health districts created pursuant to Chapter 3709 of the Ohio Revised Code should be required to be restructured as new local public health jurisdictions. These jurisdictions must have the responsibility, authority, and resources necessary to assure that the core public health functions and practices are provided to all residents of the jurisdiction.
- 2.2** The geopolitical boundaries of these restructured jurisdictions should be coincident with county boundaries, with no more than one such jurisdiction per county. A city with territory in more than one county should be a part of the jurisdiction in which the major part of the city is located.
- 2.3** Multi-county public health jurisdictions, composed of two or more contiguous counties, should be permitted when desired and required when necessary to assure the delivery of core public health functions and practices. Multi-county jurisdictions, based on a population of sufficient size to conduct valid assessments of risks to human health, to evaluate health services, and to measure the change of the health status of the population, should be pursued.
- 2.4** The formation of any multi-county jurisdiction should

originate at the local level. The Ohio Department of Health should play a facilitator role and provide assistance when requested.

- 2.5 The Director of the Ohio Department of Health should use available funds to facilitate and promote the restructuring necessary to assure the availability of core public health functions and practices to all citizens of the state. New authority granted by the enabling legislation should apply only to the restructured jurisdictions.
- 2.6 Any city may choose to continue to operate a local health department as a unit of that city's government after the enactment of enabling legislation. Any such department(s) should not be eligible for state subsidy funds. Any city(ies) in a county deciding to continue to operate a local health department shall not preclude the balance of the county from restructuring to the proposed new entity.
- 2.7 An existing city health district that does not operate a local health department should cease to exist at the end of the first full fiscal year following enactment of the enabling legislation.
- 2.8 Two years after enactment of enabling legislation, the Ohio Public Health Council should be required to evaluate, using nationally recognized standards, the availability of core public health functions and practices to all citizens of the state resulting from health district restructuring. Following, such evaluation, the Director of the Ohio Department of Health should have authority to impose any further restructuring necessary to assure availability of the core functions and practices to all Ohioans.

There are now 322 health districts in Ohio. In only 150 of these districts is there an operating health department. The remaining districts contract with other districts for public health services within their district. Current statutes do not apply uniformly to all health districts. Not all Ohioans are currently equally protected by the core public health functions. In an era of increasing governmental responsibility for health, maintaining the status quo is not an acceptable option.

The Committee strongly believes that the geopolitical boundaries of the public health jurisdiction should be the county boundaries. City health departments that desire to maintain their identity and autonomy may remain a unit of city government, but not be recognized as a public health jurisdiction. The

Health Commissioner, in those instances, would be appointed by the mayor. City health departments failing to meet the established standards would be restructured and combined with a recognized public health jurisdiction.

The Committee's vision for the future requires that local public health jurisdictions have the critical mass necessary to assure that the core public health functions are available everywhere in this state. Critical mass is defined as those characteristics necessary to provide the core public health functions and practices. It may include, but is not limited to, financial resources, qualified personnel, local commitment, and population base.

It is anticipated that in most cases, the county boundaries would provide the critical mass necessary to carry out core public health functions, but it is recognized that multi-county jurisdictions may be desired or necessary. Such determinations should be made at the local level. While the administrative offices of a multi-county jurisdiction may be centralized, the Committee envisions one or more operating or program units within each county, all under the same governance and management.

3.0 Governance

- 3.1 The governing body should be an appointed Board of Health. The appointing authority of the Board of Health should be required to assure that the Board is generally representative of the people and the population distribution within the jurisdiction.**
- 3.2 The appointing authority for the Board of Health should be a District Public Health Council.**
 - (a) The Council should consist of one County Commissioner, one trustee from each township, and the mayor or a designee from each village and the mayor or a designee from each city within the jurisdiction.**
 - (b) The Council should be required to meet in March and September of each year.**
 - (1) The purpose of the March meeting should be to elect its officers, elect a member(s) to the Board of Health, and to receive the Annual Report of the jurisdiction.**
 - (2) The purpose of the September meeting should be to**

review and comment on the proposed budget and fee schedule of the jurisdiction for the ensuing fiscal year.

- (c) A quorum, for any regular meeting of the Council, should consist of not less than a majority of the members.
 - (d) The Council should annually elect a chair, a vice-chair, and a secretary from among its members. The duties of the secretary may be delegated to the Health Commissioner.
 - (e) The Council should be permitted, by a two-thirds majority vote of the entire Council, to remove a member of the Board of Health for non-attendance or non-participation in the work of the Board or for acting in conflict of interest as a member of the Board.
- 3.3 The existing Boards of Health within a proposed restructured public health jurisdiction should be required to adopt Bylaws for the successor Board of Health. The Bylaws should become effective when approved by the Director of the Ohio Department of Health and ratified by the District Public Health Council. The Bylaws should define, within the following parameters, the size, term, and tenure for the new Board of Health.
- (a) The Board of Health of a single county jurisdiction should have a minimum of seven and a maximum of fifteen members. At least one member shall be from a recognized health profession.
 - (b) The Board of Health of a multi-county jurisdiction should have an equal number of members from each county within the jurisdiction. The minimum size should be ten members. A maximum size should be determined during the process of developing the Bylaws for the Board of Health. At least one member shall be from a recognized health profession.
 - (c) The term of Board of Health members should range from a minimum of three years to a maximum of seven years. Terms should be staggered so that no more than one-third of the terms expire in any one year.
 - (d) Board of Health members should receive a stipend and

expense reimbursement. Any such stipend should not create membership in the Public Employees Retirement System.

- 3.4 Current Board of Health members should not be excluded from appointment to a successor governing body.
- 3.5 The Board of Health's primary responsibilities are to be the policy making and hearing body for the jurisdiction.
- 3.6 A major responsibility of the Board of Health is the selection, regular evaluation, and, when necessary, replacement of the Chief Executive Officer.
- 3.7 Governing body members should be required to participate in a formal orientation to their local public health jurisdiction prior to assuming membership on the governing body.
- 3.8 Board of Health members should be required to participate in a general orientation to public health provided by the Ohio Department of Health and/or the Ohio Association of Board of Health within one year of appointment to a Board of Health. Failure to participate in such an orientation should be grounds for removal from the Board.
- 3.9 Board of Health members should be required to attend at least five hours of continuing education during the second and each succeeding year of Board membership. Such continuing education should be at seminars/workshops approved by the Director of the Ohio Department of Health. The cost of this required continuing education should be paid by the Board of Health. Failure to attend the required continuing education should be grounds for removal from the Board.

The proposed creation of the District Public Health Council is important in assuring broad representation of as well as accountability to the citizens of the public health jurisdiction. The Council's composition allows for participation by all units of local government. The elected officials designated as a part of the Board of Health appointment process must be accountable to their electorate for both their appointments to and removals from the Board of Health.

The District Public Health Council's participation in the budget process requires the Board of Health and the Health Commissioner to be accountable for the financial stability of the

jurisdiction. The receipt and review of the Annual Report requires accountability for documenting the process used for the community health assessment, the provision of core public health functions and practices, and in meeting established standards.

The Committee's recommendation that allows existing Boards of Health to adopt the Bylaws for their successor Boards is a unique aspect of this process and one that will allow for substantial participation and decision-making at the local level. This recommendation will assure that the unique characteristics and history of each district are taken into account during the transition phase.

Given the broad scope of authority and responsibility of the new Board of Health, each member must be committed to his/her responsibilities and should be knowledgeable about contemporary public health issues. Requirements for general orientation and continuing education will assist in meeting the goal of an informed Board. This training may be offered in a variety of forms, such as video discussions, teleconferencing, satellite seminars, traveling presentations, or centrally located conferences.

4.0 Administration

- 4.1 The Health Commissioner should be designated as the Chief Executive Officer of the local public health jurisdiction. As Chief Executive Officer, he/she should be responsible for all administrative functions and should serve as Secretary to the Board of Health.
- 4.2 The Board of Health and the Health Commissioner should be designated as co-appointing authorities for personnel actions. The Health Commissioner should exercise the appointing authority, with all employments subject to ratification by the Board. All disciplinary actions beyond a three day suspension should be appealable to the Board.
- 4.3 The existing Section 3709.11 of the Ohio Revised Code dealing with the qualifications of the Health Commissioner should be deleted. The qualifications of the Health Commissioner should be established by rules of the Ohio Public Health Council. The qualified individual should have a advanced degree in public health, preventive medicine, or community health.
- 4.4 After adopting a line item appropriation for each fund and establishing a reasonable spending authorization, the Board

of Health should delegate financial management responsibility to the Health Commissioner.

- (a) After enactment of enabling legislation providing for funding of the local public health jurisdiction from a reallocation of the inside millage, the following budget/appropriations procedure should be required:
- (1) The Board of Health should be required to adopt a budget for the ensuing fiscal year no later than October 1 of each year.
 - (2) The budget adopted by the Board of Health for the ensuing fiscal year should be submitted to the Budget Commission no later than October 15 of each year.
 - (3) The Board of Health should be required to adopt a temporary line item appropriation for each fund and submit it to the County Auditor no later than January 1 of each year. A permanent line item appropriation for each fund should be required to be submitted to the County Auditor no later than April 1 of each year.
 - (4) The fiscal year for local public health jurisdictions shall be January 1 through December 31.

Under current statutes, the Health Commissioner serves as the secretary to the Board of Health, with certain administrative functions reserved for the Board. This causes inefficiencies in the management of local public health jurisdictions. The Ohio Revised Code should be changed to specify the parameters of authority and responsibility for both the Board of Health and the Health Commissioner. The Board should be the policy-making body with the Health Commissioner having broad authority and responsibility to carry out the Board's policies.

As the Chief Executive Officer, the Health Commissioner must be properly educated and trained in disciplines such as epidemiology, environmental health sciences, behavioral sciences, and health planning. The Health Commissioner must also possess the necessary skills and abilities, such as team-building, conflict resolution, and strategic planning, to direct the complex administrative and management issues facing the public health jurisdiction.

5.0 Medical Leadership

- 5.1 A medical doctor or doctor of osteopathic medicine, licensed to practice in Ohio, must be appointed as the Medical Director for each local public health jurisdiction. If the Health Commissioner is a physician, that physician may also be designated as the Medical Director. However, in large, complex jurisdictions, it should be expected that these responsibilities would not be combined.
- 5.2 The Medical Director, by training, experience, and interest, must be qualified for the position. The Board of Health, upon the recommendations of the Health Commissioner, should determine such qualifications. When the appointee is qualified only "by interest," a formalized education/training process should be required within two years of appointment.
- 5.3 The Medical Director must be actively involved on the leadership team of the jurisdiction, as determined by the local Board of Health.
- 5.4 The Medical Director should be required to meet the current 50 hour per year continuing medical education requirement with not less than 20 hours in topics appropriate to public health, as determined by the Health Commissioner.

Active, knowledgeable medical leadership in public health jurisdictions is essential. Yet, current statutes do not address the qualifications of the Medical Director in a consistent manner. Section 3709.11 of the Ohio Revised Code requires that, for general health districts, if the Health Commissioner is not a physician, the Board of Health is responsible for providing adequate medical direction by employing a licensed physician as Medical Director. The Board of Health for a city health district, however, is required by statute (Section 3709.14) to appoint a Health Commissioner but is not directed to appoint a Medical Director. Moreover, no specific qualifications related to education, training, and experience are required.

A strong local public health jurisdiction must demonstrate strong capabilities in medical leadership. This leadership should be reflected by the employment of a physician who serves as Medical Director and reports to the Health Commissioner. As an active member of the leadership team, the Medical Director must be involved in the policy formation and planning process of the jurisdiction. The Board of Health shall establish expectations and responsibilities for this role in a manner consistent with

the size and demands of that jurisdiction.

6.0 Data/Information Management System(s) in State and Local Public Health Agencies

- 6.1** The Director of the Ohio Department of Health should immediately convene a Data/Information Management System Task Force and charge the Task Force to:
- (a) Review existing public health data sets and establish a standardized minimum public health data set. Such a data set should be consistent with any national data set that is developed.
 - (b) Develop a plan for the systematic computerization of personal/community health and health services data.
 - (c) Design and implement a system(s) for the electronic transfer of data.
- 6.2** The Director of the Ohio Department of Health should determine how the Data/Information Management Systems Task Force recommendations can be incorporated into or coordinated with the Ohio Health Care Data Center.
- 6.3** The Ohio Department of Health, other state agencies, and local public health jurisdictions should act as "data custodians" rather than "data owners." Data should be accessible to all legitimate users.
- 6.4** Confidentiality of personally identifiable information shall be required to be maintained.

Successful implementation of many of the Committee's recommendations will require the need for expanded and enhanced data systems. A cooperative approach between state and local agencies, and between public and private sector participants in the health care system, is necessary to accomplish the goals set forth by the Committee.

Reliable, valid, and comprehensive data are needed to fulfill community assessment objectives and assist decision-makers in policy development. The Data/Information Management System Task Force will be charged with the responsibility of planning for consistent and coordinated statewide data systems that can form the basis for program decisions and evaluation. To be effective, data systems should provide direct feedback to local public health jurisdictions.

To the extent feasible, data systems that are currently in place should be a starting point for the development of new systems. However, users of data should be aware of potential noncomparability between data sets and the difficulty in linking data from disparate sources. The issue of data duplication must also be addressed, with attempts made to reduce such duplication and its associated costs.

Data with significant potential for public health decision-making are likely to be part of the systems developed by the Ohio Health Care Data Center. Participants in the public health system should take advantage of opportunities to integrate data needed for local decision-making with statewide data collection initiatives. It is important that data be readily accessible to all legitimate users, including local public health jurisdictions, private health care providers, researchers, and academic centers.

FUNDING AND FISCAL MANAGEMENT

Historically, the funding of local health jurisdictions has been unstable and inadequate. Revenue sources do not offer health departments the possibility of long term planning, since most sources are limited to one year appropriation cycles, time limited levies, and fee-based services. The state subsidy is an amount established by the General Assembly and administered by the Ohio Department of Health and has not been effectively tied to the provision of services and the meeting of state standards. For Fiscal Year 1991, the state subsidy was approximately \$0.26 per capita.

The following section details the Committee's recommendations regarding the need for a strong and well-funded system, fiscal authority and responsibility, and funding the local public health unit.

7.0 A Strong and Well-Funded Public Health System

- 7.1 The Ohio Department of Health and local public health jurisdictions will be "strong" when they have appropriate personnel and adequate authority and resources to perform the core public health functions, resulting in the fulfillment of their public health mission.
- 7.2 The Ohio Department of Health and local public health jurisdictions will be "well-funded" when they have a funding

resource base that is:

- Adequate -- to accomplish their defined responsibilities;
- Certain -- to permit sound, long-term fiscal planning;
- Flexible -- to permit adjustments to changing needs; and
- Stable -- to avoid unexpected obstacles to achievement of their mission fulfillment

Substitute House Bill No. 179 required that the Committee "Determine ways to ensure that the Ohio Department of Health and local health districts are sufficiently strong and well-funded to provide needed public health services." The principles and criteria described above should be used to measure the adequacy of funding resources.

8.0 Funding

8.1 Funding the local public health jurisdiction should be a shared responsibility between the state and the local jurisdiction.

8.2 The state has a major responsibility to fund the cost of providing the core public health functions and practices in each public health jurisdiction.

(a) A public health trust fund should be established to fund core public health functions and practices at the state and local levels. Funding of this trust fund should come from a dedicated amount, estimated at 3-5%, of total health care expenditures in the state. The source of funding should be from either of the following:

(1) The state should institute reform of the health care system to provide for a single payor or single sponsor system to substantially reduce administrative overhead costs. Resulting savings should be used to fund the 3-5% set aside.

(2) A per capita surcharge on the basic benefit package to be offered as a part of the Ohio Health Care Board recommendations and/or a federally mandated benefit package.

(b) The Director of the Ohio Department of Health should

immediately convene a work group to review current expenditures for core public health functions and practices and to develop specific recommendations for the amount of the surcharge necessary to adequately fund the core functions and practices.

- (c) Any funds that might become available to the state from the proposed federal public health block grants should be used to strengthen core public health functions and practices at the state and local level.
 - (d) The state must not place any mandate on a local public health jurisdiction for any service or activity unless full funding or a mechanism for funding the full cost of providing such service or activity is provided by the state.
- 8.3 Local funding of the public health jurisdiction should be provided by the following:
- (a) The inside millage should be re-allocated to provide 0.8 mill to the local public health jurisdiction. Of this amount, 0.4 mill should come from the current county allocation and 0.4 mill should come from the current township, village, and city allocations.
 - (1) The County Commissioners should no longer be required to pay for office space and utilities for the public health jurisdiction.
 - (b) The Board of Health of a public health jurisdiction should have authority to establish a fee for any service provided to the public. Such fees should be based on the cost of providing the service as determined in accordance with the methodology currently defined in Ohio Public Health Council rules.
 - (c) Authority for a public health levy should be continued. There should be no statutory limit on the millage or length of such a levy.
 - (d) The taxing authority for the public health jurisdiction should have discretionary authority to propose to the electors in the jurisdiction a sales/use tax in an amount not to exceed one-fourth of one percent in addition to any other such taxes in the jurisdiction to be used in whole or in part for public health services.

- 8.4 An additional excise tax of twenty-five cents per pack on cigarettes and a comparable rate on all other tobacco products should be enacted, primarily to reduce the use of these products, with the revenue from the additional excise tax dedicated to special population-based services designed to promote health and prevent disease. These funds shall be collected and deposited into a dedicated account in the Ohio Department of Health with 90% of all funds distributed to or through local public health departments.
- 8.5 Existing tax rates should be equalized for all alcoholic beverages based on alcoholic content with the net effect being that substantial additional tax revenues be made available and dedicated to fund special population-based services designed to reduce the misuse of alcoholic beverages, to reduce and prevent intentional and unintentional injuries, and to promote health and prevent disease.
- 8.6 A \$10.00 fee shall be collected on all citations and court cases resulting in conviction for all misdemeanor assaults, including menacing, all felony assaults, all categories of murder, and all crimes involving the use of a firearm. These funds shall be collected and deposited into a dedicated account in the Ohio Department of Health with 90% of all funds distributed to or through the local public health departments for the purpose of funding community projects to reduce and prevent violent behavior.
- 8.7 The governing body of a multi-county jurisdiction should have the authority to impose in the entire jurisdiction, subject to ratification by the District Public Health Council of each county, part or all of a general health levy that any general health district in the jurisdiction was receiving at the time the district is restructured.
- 8.8 The governing body of the public health jurisdiction must have the general power to contract.
- 8.9 The local public health jurisdiction should have authority to accept gifts and bequests.

The Committee has established that the Ohio Department of Health and local public health jurisdictions will be "strong" when they have appropriate personnel and adequate authority and resources to perform the core public health functions and practices, resulting in the fulfillment of their public health mission. It is not possible to quantify the extent to which these criteria

are currently met, since, historically, funding for local public health services has not been tied to the provision of core public health functions. Based on an inconsistent, if not declining, state subsidy to local public health units, and on significant variability of per capita spending by health districts, it is clear that substantive changes are required regarding the responsibility of the state to fund public health services.

Given the proposed new structure and its emphasis on accountability as well as autonomy, local public health jurisdictions must assume significant responsibility for their own funding. The delivery of the core functions, however, must be assured through a strong system that guarantees the performance of these functions on a statewide basis. By placing the major responsibility for funding the core functions on the state, some levels of uniformity and consistency are achieved.

Data related to the dollars spent for core public health functions have not been available, and, therefore, the additional amount required to meet the needs statewide is not known. It is therefore recommended that immediately upon the release of this report, the Director of the Ohio Department of Health convene a work group to review and develop recommendations related to the funding of core public health functions.

Funding for the special services designed to promote health and prevent disease or designed to reduce and prevent violence should be available through an excise tax on specific products. These taxes are meant to serve as deterrents to the use and availability of these products and to fund targeted programs addressing identified needs of the community. These funds will be distributed to the local public health jurisdictions by the state and would be in addition to the amounts designated to fund the core functions.

In order to assure for the provision of direct services by a funding source that is adequate, certain, flexible, and stable, the local public health jurisdiction should receive a designated amount of the inside millage. The 0.8 mill recommended represents the amount proposed most frequently by Health Commissioners of general health districts as being sufficient to meet the needs of their jurisdictions. Based on a current assessed property value of \$99.99 billion for the state of Ohio, the 0.8 mill will generate approximately \$79.2 million annually. This amount compares to the \$14.0 million made available to general health districts during fiscal year 1991 (1991 Financial Report of Local Health Departments).

The governing body of the local public health jurisdiction should also be given discretionary authority to establish fees and to propose taxes for the funding of services identified as part of the assessment process.

9.0 Fiscal Authority/Responsibility

9.1 The public health jurisdiction should be permitted to be its own fiduciary agent with its own fiscal officer. Public school districts should be the model for this option.

9.2 The public health jurisdiction should have the option of choosing a county or city auditor within the jurisdiction to be the fiduciary agent and a county or city treasurer within the jurisdiction to be the custodian of all public health district funds.

(a) The public health jurisdiction should receive interest from the investment of any inactive funds.

(b) The auditor and treasurer may recover the actual costs incurred in making transactions for the public health jurisdiction.

(c) Any funds remaining in any public health jurisdiction appropriation shall carry over to the ensuing fiscal year.

9.3 The public health jurisdiction should have authority to own personal and real property.

The current system presents many barriers to the public health jurisdiction's ability to manage its financial resources. Generally, health districts cannot receive interest from the investment of inactive funds; instead, this interest is returned to the city or county general fund. Section 3709.28 of the Ohio Revised Code requires that unencumbered funds cannot be carried over to the next fiscal year. This does not allow carryover funding and may place the health district in a negative cash flow position for the first several months of the year.

Because health districts are prohibited from owning real or personal property, the County Commissioners or city governments currently provide office space for operations. This limits the jurisdiction's ability to purchase and replace equipment on a timely basis as well as ensuring the availability of adequate administrative and clinical space.

10.0 Taxing Authority

- 10.1 The County Commissioners should continue to be the taxing authority for the public health jurisdiction.**

The Committee considered the option of recommending that local public health jurisdictions should be their own taxing authority. It was determined, however, that this would be inconsistent with the presence of an appointed governing body. Therefore, the taxing method currently available to the local health district--the health levy--should be continued. The funds generated by a public health levy would provide the local jurisdiction with a funding base that would, in part, meet the four criteria of the "well-funded system."

AUTHORITY AND RESPONSIBILITY

Public health officials have not been afforded the opportunity to exercise broad authority in the governance of their units. Interpretation of statute has limited their ability to respond to problems and issues. Board of Health members and the Health Commissioner need to be able to respond to matters that have impact on the health of the community. The new vision for public health includes a Board that is fully informed and aware of the public health needs in its community and in its state.

The following section details the Committee's recommendations regarding the authority and responsibility of the local public health jurisdiction, legal counsel, and regulatory and enforcement issues.

11.0 Authority/Responsibility

- 11.1 The public health system in Ohio must reflect the interdependence of authority and responsibility between the state health agency and the local public health jurisdictions. To fulfill their mission, the local public health jurisdictions must be given statutory authority to:**

- (a) adopt rules and procedures for the conduct of its affairs;**
- (b) manage its finances;**
- (c) contract, including contracting with any other political subdivision to provide any service or to perform any activity required or permitted of the other**

- subdivisions;
- (d) promulgate regulations for the protection of the public's health;
 - (e) educate the community regarding public health issues, concerns, and problems; and
 - (f) conduct such other activities determined by the Board of Health to be in the best interests of the health of the people in the jurisdiction.

The local public health jurisdiction must be granted statutory authority to provide for its governance and its management of financial and legal affairs and be granted the tools necessary to meet its obligations in providing the core public health functions and practices.

Authority establishes what the public health unit can do. Responsibility determines what the public health unit must do. Local public health jurisdictions need authority to prevent initiation of disease or injury; prevent the extension of disease or injury, either within an individual or between individuals, groups, or communities; and prevent disability and premature death.

The authorities and responsibilities of state and local public health jurisdictions should be defined so that statewide health concerns are served by the state, while local or regional concerns are served by local jurisdictions. This would create an integrated system with assurance safeguards while maintaining substantial local involvement and autonomy.

12.0 Regulatory Authority

- 12.1 Local public health jurisdictions should have broad authority to adopt regulations, unless specifically prohibited by statute, intended for the protection of the public's health within their jurisdiction. Such regulations may be more stringent than state rules.
- 12.2 The Board of Health should have authority to grant variances from any rule or regulation adopted by that Board when the strict application of such rule or regulation creates an undue hardship and the granting of such variance does not defeat the spirit or purpose of the rule or regulation.

- 12.3 The process to be used by Boards of Health to propose, adopt, publish local regulations, and to establish due process procedures should be defined in detail in state statutes.

The Committee recommends that, unless specifically stated to the contrary, the local public health jurisdiction is assumed to possess all the necessary and sufficient powers to allow it to conduct its affairs and manage its finances. This in effect would reverse current statutory interpretation of the public health laws, which tend to hold that a particular power does not exist unless it is specifically permitted or authorized in statute.

The broad, general rule-making authority of Boards of Health contained in Sections 3709.20 and 3709.21 of the Ohio Revised Code should be retained. A presumption, however, that "unless otherwise specifically stated, rule-making authority shall be as broad as the powers conferred on the local public health jurisdiction" should be inserted in the statutory language. Because of the extremely broad scope of authority and responsibility of the local public health jurisdiction (and therefore its rule-making authority), rule-making should be subject to similar requirements set forth in the Ohio Administrative Procedures Act (Chapter 119 of the Ohio Revised Code) for state agencies. Sections 3709.20 and 3709.21 of the Ohio Revised Code should be changed to allow for this. It is also important to establish that as a general rule, local public health jurisdictions have the authority to promulgate more stringent public health regulations than state minimum standards.

There should be statutory presumption that absent specific language to the contrary, local public health jurisdictions have permitting, licensing, and registration authority that is co-extensive with the scope of their rule-making powers. No specific statutory grants of authority are required to invoke this authority. The authority to levy permit, license, and registration fees to cover the program costs of the local unit should be expressly conferred by statute. Denials, suspensions, and revocations of licenses and permits should be controlled by the provisions of the Ohio Administrative Procedures Act.

13.0 Enforcement Powers

- 13.1 The enforcement powers of Boards of Health and Health Commissioners should be clearly defined in state statutes. Such statutes should provide for:

- (a) The authority of the Health Commissioner to take appropriate immediate action whenever there is a clear and present danger to the public's health. Any such action should be appealable to the Board of Health.
- (b) The authority of the Board of Health to establish civil penalties against anyone violating a rule or regulation. Such civil penalties should be appealable to the Court of Common Pleas in the jurisdiction.
- (c) The authority of the Board of Health to negotiate a consent order with anyone violating a rule or regulation.
- (d) The right of entry onto any property for the purpose of determining whether a public health rule or regulation has been or is being violated.
- (e) The process for obtaining injunctive relief.
- (f) Criminal penalties for violation of public health rules and regulations.

The Committee recognizes the desire of the local public health jurisdiction to have the capacity to respond with rapid, effective enforcement capabilities. One option considered by the Committee included leaving the current statutes as they are. This option was not acceptable since the current language is confusing, with only some application to Chapter 119. A lack of uniformity exists in the current administrative process.

The Committee chose, instead, to recommend a modified version of Chapter 119 and to relate those modifications to local public health units. Additional capacity is required as it related to the establishment of civil penalties. This gives the local public health jurisdiction an enforcement authority in addition to an administrative resolution or a judicial process. Consent orders for compliance allow for additional flexibility. "Right of entry" language needs to be defined so that the current vagueness regarding the applicability of this enforcement power is eliminated.

14.0 Legal Counsel

- 14.1 The Prosecuting Attorney should continue to be the Chief Legal Counsel to the local public health jurisdiction and should prosecute to conclusion any violation of public health rules or regulations.

- (a) In multi-county jurisdictions, the Prosecuting Attorney of the county in which a violation occurred should be the prosecutor for that violation.

- 14.2 A Board of Health should have discretionary authority to employ special counsel for any purpose other than enforcement of public health rules or regulations.

Given the broad range of authority recommended for the new public health jurisdictions, it is anticipated that the need for legal counsel may increase. Because they are busy and often underfunded, County Prosecutors are not always able to assign high priority to health department needs, particularly in civil matters. The local public health jurisdiction has two needs as it relates to its legal demands: those related to external operations and those related to internal operations.

When the public's health is threatened, the local public health jurisdiction may require the powers of the judicial system for enforcement purposes. In those instances, the office of the Prosecuting Attorney should prosecute the violation. The Prosecuting Attorney should also represent the jurisdiction when actions are brought against it.

For internal operating purposes, in-house counsel may be needed to advise on issues that arise during the course of normal operations. In these cases, it would be beneficial for the local public health jurisdiction to obtain its own counsel, particularly if that issue is of a specialized nature. Such issues may include, but not be limited to, contracts, personnel matters, or interpretation of rules or regulations.

It is anticipated that combining the expertise of the Prosecutor's Office with the availability of special counsel will strengthen the capacity of the local public health jurisdiction to respond to complex issues in a timely manner.

ACCOUNTABILITY

Accountability, documentation of the provision of core functions and practices, and a process for assuring adherence to nationally accepted standards is critical to the success of the Committee's new vision for public health. The following section details the recommendations in these areas.

15.0 Accountability

- 15.1 Each local public health jurisdiction, through its Board of Health and Health Commissioner, shall be required to be accountable to both the people of the jurisdiction and the Director of the Ohio Department of Health.
- (a) Accountability to the people in the jurisdiction should be accomplished through a community health assessment using the Assessment Protocol for Excellence/Public Health (APEX/PH), Planned Approach to Community Health (PATCH), or any similar community process for identification and prioritization of community health needs/problems, including those mandated by federal programs. Correlation of identified problems with the Healthy People 2000 objectives and Healthy Community 2000: Model Standards, or subsequent additions to either, and the development of an action plan(s) to alleviate the problem(s) should be undertaken. Such a process should be required at least every five years.
 - (b) Accountability to the Director of the Ohio Department of Health should be accomplished by documentation that the core public health functions and practices are being provided to all residents of the jurisdiction.
- 15.2 Each local public health jurisdiction should be required to prepare and distribute a Annual Report whose minimum content is jointly agreed to by the Director of the Ohio Department of Health, the Association of Ohio Health Commissioners, and the Ohio Association of Boards of Health. The Annual Report should include an evaluation of outcomes of programs and services and the establishment of goals and objectives for the ensuing year(s).

The local public health jurisdiction is accountable by demonstrating its ability to provide the core public health functions and practices. Such accountability may be demonstrated by:

- o The capacity to demonstrate its effectiveness in identifying community needs through an assessment process that involves citizen and professional participation;
- o The capacity to demonstrate its effectiveness in assuring that appropriate and needed services are provided;
- o The capacity to demonstrate its effectiveness in planning

for the public health needs of the community;

- o The capacity to influence the citizens of the community, local, state, and federal legislative and executive officials, and special interest groups.
- o The capacity to demonstrate financial accountability through successful passage of levies and/or tax initiatives, prudent use and the wise investment of funds, and in meeting budgetary guidelines; and
- o The capacity to demonstrate the extent to which the citizenry and health professionals have been educated regarding significant community public health issues.

Because the public health system in Ohio reflects an interdependence of authority and responsibility between the local and state agencies, the local public health jurisdiction must be accountable to the Director of the Ohio Department of Health by demonstrating compliance with state standards.

Accountability must be reported to the various communities and public health jurisdictions through an organized, uniform, and timely vehicle. This vehicle should be an Annual Report.

16.0 Accreditation/Certification

- 16.1 The Ohio Public Health Council should reconstitute the Public Health Standards Task Force pursuant to Section 3701.343 of the Ohio Revised Code to develop new standards based on performance of core public health functions and practices and on nationally recognized standards such as Healthy Communities 2000: Model Standards and to recommend such changes to the Ohio Public Health Council. Such standards should be in effect no later than December 31, 1995.
- 16.2 Until such time as the new standards are developed, local public health jurisdictions should continue to be certified by meeting all minimum standards established for local health departments and by documenting compliance with these standards through a peer review process.
- 16.3 On January 1, 1997, each local public health jurisdiction should be required to be accredited by the Director of Health to be eligible for any funding from the state.

The membership of the reconstituted Public Health Standards Task Force would represent the same disciplines, although not necessarily the same people, as the previous effort, since such representation is specified in rule.

Current Public Health Standards do not conform to the model of core public health functions and practices. Consistent with the Committee's new vision of public health, it is desirable to develop standards that directly address measurable outcomes related to the performance of assessment, policy development, and assurance activities. Regardless of the schedule by which newly restructured public health jurisdictions are created, the Committee encourages prompt implementation of such standards to apply to all existing health districts.

STAFFING

Staffing the local public health jurisdiction to perform assessment, policy development, and assurance functions will require public health professionals who are well-trained in the disciplines related to public health theory and practice. Moreover, it is desirable for practitioners to have opportunities to remain current with developments in public health and to obtain new skills to enhance the capacity to deliver high quality public health services.

This following section details the Committee's recommendations regarding staffing of local public health units, staff development, and the training of public health professionals.

17.0 Staffing

- 17.1** Each local public health jurisdiction must demonstrate the ability to provide the core public health functions by employing a staff that can provide and demonstrate competence in the following areas:
- (a) Administrative leadership
 - (b) Medical leadership
 - (c) Public health nursing leadership, assessment, and assurance
 - (d) Environmental health leadership, assessment, and assurance
 - (e) Community health education
 - (f) Public Health nutrition leadership, assessment, and assurance
 - (g) Community health assessment skills
- 17.2** Local public health jurisdictions should be encouraged to jointly employ or to share staff to meet highly specialized, cyclical, seasonal, and/or emergency needs.
- 17.3** Each local public health jurisdiction should determine overall staffing requirements in accordance with local program needs and any applicable state standards.
- 17.4** Each local public health jurisdiction should establish a formal orientation for all new employees. Responsibility for conducting the orientation should be formally designated.
- (a) The Ohio Department of Health should establish and conduct a periodic orientation to public health practice and core public health functions for all new local public health jurisdiction employees.
- 17.5** Through the rule-making process, the Ohio Public Health Council should establish specific qualifications for professionals required to perform core public health functions. These qualifications should include, at a minimum, bachelor's degree level preparation for each professional discipline and Bachelor of Science in Nursing preparation for each new public health nurse hire. These

minimum qualifications should become effective no later than December 31, 2000.

To meet its obligations to perform the core public health functions, the staff of the local public health unit should possess a broad range of technical, management, and leadership skills. The Committee believes that demonstrated competence in the areas described above is minimally necessary. A set of standards or an accreditation process could be developed by the Ohio Department of Health to measure the ability or extent to which the core staff of each local public health unit is able to fulfill the core functions.

Encouraging local public health jurisdictions to share staff would result in a stronger provision of service in a manner that is cost-effective to all participating jurisdictions. An example of joint utilization or joint hiring would be employment by two or more jurisdictions of a Health Commissioner, Medical Director, epidemiologist or other public health professional with specialized technical qualifications. This might occur when a single jurisdiction lacked the population base or financial resources to support a full-time equivalent position. Personnel might also be shared to meet cyclical needs such as immunizations or environmental inspections or to allow for concentration of human resources in emergency situations.

Overall staffing requirements should be determined at the local level. Staff size and qualifications should reflect local program decisions, optimal standards, objectives and priorities in the local community, geographic size of the jurisdiction, and financial resources.

Public health workers should have an opportunity to participate in a formal orientation to the agency for which they will be employed. This orientation would focus on local operations and issues. The orientation conducted by the Ohio Department of Health would provide a uniform program to all new public health workers, focusing on general issues of public health practice and on the core public health functions. It is expected that the statewide orientation would be offered several times per year in various locations.

The Ohio Public Health Council would specify qualifications for public health professionals in addition to those qualifications required for registration or licensure. This process would not be in conflict with those bodies that set registration or licensure requirements.

18.0 Staff Development and Continuing Education

- 18.1 Local public health jurisdictions should be required to provide opportunities for all employees to participate in continuing education activities that are appropriate and relevant to each employee's responsibilities.**
- (a) A stable education/training budget set at not less than 3% of total personnel costs should be encouraged.
- 18.2 Each local public health jurisdiction should be required to adopt a written policy encouraging the professional development of its staff and defining the conditions under which staff may be reimbursed for such staff development activities.**
- (a) Boards of Health should be encouraged to establish individual training accounts for each employee in order to create incentives for every employee to continue education and training.
- 18.3 The current initiative by the Director of the Ohio Department of Health to create an Ohio Public Health Leadership Institute should be supported.**

Appropriate continuing education should have significant public health content. State and local agencies could participate in the identification of continuing education opportunities for all public health specialties. Criteria should be established to evaluate continuing education programs and determine whether they would provide personnel with enhanced skills and expertise to perform the core public health functions and to meet locally-defined program needs. All of these criteria reflect the Committee's belief that public health departments must become learning organizations in order to remain current and relevant in face of rapidly changing public health challenges.

The local public health jurisdiction's written policy on staff development and continuing education would present the criteria for acceptable continuing education programs, the policies for reimbursement for expenses associated with continuing education, and other pertinent local policies or procedures.

To help build leadership at the local level, the Committee encourages continued development of an Ohio Public Health Leadership Institute, patterned after the similar Centers for Disease Control and Prevention project. Participants would gain skills in areas such as leadership, team-building, communication,

conflict resolution, and community and statewide collaboration in problem solving and policy development.

19.0 Training of Public Health Professionals

- 19.1 More extensive public health curricula should be incorporated into education and training programs for all health professionals at all educational levels.
- 19.2 One or more schools of public health should be established in Ohio.
- 19.3 Ohio's universities should be encouraged to provide additional post-baccalaureate educational opportunities in public health disciplines.

The Committee recognizes that there is a core of knowledge necessary for excellence in public health service delivery that includes epidemiology, biostatistics, community needs assessment, health administration, environmental science, behavioral science, and health education. The Future of Public Health notes that excellence also requires an understanding of how a particular discipline relates to the whole of public health. The practice of public health requires a commitment to the public good, an ability to analyze problems over time, and skills in the political process. Yet a large percentage of individuals employed in public health settings have received no formal academic training in public health. This results in limited scope and vision in the discipline, inadequate assessment of public health problems, limited research aimed at public health practice, stunted capacity for public health policy development, minimally appropriate continuing education opportunities, and limited capacity to develop public health leadership skills.

The Committee's recommendations would provide for a stronger curriculum in public health in medical, nursing, health education, nutrition, environmental, etc., programs. This would lead to an improved public health capacity of new workers in public health settings and would offer experienced staff opportunities for additional education and development of new skills. In particular, Ohio is the only heavily populated state without a School of Public Health. Consequently, many talented individuals leave Ohio to receive training in public health and do not return. The establishment of a School of Public Health in Ohio would serve to link basic and applied research functions and would demonstrate commitment to train public health practitioners to deal with the entire scope of public health practice.

DIRECT PERSONAL HEALTH CARE AND PREVENTIVE SERVICES

The provision of direct health care and preventive services by local public health jurisdictions will be tied closely to outcomes from the assessment function. In selecting direct services to be offered, the Committee emphasizes the need to plan services in the context of community requirements, the capacity of private providers in the community, and the likelihood that services offered will have a measurable impact on the health status of the population. The Committee also recognizes that the environment for health care is changing and that such changes as occur under a reformed health care system may result in less direct service provision by local public health jurisdictions.

The assurance role of local public health jurisdictions extends to environmental health services, which are one of the predominant population-based activities of local public health jurisdictions.

The following section details the Committee's recommendations regarding the role of the local public health jurisdiction in primary health care services, clinical preventive services, communicable diseases, chronic diseases, newly recognized and emerging public health problems, environmental health, and health education.

20.0 Primary Health Care Services

- 20.1 The local public health unit should assure the provision of primary care through community health assessments, support of a community-based system of primary care, and through supplementing primary care services where needed.
- 20.2 Local public health units may choose to offer selected primary care services. Decisions to offer services should be based on documented need from community health assessments and should consider the availability of financial and human resources.
- 20.3 The local public health unit should avoid duplication of primary care services and should encourage private providers to assume responsibility in offering such services.

The Committee offers the following definition of primary care as a basis for considering the role of local public health units in the delivery of primary care services:

Primary health care services are personal health services that include health education and disease prevention, initial assessment of health problems, treatment of health problems, appropriate referral for subspecialized health services, and the overall management of an individual's or family's health care services including continuity of care.

Primary care services should have the following attributes:

- o Family centered
- o Community-oriented
- o Culturally sensitive
- o Financially accessible
- o Physically accessible
- o Temporally accessible
- o Longitudinal
- o Accountable to the individual, the community, and other health care providers

The participation of local public health units in the direct provision of primary health care services may vary widely. Performance of the assessment function will assist local public health units in determining the extent of unmet need and barriers to access in their communities. These assessments should identify sub-populations of the community that are underserved. Strategies to assure primary health care services may range from encouragement of private providers to address unmet need through existing, enhanced, or new services to direct provision of services, where feasible.

Decisions by local public health jurisdictions to provide primary care services should consider the extent to which the services are population-based and will have a measurable impact on the health status of the community. It is expected that decisions regarding the delivery of primary care will be a dynamic process, which, over time, will reflect changes in community health care needs, resources, availability and access to alternative providers, and the changing economic environment of health care provision.

21.0 Clinical Preventive Services

21.1 Based on documented needs from community health assessments, local public health units should determine whether to offer selected clinical preventive and/or risk reduction services.

21.2 The local public health unit should focus its efforts in

clinical preventive services on the control of communicable disease, a community role for which the local public health unit is uniquely suited.

- 21.3 Any clinical preventive service provided should be consistent with the recommendations of the United States Clinical Preventive Services Task Force as published in the most current edition of the Guide to Clinical Preventive Services.
- 21.4 The local public health jurisdiction should provide public health nursing with increased capacity for assessment and intervention in high risk situations, especially in comprehensive school health programs, including school-based clinics.

Clinical preventive and risk reduction services are actions to protect persons from disease and injury by direct intervention. A particular strength of the local public health unit is its ability to perform surveillance of groups and individuals identified at high risk for the development of disease or injury. The public health system is well-positioned to concentrate population-based efforts prior to the onset of disease or injury. Services offered should have a strong scientific base and should be cost-effective. The cost-effectiveness of screening versus casefinding programs should be measured explicitly.

In fulfilling its assurance function, local public health units may provide specific clinical programs to address high risk populations. Services offered should be consistent with the most recent recommendations from the Clinical Preventive Services Task Force, and may include services such as immunizations, mammography, and screening for high blood pressure, cervical cancer, and colorectal cancer (13).

Participation of the local public health unit in clinical preventive services is most appropriate when (1) the potential harm to the general population requires action to protect the population on an ongoing basis, eg., sexually transmitted diseases and immunization protection; (2) the intervention would most effectively be managed on a population basis; and (3) a consistent community-wide message is necessary to promote health and prevent disease or injury.

22.0 Communicable Diseases

- 22.1 All reportable communicable diseases should be required to be reported to the local public health unit of the

- patient's county of residence. The local public health jurisdiction should forward the reports to the Ohio Department of Health. Efforts to enhance reporting to the local public health unit and the Ohio Department of Health by electronic means should be encouraged.
- 22.2 The Director of the Ohio Department of Health should convene an appropriate work group to recommend ways to improve compliance with communicable disease reporting requirements.
- 22.3 Local public health units should assume a leadership role in the continuing education of practitioners about the requirements, procedures, and benefits for reporting communicable diseases.
- 22.4 Local public health units should have the capacity to diagnose and control communicable diseases through treatment, contact tracing, and notification. Support should be available from the Ohio Department of Health, when necessary, to assist in the management of communicable diseases.
- 22.5 The Director of the Ohio Department of Health should convene an appropriate work group to study the problems resulting from the spread of preventable communicable diseases due to recalcitrant and/or willfully negligent individuals and to recommend statutory and/or regulatory measures necessary to prevent such spread.
- 22.6 The Ohio Revised Code and the Ohio Administrative Code should be amended to reflect contemporary terminology and practices regarding communicable diseases.
- 22.7 Tuberculosis control programs that presently function independently should become part of the local public health unit. Funding for such programs should be assigned to the local public health unit.

Historically, a strength and emphasis of local public health jurisdictions has been the prevention and control of communicable diseases. These recommendations reflect the Committee's observation that significant improvements in communicable disease control are necessary. Some of the problems identified include separate reporting systems for some diseases; lack of coordination among health jurisdictions; inadequate staffing and funding; lack of adequate data and feedback. These problems suggest the need for a more interdependent and collaborative role

between the Ohio Department of Health and local public health jurisdictions.

The local public health unit should have the capacity to conduct epidemiologic investigations of communicable disease outbreaks and should conduct aggressive efforts to contact and influence the behavior of infected or exposed individuals.

Local public health units have responsibility to provide direct services in the areas of prevention, treatment, and control of reportable communicable diseases, including sexually-transmitted diseases, tuberculosis, immunizations, and surveillance of vaccine-preventable diseases.

The Director of the Ohio Department of Health's work group on reporting should include significant representation from those required to report communicable diseases, including physicians, hospitals, and laboratories. This group should address the problems that contribute to low reporting rates, including the existence of a variety of reporting systems, confusion about reporting requirements, lack of incentive (or sanctions) for reporting (or failing to report), and lack of coordination among health jurisdictions.

Terminology has changed and new concepts and terminology have been introduced since language regarding communicable diseases was written into the Ohio Revised Code and the Ohio Administrative Code. The Committee recommends that all Ohio code reflect contemporary terminology and practice.

Independently functioning tuberculosis programs exist in some Ohio communities. It is recommended that such programs, and their funding, be integrated into the functions and programs of the local public health jurisdiction. This would strengthen community-based opportunities for surveillance and control and would provide more coordinated efforts for management and follow-up of tuberculosis patients or carriers who also exhibit other communicable diseases such as HIV infection.

23.0 Chronic Diseases and Disabling Conditions

- 23.1 Local public health jurisdictions should document the incidence and prevalence of chronic diseases and disabling conditions within the jurisdiction.**
- 23.2 Local public health units should be encouraged to provide community-based health promotion and disease prevention services that are directed at reducing the morbidity and**

mortality associated with chronic diseases.

- 23.3 Based on documented needs from community health assessments, local public health units should determine whether to offer selected services for the prevention, diagnosis, and treatment of chronic diseases. Focus should be on those conditions for which population-based intervention or management is most effective.

To achieve optimal health for Ohio's individuals and communities, leading causes of morbidity and premature mortality must be reduced, as outlined in specific Year 2000 Health Objectives for the Nation. There is an important role for the public health system in controlling chronic diseases, which are accompanied by extremely high health care costs. The incidence and prevalence of many chronic disease and disabling conditions could be significantly reduced by modifying individually selected lifestyle choices. Local public health jurisdictions can achieve substantial benefits to the community through population-based services to reduce chronic disease morbidity and mortality.

Toward the goal of controlling chronic conditions, local public health units should assure access to education, prevention, and appropriate screening and detection services. Local public health units are the most appropriate and best-suited lead agency at the local level to conduct population-based needs assessments, to coordinate prevention services within the community, and to perform ongoing surveillance and monitoring of health status.

Local public health units may choose to offer selected services for the management of chronic diseases. To the extent possible, routine services that duplicate other services provided in the community should be avoided. In fulfilling its assurance function, the local public health unit should encourage these services to be offered by private providers.

24.0 Newly Recognized and Emerging Public Health Problems

- 24.1 Each local public health jurisdiction should be required to have the capacity to identify and respond to newly recognized and/or emerging public health problems and must be capable of rearranging priorities and redirecting activities so that those problems can be addressed adequately. Examples of newly recognized and/or emerging public health problems include, but are not limited to:

(a) Injuries -- both intentional and unintentional

- (b) Violence
- (c) Adverse reproductive health outcomes
- (d) HIV/AIDS

In recent years, the public health system has been challenged by numerous new or newly identified disease entities, including legionnaire's disease, toxic shock syndrome, HIV/AIDS, E. Coli 0:157 in hamburger, and Hanta virus. Additionally, many other phenomena with health related outcomes are increasingly being addressed by epidemiologic methods, with the goal of preventing and/or controlling these phenomena in the community. Examples include injuries, violence, and adverse reproductive outcomes. The newly recognized problems generally require an immediate response, whereas some emerging public health problems require a longer term approach, which might include research and subsequent efforts to modify lifestyle, behavior, or perhaps the social environment.

Local public health jurisdictions, as part of their assessment function, need the capacity to identify newly recognized and emerging health problems. Moreover, the structure, capabilities, and resources of the local public health unit must be flexible enough to reorder priorities to respond to new public health problems in a timely and appropriate manner. Such response may often require strong working relationships with other public sector agencies and with the private sector.

For example, it is most appropriate for the public health system to assume a significant community role in the prevention and control of intentional and non-intentional injuries. The potential for injuries may be related to many biological, environmental, and lifestyle factors, many of which are amenable to intervention. However, there are numerous agencies within the health care system and elsewhere in the community that deal with issues of injury prevention and education. As part of the assurance function, local public health units could serve as a coordinating agency for many services, while serving as a central community resource for injury-related morbidity and mortality data.

25.0 Management of Environmental Health

- 25.1** The public health jurisdiction should assess environmental health risks, needs, and programs within its jurisdiction. Particular emphasis should be given to injuries, indoor air quality, lead poisoning, and toxic waste.

25.2 Local public health jurisdictions should assure that adequate environmental health resources and services are available to their jurisdiction for:

- (a) providing safe drinking water.
 - (1) The existing drinking water protection programs should be strengthened in cooperation with the Ohio Department Health by providing the necessary authority and resources to the local public health jurisdictions to provide surveillance of private water supplies (potable and non-potable).
 - (2) In cooperation with the Ohio Environmental Protection Agency, the local public health jurisdiction should be provided with the necessary support, authority, and resources to assist the OEPA in its responsibility for certain public water supplies. Particular attention should be given to transient and non-transient non-community supplies serving, schools, campgrounds, manufactured home parks, restaurants, and service stations.
- (b) protecting surface and ground water supplies from pollution hazardous to health.
 - (1) The local public health jurisdictions, in cooperation with the Ohio Department of Health, Ohio Department of Natural Resources, and Ohio Environmental Protection Agency, should assess the extent to which the jurisdiction's surface and ground water supplies are protected from point and non-point sources of pollution.
 - (2) A means should be provided for funding local public health jurisdictions to conduct chemical sample screening programs when warranted. State agencies should also provide adequate chemical standards, guidelines, and technical support.
- (c) providing air free of established unsafe levels of contaminants that can affect health.
 - (1) The local public health jurisdiction, in cooperation with the Ohio Environmental Protection Agency, should assess the current air quality

needs in the jurisdiction. Additional linkages with local public health jurisdictions, which may or may not be served by a regional air authority, should be developed when improved service is warranted.

- (2) Statewide indoor air pollution programs should be developed under rules provided by the Public Health Council in conjunction with the Ohio Department of Health and the local public health jurisdictions.
- (d) providing a safe food supply.
- (1) Food regulations and program development should be based on documented factors identified with food-related disease. Clarification of agency roles in the regulation of food should be defined to minimize overlap of responsibility.
 - (2) The Ohio Department of Health should be designated in statute as the statewide authority with responsibility for all retail food protection. Authority for this protection of retail food should be the responsibility of the Ohio Department of Health and the local public health jurisdictions. Regulation of food production and distribution should continue to be the responsibility of the Ohio Department of Agriculture.
- (e) providing for safe disposal of solid and hazardous waste.
- (1) Clarification of the roles of the Ohio Environmental Protection Agency, local public health jurisdictions, and solid waste management districts should be investigated to eliminate duplication of effort and maximize utilization of resources.
 - (2) The review and redistribution of fees to support environmental health activities is warranted.
 - (3) Further exploration and consideration of the ability of local public health jurisdictions to assist the Ohio Environmental Protection Agency in the conduct of programs addressing issues of

small quantity generators of hazardous and infectious waste is warranted. Some pilot projects between the Ohio Environmental Protection Agency and selected local public health jurisdictions should be developed.

- 25.3 The Director of the Ohio Department of Health should establish a state Council on Environmental Health, consisting of representatives from state agencies with identifiable environmental programs, such as the Ohio Department of Health, Ohio Environmental Protection Agency, Ohio Department of Agriculture, and Ohio Department of Natural Resources. The Council should also include representatives from local public health jurisdictions, and knowledgeable environmental scientists from universities and/or environmental research organizations.
- 25.4 When the local public health jurisdiction acts on behalf of a state agency, it should be reimbursed for the cost of its services by that state agency. Said state agency should be authorized to set and collect fees for contracted services.
- 25.5 The Ohio Department of Health and other state agencies should have adequate resources to assure the local public health jurisdictions have the necessary laboratory and technical support to carry out these mandates to assure strong local environmental health programs.

The Committee believes in the concept of environmental health services being provided at the most local level possible. Performing the broad functions of environmental health requires the participation not only of sanitarians, but also of public health practitioners skilled in assessment, program development, administration, evaluation, and others. Local public health jurisdictions are charged with the responsibility to prevent disease, injury, and improve community health by continuing to provide traditional environmental health programs aimed at the control of water supplies, air quality, safety in public places, food protection, waste water disposal, recreation sanitation, housing, rodent and insect control, and nuisance response programs. In addition to these traditional programs, the local public health jurisdictions must be prepared to deal with the more contemporary environmental health needs related to injuries, personal health, and toxic waste.

The Committee believes that the role recommended for local public health jurisdictions in environmental health management will

result in maintaining and improving the health status of the community. The Committee further believes the recommendations will enhance the coordination and relationships between the state health and environmental agencies and the local public health jurisdictions.

26.0 Health Education

- 26.1 Health education activities should be planned and implemented based on needs identified through community assessment. Special attention should be focused on high risk groups and special populations.
- 26.2 Each local public health jurisdiction should have an identifiable unit responsible for administering and managing health education efforts that support all program areas.
- 26.3 Each local public health unit should function as a leader and a liaison between health organizations and lay, professional, and voluntary groups in the community.

The term health education refers broadly to a function that is the responsibility of many public health practitioners representing many disciplines. Physicians, nurses, nutritionists and others have the responsibility to include health education as a dimension of the services they provide.

The health education capabilities of the local public health unit should include a wide variety of services and organized efforts directed at enabling people to increase control over, and ultimately improve, their health. The local public health unit is uniquely qualified in the community to mobilize other community organizations such as schools and workplaces to participate in population-based health promotion, disease prevention, and other targeted education efforts.

To meet the needs identified through community assessment, the local public health unit has a responsibility to offer focused health education programs. In addition, it should take a leadership role in educating the community about approaches to health promotion and disease prevention. Particularly encouraged are activities that promote well-being among the general population, yet retain and encourage the individual's responsibility for maintaining his/her own health.

HEALTH SYSTEMS ISSUES

The likelihood of a reformed health care system has many implications for the public health system. Health care reform opens the possibility for partnerships among a variety of providers and payors to develop at the community level in order to provide an organized system for the delivery of health services. The role of the local public health jurisdiction may vary according to the nature of the local population, the available health care resources, and the special needs of each area. Consequently, it will be essential for public health agencies to participate with other health care providers in the development and/or adaptation of health plans for their constituent populations.

The following section details the Committee's recommendations regarding the development of community health policy and the role of local public health units in health care reform.

27.0 Development of Community Health Policy

- 27.1 Each local public health jurisdiction should have the central role in the development of community health policy and plans and in the allocation of resources for health in the community. Local public health jurisdictions should collect information to develop local priorities and plans in partnership with the entire community, including private health care providers, elected officials, and a representative array of public and private institutions.

Through its assessment function, which will incorporate both public and private data sources, the local public health jurisdiction has potential to be a comprehensive source of information about health status, health conditions, and health services in the community. Therefore, the local public health unit should be a strong coordinator and leader in the development of community policy to assure access to appropriate and effective health services. This role for the public health system will help develop a more comprehensive community health management system for planning, implementation, and evaluation of health services.

This recommendation is consistent with the recognition that policy development is one of the core public health functions. The proposed leadership role for the local public health jurisdiction is appropriate since the local public health jurisdiction is the clearly recognized and accountable governmental entity charged with the protection and improvement

of the health of its citizens.

28.0 Health Reform

- 28.1** Any proposal to reform the health care delivery system must provide for a strong and well-funded public health system.
- 28.2** Legislation should be enacted to expand membership of the Ohio Health Care Board to include either a member of a local Board of Health or a Health Commissioner from a public health jurisdiction.
- 28.3** Local public health jurisdictions should not be excluded from participating in a reformed health care system as a provider of personal health care services or as a partner in any newly formed health alliance or health plan.

There is a defined need for a strong and well-funded public health system under any newly reformed health care system. The core public health functions include services to support the infrastructure of the health care system and in particular include population-based services provided only by governmental entities. A strong and well-funded public health system is required to expand capacity to provide population-based education and preventive services, to mobilize efforts to limit barriers to access, to respond to health crises, and to ensure adequate control of environmental hazards.

The addition of a local public health representative to the Ohio Health Care Board would encourage cooperative planning efforts between the public and private agencies and organizations addressing health care reform in Ohio and would bring local public health expertise to the Board's deliberations. Participation on the Ohio Health Care Board would result in more effective planning for access to health care services and would help define the core public health function of assurance in the context of public and private providers.

The capacity of local public health jurisdictions to provide services or form a partnership to provide direct health care services under a reformed system should be explicitly recognized by the Ohio Health Care Board. This will open the opportunity to local public health jurisdictions to be knowledgeable about the entire changing health care network and to participate if necessary and appropriate in their communities.

RELATIONSHIPS TO OTHER AGENCIES

The Committee recognizes that successfully managing the scope and complexity of modern public health concerns will require local public health jurisdictions to form strong, cooperative relationships with other state and local agencies that have a direct or indirect interest in public health. Technical and programmatic support is needed from state agencies; partnerships with other local health and human services agencies are needed to fully implement the programs and activities to support core public health functions and provide direct services. It is increasingly important that the relationship between the Ohio Department of Health and the local public health jurisdictions strengthen, with both entities providing leadership as they proceed with implementing the new vision for public health.

The following section details the Committee's recommendations regarding the relationship of the local public health jurisdiction to state agencies, other local providers, and the Ohio Department of Health.

29.0 Relationship of Local Public Health Jurisdictions to State Agencies

29.1 The Directors of state agencies whose missions and activities have impact on the health of the public and leaders of local public health jurisdictions should develop collaborative relationships or partnerships in order to establish and achieve mutual goals. These state agencies may include, but are not limited to: Ohio Department of Health, Ohio Environmental Protection Agency, Ohio Department of Mental Health, Ohio Department of Alcohol and Drug Addiction Services, Ohio Department of Natural Resources, Ohio Department of Agriculture, Ohio Department of Education, Ohio Commission on Aging, and Ohio Department of Highway Safety.

Besides the obvious and strong relationship required between the Ohio Department of Health and local public health jurisdictions, other state agencies are central to successful initiatives in the public health system. Local public health jurisdictions should be encouraged to collaborate with state agencies to develop plans and policies for local community programs. This would afford the local public health jurisdiction with increased opportunities to become involved in implementing and/or monitoring a wide range of health-related programs in its community. Enhanced communication with state agencies would permit the local public health jurisdiction to integrate state level objectives and program

plans into local policy development efforts.

30.0 Relationship of Local Public Health Jurisdictions to Other Local Health and Human Service Providers

30.1 Local public health units should develop collaborative relationships with community providers, agencies, and systems with interests in health, safety, and human services. These may include, but are not limited to:

- (a) Human service system
- (b) Educational system
- (c) Correctional health care system
- (d) Voluntary health organizations

The local public health jurisdiction has been identified as playing an important role in the health care system through the following mechanisms: (1) the development of community health policy; (2) the allocation of resources for health in the community; and (3) as a participant in health care reform.

To further ensure its role as a leader and liaison with all aspects of the health care delivery system, the local public health jurisdiction should identify significant health and human services agencies in the community that have similar interests, programs, and goals. This will enhance the development and implement of community-wide programs to serve public health needs and will assist the local public health jurisdiction in fulfilling its objectives under the assurance function. Ohio's Family and Children First Initiative provides an example of local collaborative efforts among health and human service providers.

31.0 Ohio Department of Health Responsibility to Local Public Health Jurisdictions

31.1 The Ohio Department of Health should provide leadership and technical or specialized assistance to the local public health jurisdiction.

31.2 The Director of the Ohio Department of Health should convene a Task Force to examine the capacity of the Ohio Department of Health to achieve its vision and mission and to recommend appropriate changes where needed. Particular attention should be directed to:

- (a) The ability of the Department to adequately support local public health jurisdictions.
- (b) The epidemiologic capacity of the Department.

31.3 All grant funds distributed by the Ohio Department of Health for local programming should be channeled through local public health jurisdictions as long as there are no conflicts with federal requirements.

Many of the recommendations set forth by the Committee reflect a vital and important link between the Ohio Department of Health and the local public health jurisdictions. Since the public health system includes both the state and local agencies, this link requires the Ohio Department of Health to provide leadership and assistance to the local jurisdictions.

The Committee recommends that grants from the Ohio Department of Health to local agencies should flow through the local public health jurisdiction. This would serve to increase accountability and would provide opportunities for the building of strong local relationships. Channeling grant funding through local public health jurisdictions will be a method by which the Ohio Department of Health can support the jurisdictions' ability to coordinate and monitor ongoing activities and services.

Enhancing the epidemiologic capacity of the Ohio Department of Health will augment local capacity for specialized technical services. The state agency is also well-positioned to conduct epidemiologic assessments of areas that encompass large populations, such as several contiguous public health jurisdictions. These analyses of large population can complement and strengthen the scientific validity of local assessment activities.

TRANSITION TO RESTRUCTURED PUBLIC HEALTH JURISDICTIONS

The Committee recognizes that transition to a restructured public health system is a complex matter, involving numerous administrative, financial, human resources, and legal questions. The following recommendations are offered for the purpose of identifying issues that must be addressed in the course of establishing new public health jurisdictions. Adequate, appropriate, and timely consideration of these issues will ensure that the transition is accomplished smoothly and with minimum disruption in the delivery of services.

32.0 Transition

32.1 All currently employed personnel should:

- (a) Maintain employment. Title and job duties cannot be guaranteed.
- (b) Maintain current salary.
- (c) Maintain benefits to the extent possible.
- (d) Maintain time in service for calculation of vacation and sick leave benefits.
- (e) Carry over all accrued vacation leave and sick leave.
- (f) Use all compensatory time prior to effective date of restructuring.
- (g) Seniority issues should be resolved pursuant to Civil Service Rules.
- (h) Any issue not addressed above should be determined by local negotiation.

32.2 When more than one current health district is restructured into a local public health jurisdiction, the current Boards of Health and/or the successor Board of Health, up to two years after the effective date of the restructured public health jurisdiction, should be permitted to purchase up to a maximum of five years service credit with the Public Employees Retirement System. The cost of this purchase should be shared between the state and local jurisdiction.

32.3 Currently existing labor-management contracts should be honored pursuant to applicable state law. It should be recognized that such contracts may need to be re-negotiated under applicable state law.

32.4 All funds and liabilities should be transferred to the restructured jurisdiction.

32.5 The restructured jurisdiction should continue to receive all grants received by a predecessor health district until the end of the current grant period.

32.6 All contracts should be honored to the end of the current contract or re-negotiated.

- 32.7 All fixed assets and supplies should be transferred to the restructured public health jurisdiction.
- 32.8 Where applicable, free-standing public health facilities owned by County Commissioners should be transferred by deed to the public health jurisdiction.
- 32.9 The Director of the Ohio Department of Health should require that the legal services office at the Ohio Department of Health develop a "boilerplate" or model contract for use by existing health districts in restructuring to a local public health jurisdiction.

SUMMARY AND CONCLUSIONS

With the publication of this report, the Ohio Public Health Services Study Committee has completed its task. The Committee's recommendations are directed toward the goal of improving the health status of Ohioans by assuring the conditions in which all Ohioans can be healthy and live in healthy communities. To achieve this mission, Ohio's public health system is encouraged to embrace a view of public health based on the core functions of assessment, policy development, and assurance. To perform the core functions and the practices that operationalize them, the Committee envisions a restructured public health system, the highlights of which are summarized here.

- o Local public health departments should be restructured into new jurisdictions with the authority and responsibility to provide the core public health functions.
- o The geopolitical boundaries of the restructured jurisdictions should be coincident with county boundaries.
- o These jurisdictions should be governed by a Board of Health appointed by a District Public Health Council consisting of the jurisdiction's elected leadership.
- o The public health system will be strong when it has appropriate personnel, authority, and resources, and will be well-funded when its revenue base is adequate, certain, flexible, and stable.

- o The state should assume a major responsibility to fund the cost of providing core public health functions and practices. State funding for these efforts should come from a public health trust fund. Local funding should come from the inside millage, fees, and health levies.
- o Accountability and accreditation of the public health jurisdictions should be based on documented abilities to provide core public health functions and practices.
- o The public health jurisdictions should employ staff that demonstrates administrative and medical leadership, as well as competence in the public health disciplines of nursing, environmental health, health education, nutrition, and community assessment.
- o Public health jurisdictions should assure the provision of direct preventive and personal health services. These include primary care and clinical preventive services, as well as services for the management of communicable and chronic diseases and newly emerging public health problems. Priorities should emphasize population-based services.
- o Public health jurisdictions must have increased capacity to prevent and control communicable diseases through epidemiologic investigations, direct services, and timely and appropriate administrative responses.
- o Public health jurisdictions must have increased capacity to prevent and control communicable diseases through epidemiologic investigations, direct services, and timely and appropriate administrative responses.
- o Environmental health risks should be assessed within the public health jurisdiction. The jurisdiction should assure that adequate environmental health resources and services are available.
- o The public health jurisdiction should have a central role in the development of community health policy and in the allocation of resources in the community.
- o Any proposal to reform the health care delivery system must provide for a strong and well-funded public health system.

- o Public health jurisdictions should be encouraged to strengthen relationships with state agencies and with other local providers of health and human services.

The Committee's vision for an improved public health system requires a restructured system. This system must emphasize the provision of core public health functions and practices, the adherence to standards and accreditation, the availability of adequate resources, and the granting of the necessary authority and responsibility to carry out its mission.

The Committee anticipates that local health departments, the Director of the Ohio Department of Health, and the Ohio Public Health Council soon will begin implementing those recommendations that do not require any additional administrative directive or legislative mandate. Some recommendations, of course, can be implemented only by legislative initiative. The Committee would desire that the process for the introduction of that legislation begin as quickly as possible, especially in view of the rapid pace with which state and national health care reform is being pursued.

The public health community is encouraged to support these recommendations. The Committee is confident that their implementation will result in profound and sustained change. The recommendations must be embraced and promoted if the Healthy People--Healthy Communities vision is to become a reality.

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SUPPLEMENTARY STATEMENTS

It is stating the obvious to note that we live in a complex and rapidly changing world. A world where knowledge is expanding at near exponential rates and various modes of communication and rapid transportation are moving information and people with blinding speed. Merely a generation or two ago our world was barely imaginable by even the more futuristic thinkers. We have made many wonderful technological advances, yet we are failing in so many areas. For example: increasing rates of some sexually transmitted diseases; an infant mortality rate that is one of the highest among advanced countries; a resurgence of vaccine preventable diseases; skyrocketing intentional injuries; substance abuse; climbing lung cancer rates and more. Shame on us, for all of these are preventable conditions.

Although still important to maintain, gone are the days where assuring clean drinking water, treating sewage and assuring a safe food supply allowed us to make quantum gains against the primary health problems of the day. These problems were soundly defeated by the application of competent public health principles and practices implemented during the early part of the century; the same time that Ohio last updated its public health structure. Now, three-quarters of a century later, we are fighting new public health battles with a public health structure that is clearly outdated.

Dealing with the public health problems of 75 years ago, could be, and most of the time needed to be done at a very local level. However, today's more complex, interconnected and rapidly changing world needs a different system, one that can again utilize the scientific principles of public health to deal with contemporary issues, but on a necessarily larger scale. This larger scale necessitates a population base which is sufficient in size to make use of good science to identify, count and target programming. Our problems are so complex that we can no longer just clean the water and inspect the restaurants. We must work at changing specific behaviors and implementing interventions in larger, more diverse populations if we are to substantially improve the health of persons. To continue with the same antiquated system in this modern world is clearly ineffective and certainly loses much to economies of scale.

Amazingly, with all our collective knowledge, we as a society continue to spend billions on high tech health care when the expenditure of millions would prevent most of what the billions of dollars are spent for. The best way to improve the situation is with a different and expanded public health system at both the state and local level. We must have public health units that possess the capability to assess where we are, and create a vision of where we need to be. Then these public health units must create and implement dynamic plans grounded in reliable science.

There are many good people working diligently in our state and local health

departments. However, they are working in an outdated system with antique tools. And even though they may be doing things right, they may not be doing the right things relative to the needs of the complicated world in which they must function. The challenging nature of today's public health environment requires the attention of full time professionals who are educated in applicable disciplines.

People working in public health are dedicated to helping others in so many different ways. Unfortunately, even dedicated people may not be working on the most important issues, because the system in which this work occurs is not functioning well. The small size of most local health departments in Ohio is not enough to keep people from efficiently and effectively addressing the complex and rapidly changing world in which we must provide bold leadership. All other large populated states have used sound science and economic theory to cause their elected officials to structure or reinvent a local public health delivery system built on fewer, yet stronger local public health units. The application of epidemiologic principles indicates that a population of 200,000 is probably minimum for adequate public health programming for financing, staffing, disease and injury surveillance, interventions and program evaluation. This can be accomplished in Ohio by developing 31 county or multi-county public health units. Bigger may indeed be better, if improved population health status and cost efficiencies can be realized.

Frank Holtzhauer, PhD

There are numerous, serious concerns that have been echoed by County and City officials at public hearings across the state. Growing opposition to portions of the recommendations threatens the viability of the overall report. In the words of the County Commissioners' Association of Ohio letter of September 15, 1993, to the Ohio Public Health Services Study Committee, "...Committee leadership has chosen to attempt to rush to the legislative phase and try to sell something that has not been worked out at the local level. Thrown into the legislative arena with no true consensus, the struggle over these unresolved issues will become even more painful."

ISSUES OF CONCERN:

1. The study committee was predisposed from the beginning of the process toward consolidation of local public health districts.
2. The report, as drafted, does not identify problems with the current system.
3. The organizational structure of the functional unit of a local public health jurisdiction should be defined in terms of its ability to deliver core public health services to the community. The geopolitical

- boundaries of the local public health jurisdiction should not be driven by political expediency or for centralized control, but rather to optimize delivery of core services provided to citizens.
4. The promise of home rule has been that local communities could shape and control services to fulfill their unique needs. It is impossible to see how one public health jurisdiction per county can fulfill that promise.
 5. There is vast diversity in the needs of citizens for public health services in urban vs. suburban vs. rural and along the lines of race and socio-economics of local populations.
 6. The recommendations are vague regarding specific services that citizens can feel are of direct benefit to them. Again, service should be rated on citizen need and structure should be designed to optimize service delivery. The lack of geopolitical boundary options to serve the wide range of community needs suggests that the driving force behind the singular recommendation places service in a secondary role.
 7. Consolidation of local health districts into one large public health jurisdiction per county does not automatically predict cost savings or efficiency. Local health departments do not duplicate service because they provide service to separate communities and populations.
 8. Consolidation of districts into county-wide jurisdictions would dilute community representation.
 9. New, additional taxes or levies will be very difficult to sell with the likelihood of health care costs decreasing due to health care reform in general. It will be even more difficult to convince communities to pass new tax measures if they perceive a loss of control over local health department services.
 10. Transition issues are not addressed in the draft recommendations. A number of very difficult issues would need to be resolved if implementation of this proposal was to occur. Some examples are:
 - a. How would employee's rights be protected? What would the employment status be of current employees of local health districts in relationship to the new unit?
 - b. How would the disposition of real property and other assets of current districts be decided with respect to the needs of the new public health unit, given the differences between and among districts?
 - c. It is not clear from this document what specific services would be provided by this new public health unit. Further, there appears to be a need for a systematic assessment of current services in each district. Service delivery should drive the organizational structure

of the unit.

- d. Quality assurance issues are not adequately addressed in these draft recommendations.

RECOMMENDATIONS:

The following are changes to the recommendations that are strongly suggested as alternatives to current language in the document.

GEOPOLITICAL BOUNDARIES

Change the existing language as found on page 5 of the Ohio Public Health Services Study Committee Draft Recommendations dated August 30, 1993, to:

1. All existing health districts created pursuant to Chapter 3709 of the Revised Code should be allowed to exist in order to maintain political cohesiveness and a sense of "ownership," provided these health districts assure the core public health functions of assessment, policy development, and assurance are delivered.
2. A multi-county jurisdiction, composed of two or more contiguous counties, should be permitted when desired or when necessary to perform core public health functions.
3. The formation of any multi-county jurisdiction would originate at the local level. The Ohio Department of Health should play a facilitator role and provide assistance when requested.

These supplemental statements are submitted in the spirit of offering constructive alternatives for portions of the recommendations considered unworkable. It is further suggested that work go forth involving all local health commissioners willing to participate to arrive at a consensus on transition and implementation issues. No implementation date or proposed legislation should be recommended until these issues are resolved.

Note: I was directed by the chairman of the Public Health Services Study Committee on October 8, 1993, to condense the supplemental statements to only one page. The sustenance of the concerns may be lost or even deleted in this format.

R.C. Banks

As the Ohio Public Health Services Study Committee worked to formulate its report over the last year, the Federal government as well as the State of Ohio began formulating health care plans to attempt to solve the staggering problems evident in the health care system utilized today.

As of late, both the federal plan and the forthcoming plan for the State of Ohio are sending a strong message that no provisions are being made to address the care and maintenance of the chronically ill. While funding typically used for these services is facing cutbacks, no provisions are being made for the long term speech, physical, occupational and other types of therapy to ensure these patients a chance at being productive members of our society.

If Public Health is to fulfill its mission "...to assure the conditions in which all Ohioans can be healthy and live in healthy communities," then the Public Health System must be prepared to fill this important gap in health care coverage. To limit access to proper treatment denies these individuals the opportunity to reach their full potential in our society. To assure these services early in life will prevent further disability and hold down future medical costs for these individuals and their families.

In addition to having to endure the trauma of their long term personal realities, the chronically ill and their families have been forced into a system of arbitrary care denial, arbitrary contract changes and premium overcharges of astronomical proportions by health insurance carriers. The chronically ill and their families are encouraged to maintain their economic status at the poverty level in order to qualify for State and Federal assistance. The State of Ohio Department of Insurance cannot assist because they "have no authority." My own legislators stopped communicating with me on this issue when I have addressed it in the past.

In my opinion, the Public Health System, as well as the Ohio Health Care Board are bound under Section 504 of the Rehabilitation Act, and more recently under the Americans with Disabilities Act to offer services without discrimination.

In the past, services were provided at care facilities like institutions, ICMFRs or group homes where care givers had access to information and services. The trend for the future is to place these individuals out in the community--out in a more natural setting. It is our responsibility to assure these individuals remain aware of necessary services, utilize these services and to provide these services where none exist.

The local Public Health units should make available either directly or indirectly, therapy and other benefits to the population within their jurisdiction suffering from severe congenital/chronic disabilities such as cerebral palsy, cystic fibrosis, down syndrome, spina bifida, mental retardation, blindness, deafness and other disabilities. The decisions to offer these services should be based on documented need from the community health assessments.

James F. Recchio, Jr.

APPENDICES

**Committee and Staff Biographies
Subcommittee Membership
Witnesses at Regional Hearings**

COMMITTEE BIOGRAPHIES

Ned Baker, RS, MPH, has held positions with the Wood County Health Department, the Ohio Department of Health, the Health Planning Association of Northwest Ohio, and numerous others. Mr. Baker, now retired, holds an MPH degree from the University of Michigan, and is a member of the Wood County Board of Health and President of the National Association of Local Boards of Health.

R.C. Banks, RS, began his public health career at the Wood County Health Department in 1967. In 1976, he became the supervising sanitarian in Greene County, and in 1980, Mr. Banks was named Health Commissioner of Sharonville, Ohio.

John Battles received a B.S. degree from The Ohio State University in agriculture in 1956. He devoted his entire professional career to the USDA Soil Conservation Service until January, 1991, when he was elected County Commissioner in Sandusky County.

Mary O. Boyle is the first woman to serve as County Commissioner in Cuyahoga County. She heads the state-mandated Public Works Committee and is a member of the County Planning Commission and Coastal Resources Advisory Committee. Ms. Boyle is a graduate of St. Mary's College.

Representative Charles Brading graduated from Ohio Northern University in 1957 and has been a practicing pharmacist in Wapakoneta for 33 years. He has been active in professional and local associations. As a member of the House of Representatives, he has served on the Health and Retirement Committee, Energy, Environment, Public Safety, and Highways Committee.

Senator Grace Drake began her legislative career in 1984 representing portions of Cuyahoga and Medina Counties. Senator Drake serves on several Ohio Senate committees, including Education, Retirement, and Aging; Economic Development; Science and Technology; and Highway and Transportation.

Grace Duncan, RN, received her diploma in nursing at Massillon State Hospital and her bachelor's degree in nursing at the University of Akron. In 1982 she was appointed Associate Director of Nursing at the Barberton Citizens Hospital, a position she held until her retirement in 1991. Ms. Duncan serves on the Barberton Board of Health and is a Trustee, Northeast District Ohio Board of Health.

Ron Elble, MPH, received his BS degree from Eastern Kentucky University and MPH from the University of Tennessee. In 1979 he was appointed Chief Administrator of the Zanesville-Muskingum County Health Department. He currently serves as Chief, Division of Local Services at the Ohio Department of Health.

Senator Ben Espy received his Bachelor's degree from The Ohio State University his Juris Doctorate from Howard University's School of Law. From 1982-1992, he served as a member of Columbus City Council and has represented the 15th District in the Ohio Senate since 1992.

Kim Goldenberg, MD, FACP, received his medical degree from Albany Medical College. He has held numerous teaching positions and has served as Dean of Medicine at Wright State University since 1990. Dr. Goldenberg has worked on several national committees in the areas of preventive medicine and public health.

Representative Robert Hagan represents the 53rd District in the Ohio House of Representatives. By occupation, he is a locomotive engineer, Chessie System.

Thomas Halpin, MD, MPH, completed his medical studies at the University of Cincinnati and received an MPH degree from the University of Oklahoma. Dr. Halpin serves as Chief of the Division of Preventive Medicine at the Ohio Department of Health.

Frank Holtzhauer, PhD, holds a doctoral degree in Preventive Medicine from The Ohio State University. In 1978, he was appointed Chief of the Division of Epidemiology at the Ohio Department of Health. In 1987, Dr. Holtzhauer was named Assistant Health Commissioner at the Columbus City Health Department in charge of the Division of Ambulatory Services.

Karen Krause, RN, MPH, holds a diploma in nursing from Maumee Valley Hospital, a BS degree from the University of Toledo, and an MPH from the University of Michigan. She is recently retired from her position as Director of Nursing and AIDS Programs at the Lucas County Health Department.

Maurice Mullet, MD, received his medical degree from The Ohio State University. He began his public health career in 1975 as Health Commissioner for the Holmes County Health Department. In 1988, Dr. Mullet also became Health Commissioner for Knox County. He currently serves as President of the National Association of County Health Officials.

William Myers, MS, received his BA degree from Muskingum College and his MS in Preventive Medicine from The Ohio State University. Mr. Myers began his public health career with the Centers for Disease Control in 1965 and has served as Health Commissioner for the Columbus Health Department since 1980.

Kathy Peppe, RN, MS, received her BSN and MS degrees from The Ohio State University. During her 18 years with the Ohio Department of Health, Ms. Peppe has held several positions in the Division of Maternal and Child Health and currently serves as Acting Chief of that Division.

James F. Recchio, Jr. is involved in many community activities. He is President of the Stark County Board of Health and of the Ohio Association of Boards of Health.

Richard Ruppert, MD has served as President of the Medical College of Ohio since 1977. He received his medical degree from The Ohio State University and was on the College of Medicine faculty from 1966 through 1974.

Donald Schregardus, MS, received Bachelor's and Master's degrees from Miami University. He has held various positions with the U.S. Environmental Protection Agency. He currently serves as Director of the Ohio Environmental Protection Agency.

Peter Scmani, MD, PhD, is Director of the Ohio Department of Health. Previous to this appointment, he was active in medical education and research, most recently as Director of the Division of Clinical Pharmacology at the Medical College of Ohio.

Sharon Speck, RN, is a graduate of Case Western Reserve University. She has held numerous teaching positions in hospitals, nursing homes, and college settings. Ms. Speck is a member of the Board of Health for the Zanesville-Muskingum County Health Department.

Roger Suppes, RS, MPH, started his public health career as a sanitarian at the Summit County Health Department. He has served in various positions at the Ohio Department of Health since 1970, and in 1987 became Chief of the Division of Environmental Health. Mr. Suppes holds degrees from Ohio University and the University of Michigan.

STAFF BIOGRAPHIES

Nancy A. Reiches, PhD, holds a doctoral degree in epidemiology from The Ohio State University. She previously served as Director of Research at Riverside Methodist Hospitals, Columbus, and Senior Research Scientist at the OSU College of Medicine. Her current consulting practice specializes in health services research, planning, and evaluation.

Frances L. Baby, MPA, is a graduate of The Ohio State University School of Public Policy and Management. She is a former Assistant Health Commissioner for the Columbus Health Department. Her current consulting practice specializes in home health and community based services.

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