

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

1 APPEARANCES

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3 MEMBERS PRESENT:

4 Senator David Burke, Chairman
5 Christopher E. Press, Vice-Chairman
6 Martin Tremmel, Secretary
7 Kim Edwards
8 Heidi Fought
9 Tim Ingram
10 Gene Nixon
11 Dr. D. J. McFadden
12 Nancy Shapiro
13 Representative Nickie Antonio
14 Jennifer Wentzel
15 Walter Threlfall
16 Jennifer Scofield
17 Anita Scott-Jones

18 Also Present:

19 Joseph Mazzola
20 Tracy Freeman
21 Bruce McCoy
22 Jessica Crews
23 Kate Philips
24 Lyndon Jones
25 Duane Stansbury
26 William Hayes
27 Beth Bickford
28 Lindsay English
29 Susan Tilgner
30 Charles Patterson
31 Aaron Ockerman
32 Jason Orcena
33 Socrates Tuch
34 Joe Russel
35 Laura Abu-Absi
36 Melissa Bacon

37 Present via audio link:

38 James Watkins
39 Kimberly Moss
40 Gillian Solem
41 Kristen Hildreth

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AGENDA

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- 1) Welcome
 - * Chair, Senator David Burke
 - * Vice-Chair, Christopher E. Press
- 2) Approval September 11, 2012 Meeting Summary Notes
- 3) Committee Recommendations Survey Review
- 4) Discussion and Review of Recommendations
 - * Capacity, Service and Quality
 - * Jurisdictional Structure
 - * Financing
 - * Implementation
- 6) Next Meeting November 9, 2012

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1 County; and Kristen Hildreth who is from Medina County,
2 but also representing Sophie, from what I can tell on
3 the line, and there may be others who may be logged on
4 the phone who may not be on the video, so you might ask
5 the others if they might want to introduce themselves.

6 CHAIRMAN BURKE: Excellent. Joe's gone
7 through the list. I don't know if the folks on the
8 phone can hear that, if there's anybody that we missed
9 who's on the phone, if you wish to announce yourself now
10 please do.

11 Okay. With that, if folks on the phone, of
12 course, if you do have background noise or anything
13 along that line if you could mute your phone to listen,
14 of course, you're always welcome to jump in and speak as
15 issues come up.

16 In front of us we have minutes from the
17 previous meeting on September the 11th.

18 COMMISSIONER NIXON: I move to approve.

19 CHAIRMAN BURKE: We have a motion to approve
20 the minutes; do we have a second?

21 COMMISSIONER EDWARDS: Second.

22 CHAIRMAN BURKE: Okay. All those in favor
23 signify by saying aye.

24 (Thereupon all Commission Members voted
25 affirmatively.)

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1 All those opposed nay.

2 Minutes for September 11 are approved.

3 And for folks on the left side of the room
4 over here I know sometimes the stenographer has trouble
5 in hearing, so if we could speak, you know, in a way
6 that she can hear us that would be fine, as well as
7 announcing your first name until we get things rolling,
8 that would be very helpful to her as well.

9 As I look out this day will progress, as
10 Gene said, maybe we'll be done, and if that is the case
11 I openly say I will be buying rounds for everybody here
12 at the table, but I have a feeling that's probably not
13 going to happen, but if it does that's my standing
14 protocol.

15 But I do look for us to move on to 12:30, at
16 which time we'll break for lunch, run that to about
17 12:45. I picture another break happening at about 2:30
18 and that will last until about 2:45, that will give
19 folks kind of time to take a break from the action, and
20 then hopefully have time at 4:00 to wrap up.

21 I don't know if our Vice-Chair, Mr. Press,
22 has any opening words.

23 VICE-CHAIRMAN PRESS: Just glad to be here
24 today and look forward to being done by 1:00, no
25 pressure though.

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1 CHAIRMAN BURKE: All right. I did bring my
2 wallet with me, so that's a good thing.

3 We certainly have a lot of ground to cover.
4 We have an opportunity as well to talk openly. We can
5 also recess from time-to-time and just have open
6 discussion, and then come back into committee to purvey
7 whatever our thoughts were and have those recorded on
8 the record.

9 So we do have that option, if things get
10 lively, we can kind of shift away and give the
11 stenographer a break, and then come back and reiterate
12 our talking points for the record, so that's an
13 available issue.

14 So I assume that folks are up to speed with
15 where we're at. I kind of figure this in terms of --
16 maybe in this first part of the dialogue we can talk a
17 little bit about macro sense of public health, some of
18 the issues that we have talked about in terms of overall
19 health care strategy across the state.

20 I heard folks talk about the
21 standardization; we discussed a little bit about
22 standardization of fees; standardization of reporting,
23 we talked about accreditation; certainly those are good
24 macro issues to talk about in public health.

25 And just to go down the line of some of the

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1 things I've heard, I've heard folks talk about board
2 make up and term limits; I've heard folks talk about
3 central grant writing; I heard folks talk about I.T.
4 consolidation; and, again, the need for standardization
5 and measurement of fees; of jurisdiction and authority.

6 So we have a lot of things to talk about as
7 we move through the day. Maybe the best discussion is
8 the overall discussion about general health districts in
9 the state. What the State of Ohio does and how the
10 state can best make logical decisions on facts when it
11 comes to allocating resources and driving policy.

12 So I'm going to start with that broad
13 statement, ask anybody who has any comments or feelings
14 on the issue to jump in, or should I just go upstairs
15 and write it right now.

16 How about standardization? We discussed a
17 little bit, Joe brought up an overhead last meeting that
18 showed what the health department has been doing in
19 terms of standardization. I heard folks talking about
20 accreditation. How are we doing on reporting?

21 COMMISSIONER EDWARDS: Well, you're looking
22 at me so I might as well say something. I think one
23 thing would be the reporting, everything is
24 self-reported; am I correct?

25 So even if we had some movement that way,

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1 and I think that would help in the process of maybe
2 standardization. I think that's pretty easy to check
3 off really. Marty, you're nodding your head, so --

4 MR. TREMMEL: Well, you're correct in some
5 self-limiting particulars of improvement standards and
6 it's been well recognized by our colleague here that are
7 self-reporting. There was a model once upon a time, and
8 I think our colleagues in Delaware and others recall the
9 peer review.

10 But there remains some, I think, differences
11 of opinion of peer review, I think, among public health
12 systems, but I think that's worth a good conversation.

13 I think maybe it could be revisited, maybe
14 we can incorporate some other folks from other
15 disciplines, health care systems, maybe somebody from
16 county government, local government. I've heard folks
17 say maybe community members, but surely we need a public
18 health person or two from the disciplines, health
19 commissioners, D.O.N., E.H. directors.

20 And if not possible, these are very busy
21 folks on a day-to-day, maybe a subset of retired
22 colleagues from one of the associations contracting to
23 do that.

24 I've thrown out a lot just to kind of
25 formulate some discussions and differences of opinion on

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1 that.

2 COMMISSIONER EDWARDS: Right.

3 CHAIRMAN BURKE: Let me just ask a question,
4 if we were to approach the issue of a magic hundred
5 thousand person or a hundred and twenty-five health
6 districts and legislators and policy makers were to make
7 an intelligent decision, who feels that the
8 standardization process in place today allows policy
9 makers and legislators to make an intelligent decision
10 about those kinds of issues?

11 Does anyone here feel that the reports that
12 you generate out of your health departments today allow
13 us to make a reasonable decision on what that number is?

14 DR. MCFADDEN: I think if folks are honest
15 about what's going on in their districts, but I think
16 the question that's being raised here is how do you
17 answer that question?

18 I think last week we heard Commissioner Anne
19 Goon express that she feels that she might look at it in
20 prime and part each word to make sure she meets every
21 piece of it and I think others may not.

22 So I think if we -- if we as commissioner
23 are answering those questions that are being asked the
24 same way, yes, you will be able to, I think, get at what
25 the districts are able to do.

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1 The difficult piece, I think, you ask the
2 different health districts, you're going to find that
3 everyone, for the most part, agrees with standards,
4 you're not going to have a lot of disagreement there. I
5 mean the devil's in the details, which standards do you
6 use and how do you do that.

7 When you talk about standardization, I
8 think, that because of the fact that we are asked to do
9 health assessments, we are asked to create community
10 plan -- improvement plans that are unique to the
11 communities that we're in, at some level the focus of
12 the system differs, because of that process.

13 And so the standardization, as far as is
14 this community working well on infant mortality and
15 sexually transmitted diseases or is it working on
16 vaccination rates and traffic accidents, some of that is
17 driven by the process that's there.

18 And so I think the last time or two times
19 ago we talked about the standardization being within the
20 process, which started to resinate with me in a way that
21 hadn't before, because if we're looking at programs,
22 programs are going to be different based on the needs of
23 the community, which programs are there; how those
24 programs are run probably needs to be more of the same.

25 COMMISSIONER EDWARDS: But that isn't any

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1 different than a hospital. A hospital has to report,
2 and it's not -- am I correct, it's not self-reporting?

3 VICE-CHAIRMAN PRESS: I guess I need to
4 understand the term self-reporting. In the sense that
5 to me the definition of self-reporting is we generate
6 the data, we report the data. That's distinct from we
7 generate the data, it goes to, I'll say C.M.S., pick
8 somebody, and they report the data.

9 That assumes that they do something to
10 improve the quality of it or to somehow refine it in a
11 way that it takes some wires out or some errors out, but
12 to me there's a difference between self-reported data
13 and standard reported data it could also be
14 self-reported, so the standard says everybody reports
15 the same thing, even if they report it themselves.

16 Self-reporting says I might report some
17 things and somebody else reports something else, so I'm
18 a little -- we generate the data, so we report it. I
19 mean I'm just speaking of hospitals.

20 COMMISSIONER EDWARDS: Sure.

21 COMMISSIONER NIXON: I think that the
22 question about standardization, we have the standard,
23 they've been vetted through the public health community
24 through accreditation, vetted nationally through every
25 public health venue there is and it's been vetted in

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1 Ohio.

2 The Ohio Performance Standard mirrors those
3 standards, so I think we have a standard that we can
4 apply uniformly in Ohio. The question is verification;
5 how do we verify that? Just self-reported, it's
6 meaningless as far as I'm concerned, and that's what we
7 have in Ohio.

8 Now, there's another piece which we've
9 skirted or talked about, maybe not skirted, talked
10 directly, is the outcomes, the health status of our
11 community. And one of the things that is a requirement
12 under accreditation is the Community Health Assessment.

13 Now, maybe there's a mechanism to
14 standardize that in Ohio so that everybody measures
15 immunization, measures years of productive life loss,
16 and measures some of these things that could be looked
17 at consistently around the state, but I think -- I think
18 the standards are there. I don't think we need to
19 reinvent the standard.

20 The question is how are we going to verify
21 it, and then the health status of the community. I
22 think what you're talking about is how do we measure
23 health departments and see how they're moving in the
24 right direction and the health of Ohio, as a whole, and
25 the health of our communities is moving in the right

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1 direction.

2 MR. TREMMEL: Mr. Chairman, can I add on to
3 a couple of things that Commissioner Nixon mentioned,
4 and that is the current standards, as we should all know
5 and appreciate, now mirror the PHAB model, which is a
6 very good thing, the caveat on self-reporting.

7 What I struggling with -- well, let me say
8 this first. We, I think, should take a look at exactly
9 what Mr. Nixon mentioned, Community Health Assessments,
10 Community Health Improvement Plans and Strategic Plans.

11 I think that should be a part of this
12 conversation and probably a part of, I would suggest,
13 some recommendation for continuity.

14 I think that we should also take a look at,
15 as complete as they are for the specific jurisdiction,
16 getting back to Dr. McFadden's piece. The health
17 assessment in that community is going to speak to the
18 particular needs and priorities of that community.

19 The disconnect still is to me when the State
20 of Ohio is measured based on Robert Wood Johnson or
21 Trust for Americas Health or Children Defense Fund or
22 other types of national reporting systems that look at
23 the State of Ohio, and say, Ohio is 30 something, Ohio
24 is 49, Ohio is 50. Those rankings should give pause to
25 all of us as to why it is we can't move those needles.

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1 Let's take infant mortality for one example.
2 If we are not in this state moving the needle of infant
3 mortality there is a major problem. And I think there's
4 a disconnect as to how it is that we in this state, and
5 through your colleagues in the local are moving the
6 needle.

7 What I would like, I don't have an answer,
8 but I'm going to put out some things that if we could
9 all kind of attach it maybe worthwhile, maybe not.

10 If, for example, we take the data, let's
11 take like the county health rankings data or some
12 composite of that, if we were to take to the Ohio
13 Department of Health a process to say a smart objective
14 for infant mortality is, the needle in Ohio is here, it
15 needs to be moved two or three clicks left.

16 The moneys that go out to the various
17 counties are broken down accordingly, you will move the
18 needle this many clicks for this amount of money based
19 on these calculations that they're using, and if you
20 don't move that needle, based again on smart objectives,
21 you need to do the following, boom, boom, boom, you
22 agree to take this money and you move it in the clicks
23 that are necessary you will continue to be funded, if
24 you do not you won't be funded. And I think -- I think
25 that is a strategy that we need to consider.

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1 It's -- it's very loose, it's not specific
2 enough. I can understand and appreciate that, but I
3 think, if the State of Ohio continues to be and will
4 continue to be measured by these type of national
5 bodies, be what they are, we need to get in a better
6 alignment with them to tell the Ohio story better to
7 move the needle.

8 And then go back to our colleagues in the
9 administration and General Assembly and say you
10 challenged us with three things, obesity, infant
11 mortality, let's say smoking, tobacco, and we've moved
12 the needle in these three and we deserve some
13 accordingly, whatever that is.

14 So, again, not answers, just issues. I try
15 to figure out a way to connect these to the standards
16 that we now have, and if somebody can help us figure out
17 how to weed those in our work would be more near
18 complete, especially on the reporting side.

19 DR. MCFADDEN: I don't disagree with you,
20 Marty, that's a state's role, to, identify, and
21 certainly ODH, to identify the most important priorities
22 for the state. It begs the question of what the purpose
23 of the local Community Health Assessment is, if that --
24 if those are not identified, and I think obesity is
25 going to be universal.

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1 You know, in our community -- the No. 1
2 cause of infant mortality for Ohio is prematurity,
3 that's not going to be the case in our community. In
4 our community it's going to be congenital deformity,
5 genetic conditions.

6 And, you know, short of eugenics, and within
7 the Amish community some of that is being done where
8 we're actually having folks from Indiana come to Holmes
9 County to try and find mating pairs that have not, you
10 know, hereditated or tradition or whatever, but it's hard
11 for us -- you know, it's going to be hard for us to move
12 some of those needles and there's some other things
13 that's going to be more important, and I think that's
14 the dilemma.

15 You know, the No. 1 killer in Holmes County
16 is heart disease, but because our rate of heart disease
17 is half of what the state is or something like that,
18 three quarters, we're not -- we can't apply for certain
19 funds, because it's not bad enough, but it's the No. 1
20 issue for our community.

21 And I think that -- those are the pieces
22 that, you know, you struggle with where you have
23 different communities.

24 I don't disagree that for the state, you
25 know, the right thing to do is to target those pieces

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1 that are biggest for the state. I don't know how -- how
2 we do the right thing for the state and the right thing
3 for local communities, I just -- I don't know that.

4 Because what makes our community or, you
5 know, Portsmouth or other communities less healthy is
6 different than maybe what makes something else -- I
7 think the ones you mentioned are very typical and we
8 have to find some way to address.

9 REPRESENTATIVE ANTONIO: And I apologize for
10 being late, parking issues. I just caught the end of
11 what you were saying, but so maybe you addressed this in
12 your earlier remarks, but building off of what Dr.
13 McFadden just said in terms of best practices model, I
14 mean I think it's really good to have everyone be
15 working towards those pivotal issues, but are we also
16 saying that there will be some application of or at
17 least sharing of best practices, sharing of models in
18 terms of how people get there?

19 Because as D.J. just pointed out, what works
20 in one county may have some cross over to somewhere else
21 and they can say, oh, we have those same sorts of
22 issues, that's great, they're doing X, Y or Z, we can
23 apply it here, but in other places there may be
24 different models that they would need to look at,
25 because there's some different core issues.

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1 So I would just like to get your opinion
2 about that, but I guess also -- are we also talking
3 about addressing and making those available?

4 MR. TREMMEL: So herein lies the difficulty,
5 right, there are limited funds. We do not have a
6 homogeneous society necessarily, but we do have large
7 blocks of indicators, as Dr. McFadden and others
8 mentioned, like tobacco, heart disease, infant
9 mortality, all different based on certain particulars of
10 the community.

11 For those, however, because the State of
12 Ohio receives a significant amount of its money, it's
13 very specific and categorical, and because we receive
14 those federal dollars that are specific and categorical
15 we are then obliged to put together objectives and goals
16 and measures and track and move the needle on those.

17 So whether it's block grant dollars or
18 cardiovascular disease, or whether it's dollars for
19 tobacco or dollars for infant mortality, we will still
20 be locked into those.

21 My -- I should say my or our concern ought
22 to be alternatively for the other communities, like Dr.
23 McFadden's, that don't have those particular issues and
24 there's no funding for something else, because his issue
25 of heart disease, which is his No. 1 indicator in the

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1 community, I think that's what he said, if that's his
2 No. 1 indicator on his Health Assessment, Health
3 Improvement Plans, if he is half of the state rate, what
4 dollars are left for him to do anything about it, that
5 we said we're going to be able to cross provide, unless
6 we change the equation and say, we'll do so many
7 dollars, 70 percent of the money or 75 percent of the
8 money goes to whatever, largest community, that's always
9 controversial, goes to the area of highest need based on
10 population.

11 So assuming we can get to some calculation,
12 but set aside 20, 25, 30 percent for other communities
13 like Dr. McFadden's who already has rates half or
14 two-thirds or three-fourths of everyone else, and then
15 still the disconnect of the whole thing is what do you
16 do about all the other stuff that isn't funded.

17 Then I think we go back, and this is another
18 reason for an opportunity of some other block grant
19 dollars so that we can take a more qualitative look at
20 the entire public health system.

21 If we had that at our disposal, right, if we
22 had those kinds of millions of dollars we could say then
23 conversely to those health departments like Dr.
24 McFadden, your issue or your issues are slightly
25 different than others, but you do get a block grant of

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1 dollars based on your population and area of need that
2 you must move the needle in those areas, and for other
3 areas of the state, northwest Ohio or southeast Ohio,
4 your issues, here are your dollars to move them.

5 And the challenge is then the same, you must
6 take the needle and move it, if you don't take the
7 needle and move it the eligibility is just --

8 REPRESENTATIVE ANTONIO: So I had the
9 experience and the opportunity to run a women's center
10 in the '90s and one of the things that we worked
11 collaboratively on was addressing the infant mortality.

12 There were federal dollars that came in,
13 they were wonderful programs that were targeting
14 providing prenatal care for women who otherwise would
15 not have it. We moved the needle, the federal dollars
16 one way, the needle moved.

17 We're back -- and we're back, so the reason
18 why I bring this up is because I also think as we make
19 these considerations that we're also mindful of
20 maintenance.

21 Too often I think we're looking at
22 improvement and always constant, continuous improvement,
23 which is awesome, and especially in the business
24 community is a wonderful thing, but when we're dealing
25 with issues of public health and real people sometimes

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1 we also need to be mindful of what are we doing moving
2 the needle, but then maintenance for long haul.

3 And especially in issues like infant
4 mortality, we have seen that when we don't continue to
5 work on that programming, because the people change, we
6 go backwards, and so I just want to add that into our
7 process as we're talking about this.

8 CHAIRMAN BURKE: I'm going to just step out
9 one second and ask, I assume then that everyone's happy
10 with a hundred and twenty-five health districts?

11 Because if you're not, I mean, is the public
12 satisfied with that number; are we doing the best that
13 we can with a hundred and twenty-five health districts?
14 Should it be 88, should it be 200?

15 If you were going to make a decision, in
16 fact, and go back to the people who fund that health
17 district through local dollars or voters or constituents
18 that are being served at those health districts, how do
19 you go back and say, no, actually merging this health
20 district with this health district is going to improve
21 health care outcome.

22 How do I get to a point where you can
23 measure that and have facts that say, you know, just
24 like in schools, this is a failing school district, this
25 is a excellent school district, this is an outstanding

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1 school district, we're going to fund it and make mergers
2 based on standardization; is that what we are talking
3 about? But it's --

4 COMMISSIONER NIXON: Well, if I could
5 answer, the report tried to do that by creating the
6 eligibility for accreditation, didn't force
7 accreditation on anyone, because, you know, there's a
8 cost to it, we recognize that, but I think the train's
9 rolling down that road.

10 If we are -- if the State of Ohio does not
11 say accreditation is in our future then I think we're
12 missing the boat.

13 So I think that to be eligible for that does
14 what Marty says, they have the strategic planning
15 process, a Community Health Improvement and a Community
16 Health Assessment.

17 You've done those three things, you've done
18 that in your community and you're eligible for
19 accreditation, and I think if you've done that you've
20 demonstrated a certain degree of capacity and capability
21 that you need to keep up, but other than that you're
22 good to go.

23 Now, there's a lot of health departments I
24 don't think can meet that minimum standard, and I think
25 when you don't meet that standard then the report

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1 offered a mechanism to begin looking for cross
2 jurisdictional sharing of paths or functions or look at
3 consolidation, so I created a flow chart on how to get
4 there.

5 It didn't force anybody to consolidate, it
6 did not impose anything on recognizing geographical
7 differences and political stresses on communities, but
8 it did create a mechanism to move health departments and
9 nudge them in that direction.

10 So that was the solution out of the report,
11 now I think that's why we're here to debate whether that
12 makes sense or not.

13 CHAIRMAN BURKE: So how does accreditation
14 in the current standardization work together or is it
15 one or the other?

16 COMMISSIONER NIXON: Well, it's the same
17 standard. The question goes back to the verification
18 piece and accreditation process with PHAB, the national
19 program, that does the accreditation creates a mechanism
20 for outside verification.

21 VICE-CHAIRMAN PRESS: We could get a
22 verification through attestation too, right. There's
23 lots of ways to get validated data, you don't go get
24 somebody else to come in and validate, you test it
25 through an officer of the organization. So doesn't have

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1 to cost money or impose requirements of a third party.

2 DR. MCFADDEN: We've already mentioned that
3 the standards that we use in Ohio are based on PHAB
4 standards and to your question the way that ODH has
5 situated that is, you know, really quite, you know,
6 helpful and ingenious moving the state forward in that
7 there is an opportunity for folks to share best
8 practices in their community.

9 So if I want to go and look and see who has
10 things that I really want to look at based on this
11 measure, I can look and I can break it down by
12 community, my similar size, I can look and I can say,
13 you know, they're doing over in Carroll County this
14 here, that might work here. I should contact Meigs and
15 see what's going on.

16 So I think that we -- in Ohio we have
17 started a process that is really far down the road
18 compared to many places that already exist that does not
19 require PHAB.

20 I think the missing piece that everyone is
21 asking for is how, you know, how does this response
22 equal something that I can hang my hat on, I mean that's
23 the question.

24 Every board president has to sign off and
25 say this is truth, whether or not they know what that

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1 means or not, each board president has to sign off on
2 what we send to the state.

3 So I think that's -- the real question to me
4 is, how can we make the process that we have existing
5 now meet the riggor that folks will feel that it's
6 valid. I mean that, to me, is the question.

7 COMMISSIONER INGRAM: I think that the
8 accreditation is in line with the current Ohio
9 Department of Health performance standards, and those
10 standards basically, if you're meeting those really
11 takes you in two areas.

12 One is you have to have -- you have to have
13 a capacity fulfilled, but if you don't have the capacity
14 you're not going to make all those accreditation
15 standards, so that's a funding question, quite frankly,
16 and a performance question.

17 The second piece of that is there's
18 alignment with those accreditation standards with the
19 health care delivery system, and so to Representative
20 Antonio's point about sustainability, I couldn't agree
21 more.

22 And that is if you get so much money to give
23 to obesity and health and human services, you apply for
24 another grant and doesn't come your way, the question
25 now is that after you put all this money, all these

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1 people, changes in the local community relevant to
2 policy, Smoke-Free grounds, new playgrounds, walk to
3 school programs, everything we need to be doing to
4 address the obesity epidemic, how do you sustain that
5 going forward, if you lose that grant, because we live
6 and die, no matter what size you really are by that
7 categorical funding.

8 So just because you meet these accreditation
9 standards, and I actually think there needs to be an
10 outside review team to go in, and maybe that's the first
11 step, because it has been self-reported, maybe the state
12 needs to come back and say we need to have, like Marty
13 was saying, some health commissioners, some state
14 people, now some people outside the system, a consumer,
15 somebody from academia, somebody from the health
16 delivery system, almost like, and I don't want to use
17 JCAHO again, because I think we got hung up on that, but
18 there is a standard for all hospitals to be certified,
19 maybe have the state do it or have JCAHO do it, most of
20 them use JCAHO.

21 And so they could go out, it would be
22 interesting to see how that -- how that landscape
23 changes, if we went and we put that process, starting in
24 a few months, and see how we shake out in the state.

25 The bigger question though, and I'll finish

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1 with this, how do you get the outcomes? Just because
2 you have people meeting accreditation standards doesn't
3 necessarily mean we're going to change the view.

4 Because just like I said, you know, there's
5 a whole bunch of us across Ohio that just applied months
6 ago for Community Transformation Grants and Reach Grants
7 from health and human services.

8 A hundred million dollars just got awarded
9 yesterday, only one community in Ohio got one, and it
10 was the Lima County YMCA, congratulations to them, but
11 the rest of us who had health educators on staff are
12 scrambling, and guess what will happen, the investment
13 will get lost unless we come up with a way, either the
14 local communities buying in and we continue to move that
15 needle, obesity is a journey, it's not a race, to curb
16 obesity is a journey.

17 I actually truly believe size matters in
18 today's world relative to the funding. The question is
19 for this group is to find it.

20 CHAIRMAN BURKE: Let me start with one point
21 then that I hear, if you were -- one recommendation in a
22 generic sense verification of reported data. Does
23 everybody agree that is a process, whether it's a
24 committee or other, all of this is going to gel
25 together, taking one point.

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1 Does everybody agree we should somehow find
2 some way to verify the data that's reported; that make
3 sense?

4 COMMISSIONER SHAPIRO: Just want to make
5 sure when we talk about verification that our -- because
6 back in the late '80s, I'm old enough to remember that
7 unfortunately or fortunately, we did have a very brief
8 period of peer review where we did go and measure each
9 other's districts or bringing in outside, however, that
10 wants to be done and I don't know why -- I don't know
11 why it ended.

12 It probably had to do something with cost,
13 of getting people from one health district to another to
14 look at whether they were, in fact, reporting
15 accurately. So there might be some cost related to
16 that, I don't know what it is.

17 I thought that system, even though I didn't
18 love the standards back then, the standards are much
19 better now, really did give an accurate depiction,
20 because people had to produce and right now it is that
21 self-verification, so I would agree, I just don't know
22 why it ended the last time, and maybe Gene remembers.

23 COMMISSIONER NIXON: I'm not sure why that
24 ended either.

25 COMMISSIONER SHAPIRO: Yeah, do you know why

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1 it ended?

2 MR. TREMMEL: Mr. Chairman, if I could
3 respond, it would appear that there was a number of
4 reasons that the peer review ended.

5 No. 1, county health department
6 administrators had less time to be involved in the
7 process.

8 No. 2, there were some health departments
9 that did not appreciate peer review. They felt that
10 they had -- they felt that a colleague peer reviewing
11 them was not objective.

12 There were other health districts that felt
13 that the person who reviewed their neighbor was more
14 favorable to them, and then there were others that liked
15 the peer review, because they got a favorable review
16 from a neighboring colleague, because that's how you
17 treat a neighbor.

18 So there were a number of those, it would
19 seem, and interestingly, Nancy, last week during the
20 state meeting, the health commissioner meeting, I had a
21 number of colleagues, and I would ask them about peer
22 review, and it seemed to me I had half as many swore by
23 it as did swear at it.

24 So the concern here is, I think back to Mr.
25 Ingram's point, some other colleagues that have

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1 mentioned it, I personally favor the notion, I favor the
2 idea. It might need to be a slightly blended team of --
3 as was mentioned, and we probably can help describe and
4 detail what that team might look like.

5 CHAIRMAN BURKE: I could, I just threw this
6 out there, but you don't have to, as this process
7 matures and we make a recommendation to the General
8 Assembly and the administration and whatever, you know,
9 you don't have to be bullet point specific.

10 If you just agree that this data needs to be
11 verified by some mechanism, whatever that is, we can
12 re-engage the process. Obviously there'll have to be a
13 rule making process occur, so there will be an open
14 debate in the rule making process, but we don't have to
15 get, you know, rifle point accuracy here, shotgun's
16 okay.

17 COMMISSIONER NIXON: I like that a lot. I
18 think what it does is will help local health districts
19 for accreditation if, in fact, that has wheels and that
20 is -- that is accepted universally five years down the
21 road, and locally we're already doing that in some
22 watered down sense of local teams that go in and do it.

23 As accreditation becomes more formalized and
24 more necessary locally in Ohio we'll already be
25 prepared. We've already been through some of this

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1 locally, so I think it makes a lot of sense.

2 CHAIRMAN BURKE: Well, the good news is, we
3 now at least have one thing on the report.

4 Next thing I heard somebody say was
5 standardization of outcomes reporting; what do you think
6 on this? Is this the same thing, which is verification
7 of reported data or is this a different topic?

8 DR. MCFADDEN: No, I think if we're looking
9 at outcomes, obesity rate, infant mortality, you know,
10 adolescents that start smoking, stroke, you know, heart
11 attack, whatever those outcomes, I think that's
12 different from what we're talking about here, because
13 still it's a process based question that we're being
14 asked from the standard, and I would argue PHAB is more
15 process oriented.

16 To have standardization across the state on
17 those outcomes takes power that I'm not sure even a
18 hundred thousand gets to.

19 I mean at some level there needs to be a
20 partnership, you know, between the central, state and
21 local.

22 I would say that my data from Holmes County
23 is better than the state's data, because the state
24 relies on telephone surveys, for anywhere people don't
25 have telephones argues that 25 percent of the normal

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1 people don't have landline telephones, but for some
2 communities ODH may have better data.

3 So I think we need a partnership to be able
4 to get at that data, we need to determine what data we
5 want to standardization and those two pieces together,
6 and then I think if there's a will we can -- we can
7 collect that data in a similar way.

8 COMMISSIONER NIXON: I think you have to be
9 careful too on what you ask for. I mean some of this
10 data is pretty standard around the state. I mean we can
11 collect that, I don't think it necessarily needs to be
12 collected locally, you can collect it at the state
13 level.

14 You can create those continuums, this is the
15 No. 1 county in Ohio and there's the 88th, and a lot of
16 that is related to poverty, housing, education and other
17 things independent of how well your health department is
18 doing.

19 So whenever we collect that information it
20 requires a great -- some interpretation and some
21 explanation, it's not so simple as this is the worst
22 county in the State of Ohio.

23 So I think we need to be thoughtful about
24 how that's collected, how it's interpreted and how it's
25 utilized. And so I think we need to have that, and I

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1 think we do have a lot of that, it's how you report it
2 and how it's used.

3 VICE-CHAIRMAN PRESS: I can appreciate the
4 group's discussion around sort of the knowable things.

5 I guess the question I would ask the
6 professionals would be do you feel equipped to measure
7 the emerging surveyable difficulties, and I'll site as
8 one example, the increase and prevalence of heroin
9 addiction, which is a massive public health problem
10 we've never even talked about here, but are you set up
11 to measure prevalence of heroin addiction in the
12 communities as easily as we would be set up to measure
13 flu or obesity or diabetes or something like that?

14 COMMISSIONER INGRAM: No.

15 COMMISSIONER PRESS: So how would this
16 impede or accelerate that ability?

17 COMMISSIONER INGRAM: Now, you know, if I
18 may, so what I would say to try to address that
19 question, Chris, would be to look at the hospitals are
20 aware and the substance abuse system, the mental health
21 system is where the entry is for those problems, right.
22 So that's where -- that entry point, some data is being
23 collected and has to then be shared.

24 You know, this really goes to this broader
25 question, which I'm not sure we would -- we don't have

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1 the time, but we really do need to think about --

2 VICE-CHAIRMAN PRESS: We've got to 1:00.

3 COMMISSIONER INGRAM: Well, this whole issue
4 of, you know, as everybody moves to electronic health
5 records, how do you develop community data repositories
6 that protect confidentiality and proprietary interest
7 that allows for usage of this information to improve
8 health in the community.

9 There is that opportunity for the first
10 time, but, you know, the systems are just now
11 implementing electronic health records just for their
12 own benefit to improve quality of care inside the
13 system, quite frankly, and some other things, right.

14 The way we would go about it, to answer the
15 question, is we try to go out and do some type of a
16 qualitative survey, but who's going to say, yes, I'm a
17 heroin addict and I have a problem, some will, but most
18 won't.

19 So you've got to take that data that
20 protects people from perhaps legal consequences, but yet
21 gets up stream on why that problem has occurred, and
22 it's a very sensitive question, but I think begs the
23 question, how do we manage any of this data that rolls
24 up to the state.

25 CHAIRMAN BURKE: Brought this up to other

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1 folks, look at this as two tracks in my mind, jump in if
2 I'm wrong, there are issues that are beyond your
3 control, TB, influenza, I mean some could argue,
4 syphilis versus, I would say, someone with obesity,
5 which is a singular non-contagious issue.

6 Heroin addiction isn't contagious, smoking
7 isn't contagious, these are societal factors, yes, but I
8 ask myself what is the role of the Department of Health
9 in the State of Ohio in terms of the societal health
10 risks, right, bad potato salad is bad for everybody,
11 heroin addiction, I don't think I'll ever become a
12 heroin addict, potato salad I worry about.

13 I want the department of health there for
14 that one hundred percent, guaranteed, heroin addiction,
15 I mean it's an issue, but it's a personal choice too,
16 eating potato salad, I think there's two different
17 issues.

18 So I just look at it in that sense, if I'm
19 going to measure something, I want to make sure that
20 what you're doing isn't hurting my family. Someone
21 being on heroin, I don't know that directly impacts the
22 longevity of my family personally, potato salad, yes.

23 COMMISSIONER INGRAM: Well, let me just
24 respond, I understand what you're saying. I was just
25 trying to address Chris' question, how would you come up

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1 with a system to collect data on that issue, which quite
2 frankly is an issue, and it's an issue for newborns,
3 because there's a lot of movement right now in this
4 state relative to babies who unfortunately have become
5 addicted to opiates, no choice of their own, and the
6 community, medical community is trying to figure out how
7 to best treat these babies, it's a whole new era.

8 And so universal testing and it's all about
9 being upstream on this stuff, so the question is how
10 prevalent is that problem? We really don't know, but I
11 can tell you who has a sense for it, is that astute
12 physician or other allied health care professionals
13 who's seeing that.

14 CHAIRMAN BURKE: Just that you can control
15 -- the health department can control the number of cases
16 of certain things happening, like potato salad, right,
17 through inspection and other kinds of mechanisms, can't
18 necessarily control -- you can measure both, but one you
19 directly have an impact on.

20 COMMISSIONER INGRAM: I'll yield in just a
21 minute, Jennifer, but the truth of the matter is -- and
22 this decision is going on in my community and perhaps
23 others, and that is universal testing of all pregnant
24 women regardless of where they necessarily come from, if
25 they're coming into one of the systems down in the

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1 greater Cincinnati area for specifically that question.

2 Now, it hasn't taken hold. Some systems
3 have adopted it. So the question becomes -- that's a
4 policy question, that becomes a policy question for the
5 local public health system and the state system for the
6 legislature, because if we can prevent this, that baby
7 being born with that addiction we -- we prevent a lot of
8 problems down the road. Thank you, Jennifer.

9 COMMISSIONER SCOFIELD: Couple of things, I
10 just whispered to Joe about the heroin issue, just real
11 quickly, is that we're actually holding a press event
12 tomorrow morning about the increase in heroin related
13 deaths in Cuyahoga County and it was triggered by a
14 Medical Examiner who just started seeing more and more
15 cases of -- in the morgue, so he went back to 2007 and
16 started tracking deaths, and so we have a series of maps
17 that show how it has spread and the intensity and all
18 that.

19 So I think their numbers, when we talk about
20 public health, there are a number of kind of pressure
21 points that impact the system and local systems are
22 responsible for both infectious diseases and other
23 chronic diseases, so I think somehow we need to build
24 that system capacity at the state and/or local level to
25 monitor those pressure points.

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1 This is an emerging issue. We don't know
2 the scope of it, but we have to start somewhere when we
3 see a spike in deaths, what is going on and kind of go
4 back and take a look at that.

5 So I think capacity building, whether it's
6 surveillance, whether it's ongoing capacity building
7 with local health systems, whatever it might be, there
8 needs to be an investment in that capacity.

9 CHAIRMAN BURKE: What kind of outcomes do
10 you report today and are they standard? Just looking at
11 the 10,000 foot level, I mean, are the outcomes being
12 reported in some kind of -- are the same outcomes being
13 reported in a standard way?

14 DR. MCFADDEN: We report animal bites, we
15 report any outbreak that we are involved in the
16 investigation of that outbreak. We -- we're not asked
17 to report obesity rates in our community or smoke --
18 tobacco use in our community or drug abuse in our
19 community.

20 I mean, what we are asked for right now is
21 really, you know, communicable diseases and/or those
22 areas that we're licensed, but I would say that what we
23 measure gets changed.

24 I mean, if -- if we had every coroner, you
25 know, testing every death, you know, for drugs and

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1 alcohol and every E.R. did a random screen and every mom
2 was tested we would start to see something different, so
3 I think that that is, you know, whatever we decide as a
4 state something we want to target that we can -- I
5 believe we can move.

6 So to your point, Marty, I think of having
7 priorities that are from the state Department of Health
8 that says these are the three things we're going to
9 focus on for the next two years to me makes a lot of
10 sense.

11 But to your point, Senator Burke, I do think
12 that heroin and/or obesity and/or other things do affect
13 you, maybe not in the immediate, but I'm the box zone
14 treatment person for Holmes County.

15 I see young Amish kids, their parents never
16 thought that prescription drugs were going to affect
17 them, you know, this won't reach them, it has, because
18 there are folks that are targeting the Amish kids.

19 In fact, some of the Amish parties they go
20 -- there are groups that go into the Amish hoedowns and
21 they are bringing beer and they're handing out fliers
22 that say we will drop beer off at your house, we will
23 drop whatever you want off at your house. They know how
24 to target those folks.

25 I have young, you know, clean cut kids from

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1 christian homes that their parents are, you know,
2 pastors, whose kids are addicted to heroin, I mean
3 heroin's in Holmes County too. So they're saying this
4 would never affect us.

5 But I would also say that the HIV initially,
6 or tuberculosis as a result of HIV, that many of those
7 would have had some of the initial uptake, if we had
8 less cocaine use at that time, and, you know, sex with
9 drugs and others, I think that we would have seen -- it
10 still would have happened here, absolutely would have
11 occurred, but we would have seen some differences, if
12 those things were not here. So I think that we are more
13 intertwined health-wise than we care to admit.

14 COMMISSIONER NIXON: I think that what you
15 touch on is some of what's cool about public health, I
16 mean there's always something emerging. Hantavirus, you
17 know, when AIDS came around, that was something new,
18 legionnaires disease, H5N1 and I bet everybody in here
19 working in public health has the Suicide Youth
20 Initiative in their community and there's drug programs
21 and there's always something emerging.

22 So, you know, you talk about health
23 departments reporting their task and the control of
24 disease and so forth, I mean, that's what we're getting
25 to, the capacity of health departments to take, you

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1 know, standard operating procedures and doing business
2 as usual and transfer all that capacity to respond to an
3 event.

4 We have events all the time, and that's the
5 strength of public health, whether or not it's a
6 bioterrorist event or emerging suicide problem among our
7 youth, that's where you need that capacity to know and
8 that's what public health is all about.

9 VICE-CHAIRMAN PRESS: I did not mean to get
10 us off course, you asked a question about measuring and
11 I evidently blew on a nerve here, but maybe we can
12 reserve this discussion to the governance part of our
13 conversation.

14 The ability to coordinate activities with
15 both -- particularly on an issue like this, which is
16 non-contagious, with the ability to work with ADAMH
17 boards, to work with other agencies and providers, what
18 I'm really hearing here, this is a multi-factorial
19 problem and requires multi-factorial effort in response,
20 and we've gone around the edges about it in this room
21 talking about the limitations of cooperating with other
22 agencies, so maybe we should go back to your question
23 about measurement and come back to this discussion
24 later, because I do think there's something here we need
25 to talk about.

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1 COMMISSIONER INGRAM: And I understand, I
2 just wanted to say, Senator Burke, therein lies the
3 issue for the local public health system is that there
4 is so much that we can do and that we are asked to do,
5 but in the meantime there's these competing priorities
6 that we know obesity and its effects are the leading
7 cause -- it's causing people to die prematurely.

8 We know we've got a Type 2 diabetes epidemic
9 occurring in our children and it's due to obesity, and
10 in the meantime we know we have this heroin issue and
11 it's developed quite frankly because of the changes and
12 they were -- people were using prescription drugs.

13 Things have changed, the legislature
14 addressed that question and now heroin's cheaper than
15 pills and guess what else comes with this now, a huge
16 problem, at least in my neck of the woods, with
17 Hepatitis C, because they're sharing needles.

18 And we say this is all repulsive, and it is,
19 but the truth of the matter is where do you go and how
20 much can you do with the system that we currently have
21 today, what's expected of us?

22 I think we really do the best we can, we
23 try. I know everybody in this field cares tremendously
24 about what's going on in their community, but at the end
25 of the day you have certain outcomes, you want to move

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1 this dial, because you get deluded, nothing happens, you
2 get here, here, here, so how do you coordinate; how do
3 you do a better job at coordination?

4 COMMISSIONER PRESS: The answer is public
5 health can't carry the water for everybody. Obesity is
6 a problem in the schools as much as it's a problem --
7 you know, and they just repealed the BMI requirements,
8 it is what it is, but, you know, ignorance must be
9 bliss.

10 So, you know, to concur, obesity, it's going
11 to take more than public health, it's going to take more
12 than a doctor's office visit, it'll take more than
13 hospitals, it'll take more than health educators.

14 It's going to take a coordinated determined
15 effort to do that, it'll have to involve schools, so I
16 yield back to the Chair, but I hear what you're saying,
17 but there's never going to be enough money, so --

18 COMMISSIONER SCOFIELD: So I think that's
19 part of the conversation is how we define public health,
20 because all of those different partners, all of those
21 different agencies within the community are a part of
22 the public health system, so we need to look at where or
23 not -- where does the responsibility fall.

24 Is it the local health department or is it
25 another part of the system, all of those pressure points

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1 in the system that need to be pushed in order to have
2 some action so, you know, I think it's how we talk about
3 this too.

4 COMMISSIONER EDWARDS: When you talk -- let
5 me just be specific to heroin. The justice system
6 thinks it's their issue to solve. Mental health boards
7 think it's their issue to solve, so it may not be public
8 health's issue to solve.

9 You don't have anything -- public health
10 doesn't have anything with the old carrot and stick,
11 justice does.

12 I'm not saying that's always the way to go,
13 and I know that public health will receive the issues,
14 the problems to deal with as we talk about children with
15 whether they're handicapped or whether infant mortality,
16 you have a higher rate, but the justice department
17 thinks that's their issue, so I'm not sure --

18 CHAIRMAN BURKE: I just ask, as I beat this
19 horse around all sides, and, again, this process has
20 been helpful, because you're bringing up issues that
21 are, in fact, not measurable, outcomes that aren't
22 measurable.

23 If you were to measure the standardized
24 outcome reporting for a health department, what is
25 within your domain and control to be measured, what I'm

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1 hearing is the state matures certain programs, that
2 there's some standardization to say that this health
3 district compared to this health district was a higher
4 performer on these standardized outcomes for this
5 particular problem.

6 Is that -- okay. I just want to make sure
7 -- I think that's probably a good place to end this,
8 because that's probably as far as we're going to get;
9 does that make sense?

10 Okay. You know, I can change it up a little
11 bit and throw out a 700 pound gorilla, if somebody wants
12 to change it up.

13 REPRESENTATIVE ANTONIO: Can I ask a
14 question before you do that?

15 CHAIRMAN BURKE: Sure.

16 REPRESENTATIVE ANTONIO: You know, it's
17 interesting, I'm back on the hundred and twenty-five
18 districts, and one of the things that we've heard about
19 are some efforts in the works for some collaboration
20 possibly from mergers and so I was thinking, knowing how
21 that went in my own district, where we had a city health
22 department in Lakewood and it merged, it opted through a
23 process to be part of the Cuyahoga County system in the
24 health department.

25 I'm wondering if we just even knew how many

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1 of these departments are in conversation; do we know
2 that? Because that would change the number conceivably
3 if some of those actually happened, right.

4 So I was looking for a moment to throw that
5 in; does that fit with where we --

6 CHAIRMAN BURKE: I think that's probably the
7 overall theme of how we either get there, incentivize,
8 force, demand, whatever that's going to look like, yeah,
9 I think move that on, Nickie, that's -- Representative
10 Antonio, I'm sorry, where we somehow want to give us as
11 legislators the tools to say that this is a smart
12 choice, rather than I think that this is what we need to
13 do.

14 REPRESENTATIVE ANTONIO: Do we know how many
15 are in play, I guess, or in the process right now?

16 COMMISSIONER NIXON: It would only be a
17 guess right now.

18 MR. TREMMEL: So let me start with a couple,
19 or at least one comes to mind, Crawford County, my
20 recollection recently is in process with Galion.

21 MR. MAZZOLA: Galion City, some formal
22 discussions.

23 MR. TREMMEL: There continues to be Hancock
24 County, Findlay City, and I think they've revisited
25 recently, again, and there are a couple of others.

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1 COMMISSIONER NIXON: Portage County has been
2 having conversation with Stark County, Stark County and
3 Canton, Alliance. Lorain County has started it.

4 MR. TREMMEL: Lorain City.

5 COMMISSIONER NIXON: They've talked about
6 it, Mahoning County.

7 REPRESENTATIVE ANTONIO: Is somebody keeping
8 track?

9 COMMISSIONER NIXON: Those ebb and flow,
10 some are stronger than others, but those conversations
11 have gone on.

12 COMMISSIONER SHAPIRO: That was 6, 6 with a
13 total of 12.

14 COMMISSIONER EDWARDS: Well, I've got 11, 11
15 going down.

16 COMMISSIONER NIXON: It's more than that,
17 Canton, Stark and Alliance, and Portage, Urbana and Kent
18 are three.

19 COMMISSIONER SHAPIRO: Okay. So 14.

20 CHAIRMAN BURKE: Well, again, I don't know
21 what that magic number is, but it's something to --
22 we've not touched on this, but I think it's a health
23 issue, and I don't know if we take a direction on this
24 or not, but it's come up before that has to do with, you
25 know, I talked a little bit potato salad, it's kind of

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1 half joking, but it's true, the Department of Health and
2 the Department of Ag have a unique relationship.

3 You assume a lot of people are familiar with
4 this, is that anything -- I'm bringing up a third wheel
5 just to change gears, is that anything that we want to
6 talk about; is that anything we want to address? Is it
7 just this nebulous thing that goes on for years and
8 years and years?

9 COMMISSIONER NIXON: I'll offer a comment on
10 that, I don't know where we want to push that or not.

11 CHAIRMAN BURKE: Is it a problem?

12 COMMISSIONER NIXON: I don't think it's a
13 problem. I think it's a dilemma maybe that you've got
14 two agencies overseeing a program, sharing the
15 responsibilities for inspection of food service
16 operations and I have respect for both agencies, we work
17 with both agencies and I think they both do a fine job.

18 We work more closely with the Ohio
19 Department of Health. I think the department of health
20 has a responsibility for health and investigating
21 disease outbreaks and for the general health and
22 well-being of the residents of Ohio.

23 I think agriculture's job is to promote food
24 and, you know, promote the food industry and both
25 agencies do their job.

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1 The question is do you want to promote food
2 with the restaurant inspections or do you want to
3 protect public health? To me it's a no-brainer. I
4 think public health overall should have the
5 responsibility for overseeing food service operations,
6 that's what it comes down to.

7 You know, I don't think a decision is better
8 to push it off to the future and make a decision on
9 which agency is more appropriate for managing the food.

10 COMMISSIONER SCOFIELD: I would say to that
11 though, and perhaps it's just one of the
12 recommendations, that we encourage collaboration, not
13 shared responsibility for oversight or funding, but
14 encourage collaboration across departments at the state
15 level.

16 One example regarding food is that for a few
17 years I sat on the Food Policy Advisor Council that was
18 housed and administered out of the Department of
19 Agriculture, but brought in Health and Job and Family
20 Services and all of that to look at the local food
21 system.

22 So I think there's opportunities for real
23 collaboration that could help, I mean make improvements
24 in performance or other indicators or facilitate
25 efficiency.

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1 CHAIRMAN BURKE: The Governor's Common Sense
2 Initiative, right, CSI, does something like this have
3 merit, just to punt, and just ask; is it an issue?

4 I don't want to kick up a problem where
5 there's no problem, but this is -- you have this
6 representative to land on your doorstep and hear about
7 it, I'm not in the field, I don't know.

8 COMMISSIONER NIXON: Jennifer represents
9 environmental health.

10 COMMISSIONER WENTZEL: I think when we look
11 at duplication of services there is some overlap there
12 and maybe to get to the better efficient model that we
13 have one parent organization that ODH answers to when we
14 conduct our programs.

15 We answer to one for restaurants and we do
16 another for grocery stores, but when it comes down to it
17 we're enforcing the same rules.

18 When we look for the answers we call
19 whatever parent organization that we're trying to get an
20 answer for, even though the other could answer it, but
21 we may not get the same similar answer.

22 When we look at health we're doing
23 investigations with outbreaks, whether it's in a
24 restaurant or a grocery store we come to ODH for
25 answers, we rely on them.

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1 CHAIRMAN BURKE: And kicked around a little
2 bit, standardization of fees, and this is a fairly broad
3 topic that will probably ride us up through lunch. Is
4 that a problem; are there big differences on fees
5 depending on where I decide to open up a restaurant or
6 put in a leach bed in this state; why is that; is that
7 an issue we should be addressing? Many people think
8 that's a disparity.

9 COMMISSIONER NIXON: Historical one.

10 DR. MCFADDEN: We can ask the same question
11 about why gasoline cost differently in one part of the
12 state or why I could go to Cleveland and make twice as
13 much money as I make today. I mean there are issues in
14 salary, issue of distance traveled, but all going to the
15 issue of how fees are created.

16 I think when you talk about parents, for me
17 when I look at a family, if both parents, you know, mom
18 and dad are functional, they are, you know, marching
19 together, child doesn't play mom against dad.

20 You go to dad, you know, your bedtime is
21 9:00, go to mom, bedtime is 9:00, so I think for us some
22 -- it is good because of the strength that each brings
23 to the table, however, because we're in a political
24 environment when politics interfere with our parent
25 agency from being able to do what they need to do, the

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1 child is always the one that suffers at that point.

2 I think like any child, you know, whose
3 interests are sports and mom's interests are sports,
4 they talk about these common interests.

5 For us, our interest is safety of humans, we
6 want people to be safe when they go to a restaurant,
7 when they go to a grocery store.

8 The Department of Health is the parent who
9 has that common interest, but when both of them are
10 working together at a high level, like in H3N2 variant
11 everyone benefits, everyone benefits.

12 COMMISSIONER EDWARDS: So wait a minute,
13 D.J., you're telling me that it's going to cost for the
14 inspection different in Ashland County compared to
15 Holmes County --

16 DR. MCFADDEN: Yes.

17 COMMISSIONER EDWARDS: -- If TJ Mac -- or
18 TGI Friday goes in there?

19 DR. MCFADDEN: For the food inspection?

20 COMMISSIONER EDWARDS: Yes.

21 DR. MCFADDEN: Yeah.

22 COMMISSIONER EDWARDS: Why?

23 DR. MCFADDEN: Because you have a cost
24 methodology that's set by the state that's based on the
25 salaries of the staff; it's based on the hours that they

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1 spend in the program; it's based on the number of
2 establishments in the community, because that's the
3 denominator.

4 We go through, we put down all of our input,
5 gas, staff time, 30 percent of the secretary, you know,
6 the secretary and the others, over all that goes into
7 the pot, and in Holmes County we may have, whatever,
8 half the number of sites that you all have, so that
9 plays a role, our staff may get paid, you know, less
10 than what you have, that goes in the pot. So when all
11 that goes into the pot that's the magic number that gets
12 spit out.

13 Now, when the boards of health go to look at
14 many of them, when they go to look at what the fee
15 should be set, it's often -- our's wants to know what
16 the surrounding counties are, because they don't want to
17 be outside of the norm, you know, who wants to have
18 folks say, why are your fees \$50 when their's are a
19 hundred, or vice versa, why are your's a hundred and
20 their's are 50, but that's the way fees are set based on
21 what our inputs are and the number of sites that we
22 have.

23 COMMISSIONER EDWARDS: I would argue --
24 respectfully argue that it's based basically on --
25 historically on what's the fee over in Huron County,

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1 what's the fee in Crawford County, what's the fee in
2 Wooster, so that's what we're going to set it at, that's
3 what I would respectfully argue.

4 DR. MCFADDEN: But if that's higher than
5 what I can -- what ODH allows me to set my fees I'm not
6 going to do that.

7 COMMISSIONER SHAPIRO: I'm in nursing and
8 planning evaluation, but I have my friends on the
9 environmental health side who I know in our agency go
10 through the cost methodology extremely closely, are
11 factoring everything, they enter all their data into
12 computer systems that spit out how much time they spend
13 on each inspection, you get that data, you put in your
14 salary information, and then at the end you end up with
15 a number, again, you divide by the number of facilities
16 or however the cost methodology works, which the Ohio
17 Department of Health and local health departments worked
18 for, I think, about two or three years in developing, so
19 it was a very lengthy process to make sure it was fair,
20 but the costs are different.

21 We -- the costs are different between doing
22 business in Holmes County than they are in Cuyahoga
23 County, salaries differ significantly and they also
24 might have 10,000 restaurants versus the 35 D.J. may
25 have.

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1 COMMISSIONER EDWARDS: So then it would make
2 sense in a more populous area that the cost would be
3 less expensive, am I --

4 COMMISSIONER SHAPIRO: The ODH folks can
5 tell me, maybe, what the range is across the state. I
6 don't know how significant an issue it is.

7 We also have the District Licensing Council
8 now that legislatively was created a number of years
9 ago, so the people that we license are also having input
10 into the fee structure.

11 COMMISSIONER EDWARDS: I tend to go to the
12 -- I tend to look at the cost of maybe for a restaurant
13 or a business, what it's going to cost for them to put
14 in electric or their plumbing fee or any of those types
15 of fees that they would have to come to the state for,
16 those are fairly well --

17 COMMISSIONER NIXON: Local fees are going to
18 differ in each community, the building department, the
19 license, the plumbing, those are all fees.

20 COMMISSIONER EDWARDS: But the state one is
21 what I'm saying, the electrical and some of those, those
22 are pretty well standard, I'm thinking.

23 COMMISSIONER NIXON: I don't know what that
24 is, but locally there's all kinds on building fees and
25 so forth that are set by the local, that's going to be

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1 different.

2 COMMISSIONER EDWARDS: But I guess what I'm
3 saying, I would want to see that breakdown maybe of --
4 do you know where I'm going with this, Senator?

5 CHAIRMAN BURKE: Well, I understand what
6 you're saying, and, again, I don't necessarily disagree
7 with you, but just straw poled a group here, not to beat
8 a dead horse, raise of hands, how many people think
9 there's an issue today that needs to be addressed by our
10 committee regarding a standardization of fees?

11 Is this a problem that needs to be
12 addressed? Okay. No. All right. Next subject.

13 I don't want to beat a dead horse, it's not
14 a problem, we're moving on.

15 COMMISSIONER EDWARDS: All right.

16 CHAIRMAN BURKE: I heard some folks talk
17 about maybe some kind of central grant writing that the
18 state could assist with, could we have that
19 conversation, what that benefits and how it would look;
20 is that something we should do; is that something we
21 should recommend; the state have some kind of central
22 grant writing for the counties to collaborate or get
23 assistance with; is that an issue?

24 COMMISSIONER SCOFIELD: I think it would be
25 very difficult to have someone at the state to do that

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1 grant writing.

2 I think it might be reasonable to make some
3 investment in local services like that, and this gets
4 back to kind of the shared services concept, and I know
5 early on we talked about the educational service center
6 and that kind of model, if there's some opportunity
7 where it's needed to have some kind of regional shared
8 service center would be really useful.

9 That would be a recommendation, I think,
10 that could come from that, that then also helps get to
11 some of these foundational capabilities where it's
12 needed; is there an opportunity for some shared services
13 like that?

14 CHAIRMAN BURKE: And I like where you're
15 going, we've got about five, ten minutes here before
16 lunch. Could we get back to shared services and how
17 that conversation would go after lunch, because that's
18 going to take a little bit and I think it's going to be
19 a good one.

20 One of the other things that I heard, I
21 don't know if we have an appetite to do anything on, the
22 make up of the boards of health.

23 COMMISSIONER EDWARDS: Sure, sure, we do.

24 CHAIRMAN BURKE: Some that do, some that
25 don't. We can punt this around for a few minutes. Now

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1 is your time, don't be shy, that's the way, let's talk
2 about it.

3 COMMISSIONER NIXON: I would be very careful
4 and thoughtful about doing anything to disrupt the
5 current make up of the boards of health.

6 I think that when the health departments
7 were created, and I'll just use Griswold, you know, over
8 a hundred years ago, I guess not quite, close to a
9 hundred years ago, you know, it created these -- these
10 citizen boards, I think serve public health well.

11 You know they've created flexibility and a
12 lot of health departments would be able to respond, you
13 know, absent necessarily a political agenda, that
14 doesn't mean health departments aren't political
15 animals, because I don't think anybody will suggest we
16 aren't, we have our master that we report to.

17 But the board of health ultimately holds the
18 responsibility for the actions of the board of health,
19 and I think if it becomes political, you have elected
20 officials, you have representatives from other entities,
21 I think that would muddy that and make it -- you know,
22 take away from our fundamental responsibility.

23 So I don't mind talking about it, but I
24 think we should be very careful and thoughtful about
25 that.

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1 CHAIRMAN BURKE: Again, this would be a
2 recommendation, so if anyone wants to make a
3 recommendation state your piece and duke it out.

4 COMMISSIONER INGRAM: I don't necessarily
5 disagree with Gene on the subject that it needs to be
6 very thoughtful, to be really thought through, because I
7 do believe that the boards of health serve a very
8 important purpose at the local level relative to the
9 checks and balances to make sure that certain things are
10 not occurring in the community that they govern that
11 could create disease causing conditions for the citizens
12 that work and play there.

13 With that being said, I also recognize that
14 the whole system has changed as we just sort of had some
15 discussion on whether that's heroin addiction or what
16 have you, the question becomes I'm more closely thinking
17 of the health care delivery system is how do you create
18 better communication and coordination of care going
19 forward with this transforming system relative to what
20 local public health should be doing.

21 So I believe boards of health are very much
22 an overlooked -- very much overlooked important group of
23 men and women in the State of Ohio. They obviously
24 serve that capacity, because they desire to do something
25 for their community.

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1 I feel that they haven't gotten the respect
2 they deserve and I think partially because we haven't
3 probably elevated them to the status that they need to
4 have relative to continuing education.

5 I think competition is a budget question
6 relative to bringing some health care folks on to a
7 board, but not always keeping consumer representation,
8 and I would only say to you just from a practical
9 standpoint that, you know, there comes a time then it's
10 important to bring in other people, whether it's health
11 commissioners, boards of health or so forth.

12 And so, you know, there are -- don't get me
13 wrong, I've worked with some great boards and have been
14 15, 20, 25 years, same board member, but I think also
15 just if we're really realistic about it, you need
16 institutional knowledge, but also you need people coming
17 in to change things, because they're just fresh, quite
18 frankly, they're energized, so I would just approach the
19 question of should there be term limits, I don't know.

20 I would yield to one of our board of health
21 members here to see what he perhaps would think about
22 such a question.

23 COMMISSIONER THRELFALL: You want my
24 opinion, very quickly. I have the personal opinion, for
25 anything like this, like we're discussing the board,

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1 it's not about term limits, it's not about anything,
2 other than the individual.

3 No matter what we're talking about it's
4 always going to come down to the individual.

5 You have somebody that gets on a board of
6 health, and I haven't figured out yet why they get on
7 it, you have other people that are probably burned out
8 in two years. You have other people that have that
9 passion that goes on, but in order to cover all bases we
10 want to put a rule, regulation, whatever, in place so
11 it's going to be X number of years and you're gone,
12 which I don't know there's any better way to do it, so I
13 don't have the solution, maybe that's the best way.

14 But I think you lose a lot of experience and
15 great ideas in some people, but maybe you need to do
16 that in order to get rid of other people.

17 So I see the problem, I'm aware of the
18 problem, I don't have a solution, but I can see where
19 people are coming from that want to limit it to
20 whatever, two years, five years.

21 COMMISSIONER EDWARDS: Many of the boards
22 that are in your county, the ADAMH Board, the Mental
23 Health Board, Veteran's Service Board, DD Board, even
24 Historical Board, they all have term limits, so this
25 isn't anything new.

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1 COMMISSIONER THRELFALL: Oh, I'm not saying
2 it's new, I'm not disagreeing with you.

3 COMMISSIONER EDWARDS: I don't see an issue
4 with term limitation or -- and this is a voluntary board
5 and those are all voluntary boards.

6 COMMISSIONER PRESS: Mr. Tremmel handed me
7 the 1993 recommendations. I'm just trying to study up
8 here real quick, I'm assuming you handed it to me for a
9 reason.

10 MR. TREMMEL: The short part of the '93
11 recommendation, and I haven't checked the '60s version,
12 this has been a regular and revisited topic.

13 The themes are reoccurring on staggered
14 terms, term limits; the size and composition of a health
15 district, a minimum of 7, a maximum of 15. I believe
16 there's probably some health departments that are larger
17 than 15; how many board members?

18 COMMISSION NIXON: Eighteen.

19 MR. TREMMEL: In terms of board members,
20 ranges from a minimum of three to a maximum of seven
21 staggered. No more than one-third should be required to
22 attend at least five hours of continuing education.

23 I think continuing education is a revisit.
24 I think that's probably a worthwhile revisit for board
25 members, and I say it for this reason, it's not that

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1 board members don't come to the meetings engaged and
2 passionate about the issues.

3 It's that difficulty with the nature of
4 trend and issues just as we talked here, would be
5 worthwhile to have some continuing education presently.

6 I think that would be -- I think that would
7 give board members more perspective and more opportunity
8 to have detailed and specific conversations with their
9 administration and in some cases differing opinions with
10 their administration as to where they might need to be
11 going.

12 COMMISSIONER PRESS: Quick question, are we
13 re-plowing ground that's addressed in the accreditation
14 standards?

15 COMMISSIONER NIXON: No, I do think that, if
16 I could answer something else, the Boards of Health
17 Association is dealing with a lot of these issues, and I
18 think they've robustly tried to build some capacity for
19 training among boards of health that never existed
20 before and to build some uniformity around boards of
21 health structure, not only in Ohio, but nationally, so
22 this issue is ongoing and I give them some flexibility
23 to do what they're trying to do.

24 And I think before we start talking about
25 time limits or start talking about uniformity, I think

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1 we should be clear about defining what's the problem. I
2 mean what are we addressing by designing the boards of
3 health structure?

4 I don't know the problem lies there, I think
5 some of the issues go beyond that, we have a number of
6 health departments size and capacity are the issue,
7 so --

8 COMMISSIONER EDWARDS: I'm not sure I could
9 ever find a reason not to have more education, I just
10 can't find a reason not to.

11 CHAIRMAN BURKE: Don't have to go that deep
12 on the issue, just touch a recommendation for continuing
13 education, if people think that's a reasonable approach,
14 don't have to state how often or how many hours, but
15 just, you know, should; is that something that folks are
16 comfortable with as a recommendation?

17 COMMISSIONER EDWARDS: Mr. Chairman?

18 CHAIRMAN BURKE: Yes, ma'am.

19 COMMISSIONER EDWARDS: Will you be also,
20 after the lunch break and sometime in the future, asking
21 the question about governance?

22 CHAIRMAN BURKE: Yeah.

23 COMMISSIONER EDWARDS: Okay. Thank you.

24 CHAIRMAN BURKE: And we have several things
25 to cover here just so you know where we're at, shared

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1 services discussion; we have a funding discussion; we
2 have a governance discussion. Those are very broad, so
3 think how these are going to chunk up where we are
4 going.

5 Before we break for lunch real quick, just
6 to reiterate what I've heard some consensus around,
7 again, we're going to continue to build, we're going to
8 take this list and will be distributed to you prior to
9 the next meeting and we'll continue to work through the
10 additional issues, you'll have another bite at the apple
11 before we determine what this is actually going to look
12 like.

13 Just so you know, this is what I've heard at
14 this point, methods for verification of reporting or
15 recording data; some kind of standardization of outcomes
16 of reporting based a whatever state priorities are going
17 to be used to be measured; and these are very loose
18 terms, we'll work on the wording; the relationship
19 between health and Ag regarding inspections and that
20 kind of duty, and having that looked at by some kind of
21 panel or board, maybe something like a common sense
22 initiative; making a recommendation that the boards on
23 health should consider continuing education for its
24 members.

25 These are kind of generically stated; does

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1 that sound like a well rounded synopsis of what we've
2 been doing for the last hour and a half?

3 Okay. Well, I will break for lunch. If
4 you'll give us 15 minutes, more or less, get some food,
5 restroom break, have a working lunch when we return, and
6 hopefully plow through it, We'll work on shared
7 services. We'll go into recess for 15 minutes.

8 (OFF THE RECORD AT 12:37 P.M.)

9 (BACK ON THE RECORD AT 1:00 P.M.)

10 CHAIRMAN BURKE: I appreciate everybody
11 coming back from lunch, we'll go ahead and call the
12 committee back to order.

13 I know the next issue we're going to talk
14 about was shared services and very open to anybody's
15 discussion on this.

16 You know, the current administration has
17 what's called an LGIF, Local Government Innovation Fund,
18 just look down the path of that fund, what that fund
19 brings to the table, and what else we can do to add to
20 collaborative services in the form of a recommendation
21 from this body.

22 So I'm just going to leave it very open, but
23 I'm open for any points that anybody would like to make
24 that we can put into a report.

25 COMMISSIONER FOUGHT: Jennifer had mentioned

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1 in her earlier conversation about shared services, she
2 had referenced ESCs, and I think that -- and I know we
3 don't have to be specific in our recommendations, but I
4 just wanted to bring this up.

5 In the last budget, you know, there was
6 language that was put in that specifically permitted
7 townships to work with ESCs in a variety of ways, and so
8 if ESCs could -- maybe they could be of value to the
9 health boards too, and if that's not out there maybe
10 that's something that we want to say.

11 But I know there is the provision that was
12 also put in the budget last year that allows any
13 political subdivision to share services with any other
14 political subdivision. We do have blanket language that
15 allow political subdivisions to share, so I guess the
16 question that I would raise, what else is needed to help
17 with that?

18 Like what legislation or what other issues
19 do we need to address to further to help the health
20 boards share? And I don't know if anybody wants to
21 answer that, I just don't know what else is needed.

22 CHAIRMAN BURKE: Good question.

23 DR. MCFADDEN: I think multiple
24 jurisdictional levies would be one thing to talk about.

25 COMMISSIONER SHAPIRO: Permissive authority.

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1 back to another governance question too, as well as the
2 structural issue of health care. You can't do one
3 without the other and so because there are school
4 districts that cover -- that are in three counties or
5 more in some cases, depending on the case, so I just
6 want to put that back on the table.

7 And I did want to say, if you give me one
8 more opportunity I really would like to go way back to
9 the governance question without a composition.

10 CHAIRMAN BURKE: Sure, you can go ahead.

11 COMMISSIONER INGRAM: I know I made a point,
12 but I'm not sure I made -- perhaps it's not persuasive,
13 and I really feel pretty strongly about this issue, and
14 that is, I don't -- when we talk about these outcomes,
15 health outcomes and I keep thinking and why, how these
16 health care systems are transforming though based on
17 what's going on with Medicaid and Medicare reimbursement
18 rates, we will always have an important role in the
19 health of the community, because of health and policy
20 making boards.

21 But I truly believe that there should be
22 some indication through statute or recommendation by
23 this committee that the CEO of the largest health care
24 delivery system, and perhaps other individuals, become
25 part of the make up of the board of health, because I

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1 think that it is going to allow for the communication
2 and coordination to occur today.

3 Either the health commissioner has to reach
4 out and get an appointment with or somehow position
5 themselves to open up that channel, because I really
6 think that's -- going forward that's a real key -- key
7 question.

8 So I think we need some specified people in
9 composition with the board, albeit still an independent
10 board, policy making board that includes senior level,
11 and I prefer the CEO of the health delivery system in
12 that jurisdiction.

13 MR. TREMMEL: Mr. Chairman, Mr. Ingram,
14 would you be opposed or would colleagues be opposed with
15 an arrangement where, if this were the case that you had
16 a hospital health official on the health board with some
17 opportunity for a member of the board or a member of the
18 health team to be a member of the health board, and, Mr.
19 Press?

20 COMMISSIONER WENTZEL: Senator Burke, in
21 those jurisdictions that we have more than one hospital
22 system is that allowed?

23 COMMISSIONER INGRAM: And I'm not sure, Mr.
24 Chairman, if I can answer that. I think that has to be
25 something that has to be worked out perhaps through the

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1 association that represents those hospitals locally.

2 In some counties it's going to be fairly
3 clear cut or cities or others will be much more -- won't
4 be so apparent, but I do feel strongly that if it's a
5 Children's Hospital or adult care facility that it's the
6 CEO level, that they're appointed to that board, and the
7 reason why is to align the service deliveries that are
8 always -- that are starting to develop on their own
9 without public health in some communities relevant to
10 improving the health outcomes that we have been somewhat
11 talking about today.

12 I'm looking down -- I'm looking down, you
13 know, a decade or more, that's what I'm trying to
14 envision is what this health care delivery system is
15 going to look like.

16 CHAIRMAN BURKE: I don't disagree with the
17 concept. I just -- just from a technical standpoint,
18 what if you have a private hospital, I'm not sure, and I
19 appreciate Marty's point too, now you're forcing a
20 private company to have a board member by law that's
21 from a certain organization, and what if you have a
22 hospital that, although I can't imagine the case, didn't
23 want to participate?

24 COMMISSIONER INGRAM: Well, I mean, there's
25 a civic duty, it's in the statute, you have a civic

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1 obligation. I mean today an M.D. or D.O. must be a part
2 of the board of health. There's no -- I mean it's in
3 the statute, and obviously makes a lot of sense to have
4 a medical professional, M.D. or D.O., on the board of
5 health.

6 My only point is, yes, that should continue,
7 should we not bring in an administrator at another
8 health care professional at the CEO level of a health --
9 of a hospital system or health care delivery system to
10 assist with integrative care that's starting to occur as
11 all of these systems begin to move to accountable care
12 organizations, medical homes and so forth.

13 The other thing is that we're going to be
14 doing these Community Health Assessments, it's already
15 set up in the accreditation standards, and we've always
16 agreed that we're going to pursue accreditation of local
17 health, I believe, so one of the things that comes out
18 of that, there's an obligation now by the not-for-profit
19 sector, which is still the predominate player in health
20 care delivery in this state to do a Community Health
21 Assessment, by IRS rules, in order to make -- they have
22 a part of their committee benefit.

23 The other piece of that is going to be the
24 Strategic Health Care Plan, the Health Priority Plan.
25 You cannot do a Health Priority Plan in vacuum of the

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1 health care delivery system.

2 I think we're just kidding ourselves,
3 especially in light that more and more and more
4 physicians are becoming employees of health care
5 systems.

6 We've got to think about where we're going
7 to be five years down the road here, actually won't even
8 be that long probably in some areas.

9 So I'm going to go back to what I've been
10 kind of saying all along, that we need alignments. We
11 need alignments and we need coordination, and I think
12 one way you do that is put people that are responsible
13 in that area on that respective -- respective governing
14 jurisdiction, governing body.

15 COMMISSIONER PRESS: Just -- I agree with
16 what Tim is saying that the two -- there is some
17 convergence going on between the two disciplines, and
18 we've already talked about how it's difficult to get all
19 the work done that has to be done with the funding that
20 we have, to squeeze out the redundancy by coordinating
21 or aligning those efforts is important.

22 What he said is true, you either pay a
23 \$50,000 fine or we do a Community Health Assessment and
24 have public health doing one to meet its accreditation
25 requirements and us doing one to meet federal statute.

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1 We just can't afford to do that. Getting
2 coordinated on those, finding some way to have both of
3 those requirements satisfied by conducting one
4 assessment seems to be much more sensible. So whether
5 it's the CEO or -- for the record I am not the CEO of
6 the largest health system.

7 COMMISSIONER SHAPIRO: I just don't know
8 that that needs to be done legislatively. I think that
9 because there is an economy of scale to do it together
10 and there's efficiencies to do it together, that's what
11 our community is doing going forward.

12 COMMISSIONER PRESS: We heard about it last
13 time we met.

14 COMMISSIONER SHAPIRO: Well and we're doing
15 it Friday. We're starting our process to meet the
16 hospital's needs for their IRS requirements and to start
17 our new community assessment process, we're meeting
18 together and we're having joint planning, and then we're
19 going to do that going forward. That's all with local
20 negotiations and that's with Ohio Health, which is a
21 fairly large hospital system.

22 COMMISSIONER INGRAM: I understand that, but
23 I have to respectfully disagree from the standpoint of
24 that communication that occurs at that level, that
25 networking, and I would tell you, if you really think --

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1 we just had this discussion earlier about the heroin
2 issue that's -- you know, can you imagine the CEO of the
3 hospital system coming to the Board of Health and
4 saying, we have a problem with this, we may need to
5 change some policy that you have authority over to do.

6 I feel that that's missing today in our
7 public health system. I believe that communication is
8 not -- I'm not saying it's everywhere, I'm just think
9 that we don't -- we're all over the place
10 variability-wise in that area.

11 And this is about improving the entire
12 system, this is about the system lifting up and being
13 able to address these issues, because that problem is
14 everywhere, as many of these problems are, so why should
15 the services in one jurisdiction be so much better than
16 in another; can we not reach a better level? And I
17 think some of that starts right at the governance level,
18 so I would stop there.

19 COMMISSIONER NIXON: I think the governance
20 issue is a little bit of a mission created from the
21 original report, and that's fine. I think that we have
22 to address some of the governance issues and probably
23 flows from there.

24 The issue of the role of health departments
25 and aligned with health care is, I think -- I agree with

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1 Tim that that's going to be an emerging responsibility
2 for health departments and when we talk about integrated
3 services in the health care field under Medicaid and
4 some of these billing and exchanges, and some of these
5 other opportunities I think that holds great promise for
6 public health and I think that some of that needs to be
7 considered in Medicaid reform in Ohio, but it's not
8 right now.

9 Health departments, there isn't the enabling
10 legislation to allow us to be necessarily participating
11 in this new world, so I think one follows the other.

12 I think it's appropriate that we follow this
13 path and get more involved in the health care and
14 Medicaid reform, but as of -- you know, as it's written
15 now we're not part of that, so I think we need to get
16 engaged with it, I think that's the opportunity.

17 I don't think getting the CEO of the
18 hospital on the board opens up the doors. I think one
19 follows the other. Let's get the role of enabling the
20 responsibility, and then consider who should be on the
21 boards.

22 DR. MCFADDEN: I would argue a little bit, I
23 think times have changed. Unfortunately we are solving
24 a problem that -- it was solved before, I believe, and I
25 think that when we had, you know, the health

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1 commissioner, you know, was more often than not a
2 physician and I'm not saying those days we have to go
3 back, but a physician within the community had close
4 relationships with the hospital and the community, and
5 as, you know, they might see their own practice and work
6 on the health department and things were smaller then so
7 we had more of a relationship then.

8 I think that public health and clinical
9 medicine have gotten more and more specialized, we've
10 seen us get to your own silos, and I would say that
11 certainly, if we're going to move forward with the state
12 I agree with Tim in the sense that we need to find a way
13 that our two systems work together like we did pre 1940,
14 pre 1930. I mean, there's got to be a better way.

15 What I will say is that today, yesterday,
16 tomorrow, I can walk up to our CEO's secretary and I can
17 say, hey, is Tony here, you know, she'll say, yeah, why
18 don't you just walk on back, and I can tell Tony these
19 are the issues we have.

20 I also know our CEO will call me on the
21 phone and say, hey, we're looking at what we need in our
22 community, what are -- what do you -- if you had an
23 opportunity to do one thing what problem would it be to
24 address, and so we have that relationship.

25 I would argue that that is because I also am

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1 employed at his hospital as a physician who he has to
2 keep happy, but I think that there are some places, we
3 don't all have the same problem.

4 I think that we do need to find a way to
5 have better communication between our medical systems,
6 physicals, nurses, hospitals, public health to clearly
7 go forward.

8 I'm not sure that I have the right answer
9 for that, and I'm no sure that in every community we can
10 do it through the Board of Health, but I do think it's
11 very important issue.

12 COMMISSIONER EDWARDS: Yes, unfortunately in
13 our county our health department and our hospital do not
14 speak. They do not speak. They have very little
15 relationship, and what relationship has happened is
16 really with a third party and that's in mass outbreak
17 and in some other areas with the EMA director. So you
18 throw that third person in there to try to get the two
19 together.

20 What our health department has been very
21 successful in is talking with the docs, with their
22 offices, and getting information out to them, but as far
23 as the hospital itself, I would say there is no
24 relationship there.

25 But maybe you can broaden that out, and I

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1 agree with Tim, maybe we can broaden that out instead of
2 just saying the CEO of a hospital, maybe just say a --
3 this is always dangerous, because I'm talking off the
4 top here, but a health care facility or somehow to
5 spread that out more, so it's not specific to that
6 organization, I don't know.

7 CHAIRMAN BURKE: I mean, you could be very
8 broad and just say the make up of health boards should
9 be examined from time-to-time or should reflect.

10 I'm just talking in very broad language, you
11 know, just to draw attention to the fact and to send
12 folks back home, for lack of a better term, that this
13 topic came up, and we think it's an important topic. We
14 don't know if it's a hospital CEO or a doctor.

15 COMMISSIONER INGRAM: I agree, I just used
16 that because it's the most --

17 CHAIRMAN BURKE: To Representative Antonio,
18 and I that this should be a malleable issue, not one
19 that's set in stone.

20 COMMISSIONER EDWARDS: One of the things I
21 thought about when Tim was saying hospital is, well,
22 ghee, maybe the director or someone from the Area Agency
23 of Aging, you know, group should be on the health
24 department, because now you've got a whole group of baby
25 boomers, and you know where that's going.

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1 So maybe there should be a make up, a
2 different make up of just -- other than just who's
3 interested that the director chooses, I don't know.

4 CHAIRMAN BURKE: Well, I mean --

5 COMMISSIONER INGRAM: Thank you, Mr.
6 Chairman.

7 CHAIRMAN BURKE: -- We still have one more
8 meeting to go in the formulation phase, if this is
9 something people have an appetite for we can, again,
10 pull this piece of code out, have a re-discussion on it
11 starting the next meeting, if that's something folks
12 want to talk about, or do we not have an appetite for
13 this and we're beating a dead horse?

14 COMMISSIONER EDWARDS: I'm good with it.

15 CHAIRMAN BURKE: Who wants to move forward
16 with this issue and have more discussion? Two people,
17 three people. Three, well, that's where we stand, but,
18 again, you've got bites at the apple, right, come back
19 and resell your wears at the next meeting and see what
20 you get.

21 COMMISSIONER NIXON: Mr. Chairman, I think I
22 would -- I hate to open the can of worms, but the
23 problem with me it seems with the governance structure
24 it that it varies so much.

25 Every health department -- I mean we have

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1 18, a lot of health departments have only five
2 representing the township and villages, the general
3 health district and yet the majority of the districts
4 are the city, and it goes both directions and is so
5 varied among every health department that it doesn't
6 lend itself easy to just adding another member.

7 To add another member to mine would be a lot
8 more, one more out of 18 makes it 19. Well, let's add
9 somebody from the Agency on Aging while we're at it and
10 it starts to get unmanageable.

11 So I think if you really want to talk to the
12 governance issue probably there's a case to be made for
13 some uniformity with how the boards are designed
14 uniformly around the state and begin there, and then go
15 on to be who should be the best representative on that
16 board.

17 COMMISSIONER EDWARDS: Can I ask a question
18 of you, Gene?

19 COMMISSIONER NIXON: Yeah.

20 COMMISSIONER EDWARDS: Of those 18 who are
21 they; what roles do they --

22 COMMISSIONER NIXON: Thirteen cities each
23 have a representative, four represent townships and
24 villages of the -- I think, we have 17 townships and
25 villages represented by four members, and then I have

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1 one representative of the licensing council, the
2 industry that they license.

3 COMMISSIONER EDWARDS: Do they have another
4 day job?

5 COMMISSIONER NIXON: Of course.

6 COMMISSIONER EDWARDS: Then it's not --
7 could that individual be -- could it be someone from
8 maybe the health or Area Agency on Aging that represents
9 the city?

10 COMMISSIONER NIXON: Well, we have hospital
11 representatives on our board and we have attorneys on
12 our board, you know, some retired folks, so it's a wide
13 variety.

14 COMMISSIONER EDWARDS: Okay. So those
15 individuals could actually dual -- have dual roles?

16 COMMISSIONER NIXON: Well, a city by
17 contract has a representative on our board, so you'd
18 have to ask one of the cities then to have their
19 representative there on behalf of the city and the
20 hospital or an agency, so they're kind of set by --

21 COMMISSIONER EDWARDS: I'm looking at a way
22 not to increase the size, but to --

23 COMMISSIONER NIXON: Right. And the way
24 that it is now, I mean a doctor has to be on the board,
25 doesn't mandate which representative is the doctor, you

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1 just have to make sure you have a doctor and every board
2 has a doctor.

3 MR. TREMMEL: Mr. Chairman, Gene, just for
4 clarity, with you having a board of that size was that
5 designed in kind of a quid pro quo for a city to
6 contract, there was a board member?

7 COMMISSIONER NIXON: Well, it was designed
8 that way when we had three cities, you know, so it
9 wasn't -- it didn't become eight board members, it was
10 pretty -- so as each city came on the district as part
11 of it was the same -- basically the same boilerplate
12 contract, which included a representative on the board,
13 but, yes, I think the short answer is it is quid pro
14 quo.

15 MR. TREMMEL: So the '93 recommendations had
16 numbers that could range from 7 to like 15 or some such
17 number. So what would that mean for you, you would end
18 up having a couple of less so they wouldn't necessarily
19 be represented city by city, would that cause legal
20 issues or what would --

21 COMMISSIONER NIXON: Well, I would have to
22 open up 13 contracts and probably rewrite all of them
23 somehow. My contracts are yellow.

24 REPRESENTATIVE ANTONIO: So I was just
25 looking at the shared services in the report, and some

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1 of the -- everything from the survey that was done in
2 October of last year around shared services to thinking
3 about this discussion.

4 So I don't know what you -- I'd be
5 interested in what you think of this, and this is just
6 off the top of my head, but if there were more
7 formalized memorandums of agreement between the
8 different entities could that bridge reduction maybe in
9 one person representing, but take the place of in some
10 cases so that the interest of the different communities
11 are definitely there and people feel assured about that,
12 but that they don't expect that it's one person carrying
13 the banner for that community; would that -- is that a
14 possibility?

15 COMMISSIONER NIXON: Yeah, I think there's
16 all kinds of possibilities, but, you know, I think one
17 of the things that we value is our relationship with
18 each of our communities and the representative.

19 The board representatives from each city
20 carrying some of that burden as well to make sure that
21 they know we're doing a pretty good job and they
22 represent our interest and our strategic plan and where
23 we're headed. I think that would get deluded some, but
24 there, again, I think there's other ways to do it.

25 REPRESENTATIVE ANTONIO: Well, if I might,

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1 it almost seems like it -- and I've worked with
2 non-profit when we were doing collaborations and
3 strategic alliances, and a lot of times it means that
4 the affiliation and the allegiance needs to shift from
5 my individual community to a new allegiance of our
6 collective public health departments.

7 COMMISSIONER NIXON: I agree, I think it can
8 too. I think it would be traumatic short-term, but
9 long-term I think it would be fine.

10 REPRESENTATIVE ANTONIO: So it almost seems
11 like we need some -- I think the role of the health
12 department that somewhere in there should be this
13 assistance in helping make that shift, because any group
14 is going to go through things like that, so if there's
15 some kind of supportive assistance in getting there, I
16 think that could be a team or whether that team is one
17 or two people, I don't know, but that someone has that
18 role to go out and be the facilitator of that shift,
19 maybe, would you see that as the role of the health
20 department?

21 MR. TREMMEL: Are you asking me?

22 REPRESENTATIVE ANTONIO: Yeah, Martin.

23 MR. TREMMEL: So, yes, I do, and we do it in
24 some limited fashion. We have our, you know, our good
25 colleague, Joe, who has any number of 20 other things,

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1 and this is another one of those important ones, but I
2 won't speak for Joe, and, Joe, you can interrupt me at
3 any moment, but in short, he has been a part of those
4 conversations and has done some of those.

5 But it is difficult, as Commissioner Nixon
6 mentioned, and we had conversations, I don't know we had
7 face the faces up there, but it ultimately is going to
8 be that local decision and this is still the disconnect
9 between state and local public health in this -- in
10 Ohio's public health system, so it continues to be a
11 mixed bag approach.

12 It's probably the fall back position as the
13 Ohio Department of Health continues and will continue
14 and remain to be the message, whatever works for you,
15 we're good with that, because generally we are.

16 And it's difficult, unless there are other
17 rules in place, and I think as Commissioner Nixon
18 mentioned, could be traumatic at the beginning, but I do
19 wonder about a board.

20 I think there's even a board or two larger
21 than yours, when you get boards numbering 15, 16, 18, I
22 don't even know about boards 10 or 11, I don't know, I
23 just haven't had the experience, most of my experience
24 has been with boards of probably 7 or 9, some such
25 number.

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1 I don't know what point it becomes
2 unwielding, maybe it isn't, maybe the argument is --
3 maybe the argument is, you know, the greater diversity,
4 the greater the discussion, and, you know, the more
5 noble the efforts are on behalf of the districts.

6 But I do wonder, and I do give pause to what
7 Commissioner Ingram mentioned, this health care system
8 and this public health system are disconnected far too
9 long, and the short of my little soapbox measure would
10 be there needs to be a better place to get this, and if
11 it would be some combined, that's why I asked the
12 question, would be some combination of.

13 You know, I -- I was more moved by the Henry
14 County presentation when you saw the unique strategy in
15 place in a small community where you have public health
16 and the health care system linking arms, because of a
17 shared board membership that someone had the vision, and
18 it may have been Commissioners Schmalz (Phonetically
19 Spelled) 25 years ago, but credit goes to somebody there
20 who put that in place, and I think to me it was a good
21 remarkable testament of what can be done in communities
22 and I'm envious of doing similar such things.

23 So I would like to see us get to a similar
24 place, but I wouldn't want to disrupt the system and
25 cause a jeopardy.

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1 CHAIRMAN BURKE: Could I ask a favor from
2 you, and Joe as well, could you electronically and on
3 paper, for our next meeting, make a copy of those prior
4 recommendations, as well as the current code that's
5 statute for the make up of the health board, and maybe
6 we can mature on this process a little bit, and come
7 back and just have a more mature conversation.

8 I don't know if it leads to a recommendation
9 or not, but just felt when I asked my question that
10 there was apprehension, and I don't know if that -- I
11 just think now is probably not the time to talk about
12 it, but maybe we can get some information out there to
13 folks, we can come back and assess this.

14 You bring up a very valid point and Tim
15 brings up a process for resolution, but yet we're not
16 comfortable, so I do think it needs to be matured, so if
17 we could get those items for the next meeting we can
18 reflect on this and come back.

19 MR. TREMMEL: Just a point of clarity,
20 you're suggesting, Senator, Mr. Chairman, '93 and '60
21 recommendations; is that what you're asking?

22 CHAIRMAN BURKE: Yes, just to give folks a
23 scope of what has been discussed over the past 40 years,
24 and if we can again make one yard motion forward, even
25 if it's a hand-off, I'll take a hand-off.

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1 Back on shared services, we've all kind of
2 agreed for some permissive authority from
3 multi-jurisdictional levies, just to talk about that,
4 moving on.

5 MR. MAZZOLA: Do you mean specifically board
6 recommendations from those two reports or those entire
7 reports?

8 CHAIRMAN BURKE: The board recommendations,
9 cut and paste board recommendations on the statute that
10 way folks can kind of look, see where we're at, and then
11 look at their own boards, and then come back a little
12 bit more, you know, informed on the issue.

13 On shared services, what else are we missing
14 here; what else can we do?

15 COMMISSIONER FOUGHT: Mr. Chairman, can we
16 -- do we all agree on the multi-jurisdictional levy; can
17 we cross that off, if we're all in agreement that that
18 should be something we recommend?

19 CHAIRMAN BURKE: Again, we can revisit this,
20 this isn't going in stone, this is in pencil.

21 COMMISSIONER FOUGHT: I'm just thinking if
22 we do all agree we can check that off.

23 CHAIRMAN BURKE: We all agree? All right.
24 Well, there's another one, we're building.

25 Something that I kicked around, and I heard

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1 earlier, is I.T. in health departments. Since we're
2 talking about shared services and collaboration, you all
3 have much more experience in that than I do, yes, no,
4 problem?

5 COMMISSIONER NIXON: I think any opportunity
6 to share services should be encouraged. We ought to
7 find -- that should just be a blanket statement, if we
8 agree that there's too many health departments then the
9 way they're going to come together without imposing or
10 forcing it to happen is from the experience of sharing
11 services, okay, whether in sharing the governance,
12 sharing the funding for services.

13 So wherever they can, whether it be I.T.,
14 whether it be grant writing, whether it be
15 administrative services, personnel, finance, that ought
16 to be encouraged, strongly encouraged and supported, and
17 I think when you see that start to happen more
18 frequently, and I don't know why it doesn't happen more
19 now, you'll start to see health departments come
20 together more robustly than that.

21 COMMISSIONER FOUGHT: Mr. Chairman, I would
22 further add to that, I mean, we can even reference those
23 things that already have been done through the
24 legislative process recently, just to further strengthen
25 the argument.

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1 Here you have these tools, you know, we want
2 the health department to utilize these tools, such as
3 9.833 or whatever Section it is.

4 REPRESENTATIVE ANTONIO: 9.482.

5 COMMISSIONER FOUGHT: There you go, thank
6 you.

7 REPRESENTATIVE ANTONIO: You're welcome.

8 COMMISSIONER SCOFIELD: Well, Mr. Chairman,
9 just another thought on that, not only sharing services
10 like I.T. between health departments, but if we're
11 looking at building capacity or finding efficiencies in
12 those health departments that are unlikely to merge with
13 another by size or something like that, to even look at
14 sharing services with their general government.

15 For example, the Cuyahoga County Board of
16 Health has had conversations with our I.T., that county
17 government I.T. person, we've talked about sharing Human
18 Resources capacities, so I think there are a number of
19 opportunities for shared services that can help build
20 capacity and find efficiencies within local health
21 districts beyond just between local health departments.

22 REPRESENTATIVE ANTONIO: And one of the
23 things that I had eluded to before, but I want to know
24 what people think about really starting to have formal
25 letters of agreement, because one of the things that

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1 occurred -- and as I was listening to some of you, if
2 people have personal relationships with other providers
3 or with other colleagues, then the flow of shared
4 whatever services, activities is great and very high,
5 but if the people change, then sometimes the activity
6 changes.

7 And so it just seems to me that the more
8 there are letters of agreement between entities that
9 keeps that continuity as well, and I think encourages
10 other things to blossom from there, because it's a
11 formalized agreement, I'm interested in what people
12 would think of that.

13 COMMISSIONER FOUGHT: Mr. Chairman, from a
14 local government standpoint I would agree with that,
15 because the boards do change, elected officials do
16 change, personality, conflict of differences come into
17 play, and so by at least having something to reference,
18 as oppose to a handshake, it definitely is helpful.

19 That being said, people are very reluctant
20 to put stuff on paper sometimes, so I wouldn't want to
21 discourage folks from sharing, if they can't get
22 something officially on paper, but it would be helpful
23 for future years, if they would do that.

24 The other issue is liability, by having
25 something on paper you reduce liability issues. So

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1 we're strong advocates for at least making sure you have
2 something on paper for liability purposes.

3 CHAIRMAN BURKE: Is there anything that
4 stops a health district from contracting with a hospital
5 or ADAMH Board or any other person or body for whatever
6 reason; there's nothing that hinders you from doing
7 that?

8 COMMISSIONER NIXON: We have those all over
9 the place.

10 CHAIRMAN BURKE: So if I were to -- talking
11 very broad, if I were to try to get a sentence down that
12 I could look at three hours from now what would that
13 sentence say about what we're talking about, other than
14 we should strongly encourage shared services; is that
15 all that it should say, chair it and come back?

16 COMMISSIONER INGRAM: Well, I heard Heidi
17 talk about some type of written instrument, and so I
18 think perhaps a little bit more than just encouraging
19 it, that you actually request some type of
20 contractual -- I mean an agreement is a contract in a
21 sense, it's just who's paying and who's receiving, so to
22 speak, right?

23 COMMISSIONER NIXON: I think there's been
24 some models out of the Ohio Department of Health that
25 have encouraged that.

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1 A number of epidemiologists that local
2 health departments have to have based on the population
3 base, and a lot of health departments don't have that
4 population base, so they have to work together to build
5 that population base and they share, so they share the
6 epidemiologist among health departments.

7 So that mechanism's been pretty successful,
8 I think it's worked, I think it's probably built a lot
9 of collegiality that might not have been as strong
10 without that, so I think that those kind of models would
11 work pretty well.

12 CHAIRMAN BURKE: Let me -- I guess I'll just
13 ask for the favor of the committee then, we all, in
14 general, agree that that is something we want to do, we
15 can work on the words in this for the next meeting and
16 go through that particular wording; does that make
17 sense?

18 DR. MCFADDEN: I think one piece we haven't
19 really touched on here is currently code says that we
20 can consolidate with a contiguous, and so I think it's
21 part of this, it may be -- I would recommend that there
22 be the ability to consolidate, if we're talking
23 consolidate, with non-contiguous.

24 Certainly there's nothing that keeps us from
25 collaborating with non-contiguous, but I think not

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1 allowing folks to work together just because they aren't
2 sharing a border --

3 CHAIRMAN BURKE: Is there someone on the
4 phone who wants to make a comment?

5 COMMISSIONER EDWARDS: I'm going to throw
6 something real radical out there, state of North
7 Carolina has made it permissive for health departments
8 to be working in conjunction with job and family
9 services, as part of the health department that would
10 work out pretty good. My JFS director would shoot me
11 right now.

12 MR. TREMMEL: Let me respond to that. When
13 you say something radical, you're right there. So the
14 health commissioners just last week had a pleasant
15 opportunity to hear from the Director of Medicaid, Mr.
16 McCarthy (Phonetically Spelled), and Mr. McCarthy had
17 outlined some of the vision and guidance going forward
18 for the state Medicaid system.

19 And part of this is with the Affordable Care
20 Act, the number of folks that will come into the system
21 for Medicaid and the cost, and with all of this, I look
22 at, and I think my colleagues do even a better job than
23 I, where are the opportunities, and some of the
24 opportunities are in some of the case management issues.

25 So I think this is a very strong opportunity

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1 for public health, case management of folks in the
2 Medicaid system or folks in the managed care system. I
3 think there's a strong opportunity for folks in the
4 insurance system, but that's a discussion for another
5 day.

6 But I think beyond that that folks are
7 seeking the enrollment into the managed care system, why
8 is it -- I shouldn't say only, because they would use
9 technically to enroll other folks like you can enroll at
10 the library, you can enroll at your own computer, but
11 why could you not enroll -- and this struck me as
12 something a very astute prenatal nurse that was a
13 colleague of mine at the local level years ago, when the
14 young lady came in for prenatal care that was not on
15 Medicaid we had the good fortune of having Medicaid in
16 the same building as the public health system, she
17 literally would walk them there and leave them for, you
18 know, an otherwise unannounced appointment and within 24
19 hours that young lady was enrolled in the system and we
20 were a part of a Medicaid, you know, process of getting
21 her prenatal care.

22 So the short of it is, why could not or
23 could we otherwise figure out a way to serve clients and
24 enroll them in a kiosk or in a stand up stand alone
25 process of having enrollment directly into the Medicaid

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1 system, because the system will be easier to enroll, I'm
2 told by the director last week, so why couldn't we do
3 this in a public health system, enroll them right there,
4 I don't know, so --

5 COMMISSIONER SCOFIELD: To add on to that,
6 it gets back to my earlier comments about opportunities
7 of departments to work collaboratively together to
8 improve performance or find efficiencies.

9 There could be opportunities in that same
10 thing for co-locations, if you've got public health
11 department employees doing similar work with children
12 and family services, or, you know, where they can
13 co-locate and have that ability to work together,
14 whether it's case management or other things.

15 And another thing, if we're looking at
16 policy or other changes from the state that could be
17 useful to locals, as an example, all the ODJFS agencies
18 at the local level have to have ODJFS e-mail and use of
19 their equipment, which is problematic at the local
20 level, because there's all these -- we can't share data
21 between children and family services and re-entry,
22 because they're -- and that's mandatory.

23 So there might be some opportunity, and I
24 don't know all the legal details behind that, but that
25 could be something that we could, you know, make a

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1 recommendation to look at.

2 REPRESENTATIVE ANTONIO: Permission to
3 intercross those firewalls?

4 COMMISSIONER SCOFIELD: Yeah, somehow, and
5 we're working in Cuyahoga County with some folks here in
6 Columbus about that, but it's been years and years and
7 years where there was not, and because the county didn't
8 have one chief information officer it was difficult to
9 do anything, but that could be something that we could
10 recommend to look at from a state level about better
11 sharing of data to allow for better health care and that
12 kind of thing.

13 COMMISSIONER EDWARDS: An example would be
14 JFS and Children's Services cannot share child support,
15 Children's Services cannot share data with the Child
16 Support Agency, that makes no sense.

17 COMMISSIONER SCOFIELD: But they're both
18 ODJFS.

19 COMMISSIONER EDWARDS: Right.

20 CHAIRMAN BURKE: So I guess going back to
21 the original point here though on the -- I think you're
22 down the right path and it's maturing, just in the
23 generic sense to go ahead and word-smith these thoughts
24 for the next meeting. We're on the right page here,
25 we're all on the same page in terms of trying to

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1 encourage shared services.

2 COMMISSIONER FOUGHT: Mr. Chairman, I just
3 would like to go back to what D.J. had mentioned before
4 this last conversation about non-contiguous health
5 departments merging with each other, and I just want --
6 while I'm okay with non-contiguous in the same county or
7 within one county of each other I'm not okay with
8 somebody from southeast and northeast, I mean, that's
9 too far.

10 So I guess I would just ask, no, it wouldn't
11 make sense, but my point is, crazy things happen with
12 people, if you don't have legislation that spells it
13 out, and so I would just want to make sure that we are
14 defining some parameters for non-contiguous.

15 I don't mind the non-contiguous. I want to
16 make sure there are some parameters to help people make
17 sense.

18 CHAIRMAN BURKE: So if they were within a
19 reasonable geographic distance that would make sense?

20 COMMISSIONER FOUGHT: I would be one hundred
21 percent behind that, but I would just like to make sure
22 we're not opening it up to everybody.

23 CHAIRMAN BURKE: Jot that one down then.

24 COMMISSIONER SHAPIRO: Again, you have to be
25 intentional about what we're doing. I think that's

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1 happened in several counties is that you have health
2 districts that had very reliable partnerships and
3 contracts with different entities and all of a sudden
4 the entity for one reason or another has decided, a
5 major city, for example, to move to another jurisdiction
6 and that left the jurisdiction they left with
7 significant deficit of funds that they had budgeted for
8 the last 50 years, and now all of a sudden, again, you
9 have to do new business models.

10 I think there has to be some time frames put
11 in place, if someone is going to be just jurisdiction
12 hopping based on where they can get the best -- we want
13 to have efficiency, but it could be possibly
14 problematic, so --

15 CHAIRMAN BURKE: We've got two things here,
16 just want to clarify both of these. We have
17 consolidation of non-contiguous city or county health
18 districts within a reasonable geographic distance in a
19 time frame sensitive manner. I don't know how to
20 refresh that word, but --

21 COMMISSIONER SHAPIRO: Something, you have
22 to think of the long -- again, it's a resource issue and
23 if you have every year, for example, Bexley and Columbus
24 deciding that this year they want to be with Columbus,
25 next year they want to be with Franklin County, the

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1 following year, because it's close, they want to go to
2 Delaware County, because, you know, again, and if
3 they're a major source of income for that health
4 district it can be problematic.

5 CHAIRMAN BURKE: Again, I mean, I guess you
6 could theoretically have that problem in contiguous
7 areas right now.

8 COMMISSIONER SHAPIRO: You can, it's
9 happened recently.

10 CHAIRMAN BURKE: And, again, it could
11 resolve your issue by having a statutory minimum time
12 frame of like five years, but then I ask myself, if you
13 can rotate around the clock, right, then what stops you
14 from jumping around the state? I'm not sure if that
15 problem is any greater or worse, just because --

16 COMMISSIONER SHAPIRO: I don't either.

17 CHAIRMAN BURKE: -- You're up in Mentor and
18 I'm down in Cincinnati, I don't know if that is any
19 different than in Loveland, right; does that make any
20 difference? I don't know. Is that something you want
21 to include in the language? I just ask, because is it
22 really probable?

23 COMMISSIONER SHAPIRO: I can ask my
24 colleagues, it could potentially be one.

25 COMMISSIONER NIXON: The contiguous?

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1 CHAIRMAN BURKE: The relationship.

2 COMMISSIONER NIXON: I think she raises the
3 potential that that could happen, and I don't know, you
4 say it's happened?

5 COMMISSIONER SHAPIRO: Well, I think we had
6 a recent, was it maybe Pickerington, I think that
7 just --

8 MR. TREMMEL: Fairfield County.

9 COMMISSIONER SHAPIRO: They went somewhere
10 to somewhere.

11 MR. TREMMEL: Fairfield County Health
12 Department Pickerington went to --

13 COMMISSIONER SHAPIRO: Does anyone know?

14 MR. TREMMEL: Franklin County Board of
15 Health. Susan, you want to address that?

16 MS. TILGNER: If you want me to, Susan
17 Tilgner, Co-Health Commissioner of Franklin County. The
18 city of Pickerington was contracted with Fairfield
19 County Health District and that city made the decision
20 they no longer wanted to contract with Fairfield County
21 Department of Health, because of issues about what was
22 happening locally at Fairfield County, so they
23 approached us and we were able to contract with them and
24 provide their health services.

25 But I think it gets back to that particular

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1 city making a decision about where they wanted to --
2 what they wanted to do in their city with their health
3 district ultimately.

4 COMMISSIONER PRESS: I'm trying to
5 understand why that's a problem, if their needs weren't
6 being met in a contract. I don't see where it's a good
7 policy to order somebody to stay in a contract that they
8 are dissatisfied with.

9 CHAIRMAN BURKE: If you're going to do that
10 then you have to have the same standard for contiguous
11 versus non-contiguous, and then you go down the path of
12 which contracts.

13 I'd say that's a hindrance to shared service
14 now, because you're going to force me, which totally
15 goes against contract law where you have the freewill of
16 bodies coming together.

17 COMMISSIONER PRESS: I guess, if you get
18 known for sort of shopping jurisdictions it's going to
19 be harder to shop jurisdictions.

20 CHAIRMAN BURKE: Well, it would scare me, I
21 know, and I see what -- I understand, I'm just bringing
22 it up, if that is --

23 COMMISSIONER SHAPIRO: I just brought it up,
24 it's not something I'm married to, it's just something,
25 I think it's a concern that you need to look at.

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1 MR. TREMMEL: Let me add, I'm not taking
2 sides on the issue, but let me just add for the
3 Fairfield County Health Department this was an adverse
4 event for them, they lost dollars, they lost staff,
5 authorities, this brings the -- but it's not to say
6 that --

7 COMMISSIONER SHAPIRO: And it might be in
8 the best interest of Pickerington to have done what
9 they've done, and I don't -- I just said, it's the --

10 CHAIRMAN BURKE: And if that were to be a
11 learning experience, I'm just saying, there's nothing to
12 hinder somebody to putting in their own contact a period
13 of longevity.

14 COMMISSIONER NIXON: I think the point that
15 contiguous could do the same thing. We had a similar
16 experience where one of our city health departments --
17 city health departments at that time was recruiting
18 other cities within the county to be part of the -- to
19 create a larger regional health district within our
20 county, and, you now, all of those cities that they were
21 recruiting contacted with us could easily have
22 contracted with that other city and create a regional
23 health department within the county.

24 And I think -- we had to go back and say
25 what are we doing wrong that they think, you know, it's

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1 all the money thing, that they're really going to get
2 the quality, but I think that risk always is out there
3 for us with 13 cities that they could always contract
4 and become -- or rather than contract with someone else
5 start their own health department and that's always a
6 risk we face, and it goes back to my point, you know, we
7 have a citizen board, but we're still political animals.

8 We still have to have councils and mayors
9 that we have to keep happy with our services.

10 CHAIRMAN BURKE: So I'll go back to this one
11 issue then, the time issue then, do you think that's
12 covered underneath the current contract law or does
13 somebody want to spell that out?

14 MR. TREMMEL: Let me ask a clarifying
15 question, Mr. Senator. Commissioner Tilgner, do you
16 have a contract for a period of time?

17 COMMISSIONER TILGNER: We have one year
18 contracts with all of our cities, including the city of
19 Pickerington. At the end of each year that city, who is
20 their own health district, has the option to renew with
21 us or go somewhere else. So we're not merged, we're not
22 consolidated. We simply have contractual agreements
23 that are one year agreements.

24 COMMISSIONER FOUGHT: Mr. Chairman, may I
25 ask a question?

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1 CHAIRMAN BURKE: Sure.

2 COMMISSIONER FOUGHT: Is there a time frame
3 that they have to notify you in advance?

4 COMMISSIONER TILGNER: Yeah.

5 COMMISSIONER FOUGHT: Is that like a 90 day?

6 COMMISSIONER TILGNER: Four months.

7 COMMISSIONER FOUGHT: Okay. So they are
8 giving you warning to know that they're not going to
9 come back or they could come back?

10 COMMISSIONER TILGNER: Exactly, yes.

11 COMMISSIONER FOUGHT: I think that would be
12 the key for me, like if in these types of contracts I
13 would just recommend that there is a specified time
14 frame.

15 Now, that may sound like common sense, but
16 that doesn't mean that everybody is doing that, so maybe
17 that's what we do. We say there's a specific time
18 period that they have to give for withdrawal or going
19 with someone else, that would just be my suggestion.

20 CHAIRMAN BURKE: So then -- so then we don't
21 have an appetite then, I'm assuming, for putting in some
22 statutory request for a time, that's already covered;
23 are you happy with that?

24 COMMISSIONER SHAPIRO: I just brought up the
25 issue, I'm not married to it.

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1 CHAIRMAN BURKE: So if I were to say then
2 consolidation of non-contiguous cities and counties and
3 allowing for that to occur with health districts within
4 a reasonable geographic distance that we would all be in
5 agreement with that, that would be something we could
6 start to draft.

7 Okay. There's one down.

8 The second one, go back to, talked prior to
9 about encouraging shared services, memorandums of
10 agreement, contracts, et cetera, that's going to require
11 some word-smithing, but if that sounds like a general
12 pathway I'll put a checkmark and question mark by it and
13 mature it and go through it at the next meeting with
14 that still being an open topic; does that sound
15 agreeable to most folks?

16 COMMISSIONER EDWARDS: I'm thinking here on
17 the -- under shared services, didn't we talk about --
18 was that part of multi-jurisdictional levies?

19 CHAIRMAN BURKE: That's part of that.

20 COMMISSIONER EDWARDS: Okay. If each
21 jurisdiction can contract their levy dollars then that
22 wouldn't take as much word-smithing, that wouldn't take
23 as much issue with the -- I'm thinking with the
24 auditors, the county auditors, because
25 multi-jurisdictional they may have an issue with a levy,

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1 but if they can contract those dollars, if each
2 jurisdiction contracts them, then I don't think you're
3 going -- I don't think that there's going to be as much
4 of an issue, you're going to have as much push back from
5 them.

6 CHAIRMAN BURKE: Well, then that also brings
7 up another issue, auditors and treasurers are fiscal
8 agents.

9 COMMISSIONER EDWARDS: Uh-huh, there's been
10 a real push over the years to continue that, to keep
11 them as --

12 COMMISSIONER INGRAM: But there's already --
13 there's already precedence in law for this, and solid
14 waste districts do it.

15 An example, ten or more years ago I know in
16 southwest Ohio there's two non-contiguous solid waste
17 districts, Clermont County and Adams County, and Brown
18 County lies in between them, and they've formed one
19 solid waste district.

20 And I think the statute takes the approach,
21 I'm on the record, but I'm not sure if this is correct,
22 that the jurisdiction with the largest population, that
23 that auditor is the keeper of those books and the
24 treasurer, so I think it kind of goes that way, I think,
25 but there's already -- we've trovelled this path before.

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1 And so, you know, as I'm listening to this
2 I'm going to throw a little bit of a wrench in this.
3 Okay. This is all good, non-contiguous and all this,
4 but, you know, there's unintended consequences.

5 We've got to ask ourselves at the end of day
6 are we going to improve the health of all Ohioans by
7 changing that structure or allowing for that structure?

8 I mean the key here is are we going to
9 actually address whatever priorities, which obviously
10 are going to be something with obesity, tobacco, and
11 then infectious disease prevention and perhaps infant
12 mortality, at the end of the day if we have counties
13 that are splitting between themselves hopping over,
14 okay, providing services, doing infectious disease
15 control and the county in between is an island in and of
16 itself or a city that's an island that's in and of
17 itself, do we actually improve, do we have the
18 opportunity to actually improve the delivery and the
19 effectiveness of the system?

20 We may improve the value and perhaps we
21 might improve the efficiency, perhaps, I don't know
22 about that, but just think about that. I understand the
23 flexibility, but I think it's always good just to pause,
24 and say, wow, how is that going to look?

25 Because I can tell you in the case of the

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1 solid waste district I was actually in Clermont County
2 at the time that happened and we really -- when that
3 decision was made was if you look at how solid waste
4 districts are funded then these counties or
5 jurisdictions that have the landfill have the fees, and
6 I don't want to speak for anybody in that situation, but
7 there's a landfill in Brown County and there wasn't one
8 in Clermont, and there wasn't one in Adams.

9 So it made a lot more sense that all three
10 of them would have gotten together, because it's all
11 about the same thing, reduce, reuse and recycle, right,
12 eliminate the need to dispose, landfills, but there was
13 one entity that had a good funding stream and it stayed
14 that way.

15 And I think that's been problematic for the
16 legislature at times throughout the state. I know that
17 that's come up in northeastern Ohio where you have four
18 or five county health -- or solid waste districts.

19 So just there is some things out there right
20 now that's already happened that kind of we're going
21 down that path, it's a whole different purpose and one I
22 would tell you that has equal worry and perhaps greater
23 importance of the outcome.

24 COMMISSIONER FOUGHT: Mr. Chairman, to
25 respond to that, and I would agree that people, or if

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1 they're not contiguous entities, that might want to
2 consolidate or collaborate or whatever, they do have to
3 look at that, but I think the importance today, because
4 of the funding, which we haven't touched on yet, Mr.
5 Chairman, I know, but because of the funding and the
6 fact that we were overly reliant on local funding, we
7 have to provide local districts the ability to make the
8 decisions that best suit them.

9 So by eliminating some of these barriers,
10 which could be barriers, and, again, they may not choose
11 to do it after they review it, Tim, they may come back
12 and be like, nope, we don't want to do it, but for the
13 option to be there for them I think is critical.

14 That would just be where I would stand on it
15 and I think all of those barriers that we have we
16 definitely need to eliminate so that we give people more
17 choices, and then leave it up to them to make that
18 decision, because, again, it's a local decision.

19 DR. MCFADDEN: I think some of the issues
20 that we have talked about, why there's a benefit for
21 consolidating or collaborating I think are still
22 addressed by having non-contiguous, if we're talking
23 about capacity, work-force, that sort of thing. I mean,
24 I think non-contiguous addresses those.

25 I think that to your point I mean that's a

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1 different issue than we've ever discussed here as far as
2 improving public health through increasing scale is
3 having, you know, locations that are, you know, in close
4 proximity, working together in a more formal way, and I
5 think we have had that discussion.

6 But it seems to me that most of our
7 discussions around the number of a hundred thousand or
8 whatever number you put out has been about capacity,
9 which I think is addressed whether or not we share a
10 border or not.

11 You know, certainly, yes, there are
12 confusing pieces if you're not contiguous, but if the
13 middle partner doesn't want to play should the whole
14 thing be thrown out, because there's one group of people
15 that doesn't want to play.

16 And I guess I would say if we believe that
17 bigger is better, which I'm not going to necessarily say
18 that coming from a smaller, but if we believe that then
19 -- then I think non-contiguous makes sense.

20 COMMISSIONER SCOFIELD: Mr. Chairman, just
21 -- I just want to kind of chime in and it could be just
22 my experience in Cuyahoga County and surrounding
23 counties. The non-contiguous from a process and
24 operational perspective just doesn't make any sense to
25 me. So I'm just going to chime in on that and leave it

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1 there, but I look forward to maybe some additional
2 conversations, because it doesn't make sense.

3 CHAIRMAN BURKE: No, I agree, it's something
4 that's come up. I don't know what case it fits into,
5 but I do know even if you found a case it fit into, it's
6 currently not allowed, so I don't know if it benefits.
7 We've got an additional meeting or so to kick it around,
8 but I understand what you're saying.

9 Okay. Anybody else have any ideas of shared
10 services?

11 MR. TREMMEL: Mr. Chairman, let me just go
12 back to wrap up Jennifer's example, because I was trying
13 to pull from where that was and Beth reminded me.

14 In Lorain County we have the Lorain County
15 Health Department, we have the Lorain City Health
16 Department, and we have the Elyria Health Department.
17 We have a unique set of circumstances where the Elyria
18 City Health Commissioner is also now this part-time --
19 part-time Lorain City Health Commissioner, but they're
20 not contiguous jurisdictions.

21 COMMISSIONER SHAPIRO: They have a contract.

22 COMMISSIONER SCOFIELD: But they're within
23 the same county. I guess I was looking at it that that
24 to me makes them contiguous, but I don't know.

25 COMMISSIONER FOUGHT: Yeah, not necessarily,

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1 they're not land contiguous, but they're in the same
2 county, but they wouldn't be land contiguous, that's the
3 whole issue.

4 COMMISSIONER NIXON: I can think of examples
5 in northeast Ohio where non-contiguous cities may take
6 advantage of another county -- out in another county and
7 this might likely happen, if this were to actually be
8 enacted and for the right reasons, you know, I think
9 that there's decisions made on both sides of the health
10 department that's contracting and it's the other county
11 then has to decide is this in the best interest of
12 everybody, and it may be, I think it could potentially
13 work.

14 I really respect what Tim said, I think what
15 Tim said makes a lot of sense and Jennifer makes a good
16 point, although I think it could happen.

17 So to Heidi's point, I think our job is
18 trying to reduce the barriers, whatever they may be, and
19 I think if everybody's making the decision for the right
20 reason then why have the barrier, you know, I think
21 that's what we're here for and we ought to reduce those
22 barriers.

23 We'll always come up with a reason why it's
24 a monster, consequences, but, you know, I think these
25 are all people working --

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1 COMMISSIONER SCOFIELD: Just a point of
2 clarification, so just in your example, Garfield Heights
3 might contract with Portage County?

4 COMMISSIONER NIXON: Right.

5 COMMISSIONER SCOFIELD: That doesn't make
6 any sense, but okay. I just think there's so many
7 different needs and there's different leadership so, you
8 know, I'm just trying to clarify in my own head what you
9 were talking about.

10 I was thinking three cities within one
11 county would not be non-contiguous in my head, so I'm
12 glad I'm getting clarification.

13 COMMISSIONER NIXON: Garfield could find
14 that they're looking for a heightened quality of public
15 health services and Cuyahoga just is not delivering it,
16 and yet Portage County has got the best public health
17 system in the state and they're really looking at
18 enhanced services and want to go with the best that they
19 can, but under the current law they can't, they're stuck
20 with Cuyahoga County or their own health department,
21 which they frankly can't afford, that doesn't exist
22 really, but --

23 VICE PRESS: Thank you, Mr. Chairman, trying
24 to get maybe some clarity through example. So if I'm a
25 local health district someplace and I think I want to

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1 have a cooperative arrangement for health educators in
2 one place and maybe somebody else is doing my payroll
3 and somebody else is doing my epi, I could have a
4 relationship with three counties, right?

5 COMMISSIONER SHAPIRO: Uh-huh.

6 VICE-CHAIRMAN PRESS: Three other districts,
7 and I could decide I want the best of -- why would we
8 want to be in the way -- why would we want to be in the
9 way?

10 I mean I hear what you're saying, that
11 doesn't make any sense on the surface, but maybe it'll
12 make sense later when money is scarcer or people are
13 scarcer or problems are worse. I guess I'm --

14 CHAIRMAN BURKE: Just throwing out the
15 example too, Chris, on your line, telemedicine, what
16 happens if technology gets to the point where you do
17 want to engage, and you need a physician or a nurse
18 practitioner, maybe she's in Portage County and you're
19 in Allen County, there's no -- I mean that stuff is here
20 already, but you wouldn't be allowed to do that, if you
21 want to -- I mean that's just throwing out an example.

22 VICE-CHAIRMAN PRESS: Could you not share
23 services with -- you know, Commissioner Nixon's comment,
24 if a local health department would contract with an FQHC
25 for health education, right, nothing stops them from

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1 doing that if we wanted to.

2 COMMISSIONER INGRAM: I'm all for
3 eliminating barriers, I just want to throw in the other
4 side of the equation just so we're thinking it all
5 through.

6 So let me give you another example, that if,
7 in fact, this would get into statute, and counties and
8 cities that are not touching each other could cross
9 borders, I could see a scenario developing right now
10 where we would be looking for a population to serve and
11 we would go to that other community, because there's an
12 opportunity to bring grant dollars into that community,
13 which currently are not in our jurisdiction to say, hey,
14 we really need this population, because there's X amount
15 of dollars.

16 We've got the expertise in perhaps health
17 promotion and education, would you be willing to sign an
18 assignment with us so we could pit service out there and
19 include that population in our grant? I'm not saying
20 anything is wrong with that, I'm just putting out the
21 scenario.

22 MR. TREMMEL: Mr. Chairman, now while I
23 haven't thought this through much, for ten second,
24 imagine a scenario though where we deal with public
25 health hot spots, let's take the heroin addiction piece,

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1 again, let's take obesity, let's take tobacco, but let's
2 go back to the heroin piece at least momentarily.

3 If we can find dollars available to the
4 public health system for this particular issue why
5 wouldn't we want to figure out a means or mechanism,
6 even if the state -- for whatever the reason the state
7 is not eligible, the state applied unsuccessfully, the
8 wrong state entity is part of the process, why would we
9 not want to at least allow the opportunity for a
10 regional approach, a collaborative approach to secure
11 those dollars for a hot spot initiative on heroin, it
12 could be as much in Hancock as it is in Cuyahoga or
13 Cleveland?

14 COMMISSIONER SCOFIELD: Yeah, I guess I was
15 thinking about this differently, that's all. I'm
16 thinking about restaurant inspections, you know, someone
17 from the county board of health going up to Sandusky or
18 Toledo, logistically in my head that didn't make any
19 sense.

20 I'm thinking there must be a more
21 operationally efficient way of doing that versus that
22 kind of set up.

23 What you're talking about with the hot spots
24 for heroin, increased deaths, that I understand more
25 than, you know, or Cuyahoga County providing I.T. and

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1 website development for Geauga County makes more sense
2 than what I had in my head about what we are talking
3 about before.

4 So I'm better, I mean, I get more of what
5 you're saying, but --

6 MR. TREMMEL: So let me take that in a
7 couple for reiterations. Let's take I.T. for example,
8 because was it, Heidi, did you mention I.T. earlier?

9 COMMISSIONER FOUGHT: I think somebody over
10 there did.

11 MR. TREMMEL: Was it the Chairman, I'm
12 sorry, my apologies, Mr. Chairman. But so from an I.T.
13 perspective we could have a regional -- maybe I guess an
14 ESC approach. So if we use the ESC model, and I
15 wouldn't necessarily -- I like the ESC model in that it
16 serves as an opportunity for public health to do
17 something similar, so that public health systems should
18 look at the ESC model.

19 And, for example, ESC models are very good
20 and beneficial and worthwhile, especially in areas like
21 I.T. or specialty services for children.

22 So for I.T. couldn't there be a hub, a
23 regional hub where these collaborative approach of
24 servers, the systems, the data base, the software,
25 everybody has to buy Microsoft, correct, then why can't

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1 we use a hub for which to do it? So that would be one
2 opportunity.

3 Now, let's take another iteration and see,
4 it's a little more controversial, so stick with me,
5 Commissioner Edwards.

6 So now we take an approach for H.R., these
7 folks all need to hire folks, they all need to work
8 through personnel issues, for sure there's differences
9 in the employee environments as it relates to collective
10 bargaining, et cetera, but why couldn't there be a
11 regional approach, a collaborative approach, so that
12 we're dealing with these things, even collective
13 bargaining, different contracts, we're using a regional
14 approach and ESC model to deal with these kinds of
15 things at the hub.

16 There could be a regional hub that deals
17 with H.R., hiring is the same in general, you have to
18 follow the county rules, but I would qualify that to say
19 the county public health system, unless the county
20 governance had a trump, so I just put that out for
21 further thought.

22 The Health Commissioners Association has
23 taken these recommendations and kind of widdled them
24 down into a little bit more detail.

25 Next reiteration, what about auditor,

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1 treasurer? Is there real value and purpose in
2 continuing the auditor, treasurer role in that these
3 local health districts who are going out for levy
4 dollars, significant amounts of dollars, could take an
5 ESC like approach to their auditor, treasurer type of
6 roles and alternatively look at, not a three letter word
7 you might like, but a cog for which to do that?

8 And if you take that opportunity for those
9 kinds of things it brings some potential for dollars
10 that local health districts wouldn't yet see, they
11 currently do not see and that's that interest on the
12 levy.

13 See, this is a contentious thing. The local
14 health district does its best, goodwill efforts to
15 secure a levy for which the population can give a thumbs
16 up or down.

17 Such investigation, such interest of those
18 dollars stay within the county government, but there's a
19 quid pro quo, because the county government can say,
20 yes, but you either have housing, you have access to
21 your payroll systems through our databases that we
22 maintain, access to the records for your billables,
23 accounts receivable and payable, and you have access to
24 prosecutor fees and et cetera, but if we really want to
25 think businesslike, as so much large corporations would,

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1 why couldn't we do this in a regional approach, and say,
2 I'm getting a really good deal here, this county or this
3 structure gives me all the best.

4 Take the interest on my money, I know what
5 I'm paying for, H.R., I know what I'm paying for
6 payroll, I know what I'm paying for all the bill paying
7 services, et cetera, and give back to the counties all
8 the where with all that says if you want these things
9 they're not free anymore, you have to pay for them, and
10 the interest on your money goes to you, but quid pro quo
11 is you have to pay for those things accordingly.

12 So, again, a lot of things, but it's been
13 asked and answered, and it kind of remains the elephant
14 in the room sometimes we're reluctant to approach.

15 COMMISSIONER EDWARDS: Boy, you talk about
16 me being -- you open a door.

17 COMMISSIONER FOUGHT: Mr. Chairman, I
18 actually like that approach, and I say that because if
19 they get their interest then maybe our townships would
20 get their interest on their money, so that would be
21 helpful.

22 However, I'm just kidding, but -- kind of,
23 but in all seriousness the cog approach, I mean, if we
24 allow this for other entities, which we use cogs for
25 many things in this state, whether you like them or you

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1 don't like them, that's a personal decision, but in
2 terms of the efficiencies that it has provided in
3 certain areas from 911 to purchasing down in Hamilton
4 County. There's a great cog down there in Hamilton
5 County that's been great or worked very well for folks.

6 Again, if it's an option that they could --
7 could use to save money or be more efficient, why
8 wouldn't we give them that option.

9 It's not to say that they're all going to do
10 it, because maybe, Gene, you're not going to do it,
11 because you guys are pretty good the way you are, but
12 allowing D.J. and his surrounding counties to form it
13 would make sense.

14 I think, again, we are looking at things
15 from an option standpoint and removing barriers and this
16 provides an option and removes barrier at the same time.

17 COMMISSIONER SHAPIRO: So in addition to the
18 cog format and the jurisdictions that are large enough
19 and have the sophistication to handle it, to also have
20 fiscal independence, so the issue of being able to do
21 our -- manage our own money, similar to school
22 districts, we are a health district, we are our own
23 being, political subdivision, and so in addition to
24 maybe having joint collaboration, but also giving us the
25 authority to do that ourselves.

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1 COMMISSIONER EDWARDS: Mr. Chair, you look
2 like you have a really big headache right now.

3 CHAIRMAN BURKE: When you collect taxpayer
4 dollars and use a lot grant dollars, just thinking in
5 terms of accountability and where that ends up
6 ultimately, and I do like the at least arms distance
7 that occurs in an auditor, treasurer relationship.

8 Whether that auditor, treasurer is in your
9 county or not you still have an elected official that is
10 accountable to the people that sent him to that position
11 to be accounting, you know what I mean, for a third
12 party, Heidi, in this case the health district for those
13 funds and I think it becomes -- and I'm not saying this
14 would occur, fox, you know, in the hen house kind of
15 scenario.

16 But you see in township, county government,
17 some other kinds of government people take money and I
18 think when you've got nebulous things going on kind of
19 opens it up to, you know, what's -- here's a bottle of
20 vaccine for you, go ahead and do what you need to do, or
21 this is outdate, you can go ahead and have this at your
22 health district, and who's going to know, nobody is
23 going to know, and that just gives me pause as an
24 elected official. You know, I understand that.

25 COMMISSIONER SHAPIRO: I think those are the

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1 same safeguards that are in place now with school
2 districts that accept federal funds, there's auditing
3 requirements, there's safeguards in place.

4 You're always going to have those people,
5 whether they're in the private sector or the public
6 sector --

7 CHAIRMAN BURKE: But just the school board
8 has an elected board, the health district doesn't have
9 an elected board, there's no elected officials there.

10 COMMISSIONER INGRAM: I think that probably
11 becomes the crux of the question.

12 COMMISSIONER EDWARDS: Senator, okay, so if
13 you're talking about a cog, we already have something in
14 place now where we have shared services, we can do that,
15 we don't need a cog, and if we're talking about
16 lessening government or lessening all these departments
17 and districts then why are we creating more? That makes
18 no sense to me.

19 With that said, okay, now, you're saying
20 that whatever county can contract, can pull all of their
21 dollars out and contract with someone else, with another
22 county or a city or whatever, who's going to -- who's
23 going to approve to put their levy on a ballot, and if
24 the county commissioners, I'm thinking, that if those
25 health districts are willing to pay for their space, are

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1 willing to pay for their services, I'm not sure where --
2 I'd have to think it through a little thicker, but I'm
3 not sure where counties would have a problem with that.

4 But then that makes the health department
5 responsible, you're responsible for your insurances,
6 your liability, you're taking the whole ball of wax.

7 CHAIRMAN BURKE: Yeah, I agree.

8 COMMISSIONER EDWARDS: You're not going to
9 leave us holding the bag like we usually are.

10 CHAIRMAN BURKE: I agree.

11 COMMISSIONER INGRAM: You know, this is that
12 question that always, you know, when we started getting
13 into the structure, this is really what we're getting
14 to, you know, size, composition; how do we make it
15 better, improve the capacity, performance?

16 You can't do this -- I don't think you can
17 do this without bringing in funding, because the truth
18 of the matter is they're tied together, and, you know, I
19 mean, I think we can't do them separately. I think we
20 have to talk almost -- I mean I know that's probably
21 next on the list, but --

22 CHAIRMAN BURKE: It is, okay, to merge them
23 together, if you'd like, and some of them will be
24 individual items outside of this scope, but there's
25 going to overlap.

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1 COMMISSIONER INGRAM: Because, you know,
2 what we're trying to say -- I think what we're trying to
3 say is that the way we are funded today is not -- it's
4 pretty broken up and predominately by local fees, or
5 kind of had that analysis, there's no state support.

6 We're really on our own, and just like that
7 old saying, you get the best public health system you're
8 willing to pay for. The questions is, what are you
9 willing to pay for; what are you going to get in the
10 end, and I get that part.

11 So we're getting to that outcome side, would
12 settle on accreditation standards and a system to assure
13 accountability and reporting I think would help in that
14 area, let me put it that way, but you're not going to be
15 able to get all of these other services that are needed
16 that are recommended in ESC reporting without some type
17 of funding, sustainable funding, at a level that makes a
18 little bit more sense than being in the bottom tier of
19 the country.

20 So I think when you talk structure, cogs,
21 governance, you have to bring in funding in that same
22 space.

23 CHAIRMAN BURKE: We're going to touch on
24 funding in a little bit, I guess, and Marty talked a
25 little bit about hot spots. Let's go through different

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1 scenarios, no change in funding, do you allocate then on
2 a per capita basis or you start addressing hot spots and
3 issues?

4 And I go back to the Delaware County
5 conversation we had a couple of meetings ago. How would
6 you recommend to the state then with the same amount of
7 resources, we allocate those same amount of resources in
8 the next budget?

9 COMMISSIONER NIXON: I mean there's nothing
10 to allocate, I mean that's where we're at today.

11 CHAIRMAN BURKE: \$27 a head?

12 COMMISSIONER NIXON: No, like 27 cents, 17
13 cents, so a lot of health departments say, keep it, so
14 it doesn't drive anything in the system right now and
15 that's part of it.

16 DR. MCFADDEN: That's why I've been saying
17 if you give us the money we will dance to the tune, but
18 -- that 16 cents is kind of hard for me to dance.

19 COMMISSIONER EDWARDS: Can't even tie the
20 shoe strings.

21 REPRESENTATIVE ANTONIO: What is that, per
22 capita?

23 COMMISSIONER SHAPIRO: Yeah, is it 16?

24 DR. MCFADDEN: It's 16, 17.

25 MR. TREMMEL: It's 2.3 million of GRF less

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1 some overhead for the Ohio Department of Health passed
2 out to a hundred and twenty-five health departments
3 based on their population, and it amounts to, in some
4 cases, as little as a thousand dollars to the larger
5 health districts, Cuyahoga might be twenty-some
6 thousand, may be more than that.

7 COMMISSIONER NIXON: No, no, we get 80.

8 COMMISSIONER INGRAM: They're probably
9 getting close to a hundred, because we're getting almost
10 90.

11 COMMISSIONER SHAPIRO: We're getting 26.

12 COMMISSIONER EDWARDS: We're getting 11.

13 MR. TREMMEL: But a hundred thousand is the
14 highest population, this is an FTE with benefits, that's
15 -- Delaware is not that.

16 COMMISSIONER SHAPIRO: No, it's not.

17 COMMISSIONER SCOFIELD: I want to ask a
18 question about that. Do we know for those state health
19 departments or those statewide public health systems, do
20 we know how they fund local --

21 COMMISSIONER NIXON: You mean other states?

22 COMMISSIONER SCOFIELD: Yeah, so can we do
23 some benchmarking around this to see kind of where we
24 might consider going or --

25 COMMISSIONER NIXON: D.J. is right, Ohio is

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1 about at the bottom of state support. Now, that said, I
2 think if you look broadly at the funding for local
3 health departments, local health departments aren't
4 badly funded in Ohio overall, but they -- it's just
5 disproportionate.

6 MR. TREMMEL: The shift of the public health
7 system and the investment of dollars is at the local
8 level, we recognize that. I'm not speaking ill of it,
9 I'm just saying that's where we --

10 COMMISSIONER SCOFIELD: Just to finish up,
11 that might be something useful for the next meeting just
12 to have half a dozen other states saying they -- just
13 for some comparison.

14 COMMISSIONER INGRAM: There's the NACCHO,
15 National Association of City and County Health Officials
16 just did a 2010 or 2011 report that just came out on
17 funding structure of health districts across the
18 country. I think they looked at almost 1,800 or 2,000.

19 You know, the thing you've got to remember
20 and we talked about is that this really goes to a bigger
21 question. I don't think it's in front of us, but you
22 know you have centralized systems, you've got hybrid
23 systems, we've got decentralized system.

24 We have a decentralized public health system
25 and so you really have to keep them in that context.

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1 You know where Florida and Virginia are centralized,
2 Kentucky is a hybrid, Indiana is decentralized and so
3 forth, so you've got to keep that all in context.

4 COMMISSIONER SCOFIELD: Maybe we can learn
5 from some of those better performing states what that
6 combination or what that can look like and is there an
7 opportunity to make some of those improvements here. I
8 think that would be part of this.

9 DR. MCFADDEN: Question, are you asking at
10 what level they're funding or are you asking what the
11 source of the funding is, if it's excise tax or tobacco
12 money or --

13 COMMISSIONER SCOFIELD: Probably both. I
14 guess my bottom line is of those -- what is the role of
15 state health departments or health and mental hygiene
16 departments like in Maryland; what is their role in
17 this?

18 If they fund local health departments how do
19 they do it and is it per capita; is it a dollar per
20 capita; is it \$10; you know, what does that look like?

21 And then the other part of that matrix is
22 how well are they performing; is that a system that
23 seems to be working and can we look at parts of all of
24 that to try to make some recommendations for how Ohio
25 does it?

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1 CHAIRMAN BURKE: Tell you what, we're close
2 enough here to 2:30, if we could just take a five or ten
3 minute break. We'll go into recess, allow folks to take
4 a break, and then slug it out until 4:00.

5 (OFF THE RECORD.)

6 (BACK ON THE RECORD.)

7 CHAIRMAN BURKE: Call the meeting back to
8 order. We'll continue through to about 4:00, and then
9 make a couple of closing comments. One of which would
10 be a reiteration of what we've talked about along with
11 how we will communicate in the future, and some of the
12 information that I expect us to have electronically to
13 review as well.

14 With that being said, we touched a little
15 bit on funding and we can talk a little bit more about
16 funding and just reveal the dynamic amount that the
17 state puts in.

18 A little bit of review here, Joe, I think
19 you might have something from Nebraska for us to review,
20 so if you want to walk the commission -- I'm sorry.

21 DR. MCFADDEN: No, that's fine. I had
22 mentioned three or four meetings ago a suggestion of one
23 of the ways we could do it and so Nebraska is the model
24 that I was using when I looked at it.

25 I talked with folks from Kansas and

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1 Nebraska, Tom DePaul (Phonetically Spelled) I think is
2 his name who is the administrator for the State of
3 Nebraska.

4 So what they did, they did a huge revision,
5 I believe it was 2003 in their health care system,
6 public health in Nebraska, and basically what they said
7 is we have a pot of money, which they're using the
8 tobacco settlement money, which will eventually go
9 away.

10 But they took the tobacco settlement money
11 and they said we're going to send this down to local
12 jurisdictions. We send it down, you report, this is
13 their report, each year you have to report how you met
14 our standards, and so this is the report that they have
15 that this goes back.

16 But two requirements that they had, one, you
17 had to meet -- or three requirements.

18 One, you had to continue to meet the
19 standards they put forward, which are not as robust as
20 our standards, but their standards are more based on
21 outcomes; two, you have to have at least three
22 jurisdictions that agree to work together; and, three,
23 those three jurisdictions have to have at least 30,000
24 people.

25 There are counties that have less than 5,000

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1 people in Nebraska, I think, that's why they had to have
2 that, but their funding -- the question was about
3 funding and their funding is from the tobacco
4 settlement, that's the only one that I know in this
5 well.

6 But I think other states, we can look for
7 that data to your question, Jennifer, about how they are
8 funded.

9 CHAIRMAN BURKE: Again, and as we look at
10 funding from a budgetary standpoint there's probably
11 huge and varied ways to do it.

12 One is, of course, to take money from
13 somebody else, that's always an up-hill battle, good
14 luck; and the second is, of course, to identify yet
15 unused or unknown revenue streams, and that can be
16 through taxes, through fees, through other kinds on
17 promulgations where we find new revenue. Could be
18 growth in the economy or a new sector, there's different
19 ways to do it.

20 So with that being said, as I started the
21 conversation, if you were to allocate additional funds,
22 not knowing what that number is, because if you were to
23 allocate additional funds how would you do that?

24 Would you continue on a per capita type
25 equation or would you identify hot spots and

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1 deficiencies that you would address?

2 COMMISSIONER SHAPIRO: Or a combination of
3 the two.

4 CHAIRMAN BURKE: Or a combination of the
5 two.

6 COMMISSIONER THRELFALL: Where are you
7 getting these funds to allocate?

8 CHAIRMAN BURKE: Don't know, we can get into
9 that conversation. You've got permissive things that
10 the state can do with levies on property. It has
11 certain sin taxes that it could look at tobacco,
12 alcohol, et cetera.

13 COMMISSIONER THRELFALL: Did you say levies
14 on property?

15 CHAIRMAN BURKE: Millage issues, it could be
16 allowed, it could be allowed. I'm not saying we do
17 this, I'm just saying if you were to identify funding
18 streams, that could be a funding stream, but I don't
19 know if anybody has a preference for funding streams
20 before we get into expenditures; do we make
21 recommendations?

22 COMMISSIONER NIXON: Well, I don't really
23 have a preference, but are we willing to say that there
24 should be a fundamental shift in the funding burden from
25 local health departments from local to state?

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1 I mean I think that's fundamental before --
2 as we think about where that funding source should come
3 from, if there's a sin tax that's more of a state
4 collected amount, if it's millage, that's local. So I
5 don't know if we're ready, but I think that question --
6 begs that question.

7 CHAIRMAN BURKE: Well, let me just ask you,
8 are you talking about then well the collection of fees
9 that you currently get would come back up to the state,
10 and the state would then fund your health department or
11 you're talking about keeping what you have in the state
12 and the state has more?

13 COMMISSIONER NIXON: The state has more.

14 CHAIRMAN BURKE: So how then, if every
15 health district is doing everything to the best of its
16 ability and there's no need to merge and a hundred and
17 twenty-five is the magic number and the life in
18 government continues, then what am I paying for?

19 COMMISSIONER NIXON: And I think that goes
20 back to our conversation about verifiable minimum
21 standards. We have to demonstrate that, and it goes to
22 process and outcomes that we're measuring.

23 CHAIRMAN BURKE: Does anybody have any
24 thoughts, it's a pretty broad topic?

25 COMMISSIONER PRESS: Most of you have some

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1 association with some folks who are appointed by
2 political folks and all that and I don't, I'm an amateur
3 of political science here, I'm less of an amateur of
4 economics and my question is just where is the money
5 going to come from?

6 The federal government is broke and the
7 state government doesn't have a whole lot of money.
8 It's just a blessing that you're locally funded, because
9 you're closer to your funding source than a lot of folks
10 and your ability to make your case locally and earn
11 their trust is a lot better situation to be in than
12 being several areas removed.

13 We can say we want to put money in the
14 system, and just struggling to understand how.

15 The federal government is spending a
16 trillion dollars a year more than it was five years ago,
17 I'm not making a political statement, it's a fact
18 statement, almost 40 cents of every dollar.

19 So to think somebody out there is going to
20 have money or think we'll be insulated or immunized
21 against the consequences of that, I have a hard time
22 getting to that conclusion personally.

23 COMMISSIONER NIXON: I'm sorry, I don't want
24 to dominate, the -- economically, I think for us
25 nationally and for the state to continue to pour money

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1 into health care and Medicaid reform and so forth
2 without a wellness side is actually going to cause a
3 decrease in cost is ludicrous.

4 I think we have to create some wellness
5 component in that as Medicaid reform moves forward I
6 think to create a linkage with public health that can
7 connect the dots and ensure that there is a wellness
8 piece in all of this that mental health is connected to
9 the health care system, which is connected to the social
10 system and the health department is going to bill for
11 that to help support that capacity, and overall we think
12 that this model will improve the wellness of the
13 community, decrease the health care cost then there is
14 money.

15 Okay. If we are going to just invest all of
16 our money into billing for a health care independent
17 wellness system then we're going to have to continue to
18 find the money to pay for health care.

19 I think in our wisdom we ought to have a
20 wellness piece with local health departments playing
21 that in partnership with the state providing that
22 wellness part.

23 COMMISSIONER PRESS: So I agree with you,
24 but I'm not sure how the money flows, Gene, and here's
25 kind of why I say that.

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1 If Medicaid -- let me say it this way, the
2 more programs like Medicaid go capitated the more
3 incentives exist to take part of that premium dollar,
4 part of that capitated dollar and deploy against
5 wellness, why, because it reduces the bill for medical
6 loss, which means the capitation rate gives more
7 flexibility to either lower the rate, do different
8 things, reduce medical loss so the rational person in
9 that situation, the rational organization in that
10 situation would say, hum, getting capitated on Medicaid,
11 I have two ways that I can deploy that money.

12 I can buy care, buy treatment, services,
13 probably going to have to do that at some level, right,
14 or/and I can also say, you know, if we can get these
15 moms to full gestation we save a lot of money, if we can
16 get those folks to figure other outcomes, have less
17 weight, not have gestational diabetes, gestational
18 hypertension, all those things that are co-morbidities
19 that cost a lot of money, then I would hope, like you
20 do, that folks would say, well, that's not necessarily
21 something that happens in the doctor's office, that
22 could be a public health solution, but the money would
23 come in the duration.

24 If the money is already, if you will, in the
25 system it just hasn't found its way to where it belongs

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1 yet and only time and pressure will find that out.

2 COMMISSIONER NIXON: Well, and I think if we
3 create some enabling legislation that names public
4 health care in the Medicaid reform package that allows
5 the health department to bill for some of these services
6 then that can help support that, so --

7 CHAIRMAN BURKE: Help inform me about
8 health, what goes on; can you bill insurance; are you
9 credentialed to bill insurance for your services? Some
10 cities, for example, do soft billings on ambulance
11 pick-ups, why can't you do that; what hinders you from
12 seeking those soft billing kind of things?

13 COMMISSIONER NIXON: Well, part of it's the
14 variety of insurers out there, the number of insurers
15 out there that you need to have a relationship with, and
16 the scope of our services don't always create -- make us
17 eligible to be a full partner in some of that. Can you
18 help me out here; have you done some of this?

19 We do some billing, but it's very limited
20 and it's limited typically to clinical for things like
21 shots, so we can bill for some shots, some of the care
22 management activities and some of the wrap-arounds.

23 COMMISSIONER SCOFIELD: My example of that
24 is can you bill for newborn visits or could you?

25 COMMISSIONER INGRAM: Well, potentially

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1 depending on if we have a contract with Medicaid managed
2 care system or what have you.

3 I think it really begs the question, I think
4 Gene is really on the point and where you're going
5 that's a paradigm shift, Senator, that's difficult to
6 think of.

7 Chris talked about it earlier, what all that
8 is, we have a sickness system. We really do, and we
9 have a lot of morbidity among Ohioans, and so there's a
10 lot of treatment needs and the systems are doing things
11 to be able to address that and businesses are crying for
12 better value and the systems are saying they want better
13 care, but overall we need better health, and that's the
14 population piece, and to do that you've got to fix those
15 two or at least address those two.

16 And at the same time you have to get up
17 stream and start talking about the wellness system, and
18 if you take that dollar that's being spent on the
19 sickness system and say what piece of that is actually
20 going towards prevention or wellness, it's very small, I
21 forget what the number is.

22 COMMISSIONER NIXON: Four cents.

23 COMMISSIONER INGRAM: So it's a paradigm
24 shift, to say we're going to bet on this, the risk,
25 because prevention is something like you can't just walk

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1 in get a shot, you know, vaccination, you know,
2 sometimes you have to change, you know, certain
3 behaviors and so forth, and that takes time.

4 So I think that becomes the question, and
5 just build off that and that's a paradigm shift that you
6 brought up something, Senator, that I thought was really
7 like, yeah, that's those cigarillos.

8 You know, if you look at the chronic disease
9 side, okay, we chase a lot of chronic disease at the
10 local public health level, as well as the state level,
11 and if you just took tobacco and tobacco related
12 diseases, and obesity and obesity related disease,
13 whichever one you want to pick or both, there's probably
14 an opportunity there to look at that relative to a
15 funding stream.

16 Because in the past the general health
17 district, and I think I kind of went through this, the
18 way we're funded makes really no sense to what kind of
19 health outcome we need, it's based on millage, it's
20 based on valuation of a township or a city.

21 So I mean that's just the what they came up
22 with it 40, 50, 60 years ago or more, but today it just
23 -- and I've already said this, you take -- you know, I
24 just took two townships, I took one that's, you know,
25 has a lot of opportunity, jobs, a lot of commercial and

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1 industrial base, nice subdivisions, if you will, versus
2 one that's perhaps more -- doesn't have that base.

3 We'll quite frankly they'll give us just a
4 few thousand dollars as part of our budget versus the
5 other one that might give us tens of thousands of
6 dollars.

7 I'll spend five times, five more times --
8 five times in that poor township, that township giving
9 us less money than the one that's better developed.

10 There's no rhyme or reason to it as far as
11 based on need, other than the issue that there's just
12 not -- perhaps they don't have the industrial base or
13 commercial base that that other township or city might.

14 So I'm not sure what my point is in telling
15 you that, but to make you aware that that exists,
16 doesn't seem like the way we should be going forward.

17 COMMISSIONER FOUGHT: Well, to build on that
18 in that example that you gave, Tim, the idea that that
19 poorer township doesn't have the money to give more to
20 the health board to do the services that they're
21 providing more of in that specific township.

22 So based on the current model of funding
23 that we have, it doesn't work, period, and, furthermore,
24 and I'll say this, again, with respect to the loss of
25 funds that political subdivisions are experiencing over

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1 the last two years it even further exacerbates the
2 problem, because that money is coming out of their
3 general fund and those general funds are, you know,
4 lower, thus they don't have more money to help.

5 And so when we are reliant on the local
6 funding stream, which I agree, having local, close to
7 the people, we're all about that in townships, that's
8 great, but the problem is we just don't have the money
9 to further expand the services that are needed. So I
10 mean it just adds to the issue of lack of funding.

11 COMMISSIONER EDWARDS: Senator, maybe that's
12 an opportunity here, I don't want to kick the can down
13 the road, but maybe that's where we can suggest to the
14 legislature a committee to do this, to look at the
15 funding streams and some of the things that Martin
16 brought up earlier.

17 CHAIRMAN BURKE: It's an option.

18 COMMISSIONER EDWARDS: I mean we don't have
19 enough time to figure that out here, we just flat out
20 don't.

21 COMMISSIONER PRESS: My comment is to
22 piggyback Heidi's, was simply going to be creating the
23 flexibility to reduce operating costs is one way to
24 liberate resources for programming. So that's why I
25 think the flexibility is not independent of the

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1 discussion we're having here.

2 Two ways to create money, save it, spend
3 less, get more efficient, get leaner, stop doing some
4 things, redeploy, the Senator's point, I guess.

5 DR. MCFADDEN: I would love to see us have
6 multiple streams of funding, rather than relying on just
7 one.

8 I think that our local stream of funding is
9 important in that it ties us in a way to our local
10 communities, and we have conversations with our local
11 folks in a different way, I think, because of some of
12 that.

13 I think, you know, we have the only free,
14 essentially, clinic. We provide a free clinic in our
15 community and we went to \$5 co-pays for those that are
16 at zero percent, why, because tobacco is the No. 1 cause
17 of problems that we see in that population and \$5 is a
18 pack of cigarettes.

19 And when I look at what drives so much of
20 our chronic disease, very -- a large part of it is
21 decisions that we make.

22 I certainly think that we -- we're in a
23 society that's free and people have a right to make
24 decisions, however, I sometimes -- I get a little
25 frustrated with the fact that the decisions that I make

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1 I expect someone else to pay for, and when we look at
2 the cost of tobacco to the state not alone -- not to the
3 insurance companies in general, but just to the State of
4 Ohio, it's a significant number.

5 And so when I think of ways to generate
6 money for public health I would love to have us
7 encourage folks to be living healthier and certainly we
8 can ask physicians to be having those conversations with
9 their patients, and I think most of them do, if not all,
10 and we could ask hospital systems to be engaged in that
11 and I think almost all hospital systems are active on
12 discharge trying to get people to stop smoking, but I
13 think that there's a policy piece that the literature
14 has demonstrated that does, you know, at least for
15 teenagers potentially, depending on how much you do,
16 impacts adults as well.

17 By increasing the excise tax or sales tax or
18 tax period on cigarettes or cigarillos or chewing
19 tobacco or whatever, you drive people to make decisions
20 that often is in their best interest health-wise.

21 So for me I feel that is a model that I
22 think public health should be able to get behind where
23 we're encouraging people to live healthier and through
24 that encouragement we're also funding the system, and to
25 me that makes lot of sense.

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1 In 1776 the wealth of nations quote was,
2 tobacco, rum and alcohol are items which are not
3 necessary for life, or something like that, but are
4 universally common and therefore are items which are
5 right to be taxed, or something like that.

6 I can give you the direct quote, I have it
7 here somewhere, but it seems that nothing has changed
8 from 1776 till now.

9 So that's what I would share as far as
10 looking for revenue seems to me that could be one of the
11 sources.

12 I'm not sure that there is, you know, in the
13 current political climate in our nation that that's
14 something that's very palatable, but if we're going to
15 be paying for it out of state dollars for obesity, for
16 complications of tobacco, you know, the Medicaid system,
17 the state has a right, I think, to get some of that
18 money back from the people who are engaging those
19 activities.

20 COMMISSIONER INGRAM: So all us public
21 health folks, we're on board on this issue, because we
22 see too much of it. So let's just -- I'm going to go
23 back and take a look at what D.J. just talked about and
24 mix it with what Gene was driving for, I think, and that
25 is let's just say we redistribute some of the Medicaid

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1 dollars as Ohio discusses how they're going to have to
2 do their Medicaid expansion and insurance exchanges and
3 so forth, this is the time -- fund local public health
4 Medicaid expansion.

5 We're going to fund local public health out
6 of some of those dollars to get people off tobacco,
7 actually hold us accountable that we go in, we benchmark
8 it, it's at 27 percent usage, it's probably higher than
9 that in the Medicaid population, I'm just guessing, but
10 it's upwards of that, and then just benchmark it from
11 there.

12 There's going to be a special population,
13 you know, this integrated health care discovery system,
14 which is coming out of Washington, you've already seen
15 things start to take shape in Ohio.

16 You have accountable care organizations that
17 are forming across the state for the Medicare population
18 focusing on reduction of heart disease and incidences of
19 stroke and so forth, you're going to -- we've already
20 had special populations of children, children's needs
21 that are forming, we have these patient centered medical
22 homes, all of this stuff is happening right now and
23 there's a role for us in this, and the question is what
24 is that role and how is it going to be paid for?

25 So I just got to thinking about what Gene

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1 said and what D.J. said, perhaps, perhaps, that's an
2 opening.

3 Because we know how to do case management,
4 we've been doing it for years, we've been doing
5 prevention work for years, we just haven't been paid
6 very well for it.

7 And it's not about paying us well, it's
8 about paying us sufficiency so that we're not going
9 around chasing that next grant and letting the rest of
10 that program fall apart, because, in fact, there's no
11 more funding for it, but we shift, you know, we're
12 always chasing the money, quite frankly, in order to
13 provide services for our community and if we can just
14 establish some statewide health outcome goals that you
15 would hold us responsible for, I think that's important.

16 Tobacco related diseases, I mean, we've got
17 a lot of morbidity issues caused by that, and we're
18 always going to need local public health to chase down
19 those infectious diseases. We're just like the cops on
20 the street chasing the criminal to prevent the next
21 crime or the fire person doing their darnedest to
22 prevent that block from burning down.

23 Public health workers in our local public
24 health system are chasing down those germs from the
25 people that are carrying them or the animals or the

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1 doctors that are spreading them to prevent them from
2 spreading into your family or becoming that next
3 epidemic, and that's why at the end of the day
4 everything we do goes to that end, whether we're
5 inspecting restaurants, inspecting swimming pools,
6 giving vaccinations, it's all about preventing that
7 infectious disease outbreak so your family and that
8 community can have the best chance of success.

9 You will not be able to hand that off to
10 anyone else, but us, because there's due process,
11 there's rights of people that are involved in that. If
12 we have to get tough with them because -- and we have a
13 process that allows for hearings and so fourth.

14 Fundamentally you need to keep us there.
15 The hospitals need us, because what if Medicare came out
16 tomorrow and said we're going to de-incentivize you if
17 you have people coming through your system and
18 reappearing in someone else's emergency room within 30
19 days. We're also going to hold you accountable for
20 reducing smoking rates in that population, that changes,
21 that's a game changer.

22 Who's not to say it will not happen with
23 where we've been going, we need a line, we need a line,
24 so I'll stop there.

25 CHAIRMAN BURKE: I guess I just still split

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1 that into two separate categories. During the
2 conversation we've got the public health, and you've got
3 the personal health and heroin addiction and smoking,
4 obesity are individual choices, they're not
5 communicable, but some of the diseases that you work
6 with are, and I just separate the conversation out and
7 their existing funding structure.

8 When you look at the work that you do today,
9 leach beds, pools, infectious disease, immunization,
10 restaurant inspections, et cetera, et cetera, et cetera;
11 how comfortable are you?

12 When I look at the numbers I don't hear
13 legionnaire's disease anymore, I don't hear, you know
14 what I mean, these outbreaks of certain things. What
15 I'm hearing is on those community based contagions that
16 you're okay; are you talking about the next level? Tell
17 me if I'm wrong here.

18 COMMISSIONER INGRAM: You don't hear them in
19 the news; is that what our saying?

20 CHAIRMAN BURKE: I don't see Ohio having
21 issues with rabies. I don't worry about my kids, are
22 there animals with them, yes; have there always been,
23 yes; is it in check, appears to be at least as well as
24 humans can keep it in check.

25 COMMISSIONER INGRAM: I understand the point

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1 you make and this becomes that dicey kind of quagmire
2 area, and that is where do you say, you know, we know
3 smallpox is no longer -- was once upon a time, is no
4 longer a threat to anybody, because it's a huge success,
5 public health story.

6 It's public health 101, if you go through
7 public health school and they talk about how they did
8 that and where the last cases were where people were
9 vaccinated.

10 That all changed with 911. All of a sudden
11 we found out the smallpox virus is still alive. So we
12 got equipped based on funding from the federal
13 government. Many of us rolled up our sleeves and got
14 revaccinated for smallpox, because when we went into
15 Iraq there was a real concern that Saddam had smallpox
16 that he was going to throw out on us.

17 So what's my point, I don't think we can
18 ever completely rest on our laurels. I mean we should
19 celebrate our successes, but I think it's always
20 important to prioritize those diseases that we are
21 having the most havoc.

22 And we know, and I think I said this before,
23 if I just said there's one group, what's the leading
24 infectious disease group in Ohio, bar none sexually
25 transmitted diseases, contagious and spreading, and we

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1 have 50, 60,000 cases in the state of gonorrhea and
2 chlamydia, and, you know, probably several other cases
3 of syphilis and so forth and HIV.

4 And so you've got to ask yourself, what are
5 we doing, is that -- is that -- so you look at trends,
6 has that trend been going up; has it been going down;
7 has it been plateauing; that's what we've got to look
8 at. If it's going up we've got to ask ourselves why,
9 what are we not doing right, because it shouldn't be.

10 There's people that are sick from it and
11 it's contagious, so I say, we're always behind the scene
12 looking at that data and asking yourselves what are we
13 going to do; what's the most effective intervention
14 based on the evidence; what are we going to do to get
15 into that population to help eliminate that particular
16 pestilence.

17 COMMISSIONER NIXON: Your question, I'm not
18 quite sure how to address that, you know, about the
19 individual versus the population, and we are looking at
20 the numbers through epidemiology at the population.

21 So while we have individuals and we don't
22 forget about the individuals and we try to do counseling
23 on, you know, exercise and eating right and all those
24 good things that will make a person healthy, we're
25 looking at things at a population base and so in my

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1 community I can tell you almost block to block, you
2 know, death rates and causes of health and morbidity and
3 mortality and so forth, and we're trying to influence
4 that population number.

5 So overall in the state of Ohio Tim
6 mentioned 27 percent of the population smokes tobacco,
7 we're trying to nudge that number down through any means
8 possible, through policy.

9 Okay. We work policy to try to make like
10 the indoor air ordinance to influence that. We try to
11 do that by increasing the cost of tobacco, but we also
12 try to provide smoking cessation programs for
13 individuals, so that we kind of work the gamut, and it's
14 through population, but we're looking overall at those
15 numbers to increase those numbers overall.

16 We give a lot of influenza shots, okay, at
17 the hospital. They're giving them because they don't
18 want that person to get influenza this summer or this
19 winter, either one, but we're giving the shots, because
20 we don't want you giving it to everybody that surrounds
21 you, if you do get sick.

22 So a population based measure as opposed to
23 the clinical, individual medicine component.

24 So it is shifting? I think public health is
25 in a huge transition right now overall looking at those

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1 social dimensions that affect health, which we didn't
2 used to pay much attention to like housing and land
3 development and so forth, as well as in the care and
4 coordination in the community linking all of those
5 social service entities in our community.

6 And I would say in this Medicaid reform and
7 this wellness thing that we're not a minor player. I
8 mean we are the ones that are the leaders of this. If
9 not us, who, I mean the hospital has a role, mental
10 health has a role, Meals on Wheels has a role, everybody
11 has a responsibility, and nobody's linking up.

12 And I think that's where we can play a
13 fundamental leadership role that, you know, heretofore,
14 we've been connected to everybody, but haven't been the
15 one to glue it all together, so I think that's our
16 opportunity and I think if we miss it in this round it's
17 going to be a sorry state for us.

18 COMMISSIONER INGRAM: I agree, excuse me,
19 Mr. Chairman, I've been saying this to many of my
20 colleagues in the room and others saying, you know, in
21 my career I've had three opportunities that I feel to
22 make some really big change.

23 One at the beginning of my career, which was
24 almost 30 years ago sewage roles, believe it or not it's
25 now being finalized; the second one was the tobacco

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1 foundation, you know, and when Ohio Attorney General
2 Betty Montgomery sued the companies with the other
3 states and we had a master settlement in Ohio, I was
4 blessed to be appointed to that board by then Governor
5 Taft, and there was a lot of good work that occurred.

6 We didn't end up where we all wanted to end
7 up, but perhaps, you know, that's just the way it goes.

8 But there was a lot of money that was put
9 into local public health and we were making big, big
10 strides against tobacco, we had the Stand Campaign and
11 numbers were dropping. We were putting a lot of money
12 in, you know, we were putting \$10 million a year just in
13 marketing, just in branding, trying to teach kids don't
14 get caught up, sucked in to using tobacco.

15 Now, this is the third opportunity. The
16 window has opened by the legislature and the Association
17 of Ohio Health Commissioners to look at the system, give
18 us an opportunity, and happens to be a very opportune
19 time, because the health care delivery system is
20 transforming and we've got to see this by what we're
21 going to look like in 10, 15, 25 years.

22 And it should be always about improving the
23 health of all Ohioans, regardless of where they live,
24 work or play, and I know that sounds way up high, but
25 that's really what it's about.

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1 The delivery system cannot do it without a
2 strong public health system, so we can't do it without
3 funding. We have to change some of the things that
4 we're most comfortable, but I really think now is the
5 time.

6 I know there's a lot of good ideas that have
7 been floating around here and a lot of ideas behind us
8 and around us, but we'll end up in a better place, but
9 we've got to at least lead with an agenda platform that
10 allows us to not forget where we're trying to end up,
11 and that is better health for all Ohioans.

12 CHAIRMAN BURKE: Is there anyway to just get
13 the ball rolling, just think of a statement that you
14 would make, but that we could all agree on.

15 COMMISSIONER NIXON: Well --

16 CHAIRMAN BURKE: But honestly, I mean, just
17 sounds like to me like you're not talking about funding
18 what you currently do, you're talking about funding for
19 what you want to do or what --

20 COMMISSIONER NIXON: But not to the
21 exclusion of what we did. We have core
22 responsibilities, and Tim's talked about sexually
23 transmitted diseases, safe water, healthy food. So we
24 have core responsibilities that we can't forget, but I
25 think this new role is critical to really changing the

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1 whole state.

2 COMMISSIONER INGRAM: You brought the rabies
3 question, that's what got me off on that, it's really a
4 good question, we had that conversation.

5 We're not seeing any, we haven't seen human
6 rabies -- I don't know when the last case had been in
7 Ohio, a long time, but we monitor everyday.

8 In Hamilton County we log 800 to a thousand
9 animal bites a year, all computerized, you know, we're
10 getting Public Freedom Information requests all the time
11 from certain people wanting to know who's getting bit,
12 you know, that's fine, that's transparency, they're
13 welcome to it.

14 So the question is why do we do all that,
15 well, because of the fact we still want to make sure
16 that those animals have been vaccinated for rabies, you
17 know, it's that accountability.

18 Do we still need to do it that way going
19 forward, perhaps not, but I don't think we want to just
20 turn our back on it, because rabies is still a very
21 terrible virus that's still out there.

22 Come on, Doc, help me out here or perhaps
23 disagree.

24 COMMISSIONER THRELFALL: No, I would hate to
25 see us let up on that. The New York Times, a couple of

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1 days ago, the next pandemic is going to be an animal
2 disease transmitted to man and it's not going to be the
3 ones that currently occur.

4 And the most important thing, I think, and
5 Nancy can certainly disagree.

6 COMMISSIONER SHAPIRO: She doesn't.

7 COMMISSIONER THRELFALL: I'll run over her
8 later in the parking lot, I think one of the most
9 important things that our health department does is
10 education, and I wish that we could do 20 times more,
11 especially the older population, to change that whole
12 mindset, because it's predicted that the next generation
13 will not live as long of mine, because of obesity. Now,
14 how ridiculous is that?

15 I mean after all the things that we've, as a
16 human race, have come through and survived, fat is going
17 to kill us. I mean if that doesn't upset a lot of
18 people, and obviously we're not getting the word out,
19 and we are the organization that has to get that word
20 out.

21 And I mean your doctor may tell you about
22 it, your doctor may make suggestions, but as a member of
23 a profession that has been trained wellness for a
24 hundred years and herd health, if you will, preventative
25 medicine, that's what we're all about, and that's how I

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1 envision public health. It's that same mentality, we're
2 just supposed to be a higher primate, but the idea of
3 the agenda, you know, what you have discussed here is
4 what we talk about everyday, so, yeah.

5 REPRESENTATIVE ANTONIO: One of the things
6 that came to mind when I was listening to both of you
7 speak is the West Nile that we've just gone through
8 years ago, and, you know, in our community we went from
9 -- first of all calming everyone, because there was
10 panic, because there were a few deaths locally, and then
11 it was education on a grand scale, everything from what
12 to do in your backyard to get rid of all the standing
13 water to really having an eye out.

14 We went from collecting -- you know, the
15 health department collecting dead birds to all of the
16 things we went through, you know, with people calling
17 and saying where they were and all of that.

18 And our local health department also went
19 into mode about crisis management of the conversation
20 and the message so that people were more proactive than
21 panic, and so to me there's a valuable piece that I
22 would never want to lose and it really is on the ground.
23 Local health departments that go into process, when
24 something like this happens, and can turn it around.

25 The community did not want to just fog

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1 everywhere with pesticides and so the response was
2 here's what you can do proactively and be involved in
3 it, so not only did it educate, inform, calm folks down,
4 but it gave them an alternative that was in their best
5 interest that they could latch on to, and I would never
6 want to lose that piece of what our health department is
7 doing. What do you call that?

8 DR. MCFADDEN: Preparedness. I think to
9 your question, and trying to figure out how to answer
10 your question, I hear you, and maybe there's a broader
11 base that are concerned about, you know, here's
12 something that -- a contagion that seems to go where it
13 will without, you know, I can do everything right and
14 I'm still affected by that contagious.

15 And I hear you saying that that's an easier
16 thing to say, public health, you really want as a
17 society to be doing that sort of thing, and so our newer
18 threats, you know, as you have said in place many good
19 structures to address infectious disease so people don't
20 think about many of those things today and a newer
21 threat comes along, does public health have a place in
22 some of those newer threats, and I hear you maybe
23 struggling with, you know, contagions aren't showing up
24 in the United States as much and influenza and pneumonia
25 are still up there as one of the top ten, but since

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1 those aren't the major killers does public health have a
2 role in those.

3 What did I, as a community member, care
4 about person Y who smokes and gets COPD and dies on a
5 ventilator and I guess, you know, that's an interesting
6 question and I think one that we've had long debated
7 about.

8 I do think that certainly each of us are
9 affected -- eluded to this before, but to be sure, all
10 of our premiums in health insurance going up aren't just
11 because of health insurance company wants to make more
12 money.

13 A lot of it has to do the coinsured
14 individuals on our -- with our company that are making
15 unhealthy decisions. So that I, as an individual make
16 healthy decisions, but my insurance still goes up ten
17 percent every year regardless of how I live my life,
18 because someone else may not be.

19 That is one are how I'm affected, but it's
20 beyond that. There may be a day when I have a bunch of
21 people in the emergency room that wouldn't necessarily
22 have to be there if it wasn't for lifestyle issues, and
23 when something happens to me that I'm not able to get
24 the care that I need, because there are a lot of folks
25 that are there, but there are other things that happen,

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1 folks with chronic lung disease get a lot of
2 antibiotics, drug resistant organisms are leading -- you
3 know, is a rising concern in our nation.

4 Folks with diabetes are very susceptible to
5 lots of infectious diseases, they're immunocompromised,
6 they're more susceptible to influenza and so many other
7 diseases, they get a lot of antibiotics.

8 So while we may see obesity as leading to
9 diabetes as being that individual's concern, and smoking
10 and COPD and that person's concern, it may be that those
11 conditions end up affecting us, we just don't know yet
12 how they're going to affect us.

13 It may be the next super bug that can't be
14 treated by anything that we have, having to address all
15 of these individuals that we need to get to.

16 You know, we are charged with ensuring that
17 the conditions exist so that people can live healthy
18 lives. We're not ensured to cause people to live
19 healthy lives, but at least give them the conditions
20 where they can live healthy lives.

21 Some of those conditions right now are not
22 around infectious diseases that are keeping people
23 healthy, it is a very interesting discussion and I think
24 probably we need to have outside just the world of
25 public health, and it's one of the things that we

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1 struggle with in public health is we really would love
2 to have policy makers and common everyday lay persons
3 understand why we are concerned about these things.

4 And it's hard to help people understand
5 other than, you know, TB and food related outbreaks and
6 STDs and vaccinate preventable diseases, people
7 understand those pretty well.

8 I just want to -- for me it seems crystal
9 clear in the head, but I don't know that I have the
10 language yet to help my next door neighbor understand
11 why I care about obesity.

12 CHAIRMAN BURKE: I see what you're saying,
13 one of you, I don't know if it was Tim or somebody said
14 we have a sickness system, you know, we fund the
15 sickness.

16 We have the two year budget, the person
17 you're talking about with COPD or obesity, those issues
18 probably aren't going to occur this budget cycle, so you
19 know what, I don't have to pay for them, so that money
20 goes to education or roads or who knows where.

21 Looking for long-term investment in health
22 care is difficult, because it's an expenditure out and
23 out. Smallpox, it affects you today, people get in
24 line, right, this is going to happen in this budget
25 cycle, it's going to break out now; we're gonna fund it,

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1 we're going to pay for it; we can allocate it, we can
2 send it out the door, can't do that with obesity.

3 I don't know exactly when you're going to
4 turn diabetic, that might not be in this budget cycle,
5 but at the end of the day that's all that really
6 matters, right, that's the way it really works.

7 So if I were to look at the funding thing,
8 and I think I know what's in your head, the funding
9 issue is changing that paradigm to more of a long term
10 communicable health outcome, right, that's what you're
11 actually funding; is that -- am I getting close to what
12 we want to put down on paper?

13 DR. MCFADDEN: Yes.

14 MR. TREMMEL: Let me add, Senator, to the
15 conversation, I think this still remains the contagious,
16 infectious disease disconnect versus chronic disease.

17 We have seen the public health system over
18 time do a remarkable job in contagious, infectious
19 diseases. Now, there is criticism even in Ohio and the
20 public health system about capacity.

21 Some have great, complete capacity to deal
22 with these things like H1N1 and some did not. Some had
23 real problems in setting up infrastructures even with
24 millions of dollars in the public health system through
25 the Federal Government, but by and large all of those

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1 experiences day after day event after event, let's look
2 at the current ones, H3N2B, West Nile virus, these
3 things come up and on and off the radar screen.

4 The public health systems go in,
5 surveillance, diagnosis, laboratory, epidemiology,
6 control, intervention and don't think two other swipes
7 about it, just do it, showed up Monday, we're going to
8 work it two, three weeks, three, four months, in and
9 out, through and around, and then the next one crops up
10 and we do the same thing.

11 Still the disconnect becomes on the chronic
12 disease side or something like obesity or alternatively
13 on the public health issues of infant mortality, where
14 are we? Not with capacity, not with funding, so how do
15 we expect to move the needle?

16 Alternatively what do we get, these rankings
17 showing Ohio is 36, 38, 42nd, so do we need -- and some
18 folks have suggested this funding model, and it's
19 worthwhile enough to say let's take the funds from this
20 and apply the funds exactly to that intervention.

21 I would suggest a slightly different model,
22 take the funds, make those funds not specific and
23 exclusive, but more general, a block grant type of
24 strategy so the state and the local health systems can
25 come together and say what are the three, what are the

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1 five, what are the six, whatever we even agree on are
2 the interventions in the system?

3 If infant mortality is one of those then
4 this investment goes towards infant mortality. It may
5 be a million, it may be 20 million.

6 If tobacco is one of those things, it could
7 be a million, it may be 20 million, but those are the
8 kinds of conversations with a specific block of dollars
9 that should probably be occurring in the system. My
10 guess is the result will be incongruent and inconsistent
11 and not where the state would want them to be.

12 COMMISSIONER INGRAM: So that's fine,
13 figuring this out how to package it in order to get the
14 best outcomes is the key, of course.

15 I just want to float back to infectious
16 disease for a moment, because it's kind of a shoot out
17 of public health and we have changed, because chronic
18 diseases are not a leading killer, it's current life
19 expectancy, it's not infectious disease, it's still out
20 there.

21 So I would say to you that, you know, we
22 were talking about epidemiology and how that hat's an
23 important service of local public health and we've had
24 some good examples of where we shared those services, so
25 I just thought I would pull up a report coming out of

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1 southwest Ohio.

2 Now, this covers Adams, Brown, Butler,
3 Clermont, Clinton, Hamilton, Highland and Warren
4 Counties, and I'll share this with Joe so he can go out
5 on the website.

6 This is one of the monthly reports that
7 comes out, there were 419 communicable diseases reported
8 among all those counties in August.

9 Okay. That -- you don't hear about them,
10 because the media didn't pick them up or it's going to
11 become an epidemic and they're still there, and they're
12 only perhaps one person away in an incubation period of
13 becoming that.

14 For example, if you had to guess, and it
15 ranges from campylobacteriosis to varicella and, you
16 know, we've got meningitis, guess what's No. 1,
17 Hepatitis C, Hepatitis C, a hundred and forty-six cases,
18 and so we're looking at that data, that data is coming
19 in everyday to us.

20 Okay. And we're asking ourselves, where do
21 we deploy our resources to have the biggest affect on
22 improving health of the communities we serve.

23 And so anyhow I just wanted you to know that
24 happens, that happens whether it's down my way or up
25 their way or wherever, I mean that's what we do.

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1 The systems are looking, and that's why I
2 keep coming up with this alignment, systems are looking
3 at how they're performing in size, zero harm, how's our
4 quality, but when they get someone with one of these
5 contagious diseases, say it's hep A, first thing they're
6 going to do, that physician or that nurse, is they're
7 going to call their local health department.

8 They know how to get ahold of us, I hope,
9 the way they should, and they're going to make that call
10 and say, hey, we began -- we've got this outbreak,
11 perhaps, this person, and we'll begin to do that
12 prophylactic, start doing that preventive first step.

13 That's why the two systems cannot be
14 mutually exclusive, they have to be inclusive. And so
15 although chronic disease is where we're all focused and
16 that's where all the money is coming down from the feds,
17 infectious disease is what brought us here, and it will
18 never go away.

19 You know we should be -- our goal perhaps
20 should be, Senator, to have less infectious diseases,
21 you know, of certain categories.

22 I think it's completely unacceptable in our
23 state to have as many cases of syphilis as we do. We
24 should be outraged by that and we shouldn't have any
25 cases of congenital syphilis, there shouldn't be one

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1 child that's contracted syphilis, because of their
2 parents, it should be better than that. It's completely
3 preventable, it's completely treatable, and it's not
4 expensive to do so.

5 These are things -- and, you know, you don't
6 want to throw that out, nobody wants to make this into
7 an alarmed situation so you can get funding or whatever,
8 and, you know, say what's wrong with you, we want to do
9 this quietly, invisibly, but we need to know what the
10 data says so we can get it done.

11 So that's where, if the system's working
12 well, you don't hear a lot about the outbreaks, but it's
13 the people that work there, have to be, they're always
14 coming in the door. Anyway, just --

15 CHAIRMAN BURKE: Yes, please.

16 MS. SCOTT-JONES: Anita Scott-Jones
17 representing the Ohio Municipal League. I've just
18 digested a lot of information today and listened to
19 everybody, and I've heard something that's been
20 consistent is there's a disconnect between communicable
21 diseases, infectious diseases and chronic diseases.

22 And I would take a different slant on that
23 to say that, and I've also heard that, well, someone
24 who's obese doesn't affect me, someone who smokes
25 doesn't affect me, but every decision including most

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1 infectious diseases, and I say most, because some are
2 contracted by animals or whatever, but most diseases
3 begin with an individual choice.

4 If we have an epidemic of sexually
5 transmitted diseases someone made a choice to -- to
6 share their personal bodily fluid with someone, possibly
7 knowing or not knowing that they had that disease, so it
8 all starts with a choice.

9 Someone who's obese makes a decision not to
10 take care of their health, but then that affects
11 employers who are going to hire that person, it affects
12 their mortality rate, it affects the number of people
13 who live to longevity, so it does affect us.

14 That person who chooses to smoke, how many
15 incidents do we have of second-hand smoke disease and we
16 say it doesn't affect us, and so I agree with
17 Commissioner Tremmel when he says possibly a
18 recommendation might be to let the local health
19 department decide which top three, which top four, which
20 top five, because you say, well, do we pick the hot
21 spots or do we pick per capita.

22 There might be a per capita, city, county or
23 whatever that has a disease that you need to target,
24 there might be a hot spot, but if you just say one or
25 the other you're going to miss out on something.

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1 CHAIRMAN BURKE: So I'm trying to make a
2 statement, at least get one down here under funding, so
3 we can wrap up at 4:00.

4 I just have, moving towards additional
5 funding that moves towards long-term communicable
6 disease state management, or communal, not communicable,
7 communal disease state management use block grant
8 methodology with accountable for outcomes.

9 It's a very generic statement, but is that
10 at least a rough framework? Help me rephrase if it's
11 not right.

12 COMMISSIONER SHAPIRO: Can you say it one
13 more time, please.

14 CHAIRMAN BURKE: Moving towards additional
15 funding that moves towards long-term communal disease
16 state management, use block grant methodology with
17 accountability for outcomes.

18 Again, just two sentence thoughts and not
19 anything pretty, get a lot more defined than that, but
20 just trying to capture the essence in two sentences what
21 we're talking about, so we can build on it.

22 COMMISSIONER EDWARDS: I agree with that,
23 but it doesn't go far enough, because funding is more --
24 it's more than just that. It's -- okay. Is it levy
25 funded; is it state funded; is it off receipts? It gets

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1 to be more than that. It's issues from the township and
2 the villages, it's issues from the county.

3 CHAIRMAN BURKE: Well, question, those types
4 of funding methodologies are local. So if you're going
5 to talk about state funding we can write something that
6 frees you up to do one thing on your own home turf, but
7 it's another to have state allocated resources, back to
8 the health districts and what -- how it would look and
9 what it would go towards and how you would measure it.

10 COMMISSIONER EDWARDS: Well, okay. Then I
11 guess I need to ask the question, is that kind of a
12 foregone thing that the state subsidy is going to look
13 any different?

14 CHAIRMAN BURKE: I do know one thing, if you
15 don't ask it won't.

16 COMMISSIONER EDWARDS: I know. That's why I
17 think it should be part of the bigger question. I think
18 all of those things should be part of the bigger
19 question.

20 CHAIRMAN BURKE: When it comes back the
21 first question is going to be what are we paying for,
22 because, again, the schools are going to be asking for
23 money and this person is going to be asking for money.

24 COMMISSIONER EDWARDS: That's why I think
25 that there needs to be another set to look at this.

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1 COMMISSIONER SHAPIRO: I think that we've
2 talked around it with equalizing tobacco taxes as being
3 one method of possibly funding at least a part of the
4 public health system in the Ohio.

5 We've talked about other jurisdictions, I
6 know in the public health community sugar sweetened
7 beverages as another example of something that might be
8 a way of generating resources that we know are directly
9 related to the obesity and the problems that obesity
10 causes.

11 So I think there's a number of those kinds
12 of things that can be done, if there's a will to do that
13 in the state legislature and I don't know if that exists
14 or not, but we need to do something to -- as you found
15 out, 17 cents does not go very far in 2012.

16 And so there needs to be a way of increasing
17 our capacity and equalizing it a bit across the state
18 regardless of the wealth of the community to help offset
19 what we're trying to combat, both the infectious disease
20 piece and the chronic disease piece.

21 I was late today, because I was meeting with
22 our elected and appointed officials about a built in
23 environment form to talk about connectivity of trails to
24 make it more accessible for folks to do the physical
25 activity they need to do to begin to get healthy or stay

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1 healthy, and had great dialogue over that issue and
2 seeing how we can get, again, some affluent communities
3 that may have a little resources, but have trials that
4 go to nothing and that don't connect. So all of those
5 dialogues and we're bringing people to the table.

6 We had someone from the Ohio Department of
7 Natural Resources that said who we're hearing from are
8 people in public health that are bringing us together to
9 talk about it.

10 So we can talk about Alum Creek State Park,
11 the Columbus Zoo, it all comes through Delaware and how
12 to get the Ohio Erie Trail to connect up and Sunbury, so
13 all those kinds of things, and that's what we do.

14 What's paying me to do that is our public
15 health levy dollars, but it's dealing with chronic
16 disease, and we need some local funding to help us do
17 those things, in addition to taking care of syphilis.

18 COMMISSIONER EDWARDS: As we discussed
19 before, the poorer townships, poorer villages, they
20 don't have the dollars to pay for it, and they're the
21 ones that need the service the most. I think that
22 discussion still needs to happen.

23 COMMISSIONER NIXON: I like the block grant
24 idea. I like Nancy's idea about some of these excise
25 taxes, if possible, but I think we should also make some

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1 reference to opportunities in this Medicaid reform and
2 that if there is an opportunity for the local health
3 departments to be able to bill under these models for
4 wellness services that ought to be permissive authority
5 through some enabling legislation, and I think we need
6 to at least make some reference to that, I think that
7 holds the greatest potential for us.

8 COMMISSIONER SHAPIRO: If I may, just I know
9 that our nurses division right now is working with --
10 just to be billable for flu and negotiating these
11 contacts with 70,000 different health insurers is not
12 something we have the infrastructure to do.

13 And so there needs to be something with the
14 Department of Insurance that says for these services
15 health departments can be a member of your panel, as
16 long as we can document that. I don't know exactly what
17 that looks like or how it needs to be worded.

18 CHAIRMAN BURKE: All right. Well, this one
19 I'm probably not going to get a checkmark on it. We
20 still have 15 minutes to go, but before we get too far
21 down that path, I just want to add a couple of things
22 real quick.

23 If we formulated these down to paper and we
24 can save time in between meetings, correspond to refine
25 these ideas, to give you folks time to digest them on

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1 the drive home, a day or two, get them in the mail box,
2 digest them again and send it back, we end up with a
3 much more refined product at the next meeting, and then
4 we can talk about additional issues and repeat that
5 process again after the next meeting.

6 And then finally, hopefully, three meetings
7 from now, with this being No. 1, we actually have some
8 kind of document, some kind of consensus on that, at
9 least some finalized draft; does that sound like a path
10 you think we can get to?

11 Because I would like to do that. We don't
12 want to waste time now between meetings, it's too
13 valuable and your points are too acute not to get
14 absorbed and we can do that the next two weeks.

15 There are many items still remaining under
16 the recommendations and some of the things that we've
17 talked about that we need to continue to mature on,
18 topics such as should there be a minimum size of a
19 health district?

20 I know we've said a hundred thousand, is
21 there a size that we know absolutely is too small? I'm
22 justify asking.

23 If we're going to roll something out of here
24 that has something, is there too small, too-too small?
25 I don't know, I'm just asking. Is that something we

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1 should look at?

2 Financing, we still need to determine if we
3 are going to actually put down in recommendation, and I
4 heard folks say that and I plan on including it in the
5 draft, tobacco and sweetened beverages and the ability
6 to bill Medicaid reform and we see these kinds of
7 things, this is what I'm hearing, this is what I'm going
8 to send you all by e-mail.

9 So I mean with that we can keep working, but
10 I just want to reiterate on this kind of nebulous thing
11 with funding, what I've heard and what I plan on kind of
12 putting together, and then have you all respond and help
13 mature that.

14 Same thing with -- we're also going to
15 word-smith under shared services. How that's going to
16 look with the agreements and the contracts and
17 non-contiguous consolidation and those kinds of things
18 is going to be another area we're going to have to get
19 your feedback on in that direction, believe it or not,
20 that's a lot of ground, was highly productive.

21 I don't know if there's anything else
22 anybody else wants to cover or folks would like to just
23 go through them mentally where we are at.

24 I don't know how you all feel, I can push it
25 for another 10 or 15 minutes, if there's another topic

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1 somebody wants to bring up or we can put down on paper
2 what we have, send it to you electronically, allow you
3 to digest it or then approach it over the weekend or
4 whenever your time allows, you want to go ahead and do
5 that?

6 COMMISSIONER SHAPIRO: Then maybe a blank
7 for other burning issues that you have.

8 CHAIRMAN BURKE: I was thinking the same
9 thing about just leaving additional topics that folks
10 feel they would like to cover in this recommendation.
11 Let's try to get that done. Is that something you think
12 you could have out by the end of the week?

13 MR. TREMMEL: I think we can probably,
14 what's today, Tuesday?

15 CHAIRMAN BURKE: So you get the next three
16 days off, try to have something in the your mailbox by
17 the end of the day on Friday and review it over the
18 weekend at your leisure and that would give us time to
19 get it back and mature it, if we need to respond.

20 COMMISSIONER FOUGHT: I'm sorry, Mr.
21 Chairman, I was late today, so you might have touched on
22 it, two meetings ago we had asked for a list of state
23 mandates, was that talked about and I missed it?

24 CHAIRMAN BURKE: No.

25 COMMISSIONER FOUGHT: Okay. Can we have

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1 that discussion the next time, because I know that was
2 compiled by the association, but can we at least have
3 the discussion about what's on the list and if we're
4 going to make those recommendations.

5 CHAIRMAN BURKE: Sure, sure.

6 COMMISSIONER FOUGHT: I just wanted to make
7 sure that that request was out there.

8 MR. TREMMEL: Make it an agenda item.

9 COMMISSIONER FOUGHT: Yeah, and it just
10 wasn't touched on.

11 CHAIRMAN BURKE: Consider that done.

12 COMMISSIONER FOUGHT: Thank you.

13 CHAIRMAN BURKE: Thank you. Had a lot, it's
14 a plate of spaghetti and I think we have the noodles.
15 Okay. Well, with that being said, thanks everybody for
16 their time. I'll go ahead and call --

17 COMMISSIONER SHAPIRO: The next meeting is
18 it our normal -- what time do --

19 CHAIRMAN BURKE: How do folks feel about
20 where we're at? Do we want another longer meeting or do
21 like a three hour meeting between 1:00 to 4:00 will
22 suffice for what we have left? I don't want to call
23 anything on the fly, we're here, let's see.

24 COMMISSIONER EDWARDS: I think a long
25 meeting.

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CERTIFICATE

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I, Teresa L. Mantz, Certified Professional Reporter, and Notary Public in and for the State of Ohio, do certify that the foregoing is a true and correct transcript of the proceedings taken by me in this matter on September 25, 2012, and carefully compared with my original stenographic notes.

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

IN WITNESS WHEREOF, I have hereunto set my hand and official seal of office at Columbus, Ohio, this 2nd day of October, 2012.

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

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