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Susan Tilgner  
18 Charles Patterson  
Aaron Ockerman  
19 Jason Orcena  
Socrates Tuch  
20 Joe Russel  
Laura Abu-Absi  
21 Melissa Bacon

22 Present via audio link:

23 James Watkins  
Kimberly Moss  
24 Gillian Solem  
Kristen Hildreth

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1 AGENDA

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3 1) Welcome

4 \* Chair, Senator David Burke

5 \* Vice-Chair, Christopher E. Press

6 2) Approval September 11, 2012 Meeting Summary Notes

7 3) Committee Recommendations Survey Review

8 4) Discussion and Review of Recommendations

9 \* Capacity, Service and Quality

10 \* Jurisdictional Structure

11 \* Financing

12 \* Implementation

13 6) Next Meeting October 9, 2012

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4                   CHAIRMAN BURKE: We will go ahead and get  
5 started. We have a lengthy day in front of us and I  
6 welcome everybody for joining us.

7                   I know we have, at least here in the  
8 physical presence, a new young lady with us, and is it  
9 Ms. Scott-Jones; is that correct?

10                  MS. SCOTT-JONES: Yes.

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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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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.

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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.

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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?

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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.

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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?

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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?

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 an 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?

4 COMMISSIONER NIXON:

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.

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7 COMMISSIONER INGRAM:

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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...

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5 CHAIRMAN BURKE:

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:

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

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9 MS. SCOFIELD:

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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?

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DR. MCFADDEN:

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I think of having

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priorities that are from the state Department of Health

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that says these are the three things we're going to

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focus on for the next two years to me makes a lot of

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sense.

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MS. SCOFIELD: So I think that's

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part of the conversation is how we define public health,

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because all of those different partners, all of those

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different agencies within the community are a part of

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the public health system, so we need to look at where or

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not -- where does the responsibility fall.

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Is it the local health department or is it

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another part of the system, all of those pressure points

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in the system that need to be pushed in order to have

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some action so, you know, I think it's how we talk about

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this too.

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CHAIRMAN BURKE: I just ask, as I beat this

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horse around all sides, and, again, this process has

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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.

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20                   CHAIRMAN BURKE:

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1 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?

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.

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10 COMMISSIONER SCOFIELD:

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?

10 MS. 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.

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.

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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.

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.

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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.

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 MS. 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.

14 CHAIRMAN BURKE:

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.

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

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4 COMMISSIONER INGRAM:

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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 Dr. 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.

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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19 MR. TREMMEL:  
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.

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24 CHAIRMAN BURKE:

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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.

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25 MS. FOUGHT:

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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.

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

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1 MS. FOUGHT: Permissive authority  
2 for the multi jurisdictional levy; is that what you were  
3 saying, Nancy?

4 COMMISSIONER SHAPIRO: Uh-huh.

5 MS. FOUGHT: And I think that's a  
6 fair --

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COMMISSIONER INGRAM:

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.

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 makeup 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.

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 72  
1 association that represents those hospitals locally.

24 COMMISSIONER INGRAM: 73

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.

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19 COMMISSIONER NIXON: 77

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:

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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.

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12 COMMISSIONER EDWARDS: Yes, unfortunately in  
13 our county our health department and our hospital do not  
14 speak. They do not speak.

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

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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.

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.

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REPRESENTATIVE ANTONIO:

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?

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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.

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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.

15 MS. 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?

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.

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.

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8                   MS. 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.

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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.

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2 MS. 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.

15 CHAIRMAN BURKE: We've got two things here, 101  
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 --

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

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.

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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?

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

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24                   MS. FOUGHT:

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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.

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11                   MR. TREMMEL:

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.

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.

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.

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17                   MS. 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.

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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.

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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.

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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.

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21 DR. MCFADDEN:

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.

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.

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9 CHAIRMAN BURKE:

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?

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.

23 COMMISSIONER NIXON:

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.

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 --

17 COMMISSIONER FOUGHT: Well, to build on that

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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.

21 MR. 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.

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

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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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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 172

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.

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.

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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.

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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.

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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.

18                   CHAIRMAN BURKE:

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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  
179 should look at?  
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20 MS. 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  
181 that discussion the next time, because I know that was  
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.  
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1 CHAIRMAN BURKE: You want to do another  
2 11:00 to 4:00; is 11:00 a.m. a good start time? All  
3 right 11:00 a.m. it is. I appreciate your time and I

4 will call this meeting adjourned.

5 (Thereupon the Commission meeting was

6 adjourned at 3:54 p.m.)