

BEFORE THE LEGISLATIVE COMMITTEE  
ON PUBLIC HEALTH FUTURES

Tuesday, August 28, 2012  
1:03 p.m.

Ohio Department of Health  
35 East Chestnut Street  
Lower Level, Training Room A  
Columbus, Ohio 43215

AGENDA

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1) Welcome	
* Vice-Chair, Christopher E. Press	4
2) Approval of August 14 Meeting Summary Notes	12
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4) Discussion and Review of Recommendations	
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5) Next Meeting September 11, 2012	

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## APPEARANCES:

Commissioner Martin Tremmel, Secretary

Commissioner Nancy Shapiro

Commissioner Jennifer Wentzel

Commissioner Christopher E. Press, Vice-Chair

Commissioner D.J. McFadden, M.D.

Commissioner Gene Nixon Commissioner

Tim Ingram Commissioner Kim Edwards

Representative Lynn Wachtmann

Jennifer Scofield

Walter Threlfall

Joe Russell

Heidi Fought

Joe Mazzola Melissa

Bacon

## VIA VIDEO TELECONFERENCE:

Kristen Hildreth Senator

Capri Cafaro

Michael Thomas

Terry Allen

Kathy Luhn

Tim Tegge

Stephanie Branco

Kelly Smith

6 VICE CHAIR PRESS:

7 Today try to look at three

8 different areas, capacity, quality and services,

9 jurisdictional structure, and financing.

3

DR. WYMYSLO:

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I just wanted to share with you a

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couple of tidbits of information you may want to

19

know.

20

One is today we're happy to add to

21

our rank Melissa Bacon, who is joining me as our

22

Chief Policy Advisor here for the Ohio Department

23

of Health.

11                                   The second bit of information:

14           And that is

15           that Steve Wermuth has announced that he  
16           will be resigning from the position as Chief  
17           Operating Officer effective September 7th.

21           And I want to tell

22           you that there's no one I'd rather work with  
23           day-in and day-out, Steve Wermuth, here at Ohio  
24           Department of Health, and also all of you as a  
25           local health department, as well. And that

1 friendship and that relationship will continue  
2 strong as you move into the private sector to  
3 resume some activities out there in the private  
4 community that will relate to healthcare.

8                                   But I can assure you he lives,  
9 breathes, and walks public health every day of his  
10 life, caring for our needs, and the future changes  
11 that we need to carry that forward.

8 VICE CHAIR PRESS: All right.

9 Everyone has had an opportunity to receive the  
10 minutes of the summary notes, I guess minutes of  
11 the August 14th meeting.

12 I'd be happy to read them in their  
13 entirety for the group or we can entertain a  
14 motion to approve them or amend them.

15 COMMISSIONER NIXON: Move to  
16 approve.

17 VICE CHAIR PRESS: We have a  
18 motion to approve.

19 Is there a second?

20 COMMISSIONER WENTZEL: Second.

21 VICE CHAIR PRESS: Is there any  
22 discussion or corrections for the minutes?

24 Thereupon, no response was had at  
25 approximately 1:13 p.m.



14 VICE CHAIR PRESS: All right.  
15 Everyone has had a copy of a  
16 survey sent to them from Senator Burke's office.  
17 And how many replies do we have,  
18 Lindsey?

19 MS. ENGLISH: I've got eight.

10 VICE CHAIR PRESS:

11 So just as a clarifying point, as  
12 you're looking at the responses, the ranking is  
13 around the importance of that particular issue to  
14 the discussion. Ten means you highly agree, and  
15 one means you highly disagree with whatever  
16 recommendation.

2                                   SECRETARY TREMMEL:

3                                   In addition to the '60s version of  
4                   the assessment of public health and the time, we  
5                   also have the '93 version, more recent version.

6                   And Mr. Mazzola has this up on the website.

23

COMMISSIONER MCFADDEN:

25

One of the items that led to the

1 discussion that ultimately I think brought us here  
2 today is a conversation that we have had Northeast  
3 about this document probably two years ago in just  
4 asking the question where we are today, why the  
5 recommendations that were in '93 we haven't done  
6 anything with.

12 SECRETARY TREMMEL: And I would  
13 say that a couple of issues that are in '93 have  
14 been addressed.

15 I do take, for example, the one  
16 that struck me square was the IT issue.

20 Impact SIIS is an excellent  
21 example...



1

15

VICE CHAIR PRESS: Let's start

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with 7 and then if we slip back to 6 we can do

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that, but in the interest of time, trying to keep

18

us moving forward.

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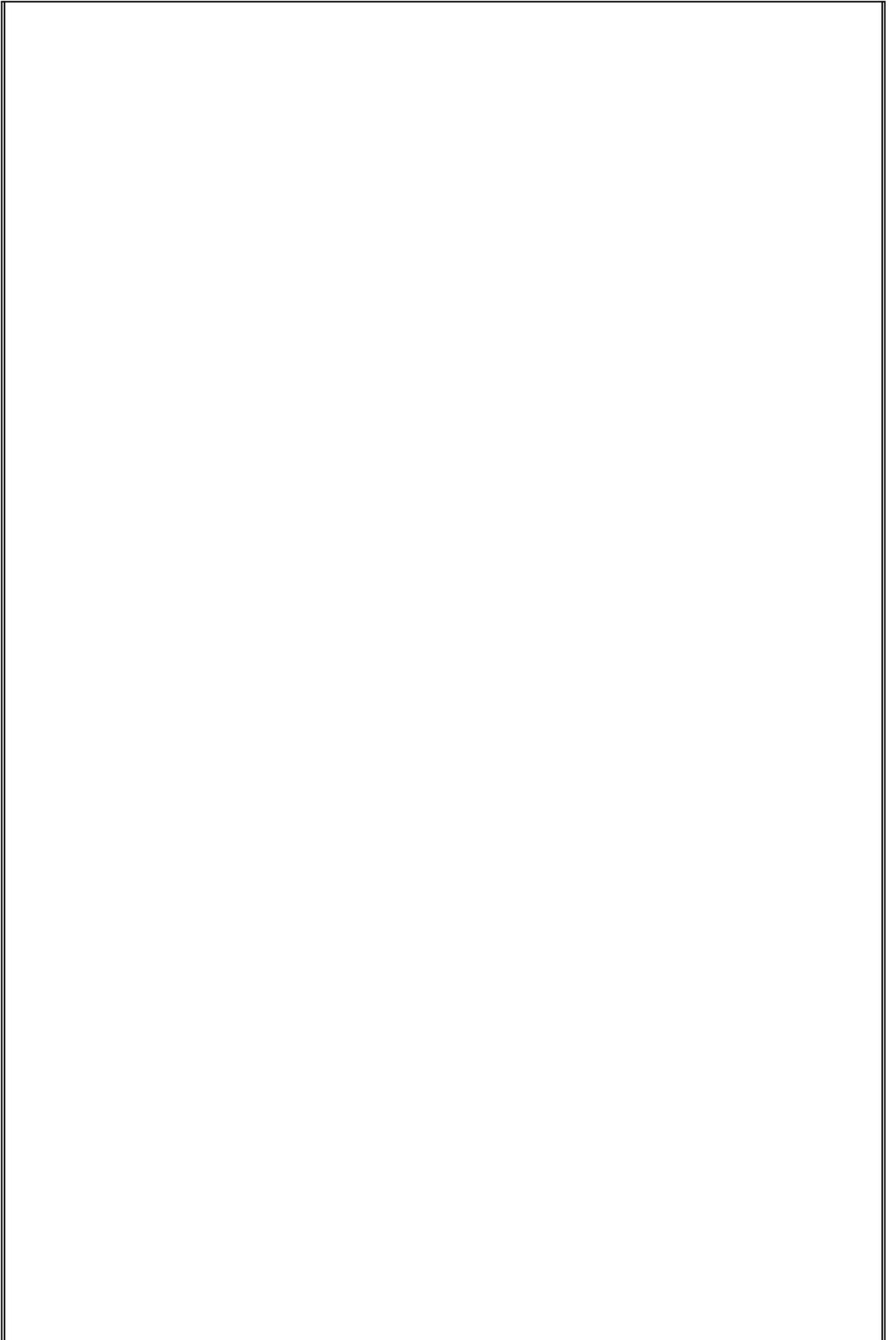
SECRETARY TREMMEL: So this would

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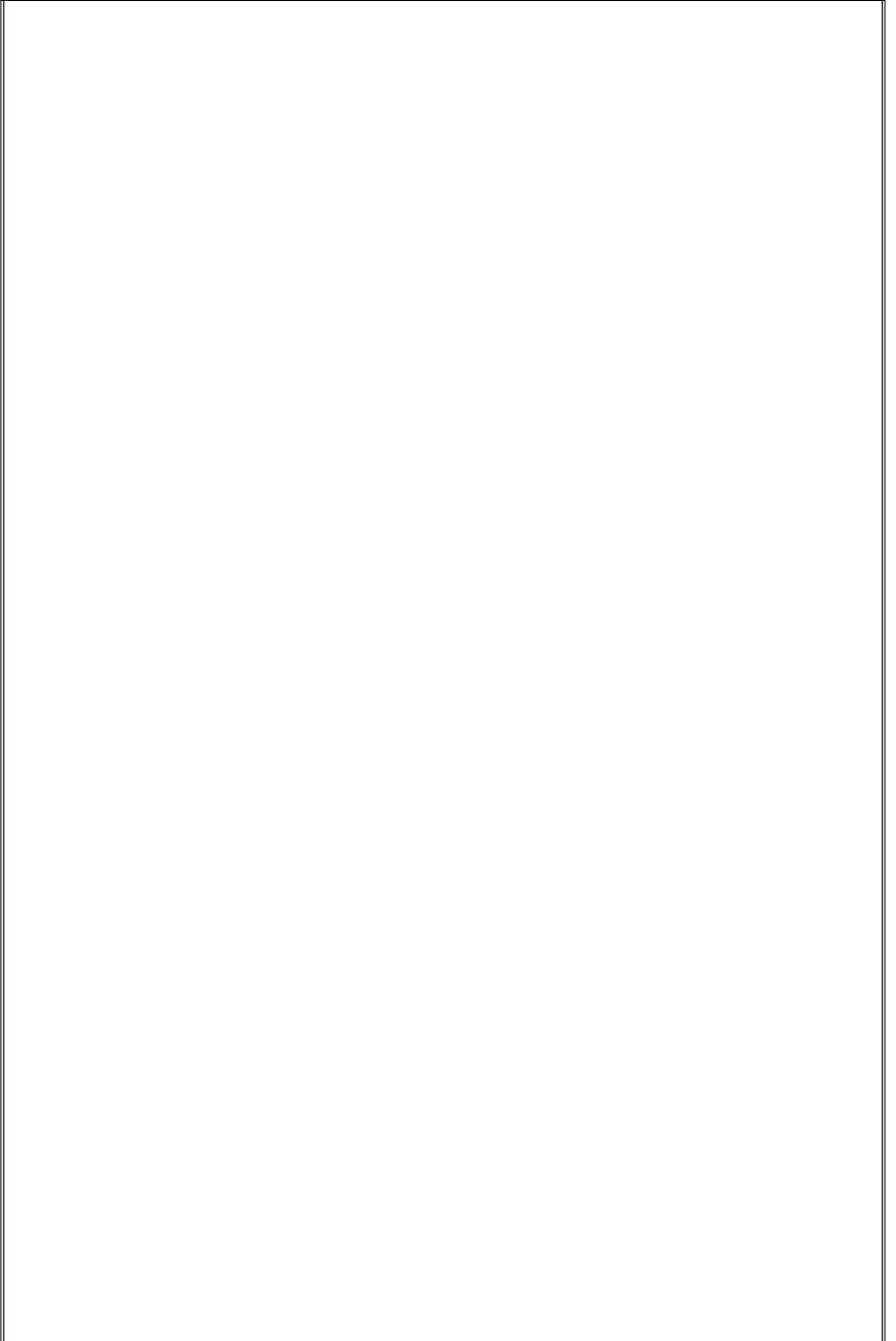
be the unfunded mandate issue conversation.

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COMMISSIONER EDWARDS: Right.

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But I'm also looking at when I

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look at the core -- when I look at the core

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package to me it seems more of the umbrella and

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not necessarily the individual -- and maybe I'm

8

wrong.

14

COMMISSIONER NIXON:

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In each community with these

3

foundational capabilities understanding where the

4

gaps are, like in our community, oral health

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services. There is a real gap in dental health

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services. There is no State funding available to

7

our community to fill that capacity. So we're

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partnering with others to build that capacity.

15

DR. WYMYSLO: So we're looking at

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our teams playing this year toward finishing the

17

ships process State Health Improvement Plan,

18

finishing now our personal ODH strategic plan and

19

ultimately approves accreditation from PHAB.

13

We're not done, but we will be in

14

the next few weeks with our strategic plan. But

15

as it is completed that will be put out to all the

16

local health departments, and it was designed with

17

much input from local health, from probably about

18

60 associations around the State, at least as it

19           moved through the process to say what they thought  
20           was important.

9 DR. WYMYSLO: And, of course, the  
10 State Health Improvement Plan is available to  
11 everyone's eyes on looking to what we should be  
12 doing with health in Ohio.

13 I tell you what, we're going to do  
14 that translation. How about the Ohio Department  
15 of Health? What's our part of the responsibility  
16 for the balance needs of the State? That's what  
17 we're determining at this point.

12 COMMISSIONER INGRAM: I would  
13 agree with your perspective, Ms. Edwards.

14 I would be remiss -- I agree with  
15 Commissioner Edwards' comments regarding making  
16 sure the governmental public health system is  
17 aligned with the healthcare delivery system as it  
18 is transforming under the Affordable Care Act.  
14 one of the big things that they need to know how  
15 to do is link their patients with services,  
16 because they're being focused on how they're to  
17 manage that population of patients, relative to  
18 just not the individual.

19  
22 VICE CHAIR PRESS:

11 What level of interest would there  
12 be in having a couple, three members of the group

13 peel off and try to look at what I'll just call  
14 the "shall versus may issue" that may exist in the  
15 statute of regulations, come back to us in a  
16 couple of weeks to say there is a lot of shalls  
17 that could be reconsidered as may's and maybe  
18 eliminated.

5 DR. WYMYSLO: I certainly have to  
6 respond to that.

11 So what we want for a public  
12 health line is to understand the communities that  
13 can make good decisions about what is in the best  
14 interest of the community.

21 REPRESENTATIVE WACHTMANN:

24 I guess I would, Mr. Chairman,  
25 bring up one other bigger issue.

1 If at least in the case of some  
2 health departments that were headed more toward  
3 case management and administrative services of the  
4 other districts, I guess it begs the question why  
5 don't we potentially allow -- and this comes from  
6 only me, nobody else -- why not allow the  
7 potential for a county hospital to become the  
8 delivery of services in Henry County, or a county  
9 hospital?

13 But it seems to me that if we're  
14 going to allow the flexibility of this animal in

15 the future of delivering public health services at  
16 least from my perspective of rural counties, I'm  
17 not sure the current system is the best. It could  
18 be. And maybe there are other alternatives.  
19 Maybe there is a large organizational group that  
20 we want to get into this business.

2 COMMISSIONER NIXON:

16 So it's not that, you know, we're  
17 in competition with hospitals, it's more that the  
18 hospitals really aren't interested in providing  
19 those services and we are the stop-gap kind of  
20 provider that services may not exist at all unless  
21 we're providing it.

18 COMMISSIONER MCFADDEN: I share an  
19 axiom of public health issues, what no one else  
20 wants to do, public health will do.

2  
We have a primary  
health clinic in

3           our health department where 68-percent of our  
4           clients are Medicaid. I guarantee to you that  
5           there is no programming that anybody has that I  
6           know of that can survive with 68-percent of their  
7           cases by Medicaid. 25-percent of our clients are  
8           no pay.

17                           I do think it is an opportunity  
18           for public health and clinical medicine to form  
19           better partnerships, because I think that the days  
20           are just waiting around for people to come to  
21           us -- I'm speaking as a physician now -- may be  
22           gone. I mean, really to give good care we're  
23           going to have to find ways as physicians to go to  
24           people -

2                           DR. WYMYSLO:

8                           And so rather than seeing yourself  
9           as filling gaps that might exist in your health  
10           community, I would much rather see you driving  
11           where the health community is going. That is,  
12           first identifying how well you're doing in the key  
13           areas of public health that we measure. We do  
14           that with county health.

15                           But then the next important part  
16           is to mobilize the resources in the community to  
17           address the needs. And it doesn't have to all be

18           you, versus just making sure someone is addressing  
19           the needs in the community.

21                           MS SHAPIRO:

3                           Our goal, hopefully, is to assist  
4           the State as individual county departments or  
5           however we're structured to help the State reach  
6           their goals, but we also have our own goals within  
7           our community based on our community gap.

8                           So I think that needs to be  
9           factored into that minimum package or what we call  
10          the other services.

11                           COMMISSIONER INGRAM:

11                           So I continue to think that going  
12          forward as this system transforms and begins to  
13          change some of the outcomes we are stagnating on,  
14          we've got to roll the governmental public health  
15          system into that process.

21                           VICE CHAIR PRESS:

11                           Do we have an approach to add  
12          specificity to No. 7?

13                           How could we get it?

14                           COMMISSIONER NIXON: We have  
15          listed those shalls in the back.

16                           Perhaps to assign a group to look  
17          to those, we already have them.

18                   If there are areas that the  
19                   committee by the next meeting see that we ought to  
20                   consider, the maybes and shalls, we should bring  
21                   it to the committee.1

18                   SECRETARY TREMMEL: It could be a  
19                   complete list I think, if possibly the health  
20                   commissioners would be so inclined.

4                   VICE CHAIR PRESS: That work for  
5                   the group?

13                   We have heard comments about  
14                   according to the local health districts, according  
15                   to the other providers in the community. That  
16                   could be a hospital, a physician practice.

1                   it does call the question how do we create  
2                   cooperation.

9                   DR. WYMYSLO: Mr. Chairman, I  
10                   would like to say, you know, about that issue,  
11                   giving those folks the opportunity to make those  
12                   determinations within the community to communicate  
13                   health teams, and community health teams are a  
14                   common site where people go to keep with the  
15                   service so that they can get oriented in the  
16                   proper direction by a single team, rather than  
17                   continually working with a number of different

18 caseworkers that aren't talking with each other.

20 VICE CHAIR PRESS:  
24 I'm really focused on jurisdiction and  
25 cooperation.

4 COMMISSIONER INGRAM:  
16 But the fundamental question that  
17 came out of those reports was what is the  
18 appropriate size of that a local governmental  
19 health district should serve.

20 And I would tell you that it's my  
21 belief that there should be a -- probably a  
22 minimum size, just because of the needs to be able  
23 to deliver efficiently and effectively, to be able  
24 to coordinate care, coordinate communication  
25 relative to what disease is going around and the

1 population that you serve today.

13 And I think we'd just be kidding  
14 ourselves and saying that right now, first of all,  
15 we have a sufficient capacity, or the appropriate  
16 sustainable funding stream to ensure that capacity  
17 going forward. I think something has to change.  
18 I don't know what the number is. The number in  
19 this book suggests it was 150,000. The '93 study  
20 said one per county. The 1960 study said 100,000,  
21 nothing less than 25, no jurisdiction smaller than  
22 25,000.

20 VICE CHAIR PRESS: I'm going to  
21 borrow from Senator Burke who says consistently --  
22 I think I've got this right -- it's not so much  
23 establishing a size, it's as establishing a  
24 rational policy and letting size sort itself out.

18 MS. SHAPIRO: I think  
19 that what the drive is, is the flexibility for  
20 again, local communities to determine what's the  
21 best way of meeting those standards.

15 So I think there is all different  
16 kinds of models. I don't think that any one size  
17 fits all as an ideal for the communities.

6 COMMISSIONER MCFADDEN:

14 I would like to convey what you're  
15 suggesting, the flexibility for local  
16 jurisdictions, be it collaboration, be it  
17 consolidation, or if you could meet it on your  
18 own. I like the flexibility that is in here  
19 currently.

5 Each of our boards could in that  
6 structure stay intact and have the local  
7 jurisdiction within the county.

8 So as ODH relates to us we're one  
9 group, we've decided that we will come to ODH as a  
10 unified body, but we still have our board.

18 VICE CHAIR PRESS:

21 If there is an area for  
22 prescription you'd rather be a little more  
23 prescriptive around minimal requirements and less  
24 prescriptive around minimum size and let that sort  
25 itself out.

5 COMMISSIONER INGRAM:

15 Then you have to ask yourself,  
16 okay, what do you need in order to increase that  
17 capacity, what services, and we've been talking  
18 about that a little bit, and what uniformity are  
19 we looking for so that when you go from one health  
20 district to another that you won't get a complete  
21 different set of services and service level as you  
22 go from one jurisdiction to another.

23                   You have more consistency of  
24                   regulation. You have a similar fee structure.  
25                   You have easier reporting from physicians and  
1                   hospitals into the public health system for our  
2                   follow-up to make sure disease is not running  
3                   rampid, and so forth.

21                   COMMISSIONER NIXON:  
9                   But right now, the fact is that  
10                   most health departments can provide the mandated  
11                   services, they can do the things that they have  
12                   do, but beyond that they come up short.

17                   I think by all measures, if you  
18                   look at the Federal numbers, I think Ohio is not a  
19                   very healthy State. And I think if we're going to  
20                   commit ourselves to doing something about that we  
21                   have to take a look at the population health  
22                   strategies.

10                   There has got to be a certain  
11                   efficiency scale that we have to encourage,  
12                   strongly encourage through some prescriptive --  
13                   strong prescriptive means, or talk about size,  
14                   because I don't think -- if we keep everything  
15                   flexible we're back to where we were in 1993.

19                   MS. SCOFIELD:  
13                   If we allow for so much  
14                   flexibility at the local level that there is no

15 attempt, that we can't bring anything to scale,  
16 that's going to be hard to measure, then I think  
17 we're doing the change the process a little  
18 disservice.

22 REPRESENTATIVE WACHTMANN:

10 I mean, somehow we've got to build  
11 some framework. To me we've got to build some  
12 framework in this where -- the only thing I know  
13 that works in the private sector is competition,  
14 because I have the privilege of going out of  
15 business.

19 No. 1, can we measure. And if we  
20 can measure technically to know what services  
21 we're getting for the bucks in various health  
22 districts, can we potentially offer some of those  
23 services potentially out to contractors, someone  
24 that maybe can do it better, more efficiently,  
25 better service skills, all the other things that

1 are important to providing good public health.

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13

DR. WYMYSLO:

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And I think we need to ask those

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questions ourselves. Are we the best people to do

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this or is someone else better. Well, talking

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about salaries, talking about the needs, sometimes

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you'll find out they actually will be willing to

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do it.

24

And those are the kind of

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conversations that I think need to be happening at

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the local level to get the highest quality of

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service for the most affordable price that we can

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out there, or we're not going to move any of this

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stuff into a better place than it is today.

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MS. FOUGHT:

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Let's use the number of 100,000 and

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look at southeastern Ohio. And I'm sorry that I

8

keep harping on the southeastern Ohio bit.

9

But I know how much my township

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struggled down there. And I'm sure all the other

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political subdivisions down there are struggling,

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as well.

5

But when you start putting a

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population threshold and tying it to funding or

7

something else, you're going to lose a group of

8 people in this state that cannot afford the  
9 services, and they're not going to be able to  
10 afford the services no matter what you put in  
11 place for them.

18 But, you know, maybe a county  
19 apart they are willing to work together. Why  
20 shouldn't they be allowed to do it?

21 And if that's the flexibility that  
22 we're looking for and those are the types of  
23 standards that maybe we should change, or at least  
24 recommend to the General Assembly to change, I  
25 think that should be the direction, as opposed  
1 told setting forth certain population standards.

12 MS. SCOFIELD:

23 There is things about the administration, the back  
24 office function that could be across the board in  
25 many situations. HR, IT, finance, those types of  
1 things can, and there are a number of ways you can  
2 talk about the shared services or shared  
3 purchasing around that that could save a lot of  
4 money.

2 MS. FOUGHT:

10 I don't think population is  
11 the best way to do it, especially given the  
12 funding that have today of the health departments,

13 population in southeastern Ohio is not going to  
14 get the job done.

12 COMMISSIONER MCFADDEN: So one  
13 comment that I'd like to throw out for folks to  
14 throw darts at.

15 So I have a little bit of  
16 difficulty with the concept of the jurisdiction of  
17 14,000 can't be a functioning health district.

3 I don't think it's based on  
4 the size of the population it serves or the size  
5 of the health district. If I have enough money I  
6 can buy enough people to get the work done.

16 I wonder what it would look like  
17 if we said you can keep doing what you're doing  
18 right now. These are the standards we're going to  
19 hold up right now. You need to meet those  
20 standards. If you choose to stay the way that you  
21 are, you know, that's fine; but -- however, the  
22 State of Ohio is going to create block grants.  
23 And I'm going to throw out some numbers here. I  
24 would be doing \$5 per capita.

1 But the State of Ohio is going to  
2 have \$55 million that we will distribute. We will  
3 only distribute it to jurisdictions that come  
4 together forming a collaborative relationship or a

5 consolidation, you guys decide, that have X number  
6 of people and X number of counties.

7 You're not eligible for this money  
8 unless, one, you meet these standards, and two,  
9 you meet this jurisdiction size.

10 COMMISSIONER INGRAM:

5 But I will tell you that I do  
6 think that it is interesting she landed on the  
7 \$55 million number, because that is the same  
8 number I actually wrote in on the survey at \$5 per  
9 capita, but the only difference was that I believe  
10 that we should look whether it is coming out  
11 through block grant, we should be looking for  
12 asking for redistribution of the existing excise  
13 tax that is on tobacco.

14 There is \$868 million that was  
15 collected in tobacco taxes in this state in 2010.  
16 And if you look at the chronic diseases that we  
17 are chasing today, most of them have some ties to  
18 tobacco or the effects of tobacco use.

19 And I know that asking for that  
20 excise tax to be increased by \$1.25 a pack to  
21 something is probably not as politically  
22 acceptable in today's environment if we go back  
23 and ask for redistribution of some of those monies  
24 up to 7-percent, to go into a reconfigure perhaps,

25 block grant public health system that will allow  
1 for health improvements to occur in the future.

2 There is another \$45 million of  
3 tobacco tax dollars that are being collected  
4 today, I think it was passed in '93, on smoke less  
5 tobacco products. Okay? And I think that was  
6 based on a percentage of 17-percent -- 17-percent  
7 type of a formula.

23 Asking for  
24 7-percent of 860 million I don't think is  
25 unreasonable for the job that is ahead of us.

2 COMMISSIONER EDWARDS: A report in  
3 1993 says a numbers in the recommendation the  
4 State should assume a major responsibility or fund  
5 the profit -- providing the core public health  
6 functions in private practices.

7 Where is the State in all of this?

8 Because when I look at our county  
9 budget, the State subsidy for a total revenue of  
10 \$565,000, the State revenue subsidy is \$11,000.

11 So where are we with the State?

12 DR. WYMYSLO: What I would say  
13 now, because of this conversation about futures  
14 and we're in a biennial budget process right now,  
15 this is an excellent time to look at where we are,

16 where people think we should be, and to make  
17 recommendations that you all think we can float  
18 up.

13 For us to, you know -- my budget  
14 is about 12-percent GRF. Is that enough, or is  
15 that not enough for me to function as a State  
16 health department.

20 I tell you, I don't like being 36  
21 in the country in our state. That's not a point  
22 of pride for me. I'm used to being first.

9 VICE CHAIR PRESS: It sounds like  
10 there is less agreement around the minimum  
11 threshold size. It sounds like there are more  
12 folks that are more in support of that and some  
13 other folks less in support of that.

20 I'm hearing some discussion around  
21 how, but no consensus around the extension beyond  
22 the minimum services.  
1 though there was some discussion.

25 COMMISSIONER EDWARDS: Can I ask a  
1 question about if we go back to the agreement  
2 on -- talk about the population and sizes?

3 Could we potentially agree to a  
4 consolidation of health districts that use the  
5 same staff, but have two different boards?

23                   One's a city. Obviously, one is a  
24 city and one is a county.

12                   MS. FOUGHT:

16                   The only issue I see with that is  
17 that is a Home Rule decision.

24                   But for the most part, the cities  
25 have the right to do that. So that wouldn't be  
1 something legislatively we could change. It would  
2 have to be done via Constitution.

3                   COMMISSIONER EDWARDS: Then we're  
4 really going to have a very big issue with  
5 consolidating cities with county cities.

6                   MS. FOUGHT: No. They can choose  
7 to do it. The cities can choose, they just would  
8 have to go back and amend their Charters to take  
9 out that health board. But it's a city choice.  
10 They're choosing to keep that.

14                   COMMISSIONER NIXON:

19                   You know, to your earlier  
20 question, Ohio ranks last in Federal support for  
21 public health. And they're the last in State  
22 support. With that said, we get strong local  
23 support -- when you look at the local support for  
24 public health, the general revenue support, we're  
25 not that far off of others states. We are very

1 close in terms of total support for public health.

2 So I think to suggest that we go  
3 to the State and "give us some more money and  
4 we'll do everything you ask," I think is  
5 short-sided. I think that that is not out of the  
6 question. But I think as a public health  
7 community we've got to demonstrate we did  
8 something up front, okay, and build better  
9 efficiencies before we do that.

14 I do think we can build  
15 efficiencies for a lot of strategies. Like I  
16 mentioned, counsel of Government, you could share  
17 administration, you can do all kind of things.

4 COMMISSIONER INGRAM:

9 there is a 1921 Ohio  
10 Supreme Court decision that actually talked about  
11 that question. It's *Cuyahoga Heights versus*  
12 *Zangerelli* [phonetic].

13 And they actually said that since  
14 health districts are creatures of state statute  
15 that they actually -- in the nature of the public  
16 health being what it is, that they actually -- the  
17 Legislature has that authority, notwithstanding  
18 Charter 6.

19 MS. FOUGHT: Exactly.

20 Non-charter cities absolutely have  
21 the ability to do it, if the Charter cities that  
22 they don't.

5 VICE CHAIR PRESS: I'd like to  
6 suggest two things maybe to wrap up.

7 Mr. Tremmel could take us through  
8 the handouts that are at your seat. And maybe we  
9 can look at those between now and the next  
10 meeting.

15 SECRETARY TREMMEL:

2 You can look at the disparity in  
3 population.

7 You can look at local revenues.

16 Out  
17 of a \$564 million total revenue infrastructure for  
18 public health as we know it -- and this is data --  
19 let me qualify the data to suggest to you this is  
20 data that is reported to us through local health  
21 departments in their local in their annual  
22 financial reports.

1 Out of \$564 million in the public  
2 health system, 430 of that are generated at the  
3 local level.

17 COMMISSIONER MCFADDEN: Well,  
18 that's one of the at least two opportunities I've

19           said something that I think disagrees with what  
20           the Commission in this case said. And that is if  
21           at the State level we are going to be expecting  
22           more from local public health, I believe  
23           personally, D.J. McFadden here speaking, that the  
24           State has to have more skin in this game.

25                        I think it is very hard to demand  
1           local public health to do more than the local  
2           population are paying for it, not to stay -- I  
3           don't have a problem with --

4                        SECRETARY TREMMEL: And we can  
5           post this up on the website. It will show the  
6           lines of the five districts.

18                       VICE CHAIR PRESS:  
6           But I guess what I would like to  
7           maybe do is would it be better, should we take one  
8           of our future dates, maybe schedule a little  
9           longer time, focus our energy a little longer so  
10          we can kind of maybe -- because eventually were  
11          are going to really have to make some  
12          recommendations here.

4                        SECRETARY TREMMEL:  
6           This is the end of August. We're  
7           staring at two opportunities in September. We  
8           were thinking a little collaboration in October

9 and wrap up the report.

12 COMMISSIONER NIXON: Do we have an  
13 idea how we'll make those decisions?

18 VICE CHAIR PRESS: I have not  
19 discussed it with the chairman. We should get  
20 some schematics on that.

6 Anything else  
7 for the good of the order, or a motion to recess  
8 till next time?

9 COMMISSIONER INGRAM: So moved.

10 VICE CHAIR PRESS: Second?

11 COMMISSIONER SHAPIRO: Second.

12 VICE CHAIR PRESS: Thank you,  
13 everyone. I really appreciate your time.

14 - - -

15 Thereupon, the meeting adjourned  
16 at approximately 3:21 p.m.

17