



Ohio

Department of Health

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**Senate Medicaid Committee
SFY 2016-17 State Operating Budget
House Bill 64**

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Chairman Burke and members of the Senate Medicaid Committee, thank you for the opportunity to share the public health priorities and funding requests in the Governor's proposed Executive Budget. I am Rick Hodges, and I serve as Director of the Ohio Department of Health (ODH).

The healthcare environment is changing due to President Obama's Affordable Care Act, the extension of Medicaid coverage in Ohio, and efforts to increase value in healthcare spending. Implications of this change include a greater emphasis on value over volume; on achieving efficiencies; on evidence-based practices; and on improving population health outcomes and the need for greater collaboration to achieve them.

Public health must be part of this change, and when Governor Kasich appointed me Director of Health last August, he gave me a mandate to position ODH for it.

We should not change what we are about fundamentally in public health. ODH's mission is to "Protect and improve the health of all Ohioans" – and our mission remains the same in this changing environment. Our core public health responsibilities also remain the same: preventing and controlling the spread of infectious diseases; emergency preparedness and response; health improvement and wellness; health equity and access; environmental health; and smart regulation to assure quality healthcare services.

What must change is how we approach our work and how we operate to achieve the desired outcomes.

For example, we have implemented a new senior leadership model for ODH with both a Director and a Medical Director to strengthen agency management and ensure broader medical involvement in agency decision-making. ODH has more than 120 programs and 1,200 employees. Such a large agency needs strong management oversight, and ODH's new senior leadership model allows me to use my management experience to focus on leading and managing the agency. ODH must address many complex medical and clinical issues on a daily basis, and our new senior leadership model allows our Medical Director, Dr. Mary DiOrio, to focus her attention on these issues.

In addition to implementing a new senior leadership model, we are implementing a new organizational structure for the agency. Within a couple of months of my arrival at ODH, I concluded that the agency has terrific programs to help protect and improve the health of Ohioans, supported by passionate, dedicated employees. However, I regularly encountered examples of how ODH's organizational structure hindered the agency's ability to achieve maximum effectiveness and efficiency. The agency's structure – based largely around funding streams – fostered operating in silos and a narrow focus on meeting grant specifications rather than encouraging collaboration across the agency to achieve target outcomes. ODH's new organizational structure aligns the agency to promote collaboration, operate more effectively and efficiently, and better plan for and manage change.

ODH also is seeking accreditation by the national Public Health Accreditation Board. In doing so, ODH is one of the earliest state health departments in the nation to embrace national standards that reflect a highly functioning public health agency. We had our accreditation visit in early January and are waiting for our notice of accreditation.

These are all examples of how we have begun to make a good agency even better.

Public health proposals in the Executive Budget complement ODH's efforts to protect and improve the health of all Ohioans in the midst of our changing healthcare environment. Under the proposed Executive Budget, ODH's overall appropriation level will total \$656,875,690 in SFY 16 and \$657,031,286 in SFY 17. These levels will be essentially flat compared to SFY 15's appropriation level of \$658,308,390. GRF funding will increase slightly from \$89,257,614 in SFY 15 to \$90,750,078 in SFY 16 and SFY 17.

Improving Population Health Outcomes

I have noted that in our changing healthcare environment there is a greater emphasis on improving population health outcomes, including collaboration to achieve them. ODH works with Director Moody of the Governor's Office of Health Transformation and other health and human services agency partners to help improve Ohio's performance on key population health outcomes. The Executive Budget seeks to improve population health outcomes through a number of funding and policy initiatives as outlined below.

Reducing Infant Mortality

Ohio's infant mortality rate, measured based on the number of live-born babies who die before their first birthday, is among the worst in the nation. And our black infant mortality rate is twice the white infant mortality rate.

Over the last four years, an unprecedented package of reforms and new GRF sources targeted infant mortality, addressing the primary causes that account for 95 percent of infant deaths: premature birth, birth defects, and sleep-related deaths.

ODH's Progesterone Prematurity Prevention Project seeks to prevent premature births through prenatal progesterone treatment to help reduce births before the 32nd week of pregnancy when they are most likely to result in death or long-term disability of the baby.

The Ohio Perinatal Quality Collaborative's 39-Week Project focuses on reducing the number of elective births earlier than 39 weeks in order to increase full-term deliveries.

Smoking cigarettes during pregnancy has been identified as one of the most significant factors contributing to poor birth outcomes including about 10 percent of all infant deaths,¹ and the Prenatal Smoking Cessation initiative helps expectant mothers quit smoking.

Required newborn screenings have been expanded to include Critical Congenital Heart Disease, a group of heart defects that cause severe and life-threatening symptoms and require medical intervention early in life. Some babies born with a heart defect appear healthy at first and can be sent home from the hospital before their heart defect is detected. CCHDs account for 5 percent of all infant deaths in Ohio.²

Unsafe sleep environments place healthy infants at risk of sudden death, including from suffocation; each week in Ohio, three infant deaths are sleep-related. ODH's Safe Sleep public education campaign builds awareness about the ABCs of safe sleep: Place infants Alone, on their Back, in a Crib.

¹ U.S. Department of Health and Human Services, *Women and Smoking: A Report of the Surgeon General (2001)*

² Ohio Department of Health Vital Statistics *Death Certificate Data (1999-2010)*

The Ohio Institute for Equity in Birth Outcomes is targeting nine counties that account for 95 percent of the state's black infant deaths and 49 percent of white infant deaths.

The Executive Budget proposes continued GRF funding in the amount of **\$7.88 million** over the biennium to support current infant mortality initiatives.

Still, we must do more to save babies' lives.

Last December, Governor Kasich spoke at the 2014 Ohio Infant Mortality Summit and said that the current infant mortality rate is "clearly unacceptable." He announced that the Ohio Departments of Medicaid and Health would work together to surge resources into the neighborhoods with the highest incidence of preterm birth and low birth-weight babies. Specifically, the Executive Budget:

- ***Supports enhanced care management for every woman in high-risk neighborhoods.*** Ohio Medicaid managed care plans will be required to provide enhanced care management services for both pregnant and non-pregnant women in the most high-risk neighborhoods as a strategy to improve health status and future birth outcomes. ODH is using vital statistics data to pinpoint specific "hot spot" neighborhoods that have the poorest birth outcomes in the state as measured by preterm birth and low birth-weight babies. Using this data, Ohio Medicaid will be directing its health plans to automatically connect pregnant women and infants in these neighborhoods to enhanced care management services. In addition, women in these neighborhoods who are not pregnant now have access to additional care management services to improve their overall health and ultimately impact the health of future babies. The cost of this initiative is included in the rate currently paid to health plans and has no impact on the budget.
- ***Engages leaders in high-risk neighborhoods to connect women to healthcare.*** In addition to automatically requiring enhanced care management for all women of child-bearing age in high-risk neighborhoods, Ohio Medicaid also will direct its managed care plans to use community health workers who live in the most high-risk neighborhoods to assist with the outreach and identification of women, especially pregnant women, to make sure they are connected to ideal healthcare and other community supports. Rather than reach into a community and risk misunderstanding the issues that confront the women who live there, this proposal requires the plans to identify individuals from within the community who understand the issues and can remove barriers for the women living there. The community health worker will be expected to address more than just healthcare, and also connect women to community services outside the health plan that support healthy living and work. The health plans will be required to coordinate with local health districts in high-risk neighborhoods and, together, develop a communications plan to ensure all healthcare and community supports are aligned toward decreasing infant mortality and improving the health of families. This provision costs \$13.4 million (\$5.0 million state share) per year in 2016 and 2017.

- ***Focuses evidence-based strategies to reduce maternal smoking.*** ODH and Ohio Medicaid will use Tobacco Master Settlement Agreement funds to develop two standardized tobacco cessation toolkits, one to *initiate* tobacco cessation (2-3 months duration) and one to *maintain* tobacco cessation (up to 12 months). The toolkits will be used by Medicaid health plans, healthcare providers, and local health districts to provide individualized assessments and match individuals to the most effective services available for them. This effort will focus first on neighborhoods identified by ODH as most at risk for poor birth outcomes, and provide an opportunity for multiple community partners to target tobacco cessation messages, health-related activities, and grassroots engagement in ways that account for regional and cultural differences. Over five years, \$13.7 million in Tobacco Master Settlement Agreement funds will support this initiative.
- ***Expands access to peer support programs for expecting mothers.*** “Centering Pregnancy” is an evidence-based healthcare delivery model that integrates maternal healthcare assessment, education, and support. ODH together with the Ohio Association of Community Health Centers will establish and evaluate the Centering Pregnancy model of care in two urban and two rural settings. The four projects will be located in communities that are at high risk for poor infant health outcomes. Governor Kasich committed \$900,000 over three years from Ohio’s Health Innovation Fund for this project, so there is no impact on the Executive Budget.

The Executive Budget also proposes an additional \$1 million per year in GRF funds to increase the state’s ability to analyze and respond to infant mortality data. ODH holds a tremendous amount of vital statistics data within its data warehouse that can be used to help drive Ohio’s infant mortality reduction initiatives at the state and local levels.

As the state continues to increase investments and focus on infant mortality, there is a greater need for increased analytical capacity to target hot spots and to evaluate state and local efforts. It is our goal to expand state capability to measure progress in reducing infant mortality, and to ensure that policy decisions are data-driven and investments are outcome-based.

Additionally, the Executive Budget proposes statutory authority for ODH to convene state-level child fatality reviews to help identify trends and systemic policy changes that will help reduce the incidence of preventable infant and child deaths. Each of Ohio’s 88 counties maintains a local board to review all infant and child deaths. The Executive Budget allows ODH to examine this data and review particularly difficult or complex cases. State-level child fatality reviews will increase knowledge about infant and child deaths, and support the development of future recommendations to decrease infant mortality.

For an overview of past, present and proposed initiatives to reduce infant mortality in Ohio, read the Governor’s Office of Health Transformation white paper titled “Reduce Infant Mortality” [here](#) or on its website at healthtransformation.ohio.gov.

Reducing Tobacco Use

Ohio ranks 8th among states in the percent of adults who smoke. More than 1.6 million Ohioans smoke every day, and Ohio's adult smoking rate was 23.4 percent in 2013 — significantly higher than the U.S. rate of 18.1 percent.³ Smoking causes cancer, heart disease, stroke, and lung diseases, and impacts the chronic disease burden in Ohio. Expectant mothers who smoke contribute to Ohio's high infant mortality rate.

There also is a tremendous economic cost associated with smoking. Healthcare expenses directly caused by smoking in Ohio are estimated to cost \$5.64 billion annually, including approximately \$1.7 billion in Medicaid costs. In addition, smoking-related productivity losses are estimated to cost Ohio businesses about \$5.88 billion per year.⁴

That is why the Kasich Administration is committing 100 percent of Tobacco Master Settlement Agreement funds totaling \$38.6 million to help reduce tobacco use in Ohio.

ODH's efforts to curb tobacco use in Ohio focus on:

- Preventing youth from starting to use tobacco.
- Helping Ohioans who want to quit using tobacco.
- Preventing exposure to secondhand smoke.

Our initiatives include public education campaigns, the Ohio Tobacco Quit Line which provides tobacco cessation counseling to qualified individuals, and the Ohio Tobacco Collaborative which is a public-private partnership.

The Executive Budget proposes several targeted initiatives to reduce tobacco use:

- ***Increases the tobacco tax to deter tobacco use.*** Increasing the price of tobacco is the single most recommended and proven strategy for decreasing smoking prevalence and preventing youth from starting to smoke. The Executive Budget proposes to increase the cigarette tax rate by \$1.00 per pack to \$2.25 per pack, impose a cigarette floor stock tax of \$1.00 per pack, eliminate cigarette discounts, increase the other tobacco product (OTP) tax rate from 17 percent to 60 percent (to equalize OTP and cigarette tax rates), eliminate the 2.5 percent discount for early payment of the OTP tax, and tax e-cigarettes equivalent to OTP. These provisions are expected to generate \$527.9 million in state general revenue funds in 2016 and \$453.5 million in 2017. The House-passed budget does not include these provisions.
- ***Bans cigarettes and tobacco in K-12 settings.*** Most K-12 settings are already tobacco-free, but some are not, and the policy is not always applied uniformly to everyone at the school. The Executive Budget requires boards of education to ban smoking and tobacco use or possession by students, and ban use by staff or visitors anywhere on school grounds or at school activities.

³ U.S. Behavioral Risk Factor Surveillance System (2013)

⁴ Tobacco Free Kids, *The Toll of Tobacco in Ohio* (2014)

- **Requires colleges and universities to adopt tobacco-free policies.** The Executive Budget requires ODH and the Ohio Board of Regents to develop a model policy for tobacco-free campuses and, within one year, requires state institutions of higher education to adopt tobacco-free policies that are not less stringent than the model policy.
- **Strengthens and enforces Ohio's Smoke Free Workplace law.** The Executive Budget strengthens the Smoke Free Workplace law, which ODH and its designees such as local health departments are responsible for enforcing.

The Smoke Free Workplace law will be strengthened by:

- Requiring proprietors to permit prompt entry for ODH or its local designees to investigate violations of the Smoke Free Workplace law.
- Authorizing ODH to issue fines for violations to retail tobacco stores that are not meeting sales reporting requirements under the existing law.
- Providing \$1.4 million annually (\$1 million in GRF and \$400,000 in fine revenue) to enforce Ohio's Smoke Free Workplace law. The House eliminated \$1 million in GRF for this purpose.
- Giving local health districts the authority to revoke food service licenses for three or more violations of Ohio's Smoke Free Workplace law within a two-year period, or for failure to pay a civil fine in excess of \$1,000 issued after the enactment of this section. The majority of repeat violators of the law are bars and private clubs, most of which hold food service licenses.

For more details about these Executive Budget proposals to curb tobacco use in Ohio, as well as other non-budgetary initiatives through the use of Tobacco Master Settlement Agreement funds, read the Governor's Office of Health Transformation white paper titled "Reduce Tobacco use" [here](#) or on its website at healthtransformation.ohio.gov.

Population Health Planning and Hospital Community Benefit

The Executive Budget proposes the creation of a Population Health Planning and Hospital Community Benefit Advisory Workgroup to align population health planning with hospital community benefit.

As background, there are 123 county and city health departments, or jurisdictions, in Ohio. Governor Kasich's Jobs Budget 2.0 for the current biennium included several new initiatives designed to give local health jurisdictions more tools to collaborate and integrate programs. It standardized the collection and reporting of public health quality indicators by local health districts, created incentives to share services among local health districts, and required local health districts to be nationally accredited by 2020.

The Executive Budget for the next biennium expands on these efforts by fostering better regional population health planning to improve health outcomes, including by addressing infant mortality, tobacco use, and chronic diseases.

The proposed Workgroup will recommend strategies by December 31, 2015 for conducting Community Health Needs Assessments and developing Community Health Improvement Plans through regional

planning. Local health districts are required to conduct both to receive accreditation by the Public Health Accreditation Board. Many hospitals also conduct Community Health Needs Assessments. However, local health jurisdictions and local hospitals do not always complete these assessments in collaboration, nor do they jointly develop and implement regional health improvement plans. The Workgroup will recommend strategies for community health improvement collaboration through regional planning.

The Executive Budget also proposes to align hospital community benefit to improve population health outcomes. Non-profit hospitals are required to report their investments in the community to the IRS in order to maintain their tax-exempt status. In 2013, 171 Ohio hospitals registered as non-profit⁵ claimed \$3.12 billion in total community benefit statewide.⁶ While other states have enacted laws establishing additional expectations of non-profit hospitals, including specific community benefit requirements, there are no such requirements in Ohio law.

The proposed Workgroup will recommend what specific demonstration of community benefit should be required for a non-profit hospital to retain its tax-exempt status, and the extent to which it should be used to address population health outcomes in alignment with the regional Community Health Improvement Plan. The Workgroup also will consider the potential benefit of establishing regional community health and wellness trusts to receive and distribute potential hospital community benefit funds, tobacco settlement funds, or other grant funds in alignment with the regional Community Health Improvement Plan.

Regional population health planning creates an opportunity to set clear population health priorities, align resources to improve health outcomes through greater collaboration, and share services to achieve better results. The House-passed budget eliminates language establishing the Workgroup.

For more information about these Executive Budget proposals, read the Governor's Office of Health Transformation white paper titled "Improve Population Health Planning" [here](#) or on its website at healthtransformation.ohio.gov.

Investing in Core Public Health Responsibilities

The Executive Budget proposes to use GRF funding for the following new initiatives that support ODH's core public health responsibilities.

Emergency Preparedness

The Executive Budget proposes **\$1.45 million each year** in GRF funding to support ODH's emergency preparedness and response activities. Currently, there are no state GRF funds designated specifically for ODH's emergency preparedness and response. In 2014, Ohioans were confronted with contaminated drinking water in northwest Ohio, mumps and measles outbreaks in greater central Ohio, and potential Ebola exposure in northeast Ohio.

⁵ Ohio Department of Health, *Hospital Registration Data (2013)*

⁶ Ohio Hospital Association, *Community Benefit Report (2013)*

This request will allow ODH to build state capacity, including training, regional planning, equipment, supplies and other resources to support our local partners during public health emergencies. Given uncertainty over the federal budget in recent years, state GRF funding will ensure that Ohio is not solely reliant upon the federal government for our preparedness and response during public health emergencies.

ODH Laboratory

A nationwide investment in advanced molecular diagnostics is under way which will transform how the U.S. public health system detects and responds to diseases. The Executive Budget proposes **\$800,000 each year** in GRF funding to support the ODH Laboratory's molecular genetics/DNA-based testing and newborn screening capabilities.

The ODH laboratory's current testing capabilities include testing clinical specimens for Ebola virus, influenza, environmental testing for West Nile virus, agents of bioterrorism, and newborn screening.

This funding request to support molecular genetics/DNA-based testing will enable faster testing during infectious disease and foodborne illness outbreaks, offer enhanced state emergency preparedness capability in the event of a disaster or act of terrorism, aid in the detection of emerging diseases, and reduce the length of time to reach an accurate clinical diagnosis for some newborn screenings.

Specifically, the ODH Laboratory will use these funds to create a designated Molecular Testing Unit, add three scientists, upgrade the Laboratory Management Information System, and increase data storage capacity.

Hepatitis Surveillance

Viral Hepatitis is the leading cause of liver cancer and the most common reason for liver transplantation. The Executive Budget proposes **\$350,000 each year** in GRF to conduct Viral Hepatitis surveillance by analyzing hepatitis data received from private/commercial clinical labs.

Through such surveillance, ODH characterizes Viral Hepatitis disease patterns, and trends throughout Ohio. This information will be available to local health departments, healthcare providers and community-based organizations, and it supports early identification of Viral Hepatitis outbreaks, helps guide prevention activities, and informs policy decisions.

The ODH Hepatitis Surveillance Program was suspended in 2008 after state funding was redirected to meet other urgent needs. In 2013, ODH redirected funds from internal programs to provide one-time funding for limited Hepatitis C data review, and later expanded it to include hepatitis surveillance. This request will maintain funding for these efforts, and will reintroduce non-perinatal Hepatitis B surveillance – which has not been performed for more than six years.

Public Health Informatics

Public health informatics involves turning public health data generated by information technology systems into actionable information that can be used to inform policy decision-making and help protect and improve the health of populations.

ODH's information technology systems and more than 150 databases store a significant amount of public health data (e.g., birth defects, cancer). To utilize this data to its fullest potential and inform policy decisions to improve health outcomes, it must be converted into actionable information. States that have created a public health informatics infrastructure have been successful in making data more readily available for public health decision-making. The Executive Budget proposes **\$1.3 million each year** in GRF funding to coordinate public health informatics.

House Funding Changes to New Initiatives

The House-passed budget modifies the following appropriation lines impacting the initiatives outlined above:

- The Emergency Preparedness and Response ALI (440477) was reduced by \$750,000 per year. This line contains contingency funding to prepare and respond to public health emergencies and provides funding to support public health informatics coordination.
- The Public Health Laboratory ALI (440451) was reduced by \$251,017 per year. This line contains funding to support hepatitis surveillance and molecular testing in the ODH laboratory.

In addition, the House version reduces funding to the Public Health Laboratory (440451), Health Care Quality Assurance (440453), and Alcohol Testing (440472) ALIs by \$440,000. The funding supports rent expenses for ODH.

Maintaining Access to ODH Safety Net Programs During Transition to Coverage

The Executive Budget proposes **flat GRF funding over the 2016-17 biennium** for most of ODH's safety net programs and services, namely the Children with Medical Handicaps Program; Ryan White HIV/AIDS Part B Program; Breast and Cervical Cancer Project; and Perinatal and Reproductive Health Services.

An evaluation of the impact of the Affordable Care Act and the extension of Medicaid coverage in Ohio has concluded that populations who have benefitted from ODH safety net programs will gain Medicaid coverage or private health insurance through the ACA's Health Insurance Marketplace. Consequently,

moving Ohioans who are served by ODH's safety net programs to coverage will reduce the need for GRF spending on these programs.⁷

ODH will make it a priority to get eligible Ohioans connected to coverage, but this transition to coverage will take some time. The Executive Budget does not reduce funding for these safety net programs in order to make sure that no Ohioans go without needed services during this transition period. Over the biennium, ODH will monitor actual utilization levels and return savings generated through reduced utilization to the General Revenue Fund. The House added a provision requiring the Joint Medicaid Oversight Committee to review the appropriations for these programs.

There are two ODH programs for which the Executive Budget proposes to reduce GRF funding for the biennium.

The Help Me Grow Home Visiting Program is a parenting education program for first-time parents whose children are at highest risk for poor birth and childhood outcomes. While the program was not part of the evaluation of the impact of the Affordable Care Act and extension of Medicaid coverage in Ohio, ODH believes that GRF funding for the program can be reduced by \$2 million each year compared to SFY 15. The proposed funding amount is in line with the amount for which Help Me Grow Home Visiting providers billed ODH in SFY 14, so the proposed reductions should not result in a reduction in services.

In addition, the Executive Budget proposes to discontinue using GRF funding beginning January 1, 2016 to purchase vaccines for distribution to local health departments to vaccinate individuals who are now eligible for vaccinations through the extension of Medicaid coverage in Ohio or private health insurance under the Affordable Care Act.

Local health departments and other providers will be expected to bill private insurers and Medicaid to recoup the cost of providing such vaccines. As a result, the Executive Budget proposes approximately a \$2.8 million reduction in the immunization line. Remaining funds in the line primarily will support non-vaccine related expenses such as the state immunization registry.

ODH proposes to continue providing GRF funding for vaccines for the first half of SFY 16 to give local health departments sufficient time to develop their billing capabilities and to build up their inventory to conduct billing. ODH and the Association of Ohio Health Commissioners are offering local health departments technical assistance in developing their billing capabilities.

Accounting Changes

The Executive Budget also proposes the following accounting changes:

- Creation of a new dedicated Public Health Emergency Preparedness Fund (3GN0, Public Health Emergency Preparedness) and ALI (440660, Public Health Emergency Preparedness) to improve budget transparency and enhance cash reconciliation efforts. This will allow ODH to segregate federal emergency preparedness funds from other federal funds, improve budget transparency,

⁷ *Mathematica Policy Research (2014)*

enhance cash reconciliation efforts, and strengthen preparedness and response efforts. This is not a request for additional funding.

- A mechanism to enable ODH to distribute approximately \$125,000 (projected for end of SFY 15) in donations and interest in the Choose Life Fund. The Choose Life Program is funded through license plate revenue which is distributed to organizations such as maternity homes and pregnancy resource centers to aid pregnant women and support adoption. Existing law only allows funds to be distributed to organizations in the county in which the revenue was generated, or contiguous counties, but funds have accumulated due to no eligible organizations applying for them.

Other Statutory Changes to Maximize Efficiency

The Executive Budget also proposes the following changes in the Ohio Revised Code to increase efficiencies:

- Make technical corrections in references to federal funding sources in the Physician and Dentist Loan Repayment Programs and eliminates the requirement for these programs to submit annual reports as this information can be made available at any time. Allow dentists participating in the program to receive reimbursement for teaching dental hygiene and expanded function dental assistant students at the service site, in addition to dental students and residents as allowed under existing law.
- Allow facsimile and electronic physician signatures on death certificates. Existing law requires physicians to certify the facts of death with an original “wet” signature. Currently, funeral homes may fill out their portion of the death record electronically but then must travel to physicians’ offices to obtain original signatures which increases costs and delays the completion of death certificates. The Ohio Funeral Directors Association supports this proposed change.

Other House Changes

The House-passed budget included several additional changes impacting ODH which are outlined below:

- The House added a new provision establishing the Hope for a Smile Program, requiring ODH to purchase a bus to provide mobile dental services to uninsured and low-income children in schools.
- The House added a new provision requiring local registrars to issue noncertified birth and death certificates.

Conclusion

Thank you again for allowing me the opportunity to present ODH’s spending and policy priorities for the next biennium. Our decisions about how to allocate and spend limited financial resources have a direct impact on the health of all Ohioans.

During this time of change in the healthcare environment including public health, ODH is committed to a renewed focus on our core public health responsibilities, and I respectfully request your support of the

Executive Budget proposals I have outlined today which will support these efforts. I am happy to answer any questions you have at this time.