

beyond medical care

Emerging policy opportunities to advance prevention and improve health value in Ohio



September 2015

High costs, poor outcomes

State government, consumers and employers in Ohio spend a lot of money on health care, but our health outcomes generally are not good. The **2014 HPIO Health Value Dashboard** finds that Ohio ranks 47th for health value. This means Ohioans are living less healthy lives despite spending more on health care than people in most other states.

Some Ohioans experience significant challenges on the path to better health. Ohio has sharp disparities in many health outcomes by race, income, geography, and other factors. Ohio's black infant mortality rate (13.93), for example, is more than twice as high as the white infant mortality rate (6.37).¹ Socioeconomic status also plays a strong role in influencing the health of Ohioans; 42% of Ohio adults with less than a high school diploma report having fair or poor health, for example, compared to only 7% of college graduates.²

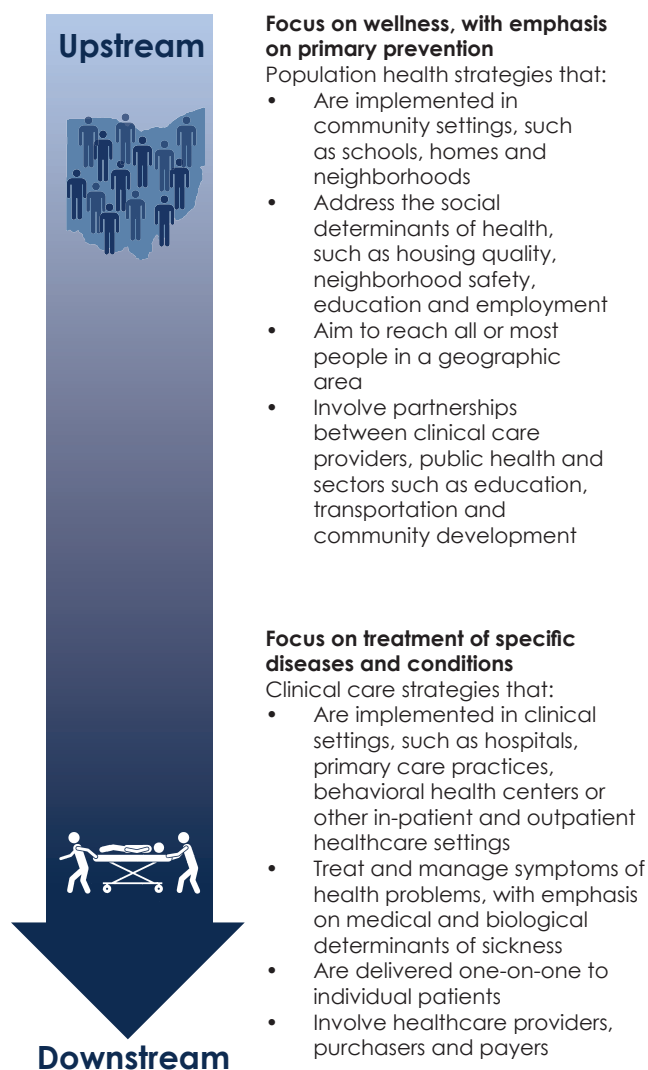
Working together, policymakers, healthcare and public health organizations and other partners can take on these challenges and improve health value in Ohio. This report provides leaders with a roadmap to expand the health policy agenda in Ohio to include a more balanced focus on the factors that shape our health both inside and outside the clinical care system.

Missed opportunities for upstream prevention

There are many reasons why Ohio has high healthcare costs and poor health outcomes, but one finding from the *Dashboard* stands out: Ohio ranks last among all states in **Public Health and Prevention**. This reflects challenges such as low childhood immunization rates, low investment in tobacco prevention, and a relatively small public health workforce.

The good news is that there are evidence-based strategies that Ohio can implement to improve outcomes. This publication focuses on policy opportunities to increase Ohio's commitment to preventing illness and injuries,

Figure 1. **Going upstream to improve population health**



with emphasis on upstream strategies that address the causes of health problems rather than just the symptoms and conditions (see Figure 1).

Upstream prevention is a critical component of population health strategies, which focus beyond the patient population and reach all people living within a geographic area. The population health approach goes beyond medical care to address the social determinants of health through community-based prevention and partnerships with sectors such as education, housing, transportation and regional planning.³

This report provides leaders with a roadmap to expand the health policy agenda in Ohio to include a more balanced focus on the factors that shape our health both inside and outside the clinical care system.

Recognizing that changes in healthcare delivery alone are unlikely to achieve needed improvements in health outcomes, healthcare leaders are increasingly embracing population health approaches. The US Centers for Medicare and Medicaid Services, for example, requires State Innovation Model (SIM) awardees (including Ohio) to develop and implement a Population Health Improvement Plan, and suggests inclusion of “community-wide strategies” such as smoking cessation groups and healthy school lunch policies.⁴ See HPIO’s publication, [What is “population health?”](#) to learn more.

Why upstream prevention?

Access to quality health care is necessary, but not sufficient, for good health. In addition to medical care, health is shaped by our behaviors and by the social, economic and physical environment. When combined, these non-medical factors like education, nutrition and air quality are estimated to be the most significant modifiable drivers of health outcomes (see Figure 2).⁵ Genes also impact our health, but are largely considered to be “non-modifiable” in terms of public policy. Research suggests that improving behavioral and environmental conditions saves more lives over time compared to expanded healthcare coverage and improved healthcare quality.⁶

Even though health starts long before we get to the doctor’s office, Ohio, like the US overall,⁷ spends most healthcare dollars on treating health problems that in many cases could have been prevented. Approximately 6% of total spending by Ohio’s five state health agencies was invested in prevention in State Fiscal Year 2013.⁸ This prevention spending includes Medicaid expenditures on screenings for cancer and sexually transmitted infections, the Ohio Department of Health’s (ODH) WIC program, and Mental Health and Addiction Services’ school-based alcohol and other drug prevention programs.

This mismatch between health determinants and healthcare spending has led to many missed opportunities to prevent illness and disability. Thousands of Ohioans have developed diabetes, missed school or work due to frequent asthma attacks, struggled with opiate addiction, or died of lung cancer as a downstream result of unbalanced investments.⁹

What is prevention?

Prevention addresses health problems before they occur, rather than after people show signs of disease, injury or disability.

Prevention programs often help individuals engage in healthier behaviors, such as driving safely or not smoking. Many also focus on improving the overall community so that healthy behaviors are expected and supported, and people have clean water to drink, safe places to walk and play and other conditions that contribute to wellbeing.

Levels of prevention

- **Primary prevention** occurs when there is no health problem present and aims to prevent a disease, injury or other health problem from occurring in the first place.
- **Secondary prevention** occurs at the first signs of a health problem and aims to detect health problems at an early stage and/or to slow or halt the progress of an existing disease or injury.

Types of prevention strategies:

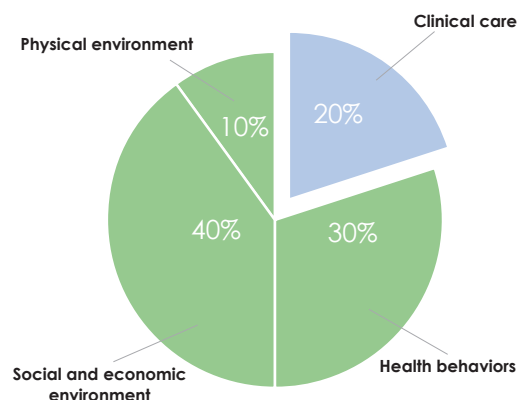
Settings and payers

- **Clinical preventive services**, such as mammograms and flu shots, are provided in a healthcare setting and are usually paid for by health insurance plans.
- **Community-based prevention programs**, such as school-based drug and violence prevention sessions and home visits for newborns, are delivered in nonclinical settings such as schools, workplaces, homes and neighborhoods, and are not typically covered by health insurance plans.
- **Population-based policy changes**, such as smoke-free workplace laws and impaired driving laws, aim to modify the environment so that everyone in the community has the opportunity to be healthy and safe.

See HPIO’s publication, [Ohio Prevention Basics](#) to learn more.

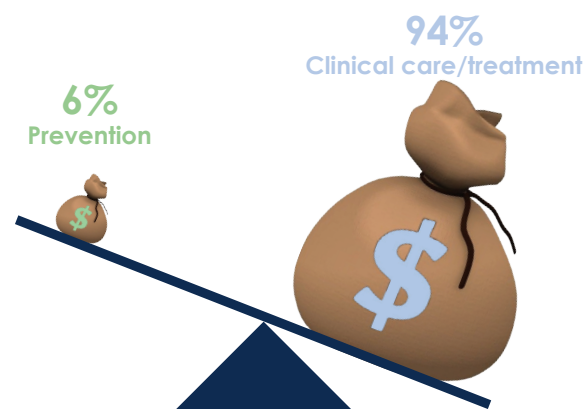
Figure 2. **Out of balance**

Factors that influence health



Source: Booske, et. al, "Different perspectives for assigning weights to determinants of health," County Health Rankings working paper, February 2010.

State health agency spending in Ohio



Source: "Ohio Prevention Basics: A closer look at prevention spending." Health Policy Institute of Ohio, 2015.

Prevention's impact on outcomes and costs

A growing body of evidence finds that prevention strategies can have a significant positive impact on population health outcomes, but that it can take many years for those benefits to be realized on a broad scale. Numerous studies¹⁰ provide evidence that specific prevention strategies can:

- Reduce the prevalence of conditions like heart disease or low birth weight
- Reduce risk factors like smoking or distracted driving
- Increase protective behaviors like physical activity or breastfeeding

There is strong evidence for the cost-effectiveness of many—but not all—prevention activities. An analysis of 20 evidence-based clinical preventive services, for example, found that some failed to yield net medical cost savings (such as cholesterol and osteoporosis screening), while others resulted in significant savings (such as childhood immunizations and smoking cessation).¹¹

Studies suggest that primary prevention, particularly community-based approaches directed at the population level, may be more cost-saving than most clinical preventive services.¹² Taken together, this emerging body of evidence indicates that upstream

prevention strategies have a critical role in improving health value.

Visit [HPIO's Guide to Evidence-Based Prevention](#) for more information about effective prevention strategies.

Towards a more balanced portfolio of health strategies

Healthcare system financing and payment have historically favored institutional clinical care over community-based strategies, and often fail to incentivize providers to effectively support behavior change or address community conditions. For this reason, it is often difficult to generate and sustain investments in upstream prevention.

Starting in 2013, HPIO began convening a group of prevention stakeholders to explore cross-cutting, state-level policy opportunities to expand the health policy agenda in Ohio beyond the "sick care" system to address the many factors that shape health beyond the doctor's office. Using decision criteria listed on page 14, the group identified opportunities with three broad aims:

1. Change incentives within the healthcare system
2. Leverage potential new sources of funding
3. Nurture cross-sector partnerships and perspectives

Taken together, these strategies represent a balanced portfolio of health improvement activities both inside and outside the healthcare system.

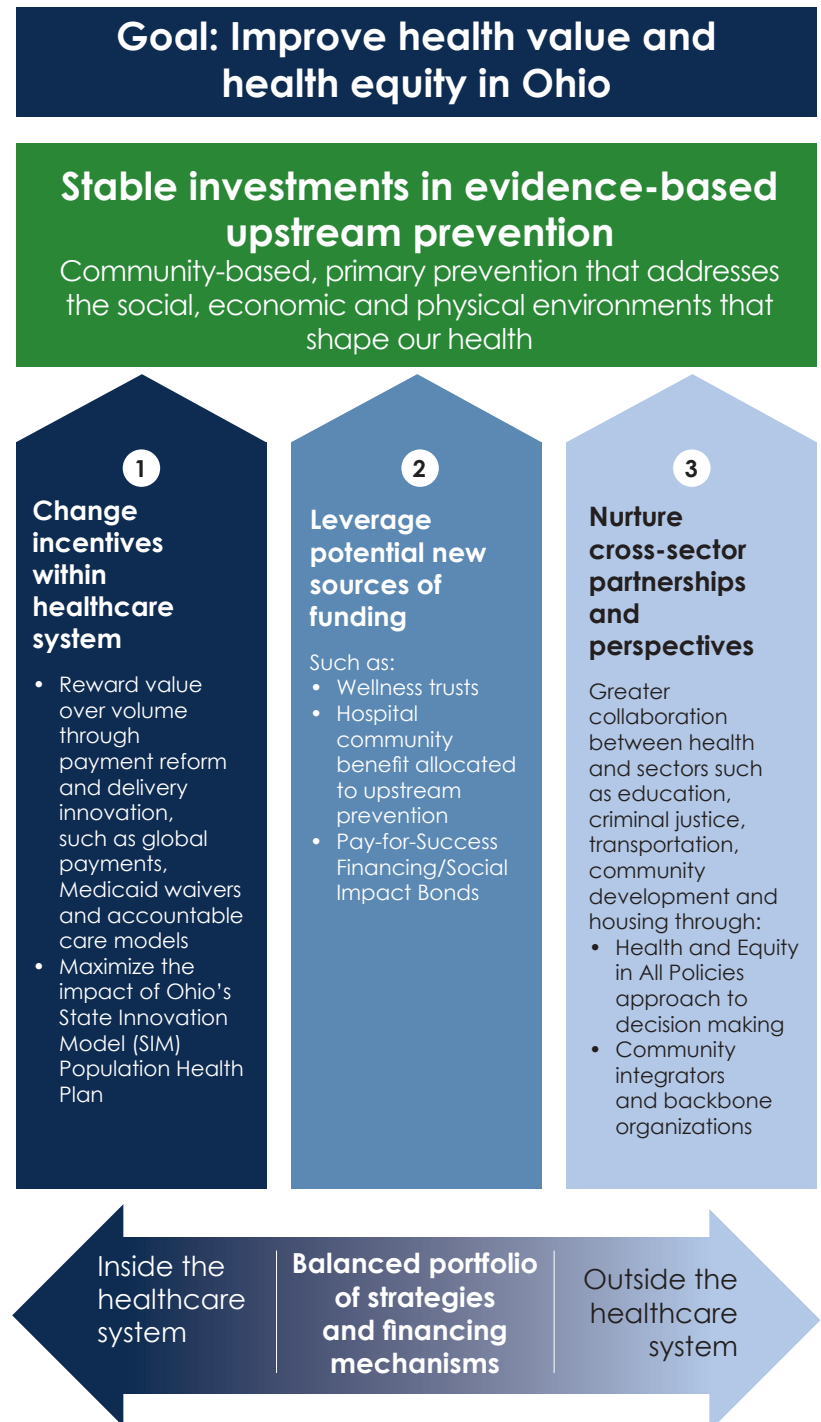
Taken together, these strategies represent a balanced portfolio of health improvement activities both inside and outside the healthcare system (see Figure 3). The overall goal of these strategies is to improve health value and health equity by increasing Ohio's commitment to evidence-based prevention.

Policy options within these three categories are briefly described in this report. Additional details on the Ohio landscape and examples from other states are included in a series of *fact sheets* that accompany this report.

Recognizing the need for a comprehensive approach to population health improvement that engages both public and private partners, this report offers recommendations that can be implemented by:

- State-level policymakers, including legislators and state agency leadership
- Healthcare leaders, including payers, providers and purchasers
- Philanthropy, employers and other private sector leaders
- Public health leaders, advocates and other community-based prevention organizations
- Local-level policymakers

Figure 3. **Emerging opportunities to advance prevention**



Many of the recommendations in this report are for “public and private partners.”

Examples of **public partners** that can act on these opportunities include:

- State agencies, such as ODH and the Ohio Department of Medicaid
- State legislators
- Local policymakers and agencies, such as county commissioners, school boards, local health departments and behavioral health (ADAMH) boards

Examples of **private partners** include:

- Hospitals and health systems
- Medicaid managed care plans
- Foundations
- Associations and other state-level nonprofit organizations
- Community-based organizations

In order to successfully link clinical care with community-based prevention, and to incentivize prevention within the healthcare system, changes to healthcare payment structures are needed.

Paying for value over volume through payment reform

Payment reform or innovation refers to policy and system changes designed to shift from paying for volume to paying for value. The goal is to transition from the current fee-for-service (FFS) system, which pays a provider for each specific service delivered to a patient, to value-based payment mechanisms that take into consideration quality of care, outcomes, and cost, and incentivize coordinated care.

Payment reform includes a continuum of payment mechanisms that differ in the extent to which providers are held financially accountable for performance. Examples include:

- Pay-for-performance (P4P) arrangements
- Care coordination payments
- Bundled or episode-based payment
- Global payment

Changes in payment mechanisms can also accompany changes in healthcare delivery models and vice versa. For example, Patient Centered Medical Homes (PCMH) receive care coordination payments in exchange for delivering enhanced primary care services to patients and meeting set performance objectives. An Accountable Care Organization (ACO) is an integrated network of providers that manages the care of a defined patient population. This healthcare delivery model can be coupled with global payment and shared savings/risk arrangements. Under a shared savings/risk arrangement, providers share in financial savings if the cost of managing their patient population is less than a set global payment amount and/or risk financial loss if the cost of care is above a set amount.

As providers take on increased risk and are held accountable for good health outcomes, they are seeking new ways to help patients stay healthy. When well structured, payment reform arrangements can increase incentives for primary and secondary prevention within

the healthcare system and create stronger links with community-based prevention partners. In an ideal environment, providers are incentivized to go beyond managing a diabetic patient's A1C levels, for example, and instead hold shared accountability for reducing the overall prevalence of type 2 diabetes within a geographic population.

To learn more about the payment reform landscape in Ohio and implications for upstream prevention, see the [Paying for value over volume fact sheet](#).

Payment reform recommendations

The following strategies would accelerate the pace of the transition from volume to value in a way that incentivizes investments in prevention.

Public and private payers can:

1. Tie payment arrangements to performance on risk-adjusted outcome measures (such as percent of patients who successfully quit smoking), not just process or clinical-encounter measures (such as percent of patients screened for smoking status).
2. Explore shared savings arrangements that require a percent of any financial savings be reinvested into community-based prevention activities.

Ohio's Medicaid program can:

3. Continue to pursue more outcome measurement and pay-for-performance (P4P) in Medicaid managed care and explore section 1115 waivers that could allow Medicaid to cover community-based interventions.
4. Encourage Medicaid managed care plans to work with local health departments, social service agencies and other community-based organizations to address non-medical issues that impact health, such as housing, violence, and access to opportunities for healthy eating and active living.

Public and private healthcare leaders can:

5. Support the spread of accountable care models (ACOs, Accountable Communities for Health, etc.) to reach larger numbers of Ohioans and incentivize greater investment in community-based prevention activities.

6. Ensure that ACOs and ACO-like organizations are specifically designed to improve health outcomes. This can be accomplished through governance and design, delivery system enhancements, tying payment to performance on population health metrics and data sharing across sectors.¹³
7. Explore ways to take the PCMH model upstream, such as care coordination fees that explicitly include coverage of Community Health Teams, Community Health Workers, and other services that actively link patients to community-based organizations that address non-medical factors such as housing and healthy food access.
8. Maximize the impact of Ohio's State Innovation Model (SIM) initiative by integrating community-based prevention into the PCMH model and other payment and delivery transformation activities, and

by developing a strong SIM Population Health Plan that supports upstream prevention strategies.

Public health leaders can:

9. Coordinate with Medicaid managed care plans, ACOs, and other healthcare partners and communicate how local health departments and other community-based partners can help them to address health behaviors and community conditions.

Behavioral health leaders can:

10. Coordinate with Medicaid managed care plans, ACOs, and other healthcare partners and communicate how local behavioral health (ADAMH) boards and community-based behavioral health providers can help them to address housing, substance abuse prevention and mental health early intervention.

2

Leverage potential new sources of funding

While payment reform may eventually lead to stronger incentives within the healthcare system to invest in upstream prevention, states and local communities in the US are experimenting with innovative financing vehicles to support community-based prevention today. These new approaches focus on increasing the sustainability of prevention funding, leveraging both public and private dollars, and prioritizing investment in evidence-based strategies that can demonstrate outcomes within medium- to long-term time horizons.

Wellness trusts

A wellness trust is a pool of funds used to support community-based prevention activities. The purpose is to establish a sustainable funding source to support a strategic and coordinated set of evidence-based prevention activities.

Rather than relying upon a state's general revenue fund or federal grants, revenue for a wellness trust can come from a variety of public and/or private sources, such as:

- Private or corporate philanthropy
- Assessments on healthcare entities, such as health insurers or hospitals

- Community benefit funds from tax-exempt hospitals
- Taxes or fees on products with known health risks, such as tobacco or sugar-sweetened beverages
- Tobacco Master Settlement Agreement funds or other legal penalties or settlements
- User fees, dedicated license plates or other portion of voluntary purchases¹⁴

The Massachusetts Wellness and Prevention Trust and the Texas Delivery System Reform Incentive Payment pool are two prominent examples, and Wisconsin and Illinois are currently exploring other innovative wellness trust approaches. For additional examples and recent activity in Ohio, see the [Wellness trust fact sheet](#).

Wellness trust recommendations

Public and private partners can consider establishing a state-level wellness trust and/or a network of local-level or regional trusts in Ohio. Stakeholders will first need to identify:

1. A source or sources of funding (see list above), and
2. An administrative body to manage the distribution of funds to the local or regional level (could be within state government or a private, nonprofit entity).

In addition, stakeholders should consider the following recommendations in defining the mission and scope of the trust:

3. Set goals to improve population health outcomes, promote health equity and reduce healthcare costs.
4. Establish a coordinated approach to outcome measurement, including public reporting on health outcome and cost indicators.
5. Fund a balanced portfolio of evidence-based health improvement activities that includes primary prevention and community-based prevention activities, as well as prevention strategies that link clinical health care with community resources.
6. Foster collaboration between hospitals and local health departments on community health improvement plans, and alignment between local/regional and state-level population health priorities.
7. Ensure that decision making is informed by engagement from community residents, public health experts and other key stakeholders.
8. Identify funding sources that are sustainable and allow for stable investments in prevention activities that may take several years to demonstrate positive population health outcomes or cost savings.

Leverage hospital community benefit for upstream prevention

The IRS requires nonprofit hospitals to justify their tax-exempt status by allocating a portion of their operating expenses towards the provision of community benefit – defined as initiatives or activities undertaken by hospitals to improve the health of the communities in which they serve. Historically, charity care and other forms of uncompensated direct patient care have made up the vast majority of hospital community benefit activities and expenditures.

Over the past few years, several policy changes have resulted in an unprecedented opportunity to shift some hospital community benefit expenditures away from charity care and other forms of direct patient care and toward community-based prevention:

- Changes in IRS reporting requirements have broadened the types of activities that are reported to the IRS as community benefit to include certain activities that address social, economic and physical environments that impact health.
- Expanded availability of health insurance through the Affordable Care Act (ACA) is reducing the number of people who are uninsured. This means that hospitals may have lower charity care costs in coming years, potentially allowing hospitals the opportunity to shift investments toward community health improvement activities, although the scope of this change is not yet known.
- The ACA requires nonprofit hospitals to conduct a Community Health Needs Assessment (CHNA) every three years and adopt an Implementation Strategy to address prioritized health needs. This requirement prompts hospitals to deepen engagement with surrounding communities in order to improve population health. Partners in this work include local health departments which are required to undertake a similar assessment and planning process.

Taken together, these and other changes have prompted many nonprofit hospitals to expand investments in upstream initiatives. Cincinnati Children's Hospital, for example, partners with the Legal Aid Society of Greater Cincinnati to address housing code violations that lead to asthma triggers like mold. Good Samaritan Hospital's Phoenix Project partnered with the City of Dayton to invest in a revitalization project in two neighborhoods adjacent to the hospital that led to the creation of a park, a playground, community gardens and a new school. These investments help improve the health of the local community, and may reduce medical costs over time.

For more information about community benefit requirements and what other states are doing to encourage hospitals to invest in upstream prevention, see the [Community benefit fact sheet](#) and HPIO's [Making the most of community health planning in Ohio: The role of hospitals and local health departments](#).

Hospital community benefit recommendations

Nonprofit hospitals can:

1. Exchange information and ideas with other nonprofit hospitals about upstream prevention activities that can be reported as community benefit.
2. Partner with local health departments and other community-based organizations to identify, implement and evaluate prevention activities.
3. Devote community benefit dollars to the implementation of evidence-based primary prevention activities.

State, local and regional associations and prevention organizations can:

4. Provide education about the broad range of activities that are allowable as community benefit expenditures by showcasing upstream work already being done by many Ohio nonprofit hospitals.
5. Offer training and technical assistance to nonprofit hospitals on evidence-based prevention strategies, program evaluation, community engagement, health equity, policy and environmental change and other population health topics.

State agency leaders can:

6. Develop guidance for nonprofit hospitals designed to increase transparency and encourage collaboration that results in greater investments in community-based prevention.
7. Bring hospital and public health stakeholders together to identify strategies for increasing alignment, coordination and effectiveness of local health improvement planning, including effective allocation of community benefit spending.

Pay-for-success financing

Pay-for-success projects, also referred to as social impact bonds (SIBs), involve a performance-based contract between a service provider (usually a private non-profit organization implementing an evidence-

based intervention) and a payer (usually a government agency). The agency agrees to pay the service provider if specific outcomes are met at the end of a set time period, typically three to seven years. In order to fund implementation of the intervention up front, the service provider raises money from philanthropy, banks or other private investors. These investors assume the risk; they receive a "success payment" if the intervention is successful, but absorb the losses if the outcomes are not achieved. The government agency benefits because it only has to pay the service provider if outcomes are met. This gives government agencies the opportunity to make investments in prevention without taking on the risk of paying for an intervention that does not work.

A third-party evaluator assesses outcomes, typically using a comparison group and rigorous evaluation methods. A fourth-party intermediary organization facilitates the contract, negotiates the financing terms and oversees the intervention.

The pay-for-success financing vehicle is best suited to program areas with clearly-defined outcomes, available administrative data and existing evidence-based interventions.¹⁵ Although initially developed in the areas of corrections, workforce training and early childhood education, SIBs can be well-suited to health-related interventions that can demonstrate cost savings within a medium-term time frame for a specific population. Efforts to reduce asthma exacerbation or preterm birth, and supportive housing for people recovering from addiction are examples of program areas that may be a good fit for this approach.

In 2014, Cuyahoga County launched Ohio's first pay-for-success project, Cuyahoga Partnering for Family Success. The goal is to reduce length of stay in out-of-home foster care placements for children whose families are homeless. To learn more about this and other examples of pay-for-success financing, see the [Pay-for-success financing fact sheet](#).

Pay-for-success financing recommendations

Public and private partners can:

1. Build collective knowledge about pay-for-success financing in Ohio.
2. Identify and cultivate champions within state and local government who can follow through on pay-for-success project ideas.
3. Identify private investors willing to participate in pay-for-success projects.
4. Build capacity to enter into pay-for-success contracts by sharing lessons learned from the Cuyahoga County project and health-related pay-for-success projects in other

states, and by engaging experienced intermediary organizations to provide guidance.

State health agencies, Medicaid managed care plans, ACOs and local governments can:

5. Identify projects that would be a good fit for the pay-for-success financing model.

State and local-level policymakers can:

6. Consider ways to reduce barriers to pay-for-success contracts, such as siloed budgets and data systems, and inflexible procurement rules and budgeting requirements.¹⁶

3

Nurture cross-sector partnerships and perspectives

Everyone has a role to play in improving the wellbeing of Ohioans. Because no single sector alone can address all the factors that shape health, healthcare and public health leaders increasingly recognize the importance of working more closely with sectors such as housing, education and transportation. Bringing multiple sectors together to identify and address common goals, however, is often fraught with logistical, bureaucratic and political hurdles. Two concepts are particularly useful for overcoming these challenges.

First, the Health and Equity in All Policies framework provides a useful way for health stakeholders to engage non-health partners in discussions about common goals and ways to embed health considerations into the policymaking process. Second, having a lead entity with the capacity to bring partners together to define, measure and achieve a common goal is a critical ingredient for successful cross-sector collaboration. This type of entity is referred to as a “community integrator” or “backbone organization.”

The Health and Equity in All Policies approach to decision making

Health and Equity in All Policies is a “collaborative approach to improving the health of all people by incorporating health considerations into decision-making across sectors and policy areas.”¹⁷ This approach uses tools such as Health Impact Assessments (HIA) to identify ways that policy decisions in sectors such as transportation,

education, criminal justice and housing may affect population health outcomes.

On the surface, for example, decisions made by the Ohio School Facilities Commission may not seem to have anything to do with health. However, the Ohio School Design Manual’s inclusion of “minimum acreage requirements” for new school sites has encouraged construction of large school buildings in remote areas, resulting in fewer children being able to safely walk or bike to school. This makes it more difficult for children to incorporate physical activity into their daily lives, potentially resulting in negative health outcomes like obesity and diabetes later in life. Taking a Health and Equity in All Policies approach to this issue, ODH is currently working with the Ohio School Facilities Commission to recommend revisions to the Ohio School Design Manual that would better support safe bike and pedestrian access to schools.

The goal of this approach is that decision makers, such as state legislators and school board members, consider the potential positive or negative impacts of their decisions on health outcomes, health equity and healthcare costs. With greater awareness of health consequences, policymakers can then minimize risks and maximize health benefits.

Several local health departments have taken the lead in conducting HIAs in Ohio. See the [Health and Equity in All Policies fact sheet](#) for these Ohio examples, as well as strategies other states are implementing to integrate health considerations into the policymaking process.

Health and Equity in All Policies recommendations

Public and private partners can help build capacity for cross-sector collaboration in Ohio by supporting:

1. Training sessions and ongoing technical assistance on Health and Equity in All Policies and Health Impact Assessments (HIA).
2. Peer-to-peer information sharing and mentoring between experienced organizations and those that are new to Health and Equity in All Policies.

Public and private funders can:

3. Institute grant requirements or Request for Proposal (RFP) components that encourage and support grantees or applicants to partner across multiple sectors, conduct HIAs, or to embed health considerations in decision-making processes.

State and local-level policymakers can:

4. Identify projects or situations when formal HIAs or “rapid HIAs” could be encouraged or required.
5. Formalize collaboration between agencies through memoranda of understanding or task forces.
6. Develop charters, such as the Summit County Health in All Policies Charter, to be voluntarily adopted by public and private organizations. Such charters can provide guidance on municipal or organizational policies that promote health, such as inclusion of sidewalks in development projects, availability of healthy food at meetings and events, or family-friendly workplace policies.

Community integrators and backbone organizations

Also known as a “backbone organization,” “community quarterback,” or “community health strategist/convener,” a community integrator is an entity that brings together partners from multiple sectors and leads a coordinated strategy to reach a common goal, such as improving the wellbeing of a neighborhood, city, county or region.

Integrators are distinct legal entities that are funded and “explicitly charged” with the task of coordinating strategies to improve community well-being.¹⁸ Integrators facilitate agreement among multi-sector stakeholders on shared goals and metrics and serve as a trusted leader.¹⁹ Key responsibilities of the integrator role are to:

- Define near-term and long-term goals and measures of success.
- Employ evidence-based programs/interventions that maximize population health impact and return on investment.
- Define value propositions for a full range of partners and integrator organizations.
- Define money flow/risk sharing.
- Ensure accountability by providing shared methods for measuring, evaluating, and reporting the effectiveness of community programs and investment portfolios.²⁰

Having a backbone organization is a key characteristic of “collective impact” — long-term initiatives that unite key players around a common agenda. The Strive Partnership, which has achieved meaningful improvements in academic outcomes in Cincinnati, is a classic example of collective impact. To learn more about examples in Ohio and other states, see the [Community integrator/backbone fact sheet](#).

Community integrator/backbone organization recommendations

Public and private partners can:

1. Deliberately create conditions that support cross-sector work, including a dedicated focus on building relationships, coordinating and measuring contributions from multiple organizations, and sustaining momentum and commitment to a common goal over the long term.
2. Build upon lessons learned in the Cincinnati region and other areas of Ohio by sharing information throughout all areas of the state about successful integrator/backbone organizations.

Public and private funders can:

3. Support organizations explicitly funded and charged with the task of bringing together organizations from multiple sectors around a common vision.
4. Fund integrator/backbone functions by explicitly allowing grant or contract funds to be used for administration, project management, data analysis and other coordination functions.
5. Include requirements to identify and support an integrator/backbone organization in Requests for Proposals (RFPs), when relevant.
6. Sustain momentum created by integrator/backbone organizations by providing ongoing support over the long term.

Preventing type 2 diabetes: An example of how Ohio can improve health value and health equity

Although genes and aging play strong roles in the development of type 2 diabetes, environmental conditions and health behaviors also contribute. Many cases of type 2 diabetes, therefore, can be prevented.

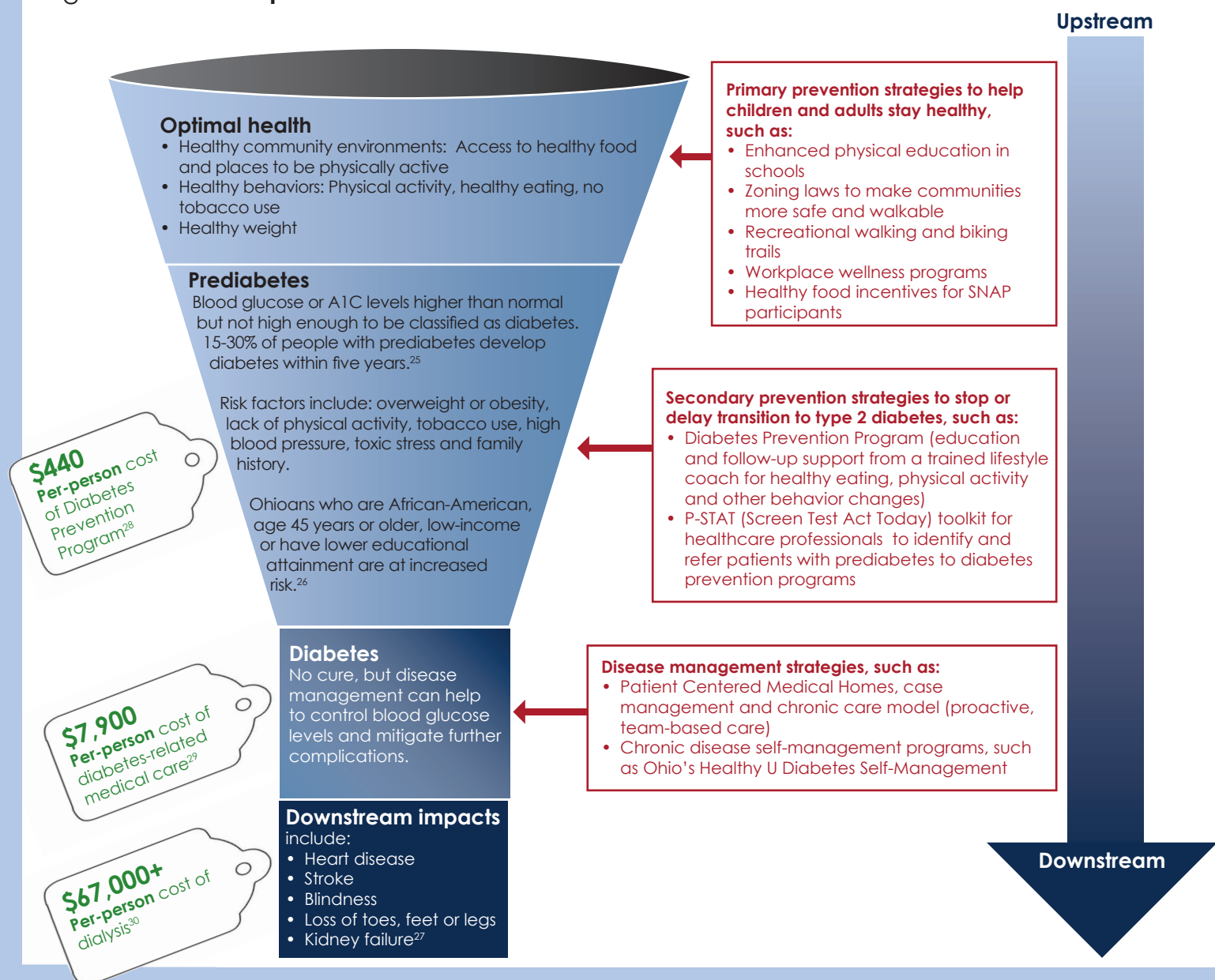
As illustrated in Figure 4, there are two primary opportunities for preventing type 2 diabetes. First, living in a community where it is easy to be physically active and eat healthy food on a regular basis helps children and adults to maintain a healthy weight and normal blood sugar levels. Primary prevention strategies, such as healthy school lunches and walking trails, are therefore the first line of defense against type 2 diabetes.

Second, people who have been told by a healthcare provider that they have prediabetes²¹ — a condition

marked by blood glucose or hemoglobin A1C levels that are higher than normal — can take steps to stop or delay the transition to type 2 diabetes by, for example, participating in a Diabetes Prevention Program (DPP).

An excellent example of secondary prevention, DPP has been shown to reduce the incidence of type 2 diabetes by 58% over a three-year period.²² Participants learn about healthy eating, physical activity and other behavior changes from a trained lifestyle coach over the course of 16 one-hour sessions. Follow-up sessions provide added support to help participants maintain their progress over time. In Ohio, several YMCAs and other organizations now offer CDC-recognized DPPs.

Figure 4. **Diabetes prevention and treatment continuum**



Once type 2 diabetes develops, there is no cure. Without appropriate control of blood sugar, many people with diabetes are at high risk for life-changing and life-threatening complications, including heart disease, kidney failure or blindness. Successful disease management, however, can help to control blood glucose levels and mitigate further downstream complications in nearly all people with diabetes.

Diabetes disproportionately affects African-American and lower-income Ohioans, and African-American men in Ohio have much higher rates of diabetes mortality compared to other groups. Diabetes mortality also varies widely by county, with the highest rates in some rural communities.²³

Culturally-competent prevention programs designed to reach high-risk groups, such as black men, and prevention resources available in rural and low-income areas are therefore critical strategies for improving health equity in Ohio.

Out of balance: Access to prevention vs. access to dialysis in Ohio

Kidney failure requiring dialysis represents one of the most costly downstream impacts of type 2 diabetes. A result of long-standing uncontrolled diabetes, kidney failure is irreversible and requires life-long treatment to control. A lifestyle change program such as DPP can prevent or delay the development of diabetes, and thus its complications.

Comparing availability of CDC-recognized DPPs and kidney dialysis centers provides a snapshot of the availability of upstream and downstream resources in Ohio:

- Almost all Ohioans (98%) live within a 30-minute drive of an Ohio-based kidney dialysis center.
- By comparison, 65% of Ohioans live within a 30-minute drive of a CDC-recognized DPP.²⁴

See the [Preventing type 2 diabetes fact sheet](#) for more details.

Regaining balance: Innovative approaches to invest in diabetes prevention

Many of the policy ideas presented in this report are already being implemented in Ohio communities and in other states. Figure 5 summarizes examples of how these opportunities have been leveraged to prevent type 2 diabetes.

Figure 5. Examples of innovations to support primary and secondary prevention of type 2 diabetes

Policy opportunity	Examples
Change incentives within the healthcare system	<p>Insurance reimbursement for community-based prevention Traditionally, health insurance plans have not covered community-based programs such as Diabetes Prevention Programs at YMCAs (Y DPP). In recent years, however, two health insurance plans in Ohio, UnitedHealthCare (UHC) and HealthSpan, now include Y DPP as a covered benefit.</p> <p>Under the HealthSpan agreement brokered by the Ohio Alliance of YMCAs, medical providers refer patients to their local Y DPP. YMCA Program Coordinators work closely with HealthSpan medical professionals to ensure the referral system thrives and stays visible to the medical providers.</p> <p>UHC and HealthSpan recognize that the downstream costs of providing care for patients with type 2 diabetes are much greater than the approximately \$400 annual per-person cost of Y DPP. UHC, for example, conducted a study of Y DPP that estimated that the savings from reduced medical spending would outweigh initial costs of widespread use of Y DPP within three years.³¹</p>
Leverage potential new sources of funding	<p>Wellness trust The Massachusetts Prevention and Wellness Trust Fund included the DPP on its rigorously-selected list of evidence-based interventions eligible for funding. Local communities are now implementing DPP in a more widespread way thanks to grants from the Trust Fund.³²</p>
Nurture cross-sector partnerships and perspectives	<p>Health and equity in all policies Frequent communication between public health, the zoning commission, and private developers is helping Columbus to become a more walkable and bikable city that promotes physical activity. Columbus Public Health has institutionalized a “rapid Health Impact Assessment” process to evaluate health impacts of zoning and development decisions. As a result, the zoning code now requires that new developments in the city feature safe pedestrian access and bike racks.</p>

Stakeholder input and prioritization process

In 2013, HPIO brought together a group of representatives from 20 public and private organizations to review emerging policy opportunities to advance prevention in Ohio. This group used the following criteria to prioritize the policy ideas discussed in this report:

1. Potential impact on population health and health value
2. Potential impact on health equity
3. Unique and appropriate role for HPIO to move priority forward
4. Cross-cutting across all prevention areas in the National Prevention Strategy framework
5. State-level policy implications
6. Readiness and interest around the state

From 2014 forward, HPIO has been disseminating information about the prevention policy priorities through the **Ohio Wellness and Prevention Network**, an information-sharing group made up of more than 100 organizations, as well as through publications and forums.



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Glossary

Accountable Care Organization (ACO) A network of providers that collectively assumes responsibility for the care of a defined patient population and shares in payer savings if set quality and cost performance metrics are met. The provider network may also be at risk and bear financial responsibility for spending that exceeds target metrics.

ADAMH Boards Alcohol Drug and Mental Health boards are responsible for planning, funding and evaluating publicly-funded mental health and alcohol and drug treatment services at the local level.

Blended funding Money from different sources is combined into a single pool.

Braided funding Coordinated multi-agency funding that keeps different funding streams in separate and distinguishable strands.

Global payment Providers or provider groups receive a fixed payment for the care of a patient during a defined period of time. Payment is generally tied to performance. Most global payment models adjust for the health status of the covered population. Capitated payment in the traditional HMO model is a similar concept, but lacks the performance measurement component.

Health disparities Differences in health status among distinct segments of the population including differences that occur by gender, race or ethnicity, education or income, disability, or living in various geographic localities.

Health equity The absence of differences in health that are caused by social and economic factors. Achieving health equity means that all people have the opportunity to achieve their full health potential, with no one at a disadvantage because of social or economic circumstances.

Health Impact Assessment (HIA) A systematic process that uses an array of data sources and analytic methods, and considers input from stakeholders to determine the potential effects of a proposed policy, plan, program, or project on the health of a population and the distribution of those effects within the population. An HIA provides recommendations on monitoring and managing those effects.

Health value The combination of improved population health outcomes and sustainable health costs. Population health outcomes include: health behaviors, conditions and diseases, overall health and wellbeing and health equity. Health costs include: total costs and costs paid by employers, consumers, Medicare, Medicaid, and the public health and mental health systems.

Medicaid waiver Mechanism used by the federal government to provide states with greater flexibility in the design of their Medicaid programs. Section 1115 waivers

allow states to cover services not typically covered by Medicaid, including those delivered by nontraditional providers or in nontraditional health settings.

Medicaid managed care plan (MCP) A private health insurance company that provides, or arranges for someone to provide, the standard benefit package to Medicaid enrollees. The Ohio Department of Medicaid contracts with five managed care plans (Buckeye Community Health Plan, CareSource, Molina Healthcare of Ohio, Paramount Advantage, and UnitedHealthcare Community Plan of Ohio) to coordinate care for Ohio Medicaid enrollees in exchange for a per member per month (PMPM) capitation payment. Three-quarters of Ohio's Medicaid enrollees were enrolled in a Medicaid MCP in State Fiscal Year 2014.

Patient Centered Medical Home (PCMH) A provider practice that receives additional payments in exchange for the delivery of care coordination services that are not currently provided or reimbursed.

Population health The distribution of health outcomes across a geographically-defined group which result from the interaction between individual biology and behaviors; the social, familial, cultural, economic and physical environments that support or hinder wellbeing; and the effectiveness of the public health and healthcare systems.

SNAP The US Supplemental Nutrition Assistance Program, formerly known as "food stamps," offers nutrition assistance to eligible, low-income individuals and families.

Social determinants of health Conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. In addition to the social, economic, and physical conditions of a person's environment, social determinants also include patterns of social engagement and sense of security and well-being. Examples of resources that can influence (or, "determine") health outcomes include safe and affordable housing, access to education, public safety, availability of healthy foods, local emergency/health services, and environments free of life-threatening toxins.

State Innovation Model (SIM) Managed by the Center for Medicare and Medicaid Innovation (CMMI) within the Center for Medicaid and Medicare Services (CMS), the State Innovation Model (SIM) initiative provides federal grants to states to design and test new healthcare delivery and payment systems.

Upstream prevention Health improvement approaches that address the causes of health problems rather than just the symptoms. Upstream strategies often involve community-based programs and policies that address the social determinants of health.

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Acknowledgements

HPIO thanks the Prevention and Public Health Policy Advisory Group for providing feedback on this report:

- Micah Berman, The Ohio State University College of Public Health and Moritz College of Law
- David Ciccone, United Way of Central Ohio
- Rebecca Cline, Ohio Domestic Violence Network
- David Ellsworth, Ohio Disability and Health Program
- Kim Gilhuly, Human Impact Partners
- Martha Halko, Cuyahoga County Board of Health
- Katie Hanna, Ohio Alliance to End Sexual Violence
- Anne Harnish, Ohio Colleges of Medicine Government Resource Center
- Kate Keller, Interact for Health
- Jim Ryan, Alcohol and Drug Abuse Prevention Association of Ohio
- Michele Shough, Ohio Department of Health
- Mike Smeltzer, Ohio Public Health Association
- Jeff Stephens, American Cancer Society
- Beth Tsvetkoff, Ohio Alliance of YMCAs
- Dr. Andrew Wapner, Ohio Department of Health
- Deborah Wilcox, Wellness Management and Recovery

To learn more

HPIO has created a series of fact sheets about the specific policy opportunities discussed in this report, including the Ohio landscape and examples from other states. Those fact sheets, as well as links to additional material, are available at:

www.hpio.net/beyond-medical-care/



www.hpio.net