

**Population Health Planning Infrastructure Subgroup**  
**October 19, 2015**  
**Meeting Notes**

TOPIC	DISCUSSION
<p><b>Welcome</b> Amy Stevens</p>	<p>Amy Stevens (HPIO) welcomed the group. The subgroup is intended to represent a balanced and diverse group of hospital and LHD folks, representing all areas of the state. Amy reminded the group that OHT's deadline to CMS is December, so the group must move quickly.</p> <p>Note: List of group members and attendees is attached at the end of minutes. Content from the meeting, including the slides and other materials can be found on the <a href="#">HPIO Population Health page</a>.</p>
<p><b>Project objectives and goals</b> Amy Bush Stevens Reem Aly</p>	<p>After brief introductions by attendees, Stevens reviewed the overall project objectives and goals, then reviewed the objective for the Infrastructure Subgroup:</p> <p>Provide recommendations for the development of a framework for state and regional population health planning that:</p> <ul style="list-style-type: none"> <li>• Aligns state and community-level population health planning processes, priorities and objectives; and</li> <li>• Provides regional coordination for the implementation of community-based health improvement activities;</li> <li>• Identifies existing financing mechanisms for implementation of community-based health improvement activities.</li> </ul> <p>Reem Aly (HPIO) reviewed the process and timeline for the overall project (see slides). Aly also reviewed the objectives for the meeting:</p> <p><b>Objective 1.</b> Affirm overall goals of developing a population health planning infrastructure framework for Ohio.</p> <p><b>Objective 2.</b> Identify strengths, challenges and opportunities for improvement for community health planning led by local health departments and hospitals.</p> <p><b>Objective 3.</b> Identify key elements of a "straw man" framework to present to the broader Advisory Workgroup at November 3rd meeting.</p> <p>Stevens then asked the group for affirmation of the overall goals for developing a population health planning infrastructure framework:</p> <ul style="list-style-type: none"> <li>• Improve the health of Ohioans by deploying a strategic set of evidence-based, upstream population health activities at the scale needed to measurably improve population health outcomes.</li> <li>• Develop a more efficient and effective way to do high-quality community health assessment and improvement planning in Ohio that: <ul style="list-style-type: none"> <li>• Results in widespread implementation and evaluation of evidence-based strategies</li> <li>• Helps nonprofit hospitals and local health departments to meet IRS and PHAB requirements</li> </ul> </li> </ul>

- Balances local innovation with statewide alignment and coordination
- Increases and supports collaboration between hospitals and local health departments, and with other community partners

**Affirmation discussion**

Heidi Gartland (University Hospitals) expressed concern that any framework needs to be broad enough to encompass the diverse regional and local health needs that exist across the state. The framework needs to be flexible, and allow for local innovation and adaptation. Heidi suggested (and the group concurred) that Goal#2, bullet #3 above should be modified to say “balances local innovation **and local needs.**”

Jason Orcena (Union County HD) added that we typically think of counties as the scale for setting population health priorities, but sometimes needs vary by cities within a county.

Jan Ruma (Hospital Council of NW Ohio) stated that hospitals and LHDs are all in different places in the journey toward population health improvement, and that any statewide framework needs to respect these differences. The goal is to establish some parameters for alignment of goals/priorities that we can all live with.

Orcena asked if the state had already decided on a set of population health priorities. Brandi Robinson (Ohio Department of Health) stated that no statewide priorities have been set, as McKinsey is still in the process of completing the data analysis for the SHA/SHIP. She stated that the goal was to provide some guidance on an infrastructure because this was not a part of previous SHIPs.

Wally Burden (Pike County General Health District) expressed frustration with the misalignment of planning timelines across LHDs, hospitals, and FQHCs. The LHDS are on a 5 year cycle, while the hospitals are on a three year planning cycle. He stated that they all worked well together in his county, but that collaboration was hampered by these differing timelines.

Beth Bickford (Association of Ohio Health Commissioners) added that it was important for any framework to include a solid implementation plan.

Teresa Long (Columbus Public Health) asked the group for clarification on the relationship/role of hospitals to the PCMH model. Terri Thompson (ProMedica) stated that the majority of their physicians operate as PCMHs, and that the focus is on clinical care coordination and care transitions. For PCMH to be effective, Thompson stated there needs to be an effective communication tool, such as electronic medical records, that are shared among the providers. Gartland said that their system has three operational ACOs, one of which is specific to pediatrics.

Dora Anim (The Health Collaborative) added that while her region has

	<p>many PCMH participants, the major hospital systems have not yet figured out how to integrate across systems. Stevens clarified that the larger population advisory group would be dealing more with PCMH issues, but that this subgroup needed to be open to understanding and considering those connections with PCMH.</p>
<p><b>Strengths, challenges, and opportunities</b> Amy Stevens</p>	<p>Stevens directed the group's attention to the <a href="#">feedback on infrastructure characteristics</a> received previously from group members via email with regard to characteristics of an ideal infrastructure, what should not change, and what should be improved or changed.</p> <p><i>Characteristics of an ideal infrastructure</i> Comments included:</p> <ul style="list-style-type: none"> <li>• consistent data elements, standards, and measures;</li> <li>• collaboration with critical community partners;</li> <li>• funding flexibility;</li> <li>• clear roles and responsibilities;</li> <li>• transparency;</li> <li>• health improvements across the life course;</li> <li>• deliberate focus on disparities;</li> <li>• and common definition of community.</li> </ul> <p><i>What should not change</i> Comments included:</p> <ul style="list-style-type: none"> <li>• assessing needs at both the state and local levels;</li> <li>• building on existing collaborations</li> </ul> <p><i>What should be improved or changed?</i> Comments included:</p> <ul style="list-style-type: none"> <li>• more collaboration around implementation strategies;</li> <li>• better and more frequent community health data collection;</li> <li>• better use of evidence-based practices; redefine community benefit.</li> </ul> <p><b><u>Discussion</u></b> <i>Community benefit definition</i> Gartland asked what was meant by "redefine community benefit" from the grid of what should be improved. She expressed concern that a redefinition of community benefit may put hospitals' tax exempt status at risk, as the IRS has a very specific definition. UH would push against this. Aly replied that under the current IRS definition of community benefit, there is room to align community benefit expenditures with community health improvement and community building activities, and noted this has been done in other states, without adding undue burden to the hospitals. Gartland responded that having to do two accountings for community benefit for the state versus what is required by the federal government would be confusing and onerous. Aly stated that there are ways to give hospitals more clarity on what community building activities are considered community benefit, while maintaining compliance with IRS</p>

guidelines.

Tim Ingram (Hamilton County Public Health) stated that it would be helpful if the infrastructure framework had a single, common definition of community benefit across the state, as the IRS guidelines are open to interpretation and there are many different ways “charitable giving” is being applied across the state. Gartland replied that UH is careful not to count any marketing activities as community benefit. Long stated that this misunderstanding/ skepticism supports the need for greater clarity, transparency, and communication between LHDs, hospitals, and other partners.

#### *Community assessment methodologies*

Ingram questioned the methodology for conducting community health assessments; how do we know we have enough of a sample size to ensure the results are representative of the community? Ward stated that her group uses a CDC tool that allows one to conduct power analyses to determine sample size. Stevens suggested that it might be helpful for the infrastructure framework to add guidance or tools for CHA methodologies, as there is currently a great deal of variability across the state in how CHAs are done. She also suggested that this might represent a peer-to-peer learning opportunity in which the Hospital Council of NW Ohio could help others replicate its methodology for CHAs.

#### *Data collection/collaboration*

Long stated that another characteristic of the ideal framework would be “actionable data” that reflects the importance of collecting data on various subpopulations. Long also emphasized the need to include behavioral health partners in the data collection process.

Jeff Klingler (Central Ohio Hospital Council) cautioned against imposing more data collection requirements on hospitals, as they are already data rich. Instead, he would like to see a sharing of primary and secondary data among hospitals and LHDs so that efforts are not duplicated. Melissa Branum (Greene County Combined Health District) said it needs to be clear who is doing primary data collection and who is doing secondary data collection: LHDs or hospitals? There needs to be more guidance on how hospitals and LHDs can work together on community health assessments that efforts are not duplicated and analyses are aligned. Krista Wasowski (Medina County Health Department) suggested providing a template or standard format for community health needs assessments, as well as a delineated list of common datasets.

#### *Joint assessments/collaborative partners*

Jessica Schultz (Mercy Health) stated that in her area, the three major hospital systems, the LHDs, EMS (emergency management systems), and the United Ways all collaborated on a single community health needs plan. Each county reported its local needs to the home office, which then solidified the needs into a single plan. Gartland expressed concern that her system would have difficulty negotiating a single plan that met the

	<p>unique needs of each county. Ingram stated that the framework should include guidance on the engagement of all community sectors and a feedback loop to vet the findings with those partners.</p>
<p><b>Preliminary infrastructure design decisions</b> Amy Bush Stevens Reem Aly</p>	<p>To kick off the discussion of the “straw man” framework, Aly gave an overview of the New York State planning model. In NY, the equivalent of the SHIP is the <i>Prevention Agenda</i>. New York requires that LHDs and hospitals collaborate on community health needs assessments and plans that address at least two of the priorities outlined in the <i>Prevention Agenda</i>, and address health disparities. The plan may include as many other local goals as needed. The LHDs and hospitals are both on a three year planning cycle. Aly highlighted several strengths of the New York system, including that it was an iterative process with hospitals and local health departments and that the state provided technical assistance on development of the assessments and plans. Aly also noted that for each intervention identified, there needed to be a clear delineation of roles across sectors. She added that there was collaboration at the assessment level, collaboration at the implementation level, and encouragement to align community benefit expenditures towards upstream evidence-based interventions.</p> <p><i>Reactions to the NYS model</i></p> <p>Gartland stated that negotiating common ground among all of the LHDs and hospitals in her region would be very complex. It is the job of the local Boards, not the State, to identify priorities. This is overreaching to ask a private hospital to do this. Aly responded that, based on HPIO’s review of CHNAs and CHAs, it should not be too hard to find some common ground, as there are a lot of common priorities across the state. Jim Adams (Canton City Health District) stated unequivocally that if the State is going to move the needle, we absolutely need shared priorities between the LHDs and hospitals, but that the LHDs should be the driver for the priorities.</p> <p>Burden asked if NYS had in fact moved the needle using this framework. Stevens said it was not clear, but that NYS was healthier than Ohio and the State sent relatively more resources to the local health departments. Gartland was interested in the per capita expenditure in Ohio versus New York. She also asked how New York dealt with specialty hospitals like rehab hospitals. Adams cautioned that it is not about how much money is spent, but whether the dollars are spent wisely. Community benefit dollars need to build on LHD needs and be smartly spent on evidence-based interventions. Stevens reminded the group that the infrastructure framework developed by this group should address specific ways to fund population health planning and implementation.</p> <p>Adams commented that New York’s method meets the goal of transparency by requiring annual reports to be submitted and reviewed by the State to ensure compliance and quality. Ward stated that the IRS already reviews the hospital’s plans, and NACCHO already reviews LHD plans. Robinson stated that the current PHAB process was not about</p>

moving the needle – it is more about meeting requirements A-F. The New York model is more about moving the needle on health outcomes.

Klingler wondered if the NYS Department of Health was responsible for licensing hospitals, and if so, whether compliance with the planning model was a condition of licensure. Aly will look into this if the group thinks this might be a viable model for Ohio.

### **Preliminary infrastructure design decisions**

Aly presented the group with a framework to consider for the straw man design. The framework, adopted from the PCMH model, has three conceptual design options:

- Standardize: required by law; contains a great deal of consistency
- Align in principle: some consistency; focus on guidance
- Differ by design: great variability at the local or community level

Aly added that this was an opportunity for the group to provide feedback with the end goal of producing an infrastructure framework we can all live with and that results in improved population health outcomes.

Stevens asked the group to review the draft infrastructure design document over lunch. Specifically, she asked the group to consider which parts of the population health assessment, planning, and implementation process they needed help with, and which parts of the process should be provided locally, regionally, or by the State.

### *Discussion of objective #1: Alignment between state level SHA/SHIP and local level CHNA/IS/CHA/CHIP*

Orcena stated that the “align in principle” approach offers a balance between the need for local flexibility and the need for some amount of statewide alignment. He added that if the state truly wants to move the needle, there will probably need to be some sort of requirement, similar to the NYS model where the state presents a menu of priorities from which to pick one or two. He added that less than 10 broad priority areas would be ideal. When several hospital representatives indicated that some priority areas, such as infant mortality, do not apply to them (e.g. our hospital does not deliver babies, for example), Orcena emphatically stated that infant mortality applies to every hospital because every hospital plays a part in addressing the risk factors for infant mortality, including drug use, smoking, poor pre-natal health, transportation barriers, etc.

Stevens asked, “If we needed to specify one thing to standardize from 1.1-1.5 on the grid, which would it be?” Adams said it made the most sense to standardize priorities, and then let the LHDs develop the strategies to address them. Charlie Solley (Akron Children’s Hospital) cautioned against standardization of strategies, as that would stifle local innovation.

Bickford said that data sources should be standardized across assessments, with the caveat that oversampling may be needed in

certain locations. Terry Allan (Cuyahoga County Board of Health) cautioned that standardizing primary data is too difficult, but would work for secondary data.

Ruma likened a move from the current “differ by design” approach to a “standardized” approach to a “shotgun wedding.” She said that standardization in theory might get the best outcomes, but only if the community partners have buy-in to support the plan. She cautioned against moving too quickly to standardization. Gartland agreed with Ruma, saying compulsory collaboration is not the way to go. Moving to standardization will be too disruptive to the system. Branum said that some sort of standardization might actually help her area partners to collaborate in a more effective way. Bickford concurred, saying that having some standards will foster collaboration across LHDs and help them to learn from each other. She supported 1.2, “IS/CHIPS must select set number of priorities from the SHIP.”

Solley asked how much weight the subgroup's recommendations would be given by OHT, ODH, and Medicaid. Stevens stated that the larger planning group would be responsible for having a discussion on how to best approach this “bridging.”

Orcena stated that the framework and recommendations must recognize a transition period with be necessary in going from a “differ by design” approach to the standardized approach. Stevens concurred that a phase-in approach would be necessary, especially since various hospitals and LHDs are in different places in their planning cycles.

Long supports 1.1, “CHNA/CHA must include certain measures collected in the SHA”, as an addition to the menu of options set by the State.

Klingler stated that he believed a bottom up approach made more sense – have the local assessments inform the state plan rather than vice versa. Aly shared that Colorado takes a bottom up approach. Orcena cautioned that it is difficult to roll up local level data because measures are not standardized across localities. He stated that a bottom up approach would result in another workgroup to decide on how to roll up the local data for state level categories.

Ward stated that in her experience, the bottom up approach does work, as does regionalization. The twenty counties she works with all used the MAP process (NACCHO) for their community health needs assessments. Every one of them aligned in some way with the SHIP and CDC prevention strategies. Each CHA may call something by a different name (e.g. obesity versus weight control), but they all shared many commonalities. In her area, the hospitals then aligned regionally to meet these needs.

Orcena added that if the bottom up approach is recommended, there still needs to be a clear delineation of the state's role in informing the locals. The process needs to be iterative, with built in feedback loops.

Adams concurred, saying that bi-directional communication and community level engagement would strengthen the SHIP/SHA process. Robinson stated that regardless of which method is chosen (top down or bottom up), the state still needs to assess and review the LHD plans.

Aly suggested that maybe we need to standardize the *process for CHAs*, such as defining a common methodology. Wasowski noted that Colorado uses a standardized CHA format, required deadlines for local submission of CHIP and then the state creates their SHIP based on those plans.

Adams agreed, saying “if we are going to improve the process, we need to standardize the process;” Standardization is part of quality improvement. Allan added that a common set of questions and a common process would be useful, but there needs to be room for some variation at the local level, such as oversampling of certain populations to identify inequities. Long agreed with Allan. Ward reminded the group that LHDs already need to follow PHAB’s process of assessment in order to be accredited.

Cory Hamilton (Zanesville Muskingum HD) likes the top-down approach where the very broad priorities are standardized at the state level, but as you move into strategies and objectives, there is local control and flexibility. She said rather than re-creating a framework, perhaps the subgroup needs to agree to an already existing framework for conducting CHNAs, such as the NACCHO process for LHD accreditation. Allan and Adams agreed. Allan added that we need to get at least somewhat more prescriptive as a state if we are going to move the needle. Adams said whichever process is adopted must be respectful of both urban and rural needs.

Klingler expressed concern about prescribed processes or requirements. He stated that the hospitals must see themselves in the priorities. Ward added that the evidence-based strategies should be up to the local hospitals. Aly DeAngelo (OHA) concurred, saying that hospital resource allocation decisions will dictate local strategies.

Ruma stated that a top-down approach requires building trust. The state can suggest priority areas, but there should not be a mandate. It should be tested first, and phased-in if it appears to be working. DeAngelo noted that if a menu of priorities was provided by the state, it is likely that most hospitals could find themselves in at least one or two of those health priorities. Other members of the group cautioned that exceptions might need to be made for specialty hospitals.

Solley stated that the group needs to keep in mind that the conversation does not end today – that the members need to consult with their constituencies for further feedback and input to this process.

#### *Discussion of regional versus local alignment*

Aly asked the group if state funding should be tied to regional health



priorities.

Ward mentioned that the ODH strategic plan says that with the next year and half, 75% of local funding will be based on the entities RHIP (regional health improvement plan). Given this, she suggested standardization of measures across RHIPs. However, she cautioned that if alignment is required at the regional level, hospitals and LHDs will lose some local community funders.

Burden stated that regional planning provides strength in numbers to move an agenda forward. He said regional planning under the current system is hampered by the misalignment of planning cycles. Aly asked if the group would like to recommend that the state move LHDs to a three-year planning cycle to correspond with hospital planning. Branum cautioned that some LHDs, such as Preble County, can't afford to do assessments every three years, especially since there is no hospital in their county to help defray the cost. Adams added that a three year planning cycle would be "terrible" for LHDs, but aligning the cycle with the IRS guidelines for hospitals is better than the current system.

Orcena expressed concern about artificially defining regions. He stated that doing so would have no more meaning than the current county lines UNLESS there is an agreement that regionalization makes sense to address a shared concern. The process should be organic as to why the regional partners are collaborating.

Burden asked if perhaps a single plan could be developed that would count for both the LHD and the hospitals. Ward said that in her organization's experience, it is much more cost effective to do joint assessments and joint implementation plans. The requirements are so similar, that it makes sense to pool resources to develop the plans jointly. It also helps the hospitals to see themselves as part of the public health system.

Wasowski asked if the hospital groups could provide a list of where local hospitals and LHDs are in their 3 year/5 year planning process. She also suggested that the "straw man" design include incentives to move toward the standardize and align boxes.

Ingram asked if OHA had a map of market areas for the major hospital systems that could be superimposed with LHD jurisdictions.

After discussion of the "preliminary infrastructure design decisions" document, there appeared to be most consensus around:

- Creating a unifying conceptual framework to be used for community-level assessments
- Aligning assessment/planning timelines for hospitals and local health departments, so that both are on a 3-year cycle
- Aligning community-level plans for hospitals and LHDs with 1-2 priorities in the SHIP

	<ul style="list-style-type: none"> <li>• Including a set of core metrics from the SHIP in community-level plans that align with shared health priorities in the SHIP. There was agreement that the plans could also include additional metrics specific to the unique needs of their community.</li> <li>• Need for more robust local/community level data</li> <li>• Reticence around regional health planning that did not draw upon organically developed collaborations and partnerships</li> </ul> <p>HPIO will use this feedback to build a “straw man” set of recommendations around a framework for improving population health planning infrastructure in Ohio. The framework will be presented to the Infrastructure Subgroup and main Population Advisory Group for feedback.</p>
<p><b>Next steps</b></p>	<p>Amy Stevens and Reem Aly thanked the group for its contributions today.</p> <p>HPIO will develop one or two “straw man” population health planning infrastructure frameworks for the group to consider.</p> <p>The next meeting of the Population Health Planning Infrastructure Subgroup will be held on <b>Tuesday, Nov. 10th</b> in the <b>third-floor conference room at One Columbus, 10 W. Broad St., Columbus, OH 43215.</b></p> <p>HPIO will share materials in advance of the meeting to prepare participants for topics of discussion.</p>

INFRASTRUCTURE SUBGROUP MEMBERS			Subgroup Meeting #1
Adams	Jim	Canton City Health District	y
Allan	Terry	Cuyahoga County Board of Health	y, call-in
Anim	Dora	Greater Cincinnati Health Council	y
Aly	Reem	HPIO	y
Bickford	Beth	Association of Ohio Health Commissioners	y
Bollig Dorn	Sarah	HPIO	y
Branum	Melissa	Greene County Combined Health District	y
Burden	Wally	Pike County General Health District	y
Bucci	Dan	University Hospitals	y
Cranciun	Kirsten	The Center for Health Affairs	y
Deangelo	Aly	Ohio Hospital Association	y
Everett	Ryan	Ohio Hospital Association	y
Gartland	Heidi	University Hospitals	y
Goon	Anne	Henry County Health Department	y, call-in
Gullett	Heidi	Health Improvement Partnership-Cuyahoga	y, call-in
Hamilton	Corey	Zanesville-Muskingum County Health Dept.	y
Himes	Lance	Ohio Department of Health	y
Ingram	Tim	Hamilton County Public Health	y
Klingler	Jeff	Central Ohio Hospital Council	y
Larson	Marty	Greater Dayton Areas Hospital Association	n
Long	Teresa	Columbus Public Health	y
Orcena	Jason	Union County Health Department	y
Robinson	Brandi	Ohio Department of Health	y
Ruma	Jan	Hospital Council of Northwest Ohio	y
Schultz	Jessica	Mercy St. Vincent	y
Solley	Charlie	Akron Children's Hospital	y
Stevens	Amy	HPIO	y
Thompson	Terri	ProMedica Health Systems	y
Wapner	Andrew	Ohio Department of Health	n
Ward	Britney	Hospital Council of Northwest Ohio	y
Wasowski	Krista	Medina County Health Department	y, call-in
OTHER ATTENDEES			
Akah	Hailey	HPIO	y
Goldberg	Janet	HPIO	y