Population Health Planning Advisory Group
October 1, 2015
Meeting Notes (corrected)

TOPIC	DISCUSSION
Welcome and introductions	Director Greg Moody (Governor's Office of Health Transformation) welcomed the group and invited members to make introductions. (Note: List of group members and attendees is attached at the end of minutes. Content (Powerpoint/homework) from the meeting can be found on the HPIO Population Health page.)
Vision for population health planning Greg Moody Amy Rohling McGee	Dir. Moody introduced the purpose of the group, stating that while specific priorities can change, the Administration is relying on this group to help them get the structure of population health planning right. He said that this is continuation of HPIO's work and a fantastic partnership. Dir. Moody discussed how Ohio has a public health infrastructure of approximately $1.0 billion and health coverage costs of approximately $81.6 billion. He stated that the group is here to discuss how we can put public health in charge of setting priorities so that spending in health system is aligned with where it needs to be to improve population health outcomes. Alignment would achieve greater impact from the resources we have in the system. He noted that NE Ohio has a great regional plan, but not all regions do. He discussed the opportunity to align hospital community benefit to address primary needs. He said that the Administration doesn't like mandates, but said that they have found that when there's a really good idea and you ask people to step up, they do. Amy Rohling McGee (HPIO) then reviewed the overall objectives of the workgroup. She also discussed the sectors represented on the Population Health Planning Advisory Group and Infrastructure subgroup. Objectives and group information is available in the slides posted here. Hugh Wirtz (Ohio Council of Behavioral Health & Family Services Providers) asked about whether OMHAS is focused on the infrastructure subgroup. Dir. Moody answered "no," because it is focused on those entities that are charged with submitting plans to the federal government; once the direction has been set, though, it will use the regular OHT process to engage others within state government.

Process and timeline Reem Aly	Reem Aly (HPIO) reviewed the process, timeline, convened groups, and meeting dates for this work.
Understanding population health Amy Bush Stevens	Amy Bush Stevens (HPIO) presented on Triple Aim and SIM focus areas, population health, and how Ohio measures up to other states in outcomes and underlying factors. For more on population health, see meeting slides and the HPIO publications What is Population Health? and the Health Value Dashboard.
Lay of the land: Ohio's population health infrastructure Reem Aly	Aly presented on Ohio's population health infrastructure, at the state and community level, and alignment between the two. Following the presentations by Dir. Moody and the HPIO staff, the group was asked: **What are the strengths/challenges of how we currently do population health planning?** • The Commission on Minority Health (CMH) has found it difficult to set priorities because data isn't disaggregated or broken down by more specific categories/ groups. • Hospitals have been conducting CNHAs for years, but don't have a clear understanding of how to do this in partnership with others; rural hospitals might be more inclined to not do so due to fewer resources. • Disparities are a cross-cutting issue; need hyper-local data to make a difference statewide. • Re. data that HPIO compiled about CHIPs/ CHNAs--some priorities emerged; example of IM • Must go beyond medical care; need to address social determinants of health. • We can come up with great plans, but need to figure out how to do this work together. • Agreement about the need for a common framework, not diseased focused, but a set of outcomes to pay attention to. Example, Ohio's Plan to Prevent and Address Chronic Disease includes a range of activities in four core focus areas (environmental approaches, health system interventions, community-clinical linkages, and data and surveillance); or the framework of HPIO Health Value Dashboard. • Also must think about age-related issues, in addition to racial/cultural. • Safe housing that supports recovery is making good progress.

	Behavioral Health (BH) drives many co-morbidities, not sure that local BH planning entities are embedded in the planning processes of hospitals/ LHDs; varies widely by local community; need to ensure that all parts of the health system are included in planning. • Data sharing is a challenge. Schools are a common example of where there's relevant data, but no good way to share it with others in the health system. It's also a challenge to determine what a desired outcome is, especially distal outcomes. • Services provided by community providers may be highly successful in long-term, but different to measure short-term. • We lack a good consumer engagement strategy. Need something more meaningful than a focus group and a survey. • Implementation requires funding. • The number of plans is overwhelming and confusing, but fortunately a lot of people are interested. • Need to meet with communities where they are and look at issues like jobs, housing. People don't traditionally view these as "health." • Hospitals have different worldviews; the patient population is the focus; some markets are very competitive. • HIE (health information exchange) is a challenge. Brandi Robinson (ODH) then discussed the State Health Improvement Plan (SHIP) addendum that will be released soon. Nine priorities were selected in 2012. The SHIP addendum is updated to create a bridge for the coming year until a new SHIP is created These nine priorities are too wide; goals should be focused and achievable, wider than just ODH's purview, and should include other partners—everything has to be measured. Dir. Moody: Ohio's current SHIP is not what we need; a "disease of the month" doesn't represent the infrastructural approach that would fit coming challenges. We need to reboot the whole SHIP, which is what this group is about, to make it a living/adaptable document that can draw out population health priorities. Robinson: If done well, LHDs can use it to create their own plans. Stevens stated that it seems that we've achieved the first objective of the meeting: To develop a common understanding of the need for improving population health planning infrastructure and alignment, including a need to improve Ohio's State Health Assessment (SHA) and SHIP. The group agreement that this

	objective had been achieved.
Selection of population health priority areas Reem Aly Amy Bush Stevens	Aly and Stevens discussed potential health priority areas. HPIO has analyzed the health priority areas identified by state-level plans, hospital community health needs assessments (CHNAs), and LHD community health assessments (CHAs). They combined and weighted the priorities to create a top 10 list, and created a set of criteria for further prioritization. Aly and Stevens then opened the floor to discussion of the criteria and priorities. Dir. Moody stated that the goal is to align clinical resources to address priorities. Comments: • Great that we would be informing PCMH; CPCI(?), etc. We shouldn't reinvent the wheel. • How is the process of picking clinical priorities linked back to community-related strategies? Dir. Moody: The answer is the funnel (see diabetes funnel for example). We should pay for primary care in a way that incentivizes health outcomes. What is happening in primary care has to link to community-level planning. Everyone is pointing in different directions, blaming each other (e.g. hospital community benefit shouldn't be spent on X, should be spent on Y [priorities with social determinant focus]). For example, picking tobacco gets primary care (PC) to pay attention to what's happening in the community so they have a place to link people to, because they're held accountable. Stevens noted that some of these priorities are behaviors, and some are conditions. We selected examples that ranked high in various plans, and had a foothold in PCMH. Comments: • Level 3 PCMH; population health components provide incentives to pick the things that are "easy," would be helpful to communicate that, no, providers can't just pick the easiest priorities to accomplish, that they'll have to meet strategically-determined priorities. • We need to look at the broader cost of the health condition on the community—not just healthcare costs. Need to demonstrate the economic case for addressing these health conditions.

- She also notes that some of these priorities are behaviors, and some are conditions. We selected examples that ranked high in various plans, and had a foothold in PCMH.

What other criteria should be considered?

Comments:

- Action-ability should be considered.

Stevens responded that we have a criterion for potential for impact and we can emphasize this criterion in subsequent prioritization. She asked the group if there was consensus on using these criteria for selecting an initial set of current state-level population health priority areas. The group indicated consensus.

Comments related to priority area selection:

- At a federal level, much funding has been siloed, but at the state level we can think about how we form a planning discussion to integrate funding.
- What can providers realistically impact? Communication is key; need to form a strong connection.
- Level 3 PCMH, reframe: "how can this process help PCMH achieve outcomes"; extraordinarily difficult for practices to make a difference; healthy eating/active living, MH, and tobacco are where he needs help; don't need someone else telling him to measure A1C
- LHD: If I knew what practices needed then I would provide it

Dir. Moody: The real problem is that there's a line where connections need to be drawn. Now primary care needs to connect with public health; instead of focusing on conditions specifically, we should focus on the structural process/connections so that people are aligned. We have what we need for PCMH, in terms of priorities and choosing content. Let's assume that people at the regional level know the priorities. Now we need the right structure/connections—we have a total breakdown right now of clinical care and public health.

Question: How do we know that it's just not an absence of structure that is the problem?

Dir. Moody: PC providers are naturally inclined to help, so he believes that structure and the lack of an ability to plan is the problem.

	Comments: • We can't ignore what's happening at the federal level, like with Medicare. If a physician is seeing a largely geriatric population, we need to pay attention to what Medicare incentivizes. • How does everyone find their role in achieving a set of priorities? This is a failure on multiple system levels; how does every system find its role? (e.g. "It's not my burden alone, but here's my role") • Thinks that the funnels are a good example of this; a lot can be done around funnels and connecting the levels within the funnels. • Feels like we're talking about primary care separate from hospital systems; some hospitals don't understand what PCMH is, and one of their objectives is to improve clinical care linkages. Alignment <u>within</u> health systems is important too. • The fundamental incentives of hospitals are not aligned at this process: what is in it for them? • How do we develop something that different markets can use and that provides incentives correctly? • Need a rethinking exercise so that people at the local level know what various sectors bring to the table. • Health begins where we live, work, and play—maybe we should highlight a few social determinants and monitor data. We need to include other entities and use policy to create change (where it was previously used to create disparities). • What's the glide path to upstream? As a PCP I'm willing to be held accountable, but I need to know the glide path. • How can PCMH help each person achieve optimal health? Remember the focus on patient-centeredness.
Next steps	McGee thanked the group for its contributions today. The next meeting of the Population Health Advisory Group will be held on Tuesday, Oct. 13th in the **third-floor conference room** at One Columbus, 10 W. Broad St., Columbus, OH 43215. HPIO will share materials in advance of the meeting to prepare participants for topics of discussion.

Last Name	First Name	Organization	
ADVISORY GROUP MEMBERS			Meeting #1
Allan	Terry	Cuyahoga County Board of Health	y
Aly	Reem	HPIO	y
Applegate	Dr. Mary	Ohio Department of Medicaid	n
Baker	Todd	OSMA	y
Beck	Andrew	Cincinnati Children's Hospital	y, call-in
Bickford	Beth	Association of Ohio Health Commissioners	y
Bollig Dorn	Sarah	HPIO	y
Cannon	Jessie	Nationwide Children's Hospital	n
Carter	Nita	UHCAN Ohio	n
Curry	Marie	Community Legal Aid Services	y
Durfee	Sarah	Ohio Public Employees Retirement System	y
Falcone	Robert	Ohio Hospital Association	y
Goon	Anne	Henry County Health Department	y
Gullett	Heidi	Health Improvement Partnership-Cuyahoga	y
Hodges	Richard	Ohio Department of Health	y
Hoyt	Karin	Ohio Department of Medicaid	n
Hutzler	Kyle	McKinsey	y
James	Tamara	AARP Ohio	y
Juenger	Monica	Governor's Office of Health Transformation	y
Keller	Kate	Interact for Health	y
Kilinc	Afet	Aetna Better Health of Ohio	y
Leprai	Chiara	McKinsey	n
Long	Teresa	Columbus Public Health	y
Michener	Melissa	CareSource	n
Misak	Jim	MetroHealth	y
Moody	Greg	Governor's Office of Health Transformation	y
Motter	Miranda	Ohio Association of Health Plans	n
Osterhues	Craig	GE Aviation	n
Robinson	Brandi	Ohio Department of Health	y
Rohling McGee	Amy	HPIO	y
Sims	Reina	Ohio Commission on Minority Health	y
Spicer	Ann	Ohio Academy of Family Physicians	n
Stevens	Amy	HPIO	y
Taylor	Robyn	ODH Office of Health Equity	y
Thackeray	Jonathan	Ohio Department of Medicaid	y
Tobias	Barb	Health Collaborative, UC	y
Waldron	Rich	MMO	y
Wapner	Andrew	Ohio Department of Health	y
Wasowski	Krista	Medina County Health Department	y
Weaver	Greg	Senders Pediatrics	y
Whitlock	J.D.	Mercy Health	y, call-in

Wills	Jon	Ohio Osteopathic Association	y
Winn	Bryony	McKinsey	y
Wirtz	Hubert	The Ohio Council of Behavioral Health & Family Services Providers	y
Wymyslo	Ted	Ohio Assoc. of Community Health Centers	n
OTHER ATTENDEES			**Meeting #1**
Akah	Hailey	HPIO	y
Deangelo	Aly	Ohio Hospital Association	y
Himes	Lance	Ohio Department of Health	y
Wiselogel	Nick	HPIO	y
Wright	Celia	HPIO	y