Population Health Planning Advisory Group
October 13, 2015
Meeting Notes

TOPIC	DISCUSSION
Welcome Greg Moody Amy Rohling McGee	Director Greg Moody (Governor's Office of Health Transformation) welcomed the group and reviewed the first advisory group meeting held on Oct. 1. He noted that "people were resisting" when we went more narrow in terms of specific priorities, and that we need to focus on structural issues regarding how we do planning. He has "high hopes" on what we can achieve. Amy Rohling McGee (HPIO) then recapped major themes from the first meeting and reviewed the objectives for today's meeting. Note: List of group members and attendees is attached at the end of minutes. Content from the meeting, including the slides and pre-meeting homework, can be found on the HPIO Population Health page.
State population health planning: SHA and SHIP Brandi Robinson Amy Bush Stevens	Brandi Robinson (Ohio Department of Health) reviewed the Public Health Accreditation Board (PHAB) process for state and local health departments. The standards and measures are largely the same for state and local health departments, with some slight differences in documentation and measures. Once accredited, entities are accredited for 5 years. Robinson said that ODH is currently on an action plan with PHAB, and submitted documents for review on Monday, October 5, including an amended SHIP. She noted that having clear, measurable objectives for the SHIP is an important part the accreditation process. Also, need to document why inequities exist, rather than just identifying disparities. Amy Bush Stevens (HPIO) then reviewed SHA/SHIP best practices from other states. She noted that assessment is the easy part; the harder part is implementation. She explained that HPIO has looked at how other states are handling population health planning. For the review of SHAs and SHIPs, HPIO started with the 9 state health departments that are already accredited. Then HPIO looked at 4 additional states that were recommended to us by national experts. New York uses an Index of Disparity to quickly convey the magnitude of disparities for different outcomes (considers race/ethnicity, education, gender and/or income as available).

	The Oregon SHA contrasts leading causes of death with Years of Potential Life Lost (YPLL) in a way that makes it very easy to see that when we focus primarily on leading causes of death—which many local assessments do—we get a skewed sense of priorities for things like injuries and heart disease. YPLL takes into account age and the life course because it's looking at the amount of time lost due to premature death (before age 75). Vermont puts data in context by using a trend lines and by comparing the state's performance to HP 2020 goals. Oklahoma uses a report card format. Stevens reviewed key considerations for the new SHIP: • Need Specific, Measurable, Achievable, Realistic and Time-bound (SMART) objectives • Specify a pathway for implementation that includes naming organizations that have accepted responsibility for implementing an activity AND identifying financing or a funding source The group then discussed the characteristics of an ideal SHA and SHIP. **Ideal SHA characteristics:** • Life course perspective (see CO and MN examples in slides) • Data focused argument/ongoing review • Social determinants of health • Health focus, not disease focus • Inclusive representation (for example, schools, consumers, other agencies) • Broad conceptual framework • Health disparities interwoven throughout the plan, not just in separate section • More than ODH data; capture data from smaller populations • Not just focus on "trendy topics" • Communities should be involved in identifying priorities; bottom-up approach vs. top-down • Need to focus on what can be measured and then be sure to report so that improvement can occur • Focus on population health data • Need to consider the 4 assessments included in MAPP- residents' health status assessment, (external) forces of change, community themes and strengths (from residents' perspective, geographic distribution), state public health system assessment • Looks at what PHAB requires for SHA and SHIP- we need to

make sure Ohio's SHA and SHIP covers these characteristics at a minimum

Ideal SHIP characteristics

- Broad plan – alignment/same as SIM population health plan
- Impact on social determinants of health
- Overarching
- Usable – one plan across multiple sectors
- Integration of health care and public health (representation)
- Broad representation – stakeholders from other sectors
- Funding commitment from state
- SHIP – provide downstream glide path to primary care (and PCMH model can include upstream glide path)

Dir. Moody commented that the state has used life course approach in its work on human services innovation with these goals: Infants are born healthy • Children are ready to learn • Children succeed in school • Youth successfully transition to adulthood • Job seekers find meaningful work • Workers support their families • Families thrive in strong communities • Ohioans special needs are met • Retirees are safe and secure

Other general comments:

- Integration is goal; need to include providers, regional health improvement collaboratives
- Since each county is required to do its own health assessment and action plan, HPIO's summary of priorities from local assessments needs to part of the SHA and SHIP.
- Cultural shifts take a long time; how to get people to feel that the "own" their health (RWJF estimates that it'll take 20 years to achieve a true "culture of health"); helping each other to get to a global ultimate goal
- People need to feel empowered through education and awareness to be in charge of their own health
- RWJF has an"action framework" for culture of health
- Everyone has a role to play - have to engage the public, can't fix from the top
- Funding – if state sets where their investments are going to be, others can align; financing piece is important
- Family/community/income-economic dynamics; tend to focus on individuals, but need to focus on families and communities (social-ecological model)
- What is it that we mean when we refer to "community"—is LHD level too large/too small?
- Who are the "trusted messengers"?

Community health planning: Local health departments (LHDs) and hospitals Reem Aly	Reem Aly (HPIO) presented on the community health planning process of LHD's and hospitals. She explained that at the end of this process, we would like to have a strong set of recommendations for aligning state and community-level planning, with a focus on hospitals and LHDs, and then increasing collaboration and alignment between hospitals and LHDs at the community-level. Under federal law, to be recognized as a 501(c)(3) organization and maintain federal tax exempt status, hospitals are required to conduct a community health needs assessment (CHNA) and adopt an implementation strategy (IS) every three years. In a final rule published in December 2014, the IRS provided hospitals with specific guidance on how to comply with new community health planning requirements. In addition, hospitals are required to report on how they are addressing the significant health needs identified in their needs assessments on Schedule H of their Form 990s to the IRS. Hospitals failing to meet these requirements may be subject to an excise tax and possible revocation of their federal tax-exempt status. LHDs in Ohio have similar requirements under state law. Under Ohio law, the director of the Ohio Department of Health (ODH) may require LHDs to apply for accreditation by July 1, 2018 and be accredited by the Public Health Accreditation Board (PHAB) by July 1, 2020, as a condition for receiving funding from ODH. As part of the PHAB accreditation process, LHDs are required to complete a community health assessment (CHA) and community health improvement plan (CHIP). PHAB requirements for LHDs around CHA/CHIP tend to be more prescriptive than hospital IRS requirements. For example as part of the CHIPs, PHAB requires LHDs develop measurable objectives and time-framed targets, identify policy changes needed to accomplish set health objectives, and designate responsibility for the objectives to partner organizations and individuals within the community. These are not elements required of hospitals by the IRS, but a hospital could also incorporate these elements into an implementation strategy. Both PHAB and the IRS allow for the development of joint community health planning documents and encourage hospital and LHD collaboration. To get a better understanding of collaboration and alignment

	between hospitals and LHDs in Ohio, HPIO conducted a research study in partnership with the Ohio Research Association for Public Health Improvement (RAPHI), where we reviewed community health planning documents for 170 hospitals and 110 LHDs. Ohio has no formal guidance around alignment between state and community-level health planning processes, or around collaboration and alignment between hospitals and local health departments. However, other states have developed policy or infrastructure around this. We identified a few best practice examples from CO, WA, CA and NY. Group members discussed the data regarding level of LHD/hospital collaboration in process. A group member said that they think that LHDs always have hospitals at the table, and thinks that RAPHI data underreports the amount of collaboration. Another commented that hospitals and LHDs collaborate on assessments; but priorities may vary and there's no requirement of implementation strategy (CHNIS/CHIP) collaboration. Rohling McGee pointed out that they may be, but it is not necessarily showing up in documents (CHNAs), which is how this data was collected. Aly also noted that there is a distinction between collaboration and meaningful engagement. A group member mentioned that the definition of community depends upon the jurisdiction of those whose health you are responsible for improving. Another stated that many LHDs work on the hospital timeline, so CHAs and CHIPs are completed every 3 years. This 3-year timeline means that local health departments are doing community health assessments more frequently than the state, making the connectivity between the state and local assessment challenging. A member noted that the Hospital Council of Northwest Ohio conducts community Health Assessment and health improvement plans that meet public health and hospital requirements for more than 30 counties in Ohio. Documents can be accessed at hcno.org under county reports and regional data can be gathered on the data link on the hcno.org website. Because the first Infrastructure subgroup will be exploring the questions in detail, and in the interest of time, the group did not discuss the meeting objective #2 questions below. (For full list of meeting objectives, see meeting 2 agenda here.) However, group members with comments on these questions are invited to email them to arohlingmcgee@healthpolicyohio.org

	Discussion for meeting objective #2
	• What are the characteristics of an ideal infrastructure for CHNA/ISs and CHA/CHIPs?
	  o SHA/SHIP alignment
	  o Hospital/LHD alignment
	• What's working well with the way that hospitals and LHDs currently conduct assessments and develop health improvement plans? What should NOT change?
	• What could be improved in order to get to better population health outcomes? What SHOULD change?

Introduction to financing option for community health planning Amy Bush Stevens Reem Aly	Aly presented on financing options for community health planning, including a detailed look at hospital community benefit (see background document). Under Part I of Schedule H, the IRS outlines eight categories of activities that are considered reportable hospital community benefit. They also require reporting on bad debt, Medicare shortfall and community building activities but these activities are not considered community benefit for federal IRS purposes. The IRS defines community health improvement services as activities or programs, subsidized by the health care organization, carried out or supported for the express purpose of improving community health. These activities include community benefit operations – so activities associated with conducting CHNAs and community benefit program administration. Community building activities, which are reported on schedule H but not considered community benefit, include activities that are more closely aligned with population health strategies. These are activities that move beyond medical care to address the social determinants of health and include physical improvements and housing, economic development, and environmental improvements. In 2012 the IRS indicated that some hospital "community building activities" may meet the definition of hospital community benefit and should actually be reported as community health improvement activities. While this IRS guidance is vague, there are some clearer parameters around what counts as community health improvement activity expenditure. If an activity meets the other requirements of community benefit, and responds to an established community need identified by a CHNA, or demonstrated as a need through a public health agency or community group, and carried out for the express purpose of improving community health, then it can count

	as community benefit. In 2013, 85.2% of hospitals in Ohio were classified as either nonprofit or government-owned, and are required to comply with ACA and IRS regulations to qualify for 501(c)(3) recognition. It's important to note that the majority of hospital community benefit is directed at charity care and other forms of uncompensated patient care. While there may be some shifts in uncompensated care with the ACA and Medicaid expansion, it is unlikely that there will be a major shift in how hospital community benefit is distributed. However, there is an opportunity to better align the resources within that community health improvement slice with implementation of community health plans and strategies. Aly discussed the per capita dollars hospitals in Ohio spend on community benefit, community health improvement, and community building activities, with the biggest majority going to uncompensated/charity care. A group member asked what the per capita breakout looks like for public health spending in these categories. An apples-to-apples analysis is not available, but referred group to HPIO's Public Health Basics publication for a look at public health spending details. States can, separate from federal standards, establish community benefit policies for tax-exempt hospitals that encourage and promote hospital community benefit activities that address that community building bucket and align with community health planning efforts. Aly described examples. Dir. Moody noted that the amount of money invested in these two systems is vastly different. He said that he doesn't want the group to get the sense that government may be "going after [hospital] money" or that this is a "regulatory exercise." Rather, there is a sense that hospitals want to do this better so we want to discuss how. A group member mentioned that advanced payment options are key, and hospitals are incentivized to do this better. Rohling McGee also noted that even though it's not a focus of this work, we do want to keep an eye on other community building/planning activities through entities like ADAMH boards and United Ways. A group member asked what authority other states have used to regulate or enforce community benefit spending. Presenters said that some states tie to property tax exemptions, and some have exercised this authority for some time.

	Group members asked for other resources on this topic, including primers and explanations of what counts as community benefit. Aly referred members to publications by the Hilltop Institute and resources from the Catholic Health Association. Other comments: • Is there a way to share savings? • Resisting the limit of the slice (the idea that the size of the community health improvement slice of the pie is unlikely to change); education dollars/housing dollars/ how to invest these strategically • What do you do with money saved? • Payers are asking providers to "go upstream"; where does PH fit in with value proposition; PH helps hospitals to manage risk; bring all of the resources that are available, including law enforcement; sees the need for 2 parallel tracks Dir. Moody said his "head is reeling" with ideas and noted that if we could reduce Medicaid shortfall, then why couldn't we expect that those savings be reinvested in community health? He said that in order to have confidence to do it, though, we need to address this issue of community health planning so that it is more effective.
Population health priorities in primary care Greg Moody	Dir. Moody then presented on population health priorities in primary care, and work McKinsey is doing around the PCMH model. He noted that regarding the care delivery model, need to monetize the benefits to address determinants so that primary care is more inclined to partner with PH. He invited feedback on the draft PCMH care delivery model from the perspective of population health.
Next steps	McGee thanked the group for its contributions today. HPIO will email group members regarding continued feedback on today's presentations. The next meeting of the Population Health Advisory Group will be held on **Tuesday, Nov. 3rd** 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.

Attendance

ADVISORY GROUP MEMBERS			Meeting #1	Meeting #2
Allan	Terry	Cuyahoga County Board of Health	y	n
Aly	Reem	HPIO	y	y
Applegate	Dr. Mary	Ohio Department of Medicaid	n	y
Baker	Todd	OSMA	y	y – Monica Hueckel
Beck	Andrew	Cincinnati Children's Hospital	y, call-in	y
Bickford	Beth	Association of Ohio Health Commissioners	y	y
Bollig Dorn	Sarah	HPIO	y	y
Cannon	Jessie	Nationwide Children's Hospital	n	y
Carter	Nita	UHCAN Ohio	n	n
Curry	Marie	Community Legal Aid Services	y	y
Durfee	Sarah	Ohio Public Employees Retirement System	y	y
Falcone	Robert	Ohio Hospital Association	y	y
Goon	Anne	Henry County Health Department	y	y, call-in
Gullett	Heidi	Health Improvement Partnership-Cuyahoga	y	y, call-in
Hodges	Richard	Ohio Department of Health	y	y
Hoyt	Karin	Ohio Department of Medicaid	n	y
James	Tamara	AARP Ohio	y	n
Juenger	Monica	Governor's Office of Health Transformation	y	y
Keller	Kate	Interact for Health	y	y
Kilinc	Afet	Aetna Better Health of Ohio	y	y
Long	Teresa	Columbus Public Health	y	y
Martin	Nancy	MMO	-	y
Michener	Melissa	CareSource	n	y
Misak	Jim	MetroHealth	y	y
Mitchell	Jodi	Health Action Council	-	y
Moody	Greg	Governor's Office of Health Transformation	y	y
Motter	Miranda	Ohio Association of Health Plans	n	y
Osterhues	Craig	GE Aviation	n	n
Robinson	Brandi	Ohio Department of Health	y	y
Rohling McGee	Amy	HPIO	y	y
Sims	Reina	Ohio Commission on Minority Health	y	y
Spicer	Ann	Ohio Academy of Family Physicians	n	n
Stevens	Amy	HPIO	y	y
Taylor	Robyn	ODH Office of Health Equity	y	n
Thackeray	Jonathan	Ohio Department of Medicaid	y	y
Tobias	Barb	Health Collaborative, UC	y	y
Waldron	Rich	MMO	y	y
Wapner	Andrew	Ohio Department of Health	y	y
Wasowski	Krista	Medina County Health Department	y	y

Weaver	Greg	Senders Pediatrics	y	y
Whitlock	J.D.	Mercy Health	y, call-in	y
Wills	Jon	Ohio Osteopathic Association	y	y
Wirtz	Hubert	The Ohio Council of Behavioral Health & Family Services Providers	y	y – Teresa Lampl
Wymyslo	Ted	Ohio Assoc. of Community Health Centers	n	y
INFRASTRUCTURE SUBGROUP ATTENDEES			**Meeting #1**	**Meeting #2**
Adams	Jim	Canton City Health District	-	y, call-in
Cranciun	Kirsten	The Center for Health Affairs	-	y, call-in
Deangelo	Aly	Ohio Hospital Association	y	y
Everett	Ryan	Ohio Hospital Association	-	y, call-in
Gartland	Heidi	University Hospitals	-	y, call-in
Hamilton	Corey	Zanesville-Muskingum County Health Dept.	-	y
Ingram	Tim	Hamilton County Public Health	-	y
Klingler	Jeff	Central Ohio Hospital Council	-	y
Larson	Marty	Greater Dayton Areas Hospital Association	-	y, call-in
Moore	Deanna	The Center for Health Affairs	-	y, call-in
Ruma	Jan	Hospital Council of Northwest Ohio	-	y, call-in
Schultz	Jessica	Mercy St. Vincent	-	y, call-in
Thompson	Terri	ProMedica Health Systems	-	y, call-in
OTHER ATTENDEES			**Meeting #1**	**Meeting #2**
Akah	Hailey	HPIO	y	n
Baker	Carrie	Ohio Children's Hospital Association	-	y
Himes	Lance	Ohio Department of Health	y	n
Hutzler	Kyle	McKinsey	y	n
Kumar	Adi	McKinsey	-	y, call-in
Vath	Kyle	Mercy Health	-	y
Winn	Bryony	McKinsey	y	n
Wiselogel	Nick	HPIO	y	n
Wright	Celia	HPIO	y	y