Population Health Planning Advisory Group
November 3, 2015
Meeting Notes

TOPIC	DISCUSSION
Welcome Greg Moody Amy Rohling McGee	Dir. Greg Moody (Office of Health Transformation) reviewed the process for the meetings and for soliciting feedback from the population health advisory and infrastructure groups. He noted that the process is not meant to get complete agreement, but rather get a sense of where there may be general consensus. Amy Rohling McGee (HPIO) reviewed the objectives for the meeting. Group members and observers in attendance were asked to introduce themselves. Materials from this and prior meetings are available here: Population Health page
SHA and SHIP recommendations Amy Bush Stevens	Amy Bush Stevens (HPIO) reviewed the process to develop recommendations to ODH for the next SHA and SHIP. She also reviewed preliminary recommendations for the SHA and SHIP, which are posted on the Population Health page. Cathy Levine (UHCAN Ohio) highlighted the need to engage community partners, and suggested that it be included in the recommendations. Stevens noted that PHAB requirements already have specific language around stakeholder engagement, but that some language can be added to the recommendations to emphasize this more. Dir. Richard Hodges (ODH) was concerned about including sectors outside of traditional health-related organizations due to their limited capacity, such as transportation. He believes that ODH should focus on core public health activities. Ted Wymyslo (Ohio Association of Community Health Centers) said that we need a whole spectrum of sectors to be engaged; but noted that it would be difficult for ODH to oversee something that broad. However, ultimately this needs to be our goal: to get to better integration. Stevens suggested that the SHA/SHIP could be approached in phases. Phase 1 could include other state-level health-related agencies, such as OhioMHAS, and then other sectors could be engaged in Phase 2 to address specific priority areas that have been identified.

	Krista Wasowski (Medina County Health Department) stated that the local level is where the "in the weeds" planning happens, including partnerships with many sectors. Dir. Moody said he agrees with everything in the recommendations, as well as the need to broaden representation within state government, but the reality is that we're so lagging on core population health measures that we need to focus and align attention on a few key priorities. Execution, at least at the beginning, needs to be more focused. Terry Allan (Cuyahoga County Board of Health) offered the example of Safe Routes to Schools programs which bring sectors such as transportation and health together. He suggested looking to best practices on measurement and collaboration. Sarah Durfee (OPERS) asked about including opportunities to communicate results to the larger population. Stevens clarified that there is a PHAB requirement requiring communication with the public, and that the SHA/SHIP preliminary recommendations were building upon PHAB requirements. Dir. Moody suggested including PHAB requirements in the recommendation document as background for those not familiar with the requirements.
Population health planning infrastructure framework Reem Aly Amy Bush Stevens	Dir. Moody commented that HPIO has done a great job wading into controversial territory and affirmed the importance of rowing in the same direction. **State and local level assessment and plan alignment** Reem Aly (HPIO) discussed the population health planning infrastructure framework draft (available here). A draft was presented to the Infrastructure Subgroup at their Oct 19th meeting, and the HPIO team modified the draft based on feedback. Aly noted that the green cells were areas of emerging consensus among the Infrastructure Subgroup. Robert Falcone (Ohio Hospital Association) said this "is very good work" and "is going to bear fruit," although he is not sure when. He said that he doesn't believe that there is consensus among hospitals at this time. They are a heterogeneous group and the Hospital Association has not polled members to see how this would impact them. He noted that hospitals are led by boards with community members who may be uncomfortable with

	changing the status quo. He also noted that hospitals will want to understand how the changes could impact IRS status and communities. Aly (HPIO) noted that this is why these areas are framed as "emerging consensus" among those who were present at the first Infrastructure Subgroup meeting. She then encouraged everyone to think about where standardization needs to occur in order to get to better results/alignment. Allan said he feels that the recommendations are intuitive because of where there has been alignment at the local level. LHDs are excited about this and think it is long overdue. Aly continued that we have already asked for written feedback from Subgroup members (hospitals/LHDs), and would like feedback from this group around what should be standardized vs. aligned in principle. She then walked through matrix showing where we are today ("differ by design") versus recommendations to either align in principle/standardize. Kate Keller (Interact for Health) asked when state "issues guidance," how does that get actualized? Aly responded that the group should focus more on whether it makes sense to standardize or align in principle on picking two priorities and less on the logistics of how this will happen through guidance or a requirement. McGee said that when New York issued guidance, the hospitals followed the guidance because they understood that this was an effective way to improve community health. Wymyslo asked about the number of statewide priorities that might be included in the SHIP. Stevens noted that "best practice" guidance and feedback from PHAB indicates that the list of priorities should be relatively narrow in order to drive strategic improvement. SHIP planners will need to think carefully about how the priorities are framed to make sure that local communities can "find themselves" in the menu of priorities. Andrew Beck (Cincinnati Children's Hospital) likes the idea of alignment. He noted that he has been encouraged by the group's discussion of the life-course approach and would want to make sure that the priorities include those that could be applicable to pediatrics. Stevens responded that when we "roll up" the priorities from the current hospital and local health department assessments/plans,

	pediatric issues do tend to get "lost in the shuffle." That's why it will be important to identify some "universal" priorities that can really apply to all Ohio communities and ages (such as healthy eating, active living, and mental and emotional wellbeing), while also building in flexibility for local communities to select additional priorities that may be extremely important within specific zip codes or neighborhoods, and/or for certain age groups, such as pediatric asthma. There was brief conversation about what the SHA/SHIP might look like. Aly asked the group to take the preliminary recommendations for the SHA/SHIP discussed by Stevens as a given for now, to help move the discussion forward. Greg Weaver (Senders Pediatrics) noted that he feels frustrated that primary care providers are cut out of the community health planning process. He noted that he's never had a health department come to him and advise on what he should be doing from a preventative perspective. Jim Misak (MetroHealth) said he would like to standardize on all three categories under section one of the infrastructure framework matrix (state and local level assessment and planning alignment). He said that Ohio needs improvement rapidly and this is a way to get there. Andrew Wapner (ODH) asked about standardization on a conceptual framework, noting that we need alignment on this. He commented that it matters less what the priority is, but more that we have alignment on how we approach strategies to address the priority. Dir. Moody noted that part of the challenge is the current SHIP. He asked the group, "if we have a better SHIP, are you willing to commit?" He acknowledges that it's difficult to do that without having the better SHIP to refer to, but encouraged the group to continue working their way through the framework. Jan Ruma suggested a phased approach, moving from where we are today to alignment in principle, then move on to standardization. **Hospital and LHD alignment** Robyn Taylor (ODH Office of Health Equity), regarding the collaboration bullets, said we need a standardized approach to collecting race/ethnicity data.

	Wasowski said that local health departments are willing to concede to a shorter timeline (move to three years to align with hospitals) but need to see other changes around alignment/ collaboration to justify the additional cost burden on local health departments. Falcone noted that there are a huge number of moving parts, and some hospitals have multiple LHDs to work with. He really likes the guidance approach versus requirement. Moody said that attendees are making the case for why moving everyone to the same three-year cycle makes sense; this would reduce some of the complexity. Anne Goon (Henry County Health Department) said that her health department works very well with their hospital in collaborative capacity, but we need to acknowledge that there will need to be greater capacity to get all these plans done in the same year. Many health departments use the same consulting group to do their assessments, and would need to build capacity to do all assessments in the same year. Aly noted that use of more common forms and templates, as well as collaboration among departments and hospitals (for example, county-level plans) could help with capacity issues. **Regionalization and funding** Falcone said that hospitals need some time to do the math (particularly because the community benefit numbers are a bit old) and to put together a group to analyze the information. He also said that 5% may be too low (for a hospital community benefit goal), especially given the impact of Medicaid expansion. Aly Deangelo (Ohio Hospital Association) noted that 3% is the average. Some hospitals may be higher, while some may be lower and it may be a significant challenge for some to change. Moody noted that the amount hospitals got from Medicaid expansion in terms of reduction in uncompensated care is the important question for analysis and consideration. Levine expressed concern that 5% could be taken as a ceiling. She also agreed that Medicaid expansion would impact this. Moody suggested using supplemental Medicaid funding as an

	incentive to increase the percentage invested in community benefit and specifically, community health improvement. Wymslo noted that right now we're focused on hospitals, but asked what other community partners would be brought to the table. He said that businesses have a stake because they want a healthier population. Keller offered an example of a regional health improvement effort in the Cincinnati area, the Collective Impact for Health initiative, that is bringing a wide variety of partners/sectors to the table (including business and hospitals). Hubert Wirtz (Ohio Council of Behavioral Health & Family Services Providers) noted a need to better define "community partners." Stevens said that the Hospital Council of Northwest Ohio has a checklist of community partners that should be at the table, which is noted in the tools section at the end of the draft infrastructure document. This list of partners includes behavioral health organizations. Jessie Cannon (Nationwide Children's Hospital) said it's hard to argue with alignment, but that she needs to know the answers to some of these questions about what it would look like before her organization can agree to a mandate. Moody noted that these changes need to occur in phases over time. He commented that it may make sense to have a requirement around reporting/transparency before having a requirement about having a plan with particular partners. The hardest thing is determining the scale; hospital markets may make most sense, but there are too many and the logistics may be too difficult. He asked about the concept for planning at least at the county level (plans and assessments conducted at a county-level at minimum). Wymyslo said that alignment with county-level data may make sense because that's how a lot of data is provided. Teresa Long (Columbus Public Health) also agreed that county-level assessments and plans could work. Aly noted that we already have a great deal of county-level assessment and planning in Ohio: 61% of hospital CHNAs defined community as 1 county or smaller and 89% of LHD CHAs identified community as one county or smaller.

	Transparency and accessibility Levine said she would like to "invite someone to make a coherent argument against" transparency. Falcone suggested that we should view the transparency and accessibility elements in the matrix as a continuum, and we should set up the reporting structures and start with voluntary reporting. J.D. Whitlock (Mercy Health) noted that there is a huge difference between sharing assessments and sharing outcome measurements. He noted that when New York required transparency and reporting on cardiac data from hospitals, they saw improvements in outcomes on those measures. Stevens stated that New York has a dashboard where they report out on population-level outcomes that align with the Prevention Agenda (SHIP). Bickford commented that it is important to ensure that local communities have access to data to report on these outcomes. Stevens noted that the purpose of Network of Care is ultimately to provide this type of data to local health departments, and that ideally NOC can be used as a dashboard platform to display outcomes for a manageable list of metrics from the new SHIP. Allan said we should not preclude additional county-level and sub-county data collection. Durfee asked about metric alignment. Stevens and Aly suggested that there could be a menu of metrics, so that if a particular priority is selected from the state plan, then metrics come along with it. Moody noted that this would be part of the SHIP process, and there would need to be agreement in metrics. Moody also noted that people have been very clear about timing issues being a challenge. He said the goal isn't to standardize everything immediately. "We want to nudge in a certain direction. We don't want to fight." Moody invited the group to share feedback on the infrastructure framework document by circling/writing responses and turning them in before leaving the meeting. Group members can also submit comments via email by Thursday, Nov. 5. The Infrastructure Subgroup was asked to submit comments via email by Wednesday, Nov. 4.

PCMH model design update Greg Moody Adi Kumar	Moody noted that it is not the intention to leave out primary care in discussions of population health (referencing Dr. Weaver's earlier comment). Hospitals/LHDs have community planning requirements, and one reason for the tight timeline for this work is that we're engaged in a process focused on rewarding primary care because primary care needs to be better linked to population health. Moody said that he now wants to share details regarding what we're actually spending money on in primary care so that we can tie back to the population health conversation. He introduced Adi Kumar, researcher from McKinsey & Company, to present their "highly preliminary" findings on primary care spending. Kumar noted that they (McKinsey) are still tweaking the data and in the cleaning process, and that today's presentation is an initial look. Levine asked what the turnover is in the top 5% (highest cost Ohio Medicaid patients). Adi said that they did not know at this point. Aly asked about the demographic breakouts available for the data. Kumar said it was available for age and gender. Rohling McGee clarified that the priority areas identified as "HPIO priorities" in the presentation are the top ten priorities identified by hospitals and local health departments in their community health assessments and plans, which HPIO shared with the group at the first Population Health Advisory Group meeting. Stevens asked Moody to explain how measure selection will occur. Moody responded that the care delivery model has been developed and that now they are going through the process of identifying measures. They will share the measures with this group and others. Kumar noted that throughout the vetting process they have heard very strongly from providers and payers that there needs to be alignment in measures. Whitlock asked, "Isn't that a given?" Kumar said that with CPCi, one of the goals was measure alignment, but payers could add on other measures. The definition of the word "alignment" is key. Moody added that this was voluntary payer participation, and the do not want to mandate anything yet. Following a question from Weaver, Kumar noted that inpatient,

	emergency departments (ED), and pharmacy are top spend areas. Carrie Baker (Ohio Children's Hospital Association) noted that it's kind of chicken vs. egg: how does the model tease out what needs to happen at the community level and how do we give assurance that the things that are selected are the ones on which providers can make a difference? Kumar noted that part of this is related to the measurement—measuring how much a primary care provider can improve relative to other primary care providers being measured in the same way. The goal is to have every measure tie to the care delivery model, with a host of other system related supports made available (i.e. provision of data back to providers). Regarding the 5% of patients accounting for 50% of spend (even after adjustments), Wymyslo noted that our population health will not improve if we only focus on this top 5%. Wapner asked that if we're holding primary care providers accountable, why wouldn't communities also be held accountable for these same metrics? Moody noted that access to getting an additional payment or other benefit from the state may be conditional on doing this. Moody also commented that alignment of these measures is something he "thinks about all of the time." He noted that this work is "a sprint" and that the objective is for all of this (PCMH model design and population health infrastructure design) to come together in December. There is also a parallel process with behavioral health system re-design that will come together around the same time. He said they also plan to use the next Population Health Advisory Group meeting as a "focus group" to test PCMH metrics. Slides from this presentation are preliminary and need to be discussed with the PCMH work/advisory groups before they are shared. However, they will be made available on the Office of Health Transformation (OHT) website in the near future. Levine expressed concern about the potential impact of recent efforts to de-fund Planned Parenthood on infant mortality due to lack of access to contraception.
Next steps	McGee thanked the group for its contributions today.

	The next meeting of the Population Health Advisory Group will be held on **Tuesday, Nov. 17th at 1:00-3:30 pm** 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	Meeting #3
Allan	Terry	Cuyahoga County Board of Health	y	n	y, call-in
Aly	Reem	HPIO	y	y	y
Applegate	Mary	Ohio Department of Medicaid	n	y	y
Baker	Todd	OSMA	y	y – M. Hueckel	y
Beck	Andrew	Cincinnati Children's Hospital	y, call-in	y	y
Bickford	Beth	Association of Ohio Health Commissioners	y	y	y
Bollig Dorn	Sarah	HPIO	y	y	y
Cannon	Jessie	Nationwide Children's Hospital	n	y	y
Curry	Marie	Community Legal Aid Services	y	y	n
Durfee	Sarah	Ohio Public Employees Retirement System	y	y	y
Falcone	Robert	Ohio Hospital Association	y	y	y
Goon	Anne	Henry County Health Department	y	y, call-in	y
Gullett	Heidi	Health Improvement Partnership-Cuyahoga	y	y, call-in	y, call-in
Hodges	Richard	Ohio Department of Health	y	y	y
Hoyt	Karin	Ohio Department of Medicaid	n	y	y
James	Tamara	AARP Ohio	y	n	y
Juenger	Monica	Governor's Office of Health Transformation	y	y	y
Keller	Kate	Interact for Health	y	y	y
Kilinc	Afet	Aetna Better Health of Ohio	y	y	y
Levine	Cathy	UHCAN Ohio	-	-	y
Long	Teresa	Columbus Public Health	y	y	y, call-in
Michener	Melissa	CareSource	n	y	n
Misak	Jim	MetroHealth	y	y	y
Mitchell	Jodi	Health Action Council	-	y	y
Moody	Greg	Governor's Office of Health Transformation	y	y	y
Motter	Miranda	Ohio Association of Health Plans	n	y	y
Robinson	Brandi	Ohio Department of Health	y	y	y
Rohling McGee	Amy	HPIO	y	y	y
Sims	Reina	Ohio Commission on Minority Health	y	y	n
Spicer	Ann	Ohio Academy of Family Physicians	n	n	y
Stevens	Amy	HPIO	y	y	y
Taylor	Robyn	ODH Office of Health Equity	y	n	y
Thackeray	Jonathan	Ohio Department of Medicaid	y	y	y
Tobias	Barb	Health Collaborative, UC	y	y	n
Waldron	Rich	MMO	y	y-N. Martin	y-D. Pirc
Wapner	Andrew	Ohio Department of Health	y	y	y
Wasowski	Krista	Medina County Health Department	y	y	y
Weaver	Greg	Senders Pediatrics	y	y	y, call-in

Whitlock	J.D.	Mercy Health	y, call-in	y	y
Wills	Jon	Ohio Osteopathic Association	y	y	y
Wirtz	Hubert	The Ohio Council of Behavioral Health & Family Services Providers	y	y – T. Lampl	n
Wymyslo	Ted	Ohio Assoc. of Community Health Centers	n	y	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	y, call-in
Deangelo	Aly	Ohio Hospital Association	y	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	y, call-in
Schultz	Jessica	Mercy St. Vincent	-	y, call-in	-
Thompson	Terri	ProMedica Health Systems	-	y, call-in	-
Ward	Britney	Hospital Council of Northwest Ohio	-	-	y, call-in
OTHER ATTENDEES			**Meeting #1**	**Meeting #2**	
Akah	Hailey	HPIO	y	n	n
Akerman	Susan	Joint Medicaid Oversight Committee	-	-	y
Baker	Carrie	Ohio Children's Hospital Association	-	y	y
Dye	James	American Cancer Society	-	-	y
Himes	Lance	Ohio Department of Health	y	n	y
Hollingshead	Larry	Board of Countryside YMCA, Atrium Medical Center, Premier Health System & Premier Health Group	-	-	y
Hutzler	Kyle	McKinsey	y	n	n
Kincaid	Sarah	Nationwide Children's Hospital	-	-	y
Kumar	Adi	McKinsey	-	y, call-in	y
Peterson	Sarah	Rep. Barbara Sear's office	-	-	y
Saladonis	Melissa	Cincinnati Children's Hospital Medical Center	-	-	y
Vath	Kyle	Mercy Health	-	y	n
Winn	Bryony	McKinsey	y	n	n
Wiselogel	Nick	HPIO	y	n	y
Wright	Celia	HPIO	y	y	y