Recommendations for population health planning infrastructure framework

Updated 11/17/15

Overall goals of population health planning infrastructure

1. Improve the health of Ohioans by deploying a strategic set of evidence-based, upstream population heath activities at the scale needed to measurably improve population health outcomes.
2. Develop a more efficient and effective way to do high-quality community health assessment and improvement planning in Ohio that:
    a. Results in widespread implementation and evaluation of evidence-based strategies
    b. Helps nonprofit hospitals and local health departments to meet IRS and PHAB requirements
    c. Balances local needs and innovation with statewide alignment and coordination
    d. Increases and supports collaboration between hospitals and local health departments, and with other community partners

Key assumptions and considerations

1. State Health Assessment (SHA)and State Health Improvement Plan (SHIP) will be:
    a. Guided by a broad conceptual framework that includes the social determinants of health, health equity, and a life-course perspective
    b. Developed through meaningful community leader input and engagement, including local health departments, hospitals and input from sectors outside of public health and health care
    c. Informed by local-level assessments, planning documents and other existing information about Ohio's health needs
    d. Actionable documents that can be used as a go-to source for priorities, metrics, objectives and evidence-based strategies
    e. Updated every three years on a timeline that allows for alignment with local community health plans
2. More strategic allocation of resources is needed to implement population health activities at the scale needed to improve population health outcomes.
3. Hospitals and Local Health Departments may choose to identify priorities in common with their entire service area or county as well as priorities that address localized health needs (such as by city, zip code, neighborhood or special population or age group).
4. Community health assessment and planning collaboration should occur at least at the county level and in some cases may be more effective across multiple counties.
5. Provision of tools (e.g. templates, checklists) and other forms of technical assistance to communities will support and strengthen the population health planning infrastructure (see page 6 for examples).
6. Additional guidance or requirements around community-level health planning will not conflict with federal and national requirements and standards.
7. Some communities are further along in collaborating and aligning on their plans and assessments and should be provided with opportunities to spread best practices to other communities.
8. Improved population health planning will provide hospitals and local health departments with a streamlined approach to more effectively and efficiently target and amplify resources to address the health needs of their community, while also meeting IRS and PHAB requirements.
9. Improved population health planning supports the transition to value-based payment models and delivery system reform.
10. Standardizing certain elements of the population health planning infrastructure may be phased in over time.
11. A system for tracking community-level progress on population health outcomes for SHIP core metrics will be developed. ODH will compile and share existing secondary data at least at the county level for the priorities and core metrics identified in the SHIP.

	Where we are today	Recommendation
1. State (SHA/SHIP) and local level (Hospital and LHD) assessment and plan alignment		
1a. Health priorities	• Limited intentional alignment of Hospital and LHD plan health priorities with the SHIP	State **issues guidance** encouraging tax-exempt Hospitals and Local Health Departments to address at least two health priorities in their plans from a menu of priorities identified in the SHIP (*referred to hereinafter as SHIP-aligned priorities*). *Guidance issued by July 2016*
1b. Measures (metrics, indicators) (see page 7 for examples)	• Not all SHIP objectives are specific and measurable • Very limited intentional alignment of Hospital and LHD assessment and plan metrics with the SHIP	State **issues guidance** encouraging tax-exempt Hospitals and Local Health Departments to include at least one core metric from the SHA/SHIP in their assessments and plans for each SHIP-aligned priority. *Guidance issued by July 2016*
1c. Evidence-based strategies	• No common definition of evidence-based strategies • Limited or unknown use of evidence-based strategies to address population-level health outcomes	State **issues guidance** encouraging tax-exempt Hospitals and Local Health Departments to select evidence-based strategies from a menu of strategies in the SHIP to address SHIP-aligned priorities. *Guidance issued by July 2016*

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	Where we are today	Recommendation
2. Hospital and LHD alignment		
2a. Collaboration on assessments and plans	• Significant variation across and within counties along collaboration continuum (from input to joint process) • Collaboration more common in assessment than implementation phase	State **issues guidance** encouraging tax-exempt Hospitals and Local Health Departments in the same counties or with shared populations to partner on assessments and plans through a common: • conceptual framework • process template or checklist • set of metrics (including metrics tracking racial and ethnic disparities) • health prioritization criteria • set of health priorities • set of objectives • set of evidence-based strategies that can be implemented in community-based and clinical settings • evaluation framework • shared accountability • exchange of data and information *Guidance issued by July 2016*
2b. Timeline	• Hospitals are on three-year cycle (as required by IRS), with many starting in 2012 on a rolling basis that varies widely across the state • Most Local Health Departments are on five-year cycles (maximum as required by PHAB) on a rolling basis that varies widely across the state	State **requires** tax-exempt Hospitals and Local Health Departments to align with a three-year timeline for assessments and plans. Hospital and Local Health Department plans covering years 2020-2022 and their related assessments must be submitted to the state in 2020 and every three years thereafter (in 2023, 2026, etc.). *Requirement issued by July 2016, effective in 2020 per subsequent guidance*

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	Where we are today	Recommendation
3. Funding		
3a. State funding for county-level assessments and plans	• Local health departments develop assessments and plans for their jurisdiction; Hospitals develop plans for their "community" • Assessments and plans for Hospitals and Local health Departments can cover a geographic area that is smaller than a county	To defray the cost of transitioning to a three-year assessment and planning cycle, the state will **seek additional funding** for Local Health Departments that choose to collaborate on one county-level assessment and plan. LHDs can pool together this additional funding to support development of multi-county collaborative assessments and plans. *Funding and disbursement methodology identified by July 2016*
3b. Hospital community benefit	• Hospitals are required to comply with federal IRS Hospital community benefit rules and regulations • Ohio has not added additional requirements or guidance	State **issues guidance** encouraging tax-exempt Hospitals to allocate a minimum portion of their total community benefit expenditures to activities that most directly support community health planning objectives, including community health improvement services and cash and in-kind contributions. *Guidance issued by July 2016*

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	Where we are today	Recommendation
4. Transparency and accessibility		
4a. Assessments and plans	• No central repository of all assessments or plans • Local health departments submit their assessments and plans to the Ohio Department of Health on a voluntary basis (information is not easily accessible to the public) and many voluntarily post documents on their own websites • Hospitals are required by the IRS to post assessments on their websites and some Hospitals post plans to their website, but this is not required by the IRS	• State **requires** tax-exempt Hospitals and Local Health Departments submit their assessments and plans to the state. • State provides online repository of all assessments and plans. *Requirement issued by July 2016, effective in 2017 and every three years thereafter*
4b. Schedule H	• Schedule H data is not compiled by the state; data is not easily accessible format for the public or state policymakers	• State **requires** tax-exempt hospitals to submit to the state their Schedule H and corresponding attachments, including reporting on each category of expenditures in Part I, Line 7(a)-(k)[1] and Part II of the Schedule H on an annual basis. (Government hospitals required to comply with 79 Fed. Reg. 78954 must submit equivalent information.) • State provides online repository of Schedule H and equivalent information. *Requirement issued by July 1, 2016, effective in 2017*

[1] Schedule H Part I, Lin 7: (a) financial assistance at cost, (b) Medicaid, (c) Costs of other means-tested government programs, (d) Financial assistance and Means-Tested Government Programs, (e) Community health improvement services and community benefit operations, (f) Health professions education, (g) Subsidized health services, (h) Research, (i) Cash and in-kind contributions

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Examples of technical assistance and other tools

Type	Description
Technical assistance	• Collaboration, building trust and collective impact • Authentic community engagement and facilitation • Primary and secondary data collection, analysis and presentation (including technical assistance on power analysis and adequate sample sizes) • Prioritization process • Identifying evidence-based strategies (CHR community health coaching model for implementation of strategies; use Community Guide, What Works for Health and National Registry of Evidence-Based Programs and Practices) • Developing SMART objectives • Identifying and aligning population health measures with clinical measures • Evaluation and ongoing monitoring
Outside facilitator/neutral convener	List of potential facilitators/neutral conveners
Public list of community health leaders	Regularly updated public list of stakeholders charged with leading their respective organizations community health planning processes (i.e. identifying the hospital and LHD liaisons)
State map of health priorities at the local level	Map that illustrates "community" as defined by each LHD and hospital assessment/plan (indicating overlap) and identifies priorities, strategies and objectives selected for each area
Learning community	Opportunities for peer-to-peer sharing with others who are leading assessments and plans
Templates, checklists, models and guides	• Assessment report template/checklist • Assessment process template/checklist • Plan report template/checklist • Plan process template/checklist • Evaluation plan template/checklist • Evaluation process template/checklist • Examples of logic models, SMART objectives • Progress reporting template/checklist • Community engagement model • Qualitative data collection templates o focus group and key-informant interview guides

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Measurement terminology

Term	Example
Measure, also referred to as a "metric" or "indicator." Observable and measurable characteristics.	*Prevalence* of cigarette smoking among Ohio adults (ages 18+), or *Percent* of Ohio adults who smoke cigarettes.
Objective. A statement about the desired change in a measure, metric or indicator.	*Decrease* the prevalence of cigarette smoking among adults (ages 18+), or *Decrease* percent of Ohio adults who smoke cigarettes.
Target. Numeric statement of desired outcome, often expressed as a number, percent or rate.	Decrease the prevalence of cigarette smoking among adults (ages 18+) *by 3.3 percentage points*, or Reduce the percent of Ohio adults who smoke from 23.3% *to 20%.*
SMART objective. An objective statement that is Specific, Measurable, Achievable, Realistic, and Time-bound. (SMART objectives include targets.)	Decrease the prevalence of cigarette smoking among adults (ages 18+) by 3.3 percentage points *from 2012 to 2020 (data source: BRFSS).*
Outcome. An actual outcome refers to the effect or impact of a program or policy.	Reduced prevalence of adult tobacco use in Ohio.

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