First meeting re-cap

Key themes to guide a vision for the future

- Clinical-community linkages, connecting funnel levels and identifying the “glide path to upstream”
- Patient-centeredness and consumer/community engagement
- Incentives to achieve better outcomes
- Better data to track disparities/equity and hyper-local conditions
- More integrated data systems to connect providers and sectors and to track costs and environments beyond health care
- Social determinants of health
Process and timeline
Population Health Planning Advisory Group

<table>
<thead>
<tr>
<th>First meeting</th>
<th>Second meeting</th>
<th>Third meeting</th>
<th>Fourth meeting</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Need to improve</td>
<td>• SHA/SHIP recommendations</td>
<td>• Recommendations for population health</td>
</tr>
<tr>
<td></td>
<td>population health</td>
<td>• Discuss state and community-level health</td>
<td>planning infrastructure reform</td>
</tr>
<tr>
<td></td>
<td>infrastructure</td>
<td>planning alignment</td>
<td>• Discuss PCMH</td>
</tr>
<tr>
<td></td>
<td>• Criteria for selecting</td>
<td>• Discuss financing options</td>
<td>alignment</td>
</tr>
<tr>
<td></td>
<td>population health</td>
<td>• Review McKinsey &amp; Company baseline</td>
<td>• Evaluation framework</td>
</tr>
<tr>
<td></td>
<td>priority areas</td>
<td>population health outcome/cost data</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Discuss population</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>health priority areas</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Population Health Infrastructure Subgroup

<table>
<thead>
<tr>
<th>First meeting</th>
<th>Second meeting</th>
<th>Third meeting</th>
</tr>
</thead>
</table>

Meeting objectives

By the end of this meeting, the group will:

**Objective 1.** Generate preliminary recommendations to improve the SHA and SHIP.

**Objective 2.** Identify strengths, challenges and opportunities for improvement for community health planning led by local health departments and hospitals. (The results of this discussion will inform the work of the Infrastructure Subgroup.)
Meeting objectives, cont.

By the end of this meeting, the group will:

**Objective 3.** Identify options for financing upstream population health activities. (The results of this discussion will inform the work of the Infrastructure Subgroup.)

**Objective 4.** Review and provide feedback on a primary care delivery model that incorporates population health priorities.

**Acronyms**

- **ASTHO:** Association of State and Territorial Health Officials
- **CHA:** Community Health Assessment (LHD)
- **CHIP:** Community Health Improvement Plan (LHD)
- **CHNA:** Community Health Needs Assessment (hospital)
- **CHNIS:** Community Health Needs Implementation Strategy (hospital)
- **LHD:** Local health department
- **PHAB:** Public Health Accreditation Board
- **SHA:** State Health Assessment
- **SHIP:** State Health Improvement Plan
PHAB
Public Health Accreditation Board
• Voluntary National Accreditation Program
• Goal is to advance quality and performance in public health
• Accreditation measures health departments against a set of nationally recognized, practice-focused and evidence-based standards

7 Steps to Accreditation
Pre-Application
Application
Document Selection and Submission
Site Visit
Accreditation Decision
Reports
Reaccreditation
ASSESS
Domain 1: Conduct and disseminate assessments focused on population health status and public health issues facing the community

INVESTIGATE
Domain 2: Investigate health problems and environmental public health hazards to protect the community

INFORM & EDUCATE
Domain 3: Inform and educate about public health issues and functions

COMMUNITY ENGAGEMENT
Domain 4: Engage with the community to identify and address health problems

POLICIES & PLANS
Domain 5: Develop public health policies and plans

PUBLIC HEALTH LAWS
Domain 6: Enforce public health laws

ACCESS TO CARE
Domain 7: Promote strategies to improve access to health care

WORKFORCE
Domain 8: Maintain a competent public health workforce
PHAB Standards & Measures

QUALITY IMPROVEMENT
Domain 9: Evaluate and continuously improve processes, programs, and interventions

EVIDENCE-BASED PRACTICES
Domain 10: Contribute to and apply the evidence base of public health

ADMINISTRATION & MANAGEMENT
Domain 11: Maintain administrative and management capacity

GOVERNANCE
Domain 12: Maintain capacity to engage the public health governing entity

PHAB’s Requirements

• Overview of State Health Assessment (SHA)
• Overview of State Health Improvement Plan (SHIP)
State Health Assessment

- Collaborative process to review data
- Demographics
- Description of health issues and distribution based on demographics
- Identify health disparities or inequities for health issues
- Description of factors that contribute to state populations health challenges
- Ongoing monitoring
State Health Improvement Plan

- Broad community partner participation
- Linked to the information from the SHA
- Identification of priorities based on a process and by stakeholders
State Health Improvement Plan

- Plan must include:
  - Measurable outcomes
  - Policy changes
  - Individuals accepting responsibility for implementing strategies
  - Consideration of local health improvement priorities and alignment with national priorities
- Process to track actions taken to implement strategies

Lessons Learned
Considerations for new SHA

- PHAB requirements
- Building blocks—what we already have
- Best practices and examples from other states

SHA building blocks

- HPIO Health Value Dashboard
- Network of Care
- Ohio Medicaid Assessment Survey
- Recent topic-specific reports (such as ODH CD report)
- McKinsey Population Health Diagnostic
Review of State SHAs and SHIPs

SHA best practices from ASTHO and PHAB

**Structure**
- Steering committee with the right people at the table, including high-level leadership, multiple agencies, and outside partners
- Vision and mission for SHA

**Indicator selection**
- Conceptual framework
- Include social determinants of health
- Criteria for narrowing selection of indicators to manageable set
- Valid and reliable data
SHA best practices continued

Stakeholder and community input
- Qualitative methods to supplement quantitative

Summarize and communicate findings
- Synthesize findings and identify overall themes
- Executive summary
- Put data in context: benchmarks, trends, disparities, US/other state comparisons, rankings, etc.
- Communications plan, including dissemination to general public
- Report card, key finding or “at-a-glance” formats and visuals

STRATEGIC ISSUE AREA:
CHRONIC DISEASE PREVENTION

LOCAL PUBLIC HEALTH SYSTEM
- Challenges in meeting disparate needs of populations due to geography, age, language, race, ethnicity, income, co-morbidities.
- Limited or no review of effectiveness of health communications, health education and prevention interventions.
- Minimal system-wide assurance of accuracy and current content of health communications, health education and promotion interventions.
- Minimal activity to assess system-wide effectiveness of efforts to reach targeted populations with culturally and linguistically appropriate health communications.
- Limited activity to manage overall system performance in informing, educating and empowering people about health issues.

FORCES OF CHANGE
- At current rates of increase, by 2030, 50% of the US adult population will be obese.
- Workplace wellness programs are on the rise, interest among employees who cannot provide health insurance.
- Model school-based programs are emerging – for example focusing on districts with workplace wellness (rather than individual schools) can have a great impact where a school district is a major employer.
- Changes in high school physical education requirements since 2000 have included physical activity in a population that is growing more obese yearly.
- There is minimal middle and high school health education course participation (under 10% of students enrolled).

THEMES AND STRENGTHS
- Diabetes, obesity and overweight, and tobacco use were specified as health issues affecting communities and in need of intervention.
- Common priority health issues have been identified by all 67 community health improvement projects, including an opportunity for strong state-level support for these issues.

HEALTH STATUS ASSESSMENT
TOBACCO
- More deaths are caused each year by tobacco use than by all deaths from human immunodeficiency virus (HIV), illegal drug use, alcohol use, motor vehicle injuries, suicide, and murders combined.
- Smoking is estimated to increase the risk of coronary heart disease and stroke by a factor of 2 to 4 and of dying from chronic obstructive lung diseases by a factor of 12.
- Tobacco use in Florida has declined over time, but substantial progress is still possible. Relaxed gains could be undone if efforts cease, leading to further surges in chronic disease mortality. Florida ranks 24th among the states with the highest proportion of smokers. This is a winnable battle providing that efforts to prevent tobacco use continue.

OVERWEIGHT, OBESITY AND PHYSICAL INACTIVITY
- An estimated 12.8% of premature deaths per year may be attributable to obesity through increased heart disease, diabetes, and cancer.
- Overweight and obesity are also associated with increased risks of heart disease, diabetes, cancer, stroke, and heart disease.
- Overweight and obesity are increasing overall and are particularly prevalent among Blacks. This increases the risk of adverse outcomes in cardiovascular disease. Florida ranks 6th among states that have the highest percentage of overweight adults. Blacks are nearly twice as likely as Whites or Hispanics to be obese. Studies have shown that adult overweight and obesity may have its beginnings in childhood.
- Regular physical activity not only helps to avoid being overweight, but it also reduces depression and anxiety, helps to maintain healthy bones, muscles, and joints; prevents falls among older people; reduces the risk of breast cancer, and promotes feelings of well-being. Florida ranks 47th among states for its low prevalence of reported physical activity.
Synthesize findings and overall themes: Colorado

Table 1. Colorado’s strengths and challenges in the national context.

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lowest obesity rate and lowest levels of physical inactivity</td>
<td>2nd highest rate of nonmedical use of prescription pain relievers</td>
</tr>
<tr>
<td>Lowest prevalence of diabetes, heart disease and stroke</td>
<td>One of the lowest rates of childhood immunization coverage (rank 42nd)</td>
</tr>
<tr>
<td>Rank 2nd for overall well-being</td>
<td>One of the states with the largest disparities between counties in overall mortality (rank 44th)</td>
</tr>
<tr>
<td>4th highest breastfeeding rate in the nation</td>
<td>5th highest suicide rate</td>
</tr>
<tr>
<td>5th lowest air pollution levels</td>
<td>Rank 27th for prevalence of binge drinking</td>
</tr>
<tr>
<td>Rank 6th for preventable hospitalizations</td>
<td>Significant racial and ethnic disparities in infant mortality and life expectancy</td>
</tr>
</tbody>
</table>

Notes:
3. Centers for Disease Control and Prevention National Immunization Survey (NIS), Preliminary Data, 2010 Series

Data in context—Disparities: New York

Figure 14. Index of Disparity* for Public Health Priority Areas, New York State, 2007-2009

- Tuberculosis Case Rate
- Gonorrhea Case Rate
- HIV-Related Case Rate
- Teen Pregnancy Rate, Ages 15-17
- Asthma Hospitalizations, Ages 0-17
- Drug-related Hospitalizations
- Diabetes Short-term Comp, Ages 18+
- Infant Mortality
- Diabetes Short-term Comp, Ages 6-17
- Colorectal Cancer Mortality
- Cervical Cancer Mortality
- Fall Hospitalizations, Ages 65+
- Congestive Heart Failure Hosp, Ages 18+
- Suicide Mortality
- Lung Cancer Incidence-Female
- COPD Hospitalizations, Ages 18+
- Cigarette Smoking-Adolescents
- Breast Cancer Mortality
- Motor vehicle mortality
- Unintentional injury Hospitalizations
- Unintentional Injury Mortality
- Pediatric Injury Hospitalizations
- Diabetes Prevalence, Ages 18+
- Stroke Mortality
- Low Birthweight (<2500 grams)
- Binge Drinking, Ages 18+
- Obese Children, Ages 2-4, WIC
- Lung Cancer Incidence-Male
- Coronary Heart Disease Hospitalizations
- Breastfeeding at 6 Mo. WIC
Data in Context—Disparities: Oregon

The following table presents a graphic summary of the disparities discussed above, which facilitate the identification of patterns of disparities for communities of color in Oregon. For all indicators, disparities are identified by how the community of color is doing in comparison to non-Latino whites.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Hispanic/Latino</th>
<th>African Americans</th>
<th>Al/AAN</th>
<th>Asian</th>
<th>Pacific Islander</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Trimester Prenatal Care</td>
<td>15%</td>
<td>20%</td>
<td>18%</td>
<td>15%</td>
<td>10%</td>
</tr>
<tr>
<td>Low Birth Weight Births</td>
<td>12%</td>
<td>10%</td>
<td>8%</td>
<td>6%</td>
<td>7%</td>
</tr>
<tr>
<td>Immunizations for 2 Year Olds*</td>
<td>80%</td>
<td>85%</td>
<td>75%</td>
<td>70%</td>
<td>70%</td>
</tr>
<tr>
<td>Cigarette Smoking Among Adults</td>
<td>25%</td>
<td>30%</td>
<td>20%</td>
<td>15%</td>
<td>15%</td>
</tr>
<tr>
<td>Cigarette Smoking Among Youth*</td>
<td>10%</td>
<td>15%</td>
<td>10%</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Obesity Among Adults</td>
<td>30%</td>
<td>35%</td>
<td>25%</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Asthma Among Adults</td>
<td>10%</td>
<td>15%</td>
<td>10%</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Diabetes Among Adults</td>
<td>15%</td>
<td>20%</td>
<td>10%</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Hypertension Among Adults</td>
<td>20%</td>
<td>25%</td>
<td>15%</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td>New Chlamydia Cases</td>
<td>10%</td>
<td>10%</td>
<td>8%</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>New HIV/AIDS Diagnosis</td>
<td>5%</td>
<td>5%</td>
<td>5%</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Teen Pregnancy Rate</td>
<td>5%</td>
<td>5%</td>
<td>5%</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Years of Potential Life Lost &lt;75</td>
<td>10 years</td>
<td>20 years</td>
<td>15 years</td>
<td>10 years</td>
<td>5 years</td>
</tr>
<tr>
<td>Percentage of Uninsured Ages 0-18</td>
<td>20%</td>
<td>25%</td>
<td>20%</td>
<td>15%</td>
<td>10%</td>
</tr>
<tr>
<td>Percentage of Uninsured Ages 19-64</td>
<td>15%</td>
<td>20%</td>
<td>15%</td>
<td>10%</td>
<td>5%</td>
</tr>
</tbody>
</table>

*Indicates a missing or out of range category for this indicator.

For more information, visit the Oregon Health Equity and Inclusions Initiative Report and website (http://www.oregon.gov/ohi/index.cfm).

Data in Context—YPLL and disparities: Oregon

Leading causes of death and years of potential life lost (YPLL) before age 75, Oregon residents, 2010

<table>
<thead>
<tr>
<th>Cause</th>
<th>YPLL</th>
<th>Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Injury</td>
<td>60,000</td>
<td>9,000</td>
</tr>
<tr>
<td>Cancer</td>
<td>50,000</td>
<td>8,000</td>
</tr>
<tr>
<td>Heart Disease</td>
<td>40,000</td>
<td>6,000</td>
</tr>
<tr>
<td>Chronic lower Resp. Disease</td>
<td>10,000</td>
<td>1,000</td>
</tr>
<tr>
<td>Other Conditions</td>
<td>5,000</td>
<td>1,000</td>
</tr>
</tbody>
</table>

Data Source: Oregon death certificate data

Years of potential life lost before age 75, Oregon, 2009

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>YPLL Before Age 75 per 100,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hispanic/Latino</td>
<td>9,992</td>
</tr>
<tr>
<td>African American</td>
<td>7,706</td>
</tr>
<tr>
<td>Al/AAN</td>
<td>8,000</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>3,342</td>
</tr>
<tr>
<td>White</td>
<td>6,047</td>
</tr>
</tbody>
</table>

Source: Oregon Vital Statistics and National Center for Health Statistics
Data note: Age-adjusted to U.S. standard population 2000
Data in Context—Trends and Benchmarks: Vermont

Marijuana Use
% of youth in grades 9-12 who report using marijuana in the past 30 days

Goal: 20%

Report Card Format: Oklahoma

STATE REPORT CARD

<table>
<thead>
<tr>
<th>MORTALITY</th>
<th>U.S.</th>
<th>OK</th>
<th>GRADE</th>
</tr>
</thead>
<tbody>
<tr>
<td>INFANT (RATE PER 1,000)</td>
<td>6.1</td>
<td>7.6</td>
<td>D</td>
</tr>
<tr>
<td>TOTAL (RATE PER 100,000)</td>
<td>747.0</td>
<td>915.5</td>
<td>F</td>
</tr>
</tbody>
</table>

LEADING CAUSES OF DEATH (RATE PER 100,000)

<table>
<thead>
<tr>
<th>Condition</th>
<th>U.S.</th>
<th>OK</th>
<th>GRADE</th>
</tr>
</thead>
<tbody>
<tr>
<td>HEART DISEASE</td>
<td>179.1</td>
<td>235.2</td>
<td>F</td>
</tr>
<tr>
<td>MALIGNANT NEOPLASM (CANCER)</td>
<td>172.8</td>
<td>191.3</td>
<td>D</td>
</tr>
<tr>
<td>CEREBROVASCULAR DISEASE (STROKE)</td>
<td>39.1</td>
<td>50.0</td>
<td>F</td>
</tr>
<tr>
<td>CHRONIC LOWER RESPIRATORY DISEASE</td>
<td>42.2</td>
<td>67.4</td>
<td>F</td>
</tr>
<tr>
<td>UNINTENTIONAL INJURY</td>
<td>38.1</td>
<td>60.5</td>
<td>F</td>
</tr>
<tr>
<td>DIABETES</td>
<td>20.8</td>
<td>26.9</td>
<td>D</td>
</tr>
<tr>
<td>INFLUENZA/PNEUMONIA</td>
<td>15.1</td>
<td>19.7</td>
<td>D</td>
</tr>
<tr>
<td>ALZHEIMER’S DISEASE</td>
<td>25.1</td>
<td>26.1</td>
<td>C</td>
</tr>
<tr>
<td>NEPHRITIS (KIDNEY DISEASE)</td>
<td>15.3</td>
<td>15.0</td>
<td>C</td>
</tr>
<tr>
<td>SUICIDES</td>
<td>12.1</td>
<td>16.5</td>
<td>D</td>
</tr>
</tbody>
</table>

DISEASE RATES

<table>
<thead>
<tr>
<th>Condition</th>
<th>U.S.</th>
<th>OK</th>
<th>GRADE</th>
</tr>
</thead>
<tbody>
<tr>
<td>DIABETES PREVALENCE</td>
<td>9.7%</td>
<td>11.5%</td>
<td>B</td>
</tr>
<tr>
<td>CURRENT ASTHMA PREVALENCE</td>
<td>8.9%</td>
<td>10.2%</td>
<td>B</td>
</tr>
<tr>
<td>CANCER INCIDENCE (RATE PER 100,000)</td>
<td>460.5</td>
<td>456.9</td>
<td>C</td>
</tr>
</tbody>
</table>

RISK FACTORS & BEHAVIORS

<table>
<thead>
<tr>
<th>Behavior</th>
<th>U.S.</th>
<th>OK</th>
<th>GRADE</th>
</tr>
</thead>
<tbody>
<tr>
<td>MINIMAL FRUIT CONSUMPTION</td>
<td>37.7%</td>
<td>50.2%</td>
<td>F</td>
</tr>
</tbody>
</table>
Considerations for new SHIP

- PHAB requirements
- Building blocks—what we already have
- Best practices and examples from other states
SHIP building blocks

SHIP best practices from ASTHO and PHAB

Structure
- Use planning model such as MAPP, ACHI, CHA, APEX/PH
- Executive committee + Broad-based, multi-sector implementation partnership + priority-specific committees
- Adequate staff to support committees

Visioning and conceptual framework
- Conceptual framework that includes equity, social determinants of health and systems thinking
- Mission, vision and values statements for SHIP

Prioritization process
- Identify prioritization criteria
- Be open and iterative during prioritization process
- Identify cross-cutting issues
- Alignment with national priorities, such as HP 2020 and National Prevention Strategy
SHIP best practices continued

Objectives and strategies
☑ Use logic model framework to articulate goals and outcomes
☑ Set measurable objectives with time-bound targets (SMART)
☑ Use resources such as Community Guide and What Works for Health to identify evidence-based strategies
☑ Identify policy strategies to address social determinants of health

Implementation and monitoring
☑ Identify financing for implementation
☑ Designate organizations and individuals responsible for implementation
☑ Track progress and impact, share through annual progress reports or dashboards

Conceptual Framework: Minnesota

[Diagram showing interconnections between various health and social indicators, such as Prenatal care, Breastfeeding, Food security, etc., leading to improved lifetime health, reduced health disparities, and better education outcomes. Also shows how all people in Minnesota enjoy healthy lives and healthy communities.]
Conceptual framework: Colorado

Health Equity
An Explanatory Model for Conceptualizing the Social Determinants of Health

LIFE COURSE
- Pregnancy
- Early Childhood
- Childhood
- Adolescence
- Adulthood
- Older Adults

SOCIAL DETERMINANTS OF HEALTH
- Economic Opportunity
- Social Support
- Education
- Employment
- Health
- Housing
- Transportation
- Water
- Air
- Safety

HEALTH FACTORS
- Participation
- Social Support
- Leadership
- Political Influence
- Organizational Networks
- Violence
- Rogers

HEALTH BEHAVIORS & CONDITIONS
- Smoking
- Physical Activity
- Tobacco Use
- Skin Cancer
- Injury
- Oral Health
- Sexual Health
- Obesity
- Cholesterol
- High Blood Pressure

MENTAL HEALTH
- Mental Health Status
- Stress
- Substance Abuse
- Transitional Status

QUALITY OF LIFE
- Access
- Utilization & Quality Care

MORBIDITY
- Mortality
- Life Expectancy

PUBLIC HEALTH'S ROLE IN ADDRESSING THE SOCIAL DETERMINANTS OF HEALTH
- Advocating for and defining public policy to achieve health equity
- Coordinated interagency efforts
- Creating organizational environments that enable change
- Data collection, monitoring, and surveillance
- Population-based interventions to address health factors
- Community engagement and capacity building

Conceptual Framework: Oklahoma

HEALTH DETERMINANTS MODEL

Adapted from the Dahlgren-Whitehead Model
Conceptual framework: Oregon

Prioritization: Illinois
Relative Contribution of Each Criterion to Overall Ranking
SMART Objectives and Alignment with National Priorities: Florida

**Strategy CD4.3** Eliminate Floridians’ exposure to secondhand tobacco smoke.

**OBJECTIVE CD4.3.1** By Dec. 31, 2015, reduce the percentage of Florida adults who were exposed to secondhand smoke at home during the past 7 days from 8.6% (2010) to 7.7%.

**OBJECTIVE CD4.3.2** By Dec. 31, 2015, reduce the percentage of Florida youth, ages 11-17 that were exposed to secondhand smoke in a room or car during the past 7 days from 50.3% (2010) to 45.3%.

**COORDINATING AGENCY** DOH

**PARTNERS AND STAKEHOLDERS** American Cancer Society, American Heart Association, American Lung Association

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Policy Strategies: Oregon

**FINAL** Oregon Health Improvement Plan: 2011 - 2020

**Goal 1:** Achieve health equity and population health by improving social, economic and environmental factors.

<table>
<thead>
<tr>
<th>2011</th>
<th>2012 - 2014</th>
<th>2015 - 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maintain funding for access and participation in early childhood education</td>
<td>Expand funding for access/participation in early childhood education</td>
<td>Target resources for affordable housing to families with incomes &lt;30% of median income</td>
</tr>
<tr>
<td>Pass legislation requiring schools/districts to assess/address health barriers to learning</td>
<td>Support partnerships with organizations focused on health improvement of students and staff</td>
<td>Support organizations to improve educational attainment among children</td>
</tr>
<tr>
<td>Support partnerships with organizations focused on health improvement of students and staff</td>
<td>Inventory, expand and improve K-12/college programs aimed at diversifying the health and health-care workforce</td>
<td>Support Health Impact Assessments for building or transportation projects near schools</td>
</tr>
<tr>
<td>Support Health Impact Assessments for building or transportation projects near schools</td>
<td>Improve prompt access to mental health services for school children and youth</td>
<td>Improve prompt access to mental health services for school children and youth</td>
</tr>
</tbody>
</table>

**Strategy:** Target resources to improve child and student health (birth through higher education) to support improved educational outcomes.
Identify Financing: Oregon

Health Improvement Plan Recommendations

Cost Analysis Table

<table>
<thead>
<tr>
<th>Recommended investment for FY2017-2020</th>
<th>Benefit from full investment</th>
<th>Lost or no investment</th>
</tr>
</thead>
<tbody>
<tr>
<td>$3 billion over 10 years</td>
<td>More than $16 billion</td>
<td>More than $3 billion</td>
</tr>
</tbody>
</table>

Target resources to improve child and student health (birth through higher education) to support improved educational outcomes.

- $17 million per year (for 10 years) to implement Coordinated School Health in Oregon School Districts. $37 million per year (for 7 years) to expand the Oregon Pre-Kindergarten Program to cover all eligible 3- and 4-year-olds. $371 million per year (for 7 years) to expand Early Head Start to cover all eligible children (prenatal through 3 years of age).
- Studies have found a 5.4:1 ROI for investment in Coordinated School Health, and ROI as high as 16:1 for investment in early childhood education. Benefits seen are increased wages, more taxes paid, reduced need for welfare and medical assistance programs, and lower crime rates. For an ROI of 5:4:1, the benefit of a $3 billion investment over 10 years would be over $16 billion. ([http://healthyamericans.org/reports/prevention08/Prevention08.pdf](http://healthyamericans.org/reports/prevention08/Prevention08.pdf)).
- Approximately $173 million dollars in tax revenue is lost each year due to the decreased earnings of individuals that did not earn a diploma in high school. (Cascade Policy Institute March 2010) Oregon spends more than $200 million providing Medicaid services to people who did not graduate high school. (Cascade Policy Institute March 2010).

Track and Share Progress: Maryland

Babies With Low Birth Weight

This indicator shows the percentage of live births that are a low birth weight (2500 grams or less). Babies born with a low birth weight are at increased risk for serious health consequences including disabilities and death. LBW infants weigh less than 2,500 grams (5.5 pounds). Maryland's LBW percentage is higher than the national average.

Measurement Period: 2013

- **State Chart**
- **Maryland Historic Chart**
- **County Chart**
- **All Charts**

![Graph showing percentage of low birth weight births in Maryland and other states](image)
Discussion for meeting objective #1

1. What are the characteristics of an ideal SHA?
2. What are the characteristics of an ideal SHIP?
3. What is most important?
4. What do you recommend to improve the next SHA and SHIP?

Meeting objective #1 met?

The group will generate preliminary recommendations to improve the SHA and SHIP.
Community health planning: LHDs and hospitals

Population health planning infrastructure in Ohio

Ohio Department of Health
Ohio Medicaid
Governor’s Office of Health Transformation

State Health Assessment (SHA) and State Health Improvement Plan (SHIP)
SIM Population Health Plan

Community-level public and private partners

Local health departments
Hospitals

Community health assessment (CHA) and Community health improvement plan (CHIP)
Community health needs assessment (CHNA) and Implementation strategy (IS)

Other community plans: Federally qualified health centers • Local behavioral health boards • Family and Children First Councils • Community Action Agencies • United Ways • Banks
Hospital

CHNA: Community health needs assessment

IS: Implementation strategy

Local health department

CHA: Community health assessment

CHIP: Community Health Improvement Plan
501(c)(3) hospital organizations are recognized by the Internal Revenue Service (IRS) as being federally tax-exempt, charitable organizations.
### Community Health Needs Assessment

<table>
<thead>
<tr>
<th>Number</th>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Was the facility first licensed, registered, or similarly recognized by a State as a hospital facility in the current tax year or the immediately preceding tax year?</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If &quot;Yes,&quot; provide details of the acquisition in Section C.</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>During the tax year or either of the two immediately preceding tax years, did the hospital conduct a community health needs assessment (CHNA)? If &quot;No,&quot; skip to line 12.</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>

If "Yes," indicate what the CHNA report describes (check all that apply):

- [ ] A definition of the community served by the hospital facility
- [ ] Demographics of the community
- [ ] Existing health care facilities and resources within the community that are available to respond to the health needs of the community
- [ ] How data was obtained
- [ ] The significant health needs of the community
- [ ] Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups
- [ ] The process for identifying and prioritizing community health needs and services to meet the community health needs
- [ ] The process for consulting with persons representing the community’s interests
- [ ] Information gaps that limit the hospital facility’s ability to assess the community’s health needs
- [ ] Other (describe in Section C)

4. Indicate the tax year the hospital facility last conducted a CHNA: 20

5. In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted.

6a. Was the hospital facility’s CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C.

6b. Was the hospital facility’s CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C.

7. Did the hospital facility make its CHNA report widely available to the public?

If "Yes," indicate how the CHNA report was made widely available (check all that apply):

...
Summary of community health planning requirements for hospitals and local health departments (LHDs)

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Internal Revenue Service (Hospitals)</th>
<th>Public Health Accreditation Board (LHDs)</th>
</tr>
</thead>
</table>
| **Assessment**               | Community health needs assessment (CHA) must:  
|                              | • describe the health and demographics of the population,  
|                              | • identify areas for health improvement,  
|                              | • identify sources of health outcomes,  
|                              | • identify community assets and resources that can be mobilized to improve population health.  
| **Definition of “Community”**| Community health assessment (CHA) must:  
|                              | • describe the health and demographics of the population,  
|                              | • identify areas for health improvement,  
|                              | • identify contributing factors that impact health outcomes,  
|                              | • identify community assets and resources that can be mobilized to improve population health.  
| **Timeline**                 | CHAs and Implementation strategies (IIs) must be completed every three years, whenever CHAs include areas beginning after March 23, 2012. Hospitals must provide information annually to the LHD on how they are addressing the significant health needs identified in their CHAs.  
|                              | CHAs and community health improvement plans (CHIPs) must be completed at least every five years.  
| **Collaboration and partnerships** | CHAs must include input from persons who represent the broad interest of the community including:  
|                              | • those with special knowledge or expertise in public health and member of underserved, low-income, and minority populations,  
|                              | • CHAs may be conducted in collaboration with other organizations including governmental departments (public health or local health department) and nonprofit organizations.  
|                              | Partnerships with other organizations outside of the health department are required in conducting the CHA and CHIP and documentation of the following must be provided:  
|                              | • partners outside of the LHD that represent community populations and a variety of state and local community sectors,  
|                              | • partners include organizations from two or more populations that are at a higher health risk or have poorer health outcomes than other populations, and  
|                              | • regular meetings or communications with partners.  
| **Satisfaction of input and feedback** | Hospitals must assess and take into account written comments received on their most recently conducted CHA and implementation strategies.  
|                              | Preliminary findings of the CHA and CHIP must be distributed to the community at large and community input must be sought.  |
Regionalization – definition of community

Hospital CHNA
(n=170)

- 30% 3 or more counties
- 61% 1 county or smaller
- 9% 2 counties

LHD CHA
(n=110)

- 89% 1 county or smaller
- 2% 2 counties
- 9% 3 or more counties

189 nonprofit/government hospitals (as of July, 2014)
124 local health departments (as of September, 2014)

170 CHNAs
110 CHAs
80 ISs
65 CHIPS
Collaboration among LHDs (n=110)

- 64.5% One LHD
- 35.5% Two or more LHDs together

Collaboration among hospitals (n=170)

- 65.9% collaborated within own hospital system
- 50% collaborated with at least one hospital outside of own health system
- 20% no collaboration with another hospital facility

Percent of hospitals and LHDs reporting collaboration on CHNA

- 10.6% No LHD/hospital involvement
- 17.3% CHA CHNA joint document
- 16.4% Hospitals (n=170)
- 18.8% LHDs (n=110)
Percent of hospitals and LHDs reporting collaboration on CHNA

- **Provided secondary data**: 31.8% (Hospitals) vs. 38.2% (LHDs)
- **Partner in data collection**: 33.6% (Hospitals) vs. 38.2% (LHDs)
- **Involved in focus groups or key informant interviews**: 18.2% (Hospitals) vs. 48.2% (LHDs)
- **Involved in prioritization**: 14.5% (Hospitals) vs. 31.8% (LHDs)
- **CHA/CHNA partnership**: 30% (Hospitals) vs. 45.7% (LHDs)
- **CHA/CHNA leadership role**: 33.6% (Hospitals) vs. 33.6% (LHDs)

Percent of hospitals and LHDs reporting collaboration on CHNA

- **IS partnership**: 18.8% (Hospitals) vs. 18.5% (LHDs)
- **IS leadership role**: 13.8% (Hospitals) vs. 24.6% (LHDs)
- **CHIP/IS joint document**: 10% (Hospitals) vs. 6.2% (LHDs)
Best practice examples: LHD and hospital alignment

<table>
<thead>
<tr>
<th></th>
<th>Colorado</th>
<th>Washington</th>
<th>California</th>
<th>New York</th>
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<tbody>
<tr>
<td>LHD and hospital collaboration guidance</td>
<td></td>
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<tr>
<td>Community health leader contact information</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>LHD-Hospital timeline alignment</td>
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<td></td>
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<td>X</td>
</tr>
<tr>
<td>Community health planning process template or requirements</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

X – Both hospitals and local health departments
X – hospitals
X – LHDs

Work in progress; subject to change
## Best practice examples: State and local alignment

<table>
<thead>
<tr>
<th>State and local alignment of priorities</th>
<th>Colorado</th>
<th>Washington</th>
<th>California</th>
<th>New York</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>State and local alignment of evidence-based strategies</td>
<td>X</td>
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<td>X</td>
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<tr>
<td>Technical assistance provided</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
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</tbody>
</table>

*X – Both hospitals and local health departments
X – hospitals
X – LHDs*
### Colorado

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>State compilation of plans and priorities</td>
<td>X</td>
</tr>
<tr>
<td>State and local alignment of priorities</td>
<td>X</td>
</tr>
<tr>
<td>State and local alignment of evidence-based strategies</td>
<td>X</td>
</tr>
<tr>
<td>Technical assistance provided</td>
<td>X</td>
</tr>
</tbody>
</table>

- Both hospitals and local health departments: X
- Hospitals: X
- LHDs: X

Updated October, 2019

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### Washington

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Status</th>
</tr>
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<tbody>
<tr>
<td>LHD and hospital collaboration guidance</td>
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<tr>
<td>Community health planning process template or requirements</td>
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</tr>
</tbody>
</table>

- Both hospitals and local health departments: X
- Hospitals: X
- LHDs: X

Information to be made widely available by certain hospitals — Community health needs assessment — Description of community served — Community benefit implementation strategy.

(1) Effective January 1, 2013, each hospital that is recognized by the internal revenue service as a 501(c)(3) nonprofit entity must make its federally required community health needs assessment widely available to the public within fifteen days of submission to the internal revenue service. Following completion of the initial community health needs assessment, each hospital in accordance with the internal revenue service shall comply and make widely available to the public an assessment once every three years.

(2) Unless contained in the community health needs assessment under subsection (1) of this section, a hospital subject to the requirements under subsection (1) of this section shall make public a description of the community served by the hospital, including both a geographic description and a description of the general population served by the hospital, and demographic information such as leading causes of death, levels of human distress, and descriptions of the medically underserved, low-income, and minority and elderly populations in the community.

(3a) Each hospital subject to the requirements of subsection (1) of this section shall make widely available to the public a community benefit implementation strategy within one year of completing its community health needs assessment. In developing the implementation strategy, hospitals shall consult with community-based organizations and stakeholders, and local public health jurisdictions, as well as any additional consultation the hospital deems necessary. Unless contained in the implementation strategy under the subsection (1), the hospital must provide a brief explanation for not accepting recommendations for community benefit proposals identified in the assessment and a description of the process used to implement the assessment.

(3b) The implementation strategy must be evidence based, where available, or development and implementation of innovative programs and practices should be supported by evaluation measures.

For the purposes of this section, the term ‘widely available to the public’ has the same meaning as in the internal revenue service guidelines.

(2012 36th Leg.)
SB 697 (Chapter 812, Statutes of 1994)

127355. Each hospital shall do all of the following:

(a) By July 1, 1995, reaffirm its mission statement that requires its policies integrate and reflect the public interest in meeting its responsibilities as a not-for-profit organization.

(b) By January 1, 1996, complete, either alone, in conjunction with other health care providers, or through other organizational arrangements, a community needs assessment evaluating the health needs of the community served by the hospital, that includes, but is not limited to, a process for consulting with community groups and local government officials in the identification and prioritization of community needs that the hospital can address directly, in collaboration with others, or through other organizational arrangements. The community needs assessment shall be updated at least once every three years.

(c) By April 1, 1996, and annually thereafter adopt and update a community benefits plan for providing community benefits either alone, in conjunction with other health care providers, or through other organizational arrangements.

(d) Annually submit its community benefits plan, including, but not limited to, the activities that the hospital has undertaken in order to address community needs within its mission and financial capacity to the Office of Statewide Health Planning and Development. The hospital shall, to the extent practicable, assign and report the economic value of community benefits provided in furtherance of its plan. Effective with hospital fiscal years, beginning on or after January 1, 1996, each hospital shall file a copy of the plan with the office not later than 100 days after the hospital's fiscal year ends. The reports filed by the hospitals shall be made available to the public by the office. Hospitals under the common control of a single corporation or another entity may file a consolidated report.

127355. The hospital shall include all of the following elements in its community benefits plan:

(a) Mechanisms to evaluate the plan’s effectiveness including, but not limited to, a method for soliciting the views of the community served by the hospital and identification of community groups and local government officials consulted during the development of the plan.

(b) Measurable objectives to be achieved within specified timeframes.

(c) Community benefits categorized into the following framework:
   (1) Medical care services.
   (2) Other benefits for vulnerable populations.
   (3) Other benefits for the broader community.
   (4) Health research, education, and training programs.
   (5) Nonquantifiable benefits.
### California

<table>
<thead>
<tr>
<th>State compilation of plans and priorities</th>
<th>X</th>
</tr>
</thead>
<tbody>
<tr>
<td>State and local alignment of priorities</td>
<td></td>
</tr>
<tr>
<td>State and local alignment of evidence-based strategies</td>
<td></td>
</tr>
<tr>
<td>Technical assistance provided</td>
<td></td>
</tr>
</tbody>
</table>

- X – Both hospitals and local health departments
- X – hospitals
- X – LHDs

### New York

| New York |
|------------------------------------------|---|
| LHD and hospital collaboration guidance | X |
| Community health leader contact information | X |
| LHD-Hospital timeline alignment | X |
| Community health planning process template or requirements | X |

- X – Both hospitals and local health departments
- X – hospitals
- X – LHDs

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**Local Health Department Community Health Assessment and Improvement Plan and Hospital Community Service Plan Guidance, 2013**

**I. Background**

This guidance describes the essential elements of a local health department Community Health Assessment and Community Health Improvement Plan, as well as the requirements for hospital Community Service Plans. In keeping with the New York State Health Improvement Plan, the Prevention Agenda 2013-17, the Department is asking local health departments and hospitals to collaborate with each other and community partners on the development of these documents. Collaboration is an essential element for improving population health in communities and in the State as a whole. Furthermore, working together to develop a community health assessment and community health improvement plan will reduce duplication and assist local health departments and hospitals to conduct this work in an effective, efficient manner.

This 2013 guidance is informed by several factors. First, it incorporates state and local experience developing and implementing the Prevention Agenda 2008, and builds upon the Department’s previous guidance for development of these documents as required by Article 6 and Article 28 of state public health law. Secondly it has been shaped by national accreditation of state and local public health agencies. State and local health departments that wish to become accredited must complete periodic health assessments and health improvement plans in collaboration with community partners. Lastly, the Affordable Care Act requires nonprofit hospitals to conduct a periodic community health needs assessment and adopt an implementation strategy to meet the community health needs identified in the assessment. This guidance is intended to facilitate responses to these requirements and promote collaboration in doing so.

**II. NYS DOH Requirements for Local Health Department Community Health Assessments and Health Improvement Plans, and Hospital Community Service Plans**

Local health departments (LHDs) are being asked to work with local hospitals as well as other area partners to complete a Community Health Assessment that includes a Community Health Improvement Plan for 2014-2017. Many communities have been planning and implementing improvement strategies. Up until now, community health improvement activities conducted by local health departments were described in the Municipal Public Health Services Plan [MPPSP]. In 2014, the local health department Community Health Assessment will no longer be part of the MPPSP.\(^1\)

For 2013-2015, hospitals are being asked to work with local health departments to complete a Community Service Plan that mirrors the Community Health Needs Assessment and Improvement Strategy required for nonprofit hospitals per the Affordable Care Act. The new federal law also requires hospitals to develop an implementation plan that describes how they will address the needs identified in their assessment.\(^2\)

---

1. \(^{1}\) \[^{1}\]Public Health Law §602 and §802 L.
2. \(^{2}\) Public Health Accreditation Board Standards and Measures Version 1.0 (Updated December 22, 2011). Completing a community health assessment and a community health improvement plan are prerequisites for voluntary accreditation.
3. \(^{3}\) Section 9027 of the Patient Protection and Affordable Care Act added a new section 5007(c) to the Internal Revenue Code entitled “Additional Requirements for Charitable Hospitals.” This section stipulates that a hospital’s eligibility for tax exempt status is based on satisfying four separate requirements including one that requires hospitals to develop a community health needs assessment.
4. \(^{4}\) For LHDs, the costs associated with conducting a Community Health Assessment will continue to be eligible for state aid reimbursement, and completing a Community Health Assessment is a requirement for state aid.
Discussion for meeting objective #2

1. What are the characteristics of an ideal infrastructure for CHNA/ISs and CHA/CHIPs?
   - SHA/SHIP alignment
   - Hospital/LHD alignment

2. What’s working well with the way that hospitals and LHDs currently conduct assessments and develop health improvement plans? What should NOT change?

3. What could be improved in order to get to better population health outcomes? What SHOULD change?
The group will identify strengths, challenges and opportunities for improvement for community health planning led by local health departments and hospitals. (The results of this discussion will inform the work of the Infrastructure Subgroup.)
What is hospital community benefit?

Stable investments in evidence-based upstream prevention
Community-based, primary prevention that addresses the social, economic and physical environments that shape our health

1. Change incentives within healthcare system
   - Reward value over volume through payment reform and delivery innovation strategies, such as global payments, Medicare waivers and accountable care models.
   - Maximize the impact of Ohio’s State Innovation Model (SIM) Population Health Plan.

2. Leverage potential new sources of funding
   - Such as: Wellness trusts
   - Hospital community benefit allocated to upstream prevention
   - Pay for Success Financing/Social Impact Bonds

3. Nurture cross-sector partnerships and perspectives
   - Greater collaboration between health and sectors such as education, criminal justice, transportation, community development and housing through:
     - Health and Equity in All Policies approach to decision making
     - Community integrators and backbone organizations

Inside the healthcare system | Balanced portfolio of strategies and financing mechanisms | Outside the healthcare system
3. Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization’s patients during the tax year.
   a. Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing free care? If “Yes,” indicate which of the following was the FPG family income limit for eligibility for free care:
      - 100%
      - 150%
      - 200%
      - Other __%
   b. Did the organization use FPG as a factor in determining eligibility for providing discounted care? If “Yes,” indicate which of the following was the family income limit for eligibility for discounted care:
      - 200%
      - 250%
      - 300%
      - 350%
      - 400%
      - Other __%
   c. If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care.

4. Did the organization’s financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the “medically indigent”? If “Yes,” indicate which of the following was the medically indigent income threshold:
   a. If “Yes,” did the organization’s financial assistance expenses exceed the budgeted amount?
   b. If “Yes,” to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?
   c. Did the organization prepare a community benefit report during the tax year?
   d. If “Yes,” did the organization make it available to the public?

Complete the following table using the worksheets provided in the Schedule H instructions. Do not submit

<table>
<thead>
<tr>
<th>Financial Assistance and Certain Other Community Benefits at Cost</th>
<th>a</th>
<th>b</th>
<th>c</th>
<th>d</th>
<th>e</th>
<th>f</th>
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<tbody>
<tr>
<td>Financial Assistance and Means-Tested Government Programs</td>
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<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Financial Assistance at cost (from Worksheet 1)</td>
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<tr>
<td>b. Medicaid (from Worksheet 3, column b)</td>
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</tr>
<tr>
<td>c. Costs of other means-tested government programs (from Worksheet 3, column b)</td>
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<tr>
<td>d. Total Financial Assistance and Means-Tested Government Programs</td>
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<tr>
<td>Other Benefits</td>
<td></td>
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</tr>
<tr>
<td>a. Community health improvement services and community benefit programs (from Worksheet 4)</td>
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<td>b. Health professions education (from Worksheet 5)</td>
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<td>c. Subsidized health services (from Worksheet 6)</td>
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<tr>
<td>d. Research (from Worksheet 7)</td>
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<tr>
<td>e. Cash and in-kind contributions for community benefit (from Worksheet 8)</td>
<td></td>
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<tr>
<td>f. Total, Other Benefits</td>
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<tr>
<td>g. Total</td>
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</tr>
</tbody>
</table>

7. Financial Assistance and Certain Other Community Benefits at Cost

Hospital community benefit

Financial assistance or “charity care”

Medicaid and other means-tested government program shortfall

Subsidized health services

Community health improvement services

Health professions education

Research

Cash and in-kind contributions

DOES NOT COUNT as hospital community benefit (still reported on Schedule H)

Bad debt

Medicare shortfall

Community building activities
Community health improvement services

“activities or programs, subsidized by the health care organization, carried out or supported for the express purpose of improving community health”

Community building activities

<table>
<thead>
<tr>
<th>Community building</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical improvements and housing</td>
<td>Rehabbing or providing housing for vulnerable populations, neighborhood improvement projects, developing parks or playgrounds to increase physical activity</td>
</tr>
<tr>
<td>Economic development</td>
<td>Assisting small business development for vulnerable populations; creating new jobs in areas with high jobless rates</td>
</tr>
<tr>
<td>Community support</td>
<td>Child care and mentoring programs for vulnerable populations; disaster preparedness (beyond what’s required by law)</td>
</tr>
<tr>
<td>Environmental improvements</td>
<td>Alleviating air or water pollution; waste removal and treatment</td>
</tr>
<tr>
<td>Leadership development and training for community members</td>
<td>Conflict resolution training; medical interpreter skills for community residents; civic, cultural or language skills</td>
</tr>
<tr>
<td>Coalition building</td>
<td>Participating in community coalitions and other collaborations to address health and safety</td>
</tr>
<tr>
<td>Community health improvement advocacy</td>
<td>Supporting policies and programs (access, housing, environment, transportation)</td>
</tr>
<tr>
<td>Workforce development</td>
<td>Recruiting to shortage areas; training and recruiting health professionals needed in community</td>
</tr>
</tbody>
</table>

Source: Community Catalyst
Community building activities
- Environmental improvements
- Physical improvements
- Economic development

Meets specific requirements

Community health improvement services

Reporting activities under community health improvement

☑ Responds to an established community need
☑ Meets at least one community benefit objective, including improving access to health services, enhancing public health, advancing generalizable knowledge, and relief of government burden to improve health
☑ Subsidized by the organization
☑ Does not generate an inpatient or outpatient bill
☑ Not provided for marketing purposes
☑ Not more beneficial to the organization than to the community.
☑ Not required for licensure or accreditation.
☑ Not restricted to individuals affiliated with the organization (such as employees and physicians)

Catholic Health Association; 2014 IRS Instructions for Form 990, Schedule H
Reporting activities under community health improvement

☑ Responds to an established community need through:
  - A CHNA conducted or accessed by the organization
  - Documentation of a demonstrated community need or request from a public health agency or community group
  - Involvement of unrelated collaborative tax-exempt or government organizations as partners in the activity or program carried out for the express purpose of improving community health

2014 IRS Instructions for Form 990, Schedule H
Hospitals by ownership type, 2013

United States
- For profit: 21.3%
- Non-profit: 58.4%
- State/local government: 20.3%

Ohio
- For profit: 14.8%
- Non-profit: 75.4%
- State/local government: 9.8%


Hospital community benefit expenditures

National¹, 2009
- Subsidized health services: 14.7%
- Health professions education: 5.3%
- Research: 1.3%
- Community health improvement: 5.3%
- Charitable care: 25.3%

Ohio², 2012
- Community health improvement: 3.3%

²HPIO analysis of Ohio nonprofit and government hospital 990, Schedule H forms, 2012
Ohio hospital community benefit expenditures, 2012

Net total community benefit expenditures (n=156)
- Actual dollar amounts: $124,675 - $747,744,582

Net total community health improvement expenditures (n=141 corrected)
- Actual dollar amounts: $1,851 - $34,182,807

Net total community building expenditures (n=99 corrected)
- Actual dollar amounts: $1,325 - $6,383,588

Source: HPIO analysis of Ohio nonprofit and government hospital 990, Schedule H forms, 2012. Range includes both individual hospital facilities and health systems encompassing multiple facilities.
Ohio hospital community benefit expenditures, 2012
Range per hospital/health system*

**Net total community benefit expenditures** (n=156)
- Percent of total hospital expense: 0.28%-30.28%

**Net total community health improvement expenditures** (n=141 corrected)
- Percent of total hospital expense: 0.01%-4.37%

**Net total community building expenditures** (n=99 corrected)
- Percent of total hospital expense: 0.01%-0.48%

*Range includes both individual hospital facilities and health systems encompassing multiple facilities.

Scale of resources

<table>
<thead>
<tr>
<th></th>
<th>Per capita</th>
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<tr>
<td>Net total community</td>
<td>$333.97</td>
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<tr>
<td>benefit expenditures</td>
<td>Per capita</td>
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<tr>
<td>2012 (n=156)</td>
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<tr>
<td>Net total community</td>
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<tr>
<td>building expenditures</td>
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<td>2012 (n=99 corrected)</td>
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</tbody>
</table>

Range includes both individual hospital facilities and health systems encompassing multiple facilities.
**Defining community benefit**

**California and Maryland:** Define community benefit as a hospital activity “intended to address community needs and priorities primarily through disease prevention and improvement of health status.” Cal. Health & Safety Code § 12735(c); Md. Code Ann. Health-Gen 19-303(a)(3)

- **California:** Includes food, shelter, clothing, education, transportation, and other goods or services that help maintain a person’s health
- **Maryland:** Includes community-building activities

**New Hampshire:** Classifies community-building activities as a category of reportable community benefits. Community Benefits Reporting Guide
Community benefit transparency

California, Illinois, Indiana, Maryland, New Hampshire, New York, Rhode Island, Texas, and Vermont require reporting of hospital community benefit to a state agency.

New Hampshire and Maryland: Require reporting of community benefit on standardized reporting forms that include reporting on different categories of community building.

California, Vermont, Washington, and Maryland require transparency with the general public through posting on a state website, required posting on hospital site, or compilation of information into a state-wide report.

Discussion for meeting objective #3

What options for financing upstream population health activities should be explored by this group?

Meeting objective #3 met?

The group will identify options for financing upstream population health activities. (The results of this discussion will inform the work of the Infrastructure Subgroup.)
Key characteristics of population health strategies

- Beyond the patient population
- Beyond medical care
- Measuring outcomes
- Closing gaps (improvement for all groups)
- Shared accountability

Pathway to improved health value: A conceptual framework (11.10.14)

Systems and environments that affect health:
- Healthcare system
- Public health and prevention
- Access
- Social and economic environment

Equitable, effective and efficient systems

Optimal environments

Improved population health:
- Health behaviors
- Health equity
- Health status
- Mortality

IMPROVED HEALTH VALUE

Sustainable health costs:
- Public sector
- Private sector
- Consumers

World Health Organization definition of health: Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.
Health Impact Pyramid

Counseling and education
- Quality counseling
- Public education about drunk driving, physical activity, youth violence, etc.

Clinical interventions
- Treatment of hypertension and hyperlipidemia
- Screening for fall risk
- Immunizations
- Tobacco cessation services
- Dental sealants
- Grab bars and hand rails to prevent falls

Long-lasting protective interventions
- Clean water
- Fluoridation
- Elimination of lead paint and asbestos exposure
- Smoke free workplaces
- Improved living and working environments
- Safe and accessible places to promote physical activity

Changing the context to make individuals' default decisions healthy
- Poverty reduction
- Improved education
- Improved housing and sanitation

Mechanisms by Which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan