Population Health Planning Infrastructure Subgroup
November 10, 2015
Meeting Notes

<table>
<tr><th>TOPIC</th><th>DISCUSSION</th></tr>
<tr><td>Welcome
Amy Rohling McGee
Greg Moody</td><td>Greg Moody (Office of Health Transformation) reviewed the work that the Advisory Group has done, informed by Infrastructure Subgroup work, since the last Subgroup meeting. Amy Rohling McGee (HPIO) reviewed meeting objectives and overall project goals.

Note: List of group members and attendees is attached at the end of minutes. Content from the meeting, including the slides and other materials can be found on the HPIO Population Health page.</td></tr>
<tr><td>Infrastructure design discussion
Reem Aly
Amy Bush Stevens</td><td>Amy Bush Stevens (HPIO) reviewed the timeline of drafts and work completed by the groups so far. She then reviewed the preliminary SHA/SHIP recommendations one-page overview.

Theresa Long (Columbus Public Health) noted that the one-page overview doesn't specifically mention backbone organizations and asked for thoughts on that. Stevens replied that backbone organizations are specifically mentioned in the full version of the recommendations document related to Recommendation #10 (see full document here).

Reem Aly (HPIO) shared trends in America's Health Rankings for Ohio and New York (see slides). Heidi Gartland (University Hospitals) asked how New York's investment in public health compares to Ohio's historically. Stevens provided information on per capita public health funding at the state and local levels which shows that for the most-recently-available data, New York spends considerably more on public health than Ohio. Aly noted that the proportion of public health spending as part of overall health/healthcare spending is small.

Key assumptions
Aly reviewed the updates made to the assumptions on the infrastructure framework (see "Preliminary recommendations for infrastructure framework document" here)

Moody noted that it's hard to make the case that people need to be connected to something (a high quality SHA/SHIP) that doesn't exist yet; therefore, in general, he said that the state is more comfortable with providing guidance on targets. In the future, they may look at whether requirements are necessary, including a couple of areas where we think we should require standardization.

State and local level assessment and plan alignment
Aly reviewed the updated vertical alignment items in the infrastructure framework document.

Moody noted that as we look at the SHIP, it's important that we take a life-course perspective so we get at different dimensions of health. The broader life-cycle view is important.</td></tr>
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	Long noted that the top 5 priorities of NY include two (infectious disease and environment) that didn't make it into the top 10 of local priorities identified by HPIO analysis, but otherwise they are the same. Tim Ingram (Hamilton County Public Health) asked about the "exchange of data and information," particularly between local health departments and hospitals. Stevens said there will need to be additional guidance about what that should look like. Ingram also asked who is going to hold the data, if that would be regional. Stevens said that we should use what we already have in terms of secondary data, but that there may be additional data needed for assessment and evaluation. Additional data needed is a topic of discussion for this group. The goal is to make sure that existing secondary data at least at the county level is widely available in a way that reduces burden at the local level. Moody noted he would like to hear that discussion now. He noted that right now there's a lot of confusion because there are too many assessments and plans and that the work is not focused. He asked what is not being shared that should be. Rohling McGee asked Ingram to share his perspective from the work being done in Hamilton County, noting that he is in a unique position of serving on the board of Mercy Health while also serving as health commissioner (Anne Goon also serves on hospital board in addition to serving as health commissioner). Ingram talked about Collective Impact for Health, trying to get to transparency, and the need for cost transparency. He asked if systems want to put quality data in a common database. He noted that population health gets the least attention. Dora Anim (Greater Cincinnati Health Council) said having guidance around transparency from a "higher authority" would be helpful. Moody said the reason that this work is urgent and that he wants to get to recommendations by the end of the year is that we want to make sure that we're paying for the triple aim in primary care. He noted that OHT and McKinsey are working on set of metrics (about 14) for the PCMH model. He noted that in past they would have just picked clinical measures, but because of this work they've selected metrics that are tied to public health/population health. They are creating sensitivity on the clinical side to population health outcomes. Gartland asked if the metrics are available. Moody said not currently, but noted that the University Hospital team has been involved, so they have a working list. The next HPIO Population Health Planning Advisory Group meeting will include a focus group on the metrics. He also noted that they need payer agreement (public/private) on the metrics. Ingram noted that health systems generally view population health as their patient population, but they have evolved through the Collective

	Impact on Health initiative in Cincinnati. He said that equity has become a key focus of the work. *Hospital and LHD alignment* Aly and Stevens discussed the horizontal alignment items in the preliminary framework. Moody noted that we're walking a fine line regarding requiring things and encouraging. He stated that the timeline requirement is important because alignment is more efficient. Gartland said that her hospital system is in 22 counties, and that their timeline for county collaboration may be different. She also noted that her board only meets four times a year and is required to approve the assessment and plan. She also noted nervousness on IRS concerns, and said it "makes our tax accountants nervous." Moody said he is open to ways to make it easier. The burden of a three year timeline really falls harder on public health, and is only meaningful if it brings collaborative hospitals to the table. He noted that this is NOT requiring LHDs to sign off on hospital plans. Krista Cranciun (The Center for Health Affairs) stated that she sees a need for hospitals to align with each other as well. Moody said the recommendation is that by 2020, everyone would be on the same timeline. Jan Ruma (Hospital Council of Northwest Ohio) said that the Hospital Council is doing 40 health assessments. She said that she would move the timeline recommendation back to "state issues guidance" and thinks that we can figure it out without a requirement. She noted a concern that if there's a health issue that changes from year to year, communities might miss it if everyone is on the same three-year timeline. She also noted that other partners, such as United Ways and mental health boards, are contributing financially to development of the assessments and plans. Britney Ward (Hospital Council of Northwest Ohio) added that they're afraid they would lose those payers and outside partners. Ward said that the IRS requirement is tied to when you post it, but that a hospital can do an assessment any time before that. Aly said that as far as collaboration is concerned, being on different timelines is not helpful. Gartland noted that she thinks we can get there (to aligned timelines), but thinks that before we can put a red box around it as a required item, we need a sub-conversation with people who do this work. Moody said he's hearing a defense of the way things are because doing things differently is hard. He acknowledged capacity issues and noted that some have figured out how to collaborate despite challenges, but many have not. Jason Orcena (Union County Health Departments) said it took about four years to get everyone on the same cycle, including outside partners like

	the mental health board and United Way. The 2020 deadline is about that far away-- it's difficult but possible. He said that his fear is that if there isn't a deadline, it wouldn't happen; "we'll finish the SIM grant and everyone will walk away." Ruma noted that there is a big difference between a three-year cycle and saying "do it in 2020." Jeff Klingler (Central Ohio Hospital Council) suggested that we don't need to be on the same timeline as the rest of state, just the same three-year timeline within the community (county-level time cycle alignment vs. statewide time cycle alignment). Moody asked the group that if the recommendation requires hospitals and LHDs to be on the same three-year schedule, rather than same date, does that create any new problems? Gartland said that it does for her system. She said that they go by the same three-year timeline for all of their 13 hospitals. They are in multiple counties, and if they were not all on the same timeline, "we'd be going to our board with a document every board meeting and it would be a nightmare for our staff." Moody noted that convenience for a health system's tax planning is not the objective; we want a rational approach to health planning. Gartland said that that University Hospital shares the same objective: to improve the health of the community. But they want a timeline that's operationally effective. Corey Hamilton (Zanesville-Muskingum County Health Department) said that she is happy with the three3-year timeline and they can shift to that over time. She noted that she is concerned about leaving enough collaboration time between the assessment and the plan. Ingram stated, "Let's not just check boxes; let's get some good standardization around what's authentic collaboration." He is concerned with quality, not just coordinated timeline. Stevens pointed the group to a list of tools and suggested technical assistance/guidance at the end of the framework document. She also discussed slides looking at the continuum of collaboration currently going on in the state and the collaboration continuum used by the Hospital Council of Northwest Ohio. Terry Allan (Cuyahoga County Board of Health) suggested some guidelines around what meaningful collaboration is and guidelines on quality data. Charlie Solley (Akron Children's Hospital) noted that he likes the idea of flexibility in the timeline. However, he noted that if pursuit of alignment is not successful, competing timelines for counties within a single health system may result in inefficiencies. He said further conversation could help. Ward gave a description of how Mercy and ProMedica work. Local hospitals have latitude as to what time they pick, and it all comes down to when they post their documents.

	McGee noted that those invited to participate as members of this subgroup are generally "ahead of the curve" in terms of collaboration. The degree of collaboration is currently shaped somewhat like a bell curve along the collaboration continuum, and the idea is to bring everyone further along through these recommendations. Moody said the collaboration going on shows how they have worked effectively to overcome barriers, for example with the template in Ward's Mercy/ProMedica example. He noted that in other places, though, they could be completely unrelated assessments, and that's the challenge we're getting at here. He thanked the group for the discussion and said he has learned a couple of things that change his perspective. Regardless of whether it is required and working through the legislature, or if it's guidance and working to get something the state can issue, he doesn't want the complexity to stop us from making decisions so that we can move on. *Funding; Transparency and accessibility* Moody noted that the framework includes some state funding to local health departments to help defray the cost of transitioning to a three-year cycle. He said the funding would not last forever, but would be provided for at least one or two rounds to help LHDs make the transition. Anne Goon (Henry County Health Department) asked if LHDs that are already conducting county-level assessments and plans on a three-year timeline would be eligible for this state funding. Moody said that they would be eligible for funding; communities that are already collaborating and aligning should not be disadvantaged. Aly walked the group through an overview of community benefit, community health improvement (CHI) and community building activities, and IRS reporting (see slides for more information). Klinger gave an example from his organization of spending on an infant mortality initiative. Because the money was given to an outside organization to facilitate the initiative, the money counts in the "Cash and In-Kind Donations" category rather than the CHI services category (although both fall under community benefit). Gartland said that their view is that CHI includes programs conducted by their own staff, such as health fairs, while they often give donations to other community partners, which counts in the Cash and In-Kind Donations category. She said that the *New England Journal of Medicine* pie chart being used for national comparison in the slides is too old (data are from 2009, prior to new federal regulations) and we should wait for a more updated pie chart before asking Ohio to meet national levels. Moody suggested reporting on several categories (research, education, CHI, cash). Gartland said form 990 specifies how CHI should be reported. Ingram suggested we need to standardize reporting at the state level, based on what we want to measure, rather than just looking at IRS reporting. Moody said that we want to stay in guidance territory, not

	specific on how much you should do, but we should require reporting of what was done. Ward pointed out that Schedule H isn't required for government hospitals, which make up about 10% of hospitals in Ohio. Moody said this is a gap where a state expectation is necessary for government hospitals as they are also tax exempt. Gartland noted that very little of community benefit will flow into row "e" on Schedule H (CHI). She thinks that we are underreporting on CHI. Rohling McGee said she agrees that there is likely underreporting. Moody noted that timeframe, reporting, and financial assistance to LHDs are the kinds of things that we're thinking about standardizing. Long noted that she appreciates the summary. She added that she would want flexibility in the assessment or plan that's being submitted, including the flexibility for every other assessment (alternating every three years) to be more of a refresher or update rather than a full blown assessment. Stevens noted that this would be possible, as long as the assessment/plan still met PHAB and IRS guidelines. Moody noted the need to come up with language that is PHAB and IRS friendly, but allows for flexibility. Anne Goon (Henry County Health Department) pointed out that many LHDs and hospitals use the MAPP process, which has four different assessments, and wants to be clear about which assessment has to be conducted every three years. She assumes we are talking about the Community Health Status Assessment, since that's the one that is most critical to do every three years. Stevens replied that MAPP components that don't directly align with PHAB requirements, such as the Forces of Change or Local Public Health System Assessment, would not need to be repeated every three years. Ingram said the focus should be on results, not just assessments, and asked about outcome reporting. Long noted that her health department issues a key community health indicator report every year, and suggested that that is something the state could do. Moody noted that there has not been as much agreement on standardization as he would like, but realizes that where we've agreed to standardization it's not easy.
Timeline and next steps Amy Rohling McGee Greg Moody	Moody and Rohling McGee thanked the group for its contributions today. Based on feedback from this meeting, HPIO will update the preliminary infrastructure framework and distribute to Infrastructure Subgroup members for comment in advance of the final Advisory Group meeting. This was the final meeting of the Infrastructure Subgroup. Members are welcome to attend the final meeting of the Population Health Planning Advisory Group as observers. The meeting will be held on **Tuesday, Nov. 17th from 1:00-3:30 pm** in the **third-floor conference room at One Columbus, 10 W. Broad St., Columbus, OH 43215.** Please contact Sarah Bollig Dorn at sdorn@hpio.net if you plan to attend.

INFRASTRUCTURE SUBGROUP MEMBERS			Subgroup Meeting #1	Subgroup Meeting #2
Adams	Jim	Canton City Health District	y	y
Allan	Terry	Cuyahoga County Board of Health	y, call-in	y, call-in
Aly	Reem	HPIO	y	y
Anim	Dora	Greater Cincinnati Health Council	y	y
Bickford	Beth	Association of Ohio Health Commissioners	y	n
Bollig Dorn	Sarah	HPIO	y	y
Branum	Melissa	Greene County Combined Health District	y	y, call-in
Burden	Wally	Pike County General Health District	y	n
Cranciun	Kirsten	The Center for Health Affairs	y	y
Deangelo	Aly	Ohio Hospital Association	y	y
Everett	Ryan	Ohio Hospital Association	y	y
Gartland	Heidi	University Hospitals	y	y
Goon	Anne	Henry County Health Department	y, call-in	y
Hamilton	Corey	Zanesville-Muskingum County Health Dept.	y	y
Himes	Lance	Ohio Department of Health	y	y
Ingram	Tim	Hamilton County Public Health	y	y
Juenger	Monica	Office of Health Transformation	n	y
Klingler	Jeff	Central Ohio Hospital Council	y	y
Long	Teresa	Columbus Public Health	y	y
Moody	Greg	Office of Health Transformation	n	y
Orcena	Jason	Union County Health Department	y	y
Rohling McGee	Amy	HPIO	n	y
Robinson	Brandi	Ohio Department of Health	y	y
Ruma	Jan	Hospital Council of Northwest Ohio	y	y
Schultz	Jessica	Mercy St. Vincent	y	y
Solley	Charlie	Akron Children's Hospital	y	y
Stevens	Amy	HPIO	y	y
Thompson	Terri	ProMedica Health Systems	y	y, call-in
Wapner	Andrew	Ohio Department of Health	n	y
Ward	Britney	Hospital Council of Northwest Ohio	y	y
Wasowski	Krista	Medina County Health Department	y, call-in	y
OTHER ATTENDEES				
Akah	Hailey	HPIO	y	-
Baker	Carrie	Ohio Children's Hospital Association	-	y
Borgemenke	Scott	Ohio Hospital Association	-	y
Bucci	Dan	University Hospitals	y	-
Gullett	Heidi	Health Improvement Partnership-Cuyahoga	y, call-in	-
Goldberg	Janet	HPIO	y	-
Hoyt	Karin	Ohio Department of Medicaid	-	y
Wiselogel	Nick	HPIO	-	y
Wright	Celia	HPIO	-	y