## HPIO Health Measurement Advisory Group

<table>
<thead>
<tr>
<th>Governor’s Office of Health Transformation</th>
<th>Ohio Department of Health</th>
<th>Ohio Department of Mental Health and Addiction Services</th>
<th>Philanthropy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local health commissioners</td>
<td>Regional health initiatives</td>
<td>Provider associations</td>
<td>Employer associations</td>
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<tr>
<td>Ohio Hospital Association</td>
<td>Consumer advocacy</td>
<td>Managed care plans</td>
<td>Ohio Department of Medicaid</td>
</tr>
<tr>
<td>Academia</td>
<td>Ohio Commission on Minority Health</td>
<td>Ohio Association of Health Plans</td>
<td>Education and early childhood</td>
</tr>
</tbody>
</table>
What is health value?

Population health outcomes  

Health value  

Health costs
Factors that influence health

- Physical environment: 10%
- Clinical care: 20%
- Social and economic environment: 40%
- Health behaviors: 30%

Source: County Health Rankings and Roadmaps

Health spending

- 95% Clinical care
- 5% Prevention and public health

Source: McGinley, 2002
Pathway to improved health value: A conceptual framework

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

Public health and prevention

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.
What makes this dashboard different?

<table>
<thead>
<tr>
<th>Primary format</th>
<th>America's Health Rankings</th>
<th>Commonwealth Scorecard</th>
<th>County Health Rankings</th>
<th>Kaiser State Health Facts</th>
<th>Gallup-Healthways Wellbeing Index</th>
<th>RWJF DataHUB</th>
<th>Network of Care</th>
<th>HPIO</th>
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<td>Interactive &amp; At-a-glance</td>
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<td>Healthcare costs</td>
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= adequately covered

= minimally covered

= not covered
What makes this dashboard different?

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Legend:
- = adequately covered
  - = minimally covered
  - = not covered
Dashboard

✓ Data in context to guide decision making
✓ Compares Ohio’s performance to other states
✓ Tracks change over time
✓ Information on disparities or “gaps” in performance
How does Ohio do?
Ohio ranks 47th on health value
HPIO Health Value Dashboard, Overview

Population health
Ohioans are less healthy than people in most other states.
Ohio ranks 40th on a composite measure of population health. Thirty-nine states are healthier.
This overall rank is based on Ohio’s rank in the following areas:

- **Overall health and wellbeing**
  - Length and quality of life
- **Health behaviors**
  - Tobacco, alcohol, physical activity
- **Conditions and diseases**
  - Physical, mental and oral health

Healthcare costs
Ohio spends more than most other states on health care.
Ohio ranks 40th on a composite measure of healthcare costs. Thirty-nine states spend less.
This overall rank is based on Ohio’s rank in the following areas:

- **Total spending**
  - Overall healthcare spending per capita and spending growth
- **Employer costs**
  - Average premiums for single adults and families
- **Consumer costs**
  - Commercial health spending per enrollee and out of pocket spending
- **Medicare spending**
  - Spending per enrollee and spending growth

Health value in Ohio
We are not getting good value for our healthcare dollar.
Ohio ranks 47th on a composite measure of health value—the combination of healthcare costs and population health, weighted equally.

Health + Cost = Value
Where states rank in health value...

Highest value states
States in the top quartile for both population health and healthcare costs

Lowest value states
States in the bottom quartile for both population health and healthcare costs

Note: Rankings for the above domains are based on most-recently available data from 2008 to 2013. A ranking of 1 is the best and 51 is the worst.

*The overall domain rank (e.g., healthcare costs) is the composite of the sub-domain ranks (e.g., total and employer). The subdomain ranks are the composite of the ranks for the individual metrics (e.g., healthcare spending per capita).
How do we compare to other states?
State comparison on health value

- **Top quartile** of the 50 states and the District of Columbia.
- **Second quartile** of the 50 states and the District of Columbia.
- **Third quartile** of the 50 states and the District of Columbia.
- **Bottom quartile** of the 50 states and the District of Columbia.
Why does Ohio rank so poorly?
Snapshot of health challenges and strengths
Snapshot of disparities

In order to improve health value for all Ohioans, it is important to identify and address disparities, or gaps, in outcomes between different groups. The following graphics display Ohio’s three lowest-ranked population health outcomes broken out by race/ethnicity, income level, and county.

**Adult Ohioans who are current smokers, by income level, 2013**

**Infant mortality in Ohio, by race/ethnicity, 2012**

- All: 7.57
- White: 6.37
- Black: 13.93

*Source: Ohio Department of Health*

**A closer look**

Additional data for many of the metrics included in this dashboard by race/ethnicity, income and education levels, age and local geography is available from the following websites: Commonwealth Scorecard on Health System Performance (state and local versions). Network of Care, RWJF DataHub and County Health Rankings and Roadmaps. Click here for a crosswalk that indicates which dashboard metrics are available from these sources.
Factors impacting health and costs

**Healthcare system**
- Preventive services: breastfeeding support, flu immunization, diabetes management
- Hospital utilization: heart failure readmissions, emergency department visits
- Timeliness, effectiveness and quality of care: healthcare-associated infections, stroke care, nursing home care, patient experience, mortality amenable to health care

**Public health and prevention**
- Workforce and accreditation: state and local public health workforce, accreditation of local health departments
- Communicable disease control: and environmental health, sexually transmitted infections, vector control
- Emergency preparedness: emergency preparedness funding
- Health promotion and prevention: prevention of chronic disease, infant mortality and injuries

**Health spending**
- 95% Clinical care
- 5% Prevention and public health

Source: McCullough, 2002
Factors that influence health

- Physical environment: 40%
- Social and economic environment: 30%
- Health behaviors: 20%
- Clinical care: 10%

Source: County Health Rankings and Roadmaps

Health spending

- 95% Clinical care
- 5% Prevention and public health

Source: McGinnis, 2002
Online Dashboard tools

Downloads

- Complete 2014 Health Value Dashboard (including methodology and sources)
- Two-page overview
- Four-page overview (includes a snapshot of Ohio’s greatest health challenges and strengths and a snapshot of disparities)
- State ranking maps
- Frequently Asked Questions (FAQ) about the Dashboard
- Excel spreadsheet of Ohio data
- [NEW] A recorded HPIO webinar introducing the Dashboard (41 minutes)

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High priorities

✓ Tobacco use
✓ Behavioral health access
✓ Food insecurity/ healthy food access
✓ Costs
Programs and policies

Public policy changes
- State level
- Local level

Regional initiatives
such as:
- Health Collaborative
- Healthcare Collaborative of Greater Columbus
- Better Health Greater Cleveland

Private sector changes and organizational policy
- Employers
- Philanthropy

Systems and environments that affect health

- Healthcare system
- Prevention and public health
- Access
- Social and economic environment
- Physical environment
Current cigarette smoking among Medicaid-enrolled adults (age 19-64) in Ohio, 2012

- Not Medicaid enrolled: 25.6% current smoker
- Medicaid enrolled: 48.6% current smoker
- Medicaid enrolled with mental-health related impairment (MHI): 58.5% current smoker

Source: 2012 Ohio Medicaid Assessment Survey (OMAS)
<table>
<thead>
<tr>
<th>Metric</th>
<th>Ohio’s rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult cigarette smoking</td>
<td>44</td>
</tr>
<tr>
<td>Secondhand smoke exposure for children</td>
<td>49</td>
</tr>
<tr>
<td>Tobacco prevention and control spending</td>
<td>46</td>
</tr>
</tbody>
</table>

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### Ohio’s greatest health challenges

Ohio ranks in the **bottom quartile** for the following metrics...

<table>
<thead>
<tr>
<th>Domain</th>
<th>Indicator</th>
<th>Ohio’s rank</th>
<th>Most recent date</th>
<th>Best state</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population health</td>
<td>Adult smoking Percent of adults who are current smokers</td>
<td>44</td>
<td>23.4%</td>
<td>10.3%</td>
</tr>
<tr>
<td></td>
<td>Adult diabetes Percent of adults diagnosed with diabetes</td>
<td>46</td>
<td>11.7%</td>
<td>7%</td>
</tr>
<tr>
<td></td>
<td>Infant mortality Infant deaths per 100,000 population</td>
<td>47</td>
<td>7.69</td>
<td>3.8%</td>
</tr>
<tr>
<td>Healthcare system</td>
<td>Available emergency department visits for Medicare beneficiaries</td>
<td>44</td>
<td>215</td>
<td>129 HI</td>
</tr>
<tr>
<td></td>
<td>State public health workforce Number of state public health agency staff FTEs per 100,000 population</td>
<td>44</td>
<td>9.9</td>
<td>250.7 WY</td>
</tr>
<tr>
<td>Public health and prevention</td>
<td>Emergency preparedness funding Median per capita funding for emergency preparedness</td>
<td>44</td>
<td>$1.50</td>
<td>$9.93 DC</td>
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<tr>
<td></td>
<td>Tobacco prevention spending Tobacco prevention and control spending, as percent of the CDC recommended level</td>
<td>46</td>
<td>4.4%</td>
<td>114.8% ND</td>
</tr>
<tr>
<td></td>
<td>Child immunization Percentage of children ages 19 to 35 months who have received vaccinations</td>
<td>48</td>
<td>61.7%</td>
<td>82.1% IA</td>
</tr>
<tr>
<td>Healthcare costs</td>
<td>Medicare spending growth per enrollee Average annual percent growth in Medicare spending per enrollee</td>
<td>45</td>
<td>5.2%</td>
<td>1.4% ND</td>
</tr>
<tr>
<td>Access</td>
<td>Unmet need for illicit drug use treatment Percent of individuals ages 12 and older needing but not receiving treatment for illicit drug use in the past year</td>
<td>43</td>
<td>2.6%</td>
<td>1.9% HI</td>
</tr>
<tr>
<td>Physical environment</td>
<td>Food insecurity Percent of households with uncertain access to adequate food</td>
<td>40</td>
<td>16.1%</td>
<td>8.7% ND</td>
</tr>
<tr>
<td></td>
<td>Outdoor air quality Average exposure of the general public to particulate matter of 2.5 microns or less in size</td>
<td>47</td>
<td>11.6</td>
<td>5.3 WY</td>
</tr>
<tr>
<td></td>
<td>Secondhand smoke Percent of children who live in homes where someone uses tobacco or smokes inside home</td>
<td>49</td>
<td>10.3%</td>
<td>0.4% CA</td>
</tr>
</tbody>
</table>
Percent of adults who are current smokers
In states with best health value and Ohio

Source: HPIO Health Value Dashboard, 2014 and BRFSS, 2013
Tobacco prevention and control funding in Ohio, 2003-2015

Source: American Lung Association
Policy options that send a strong message that tobacco use is harmful

- Increase the cigarette tax and taxes on other tobacco products.
- Increase scope and intensity of media campaigns.
- Raise the legal age to purchase tobacco to 21.
Policy options that scale up and enhance access to cessation services

- Increase funding for cessation strategies.
- Increase use of the Ohio Quit Line.
- Monitor compliance of private health insurance plans with cessation coverage requirements.
- Improve cessation benefits for state employees.
Policy options that strengthen Ohio’s tobacco prevention and control infrastructure

☐ Invest in staffing for the Tobacco Free Ohio Alliance.

☐ Release and promote a strategic plan.

☐ Fund research and evaluation.
Policy options that integrate tobacco cessation into healthcare system reform

- Incorporate tobacco cessation into Medicaid modernization.
- Behavioral health system redesign.
- Other payment and delivery design efforts, such as Patient Centered Medical Homes (PCMHs) and Accountable Care Organizations (ACOs).
OHIO TOBACCO QUITLINE
CALL IT QUITS.
1-800-QUI-NT-NOW
1-800-784-8669
Accountability map

Mapping accountability to improve Ohio’s performance on tobacco use

The majority of adult smokers (69%) report they want to stop smoking, yet tobacco use is the leading cause of preventable death and disease in the U.S. and is a significant contributor to high healthcare costs. Studies estimate that 8.7% of annual healthcare spending in the U.S. is associated with tobacco use — amounting to $136.3 billion. Across state Medicaid programs, the percent of spending associated with smoking is estimated to be even higher — accounting for 15% ($39.5 billion) of annual Medicaid expenditures.

Ranked 46th for adult cigarette smoking and 44th for secondhand smoke exposure for children, Ohio has higher tobacco use rates than most other states.

There are many public and private entities invested in reducing tobacco use for Ohioans and all share responsibility in improving Ohio’s performance. However, progress can be difficult to gauge if there is no measurement system in place to hold public health and healthcare organizations accountable for set objectives or targets to reduce tobacco use.

This publication builds on the Health Policy Institute of Ohio’s brief, The state of tobacco use prevention and cessation in Ohio: Environmental scan and policy implications by providing policymakers and other stakeholders with an understanding of how tobacco related measures are tracked and what, if any, mechanisms are in place to ensure accountability for improving Ohio’s performance. To do this, HPIO developed a tobacco measurement accountability map, constructed around three primary objectives:

1. Identify the types of tobacco-related measures that are tracked and reported in Ohio
2. Determine whether tracking and reporting on tobacco-related measures is voluntary or mandatory
3. Learn who is accountable for meeting set targets or benchmarks for tobacco-related measures

Tobacco use in Ohio at a glance

23.4% of Ohio adults smoked cigarettes in 2013 — well above the Healthy People 2020 goal of 12%.

There are large disparities in tobacco use across demographic groups in Ohio.

Tobacco use is particularly high among Medicaid enrollees and Ohioans with mental illness or other disabilities, as well as among non-white Ohioans and those living in rural central counties in Ohio.
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<td>Ohio Department of Education (regarding school district reporting)</td>
<td>Ohio Public Employees Retirement System</td>
<td>Ohio Department of Administrative Services</td>
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<tr>
<td>Local health departments</td>
<td>Health insurers (plans)</td>
<td>Healthcare providers (e.g. hospitals, group practices, healthcare professionals and federally qualified health centers)</td>
<td>State and regional health initiatives</td>
</tr>
</tbody>
</table>
Who is tracking and held accountable for tobacco-related measures in Ohio?

<table>
<thead>
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<th>Tracks</th>
<th>Required to track</th>
<th>Measurable objectives</th>
<th>Penalty or reward</th>
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<tr>
<td>one or more tobacco-related measures</td>
<td>one or more tobacco-related measure (external organization requiring reporting)</td>
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15 entities

9 entities

5 entities

3 entities
Types of tobacco measures

Patient level

- Cessation process
- Cessation outcome

Population level

- Prevention process
- Tobacco-use prevalence
Types of tobacco measures

Patient level
- Cessation process
  - 12 entities
- Cessation outcome
  - 1 entity

Population level
- Prevention process
  - 4 entities
- Tobacco-use prevalence
  - 4 entities
* Held accountable by penalty, incentive or accreditation requirements for meeting specific targets
Ohio ranks 47th on health value
CHANGE AHEAD
Community health planning is a collaborative process to assess and prioritize a communities’ most significant health needs and develop implementation plans and strategies to address those needs.
Hospital

**CHNA:** Community health needs assessment

**IS:** Implementation strategy

Local health department

**CHA:** Community health assessment

**CHIP:** Community Health Improvement Plan
Overview

- Hospital and local health department (LHD) community health planning requirements
- Quick Strike study findings
- Strategies to improve community health planning in Ohio
501(c)(3) hospital organizations are recognized by the Internal Revenue Service (IRS) as being federally tax-exempt, charitable organizations.
DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Parts 1, 53, and 802

TD 9708

RIN 1545-BK57; RIN 1545-BL36; RIN 1545-BL58

Additional Requirements for Charitable Hospitals; Community Health Needs Assessments for Charitable Hospitals; Requirements for a Section 4959 Excise Tax Return and Time for Filing the Return

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Final regulations and removal of temporary regulations.

SUMMARY: This document contains final regulations that provide guidance regarding the requirements for charitable hospital organizations added by the Patient Protection and Affordable Care Act of 2010. The regulations will affect charitable hospital organizations.

DATES: Effective Date: The final regulations are effective on December 30, 2014.

Applicability Date: For dates of applicability, see §§1.501(c)-7(a); 1.6033-20(k)(4); 53.4950-1(b); and 53.6071-11(c)(2).

FOR FURTHER INFORMATION CONTACT:
Amy F. Giuliani, Amber L. MacKenzie, or Stephanie N. Robbins at (202) 317-5506 (not a toll-free number).

SUPPLEMENTARY INFORMATION:

Paperwork Reduction Act:
The collection of information contained in these final regulations was approved by the Office of Management and Budget under control number 1545-0820 and applies only to organizations that are required to file a return under section 4959(f) of the Code.

New and Revised Form:
IRS Form 990-Z has been revised and is now titled "Charitable Organization Financial Information.

1. 2012 Proposed Regulations

On June 29, 2012, the Department of the Treasury (Treasury Department) and the IRS published a notice of proposed rulemaking (NPRM) (REG-139263-11; 77 FR 38148) that contained proposed regulations regarding the requirements of sections 501(c)(4) through 501(c)(6) relating to FAPs, limitations on charges, and billing and collections (the 2012 proposed regulations). The 2012 proposed regulations estimated that the collection of information in the proposed regulations relating to sections 501(c)(4) and 501(c)(6) would result in an average annual paperwork burden per recordkeeper of 21.5 hours. (The requirements of section 501(c)(3) were addressed in different proposed regulations, released in 2013, and the collection of information associated with those proposed regulations is addressed in section 2 of this portion of the preamble relating to the Paperwork Reduction Act.)

In response to this burden estimate, the Treasury Department received 15 comments. One commenter noted that the Treasury Department and the IRS have increased their estimate of the average amount of time a hospital organization will devote to amending policies and procedures and altering information systems in the first year to come into compliance with §§1.501(c)-4 and 1.501(d)-6(c) to 60 hours (with additional time needed each year to implement the requirements).

One commenter stated that hospitals' experience in administering charity care programs under existing state law required more than 100 annual staff hours per hospital, and that the proposed regulations would impose a burden. However, in light of the comments received, the Treasury Department and the IRS have increased their estimate of the average amount of time a hospital organization will devote to amending policies and procedures and altering information systems in the first year to come into compliance with §§1.501(c)-4 and 1.501(d)-6(c) to 60 hours (with additional time needed each year to implement the requirements).

The Treasury Department and the IRS also expected that hospitals would be building upon existing policies and processes rather than establishing entirely new policies. For example, §1.501(c)-6(c)(2) of the 2012 proposed regulations was intended to enable hospitals to notify patients about the FAP primarily by adding information to billing statements, necessitating some time to change the template of the billing statement but presumably relatively little time thereafter.

Information systems in the first year would be updated in subsequent years as necessary.

2. 2013 Proposed Regulations

On June 13, 2013, the Treasury Department and the IRS published another NPRM (REG-140480-13; 78 FR 34657) to address the requirements of sections 501(c)(4) through 501(c)(6) relating to FAPs, limitations on charges, and billing and collections (the 2013 proposed regulations).

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Information systems in the first year would be updated in subsequent years as necessary.

3. Final Regulations

On December 30, 2014, the Treasury Department published the final regulations (2014 final regulations) regarding the requirements of sections 501(c)(4) through 501(c)(6) relating to FAPs, limitations on charges, and billing and collections.

The 2014 final regulations estimated that the collection of information in the final regulations relating to sections 501(c)(4) and 501(c)(6) would result in an average annual paperwork burden per recordkeeper of 21.5 hours. (The requirements of section 501(c)(3) were addressed in different final regulations, released in 2014, and the collection of information associated with those final regulations is addressed in section 2 of this portion of the preamble relating to the Paperwork Reduction Act.)

In response to this burden estimate, the Treasury Department received 15 comments. One commenter noted that the Treasury Department and the IRS have increased their estimate of the average amount of time a hospital organization will devote to amending policies and procedures and altering information systems in the first year to come into compliance with §§1.501(c)-4 and 1.501(d)-6(c) to 60 hours (with additional time needed each year to implement the requirements).

One commenter stated that hospitals' experience in administering charity care programs under existing state law required more than 100 annual staff hours per hospital, and that the final regulations would impose a burden. However, in light of the comments received, the Treasury Department and the IRS have increased their estimate of the average amount of time a hospital organization will devote to amending policies and procedures and altering information systems in the first year to come into compliance with §§1.501(c)-4 and 1.501(d)-6(c) to 60 hours (with additional time needed each year to implement the requirements).

The Treasury Department and the IRS also expected that hospitals would be building upon existing policies and processes rather than establishing entirely new policies. For example, §1.501(c)-6(c)(2) of the 2012 proposed regulations was intended to enable hospitals to notify patients about the FAP primarily by adding information to billing statements, necessitating some time to change the template of the billing statement but presumably relatively little time thereafter.

Information systems in the first year would be updated in subsequent years as necessary.

The regulations applicable to sections 501(c)(4) through 501(c)(6) relating to FAPs, limitations on charges, and billing and collections are effective on December 30, 2014.

Applicability Date: For dates of applicability, see §§1.501(c)-7(a); 1.6033-20(k)(4); 53.4950-1(b); and 53.6071-11(c)(2).
## Facility Policies and Practices

**Section B. Facility Policies and Practices**

(Complete a separate Section B for each of the hospital facilities or facility reporting groups listed in Part V, Section A)

### Name of hospital facility or letter of facility reporting group

Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A):

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

### Community Health Needs Assessment

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<tr>
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<th>1</th>
<th></th>
<th>2</th>
<th></th>
<th>3</th>
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<tbody>
<tr>
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</tr>
</tbody>
</table>

- **Was the hospital 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?**
- **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 "Yes," provide details of the acquisition in Section C.
- **During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)?** If "No," skip to line 12.
- **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 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)

- **If the hospital facility last conducted a CHNA: 20**
- **In Section C, how did the hospital facility take into account input from persons who represent the community served by the hospital facility, including those with special knowledge of community health needs, and services to meet the community health needs?**
- **In Section C, how did the hospital facility consult persons the hospital facility believes have shared responsibility for the health of persons served by the hospital facility, or hospital facilities?**
Hospitals by ownership type

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

Ohio
- Non-profit: 75.4%
- For profit: 14.8%
- State/local government: 9.8%
3701.13 Department of health - powers.

The department of health shall have supervision of all matters relating to the preservation of the life and health of the people and have ultimate authority in matters of quarantine and isolation, which it may declare and enforce, when neither exists, and modify, relax, or abolish, when either has been established. The department may approve methods of immunization against the diseases specified in section 3313.671 of the Revised Code for the purpose of carrying out the provisions of that section and take such actions as are necessary to encourage vaccination against those diseases.

The department may make special or standing orders or rules for preventing the use of fluoroscopes for nonmedical purposes that emit doses of radiation likely to be harmful to any person, for preventing the spread of contagious or infectious diseases, for governing the receipt and conveyance of remains of deceased persons, and for such other sanitary matters as are best controlled by a general rule. Whenever possible, the department shall work in cooperation with the health commissioner of a general or city health district. The department may make and enforce orders in local matters or reassign substantive authority for mandatory programs from a general or city health district to another general or city health district when an emergency exists, or when the board of health of a general or city health district has neglected or refused to act with sufficient promptness or efficiency, or when such board has not been established as provided by sections 3709.02, 3709.03, 3709.05, 3709.06, 3709.11, 3709.12, and 3709.14 of the Revised Code. In such cases, the necessary expense incurred shall be paid by the general health district or city for which the services are rendered.

The department of health may require general or city health districts to enter into agreements for shared services under section 9.482 of the Revised Code. The department shall prepare and offer to boards of health a model contract and memorandum of understanding that are easily adaptable for use by boards of health when entering into shared services agreements. The department also may offer financial and other technical assistance to boards of health to encourage the sharing of services.

As a condition precedent to receiving funding from the department of health, the director of health may require general or city health districts to apply for accreditation by July 1, 2018, and be accredited by July 1, 2020, by an accreditation body approved by the director. The director of health, by July 1, 2016, shall conduct an evaluation of general and city health district preparation for accreditation, including an evaluation of each district’s reported public health quality indicators as provided for in section 3701.98 of the Revised Code.

The department may make evaluative studies of the nutritional status of Ohio residents, and of the food and nutrition-related programs operating within the state. Every agency of the state, at the request of the department, shall provide information and otherwise assist in the execution of such studies.

Amended by 130th General Assembly File No. 25, HB 59, §101.01, eff. 09/29/2013.

Effective Date: 02-12-2004; 05-06-2005
Hospitals

Local health departments
189 nonprofit/government hospitals (as of July, 2014)

170 CHNAs

80 ISs

124 local health departments (as of September, 2014)

110 CHAs

65 CHIPs
Cross-jurisdictional LHD CHA/CHIP (n=110)

- 64.5% 1 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 reporting LHD collaboration on CHNA (n=170)

<table>
<thead>
<tr>
<th>Role</th>
<th>Percentage</th>
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</thead>
<tbody>
<tr>
<td>No LHD involvement</td>
<td>10.6%</td>
</tr>
<tr>
<td>Provided secondary data</td>
<td>31.8%</td>
</tr>
<tr>
<td>Partner in data collection</td>
<td>38.2%</td>
</tr>
<tr>
<td>Involved in focus groups or key informant interviews</td>
<td>48.2%</td>
</tr>
<tr>
<td>Involved in prioritization</td>
<td>31.8%</td>
</tr>
<tr>
<td>CHNA partnership</td>
<td>45.9%</td>
</tr>
<tr>
<td>CHNA leadership role</td>
<td>35.9%</td>
</tr>
<tr>
<td>CHA CHNA joint document</td>
<td>18.8%</td>
</tr>
</tbody>
</table>
Percent of LHDs reporting hospital collaboration on CHA (n=110)

- No hospital involvement: 17.3%
- Provided secondary data: 38.2%
- Partner in data collection: 33.6%
- Involved in focus groups or key informant interviews: 18.2%
- Involved in prioritization: 14.5%
- CHA partnership: 30%
- CHA leadership role: 33.6%
- CHA CHNA joint document: 16.4%
Percent of hospitals reporting LHD collaboration on implementation plan or strategy  (among hospitals with an IS, n=80)

- LHD partner: 18.8%
- LHD leadership role: 13.8%
- CHP IS joint document: 10%
Other Quick Strike findings

• LHDs and hospitals bring different skills and perspectives to community health planning
• These differences appear to be complimentary
• Quality of community health planning documents improves with meaningful hospital – LHD collaboration
Making the most of community health planning in Ohio
The role of hospitals and local health departments

Introduction
Community health planning is a collaborative process that engages a variety of partners to identify and implement strategies that address a community’s most pressing health needs. The overarching aim of community health planning is to improve the health and wellbeing of community residents.

Recent federal and state policy changes require nonprofit hospitals and local health departments (LHDs) to engage in community health planning activities. Hospitals and LHDs are required to collaborate with organizations within their community to prioritize health needs and develop plans and implement strategies to address those needs. Under this new policy landscape, hospitals and LHDs can play a critical role in aligning and leveraging community health planning activities across the state to improve the overall health of Ohioans.

Key community health planning terms
Community health needs assessment (CHNA): an assessment conducted by a hospital every three years to identify and prioritize the community’s health needs and identify potential measures and resources available to address the community’s prioritized health needs.

Implementation strategy (IS): a plan identifying how a hospital will address the significant health needs identified in the CHNA.

Community health assessment (CHA): a collaborative assessment conducted at least every five years by a LHD to describe the health of the population, identify areas for health improvement, and develop and implement projects, programs, and policies to improve the health of the population in the jurisdiction that the LHD serves.

Community Health Improvement Plan (CHIP): a collaborative plan conducted by a LHD that builds upon the CHA to set priorities, direct the use of resources, and develop and implement projects, programs, and policies to improve the health of the population in the jurisdiction that the LHD serves.

Part 1: Community health planning requirements for hospitals, LHDs, and other entities
Part 2: Hospital community benefit: Promoting a population health approach to community health planning
Part 3: Selected findings from a study of hospital and LHD community health planning documents
Part 4: Opportunities for increasing the effectiveness of community health planning
Align state and local level health plans

- SIM Population Health Plan
- Hospital and local health department community health plans
- State Health Improvement Plan (SHIP)
Encourage collaboration, partnership and meaningful community engagement.
Increase transparency around hospital and LHD community health planning activities
Encourage investment in evidence-based population health strategies

**Patient care**

- Focus on:
  - Treatment of specific diseases and conditions
  - Downstream symptoms of health problems
  - Medical and biological determinants of sickness
  - Patients
  - Healthcare providers, purchasers and payers

**Population health**

- Focus on:
  - Wellness, prevention and health promotion
  - Upstream causes of health problems
  - Social determinants of health and community conditions
  - All people
  - Partnerships between health and sectors such as education, transportation and housing
Sources for evidence-based population health strategies

- **HPIO’s What is “Population Health”**
- **HPIO’s Guide to evidence-based prevention**
- **What Works for Health**
- **The Community Guide**
Encourage investment in evidence-based population health strategies through hospital community benefit.

National distribution of community benefit expenditures, 2009

- Charity care: 25.3%
- Unreimbursed costs for means-tested government programs: 45.3%
- Subsidized health services: 14.7%
- Community health improvement: 5.3%
- Cash or in-kind contributions to community groups: 2.7%
- Research: 1.3%
- Health professions education: 5.3%

Note: See Figure 14 for a description of these categories.
Source: County Health Rankings and Roadmaps population health model¹
SUCCESS
HPIO funders

Interact for Health
Mt. Sinai Health Care Foundation
The Cleveland Foundation
The George Gund Foundation
Saint Luke’s Foundation of Cleveland
HealthPath Foundation of Ohio
Sisters of Charity Foundation of Canton
Sisters of Charity Foundation of Cleveland
United Way of Greater Cincinnati
Mercy Health
CareSource Foundation
SC Ministry Foundation
United Way of Central Ohio
Cardinal Health Foundation
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