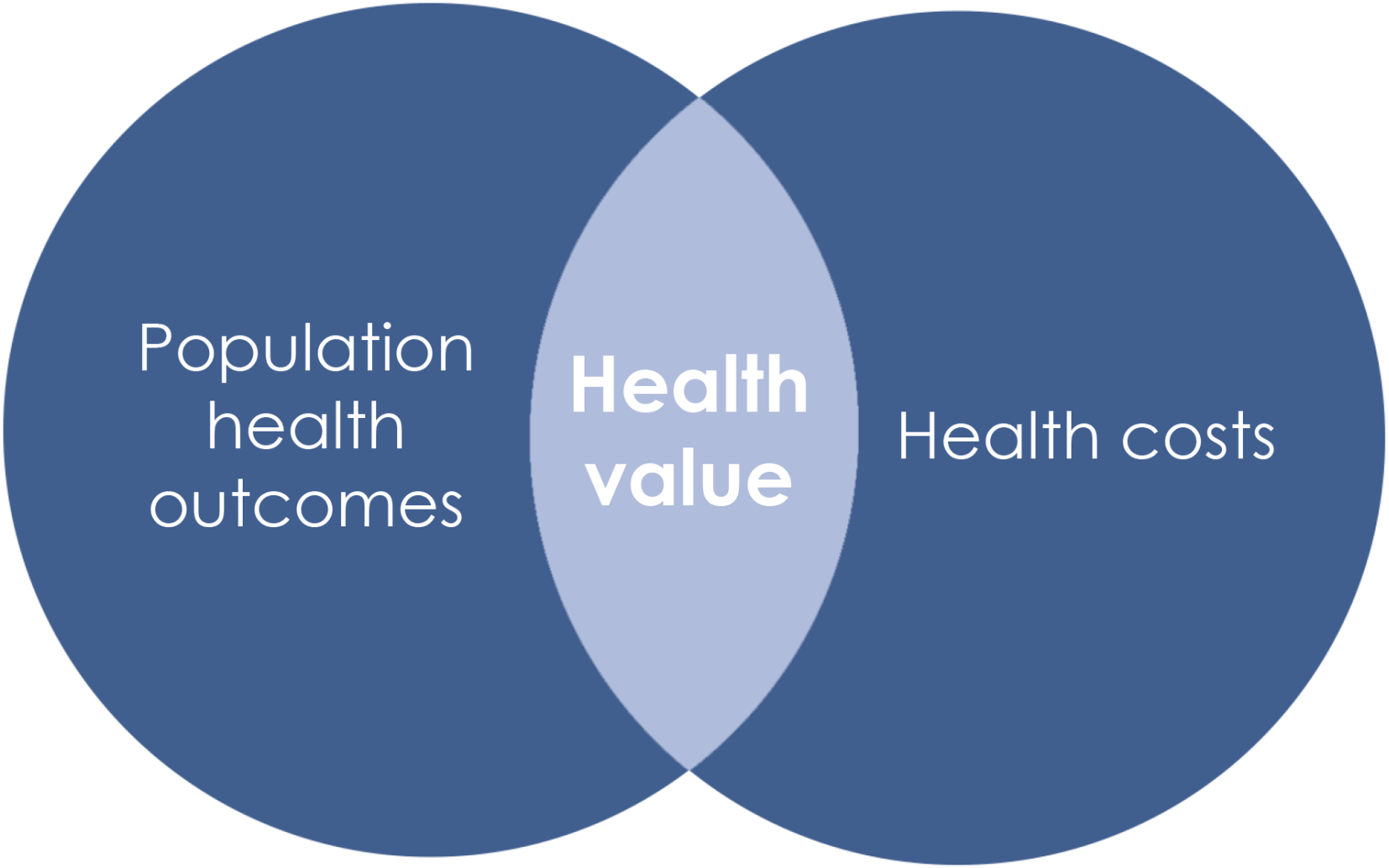

Value
Costs
hpio
health policy institute of ohio
2014
Health
Value
Dashboard

HPIO Health Measurement Advisory Group

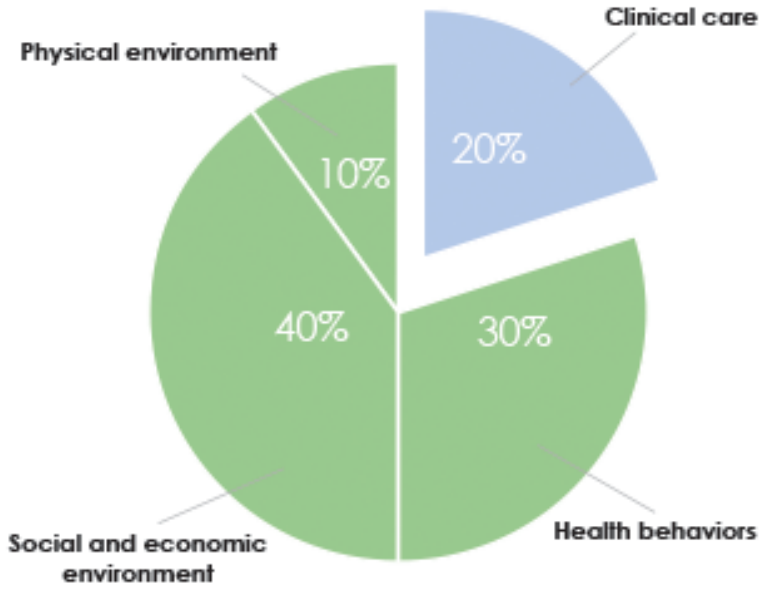
Governor's Office of Health Transformation	Ohio Department of Health	Ohio Department of Mental Health and Addiction Services	Philanthropy
Local health commissioners	Regional health initiatives	Provider associations	Employer associations
Ohio Hospital Association	Consumer advocacy	Managed care plans	Ohio Department of Medicaid
Academia	Ohio Commission on Minority Health	Ohio Association of Health Plans	Education and early childhood


Value
Costs
hpio
health policy institute of ohio
2014
Health
Value
Dashboard

What is health value?

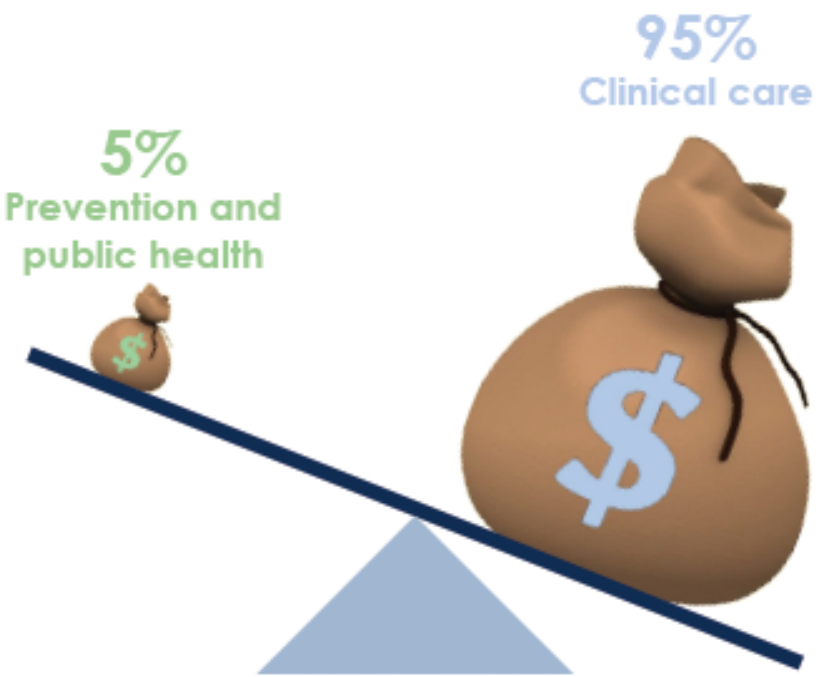


Factors that influence health



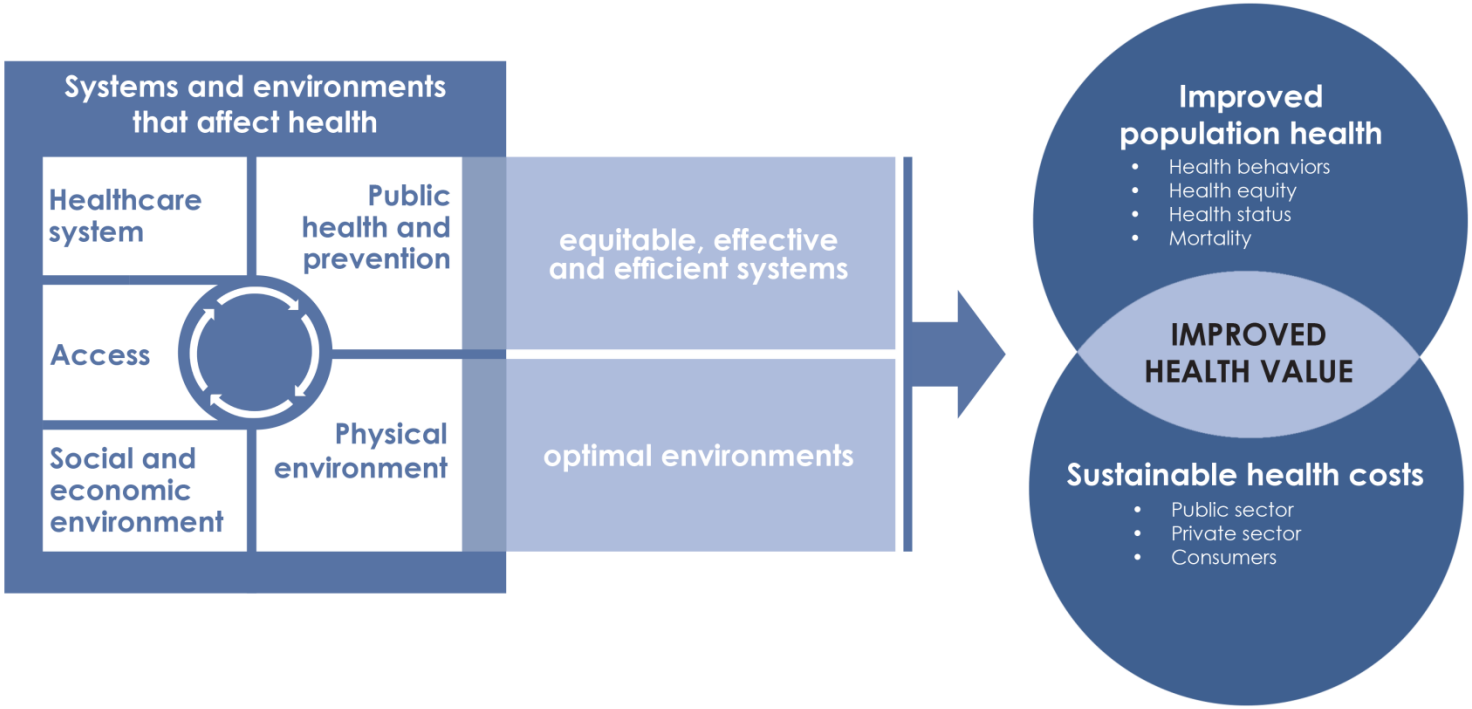
Source: County Health Rankings and Roadmaps

Health spending



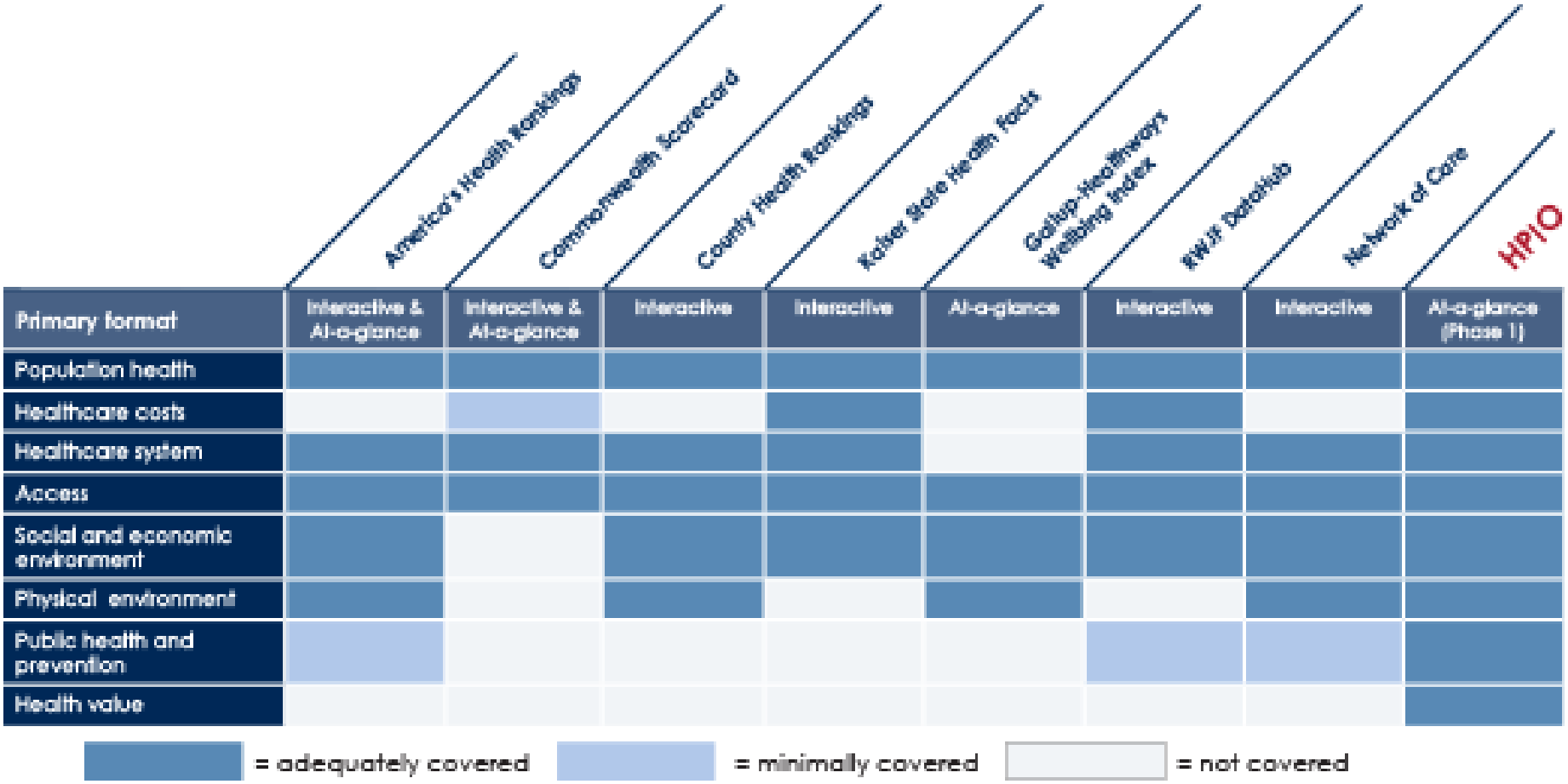
Source: McGinnis, 2002

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

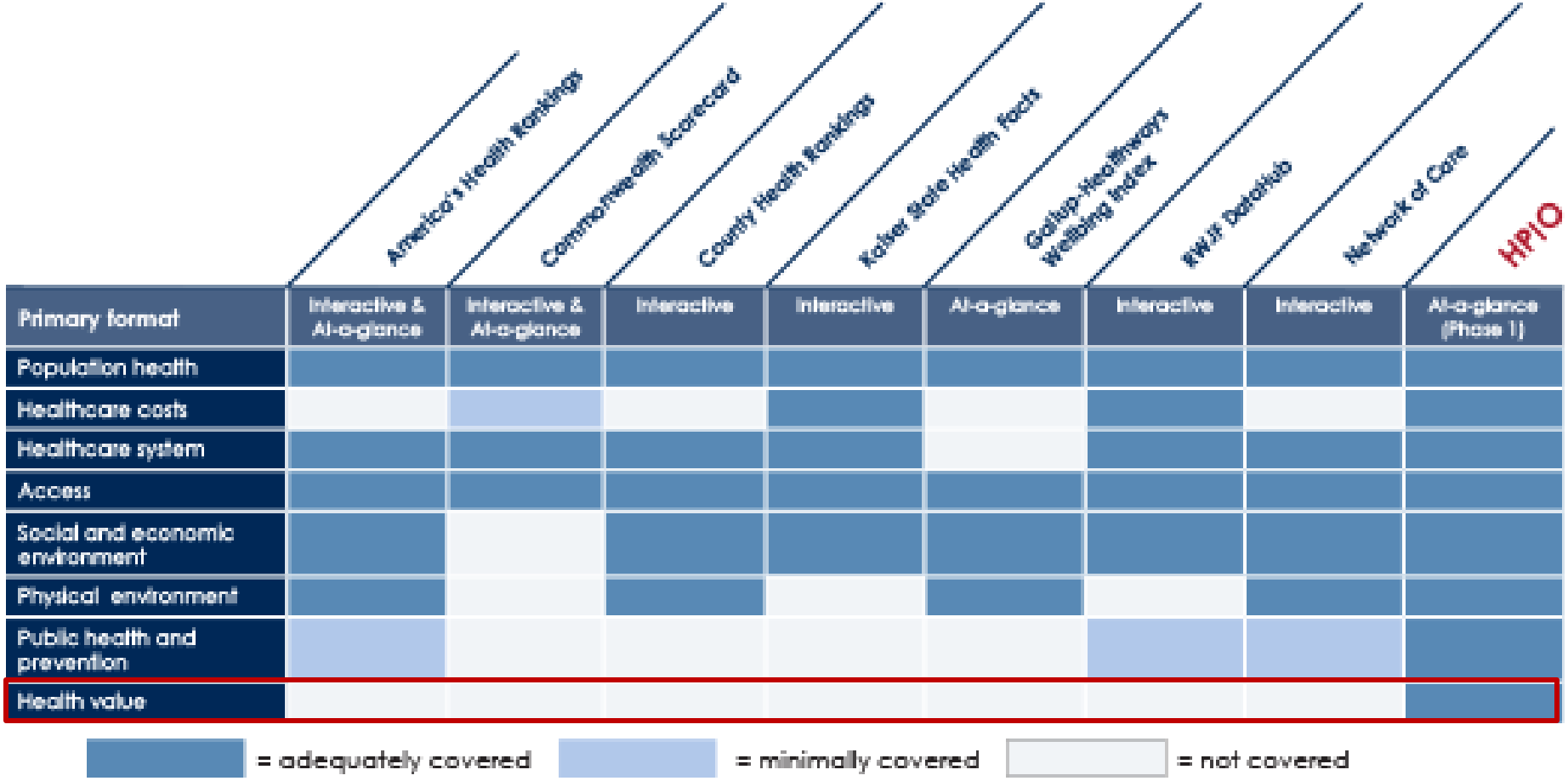


World Health Organization definition of health: Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.

What makes this dashboard different?



What makes this dashboard different?

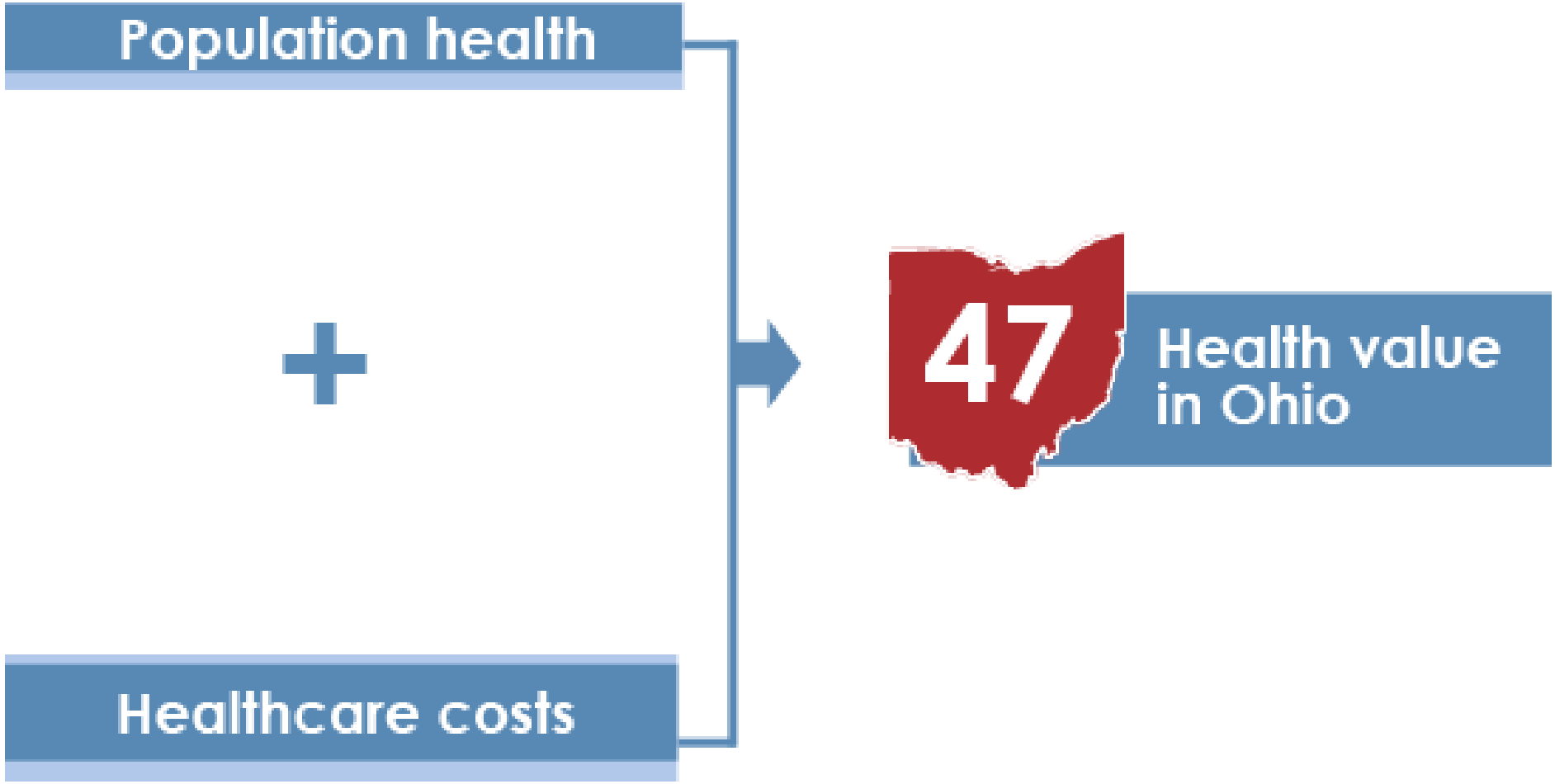


Dashboard

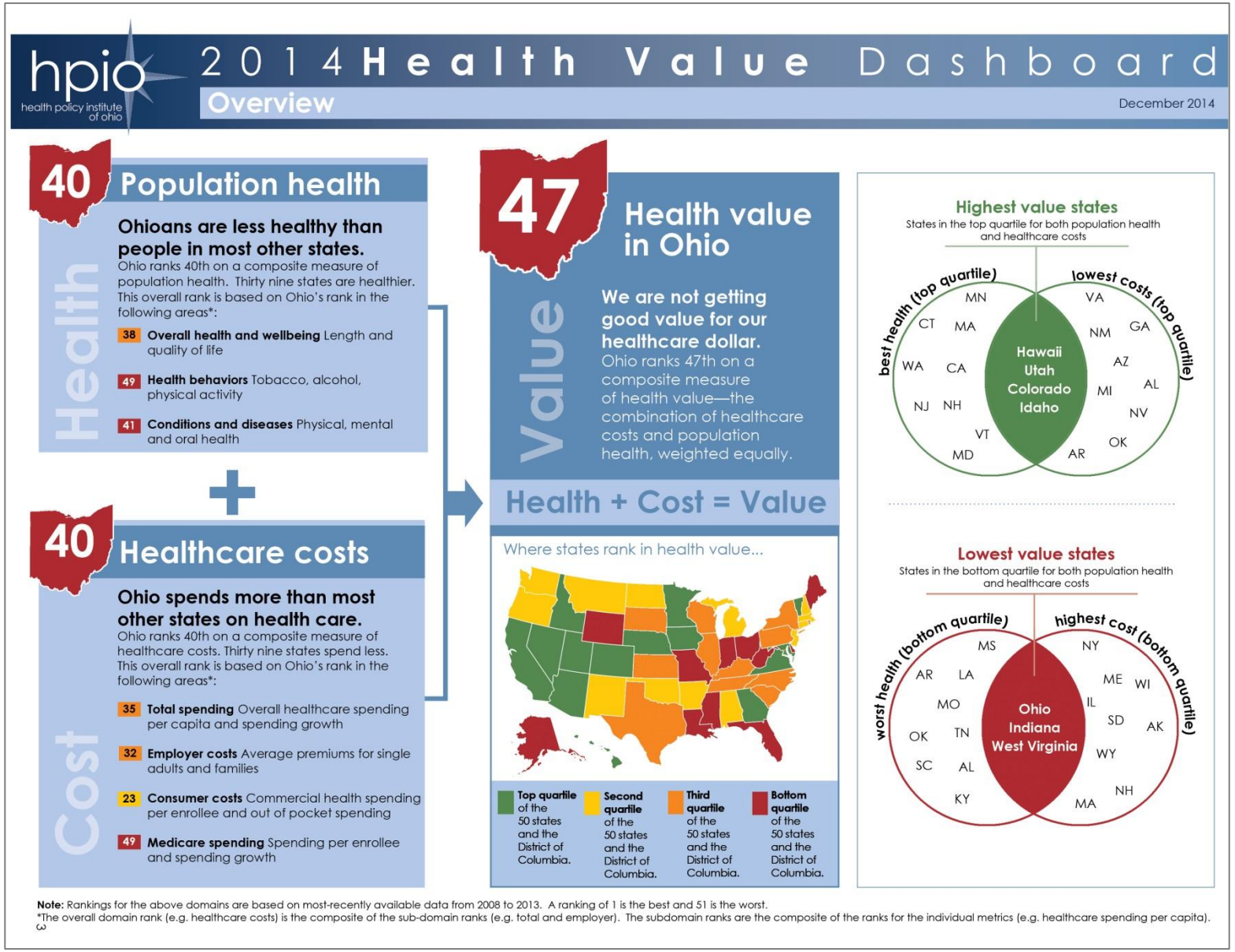
- ✓ Data in context to guide decision making
- ✓ Compares Ohio's performance to other states
- ✓ Tracks change over time
- ✓ Information on disparities or "gaps" in performance

How does Ohio do?

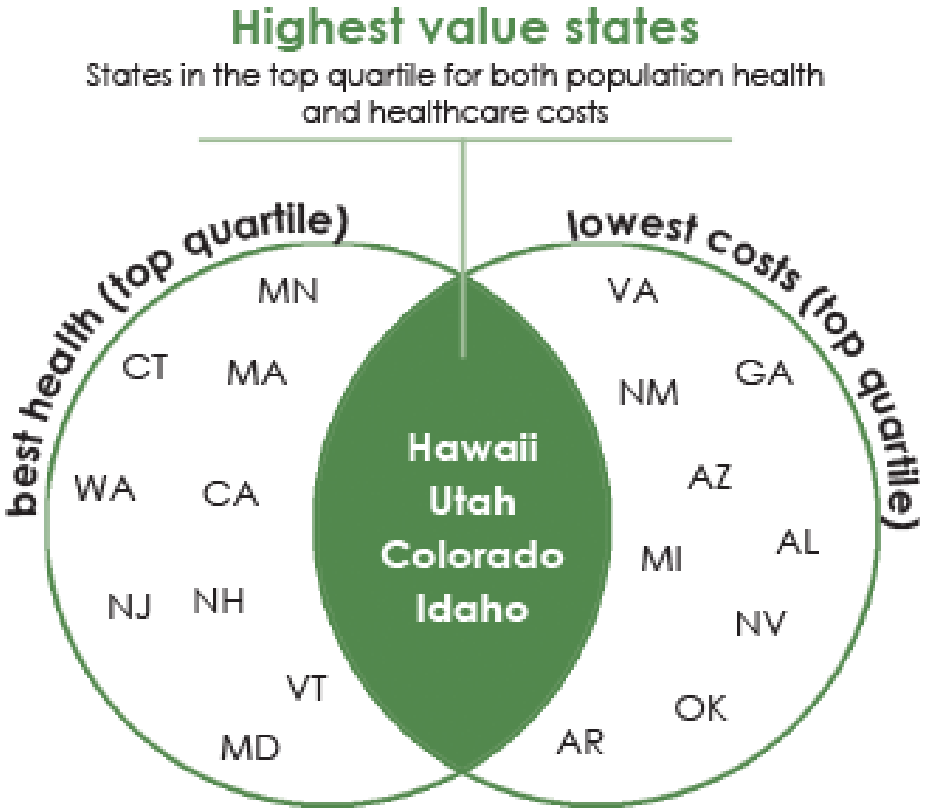
Ohio ranks 47th on health value

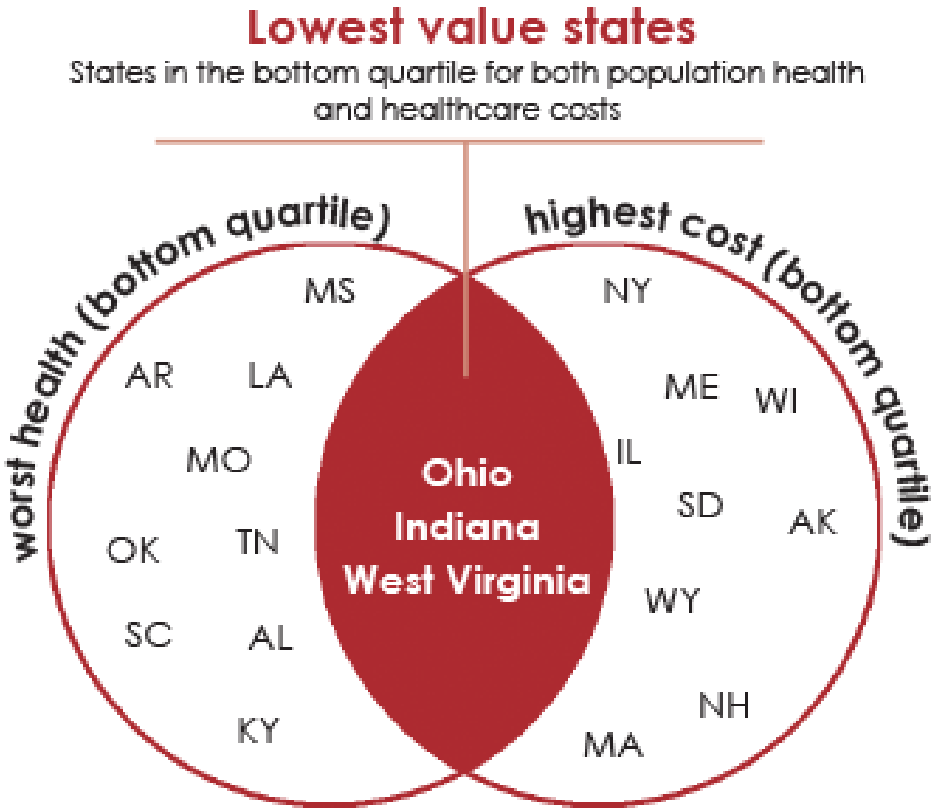


HPIO Health Value Dashboard, Overview

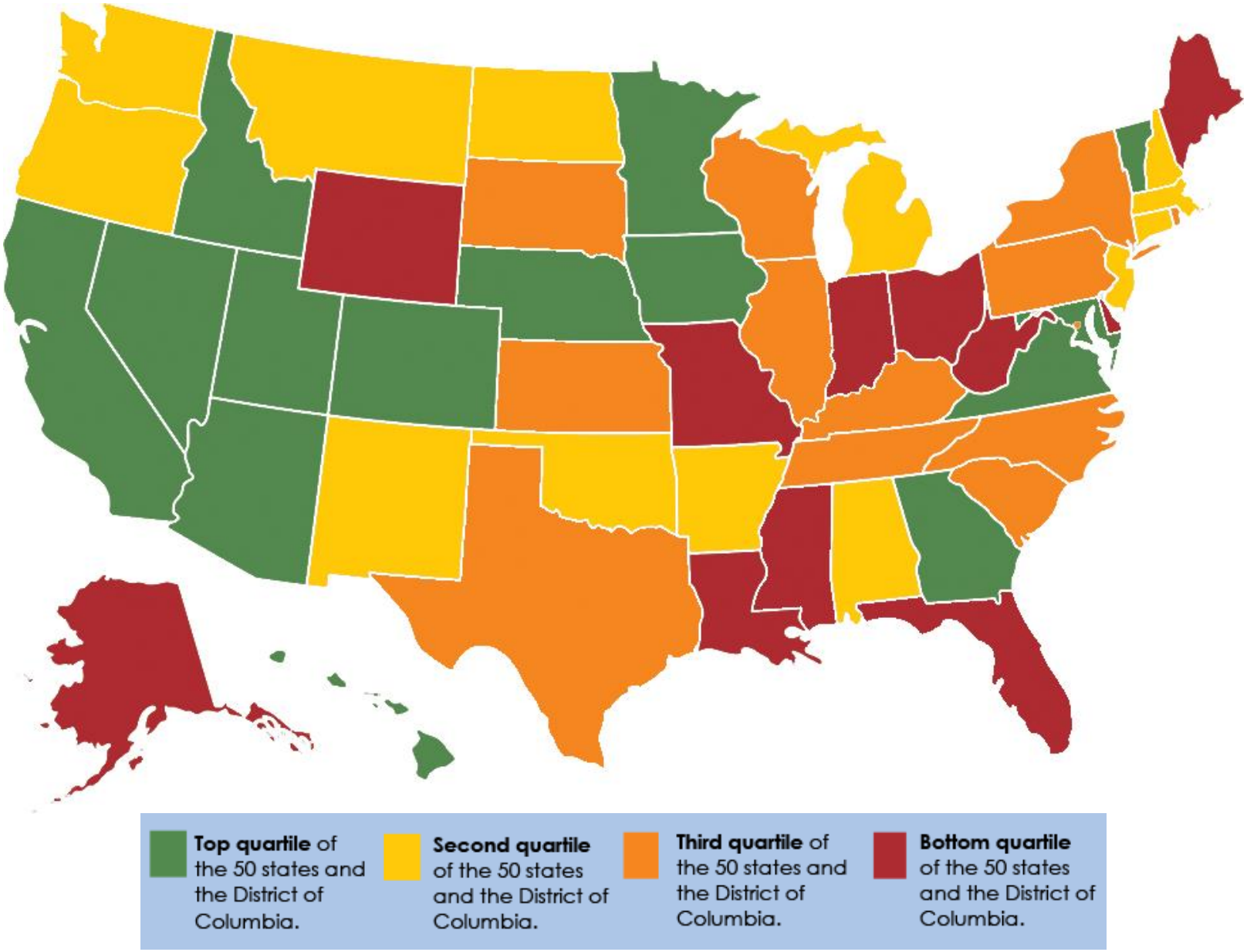


How do we compare to other states?

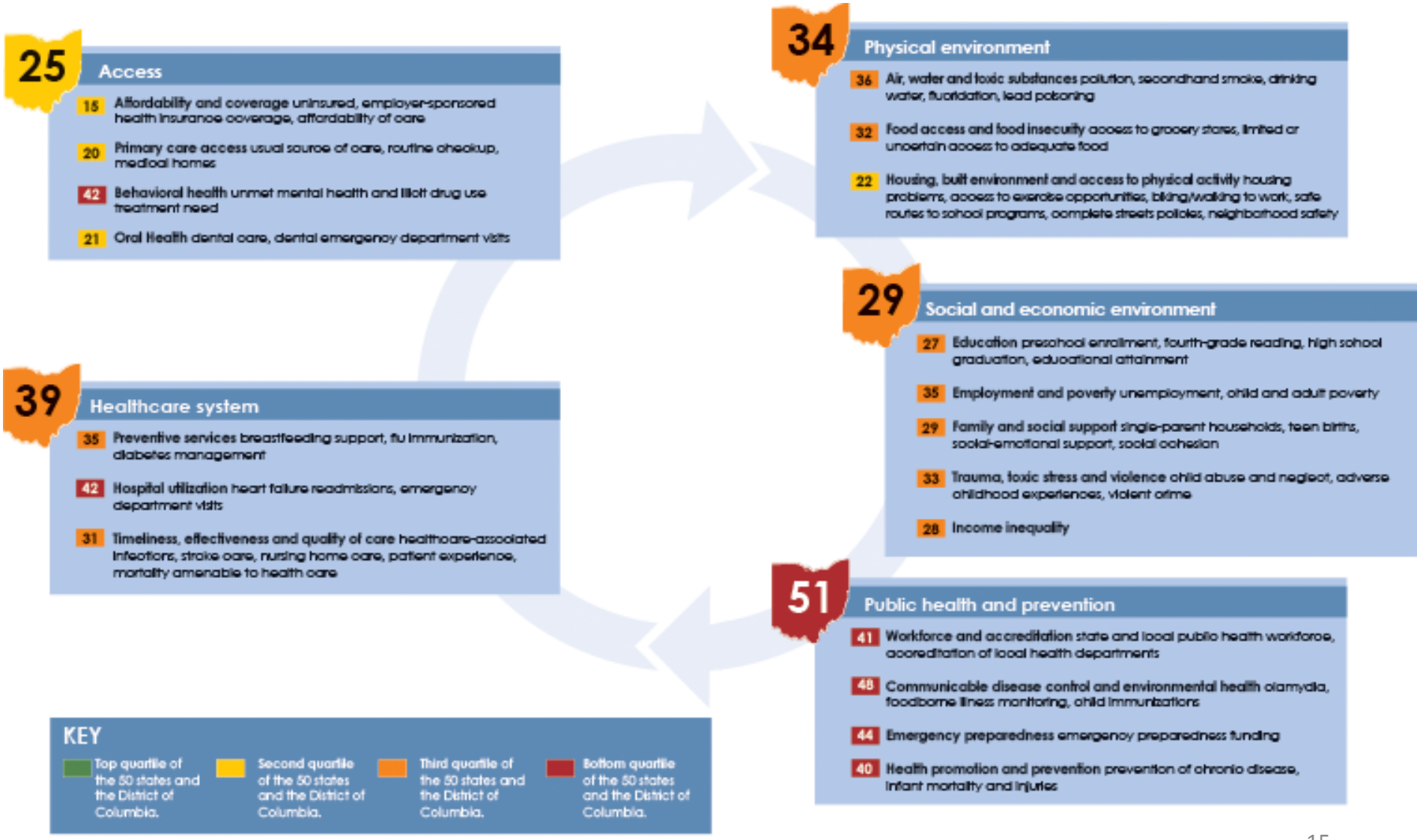




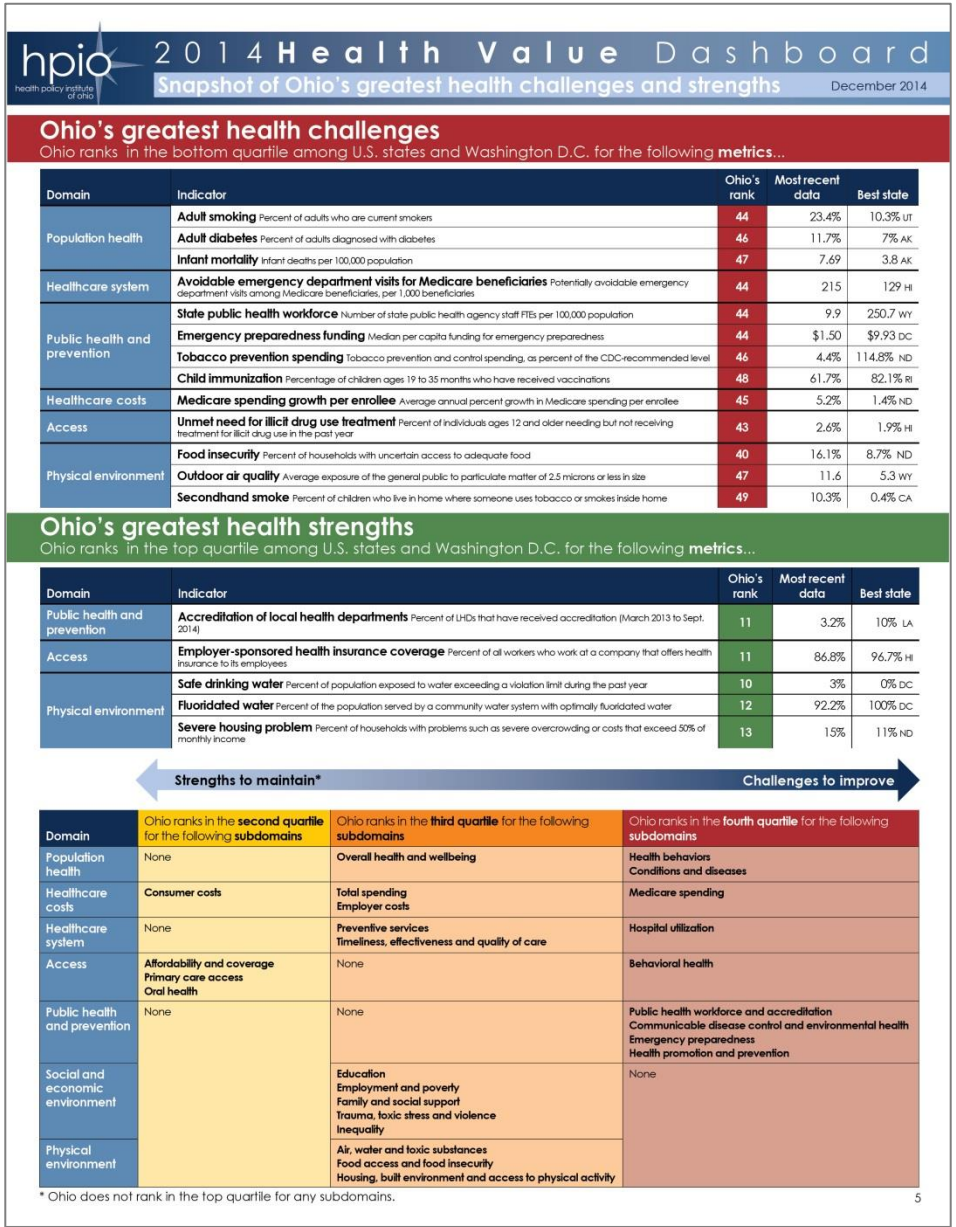
State comparison on health value



Why does Ohio rank so poorly?



Snapshot of health challenges and strengths



hpio health policy institute of ohio

2014 Health Value Dashboard

Snapshot of Ohio's greatest health challenges and strengths — December 2014

Ohio's greatest health challenges

Ohio ranks in the bottom quartile among U.S. states and Washington D.C. for the following **metrics**...

Domain	Indicator	Ohio's rank	Most recent data	Best state
Population health	**Adult smoking** Percent of adults who are current smokers	44	23.4%	10.3% UT
	Adult diabetes Percent of adults diagnosed with diabetes	46	11.7%	7% AK
	Infant mortality Infant deaths per 100,000 population	47	7.69	3.8 AK
Healthcare system	**Avoidable emergency department visits for Medicare beneficiaries** Potentially avoidable emergency department visits among Medicare beneficiaries, per 1,000 beneficiaries	44	215	129 HI
Public health and prevention	**State public health workforce** Number of state public health agency staff FTEs per 100,000 population	44	9.9	250.7 WY
	Emergency preparedness funding Median per capita funding for emergency preparedness	44	$1.50	$9.93 DC
	Tobacco prevention spending Tobacco prevention and control spending, as percent of the CDC-recommended level	46	4.4%	114.8% ND
	Child immunization Percentage of children ages 19 to 35 months who have received vaccinations	48	61.7%	82.1% RI
Healthcare costs	**Medicare spending growth per enrollee** Average annual percent growth in Medicare spending per enrollee	45	5.2%	1.4% ND
Access	**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	43	2.6%	1.9% HI
Physical environment	**Food insecurity** Percent of households with uncertain access to adequate food	40	16.1%	8.7% ND
	Outdoor air quality Average exposure of the general public to particulate matter of 2.5 microns or less in size	47	11.6	5.3 WY
	Secondhand smoke Percent of children who live in home where someone uses tobacco or smokes inside home	49	10.3%	0.4% CA

Ohio's greatest health strengths

Ohio ranks in the top quartile among U.S. states and Washington D.C. for the following **metrics**...

Domain	Indicator	Ohio's rank	Most recent data	Best state
Public health and prevention	**Accreditation of local health departments** Percent of LHDs that have received accreditation (March 2013 to Sept. 2014)	11	3.2%	10% LA
Access	**Employer-sponsored health insurance coverage** Percent of all workers who work at a company that offers health insurance to its employees	11	86.8%	96.7% HI
Physical environment	**Safe drinking water** Percent of population exposed to water exceeding a violation limit during the past year	10	3%	0% DC
	Fluoridated water Percent of the population served by a community water system with optimally fluoridated water	12	92.2%	100% DC
	Severe housing problem Percent of households with problems such as severe overcrowding or costs that exceed 50% of monthly income	13	15%	11% ND

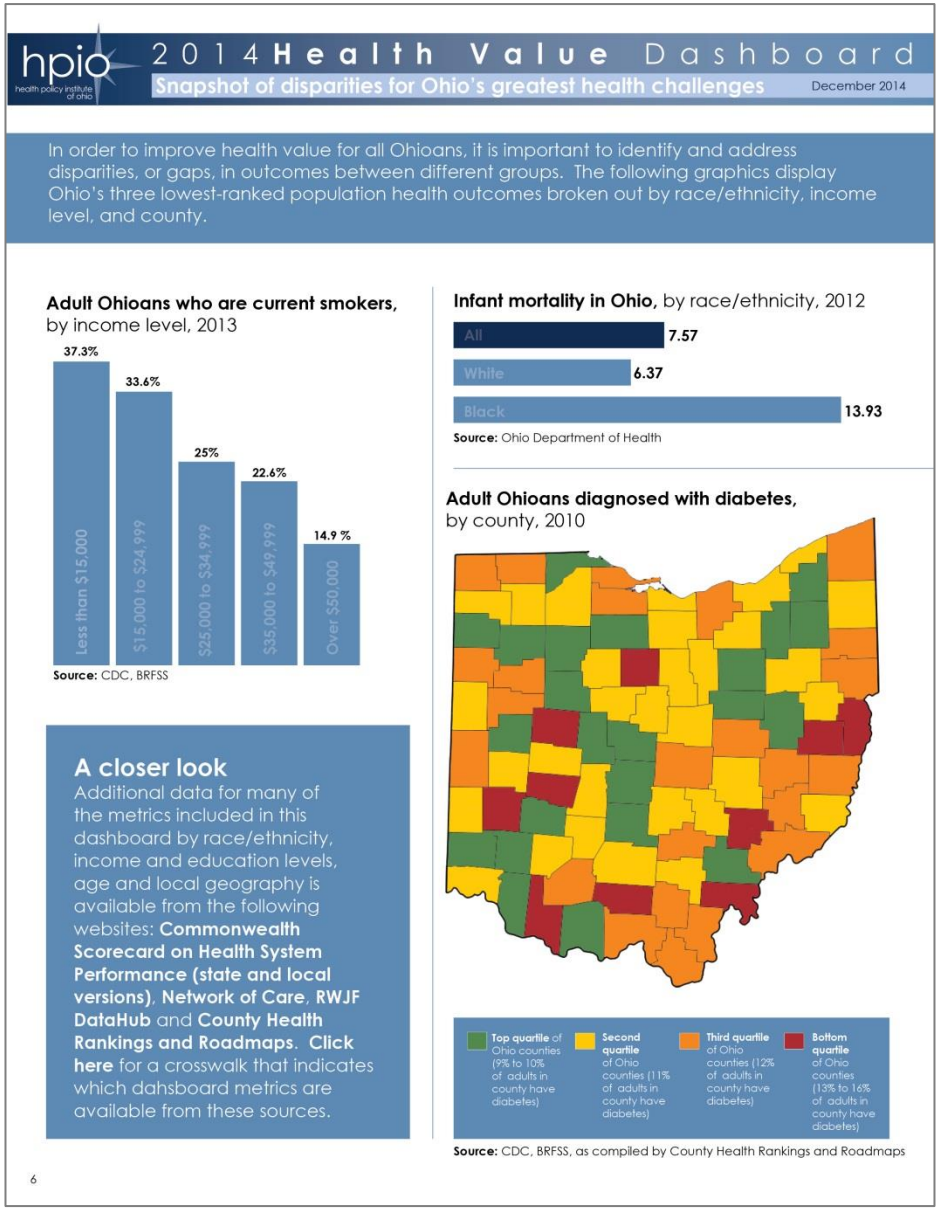
Strengths to maintain* ← → **Challenges to improve**

Domain	Ohio ranks in the **second quartile** for the following **subdomains**	Ohio ranks in the **third quartile** for the following **subdomains**	Ohio ranks in the **fourth quartile** for the following **subdomains**
Population health	None	**Overall health and wellbeing**	**Health behaviors** **Conditions and diseases**
Healthcare costs	**Consumer costs**	**Total spending** **Employer costs**	**Medicare spending**
Healthcare system	None	**Preventive services** **Timeliness, effectiveness and quality of care**	**Hospital utilization**
Access	**Affordability and coverage** **Primary care access** **Oral health**	None	**Behavioral health**
Public health and prevention	None	None	**Public health workforce and accreditation** **Communicable disease control and environmental health** **Emergency preparedness** **Health promotion and prevention**
Social and economic environment		**Education** **Employment and poverty** **Family and social support** **Trauma, toxic stress and violence** **Inequality**	None
Physical environment		**Air, water and toxic substances** **Food access and food insecurity** **Housing, built environment and access to physical activity**	

* Ohio does not rank in the top quartile for any subdomains.

5

Snapshot of disparities



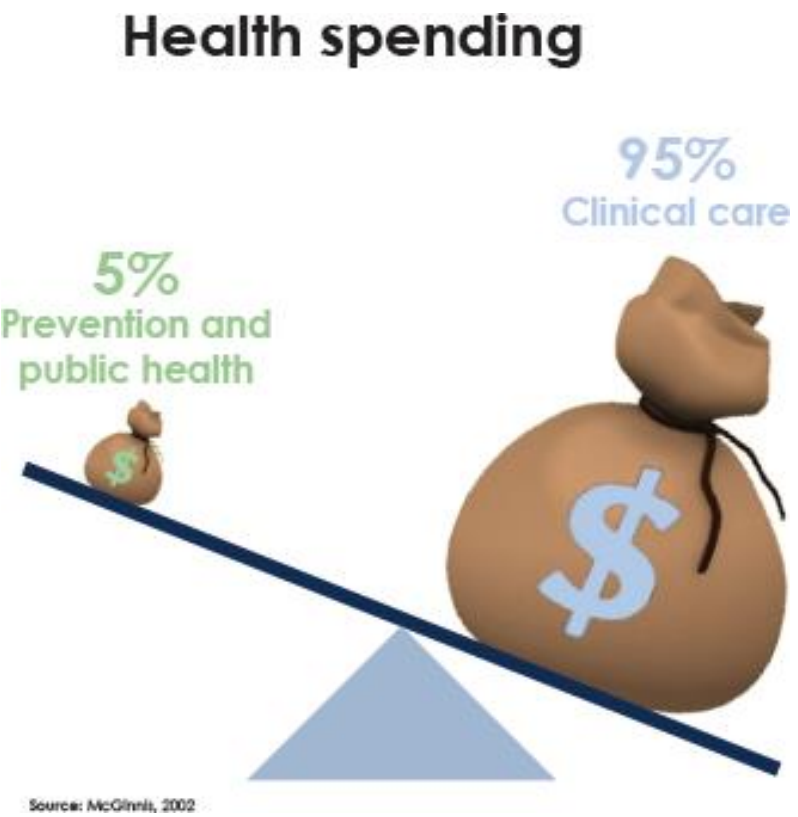
Factors impacting health and costs

39 Healthcare system

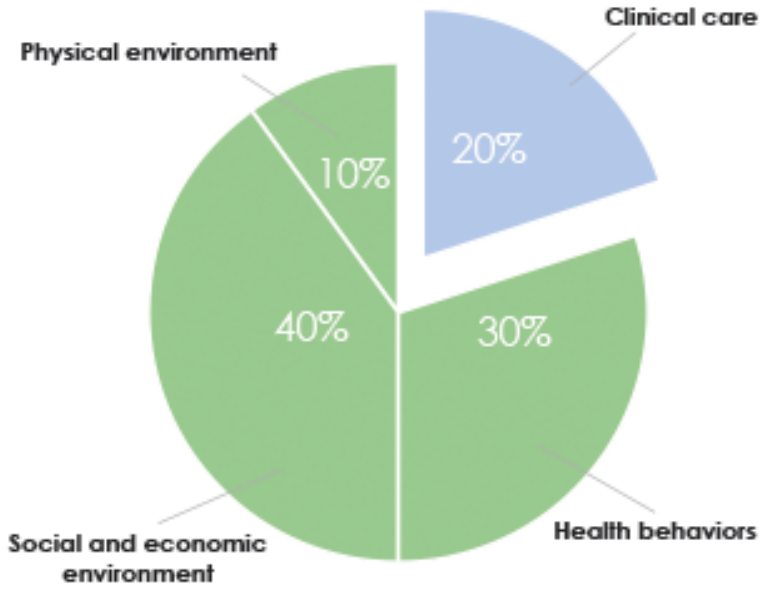
- 35 Preventive services breastfeeding support, flu immunization, diabetes management
- 42 Hospital utilization heart failure readmissions, emergency department visits
- 31 Timeliness, effectiveness and quality of care healthcare-associated infections, stroke care, nursing home care, patient experience,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

51 Public health and prevention

- 41 Workforce and accreditation state and local public health workforce, accreditation of local health departments
- 48 Communicable disease control and environmental health clamydia, foodborne illness monitoring, child immunizations
- 44 Emergency preparedness emergency preparedness funding
- 40 Health promotion and prevention prevention of chronic disease, infant mortality and injuries

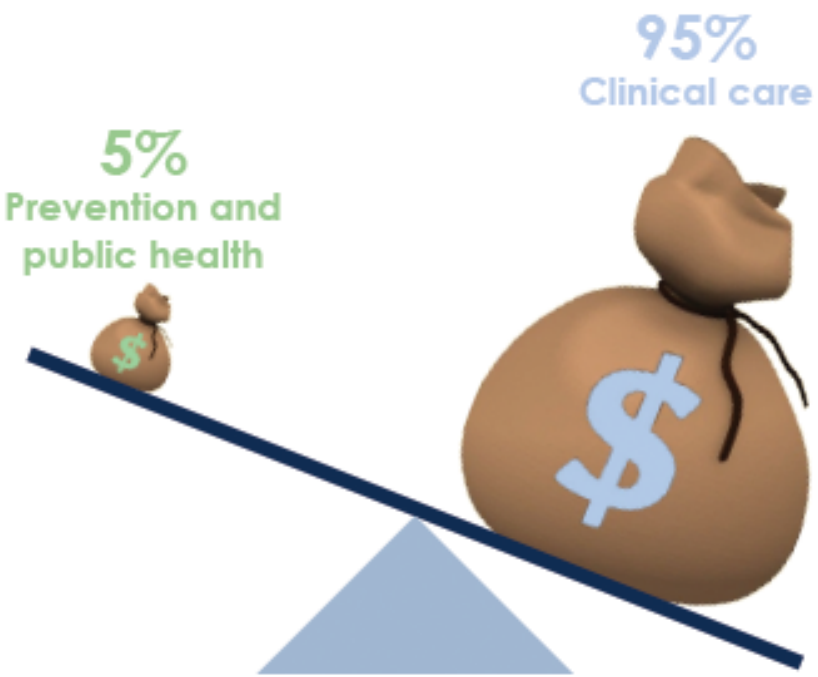


Factors that influence health



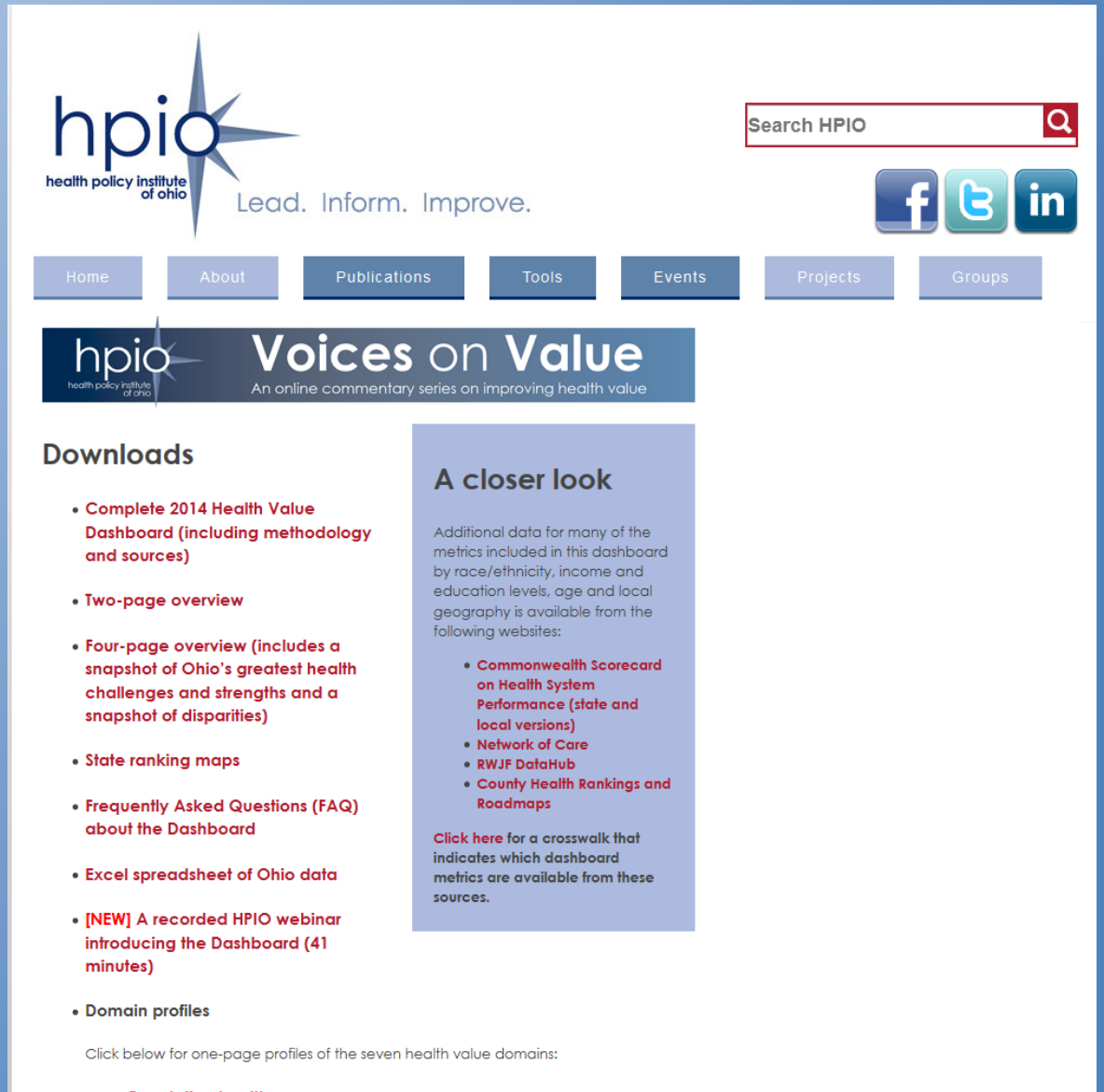
Source: County Health Rankings and Roadmaps

Health spending



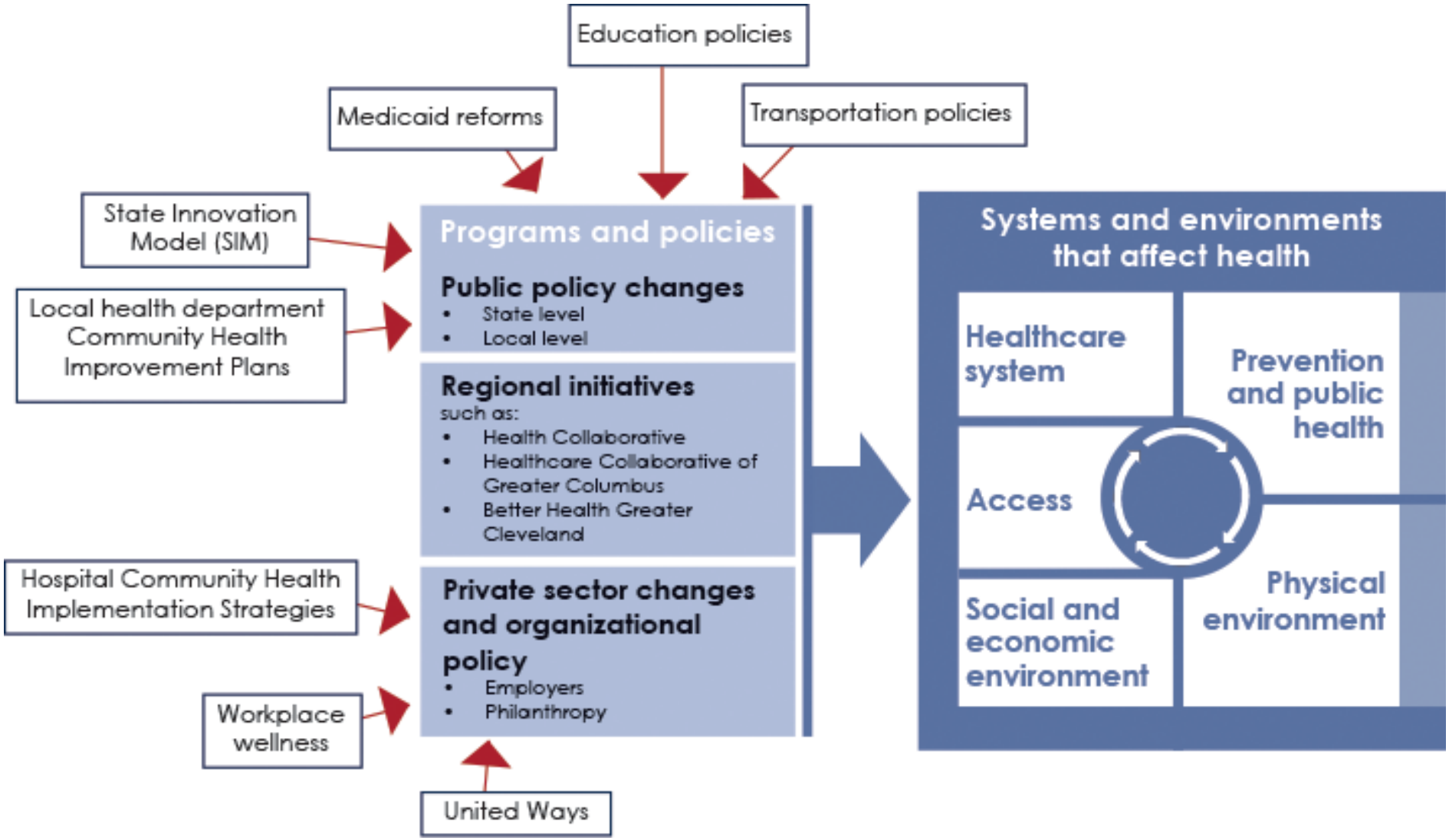
Source: McGinnis, 2002

Online *Dashboard* tools



High priorities

- ✓Tobacco use
- ✓Behavioral health access
- ✓Food insecurity/ healthy food access
- ✓Costs


Education policies
Medicaid reforms
Transportation policies
State Innovation Model (SIM)
Local health department Community Health Improvement Plans
Hospital Community Health Implementation Strategies
Workplace wellness
United Ways
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
Physical environment
Social and economic environment

hpio health policy institute of ohio

Health Policy Brief

June 2015

Executive summary

The state of tobacco use prevention and cessation in Ohio

Environmental scan and policy implications

Policy landscape and tobacco use prevalence

Smoking and secondhand smoke exposure are associated with many of Ohio's most pressing health policy challenges, including infant mortality, rising Medicaid costs and high rates of chronic diseases such as diabetes and cancer.

Ohio now lags behind most other states, ranking 44th for adult smoking.[1]

A decade ago Ohio was making significant progress in reducing smoking rates. Funded by the Master Settlement Agreement (MSA) with major tobacco companies, the Ohio Tobacco Use Prevention and Control Foundation helped 38,000 Ohioans quit smoking.[2] In 2006, Ohio passed the comprehensive Smoke-Free Workplace Act. From 2002 to 2008, Ohio's adult smoking rate declined 24.4%, placing Ohio in the top quartile of states with the steepest declines during that time period.[3]

When the MSA was securitized and the Foundation was abolished in 2008, Ohio's investment in tobacco prevention and control dropped from a high of $54.8 million in SFY 2005 to a low of $2.2 million in SFY 2011 (see trend graph on next page). As a result, the scope and intensity of prevention and cessation activities in Ohio was greatly diminished.

Ohio's implementation of evidence-based strategies

There is a strong body of evidence on what works to prevent tobacco use, help smokers quit, and reduce exposure to secondhand smoke (see box on next page). Ohio is currently employing many of these strategies, but the scope and intensity of these activities in recent years appears to be inadequate to produce the desired results. Ohio's Quit Line, for example, achieves excellent quit rates, although Quit Line utilization is much lower than in most other states and eligibility is limited. As a result, only a small number of Ohioans are able to take advantage of this effective service.

Ohio's strengths in implementing evidence-based strategies include:

- **Highly comprehensive Smoke-Free Workplace law** that includes restaurants, bars and casinos.
- **Medicaid cessation benefits** that align well with evidence-based recommendations for cessation counseling and medications.

Key facts

- Ohio ranks 44th for adult cigarette smoking and 49th for secondhand smoke exposure for children, indicating that Ohio has higher tobacco use rates than most other states.[4]
- Ohio's youth tobacco use rate (21.7%) is slightly below the national rate (22.4%).[5] Youth are much more likely than adults to use tobacco products other than cigarettes, such as smokeless tobacco, E-cigarette and hookah use among young people is quickly rising.[6]
- Tobacco use is particularly high among Medicaid enrollees and Ohioans with mental illness or other disabilities. Almost half of working-age Medicaid enrollees were current smokers in 2012.[7]
- Researchers estimate that 15% of Medicaid costs are attributable to cigarette smoking.[8]

hpio health policy institute of ohio

Health Policy Brief

June 2015

Mapping accountability to improve Ohio's performance on tobacco use

The majority of adult cigarette smokers (69%) report they want to stop smoking.[1] 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.[2] Researchers estimate that 8.7% of annual aggregated healthcare spending in the U.S. is associated with cigarette smoking – amounting to $169.3 billion.[3] Across state Medicaid programs, the percent of spending associated with cigarette smoking is estimated to be even higher – accounting for 15% ($39.6 billion) of annual Medicaid expenditures.[4]

ked 44th for adult cigarette smoking and secondhand smoke exposure for Ohio has higher tobacco use rates other states.[5]

y public and private entities ing tobacco use for Ohioans nsibility in improving Ohio's ever, progress can be e is no measurement public health and accountable for set uce tobacco use.

alth Policy of tobacco ohio:

ctions by keholders

Tobacco use in Ohio at a glance

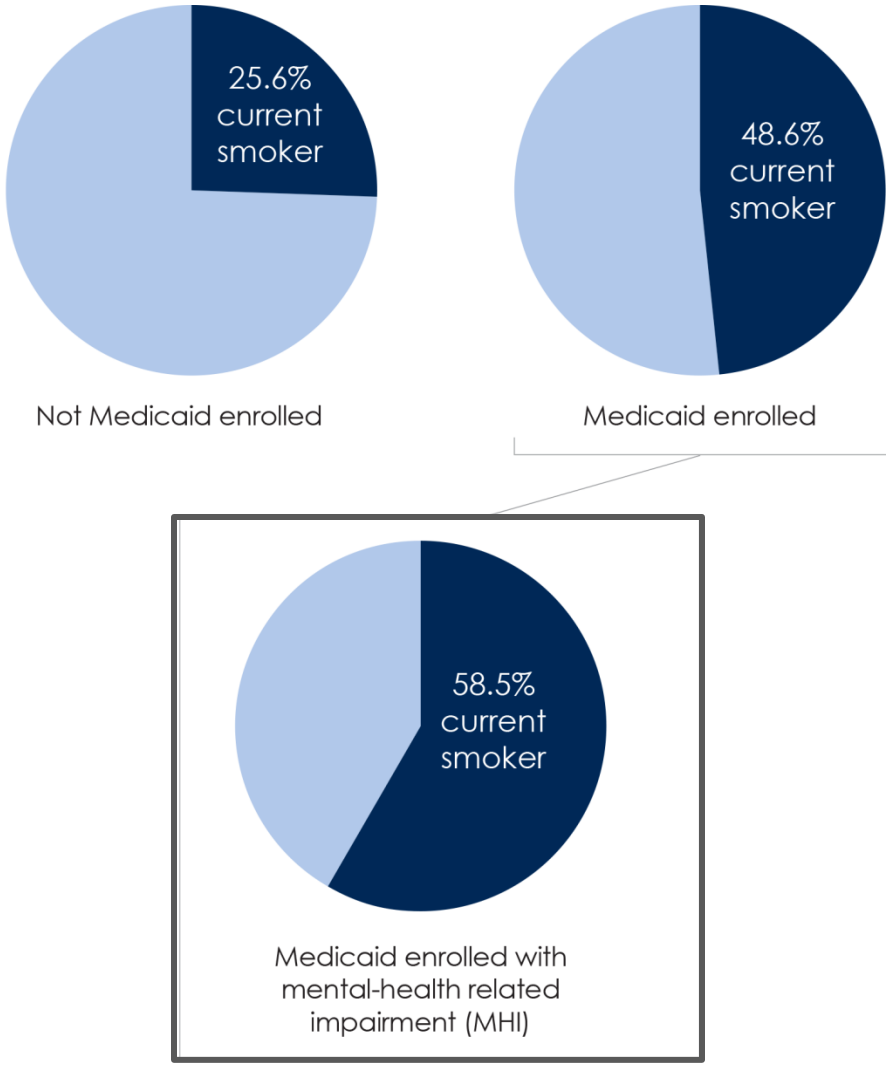
23.4% of Ohio adults smoked cigarettes in 2013 –

well above the Healthy People 2020 goal of 12%.[6]

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. Almost half of working-age Medicaid enrollees were current smokers in 2012.[10]

Current cigarette smoking among Medicaid-enrolled adults (age 19-64) in Ohio, 2012



Source: 2012 Ohio Medicaid Assessment Survey (OMAS)

Metric	Ohio's rank
Adult cigarette smoking	44
Secondhand smoke exposure for children	49
Tobacco prevention and control spending	46

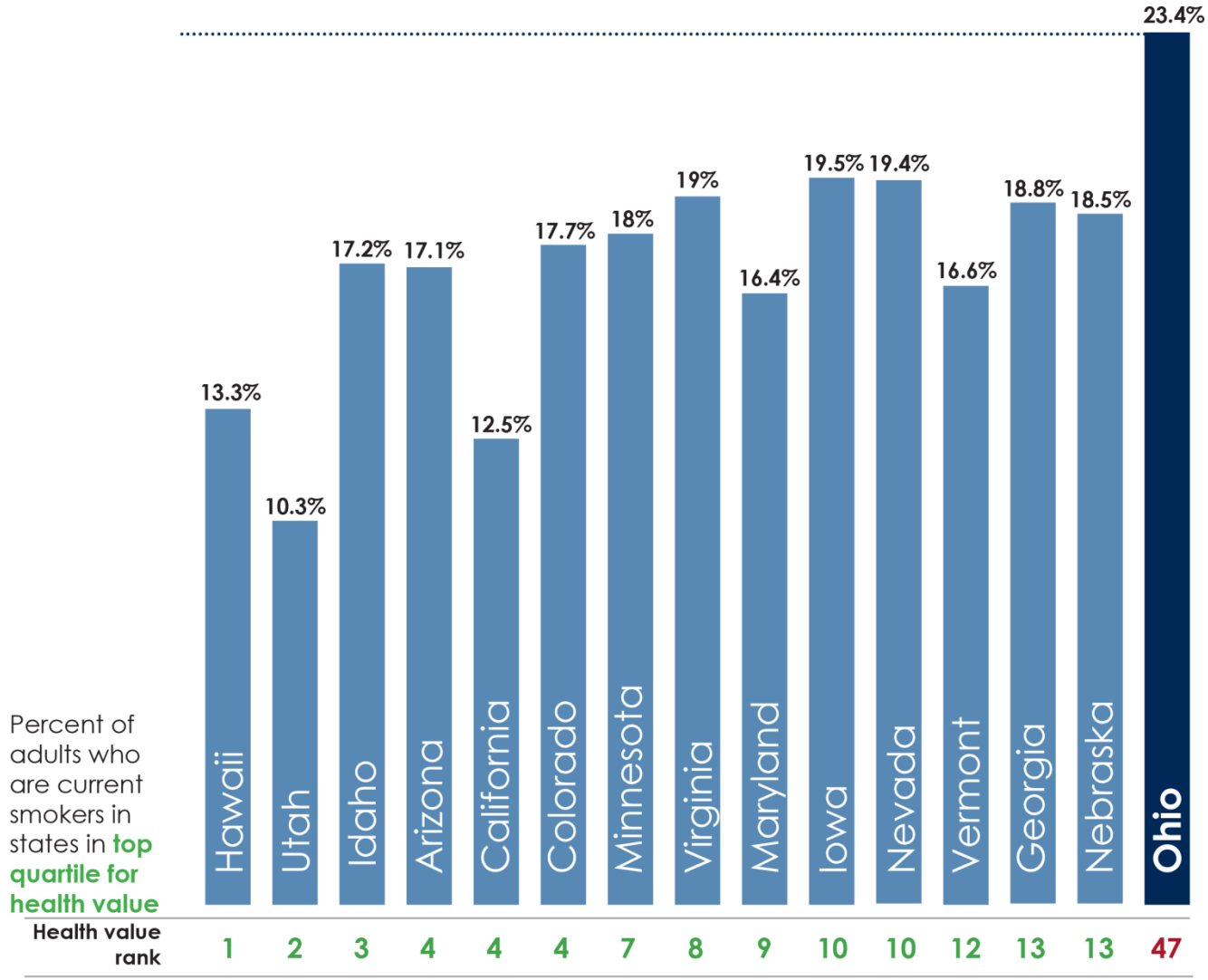
Ohio's greatest health challenges

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

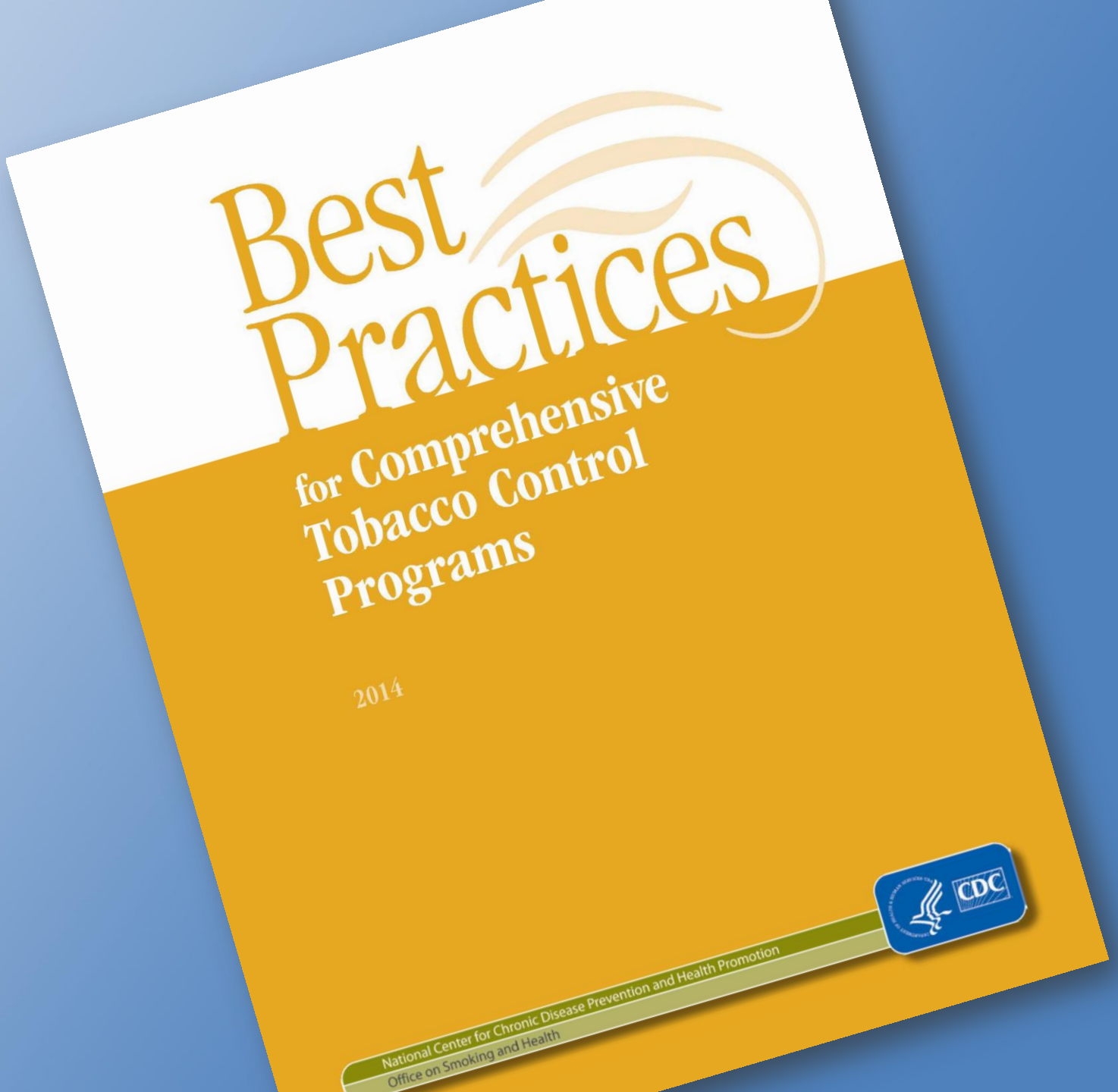
Domain	Indicator	Ohio's rank	Most recent data	Best state
Population health	**Adult smoking** Percent of adults who are current smokers	44	23.4%	10.3% UT
	Adult diabetes Percent of adults diagnosed with diabetes	46	11.7%	7% AK
	Infant mortality Infant deaths per 100,000 population	47	7.69	3.8 AK
Healthcare system	**Avoidable emergency department visits for Medicare beneficiaries** Potentially avoidable emergency department visits among Medicare beneficiaries, per 1,000 beneficiaries	44	215	129 HI
Public health and prevention	**State public health workforce** Number of state public health agency staff FTEs per 100,000 population	44	9.9	250.7 WY
	Emergency preparedness funding Median per capita funding for emergency preparedness	44	$1.50	$9.93 DC
	Tobacco prevention spending Tobacco prevention and control spending, as percent of the CDC-recommended level	46	4.4%	114.8% ND
	Child immunization Percentage of children ages 19 to 35 months who have received vaccinations	48	61.7%	82.1% RI
Healthcare costs	**Medicare spending growth per enrollee** Average annual percent growth in Medicare spending per enrollee	45	5.2%	1.4% ND
Access	**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	43	2.6%	1.9% HI
Physical environment	**Food insecurity** Percent of households with uncertain access to adequate food	40	16.1%	8.7% ND
	Outdoor air quality Average exposure of the general public to particulate matter of 2.5 microns or less in size	47	11.6	5.3 WY
	Secondhand smoke Percent of children who live in home where someone uses tobacco or smokes inside home	49	10.3%	0.4% CA

Percent of adults who are current smokers

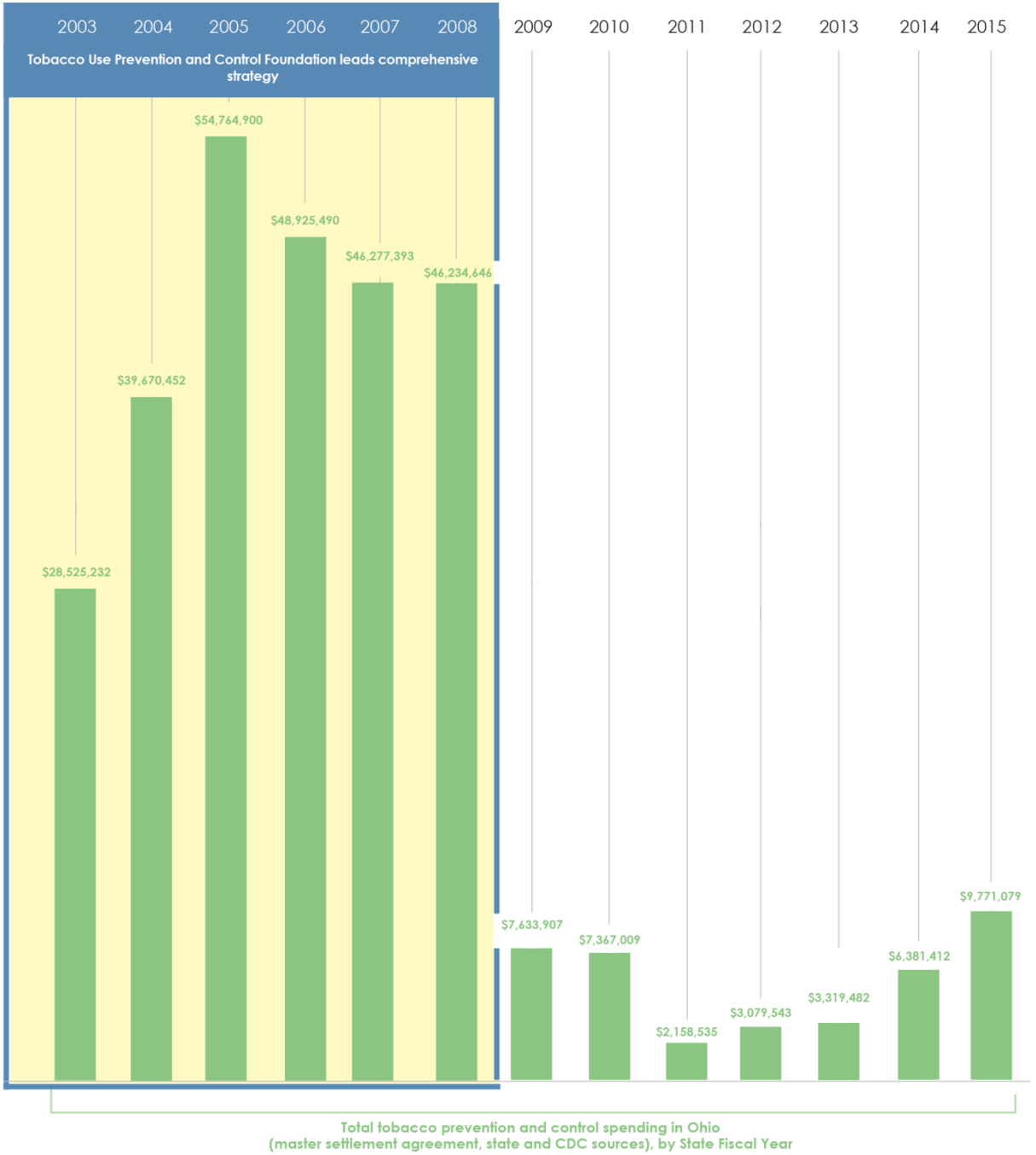
In states with best health value and Ohio



Source: HPIO *Health Value Dashboard*, 2014 and BRFSS, 2013


Best Practices
for Comprehensive Tobacco Control Programs
2014
CDC
National Center for Chronic Disease Prevention and Health Promotion
Office on Smoking and Health

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-QUIT-NOW

1-800-784-8669

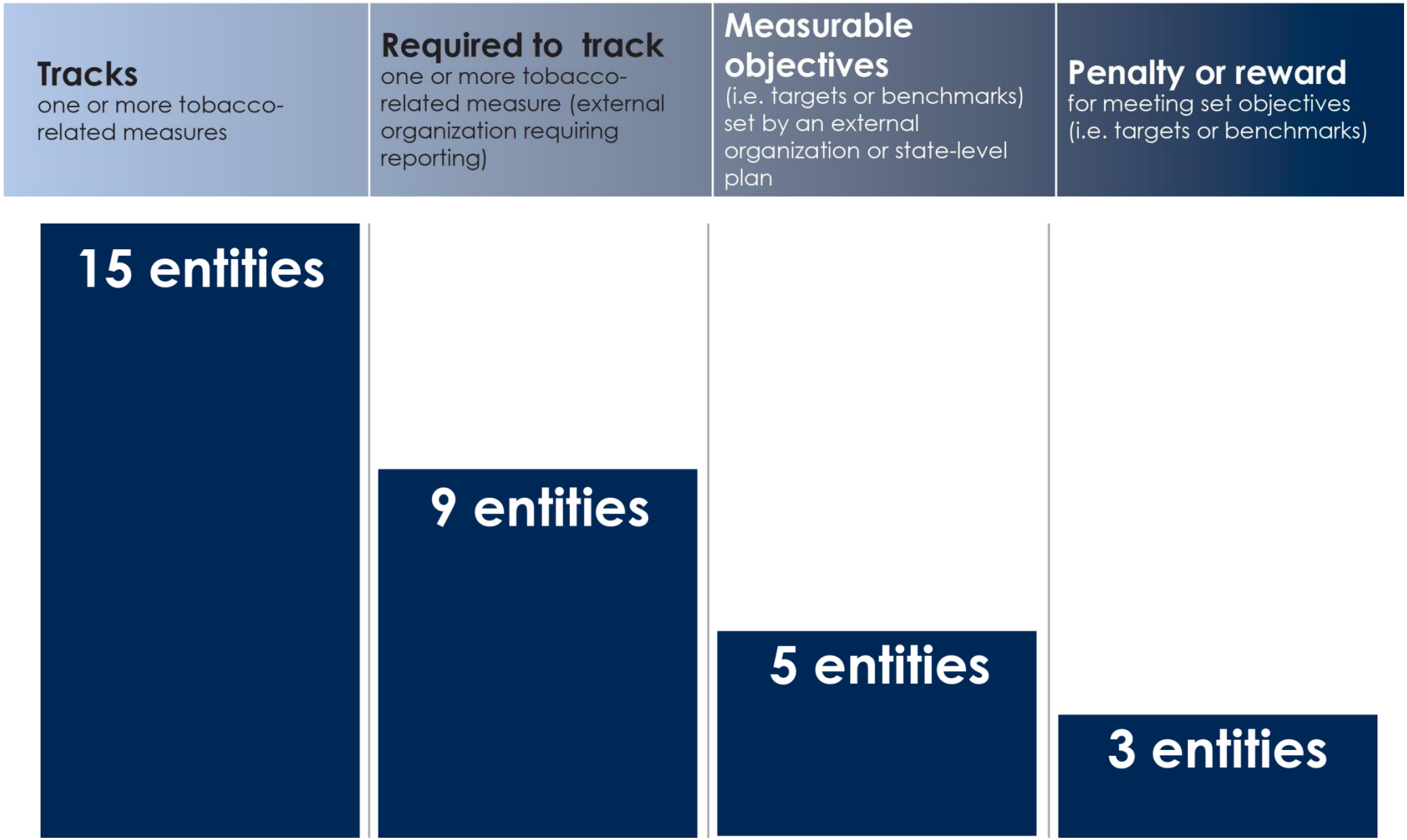
Accountability map

Office of Health Transformation	**Ohio Department of Health**	**Ohio Medicaid**	**Ohio Department of Mental Health and Addiction Services**
Ohio Commission on Minority Health	**Ohio Department of Education** (regarding school district reporting)	**Ohio Public Employees Retirement System**	**Ohio Department of Administrative Services**
Local health departments	**Health insurers (plans)**	**Healthcare providers** (e.g. hospitals, group practices, healthcare professionals and federally qualified health centers)	**State and regional health initiatives**

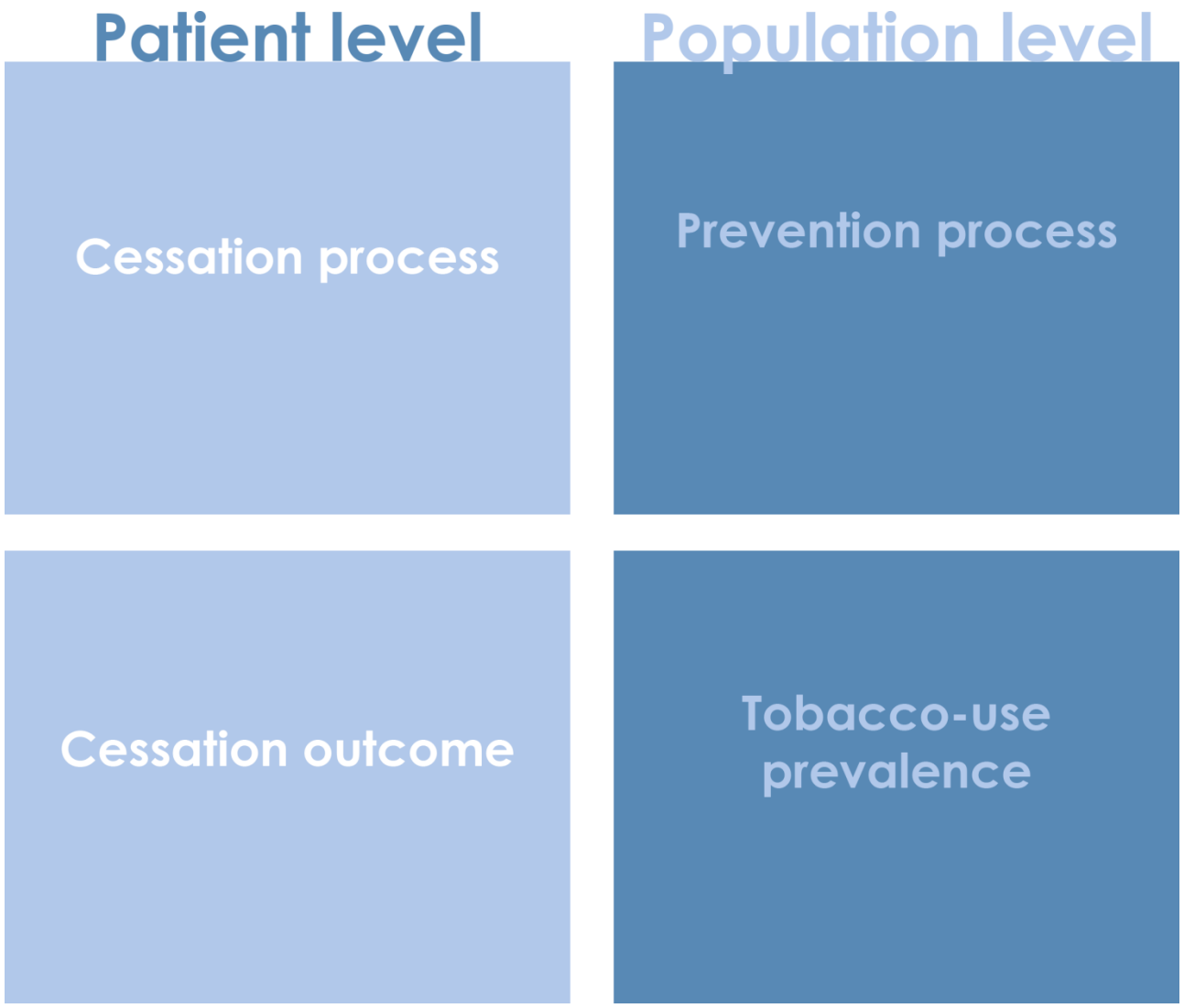
Who is tracking and held accountable for tobacco-related measures in Ohio?

Tracks	Required to track	Measurable objectives	Penalty or reward
one or more tobacco-related measures	one or more tobacco-related measure (external organization requiring reporting)	(i.e. targets or benchmarks) set by an external organization or state-level plan	for meeting set objectives (i.e. targets or benchmarks)

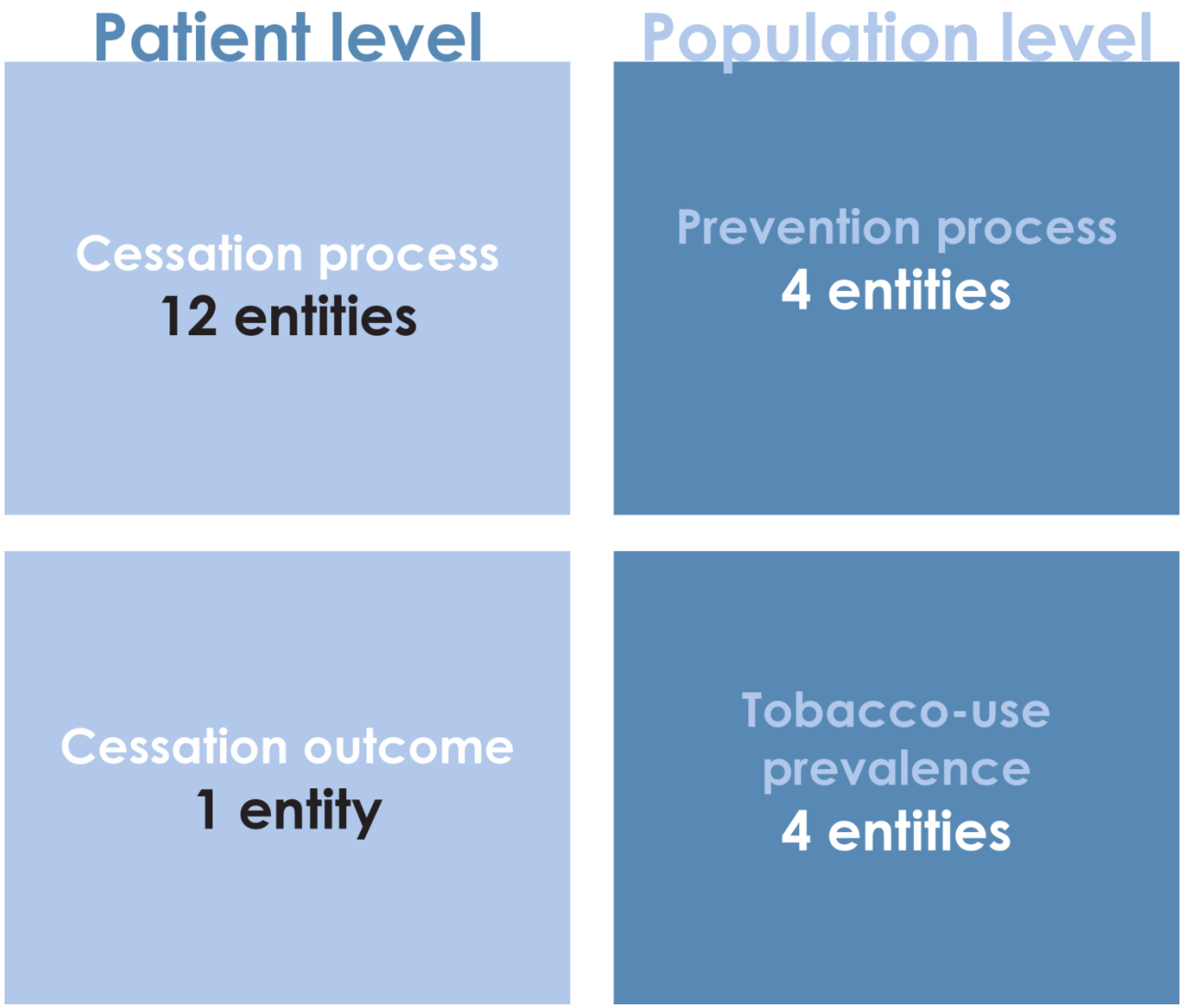
Who is tracking and held accountable for tobacco-related measures in Ohio?



Types of tobacco measures



Types of tobacco measures



Patient-level data

Population-level data

Screened for tobacco use	Received cessation services	Quit tobacco use	Abstained from tobacco 3-12 months
10 entities tracking	9 entities tracking	1 entity tracking	1 entity tracking
3 held accountable*	3 held accountable*	0 held accountable*	0 held accountable*

HPIO Health Value Dashboard

Population health

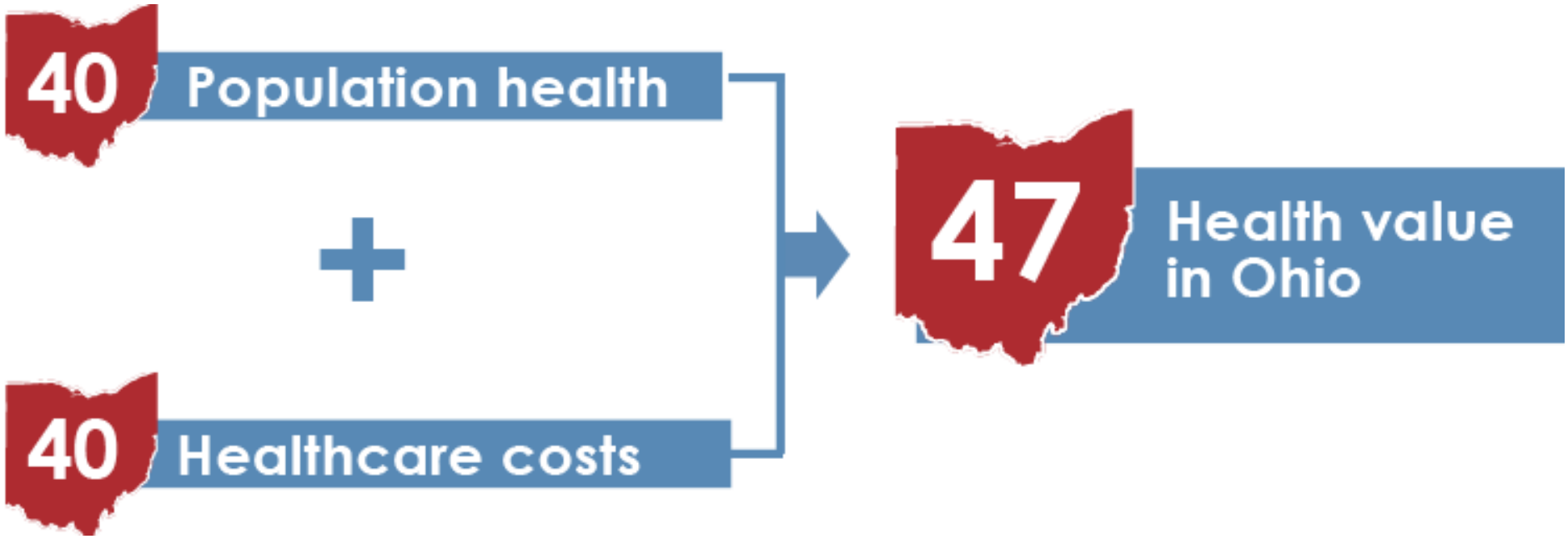
Adult smoking Percent of adults who are current smokers

4 entities tracking

0 held accountable*

* 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 602

[TD 9708]

RIN 1545–BK57; RIN 1545–BL30; RIN 1545–BL58

Additional Requirements for Charitable Hospitals; Community Health Needs Assessments for Charitable Hospitals; Requirement of 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 29, 2014.

Applicability Date: For dates of applicability, see §§ 1.501(r)–7(a); 1.6033–2(k)(4); 53.4959–1(b); and 53.6071–1(i)(2).

FOR FURTHER INFORMATION CONTACT: Amy F. Giuliano, Amber L. MacKenzie, or Stephanie N. Robbins at (202) 317–5800 (not a toll-free number).

SUPPLEMENTARY INFORMATION:

Paperwork Reduction Act

The collection of information contained in [illegible] conditions; and section 501(r)(6), which requires a hospital organization to make reasonable efforts to determine whether an individual is eligible for assistance under a FAP before engaging in extraordinary collection actions. The expected recordkeepers are hospital organizations described in sections 501(c)(3) and 501(r)(2).

1. 2012 Proposed Regulations

On June 26, 2012, the Department of the Treasury (Treasury Department) and the IRS published a notice of proposed rulemaking (NPRM) (REG–130266–11; 77 FR 38148) that contained proposed regulations regarding the requirements of sections 501(r)(4) through 501(r)(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(r)(4) and 501(r)(6) would result in an average annual paperwork burden per recordkeeper of 11.5 hours. (The requirements of section 501(r)(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 [illegible] the Treasury Department received 15 comments that the [illegible] information systems in the first year. 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(r)–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. 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(r)–4 and 1.501(r)–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 [illegible] that burden. [illegible] of time

Part V **Facility Information** *(continued)*

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):

Community Health Needs Assessment

		Yes	No
1	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?		
2	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		
3	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 ☐ A definition of the community served by the hospital facility

b ☐ Demographics of the community

c ☐ Existing health care facilities and resources within the community that are available to respond to the health needs of the community

d ☐ How data was obtained

e ☐ The significant health needs of the community

f ☐ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups

g ☐ The process for identifying and prioritizing community health needs and services to meet the community health needs

h ☐ The process for consulting with persons representing the community's interests

i ☐ Information gaps that limit the hospital facility's ability to assess the community's health needs

j ☐ Other (describe in Section C)

12 If the hospital facility last conducted a CHNA: 20 ___

13 Was the hospital facility last conducted a CHNA, did the hospital facility take into account input from persons who represent

14 Was the hospital facility last conducted a CHNA, did the hospital facility, including those with special knowledge of c

15 Was the hospital facility last conducted a CHNA, did the hospital facility served by the hospital facility took into account input fro

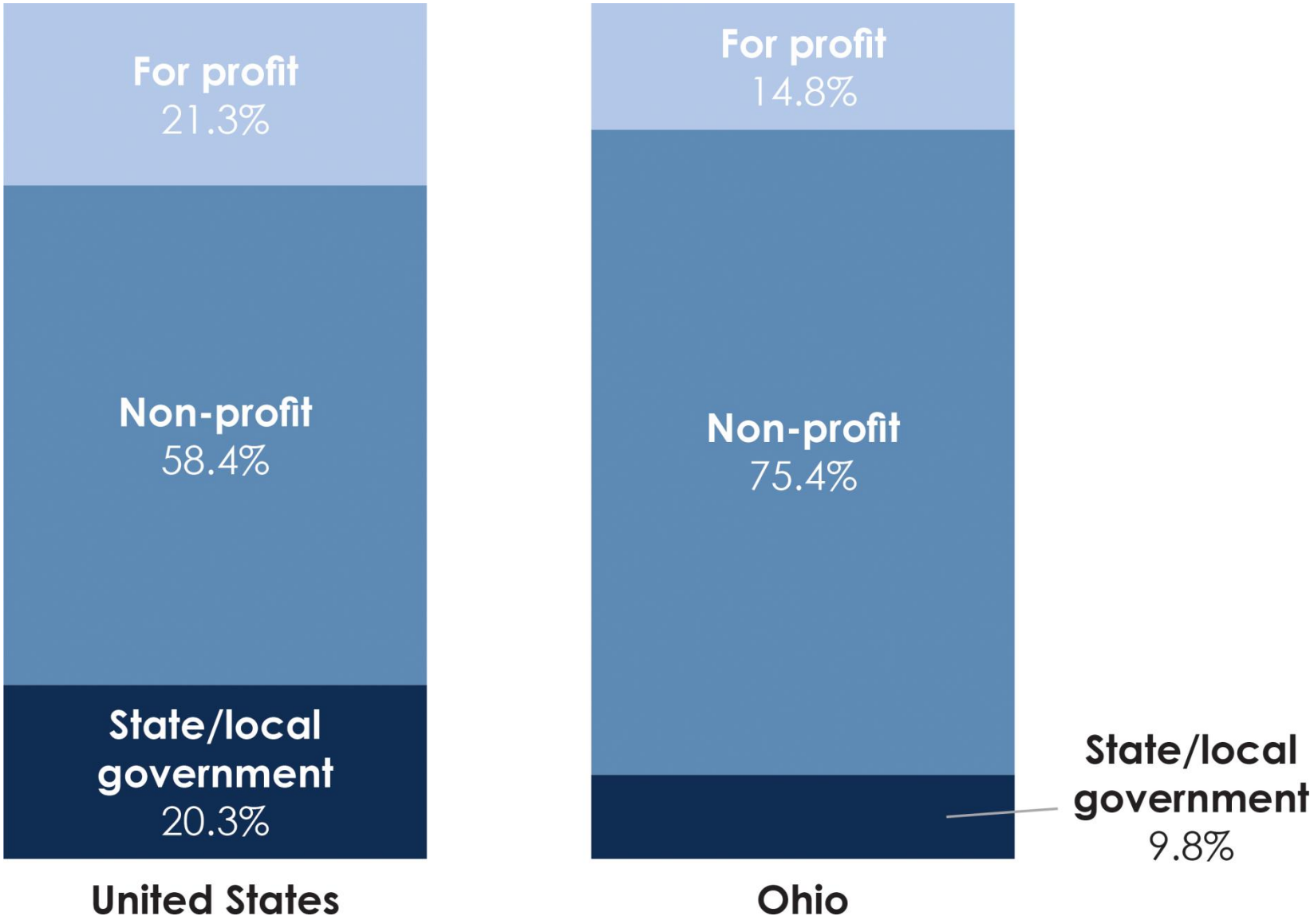
16 Was the hospital facility last conducted a CHNA, did the hospital facility in Section C how the hospital facility consulted

17 Was the hospital facility last conducted a CHNA, did the hospital facility persons the hospital facility consulted

18 Was the hospital facility last conducted a CHNA, did the hospital facility or hospital facilities? If "Yes," list the o

19 Was the hospital facility last conducted a CHNA, did the hospital facility hospital facilities? If "

Hospitals by ownership type



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. 9/29/2013.

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

PHAB

Advancing public health performance

Public Health Accreditation Board

STANDARDS & Measures

VERSION 1.5

Adopted December 2013


Hospitals
Local health departments

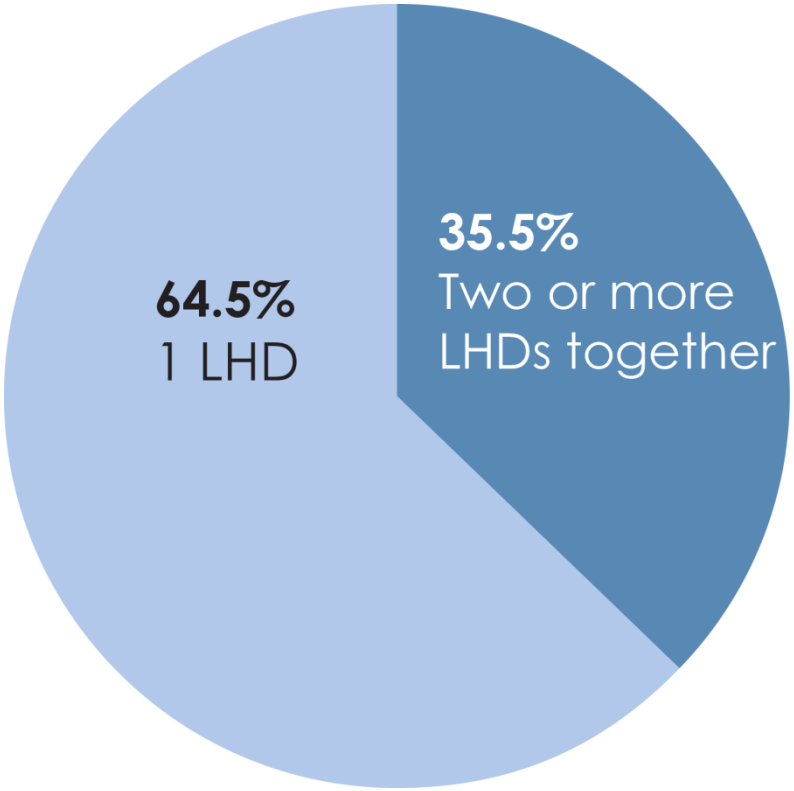

Hospitals
Local
health
departments

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

124 local health departments (as of September, 2014)

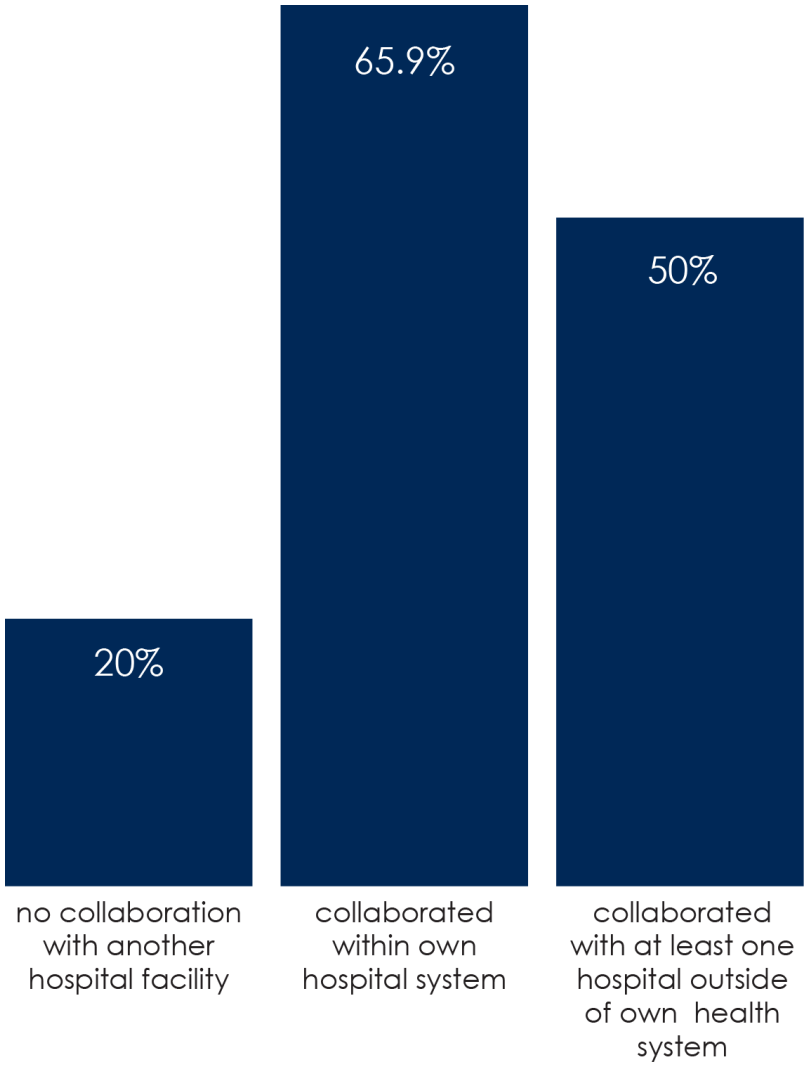
Cross-jurisdictional LHD CHA/CHIP

(n=110)

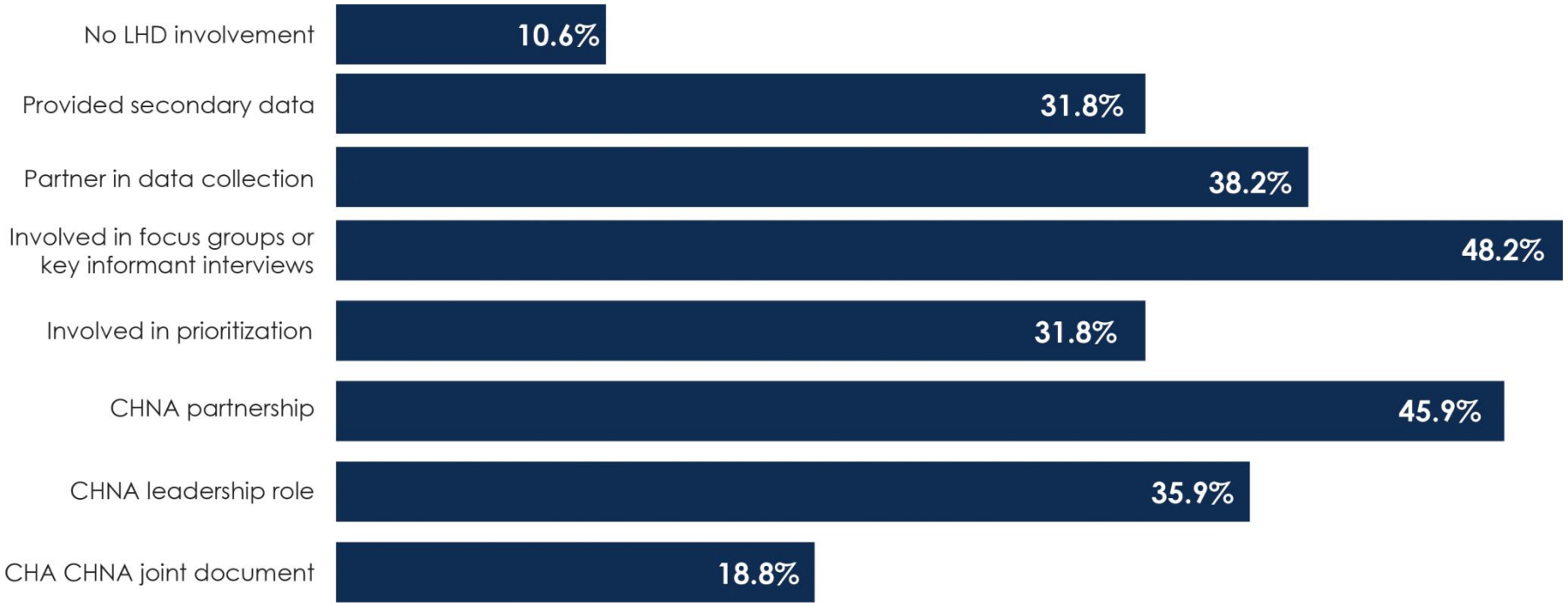


Collaboration among hospitals

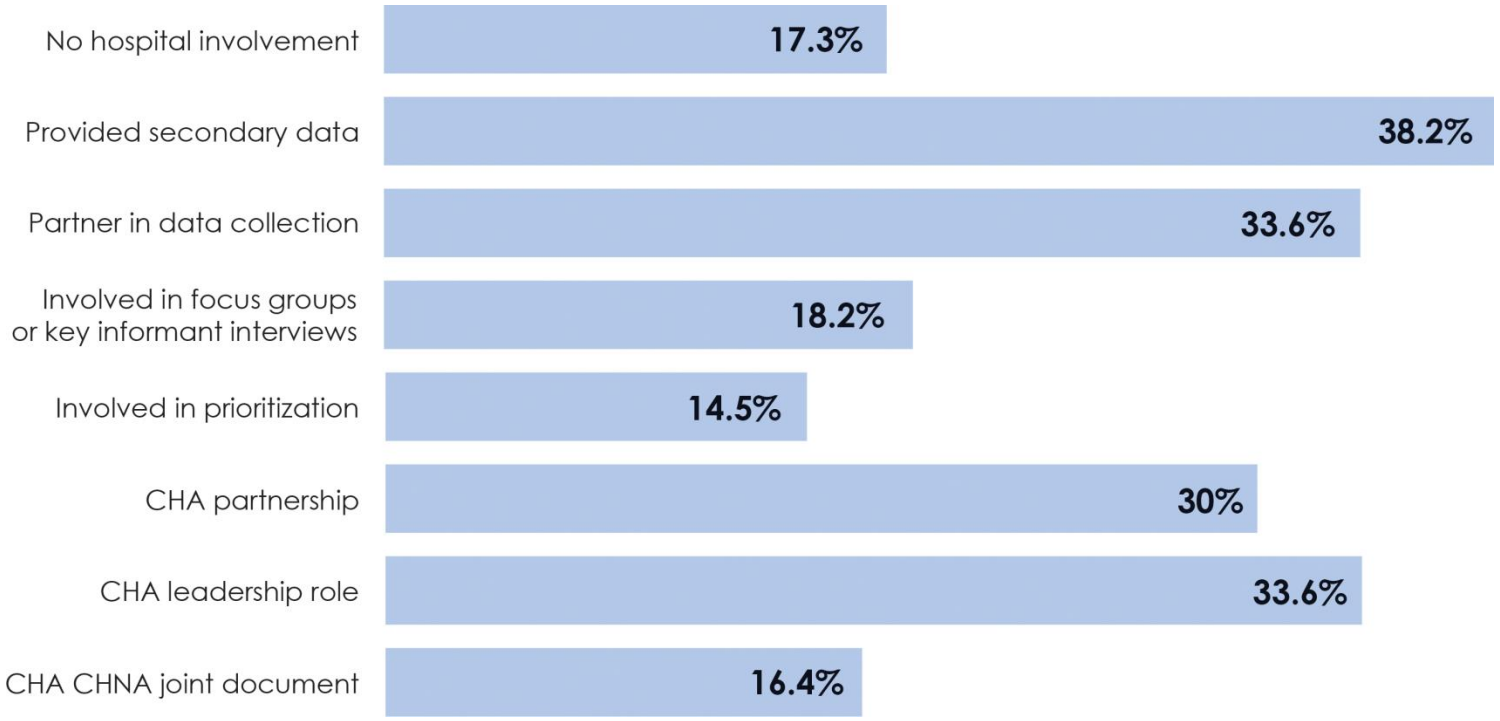
(n=170)



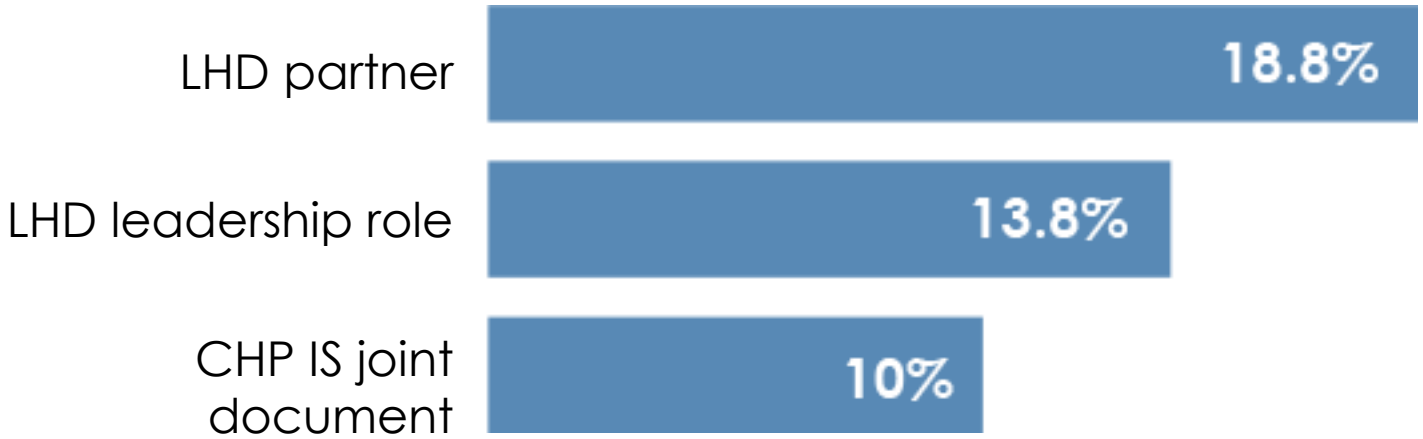
Percent of hospitals reporting LHD collaboration on CHNA (n=170)



Percent of LHDs reporting hospital collaboration on CHA (n=110)



Percent of hospitals reporting LHD collaboration on implementation plan or strategy (among hospitals with an IS, n=80)



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

hpio Health Policy Brief

April 2015

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 their community's 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.

INSIDE

Key community health planning terms

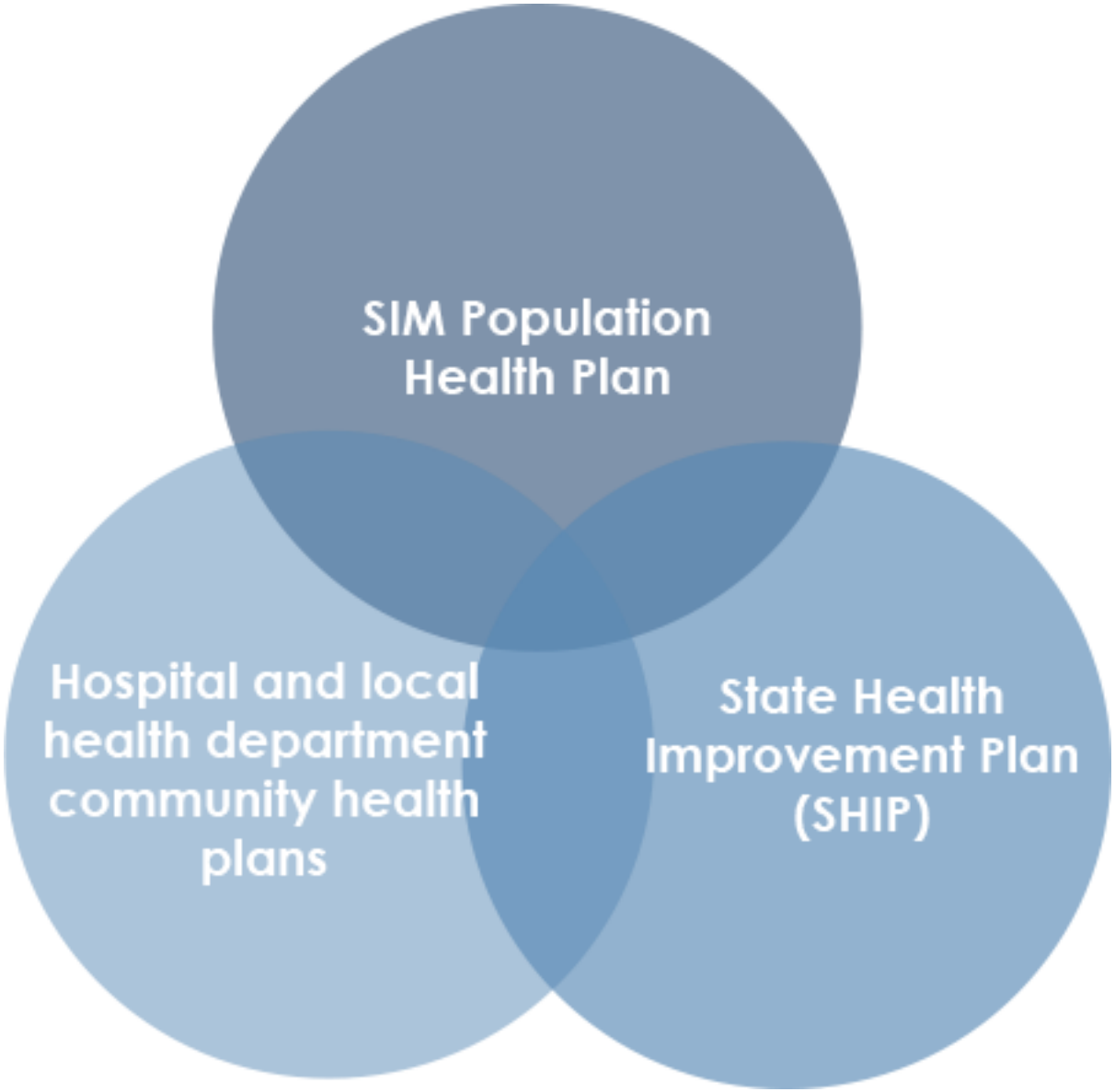
Community health needs assessment (CHNA): an assessment conducted by a hospital every three years to identify and prioritize its community's health needs and identify potential measures and resources available to address its community's prioritized health needs.

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

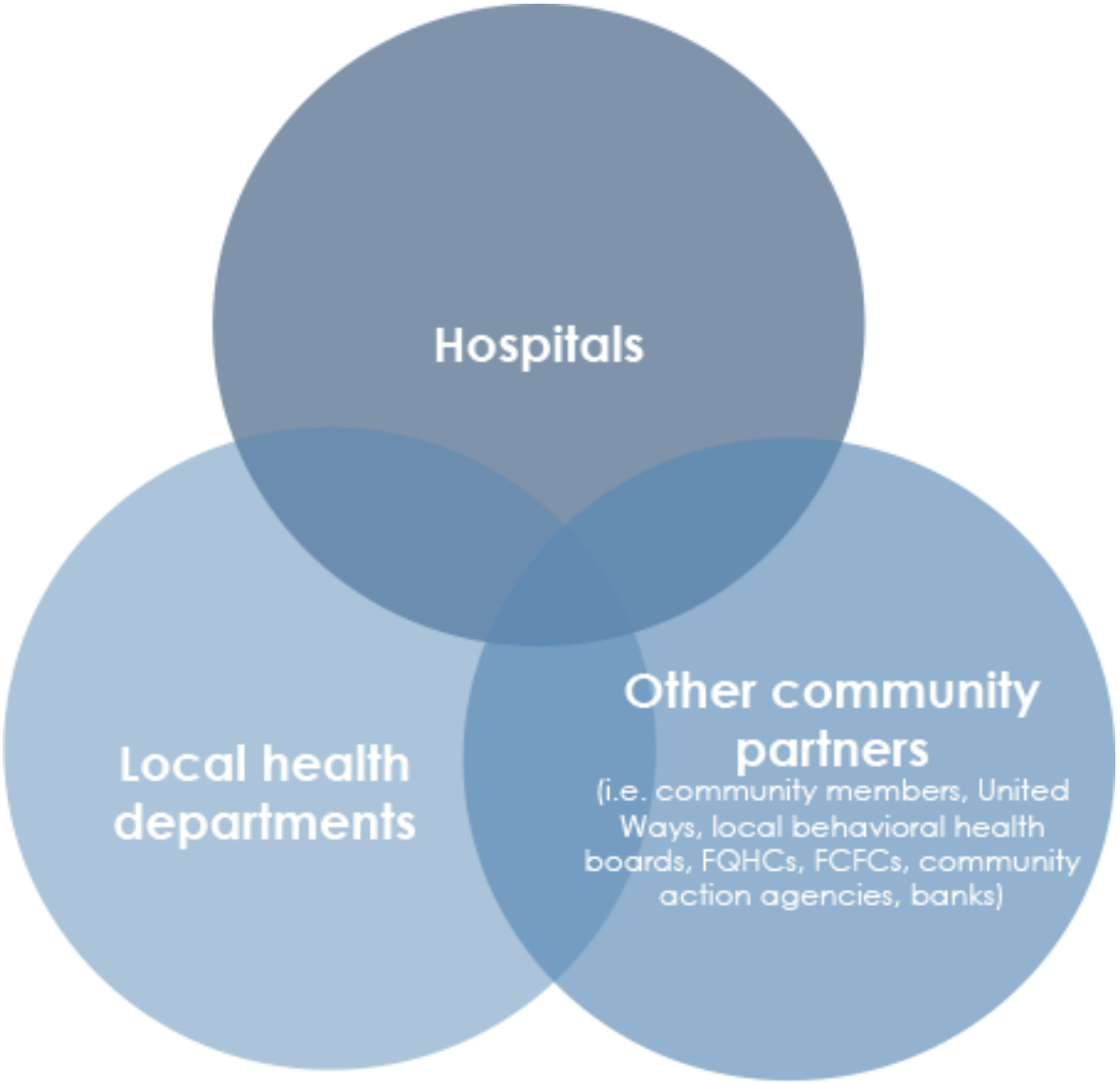
Community health assessment (CHA): a collaborative assessment conducted at least every five years by a LHD to describe the health of the population, identify areas for health improvement, contributing factors that impact health outcomes and community assets and resources that can be mobilized to improve population health.

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 of the jurisdiction that the LHD serves.

Align state and local level health plans



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 ⟷ **Population health**

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

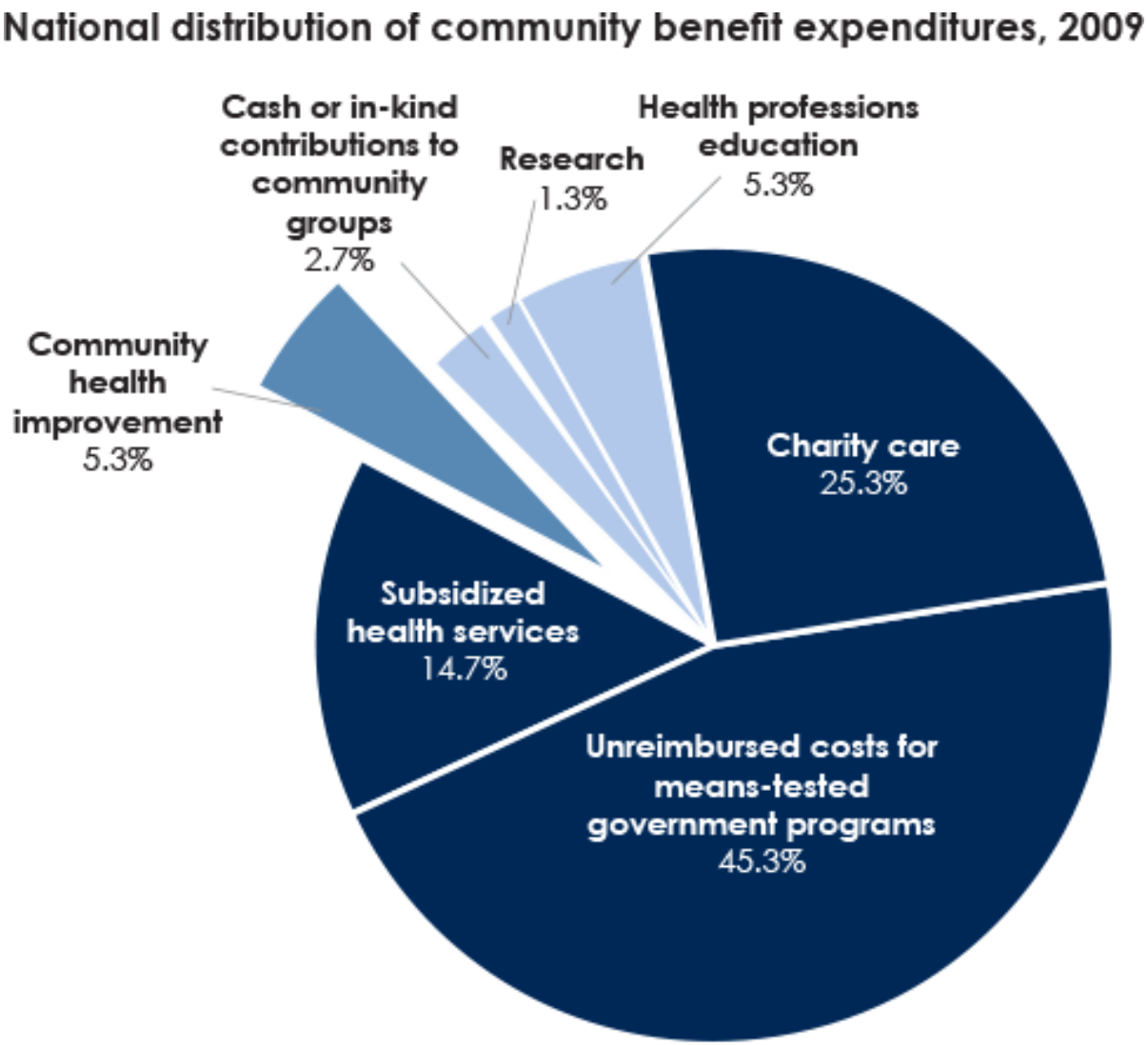
Focus on:

- 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 eduction, transportation and housing

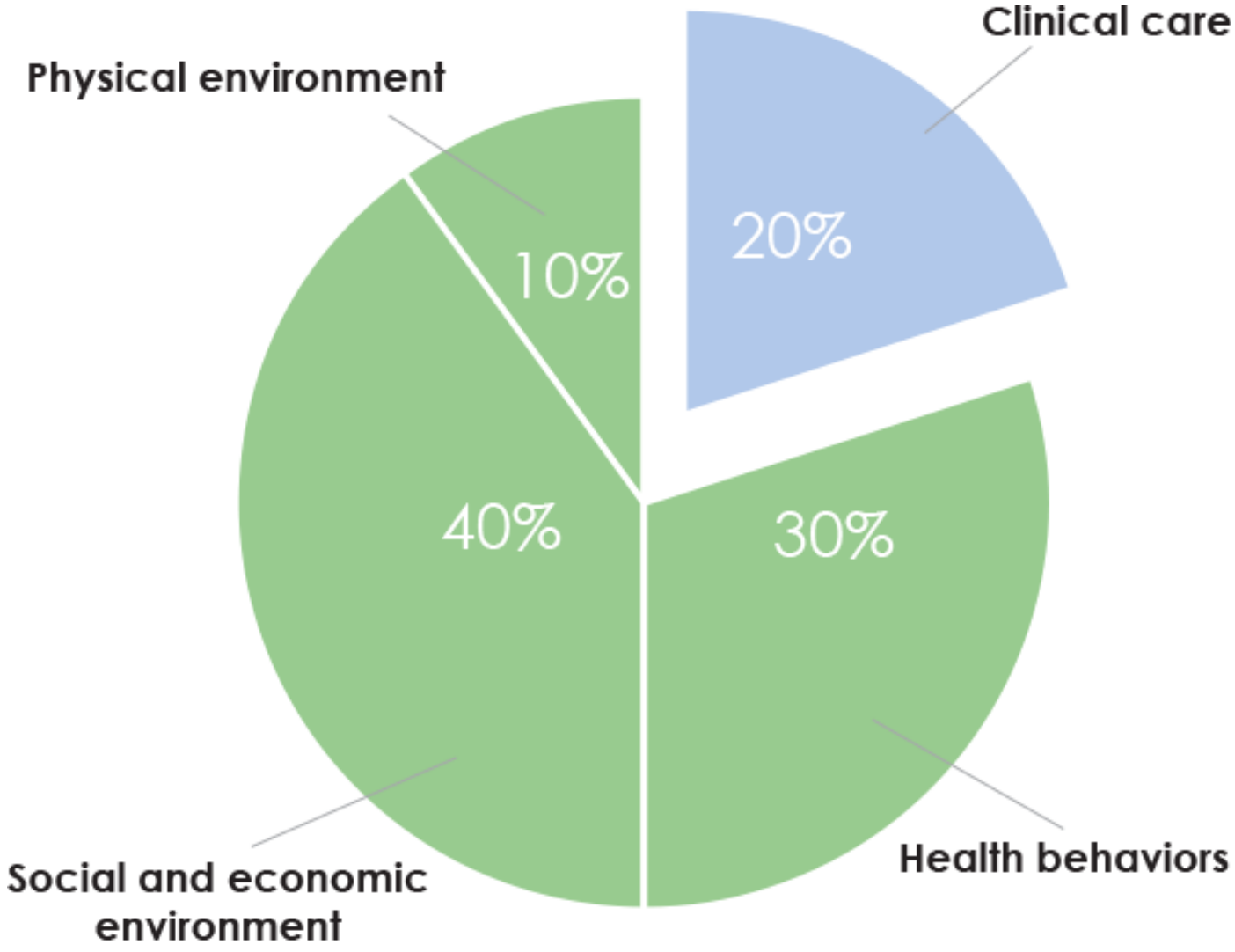
Sources for evidence-based population health strategies

- *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**



Source: Young, Gary J., et. al."Provision of Community Benefits by Tax-Exempt U.S. Hospitals." New England Journal of Medicine, Oct. 2014.
Note: See Figure 14 for a description of these categories.



Source: County Health Rankings and Roadmaps population health model[1]


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

hpio
health policy institute of ohio


CardinalHealth


National Network
of Public Health Institutes

Contact

Health Policy Institute of Ohio
10 W Broad St Suite 1050
Columbus, OH 43215
(614) 224-4950
arohlingmcgee@healthpolicyohio.org
astevens@healthpolicyohio.org
raly@healthpolicyohio.org

hpio
health policy institute of ohio