# An Update on Public Health: Integrating Public Health and Healthcare from Planning to Implementation


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**Assistant Professor – Practice**
**OSU College of Public Health**


**COUNTRY RANKINGS**

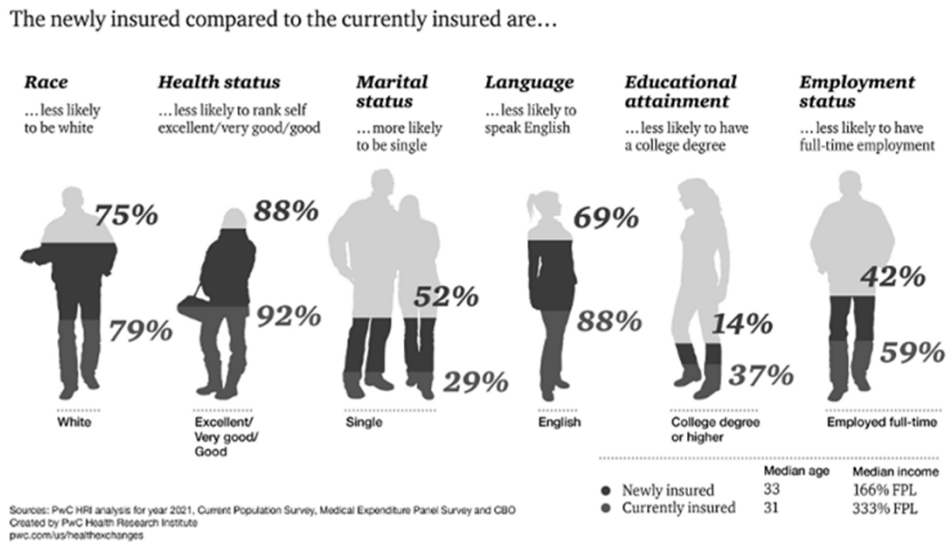
Top 2*
Middle
Bottom 2*

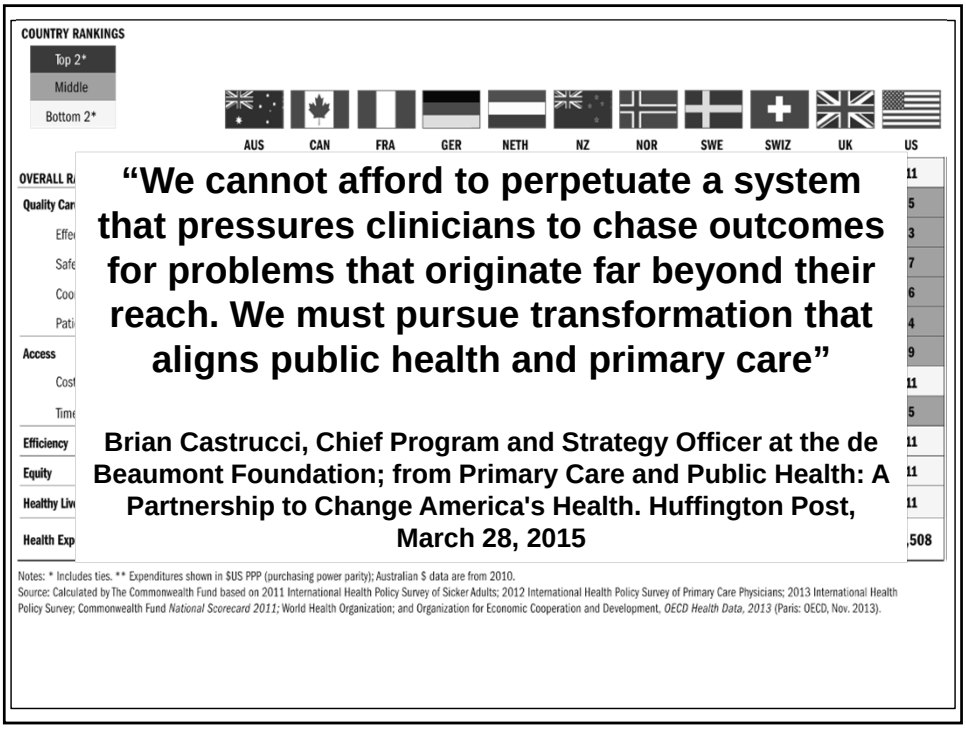
| | AUS | CAN | FRA | GER | NETH | NZ | NOR | SWE | SWIZ | UK | US |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **OVERALL RANKING (2013)** | 4 | 10 | 9 | 5 | 5 | 7 | 7 | 3 | 2 | 1 | 11 |
| **Quality Care** | 2 | 9 | 8 | 7 | 5 | 4 | 11 | 10 | 3 | 1 | 5 |
| Effective Care | 4 | 7 | 9 | 6 | 5 | 2 | 11 | 10 | 8 | 1 | 3 |
| Safe Care | 3 | 10 | 2 | 6 | 7 | 9 | 11 | 5 | 4 | 1 | 7 |
| Coordinated Care | 4 | 8 | 9 | 10 | 5 | 2 | 7 | 11 | 3 | 1 | 6 |
| Patient-Centered Care | 5 | 8 | 10 | 7 | 3 | 6 | 11 | 9 | 2 | 1 | 4 |
| **Access** | 8 | 9 | 11 | 2 | 4 | 7 | 6 | 4 | 2 | 1 | 9 |
| Cost-Related Problem | 9 | 5 | 10 | 4 | 8 | 6 | 3 | 1 | 7 | 1 | 11 |
| Timeliness of Care | 6 | 11 | 10 | 4 | 2 | 7 | 8 | 9 | 1 | 3 | 5 |
| **Efficiency** | 4 | 10 | 8 | 9 | 7 | 3 | 4 | 2 | 6 | 1 | 11 |
| **Equity** | 5 | 9 | 7 | 4 | 8 | 10 | 6 | 1 | 2 | 2 | 11 |
| **Healthy Lives** | 4 | 8 | 1 | 7 | 5 | 9 | 6 | 2 | 3 | 10 | 11 |
| **Health Expenditures/Capita, 2011**** | $3,800 | $4,522 | $4,118 | $4,495 | $5,099 | $3,182 | $5,669 | $3,925 | $5,643 | $3,405 | $8,508 |

Notes: * Includes ties. ** Expenditures shown in $US PPP (purchasing power parity); Australian $ data are from 2010.
Source: Calculated by The Commonwealth Fund based on 2011 International Health Policy Survey of Sicker Adults; 2012 International Health Policy Survey of Primary Care Physicians; 2013 International Health Policy Survey; Commonwealth Fund *National Scorecard 2011;* World Health Organization; and Organization for Economic Cooperation and Development, *OECD Health Data, 2013* (Paris: OECD, Nov. 2013).

**2014 Update, Mirror, Mirror On The Wall: How the Performance of the U.S. Health Care System Compares Internationally. Commonwealth Fund, June 2014**

# What will the newly insured look like?




**"We cannot afford to perpetuate a system that pressures clinicians to chase outcomes for problems that originate far beyond their reach. We must pursue transformation that aligns public health and primary care"**

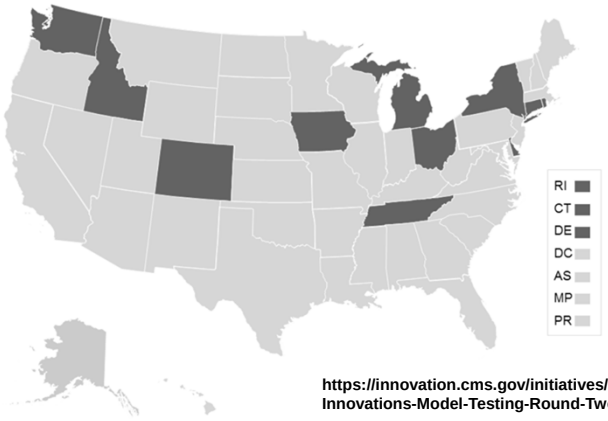
**Brian Castrucci, Chief Program and Strategy Officer at the de Beaumont Foundation; from Primary Care and Public Health: A Partnership to Change America's Health. Huffington Post, March 28, 2015**

## State Innovation Models Initiative: Model Test Awards Round Two

Share

The State Innovation Models Initiative Model Test Awards will provide financial and technical support over a four-year period for states to test and evaluate multi-payer health system transformation models. States must produce and implement a detailed and fully developed proposal capable of creating state-wide health transformation for the majority of care within the state.

**Select anywhere on the map below to view the interactive version**




**https://innovation.cms.gov/initiatives/State-Innovations-Model-Testing-Round-Two/**

State Innovation Models Initiative: Model Test Awards Round Two

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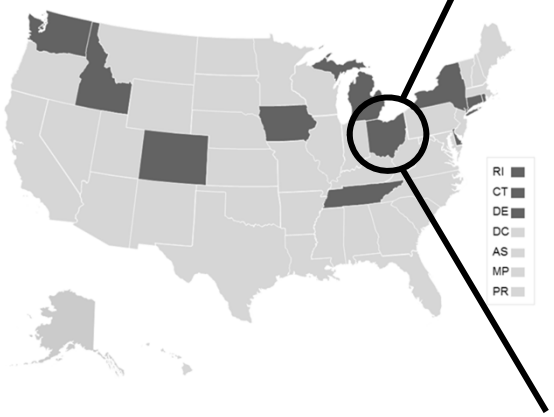


- **Episodes of Care**
- **Expansion of Patient-Centered Primary Care models**
- **Aligning Population Health Planning**

State Innovation Models Initiative: Model Test Awards Round Two

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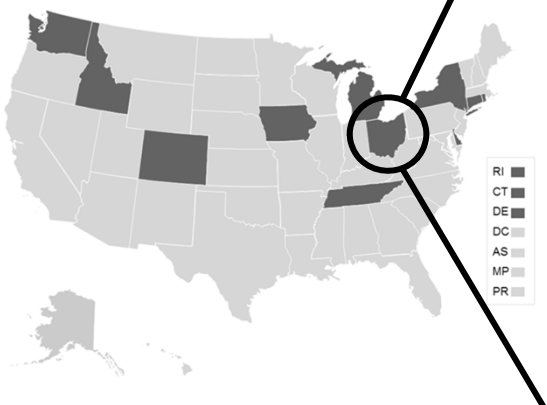



- **Episodes of Care**
- **Expansion of Patient-Centered Primary Care Models**
- **Aligning Population Health Planning**

PHAB

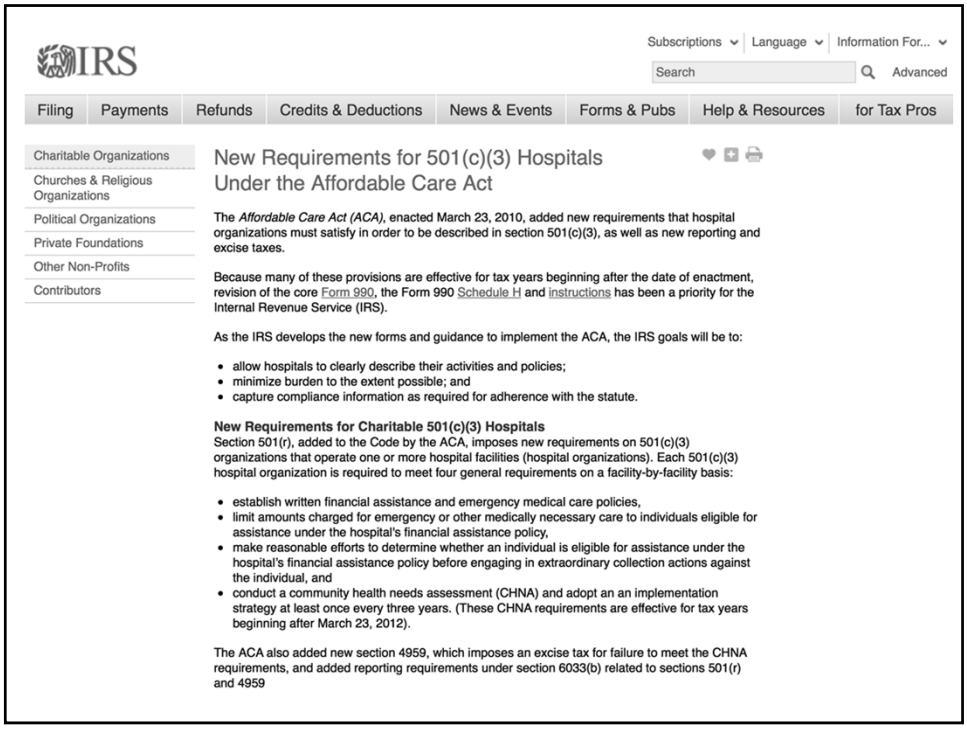
*Advancing public health performance*

Public Health Accreditation Board

# STANDARDS & Measures

VERSION 1.5

Adopted December 2013


IRS
Subscriptions
Language
Information For...
Search
Advanced
Filing
Payments
Refunds
Credits & Deductions
News & Events
Forms & Pubs
Help & Resources
for Tax Pros
Charitable Organizations
Churches & Religious Organizations
Political Organizations
Private Foundations
Other Non-Profits
Contributors
New Requirements for 501(c)(3) Hospitals Under the Affordable Care Act
The Affordable Care Act (ACA), enacted March 23, 2010, added new requirements that hospital organizations must satisfy in order to be described in section 501(c)(3), as well as new reporting and excise taxes.
Because many of these provisions are effective for tax years beginning after the date of enactment, revision of the core Form 990, the Form 990 Schedule H and instructions has been a priority for the Internal Revenue Service (IRS).
As the IRS develops the new forms and guidance to implement the ACA, the IRS goals will be to:
allow hospitals to clearly describe their activities and policies;
minimize burden to the extent possible; and
capture compliance information as required for adherence with the statute.
New Requirements for Charitable 501(c)(3) Hospitals
Section 501(r), added to the Code by the ACA, imposes new requirements on 501(c)(3) organizations that operate one or more hospital facilities (hospital organizations). Each 501(c)(3) hospital organization is required to meet four general requirements on a facility-by-facility basis:
establish written financial assistance and emergency medical care policies,
limit amounts charged for emergency or other medically necessary care to individuals eligible for assistance under the hospital's financial assistance policy,
make reasonable efforts to determine whether an individual is eligible for assistance under the hospital's financial assistance policy before engaging in extraordinary collection actions against the individual, and
conduct a community health needs assessment (CHNA) and adopt an an implementation strategy at least once every three years. (These CHNA requirements are effective for tax years beginning after March 23, 2012).
The ACA also added new section 4959, which imposes an excise tax for failure to meet the CHNA requirements, and added reporting requirements under section 6033(b) related to sections 501(r) and 4959

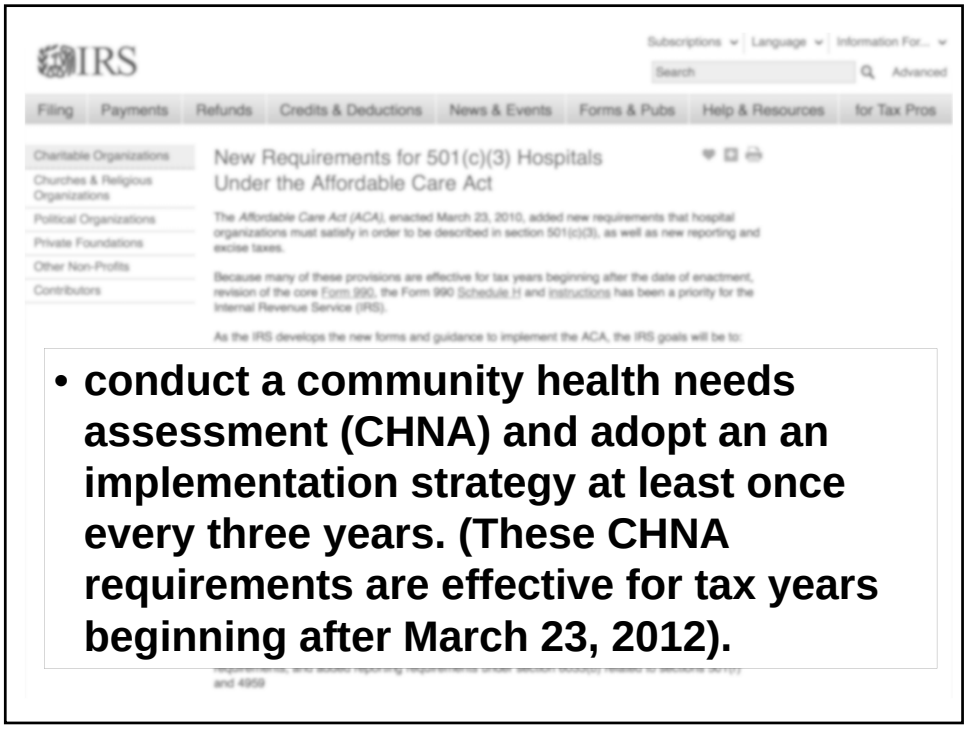
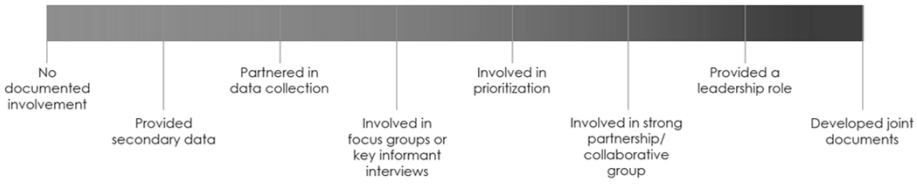

IRS
Filing
Payments
Refunds
Credits & Deductions
News & Events
Forms & Pubs
Help & Resources
for Tax Pros
New Requirements for 501(c)(3) Hospitals Under the Affordable Care Act
• conduct a community health needs assessment (CHNA) and adopt an an implementation strategy at least once every three years. (These CHNA requirements are effective for tax years beginning after March 23, 2012).

Figure ES.3. **Continuum of collaboration between local health departments and hospitals**




**Source:** HPIO and the Ohio Research Association for Public Health Improvement analysis of local health department and hospital community health planning documents, March 2015. For more information, see HPIO's publication "Making the most of community health planning in Ohio: The role of hospitals and local health departments."

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**Hospital and LHD collaboration**

Figure 19. **Percent of hospitals reporting LHD collaboration on the CHNA and IS**

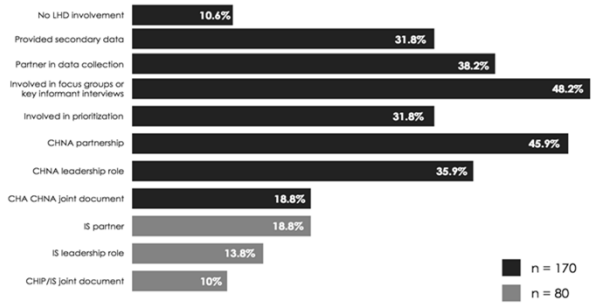
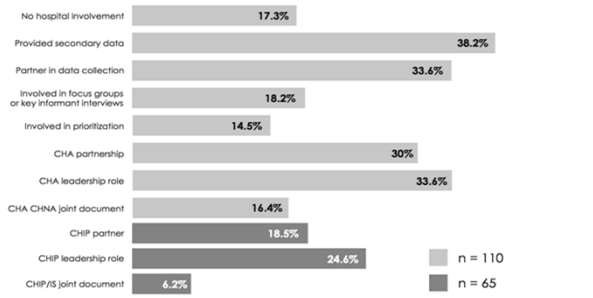
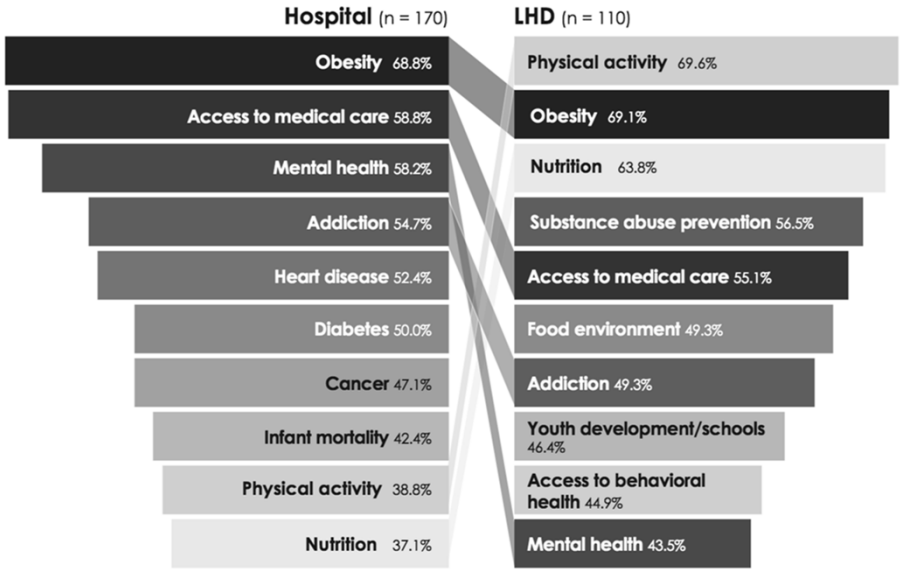



Figure 20. **Percent of LHDs reporting hospital collaboration on the CHA and CHIP**




**HPIO Policy Brief: *Making the most of community health planning in Ohio. The role of hospitals and local health departments.* May 2015**

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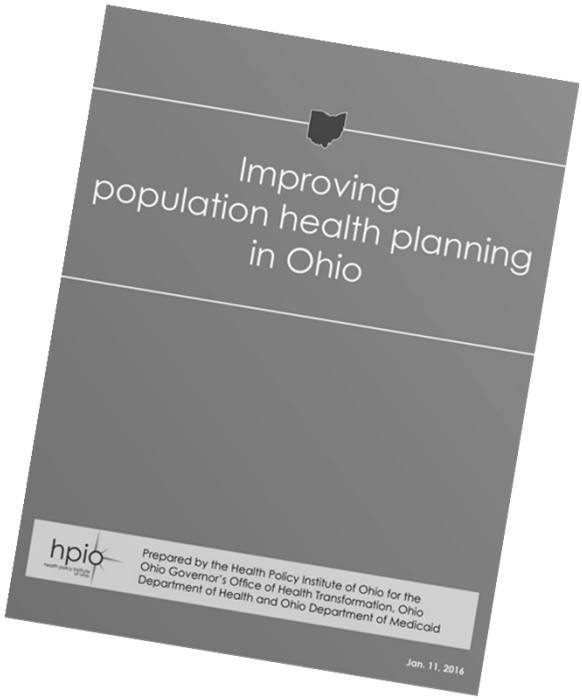


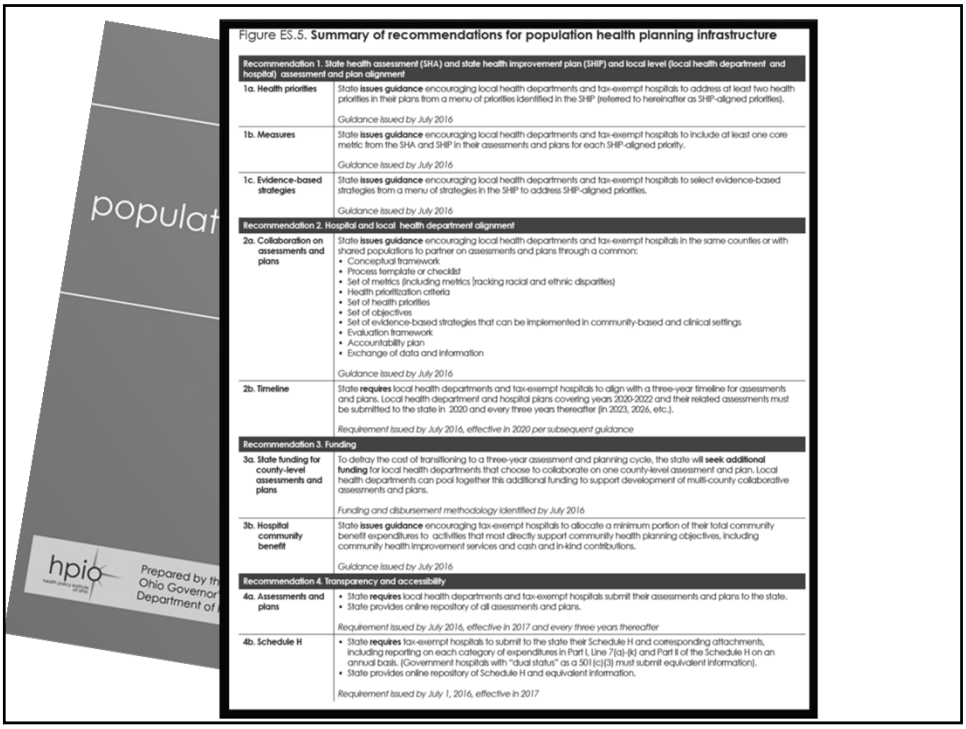



Figure ES.5. **Summary of recommendations for population health planning infrastructure**

| | |
|---|---|
| **Recommendation 1. State health assessment (SHA) and state health improvement plan (SHIP) and local level (local health department and hospital) assessment and plan alignment** | |
| **1a. Health priorities** | State **issues guidance** encouraging local health departments and tax-exempt hospitals to address at least two health priorities in their plans from a menu of priorities identified in the SHIP (referred to hereinafter as SHIP-aligned priorities).<br><br>*Guidance issued by July 2016* |
| **1b. Measures** | State **issues guidance** encouraging local health departments and tax-exempt hospitals to include at least one core metric from the SHA and SHIP in their assessments and plans for each SHIP-aligned priority.<br><br>*Guidance issued by July 2016* |
| **1c. Evidence-based strategies** | State **issues guidance** encouraging local health departments and tax-exempt hospitals to select evidence-based strategies from a menu of strategies in the SHIP to address SHIP-aligned priorities.<br><br>*Guidance issued by July 2016* |
| **Recommendation 2. Hospital and local health department alignment** | |
| **2a. Collaboration on assessments and plans** | State **issues guidance** encouraging local health departments and tax-exempt hospitals in the same counties or with shared populations to partner on assessments and plans through a common:<br>• Conceptual framework<br>• Process template or checklist<br>• Set of metrics (including metrics tracking racial and ethnic disparities)<br>• Health prioritization criteria<br>• Set of health priorities<br>• Set of objectives<br>• Set of evidence-based strategies that can be implemented in community-based and clinical settings<br>• Evaluation framework<br>• Accountability plan<br>• Exchange of data and information<br><br>*Guidance issued by July 2016* |
| **2b. Timeline** | State **requires** local health departments and tax-exempt hospitals to align with a three-year timeline for assessments and plans. Local health department and hospital plans covering years 2020-2022 and their related assessments must be submitted to the state in 2020 and every three years thereafter (in 2023, 2026, etc.).<br><br>*Requirement issued by July 2016, effective in 2020 per subsequent guidance* |
| **Recommendation 3. Funding** | |
| **3a. State funding for county-level assessments and plans** | To defray the cost of transitioning to a three-year assessment and planning cycle, the state will **seek additional funding** for local health departments that choose to collaborate on one county-level assessment and plan. Local health departments can pool together this additional funding to support development of multi-county collaborative assessments and plans.<br><br>*Funding and disbursement methodology identified by July 2016* |
| **3b. Hospital community benefit** | State **issues guidance** encouraging tax-exempt hospitals to allocate a minimum portion of their total community benefit expenditures to activities that most directly support community health planning objectives, including community health improvement services and cash and in-kind contributions.<br><br>*Guidance issued by July 2016* |
| **Recommendation 4. Transparency and accessibility** | |
| **4a. Assessments and plans** | • State **requires** local health departments and tax-exempt hospitals submit their assessments and plans to the state.<br>• State provides online repository of all assessments and plans.<br><br>*Requirement issued by July 2016, effective in 2017 and every three years thereafter* |
| **4b. Schedule H** | • State **requires** tax-exempt hospitals to submit to the state their Schedule H and corresponding attachments, including reporting on each category of expenditures in Part I, Line 7(a)-(k) and Part II of the Schedule H on an annual basis. (Government hospitals with "dual status" as a 501(c)(3) must submit equivalent information).<br>• State provides online repository of Schedule H and equivalent information.<br><br>*Requirement issued by July 1, 2016, effective in 2017* |

# Public health funding

# Regional variation in public health services

## An Update on Public Health: Integrating Public Health and Healthcare from Planning to Implementation

**Tim Ingram**
**Health Commissioner**
**Hamilton County Public Health**

# Using Collaboration and the Collective Impact Process to Achieve the Triple Aim

**Better Health, Better Care, and Lower Costs**
**in**
**Greater Cincinnati Area**

# What is the Practical Playbook?

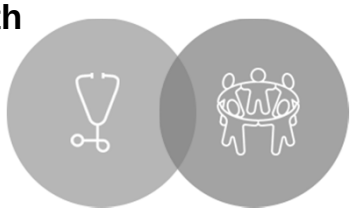
***A cornerstone of the next transformation of health, in which health care and public health groups work collaboratively to achieve population health improvement.***

**www.practicalplaybook.org**

# What Can Collaboration Offer?

## Public Health

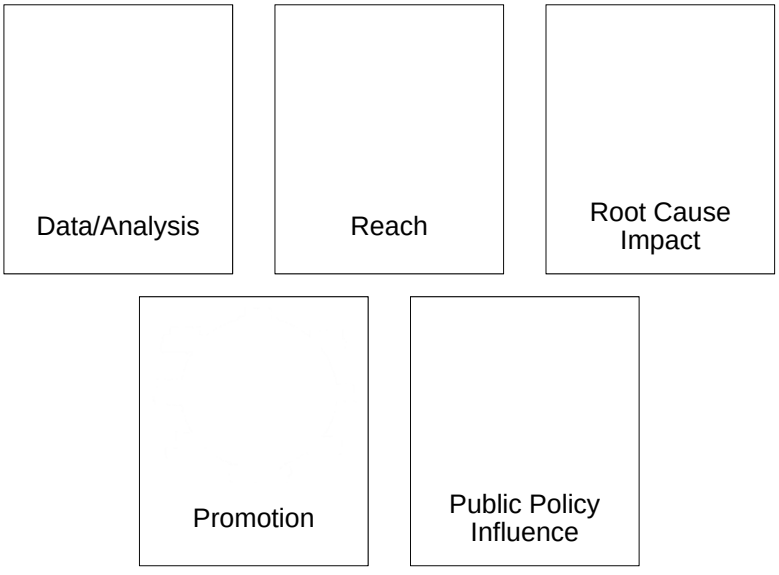
- **Data and Analytics**
- **Reach**
- **Impact on Root Causes of Health**
- **Promotion**
- **Policy Influence**



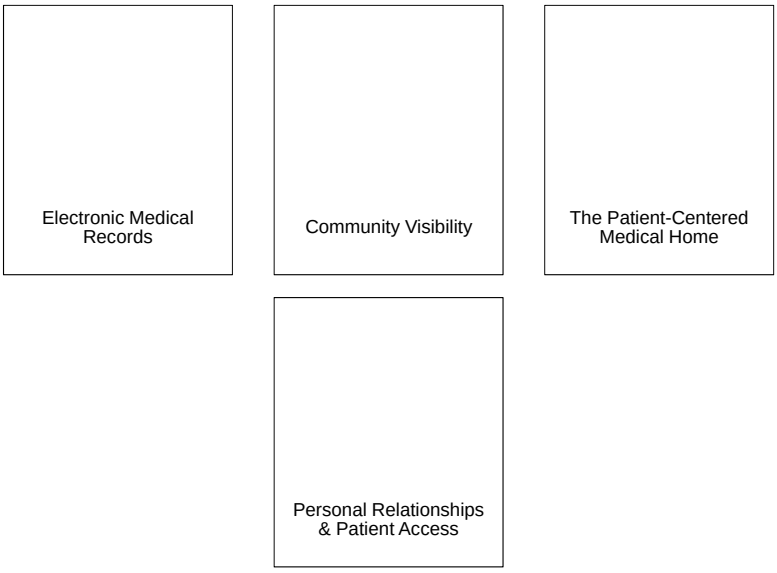
## Health Care

- **Information**
- **Access to Patients**
- **Credibility**
- **Innovation**
- **Commitment**

# Strengths Public Health Can Bring to the Partnership



## Strengths Health Systems Can Bring to the Partnership




## A Role for Everyone

### Health Care

- Clinical Providers
- Billing System
- Data on Patients
- Data Warehousing

### Public Health

- Portal to other community agencies
- Epidemiological data
- Health educators and nutritionists

### Other Partners

- Insurance Providers
- Social Services
- Mental Health Services
- Community Advocates / Councils

THE HEALTH COLLABORATIVE

# COLLECTIVE IMPACT ON HEALTH

DATA-DRIVEN HEALTH IMPROVEMENT IN GREATER CINCINNATI

## Principles of Collective Impact

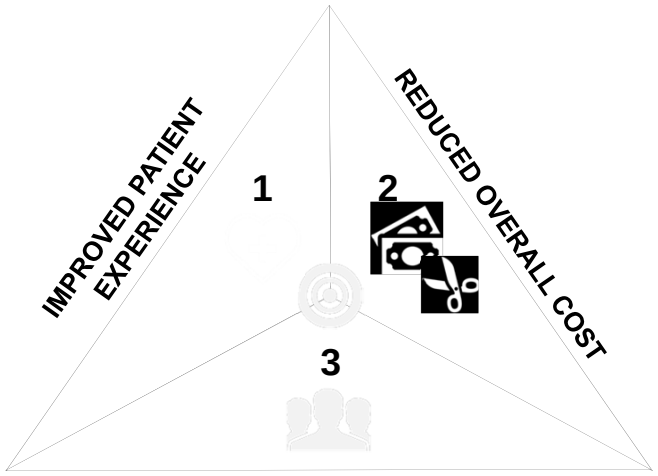
**Common agenda reached though multi-stakeholder consensus**

**Partnerships with alignment of mutually reinforcing activities led by a Backbone Organization**

**Shared Measurement and Accountability for Improvement**

COLLECTIVE IMPACT ON HEALTH

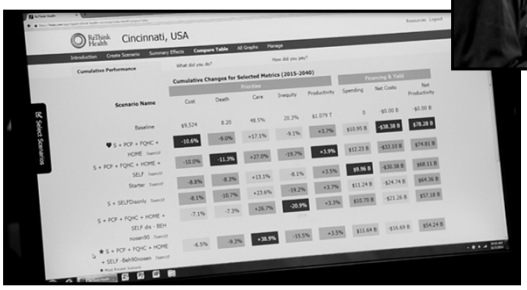
## Small number of doable things that in combination have power to impact the triple-aim




COLLECTIVE IMPACT ON HEALTH

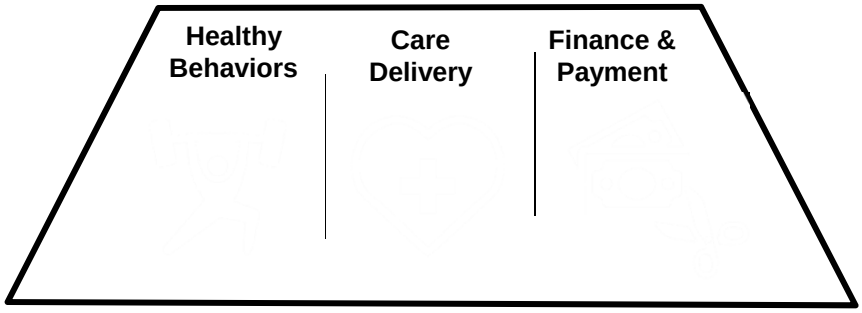
# The Value of the ReThink Model

- **Shared Understanding of**
  - **Possible initiatives**
  - **Outcomes over time**
  - **Cost of effort**



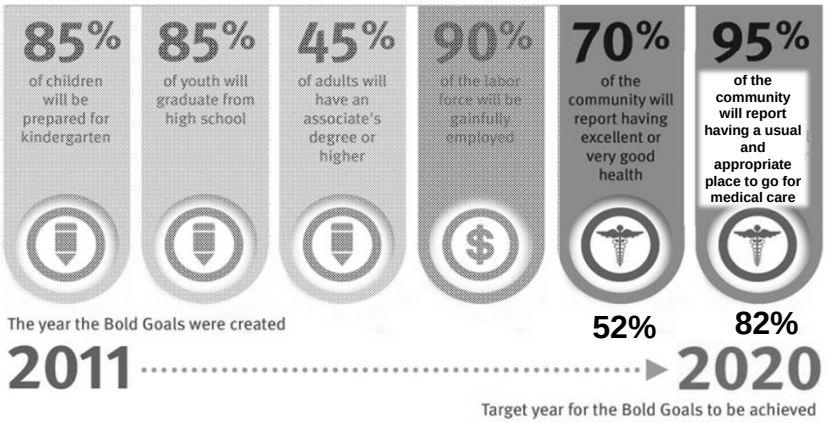

ReThink Health

# 3 Action Areas




COLLECTIVE IMPACT ON HEALTH

# Bold Goals
## + 50% Reduction in Disparities
## + Commitment to a Cost Goal




COLLECTIVE IMPACT ON HEALTH

# Health Status by the Numbers

| EX or VG Health<br>50% reduction in disparities | All Adult | African American Adult | Total Adult below 200% FPL |
|---|---|---|---|
| Current | 767,000<br>52%* | 84,000<br>46% | 180,000<br>32% |
| **To goal** | +266,000<br>70% | +37,000<br>67% | +129,000<br>55% |

**Barriers to Excellent or Very Good Health (self reported)**

- **Chronic Disease| Poor diet and exercise | Weight**
- **Barriers to healthy choices attributable to socioeconomic determinants of health**

COLLECTIVE IMPACT ON HEALTH

***63% above 200%FPL**

# Access by the Numbers

| Regular and appropriate source of care<br><br>50% reduction in disparities | All Adult | African American Adult | Total Adult below 200% FPL |
|---|---|---|---|
| Current | 1,210,000<br>82% | 138,000<br>76% | 393,000<br>70% |
| To goal | +191,000<br>95% | +49,000<br>92% | +123,000<br>89% |

**Barriers to Access (self reported)**

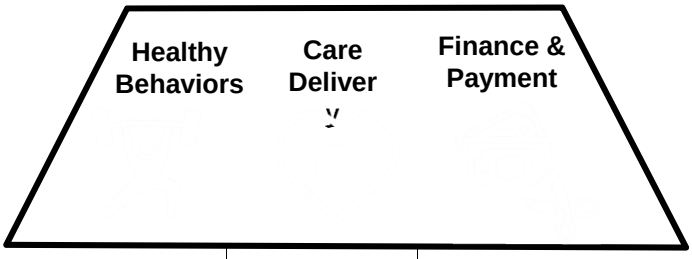
- **Insurance status | Out of pocket expense| Transportation**

**1475,000 adults 182,000 African Americans 562,000 below 200%fpl**

COLLECTIVE IMPACT ON HEALTH

COLLECTIVE IMPACT ON HEALTH

## 3 Action Areas




**Healthy Behaviors**
**Empower people to:**
- **Eat Healthy**
- **Move More**
- **Smoke Less**
- **Manage Stress**

**Care Delivery**
- **Address barriers to access**
- **Improve control and reduce prevalence of:**
  - **Obesity**
  - **Hypertension**
  - **Diabetes**
  - **COPD**
- **Improve clinical and community linkages**

**Finance & Payment**
**Rank in the lowest spending quartile for comparable communities.**
- **Reduce unnecessary and wasted care**
- **Emphasize primary care based coordination of care**
- **Empower patients to choose based on quality and affordability**

THE HEALTH GENERATION

GEN-H

GREATER CINCINNATI / N. KENTUCKY

# Position Statement

**“Good health empowers our human potential and improves our quality of life. When health is accompanied by shared accountability for efficient delivery and consumption of health care, it drives economic prosperity for individuals and for our region.”**

THE HEALTH GENERATION
GEN-H
GREATER CINCINNATI / N. KENTUCKY