

# 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

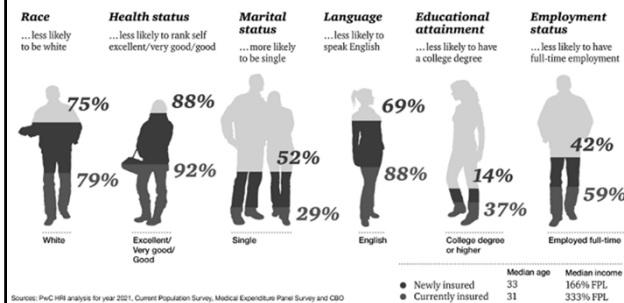
COUNTRY RANKINGS											
<div> <div>Top 2*</div> <div>Middle</div> <div>Bottom 2*</div> </div>											
	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
OVERALL RANKING (2013)	4	10	9	5	5	7	7	3	2	1	11
Quality Care	2	9	8	7	5	4	11	10	3	1	5
Effective Care	4	7	9	6	5	2	11	10	8	1	3
Safe Care	3	10	2	6	7	9	11	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 Problems	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 Primary Care Physicians; 2013 International Health Policy Survey; Commonwealth Fund National Scorecard 2011; World Health Organization; and Organisation 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?

The newly insured compared to the currently insured are...



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**“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

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/>

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

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Public Health Accreditation Board

**STANDARDS & Measures**

VERSION 1.5  
Adopted December 2013

PHAB  
Advancing public health performance

IRS

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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 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

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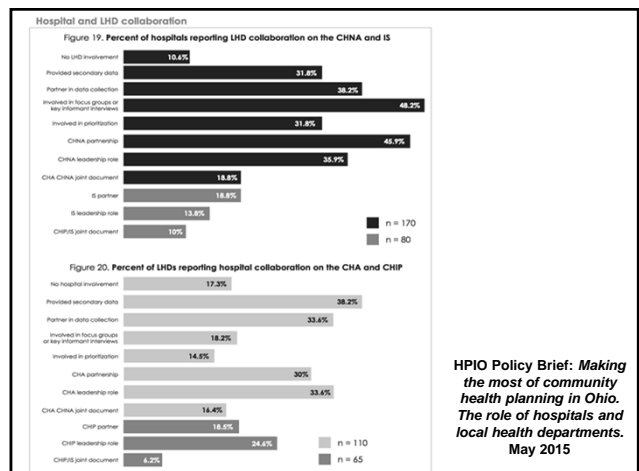
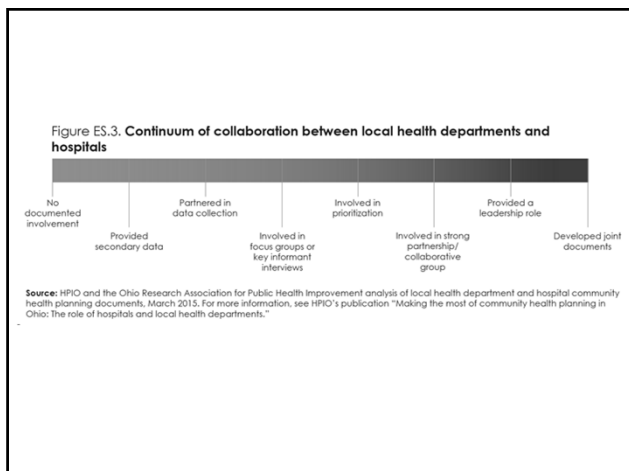
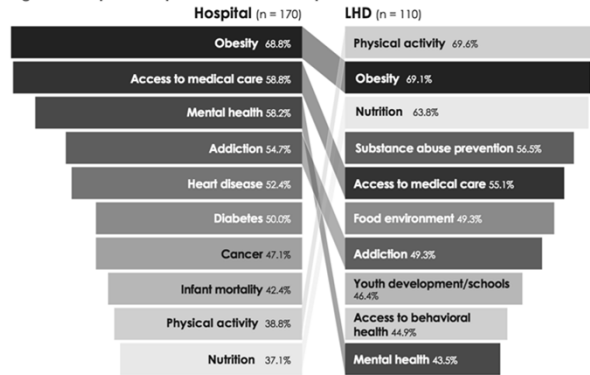


Figure 23. Top ten hospital and LHD health priorities



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

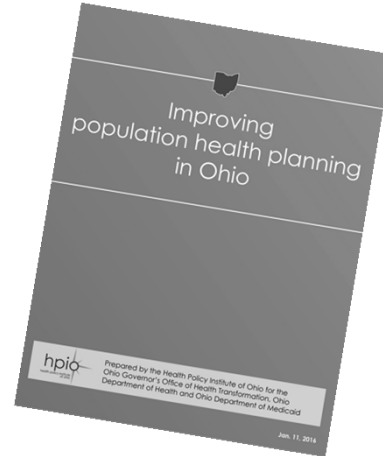


Figure 25.5. Summary of recommendations for population health planning infrastructure

Recommendation 1. State health assessment (SHA) and state health improvement plan (SHIP) and local health department and hospital assessment and plan alignment	
1a. Health priorities	State health guidance encouraging local health departments and local health departments to address at least one health priority in their plans from a menu of priorities identified in the SHIP (patterned to hospitals as SHIP-aligned priorities).
1b. Measures	State health guidance encouraging local health departments and local health departments to include at least one core metric from the SHA and SHIP in their assessments and plans for each SHIP-aligned priority.
1c. Evidence-based strategies	State health guidance encouraging local health departments and local health departments to select evidence-based strategies from a menu of strategies in the SHIP to address SHIP-aligned priorities.
Guidance issued by July 2016	
Recommendation 2. Hospital and local health department alignment	
2a. Collaboration on assessments and plans	State health guidance encouraging local health departments and local health departments in the same counties or with shared jurisdictions to partner on assessments and plans through a common: <ul style="list-style-type: none"> <li>Conceptual framework</li> <li>Process template or model</li> <li>Set of metrics (e.g., demographics, background and ethnic disparities)</li> <li>Health population cases</li> <li>Set of health priorities</li> <li>Set of objectives</li> <li>Set of evidence-based strategies that can be implemented in community-based and clinical settings</li> <li>Collaborative framework</li> <li>Accountability plan</li> <li>Exchange of data and information</li> </ul>
2b. Timeline	State requires local health departments and local health departments to align with a three-year timeline for assessments and plans. Local health department and hospital plans covering years 2020-2022 and that related assessments must be submitted to the state in 2020 and every three years thereafter (e.g., 2023, 2026, etc.).
Recommendation 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 in one county-level assessment and plan. Local health departments can pool together the additional funding to support development of multi-county collaborative assessments and plans.
3b. Hospital community benefit	Funding and documentation methodology identified by July 2016
3c. Hospital community benefit	State health guidance encouraging local health departments 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 and care and in-kind contributions.
Guidance issued by July 2016	
Recommendation 4. Transparency and accountability	
4a. Assessments and plans	State requires local health departments and local health departments submit their assessments and plans to the state. <ul style="list-style-type: none"> <li>State provides online repository of all assessments and plans.</li> </ul>
4b. Schedule it	Recommendation issued by July 2016, effective in 2017 and every three years thereafter <ul style="list-style-type: none"> <li>State requires local health departments to submit to the state their schedule and corresponding attachments, including reporting on each category of expenditures (Part 1, line 10a) and Part of the Schedule from an annual Local Government Hospital and "Hospital" as a 301(c)(3) that is not required to be submitted.</li> <li>State provides online repository of schedules and required information.</li> </ul>
Recommendation 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](http://www.practicalplaybook.org)



## What Can Collaboration Offer?

### Public Health

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



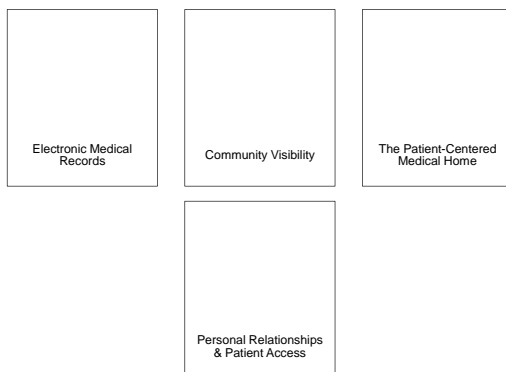
### Health Care

- 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	Public Health	Other Partners
<ul style="list-style-type: none"> <li>• Clinical Providers</li> <li>• Billing System</li> <li>• Data on Patients</li> <li>• Data Warehousing</li> </ul>	<ul style="list-style-type: none"> <li>• Portal to other community agencies</li> <li>• Epidemiological data</li> <li>• Health educators and nutritionists</li> </ul>	<ul style="list-style-type: none"> <li>• Insurance Providers</li> <li>• Social Services</li> <li>• Mental Health Services</li> <li>• Community Advocates / Councils</li> </ul>

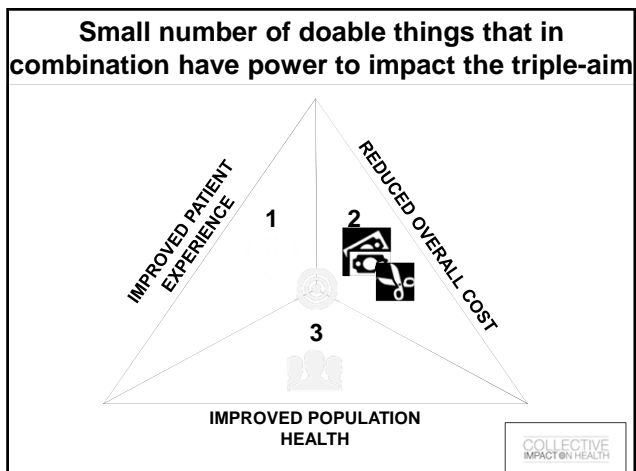


## Principles of Collective Impact

Common agenda reached through multi-stakeholder consensus

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

Shared Measurement and Accountability for Improvement

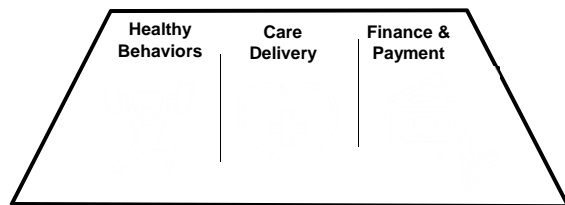


## The Value of the ReThink Model

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



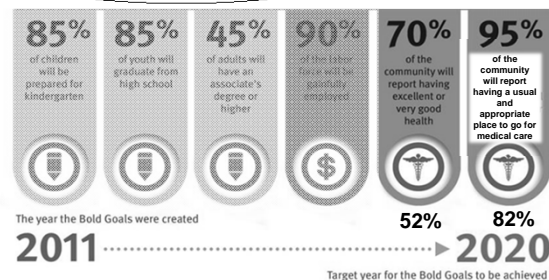
## 3 Action Areas



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 50% reduction in disparities	All Adult	African American Adult	Total Adult below 200% FPL
Current	767,000 52%*	84,000 46%	180,000 32%
To goal	+266,000 70%	+37,000 67%	+129,000 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

\*63% above 200%FPL

COLLECTIVE  
IMPACT ON HEALTH

## Access by the Numbers

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

Barriers to Access (self reported)

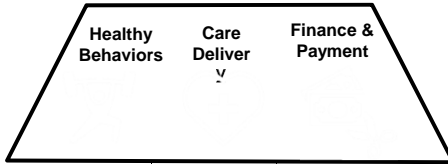
- Insurance status | Out of pocket expense | Transportation

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

COLLECTIVE  
IMPACT ON HEALTH



### 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

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