

## Office of Health Transformation **Improve Population Health Planning**

### **Governor Kasich's Budget:**

- *Aligns population health planning to improve health outcomes.*
- *Connects hospital community benefit to population health priorities.*
- *Strengthens infectious disease planning and preparedness.*
- *Focuses resources to reduce infant mortality and tobacco use.*

### **Background:**

There are 123 county and city health departments in Ohio operating at various levels of capacity. These local health districts (LHD) range from employing 2 to 275 full-time workers, from serving 6,441 to 854,975 residents, and from expending \$8 to \$232 in public health funding per resident. For 50 years, experts have been recommending better ways to organize public health. A 1960 report recommended a minimum size for LHDs, and used as examples 100,000 residents for city health departments and 50,000 residents for all other health districts.<sup>1</sup> A 1993 report recommended that LHD jurisdictions be required to have the critical mass necessary to provide core public health functions and that, in most cases, county boundaries would provide the critical mass necessary.<sup>2</sup> And a 2012 Institute of Medicine report recommended providing a “minimum package of public health services” in every community, and greater collaboration between public health and its clinical care counterparts to improve the outcomes of clinical care and the field’s contributions to population health.<sup>3</sup>

### **First Four Years:**

In 2011, the Association of Ohio Health Commissioners (AOHC) established a *Public Health Futures* project to explore new ways to structure and fund local public health. The project guided AOHC members through a critical look at the current status of local public health and a careful examination of cross-jurisdictional shared services and consolidation as potential strategies for improving efficiency and quality. Members defined the core public health services that each LHD should provide, and foundational capabilities that can be internal or accessed through cross-jurisdictional sharing. The project culminated in recommendations that linked future decisions about services, jurisdictional structure, and financing to each LHDs capacity to provide core public health services.<sup>4</sup> The report concluded that most LHDs may benefit from cross-jurisdictional sharing, but LHDs serving populations of 100,000 residents or less would particularly benefit from pursuing cross-jurisdictional sharing or consolidation.

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<sup>1</sup> Ohio Legislative Service Commission, [Organization and Financing of General Health Districts](#) (1960)

<sup>2</sup> Ohio Public Health Services Study Committee, [Healthy People, Healthy Communities](#) (1993)

<sup>3</sup> IOM, [For the Public's Health: Investing in a Healthier Future](#) (2012)

<sup>4</sup> AOHC, [Public Health Futures Final Report and Recommendations](#) (June 2012)

In response to *Public Health Futures*, Governor Kasich's Jobs Budget 2.0 (enacted in 2013) included several new initiatives designed to give public health more tools to collaborate and integrate programs. It standardized the collection and reporting of public health quality indicators from LHDs, required accreditation of all LHD's by 2020, created incentives to share services among LHDs, and required continuing education for LHD board members.

### **Executive Budget Proposal and Impact:**

The Executive Budget expands on earlier steps to improve collaboration among LHDs and creates a new opportunity through better regional planning to address Ohio's infant mortality rate, ongoing tobacco use, and chronic disease burden. The thoughtful coordination of hospital community benefit resources, for example, presents an opportunity to positively impact the health of all Ohioans. The Executive Budget proposes the following:

- ***Facilitate local health district accreditation through regional assessment and planning.*** The Executive Budget requires ODH to convene a *Population Health Planning and Hospital Community Benefit Advisory Workgroup* to recommend strategies for conducting regional community health needs assessments (CHA) and developing regional community health improvement plans (CHIP). The goal is to support LHD accreditation and align with the State Health Assessment (SHA), State Health Improvement Plan (SHIP), and State Innovation Model (SIM) population health plan. Regional CHAs and CHIPs create an opportunity to set clear population health priorities, align resources to improve outcomes, and share services to achieve better results with existing resources.
- ***Align hospital community benefit to improve population health outcomes.*** Historically, "community benefit" has been the Internal Revenue Service's (IRS) legal standard that nonprofit hospitals must satisfy in order to qualify for federal tax exemptions. In 2010, the federal government clarified community benefit requirements by establishing new standards for community health needs assessments and implementation strategies. In 2013, 171 Ohio hospitals registered as nonprofit<sup>5</sup> based on claiming \$3.12 billion in total community benefit statewide, including Medicaid losses, charity care, and special projects.<sup>6</sup> While a number of states have enacted laws setting forth additional expectations of nonprofit hospitals, including specific community benefit requirements, there are no requirements in Ohio law for nonprofit hospitals to provide a specified level of community benefit, report community benefit, conduct community health needs assessments, or develop community benefit plans or implementation strategies. The Executive Budget establishes a *Population Health Planning and Hospital Community Benefit Advisory Workgroup* to recommend what specific demonstration of community benefit should be required for a nonprofit hospital to retain tax exempt status.

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<sup>5</sup> Ohio Department of Health, [Hospital Registration Data](#) (2013)

<sup>6</sup> Ohio Hospital Association, [Community Benefit Report](#) (2013)

Specifically, the Workgroup will recommend the extent to which community benefit should be used to address prioritized population health outcomes in direct alignment with the regional CHIP. The Workgroup also will consider the potential benefit of establishing regional community health and wellness trusts to receive and distribute hospital community benefit funds, tobacco settlement funds, or other grant funds in alignment with the regional CHIP.

- **Coordinate infectious disease regional planning and preparedness.** In 2014, Ohioans were confronted with contaminated drinking water in northwest Ohio, mumps and measles record outbreaks, and the Ebola exposures that affected 19 local health districts and multiple hospital systems in northeast Ohio. A recent article in the Centers for Disease Control and Prevention’s Morbidity and Mortality Weekly Report highlighted several best practices in Ohio’s Ebola response but reiterated the need for specific planning and collaboration among public health, hospitals and first responders.<sup>7</sup> The Executive Budget provides \$2.75 million each year in 2016 and 2017 that can be used during an infectious disease outbreak or other emergency. In addition, a portion of this funding will assist LHDs and hospitals to jointly plan to ensure Ohioans are protected.
- **Monitor reductions in clinical services as a result of coverage expansions** ODH contracted with Mathematica to evaluate the impact of extending Medicaid coverage and the creation of Marketplace Exchanges on services provided by the department. In a December 2014 report, Mathematica concluded that population that have benefited from several ODH programs will gain insurance or Medicaid that will cover many of the services the ODH programs have provided with state and federal funds. Because ODH is the payer of last resort, Mathematica estimates that moving Ohioans to coverage will reduce the need for ODH spending in the Children with Medical Handicaps Program (\$6.8 million less required), Ryan White HIV/AIDS Part B Program (\$6.8 to \$8.6 million less required), Breast and Cervical Cancer Project (\$823,000 less required), and other Bureau of Child and Family Health Services programs (\$609,400 less required). Also, because immunizations are now an essential health benefit that insurance is required to cover, Mathematica estimated reduced spending by the ODH Immunization Program (\$8.8 million less required). Although ODH will prioritize getting these Ohioans connected to a regular source of insurance coverage, the Executive Budget does not reduce funding for these programs in order to ensure that no Ohioans go without needed services during this transition period. For the next two years ODH will monitor actual utilization levels and, if increased access to insurance results in less demand for these programs, adjust future funding levels accordingly. This approach has no impact on the budget because it flat-funds the programs described above with one exception, immunizations as described below.
- **Require local health districts to bill for immunizations.** ODH currently encourages local health districts (LHDs) to bill Medicaid or private insurance for eligible services to reduce

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<sup>7</sup> CDC MMWR, [Response to Importation of a Case of Ebola Virus Disease, Ohio](#) (November 2014)

their need for general revenue funds. In addition, AOHC has been working with LHDs to ensure they have the capability to bill for services, specifically immunizations. The Executive Budget requires ODH to notify LHDs that the state will no longer provide GRF-funded vaccines beginning on January 1, 2016. ODH will provide funding for vaccines for the first half of FY 2016 (June 1-December 31, 2015) so LHDs can build up their inventory upon which to conduct this billing. This provision reduces immunization program spending \$2.8 million in 2016 and holds funding flat in 2017.

- ***Leverage better public health planning to address specific health challenges.*** In addition to the activities described above, the Executive Budget also includes several major initiatives to improve specific health outcomes. It focuses on reducing infant mortality by providing enhanced maternal services through Medicaid health plans for every woman in neighborhoods most at risk for poor infant health outcomes, and requires Medicaid health plans to engage leaders from within high-risk neighborhoods to connect women to health care and other services (see *Reduce Infant Mortality*). It also commits Tobacco Master Settlement Agreement funds to launch a significant new campaign to reduce tobacco use (see *Reduce Tobacco Use*). These initiatives are complex and require collaboration across multiple entities and levels of government. Better public health planning, as proposed in the budget, will assist to leverage these activities to their fullest potential.

*Updated February 2, 2015*