

Value

Costs



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

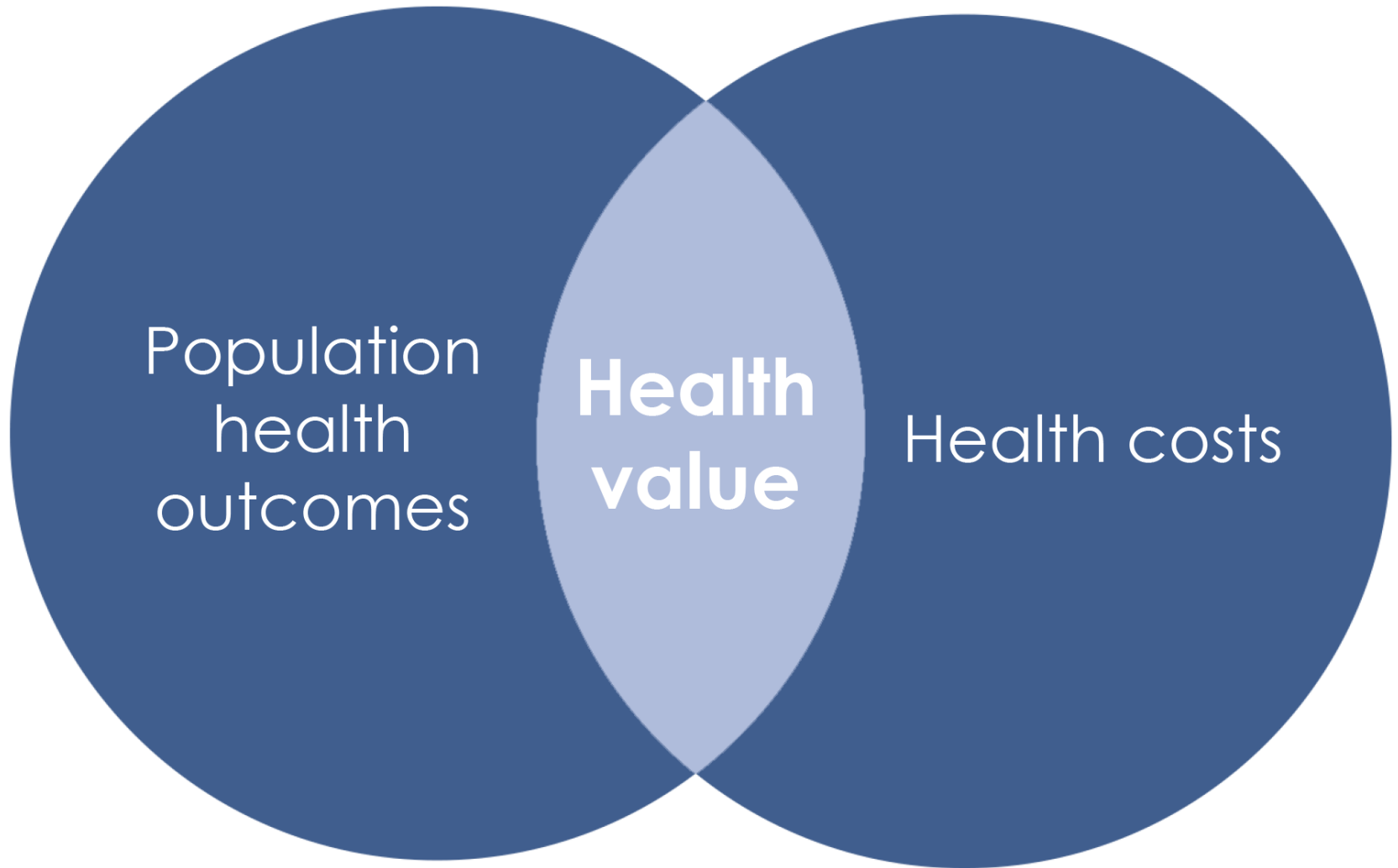
Value

Costs

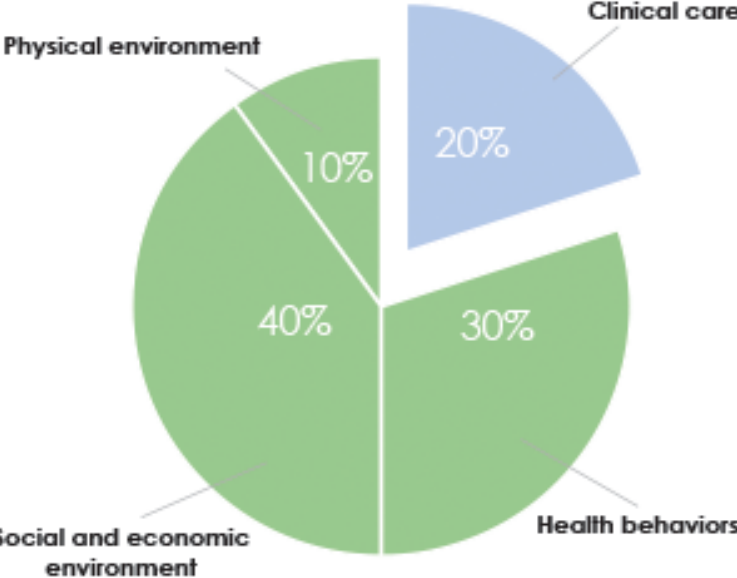


2014  
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Value  
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# What is health value?

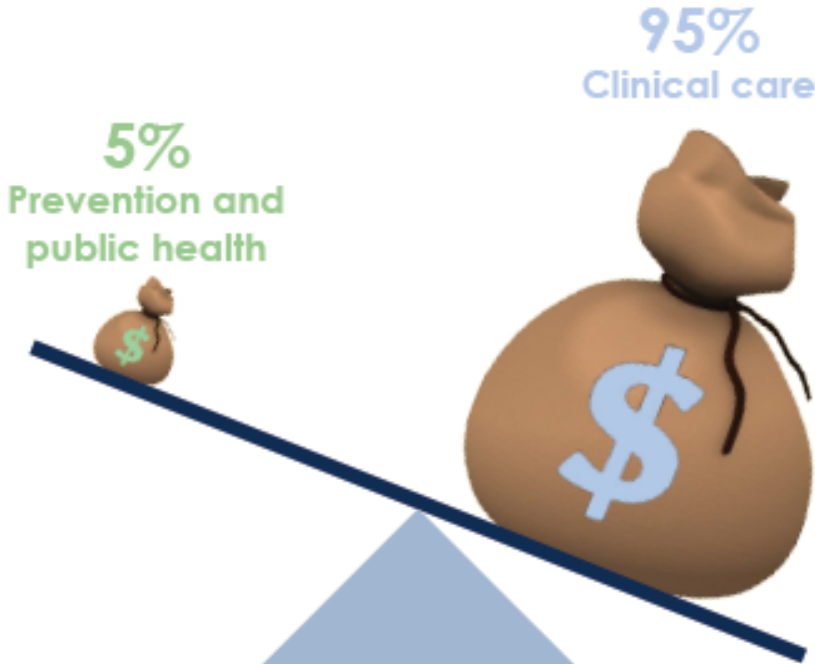


# Factors that influence health



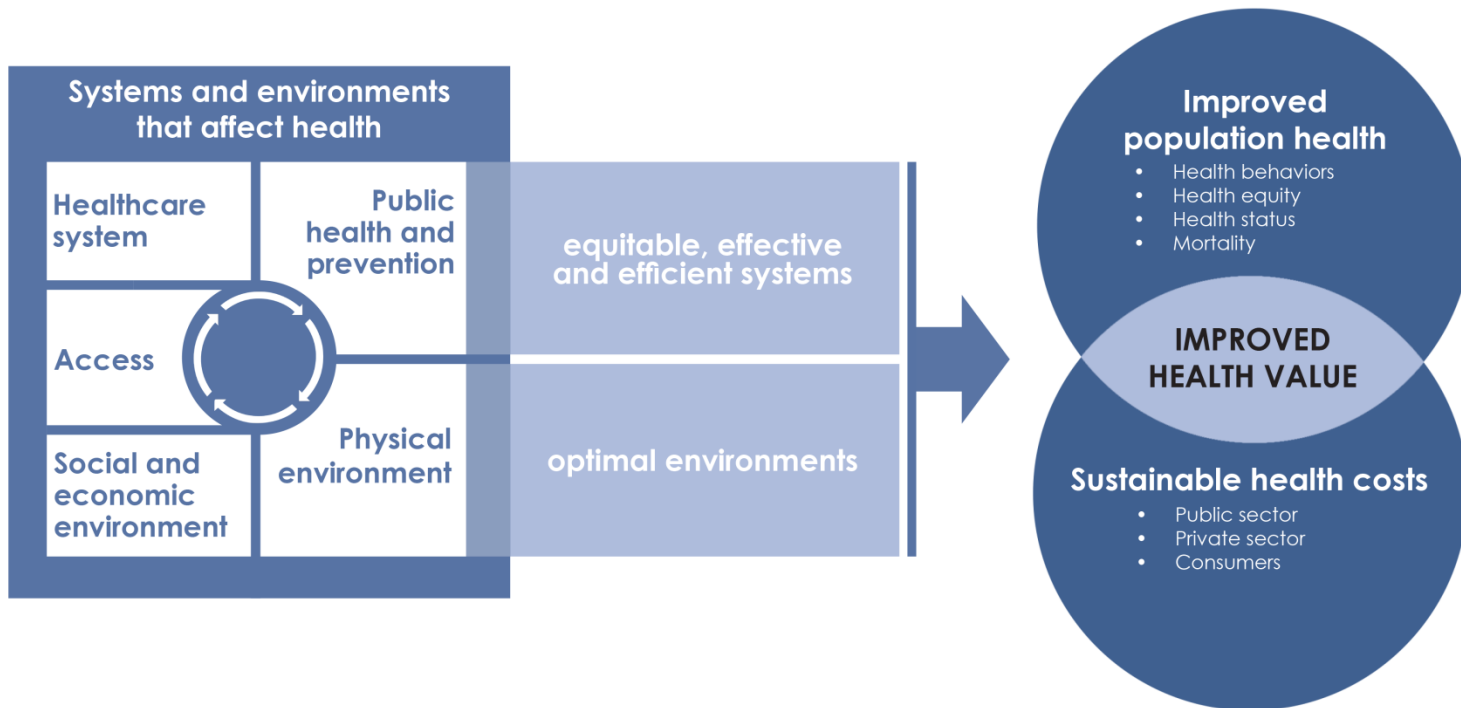
Source: County Health Rankings and Roadmaps

# 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?

	America's Health Rankings	Commonwealth Scorecard	County Health Rankings	Kaiser State Health Facts	Gallup-Healthways Wellbeing Index	RWJ DataHub	Network of Care	HP/O
Primary format	Interactive & AI-a-glance	Interactive & AI-a-glance	Interactive	Interactive	AI-a-glance	Interactive	Interactive	AI-a-glance (Phase I)
Population health	Adequately covered	Adequately covered	Adequately covered	Adequately covered	Adequately covered	Adequately covered	Adequately covered	Adequately covered
Healthcare costs	Not covered	Minimally covered	Not covered	Adequately covered	Not covered	Adequately covered	Not covered	Adequately covered
Healthcare system	Adequately covered	Adequately covered	Adequately covered	Adequately covered	Not covered	Adequately covered	Adequately covered	Adequately covered
Access	Adequately covered	Adequately covered	Adequately covered	Adequately covered	Adequately covered	Adequately covered	Adequately covered	Adequately covered
Social and economic environment	Adequately covered	Not covered	Adequately covered	Adequately covered	Adequately covered	Adequately covered	Adequately covered	Adequately covered
Physical environment	Adequately covered	Not covered	Adequately covered	Not covered	Adequately covered	Not covered	Adequately covered	Adequately covered
Public health and prevention	Minimally covered	Not covered	Not covered	Not covered	Not covered	Minimally covered	Minimally covered	Adequately covered
Health value	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Adequately covered

= adequately covered
  = minimally covered
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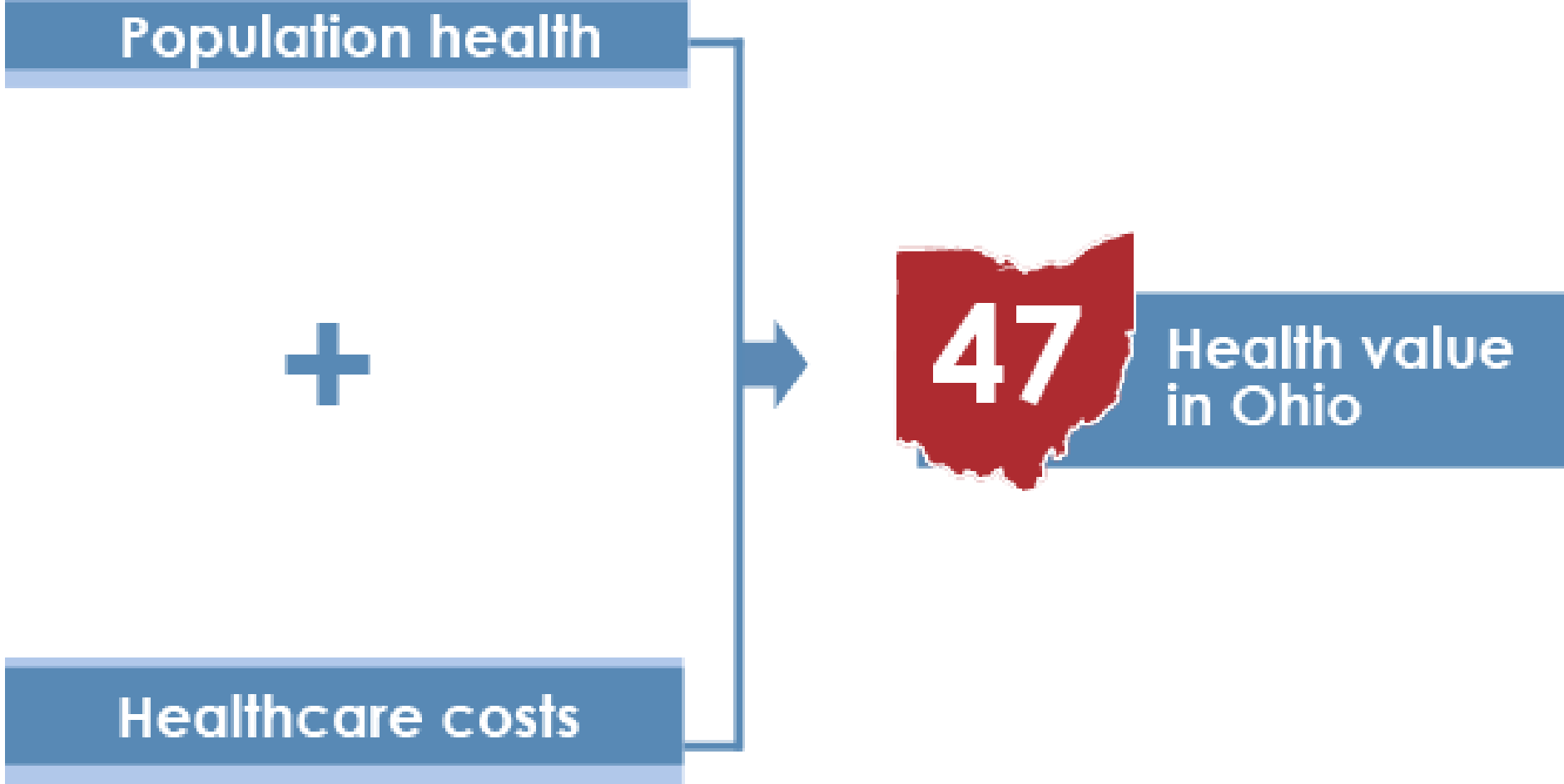
# Dashboard

- ✓ 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 47<sup>th</sup> on health value



# HPIO Health Value Dashboard, Overview

**40** 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\*:

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

**40** 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\*:

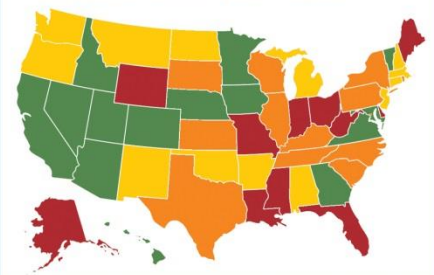
- 35 Total spending** Overall healthcare spending per capita and spending growth
- 32 Employer costs** Average premiums for single adults and families
- 23 Consumer costs** Commercial health spending per enrollee and out of pocket spending
- 49 Medicare spending** Spending per enrollee and spending growth

**47** Health value in Ohio

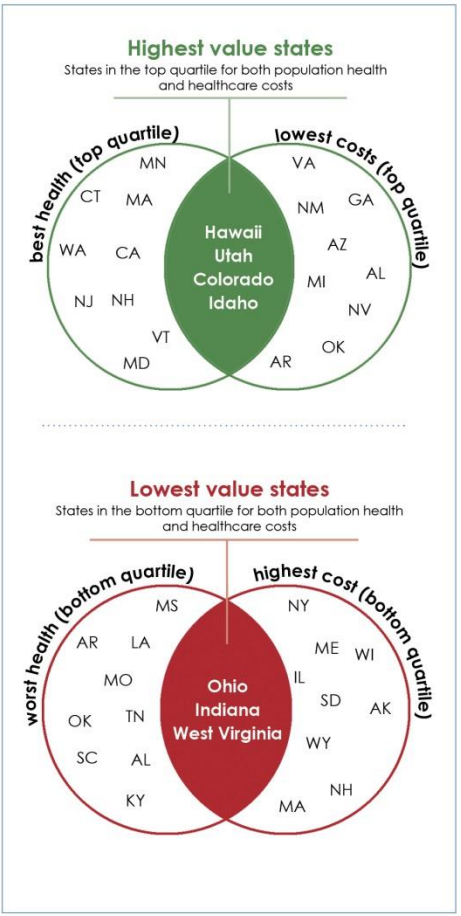
**We are not getting good value for our healthcare dollar.**  
 Ohio ranks 47th on a composite measure of health value—the combination of healthcare costs and population health, weighted equally.

Health + Cost = Value

Where states rank in health value...



**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.

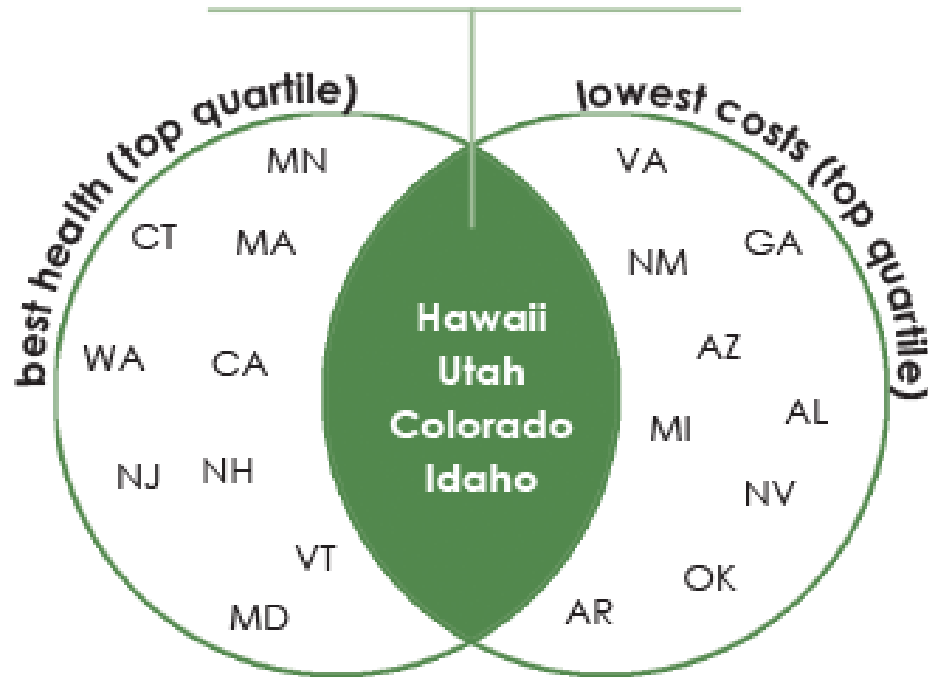


**Note:** Rankings for the above domains are based on most-recently available data from 2008 to 2013. A ranking of 1 is the best and 51 is the worst.  
 \*The overall domain rank (e.g. healthcare costs) is the composite of the sub-domain ranks (e.g. total and employer). The subdomain ranks are the composite of the ranks for the individual metrics (e.g. healthcare spending per capita).

# How do we compare to other states?

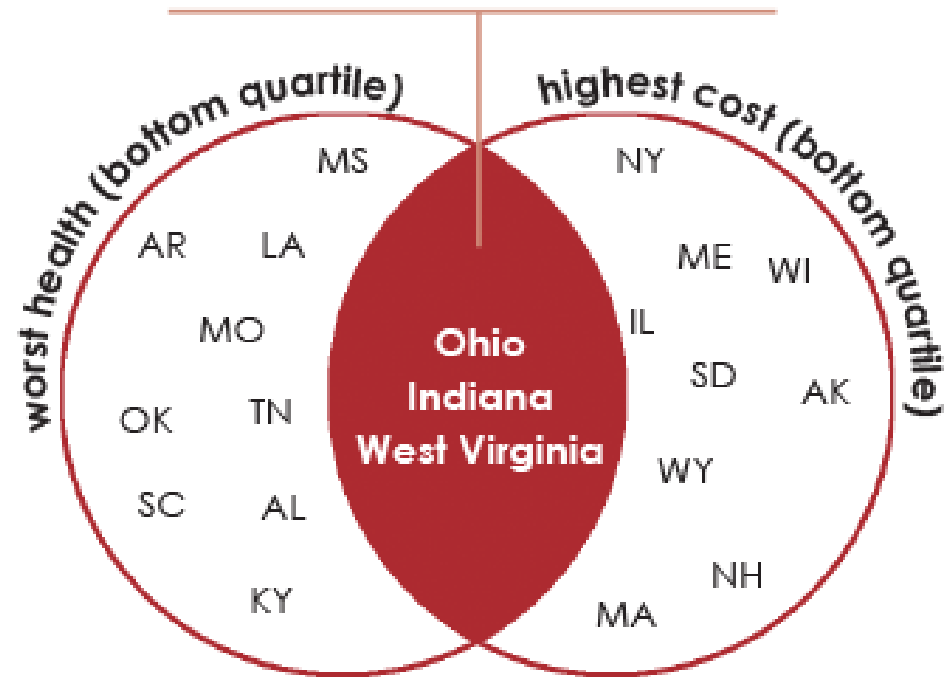
## Highest value states

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



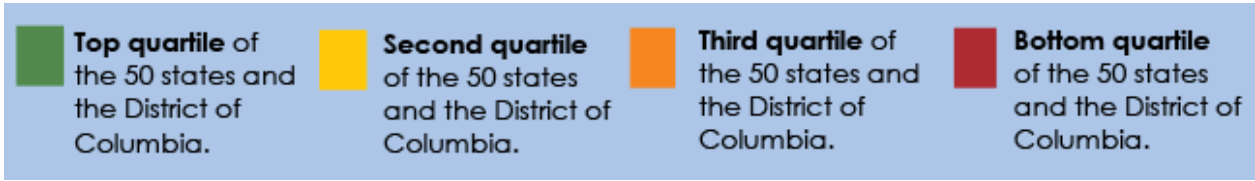
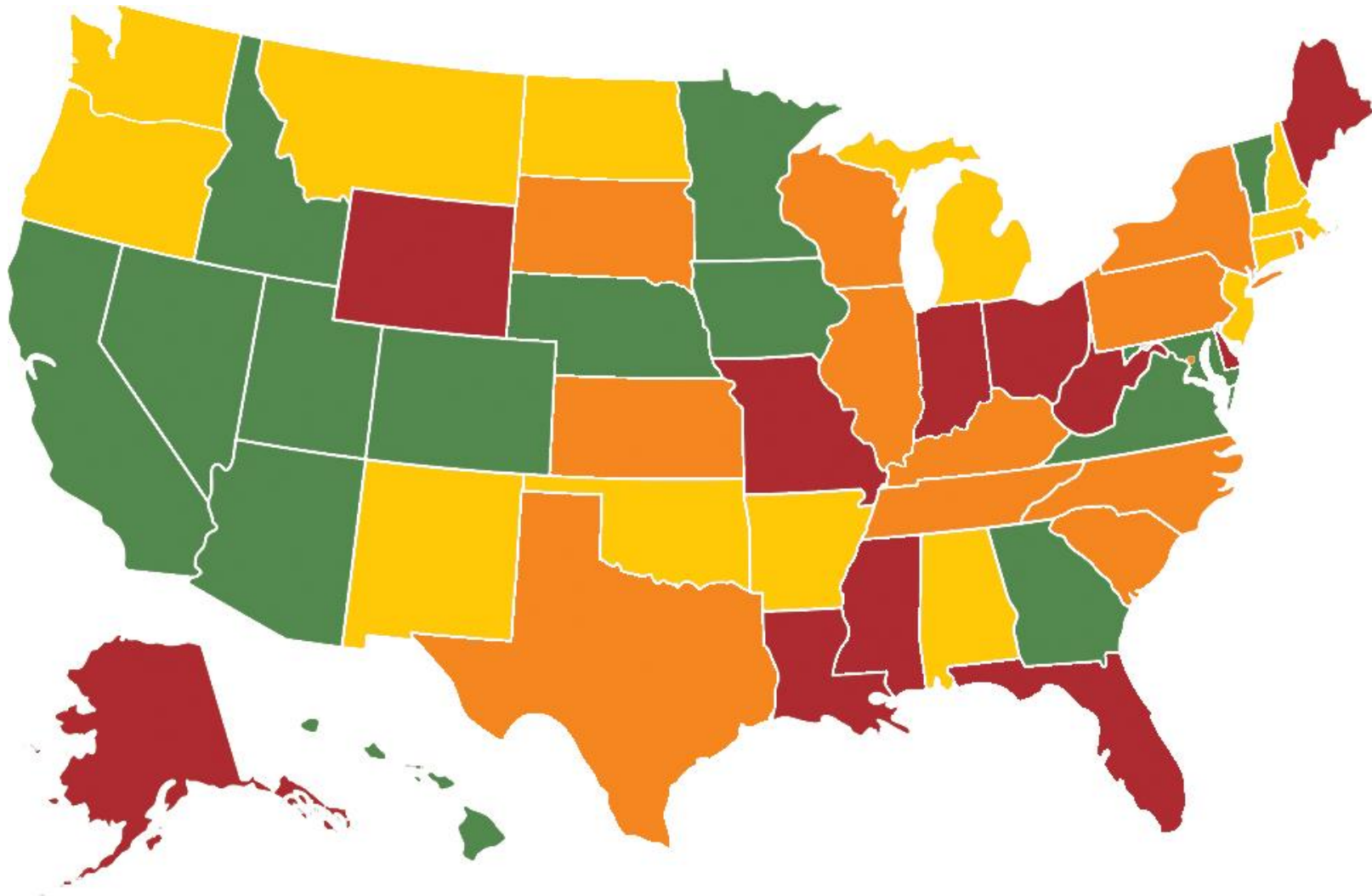
## Lowest value states

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

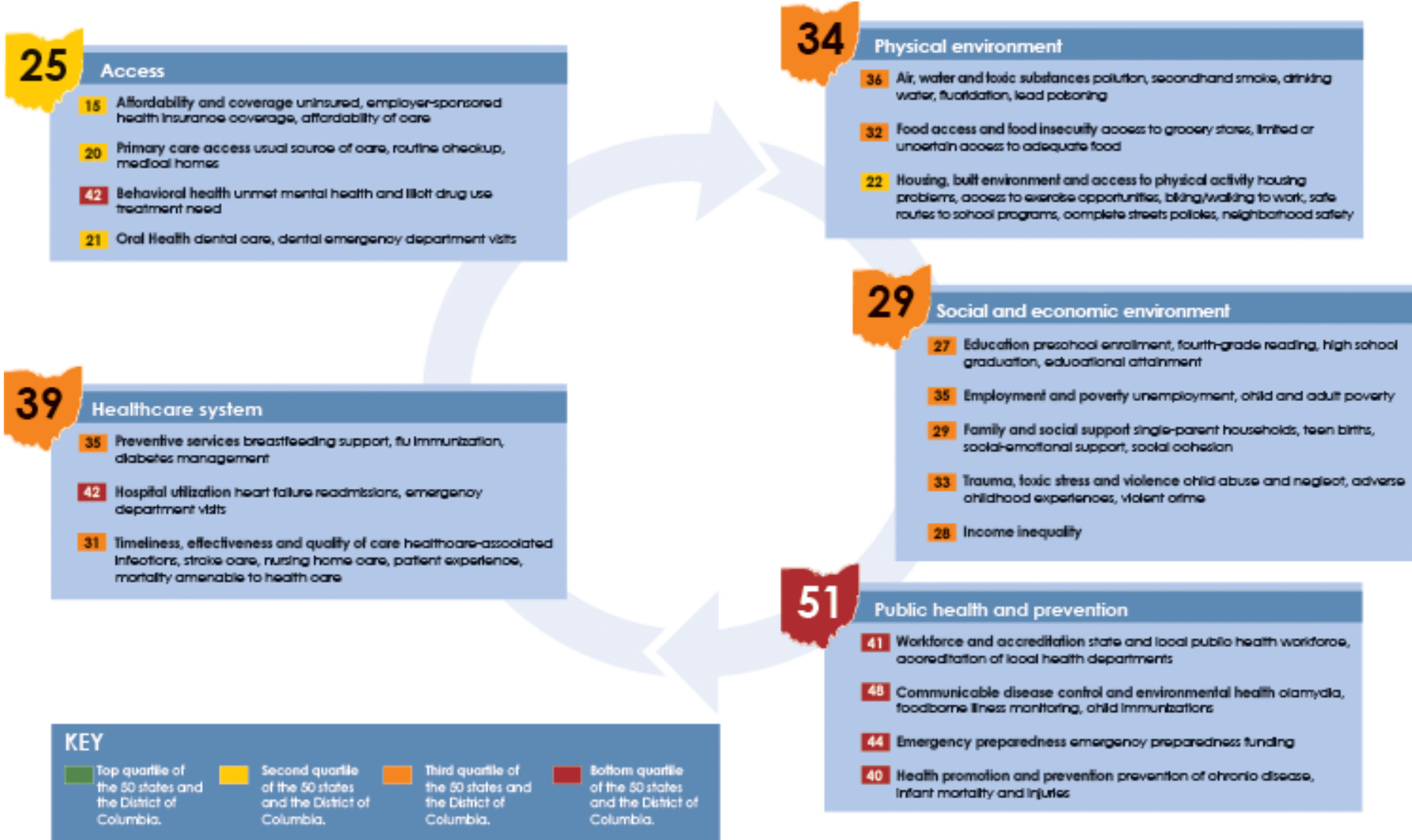




# State comparison on health value



# Why does Ohio rank so poorly?



# Snapshot of health challenges and strengths

**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	<b>Adult smoking</b> Percent of adults who are current smokers	44	23.4%	10.3% UT
	<b>Adult diabetes</b> Percent of adults diagnosed with diabetes	46	11.7%	7% AK
	<b>Infant mortality</b> Infant deaths per 100,000 population	47	7.69	3.8 AK
Healthcare system	<b>Avoidable emergency department visits for Medicare beneficiaries</b> Potentially avoidable emergency department visits among Medicare beneficiaries, per 1,000 beneficiaries	44	215	129 HI
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	<b>Child immunization</b> Percentage of children ages 19 to 35 months who have received vaccinations	48	61.7%	82.1% RI
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Access	<b>Unmet need for illicit drug use treatment</b> 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
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	<b>Secondhand smoke</b> 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	<b>Accreditation of local health departments</b> Percent of LHDs that have received accreditation (March 2013 to Sept. 2014)	11	3.2%	10% LA
Access	<b>Employer-sponsored health insurance coverage</b> Percent of all workers who work at a company that offers health insurance to its employees	11	86.8%	96.7% HI
Physical environment	<b>Safe drinking water</b> Percent of population exposed to water exceeding a violation limit during the past year	10	3%	0% DC
	<b>Fluoridated water</b> Percent of the population served by a community water system with optimally fluoridated water	12	92.2%	100% DC
	<b>Severe housing problem</b> Percent of households with problems such as severe overcrowding or costs that exceed 50% of monthly income	13	15%	11% ND



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	None	Education Employment and poverty Family and social support Trauma, toxic stress and violence Inequality	None
Physical environment	None	Air, water and toxic substances Food access and food insecurity Housing, built environment and access to physical activity	None

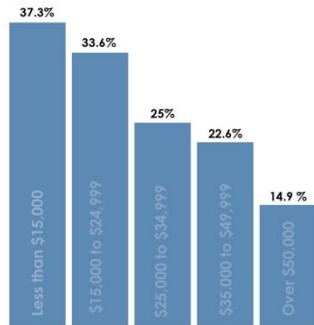
\* Ohio does not rank in the top quartile for any subdomains. 5



# 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**



Source: CDC, BRFSS

### A closer look

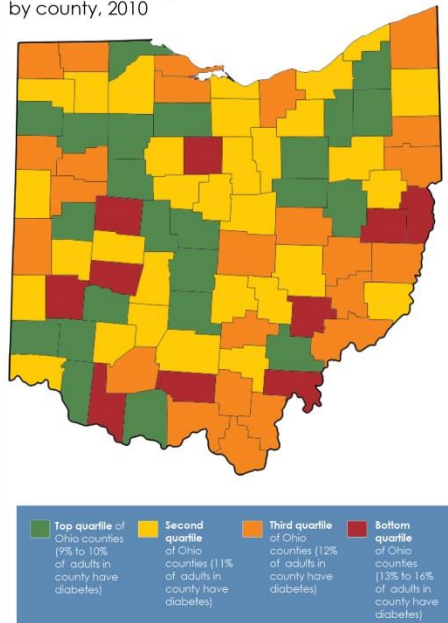
Additional data for many of the metrics included in this dashboard by race/ethnicity, income and education levels, age and local geography is available from the following websites: [Commonwealth Scorecard on Health System Performance \(state and local versions\)](#), [Network of Care](#), [RWJF DataHub](#)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

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



Source: Ohio Department of Health

**Adult Ohioans diagnosed with diabetes, by county, 2010**



Source: CDC, BRFSS, as compiled by County Health Rankings and Roadmaps

# Factors impacting health and costs

39

## Healthcare system

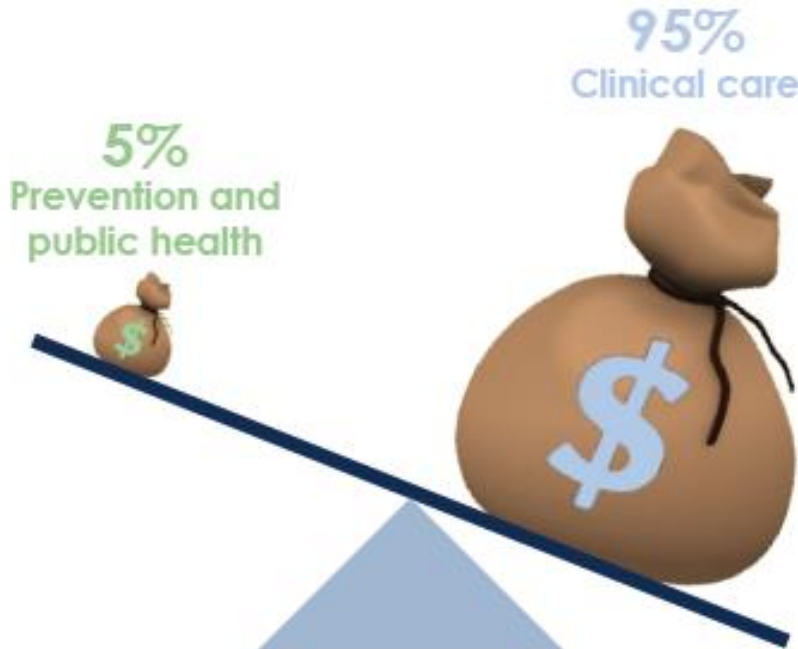
- 35 Preventive services breastfeeding support, flu immunization, diabetes management
- 42 Hospital utilization heart failure readmissions, emergency department visits
- 31 Timeliness, effectiveness and quality of care healthcare-associated infections, stroke care, nursing home care, patient experience,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

51

## Public health and prevention

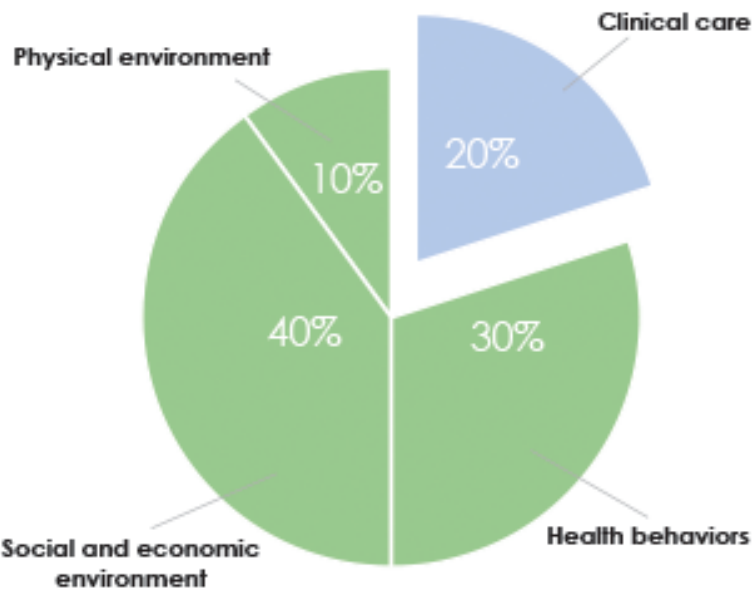
- 41 Workforce and accreditation state and local public health workforce, accreditation of local health departments
- 49 Communicable disease control and environmental health chlamydia, foodborne illness monitoring, child immunizations
- 44 Emergency preparedness emergency preparedness funding
- 40 Health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

## Health spending



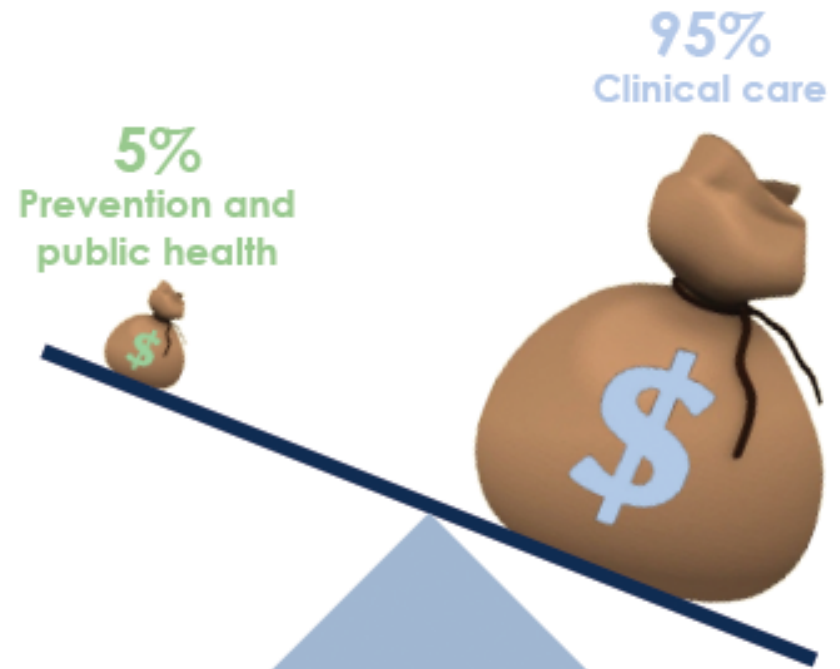
Source: McGinnis, 2002

## Factors that influence health



Source: County Health Rankings and Roadmaps

## Health spending



Source: McGinnis, 2002

# Online *Dashboard* tools

The screenshot shows the HPIO website dashboard. At the top left is the HPIO logo with the tagline "Lead. Inform. Improve." and the text "health policy institute of ohio". To the right is a search bar labeled "Search HPIO" with a magnifying glass icon. Below the search bar are social media icons for Facebook, Twitter, and LinkedIn. A horizontal navigation menu contains buttons for "Home", "About", "Publications", "Tools", "Events", "Projects", and "Groups". Below the navigation menu is a banner for "Voices on Value" with the subtitle "An online commentary series on improving health value". The main content area is divided into two columns. The left column is titled "Downloads" and lists several resources: "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)", and "Domain profiles". Below this list is a link: "Click below for one-page profiles of the seven health value domains:". The right column is titled "A closer look" and contains text: "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:". Below this text is a bulleted list of sources: "Commonwealth Scorecard on Health System Performance (state and local versions)", "Network of Care", "RWJF DataHub", and "County Health Rankings and Roadmaps". At the bottom of this column is a link: "Click here for a crosswalk that indicates which dashboard metrics are available from these sources."

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**Voices on Value**  
An online commentary series on improving health value

## 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)**
- **Domain profiles**

Click below for one-page profiles of the seven health value domains:

## A closer look

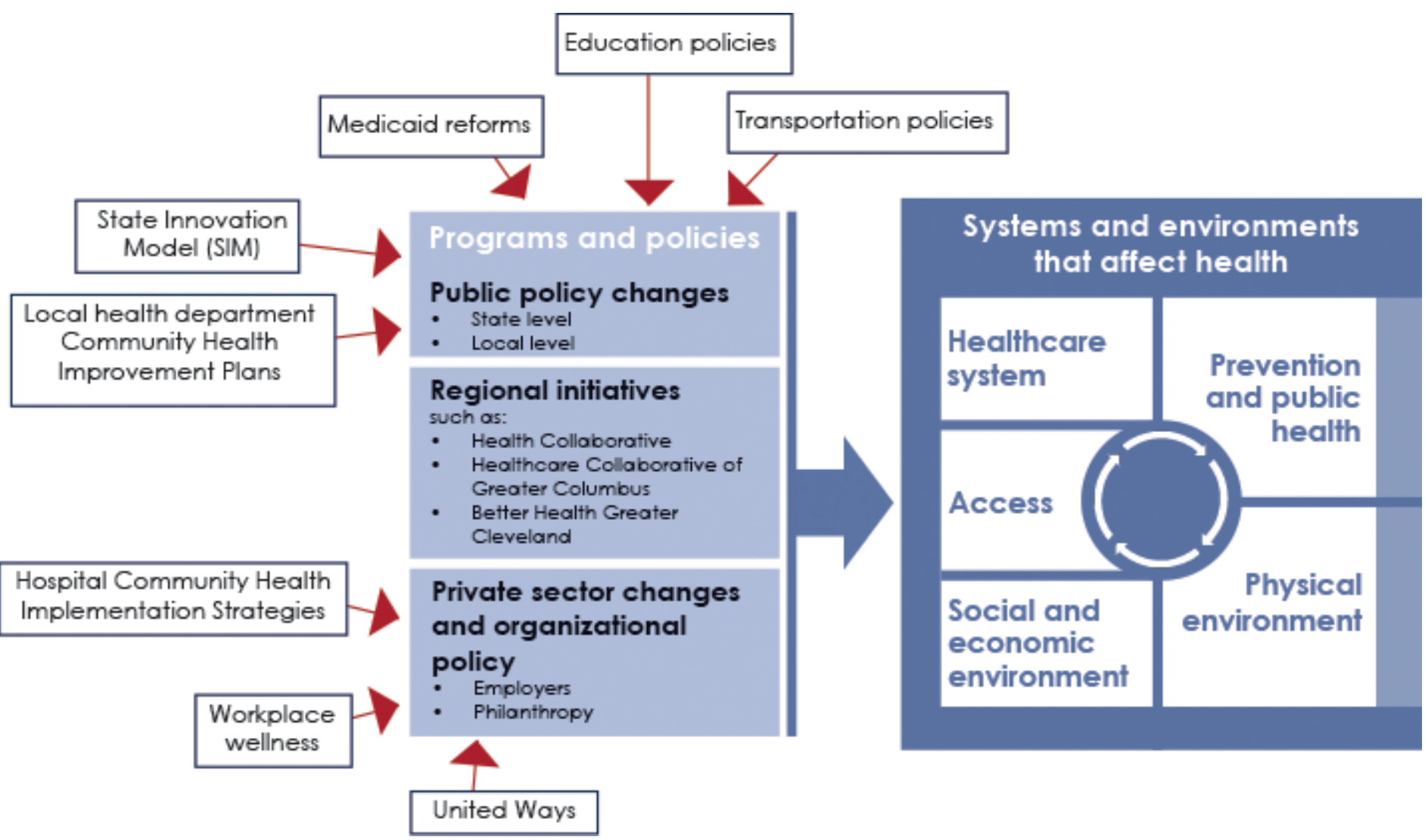
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# High priorities

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





# Health Policy Brief

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.<sup>1</sup>

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.<sup>2</sup> 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.<sup>3</sup>

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

#### 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.<sup>4</sup>
- Ohio's youth tobacco use rate (21.7%) is slightly below the national rate (22.4%).<sup>5</sup> 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.<sup>6</sup>
- Tobacco use is particularly high among Medicaid enrollees and other Ohioans with mental illness or other disabilities. Almost half of working-age Medicaid enrollees were current smokers in 2012.<sup>7</sup>
- Researchers estimate that 15% of Medicaid costs are attributable to cigarette smoking.<sup>8</sup>

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.

# Health Policy Brief

## Mapping accountability to improve Ohio's performance on tobacco use

The majority of adult cigarette smokers (69%) report they want to stop smoking!<sup>1</sup> Yet, tobacco use is the leading cause of preventable death and disease in the U.S. and a significant contributor to high healthcare costs.<sup>2</sup> Researchers estimate that 8.7% of annual aggregated healthcare spending in the U.S. is associated with cigarette smoking – amounting to \$169.3 billion.<sup>3</sup> 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.<sup>4</sup>

Ohio ranks 44th for adult cigarette smoking and 49th for secondhand smoke exposure for children. Ohio has higher tobacco use rates than most other states.<sup>5</sup>

Public and private entities responsible for tobacco use for Ohioans have made progress in improving Ohio's performance. However, progress can be improved. Public health and tobacco use accountability for set-aside tobacco use.

Health Policy Brief: Tobacco Use: Implications by Demographic

### Tobacco use in Ohio at a glance

23.4% of Ohio adults smoked cigarettes in 2013 ...

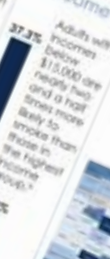


well above the Healthy People 2020 goal of 12%.<sup>6</sup> There are large disparities in tobacco use across demographic groups in Ohio.

#### Education



#### Income



#### Geography

Smoking prevalence is higher (darker shading) in Appalachian counties as well as some north-central counties in Ohio.<sup>9</sup>

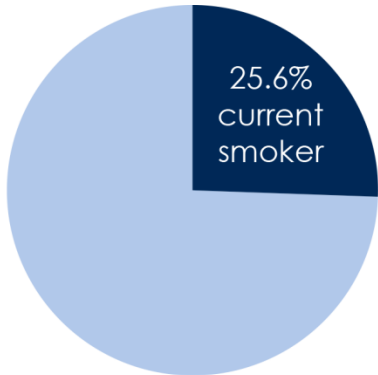


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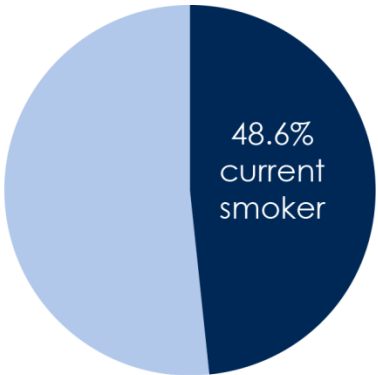
#### Disability status<sup>11</sup>



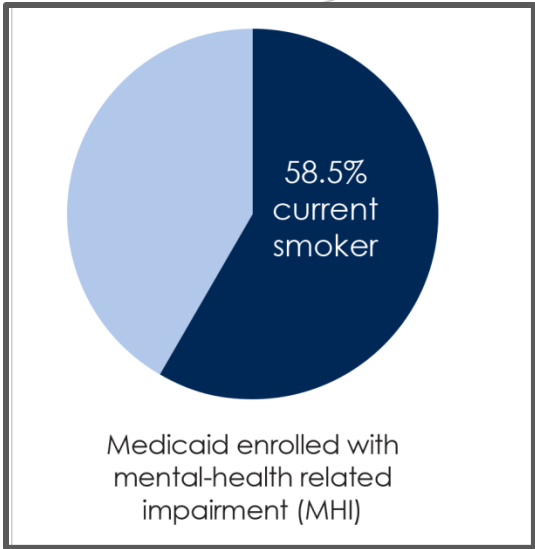
# Current cigarette smoking among Medicaid-enrolled adults (age 19-64) in Ohio, 2012



Not Medicaid enrolled



Medicaid enrolled



Medicaid enrolled with mental-health related impairment (MHI)

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

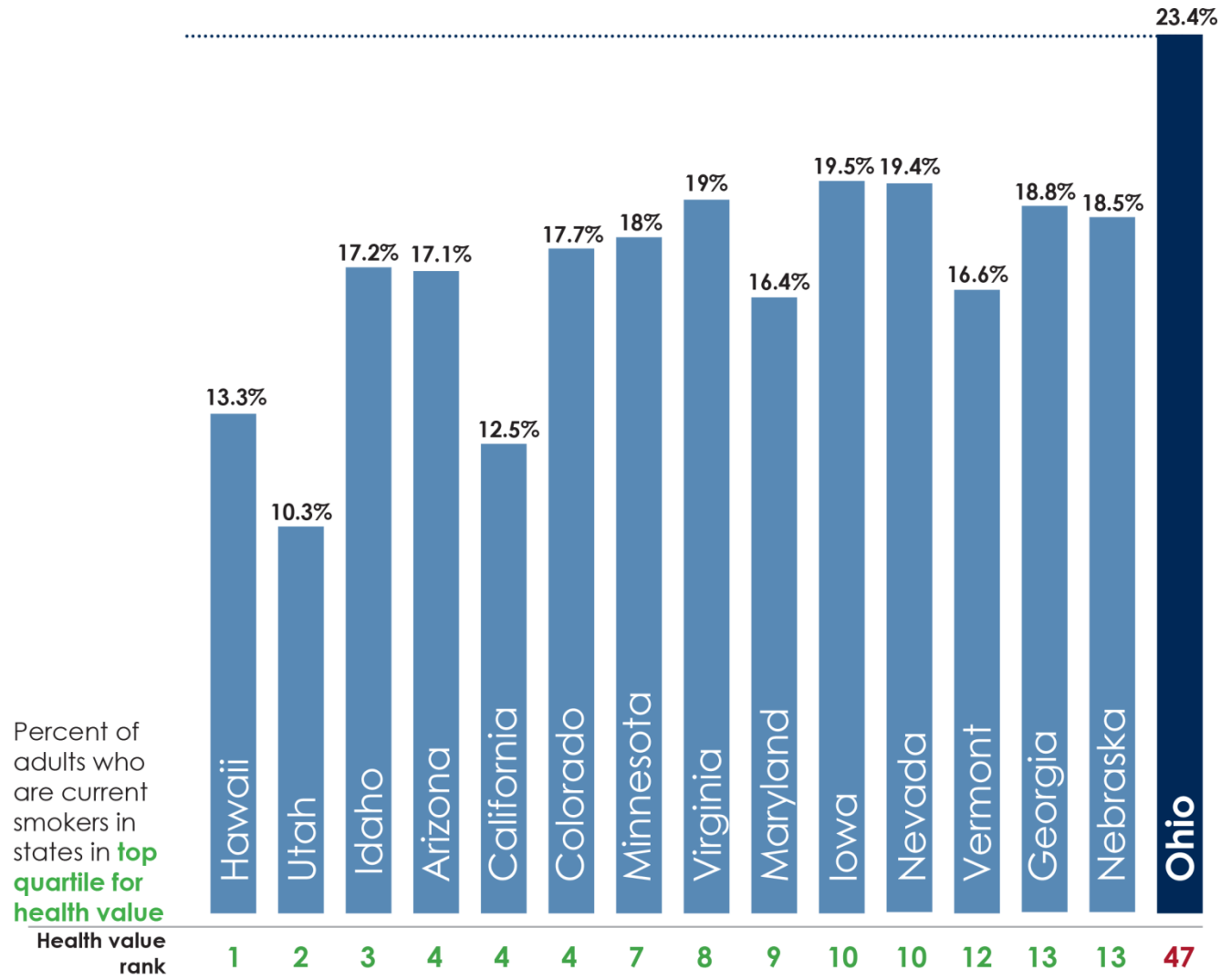
## Ohio's greatest health challenges

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# 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

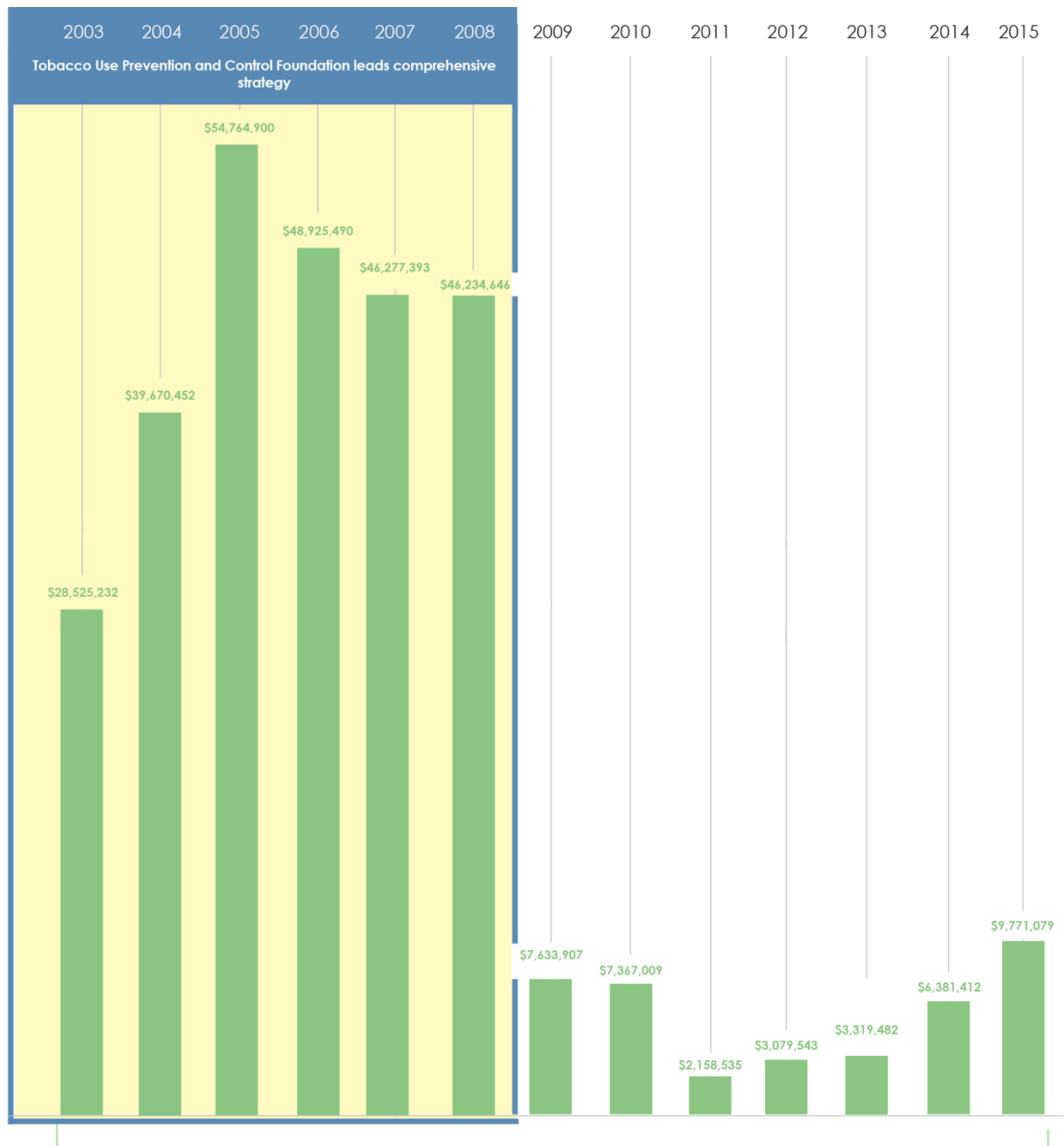
## for Comprehensive Tobacco Control Programs

2014

National Center for Chronic Disease Prevention and Health Promotion  
Office on Smoking and Health



# Tobacco prevention and control funding in Ohio, 2003-2015



Total tobacco prevention and control spending in Ohio (master settlement agreement, state and CDC sources), by State Fiscal Year

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).



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# Accountability map



## Health Policy Brief

June 2013

# Mapping accountability to improve Ohio's performance on tobacco use

The majority of adult cigarette smokers (69%) report they want to stop smoking.<sup>1</sup> Yet, tobacco use is the **leading** cause of preventable death and disease in the U.S. and a significant contributor to high healthcare costs.<sup>2</sup> Researchers estimate that 8.7% of annual aggregated healthcare spending in the U.S. is associated with cigarette smoking – amounting to \$169.3 billion.<sup>3</sup> 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.<sup>4</sup>

Ranked 44th for adult cigarette smoking and 49th for secondhand smoke exposure for children, Ohio has higher tobacco use rates than most other states.<sup>5</sup>

There are many public and private entities vested 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: An environmental scan and policy implications* by providing policymakers and other stakeholders with an understanding of how tobacco-related measures are tracked in Ohio and what, if any, mechanisms are in place to ensure accountability for improving Ohio's performance. To do this, HPIC developed a tobacco measurement accountability map, constructed around three primary objectives:

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

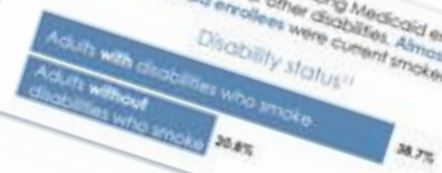
### Tobacco use in Ohio at a glance



### 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.<sup>9</sup>



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

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

## Tracks

one or more tobacco-related measures

## Required to track

one or more tobacco-related measure (external organization requiring reporting)

## Measurable objectives

(i.e. targets or benchmarks) set by an external organization or state-level plan

## Penalty or reward

for meeting set objectives (i.e. targets or benchmarks)

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

## Tracks

one or more tobacco-related measures

## Required to track

one or more tobacco-related measure (external organization requiring reporting)

## Measurable objectives

(i.e. targets or benchmarks) set by an external organization or state-level plan

## Penalty or reward

for meeting set objectives (i.e. targets or benchmarks)

**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**



Process

Outcome



Patient-level data

Population-level data

Screened for tobacco use

Received cessation services

Quit tobacco use

Abstained from tobacco 3-12 months

HPIO Health Value Dashboard

Population health

10 entities tracking



3 held accountable\*

9 entities tracking



3 held accountable\*

1 entity tracking



0 held accountable\*

1 entity tracking



0 held accountable\*

4 entities tracking



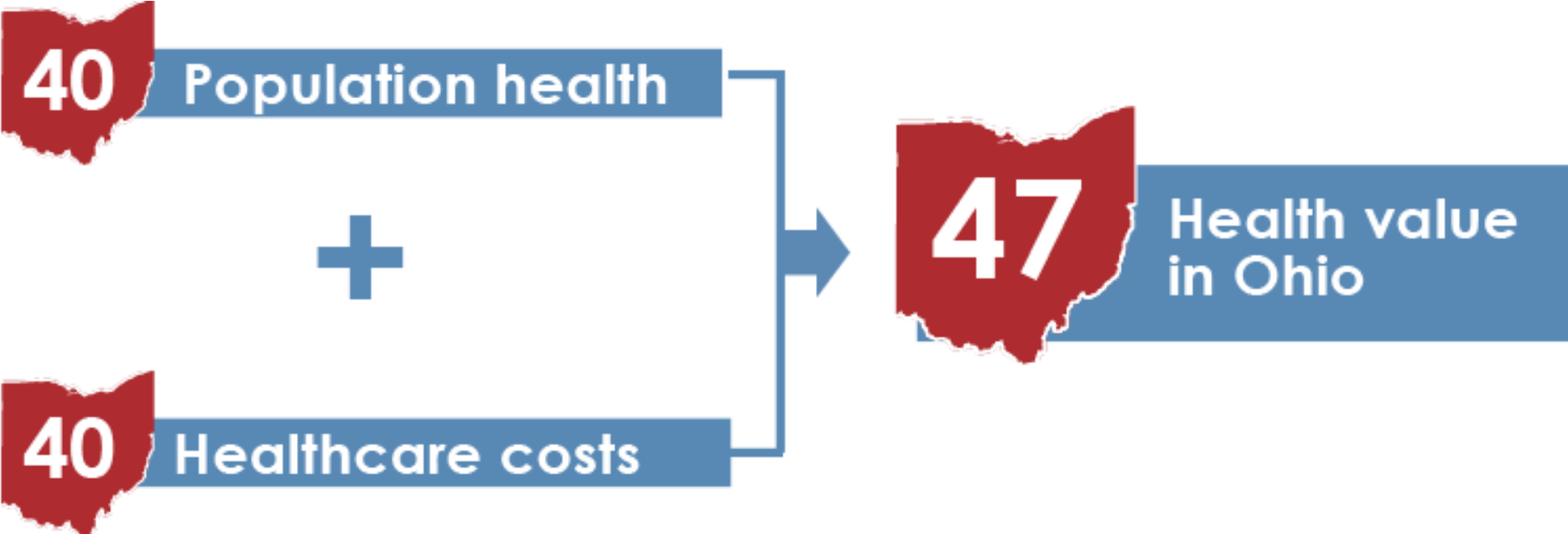
0 held accountable\*

Adult smoking Percent of adults who are current smokers

\* Held accountable by penalty, incentive or accreditation requirements for meeting specific targets



# Ohio ranks 47<sup>th</sup> 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.

HEALTH IMPROVEMENT  
**hip**  
cuyahoga

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Community Health  
Status Assessment for  
Cuyahoga County, Ohio



Community Health Needs Assessment  
Implementation Plan 2013



The  
**Christ Hospital**<sup>™</sup>  
Health Network

## 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

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  
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 relating to the  
collection of information in the  
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 estimate,  
the Treasury Department received 15 comments  
that the collection of information

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  
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 would increase  
that burden. However, the commenter  
of time spent on these activities was



**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):**

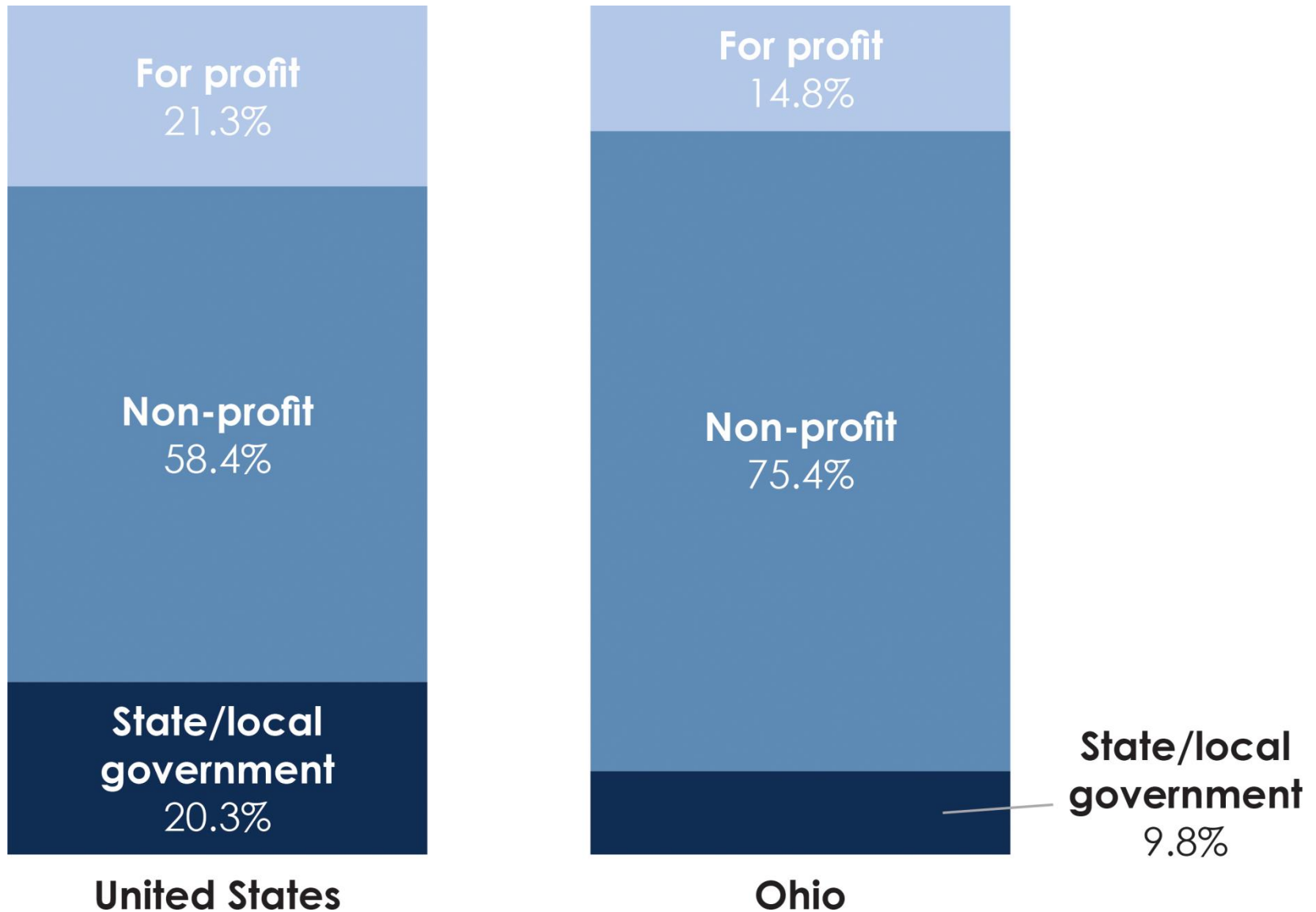
**Community Health Needs Assessment**

- 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
  - b**  Demographics of the community
  - c**  Existing health care facilities and resources within the community
  - d**  health needs of the community
  - e**  How data was obtained
  - f**  The significant health needs of the community
  - g**  Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups
  - h**  The process for identifying and prioritizing community health needs and services to meet the community health needs
  - i**  The process for consulting with persons representing the community's interests
  - j**  Information gaps that limit the hospital facility's ability to assess the community's health needs
  - k**  Other (describe in Section C)

	Yes	No
<b>1</b>		
<b>2</b>		
<b>3</b>		



# 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



A close-up photograph of two hands holding two interlocking blue puzzle pieces. The puzzle pieces are a vibrant blue color and have a textured surface. The hands are positioned on the left and right sides of the frame, with fingers gripping the edges of the pieces. The background is a plain, light-colored surface.

**Hospitals**

**Local health  
departments**



**Hospitals**

**Local  
health  
departments**

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

**124** local health departments  
(as of September, 2014)

**170**  
CHNAs

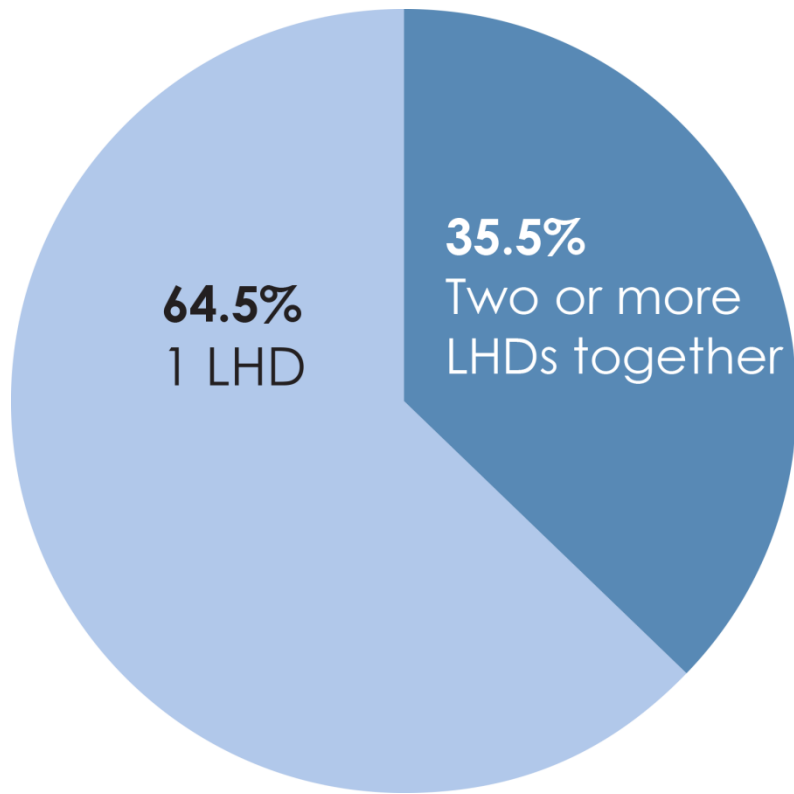
**110**  
CHAs

**80**  
ISs

**65**  
CHIPs

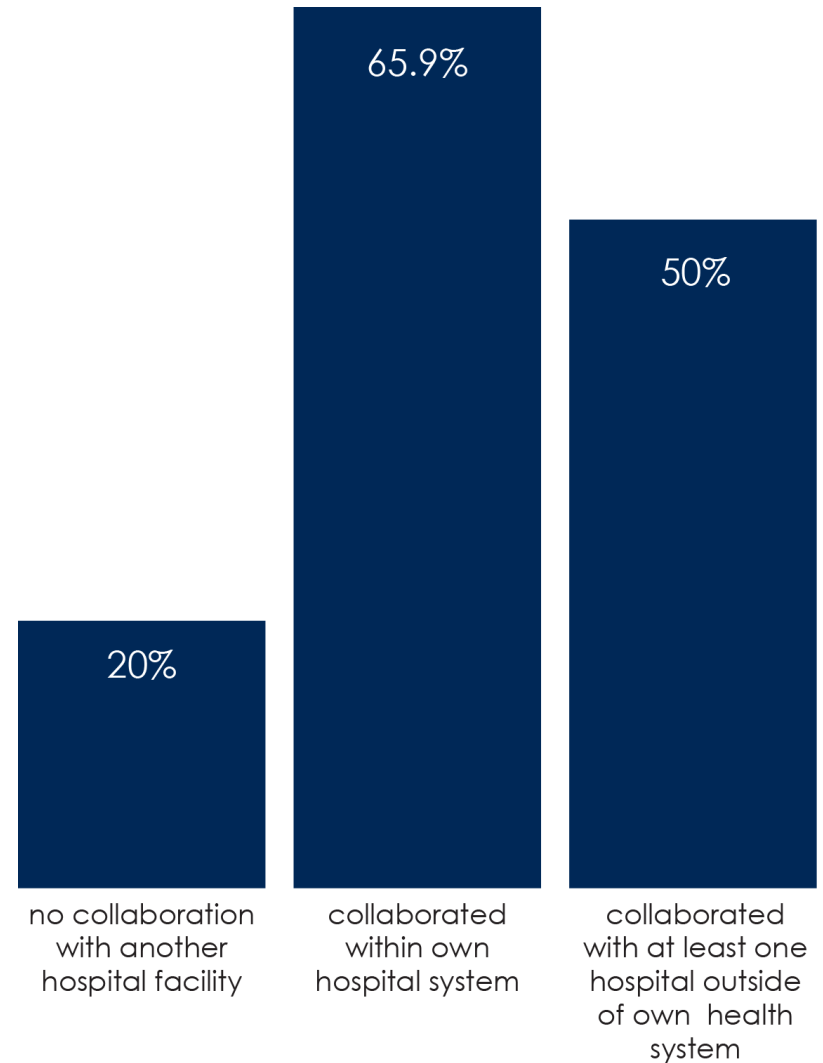
# Cross-jurisdictional LHD CHA/CHIP

(n=110)



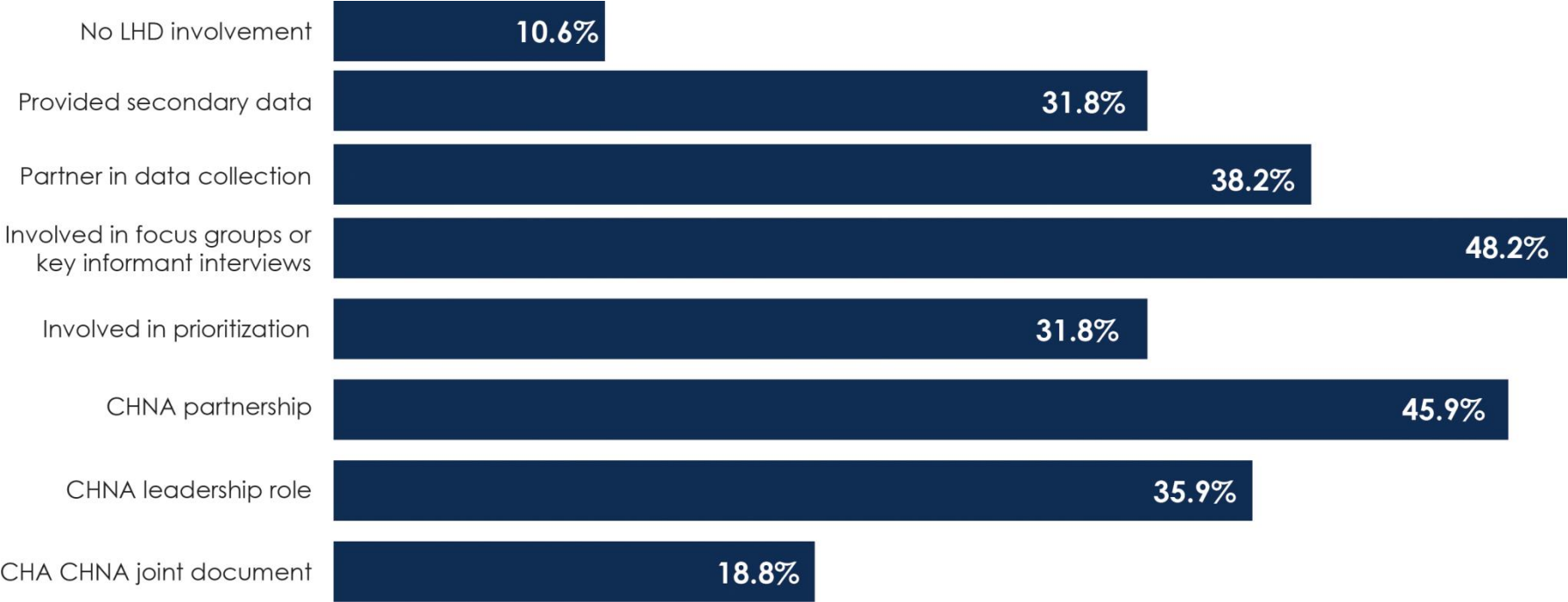
# Collaboration among hospitals

(n=170)

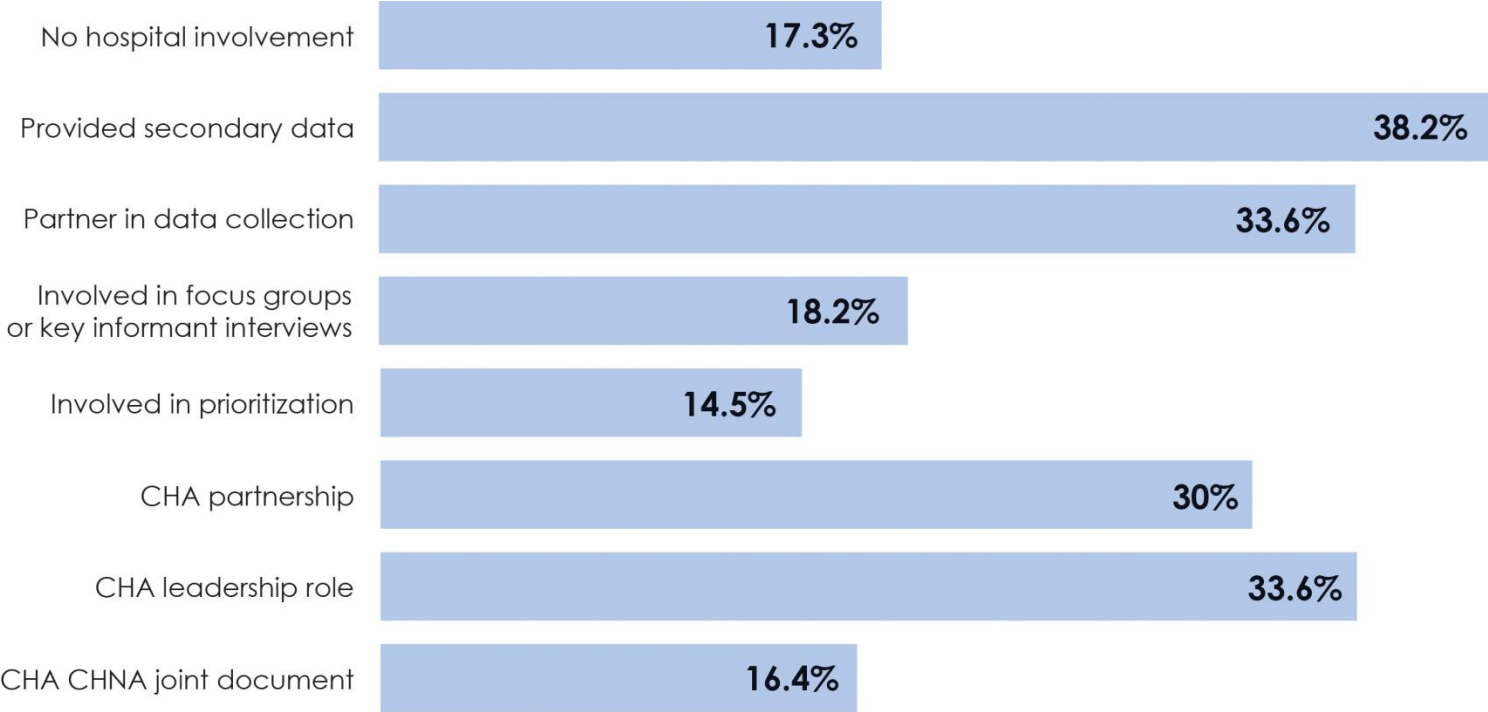




# Percent of hospitals reporting LHD collaboration on CHNA (n=170)

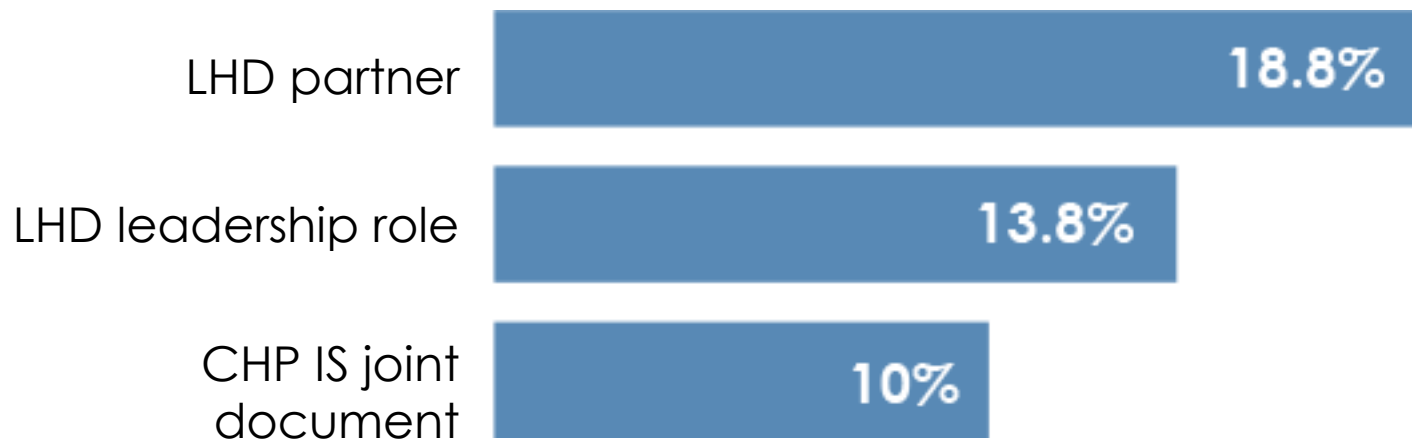


# Percent of LHDs reporting hospital collaboration on CHA (n=110)



# 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



# 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.

### 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.

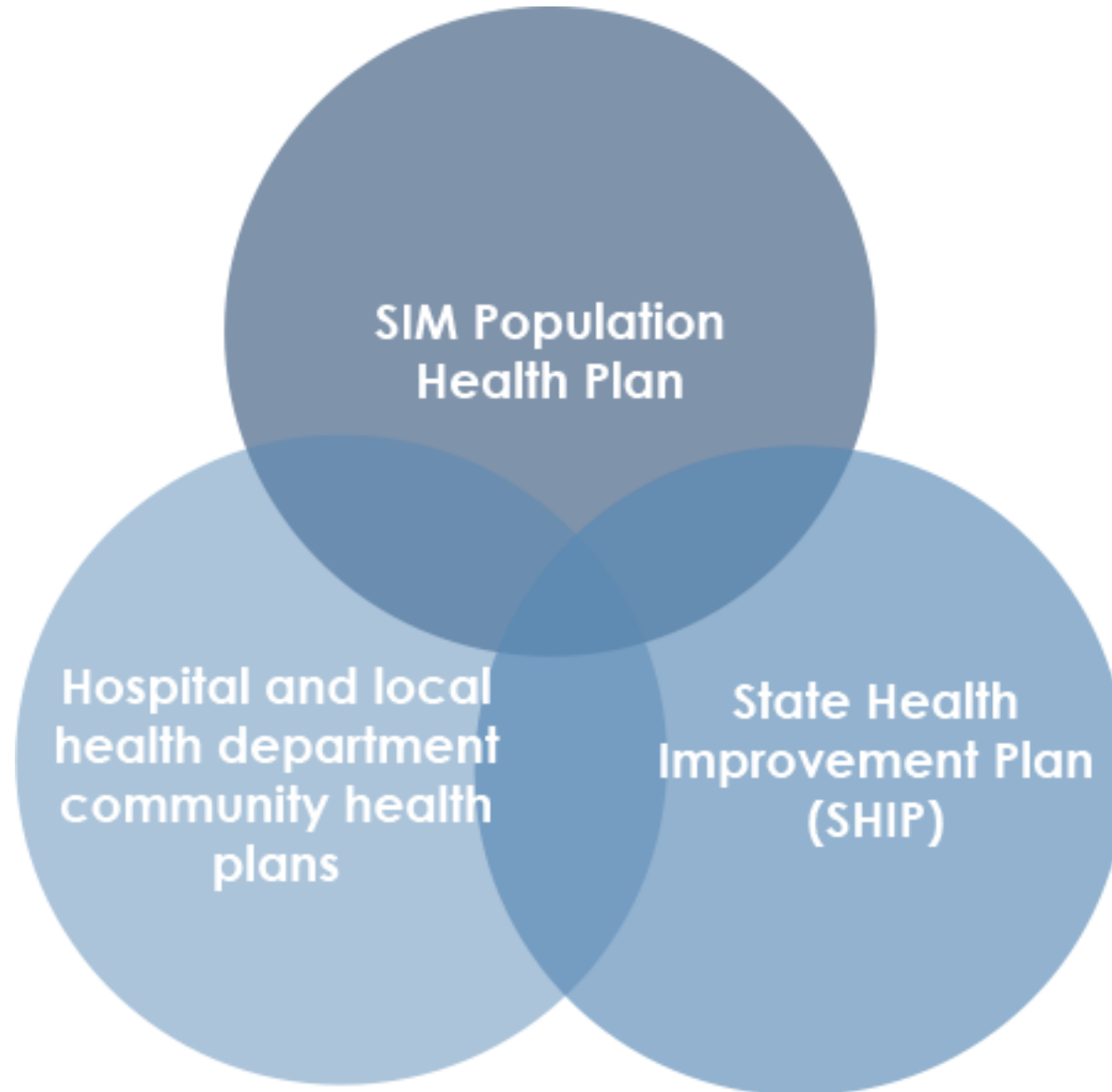
**Community health assessment (CHA):** a collaborative assessment conducted at least every five years by a LHD to describe the health of the population, identify areas for health improvement, contributing factors that impact health outcomes and community assets and resources that can be mobilized to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

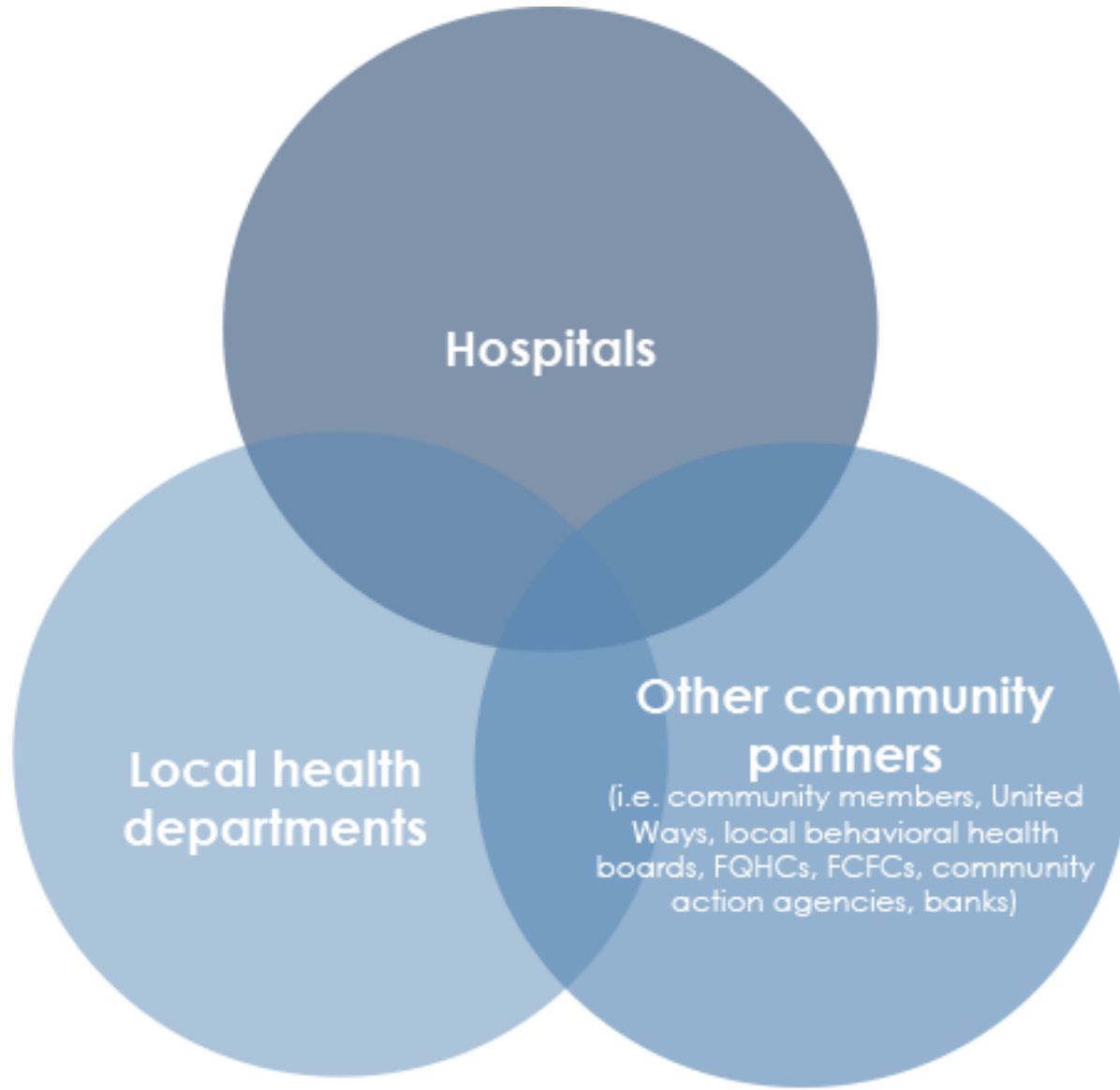
### INSIDE

- Part 1: Community health planning requirements for hospitals, LHDs and other entities **2**
- Part 2: Hospital community benefit: Promoting a population health approach to community health planning **10**
- Part 3: Selected findings from a study of hospital and LHD community health planning documents **15**
- Part 4: Opportunities for increasing the effectiveness of community health planning **20**

# 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:

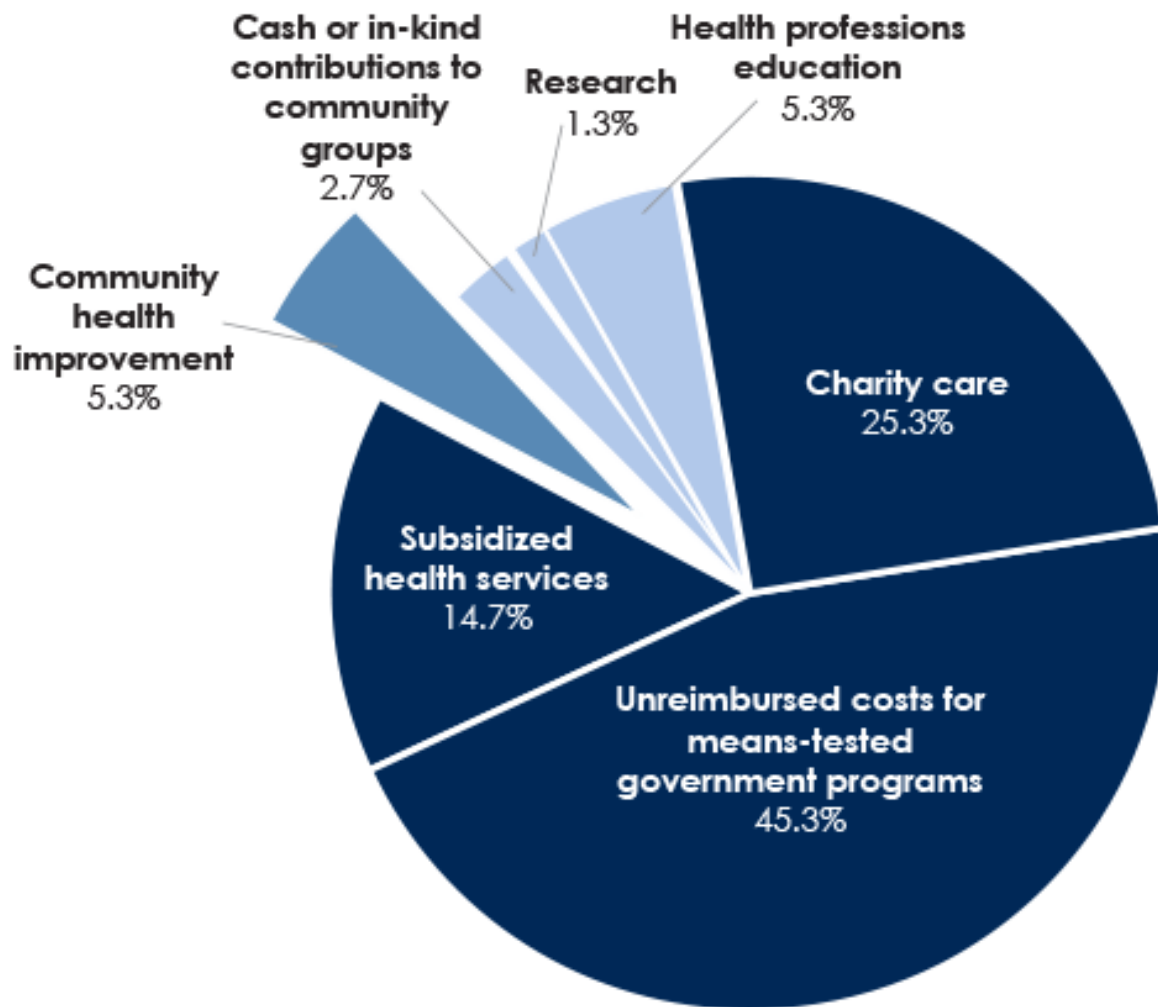
- Wellness, prevention and health promotion
- Upstream causes of health problems
- Social determinants of health and community conditions
- All people
- Partnerships between health and sectors such as education, transportation and housing

# Sources for evidence-based population health strategies

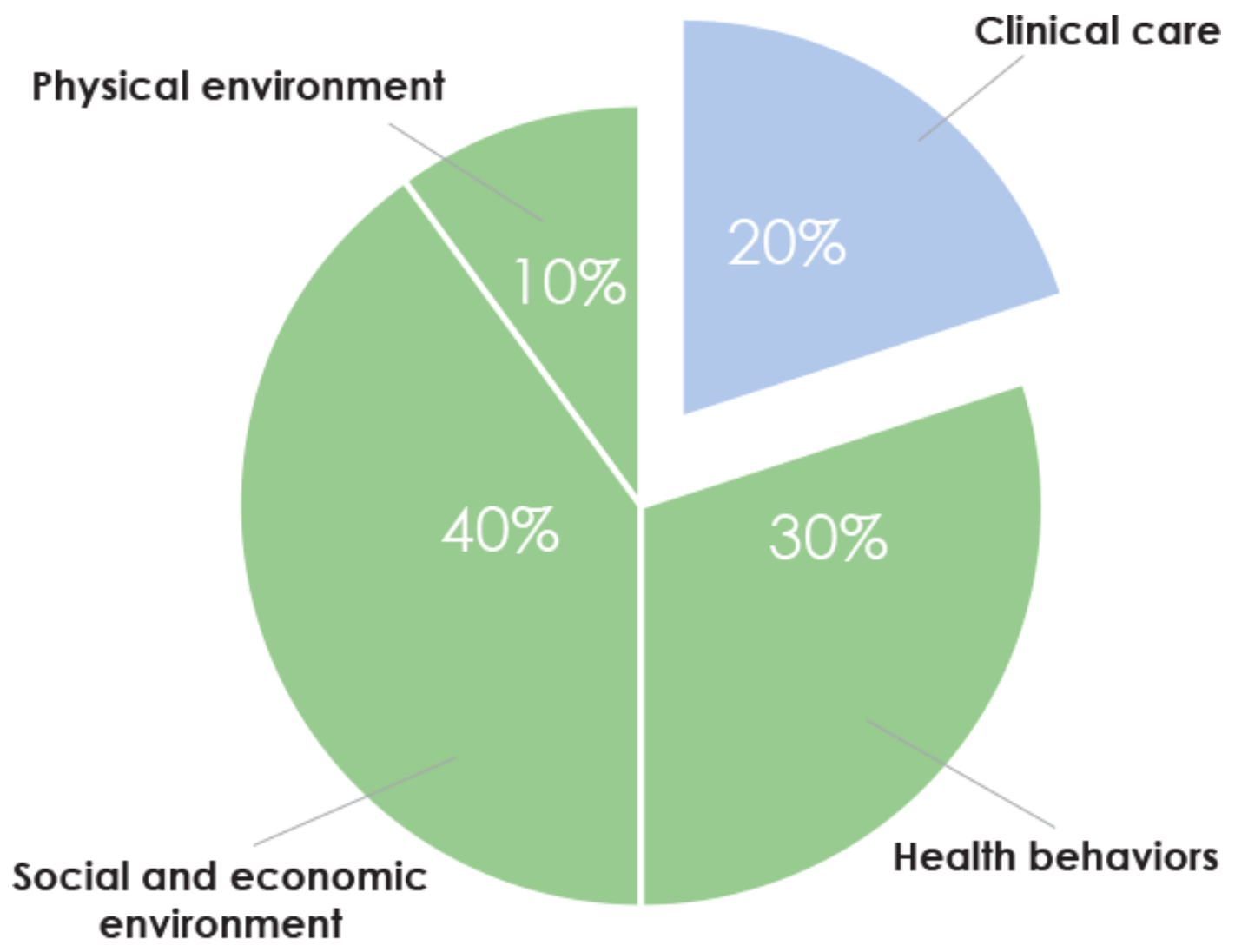
- *HPIO's What is "Population Health"*
- *HPIO's Guide to evidence-based prevention*
- *What Works for Health*
- *The Community Guide*

Encourage investment in evidence-based population health strategies through hospital community benefit

National distribution of community benefit expenditures, 2009



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<sup>1</sup>





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





**CardinalHealth**



National Network  
of Public Health Institutes

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