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Good afternoon Vice Chair Burke and Members of the Committee. My name is Amy Rohling McGee and I am the President of the Health Policy Institute of Ohio (HPIO). The mission of HPIO is to provide the independent, unbiased and nonpartisan information needed to create sound health policy. Thank you for the opportunity to share the recently released *Health Value Dashboard*. I am joined by my colleagues, Reem Aly and Amy Bush Stevens in making today's presentation.

HEALTH VALUE DASHBOARD

HPIO worked with many stakeholders to create *Dashboard* for several reasons:

- We know that advancing the health of Ohioans is a goal that many share. We also know that the amount we spend on health care is a concern for policymakers, businesses and consumers.
- There are multiple efforts underway to improve health and bend the curve in terms of healthcare spending. However, there has not been consensus on what success will look like. Put another way, if collectively we are successful in improving health and reducing cost growth, how will we know? What metrics should we all be paying attention to in order to know whether we're moving in the right direction? To take that to another level, what metrics if paid attention to, can move us in the right direction?
- We developed the *Dashboard* so that policymakers have a tool for setting state health policy priorities and tracking progress. We were mindful to align the *Dashboard* with other efforts that are going on in the state, such as the State Health Improvement Plan and the State Innovation Model

(SIM) plan. Our intention is to update the data in the *Dashboard* every two years, so that as a new biennium starts, policymakers can take stock in what has changed since the last iteration of the *Dashboard*.

A need for a broader look at all the factors that impact health and a need to examine costs

We define health value as the intersection of improved population health and sustainable health care costs. Researchers estimate that our health is influenced by a number of factors with 20% attributed to clinical care (meaning both access to care and quality of care), 30% to behaviors, 40% to social and economic factors and 10% to physical environment.

While attention is often paid to clinical access and quality, we know that these are necessary but not sufficient to achieving positive health outcomes. For this reason, we included domains related to social, economic and physical environments, which combined, are the largest contributors to our overall health outcomes. This is the conceptual framework from which we built the *Dashboard*.

On page 15 of the *Dashboard* you can see that while there are many other scorecards and dashboards in existence, the Health Value *Dashboard* is the first in the nation to develop a state ranking of "health value," placing equal emphasis on population health outcomes and healthcare costs.

The dashboard provides data in context to guide decision making by comparing Ohio's performance to other states, tracking change over time. It also includes information on best state performance as well as disparities or "gaps" in performance across Ohio's subpopulations.

What does the Health Value Dashboard tell us?

Analysis of the 106 metrics included in the Health Value Dashboard is sobering: Ohio ranks 47th on health value. This tells us that we are not getting good value for our healthcare dollar. We rank 40th in terms of population health outcomes, where we looked at metrics such as overall health status, adult smoking and adult diabetes.

We rank 40th in terms of healthcare costs, including metrics such as healthcare spending per capita, average premium per enrolled employee and Medicare spending growth per enrollee. The bottom line is that while we spend a lot on health care, we are not seeing this spending translate into good population health outcomes for Ohioans.

The *Dashboard* identifies Hawaii, Utah, Colorado and Idaho as high value states, which rank in the top quartile for both population health outcomes and healthcare costs. On the opposite end of the spectrum, the *Dashboard*

identifies the lowest value states, ranking in the bottom quartile on both population health and healthcare costs. Ohio is joined by Indiana and West Virginia as low value states, with poor population health outcomes and high healthcare costs.

When you look at the *Dashboard's* overall health value ranking map, many states fare better than Ohio because they either have better population health outcomes or spend less on health care. Ohio does poorly in both areas – bringing our overall health value rank down.

It's important to note that age, income and poverty are factors impacting health, but a younger population or higher income alone does not guarantee good health or good health value. The University of Cincinnati's Economics Center conducted a correlation analysis of the *Dashboard* data to determine the strength of the relationship between health value and age distribution and poverty. This tells us that states that are older or poorer are slightly more likely to have a low health value rank, but the strength of this relationship is relatively weak.

Some high-value states, such as Iowa and Hawaii, have older populations than Ohio, or higher poverty rates than Ohio, such as California. This indicates that it is possible to have a high health value rank with an older or poorer population.

One may ask why Ohio ranks 47th on this composite measure of health value? The answer is not simple. On page 4 you will note that there are many factors that impact Ohio's population health outcomes and healthcare costs, and Ohio performs poorly in many of these areas. Ohio's healthcare system faces significant challenges and ranks 39th in the nation. At the same time, we are last in the nation, ranked 51st, on public health and prevention, which includes metrics on health promotion and prevention, communicable disease control, and environmental health.

In addition, Ohio struggles when it comes to its physical, social and economic environments, which have a significant impact on our overall health. We rank 34th on our physical environment which includes metrics on Ohio's housing, built environment, and access to physical activity, as well as food access and food insecurity. We rank 29th on our social and economic environment, which includes metrics on employment, poverty, education and income inequality.

Page 5 of the *Dashboard* highlights Ohio's strengths and challenges. Our strengths include the percent of workers employed at a company that offers health insurance and the availability of affordable housing. Ohio's greatest health challenges include infant mortality, tobacco use, access to treatment for illicit drug use, diabetes and food insecurity.

Notably, the General Assembly has focused intently on issues such as infant mortality and drug use in recent years. HPIO is cataloging policy changes in high-priority areas and tracking whether and how outcomes are impacted over time.

On page six of the *Dashboard*, we provide a snapshot of disparities for Ohio's greatest health challenges. We did this to highlight the importance of addressing disparities or gaps in health outcomes across Ohio's subpopulations. Here we identified the population health outcomes for which we perform the worst and displayed these outcomes by either race or ethnicity, income level or by county.

It is important to note that the majority of our healthcare spending is on clinical care received within the healthcare system and that far fewer of our healthcare dollars are spent on public health and prevention.

While the amount we're spending is a concern, how we're investing those dollars is more disconcerting. If we could invest existing dollars more wisely to address factors outside of the healthcare system that are impacting our health, it is likely that Ohio would have better health outcomes.

Addressing costs is necessary for sustainability, but making sure that we're investing in a balanced portfolio of strategies both inside and outside the healthcare system is critical to achieving better health value for Ohioans.

We developed the dashboard so that it is (1) concise, (2) visual and at-a-glance, (3) includes the most important indicators, (4) and provides data to help guide decision making. We have provided you with a hard copy of the *Dashboard* today, but please know that there are additional tools related to the *Dashboard* on our Website (http://www.healthpolicyohio.org/2014-health-value-dashboard/).

We used the most recent publicly available data in creating the Dashboard, but, as is the case with similar efforts, much of the data in the Dashboard is 1-4 years old. This means that outcomes related to recent policy changes, such as those focused on infant mortality, opiate abuse and Medicaid eligibility, will not be evident in this iteration of the Dashboard.

While the process we used to create the Dashboard was highly collaborative, comprehensive and detail-oriented, we plan to revisit the metrics at the end of this year. We'd appreciate your feedback regarding the metrics and the layout of the Dashboard.

The *Dashboard* provides data to guide priorities and track progress over time. In order to make this an action-oriented tool, HPIO plans to conduct further analysis on evidence-based policy strategies that can be used to move Ohio

toward greater health value. We will also look at where we may have gaps in accountability for specific outcomes.

To these ends, HPIO recently released 2 briefs focused on tobacco use, one of Ohio's primary health challenges. My colleague, Amy Bush Stevens, will speak next about these briefs focused on evidence-based strategies and accountability for reducing tobacco use.

We will also be looking at how the many policies and initiatives already in place in Ohio align with the systems and environments that affect health, and where we may have gaps in accountability for specific outcomes.

Given that Ohio's Medicaid program serves roughly a quarter of Ohioans and cost nearly $22 billion in SFY 2014, the concept of "value" is particularly relevant. The initiatives that are underway through Ohio's SIM grant are steps in the right direction in terms of focusing on cost reduction and quality improvement. For example, the multi-payer Comprehensive Primary Care Initiative in the Cincinnati/Dayton region is focusing on key issues such as diabetes, blood pressure and heart disease. These efforts may result in improvements in healthcare system metrics such as mortality amenable to healthcare and population health metrics such as overall health status, life expectancy and premature death. As CPCi is rolled out in additional regions over the next 5 years as a part of SIM initiative, it will be important to evaluate impact on the health of Ohioans.

TOBACCO PREVENTION AND CESSATION

Attitudes about smoking have changed dramatically since the days of *Mad Men* and doctors appearing in Lucky Strike ads. Millions of Americans have quit smoking since the 1960s and most who still smoke report that they *want to quit*—including 71% of adult smokers covered by Medicaid.[i] Yet, adult smoking rates remain stubbornly high in Ohio and tobacco use is still the leading cause of preventable death and disease.

In June, we released two policy briefs on this topic:

- ***The state of tobacco use prevention and cessation in Ohio***, and
- ***Mapping accountability to improve Ohio's performance on tobacco use***

Today I will briefly describe the key findings and policy implications from these reports.

Smoking and secondhand smoke exposure contribute to 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.

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.[ii] Researchers estimate that 15% of U.S. Medicaid costs are attributable to cigarette smoking, totaling nearly $40 billion dollars annually.[iii]

When we released our *Health Value Dashboard* in December 2014, one of the most striking findings was that Ohio performed in the bottom quartile of states for:

- Adult cigarette smoking (Ohio ranks 44th),
- Secondhand smoke exposure for children (Ohio ranks 49th), and
- Tobacco prevention and control spending (Ohio ranks 46th).

This means that Ohio lags behind most other states on these key indicators of population health.[iv]

All states in the top quartile for health value have adult smoking rates that are lower than Ohio's. Strategies to reduce tobacco use, therefore, should be a key component of efforts to improve health value in Ohio.

Evidence-based strategies

There is a strong body of evidence on what works to reduce tobacco use. The U.S. Centers for Disease Control and Prevention (CDC) recommends strategies based upon rigorous reviews of large numbers of research studies.

Ohio is currently employing many of these strategies, which are listed in the first report, but the scope and intensity of these activities in recent years appears to be inadequate to produce the desired results.

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.[v] In SFY 2015, Ohio spent $9.8 million (state and federal funding combined), which is 7.4% of the amount recommended by the CDC.[vi] As a result, the number of Ohioans who have been reached by the Quit Line, media campaigns, and prevention activities has been greatly diminished in recent years.

The 2016-2017 state budget significantly increases the state's investment in tobacco prevention and cessation, although Ohio still remains far below the CDC-recommended funding level.

Policy implications

This first policy brief provides a list of state-level policy options that research tells us are most likely to reduce tobacco use in Ohio:

- First, we identify policy options that send a strong message that tobacco use is harmful, including:
    - Increasing the cigarette tax and taxes on other tobacco products. Research shows that the higher the tax increase, the greater the impact on tobacco use.[vii] The $0.35 cigarette tax increase in the 2016-2017 state budget is very modest and is a small step in the right direction.
    - Next in this category of policy options is increasing the scope and intensity of media campaigns; and, finally
    - Raising the legal age to purchase tobacco to 21. Given that many Medicaid-covered births are to women under age 21,[viii] this strategy may be helpful for improving birth outcomes in the Medicaid population.

- Second, we identify policy options that scale up and enhance access to cessation services, including:
    - Increasing funding for cessation strategies and use of the Ohio Quit Line; and,
    - Monitoring compliance of private health insurance plans with cessation coverage requirements.

- Third, we identify policy options that would strengthen Ohio's tobacco prevention and control infrastructure.

- Finally, we identify policy options that integrate tobacco cessation into Medicaid modernization, behavioral health system redesign, and other healthcare system reforms. Given that these topics are of particular interest to this committee, I will go into a bit more detail on these policy options.

It appears that much more could be done to help and encourage Medicaid enrollees to quit smoking in Ohio. Given that about half of working-age Medicaid enrollees smoke,[ix] and that about 70% of U.S. Medicaid enrollees report that they want to quit,[x] tobacco cessation appears to be an excellent opportunity to improve outcomes and control costs. But quitting tobacco is extremely difficult. Nicotine is a drug nearly as addictive as heroin.[xi]

An intensive strategy is therefore needed to help more Ohio Medicaid enrollees to quit. There are three general approaches that could be taken to increase tobacco cessation among Ohio Medicaid enrollees.

The first is to incentivize providers and Medicaid managed care plans to increase successful tobacco cessation among Medicaid enrollees. This could be done by adding tobacco cessation metrics to performance standards.

Currently, Ohio's 24 performance measures do not include any metrics specifically related to tobacco use or cessation.[xii]

The second is to focus directly on enrollees by increasing awareness of covered cessation services, removing all barriers to cessation counseling and medications, and/or by providing incentives to enrollees. A Massachusetts program, for example, brought about a 10% reduction in smoking among the Medicaid population by broadly promoting a comprehensive set of smoking cessation benefits.[xiii] Based on the cost of inpatient admissions for cardiovascular conditions alone, the program had a $2.12 return-on-investment; that is, the program saved $.12 in medical costs for every $1.00 in program costs.[xiv]

Medicaid programs in other states have used the Medicaid Incentives for Prevention of Chronic Disease grant or 1115 waivers to design programs that provide monetary or other incentives to enrollees for using cessation services or for successfully quitting. Results on the effectiveness of these programs should be available in 2016.

Finally, another approach is to develop programs to reach specific high-risk populations, such as pregnant women and people with behavioral health conditions. The 2016-17 state budget includes such a program for pregnant women—$2 million over the biennium for Moms Quit for Two. In order to ensure that people struggling with additional addictions or mental illness are reached by cessation services, tobacco cessation metrics could be added to future outcome measurement or value-based purchasing systems within the behavioral health carve-in.

Taken together, these policy options emphasize the importance of:

- Pairing policies that encourage smokers to quit, such as an increase in the cigarette tax, with the availability of cessation services for those who are ready to quit; and
- Increasing the intensity of our focus on helping today's smokers quit, while also preventing young people from ever starting to use tobacco in the first place.

Accountability map

Now I'm going to describe the key findings from the second policy brief, ***Mapping accountability to improve Ohio's performance on tobacco use***.

The purpose of this accountability map was to go a step further from the *Health Value Dashboard* in order to find out which healthcare and public health entities in Ohio are currently tracking performance on the prevention and cessation activities that feed into overall state performance on metrics like adult

smoking and secondhand smoke exposure for children. Our goal was to provide an initial snapshot of who is currently being held accountable for meeting specific targets in order to identify strengths and gaps in Ohio's current efforts to reduce tobacco use.

There are many public and private entities working to reduce tobacco use in Ohio. We contacted the entities listed here and asked them a series of questions regarding:

- Which tobacco-related measures they are currently tracking,
- If they are required by an external organization to track any of these measures,
- If they have any measurable objectives or targets set by an external organization, and
- If there is any incentive, penalty or reward for meeting set objectives.

What we found was that most entities were tracking at least one tobacco-related measure, but far fewer were being held accountable through performance on measurable objectives.
We also looked at patient-level vs. population-level measures, and process vs. outcome measures:

- Patient-level measures look at patients of a specific provider, members of a health plan, or individuals in a program.
- Population-level measures look at the overall population of Ohioans, or specific populations such as pregnant women, regardless of where or whether they receive health care services.
- Process measures look at things that *providers or programs do*, such as screening for tobacco use.
- Outcome measures, on the other hand, look at *what actually happens as a result* of an intervention, such as the percent of patients who quit smoking or the percent of babies born to women who smoke.

What we found was that many entities are tracking cessation *process* measures, but only one—the Ohio Tobacco Quit Line—is actually tracking cessation *outcomes*.

We also found that some entities are tracking tobacco use prevalence at the population level, but none are really being held accountable by an external organization for meeting specific targets.

Ultimately this analysis tells us that there is room for improvement in terms of tracking outcomes for Ohioans receiving cessation services. That is, we need better information that will answer questions such as, "which entities are most effective in actually helping people to quit?" Secondly, we need better mechanisms for setting targets at the patient and population levels, and for

holding entities accountable for reaching those targets in realistic and meaningful ways that incentivize quality improvement. Finally, this data should be transparent and easily accessible to the public when public funds are used.

Before I turn it over to Reem to present the final section of our testimony, I would like to bring together the *Health Value Dashboard* with the tobacco use information. Many state policy decisions have the potential to impact Ohio's performance on the metrics in the *Dashboard*. As shown here, the *Dashboard* looks at the smoking rate for the overall population of Ohio adults. But no single entity is really held accountable for improving our performance on this metric. Instead, we have a patchwork of accountability systems for some of the process and outcome measures that will lead to a reduction in adult smoking. And, as you can see from this slide, we have an "accountability no-man's land" when it comes to tobacco cessation outcomes.

So, as you move forward with monitoring outcomes and cost growth in the Medicaid program, and redesigning the community behavioral health system, please keep in mind the high prevalence of tobacco use among the Medicaid population; the illness, disability and early death caused by tobacco use; and the importance of tracking cessation outcomes and helping more Ohioans to actually quit.

COMMUNITY HEALTH IMPROVEMENT PLANNING

As my colleagues highlighted, our reality in Ohio is that we have poor health outcomes and pay more for healthcare than most other states. We know that no one entity alone can change this and that we all must work together, sharing accountability and responsibility for improving the health of Ohioans.

Community health planning can be a critical vehicle for this change. Community health planning activities share a common goal: they encourage entities to, through a collaborative process, assess and prioritize their communities' most significant health needs and develop implementation plans and strategies to address those needs. In recent years, due to federal and state policy changes, there has been particular focus on hospital and local health department (LHD) community health planning activities. Under this new policy landscape, hospitals and LHDs can play a critical role in aligning and leveraging their community health planning activities across the state to improve the overall health of Ohioans.

In my testimony today, I will:

1. Provide you with a brief overview of hospital and LHD community health planning requirements
2. Share findings from a "Quick Strike" research study we conducted in partnership with The Ohio Research Association for Public Health

Improvement (RAPHI), housed at Case Western Reserve University, funded by the Robert Wood Johnson Foundation, to compile and review Ohio hospital and LHD community health planning documents, and
3. Share strategies that can be leveraged to improve the effectiveness of community health planning activities in Ohio

Under federal law, to be recognized as a 501(c)(3) organization and maintain federal tax exempt status, hospitals are required to conduct a community health needs assessment (CHNA) and adopt an implementation strategy (IS) every three years.[xv] The Internal Revenue Service (IRS) published a final rule in December 2014, providing hospitals with specific guidance on how to comply with these new community health planning requirements.[xvi]

In addition, hospitals are required to report on how they are addressing the significant health needs identified in their needs assessments on Schedule H of their Form 990s to the IRS.[xvii] Hospitals failing to meet these requirements may be subject to an excise tax and possible revocation of their federal tax-exempt status.[xviii]

In 2013, 85.2% of hospitals in Ohio were classified as either nonprofit or government-owned, and are required to comply with federal regulations to qualify for 501(c)(3) recognition.[xix] Most of these hospitals have completed their first round of community health planning activities and are in the process of conducting a second round for their communities.

Under Ohio Revised Code (ORC) § 3701.13, the director of the Ohio Department of Health (ODH) may require LHDs to be accredited by the Public Health Accreditation Board (PHAB) by July 1, 2020, as a condition for receiving funding from ODH. As a prerequisite for PHAB accreditation, LHDs must complete a community health assessment (CHA) and a community health improvement plan (CHIP) at least every five years.[xx]

There are currently 123 LHDs in Ohio. As of March 2015, five Ohio LHDs had received accreditation from PHAB (Columbus city, and Delaware, Licking, Mahoning and Summit counties).[xxi] However, in anticipation of the ORC requirement, many LHDs in Ohio are moving towards full PHAB accreditation and have already conducted or are in the process of conducting CHAs and CHIPs for their local health districts.

While there are differences in the specificity of community health planning requirements for hospitals and LHDs, there is also a great deal of alignment on many of the requirements. Both hospitals and LHDs must:

- develop a needs assessment and a plan or strategy that identifies, prioritizes and addresses the health needs of the hospital's or LHD's "community,"
- identify community resources available to address health needs,
- engage community members and solicit input from a broad range of stakeholders and sectors within the community including vulnerable populations,
- focus on health disparities and the health issues of vulnerable populations,
- review how factors outside of the health care system, such as social, economic, behavioral and environmental factors, impact the health of the community, and
- distribute and communicate their findings to the public.

Despite these similarities, quite often, hospital and LHD community health planning processes are not aligned, and coordination between these different assessment processes is lacking. As a result, there are missed opportunities at the local level in Ohio to implement community health planning in an integrated, meaningful and effective way, and in a way that efficiently allocates community resources.

In the Quick Strike research study we conducted in partnership with the Ohio Research Association for Public Health Improvement (RAPHI), we reviewed community health planning documents for 170 hospitals and 110 LHDs – looking at, among other things, the extent and nature of collaboration between hospitals and LHDs in developing their community health planning documents.

Among the 110 LHD community health planning documents reviewed, only 39 (35.5%) were conducted cross jurisdictionally – meaning one or more LHDs partnered to develop the CHA and/or CHIP. Of the 170 hospital CHNAs reviewed, 34 (20%) did not collaborate with any other hospital facility. 112 (65.9%) collaborated with hospitals within the same health system, and 85 (50%) collaborated with hospitals outside of the hospital system.

We also found that collaboration among hospitals and LHDs on their community planning processes occurred on a continuum. The continuum ranged from no hospital and LHD collaboration to the development of joint documents, where the same document was used to fulfill both hospital and LHD community health planning requirements. There was no LHD involvement in the development of the CHNA for 18 (10.6%) of the hospital CHNA documents reviewed, while 32 (18.8%) of the CHNAs reviewed were joint CHNA/CHA documents.

Similarly, 19 (17.3%) of LHD CHAs reviewed indicated that hospitals were involved at some level in developing the CHA but only 18 (16.4%) were joint CHA/CHNA documents. Notably, it was even less likely for collaboration to occur in the

development of implementation plans and strategies – which is arguably the most critical part of the community health planning process.

We also found that hospitals and LHDs bring different skill sets to the community health planning table. These different skill sets appeared to be complimentary as the quality of hospital and LHD community health planning documents improved with meaningful collaboration.

In April, we released a policy brief on hospital and LHD community health planning activities: "Making the most of community health planning in Ohio: the role of hospitals and local health departments", where we identified key strategies for increasing the effectiveness of community health planning processes in Ohio. I'm going to highlight a few of these key strategies.

The first strategy is encouraging alignment across state and local level health plans. Ideally, hospital and LHD community health plans and state-level plans, such as the Centers for Medicare and Medicaid Services (CMS) State Innovation Model (SIM) Population Health Plan, and the State Health Improvement Plan, would be aligned in their health priorities and coordinated in their implementation plans and strategies. States that have been successful in aligning state and community health planning processes have developed mechanisms for bi-directional communication between state and community health leaders.

For example, some states require hospitals and LHDs to address state heath priorities in their community health planning processes.[xxii] Nonprofit hospitals and local health departments in New York are required to address two priorities from the New York State Health Improvement Plan (SHIP), the *Prevention Agenda 2013-17* in their community health planning documents.

The second strategy is encouraging collaboration, partnership and meaningful community engagement throughout the community health planning process among hospitals, LHDs and other community partners. There are several other entities in Ohio required to conduct community assessments including federally qualified health centers (FQHCs); alcohol, drug and mental health boards; and Family and Children First Councils. While the specific focus of these community assessments differ, they all aim to address the many factors that impact the overall health and wellbeing of the community. To emphasize the value of collaboration and community engagement, a number of other states, such as California and Texas, have instituted guidelines requiring or encouraging hospitals to collaborate with LHDs and other community stakeholders throughout their community health planning processes.[xxiii]

In addition, North Carolina is pursuing a requirement that would synchronize the five year timeline for LHD community health planning activities with the three year timeline for hospitals.[xxiv] North Carolina has also established a partnership between healthcare and public health stakeholders. The partnership set measurable objectives for hospital and LHD collaboration around community health planning, as well as objectives for improving the state's overall health outcomes.[xxv]

The third strategy is increasing transparency around hospital and LHD community health planning activities. In Ohio, there is no one place to easily access all of Ohio's most recent hospital and LHD community health planning documents or information on hospital and LHD community health improvement activities. As a result, it is difficult to assess what health issues have been prioritized by communities and what strategies are being deployed to address these health issues. Some states, like Texas, Illinois, Maryland and Indiana, require hospitals and LHDs to submit information on their community health assessments and plans to a state agency and some require hospitals and local health departments to make their documents more readily accessible to the public.[xxvi]

Finally, the fourth strategy is encouraging investment in the implementation and evaluation of evidence-based population health strategies to address a community's prioritized health needs. The term "population health" acknowledges that our health is a product of factors both inside and outside of the healthcare system, including our social, economic and physical environment. Because population health strategies are designed to reach geographically-defined audiences, rather than patient populations, community health planning at the city, county or regional level is an important vehicle for improving population health outcomes. There are a number of tools that identify population health and evidence-based strategies that can be incorporated in hospital and LHD community health planning processes such as:

- *HPIO What is "Population Health"* at http://www.healthpolicyohio.org/what-is-population-health/.
- *HPIO Guide to evidence-based prevention* at http://www.healthpolicyohio.org/tools/health-policy-tools/guide-to-evidence-based-prevention/
- *What Works for Health* at http://www.countyhealthrankings.org/roadmaps/what-works-for-health
- *The Community Guide* at http://www.thecommunityguide.org/

In addition, it is important to build hospital and LHD capacity to track progress towards defined and measurable objectives and outcomes. This ensures that the strategies implemented by hospitals and LHDs are effective at improving the health of Ohioans.

The IRS requires nonprofit hospitals to justify their tax exempt status by allocating a portion of their operating expenses towards the provision of community benefit – defined as activities undertaken by hospitals to improve the health of the communities in which they serve. Currently, charity care and other forms of uncompensated patient care account for the majority of hospital community benefit dollars.

However, within the past few years the IRS has broadened the traditional definition of community benefit to include activities which move beyond medical care to address the other systems and environments that impact a community's health.

Under these regulations, there is a great opportunity for hospitals to shift investment of community benefit dollars away from charity care and towards the implementation of evidence-based population health strategies such as addressing housing code violations that lead to asthma triggers, investing in workforce development and job training programs, and improving access to parks, healthy foods and active transportation particularly for those living in low-income neighborhoods.

Ohio truly has potential to become a high value state in terms of health. Our hope today is that we provided you with some strategies and resources that can help move Ohio forward on this path.

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[iv] HPIO Health Value Dashboard, 2014.
[v] Data provided by the American Lung Association (ALA). FY2003-FY2015 Tobacco Prevention and Cessation Funding Overview spreadsheet. Provided May 21, 2015.
[vi] American Lung Association. *State of Tobacco Control 2015.*
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[viii] Report on pregnant women, infants and children, Ohio Department of Medicaid, March 2015. Accessed 7/10/15: http://www.jmoc.state.oh.us/Assets/documents/reports/PWIC-Report-2014.pdf
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[x] U.S. data. Quitting smoking among adults—United States, 2001-2010. Morbidity and Mortality Weekly, Vol. 60, No. 44, 2011.
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[xv] Affordable Care Act (ACA) § 9007.
[xvi] Internal Revenue Service Rules and Regulations. "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." Federal Register 79, no. 250 (December 31, 2014): 78954. http://www.gpo.gov/fdsys/pkg/FR-2014-12-31/pdf/2014-30525.pdf
[xvii] Internal Revenue Service Rules and Regulations. "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." Federal Register 79, no. 250 (December 31, 2014): 78954. http://www.gpo.gov/fdsys/pkg/FR-2014-12-31/pdf/2014-30525.pdf
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