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Dear Governor Kasich, President Obhof, Speaker Rosenberger, Leader Yuko, and Leader Strahorn:

On behalf of the re-established Legislative Committee on Public Health Futures (“Committee”), we are pleased to submit for your consideration our report that includes recommendations to improve the public health system in Ohio.

Am. Sub. H.B. 64 re-established the Committee to review the June 2012 report of the Public Health Futures Project Steering Committee of the Association of Ohio Health Commissioners, and the October 2012 report of the previous Legislative Committee on Public Health Futures. The re-established Committee was well represented by public health disciplines and associations as well as state and local government associations and members of the General Assembly.

The Committee has reviewed the work of the previous Legislative Committee on Public Health Futures, discussed developments since then, reviewed the Governor’s Office of Health Transformation white paper Strengthen Public Health Infrastructure, and considered next steps to improve Ohio’s public health system. Committee members agree that all Ohioans deserve and should expect to be served by core public health services.

We would like to personally thank Committee members for giving their time to participate in discussing the future of public health in Ohio.

David Burke
State Senator, 26th District
Chair

Tim Ingram
Health Commissioner, Hamilton County Public Health
Vice-Chair
RE-ESTABLISHED LEGISLATIVE COMMITTEES
ON PUBLIC HEALTH FUTURES

On June 30, 2015, Governor John Kasich signed into law Am. Sub. H.B. 64 (Appendix 1) which re-established the Legislative Committee on Public Health Futures. The bill charged the Committee with reviewing the Public Health Futures Project Steering Committee of the Association of Ohio Health Commissioners June 2012 report, along with the October 2012 report of the previous Legislative Committee on Public Health Futures.

On October 31, 2012, the original Legislative Committee on Public Health Futures presented recommendations in a report to Governor Kasich and the General Assembly. Recommendations covered:

- Performance standards and accreditation
- Outcomes and data
- Multiple agency program administration
- Shared services resources
- Contract/consolidate/merger of contiguous and non-contiguous cities or counties
- Reimbursable services
- Reconvening Committee at a later date
The re-established Committee met on March 10, 2016 at the Ohio Department of Health. Pursuant to Section 737.10 of the legislation, the Committee included members of the state legislature and various public health and government associations (Appendix 2). The Committee selected its Chair, Vice-Chair, and Secretary pursuant to the legislation.

Chairman David Burke opened the Committee meeting by noting that members would assess how to improve the public health system in Ohio, including the characteristics of a high performing local health district. Committee members then heard presentations from several speakers.

PRESENTATIONS (APPENDIX 3)

2012 Recommendations and Accreditation Status
Brandi Robinson, Deputy Director
Office of Health Policy and Performance Improvement
Ohio Department of Health

Population Health Planning and Infrastructure Improvements
Greg Moody, Director
Governor’s Office of Health Transformation

Pathways to PHAB Accreditation
Rick Hodges, Director
Ohio Department of Health

Statutory Implications Post-2020
Lance Himes, General Counsel
Ohio Department of Health

Local Health Districts
Corey Hamilton, Health Commissioner
Zanesville-Muskingum County Health Department
DISCUSSION

After the presentations, Committee members discussed the process of local health districts becoming accredited by the Public Health Accreditation Board and the need for collaboration across the state to achieve accreditation. By April 2017, 16 local health districts had become accredited.

Chairman Burke authorized the creation of subcommittees to further discuss accreditation and collaboration in more detail. The Committee agreed that funding was a central topic but would require further discussion after the Subcommittee’s reports. The Subcommittee on Funding did not meet, as the Chairman announced that the funding discussion would continue in the upcoming State Fiscal Years 2018-19 budget deliberations.
COMMUNITY HEALTH ASSESSMENT AND COMMUNITY HEALTH IMPROVEMENT PLAN
A Community Health Assessment and Community Health Improvement Plan are foundations for accreditation, and many local health districts are in the process of developing them. The Subcommittee discussed what should be included in guidance from the Ohio Department of Health regarding the development of a Community Health Assessment and Community Health Improvement Plan. Such guidance should address the involvement of hospitals in the planning process and other topics to assist local health districts throughout the planning process.

The Ohio Department of Health shared with Subcommittee members the legislative language requiring all local health districts to submit to the Ohio Department of Health by July 2017 a Community Health Assessment and Community Health Improvement Plan, and tax-exempt hospitals to submit a Community Health Needs Assessment and Improvement Strategies as well as IRS Form 990/(Schedule H (Appendix 5). In addition, local health districts and hospitals must move to a three-year planning cycle to align with the State Health Improvement Plan by 2020. The Ohio Department of Health will issue guidance regarding local alignment with a minimum of two State Health Improvement Plan priorities, metrics, and evidence-based strategies.

RECOMMENDATIONS FOR SUPPORTING COMMUNITY PLANNING
Templates
Provide templates that local health districts can use to complete their Community Health Assessment and Community Health Improvement Plan, and for other accreditation prerequisites. Local health districts also request templates to assist with developing shared and contracted services, mergers and the Council of Governments model.

Training
Training should be provided to local health districts regarding the development of a Community Health Assessment and Community Health Improvement Plan. Follow-up coaching and technical assistance should be offered as they complete their community assessment and plan, perhaps by a statewide accreditation coordinator.
Data
Some Subcommittee members indicated that primary data is expensive and often one of the biggest hurdles for local health districts in completing their Community Health Assessment, and suggested providing data resources. Others asked whether there is a way to provide county level data regarding certain metrics that tie to the State Health Improvement Plan for local health districts to use. This would help create consistency among Community Health Assessments across the state and reduce some of the burden on local health districts.

Recognizing Differences in Local Health District and Hospital Planning
Local health districts use different processes in completing their Community Health Assessment and Community Health Improvement Plan compared to how hospitals complete their Community Health Needs Assessment and Improvement Strategies. These differences have been identified by the Health Policy Institute of Ohio in Appendix 2A of the Improving Population Health Planning in Ohio report. Guidance should be provided to address these differences, including community planning in health districts with no hospitals.

PATHWAYS TO ACCREDITATION
Subcommittee members discussed the primary concerns about the alternative pathways to accreditation and the support necessary to assist local health districts on their journey to accreditation.

Pathways to accreditation are:

- **Independent Accreditation as a Single Entity** – Local health districts may choose to pursue accreditation on their own as a single entity.

- **Council of Governments** – Under Ohio’s Council of Governments law, several local health districts may form a single operating unit to share certain services that are required for accreditation.

- **Merger** – Local health districts may choose to merge if they and their communities determine that makes sense for them. The merged entity can then pursue accreditation with their combined resources.

- **Shared/Contracted Services** – Local health districts that do not have services required for accreditation may contract with another local health district to provide those services in order to meet the accreditation requirement.

- **Reassignment** – As an option of last resort, the Director of the Ohio Department of Health may choose to reassign responsibility for mandatory programs in a local health district to another local health district.
The Subcommittee discussed some of the concerns with the Council of Governments pathway, which takes a significant amount of time to develop, and the initial financial resources required are a barrier. The timeframe required for pursuing the Council of Governments pathway is a concern given the approaching 2020 accreditation deadline.

**RECOMMENDATIONS FOR SUPPORTING ACCREDITATION PATHWAYS PLANNING**

**Accreditation Pathways Decision Tree**

Develop a comprehensive decision tree that local health districts can use to help determine the most appropriate pathway to accreditation for their community. Local health districts can use the decision tree when discussing pathway options with their District Advisory Council, City Council, Township Trustees, the Ohio Department of Health and other stakeholders.

**Templates**

Develop templates for contracts, mergers, the Council of Governments pathway, Community Health Assessments, Community Health Improvement Plans, and other accreditation prerequisites. Subcommittee members recommended the development of a checklist/flowchart of what is required for each accreditation pathways (particularly the Council of Governments pathway) to help local health districts determine which pathway is most appropriate for their community.
RECOMMENDATIONS

Accreditation Resources
Local health districts have varying levels of resources, support and expertise available for accreditation efforts. Some local health districts are able to fund their accreditation efforts by shifting financial resources from levy funds and other sources, while others are unable to do so. Some Subcommittee members also expressed concern about the rising cost of accreditation fees.

Several Subcommittee members noted that some local health districts have limited staff resources to complete accreditation requirements and have tasked existing staff with accreditation responsibilities which takes away from their primary focus. Others have reported adding additional positions to meet and maintain accreditation requirements.

Data Analysis
Some local health districts also report that they do not have staff capable of conducting data analysis. The Public Health Accreditation Board’s updated standards include a requirement for data analysis, which will be a challenge for local health districts without this capability. The board is creating an alternative accreditation process for smaller local health districts with fewer resources, but this work has not been completed.

Training
Access to training is a concern for local health districts since training is necessary to achieve and maintain accreditation. Subcommittee members identified specific training needs:

- Training/exposure to health policy advocacy
- Community engagement – specifically public health nurses (moving from a clinical framework)
- Strategic planning and how to use it for the performance management plan
- Performance management system
- Workforce development planning
- Customer service
- Marketing
- Facilitation
- Quality improvement/LEAN
- Ohio Profile Performance Database and annual financial review training annually
- Network of Care
- Health equity
- Differences between Public Health Accreditation Board standards versions 1.0 and 1.5

Offer a combination of training that includes train-the-trainer and direct training for local health districts in specific areas of need, as well as a combination of statewide and regional training opportunities.

**Ohio Profile Performance Database**

Subcommittee members recognized that there may be opportunities where information can be shared among local health districts, but indicated there needs to be a better platform for doing so. The Ohio Profile Performance Database was built to be this platform, but many Subcommittee members say that it is not user friendly and needs to be upgraded to enable the collection and sharing of best practices.
On January 12, 2017, the re-established Committee convened again at the Ohio Department of Health to review its charge; the 2012 Committee's recommendations; Subcommittee reports; the new State Health Assessment and State Health Improvement Plan; local health district accreditation status, training and resources; and to discuss the development of the Committee's final report.

PRESENTATIONS (APPENDIX 3)

Review of Committee's Charge
Rick Hodges, Director
Ohio Department of Health

Review of Recommendations of 2012 Legislative Committee
Brandi Robinson, Deputy Director
Office of Health Policy and Performance Improvement
Ohio Department of Health

Subcommittee Reports
Brandi Robinson, Deputy Director
Office of Health Policy and Performance Improvement
Ohio Department of Health

State Health Assessment & State Health Improvement Plan
Brandi Robinson, Deputy Director
Office of Health Policy and Performance Improvement
Ohio Department of Health

Accreditation Status, Training and Resources
Lance Himes, General Counsel
Ohio Department of Health
Wally Burden, Deputy Director
Office of Health Policy and Planning
Ohio Department of Health
DISCUSSION

After the presentations, Committee members discussed the work that has been completed since the 2012 Legislative Committee on Public Health Futures. Committee members asked that an appendix be included (Appendix 6) in its written report with an update on the 2012 Committee report’s recommendations.

The Committee reviewed and adopted the reports of the Subcommittee on Collaboration and the Subcommittee on Accreditation Support. Committee members said that they would like to see incentives for local health districts to collaborate in pursuing accreditation. Chairman Burke stated that this could be further developed in the State Fiscal Years 2018-19 budget (Note: the proposed Executive Budget includes $3.5 million over the biennium for accreditation fees, accreditation coordination, and infrastructure costs for local health districts who merge resources in order to gain the necessary scale to provide the level of public health services required for accreditation).

The Committee agreed that they should informally reconvene in 2018 to review local health district accreditation readiness and progress on implementing the Committee’s recommendations.
IMPLEMENTATION

The Ohio Department of Health has already taken steps to begin implementing many recommendations of the Legislative Subcommittees on Public Health Futures.

ACCREDITATION TECHNICAL ASSISTANCE, GUIDANCE AND SUPPORT

To support local health districts on their journey to accreditation, the Ohio Department of Health contracted with the OSU Center for Public Health Practice to:

- Develop profiles of Ohio’s local health districts, including an accreditation readiness assessment
- Develop action plan templates for the alternative accreditation pathways
- Provide accreditation, technical assistance, training and support tools

The Ohio Department of Higher Education has provided approximately $1.9 million from the Research Incentive Third Frontier Fund for the OSU Center for Public Health Practice engagement.

ACCREDITATION READINESS ASSESSMENT

In order to assist local health districts in selecting their preferred accreditation pathway and to identify training and technical assistance needs, the OSU Center for Public Health Practice will conduct an assessment to create a statewide profile of public health and identify factors that influence accreditation readiness and delivery of core public health services. This profile and accreditation readiness assessment will include local health district type and size, population served, staffing, services provided, financial status, sources of revenue, and progress toward accreditation.

FUNDING

In July 2016, the Ohio Department of Health provided funding to local health districts for internet and email costs — funding which if not needed for these purposes could also be used to support accreditation efforts. The Ohio Department of Health also allocated $1 million in the summer of 2016 to support completion of Community Health Assessments and Committee Health Improvement Plans for local health districts that applied for the funding.
The proposed Executive Budget for State Fiscal Years 2018-19 doubles the state subsidy for accredited local health districts. It includes $1 million over the biennium to provide grants for local health districts to assist them in transitioning from a five-year planning cycle to a three-year planning cycle for community health assessments and community health improvement plans. The proposed budget also includes an additional $3.5 million over the biennium for accreditation fees, accreditation coordination, and infrastructure costs for local health districts who merge resources in order to gain the necessary scale to provide the level of public health services required for accreditation. The proposed budget increases the state’s investment in local public health through a tiered system subsidizing local health districts who obtain accreditation either individually or through a merger with another local health districts.

TEMPLATES
One of the primary uses of the accreditation readiness assessment will be to provide participating local health districts with information to create an action plan to achieve accreditation. To assist with action plan development, the OSU Center for Public Health Practice will create action plan templates for accreditation pathway options. OSU will work with Ohio Department of Health to assist local health districts in completing their accreditation action plans and will provide guidance and assistance on pathway template use. OSU also will develop templates for contracts, mergers, the Council of Governments pathway, Community Health Assessments, Community Health Improvement Plans, and other accreditation prerequisites.

TRAINING
Through its contract with the OSU Center for Public Health Practice, the Ohio Department of Health is providing accreditation training assistance to local health districts. By the end of 2016, 15 local health district teams had completed performance improvement training. Additional training opportunities will be conducted in 2017 and 2018.

OHIO PROFILE PERFORMANCE DATABASE
As part of its contract with the Ohio Department of Health, OSU’s Center for Public Health Practice will assess and make recommendations on updating the Ohio Profile Performance Database to improve its effectiveness as an accreditation tool.

ACCREDITATION DEADLINE EXTENSION FOR QUALIFYING LOCAL HEALTH DISTRICTS
Recognizing the time required to pursue the merger or Council of Governments accreditation pathways, the proposed Executive Budget for State Fiscal Years 2018-19 extends the deadline to obtain accreditation from 2020 to 2021 for any local health districts that merge between January 1, 2016 and prior to July 1, 2019.
APPENDIX 1

Law Re-Establishing Legislative Committee on Public Health Futures

SECTION 737.10. The Legislative Committee on Public Health Futures is re-established. The committee shall review the June 2012 report of the Public Health Futures Project Steering Committee of the Association of Ohio Health Commissioners, and the October 2012 report of the previous Legislative Committee on Public Health Futures that was established by Am. Sub. H.B. 487 of the 129th General Assembly. The Legislative Committee shall review the effectiveness of recommendations from those reports that are being or that have been implemented. And, based on the knowledge and insight gained from its reviews, the Legislative Committee shall make legislative and fiscal policy recommendations that it believes would improve local public health services in Ohio.

The Legislative Committee, not later than January 31, 2016, shall prepare a report that describes its review of the reports and its review of the recommendations that are being or that have been implemented, and that states and provides explanations of the Committee’s new policy recommendations.

The Legislative Committee shall transmit a copy of its report to the Governor, the President and Minority Leader of the Senate, and the Speaker and Minority Leader of the House of Representatives. Upon transmitting its report, the Legislative Committee ceases to exist.

Each of the following associations shall appoint one individual to the Legislative Committee: the County Commissioners Association of Ohio, the Ohio Township Association, the Department of Health, the Ohio Public Health Association, the Ohio Environmental Health Association, the Ohio Boards of Health Association, the Ohio Municipal League, and the Ohio Hospital Association. The Association of Ohio Health Commissioners shall appoint two individuals to the Legislative Committee. The President and Minority Leader of the Senate each shall appoint two members to the Legislative Committee. The Speaker and Minority Leader of the House of Representatives each shall appoint two members to the Legislative Committee. Of the two appointments made by each legislative leader, one shall be a member of the General Assembly from the appointing member’s chamber. Appointments shall be made as soon as possible but not later than thirty days after the effective date of this section. Vacancies on the Legislative Committee shall be filled in the same manner as the original appointment.

As soon as all members have been appointed to the Legislative Committee, the President of the Senate shall fix a time and place for the committee to hold its first meeting. At that meeting, the committee shall elect from among its membership a chairperson, a vice-chairperson, and a secretary. The Director of Health shall provide the Legislative Committee with meeting and office space, equipment, and professional, technical, and clerical staff as are necessary to enable the Legislative Committee successfully to complete its work.
## APPENDIX 2

### Members of the Re-Established Legislative Committee on Public Health Futures

<table>
<thead>
<tr>
<th>APPOINTING ASSOCIATIONS AND LEGISLATORS</th>
<th>APPOINTEE</th>
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<tbody>
<tr>
<td>County Commissioners Association of Ohio</td>
<td>Kerry Metzger, Tuscarawas County Commissioner¹</td>
</tr>
<tr>
<td>Ohio Township Association</td>
<td>Heidi Fought, Director of Government Affairs</td>
</tr>
<tr>
<td>Ohio Department of Health</td>
<td>Director Hodges</td>
</tr>
<tr>
<td>Ohio Public Health Association</td>
<td>Claire Boettler, President</td>
</tr>
<tr>
<td>Ohio Environmental Health Association</td>
<td>Jennifer Wentzel, EH Director, Public Health – Dayton &amp; Montgomery County²</td>
</tr>
<tr>
<td>Ohio Association of Boards of Health</td>
<td>Walter Threlfall, DVM, Delaware County General Health District</td>
</tr>
<tr>
<td>Ohio Municipal League</td>
<td>Anita Scott Jones, Middletown City Council³</td>
</tr>
<tr>
<td>Ohio Hospital Association</td>
<td>Orelle Jackson, System Director, Community and Wellness, OhioHealth⁴</td>
</tr>
<tr>
<td>Association of Ohio Health Commissioners</td>
<td>Krista Wasowski, Health Commissioner, Medina County Combined General Health District</td>
</tr>
<tr>
<td>Association of Ohio Health Commissioners</td>
<td>Corey Hamilton, Health Commissioner, Zanesville-Muskingum County Health Department</td>
</tr>
<tr>
<td>Speaker Rosenberger</td>
<td>Representative Timothy Ginter</td>
</tr>
<tr>
<td>Speaker Rosenberger</td>
<td>(vacant)⁵</td>
</tr>
<tr>
<td>Leader Strahorn</td>
<td>Representative Dan Ramos</td>
</tr>
<tr>
<td>Leader Strahorn</td>
<td>(vacant)</td>
</tr>
<tr>
<td>President Faber</td>
<td>Senator Dave Burke</td>
</tr>
<tr>
<td>President Faber</td>
<td>Tim Ingram, Health Commissioner, Hamilton County General Health District</td>
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<tr>
<td>Leader Schiavoni</td>
<td>Senator Kenny Yuko</td>
</tr>
<tr>
<td>Leader Schiavoni</td>
<td>Carla Hicks</td>
</tr>
</tbody>
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¹ Cheryl Subler, County Commissioners Association of Ohio Policy Director, attended in place of Kerry Metzger
² Chad Brown, Ohio Environmental Health Association President, attended in place of Jennifer Wentzel
³ Did not attend
⁴ Did not attend
⁵ Wally Burden, Health Commissioner, Pike County General Health District attended as the original appointee
APPENDIX 3

Presentations to the Re-Established Legislative Committee on Public Health Futures

2012 Recommendations and Accreditation Status

Pathways to PHAB Accreditation

Better Planning for Better Health

Local Health Districts

Legislative Committee meeting on January 12, 2017
APPENDIX 4

Subcommittee Members

SUBCOMMITTEE ON ACCREDITATION SUPPORT MEMBERS6

<table>
<thead>
<tr>
<th>APPOINTEE</th>
<th>LOCAL HEALTH DEPARTMENT</th>
</tr>
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<tbody>
<tr>
<td>Jason Orcena</td>
<td>Union County Health Department</td>
</tr>
<tr>
<td>Anne Goon</td>
<td>Henry County Health Department</td>
</tr>
<tr>
<td>Melissa Branum</td>
<td>Greene County Public Health</td>
</tr>
<tr>
<td>Jim Adams</td>
<td>Canton City Health Department</td>
</tr>
<tr>
<td>Terry Allan</td>
<td>Cuyahoga County Health District</td>
</tr>
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SUBCOMMITTEE ON COLLABORATION7

<table>
<thead>
<tr>
<th>APPOINTEE</th>
<th>LOCAL HEALTH DEPARTMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pam Bauer</td>
<td>Clinton County Health Department</td>
</tr>
<tr>
<td>Chad Brown</td>
<td>Licking County Health Department</td>
</tr>
<tr>
<td>Wally Burden</td>
<td>Pike County General Health District</td>
</tr>
<tr>
<td>Angela DeRolph</td>
<td>Perry County General Health District</td>
</tr>
<tr>
<td>Corey Hamilton</td>
<td>Zanesville-Muskingum County Health Office</td>
</tr>
<tr>
<td>Tim Ingram</td>
<td>Hamilton County General Health District</td>
</tr>
<tr>
<td>Krista Wasowksi</td>
<td>Medina County Combined General Health District</td>
</tr>
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6, 7 Additional stakeholders participated in Subcommittees meetings.
APPENDIX 5

New Requirements for Local Health Districts and Tax-Exempt Hospitals

Sec. 3701.981. (A) As used in this section:

(1) "Assessment" means either of the following:

(a) A hospital community health needs assessment that meets the requirements set forth in 26 C.F.R. 1.501(r)-3(b);

(b) An assessment of community health conducted by a board of health.

(2) "Board of health" means the board of health of a city or general health district or the authority having the duties of a board of health under section 3709.05 of the Revised Code. (3) "Plan" means either of the following:

(a) A hospital implementation strategy that meets the requirements set forth in 26 C.F.R. 1.501(r)-3(c);

(b) A plan regarding improving community health created by a board of health.

(4) "Tax-exempt hospital" means a nonprofit hospital or government-owned hospital that is exempt from income tax under section 501(c)(3) of the Internal Revenue Code of 1986, 26 U.S.C. 1, as amended, and that under federal law is a hospital organization required to meet community health needs assessment requirements set forth in 26 C.F.R. 1.501(r)-3.

(B)(1) Not later than July 1, 2017, each board of health and tax-exempt hospital shall submit to the department of health any existing plans and assessments for the most recent assessment and planning period.

(2) Beginning January 1, 2020, each board of health and tax-exempt hospital shall complete assessments and plans in alignment on a three-year interval established by the department. Not later than October 1, 2020, each board of health and tax-exempt hospital shall submit to the department plans and related assessments covering years 2020 through 2022. Beginning October 1, 2023, and every three years thereafter, each board of health and tax-exempt hospital shall submit subsequent plans and related assessments to the department. The department shall provide guidance regarding submitting plans and assessments and shall provide an online repository for the plans and assessments.

(C)(1) Not later than July 1, 2017, and annually thereafter, each tax-exempt hospital shall submit information to the department as follows:

(a) If the hospital is not a government-owned hospital, the hospital shall submit a copy of the hospital’s schedule H (form 990) submitted to the internal revenue service for the preceding fiscal year, including corresponding attachments and reporting on financial assistance and means-tested government programs and community building activities in parts I and II of schedule H. Subsequent annual schedule H filings shall be submitted to the department not later than thirty days after filing with the internal revenue service.
(b) If the hospital is a government-owned hospital, the hospital shall submit information that is equivalent to the information that is submitted by a hospital under division (C)(1)(a) of this section. (2) The department shall provide an online repository for schedule H and equivalent information submitted by tax-exempt hospitals.

(C)(1) Not later than July 1, 2017, and annually thereafter, each tax-exempt hospital shall submit information to the department as follows:

(a) If the hospital is not a government-owned hospital, the hospital shall submit a copy of the hospital’s schedule H (form 990) submitted to the internal revenue service for the preceding fiscal year, including corresponding attachments and reporting on financial assistance and means-tested government programs and community building activities in parts I and II of schedule H. Subsequent annual schedule H filings shall be submitted to the department not later than thirty days after filing with the internal revenue service.

(b) If the hospital is a government-owned hospital, the hospital shall submit information that is equivalent to the information that is submitted by a hospital under division (C)(1)(a) of this section. (2) The department shall provide an online repository for schedule H and equivalent information submitted by tax-exempt hospitals.
APPENDIX 6

Progress on 2012 Legislative Committee Report’s Recommendations

PERFORMANCE STANDARDS AND ACCREDITATION
All local health districts shall meet PHAB eligibility within five years. Such documentation shall be independently verified.

The State Fiscal Years 2014-15 budget bill (HB 59) provided the Director of Health with the authority to require local health districts to apply for accreditation by July 1, 2018 and to achieve accreditation by July 1, 2020.

OUTCOMES AND DATA
The Ohio Department of Health and local health districts shall create a standardized process of specific data collection and identification of common public health indicators to include quality, quantity, comparables and efficiency. The sharing of de-identified health related data among payers, providers and public health is encouraged.

This was codified in the State Fiscal Years 2014-15 budget bill (HB 59). The administrative rules, adopted in July 2014, were adopted governing quality indicator reporting requirements. The first report, released in July 2015, created a baseline to compare future data.

BOARDS OF HEALTH CONTINUING EDUCATION
Local health district board members shall participate in continuing education requirements related to public health practice, ethics, and governance.

This was codified in the State Fiscal Years 2014-15 budget bill (HB 59). Local health district board members are required to participate in continuing education requirements. This was prescribed in Ohio Administrative Code, and rules were adopted in July 2014.

MULTIPLE AGENCY PROGRAM ADMINISTRATION
Identify and refer programs currently administered by two agencies (Ohio Department of Agriculture and Ohio Department of Health) such as food safety and water park/swimming pools to the Common Sense Initiative for further review and recommendations related to the program efficiency.

The Ohio Department of Health and the Ohio Department of Agriculture have continued to work together to find synergies within existing programs and other operations.
MULTI-DISTRICT PUBLIC HEALTH LEVY
Revise Ohio Revised Code 3709.29 to allow for permissive multi-county levy authority for public health services.

The proposed Executive Budget for State Fiscal Years 2014-15 included language allowing a combined general health district located in more than one county to have the tax levy question placed on each county’s ballot. The language was removed during House deliberations on the budget. The proposed Executive Budget for State Fiscal Years 2018-19 includes similar language allowing for multi-county levy authority for public health services.

SHARED SERVICES RESOURCES
The Ohio Department of Health shall encourage and enhance shared services by local health districts such as, but not limited to, the sharing of model contracts, memorandums of understanding, financial, and other technical assistance, that are easily adaptable by local boards.

The State Fiscal Years 2014-15 budget bill (HB 59) required the Ohio Department of Health to prepare model contracts and memorandums of understanding for use by local boards of health when entering into shared services agreements, and authorized the agency to offer technical assistance. The model contracts and memorandums of understanding are going to be developed by the OSU Center for Public Health Practice as part of its contract with the Ohio Department of Health to support local health districts on their journey to accreditation.

CONTRACT/CONSOLIDATE/MERGER OF CONTIGUOUS AND NON-CONTIGUOUS CITIES OR COUNTIES
Revise Ohio Revised Code sections 3709.051 and 3709.10 to allow contiguous and non-contiguous city and county health districts to contract/consolidate/merge together within a “reasonable” geographic distance consider Association of Ohio Health Commissioners regions).

The State Fiscal Years 2014-15 budget bill (HB 59) codified the Committee’s recommendation to remove statutory barriers to consolidation and shared services among non-contiguous local health districts.
REIMBURSABLE SERVICES

The Ohio Department of Insurance should work to enhance the ability of local health districts to contract and credential with private payers and Medicaid for services such as immunizations and other public health and clinical services, integrated health management and other care models. This recommendation is not to be interpreted as supporting new legislative mandates or the placing of mandates upon local health districts.

The State Fiscal Years 2016-17 budget bill (HB 64) provided that beginning January 1, 2016, general revenue funding to purchase vaccine for distribution to local health districts for insured individuals would be discontinued. Local health districts may continue to offer vaccines to insured individuals but must bill private insurers or Medicaid to recoup the cost. The Ohio Department of Health encourages local health districts to bill Medicaid or private insurance for eligible services to reduce their need for general revenue funding. In addition, the Association of Ohio Health Commissioners has created a billing consortium for local health districts to ensure they have the capability to bill for services, including immunizations.

CHRONIC DISEASE BLOCK GRANT FUNDING

The Ohio Department of Health shall initiate review and advocate federal, state and regional authorities for a “blended funding” approach that integrates all state/federal public health funding using block grants (when/where possible) to reduce fragmentation in an effort to increase public health funding.

Since the 2012 Legislative Committee on Public Health Futures, the Ohio Department of Health has worked on reviewing its grants structure and moved to a deliverables-based grants model. With the release of State Health Improvement Plan guidance, the Ohio Department of Health will continue to build upon these efforts and consider additional funding methods.

SUSTAINABLE FUNDING

Ohio should explore sustainable funding to achieve Ohio’s public health mission and responsibilities. This work should include steps to: implement standard measures of outcomes, examine the link between funding disparities at the health district level and health outcomes, identify any additional opportunities for operational efficiencies, review incentives to drive outcomes at the local level and pursue federal funding opportunities.
The Ohio Department of Health is seeking to align public health in Ohio to help improve health outcomes and population health. Exploring funding and resources to achieve these objectives is part of this process. The proposed Executive Budget for State Fiscal Years 2018-19 doubles the state subsidy for accredited local health districts. It includes $1 million over the biennium to provide grants for local health districts to assist them in transitioning from a five-year planning cycle to a three-year planning cycle for community health assessments and community health improvement plans. The proposed budget also includes an additional $3.5 million over the biennium for accreditation fees, accreditation coordination, and infrastructure costs for local health districts who merge resources in order to gain the necessary scale to provide the level of public health services required for accreditation. The proposed budget increases the state’s investment in local public health through a tiered system subsidizing local health districts who obtain accreditation either individually or through a merger with another local health districts. The Governor’s Executive Budget proposal for State Fiscal Years 2018-19 would double the state subsidy for accredited local health districts.

RECONVENE COMMITTEE

The Director of Health shall reconvene a similar committee no later than three years after report submission of October 31, 2012 to review its purpose and implementation of recommendations.

The Committee met again in 2016 and 2017, and the Director of Health will reconvene the group informally in 2018 to review local health district accreditation readiness and progress on implementing the Committee’s recommendations.
APPENDIX 7

Governor’s Office of Health Transformation White Paper: Strengthen Public Health Infrastructure

BACKGROUND
As of January 1, 2017, there were 118 county and city health departments in Ohio operating at various levels of capacity. These districts range from employing only two to more than 250 full-time workers, serving less than 6,500 to more than 850,000 residents, and spending $3.68 to $138.13 per resident. For nearly 60 years, experts have recommended better ways to organize public health. A 1960 report recommended a minimum size in the range of 50,000 residents for any health district and 100,000 residents for a city. A 1993 report recommended that local jurisdictions be required to have the critical mass necessary to provide core public health functions and, in most cases, county boundaries would provide the critical mass necessary.

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 local health district 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 district’s capacity to provide core public health services. The final report concluded that most health districts may benefit from cross-jurisdictional sharing, but districts serving populations of 100,000 residents or less would particularly benefit from shared services or consolidation.

TRANSFORMATION STRATEGY
In response to Public Health Futures, Governor Kasich’s second budget (enacted in 2013) included several new initiatives designed to give public health more tools to collaborate and integrate programs. It also required state and local health department accreditation from the Public Health Accreditation Board (PHAB). The purpose of PHAB accreditation is to measure health department performance against a set of nationally recognized standards, ensure that a department has at least the minimum capabilities required to improve and protect the health of the public, and recognize departments that achieve this level of capability. The Ohio Department of Health (ODH) became PHAB accredited in November 2015 and, as a condition of receiving state funds, local health departments are required to be accredited by July 2020.
To support accreditation, in 2015 the Governor’s Office of Health Transformation (OHT) and Health Policy Institute of Ohio (HPIO) convened an expert Population Health Planning Advisory Group to recommend strategies that strengthen Ohio’s public health infrastructure, and to set clear priorities for population health improvement. The extensive stakeholder process included state health officials, local boards of health, health care providers, community-based organizations, and payers and purchasers of health care, including businesses. HPIO reviewed multiple community health assessments and improvement plans, including 10 state-level, 110 local health district, and 170 hospital assessments and plans. HPIO published the findings from these activities in a comprehensive Report for *Improving Population Health Outcomes*.

The HPIO report provides a roadmap for strengthening Ohio’s public health infrastructure. The state has already implemented much of the report, including recommendations to:

- Adopt one clear definition of population health across all state programs (completed).\(^1\)
- Update Ohio’s existing State Health Assessment (completed September 2016) and State Health Improvement Plan (completed January 2017).
- Require local health districts and tax-exempt hospitals to align assessment and planning activities (enacted ORC 3701.981 in 2016 to require health districts and hospitals to align on the same three-year timeline for assessments and improvement plans beginning in 2020, and submit assessments and plans to the state to post online).
- Provide state guidance encouraging local health departments and tax-exempt hospitals in the same counties or with shared populations to partner on assessments and plans, and to align those plans with priorities identified in the State Health Improvement Plan (completed January 2017).
- Appropriate state funding to support local health departments that collaborate on one county-level assessment and plan (in the Executive Budget).
- Incorporate State Health Improvement Plan priorities into value-based payment models, including the State Innovation Model (SIM) test (in the Executive Budget).

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\(^1\)Population health is the distribution of health outcomes across a geographically-defined group which result from the interaction between individual biology and behaviors; the social, familial, cultural, economic and physical environments that support or hinder wellbeing; and the effectiveness of the public health and health care systems.
EXECUTIVE BUDGET PROPOSAL AND IMPACT
The Executive Budget accelerates the significant recent progress to ensure every Ohioan has access to accredited public health services. It provides an additional $8 million over the next two years for local health districts that are making progress toward accreditation. It also aligns Medicaid and other program spending – not just public health spending – to support the priorities identified in the 2017 State Health Improvement Plan. Together, these reforms add up to the most aggressive effort in 30 years to strengthen Ohio’s public health infrastructure.

SUPPORT ACCREDITATION
The Executive Budget accelerates the significant recent progress to ensure every Ohioan has access to accredited public health services. It provides an additional $8 million over the next two years for local health districts that are making progress toward accreditation. The budget:

• **Doubles the state subsidy for accredited local health districts.** ODH currently provides $2.2 million in state subsidy per year to 118 local health districts, which equates to about 19 cents per capita. The Executive Budget doubles the state subsidy to 38 cents per capita for any district that achieves PHAB accreditation. Local health districts that are already accredited will receive the additional subsidy beginning in July 2017, and other districts will receive the increase upon achieving accreditation. This provision is estimated to cost up to $1.4 million to provide an additional subsidy for up to 27 accredited health districts in 2018 and $1.9 million for up to 36 accredited local health districts in 2019. There are currently 14 accredited districts. If the number of future accredited local health districts is less than projected in the biennium, then use of any remaining funds would be limited to accreditation-related training and activities, like health improvement planning.

• **Provides Technical Support for Accreditation.** Using $1.9 million from the Ohio Department of Higher Education’s Research Incentive Third Frontier Fund, ODH contracted with the Ohio State University College of Public Health Center for Public Health Practice (CPHP) to: (1) assess the readiness of every local health district for accreditation; (2) facilitate the development and implementation of pathway action plan for each district to ensure residents receive service from an accredited organization; and (3) provide technical assistance, training and support tools to assist local health districts progress toward accreditation or another pathway to ensure residents receive service from an accredited organization. The OSU Center for Public Health Practice has trained 14 teams from local health districts on performance improvement, and trained seven regional trainers on accreditation and performance improvement. In addition, $500,000 has been set aside for CPHP to provide specialized training in areas requested by local health districts. CPHP will release accreditation readiness assessment reports for local health districts in February 2017, and be available to local health districts for training assistance through 2020.
• **Supports local health districts that want to merge to achieve accreditation.** A few, small local health districts that might not have the capacity to achieve PHAB accreditation are considering a merger with another health district as a strategy to ensure that every citizen within their jurisdiction has access to PHAB-accredited services. The Executive Budget supports local health districts that want to merge by providing funding for accreditation fees, accreditation coordination, and other infrastructure costs. It sets aside $3.5 million in one-time funds over two years to support up to 24 local health district mergers. In addition, the Executive Budget also extends the timeframe to obtain accreditation from 2020 to 2021 for any local health districts that merge between January 1, 2016 and July 1, 2019.

• **Authorizes multi-county levies to support local health district consolidation.** In order to remove financial barriers to merge local health districts, new statutory language authorizing multi-county public health levies is proposed. The language would allow newly merged health districts propose a joint levy funded by both jurisdictions. Specifically, if the new general health district is a multi-county health district, the board of health for the combined districts is the taxing authority for such a district.

**ALIGN COMMUNITY HEALTH PRIORITIES**

Local health districts and 501(c)(3) tax-exempt hospitals have similar health assessment and planning requirements, but the timing and implementation of these plans frequently do not align or match up to statewide priorities. As a result, there are missed opportunities at the state and local levels to conduct population health planning in an integrated, meaningful way. To support better alignment of state and local health priorities, the Executive Budget:

• **Makes State Health Assessment data more accessible for community planning.** The [2016 State Health Assessment](#) describes the current status of health and wellbeing in Ohio and highlights opportunities to improve health outcomes, reduce disparities, and control health care spending. It identifies 10 population health priority topics – obesity, physical activity, nutrition, substance abuse treatment and prevention, infant mortality, tobacco use, mental health, diabetes, cancer, and heart disease – and displays 140 metrics on these topics as a baseline to improve. The Assessment includes county-level data when possible to assist health districts in completing a local assessment, which is required for PHAB accreditation. To make the assessment process easier for local communities, the Office of Health Transformation (OHT) and Departments of Health and Administrative Services are developing an online version of the Assessment. The initial cost of developing the system was supported with $150,000 from OHT and the ongoing cost of maintaining the system is included in the ODH budget.
• **Creates a state website to post local health district and hospital health improvement plans.** ORC 3701.981 requires local health districts and tax-exempt hospitals to align with a three-year timeline for health assessments and improvement plans beginning in 2020 and every three years thereafter, and to submit assessments and plans to the state to post online, beginning with existing plans in 2017. The Executive Budget provides funds from within ODH resources to create and maintain a website for this purpose.

• **Supports local health districts’ shift to a more frequent planning cycle.** ORC 3701.981 requires local health districts to move from the current five-year planning cycle to a new three-year planning cycle beginning in 2020. The goal is to make it easier for local health districts to collaborate on assessments and plans with local hospitals, which already are required to use a three-year planning cycle for tax purposes. The Executive Budget provides $1 million in one-time funding over two years – $12,500 each for up to 80 county-level grants – to help participating health districts move to the more frequent three-year schedule. In addition, the state also will move to a three-year planning cycle beginning with the 2020-2023 State Health Improvement Plan to further reinforce alignment across state and local priorities.

• **Provides guidance for collaborative, community-level health improvement planning.** As required by ORC 3701.981, ODH published guidance in January 2017 encouraging a broad range of community partners to undertake a single, joint health improvement planning process, or at least complete individual plans that are aligned and informed by community-level collaboration. The guidance identifies specific strategies to align state and local population health priorities (Figure 1), encourages local planning to occur at least at the county level, recommends that local health districts and hospitals take the lead in convening community-level health improvement activities, and identifies a broad range of community partners for active participation and input in the process.

• **Aligns state funding to support statewide health improvement priorities.** The 2017-2019 **State Health Improvement Plan** takes a comprehensive approach to improving Ohio’s greatest health priorities. It focuses on the three population health priorities identified in the 2016 State Health Assessment – mental health and addiction, chronic disease, and maternal and infant health – and cross-cutting factors that have the potential to impact all of these priorities, including the health care delivery system, public health and prevention, social determinants of health, and equity (See Figure 1 on next page). The Executive Budget makes significant investments in all of these priority areas. For more information, see **Set Clear Priorities for Health Improvement.**

Updated January 30, 2017
State health improvement plan (SHIP) overview

### Overall health outcomes
- Health status
- Premature death

### Three priority topics
| Mental health and addiction | Chronic disease | Maternal and infant health |

### Ten priority outcomes
- Depression
- Suicide
- Drug dependency/abuse
- Drug overdose deaths
- Heart disease
- Diabetes
- Asthma
- Preterm births
- Low birth weight
- Infant mortality

### Equity: Priority populations for each outcome

### Four cross-cutting factors
- Social determinants of health
- Public health system, prevention and health behaviors
- Healthcare system and access

#### Definition
- **CHA** — Community health assessment led by a local health department
- **CHNA** — Community needs assessment led by a hospital
- **Indicator** — A specific metric or measure used to quantify an outcome, typically expressed as a number, percent or rate; Example: Number of deaths due to suicide per 100,000 population.
- **Outcome** — A desired result. Example: Reduced suicide deaths.

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**FIGURE 1**

Overview of guidance for local alignment with the SHIP

See ODH guidance for aligning state and local efforts for details

- Select at least 2 priority topics (based on best alignment with findings of CHA/CHNA)
- Select at least 1 priority outcome indicator within each selected priority topic (see SHIP master list of indicators)
- Identify priority populations for each priority outcome indicator (based on findings from CHA/CHNA) and develop targets to reduce or eliminate disparities
- Select at least 1 cross-cutting strategy relevant to each selected priority outcome (see community strategy and indicator tools) AND
- Select at least 1 cross-cutting outcome indicator relevant to each selected strategy (see community strategy and indicator tools)

For stronger plan (optional), select 1 strategy and 1 indicator for each of the 4 cross-cutting factors.

- Prioritize selection of strategies likely to decrease disparities (see community strategy and indicator tools)
- Ensure that delivery of selected strategies is designed to reach priority populations and high-need geographic areas

**Priority population** — A population subgroup that has worse outcomes than the overall Ohio population and should therefore be prioritized in SHIP strategy implementation. Examples include racial/ethnic, age or income groups; people with disabilities; and residents of rural or low-income geographic areas.

**Target** — A specific number that quantifies the desired outcome. Example: 12.51 suicide deaths per 100,000 population in 2019.
LEGISLATIVE COMMITTEE on
Public Health Futures