

Improving Population Health Planning In Ohio:

GUIDANCE FOR ALIGNING
STATE AND LOCAL EFFORTS





Content

Background	3
Local Collaboration	4
Overview	4
Guidance	4
Example Local Collaboration at Work:	6
Alignment	7
Example	8
Tools Available	9
Hospital Community Benefit	9
Transparency and Accessibility	11
LHD Reporting Requirement	11
Hospital Reporting Requirement	11
Appendix A:	12
General Resources	12
Community Benefit	12
Reports	12
Appendix B:	13
Community Engagement Stakeholder List	13
Appendix C:	14
Conceptual Framework	14
Appendix D:	15
Local Indicator and Strategy Toolkits	15
Appendix E:	16
Examples of hospital community benefits activities that align with SHIP priorities and strategies	16
Appendix F:	18
Population Health Planning Infrastructure Timeline	18
Local Guidance/Implement Timeline	19
Appendix G:	
State-local SHIP alignment	20



Background

As noted in the [2016 Improving Population Health Planning in Ohio](#) report, performance on population health outcomes has steadily declined relative to other states.¹ This report outlines four recommendations about improving population health planning infrastructure in Ohio made by the [Population Health Advisory Group](#).

1. **State and local plan alignment:** State should issue guidance encouraging local health departments and tax-exempt² hospitals to align priorities, metrics, and strategies.
2. **Hospital and local health department alignment:** State should issue guidance encouraging local health departments and tax-exempt hospitals to partner on assessments and plans; additionally the state should require alignment to a three-year timeline for assessments and plans.
3. **Funding:** State should issue guidance encouraging tax-exempt hospitals to allocate a minimum portion of their total community benefit expenditures to activities that most directly support community health planning objectives, including community health improvement services and cash and in-kind contributions.
4. **Transparency and accessibility:** State should require local health departments and tax-exempt hospitals to submit all plans and assessments to the state. Additionally, tax-exempt hospitals should be required to submit their Schedule H and corresponding attachments on an annual basis. All plans, assessments and schedules should be made available online by the state.

HB 390 (ORC 3701.981) was enacted in July 2016 to address the final recommendation about transparency and accessibility. This guidance document is issued to local health departments (LHDs) and tax-exempt hospitals to address the other three recommendations. It has been informed by the [Population Health Planning in Ohio](#) report, Public Health Accreditation Board (PHAB) standards, Patient Protection and Affordable Care Act, research of best practices and input from stakeholders.

¹ Health Policy Institute of Ohio. *Improving Population Health Planning in Ohio*, Figure ES.1, p.5. January 2016.

² Note: Tax-exempt hospitals refers to all nonprofit and government owned hospitals that are recognized as a tax-exempt charitable organization under §501(c)(3) of the Internal Revenue Code and that are required to comply with the Internal Revenue Service community health needs assessment requirements; 79 Fed.Reg. 78954.



Local Collaboration

Overview:

Working toward better population health collaboration across public health and clinical care, along with other sectors, is imperative to the success of improved population health. There is a need at the local level to complete required health assessments in a more efficient and effective manner. Collaboration is an essential element to improving population health at the state and community level. Working together across all sectors will reduce duplication and assist all engaged community partners to conduct this work in an effective and efficient manner.

This guidance around collaboration is broad to acknowledge partnerships that already exist and support those that are just forming in the community. The focus is a collaborative effort that allows partners options to complete 1) a single (joint) plan to serve all community partners engaged in the process, or 2) individual plans that are aligned and informed by the collaborative assessment and planning efforts of the collaborative group. Either of these options provide a foundation for the community that begin to link priorities and planning to the State Health Improvement Plan (SHIP) and improve population health planning.

Guidance:

Collaborate with a broad range of community partners. Local health departments (LHDs), hospitals, federally qualified health centers (FQHC), Rural Health Clinics, healthcare providers, Alcohol Drug and Mental Health Boards (ADAMH), health plans, schools, employers, governmental and nongovernmental agencies and businesses should collaborate within the county to identify local health priorities, plan and implement strategies that will contribute to improving the health status of the community (see [Alignment](#)). These planning efforts should include a broad range of community partners as required by PHAB measure 1.1.1 for local health departments and outlined in 26 CFR 1.501(r)-3 for hospitals (list of potential community partners included in [Appendix B](#)).

Some of these same community partners that LHDs and hospitals should partner with also conduct their own assessments and plans. Coordinating these planning and assessment efforts in the community to align all of the plans and stakeholder engagement may be beneficial not only to public health but to all of the community partners involved. Sharing of knowledge, data, expertise and resources may begin to show economies of scale and a synergy around shared missions related to improving the health and well-being of the community.



Guidance

Collaboration should occur at the county level, at minimum. Within a county there may be one or more local health departments and hospitals. All should be working together within that county to conduct a community health assessment to be shared among all collaborating partners. As LHDs and hospitals begin to work toward collaborative approaches, there are opportunities that may lend themselves to a broader, perhaps regional, approach to planning. For example, hospitals often serve multiple counties. Collaboration will require an approach that will allow the hospital system to serve their entire population while meeting the needs identified by the LHDs within each county. To further elaborate, this may mean that some hospitals will have to define their “community” using a dual lens: the county in which the hospital is located, as well as its Market Service Area, which may cover multiple counties and different needs. This may require flexibility among all community partners to consider multiple LHDs and hospital systems to work together through the planning phases. While each may still have their own plans in the end, the collaborative planning process and the identification of shared community strategies that align to the SHIP are the imperative points in this process.

LHD and tax-exempt hospitals should be the lead partners in the assessment and planning process. While each of the community partners may have varying requirements in their planning processes, the team should focus on commonalities and what can be identified as a process that all can share.³ Once identified, all community partners should commit to the process even if there may be steps not necessary for their specific assessment. Collaboration will create shared initiatives and greater teamwork in the community and is essential for improving population health. Community partners should participate in a county collaborative health improvement planning process and align their own community improvement plan to the community health improvement plan/implementation strategy (CHIP/IS).

Local community planning should look to and align with the State Health Assessment and State Health Improvement Plan (SHA/SHIP). The SHA and SHIP are the prominent source of information about Ohio’s overall population health priorities. The planning/assessment process for the SHA/SHIP included strong participation from hospitals, LHDs and many other stakeholder groups to ensure priorities, outcome indicators and evidence-based strategies are relevant to the communities throughout Ohio. As local planning ensues, teams should use the outcome indicators (see [SHA/SHIP tools](#)) identified in the SHA/SHIP, evidence-based strategies, and framework as a foundation for their assessment/planning (see [Alignment](#) for additional details). Community partners should work to identify common areas that can be shared among individual plans that relate to these common initiatives in the collaborative CHIP/IS. There should be clear connections where there are linkages from other community partner plans to the CHIP/IS.

The [MAPP Framework](#) should be used during the assessment and planning phase. By using the same framework across the state, and aligning with the framework used for the SHA/SHIP, economies of scale should be recognized as expertise can be shared among staff and community partners. Using the same process should assist hospitals that work with multiple LHDs. This framework is recognized and can be modified to meet the specific needs of a local community. Hospitals can also modify the framework to fit their federal assessment and planning requirements.

³[2016 Improving Population Health Planning in Ohio \(Appendix 2E\)](#) details the types of community assessments and requirements of each type of partner. [Appendix 2A](#) of the report provides information about requirements for public health and tax-exempt hospitals.



Guidance

SHA/SHIP [conceptual framework](#), the “pathway to health value,” should be used for the local planning/assessment processes. This conceptual framework has been vetted through a multi-stakeholder process and serves as the foundation for the state plans (See the [State Health Assessment](#) for additional information on the conceptual framework).

Map out data needs of community partners. One place to start with this collaborative approach is to identify the data needed by each of the community partners. This will begin to show where overlap in plans already exists. Identify and map each of the community partner’s priorities, strategies, outcome measures and the populations they target; identify commonalities; and build from there. Community partners should share with the team all data, plans, and assessments that are available from their organizations.

There are many resources that exist to provide information regarding the development of community health [assessments/plans](#). ODH will continue to work throughout the next year to develop templates that can be used to facilitate these processes. Additionally, ODH will identify key data metrics/indicators that can be shared regionally and at the county level to assist community partners with their community health assessment data needs to assist with the burden of gathering local data. The SHA/SHIP metrics will be the starting point of where additional data/metrics may be provided at a regional/county level.

Example Local Collaboration at Work:

[HIP-Cuyahoga](#) is a community partnership among multiple organizations in one county working together to improve the conditions of their community in an effort to have an impact on the health and well-being of community members. Partners are committed to a shared vision and common agenda with an understanding that no single organization can create a large-scale and lasting change on a community. Partners coordinate work and resources around defined priorities and goals to have the greatest impact.

General Local Example: One common example of collaboration for nutrition/physical activity includes a hospital implementing the Ohio Hospital Association (OHA) Good4You initiative, in which they move to healthy cafeterias, healthy vending and healthy meetings. Then the United Way might take the lead on the summer food program for kids or funding the MyPlate program in the schools, and then the health department facilitates the program in the schools. The YMCA may take the lead on other programming around physical activity/nutrition and community races. For communities with FQHCs, there may be collaboration with the FQHC, hospital and the LHD in creating school-based health clinics. Additionally, local churches get involved by opening their facilities to the community for free gym time or walking. All of these activities can be identified in the collaborative CHIP/IS. Each community partner shows how they are supporting the community health priorities for their county in their specific planning documents and which actions they are specifically responsible for taking the lead.



Alignment

LHDs and hospitals are encouraged as part of their collaborative planning and assessment process to select at least two priority topic areas from the SHIP (maternal and infant health, chronic disease, and/or mental health and addiction) to address in the collaborative community health improvement plan (CHIP)/implementation strategy (IS). The final priority selection should be guided by the needs that are identified through the data collection and analysis. This does not require **each entity** to select two, but rather the two priorities should be selected as part of the collaborative process agreed upon by both the LHD(s)/hospital(s) for the county.

As communities are selecting overall priorities for their communities, which are guided by the data collected, they should ensure that they are taking a comprehensive approach to decreasing health disparities and achieving health equity. Communities can do this by including strategies that address the social determinants of health, identifying priority populations experiencing the worst disparities in health outcomes, and making recommendations to reach those populations.

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Disparity: the difference in health status rates between population groups.

Inequity: the difference in resource distribution (economic, social, environmental or healthcare resources) that leads to the inequity.

.....

For each of the two **priority** topics selected:

- Select at least one **priority outcome indicator** (e.g. suicide rate, infant mortality, diabetes prevalence) to track.
- Select at least **one cross-cutting strategy** to implement and **one related cross-cutting indicator** to measure impact of the selected strategy.
 - o For a stronger plan, LHDs/hospitals should consider selecting one cross-cutting strategy to implement and one cross-cutting indicator to measure impact **for each of the three cross-cutting factors** (i.e., total of at least three strategies and **three cross-cutting indicators**):
 - At least one strategy from the social determinants of health and a related indicator
 - At least one strategy from the public health and prevention and a related indicator
 - At least one strategy from the healthcare and access and a related indicator

LHDs and hospitals can designate other local community partners to assist in implementing the strategies identified in the collaborative CHIP/IS.



Guidance

Example

The LHD and hospital in the community complete the CHA/CHNA and identify diabetes within chronic disease as a priority from the data in the community assessments. Additionally, infant mortality within the Maternal and Infant Health priority topic was identified. Using the Community Strategy and Indicator Toolkits the following outline shows the possible selections for this scenario.

- Priority Topic:** Chronic Disease (CD)
- Priority Outcome:** Reduced diabetes prevalence
- Priority Outcome Indicator:** Percent of adults who have been told by a health professional they have diabetes

- Priority Topic:** Maternal & Infant Health (MIH)
- Priority Outcome:** Reduced infant mortality
- Priority Outcome Indicator:** Rate of infant deaths per 1,000 live births

Strategies

Priority Area	Cross-Cutting Factors	Evidence-Based Strategy	Related Indicator	Lead Entity
CD- Diabetes	Public Health & Prevention	Healthy Eating, Farmer’s Markets	Percentage of population with limited access to healthy food defined as the percentage of low income individuals (<200 percent FPG) living more than 10 miles from a grocery store in rural areas and more than one mile in non-rural areas	LHD
MIH – Infant Mortality	Social Determinants of Health	Smoke-free policies (multi-unit housing, schools, other settings)	Percent of children exposed to secondhand smoke	LHD

LHDs and hospitals are encouraged to take a comprehensive approach to addressing the SHIP priorities. Several of the evidence-based strategies identified in the Community Strategy and Indicator Toolkits (see below) impact multiple priority topic outcomes. Furthermore, approaches that address all cross-cutting factors (equity, social determinants of health, public health and prevention, and healthcare system and access) are more likely to be effective than less comprehensive approaches. We therefore encourage LHDs and hospitals to consider selecting an evidence-based strategy from **each** of the cross-cutting factors when feasible. Community partners are encouraged to use action plans for each of the strategies to identify the action steps necessary for implementation and the community partners responsible for these actions.



Guidance

Tools Available

The following documents provide information needed to adhere to this guidance:

- 2017-2019 State Health Improvement Plan
- Community strategy and indicator toolkits (includes cross-cutting strategies and indicators, approaches to achieving health equity and resources for collaboration and community engagement)
 - o Community strategy and indicator toolkit: Chronic Disease
 - o Community strategy and indicator toolkit: Maternal and Infant Health
 - o Community strategy and indicator toolkit: Mental Health and Addiction
- Master list of SHIP indicators (Excel file)

Hospital Community Benefit

Hospital community benefit and community health planning requirements provide an opportunity for hospitals to better align their investments in a way that more effectively and efficiently supports their community's prioritized health needs.

501(c)(3) hospitals are required to justify their tax-exempt status to the Internal Revenue Service (IRS) by allocating a portion of their operating expenses towards "hospital community benefit" activities. The IRS outlines seven categories of expenditures that are considered legitimate, reportable hospital community benefit:

1. Financial assistance at cost or "charity care"
2. Unreimbursed costs from Medicaid and other means-tested government programs
3. Subsidized health services
4. Community health improvement services and community benefit operations
5. Health professions education
6. Research
7. Cash and in-kind contributions

Of these seven categories, *community health improvement services* and *cash and in-kind contributions* most directly align with a hospital's community health planning activities and a broader approach to community-wide health.

Community health improvement services are defined as "activities or programs, subsidized by the [hospital], carried out or supported for the express purpose of improving community health."

Cash and in-kind contributions are "contributions made by the [hospital] to healthcare entities and other community groups restricted, in writing, to one or more of the community benefit activities" outlined by the Internal Revenue Service.



Guidance

The Health Policy Institute of Ohio conducted a review of Ohio hospital community benefit activities in the [Improving Population Health Planning in Ohio Report](#). Based on 2012 Schedule H data, approximately 5 percent of Ohio hospitals total net community benefit expenditures were allocated towards community health improvement services and cash and in-kind contributions. In comparison, the national average for these categories was 7.5 percent in 2011. Ohio hospitals are already making significant investments in their communities through their community benefit activities and are well positioned to more strategically align their spending to address their community's prioritized health needs.

The development of ongoing collaborative partnerships at the community and regional level between hospitals, local health departments and other community partners can ensure that prioritized health needs are aligned across entities within a community. A hospital's engagement in a collaborative approach around community health improvement planning that aligns with the SHIP can also ensure that resources within a community are targeted towards specific evidence-based interventions that can more effectively improve a community's overall health.

As collaborative efforts expand with public health and community partners, hospitals should engage in these collaborative community-wide approaches to planning and contribute resources, along with other community partners, to address the needs of their communities and improve the health of community residents. Hospitals are encouraged to coordinate with other hospitals where populations overlap and consider larger collaborative efforts if their populations are served by more than one local health department.

Many Ohio hospitals are already taking steps to reallocate some of their community benefit spending towards activities that have a greater impact on their community's overall health. Many others are realigning their investments to target their community's prioritized health needs. Ohio hospitals are encouraged to work towards exceeding the national average for investments in the community health improvement services and cash and in-kind contributions community benefit categories. Additionally, over time, Ohio hospitals should increasingly align their community benefit investments with the priorities and evidence-based strategies identified in their community's health improvement plan/implementation strategy and the SHIP.

H.B. 390 (ORC 3701.981) requires tax-exempt hospitals to submit their Schedule H to ODH, which includes information on a hospital's community benefit expenditures. Hospitals are also required to submit their community health needs assessment and implementation strategy to ODH. ODH will report on where hospitals community benefit dollars are allocated in comparison to the national and state average. Additionally, ODH will report on a hospital's alignment with priorities and evidence-based strategies identified in the SHIP and a hospital's level of collaboration with local health partners.

See [Appendix E](#) for examples of community benefit activities that align with SHIP priorities and strategies.



Transparency and Accessibility

LHD Reporting Requirement

By July 1, 2017, [ORC 3701.981](#) requires all local health departments to submit to ODH existing Community Health Assessments (CHA) and Community Health Improvement Plans (CHIP). As part of the LHD Pathways Project with The Ohio State University's Center for Public Health Practice (CPHP), many LHDs have submitted current CHA/CHIP. If an LHD has submitted these documents through this process they will not be required to submit again. If an LHD did not submit their CHA/CHIP to CPHP then they are required to upload their current CHA/CHIP into OPPD by July 1, 2017.

LHDs will be sent a survey link in June to identify if their current CHA/CHIP aligns with any of the state SHIP priorities. While it is recognized that communities are not required to align to the SHIP until 2020, we would like to assess the current status of alignment in the state as we move in this direction.

Hospital Reporting Requirement

By July 1, 2017, [ORC 3701.981](#) requires all tax-exempt hospitals to submit to ODH existing community health needs assessments and plans. Additionally hospitals are required to submit to ODH a copy of the hospital's schedule H (form 990), corresponding attachments and reporting on financial assistance and means-tested government programs and community building activities in parts I and II of schedule H. These documents will be submitted to ODH using a dedicated email address that will be shared with all tax-exempt hospitals in a notice that will be sent in March 2017.

Tax-exempt hospitals will be provided with a form template to complete to identify if their current priorities align with any of the state's SHIP priorities. While it is recognized that communities are not required to align to the SHIP until 2020, we would like to assess the current status of alignment in the state as we move in this direction.

Hospitals will be required to submit Schedule H documents to ODH annually.

Please refer to [Appendix F](#) for details on the timeline for reporting.



Guidance

Appendix A:

Details of the similarities and differences between the assessment and planning process for LHDs and hospitals. ([HPIO Improving Population Health Planning in Ohio Report, Appendix 2A](#) requirements for the ODH LHD and 501 (c)(3) tax-exempt hospitals)

MAAP (Mobilizing for Action through Planning & Partnerships) Resource:
<http://archived.naccho.org/topics/infrastructure/mapp/index.cfm>

NACCHO CHA/CHIP Guidance:
<http://archived.naccho.org/topics/infrastructure/CHAIP/accreditation-preparation.cfm>

Community Toolbox: <http://ctb.ku.edu/en/table-of-contents>

General Resources

http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/index.htm

<http://www.health.state.mn.us/divs/opi/pm/lphap/>

<http://www.cdc.gov/chinav/case/index.html> - CDC Community Health Improvement Navigator

<https://www.healthypeople.gov/> HealthyPeople.gov

Community Benefit

<https://www.chausa.org/communitybenefit/community-benefit>

<http://www.phi.org/resources/?resource=supporting-alignment-and-accountability-in-community-health-improvement-the-development-and-piloting-of-a-regional-data-sharing-system>

Reports

"Making the most of community health planning in Ohio, The role of hospitals and local health departments", May 2015, http://www.healthpolicyohio.org/wp-content/uploads/2016/03/PolicyBrief_CHAS_CHNAS_FINAL.pdf

"Improving Population Health Planning in Ohio", January 2016, <http://www.healthpolicyohio.org/populationhealth/>



Appendix B: Community Engagement Stakeholder List

See PHAB Standard 1.1.1

These stakeholders can be used at any point during the assessment and planning process. The list is not meant to be all inclusive, but to provide a starting point of ideas of ways to engage non-traditional partners in planning activities and community engagement activities.

Hospitals

Local Health Departments

Federally Qualified Health Centers (FQHC)

Rural Health Clinics and/or Networks

Healthcare Providers

Patient-Centered Medical Homes

Health Plans

Area Agency on Aging

Alcohol Drug and Mental Health Board (ADAMH)

Schools and other education providers (throughout the life course)

Employers & Businesses – (i.e., Economic Development Corporation)

Governmental Agencies

Non-Governmental Agencies & Community-Based Organizations

Community-based health & human service agencies

Advocacy Groups that specifically deal with underrepresented populations in your area

Regional Planning Organizations

Organizations providing mental health and substance abuse services

Criminal Justice and Law Enforcement

Policy makers

Children Family First Council

United Way

Churches / Ministerial Associations

Reentry Coalitions

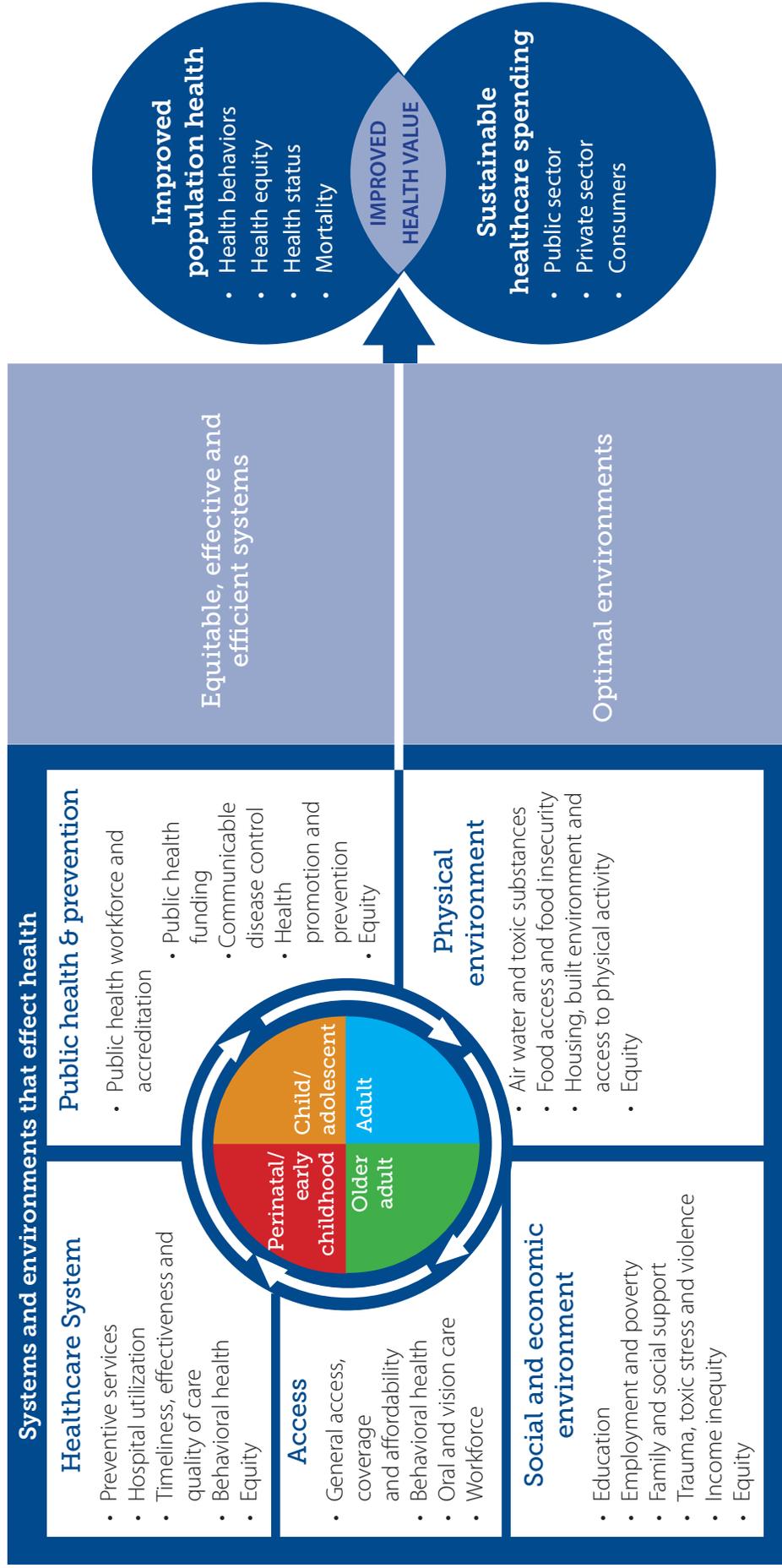


Guidance

Appendix C

Conceptual Framework

Figure ES.2. State health assessment and state health improvement plan conceptual framework: Pathway to health value



World Health Organization definition of health: Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

See [State Health Assessment](#) for more details



Guidance

Appendix D: Community Strategy and Indicator

Mental Health and Addiction Toolkit

<http://www.odh.ohio.gov/-/media/ODH/ASSETS/Files/chss/ship/CommunityToolkitMHA02082017.pdf?la=en>

Chronic Disease Toolkit

<http://www.odh.ohio.gov/-/media/ODH/ASSETS/Files/chss/ship/CommunityToolkitCD02082017.pdf?la=en>

Maternal & Infant Health Toolkit

<http://www.odh.ohio.gov/-/media/ODH/ASSETS/Files/chss/ship/CommunityToolkitMIH02082017.pdf?la=en>

Master List of SHIP Indicators <http://www.odh.ohio.gov/SHA-SHIP>



Appendix E: Examples of hospital community benefit activities that align with SHIP priorities and strategies

Note: Examples below should not be construed as legal or tax advice. These examples are not an all inclusive list and are provided for informational purposes only. A hospital should consult with their legal/tax counsel regarding their organization’s community benefit activities and reporting.

SHIP priority	SHIP strategy	Example of community benefit activity*	Source for community benefit activity examples
Maternal and infant health Chronic disease Mental health and addiction	Increase earned income tax credit uptake	Income tax assistance program: Hospital participated in a Volunteer Income Tax Assistance (V.I.T.A) program with the IRS. This free tax preparation program is available to individuals and families who earn less than \$46,000 a year. Hospital is used as a site for meeting with clients and hospital employees can sign up to deliver the service.	Catholic Health Association
Maternal and infant health Chronic disease Mental health and addiction	School-based nutrition education programs	School-based food education: Hospital participates in a community-wide environmental sustainability project that includes providing school based education on healthy eating habits to students in low-income neighborhoods.	Catholic Health Association
Maternal and infant health Chronic disease Mental health and addiction	Community healthy food access: <ul style="list-style-type: none"> • Healthy food initiatives in food banks, • WIC and senior farmers’ market nutrition programs, • SNAP infrastructure at farmers’ markets/EBT payment at farmers’ markets 	Monthly mobile food market: A health system’s WIC nutrition program collaborated with community groups and local governments to provide a monthly mobile food market. The market offers free healthy groceries, provided by the local food bank. The hospital staff and partner agencies offer additional health services at the market, including blood pressure and blood sugar screenings, flu vaccinations, and information about enrollment in SNAP benefits, health insurance and WIC services.	Health Resources in Action



Guidance

Appendix E

SHIP priority	SHIP strategy	Example of community benefit activity*	Source for community benefit activity examples
Maternal and infant health Chronic disease Mental health and addiction	Community healthy food access: <ul style="list-style-type: none"> • SNAP infrastructure at farmers' markets/EBT payment at farmers' markets • Competitive pricing—fruit and vegetable incentive programs 	Supplemental Nutrition Assistance Program (SNAP) Double Dollars Program: Hospital participated in a SNAP Double Dollars Program, which is an incentive program designed to encourage SNAP recipients to purchase fresh, local foods at farmers markets. Shoppers at participating markets receive \$10 in matching funds for SNAP purchases of fresh fruits and vegetables.	Building Healthy Places (pg. 11)
Maternal and infant health Chronic disease Mental health and addiction	Local/regional built environment changes to support active living and social connectedness: <ul style="list-style-type: none"> • Community-scale urban design land use policies/ Streetscape design (Complete Streets); • Bike and pedestrian master plans 	Building bike and walking paths: A hospital worked with local government on projects such as the building of biking and walking paths. One such project is a path and boardwalk that will connect two affordable housing complexes, so that residents can safely walk to schools, jobs and grocery stores.	Hospitals in Pursuit of Excellence
Maternal and infant health Chronic disease Mental health and addiction	Tobacco prevention and cessation, including: <ul style="list-style-type: none"> • Mass-reach tobacco prevention and cessation campaigns • Policies to decrease availability of tobacco products 	Tobacco prevention and cessation campaigns: Hospital participates on and provides financial support to tobacco control coalitions and their policy work	Change Lab Solutions
Maternal and infant health Chronic disease Mental health and addiction	Local strategies to reduce asthma triggers in rental housing (such as advocacy, legal aid, rental registry, etc.)	Removal of harmful materials in housing: Hospital participates in local coalition and provides financial support to remove harmful materials (such as asbestos or lead) in public housing	Catholic Health Association

*Program descriptions come directly from source and serve only as examples of community benefit activities.



Guidance

Local Guidance/Implementation Timeline

Date	Activity
March 1, 2017	Notice regarding reporting requirements sent to LHDs and Hospitals
June 15, 2017	Survey distributed to LHDs regarding SHIP alignment with existing CHIP
July 1, 2017	LHDs shall submit all existing CHA/CHIPs via OPPD
	Hospitals shall submit current CHNA/Improvement Strategy to ODH using dedicated email. Submission will include cover page template to identify SHIP alignment with existing plans
	Hospitals shall submit Schedule H and corresponding attachments to ODH. If extension is filed hospital should send extension
October 15, 2017	ODH to publish all local plans/assessments/analysis to public site
February – December 2017	ODH to provide training via webinars, regional training, and statewide training on the use and implementation of guidance
July 1, 2018	LHD and hospital submit any update plans/assessment from prior year Submit metrics that were measured (aligned with SHIP)
	Hospitals shall submit Schedule H and corresponding attachments to ODH. If extension is filed hospital should send extension
October 15, 2018	ODH to publish all local plans/assessments/analysis to public site
Fall/Winter 2018	SHA process to begin
Spring 2019	SHIP process to begin
November 2019	SHIP Finalized



Guidance

Appendix G: State-local SHIP alignment

State health improvement plan (SHIP) overview

Overview of guidance for local alignment with the SHIP
See ODH guidance for aligning state and local efforts for details

Overall health outcomes

- ↑ Health status
- ↓ Premature death

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

Select at least 2 priority topics (based on best alignment with findings of CHA/CHNA)

Ten priority outcomes	
<ul style="list-style-type: none"> ↓ Depression ↓ Suicide ↓ Drug dependency/abuse ↓ Drug overdose deaths 	<ul style="list-style-type: none"> ↓ Heart disease ↓ Diabetes ↓ Asthma
	<ul style="list-style-type: none"> ↓ Preterm births ↓ Low birth weight ↓ Infant mortality

Select at least 1 priority outcome indicator within each selected priority topic (see SHIP master list of indicators)

Equity: Priority populations for each outcome

Identify priority populations for each priority outcome indicator (based on findings from CHA/CHNA) and develop targets to reduce or eliminate disparities

Four cross-cutting factors

- 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.

- Social determinants of health
- Public health system, prevention and health behaviors
- Healthcare system and access

Equity

- 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

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.

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.

