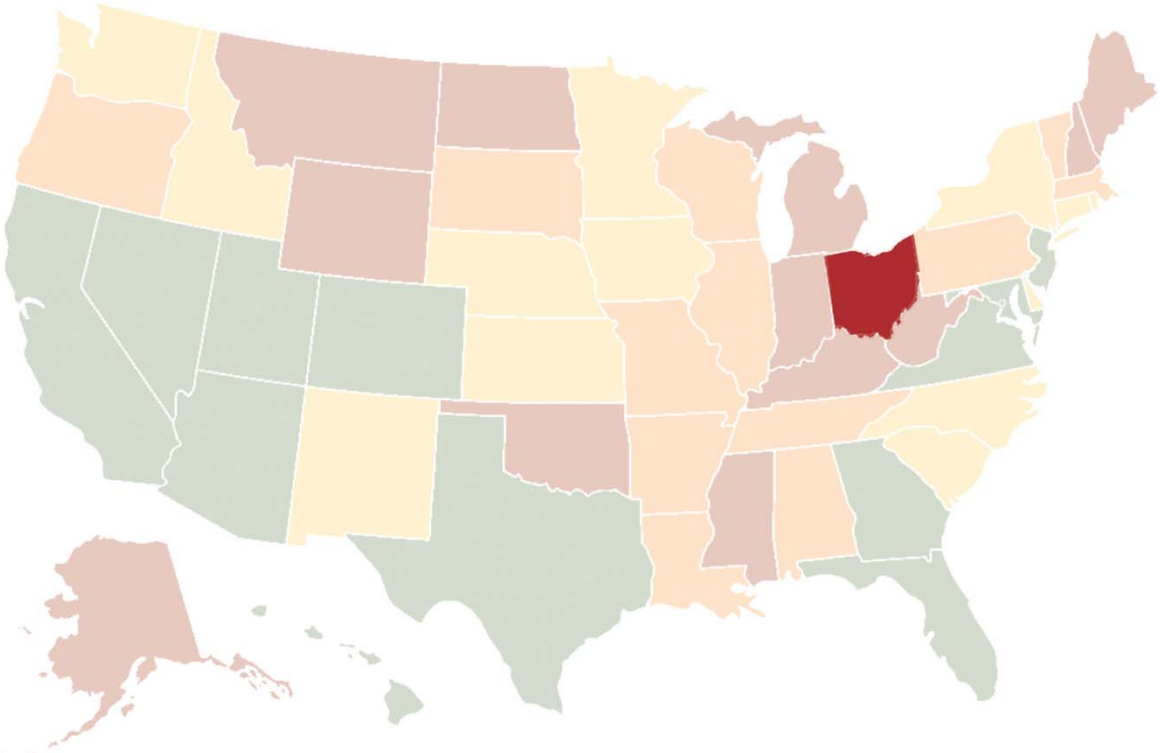
health policy institute of ohio

Greatest challenges from the 2017 *Health Value Dashboard*

September 2017



2017 Health Value Dashboard™

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Ohio's strengths and challenges

Ohio's greatest health value strengths

Domain	Metric	Ohio's rank	Trend
Access	**Underserved, primary care physicians.** Percent of need not met by current supply in designated primary care health professional shortage areas (2016)	11	No change
	Uninsured adults. Percent of 18-64 year olds that are uninsured (2014)	13	Moderately improved
	Employer-sponsored health insurance coverage. Percent of all workers who work at a company that offers health insurance to its employees (2015)	13	No change
	Unable to see doctor due to cost. Percent of adults who went without care because of cost in the past year (2015)	13	Greatly improved
Physical environment	**Fluoridated water.** Percent of the population served by a community water system with optimally fluoridated water (2014)	12	No change
Population health	**Youth all-tobacco use.** Percent of youth ages 12-17 who used cigarettes, smokeless tobacco, cigars or pipe tobacco during past 30 days (2013-2014)	37	Greatly improved
	Life expectancy. Life expectancy at birth based on current mortality rates (2010)	37	Moderately improved
	Adult smoking. Percent of population age 18 and older that are current smokers (2015)	43	Moderately improved
Access to care	**Unmet need for illicit drug use treatment.** Percent of individuals, ages 12 and older, needing but not receiving treatment for illicit drug use in the past year (2013-2014)	26	Moderately improved
Healthcare system	**Heart failure readmissions for Medicare beneficiaries.** Rate of Medicare beneficiaries discharged from the hospital with a principal diagnosis of heart failure who were readmitted for any cause within 30 days after the index admission date, per 100 index cases (2014)	17	Greatly improve
	Breastfeeding support in hospitals. Average Maternity Practice in Infant Nutrition and Care (mPINC) score among hospitals and birthing facilities to support breastfeeding (2013)	24	Moderately improved
	Stroke care. Percent of ischemic stroke patients who got medicine to break up a blood clot within 3 hours after symptoms started (2014-2015)	25 (out of 50)	Greatly impr
	Prenatal care. Percent of women who completed a pregnancy in the last 12 months and who received prenatal care in the first trimester (2014)	28 (out of 48)	Moderat improv
Public health and prevention	**Youth marijuana use.** Past-year initiation of marijuana use (used it for the first time), percent of youth ages 12-17 (2014)	18	Greatly i
	Fourth-grade reading. Percent of 4th graders proficient in reading by a national assessment (NAEP) (2015)	18	Mo im
Social and economic environment	**Unemployment.** Annual average unemployment rate, ages 16 and older (2015)	21	Grea
Physical environment	**Bike and pedestrian infrastructure.** Per capita federal transportation funding obligated to bike and/or pedestrian projects (2012-2014)	22 (out of 50)	
	Outdoor air quality. Average exposure of the general public to particulate matter of 2.5 microns or less in size (PM2.5) (2012-2014)	45	
	Children exposed to second-hand smoke. Percent of children who live in a home where someone uses tobacco or smokes inside the home (2011/2012)	49	

Top quartile | Second quartile | Third quartile | Bottom quartile
Of the 50 states and D.C.

Trend note: Improved or worsened refers to a change that exceeds one-half standard deviation in the metric's value from bas recent year. Changes that do not meet this threshold are marked "no change."

Ohio's greatest health value challenges

Bottom quartile metrics

Domain	Metric	Ohio's rank	Trend
Population health	**Infant mortality.** Number of infant deaths per 1,000 live births (within 1 year) (rank-2014, trend-2015)	39	Moderately worsened
	Cardiovascular disease mortality. Number of deaths due to all cardiovascular diseases, including heart disease and strokes, per 100,000 population (age adjusted) (2015)	40	No change
	Limited activity due to health problems. Average number of days in the previous 30 days when a person reports limited activity due to physical or mental health difficulties (ages 18 and older) (2014)	41	No change
	Adult smoking. Percent of population age 18 and older that are current smokers (2015)	43	Moderately improved
Healthcare spending	**Drug overdose deaths.** Number of deaths due to drug overdoses per 100,000 population (age-adjusted) (2015)	49	Greatly worsened
	Average monthly marketplace premiums, after advanced premium tax credit. Average monthly premium for all enrollees in the federal marketplace after application of an advanced premium tax credit (2016)	38 (out of 38)	Greatly increased
	Total Medicare spending (Parts A and B), per Medicare enrollee. Price, age, sex and race-adjusted Medicare reimbursements per Medicare enrollee (Parts A and B) (2012)	46	No change
Healthcare system	**Hospital admissions for asthma per 100,000 population, ages 2-17.** Admissions for asthma per 100,000 population, ages 2-17 (2013)	31 (out of 41)	No change
	Mortality amenable to healthcare. Number of deaths before age 75 per 100,000 population that resulted from causes considered at least partially treatable or preventable with timely and appropriate medical care (2012-2013)	39	No change
	Cancer early stage diagnosis, female breast cancer cases. Percent of female breast cancer cases diagnosed at an early stage (2009-2013)	40 (out of 50)	No change
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Public health and prevention	**Cancer early stage diagnosis, all.** Percent of all cancer cases diagnosed at an early stage (2009-2013)	46 (out of 50)	No change
	State public health workforce. Number of state public health agency staff FTEs per 100,000 population (2012)	44 (out of 49)	No change
	Emergency preparedness funding. Total per capita funding for state and local health departments' emergency preparedness (2016)	44	N/A
	Child immunization. Percent of children ages 19 to 35 months who received all recommended vaccines (2013) confirmed (2015)	48 (out of 50)	Greatly worsened
	Foodborne illness monitoring. Proportion of foodborne illness outbreaks for which an etiologic agent is	50	Moderately worsened
Physical environment	**Outdoor air quality.** Average exposure of the general public to particulate matter of 2.5 microns or less in size (PM2.5) (2012-2014)	45	Moderately improved
	Food insecurity. Percent of households with limited or uncertain access to adequate food (2013-2015)	45	No change
	Children exposed to secondhand smoke. Percent of children who live in a home where someone uses tobacco or smokes inside the home (2011/2012)	49	Greatly improved

Other metrics that worsened

Domain	Metric	Ohio's rank	Trend
Population health	**Adult insufficient physical activity.** Percent of adults 18 years and older not meeting physical activity guidelines for muscle strength and aerobic activity (2015)	30	Moderately worsened
	Poor oral health. Percent of adults who have lost teeth due to decay, infection or disease (2014)	38	Moderately worsened
Healthcare spending	**Average family premium, per enrolled employee.** Average total family premium per enrolled employee for employer-sponsored health insurance (2015)	21	Moderately increased
	Average single premium, per enrolled employee. Average total single premium per enrolled employee for employer-sponsored health insurance (2015)	31	Moderately increased
Access to care	**Medical home, children.** Percent of children who have a personal doctor or nurse, have a usual source for sick and well care, receive family-centered care, have no problems getting needed referrals and receive effective care coordination when needed (2011/2012)	24	Greatly worsened
Social and economic environment	**Social capital and cohesion.** Composite measure that includes connections with neighbors, supportive neighborhoods, voter turnout and volunteerism (2015)	24 (out of 50)	Greatly worsened

Metric	Ohio's rank
Adult smoking	43
Drug overdose deaths	49

Ohio's greatest health value challenges

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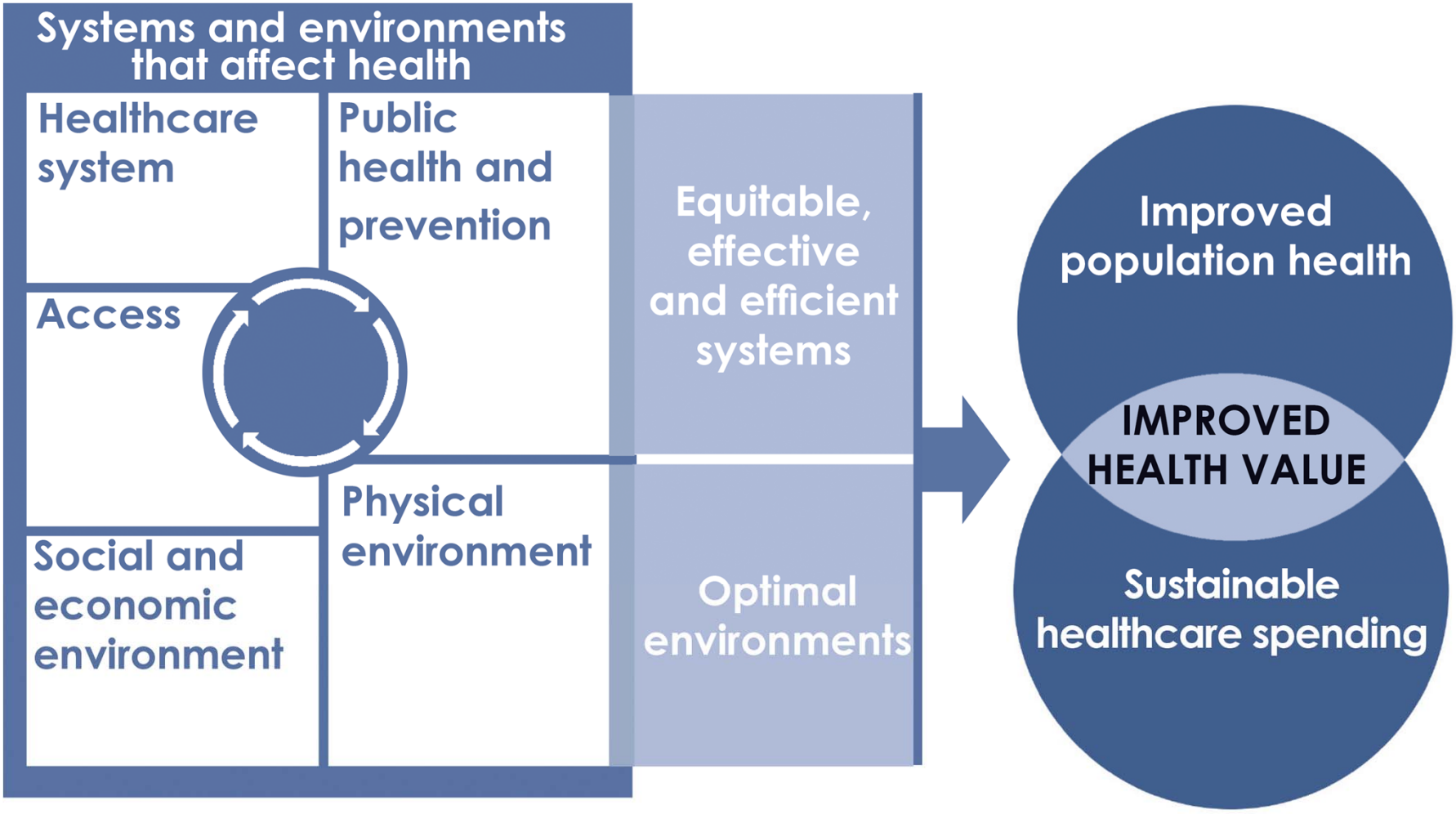
Pathway to improved health value:
A conceptual framework



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.

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Data in context

	Examples
Rankings	
Progress and trends	**Greatly improved**
Highlighting other states	**Most improved state(s)** TN, NV, LA
Disparities and inequities	Little to no disparity Medium disparity Large disparity

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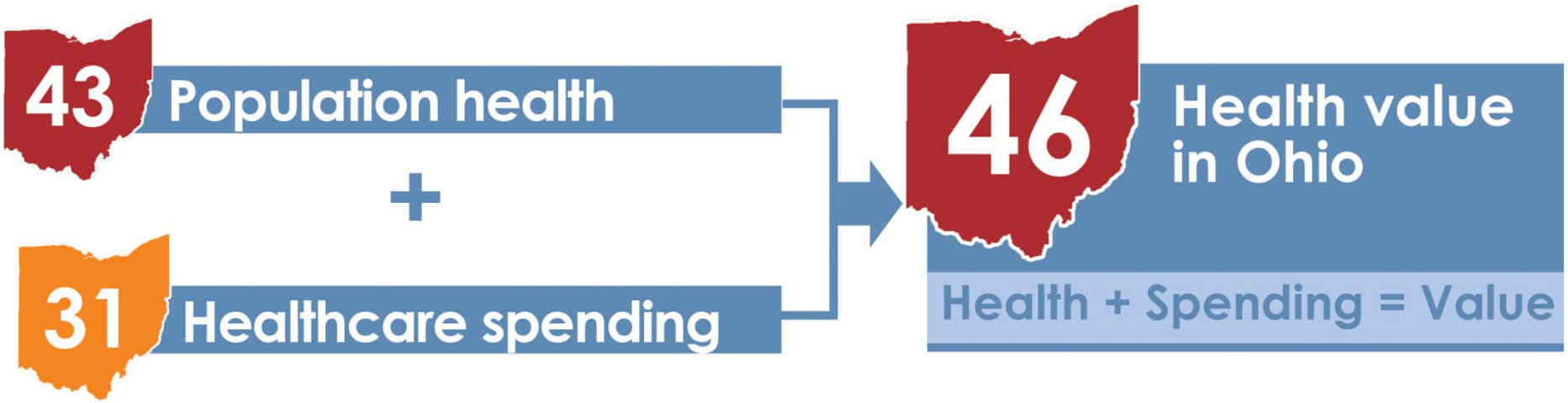
How does Ohio do?

Where does Ohio rank?



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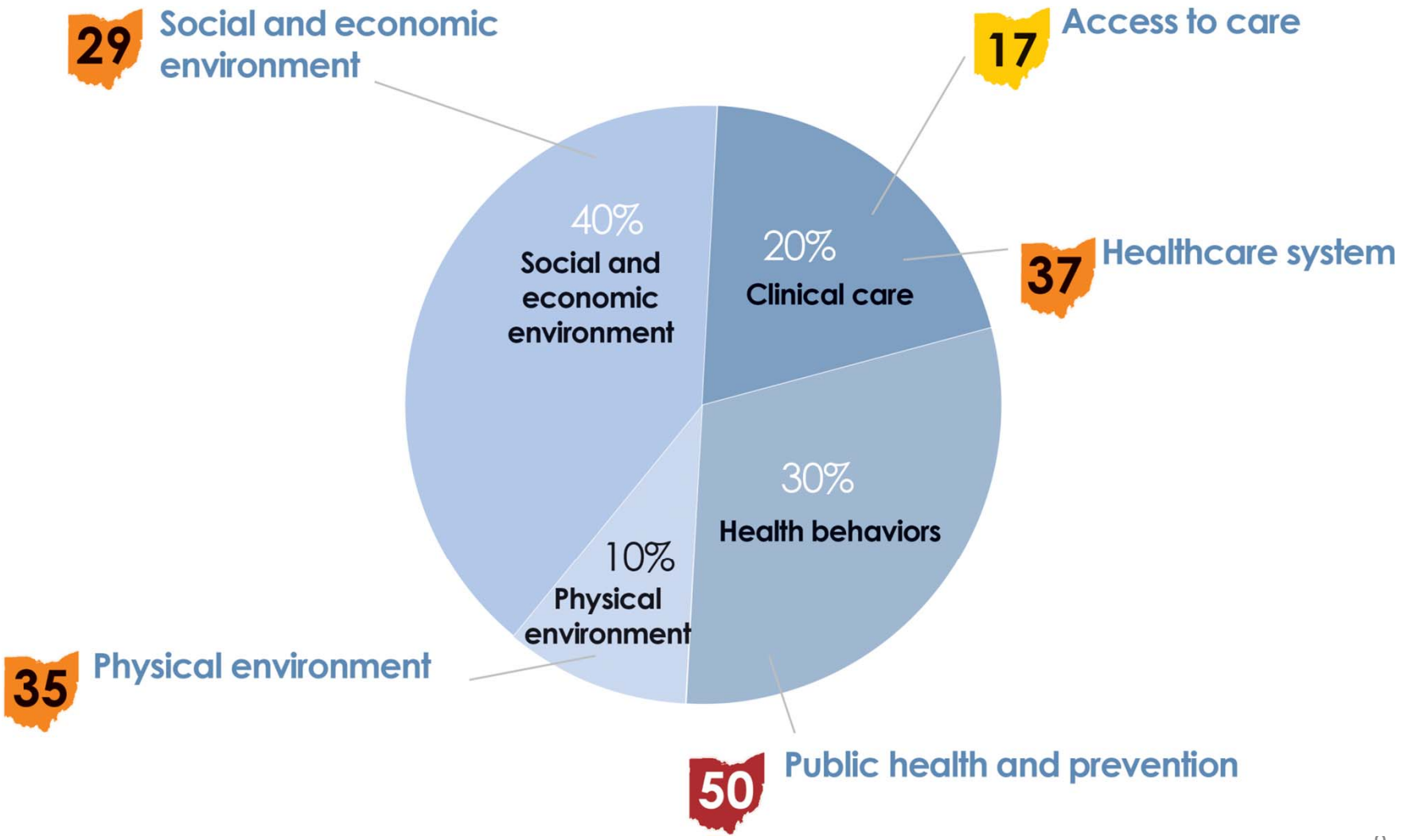
Why does Ohio rank so poorly?

Ohio performs poorly on many of the factors that impact health value



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Dashboard material

http://www.hpio.net/2017-health-value-dashboard/

- Full Dashboard
- 2-page executive summary
- 8-page snapshot
- Methodology
- Local-level data crosswalk
- FAQ
- Excel with metric descriptions

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Metric	Ohio's rank
Adult smoking	43
Drug overdose deaths	49

Ohio's greatest health value challenges

Bottom quartile metrics

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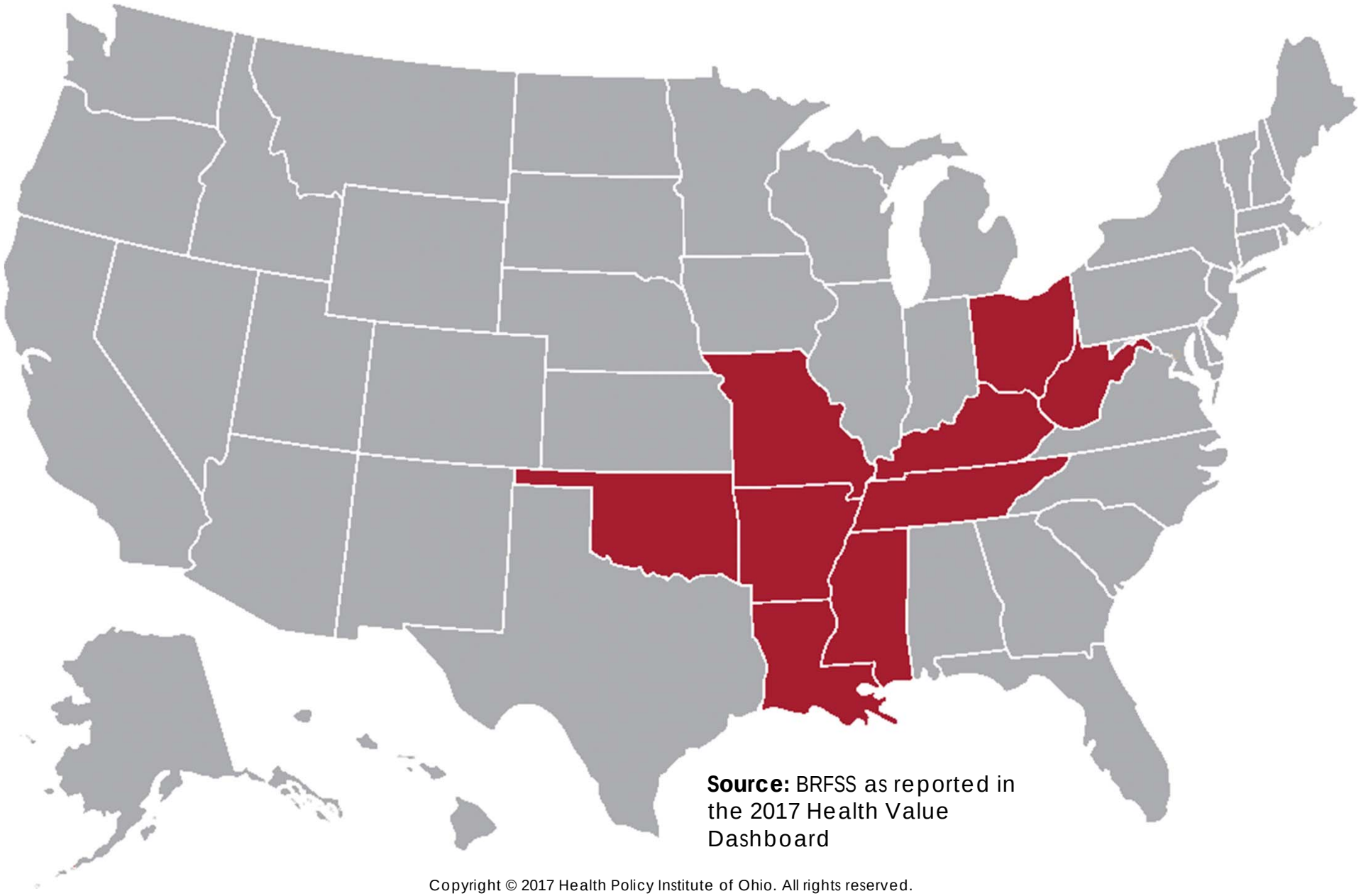
States with the highest adult smoking rate

Percent of population age 18 and older that are current smokers (2015)



Source: BRFSS as reported in the 2017 Health Value Dashboard

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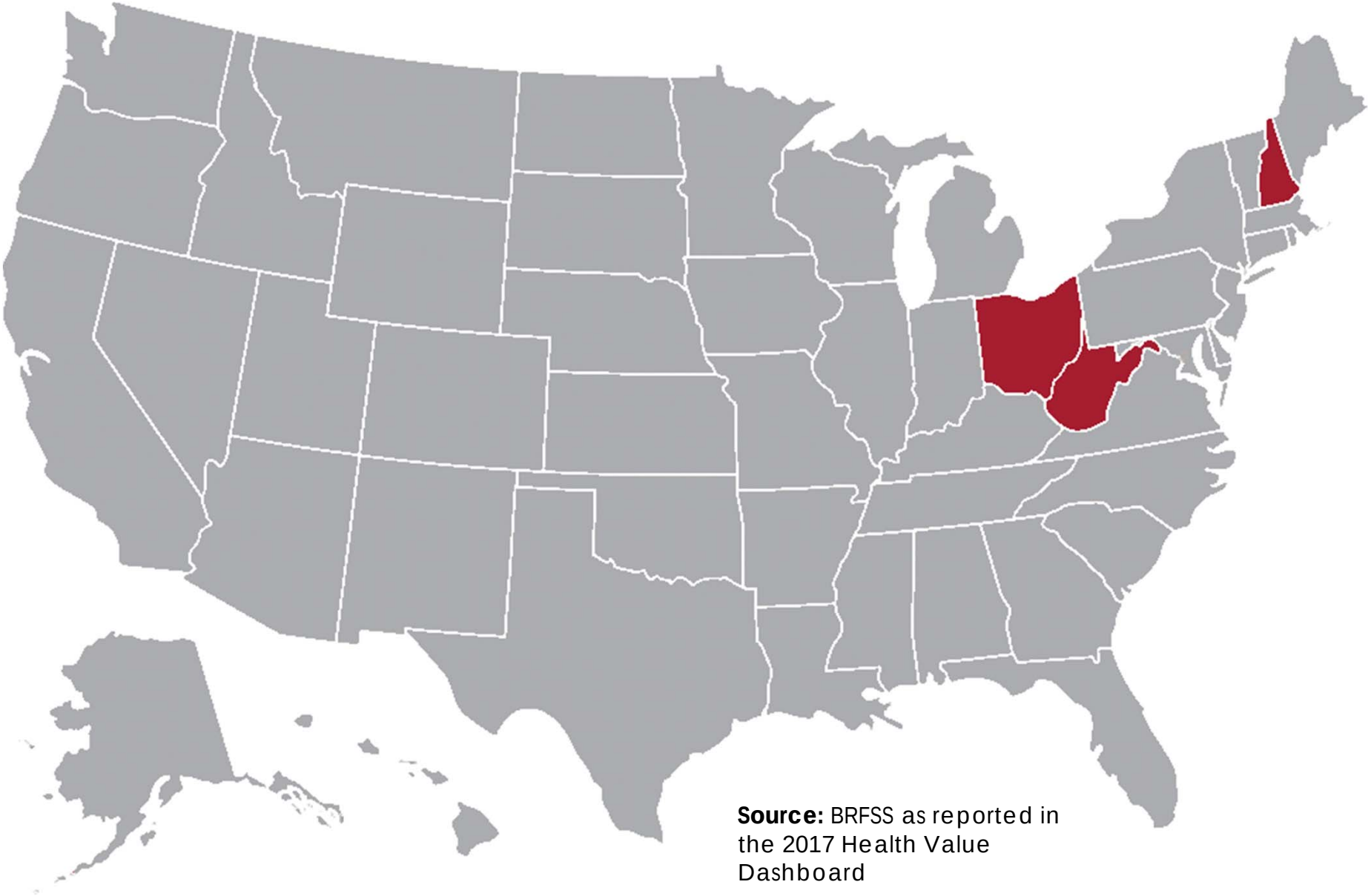
States with the highest drug overdose death rate

Number of deaths due to drug overdoses per 100,000 population (age-adjusted) (2015)



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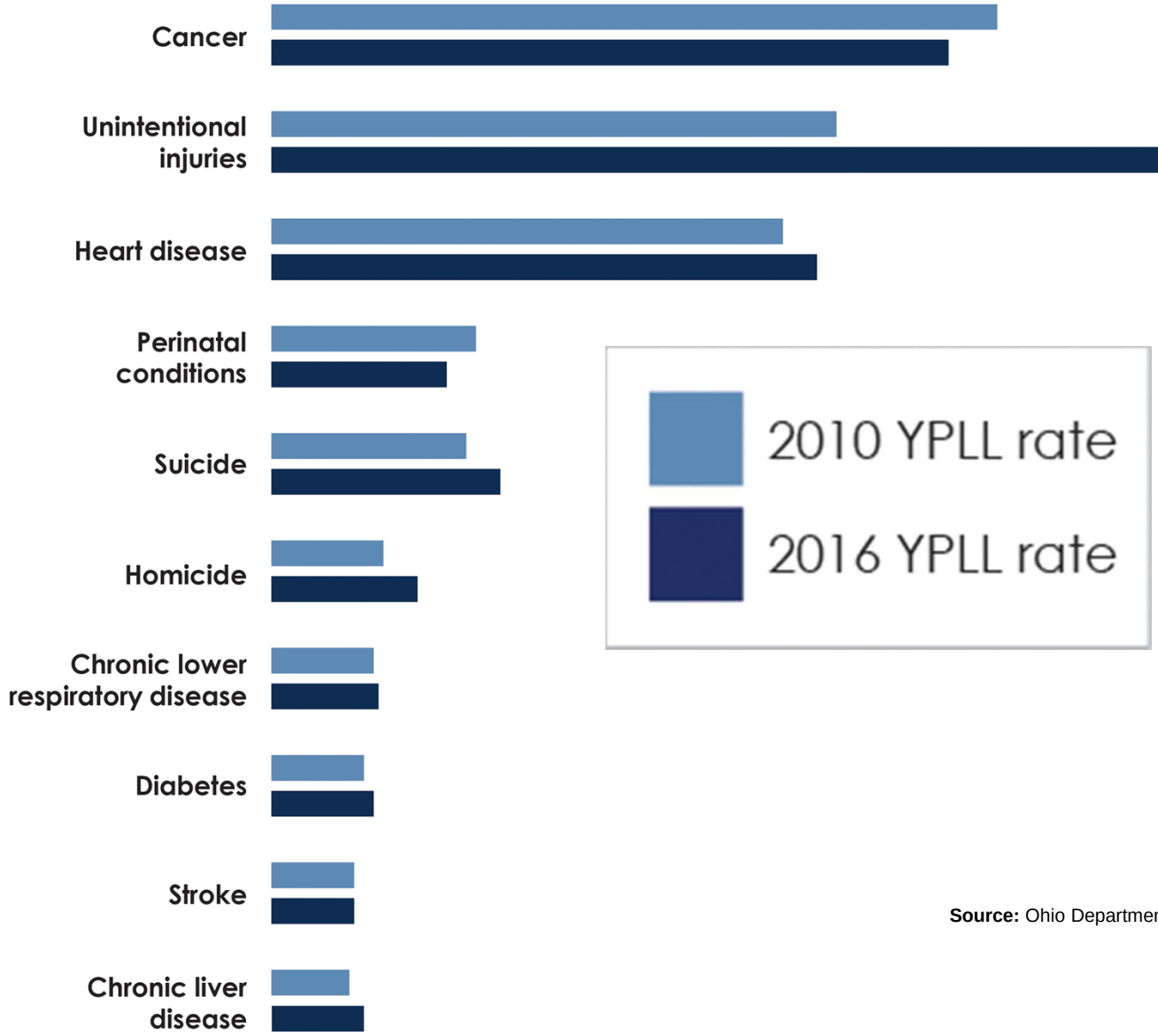
Premature death, by cause, Ohio

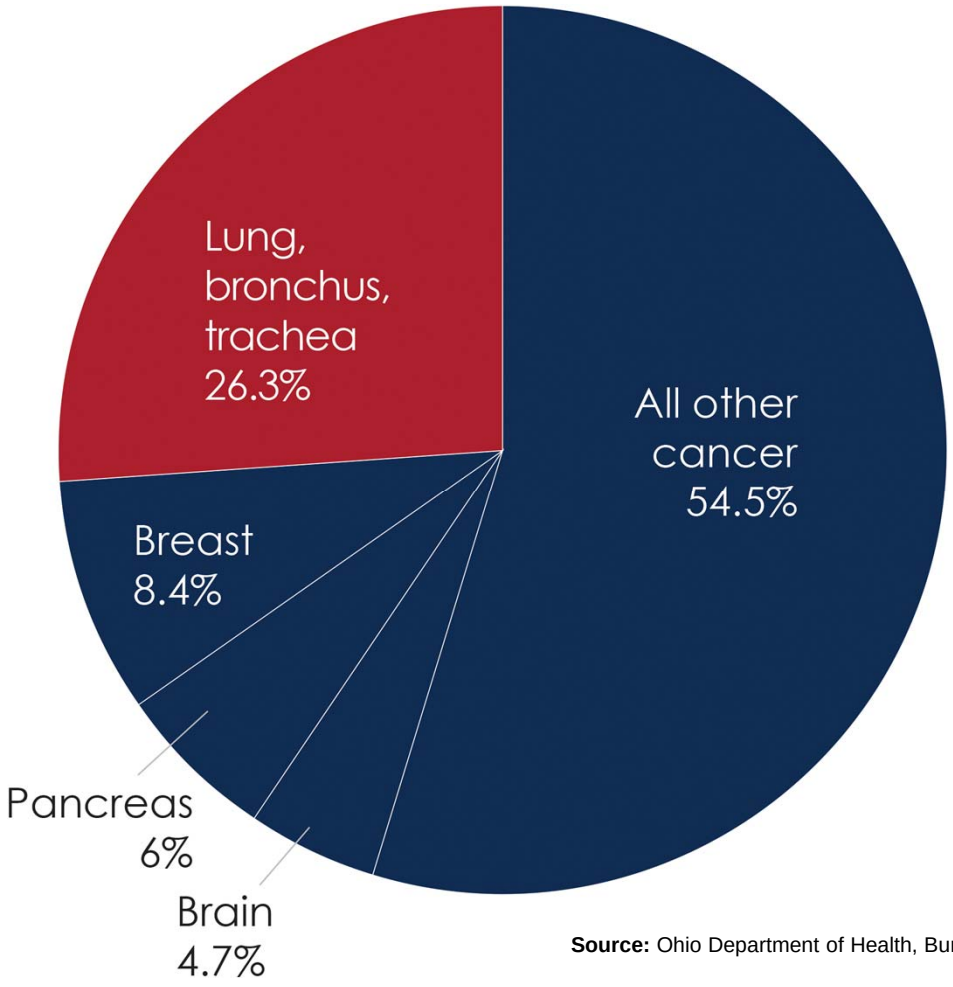
YPLL before age 75, age adjusted rate per 1,000 pop.



Source: Ohio Department of Health, Bureau of Vital Statistics

Years of potential life lost among all cancers, Ohio, 2016

YPLL before age 75, age adjusted



Source: Ohio Department of Health, Bureau of Vital Statistics

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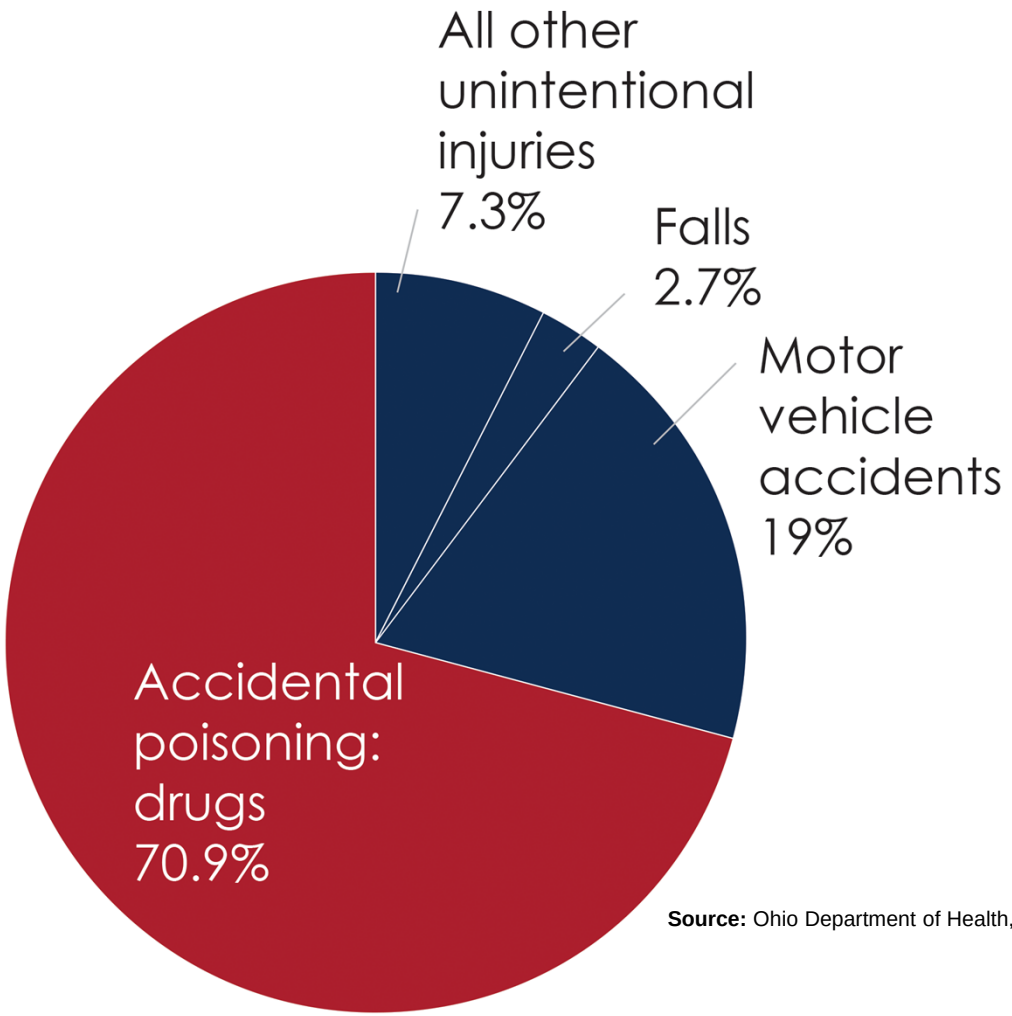
Years of potential life lost among all unintentional injuries, Ohio, 2016

YPLL before age 75, age adjusted



Source: Ohio Department of Health, Bureau of Vital Statistics

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Ohio's greatest health challenges

Tobacco and opiates

- Prevalence and trends
- Groups most at risk (disparities)
- Impact on healthcare spending
- Life course
- Evidence-based strategies

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Tobacco

June 2015

hpio Health Policy Brief

The state of tobacco use prevention and cessation in Ohio

Environmental scan and policy implications

After releasing the *Health Value Dashboard* in December 2014, HPIO convened a group of healthcare and public health stakeholders to review Ohio's greatest health strengths and challenges. This group identified tobacco use as a significant concern, noting that compared to other states, Ohio performed in the bottom

prevalence of tobacco use given the strengths and challenges of Ohio's current tobacco policies.

In addition, HPIO will soon release an accountability map that describes how various public health and healthcare entities in Ohio

health policy institute of ohio

Updated March 2017

POLICY OPTIONS FACT SHEET

State policy options to reduce tobacco use and secondhand smoke exposure

Tobacco use and secondhand smoke exposure

Health outcomes

- Ohio has higher tobacco use rates than most other states, ranking **39** for adult cigarette smoking[1] and **49** for secondhand smoke exposure for children.[2]
- Tobacco use and secondhand smoke exposure contribute to infant mortality, heart disease, cancer, diabetes and many other health problems.

Healthcare costs

- **42 percent** of working-age Ohio Medicaid enrollees were current smokers in 2015.[3]
- Researchers estimate that **15 percent** of U.S. Medicaid costs are attributable to cigarette smoking.[4]
- It costs employers an estimated **$5,816** more per year to employ a smoker than a non-smoker, including healthcare and other costs.[5]

Evidence-based prevention strategies relevant to state policy

Increase unit price for tobacco products ★

Ohio status	Policy options
Excise tax rate on traditional cigarettes • Ohio's cigarette tax was increased by $0.35 in 2015 and is now $1.60 per pack, similar to the national average of $1.61 per pack.[6] *Excise tax rates for other tobacco products and e-cigarettes* • Little cigars: 37 percent of wholesale price[7] • Other tobacco products: 17 percent of wholesale price (unchanged since 1993)[8] • Electronic smoking devices and nicotine liquid: None	• Increase excise taxes on any or all of the above products and/or allow local municipalities to do so. Impacts on tobacco use are proportional to the size of the price increase. • Revise Ohio's minimum price law to prohibit the use of price discounting tactics.

Media campaigns (mass-reach health communication interventions)

Ohio status	Policy options
• The Ohio Department of Health (ODH) manages mass media campaigns delivered via TV, radio, social media, etc. The Centers for Disease Control and Prevention (CDC) funds and implements the national "Tips for Former Smokers" campaign in Ohio. • Ohio spent approximately $1.9 million on media campaigns in SFY 2016;[9] the CDC-recommended level of investment for Ohio is $14.4 million.[10]	Increase investment in mass media campaigns aimed at adults and/or youth. Evidence suggests that adult-focused cessation campaigns have the greatest impact on smoking prevalence and medical costs.[11]

June 2015

hpio Health Policy Brief

Mapping accountability to improve Ohio's performance on tobacco use

The majority of adult cigarette smokers (69%) report they want to stop smoking.[1] Yet, tobacco use is the **leading** cause of preventable death and disease in the U.S. and is a significant contributor to high healthcare costs.[2] Researchers estimate that 8.7% of annual aggregated healthcare spending in the U.S. is associated with cigarette smoking – amounting to $169.3 billion.[3] Across state Medicaid programs, the percent of spending associated with cigarette smoking is estimated to be even higher – accounting for 15% ($39.6 billion) of annual Medicaid expenditures.[4]

Tobacco use in Ohio at a glance

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

well above the Healthy People 2020 goal of **12%**.[5]

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2017 Health Value Dashboard™

A closer look at tobacco use and health value

The *2017 Health Value Dashboard* found that Ohio ranks 46 out of 50 states and the District of Columbia on health value, a composite measure of population health outcomes and healthcare spending. This means that Ohioans are living less healthy lives and spending more on health care than people in most other states.

Tobacco use is one of the key factors contributing to Ohio's poor performance. Ohio ranks in the bottom quartile for both adult smoking and secondhand smoke exposure for children. Analysis of *Dashboard* data found a strong correlation between a state's adult smoking rate and its health value rank. As shown in figures 1 and 2, states with a lower adult smoking rate are more likely to have a better health value rank—meaning better population health outcomes and lower healthcare spending.

What works to reduce tobacco use?
There is a strong body of evidence on what works to reduce tobacco use. As outlined in an HPIO policy options fact sheet, the most effective strategies include:

- Increasing the unit price of tobacco products, including excise taxes on cigarettes and other tobacco products
- Media campaigns
- Access to cessation counseling and medication
- Smoke-free policies

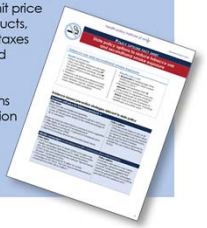
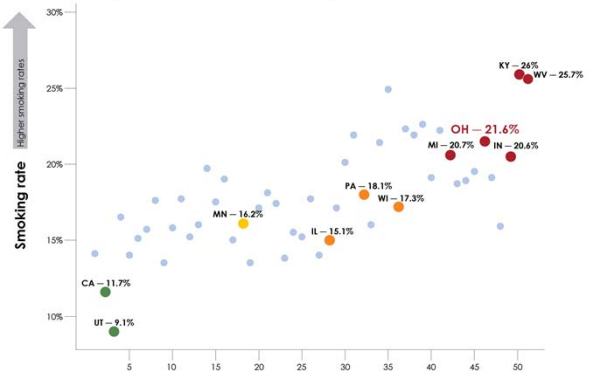


Figure 1. **Correlation between smoking rate and health value rank**
2015 adult smoking rate and 2017 health value rank (r=.70)



Trend highlights

- **Adult cigarette smoking: Gradual decline**
- **Youth cigarette smoking: Big decline from 2000 to 2014**
- **Youth e-cigarette use: Increased from 2010 to 2014**

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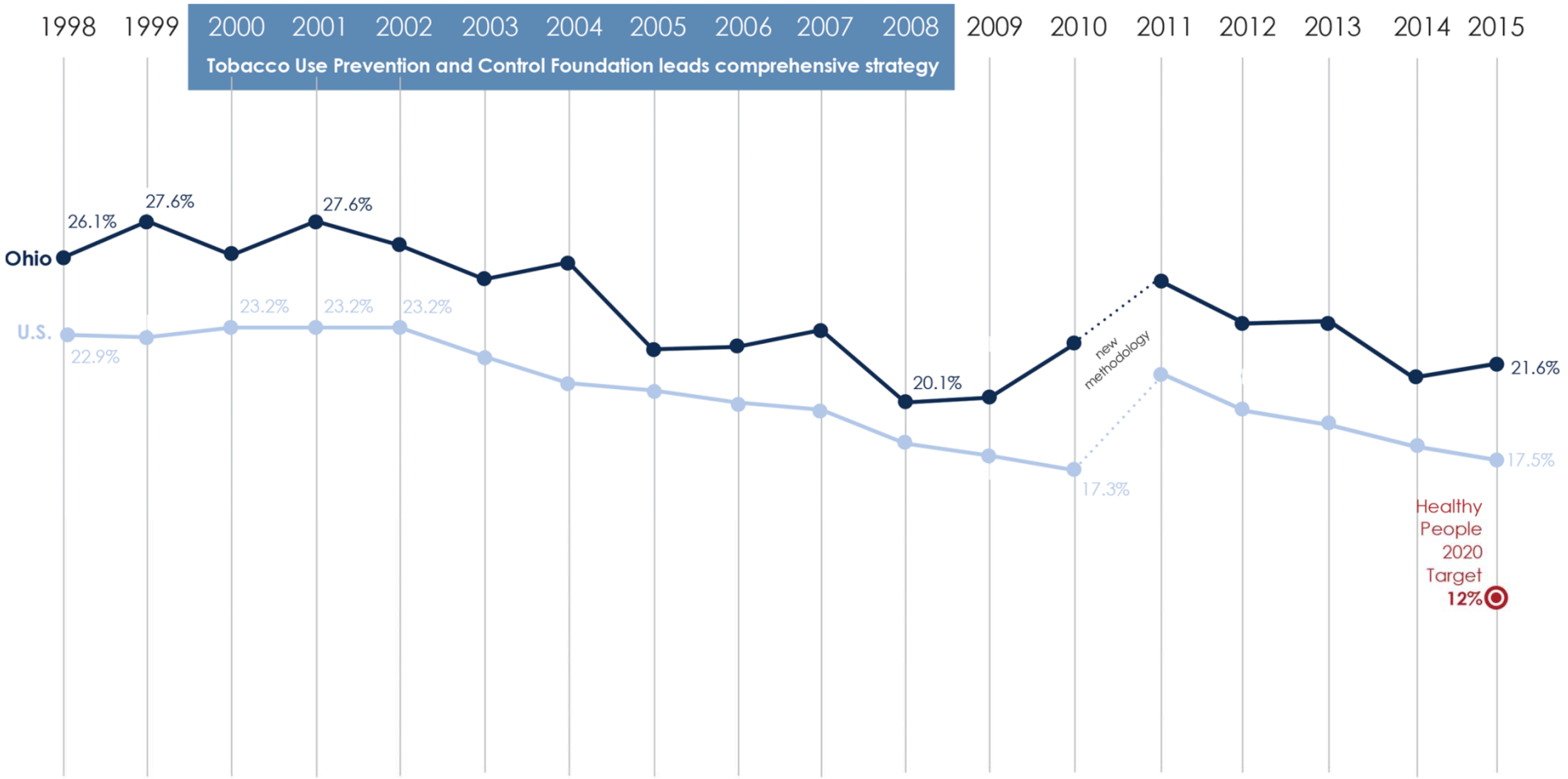
Adult cigarette smoking prevalence in Ohio, 1998-2015



Source: BRFSS

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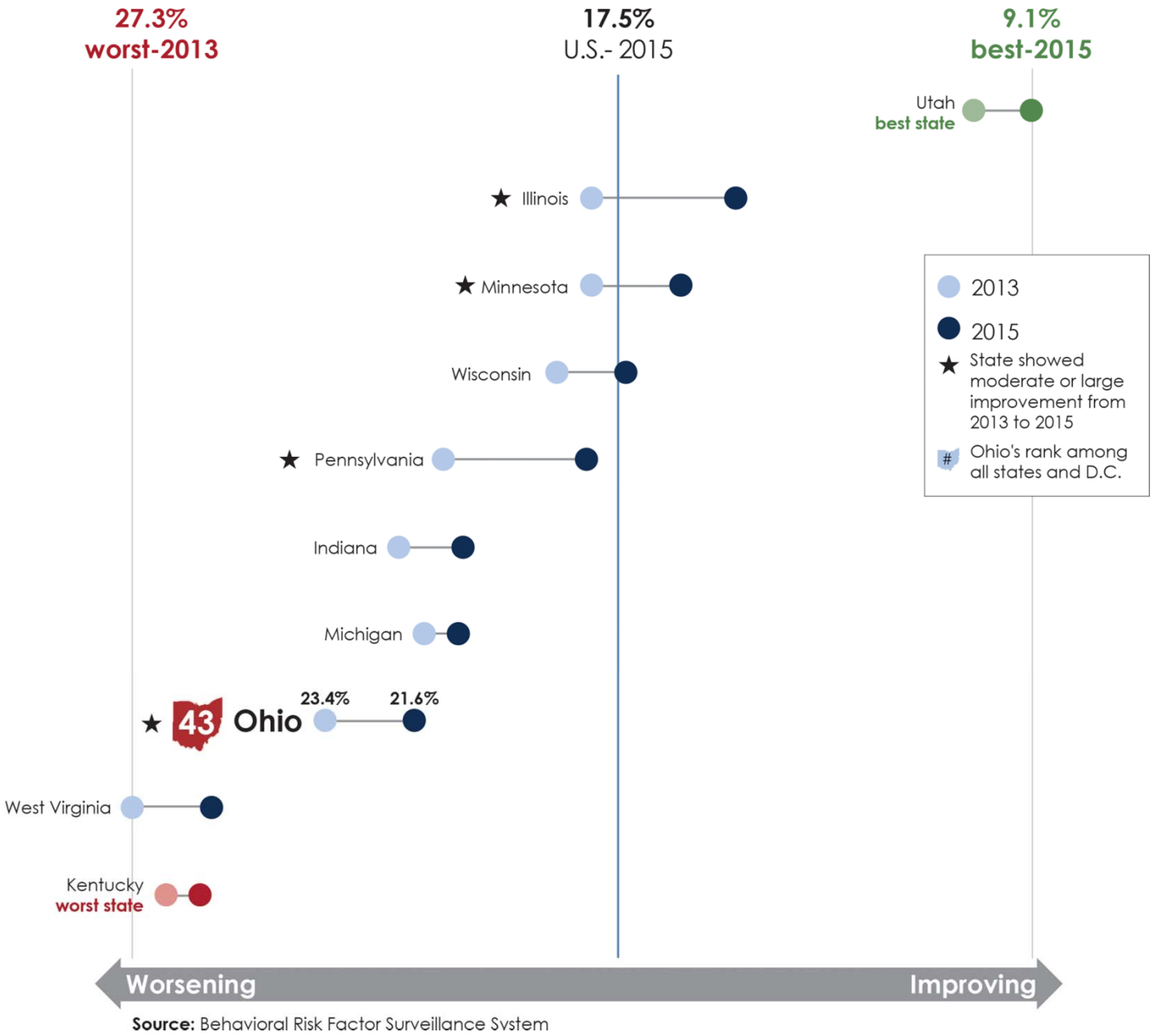
Percent of population age 18 and older that are current smokers



Source: Behavioral Risk Factor Surveillance System

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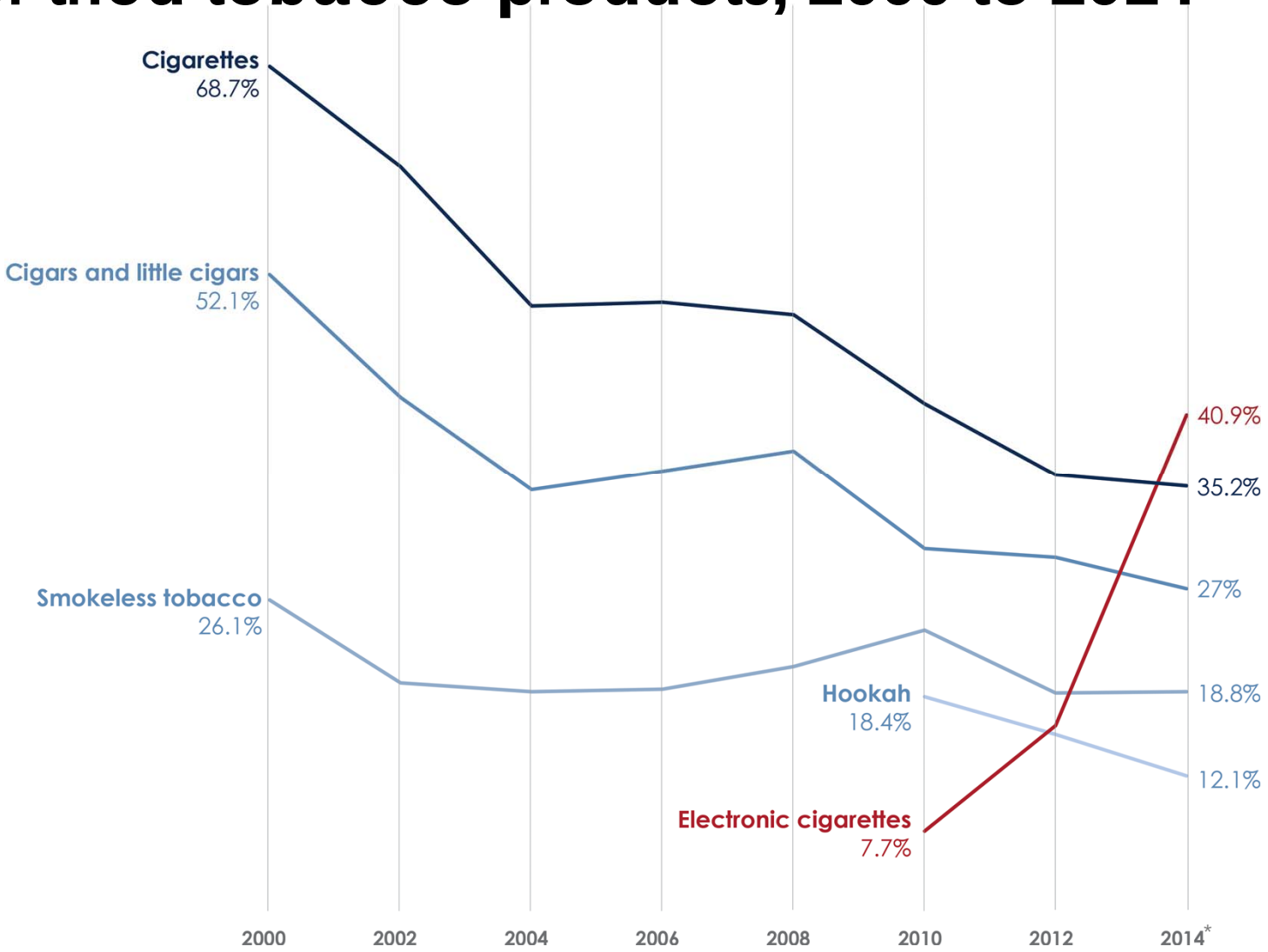
Percent of Ohio high school students who have ever tried tobacco products, 2000 to 2014



*2014 should be interpreted with caution due to low response rates.
Source: Ohio Youth Tobacco Survey, Ohio Department of Health Tobacco Program

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Ohioans most at risk

Adults with…

- **Behavioral health conditions**
- **Disabilities**
- **Low incomes**
- **Low levels of education**
- **Medicaid**
- **Rural counties**

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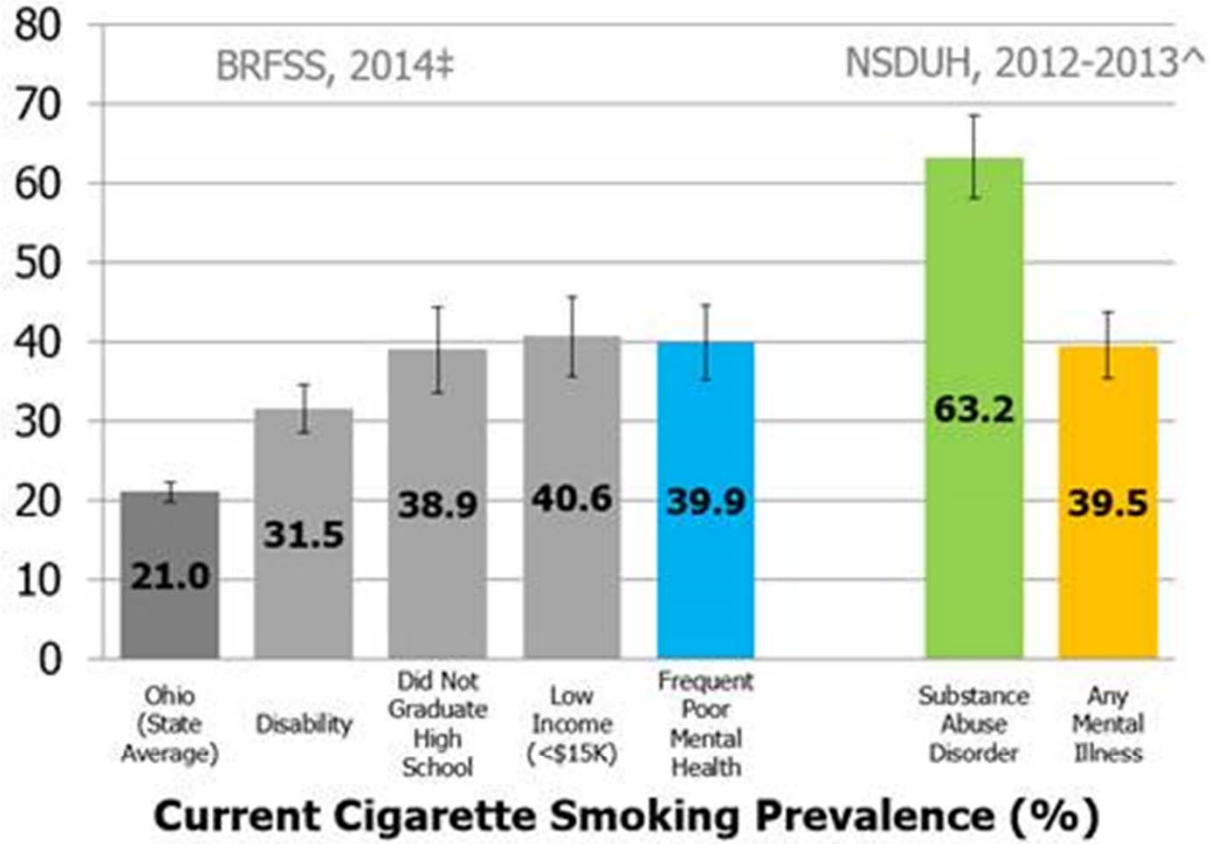
Adult current cigarette smoking prevalence: High-risk groups



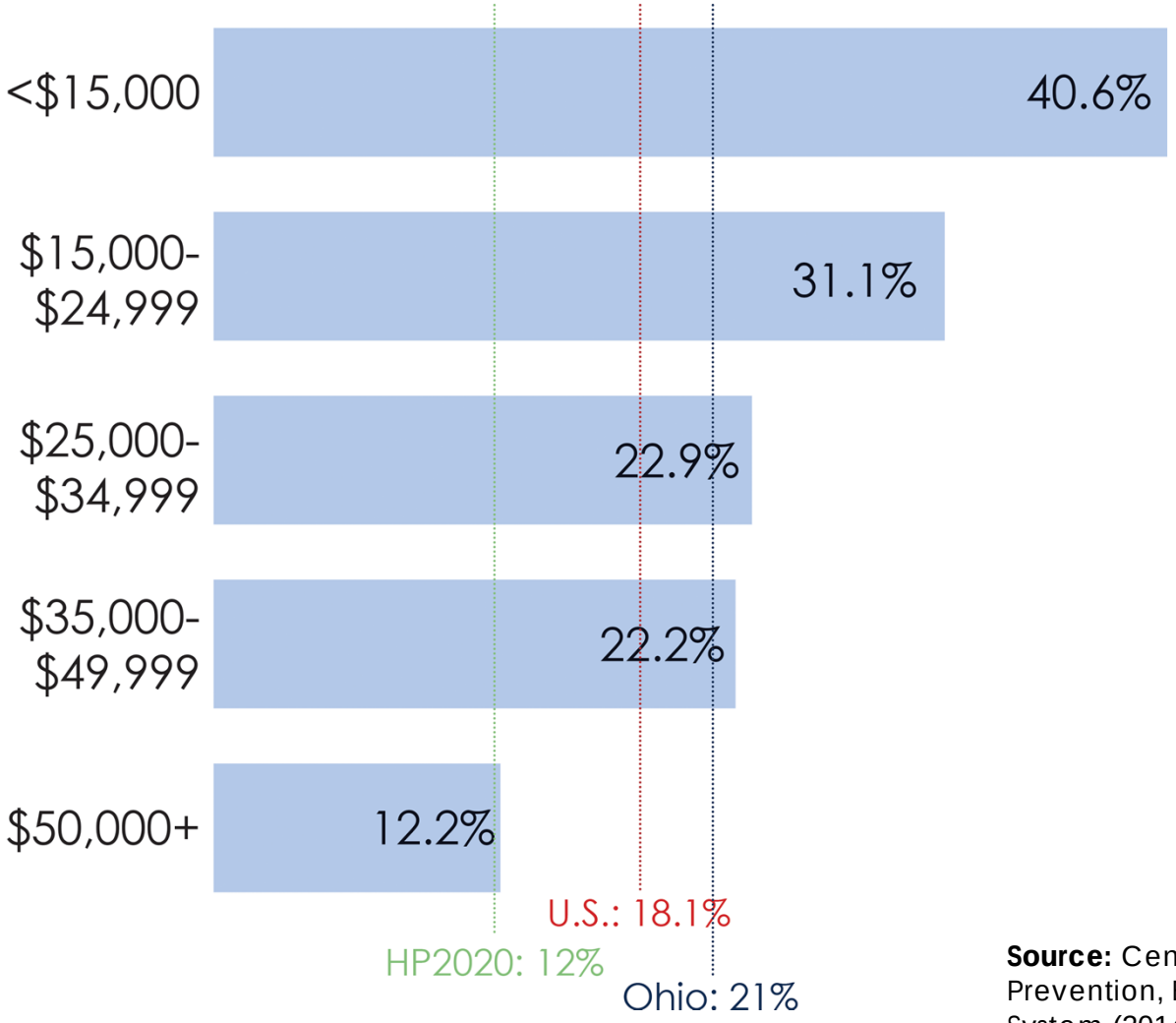
^ National Survey on Drug Use and Health, 2012-2013; any mental illness includes mild, moderate, and serious mental illness; substance abuse disorder includes any illicit drug or alcohol abuse or dependence (# estimate among Ohioans 12+ years, all other values for 18+ years)

‡ *Ohio Behavioral Risk Factor Surveillance System*, 2014; frequent poor mental health is 14+ day/month of "not good" mental health, including stress, depression, and problems with emotions.

Source: Ohio Department of Health

Adult smoking, by income

Percent of population age 18 and older that are current smokers (2014)



Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System (2014)

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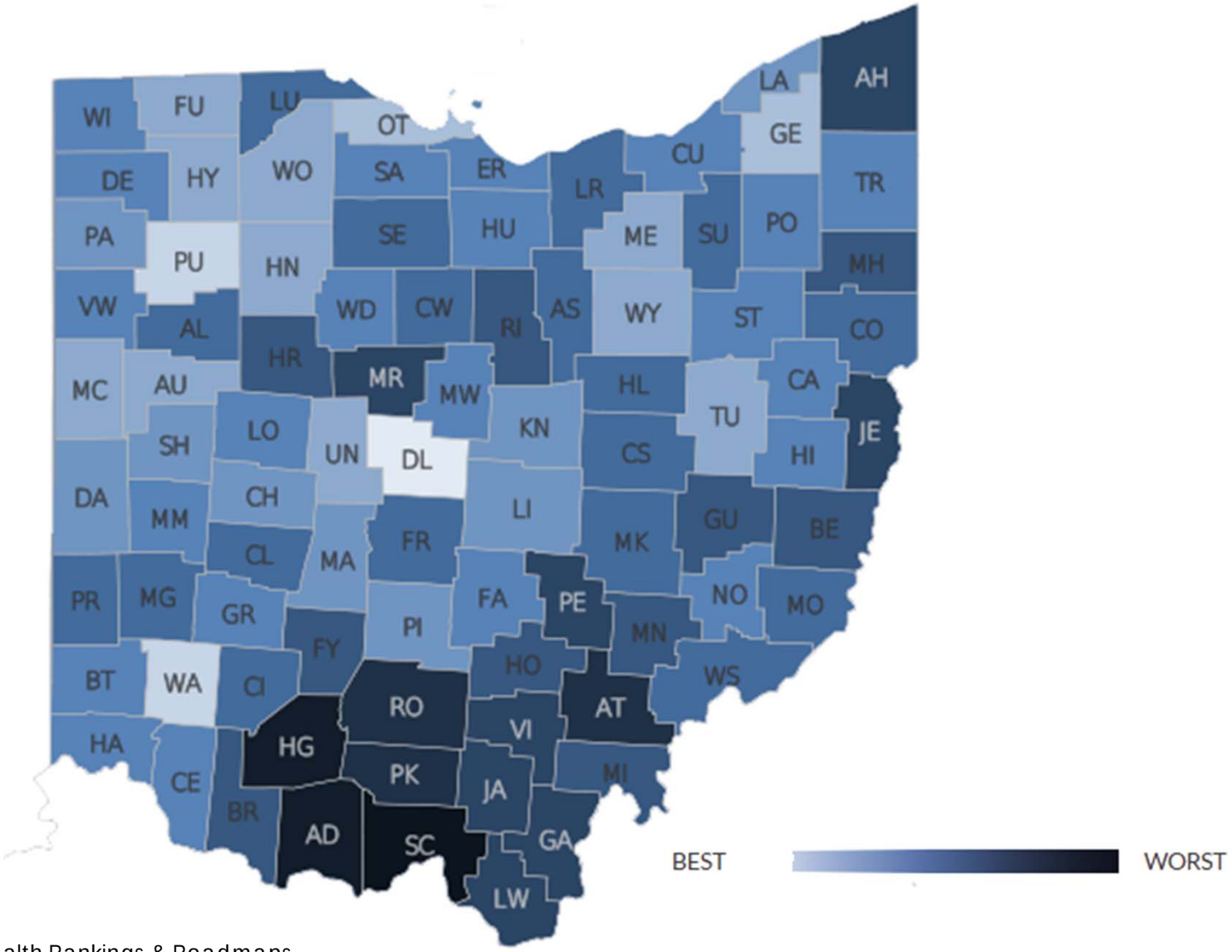
Adult smoking by county, 2015



Source: 2017 County Health Rankings & Roadmaps

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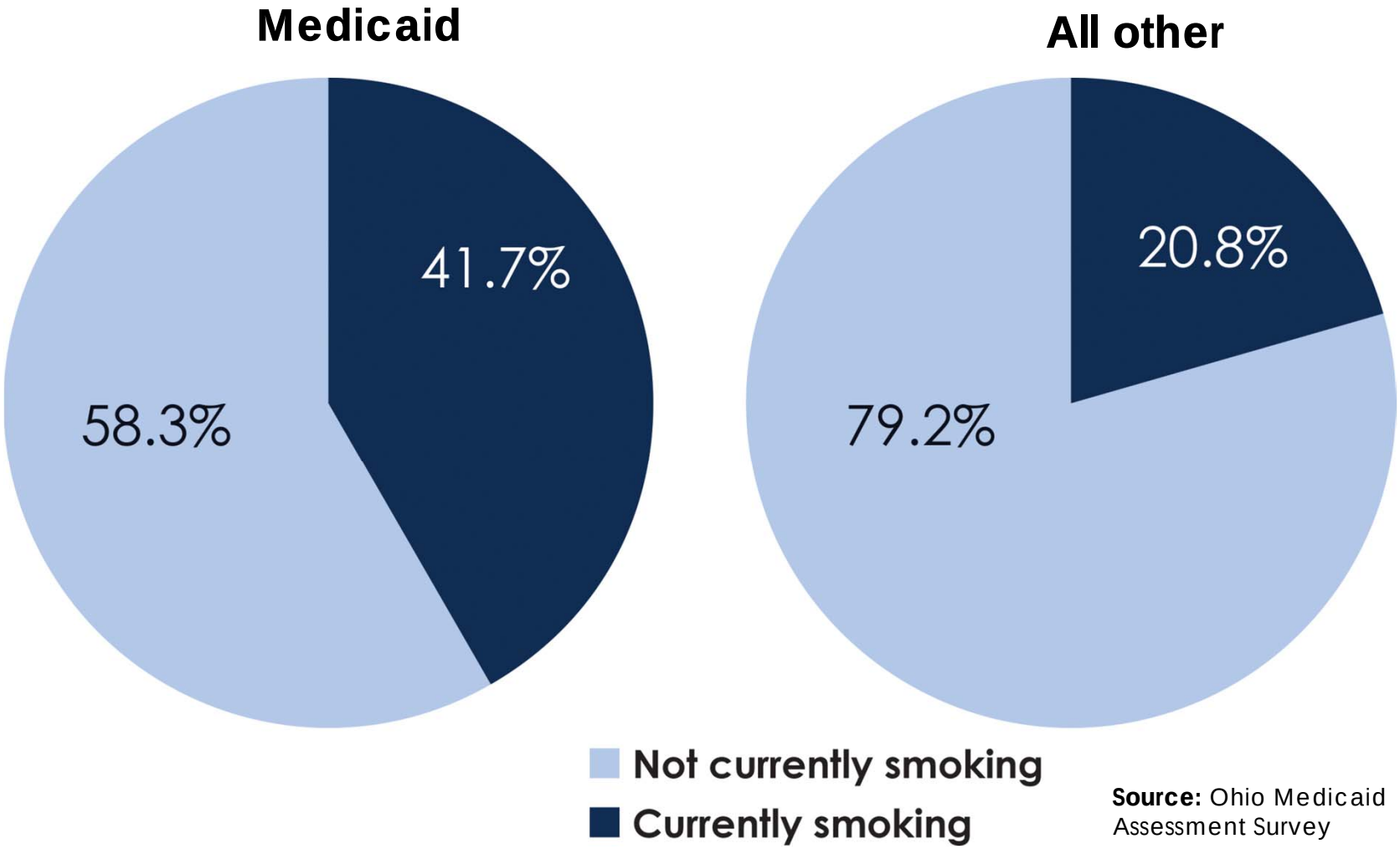
Current cigarette smoking among Medicaid-enrolled adults (ages 19-64) in Ohio, 2015



Source: Ohio Medicaid Assessment Survey

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Impact on healthcare spending

- **15% of U.S. Medicaid costs attributable to smoking** (Xu, 2015)
- **Indiana Medicaid study: PMPM Medicaid expenditures 51% higher for smokers than non-smokers** (SVC, 2017)
- **Higher healthcare costs for employers** (Berman, 2014)

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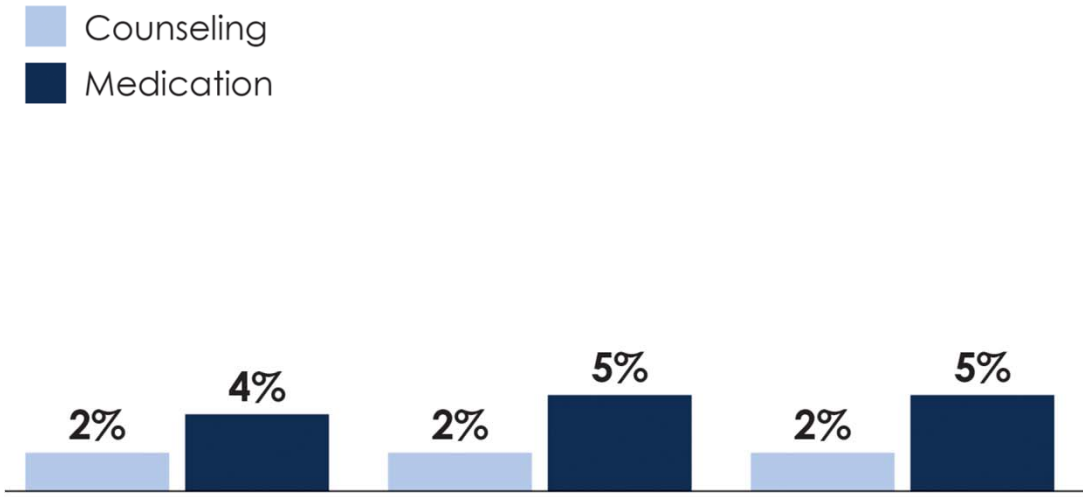
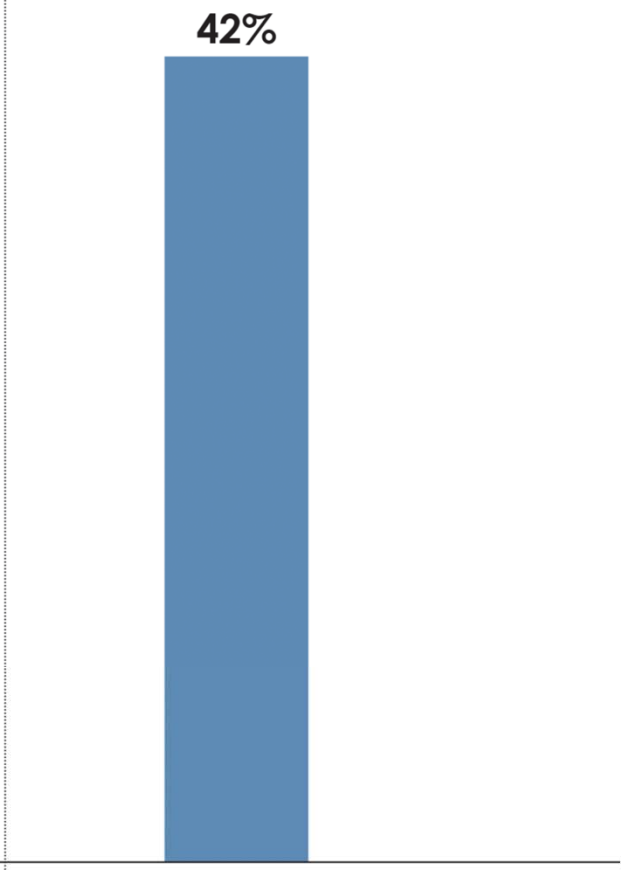
Percent of Medicaid managed care enrollees age 18+ who received tobacco cessation counseling or medication



Source: Ohio Department of Medicaid, 2016
Note: Counseling refers to cessation counseling of various durations (procedures). Medication refers to smoking deterrents and nicotine receptor partial agonists (DM therapeutic class)

Percent of Medicaid enrollees age 19-64 who smoke



Source: Ohio Medicaid Assessment Survey, Adult Dashboard, accessed 3/3/17

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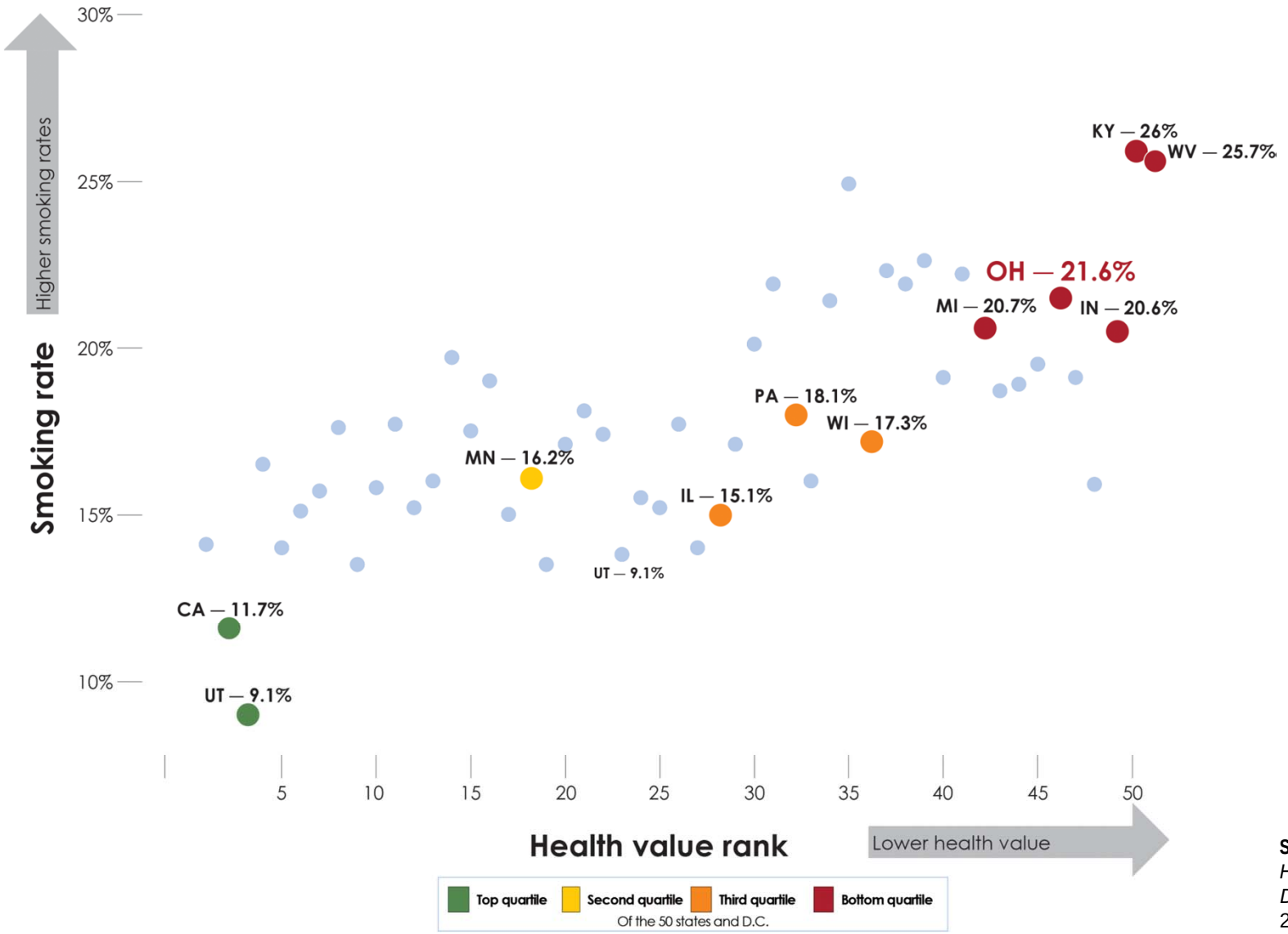
Smoking rate and health value rank

2015 adult smoking rate and 2017 health value rank (r= .70)



Source: HPIO 2017 *Health Value Dashboard* (value), 2015 BRFSS (smoking)

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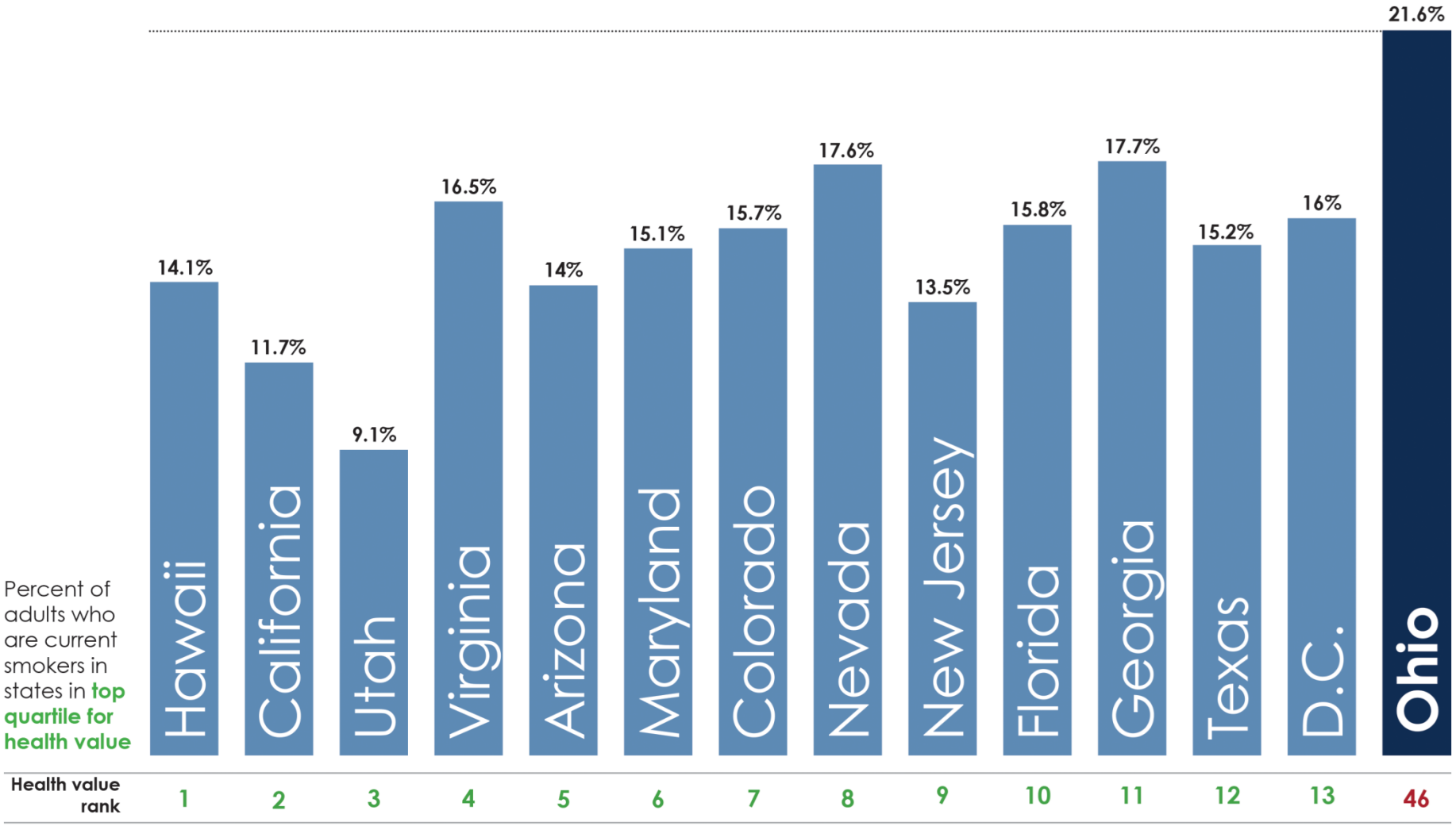
Percent of adults who are current smokers: In states with best health value and Ohio



Source: HPIO 2017 *Health Value Dashboard* (value), 2015 BRFSS (smoking)

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Opiate addiction

Ohio Department of Health

2016 Ohio Drug Overdose Data: General Findings

Fentanyl and Related Drugs Like Carfentanil as well as Cocaine Drove Increase in Overdose Deaths

Ohio's opioid epidemic continued to evolve in 2016 to stronger drugs, driving an increase in unintentional overdose deaths. The data shows a significant increase in overdose deaths involving the opioid fentanyl, the emergence of more powerful fentanyl-related drugs like carfentanil, and indications that cocaine was used with fentanyl and other opiates. The data also shows some promising progress – the fewest unintentional overdose deaths involving prescription opioids since 2009 (excluding deaths involving fentanyl and related drugs).

Illegally produced fentanyl can be hundreds of times stronger than heroin, and carfentanil and other related drugs can be stronger than fentanyl.

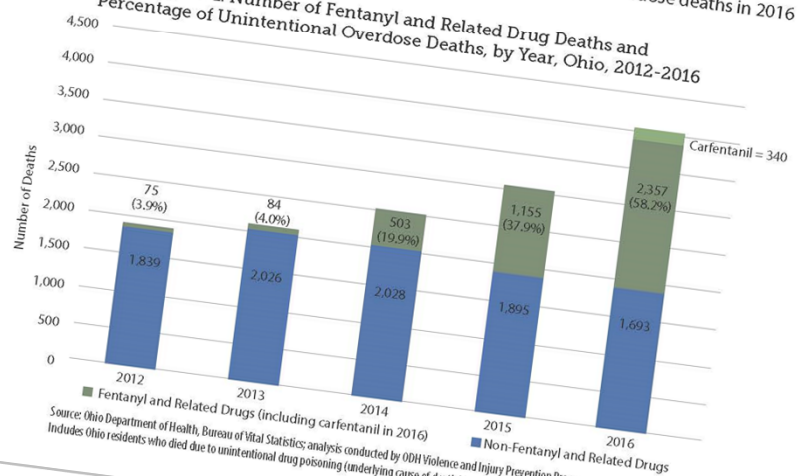
In 2016, unintentional drug overdoses caused the deaths of 4,050 Ohio residents, a 32.8 percent increase compared to 2015 when there were 3,050 overdose deaths.

Fentanyl and related drugs were involved in 58.2 percent (2,357) of all unintentional drug overdose deaths in 2016. By comparison, fentanyl was involved in 37.9 percent (1,155) in 2015, 19.9 percent (503) in 2014, 4.0 percent (84) in 2013, and 3.9 percent (75) in 2012 (see Figures 1 and 2). With the emergence of carfentanil in 2016, the fentanyl-related drug was involved in 340 overdose deaths, most of them during the second half of the year. For males and females respectively, the largest number of fentanyl and related drug overdose deaths were among the 25-34 age group. (see Figure 3). The increase in fentanyl and carfentanil overdose deaths in 2016 corresponded with an increase in drug seizure reports by law enforcement (see Figure 4).

The number of cocaine-related overdose deaths rose significantly from 685 in 2015 to 1,109 in 2016 — a 61.9 percent increase (see Table 1). Of cocaine-related overdose deaths in 2016, 80.2 percent also involved an opiate, and 55.8 percent involved fentanyl and related opiates in particular.

The number of overdose deaths involving heroin remained relatively flat with 1,444 overdose deaths in 2016 compared to 1,424 in 2015 (see Table 1).

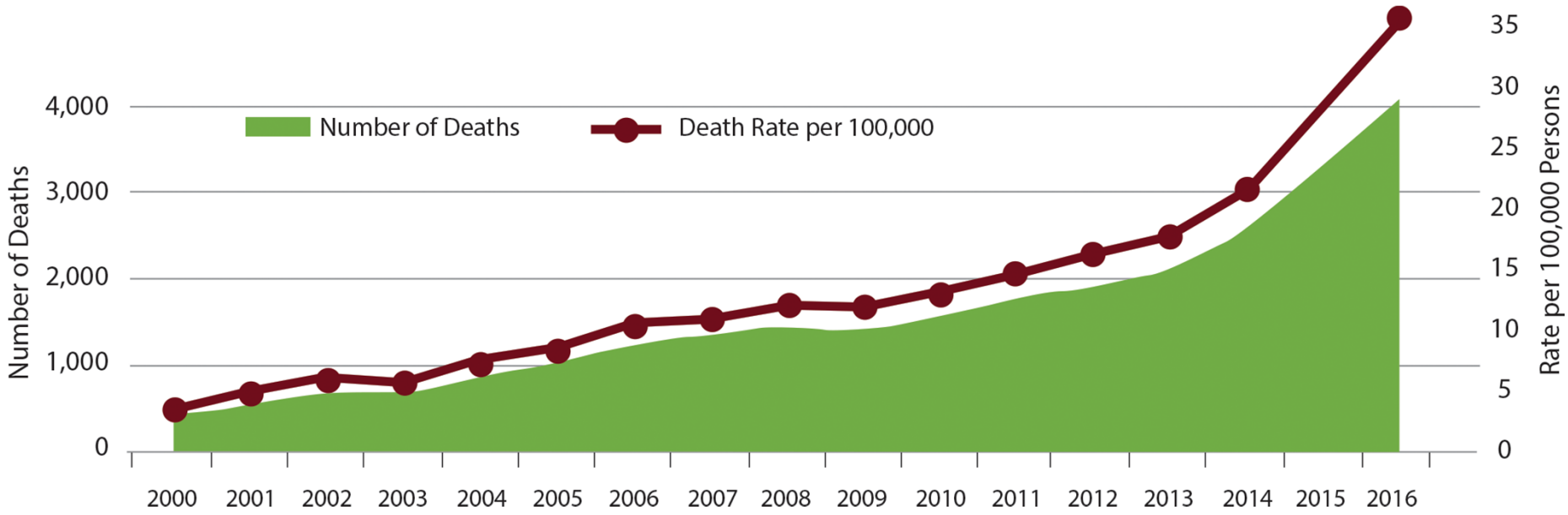
Figure 1. Number of Fentanyl and Related Drug Deaths and Percentage of Unintentional Overdose Deaths, by Year, Ohio, 2012-2016



Source: Ohio Department of Health, Bureau of Vital Statistics; analysis conducted by ODH Violence and Injury Prevention Program.
Includes Ohio residents who died due to unintentional drug poisoning (underlying cause of death ICD-10 codes X40-X44).

Drug overdose deaths

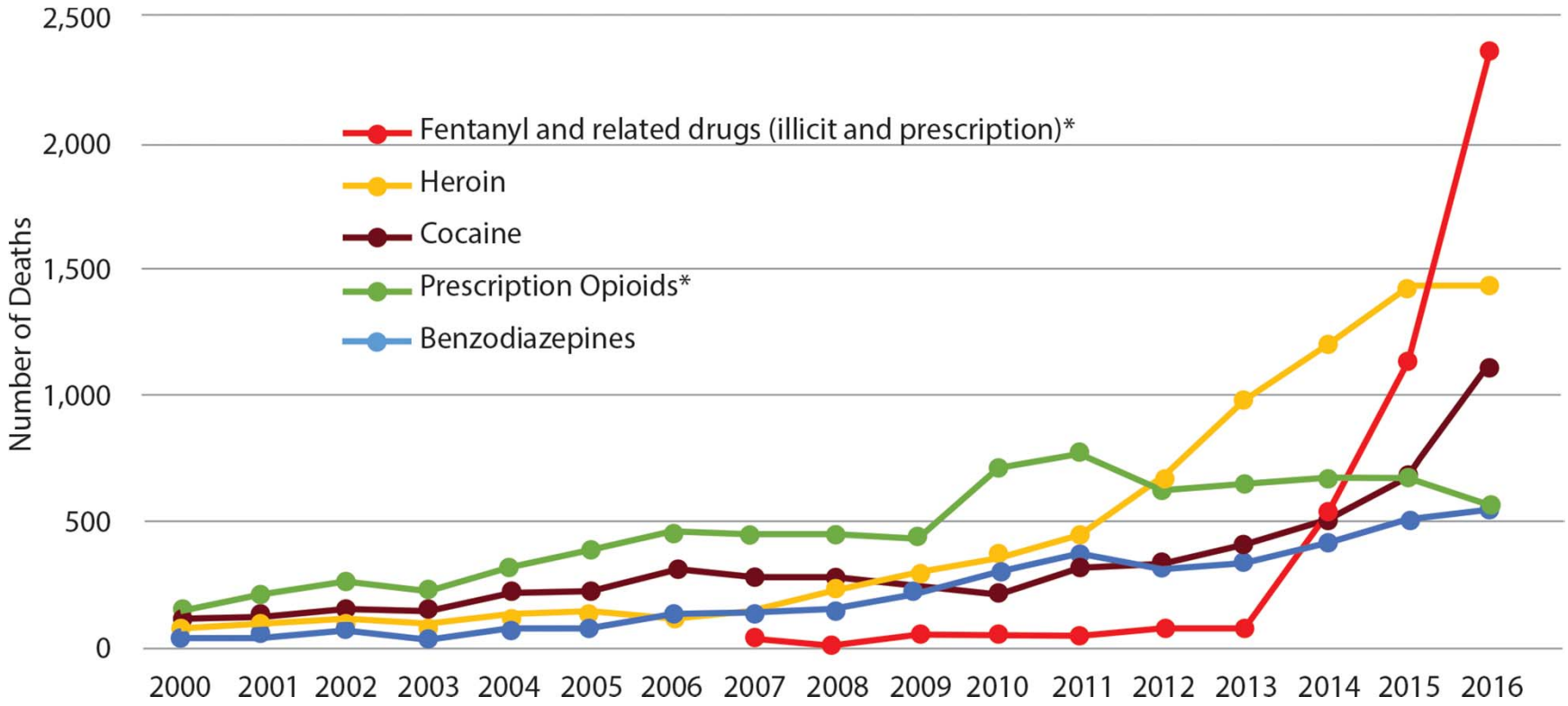
Number of deaths and annual age-adjusted death rate* per 100,000 population from unintentional drug overdose by year, Ohio residents, 2000-2016



Source: "2016 Ohio Drug Overdose Data: General Findings," Ohio Department of Health. Data is from Ohio Department of Health, Bureau of Vital Statistics; analysis conducted by ODH Violence and Injury Prevention Program.
*The death rate is presented as age-adjusted which allows a comparison of death rates between populations (e.g. counties and states). The rates are adjusted to the U.S. 2000
standard population to allow a comparison of the overall risk of dying between different populations.

Overdose death, by drug type

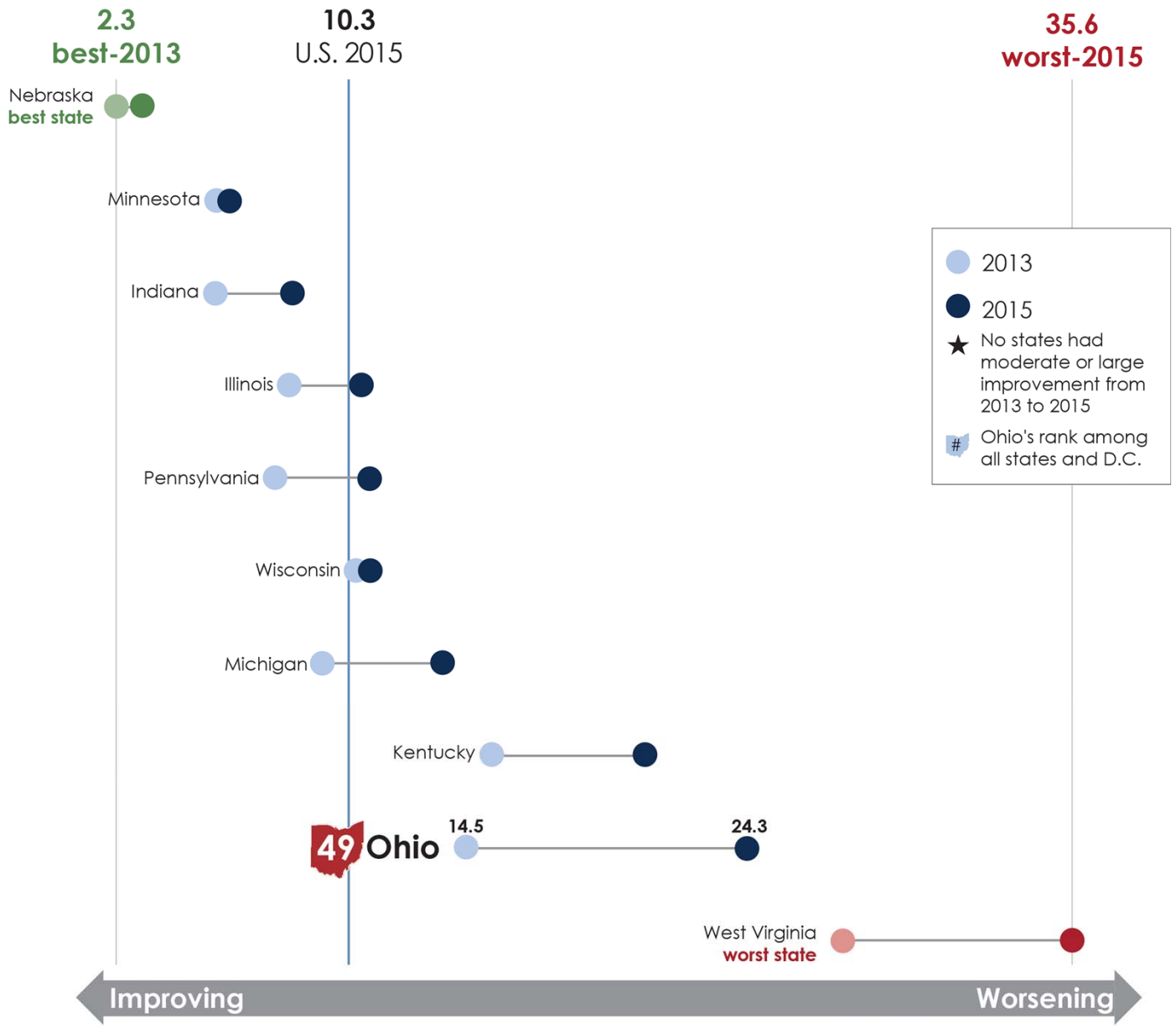
Number of unintentional drug overdose deaths
involving selected drugs, by year, Ohio, 2000-2016



Source: "2016 Ohio Drug Overdose Data: General Findings," Ohio Department of Health. Data is from Ohio Department of Health, Bureau of Vital Statistics; analysis conducted by ODH Violence and Injury Prevention Program. Multiple drugs are usually involved in overdose deaths. Individual deaths may be reported in more than one category. Includes Ohio residents who died due to unintentional drug poisoning (underlying cause of death ICD-10 codes X40-X44).

* Excludes deaths involving fentanyl and related drugs.

Number of deaths due to drug overdoses per 100,000 population, age-adjusted



Source: Centers for Disease Control and Prevention, WONDER

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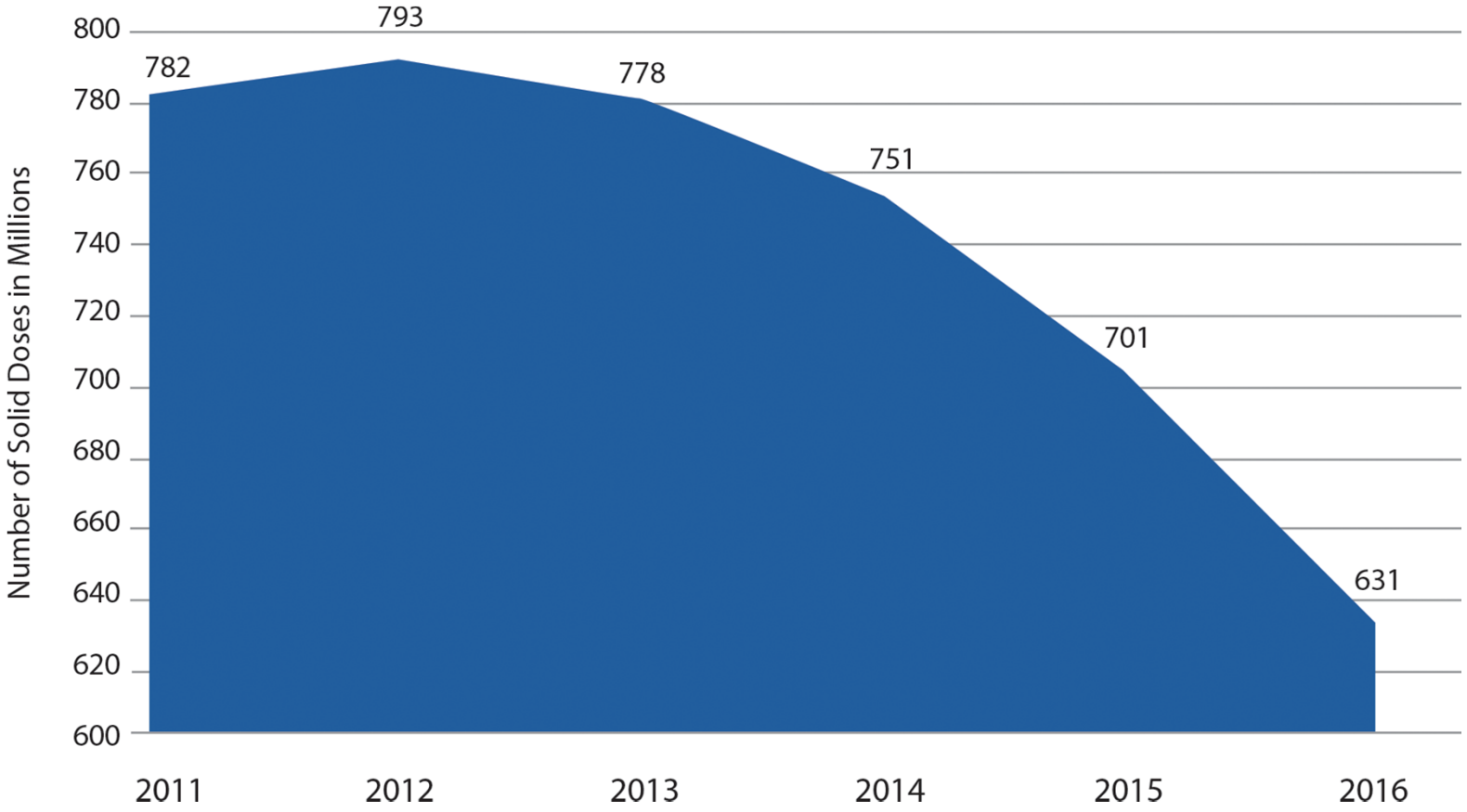
Opioid doses dispenses

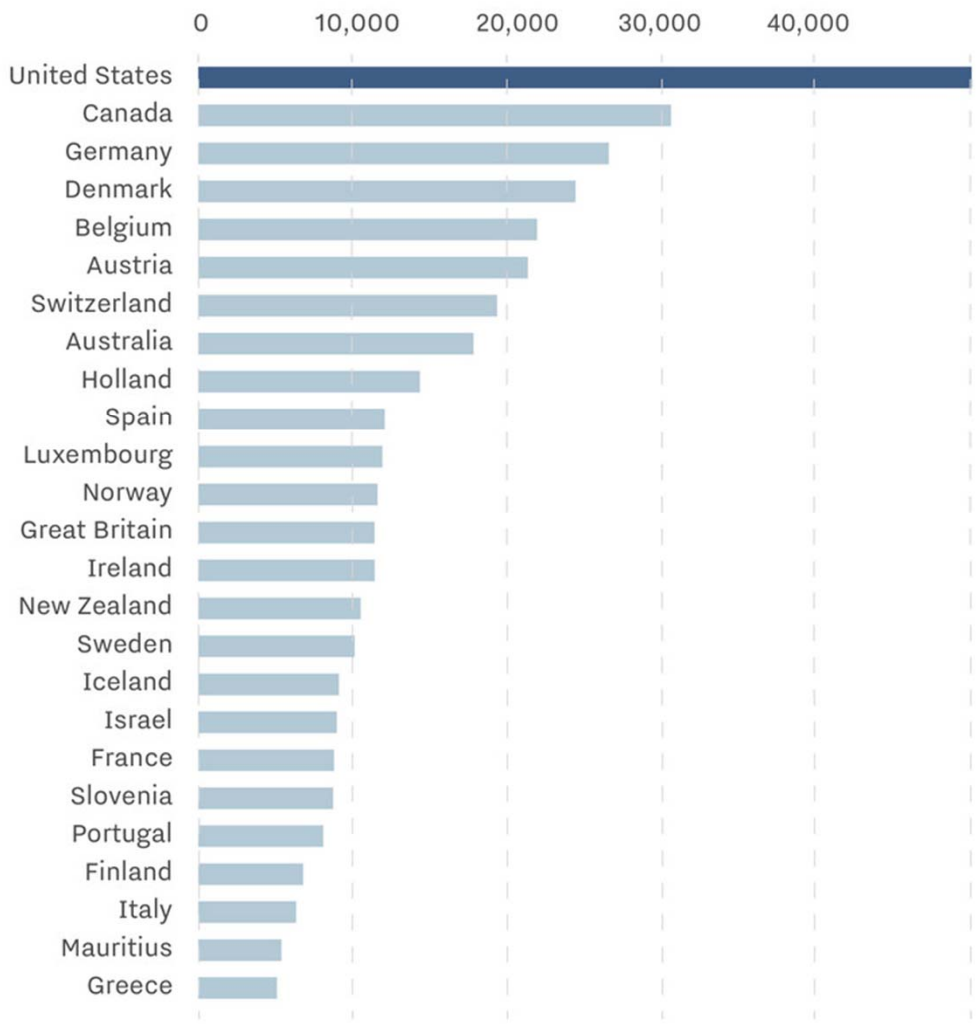
Opioid solid doses dispensed to Ohio patients, by year, 2011-2016



Source: "2016 Ohio Drug Overdose Data: General Findings," Ohio Department of Health. Data is from State of Ohio Board of Pharmacy, Ohio Automated Rx Reporting System.

Americans consume more opioids than any other country

Standard daily opioid dose for every 1 million people



Source: United Nations International Narcotics Control Board

Credit: Sarah Frostenson

Vox

Ohioans most at risk

2017-19 State Health Improvement Plan overdose death priority populations:

- **White males age 25-64**
- **Black males age 25-64**
- **White females age 25-54**

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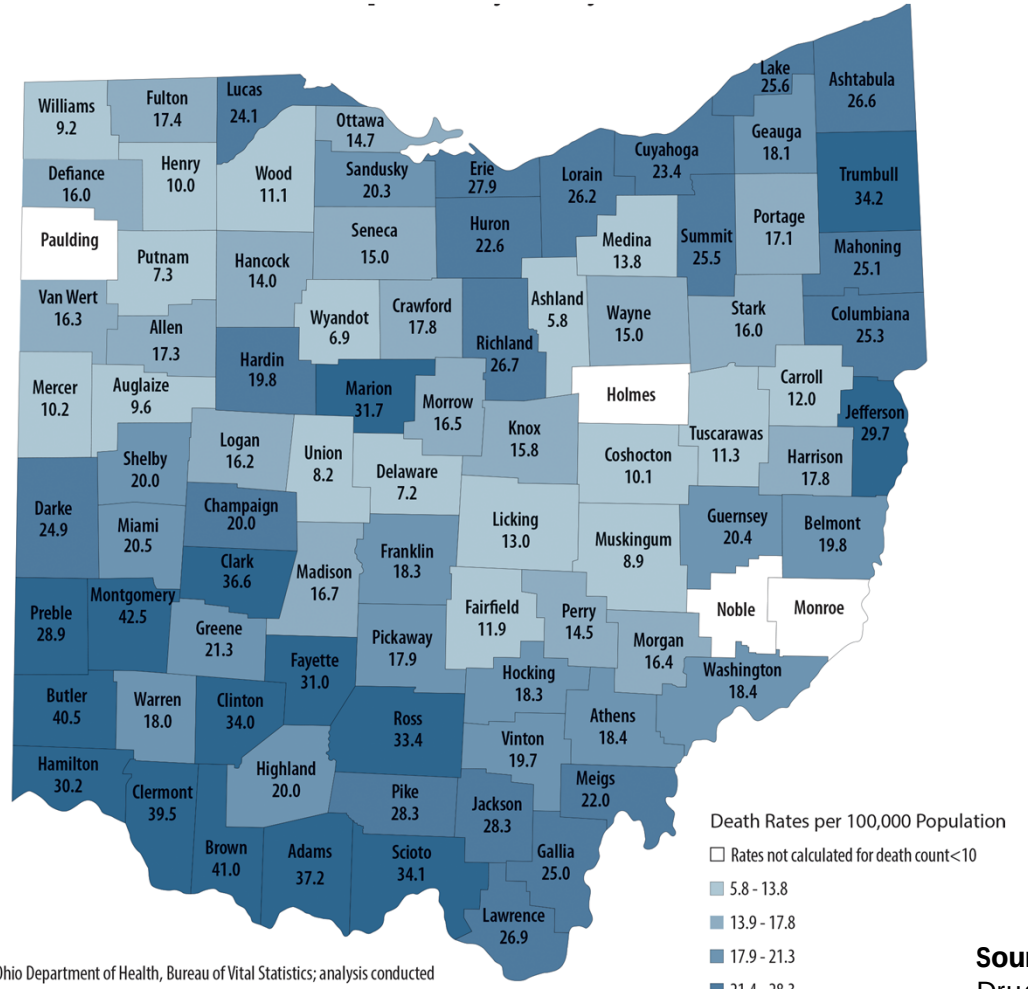
Overdose deaths, by county

Average age-adjusted unintentional drug overdose death rate per 100,000 population, by county, 2011-2016[1,2]



[1] Sources: Ohio Department of Health, Bureau of Vital Statistics; analysis conducted by ODH Violence and Injury Prevention Program; U.S. Census Bureau (Vintage 2016 population estimates).

[2] Includes Ohio residents who died due to unintentional drug poisoning (underlying cause of death ICD-10 codes X40-X44).
Rate suppressed if < 10 total deaths for 2011-2016.

Source: "2016 Ohio Drug Overdose Data: General Findings," Ohio Department of Health.

Montgomery County has the highest rate of overdose deaths in Ohio and Ashland County has the lowest

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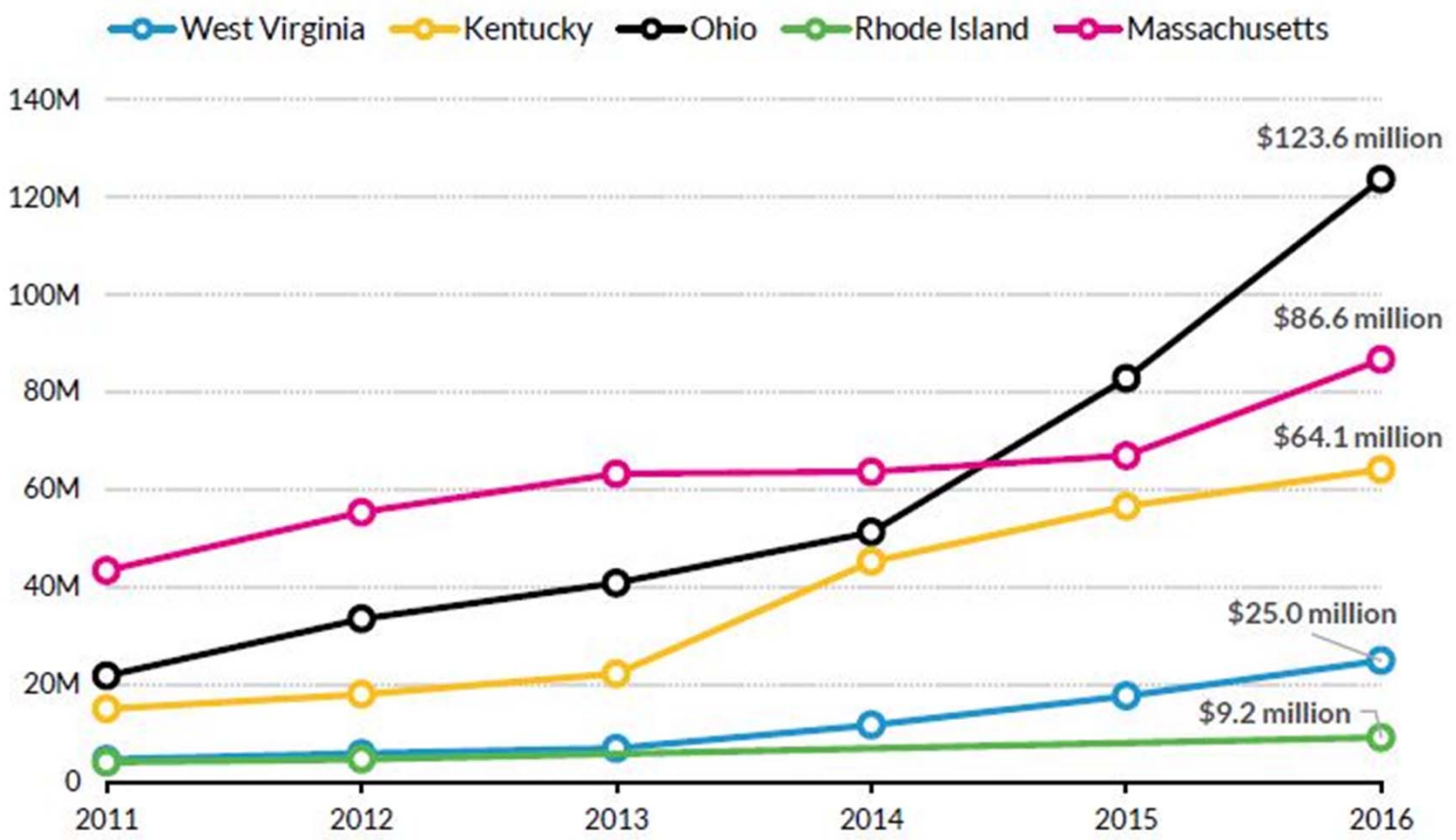
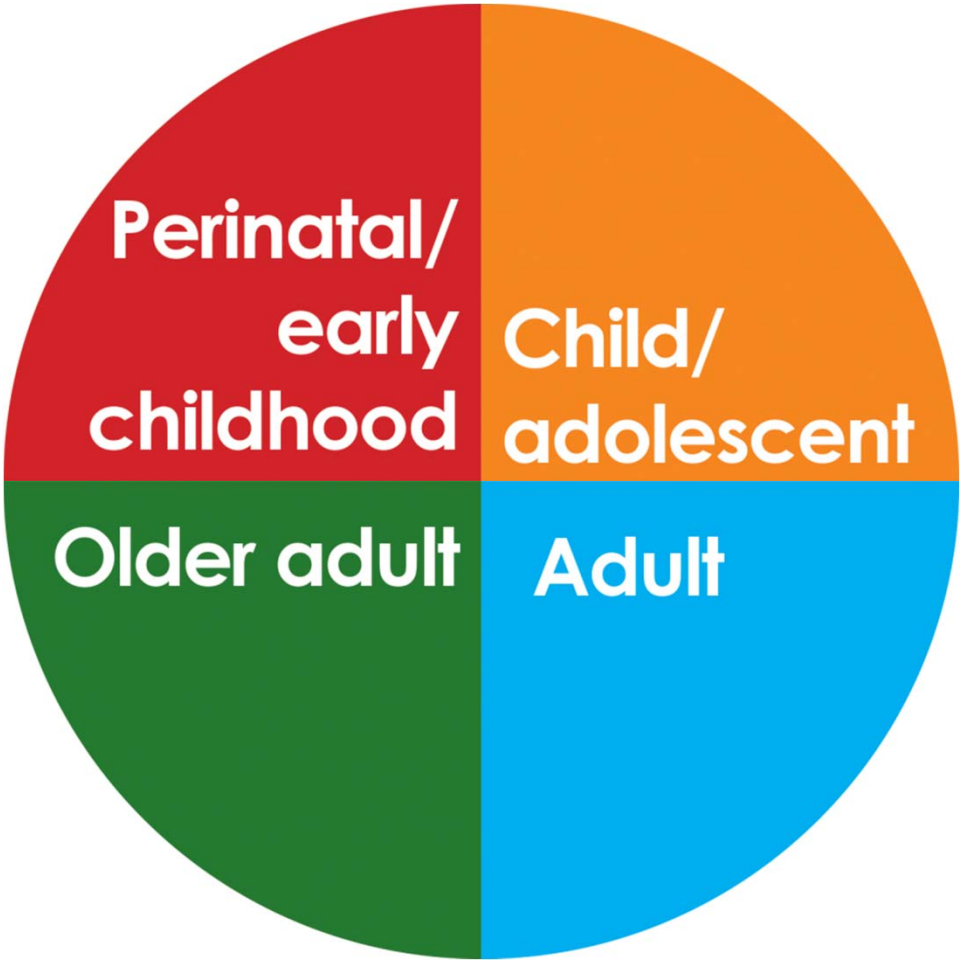
Medicaid Spending on Buprenorphine, Naltrexone, and Naloxone Prescriptions for OUD in Expansion States in 2016 with the Five Highest Drug Overdose Mortality Rates in the Previous Year



Source: Urban Institute analysis of State Drug Utilization data from the Centers for Medicare & Medicaid Services.
Notes: Rhode Island 2013–15 data are suppressed because of data quality concerns. New Hampshire, which has the second-highest death rate of all states, is not displayed because it is a late-expansion state.

Addiction across the life course



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Secondhand smoke exposure and child health

- **Asthma**
- **Ear infections (middle ear disease)**
- **Sudden Infant Death Syndrome**

(Source: Surgeon General, 2014)

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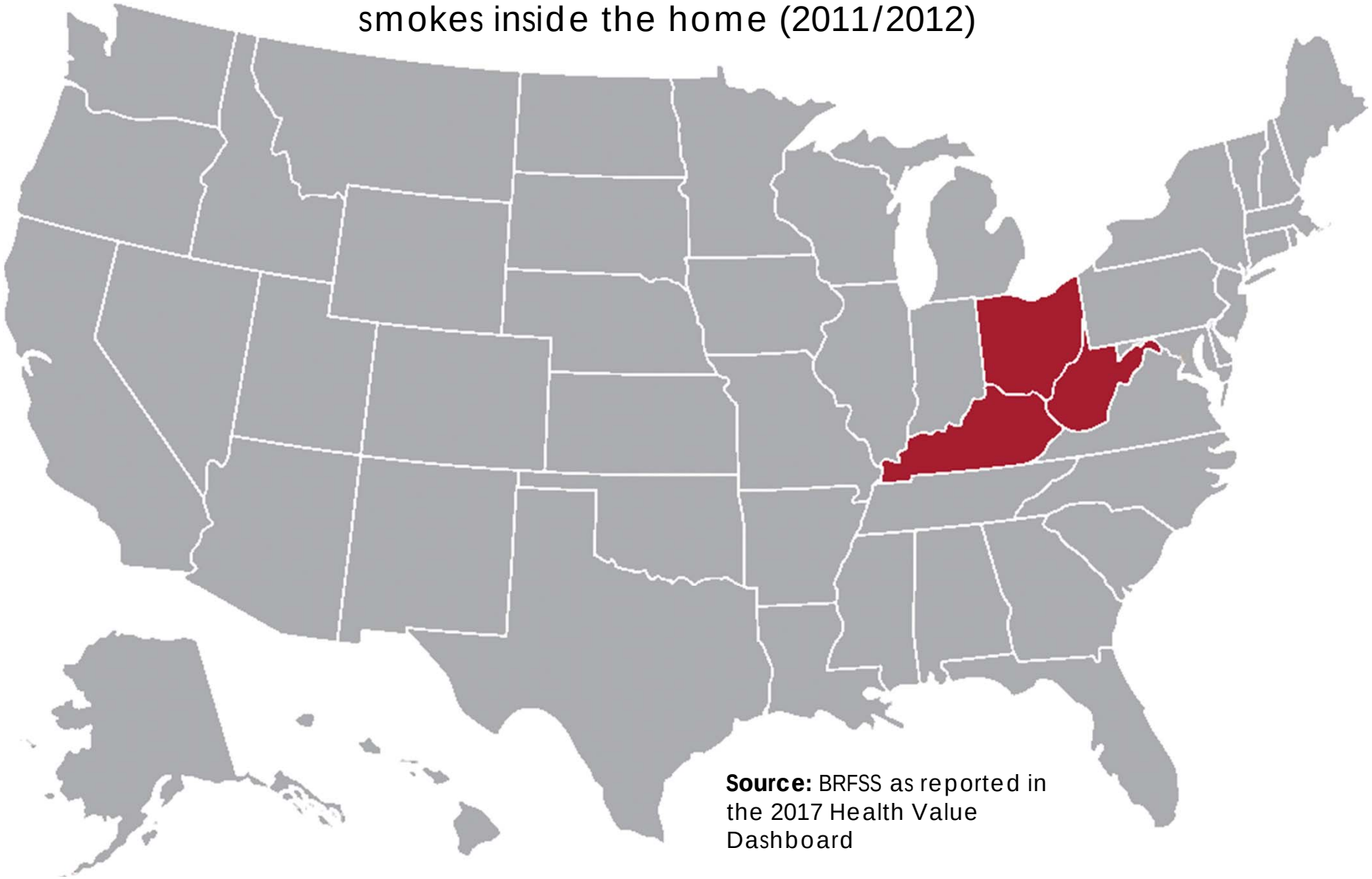
States with the highest rate of secondhand smoke exposure for children

Percent of children who live in a home where someone uses tobacco and smokes inside the home (2011/2012)



Source: BRFSS as reported in the 2017 Health Value Dashboard

Largest disparities and inequities across 29 metrics reviewed in 2017 *Health Value Dashboard*

Metric	Group with worst outcomes	Estimated impact if disparity eliminated
Children exposed to second-hand smoke	Low-income	126,776 Ohio children
Adverse childhood experiences	Low-income	207,722 Ohio children
Child poverty	Black	134,142 Ohio children
Adult depression	People with a disability	440,990 Ohio adults

Estimated impact: This calculation estimates the impact on Ohioans if the group with the worst outcomes on a metric had the same level of performance as the group with the best outcomes.

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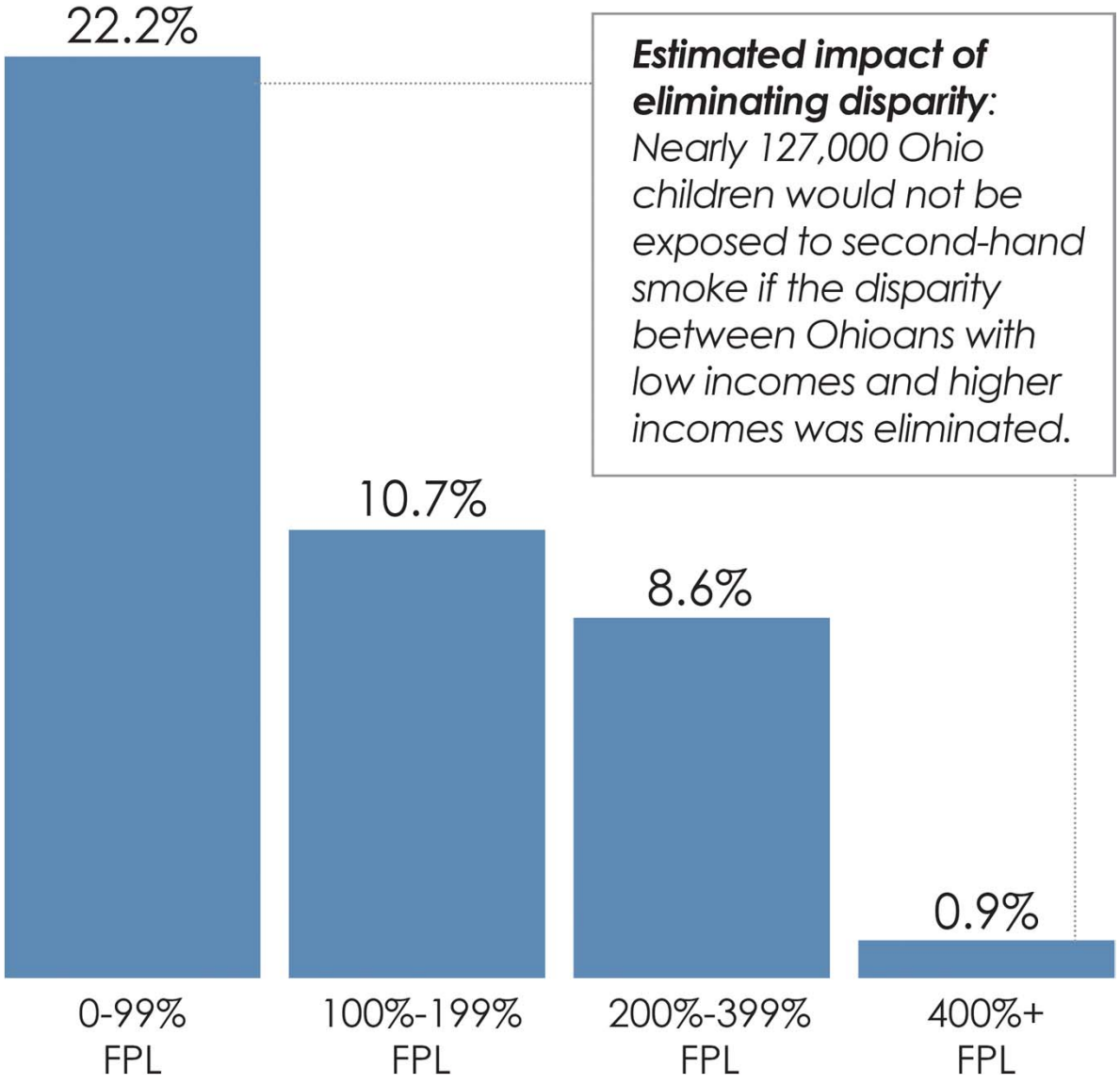
Ohio children exposed to secondhand smoke, by family income level



Source: National Survey of Children's Health

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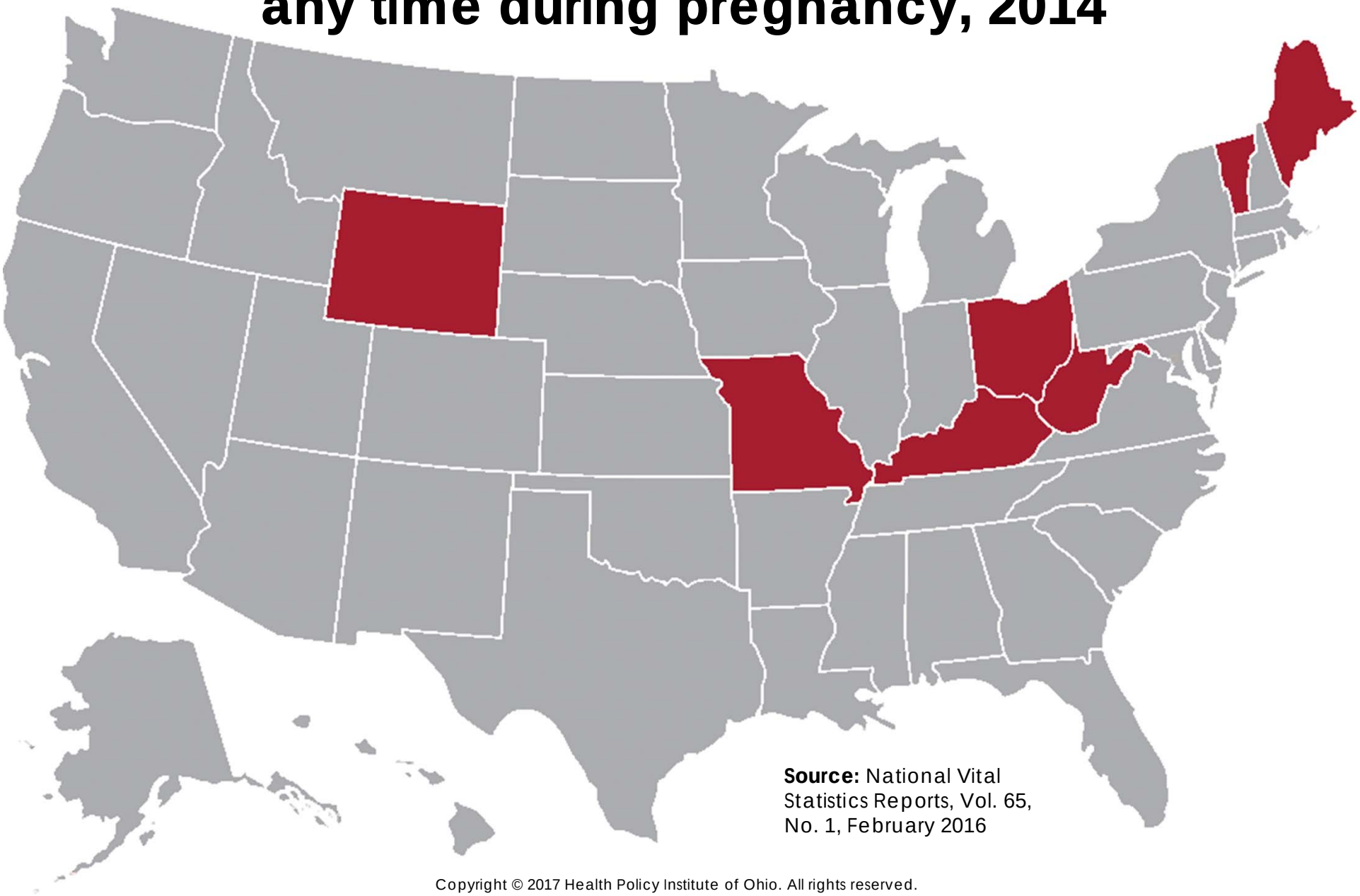
States with highest prevalence of maternal smoking any time during pregnancy, 2014



Source: National Vital Statistics Reports, Vol. 65, No. 1, February 2016

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Smoking and coping

I have three little boys…it's like, you know, 'I'm hungry, mommy--I need this washed, mommy--I need this,' and it's like I can't do everything at once…I mean, I don't mind doing it, but it's just like sometimes it's just like 'Oh my God just leave me alone,' you know. It's so stressful that I just like smoke two or three cigarettes within five minutes. –Athens

Source: Dr. Carol Carstens, OMHAS, 2017

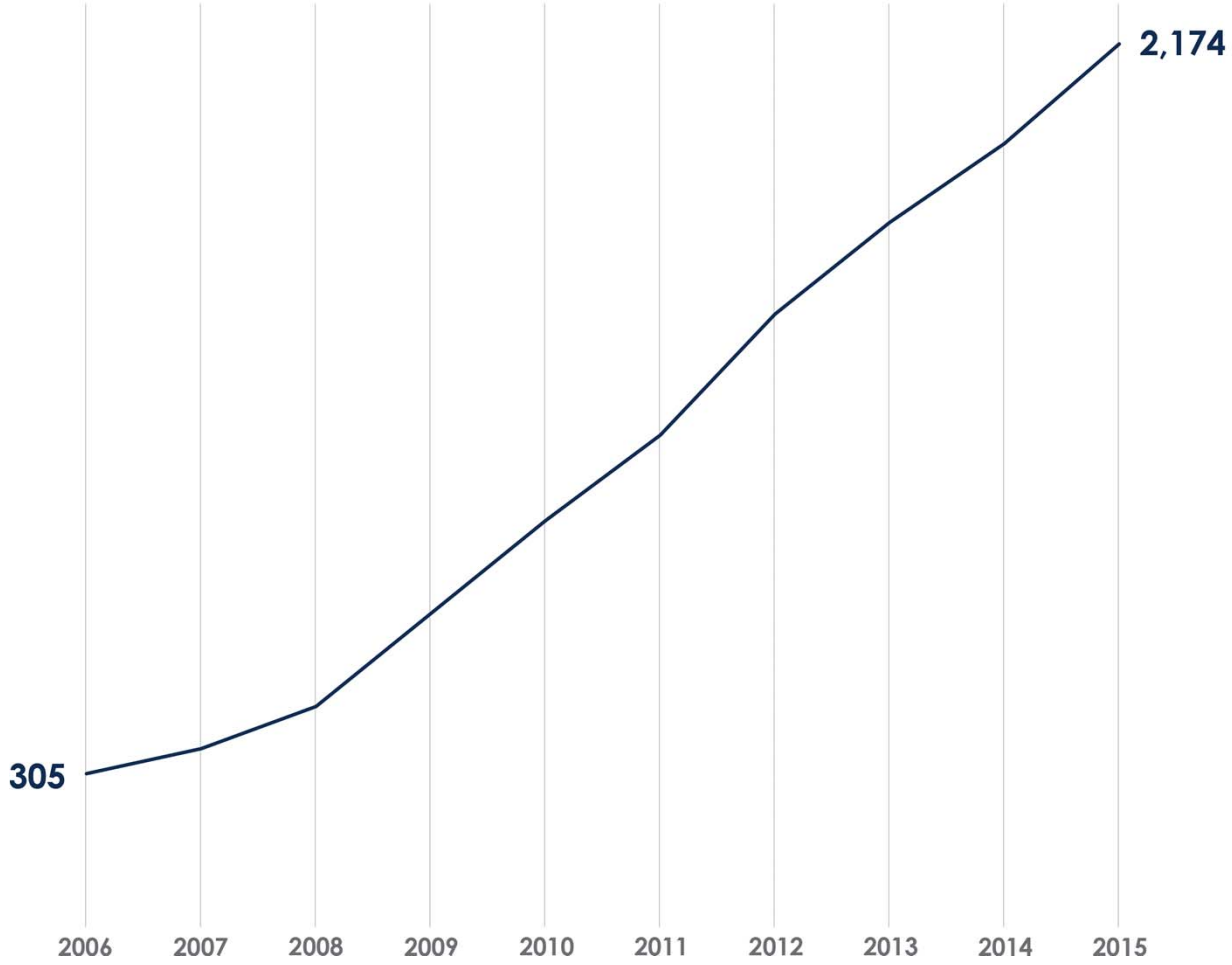
Quitting is hard

…All of the [cessation] counseling in the world is not going to help unless your life is where you need it to be and it has to be. Because if you have your problems and your kids, it's just going to pile up and you're just going to be like "why quit smoking? Why am I going to counseling when it isn't working?" --Athens

Source: Dr. Carol Carstens, OMHAS, 2017

Neonatal abstinence syndrome

Inpatient discharges in Ohio, 2006-2015



Source: Neonatal Abstinence Syndrome (NAS) In Ohio 2006-2015 Report, Table 1A. Ohio Department of Health, Office of Health Improvement and Wellness, Bureau of Health Services Violence and Injury Prevention Program

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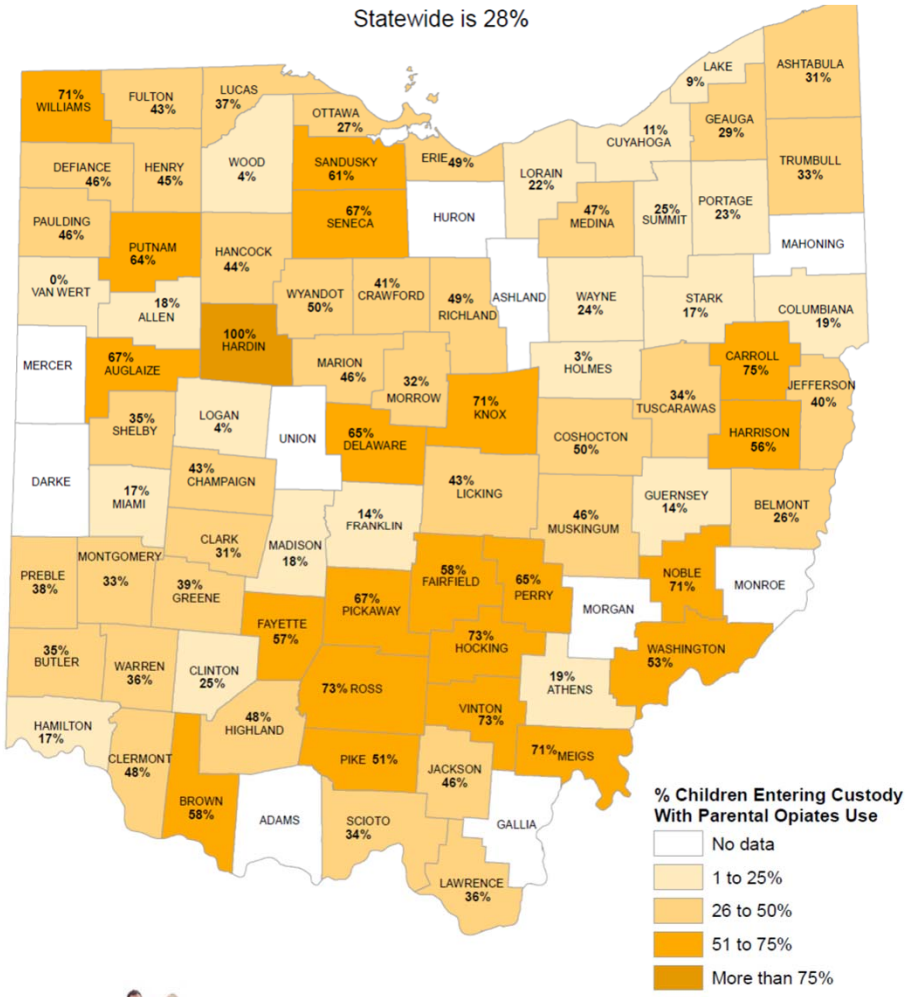
Impact of Opioid Epidemic on Children



PCSAO surveyed county PCSAs to determine the impact of opiates on children in custody (out-of-home care). 74 PCSAs responded and revealed:

- 28% of children taken into custody in 2015 had parents who were using opiates, including heroin, at time of removal

Source: PCSAO Opiate Survey, April 2016

Adverse childhood experiences

Psychological, physical or sexual abuse

Witnessing violence against the mother

Living with household members…

With substance abuse or mental health conditions

Who have attempted or committed suicide

Who have ever been imprisoned

Source: Adapted from Felitti, Vincent J. et al. (1988)

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Where do we go from here?

HPIO Guide to improving health value

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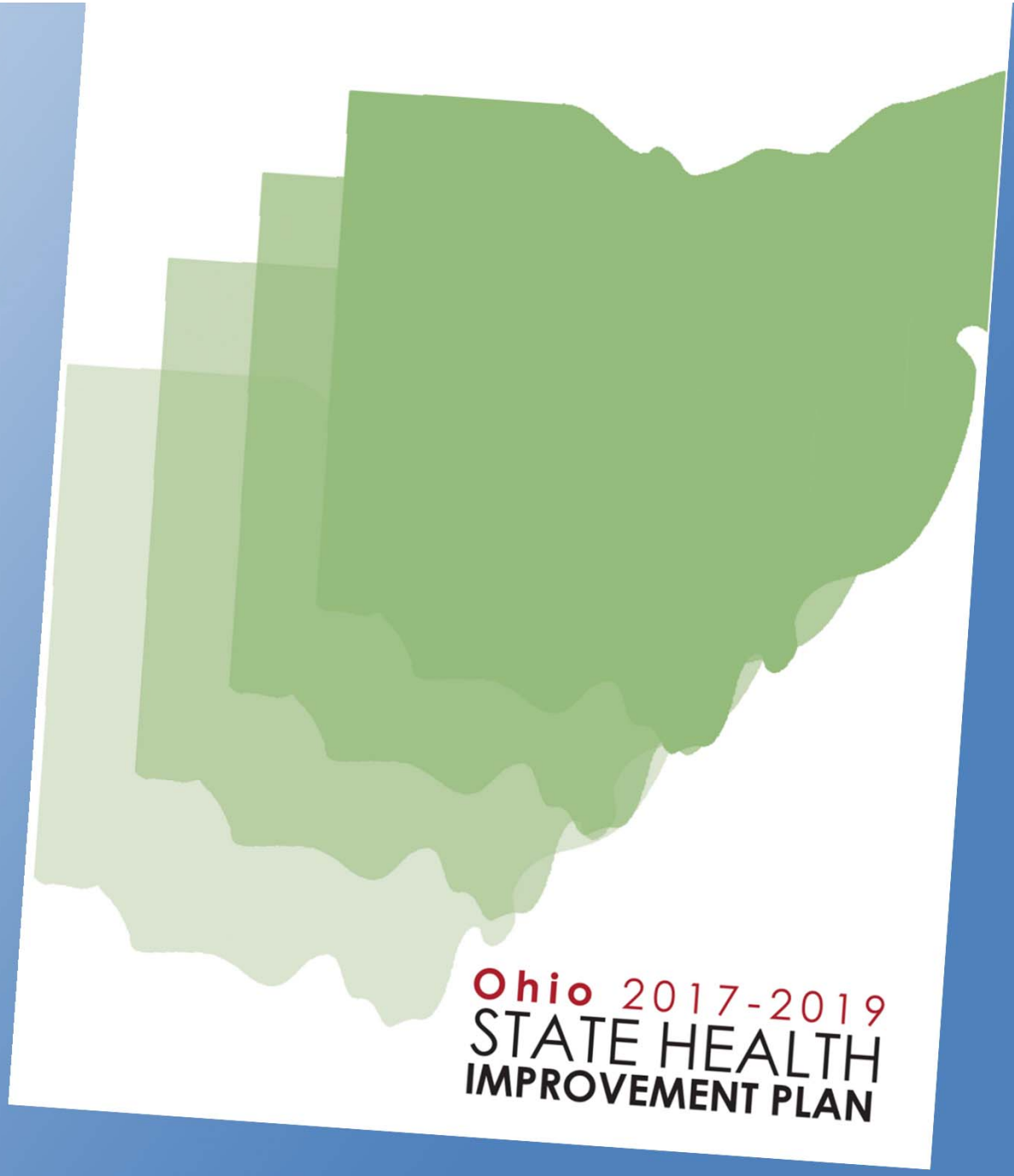
HPIO Addiction Evidence Project
• Evidence resource page
• Policy inventory
• Policy scorecard
Coming Soon

Key elements of a comprehensive response to addiction

Health Policy Institute of Ohio adapted from Addiction Policy Forum (2017)



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Ohio 2017-2019 state health improvement plan (SHIP)

Overall health outcomes

- ⬆ Health status
- ⬇ Premature death

3 priority topics

Mental health and addiction

10 priority outcomes

- ⬇ Depression
- ⬇ Suicide
- ⬇ Drug dependency/ abuse
- ⬇ Drug overdose deaths

Chronic disease

10 priority outcomes

- ⬇ Heart disease
- ⬇ Diabetes
- ⬇ Child asthma

Maternal and infant health

10 priority outcomes

- ⬇ Preterm births
- ⬇ Low birth weight
- ⬇ Infant mortality

Equity: Priority populations for each outcome above

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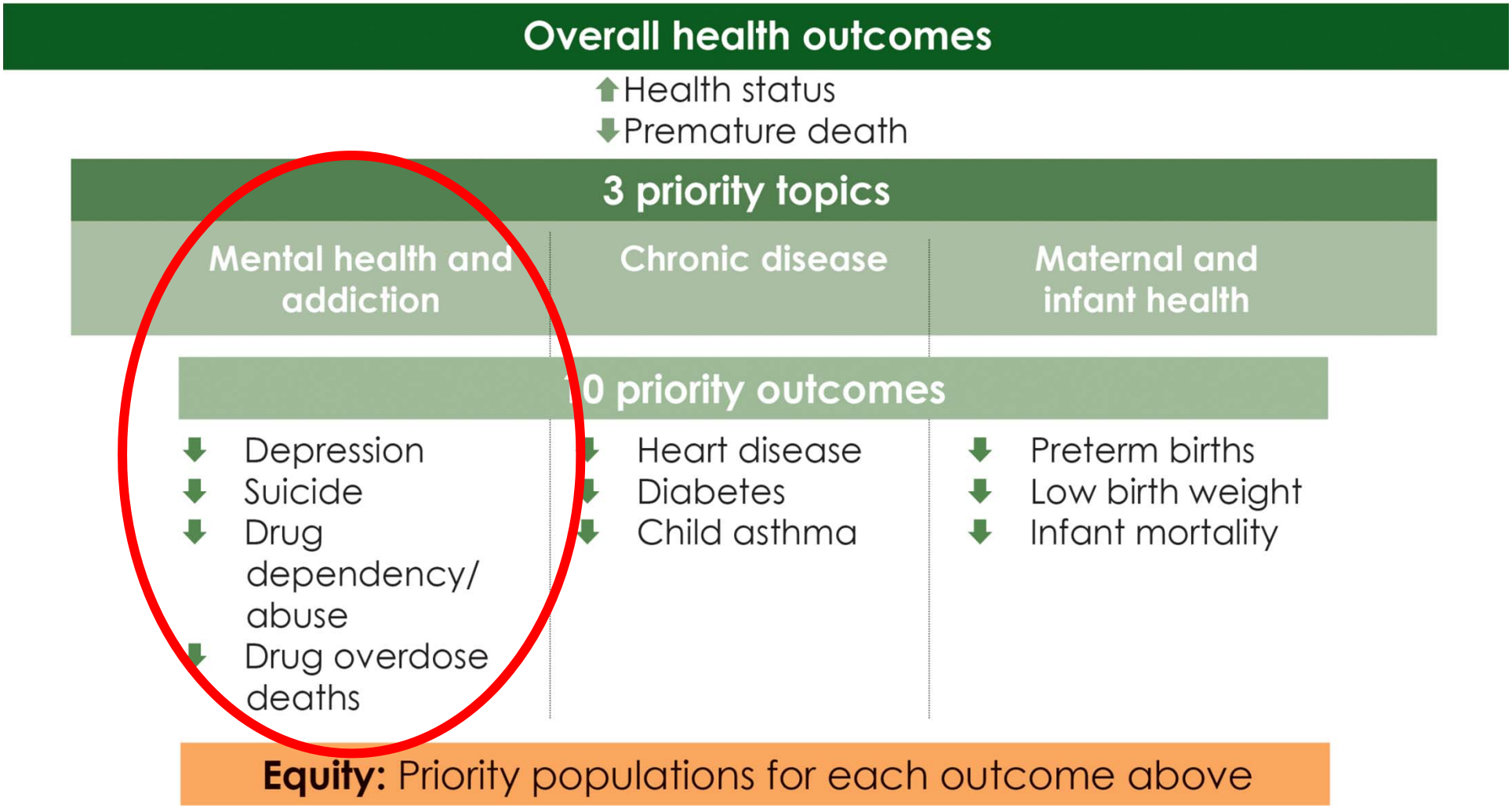
Ohio 2017-2019 state health improvement plan (SHIP)



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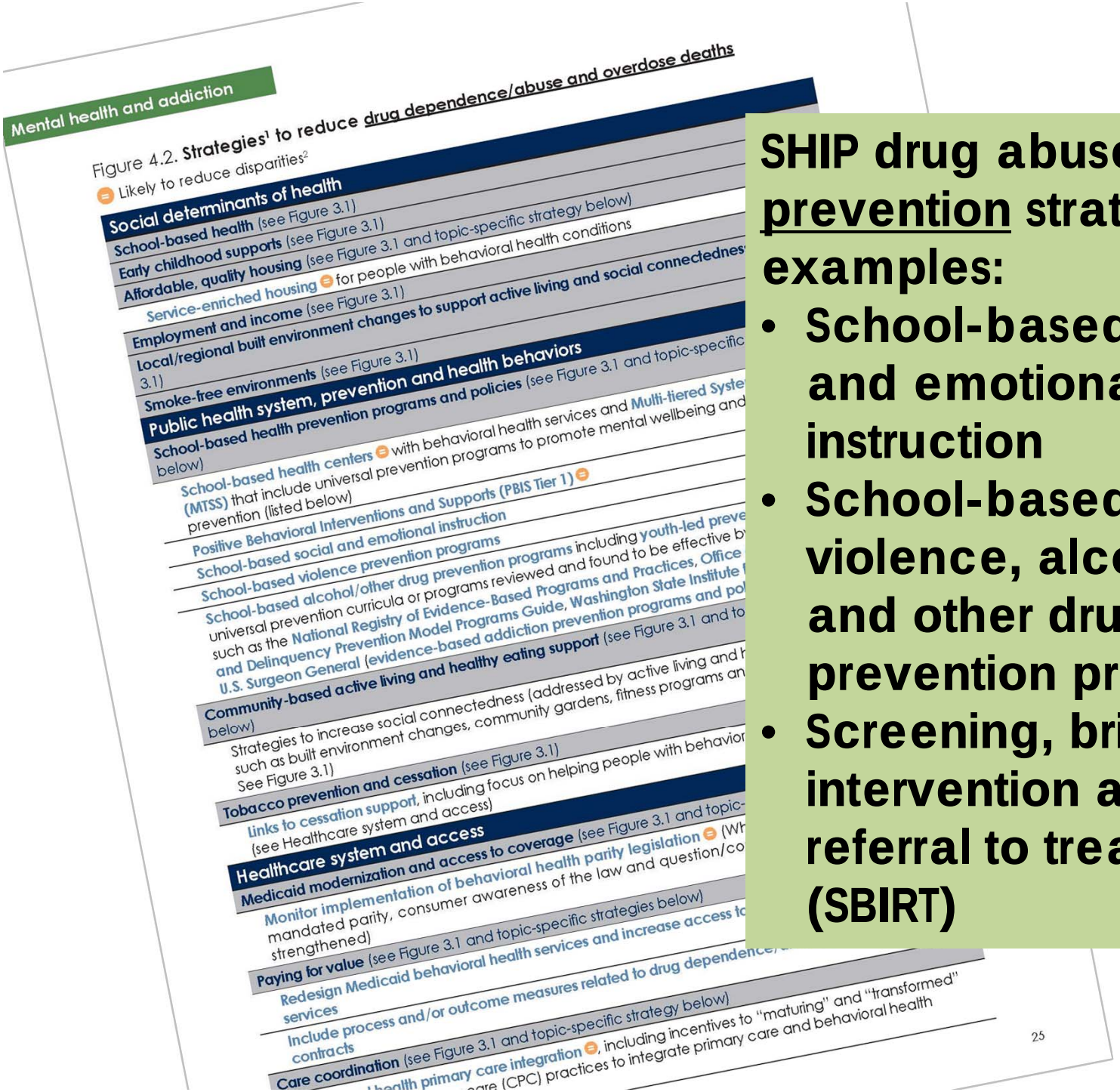
Mental health and addiction

Figure 4.2. **Strategies[1] to reduce drug dependence/abuse and overdose deaths**

Likely to reduce disparities[2]

Social determinants of health

School-based health (see Figure 3.1)

Early childhood supports (see Figure 3.1)

Affordable, quality housing (see Figure 3.1 and topic-specific strategy below)

Service-enriched housing for people with behavioral health conditions

Employment and income (see Figure 3.1)

Local/regional built environment changes to support active living and social connectedness (see Figure 3.1)

Smoke-free environments (see Figure 3.1)

Public health system, prevention and health behaviors

School-based health prevention programs and policies (see Figure 3.1 and topic-specific below)

School-based health centers with behavioral health services and Multi-tiered Syste (MTSS) that include universal prevention programs to promote mental wellbeing and prevention (listed below)

Positive Behavioral Interventions and Supports (PBIS Tier 1)

School-based social and emotional instruction

School-based violence prevention programs

School-based alcohol/other drug prevention programs including youth-led preve universal prevention curricula or programs reviewed and found to be effective b such as the National Registry of Evidence-Based Programs and Practices, Office and Delinquency Prevention Model Programs Guide, Washington State Institute U.S. Surgeon General (evidence-based addiction prevention programs and po

Community-based active living and healthy eating support (see Figure 3.1 and to below)

Strategies to increase social connectedness (addressed by active living and h such as built environment changes, community gardens, fitness programs an See Figure 3.1)

Tobacco prevention and cessation (see Figure 3.1)

Links to cessation support, including focus on helping people with behavior (see Healthcare system and access)

Healthcare system and access

Medicaid modernization and access to coverage (see Figure 3.1 and topic-

Monitor implementation of behavioral health parity legislation (Wh mandated parity, consumer awareness of the law and question/co strengthened)

Paying for value (see Figure 3.1 and topic-specific strategies below)

Redesign Medicaid behavioral health services and increase access to services

Include process and/or outcome measures related to drug dependence/ contracts

Care coordination (see Figure 3.1 and topic-specific strategy below)

health primary care integration, including incentives to "maturing" and "transformed" care (CPC) practices to integrate primary care and behavioral health

25

SHIP drug abuse <u>prevention</u> strategy examples:

- **School-based social and emotional instruction**
- **School-based violence, alcohol and other drug prevention programs**
- **Screening, brief intervention and referral to treatment (SBIRT)**

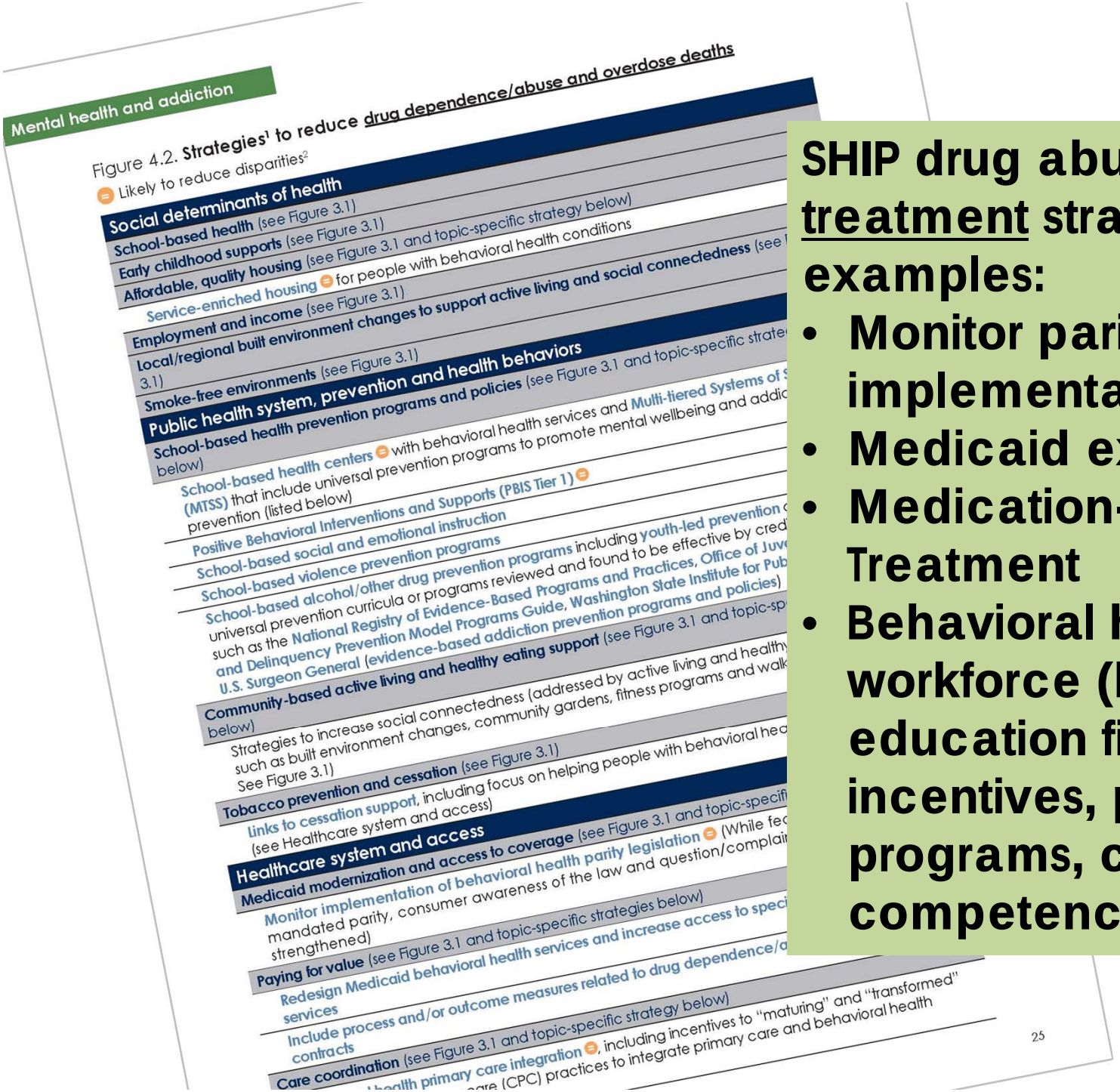
Mental health and addiction

Figure 4.2. **Strategies[1] to reduce drug dependence/abuse and overdose deaths**

= Likely to reduce disparities[2]

Social determinants of health

School-based health (see Figure 3.1)

Early childhood supports (see Figure 3.1)

Affordable, quality housing (see Figure 3.1 and topic-specific strategy below)

Service-enriched housing = for people with behavioral health conditions

Employment and income (see Figure 3.1)

Local/regional built environment changes to support active living and social connectedness (see Figure 3.1)

Smoke-free environments (see Figure 3.1)

Public health system, prevention and health behaviors

School-based health prevention programs and policies (see Figure 3.1 and topic-specific strategies below)

School-based health centers = with behavioral health services and Multi-tiered Systems of Support (MTSS) that include universal prevention programs to promote mental wellbeing and addiction prevention (listed below)

Positive Behavioral Interventions and Supports (PBIS Tier 1) =

School-based social and emotional instruction

School-based violence prevention programs

School-based alcohol/other drug prevention programs including youth-led prevention programs such as the National Registry of Evidence-Based Programs and Practices, Office of Juvenile Justice and Delinquency Prevention Model Programs Guide, Washington State Institute for Public Policy, U.S. Surgeon General (evidence-based addiction prevention programs and policies)

Community-based active living and healthy eating support (see Figure 3.1 and topic-specific strategies below)

Strategies to increase social connectedness (addressed by active living and healthy eating such as built environment changes, community gardens, fitness programs and walking groups)

Tobacco prevention and cessation (see Figure 3.1)

Links to cessation support, including focus on helping people with behavioral health conditions (see Healthcare system and access)

Healthcare system and access

Medicaid modernization and access to coverage (see Figure 3.1 and topic-specific strategies below)

Monitor implementation of behavioral health parity legislation = (While federally mandated parity, consumer awareness of the law and question/complaint mechanisms strengthened)

Paying for value (see Figure 3.1 and topic-specific strategies below)

Redesign Medicaid behavioral health services and increase access to specialty services

Include process and/or outcome measures related to drug dependence/abuse in contracts

Care coordination (see Figure 3.1 and topic-specific strategy below)

...health primary care integration =, including incentives to "maturing" and "transformed" ...care (CPC) practices to integrate primary care and behavioral health

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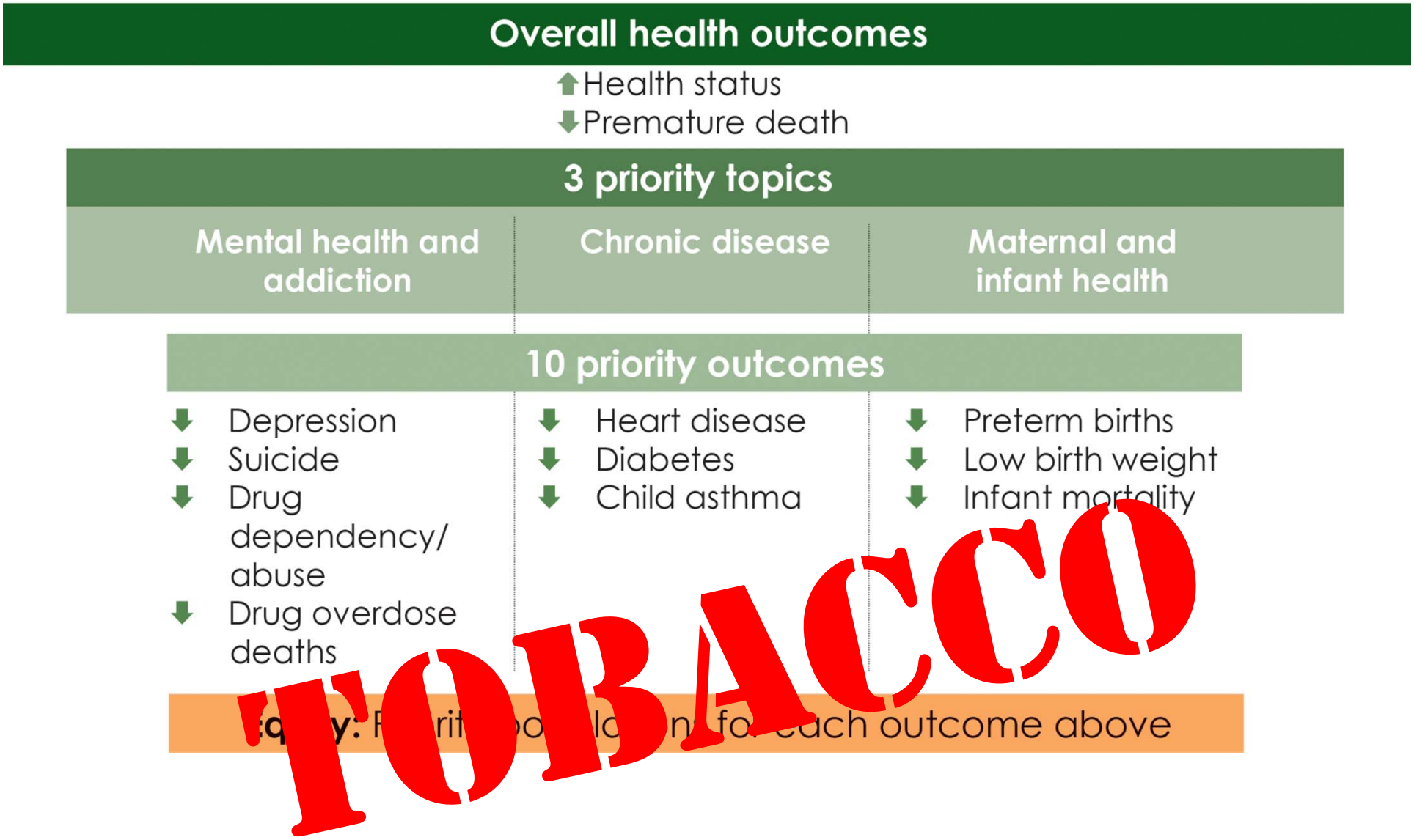
SHIP drug abuse <u>treatment</u> strategy examples:

- **Monitor parity law implementation**
- **Medicaid expansion**
- **Medication-Assisted Treatment**
- **Behavioral health workforce (higher education financial incentives, pipeline programs, cultural competence, etc.)**

Ohio 2017-2019 state health improvement plan (SHIP)



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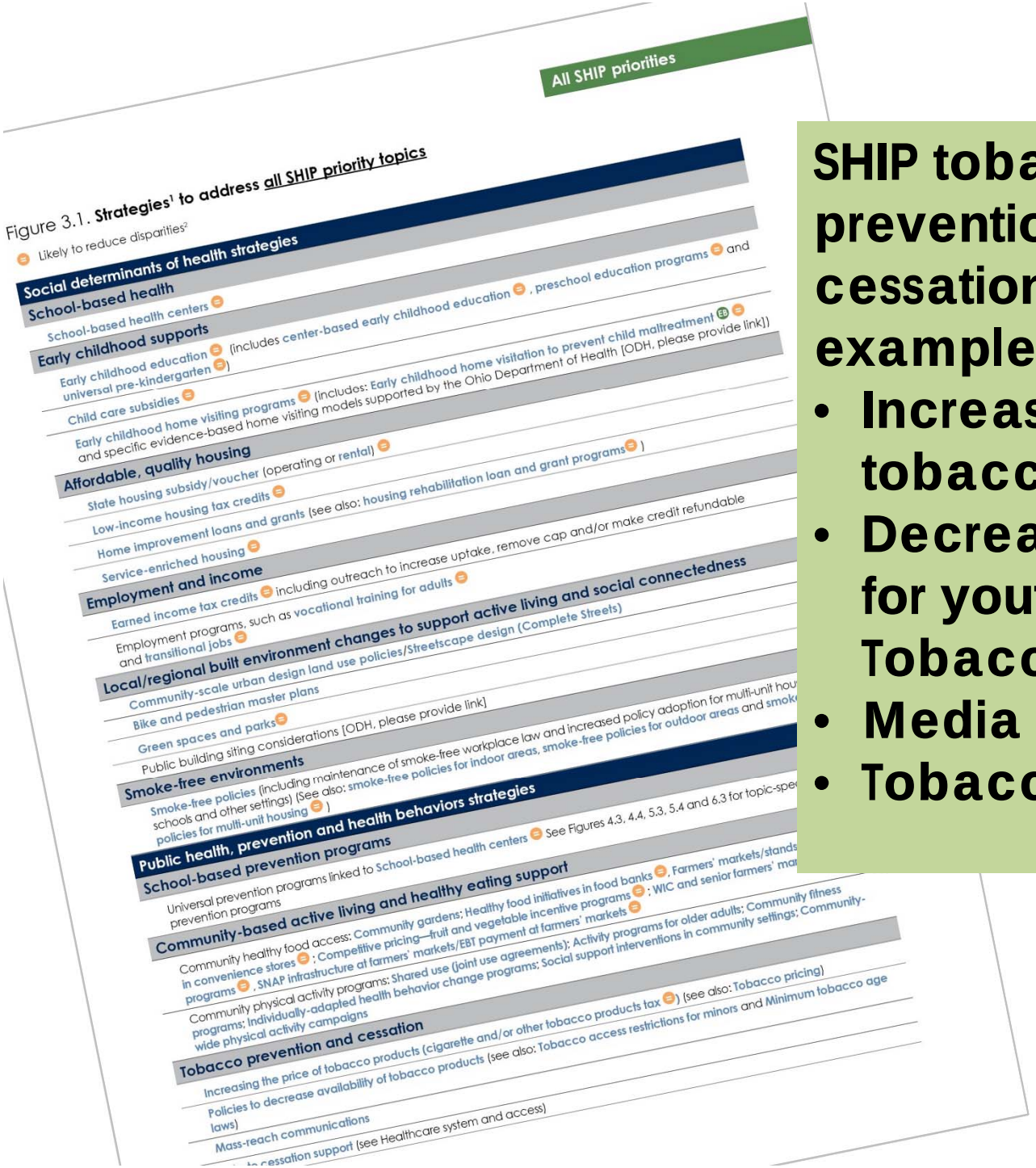

All SHIP priorities

Figure 3.1. **Strategies[1] to address all SHIP priority topics**

Likely to reduce disparities[2]

Social determinants of health strategies

School-based health

School-based health centers

Early childhood supports

Early childhood education (includes center-based early childhood education, preschool education programs and universal pre-kindergarten)

Child care subsidies

Early childhood home visiting programs (includes: Early childhood home visitation to prevent child maltreatment EB and specific evidence-based home visiting models supported by the Ohio Department of Health [ODH, please provide link])

Affordable, quality housing

State housing subsidy/voucher (operating or rental)

Low-income housing tax credits

Home improvement loans and grants (see also: housing rehabilitation loan and grant programs)

Service-enriched housing

Employment and income

Earned income tax credits including outreach to increase uptake, remove cap and/or make credit refundable

Employment programs, such as vocational training for adults and transitional jobs

Local/regional built environment changes to support active living and social connectedness

Community-scale urban design land use policies/Streetscape design (Complete Streets)

Bike and pedestrian master plans

Green spaces and parks

Public building siting considerations [ODH, please provide link]

Smoke-free environments

Smoke-free policies (including maintenance of smoke-free workplace law and increased policy adoption for multi-unit hou
schools and other settings) (See also: smoke-free policies for indoor areas, smoke-free policies for outdoor areas and smok
policies for multi-unit housing)

Public health, prevention and health behaviors strategies

School-based prevention programs

Universal prevention programs linked to School-based health centers See Figures 4.3, 4.4, 5.3, 5.4 and 6.3 for topic-spe
prevention programs

Community-based active living and healthy eating support

Community healthy food access: Community gardens; Healthy food initiatives in food banks, Farmers' markets/stands
in convenience stores; Competitive pricing—fruit and vegetable incentive programs; WIC and senior farmers' ma
programs, SNAP infrastructure at farmers' markets/EBT payment at farmers' markets

Community physical activity programs: Shared use (joint use agreements); Activity programs for older adults; Community fitness programs; Individually-adapted health behavior change programs; Social support interventions in community settings; Community-wide physical activity campaigns

Tobacco prevention and cessation

Increasing the price of tobacco products (cigarette and/or other tobacco products tax) (see also: Tobacco pricing)

Policies to decrease availability of tobacco products (see also: Tobacco access restrictions for minors and Minimum tobacco age laws)

Mass-reach communications

to cessation support (see Healthcare system and access)

SHIP tobacco prevention and cessation strategy examples:

- **Increase price of tobacco products**
- **Decrease availability for youth (including Tobacco 21)**
- **Media campaigns**
- **Tobacco QuitLine**

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