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State health assessment (SHA) and state health improvement plan (SHIP) Steering Committee stakeholder lists

Organizations participating in the Steering Committee (as of April 2019)

- Governor's Minority Affairs Liaison
- Office of Ohio Governor Mike DeWine, Children's Initiatives
- Ohio Commission on Minority Health
- Ohio Department of Aging
- Ohio Department of Developmental Disabilities
- Ohio Department of Education
- Ohio Department of Health
- Ohio Department of Job and Family Services
- Ohio Department of Medicaid
- Ohio Department of Mental Health and Addiction Services
- Ohio Department of Transportation
- Ohio Housing Finance Agency
- RecoveryOhio

Organizations participating in the Advisory Committee (as of April 2019)

- Adaptive Sports Program of Ohio
- Adena in Ross County
- Advocates for Ohio's Future
- Aetna Better Health of Ohio
- Akron Children's Hospital
- American Cancer Society Cancer Action Network
- Association of Ohio Health Commissioners
- Better Health Partnership
- Butler County Health Department
- Canton City Public Health
- CareSource
- Case Western Reserve University School of Medicine
- Cincinnati Children's Hospital Medical Center
- Cleveland Clinic
- Columbus Public Health
- Community Legal Aid
- Cradle Cincinnati
- Cuyahoga County Board of Health
- Dayton Children's Hospital
- Employers Health
- Equitas Health Institute
- First Year Cleveland
- Franklin County Public Health
- Greene County Public Health
- Health Action Council
- Hospital Council of Northwest Ohio
- Interact for Health
- LeadingAge Ohio
- Local Initiatives Support Corporation
- Mahoning County District Board of Health
- Marietta/Belpre City Health Department
- Mental Health America of Franklin County
- Mental Health and Addiction Advocacy Coalition
- Mental Health Services for Clark and Madison Counties Inc.
- Mid-East Ohio Regional Council of Government
- Mid-Ohio Foodbank
- Mt. Sinai Health Care Foundation
- National Alliance on Mental Illness Ohio
- North Canton Medical Foundation
- Northwest Ohio Medical Services
- Novartis
- Ohio Academy of Family Physicians
- Ohio Association of Area Agencies on Aging
- Ohio Association of Community Health Centers
- Ohio Association of County Behavioral Health Authorities
- Ohio Association of Health Plans
- Ohio Attorney General's Office
- Ohio Business Roundtable
- Ohio Center for Autism and Low Incidence
- Ohio Chamber of Commerce
- Ohio Child Care Resource and Referral Association
- Ohio Civil Rights Commission
- Ohio Commission on Minority Health
- Ohio Department of Aging
- Ohio Department of Education
- Ohio Department of Health
- Ohio Department of Medicaid
- Ohio Disability and Health Program
- Ohio Domestic Violence Network
- Ohio Housing Finance Agency
- Ohio University
- Oral Health Ohio
- Philanthropy Ohio
- Policy Matters Ohio
- Prevention Action Alliance
- RecoveryOhio
- Sisters Health Foundation
- Sisters of Charity Foundation of Canton
- Stark County Health Department
- The Center for Community Solutions
- The Center for Health Affairs
- The Health Collaborative
- The Kirwan Institute for the Study of Race and Ethnicity
- The Ohio Council of Behavioral Health and Family Services Providers
- The Ohio State University
- The Ohio State University College of Nursing
- The Ohio State University College of Public Health
- University Hospitals
- University of Cincinnati
- Washington County Health Department
- Williams County Health Department
- Wright State University
- Zanesville-Muskingum County Health Department

Alignment of 2016 and 2019 SHA components with relevant PHAB standards and measures

Public Health Accreditation Board (PHAB) Standards and Measures, Version 1.5

Standard 1.1. Participate in or Lead a Collaborative Process Resulting in a Comprehensive Community Health Assessment

Measure	2016 SHA alignment	2019 SHA alignment <i>Italics= enhanced components in 2019</i>
<p>Measure 1.1.1 S A state partnership that develops a comprehensive state community health assessment of the population of the state</p>	<ul style="list-style-type: none"> • SHA/SHIP Advisory Committee made up of representatives from a wide variety of sectors (98 organizations represented) • Internal Population Health Infrastructure Team (SHA/SHIP Steering Committee) made up of representatives from health-related state agencies • Regular meetings of the above groups. All meeting materials transparently posted on HPIO website. • Collaborative process used to identify health issues and assets, including 5 regional forums (372 participants), using the Mobilizing for Action through Planning and Partnerships (MAPP) model, plus an online survey (32 respondents) 	<ul style="list-style-type: none"> • SHA/SHIP Advisory Committee made up of representatives from a wide variety of sectors (101 participants as of April 2019) • SHA/SHIP Steering Committee made up of directors (or their designees) from 13 state agencies (<i>including agencies in sectors beyond health, such as the departments of Transportation and Education</i>) • Regular meetings of the above groups, <i>including some meetings held via webinar to improve access for partners in all parts of the state</i>. All meeting materials transparently posted on HPIO website. • Collaborative process used to identify health issues and assets, including 5 regional forums (521 participants) using the Mobilizing for Action through Planning and Partnerships (MAPP) model, plus an online survey (308 respondents)

Measure	2016 SHA alignment	2019 SHA alignment <i>Italics= enhanced components in 2019</i>
<p>Measure 1.1.2 S A state level community health assessment</p>	<ul style="list-style-type: none"> • Qualitative and primary data source: Small group discussions at regional forums; Document review of 211 local health department community health assessments/plans and hospital community health needs assessments/ implementation strategies; key-informant interviews with 37 representatives of community-based organizations • Quantitative data sources: Secondary data on over 140 metrics from wide variety of sources on a comprehensive range of topics, including the social, economic and physical environment. • Demographics data included in SHA document • Data reported by race/ ethnicity, disability, geography, education level and income for some metrics, with discussion of disparities and inequities • SHA narrative includes description of health issues and descriptions of specific population groups with particular health issues and health disparities or inequities, as well as description of factors that contribute to the state populations' health challenges • State asset inventory compiled by the Governor's Office of Health Transformation • Draft SHA posted on the ODH and HPIO websites and shared with stakeholders for input via an online survey 	<ul style="list-style-type: none"> • Qualitative and primary data source: Small group discussions at regional forums and open-ended questions in online survey • Quantitative data sources: Secondary data on over 280 <i>metrics</i> from wide variety of sources on a comprehensive range of topics, including the social, economic and physical environment. <i>New metric additions: transportation, housing and child welfare</i> • <i>Online SHA: New online interactive format, including county-level data</i> • Demographics data included in online SHA • Data reported by race/ ethnicity, disability, geography, education level, income and <i>LGBTQ status</i> for some metrics, with discussion of disparities and inequities • SHA summary report narrative includes description of health issues and descriptions of specific population groups with particular health issues and health disparities or inequities, as well as description of factors that contribute to the state populations' health challenges • State asset inventory <i>focused on state and local-level plans from agencies participating in the Steering Committee (including sectors beyond health)</i> • Draft SHA posted on the ODH and HPIO websites and shared with stakeholders for input via an online survey (59 respondents)
<p>Measure 1.1.3 A Accessibility of community health assessment to agencies, organizations, and the general public</p>	<p>SHA disseminated via the ODH website</p>	<p>Share SHA with stakeholders and general public: <i>ODH to implement more comprehensive dissemination strategy in 2019, including outreach to sectors beyond health</i></p>

State and local asset inventory

The following outward-facing plan documents include state and local priorities, goals, objectives, performance metrics and/or strategies. SHIP planners will consider and build upon these existing assets, focusing on the state agencies participating in the SHA/SHIP Steering Committee and their local partners.

Agency	State-level plans	Local-level plans
Ohio Department of Health	<ul style="list-style-type: none"> • 2017-2019 State Health Improvement Plan • Mental Health and Addiction • Chronic Disease • Maternal and Infant Health 	<ul style="list-style-type: none"> • Population Health Local Plans and Assessments • Improving Population Health Planning in Ohio: Guidance for Aligning State and Local Efforts
Ohio Commission on Minority Health	Strategic Plan: 2016-2020	Local Offices on Minority Health, Local Conversation Reports
Ohio Department of Aging	State Plan on Aging	Local Area Agencies on Aging are required to submit plans to the Ohio Department of Aging. Recent plans are not currently posted.
Ohio Department of Developmental Disabilities	<ul style="list-style-type: none"> • Employment First Strategic Plan • State Systemic Improvement Plan 	<ul style="list-style-type: none"> • County Board Three-Year Calendar Plan • County Board- Seven Essential Elements of a Person-Centered Plan
Ohio Department of Education	Each Child Our Future, Ohio strategic Plan for Education 2019-2024	Local Equity Access Planning (LEAP)
Ohio Department of Higher Education	Ohio Attainment Goal 2025: 2018 Annual Report	NA
Ohio Department of Job and Family Services	State of Ohio Child and Family Services Plan 2015-2019	Regional and Local Plans describe the delivery of Workforce Innovation and Opportunity Act (WIOA) services in each locality in the state
Ohio Department of Medicaid	<ul style="list-style-type: none"> • Medicaid State Plan 	NA

Note: **Blue font** indicates clickable hyperlink.

Agency	State-level plans	Local-level plans
Ohio Department of Mental Health and Addiction Services (OMHAS)	NA	ADAMH boards are required to submit a Community Plan to OMHAS every two years. Plan template includes priorities, strategies and measurement. Recent plans are not currently posted.
Ohio Department of Transportation	2018-2021 STIP The Statewide Transportation Improvement Program (STIP)	NA
Ohio Department of Veterans' Services	NA	NA
Ohio Family and Children First	<ul style="list-style-type: none"> • FCFC Shared Plan Model (HB 289) • Family and Children First Council (FCFC) HB 289 Shared Plan Guidance 	County FCFC Shared Plans (HB 289)
Ohio Housing Finance Agency	<ul style="list-style-type: none"> • 2018 Annual Report • 2019 Annual Plan • Housing Needs Assessment Executive Summary 	NA
RecoveryOhio	RecoveryOhio Advisory Council Initial Report, March 2019	NA

Data gaps and limitations

Secondary data used in the 2019 State Health Assessment (SHA) provides an important picture of health and wellbeing in Ohio. The 2019 SHA data comes from a variety of sources, including survey, vital statistics, administrative and claims data. Care was taken to select metrics from credible sources; however, it is important to note that each of these sources has its own limitations. In addition, existing secondary data does not reflect all the factors and issues related to the health and wellbeing of Ohioans.

SHA data gaps and limitations include:

Data lag and trend reporting. There is typically a lag of one to three years between the time data is collected and when it is finalized and publicly released. Data lag was particularly problematic in assessing progress on the 2017-2019 SHIP priority outcomes because 2017 is the most recent year of data available from most sources. Sources also report data on different timelines. Some data (such as Vital Statistics or the Behavioral Risk Factor Surveillance Survey (BRFSS)) is reported on an annual basis, while other sources are collected and reported less frequently (such as the Ohio Medicaid Assessment Survey). As a result, evaluation of trend performance often spans different time periods and intervals across metrics.

U.S. comparison data. Some sources collect data for Ohio only, such as the OMAS, the Kindergarten Readiness Assessment and data collected by state agencies. These sources usually do not provide comparable data for the U.S. or other states which limits the ability to put Ohio's performance into meaningful context.

Disaggregated data, health disparities and inequities. There is no standard set of population groups for which data is collected, disaggregated and reported on across the sources used in the SHA. As a result, data is not available for some groups of Ohioans that experience health disparities and inequities. Populations often lacking data include sexual and gender minorities, immigrants and refugees or sub-racial and ethnic groups – such as southeast Asian, Arab/Middle Eastern or sub-Saharan African.

Even when data is collected, sample sizes are often small, and estimates are suppressed or unreliable. This is particularly an issue for survey data and disaggregation of data at the local level.

The magnitude of health disparities and inequities are also often not fully captured in existing data. For example, Ohioans who are members of more than one group facing poor health outcomes, such as Ohioans of color or Ohioans with a disability, may experience larger gaps in outcomes than the data demonstrates. Aggregated data can also mask health disparities, particularly for subpopulations. Asian Americans, for example, tend to perform well as a whole on many health indicators. However, data on southeast Asians and immigrant or refugee populations from Asia, such as Bhutanese-Nepali refugees, suggest these subpopulations experience poorer health outcomes.¹

Child and adolescent health survey data. There are several issues associated with child and adolescent health survey data that limit the comprehensiveness of this data for Ohio:

- Youth Risk Behavior Surveillance System (YRBSS): National school-based survey administered every other year. Over the past few years, the sample size for this survey was not adequate to report state-level data for Ohio. County-level data is also not available.
- Ohio Healthy Youth Environments Survey (OHYES!) and other school-based surveys, such as PRIDE: These are optional surveys administered by local school districts. State-level data is not available.

National Survey of Children's Health: This survey is now administered by the Census Bureau on an annual basis. However, small sample sizes over the past few years have limited the ability to disaggregate the data.

Behavioral health: The National Survey of Drug Use and Health provides state and sub-state level data on mental health, substance use and abuse disorders, and access to treatment. State-level data is reported using at least two pooled years of data and stratified by age and "sub-state region," but not for subpopulations. National data is stratified by race/ethnicity, gender, education and employment status.

Data on provider workforce capacity for substance use treatment is limited. For example, the Health Resources Services Administration provides data on the ratio of primary care and mental health professionals, but not for substance use treatment providers.

Healthcare spending and clinical care data.

Population-level healthcare spending and clinical care data, such as private health plan claims data or patient data from electronic medical records, are difficult to obtain at both the state and local level. Different data platforms across healthcare providers and community partners, proprietary data concerns and restrictions, lack of data sharing agreements and health information privacy laws contribute to this issue.

Social determinants of health data. Data on the social determinants of health, including housing, transportation, employment and income is available from many sources, most notably the U.S. Census Bureau. However, the outcomes

addressed by these sources are not directly linked to health outcomes. For example, the American Community Survey provides data about health insurance coverage in a community, but not the extent to which health insurance enables access to healthcare services for people living in that community. Additional limitations include:

- The need to pool years of data to generate estimates for smaller populations (i.e. rural counties and sub-racial and ethnic groups). This makes it more difficult to assess trend and the impact of interventions on outcomes.
- Transportation data are limited and data on specific transportation-related barriers to healthcare access is not available.
- Sectors that address social determinants of health collect, stratify and report data using different standards and definitions. For example, most housing outcomes are disaggregated by Area Median Income and most health outcomes are stratified by percent of the Federal Poverty Level.

Note

1. Surendra Bir Adhikari et al. Epidemiology of Mental Health, Suicide and Post-Traumatic Stress Disorders among Bhutanese Refugees in Ohio, 2014. Columbus, OH: Ohio Department of Mental Health and Addiction Services, Community Refugee and Immigration Services, 2015.