Working draft subject to change (10/28/2015)

Preliminary recommendations for Ohio's next State Health Assessment (SHA) and State Health Improvement Plan (SHIP)

Health Policy Institute of Ohio

Summary of recommendations

The following recommendations are based upon feedback from members of the Population Health Advisory Workgroup gathered during the October 13, 2015 meeting, as well as the PHAB *Standards and Measures 1.5*, guidance from the Association of State and Territorial Health Officials (ASTHO)[1], and best practice examples from other states. These recommendations are consistent with Public Health Accreditation Board (PHAB) requirements, but in some cases are more specific or emphasize elements of particular importance to Ohio.

Cross-cutting recommendations for SHA and SHIP	
1. Conceptual framework	The SHA and SHIP should be guided by a broad conceptual framework that includes the social determinants of health, health equity, and a life-course perspective.
2. Leadership and cross-sector engagement	The SHA/SHIP development process should engage leadership from within ODH and other state agencies and include input from sectors beyond health.
SHA recommendations	
3. Existing data	The SHA should build upon existing information about Ohio's health needs.
4. Metric selection	The SHA should select metrics based upon specific prioritization criteria.
5. Communicating findings	The SHA should summarize and synthesize the findings in a compelling format that puts data into context and directly informs the SHIP.
SHIP recommendations	
6. Existing plans	The SHIP should build upon related state-level plans.
7. Prioritization process	The SHIP should select priority health areas based upon specific prioritization criteria.
8. Objectives, strategies and evaluation	The SHIP should include SMART objectives, evidence-based strategies, and an evaluation plan.
9. Implementation and financing	The SHIP should specify how the strategies will be implemented and financed.

Cross-cutting recommendations for SHA and SHIP

Recommendation #1. Conceptual framework. ***The SHA and SHIP should be guided by a broad conceptual framework that includes the social determinants of health, health equity, and a life-course perspective.***

A broad conceptual framework would ensure that the SHA includes data on upstream determinants of health and health disparities, and information about the unique needs of children, adolescents, and adults of all ages. Similarly, a broad conceptual framework would ensure that the strategies outlined in the SHIP include sectors beyond health (such as education, transportation and housing), use a "health in all policies" approach, and identify

evidence-based interventions shown to be effective in reducing health disparities and promoting healthy growth and development throughout the life course.

Ohio should consider existing conceptual frameworks, such as:

- **HPIO Health Value Dashboard.** The Dashboard conceptual framework was developed by a multi-stakeholder group in Ohio with the end goal of improving health value for Ohioans, equally weighting population health outcomes and healthcare costs. The Dashboard includes the Social and Economic Environment, Physical Environment, Prevention and Public Health, Healthcare System, and Access as determinant domains. The Dashboard also includes health behaviors and equity measures. The Dashboard framework is very similar to the County Health Rankings model, but also includes healthcare costs. HPIO recommends this as the preferred framework for the SHA.
- **National Prevention Strategy.** This framework embodies a positive focus on health, rather than a negative focus on disease. For example, rather than focusing on "obesity" as a priority, this model refers to "Healthy Eating" and "Active Living." It also includes "Empowered People" and "Elimination of Health Disparities" as strategic directions and incorporates the life-course perspective as part of the overall goal. HPIO recommends this as the preferred framework for the SHIP.
- **Colorado SHIP framework:** Adds life-course stages to a classic population health framework.
- **Minnesota SHIP framework:** Includes specific focus on early childhood and identifies nine education, social and economic outcomes that impact health.

See appendix for conceptual frameworks.

The SHA/SHIP's life-course perspective should build from the goals developed by Ohio's Human Services Innovation initiative:

- Infants are born healthy
- Children are ready to learn
- Children succeed in school
- Youth successfully transition to adulthood
- Job seekers find meaningful work
- Workers support their families
- Families thrive in strong communities
- Ohioans special needs are met
- Retirees are safe and secure

The SHA/SHIP conceptual framework should also include pathways to connect clinical care—particularly Patient-Centered Medical Homes—to upstream population health strategies. (See "upstream glide path" framework in appendix.)

It is important to note that there is a tension between having a SHA and SHIP that are too broad versus not broad enough. Advisory group members advocated for adopting a very broad conceptual framework that goes beyond "diseases of the month" and includes a wide range of sectors. On the other hand, the previous SHIP was criticized for including too many priorities and "being all things to all people." One way to address this tension would be to adopt a conceptual framework that acknowledges a broad range of determinants, and to then identify a concise set of "flagship" priorities for the SHIP. The broader conceptual framework could be used by local communities, who may want to select priorities that are outside the "flag ship" priorities but are nonetheless outlined in the framework.

Overall, the purpose of selecting/developing a conceptual framework should be to result in a SHA that has a useful and comprehensive set of metrics and data, and a SHIP that presents a concept of health and a way of framing priorities that is useful to local community health planners and prompts implementation of upstream activities.

Recommendation #2. Leadership and cross-sector engagement. *The SHA/SHIP development process should engage leadership from within ODH and other state agencies and include input from sectors beyond health.*
The SHA and SHIP steering committees should include high-level leadership from within ODH and from other state agencies such as Medicaid, Mental Health and Addiction Services, Aging and Job and Family Services.

Partners from sectors beyond health (such as transportation, education and housing) should also be included in some way in the process, most likely through a multi-sector SHIP planning and implementation coalition. ODH should provide adequate staffing and "backbone support" to facilitate recruitment and ongoing communication with the coalition and subcommittees focused on specific priorities.

In addition, ODH should engage a neutral convener with experience bringing Ohio stakeholders together to select metrics, priorities and strategies.

SHA recommendations

Recommendation #3. Existing data. *The SHA should build upon existing information about Ohio's health needs.*

Rather than "starting from scratch," the SHA should incorporate information from some or all the following sources:

- Network of Care (secondary data website)
- 2014 HPIO Health Value Dashboard (second edition to be released January 2017)
- Ohio Medicaid Survey (2015 and previous years)
- SIM Population Health Diagnostic (McKinsey, 2015)
- Recent topic-specific reports, such as the Impact of Chronic Disease in Ohio (ODH, 2015)

HPIO recommends use of the Health Value Dashboard as a central component of the SHA. See the appendix for a potential timeline for aligning the SHA with the Dashboard.

The SHA should include a crosswalk that illustrates the overlaps and differences between Network of Care, the HPIO Health Value Dashboard and the Ohio Medicaid Assessment Survey. It may also be helpful to include a crosswalk for the Ohio Medicaid Assessment Survey and other commonly used surveys, such as the BRFSS, YRBS, NCHS and Oh YES!

In addition, the SHA should use an existing planning model such as MAPP, ACHI, CHA, APEX/PH.

Recommendation #4. Metric selection. *The SHA should select metrics based upon specific prioritization criteria.*
When selecting the metrics to include in the SHA report, the SHA steering committee should:

- Identify a set of decision criteria to guide selection of metrics to include in the SHA report. (Examples of criteria are included in the appendix.)
- Select metrics that measure the health determinants and outcomes outlined in the conceptual framework and align with the resources listed in recommendation #3.

The SHA should include a set of metrics that is comprehensive enough to reflect a broad view of health determinants, yet concise enough to be presented in an actionable format. The categories and terms used in the SHA should provide a typology of health issues that can be used by local communities. (See appendix for examples of health priority categories.)

Recommendation #5. Communicating findings. ***The SHA should summarize and synthesize the findings in a compelling format that puts data into context and directly informs the SHIP.***
The SHA should include an executive summary that summarizes key findings and identifies overall themes. The report should put data in context through the use of benchmarks (e.g., Healthy People 2020 goals), trends, and/or comparisons to other states or the US overall. Information about disparities should be displayed in a compelling way (see appendix for examples) and the narrative should explore reasons for disparities. Data should be updated on a regular basis to allow for ongoing monitoring using the Network of Care website.

SHIP recommendations

Recommendation #6. Existing plans. ***The SHIP should build upon related state-level plans.***
SHIP planners should turn to existing statewide plans for potential priorities, metrics, objectives, and strategies to include in the next SHIP. Examples include the 2015-2016 SHIP Addendum, the Ohio Infant Mortality Reduction Plan 2015-2020, Ohio's Plan to Prevent and Reduce Chronic Disease 2014-2018, The Ohio Comprehensive Cancer Control Plan 2015-2020, and the Ohio Adolescent Health Partnership Strategic Plan 2013-2020. The chronic disease and cancer control plans, in particular, include several useful examples of SMART objectives.

Recommendation #7. Prioritization process. ***The SHIP should select priority health areas based upon specific prioritization criteria.***
When selecting priorities to include in the SHIP, planners should:

- Identify a set of decision criteria to guide selection of priorities. (Examples of criteria are included in the appendix.)
- Be open and iterative during the prioritization process, allowing for input from a wide range of stakeholders.
- Consider priorities identified by local communities through their hospital and local health department assessments and improvement plans ("bottom up" approach to identifying priorities).
- Consider priorities that align with national priorities, such as the National Prevention Strategy.

The resulting set of priorities should be concise enough to drive targeted action to "move the needle" on a strategic set of health outcomes. The SHIP may need to elevate a small number of "flagship" priorities that apply to all or most areas of the state, while acknowledging a broader range of additional priorities that vary widely by location. The categories and terms used for the SHIP priorities should provide a typology of health issues that can be used by local communities. (See appendix for examples of health priority categories.)

Recommendation #8. Objectives, strategies and evaluation. ***The SHIP should include SMART objectives, evidence-based strategies, and an evaluation plan.***
The SHIP should include measurable "SMART objectives"[2] with time-bound targets for each priority. The evaluation plan should specify how progress toward process and outcome objectives will be monitored over time and reported to the public and other stakeholders.

An evidence-based strategy is defined as a program or policy that has been evaluated and demonstrated to be effective in achieving the desired outcome based upon the best-available research evidence, rather than upon personal belief or anecdotal evidence. SHIP planners should use the following sources of best-available evidence for population health strategies:

- The Guide to Community Preventive Services (Community Guide)
- What Works for Health
- Other systematic reviews and evidence registries, as described in the HPIO Guide to Evidence-Based Prevention

Strategies should be selected using specific criteria (see appendix for examples), and should include a range of strategies that:

- Link clinical and community settings, including ways to connect Patient-Centered Medical Homes with community-based prevention programs
- Address upstream social determinants of health, including housing, transportation, education, income/employment, etc.
- Involve policy, system or environmental change
- Are designed to decrease health disparities and achieve health equity
- Promote health at each stage of life
- Address the strengths, needs and empowerment of individuals, families and communities

Recommendation #9. Implementation and financing. ***The SHIP should specify how the strategies will be implemented and financed.***
SHIP planners should identify a responsible party and funding source for each strategy. The SHIP should identify state-level backbone organizations that accept leadership and accountability for each priority area, along with dedicated funding sources (e.g., ODH grants) or other financing mechanisms (e.g., Medicaid reimbursement, hospital community benefit, Pay for Success, etc.). In some cases the appropriate backbone organization may be ODH, although other organizations or agencies could also serve as backbones for SHIP priorities. (A backbone organization, also referred to as a "community integrator," is an entity with the capacity to bring partners together to define, measure and achieve a common goal. Backbone organizations must have adequate staffing to support project management, administration, data analysis, communications and other coordination functions.[3])

The SHIP dissemination plan should include ways to engage trusted messengers to recruit additional community partners to implement and/or fund SHIP strategies at the local level, including private philanthropy and sectors beyond health.

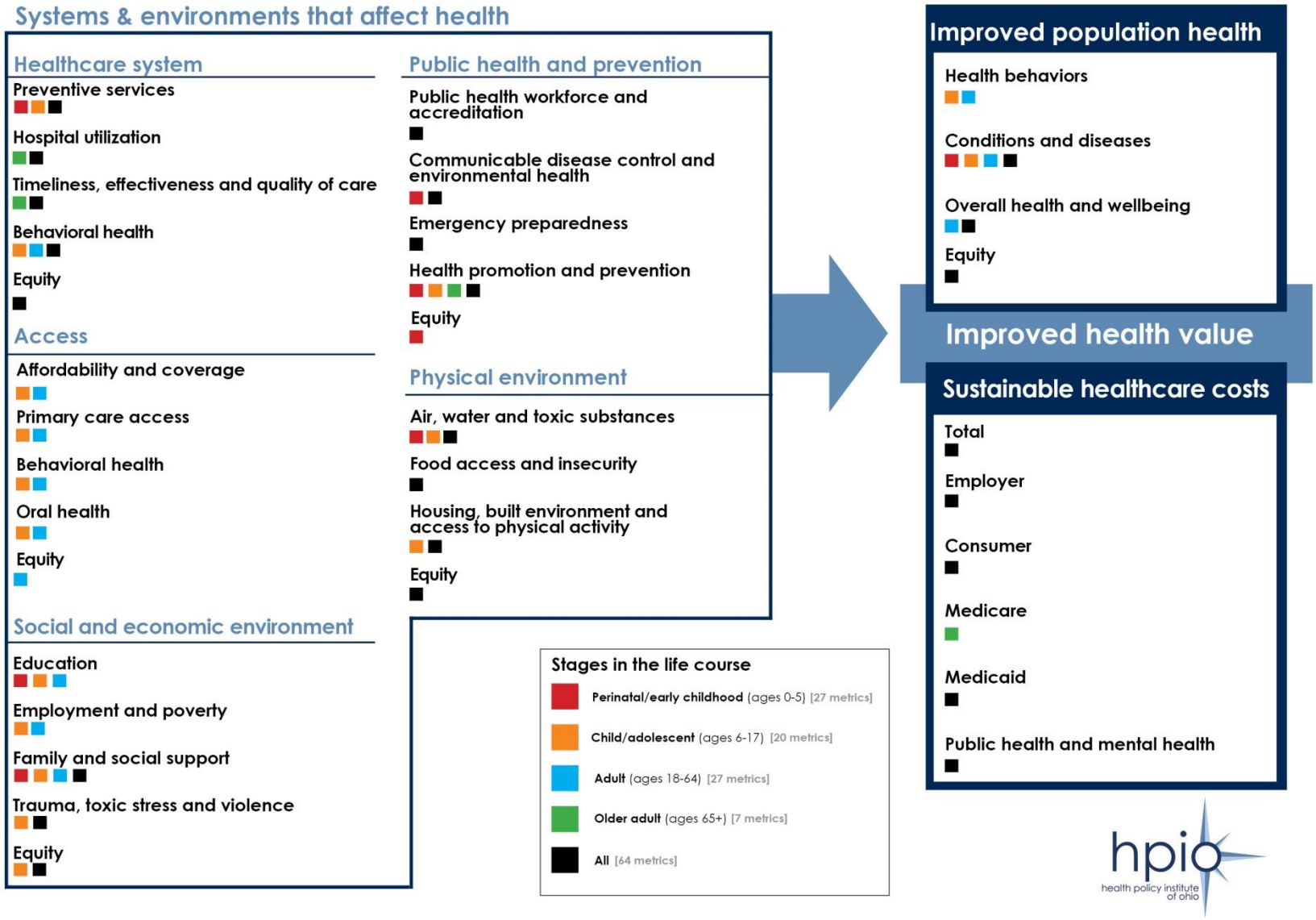
Appendix

Conceptual framework examples

National Prevention Strategy

The pathway to improved health value

Life course overview of *2014 Health Value Dashboard* metrics (**DRAFT** 10.27.15)



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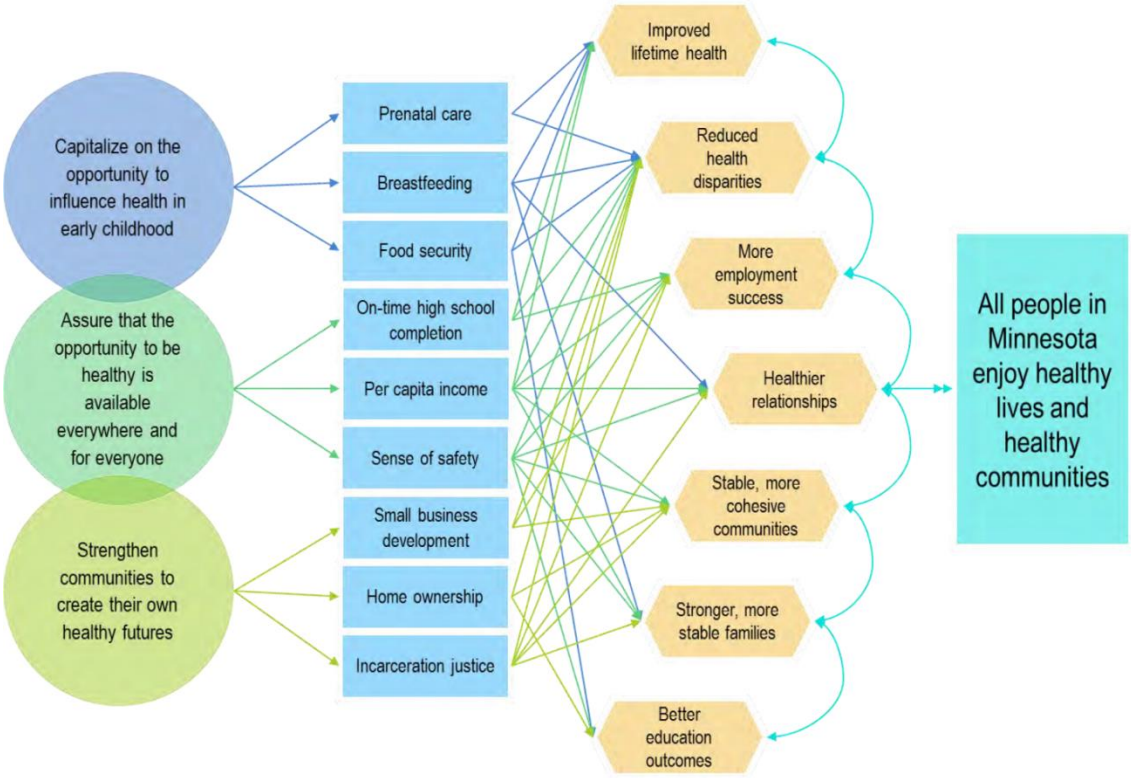
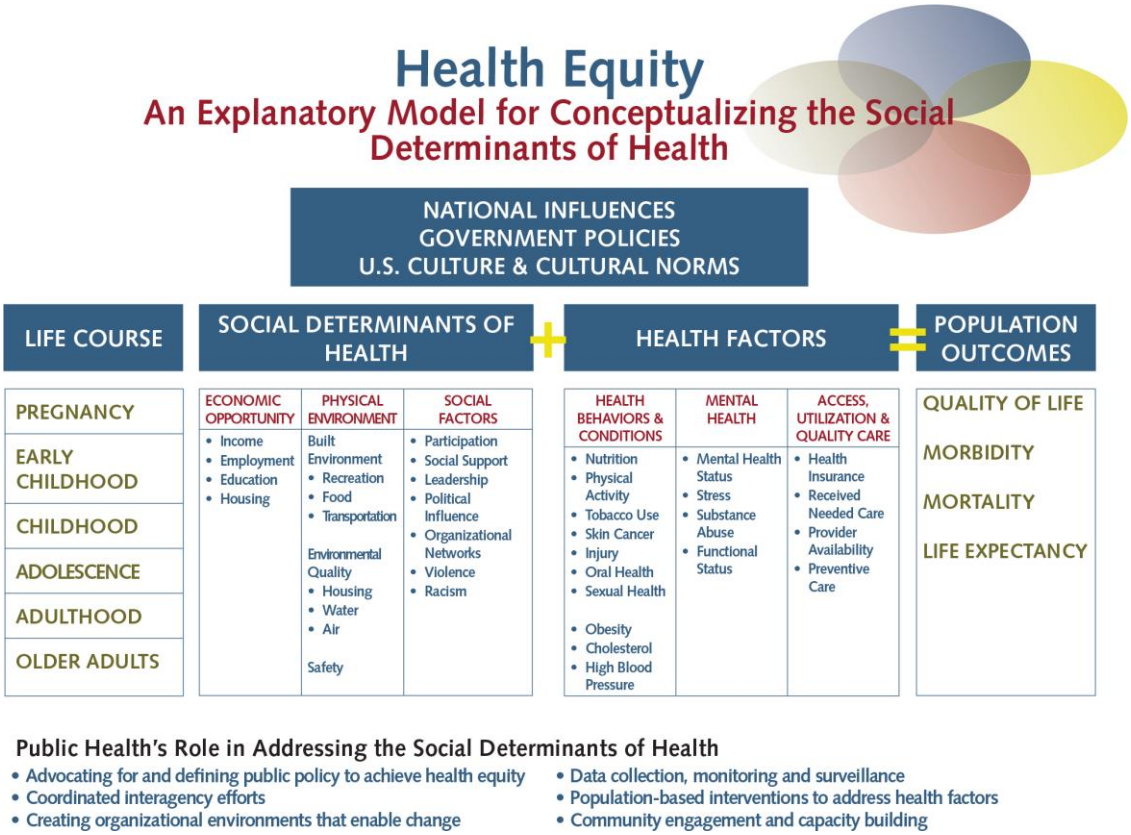
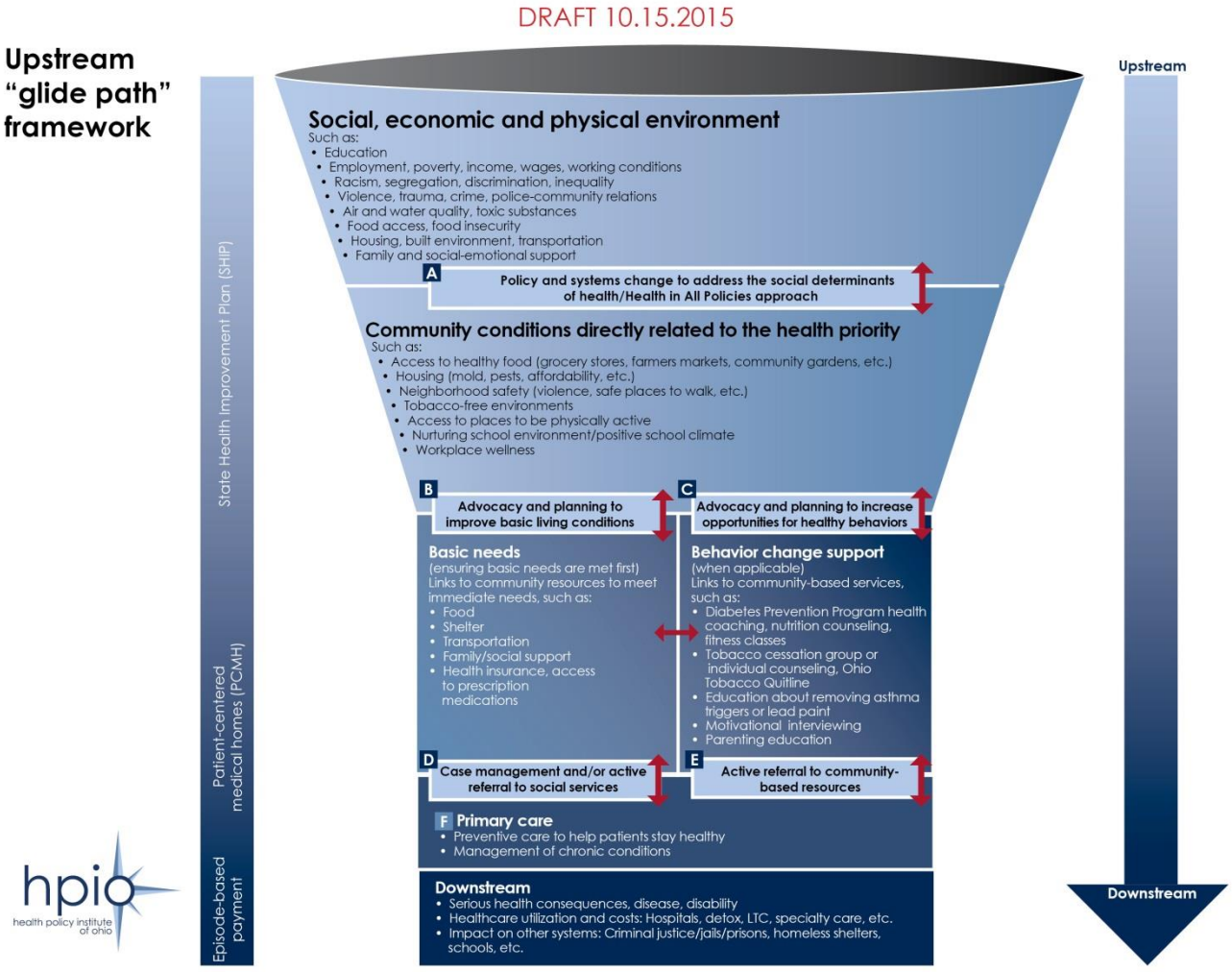
Minnesota SHIP framework



Colorado SHIP framework



Upstream "glide path" diagram



Metric selection prioritization criteria

HPIO Health Value Dashboard prioritization criteria

1. **State-level:** Statewide data are available for Ohio and other states. State data is consistent across states (allowing for state rankings, if appropriate).
2. **Sub-state geography:** Data are available at the regional, county, city, or other geographic level within Ohio.
3. **Ability to track disparities:** Data are available for sub-categories such as race/ethnicity, income level, age, or gender.
4. **Availability and consistency:** There is a high probability that data for this metric will continue to be gathered in the future and will be provided in a relatively consistent format across time periods.
5. **Timeliness:** Data for this metric is released on a regular basis (at least yearly or every other year).
6. **Source integrity:** The metric is nationally recognized as a valid and reliable indicator and the data are provided by a reputable national organization or state or federal agency.

7. **Data quality:** The data are complete and accurate. The data collection method is the best available for the construct being measured (e.g., biometric, self-report, administrative).
8. **Alignment:** Aligns with an existing requirement, performance measure, program evaluation indicator, or other measures currently being compiled by a state or federal agency (e.g., ODH, OHT, ODE, CMS, HHS, AHRQ), national organization (e.g. Catalyst for Payment Reform), or regional project (e.g., Health Collaborative, AccessHealth Columbus, Better Health Greater Cleveland). Does not add data collection burden to stakeholders.
9. **Benchmarks:** Benchmark values have been established for the metric by a reputable state or national organization or agency (e.g., Healthy People 2020).
10. **Face value:** The metric is easily understood by the public and policymakers.
11. **Relevance:** The metric addresses an important health-related issue that affects a significant number of Ohioans.

Priority selection prioritization criteria

Population Health Planning Advisory Group prioritization criteria

Criteria	Description	Information sources
Nature of the problem*		
1. Magnitude of the health problem	Number or percent of Ohioans affected	• Health Value Dashboard • ODH chronic disease report • Leading causes of death (SHA page 13)
2. Severity of the health problem	Risk of morbidity and mortality associated with the problem	• Years of potential life lost by cause of death (SHA page 15) • Leading "actual" causes of death (Mokdad, 2004) • Expertise of group members
3. Magnitude of health disparities and impact on vulnerable populations	• Size of gap between racial/ethnic groups and income/poverty status groups • Impact on children, families living in poverty, people with disabilities, etc.	• ODH chronic disease report • SHA page 14 (Black/White ratio for causes of death) • RWJ DataHub, Commonwealth Scorecard on State Health System Performance for Low-Income Populations, etc.
4. Ohio's performance relative to benchmarks or other states	Extent to which Ohio is doing much worse than national benchmarks, other states, or the US overall	• Health Value Dashboard (comparison to best state) • Network of Care (Ohio performance on Healthy People 2020 targets)
5. Trends	Extent to which the problem has been getting worse in recent years	• Health Value Dashboard • Additional sources
Impact on healthcare costs and employment		
6. Impact on healthcare costs—total cost	Contribution of the health problem to healthcare costs for all payers—total cost	• McKinsey diagnostic (TBD) • Chronic Disease Cost Calculator (CDC)

		• Additional sources
7. Impact on healthcare costs—per-person treated	Contribution of the health problem to healthcare costs for all payers—per person treated	• McKinsey diagnostic (TBD) • Chronic Disease Cost Calculator (CDC) • Additional sources
8. Impact on employment and productivity	Impact of the health problem on a person's ability to get and keep a job, on workplace productivity, and school absenteeism/ability to learn in school	• Chronic disease cost calculator (absenteeism costs) • Expertise of group members
Potential for impact*		
9. Preventability of disease or condition	Disease or condition is largely caused by behaviors, community environments and/or other modifiable factors (rather than genetics or biological characteristics) that can be addressed by prevention programs or policies	• Expertise of group members • Actual causes of death (Mokdad, 2004)
10. Availability of evidence-based strategies	• Existence of population health strategies • Strength of evidence for available strategies	• Community Guide and What Works for Health • Expertise of group members
11. Potential strategies are cross-cutting or have co-benefits	Existing evidence-based strategies to address this health problem would also address other health problems (e.g., healthy eating and active living strategies impact obesity, diabetes, heart disease, mental health, etc.)	• Expertise of group members • Funnel diagrams
12. Opportunity to add value	• There is a need for increased activity and/or alignment on this issue at the statewide level • There is a gap in leadership or collective impact that could be filled by the SIM Population Health Plan	Expertise of group members
Clinical alignment and data availability**		
13. Alignment with PCMH model and opportunities for clinical-community linkages	• Relevance of issue to the target patients and scope of the SIM PCMH model (e.g., all patients vs. certain risk levels only) • Issue involves opportunities for linking PCMHs with community-based prevention activities	• PCMH design team (TBD- not yet available) • Expertise of group members regarding opportunities for clinical-community linkages

14. Availability of clinical performance indicators (PCMH quality metrics) and data	• Progress on the issue can be tracked using clinical indicators that can be integrated into the PCMH model, with priority given to CPCI and NQF metrics • Statewide data will be available from PCMHs as of 2018	• PCMH design team • HEDIS • NQF • CMS (PQRS, CPCI, ACO MSSP, Meaningful Use, CAHPS) • Medicaid metrics • Other existing clinical metrics
15. Availability of population-level performance indicators and data	• Progress on the issue can be tracked using existing population-level indicators • Statewide data is or will be available as of 2016-18	• PCMH design team • Healthy People 2020 • Health Value Dashboard • Network of Care

*Sources include Catholic Health Association of the United States, the Association of State and Territorial Health Officials, and SHIPs from PHAB-accredited state health departments.
**Necessary for alignment between PCMH model and Population Health Plan, and for evaluation.
SHA= 2011 State Health Assessment, ODH
Mokdad, 2004= *Actual causes of death in the United States*, 2000, JAMA 2004

Strategy selection prioritization criteria

In 2013, HPIO partnered with ODH to develop a guide to selecting effective prevention strategies. This guide includes an *Evidence-Based Strategy Selection Worksheet* with the following decision criteria:

- **Strength of evidence:** Strength of the evidence of effectiveness as rated by the Community Guide or What Works for Health.
- **Readiness:** Some groundwork has been laid for the strategy, or it is already being implemented in some local communities but needs to be scaled up or spread throughout the state.
- **Coordination:** Avoids duplicating current efforts and/or adds value in some way to existing work. Selecting and implementing this strategy would accelerate or expand existing work in a meaningful way.
- **Available funding:** We can identify potential funding sources for implementation and/or the strategy requires minimal funding.
- **Political will and political timing:** The timing is right within the current political context to implement this strategy.
- **Feasibility:** It is feasible to implement this strategy within the allowable timeframe, including feasibility of logistics, timing, and meaningful support from key partners.
- **Reach:** Estimated number of people to be impacted by the strategy and potential to be implemented statewide in urban, suburban, and rural communities.

Examples of health priority categories

The Research Association for Public Health Improvement (RAPHI), in partnership with HPIO, developed the following categories of health priorities based upon health issues identified in hospital CHNAs/ISs and local health department CHA/CHIPs. HPIO recommends using a modified version of this set of categories.

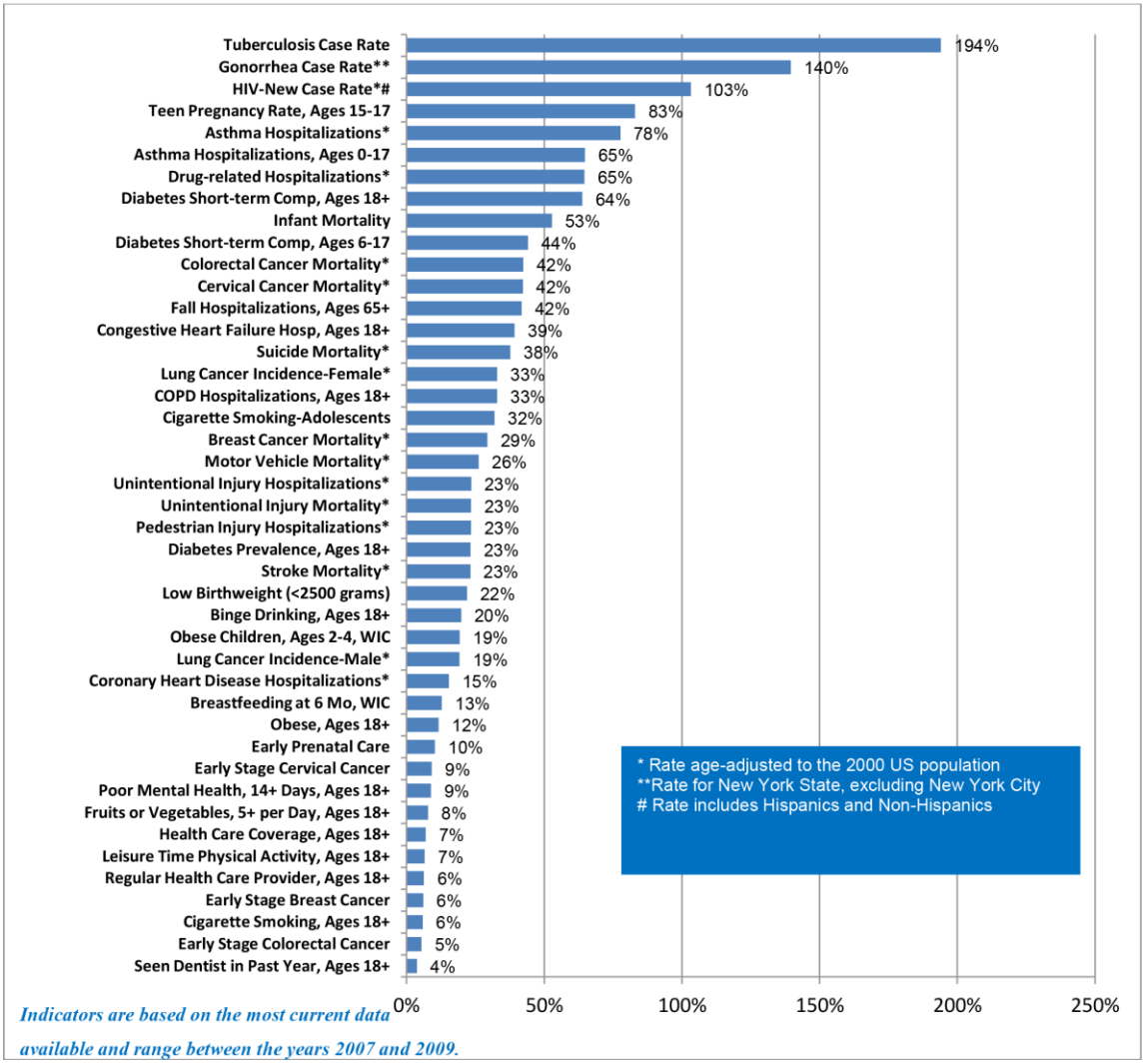
Health conditions	**Health behaviors**
Heart disease Diabetes Asthma/COPD Obesity Cancer Infectious diseases Infant mortality/low birth weight Oral health Substance abuse treatment Mental health Under-immunization	Chronic disease (management) Tobacco use Physical activity Nutrition Substance abuse Emotional health Youth development/school health Sexual and reproductive health Injury protection Family violence
Community conditions	**Health system conditions**
Build environment (place) Food environment Active living environment Social determinants of health/health equity Community partnership	Under-insurance Access to medical care Access to behavioral health care Access to dental care Bridging public health and medicine Quality improvement Hospital/clinical infrastructure Health information technology Workforce development Funding/financing/cost of services

In addition, Healthy People 2020 topics and objectives provide a commonly-used typology of health issues.

Examples of ways to display health disparities

New York example

Figure 14. Index of Disparity* for Public Health Priority Areas, New York State, 2007-2009



Oregon example

The following table presents a graphic summary of the disparities discussed above, which facilitates the identification of patterns of disparities for communities of color in Oregon. For all indicators, disparities are identified by how the community of color is doing in comparison to non-Latino whites.

Disparity	These measures suggest disparities between at least one community of color and non-Latino whites. Further analysis of both possible reasons for these disparities and remedial interventions are needed. Disparities could be influenced by many factors, such as co-morbidities, poverty, education, social exclusion, and lack of social support, so we caution the reader to not view these disparities as the result of a single cause.
No Disparity	The comparison of communities of color to non-Latino whites shows little or no difference between the groups with regard to the given indicator.
Doing Better	The community of color has better outcomes than non-Latino whites.

Indicator	Hispanic/ Latino	African American	AI/AN	Asian	Pacific Islander
First Trimester Prenatal Care					
Low Birth Weight Births					
Immunizations for 2 Year Olds*					
Cigarette Smoking Among Adults					
Cigarette Smoking Among Youth*					
Obesity Among Adults					
Asthma Among Adults					
Diabetes Among Adults					
Hypertension Among Adults					
New Chlamydia Cases					
New HIV/AIDS Diagnosis					
Teen Pregnancy Rate					
Years of Potential Life Lost <75					
Percentage of Uninsured Ages 0-18					
Percentage of Uninsured Ages 19-64					

*Hispanics/Latinos included in all race categories for this indicator
** For more information: OHA Office of Equity and Inclusion State of Equity Report and website http://www.oregon.gov/oha/oei/pages/soe/index.aspx.

Potential strategy for aligning Ohio's State Health Assessment (SHA) with the HPIO Health Value Dashboard (HVD)

	2014	2015	2016	2017	2018	2019	2020
HPIO HVD	Release 2014 HVD (Dec.)			Release 2017 HVD (Jan.)		Release 2019 HVD (Jan.)	
ODH SHA/SHIP	Initial PHAB application	• Revised PHAB application • SHIP addendum	Complete SHA • Compile updated Ohio data for HVD metrics • Include additional material required by PHAB • Include deeper dive on disparities for HVD metrics Complete SHIP	Assess alignment of SHIP with new data presented in the 2017 HVD; modify SHIP as needed			PHAB renewal application (5-year cycle)
Partnership process			Convene subgroup of HPIO Health Measurement Advisory Group to inform the SHA process		• Develop process and timeline for aligning release of HVD with the next full iteration of the SHA • Develop process and timeline for aligning local health department and hospital community health planning processes with development of the SHA and SHIP		

Data elements

HVD includes:

- State rankings (data for all states and DC)
- Two points in time (most-recently available and baseline)
- Best state comparison
- Limited disparity data

SHA could include for the HVD metrics:

- Most-recently available data for Ohio
- Deeper dive on disparities, trends, or other factors

- Links to local-level data through Network of Care

SHA must include the following components that are not part of the HVD:
- State assets and resources
- Qualitative data
- General demographic characteristics
- Description of health issues and inequities

Process
- The Health Measurement Advisory Group convened by HPIO could potentially serve as a stakeholder group for the SHA.
- The HVD conceptual framework and metrics would serve as the conceptual framework and metrics for the SHA.

[1] State Health Assessment Guidance and Resources, and Developing a State Health Improvement Plan: Guidance and Resources.
[2] Specific, Measurable, Achievable, Realistic and Time-bound.
[3] Beyond medical care fact sheet: Community integrators and backbone organizations. HPIO, 2015.