In fee-for-service, we get what we pay for

- **More volume** – to the extent fee-for-service payments exceed costs of additional services, they encourage providers to deliver more services and more expensive services
- **More fragmentation** – paying separate fees for each individual service to different providers perpetuates uncoordinated care
- **More variation** – separate fees also accommodate wide variation in treatment patterns for patients with the same condition – variations that are not evidence-based
- **No assurance of quality** – fees are typically the same regardless of the quality of care, and in some cases (e.g., avoidable hospital readmissions) total payments are greater for lower-quality care

Ohio is one of 17 states awarded a federal grant to test payment innovation models

<table>
<thead>
<tr>
<th>State's Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Shift rapidly to PCMH and episode model in Medicaid fee-for-service</td>
</tr>
<tr>
<td>- Require Medicaid MCO partners to participate and implement</td>
</tr>
<tr>
<td>- Incorporate into contracts of MCOs for state employee benefit program</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient-centered medical homes</th>
<th>Episode-based payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>• In 2014 focus on Comprehensive Primary Care Initiative (CPCi)</td>
</tr>
<tr>
<td>2015</td>
<td>• Collaborate with payers on design decisions and prepare a roll-out strategy</td>
</tr>
<tr>
<td>2016</td>
<td>• Model rolled out to at least two major markets</td>
</tr>
<tr>
<td>2017-2018</td>
<td>• Model rolled out to all markets</td>
</tr>
</tbody>
</table>

80-90 percent of Ohio’s population in some value-based payment model (combination of episodes- and population-based payment) within five years

**Goal**

Goal: 80-90 percent of Ohio’s population in some value-based payment model (combination of episodes- and population-based payment) within five years.

**State’s Role**

- Shift rapidly to PCMH and episode model in Medicaid fee-for-service
- Require Medicaid MCO partners to participate and implement
- Incorporate into contracts of MCOs for state employee benefit program

**Patient-centered medical homes**

- Round 1 Model Test States
- Round 2 Model Test Awardees
- Round 2 Model Design Awardees
- Comprehensive Primary Care

**Episode-based payments**

- **2014**
  - Focus on Comprehensive Primary Care Initiative (CPCi)
- **2015**
  - Collaborate with payers on design decisions and prepare a roll-out strategy
  - Leads design of six episodes: asthma acute exacerbation, COPD exacerbation, perinatal, acute and non-acute PCI, and joint replacement
- **2016**
  - Model rolled out to at least two major markets
- **2017-2018**
  - Model rolled out to all markets
  - 80% of patients are enrolled

**Source:** UnitedHealth, *Farewell to Fee-for-Service: a real world strategy for health care payment reform* (December 2012)
1. **State Innovation Model**: Reset market incentives to reward better health outcomes and appropriate data sharing.

2. **Population Health Plan**: Align statewide population health priorities to send clear signals to the market.

3. **Health IT Strategy**: Facilitate the data sharing that is necessary to improve population health outcomes.

**Better Planning for Better Health in Ohio**

- **State**:
  - State Health Improvement Plan
  - State Innovation Model Population Health Plan

- **Regional**:
  - Regional Health Improvement Plan

- **Local**: Local Health Department, 123 Community Health Improvement Plans, 500+ Patient-Centered Medical Homes

Overall objectives

Align population health priority areas, measures, objectives, and evidence-based strategies with the design and implementation of the Patient-Centered Medical Home (PCMH) model in Ohio.

Objective 1. Identify an initial set of population health priority areas, measures, and objectives to inform PCMH model design.

Objective 2. Develop a menu of evidence-based strategies that can lead to improved population health outcomes.

Objective 3. Provide recommendations for aligning identified population health objectives with PCMH model design.

Objective 4. Provide recommendations to strengthen the population health planning and implementation infrastructure in Ohio.

Objective 5. Provide recommendations for improving the State Health Assessment (SHA) and State Health Improvement Plan (SHIP) to inform state and community-level public health priorities.

Objective 6. Develop an evaluation framework for tracking Ohio’s progress on improving population health.

By the end of this meeting, we will achieve:

Objective 1. Common understanding of need for improving population health planning and implementation infrastructure in Ohio.

Objective 2. Consensus on criteria for selecting an initial set of current state-level population health priority areas.

Objective 3. Consensus on an initial set of state-level population health priority areas.
**Process**

Process and timeline

**Population Health Planning Advisory Group**

- First meeting: Oct. 1, 2015
  - Need to improve population health infrastructure
  - Criteria for selecting population health priority areas
  - Initial set of population health priority areas

- Second meeting: Oct. 13, 2015
  - Population health and clinical measures and objectives
  - Evidence based strategies
  - Alignment with PCMH design model

- Third meeting: Nov. 3, 2015
  - Population health and clinical measures and objectives
  - Evidence based strategies
  - Alignment with PCMH design model
  - Recommendations to improve SHIP

- Fourth meeting: Nov. 17, 2015
  - Recommendations for improved population health infrastructure
  - Evaluation framework

**Population Health Infrastructure Subgroup**

- First meeting: Oct. 19, 2015
- Second meeting: Nov. 9, 2015
- Third meeting: Nov. 19, 2015

**Understanding population health**

- Alignment of state and community-level population health planning processes, priorities and objectives
- State and community-level coordination for implementation of community-based health improvement activities
- Potential financing mechanisms for implementation of community-based health improvement activities
Population health definition

Population health is
- The distribution of health outcomes across a geographically-defined group
- Which result from the interaction between individual biology and behaviors
- The social, familial, cultural, economic and physical environments that support or hinder wellbeing
- The effectiveness of the public health and healthcare systems

Source: Paul Wallace, Institute of Medicine, presentation at 2013 Ohio Public Health Combined Conference
Key characteristics of population health strategies

- Beyond the patient population
- Beyond medical care
- Measuring outcomes
- Closing gaps (improvement for all groups)
- Shared accountability

Beyond the patient population

- Population health strategies focus on improving health of the overall population or subpopulations

Beyond medical care

Focus on:
- Treatment of specific diseases and conditions
- Downstream symptoms of health problems
- Medical and biological determinants of sickness
- Patients
- Healthcare providers, purchasers and payers

Measuring outcomes

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Ohio's rank</th>
<th>Data value 2013</th>
<th>Data value 2016</th>
<th>Trend</th>
<th>Goal state</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall health and wellbeing</td>
<td>39</td>
<td>1.5</td>
<td>1.6</td>
<td>↓</td>
<td>Improvement of adults' health outcomes; average number of days in last 30 with limited activity: 3 days</td>
</tr>
<tr>
<td>Overall health status, percent of adults who report fair or poor health</td>
<td>35</td>
<td>18%</td>
<td>18.2%</td>
<td>↓</td>
<td>11.7%</td>
</tr>
<tr>
<td>Life expectancy: life expectancy at birth, 50 years</td>
<td>77</td>
<td>77.5</td>
<td>77.9</td>
<td>↑</td>
<td>81.3</td>
</tr>
<tr>
<td>Premature death: years of potential life lost before age 75</td>
<td>38</td>
<td>NA</td>
<td>7.2 years</td>
<td>NA</td>
<td>4.8 years</td>
</tr>
</tbody>
</table>
Reducing disparities and promoting health equity

GREATER COLUMBUS INFANT MORTALITY REPORT CARD

In 2011:
- 18,040 babies were born in Franklin County
- 1,740 of these babies died before their first birthday
- 2,162 were born prematurely at less than 37 weeks gestation

Achieving our 2020 goals means that 65 more babies in our community will celebrate their first birthdays.

Tracking Our Progress:

<table>
<thead>
<tr>
<th>Franklin County Indicator</th>
<th>Baseline</th>
<th>2020 Goal</th>
<th>Reporting Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infant Mortality/1,000 live births</td>
<td>Total 9.6</td>
<td>6</td>
<td>To be determined annually</td>
</tr>
<tr>
<td></td>
<td>White 7.5</td>
<td>5.8</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Black 12.7</td>
<td>4.6</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hispanic 5.3</td>
<td>4.0</td>
<td></td>
</tr>
<tr>
<td>Sleep-related infant death/1,000 live births</td>
<td>Total 1.3</td>
<td>0.64</td>
<td></td>
</tr>
<tr>
<td></td>
<td>White 2.2</td>
<td>2.2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Black 2.1</td>
<td>2.1</td>
<td></td>
</tr>
<tr>
<td>Prematurity/total births</td>
<td>Total 13.6%</td>
<td>9.6%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>White 11.8%</td>
<td>11.8%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Black 17.2%</td>
<td>17.2%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hispanic 9.1%</td>
<td>9.1%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1st birth weight &lt;2500 grams</td>
<td>Total 9.3%</td>
<td>7.8%</td>
</tr>
<tr>
<td></td>
<td>White 10.2%</td>
<td>10.2%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Black 7.5%</td>
<td>7.5%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hispanic 8.6%</td>
<td>8.6%</td>
<td></td>
</tr>
</tbody>
</table>

Strategy Implementation

Shared accountability

Diabetes prevention example

Primary prevention strategies to help children stay healthy:
- Enhanced physical activity
- Healthy food incentives

Secondary prevention strategies to stop or delay transition to type 2 diabetes:
- Education and follow-up support

Disease management strategies:
- Patient-centered medical home

Types of prevention strategies

Prevention

Community setting
- Population-Based Prevention Policies
- Community-Based Prevention Programs

Healthcare setting
- Clinical Preventive Services
**Types of prevention strategies**

**Prevention**
- **Community setting**
- **Healthcare setting**

**Population-Based Prevention Policies**
Delivered to all residents in a geographic area, or for all students or employees in a school or workplace.

**Community-Based Prevention Programs**
Delivered to program participants as individuals, families, or groups.

**Clinical Preventive Services**
Delivered to individual patients, clients, and consumers.

---

**Diabetes prevention example**

**Optimal health**
- Healthy community environments: access to healthy food and places to be active.
- Healthy people: physical activity, healthy eating, no tobacco use.

**Prediabetes**
Blood glucose (A1C) levels higher than normal but not high enough to be classified as diabetes.

**Risk factors** include: overweight or obesity, lack of physical activity, tobacco use, high blood pressure, high cholesterol, genetic factors, and family history.

**Downstream impacts** include:
- Hospitalization
- Facility
- Pharmacy
- Loss of vision, foot or leg
- Loss of limbs
- Diabetes-related deaths

**Beyond the patient population**
- Beyond medical care
- Measuring outcomes
- Closing gaps (improvement for all groups)
- Shared accountability

**How does Ohio do?**
Pathway to improved health value: A conceptual framework

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

Population health

Ohioans are less healthy than people in most other states.
Ohio ranks 40th on a composite measure of population health. Thirty nine states are healthier.
This overall rank is based on Ohio’s rank in the following areas:

- **Overall health and wellbeing**: Length and quality of life
- **Health behaviors**: Tobacco, alcohol, physical activity
- **Conditions and diseases**: Physical, mental and oral health

Why does Ohio rank so poorly?

- **Physical environment**
- **Healthcare system**
- **Public health and prevention**

Key:
- **Environmental conditions and land use**: Conditions that affect health
- **Health behaviors and lifestyle**: Factors that influence health
- **Healthcare system**: Structures and services that support health
- **Public health and prevention**: Strategies to promote health
Public health and prevention

- Workforce and accreditation: state and local public health workforce, accreditation of local health departments
- Communicable disease control and environmental health: chlamydia, foodborne illness monitoring, child immunizations
- Emergency preparedness: emergency preparedness funding
- Health promotion and prevention: prevention of chronic disease, infant mortality, and injuries

Population health infrastructure in Ohio

Community-level public and private partners

- Local health departments
- Federally Qualified Health Centers
- Local behavioral health boards
- Family and Children First Councils
- Providers
- Hospitals
- Employers
- Community Action Agencies
- Banks
- United Ways
- Philanthropy

Other partners: Schools • Housing • Transportation, regional planning community development • Civic groups

Population health planning infrastructure in Ohio

- Ohio Department of Health
- Ohio Medicaid
- Governor’s Office of Health Transformation
- Other state agencies

Community health assessment (CHA) and Community health improvement plan (CHIP)

Community health needs assessment (CHNA) and implementation strategy (IS)

Other community plans: Federally qualified health centers • Local behavioral health boards • Family and Children First Councils • Community Action Agencies • United Ways • Banks
State and community health planning requirements

Assessment and Plan
- Identify and prioritize health needs of the community
- Identify community resources available to address community’s health needs
- Identify strategies to address community’s health needs

Process
- Engage community members in health planning process
- Solicit feedback from a broad range of stakeholders
- Include social determinants of health
- Communicate findings to the public

Local health department
- Community health needs assessment
- Community health assessment
- Implementation strategy

Hospital
- Community Health Needs Assessment
- Community Health Improvement Plan

State
- State Health Assessment
- State Health Improvement Plan
- Population Health Plan
- Hospital Community-Level

State Community-level
Alignment of state and community-level health plan processes

SIM Population Health Plan
Hospital and local health department community health plans
State Health Improvement Plan (SHIP)

Alignment of population health priorities, objectives and strategies

Discussion for meeting objective #1

What are the strengths and challenges of how we currently plan and implement population health strategies in Ohio?
Meeting objective #1 met?

- Common understanding of need for improving population health planning infrastructure and alignment, including need to improve Ohio’s State Health Assessment (SHA) and State Health Improvement Plan (SHIP)

Selection of population health priority areas

PCMH > PHP > SHIP

1. Plans include: Ohio State Health Improvement Plan Addendum, Ohio Infant Mortality Reduction Plan; The Ohio Comprehensive Cancer Control Plan; Ohio’s Plan to Prevent and Reduce Chronic Disease; Ohio Adolescent Health Strategic Plan; Ohio Suicide Prevention Foundation Strategic Plan; Ohio Injury Prevention Partnership; Child Injury Action Group Strategic Plan; Ohio Commission on Minority Health White Paper: Achieving Equity and Eliminating Infant Mortality Disparities within Racial and Ethnic Populations; Ohio Older Adult Falls Prevention Coalition State Plan.

2. Needs assessment and/or plan completed within the past five years, 2009-2014.

3. Needs assessment and/or implementation strategy completed within the past three years, 2010-2014.
### Health Conditions
- Heart disease (15.9%)
- Diabetes (18.8%)
- Asthma/COPD (2.9%)
- Obesity (49.1%)
- Cancer (18.6%)
- Infectious Disease (10.1%)
- Infant mortality (17.4%)
- Oral health (5.7%)
- Substance abuse (treatment) (49.3%)
- Mental health (43.5%)
- Under-immunization (7.2%)

### Health Behaviors
- Chronic disease (management) (28.5%)
- Tobacco use (31.1%)
- Physical activity (49.6%)
- Nutrition (43.8%)
- Substance abuse (treatment) (49.3%)
- Emotional health (55.9%)
- Youth development/School health (44.4%)
- Sexual and reproductive health (19.1%)
- Injury prevention (23.3%)
- Family violence (8.7%)

### Community Conditions
- Built environment (place) (34.8%)
- Food environment (49.3%)
- Active living environment (32.8%)
- Social determinants of health (10.1%)
- Community partnership (33.5%)

### Health System Conditions
- Under-insurance (27.5%)
- Access to medical care (55.1%)
- Access to dental care (44.1%)
- Access to behavioral health care (18.0%)
- Bridging public health and medicine (18.6%)
- Quality improvement (5.8%)
- Hospital/Clinical infrastructure (13.5%)
- Health Information Technology (19.4%)
- Workforce development (10.1%)
- Funding/financing/cost of services (8.8%)

### Percent of State-Level Health Planning Documents that Include Health Priority

### Health Conditions
- Heart disease (20%)
- Diabetes (30%)
- Asthma/COPD (20%)
- Obesity (20%)
- Cancer (30%)
- Infectious Disease (10%)
- Infant health/mortality (60%)
- Oral health (10%)
- Substance abuse (treatment) (30%)
- Mental health (10%)
- Under-immunization (20%)

### Community Conditions
- Built environment (place) (20%)
- Food environment (10%)
- Active living environment (60%)
- Social determinants of health/Health equity (10%)
- Community partnership (0%)

### Health System Conditions
- Under-insurance (0%)
- Access to medical care (0%)
- Access to dental care (0%)
- Bridging public health and medicine (0%)
- Quality improvement (10%)
- Hospital/Clinical infrastructure (0%)
- Health Information Technology (0%)
- Workforce development (10%)
- Funding/financing/cost of services (10%)

### Percent of Local Health Department Planning Documents that Include Health Priority

### Health Conditions
- Heart disease (15.9%)
- Diabetes (18.8%)
- Asthma/COPD (2.9%)
- Obesity (49.1%)
- Cancer (18.6%)
- Infectious Disease (10.1%)
- Infant mortality (17.4%)
- Oral health (5.7%)
- Substance abuse (treatment) (49.3%)
- Mental health (43.5%)
- Under-immunization (7.2%)

### Health Behaviors
- Chronic disease (management) (28.5%)
- Tobacco use (31.1%)
- Physical activity (49.6%)
- Nutrition (43.8%)
- Substance abuse (treatment) (49.3%)
- Emotional health (55.9%)
- Youth development/School health (44.4%)
- Sexual and reproductive health (19.1%)
- Injury prevention (23.3%)
- Family violence (8.7%)

### Community Conditions
- Built environment (place) (34.8%)
- Food environment (49.3%)
- Active living environment (32.8%)
- Social determinants of health/Health equity (20.0%)
- Community partnership (33.5%)

### Health System Conditions
- Under-insurance (27.5%)
- Access to medical care (55.1%)
- Access to dental care (44.1%)
- Access to behavioral health care (18.0%)
- Bridging public health and medicine (18.6%)
- Quality improvement (5.8%)
- Hospital/Clinical infrastructure (13.5%)
- Health Information Technology (19.4%)
- Workforce development (10.1%)
- Funding/financing/cost of services (8.8%)

### Percent of Hospital Health Planning Documents that Include Health Priority

### Health Conditions
- Heart disease (20.4%)
- Diabetes (30.4%)
- Asthma/COPD (20.4%)
- Obesity (18.8%)
- Cancer (18.8%)
- Infectious Disease (12.9%)
- Infant mortality (42.4%)
- Oral health (5.9%)
- Substance abuse (treatment) (64.7%)
- Mental health (58.2%)
- Under-immunization (5.9%)

### Community Conditions
- Built environment (place) (15.3%)
- Food environment (14.1%)
- Active living environment (1.2%)
- Social determinants of health/Health equity (15.2%)
- Community partnership (4.7%)

### Health System Conditions
- Under-insurance (22.9%)
- Access to medical care (38.8%)
- Access to dental care (22.4%)
- Bridging public health and medicine (0.6%)
- Quality improvement (4.7%)
- Hospital/Clinical infrastructure (1.2%)
- Health Information Technology (1.8%)
- Workforce development (4.1%)
- Funding/financing/cost of services (0.8%)
Percent of planning documents that include health priority (state-level, hospital and local health department weighted equally)

<table>
<thead>
<tr>
<th>Health conditions</th>
<th>Health behaviors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart disease (29.43%)</td>
<td>Chronic disease (management)</td>
</tr>
<tr>
<td>Diabetes (32.93%)</td>
<td>Tobacco use (38.10%)</td>
</tr>
<tr>
<td>Asthma/COPD</td>
<td>Physical activity (49.47%)</td>
</tr>
<tr>
<td>Obesity (55.97%)</td>
<td>Nutrition (46.97%)</td>
</tr>
<tr>
<td>Cancer (31.97%)</td>
<td>Substance abuse (33.53%)</td>
</tr>
<tr>
<td>Infectious Disease</td>
<td>Emotional health</td>
</tr>
<tr>
<td>Infant mortality/infant health (39.93%)</td>
<td>Youth development/School health</td>
</tr>
<tr>
<td>Oral health</td>
<td>Sexual and reproductive health</td>
</tr>
<tr>
<td>Substance abuse (treatment) (44.47%)</td>
<td>Injury prevention</td>
</tr>
<tr>
<td>Mental health (37.23%)</td>
<td>Family violence</td>
</tr>
</tbody>
</table>

Community conditions
- Built environment (place)
- Food environment
- Active living environment
- Social determinants of health/Health equity
- Community partnership

Health system conditions
- 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

Top ten health priorities

<table>
<thead>
<tr>
<th>Health priority*</th>
<th>Percent of documents that include health priority (state-level, hospital and local health department weighted equally)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Obesity</td>
<td>55.97%</td>
</tr>
<tr>
<td>2. Physical activity</td>
<td>49.47%</td>
</tr>
<tr>
<td>3. Nutrition</td>
<td>46.97%</td>
</tr>
<tr>
<td>4. Substance abuse treatment/prevention</td>
<td>44.67%/33.53%</td>
</tr>
<tr>
<td>5. Infant mortality</td>
<td>39.93%</td>
</tr>
<tr>
<td>6. Tobacco use</td>
<td>38.10%</td>
</tr>
<tr>
<td>7. Mental health</td>
<td>37.23%</td>
</tr>
<tr>
<td>8. Diabetes</td>
<td>32.93%</td>
</tr>
<tr>
<td>9. Cancer</td>
<td>31.97%</td>
</tr>
<tr>
<td>10. Heart disease</td>
<td>29.43%</td>
</tr>
</tbody>
</table>

*To ensure adequate alignment with PCMH model design, health priorities falling within the health system and community condition domains were removed from the top ten health priority list. Community conditions will be considered during discussion of the evidence-based strategies that can be implemented to improve outcomes for selected health priority areas.

Prioritization criteria

- Nature of the problem
- Impact on healthcare costs
- Potential for impact
- Clinical alignment and data availability

Discussion for meeting objective #2

1. Any clarifications or modifications on the criteria?
2. Do any of these criteria rise to the top as being much more important than other criteria?
Meeting objective #2 met?

- Consensus on criteria for selecting an initial set of current state-level population health priority areas

Summary of preliminary rating scores

<table>
<thead>
<tr>
<th>Health Issue</th>
<th>Total score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tobacco use</td>
<td>32</td>
</tr>
<tr>
<td>Obesity</td>
<td>29</td>
</tr>
<tr>
<td>Diabetes</td>
<td>28</td>
</tr>
<tr>
<td>Physical inactivity</td>
<td>28</td>
</tr>
<tr>
<td>Poor nutrition</td>
<td>28</td>
</tr>
<tr>
<td>Heart disease</td>
<td>27</td>
</tr>
<tr>
<td>Mental health conditions</td>
<td>27</td>
</tr>
<tr>
<td>Addiction/Substance abuse</td>
<td>26</td>
</tr>
<tr>
<td>Infant mortality/Perinatal</td>
<td>23</td>
</tr>
<tr>
<td>Cancer</td>
<td>24</td>
</tr>
</tbody>
</table>

Discussion for meeting objective #3

1. Any changes to 1-2-3 ratings?
2. What priority areas should we select?

Approaches to framing priority areas

- Upstream/downstream, Primary prevention/Secondary prevention/Treatment
- Community conditions vs. Behaviors vs. Medical conditions/diseases
- Life-course: Pregnancy, Early childhood, Childhood, Adolescence, Adulthood, Older adult
- Dashboard conceptual framework
- Social-ecological model: Individual, Relationship, Community, Society
- National Prevention Strategy
- Health Impact Pyramid
Potential priority areas

- Diabetes
- Hypertension
- Tobacco use
- Depression

Diabetes prevention and treatment

Hypertension prevention and treatment

Tobacco prevention and cessation

Depression prevention and treatment
Depression

Depression and other mental health conditions prevention and treatment

Optimal health

• Healthy communities: Safe neighborhoods, education, housing, public health, and economic development

Mental, emotional, and behavioral health conditions among children and adolescents

• depression is the leading cause of illness in children worldwide, affecting 5-20% of children

Depression and other mental health conditions among adults

• the leading cause of disability worldwide, affecting 20% of adults

Depression and other mental health conditions among older adults

• the leading cause of disability among older adults, affecting 20% of older adults

Next steps

Meeting objective #3 met?

• Consensus on an initial set of state-level population health priority areas

Next steps