Ohio’s 2016 state health improvement plan (SHIP)
Advisory Committee meeting
Oct. 13, 2016
Vision
Ohio is a model of health and economic vitality.

Mission
Improve the health of Ohioans by implementing a strategic set of evidence-based population health activities at the scale needed to measurably improve population health outcomes and achieve health equity.
Improving Population Health Planning in Ohio

Guidance for Community Health Assessments & Plans

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Office of Health Policy & Performance Improvement
Improving population health planning in Ohio

Prepared by the Health Policy Institute of Ohio for the Ohio Governor’s Office of Health Transformation, Ohio Department of Health and Ohio Department of Medicaid

Jan. 11, 2016
Health Priorities

State issues guidance encouraging local health departments and tax-exempt hospitals to address at least two health priorities in their plans from a menu of priorities identified in the SHIP.
Measures, Metrics, Indicators

State issues guidance encouraging local health departments and tax-exempt hospitals to include at least one core metric from the SHA and SHIP in their assessments and plans for each SHIP-aligned priority.
Evidence-based Strategies

State issues guidance encouraging local health departments and tax-exempt hospitals to select evidence-based strategies from a menu of strategies in the SHIP to address SHIP-aligned priority
Collaboration on assessments and plans

State issues guidance encouraging local health departments and tax-exempt hospitals in the same counties or with shared populations to partner on assessments and plans through a common: conceptual framework; process template or checklist; set of metrics; health prioritization criteria; set of health priorities; set of SMART objectives; set of evidence-based strategies that can be implemented in community-based and clinical settings; evaluation framework; accountability plan; exchange of data and information.
Hospital Community Benefit

State issues guidance encouraging tax-exempt hospitals to allocate a minimum portion of their total community benefit expenditures to activities that most directly support community health planning objectives, including community health improvement services and cash and in-kind contributions.
Submission of Assessments, Improvement Plans, Schedule H

H.B. 547 (ORC 3701.981)

Beginning July 1, 2017 and annually thereafter, all LHDs and tax-exempt hospitals must annually submit all assessments and plans associated with the assessments to ODH.
General Resources

Appendix of general resources for CHA/CHIP
MAPP
Community Benefit
Evidence-Based Strategies
Additional templates to be created
Recommended Community Engagement
   Stakeholder List
Conceptual Framework
Feedback

1. Does each section of the guidance encourage the local health department and tax-exempt hospital to comply with the guidance?
2. Is the language clear and concise?
3. Is there any additional necessary guidance that you would recommend for a specific section of the guidance?
Feedback Responses

Please email your feedback on the LHD & Hospital Guidance to:

Brandi.Robinson@odh.ohio.gov

Responses should be sent by October 27th
Framework for identifying objectives and strategies for the SHIP

| Chronic disease                      | 1. Outcome objective  
|--------------------------------------|------------------------
| Priority topic outcome objectives    | 2. Outcome objective   
|                                      | 3. Outcome objective   |

<table>
<thead>
<tr>
<th>Cross-cutting factors</th>
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</thead>
</table>
| Health equity                        | • Objective(s)            
|                                      | • Strategies              |
| Social determinants of health        | • Objective(s)            
| (including social, economic and     | • Strategies              |
| physical environment)                |                           |
| Public health system, prevention     | • Objective(s)            
| and health behaviors                 | • Strategies              |
| (including active living, healthy    | [Including tobacco        |
| eating and tobacco-free living)      | objective(s) and          |
|                                      | strategies]               |
| Healthcare system and access         | • Objective(s)            
|                                      | • Strategies              |
Criteria for selecting priority outcomes

- Importance of the problem
- Ability to impact
- Alignment and connections
Outcome selection process: Mental health and addiction

Measurable outcomes from:
- SHA
- State plans
- National sources

Narrowed down by state agency team

Final set of outcomes
- Reduce suicide rate
- Reduce major depressive episodes (youth and adults)
- Reduce past-year illicit drug dependence or abuse among ages 12 and above
- Reduce unintentional drug overdose deaths

28 (plus 7 new added by ODH)

12

4
Relationships between outcomes: Mental health and addiction

**Overall goal:** Promote mental wellbeing and prevent alcohol and other drug dependence and abuse.

### Social determinants of health
- Nurturing home, school and community environments
- Family and social support
- Social norms
- Access to drugs and alcohol
- Trauma, toxic stress and violence
- Education
- Employment and poverty
- Additional factors from the social and economic environment and physical environment identified by work team

### Adolescent attitudes and behaviors
- Delayed onset of first use of illicit drugs
- Perceived risk of marijuana use (youth)
- Perceived parental disapproval of drug use (youth)
- Delayed onset of first use of alcohol
- Perceived risk of alcohol use (youth)
- Perceived parental disapproval of alcohol use (youth)
- Tobacco use

### Mental illness and drug and alcohol dependence conditions
- Depressive episodes (youth, adult)
- Poor mental health days
- Depression prevalence
- Mental illness prevalence
- Severe and persistent mental illness prevalence

### Mortality
- Suicide
- Premature mortality among people with mental illness
- Drug overdose deaths
- Alcohol-related crash deaths
- Other deaths related to drug and alcohol use

### Healthcare system and access, including:
- Access to behavioral health care, including workforce
- Quality of behavioral health care, including cultural competence
- Opioid prescribing practices (opioid prescriptions dispensed)

### Public health system, prevention and health behaviors

### Equity

Red font = SHEP priority outcome
▲ = Must be addressed in cross-cutting factors
# Outcome selection process: Chronic disease

<table>
<thead>
<tr>
<th>Measurable outcomes from:</th>
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</thead>
<tbody>
<tr>
<td>• SHA</td>
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<tr>
<td>• State plans</td>
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<tr>
<td>• National sources</td>
</tr>
</tbody>
</table>

Narrowed down by

**state agency team**

<table>
<thead>
<tr>
<th>Final set of outcomes based on:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Reduce heart disease prevalence among adults</td>
</tr>
<tr>
<td>• Reduce diabetes prevalence among adults</td>
</tr>
<tr>
<td>• Reduce rate of hospital admissions for pediatric asthma</td>
</tr>
</tbody>
</table>
Relationships between outcomes: Chronic disease

Overall goal: Prevent and reduce the burden of chronic disease for all Ohioans
Note: This is the goal of Ohio’s Plan to Prevent and Reduce Chronic Disease: 2014-2018

Social determinants of health
- Tobacco-free environments
- Food security and access to healthy food
- Active living environments and access to physical activity
- Air quality
- Additional factors from the social and economic and physical environment identified by work team (violence, poverty, etc.)

Behavioral risk factors
- Tobacco use ▲
- Nutrition ▲
- Physical activity ▲
- Heavy alcohol use

Clinical risk factors*
- Hypertension ▲
- High cholesterol
- Obesity

Disease burden (incidence/prevalence)*
- Heart disease
- Stroke
- Diabetes
- Cancer
- Asthma
- COPD/CLRD
- Arthritis

Mortality*
- Heart disease mortality
- Stroke mortality
- Diabetes mortality
- Cancer mortality
- Asthma mortality
- COPD/CLRD mortality

Healthcare system and access

Public health system, prevention and health behavior

Equity

Red font = SHIP priority outcome
▲ = Must be addressed in cross-cutting factors

Outcome selection process: Maternal and infant health

Measurable outcomes from:
- SHA
- State plans
- National sources

Narrowed down by state agency team

Final set of outcomes
- Reduce the rate of all infant deaths
- Reduce preterm births
- Reduce low birth weight
Relationships between outcomes: Maternal and infant health

Overall goal: All Ohio babies are born healthy, live in healthy families and thrive in their first year of life.

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**Social determinants of health** (relationship and community level)
- Racism and discrimination
- Trauma, toxic stress and violence
- Tobacco-free environments
- Food access and food security
- Active living environments and access to physical activity
- Education
- Employment and poverty
- Family and social support
- Housing
- Transportation
- Additional factors from the social and economic environment and physical environment identified by work team

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**Risk and protective factors** (individual level)
- Inter-pregnancy interval <18 months (birth spacing)
- Unintended pregnancy
- Teen pregnancy
- Child maltreatment
- Safe sleep
- Breastfeeding
- Maternal tobacco use
- Secondhand smoke exposure
- Maternal drug and alcohol use
- Nutrition, including folic acid
- Physical activity
- Sexual behavior
- Contraception use

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**Maternal health and clinical risk factors**
- Chronic disease among women of childbearing age
  - Diabetes
  - Gestational diabetes
  - Hypertension
  - Obesity
  - Underweight
- Mental health and addiction among women of childbearing age
  - Chronic stress
  - Depression, anxiety and other conditions
  - Post-partum depression
  - Substance use disorders
- Infectious disease
  - Chlamydia
  - HIV
  - Syphilis
  - Hepatitis B

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**Poor birth outcomes and other causes of infant morbidity/mortality**
- Preterm birth (<32 and <37 weeks)
- Low birth weight
- Birth defects
- Injuries
- Neonatal Abstinence Syndrome

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**Mortality**
- Infant mortality
  - Sudden Unexpected Infant Death
  - Abusive head trauma
  - Other forms of perinatal, neonatal and post-neonatal mortality
- Maternal mortality

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**Healthcare system and access, including:**
- Access to pre-conception, prenatal and post-natal care
- Access to contraception
- Quality of care, including cultural competence

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**Public health system, prevention and health behaviors**

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**Equity**

Red font = SHIP priority outcome

▲ = Must be addressed in cross-cutting factors
<table>
<thead>
<tr>
<th>Mental health and addiction</th>
<th>Chronic disease</th>
<th>Maternal and infant health</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Depression (youth and adult Major Depressive Episodes)</td>
<td>5. Heart disease prevalence (adult)</td>
<td>8. Preterm birth (&lt;32 and &lt;37)</td>
</tr>
<tr>
<td>2. Suicide</td>
<td>6. Diabetes prevalence (adult)</td>
<td>9. Low birth weight</td>
</tr>
<tr>
<td>3. Illicit drug dependence or abuse</td>
<td>7. Asthma morbidity (child)</td>
<td>10. Infant mortality</td>
</tr>
<tr>
<td>4. Unintentional drug overdose deaths</td>
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<tr>
<td>• Tobacco</td>
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Cross-cutting factor workshops
Oct 3-5

Number of participants:
• Mental health & addiction: 43
• Chronic Disease: 43
• Maternal & infant health: 40
Workshops

• Reviewed existing plans and state agency activities
• Looked to credible sources of research evidence
• Created a “wish list” of the most powerful strategies to achieve our priority topic outcomes
• Identified priority populations for each priority target outcome
Evidence sources reviewed at workshops

• Hi-5: Health Impact in 5 Years (CDC)
• 6/18: Accelerating Evidence into Action (CDC)
• The Guide to Community Preventive Services (Community Guide) (CDC)
• What Works for Health (County Health Rankings and Roadmaps)
• U.S. Preventive Services Task Force Recommendations (AHRQ)
• Additional topic-specific sources
Criteria for prioritizing strategies at workshops

- Evidence of effectiveness
- Potential size of impact
- Opportunities given the current status
State health improvement plan
Cross-cutting factors workshop summary
HPID 10/7/16

Overview of workshop process
HPID hosted a series of three in-person workshops to identify strategies to address cross-cutting factors in the SHP:
- Mental health and addiction, Oct. 4, 2016
- Chronic disease, Oct. 5, 2016

Within each workshop, participants worked in small groups to address the SHP cross-cutting factor:
- Equity
- Social determinants of health
- Public health, prevention and health behaviors
- Healthcare system and access

Prior to and during the meetings, participants reviewed information about SHP cross-cutting factors, strategies developed by other states, and evidence on interventions that may be effective based on reviews from sources such as:
- HHS: Accelerating Evidence into Action (U.S. Centers for Disease Control and Prevention)
- The Guide to Community Preventive Services (Community Guide)
- Disease Control and Prevention
- What Works for Health (County Health Rankings and Roadmaps)
- U.S. Preventive Services Task Force Recommendations (Agency for Healthcare Research and Quality)

Additional topic-specific resources

Participants then identified strategies they recommended be included in the SHP; these recommendations during small group discussions, and were not limited to those recommendations based on the following criteria:
- Evidence of effectiveness
- Potential size of impact
- Potential for replication
- Opportunities given the current status

Facilitators identified the top five strategies within each small group and presented these recommendations during plenary discussions. The top five strategies within each small group were:
- Health systems approach (P4)
- Tobacco control (P4)
- Cancer screening and research (P4)
- Chronic disease (P4)
- Maternal and infant health (P4)

Workshop results matrix: Prioritized strategies

<table>
<thead>
<tr>
<th>Mental health and addiction</th>
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<th>Maternal and infant health</th>
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<tbody>
<tr>
<td><strong>Strategies for prevention and health behavior</strong></td>
<td><strong>Strategies for addressing health disparities</strong></td>
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</tr>
<tr>
<td>- Tobacco control strategies (P4)</td>
<td>- Chronic disease intervention and support (P4)</td>
<td>- Early childhood home visiting programs (P4)</td>
</tr>
<tr>
<td>- School-based health centers (P4)</td>
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<td>- School-based health clinics (P4)</td>
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<tr>
<td>- Alcohol and substance abuse prevention and support (P4)</td>
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<td>- Health insurance enrollment and support (P4)</td>
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**Additional resources**
- HealthPolicyOHio.org (http://www.healthpolicyohio.org)
- Cross-cutting Workshop Summary (ABS-ARM-1.pdf)
Strategy selection process

• Recommendations from workshops
• Advisory Committee feedback today:
  – Connections across priority areas
  – Clinical-community linkages/ glide path considerations
  – Getting more specific about strategies
  – Implications for adding to and/or narrowing list of strategies
  – No final decisions about SHIP strategies today
Strategy selection process, continued

- Identify and narrow down set of specific state-level strategies (lead by state team)
- Identify and narrow down local-level menu of strategies (Work Team input)
- Considerations for narrowing down list include:
  - Feasibility (political will, funding availability, cost-effectiveness)
  - Alignment with other initiatives and plans
  - Likely impact on disparities, balance of strategies for different age groups and types of communities, etc.
Ensuring equity in the SHIP

• Impact underlying causes of health inequities by addressing the social determinants of health
• Highlight and prioritize strategies most likely to decrease disparities with “*” (based on WWFH and CG evidence reviews)
• Identify priority populations for each topic
• Recommend strategies be targeted towards certain priority populations and adapted to fit cultural contexts as needed
Ensuring equity in the SHIP, continued

- Set objective targets specific to identified priority populations (contingent upon the availability of baseline data)
- Identify priority population groups for which data is necessary but not available
- Make recommendations to invest in data infrastructure and linkages that can improve the collection and availability of data across population groups
Today: Small groups round 1

- 3 groups (topics: MHA, CD, MIH)
- Connections across priority areas (horizontal)
- Glide path connections (vertical)
Examples of horizontal connections and themes

• Housing - all three topics
• Income/poverty - all three topics
• Physical activity - could impact more than chronic disease
• Social connectedness - could impact more than mental health and addiction
**Outcome: Reduce diabetes prevalence**

*Workshop-recommended strategies*

- Built environment changes to support active living, including complete streets, green space and parks, etc.
  - Community healthy food access
  - Diabetes Prevention Program (DPP)

- Food insecurity screening and follow-up

- Healthcare system and access
Outcome: Reduce diabetes prevalence
Workshop-recommended strategies, plus complete glide path

- Community physical activity/fitness programs
- Community healthy food access
- Diabetes Prevention Program (DPP)

- Screening for abnormal glucose, with referral to DPP (PSTAT initiative)
- Food insecurity screening and follow-up, with referral to community health food access programs
- Prescriptions for physical activity and fruits and vegetables
- Value-based purchasing, including PCMH, with incentives and outcome monitoring to support above activities

Built environment changes to support active living, including complete streets, green space and parks, etc.
Today: Small groups round 2

• 3 groups (cross cutting factors: SDOH, PHP, HSA)
• Getting more specific for each strategy
  – State-level
  – Local-level
  – Opportunities
  – Pitfalls
Next steps

- Work Team conference calls (see website for dates)
- December Advisory Committee meeting (date TBD)