Please type questions in the chat box

Talking: Lucy, Ben

Options

Attendees 4

Lucy (organizer, presenter)
Terry
Karen
Ben (me)

Chat

Stop recording
This session is being recorded.
Meeting ID: 704-918-346
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.
Agenda for today’s call

• Update on recent progress
• SMART objectives for priority outcomes
• Glide path
• Local Strategy and Indicator Toolkit
Update on SHIP progress in October

✓ 3 workshop meetings
✓ Advisory Committee meeting and state team input
✓ Outreach to Work Team members to gather detail about potential strategies
✓ SMART objectives for priority outcomes
### Work Team activities

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

| Cross-cutting factors |  
|-----------------------|---
| **Health equity** | • Objective(s)  
| | • Strategies  
| **Social determinants of health** (including social, economic and physical environment) | • Objective(s)  
| | • Strategies  
| **Public health system, prevention and health behaviors** (including active living, healthy eating and tobacco-free living) | • Objective(s)  
| | • Strategies  
| | [Including tobacco objective(s) and strategies]  
| **Healthcare system and access** | • Objective(s)  
| | • Strategies  

**Workshops**

1st conference call & survey
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

**Overview of workshop process**

HP0 conducted a series of three cross-cutting workshops to identify strategies to address cross-cutting factors in the SHIP.
- **Mental health and addiction**, Oct. 4, 2016
- **Chronic disease**, Oct. 3, 2016

*Note: Each workshop participants worked in small groups to address the SHIP cross-cutting factors.*

- **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 cross-cutting factors, including potential strategies with strong evidence for effectiveness based on evaluation reports from sources such as:
- 1965 Health Areas, 3-year U.S. Centers for Disease Control Preventive Services Model for Health Improvement
- The Guide to Community Preventive Services (Community Guide) and Ohio Department of Health
- The GAP in Health County Health Rankings and Roadmaps, U.S. Preventive Services Task Force Recommendations [AHRQ]
- Additional topic-specific sources

Participants then identified strategies they recommended for integration into the plan, including small group discussions, and developed a draft document outlining specific recommendations. The recommendations will be further refined during the final phase of the planning process.

**Workshop results matrix: Prioritized strategies**

<table>
<thead>
<tr>
<th>Mental health and addiction</th>
<th>Chronic disease</th>
<th>Maternal and infant health</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategies for improving social determinants</strong></td>
<td><strong>Strategies for improving clinical health outcomes</strong></td>
<td><strong>Strategies for increasing health</strong></td>
</tr>
<tr>
<td>- Social determinants (SD)</td>
<td>- Clinical health outcomes (CH)</td>
<td>- Health outcomes (HO)</td>
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<tr>
<td>- Social determinants (SD)</td>
<td>- Clinical health outcomes (CH)</td>
<td>- Health outcomes (HO)</td>
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<td>- Clinical health outcomes (CH)</td>
<td>- Health outcomes (HO)</td>
</tr>
</tbody>
</table>

- **Strategies for improving social determinants**
  - School-based mental health initiatives
  - Substance abuse prevention programs
  - School health education programs
- **Strategies for improving clinical health outcomes**
  - Tobacco control programs
  - School health education programs
- **Strategies for increasing health**
  - School health education programs
  - School health education programs

*Links to supporting documents and additional strategies can be found in the original workshop summary document.*
Revised list of proposed strategies

Advisory Committee and state team feedback on:

• Common themes across priority topics
  – Which strategies impact all or most outcomes?
  – How does it all fit together?

• Complete “glide paths” to reach priority outcomes
  – Where are the gaps?
  – How can we connect clinical to community? (downstream to upstream)
  – Which strategies are less necessary to achieve the priority outcomes?
**Summary of proposed SHIP strategies**

<table>
<thead>
<tr>
<th>Strategies</th>
<th>Mental health and addiction</th>
<th>Chronic disease</th>
<th>Maternal and infant health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social determinants of health: Advocate sectors to expand opportunities for health and equity</td>
<td><strong>Focus on Service-enriched Housing</strong>, including focus on service-enriched housing, focused on improving and enhancing health and opportunities for health and equity in communities.</td>
<td><strong>Focus on Service-enriched Housing</strong>, including focus on service-enriched housing, focused on improving and enhancing health and opportunities for health and equity in communities.</td>
<td><strong>Focus on Service-enriched Housing</strong>, including focus on service-enriched housing, focused on improving and enhancing health and opportunities for health and equity in communities.</td>
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<tr>
<td>Emotional and behavioral health: to improve academic outcomes, emotional health, and social skills</td>
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<tr>
<td>Early childhood educational opportunities, including child care subsidies and home visiting</td>
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<tr>
<td>Providers access that prevents health problems and integrates services for priority populations</td>
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<tr>
<td>Support systems, quality housing through state funding (property sales, operating expenses), low-income housing tax credits, and home improvement loans</td>
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</tr>
<tr>
<td>Service-enriched housing*</td>
<td><strong>Check</strong></td>
<td><strong>Check</strong></td>
<td><strong>Check</strong></td>
</tr>
</tbody>
</table>

**Promote work and reduce poverty:**
- Earned income tax credit* (including outreach to increase uptake, remove gaps and/or reduce credit)
- Local voluntary living wage project*

**Physical environments that support active living and social connectedness:**
- Regional built environment changes, such as complete streets policies, green space, park and trails

**Public health and prevention:**
- Strengthen the population health infrastructure to support healthy communities, healthy behaviors and connections with clinical care

**Population health infrastructure, including:**
- Acclimation of life cycle alignment and collaboration, including three-year aligned planning cycle for health department, hospitals and Alcohol, Drug and Mental Health boards
- Tobacco and transportation

**School-based health:**
- Focus on school-based health to promote mental well-being and healthy behaviors, including tobacco-free and alcohol-free schools, including comprehensive school-based health services
- Integrate school-based health services with links to:
  - Multi-tiered Systems of Support (MTSS)
  - School-based social and emotional learning
  - School-based violence prevention programs
  - School-based health/other dual prevention programs, including youth substance prevention

**Focus on:**
- **Service-enriched housing**, including focus on service-enriched housing, focused on improving and enhancing health and opportunities for health and equity in communities.
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  - **Focus on:**
    - **Service-enriched housing**, including focus on service-enriched housing, focused on improving and enhancing health and opportunities for health and equity in communities.

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Common themes: Social determinants of health

• Student success and educational attainment
• Housing access that prevents health problems and integrates services for priority populations
• Promote work and reduce poverty
• Physical environments that support active living and social connectedness
Common themes: Public health, prevention and health behaviors

- Population health infrastructure
- School-based health
- Tobacco prevention and cessation
- Active living and healthy eating support
Common themes: Healthcare system and access

- Modernize Medicaid and increase access to coverage
- Pay for value through PCMH, episode-based payments, MCOs, and quality measurement
- Strengthen healthcare workforce to improve access
- Access to and use of tobacco cessation
- Infrastructure to collect accurate data about access, outcomes, and disparities
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
## Summary of proposed SHIP strategies

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<tr>
<td>Social determinants of health:</td>
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<td></td>
<td></td>
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<tr>
<td>Add educational attainment:</td>
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<tr>
<td>• School-based</td>
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<td></td>
<td></td>
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<tr>
<td>• Early childhood education and support</td>
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<tr>
<td>• Lack of access to health care and services for priority populations</td>
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<tr>
<td>• Support for individuals, family housing through state housing subsidy, operating expenses, low-income housing tax credit, and home improvement loan</td>
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<tr>
<td>• Service-enriched housing</td>
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<tr>
<td>Physical environments that support active living and social connectedness:</td>
<td></td>
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<tr>
<td>• Regional built environment changes, such as complete streets policies, green space, parks and trails</td>
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<td>Public health and prevention:</td>
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<tr>
<td>Strengthen the population health infrastructure to promote healthy communities, healthy behaviors and connections with clinical care</td>
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<tr>
<td>School-based health:</td>
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<tr>
<td>• Focus on school-based health to promote mental wellbeing and prevent substance abuse (including tobacco) and violence, including school-based behavioral health services with links to</td>
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<tr>
<td>• Multidimensional Supportive (MDS)</td>
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<tr>
<td>• School-based social and emotional learning</td>
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<tr>
<td>• School-based violence prevention programs</td>
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<tr>
<td>• School-based physical activity programs, including youth-led prevention</td>
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<tr>
<td>Tobacco prevention and cessation, including (TBP):</td>
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<tr>
<td>• Screening the SHIP and appropriate tailoring</td>
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<tr>
<td>• Monarch Communications</td>
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<tr>
<td>• Link to cessation</td>
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<td></td>
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<tr>
<td>Active living and healthy eating support:</td>
<td></td>
<td></td>
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<tr>
<td>• Community health food access, including fruit and vegetable incentives, healthy food service and support</td>
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<tr>
<td>• Community physical activity programs, including fitness programs and physical activity interventions</td>
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<tr>
<td>Focus on: Link to cessation support, including helping individuals with behavioral health conditions to quit smoking and others with alcoholism.</td>
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<tr>
<td>Focus on: Link to nutrition support, including helping parents of children with behavioral health conditions to quit smoking and others with alcoholism.</td>
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<tr>
<td>Focus on: Link to cessation support, including helping pregnant women and people of childbearing age to quit smoking and others with alcoholism.</td>
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<tr>
<td>Diabetes Prevention Program</td>
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<tr>
<td>Focus on:</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>• Tobacco counseling and support</td>
<td></td>
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<td></td>
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<tr>
<td>• Access to comprehensive contraception options</td>
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</tbody>
</table>
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
<table>
<thead>
<tr>
<th>Mental Health and addiction</th>
<th>Chronic disease</th>
<th>Maternal and infant health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>Heart disease</td>
<td>Preterm births</td>
</tr>
<tr>
<td>Suicide</td>
<td>Diabetes</td>
<td>Low birth weight</td>
</tr>
<tr>
<td>Drug dependence or abuse</td>
<td>Asthma</td>
<td>Infant mortality</td>
</tr>
<tr>
<td>Drug overdose deaths</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# CD Priority Outcome Objectives

<table>
<thead>
<tr>
<th>Desired outcome</th>
<th>Indicator</th>
<th>Baseline (year)</th>
<th>2019 target</th>
<th>2022 target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce heart disease</td>
<td>Percent of adults ever diagnosed with coronary heart disease</td>
<td>4.2% (2015)</td>
<td>--</td>
<td>4.0%</td>
</tr>
<tr>
<td></td>
<td>Percent of adults ever diagnosed with heart attack</td>
<td>4.7% (2015)</td>
<td>4.7%</td>
<td>4.4%</td>
</tr>
<tr>
<td></td>
<td>Percent of adults ever diagnosed with hypertension</td>
<td>34.3% (2015)</td>
<td>34.3%</td>
<td>32.6%</td>
</tr>
<tr>
<td>Reduce diabetes</td>
<td>Percent of adults who have been told by a health professional that they have diabetes</td>
<td>11% (2015)</td>
<td>--</td>
<td>10.4%</td>
</tr>
<tr>
<td></td>
<td>Percent of adults who have been told by a health professional that they have pre-diabetes</td>
<td>7.5% (2015)</td>
<td>7.9%</td>
<td>7.5%</td>
</tr>
<tr>
<td>Reduce child asthma</td>
<td>Emergency department visits for pediatric asthma, per 10,000 children ages 0-4 and 5-17</td>
<td>118.6 (0-4) 75.6 (5-17) (2012)</td>
<td>112.6 (0-4) 71.9 (5-17)</td>
<td>106.7 (0-4) 68.1 (5-17)</td>
</tr>
</tbody>
</table>
Glide paths
Glide path example
Outcome: Reduce diabetes prevalence

- Community healthy food access
- Diabetes Prevention Program (DPP)

Food insecurity screening and follow-up

Built environment changes to support active living, including complete streets, green space and parks, etc.
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.
Glide path discussion questions

- If fully implemented, is the set of strategies listed in the glide path adequate to achieve the outcome objectives and reduce disparities?
- If not, where are the biggest gaps?
- Are there any strategies that seem unnecessary because they do not directly contribute to the outcome objectives?
Glide path discussion questions

- Do the strategies in the glide path provide adequate options that are feasible for a variety of different communities to implement?
  - Urban, suburban, rural, Appalachian
  - High-poverty and lower poverty communities
  - All stages of the life course
  - Different types of lead organizations, including LHDs, hospitals, ADAMH boards, FCFCs, United Ways, etc.
Local Strategy and Indicator Toolkit

Toolkit components

Maternal and infant health (MIH) (pages 2-4)
- Priority outcome indicators
- Cross-cutting strategies and indicators (social determinants of health, public health and prevention, healthcare system and access)

Chronic disease (CD) (pages 5-8)
- Priority outcome indicators
- Cross-cutting strategies and indicators (social determinants of health, public health and prevention, healthcare system and access)

Mental health and addiction (MHA) (pages 9-12)
- Priority outcome indicators
- Cross-cutting strategies and indicators (social determinants of health, public health and prevention, healthcare system and access)

Approaches to achieve health equity (page 13)

Appendix (18D)
- Frequency of data availability and other notes on limitations for local level indicators
Local toolkit discussion questions

- Is the structure of the toolkit useful and actionable for local level partners?
- If not, what can be improved?
Next steps

- Local Toolkit
- State commitments
- SMART objectives for cross-cutting factors
- Draft document
- December Advisory Committee meeting: Dec. 14, 9:30 to 11:30 am at Medicaid
**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

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**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

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**Healthcare system and access**

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**Public health system, prevention and health behavior**

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**Equity**

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