Roadmaps to equity
Opportunities for closing health gaps in Southwest Ohio

May 11, 2017
Understanding health disparities and inequities
A discussion of the data

Health Policy Institute of Ohio
May 2017
Learning objectives

1. Understanding the concepts: health disparities, health inequities and health equity
2. Discussing Ohio’s greatest health challenges, disparities and inequities
3. Identifying the data challenges

What is health equity?

Address avoidable inequalities
Opportunity to achieve
SOCIAL STANDING Injustices
Valuing everyone equally
Highest level of health
No one at a disadvantage
Resource allocation Discrimination

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Health inequities, disparities and equity

Health inequities

Health disparities

Health equity

*Working definition from the CDC Health Equity Working Group, October 2007

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1. Collect data to assess community health needs – including the needs and strengths of specific population groups
2. Examine root causes of health disparities
3. Advocate for improvement to local and state-level data collection
What is the state health assessment (SHA)?

A comprehensive and actionable picture of health and wellbeing in Ohio

- Informs identification of priorities for the State Health Improvement Plan
- Provides template for state agencies and local partners (uniform set of categories and metrics)

SHA key finding No. 2

Many opportunities exist to decrease health disparities and inequities by:
- Race and ethnicity
- Income and education-level
- Age and gender
- Disability status
- Geography
## Racial and ethnic disparities and inequities

### African-American/black Ohioans’ outcomes compared to U.S. overall rate on metrics included in state health assessment data profile

**BOLD** Metrics for which African-American/black Ohioans outcomes are better than U.S. overall rate (n=1)

**Metrics for which African-American/black Ohioans outcomes are worse than U.S. overall rate (n=21)**

<table>
<thead>
<tr>
<th>Category</th>
<th>U.S. (n=21)</th>
<th>African-American/black (n=1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population health</td>
<td>100% (9 metrics)</td>
<td>100% (9 metrics)</td>
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<tr>
<td>Healthcare system</td>
<td>85.7% (6 metrics)</td>
<td>100% (1 metric)</td>
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<tr>
<td>Access to health care</td>
<td>100% (2 metrics)</td>
<td>100% (2 metrics)</td>
</tr>
<tr>
<td>Public health and prevention</td>
<td>100% (1 metric)</td>
<td>100% (1 metric)</td>
</tr>
<tr>
<td>Social and economic environment</td>
<td>100% (3 metrics)</td>
<td>100% (3 metrics)</td>
</tr>
</tbody>
</table>

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African-American/black Ohioans were much more likely than any other racial and ethnic group to experience poor health outcomes.
Disparities by income level

Adult diabetes, by income. Percent of adults who have been told by a health professional that they have diabetes (2014)

- <$15,000: 18.9%
- $15,000-$24,999: 17.2%
- $25,000-$34,999: 13.6%
- $35,000-$49,999: 10.4%
- $50,000+: 7.7%

Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System (2014)

Diabetes, obesity, hypertension and tobacco use were all more common among lower-income Ohioans (those with household incomes less than $25,000) than among Ohioans with household incomes at $50,000 or more.

Disparities by age

Hypertension prevalence, by age. (2013)

- 18-24: 6.6%
- 25-34: 12.1%
- 35-44: 20.9%
- 45-54: 34.9%
- 55-64: 48.7%
- 65+: 63.1%

Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System (2013)

Diabetes and hypertension prevalence increased with age, greatly impacting those ages 65 and older.
Disparities and inequities by disability status

Adult depression prevalence, by disability status (2014)

People with disabilities experienced substantial disparities across metrics related to health outcomes and accessing health care.

Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System (2014)

Disparities and inequities by geography

Appalachian counties in southern and eastern Ohio generally had poorer health-related outcomes, such as higher rates of child poverty, although there are counties with significant health challenges in all areas of the state.

Source: 2016 County Health Rankings, based on 2014 data
Pathway to improved health value:
A conceptual framework
### Data in context

<table>
<thead>
<tr>
<th>Examples</th>
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</thead>
<tbody>
<tr>
<td><strong>Rankings</strong> 46</td>
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<tr>
<td><strong>Progress and trends</strong></td>
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<tr>
<td><strong>Greatly improved</strong></td>
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<tr>
<td><strong>Highlighting other states</strong></td>
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<tr>
<td>Most improved state(s)</td>
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<tr>
<td>TN, NV, LA</td>
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</table>

<table>
<thead>
<tr>
<th>Disparities and inequities</th>
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<tbody>
<tr>
<td>Little to no disparity</td>
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<tr>
<td>Medium disparity</td>
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<tr>
<td>Large disparity</td>
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</tbody>
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### How does Ohio do?
Where does Ohio rank?

Ohio performs poorly on many of the factors that impact health value.

Why does Ohio rank so poorly?

Ohio performs poorly on many of the factors that impact health value.

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Data in context

Examples

Rankings

Greatly improved

Progress and trends

Most improved state(s)

TN, NV, IA

Highlighting other states

Disparities and inequities

Little to no disparity

Medium disparity

Large disparity

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Disparity ratio

<table>
<thead>
<tr>
<th>Little to no disparity</th>
<th>Disparity ratio between group with the worst outcomes and group with the best outcomes is less than 1.10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medium disparity</td>
<td>Disparity ratio between group with the worst outcomes and group with the best outcomes is between 1.10 and 2</td>
</tr>
<tr>
<td>Large disparity</td>
<td>Disparity ratio between group with the worst outcomes and group with the best outcomes is greater than 2</td>
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</tbody>
</table>

Data availability

Data availability for population groups in the equity profiles

<table>
<thead>
<tr>
<th>Race and ethnicity</th>
<th>Number of metrics assessed</th>
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<tbody>
<tr>
<td>Income</td>
<td>15</td>
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<tr>
<td>Education level</td>
<td>17</td>
</tr>
<tr>
<td>Disability status</td>
<td>28</td>
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</tbody>
</table>

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Key findings: disparities and inequities
Ohioans who are black or have a low income are more likely to experience larger disparities and inequities across metrics.

Percent of metrics with large disparities by population group

<table>
<thead>
<tr>
<th>Population Group</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Income</td>
<td>64.2%</td>
</tr>
<tr>
<td>Race and ethnicity</td>
<td>53.6%</td>
</tr>
<tr>
<td>Disability status</td>
<td>26.7%</td>
</tr>
<tr>
<td>Education level</td>
<td>12.5%</td>
</tr>
</tbody>
</table>

Key findings: disparities and inequities
Disparities and inequities must be addressed to improve health value.

Largest disparities and inequities across equity profiles

<table>
<thead>
<tr>
<th>Metric</th>
<th>Group with worst outcomes</th>
<th>Estimated impact if disparity eliminated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children exposed to second-hand smoke</td>
<td>Low-income</td>
<td>126,776 Ohio children</td>
</tr>
<tr>
<td>Adverse childhood experiences</td>
<td>Low-income</td>
<td>207,722 Ohio children</td>
</tr>
<tr>
<td>Child poverty</td>
<td>Black</td>
<td>134,142 Ohio children</td>
</tr>
<tr>
<td>Adult depression</td>
<td>People with a disability</td>
<td>440,990 Ohio adults</td>
</tr>
</tbody>
</table>

*Estimated impact*: This calculation estimates the impact on Ohioans if the group with the worst outcomes on a metric had the same level of performance as the group with the best outcomes.
Ohio children exposed to secondhand smoke, by family income level

![Bar Chart]

- 0-99% FPL: 22.2%
- 100%-199% FPL: 10.7%
- 200%-399% FPL: 8.6%
- 400%+ FPL: 0.9%

**Estimated impact of eliminating disparity:**
Nearly 127,000 Ohio children would not be exposed to second-hand smoke if the disparity between Ohioans with low incomes and higher incomes was eliminated.

Source: National Survey of Children’s Health and 2017 Health Value Dashboard analysis

Ohio children living in poverty, by race and ethnicity

![Bar Chart]

- Black: 45.9%
- Hispanic: 33.4%
- White: 14.5%
- Asian-American: 10.9%

**Estimated impact of eliminating disparity:**
More than 130,000 black children in Ohio would not be living in poverty if the racial disparity was eliminated.

Source: National Survey of Children’s Health and 2017 Health Value Dashboard analysis

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Residential segregation
Black/white dissimilarity index, 2010-2014

*Cincinnati dissimilarity index is calculated from Ohio census tracts only.
Source: American Community Survey, 5-Year Census Tract Estimates. Calculations by the Kirwan Institute for the Study of Race and Ethnicity

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Understanding the problems with the data

Data is not consistently collected across population groups

Aggregated data can mask health disparities and inequities within population groups

Need comprehensive data across all factors that impact health

1. Collect data to assess community health needs – including the needs and strengths of specific population groups
2. Examine root causes of health disparities
3. Advocate for improvement to local and state-level data collection
1. Prioritize health issues with large disparities and inequities
2. Identify priority populations or geographic areas that have worse outcomes for priority health issues
3. Set specific and measurable objectives for priority populations
4. Ensure that targets are aggressive to reduce or eliminate existing disparities and inequities
Equal opportunity

Social, economic and physical environment

Adapted from Saskatoon Health Region’s Public Health Observatory

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Life expectancy vs. Income level

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Universal proportionalism - intensity of investment should increase with need

Ohio’s journey towards health equity
Dashboard material

http://www.hpio.net/2017-health-value-dashboard/

- Full Dashboard with sources
- 2-page executive summary
- 8-page snapshot
- Methodology
- Local-level data crosswalk
- FAQ
- Excel with metric descriptions

Roadmaps to equity
Opportunities for closing health gaps in Southwest Ohio

May 11, 2017
Vision and Mission

Greater Cincinnati is healthy by design and everyone is connected to quality, affordable healthcare

To lead data-driven improvement that results in healthier people, better care, and lower costs
Cincinnati Expecting Success
Acknowledgements

Initial Funding:
• Robert Wood Johnson Foundation: Aligning Forces for Quality

Consultation and Support:
• Interact for Health
• Center for Closing the Health Gap

Equality doesn’t mean Equity
(Image reproduced with permission from the Public Health Observatory - Saskatoon Health Region, 2014)
Cincinnati Experience

• Background
• Data Collection
• Lessons and Challenges
• Moving Towards Improvement

Getting to equity starts with data
Getting to equity starts with data

Data collection standardization is key
• Support and buy-in from key leaders
• State your case: how will the data be used and for what purpose, ultimate outcome?
• Promote the opportunities
• Stand up for what you believe: it’s the right thing to do

Key Project Components

• Data Collection Gap Analysis
• Consensus on standard categories
• Reconfiguration of hospital EHRs
• Training registration/admission staff to obtain self-reported REL
• Community awareness campaign
• Data quality assurance
Disparities

Lessons Learned

• Training and data collection are ongoing processes
• Better training yields better results
• Prepare staff and community for REL data collection
• Data integrity is critical
• Keep leadership informed
• Work with quality teams
Fast Forward to 2016

Healthcare Workforce Diversity Initiative Strategies

<table>
<thead>
<tr>
<th>Strategies</th>
<th>Timeline</th>
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</thead>
<tbody>
<tr>
<td>1. Convene THC members and conduct peer to peer learning sessions in order to share best practices and conduct deep dives into policy, employee recruitment and development, and cultural competency training</td>
<td>2016 – 2017</td>
</tr>
<tr>
<td>2. Partner with other organizations to find and develop talent by expanding school outreach, coordinating with the Diverse by Design Initiative, and evaluating the feasibility of MD Jobs to include other health careers</td>
<td>2016 – 2017</td>
</tr>
<tr>
<td>3. Focus on health disparities among targeted populations by developing a project focusing on a condition linked to CPC and Collective Impact, using standardized REAL data, and identifying strategies to reduce the disparity</td>
<td>2016 – 2018</td>
</tr>
</tbody>
</table>
3. Focus on **health disparities** among targeted populations by developing a project focusing on a condition linked to CPC and Collective Impact, using standardized REAL data, and identifying strategies to reduce the disparity.

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**Project Timeline**

<table>
<thead>
<tr>
<th>Equity Improvement Project Workplan</th>
<th>Q4</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
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<td>Key Driver Diagram</td>
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HPIO 2017 Health Value Dashboard

Diabetes Long-Term Complications Admission Rate Among Black and White With Primary Diagnosis Only vs. All Diagnoses (All Age, All Payer, 2015 Q1-Q3)

<table>
<thead>
<tr>
<th></th>
<th>Black</th>
<th>White</th>
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<tbody>
<tr>
<td>Rate Per 1000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All</td>
<td>68</td>
<td>50</td>
</tr>
<tr>
<td>Primary</td>
<td>11</td>
<td>7</td>
</tr>
</tbody>
</table>

Data Source: OHA all payer data 2015Q1-Q3. Data combines inpatient discharges from all regional hospitals. Rates are shown as actual rates per 1,000 inpatient discharges. Numerators: Admissions identified using AHRQ diabetes with long-term complications diagnosis codes as defined in PQ3. Denominators: Inpatient discharges from all regional hospitals.
Equity Improvement Project

Key Driver Diagram

To bolster diabetes self-management skills after an acute care episode in 75% of African-American patients with additional risk factors for long-term complications of diabetes in participating practices by September 30, 2018.

Improve Clinical Processes

Improve Patient Engagement

Increase Community and provider Awareness of Disparities

Next Steps

- Refine charter
- Confirm practices
- Develop measures
- Secure Data Use Agreements
- Execute on Key Drivers
- Convene Learning Collaboratives
- Measure Outcomes
- Develop Sustainability Plan
Roadmaps to equity
Opportunities for closing health gaps in Southwest Ohio

May 11, 2017

Evidence-informed strategies to decrease inequities

Health Policy Institute of Ohio
May 2017
Learning objectives

2. Where to find effective strategies to reduce disparities and inequities
3. Upstream partners
Prioritize selection of policies and programs:
- Likely to reduce disparities
- Address underlying causes of health inequities

What are we talking about?

promising practice
recommended
model program
best practice
proven program
evidence-based
Evidence-based strategy

(HPIO definition)

Programs, policies or other strategies that have been evaluated and demonstrated to be effective in improving outcomes based upon the best-available research evidence, rather than upon personal belief or anecdotal evidence.
What criteria would you like a HEALTHCARE PROVIDER to use in deciding how to treat you?

1. Intuition (gut feeling) about what will be effective
2. What they have heard from co-workers is effective
3. Past experience with similar situations
4. Results of controlled experimental studies that show a method is helpful
5. What they know by critically reading the literature in their field

Adapted from: E. Gambrill, Critical Thinking for Helping Professionals

A framework for thinking about evidence
Local community health improvement plan example

Evidence-based decision making

- Best available research evidence
- Experiential evidence
- Contextual evidence

Recommendations from the 2017-2019 SHIP, What Works for Health and Community Guide

Information about community preferences and readiness, available funding, political will and coordination with relevant stakeholders

Expertise and experience of planning team

Source: Puddy and Wilkens (2011)

Limitations
policy and systems change
Research evidence

- Overall effectiveness
- Effectiveness for decreasing disparities
- Fidelity to model

Community fit

- Community member needs & interests
- Community norms, readiness & capacity
- Culture & language of priority populations

Evidence helps us to steer resources toward what really works.
Where should we look for effective strategies?

HPIO Guide to improving health value

Navigating sources of evidence
A guide to effective prevention strategies

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Recommended sources for what works to decrease disparities

**What Works for Health**
Disparity ratings

**Community Guide**
Equity systematic reviews

2017-2019 state health improvement plan (SHIP)

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**WHAT WORKS FOR HEALTH**

Find effective programs and policies at www.countyhealthrankings.org/what-works-for-health
WHAT WORKS FOR HEALTH EVIDENCE RATINGS

- Scientifically Supported
- Some Evidence
- Expert Opinion
- Insufficient Evidence
- Mixed Evidence
- Evidence of Ineffectiveness

WHAT WORKS FOR HEALTH DISPARITY RATINGS

- Likely to decrease disparities
- No impact on disparities likely
- Likely to increase disparities
- Disparities by
  - Socio-economic status
  - Race or ethnicity
  - Geographic area
EXAMPLE: SCHOOL BREAKFAST PROGRAMS

School breakfast programs offer students a nutritious breakfast, often incorporate healthy and culturally relevant choices. Breakfast can be served in the cafeteria, from grab and go carts in hallways, or in classrooms as the school day begins. Schools offer breakfast during a morning break, called second chance breakfast (BNK CBB-School breakfast). Schools that participate in the federal School Breakfast Program receive subsidies for each breakfast served. Students from families with income below the federal poverty level (FPL) are eligible for free breakfast and children from families with incomes between 130% and 185% FPL qualify for reduced-cost breakfasts. If a student is not eligible for free or reduced-cost breakfasts, participation in the federal program varies by state and region (Bartfeld 2020). Participating schools offer free breakfast to all students, or others only qualify (FRAC-Woo 2015).

**Expected Beneficial Outcomes (Rated)**
- Improved cognitive function
- Increased academic achievement
- Increased healthy food consumption

**Other Potential Beneficial Outcomes**
- Improved nutrition
- Increased food security

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Evidence of Effectiveness

There is strong evidence that having access to school breakfast programs improves cognition and scholastic achievement, especially among nutritionally deficient or malnourished children (Frisvold 2015, Hoyland 2009, Meyers 1989, Adolphus 2013). Access to school breakfast programs also increases healthy food consumption and can improve breakfast nutrition (Bhattacharya 2006, Murphy 2011, Ask 2006, ERS-Fox 2004, Frisvold 2015).

School breakfast availability can reduce short-term hunger (Mhurchu 2012), marginal food insecurity, and food-related worries in low-income households (USDA-Bartfeld 2009, Bartfeld 2009).

**Impact on Disparities**

Likely to decrease disparities

Implementation Examples

In the 2013-2014 school year, the federal School Breakfast Program served approximately 11.2 million low-income children on a typical day (FRAC-Woo 2015). Low-income children participate in the School Breakfast Program much more than higher income children, and schools that serve

Implementation Resources


FRAC-SBP - Food Research and Action Center (FRAC). School breakfast program.

NHCI CBB: School breakfast - No Kid Hungry Center for Best Practices (NHCI CBB). School breakfast
School breakfast programs
Columbus and Newark

Health Equity: School-Based Health Centers

Summary of Task Force Finding
The Task Force recommended that the implementation and maintenance of school-based health centers (SBHCs) in low-income communities improves educational and health outcomes.

Educational outcomes include the following:
- School performance
- Grade promotion

If targeted to low-income communities, SBHCs are likely to reduce gaps in education and improve health equity.
School-based health centers
Cincinnati and Cleveland
Social, economic and physical environment

Equal opportunity

Adapted from Saskatoon Health Region's Public Health Observatory

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Strategies likely to increase opportunity & health equity: 8 examples from the SHIP

- School-based health centers
- Tobacco QuitLine
- Healthy food in convenience stores
- Fruit and vegetable SNAP incentives
- School breakfast
- Earned Income Tax Credit
- Housing assistance
- Early childhood education

Lack of healthcare access
Lack of healthy food access
Low wages, low economic mobility and poverty

Ohio Tobacco QuitLine
Healthy food in convenience stores

Lorain

Columbus- Westside
Cleveland

Fruit and vegetable incentives
Montgomery County

YOU SNAP. WE MATCH.

Shop with SNAP/EBT, get up to $10 in FREE fruits & vegetables!

Buy 1 Get 2

The healthy way to stretch your SNAP.

Visit the Information Booth to participate
produceperks.org

Shop with SNAP/EBT, get up to $10 in FREE fruits & vegetables!

MARKET LOCATIONS
Montgomery County

1. MARKET AT
   WRIGHT STOP PLAZA
   Tues-Thurs, 11am-5pm (Year-Round)
   65 W. Main St., Dayton

2. SHILOH FARMERS MARKET
   Sat, 8am-1pm (May-Oct)
   13800 Miami Trail, Dayton

3. MISSION OF MARY CSA
   Picking 7 days a week (Year-Round)
   699 Silver Lane, Dayton

4. MISSION OF MARY
   FARMSTAND
   Fri, 10am-1pm (May-Oct)
   423 James Ave., Dayton

5. 2nd STREET MARKET
   Tues, 11am-3pm (May-Oct)
   500 E 2nd St., Dayton

For More Information
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*Receive a dollar-for-dollar match to every dollar you spend (up to $10 total) using an Ohio Direction Card at the market.
Earned income tax credit outreach
Columbus, Cleveland and Cincinnati

Service-enriched housing and Rental vouchers
Columbiana County
Early childhood education
Cincinnati and Cleveland

Voters approve Cincinnati Public Schools tax levy to fund district-wide preschool program

Pathway to improved health value

World Health Organization definition of health: Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.
Upstream partners to achieve equity

- Who are they?
- What works to engage upstream partners?

Who are your upstream equity partners?

- People most affected by inequities
- Health leaders
- Leaders from sectors beyond health
- Policymakers
Who are your upstream equity partners?

- People most affected by inequities
- Health leaders
- Leaders from sectors beyond health
- Policymakers

Examples of decision makers in sectors beyond health

- School district superintendent or principal
- Police Chief or County Sheriff
- Convenience store owner
- Transitional housing agency director
- CEO of a large employer
- Farmer
Examples of policymakers

- State legislator (representative or senator)
- State Board of Education member
- Director of Ohio Department of Job and Family Services
- City Council member
- County Commissioner
- Metropolitan Planning Commission board member

Decision maker analysis

- What do you want?
- Who has the decision-making authority to make it happen?
What works to engage cross-sector partners and policymakers?

1. Find out what’s in it for them
2. Use effective messaging
3. Build relationships
4. Use “collective impact” (or similar framework) to sustain common agenda over time

Prioritize selection of policies and programs:
- Likely to reduce disparities
- Address underlying causes of health inequities
Identify and engage upstream equity partners:
- People most affected by inequities
- Health leaders
- Leaders from sectors beyond health
- Policymakers
What policy change would you like to see?

Who has the power to make the decision to enact this policy change?

Will you need to reach out to individual policymakers?
### Advocacy

- Education
- Facts
- Bipartisan
- Balanced
- No call to action (position not taken)
- Activities that defend, support or maintain a cause
- Usually broad issues

### Lobbying

- Influencing legislation, regulation, funding
- Actions aimed at influencing public officials to promote or secure passage of specific bill or funding
- A paid representative for a particular organization

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### Ways to influence policy

- Write letters, emails or make phone calls
- Provide district specific data
- Provide analysis of a bill
- Provide testimony at a legislative hearing
- Provide a one-page fact sheet
- Organize community partners to visit key policymakers
- Invite policymakers to visits your organization or speak at a meeting you host
Who represents you?

https://capwiz.com/nra/dbq/officials/
Policymaking basics

https://osupublichealth.catalog.instructure.com

Roadmaps to equity
Opportunities for closing health gaps in Southwest Ohio

May 11, 2017