

**Ohio Health Quality Improvement Summit Planning Committee
Promoting Health/Preventing Disease and Injury Focus Area**

Caveats:

Suggested tactics and metrics for each strategy are examples only, derived from a general literature review and survey of other states’ initiatives and policy brainstorming. Further work is needed to (1) determine the extent to which these tactics and metrics are already under development or being used in Ohio, (2) probe the merit and viability of these tactics and determine whether there are better tactics for achieving the desired goals, (3) assess which mix of tactics would work best for Ohio, and (4) determine appropriate timeframes and targets for achieving the indicated metrics.

Additionally, our committee wishes to emphasize the importance of the seven cross-cutting “areas” reflected in the fourth column. In many ways, each of the seven topics in this column could form its own “strategy,” and it is our hope that when the work of the November conference is done, the tactics in all 7 areas can be mapped and tracked across all four focus areas of the conference (cost and efficiency, patient safety, chronic disease management, and prevention).

Finally, not all committee members supported every strategy or tactic and indeed, some members opposed certain strategies and tactics. Also, not every strategy or tactic currently being supported or pursued by each of our committee members is listed in this chart. Nonetheless, the strategies and tactics listed in this chart had sufficiently broad support among our committee’s members to warrant further consideration at the November summit.

Proposed strategy	Rationale (with citations, and estimated return on investment)	Supporting tactics (general) ¹	Supporting tactics in the areas of (1) health information technology; (2) payment reform; (3) addressing and reducing disparities ² ; and (4) workforce development ³	Metrics for measuring progress
Decrease the prevalence of tobacco use in Ohio	<ul style="list-style-type: none"> • Ohio has significant room for improvement in improvement in smoking and solutions would need to target lower income citizens⁴ • Ohio’s rate of smoking is high, but falling • 1998: <ul style="list-style-type: none"> ○ Ohio: 26% 	<ul style="list-style-type: none"> • Decreasing the rate of new smokers, among young adults, in particular <ul style="list-style-type: none"> ○ Increasing awareness of the harmful effects ○ Limiting access to tobacco among minors 	The following are example tactics only, further work is needed to (1) determine the extent to which these tactics are already under development or in progress in Ohio, (2) consider the merit and viability of these tactics, and (3) assess which mix of tactics would work best in Ohio.	<ul style="list-style-type: none"> • Measure and set enrollment goals for ODH and other state smoking cessation programs • Measure and set goals for Ohio employers who adopt smoking

	<ul style="list-style-type: none"> ○ US: 23% ○ 1st quartile of states: 20% • 2002 <ul style="list-style-type: none"> ○ Ohio: 26% ○ US: 23% ○ 1st quartile of states: 19% • 2006: <ul style="list-style-type: none"> ○ Ohio: 22.4% ○ US: 20.1% • 1st quartile of states: 16.1% • Smoking is more common among the poor <ul style="list-style-type: none"> ○ % prevalence by household (HH) <ul style="list-style-type: none"> ▪ < 15,000: 39% ▪ \$15 -50,000:26% ▪ > \$50,000: 15% • However solutions need to address all segments of the population <ul style="list-style-type: none"> ○ % of smokers in Ohio, by HH income <ul style="list-style-type: none"> ▪ 100% = 2.Million) ▪ < 15,000: 23 ▪ \$15 - \$50,000: 47% ▪ > \$50,000: 30 <p>Life and Health Objectives</p> <ul style="list-style-type: none"> • By reducing smoking to the 1st quartile state average: • ~500,000 fewer smokers in Ohio • 2 – 5 million years of life potential gained <p>Economic efficiency</p> <ul style="list-style-type: none"> • By reducing smoking to the 1st quartile state average: • \$0.8 – 1.8 billion reduction in healthcare expenditures • \$0.9 – 2.2 billion reduction in indirect cost <p>Fairness and equity</p> <ul style="list-style-type: none"> • Smoking is more than 2x more 	<ul style="list-style-type: none"> • Increasing the availability, adoption and effectiveness of interventions to help smokers quit • Creating/strengthening incentives/disincentives to not smoke (or quit smoking) • Potential for impact against system objectives in the following five areas:^{9, 10, 11} • Increase the tax on smokeless tobacco <p>Employers:</p> <ul style="list-style-type: none"> • Subsidize and/or promote smoking cessation programs • Use benefit design • Incentives for smoking cessation • Cover value-adding treatments • More closely measure and track productivity by smoking status • Restricting hiring of smokers • Prevent/ restrict smoking at work or on company grounds <p>Government:</p> <ul style="list-style-type: none"> • Increase funding of prevention and cessation programs • Restrict advertising & promotion by tobacco companies and/or distribution • Reduce youth access to tobacco products through new laws/policies or greater enforcement of existing policies/laws • Freely distribute full courses of nicotine replacement therapies • Increase tobacco taxes • Tie tobacco taxes to inflation rate • Require lower nicotine levels in cigarettes • More aggressively combat 	<p>HIT:</p> <ul style="list-style-type: none"> • Electronic records could better track health consequences of smoking and value of interventions. • Improved sharing of information. <p>Payment reform /value purchasing:</p> <ul style="list-style-type: none"> • Reimburse providers for prevention / cessation counseling; • Increase reimbursement for prevention services; • Reimburse for supportive cessation services. • Use joint purchasing power to obtain training, services, and/or products. <p>1st Payment reform by reducing smoking to the 1st quartile state average:</p> <ul style="list-style-type: none"> • Assuming a prevalence of 22.4% (from CDC BRFSS data), there are ~1.9 million adult smokers in Ohio • Assuming the 1st quartile of states have an average prevalence of 16.8% (range from 20.1-24.7 from CDC BRFSS data), there would be ~1.5 million adult smokers, a difference of ~500,000 • If each of the additional smoker loses, on average, 7.2 years of potential life, by moving to the 1st quartile average Ohioans would gain ~3.5 million years of potential life (range from 2-5 million) • The average years of potential life lost per smoker was calculated using estimates from Taylor et al., 2002 • Estimates from Taylor et al. were weighted to represent the prevalence of smoking in Ohio by 	<p>cessation incentive programs for their employees</p> <ul style="list-style-type: none"> • Measure and track employer productivity by smoking status • Measure and track employers who prevent/restrict smoking on company grounds • Measure and track schools who adopt mandate a 100% tobacco free school campus policies
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	<p>prevalent among Ohioans with a household income less than \$15,000</p> <p>Shorter life expectancy (# of years of average life)⁵</p> <ul style="list-style-type: none"> • Nonsmoker = 77 yrs. • Smoker = 67 yrs. • Assuming a prevalence of 22.4% (from CDC BRFSS data), there are ~1.9 million adult smokers in Ohio • Assuming the 1st quartile of states have an average prevalence of 16.8% (range from 20.1-24.7 from CDC BRFSS data), there would be ~1.5 million adult smokers, a difference of ~500,000 • If each of the additional smoker looses, on average, 7.2 years of potential life, by moving to the 1st quartile average Ohioans would gain ~3.5 million years of potential life (range from 2-5 million) <ul style="list-style-type: none"> ○ The average years of potential life lost per smoker was calculated using estimates from Taylor et al., 2002 ○ Estimates from Taylor et al. were weighted to represent the prevalence of smoking in Ohio by age group and gender, resulting in an overall weighted average of 7.2 • Assuming each smoker costs an additional \$2600 in direct medical expenditures and \$3200 in indirect costs, by moving to the 1st quartile average prevalence Ohio would save ~\$1.3 billion in direct medical expenditures (range from \$ 0.8-1.8) and \$1.6 million in indirect costs (range from \$0.9-2.2) 	<p>smoking within Medicaid population</p> <ul style="list-style-type: none"> • Modify laws/regulation to provide health plans and employers more flexibility in aggressively combating smoking <p>Health Plans:</p> <ul style="list-style-type: none"> • Higher premiums for current smokers • Incentive programs for smoking cessation • Educate providers on effective smoking cessation tools • Promote, encourage, and/or incent use of smoking cessation <p>Providers:</p> <ul style="list-style-type: none"> • Provide more education to patients • Counsel tobacco-using patients to not smoke in their homes <p>ODH:</p> <ul style="list-style-type: none"> • Enhance the operating of a statewide Quit Line • Encourage adoption of 100% tobacco free school campus policies 	<p>age group and gender, resulting in an overall weighted average of 7.2</p> <ul style="list-style-type: none"> • Assuming each smoker costs an additional \$2600 in direct medical expenditures and \$3200 in indirect costs, by moving to the 1st quartile average prevalence Ohio would save ~\$1.3 billion in direct medical expenditures (range from \$ 0.8-1.8) and \$1.6 million in indirect costs (range from \$0.9-2.2) <p>Leveraging partnerships:</p> <ul style="list-style-type: none"> • Create comparable coverage requirements and polices across state health systems <p>Disparities:</p> <ul style="list-style-type: none"> • Efforts should be targeted to address the populations most affected by tobacco use. • Assure access to affordable appropriate services and care <p>Workforce development:</p> <ul style="list-style-type: none"> • Assure providers are trained to prevent and address tobacco use. Expand training of counselors. 	
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	<ul style="list-style-type: none"> ○ Estimates from the CDC were inflated to 2007 using the average increase in medical expenditures in Ohio <p>Higher Absenteeism and presenteeism means lost hours per year ⁶</p> <p>* Note, this is taken directly from Bunn et al., 2006 in which volunteers were asked to complete a wellness inventory that measured productivity losses related to 11 health conditions (including smoking status) affecting employee health</p> <ul style="list-style-type: none"> ● Nonsmoker = 78 ● Smoker = 130 <p>Higher Lifetime medical costs (\$ above nonsmokers)⁷</p> <p>* Note, this is taken directly from Hodgson, 1992 in which the lifetime costs of smoking were calculated in 1990 dollars (this includes the impact of earlier death of smokers). The lifetime costs were then updated to 2007 dollars using the CAGR of medical expenditures in Ohio from 2000-2004.</p> <ul style="list-style-type: none"> ● Smoker = 22,000 <p>Ohio's smoking ban and pending increases in tobacco taxes are likely to help to curb smoking⁸</p> <ul style="list-style-type: none"> ● Tobacco control programs in New York City helped reduce smoking such as the following: <ul style="list-style-type: none"> ○ \$0.39 tax increase in 2002 ○ 2002 smoke-free act and free nicotine patch program ○ \$1.42 tax increase in 2003 ○ Television and ad campaign in 2006 			
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	<ul style="list-style-type: none"> • However, taxes have a greater influence on smoking behavior than bans (% of smokers in NY City in 2002/2003) <p>Responses to 2002 tax increase</p> <ul style="list-style-type: none"> ○ No Impact = 53 ○ Reduced cigarettes = 21 ○ Thought about quitting = 8 ○ Tried to quit = 11 ○ Quit = 6 <p>Responses to WORKPLACE ban</p> <ul style="list-style-type: none"> ○ No Impact = 70 ○ Reduced cigarettes = 21 ○ Thought about quitting = 3 ○ Tried to quit = 2 ○ Quit = 2 <p>According to CDC, providing QL counseling increases the rate of successful quit attempts from 5% (cold turkey) to 22%.</p> <p>The ROI for Ohio’s quit line was independently analyzed and reported in the “working with business partners” article by the Oregon Health and Science University Smoking Cessation Center as follows:</p> <ul style="list-style-type: none"> • A \$39 investment produced a \$63.16 return or a \$24.16 gain after 1 year • An investment of \$39 equals \$492.12 return or \$453.12 gain after 5 years. • 100% tobacco free school policies combined with school-based education and community and mass media efforts can effectively prevent or postpone the onset of smoking by 20-40% among US teens. (Source: 2001 Surgeon General’s Report on reducing tobacco use.) 			
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	<ul style="list-style-type: none"> North Carolina has done a very recent analysis of their 100% tobacco-free schools program and has shown that students attending high schools in districts with an established 100% TFS policy are 40% less likely to be smokers than are students in non-TFS districts. 			
<p>Reduce the growth rate in the prevalence of obesity in Ohio</p>	<ul style="list-style-type: none"> Ohio has significant room for improvement in obesity¹² Ohio's rate of obesity is high and growing and worse than the national average 1998: <ul style="list-style-type: none"> Ohio: 20% US: 18% 1st quartile of states: 15% 2002 <ul style="list-style-type: none"> Ohio: 23% US: 22% 1st quartile of states: 18% 2006: <ul style="list-style-type: none"> Ohio: 28% US: 24% 1st quartile of states: 20% 14% of Ohio's children were obese in 2003-04^{13,14} Obesity is more common among the poor but solutions need to address all population segments Percent of obese Ohioans, by household income <ul style="list-style-type: none"> < 15,000: 41% \$15 - \$50,000: 43% <p>Life and health Objectives</p> <ul style="list-style-type: none"> Reduce obesity to the 1st quartile state average, which would correlate to ~ 600,000 fewer obese Ohioans and 1.7-1.9 million years of life potential 	<p>Increase public awareness by intense media attention directed to increasing obesity rates via social marketing to help increase concern among Ohio</p> <p>Launch programs in the businesses community with the goal of increasing business participation in employer actions pertaining to obesity prevention. (i.e. Weight Watchers incentive program like OSU)</p> <ul style="list-style-type: none"> OSU's program reimburses weight watchers (registration + weekly sessions) at 50%. Individuals need to register and attend 5 sessions. Based on preliminary analysis, OSU's experience with this program indicates that individuals with a BMI of <33 do good on weight watchers and have lost an average of 2 BMI <p>Employers:</p> <ul style="list-style-type: none"> Subsidize and/or promote weight-loss programs, drugs, procedures, or other medical approaches proven to combat obesity Encourage healthy lifestyles with food options, on-site gyms, etc. Create incentives for reducing obesity Education and awareness 	<p>The following are example tactics only, further work is needed to (1) determine the extent to which these tactics are already under development or in progress in Ohio; (2) consider the merit and viability of these tactics; and (3) assess which mix of tactics would work best in Ohio.</p> <p>HIT</p> <ul style="list-style-type: none"> use claims and medical records to record BMI, counseling, strategies Payment reform: reimburse providers to increase identification of overweight and obesity; incent counseling and treatment; employer/insurer incentives Value purchasing/ Leveraging partnerships: leveraging state medical assistance and retirement programs Medicaid; state employees; retirees to test incentives <p>Payment Reform</p> <ul style="list-style-type: none"> Reimburse providers for early identification of overweight and related counseling Increase reimbursement for prevention services; Reimburse for supportive services <p>Addressing and reducing disparities</p> <ul style="list-style-type: none"> Focus on specific programs that 	<p>Addresses feasibility as well as proposed metrics.</p> <p>Stakeholder alignment</p> <ul style="list-style-type: none"> Some solutions could involve restrictions on individuals or regulation of businesses that would face resistance <p>Investment required</p> <ul style="list-style-type: none"> Investment dependent on solution, but likely would include investment in stronger incentives, increasing use of effective weight loss programs, infrastructure to support physical activity, and awareness building programs Some solutions may not add cost to the system <p>Time to meaningful impact</p> <ul style="list-style-type: none"> 7+ Years

	<p>gained</p> <p>Economic efficiency</p> <ul style="list-style-type: none"> Reduce obesity to the 1st quartile state average, which would equal a \$1.4 – 1.6 billion reduction in healthcare expenditures and a \$1.3 – 1.6 billion reduction in indirect healthcare cost <ul style="list-style-type: none"> This is because increases in population factors like obesity account for ~27% of the growth in healthcare costs <p>Fairness and equity</p> <ul style="list-style-type: none"> Prevalence of obesity is higher for individuals with less than \$15,000 in household income The prevalence of obesity is almost 2x higher for black than white Ohioans <ul style="list-style-type: none"> > \$50,000: 16% <p>Obesity reduces life expectancy, lowers productivity (school and work), and increases healthcare costs</p> <p>Shorter life expectancy (# of years of average life):</p> <ul style="list-style-type: none"> Non-obese = 78 Obese = 75 National estimates of years of life lost (YLL) due to obesity segmented by gender, age, and BMI was taken from Fontaine et al, (2003) The national estimates were converted to Ohio-specific YLL due to obesity by taking a weighted average of the national YLL estimates based on Ohio's distribution of obesity prevalence by age group from the CDC BRFSS data (this process was done for both males and females) 	<ul style="list-style-type: none"> More closely measure and track productivity by BMI and health status i.e. The Ohio Business Roundtable and/or the Employers Health Coalition of Ohio are candidates for convening larger employers toward the reduction in the prevalence of obese Ohioans. <p>Government:</p> <ul style="list-style-type: none"> Regulation of junk food or fast food advertising Disclose requirements for restaurants Subsidize healthy foods Modify public assistance to encourage healthy food choices School regulations Cafeteria, vending machines Regular physical education More investment in parks and promotion of healthy activities such as walking, biking, etc. More aggressively combat obesity within Medicaid population Modify laws/regulation to provide health plans and employers more flexibility in aggressively combating obesity Mandate that health plans or employers provide benefits for drugs, procedures, or other medical approaches proven to combat obesity Leveraging state medical assistance and retirement programs: see above comments under payment reform. Expand Ohio regulations for 	<p>reduce the prevalence of obesity for individuals with less than \$15,000 in household income, as obesity is higher for individuals in these households</p> <ul style="list-style-type: none"> Tailor programs that focus on decreasing the prevalence of obesity for black Ohioans where the prevalence is almost 2x higher than white Ohioans Increase the number of early learning centers in high risk neighborhoods that receive consultation in providing nutritious meals and snacks and structured time for physical activity such as the Healthy Children, Healthy Weights program <p>Value purchasing</p> <ul style="list-style-type: none"> Use of Snackwise® Nutrition Rating System (developed by Center for Healthy Weight and Nutrition at Nationwide Children's Hospital,) for school or business foodservice operations to analyze menu items (can rank them as best choices to worse choices) for consumers (OSU & Westerville schools already using this system) Buy Ohio local produce for schools, businesses <p>Leveraging Partnerships</p> <ul style="list-style-type: none"> Require all SBP and NSLP menus to be reviewed by dietitian or food-service manager by nutritionist/dietitian Incentives to businesses that comply with menu labeling HB 254 key partnerships Ohio Action for Healthy Kids (and 	<ul style="list-style-type: none"> Getting traction against obesity is likely to require 10-15 years The full benefits of reducing obesity may take several years to accrue for any given individual <p>Nutrition:</p> <ul style="list-style-type: none"> Measure and track BMI improvements (students and employees) Annual review by state on compliance of nutrition guidelines in schools Consider statewide testing of nutrition knowledge of school foodservice managers (if they are NOT dietitians) <p>ODH</p> <ul style="list-style-type: none"> Statewide surveillance to measure behavior changes in key obesity related areas such as physical activity, healthy eating, access to grocery stores, school wellness plans and
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	<ul style="list-style-type: none"> The weighted averages for males (3.03) and females (2.80) were both close to 3, so 3 years were subtracted from the average life expectancy Assuming 3 YLL due to obesity, the average life-expectancy for non-obese Ohioans must be 78 to allow for the weighted average life-expectancy of obese and non-obese Ohioans to equal 77, the known average life-expectancy of any Ohioan <p>Higher Absenteeism and presenteeism at work (\$ lost per worker) ^{15, 16}</p> <ul style="list-style-type: none"> Non-obese = \$1,201 Obese = \$1,627 <p>Higher Healthcare costs (\$ per capita)</p> <ul style="list-style-type: none"> Non-obese = \$3,254 Obese = \$3,925 - \$5,695 <ul style="list-style-type: none"> Healthcare costs for non-obese and obese workers were taken directly from "Obesity in the Workforce" report which used a national database to calculate per-member medical costs in 2003-2005 based on BMI (calculated from self-reported height and weight) Higher healthcare costs range from 3,925 for class I (BMI 30-34.9) and 5,695 for class III (BMI > 40) obesity <p>Many obesity-related school standards have not been adopted in Ohio, data as of 2007 (# of states who have adopted standards), (In place in Ohio: Yes or No) ¹⁷</p> <ul style="list-style-type: none"> Nutritional standards for school food that are stricter than USDA 	<p>Child Care Centers to include: limited sugar sweetened beverages, limited foods of low nutritional value, children not forced to eat, food not used as a reward, limited screen time, and physical activity required daily a number of minutes per day</p> <p>Health Plans:</p> <ul style="list-style-type: none"> Charge higher premiums for obese (controversial) Create and promote incentive programs Provide benefits for drugs, procedures, or other medical approaches proven to combat obesity <p>Providers:</p> <ul style="list-style-type: none"> Children's hospitals/pediatricians <ul style="list-style-type: none"> Curb fast food offerings Educate parents Adult hospitals <ul style="list-style-type: none"> Nutrition education Targeted counseling <p>Nutrition tactics:</p> <ul style="list-style-type: none"> Pass H.B No. 254 to establish nutritional standards for certain foods and beverages sold in public and chartered nonpublic schools, to require public and chartered nonpublic schools to implement local wellness policies, and to make other changes regarding student nutrition and physical activity.²¹ Require Ohio schools to prohibit non-USDA junk foods/drinks in ala carte or vending venues Eliminate "Red foods" based on 	<p>their state website lists all parties involved was the lead on this legislation²²</p> <ul style="list-style-type: none"> Opponents - and important to note - BASA (Buckeye Association of School Administrators); OSBA (Ohio School Board Association), OAESA (Ohio Association of Elementary School Administrators) and maybe OASBO (Ohio Association of School Business Officials). The House Republicans are all about "local control" and think the choice should be at the local level. Employers and schools to implement Snackwise® system for vending Reimbursement for buying local produce (within state lines) 	<p>state 3rd grade BMI data and other federal YRBS and BRFSS data</p>
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	<p>requirements (17), (No)</p> <ul style="list-style-type: none"> • Nutritional standards for competitive foods sold a la carte (22), (No) • Limits on when and where competitive foods may be sold beyond federal requirements (26), (No) • Some form of requirements for physical education for students (50), (Yes) • Passed legislation enabling schools to test students' BMI levels (16), (No) • Enacted legislation requiring screening students at risk of type 2 diabetes (2), (No) • Require schools to provide health education (48), (Yes) • Received CDC funds to support school-based, obesity reduction initiatives in 2006 (23), (No) <p>Nutrition info:</p> <ul style="list-style-type: none"> • 2006 School Health Practices and Policies Study (SHPPS) data illustrate the common availability of cookies (78%), soda (98%), and chips (69%) in secondary schools¹⁸ • SHPPS indicate that only 30-39% of the districts surveyed (n=538) require that schools prohibit junk foods in ala carte or vending venues; an additional 29% to 30% of districts recommend (but do not require) that schools do this.⁷ • The Changing Individuals' Purchase of Snacks study examined the effect of price reductions on sales of fresh fruits and vegetables in school cafeterias at 12 secondary schools in Minnesota- prices were reduced by 50% and results showed a 4-fold increase in fruit sales and 2-fold in vegetable sales¹⁹ 	<p>Snackwise® rating system</p> <ul style="list-style-type: none"> • Promote “Green” foods; limit “yellow” foods • Food for Thought (Kenyon College) curriculum that has developed a sustainable local food system through student research • Increase nutrition standards for a School Breakfast Program (SBP) and National School Lunch Programs (NSLP) • Implement BMI determination at schools and workplaces • Statewide menu-labeling law (i.e. NYC) • Price reduction on sales of fresh fruits and vegetables in school cafeterias • Develop policies that restrict marketing to children advertising/marketing of “low-energy dense foods and beverages” (i.e. similar to many European countries) • Mandate nutrition education standards • Implement Food for Thought curriculum at OSU and other Ohio universities • Require BMI assessments to be conducted at school-year start; incentives for overweight/obese students BMI improvements (reports to be sent to parents); possible requirement for nutrition education to these students/parents; also could incent employers to conduct BMI screenings for employees • Encourage the creation of pedestrian friendly communities that will facilitate more physical 		
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	<ul style="list-style-type: none"> • Only 28% of school districts have a formal policy in place that restrict advertising/marketing to students ²⁰ <ul style="list-style-type: none"> • Westerville schools implemented Snackwise system in 2007 <p>ODH: The rise in obesity rates during the past three decades is contributing to the increase in costly chronic diseases such as heart disease and diabetes, along with an unsustainable growth in healthcare costs. Many experts agree that the generation of children growing up today will live shorter lives than their parents.</p> <ul style="list-style-type: none"> • Chronic illnesses account for 75 cents of every dollar spent on healthcare and are responsible for seven out of every ten deaths in the country. These could be prevented through improved nutrition and physical activity • An investment of \$10 per person in primary prevention could result in a return in Ohio of over \$6.00 for every \$1.00 spent within five years. • The cost to business due to obesity-related health care in the U.S. is estimated to total \$15.4 billion. This does not include lost productivity or increased absenteeism. • The average annual health care costs for obese adults in the U.S. are 36 percent higher than for normal weight individuals. • Students who are healthier do better in school. 	<p>activity and can contribute to economic development. Neighborhoods without sidewalks or poor connectivity prohibit active living.</p> <ul style="list-style-type: none"> • Communities need community wide plans, coalitions and infrastructure to address challenges unique to their population. For example, policy changes or incentives to have local government lead community wide plans to help avoid duplication and maximize resources. • Policy changes that improve access to affordable and nutritious food will help people improve diets. For example, tax incentives for food operator to open in underserved areas. 		
<p>Part 1) Increase the percent of adults who receive</p>	<p>Part 1) In 2004, Ohio ranked 34th with a rate of 38.1%. COLON: Based on the 2004 BRFSS, Ohio</p>	<p>Part 1) Work with providers (physicians, hospitals, clinics, AAA’s, Depts. of Health, other “influencers” to</p>	<p>Part 1) HIT: ensure adequate IT resources for universal (non-punitive) claims data collection and reporting process to</p>	<p>Part 1) Track implementation of tactics (i.e., # of providers with EMR &</p>

<p>recommended screening and preventive care (targeted conditions: colon cancer, breast cancer, cervical cancer)</p>	<p>ranked 25th among states with a rate of 53.2% (age 50-64 = 45.3%, age 65+ = 63.3%, and age 50+ = 53.2%). The states median rate was 53.2%. BREAST: Based on the 2004 BRFSS, Ohio ranked 14th among the states with a rate of 80.0% (age 50-64 = 78.5%, age 65+ = 81.7%, and age 50+ = 80.0%). PAP: Based on the 2004 BRFSS, Ohio ranked 20th among states with a rate of 86.5%. The all states median was 86.0%.</p>	<p>encourage appropriate screening and prevention for targeted conditions Intervention</p> <p>Incorporate incentives (for patients and providers) for screenings and preventive care into programs and plans controlled by the State of Ohio, such as Medicaid, proposed SCI programs, state employee health plan, and state employee retirement systems and urge other payers to commit the same.</p>	<p>accurately assess access to and utilization of services. HIT: Personal and portable PHRs.</p> <p>Provider reimbursement: 1) Incorporate incentives in reimbursement for patients who are receiving preventive services. 2) Encourage coordination across payers so that providers experience the same incentives and standards for all patients; create partnerships across provider groups (primary care physicians, specialists, hospitals) to share information and incentives.</p> <p>Leveraging: See tactics for leveraging of state systems.</p>	<p>participating in reporting process).</p> <p>Assess performance via BRFSS over time.</p> <p>Review trend of the appropriate HEDIS metrics within NCQA-accredited health plans in the commercial and non-commercial populations.</p>
<p>Part 2) Assure that children and adults receive recommended and appropriate immunizations.</p>	<p>Part 2) Flu: according to 2006 BRFSS results, Ohio ranked 30th among states with reported coverage of 68.2% Pneumonia: According to 2006 BRFSS results, Ohio ranked 17th among states with reported coverage of 68.5% Childhood Vaccination Coverage: According to the CDC National Immunization Survey results for 2007, Ohio ranked 21st among states for the 4 DTP, 3 polio, 1 MMR, 3 Hib, 3 hepatitis B, and 1 varicella vaccine series. Ohio's rate is 77.7%, while the national rate is 77.4%</p>	<p>Part 2) Work with partners (WIC, private providers, clinics, local health departments, ODJFS, community-based organizations, places of worship, and non-profits organizations) to identify children and adults not currently being vaccinated.</p> <p>Continue to increase the number of providers enrolled in the Vaccines for Children program.</p> <p>Increase the number of providers receiving vaccine assessment and feedback reviews to decrease missed opportunities to vaccinate.</p> <p>Use educational campaigns and social marketing to reach vulnerable populations.</p> <p>Increase use of the statewide immunization registry to better track immunization usage and remind</p>	<p>HD: BRFSS oversampling of underserved communities WD: 1) Increase providers in primary care; increase use of physician extenders. 2) Incentive pay for practices with Health IT personnel.</p> <p>Part 2) HIT: Increase use of the statewide immunization registry to monitor vaccine usage, remind patients when vaccines are due. Work toward gaining support for registry legislation to require physician participation.</p> <p>Reduce state GRF vaccine cost by fully implementing delegation of authority in local health departments, use the immunization registry to reduce over-vaccination, encourage first-dollar coverage for vaccines.</p> <p>Recruit partners (e.g., Healthy Ohio) to</p>	<p>Part 2) Track implementation of tactics (i.e., # of partnerships created or providers accurately reporting to registry).</p> <p>Access performance via assessment visits, National Immunization Survey, and BRFSS results.</p> <p>Review trend of the appropriate HEDIS metrics within NCQA-accredited health plans in the commercial and non-commercial populations.</p>

		patients when vaccines are due.	<p>increase education about the need to vaccinate and vaccine safety. Increase access to vaccines through WIC and other providers.</p> <p>As above, maximize delegation of authority to increase the number of children able to access the federal Vaccines for Children program to reduce two-tiered systems in public clinics. Continue to adhere to the \$.40 cap on vaccine price differentials to maximize vaccine funding. Monitor vaccine usage and accountability in provider offices to minimize vaccine waste</p>	
<p>Preventing unintentional injuries with specific emphasis on:</p> <ul style="list-style-type: none"> • Reduce rates of fall-related injury among Ohio adults aged 65 and older. 	<ul style="list-style-type: none"> • 1 in 3 older adults will fall, and falls are recurrent. • Fall injury and death rates are increasing. • Fall injury and death rates are considerably higher for ages 65+. • 70% (\$830 million from '02-05) of inpatient charges for falls are among Ohioans 65+ • fall prevention programs for older adults are cost effective for insurance providers. >\$207 million in annual treatment charges for falls aged 65+ in OH. 	<p>Develop and offer comprehensive fall injury prevention program as part of health insurance benefit: a) Medical Management/Risk Assessment; b) Physical Activity and Exercise and C) Environmental Home Modification.</p> <p>Conduct <i>Fall screenings</i> to determine fall risk at physician offices, ERs, etc.</p> <p>Support EMS home visit programs.</p>	<ol style="list-style-type: none"> 1. Improve surveillance efforts – physicians ask older patients about previous falls – info. available in central registry. 2. Produce specialized fall prevention plans for patients based on screening info. Collected 3. Offer incentives to participate in fall prevention/physical activity programs. Reimburse physicians for enrolling patients in fall prev. programs 4. Home modifications (e.g., grab bars in bath tub) 5. Chronic disease, aging, physical activity partners 6. Medicare 	<ul style="list-style-type: none"> • Increase number of older adults enrolled in fall prevention programs. • Increase number of older adults engaged in physical activity programs. • Track BRFSS trends for fall prevalence • Decrease ER visit rates for falls
<ul style="list-style-type: none"> • Reduce death rates from unintentional poisoning among Ohioans aged 35-54. 	<ul style="list-style-type: none"> • Unintentional poisoning death rates increased 191% from 1999 to 2005 in Ohio – mostly due to prescription drugs. • Ohioans aged 35-54 are at the greatest risk for drug/ medication poisoning death. <p>Total cost of poisoning death \$1,658,821,200</p>	<ul style="list-style-type: none"> • New epidemic. 	<ol style="list-style-type: none"> 1. Improve poisoning surveillance – create poisoning registry – link controlled substance registry with poison data. 2. Monitor reimbursements for prescription drugs. 3. Offer incentives for physicians who identify and refer patients for substance abuse treatment. 	<ul style="list-style-type: none"> • Track Prescription drug use trends for use of controlled substances • Physician prescribing practices/use of controlled

<ul style="list-style-type: none"> • Reduce unintentional injury rates among Ohioans aged 1-19. <p>* Please note that these strategies represent the current injury prevention priorities at ODH.</p>	<ul style="list-style-type: none"> • Injury is the leading cause of death for Ohioans aged 1-19. • 61% of all deaths in this age range are caused by injury. • MV traffic death rates are particularly high for ages 15-19. <p>For every dollar spent on bike helmet, safety seat and smoke alarm, \$30, \$32 and \$69 are saved (respectively) in direct medical costs.</p> <p>The information in these bullet points is from the ODH-Office of Vital Statistics and the Ohio Hospital Association</p>	<p>Increase availability of Safety devices (car seats, helmets, smoke alarms, etc.) included as a health insurance benefit (like preventive medications & immunizations)</p>	<ol style="list-style-type: none"> 4. Make overdose prevention kits more available 5. Improve autopsy reporting to separate unintentional from intentional overdoses. <hr/> <ol style="list-style-type: none"> 1. Collect risk/preventive behavior data on injury at physician visits B. Develop individualized patient safety plans based on age and risk assessment 2. Reimbursement for safety devices/vouchers. 3. Reimburse physicians for counseling/educating about importance of safety devices/injury prevention. 4. Arrange quantity discounts in purchase of devices or discount voucher program. 5. Manufacturers, pediatricians 6. Medicaid –(see attached article re: cost effectiveness of CPS) 7. Pass a primary seat belt law in Ohio 8. Create uniform bicycle regulations throughout Ohio 9. Encourage adoption of Complete Streets policies in all Ohio cities. 10. Initiate a program to make bike helmets and car seats available for low income families.²³ 	<p>substances registry.</p> <ul style="list-style-type: none"> • Non-fatal “overdose” rates for drug poisoning. • Death rates for drug poisoning <hr/> <ul style="list-style-type: none"> • Increase use of safety devices (e.g., car seats, seat belts, bike helmets, smoke alarms, etc). • Decrease injury ER visits, hospitalizations and death rates for ages 1-34. • Increase number of localities with Complete Streets policies.
<p>Educate and inform all Ohioans on how to achieve wellness and prevent disease and injury.</p> <p>(Cecilia and Marjorie)</p>	<p>90 million Adults in the US are unable to adequately comprehend health information attributing 50-73 million dollars a year in healthcare costs to low health literacy. Health literacy is the degree which individuals have the capacity to obtain, process and understand basic health information and services to make appropriate health decisions. (US Department of Health and Human Services, National Institutes of Health, National</p>	<p>Targeted Populations:</p> <ol style="list-style-type: none"> 1. Early Childhood <ol style="list-style-type: none"> a. Health Related Program development b. Adequate related trainings c. Reverse marketing strategies 2. PreK-12/ Ohio Schools <ol style="list-style-type: none"> a. Standards-based instructions b. Coordinated approach to school health c. Expansion of opportunities 	<p>Varied see below</p>	<p>Varied see below</p>

	<p>Library of Medicine (NLM.)</p> <p>A 2000 study reports that only 2% of children aged 2-19 years of age meet the five main recommendations for a healthy diet from the Food Guide Pyramid.</p> <p>The 2005 National Survey for Children's Health reports Ohio 65.4 % of Ohio children ages 0-5 were breastfed, compared to the national average of 72.3%</p> <p>Immunizations of Ohio's 2 year olds (82%) are just below the national average of 83%</p> <p>54% of Ohio Children aged 3-5 are enrolled in nursery school, preschool or kindergarten</p>	<p>outside of the school day</p> <p>3. Adults aged 18-25</p> <ul style="list-style-type: none"> a. clear and concise information b. increased health literacy c. value of wellness <p>4. Aging Populations</p> <ul style="list-style-type: none"> a. optimal access to information and services <p>Early Childhood</p> <p>Develop a strategic planning collaborative to evaluate current and/or</p> <p>Draft additional comprehensive but attractive and engaging materials for child care providers, parents and children Birth to preK that provide a foundation for healthy behavior choices.</p> <p>Require at least "one" staff member of a state and private preK facility to have complete a nutrition education class</p> <p>Develop Early Childhood Physical Education/Physical Activity Standards and provide professional development to child care providers</p> <p>Restrict statewide TV advertisements, that promote foods lacking nutritional value and promote screen related activities, marketed towards this age group broadcast @ early childhood programs times (i.e. Sesame Street)</p> <p>Identify optimal point of intervention for increased awareness of long term benefits of breastfeeding.</p> <p>Create or revise informational breastfeeding materials and include</p>	<p>Leveraging Partnerships: strategic planning participants should include Ohio Family and Children First, Voices, Ohio Action For Healthy Kids, OAHPERD, Head Start, ODH, ODE, ODJFS etc.</p> <p>Partner with Children's Hospital Association, Ohio Academy of Pediatrics, ODJFS and local health agencies to communicate importance of materials and subject matter. Local community dietitians (WIC, Nationwide Children's Hospital)</p> <p>Addressing and reducing disparities: revise materials as needed to address cultural competency issues.</p>	<p>Pediatric BMI trends</p> <p># of Trained Child Care Staff in Nutrition and PE/PA standards</p> <p>Rate of Distribution of Materials</p> <p>% of Breastfeeding Mothers in Ohio equal to National</p> <p>Policy development</p>
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	<p>Ohio is the 48th state to adopt standards in physical education and is one of 6 states that have not adopted statewide health education standards.</p> <p>Ohio is one of two states without a health education coordinator in the Department of Education.</p> <p>While the national recommendation for physical education is 150 minutes for elementary and 225 minutes for middle and high school aged students per week. Ohio reports approximately 60 minutes a week for elementary and 80 minutes a week for MS.</p> <p>A 2000 study reports that only 2% of children aged 2-19 years of age meet the five main recommendations for a healthy diet from the Food Guide Pyramid.</p> <p>Between 1989 and 1996, children's calorie intake has increased by 80 to 230 extra calories per day. 3 of 4 high school students do not eat the recommended 5 or more servings of Fruits and Vegetables</p> <p>Ohio's high school aged population reports 55% inactivity levels (11% percent above the national average) and ranks 4th in overweight nationally.</p> <p>Ohio is one of 13 states that allows ALL high school physical education coursework to be exempted (marching band, cheerleading and athletics).</p>	<p>nutritional benefits as well as obesity prevention data.</p> <p>Statewide education certification in basic nutrition for pediatricians or nurse practitioners, DO's, etc.</p> <p>PreK-12 Public Education: State level oversight and enforcement of standards-based instruction in health and physical education with adequate supports including but not limited to:</p> <ol style="list-style-type: none"> 1. Instructional time equal to national recommendations, 2. Equipment and Adequate Facilities for optimal learning including design-build guidelines that support optimal use of space rather than multiple use of space and mandate at least \$2 of per pupil spending be secured for PE and HE equipment <p>Mandate Health and Physical Education Teachers be licensed/certified in subject area of instruction.</p> <p>Increase Coordinated Approach to School Health programs throughout Ohio's PreK-12 schools statewide that include all six School Health Components:</p> <ol style="list-style-type: none"> 1. Health Education 2. Physical Education 3. Health Services 4. Mental Health Services and Social Services 5. Nutrition Services 6. Faculty and Staff Health Promotion <p>Repeal all High School PE Substitution/ Exemption Policies</p> <p>Encourage shared use agreements to</p>	<p>Health information technology/ Value purchasing: leveraging Partnerships: State level coordination of instruction: ODE - Office of Safety, Nutrition and Health (through ODH coordinated efforts), and the ODE Office of Curriculum and Instruction</p> <p>Value purchasing: use of existing regional service delivery system to engage, train and support quality, up-to-date instructions.</p> <p>Addressing and reducing disparities: advocate, through social justice tenets, the need for all children to receive quality wellness instruction without concern for public school standing (i.e. academic emergency). When necessary, secure appropriations to address health disparities.</p> <p>Leveraging Partnerships: Incorporate Best Practices of related organizations including but not limited to SOPHE, NCHCEC, OAHPERD, AAHE, NASPE, PE4Life, etc.</p> <p>Leveraging Partnerships: Concentrated efforts that involve internal and external participation towards health promotion in the entire school environment</p> <p>Health information technology/ Leveraging Partnerships/ Addressing and reducing disparities: Use of the</p>	<p>Reported use of quality assessments: BMI, Fitnessgram, Other approved fitness level assessments</p> <p>Trends in YBRFSS</p> <p>Increased participation in School Health Index trainings, evaluations and scores</p> <p>50% of Schools participating in the Buckeye Best Awards From app. 25% in 2007-2008</p> <p>Add "wellness scores" to mandated public School Report Cards</p> <p>Policy developments to enforce statutory instruction mandates</p> <p>Increased number of National Board Certified Health and Physical Education teachers by 20%</p>
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	<p>90 million Adults in the US are unable to adequately comprehend health information attributing 50-73 million dollars a year in healthcare costs to low health literacy.</p>	<p>use school facilities for programming outside the school day with local agencies and recreation departments</p> <p>Encourage promotion of available after-school and recreation programming for all ages through school populations</p> <p>Adults aged 18-25</p> <p>Evaluate the avenues for health care used by 18-25 year old adults to direct messaging</p> <p>Create and distribute materials to young adults of the need to continue the lifelong continuum of understanding health information (i.e. health literacy)</p> <p>Require a statewide wellness/health literacy course for graduation from all Ohio's public universities and colleges</p> <p>Identify best practices for program implementation through SOPHE, NCHEC and CDC</p> <p>Aging Populations:</p> <p>Provide Ohio adults with resources to obtain basic health information that is easy to understand</p> <p>Provide assistance to aging Ohioans in making informed decisions about their health (educational materials and services)</p> <p>Locate existing programs through local agencies that increase physical activity, wellness programs and health literacy; encourage them to expand their programs to aging adults</p>	<p>education community to promote and provide opportunities for Health Literacy programs (i.e. school health fairs, family nights) Local community dietitians (WIC, Nationwide Children's Hospital)</p> <p>Health information technology/ Addressing and reducing disparities/ (7) Social Marketing Campaign using latest technologies to communicate need for healthy behavior choices and access to health literacy information</p> <p>Health information technology/ Leveraging Partnerships: Develop partnerships between OMA, Board of Regents, Inter-University Council and Association of Independent Colleges and Universities of Ohio as well as OAHPERD, OPRA, ODH and HO</p> <p>Health information technology: addressing and reducing disparities: Target populations and adjust technologies as appropriate based upon cultures, age and education levels.</p> <p>Health information technology: Retain traditional methods of communications, without respect to cost, to increase access to information.</p> <p>Leveraging Partnerships: Develop partnerships for increased success through ODA, AARP, OBRT, ODH, HO, OPRA, Ohio Hospital Association, OMA, etc. Local community dietitians (WIC, Nationwide Children's Hospital)</p>	<p>BRSS trends</p> <p>Track "Hits" on information sources</p> <p># of ER visits comparison from 2009-2013</p> <p>From 2009-2013: YRBSS trends Reduced ER visits Track Health Care costs</p> <p>Record Contacts to: ODA, ODH, Hotlines,</p> <p>Increased "medical home" usage</p> <p># of participants in recreation programs, mentor programs and other health related</p>
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		<p>Increase participation in mentor programs in Ohio’s public schools to create an inter-generational learning support towards optimal wellness</p> <p>Promote employer strategies that support worksite wellness programs including:</p> <ol style="list-style-type: none"> 1. health education 2. personal health assessment 3. on-campus biometric screenings 4. care coordination/ disease management 5. health coaching 6. worksite health fairs <p>Promote worksite wellness programs through Healthy Ohio Business Council and for state employees and recognize leaders in employee wellness support.</p>		<p>activities and programs.</p> <p>Increased participation in Healthy Ohio Business Council Awards</p>
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¹ Note: suggested tactics are examples only, derived from a general literature review and survey of other states' initiatives and policy brainstorming; further work is needed to (1) determine the extent to which these tactics are already under development or in progress in Ohio through, for example, the quality collaborative of the OHA, (2) probe the merit and viability of these tactics, and (3) assess which mix of tactics would work best in Ohio.

² Note: disparities could include, but are not limited to, the following examples: age, culture, disability, ethnicity, gender, geography, race, religion, and sexual orientation.

³ Note: suggested tactics are examples only, derived from a general literature review and survey of other states' initiatives and policy brainstorming; further work is needed to (1) determine the extent to which these tactics are already under development or in progress in Ohio through, for example, the quality collaborative of the OHA, (2) probe the merit and viability of these tactics, and (3) assess which mix of tactics would work best in Ohio.

⁴ Centers for Disease Control, Behavioral Risk Factor Surveillance System Survey Data (available at: <http://www.cdc.gov/brfss/>). All prevalence data were calculated from the Center for Disease Control's behavioral risk factor surveillance survey, which is a telephone health survey that asks respondents to self-report current smoking status

⁵ Doll et al. (2004). *BMJ*. 328(7455):1519.

⁶ Bunn et al. (2006). *J Occup Environ Med*. 48(10):1099-108.

⁷ Hodgson (1992) *Milbank Quarterly*, 70(1): 81-115.

⁸ Frieden et al. (2005). *American Journal of Public Health*. 95(6), pp. 1016-23

⁹ Centers for Disease Control, Behavioral Risk Factor Surveillance System Survey Data (available at: <http://www.cdc.gov/brfss/>). All prevalence data were calculated from the Center for Disease Control's behavioral risk factor surveillance survey, which is a telephone health survey that asks respondents to self-report current smoking status

¹⁰ Centers Taylor et al. *Am J Public Health*. 2002 Jun;92(6):990-6.

¹¹ Centers for Disease Control (available at: <http://www.cdc.gov/tobacco/>)

¹² Centers for Disease Control, Behavioral Risk Factor Surveillance System Survey Data (CDC BRFSS; available at: <http://www.cdc.gov/brfss/>). *Note this is a telephone health survey that asks respondents to self-report height and weight with obesity defined as a BMI over 30

¹³ Ogden et al. (2006). *JAMA Apr*;13(295):1549-1555

¹⁴ National survey of children's health (available at: <http://0-www.cdc.gov.mill1.sjlibrary.org/nchs/about/major/slaits/nsch.htm>)

¹⁵ Ricci and Chee. (2005). *Journal of Occupational and Environmental Medicine*. 47(12), 1227-34

¹⁶ Thomson Healthcare, *Obesity in the Workforce*.

¹⁷ *F as in Fat; How Obesity Policies are Failing in America, 2007*

¹⁸ School Health Practices and Policies Study. Center for Disease Control and Prevention Web site. <http://www.cdc.gov/HealthyYouth/shpps/index.htm>. Accessed September 16, 2008.

¹⁹ French SA. Pricing effects on food choices. *J Nutr*. 2003;133 (suppl):841S-843S.

²⁰ School Nutrition Operations Report: The State of School Nutrition 2007. Alexandria, VA: School Nutrition Association; 2007.

²¹ http://www.legislature.state.oh.us/bills.cfm?ID=127_HB_254_I

²² http://www.ohioactionforhealthykids.org/zone_teams/zone8.htm

²³ http://www.prnewswire.com/cgi-bin/micro_stories.pl?ACCT=159681&TICK=CHOP&STORY=/www/story/01-16-2008/0004737423&EDATE=Jan+16,+2008