SHIP

State Health Improvement Plan

Ohio 2020-2022

April 2020

Acknowledgments

The Ohio Department of Health (ODH) contracted with the Health Policy Institute of Ohio (HPIO) to develop this State Health Improvement Plan (SHIP).

ODH and HPIO are grateful to the members of the SHIP Steering Committee, Advisory Committee and work teams that contributed ideas and expertise to this project.

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Contents

Acronyms used in this report

Acronym	Meaning
6/18	U.S. Centers for Disease Control and Prevention 6/18 Initiative (targeting six common and costly health conditions with 18 proven strategies)
ACS	American Community Survey (U.S. Census Bureau)
AHR	America's Health Rankings
BRFSS	Behavioral Risk Factor Surveillance System
CDC	U.S. Centers for Disease Control and Prevention
CG	Community Guide
CHC	Creating Healthy Communities
Hi-5	CDC Health Impact in 5 Years initiative
HPIO	Health Policy Institute of Ohio
HRSA	Health Resources and Services Administration
KFF	Kaiser Family Foundation
KRA	Kindergarten Readiness Assessment
MHA	Mental Health America
NLIHC	National Low-Income Housing Coalition
NSCH	National Survey of Children's Health
NSDUH	National Survey on Drug Use and Health
ODA	Ohio Department of Aging
ODE	Ohio Department of Education
ODH	Ohio Department of Health
ODJFS	Ohio Department of Job and Family Services
OHA	Ohio Hospital Association
OHFA	Ohio Housing Finance Agency
OMHAS	Ohio Department of Mental Health and Addiction Services
OYTS	Ohio Youth Tobacco Survey
SACWIS	Statewide Automated Child Welfare Information System
SAMHSA	Substance Abuse and Mental Health Services Administration
USPSTF	U.S. Preventive Services Task Force
VS	Vital Statistics
WSIPP	Washington State Institute for Public Policy
WWFH	What Works for Health
YRBS	Youth Risk Behavior Survey

Looking for something?
Use "control F" on your keyboard to search the SHIP PDF document for specific terms.

Note: **Bold blue font** throughout text and graphics indicates clickable hyperlink.

Executive summary

What is the SHIP?

The State Health Improvement Plan (SHIP) is a tool to strengthen state and local efforts to improve health, well-being and economic vitality in Ohio. The SHIP's main components are:

- Six priorities including three factors and three health outcomes (see figure 1.2)
- Thirty-seven measurable objectives
- A menu of evidence-informed strategies
- An evaluation plan to track and report progress

With the long-term goal of ensuring all Ohioans achieve their full health potential, the SHIP takes a comprehensive approach to achieving equity and addressing the many factors that shape our health, including housing, poverty, education and trauma (see figure 1.2).

Why is the SHIP important?

The SHIP is Ohio's roadmap to address the many challenges identified in the **2019 State Health Assessment** (SHA), including a troubling drop in life expectancy from 2010 to 2017. Given the scope and complexity of Ohio's health challenges, the SHIP calls for cross-sector partnerships and alignment on a manageable set of measurable goals.

How was the SHIP developed?

Facilitated by the Health Policy Institute of Ohio (HPIO), under contract with the Ohio Department of Health (ODH), the SHIP was developed with input from hundreds of Ohioans through:

- Regional forums and an online survey completed in 2018 as part of the 2019 SHA (622 participants)
- Steering Committee made up of representatives from 13 state agencies, including sectors beyond health
- Advisory Committee with 176 participants, including subject matter experts from around the state who participated in work teams to set objectives and select strategies

How to get involved

- Visit the **SHIP page on the ODH website** and read the SHIP document
- If not already connected, reach out to the **local health department(s)**, **hospital(s)**, **ADAMH board** and/or community health improvement coalition in your area to find out how the SHIP is being implemented
- Identify SHIP priorities from figure 1.2 that align with your organizational or constituent priorities
- Use the SHIP to identify evidence-informed strategies that can impact these priorities (see parts 3-8 of this document)
- Partner with others to implement and evaluate SHIP strategies

How will the SHIP be implemented?

The SHIP is designed to be implemented by a wide range of public and private partners. The menu of objectives and strategies in the SHIP provides flexible options for rural, Appalachian, suburban and urban communities, as well as approaches to improve outcomes for Ohioans of all ages.

State and local partners

There are many partners at the state and local levels that contribute to achieving the vision of the SHIP, such as:

- State agencies and other statewide organizations
- Hospitals
- Local health departments
- Alcohol, Drug and Mental Health (ADAMH) boards
- Area Agencies on Aging
- Boards of developmental disabilities
- Community behavioral health providers
- Employers and workforce development organizations
- Housing organizations
- Medicaid managed care plans
- Philanthropy
- Schools
- Other local agencies and organizations

Public and private partners must row in the same direction to achieve the **SHIP vision: Ohio is a model of health, well-being and economic vitality**

1 Purpose and overview

What is the SHIP?

The **2020-2022 State Health Improvement Plan (SHIP)** is Ohio's roadmap to address the many challenges identified in the **2019 State Health Assessment (SHA)**. Given the scope and complexity of Ohio's health challenges, the SHIP calls for cross-sector partnerships and alignment to meet a manageable set of measurable goals.

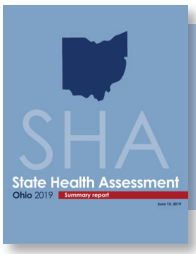
The SHIP is a tool to strengthen state and local efforts to improve health, well-being and economic vitality in Ohio. The SHIP's main components are:

- Six priorities including three factors and three health outcomes (see figure 1.2)
- Thirty-seven measurable objectives
- A menu of evidence-informed strategies
- An evaluation plan to track and report progress

The SHIP takes a comprehensive approach to achieving equity and addressing the many factors that shape our health.

What shapes our health and well-being?

There are many modifiable factors that influence overall health (see figure 1.1). These factors are sometimes referred to as the "social determinants of health" or the "social drivers of health." The SHIP addresses many of these drivers, including housing, poverty, education, health behaviors and healthcare access.



2019 State Health Assessment

- Focused on data
- Described current status
- Comprehensive

2020-2022 State Health Improvement Plan

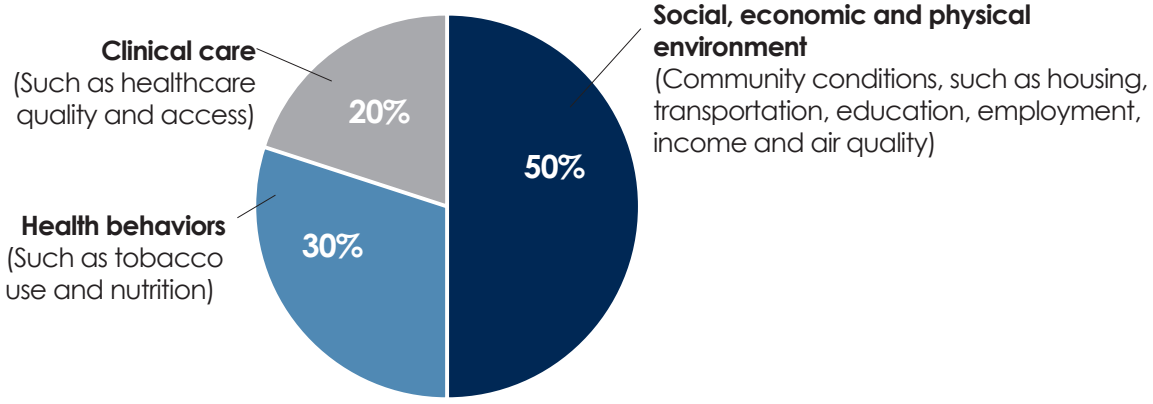
- Focused on outcomes and strategies
- Action-oriented plan for the future
- Prioritized

How will we know if health is improving in Ohio?

The SHIP's overall goal is that all Ohioans achieve their full health potential. To track progress toward this goal, the SHIP measures improved health status and reduced premature death for Ohioans, as well as 35 other measurable objectives across the six priorities (three factors and three health outcomes) listed in figure 1.2.

Data on the SHIP's objectives will be tracked and reported on an annual basis.

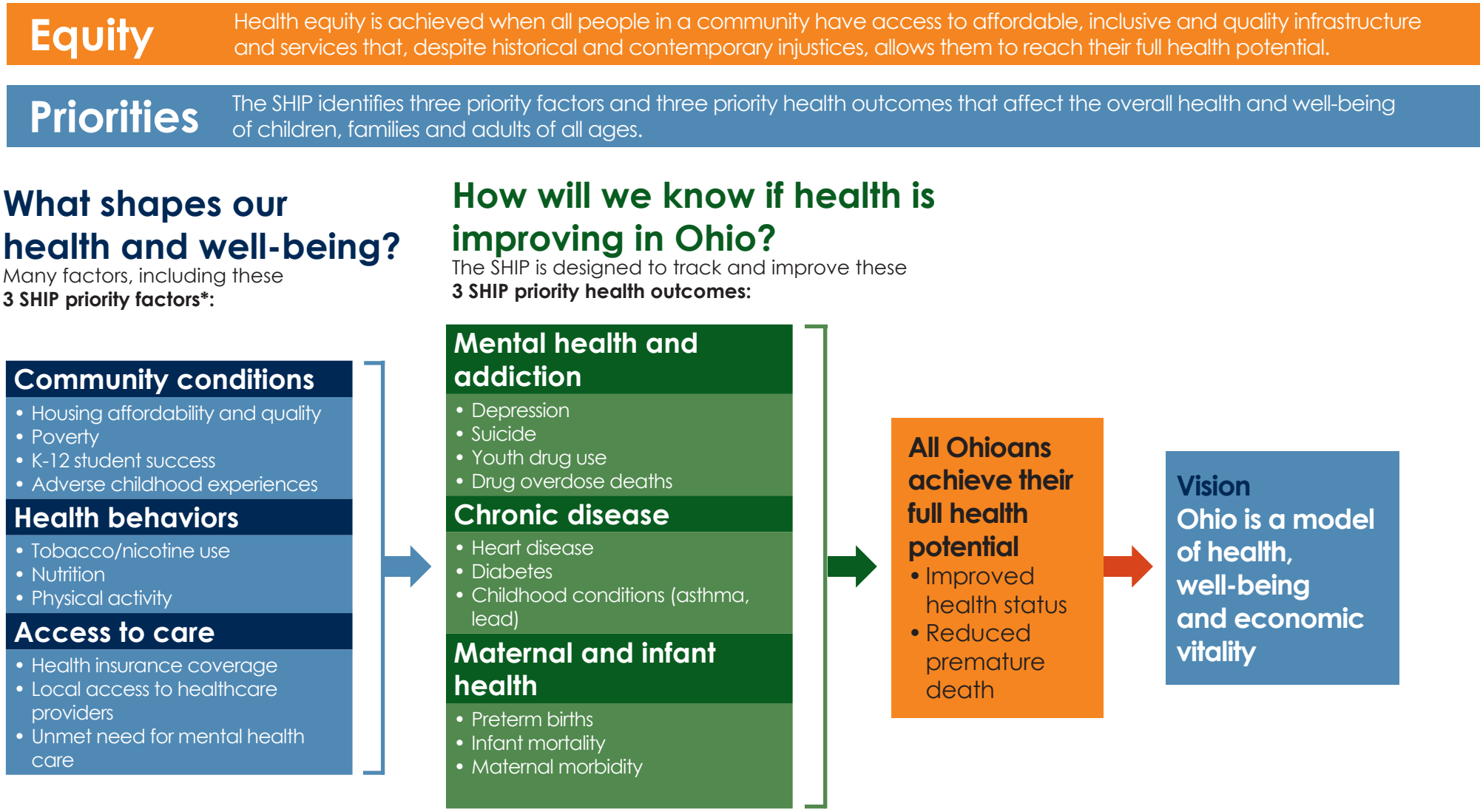
Figure 1.1. **Factors that influence health***



Underlying drivers of inequity such as poverty, racism, discrimination, trauma, violence and toxic stress

* These factors are sometimes referred to as the "social determinants of health" or the "social drivers of health."
Source: Booske, Bridget C. et. al. *County Health Rankings Working Paper: Different Perspectives for Assigning Weights to Determinants of Health*. University of Wisconsin Public Health Institute, 2010.

Figure 1.2. **SHIP framework**



* These factors are sometimes referred to as the social determinants of health or the social drivers of health

Stakeholder engagement

Facilitated by the Health Policy Institute of Ohio (HPIO), under a contract with the Ohio Department of Health (ODH), the SHIP was developed with input from hundreds of Ohioans through:

- Regional forums and an online survey completed in 2018 as part of the 2019 SHA (622 participants)
- Steering Committee made up of representatives from 13 state agencies, including sectors beyond health
- Advisory Committee with 176 participants, including subject matter experts from around the state who participated in work teams to set objectives and select strategies

ODH and HPIO have partnered to develop the SHIP in coordination with the Maternal and Child Health (MCH) services block grant and the Maternal, Infant and Early Childhood Home Visiting (MIECHV) needs assessments. Input from the MCH/MIECHV stakeholders—including an MCH/MIECHV Steering Committee and regional forum discussions on MCH topics—has resulted in strong alignment of priorities in the SHIP and the MCH assessment/plan.

See Appendix C for additional information about the stakeholder groups, including a list of organizations that participated in the Steering and Advisory Committees.

Implementation

ODH and other state agencies will use the SHIP to guide policy and funding decisions that support SHIP objectives.

In addition to state agencies, the SHIP is designed to be implemented by a wide range of public and private partners, such as **local health department(s)**; **hospital(s)**; **Alcohol, Drug and Mental Health (ADAMH) boards**; **Area Agencies on Aging**; **boards of developmental disabilities**; **philanthropy**; school districts; housing organizations; employers; and others. The menu of objectives and strategies in the SHIP provides flexible options for rural, Appalachian, suburban and urban communities, as well as approaches to improve outcomes for Ohioans of all ages.

The purpose of the SHIP is to get a wide range of public and private partners across the state rowing in the same direction to improve well-being. Local health departments and behavioral health providers, for example, can contribute to school district efforts to reduce chronic absenteeism by reducing asthma triggers and providing mental health early intervention services. Health systems can direct community benefit investments to support the goal of increasing affordable housing units. Working together, all partners can increase the effectiveness of their investments.

How to get involved

1. Identify SHIP priorities from figure 1.2 that align with your organizational or constituent priorities
2. Use the SHIP to identify evidence-informed strategies that can impact these priorities (see parts 3-8 of this document)
3. Partner with others to implement and evaluate SHIP strategies

How to use the SHIP document

The SHIP provides a long-term vision using a "big picture" framework (figure 1.2) and a concise set of top-line priorities. This document provides foundational tools for implementation, including measurable objectives and a menu of evidence-informed strategies. It is a roadmap, rather than a step-by-step implementation guide. Future materials from ODH may provide additional guidance.

The next four pages provide a description of four main components of the SHIP:

Equity

Health equity definition

Health equity is achieved when all people in a community have access to affordable, inclusive and quality infrastructure and services that, despite historical and contemporary injustices, allows them to reach their full health potential.[1]

Equity is often discussed in terms of disparities and inequities.

Disparities refer to avoidable differences in health outcomes that exist across communities. For example, this includes gaps in hypertension, infant mortality and life expectancy.

Inequities refer to differences in access to resources. For example, this includes gaps in outcomes related to access to health care; healthy foods; a job that pays a self-sufficient income; adequate, stable housing; and quality education.

Disparities and inequities indicate the cumulative impact of racism and discrimination over time. These gaps in outcomes are rooted in systemic, historic, unjust or racist structures, policies and norms within society.

How does the SHIP address equity?

The SHIP addresses equity in the following ways:

- **Priority populations:** These are groups of Ohioans with outcomes that are at least 10% worse than outcomes for Ohio overall, when disaggregated data is available. SHIP performance will be monitored for these groups. Resources should be allocated specifically to meet the needs of these communities in order to close gaps in outcomes over time.

- **Universal targets:** Most SHIP objectives include long-term targets that are the same for priority populations and Ohio overall. This reflects the goal of eliminating disparities and inequities within 10 years, recognizing that it will take time to achieve these goals.

- **Strategy selection:** Throughout the SHIP, this symbol = indicates strategies likely to reduce disparities and inequities based on a review by What Works for Health and/or the Community Guide. These sources consider potential impacts on disparities and inequities by racial/ethnic, socioeconomic, geographic or other characteristics. It is important to note that the evidence base on what works to decrease disparities is limited and evolving. Some strategies not identified as "likely to decrease disparities" may in fact be effective, especially if targeted, culturally adapted and tailored to meet the needs of priority populations.

- **Strategy implementation:** The SHIP is most likely to be successful in reducing disparities and inequities if:
  - Strategies are evidence-informed and targeted and tailored to communities where need is greatest
  - State and local partners directly address racism and discrimination

Relevant resources

- **Closing Health Gaps: Moving Towards Equity**, HPIO
- **Health Equity and Mobility Justice: Frequently Asked Questions**, ODH

Priorities

The SHIP framework (figure 1.2) outlines three **health factor priorities** in blue:

- **Community conditions**
- **Health behaviors**
- **Access to care**

The framework also outlines three **health outcome priorities** in green:

- **Mental health and addiction**
- **Chronic disease**
- **Maternal and infant health**

Within each of these priorities, there is a more specific set of desired outcomes. For example, within community conditions, there is a desired outcome to improve housing affordability and quality; and within mental health and addiction, there is a desired outcome to reduce depression.

These priorities were identified through a multi-step process involving input from hundreds of Ohioans and review of secondary data. The following informed the prioritization process:

- SHA: Regional forum small group discussions, online survey and analysis of secondary data for over 140 metrics
- Steering and Advisory committees: Small group discussions, online prioritization survey and work team webinar discussions and polling
- Input from state agency subject matter experts at ODH
- MCH/MIECHV Steering Committee discussions

See Appendix C for the topic prioritization criteria.

Priority factors*

1 Community conditions

- Housing affordability and quality
- Poverty
- K-12 student success
- Adverse childhood experiences

2 Health behaviors

- Tobacco/nicotine use
- Nutrition
- Physical activity

3 Access to care

- Health insurance coverage
- Local access to healthcare providers
- Unmet need for mental health care

* These factors are sometimes referred to as the social determinants of health or the social drivers of health.

Priority health outcomes

1 Mental health and addiction

- Depression
- Suicide
- Youth drug use
- Drug overdose deaths

2 Chronic disease

- Heart disease
- Diabetes
- Childhood conditions (asthma, lead)

3 Maternal and infant health

- Preterm births
- Infant mortality
- Maternal morbidity

Tracking progress with SMART objectives

Terms used in the SHIP

Objectives are statements describing a specific outcome to be achieved. Objectives include the following components:

- **Desired outcome.** A general statement about a desired result.
- **Indicator.** A specific metric or measure used to quantify an outcome, typically expressed as a number, percent or rate.
- **Baseline.** Data value for the current (or most-recently-available) year. Baseline data provides a comparison to measure against in the future.
- **Target.** A specific number that quantifies the desired outcome. The SHIP includes short-term (2022), intermediate (2025) and long-term (2028) targets.
- **Universal target.** For most objectives, long-term targets in the SHIP are the same for priority populations and Ohio overall. This reflects the goal of eliminating disparities and inequities within 10 years, recognizing that it will take time to achieve this goal.

The SHIP identifies 37 measurable objectives that will be tracked over time to assess Ohio's progress on improving health and well-being (see Appendix A for the complete list of indicators and notes on local data availability).

Objectives are statements describing a specific outcome to be achieved and are a tool for measuring progress over time in a way that fosters transparency, accountability and continuous quality improvement. The SMART objective framework is used to ensure that objectives are precise:

Specific
Measurable } **Indicator and source**

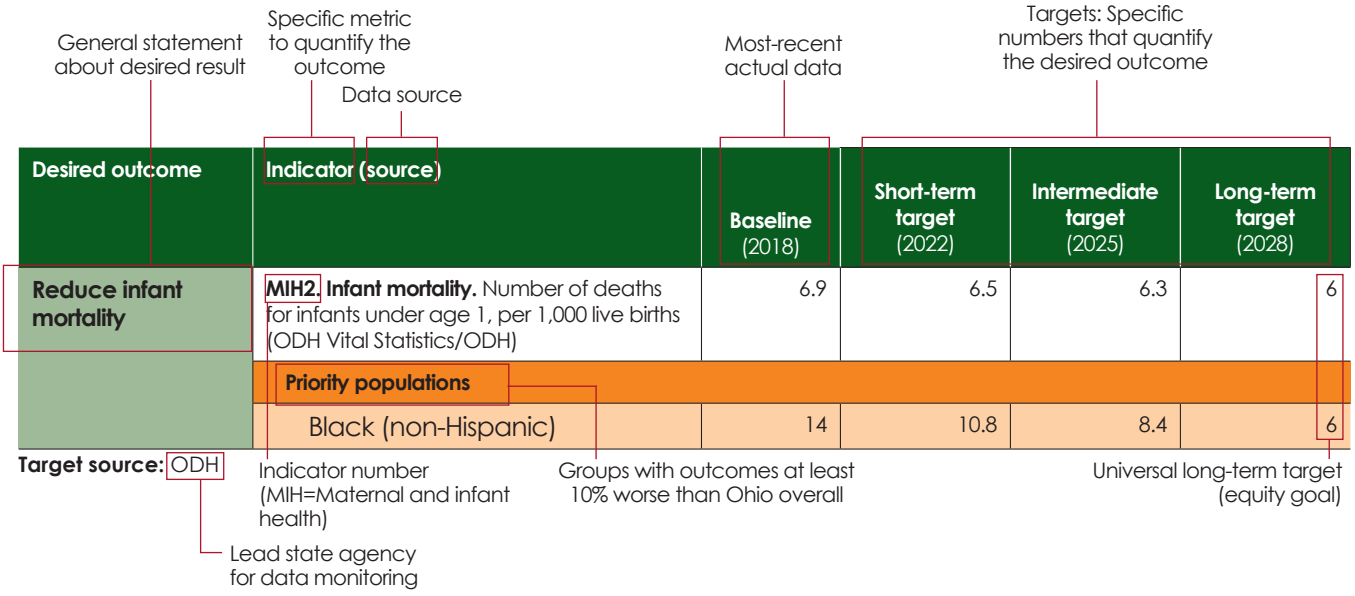
Achievable*
Realistic* } **Target data value**

Time-bound } **Baseline and target years**

*SHIP stakeholders recommended striking a balance between setting targets that are achievable/realistic and aspirational.

State agencies represented on the Steering Committee set the SHIP targets (see Appendix C for more information about the target-setting process). ODH will report annual performance on SHIP objectives. Annual progress reports will be used to foster shared accountability and identification of areas for continuous quality improvement and resource allocation. See Part 9 for a description of the evaluation plan.

SMART objective example



Strategies

Strategies are policies, programs or services. All strategies in the SHIP are evidence-informed, meaning that there is either rigorous research evidence showing that the strategy has achieved positive outcomes relevant to SHIP priorities, or there is information provided by subject matter experts that the approach is promising. If well-implemented, these strategies are likely to improve Ohio's performance on SHIP objectives. See Appendix C for strategy prioritization criteria and evidence sources, which were reviewed by HPIO as of August 2019.

In addition to implementation by state agencies, SHIP strategies will be implemented as part of community health improvement efforts led by local health departments, hospitals (using community benefit expenditures) and other community-based partners. SHIP strategies therefore focus on:

- **Primary prevention**, including upstream activities that address community conditions
- **Secondary prevention**, including screening and early intervention
- **Access to care**, including innovative settings or methods (such as school-based health care or telehealth)

Clinical care or treatment strategies are not included in the SHIP unless there is an emerging or unique unmet need within the healthcare system (e.g., clinical quality practices to reduce maternal morbidity).

Featured strategies

Strategies are listed in parts 3-8 of this report. In order to provide a more concise list of strategies, two to five strategies within most sections are identified as "featured strategies." HPIO worked with SHIP stakeholders to apply the criteria below to identify these strategies.

Required criteria. Featured strategies must have these characteristics:

- **Evidence rating**: Highly-rated by an evidence registry, indicating credible evidence of effectiveness[2]
- **Direct outcomes:** The strategy's demonstrated outcomes directly match the relevant SHIP indicator[3]

For a high-level compilation of SHIP strategies, see Appendix B, the **SHIP Strategy Quick Guide**.

Additional considerations. For some topics, there were a large number of strategies that met the above criteria. In these cases, the following considerations were used to narrow down the list of featured strategies:

- Strategy is likely to reduce disparities[4] (Note that this information is somewhat limited. Most strategies could potentially reduce disparities or inequities if well-implemented and targeted and tailored to the communities most in need.)
- Continuity with the **2017-2019 SHIP**
- Recommended by CDC's **Hi-5** and/or **6/18** initiatives
- Alignment with an existing plan, program or initiative
- Strongest evidence rating[5]
- Impacts multiple SHIP outcomes
- Opportunities given current status (highly relevant to Ohio policy landscape and specific unmet needs)
- Political feasibility and approval by the governor's office
- Logistical feasibility and cost
- Return on investment or cost-effectiveness (**WSIPP** consulted, when available)
- Potential magnitude of impact

Notes

1. "**Health Equity and Mobility Justice: Frequently Asked Questions**," ODH. Accessed Sept. 27, 2019.
2. Rated as "scientifically supported" or "some evidence" in WWFH, or recommended or highly-rated by other rigorous source (such as CG, USPSTF or Social Programs that Work)
3. In WWFH, the "expected beneficial outcome(s)" directly matches the relevant SHIP indicator
4. Rated "likely to decrease disparities" in WWFH or identified as an "equity strategy" in CG
5. Rated "scientifically supported" by WWFH (highest rating only)

2 Overall health and equity

The overall goal of the SHIP is that all Ohioans achieve their full health potential, as measured by improved health status and reduced premature death.

Health status

Self-reported health status is a widely-used measure of health-related quality of life. The health status objective is to reduce the percent of adults reporting fair or poor health from 18.9% in 2017 to 17% in 2028 (see figure 2.1). The groups highlighted in orange in figure 2.1 are the priority populations for the health status objective. These groups had health status outcomes that were at least 10% worse than Ohio overall at baseline.

Figure 2.1. **Health status objective**

Desired outcome	Indicator (source)	Baseline (2017)	Short-term target (2022)	Intermediate target (2025)	Long-term target (2028)
Improve overall health status	**OH1. Adult health status.** Percent of adults, ages 18 and older, with fair or poor health (BRFSS)	18.9%	18%	17.5%	17%
	Priority populations				
	Black, non-Hispanic	23.7%	20.7%	18.8%	17%
	Hispanic	23.4%	20.5%	18.7%	17%
	Adults, ages 55-64	24.4%	23.6%	22.8%	22%
	Adults, ages 65+	25.5%	24.7%	23.9%	23%
	Low-income (less than $15,000 annual household income)	45.1%	32.3%	24.7%	17%
	People with a disability	43.4%	31.4%	24.2%	17%
	Sexual and gender minorities	25.4%	21.6%	19.3%	17%

Target source: ODH

Premature death

Premature death refers to years of potential life lost (YPLL) before age 75, reflecting the burden of deaths that potentially could have been prevented. When calculating YPLL, every death occurring before age 75 contributes to the total number of years of life lost. For example, a person dying at age 25 contributes 50 years of life lost, whereas a person who dies at age 65 contributes 10 years of life lost.

Ohio's premature death rate due to unintentional injuries began to rise in 2010, primarily driven by drug overdose deaths. In 2015, unintentional injuries overtook cancer as the leading cause of premature death in Ohio. (See the **2019 SHA** for details.)

The premature death objective is to reduce YPLL from 8,227.2 in 2018 to 8,000 in 2028 (see figure 2.2). The groups highlighted in orange in figure 2.2 are the priority populations for this objective. These groups had premature death rates that were at least 10% worse than Ohio overall at baseline.

Figure 2.2. **Premature death objective**

Desired outcome	Indicator (source)	Baseline (2018)	Short-term target (2022)	Intermediate target (2025)	Long-term target (2028)
Reduce premature death	**OH2. Years of Potential Life Lost (YPLL) before age 75.** Years of potential life lost before age 75, per 100,000 population (age adjusted) (ODH Vital Statistics)	8,227.2	8,200	8,100	8,000
	Priority populations				
	Black, non-Hispanic	12,158.9	10,268.5	9,134.3	8,000
	Residents of Appalachian counties*	9,382.2	8,753.9	8,377	8,000
	Male	10,311.6	9,260.9	8,630.4	8,000

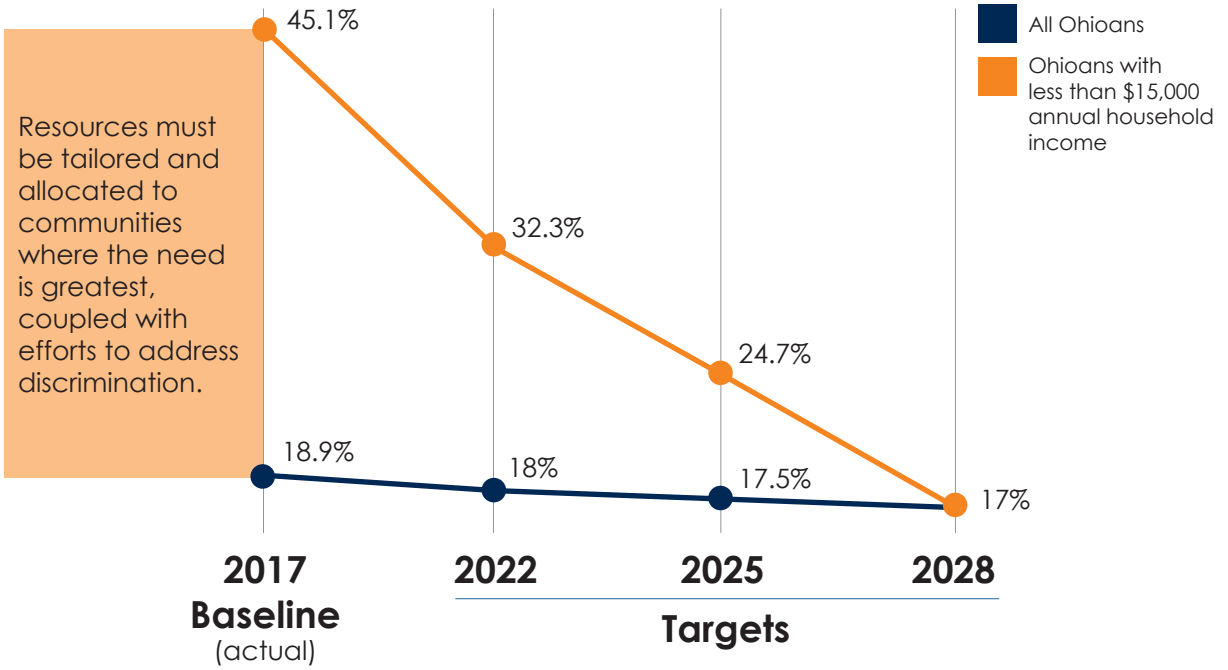
*County typology from the Ohio Medicaid Assessment Survey. See Appendix C for map of county types.
Target source: ODH

Equity: Universal targets and implications for SHIP implementation

As shown in figures 2.1 and 2.2, the long-term targets are the same for Ohio overall as for the priority populations. These universal long-term targets reflect the goal of eliminating disparities within 10 years.

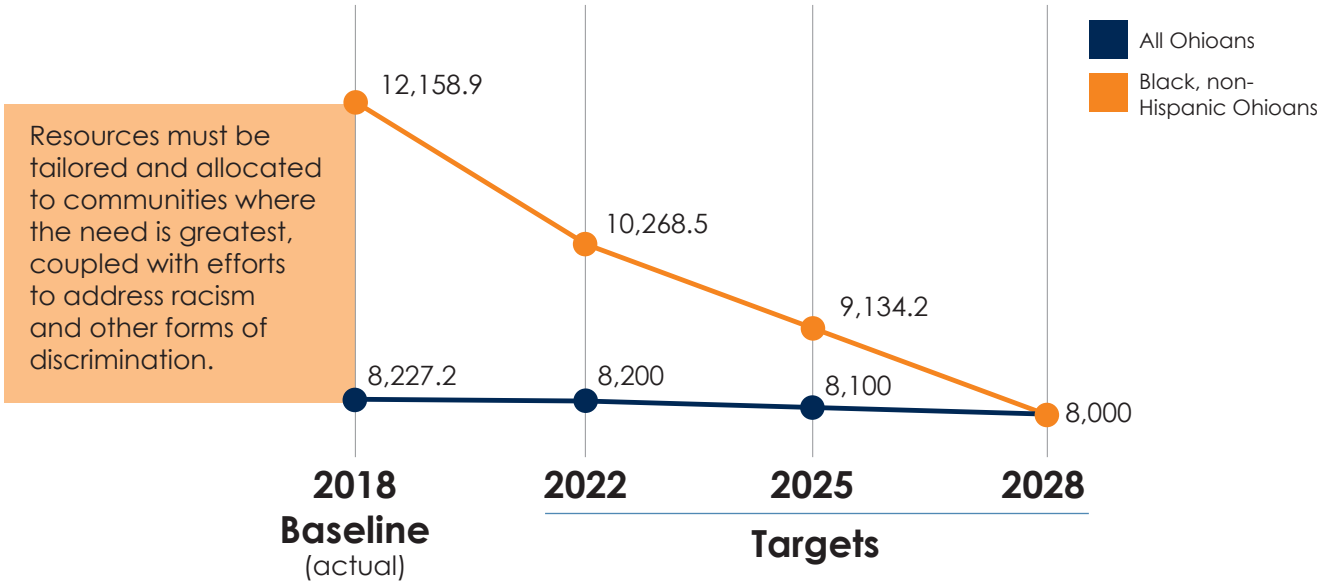
To achieve these universal long-term targets, the rate of improvement for priority populations must be aggressive. Figure 2.3 provides an example of what this looks like for the health status of Ohioans with low incomes, and figure 2.4 is an example for YPLL for black Ohioans.

Figure 2.3. **Universal target example: Percent of adults, ages 18 and older, with fair or poor health**



Data source: ODH Vital Statistics
Target source: ODH

Figure 2.4. **Universal target example: Years of potential life lost (YPLL) before age 75, per 100,000 population (age adjusted)**



Data source: ODH Vital Statistics
Target source: ODH

Equity: Priority populations throughout the SHIP

Priority populations are groups of Ohioans with outcomes that are at least 10% worse than outcomes for Ohio overall. SHIP performance will be monitored for these groups over time. Resources will need to be allocated specifically to address the needs of priority populations in order to meet SHIP targets.

Figure 2.5 lists the priority populations included in the SHIP. Orange shading indicates the groups identified as priority populations for each desired outcome. White shading indicates a priority population has not been identified because there were no groups with outcomes at least 10% worse than Ohio overall, disaggregated data is not available or groups were not specified due to lead state agency recommendation (see Appendix A for lead state agency). Note that some population categories vary by data source (such as black vs. African American).

Two limitations are important to note:

- Data is not available for some groups of Ohioans that may experience health disparities and inequities. Disaggregated data is often not available for groups such as sexual and gender minorities, veterans, immigrants and refugees and specific sub-populations.
- The magnitude of health disparities and inequities may not be fully captured in existing data. For example, Ohioans who are members of more than one group facing poor health outcomes, such as Ohioans of color who also have a disability, may experience larger gaps in outcomes than the data demonstrate.

Figure 2.5. **Priority populations in the 2020-2022 SHIP, by desired outcome**

Desired Outcome	Race/ ethnicity	Age	Income and education	Disability status	Geography*	Sex	Sexual orientation and gender identity
Improve overall health status	• Black, non-Hispanic • Hispanic	• Adults, ages 55-64 • Adults, ages 65+	Low-income (less than $15,000 annual household income)	People with a disability			Sexual and gender minorities
Reduce premature death	Black, non-Hispanic				Residents of Appalachian counties	Male	
Improve housing affordability and quality							
Reduce poverty	• Black (includes Hispanic and non-Hispanic) • Hispanic or Latino (any race)		Low educational attainment (less than a high school graduate)	• Children with a disability • Adults with a disability		Female	
Improve K-12 student success	• Black, non-Hispanic • Hispanic or Latino		• Economically disadvantaged • English Learners	Students with a disability			
Reduce adverse childhood experiences	• Black, non-Hispanic • Hispanic		Low income (household income below 200% FPL)	Children with special healthcare needs (CSHCN)			
Decrease tobacco/ nicotine use	• Black, non-Hispanic • Hispanic	• Adults, ages 25-34 • Adults, ages 35-44 • Adults, ages 45-54	Low-income (less than $15,000 annual household income)	People with a disability		Women who are pregnant**	Lesbian, gay, bisexual or transgender adults and students
Improve nutrition							
Increase physical activity	• Black (non-Hispanic) • Hispanic	Adults, age 65+	Low-income (less than $25,000 annual household income)	People with a disability			
Increase health insurance coverage	• Black (includes Hispanic and non-Hispanic) • Hispanic or Latino (any race)		• Income below 138% FPL • Income below 200% FPL			Male	

* County typology from Ohio Medicaid Assessment Survey. See Appendix C for map of county types.
** Selected based on Advisory Committee feedback (not 10% threshold)

Groups identified as priority populations (outcomes at least 10% worse than Ohio overall)

Priority population not identified (see page 15 for description)

Figure 2.5. **Priority populations in the 2020-2022 SHIP, by desired outcome** (cont.)

Desired Outcome	Race/ ethnicity	Age	Income and education	Disability status	Geography*	Sex	Sexual orientation and gender identity
Increase local access to healthcare services							
Reduce unmet need for mental healthcare							
Reduce depression							
Reduce suicide deaths	White, non-Hispanic	• Adults, ages 35-44 • Adults, ages 55-64			Residents of Appalachian counties	Male	
Reduce youth drug use	• Black students • Hispanic students					Female students	Gay, lesbian or bisexual students
Reduce drug overdose deaths		• Adults, ages 25-34 • Adults, ages 35-44 • Adults, ages 45-54			• Residents of Appalachian counties • Residents of urban counties	Male	
Reduce heart disease	Black, non-Hispanic	• Adults, ages 55-64 • Adults, ages 65+	Low-income (less than $15,000 annual household income)	People with a disability	Residents of Appalachian counties	Male	
Reduce diabetes	Black (non-Hispanic)	• Adults, 55-64 • Adults, 65+	Low-income (less than $15,000 annual household income)	People with a disability	Residents of Appalachian counties		
Reduce harmful childhood conditions	African American				Residents of high risk-zip codes (as defined in ODH data warehouse)		
Reduce preterm births	Black (non-Hispanic)	• Adults, ages 35-44 • Adults, ages 45+	Low educational attainment (no high school diploma)				
Reduce infant mortality	Black (non-Hispanic)	• Youth, ages 15-17 • Adults, ages 18-24 • Adults, ages 45-54			Residents of urban counties		
Reduce maternal morbidity/ mortality ***	• Black, non-Hispanic • Hispanic	• Women, ages 15-19 • Women, ages 35-39 • Women, ages 40-55			Residents of Appalachian counties		

* County typology from Ohio Medicaid Assessment Survey. See Appendix C for map of county types.
*** For severe maternal morbidity, women with Medicaid and other public coverage were also identified as a priority population.

3 Community conditions

Housing affordability and quality

Poverty

K-12 student success: Chronic absenteeism

K-12 student success: Kindergarten readiness

Adverse childhood experiences

See Part 1 for information on:

Equity

Priorities

Tracking progress with SMART objectives

Strategies

Housing affordability and quality

What shapes our health and well-being?

Lack of well-maintained and affordable housing contributes to a range of physical and mental health problems, including toxic and persistent stress and exposure to harmful contaminants such as lead and mold. High housing costs make it more difficult for families with low incomes to pay for other necessities, such as food and medical care, which also has a direct and negative impact on health.

Objectives

Ohio will use the following objectives to monitor progress toward improving housing affordability and quality. Local communities can select this indicator to evaluate their own community health improvement activities. There are no priority populations for this indicator (see page 15 for further explanation).

Indicator (source)	**Baseline** (2017)	**Short-term target** (2022)	**Intermediate target** (2025)	**Long-term target** (2028)
CC1. Affordable and available housing units (very low income). Number of affordable and available units per 100 renters with income below 50% of Area Median Income (very low income) (National Low-Income Housing Coalition analysis of the American Community Survey, as compiled by OHFA)	80	82.3	83.6	85

Target source: OHFA

Strategies

If well-implemented, the following evidence-informed strategies are likely to achieve the SHIP objectives for improving housing affordability and quality in Ohio.

Strategies▲	Includes
Rental assistance	• Expand affordable housing programs for the lowest-income renters, including the **Housing Choice Voucher Program (Section 8)*** 〓 ◦ Collaborate with state and local U.S. Department of Housing and Urban Development agencies to access local data and coordinate efforts to direct assistance to renters with lowest incomes ◦ Advocate for increased federal funding of rental assistance programs • Increase state investment in rental and housing assistance and housing solutions for Ohioans with low incomes**
Affordable housing development and preservation	• Maintain and increase incentives for affordable housing developers that partner with healthcare and social services agencies to leverage federal funding, such as the **Low-Income Housing Tax Credit** 〓 and **HOME Investment Partnerships***** 〓 for affordable housing development • Advocate for increased funding for **housing trust funds***** 〓 to provide gap financing for affordable housing development; see **Ohio Housing Trust Fund** • Advocate for local **inclusionary zoning and housing policies** to expand the areas where affordable housing can be built 〓 • Preserve and develop affordable housing in neighborhoods with increasing land values through **community land trusts** 〓, such as **The Land Trust Program** in Cleveland
Neighborhood improvements	• Develop and/or expand **land banking** 〓 programs • Prioritize **Community Development Block Grant (CDBG)** 〓 funding for neighborhood improvements and affordable housing development and preservation

▲ None of the strategies for this topic area met the criteria for featured strategies. These criteria are listed in Part 1 and Appendix C.
*Other affordable housing programs that have not been evidence-rated include HUD Multifamily Developments, Public Housing buildings and USDA Rural Development properties
For example, the Ohio Housing Finance Agency invested in **Healthy Beginnings at Home, a pilot project to research the impact of housing subsidies and other supports on birth, perinatal and infant health. Additionally, the Ohio Housing Trust Fund provides funding for housing repairs and homelessness solutions.
*** Rated "expert opinion" in WWFH
〓 = Likely to reduce disparities, based on review by WWFH, or health equity strategy in CG

Relevant resources

- **Ohio Housing Finance Agency (OHFA) 2020 Annual Plan**
- **OHFA Fiscal Year 2020 Housing Needs Assessment**
- **OHFA Qualified Allocation Plan**
- **Ohio Housing and Homelessness Collaborative Plan to End Homelessness**, Ohio Development Services Agency and the Ohio Department of Mental Health and Addiction Services
- **Ohio Housing Trust Fund Annual Reports and other information**

Poverty

What shapes our health and well-being?

Poverty negatively impacts health through neighborhood conditions, access to health care and opportunities to engage in healthy behaviors. Increased income allows greater access to high-quality education, nutritious food, safe housing and health insurance coverage. People living in poverty are also more likely to experience toxic and persistent stress, which can negatively affect health.

Objectives

Ohio will use the following objectives to monitor progress toward reducing poverty. Local communities can select these indicators to evaluate their own community health improvement activities. Priority populations refer to groups with outcomes worse than Ohio overall.

Indicator (source)	**Baseline** (2017)	**Short-term target** (2022)	**Intermediate target** (2025)	**Long-term target** (2028)
CC2. Child poverty. Percent of children, ages 17 and under, who live in households at or below the poverty threshold (ACS, 1-year estimates)	20.1%	Monitor only, no target		
Priority populations				
Black (includes Hispanic and non-Hispanic)	42.1%	Monitor only, no target		
Hispanic or Latino (any race)	34.3%	Monitor only, no target		
Children with a disability	33%	Monitor only, no target		
CC3. Adult poverty. Percent of adults, ages 18 and older, who live in households at or below the poverty threshold (ACS, 1-year estimates)	12.2%	Monitor only, no target		
Priority populations				
Black (includes Hispanic and non-Hispanic)	23.9%	Monitor only, no target		
Hispanic or Latino (any race)	22.4%	Monitor only, no target		
Low educational attainment (less than a high school graduate)	27.3%*	Monitor only, no target		
Adults with a disability	21.1%	Monitor only, no target		
Female	13.7%	Monitor only, no target		

*Adult poverty by educational attainment is for adults ages 25 and older, not ages 18 and older
Target source: ODJFS

Strategies

If well-implemented and targeted to meet the needs of priority populations, the following evidence-informed strategies are likely to achieve the SHIP objectives for reducing poverty in Ohio.

Featured strategies	Includes
Child care subsidies	• Child care subsidies (=) • Increase publicly funded child care eligibility to 150% of the Federal Poverty Level • Incentivize and support early childhood education programs to participate in Step Up to Quality and achieve high-quality ratings
Adult employment programs	• Post-secondary career-technical education (adult vocational training) (=) • Transitional jobs (=)
High school equivalency programs	• GED certificate programs (=) • High School Equivalency Test (HiSET) • Test Assessing Secondary Completion (TASC)

Additional strategies	Includes
Income support policies	
Local wage policies	• Living wage laws for local municipalities (=) • Voluntary living wage policies by private employers
Paid leave	Paid family leave (=)
Child and youth-focused programs	
Early childhood education programs **Hi-5**	• Publicly-funded pre-kindergarten programs (=) Specific evidence-based models include: • Early Head Start (=) • HighScope Perry Preschool model (=) • Chicago Child-Parent Centers (=)
Early childhood home visiting	Some home visiting programs have been evaluated to assess impact on family economic security. The links below provide additional information: • Early childhood home visiting programs (=) • Nurse-Family Partnership (NFP) (=)
Career training for high school students	• Career and technical education for high school graduation (=) • Career Academies (=) • Summer youth employment programs (=)
Strengthen Ohio's Comprehensive Case Management and Employment Program (CCMEP)	• Evaluate capacity of provider agencies and case managers and engagement of the target population • Evaluate alignment of performance standards and outcomes with the needs and abilities of program participants • Outreach to target population

(=) = Likely to reduce disparities, based on review by WWFH, or health equity strategy in CG; **Hi-5** = Health Impact in 5 years (CDC)

Additional strategies (cont.)	Includes
Adult training and employment programs	
Sector-based workforce initiatives	**Sector-based workforce initiatives** such as the ApprenticeOhio program through OhioMeansJobs 🟰
Financial literacy and wealth building initiatives	**Matched dollar incentives for saving tax refunds** 🟰
Housing and other programs	
Rental assistance programs	• **Housing Choice Voucher Program (Section 8)** 🟰 ◦ Collaborate with state and local U.S. Department of Housing and Urban Development agencies to access local data and coordinate efforts to direct assistance to renters with lowest incomes ◦ Advocate for increased federal funding of rental assistance programs • Increase state investment in rental assistance
Rapid re-housing programs	**Rapid re-housing programs** 🟰
Medical-legal partnerships	**Medical-legal partnerships** 🟰 (legal services integrated into healthcare settings to address patient concerns related to housing, food and utilities assistance, domestic violence and social services)

🟰 = Likely to reduce disparities, based on review by WWFH, or health equity strategy in CG; **Hi-5** = Health Impact in 5 years (CDC)

Relevant resources

- **A Roadmap to Reducing Child Poverty**, National Academies of Sciences, Engineering and Medicine
- **Rise Together: A Blueprint for Reducing Poverty in Franklin County**, Franklin County Board of Commissioners

K-12 student success: Chronic absenteeism

What shapes our health and well-being?

Chronic absenteeism refers to students missing at least 10% of school days in a year. Students who are chronically absent risk falling behind peers academically, especially in the first few years of schooling. Chronic absenteeism can hinder academic success and is an early warning sign of dropout from high school. Lower educational attainment is linked to many negative health outcomes, including diabetes, depression and poor overall health status.

Objectives

Ohio will use the following objectives to monitor progress toward reducing chronic absenteeism. Local communities can select this indicator to evaluate their own community health improvement activities. Priority populations refer to groups with outcomes worse than Ohio overall.

Indicator (source)	**Baseline** (2018-2019 school year)	**Short-term target** (2021-2022 school year)	**Intermediate target** (2024-2025 school year)	**Long-term target** (2027-2028 school year)
CC4. Chronic absenteeism (K-12 students). Percent of students, grades K-12, who are chronically absent (ODE)	16.7%	9.3%	6.1%	5%
Priority populations				
Black, non-Hispanic	31%	19%	14.9%	13.6%
Hispanic	21.2%	14.1%	11.1%	10.1%
Economically disadvantaged	25.8%	16.6%	13%	11.9%
Students with a disability	25.4%	16.9%	13.3%	12.1%

Target source: ODE

Strategies

If well-implemented and targeted to meet the needs of priority populations, the following evidence-informed strategies are likely to achieve the SHIP objectives for reducing chronic absenteeism in Ohio.

Featured strategies	Includes
Attendance interventions for chronically absent students	**Attendance interventions for chronically absent students** 🟰, including the specific interventions recommended by **Proving Ground**, an initiative of the Harvard University Center for Education Policy Research, prepared for the Ohio Department of Education
Social-emotional learning and positive behavior initiatives	• **School-based social and emotional instruction** • **Functional behavioral assessment-based interventions**
Middle and high school programs and policies that increase attendance	• **Career Academies** 🟰 • **Later middle and high school start times** 🟰

Additional strategies	Includes
Resilience programs for families with young children	• **Families and Schools Together** 🟰 • **Incredible Years** 🟰
School-based health support programs	• **School breakfast programs** 🟰 • **Active recess** • **School-based health centers**, which can offer a wide range of services, such as medical, vision, dental and mental healthcare services 🟰
Student mental health and positive behavior initiatives	• **School-wide Positive Behavioral Interventions and Supports (Tier 1)** 🟰 and Positive Behavioral Interventions and Supports (Tiers 2 and 3) • **Trauma-informed schools** 🟰
Middle and high school engagement strategies	• **Dropout prevention programs** 🟰 • **Success highways**
Housing strategies	• **Housing rehabilitation loan and grant programs** 🟰 **Hi-5** • **Rapid re-housing programs** 🟰 • **Weatherization Assistance Programs (WAP)** 🟰
Asthma management strategies	See asthma strategies on page 72

🟰 = Likely to reduce disparities, based on review by WWFH, or health equity strategy in CG; **Hi-5** = Health Impact in 5 years (CDC)

Relevant resources

- **Ohio's Every Student Succeeds Act (ESSA) state plan**, Ohio Department of Education (ODE)
- **Ohio's Strategic Plan for Education**, ODE
- **Ohio's Part C State Performance Plan**, Ohio Department of Health and Ohio Department of Developmental Disabilities Ohio
- **Proving Ground: Chronic absenteeism interventions list**, ODE partnership with the Harvard University Center for Education Policy Research
- **Ohio Perkins V Transition Plan**, ODE
- **Child Care and Development Fund Plan for Ohio (FFY 2019-2021)**, ODJFS
- **Ohio's Plan to Improve Learning Experiences and Outcomes for Students with Disabilities**, ODE (in progress)
- **Family First Prevention Services Act prevention plan**, ODJFS (in progress)

K-12 student success:
Kindergarten readiness

What shapes our health and well-being?

Children who come to kindergarten unprepared are at a disadvantage for future academic success. Lower educational attainment is linked to many negative health outcomes, including diabetes, depression and poor overall health status. High-quality early childhood education can counteract harms and stressors that negatively affect children.

Objectives

Ohio will use the following objectives to monitor progress toward improving kindergarten readiness. Local communities can select this indicator to evaluate their own community health improvement activities. Priority populations refer to groups with outcomes worse than Ohio overall.

Indicator (source)	**Baseline** (2018-2019 school year)	**Short-term target** (2021-2022 school year)	**Intermediate target** (2024-2025 school year)	**Long-term target** (2027-2028 school year)
CC5. Kindergarten readiness. Percent of kindergarten students demonstrating readiness (entered kindergarten with sufficient skills, knowledge and abilities to engage with kindergarten-level instruction) (KRA)	40.9%	Monitor only, no target		
Priority populations				
Economically disadvantaged	27.2%	Monitor only, no target		
Students with a disability	14.4%	Monitor only, no target		
English learners	17.5%	Monitor only, no target		

Target source: ODE

Strategies

If well-implemented and targeted to meet the needs of priority populations, the following evidence-informed strategies are likely to achieve the SHIP objectives for improving kindergarten readiness in Ohio.

Featured strategies	Includes
Early childhood home visiting	• Early childhood home visiting programs (=) • Nurse-Family Partnership (NFP) (=) • Healthy Families America (HFA)* (=) • Parents as Teachers (PAT) (=)
Early childhood education	• Publicly-funded pre-kindergarten programs (=) Hi-5 • Preschool education programs (=) Hi-5 • Early Head Start (EHS) (=) • Smart Start North Carolina (=)
K-12 and family resilience	Families and Schools Together (=)

Additional strategies	Includes
Preschool and child care quality	Preschool and child care quality rating and improvement system (QRIS) (referred to as Step Up to Quality in Ohio)
Parenting and family resilience programs	• Incredible Years (=) • Group-based parenting programs • Father involvement programs (=)

(=) = Likely to reduce disparities, based on review by WWFH, or health equity strategy in CG; **Hi-5** = Health Impact in 5 years (CDC)
* The research evidence for Healthy Families America does not show direct outcomes for increased school readiness, improved cognitive skills or improved child development. The expected beneficial outcome in WWFH is improved parenting.

Relevant resources

- Ohio's Every Student Succeeds Act (ESSA) state plan, Ohio Department of Education (ODE)
- Ohio's Strategic Plan for Education, ODE
- Ohio's Part C State Performance Plan, Ohio Department of Health and Ohio Department of Developmental Disabilities
- Child Care and Development Fund Plan for Ohio (FFY 2019-2021), ODJFS
- Ohio's Plan to Improve Learning Experiences and Outcomes for Students with Disabilities, ODE (in progress)
- Family First Prevention Services Act prevention plan, ODJFS (in progress)
- Heckman: The Economics of Human Potential

Adverse childhood experiences

What shapes our health and well-being?

Adverse childhood experiences (ACEs) are strongly linked to the development of a wide range of physical health, mental health and addiction problems, such as diabetes, depression, alcohol and other drug use and premature death. ACEs include a child's exposure to family dysfunction, violence in the home or neighborhood and living in a family with financial hardship. As the number of ACEs a child is exposed to increases, so does his or her risk for poor health outcomes.

Objectives

Ohio will use the following objectives to monitor progress toward reducing ACEs. Priority populations refer to groups with outcomes worse than Ohio overall.

Indicator (source)	**Baseline** (2016-2017)	**Short-term target** (2022)	**Intermediate target** (2025)	**Long-term target** (2028)
CC6. Adverse childhood experiences (ACEs). Percent of children, ages 0-17, who have experienced two or more adverse experiences (NSCH)	25.1%	Monitor only, no target		
Priority populations				
Black, non-Hispanic	41.6%*	Monitor only, no target		
Hispanic	30.6%*	Monitor only, no target		
Low-income (household income below 200% FPL)	39.3%	Monitor only, no target		
Children with special health care needs (CSHCN)	41.6%	Monitor only, no target		
Indicator (source)	**Baseline** (2018)	**Short-term target** (2022)	**Intermediate target** (2025)	**Long-term target** (2028)
CC7. Child abuse and neglect. Number of screened-in reports of child abuse and/or neglect, per 1,000 children in the population** (SACWIS, via ODJFS)	43.5	Monitor only, no target		

*Estimate should be interpreted with caution: estimate has a 95% confidence interval width exceeding 20 percentage points or 1.2 times the estimate and may not be reliable (per National Survey of Children's Health)

**Data represents the count of Distinct Alleged Child Victim (ACV) and Child Subject of Report (CSR) for Child Abuse and Neglect Reports received in calendar year 2018. Ohio uses a Differential Response model, which allows reports of potential child abuse or neglect to be processed through the Traditional Pathway or an Alternative Response Pathway. This data includes reports that are "screened-in" to either pathway, indicating a potential case of child abuse or neglect.

Target source: ODJFS

Strategies

The National Survey of Children's Health includes the following adverse experiences in its ACEs indicator. The table below crosswalks each ACE to the section of the SHIP where it is being addressed.

Adverse childhood experience (ACE)	Section of SHIP framework where ACE is addressed
Income hardship	Poverty (community conditions)
Divorce or separation	No evidence-informed strategies identified in the evidence registries consulted (see Appendix C)
Parent/guardian death	Premature death (overall health)
Parent/guardian served time in jail	Adverse childhood experiences (this section, within community conditions)
Witness of domestic violence	Adverse childhood experiences (this section, within community conditions)
Victim of violence or witness of violence in neighborhood	Adverse childhood experiences (this section, within community conditions); see below for information on child abuse and neglect
Lived with anyone experiencing mental health issues	Mental health and addiction
Lived with anyone abusing drugs	Mental health and addiction
Treated or judged unfairly due to race/ ethnicity	No evidence-informed strategies identified in the evidence registries consulted (see Appendix C)

Blue shading = outcome is addressed in this section of the SHIP

Strategies that have positive outcomes for reducing child abuse and neglect but that do not impact another ACE (e.g., incarceration, domestic violence, neighborhood violence) are not included in this inventory. SHIP partners seeking to decrease child maltreatment should align with strategies included in the Ohio Department of Job and Family Services federal Family First Prevention Services Act Prevention Plan. The plan is currently under development and will include evidence-based practices to prevent foster care placement and improve child welfare outcomes.

If well-implemented and targeted to meet the needs of priority populations, the following evidence-informed strategies are likely to achieve the SHIP objectives for reducing exposure to ACEs in Ohio.

For a crosswalk of specific ACEs that are likely to be impacted by each strategy, see the **HPIO website**.

Featured strategies	Includes
Early childhood home visiting	• Early childhood home visiting programs (=) • Nurse-Family Partnership (NFP) (=)
Parenting, mentorship and school-based prevention	• School-based violence and bullying prevention programs Hi-5 • Big Brothers Big Sisters (BBBS) (=)
Supports for system-involved children and youth	• Multisystemic Therapy (MST) for juvenile offenders • Functional Family Therapy (FFT)
Violence prevention and crime deterrence	• Cure Violence Health model (=) • Focused deterrence strategies (=) • Mentoring programs: delinquency (=)
Neighborhood conditions	Alcohol outlet density restrictions

(=) = Likely to reduce disparities, based on review by WWFH, or health equity strategy in CG; **Hi-5** = Health Impact in 5 years (CDC)

Adverse childhood experiences

Additional strategies	Includes
Parenting and early childhood education	
Early childhood education programs Hi-5	• Preschool education programs (=) • Early Head Start (EHS) (=) • Chicago Child-Parent centers (=) • HighScope Perry Preschool Model (=) • Preschool programs with family support services (=)
School-based	
K-12 school-based strategies	• School-based social emotional instruction Hi-5 • Extracurricular activities for physical activity Hi-5 • School-based intimate partner violence prevention programs Hi-5 • Promise Academy Charter Schools (=)
Employment	
Career training for high school students	• Career and technical education for high school graduation (=) • Summer youth employment programs (=) • Youth peer mentoring
Adult employment readiness	• Post-secondary career-technical education (adult vocational training) (=) • Transitional jobs (=) • GED certificate programs (=)
Law enforcement, criminal justice and firearm access	
Recidivism reduction strategies	• Cognitive-behavioral therapy (CBT) for offenders • Restorative justice in the criminal justice system • Specialized dockets, such as drug courts
Firearm access strategies	• Limit access to firearms for children and people who do not have the legal rights to possess firearms
Law enforcement and policing	• Hot spot policing • Community policing • Neighborhood watch
Community-based	
Foster care and child support	• Treatment Foster Care (and Treatment Foster Care Oregon) • Safe and Together Model
Built environment strategies	• Housing Choice Voucher Program (Section 8) (=) ◦ Collaborate with state and local U.S. Department of Housing and Urban Development agencies to access local data and coordinate efforts to direct assistance to renters with lowest incomes ◦ Advocate for increased federal funding of rental assistance programs • Community gardens • Complete Streets and streetscape design initiatives Hi-5 • Green space and parks (=) • Low Income Housing Tax Credits (LIHTCs) (=) Hi-5 • Zoning regulations for land use policy
Alcohol access strategies	• Alcohol day of sale restrictions (=) • Responsible beverage server training
Healthcare system	
Screening for intimate partner violence	Healthcare screening and follow-up for intimate partner violence

(=) = Likely to reduce disparities, based on review by WWFH, or health equity strategy in CG **Hi-5** = Health Impact in 5 years (CDC)

Relevant resources

- Maternal and Child Health Block Grant State Action Plan, Ohio Department of Health (ODH) (in progress)
- Maternal, Infant and Early Childhood Home Visiting Needs Assessment, ODH (in progress)
- Family First Prevention Services Act Prevention Plan, Ohio Department of Job and Family Services (in progress)
- **Title IV-E Prevention Services Clearinghouse**, U.S. Office of Planning, Research and Evaluation
- **California Evidence-Based Clearinghouse for Child Welfare**
- **Violence prevention technical package: Intimate partner violence**, U.S. Centers for Disease Control and Prevention (CDC)
- **Violence prevention technical package: Youth violence**, CDC
- **Violence prevention technical package: Sexual violence**, CDC
- **Placing Black Girls at Promise: Rise Sister Rise**

Ohio's response to improve community conditions

Youth Homelessness
The Ohio Department of Health is excited to expand its work addressing the social determinants of health through a $5 million appropriation for youth homelessness services from Governor Mike DeWine's budget for state fiscal years 2020-2021. This funding is being allocated to up to 15 community partners throughout the state to address or prevent homelessness among youths and young adults between 14 and 24, and pregnant or parenting youths and young adults up to 24 years of age. In ODH's first targeted effort on "housing as health," all funded partners will work with youths in their service areas to provide or coordinate housing, education and/or employment opportunities, physical and behavioral health services, and the formation of permanent community connections.

Home Visiting: Poverty and Adverse Childhood Experiences
As part of Governor Mike DeWine's "Opportunity for Every Ohio Kid" plan, he committed to expanding evidence-based home visiting services to triple the number of families being served. Through the biennial budget process, ODH received a $30 million increase to Help Me Grow Home Visiting funding, moving the investment from $19 million in SFY 18 to $30 million in SFY 20 and $39 million in SFY 21. This allows ODH to increase the number of families served by 68%. Additionally, the new funding allowed ODH to stabilize the provider network by increasing the rates on January 1.

Home Visiting: K-12 School Readiness
Evidence-based home visiting works with families to promote positive child growth and development through the use of on-going developmental screenings and activities for parents to complete with their babies to enhance social, emotional, physical and cognitive development. These activities are shared and modeled through the enrollment based on the age and developmental needs of each individual child. Additionally, home visitors, at the time that a family is graduating or exiting from the program, works with families to obtain additional early childhood programming that will continue to prepare their children for kindergarten entry.

Child Care
Quality childcare can set children up for a lifetime of success, especially our most vulnerable children. The state operating budget invested more than $99 million annually to improve the quality of Ohio's childcare system. Funding is targeted to help recruit qualified teachers, while also giving children living at or below 130 percent federal poverty level equal access to quality childcare settings. Additionally, there was a one-time, $10 million investment to help childcare providers become Step Up to Quality rated. Step Up to Quality is a five-star quality rating and improvement system that recognizes and promotes learning and development. As of December 2019, 86% of Ohio providers are Step Up to Quality rated.

Student Wellness
Kids today are facing unprecedented challenges at home that come with them into the classroom, creating challenges for both students and teachers. The operating budget included a brand-new funding stream called Student Wellness and Success. This $675 million fund can be used to support student health, mental wellbeing, and academic success by providing schools with the financial resources to embed mental health counseling, physical health services, mentoring, after-school programs, and much more into their school buildings. As a result, schools will have more support and students will be better equipped for a brighter future.

4 Health behaviors

Tobacco/nicotine use

Nutrition

Physical activity

See Part 1 for information on:

Equity

Priorities

Tracking progress with SMART objectives

Strategies

Tobacco/nicotine

What shapes our health and well-being?

Tobacco use and secondhand smoke exposure contribute to many of Ohio's greatest health challenges, including cancer, infant mortality, heart disease and asthma. In recent years, there has been a surge in e-cigarette use (vaping) among youth in the U.S., raising concerns about future addiction to nicotine and other drugs.

Objectives

Ohio will use the following objectives to monitor progress toward reducing tobacco and nicotine use. Priority populations refer to groups with outcomes worse than Ohio overall.

Indicator (source)	**Baseline** (2017)	**Short-term target** (2022)	**Intermediate target** (2025)	**Long-term target** (2028)
HB1. Adult smoking. Percent of adults, ages 18 and older, that are current smokers (BRFSS)	21.1%	20.1%	19.6%	19%
Priority populations				
Black, non-Hispanic	24.6%	22.1%	20.5%	19%
Hispanic	24.4%	21.9%	20.5%	19%
Adults, ages 25-34	27.5%	23.6%	21.3%	19%
Adults , ages 35-44	27.8%	23.8%	21.4%	19%
Adults, ages 45-54	25.2%	22.4%	20.7%	19%
Low-income (less than $15,000 annual household income)	41.1%	31.1%	25%	19%
People with a disability	30.8%	25.4%	22.2%	19%
Sexual and gender minorities	31.9%	26%	22.5%	19%
Women who are pregnant*	13.8%	10.1%	8.7%	8.3%

Indicator (source)	**Baseline** (2019)	**Short-term target** (2021)	**Intermediate target** (2025)	**Long-term target** (2029)
HB2. Youth all-tobacco/nicotine use. Percent of high school students who have used cigarettes, smokeless tobacco (i.e. chewing tobacco, snuff or dip), cigars, pipe tobacco, hookah, bidis, e-cigarettes or other vaping products during the past 30 days (OYTS)	35.6%	34.5%	32.3%	30.3%
Priority populations				
Gay, lesbian or bisexual students	43.9%	41.2%	35.8%	30.3%

Target source: ODH
* Selected based on Advisory Committee feedback (not 10% threshold)

Tobacco/nicotine

Strategies

If well-implemented and targeted to meet the needs of priority populations, the following evidence-informed strategies are likely to achieve the SHIP objectives for reducing tobacco and nicotine use in Ohio. Although the tobacco indicators are for adults and high school students, prevention strategies will be most effective if directed at young Ohioans in grades K-12.

Featured strategies	Includes
General tobacco control and prevention	
Increase the unit price of tobacco products Hi-5	• Revise Ohio's **minimum price law to prohibit use of price discounting tactics**
Smoke-free policies Hi-5	• **Smoke-free policies for indoor areas** (including enforcement of Ohio's smoke-free workplace law) • Smoke-free policies for multi-unit housing and schools, including colleges and universities
Mass media campaigns against tobacco use Hi-5	**Mass media campaigns against tobacco use** and second-hand smoke exposure
Tobacco cessation	
Tobacco cessation access 6/18	• **Tobacco cessation therapy affordability** (=) • **Health care provider reminder systems for tobacco cessation** (=) • Telephonic tobacco cessation programs (**tobacco quitlines** and **text message-based health interventions**)

Additional strategies	Includes
General tobacco control and prevention	
Tobacco 21	• Continue to enforce Ohio's statewide Tobacco 21 law (**minimum tobacco age laws**) • Implement **model Tobacco 21 ordinances**, including enforcement, at the local level
School-based tobacco prevention and evaluation initiatives	• **School-based tobacco prevention skill-building programs** • **Encourage schools to participate in the Youth Risk Behavior Survey/Ohio Youth Tobacco Survey** • **Ensure all youth tobacco prevention policies and programs include emphasis on e-cigarettes/nicotine addiction**
Tobacco marketing restrictions	• **Tobacco marketing restrictions** • Limit youth exposure to marketing of flavored nicotine products
Smoke-free policies for outdoor areas	**Smoke-free policies for outdoor areas**
Healthcare system	
Tobacco cessation tailored for specific populations	Intensive tobacco/nicotine cessation services tailored for the following groups: • **Pregnant women and women of childbearing age** • **People with behavioral health conditions** • **Parents of children with asthma** • **People with disabilities** • **Youth (including focus on e-cigarette cessation)**

(=) = Likely to reduce disparities, based on review by WWFH, or health equity strategy in CG; **Hi-5** = Health Impact in 5 years (CDC); **6/18** = included in CDC's 6/18 initiative (targeting six common and costly health conditions with 18 proven interventions)

Relevant resources

- **2016 Surgeon General's Report: E-Cigarette Use Among Youth and Young Adults**
- Tobacco-Free Ohio Alliance strategic plan (currently in development)
- **Best Practices for Comprehensive Tobacco Control Programs — 2014**, Centers for Disease Control and Prevention
- **Public Health Consequences of E-Cigarettes**, National Academies of Sciences, Engineering, and Medicine

Nutrition

What shapes our health and well-being?

Poor nutrition contributes to many of Ohio's greatest health challenges, including heart disease, diabetes and infant mortality. Nutritious food promotes healthy child development, student success and healthy aging, and communities with good access to affordable, healthy food support improved health outcomes across the life course.

Objectives

Ohio will use the following objectives to monitor progress toward improving nutrition. There are no priority populations for these indicators (see page 15 for further explanation).

Indicator (source)	**Baseline** (2019)	**Short-term target** (2021)	**Intermediate target** (2025)	**Long-term target** (2029)
HB3. Youth fruit consumption. Percent of high school students who did not eat fruit or drink 100% fruit juices during past 7 days (YRBS)	10.6%	10.4%	10%	9.6%
HB4. Youth vegetable consumption. Percent of high school students who did not eat vegetables (excluding french fries, fried potatoes or potato chips) during past 7 days (YRBS)	8.7%	8.5%	8.1%	7.7%

Target source: ODH

Strategies

If well-implemented, the following evidence-informed strategies are likely to achieve the SHIP objectives for improving nutrition in Ohio. Although the nutrition indicators are for high school students, prevention strategies will be most effective if directed at young Ohioans in grades K-12.

Featured strategies	Includes
Healthy meals served at schools	• School breakfast programs 🟰 • Healthy school lunch initiatives 🟰 • School nutrition standards 🟰 • School-based nutrition education programs
Fruit and vegetable access and education	• Community gardens • School fruit and vegetable gardens • Farm to institution programs, including farm-to-school programs • Fruit and vegetable taste testing
Outreach and advocacy to maintain or increase enrollment in federal food assistance programs (WIC and SNAP)	• Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), including coordination of outreach and enrollment with local WIC clinics • Supplemental Nutrition Assistance Program (SNAP), including coordination of outreach and enrollment with County Department of Job and Family Services locations • Increase outreach to caregivers, including pregnant women, parents and older adults
Healthy food in food banks	Healthy food initiatives in food banks 🟰 **CHC**, such as Ohio Agricultural Clearance Program and produce distribution in partnership with food banks/pantries
Fruit and vegetable initiatives	Fruit and vegetable incentive programs 🟰, such as Ohio Produce Perks **CHC**

Additional strategies	Includes
Community-based	
Healthy food retailers	• Farmers markets **CHC**, including WIC and Senior Farmers' Market Nutrition Programs 🟰 and Electronic Benefit Transfer (EBT) payment at farmers markets 🟰 **CHC** • Healthy food in convenience stores 🟰, such as Ohio's Good Food Here program **CHC** • Incentives to bring grocery stores and other healthy food retailers to underserved communities, such as the Healthy Food Financing Initiative
Healthy eating decision-making supports and incentives	• Point-of-purchase prompts for healthy foods • Competitive pricing for healthy foods • Place, present and promote healthy foods in retail, school, workplace and other community settings
Limits on youth-focused advertising for unhealthy foods	• Child-focused advertising restrictions for unhealthy foods & beverages • Screen time interventions for children
Other community-based nutrition strategies	• Multi-component obesity prevention interventions (i.e. combination of educational, environmental and behavioral activities to address nutrition) • Good Food Here policies (from the Ohio Food and Beverage Guidelines Toolkit) adopted and implemented in community settings **CHC**

🟰 = Likely to reduce disparities, based on review by WWFH, or health equity strategy in CG; **CHC** = Creating Healthy Communities (ODH program)

Additional strategies (cont.)	Includes
School-based	
School-based nutrition and physical activity programs	• **Nutrition and physical activity interventions in preschool and childcare**, including adopting menu changes to meet the **Child and Adult Care Food Program (CACFP) nutrition standards** and adding nutrition standards to the **Step Up To Quality** rating system • **Multi-component school-based obesity prevention interventions**
Healthcare system	
Healthcare provider strategies to increase healthy food consumption	• **Nutrition prescriptions**, often referred to as "produce prescriptions" or "fruit and vegetable prescriptions" • **Food insecurity screening and referral**

= Likely to reduce disparities, based on review by WWFH, or health equity strategy in CG; **CHC** = Creating Healthy Communities (ODH program)

Relevant resources

- **Creating Healthy Communities**, Ohio Department of Health (ODH)
- **Ohio Food and Beverage Guidelines Toolkit**, ODH
- **The CDC Guide to Strategies to Increase the Consumption of Fruits and Vegetables**
- **About WIC- How WIC Helps**, U.S. Department of Agriculture
- **Parenting at Mealtime and Playtime**, American Academy of Pediatrics

Physical activity

What shapes our health and well-being?

Physical activity contributes to many positive health outcomes, including prevention of diabetes, heart disease, hypertension, cancer and obesity. Exercise can also be an important part of chronic disease management for those living with these conditions. Active living supports mental health, brain health for older adults (dementia prevention) and academic achievement for children.

Objectives

Ohio will use the following objectives to monitor progress in improving physical activity. Priority populations refer to groups with outcomes worse than Ohio overall.

Indicator (source)	**Baseline** (2016-2017)	**Short-term target** (2022)	**Intermediate target** (2025)	**Long-term target** (2028)
HB5. Child physical activity. Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day (NSCH)	29%	31%	33%	35%
Indicator (source)	**Baseline** (2017)	**Target** (2022)	**Target** (2025)	**Target** (2028)
HB6. Adult physical activity. Percent of adults, age 18 and older, reporting no leisure time physical activity (BRFSS)	29.6%	29%	27%	26%
Priority populations				
Hispanic	37.5%	32.3%	29.1%	26%
Black (non-Hispanic)	34.6%	30.7%	28.3%	26%
Adults, 65+	37.7%	37.1%	36.4%	35.8%
Low income (less than $15,000 annual household income)	40.5%	33.9%	30%	26%
People with a disability	43.9%	35.8%	30.9%	26%

Target source: ODH and ODA (for older adult priority populations)

Strategies

If well-implemented and targeted to meet the needs of priority populations, the following evidence-informed strategies are likely to achieve the SHIP objectives for increasing physical activity in Ohio.

Featured strategies	Includes
School-based	
School-based programs to increase physical activity Hi-5	• Active recess • Physically active classrooms • School-based physical education enhancements
Safe Routes to School	• Safe Routes to School programs that promote biking and walking to school through education, incentives and pedestrian-friendly infrastructure changes Hi-5, CHC • Walking school buses
Community-based	
Transportation and land use policies (built environment changes and green space)	• Green spaces and parks (=) CHC • Bike and pedestrian master plans (active transportation plans) CHC • Complete Streets and streetscape design initiatives CHC • Zoning regulations for land use policy CHC • Mixed-use development
Community fitness programs	• Community fitness programs • Social support for physical activity interventions in community settings (See also: WWFH) • Individually-adapted physical activity programs • Community-wide physical activity campaigns (See also: WWFH)
Healthcare system	
Exercise prescriptions	Exercise prescriptions from healthcare providers (an exercise plan with achievable goals and follow-up steps, which may include counseling, activity logs, reminder calls, etc.)

Additional strategies	Includes
Workplace physical activity programs and policies	• Worksite obesity prevention interventions Hi-5 • Multi-component workplace supports for active commuting CHC • Individual incentives for public transportation
Physical activity policies and programs	• Shared use agreements (=) • Activity programs for older adults • Diabetes Prevention Program (and other combined diet and physical activity promotion programs to prevent type 2 diabetes)
Physical activity interventions in early childhood settings	Nutrition and physical activity interventions in preschool and child care, such as the Ohio Healthy Program

(=) = Likely to reduce disparities, based on review by WWFH, or health equity strategy in CG; **Hi-5** = Health Impact in 5 years (CDC); **CHC** = Creating Healthy Communities (ODH program)

Relevant resources

- Creating Healthy Communities, ODH program
- Physical Activity Guidelines for Americans, U.S. Department of Health and Human Services
- Youth Compendium of Physical Activities, National Collaborative on Childhood Obesity Research
- Active People, Healthy Nation, CDC
- Ohio Department of Transportation Statewide Pedestrian and Bicycle Plan
- Health Equity and Mobility Justice, ODH

Ohio's response to improve health behaviors

Student Wellness
Kids today are facing unprecedented challenges at home that come with them into the classroom, creating challenges for both students and teachers. The operating budget included a brand-new funding stream called Student Wellness and Success. This $675 million fund can be used to support student health, mental wellbeing, and academic success by providing schools with the financial resources to embed mental health counseling, physical health services, mentoring, after-school programs, and much more into their school buildings. As a result, schools will have more support and students will be better equipped for a brighter future.

Tobacco 21
Ohio's adoption of a statewide "Tobacco 21" law to increase the minimum age of sale for tobacco products, including e-cigarette and vaping products, from 18 to 21 is a bold step toward addressing the increasing problem of youth tobacco use in Ohio. Multiple state agencies were involved in the implementation of this initiative that is expected to decrease the availability of tobacco products to youth and young adults. Evidence indicates this initiative will assist in preventing youth from initiating tobacco use and will decrease the number of youth and young adults who transition from irregular use to daily use of tobacco. As we move into the future, this policy is expected to significantly contribute to decreases in adult tobacco use rates and tobacco-associated deaths.

Vaping
The increase in youth vaping has been labelled an epidemic by the United States Surgeon General. Progress toward slowing the use of tobacco by youth over the past decade has been reversed by ever increasing percentages of youth who are now currently using e-cigarettes or vaping products. Helping to create this atmosphere of unprecedented use are the targeting of youth by tobacco company marketing campaigns and misperceptions about the harm of these products. Youth are being addicted to nicotine, which is in virtually all products and significantly impacts their short and long-term health. Ohio is taking action to address this issue at state and local levels through policy efforts to curtail access and availability, funding to assist in building local capacity, mass media communications, ongoing educational opportunities, and promising and innovative initiatives to engage youth in prevention and cessation activities.

WIC
WIC is the Special Supplemental Nutrition Program for Women, Infants, and Children. WIC helps income eligible pregnant and breastfeeding women, women who recently had a baby, infants, and children up to 5 years of age in all 88 Ohio counties. The program improves pregnancy outcomes by providing or referring women to support services necessary for full-term pregnancies and reduces infant mortality by reducing the incidence of low birth weight. (Infants under 5.5 pounds are at greater risk of breathing problems, brain injuries, and physical abnormalities). It also gives infants and children a healthy start in life by improving poor or inadequate diets.
Specifically, WIC provides nutrition education; breastfeeding education and support; supplemental, highly nutritious foods and iron-fortified infant formula; and referrals to prenatal and pediatric health care and other human service programs.
Half of the babies born in Ohio are born into WIC-eligible families. WIC serves over 200,000 families per month, and the Ohio WIC program is the ninth largest WIC program in the United States.
The separate Supplemental Nutrition Assistance Program (SNAP) provides nutrition benefits to supplement the food budget of eligible families so they can purchase healthy food and move toward self-sufficiency. SNAP-eligible families with pregnant or postpartum women, infants, and children up to age 5 are also eligible for WIC.

Farmer's Markets for Aging
Access to healthy food options is vital to the well-being of Ohioans. To expand access, Ohio recently expanded the Senior Farmers' Market Nutrition Program, which provides seniors with vouchers to purchase qualifying produce at farmer's markets and roadside stands. The program has grown to 45, mostly rural counties.

Farm to School
It is important to provide children with access to healthy meals through school- and community-based programs. The Fresh Fruit and Vegetable Program provides all children in participating schools with a variety of free fresh fruits and vegetables throughout the school day. The Child and Adult Care Food Program offers childcare centers access to funding for nutritious meals and snacks. All children ages 1 through 18 are eligible to receive free meals during the summer months through the Summer Food Service Program.

Physical Activity
The Ohio Department of Health's Creating Healthy Communities (CHC) program works to increase access to physical activity opportunities by funding 23 local health departments to implement evidence-based strategies such as inclusive park/playground improvements, complete streets policies, active transportation planning, bike and pedestrian infrastructure, public transit improvements, and multi-use trails. The CHC program also partners with the Ohio Department of Transportation (ODOT) to implement active transportation strategies in local CHC communities.

5 Access to care

Health insurance coverage

Local access to healthcare providers

Unmet need for mental health care

See Part 1 for information on:

- Equity
- Priorities
- Tracking progress with SMART objectives
- Strategies

Health insurance coverage

What shapes our health and well-being?

Health insurance improves access to care, limits out-of-pocket spending on healthcare services and makes healthcare costs more predictable. People with health insurance are less likely to delay or forgo needed care, seek care in emergency departments and experience financial hardship from medical debt. Expanding access to health insurance coverage reduces disparities in access to care, a critical factor for achieving health equity for all Ohioans.

Objectives

Ohio will use the following objectives to monitor progress toward increasing health insurance coverage. Local communities can select these indicators to evaluate their own community health improvement activities. Priority populations refer to groups with outcomes worse than Ohio overall.

Indicator (source)	**Baseline** (2017)	**Short-term target** (2022)	**Intermediate target** (2025)	**Long-term target** (2028)
AC1. Uninsured adults. Percent of adults, ages 19-64, who are uninsured (ACS, 1-year estimates)	8%	6.2%	5.1%	4%
Priority populations				
Hispanic or Latino (any race)	21%	13.3%	8.6%	4%
Black (includes Hispanic and non-Hispanic)	10.4%	7.5%	5.7%	4%
Income below 138% of the federal poverty level (FPL)	14.4%	9.7%	6.8%	4%
Male	9.5%	7%	5.5%	4%
Indicator (source)	**Baseline** (2017)	**Target** (2022)	**Target** (2025)	**Target** (2028)
AC2. Uninsured children. Percent of children, ages 0-18, who are uninsured (ACS, 1-year estimates)	4.5%	2.9%	2%	<1%
Priority populations				
Hispanic or Latino (any race)	6.4%	3.9%	2.5%	<1%
Income below 200% FPL	6.4%	3.9%	2.5%	<1%

Target source: ODH

Insurance coverage

Strategies

If well-implemented and targeted to meet the needs of priority populations, the following evidence-informed strategies are likely to achieve the SHIP objectives for increasing health insurance coverage in Ohio.

Featured strategies	Includes
Outreach and advocacy to maintain Ohio Medicaid eligibility levels and enrollment assistance	• Maximize enrollment in Ohio Medicaid for currently eligible individuals • Monitor the impact of upcoming changes to the Ohio Medicaid program on health insurance coverage rates • **Culturally and linguistically appropriate services** and other outreach to identify and remove barriers to Medicaid enrollment, with emphasis on priority populations
Insurance enrollment assistance for adults and children	• Provide ongoing **Health insurance enrollment outreach and support** (=) to people without access to employer-sponsored insurance coverage • Utilize existing resources, such as **Community Health Workers (CHWs)** (=), and collaborate with state and local agencies, community groups and healthcare providers to raise awareness of health insurance enrollment assistance

(=) = Likely to reduce disparities, based on review by WWFH, or health equity strategy in CG

Relevant resources

- **Ohio Department of Medicaid (ODM)**
- **Medicaid enrollment reports**, ODM
- **Ohio Department of Insurance**

Local access to healthcare providers

What shapes our health and well-being?

Ensuring local access to healthcare providers makes it easier for residents to get to primary and specialty healthcare services. Increasing access to local healthcare providers in underserved areas can reduce disparities in access to care and improve health outcomes.

Objectives

Ohio will use the following objectives to monitor progress toward increasing local access to healthcare providers. There are no priority populations for these indicators (see page 15 for further explanation).

Indicator (source)	**Baseline** (2018)	**Short-term target** (2022)	**Intermediate target** (2025)	**Long-term target** (2028)
AC3. Primary care health professional shortage areas. Percent of Ohioans living in a primary care health professional shortage area* (HRSA, as compiled by KFF)	12.5%	Monitor only, no target		
AC4. Mental health professional shortage areas. Percent of Ohioans living in a mental health professional shortage area* (HRSA, as compiled by KFF)	22%	Monitor only, no target		

*This indicator has limitations for tracking progress over time. In the future, this indicator will be replaced with an indicator from the Minimum Data Set. Local communities may want to use the primary care physician, other primary care provider, or mental health provider ratios from **County Health Rankings**.

Target source: ODH

Local access

Strategies

If well-implemented, the following evidence-informed strategies are likely to achieve the SHIP objectives for increasing local access to healthcare providers in Ohio.

Featured strategies	Includes
Comprehensive and coordinated primary care	• **Medical homes** 🟰, such as Ohio Comprehensive Primary Care practices • Healthcare safety net providers, including **federally qualified health centers (FQHCs)** 🟰 and **school-based health centers (SBHCs)** 🟰
Culturally competent workforce in underserved communities	• **Community health workers** 🟰 • **Community-based training for health professions students in rural** and other underserved areas 🟰 • **Financial incentives to recruit and retain health professionals in underserved areas** 🟰
Telehealth	**Telemedicine** 🟰

Additional strategies	Includes
Healthcare workforce professional development	• **Health career recruitment for minority students** 🟰 and other underrepresented or disadvantaged students (for example, **Career Academies** 🟰)
Telehealth for mental health	**Telemental health services** 🟰
Public transportation	Develop, improve and maintain **public transportation systems** 🟰
Other access supports	• **Paid sick leave laws** 🟰 • **Health literacy interventions** 🟰

🟰 = Likely to reduce disparities, based on review by WWFH, or health equity strategy in CG

Relevant resources

- **Community Health Worker Statewide Assessment**, Ohio Department of Health
- **Community Paramedicine Compendium**, Ohio Department of Public Safety
- **RecoveryOhio Advisory Council's Initial Report**
- **Rural Health Care Access**, Ohio University
- **Community Commons Initiative**
- **CARES Engagement Network**, University of Missouri

Unmet need for mental health care

What shapes our health and well-being?

Access to quality mental healthcare services is critical for maintaining mental health, managing mental illness, preventing and assisting with mental health crises and reducing premature death. Equal access to mental health care is also an important step toward achieving health equity for all Ohioans.

Objectives

Ohio will use the following objectives to monitor progress toward reducing unmet need for mental health care. There are no priority populations for these indicators (see page 15 for further explanation).

Indicator (source)	**Baseline** (2014-2016)	**Short-term target** (2020-2022)	**Intermediate target** (2023-2025)	**Long-term target** (2026-2028)
AC5. Youth depression treatment unmet need. Percent of youth, ages 12-17, with major depressive episode who did not receive any mental health treatment within the past year (MHA analysis of NSDUH)	51.6%	49%	47.7%	46.4%
Indicator (source)	**Baseline** (2013-2015)	**Short-term target** (2020-2022)	**Intermediate target** (2023-2025)	**Long-term target** (2026-2028)
AC6. Adult mental health care unmet need. Percent of adults, ages 18 and older, with past year mental illness who reported perceived need for treatment/counseling that was not received (MHA analysis of NSDUH)	20.2%	19.1%	18.6%	18.1%

Target source: OMHAS

Mental health care

Strategies

If well-implemented, the following evidence-informed strategies are likely to achieve the SHIP objectives for reducing unmet need for mental health care in Ohio.

Featured strategies	Includes
Comparable insurance coverage for behavioral health (parity)	**Mental health benefits legislation, along with monitoring for implementation and compliance** 〓
Telehealth for mental health	**Telemental health services** 〓

Additional strategies	Includes
Culturally competent workforce in underserved communities	• Certified **community health workers** 〓 • Support and expand the role of **peer support specialists** • **Health career recruitment for minority students** 〓 and other underserved communities (for example, **Career Academies** 〓) • **Rural training in medical education** 〓 and other underserved communities • **Higher education financial incentives for health professionals serving underserved areas** 〓
Coordinated care for behavioral health conditions	• **Integration of behavioral health services into primary care** 〓 • **Chronic disease management programs**
Digital access to treatment services and crisis response	• **mHealth for mental health** • **Crisis lines** (for example, text "4hope")

〓 = Likely to reduce disparities, based on review by WWFH, or health equity strategy in CG

Relevant resources

- **Ohio Peer Recovery Supporter Certification and Recertification Process**, Ohio Department of Mental Health and Addiction
- **Healthchek Services for Children Younger than Age 21**, Ohio Department of Medicaid

Ohio's response to improve access to care

Student Wellness
Kids today are facing unprecedented challenges at home that come with them into the classroom, creating challenges for both students and teachers. The operating budget included a brand-new funding stream called Student Wellness and Success. This $675 million fund can be used to support student health, mental wellbeing, and academic success by providing schools with the financial resources to embed mental health counseling, physical health services, mentoring, after-school programs, and much more into their school buildings. As a result, schools will have more support and students will be better equipped for a brighter future.

Mental Health Care When and Where It is Needed
Immediate access to treatment and support to help people who are struggling with mental health or substance use disorders is critical. That is why Governor DeWine directed more than $22 million to local Alcohol, Drug and Mental Health Boards so communities can provide crisis response efforts to families when they need it the most.

6 Mental health and addiction

Depression

Suicide

Youth drug use

Drug overdose deaths

See Part 1 for information on:

Equity

Priorities

Tracking progress with SMART objectives

Strategies

Depression

How will we know if health is improving in Ohio?

Fewer Ohioans will have depression, disparities in the depression rate will be eliminated and all Ohioans will have the support they need to maintain mental and emotional well-being.

Objectives

Ohio will use the following objectives to monitor progress toward reducing depression. There are no priority populations for these indicators (see page 15 for further explanation).

Indicator (source)	**Baseline** (2015-2016)	**Short-term target** (2021-2022)	**Intermediate target** (2024-2025)	**Long-term target** (2027-2028)
MHA1. Youth depression (major depressive episode). Percent of youth, ages 12-17, who experienced a major depressive episode within the past year (NSDUH)	14%	11.7%	10.5%	9.3%
MHA2. Adult depression (major depressive episode). Percent of adults, ages 18 and older, who experienced a major depressive episode within the past year (NSDUH)	7.9%	7.2%	6.9%	6.6%

Target source: OMHAS

Strategies

If well-implemented, the following evidence-informed strategies are likely to achieve the SHIP objectives for reducing depression in Ohio. To effectively reduce depression, SHIP partners should also implement community conditions, health behaviors and access to care strategies (see parts 3-5).

Featured strategies	Includes
School-based	
Social and emotional instruction	**School-based social and emotional instruction**, including comprehensive implementation of **Ohio's Social and Emotional Learning Standards** For more specific guidance on programs see: • **Ohio Department of Education's Evidence-Based Clearinghouse** • **Collaborative for Academic, Social, and Emotional Learning (CASEL) Guide to effective social and emotional learning programs**
Healthcare system	
Coordinated care for behavioral health	• **Integration of behavioral health services into primary care** (=) • **Chronic disease management programs**
Digital access to treatment services and crisis response	• **mHealth for mental health** • **Crisis lines** (for example, text "4hope") • **Health services delivered through telephone or videoconference**
Community-based	
Physical activity programs	• **Activity programs for older adults** • **Community-based social support for physical activity**
Parenting programs	• **Group-based parenting programs** • For more specific guidance on programs: The **California Evidence-Based Clearinghouse for Child Welfare**

Additional strategies	Includes
School-based	
School-based depression prevention and treatment	**School-based Cognitive Behavioral Therapy**, including both targeted and universal approaches
Healthcare system	
Depression screening	• **Depression screening**, using a **standardized, evidence-based tool,** for adolescents aged 12 to 18 years, with adequate systems in place to ensure accurate diagnosis, referral if clinically necessary, effective treatment, and appropriate follow up • **Depression screening**, using a **standardized, evidence-based tool**, for adults, with adequate systems in place to ensure accurate diagnosis, referral if clinically necessary, effective treatment and appropriate follow up
Collaborative care for depression	**Collaborative care for depression** (see WSIPP for benefit/cost analysis for specific approaches for children, adults and older adults)
Comparable insurance coverage for behavioral health (parity)	**Mental health benefits legislation, along with monitoring for implementation and compliance** (=)

(=) = Likely to reduce disparities, based on review by WWFH, or health equity strategy in CG

Additional strategies (cont.)	Includes
Community based	
Mental health education	• **Mental health first aid** courses for community members, school staff, first responders and others • **Motivational interviewing training** for those who may be trusted resources for people with mental health challenges, such as clinicians, providers, case managers and community health workers
Depression programs for older adults	• **Program to Encourage Active, Rewarding Lives** (PEARLS) • **Healthy IDEAS**
Housing quality	• **Home improvement loans and grants** **Hi-5** • **Housing rehabilitation loans and grants** =
Green spaces and parks	Increase, renovate or expand **green spaces and parks** =

= Likely to reduce disparities, based on review by WWFH, or health equity strategy in CG; **Hi-5** = Health Impact in 5 years (CDC)

Relevant resources

- **Parity at 10 initiative** (behavioral health parity), Legal Action Center
- **Blueprints for Healthy Youth Development**, University of Colorado Boulder (registry of evidence-based, youth-focused programs sortable by outcome, including depression)
- **Behavioral Health and Wellness Education Advisory Committee Report and Recommendations**, Ohio Department of Education (includes toolkit for school-based behavioral health and wellness resources)
- **Depression and Aging webpage**, U.S. Centers for Disease Control and Prevention
- **Depression and Older Adults,** National Institute on Aging

Suicide

How will we know if health is improving in Ohio?

Fewer Ohioans will die by suicide, disparities in the suicide rate will be eliminated and supports will be available for all Ohioans in crisis.

Objectives

Ohio will use the following objectives to monitor progress toward reducing deaths by suicide. Local communities can select these indicators to evaluate their own community health improvement activities. Priority populations refer to groups with outcomes worse than Ohio overall.

Indicator (source)	**Baseline** (2018)	**Short-term target** (2022)	**Intermediate target** (2025)	**Long-term target** (2028)
MHA3. Youth suicide deaths. Number of deaths due to suicide for youth, ages 8-17, per 100,000 population (ODH Vital Statistics)	5.7	5.3	4.9	4.6
Priority populations				
White, non-Hispanic	6.5	5.7	5.2	4.6
Residents of Appalachian counties*	8.5	6.9	5.8	4.6
Male	8.1	6.7	5.7	4.6
MHA4. Adult suicide deaths. Number of deaths due to suicide for adults, ages 18 and older, per 100,000 population (ODH Vital Statistics)	19.3	17.7	16.6	15.4
Priority populations				
Adults, ages 35-44	21.3	18.9	17.2	15.4
Adults, ages 55-64	21.2	18.9	17.1	15.4
Residents of Appalachian counties*	23.3	20.1	17.8	15.4
Male	31.5	25.1	20.2	15.4

*County typology from the Ohio Medicaid Assessment Survey. See Appendix C for map of county types.

Target source: ODH and OMHAS

Suicide

Strategies

If well-implemented and targeted to meet the needs of priority populations, the following evidence-informed strategies are likely to achieve the SHIP objectives for reducing deaths by suicide in Ohio. To effectively reduce suicide, SHIP partners should also implement community conditions, health behaviors and access to care strategies (see parts 3-5).

Featured strategies	Includes
Suicide awareness, prevention and peer norm programs	• **Universal school-based suicide awareness and education programs** (included in **Preventing Suicide: A technical package of policy, programs, and practices**) • **Youth peer mentoring** (for example **Sources of Strength**, included in **Preventing Suicide: A technical package of policy, programs, and practices**) For more specific guidance on programs see: • **SAMHSA's Preventing Suicide: A Toolkit for High Schools**
Limits on access to lethal means	• **Child firearm access prevention** • **Suicide hotspot interventions**

Additional strategies	Includes
Healthcare system	
Coordinated care for behavioral health	**Integration of behavioral health services into primary care** (=)
Digital access to treatment services and crisis supports	• **Crisis lines** (for example, the National Suicide Prevention Hotline Lifeline at 1-800-273-TALK (8255) or text "4hope") • **Telemental health services** (=)
Comparable insurance coverage for behavioral health (parity)	**Mental health benefits legislation, along with monitoring for implementation and compliance** (=)
Safer suicide care through systems change	**Zero Suicide**, a framework for healthcare systems that includes assessment, safety planning and aftercare components (see also **Preventing Suicide: A technical package of policy, programs, and practices**)
Community based	
Mental health education	• **Mental health first aid** courses for community members, school staff, first responders and others • **Question Persuade Refer training** • **Motivational interviewing training** for those who may be trusted resources for people with mental health challenges, such as clinicians, provider, case managers and community health workers
Limits on alcohol access	**Alcohol outlet density restrictions** (=)
Housing quality	• **Home improvement loans and grants** **Hi-5** • **Housing rehabilitation loans and grants** (=)
Supports for system-involved children and youth	**Multisystemic Therapy (MST) for juvenile offenders**
Safe media reporting and messaging about suicide	• **Ohio Suicide Reporting Guidelines** • **National Recommendations for Reporting on Suicide**
Surveillance and data collection	**Suicide Death Review Teams** and other **approaches to gathering data** after a suicide has occurred

(=) = Likely to reduce disparities, based on review by WWFH, or health equity strategy in CG; **Hi-5** = Health Impact in 5 years (CDC)

Relevant resources

- **Suicide Prevention Toolkit,** Ohio Department of Mental Health and Addiction Services
- **The Suicide Prevention Plan for Ohio, 2020-2022**, Ohio Suicide Prevention Foundation
- **Ohio Suicide Prevention Foundation's website** (information about community coalitions)
- **Behavioral Health and Wellness Education Advisory Committee Report and Recommendations**, Ohio Department of Education (includes toolkit for school-based behavioral health and wellness resources)
- **Preventing Suicide: A technical package of policy, programs, and practices**, U.S. Centers for Disease Control and Prevention
- **Means Matter**, Harvard School of Public Health
- **Promoting Emotional Health and Preventing Suicide: A Tool Kit for Senior Centers**, Substance Abuse and Mental Health Services Administration

Youth drug use

How will we know if health is improving in Ohio?

Fewer adolescents will use alcohol or marijuana, disparities in youth drug use will be eliminated and fewer young people will go on to develop substance use disorder.

Objectives

Ohio will use the following objectives to monitor progress toward reducing youth drug use. Priority populations refer to groups with outcomes worse than Ohio overall.

Indicator (source)	**Baseline** (2019)	**Short-term target** (2021)	**Intermediate target** (2025)	**Long-term target** (2029)
MHA5. Youth alcohol use. Percent of high school students who have used alcohol within the past 30 days (YRBS)	25.9%	24.9%	22.9%	20.9%
Priority populations				
Female students	29.6%	27.9%	24.4%	20.9%
MHA6. Youth marijuana use. Percent of high school students who have used marijuana within the past 30 days (YRBS)	15.8%	14.8%	12.8%	10.8%
Priority populations				
Black students	23.9%	21.3%	16%	10.8%
Hispanic students	18.4%	16.9%	13.8%	10.8%
Gay, lesbian or bisexual students	25.3%	22.4%	16.6%	10.8%

Note: Youth tobacco/nicotine use is included in the health behaviors section (see page 34).
Target source: ODH and OMHAS

Strategies

If well-implemented and targeted to meet the needs of priority populations, the following evidence-informed strategies are likely to achieve the SHIP objectives for reducing youth drug use in Ohio. To effectively reduce youth drug use, SHIP partners should also implement community conditions, health behaviors and access to care strategies (see parts 3-5). Although the youth drug use indicators are for high school students, prevention strategies will be most effective if directed at young Ohioans in grades K-12.

Featured strategies	Includes
K-12 drug prevention education	**Universal school-based alcohol prevention programs** For specific skills-based health education curricula and universal drug prevention programs, see: • **Office of Juvenile Justice and Delinquency Prevention (OJJDP) Model Programs Guide** • **Washington State Institute for Public Policy (WSIPP) Benefit-Cost Analyses**
Alcohol policy changes	• **Enhanced enforcement of laws prohibiting alcohol sales to minors** • **Alcohol advertising restrictions**
Alcohol and other drug use screening (SBIRT)	• Screening, brief intervention and referral to treatment (SBIRT) (WWFH: **Alcohol brief interventions**) • Referral and follow-up to evidence-based treatment as needed • Screening can be conducted in healthcare settings, schools or other community locations

Additional strategies	Includes
K-12 social-emotional learning and positive behavior initiatives	• **School-based social and emotional instruction**, including comprehensive implementation of Ohio's **Social and Emotional learning standards** • **School-wide Positive Behavioral Interventions and Supports (Tier 1)** 🟠, Tier 2 and Tier 3
K-12 school climate improvement initiatives	• **Later middle and high school start times** 🟠 • Comprehensive implementation of **Ohio School Climate Guidelines,** including student and parent engagement, school safety and fair and consistent discipline policies
Youth resilience programs	• **Mentoring programs: delinquency** 🟠 • **Big Brothers, Big Sisters** 🟠 and other mentoring programs reviewed in **OJJDP Model Programs Guide** or **WSIPP** • **Youth-led prevention**
Parental engagement	• **Group-based parenting programs** • For more specific guidance on parenting programs see the **California Evidence-Based Clearinghouse for Child Welfare** • **Education for parents on how to build youth resilience and protective factors and how to communicate with their children about alcohol and other drugs**
Community drug prevention coalitions	PROmoting School-Community-University Partnerships to Enhance Resilience (PROSPER), Communities That Care (CTC) and other coalition models recommended by **the U.S. Surgeon General** and the **Ohio Statewide Prevention Coalition Association**

🟠 = Likely to reduce disparities, based on review by WWFH, or health equity strategy in CG

Relevant resources

- **Ohio Attorney General Drug Use Prevention Education Resource Guide**
- **Health and Opioid-Abuse Prevention Education (HOPE) curriculum**, Ohio Department of Mental Health and Addiction Services
- **Ohio Association for Health, Physical Education, Recreation and Dance Health Education Model Curriculum**
- **RecoveryOhio Advisory Council Initial Report**
- **Connections between education and health #4: School-based drug and violence prevention and mental health promotion**, Health Policy Institute of Ohio
- **Behavioral Health and Wellness Education Advisory Committee Report and Recommendations**, Ohio Department of Education (includes toolkit for school-based behavioral health and wellness resources)

Drug overdose death

How will we know if health is improving in Ohio?

Fewer Ohioans will die from drug overdoses, disparities in the drug overdose death rate will be eliminated and more Ohioans will be on the path to recovery from addiction.

Objectives

Ohio will use the following objectives to monitor progress toward reducing drug overdose death. Local communities can select this indicator to evaluate their own community health improvement activities. Priority populations refer to groups with outcomes worse than Ohio overall.

Indicator (source)	**Baseline** (2018)	**Short-term target** (2022)	**Intermediate target** (2025)	**Long-term target** (2028)
MHA7. Unintentional drug overdose deaths. Number of deaths due to unintentional drug overdose, per 100,000 population (age adjusted) (ODH Vital Statistics)	34.1	28.7	24.6	20.5
Priority populations				
Adults, ages 25-34	68.8	49.5	35	20.5
Adults, ages 35-44	75.8	53.7	37.1	20.5
Adults, ages 45-54	47.3	36.6	28.5	20.5
Residents of Appalachian counties*	39.4	31.8	26.2	20.5
Residents of urban counties*	37.7	30.8	25.7	20.5
Male	45.8	35.7	28.1	20.5

*County typology from the Ohio Medicaid Assessment Survey. See Appendix C for map of county types.

Note: The unintentional drug overdose death rate for non-Hispanic white Ohioans (36.5 deaths per 100,000 population) and non-Hispanic black Ohioans (33.5 deaths per 100,000 population) were both within 10% of the overall rate in 2018.

Target source: ODH and OMHAS

Strategies

If well-implemented and targeted to meet the needs of priority populations, the following evidence-informed strategies are likely to achieve the SHIP objectives for reducing drug overdose deaths in Ohio. To effectively reduce drug overdose deaths, SHIP partners should also implement community conditions, health behaviors and access to care strategies (see parts 3-5).

Strategies▲	Includes
Overdose prevention and reversal programs	
Naloxone education and distribution programs	**Naloxone education and distribution programs** 〓 Ohio-specific activities: • Increase the number of Project DAWN and other community sites that can distribute naloxone • Integrate naloxone distribution models within addiction treatment settings, reentry from prison and jail and syringe services programs • Increase utilization of the **Community Innovation Fund**, which provides local health departments with funding to purchase naloxone for first responders
Prescription drug monitoring programs (PDMPs)	**Prescription drug monitoring programs (PDMPs)** (known as OARRS in Ohio) Ohio-specific activities: • Increase OARRS integration with electronic health records • Continually enforce OARRS tracking requirements • Provide education and technical assistance to prescribers to operationalize opioid prescribing limits and guidelines • Utilize the **OARRS Peer Review Module**
Syringe services programs (SSPs)	**Syringe services programs (SSPs)** (also known as needle exchange programs) 〓 Ohio-specific activities: • Provide technical assistance to SSPs so that they can obtain **Terminal Distributor of Dangerous Drugs (TDDD) licenses** and distribute naloxone • Increase the number of SSPs in Ohio, particularly in counties with the highest rates of hepatitis C and HIV • Establish a statewide coordination hub for SSPs that can assist local programs with information sharing, technical assistance, evaluation and quality improvement • Increase referrals and links from SSPs to substance use treatment and social support services
Addiction treatment access	
Medication-assisted treatment (MAT) access	• **MAT access enhancement initiatives,** including access to buprenorphine, methadone and naltrexone 〓 • Increase the number of physicians, physician assistants and advance practice nurses who have obtained a waiver to prescribe buprenorphine (**DATA 2000 waiver**) • Provide technical assistance and support to providers who have a waiver to prescribe MAT
Comparable insurance coverage for behavioral health (parity)	**Mental health benefits legislation, along with monitoring for implementation and compliance** 〓

▲ None of the strategies for this topic area met the criteria for featured strategies. These criteria are listed in Part 1 and Appendix C.
〓 = Likely to reduce disparities, based on review by WWFH, or health equity strategy in CG

Strategies▲ (cont.)	Includes
Addiction treatment access (cont.)	
Culturally competent workforce in underserved communities	• Certified **community health workers** 〓 • Support and expand the role of **peer support specialists** • **Health career recruitment for minority students** 〓 and other underserved communities (for example, **Career Academies** 〓) • **Rural training in medical education** 〓 and other underserved communities • **Higher education financial incentives for health professionals serving underserved areas** 〓
Recovery supports	
Recovery communities and peer supports	Support recovery-friendly communities and workplaces, including: • Peer recovery organizations • Recovery community organizations • Recovery-oriented high schools • Collegiate recovery communities • Alternative peer groups
Housing programs for people with behavioral health conditions	• **Certified recovery housing** • **Housing First** 〓

▲ None of the strategies for this topic area met the criteria for featured strategies. These criteria are listed in Part 1 and Appendix C.
〓 = Likely to reduce disparities, based on review by WWFH, or health equity strategy in CG

Relevant resources

- **RecoveryOhio Advisory Council Initial Report**
- **Addiction Evidence Project**, Health Policy Institute of Ohio
- **Parity at 10** initiative, Legal Action Center

Ohio's response to improve mental health and addiction

Student Wellness
Kids today are facing unprecedented challenges at home that come with them into the classroom, creating challenges for both students and teachers. The operating budget included a brand-new funding stream called Student Wellness and Success. This $675 million fund can be used to support student health, mental wellbeing, and academic success by providing schools with the financial resources to embed mental health counseling, physical health services, mentoring, after-school programs, and much more into their school buildings. As a result, schools will have more support and students will be better equipped for a brighter future.

Mental Health Care When and Where It is Needed
Immediate access to treatment and support to help people who are struggling with mental health or substance use disorders is critical. That is why Governor DeWine directed more than $22 million to local Alcohol, Drug and Mental Health Boards so communities can provide crisis response efforts to families when they need it the most.

Suicide
The Ohio Department of Health (ODH)'s Violence and Injury Prevention Section (VIPS) supports suicide prevention by collecting and analyzing data and supporting a statewide coalition specifically for sharing best practices on youth suicide prevention.

VIPS houses the Ohio Violent Death Reporting System (OH-VDRS), which collects information from multiple sources in an attempt to better understand the circumstances surrounding suicides and other violent deaths. To create a comprehensive record of each death, OH-VDRS links information from: the ODH Bureau of Vital Statistics (including death certificates); coroners and medical examiners; state and local law enforcement agencies; and the Ohio Automated Rx Reporting System.

Additionally, VIPS is implementing a project to monitor state and local emergency department (ED) visits to identify nonfatal suicide-related outcomes. This project will disseminate collected data to local health departments and the public using dashboards. This will allow for the studying of trends, the identification of risk factors, and the development of data-to-action intervention and prevention strategies.

Further, VIPS, through the Ohio Injury Prevention Partnership's Child Injury Action Group, facilitates a youth suicide subcommittee to identify and share best practices from local projects.

VIPS also has provided funding to three local sub-grant programs to facilitate community engagement, strategic planning and implementation of prevention strategies including:
- Partnering with emergency departments to establish policies requiring Counseling on Access to Lethal Means (CALM) trainings.
- Providing technical assistance to EDs to establish patient safety planning and crisis support plans for parents.

Drug Overdose Death
The Ohio Department of Health (ODH) Violence and Injury Prevention Section (VIPS) collects timely, high-quality surveillance data on fatal and nonfatal unintentional drug overdoses to identify, focus, and implement appropriate and timely prevention strategies at the state and local levels. Specific prevention strategies and programs include:

- ***Community naloxone distribution,*** with an emphasis on reaching high-risk people through community agencies, jails, recovery housing, emergency departments, homeless outreach, mail, drug courts, syringe access programs, and Federally Qualified Health Centers.
- ***Local supports and linkages,*** through funding local projects in high-burden areas to facilitate local coalitions, strategic plan implementation, overdose fatality reviews, community response plans, community/clinical links, and implementation of comprehensive care systems.
- ***Health care systems support,*** through emergency department projects to support comprehensive care and resources for primary care providers to implement Ohio prescribing rules and guidelines.
- ***Public/prescriber engagement,*** through social media campaigns aimed at informing the public; reducing stigma on use of Medication-Assisted Treatment among health care providers; and educating people who use drugs on the dangers of fentanyl in Ohio's drug supply.

The VIPS ***data-to-action*** framework informs prevention efforts using several data resources including the Ohio Violent Death Reporting System (OH-VDRS) to collect and identify detailed circumstances of overdose deaths. Additional comprehensive data is collected from other ODH departments and state agencies as well as from emergency departments, studies, and several other external sources.

Prevention Education
Investing in Ohio's children is key to a healthy Ohio. The Governor's budget includes a $20 million investment to provide Ohio's schools with free, evidence-based prevention curricula and professional development for school personnel. This funding helps give students the social and emotional skill foundation they need to make healthy decisions throughout their lives. Ohio's local Alcohol, Drug and Mental Health Boards in partnership with their local school districts will receive the funds for the curricula and the Educational Service Centers will conduct professional development for teachers on prevention education.

7 Chronic disease

Heart disease and diabetes

Childhood conditions: Asthma

Childhood conditions: Lead poisoning

See Part 1 for information on:

Equity

Priorities

Tracking progress with SMART objectives

Strategies

Heart disease and diabetes

How will we know if health is improving in Ohio?

Fewer Ohioans will develop type 2 diabetes or heart disease, disparities will be eliminated and all Ohioans will have the opportunity to engage in healthy behaviors that prevent chronic disease.

Objectives

Ohio will use the following objectives to monitor progress toward reducing heart disease and diabetes. Priority populations refer to groups with outcomes worse than Ohio overall.

Indicator (source)	**Baseline** (2017)	**Short-term target** (2022)	**Intermediate target** (2025)	**Long-term target** (2028)
CD1. Coronary heart disease. Percent of adults, ages 18 and older, ever diagnosed with coronary heart disease (BRFSS)	4.7%	4.5%	4.3%	4.2%
Priority populations				
Adults, ages 55-64	7.4%	7.3%	7.2%	7%
Adults, ages 65+	12.3%	12.2%	12%	11.9%
Low-income (less than $15,000 annual household income)	8.3%	6.4%	5.3%	4.2%
People with a disability	10%	7.4%	5.8%	4.2%
Male	5.6%	5%	4.6%	4.2%
Indicator (source)	**Baseline** (2018)	**Short-term target** (2022)	**Intermediate target** (2025)	**Long-term target** (2028)
CD2. Premature death - heart disease. Years of potential life lost before age 75 due to heart disease, per 100,000 population (age adjusted) (ODH Vital Statistics)	1,124.9	1,100	1,100	1,095
Priority populations				
Black, non-Hispanic	1,824.8	1,532.9	1,313,9	1,095
Residents of Appalachian counties*	1,345.4	1,245.3	1,170.1	1,095
Male	1,539.3	1,361.6	1,228.3	1,095

*County typology from the Ohio Medicaid Assessment Survey. See Appendix C for map of county types.

Target source: ODH and ODA (for older adult priority populations)

Heart disease/diabetes

Indicator (source)	**Baseline** (2017)	**Short-term target** (2022)	**Intermediate target** (2025)	**Long-term target** (2028)
CD3. Hypertension. Percent of adults, ages 18 and older, ever diagnosed with hypertension (BRFSS)	34.7%	34.3%	33.7%	33%
Priority populations				
Black (non-Hispanic)	39.9%	36.8%	34.9%	33%
Adults, ages 55-64	49.7%	49.2%	48.2%	47.2%
Adults, ages 65+	60%	59.4%	58.2%	57%
Low-income (less than $15,000 annual household income)	46.6%	40.4%	36.7%	33%
People with a disability	51.4%	43%	38%	33%
CD4. Diabetes. Percent of adults, ages 18 and older, ever diagnosed with diabetes (BRFSS)	11.3%	11.3%	11%	10.7%
Priority populations				
Black (non-Hispanic)	14.3%	12.7%	11.7%	10.7%
Adults, 55-64	18.6%	18.3%	18%	17.7%
Adults, 65+	22.8%	22.6%	22.4%	22.1%
Low-income (less than $15,000 annual household income)	19.4%	15.4%	13.1%	10.7%
People with a disability	20.9%	16.3%	13.5%	10.7%

Target source: ODH and ODA (for older adult priority populations)

Strategies

If well-implemented and targeted to meet the needs of priority populations, the following evidence-informed strategies are likely to achieve the SHIP objectives for reducing diabetes and heart disease in Ohio. To effectively reduce heart disease and diabetes, SHIP partners should also implement community conditions, health behaviors and access to care strategies (see parts 3-5).

Featured strategies	Includes
Hypertension	
Hypertension screening and follow up	**Blood pressure screening for adults aged 18 and older, including obtaining measurements outside of the clinical setting** Approaches to increase screening access and follow up: • Electronic health record utilization to identify undiagnosed hypertension • Systematic referrals of adults with hypertension to community programs • Engagement of non-physician team members (nurses, pharmacists, social workers, etc.) in screening and referral
Healthcare system	
Prediabetes screening, testing and referral to Diabetes Prevention Program (DPP) (DPP can reduce blood pressure and A1c for those with hypertension and prediabetes)	Implementation of systemic approaches in healthcare settings to screen, test and refer patients with prediabetes as part of standard care practices: • Screen all adults for prediabetes using the **American Diabetes Association (ADA) prediabetes risk assessment** • **Blood glucose test** for adults who scored 5 or higher on the ADA prediabetes risk assessment (assign ICD-10 Code R73.03 as appropriate) • Refer to **Combined diet and physical activity promotion programs to prevent Type 2 Diabetes among people at increased risk**, such as DPP **ODAP**, **6/18**
DPP health insurance coverage and accessibility	Approaches to increase access to and coverage for **Combined diet and physical activity promotion programs to prevent Type 2 Diabetes among people at increased risk**, such as DPP, for people with prediabetes: • Establish new DPPs or expand satellite sites in identified underserved areas of the state (e.g., Appalachia, African-American communities, locations lacking a DPP) • Collaborate with payers and relevant public and private sector organizations to expand availability of DPP as a covered health or wellness benefit **ODAP**, **6/18**

Additional strategies	Includes
Preventive care delivered through patient-centered medical homes	• **Medical homes** (=) • **Ohio Comprehensive Primary Care model (CPC)** **ODAP**
Healthy behavior support delivered through technology	**Text message-based health interventions**, including reminders, education or self-management assistance to support physical activity, nutrition and weight loss
Tobacco/nicotine use reduction strategies	See page 35
Nutrition strategies	See page 37
Physical activity strategies	See page 40

(=) = Likely to reduce disparities, based on review by WWFH, or health equity strategy in CG; **ODAP** = Ohio Diabetes Action Plan; **6/18** = included in CDC's 6/18 initiative

Heart disease/diabetes

Relevant resources

- **Ohio Diabetes Action Plan**, Ohio Department of Health (ODH)
- **Diabetes Prevention and Management Program**, ODH
- **Heart Disease Prevention and Management Program**, ODH
- **The Impact of Chronic Disease in Ohio 2015**, ODH
- **HEALTHY U Ohio chronic disease programs**, Ohio Department of Aging
- **Directory of recognized lifestyle change programs, including interactive tool to find an in-person DPP class**, U.S. Centers for Disease Control and Prevention (CDC)
- **American Diabetes Association Prediabetes Risk Assessment**
- **Prevent Diabetes**, American Medical Association (AMA)
- **Prevent Diabetes STAT Toolkit**, CDC/AMA
- **National Diabetes Prevention Program Coverage Toolkit**, CDC

Oral health and chronic disease

There is growing recognition of the relationship between oral health and chronic disease conditions such as type 2 diabetes and hypertension. While there is not strong conclusive evidence that gum disease (periodontitis) therapy can reduce hypertension, the association between these conditions indicate that oral health should be part of a comprehensive approach to chronic disease.[1]

Childhood conditions:
Asthma

How will we know if health is improving in Ohio?

More Ohio children will live in homes and communities free of asthma triggers, children with asthma will have their symptoms under control without frequent trips to the emergency department and disparities in asthma outcomes will be eliminated.

Objectives

Ohio will use the following objective to monitor progress toward improving child asthma. Priority populations refer to groups with outcomes worse than Ohio overall.

Indicator (source)	**Baseline** (2016)	**Short-term target** (2022)	**Intermediate target** (2025)	**Long-term target** (2028)
CD5. Child asthma morbidity. Emergency department visits for pediatric asthma for children, ages 0-17, per 10,000 population (excludes patients with cystic fibrosis or abnormalities of the respiratory system, and transfers from other institutions) (OHA, via ODH)	72.3*	65.7	62.4	59.1
Priority population				
African American	175.9*	117.5	88.3	59.1

*The transition from ICD-9 to ICD-10 impacted reporting for emergency department visits for pediatric asthma, and age range changed from 2015 to 2017. According to ODH, progress should be determined using a baseline that is set after additional data is collected using ICD-10.

Target source: ODH

Strategies

If well-implemented and targeted to meet the needs of priority populations, the following evidence-informed strategies are likely to achieve the SHIP objectives for improving child asthma in Ohio. To effectively reduce child asthma, SHIP partners should also implement community conditions, health behaviors and access to care strategies (see parts 3-5).

Featured strategies	Includes
Multicomponent asthma interventions	• **EXHALE framework** (includes self-management education, smoking reduction, home visits, medical management, coordination of care and environmental policies) • **Healthy home environment assessments** (=) • **Home-based multi-trigger, multicomponent environmental interventions for children and adolescents** • **Home visits to improve self-management education and reduce home asthma triggers** 6/18
Housing improvements	• **Home Improvement Loans and Grants** Hi-5 • **Housing rehabilitation loan and grant programs** (=)

Additional strategies	Includes
School-based health	• **School-Based Health Centers** (see also WWFH: **School-based health centers** (=)) • School-based primary care that includes guidelines-based medical management as described in the **EXHALE framework** and changes to school environment as described in **Asthma Environmental Intervention Guide for School-Based Health Centers**
Culturally adapted care	**Culturally adapted health care** (=)
Tobacco cessation tailored for specific populations	• Intensive tobacco/nicotine cessation services tailored for parents of children with asthma • See tobacco section on page 35 for evidence-based tobacco cessation access strategies

(=) = Likely to reduce disparities, based on review by WWFH, or health equity strategy in CG; **Hi-5** = Health Impact in 5 years (CDC); **6/18** = included in CDC's 6/18 initiative

Relevant resources

- **Asthma Program**, Ohio Department of Health
- **EXHALE- A Technical Package to Control Asthma**, U.S. Centers for Disease Control and Prevention
- **Asthma Environmental Intervention Guide for School-Based Health Centers**, Regional Asthma Management and Prevention (RAMP), a project of the Public Health Institute, in partnership with the California School-Based Health Alliance
- **Guidelines for the Diagnosis and Management of Asthma**, National Asthma Education and Prevention Program (Note: The National Asthma Education and Prevention Program **Expert Panel Report 4 (EPR-4) Working Group** was convened in 2018 to update the 2007 Guidelines.)

Childhood conditions:
Lead poisoning

How will we know if health is improving in Ohio?

More Ohio children will live in homes and communities free of lead, Ohioans at risk of lead exposure will have the resources to mitigate lead hazards and disparities in lead poisoning outcomes will be eliminated.

Objectives

Ohio will use the following objective to monitor progress toward reducing child lead poisoning. Local communities can select this indicator to evaluate their own community health improvement activities. Priority populations refer to groups with outcomes worse than Ohio overall.

Indicator (source)	**Baseline** (2017)	**Short-term target** (2022)	**Intermediate target** (2025)	**Long-term target** (2028)
CD6. Child lead poisoning. Percent of children, ages 0-5, with elevated blood lead levels (BLL ≥5 ug/dl) (confirmed only) (ODH)	2.8%	2.25%	2.2%	2.15%
Priority population				
Residents of high-risk zip codes (As defined in ODH data warehouse)	3.5%	2.89%	2.52%	2.15%

Target source: ODH

Strategies

If well-implemented and targeted to meet the needs of priority populations, the following evidence-informed strategies are likely to achieve the SHIP objectives for reducing child lead poisoning in Ohio. To effectively reduce child lead poisoning, SHIP partners should also implement community conditions, health behaviors and access to care strategies (see parts 3-5).

Strategies▲	Includes
Blood lead level screening for at risk pregnant women and children	• Blood lead level (BLL) screening/testing[2] for pregnant women and children who are age 6 and under and who are at risk and/or on Medicaid. This testing is **required by the federal government** for children on Medicaid at 12 and 24 months of age, and any child on Medicaid between 24 and 72 months with no record of a previous blood lead screening test must receive one.[3] • Appropriate referrals and treatment as specified in **Pediatric Lead Assessment Network Training (PLANET)** Ohio-specific information: In addition to the Medicaid BLL screening requirement, a pending rule change (OAC 3701-30-02) will require primary health care providers for children who are at risk of lead poisoning to perform a BLL screening test at the child's one and two year well child visit and annually thereafter as medically indicated
Targeted outreach efforts in communities at risk of lead exposure	Intensive outreach in neighborhoods identified as most at risk, utilizing the **ODH Data Warehouse**[4] and/or the **Lead Exposure Risk Index**, encouraging parents of young children to request a blood lead level test
Public transparency regarding housing with or without lead hazards	**Real estate disclosures about potential lead hazards** Ohio-specific information: • The **Ohio Lead Hazardous Properties** dataset contains a searchable list of properties in Ohio whose owners have refused to comply with an order from the ODH or its delegated local board of health to correct known lead hazards • The **Ohio Housing Locator** allows the sorting of available rental units for those that are lead-safe[5]
Exposure to lead in homes and other settings to prevent lead poisoning	• **Lead paint abatement programs** completely control lead-based paint hazards. Exposure to lead paint can be addressed by eliminating the paint or mitigating and controlling by enclosure or encapsulation.[6] This work must be performed by **a professional who is certified**. • **Increased enforcement** of the **federal renovation, repair, and painting rule** at the state level

▲ None of the strategies for this topic area met the criteria for featured strategies. These criteria are listed in Part 1 and Appendix C.

Relevant resources

- **10 Policies to Prevent and Respond to Childhood Lead Exposure**, Health Impact Project
- **Childhood Lead Poisoning Prevention Program**, Centers for Disease Control and Prevention
- **Guidelines for the Identification and Management of Lead Exposure in Pregnant and Lactating Women**, Centers for Disease Control and Prevention
- **Prevention of Childhood Lead Toxicity**, Council on Environmental Health
- **Lead-Safe Certified Guide to Renovate Right**, U.S. Environmental Protection Agency
- **Federal Action Plan to Reduce Childhood Lead Exposures and Associate Health Impacts**
- **Ohio Healthy Homes Network**
- **Information about lead poisoning prevention and testing**, Ohio Department of Medicaid
- **Ohio Healthy Homes and Lead Poisoning Prevention Program**, Ohio Department of Health
- **ODH Lead Licensure and Accreditation Program**
- **Ohio Departments of Health (ODH) and Medicaid grants for lead paint hazard testing and removal**

Notes

1. Munoz Aguilera, Eva, et. al. "Periodontitis is associated with hypertension: a systematic review and meta-analysis." Cardiovascular Research, cvz201 (2019).
2. All capillary (finger/heel stick) test results ≥ 5 µg/dL must be confirmed by venous draw. Any confirmed level of lead in the blood is a reliable indicator that the child has been exposed to lead. All blood lead test results, by State law, are required to be reported to ODH by the analyzing lead pipe laboratory within seven days of analysis.
3. The USPSTF found insufficient evidence to recommend universal BLL screening for children and pregnant women.
4. A module is available in the ODH Data Warehouse to make childhood blood lead level data reported to the ODH accessible to public health professionals and the general public. ODH uses a predictive statistical model and known risk factors for elevated childhood blood-lead levels in Ohio incorporating a new target level of 5 µg/dL to define lead poisoning. ODH uses this model to target health promotion, funding, and environmental interventions to the most at risk areas of the state.
5. ODH recently developed a multimedia marketing campaign to recruit owners and agents of rental housing to apply to list their properties as Lead-Safe in the Ohio Housing Locator. ODH also recently created a targeted marketing plan to inform those seeking rental housing to utilize the Ohio Housing Locator to search for Lead-Safe housing.
6. The U.S. Environmental Protection Agency refers to this as the **Renovation, Repair and Painting** (RRP) rule.

Ohio's response to improve chronic disease

Comprehensive Primary Care for Kids
While Ohio ranks high nationally for access to medical care, Ohioans, including children, often have poorer health outcomes. To improve child health and wellness across the state, the Ohio Department of Medicaid launched the Comprehensive Primary Care for Kids program in early 2020. The program will provide $6 million in financial incentives to Ohio's pediatric primary care providers that focus on preventative care and achieve quality outcomes for children.

Lead Reduction
It is wrong that in 2020 there are still children whose opportunities are stifled because they live in homes where they are exposed to lead paint. The operating budget invested $25 million to prevent and treat lead poisoning and remediate homes of toxic lead. Governor Mike DeWine also convened a multi-disciplinary lead advisory committee in the fall of 2019. The Governor's Lead Advisory Committee is tasked with developing recommendations to address lead contamination in the state. Members include professional from public health, medicine, housing, construction trades, and state and local governments.

Student Wellness
Kids today are facing unprecedented challenges at home that come with them into the classroom, creating challenges for both students and teachers. The operating budget included a brand-new funding stream called Student Wellness and Success. This $675 million fund can be used to support student health, mental wellbeing, and academic success by providing schools with the financial resources to embed mental health counseling, physical health services, mentoring, after-school programs, and much more into their school buildings. As a result, schools will have more support and students will be better equipped for a brighter future.

Heart Disease/Diabetes
The Ohio Department of Health's Diabetes and Heart Disease Prevention and Management (DHDPM) Program implements and evaluates evidence-based strategies to prevent and manage diabetes and cardiovascular disease (CVD) in high-burden populations in Ohio. Strategies focus on:

- Improving care and management of people with diabetes.
- Improving access to, participation in, and coverage for the National Diabetes Prevention Program (DPP) Lifestyle Change Program for people with prediabetes, particularly in underserved areas.
- Use of electronic health records and health information technology to improve identification and management of adults with hypertension.
- Implementation of team-based care and other evidence-based best practices for hypertension and cholesterol management in clinical settings.
- Adoption of medication therapy management to improve management of diabetes, hypertension and high blood cholesterol.
- Linking community resources and clinical services that support systemic referrals, self-management, and lifestyle changes for patients with hypertension.

Asthma
The Asthma Program at the Ohio Department of Health (ODH) works to improve the reach, quality, effectiveness, and sustainability of asthma control services and to reduce asthma morbidity, mortality, and disparities by implementing evidence-based strategies across multiple sectors. Activities align with the Centers for Disease Control and Prevention initiative, Controlling Childhood Asthma Reducing Emergencies (CCARE), which focuses on key areas to improve childhood asthma outcomes. The Asthma Program has a priority focus on strengthening our existing organizational infrastructure to expand the reach of services through the six **EXHALE** strategies: **E**ducation on asthma self-management; e**X**tinguishing smoking and exposure to second-hand smoke; **H**ome visits for trigger reduction and asthma self-management education (AS-ME); **A**chievement of guidelines-based medical management; **L**inkages and coordination of care; and **E**nvironmental policies or best practices to reduce indoor and outdoor asthma

triggers. Key outcomes include increased capacity to deliver AS-ME, expanded services for those with the highest burden, improved asthma control, increased insurance coverage, coordinated care, and reduced health disparities. Long-term outcomes will contribute to the national CCARE goal of preventing 500,000 hospitalizations and emergency department visits among children with asthma within five years.

Lead Screening

Ohio has universal blood lead screening for children in targeted areas of the state and those who receive Medicaid assistance. Children should be screened at 12 and 24 months of age (or between 36 and 72 months if earlier tests are missed). Children are identified for blood lead screening by their primary care provider. In 2018, 168,352 children under the age of 6 received a blood lead screening test. Of those screened, 3,856 children had a confirmed elevated blood lead level. Ohio maintains a pediatric lead training network and an ongoing partnership with the Ohio chapter of the American Academy of Pediatrics that ensures that current lead screening requirements for children at risk are available for providers to follow.

8 Maternal and infant health

Preterm birth and infant mortality

Maternal morbidity

See Part 1 for information on:

Equity

Priorities

Tracking progress with SMART objectives

Strategies

Preterm birth and infant mortality

How will we know if health is improving in Ohio?

More babies will be born healthy, at full-term and will celebrate their first birthdays. Disparities in preterm birth and infant mortality will be eliminated.

Objectives

Ohio will use the following objectives to monitor progress toward reducing preterm birth and infant mortality. Local communities can select these indicators to evaluate their own community health improvement activities. Priority populations refer to groups with outcomes worse than Ohio overall.

Indicator (source)	**Baseline** (2018)	**Short-term target** (2022)	**Intermediate target** (2025)	**Long-term target** (2028)
MIH1. Total preterm births. Percent of live births that are preterm: before 37 weeks gestation (ODH Vital Statistics)	10.3%	10.1%	10%	9.9%
Priority population				
Black (non-Hispanic)	13.8%	12.2%	11.1%	9.9%
Women, ages 35-44	11.9%	11.1%	10.5%	9.9%
Women, ages 45+	20.7%	16.4%	13.1%	9.9%
Low educational attainment (no high school diploma)	11.4%	10.8%	10.4%	9.9%
MIH2. Infant mortality. Number of deaths for infants under age 1, per 1,000 live births (ODH Vital Statistics)	6.9	6.5	6.3	6
Priority population				
Black (non-Hispanic)	14	10.8	8.4	6
Youth, ages 15-17	10.8	8.9	7.4	6
Women, ages 18-24	8.1	7.3	6.6	6
Women, ages 45+	12.4	9.8	7.9	6
Low educational attainment (no high school diploma)	10.3	8.6	7.3	6
Residents of urban counties*	7.7	7	6.5	6

*County typology from the Ohio Medicaid Assessment Survey. See Appendix C for map of county types.
Target source: ODH

Strategies

If well-implemented and targeted to meet the needs of priority populations, the following evidence-informed strategies are likely to achieve the SHIP objectives for reducing preterm birth and infant mortality in Ohio. To effectively reduce preterm birth and infant mortality, SHIP partners should also implement community conditions, health behaviors and access to care strategies (see parts 3-5).

Featured strategies	Includes
Smoke-free policies Hi-5	• **Smoke-free policies for indoor areas** (including enforcement of Ohio's smoke-free workplace law) • Smoke-free policies for multi-unit housing and schools, including colleges and universities
Early childhood home visiting	• **Early childhood home visiting programs**, including prenatal and postnatal visits (=) • For information about evidence-based home visiting programs see: **U.S. Department of Health and Human Services, Home Visiting Evidence of Effectiveness**
Group prenatal care	**CenteringPregnancy** (=)

Additional strategies	Includes
Paid Leave	**Paid family leave** (=)
Tobacco cessation tailored for pregnant women	• Intensive tobacco/nicotine cessation services tailored for pregnant women and people of childbearing age, including **Baby and Me Tobacco Free program** • See tobacco section on page 35 for evidence-based tobacco cessation access strategies
Non-Emergency Medical Transportation	• **Non-Emergency Medical Transportation (NEMT) to improve access to care and prenatal care** • Monitor and improve NEMT provided by Ohio Medicaid managed care plans. For specific recommendations, see: **A New Approach To Reduce Infant Mortality and Achieve Equity: Policy recommendations to improve housing, transportation, education and employment**
Care coordination and access to well-woman care	• **Community health workers** (=) • **Certified Pathways Community HUB model** • **Patient navigators** (=) • **Continuous support for women during pregnancy and childbirth, includes certified doulas** • **Mobile reproductive health clinics** (=) • **Synthetic progesterone (17P) access** (=), includes provider use of the **Pregnancy Risk Assessment Form** • **Preconception education interventions**, includes nutrition, exercise and weight management, birth control methods, sexually transmitted infection prevention, chronic disease, alcohol consumption, tobacco cessation and other tobacco use or improving mental health

(=) = Likely to reduce disparities, based on review by WWFH, or health equity strategy in CG; **Hi-5** = Health Impact in 5 years (CDC)

Relevant resources

- **Infant Mortality Reduction Plan 2015-2020**, Ohio Collaborative to Prevent Infant Mortality (OCPIM)
- **Annual Infant and Fetal Mortality Reports**, Ohio Department of Health (ODH)
- **Progesterone Messaging Toolkit**, OCPIM
- **Maternal and Child Health Program**, ODH
- **A New Approach to Reduce Infant Mortality and Achieve Equity: Policy recommendations to improve housing, transportation, education and employment**, Health Policy Institute of Ohio
- **State Infant Mortality (SIM) Toolkit: A Standardized Approach for Examining Infant Mortality**, Association of Maternal and Child Programs
- **Preventing Child Abuse and Neglect: A Technical Package for Policy, Norm, and Programmatic Activities 2016**, U.S. Centers for Disease Control and Prevention
- **California Evidence-Based Clearinghouse for Child Welfare (CEBC)**
- **Medical Expert Panel: White Paper, Achieving Equity and Eliminating Infant Mortality Disparities within Racial and Ethnic Populations: From Data to Action**, Ohio Commission on Minority Health

Maternal morbidity

How will we know if health is improving in Ohio?

More women of child-bearing age will have healthy pregnancies and safe deliveries. All expectant mothers will receive high-quality well-woman, prenatal, delivery, postpartum and interpregnancy care. Disparities in maternal morbidity will be eliminated.

Objectives

Ohio will use the following objectives to monitor progress toward reducing maternal morbidity. Priority populations refer to groups with outcomes worse than Ohio overall.

Indicator (source)	**Baseline** (2016)	**Short-term target** (2022)	**Intermediate target** (2025)	**Long-term target** (2028)
MIH3. Severe maternal morbidity. Number of delivery hospitalizations with one or more of 18 conditions (maternal morbidities) as defined by the CDC, per 10,000 delivery hospitalizations (OHA, via ODH)	107.8	100.9	95.3	91.1
Priority population				
Black, non-Hispanic	152	121.6	106.3	91.1
Hispanic	133.2	112.2	101.6	91.1
Youth, ages 15-19	133.5	112.3	101.7	91.1
Women, ages 35-39	119.6	105.4	98.2	91.1
Women, ages 40-55	223.8	157.5	124.3	91.1
Women with Medicaid coverage and other public coverage	135.7	113.4	102.3	91.1
Residents of Appalachian counties*	123.5	107.3	99.2	91.1

*County typology from the Ohio Medicaid Assessment Survey. See Appendix C for map of county types.
Target source: ODH

Strategies

If well-implemented and targeted to meet the needs of priority populations, the following evidence-informed strategies are likely to achieve the SHIP objectives for reducing maternal morbidity in Ohio. To effectively reduce maternal morbidity, SHIP partners should also implement community conditions, health behaviors and access to care strategies (see parts 3-5).

Strategies▲	Includes
Income support policies	
Paid leave	Paid family leave (=)
Family, social and educational support programs	
Early childhood home visiting	• Early childhood home visiting programs, including prenatal and postnatal visits (=) • For information about evidence-based home visiting programs see: U.S. Department of Health and Human Services, Home Visiting Evidence of Effectiveness
Group prenatal care	CenteringPregnancy (=)
Tobacco cessation	
Tobacco cessation tailored for pregnant women	• Intensive tobacco/nicotine cessation services tailored for pregnant women and people of childbearing age, including Baby and Me Tobacco Free program • See tobacco section on page 35 for evidence-based tobacco cessation access strategies
Clinical interventions and care coordination	
Care coordination and access to well-woman care	• Non-Emergency Medical Transportation (NEMT) to improve access to care and prenatal care • Monitor and improve NEMT provided by Ohio Medicaid managed care plans. For specific recommendations, see: A New Approach To Reduce Infant Mortality and Achieve Equity: Policy recommendations to improve housing, transportation, education and employment • Preconception education interventions (including nutrition, exercise and weight management, birth control methods, sexually transmitted infection prevention, chronic disease, alcohol consumption, tobacco cessation and other tobacco use or improving mental health) • Optimizing Postpartum Care, includes ongoing postpartum care with services and support tailored to individual needs • Continuous support for women during pregnancy and childbirth, includes certified doulas • Mobile reproductive health clinics (=) • Telemedicine/Telehealth (=) • Patient financial incentives for preventive care (=) • Patient navigators (=)
Clinical prevention, screening and treatment	• Screening and referring mothers postpartum at pediatric visits • Lifestyle Interventions to Reduce the Risk of Gestational Diabetes and Type 2 Diabetes • Gestational Diabetes Mellitus, Screening • Low-Dose Aspirin Use for the Prevention of Morbidity and Mortality from Preeclampsia: Preventive Medication

(=) = Likely to reduce disparities, based on review by WWFH, or health equity strategy in CG

▲ None of the strategies for this topic area met the criteria for featured strategies. These criteria are listed in Part 1 and Appendix C.

Strategies (cont.)	**Includes**
Continuous quality improvement	
Safety and quality improvement	• **Severe Maternal Morbidity: Screening and Review by delivery facilities** • **Safe Prevention of the Primary Cesarean Delivery** • **Interventions to Minimize Preterm and Low birthweight Infants using Continuous quality Improvement Techniques (IMPLICIT)** interconception care toolkit • **Maternal safety bundles (AIM)** • **Assure risk-appropriate care (deliveries occur at the appropriate level, by facilities)**
Provider and cultural competency trainings	• **POST-BIRTH Warning Signs Education Program** • **The Ohio Pregnancy Associated Mortality Review: Simulation Training to Prepare for Obstetric Emergencies** • **Cultural competence training for health care professionals** and implicit bias training (=)

(=) = Likely to reduce disparities, based on review by WWFH, or health equity strategy in CG

▲ None of the strategies for this topic area met the criteria for featured strategies. These criteria are listed in Appendix C.

Relevant resources

- **CDC Levels of Care Assessment Tool (CDC LOCATe)**
- **Eliminate Preventable Maternal Mortality**, American College of Obstetricians and Gynecologists (ACOG)
- **ACOG Committee Opinion No. 736: Optimizing Postpartum Care**
- **Health for Every Mother: A Maternal Health Resource and Planning Guide for States**, The Association of Maternal and Child Health Programs (AMCHP)
- **Alliance for Innovation on Maternal Health (AIM-Maternal Health)**, Council on Patient Safety in Women's Health Care
- **Review to Action**, Working Together to Prevent Maternal Morbidity
- **Pregnancy Mortality Surveillance System**, U.S. Centers for Disease Control and Prevention
- **POST-BIRTH Warning Signs Toolkit**, AWHONN (Fee required to access)

Ohio's response to improve maternal and infant health

Home Visiting
As part of Governor Mike DeWine's "Opportunity for Every Ohio Kid" plan, he committed to expanding evidence-based home visiting services to triple the number of families being served. Through the biennial budget process, ODH received a $30 million increase to Help Me Grow Home Visiting funding, moving the investment from $19 million in SFY 18 to $30 million in SFY 20 and $39 million in SFY 21. This allows ODH to increase the number of families served by 68%. Additionally, the new funding allowed ODH to stabilize the provider network by increasing the rates on January 1.

Ohio Equity Institute
"Ohio Equity Institute (OEI): Working to Achieve Equity in Birth Outcomes" is a grant-funded collaboration between the Ohio Department of Health and local partners created in 2012 to address racial inequities in birth outcomes. Population data is used to target areas for outreach and services in the nine counties with the largest disparities. The goal of the program is to address the biggest drivers of inequities in poor birth outcomes and infant mortality. Each county is tasked with addressing disparities in perinatal, infant, and maternal health in two ways: 1) local Neighborhood Navigators identify and connect a portion of each county's priority prenatal population to clinical and social services to reduce stress and improve access to needed resources; and 2) local entities facilitate the development, adoption, or improvement of policies and/or practices that impact the social determinants of health related to preterm birth and low birth weight in OEI counties.

Ohio Department of Medicaid Infant Mortality Grant for Ohio Equity Institute Communities
Ohio has one of the highest infant mortality rates in the country. In order to have better birth outcomes, the state operating budget has invested $26 million to support evidence-based programs in the nine Ohio Equity Institute communities identified as having elevated infant mortality rates. Use of these grant dollars will align with Ohio Medicaid's strategies including supporting community-driven models of care and health equity efforts.

Maternal Infant Supports Program
The Ohio Department of Medicaid is designing a new service to support expectant mothers that may need supportive services beyond standard obstetrical care. This new service line will bring together home visiting programs, peer supporters, doulas and other care navigators, and much more to meets the needs of Ohio's highest risk pregnant women. Through collaboration, leveraging expertise, and a sense of urgency, the Maternal Infant Supports Program will help improve outcomes for women and children.

Maternal Morbidity
Ohio's Pregnancy-Associated Mortality Program (PAMR) was developed in 2010 to reduce preventable maternal morbidity and mortality. In 2019, ODH was awarded approximately $12.2 million in grants from the Health Resources and Services Administration and the Centers for Disease Control and Prevention to support prevention and reduce disparities. Findings from PAMR's multidisciplinary review of deaths were used to plan data-driven grant activities for the next five years. They include:

- Training on implicit bias for public health and clinical providers.
- Quality improvement within delivery facilities to assure adherence to evidence-based care for hypertension.
- Raising awareness of Urgent Maternal Warning Signs through public health providers.
- Training on telehealth delivery.
- Implementation of brief postpartum screenings and referrals during infant well-child visits.

In 2020, Ohio will establish the Ohio Collaborative to Advance Maternal Health (OH-CAMH) to guide and advance this work.

9 Evaluation plan

The Ohio Department of Health (ODH) will establish a statewide governance infrastructure that addresses both accountability for statewide State Health Improvement Plan (SHIP) implementation and sustainability over time. This evaluation plan outlines the intent of that structure and will be updated to reflect a final evaluation plan as part of the first SHIP annual report. ODH will offer support and guidance to state and local agencies to assure alignment with the SHIP and implementation of related initiatives.

The 2020-2022 SHIP evaluation will:

- Assess progress on the 37 SMART objectives
- Track implementation of SHIP strategies at the state and local levels
- Communicate progress and demonstrate accountability to key SHIP stakeholders and the public on a regular basis
- Ensure that ODH meets Public Health Accreditation Board (PHAB) standards related to SHIP implementation
- Inform development of the 2022 State Health Assessment (SHA) and any needed updates for the 2023-2025 SHIP

State-level outcome evaluation

Performance related to each SHIP indicator will be monitored and reported on an annual basis (or more frequently for data sources that are available). Lead agencies for each indicator are listed in Appendix A and are typically the state-level entity that compiles and/or manages the data for the relevant indicator. ODH will compile the data provided by the lead state agencies.

ODH will share progress on SHIP objectives with the SHA/SHIP Steering Committee and the public through an annual report or online dashboard that communicates which indicators are improving, getting worse, or staying the same, and whether short-term targets have been met. Annual SHIP reporting will include state-level data for Ohio overall and for all priority populations. Agencies are encouraged to use the findings of these progress reports to guide continuous quality improvement and resource allocation, with support from ODH.

State-level process evaluation

Each state agency that is a member of the established statewide governance entity will document implementation of SHIP strategies and any other process steps taken to achieve relevant SHIP objectives. Agencies are encouraged to identify and report to ODH:

- A list of the specific SHIP objectives to which they contribute (i.e. select objectives that most closely align with their mission, strategic plan and programs)
- Relevant SHIP strategies they are currently implementing or plan to implement in the future
- Other strategies they are implementing or plan to implement that may contribute to progress on selected SHIP objectives

If not already in place, agencies are encouraged to develop action plans that describe specific inputs, outputs and activities that support implementation of SHIP strategies. Quarterly or semi-annual reviews of progress on these action plans, along with the annual outcome reports described above, will guide continuous quality improvement within each agency.

Local-level outcome evaluation

Local health departments, hospitals, Alcohol, Drug and Mental Health (ADAMH) boards and other local partners are encouraged to select SHIP indicators that align with their community priorities (see Appendix A for complete list of indicators and sources). Local partners can obtain baseline data for the indicator for their geographic area (e.g., city, county, school district or region), if available, and set targets for the overall population and for priority populations. The **online SHA** provides county-level data for many SHIP indicators. Regular reporting of progress on the selected indicators can be used to evaluate the outcomes of community health improvement efforts.

Local-level process evaluation

Local health departments and tax-exempt hospitals are required to submit their community health improvement plans (CHIPs) and community health needs assessment implementation strategies (CHNAISs) to ODH. As part of this submission process, ODH will ask these organizations to identify which SHIP priorities, indicators and strategies are included in their plans. ODH will report the extent to which SHIP strategies are being implemented around the state through an annual report or online dashboard.

Considerations for the 2022 SHA and 2023-2025 SHIP

As part of development of the 2022 SHA, ODH will assess the extent to which the 2019 SHA and 2020-2022 SHIP have contributed to the following:

1. Improved health outcomes and reduction of disparities and inequities
2. Stronger alignment between local assessments (CHAs and CHNAs) and the SHA
3. Stronger alignment between local plans (CHIPs and CHNA-ISs) and the SHIP
4. Increased collaboration between local health departments and hospitals on assessments and plans (in communities where this collaboration was not already happening or was happening in a minimal way)
5. Increased cross-sector collaboration, including partnerships between health organizations and housing, education, violence prevention, child welfare and other organizations
6. Increased collaboration across state agencies to implement and sustain SHIP strategies
7. More efficient and effective resource allocation toward SHIP-aligned priorities and strategies at the state level
8. Increased transparency of hospital community benefit spending and voluntary community benefit investment in CHNA-IS-aligned strategies, including SHIP strategies that address community conditions
9. More widespread implementation of SHIP-aligned evidence-based strategies at the state and local levels, including policy and systems changes
10. Increased implementation of strategies in priority population communities, including programs and services delivered by culturally-competent providers and adapted to fit cultural context
11. Stronger coordination between state agencies, including agencies in sectors beyond health
12. Improved data collection and reporting, including better access to county-level and sub-group data (by race, ethnicity, disability status, etc.) for SHIP indicators

appendix A List of SHIP indicators

Overall health

Desired outcome	Indicator	Source	Lead state agency	Local data availability
Improve overall health status	**OH1. Adult health status.** Percent of adults, ages 18 and older, with fair or poor health	BRFSS	ODH	Yes: County-level data is available from **County Health Rankings & Roadmaps**. See also, online SHA.
	Priority populations: Black, non-Hispanic; Hispanic; Adults, ages 55-64; Adults, ages 65+; Low-income (less than $15,000 annual household income); People with a disability; Sexual and gender minorities			
Reduce premature death	**OH2. Years of Potential Life Lost (YPLL) before age 75.** Years of potential life lost before age 75, per 100,000 population (age adjusted)	ODH Vital Statistics	ODH	Yes: Requires calculation. Data can be accessed through the **Ohio Department of Health's Public Health Data Warehouse**. See dataset documentation for considerations for smaller geographic areas. See also, online SHA.
	Priority populations: Black, non-Hispanic; Residents of rural; Appalachian counties*; Male			

*County typology from the Ohio Medicaid Assessment Survey. See Appendix C for map of county types.

Community conditions

Desired outcome	Indicator	Source	Lead state agency	Local data availability
Improve housing affordability and quality	**CC1. Affordable and available housing units (very low income).** Number of affordable and available units per 100 renters with income below 50% of Area Median Income (very low income)	NLIHC analysis of ACS	OHFA	Yes: County-level data available from the **Ohio Housing Finance Agency's Housing Needs Assessment**.
Reduce poverty	**CC2. Child poverty.** Percent of children, ages 17 and under, who live in households at or below the poverty threshold	ACS	ODJFS	Yes: County and census tract data available at **data.census.gov**. Consider using five-year estimates for smaller population sizes. See also, online SHA.
	Priority populations: Black (includes Hispanic and non-Hispanic); Hispanic or Latino (any race); Children with a disability			
	CC3. Adult poverty. Percent of adults, ages 18 and older, who live in households at or below the poverty threshold	ACS	ODJFS	Yes: County and census tract data available at **data.census.gov**. Consider using five-year estimates for smaller population sizes. See also, online SHA.
	Priority populations: Black (includes Hispanic and non-Hispanic); Hispanic or Latino (any race); Low educational attainment (less than a high school graduate)*; Adults with a disability; Female			

*Poverty by educational attainment is for adults ages 25 and oder, not ages 18 and older

Community conditions (cont.)

Desired outcome	Indicator	Source	Lead state agency	Local data availability
Improve K-12 student success	**CC4. Chronic absenteeism (K-12 students).** Percent of students, grades K-12, who are chronically absent	ODE	ODE	Yes: School- and school district-level data are available from **Ohio School Report Cards**.
	Priority populations: Black, non-Hispanic; Hispanic; Economically disadvantaged; Students with a disability			
	CC5. Kindergarten readiness. Percent of kindergarten students demonstrating readiness (entered kindergarten with sufficient skills, knowledge and abilities to engage with kindergarten-level instruction)	KRA	ODE	Yes: County- and school district-level data are available for download from **Ohio School Report Cards** website.
	Priority populations: Economically disadvantaged; Students with a disability; English learners			
Reduce adverse childhood experiences	**CC6. Adverse childhood experiences (ACEs).** Percent of children, ages 0-17, who have experienced two or more adverse experiences	NSCH	ODJFS	No
	Priority populations: Black, non-Hispanic; Hispanic; Low-income (household income below 200% FPL); Children with special health care needs (CSHCN)			
	CC7. Child abuse and neglect. Rate of screened-in child abuse and neglect reports per 1,000 children in population*	SACWIS, via ODJFS	ODJFS	Yes, upon reqest; Local data may be available upon request from **County Department of Job and Family Services**.

*Data represents the count of Distinct Alleged Child Victim (ACV) and Child Subject of Report (CSR) for Child Abuse Neglect Reports Received in calendar year 2018. Ohio uses a Differential Response model which allows reports of potential child abuse or neglect to be processed through the Traditional Pathway or an Alternative Response Pathway. This data includes reports that are "screened-in" to either pathway, indicating a potential case of child abuse or neglect.

Health behaviors

Desired outcome	Indicator	Source	Lead state agency	Local data availability
Decrease tobacco/nicotine use	**HB1. Adult smoking.** Percent of adults, ages 18 and older, that are current smokers	BRFSS	ODH	Yes: County-level data is available from **County Health Rankings & Roadmaps**. See also, online SHA. For women who are pregnant, request access to the Ohio Department of Health's Secure Public Health Data Warehouse.
	Priority populations: Black, non-Hispanic; Hispanic; Adults, ages 25-34; Adults , ages 35-44; Adults, ages 45-54; Low-income (less than $15,000 annual household income); People with a disability; Lesbian, gay, bisexual or transgender adults; Women who are pregnant			
	HB2. Youth all-tobacco/ nicotine use. Percent of high school students who have used cigarettes, smokeless tobacco (i.e. chewing tobacco, snuff or dip), cigars, pipe tobacco, hookah, bidis, e-cigarettes or other vaping products during the past 30 days	OYTS	ODH	No
	Priority population(s): Lesbian, gay or bisexual students			
Improve nutrition	**HB3. Youth fruit consumption.** Percent of high school students who did not eat fruit or drink 100% fruit juices during past 7 days	YRBS	ODH	No
	HB4. Youth vegetable consumption. Percent of high school students who did not eat vegetables (excluding french fries, fried potatoes or potato chips) during past 7 days	YRBS	ODH	No
Increase physical activity	**HB5. Child physical activity.** Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day	NSCH	ODH	No
	HB6. Adult physical inactivity. Percent of adults, age 18 and older, reporting no leisure time physical activity	BRFSS	ODH	Yes, similar: County-level data for a similar indicator is available from **County Health Rankings & Roadmaps**.
	Priority populations: Hispanic; Black (non-Hispanic); Adults, 65+; Low-income (less than $15,000 annual household income); People with a disability			

Access to care

Desired outcome	Indicator	Source	Lead state agency	Local data availability
Increase health insurance coverage	**AC1. Uninsured adults.** Percent of adults, ages19-64, who are uninsured	ACS	ODH	Yes: County and census tract data available at **data.census.gov**. Consider using five-year estimates for smaller population sizes. See also, online SHA.
	Priority populations: Hispanic or Latino (any race); Black (includes Hispanic and non-Hispanic); Income below 138% of the federal poverty level (FPL); Male			
	AC2. Uninsured children. Percent of children, ages 0-18, who are uninsured	ACS	ODH	Yes: County and census tract data available at **data.census.gov**. Consider using five-year estimates for smaller population sizes. See also, online SHA.
	Priority populations: Hispanic or Latino (any race); Income below 200% FPL			
Increase local access to healthcare services	**AC3. Primary care health professional shortage areas.** Percent of Ohioans living in a primary care health professional shortage area	HRSA, as compiled by KFF	ODH	Yes, similar: County-level data for a similar indicator is available from **County Health Rankings & Roadmaps**. See also, online SHA.
	AC4. Mental health professional shortage areas. Percent of Ohioans living in a mental health professional shortage area	HRSA, as compiled by KFF	ODH	Yes, similar: County-level data for a similar indicator is available from **County Health Rankings & Roadmaps.** See also, online SHA.
Reduce unmet need for mental health care	**AC5. Youth depression treatment unmet need.** Percent of youth, ages 12-17, with major depressive episode who did not receive any mental health treatment within the past year	MHA analysis of NSDUH	ODH	No
	AC6. Adult mental health care unmet need. Percent of adults, ages 18 and older, with past year mental illness who reported perceived need for treatment/counseling that was not received	MHA analysis of NSDUH	ODH	No

Mental health and addiction

Desired outcome	Indicator	Source	Lead state agency	Local data availability
Reduce depression	**MHA1. Youth depression (major depressive episode).** Percent of youth, ages 12-17, who experienced a major depressive episode within the past year	NSDUH	OMHAS	No
	MHA2. Adult depression (major depressive episode). Percent of adults, ages 18 and older, who experienced a major depressive episode within the past year	NSDUH	OMHAS	Yes, similar: County-level data for a similar indicator is available from **County Health Rankings & Roadmaps.** See also, online SHA.
Reduce suicide deaths	**MHA3. Youth suicide deaths.** Number of deaths due to suicide for youth, ages 8-17, per 100,000 population	ODH Vital Statistics	ODH and OMHAS	Yes: County-level data is available from the **Ohio Department of Health's Public Health Data Warehouse**. See also, online SHA.
	Priority populations: White, non-Hispanic; Residents of Appalachian counties*; Male			
	MHA4. Adult suicide deaths. Number of deaths due to suicide for adults, ages 18 and older, per 100,000 population	ODH Vital Statistics	ODH and OMHAS	Yes: County-level data is available from the **Ohio Department of Health's Public Health Data Warehouse**. See also, online SHA.
	Priority populations: Adults, ages 35-44; Adults, ages 55-64; Residents of Appalachian counties*; Male			
Reduce youth drug use	**MHA5. Youth alcohol use.** Percent of high school students who have used alcohol within the past 30 days	YRBS	ODH and OMHAS	No
	Priority population(s): Female students			
	MHA6. Youth marijuana use. Percent of high school students who have used marijuana within the past 30 days	YRBS	ODH and OMHAS	No
	Priority population(s): Black students; Hispanic students; Gay, lesbian or bisexual students			
Reduce drug overdose deaths	**MHA7. Unintentional drug overdose deaths.** Number of deaths due to unintentional drug overdose, per 100,000 population (age adjusted)	ODH Vital Statistics	ODH and OMHAS	Yes: County-level data is available from the **Ohio Department of Health's Public Health Data Warehouse.** See also, online SHA.
	Priority populations: Adults, ages 25-34; Adults, ages 35-44; Adults, ages 45-54; Residents of Appalachian counties*; Residents of urban counties*; Male			

*County typology from the Ohio Medicaid Assessment Survey. See Appendix C for map of county types.

Chronic disease

Desired outcome	Indicator	Source	Lead state agency	Local data availability
Reduce heart disease	**CD1. Coronary heart disease.** Percent of adults, ages 18 and older, ever diagnosed with coronary heart disease	BRFSS	ODH	No
	Priority populations: Adults, ages 55-64; Adults, ages 65+; Low-income (less than $15,000 annual household income); People with a disability; Males			
	CD2. Premature death - heart disease. Years of potential life lost before age 75 due to heart disease, per 100,000 population (age adjusted)	ODH Vital Statistics	ODH	Yes: Requires calculation. Data can be accessed through the **Ohio Department of Health's Public Health Data Warehouse**. See dataset documentation for considerations for smaller geographic areas. See also, online SHA.
	Priority populations: Black, non-Hispanic; Residents of Appalachian counties*; Males			
	CD3. Hypertension. Percent of adults, ages 18 and older, ever diagnosed with hypertension	BRFSS	ODH	No
	Priority populations: Black (non-Hispanic); Adults, ages 55-64; Adults, ages 65+; Low-income (less than $15,000 annual household income); People with a disability			
Reduce diabetes	**CD4. Diabetes.** Percent of adults, ages 18 and older, ever diagnosed with diabetes	BRFSS	ODH	Yes, similar: County-level data for a similar indicator is available from **County Health Rankings & Roadmaps**. See also, online SHA.
	Priority populations: Black (non-Hispanic); Adults, 55-64; Adults, 65+; Low-income (less than $15,000 annual household income); People with a disability			
Reduce harmful childhood conditions	**CD5. Child asthma morbidity.** Emergency department visits for pediatric asthma for children, ages 0-17, per 10,000 population (excludes patients with cystic fibrosis or abnormalities of the respiratory system, and transfers from other institutions)**	OHA, via ODH	ODH	No
	Priority population: African American			
	CD6. Child lead poisoning. Percent of children, ages 0-5, with elevated blood lead levels (BLL ≥5 ug/dl)	ODH	ODH	Yes: County-level data is available from the **Ohio Department of Health's Public Health Data Warehouse**. See also, online SHA.
	Priority populations: Residensts of high risk zip codes (As defined in ODH data warehouse)			

*County typology from the Ohio Medicaid Assessment Survey. See Appendix C for map of county types.
**The transition from ICD-9 to ICD-10 impacted reporting for emergency department visits for pediatric asthma. Progress should be determined using a baseline set after additional data is collected using ICD-10.

Maternal and infant health

Desired outcome	Indicator	Source	Lead state agency	Local data availability
Reduce preterm births	**MIH1. Total preterm births.** Percent of live births that are preterm: before 37 weeks gestation	ODH Vital Statistics	ODH	Yes: County-level data is available from the **Ohio Department of Health's Public Health Data Warehouse**. See also, online SHA.
	Priority population(s): Black (non-Hispanic); Women, ages 35-44; Women, ages 45+; Low educational attainment (no high school diploma)			
Reduce infant mortality	**MIH2. Infant mortality.** Number of deaths for infants under age 1, per 1,000 live births	ODH Vital Statistics	ODH	Yes: County-level data is available from the **Ohio Department of Health's Public Health Data Warehouse**. See also, online SHA.
	Priority population(s): Black (non-Hispanic); Youth, ages 15-17; Women ages 18-24; Womens ages 45+; Low educational attainment (no high school diploma); Residents of urban counties*			
Reduce maternal morbidity/mortality	**MIH3. Severe maternal morbidity.** Number of delivery hospitalizations with one or more of 18 conditions (maternal morbidities) as defined by the CDC, per 10,000 delivery hospitalizations	OHA, via ODH	ODH	No
	Priority population(s): Black, non-Hispanic; Hispanic; Women, ages 15-19; Women, ages 35-39; Women, ages 40-55; Women with Medicaid coverage and other public coverage; Residents of Appalachian counties*			

*County typology from the Ohio Medicaid Assessment Survey. See Appendix C for map of county types.

appendix B SHIP strategy quick guide

This is a high-level compilation of SHIP strategies. For more detail:
- See Appendix A for more information about indicators
- See topic sections in Parts 3-8 for more information about strategies

= One or more specific strategies within this category are likely to reduce disparities, based on review by WWFH, or health equity strategy in CG

★ Strategy is identified in two or more SHIP topic areas

▲ None of the strategies for this topic area met the criteria for featured strategies. These criteria are listed in Part 1 and Appendix C. Because no featured strategies are available, all strategies for this topic are displayed.

SHIP topic area	Featured strategies
Community conditions	
Housing affordability and quality ▲ Indicator CC1	• Rental assistance = • Affordable housing development and preservation = • Neighborhood improvements =
Poverty Indicators CC2 and CC3	• Child care subsidies = • Adult employment programs = • High school equivalency programs =
K-12 student success: Chronic absenteeism Indicator CC4	• Attendance interventions for chronically absent students = • Social-emotional learning and positive behavior initiatives • Middle and high school programs and policies that increase attendance =
K-12 student success: Kindergarten readiness Indicator CC5	• Early childhood home visiting = ★ • Early childhood education = • K-12 and family resilience =
Adverse childhood experiences Indicators CC6 and CC7	• Early childhood home visiting = ★ • Parenting, mentorship and school-based prevention = • Supports for system-involved children and youth • Violence prevention and crime deterrence = • Neighborhood conditions
Health behaviors	
Tobacco/nicotine use Indicators HB1 and HB2	• Increase the unit price of tobacco products = • Smoke-free policies ★ • Mass media campaigns against tobacco use • Tobacco cessation access =
Nutrition Indicators HB3 and HB4	• Healthy meals served at schools = • Fruit and vegetable access and education • Outreach and advocacy to maintain or increase enrollment in federal food assistance programs • Healthy food in food banks = • Fruit and vegetable initiatives =
Physical activity Indicators HB5 and HB6	• School-based programs to increase physical activity • Safe Routes to School • Transportation and land use policies (built environment changes and green space) = • Community fitness programs • Exercise prescriptions

SHIP strategy quick guide (cont.)

SHIP topic area	Featured strategies
Access to care	
 **Health insurance coverage** Indicators AC1 and AC2	• Outreach and advocacy to maintain Ohio Medicaid eligibility level and enrollment assistance • Insurance enrollment assistance for adults and children
 **Local access to healthcare providers** Indicators AC3 and AC4	• Comprehensive and coordinated primary care • Culturally competent workforce in underserved communities ★ • Telehealth
 **Unmet need for mental health care** Indicators AC5 and AC6	• Comparable insurance coverage for behavioral health (parity) ★ • Telehealth for mental health
Mental health and addiction	
 **Depression** Indicators MHA1 and MHA2	• Social and emotional instruction • Coordinated care for behavioral health • Digital access to treatment services and crisis response ★ • Physical activity programs • Parenting programs
 **Suicide** Indicators MHA3 and MHA4	• Suicide awareness, prevention and peer norm programs • Limits on access to lethal means
 **Youth drug use** Indicators MHA5 and MHA6	• K-12 drug prevention education • Alcohol policy changes • Alcohol and other drug use screening (SBIRT)
 **Drug overdose deaths** ▲ Indicator MHA7	• Naloxone education and distribution programs • Prescription drug monitoring programs (PDMPs) • Syringe services programs (SSPs) • Medication-assisted treatment (MAT) access • Comparable insurance coverage for behavioral health (parity) ★ • Culturally competent workforce in underserved communities ★ • Recovery communities and peer supports • Housing programs for people with behavioral health conditions

SHIP strategy quick guide (cont.)

SHIP topic area	Featured strategies
Chronic disease	
 **Heart disease and diabetes** Indicators CD1, CD2, CD3 and CD4	• Hypertension screening and follow up • Prediabetes screening, testing and referral to Diabetes Prevention Program (DPP) • DPP health insurance coverage and accessibility
 **Childhood conditions: Asthma** Indicator CD 5	• Multicomponent asthma interventions 〓 • Housing improvements 〓
 **Childhood conditions: Lead poisoning▲** Indicator CD 6	• Blood lead level screening for at risk pregnant women and children • Targeted outreach efforts in communities at risk of lead exposure • Public transparency regarding housing with or without lead hazards • Exposure to lead in homes and other settings to prevent lead poisoning
Maternal and infant health	
 **Preterm birth and infant mortality** Indicators MIH1 and MIH 2	• Smoke-free policies ★ • Early childhood home visiting 〓 ★ • Group prenatal care 〓 ★
 **Maternal morbidity▲** Indicator MIH 3	• Paid leave 〓 • Early childhood home visiting 〓 ★ • Group prenatal care 〓 ★ • Tobacco cessation tailored for pregnant women • Care coordination and access to well-woman care 〓 • Clinical prevention, screening and treatment • Safety and quality improvement • Provider and cultural competency trainings 〓