



2014

Year in Review

**Ohio's Plan to Prevent and
Reduce Chronic Disease
2014 - 2018**

Overview

Chronic diseases, such as heart disease, stroke, diabetes and cancer, are the leading cause of death and disability in Ohio. Along with their associated risk factors (high blood pressure, obesity, tobacco use, physical inactivity, poor nutrition), treating chronic diseases cost Ohio more than \$27 billion a year in workplace absenteeism and in direct medical costs. Much of this burden is preventable, and even small changes in the health of Ohioans can contribute to preventing more than 600,000 new cases of cancer, diabetes, heart disease and stroke in the future.

Ohio's Plan to Prevent and Reduce Chronic Disease: 2014-2018 (CD Plan), originally created as part of the Ohio State Health Improvement Plan (SHIP), was developed to achieve one overarching goal: To prevent and reduce the burden of chronic disease for all Ohioans. The plan presents a set of priority-driven objectives tied to long-term outcomes to improve population health. Experts from public health, health care, business, education, transportation and planning, and state and local government used national guidelines and state and county data to develop a coordinated approach to chronic disease prevention and health promotion.

Throughout 2014, stakeholders within key sectors—schools and universities, community organizations, state and local governments, worksites, and healthcare systems and providers—aligned their activities and leveraged resources to support the plan's objectives and build communities that support health. The year-in-review annual snapshot comprising this report features key objective and strategy progress achieved in each of four Core Focus Areas (CFAs). Also highlighted are success stories from members of the Ohio Chronic Disease Collaborative (OCDC), the statewide group formed to implement the CD Plan through coordinated efforts across different community sectors.

Since its release in early 2014, the CD Plan has been used across the state in a number of ways. The Ohio Department of Health (ODH) used the objectives within the plan to successfully apply for chronic disease funding—one of only 17 states to receive this funding. ODH in turn used the CD Plan's objectives to structure a request for proposal to fund local public health to better integrate strategies across all four core focus areas within high-need communities in their districts. Several local coalitions used the plan during their health improvement planning, including those convened by the Delaware General Health District and Cuyahoga County Board of Health. Additionally, OCDC members presented the plan at a number of local and state conferences and other events around the state.

The CD Plan is Ohio's first coordinated approach to chronic disease prevention and control and relies on cross-cutting impact of the objectives and strategies chosen. To achieve this level of integration, the objectives were grouped in four CFAs. Each CFA represents a critical component of improving population health outcomes and is designed to augment the success seen in the other three CFAs. This approach was first developed by the Centers for Disease Control and Prevention (CDC) and is now being used by states across the country in chronic disease planning.

2014 Accomplishments and Successes

The following section presents objectives by CFA and specific accomplishments and success stories achieved in 2014. Successfully accomplishing the objectives requires participation from many sectors, as noted by the sector icons, to implement the various strategies and often involve cross-sector partnerships to leverage resources and maximize reach in communities. Information for this year-in-review was obtained by OCDC partners through a standardized reporting document to ensure comprehensive evaluation of the CD Plan.

Core Focus Area 1: Environmental Approaches

Building strong communities to ensure Ohioans of all ages and abilities can live disease free.



Schools and Universities



Government



Community Organizations



Worksites



Healthcare Systems

Objectives

- 1.1 Increase the number of K-12 school districts that are 100 percent tobacco-free.
- 1.2 Increase the number of universities, regional campuses and community colleges in Ohio that are 100 percent tobacco-free.
- 1.3 Increase the number of multi-unit housing complexes that are smoke-free.
- 1.4 Increase the excise tax on other tobacco products.
- 1.5 Increase the number of schools with completed school travel plans.
- 1.6 Increase the number of Ohio communities that adopt Complete Streets policies.
- 1.7 Increase the number of Shared-Use Policies and Agreements between schools, communities, parks and recreation, and other groups to increase physical activity opportunities in the community.
- 1.8 Increase the number of public and private worksites in Ohio that meet Healthy Ohio Business Council recognized worksite wellness criteria.
- 1.9 Increase the number of licensed early child and school-aged child care providers that have adopted organizational healthy eating/active living policies.
- 1.10 Increase the number of middle and high schools that provide physical activity breaks throughout the school day outside of physical education.
- 1.11 Increase the percent of Ohio farmers' markets that accept nutrition assistance benefits, including electronic benefit transfers (EBT), or vouchers for Supplemental Nutrition Assistance Program (SNAP), and Women, Infants and Children (WIC) Farmers' Market Nutrition Program (WIC FMNP).

- 1.12 Increase the percentage of census tracts that have at least one healthy retail option located within the tract or within half a mile of tract boundaries.
- 1.13 Increase the number of Ohio school districts participating in a comprehensive Farm to School Program.
- 1.14 Increase the percent of babies who are breastfed while in the hospital.
- 1.15 Establish a statewide food council network to help create a supportive Ohio food system.

Key Accomplishments

- ▶ **Reducing tobacco use and exposure was a priority in the Governor’s Fiscal Year 2016-2017 Blueprint for a New Ohio.** Language included a proposal to make K-12 school campuses and college and university campuses 100 percent tobacco-free. The Governor also proposed a \$1 increase in the excise tax on cigarettes and an increase in the excise tax on other tobacco products.
- ▶ **More than 330,000 children in Ohio will now go to schools that support biking and walking to school.** The number of schools with school travel plans increased from 449 schools to 739. This change far exceeded the objective’s five-year target and is a quarter of the total number of schools in Ohio.
- ▶ **More Ohioans will be able to find healthy foods in schools and in their communities.** The Ohio State University Extension, ODH Creating Healthy Communities Program and Ohio Action for Healthy Kids trained more than 280 school food service professionals and community stakeholders across the state on how to bring more local fruits and vegetables to schools. Local public health is also increasing the number of small food stores—such as gas stations and convenience stores—that sell healthy foods, with 11 new stores in high-need communities in Columbus and Cleveland.

Success Stories

Early Childhood Healthy Eating and Active Living – Habits that start early can last a lifetime. Unfortunately by the time children become teenagers, many already have developed unhealthy behaviors. For example, in Ohio only about a quarter of students in grades 9-12 engage in the recommended amount of daily physical activity, and only about 10 percent eat three or more servings of vegetables each day. Because most behaviors around healthy eating and being active are learned in the first years of life, national experts agree that addressing healthy eating and active living in early childhood is one of the most effective ways to reduce the risk of developing chronic diseases later in life. The CD Plan’s Objective 1.9 is aimed at increasing the number of licensed early child and school-aged child care providers that adopt healthy eating and active living (HEAL) policies to provide children with opportunities to learn healthy habits they can carry on through adulthood.

The Ohio Early Childhood Health Network (the Network), comprised of 51 different organizations, including the Ohio Chapter of the American Academy of Pediatrics (Ohio AAP) and Mount Sinai Health Care Foundation, has been instrumental in working with early childhood education (ECE) centers to implement HEAL policies. Thus far, the Network has established a statewide training program to help early learning centers adopt and implement HEAL policies. The program has already helped more than 20 ECEs implement comprehensive policies to reduce screen time, provide healthier foods at mealtimes and offer nutrition trainings to parents and staff. The program's success has led to an expansion of the trainings to in-home early child care providers, reaching many of Ohio's most vulnerable children. The Network has also developed a set of licensing recommendations to guide state decision makers in incorporating HEAL policies into ECE licensing. In late 2014, these activities led to Ohio being chosen to participate in a national pediatric obesity Collaborative Improvement and Innovation Network (CollIN). The CollIN is a partnership between ODH, the Ohio Department of Job and Family Services and the Ohio Department of Education to incorporate some of the Network's recommendations into state ECE licensing and further align the work at the state and local level.

Breastfeeding – Stakeholders from across Ohio have come together as part of the OCDC to increase the percentage of babies who are breastfed while in the hospital. The benefits of breastfeeding are significant. Infants who are breastfed for at least six months are protected against common childhood illnesses and infections, have a lower risk of sleep-related death and have less chance of developing type 1 diabetes. For mothers, breastfeeding may lower their risk of some cancers and help them return to a healthy weight after pregnancy.

Organizations, including the Ohio Hospital Association, the Ohio Lactation Consultant Association, the Ohio Breastfeeding Alliance and ODH, established Ohio First Steps for Healthy Babies. This initiative recognizes birthing centers that meet all or part of a 10-step list adapted from the World Health Organization and Baby-Friendly USA's "Ten Steps to Successful Breastfeeding." Hospitals that volunteer to participate are trained on best practices to promote, protect and support breastfeeding among new parents and babies. A kick-off webinar attended by more than 85 people was hosted in March 2015 to promote this initiative. Sixty-five hospitals have already expressed interest in participating.

Core Focus Area 2: Health System Interventions

Ensure Ohioans are receiving optimum preventive services to prevent and reduce disease.



Government



Community
Organizations



Healthcare
Systems

Objectives

- 2.1 Increase the number of Ohio tobacco users who are eligible to receive telephonic tobacco cessation counseling through the Ohio Tobacco Quit Line.
- 2.2 Increase the percentage of adults who are asked by a healthcare professional if they smoke.
- 2.3 Increase the percentage of adults screened according to guidelines for breast, colorectal and cervical cancers.
- 2.4 Establish use of the Check It. Change It. Control It. Your Heart Depends On It. Toolkit in primary care centers in Ohio.
- 2.5 Develop an Ohio-based, online practice management platform to expand access to QI tools to family medicine providers to improve prevention, risk factor identification and management of chronic disease.
- 2.6 Increase the number of high-risk children and youth receiving interventions to prevent and manage obesity through a healthcare provider.

Key Accomplishments

- ▶ **Healthcare providers are better able to help their patients quit using tobacco.** People with diabetes now get tailored information from the Ohio Tobacco Quit Line on smoking cessation and diabetes management. Additionally, providers in four Appalachian counties are participating in the Ohio Partners for Smoke-Free Families tobacco cessation saturation project, which will train healthcare providers in multiple settings to provide the evidence-based 5A's tobacco cessation program to women in Gallia, Ross, Lawrence and Scioto counties.
- ▶ **More Ohioans are receiving recommended cancer prevention services.** The Ohio Academy of Family Physicians (OAFP) in partnership with the ODH and the American Cancer Society implemented the 2014 Colorectal Cancer Screening Improvement Project with 18 practices across the state. The quality improvement project trains providers to customize an office protocol to properly identify patients at risk for colorectal cancer and how to appropriately refer for screening. Participating practices saw a combined average of 60 percent increase in colorectal cancer screening rates from baseline to project completion.

Success Stories

Improving Hypertension Management – Nearly one-third of adults in Ohio report having high blood pressure. High blood pressure is one of the most common risk factors for developing chronic diseases such as heart disease and stroke—the most common causes of death and disability in Ohio, especially for African Americans, who are more likely to have uncontrolled hypertension and to die due to heart disease. While preventing high blood pressure is possible, successful management through high-quality health care is the most effective way to reduce the risk of developing heart disease. Primary care providers in Ohio are meeting this challenge head on by developing culturally appropriate skills and practice habits to better serve the most at-risk Ohioans.

The OAFP, ODH, the Ohio Association of Community Health Centers, the Health Services Advisory Group and the Ohio Health Information Partnership (OHIP) are working together to provide training to family medicine practices on how to create protocols, streamline practice efficiencies and use quality improvement practices to improve hypertension management for their patients, with a focus on African Americans. Practices are implementing the *Check It. Change It. Control It. Your Heart Depends on It.* Toolkit to successfully address high blood pressure in African Americans.

During the five-month quality improvement project, practices collected baseline data on a set of six measurements and provided monthly outcome reports. Subject matter experts with advanced knowledge of electronic health record use worked with each practice to help guide and support the groups through the data collection period. The learning collaborative began in Summit County with 11 practices participating. The pilot was funded through the national Million Hearts Initiative and the results were highlighted by national partners.

Provider teams participating in the Summit County pilot collaborative made significant changes to their practices. These changes resulted in an increase in hypertension control rates from 66.8 percent to 72.1 percent; an increase in the percent of patients with hypertension who have a follow-up appointment scheduled from 65.6 percent to 68.5 percent; and an increase of 9 percent in the number of newly identified African-American male patients with hypertension. Additional team trainings are currently being held and future plans include expansion to community health centers and alignment with additional healthcare interventions to improve control of blood pressure and diabetes.

Early Childhood Obesity Prevention – Successfully addressing childhood obesity requires the involvement of a number of sectors. Along with healthy eating and active living in early child care, healthcare providers are in a unique position to educate parents of infants and young children on establishing healthy habits at home that can become healthy behaviors as their children grow. This is most important for families who are at highest risk for developing chronic diseases. In Ohio, families living at or below the poverty level are more at risk for poor health outcomes than other Ohioans. The CD Plan is addressing this disparity by focusing on improving how pediatricians address childhood obesity for families receiving Medicaid.

Developed with the Ohio AAP, the Parenting at Mealtime and Playtime (PMP) Learning Collaborative leads pediatric practices through a quality improvement approach to provide high-quality anticipatory guidance and assess obesity-related health risks of infants and young children. Over a six-month period, PMP tracks physician, parent and child participation, body mass index (BMI) screening, and nutritional and physical activity counseling. PMP monitors changes in physician documentation for key measures including height, length, BMI, weight categorization, blood pressure and blood pressure categorization. The PMP Learning Collaborative includes ongoing educational sessions for physicians, patient registry access, quality improvement technical assistance from OAAP and site visits to assist practice implementation of the PMP tools.

The first wave of the PMP Learning Collaborative began in April 2014, with 12 primary care practices participating. These practices included 36 providers (physicians, registered dietitians and registered nurses) with a combined patient population of more than 50,000 children, about 20,000 of whom were receiving Medicaid. Results from wave one were dramatic, with all practices significantly improving in all areas of assessment and counseling. Some examples of this success include documentation of weight status increasing by 124.5 percent, documentation of blood pressure categorization increasing by 47.3 percent, and nutritional and physical activity counseling documentation increasing by 23.5 percent and 42.7 percent, respectively. Wave two of PMP began in late 2014 with another eight practices.

Core Focus Area 3: Community-Clinical Linkages

Ensure Ohioans are connected to the appropriate healthcare and public health services within their communities.



Government



Community Organizations



Worksites



Healthcare Systems

Objectives

- 3.1** Develop recommendations for evidence-based chronic disease and diabetes self-management education programs (SMEPs) that include essential program elements, desired outcomes, evaluation methods, quality assurance, cost guidelines, and reimbursement methods.
- 3.2** Increase the percentage of people with prediabetes enrolled in CDC-recognized lifestyle change programs.
- 3.3** Increase the number of community health worker models being used to address chronic disease prevention and management.

Key Accomplishments

- ▶ **More Ohioans will receive support in managing their diabetes.** The Ohio Department of Aging is working with the Area Agency on Aging and Federally-Qualified Health Centers in Lima, Ohio, to increase access of the Diabetes Self-Management Training (DSMT) to people with diabetes. Additionally, a successful public/private partnership led to increased coverage of the DSMT to many of the Ohio Public Employees Retirement System's retired members.

Success Story

Diabetes Prevention Programs – A Diabetes Prevention Program (DPP) is a lifestyle change program that can help adults prevent or delay type 2 diabetes mellitus (T2DM). Led by a trained health coach, a group of participants learn how to eat healthier, increase their physical activity level and reduce stress through problem-solving and coping skills. People participating in the DPP lose an average of 5 percent of their weight in the 12-month program. While only a modest change, losing at least 5 percent of your weight can significantly reduce the risk of developing T2DM for years to come. Ohio's first DPPs were started in YMCAs in Cleveland, Columbus, Cincinnati and Dayton, with seven more YMCA DPPs added since. Along with the YMCA sites, there are a number of additional DPP sites in Ohio and more are starting every year. If enough people in Ohio lost 5 percent of their weight, Ohio could save almost \$27 billion in healthcare costs and lost productivity at work by 2030.

Core Focus Area 4: Data and Surveillance

Effectively use data and information to assess, plan, deliver and evaluate strategies to improve population health.



Government



Community
Organizations



Healthcare
Systems

Objectives

- 4.1 Establish one set of comprehensive, high-quality and timely data sources to better assess, monitor and evaluate the burden of chronic disease in Ohio and the success of interventions at the state and local level.
- 4.2 Establish and maintain at least two publicly accessible data sources for systematic dissemination of chronic disease and risk factor data to multiple audiences.
- 4.3 Pilot and disseminate results from at least one project combining electronic health record (EHR) and other health system data with population health surveillance data to identify, assess and monitor populations with high chronic disease burden.
- 4.4 Provide/promote 10 trainings to build capacity in the use of data and information for decision making across multiple sectors.

Key Accomplishments

- ▶ **Using EHRs for population health management.** Healthcare providers in high-need communities in Ohio will be able to use health information technology to support how they manage high blood pressure for their populations. Through funding from the CDC, ODH is working with OHIP and health systems to use electronic health records to identify patients with uncontrolled high blood pressure. This information will be used to better understand both the health of the practice's population as well as the health of the surrounding community.

Success Story

Health Impact Assessments – Sectors such as transportation, education and community development can positively affect the population's health when decision making is informed and influenced by health data. Tools such as Health Impact Assessments (HIA) can identify the ways that policy decisions in sectors such as transportation, education, housing and regional planning may affect population health outcomes. The goal of this approach is for decision makers, from school board members to state legislators, to consider the potential positive or negative impacts of their decisions on health outcomes, health equity and healthcare costs. With greater awareness of health consequences, policymakers can then minimize risks and maximize health benefits.

A complete HIA involves six steps and results in a report that describes the potential health impacts of the policy or project that was studied and makes recommendations regarding how any negative health or equity impacts can be mitigated. HIAs can be led by a state or local government agency, a university or any organization that has the capacity to conduct research and facilitate a multi-sector assessment process.

In Ohio, health departments have taken the lead in conducting HIAs. The Columbus, Cincinnati, Cuyahoga County and Delaware County health departments have either completed or are in the process of conducting assessments. The Delaware County General Health District, for example, convened a collaborative assessment of the potential impacts of a proposed outlet mall project on health outcomes such as traffic injuries, cardiovascular disease and physical activity. As a result, the mall developer updated the project's master plan to include sidewalks, green space and a walking trail.

Additionally, the Cuyahoga County Board of Health, with Landscape Art Neighborhoods Development studio, Cuyahoga County Planning Commission, and Human Impact Partners, is leading the Eastside Greenway HIA to inform and influence planning and implementation decisions related to the establishment of a trail and greenway network traversing 14 diverse communities on Cuyahoga County's east side. The HIA will provide recommendations on plan development, design and implementation that will impact between 100,000 and 200,000 county residents. For more information, visit <http://neohiap.org.ccbh.info/wp/?tag=eastside-greenway>.

How to Get Involved

Beginning as the workgroup charged with creating the SHIP's Chronic Disease section, the OCDC has grown to include more than 70 member organizations and remains open to all interested organizations. These organizations represent various sectors, including health care, public health, workplaces, schools, communities, non-profit and others. Partners can actively engage in planning, implementing and evaluating the objectives or can participate in just networking and information sharing. The intention of the OCDC is to continue to implement, evaluate and improve the CD Plan over time. Continued participation from a broad sector of representatives will be critical to ensure the plan is adapting to the changing landscape of population health work in Ohio. For information about how to join the OCDC, visit www.healthy.ohio.gov/CDPlan.



The Impact of Chronic Disease In Ohio

MORE OHIOANS DIE FROM CHRONIC DISEASES THAN ALL OTHER CAUSES COMBINED



and spend more on health care than all but 17 other states

THE BURDEN OF
CHRONIC DISEASE
COSTS OHIO

\$27
BILLION
EVERY YEAR



MUCH OF THIS IS
PREVENTABLE BY:


Creating physically active communities


Establishing 100% tobacco-free environments


Increasing access to healthy food


Improving preventive care


Connecting communities to health and social services