

Ohio

2012-2014

STATE HEALTH IMPROVEMENT PLAN





Ohio 2012 – 2014 State Health Improvement Plan

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■ ■ ■ ■ ■ INTRODUCTION

As a component of the public health agency accreditation process, the Ohio Department of Health (ODH) convened public health partners and stakeholders to first complete a State Health Assessment (SHA) and from it develop the State Health Improvement Plan (SHIP). Both the SHA and the SHIP have been conducted with input from a multi-sectorial, statewide Planning Council with broad representation from local health departments, public health organizations, other state agencies, Ohio's Prevention Research Centers and academic institutions, healthcare partners and professional associations, regional planning commissions, and other relevant stakeholders and partners. The Planning Council consisted of more than 40 state and local public health and healthcare representatives and, from its beginning, maintained an open process to continually accept new members. Council members continued to engage stakeholders throughout the SHIP process.

The process began in 2010 with the SHA, which was completed in 2011. This document was created to help identify and better address the population health needs of the state. The SHA identified indicators and data for 11 areas of focus addressing disease burden, including data on the leading causes of death in Ohio; the prevalence of chronic, communicable, and infectious diseases; unintentional and intentional injury rates; health behaviors, clinical risk factors, and recommended care; maternal and child health; health system access; and environmental health. Using this information, along with additional statewide data and national guidelines (CDC Winnable Battles, National Prevention Strategy, and Healthy People 2020 Leading Health Indicators), the Planning Council next began work on the SHIP.

The SHIP process began in August 2011 with a meeting facilitated by the Association of State and Territorial Health Officials (ASTHO). During that meeting, ASTHO shared: (1) an overview of existing state health plans; (2) an overview of the Public Health Accreditation Board (PHAB) requirements for a SHIP; and, (3) recommendations for how to develop a SHIP. Goals for the SHIP process included developing measurable and achievable goals; identifying strategies and specific activities; identifying key partners and funding sources; establishing 12-month and 24-month outcomes; developing and implementing a work plan; and monitoring, evaluating and updating the SHIP.

During that same timeframe, an assessment of Ohio's public health system was completed using the National Public Health Performance Standards Program (NPHPSP) with facilitation provided by The Ohio State University College of Public Health's Center for Public Health Practice. Four model performance standards for each of the 10 essential public health services were assessed—Planning and Implementation; State-Local/Relationships; Performance Management and Quality Improvement; and, Capacity and Resources—to determine performance for the state public health system. Strengths and opportunities for improvement were identified for each model standard, and a priority rating was assigned. The results of this assessment were also used by the SHIP Planning Council as a tool to help identify priorities, particularly in the service and operational improvement areas.

Toward the end of 2011, priorities were selected for the SHIP to fit within three categories—Health Improvements, Service Improvements, and Operational Improvements. To select priorities, the Planning Council developed a list of criteria for a topic to meet to be considered a priority. Once a list of potential priorities was created, the council voted on the top 11. These were later reduced to 9 through consolidation of similar topics. The criteria for priority selection were:

- Cost-Effectiveness
- Ohio ranking worse than most states
- Political and legislative feasibility
- Feasibility of Correcting
(changed name to "feasibility of positively impacting")
- Trend Direction
- Magnitude of the Problem
- Mission Critical (combined with Prevention Potential)
- Quality of Life
- Seriousness of Consequences

The nine selected priorities are listed in the table below.

Health Improvements	Service Improvements	Operational Improvements
Chronic Disease	Access to Care	Electronic Health Records/Health Information Exchange
Injury and Violence	Integration of Physical and Behavioral Healthcare	Workforce Development
Infectious Diseases		Public Health Funding
Infant Mortality/Premature Births		

Beginning in January 2012, the Planning Council met to identify guiding principles, review recommendations for priority workplan development; and discuss the formation of workgroups to complete the SHIP. Guiding principles for the SHIP were set to provide a baseline for all priorities to be considered and were the following:

- Address health disparities to achieve health equity
- Clearly define and communicate our outcomes
- Make data driven, evidence informed decisions
- Be transparent
- Engage a broad spectrum of partners to achieve shared goals and outcomes
- Integrate strategies across priorities
- Engage communities throughout the process (planning, development, implementation and evaluation)
- Advocate for realignment of public/private resources to achieve the outcomes we identify as priorities
- Commit our resources to achieving the outcomes we identify as priorities

Between February and June 2012, a workgroup for each priority met several times to decide on a limited number of high-priority strategies. The intention of these workgroups was not to list all necessary interventions within the given area, but to identify those action steps that would be most important to achieve the stated goal and advance other work across the state. In order to prevent duplication of effort, members of the Planning Council created a list of organizations and coalitions around the state that were thought to be active within each priority (see Appendix). A survey was developed to better understand the work these groups were involved in and whether they had a plan or a set of strategies that could be used for the SHIP. Interviews with key partners were conducted by Planning Council members. Results from these interviews were collected and reported on by SHIP priority.

Each workgroup completed a workplan to describe the overall goal for the priority, and identify a set of strategies and associated action steps, key partners, existing funding to support the activities, and 12- and 24-month outcomes. Workplans were completed in June 2012, with subject matter experts continuing to refine and complete the details throughout the summer. The SHIP was finalized and began implementation in July 2012, with priority workgroups working on their own to move their section forward.

ACCESS TO CARE



Patient-centered medical homes are a part of a medical neighborhood focused on prevention and health.

■ ■ ■ ■ ■ ACCESS TO CARE

While access to high-quality health care is recognized as a significant step toward improving health status, as many as 1.5 million Ohioans, including 125,000 children, are uninsured, and an estimated 1.3 million Ohioans live in areas without adequate access to primary care services. Evidence shows that a relationship with a primary care provider can often prevent disease, improve disease outcomes and reduce health care system use and overall cost; this relationship is strongest through the patient-centered medical home. Strategies to ensure all Ohioans are connected to a patient-centered medical home include helping providers transition their practice so that their services are based on value rather than volume, training tomorrow's health care providers to practice patient-centered care, engaging consumers as partners in their health care and strengthening the safety net to ensure everyone has access to health services regardless of income, race or geographic location. Patient-centered medical homes are the center of the medical neighborhood, valuing the partnership between patients and providers and focusing on health and prevention.

GOAL

Establish, support and promote policies and systems to identify and reduce barriers that prevent access to appropriate health care for all Ohioans.

■ ■ ■ ■ STRATEGY 1 ■ ■ ■ ■

Ensure all Ohioans have a patient-centered medical home that assists them in navigating the health care system and is integrated with all providers to provide continuity of care.

ACTION STEP 1

Educate future and current providers, policy makers, consumers, payers and employers on the implementation and benefits of a patient-centered model of care.

12 MONTH OUTCOMES

OUTCOME 1

Assess what exists relative to training for each target group and what gaps remain.

OUTCOME 2

Continue to engage Board of Regents to encourage the teaching of the patient-centered medical home model in educational programs across the spectrum of health care workers.

24 MONTH OUTCOMES

OUTCOME 1

Develop trainings and resources to address identified gaps.

OUTCOME 2

Support efforts to ensure providers working in patient-centered medical home practices mentor students and trainees.

ACTION STEP 2

Support efforts throughout the state to increase the number of patient-centered medical homes.

12 MONTH OUTCOME

Create a centralized online site for materials and resources to help providers transform to a patient-centered medical home model of care.

ACTION STEP 3

Address the issue of payment reform, through the convening of stakeholders, to include large employers and health plans. Stakeholders will be convened and strategies explored through the Governor's Advisory Council on Health Care Payment Innovation and the Ohio Patient-Centered Primary Care Collaborative.

12 MONTH OUTCOME

Engage key stakeholders to develop a payment model that will incentivize/reward providers for the provision of high quality primary care services.

24 MONTH OUTCOME

Begin to test and implement the new payment model.

■■■ STRATEGY 2 ■■■

Equip consumers to be full partners in their health care.

ACTION STEP 1

Educate consumers about the value of the patient-centered medical home model, what to expect of a patient-centered medical home provider and their responsibilities in their own health care.

12 MONTH OUTCOME

Assess available marketing campaign materials (e.g., materials developed by Health Care Coverage and Quality Council (HCCQC) and what is effective.

24 MONTH OUTCOME

ACTION STEP 2

Increase awareness and use of Benefit Bank to increase access to healthcare for Medicaid-eligible individuals.

12 MONTH OUTCOME

Develop plan for how to engage Community Health Centers (CHC), community groups, etc. in utilization of Benefit Bank.

24 MONTH OUTCOME

Implement plan to increase use of Benefit Bank.

ACTION STEP 3

Develop a single source repository for information on health care providers and services.

12 MONTH OUTCOME

Develop the repository and establish a plan for how it will be maintained.

24 MONTH OUTCOME

Maintain the repository, as well as identify any gaps to be addressed.

■■■ STRATEGY 3 ■■■

Increase the numbers, diversity, distribution and cultural competency of the health care work force.

ACTION STEP 1

Adopt and implement a Minimum Data Set (MDS) across all health professions.

12 MONTH OUTCOME

Adopt a standard MDS for all health professions (e.g., what is a “community health worker”).

24 MONTH OUTCOME

Implement the process of capturing the MDS for all health care professionals in Ohio.

ACTION STEP 2

Disseminate information to support health-related educational opportunities for minorities.

12 MONTH OUTCOMES

OUTCOME 1

Develop a summary of “Horizon”-type programs (Wright State University) for high school students interested in health careers.

OUTCOME 2

Release ODH’s Workforce Development Plan.

24 MONTH OUTCOME

Develop and implement plan to disseminate information across the state (e.g., via high school guidance counselors) so that students are aware of the opportunities.

ACTION STEP 3

Increase the number of community-based primary care residency programs.

12 MONTH OUTCOME

Convene group including community health centers, residency programs, existing model programs, foundations supporting health, nursing, and possibly Health Resources and Services Administration (HRSA), to identify opportunities.

ACTION STEP 4

Increase utilization of all members of the patient care team, including lay health workers, with intentional mindfulness of cultural competency.

12 MONTH OUTCOME

Identify members, roles and spread of certified community health workers, home and community based programs and patient navigators.

ACTION STEP 5

Focus on retroactive financial support for professional education via Match opportunities.

12 MONTH OUTCOME

Catalogue the list of existing opportunities (e.g., public service loan repayment).

24 MONTH OUTCOME

Increase awareness of existing loan repayment programs.

■■■ STRATEGY 4 ■■■

Strengthen the safety net system.

ACTION STEP 1

Engage in advocacy work with state legislators.

12 MONTH OUTCOME

Stabilize state subsidy.

24 MONTH OUTCOME

Enhance capacity building for clinics to compete for federal dollars (e.g., incubators, look-alike programs)

INFANT MORTALITY / PRETERM BIRTHS



**Help them celebrate
day 366. In Ohio,
every baby matters.**

■ ■ ■ ■ ■ INFANT MORTALITY / PRETERM BIRTHS

The infant mortality rate is an important measure of a population's overall health. Unfortunately, Ohio's infant mortality rate remains higher than the national rate and has not declined in the past decade. More concerning are the disparities in birth outcomes for certain racial, ethnic and geographic groups in Ohio, with African American babies being twice as likely to die in the first year of life. Strategies to address infant mortality and preterm birth are supported through statewide partnerships and include strengthening connections between families and community support systems, improving the quality of care provided to women during pregnancy and to their infants after delivery, and aligning with statewide efforts to reduce sleep-related infant deaths. Through collaboration and a focus on removing disparities, all babies in Ohio can live to see their first birthday and celebrate day 366.

GOAL

Decrease Ohio's infant mortality rate and reduce disparities in birth outcomes.

■ ■ ■ ■ STRATEGY 1 ■ ■ ■ ■

Implement or provide access to an evidence-based care coordination model, emphasizing communities at highest risk, to public and private providers who impact birth outcomes, including patient-centered medical homes.

ACTION STEP 1

Support the expansion of the "Pathways" (HUB) model of service delivery and payment for pregnancy care coordination for women and children within targeted "pathways."

12 MONTH OUTCOMES

OUTCOME 1

The "Pathways" (HUB) model serves a six- county region in Appalachian Ohio.

OUTCOME 2

Distribute evidence-based care coordination toolkit information from Agency for Healthcare Research and Quality's (AHRQ) Health Care Innovations Exchange.

24 MONTH OUTCOMES

OUTCOME 1

The "Pathways" (HUB) model has been successfully replicated in the Appalachian region.

OUTCOME 2

At least three communities in Ohio have used the toolkit to begin the development of the "Pathways" (HUB) model.

ACTION STEP 2

Leverage additional funds to implement evidence-based models, including direct reimbursement for care coordination from Medicaid and other third-party payers

12 MONTH OUTCOME

At least one Help Me Grow (HMG) provider serving each Ohio county is enrolled in ODH reimbursement plan and implementing HMG standards.

24 MONTH OUTCOME

At least one HMG provider serving each Ohio county has successfully implemented the ODH reimbursement plan.

ACTION STEP 3

Collect consistent data across care coordination / home visiting programs.

12 MONTH OUTCOME

Ohio Infant Mortality Reduction Initiative (OIMRI) data collection tab is implemented in Early Track. Ohio Collaborative to Prevent Infant Mortality (OCPIM) Care Coordination workgroup has identified five common data fields that all collaborating care coordination agencies will collect in a pilot.

24 MONTH OUTCOME

Statewide plan for the collection of consistent data fields across evidence-based programs is developed. OCPIM Care Coordination workgroup has piloted and evaluated the collection of five common data fields.

ACTION STEP 4

Support the movement of care coordination programs from promising practices to evidence-based programs (e.g., OIMRI, federal Healthy Start).

12 MONTH OUTCOME

Ohio federal Healthy Start (HS) programs are participating in national dialogue concerning the evaluation of HS. OIMRI birth outcome data has been compared to similar cohorts by ODH epidemiologist. A manuscript reporting the evaluation of one promising practice has been drafted.

24 MONTH OUTCOME

Ohio federal HS programs have initiated steps toward becoming evidence-based. Formal evaluation of the OIMRI program has been developed. A manuscript reporting the evaluation of one promising practice has been accepted for publication.

■■■■ STRATEGY 2 ■■■■

Implement and spread quality improvement (QI) initiatives via the Ohio Perinatal Quality Collaborative (OPQC) to all public and private systems to reduce infant mortality and birth outcomes disparities.

ACTION STEP 1

Spread the 39 week QI project (scheduled births between 36 and 38 6/7 weeks without a medical indication) in Ohio maternity hospitals beyond the original 20.

12 MONTH OUTCOME

Decrease scheduled deliveries without medical indication to <5% 15 pilot hospitals.

24 MONTH OUTCOME

Decrease scheduled deliveries without medical indication to <5% in approximately 80 hospitals.

ACTION STEP 2

Improve birth certificate data accuracy and timeliness to support QI efforts in hospitals via site visits and webinar (how to use automated Vital Statistics (VS) and Birth Certificate (BC) reports).

12 MONTH OUTCOME

Key BC variables will be transmitted accurately in 95% of records within 10 days of birth in 15 pilot hospitals.

24 MONTH OUTCOME

Key BC variables will be transmitted accurately in 95% of records within 10 days of birth in approximately 80 hospitals.

ACTION STEP 3

Improve use and spread of appropriate antenatal steroids administration and documentation for women at risk to deliver between 24 and 33 weeks gestation via QI learning sessions and team calls.

12 MONTH OUTCOME

>90% of eligible infants receive antenatal corticosteroids (ANCS) in 20 hospitals.

24 MONTH OUTCOME

>90% of eligible infants receive ANCS in XX hospitals (determined after Year One).

ACTION STEP 4

Increase the use of human milk administered to 22-29 week premature infants as part of a Blood Stream Infection QI Project via learning sessions and team calls.

12 MONTH OUTCOME

80% of 22-29 week infants get human milk in <72 hours in 24 neonatal intensive care units (NICU).

24 MONTH OUTCOME

80% of 22-29 week infants get human milk in <72 hours in XX NICUs (determined after Year One.)

ACTION STEP 5

Design, implement and promote use of progesterone supplementation in high risk women by Ohio providers. High risk women will be identified, screened and treated.

12 MONTH OUTCOME

Establish outcome variables (NICU, birth certificate, gestational age, infant mortality rate [IMR]) in 20 OPQC hospitals.

24 MONTH OUTCOME

See Year One outcomes expanded into XX additional outcomes (determined after Year One).

■■■■ STRATEGY 3 ■■■■

Partner with Ohio Injury Prevention Partnership (OIPP) and Child Injury Action Group (CIAG) to implement its action plan.

ACTION STEP 1

Promote and support amending Claire's Law to include safe sleep policies and parent education policies in birthing hospitals and licensed child care centers.

12 MONTH OUTCOME

Participate in OIPP/CIAG meetings. Policy language completed, legislative champions recruited.

24 MONTH OUTCOME

Implementation of action plan for policy makers.

ACTION STEP 2

Partner with at least one baby product retailer to promote safe sleep to customers.

12 MONTH OUTCOME

Announce partnership in media.

24 MONTH OUTCOME

Safe Sleep promotion plan developed with retailer.

ACTION STEP 3

Ensure that prenatal care providers and pediatric health care providers are promoting and distributing current safe sleep messages.

12 MONTH OUTCOME

Survey tool and contact list of prenatal and pediatric care providers created; standardized educational materials posted on ODH website.

24 MONTH OUTCOME

Baseline survey completed; number of providers receiving materials identified.

ACTION STEP 4

Collaborate with other organizations to conduct a statewide safe sleep campaign.

12 MONTH OUTCOME

Creation of marketing and evaluation plan.

24 MONTH OUTCOME

Evaluation report completed and promoted via partners.

ACTION STEP 5

Partner with the Early Childhood Advisory Council to enact a policy requiring all identified state agencies with a role in parent education, early intervention, or child care to follow and promote current safe sleep recommendations.

12 MONTH OUTCOME

Number of partner coalitions recruited; completion of suggested policy; completion of impact statement/report.

24 MONTH OUTCOME

Passage of safe sleep policy, number of member organizations receiving educational materials.

■■■■ STRATEGY 4 ■■■■

Continue the decreasing trend in birth rate among 13-19 year olds in Ohio.

ACTION STEP 1

Delay the onset of sexual activity.

12 MONTH OUTCOME

[To be provided by Ohio Adolescent Health Program (OAHP)].

24 MONTH OUTCOME

Decreased prevalence of first sexual intercourse before age 13 years.

ACTION STEP 2

Increase parent and teen communication about reproductive health.

12 MONTH OUTCOME

[To be provided by OAHP].

24 MONTH OUTCOME

Tracking measures are implemented.

ACTION STEP 3

Increase access and provision of reproductive health services to adolescents through medical homes and family planning clinics.

12 MONTH OUTCOME

Tracking measures to identify changes in provider practice are developed and implemented.

24 MONTH OUTCOME

[To be provided by OAHP].

ACTION STEP 4

Increase the number of schools with comprehensive health education including reproductive health.

12 MONTH OUTCOME

Schools and legislature educated on benefits of health education standards; at least one advocacy day for legislators and two school health meeting presentations conducted. [To be provided by OAHP]

24 MONTH OUTCOME

Bill introduced (Buckeye Healthy School Alliance)

ACTION STEP 5

Increase the use of effective and appropriate contraception among adolescents, including the use of dual contraceptive methods.

24 MONTH OUTCOME

Increased use of effective contraception by adolescents.

■■■■ STRATEGY 5 ■■■■

Address the effects of racism and the impact of racism on infant mortality.

ACTION STEP 1

Disseminate the Action Learning Collaborative Racism and Infant Mortality Orientation Toolkit (video and educational materials) to health and social service providers.

12 MONTH OUTCOME

XX IM Racism and IM Toolkits distributed to XX providers.

ACTION STEP 2

Incorporate ongoing cultural competence training within provider facilities.

12 MONTH OUTCOME

Diversity training program developed and selected distribution training plan developed.

24 MONTH OUTCOME

Training conducted in XX locations with XX providers.

■■■■ STRATEGY 6 ■■■■

Reduce the percentage of women who smoke during pregnancy.

ACTION STEP 1

Build the capacity of maternal and child healthcare systems to support the Five Major Steps to Intervention (The “5A’s”) evidence-based smoking cessation intervention and assist maternal and child health (MCH) practitioners to integrate the five steps (Ask-Advise-Assess-Assist-Arrange) as a standard of care (U.S. Public Health Service Treating Tobacco Use and Dependence Guidelines).

12 MONTH OUTCOME

Assessment completed for MCH healthcare systems (i.e., Women, Infant and Children (WIC), Child and Family Health Services [CFHS]) capacity to support evidence-based smoking cessation interventions.

24 MONTH OUTCOME

MCH healthcare systems are in place to screen women for tobacco use and offer treatment; practitioners have tools, training and technical assistance needed to treat smokers effectively.

ACTION STEP 2

Increase MCH provider awareness of Ohio Tobacco Quitline as a cessation resource for pregnant women.

12 MONTH OUTCOME

Assessment completed for MCH healthcare systems (i.e., WIC, CFHS) awareness of evidence-based smoking cessation interventions.

24 MONTH OUTCOME

MCH practitioners are aware of available evidence-based smoking cessation interventions.

CHRONIC DISEASE



Preventing and reducing chronic disease is the foundation for a healthy, competitive and prosperous state.

■ ■ ■ ■ CHRONIC DISEASE

Chronic diseases (e.g., heart disease, stroke, diabetes, chronic lung diseases and cancer) are among the most common, costly, and preventable of all health problems in Ohio. Nearly two out of every three deaths is due to a chronic disease, and they cost Ohio billions of dollars every year in healthcare costs and lost productivity. Yet despite this burden, they are largely the result of three preventable health risk factors: tobacco use, poor nutrition and lack of physical activity. Strategies to reduce the burden of chronic disease include ensuring communities support healthy living and building the connections between community members, healthcare providers and community resources to improve disease management, prevent disease whenever possible and reduce risk factors associated with tobacco use, poor nutrition and lack of physical activity. Preventing and reducing chronic disease is the foundation for a healthy, competitive and prosperous state.

GOAL

Prevent and reduce the burden of chronic disease for all Ohioans.

■ ■ ■ STRATEGY 1 ■ ■ ■

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

ACTION STEP 1

Comprehensively assess the public health system's collection and use of data regarding chronic diseases, associated risk factors and social determinants of health.

12 MONTH OUTCOME

By June 30, 2013, complete a comprehensive assessment of data sources and collection methods regarding chronic diseases, associated risk factors and social determinants of health.

24 MONTH OUTCOMES

OUTCOME 1

By June 30, 2014, complete an analysis of data sources and collection methods and disseminate findings.

OUTCOME 2

By June 30, 2014, identify partners for a lead group to work on integrating data collection strategies, identify gaps and redundancies, identify best practices and novel uses, improve data availability, and meet Health and Human Services (HHS) Data Standards for race, ethnicity, sex, primary language, and disability status.

■ ■ ■ STRATEGY 2 ■ ■ ■

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

ACTION STEP 1

Increase the number of K-12 school districts that are 100% tobacco-free.

12 MONTH OUTCOME

By June 30, 2013, develop advocacy plan for a statewide policy to support school districts having a tobacco-free campus policy.

24 MONTH OUTCOMES

OUTCOME 1

By June 30, 2014, introduce legislation for a statewide policy to support school districts having a tobacco-free campus policy.

OUTCOME 2

By June 30, 2014, increase the number of Ohio school districts with 100% tobacco-free campus policies from 114 to 134.

ACTION STEP 2

Increase the number of public colleges and universities that are 100% tobacco-free.

12 MONTH OUTCOMES

OUTCOME 1

By June 30, 2013, send letters to 13 major (two year and four year) public colleges and universities to encourage eliminating tobacco use on their campuses.

OUTCOME 2

By June 30, 2013, provide ongoing technical assistance to public colleges and universities to support adoption and implementation of tobacco-free policies.

24 MONTH OUTCOME

By June 30, 2014, increase from zero to three the number of public college or university campuses that are 100% tobacco-free.

ACTION STEP 3

Promote policies, standards and practices that ensure a healthy and productive workforce in Ohio.

12 MONTH OUTCOMES

OUTCOME 1

By June 30, 2013, increase by 20% membership and participation in the Healthy Ohio Business Council (HOBC) regional councils.

OUTCOME 2

By June 30, 2013, develop a toolkit for public and private organizations to provide comprehensive workplace wellness programs.

OUTCOME 3

By June 30, 2013, increase the number of public and private organizations that will receive recognition (HOBC Award; US Healthiest HealthLead Accreditation, etc.) for adopting comprehensive workplace wellness policies.

24 MONTH OUTCOMES

OUTCOME 1

By June 30, 2014, increase membership and participation in the HOBC regional councils by 30%.

OUTCOME 2

By June 30, 2014, disseminate the workplace wellness toolkit to public and private institutions and organizations.

OUTCOME 3

By June 30, 2014, increase the number of additional public and private organizations that will receive recognition (HOBC Award; US Healthiest HealthLead Accreditation, etc.) for adopting comprehensive workplace wellness policies.

ACTION STEP 4

Implement priority strategies to increase physical activity and improve nutrition in Ohio following the Institute of Medicine (IOM) Accelerating Progress in Obesity Prevention report.

12 MONTH OUTCOME

By June 30, 2013, assess and identify priority strategies, partners and funding sources and integrate them into local and statewide chronic disease/obesity prevention plans.

24 MONTH OUTCOME

By June 30, 2014, implement two to three priority strategies at the state, regional and local levels.

■■■ STRATEGY 3 ■■■

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

ACTION STEP 1

Improve screening and early detection and follow-up for breast, colorectal (CRC) and cervical cancers.

12 MONTH OUTCOMES

OUTCOME 1

By June 30, 2013, create strategic partnerships with state and local systems or networks to reach age-appropriate individuals who should be screened for breast, CRC, and cervical cancers.

OUTCOME 2

By June 2013, educate primary care physicians by a variety of modes (webinar, face to face, etc.) on the creation of a practice to increase screening rates.

24 MONTH OUTCOMES

OUTCOME 1

By June 30, 2014, increase the number of adults 50 years or older who receive CRC in accordance with Centers for Disease Control and Prevention (CDC) Best Practices, and increase the proportion of women aged 40 years and older who have had a mammogram within the past year.

OUTCOME 2

By June 2014, identify 50 practices that have made changes in their office protocol to increase screening rates.

ACTION STEP 2

Increase the number of health systems that use clinical guidelines and evidence-based practices around blood pressure and cholesterol levels when treating individuals at risk for and with chronic disease.

12 MONTH OUTCOME

By June 2013, partner with Ohio KePRO to establish the Ohio Million Hearts Cardiovascular Learning and Action Network (CVLAN) with 70 physician practices in Ohio.

24 MONTH OUTCOME

By June 2014, provide training and resources to all Million Hearts CVLAN members to increase the number of patients with blood pressure and blood cholesterol levels that meet clinical guidelines.

ACTION STEP 3

Advocate for all Ohioans to have access to tobacco cessation services.

12 MONTH OUTCOME

By June 30, 2013, develop advocacy plan for increasing access to evidence-based cessation resources in Ohio.

24 MONTH OUTCOME

By June 30, 2014, implement advocacy plan for increasing access to evidence-based cessation resources in Ohio.

ACTION STEP 4

Identify and disseminate evidence-based obesity management interventions to primary care providers.

12 MONTH OUTCOME

By June 30, 2013, train primary care providers in Ohio on weight management interventions for children and adolescents.

24 MONTH OUTCOME

By June 30, 2014, increase training in and use of weight management interventions in primary care.

■■■ STRATEGY 4 ■■■

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

ACTION STEP 1

Identify and recruit partners to implement the Chronic Disease Self-Management Program (CDSMP) and the Diabetes Self-Management Program (DSMP).

12 MONTH OUTCOMES

OUTCOME 1

By June 30, 2013, 40 new Master trainers and lay leaders will be certified in CDSMP/DSMP in Ohio.

OUTCOME 2

By June 30, 2013, 30 Community Health Workers will be recruited and trained in CDSMP/DSMP in Ohio.

24 MONTH OUTCOMES

OUTCOME 1

By June 30, 2014, increase the number of participants attending and completing CDSMP/DSMP workshops.

OUTCOME 2

By June 30, 2014, 60 Community Health Workers will be recruited and trained in CDSMP/DSMP in Ohio

ACTION STEP 2

Develop sustainable payment models for CDSMP/DSMP.

12 MONTH OUTCOME

By June 2013, establish two pilots, one with Rehabilitative Service and one with a healthcare organization to implement reimbursable CDSMP/DSMP for members/clients.

24 MONTH OUTCOME

By June 2014, have in place Medicaid reimbursement for CDSMP as an approved waiver service for Ohio Department of Job and Family Services (ODJFS) / Ohio Department of Aging (ODA) Home and Community Based Services waiver.

ACTION STEP 3

Expand the CDSMP/DSMP by offering additional culturally appropriate and condition-specific modules.

12 MONTH OUTCOMES

OUTCOME 1

By June 30, 2013, 50 faith-based organization Lay Leaders will be trained in CDSMP/DSMP.

OUTCOME 2

By June 30, 2013, collect clinical and demographic data for all faith-based church CDSMP/DSMP participants.

OUTCOME 3

By June 30, 2013, create a CDSMP/DSMP Implementation Tool Kit.

24 MONTH OUTCOMES

OUTCOME 1

By June 30, 2014, 100 ethnic Lay Leaders will be trained in CDSMP/DSMP from the ethnic coalitions, faith-based organizations and local conversation projects.

OUTCOME 2

By June 30, 2014, collect clinical and demographic data for all faith-based church CDSMP/DSMP participants.

OUTCOME 3

By June 30, 2014, utilize CDSMP/DSMP Implementation Tool Kit to expand faith-based CDSMP/DSMP statewide.

ACTION STEP 4

Offer assistance in implementation of Community Health Worker model to support systems with improving screening rates.

12 MONTH OUTCOME

By June 30, 2013, offer education to systems, with focus on Federally Qualified Health Centers (FQHCs), on benefits of and how to utilize the community health worker model.

24 MONTH OUTCOME

By June 30, 2014, provide culturally appropriate tools and resources for community health workers that address cancer screening, tobacco cessation, nutrition and physical activity.

INJURY AND VIOLENCE PREVENTION (IVP)



Violence and injury prevention is critical to ensure all Ohioans have the opportunity to be tomorrow's leaders.



■■■ INJURY AND VIOLENCE PREVENTION (IVP)

Unintentional injury is the leading cause of death for Ohioans aged 1–44 years, and with suicides and homicides included, injuries are the third-leading cause of overall death for Ohioans. Typically thought of as accidents, most intentional and unintentional injuries are both predictable and preventable. Strategies to reduce all injuries in Ohio align with the OIPP plan and will focus on increasing awareness of injury and violence as public health issues, strengthening policies to help reduce violence and injury-related deaths, implementing proven strategies to reduce injuries across the lifespan and improving the collection and accessibility of injury- and violence-related data. Violence and injury prevention is critical to ensure all Ohioans have the opportunity to be tomorrow's leaders.

GOAL

Promote public awareness, policy, programs and data that demonstrate that injury and violence are preventable.

■■■ STRATEGY 1 ■■■

Promote public and professional awareness of injury and violence as preventable public health issues.

ACTION STEP 1

Hold a forum of injury stakeholders to share key points from existing injury and violence plans.

12 MONTH OUTCOME

Identify strategies for cross-collaboration and promotion of IVP plans.

24 MONTH OUTCOME

Hold annual forums to reassess strategies.

ACTION STEP 2

Identify shared branding campaign.

12 MONTH OUTCOME

Promote branding campaign across IVP groups.

24 MONTH OUTCOME

Assess use and usefulness of branding.

ACTION STEP 3

Promote existing IVP state plans to multidisciplinary professionals.

■■■ STRATEGY 2 ■■■

Implement injury and violence prevention policy.

ACTION STEP 1

Identify priority policy issues from key IVP groups. Identify strategies for joint support of identified policy priorities.

12 MONTH OUTCOME

Create policy document with identified priorities.

24 MONTH OUTCOME

Measure success (e.g., data available, decision-makers educated, coalition mobilization, etc.) in promoting identified policy changes.

■■■ STRATEGY 3 ■■■

Identify IVP program needs and gaps.

ACTION STEP 1

Identify and promote evidence-based IVP strategies (e.g., *Tai Chi: Moving for Better Balance* for older adult fall prevention).

12 MONTH OUTCOMES

OUTCOME 1

At least 30 *Tai Chi: Moving for Better Balance* classes will be held in Ohio.

OUTCOME 2

Assess gaps in availability of *Tai Chi: Moving for Better Balance*.

ACTION STEP 2

Identify gaps in IVP capacity at the state and local level (e.g., lack of local funding for injury prevention).

12 MONTH OUTCOME

Identify gaps in IVP capacity and develop recommendations for addressing them.

ACTION STEP 3

Promote effective strategies (e.g., resiliency / asset building) and cross collaboration to intervene with youth around suicide, relationship violence and youth violence prevention.

12 MONTH OUTCOME

IVP leadership groups will support development of the IVP action plan within the Ohio Adolescent Health Partnership Plan.

24 MONTH OUTCOME

To be determined by Ohio Adolescent Health Partnership.

ACTION STEP 4

Assess gaps in statewide youth violence prevention efforts and capacity.

12 MONTH OUTCOME

Identify gaps in statewide youth violence prevention efforts.

24 MONTH OUTCOME

Develop recommendations for statewide youth violence prevention efforts.

■■■ STRATEGY 4 ■■■

Improve IVP data quality and accessibility.

ACTION STEP 1

Identify data gaps and develop a plan to address them through data systems. Explore existing sources or identify potential new sources to address gaps.

12 MONTH OUTCOME

Identify IVP data gaps.

24 MONTH OUTCOME

Develop IVP data plan with recommendations for improving Ohio IVP data.

ACTION STEP 2

Support external-cause-of-injury (E-coding) and other improvements to data sources.

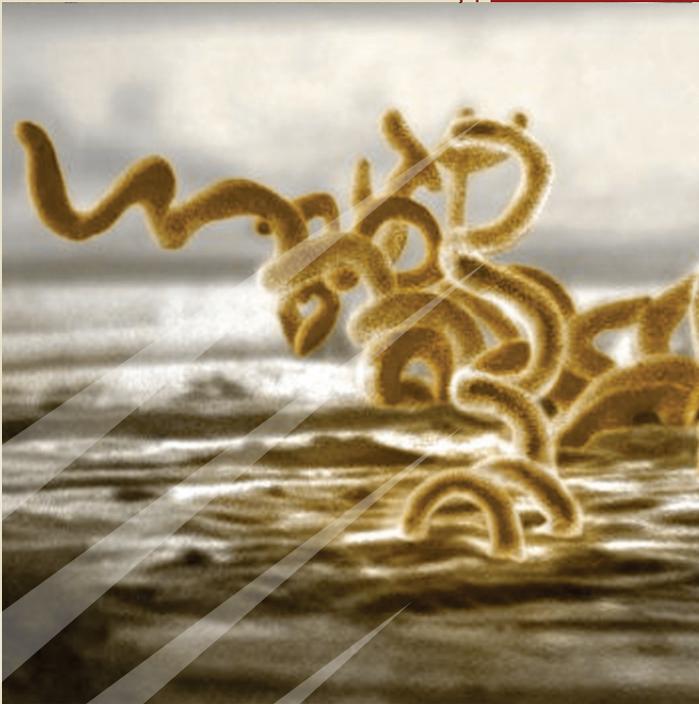
12 MONTH OUTCOME

Assess changes in E-coding in transition of hospitals from International Classification of Disease (ICD)-9 to ICD-10 coding.

24 MONTH OUTCOME

If needed, identify resources to host E-coding training for hospital billing coders.

INFECTIOUS DISEASE



Monitoring infectious diseases and preventing outbreaks remains a critical function of local, state and national public health.

■■■■ INFECTIOUS DISEASE

Considered one of the greatest public health achievements of the 20th century, the control of infectious diseases remains an important example of how public health impacts our lives every day. However, despite successes seen through improved data collection, vaccinations, medications and sanitation, our changing world also provides increasing opportunities for the emergence and spread of these diseases. In Ohio in 2009 alone, public health experts continuously monitored more than 80 specific diseases and responded to more than 200 disease outbreaks in counties across the state. Strategies to reduce the burden of infectious diseases in Ohio include strengthening the detection and monitoring of both diseases and outbreaks and the coordination of efforts within the community. Collaborating across the public health system to monitor infectious diseases and prevent outbreaks remains a critical function of local, state and national public health.

GOAL

Reduce and/or prevent reportable infectious diseases through comprehensive and integrated community health approaches.

■■■■ STRATEGY 1 ■■■■

Collect, analyze, interpret and report useful data.

ACTION STEP 1

Ensure inclusion and completeness of all required elements in the collection of public health reporting.

12 MONTH OUTCOME

Determine current baseline and establish target of reportable elements, to increase the percentage reported.

24 MONTH OUTCOME

Achieve identified target for percentage of reportable elements reported.

■■■■ STRATEGY 2 ■■■■

Identify and implement best practices for infectious disease surveillance, prevention and control.

ACTION STEP 1

Develop and strengthen relationships between infectious disease practitioners and primary care practitioners.

12 MONTH OUTCOMES

OUTCOME 1

Engage in four new communication opportunities with practitioners.

OUTCOME 2

Evaluate feasibility of using a model to bring groups together.

ACTION STEP 2

Ensure prevention message is included in all communications.

12 MONTH OUTCOME

Assess communications to ensure compliance.

■■■■ STRATEGY 3 ■■■■

Enhance, engage, and support traditional and non-traditional community partnerships.

ACTION STEP 1

Identify and assess existing partnerships.

12 MONTH OUTCOME

Complete assessment and disseminate to all partners.

ACTION STEP 2

Convene a statewide summit for partners to integrate and collaborate.

12 MONTH OUTCOME

Complete plan for summit and secure funding.

24 MONTH OUTCOME

Hold summit.

ACTION STEP 3

Identify model partnerships at the state level and engage local partners.

12 MONTH OUTCOME

Identify two model partnerships.

24 MONTH OUTCOME

Invite non-traditional partners (two-four) to develop the process.

■■■■ STRATEGY 4 ■■■■

Maximize community and statewide resources and efforts.

ACTION STEP 1

Develop a centralized mechanism to engage medical and public health students and fellows in appropriate learning experiences.

12 MONTH OUTCOME

Mechanism is fully developed.

24 MONTH OUTCOME

Mechanism is being implemented with first set of students.

INTEGRATION OF PHYSICAL AND BEHAVIORAL HEALTH



Better health outcomes are possible through the integration of physical and behavioral health.

■■■■ INTEGRATION OF PHYSICAL AND BEHAVIORAL HEALTH

[in development]

■■■■ STRATEGY 1 ■■■■

[in development]

ACTION STEP

[in development]

12 MONTH OUTCOMES

OUTCOME 1

[in development]

PUBLIC HEALTH SYSTEM FUNDING



Investing in public health is investing in Ohio's future.

■ ■ ■ ■ ■ PUBLIC HEALTH SYSTEM FUNDING

Nearly all of the significant benefits to our health seen in the past 100 years are due to the success of public health. Despite this, spending on public health initiatives in our communities to prevent disease and disability is less than 5 cents of every dollar spent on healthcare. Furthermore, Ohio remains one of the least-funded states for critical public health functions. This jeopardizes not only the health of all Ohioans but our ability to compete in today's business environment, because a successful economy requires a healthy and productive workforce. Strategies to improve Ohio's ability to prevent, reduce and respond to public health threats include aligning resources at local and state levels, improving Ohio's ability to successfully win funding and building long-term funding streams to support the state's public health priorities. A strong public health system means stronger families, successful students, productive employees, and connected communities. Investing in public health is investing in Ohio's future.

GOAL

Ohio's public health organizations have the resources and capacity they need to assure the health and wellbeing of all Ohioans.

■ ■ ■ ■ STRATEGY 1 ■ ■ ■ ■

Improve health organizations' capacity to effectively manage resources.

ACTION STEP 1

Make sure existing funding is appropriately aligned with identified SHIP priorities and is being used for evidence-based and/or evaluated programs.

12 MONTH OUTCOMES

OUTCOME 1

Document the alignment of ODH funding with SHIP priorities. (June 20, 2013)

OUTCOME 2

Evaluate and make recommendations for refinement of the Annual Financial Report (AFR) expenditure categories to be more aligned with SHIP priorities. (June 30, 2013)

OUTCOME 3

Complete and publish the Association of Ohio Health Commissioners (AOHC) Public Health Futures study. (June 30, 2013)

OUTCOME 4

Develop a template data collection tool for use by other organizations, agencies and entities to assess alignment of funding with SHIP priorities. (See IOM report)

24 MONTH OUTCOMES

OUTCOME 1

Assist smaller local communities in completing comprehensive health assessments as requested. (June 30, 2014)

OUTCOME 2

Convene a work group to evaluate identified funding alignment opportunities and to make recommendations for improvement. (June 30, 2014)

OUTCOME 3

Develop a method to assess the outcomes and effectiveness of funded initiatives, drawing on existing national frameworks (e.g., Healthy People 2020 or National Prevention Strategy). (June 30, 2014)

■■■ STRATEGY 2 ■■■

Identify additional sources of funding and establish a system to increase funds.

ACTION STEP 1

Pursue funds that align with the SHIP.

12 MONTH OUTCOMES

OUTCOME 1

OGA: Ohio General Assembly

Identify websites where grant opportunities can be found and share with partners. (June 30, 2013)

OUTCOME 2

Establish a group of Planning Council members who will review websites and disseminate opportunities to partners.

(June 30, 2013)

OUTCOME 3

Establish, regular interactive communication system for sharing funding opportunities (June 30, 2013)

OUTCOME 4

"Pitch" possible funding opportunities to partners. (June 30, 2013)

OUTCOME 5

Facilitate authentic collaboration in all appropriate applications. (June 30, 2013)

24 MONTH OUTCOME

Increase number of funded collaborative applications in SHIP priority areas. (June 30, 2014)

ACTION STEP 2

Implement a system for review of non-funded grant applications to identify areas for improvement or themes of weaknesses.

12 MONTH OUTCOMES

OUTCOME 1

ODH will review internal unfunded federal grant applications from the past five years. (June 30, 2013)

OUTCOME 2

Other organizations, agencies and entities will review their non-funded grant applications to public and private funders.

(June 30, 2013)

24 MONTH OUTCOMES

OUTCOME 1

Increase number of funded collaborative applications in SHIP priority areas. (June 30, 2014)

OUTCOME 2

Develop grant writing training to address identified weaknesses. (June 30, 2014)

■■■ STRATEGY 3 ■■■

Engage federal and state policy makers to provide or obtain long-term, sustainable, SHIP-aligned funding sources for health improvement strategies.

ACTION STEP 1

Develop a unified prevention message and advocacy campaign to engage policy makers to support wellness and prevention through adequate resource allocation and effective policy strategies.

12 MONTH OUTCOME

Develop the Health Policy Institute of Ohio (HPIO) Wellness & Prevention Collaborative unified prevention message and advocacy plan. (June 30, 2013)

24 MONTH OUTCOMES

OUTCOME 1

Implement the advocacy strategy. (June 30, 2014)

OUTCOME 2

Identify legislative champions to support funding and policies that align with SHIP priorities. (June 30, 2014)

ACTION STEP 2

Train and engage health professionals and others to advocate for funding.

12 MONTH OUTCOMES

OUTCOME 1

HPIO Wellness & Prevention Collaborative will host training sessions for prevention professionals. (June 30, 2013)

OUTCOME 2

Ohio Public Health Association (OPHA) will develop the county-level legislative liaison program. (June 30, 2013)

OUTCOME 3

HPIO and partners will provide annual "Orientation to Health Policy in Ohio" sessions for incoming legislators. (June 30, 2013)

24 MONTH OUTCOME

Develop an "Orientation to Wellness and Prevention" session for legislators. (June 30, 2014)

ACTION STEP 3

Revisit current laws and regulations to determine if or where mandates might be revised or eliminated to repurpose existing funds to align with SHIP priorities.

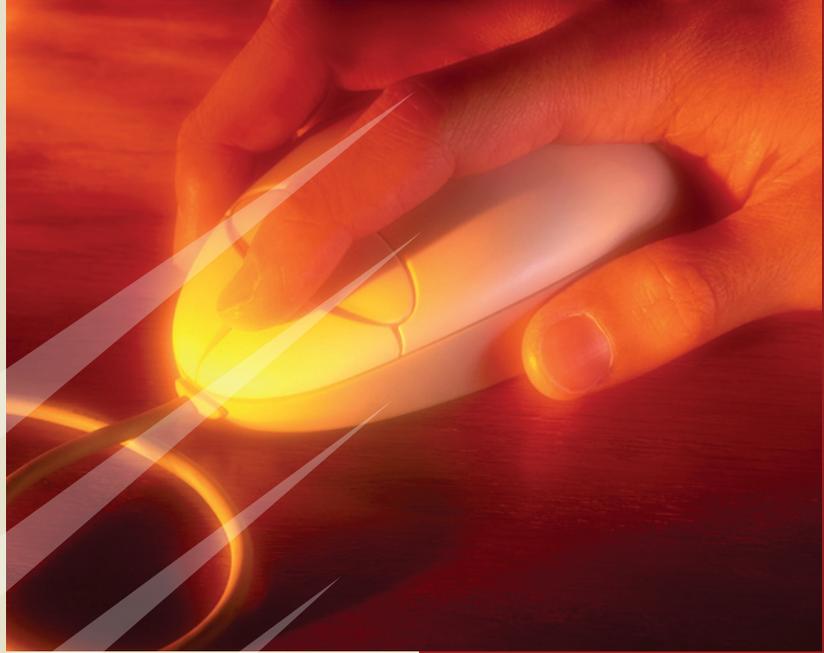
24 MONTH OUTCOMES

OUTCOME 1

Work with legislative champions to identify laws, regulations and mandates that might be eliminated to repurpose existing funds. (June 30, 2014)

OUTCOME 2

Advocate for block grants when possible, to allow communities to implement programs based on health assessment priorities. (June 30, 2014)



**A connected
healthcare system
focuses on providing
up-to-date, patient-
centered care across
Ohio.**

■ ■ ■ ■ ■ ELECTRONIC HEALTH RECORDS / HEALTH INFORMATION EXCHANGE / DATA WAREHOUSE

The ability to exchange health information electronically is the foundation of efforts to improve health care quality and safety. By connecting health systems with each other, providers can focus on providing care rather than chasing information, and patients' medical histories go where they go—saving time and money and preventing duplication. Ohio is a national leader in electronic health record (EHR) adoption by physicians and is working to connect all EHR users in a statewide health information exchange. Strategies include building capacity to ensure all healthcare providers have the training and support personnel to use EHRs and completing a two-way electronic exchange of health information capable of connecting all providers. A connected healthcare system focuses on providing up-to-date, patient-centered care across Ohio, while reducing waste and streamlining care.

GOAL

The majority of providers in Ohio are using an electronic health records system that is fully operational with a two-way state Health Information Exchange (HIE).

■ ■ ■ ■ STRATEGY 1 ■ ■ ■ ■

Assessment.

ACTION STEP 1

Identify status of two-way data exchange between HIE and EHR systems.

- a. HIE status in Ohio
- b. Provider use and plans for EHRs

12 MONTH OUTCOME

Enumerate all Ohio healthcare providers (HCP) from Ohio Health Information Partnership (OHIP), HealthBridge (HB), Office of Health Transformation (OHT).

- Assess HCP plans for EHR adoption; i.e., have EHR, plan EHR, not planning EHR and why (OHIP and HB) and report by provider type.

24 MONTH OUTCOME

Ninety percent of all HCPs are using EHRs and connected to HIEs.

ACTION STEP 2

Create capacity to use health information technologists (HIT):

- a. Educate legislators about the need to support this emerging market;
- b. Educate providers and hospitals about the HIT program and what graduates can do;
- c. Create geek squad for this newly graduated HIE brain trust.

12 MONTH OUTCOMES

OUTCOME 1

Identify and assess knowledge of HIT jobs among key advocates in Ohio General Assembly (OGA) and JobsOhio.

OUTCOME 2

Assess both HCP and HIT needs and HIT training graduates supply.

OUTCOME 3

Create and maintain a list of HIT graduates.

24 MONTH OUTCOMES

OUTCOME 1

One hundred percent of key advocates in OGA and JobsOhio understand importance of HIT jobs.

OUTCOME 2

Eighty-five percent of all HCP have needed HIT staff (adjust final percent based on 12-month assessment).

OUTCOME 3

Maintain developed list of HIT graduates.

ACTION STEP 3

Assess specific data needs for public health and PCMHs.

12 MONTH OUTCOME

Assess public health and PCMH data needs.

24 MONTH OUTCOME

Maintain ongoing list of public health and PCMH unmet data needs.

■■■ STRATEGY 2 ■■■

Workforce development.

ACTION STEP 1

Assess trainings currently available.

12 MONTH OUTCOME

All HIT training opportunities identified and listed.

24 MONTH OUTCOME

Fifty percent of applicable ODH programs will be trained to ensure exchange of electronic health information.

ACTION STEP 2

Create or enhance Continuing Education (CE) and Continuing Medical Education (CME) trainings. Trainings should encompass technology's link to higher quality care (see Ohio State Medical Association's "Performance Improvement CME" as example), and take advantage of public health conference opportunities.

12 MONTH OUTCOME

Create two web-based trainings (ODH and partners) to support PCMH with a session at fall and spring conference.

24 MONTH OUTCOME

Complete two web-based HIT training programs and HIT training presentations at two public health conferences.

ACTION STEP 3

Assure HIT training template is part of academic workforce development.

24 MONTH OUTCOME

All Ohio academic workforce development templates will include HIT training.

■■■ STRATEGY 3 ■■■

Adoption and implementation of EHR and HIE across the state.

ACTION STEP 1

Ensure all EHRs are integrated into a fully-functional HIE.

- a. Determine number of HIEs in Ohio.

12 MONTH OUTCOME

Plan develop to encourage HCPs to use HIEs.

- a. Policy developed by OHT for HIEs in Ohio.

24 MONTH OUTCOME

95% of HCPs with EHRs will utilize an approved HIE.

ACTION STEP 2

Ensure that an HIE that is created that provides for two-way data exchange and automatically inter-operates with health surveillance systems:

- a. Develop a collaborative committee to make decisions about requirements (from provider perspective as well as state agencies) for EHR and HIE;
- b. Assure ODH and other state systems' data needs are met.

12 MONTH OUTCOME

HIEs will provide assurance their HIE can exchange bi-directionally with any certified HCP EHR and priority health surveillance systems

- a. OHT will convene a committee to provide governance for EHRs and HIE
- b. OHT will plan the interoperability between HIEs and Ohio Health and Human Services Enterprise Exchange (OHHSEE).

24 MONTH OUTCOME

All approved HIEs in Ohio will provide bi-directional data exchange and be interoperable with health surveillance and other health reporting systems, either directly or through the OHHSEE.

WORK FORCE DEVELOPMENT



A well-trained
public health and
healthcare workforce
is one of Ohio's
greatest assets.

■ ■ ■ ■ ■ WORKFORCE DEVELOPMENT

Ohioans face a number of threats to their health, including increasing rates of chronic diseases, disparities in infant mortality, rising rates of tobacco use and rising healthcare costs. As patient-centered medical homes expand and as local public health evolves to meet today's public health needs, tomorrow's public health and healthcare workers will need the skills to effectively deliver high-quality health services and the tools to connect communities with resources needed to maintain and restore health. Strategies to develop a competent and well-equipped workforce include aligning state and local workforce development plans, establishing a statewide data system to help identify workforce shortages and redundancies, and increasing the number of health care providers in the state's healthcare shortage areas.

GOAL

Ensure a sufficient quantity of competent public health and clinical health workers to meet the needs of all Ohioans.

■ ■ ■ ■ STRATEGY 1 ■ ■ ■ ■

Coordinate health-related workforce development plans.

ACTION STEP 1

Conduct a joint review of OSU's Center for Public Health Practice (CPHP) workforce development plan and ODH's Bureau of Community Health Services and Patient Centered Primary Care (BCHSPCPC) workforce plan.

12 MONTH OUTCOME

Identify overlap between the two plans and designate them as state priorities.

ACTION STEP 2

Identify other health-related workforce development plans.

12 MONTH OUTCOME

Complete a scan of appropriate Ohio organizations to identify additional plans.

ACTION STEP 3

Examine opportunities for coordination among health-focused workforce development meetings.

24 MONTH OUTCOME

Identify overlap across plans to leverage opportunities to reduce duplication and increase efficiency.

■ ■ ■ ■ STRATEGY 2 ■ ■ ■ ■

Establish a comprehensive, statewide healthcare workforce data system.

ACTION STEP 1

Decide what information to track and which health professions to include.

12 MONTH OUTCOMES

OUTCOME 1

Brief partners on the HRSA model for a Minimum Data Set (MDS) pertaining to healthcare workforce.

OUTCOME 2

Create a comprehensive list of needed variables and the types of healthcare workers to include in the system.

ACTION STEP 2

Understand what data are currently being collected and where the data are housed.

12 MONTH OUTCOME

Create comprehensive list of what data are being collected, and by whom.

ACTION STEP 3

Identify gaps between needed data and data currently collected.

24 MONTH OUTCOME

Identify gaps and develop plan for addressing them.

■■■ STRATEGY 3 ■■■

Increase the numbers, diversity and distribution of the healthcare work force.

ACTION STEP 1

Focus on retroactive financial support for professional education via Match opportunities.

12 MONTH OUTCOMES

OUTCOME 1

Catalogue the list of opportunities that exist (e.g., public service loan repayment).

OUTCOME 2

Find out what scholarship opportunities exist.

24 MONTH OUTCOME

Increase awareness of loan repayment programs that already exist.

ACTION STEP 2

Focus on proactive financial support for professional education, training and development via scholarship opportunities and free or low-cost training opportunities.

12 MONTH OUTCOME

Identify existing scholarship opportunities.

24 MONTH OUTCOMES

OUTCOME 1

Increase awareness of existing scholarship opportunities.

OUTCOME 2

Create collaborations among potential education funders (e.g., coordinate target audience for multiple scholarship opportunities).

ACTION STEP 3

Improve coordination and planning of training programs.

24 MONTH OUTCOME

Develop strategies to attract high-quality health profession candidates, who are likely to practice within the communities they train in.

APPENDIX



Stakeholder
Interviews Final
Report May 2012

State Health Improvement Plan

Stakeholder Interviews Final Report May 2012

Introduction: How to Use this Spreadsheet

This Spreadsheet includes an individual tab for each of the original 11 State Health Improvement Plan priorities. For the final report narrative, patient centered medical home was combined and reported with Access to Care, to arrive at the final priority areas. The format of each tab is consistent for all priorities. Stakeholder organizations were classified as having a single primary priority, and up to ten secondary priorities. For each tab, the following appear:

Each SHIP Priority sheet includes three groupings of organizations:

1. Organizations for which this priority was identified as their primary priority, and for which an interview was completed
2. Organizations for which this priority was identified as secondary, with a cross reference to the primary priority
3. Organizations for which this priority was identified as a primary priority, but for which an interview was not completed

Lists of additional resources/supplemental documents provided by organizations are included at the bottom of each priority sheet. Also included for each organization is the contact information, interviewer and, when contacted by the Center for Public Health Practice, tracking of each contact.

Symbols used in the spreadsheet are:

* = An interview was completed by planning member, and no additional information other than what appears here was provided

Δ = At least one additional resource/supplemental document was provided by the organization

○ = Organization reported at least one secondary priority

In addition to this Excel spreadsheet, products of this project are:

- Report that includes a description of the project, and a summary of the interviews (Word document)
- Thumb drive containing electronic files, including the spreadsheet and all collected resources/supplemental documents. The thumb drive is organized by priority area.

For questions, contact: Joanne Pearsol at the Center for Public Health Practice, College of Public Health, Ohio State University; 614-292-1085; jpearsol@cph.osu.edu or Lynnette Cook, Ohio Department of Health; 614-995-5169; lynnette.cook@odh.ohio.gov

NOTE: Additional partner interviews were added after the completion of the initial report; these additional partners are identified in green.

PRIORITY: Access to Care - see also Access to Care 2 of 2

Potential Partner	Summary
HealthPath Foundation of Ohio	In process of developing a funding strategy for new initiative-Strengthening Ohio's Safety Net; plan has two goals: increasing access to care and increasing the number, distribution & diversity of primary care workforce. There is emphasis on rural Ohio. Funding determined in April 2012. Focus on oral health: Children's Oral Health Action Team, Oral Health Capacity Building Project, Early Childhood Oral Health Project. Gaps: Increased attention on rural Ohioans.
Ohio Department of Aging ΔO	ODA has included access to care in several of the agency plans and initiatives. Medicaid funds are distributed to the PASSPORT Administrative Agencies for a variety of tasks. Strategic plan includes "develop and improve plans for care coordination" etc. Gaps: Access to and coordination of access to acute care.
Ohio Dental Association O	Support programs such as "Give Kids a Smile" (100 locations in OH) events and dental clinics for adults; 2.5 million in services donated. The ODA and its subsidiaries spend in excess of \$200,000 annually on access to care initiatives. Working on proposal to encourage dentists to treat infants by age 1; active in advocacy for dental issues. Gaps: Oral health as a higher priority; increase focus on prevention.
Children's Oral Health Action Team (COHAT) O	Grant funding from HealthPath Foundation, Sisters of Charity Foundation and Delta Dental Foundation to work on access to oral health care for children. Many varied partners. Gaps: Access to care continues to be a challenge, particularly for low-income minorities and Appalachians.
Access Health Columbus O	Funding from multiple sources to address access to care. Many partners. Gaps: Growing imbalance between increasing number of uninsured/underinsured people and scarce resources for improving access to care, especially in the health care safety-net. Plan is online.
Asian American Community Services ΔO	Main priority is to educate public about health resources available in Columbus. Holds weekly free health clinics, quarterly Hep. B clinics, and starting workshops in community to educate members about how to manage chronic diseases. Gaps: Language barrier, lack of insurance, money for care.
Salvation Army - Central Ohio O	Offers material / housing assistance to those in need; anti-human trafficking program; career enhancement program; GED assistance. Partners with the Benefit Bank and CareSource. Gap: People have income, but not enough to cover all necessary expenses.
Access Center for Independent Living O	Ensures that people with disabilities have complete access to the communities in which they wish to live. Significant amounts of advocacy for community based home care. Gaps: Supportive of Medicaid modernization; would like to eliminate all states spend down.
Better Health Greater Cleveland ΔO	Members publicly report their performance in quality of care and outcomes for 3 chronic conditions (diabetes, high blood pressure, heart failure). Better Health's Professional Practice Coaches utilize this data and assist the primary care practices to achieve PCMH NCOA recognition, optimize their EMR, and improve performance over time. Funded through grants (\$1.3 million from Robert Wood Johnson), dues & sponsorships. Gaps: Need for increasing involvement of employers health care delivery, designing benefit plans and ultimately affecting health outcomes.
Central Ohio Hospital Council O	Focus on access to mental health and dental services. Gaps: Lack of availability of community based mental health services and inpatient beds for mental health patients.
Voices for Ohio's Children ΔO	Leads Simplification work in the state to make Medicaid more accessible to children and their families. Funded primarily through David and Lucille Packard Foundation. Chair the Ohio Covering Kids and Families Coalition that focuses on enrolling and keeping kids enrolled to public health coverage. Gaps: Outreach and enrollment is often an afterthought to public programs.
Office of Health Transformation*	Plan on their website which included federal match, involvement of all state agencies, etc.
Health Policy Institute of Ohio, Access Collaborative* Δ	Plan developed by summer 2012; plan to produce "access 101" white paper and a dashboard of Ohio access indicators.
Ohio Association of Community Health Centers*	
Ohio Perinatal Quality Collaborative	See Infant mortality / pre-term birth
Paint Valley Alcohol, Drug Addiction and Mental Health Board (Fayette, Highland, Pickaway, Pike, Ross)	See Mental Health
Osteopathic Heritage Foundation	The Foundation supports efforts to improve access to affordable and sustainable oral health care services in central and south-eastern Ohio. Works with Children's Oral Health Action Team, Oral Health Capacity Building Project, Safety Net Solutions, and local stakeholders / dental clinics. See Funding.
Ohio Department of Alcohol and Drug Addiction Services	Improved access to prevention, treatment and recovery services through securing additional discretionary funds, reducing stigma, and making use of technologies such as telehealth. See Mental Health.
United Way of Greater Toledo	Focus on mothers and children receiving quality preventative care, coordinate school-based health services to increase access and create more connected system, and create a seamless, high quality and equitable healthcare system. Provide safety-net services and short term income supports for individuals and families in need. Hospital Council where MDs volunteer to take so many uninsured patients. See Funding.
Four County Alcohol, Drug Addiction and Mental Health Board (Defiance, Fulton, Henry, Williams)	Major initiative on all contracts. Gaps: hospitalization capacity, funding, case management services (FMD). See Mental Health.
Ohio Sickle Cell and Health Association	See Chronic Disease
Ohio Geographically Referenced Information Program	See Data Exchange
Ohio Commission on Minority Health	Educate community organizations with culturally relevant program designs. See Chronic Disease.
Family Violence Prevention Center	Provides resources to survivors including employment and housing protection. See Injury.
Stonewall Columbus	Provides resources for GLBT individuals. See Infectious Disease.
American Lung Association	See Chronic Disease.

Potential Partner	Summary
Ohio Partners for Cancer Control	See Chronic Disease.
Mothers Against Drunk Driving	Provides medical, legal and counseling referrals. See Injury.
Central Ohio Area Agency on Aging	See Injury
The Raymond John Wean Foundation	See Funding
Ohio Children's Foundation	See Funding.
Ohio Department of Developmental Disabilities	See Mental Health
Ohio Provider Resource Association	See WFD
AIDS Resource Center Ohio	See Infectious Disease
YMCA of Central Ohio	Focus on housing specifically. See Chronic Disease.
American Cancer Society	National, state and local efforts towards patient-focus advocacy. Access to free/reduced cost resources, transportation and lodging. Provided assistance to determine what is available under individual's insurance policy. See Chronic Disease.
Ohio Patient-Centered Primary Care Collaborative	See PCMH
State Highway Patrol Public Information Office	Utilizes a community referral book with a list of resources. See Injury.
Ohio Dietetic Association	Medicaid codes for areas of nutrition. See Chronic Disease.
Ohio State Medical Association	Local medical societies to help facilitate networks to providers/patients. See Workforce Development.
Ohio Association of Health Plans	See PCMH
Ohio School-Based Health Care Association	See Chronic Disease
Ohio Commission on Hispanic/Latino Affairs	Connect individuals with free clinics. See Chronic Disease.
Health Policy Institute of Ohio	Decision to focus on ensuring access to care for all Ohioans is based on several factors: uninsured population, timeliness and setting of care, primary care access, ACA provisions, safety net capacity limitations, fair access for all Ohioans. See Data Exchange.
Ohio Public Health Association	See Funding
March of Dimes Ohio Chapter	Specifically for pregnant women, infants and children. See Infant Mortality.
MOMS2B	Ensure mom enter prenatal care early. See Infant Mortality.
ODH Child Fatality Review	See Infant Mortality.
Ohio Better Birth Outcomes	Specifically for pregnant women. See Infant Mortality.
Ohio Collaborative to Prevent Infant Mortality	See Infant Mortality
OhioHealth	See Infant Mortality
American Heart Association, Great Rivers Affiliate	See Infant Mortality / Chronic Disease
Ohio Adolescent Health Partnership	See Chronic Disease
Galade Research & Project Management	Directing a study of Ohio children's access to psychiatric care. See Injury.
Ohio Hospital Association	See Mental Health
Ohio Citizen Advocates	See Mental Health
Ohio Department of Alcohol and Drug Addiction Services	See Mental Health
Buckeye Healthy School Alliance	See Chronic Disease
Medical Mutual Wellness program	See Chronic Disease
Clinical Coordinating Center at MetroHealth Medical Center	See Chronic Disease
Oh Academy of Family Physicians	See Chronic Disease
Comprehensive Cancer Control Program	See Chronic Disease
Ohio Diabetes Prevention & Control Program	See Chronic Disease
United Way of Central Ohio	See Funding
Central Ohio Diabetes Association	See Chronic Disease
National Alliance on Mental Illness	See Mental Health
Mental Health America of Franklin County	See Mental Health
Ohio Association of County Behavioral Health Authorities	See Mental Health
Ohio Developmental Disabilities Council	Provide volunteer credentialing program for direct service providers. Focused on maximizing resources including housing and transportation for individuals with disabilities. See Mental Health.
American Heart Association / American Stroke Association	See WFD
Ohio Patient Safety Institute	Ensure hospitals have resources to provide to patients. See Injury.

PRIORITY: Access to Care - see also Access to Care2of2 - PCMH tab

Potential Partner	Summary
BEACON	See Infant Mortality
Medicaid Health Homes	See PCMH
Muskingum Area Mental Health Board (Coshocton, Guernsey, Morgan, Muskingum, Noble)	See Mental Health
Ohio Asian American Health Coalition	
Resources:	Better Health Greater Cleveland - Executive Summary Winter 2012 (CG), Health Policy Inst. Of Ohio 2011-2013 Strategic Plan Health Policy Institute of Ohio White Paper, Asian American Community Service, Voice's for Ohio's Children, ODA logic model

PRIORITY: Access to Care - see also Access to Care 1of 2

Potential Partner	Summary
HB 198 Pilot sites Δ	\$1 million funds dedicated to transforming 44 practices to PCMH model. Gap: Will there be enough payer sponsorship to convince providers to invest in the transformation?
Medicaid Health Homes 0	Focus on integration and getting to outcomes. Dual eligible Medicare / Medicaid - leads to increased spending due to care that is not coordinated. Gaps: Coordination, preventative care, and lack of alternatives to nursing homes.
Ohio Association of Health Plans 0	As a trade organization, main function is information sharing between members. Member health plans (#20) determine individual focus.
Ohio Patient-Centered Primary Care Collaborative 0	Voluntary information/resource clearinghouse. About 200 people on list of members. Still working on finalizing plan and too early to determine any gaps.
Ohio Department of Alcohol and Drug Addiction Services	Through the implementation of a comprehensive capacity management system that enables ODADAS to identify the extent to which clients are being assigned to the appropriate level of care and identify treatment access barriers related to needed levels of care and wait times to access treatment. See Mental Health.
United Way of Greater Toledo	Ensure all students have and utilize a medical home. Working with St. Vincent on this. See Funding.
The Rite Bite - Fitness and Nutrition Center	Provides corporate wellness; assists those employers in applying for Bureau of Worker's Compensation grant to decrease expenses for corporate wellness program. See Chronic Disease.
Four County Alcohol, Drug Addiction and Mental Health Board (Defiance, Fulton, Henry, Williams)	Just getting started on this initiative. Gaps: hospitalization capacity, funding, case management services (FMD). See Mental Health.
Ohio Sickle Cell and Health Association	See Chronic Disease
Ohio Geographically Referenced Information Program	See Data Exchange
Ohio Commission on Minority Health	See Chronic Disease
American Lung Association	See Chronic Disease
Ohio Partners for Cancer Control	Focus on increasing screening. See Chronic Disease.
Access Center for Independent Living	Consumer control. See Access to Care.
Ohio Provider Resource Association	See WFD
AIDS Resource Center Ohio	Clinic will open this fall to provide medical home to HIV/AIDS clients. See Infectious Disease.
American Cancer Society	See Chronic Disease
Ohio Dietetic Association	Educational programs for dieticians are in progress. See Chronic Disease.
Ohio State Medical Association	Involvement in educational efforts towards this topic. See WFD.
Ohio School-Based Health Care Association	See Chronic Disease
HealthBridge & Tri-State Regional Extension Center	Greater Cincinnati Beacon Collaboration. See Data Exchange.
Ohio Health Information Partnership	Focusing HIE service development among health homes. See Data Exchange.
Ohio Collaborative to Prevent Infant Mortality	See Infant Mortality
OhioHealth	See Infant Mortality
American Heart Association, Great Rivers Affiliate	See Infant Mortality / Chronic Disease
Ohio Adolescent Health Partnership	See Chronic Disease
Ohio Hospital Association	See Mental Health
Children's Oral Health Action Team (COHAT)	Focus on integration of oral health in pediatric well-child visits. See Access to Care.

Potential Partner	Summary
Access Health Columbus	See Access to Care
Ohio Dental Association	Dentist Loan repayment program; oral health access supervision. See Access to Care.
Better Health Greater Cleveland	Convenes purchasers and payers with providers to re-design payment and benefit plans to support this transformation and sustain this model over time. See Access to Care.
Ohio Department of Aging	Support the access to self-management programs requirement included in NCOA PCMH certification. See Chronic Disease.
Buckeye Healthy School Alliance	See Chronic Disease
Medical Mutual Wellness program	See Chronic Disease
Clinical Coordinating Center at MetroHealth Medical Center	See Chronic Disease
Oh Academy of Family Physicians	Would like to see linkages between chronic and the importance of the PCMH model of care. See Chronic Disease.
Comprehensive Cancer Control Program	See Chronic Disease
Ohio Diabetes Prevention & Control Program	See Chronic Disease
ODH Heart Disease & Stroke Prevention	See Chronic Disease
American Heart Association / American Stroke Association	Support healthcare professionals' quest for continuous quality improvement (eg. The Guideline Advantage - program for outpatient practices at no cost to provider, supports consistent use of evidence-based guidelines for prevention & disease management through existing healthcare technology; Lifeline - national, community-based initiative focusing on streamlining and coordinating process to help speed the delivery of appropriate treatment). See WFD.
Central Ohio Diabetes Association	See Chronic Disease
National Alliance on Mental Illness	One staff member focused on PCMH. See Mental Health.
Ohio Developmental Disabilities Council	See Mental Health
United Way of Central Ohio	See Funding
BEACON	See Infant Mortality
Muskingum Area Mental Health Board (Coshocton, Guernsey, Morgan, Muskingum, Noble)	See Mental Health
Better Health Greater Cleveland	See Access to Care
Voices for Ohio's Children	See Access to Care
Resources:	HB 198 PCMH Education Pilot Project - Final Draft, PCMH Education Advisory Group Members

PRIORITY: Integrate Physical Health and Mental Health / Addiction

Potential Partner	Summary
Mental Health Advocacy Coalition	See Mental Health
Ohio Adolescent Health Partnership	In process of writing strategic plan that will encompass goals and objectives through 2015 (priority areas include MH, substance abuse, injury/violence, reproductive health, nutrition/physical activity/sleep, access, collaboration/coordination, education, disparities, environmental changes. See Chronic Disease.
Ohio Hospital Association	87 private inpatient psychiatric service providers (serve more than state mental health hospitals operated by ODMH). See Mental Health.
Asian American Community Services	Holds weekly free clinics and makes referrals to another free clinic that provides a psychiatrist. See Access to Care.
Central Ohio Diabetes Association	See Chronic Disease
National Alliance on Mental Illness	Received a grant last year to train direct service providers on impact of mental health medications on chronic diseases. See Mental Health.
Ohio Association of County Behavioral Health Authorities	See Mental Health
Salvation Army - Central Ohio	Addressing this topic in anti-human trafficking program. See Access to Care.
Ohio Developmental Disabilities Council	\$75,000 (up to 5 years) for Coordinating Center of Excellence in Dual Diagnosis for Individuals with MI/DD. See Mental Health.
Ohio Department of Alcohol and Drug Addiction Services	Through the implementation of a comprehensive capacity management system that enables ODADAS to identify the extent to which clients are being assigned to the appropriate level of care and identify treatment access barriers related to needed levels of care and wait times to access treatment. See Mental Health.
Ohio Perinatal Quality Collaborative	See Infant Mortality.
Paint Valley Alcohol, Drug Addiction and Mental Health Board (Fayette, Highland, Pickaway, Pike, Ross)	AOD and mental health provider working to get primary care physician to work out of mental health office 1 day/week. Working with local primary care providers to get them to allow outside mental health services/screenings in their office. See Mental Health.
United Way of Greater Toledo	Piloting program with child care centers to provide readers and assessments for 2-4 year olds with emotional problems. See Funding.
The Rite Bite - Fitness and Nutrition Center	Provides corporate wellness; assists those employers in applying for Bureau of Worker's Compensation grant to decrease expenses for corporate wellness program. See Chronic Disease.
Four County Alcohol, Drug Addiction and Mental Health Board (Defiance, Fulton, Henry, Williams)	Major focus. Gaps: hospitalization capacity, funding, case management services (FMD). Most funding from state; small amount from ODMH. See Mental Health.
Ohio Geographically Referenced Information Program	See Data Exchange
Mothers Against Drunk Driving	See Injury.
Central Ohio Area Agency on Aging	Standardized assessment includes mental health and makes referrals accordingly. See Injury.
Ohio Department of Developmental Disabilities	See Mental Health
Access Center for Independent Living	See Access to Care
Ohio Provider Resource Association	Advocating for this priority. See WFD.
AIDS Resource Center Ohio	Clinic will open this fall to provide medical home to HIV/AIDS clients. See Infectious Disease.
Ohio Patient-Centered Primary Care Collaborative	See PCMH
State Highway Patrol Public Information Office	Utilizes a community referral book with a list of resources. See Injury.
Ohio Association of Health Plans	One initiative through Medicaid. See PCMH.
Ohio School-Based Health Care Association	See Chronic Disease
Ohio Health Information Partnership	Supporting Ohio's Medicaid Behavioral health Home Initiative. See Data Exchange.
ODH Child Fatality Review	See Infant Mortality
Ohio Collaborative to Prevent Infant Mortality	See Infant Mortality
Ohio Adolescent Health Partnership	See Chronic Disease.
OH Suicide Prevention Foundation	Advocates for this priority. See Injury.
Ohio Hospital Association	See Mental Health
Ohio Citizen Advocates	See Mental Health
Ohio Department of Alcohol and Drug Addiction Services	See Mental Health
Access Health Columbus	See Access to Care
Better Health Greater Cleveland	Depression screenings in PCP offices. See Access to Care.
Ohio Department of Aging	See Chronic Disease
BEACON	See Infant Mortality
Medicaid Health Homes	See PCMH
Muskingum Area Mental Health Board (Coshocton, Guernsey, Morgan, Muskingum, Noble)	See Mental Health
Voices for Ohio's Children	See Access to Care

PRIORITY: HIE / ERH/ Data Warehouse

Potential Partner	Summary
Ohio Geographically Referenced Information Program O	Provide geocoding services to spatially enable public health data. Gaps: quality of the location information available to support ODH geocoding needs.
HealthBridge & Tri-State Regional Extension Center O	\$10.1 million and \$13.75 million in multi-year cooperative agreements with the Office of the National Coordinator for Health Information Technology. Many partners include health plans, hospitals, professional associations. Feels current federal and state programming is fairly comprehensive.
Health Policy Institute of Ohio AO	Recently created strategic plan includes Ohio health system data transparency as an objective. Creation of All Claims Payer Database is being considered. Majority of funders are foundations. Broad base of partners. Gap: Lack of established standards on what is most meaningful data.
Ohio State Medical Association O	Tools available to help physicians implement, adopt and achieve Meaningful Use of certified EHR technology to draw down Medicare/Medicaid incentive payments. Assist physicians with e-prescribing, HIPAA requirements and data privacy / security. Gaps: Private practice physicians often cite large upfront cost and lack of in-house technical expertise as barriers to EHR adoption.
Ohio Health Information Partnership AO	Building the infrastructure to support health information exchange in Ohio and supplement initial hospital / physician integration costs to encourage adoption. Funded through federal State Grants to Promote Health Information Technology Planning and Implementation for Ohio (\$14,872,199 through Feb. 2014) and \$2,151,901 in funds from State of Ohio. Federally approved HIE state plan (being revised). Gaps: IT resources, funding, and a vendor's ability to deliver products.
Central Ohio Diabetes Association	See Chronic Disease
Ohio Association of County Behavioral Health Authorities	Working with state to educate the behavioral health field about data exchange. See Mental Health.
Ohio Perinatal Quality Collaborative	See Infant Mortality
Ohio Department of Alcohol and Drug Addiction Services	Enhance the use of information technology through ensuring effective claiming and reimbursement for Medicaid and Non-Medicaid services and ensuring availability of information to facilitate clinical decision making and resource management. See Mental Health.
The Rite Bite - Fitness and Nutrition Center	Provides corporate wellness; assists those employers in applying for Bureau of Worker's Compensation grant to decrease expenses for corporate wellness program. At center have capabilities of medical charting on-line. See Chronic Disease.
Ohio Sickle Cell and Health Association	See Chronic Disease
Ohio Commission on Minority Health	Very interested in this topic, but lack of funding. See Chronic Disease.
Ohio Partners for Cancer Control	See Chronic Disease
The Raymond John Wean Foundation	Current grant to COMPASS. See Funding.
Central Ohio Hospital Council	See Access to Care
Ohio Department of Developmental Disabilities	See Mental Health
Ohio Provider Resource Association	See WFD
AIDS Resource Center Ohio	See Infectious Disease
Association of Ohio Health Commissioners	See WFD.
Ohio Patient-Centered Primary Care Collaborative	See PCMH
Ohio State Medical Association	See WFD
Ohio Association of Health Plans	See PCMH
ODH Child Fatality Review	See Infant Mortality
Ohio Collaborative to Prevent Infant Mortality	See Infant Mortality
American Heart Association, Great Rivers Affiliate	See Infant Mortality / Chronic Disease
Ohio Department of Public Safety - Office of Criminal Justice Services	Operational Improvements with data exchange. See Injury.
Ohio Patient Safety Institute	Supports Ohio Health Information Partnership. See injury.
Ohio Adolescent Health Partnership	See Chronic Disease
Ohio Hospital Association	See Mental Health
Ohio Department of Alcohol and Drug Addiction Services	See Mental Health
Access Health Columbus	See Access to Care
Better Health Greater Cleveland	Reporting data collected via EHR. See Access to Care.
Buckeye Healthy School Alliance	See Chronic Disease
Ohio Coverdell Acute Stroke Registry Program	See Chronic Disease
Clinical Coordinating Center at MetroHealth Medical Center	See Chronic Disease
Oh Academy of Family Physicians	See Chronic Disease
ODH Heart Disease & Stroke Prevention	See Chronic Disease

PRIORITY: HIE / ERH/ Data Warehouse

Potential Partner	Summary
Health Policy Institute of Ohio, 2012 County Health Rankings Action Project (in partnership with ODH and AOHC)	The County Health Rankings provide a user-friendly place to find health data. See Chronic Disease.
American Heart Association / American Stroke Association	Look to partner on data collection to reduce duplication. Support healthcare professionals' quest for continuous quality improvement (eg. The Guideline Advantage - program for outpatient practices at no cost to provider, supports consistent use of evidence-based guidelines for prevention and disease management through existing healthcare technology; Lifeline - national, community-based initiative focusing on streamlining and coordinating process to help speed the delivery of appropriate treatment) See WFD.
BEACON	See Infant Mortality
Medicaid Health Homes	See PCMH
The Academy of Medicine of Cleveland and Northern Ohio (AMCNO)	Have priority of physician practices, physicians treating patients, Health Information Exchange (HIE) and Electronic Health Records (EHR).
Resources:	Health Policy Inst. Of Ohio 2011-2013 Strategic Plan Ohio Health Information Partnership HIS State Plan

PRIORITY: Workforce Development

Potential Partner	Summary
Health Policy Institute of Ohio - Health and Wellness Communication Collaborative Δ 0	Have draft logic model; point out that many organizations still lack skills and capacity to do effective advocacy and policy change work Many partners. Gap: Fragmentation of prevention community through funding silos; minimal training around communications and messaging is provided to prevention organizations. Will be seeking additional funding to support the work of their collaborative.
American Heart Association / American Stroke Association 0	Supports healthcare professional's quest for continuous quality improvement through up-to date treatment guidelines, tools and resources. "Get With the Guidelines" helps ensure consistent application of most recent guidelines for patient treatment. "Guideline Advantage" is designed for outpatient practices, at no cost to providers, supports consistent use of evidence-based guidelines for prevention & disease management through existing healthcare technology. "Lifeline" is a national, community-based initiative focusing on streamlining and coordinating process to help speed the delivery of appropriate treatment. Gap: Some overlap in efforts with the creation of new initiatives.
Ohio Hospital Association	Workforce plan formalized a few years ago, but may be abandoned for lack of interest by members. Cite numerous other parties involved in workforce development; questions whether gaps currently exist.
Ohio Provider Resource Association 0	Membership dues organization that works with agency providers that work with individuals with disabilities. Gaps: Lack of incentives for employers to hire developmentally disabled individuals; 43% turnover rate in field; underpaid staff.
Ohio State Medical Association 0	Association that represents physicians, residents and medical students. Dedicated to making medicine less complicated and more satisfying for all by advocating, saving time and money, and promoting medical profession through education. Need for a on-going strategic plan. No funding outside of association resources.
Association of Ohio Health Commissioners 0	Trade association for local health officers - broad spread of involvement. Focus on public policy advocacy, professional development and infrastructure development. Partnerships with other professional associations, state health department.
OSU Center for Public Health Practice Δ	Draft state-wide workforce development plan created with input from associations, academic institutions, state and local governmental public health.
National Alliance on Mental Illness	Partnered with Dartmouth College to provide Supported Employment. See Mental Health.
Paint Valley Alcohol, Drug Addiction and Mental Health Board (Fayette, Highland, Pickaway, Pike, Ross)	Organizational policy which includes tuition reimbursement for college. See Mental Health.
Osteopathic Heritage Foundation	Funding has been directed to Ohio University's Heritage College of Osteopathic Medicine to address primary care physician shortage in Ohio, increase number of graduates selecting primary care, improve the quality of medical education, enhance medical research in diabetes, and provide training of additional physician scientists. See Funding.
Ohio Department of Alcohol and Drug Addiction Services	Improving quality, effectiveness and efficiency of service delivery through a comprehensive management system, streamlining reporting requirements, revising reimbursement methodologies, and enhancing capabilities of the workforce to provide high quality prevention and treatment services. See Mental Health.
The Rite Bite - Fitness and Nutrition Center	Provides corporate wellness; assists those employers in applying for Bureau of Worker's Compensation grant to decrease expenses for corporate wellness program. See Chronic Disease.
Four County Alcohol, Drug Addiction and Mental Health Board (Defiance, Fulton, Henry, Williams)	See Mental Health
Ohio Sickle Cell and Health Association	Trains state support groups to provide education in communities. See Chronic Disease.
Ohio Geographically Referenced Information Program	See Data Exchange
Ohio Commission on Minority Health	Train lay leaders to provide information to individuals with chronic disease. See Chronic Disease.
Family Violence Prevention Center	Legislation regarding sexual violence, stalking, domestic violence. See Injury.
Ohio Partners for Cancer Control	Works with CDC to provide training for local health departments to use cancer data for planning, identifying risk factors, and access to care information. See Chronic Disease.
Mothers Against Drunk Driving	Trains advocates and volunteers. See Injury.

PRIORITY: Workforce Development

Potential Partner	Summary
The Raymond John Wean Foundation	See Funding.
Ohio Department of Developmental Disabilities	Statewide initiative to support employment this year. Individuals have a better life when integrated in society, not sheltered workplaces. See Mental Health.
Access Center for Independent Living	Part of enactment of ADA, but still high unemployment in disabled individuals. See Access to Care.
AIDS Resource Center Ohio	In process of creating plan to focus on this priority in the future. See Infectious Disease.
Ohio Patient-Centered Primary Care Collaborative	See PCMH
State Highway Patrol Public Information Office	See Injury
Ohio Dietetic Association	Important part is including dieticians in organizations to enhance their professional development. See Chronic Disease.
Ohio Department of Education-Office for Child Nutrition	Provides trainings/webinars on new legislation. See Chronic Disease.
HealthBridge & Tri-State Regional Extension Center	ONC REC and Beacon programs. See Data Exchange.
Ohio Health Information Partnership	Have submitted a CMS Innovation Grant application to join efforts with Ohio's community colleges to further develop the IT workforce and to offer training for physicians to adopt and use EHRs to support health home models. See Data Exchange.
MOMS2B	Collaborating with a MEDTAPP workforce development project. See Infant Mortality.
ODH Child Fatality Review	See Infant Mortality.
Ohio Collaborative to Prevent Infant Mortality	See Infant Mortality.
Ohio Domestic Violence Network	Provides trainings on sexual violence and intimate partner violence. See Injury.
Ohio Adolescent Health Partnership	See Chronic Disease
OSU Community Safety Institute, OSU YVPAB and CeaseFire Columbus	See Injury
Ohio Hospital Association	See Mental Health
Ohio Department of Alcohol and Drug Addiction Services	See Mental Health
Ohio Department of Aging	See Chronic Disease
Buckeye Healthy School Alliance	Provides professional development for school health professionals and orgs that work in school settings. See Chronic Disease.
Clinical Coordinating Center at MetroHealth Medical Center	See Chronic Disease
Oh Academy of Family Physicians	See Chronic Disease
Central Ohio Diabetes Association	See Chronic Disease
Mental Health America of Franklin County	See Mental Health
Ohio Association of County Behavioral Health Authorities	See Mental Health
Salvation Army - Central Ohio	Career enhancement program to assist in obtaining/maintaining a job; GED classes. See Access to Care.
Ohio Developmental Disabilities Council	Conducting projects focused on employment, housing and transportation for individuals with disabilities. See Mental Health.
United Way of Central Ohio	Provide workforce development through public policy and advocacy. See Funding.
Ohio Public Health Association	See Funding.
BEACON	Workforce doesn't match who they are taking care of. Focusing on training in an integrated setting and placing them in high need areas. See Infant Mortality.
Medicaid Health Homes	See PCMH
HealthPath Foundation of Ohio	"Strengthening Ohio's Safety Net" has 2 goals, one of which is increasing the number, distribution & diversity of primary care workforce within service area, with emphasis on rural Ohioans. See Access to care.
Universal Health Care Action Network Ohio	
Resources:	Health Policy Inst. Of Ohio 2011-2013 Strategic Plan COPHP Statewide Strategic WFD Plan

PRIORITY: Funding

Potential Partner	Summary
Ohio Grantmakers Forum Health Initiative	Formal plan is in development; five primary goals: engagement in public education campaigns, participate in education events, building relationships that demonstrate the roles funders can play in health care reform, identify ways to collaborate regionally and statewide funding opportunities, support policy changes to improve health care systems. Initiative began with funds from coalition members - now funded by 5 Ohio foundations.
Ohio Children's Foundation O	Focus on early childhood care, Kindergarten readiness, educational achievement, advocacy and access to food. Provides operational, infrastructure, professional, technical support. No funding. Gaps: Early childhood centers are financially strapped because of requirements and credentials needed; competition between early childhood centers over funding.
Ohio Public Health Association O	Working to strengthen our Growing Ohio's Public Health Resources group (GOPHR); hoping to enable public health retirees to assist as grant writers and technical consultants. No funding. Multiple partners involved. Gaps: Funds for staffing to be more intentional / dedicated to work around these topics; community engagement in public health processes.
Osteopathic Heritage Foundation AO	The Foundation supports health issues by increasing the capacity and effectiveness of non-profit organizations. Programs address obesity, access to oral care, community collaboration, and pre and post-doctoral medical education and research. The homelessness funding priority is designed to improve the capacity, coordination and services to prevent and reduce homelessness.
United Way of Central Ohio AO	Provide training and technical assistance to organizations being funded by United Way to assist in evaluation. (TA)
United Way of Greater Toledo AO	\$1.671 million in health related funding. Part of Health Mobilization through United Way Worldwide (working with Robert Wood Johnson Foundation and Prevention Institute). Provide safety-net services and short term income supports for individuals and families in need; priority of healthy births and childhood development. Many partners. Gaps: Access to care, healthy eating,
The Raymond John Wean Foundation O	Main focus of the foundation is community revitalization and education. The Healthy Eating Active Living Convergence Partnership grant (\$200,000 over 2 years) is focused on healthy food access (planning grant).
Ohio Patient Safety Institute	Enables hospitals to pay franchise fee as part of state budget and draw down matching Medicaid fees - give some of this money back to hospitals to provide resources for Medicaid patients. See Injury.
Ohio Commission on Minority Health	No current funds for technical assistance. Program staff used to go to major cities to provide technical assistance for grant funding. See Chronic Disease.
Central Ohio Diabetes Association	See Chronic Disease
Salvation Army - Central Ohio	See Access to Care
Ohio Developmental Disabilities Council	Staff collaborates and attends trainings/conferences with different organizations. See Mental Health.
Ohio Perinatal Quality Collaborative	See Infant Mortality
Paint Valley Alcohol, Drug Addiction and Mental Health Board (Fayette, Highland, Pickaway, Pike, Ross)	See Mental Health
The Rite Bite - Fitness and Nutrition Center	Provides corporate wellness; assists those employers in applying for Bureau of Worker's Compensation grant to decrease expenses for corporate wellness program. See Chronic Disease.
Four County Alcohol, Drug Addiction and Mental Health Board (Defiance, Fulton, Henry, Williams)	See Mental Health
Ohio Sickle Cell and Health Association	See Chronic Disease
Ohio Geographically Referenced Information Program	Building the capacity within local government to develop and maintain good address and transportation data is the key to improving services and ensuring that data collected and locations developed are accurate. See Data Exchange.
Family Violence Prevention Center	Free grant writing, evidence based practices, and strategic planning assistance each month for all agencies. See Injury.
Mothers Against Drunk Driving	See Injury
American Heart Association / American Stroke Association	See WFD
Ohio Department of Developmental Disabilities	See Mental Health
Ohio Provider Resource Association	See WFD
Association of Ohio Health Commissioners	See WFD
YMCA of Central Ohio	See Chronic Disease
Ohio Department of Education-Office for Child Nutrition	See Chronic Disease
Ohio School-Based Health Care Association	Provides technical assistance and advocacy. Works with state Medicaid program to help school based clinic be own provider category to capture all services for appropriate billing. See Chronic Disease.
ODH Child Fatality Review	See Infant Mortality
American Heart Association, Great Rivers Affiliate	See Infant Mortality / Chronic Disease
Ohio Domestic Violence Network	DELTA provides these services in Ohio for intimate partner violence primary prevention. See Injury.



Potential Partner	Summary
Ohio Adolescent Health Partnership	See Chronic Disease
OSU Community Safety Institute, OSU YVPAB and CeaseFire Columbus	See Injury
Galade Research & Project Management	See Injury
OH Suicide Prevention Foundation	Always working on sustainability, grant writing and fund raising. See Injury.
Ohio Department of Alcohol and Drug Addiction Services	See Mental Health
Ohio Commission on Hispanic/Latino Affairs	Assist organizations in finding / writing grants. See Chronic Disease.
Buckeye Healthy School Alliance	Provides technical assistance to educators and coalitions. See Chronic Disease.
Clinical Coordinating Center at MetroHealth Medical Center	See Chronic Disease
ODH Tobacco Use Prevention & Cessation Program	Works on Operational Improvement - currently fund 9 local sub-grants and provide some TA to the grantees during the grant period. See Chronic Disease.
Health Policy Institute of Ohio, Health & Wellness Communications Collaborative	Have draft logic model; point out that many organizations still lack skills and capacity to do effective advocacy and policy change work. Will be seeking additional funding to support the work of their collaborative. See WFD.
BEACON	See Infant Mortality
Asian American Community Services	The topic of capacity building within their organization is not their primary concern because funding is stable at the moment. But discussed need for more administrative assistance for free clinic provided. See Access to Care.
United Way of Greater Cincinnati	
African American Communities for Optimum Health	
Resources:	Ohio Commission on Minority Health Goals and Strategies (CG), United Way of Central OH 2011 Annual Report United Way of Greater Toledo Health Strategy Map, The Osteopathic Heritage Foundations Programs



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