

Get Healthy Idaho: Measuring and Improving Population Health

Idaho Health Improvement Plan

Introduction:

Get Healthy Idaho: Measuring and Improving Population Health is a new initiative of the Department of Health and Welfare, Division of Public Health that consists of two integral parts: a statewide, comprehensive assessment that provides a foundation for understanding the health of Idahoans and communities; followed by a population health improvement plan that focuses public health efforts to address specific priority areas. The intended outcome of *Get Healthy Idaho* is to improve the health of all Idahoans through broader partnerships to deliver the outlined strategies.

Get Healthy Idaho supports the Division of Public Health Strategic Plan central challenge - to advance public health's influence within the changing health system. It supports the identified priority areas of the Strategic Plan to define and promote the role of public health and achieve public health accreditation. This work satisfies Public Health Accreditation Board (PHAB) standards 1.1 (statewide health assessment) and 5.2 (statewide health improvement plan). Additionally, the State Healthcare Innovation Plan (SHIP) Model Test Grant requires the development and implementation of a population health improvement plan. *Get Healthy Idaho* serves dual roles to meet both the requirements of PHAB and the SHIP Model Test Grant. *Get Healthy Idaho* will be reviewed and updated annually from perspectives of both the data and the identified strategies and will transform as the SHIP transforms.

The priorities identified in the *Get Healthy Idaho* population improvement plan, will help shape the focus of public health over the next five years, including priorities outlined in the SHIP and those identified by the *Get Healthy Idaho* assessment conducted during the fall of 2014.

State Healthcare Innovation Plan (SHIP)

SHIP is a national undertaking by the Center for Medicare and Medicaid Innovation (CMMI) to re-design the healthcare delivery and payment system and create new models across states. In Idaho, the goal of the SHIP is to re-design the healthcare system, evolving from a fee-for-service, volume-based system to a value-based system of care that rewards improved health outcomes. The foundational goal is to increase access to and coordinate care among primary care providers; practice patient-centered medical care, and create the broader medical neighborhoods of specialists, hospitals, behavioral health professionals, long-term care providers, public health services and other ancillary medical care and social services. Idaho received a CMMI Model Test Grant to implement the SHIP. This grant is administered by the Department of Health and Welfare, but advised by the Governor-appointed Idaho Healthcare Coalition. Public health is central to these efforts and will lead the seven Regional Health Collaboratives (RHCs) that will be created to locally support provider practices as they transform and address regional population health issues. The Population Health Workgroup, a workgroup of the Idaho Healthcare Coalition, will advise on the model test grant as well as the *Get Healthy Idaho* initiative.

A requirement of CMMI model test grant is the development and implementation of a population health improvement plan focused on the three priority areas of:

1. Diabetes
2. Obesity in Children
3. Tobacco

Get Healthy Idaho: Assessment

The *Get Healthy Idaho* assessment was conducted during the summer and fall of 2014, with an in-person meeting of stakeholders in October, 2014. To conduct the assessment, data were gathered from a variety of resources. Idaho's Leading Health Indicators document, developed by the Division of Public Health, was used as the framework for the core data of the assessment. The Leading Health Indicators document offers a consistent approach to assess the health of Idahoans and provides a way to determine if health status is changing and/or improving over time.

Community level data in the format of local public health and hospital community health needs assessments, other health assessments such as the Maternal and Child Health Five Year Needs Assessment and the Primary Care Needs Assessment were collected and summarized. Issues and outcomes were arranged and grouped to align with the seven local public health district jurisdictions across Idaho. The Public Health Accreditation Board (PHAB) standards also informed the data refining process. PHAB identifies what it considers core public health programs and, as data were assessed, only data that fell within the framework of PHAB were prioritized to move forward for consideration in the health improvement plan.

The top six public health issues in rank order, identified in the *Get Healthy Idaho* assessment were:

1. Healthcare Access
2. Obesity
3. Heart Disease and Stroke
4. Vaccine Preventable Diseases
5. Exercise
6. Suicide

Identification of Population Health Priorities (2015 to 2020)

The Division of Public Health reviewed the outcomes of the population health assessment through the lens of the SHIP Model Test Grant Idaho received and the requirement and the requirement to address diabetes, obesity in children and tobacco use. Division leadership identified four health priorities for the first year of *Get Healthy Idaho* as Access to Care, Diabetes, Tobacco, and Obesity. Rationale for how these priorities were selected is outlined below.

The public health issues of the SHIP and *Get Healthy Idaho* have obvious overlap. **Access to Care** was the number one priority of the assessment and is foundational to the SHIP. Therefore, as healthcare transformation unfolds in Idaho, it makes sense that Access to Care is a first year priority. Even though **Diabetes** was not identified as a priority health issue of the population health assessment, the economic burden and morbidity estimations of diabetes in Idaho also make it a first year priority. **Tobacco Use** is a major behavioral risk factor that impacts heart disease and stroke directly, the third priorities of the population health assessment. By adopting Tobacco Use as a year one priority, we may indirectly impact the priority health issues of heart disease and stroke. The Time Sensitive Emergency (TSE) System of Care was approved and funded by the Idaho Legislature in 2014. TSE will directly impact three of the top five leading causes of death in Idaho: trauma, stroke, and heart attack. The outcomes associated with a comprehensive TSE system of care are improved patient outcomes, reduced frequency of

preventable death, and improved quality of life of the patient. Finally, **Obesity** was identified as a priority issue for both the SHIP and the population health assessment. An obvious connection to obesity is Exercise, the fifth priority health issue of the population assessment. Exercise will be addressed through the strategies developed to address Obesity.

The population health assessment, evaluated contributing risk factors to the identified priority health issues. As expected, several risk factors, high-risk populations and resources/assets overlapped priority areas. Three priority areas (Heart Disease and Stroke, Obesity and Exercise) share many contributing factors including lack of exercise, lack of fruits and vegetables, limited education, access to transportation, access to preventive medicine, depression, cultural influences and genetics. In addition, Heart Disease and Stroke, Obesity and Exercise share similar high-risk populations including people with diabetes, Hispanics, Native Americans, those living in poverty, rural Idahoans, those with limited education and those suffering from depression. In general, resources vary by geographic area but similar resources for Heart Disease and Stroke, Obesity and Exercise include community education, healthcare providers, weight loss programs and nutrition programs.

Vaccine Preventable Disease and Suicide were not identified as year one priorities, however work to address these issues continues in the Division. The 2015 Legislature passed a Concurrent Resolution SCR104 acknowledging the importance and severity of the incidence of suicide in Idaho and directing a review of the resources and opportunities available to address suicide. While Vaccine Preventable Diseases and Suicide lack the same amount of overlap as the other health priority areas, there are still similarities among them, including lack of preventive services, limited access to providers, lack of insurance, low socioeconomic status and those living in rural areas.

Idaho's Challenges and Opportunities

Access

Idaho is the 11th largest state in the nation and 39th in population size with 1,567,582 people based on the 2010 decennial census. The state's per capita income is significantly less than the national average (\$22,581 compared to \$28,051) and the poverty rate is above the national average (15.1% compared to 14.9%).

The Idaho Department of Commerce defines rural as any county that does not have a population center with 20,000 persons or greater, this definition includes 35 of Idaho's 44 counties. Based on 2010 Census data, on average, there are 19 persons per square mile in the state of Idaho, and 18 of Idaho's 44 counties have a frontier classification (less than 6 people per square mile, National Center for Frontier Communities¹).

Using 2013 data from U.S. Department of Health and Human Services, CQ Press ranks Idaho 13th nationally in percent of population lacking access to primary care services at 17.4%, 6.5% greater than the national average (SAGE Publications, Inc., 2013). Idaho also ranks 48th out of 50 states with 70 physicians per 100,000 population according to CQ Press, well under the national rate of 98 physicians per 100,000 population (SAGE Publications, Inc., 2012).

Primary Care: There are 43 Health Professional Shortage Area (HPSA) designations for geographic areas and population groups across the State of Idaho. These designations cover 96.36% of the state's total land area: approximately 60.54% of Idaho's geography is designated as a population group HPSA, while 35.82% is designated as a geographic HPSA in the primary care discipline.

Dental Health: There are 43 HPSA designations for geographic areas and populations across the State of Idaho. These designations cover a total of 97.01% of the state's land area: approximately 78.18% of Idaho's geography is designated as a population group HPSA, while 18.83% is designated as a geographic HPSA in the dental discipline.

Mental Health: There are 7 HPSA designations, which encompass all 44 counties, for geographic areas and populations across the State of Idaho. Due to the severe shortage of mental health professionals across the state, the Idaho Primary Care Office reviews the state's geography on a regional basis. As a geographic HPSA, these mental health designations encompass 100% of Idaho's land area and population.

Diabetes

Effectively managing diabetes will help Idahoans living with diabetes lead more productive and healthier lives. An estimated 100,000 Idaho adults, or 8.4% of the adult population, live with diabetes and an estimated 84,000 Idaho adults, or 7.5% of the adult population, live with pre-diabetes. Diabetes is the seventh leading cause of death in Idaho and about one third of Idaho adults living with diabetes do not know they have the disease. The direct medical cost of diagnosed cases of diabetes in Idaho is estimated as more than \$172 million annually. Improperly managed

¹ <http://www.frontierus.org/2010census.php>

diabetes often leads to costly diabetes related complications and has a tremendous impact on Idaho's Medicaid program as well as other Idaho health insurers. Most diabetes can be prevented or delayed if a range of risk factors is eliminated particularly physical inactivity, unhealthy diets, tobacco use and alcohol misuse. Numerous studies demonstrate that diabetes treatments and therapies improve diabetes control and reduce the incidence of complications due to diabetes. With affordable access to evidence-based, community-based diabetes prevention programs many people with pre-diabetes can prevent or significantly delay the onset of type 2 diabetes. With proper management and treatment, individuals with diabetes can live healthy, productive lives.

Tobacco

Tobacco use is the single most preventable cause of disease, disability and death in the United States, resulting in an estimated 480,000 people dying prematurely from smoking or exposure to secondhand smoke (U.S. Department of Health and Human Services, 2014). Smoking kills more people than alcohol, AIDS, car accidents, illegal drugs, murders, and suicides combined. Comprehensive strategies have been identified and proven effective for preventing youth from starting, helping smokers quit, and reducing secondhand smoke exposure, making the fight against tobacco use a winnable battle. High tobacco taxes, smoke-free or tobacco-free policies, well-funded youth prevention programs and regulation of tobacco products are proven ways to reduce death and disease caused by tobacco use. Tobacco use remains the leading preventable cause of death and disease in Idaho. Idaho's most recent Behavioral Risk Factor Surveillance Survey (BRFSS 2013) indicates the current smoking rate is 17.2%. While this is lower than the national average of 18.1%, the rate has not changed significantly over the last five years. Data from the Centers for Disease Control and Prevention (CDC, 2014) show the Idaho youth smoking rate to be 12.2% with approximately 1,400 youth under 18 becoming new daily smokers each year. The economic burden incurred in Idaho from smoking has reached \$508 million in total medical costs (\$83 million covered by Medicaid) and \$358 million in lost productivity from premature death each year (CDC, 2014). This amount does not include health costs caused by exposure to secondhand smoke, smoking-caused fires, smokeless tobacco use, or cigar and pipe smoking. Tobacco use also imposes additional costs such as workplace productivity losses and damage to property. Despite a continued focus on eliminating tobacco-related health disparities, the prevalence of tobacco use and subsequent health consequences continue to disproportionately impact specific populations. American Indians/Alaskan Natives, Hispanics and Latinos, members of the lesbian, gay, bisexual, transgender (LGBT) community, those of low socio-economic status, those living with mental illness, Medicaid enrollees, and veterans represent Idaho population groups that experience tobacco-related health disparities. The following descriptions provide a summary of population estimates in Idaho, current tobacco use (smoking), rates of initiation, reported exposure to secondhand smoke, tobacco consumption, and cessation for disparate populations.

Obesity

Idaho, like most states, is seeing a steady increase in the percentage of its population that is overweight or obese. Overweight and obesity are both labels for ranges of weight that are excessive for a certain height. Due to the difficulty of measuring body fat directly, overweight and obesity are estimated by body mass index (BMI). Adults with a BMI between 25.0 and 29.9 are considered overweight and those with a measure of 30 and greater are considered obese. Childhood and adolescent BMI measures take sex and age into consideration. Most obesity data is self-reported

through the Behavioral Risk Factor Surveillance Survey (BRFSS). Alarming, the majority of Idahoans are considered overweight or obese (62.5%). The breakout is 35.8% overweight and 26.8% obese. Across Idaho, males are more overweight than females (69.6% compared with 54.9%) and more obese than females (27.3% compared with 26.2%). Overall, Idaho children are less overweight or obese than national rates (27.8% vs. 31.3%), but Hispanic children are significantly more overweight and obese than white, non-Hispanic children (37.3% vs. 26.2%). Idaho schools are not required to collect height and weight data or report BMI. However, during the 2011-2012 school year, the Division's Bureau of Community and Environmental Health conducted the Idaho 3rd Grade BMI Assessment. That assessment found 29.7% of 3rd graders to be overweight or obese. Childhood overweight and obesity rates range from 10 to 50 percent in communities across Idaho. Many of the leading causes of preventable disease and death, including heart disease, stroke, type 2 diabetes and certain types of cancer are obesity related. A 2012 Robert Wood Johnson Foundation Trust for America's Health Report estimated that Idaho spends more than \$2.7 billion in costs due to obesity, which are projected to rise to more than \$3 billion by 2030. The Report also estimates that a five percent decrease in obesity would save Idaho \$1.2 billion by 2020 and \$3.3 billion by 2030.

Prolonged breastfeeding has been shown to decrease the risk of overweight in children (<http://pediatrics.aappublications.org/content/113/2/e81.short>). Breastfeeding longer than six (6) months postpartum provides several health benefits to both the infant and the mother. Typically, during the time period after the birth of the infant up to three (3) months postpartum is when women tend to stop breastfeeding. There are several factors that impact the decision to stop breastfeeding. However, with focused support during this critical period, many women can be encouraged to continue to breastfeed. While Idaho generally has good breastfeeding rates, improving in this area can have multiple and long term benefits for both mothers and children.

Advancing Population Health

Major models of healthcare reform focus primarily on controlling the costs of care and improving patient's outcomes and experience. The population health measures tend to focus on clinical preventive services but do not address "up-stream" or higher-level determinants of health. Clinical services account for a relatively small impact on population health. To improve the health of a broadly defined population, integration of clinical services, public health and community based initiatives is necessary.

Knowing that a balanced portfolio of measures will include both practice- and community-wide measures *Get Healthy Idaho* has adopted John Auerbach's (Associate Director for Policy, Centers for Disease Control and Prevention) method for analyzing the measures of health at the patient level, clinic-community level and community level. Auerbach refers to these levels as buckets and defines these as:

- Bucket #1  – Traditional Clinical Approaches. The focus is on an individual and has a patient construct. It provides for typical clinical services done in a one-on-one patient interaction.
- Bucket #2  – Innovative Clinical Care. The focus is a patient construct with a narrow population view such as a practice or an accountable care organization. It provides linkages that support patients in the community.
- Bucket #3  – Community-wide Health. The focus is on a broad population, such as a Health District or the state of Idaho, and has a community construct. It typically is mostly policy focused.

The following table defines these three levels of services and includes disease and risk factor examples.

Bucket #1: Traditional Clinical Approaches 	Bucket #2: Innovative Clinical Care – Patient Centered 	Bucket #3: Community-wide Health 
Focused on an individual patient construct	Focused on an individual patient construct with a narrow population view	Focused on a broad population; community construct
Typical clinical services done in a one-on-one patient interaction	Linkages that support patients in the community	Broader, mostly policy focused
ASTHMA Example		
Diagnosis, treatment, asthma action plan, medication, clinical guidance	Community Health Worker (CHW) conducts a home visit to assess asthma triggers, post-clinical counseling, conducts limited remediation in the home; focus is on linkages and referrals	Community standards on housing, reducing environmental exposures, air quality regulations, reducing smoking rates, smoking policies
HEART DISEASE Example		
Blood pressure management, aspirin adherence, cholesterol screening, tobacco use screening	Linking CHWs and Community Health Emergency Medical Services (CHEMS) to patients after clinical care; increase the health capacity of the individual	Community prevention to reduce need for treatment with policies like tobacco control, sodium reduction, trans fat elimination
TOBACCO Example		
Screening patients for smoking, ensuring smoking cessation referral, physician/patient counseling	Linkages that support patients in community, linking patient to cessation class or QuitLine/QuitNet	Practices and policies to lower smoking rates statewide

Crosscutting Initiatives

The Division of Public Health makes every effort to integrate and collaborate both within the Division as well as with external partners to maximize positive impacts to population health measures. Idaho's Leading Health Indicators focus our work and assure that we maintain a population health perspective that spans the life course. Large initiatives that are impacting population health outcomes in Idaho in 2015 are briefly described below. Where appropriate, links have been added to access more detailed information on these initiatives. Throughout this action plan you will see these initiatives noted under cross-cutting initiatives. This is a shorthand notation to acknowledge the synergistic impact of multiple initiatives.

- i) State Healthcare Innovation Plan
(SHIP) <http://healthandwelfare.idaho.gov/Medical/StateHealthcareInnovationPlan/tabid/2282/Default.aspx> -- In December 2014, the Idaho Department of Health and Welfare received a state innovation model test grant for \$39,683,813. The grant, from the Center for Medicare and Medicaid Innovation, will fund a four-year model test that began on Feb. 1, 2015, to implement the Idaho State Healthcare Innovation Plan (SHIP). During the grant period, Idaho will demonstrate that the state's entire healthcare system can be transformed through effective care coordination between primary care providers practicing patient-centered care, and the broader medical neighborhoods of specialists, hospitals, behavioral health professionals, long-term care providers, and other ancillary care services. The goal of the SHIP is to redesign Idaho's healthcare system, evolving from a fee-for-service, volume-based system to a value-based system of care that rewards improved health outcomes.
- ii) Chronic Disease Prevention Grant
1305 – State and Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health is commonly referred to as 1305 (per the federal grant number). The primary purpose of this funding is to support statewide implementation of cross-cutting approaches to promote health and prevent and control chronic diseases and their risk factors. It addresses four chronic disease programs: Diabetes; Heart Disease and Stroke Prevention; Nutrition, Physical Activity and Obesity and School Health. Outcomes related to health promotion activities that are addressed include: increased adoption of healthy food service guidelines/nutrition standards; increased adoption of physical education/physical activity in schools; increase adoption of physical activity in early care and education sites and worksites; increased reporting of blood pressure and A1C measures; increased awareness of high blood pressure among patients; increased awareness of pre-diabetes among people at high risk for type 2 diabetes; and increased participation in diabetes self-management education programs. In addition, the following outcomes related to implementation activities that are addressed include: increased consumption of nutritious food and beverages and increased physical activity across the life span; increased breastfeeding initiation, duration, and exclusivity; improved medication adherence for adults with high blood pressure and adults with diabetes; increased self-monitoring of high blood pressure tied to clinical support; increased use of

diabetes self-management and primary prevention programs; improved prevention and control of hypertension; improved prevention and control of diabetes; and improved prevention and control of overweight and obesity.

iii) Collaborative Improvement and Innovation Network (CoIIN) to Reduce Infant Mortality (<http://mchb.hrsa.gov/infantmortality/coiin/>).

CoIIN is a public-private partnership to reduce infant mortality and improve birth outcomes. Participants learn from one another and national experts, share best practices and lessons learned, and track progress toward shared benchmarks. CoIIN builds on the success of multiple public and private investments to improve birth outcomes. The following are common strategies of CoIIN:

- Reduce elective delivery at less than 39 weeks of pregnancy;
- Expand access to inter-conception care (between pregnancies) through Medicaid;
- Promote smoking cessation among pregnant women;
- Promote infant safe sleep practices; and
- Improve perinatal regionalization (a geographically-targeted approach to assure risk-appropriate care for mothers and infants).

In Idaho, the two strategies that were selected to reduce infant mortality are smoking cessation among pregnant women and promoting safe sleep practices for infants.

iv) Meaningful Use

The goals of the Centers for Medicare and Medicaid Services Meaningful Use Electronic Health Record (EHR) Incentives and Certification Program is to leverage certified EHR technology to improve health care quality, safety, efficiency, and reduce health disparities; engage patients and families; improve care coordination, and population and public health; and maintain privacy and security of patient health information. Starting in 2009 with the Meaningful Use Program's inception of Stage 1, Idaho Public Health has partnered with providers and hospitals to help them meet the requirements of public health reporting to receive Medicare incentives. Since the Idaho Medicaid Program's implementation in July 2011, the Division of Public Health has worked with providers and hospitals to receive Medicaid incentive payments by meeting public health reporting requirements. Idaho is currently working with health care providers throughout Idaho to electronically receive laboratory reports for reportable diseases and conditions, immunization registry data, emergency department syndromic surveillance data, and cancer registry data. With Meaningful Use, there is increased opportunity to reduce disparities, control chronic diseases, and build a healthcare system that promotes well-being and is accountable for both individual health and the health of communities.

Population Health Improvement Plan

Health Priority: ACCESS TO CARE

Five Year Goal: Increase Access to Health Care Services

SMART Objective: Initiate three efforts to identify or address barriers facing Idaho’s underserved areas and populations by December of 2016.

Strategy 1: Review and renew health care shortage areas.						
	Measure	Baseline	Target	Who	Cross Cutting initiative	Data Source
	Number of designated areas qualifying as dental, mental, primary care Health Professional Shortage Areas	0 (CY15)	70	Bureau of Rural Health and Primary Care (BRHPC)	SHIP	Provider data
	Number of designated areas qualifying as Medically Underserved Areas.	0 (CY15)	54	BHRPC	SHIP	SHIP Report

Strategy 2: Develop and implement Community Health Emergency Medical Services (CHEMS) programs.						
	Measure	Baseline	Target	Who	Cross Cutting initiative	Data Source
	Number of Idaho EMS agencies recruited to participate in the CHEMS initiative	2(CY15)	3	Bureau of EMS and Preparedness (BEMSP), BRHPC, Idaho State University	SHIP	SHIP Report
	Number of paramedics receiving formal CHEMS trainings	0 (CY15)	12	BEMSP, BRHPC, EMS Physician Commission, CHEMS Taskforce	SHIP	SHIP Report

Strategy 3: Recruit new and existing primary care medical homes (PCMH) to participate in the SHIP.

	Measure	Baseline	Target	Who	Cross Cutting Initiative	Data Source
	Number of primary care clinics recruited to participate in the SHIP PCMH transformation.	13(CY15)	55	Idaho Healthcare Coalition (IHC), BRHPC, Public Health Districts (PHDs), IDHW	SHIP	SHIP Report
	Number of Regional Health Collaboratives established	0(CY15)	7	BRHPC, PHDs, IHC, IDHW	SHIP	SHIP Report (RHC)

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Health Priority: DIABETES

Five Year Goal: Reduce the economic burden of diabetes in Idaho and improve the quality of life for those who have or are at risk for diabetes

SMART Objective: Increase by 10% the availability of educational opportunities for Idahoans to manage modifiable risk factors associated with diabetes or pre-diabetes by July 2016

Strategy 1: Increase the number of CDC-recognized Diabetes Prevention Programs (DPP) and American Diabetes Association (ADA) or American Association of Diabetic Educators (AADE) Diabetes Self-Management Education (DSME) Programs.						
	Measure	Baseline	Target	Who	Cross Cutting initiative	Data Source
	Number of ADA/AADE DSME programs where DSME classes are offered	28 (SFY15)	33	Division of Public Health Diabetes Prevention and Control Program (DPCP) and Heart Disease and Stroke Prevention Program (HDSP)	1305 SHIP	ADA/AADE Registry
	Number of CDC-recognized DPPs.	3 (SFY15)	9	DPCP	1305 SHIP	CDC Registry

Strategy 2: Increase referrals to CDC-recognized Diabetes Prevention Programs and ADA/AADE Diabetes Self-Management Education Programs						
	Measure	Baseline	Target	Who	Cross Cutting initiative	Data Source
	Number of persons with prediabetes or at high risk for type 2 diabetes who enroll in a CDC-recognized DPP	89 (SFY14)	300	DPCP	1305 SHIP	Diabetes Prevention Recognition Program (DPRP) State Level Report, January 201
	Number of people with diabetes who have at least one encounter at an	6534 (SFY13)	8000	DPCP	1305 SHIP	ADA/AADE

	ADA/AADE DSME Program					
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Health Priority: TOBACCO

Five Year Goal: Smoke Free Idaho

SMART Objective: Increase the percentage of Idaho adult smokers that have attempted to quit smoking in the past 12 months from 61.3% to 66.3% by July 2016.

Strategy 1 (evidence based practice): Increase referrals to cessation services						
	Measure	Baseline	Target	Who	Cross Cutting initiative	Data Source
	Number of women 21-64 years of age referred for QL/QN, cessation classes	708 (SFY14)	825	Women's Health Check, PHDs, Primary Care Providers	SHIP, CoIIN	WHCRT
	Number of 18-24 year olds who registered for QL/QN cessation services (1-call, multi-call, online)	852 (SFY15)	895	Project Filter, PHDs	SHIP	IDHW

Strategy 2 (evidence based practice): Promote the use of nicotine replacement therapy (NRT) for appropriate individuals enrolled in cessation services						
	Measure	Baseline	Target	Who	Cross Cutting initiative	Data Source
	Number of 18 – 24 year olds that were shipped 8 weeks of NRT	281 (SFY15)	295	Project Filter	SHIP	IDHW
	Proportion of registrants ordering NRT through the Idaho Quitline	73% (SFY15)	75%	Project Filter	SHIP	IDHW

Health Priority: OBESITY

Five Year Goal: Reduce the burden of obesity in Idaho. (28.6% obese, overweight + obese=62.5%)

SMART Objective: Decrease the percentage of children who are overweight / obese from 27.8 to 26.8 by July 2016.

Strategy: increase healthy options for infants and children through education and collaboration.						
	Measure	Baseline	Target	Who	Cross Cutting initiative	Data Source
	The number of childcare providers who have attended Let's Move trainings.	170	280	IDHW, PHDs, IAEYC	1305	IDHW
	The percent of children on WIC age 2-5 who are obese	7%	6%	WIC, PHDs	SHIP	WISPr
	The percent of children on WIC age 2-5 who are overweight	9%	8%	WIC, PHDs	SHIP	WISPr
	The percentage of women on WIC who initiated breastfeeding at birth.	86% (SFY13)	90%	WIC, Birthing Hospitals and Centers, Primary Care Providers, Regional Breastfeeding Coalitions		WISPr
	The percentage of women on WIC who are still breastfeeding at 3 months.	52% (SFY13)	55%	WIC, Birthing Hospitals and Centers, Primary Care Providers, Regional Breastfeeding Coalitions		WISPr

Acronym Dictionary

1305

ADA / AADE

BRH-PC

CDC

CHEMS

CoIIN

CY

DPP

DSME

DPRP

EMS

IAEYC

IDHW

IHC

ISU

NRT

PCMH

PHD

QL / QN

RHC

SHIP

SFY

WHCRT

WIC

WISPr

DRAFT