2019 *Health Value Dashboard* Frequently Asked Questions (FAQ)

Health Policy Institute of Ohio
Updated April 3, 2019

General questions

1. **What is the *HPIO Health Value Dashboard*?** The Health Policy Institute of Ohio *Health Value Dashboard* is a tool to track Ohio's progress toward health value — a composite measure of Ohio's performance on population health outcomes and healthcare spending. The *Dashboard* examines Ohio's rank and trend performance relative to other states and highlights gaps in outcomes between groups for some of Ohio's most at-risk populations.

   The *Dashboard* is based on the *Pathway to Improved Health Value* conceptual framework. The framework defines health value and outlines the systems and environments that affect health. The *Dashboard* examines Ohio's performance relative to other states on these various systems and environments, including access to care, healthcare system performance, public health and prevention, social and economic environment and the physical environment.

   The 2019 *Health Value Dashboard* is the third edition. HPIO released previous editions in 2014 and 2017.

2. **Why does HPIO produce the *Dashboard*?** We know that improving health and addressing healthcare spending growth are concerns shared by policymakers and others. We also know that many Ohioan's face barriers to being healthy. We believe that collecting publicly available data in one place on health, spending and the drivers of health provides an important starting place for us to understand Ohio's performance relative to other states. The *Dashboard* also highlights nine evidence-based policies that can be deployed at the state and local-level to address Ohio's many health challenges and move the state toward achieving health equity.

3. **How was the *Dashboard* initially developed?** Since 2013, HPIO has convened the **Health Measurement Advisory Group (HMAG)** to advise development and revisions to the *Health Value Dashboard*. HMAG includes Ohio stakeholders from a wide array of sectors and public and private organizations.

   In 2013-2014, HMAG advised HPIO on the development of the *Pathway to Improved Health Value* conceptual framework on which the Dashboard is based. For each edition of the *Dashboard*, members of HMAG have served on workgroups to inform selection and updating of metrics and advising on the layout, methodology and equity components. HPIO's **Equity Advisory Group** also provided feedback on the equity profiles in the *Dashboard*.

   HPIO contracted with researchers at the Voinovich School of Leadership and Public Affairs at Ohio University to assist in data compilation, analysis and ranking for the 2017 and 2019 editions.

4. **How is the 2019 *Dashboard* different from the 2017 Dashboard?**
   - **Maintains consistency** in methodology for ranking and trend
   - **Stronger focus on describing the factors driving gaps in health outcomes** across different groups of Ohioans
   - **Highlights a concise set of nine actionable, evidence-based strategies** that state policymakers can deploy to improve health value
   - **Most metrics (88%) are the same or similar as the 2017 edition.** Of 111 metrics in the 2019 *Dashboard*, 83 were the same, 10 were revised and 18 were new. Metrics were modified, removed or replaced because of changes in data availability or to ensure that more updated or higher quality data was used.

5. **Why is there a focus on healthcare spending instead of "total health" spend?** Total health spend refers to all health-related spending – including social service spending from sectors such as education, transportation and housing that impacts health.

   We focus on healthcare spending because we know that rising healthcare costs are a major concern for policymakers, employers and consumers. We also know that our current spending on health care is just not sustainable. Consequently, the *HPIO Health Value Dashboard* addresses the specific value problem of *unsustainable* healthcare spending.

   There has been a great deal of discussion at the national level on calculating "total health" spend. Some of the issues around the calculation of "total health" spend are outlined below:
   - ***No consensus on a methodology.*** There is not currently consensus from national experts on how to calculate "total heath" spend (e.g. what portion of social service spending should be attributed to total health spend?).
   - ***Chicken and egg.*** The actual impact of social services spending on population health outcomes is not clear. Does increasing social service spending improve population health outcomes or do states with higher social services spending relative to healthcare spending have healthier populations?
   - ***Not always an inverse relationship.*** Increasing social service spending does not necessarily mean that healthcare spending will go down. Healthcare spending is a product of a number of market dynamics that are independent of social services spending.

This article by Elizabeth Bradley and *The Health of the States Summary Report* can provide more context on this discussion.

6. **How is the *Dashboard* different from other scorecards and rankings that are out there?** Unlike other scorecards, HPIO's *Dashboard* places a heavy emphasis on the sustainability of healthcare spending, a critical component of any policy discussion on improving health, but one that often is not included on state rankings. In fact, the *Health Value Dashboard* is the first in the nation to develop a state ranking of "health value," placing equal emphasis on population health outcomes and healthcare spending. The *Dashboard* also provides a more comprehensive look at

other factors that impact population health outcomes and healthcare spending. It addresses the wide range of factors, such as a state's social, economic and physical environment, that contribute to health value.

Ohio's rank on health outcomes is similar across scorecards:

Ohio's rank	America's Health Rankings, 2018 Edition	Commonwealth State Scorecard, 2018 Edition	Gallup-Healthways Wellbeing Index, 2017	HPIO 2019 Health Value Dashboard
Overall	40	36	44	46
Rank for health outcomes*	40	43	43	43

*Rank for specific domains: America's Health Rankings: Health Outcomes; Commonwealth: Healthy Lives; Gallup: Physical; HPIO *Health Value Dashboard*: Population Health

Questions about correlations, metrics and methodology

7. **How are age and poverty correlated with a state's rank on health value, population health and healthcare spending?** The correlation between percent of a state's population age 65 and older and health value rank is relatively weak (r=.29). The correlations between children living in poverty and adults living in poverty are weak as well (r=.3 and r=.33, respectively). This tells us that the population age distribution for over 65 and poverty rates in a state are not driving health value rank.

   States with both poorer and older populations than Ohio (Florida, Arizona and Oregon), or larger and more diverse populations (California, Florida and Texas) have higher health value ranks, performing better on both population health outcomes and healthcare spending.

   There is, however, a stronger correlation between child and adult poverty with the population health domain rank (r=.67 and r=.69, respectively), indicating that poverty is associated with poor population health.

   The correlation between the percent of a state's population aged 65 and older and population health rank, however, is very weak (r=.2), indicating that having an older population does not drive poorer health outcomes overall.

   Child poverty, adult poverty and percent of the population over age 65 were not strongly correlated with healthcare spending rank. This tells us that the population age distribution for over 65 and poverty rates in a state are not driving the healthcare spending rank.

8. **Which domains most strongly correlate with population health rank?** The public health and prevention (r= .69), social and economic environment (r= .66) and physical environment (r=.68) domains have the strongest correlations with population health rank. Healthcare system (r=.5) has a moderate correlation, and access to care (r=.33) has a weak correlation.

9. **How many of the metrics were changed from the 2017 edition to the 2019 edition of the *Dashboard*?** Of 111 metrics in the 2019 *Dashboard*, 83 were the same, 15 were revised and 13 were new. Metrics were modified, removed or replaced because of changes in data availability or to ensure that more updated or higher quality data was used.

10. **How many metrics are in the Dashboard and where does the data come from?**
    - **There are a total of 111 metrics in the 2019 *Dashboard*. Of these, 100 are ranked.** Metrics with more than 10 missing states were not ranked. Some metrics were also not ranked because the data should not be compared across states or desired direction could not be identified.
    - **All *Dashboard* data were compiled from publicly available sources,** including national population health surveys, vital statistics and administrative data from federal agencies.
    - The 2019 Dashboard includes data from 46 different sources

11. **Where can I find information about metrics (e.g. sources, years, descriptions)?** See the Excel appendix posted on the **Health Measurement Advisory Group webpage** for more information about individual metrics.

12. **Where can I find more information about the methodologies/methods used in the *Dashboard*?** See the ***Dashboard* process, methodology and metric information document** for more information on:
    - The metric selection process
    - The ranking methodology for metrics, subdomains, domains and health value
    - Trend calculations
    - Equity profile calculations

Questions about 2019 *Dashboard* findings

13. **Where does Ohio rank?**
    - **Ohio ranks 46** out of 50 states and the District of Columbia (D.C.) on health value, landing in the bottom quartile. This means that Ohioans are less healthy and spend more on health care than people in most other states.
    - **Ohio ranks in the bottom quartile on nearly 30 percent of metrics** and in the top quartile on only 5 percent of metrics, out of 100 ranked metrics in the *Dashboard*.

14. **Did Ohio improve?**
    - Ohio's health value rank is the same, 46, as it was in 2017
    - It's important to remember that our rank is relative to other states, so our performance on the underlying metrics is being measured against the performance of other states
    - Looking at trend over time relative to other states across all metrics in the *Dashboard*, Ohio saw more worsening than improvement. Ohio improved on 13 percent and worsened on 15 percent of metrics. (This is similar to the pattern for the U.S. overall.)

- There was net worsening on metrics in the population health, healthcare spending and access to care domains. Negative trends were most pronounced in the population health domain (38% of metrics worsened).
- There was net improvement on metrics in the healthcare system, social and economic environment and physical environment domains, and no net change in metric performance in the public health and prevention domain.

15. Why does Ohio rank so poorly?

Dashboard analysis—including identification of Ohio's greatest health challenges (see page 8 of the 2019 *Dashboard*), calculation of disparity ratios (see pages 21-25) and correlation analysis (see FAQs below), points to several potential reasons for Ohio's relatively poor performance:

- **Too many Ohioans are left behind. *Without a strong foundation, not all Ohioans have the same opportunity to be healthy*.** For example, Ohioans with disabilities or Ohioans who are racial or ethnic minorities, have lower income or educational attainment, are sexual or gender minorities and/or who live in rural or Appalachian counties, are more likely to face multiple barriers to health.
- **Ohio's resources are out of balance. *Ohio's healthcare spending is mostly on costly downstream care to treat health problems that could have been avoided or better managed*,** as a result of many missed opportunities to prevent illness and disability for thousands of Ohioans.
- **Addiction is holding Ohioans back. *Critical gaps remain in addressing Ohio's addiction crisis***, including a patchwork approach to school and community-based prevention and inadequate provider capacity for medication-assisted treatment, psychosocial treatment and recovery services.

16. How do states rank health value?

2019 Health value rank	**State**
1	Hawaii
2	Utah
3	California
4	Colorado
5	Arizona
6	Nevada
7	Virginia
8	Washington
9	Georgia
10	New Mexico
11	Idaho
12	Oregon
13	Maryland
14	New Jersey

15	Texas
16	Alaska
17	Florida
18	Wyoming
19	North Carolina
20	Nebraska
21	Connecticut
22	South Carolina
23	Kansas
24	New York
25	Massachusetts
26	Minnesota
27	Iowa
28	Illinois
29	New Hampshire
30	Montana
31	South Dakota
32	Wisconsin
33	Vermont
34	Rhode Island
35	Delaware
36	Pennsylvania
37	Michigan
38	Tennessee
39	District of Columbia
40	North Dakota
41	Oklahoma
42	Indiana
43	Maine
44	Alabama
45	Missouri
46	Ohio
47	Arkansas
48	Louisiana
49	Mississippi
50	Kentucky
51	West Virginia

17. **What are the regional differences?** There is a fairly clear regional pattern for healthcare spending rank. All states in the bottom quartile for spending (indicating higher spending) are in the north, while states in the top quartile for spending (indicating lower spending) are clustered in the southwest and southeast.

    States in the bottom quartile for population health are clustered toward the center of the country from Michigan to Louisiana, encompassing portions of the Midwest, Appalachia and the south.

    The pattern for health value rank is somewhat less pronounced, although western states tend to perform best.

18. **Which states had the most improvement and worsening?** Trends are measured by looking at state performance on individual metrics (not by comparing ranks over time). The four states with the most net improvement on specific metrics from baseline to most recent year were: Georgia, Arizona, Louisiana (tied) and Missouri (tied). The four states with the most net worsening on specific metrics from baseline to most recent year were: Maine (tied), Minnesota (tied), Vermont (tied) and Delaware.

Questions about strategies to improve health value

19. **How can we improve health value in Ohio?** To address Ohio's top health challenges identified in the *Dashboard* analysis, the 2019 *Dashboard* highlights three key approaches and nine strategies with strong evidence of effectiveness for state policymakers. Research evidence indicates that all these policies and programs are likely to decrease disparities, and most have demonstrated to be cost effective or cost saving. See page 5 of the 2019 *Dashboard* for a list of the strategies, and see questions below for additional detail.

20. **How did HPIO prioritize the strategies highlighted in the 2019 *Dashboard*?** There are many effective strategies to improve health and control healthcare spending. The nine strategies in the 2019 *Dashboard* are not an exhaustive list**.** HPIO used the following criteria to prioritize an actionable and relevant set strategies to elevate in the 2019 *Dashboard*:
    - **Dashboard analysis.** HPIO drew upon the following analysis: identification of Ohio's greatest health challenges (see page 8 of the 2019 *Dashboard*), calculation of disparity ratios (see pages 21-25), Ohio's rank on different domains and subdomains, and correlations between determinant domains and the ranks for population health, healthcare spending and health value.
    - **Strong evidence of effectiveness.** All of the strategies prioritized here have been recommended by **The Guide to Community Preventive Services (CG)** based on systematic reviews of evidence of effectiveness and/or are included in **What Works for Health (WWFH).** WWFH has rated most of these strategies as "scientifically supported," indicating strong evidence of effectiveness.
    - **Alignment with evidence-based initiatives in Ohio.** All of the strategies are included in the **2017-2019 State Health Improvement Plan** and/or have otherwise

been recommended by Ohio-based, multi-stakeholder groups convened by HPIO over the past two years (e.g., the Social Determinants of Infant Mortality Advisory Group or the Addiction Evidence Project Advisory Group). In addition, HPIO prioritized strategies with current, active support from Ohio stakeholders.

- **Likely to reduce disparities.** HPIO prioritized policies and programs identified by WWFH and/or CG as likely to decrease health disparities or to achieve equity. WWFH assesses a policy or program's likely effect on various groups in reducing health disparities based on the best available research evidence. CG identifies equity strategies based on findings from systematic reviews of effectiveness and economic evidence issued by the Community Preventive Services Task Force.
- **Cost savings or cost effectiveness.** Five of the 9 strategies highlighted in the *Dashboard* are recommended by the **CDC's Health Impact in 5 Years initiative (Hi-5)** which highlights approaches that have evidence of positive health impacts, results within five years and cost effectiveness and/or cost savings over the lifetime of the population or earlier. For benefit-cost information about many of the other strategies listed here, see benefit-cost analyses from the **Washington State Institute for Public Policy**. For the estimated impact of various tobacco prevention and cessation policies on medical care costs, see the **Community Health Advisor**.
- **Actionable for state policymakers.** HPIO's primary audience is state policymakers. All of the strategies included in the *Dashboard* can be acted upon by state-level policymakers; some can also be enacted at the local level. HPIO considered the current political landscape when prioritizing these strategies (i.e., political feasibility, stakeholder support, momentum and relevance to the state budget process).

21. What is the strength of the evidence of effectiveness for the nine strategies highlighted in the 2019 *Dashboard*?

The following table summarizes **The Guide to Community Preventive Services (CG)** recommendations and **What Works for Health (WWFH)** evidence ratings relevant to the nine strategies highlighted in the 2019 *Dashboard*. Alignment with the **HI-5 initiative** is noted as well.

	Community Guide recommendation based on systematic review	**What Works for Health evidence of effectiveness rating**	**HI-5 interventions**
Create opportunities for all Ohio children to thrive			
Early childhood home visiting	Recommended (to prevent child maltreatment)	Scientifically supported*	
Early childhood education (center-	Recommended*	Scientifically supported*	X

based early childhood education, preschool programs, universal pre-k)			
Child care subsidies	Not reviewed	Scientifically supported*	
Lead abatement programs	Not reviewed	Scientifically supported	
Invest upstream in employment, housing and transportation			
Earned income tax credit	Not reviewed	Scientifically supported*	X
Housing trust funds	Not reviewed	Expert opinion*	
Specific services supported by housing trust funds:			
Housing rehabilitation loan and grant programs	Not reviewed	Scientifically supported*	X
Housing First	Not reviewed	Scientifically supported*	
Rapid re-housing programs	Not reviewed	Some evidence*	
Public transportation systems	Not reviewed	Scientifically supported*	X
Build and sustain a high-quality addiction prevention, treatment and recovery system			
Tobacco cessation- Reducing out-of-pocket costs for evidence-based cessation treatments	Recommended	Scientifically supported*	
Tobacco cessation- Quitline	Recommended	Scientifically supported	

and mobile-phone-based interventions			
Tobacco-related mass-reach health communication interventions and health communication and social marketing campaigns	Recommended	Scientifically supported	X (strategy included in Tobacco Control Interventions)
Interventions to increase the unit price for tobacco products (including tobacco taxes)	Recommended	Scientifically supported*	X (strategy included in Tobacco Control Interventions)
Community mobilization with additional interventions to restrict minors' access to tobacco products	Recommended	Not reviewed	
Minimum tobacco age laws (tobacco 21)	Not reviewed	Expert opinion	
Tobacco marketing restrictions	Not reviewed	Some evidence	
Universal school-based alcohol prevention programs	Not reviewed	Some evidence	
School-based social and emotional instruction	Not reviewed	Scientifically supported	
School-wide Positive Behavioral Interventions and Supports (Tier 1)	Not reviewed	Scientifically supported*	
Mental health benefits legislation (parity)	Recommended	Scientifically supported*	
Higher education financial incentives for health	Not reviewed	Some evidence*	

professionals serving underserved areas			
Behavioral health primary care integration	Not reviewed	Scientifically supported*	

*Equity approach (CG) or Likely to decrease disparities (WWFH)

Note: What Works for Health rates each program and policy on a five-point scale, from "evidence of ineffectiveness" to "scientifically supported."