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Good afternoon Chairwoman Jones, Vice Chairwoman Lehner, Ranking Member Tavares, and Members of the Committee. My name is Amy Rohling McGee and I am the President of the Health Policy Institute of Ohio (HPIO). The mission of HPIO is to provide the independent, unbiased and nonpartisan information needed to create sound health policy.

Thank you for the opportunity to share the recently released *Health Value Dashboard*. I am joined by my colleagues, Reem Aly and Amy Bush Stevens, who led the extensive process to plan, create and launch the *Dashboard*.

HPIO worked with many stakeholders to create *Dashboard* for several reasons:

- We know that advancing the health of Ohioans is a goal that many share. We also know that the amount we spend on health care is a concern for policymakers, businesses and consumers.

- There are multiple efforts underway to improve health and bend the curve in terms of healthcare spending. However, there has not been consensus on what success will look like. Put another way, if collectively we are successful in improving health and reducing cost growth, how will we know? What metrics should we all be paying attention to in order to know whether we're moving in the right direction? To take that to another level, what metrics if paid attention to, can move us in the right direction?

- We developed the *Dashboard* so that policymakers have a tool for setting state health policy priorities and tracking progress. We were mindful to align the *Dashboard* with other efforts that are going on in the state, such as the State Health Improvement Plan and the State Innovation Model (SIM) plan. Our intention is to update the data in the *Dashboard* every two years, so that as a new biennium starts, policymakers can take stock in what has changed since the last iteration of the *Dashboard*.

We define health value as the intersection of improved population health and sustainable health care costs. Research tells us that our health is influenced by a number of factors with 20% attributed to clinical care (meaning both access to care and quality of care), 30% to behaviors, 40% to social and economic factors and 10% to physical environment.

While attention is often paid to clinical access and quality, we know that these are necessary but not sufficient to achieving positive health outcomes. For this reason, we included domains related to social, economic and physical environments, which combined are the largest contributors to our overall health outcomes. This is the conceptual framework from which we built the *Dashboard*.

On page 15 of the *Dashboard* you can see that while there are many other scorecards and dashboards in existence, 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 costs.

The dashboard provides data in context to guide decision making by comparing Ohio's performance to other states, tracking change over time. It also includes information on best state performance as well as disparities or "gaps" in performance across Ohio's subpopulations.

Analysis of the 106 metrics included in the Health Value Dashboard is sobering: Ohio ranks 47th on health value. This tells us that we are not getting good value for our healthcare dollar. We rank 40th in terms of population health outcomes, where we looked at metrics such as overall health status, adult smoking and adult diabetes.

We rank 40th in terms of healthcare costs, including metrics such as healthcare spending per capita, average premium per enrolled employee and Medicare spending growth per enrollee. The bottom line is that while we spend a lot on health care, we are not seeing this spending translate into good population health outcomes for Ohioans.

The *Dashboard* identifies Hawaii, Utah, Colorado and Idaho as high value states, which rank in the top quartile for both population health outcomes and healthcare costs. On the opposite end of the spectrum, the *Dashboard* identifies the lowest value states, ranking in the bottom quartile on both population health and healthcare costs. Ohio is joined by Indiana and West Virginia as low value states, with poor population health outcomes and high healthcare costs.

When you look at the *Dashboard's* overall health value ranking map, many states fare better than Ohio because they either have better population health outcomes or spend less on health care. Ohio does poorly in both areas – bringing our overall health value rank down.

It's important to note that age, income and poverty are factors impacting health, but a younger population or higher income alone does not guarantee good health or good health value. The University of Cincinnati's Economics Center conducted a correlation analysis of the *Dashboard* data to determine the strength of the relationship between health value and age distribution and poverty. This tells us that states that are older or poorer are

slightly more likely to have a low health value rank, but the strength of this relationship is relatively weak.

Some high-value states, such as Iowa and Hawaii, have older populations than Ohio, or higher poverty rates than Ohio, such as California. This indicates that it is possible to have a high health value rank with an older or poorer population.

One may ask why Ohio ranks 47th on this composite measure of health value? The answer is not simple. On page 4 you will note that there are many factors that impact Ohio's population health outcomes and healthcare costs, and Ohio performs poorly in many of these areas. Ohio's healthcare system faces significant challenges and ranks 39th in the nation. At the same time, we are last in the nation, ranked 51st, on public health and prevention, which includes metrics on health promotion and prevention, communicable disease control, and environmental health.

In addition, Ohio struggles when it comes to its physical, social and economic environments, which have a significant impact on our overall health. We rank 34th on our physical environment which includes metrics on Ohio's housing, built environment, and access to physical activity, as well as food access and food insecurity. We rank 29th on our social and economic environment, which includes metrics on employment, poverty, education and income inequality.

Page 5 of the *Dashboard* highlights Ohio's strengths and challenges. Our strengths include the percent of workers employed at a company that offers health insurance and the availability of affordable housing. Ohio's greatest health challenges include infant mortality, tobacco use, access to treatment for illicit drug use, diabetes and food insecurity.

Notably, the General Assembly focused intently on infant mortality and drug use in recent years. HPIO plans to catalog policy changes in these high-priority areas and track whether and how outcomes are impacted over time.

On page six of the *Dashboard*, we provide a snapshot of disparities for Ohio's greatest health challenges. We wanted to highlight the importance of addressing disparities or gaps in health outcomes across Ohio's subpopulations. Here we identified the population health outcomes for which we perform the worst and displayed these outcomes by either race or ethnicity, income level or by county.

The *Dashboard* provides a jumping-off point for identifying health and cost issues that warrant further attention from policymakers in Ohio. Tobacco use, for example, is a topic that has been getting increased attention in our state. The *Dashboard* finds that Ohio ranks toward the bottom of all states for adult smoking and the percent of children exposed to secondhand smoke. By contrast, all of the states in the top quartile for health value have lower adult smoking rates than Ohio. As we move forward with this work, we will explore the types of policies in place in higher-value states and strategies that Ohio could adopt that would help us to improve our performance on these high-priority health problems.

It is important to note that the majority of our healthcare spending is on clinical care received within the healthcare system and that far fewer of our healthcare dollars are spent

on public health and prevention. Returning to the smoking example, we spend far more on treating the consequences of tobacco use than we do on tobacco prevention or cessation.

While the amount we're spending is a concern, **how** we're investing those dollars is more disconcerting. If we could invest existing dollars more wisely to address factors outside of the healthcare system that are impacting our health, it is likely that Ohio would have better health outcomes.

Addressing costs is necessary for sustainability, but making sure that we're investing in a balanced portfolio of strategies both inside and outside the healthcare system is critical to achieving better health value for Ohioans.

We developed the dashboard so that it is (1) concise, (2) visual and at-a- glance, (3) includes the most important indicators, (4) and provides data to help guide decision making. We have provided you with a hard copy of the *Dashboard* today, but please know that there are additional tools related to the *Dashboard* on our Website (http://www.healthpolicyohio.org/2014-health-value-dashboard/).

In closing, the *Dashboard* provides data to guide priorities and track progress over time. HPIO plans to conduct further analysis on evidence-based policy strategies that can be used to move Ohio toward greater health value.

We will also be looking at how the many policies and initiatives already in place in Ohio align with the systems and environments that affect health, and where we may have gaps in accountability for specific outcomes. We look forward to working with you as we study these opportunities.

Thank you to Chairwoman Jones for the opportunity to share the Health Value *Dashboard* with the committee. We are happy to respond to questions.