



HEALTH VALUE DASHBOARD

# ADVISORY GROUP

February 26, 2025



# VISION

Ohio is a model of health, well-being and economic vitality

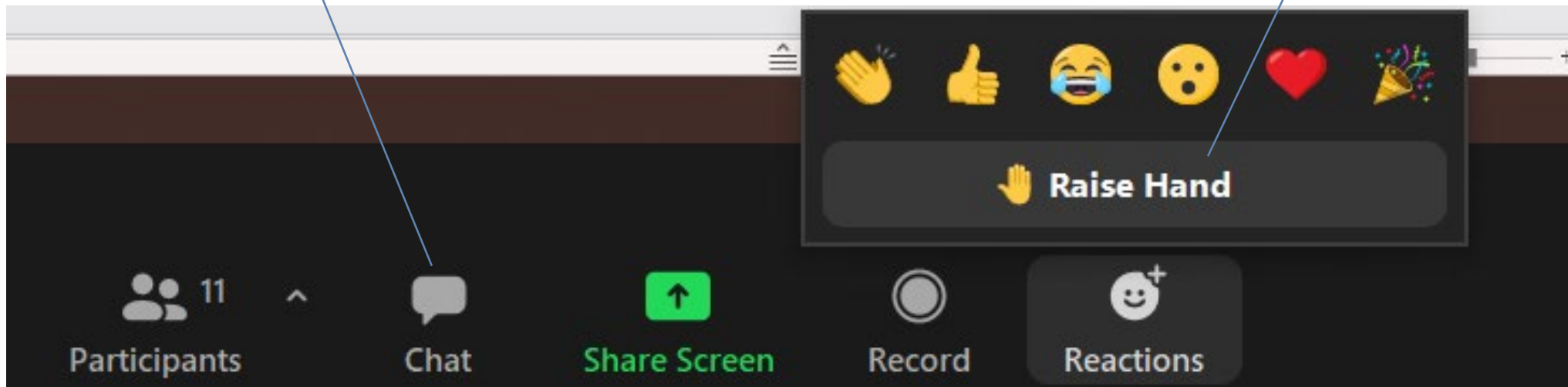
# MISSION

To advance evidence-informed policies that improve health, achieve equity, and lead to sustainable healthcare spending in Ohio.

# Participating in Zoom

Chat  
(found in bottom toolbar)

Raise hand  
(found inside reactions button)



# Health Value Dashboard Advisory Group

## Advisory Groups

Overview

Adverse Childhood Experiences (ACES) Advisory Group

Criminal Justice and Health Advisory Group

Equity Advisory Group

**Health Value Dashboard Advisory Group**

As HPIO begins developing the next edition of the Health Value Dashboard™, we asked experts from throughout the state to join HPIO's Health Value Dashboard Advisory Group. The Dashboard Advisory Group will provide input on development of the 6th edition of the Health Value Dashboard, which will be released in 2024.

The *Health Value Dashboard* is a tool to track Ohio's progress towards health value — a composite measure of Ohio's performance on population health outcomes and healthcare spending. The *Dashboard* examines Ohio's performance relative to other states, tracks change over time and examines Ohio's greatest health disparities and inequities.

[VIEW ADVISORY GROUP MEMBERS](#)

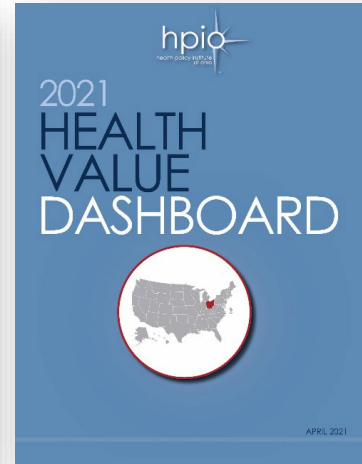
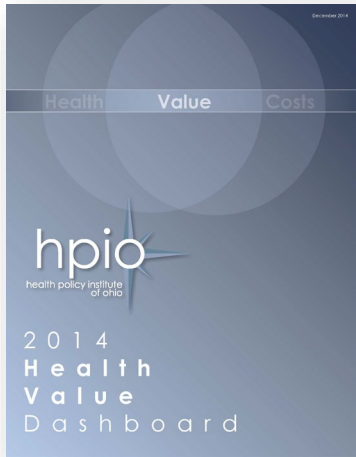
# Agenda

- Welcome and overview
- Timeline of upcoming work
- Analysis discussion
- Small group work
- Next steps

# Objectives

## **As a result of this meeting, Advisory Group members will:**

- Be aware of the process for developing the *2026 Health Value Dashboard*, including the role of the Dashboard Advisory Group
- Understand and provide feedback on potential updates to *Dashboard* methodology



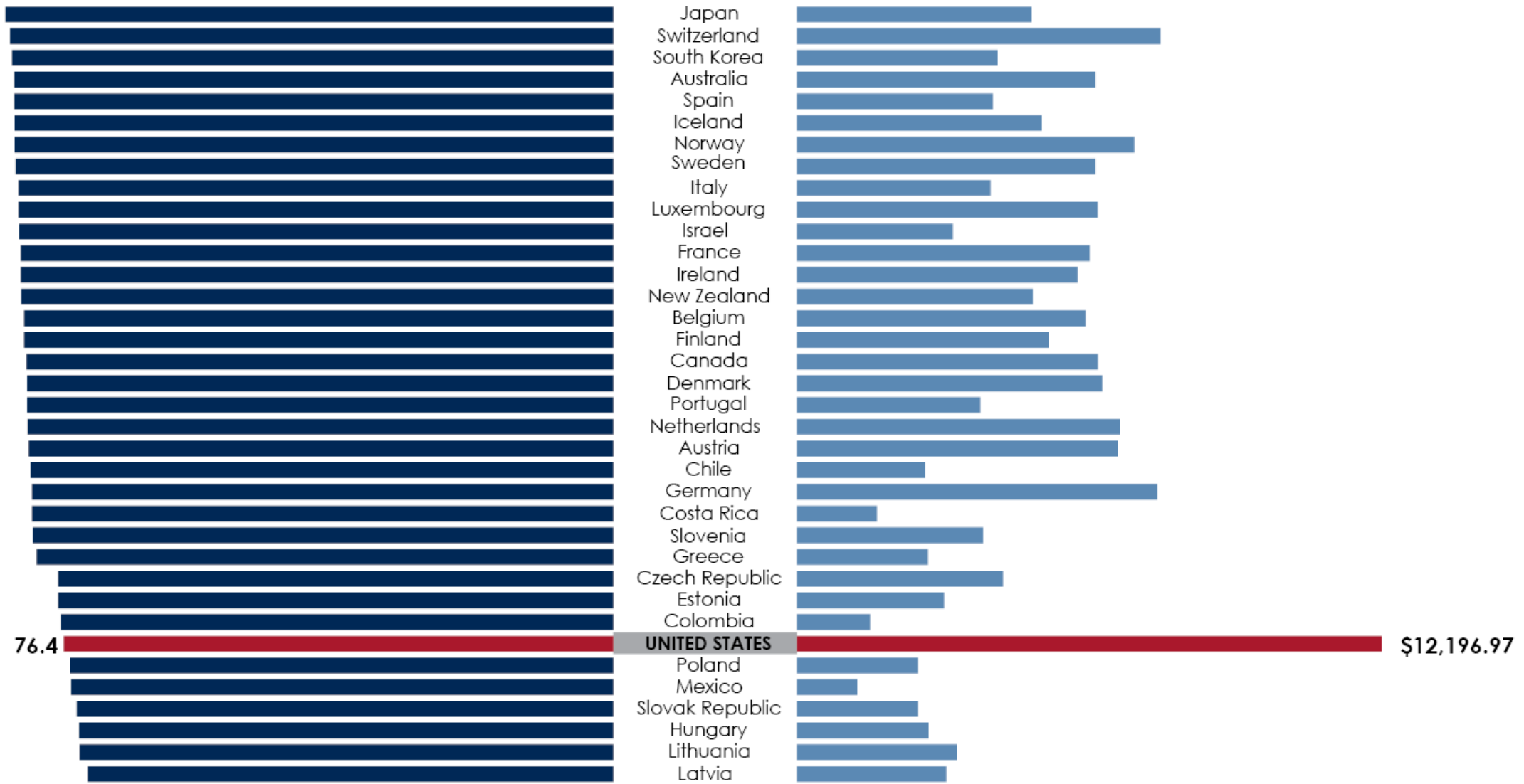
2014



2025

## Life expectancy at birth (2021)

## Total healthcare spending per capita (2021)



**Note:** Graphic only include OECD member countries and 2021 data is not available for all member countries

**Source:** The Organisation of Economic Co-operation and Development (OECD)



# 2013 beta



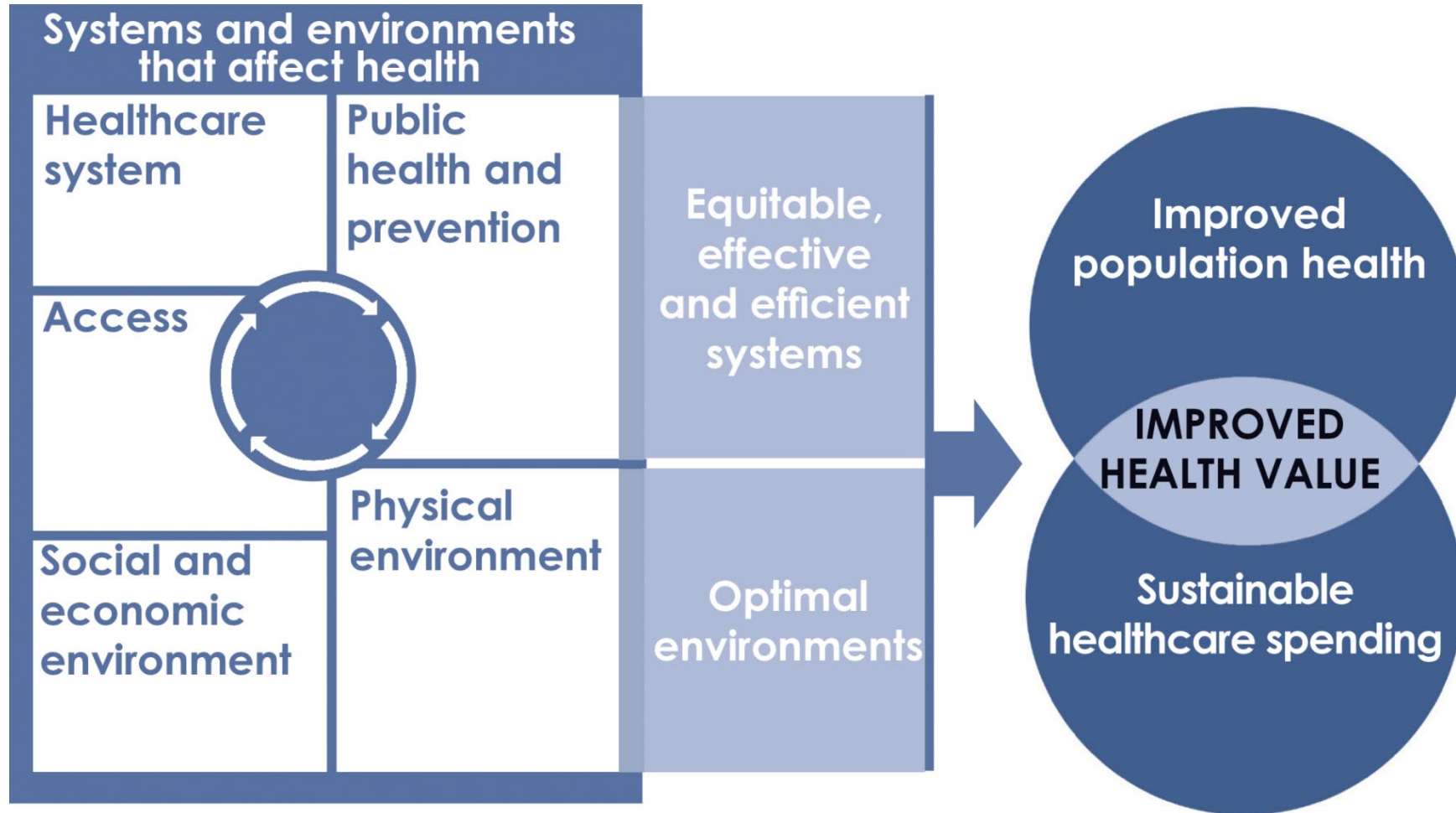
## Health in Ohio: How we rank

Indicator	Rank 2012	Rank		Progress
		2007	2012	
<b>Overall health outcomes rank</b>	<b>37</b>	<b>41</b>	<b>37</b>	
		Data value <sup>1</sup>		
		2007	2012	
Mortality amenable to health care	37	115.6 per 100,000	105.6 per 100,000	+
Infant mortality	42 <sup>2</sup>	7.7 per 1,000	7.9 per 1,000	=
Poor mental health days	34	4 per 30 days	4.1 per 30 days	=
Poor physical health days	32	3.7 per 30 days	4.1 per 30 days	-
Limited activity due to physical, mental, or emotional problems	41	15%	20%	-
Cardiac heart disease	41	6%	5%	+
Diabetes	30	7%	10%	-
Obesity	38	28%	30%	-
Smoking	43	22%	25%	-
<b>Health care costs</b>				
Health spending per capita	33	\$6,558	\$7,076	-
Average expenses for day of hospital care	37	\$1,833	\$2,138	-
Average annual percent growth in health spending	5	5.8% from 1991-2009		NA

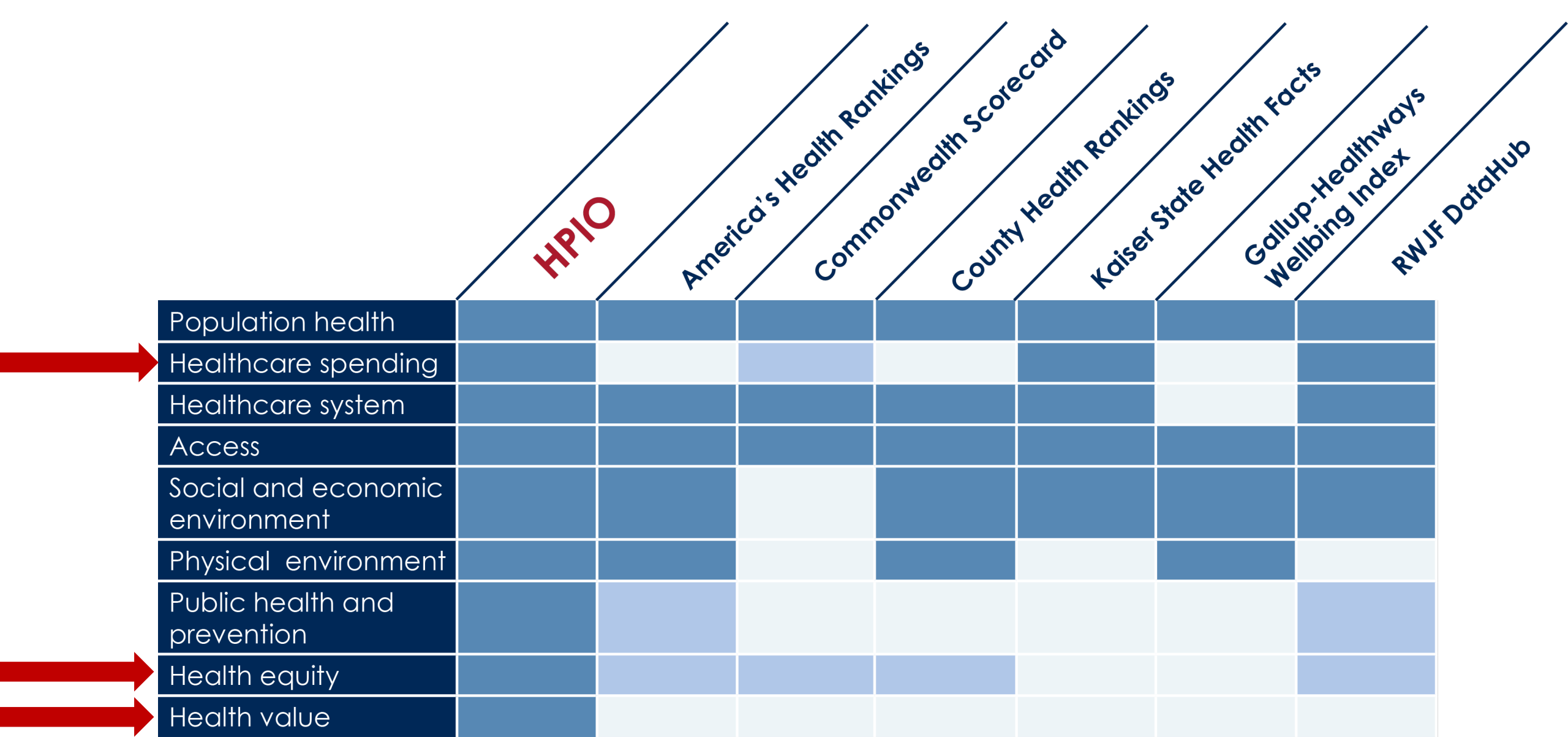
Key

Rank	Best	Middle	Worst
	<b>Upper Third.</b> Ohio ranks in the upper third of the 50 states and the District of Columbia.	<b>Middle Third.</b> Ohio ranks in the middle third of the 50 states and the District of Columbia.	<b>Lower Third.</b> Ohio ranks in the lower third of the 50 states and the District of Columbia.
Progress	<b>+</b> <b>Health Improving.</b> Percent change improved more than 3% since 2007. <b>=</b> <b>Health No change.</b> Percent change less than or equal to 3% in either direction. <b>-</b> <b>Health Getting Worse.</b> Percent change worsened more than 3% since 2007.	<b>+</b> <b>Costs Declining.</b> Percent change declined more than 3% since 2007. <b>=</b> <b>Costs No change.</b> Percent change less than or equal to 3% in either direction. <b>-</b> <b>Costs Increasing.</b> Percent change increased more than 3% since 2007.	

# Pathway to improved health value



**World Health Organization definition of health:** Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

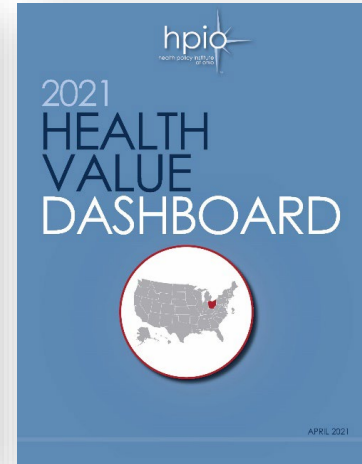
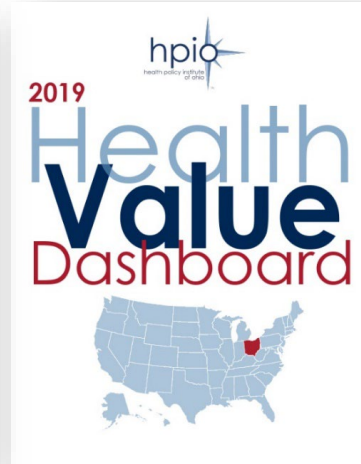
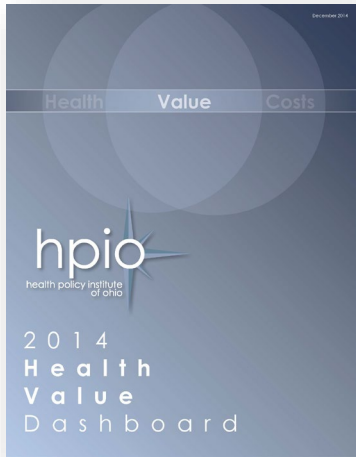


= adequately covered
  = minimally covered
  = not covered

# What is the health value rank?

Population health rank + Healthcare spending rank

= Health value rank



2014



2024

Data in context

Data to answer questions

Data for action



Informed  
policy  
decisions

# Data in context

Rankings



Progress and trends

Moderately improved

Gaps in outcomes

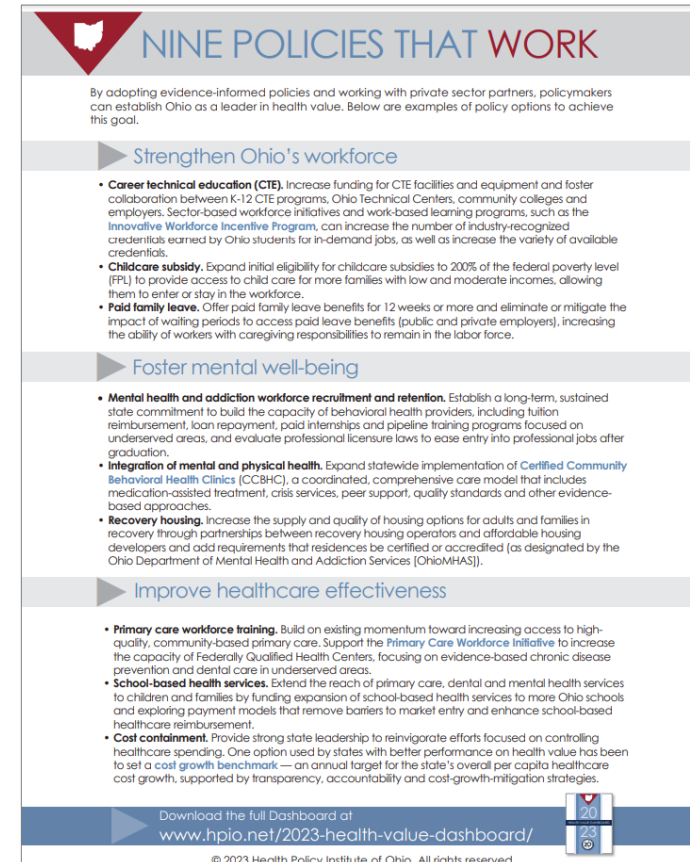
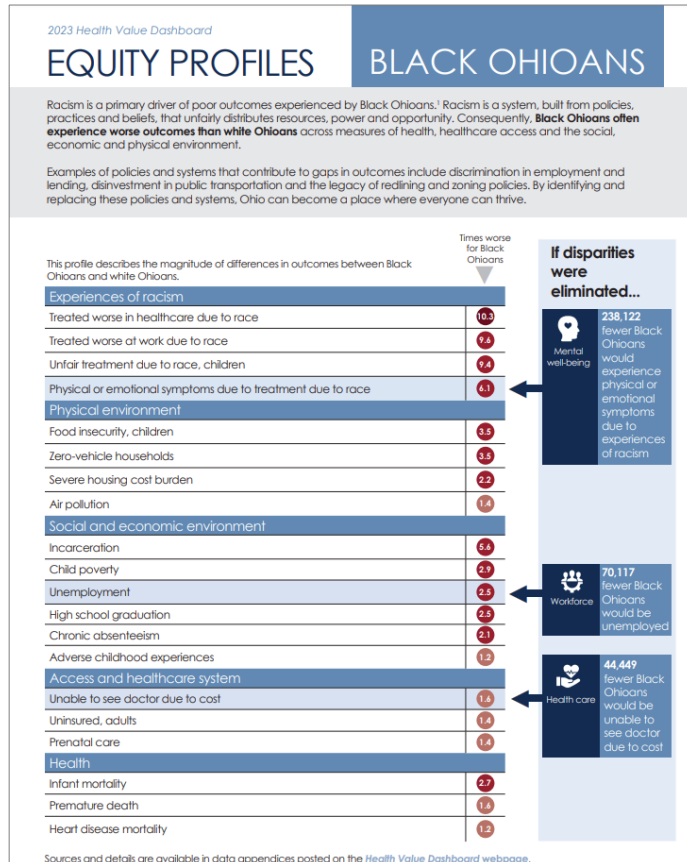
Times worse  
for Black  
Ohioans



# Data to answer questions

## What drives disparities and inequities?

## How can we improve?





# Informed policy decisions



Data in  
context



Concise key  
findings



Highlight  
what works

# Health Value Dashboard timeline

## And the Ohio operating budget process



# 2025-2026 Timeline

## 2025

- January – April: AG and workgroup meetings
- May – August: Trend data compilation; metric research
- August – December: Data compilation and analysis

## 2026

- January – May: Layout and review
- May: Dashboard release

2026 DASHBOARD  
METHODOLOGY  
**LARGE GROUP DISCUSSION**

# HEALTH VALUE

# What is the health value rank?

Population health rank + Healthcare spending rank

= Health value rank

# Ohio's health value rank



2014



2017



2019



2021



2023



2024

Top quartile

Second quartile

Third quartile

Bottom quartile

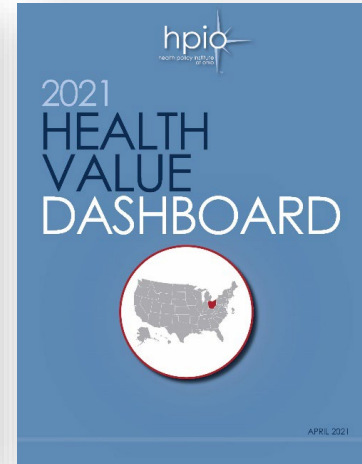
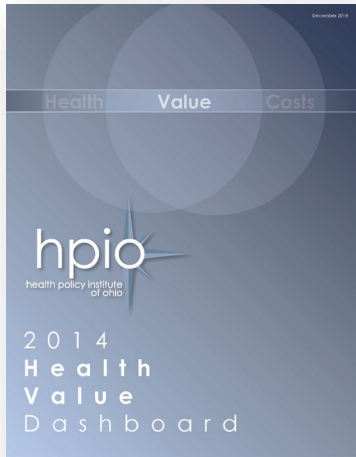
Of the 50 states and D.C.

# Discussion questions

- What is useful about the Health Value ranking or the concept of “health value”?
- What is challenging about the Health Value ranking or the concept of “health value”?



# TEN-YEAR TREND AND CORRELATION ANALYSIS



2014

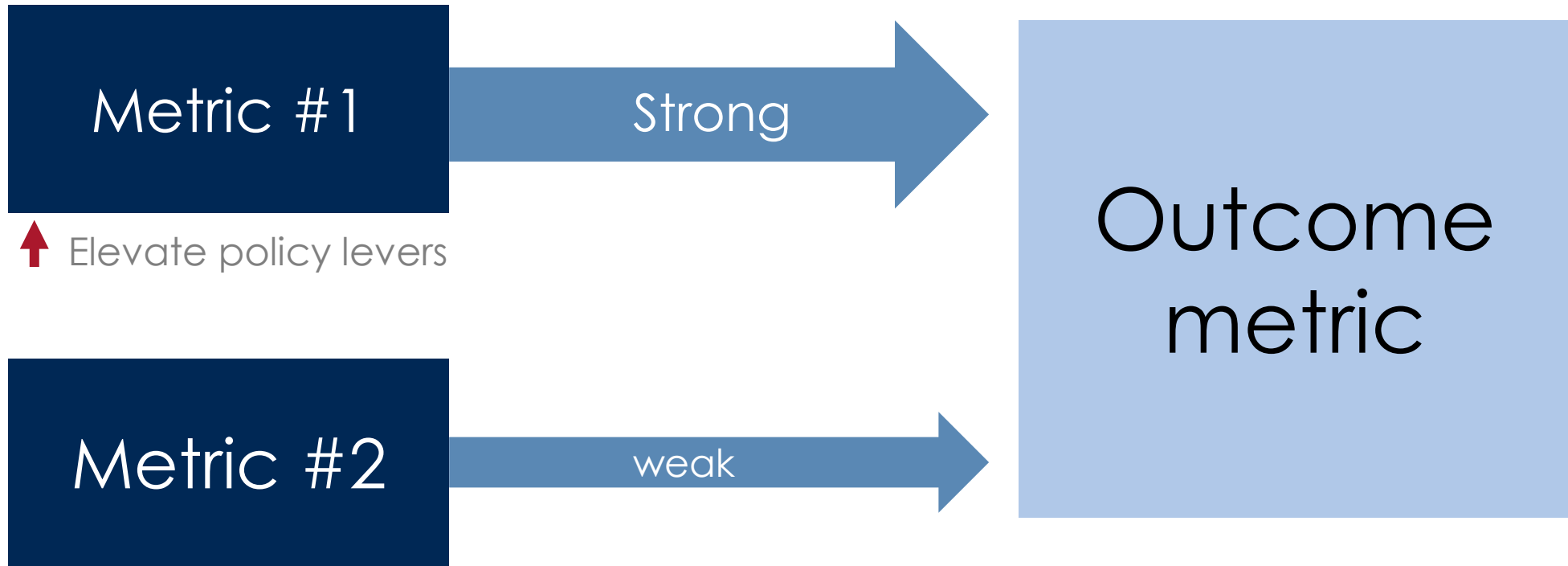


2024

# Ten-year trend and correlation analysis

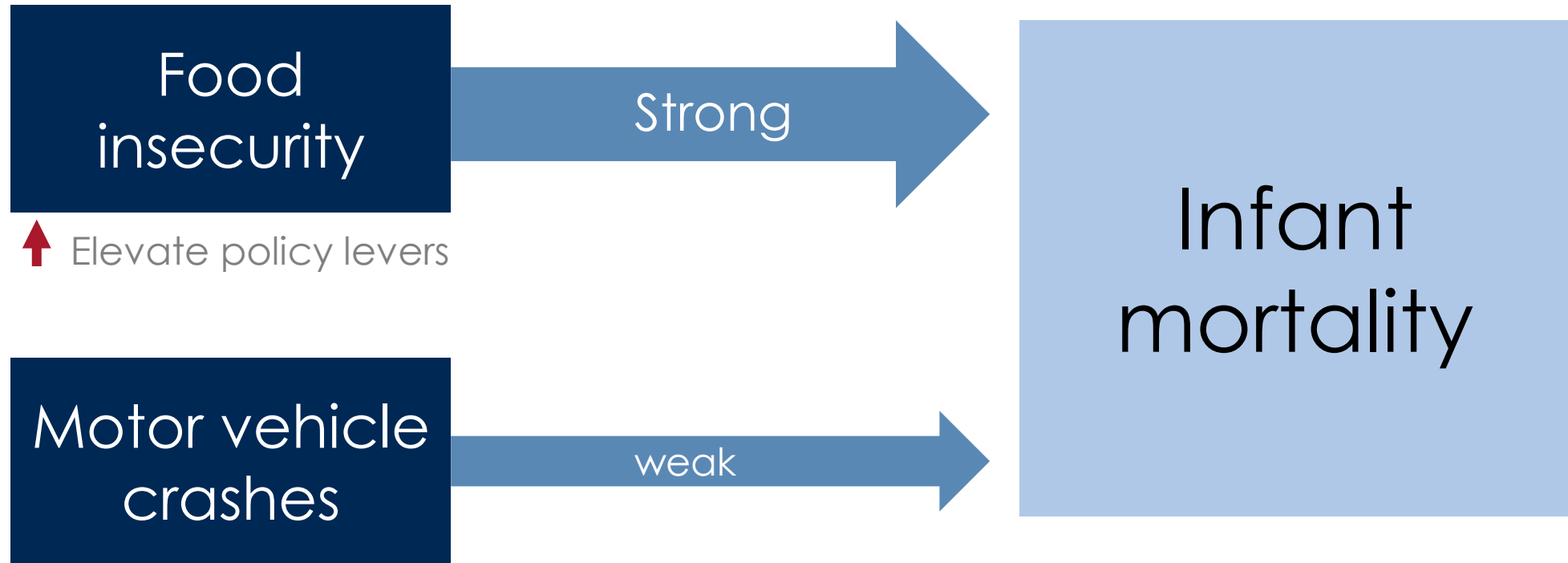
- Collect up to ten years of data for all metrics for which it is available
- Calculate long-term trend
- Observe states that have improved, look for policy levers

# Correlation analysis



# Correlation analysis

Example of a possible outcome:



# Correlation analysis

Potential outcome metrics:

- **Life expectancy at birth**, National Center for Health Statistics
- **Infant mortality**, National Center for Health Statistics
- **Out-of-pocketing spending**, Current Population Survey Annual Social and Economic Supplement public use micro data files by the State Health Access Data Assistance Center as compiled by State Health Compare
- **Total employer-sponsored health insurance spending**, per enrollee, Health Care Cost Institute, Health Care Cost and Utilization Report
- **Total Medicare spending, per beneficiary**, The Dartmouth Institute for Health Policy and Clinical Practice, Dartmouth Atlas of Health Care

# Correlation analysis

## Pros:

- ✓ No one in Ohio has done anything like this correlation analysis
- ✓ No one in Ohio has done this much trended data

## Cons:

- May or may not be possible, based on data availability



OHIO  
UNIVERSITY

**Voinovich School of  
Leadership and Public Affairs**



# Discussion questions

- What questions of clarity do you have about the correlation analysis?
- What do you think will be useful about the long-term trend and correlation analyses? What are the challenges?
- What are your reactions to the proposed outcome measures for the correlation analysis? Any suggested revisions?

2026 DASHBOARD  
METHODOLOGY  
**SMALL GROUP DISCUSSION**

# Ranked vs unranked measures

- Use outcome of correlation analysis to select which measures contribute to overall domain ranking
- Could reduce collinearity, but still allow us to display all the metrics

# National benchmarks

- Many of our metrics have national Healthy People 2030 benchmarks
- Would like to find a way to highlight these

# Ohio-only data

- Pulling Ohio-only data out of the domains (since they can't be ranked) and having a section with state-level data
- County type analysis or maps
- Elevate administrative/state agency data

# Discussion questions

- What are your thoughts on having ranked vs. unranked metrics?  
i.e., metrics that contribute to the overall ranking of the domain?
- What are your thoughts on the usefulness of Ohio-only data? Benchmarks?

BREAK INTO SMALL GROUPS

# Metric considerations and criteria

- 1. State-level:** Statewide data are available for Ohio and other states. State data is consistent across states (allowing for state rankings, if appropriate).
- 2. Sub-state geography:** Data are available at the regional, county, city, or other geographic level within Ohio.
- 3. Ability to track disparities:** Data are available for sub-categories such as race/ethnicity, income level, age, or gender.
- 4. Availability and consistency:** There is a high probability that data for this metric will continue to be gathered in the future and will be provided in a relatively consistent format across time periods.
- 5. Timeliness:** Data for this metric is released on a regular basis (at least yearly or every other year).
- 6. Source integrity:** The metric is nationally recognized as a valid and reliable indicator and the data are provided by a reputable national organization or state or federal agency.



# Metric considerations and criteria

(cont.)

- 7. Data quality:** The data are complete and accurate. The data collection method is the best available for the construct being measured (e.g., biometric, self-report, administrative).
- 8. Alignment:** Aligns with an existing requirement, performance measure, program evaluation indicator, or other measures currently being compiled by a state or federal agency (e.g., ODH, OHT, ODE, CMS, HHS, AHRQ), national organization (e.g. Catalyst for Payment Reform), or regional project (e.g., Health Collaborative, AccessHealth Columbus, Better Health Greater Cleveland). Does not add data collection burden to stakeholders.
- 9. Benchmarks:** Benchmark values have been established for the metric by a reputable state or national organization or agency (e.g., Healthy People 2020).
- 10. Face value:** The metric is easily understood by the public and policymakers.
- 11. Relevance:** The metric addresses an important health-related issue that affects a significant number of Ohioans.

# Discussion questions

- Do these considerations and criteria capture the goals for the content and quality of data we want to include in the Dashboard?
- Anything you would add or remove?

# NEXT STEPS

# Domain workgroups

- **Access to Care** — March 20 (10-11:30)
- **Healthcare System** — March 27 ( 10-11:30)
- **Public Health and Prevention** — April 3 ( 11-12:30)
- **Healthcare Spending** — April 10 (10-11:30)
- **Population Health** — April 17 (10-11:30)
- **Social and Economic Environment** — April 24 (10-11:30)
- **Physical Environment** — May 1 (11-12:30)

# Equity Advisory Group

- **Tuesday March 25th from 1-2:30 PM**
- Please let us know in the chat if you would like to join us, and we will send you the link
- This will be another data-heavy methodology conversation



# Contact

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THANK YOU