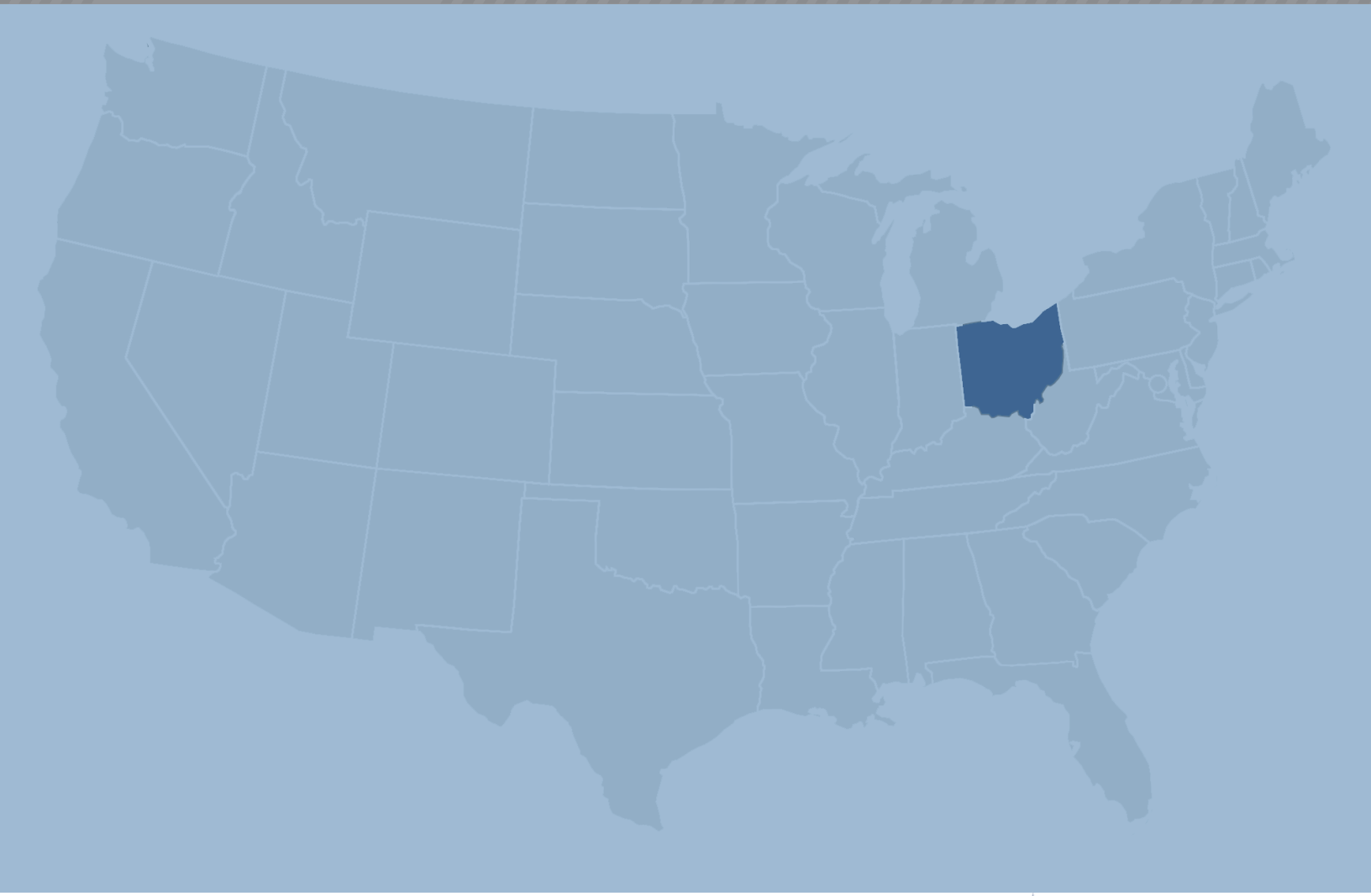
APRIL 2024

HEALTH VALUE DASHBOARD™

2024



health policy institute of ohio™

Inside

What is the *Health Value Dashboard*?

The Health Policy Institute of Ohio's *Health Value Dashboard*™ is a data-rich 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* relies upon the most-recent publicly available data from 69 distinct sources to provide a picture of Ohio's performance compared to other states .

In most cases (84% of metrics), the most-recent data presented in the domain profiles is from 2020 or later, meaning that it captured the pandemic or post-pandemic time period.

For more information

Visit the **2024 Health Value Dashboard web page** to access the following materials that provide additional detail about the *Dashboard* methodology and data:

- Process and methodology
- Frequently Asked Questions (FAQ)
- Ranked metric appendix with descriptions, years, sources and Ohio data
- Equity profile metric appendix with descriptions, years, sources and Ohio data

SNAPSHOT

Where does Ohio rank, and what can we do about it?
Ohio ranks 44th on health value (a combination of population health and healthcare spending metrics) out of 50 states and D.C. This means that Ohioans live less healthy lives and spend more on health care than people in most other states. This snapshot describes four policy priorities to improve health value, based on 2024 *Dashboard* findings.

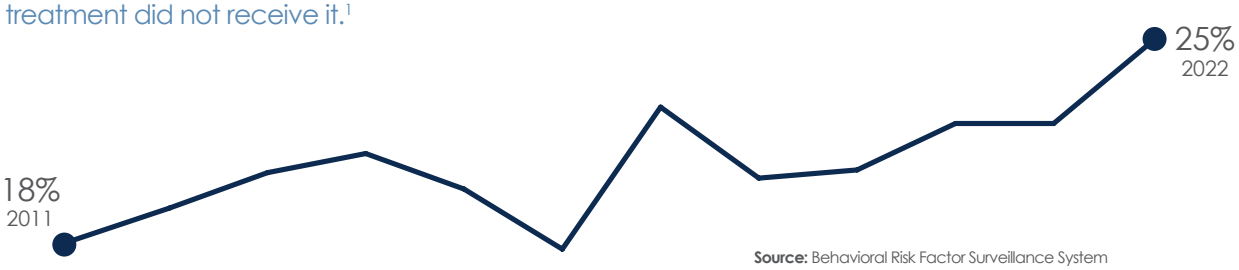
Policy priorities to improve health value

Mental well-being

Data shows that mental health challenges are common among Ohioans of all ages.

Ohio rank 41 Adult depression

The rate of depression increased from 2011 to 2022, with a quarter of Ohio adults now reporting this condition. Additionally, in 2018 and 2019, one in every four Ohio adults who needed mental health treatment did not receive it.[1]

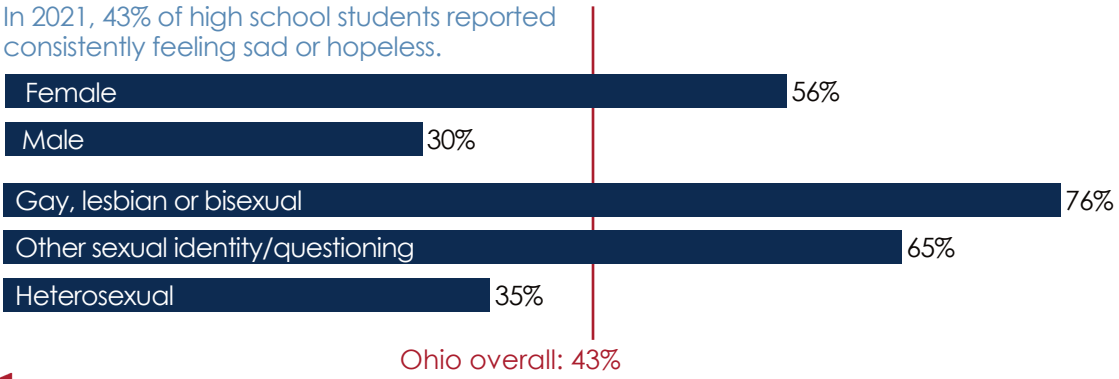


Source: Behavioral Risk Factor Surveillance System

Mental health challenges among high school students

Significant disparities in mental well-being exist among Ohio teens, especially for female students and students who are members of the LGBTQ+ community.

In 2021, 43% of high school students reported consistently feeling sad or hopeless.



Note: Question asked "During the past 12 months, did you ever feel so sad or hopeless almost every day for two weeks or more in a row that you stopped doing some usual activities?"
Source: Youth Risk Behavior Surveillance System

Policies to drive improvement in Ohio

- Improve access to **telemental health services** and reduce existing barriers for patients, such as gaps in insurance coverage and lack of broadband availability.
- Fund programs with evidence of mental health benefits, such as **mental health first aid**, **cross-age youth peer mentoring** and **trauma-informed schools**.
- Improve the behavioral health crisis system, including the **988 lifeline** and mobile crisis response, ensuring that these services are adequately funded and available across the state.

Policy priorities to improve health value

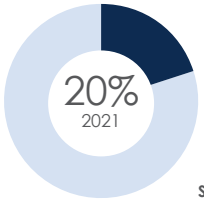
Tobacco and cannabis prevention

Use of tobacco products

Nicotine dependence and tobacco are leading drivers of poor health outcomes, such as cancer, heart disease and stroke, and contribute to higher healthcare spending.

Ohio rank **33** out of 43

Youth e-cigarette use



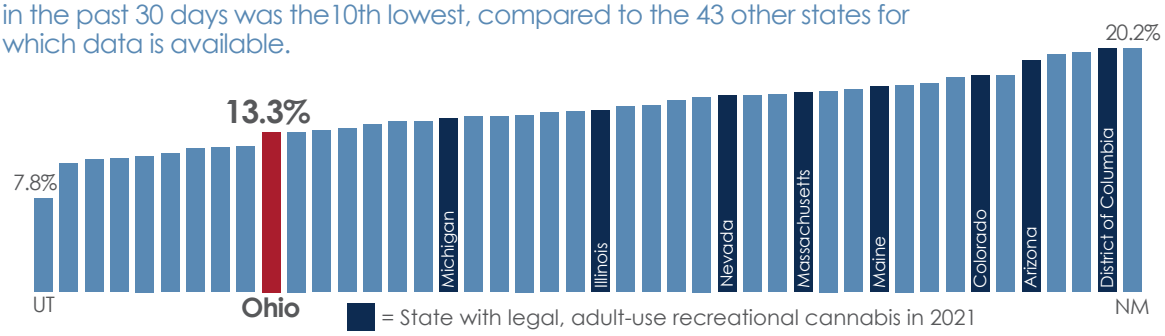
In 2021, one in five Ohio high school students reported using an electronic vapor product at least once in the past 30 days. High rates of tobacco use continue for Ohioans into adulthood; Ohio ranks 46th on adult smoking.[2]

Source: Youth Risk Behavior Surveillance System

Cannabis use

Cannabis use among Ohio teens was relatively low in 2021, but with the recent legalization of recreational use for adults, policymakers will have to consider strategies to ensure that use does not increase among teens. Policymakers will need to weigh public health, public safety and equity considerations, and draw upon **lessons learned** from decades of tobacco control policy as they create recreational cannabis regulations.

In 2021, the percent of Ohio high school students who had used cannabis in the past 30 days was the10th lowest, compared to the 43 other states for which data is available.



Note: Data is not available for Alaska, California, Georgia, Minnesota, Oregon, Washington and Wyoming. Adult-use recreational cannabis was legal in Washington, Alaska, California and Oregon in 2021.
Source: Youth Risk Behavior Surveillance System

Policies to drive improvement in Ohio

- Establish state-level tobacco retailer licensing and fund robust public health enforcement of "**Tobacco 21**" age restrictions.
- Implement **marketing restrictions** on tobacco and cannabis products and prohibit product types that are attractive to children and adolescents (including flavors and products that look like candy).
- Ensure that Ohio's new cannabis regulatory framework **balances important policy goals** such as protecting youth health and promoting equity.

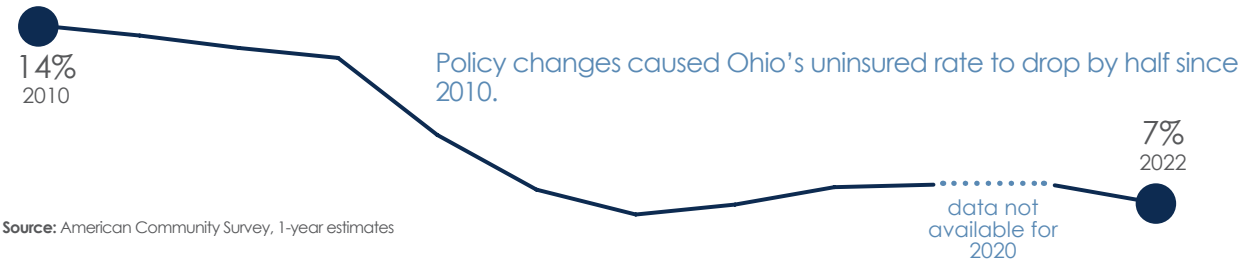
Policy priorities to improve health value

Healthcare affordability

Though Ohio's uninsured rate has dropped significantly over the past decade and is lower than most other states, access to affordable care is still out of reach for many Ohioans.

Ohio rank 16 Uninsured rate

Over the past decade, there have been major policy changes to improve access to care, including Ohio's expansion of Medicaid eligibility in 2014. Policymakers should monitor Ohio's uninsured rate as the state continues **unwinding** COVID-related policy changes to Medicaid eligibility.



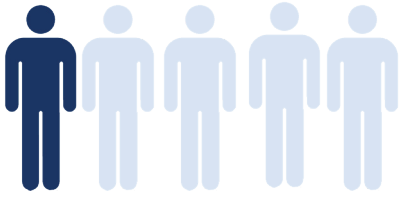
Source: American Community Survey, 1-year estimates

Healthcare access and affordability

Many Ohioans are facing substantial out-of-pocket healthcare expenses, and Ohioans are more likely to seek care in emergency department (ED) settings than people in most other states, which can increase costs.

Ohio rank 35 Total out-of-pocket spending

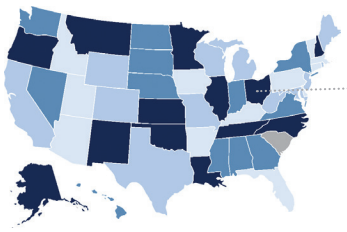
In 2021, nearly one in five Ohioans — over **2,159,000 people** — lived in families with high out-of-pocket healthcare spending, paying more than 10% of their annual household income for health care.



Source: State Health Access Data Assistance Center analysis of Current Population Survey Annual Social and Economic Supplement microdata

Potentially avoidable emergency department visits for employer-insured enrollees

Receiving care in the ED is very costly, and some ED visits could be prevented if affordable care was accessible earlier in a lower-intensity setting.



Ohio rank 45 out of 49

143.2 potentially avoidable ED visits per 100,000 enrollees in 2021

Source: Merative MarketScan, as compiled by The Commonwealth Fund

Policies to drive improvement in Ohio

- Establish a healthcare cost study commission to examine the key contributors to high healthcare spending, as well as ways to lower costs for consumers and employers, such as those created in **Indiana** and **other states**.
- Ensure timely access to primary care, mental health, substance use disorder and dental services by strengthening **provider network accuracy and adequacy** and increasing provider workforce capacity.
- Monitor the results of the new federal **All-Payer Health Equity Approaches and Development (AHEAD) model**, through which the federal government will collaborate with selected states to improve health, advance health equity and reduce healthcare cost growth.

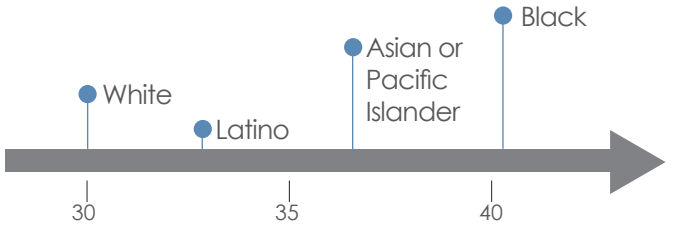
Policy priorities to improve health value

Creating opportunities to thrive

Not all communities in Ohio have access to the resources, experiences and environments needed to thrive. Many Ohioans, including Ohioans of color, Ohioans with disabilities, Ohioans with low incomes, Ohioans with less education, Ohioans living in rural and Appalachian areas, and LGBTQ+ Ohioans, continue to face barriers to health where they live, work and play.

Ohio rank 41 Outdoor air quality

Discriminatory policies and practices have shaped where Ohioans of color live and whether they have access to safe neighborhoods free from harmful conditions, such as air pollution. Historical practices like **redlining** resulted in disinvestment, concentrated poverty and depleted property values in neighborhoods where Ohioans of color lived. Those areas then became vulnerable to highway and industry development, resulting in exposure to greater levels of air pollution that continue today.[3]



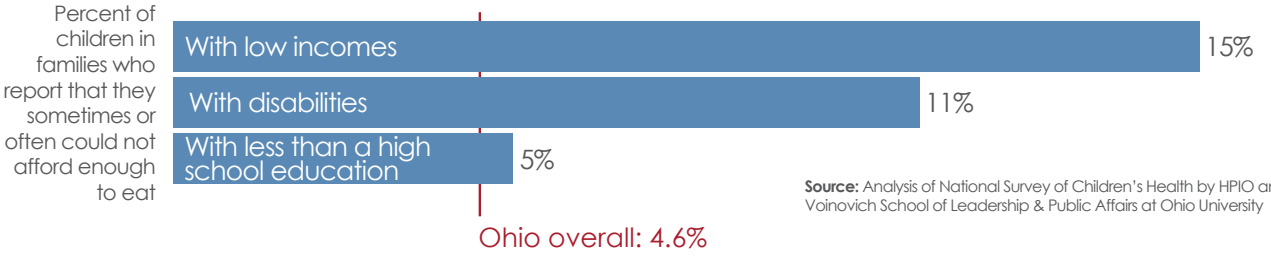
Ohioans of color were more likely to experience exposure to air pollutants (based on a national scale of 1 to 100) than white Ohioans in 2020.

Source: U.S. Environmental Protection Agency data compiled by the National Equity Atlas

Food insecurity among children

Factors like discrimination and poverty can cause barriers to opportunity, such as an inability to access healthy foods, stable housing and meaningful employment, for groups of Ohioans.

Children with disabilities, from families with low incomes and from families with low educational attainment were more likely to be food insecure than Ohioans overall in 2019-2022.



Source: Analysis of National Survey of Children's Health by HPIO and The Voinovich School of Leadership & Public Affairs at Ohio University

Policies to drive improvement in Ohio

- Increase the presence and accessibility of **green spaces and parks** that provide **environmental and health benefits to communities**, prioritizing areas that have historically lacked access to green spaces.
- Increase food access for Ohioans most at-risk of food insecurity through initiatives such as **the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) and Senior Farmers' Market Nutrition Programs**.
- Use **health equity impact assessments** to identify the potential health impacts of proposed policies, programs and services on systematically disadvantaged groups.

POPULATION HEALTH

Ohio rank **43**

Half of the health value equation

Ohio's **population health** ranking in previous *Dashboard* editions: 40 (2014) | 43 (2017) | 43 (2019) | 43 (2021) | 43 (2023)

Ohio's rank	Metric	Most recent data	Trend*
45	**Health behaviors**		
34	**Excessive drinking.** Percent of adults that report either binge drinking, defined as consuming more than four (women) or five (men) alcoholic beverages on a single occasion in the past 30 days, or heavy drinking, defined as having seven or more (women) or 14 or more (men) drinks per week (2021). Rank out of 50.	18.2%	No change
36	**Physical inactivity.** Percent of adults, ages 18 and older, reporting no leisure time physical activity during the past 30 days (2022). Rank out of 51.	25.1%	No change
33	**Youth e-cigarette use.** Percent of youth, grades 9-12, who used electronic vapor products on at least one day in the past 30 days (2021). Rank out of 43.	20%	**Greatly improved**
46	**Adult smoking.** Percent of adults, ages 18 and older, who currently smoke (2022). Rank out of 51.	17.1%	Moderately improved
43	**Conditions and diseases**		
20	**Suicide deaths.** Number of deaths due to suicide, per 100,000 population (age adjusted) (2020). Rank out of 51.	13.8	No change
39	**Poor oral health.** Percent of adults, ages 18-64, who have lost six or more teeth because of tooth decay, infection or gum disease (2020). Rank out of 51.	10.8%	Moderately improved
41	**Adult depression.** Percent of adults who have ever been told by a health professional that they have depression (2022). Rank out of 51.	25%	Moderately worsened
41	**Adult diabetes.** Percent of adults who have ever been told by a health professional that they have diabetes (2022). Rank out of 51.	13.1%	No change
41	**Heart disease mortality.** Number of deaths due to heart diseases, per 100,000 population (age adjusted) (2020). Rank out of 51.	196.9	No change
42	**COVID-19 mortality.** Number of deaths from COVID-19 per 100,000 population (age-adjusted) from January 1, 2020 to November 4, 2023. Rank out of 51.	337.3	N/A
47	**Drug overdose deaths.** Number of deaths due to drug overdose, per 100,000 population (age adjusted) (2020). Rank out of 51.	47.2	Moderately worsened
43	**Overall health and well-being**		
38	**Overall health status.** Percent of adults who report excellent, very good or good health (2022). Rank out of 51.	81.3%	Moderately worsened
38	**Premature death.** Average number of years of potential life lost before age 75, per 100,000 population (2020). Rank out of 51.	9,187	Moderately worsened
39	**Life expectancy at birth.** Life expectancy at birth based on current mortality data and population estimates (2020). Rank out of 50.	75.3	Moderately worsened
42	**Infant mortality.** Number of infant deaths, per 1,000 live births (within one year) (2021). Rank out of 49.	7.1	No change
47	**Limited activity due to health problems.** Average number of days in the previous 30 days when a person reports limited activity due to physical or mental health difficulties, ages 18 and older (2022). Rank out of 51.	2.2	**Greatly worsened**

Top quartile | Second quartile | Third quartile | Bottom quartile

Of the 50 states and D.C.

N/A Data not available for trend

* Worsened or improved compares Ohio's change from baseline to most recent year relative to other states' performance on the metric. For more details, see the methodology section on the ***2024 Health Value Dashboard* web page**.

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HEALTHCARE SPENDING

Ohio rank 34

Half of the health value equation

Ohio's **healthcare spending** ranking in previous *Dashboard* editions: 40 (2014) | 31 (2017) | 28 (2019) | 37 (2021) | 40 (2023)

Ohio's rank	Metric	Most recent data	Trend*
35	**Out-of-pocket spending**		
31	**Employer-sponsored health insurance out-of-pocket spending, per enrollee.** Out-of-pocket spending, such as co-payments, co-insurance and deductibles, per enrollee under age 65, in major employer-sponsored health insurance plans (2021). Rank out of 50.	$923.44	No change
35	**Total out-of-pocket spending.** Percent of individuals who are in families where out-of-pocket spending on health care, including premiums, accounts for more than 10 percent of annual income (2021). Rank out of 51.	18.6%	No change
35	**Healthcare service area spending**		
19	**Nursing home average daily cost, per capita.** Average cost for an individual to pay the full, private pay cost for a shared room in a nursing home (i.e., without insurance contribution) (October 2021). Rank out of 51.	$240	No change
31	**Employer-sponsored health insurance prescription drug spending, per enrollee.** Spending on pharmacy claims for prescription drugs and devices, per enrollee under age 65, in major employer-sponsored health insurance plans (2021). Rank out of 50.	$1,395.02	Moderately increased
38	**Employer-sponsored health insurance outpatient spending, per enrollee.** Spending on outpatient services, per enrollee under age 65, in major employer-sponsored health insurance plans (2021). Rank out of 50.	$2,305.11	No change
39	**Hospital adjusted expenses per inpatient day.** Adjusted expenses per inpatient day for community hospitals (2021). Rank out of 51.	$3,162	No change
37	**Private health insurance spending**		
27	**Employee contributions to employer-sponsored insurance premiums.** Employee contributions to employer-sponsored health insurance premiums as a percent of state median income (2021). Rank out of 51.	6.8%	Moderately increased
35	**Total employer-sponsored health insurance spending, per enrollee.** Total spending on medical and pharmacy claims, per enrollee under age 65, in major employer-sponsored health insurance plans (2021). Rank out of 50.	$6,721.65	Moderately increased
36	**Average monthly marketplace premium.** Average monthly premium for enrollees in the federal Affordable Care Act Health Insurance Marketplace or state-based exchanges after application of an advanced premium tax credit (2023). Rank out of 51.	$196	Moderately decreased
24	**Medicare spending**		
15	**Average total cost, per Medicare beneficiary without chronic conditions.** Average total cost per Medicare beneficiary without chronic conditions (2022). Rank out of 51.	$3,936	No change
18	**Average total cost, per Medicare beneficiary with one chronic condition.** Average total cost per Medicare beneficiary with one chronic condition (2022). Rank out of 51.	$5,269	No change
19	**Average total cost, per Medicare beneficiary with two chronic conditions.** Average total cost per Medicare beneficiary with two chronic conditions (2022). Rank out of 51.	$5,988	Moderately decreased
37	**Average total cost, per Medicare beneficiary with three or more chronic conditions.** Average total cost per Medicare beneficiary with three or more chronic conditions (2022). Rank out of 51.	$13,124	Moderately decreased
42	**Total Medicare spending, per beneficiary.** Total Medicare reimbursements, per Medicare beneficiary (Parts A and B), ages 65-99 (2019). Rank out of 51.	$11,665.92	Moderately increased

Top quartile | Second quartile | Third quartile | Bottom quartile

Of the 50 states and D.C.

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ACCESS TO CARE

Ohio rank **18**

Ohio's **access to care** ranking in previous *Dashboard* editions: 25 (2014) | 17 (2017) | 18 (2019) | 7 (2021) | 20 (2023)

Ohio's rank	Metric	Most recent data	Trend*
23	**Coverage and affordability**		
16	**Uninsured, non-elderly.** Percent of population ages 64 and under who are uninsured (2022). Rank out of 51.	7.1%	No change
22	**Unable to see doctor due to cost.** Percent of adults who went without care because of cost in the past year (2022). Rank out of 51.	9.8%	No change
30	**Employer-sponsored health insurance coverage.** Percent of all workers who work at a company that offers health insurance to its employees (2022). Rank out of 51.	84.6%	Moderately worsened
7	**Primary care access**		
4	**Routine checkup.** Percent of adults, ages 65 and older, with self-reported fair or poor health, who had a routine checkup in the past 12 months (2021). Rank out of 50.	95.6%	No change
15	**Without a usual source of care.** Percent of adults, ages 18 and older, who do not have at least one person they think of as their personal healthcare provider (2022). Rank out of 51.	14.6%	**Greatly improved**
20	**Medical home, children.** Percent of children, ages 0-17, who have a personal doctor or nurse, have a usual source for sick care, receive family-centered care, have no problems getting needed referrals and receive effective care coordination when needed (2020-2021). Rank out of 51.	50.1%	Moderately worsened
9	**Behavioral health**		
11	**Received mental health treatment in past year, children.** Percent of children, ages 3-17, who received treatment or counseling from a mental health professional when needed during the past 12 months (2020-2021). Rank out of 51.	84.5%	Moderately improved
12	**Medication for Opioid Use Disorder.** Percent of outpatient substance use treatment facilities that offer methadone/buprenorphine maintenance or naltrexone treatment (2020). Rank out of 51.	56%	Moderately improved
23	**Unmet need for mental health treatment, adults.** Percent of adults, ages 18 and older, with any mental illness who had a need for mental health treatment or counseling and did not receive it in the past year (2018-2019). Rank out of 51.	25%	**Greatly worsened**
48	**Oral health**		
30	**Dental visit in past year, adults.** Percent of adults, ages 18 and older, who have visited a dentist, dental clinic or dental specialist within the past year (2022). Rank out of 51.	64.4%	No change
50	**Preventive dental care, children.** Percent of children, ages 1-17, who have seen a dentist or other oral health care provider for preventive dental care, such as check-ups, dental cleanings, dental sealants or fluoride treatments in the past year (2020-2021). Rank out of 51.	69.6%	**Greatly worsened**
29	**Workforce**		
20	**Underserved, mental health.** Percent of need not met by current supply of mental health professionals in designated mental health care professional shortage areas (September 30, 2023). Rank out of 50.	69.1%	Moderately worsened
26	**Underserved, primary care physicians.** Percent of need not met by current supply of primary care physicians in designated primary care health professional shortage areas (September 30, 2023). Rank out of 51.	52.1%	Moderately worsened
38	**Underserved, dentists.** Percent of need not met by current supply of dentists in designated dental care health professional shortage areas (September 30, 2023). Rank out of 51.	72.6%	No change

Top quartile | Second quartile | Third quartile | Bottom quartile

Of the 50 states and D.C.

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HEALTHCARE SYSTEM

Ohio rank **38**

Ohio's **healthcare system** ranking in previous *Dashboard* editions: 39 (2014) | 37 (2017) | 36 (2019) | 38 (2021) | 30 (2023)

Ohio's rank	Metric	Most recent data	Trend*
27	**Preventive services**		
16	**Breastfeeding and infant care supports in hospitals.** Composite Maternity Practice in Infant Nutrition and Care (mPINC) score of breastfeeding and infant care supports provided at hospitals and birthing facilities (2022). Rank out of 49.	84	**Greatly improved**
26	**Prenatal care.** Percent of women who completed a pregnancy in the last 12 months and who received prenatal care in the first trimester (2022). Rank out of 51.	77.1%	No change
28	**Female breast cancer early stage diagnosis.** Percent of female breast cancer cases diagnosed at an early stage (2015-2019). Rank out of 51.	72%	**Greatly improved**
43	**Colon and rectal cancer early stage diagnosis.** Percent of colon and rectal cancer cases diagnosed at an early stage (2015-2019). Rank out of 51.	34.4%	**Greatly worsened**
NR	**Behavioral health**		
NR	**Substance use disorder treatment retention.** Percent of Medicaid enrollees, ages 12 and older, with an intake assessment who received one outpatient service within a week and two additional outpatient clinical services within 30 days of intake (SFY 2022).	48.7%	N/A
49	**Hospital utilization**		
31	**Diabetes with long-term complications.** Number of admissions with a principal diagnosis of diabetes with long-term complications for Medicare fee-for-service Part A beneficiaries, ages 18 and older, per 100,000 beneficiaries (2022). Rank out of 51.	221	No change
39	**Heart failure admissions for Medicare beneficiaries.** Number of admissions with a principal diagnosis of heart failure for Medicare fee-for-service Part A beneficiaries, ages 18 and older, per 100,000 beneficiaries (2022). Rank out of 51.	1,250	No change
45	**Potentially avoidable emergency department visits for employer-insured enrollees.** Number of potentially avoidable emergency department visits for people, ages 18-64, with employer-sponsored insurance, per 1,000 enrollees (2021). Rank out of 49.	143.2	**Greatly improved**
47	**30-day hospital readmissions for employer-insured enrollees.** Number of readmissions for people, ages 18-64, with employer-sponsored insurance within 30 days of an acute hospital stay for any cause, per 1,000 enrollees (2021). Rank out of 48.	3.3	No change
24	**Timeliness, effectiveness and quality of care**		
17	**Back pain recommended treatment.** Percent of outpatients with low back pain who had an MRI without trying recommended treatments first, such as physical therapy (FY 2022). Rank out of 51.	35.3%	No change
18	**Hospitals with better-than-average patient experience ratings.** Percent of hospitals in the state with overall patient experience ratings higher than the national average (2021). Rank out of 50.	52%	No change
20	**Nursing home pressure ulcers.** Percent of long-stay, high-risk nursing home residents with pressure ulcers (Q1-Q4 2022). Rank out of 51.	7.4%	No change
28	**Central line-associated bloodstream infections.** Standardized infection ratio for central line-associated bloodstream infections in acute care hospitals (2021). Rank out of 51.	0.9	Moderately worsened
37	**Mortality amenable to healthcare.** Number of deaths before age 75 that resulted from causes considered at least partially treatable or preventable with timely and appropriate medical care, per 100,000 population (2019-2020). Rank out of 51.	96.3	No change
34	**Healthcare system structure**		
11	**Large group insurance market competition.** Herfindahl-Hirschman Index (HHI) score, a measure of how evenly market share is distributed across insurers in the large group insurance market (2019). Rank out of 51.	2,811	No change
32	**Private insurance reimbursement rates.** Relative price ratio, a measure of how much more private insurers pay for hospital services than Medicare (2020). Rank out of 50.	2.68	Moderately worsened
35	**Hospital beds, per capita.** Number of hospital beds, per 1,000 population (2021). Rank out of 51.	2.8	No change
44	**Primary care physicians.** Ratio comparing the number of specialist physicians to the number of primary care physicians (September 2023). Rank out of 51.	1.185	No change

Top quartile | Second quartile | Third quartile | Bottom quartile

Of the 50 states and D.C.

NR Not ranked | N/A Data not available for trend

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PUBLIC HEALTH AND PREVENTION

Ohio rank **36**

Ohio's **public health and prevention** ranking in previous *Dashboard* editions: 51 (2014) | 50 (2017) | 47 (2019) | 32 (2021) | 37 (2023)

Ohio's rank	Metric	Most recent data	Trend*
7	**Public health system and workforce**		
2	**Accreditation of local health departments.** Percent of local health departments that have achieved accreditation or reaccreditation (October 2023). Rank out of 50.	77.5%	**Greatly improved**
34	**State public health funding, per capita.** State public health funding during the fiscal year, per capita (2021). Rank out of 46.	$24	No change
48	**State public health workforce.** Number of state public health agency full-time equivalent (FTE) employees, per 100,000 population (2019). Rank out of 51.	8.9	No change
NR	**Local public health workforce.** Median number of local health department FTE employees, per 100,000 population (2019).	42.96	N/A
NR	**Local public health department spending, per capita.** Median annual local health expenditures, per capita (FY 2020).	$39.60	N/A
36	**Communicable disease control and environmental health**		
25	**Chlamydia.** Number of reported cases of chlamydia, per 100,000 population (2021). Rank out of 50.	479.8	Moderately improved
26	**Child immunization.** Percent of children, ages 19-35 months, who received recommended vaccines (2021). Rank out of 51.	72%	Moderately improved
35	**COVID-19 vaccinations.** Percent of the total population that has received the primary series of the COVID-19 vaccination (As of October 23, 2023). Rank out of 51.	60.7%	N/A
41	**Environmental and occupational health.** Composite score of the Environmental and Occupational Health domain of the National Health Security Preparedness Index, which measures actions to maintain the security and safety of water and food supplies, to test for hazards and contaminants in the environment and to protect workers and emergency responders from health hazards (2020). Rank out of 51.	6.3	Moderately improved
31	**Health promotion and prevention**		
10	**Youth marijuana use.** Percent of high school students who used marijuana in the past 30 days (2021). Rank out of 44.	13.3%	Moderately improved
20	**Motor vehicle crash deaths.** Number of deaths due to traffic accidents involving a motor vehicle, per 100,000 population (2021). Rank out of 51.	12.8	No change
22	**Falls among older adults.** Percent of adults ages 65 and older who reported falling in the past 12 months (2020). Rank out of 51.	28%	No change
29	**Cigarette tax.** State excise tax per pack of cigarettes (as of March 31, 2023). Rank out of 51.	$1.60	No change
30	**Low birth weight.** Percent of live births where the infant weighed less than 2,500 grams (5.5 pounds) (2022). Rank out of 51.	8.7%	No change
32	**Teen birth.** Number of births to females, ages 15-19, per 1,000 females, ages 15-19 (2022). Rank out of 51.	15.4	No change
34	**Tobacco prevention spending.** Percent of the Centers for Disease Control and Prevention-recommended level of funding for tobacco prevention and control spending (FY 2023). Rank out of 51.	13.1%	No change
43	**Seat belt use.** Percent of front seat occupants observed using a seat belt (2021). Rank out of 51.	84.1%	No change
NR	**Overdose reversals.** Number of known overdose reversals using naloxone (2022).	18,244	N/A
51	**Emergency preparedness and surveillance**		
29	**Epidemiologists.** Rate of full-time equivalent epidemiologist in state public health agencies, per 100,000 population (2019). Rank out of 47.	0.82	No change
44	**Emergency preparedness funding, per capita.** State public health agency Public Health Emergency Preparedness cooperative agreement funding, per capita (FY 2022). Rank out of 51.	$1.55	No change
51	**Health security surveillance.** Composite score of the Health Security Surveillance domain of the National Health Security Preparedness Index, which measures actions to monitor and detect health threats, and to identify where hazards start and spread so that they can be contained rapidly (2020). Rank out of 51.	6.8	No change

Top quartile | Second quartile | Third quartile | Bottom quartile

Of the 50 states and D.C.

NR Not ranked | N/A Data not available for trend

* Worsened or improved compares Ohio's change from baseline to most recent year relative to other states' performance on the metric. For more details, see the methodology section on the **2024 Health Value Dashboard web page**.

Data sources are available in data appendices posted on the **2024 Health Value Dashboard web page**.

SOCIAL AND ECONOMIC ENVIRONMENT

Ohio rank **31**

Ohio's **social and economic environment** ranking in previous *Dashboard* editions: 29 (2014) | 29 (2017) | 32 (2019) | 34 (2021) | 31 (2023)

Ohio's rank	Metric	Most recent data	Trend*
30	**Education**		
8	**Fourth-grade reading**. Percent of fourth grade public school students proficient in reading by a national assessment (National Assessment of Educational Progress) (2022). Rank out of 51.	35%	Moderately worsened
26	**Preschool enrollment.** Percent of 3- and 4-year-olds enrolled in preschool (2017-2021). Rank out of 51.	43%	No change
28	**High school graduation.** Percent of incoming ninth graders who graduate in four years from a public high school with a regular degree (2019-2020 school year). Rank out of 49.	84.4%	Moderately improved
32	**Some college.** Percent of adults, ages 25-44, with some post-secondary education, such as enrollment in vocational/technical schools, junior colleges or four-year colleges, including individuals who pursued education following high school but did not receive a degree (2017-2021). Rank out of 51.	65.8%	No change
37	**Employment and poverty**		
29	**Income inequality.** Ratio of median household income at the 80th percentile to that at the 20th percentile (2017-2021). Rank out of 51.	4.6	No change
32	**Labor force participation.** Percent of people, ages 16 and older, who are in the labor force (2022). Rank out of 51.	61.5%	No change
38	**Unemployment.** Percent of people, ages 16 and older, who are jobless, looking for a job and available for work (2022). Rank out of 51.	4%	**Greatly improved**
39	**Adult poverty.** Percent of people, ages 18 and older, in households with incomes below the federal poverty level in the past 12 months (2022). Rank out of 51.	12.2%	No change
39	**Child poverty.** Percent of people under age 18, in households with incomes below the federal poverty level in the past 12 months (2022). Rank out of 51.	17.7%	No change
37	**Family and social support**		
28	**Disconnected youth.** Percent of youth, ages 16-24, who are not working or in school (2022). Rank out of 50.	10.8%	No change
38	**Children in single-parent households.** Percent of children, ages 0-17, who live in a household headed by a single parent (2017-2021). Rank out of 51.	26.8%	**Greatly improved**
39	**Incarceration.** Number of people sentenced and imprisoned under the jurisdiction of state or federal correctional authorities, per 100,000 population (2021). Rank out of 50.	382	No change
20	**Trauma, toxic stress and violence**		
18	**Violent crime.** Number of violent crimes (murder, rape, robbery and aggravated assault), per 100,000 population (2021). Rank out of 51.	309	No change
24	**Adverse childhood experiences.** Percent of children who have experienced two or more adverse experiences (2022). Rank out of 51.	23.6%	No change
28	**Child abuse and neglect.** Number of reported and substantiated child maltreatment victims, per 1,000 children (FY 2019). Rank out of 51.	9.9	No change
13	**Civic engagement**		
11	**Voter registration.** Percent of citizens of voting age who reported being registered to vote in presidential election years (2020). Rank out of 51.	77%	**Greatly improved**
16	**Voting rates.** Percent of citizens of voting age who reported voting in presidential election years (2020). Rank out of 51.	70.1%	**Greatly improved**

Top quartile | Second quartile | Third quartile | Bottom quartile

Of the 50 states and D.C.

NR Not ranked | N/A Data not available for trend

* Worsened or improved compares Ohio's change from baseline to most recent year relative to other states' performance on the metric. For more details, see the methodology section on the ***2024 Health Value Dashboard* web page**.

Data sources are available in data appendices posted on the ***2024 Health Value Dashboard* web page**.

PHYSICAL ENVIRONMENT

Ohio rank **37**

Ohio's **physical environment** ranking in previous *Dashboard* editions: 34 (2014) | 35 (2017) | 40 (2019) | 38 (2021) | 38 (2023)

Ohio's rank	Metric	Most recent data	Trend*
49	**Air, water and toxic substances**		
41	**Outdoor air pollution.** Average exposure of the general public to particulate matter of 2.5 microns or less in size (PM2.5), measured in micrograms per cubic meter (2019-2021). Rank out of 51.	8.7	Moderately improved
47	**Child in a household with a person who smokes**. Percent of children, ages 0-17, who live in households where someone smokes (cigarettes, cigars or pipe tobacco) (2020-2021). Rank out of 51.	20.6%	Moderately improved
48	**Toxic pollutants (Risk-Screening Environmental Indicators score)**. Unitless value that accounts for the size of the chemical release, the fate and transport of chemicals through the environment, the size and location of the exposed population and the chemical's toxicity (2021). Rank out of 51.	21,554,865	N/A
NR	**Lead poisoning**. Percent of children, ages 0-5, who received a blood lead test and had elevated blood lead levels (BLL > 5 ug/dL) (2022).	1.9%	N/A
34	**Food access and food insecurity**		
29	**Healthy food access**. Percent of population with limited access to healthy food, defined as the percent of low-income individuals (<200% federal poverty guideline) living more than 10 miles from a grocery store in rural areas and more than one mile in non-rural areas (2019). Rank out of 51.	6.9%	No change
40	**Food insecurity**. Percent of inhabitants who are food insecure (2021). Rank out of 51.	11.8%	Moderately improved
18	**Housing, built environment and access to physical activity**		
12	**Severe housing problems**. Composite measure of the percent of households that have one or more of the following problems: 1) housing unit lacks complete kitchen facilities, 2) housing unit lacks complete plumbing facilities, 3) household is severely overcrowded, 4) monthly housing costs, including utilities, exceed 50 percent of monthly income (2016-2020). Rank out of 51.	12.8%	No change
17	**Long commute, driving alone**. Percent of commuters, among those who commute to work by car, truck, or van, alone, who drive 30 minutes or longer to work each day (2022). Rank out of 51.	30.2%	No change
17	**Neighborhood resources**. Composite measure of the percent of children living in a neighborhood that contains each of the following amenities: sidewalks or walking paths; parks or playgrounds; recreation centers, community center, or boys' and girls' club; and libraries or bookmobiles (2020-2021). Rank out of 51.	37%	No change
22	**Access to exercise opportunities**. Percent of population who live reasonably close to locations for physical activity (2020 and 2022). Rank out of 51.	83.8%	No change
30	**Alternative commute modes**. Percent of trips to work via bicycle, walking or public transportation (combined) (2022). Rank out of 51.	3.2%	No change
37	**Neighborhood safety**. Percent of children living in a safe neighborhood as reported by a parent or guardian (2020-2021). Rank out of 51.	94.9%	No change

Top quartile | Second quartile | Third quartile | Bottom quartile

Of the 50 states and D.C.

NR Not ranked | N/A Data not available for trend

* Worsened or improved compares Ohio's change from baseline to most recent year relative to other states' performance on the metric. For more details, see the methodology section on the ***2024 Health Value Dashboard* web page**.

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EQUITY PROFILES

BLACK OHIOANS

Racism is a primary driver of poor outcomes experienced by Black Ohioans.[4] Racism is a system, built from policies, practices and beliefs, that unfairly distributes resources, power and opportunity. Consequently, **Black Ohioans often experience worse outcomes than white Ohioans** across measures of health, healthcare access and the social, economic and physical environment.

Examples of policies and systems that contribute to gaps in outcomes include discrimination and unfair treatment in employment and lending, disinvestment in public transportation and public education, and the legacy of redlining and zoning policies. Increasing trust and engagement between policymakers and members of Black communities, increasing provider diversity and cultural humility skill development and providing equitable access to financing and employment opportunities can close gaps in outcomes for Black Ohioans.

This profile describes the magnitude of difference in outcomes between Black Ohioans and white Ohioans. Sources and additional data are available in the equity appendix posted on the ***Health Value Dashboard* web page**.

	Times worse for Black Ohioans
Experiences of racism	
Treated worse in healthcare due to race	13.7
Unfair treatment due to race, children	9.4
Treated worse at work due to race	8.5
Physical symptoms as a result of experiences of racism	7.9
Physical environment	
Food insecurity, children	3.5
Zero-vehicle households	3.3
Severe housing cost burden	2.2
Air pollution	1.4
Social and economic environment	
Incarceration	5.7
Child poverty	3
Unemployment	2.5
High school graduation	2.4
Chronic absenteeism	2.1
Disconnected youth	2
Access and healthcare system	
Unable to see doctor due to cost	1.7
Uninsured, adults	1.5
Prenatal care	1.4
Health	
Infant mortality	2.7
Premature death	1.6
Heart disease mortality	1.4

If disparities were eliminated...

189,344 fewer Black Ohioans would experience racism when seeking healthcare

16,973 fewer Black Ohioans would be incarcerated

60,004 fewer years of life would be lost by Black Ohioans

EQUITY PROFILES

HISPANIC/LATINO OHIOANS

Racism is a primary driver of poor outcomes experienced by Hispanic/Latino Ohioans.[5] Racism is a system, built from policies, practices and beliefs, that unfairly distributes resources, power and opportunity. Consequently, **Hispanic/ Latino Ohioans often experience worse outcomes than white, non-Hispanic Ohioans** across measures of healthcare access and the social, economic and physical environment.

Examples of policies and systems that contribute to gaps in outcomes include discrimination and unfair treatment within the healthcare system and limited access to health insurance and translation and interpretation services to assist with accessing and navigating care. Increasing translation and interpretation services, provider diversity and cultural humility skill development can close gaps in outcomes for Hispanic/Latino Ohioans.

This profile describes the magnitude of difference in outcomes between Hispanic/Latino Ohioans and white, non-Hispanic Ohioans. Sources and additional data are available in the equity appendix posted on the ***Health Value Dashboard* web page**.

	Times worse for Hispanic Ohioans
Experiences of racism	
Unfair treatment due to race, children	8.5
Physical symptoms as a result of experiences of racism	4.6
Physical environment	
Food insecurity, children	3.2
Severe housing cost burden	1.6
Zero-vehicle households	1.5
Air pollution	1.1
Broadband internet access	1.1
Social and economic environment	
High school graduation	2.3
Child poverty	2.1
Unemployment	1.7
Chronic absenteeism	1.7
Disconnected youth	1.4
Fourth-grade reading	1.4
Adverse childhood experiences	1.1
Access and healthcare system	
Uninsured, adults	2.7
Unable to see doctor due to cost	2.5
Prenatal care	1.4
Flu vaccinations	1.1
Health	
Adult depression	1.3

If disparities were eliminated...

19,486 fewer Hispanic Ohioans would experience physical symptoms due to experiences of racism

9,473 fewer Hispanic Ohioans would be unemployed

37,695 fewer Hispanic Ohioans would be unable to see a doctor due to cost

EQUITY PROFILES

ASIAN OHIOANS

Racism is a primary driver of poor outcomes experienced by Asian Ohioans.[6] Racism is a system, built from policies, practices and beliefs, that unfairly distributes resources, power and opportunity. Consequently, **Asian Ohioans experience worse outcomes than white Ohioans** across measures of healthcare access and the physical and social environment.[7]

Examples of policies and systems that contribute to gaps in outcomes include gentrification of historically Asian neighborhoods, which impacts housing affordability, and limited access to translation and interpretation services to assist with accessing and navigating care. Providing comprehensive language supports, increasing housing and community supports and increasing health insurance access can improve outcomes for Asian Ohioans.

This profile describes the magnitude of difference in outcomes between Asian Ohioans and white Ohioans. Sources and additional data are available in the equity appendix posted on the ***Health Value Dashboard* web page**.

	Times worse for Asian Ohioans
Experiences of racism	
Unfair treatment due to race, children	9.4
Physical environment	
Severe housing cost burden	1.3
Zero-vehicle households	1.2
Air pollution	1.2
Access and healthcare system	
Uninsured, adults	1.1
Prenatal care	1.1

If disparities were eliminated...

6,051 fewer Asian children would experience unfair treatment due to racism

910 fewer Asian Ohioans would lack access to a vehicle

784 fewer Asian Ohioans would be uninsured

Better data needed for Asian Ohioans

Asian Ohioans represent a diverse group of ethnicities from a large geographic area with different cultural heritage. Collecting and grouping these diverse communities together can mask disparities and the underlying challenges experienced by specific groups. For example, while Asian Americans, as a group, may perform well on certain indicators, existing data on groups from Southeast Asia and Bhutanese and Nepali refugees suggest that these communities experience poorer outcomes.

Oversampling when collecting data can help ensure that data is representative, especially for groups with smaller population sizes, and allow for more meaningful disaggregation.

EQUITY PROFILES

OHIOANS WITH DISABILITIES

Ableism is a primary driver of poor outcomes experienced by Ohioans with disabilities.[8] Ableism is a system of discriminatory policies, practices and beliefs that value people without disabilities over people with disabilities. Consequently, **Ohioans with disabilities often experience worse outcomes than Ohioans without disabilities** across measures of health, healthcare access and the social, economic and physical environment.[9]

Examples of policies and systems that contribute to gaps in outcomes include inaccessible transportation, buildings and programs and employment discrimination. Improving enforcement of civil rights protections for people with disabilities and accessibility and accommodations in employment and healthcare settings can close gaps in outcomes for Ohioans with disabilities.

This profile describes the magnitude of difference in outcomes between Ohioans with disabilities and without disabilities. Sources and additional data are available in the equity appendix posted on the ***Health Value Dashboard* web page**.

	Times worse for Ohioans with disabilities
Physical environment	
Food insecurity, children	2.8
Social and economic environment	
Labor force participation	3.3
Disconnected youth	3.2
High school graduation	2.4
Adverse childhood experiences	1.8
Child poverty	1.8
Fourth-grade reading	1.4
Access and healthcare system	
Unable to see doctor due to cost	2.8
Health	
Adult depression	3.4
Adult diabetes	2.1

If disparities were eliminated...

623,070 fewer Ohioans with disabilities would be out of the labor force

174,923 fewer Ohioans with disabilities would be unable to see a doctor due to cost

556,866 fewer Ohioans with disabilities would experience depression

EQUITY PROFILES

OHIOANS WITH LOWER INCOMES AND/OR LESS EDUCATION

Ohioans with less than a high school education and/or lower incomes often experience worse outcomes across measures of health, healthcare access and the social, economic and physical environment than Ohioans with higher educational attainment and/or incomes.

A lack of opportunities to build wealth and the high cost of post-secondary education can prevent people with low incomes from furthering their education, contributing to reduced employment opportunities, high student debt and lower wages. Improving access to education and higher-wage jobs that pay a self-sufficient income can also increase access to resources that are critical for health, such as safe and quality housing, healthy foods and health care.

Ohioans with lower incomes

This profile describes the magnitude of difference in outcomes between Ohioans with lower incomes and Ohioans with higher incomes.

	Times worse for Ohioans with lower income
Physical environment	
Food insecurity, children	91.1
Child in a household with a person who smokes	3.5
Social and economic environment	
High school graduation	3.2
Adverse childhood experiences	3.1
Chronic absenteeism	2.7
Disconnected youth	2.2
Fourth-grade reading	1.5
Health	
Poor oral health	3.6
Adult depression	2.4

Ohioans with less education

This profile describes the magnitude of difference in outcomes between Ohioans with less than a high school education and those with a college degree or higher.

	Times worse for Ohioans with less education
Physical environment	
Broadband internet access	7.6
Social and economic environment	
Unemployment	4.9
Labor force participation	3.9
Access and healthcare system	
Uninsured, adults	6.4
Prenatal care	3.8
Unable to see doctor due to cost	3.5
Health	
Adult diabetes	2.1

If disparities were eliminated...

40,126 fewer children from families with low incomes would live with a person who smokes

266,555 fewer Ohioans with low incomes would have poor oral health

85,093 fewer Ohioans with less than a high school education would be uninsured

Sources and additional data are available in the equity appendix posted on the ***Health Value Dashboard web page***.

EQUITY PROFILES

LGBTQ+ OHIOANS

Homophobia and transphobia are primary drivers of poor outcomes experienced by LGBTQ+ Ohioans.[10] Experiencing these forms of discrimination can cause toxic stress, leading to poor health outcomes over time. **LGBTQ+ Ohioans often experience worse outcomes than heterosexual and/or cisgender Ohioans** across measures of health and the social environment.

Policies and practices that limit access to necessary health care and a lack of protections for Ohioans based on sexual orientation and gender identity contribute to worse health outcomes for LGBTQ+ people compared to their heterosexual and/or cisgender peers.[11] By ensuring access to developmentally appropriate care, improving provider education and including sexual orientation and gender identity in anti-discrimination laws, Ohio can close gaps in health outcomes for LGBTQ+ Ohioans.

Lesbian, gay and bisexual Ohioans

This profile describes the magnitude of difference in outcomes between lesbian, gay and bisexual Ohioans and heterosexual Ohioans. Sources and additional data are available in the equity appendix posted on the ***Health Value Dashboard* web page**.

	Times worse for lesbian, gay and bisexual Ohioans
Social and economic environment	
Experiences with online bullying	2
Experiences with physical bullying	1.7
Health	
Youth considering suicide	4.8
Youth suicide attempt	4.3
Youth mental health	2.6
Youth all-tobacco use	1.8
Youth binge drinking	1.6
Adult smoking	1.2

Transgender Ohioans

This profile describes the magnitude of difference in outcomes between transgender Ohioans and cisgender Ohioans. Sources and additional data are available in the equity appendix posted on the ***Health Value Dashboard* web page**.

	Times worse for transgender Ohioans
Health	
Adult depression	2.8
Excessive drinking	1.8
Overall health status	1.6

Note: Analysis of estimated impact could not be completed for this equity profile because population estimates of LGBTQ+ Ohioans are not available publicly. Intentionally sampling underrepresented groups, like LGBTQ+ people, can improve data quality and reporting.

Other Ohioans who experience barriers to health

Other groups of Ohioans who often experience barriers to health, or systematic disadvantage, include:

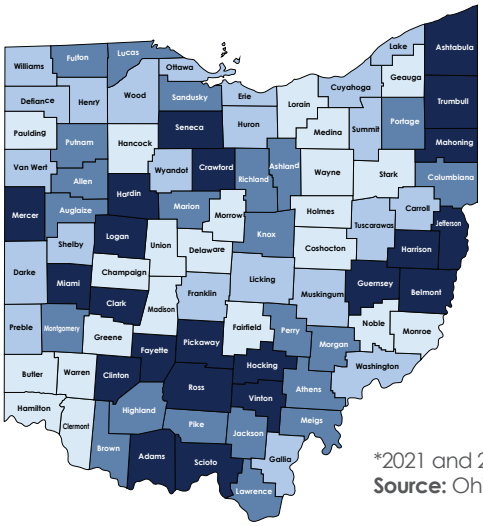
Ohioans who are immigrants or refugees

Despite being more likely to have an advanced degree and participate in the labor force, Ohioans who were born outside of the United States were more likely to live in poverty than their U.S. born peers in 2022.[12]

Ohioans who live in rural or Appalachian areas

Heart disease death rates among working-age Ohioans were highest in rural and Appalachian counties in 2021-2022.[13]

Age-adjusted rate of heart disease deaths
per 100,000 population, for Ohioans ages 15-64, 2021-2022*



Heart disease deaths per 100,000 population

- 132.6-177.4
- 179.2-198.9
- 199-227.8
- 228.3-272.5

Heart disease death rates vary greatly by county, with the highest rates found in Appalachian (southern and eastern Ohio) and rural counties. Mercer County had the highest rate, at 272.5 per 100,000 population, which is 40% higher than the overall state rate (194.8).

*2021 and 2022 data is preliminary
Source: Ohio Department of Health, Public Health Data Warehouse

Older Ohioans

There were 36,016 reports of abuse, neglect or exploitation of Ohioans, ages 60 and older, in state fiscal year 2022.[14] This is likely an undercount because many cases are not reported.

Veterans

In 2020, the suicide rate for veterans in Ohio (30.9 per 100,000 veterans) was 1.8 times higher than the suicide rate for non-veteran Ohioans (17.4 per 100,000 non-veterans).[15]

Opportunities to improve data collection

Public and private entities can improve the quality and availability of publicly available data by:

- Consistently collecting disaggregated data on race/ethnicity, income, geography, disability status, sexual orientation/gender identity and other factors across data sources and years.
- Oversampling groups with smaller population sizes to ensure that they are represented in the data. This also increases the ability to measure the experiences of Ohioans who are part of more than one systematically disadvantaged group.
- Providing local data at the county, zip code and/or census tract levels, when possible.
- Providing training on how to collect demographic data to reduce non-response and missing data.

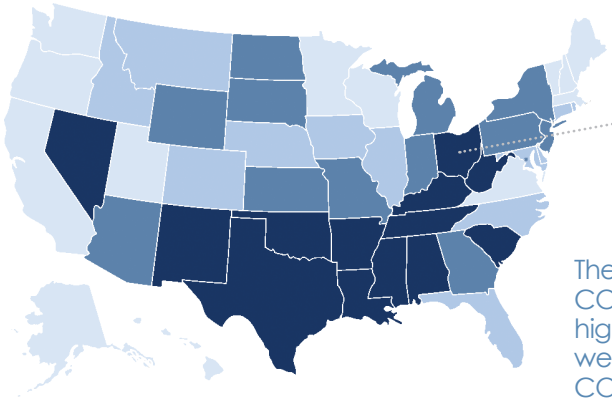
HPIO's **equity publications and resources** contain more information on data, resources and evidence-informed strategies to advance equity.

Impact of COVID-19 on health value

How does Ohio compare to other states on COVID-19 mortality?

Ohioans continue to die from COVID-19 at a higher rate than people in most other states, as shown below. Ohio's rank worsened considerably from 29 to 42 in this edition of the *Dashboard*.

Age-adjusted number of deaths from COVID-19
per 100,000 population (Jan. 1, 2020 to Nov. 4, 2023)



Ohio's rank

2023 Dashboard	2024 Dashboard
29	42

There are likely a variety of contributors to Ohio's high COVID-19 death rate. Some probable factors include higher rates of co-occurring health conditions, as well as Ohio's relatively high poverty rate[16] and low COVID-19 vaccination rate.[17]

Top quartile | Second quartile | Third quartile | Bottom quartile

Of the 50 states and D.C.

Source: Centers for Disease Control and Prevention, COVID Data Tracker

How did COVID-19 and the pandemic response affect other outcomes?

The vast majority (84%) of the metrics in the 2024 *Health Value Dashboard* are based on data from 2020 or later, so the effects of the COVID-19 pandemic are becoming clearer.

Some COVID-related challenges in the social and economic domain were mitigated by federal policies. However, the impacts of the unwinding of policies, such as enhanced Supplemental Nutrition Assistance Program (SNAP) benefits and continuous Medicaid enrollment beginning in early 2023, are not yet known. Due to the lag in data availability, this edition of the *Dashboard* does not reflect these changes.

New research continues to emerge about the impact of COVID-19 school closures and remote learning on educational outcomes:

- Analysis of *Dashboard* metrics found that the percent of Ohio fourth-graders proficient in reading dropped from 39% in 2017 to 35% in 2022. However, Ohio's rank improved to 8th, meaning other states have seen even larger decreases.
- The rate of chronic absenteeism among economically disadvantaged students in Ohio increased from 26% in the 2018-2019 school year to 39% in the 2022-2023 school year. This was 2.7 times worse than students who were not economically disadvantaged in 2022-2023.

The *Dashboard* domains in which Ohio's performance worsened on the largest number of metrics were population health and access to care. However, there were also a number of metrics on which Ohio's performance unexpectedly improved across the course of the COVID-19 pandemic. Examples include adult smoking, youth e-cigarette and marijuana use, child immunizations and the percentage of adults with a usual source of health care.

Ohio's strengths and challenges
compared to other states

Where Ohio is doing well
Metrics in which Ohio ranks in the **top quartile**

Ohio rank	
2	**Accreditation of local health departments*** (out of 50)
4	**Routine checkup** (out of 50)
8	**Fourth-grade reading** (out of 51)
10	**Youth marijuana use** (out of 44)

Ohio rank	
11	**Received mental health treatment in past year, children** (out of 51)
11	**Large group insurance market competition** (out of 51)
11	**Voter registration** (out of 51)
12	**Medication for Opioid Use Disorder** (out of 51)

*Ohio is the only state that requires accreditation of local health departments

Where Ohio can improve
Metrics in which Ohio ranks in the **bottom quartile**

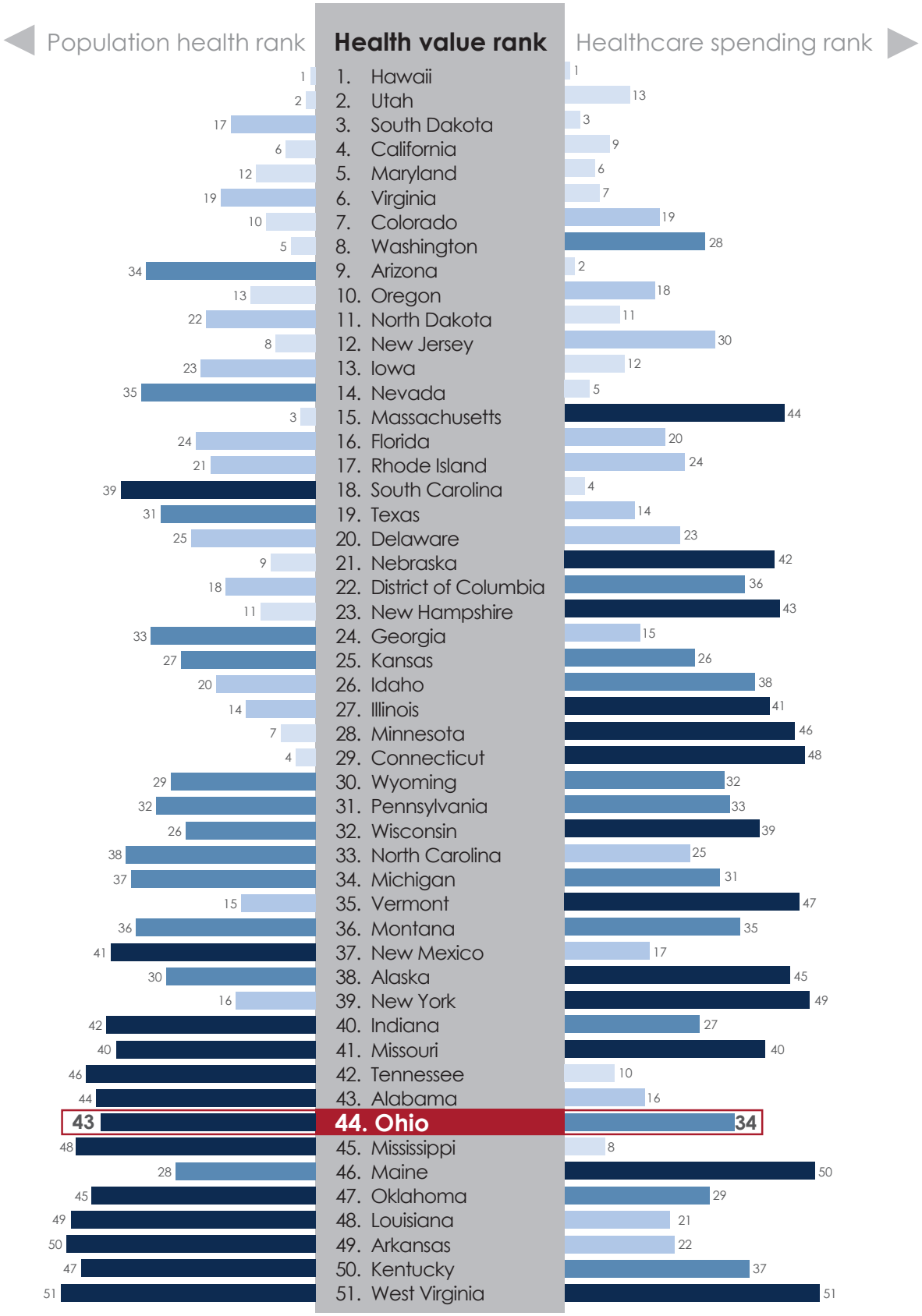
Contributing factors

Ohio rank	
Physical environment	
48	**Toxic pollutants (Risk-Screening Environmental Indicators score)** (out of 51)
47	**Child in a household with a person who smokes** (out of 51)
41	**Outdoor air pollution** (out of 51)
40	**Food insecurity** (out of 51)
Access to care	
50	**Preventive dental care, children** (out of 51)
Healthcare system	
45	**Potentially avoidable emergency department visits for employer-insured enrollees** (out of 49)
44	**Primary care physicians** (out of 51)
43	**Colon and rectal cancer early-stage diagnosis** (out of 51)
39	**Heart failure admissions for Medicare beneficiaries** (out of 51)
Public health and prevention	
51	**Health security surveillance** (out of 51)
48	**State public health workforce** (out of 51)
44	**Emergency preparedness funding, per capita** (out of 51)
43	**Seat belt use** (out of 51)
41	**Environmental and occupational health** (out of 51)
Social and economic environment	
39	**Child poverty** (out of 51)
39	**Adult poverty** (out of 51)
39	**Incarceration** (out of 50)

Value factors

Ohio rank	
Population health	
47	**Drug overdose deaths** (out of 51)
47	**Limited activity due to health problems** (out of 51)
46	**Adult smoking** (out of 51)
42	**COVID-19 mortality** (out of 51)
42	**Infant mortality** (out of 49)
41	**Adult depression** (out of 51)
41	**Heart disease mortality** (out of 51)
41	**Adult diabetes** (out of 51)
39	**Poor oral health** (out of 51)
39	**Premature death** (out of 51)
38	**Life expectancy** (out of 50)
33	**Youth e-cigarette use** (out of 43)
Healthcare spending	
42	**Total Medicare spending, per beneficiary** (out of 51)
39	**Hospital adjusted expenses per inpatient day** (out of 51)
38	**Employer-sponsored health insurance outpatient spending, per enrollee** (out of 50)

Where other states rank



Of the 50 states and D.C.

12 policies that drive improvement

Where does Ohio rank, and what can we do about it?
Ohio ranks 44th on health value (a combination of population health and healthcare spending metrics) out of 50 states and D.C. This means that Ohioans live less healthy lives and spend more on health care than people in most other states. Below are four policy priorities to improve health value, based on 2024 *Dashboard* findings.

Mental well-being

- Improve access to **telemental health services** and reduce existing barriers for patients, such as gaps in insurance coverage and lack of broadband availability.
- Fund programs with evidence of mental health benefits, such as **mental health first aid**, **cross-age youth peer mentoring** and **trauma-informed schools**.
- Improve the behavioral health crisis system, including the **988 lifeline** and mobile crisis response, ensuring that these services are adequately funded and available across the state.

Tobacco and cannabis prevention

- Establish state-level tobacco retailer licensing and fund robust public health enforcement of "**Tobacco 21**" age restrictions.
- Implement **marketing restrictions** on tobacco and cannabis products and prohibit product types that are attractive to children and adolescents (including flavors and products that look like candy).
- Ensure that Ohio's new cannabis regulatory framework **balances important policy goals** such as protecting youth health and promoting equity.

Healthcare affordability

- Establish a healthcare cost study commission to examine the key contributors to high healthcare spending, as well as ways to lower costs for consumers and employers, such as those created in **Indiana** and **other states**.
- Ensure timely access to primary care, mental health, substance use disorder and dental services by strengthening **provider network accuracy and adequacy** and increasing provider workforce capacity.
- Monitor the results of the new federal **All-Payer Health Equity Approaches and Development (AHEAD) model**, through which the federal government will collaborate with selected states to improve health, advance health equity and reduce healthcare cost growth.

Creating opportunities to thrive

- Increase the presence and accessibility of **green spaces and parks** that provide **environmental and health benefits to communities**, prioritizing areas that have historically lacked access to green spaces.
- Increase food access for Ohioans most at-risk of food insecurity through initiatives such as **the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) and Senior Farmers' Market Nutrition Programs**.
- Use **health equity impact assessments** to identify the potential health impacts of proposed policies, programs and services on systematically disadvantaged groups.

Notes

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HPIO Dashboard advisory groups
The Health Value Dashboard Advisory Group (Dashboard AG) members contributed expertise to metric revisions, the selection of policy priorities and the layout and design of the *Dashboard*. A complete list of members is posted on the **Dashboard AG web page**.

HPIO's Equity Advisory Group (EAG) members informed development of the equity profiles. A complete list of EAG members is posted on the **EAG web page**.

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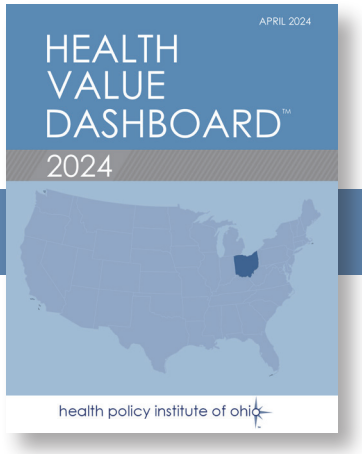

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