Factors that influence health

- Physical environment: 40%
- Social and economic environment: 30%
- Health behaviors: 20%
- Clinical care: 10%

Access to quality health care is necessary, but not sufficient, for good health.

Health spending

- 95% Clinical care
- 5% Prevention and public health

...But we spend most of our healthcare dollars on clinical “sick care” instead of prevention.

Source: County Health Rankings and Roadmaps population health model

Source: Analysis of national health expenditures
Systems and environments that affect health

<table>
<thead>
<tr>
<th>Healthcare system</th>
<th>Public health and prevention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access</td>
<td></td>
</tr>
<tr>
<td>Social and economic environment</td>
<td>Physical environment</td>
</tr>
</tbody>
</table>

equitable, effective and efficient systems

optimal environments

Improved population health
- Health behaviors
- Health equity
- Health status
- Mortality

IMPROVED HEALTH VALUE

Sustainable healthcare costs
- Public sector
- Private sector
- Consumers
Meeting objectives


2. Participants will be aware of the timeline, process and workgroups for the 2017 Dashboard.

3. The group will reach consensus on the criteria and process for reviewing and finalizing metrics for inclusion in 2017 Dashboard.

4. The group will generate ideas for improving the effectiveness of the 2017 Dashboard.
2014 Dashboard activities and impact
Dashboard dissemination

- **Released Dec. 2014 at HPIO forum** (94 participants)
- **2 webinars** in Feb. 2015 (101 total participants)
- **35 presentations** (2014-2015)
- **3x legislative testimony** (2015)
- **13 media stories** (2014-2015)
- **6,756 page views** on Dashboard website (2014-2015)
Ohio 47th in bang for health-care buck

By Ben Sutherly
The Columbus Dispatch • Sunday April 12, 2015

Ohio’s reputation has taken repeated hits in recent years for its poor showing on several key measures of health, including infant mortality, tobacco use, and diabetes and childhood-immunization rates.

Now, a recent report card prepared by the nonpartisan Health Policy Institute of Ohio has found that the state is practically at the back of the pack nationally when taking into account the overall value, or effectiveness, of its health-care spending.

The report gives the health of each state’s population and its health-care costs equal weight in determining value. It ranked Ohio 47th among all states and the District of Columbia. Only Maine, Wyoming, Indiana and West Virginia ranked lower.

Some states such as Mississippi are less healthy than Ohio, but they spend far less on care, too. The upshot, according to the report: Those states get more value from their limited spending than Ohio does by spending more.

For Ohio, the bad news is jarring — not only because the state scores at or near the bottom on some key measures but also because it fares so poorly on so many of them.

The state ranked dead last on the value it gets from its public-health and prevention spending and also ranked low for adult smoking (44th), adult diabetes (46th), growth in spending per Medicare enrollee (45th), infant mortality (47th), child immunizations (48th), emergency/trauma-center funding (48th) and avoidable

How Ohio ranks
Ohio ranks 47th among U.S. states and the District of Columbia for health value — the combination of its health-care costs and population health, weighted equally. Among the contributing factors to the poor showing:

<table>
<thead>
<tr>
<th>WEAKNESSES</th>
<th>OHIO’S RANK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult smoking</td>
<td>44</td>
</tr>
<tr>
<td>Adult diabetes</td>
<td>46</td>
</tr>
<tr>
<td>Infant mortality</td>
<td>47</td>
</tr>
<tr>
<td>Available emergency-department visits for</td>
<td>44</td>
</tr>
<tr>
<td>Medicare beneficiaries</td>
<td></td>
</tr>
<tr>
<td>State public-health workforce per 100,000</td>
<td>44</td>
</tr>
<tr>
<td>Emergency-preparedness funding</td>
<td>44</td>
</tr>
<tr>
<td>Tobacco-prevention spending</td>
<td>46</td>
</tr>
<tr>
<td>Child immunizations</td>
<td>48</td>
</tr>
<tr>
<td>Medicaid spending growth per enrollee</td>
<td>45</td>
</tr>
<tr>
<td>Unmet need for illicit drug-use treatment</td>
<td>43</td>
</tr>
<tr>
<td>Food insecurity</td>
<td>40</td>
</tr>
<tr>
<td>Outdoor air quality</td>
<td>47</td>
</tr>
<tr>
<td>Secondhand smoke exposure in children</td>
<td>49</td>
</tr>
</tbody>
</table>

| STRENGTHS                                        |         |
| Accreditation of local health departments        | 11      |
| Employer-sponsored health insurance              | 11      |
| Safe drinking water                             | 10      |
| Fluoridated water                               | 12      |
| Severe housing problem                          | 13      |

Source: Health Policy Institute of Ohio 2014 Health Value Dashboard

That we have,” said Beth Hackford, the executive director of the Association of Ohio Health Commissioners. “If we were putting more money into front-end prevention, there’d be a lot of money to be saved on the back end in
HPIO’s top 5 most useful publications of 2015

“Which publications/resource pages did you find most useful for influencing the policymaking process?” (n=234)

- **Health Value Dashboard**: 57%
- **Ohio Medicaid Basics 2015**: 42%
- **Beyond Medical Care**: 39%
- **Ohio Prevention Basics: A closer look at prevention spending**: 31%
- **Making the Most of Community Health Planning in Ohio**: 29%
“How does your organization plan to use the 2014 Health Value Dashboard?”
(n=38 hard copy order form respondents)
Legislators turn to the Dashboard

“The 2014 HPIO Health Value Dashboard served as a backdrop for all of our [Senate Health and Human Services Committee] work during this General Assembly and I will continue to use this dashboard as a reference point for us as we enter 2016. We must continue to hold ourselves accountable to shared, transparent metrics and HPIO's work provides us with such an opportunity.”

--Senator Shannon Jones (R-7)
2015 Wrap Up Newsletter, December 2015
Legislators turn to the Dashboard

“It’s nice to have organizations, such as HPIO, measuring the same guidelines that we are also trying to measure internally within the state. To have an external source measure it, as well, and let us know if we are moving the needle: what we’re doing right, what we’re doing wrong.”

---Senator David Burke (R-26)

Joint Medicaid Oversight Committee hearing, July 2015
Annual Stakeholder Survey quotes

“The Health Value Dashboard is an amazing tool utilized at the organizational level to persuade policymakers to make changes in statute and regulation to improve Ohio's health care outcomes.”

“The 2015 Dashboard continues to be the go to document that is shaping policy within many state level meetings.”

“HPIO's dashboard is recognized on a bi-partisan basis as setting benchmarks for Ohio's performance on quality indicators.”
The state of tobacco use prevention and cessation in Ohio
Environmental scan and policy implications

Policy landscape and tobacco use prevalence
Smoking and secondhand smoke exposure are associated with many of Ohio's most pressing health policy challenges, including infant mortality, rising Medicaid costs, and high rates of chronic diseases such as diabetes and cancer.

Ohio now lags behind most other states when it comes to adult smoking rates.

A decade ago Ohio was making significant progress in reducing smoking rates. Funded by the Master Settlement Agreement (MSA) with major tobacco companies, the Ohio Tobacco Use Prevention and Control Foundation helped 38,000 Ohioans quit smoking. In 2012, Ohio passed the comprehensive Smoke-Free Workplace Act, which created a ban on smoking in most workplaces. In 2013, Ohio's adult smoking rate declined to 24.2%, placing Ohio in the top quartile of states with the lowest declines in that period.

When the MSA was secularized and the Foundation was abolished in 2008, Ohio's investment in tobacco prevention and control dropped from a high of $4.8 million in 2008 to $3.2 million in 2011. (see trend graph on next page). As a result, the scope and intensity of prevention and cessation activities in Ohio was greatly diminished.

Ohio's implementation of evidence-based strategies
There is a strong body of evidence on what works to prevent tobacco use, help smokers quit, and reduce exposure to secondhand smoke (see box on next page). Ohio is currently employing many of these strategies but the scale and intensity of these activities in recent years appears to be inadequate.

Key facts
- Cigarette use by adults who smoke cigarettes and 21.9% of Ohio's adults smoked cigarettes in 2013.
- Ohio's adult smoking rate was below the national average of 21.1% in 2013.
- Ohio's smoking rate is lower than the national average.
- Ohio's smoking rate is lower than the national average.
- Ohio's smoking rate is lower than the national average.

To produce the desired results, Ohio's Quit Line, for example, achieves excellent quit rates, although Quit Line utilization is much lower than in other states and eligibility is limited. As a result, only a small number of Ohioans are able to take advantage of this effective service.

Ohio's strengths in implementing evidence-based strategies include:
- Highly comprehensive smoke-free workplace laws that includes restaurants, bars, and casinos.
- Medicaid cessation benefits that align well with evidence-based recommendations for cessation counseling and medications.
Improving population health planning in Ohio

Prepared by the Health Policy Institute of Ohio for the Ohio Governor’s Office of Health Transformation, Ohio Department of Health and Ohio Department of Medicaid

Jan. 11, 2016
Dashboard process and timeline
Systems and environments that affect health

- Healthcare system
- Access
- Social and economic environment

Public health and prevention
- equitable, effective and efficient systems
- Physical environment
- optimal environments

Improved population health
- Health behaviors
- Health equity
- Health status
- Mortality

IMPROVED HEALTH VALUE

Sustainable healthcare costs
- Public sector
- Private sector
- Consumers
What makes this dashboard different?

<table>
<thead>
<tr>
<th>Primary format</th>
<th>America’s Health Rankings</th>
<th>Commonwealth Scorecard</th>
<th>County Health Rankings</th>
<th>Kaiser State Health Facts</th>
<th>Gallup-Healthways Wellbeing Index</th>
<th>RWJF DataHub</th>
<th>Network of Care</th>
<th>HPiO</th>
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<tbody>
<tr>
<td>Population health</td>
<td>Interactive &amp; AI-a-glance</td>
<td>Interactive &amp; AI-a-glance</td>
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<td>Interactive</td>
<td>AI-a-glance</td>
<td>Interactive</td>
<td>Interactive</td>
<td>All-a-glance (Phase I)</td>
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<td>Healthcare costs</td>
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= adequately covered  = minimally covered  = not covered
What is the value added?

- Includes costs
- Comprehensive set of health determinants
- Concise at-a-glance format for policymaker audience
Health Value Dashboard logic model

**Dashboard key components**
- Data in context
- Value (health + cost)
- Health equity
- Comprehensive range of factors that impact health
- Accurate and credible
- Visual, compelling, relevant and easy to understand

**Short-term outcomes**
- Policymakers have a tool to track Ohio's progress in improving health value
- Policymakers are motivated to address Ohio’s challenges and factors within and beyond health care
- Public and private stakeholders have a uniform set of metrics and common understanding of health value

**Long-term outcomes**
- Policymakers make informed health policy decisions
- Public and private stakeholders implement effective strategies
- Improved population health outcomes
- Sustainable healthcare costs
2017 Dashboard timeline

Health Measurement Advisory Group and Dashboard workgroups

Finalize selection of 2017 Dashboard metrics

Data compilation

Develop trend and equity methodology

Layout and design

Dashboard release

Dissemination (webinars, presentations, trainings) (throughout 2017)
Dashboard workgroups

Health Measurement Advisory Group

Metric selection workgroups
1. Population health
2. Healthcare costs
3. Healthcare system
4. Public health and prevention
5. Access
6. Social, economic and physical environment

Additional workgroups
1. Equity
2. Methodology
3. Layout and messaging
Workgroup sign-ups

Health Measurement Advisory Group
Metric selection workgroups

Note: All metric selection workgroup meetings to be held remotely via GoTo Meeting.

Population health

<table>
<thead>
<tr>
<th>Staff lead: Amy Bush Stevens</th>
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</table>
| astevens@healthpolicyohio.org

<table>
<thead>
<tr>
<th>Member Name</th>
<th>Organization</th>
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<tbody>
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<td>12.</td>
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</tbody>
</table>

Healthcare costs

<table>
<thead>
<tr>
<th>Staff lead: Reem Aly</th>
</tr>
</thead>
</table>
| raly@healthpolicyohio.org

<table>
<thead>
<tr>
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<td>1.</td>
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<td>5.</td>
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</table>

Meeting dates:
- Friday, March 11, 10:00-11:30 am
- Monday, April 4, 10:00-11:30 am

Meeting dates:
- Tuesday, April 5, 9:00-10:30 pm
- Tuesday, April 19, 9:00-10:30 pm
Metric review process
### How is Ohio doing?

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Overall</td>
<td>47</td>
<td>39</td>
<td>33</td>
<td>47</td>
</tr>
<tr>
<td>Health outcomes domains*</td>
<td>40</td>
<td>41</td>
<td>41</td>
<td>40</td>
</tr>
</tbody>
</table>

*Similar to HPIO Dashboard Population Health domain: (“Health outcomes” for AHR; “Healthy Lives” for Commonwealth; “Physical” for Gallup)
Ohio’s rank in America’s Health Rankings from 1990 to 2015

Ohio rank in Gallup Healthways Wellbeing Index

Percent of families living in poverty

13.5% U.S.
12.4% Ohio

KEY
- Ohio ranks in the top quartile
- Ohio ranks in the second quartile
- Ohio ranks in the third quartile
- Ohio ranks in the bottom quartile

New metric lists to consider

- National Health Equity Index
- Vital Signs: Core Metrics for Health and Health Care Progress (Institute of Medicine)
- Robert Wood Johnson Foundation Culture of Health Action Framework
- The State of Mental Health in America
- Commonwealth Fund Quality-Spending Interactive
- Ohio patient-centered medical home (PCMH) quality measures
- Improving population health planning in Ohio report
Revisiting the “bike rack”
Revisiting the “wish list”
Decision criteria for updating metrics

Rigor
Relevance
Reality

Consistency across editions = comparisons over time
Suggestions for improving effectiveness of the Dashboard
Ideas for 2017 edition

- Evidence-based strategies
- Equity
- Change over time, post-ACA implementation
- In-depth look at cost
- Impact projections
- National advisors
- Follow-up on tobacco, food insecurity, behavioral health access
Discussion questions

1. What are the **key changes in the overall health value landscape** that we should keep in mind as we plan for the next edition of the Dashboard?

2. What **suggestions do you have for improving the layout, messaging and dissemination** of the Dashboard? Which of these are most important?

3. What **other suggestions** do you have for improving the effectiveness of the Dashboard? Which of these are most important?
Health Value Dashboard logic model

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- Sustainable healthcare costs
Next steps
Health Measurement Advisory Group

February 11, 2016 meeting materials

- Pre-meeting materials
- More material, including notes, will be posted after the meeting

2014 Health Value Dashboard