Welcome and introductions
Amy Rohling McGee welcomed the group, reviewed the Health Value Dashboard conceptual framework and shared the meeting objectives:

- **Objective 1.** HPIO will update the group on Health Value Dashboard activities and impact from Dec. 2014-Jan. 2016.
- **Objective 2.** Participants will be aware of the timeline, process and workgroups for the 2017 Dashboard.
- **Objective 3.** The group will reach consensus on the criteria and process for reviewing and finalizing metrics for inclusion in 2017 Dashboard.
- **Objective 4.** The group will generate ideas for improving the effectiveness of the 2017 Dashboard.

2014 Dashboard activities and impact
Amy Bush Stevens reviewed 2014-2015 Dashboard dissemination activities, impact and feedback from stakeholders. The 2014 Dashboard was extremely popular with HPIO stakeholders, many of whom reported using it to identify priorities for their organization or community or to influence the policymaking process.

Dashboard process and timeline
Reem Aly reviewed the logic model, process and timeline for developing the 2017 Dashboard. Aly discussed the following timeline:

- Finalize selection of the 2017 Dashboard metrics (Feb. to April 2016)
- Data compilation (May-Aug. 2016)
- Develop trend and equity methodology (May-Aug. 2016)
- Dashboard layout and design (Sept. - Dec. 2016)
- Dashboard release (Jan. 2016)
- Dissemination activities (webinars, presentations, trainings) (throughout 2017)

Participants were invited to sign up for metric selection workgroups aligning with the seven Dashboard domains. Several other workgroups (equity, methodology and layout and design) will be convened throughout 2016.

Aly also noted that HPIO will explore other entities to contract with for compilation of and ranking the 2017 Dashboard data (due to staffing changes at the University of Cincinnati Economics Center).

Participant suggestions for additional HMAG members: Ohio Department of Insurance; health insurers (note: several health insurance representatives are participating, but were not able to attend this meeting).

Metric review process
Stevens discussed the changing “metric landscape” and reviewed trends in Ohio’s rank over time by America’s Health Rankings, Commonwealth State Scorecard and Gallup Healthways Wellbeing Index. Ohio’s rank on the Health Value Dashboard is consistent with these other national rankings.

Stevens shared new metric sources that have emerged in 2014-2015 and asked the group for additional sources. The National Equity Atlas (Policy Link) was suggested.

Stevens reminded the group that we developed “bike rack” and “wish list” lists of metrics that did not make it into the 2014 Dashboard. We will revisit these lists this year. Groux suggested that HPIO should post the bike rack list and wish list and advocate for availability of needed data.

The group discussed considerations for the next edition of the Dashboard, including the following comments:

- Wymyslo: Need to remember that we might be getting better (in terms of the actual data values), but our rank may not get better over time. Our rank is relative to other states, so if other states are doing a lot better, it will affect our ranking. Need to contextualize this.
- Stevens: We don’t want to over emphasize the change in rank, as opposed to the change in the actual data value over time.
- Orcena: Don’t back off of ranking, though, because what matters is whether we’re getting better on the health value composite rank (meaning other states are getting better value)
- Hamilton: What is unique to Ohio that is causing us to have such consistently poor rankings? We need to address this.
- Shalala: Consider adding data on progress toward greater transparency and/or % of payments linked to value, such as from Catalyst for Payment Reform (CPR) related measures; Add/improve cost metrics (although some may be “unicorns”)
- Curry: Include PCMH related cost data
- Criss: In looking at cost, some services are paid for with grants in behavioral health and wouldn’t show up in total cost of care from payers; also with HDHP, people are paying more out of pocket
- Weaver: It would be useful to know “What is the estimated cost of moving up 1-point?” (e.g., how much would it cost to improve our infant mortality rate by X percent?)
- Cook: we are going to have to weigh criteria also taking into consideration the desire to track trend over time

Stevens led the group through a review of the draft decision criteria for updating the metrics. The Dashboard is intended to assess progress toward improved health value in Ohio over time. For this reason, metrics included in the Dashboard should be as consistent as possible across editions. We will use the criteria (provided in the pre-meeting packet and at the meeting) to consider any changes that may need to be made to the list of metrics. We will not
increase the total number of metrics (any new metrics will need to replace existing metrics).

**Rigor**
No changes

**Relevance**
- Chubinski: Suggested adding new criteria to: *New evidence: Consider replacing a metric if new evidence has become available about a factor that influences health.* (e.g., adding a metric for fruit and vegetable consumption)
- Hollingshead: Achieving alignment with other metrics (such as HEDIS) of the actors that we want to influence is important; we need to speak the same language as the people we want to change

**Reality**
- Ingram: Recommended a 12/15 New York Times article regarding HCCI institute data; this data is surprising because it calls into question our understanding of what drive healthcare costs; [http://www.healthcostinstitute.org/](http://www.healthcostinstitute.org/)
- Orcena: Consider of the availability of cost data in relation to related metrics in other domains. For example, include data on the cost of senior falls, which is a metric in the Prevention and Public Health Domain
- Wapner: Consider including spending outside of healthcare (i.e. education); are there ratios of spending in different areas we should look at?
- Aly: We will explore availability of data on spending in non-health sectors, such as data used by Elizabeth Bradley and Lauren Taylor data; if available we could consider adding to Dashboard
- Mayhoor: We need to explore how do we can find better oral health data
- Ingram: Ohio Hospital Association has data on number of ED visits due to dental care; we should explore availability of this data
- Shalala: Noted that there are several data transparency tools available from which cost data could be provided, such as the Health Care Cost Institute site Guroo, however cautioned that often these were industry-driven tools. Cited Maine as having a good healthcare cost data transparency site.

**Suggestions for improving effectiveness of the Dashboard**
Aly reviewed ideas HPIO is currently considering to enhance the Dashboard:
- Greater focus on evidence-based strategies
- Greater focus on equity
- Greater focus on change over time and post-ACA implementation
- In-depth look at cost
- Impact projections
- National advisors
- Follow-up on tobacco, food insecurity, behavioral health access

Several participants suggested national advisors to consider:
Francois DeBrantes; HCI3
Curry: Mark Fenrick; Consumers Union
Orcena: Patrick Bumett (FL); J P Meter (Johns Hopkins)
Wymslo: NACCHO, ASTHO-interested in partnering
Wang: Network for Regional Healthcare Improvement (suggested metrics for national dashboard) (Shalala and Wymslo agreed)

Mayhoor asked, what do we mean by “health equity”? HPIO uses the following definition: The absence of differences in health that are caused by social and economic factors. Achieving health equity means that all people have the opportunity to achieve their full health potential, with no one at a disadvantage because of social or economic circumstances. Aly noted that the health equity workgroup will advise on how to translate the definition of health equity into the messaging and layout of the Dashboard.

Aly led the group discussion around ways to improve the effectiveness of the Dashboard.

Discussion Question #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?

- Curry: affordability is a big issue in health plans; simply having coverage isn’t enough
- Aly noted that we may need some measures related to marketplace
- Orcena: growing consensus on core set of public health services; replicate metrics from NACCHO
- Pack: Rx costs are driving overall costs; may be a change from the last iteration (although probably impacting all states consistently)
- Wymslo: Burwell’s comments about paying for value are new goals; changing payment arrangements
- Ingram: Is anyone measuring health literacy in a way that could be used in the Dashboard? Mulvin suggested looking to AHRQ for this and Mayhoor suggested looking at patient/family advisory councils.
- Young: Look at what’s happening in local communities
- Gilligan: When looking at trend data, its import to explain context, especially in light of policy changes, such as timing of ACA implementation and expanded Medicaid eligibility.
- Mitchell: Somehow measuring engagement in community-based programs, such as connections to community-based organizations through the Accountable Health Community model
- Gilligan: Be sure to maintain/highlight issues where there has been emphasis in the state, such as infant mortality and opiates.
- Aly: HPIO would like to develop a “POOTL” tool for tracking policy changes for specific high-priority topics (Policy Output and Outcome Tracking Log)
• Wymslo: In Ohio, we are missing a “culture of health”; we don’t have health education; what are the states that are doing better doing and how can we do this more systematically?

Discussion Question #2: What suggestions do you have for improving the layout, messaging and dissemination of the Dashboard?

• Wapner: Weighting the domains or subdomains tells people that something is more important
• Groux: Cautioned that it is difficult to explain weighting methodology to many audiences
• McGee: Mentioned that Chubinski expressed concerned about indices
• Wapner: Weight upstream over downstream; now food insecurity is weighted the same as A1C
• Orcena: Maybe consider additional analysis post-release of Dashboard
• Aly: We could look at additional correlations with high value rank
• Mitchell: Be more attentive to variety of stakeholder audiences
• Shalala: Need an interactive component and brief, smaller chunks; more tweets; appeal to legislative aides, who tend to be younger
• Hamilton: Can take the smaller pieces from the static document
• Reed: Overwhelming, too much detail provided even in the overview, can be difficult to identify the key messages of the Dashboard
• Chubinski: Engage an external graphic designer to help us tell the story; for each page decide, “What story do we want to tell?”; would rather have a 40-page report that is laid out in a way that works for everyone, rather than something shorter that is confusing
• Hollingshead: Create a porta with links to other publications
• Pack: remember to keep in mind the audience (policymakers) and maintain consistency
• Wapner: More work focused on states that are “like us”
• Stevens: For example, in the tobacco policy brief, rather than just look at states that do better than Ohio on tobacco use (such as Utah, which is not much like Ohio), we highlighted states that used to look like Ohio, but made dramatic improvements over time (such as New York).
• Orcena: Caution—don’t tell too much of a story because that may turn some off because they will think that we’re steering in a particular direction; current Dashboard does accomplish the goals we laid out in the beginning by being objective
• Curry: Keeps finding herself looking for the front page of the 4-pager; maybe a sentence of introduction that explains what it is, orient the reader to navigate the 4-page document
• Ingram: We should survey the audience that we’re wanting to reach
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