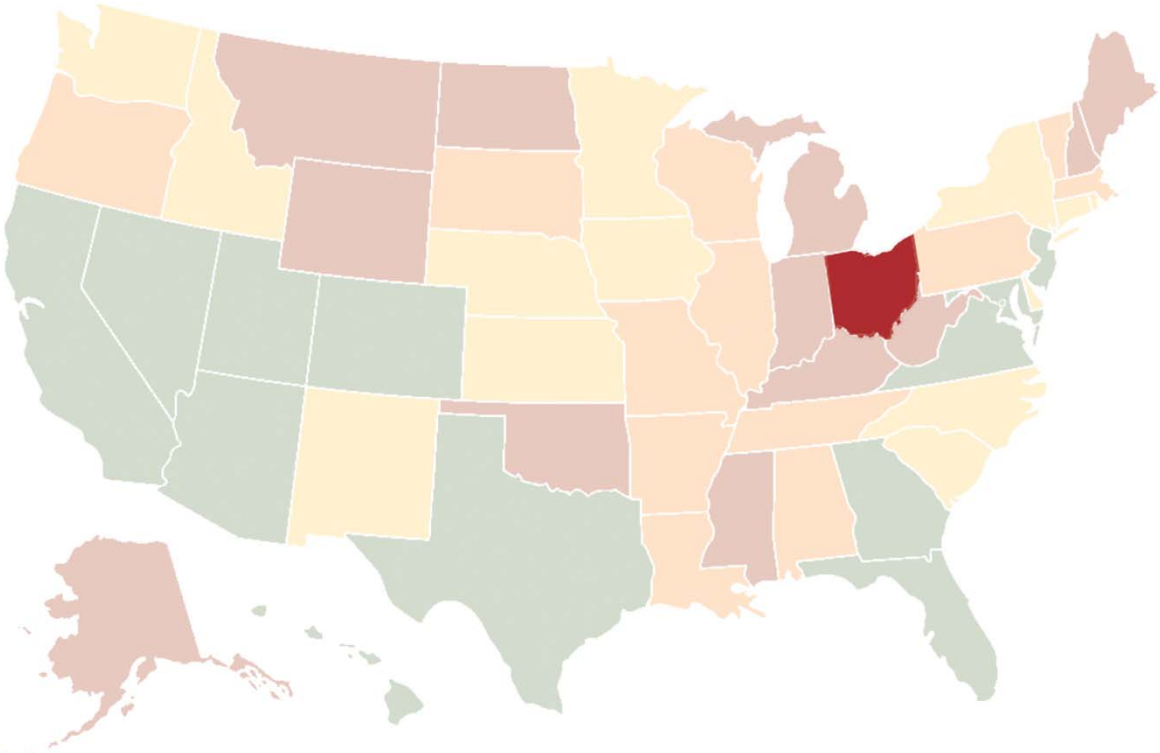
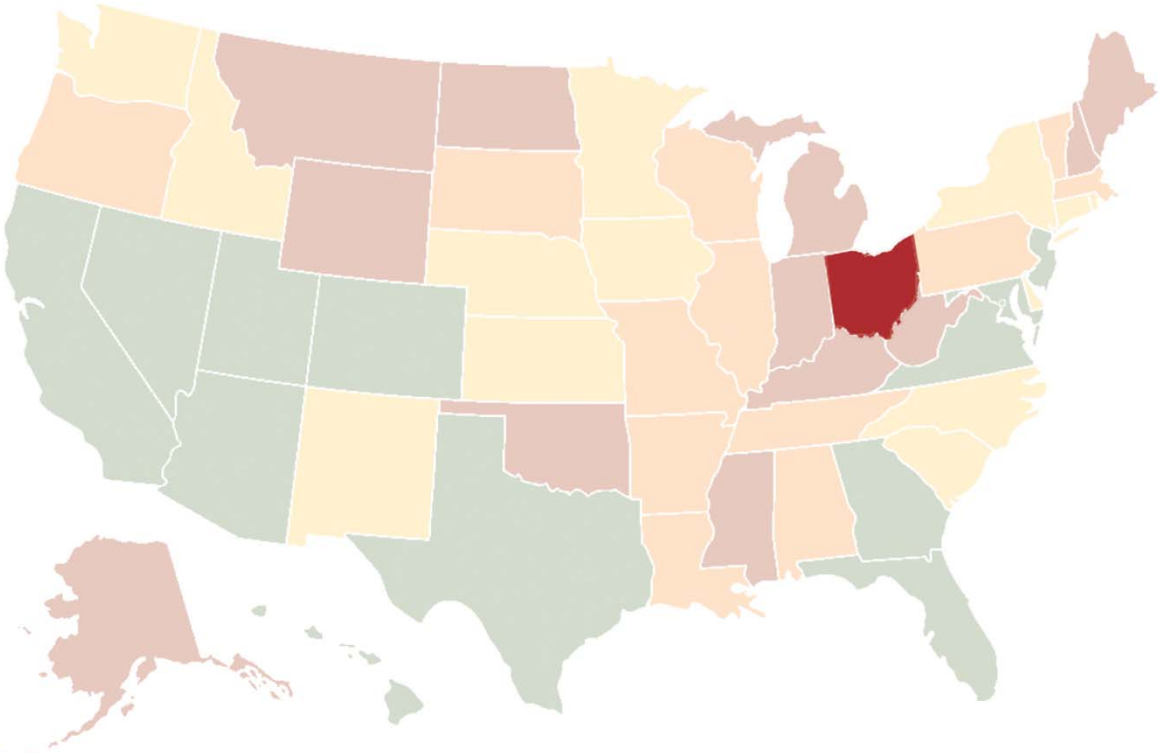


2017 Health Value™ Dashboard

Amy Bush Stevens
Vice President, Prevention and Public Health Policy

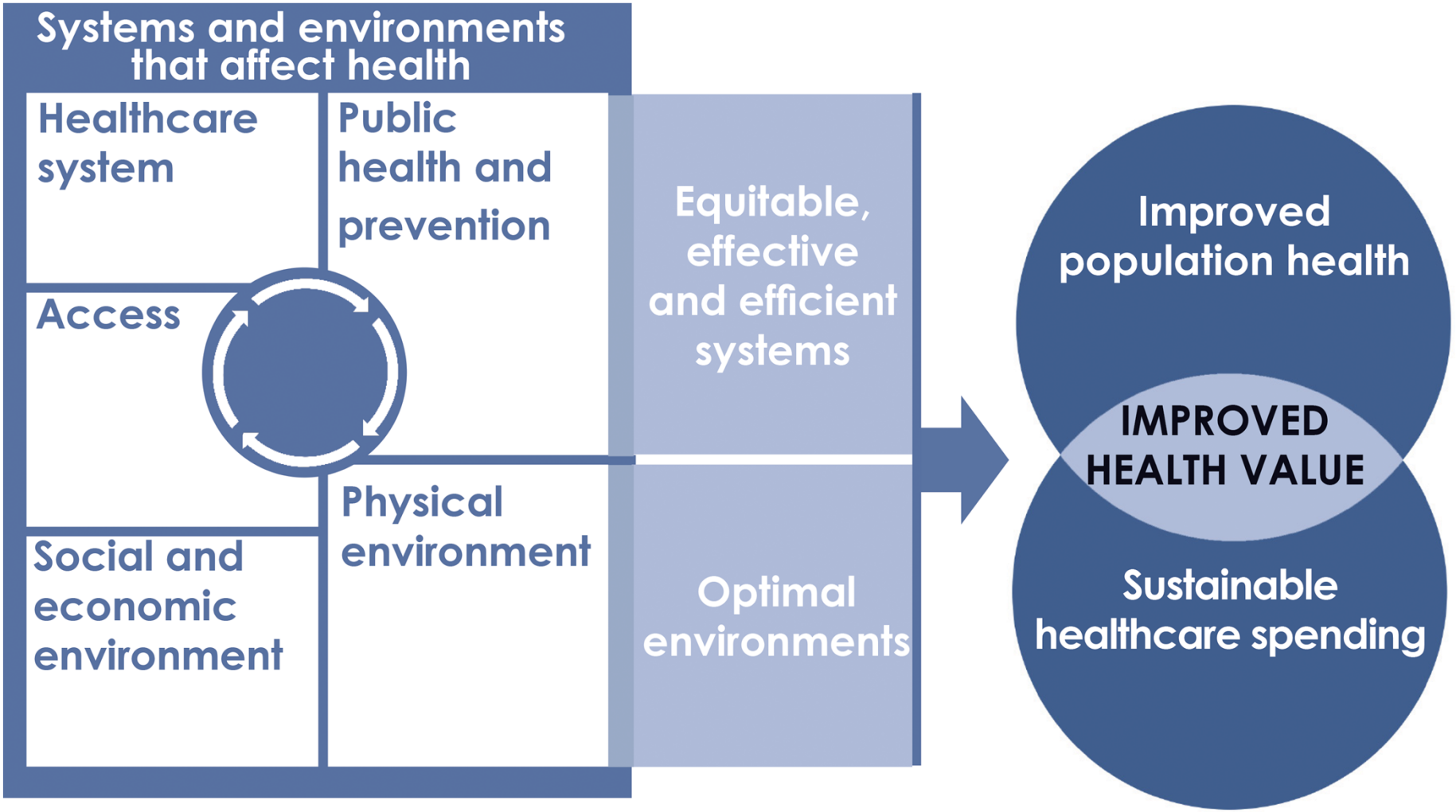
Reem Aly
Vice President, Healthcare System and Innovation Policy

Please type questions in the question box



2017 Health Value™ Dashboard

Pathway to improved health value:
A conceptual framework



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

Data in context

	Examples
Rankings	
Progress and trends	**Greatly improved**
Highlighting other states	**Most improved state(s)** TN, NV, LA
Disparities and inequities	Little to no disparity Medium disparity Large disparity


omparison on health value

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."*

Annual Stakeholder Survey quotes

*"The 2014 Dashboard continues to be the **go-to document that is shaping policy** within many state level meetings."*

Annual Stakeholder Survey quotes

*"HPIO's dashboard is recognized on a **bi-partisan basis** as setting benchmarks for Ohio's performance on quality indicators."*

Collaboration

Rigor

Alignment

Thank you

Local health commissioners	Ohio Department of Health	Ohio Department of Mental Health and Addiction Services	Philanthropy
Education and early childhood	Regional health initiatives	Provider associations	Employer associations
Ohio Hospital Association	Consumer advocacy	Managed care plans	Ohio Department of Medicaid
Academia	Ohio Commission on Minority Health	Ohio Association of Health Plans	Community-based organizations

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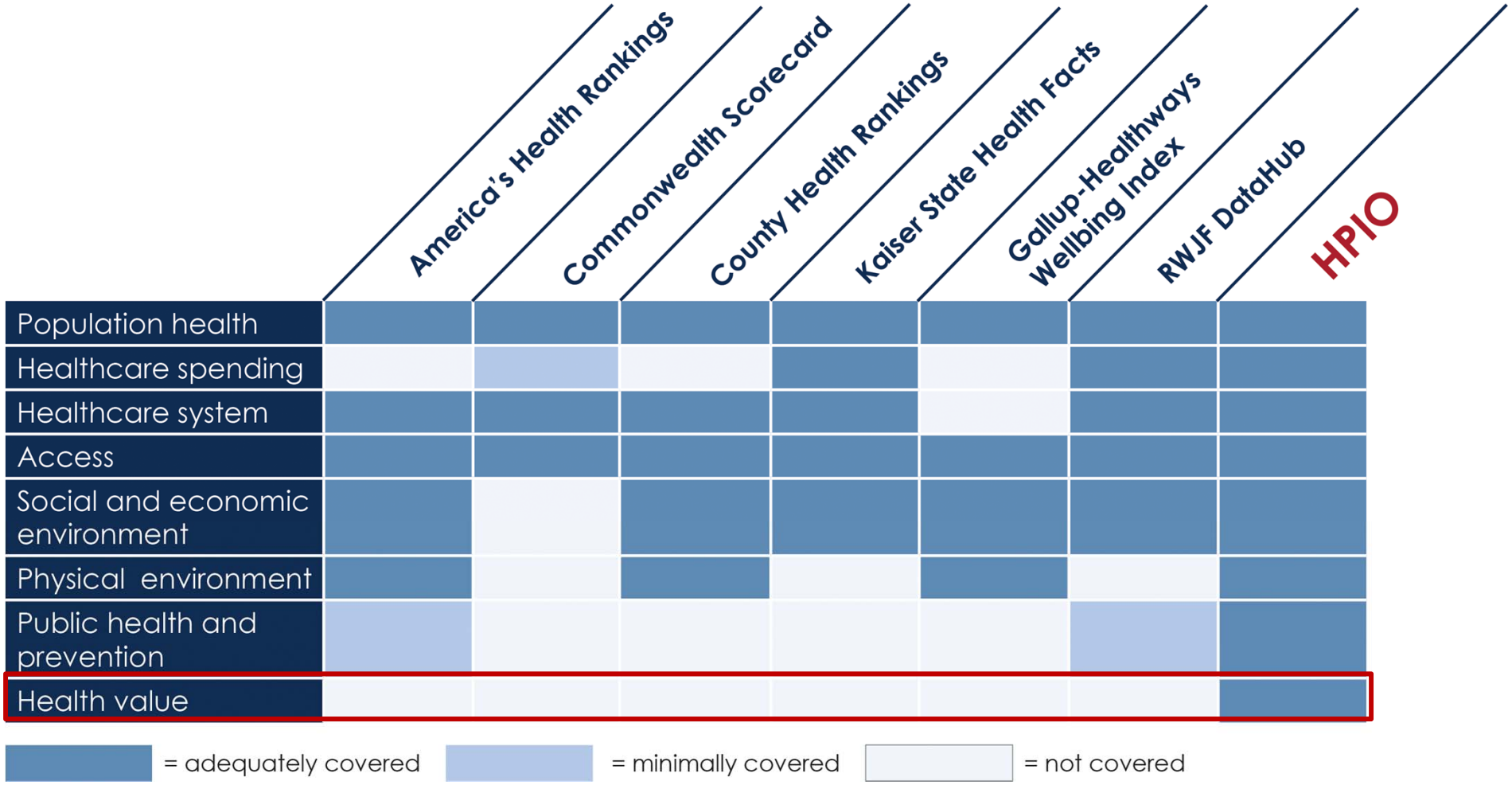


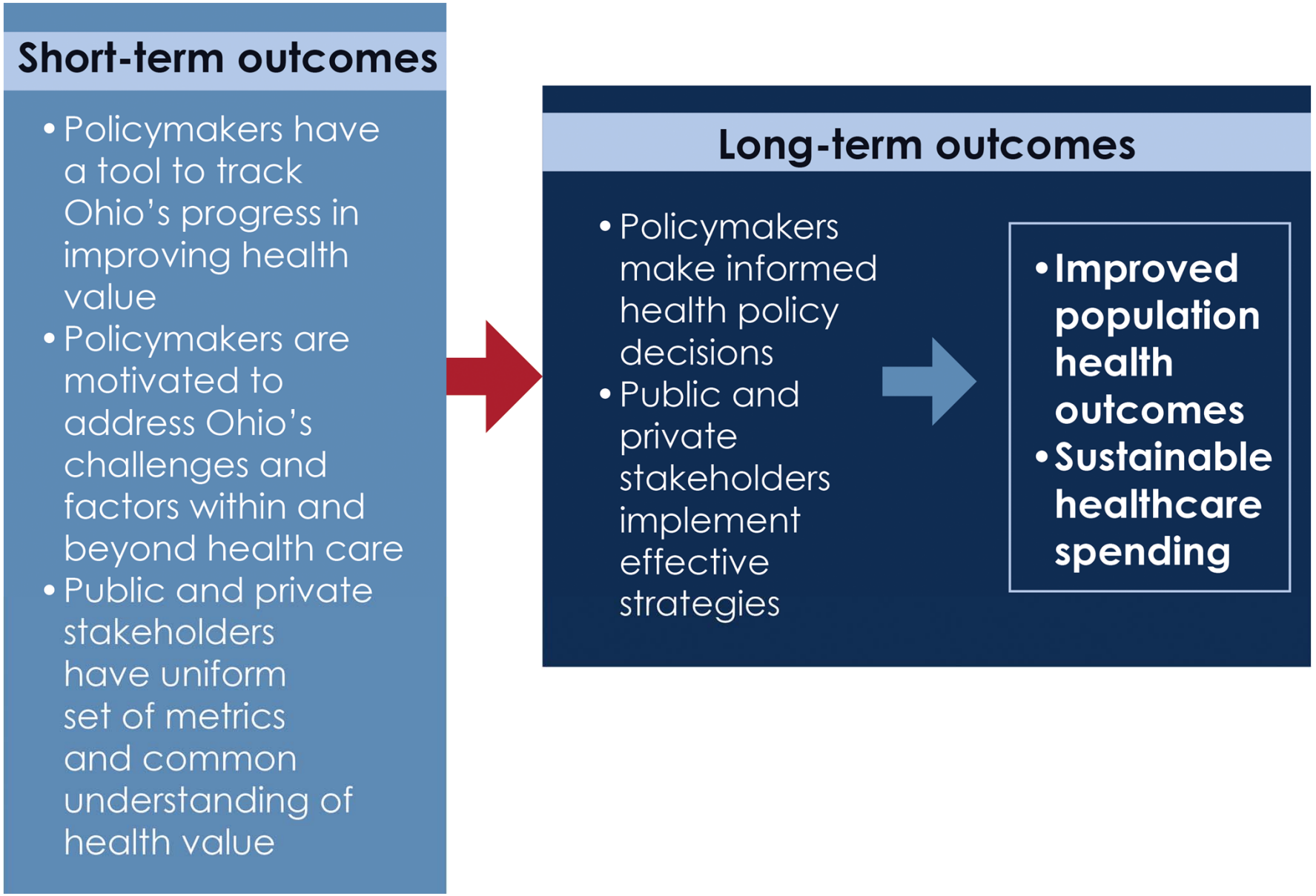
What makes this different?

- ✓Includes spending
- ✓Comprehensive set of health determinants
- ✓Concise at-a-glance format for policymaker audience

What's new in the 2017 Dashboard?

- Trend
- Disparities and inequities
- Improved ranking methodology
- Updated metrics
- Guide to Improving Health Value

Health Value Dashboard logic model



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2017 Health Value Dashboard

What is the Health Value Dashboard?

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

46

Where does Ohio rank?

Ohio ranks 46 out of 50 states and the District of Columbia (D.C.) on health value, landing in the bottom quartile. This means that Ohioans are living less healthy lives and we spend more on health care than people in most other states.

Downloads

- **Full dashboard with methodology and appendix**
- **2 page exec summary**
- **8 page overview**
- **Trend component**
- **Equity component**
- **Frequently Asked Questions (FAQ) about the Dashboard**

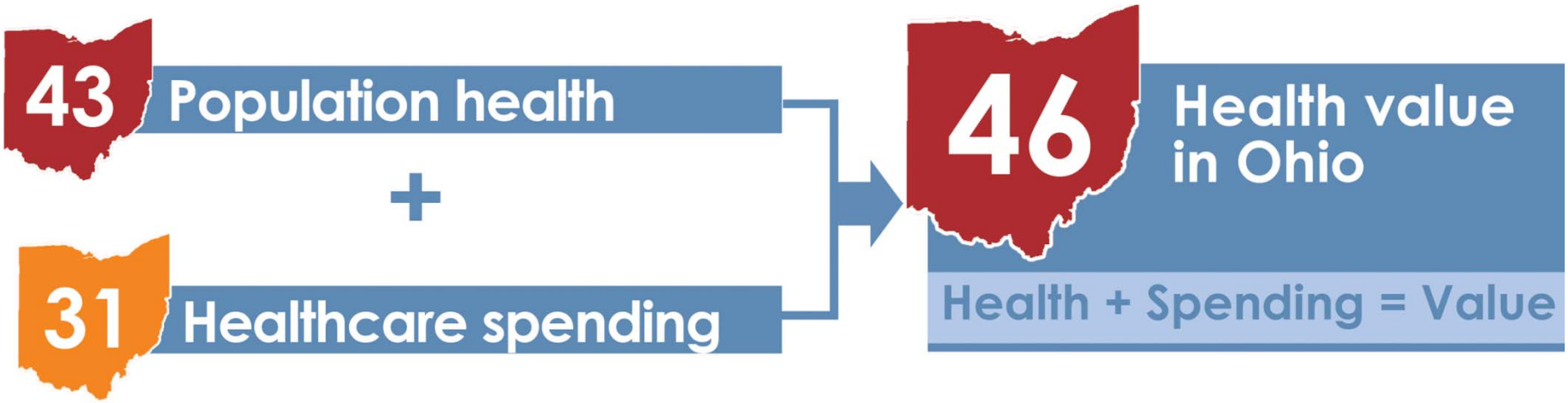
Guide to improving health value

This **HPIO resource page** includes:

- State policy option fact sheets on tobacco use, food insecurity and Ohio's other top health challenges
- Additional resources for evidence-based policymaking, including cost-effectiveness research
- Tools for local community health improvement planners

How does Ohio do?

Where does Ohio rank?



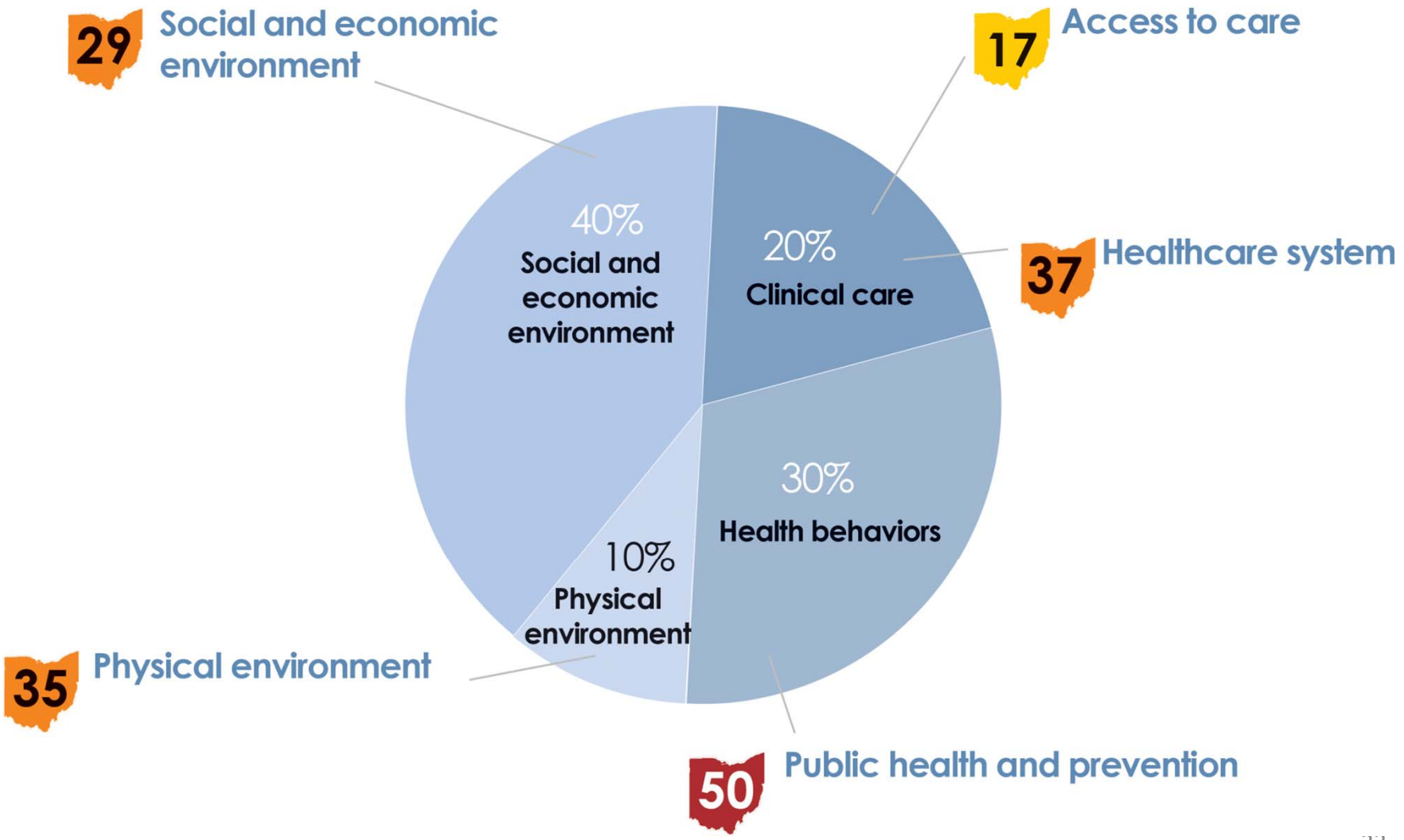
Where does Ohio rank?

Ohio's rank	America's Health Rankings, 2016 edition	Commonwealth State Scorecard, 2017 edition	Gallup-Healthways Wellbeing Index, 2016	HPIO 2017 Health Value Dashboard
Overall	40	32	45	46
Rank for health outcomes*	40	38	42	43

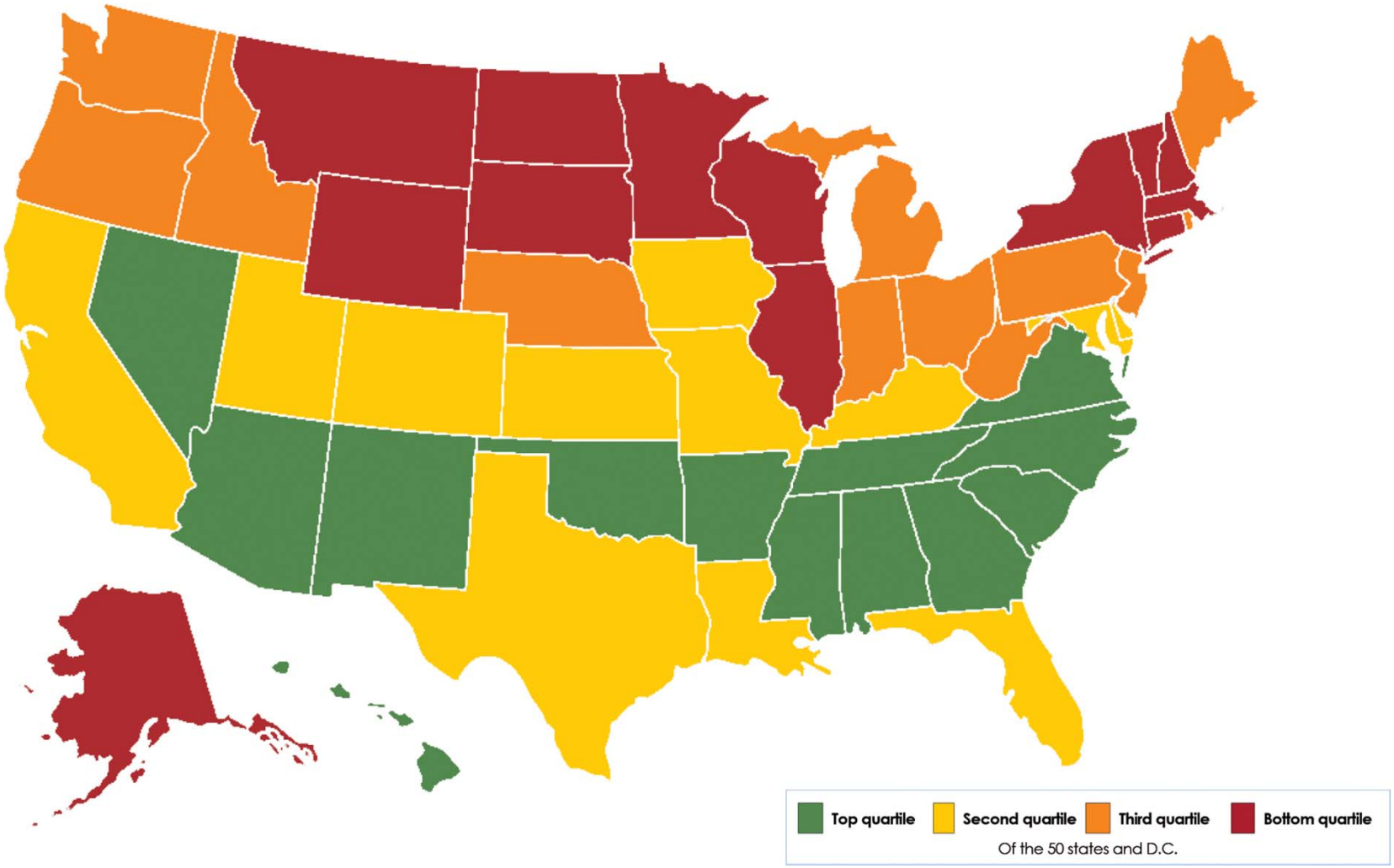
*Rank for specific domains: America's Health Rankings: Health Outcomes; Commonwealth: Healthy Lives; Gallup: Physical; HPIO Health Value Dashboard: Population Health; Annie E. Casey Foundation: Health

Why does Ohio rank so poorly?

Ohio performs poorly on many of the factors that impact health value

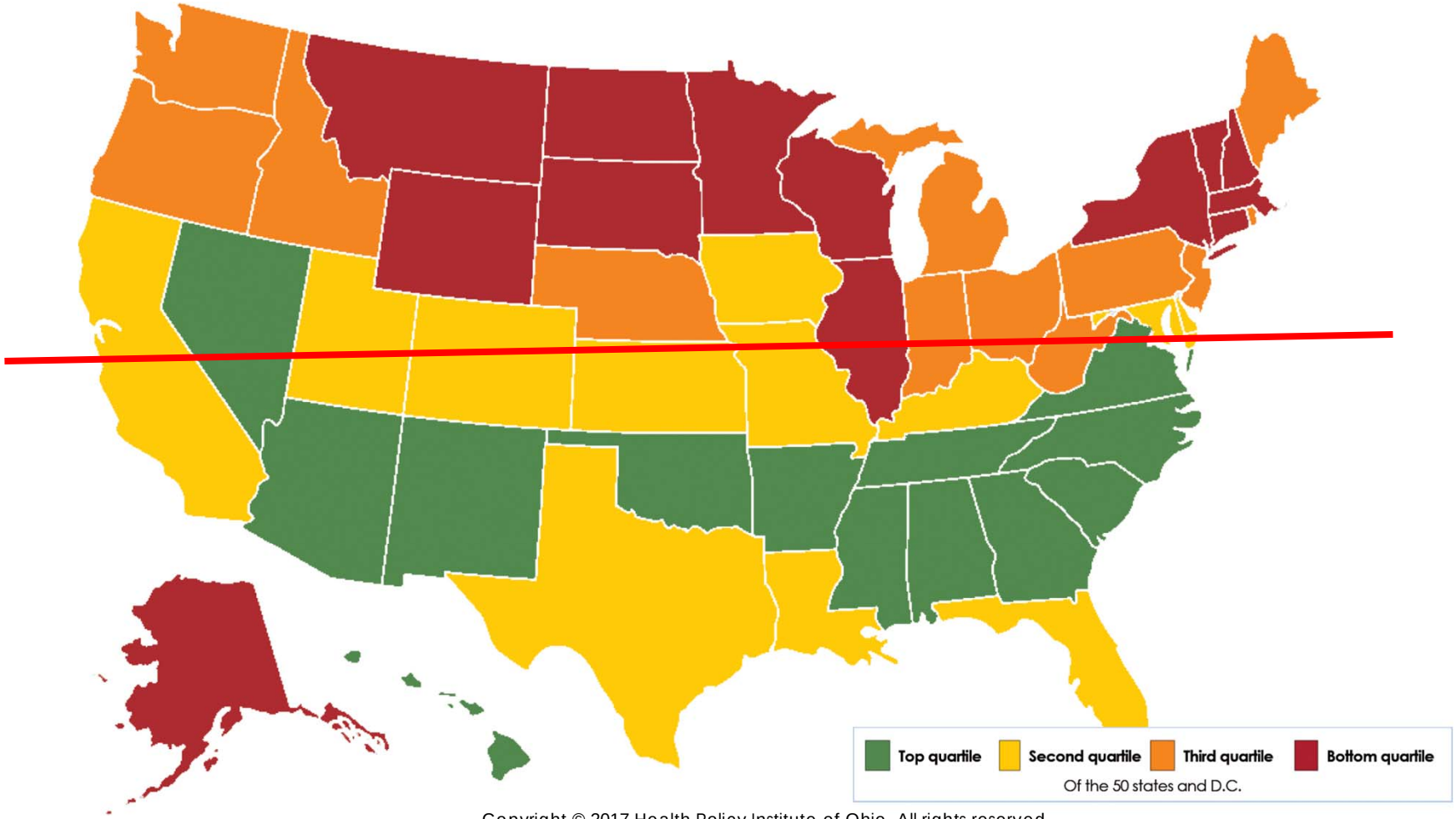


Where do other states rank on healthcare spending?

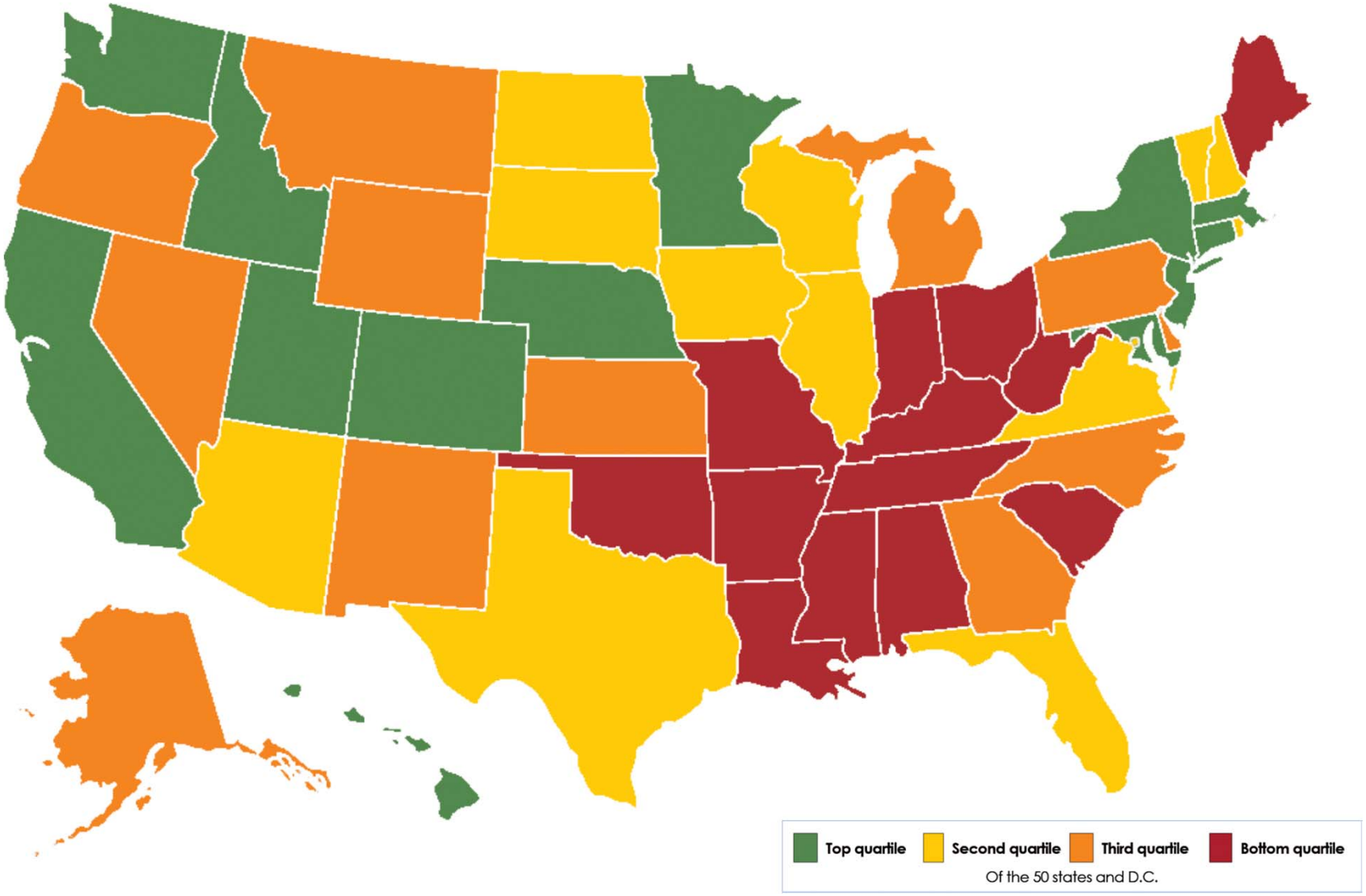


Where do other states rank on healthcare spending?

States in the north tend to have higher healthcare spending, while states in the south have lower healthcare spending

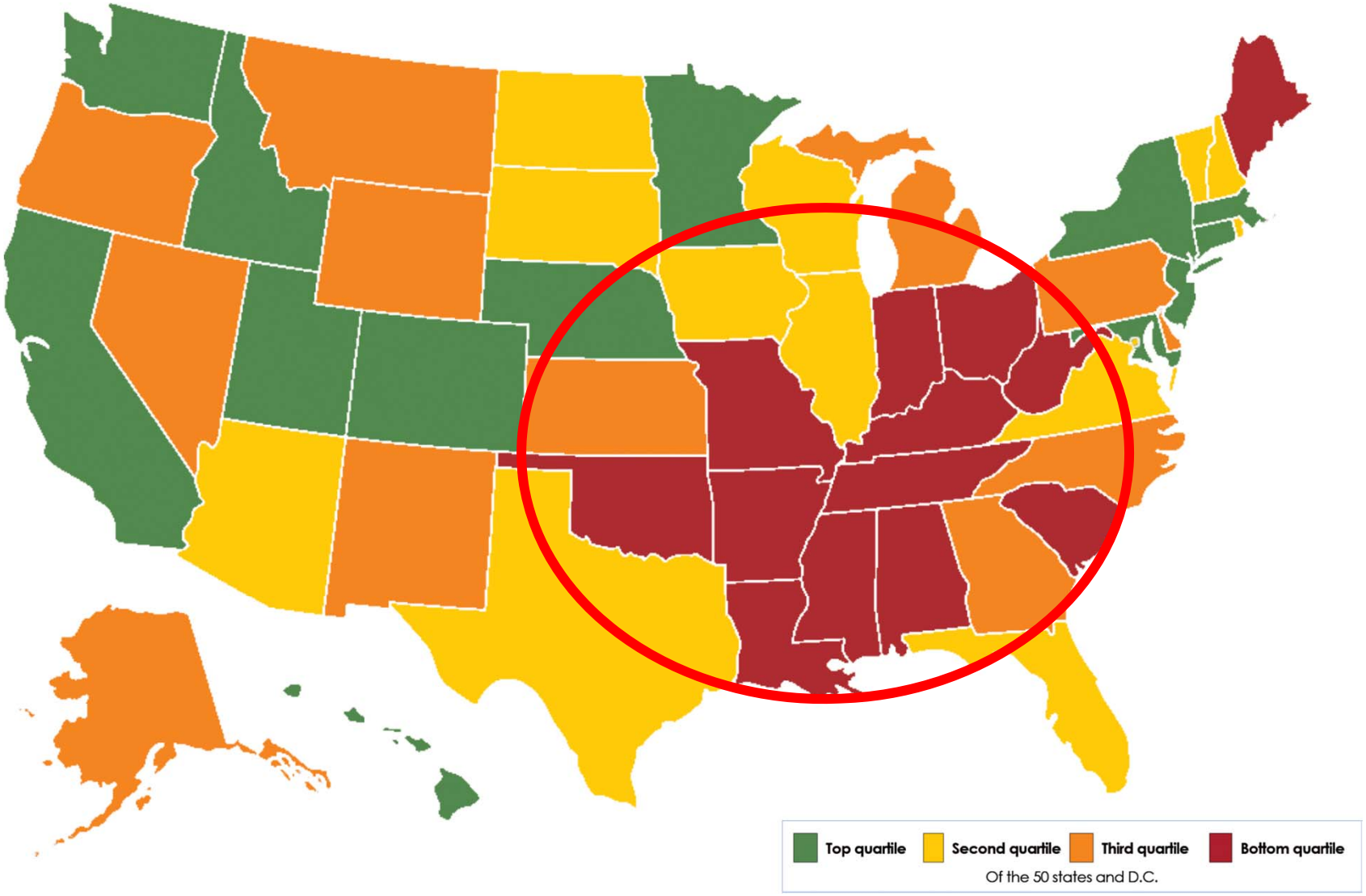


Where do other states rank on population health?

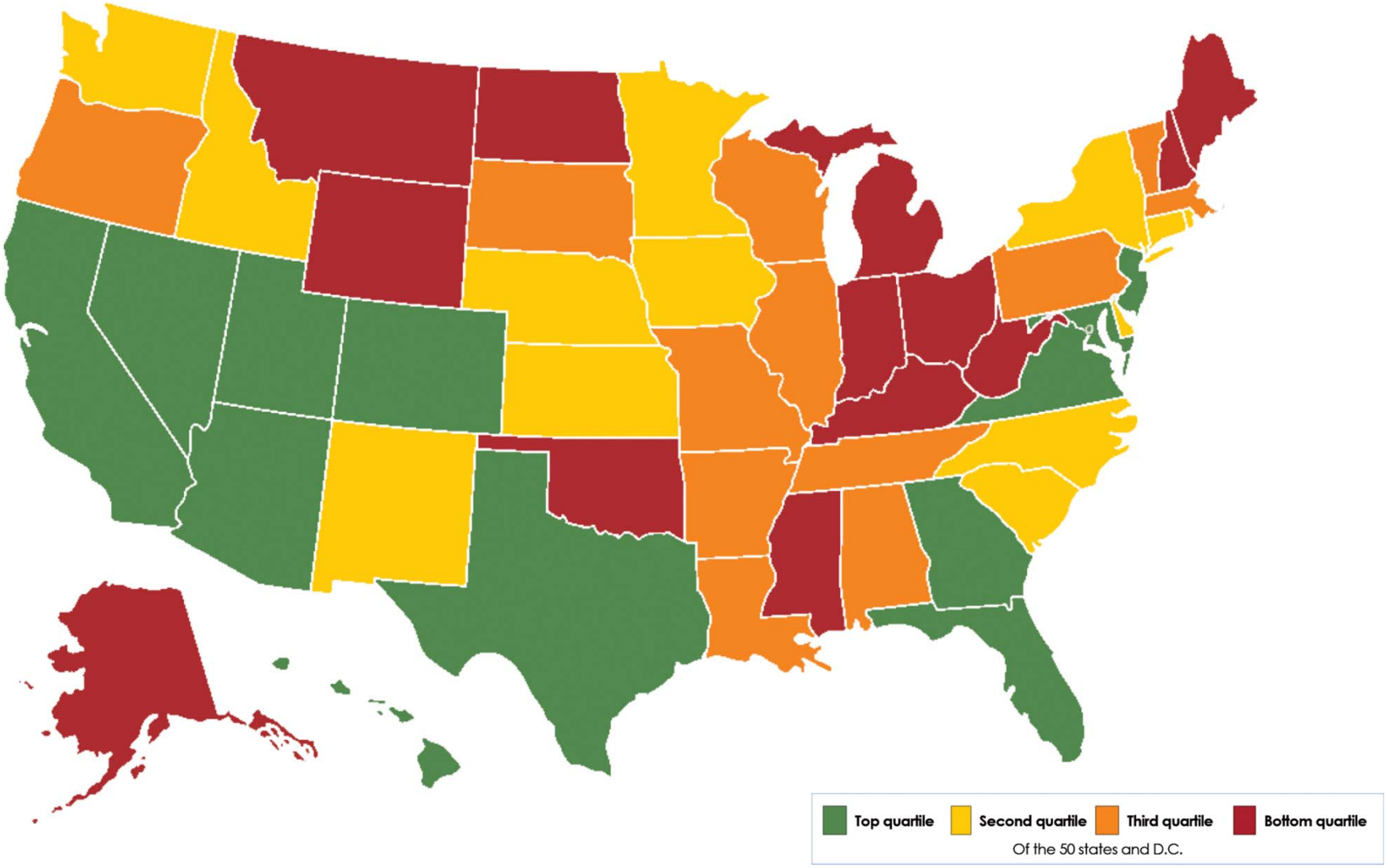


Where do other states rank on population health?

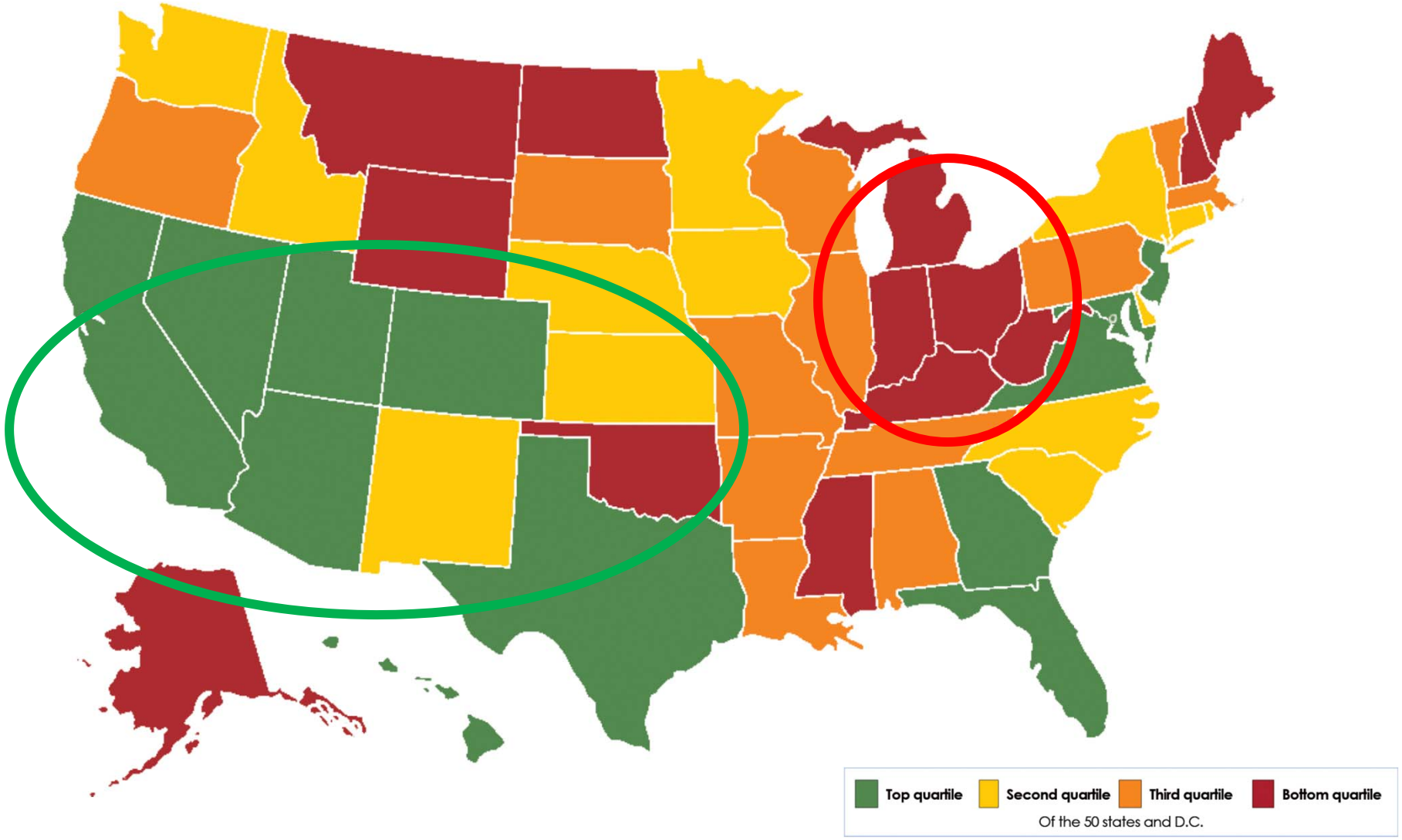
The Appalachian region and parts of the South tend to have the worst population health outcomes



Where do other states rank on health value?



Where do other states rank on health value? There is wider geographic variation in health value rank



What is the path to health value?

There are many paths to health value and it is possible for Ohio to improve

Healthcare spending	Population health: Best health (Top 2 quartiles)	Population health: Worst health (Bottom 2 quartiles)
Lowest spending (Top 2 quartiles)	Arizona, California, Colorado, District of Columbia, Florida, Hawaii, Iowa, Maryland, Texas, Utah, Virginia	Alabama, Arkansas, Delaware, Georgia, Kansas, **Kentucky**, Louisiana, Mississippi, Missouri, New Mexico, Nevada, North Carolina, Oklahoma, South Carolina, Tennessee
Highest spending (Bottom 2 quartiles)	Connecticut, Idaho, **Illinois**, Massachusetts, **Minnesota**, Nebraska, New Hampshire, New Jersey, New York, North Dakota, Rhode Island, South Dakota, Vermont, Washington, **Wisconsin**	Alaska, **Indiana**, Maine, **Michigan**, Montana, **Ohio**, Oregon, **Pennsylvania**, **West Virginia**, Wyoming

Note: Midwestern (Department of Health and Human Services Region V) and neighboring states are **bolded**.

Key findings: Challenges

Ohio's greatest health value challenges

Bottom quartile metrics

Domain	Metric	Ohio's rank	Trend
Population health	**Infant mortality.** Number of infant deaths per 1,000 live births (within 1 year) (rank-2014, trend-2015)	39	Moderately worsened
	Cardiovascular disease mortality. Number of deaths due to all cardiovascular diseases, including heart disease and strokes, per 100,000 population (age adjusted) (2015)	40	No change
	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) (2014)	41	No change
	Adult smoking. Percent of population age 18 and older that are current smokers (2015)	43	Moderately improved
Healthcare spending	**Drug overdose deaths.** Number of deaths due to drug overdoses per 100,000 population (age-adjusted) (2015)	49	Greatly worsened
	Average monthly marketplace premiums, after advanced premium tax credit. Average monthly premium for all enrollees in the federal marketplace after application of an advanced premium tax credit (2016)	38 (out of 38)	Greatly increased
	Total Medicare spending (Parts A and B), per Medicare enrollee. Price, age, sex and race-adjusted Medicare reimbursements per Medicare enrollee (Parts A and B) (2012)	46	No change
Healthcare system	**Hospital admissions for asthma per 100,000 population, ages 2-17.** Admissions for asthma per 100,000 population, ages 2-17 (2013)	31 (out of 41)	No change
	Mortality amenable to healthcare. Number of deaths before age 75 per 100,000 population that resulted from causes considered at least partially treatable or preventable with timely and appropriate medical care (2012-2013)	39	No change
	Cancer early stage diagnosis, female breast cancer cases. Percent of female breast cancer cases diagnosed at an early stage (2009-2013)	40 (out of 50)	No change
	Diabetes with long-term complications. Admissions for Medicare beneficiaries with a principal diagnosis of diabetes with long-term complications per 100,000 beneficiaries, ages 18 years and older (2014)	41	No change
	Cancer early stage diagnosis, colon and rectal cancer cases. Percent of colon and rectal cancer cases diagnosed at an early stage (2009-2013)	41 (out of 50)	No change
	Avoidable emergency department visits for Medicare beneficiaries. Potentially avoidable emergency department visits among Medicare beneficiaries, per 1,000 beneficiaries (2013)	45	No change
Public health and prevention	**Cancer early stage diagnosis, all.** Percent of all cancer cases diagnosed at an early stage (2009-2013)	46 (out of 50)	No change
	State public health workforce. Number of state public health agency staff FTEs per 100,000 population (2012)	44 (out of 49)	No change
	Emergency preparedness funding. Total per capita funding for state and local health departments' emergency preparedness (2016)	44	N/A
	Child immunization. Percent of children ages 19 to 35 months who received all recommended vaccines (2013)	48 (out of 50)	Greatly worsened
	Foodborne illness monitoring. Proportion of foodborne illness outbreaks for which an etiologic agent is confirmed (2015)	50	Moderately worsened
Physical environment	**Outdoor air quality.** Average exposure of the general public to particulate matter of 2.5 microns or less in size (PM2.5) (2012-2014)	45	Moderately improved
	Food insecurity. Percent of households with limited or uncertain access to adequate food (2013-2015)	45	No change
	Children exposed to secondhand smoke. Percent of children who live in a home where someone uses tobacco or smokes inside the home (2011/2012)	49	Greatly improved

Other metrics that worsened

Domain	Metric	Ohio's rank	Trend
Population health	**Adult insufficient physical activity.** Percent of adults 18 years and older not meeting physical activity guidelines for muscle strength and aerobic activity (2015)	30	Moderately worsened
	Poor oral health. Percent of adults who have lost teeth due to decay, infection or disease (2014)	38	Moderately worsened
Healthcare spending	**Average family premium, per enrolled employee.** Average total family premium per enrolled employee for employer-sponsored health insurance (2015)	21	Moderately increased
	Average single premium, per enrolled employee. Average total single premium per enrolled employee for employer-sponsored health insurance (2015)	31	Moderately increased
Access to care	**Medical home, children.** Percent of children who have a personal doctor or nurse, have a usual source for sick and well care, receive family-centered care, have no problems getting needed referrals and receive effective care coordination when needed (2011/2012)	24	Greatly worsened
Social and economic environment	**Social capital and cohesion.** Composite measure that includes connections with neighbors, supportive neighborhoods, voter turnout and volunteerism (2015)	24 (out of 50)	Greatly worsened

Key findings: Challenges

Metric	Ohio's rank	Trend
Infant mortality (rank-2014, trend-2015)	**39**	Moderately worsened
Cardiovascular disease mortality (2015)	**40**	No change
Adult smoking (2015)	**43**	Moderately improved
Food insecurity (2013-2015)	**45**	No change
Drug overdose deaths (2015)	**49**	**Greatly worsened**
Average monthly marketplace premiums, after advanced premium tax credit (2016)	**38** (out of 38)	**Greatly increased**

Key findings: Strengths

Ohio's greatest health value strengths

Domain	Metric	Ohio's rank	Trend
Access	**Underserved, primary care physicians.** Percent of need not met by current supply in designated primary care health professional shortage areas (2016)	11	No change
	Uninsured adults. Percent of 18-64 year olds that are uninsured (2014)	13	Moderately improved
	Employer-sponsored health insurance coverage. Percent of all workers who work at a company that offers health insurance to its employees (2015)	13	No change
	Unable to see doctor due to cost. Percent of adults who went without care because of cost in the past year (2015)	13	Greatly improved
Physical environment	**Fluoridated water.** Percent of the population served by a community water system with optimally fluoridated water (2014)	12	No change
Population health	**Youth all-tobacco use.** Percent of youth ages 12-17 who used cigarettes, smokeless tobacco, cigars or pipe tobacco during past 30 days (2013-2014)	37	Greatly improved
	Life expectancy. Life expectancy at birth based on current mortality rates (2010)	37	Moderately improved
	Adult smoking. Percent of population age 18 and older that are current smokers (2015)	43	Moderately improved
Access to care	**Unmet need for illicit drug use treatment.** Percent of individuals, ages 12 and older, needing but not receiving treatment for illicit drug use in the past year (2013-2014)	26	Moderately improved
Healthcare system	**Heart failure readmissions for Medicare beneficiaries.** Rate of Medicare beneficiaries discharged from the hospital with a principal diagnosis of heart failure who were readmitted for any cause within 30 days after the index admission date, per 100 index cases (2014)	17	Greatly improved
	Breastfeeding support in hospitals. Average Maternity Practice in Infant Nutrition and Care (mPINC) score among hospitals and birthing facilities to support breastfeeding (2013)	24	Moderately improved
	Stroke care. Percent of ischemic stroke patients who got medicine to break up a blood clot within 3 hours after symptoms started (2014-2015)	25 (out of 50)	Greatly improved
	Prenatal care. Percent of women who completed a pregnancy in the last 12 months and who received prenatal care in the first trimester (2014)	28 (out of 48)	Moderately improved
Public health and prevention	**Youth marijuana use.** Past-year initiation of marijuana use (used it for the first time), percent of youth ages 12-17 (2014)	18	Greatly improved
Social and economic environment	**Fourth-grade reading.** Percent of 4th graders proficient in reading by a national assessment (NAEP) (2015)	18	Moderately improved
	Unemployment. Annual average unemployment rate, ages 16 and older (2015)	21	Greatly improved
Physical environment	**Bike and pedestrian infrastructure.** Per capita federal transportation funding obligated to bike and/or pedestrian projects (2012-2014)	22 (out of 50)	Moderately improved
	Outdoor air quality. Average exposure of the general public to particulate matter of 2.5 microns or less in size (PM2.5) (2012-2014)	45	Moderately improved
	Children exposed to second-hand smoke. Percent of children who live in a home where someone uses tobacco or smokes inside the home (2011/2012)	49	Greatly improved

Top quartile | Second quartile | Third quartile | Bottom quartile
Of the 50 states and D.C.

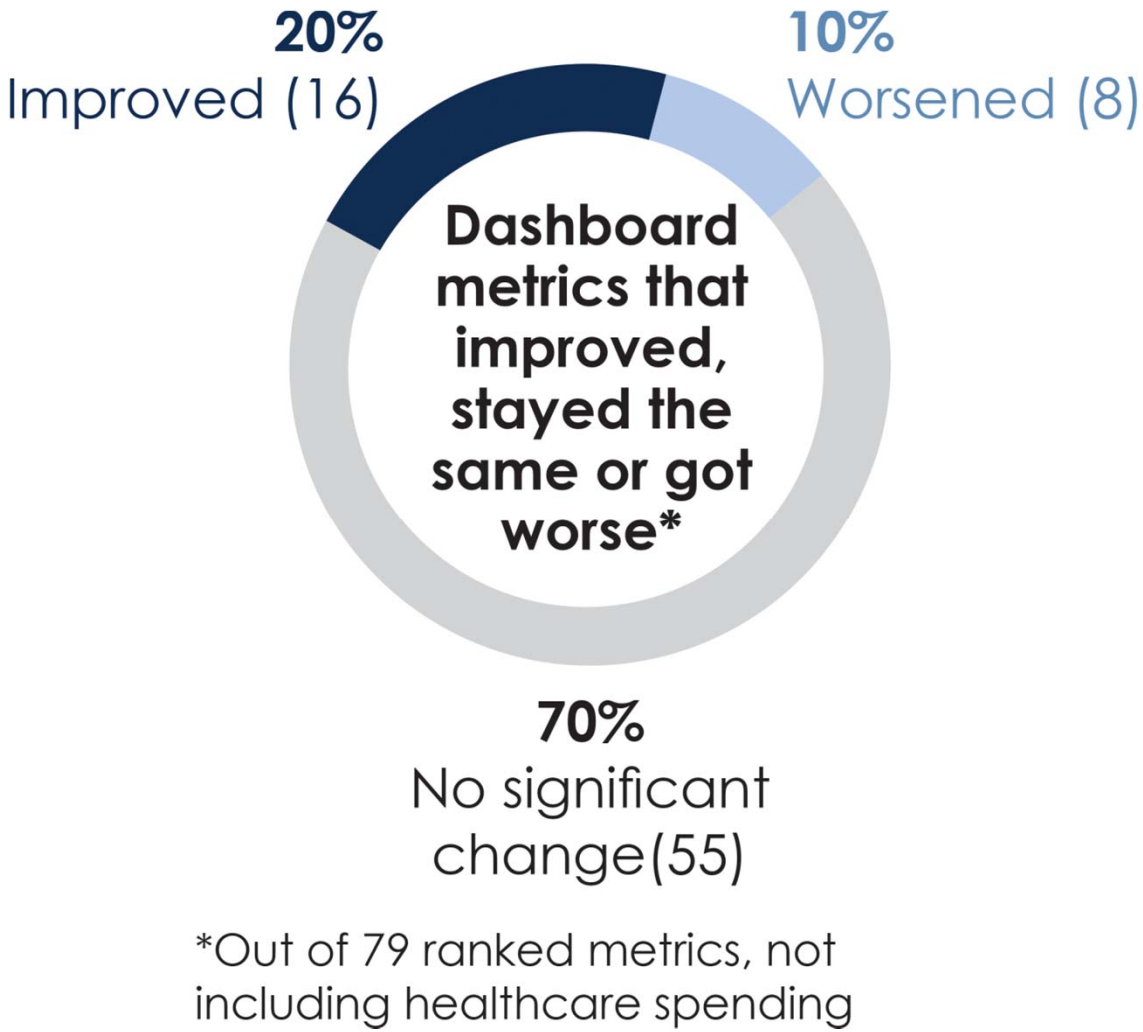
Trend note: Improved or worsened refers to a change that exceeds one-half standard deviation in the metric's value from baseline year to most recent year. Changes that do not meet this threshold are marked "no change."

Key findings: Strengths

Metric	Ohio's rank	Trend
Uninsured adults (2014)	13	Moderately improved
Unable to see doctor due to cost (2015)	13	**Greatly improved**
Heart failure readmissions for Medicare beneficiaries (2014)	17	**Greatly improved**
Youth marijuana use (2014)	18	**Greatly improved**
Unemployment (2015)	21	**Greatly improved**

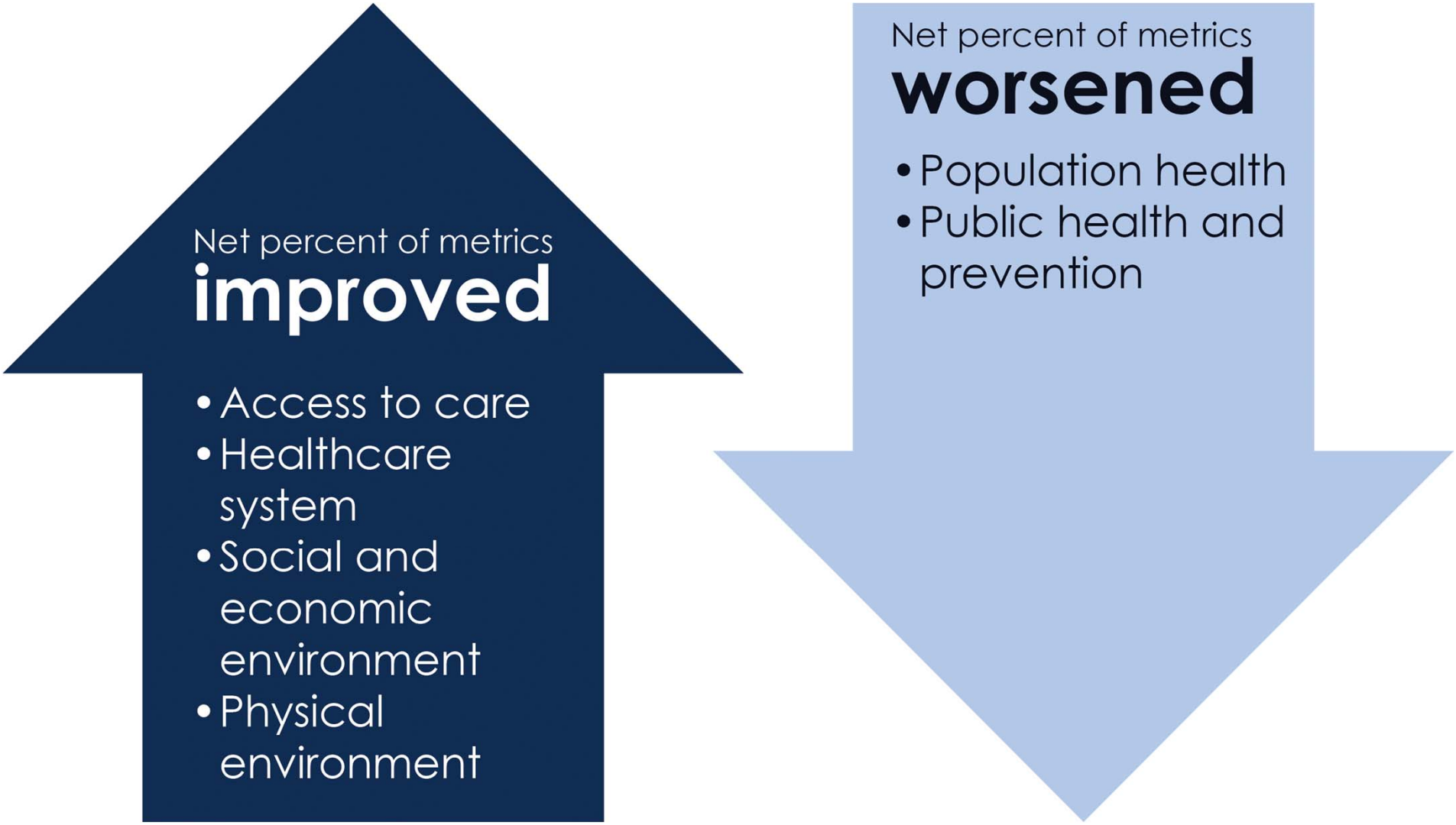
Key findings: Trends

Ohio is moving in the right direction overall



*Out of 79 ranked metrics, not including healthcare spending

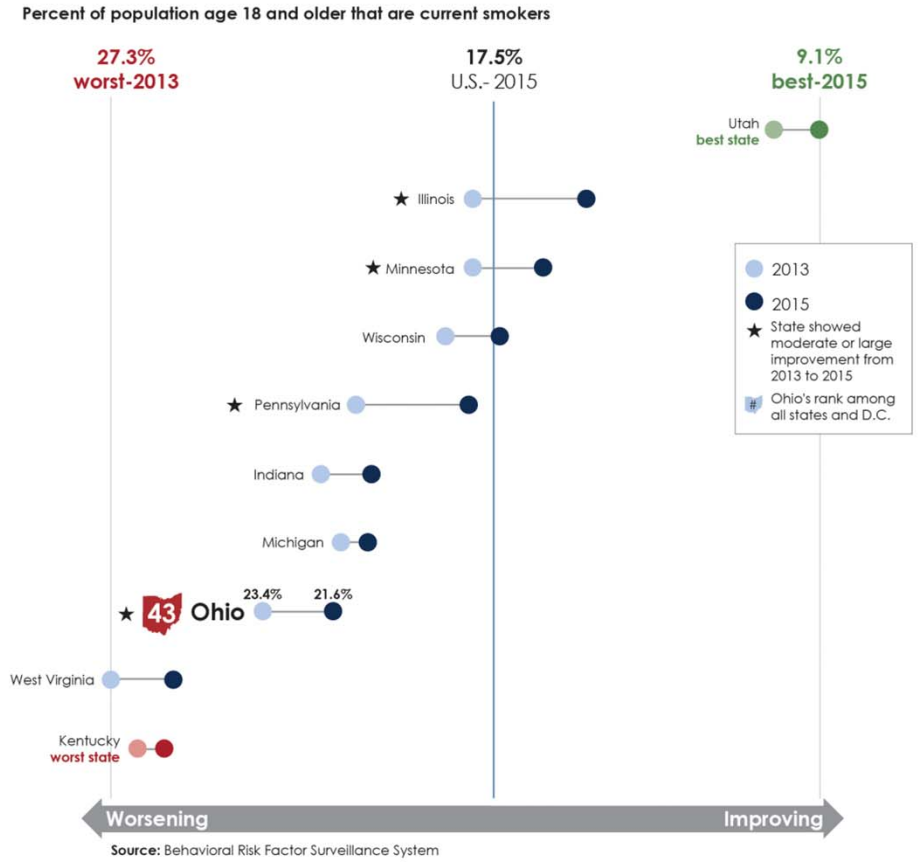
Key findings: Trends



Percent of metrics that improved or worsened, not including healthcare spending

Key findings: A closer look at trends

Adult smoking: Ohio improved, but still performs worse than most other states



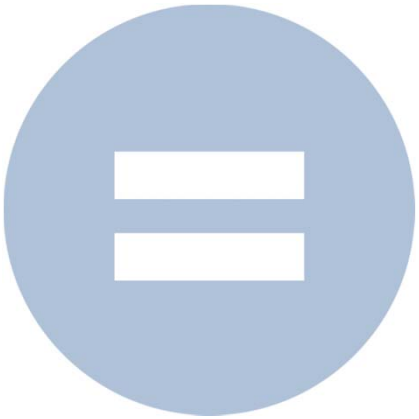
Source: Behavioral Risk Factor Surveillance System

Policy spotlight: Cigarette taxes

Research indicates that increasing the price of tobacco products is an effective way to reduce tobacco use.[5] Cigarette taxes increased between 2012 and 2015 in all the Midwestern states above that had significant reductions in adult smoking.

- Illinois and Pennsylvania allow certain municipalities to add their own tobacco taxes. In 2012, Illinois increased its cigarette tax by $1.00,[6] and Chicago and Cook County each raised their cigarette taxes in 2013.[7] Pennsylvania's cigarette tax increased in 2009 and 2016[8] and Philadelphia's cigarette tax went up $2.00 in 2014.[9]
- In 2013, Minnesota increased its cigarette tax $1.60 in and began annual adjustments pegged to inflation.[10]
- Ohio's cigarette tax increased $0.35 per pack in 2015[11] and is lower than the rates in Utah, Illinois, Minnesota, Wisconsin, Pennsylvania and Michigan.

Ohio's journey towards health equity



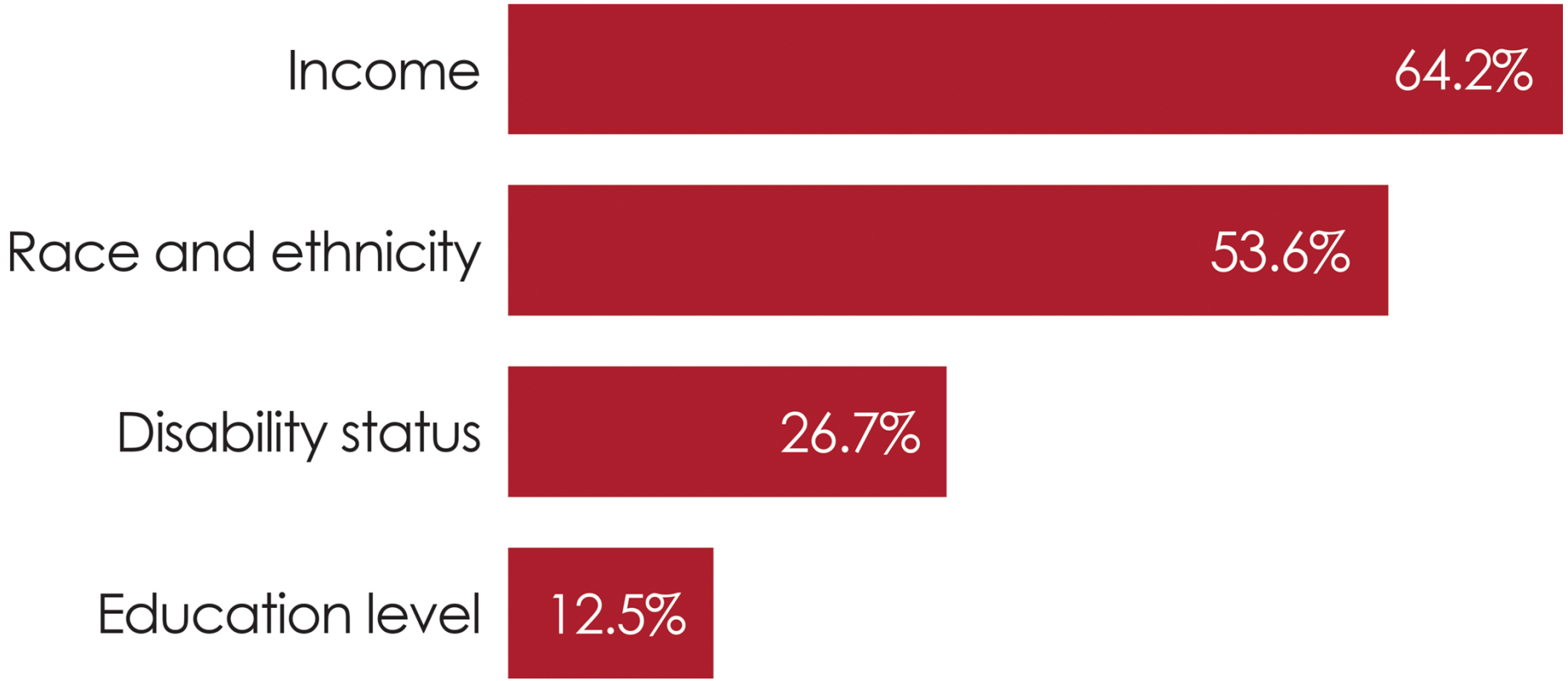
Health disparities are differences in health status among segments of the population such as by race or ethnicity, education, income or disability status

Health inequities are disparities that are a result of systemic, avoidable and unjust social and economic policies and practices that create barriers to opportunities

Key findings: disparities and inequities

Ohioans who are black or have a low income are more likely to experience larger disparities and inequities across metrics

Percent of metrics with large disparities by population group



Key findings: disparities and inequities

Disparities and inequities must be addressed to improve health value

Largest disparities and inequities across equity profiles

Metric	Group with worst outcomes	Estimated impact if disparity eliminated
Children exposed to second-hand smoke	Low-income	126,776 Ohio children
Adverse childhood experiences	Low-income	207,722 Ohio children
Child poverty	Black	134,142 Ohio children
Adult depression	People with a disability	440,990 Ohio adults

Estimated impact: This calculation estimates the impact on Ohioans if the group with the worst outcomes on a metric had the same level of performance as the group with the best outcomes.

Key findings: disparities and inequities

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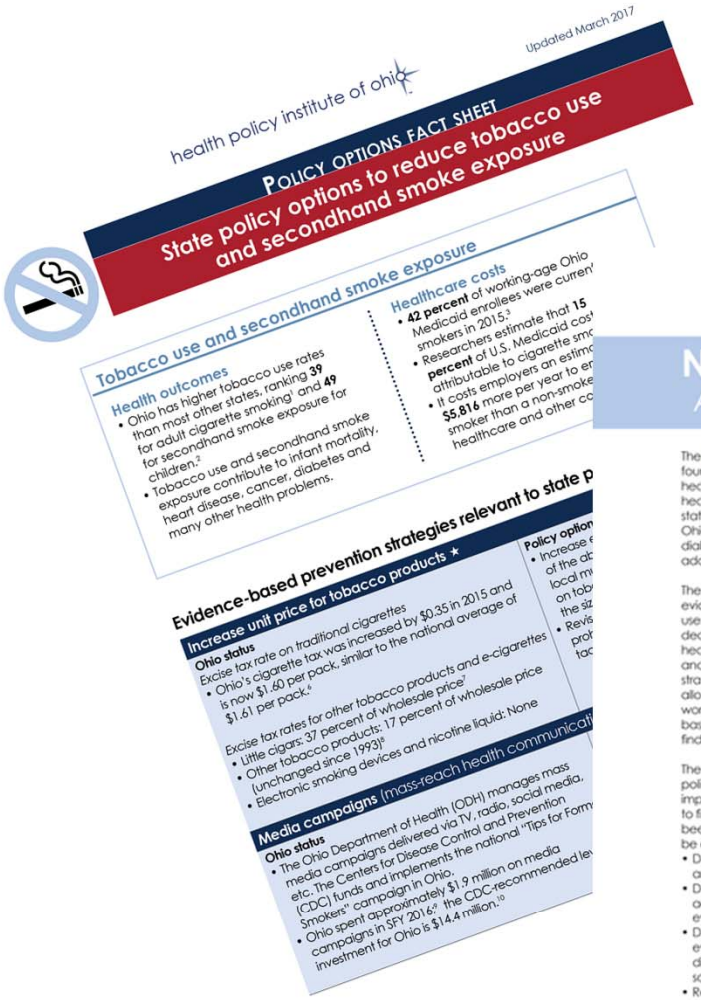
Adult depression	People with a disability	440,990 Ohio adults

Estimated impact: This calculation estimates the impact on Ohioans if the group with the worst outcomes on a metric had the same level of performance as the group with the best outcomes.


So…where do we go from here?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Updated March 2017

POLICY OPTIONS FACT SHEET

State policy options to reduce tobacco use and secondhand smoke exposure

Tobacco use and secondhand smoke exposure

Health outcomes

- Ohio has higher tobacco use rates than most other states, ranking **39** for adult cigarette smoking[1] and **49** for secondhand smoke exposure for children.[2]
- Tobacco use and secondhand smoke exposure contribute to infant mortality, heart disease, cancer, diabetes and many other health problems.

Healthcare costs

- **42 percent** of working-age Ohio Medicaid enrollees were current smokers in 2015.[3]
- Researchers estimate that **15 percent** of U.S. Medicaid cost attributable to cigarette smo
- It costs employers an estimc **$5,816** more per year to er smoker than a non-smoke healthcare and other co

Evidence-based prevention strategies relevant to state p

Increase unit price for tobacco products ★

Ohio status

Excise tax rate on traditional cigarettes
- Ohio's cigarette tax was increased by $0.35 in 2015 and is now $1.60 per pack, similar to the national average of $1.61 per pack.[4]

Excise tax rates for other tobacco products and e-cigarettes
- Little cigars: 37 percent of wholesale price[5]
- Other tobacco products: 17 percent of wholesale price (unchanged since 1993)[6]
- Electronic smoking devices and nicotine liquid: None

Policy option

- Increase of the ab local m on tob the siz
- Revis prot tac

Media campaigns (mass-reach health communicati

Ohio status

- The Ohio Department of Health (ODH) manages mass media campaigns delivered via TV, radio, social media, etc. The Centers for Disease Control and Prevention (CDC) funds and implements the national "Tips for Form Smokers" campaign in Ohio.
- Ohio spent approximately $1.9 million on media campaigns in SFY 2016[8], the CDC-recommended le investment for Ohio is $14.4 million.[10]

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Navigating sources of evidence

A guide to effective prevention strategies

The 2014 HPIO *Health Value Dashboard* found that Ohioans are living shorter, less healthy lives despite spending more on health care than people in most other states. Specific health challenges facing Ohio include high rates of tobacco use, diabetes, infant mortality and opiate addiction.

The good news is that there are many evidence-based strategies Ohio can use to prevent these health problems, decrease health disparities and control healthcare costs. More widespread and strategic implementation of these strategies would help Ohio to better allocate resources toward "what really works" and to enact policy changes based on the best-available research findings.

The purpose of this guide is to help policymakers, community health improvement planners and philanthropy to find prevention strategies that have been carefully evaluated and found to be effective. This publication:

- Defines "evidence-based prevention" and related terms
- Describes the limitations and advantages of research-based evidence
- Describes the landscape of online evidence sources and how to distinguish between different types of sources
- Recommends credible and user-friendly sources of evidence for specific policies and programs that address Ohio's greatest health challenges

GUIDE TO EVIDENCE-BASED PREVENTION

In addition to this publication, HPIO has developed topic-specific tools that are posted on the HPIO website:

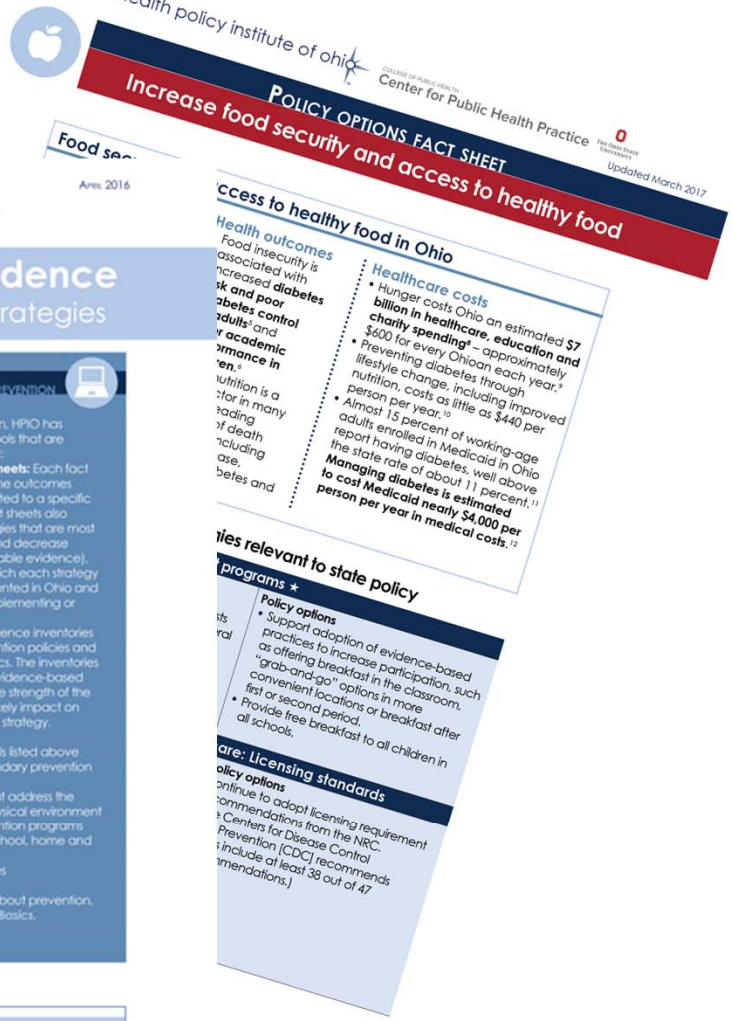
- **Evidence summary fact sheets:** Each fact sheet briefly summarizes the outcomes and healthcare costs related to a specific health challenge. The fact sheets also identify prevention strategies that are most likely to improve health and decrease disparities (strongest-available evidence), describe the extent to which each strategy is currently being implemented in Ohio and offer policy options for implementing or expanding the strategies.
- **Evidence inventories:** Evidence inventories compile reviews of prevention policies and programs for specific topics. The inventories provide a list of specific evidence-based strategies and indicate the strength of the research evidence and likely impact on health disparities for each strategy.

This publication and the tools listed above focus on primary and secondary prevention strategies, including:

- Policies and programs that address the social, economic and physical environment
- Community-based prevention programs (including programs for school, home and workplace settings)
- Clinical preventive services

For additional information about prevention, see HPIO's **Ohio** *Prevention Basics.*

INSIDE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College of Public Health Center for Public Health Practice The Ohio State University

Updated March 2017

POLICY OPTIONS FACT SHEET

Increase food security and access to healthy food

Food se

April 2016

ccess to healthy food in Ohio

Health outcomes

Food insecurity is associated with ncreased **diabetes sk and poor abetes control adults**[3] and **r academic ormance in en.**[4] utrition is a tor in many eading f death ncluding ase, betes and

Healthcare costs

- Hunger costs Ohio an estimated **$7 billion in healthcare, education and charity spending**[8] – approximately $600 for every Ohioan each year.[9]
- Preventing diabetes through lifestyle change, including improved nutrition, costs as little as $440 per person per year.[10]
- Almost 15 percent of working-age adults enrolled in Medicaid in Ohio report having diabetes, well above the state rate of about 11 percent.[11] **Managing diabetes is estimated to cost Medicaid nearly $4,000 per person per year in medical costs.**[12]

ies relevant to state policy

programs ★

Policy options

- Support adoption of evidence-based practices to increase participation, such as offering breakfast in the classroom, "grab-and-go" options in more convenient locations or breakfast after first or second period.
- Provide free breakfast to all children in all schools.

are: Licensing standards

olicy options

ontinue to adopt licensing requirement commendations from the NRC. Centers for Disease Control Prevention (CDC) recommends include at least 38 out of 47 mmendations.)

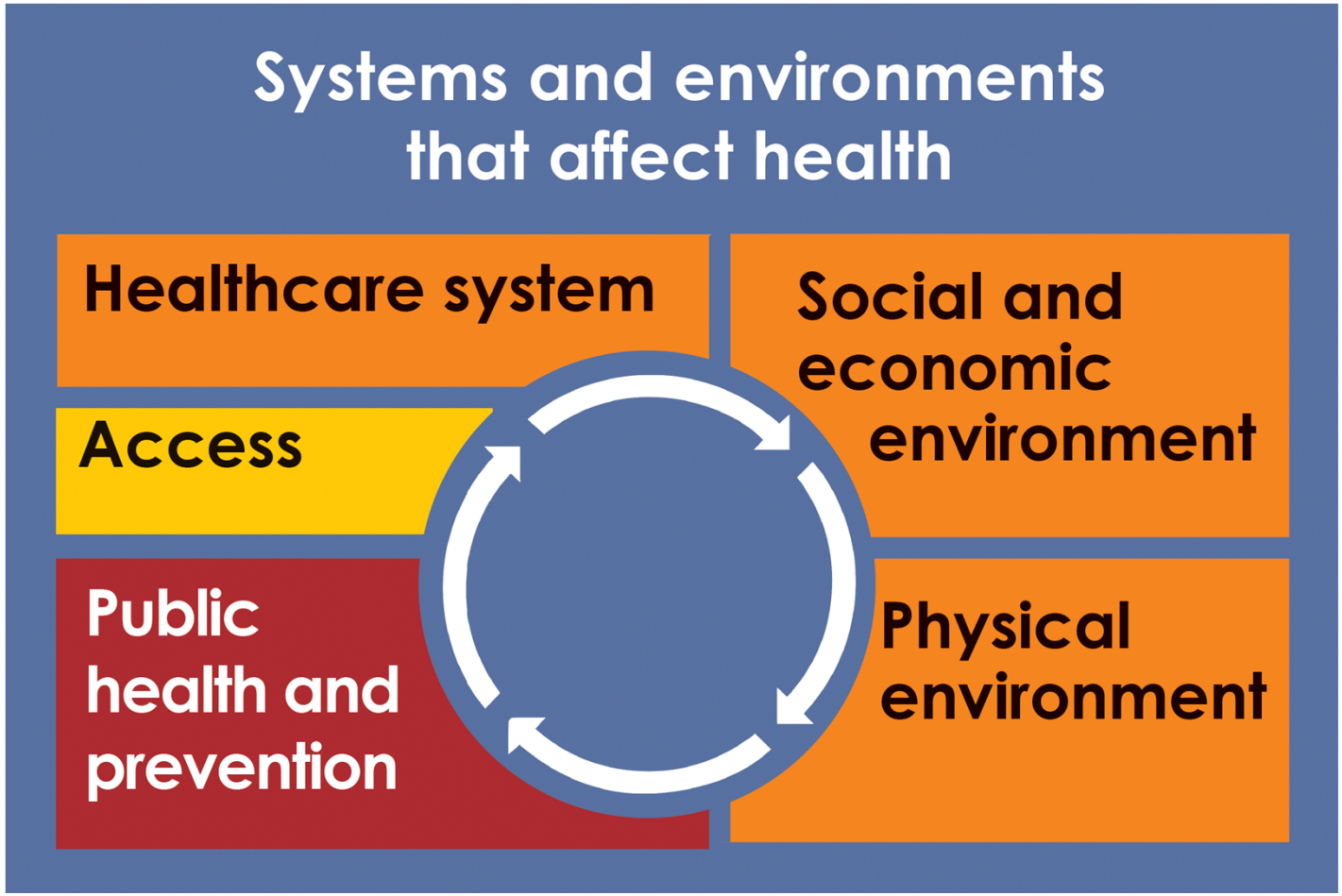
Approaches most likely to yield positive outcomes

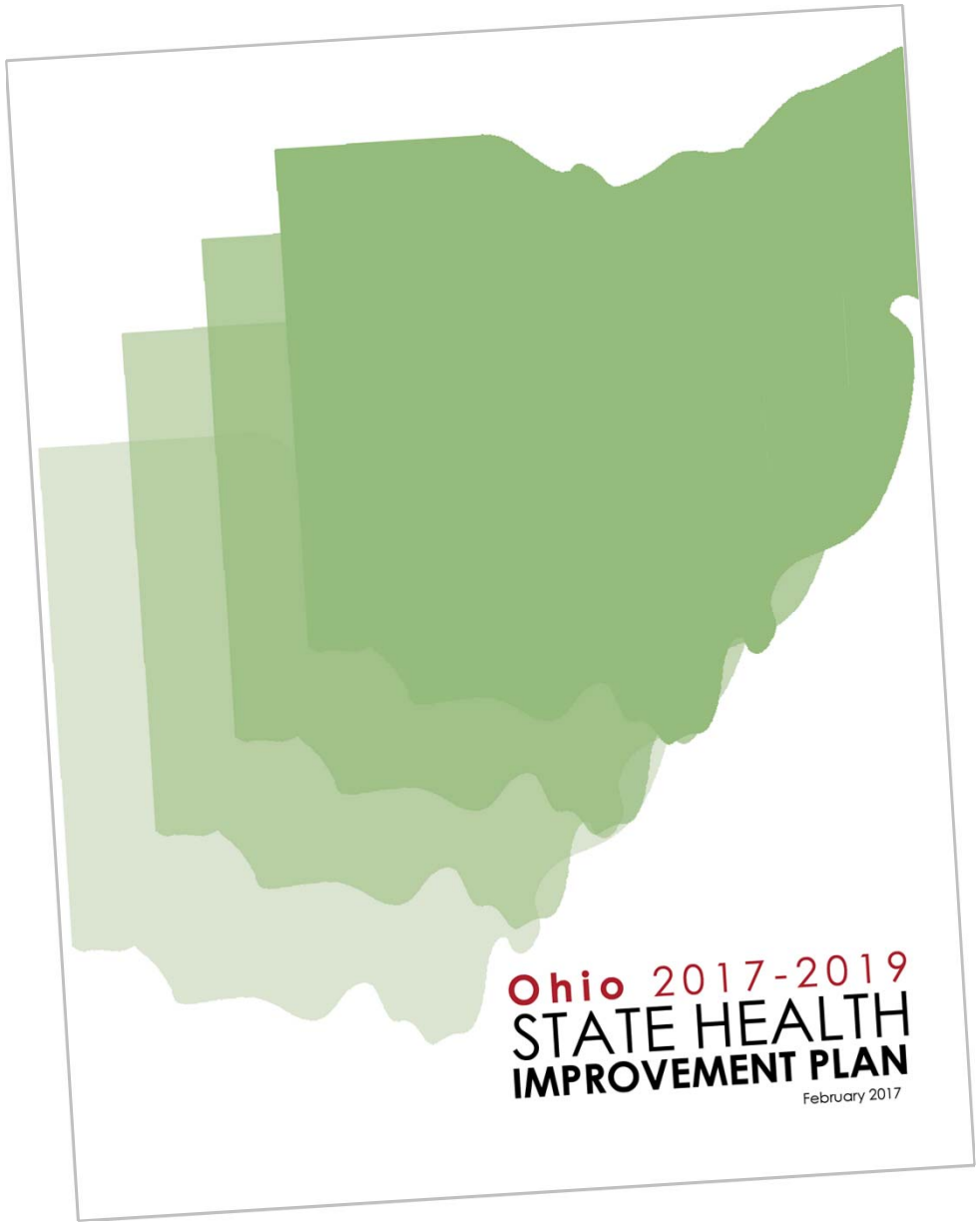
Improve Ohio's social and economic environment

Strengthen Ohio's commitment to public health and prevention

Start early with children and families

Ohio 2017-2019 STATE HEALTH IMPROVEMENT PLAN





health policy institute of ohio

Updated March 2017

POLICY OPTIONS FACT SHEET

State policy options to reduce tobacco use and secondhand smoke exposure

Tobacco use and secondhand smoke exposure

Health outcomes

- Ohio has higher tobacco use rates than most other states, ranking **39** for adult cigarette smoking[1] and **49** for secondhand smoke exposure for children.[2]
- Tobacco use and secondhand smoke exposure contribute to infant mortality, heart disease, cancer, diabetes and many other health problems.

Healthcare costs

- **42 percent** of working-age Ohio Medicaid enrollees were current smokers in 2015.[3]
- Researchers estimate that **15 percent** of U.S. Medicaid costs are attributable to cigarette smoking.[4]
- It costs employers an estimated **$5,816** more per year to employ a smoker than a non-smoker, including healthcare and other costs.[5]

Evidence-based prevention strategies relevant to state policy

Increase unit price for tobacco products ★

Ohio status

Excise tax rate on traditional cigarettes

- Ohio's cigarette tax was increased by $0.35 in 2015 and is now $1.60 per pack, similar to the national average of $1.61 per pack.[6]

Excise tax rates for other tobacco products and e-cigarettes

- Little cigars: 37 percent of wholesale price[7]
- Other tobacco products: 17 percent of wholesale price (unchanged since 1993)[8]
- Electronic smoking devices and nicotine liquid: None

Policy options

- Increase excise taxes on any or all of the above products and/or allow local municipalities to do so. Impacts on tobacco use are proportional to the size of the price increase.
- Revise Ohio's minimum price law to prohibit the use of price discounting tactics.

Media campaigns *(mass-reach health communication interventions)*

Ohio status

- The Ohio Department of Health (ODH) manages mass media campaigns delivered via TV, radio, social media, etc. The Centers for Disease Control and Prevention (CDC) funds and implements the national "Tips for Former Smokers" campaign in Ohio.
- Ohio spent approximately $1.9 million on media campaigns in SFY 2016;[9] the CDC-recommended level of investment for Ohio is $14.4 million.[10]

Policy options

Increase investment in mass media campaigns aimed at adults and/or youth. Evidence suggests that adult-focused cessation campaigns have the greatest impact on smoking prevalence and medical costs.[11]

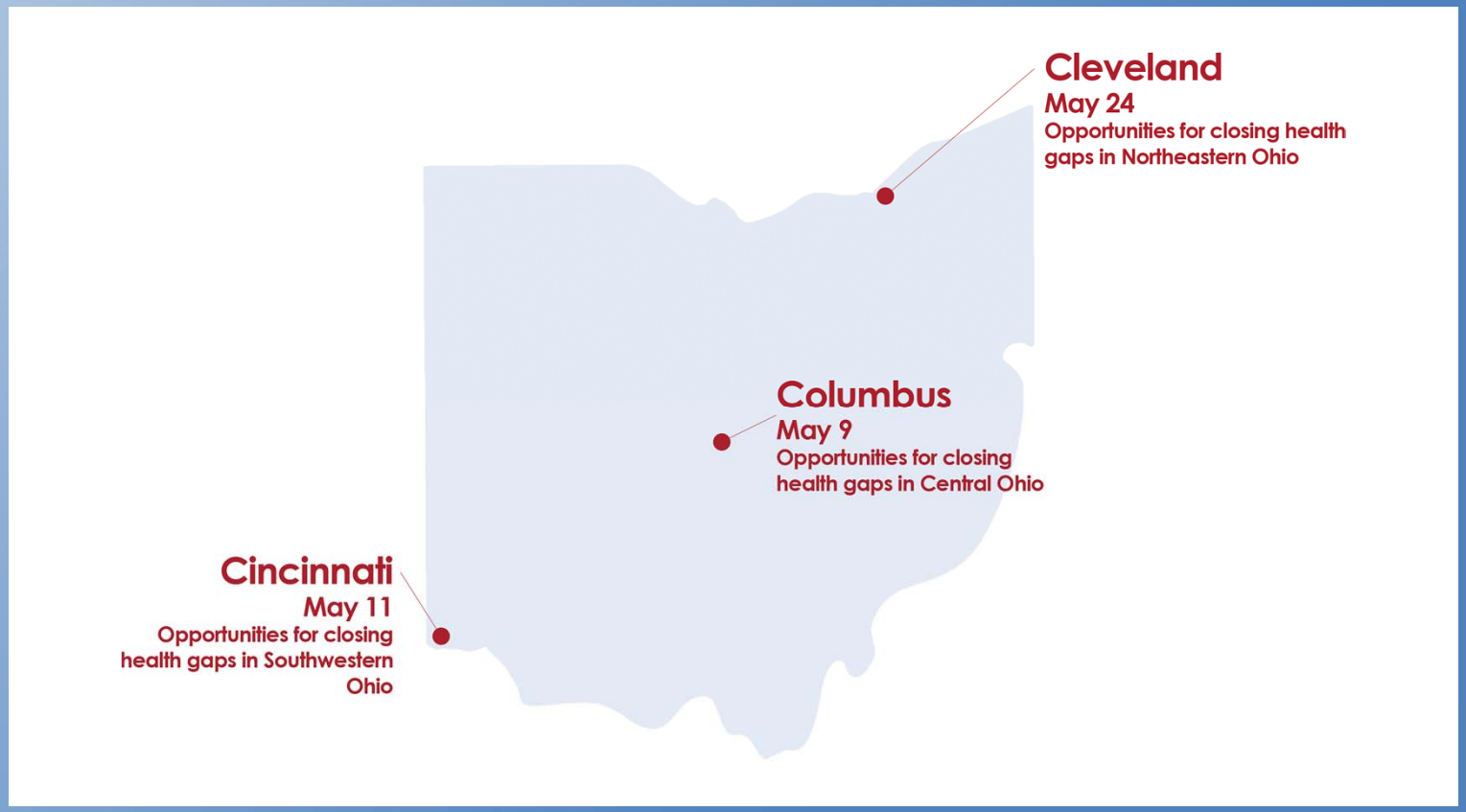
Dashboard material

http://www.hpio.net/2017-health-value-dashboard/

- Full Dashboard
- 2-page executive summary
- 8-page snapshot
- Methodology
- Local-level data crosswalk
- FAQ
- Excel with metric descriptions
- **Slides and recording from today's webinar (coming soon)**

Upcoming regional forums

Roadmaps to equity: Opportunities for closing health gaps in Ohio



Learn more at:

http://bit.ly/2m9sBSu

Questions?

Note: There is also a frequently asked questions document available on *Dashboard* page

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