



# 2021 HEALTH VALUE DASHBOARD™



APRIL 2021

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## 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* provides a picture of Ohio's performance compared to other states using the most-recently available data, most of which does not include 2020, the year the COVID-19 pandemic was declared (see page 20 for more information on the pandemic's impact on health value).

## For more information

Visit the 2021 HPIO [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 metric appendix with descriptions, years, sources and Ohio data

## Note on language HPIO uses to describe populations and individuals

HPIO follows the Associated Press Stylebook in descriptions of races and ethnicities. See [HPIO's web page](#) for a more detailed explanation.

# Snapshot



Ohio ranks 47 on **health value** out of 50 states and D.C.

## BOTTOM LINE

Ohioans are living less healthy lives and spending more on health care than people in most other states

## Why does Ohio rank poorly?

Ohio's healthcare spending is mostly on costly downstream care to treat health problems. This is largely because of a lack of attention and effective action in the following areas:

### 1 CHILDREN

**Childhood adversity and trauma have long-term consequences**

More than four in 10 Ohio children (42%) have **experienced trauma and adversity**.



### 2 EQUITY

**Ohioans with the worst outcomes face systemic disadvantages**

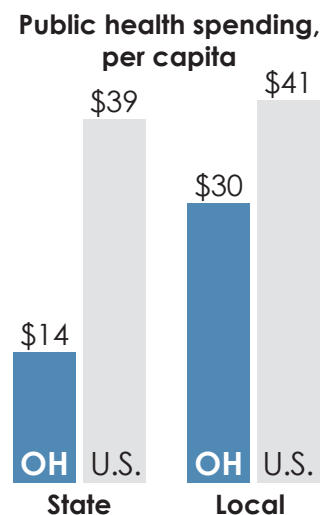
Many Ohioans experience **poorer outcomes** and live **shorter lives** because of policies, systems and beliefs that discriminate against and unfairly limit access to resources.



### 3 PREVENTION

**Sparse public health workforce leads to missed opportunities for prevention**

Ohioans spend a lot on downstream medical care, but **investment in public health infrastructure is limited** and prevention policies could be stronger.



**Health value** is calculated by equally weighting population health and healthcare spending metrics. For more information, see [methodology](#).

Data sources are available in data appendices posted on the [HPIO Health Value Dashboard web page](#)

# Nine policies that work to improve health value

By adopting evidence-informed policies and working with private-sector partners, policymakers can make Ohio a leader in health value. Below are examples of policy opportunities for the state.

## 1 CHILDREN

- **Close widening academic gaps** by prioritizing federal COVID-19 relief funds for high-intensity tutoring, chronic absenteeism interventions and school-based trauma counseling for children who have experienced adversity, disruption and learning loss
- **Strengthen K-12 student wellness** by allocating funds to evidence-based drug prevention, social-emotional learning and school-based mental health
- **Expand access to quality early childhood care and education** by increasing eligibility for Ohio's child care subsidy to at least 200% of the federal poverty level, paying childcare workers more, and streamlining rapid access to child care

## 2 EQUITY

- **Advance anti-racist and anti-discriminatory policies** by promoting diversity, equity and inclusion in leadership; engaging in training on racism, discrimination and its impacts; and improving access to culturally and linguistically competent information and services
- **Level the playing field**, starting with increasing funding and/or allocating one-time federal COVID-19 relief funding to lead hazard mitigation; construction of accessible, affordable, quality housing for people with very low incomes; rental assistance initiatives and eviction prevention
- **Identify gaps in outcomes and evaluate policy impacts** by building systems and capacity across the public and private sectors to collect and break out data on systematically disadvantaged Ohioans (e.g., race and ethnicity, disability status, education and income)

## 3 PREVENTION

- **Strengthen the public health workforce and data systems** by ensuring that the state and local health departments have diverse and adequate staffing for epidemiology, communicable disease control and communications, and by fully implementing the recommendations of the March 2021 [Ohio Auditor of State Performance Audit](#)
- **Prevent addiction and overdose deaths** by dedicating a portion of future revenue from tobacco and alcohol taxes, opioid settlements and pandemic relief toward smoking prevention, addiction treatment, recovery supports, harm reduction and overdose reversal
- **Prevent chronic disease through improved access to healthy food** by streamlining access to SNAP and WIC for eligible Ohioans and expanding Produce Perks and Produce Prescriptions

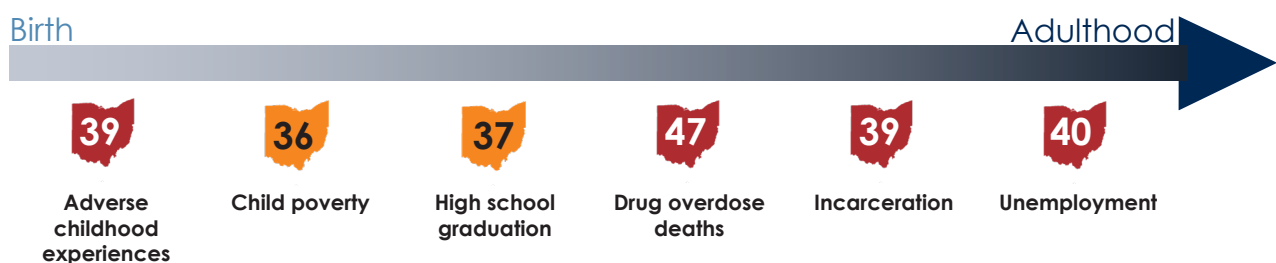
# Why does Ohio rank poorly?

## 1 Childhood adversity and trauma have long-term consequences

- **Many of Ohio's children experience early adversity and trauma**, including exposure to Adverse Childhood Experiences (ACEs) such as child abuse and neglect, living in poverty and experiencing racism.
- **Ohio ranks in the bottom half of states on measures that put children at increased risk of exposure to adversity and trauma**, including adult depression, drug overdose deaths, excessive drinking and incarceration.

### Burdens from childhood adversity and trauma carry forward across generations

#### Childhood adversity and trauma influence health and well-being at all stages of life



#### If adverse childhood experiences were eliminated...

- ▶ **More than \$10 billion a year** in healthcare spending could be **saved** in Ohio
- ▶ **\$319 million in lost wages** could be **eliminated** each year in Ohio

## How can we improve through state policy?

- **Close widening academic gaps** by prioritizing federal COVID-19 relief funds for high-intensity tutoring, chronic absenteeism interventions and school-based trauma counseling for children who have experienced adversity, disruption and learning loss
- **Strengthen K-12 student wellness** by allocating funds to evidence-based drug prevention, social-emotional learning and school-based mental health
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# Why does Ohio rank poorly?

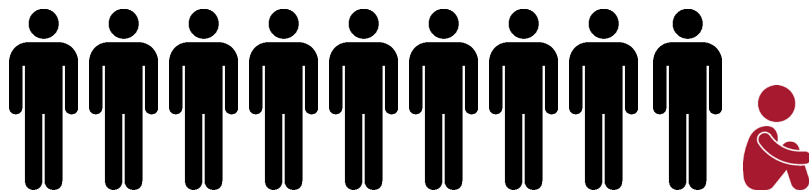
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## Ohioans with the worst outcomes face systemic disadvantages

- **Racism and other forms of discrimination drive troubling differences in outcomes across Ohio.** This includes racist and discriminatory beliefs and interactions among Ohioans and structural racism and discrimination embedded within systems and across sectors, rooted in ageism, ableism, xenophobia, homophobia and other "isms" or "phobias."
- **Ohioans experiencing the worst health outcomes are also more likely to be exposed to risk factors for poor health.** These include trauma and adversity, toxic stress, violence and stigma, and inequitable access to resources.

Our systems, policies and beliefs unfairly favor some Ohioans over others

One in 10 Black children in Ohio is **treated unfairly due to their race**, 17 times higher than the rate for white children



Inequitable distribution of infrastructure, power, resources and dollars result in **obstacles to accessing education, food, transportation, housing, health care and other resources** for Ohio's most at-risk groups.

If these inequities were eliminated:

**58,507**

fewer Black children and 13,373 fewer Hispanic children would experience food insecurity

**362,917**

fewer low-income households would be severely cost burdened for housing

**238,174**

more Ohioans with less than a high school diploma would have broadband internet access

**181,488**

Ohioans with disabilities would not have to delay health care due to cost

## How can we improve through state policy?

- **Advance anti-racist and anti-discriminatory policies** by promoting diversity, equity and inclusion in leadership; engaging in training on racism, discrimination and its impacts; and improving access to culturally and linguistically competent information and services
- **Level the playing field**, starting with increasing funding and/or allocating one-time federal COVID-19 relief funding to lead hazard mitigation; construction of accessible, affordable, quality housing for people with very low incomes; rental assistance initiatives and eviction prevention
- **Identify gaps in outcomes and evaluate policy impacts** by building systems and capacity across the public and private sectors to collect and break out data on systematically disadvantaged Ohioans (e.g., race and ethnicity, disability status, education and income)

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# Why does Ohio rank poorly?

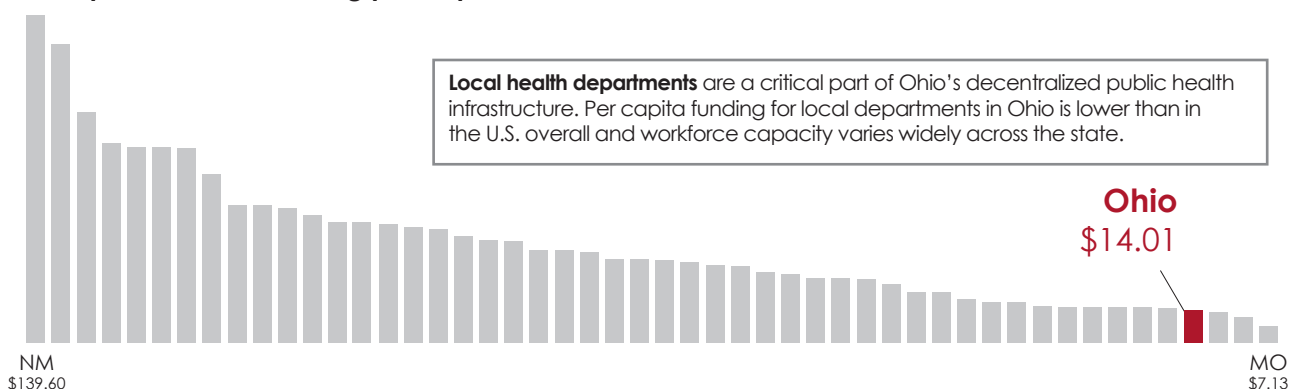
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## Sparse public health workforce leads to missed opportunities for prevention

- **Limited investment in public health.** Only three other states spend less on public health than Ohio, limiting public health workforce and ability to proactively implement comprehensive approaches to our state's greatest health challenges.
- **Patchwork approach to community-based prevention.** Ohio struggles on several outcomes that could be prevented, such as addiction and chronic disease. Stretched thin by the many demands of the COVID-19 pandemic, public health departments now have even fewer resources to devote to these issues.

### Going upstream to prevent health problems reduces costly sick care later

State public health funding per capita, 2019



#### Greatest challenges

Ohio in the bottom quartile

Greatest challenges	Missed opportunities for prevention policy
<b>Adult smoking and youth all-tobacco use</b>	Ohio invests 10.6% of what the CDC recommends for state tobacco prevention and control
<b>Drug overdose deaths</b>	Administrative barriers to naloxone distribution and an overly complex Good Samaritan policy
<b>Excessive drinking</b>	Lack of a sustained, long-term approach to school-based alcohol and drug prevention
<b>Heart disease mortality and food insecurity</b>	Limited reach of programs to increase access to healthy food, such as fruit and vegetable incentives and school breakfast

## How can we improve through state policy?

- **Strengthen the public health workforce and data systems** by ensuring that the state and local health departments have diverse and adequate staffing for epidemiology, communicable disease control and communications, and by fully implementing the recommendations of the March 2021 [Ohio Auditor of State Performance Audit](#)
- **Prevent addiction and overdose deaths** by dedicating a portion of future revenue from tobacco and alcohol taxes, opioid settlements and pandemic relief toward smoking prevention, addiction treatment, recovery supports, harm reduction and overdose reversal
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# POPULATION HEALTH



Ohio's rank	Metric	Most recent data	Trend*
<b>46</b>	<b>Health behaviors</b>		
27	<b>Excessive drinking.</b> 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 chronic drinking, defined as having eight or more (women) or 15 or more (men) drinks per week (2019)	18.7%	No change
34	<b>Physical inactivity.</b> Percent of adults, ages 18 and older, reporting no leisure time physical activity during the past 30 days (2019)	32.3%	No change
40	<b>Youth all-tobacco use.</b> Percent of youth, ages 12-17, who used cigarettes, smokeless tobacco, cigars or pipe tobacco during the past 30 days (does not include e-cigarettes) (2018-2019)	5.5%	<b>Greatly improved</b>
48	<b>Adult smoking.</b> Percent of adults, ages 18 and older, who currently smoke (2019)	20.8%	No change
<b>43</b>	<b>Conditions and diseases</b>		
24	<b>Suicide deaths.</b> Number of deaths due to suicide, per 100,000 population (age adjusted) (2018)	15.3	No change
29	<b>Adult depression.</b> Percent of adults who have ever been told by a health professional that they have depression (2019)	20.3%	Moderately improved
37	<b>Adult diabetes.</b> Percent of adults who have ever been told by a health professional that they have diabetes (2019)	12%	No change
40	<b>Poor oral health.</b> Percent of adults, ages 18-64, who have lost six or more teeth because of tooth decay, infection or gum disease (2018)	12%	No change
42	<b>Heart disease mortality.</b> Number of deaths due to heart diseases, per 100,000 population (age adjusted) (2018)	191.1	No change
47	<b>Drug overdose deaths.</b> Number of deaths due to drug overdose, per 100,000 population (age adjusted) (2018)	35.9	No change
<b>43</b>	<b>Overall health and well-being</b>		
36	<b>Overall health status.</b> Percent of adults who report excellent, very good or good health (2019)	80.7%	No change
40	<b>Premature death.</b> Average number of years of potential life lost before age 75, per 100,000 population (age adjusted) (2018)	8,165.5	No change
42	<b>Infant mortality.</b> Number of infant deaths, per 1,000 live births (within one year) (2019**)	6.9	No change
44	<b>Limited activity due to health problems.</b> 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 (2019)	2	Moderately worsened



\*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 [2021 Health Value Dashboard web page](#).

\*\*2019 data was available for Ohio, but not for other states. 2018 data was used for rank and trend.

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# HEALTHCARE SPENDING

Ohio rank  
**37**



Ohio's rank	Metric	Most recent data	Trend*
<b>27</b>	<b>Out-of-pocket spending</b>		
21	<b>Total out-of-pocket spending.</b> Percent of individuals who are in families where out-of-pocket spending on health care, including premiums, accounts for more than 10% of annual income (2019)	18.5%	Moderately decreased
37	<b>Out-of-pocket employer-sponsored health insurance spending, per enrollee.</b> Out-of-pocket spending, such as co-payments, co-insurance and deductibles, per enrollee under age 65 in major employer-sponsored health insurance plans (2018)	\$1,043	Moderately increased
<b>43</b>	<b>Healthcare service area spending</b>		
17	<b>Nursing home average daily cost, per capita.</b> Average daily cost for an individual to pay the full, private pay cost for a shared room in a nursing home (i.e., without insurance contribution) (2019)	\$230	N/A
37	<b>Prescription drug employer-sponsored health insurance spending, per enrollee.</b> Prescription drug and device total spending, per enrollee under age 65 in major employer-sponsored health insurance plans (2018)	\$1,208	Moderately increased
39	<b>Hospital adjusted expenses per inpatient day.</b> Adjusted expenses per inpatient day for community hospitals (2018)	\$2,829	No change
42	<b>Outpatient employer-sponsored health insurance spending, per enrollee.</b> Outpatient service total spending, per enrollee under age 65 in major employer-sponsored health insurance plans (2018)	\$2,077	Moderately increased
<b>29</b>	<b>Private health insurance spending</b>		
12	<b>Employee contributions to employer-sponsored insurance premiums.</b> Employee contributions to employer-sponsored health insurance premiums as a percent of state median income (2019)	5.5%	No change
37	<b>Total employer-sponsored health insurance spending, per enrollee.</b> Total spending on medical and pharmacy claims, per enrollee under age 65 in major employer-sponsored health insurance plans (2018)	\$6,181	Moderately increased
39 <small>(out of 49)</small>	<b>Average monthly marketplace premium.</b> 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 (2020)	\$230	No change
<b>26</b>	<b>Medicare spending</b>		
22	<b>Average total cost per Medicare beneficiary without chronic conditions.</b> Average total cost per Medicare beneficiary without chronic conditions (2018)	\$3,909	No change
25	Average total cost per Medicare beneficiary <b>with one chronic condition</b>	\$5,437	No change
21	Average total cost per Medicare beneficiary <b>with two chronic conditions</b>	\$6,373	No change
38	Average total cost per Medicare beneficiary <b>with three or more chronic conditions</b>	\$13,938	No change
43	<b>Total Medicare spending, per beneficiary.</b> Total Medicare reimbursements, per Medicare beneficiary (Parts A and B), ages 65-99 (2017)	\$10,862	Moderately increased

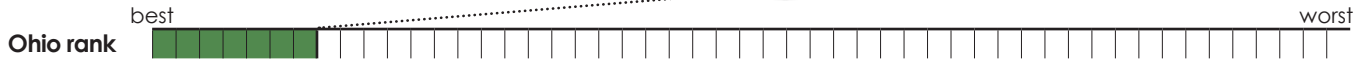
Top quartile
  Second quartile
  Third quartile
  Bottom quartile
 NR Not ranked
 N/A Data not available for trend

Of the 50 states and D.C.

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2021 *Health Value Dashboard*  
**ACCESS TO CARE**



Ohio's rank	Metric	Most recent data	Trend*
<b>15</b>	<b>Coverage and affordability</b>		
17	<b>Uninsured, non-elderly.</b> Percent of population, ages 64 and under, who are uninsured (2019)	7.8%	No change
22	<b>Employer-sponsored health insurance coverage.</b> Percent of all workers who work at a company that offers health insurance to its employees (2019)	85.7%	No change
22	<b>Unable to see doctor due to cost.</b> Percent of adults who went without care because of cost in the past year (2019)	12.1%	No change
<b>6</b>	<b>Primary care access</b>		
2	<b>Routine checkup.</b> Percent of adults, ages 65 and older, with self-reported fair or poor health, who had a routine checkup in the past 12 months (2018)	97%	<b>Greatly improved</b>
7	<b>Medical home, children.</b> 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 (2018-2019)	53.6%	No change
17	<b>Without a usual source of care.</b> Percent of adults, ages 18 and older, who do not have at least one person they think of as their personal healthcare provider (2019)	20.4%	No change
<b>4</b>	<b>Behavioral health</b>		
7	<b>Unmet need for mental health treatment, adults.</b> 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 (2016-2017)	20%	No change
8	<b>Received mental health treatment in past year, children.</b> Percent of children, ages 3-17, who needed and received treatment or counseling from a mental health professional during the past 12 months (2018)	89%	No change
12	<b>Outpatient medication-assisted treatment.</b> Percent of outpatient substance use treatment facilities that offer methadone/buprenorphine maintenance or naltrexone treatment (2019)	50.5%	No change
<b>31</b>	<b>Oral health</b>		
27	<b>Received dental care in past year, adults.</b> Percent of adults, ages 18 and older, who have visited a dentist, dental clinic or dental specialist within the past year (2018)	67.4%	N/A
33	<b>Preventive dental care, children.</b> 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 (2018-2019)	78.4%	Moderately improved
<b>12</b>	<b>Workforce</b>		
6	<b>Underserved, primary care physicians.</b> Percent of need not met by current supply of primary care physicians in designated primary care health professional shortage areas (2020)	37.9%	N/A
7 (out of 50)	<b>Underserved, mental health.</b> Percent of need not met by current supply of mental health professionals in designated mental health care professional shortage areas (2020)	60.4%	N/A
26	<b>Underserved, dentists.</b> Percent of need not met by current supply of dentists in designated dental care health professional shortage areas (2020)	66%	N/A

Top quartile
  Second quartile
  Third quartile
  Bottom quartile
 NR Not ranked
 N/A Data not available for trend

Of the 50 states and D.C.

\*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 [2021 Health Value Dashboard web page](#).

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# HEALTHCARE SYSTEM



Ohio's rank	Metric	Most recent data	Trend*
<b>41</b>	<b>Preventive services</b>		
24	<b>Breastfeeding support in hospitals.</b> Average Maternity Practice in Infant Nutrition and Care (mPINC) score among hospitals and birthing facilities to support breastfeeding (2018)	78	N/A
25	<b>Prenatal care.</b> Percent of women who completed a pregnancy in the last 12 months and who received prenatal care in the first trimester (2019)	76.5%	No change
30	<b>Female breast cancer early stage diagnosis.</b> Percent of female breast cancer cases diagnosed at an early stage (2013-2017)	71%	<b>Greatly improved</b>
42	<b>Colon and rectal cancer early stage diagnosis.</b> Percent of colon and rectal cancer cases diagnosed at an early stage (2013-2017)	36.3%	<b>Greatly worsened</b>
45	<b>Cancer early stage diagnosis.</b> Percent of cervical, colon and rectal, lung and bronchial, female breast and prostate cancer cases diagnosed at an early stage (2013-2017)	50.5%	No change
<b>43</b>	<b>Hospital utilization</b>		
33	<b>Diabetes with long-term complications for Medicare beneficiaries.</b> 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 (2018)	278	<b>Greatly worsened</b>
34	<b>30-day hospital readmissions for employer-insured enrollees.</b> 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 (2017)	3.3	No change
42	<b>Potentially avoidable emergency department visits for employer-insured enrollees.</b> Number of potentially avoidable emergency department visits for people, ages 18-64, with employer-sponsored insurance, per 1,000 enrollees (2017)	168.7	No change
46	<b>Heart failure admissions for Medicare beneficiaries.</b> 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 (2018)	1,722	No change
<b>25</b>	<b>Timeliness, effectiveness and quality of care</b>		
7	<b>Back pain recommended treatment.</b> Percent of outpatients with low back pain who had an MRI without trying recommended treatments first, such as physical therapy (Fiscal Year 2019)	35.9%	Moderately improved
20	<b>Hospitals with better-than-average patient experience ratings.</b> Percent of hospitals in the state with overall patient experience ratings higher than the national average (2018)	60%	No change
24	<b>Nursing home pressure ulcers.</b> Percent of long-stay, high-risk nursing home residents with pressure ulcers (2019)	6.8%	<b>Greatly worsened</b>
36	<b>Central line-associated bloodstream infections.</b> Standardized infection ratio for central line-associated bloodstream infections in acute care hospitals (2019)	0.72	No change
39	<b>Mortality amenable to healthcare.</b> 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 (2016-2017)	95.9	No change
<b>NR</b>	<b>Behavioral health</b>		
NR (Ohio only)	<b>Substance use disorder treatment retention.</b> Percent of individuals, 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 (State Fiscal Year 2019)	29.9%	N/A



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# PUBLIC HEALTH AND PREVENTION

Ohio rank  
**32**



Ohio's rank	Metric	Most recent data	Trend**
<b>10*</b>	<b>Public health system and workforce</b>		
2 (out of 49)	<b>Accreditation of local health departments.</b> Percent of local health departments that have achieved accreditation (2020)	35%	N/A
48	<b>State public health workforce.</b> Number of state public health agency full-time equivalent employees, per 100,000 population (2019)	8.9	No change
48	<b>State public health funding, per capita.</b> State public health funding during the fiscal year, per capita (2019)	\$14.01	No change
NR (Ohio only)	<b>Local public health workforce.</b> Median number of local health department full-time equivalent employees, per 100,000 population (2018)	43	N/A
NR (Ohio only)	<b>Local public health department spending, per capita.</b> Median annual local health department expenditures, per capita (Fiscal Year 2018)	\$30.39	N/A
<b>35</b>	<b>Communicable disease control and environmental health</b>		
17	<b>Child immunization.</b> Percent of children, ages 19-35 months, who received recommended vaccines (2018)	75%	<b>Greatly improved</b>
31	<b>Chlamydia.</b> Number of reported cases of chlamydia, per 100,000 population (2018)	542.3	No change
41	<b>Environmental and occupational health.</b> 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, test for hazards and contaminants in the environment and protect workers and emergency responders from health hazards (2019)	6.2	Moderately improved
<b>25</b>	<b>Health promotion and prevention</b>		
12	<b>Falls among older adults.</b> Percent of adults, ages 65 and older, who have had a fall within the last 12 months (2018)	25.6%	<b>Greatly improved</b>
15	<b>Motor vehicle crash deaths.</b> Number of deaths due to traffic accidents involving a motor vehicle, per 100,000 population (2018)	10.2	No change
19	<b>Youth marijuana use.</b> Percent of youth, ages 12-17, who used marijuana in the past year (2018-2019)	11.9%	No change
27	<b>Cigarette tax.</b> State excise tax per pack of cigarettes (2019)	\$1.60	No change
28	<b>Prescription opioid use.</b> Number of dispensed prescriptions for opioids, per 100 population (2018)	53.5	<b>Greatly improved</b>
31	<b>Low birth weight.</b> Percent of live births where the infant weighed less than 2,500 grams (5.5 pounds) (2019)	8.6%	No change
33	<b>Teen birth.</b> Number of births to females, ages 15-19, per 1,000 female ages 15-19 (2019)	18.8	No change
36	<b>Tobacco prevention spending.</b> Tobacco prevention and control spending as a percent of the Centers for Disease Control and Prevention-recommended level (State Fiscal Year 2020)	10.6%	No change
39	<b>Seat belt use.</b> Percent of front seat occupants observed using a seat belt (2019)	85.9%	Moderately improved
<b>51</b>	<b>Emergency preparedness and surveillance</b>		
30 (out of 47)	<b>Epidemiologists.</b> Number of full-time equivalent epidemiologists in state public health agencies, per 100,000 population (2019)	0.8	No change
35 (out of 50)	<b>Emergency preparedness funding, per capita.</b> State public health agencies' per capita expenditures on All Hazards Preparedness and Response Activities (Fiscal Year 2018)	\$2.35	No change
51	<b>Health security surveillance.</b> Composite score of the Health Security Surveillance domain of the NHSPI, which measures actions to monitor and detect health threats, and to identify where hazards start and spread so that they can be contained rapidly (2019)	6.8	No change

Top quartile
  Second quartile
  Third quartile
  Bottom quartile
 NR Not ranked
 N/A Data not available for trend

Of the 50 states and D.C.

\* For more information about this ranking, see question 14 of the FAQ posted on the [HPIO Health Value Dashboard web page](#).  
 \*\* 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 [2021 Health Value Dashboard web page](#).

# SOCIAL AND ECONOMIC ENVIRONMENT



Ohio's rank	Metric	Most recent data	Trend*
<b>33</b>	<b>Education</b>		
16	<b>Fourth-grade reading.</b> Percent of fourth grade public school students proficient in reading by a national assessment (National Assessment of Educational Progress) (2019)	36%	No change
24	<b>Preschool enrollment.</b> Percent of 3- and 4-year-olds enrolled in preschool (2017-2019)	46%	No change
30	<b>Some college.</b> 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 (2014-2018)	65.4%	Moderately improved
37	<b>High school graduation.</b> Percent of incoming ninth graders who graduate in four years from a public high school with a regular degree (2017-2018 school year)	82.1%	No change
<b>37</b>	<b>Employment and poverty</b>		
29	<b>Labor force participation.</b> Percent of people, ages 16 and older, who are in the labor force (2019)	62.8%	No change
29	<b>Income inequality.</b> Ratio of household income at the 80th percentile to that at the 20th percentile (2014-2018)	4.7	No change
32	<b>Adult poverty.</b> Percent of people, ages 18 and older, in households with incomes below the federal poverty level (2019)	11.5%	No change
36	<b>Child poverty.</b> Percent of people under age 18, in households with incomes below the federal poverty level (2019)	18.4%	No change
40	<b>Unemployment.</b> Percent of people, ages 16 and older, who are jobless, looking for a job and available for work (2019)	4.1%	<b>Greatly improved</b>
<b>33</b>	<b>Family and social support</b>		
22	<b>Disconnected youth.</b> Percent of youth, ages 16-24, who are not working or in school (2019)	10%	No change
39	<b>Children in single-parent households.</b> Percent of children, ages 0-17, who live in a household headed by a single parent (2014-2018)	36%	No change
39 (out of 50)	<b>Incarceration.</b> Number of people imprisoned under the jurisdiction of state or federal correctional authorities, per 100,000 population (2019)	430	No change
<b>31</b>	<b>Trauma, toxic stress and violence</b>		
18	<b>Violent crime.</b> Number of violent crimes (murder, rape, robbery and aggravated assault), per 100,000 population (2019)	293	No change
28	<b>Child abuse and neglect.</b> Number of reported and substantiated child maltreatment victims, per 1,000 children (Fiscal Year 2018)	9.7	No change
39	<b>Adverse childhood experiences.</b> Percent of children who have experienced two or more adverse experiences (2018-2019)	21.9%	Moderately improved

Top quartile
  Second quartile
  Third quartile
  Bottom quartile
 NR Not ranked
 N/A Data not available for trend

Of the 50 states and D.C.

\*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 [2021 Health Value Dashboard web page](#).

Data sources are available in data appendices posted on the [HPIO Health Value Dashboard web page](#).

# PHYSICAL ENVIRONMENT



Ohio's rank	Metric	Most recent data	Trend*
<b>43</b>	<b>Air, water and toxic substances</b>		
36	<b>Child in a household with a person who smokes.</b> Percent of children, ages 0-17, who live in households where someone smokes (cigarettes, cigars or pipe tobacco) (2018-2019)	17.7%	<b>Greatly improved</b>
46	<b>Outdoor air quality.</b> Average exposure of the general public to particulate matter of 2.5 microns or less in size (PM2.5) (2017-2019)	8.7	<b>Greatly improved</b>
48	<b>Toxic pollutants (Risk-Screening Environmental Indicators score).</b> Composite score that accounts for the size of toxic chemical releases, the fate and transport of chemicals through the environment, the size and location of the exposed population and the chemical's toxicity that is only meaningful in comparison to other RSEI scores (2018)	27,391,214	N/A
NR (Ohio only)	<b>Lead poisoning.</b> Percent of children, ages 0-5, who received a blood lead test and had elevated blood lead levels (BLL > 5 ug/dL) (2019)	2.1%	N/A
<b>35</b>	<b>Food access and food insecurity</b>		
29	<b>Healthy food access.</b> 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 (2015)	6.8%	No change
39	<b>Food insecurity.</b> Percent of households that are food insecure (2017-2019)	12.6%	<b>Greatly improved</b>
<b>28</b>	<b>Housing, built environment and access to physical activity</b>		
13	<b>Severe housing problems.</b> 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 (2013-2017)	13.7%	No change
17	<b>Long commute, driving alone.</b> Percent of commuters, among those who commute to work by car, truck, or van, alone, who drive longer than 30 minutes to work each day (2019)	32.4%	No change
19	<b>Neighborhood resources.</b> 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 centers or boys' and girls' club; and libraries or bookmobiles (2018-2019)	38.9%	No change
25	<b>Access to exercise opportunities.</b> Percent of individuals who live reasonably close to a location for physical activity, defined as parks or recreational facilities (2010 and 2019)	83.9%	No change
30	<b>Alternative commute modes.</b> Percent of trips to work via bicycle, walking or mass transit (combined) (2019)	4.1%	No change
33	<b>Neighborhood safety.</b> Percent of children living in a safe neighborhood as reported by a parent or guardian (2018-2019)	95%	No change



\*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 [2021 Health Value Dashboard web page](#).

Data sources are available in data appendices posted on the [HPIO Health Value Dashboard web page](#).

# EQUITY PROFILES

## Black Ohioans

Racist and discriminatory policies, systems and beliefs unfairly limit Black Ohioans' access to resources, representation and opportunity and result in, for example:

- Disproportionate incarceration
- Residential segregation
- Discrimination within the healthcare system

**If the playing field was leveled:**

**16,690** Black Ohioans would not be incarcerated

**19,700** more Black youth would be working or in school

**68,009** Black Ohioans would not be severely cost burdened by housing

**175,447** Black Ohioans would not experience the physical or emotional impacts of poor treatment due to race

**Black Ohioans experience much worse outcomes than white Ohioans** across measures of health, healthcare and the social, economic and physical environment. Racism is a primary driver of the poor outcomes facing Black Ohioans.

Health	
Infant mortality	2.8 times worse for Black Ohioans
Premature death	1.5 times worse for Black Ohioans
Adult diabetes	1.2 times worse for Black Ohioans
Heart disease mortality	1.2 times worse for Black Ohioans
Poor oral health	1.2 times worse for Black Ohioans
Access and healthcare system	
Unable to see doctor due to cost	1.5 times worse for Black Ohioans
Uninsured, adults	1.4 times worse for Black Ohioans
Prenatal care	1.4 times worse for Black Ohioans
Flu vaccinations	1.2 times worse for Black Ohioans
Social and economic environment	
Incarceration	5.4 times worse for Black Ohioans
Child poverty	3 times worse for Black Ohioans
Chronic absenteeism	2.8 times worse for Black Ohioans
Unemployment	2.7 times worse for Black Ohioans
High school graduation	2.3 times worse for Black Ohioans
Disconnected youth	2 times worse for Black Ohioans
Adverse childhood experiences	1.8 times worse for Black Ohioans
Fourth-grade reading	1.5 times worse for Black Ohioans
College enrollment within two years	1.3 times worse for Black Ohioans
Physical environment	
Food insecurity	3.9 times worse for Black Ohioans
Zero-vehicle households	3.5 times worse for Black Ohioans
Child in a household with a person who smokes	2.4 times worse for Black Ohioans
Severe housing cost burden	2.2 times worse for Black Ohioans
Living in a high-homicide county	1.7 times worse for Black Ohioans
Broadband internet access	1.6 times worse for Black Ohioans
Air pollution	1.4 times worse for Black Ohioans
Experiences of racism	
Unfair treatment due to race for children	17.3 times worse for Black Ohioans
Physical or emotional symptoms experienced due to treatment based on race	5.6 times worse for Black Ohioans
Treated worse in healthcare due to race	5.6 times worse for Black Ohioans
Treated worse at work due to race	4.8 times worse for Black Ohioans

This profile describes the magnitude of difference in outcomes between Black Ohioans and white Ohioans. Data sources are available in data appendices posted on the [HPIO Health Value Dashboard web page](#).

# EQUITY PROFILES

## Hispanic/Latino(a) Ohioans

Racist and discriminatory policies, systems and beliefs unfairly limit Hispanic/Latino(a) Ohioans' access to resources, representation and opportunity and result in, for example, difficulty accessing and navigating social supports due to cultural and linguistic barriers and discrimination within the healthcare system.

**If the playing field was leveled:**

**36,016** Hispanic Ohioans would be insured

**28,094** Hispanic children would not live in poverty

**4,837** Hispanic Ohioans would have access to a car

**15,881** Hispanic children would not be treated unfairly due to their race

**Hispanic/Latino(a) Ohioans experience much worse outcomes than white Ohioans** across measures of healthcare and the social, economic and physical environment. Racism and other forms of discrimination, such as xenophobia, are primary drivers of the poor outcomes facing Hispanic/Latino(a) Ohioans.

Health	
Infant mortality	1.1 times <b>worse</b> for Hispanic Ohioans
Adult depression	Little to no disparity for Hispanic Ohioans
Access and healthcare system	
Uninsured, adults	2.8 times <b>worse</b> for Hispanic Ohioans
Unable to see doctor due to cost	1.6 times <b>worse</b> for Hispanic Ohioans
Prenatal care	1.4 times <b>worse</b> for Hispanic Ohioans
Flu vaccinations	1.1 times <b>worse</b> for Hispanic Ohioans
Social and economic environment	
Child poverty	2.2 times <b>worse</b> for Hispanic Ohioans
High school graduation	2.1 times <b>worse</b> for Hispanic Ohioans
Chronic absenteeism	1.9 times <b>worse</b> for Hispanic Ohioans
Unemployment	1.7 times <b>worse</b> for Hispanic Ohioans
Adverse childhood experiences	1.5 times <b>worse</b> for Hispanic Ohioans
Disconnected youth	1.5 times <b>worse</b> for Hispanic Ohioans
College enrollment within two years	1.4 times <b>worse</b> for Hispanic Ohioans
Fourth-grade reading	1.4 times <b>worse</b> for Hispanic Ohioans
Physical environment	
Food insecurity	2.8 times <b>worse</b> for Hispanic Ohioans
Child in a household with a person who smokes	1.9 times <b>worse</b> for Hispanic Ohioans
Zero-vehicle households	1.7 times <b>worse</b> for Hispanic Ohioans
Severe housing cost burden	1.6 times <b>worse</b> for Hispanic Ohioans
Living in a high-homicide county	1.3 times <b>worse</b> for Hispanic Ohioans
Broadband internet access	1.2 times <b>worse</b> for Hispanic Ohioans
Air pollution	1.1 times <b>worse</b> for Hispanic Ohioans
Experiences of racism	
Unfair treatment due to race for children	15.8 times <b>worse</b> for Hispanic Ohioans

This profile describes the magnitude of difference in outcomes between Hispanic/Latino(a) Ohioans and white Ohioans. Data sources are available in data appendices posted on the [HPIO Health Value Dashboard web page](#).



# EQUITY PROFILES

## Disability status

Ableist and other discriminatory policies, systems and beliefs unfairly limit Ohioans with disabilities' access to resources, representation and opportunity and result in, for example, lack of education and employment accommodations and accessible transportation, housing and healthcare.

### If the playing field was leveled:

**181,488** Ohioans with disabilities would not delay care due to cost

**25,666** Ohioans with disabilities would be employed

The percent of students with disabilities who were chronically absent from school would drop from about one in five to one in ten.

Ohioans with disabilities experience much worse outcomes than Ohioans without disabilities across measures of health, healthcare and the social, economic and physical environment. Ableism and other forms of discrimination are primary drivers of the poor outcomes facing Ohioans with disabilities.

Health	
Adult depression	3.6 times worse for Ohioans with disabilities
Adult diabetes	2.1 times worse for Ohioans with disabilities
Access and healthcare system	
Unable to see doctor due to cost	2.6 times worse for Ohioans with disabilities
Social and economic environment	
Disconnected youth	3.3 times worse for Ohioans with disabilities
Unemployment	2.5 times worse for Ohioans with disabilities
High school graduation	2.4 times worse for Ohioans with disabilities
Adverse childhood experiences	2.1 times worse for Ohioans with disabilities
Chronic absenteeism	1.7 times worse for Ohioans with disabilities
Child poverty	1.6 times worse for Ohioans with disabilities
Fourth-grade reading	1.5 times worse for Ohioans with disabilities
Physical environment	
Food insecurity	3.1 times worse for Ohioans with disabilities

This profile describes the magnitude of difference in outcomes between Ohioans with disabilities and without disabilities. Data sources are available in data appendices posted on the [HPIO Health Value Dashboard web page](#).

# EQUITY PROFILES

## Education and income

Without a post-secondary education, Ohioans are less likely to work in a job that pays a self-sufficient income, resulting in a lack of access to critical resources such as health care, safe and quality housing, healthy foods, reliable transportation and child care.

### If the playing field was leveled:

**88,248** Ohioans with less than a high school education would not delay health care due to cost

**26,148** Ohioans with less than a high school education would be employed

**96,510** children in families with low incomes would have enough to eat

**Ohioans with less than a high school education and lower incomes have much worse outcomes than Ohioans with higher educational attainment and incomes** across measures of health, healthcare and the social, economic and physical environment.

Health	
Poor oral health	3.2 times <b>worse</b> for people with low incomes
Adult diabetes	2.2 times <b>worse</b> for people with less than high school education
Adult depression	1.8 times <b>worse</b> for people with less than high school education
Heart disease mortality	1.4 times <b>worse</b> for people with less than high school education
Access and healthcare system	
Uninsured, adults	6.6 times <b>worse</b> for people with less than high school education
Prenatal care	3.7 times <b>worse</b> for people with less than high school education
Unable to see doctor due to cost	2.6 times <b>worse</b> for people with less than high school education
Social and economic environment	
Unemployment	6 times <b>worse</b> for people with less than high school education
Chronic absenteeism	3.8 times <b>worse</b> for people with low incomes
High school graduation	3.2 times <b>worse</b> for people with low incomes
Adverse childhood experiences	2.1 times <b>worse</b> for children with parents with less than a high school education
Disconnected youth	1.8 times <b>worse</b> for people with less than high school education
Fourth-grade reading	1.7 times <b>worse</b> for people with low incomes
Physical environment	
Food insecurity	13.1 times <b>worse</b> for Ohioans with low incomes
Broadband internet access	7.1 times <b>worse</b> for people with less than high school education
Child in a household with a person who smokes	4.5 times <b>worse</b> for children with parents with less than a high school education

This profile describes the magnitude of difference in outcomes between Ohioans with a high school education or less and those with a college degree or higher or people with low incomes and people with higher incomes. Data sources are available in data appendices posted on the [HPIO Health Value Dashboard web page](#).

# EQUITY PROFILES

## Other systematically disadvantaged Ohioans

Not all groups that experience poorer outcomes are represented in existing and/or publicly available data due to factors discussed in the data challenges section below. In addition, many Ohioans are part of more than one systematically disadvantaged group, and as a result, experience more disparate outcomes than what is captured in data.

Racist, xenophobic, homophobic, transphobic, ageist and other discriminatory policies, systems and beliefs lead to acts of hate and violence and unfairly limit equitable access to resources, representation and opportunity for these additional groups of Ohioans:



- In 2019, the percent of adults who were unable to see a doctor due to cost was 1.6 times higher for Asian American Ohioans than for white Ohioans.
- In 2016-2019, the percent of Asian American children in Ohio who have ever been treated or judged unfairly because of their race was 10.3 times higher than for white children.



- In 2018, 32.9% of Ohioans who identified as LGBT reported poor mental health for more than two weeks out of the past month, compared to 13.7% who did not identify as LGBT.<sup>1</sup>
- In 2008, the percent of Ohioans with very low incomes who identified as transgender or gender non-conforming was 4.3 times higher than in the general population.<sup>2</sup>



- As of March 2021, 93% of people who died with COVID-19 were age 60 or older and 38% of total deaths were for residents of long-term care facilities.<sup>3</sup> Living in a congregate setting is a risk factor for contracting COVID-19.<sup>4</sup>
- In 2017, between 7.8% and 14.5% of Ohioans, ages 65 and older, avoided health care due to lack of transportation.<sup>5</sup>



- In 2018, the youth suicide rate in Appalachian counties was 1.5 times higher than the overall youth suicide rate.<sup>6</sup>
- There is a gap of more than 29 years in life expectancy at birth in Ohio depending on the census tract where a person lives.<sup>7</sup>

## Data challenges

### • Limited ability to stratify data on multiple levels.

Disaggregated data for Ohioans who are part of more than one systematically disadvantaged group is very limited (e.g., Ohioans of color with disabilities).

### • Lack of comprehensive data collection.

Comprehensive information to identify gaps in outcomes is not consistently collected across systems and sectors (e.g., sexual and gender identity, detailed race and ethnicity and immigration and/or refugee status information).

### • Data not reported for small population groups.

Data for groups with smaller population sizes is sometimes not reported or aggregated with data for other groups (e.g., not reporting data on communities of

color living in Appalachian counties or aggregating data for all Asians and Pacific Islanders). This is done to protect privacy or due to concerns about the reliability of data collected from small samples. The consequence, however, is a lack of data to identify inequities and disparities faced by these groups.

### • Lack of local data.

Disaggregated data often is not available for localities, such as county, zip code or census tract.

### • Non-response.

Inadequate training on how to collect personal, demographic data, including lack of explanation on why data is being collected, can lead to high "no response" rates.

## Notes

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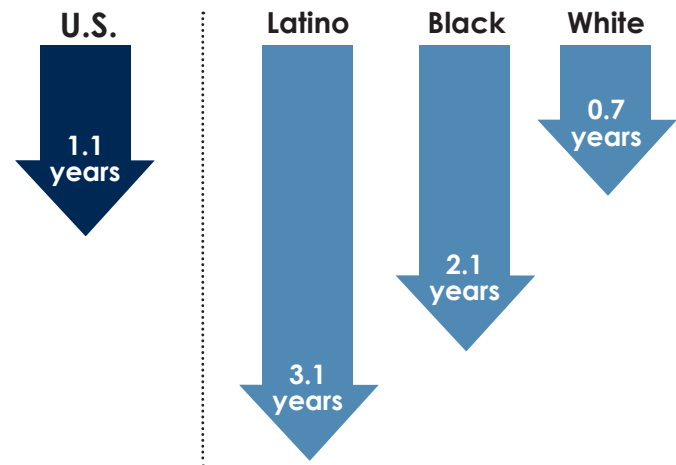
# Impact of COVID-19 on health value

The COVID-19 pandemic has resulted in numerous health, social and economic challenges since March 2020. Though the full impacts of COVID-19 on health value cannot yet be fully assessed, researchers estimate that life expectancy in the U.S. dropped by 1.1 years in 2020, the largest single-year decline in more than 40 years.<sup>1</sup>

Preliminary data and analysis suggest that COVID-19 has affected, and will continue to affect, the many factors that influence health, including employment, education, public health and healthcare. Examples of specific impacts include:

- **Education.** Reading test scores indicate that Ohio third-graders experienced about one-third of a year of learning loss by fall of 2020.<sup>2</sup>
- **Unemployment.** The economic downturn stemming from the COVID-19 pandemic led to increased unemployment in the U.S. Ohio's unemployment rate more than tripled in the early months of the pandemic, growing from 4.9% in March 2020 to 16.4% in April 2020. As of Feb. 2021, the rate is 5%.<sup>3</sup>
- **Immunizations.** Child immunizations have decreased rapidly since the beginning of the COVID-19 pandemic, likely due to delayed routine check-ups.<sup>4</sup>
- **Early cancer diagnosis.** Cancer screenings decreased early in the pandemic.<sup>5</sup>
- **Healthcare spending.** More than one in three non-elderly adults in the U.S. have reported that they delayed seeking or getting healthcare since March 2020.<sup>6</sup> Year-to-year spending on healthcare services fell by approximately 2% from 2019 to 2020, the first decline in health spending in decades.<sup>7</sup>
- **Drug overdose deaths.** Rates of substance use and opioid use disorder are likely to increase, although the magnitude of COVID-19's impact is not yet known.<sup>8</sup> Preliminary data from 2020 show that overdose rates increased by 20% in Ohio compared to 2019, reversing a previous downward trend.<sup>9</sup>

## Estimated decline in life expectancy from 2019 to 2020



## Impact on health equity

The COVID-19 pandemic is disparately impacting systematically disadvantaged communities across Ohio, including Ohioans of color, with disabilities and residents of urban or Appalachian counties.<sup>10</sup> In many cases, the impact of the pandemic is widening existing inequities and health disparities. For example:

- **Life expectancy.** Researchers estimate that Black and Hispanic Americans will experience an outsized decline in life expectancy — 2.1 years and 3.1 years respectively — compared to the 1.1 years of decline in life expectancy for all Americans because of the COVID-19 pandemic.<sup>11</sup>
- **Education.** Analysis of Ohio data in the fall 2020 found that declines in third-grade reading test scores for economically disadvantaged students were more pronounced for non-economically disadvantaged students.<sup>12</sup>
- **Unemployment.** In the fourth quarter of 2020, the unemployment rate for Black Ohioans (11.1%) was 2.3 times that of white Ohioans (4.8%).<sup>13</sup>

## Notes

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11. Andrasfay, Theresa and Noreen Goldman, "Reductions in 2020 US life expectancy due to COVID-19 and the disproportionate impact on the Black and Latino populations." Proceedings of the National Academy of Sciences Feb 2021, 118 (5) e2014746118; DOI: 10.10173/pnas.2014746118
12. Kogan, Vladimir and Stéphane Lavertu. "The COVID-19 Pandemic and Student Achievement on Ohio's Third-Grade English Language Arts Assessment\*." The Ohio State University, 2021. [http://gienn.osu.edu/educational-governance/reports/reports-attributes/ODE\\_ThirdGradeELA\\_KL\\_1-27-2021.pdf](http://gienn.osu.edu/educational-governance/reports/reports-attributes/ODE_ThirdGradeELA_KL_1-27-2021.pdf)
13. "State unemployment by race and ethnicity." Economic Policy Institute, Economic Indicators, March 2021. <https://www.epi.org/indicators/state-unemployment-race-ethnicity/>

# Access to care

## Ohio's success

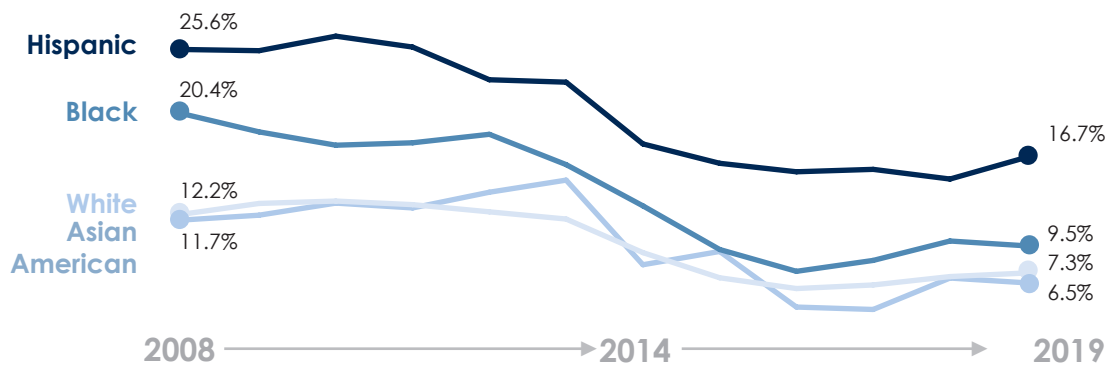
Looking back over the four editions of the *Health Value Dashboard*, Ohio's performance on access to care stands out as an important trend.

**Strong performance.** In 2021, Ohio ranks seven in the access-to-care domain — the first time Ohio has ranked in the top quartile on a *Health Value Dashboard* domain. Ohio performed particularly well relative to other states on primary care access and behavioral health. (Performance on oral health access however, was not strong compared to other states, signaling an opportunity for improvement.)



**Improvement is possible. Policy works.** Over the past decade, there have been major policy changes to improve access to care, including Ohio's expansion of Medicaid eligibility in 2014 and initiatives to improve primary care and increase access to addiction treatment. Ohio's non-elderly uninsured rate fell from 14% in 2008 to 8% in 2019, with disparity gaps moderately narrowing.

### Percent of non-elderly Ohioans who are uninsured, ages 0-64, 2008-2019



**Necessary, but not sufficient.** Ohio's population health outcomes remain poor, despite Ohio's relatively strong performance on access to care. Access to care is critical, particularly for Ohioans with serious health conditions. But health is shaped by many factors, including our social, economic and physical environments. In order to improve health value, Ohio will need to maintain gains in access to care and go further upstream to comprehensively address all drivers of health and equity.

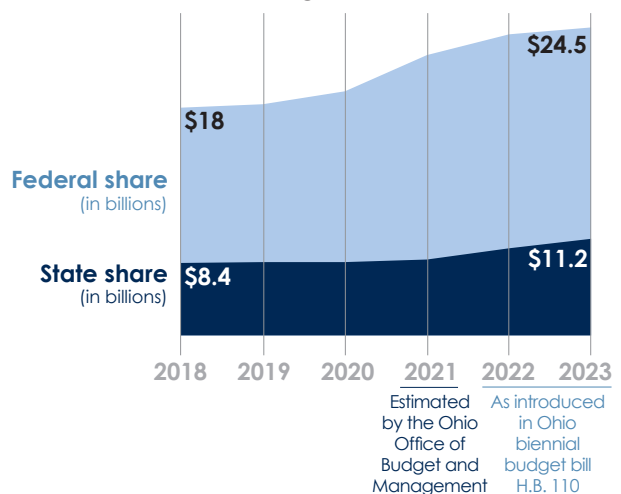
### Medicaid and access

**About one-quarter of Ohioans (26%) were enrolled in Medicaid in SFY 2020.** Ohio's per-enrollee spending is similar to the overall U.S. rate. The federal government funded 68% of Ohio's Medicaid spending in SFY 2020. The state's share of total Medicaid spending rose slowly from 2018 to 2021 and is projected to increase after discontinuation of enhanced federal assistance during the pandemic.

#### Medicaid spending per enrollee, FY 2019



#### Ohio Medicaid spending, 2018-2023



# Strengths & Challenges

Metrics in which Ohio ranks in the **top quartile**

## HEALTHCARE SPENDING

12	Employee contributions to employer-sponsored insurance premiums
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## ACCESS TO CARE

2	Routine checkup
6	Underserved, primary care physicians
7	Medical home, children
7	Unmet need for mental health treatment, adults
7 <small>(out of 50)</small>	Underserved, mental health
8	Received mental health treatment in past year, children
12	Outpatient medication-assisted treatment

## HEALTHCARE SYSTEM

7	Back pain recommended treatment
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## PUBLIC HEALTH AND PREVENTION

2 <small>(out of 49)</small>	Accreditation of local health departments
12	Falls among older adults

## PHYSICAL ENVIRONMENT

13	Severe housing problems
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Metrics in which Ohio ranks in the **bottom quartile**

## POPULATION HEALTH

48	Adult smoking
47	Drug overdose deaths
44	Limited activity due to health problem
42	Heart disease mortality
42	Infant mortality
40	Youth all-tobacco use
40	Poor oral health
40	Premature death

## HEALTHCARE SPENDING

43	Total Medicare spending, per beneficiary
42	Employer-sponsored health insurance outpatient spending, per enrollee
39	Hospital adjusted expenses per inpatient day
39 <small>(out of 49)</small>	Average monthly marketplace premium

## HEALTHCARE SYSTEM

46	Heart failure admissions for Medicare beneficiaries
45	Cancer early stage diagnosis
42	Colon and rectal cancer early stage diagnosis
42	Potentially avoidable emergency department visits for employer-insured enrollees
39	Mortality amenable to healthcare

## PUBLIC HEALTH AND PREVENTION

51	Health security surveillance
48	State public health workforce
48	State public health funding, per capita
41	Environmental and occupational health
39	Seat belt use

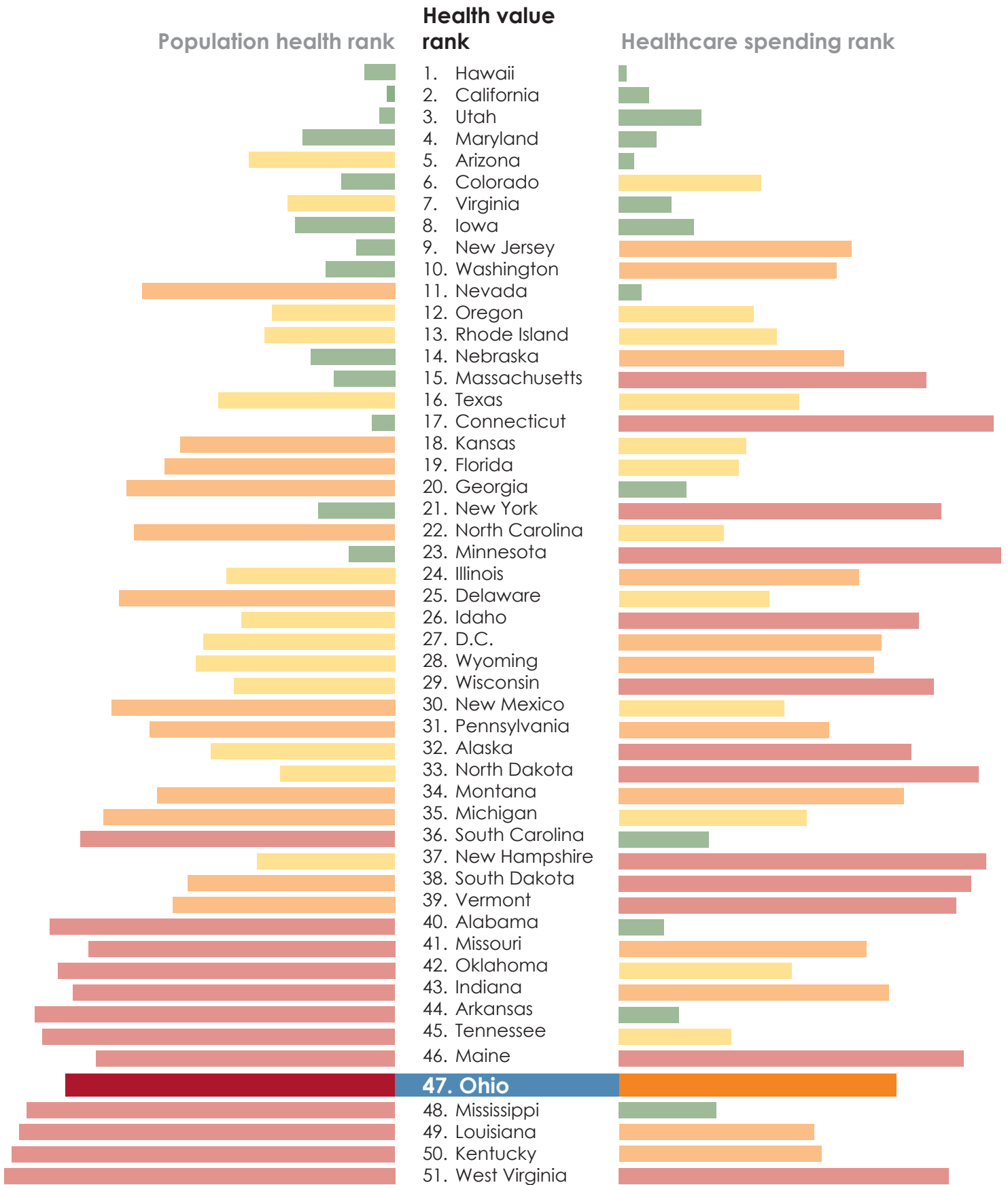
## SOCIAL AND ECONOMIC ENVIRONMENT

40	Unemployment
39	Children in single-parent households
39 <small>(out of 50)</small>	Incarceration
39	Adverse childhood experiences

## PHYSICAL ENVIRONMENT

48	Toxic pollutants (Risk-Screening Environmental Indicators score)
46	Outdoor air quality
39	Food insecurity

# Where other states rank



# Acknowledgments

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## HPIO Dashboard advisory groups

Health Measurement Advisory Group (HMAG) members contributed expertise on development of the conceptual framework, selection of metrics, and layout and design of the *Dashboard*. A complete list of HMAG members is posted on the [HMAG 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](#).



HPIO thanks our core funders, who support the creation of the *Health Value Dashboard* and advancing the health of Ohioans through informed policy decisions.

- **bi3**
- **CareSource Foundation**
- **The Cleveland Foundation**
- **The George Gund Foundation**
- **HealthPath Foundation of Ohio**
- **Interact for Health**
- **Mercy Health**
- **Mt. Sinai Health Care Foundation**
- **Nord Family Foundation**
- **North Canton Medical Foundation**
- **Saint Luke's Foundation of Cleveland**
- **Sisters of Charity Foundation of Canton**
- **Sisters of Charity Foundation of Cleveland**



The HPIO *Health Value Dashboard* was funded in part by Health Action Council.