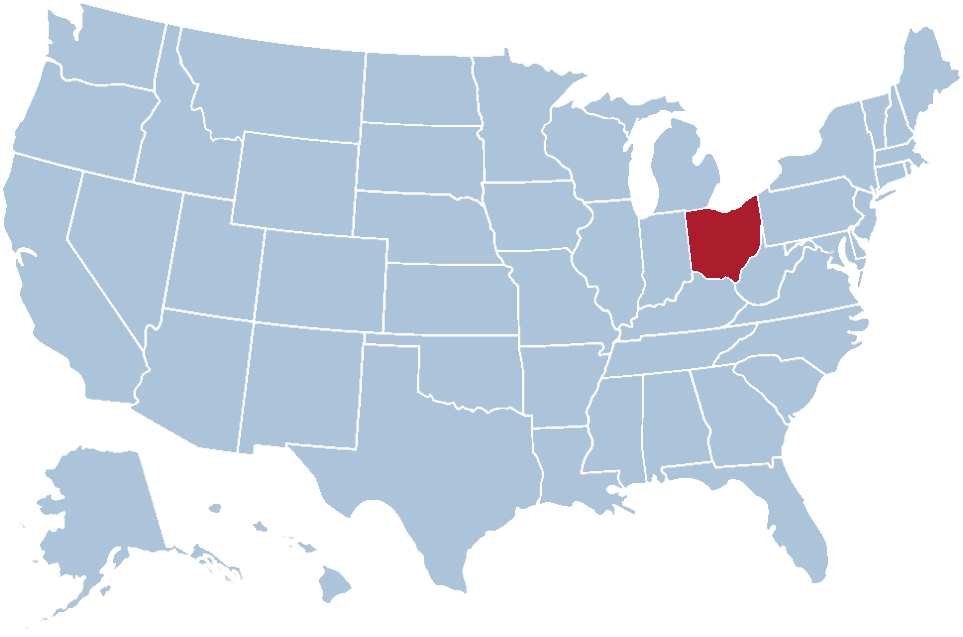
hpio
health policy institute of ohio

2019 Health Value Dashboard



April 2019

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Snapshot

What is the *Health Value Dashboard*?

The Health Policy Institute of Ohio's *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 rank and trend performance relative to other states and highlights gaps in outcomes between groups for some of Ohio's most at-risk populations.

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 less healthy and spend more on health care than people in most other states.
- **Ohio ranks in the bottom quartile on nearly 30 percent of metrics** and in the top quartile on only 5 percent of metrics, out of 100 metrics ranked in the *Dashboard*.

Key findings

- **Access to care is necessary, but not sufficient**. Ohio performs relatively well on access to care (second quartile) but poorly on the other factors that influence overall health, landing in the bottom half of states for the social and economic environment, physical environment, public health and prevention and healthcare system domains.
- **Tobacco use drives poor health**. Ohio ranks in the bottom quartile for adult smoking and children living in a household with a smoker. All states in the top quartile for health value have lower rates of adult smoking than Ohio.
- **Ohio's per person spending for older Medicaid enrollees (aged category) is 1.4 times more than the U.S. rate**; however, Ohio's overall Medicaid spending per enrollee is relatively similar to other states. This suggests Ohio's healthcare spending needs to be re-aligned to provide greater support for healthy aging and prevention as a way to reduce spending on costly sick care later in life.

Why does Ohio rank poorly?

Too many Ohioans are left behind

Without a strong foundation, not all Ohioans have the same opportunity to be healthy. For example, Ohioans with disabilities or Ohioans who are racial or ethnic minorities, have lower incomes or educational attainment, are sexual or gender minorities and/or who live in rural or Appalachian counties, are more likely to face multiple barriers to health.

Resources are out of balance

Ohio's healthcare spending is mostly on costly downstream care to treat health problems. This is largely because of many missed upstream opportunities to prevent or better manage injury, illness and disability for thousands of Ohioans.

Addiction is holding Ohioans back

Addiction is a complex problem at the root of many of Ohio's greatest health value challenges, including drug overdose deaths, unemployment and incarceration.

View all 2019 *Health Value Dashboard* materials at:

www.hpio.net/2019-health-value-dashboard

Nine strategies that work to improve health value

The prioritized strategies highlighted below have strong evidence of effectiveness[1], address key factors identified by *Dashboard* analysis and are actionable for state policymakers. In addition, research evidence indicates that all these policies and programs are likely to decrease disparities[2], and most have also been found to be cost effective or cost saving.[3]

Create opportunities for all Ohio children to thrive

1. **Increase investment in evidence-based home visiting** to ensure Ohio's most at-risk families have access to services, including all families under 200 percent of the federal poverty level.
2. **Expand access to quality early childhood education** by fully implementing Ohio's Step Up to Quality rating system and expanding eligibility for Ohio's child care subsidy from 130 percent to at least 200 percent of the federal poverty level.
3. **Expand access to lead screening and abatement services** by increasing funding to the state's lead poisoning prevention fund, providing tax incentives for lead abatement and expanding the lead abatement workforce to reduce lead exposure for Ohio's most at-risk children, including children living in low-income families.

Invest upstream in employment, housing and transportation

4. **Strengthen the state earned income tax credit** by increasing the rate above 10 percent, lifting the existing cap on the credit and/or making it refundable.
5. **Increase the availability of safe, accessible and affordable housing** for low-income and other at-risk Ohioans by increasing investment in the Ohio Housing Trust Fund.
6. **Increase state investment in public transportation**, prioritizing transit strategies that improve accessibility and better connect low-income workers to jobs and education.

Build and sustain a high-quality addiction prevention, treatment and recovery system

7. **Prioritize tobacco reduction** by increasing use of cessation counseling and medications, expanding prevention media campaigns, increasing the price of tobacco products and restricting youth access to e-cigarettes.
8. **Implement comprehensive evidence-based drug prevention programs and social-emotional learning in schools**, such as LifeSkills, PAX Good Behavior Game and Positive Behavioral Interventions and Supports (PBIS). Sustain effective programs over time through better state agency coordination and establishment of a wellness trust.
9. **Strengthen the behavioral health workforce** through increased reimbursement rates, equal insurance coverage for behavioral health services (parity), student loan repayment programs and continuing to integrate with physical health care.

1. All of the strategies prioritized here have been recommended by the **Guide to Community Preventive Services** (CG) based on systematic reviews of evidence of effectiveness and/or are included in **What Works for Health** (WWFH). WWFH has rated most of these strategies as "scientifically supported," indicating strong evidence of effectiveness. This is not an exhaustive list of effective strategies.
2. WWFH assesses a policy or program's likely effect on various groups in reducing health disparities based on the best available research evidence. CG identifies equity strategies based on findings from systematic reviews of effectiveness and economic evidence issued by the Community Preventive Services Task Force.
3. Five of the strategies listed above are recommended by the **CDC's Health Impact in 5 Years initiative (Hi-5)** which highlights approaches that have evidence of positive health impacts, results within five years and cost effectiveness and/or cost savings over the lifetime of the population or earlier. For benefit-cost information about many of the other strategies listed here, see benefit-cost analyses from the **Washington State Institute for Public Policy**.

Where does Ohio rank?

Ohioans are less healthy and spend more on health care than people in most other states.

43 Population health

Ohio ranks 43rd on population health. Forty-two states are healthier. This domain rank* includes subdomain rankings for:

- 46 **Health behaviors**
- 44 **Conditions and diseases**
- 40 **Overall health and wellbeing**

+

28 Healthcare spending

Ohio ranks 28th on healthcare spending. Twenty-seven states spend less. This domain rank* includes subdomain rankings for:

- 22 **Total and out-of-pocket spending**
- 19 **Private health insurance spending**
- 35 **Healthcare service area spending**
- 27 **Medicare spending**

46 Health value in Ohio

Ohio ranks 46th on health value — a composite measure of population health and healthcare spending metrics.

Top quartile | Second quartile | Third quartile | Bottom quartile

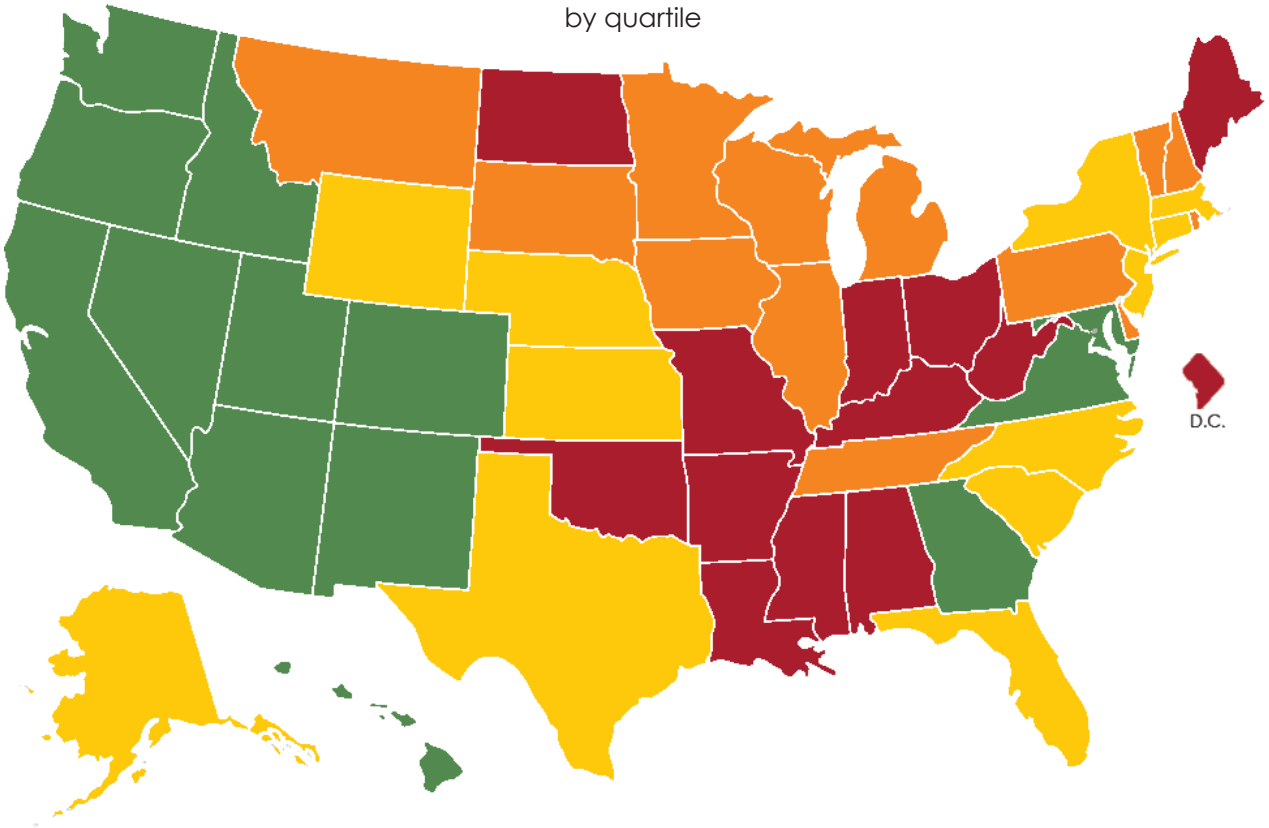
Of the 50 states and D.C.

*The domain and subdomain ranks are the composite of individual metric ranks. For example, adult smoking is a metric under the health behaviors subdomain of population health.

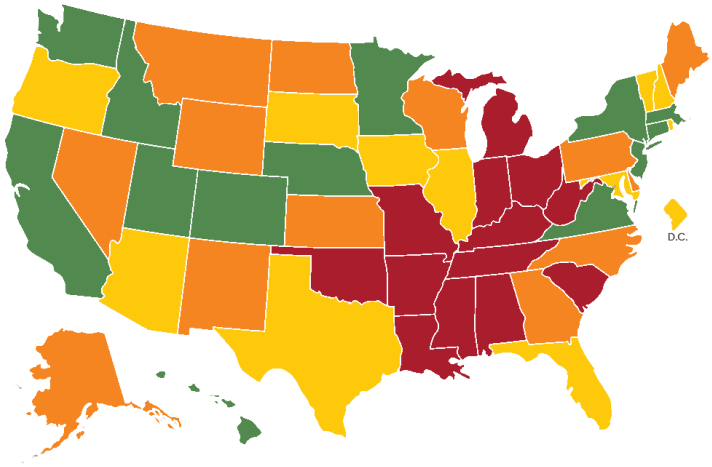
Note: Health value rank equally weights the population health and healthcare spending domains. The rank is not an average of population health and healthcare spending rank. For more details, see the methodology section on the ***2019 Health Value Dashboard*** **webpage**.

Where do other states rank?

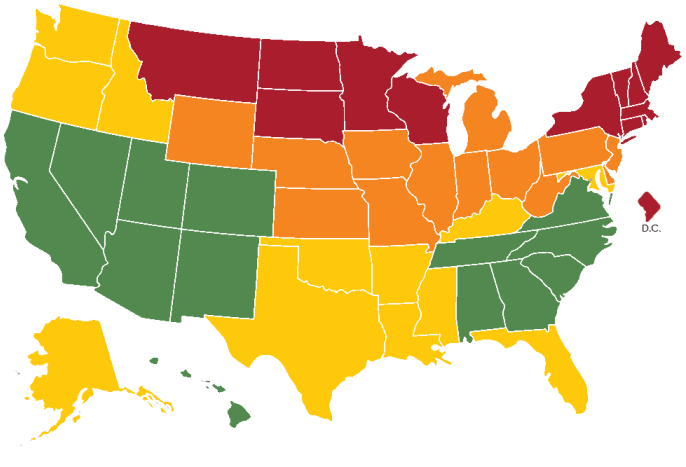
Health value rank
by quartile



Population health rank
by quartile



Healthcare spending rank
by quartile



Top quartile | Second quartile | Third quartile | Bottom quartile

Of the 50 states and D.C.

Note: Health value rank equally weights the population health and healthcare spending domains. The rank is not an average of population health and healthcare spending rank. For more details, see the methodology section on the **2019 *Health Value Dashboard* webpage**.

Ohio's greatest health value strengths and challenges

Top and **bottom** quartile metrics in the domains that contribute to health value

Social and economic environment

43	Unemployment
38	Adult incarceration*

Physical environment

48	Child in household with a smoker
46	Outdoor air quality
40	Food insecurity

Access to care

11	Medical home, children
47	Preventive dental care, children

Healthcare system

13	Back pain recommended treatment
48	Cancer early stage diagnosis
44	Potentially avoidable emergency department visits for employer-insured enrollees**
43	Colon and rectal cancer early stage diagnosis
41	30-day hospital readmissions for employer-insured enrollees**

Public health and prevention

7	Comprehensiveness of public health system***
51	Health security surveillance
48	Emergency preparedness funding, per capita
46	Child immunization
45	State public health workforce*
45	Environmental and occupational health
42	Seat belt use

Top and **bottom** quartile metrics for health value

Population health

50	Drug overdose deaths
44	Infant mortality
44	Adult smoking
43	Premature death
42	Life expectancy
42	Poor oral health
41	Adult obesity
40	Adult insufficient physical activity
39	Cardiovascular disease mortality

Healthcare spending

3	Employee contributions to employer-sponsored insurance premiums
41	Nursing home care spending, per capita
41	Hospital care spending, per capita
39	Total Medicare spending, per beneficiary
39	Average total cost, per Medicare beneficiary with three or more chronic conditions

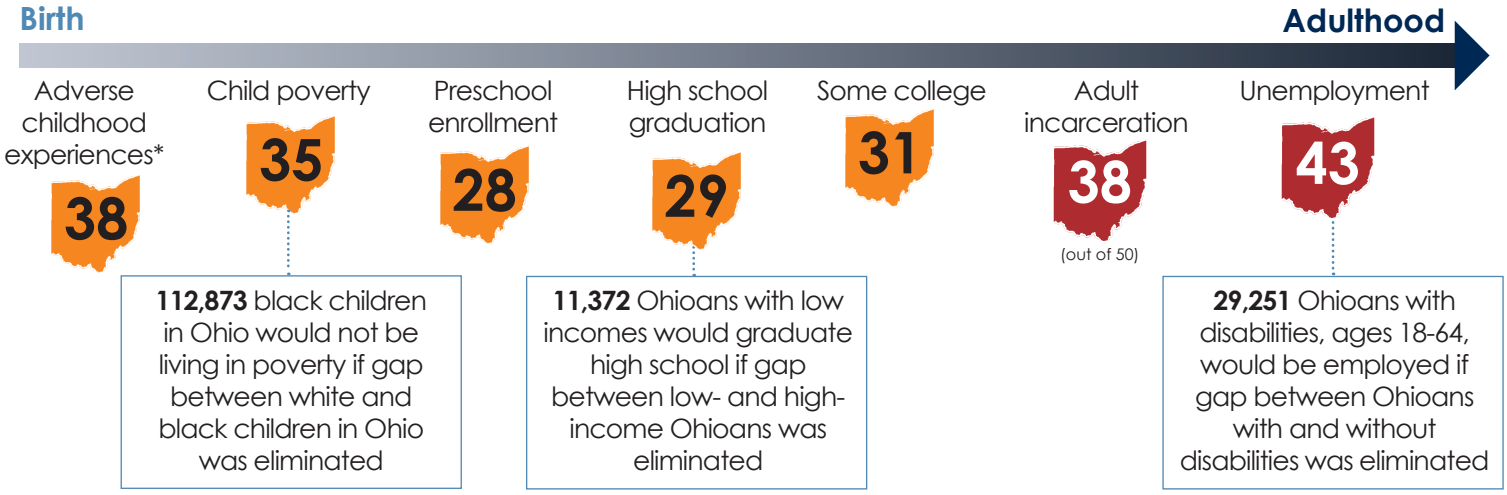
* Ranking out of 50 states
** Ranking out of 49 states
*** Ranking out of 48 states
Note: Metrics in the top quartile that greatly worsened are not included. Ohio has no top quartile metrics for social and economic environment, physical environment and population health.

Why does Ohio rank poorly?

Too many Ohioans are left behind

- **Many Ohioans experience poorer health outcomes** including Ohioans with disabilities or Ohioans who are racial or ethnic minorities, have lower incomes or educational attainment, are sexual or gender minorities and/or who live in rural or Appalachian counties.
- **These groups of Ohioans face barriers to being healthy** due to, for example, unequal access to post-secondary education, a job that pays a self-sufficient income, quality housing and increased exposure to adverse childhood experiences, racism and discrimination.

Without a strong foundation, not all Ohioans have the same opportunity to be healthy



*Adverse childhood experiences include a child's exposure to family dysfunction, addiction in the home, domestic or neighborhood violence and living in a family with financial hardship.

How can we improve?

Create opportunities for all Ohio children to thrive

What works?[1]

- **Increase investment in evidence-based home visiting** to ensure Ohio's most at-risk families have access to services, including families under 200 percent of the federal poverty level.
- **Expand access to quality early childhood education** by fully implementing Ohio's Step Up to Quality rating system and expanding eligibility for Ohio's child care subsidy from 130 percent to at least 200 percent of the federal poverty level.
- **Expand access to lead screening and abatement services** by increasing funding to the state's lead poisoning prevention fund, providing tax incentives for lead abatement and expanding the lead abatement workforce to reduce lead exposure for Ohio's most at-risk children and children living in low-income families.

1. All of the strategies prioritized here have been recommended by The Guide to Community Preventive Services and/or are rated by What Works for Health as "scientifically supported," indicating strong evidence of effectiveness.

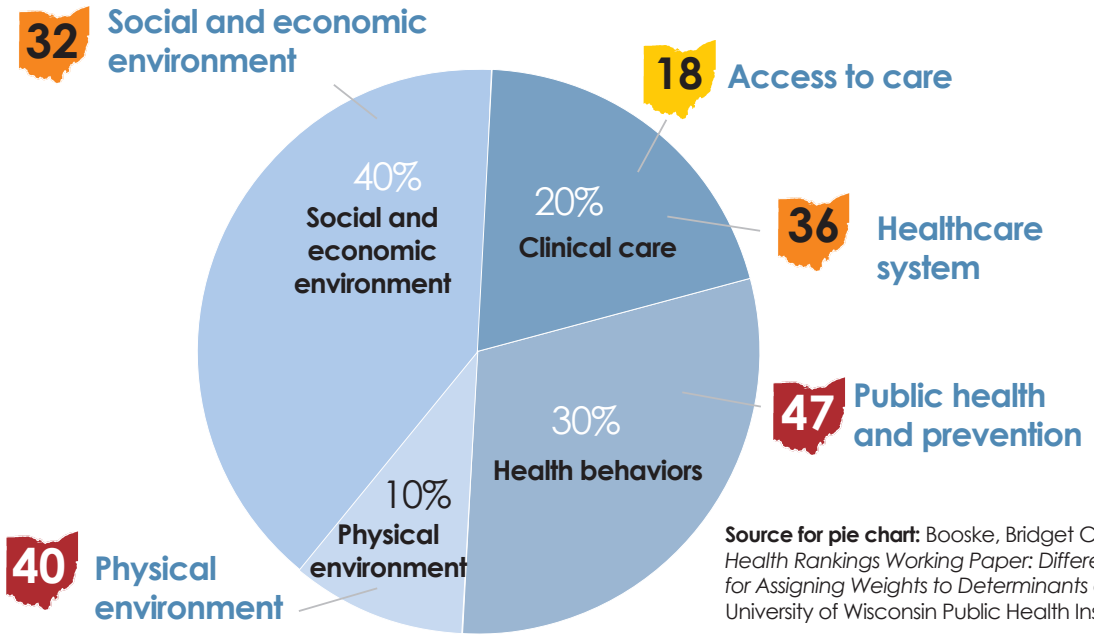
Why does Ohio rank poorly?

Resources are out of balance

- **Ohio performs poorly on many of the factors that influence overall health,** but relatively well on access to care.
- **Ohio's healthcare spending is mostly on costly downstream care to treat health problems.** This is largely because of many missed upstream opportunities to prevent or better manage injury, illness and disability for thousands of Ohioans.

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

Researchers estimate that only 20 percent of the modifiable factors that influence health are attributed to clinical care. Eighty percent of overall health is shaped by nonclinical factors in the social, economic and physical environments, such as access to quality education and housing, as well as our behaviors.



Source for pie chart: Booske, Bridget C. et. Al. *County Health Rankings Working Paper: Different Perspectives for Assigning Weights to Determinants of Health*. University of Wisconsin Public Health Institute, 2010.

How can we improve?

Invest upstream in employment, housing and transportation

What works?[1]

- **Strengthen the state earned income tax credit** by increasing the rate above 10 percent, lifting the existing cap on the credit and/or making it refundable.
- **Increase the availability of safe, accessible and affordable housing** for low-income and other at-risk Ohioans by increasing investment in the Ohio Housing Trust Fund.
- **Increase state investment in public transportation**, prioritizing transit strategies that improve accessibility and better connect low-income workers to jobs and education.

1. All of the strategies prioritized here are included in What Works for Health (WWFH). WWFH has rated most of these strategies as "scientifically supported," indicating strong evidence of effectiveness.

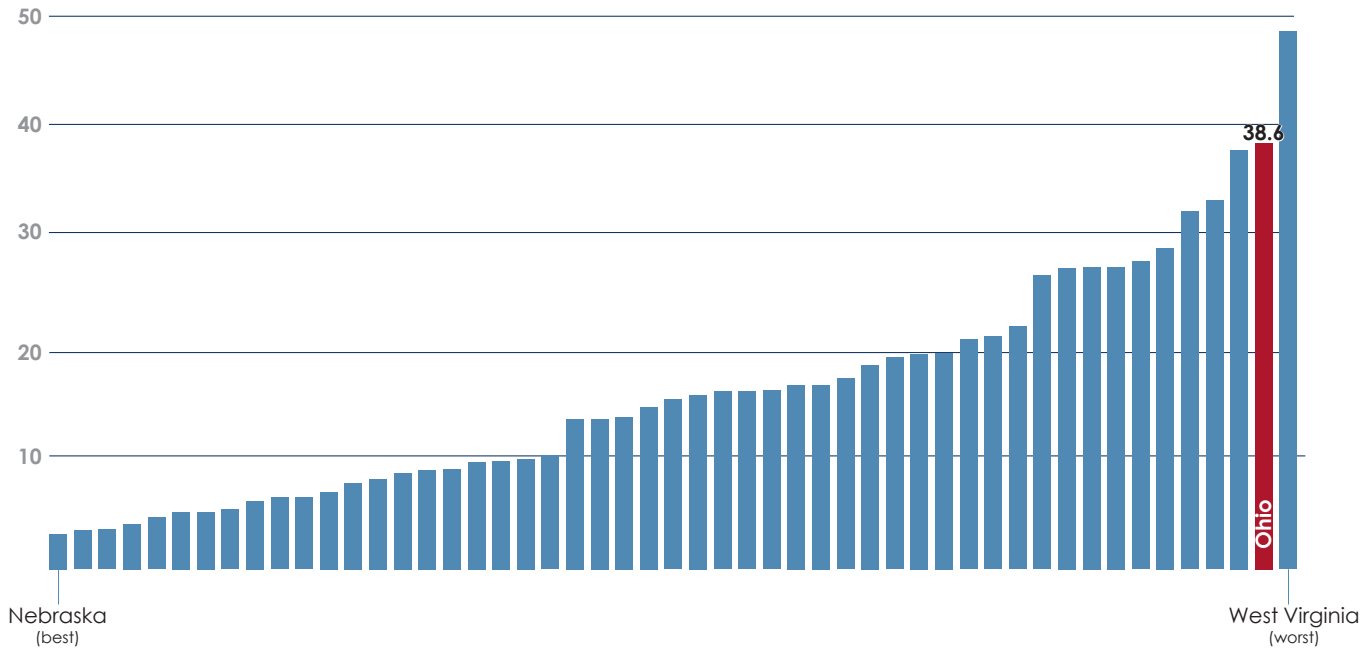
Why does Ohio rank poorly?

Addiction is holding Ohioans back

- **Addiction is a complex problem at the root of many of Ohio's greatest health value challenges**, including drug overdose deaths, unemployment and incarceration.
- **Critical gaps remain in addressing Ohio's addiction crisis**, including a patchwork approach to school and community-based prevention and inadequate provider capacity for medication-assisted treatment, psychosocial treatment and recovery services.

Ohio ranks at the bottom for overdose death rate

Overdose death rate per 100,000 population, 2017



Source: Centers for Disease Control and Prevention, Wide-ranging Online Data for Epidemiologic Research (CDC WONDER)

How can we improve?

Build and sustain a high-quality addiction prevention, treatment and recovery system

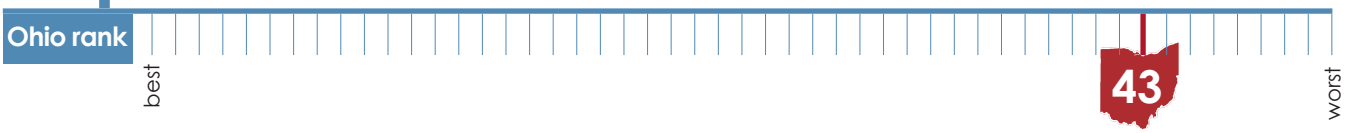
What works?[1]

- **Implement comprehensive evidence-based drug prevention programs and social-emotional learning in schools**, such as LifeSkills, PAX Good Behavior Game and Positive Behavioral Interventions and Supports (PBIS).
- **Sustain effective programs over the long term** by establishing one state-level entity to coordinate, evaluate and support school-based prevention and mental health promotion and creating a wellness trust to fund school and community-based prevention in all Ohio communities.
- **Strengthen the behavioral health workforce** through increased reimbursement rates, equal insurance coverage for behavioral health services (parity), student loan repayment programs and continuing to integrate with physical health care.

1. All of the strategies prioritized here have been recommended by The Guide to Community Preventive Services and/or are included in What Works for Health (WWFH). WWFH has rated most of these strategies as "scientifically supported," indicating strong evidence of effectiveness.

2019 **Health Value Dashboard**

Population health



Ohio's rank	Metric	Most recent data	Trend
46	**Health behaviors**		
37	**Excessive drinking.** Percent of adults that report either binge drinking, defined as consuming more than four (women) or five (men) alcoholic beverages on a single occasion in the past 30 days, or heavy drinking, defined as drinking more than one (women) or two (men) drinks per day on average (2017)	20.2%	No change
37	**Youth all-tobacco use.** 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) (2016-2017)	6.8%	Moderately improved
40	**Adult insufficient physical activity.** Percent of adults, ages 18 and older, not meeting physical activity guidelines for muscle strength and aerobic activity (2017)	81.7%	No change
44	**Adult smoking.** Percent of adults, ages 18 and older, who are current smokers (2017)	21.1%	No change
44	**Conditions and diseases**		
20 (out of 50)	**Suicide deaths.** Number of deaths due to suicide, per 100,000 population (2016)	14.2	No change
36	**Adult depression.** Percent of adults who have ever been told by a health professional that they have depression (2017)	22.6%	Moderately worsened
37	**Adult diabetes.** Percent of adults who have ever been told by a health professional that they have diabetes (2017)	11.3%	No change
39	**Cardiovascular disease mortality.** Number of deaths due to all cardiovascular diseases, including heart disease and strokes, per 100,000 population (2016)	276.4	No change
41	**Adult obesity.** Percent of adults, ages 18 and older, who are obese (body mass index of 30 or higher) (2017)	33.8%	**Greatly worsened**
42	**Poor oral health.** Percent of adults, ages 18-64, who have lost six or more teeth because of tooth decay, infection or gum disease (2016)	14%	No change
44	**Infant mortality.** Number of infant deaths, per 1,000 live births (within one year) (2017*)	7.2*	No change
50	**Drug overdose deaths.** Number of deaths due to drug overdose, per 100,000 population (2017)	38.6	**Greatly worsened**
40	**Overall health and wellbeing**		
34	**Overall health status.** Percent of adults who report excellent, very good or good health (2017)	81.1%	Moderately worsened
36	**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 (2017)	1.8	Moderately worsened
42	**Life expectancy.** Life expectancy at birth based on current mortality data and population estimates (2016)	77.1	No change
43	**Premature death.** Average number of years of potential life lost before age 75, per 100,000 population (2017)	8,724	Moderately worsened

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.

Trend note: 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 ***2019 Health Value Dashboard* webpage**.

*2017 data was available for Ohio, but not for other states. 2016 data was used to rank and for all other states.

Deeper dive: **Population health**

Tobacco use drives poor health

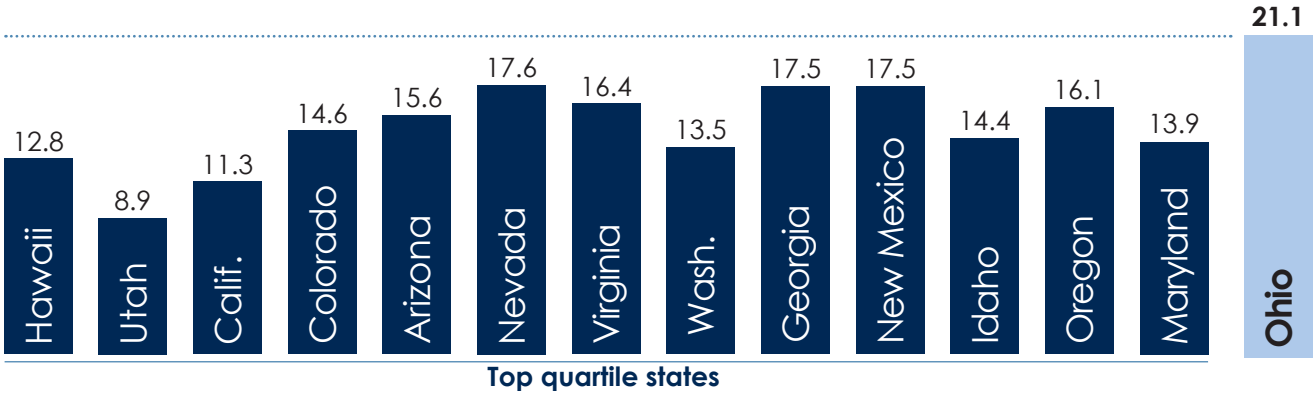
Tobacco use is a key factor contributing to Ohio's poor performance on health:

- **Ohio ranks in the bottom quartile** for adult smoking and children living in a household with a smoker.
- **Tobacco use and secondhand smoke exposure contribute to many of Ohio's greatest health challenges**, including infant mortality, cardiovascular disease, cancer and asthma.
- Researchers estimate that **15 percent of U.S. Medicaid costs are attributable to cigarette smoking**.[1] Fourty-six percent of working-age Ohio Medicaid enrollees were current smokers in 2017.[2]

What works?

- **Increase use of cessation counseling and medications** by promoting greater use of the Ohio Tobacco Quit Line, prioritizing cessation in the Medicaid managed care plan re-procurement process and expanding the Baby and Me Tobacco Free program to reach more pregnant women.
- **Expand media campaigns** designed to motivate cessation and prevent youth use. Ohio only spends 35 percent of the CDC-recommended amount on media campaigns because of limited state funding.[3]
- **Increase the price of tobacco products** by raising excise taxes on cigarettes, e-cigarettes and other tobacco products or revising Ohio's minimum price law to prohibit use of price discounting tactics.

All states in the top quartile for health value have lower rates of adult smoking than Ohio



Sources: HPIO 2019 *Health Value Dashboard* (value rank), 2017 Behavioral Risk Factor Surveillance System (smoking)

Youth e-cigarette use

Rising e-cigarette use threatens to undo progress in youth prevention

- E-cigarette use increased from 11.7% to 20.8% among U.S. high school students from 2017 to 2018.[4]
- After a decline in traditional cigarette use, e-cigarettes have emerged as the most commonly used nicotine product among adolescents.[5]

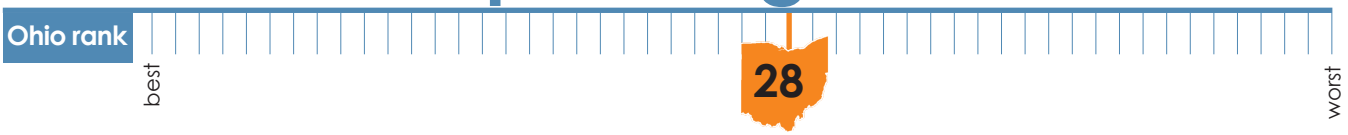
Recommended state policy response

In 2018, the U.S. Surgeon General issued an advisory on e-cigarettes that called for states to **restrict youth access** to these products.[6] Specific strategies include:

- Limit sales to adult-only stores
- Prohibit all flavored products
- Apply the other tobacco product tax to e-cigarettes and invest a portion of the proceeds in youth prevention programs
- Implement and enforce a strong tobacco 21 policy that includes e-cigarettes

1. Xu, X., et al. "Annual Healthcare Spending Attributable to Cigarette Smoking: An Update." American Journal of Preventive Medicine 48, no.3 (2015): 326- 333. doi: 10.1016/j. amepre.2014.10.012.
2. Data provided by the Ohio Colleges of Medicine Government Resource Center. Ohio Medicaid Assessment Survey. Provided March 15, 2019.
3. Source for state spending on tobacco prevention/ cessation media (state fiscal year 2018 spending): Ohio Department of Health, March 2019. Source for spending amount recommended by CDC: U.S. Centers of Disease Control and Prevention. Best Practices for Comprehensive Tobacco Control Programs. 2014. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014.
4. Centers for Disease Control and Prevention. Vital Signs. Tobacco use by youth is rising. Feb. 2019.
5. Ibid.
6. Surgeon General's Advisory on E-Cigarette Use Among Youth. Dec. 2018.

Healthcare spending



Ohio's rank	Metric	Most recent data	Trend
22	**Total and out-of-pocket spending**		
17	**Out-of-pocket spending.** Percent of individuals who are in families where out-of-pocket spending on health care, including premiums, accounts for more than 10 percent of annual income (2016)	20.5%	Moderately decreased
35	**Total healthcare spending, per capita.** Spending for all privately and publicly funded personal healthcare services and products, per capita (2014)	$8,712	Moderately increased
19	**Private health insurance spending**		
3	**Employee contributions to employer-sponsored insurance premiums.** Employee contributions to employer-sponsored health insurance premiums as a share of state median income (2016)	5%	No change
24	**Private health insurance spending, per enrollee.** Private health insurance spending on personal healthcare services and products, per enrollee (2014)	$4,371	No change
28 (out of 49)	**Employer-sponsored plan spending, per enrollee.** Total employer-sponsored health insurance plan spending, per enrollee (2015)	$4,770	No change
36	**Average monthly marketplace premium.** Average monthly marketplace premium after application of an advanced premium tax credit (2018)	$220.42	No change
35	**Healthcare service area spending**		
18	**Prescription drug and medical nondurable spending, per capita.** Retail sales of prescription and non-prescription drugs and medical products, per capita (2014)	$1,023	No change
41	**Hospital care spending, per capita.** Spending for all hospital services provided to patients, per capita (2014)	$3,809	No change
41	**Nursing home care spending, per capita.** Spending on nursing and rehabilitative services provided in freestanding nursing home facilities, per capita (2014)	$605	No change
27	**Medicare spending**		
22	**Average total cost, per Medicare beneficiary without chronic conditions.** Average total cost per Medicare beneficiary without chronic conditions (2016)	$3,946	**Greatly increased**
24	Average total cost, per Medicare beneficiary **with one chronic condition**	$5,539	No change
22	Average total cost, per Medicare beneficiary **with two chronic conditions**	$6,554	No change
39	Average total cost, per Medicare beneficiary **with three or more chronic conditions**	$14,086	Moderately increased
39	**Total Medicare spending, per beneficiary.** Total Medicare reimbursements, per Medicare beneficiary (Parts A and B), ages 65-99 (2015)	$10,025	No change

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

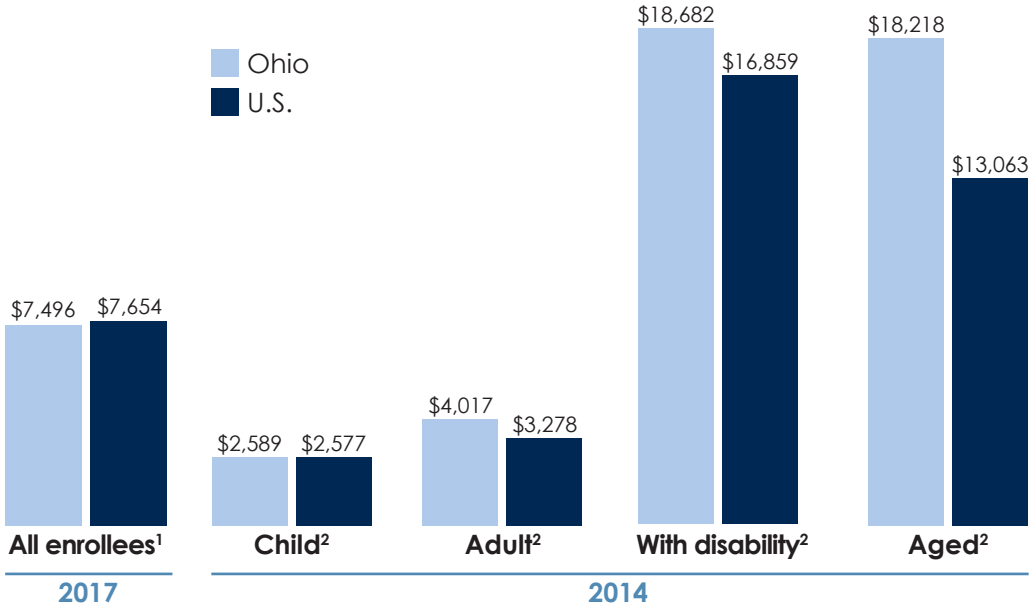
Of the 50 states and D.C.

Trend note: Increased or decreased 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 ***2019 Health Value Dashboard* webpage**.

Deeper dive: **Healthcare spending**

Ohio's spending is largely on costly sick care later in life, not prevention and healthy aging

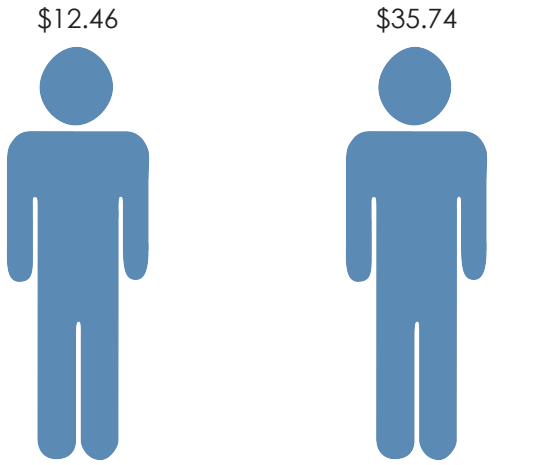
Medicaid benefit spending, per full year equivalent enrollee, by eligibility group



Sources: 1. MACStats: Medicaid and CHIP Data Book. Washington, DC: Medicaid and CHIP Payment and Access Commission, 2018. 2. 2014 Medicaid Statistical Information System (MSIS) and Urban Institute estimates from CMS-64 reports, as compiled by the Kaiser Family Foundation. Includes full or partial benefit enrollees; State Health Access Data Assistance Center. "State Health Compare."

Ohio's per person spending for older Medicaid enrollees (aged category) is 1.4 times more than the U.S. rate; however, Ohio's overall Medicaid spending per enrollee is relatively similar to other states. This suggests Ohio's healthcare spending needs to be re-aligned to provide greater support for healthy aging and prevention as a way to reduce spending on costly sick care later in life.

State and local public health funding in Ohio

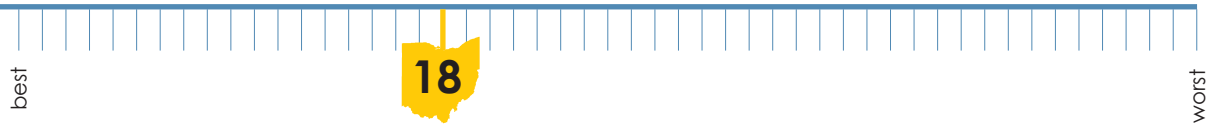


Sources: 1. State Health Access Data Assistance Center. "State Health Compare." 2. National Association of County and City Health Officials 3. Health Policy Institute of Ohio, *Ohio Prevention Basics: A Closer Look at Prevention Spending*. 2015.

- **State and local public health funding provides critical resources for health behavior, promotion and prevention services in Ohio**, such as tobacco prevention and cessation services, infant mortality reduction, healthy food access, senior fall prevention and infectious disease control.
- **Ohio has a decentralized public health system** with much of the funding for public health sourced at the local level.
- **Fewer state dollars are allocated to prevention.** Medicaid spending includes funding for clinical preventive services; however, Medicaid dollars are primarily allocated to the treatment of health conditions and diseases. State funding for prevention in other health-related agencies is relatively small.[3]

Access to care

Ohio rank



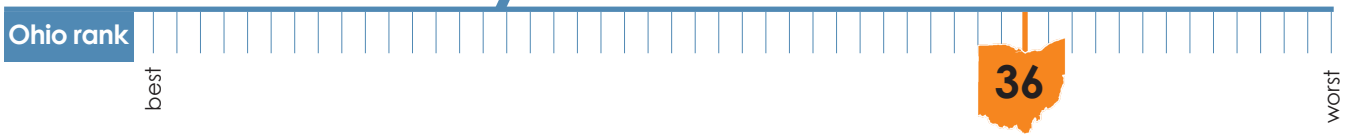
Ohio's rank	Metric	Most recent data	Trend
15	**Coverage and affordability**		
15	**Employer-sponsored health insurance coverage.** Percent of all workers who work at a company that offers health insurance to its employees (2017)	85.8%	No change
15	**Unable to see doctor due to cost.** Percent of adults who went without care because of cost in the past year (2017)	11.3%	No change
16	**Uninsured, non-elderly.** Percent of population, ages 64 and under, who are uninsured in the state (2017)	7%	No change
11	**Primary care access**		
11	**Medical home, children.** Percent of children, ages 0-17, 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 (2016-2017)	53.7%	N/A
17	**Without a usual source of care.** Percent of adults, ages 18 and older, who do not have at least one person they think of as their personal healthcare provider (2017)	18.8%	No change
19	**Routine checkup.** Percent of adults, ages 50 and older, in fair or poor health, or ever told they have pre-diabetes, acute myocardial infarction, heart disease, stroke or asthma, who did not visit a doctor for a routine checkup in the past two years (2015)	12%	No change
19	**Behavioral health**		
14 (out of 50)	**Youth with depression who did not receive treatment.** Percent of youth, ages 12-17, who had a major depressive episode and did not receive treatment for depression in the past year (2011-2015)	56%	Moderately improved
18	**Unmet need for mental health treatment.** 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 (2013-2015)	20%	No change
34	**Unmet need for illicit drug use treatment.** Percent of individuals, ages 12 and older, who needed but did not receive treatment for illicit drug use in the past year (2016-2017)	2.5%	No change
38	**Oral health**		
20	**Received dental care in past year, adults.** Percent of adults, ages 18 and older, who have visited the dentist or a dental clinic within the past year (2016)	67.9%	No change
47	**Preventive dental care, children.** Percent of children, ages 1-17, who have seen a dentist or other oral health care provider for preventive dental care, such as check-ups, dental cleanings, dental sealants or fluoride treatments in the past year (2016-2017)	75.7%	N/A
25	**Workforce**		
22	**Underserved, primary care physicians.** Percent of need not met by current supply of primary care physicians in designated primary care health professional shortage areas (2017)	44.8%	**Greatly worsened**
28	**Underserved, dentists.** Percent of need not met by current supply of dentists in designated dental care health professional shortage areas (2017)	65.6%	No change
28 (out of 50)	**Underserved, psychiatrists.** Percent of need not met by current supply of psychiatrists in designated mental health care professional shortage areas (2017)	68%	**Greatly worsened**

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.

Trend note: 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 ***2019 Health Value Dashboard* webpage**.

Healthcare system



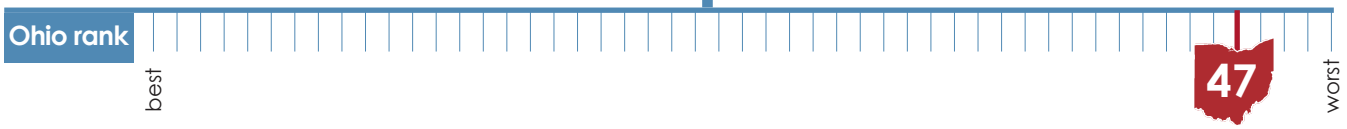
Ohio's rank	Metric	Most recent data	Trend
41	**Preventive services**		
22	**Breastfeeding support in hospitals.** Average Maternity Practice in Infant Nutrition and Care (mPINC) score among hospitals and birthing facilities to support breastfeeding (2015)	80	**Greatly improved**
30	**Prenatal care.** Percent of women who completed a pregnancy in the last 12 months and who received prenatal care in the first trimester (2017)	74.8%	No change
35	**Female breast cancer early stage diagnosis.** Percent of female breast cancer cases diagnosed at an early stage (2011-2015)	69.7%	Moderately improved
43	**Colon and rectal cancer early stage diagnosis.** Percent of colon and rectal cancer cases diagnosed at an early stage (2011-2015)	37.6%	No change
48	**Cancer early stage diagnosis.** Percent of cervical, colon and rectal, lung and brochial, female breast and prostate cancer cases diagnosed at an early stage (2011-2015)	49.2%	No change
NR	**Behavioral health**		
NR (Ohio only)	**Substance use disorder treatment retention.** 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 [SFY] 2018)	39.3%	N/A
NR (Ohio only)	**Mental illness hospitalization follow-up.** Percent of Medicaid enrollees, ages 6 and older, who received follow-up after hospitalization for mental illness within 30 days of intake (SFY 2018)	54.2%	N/A
40	**Hospital utilization**		
7	**Heart failure readmissions for Medicare beneficiaries.** Number of readmissions within 30 days for any cause for Medicare fee-for-service Part A beneficiaries, ages 18 and older, with a principal diagnosis of heart failure, per 100 cases (2016)	21	**Greatly worsened**
31	**Diabetes with long-term complications.** Number of discharges 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 (2016)	208	**Greatly improved**
41 (out of 49)	**30-day hospital readmissions for employer-insured enrollees.** Number of readmissions for people, ages 18-64, within 30 days of an acute hospital stay for any cause, per 1,000 enrollees (2015)	3.4	N/A
44 (out of 49)	**Potentially avoidable emergency department visits for employer-insured enrollees.** Number of potentially avoidable emergency department visits for people, ages 18-64, with employer-sponsored insurance, per 1,000 enrollees (2015)	177	N/A
22	**Timeliness, effectiveness and quality of care**		
13	**Back pain recommended treatment.** Percent of outpatients with low back pain who had an MRI without trying recommended treatments first, such as physical therapy (2016-2017)	37.9%	No change
20	**Patient-centered care.** Percent of patients who reported hospital staff did not always manage pain well, respond when they needed help to get to the bathroom or pressed a call button, and explain medicines and side effects (2016)	31%	No change
22	**Central line-associated bloodstream infections.** Standardized infection ratio for central line-associated bloodstream infections in acute care hospitals (2016)	0.84	No change
22	**Nursing home pressure ulcers.** Percent of long-stay, high-risk nursing home residents with pressure ulcers (2017)	4.9%	Moderately improved
37	**Mortality amenable to healthcare.** Number of deaths that resulted from causes considered at least partially treatable or preventable with timely and appropriate medical care before age 75, per 100,000 population (2014-2015)	94.5	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.

Trend note: 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 ***2019 Health Value Dashboard* webpage**.

Public health and prevention



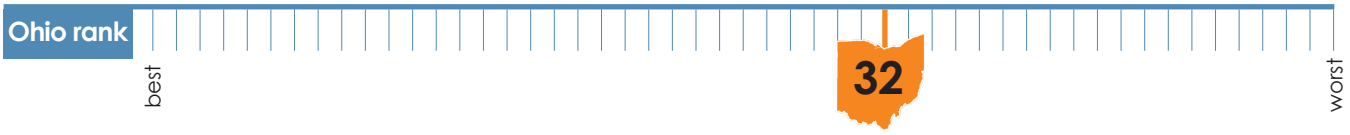
Ohio's rank	Metric	Most recent data	Trend
26	**Public health system and workforce**		
7 (out of 48)	**Comprehensiveness of public health system.** Percent of population served by a comprehensive public health system (2016)	48%	**Greatly improved**
45 (out of 50)	**State public health workforce.** Number of state public health agency full-time equivalent (FTE) employees, per 100,000 population (2016)	9.3	No change
NR (Ohio only)	**Local public health workforce.** Median number of local health department FTE employees, per 100,000 population (2015)	39.1	N/A
48	**Communicable disease control and environmental health**		
31	**Chlamydia.** Number of reported cases of chlamydia, per 100,000 population (2017)	528.6	No change
45	**Environmental and occupational health.** Composite score of the Environmental and Occupational Health domain of the National Health Security Preparedness Index (NHSPI), which measures actions to maintain the security and safety of water and food supplies, to test for hazards and contaminants in the environment and to protect workers and emergency responders from health hazards while on the job (score out of 10 possible points) (2017)	5.5	**Greatly improved**
46	**Child immunization.** Percent of children, ages 19-35 months, who received recommended vaccines (2017)	66.4%	No change
32	**Health promotion and prevention**		
17	**Falls among older adults.** Percent of adults, ages 65 and older, who have had a fall within the last 12 months (2016)	28.8%	Moderately worsened
21	**Motor vehicle crash deaths.** Number of deaths due to traffic accidents involving a motor vehicle, per 1,000 population (2010-2016)	10	No change
25	**Cigarette tax.** State cigarette excise tax rate (2017)	$1.60	No change
27	**Youth marijuana use.** Percent of youth, ages 12-17, who used marijuana in the past year (2016-2017)	12.2%	No change
29	**Teen birth.** Number of births to females, ages 15-19, per 1,000 births (2017)	20.8	No change
31	**Low birth weight.** Percent of live births where the infant weighed less than 2,500 grams (5.5 pounds) (2017)	8.7%	No change
34	**Tobacco prevention spending.** Tobacco prevention and control spending as a percent of the Centers for Disease Control and Prevention-recommended level (state fiscal year 2018)	11%	No change
37	**Prescription opioid use.** Number of dispensed prescriptions for opioids, per 1,000 population (12 months ending June 30, 2016)	828	N/A
42	**Seat belt use.** Percent of front seat occupants observed using a seat belt (2017)	82.8%	No change
51	**Emergency preparedness**		
48	**Emergency preparedness funding, per capita.** Total funding for state and local health departments' emergency preparedness, per capita (federal fiscal year 2017)	$1.51	No change
51	**Health security surveillance.** 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 (score out of 10 possible points) (2017)	6.5	**Greatly worsened**

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.

Trend note: 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 ***2019 Health Value Dashboard* webpage**.

Social and economic environment



Ohio's rank	Metric	Most recent data	Trend
27	**Education**		
14	**Fourth-grade reading.** Percent of fourth grade public school students proficient in reading by a national assessment (National Assessment of Educational Progress) (2017)	39%	No change
28	**Preschool enrollment.** Percent of 3- and 4-year-olds enrolled in preschool (2014-2016)	44%	No change
29	**High school graduation.** Percent of incoming ninth graders who graduate in four years from a public high school with a regular degree (2015/2016 school year)	83.5%	No change
31	**Some college.** Percent of adults, ages 25-44, with some post-secondary education, such as enrollment in vocational/technical schools, junior colleges, or four-year colleges, including individuals who pursued education following high school but did not receive a degree (2012-2016)	64.5%	No change
36	**Employment and poverty**		
31	**Labor force participation.** Percent of people, ages 16 and older, who are in the labor force (2017)	62.9%	No change
31	**Adult poverty.** Percent of people, ages 18 and older, in households with incomes below the federal poverty level (2017)	12.2%	No change
31	**Income inequality.** The ratio of household income at the 80th percentile to that at the 20th percentile (2012-2016)	4.8	No change
35	**Child poverty.** Percent of people, under age 18, in households with incomes below the federal poverty level (2017)	20.1%	No change
43	**Unemployment.** Percent of people, ages 16 and older, who are jobless, looking for a job and available for work (2017)	5%	No change
29	**Family and social support**		
21	**Low-income working families with children.** Percent of families with at least one child under age 18, income below 200 percent of the federal poverty level and at least one parent working year-round during the previous year (2016)	20%	No change
23	**Disconnected youth.** Percent of youth, ages 16-24, who are not working or in school (2016)	11.1%	Moderately improved
38 (out of 50)	**Adult incarceration.** Number of people imprisoned under the jurisdiction of state or federal correctional authorities, per 100,000 population (2016)	449	No change
30	**Trauma, toxic stress and violence**		
18	**Violent crime.** Number of violent crimes (murder, rape, robbery and aggravated assault), per 100,000 population (2017)	298	No change
26	**Child abuse and neglect.** Number of child maltreatment victims, per 1,000 children (federal fiscal year 2016)	9	No change
38	**Adverse childhood experiences.** Percent of children who have experienced two or more adverse experiences (2016-2017)	25.1%	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.

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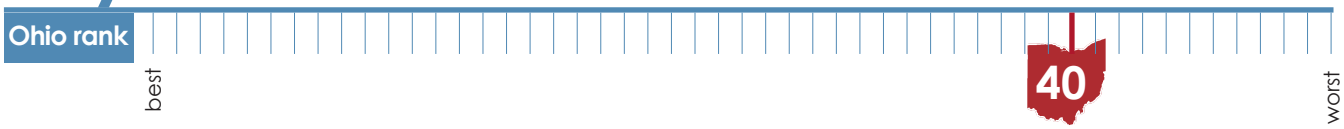
2019 **Health Value Dashboard**

Physical environment



Ohio's rank	Metric	Most recent data	Trend
50	**Air, water and toxic substances**		
30	**Toxic pollutants, per capita.** Total pounds of toxic chemicals released into the environment, per capita (total on-site disposal or other releases for all industries and all chemicals) (2016)	8.3	N/A
46	**Outdoor air quality.** Average exposure of the general public to particulate matter of 2.5 microns or less in size (PM2.5) (2015-2017)	9	Moderately improved
48	**Child in household with a smoker.** Percent of children, ages 0-17, who live in households where someone smokes (cigarettes, cigars or pipe tobacco) (2016-2017)	23%	N/A
NR (Ohio only)	**Lead poisoning.** Percent of children, ages 0-5, with elevated blood lead levels (BLL > 5 ug/dL) (2017)	2.8%	N/A
33	**Food access and food insecurity**		
29	**Healthy food access.** Percent of population with limited access to healthy food, defined as the percent of low-income individuals (<200% federal poverty guideline) living more than 10 miles from a grocery store in rural areas and more than one mile in non-rural areas (2015)	6.8%	No change
40	**Food insecurity.** Percent of households that are food insecure (2015-2017)	13.7%	Moderately improved
16	**Housing, built environment and access to physical activity**		
14	**Severe housing problems.** 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 (2011-2015)	14.5%	No change
18	**Neighborhood resources.** Percent of children living in a neighborhood that contains each of the following amenities: sidewalks or walking paths; parks or playgrounds; recreation centers, community center, or boys' and girls' club; and libraries or bookmobiles (2016-2017)	38.7%	N/A
20	**Long commute, driving alone.** 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 (2012-2016)	30%	No change
21	**Access to exercise opportunities.** Percent of individuals who live reasonably close to a location for physical activity, defined as parks or recreational facilities (2010 and 2016)	84.7%	No change
31	**Alternative commute modes.** Percent of trips to work via bicycle, walking or mass transit (combined) (2017)	3.9%	No change
35	**Neighborhood safety.** Percent of children living in a safe neighborhood (2016-2017)	94.6%	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.

Trend note: 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 **2019 *Health Value Dashboard* webpage**.

Equity profiles

Race/ethnicity: Black Ohioans

- Racist policies such as slavery, Jim Crow laws and redlining were eliminated years ago, but the long-term impact of these policies persists.
- Coupled with continued discrimination and racism, these policies have led to poorer socioeconomic and community conditions for black Ohioans. Because of this, **black Ohioans do not have the same opportunity as white Ohioans to live healthy lives**.

This profile describes the magnitude of difference in outcomes between black Ohioans and white Ohioans.

Black children in Ohio are **4.7 times more likely to attend a high poverty school than white Ohioans**, which often have lower graduation rates.

Lacking a sufficient education makes it more difficult to provide basic needs, such as quality housing. If the gap in quality housing between black and white Ohioans was eliminated, more than **79,000 black Ohioans would live in higher quality housing**.

These differences have led to poorer health outcomes for black Ohioans. For example, **black infants are dying at nearly three times the rate** of white infants in Ohio.

Socio-economic factors	
Child poverty	2.9 times **worse** for black Ohioans
Unemployment	2.7 times **worse** for black Ohioans
High school graduation	2.7 times **worse** for black Ohioans
Adult poverty	2.5 times **worse** for black Ohioans
Fourth-grade reading	1.5 times **worse** for black Ohioans
Community conditions	
Attending a high-poverty school	4.7 times **worse** for black Ohioans
Housing quality	2.3 times **worse** for black Ohioans
Living in a high-homicide county	1.7 times **worse** for black Ohioans
Food deserts	Little or no disparity for black Ohioans*
Health care	
Prenatal care	1.7 times **worse** for black Ohioans
Unable to see doctor due to cost	1.6 times **worse** for black Ohioans
Uninsured, adults	1.4 times **worse** for black Ohioans
Without a usual source of care	1.3 times **worse** for black Ohioans
Health outcomes	
Infant mortality	2.9 times **worse** for black Ohioans
Premature death	1.5 times **worse** for black Ohioans
Adult diabetes	1.3 times **worse** for black Ohioans
Overall health status	1.3 times **worse** for black Ohioans
Adult overweight and obese	Little or no disparity for black Ohioans
Adult depression	Little or no disparity for black Ohioans*

Note: Darker red indicates larger magnitude of difference. Metric information (description, year, source) is in the *Dashboard* appendix.
*Disparity ratio is less than 1, indicating that outcomes are better for black Ohioans compared to white Ohioans

Equity profiles

Race/ethnicity: Hispanic/Latinx Ohioans

- Research suggests that Hispanic/Latinx people have better health than non-Hispanic whites at the start of their migration to the U.S. due to stronger social networks and lower smoking rates, among other factors.[1]
- However, as longevity in the U.S. increases, the Hispanic/Latinx community faces many of the same barriers as other minority groups such as poorer socioeconomic and community conditions, racism and discrimination. As a result, the health advantage for the Hispanic/Latinx community in the U.S. is shrinking, and **Hispanic/Latinx people face potential for negative trends in health outcomes**.

This profile describes the magnitude of difference in outcomes between Hispanic/Latinx Ohioans and white Ohioans.

Hispanic children are **2.1 times more likely to live in poverty** compared to white children in Ohio.

With nearly **three times the uninsured rate** as white Ohioans, Hispanic/Latinx Ohioans face additional barriers to health care such as language, cultural differences and status in the county.

These barriers contribute to **Hispanic infants dying at 1.4 times the rate** of white infants in Ohio.

Socio-economic factors	
High school graduation	2.2 times **worse** for Hispanic Ohioans
Child poverty	2.1 times **worse** for Hispanic Ohioans
Adult poverty	2 times **worse** for Hispanic Ohioans
Unemployment	1.7 times **worse** for Hispanic Ohioans
Fourth-grade reading	1.3 times **worse** for Hispanic Ohioans
Community conditions	
Attending a high-poverty school	3 times **worse** for Hispanic Ohioans
Housing quality	1.8 times **worse** for Hispanic Ohioans
Living in a high-homicide county	1.3 times **worse** for Hispanic Ohioans
Food deserts	Little or no disparity for Hispanic Ohioans
Health care	
Uninsured, adults	2.8 times **worse** for Hispanic Ohioans
Without a usual source of care	2.3 times **worse** for Hispanic Ohioans
Unable to see doctor due to cost	1.8 times **worse** for Hispanic Ohioans
Prenatal care	1.6 times **worse** for Hispanic Ohioans
Health outcomes	
Infant mortality	1.4 times **worse** for Hispanic Ohioans
Overall health status	1.3 times **worse** for Hispanic Ohioans
Adult overweight and obese	Little or no disparity for Hispanic Ohioans
Adult depression	Little or no disparity for Hispanic Ohioans
Adult diabetes	Little or no disparity for Hispanic Ohioans*
Premature death	Little or no disparity for Hispanic Ohioans*

Note: Darker red indicates larger magnitude of difference. Metric information (description, year, source) is in the *Dashboard* appendix.
*Disparity ratio is less than 1, indicating that outcomes are better for Hispanic/Latinx Ohioans compared to white Ohioans

1. Scommegna, Paola. "Exploring the Paradox of U.S. Hispanics' Longer Life Expectancy." Population Reference Bureau, July 12, 2013. https://www.prb.org/us-hispanics-life-expectancy/

Equity profiles

Education and income

- Post-secondary education lays the foundation for positive employment outcomes and higher earnings over a person's lifetime.
- Having a sufficient income is critical for covering basic needs, such as housing, food, transportation, child care and health care. Because of this, **Ohioans with less than a high school degree do not have the same opportunity to provide for their families or live healthy lives as Ohioans with a college degree**.

This profile describes the magnitude of difference in outcomes between Ohioans with less than a high school education and Ohioans with college degrees. When educational attainment data is not available, the difference in outcomes between low-income and high-income Ohioans is displayed.

Ohioans with less than a high school education are **six times more likely to be unemployed** than Ohioans with college degrees.

Employment provides many benefits, including higher income and access to health insurance coverage. Ohioans with less than a high school education are **6.6 times more likely to be uninsured** compared to those with college degrees.

If the gap in outcomes between Ohioans with less than a high school degree and those with a college degree was eliminated, **more than 320,000 Ohioans** would report having better overall health status.

Socio-economic factors	
Adult poverty	7.2 times **worse** for people with less than high school education
Unemployment	6 times **worse** for people with less than high school education
High school graduation	3.5 times **worse** for people with low incomes
Fourth-grade reading	1.7 times **worse** for people with low incomes
Community conditions	
Housing quality	3.7 times **worse** for people with less than high school education
Food deserts	3.1 times **worse** for people with low incomes
Health care	
Uninsured, adults	6.6 times **worse** for people with less than high school education
Prenatal care	3.3 times **worse** for people with less than high school education
Unable to see doctor due to cost	2.2 times **worse** for people with less than high school education
Without a usual source of care	1.5 times **worse** for people with less than high school education
Health outcomes	
Overall health status	5 times **worse** for people with less than high school education
Infant mortality	2.5 times **worse** for people with less than high school education
Adult diabetes	2 times **worse** for people with less than high school education
Adult depression	2 times **worse** for people with less than high school education**
Adult overweight and obese	Little or no disparity for people with less than high school education

Note: Darker red indicates larger magnitude of difference. Metric information (description, year, source) is in the *Dashboard* appendix.
** Shading based on unrounded value

Equity profiles

Disability status

- Ohioans with disabilities face many barriers to health, including lack of adequate employment accomodation and lack of accessible health care, transportation, housing and recreation.
- The misperception that people with disabilities cannot be healthy or productive, coupled with other barriers to health, means that **Ohioans with disabilities do not have the same opportunity to live healthy lives as Ohioans without disabilities**.

This profile describes the magnitude of difference in outcomes between Ohioans with and without disabilities.

Ohioans with disabilities are **2.5 times more likely to be unemployed** than those without disabilities.

Employment provides many benefits, including higher income, **the ability to afford health care** and improved mental health.

Ohioans with disabilities are **six times more likely to report fair or poor health status** than Ohioans without disabilities. Programs and policies that are designed to include Ohioans with disabilities will enable more Ohioans to live a healthy life, regardless of disability status.

Socio-economic factors	
Unemployment	2.5 times **worse** for Ohioans with disabilities
High school graduation	2.2 times **worse** for Ohioans with disabilities
Adult poverty	2 times **worse** for Ohioans with disabilities
Child poverty	1.7 times **worse** for Ohioans with disabilities
Fourth-grade reading	1.6 times **worse** for Ohioans with disabilities
Health care	
Unable to see doctor due to cost	2.4 times **worse** for Ohioans with disabilities
Without a usual source of care	Little or no disparity for Ohioans with disabilities
Uninsured, adults	Little or no disparity for Ohioans with disabilities*
Health outcomes	
Overall health status	6 times **worse** for Ohioans with disabilities
Adult depression	4 times **worse** for Ohioans with disabilities
Adult diabetes	2.2 times **worse** for Ohioans with disabilities
Adult overweight and obese	1.1 times **worse** for Ohioans with disabilities

Note: Darker red indicates larger magnitude of difference. Metric information (description, year, source) is in the *Dashboard* appendix.
*Disparity ratio is less than 1, indicating that outcomes are better for Ohioans with disabilities compared to Ohioans without disabilities.

Equity profiles

Data challenges and other Ohioans experiencing barriers

Not all Ohioans impacted by health disparities are reflected in existing, publicly-available data:

- Ohioans who are members of more than one group facing poor health outcomes, such as black Ohioans with a disability, often experience even larger gaps in outcomes than depicted by the existing data.
- Data is not consistently collected for all population groups. For example, there is little data on the lesbian, gay, bisexual, transgender, queer or questioning (LGBTQ) community in Ohio, immigrants and refugees or subpopulation groups – such as southeast Asian, Arab/Middle Eastern or sub-Saharan African Ohioans.
- Disaggregated data often is not available at the local level.

Asian Ohioans

Aggregated data can mask health disparities, particularly for subpopulations. Asian Americans, for example, tend to perform well as a whole on many health indicators. However, data on southeast Asians and immigrant or refugee populations from Asia, such as Bhutanese-Nepali refugees, suggest these subpopulations experience poorer health outcomes. For example, a 2014 study found that Bhutanese refugees in Ohio experienced high rates of alcohol and tobacco use, mental health issues and suicide.[1]

LGBTQ

Questions regarding sexual orientation and gender identity are not consistently asked on many national and state surveys, making it difficult to assess the health needs of Ohio's LGBTQ community. Further, available data is often limited to information on solely the 'LGBT' population, excluding data on individuals who identify with the 'Q' (queer or questioning). All seven objectives related to LGBTQ health from Healthy People 2020 focus on increasing the number of population-based data systems collecting data on LGBTQ populations.

According to national data, the LGBTQ community experiences many gaps in outcomes linked to their status as sexual and gender minorities. LGBTQ individuals may refuse to engage in health care due to stigma, discrimination or having previously had a bad experience with a provider.[2] Elderly LGBT individuals face additional barriers due to isolation and lack of culturally-sensitive care among social and medical service providers.[3] LGBT individuals also face higher rates of violence and victimization[4], are five times more likely to attempt suicide during youth[5] and have higher rates of tobacco, alcohol and other drug use.[6]

Geography

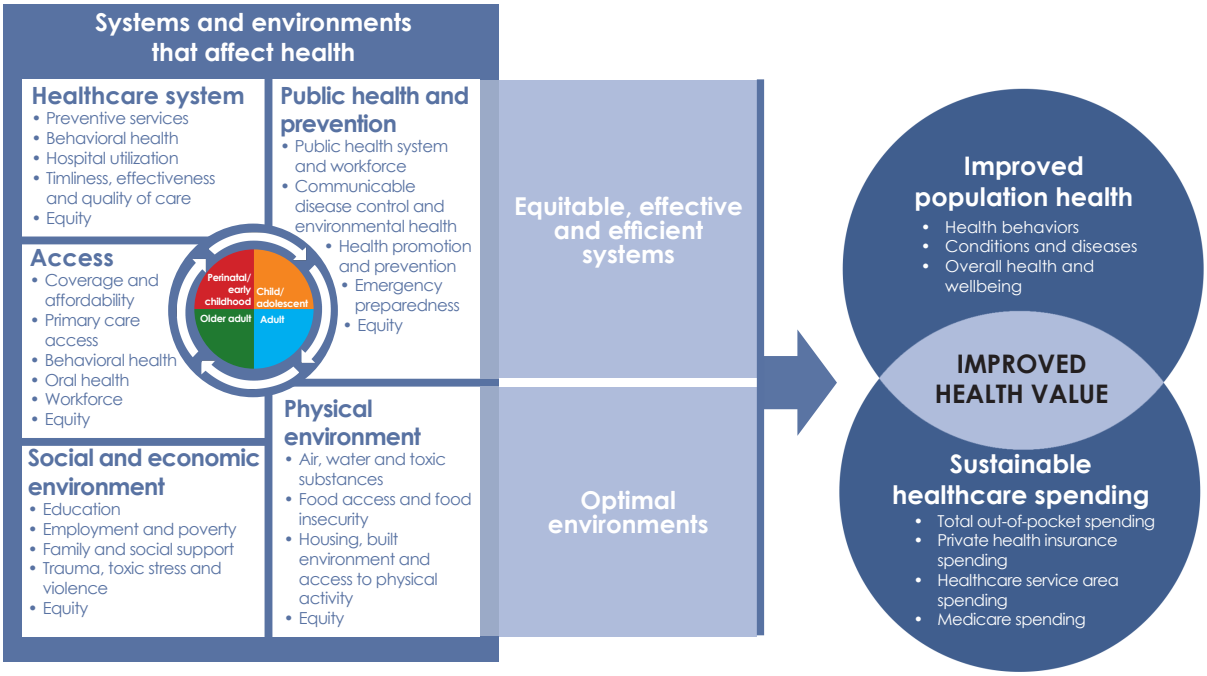
There is a gap of more than 29 years in life expectancy at birth in Ohio depending on where a person lives, ranging from a low of 60 years in a Census tract in the Franklinton neighborhood of Columbus (Franklin County) to a high of 89.2 years in the Stow area (Summit County). Census tracts with the lowest life expectancy in Ohio share similar characteristics, such as a much lower median household income than the state and higher percentages of black Ohioans, people who did not graduate high school and Ohioans with a disability living in the Census tract.[7] Rural and Appalachian regions of the state also face multiple barriers to health including issues with accessing health care and adequate transportation.[8]

1. Surendra Bir Adhikari et al. *Epidemiology of Mental Health, Suicide and Post-Traumatic Stress Disorders among Bhutanese Refugees in Ohio, 2014*. Columbus, OH: Ohio Department of Mental Health and Addiction Services, Community Refugee and Immigration Services, 2015.
2. When Health Care Isn't Caring: Lambda Legal's Survey on Discrimination Against LGBT People and People Living with HIV. New York: Lambda Legal, 2010. https://www.lambdalegal.org/sites/default/files/publications/downloads/whcic-report_when-health-care-isnt-caring.pdf
3. Cahill S, K. South and J. Spade. Outing age: Public policy issues affecting gay, lesbian, bisexual and transgender elders. Washington: National Gay and Lesbian Task Force, 2009
4. "Lesbian, Gay, Bisexual, and Transgender Health." Healthy People 2020, Office of Disease Prevention and Health Promotion. Accessed March 25, 2019. https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health
5. *Sexual Identity, Sex of Sexual Contacts, and Health-Risk Behaviors Among Students in Grades 9-12*. Youth Risk Behavior Surveillance. Atlanta, GA: Centers for Disease Control and Prevention, 2016
6. "Lesbian, Gay, Bisexual, and Transgender Health." Healthy People 2020, Office of Disease Prevention and Health Promotion. Accessed March 25, 2019. https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health
7. Health Policy Institute of Ohio. "Closing Ohio's Health Gaps: Moving Towards Equity," October 2018.
8. Health Policy Institute of Ohio. "2019 State Health Assessment: Regional Forum Findings," December 2018.

Background

The 2019 *Health Value Dashboard* is based on the Pathway to Improved Health Value conceptual framework developed by HPIO's multi-sector **Health Measurement Advisory Group**.

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.

For more information

Visit the **2019 HPIO *Health Value Dashboard* webpage** to access the following materials that provide additional detail about the *Dashboard* methodology and data:

- Process, methodology and metric information
- Frequently Asked Questions (FAQ)
- Excel appendix with metric descriptions, years, sources and Ohio data
- Equity Excel appendix with metric descriptions, years, sources and Ohio data
- Crosswalk to sources that display disaggregated data

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**.

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