Health Value Dashboard FAQ

General questions

1. What is the HPIO Health Value Dashboard?

The HPIO Health Value Dashboard is a tool to track Ohio's progress towards health value – the combination of population health outcomes and healthcare costs. Population health outcomes and healthcare costs were weighted equally, reflective of feedback from our stakeholders that both goals, improved population health and sustainable healthcare costs, are important for Ohioans.

The dashboard compares Ohio's performance to other states, tracks change over time and includes information on best state performance and disparities or "gaps" in performance across Ohio's subpopulations. The dashboard also reflects the many factors impacting population health outcomes and healthcare costs, including healthcare system performance, public health and prevention, access to health care, and the social, economic and physical environments.

2. Why did you create the dashboard?

We know that health outcomes in Ohio are among the country's worst. We also know that rising healthcare costs are a major concern for policymakers, employers and consumers. Consequently, our work was guided by the question, "How will we know if we are successful in achieving improved health value for Ohioans?"

HPIO's primary audience is state policymakers. We wanted to create an easy-to-read and easy-to-use document that could be taken to policymakers, and help provide information and catalyze conversations about where Ohio is doing well and where we need improvement when we look at our population health outcomes and healthcare costs as a state. With this in mind, we developed the dashboard so that it is (1) concise, (2) visual and at-a- glance, (3) includes the most important indicators, (4) and provides data to help guide decision making.

Our aim is that the dashboard catalyzes new alignments and partnerships that will move us out of the red and into the green as a high performing state in health value in the future.

3. Why does Ohio's rank on health value matter?

Ohioans are living less healthy lives and are spending more on health care than people in most other states. Our current system of health is just not sustainable. All Ohioans are impacted by health value. Improving health value means consumers have access to healthcare services that are affordable, employers pay less money for their employee's health care, Ohio's workforce is stronger, healthier and more productive, and Ohioans live longer healthier lives.

4. Why did Ohio rank 47th on health value?

Our health value rank is a composite measure that is the combination of healthcare costs and population health, weighted equally. There are many factors that impact population health

outcomes and healthcare costs, and Ohio performs poorly in many of these arenas. The public health and prevention and the healthcare system in Ohio face significant challenges. Ohio also struggles when it comes to the other factors that impact health, which includes our physical, social and economic environments. Notably, our social, economic, and physical environments combined are actually the largest contributors to our overall health outcomes. On the cost side, clinical care received within the healthcare system accounts for the majority of our healthcare costs. Far fewer of our healthcare dollars are being spent on public health and prevention.

5. What does this ranking mean?

We are not getting good value for our healthcare dollar. Ohio has high healthcare spending and poor overall population health outcomes. While we spend a lot on health care, we are not seeing this spending translate into better health outcomes for Ohioans.

6. Are age, income and poverty the primary drivers of Ohio's health value rank?

Age, income and poverty are important factors impacting health, but a younger population or higher income do not guarantee good health or good health value. The University of Cincinnati's Economics Center (UC) conducted a correlation analysis of the Dashboard data to determine the strength of the relationship between health value and age distribution and poverty. The correlation between a state's health value rank and the percent of the population age 65+ was 0.21. The correlation between a state's health value rank and the percent of children living in poverty (age <18) was 0.27, and was 0.22 for the percent of adults in poverty (ages 18-64). Therefore, states that are older or poorer are slightly more likely to rank poorly on health value, but the strength of this relationship is relatively weak. Some high-value states, such as Iowa and Hawaii have slightly older populations than Ohio, indicating that it is possible to have higher health value rank with an older population. Similarly, California, a high-value state, has a higher child poverty rate than Ohio. Finally, Ohio ranks 29th for child poverty and 35th for adult poverty, indicating there are many states that are poorer than Ohio.

7. Who is responsible for Ohio's ranking?

We all share responsibility for improving population health outcomes and ensuring that healthcare costs are sustainable for Ohioans. All stakeholders must work together to move the needle on improving health value. No single organization or sector can do this work alone. There is a need for a multi-sector, collaborative approach to improve Ohio's health value rank.

8. How can we improve Ohio's ranking?

Improving health value starts with making changes where Ohioans live, learn, work, and play. To change our health value rank, we need to improve conditions in Ohioans physical, social and economic environments, as well as improve the efficiency and effectives of our healthcare and public health system. The dashboard provides a snapshot of Ohio's greatest health challenges and strengths by identifying metrics where Ohio ranks in the bottom quartile and top quartile among U.S. states and the District of Columbia. Maintaining our strengths and identifying and implementing strategies to improve Ohio's performance on bottom quartile metrics can serve as a starting place for improving Ohio's overall health value rank.

Questions on comparability of HPIO Health Value Dashboard to other scorecards and rankings

9. How is the dashboard different from others that are out there?

Unlike other scorecards, HPIO's dashboard places a heavy emphasis on the sustainability of healthcare costs, a critical component of any policy discussion on improving health, but one that often is not included on state rankings. In fact, ours is the first dashboard that we are aware of in the nation to develop a state ranking of "health value," placing equal emphasis on population health outcomes and healthcare costs.

The dashboard also provides a more comprehensive look at other factors that impact population health outcomes and healthcare costs. It addresses the wide range of factors, such as a state's social, economic and physical environment, that contribute to health value.

10. How do HPIO's Health Value Dashboard rankings compare to ranking results from other national scorecards?

Our dashboard's rankings for Ohio are quite similar to America's Health Rankings, Commonwealth State Scorecard and the Gallup-Healthways Wellbeing Index. However, unlike other dashboards, we are looking at health value, not just overall health outcomes or healthcare system performance.

Ohio's rank	HPIO Health Value Dashboard, 2014	America's Health Rankings, 2014 edition	Commonwealth State Scorecard, 2014 edition	Gallup-Healthways Wellbeing Index, 2013
Overall	47	40	31	46
Health outcomes* ("Health outcomes" in America's Health Rankings; "Healthy Lives" in Commonwealth)	40	39	42	NA

*This is similar to the HPIO Population Health domain

Methodology and design questions

11. What was your process for metric selection and analysis?

The dashboard metrics were selected by a wide array of experts who participated in the multi-stakeholder, multi-sector Health Measurement Advisory Group (HMAG)convened by HPIO. The process was guided by criteria developed by HPIO and HMAG (see pages 15-17 of the dashboard). Data collection and analysis for the dashboard was accomplished in partnership with the University of Cincinnati Economics Center.

12. Where do you get your data?

Our data comes from publicly-available sources, such as the US Census Bureau, the Centers for Disease Control and Prevention (CDC), the Agency for Healthcare Research and Quality (AHRQ), and the Centers for Medicare and Medicaid Services (CMS). We did not develop any

new metrics or collect any new data for this dashboard. It builds upon existing scorecards and rankings, such as America's Health Rankings, County Health Rankings and Roadmaps, Commonwealth Fund State Scorecard, Network of Care and Kaiser State Health Facts. Some data sources were not considered or were eliminated because we wanted to compare Ohio's performance to other states, track change over time, and include information on best state performance.

13. Why are metrics and domains not weighted?

Some national rankings, such as America's Health Rankings and County Health Rankings and Roadmaps (CHR&R) place different weights on different health determinant metrics to reflect their relative contribution to health outcomes. Like the Commonwealth State Scorecard, we chose NOT to weight metrics or subdomains differently. This is largely because we feel the research base for quantifying the relative contribution of our five different domains on health value is not yet strong enough to justify assignment of weights.

CHR&R provides a very useful model for weighting the following determinants of health—clinical care (20%), social and economic environment (40%), physical environment (10%) and health behaviors (30%). Our model encompasses all of these areas, and also factors in access and public health and prevention. Furthermore, our end point is health value, which accounts for healthcare costs rather than population health outcomes alone. For these reasons, it would not be appropriate for us to apply the same weights used by CHR&R.

14. How are health disparities displayed in the dashboard?

We made sure to include at least one metric in each of the dashboard domains (with the exclusion of healthcare costs which portrays disparities or "gaps" in performance across a subpopulation in Ohio. The "gap" metric is displayed visually on the dashboard in each of the domain profile pages. We also include a page in the dashboard that highlights disparities around Ohio's greatest health challenges and includes a link to a **crosswalk** that lists all 106 metrics and where available, links to sites where the data for the metric has been broken down by race/ethnicity, income level, or sub-state geography (such as RWJF Datahub or County Health Rankings).

Ranking equity measures can be very complicated. We hope to explore further how to best rank and display the equity metrics in future editions of the dashboard.

15. What are the biggest limitations to your methodology?

We were careful to select metrics that are available from credible sources. However, it is important to keep in mind that each of these sources has its own limitations, such as reliance upon self-reported conditions or behaviors. However, the wide variety of data sources used in this dashboard,—such as biometric, survey, claims, and administrative data—helps to strengthen our methodology.

Second, there is lag in the publicly-available data we used for the dashboard. From a policy perspective, this is important to acknowledge. It is not possible to draw conclusions about recent policy changes including the impact of various provisions of the Affordable Care Act—much of

which was not implemented until 2014—from this dashboard. However, the dashboard now provides a comprehensive baseline for evaluating these more recent policy changes.

Finally, we did not adjust for cost of living, climate, or other factors that may cause differences in health value across different regions of the country.

16. When will you update the dashboard?

We plan to update this dashboard once a year or every other year, depending upon interest and available resources.

We do not plan to update the data on a "rolling" ongoing basis, but rather to release editions.

17. How can a rank of 40 for population health and 40 for healthcare costs come out to an overall health value ranking of 47?

The overall health value rank was calculated by taking the average rank across the population health and health care costs domain and then ranking it among states. For example, Ohio's average is 40 ((40 + 40= 80) / 2= 40), and Kentucky's average is 32.5 (ranked 48 on population health and 17 on costs= average ranking of 32.5). So Kentucky is ranked above Ohio for health value because its better ranking for healthcare costs (17) pulls it up in the ranking above Ohio.

The final health value rank is not just the average ranking of the two domains, but the state ranking of the average ratings across the two domains.

18. There is more recent data available for some of these metrics. Why did you use older data?

There are 2 main reasons for this. First, sometimes newer data is available for Ohio only, but not yet for other states. Because we wanted to be able to compare Ohio to other states, we used the data that were available for all states which is sometimes a year older than available Ohio data. Second, we compiled most of the data in September 2014. Data released after that date will be included in the next iteration of the dashboard.

19. How do you account for missing states?

Metrics for which data for 10 or more states were not available are not included in the metric, subdomain or domain rankings.