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Forum Brief

Kansas Health Policy Forums 2007

Aiming Higher: Results from a State Scorecard on Health System Performance

Wednesday, July 18, 2007 • 8:30 – 10:30 a.m.
212 SW Eighth Avenue, Topeka, KS
Lower Level Conference Room

A DISCUSSION FEATURING

Joel C. Cantor, Sc.D.
Director, Center for State Health Policy
Professor of Public Policy, Rutgers University

PANELISTS

Thomas Bell, J.D.
President, Kansas Hospital Association

Secretary Roderick Bremby, M.P.A.
Kansas Department of Health and Environment

Senator Laura Kelly
Kansas Senate, 18th District

Kenneth Mishler, Pharm.D.
Senior Vice President, Kansas Foundation for Medical Care

KANSAS HEALTH INSTITUTE

Speaker Melvin Neufeld
Kansas House of Representatives

Marcia Nielsen, Ph.D., M.P.H.
Executive Director, Kansas Health Policy Authority

Commissioner Sandy Praeger
Kansas Insurance Department

About this Brief

The Kansas Health Institute is an active participant in the State Health Policy Centers Collaborative. The Collaborative is a membership organization of state-focused health policy centers in both academic and non-academic settings in more than a dozen states. In partnership with the Commonwealth Fund, the Collaborative is disseminating and discussing the *Aiming Higher: Results from a State Scorecard on Health System Performance* report in several states. It is the hope of KHI that the release of the *Scorecard* and the opportunity for a discussion about its relevance and application in Kansas will help to spark a sustained conversation about the measurement and improvement of health system performance in Kansas.

This *Forum Brief* was compiled by Jessica Hembree and Sarah Carkhuff Fizell of the Kansas Health Institute. Information for this *Brief* was drawn from material provided by the Commonwealth Fund and through a contract with Quality Matters, Inc. Jim McLean, Cathy McNorton and Robert St. Peter, also of KHI, reviewed and edited the *Brief*.

About the Forums

Kansas Health Policy Forums are a series of interactive sessions for policymakers examining a broad array of health issues. Forums present a wide range of national and local expertise on current health policy issues followed by facilitated discussion and dialogue in a non-partisan setting. *Forum Briefs* analyze issues, present relevant data and information, and are produced as background material for each forum.

Speaker Biography: Joel C. Cantor, Sc.D.

Joel C. Cantor, Sc.D., is the Director of the Center for State Health Policy and Professor of Public Policy at the Edward J. Bloustein School of Planning and Public Policy at Rutgers. Dr. Cantor's research focuses on issues of health care financing and delivery at the state and local levels. His recent work includes studies of health insurance market regulation, access to care for low-income and minority populations, the health care safety net, and the supply of physician services.

Dr. Cantor has published widely on health policy topics, and serves on the editorial board of the policy journal *Inquiry*. Dr. Cantor frequently serves as an advisor to New Jersey government on health care policy. Most recently, he was appointed to the state's Mandated Health Benefits Advisory Commission by Governor McGreevey and he serves as chair of that panel. Prior to joining the faculty at Rutgers, Dr. Cantor served as director of research at the United Hospital Fund of New York and director of evaluation research at the Robert Wood Johnson Foundation.

He received his doctorate in health policy and management from the Johns Hopkins University School of Hygiene and Public Health in 1988, and was elected a Fellow of AcademyHealth (formerly the Academy for Health Services Research and Health Policy) in 1996.

Aiming Higher: Results from a State Scorecard on Health System Performance

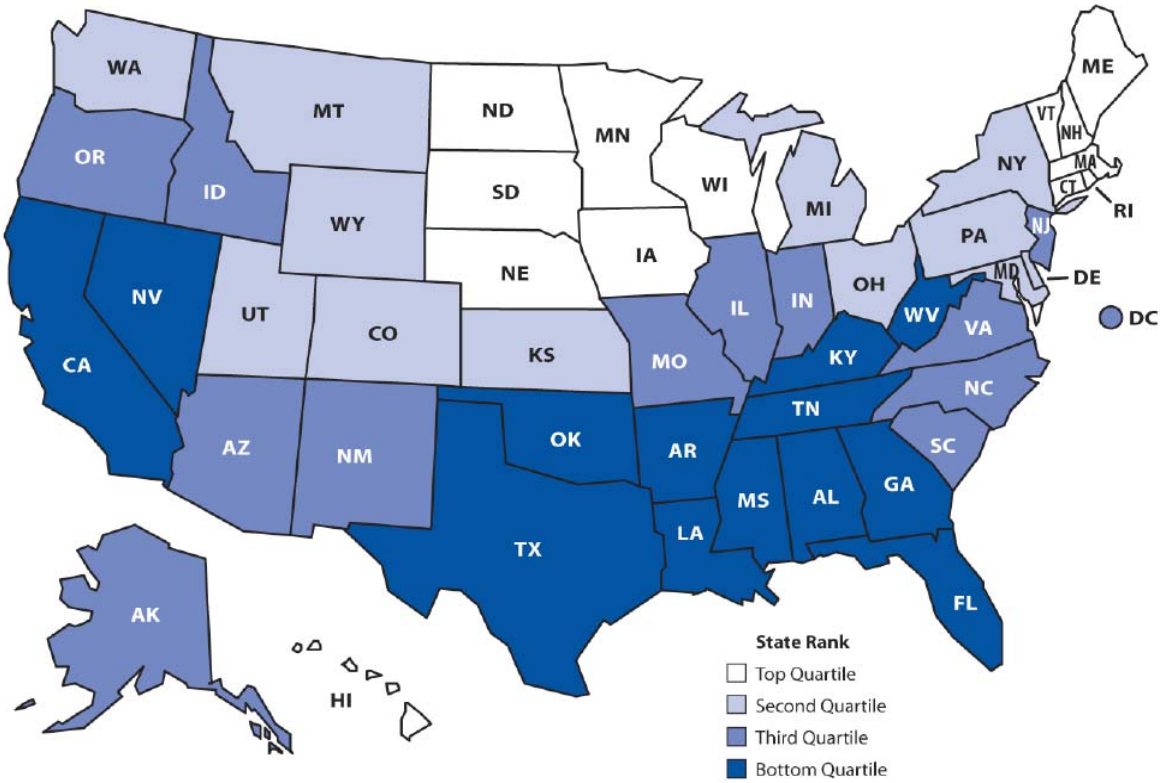
INTRODUCTION

The Commonwealth Fund, an independent, private foundation, promotes the creation of a high-performing health care system by supporting independent research on health issues, practice, and policy.

In September 2006, the Commonwealth Fund released the *National Scorecard on U.S. Health System Performance*. The *National Scorecard* assesses how well the U.S. is performing across key areas of health care relative to achievable benchmarks. It also points to deficient areas where public and private action is needed — and provides a yardstick against which to measure the success of new policies.

Recognizing the influence of state policy on health care system performance, the Commonwealth Fund recently released *Aiming Higher: Results from a State Scorecard on Health System Performance*, which offers a framework to evaluate state health care system performance across five dimensions: access, quality, avoidable hospital use and costs, equity, and healthy lives.

State Ranking on Overall Health System Performance



SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2007

WHAT THE *SCORECARD* MEASURES

Dimensions and Indicators

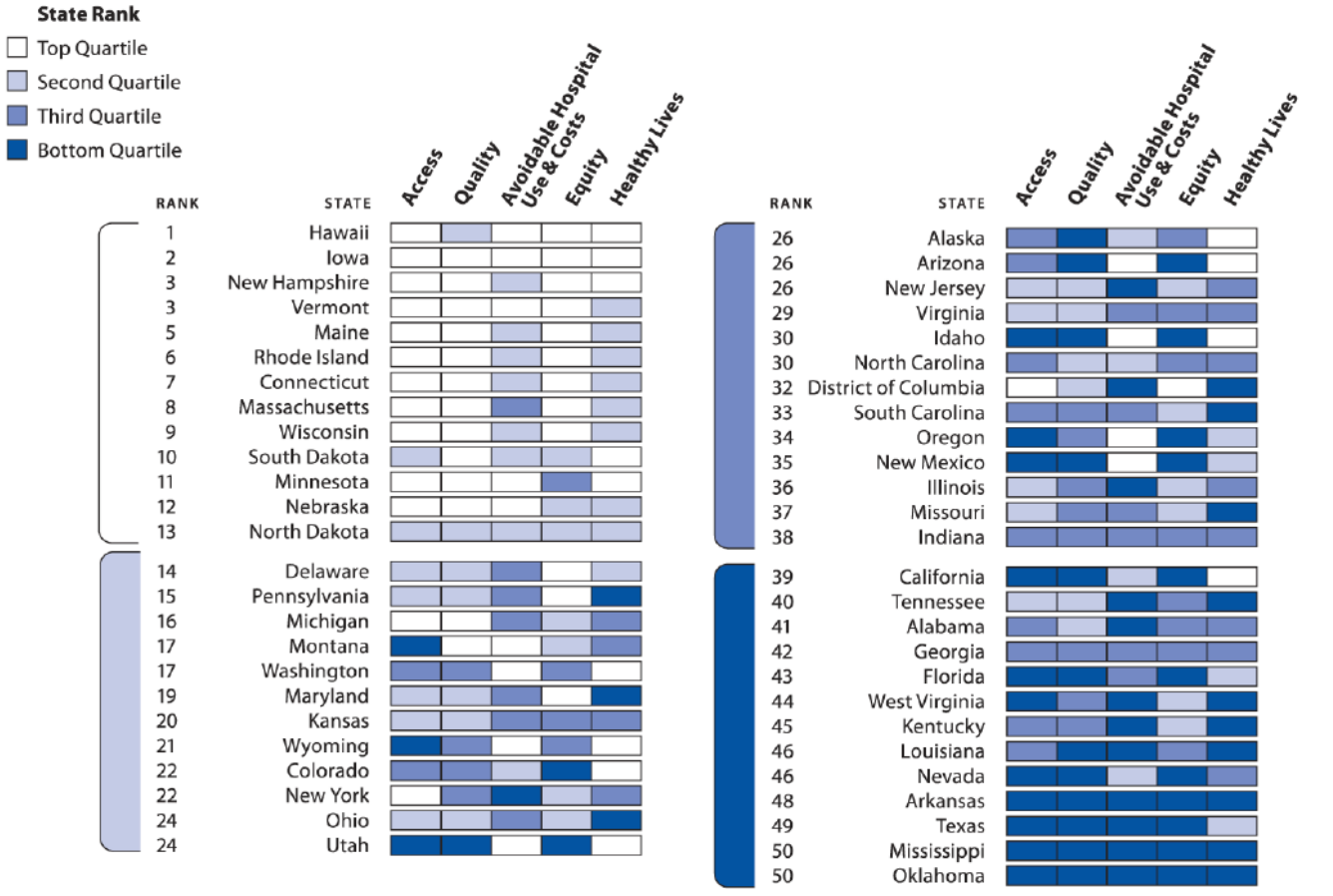
The *Scorecard* measures health system performance for all 50 states and the District of Columbia using 32 key indicators. It organizes indicators by five broad dimensions that capture critical aspects of health system performance:

- **Access** includes rates of insurance coverage for adults and children and indicators of access and affordability of care.
- **Quality** includes indicators that measure three related components: receipt of the "right care," coordinated care, and patient-centered care.
- **Potentially Avoidable Use of Hospitals and Costs of Care** includes indicators of hospital care that might have been prevented with approprite care and follow-up, as well as the annual costs of Medicare and private health insurance premiums.
- **Equity** includes differences in performance associated with patients' income level, type of insurance, or race and ethnicity.
- **Healthy Lives** includes indicators that measure the degree to which a state's residents enjoy long and healthy lives.

Kansas, as the map on page three shows, achieved an overall ranking of 20, placing it in the second quartile of states.

The table below shows the rankings Kansas achieved in the various performance dimensions and its overall ranking relative to other states.

State Scorecard Summary of Health System Performance Across Dimensions



SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2007

Whenever possible, indicators were selected to be equivalent to those used in the *National Scorecard on U.S. Health System Performance*. However, comparable state-level data were not available for some important topics covered by the *National Scorecard*. In particular, as a nation, we lack state-level indicators to measure how well patients and their doctors are controlling chronic diseases and how often patients experience adverse effects from their treatment, as well as other safety indicators. We also lack state-level data on system capacity. Moreover, many quality metrics are still in the early stages of development and thus are limited in scope. Therefore, *Scorecard* indicators should be considered a "starter set" to be expanded over time.

RESULTS FOR KANSAS

Overall and Dimension Ranking	
OVERALL	**20**
Access	17
Quality	19
Avoidable Hospital Use & Costs	26
Equity*	34
Healthy Lives	27

Summary of Indicator Rankings	
Total number of main indicators for this state:	31
Number of indicators for which this state ranked in the:	
Top 5	0
Top Quartile	6
2nd Quartile	12
3rd Quartile	12
Bottom Quartile	1
Bottom 5	1

Dimension and Indicator	Year	State Rate	All States Median Rate	Top 5 States Average Rate	Best State Rate	Rank
ACCESS						**17**
Percent of adults (ages 18–64) insured	2004–2005	85.2	81.5	87.3	89.0	10
Percent of children (ages 0–17) insured	2004–2005	93.3	91.1	94.7	94.9	11
Percent of adults visited a doctor in the past two years	2000	83.1	83.4	89.9	91.5	27
Percent of adults without time in past year when they needed to see a doctor but could not because of cost	2004	88.1	87.2	93.1	96.6	19
QUALITY						**19**
Percent of adults age 50 and older received recommended screening and preventive care	2004	39.7	39.7	48.8	50.1	26
Percent of adult diabetics received recommended preventive care	2004	43.2	42.4	58.5	65.4	22
Percent of children ages 19–35 months received all recommended doses of five key vaccines	2005	83.8	81.6	88.3	93.5	13
Percent of children with both a medical and dental preventive care visit in the past year	2003	60.7	59.2	72.6	74.9	21
Percent of children with emotional, behavioral, or developmental problems received some mental health care in the past year	2003	61.3	61.9	74.2	77.2	28
Percent of hospitalized patients received recommended care for acute myocardial infarction, congestive heart failure, and pneumonia	2004	84.0	83.4	87.8	88.4	20
Percent of surgical patients received appropriate timing of antibiotics to prevent infections	2005	65.5	69.5	82.8	90.0	34
Percent of adults with a usual source of care	2004	84.2	81.1	88.3	89.4	11
Percent of children with a medical home	2003	49.8	47.6	59.7	61.0	18
Percent of heart failure patients given written instructions at discharge	2004–2005	31.0	49.0	63.6	67.0	48
Percent of Medicare patients whose health care provider always listens, explains, shows respect, and spends enough time with them	2003	68.3	68.7	73.2	74.9	35
Percent of Medicare patients giving a best rating for health care received in the past year	2003	71.5	70.2	73.7	74.4	12
Percent of high-risk nursing home residents with pressure sores	2004	12.2	13.2	8.1	7.6	18
Percent of nursing home residents who were physically restrained	2004	3.6	6.2	2.4	1.9	10
AVOIDABLE HOSPITAL USE & COSTS						**26**
Hospital admissions for pediatric asthma per 100,000 children	2002	162.8	176.7	81.3	54.9	15
Percent of asthmatics with an emergency room or urgent care visit in the past year	2001–2004	NA	15.5	10.8	9.1	NA
Medicare hospital admissions for ambulatory care sensitive conditions per 100,000 beneficiaries	2003	7,328	7,278	4,610	4,069	27
Medicare 30-day hospital readmissions as a percent of admissions	2003	18.9	17.6	13.8	13.2	38
Percent of long-stay nursing home residents with a hospital admission	2000	14.2	16.1	8.7	8.3	18
Percent of nursing home residents with hospital readmission within three months	2000	13.1	11.7	7.5	6.7	36
Percent of home health patients with a hospital admission	2004	27.2	26.9	20.1	18.3	28
Total single premium per enrolled employee at private-sector establishments that offer health insurance	2004	3,711	3,706	3,216	3,034	27
Total Medicare (Parts A & B) reimbursements per enrollee	2003	6,070	6,070	4,828	4,530	26
HEALTHY LIVES						**27**
Mortality amenable to health care, deaths per 100,000 population	2002	91.0	96.9	74.1	70.2	22
Infant mortality, deaths per 1,000 live births	2002	7.2	7.1	4.8	4.3	27
Breast cancer deaths per 100,000 female population	2002	26.4	25.3	19.9	16.2	36
Colorectal cancer deaths per 100,000 population	2002	20.2	20.0	16.3	15.3	29
Percent of adults under age 65 limited in any activities because of physical, mental, or emotional problems	2004	13.8	15.3	11.5	10.8	14

SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2007

*The equity dimension was ranked based on gaps between the most vulnerable group and the U.S. national average for selected indicators. Comparisons were made by income, insurance, and race/ethnicity. Refer to Equity section in State Scorecard Data Tables.

Scorecard Ranking Methodology

The *Scorecard* first ranks states from best to worst on each of the 32 performance indicators. To construct dimension rankings, the authors of the *Scorecard* averaged the rankings for those indicators within each of the five dimensions. Then the dimension rankings were averaged to arrive at an overall ranking of health system performance. This approach gives each dimension equal weight and, within dimensions, weights the indicators equally. Average state rankings were used because they are easily understandable.

For the equity dimension, states were ranked based on the difference between the most vulnerable subgroup (i.e. low-income, uninsured, or racial/ethnic minority) and the U.S. national average — an absolute standard.

HOW KANSAS FARES

Kansas achieved an overall ranking of 20. As the tables on page 5 illustrate, Kansas scored in the second and third quartiles in 24 of the 32 measures. It achieved top quartile rankings in only six categories and ranked in the bottom quartile in only two.

Kansas in the Top Quartile

Access

- Percent of adults (ages 18 to 64) insured — **10th**
- Percent of children (ages 0 to 17) insured — **11th**

Quality

- Percent of children ages 19 to 35 months received all recommended doses of five key vaccines — **13th**
- Percent of adults with a usual source of care — **11th**
- Percent of Medicare patients giving a best rating for health care received in the past year — **12th**
- Percent of nursing home residents who were physically restrained — **10th**

Kansas in the Bottom Quartile

Quality

- Percent of heart failure patients given written instructions at discharge — **48th**

Avoidable Hospital Use and Costs

- Medicare 30-day hospital readmissions as a percent of admissions — **38th**

WHAT DOES THE *SCORECARD* MEAN FOR KANSAS?

The Commonwealth Fund *Scorecard* is just one of many efforts at the national level to measure the quality and performance of health care system. In this context, what can we learn from the *Scorecard?*

- Beyond its specific findings, the *Scorecard* contributes to the goal of health system improvement by helping to focus national and state policy discussions. Health system performance is an issue of critical importance; measurement provides opportunities for accountability, improvement, and conversation.

- The *Scorecard* is one of multiple efforts at the national level to measure quality and performance in states. Within weeks of the *Scorecard's* release, two similar quality reports were released. Rather than operating with different indicators, stakeholders should coalesce around one common set of indicators. It would benefit residents of Kansas for relevant health care leaders to prioritize the same set of indicators.

- Current measurement strategies are neither sufficient nor perfect. Still, we can conclude that:
  - o Opportunities for improvement can be found everywhere in the system in every state;
  - o Although, in general, Kansas performs in the middle of the distribution, these reports identify certain areas of relative strengths and weaknesses; and
  - o Measurement can be a powerful force in guiding change and defining an agenda to improve system performance.

What Does Poor Health System Performance Cost Kansas?

Amidst discussions about how to measure health system accountability, it is far too easy to forget why we care about doing so in the first place. The *Scorecard* serves to remind us that poor health system performance has real financial and human costs. The table on page 7 illustrates what could be achieved through a purposeful approach

to improving the state's performance in the specific areas highlighted by the *Scorecard*. Note that these are the gains that could be realized in Kansas if our health system performed as well as the systems in top performing states. For example, if the rate of preventable hospitalizations among Medicare beneficiaries in Kansas was the same as that achieved by the top performing states of Hawaii, Utah, Washington, Alaska and Oregon, about 10,000 hospitalizations would be avoided and more than $42 million would be saved each year. Similarly, if we achieved in Kansas the same rate of hospital readmissions among Medicare beneficiaries as the top performing states of Vermont, Wyoming, Iowa, Oregon and Nebraska, we could prevent another 2,600 admissions and save an additional $35 million per year. These are just some of the real costs, both financial and human, of a health system that performs at a level below what we know is achievable, and in fact is already being achieved in other states.

Moving Forward

One key interpretation of the *Scorecard* data is that performance is best in states that have made a concerted effort to activate resources to address these problems. Examples of successful approaches to improve performance abound. One is the neighboring state of Iowa. A description of that state's collaborative approach is briefly described in the box at the bottom of this page.

INDICATOR	IF KANSAS' PERFORMANCE IMPROVED TO THE LEVEL OF THE BEST-PERFORMING STATE FOR THIS INDICATOR, THEN:	
Insured Adults	62,055	more adults (ages 18 – 64) would be covered by health insurance (public or private), and therefore would be more likely to receive health care when needed.
Insured Children	11,237	more children (ages 0 – 17) would be covered by health insurance (public or private), and therefore would be more likely to receive health care when needed.
Adult Preventive Care	78,921	more adults (age 50 and older) would receive recommended preventive care, such as colon cancer screenings, mammograms, pap smears, and flu shots at appropriate ages.
Diabetes Care	29,576	more adults (age 18 and older) with diabetes would receive three recommended services (eye exam, foot exam, and hemoglobin A1c test) to help prevent or delay disease complications.
Childhood Vaccinations	5,721	more children (ages 19 – 35 months) would be up-to-date on all recommended doses of five key vaccines.
Adults with a Usual Source of Care	106,094	more adults (age 18 and older) would have a usual source of care to help ensure that care is coordinated and accessible when needed.
Children with a Medical Home	77,457	more children (ages 0 – 17) would have a medical home to help ensure that care is coordinated and accessible when needed.
Preventable Hospital Admissions	10,194 $42,741,000	fewer hospitalizations for ambulatory care sensitive conditions would occur among Medicare beneficiaries (age 65 and older) and dollars would be saved from the reduction in hospitalizations.
Hospital Readmissions	2,601 $35,765,000	fewer hospital readmissions would occur among Medicare beneficiaries (age 65 and older) and dollars would be saved from the reduction in readmissions.
Hospitalization of Nursing Home Residents	1,198 $9,465,000	fewer long-stay nursing home residents would be hospitalized and dollars would be saved from the reduction in hospitalizations.
Mortality Amenable to Health Care	520	fewer premature deaths (before age 75) might occur from causes that are potentially treatable or preventable with timely and appropriate health care.

IOWA HEALTHCARE COLLABORATIVE

The Iowa Healthcare Collaborative (IHC) is a provider-led organization dedicated to promoting "an Iowa health care culture of continuous improvement in quality, patient safety, and value." Originally formed through a partnership of the Iowa Hospital Association (IHA) and the Iowa Medical Society (IMS), initiatives focus provider-directed efforts to facilitate engagement, communication, sharing of data, and best practices. Primary staff support has been provided by the IHA and IMS, with additional support from the Iowa Health System, Mercy Health Network, the Iowa Foundation for Medical Care, and the University of Iowa College of Public Health.

IHC uses a "multi-stakeholder" approach, aggregating expertise through board membership and other collaborative relationships. It is supportive and complementary to national quality and patient safety initiatives and works closely with national organizations like the Institute for Healthcare Improvement, the National Patient Safety Foundation, the American Hospital Association, and the American Medical Association.

IHC has a unique role in accelerating clinical improvement in Iowa. It provides an objective, inclusive focal point for public reporting of accurate and clinically-relevant performance data. IHC puts doctors and nurses in positions of leadership — driving clinical progress, accelerating the pace of change, hardwiring clinical improvements, and promoting patient safety. This unique structure has been suggested as a model for use in other states to achieve engagement and to improve the health of the public.

SOURCE: Iowa Healthcare Collaborative Web site, http://www.ihconline.org/aboutus/aboutus.cfm.

Comprehensive Approach Needed

The *Scorecard* suggests a need for a more comprehensive approach for managing policies and practices. Change can be managed at federal, regional, state, county, local, organizational, and/or population levels. There exists an extensive menu of approaches that range from broad policy changes to organizational practices to the promotion of healthful individual behaviors. Each stakeholder has the potential to enhance performance on its own as well as through collaboration and contribution.

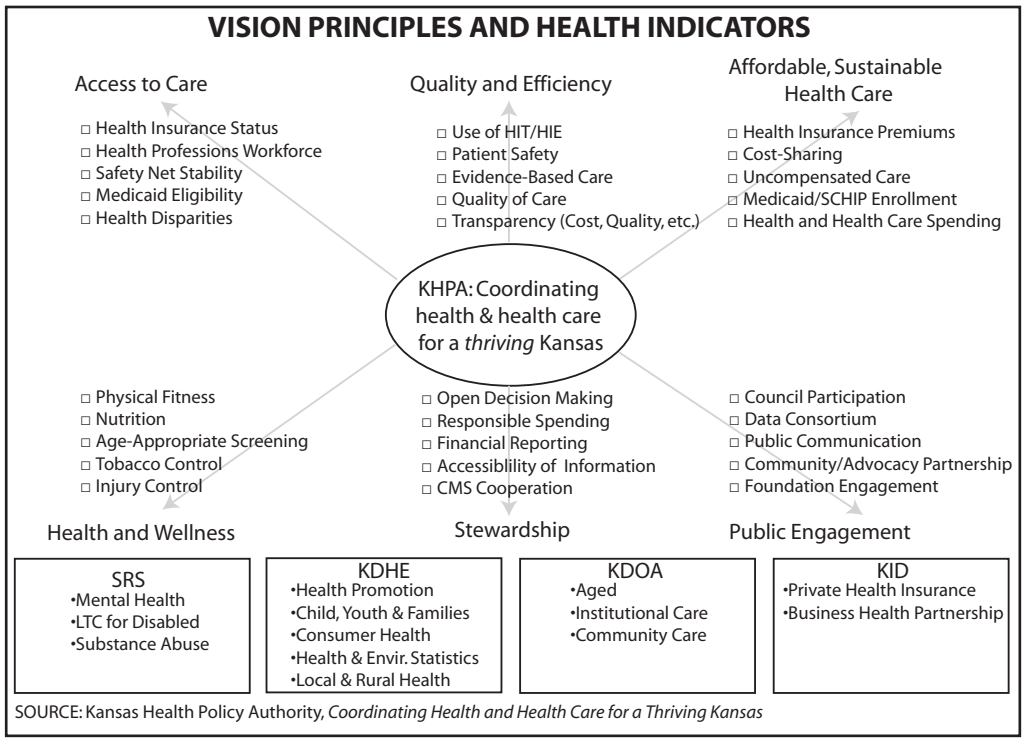
While health and performance outcomes are a result of the interaction of many factors, specific stakeholders make important independent contributions to health system performance. Both multi-stakeholder initiatives as well as individual stakeholder activities are necessary to move the system. To be successful, stakeholders must jointly establish priorities, create actionable agendas, and commit to purposeful and effective measurement to assure successful implementation, identify intended and unintended consequences, and reorder priorities.

The existence of the Kansas Health Policy Authority (KHPA) provides us with an opportunity in Kansas. The broad mission of the KHPA is to improve the health of Kansans. Clearly, a key to achieving that mission is the improvement of the health system. The graphic below illustrates a comprehensive set of indicators that the health policy authority is considering to track progress in fulfilling its mission.

CONCLUSION

Aiming Higher: Results from a State Scorecard on Health System Performance has the potential to become an important stimulus for state and national efforts to improve health system performance. There are human costs of poor performance and of system failures. People die or suffer needlessly because of inadequate health care services, failed policies, and misplaced priorities. Minority populations bear a disproportionate burden of illness, in part because these consequences remain invisible to policymakers and the people they represent.

The Institute of Medicine, one of the National Academies of Science, has defined high quality health care as effective, efficient, timely, patient-centered, and equitable. These are identifiable standards that, with effort, can be measured and tracked. The *Scorecard* provides us with real goals that, if achieved, can result in the overall improvement of the health system and the health of Kansans.



SOURCE: Kansas Health Policy Authority, *Coordinating Health and Health Care for a Thriving Kansas*