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

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The Kansas Health Institute is an independent, nonprofit health policy and research organization based in Topeka, Kansas. Established in 1995 with a multi-year grant from the Kansas Health Foundation, the Kansas Health Institute conducts research and policy analysis on issues that affect the health of Kansans.

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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*, the preparation of this review, 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.

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OVERVIEW

The Commonwealth Fund State Scorecard, entitled *Aiming Higher: Results from a State Scorecard on Health System Performance,* uses a series of 32 indicators to characterize the dimensions of:

- Access to Health Care,
- Health Care Quality,
- Avoidable Hospital Use and Costs,
- Equity, and
- Healthy Lives.

The *Scorecard* has an important role to play in stimulating critical conversations about how the health and health care of Kansans may be improved. It also serves to remind us that:

- The health of Kansans and the performance of the Kansas health system are inextricably linked to the larger U.S. health care system;
- States, and state policies, have the potential to make a significant difference in health and health care; and
- Variation across the states represents the cumulative impact of very many deliberate choices by stakeholders including policymakers, organizations, and individuals. There is clear evidence that states which set about making changes with an ordered approach to focusing on and solving health problems tend to do better.

One significant contribution of this report is that it demonstrates the idea that high performance happens where attention is paid specifically to producing high performance. These findings represent a call to action for policymakers, health care organizations and the citizens of Kansas, and present us with an opportunity to learn from the experiences of others as we chart a course for raising the bar on health care quality in Kansas.

Although many groups and individual organizations are already engaged in a wide array of health-related initiatives in Kansas, this *Scorecard* provides a foundation of measurement upon

which to build specific, prioritized initiatives that are targeted toward a better-performing health system.

Although there are many lessons to learn from this *Scorecard*, several overarching considerations emerge:

- High performance happens where high performance is a priority. High-performing health systems are not due to luck of the draw, the spending of money without evidence and purpose, or as a reward for unfocused hard work. Commitment, attention, and well-applied resources are the tools that have the potential to significantly improve performance.
- There are sufficient opportunities for improvement and Kansas should consider an organized and focused response that explicitly develops priorities and articulates an agenda. Such agenda-setting is a prerequisite to the management and organization of a thoughtful approach to change.

Meaningful change requires the integration of periodic measurement and strategic interventions. Each stakeholder has many independent opportunities to improve the system. In addition, there is an obvious need to collaborate among stakeholders and integrate approaches.

CONSIDERATIONS: A CONTEXT FOR MEASUREMENT

These indicators and the data that underlie them represent one of many possible systematic approaches to measurement and reporting and have been developed for a variety of reasons. Some, like infant mortality and childhood immunization rates, are longstanding measures of public health and health care that are well understood in many contexts. Others, like the measures of costs, are more specific and less well understood in terms of their implications and causes. Still others, like the measures capturing patients' experiences of care, were designed to promote accountability and the development of a better informed health care market.

The goal of health care should be to provide the right services to the right people in a technically proficient way, not simply to do better than three-quarters of the other states.

New data are becoming available all of the time. Multiple organizations are reporting data in ways that seem to overlap and at times to contradict one another. In the past month, we have seen the release of *Hospital Quality Reports on Cardiac Care* by the Centers for Medicare and Medicaid Services (CMS) and *The National Healthcare Quality Report State Snapshots* from the Agency for Healthcare Research and Quality (AHRQ), which offers more than 120 measures of quality. The AHRQ report places Kansas 44th in its rate of immunizations at 77.5 percent immunized using 2004 data, while the Commonwealth Fund's *Scorecard* places Kansas 13th (at just over 83 percent) using 2005 data. This presents a current example of the potential for inconsistency among quality measures and the need for exploration as part of a thoughtful and purposeful response to these or any quality measures.

On the other extreme, the *New York Times* laments that the recent publication by CMS of hospital ratings using a three category system of "average," "above average," and "below average." This system places virtually 98 percent of hospitals in the average category, which limits the usefulness of the evaluation and its application as a tool to induce system improvement.

Despite the emphasis on relative measures of performance and the prominence of state rankings, there is an absolute aspect to performance that should not be obscured by the relative measures. For example, in 2004 nearly one in four children in Kansas was not fully immunized. In 2005 that number still exceeded more than one in six. Complacence is not supported by either finding.

GENERAL FINDINGS

According to the *Scorecard*, Kansas' performance is not distinguished. While some may be relieved to note that Kansas did not show any signs of failing badly in any of the domains, neither was Kansas a leader. On individual measures, Kansas had one or two that lagged and several that were in the top quartile of states. Thus there is a lot of subjective room for interpretation and several legitimate ways to focus the discussion by acknowledging the following points:

- In a system that is stressed and underperforming, Kansas does some things consistently better than average;
- In all areas, Kansas has some room for improvement with the potential to benefit its citizens; and
- The existence of alternative approaches to measurement does not negate what these data show.

SPECIFIC FINDINGS AND HIGHLIGHTS FROM THE DATA

Table 1, which starts on page 6, complements the *Scorecard* data. To help explain where Kansas is on the distributions, we have developed a Performance Quotient (PQ) that can be interpreted statistically like an IQ score — a higher number is most always interpreted as better. The numbers also demonstrate the explicit differences between Kansas' performance and the median and between Kansas and the mean of the top five states.

Additionally, if the data reveal that even the best states only meet a certain level of performance three-quarters of the time, a judgment needs to be made as to whether or not that is sufficient. If it is felt not to be good enough, then it suggests a role for advocacy and innovation to develop systematic improvements in the way that health care is delivered.

Reviewing Kansas' overall performance on the measures, Kansas does best in areas that are either specific measures of access or reliant on access (e.g., adults with a usual source of care). Efforts to insure the children of Kansas are paying off, with 93.3 percent of children insured. A high rate of adults with insurance suggests that pending health care reform legislation may further strengthen access. However, these findings are tempered by racial and ethnic disparities that mean that these successes are not equally shared by all Kansans. The absence of a well-developed safety net system in Kansas further complicates the existence of disparities in insurance coverage. On the majority of the measures, Kansas generally falls near the middle, only ranking toward the bottom on a few indicators.

It is important to note that this data set represents a sampling of measures that are uniformly available across the states. As such, it is difficult to use these measures to understand what the

causes of mediocre performance might be or to identify specific processes that represent opportunities for improvement.

Following the data summary table, we present several brief analytic narratives. These narratives are intended to be illustrations that represent potential ways of looking at and of using these data to prompt additional analyses, to inform the conversation and to stimulate action. These are highlighted by examples of work currently underway in Kansas and elsewhere, along with some lessons from the literature.

Table 1. **Data Summary**

Variable	U.S. Mean	Kansas Score	Mean Top 5	Difference (Top 5)	Top 5 States	U.S. Median	Difference (Median)	Kansas PQ	Kansas Rank
Percent insured adults < 65 yrs	81.0	85.2	87.3	-2.1	MN IA HI WI ME	81.5	3.7	110	10
Percent insured children	90.4	93.3	94.7	-1.4	VT MA HI IA MI	91.1	2.2	108	11
Percent adults visited doctor in past two years	83.3	83.1	89.9	-6.8	DC MA RI MD HI	83.4	-0.3	99	27
Percent adults without time when could not see doctor because of cost	87.1	88.1	93.1	-5.0	HI ND MA WI IA	87.2	0.9	103	19
Percent adults age 50+ received recommended preventive care	40.4	39.7	48.8	-9.1	MN MD NH RI CT	39.7	0.0	98	26
Percent adult diabetics received recommended preventive care	43.7	43.2	58.5	-15.3	HI ND MN DE SD	42.4	0.8	99	22
Percent children ages 19–35 months received five vaccines	80.7	83.8	88.3	-5.0	MA NE SD CT VA	81.6	2.2	106	13
Percent children with medical and dental preventive care visits	58.9	60.7	72.6	-11.9	MA RI NH CT VT	59.2	1.5	102	21
Percent children with emotional, behavioral, or developmental problems received mental health care	61.4	61.3	74.2	-12.9	WY PA CT NE SD	61.9	-0.6	100	28
Percent hospitalized patients received recommended care for AMI, CHF, and pneumonia	83.5	84.0	87.8	-3.8	RI NE NJ IA CT	83.4	0.6	102	20

Notes:

- *Italicized* measures are reverse scored, that is the differences, standard score, and performance quotient (PQ) recognizes that lower scores are better.
- *Kansas Score* is Kansas actual performance on a given measure.
- *Difference (Top 5)* is the difference between the score for Kansas on the measure and the Mean of the Top 5 for that measure.
- *Kansas PQ, or performance quotient,* is another method for displaying Kansas' performance normalized to a format similar to an IQ score, with a mean of 100 and a standard deviation of 10.

Table 1 (continued). **Data Summary**

Variable	U.S. Mean	Kansas Score	Mean Top 5	Difference (Top 5)	Top 5 States	U.S. Median	Difference (Median)	Kansas PQ	Kansas Rank
Percent surgical patients received appropriate timing of antibiotics to prevent infections	69.1	65.5	82.8	-17.3	CT RI ND SD MT	69.5	-4.0	95	34
Percent adults with a usual source of care	80.2	84.2	88.3	-4.1	DE ME PA NH MA	81.1	3.1	108	11
Percent children with a medical home	47.0	49.8	59.7	-9.9	NH RI MA CT VT	47.6	2.2	104	18
Percent heart failure patients given instructions at discharge	47.0	31.0	63.6	-32.6	RI NJ ME SD OH	49.0	-18.0	85	48
Percent Medicare patients experienced good communication with provider	69.0	68.3	73.2	-4.9	VT ME RI LA MT	68.7	-0.4	97	35
Percent Medicare patients giving best rating for care received	69.5	71.5	73.7	-2.2	MT HI RI ME PA	70.2	1.3	107	12
Percent high-risk nursing home residents with pressure sores	*12.8*	*12.2*	*8.1*	*4.1*	ND MT NE ID IA	*13.2*	*-1.0*	*98*	*18*
Percent nursing home residents were physically restrained	*6.7*	*3.6*	*2.4*	*1.2*	NE IA DC ND DE	*6.2*	*-2.6*	*91*	*10*
Hospital admissions for pediatric asthma per 100,000 children	*174.7*	*162.8*	*81.3*	*-81.5*	VT OR NE UT IA	*176.7*	*13.9*	*98*	*15*
Percent asthmatics with emergency room or urgent care visit	*16.5*	*.*	*10.8*		IA MN ID UT WA	*15.5*	*.*	*.*	*.*

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Table 1 (continued). **Data Summary**

Variable	U.S. Mean	Kansas Score	Mean Top 5	Difference (Top 5)	Top 5 States	U.S. Median	Difference (Median)	Kansas PQ	Kansas Rank
Medicare admissions for ACS conditions per 100,000 beneficiaries	*7340.4*	*7328.0*	*4610*	*2718*	HI UT WA AK OR	*7278.0*	*-50.0*	*100*	*27*
Medicare 30-day hospital readmission rates	*17.5*	*18.9*	*13.8*	*5.1*	VT WY IA OR NE	*17.6*	*-1.3*	*106*	*38*
Percent long-stay nursing home residents with hospital admission	*15.7*	*14.2*	*8.7*	*5.5*	UT NM ME NH OR	*16.1*	*1.9*	*97*	*18*
Percent nursing home residents with readmission within three months	*11.7*	*13.1*	*7.5*	*5.6*	OR AZ CA UT WA	*11.7*	*-1.4*	*95*	*36*
Percent home health patients with hospital admission	*27.7*	*27.2*	*20.1*	*7.1*	UT AZ OR WA FL	*26.9*	*-0.3*	*99*	*28*
Total single health insurance premium per enrolled employee	*$3705.7*	*$3711.0*	*$3216*	*$495*	UT HI AK GA ND	*$3706*	*-5.0*	*100*	*27*
Total Medicare reimbursements per enrollee	*$6168.2*	*$6070.0*	*$4828*	***$**1242*	HI ND IA OR SD	*$6070*	*0.0*	*99*	*26*
Mortality amenable to health care, deaths per 100,000 population	*100.6*	*91.0*	*74.1*	*16.9*	MN UT VT WY AK	*96.9*	*5.9*	*105*	*22*
Infant mortality, deaths per 1,000 live births	*7.1*	*7.2*	*4.8*	*2.4*	ME VT MA NH MN	*7.1*	*-0.1*	*99*	*27*
Breast cancer deaths per 100,000 female population	*25.1*	*26.4*	*19.9*	*6.5*	HI WY AK VT NM	*25.3*	*-1.1*	*95*	*36*

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Table 1 (continued). **Data Summary**

Variable	U.S. Mean	Kansas Score	Mean Top 5	Difference (Top 5)	Top 5 States	U.S. Median	Difference (Median)	Kansas PQ	Kansas Rank
Colorectal cancer deaths per 100,000 population	*19.8*	*20.2*	*16.3*	*3.9*	UT ID AZ WA CA	*20.0*	*-0.2*	*98*	*29*
Percent adults under age 65 limited in activities because of physical, mental, or emotional problems	*15.4*	*13.8*	*11.5*	*2.3*	DC CA ND IA IL	*15.3*	*1.5*	*107*	*14*

Notes:

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DEVELOPING MEANING FROM DATA: A CONTEXT FOR UNDERSTANDING AND IMPROVEMENT

Access to Care: A Necessary First Step

What the Data Tell Us

The Scorecard divides quality indicators into four dimensions of access, quality, avoidable hospital use and costs, and healthy lives. In addition to the four indicators classified under access, measures in other dimensions reflect access issues either directly or indirectly. Kansas performs consistently well on measures of access, ranking 10th and 11th of indicators of adult and child health insurance (85.2 and 93.3 percent), and 11th for the percent of adults reporting a usual source of care (84.2 percent). Kansas joins many states in recognizing the fruits of substantial and ongoing efforts to ensure that our children are covered by health insurance.

The Need to Reduce Disparities

A 2007 report from the Kansas Health Institute, *Understanding Health Insurance in Kansas,* highlights the fact that racial and ethnic minority adults and children are much less likely to be insured than non-Hispanic white adults and children. Hispanic adults and children are more than three times as likely to be uninsured as their white non-Hispanic peers, with blacks having intermediate rates. These findings are particularly important in a state such as Kansas that does not have a well-developed system of safety net providers for those who are not insured. Equitable health and health care in Kansas will only be achieved once steps are taken to address these disparities in coverage and access.

A Policy Priority

Kansas continues to place priority on access to care with passage of the *Foundations of Health Reform Act of 2007* (S.B. 11). In addition to a focus on affordable insurance, this bill also places measures on the table that are intended to result in savings for the Medicaid program, as well as increase the focus on detecting fraud, waste and abuse.

An Opportunity to Save Lives: Reducing Breast Cancer Deaths in Kansas

What the Data Tell Us

The *Scorecard* ranks Kansas 36th in the country in terms of deaths from breast cancer. The implications of these data and the need for action can be amplified by other complementary data that are currently available. The 2006 Behavioral Risk Factor Surveillance Survey found that more than one in four Kansas women over 40 had not had a mammogram in the previous two years. This was worse than the findings of the 2004 survey that found that 23.9 percent of women had not had mammograms. In keeping with the concerns about equity noted above, the 2004 survey found that 21.3 percent of insured women and more than half of all uninsured women had not had mammography in the previous two years. In Kansas, insurance seems to be a critical gateway to obtaining preventive services.

Data from the AHRQ *Snapshot* shows that Kansas lags in its ability to identify breast cancer in early stages. These consistent findings begin to suggest a logic model: insurance is necessary for the predictable receipt of preventive services, and lack of insurance among some women (especially black and Hispanic women) causes Kansas women to lag behind in breast cancer screening, which leads to cancers that are diagnosed at later stages and result in more deaths. Issues of the quality of care for women and issues of racial and ethnic disparities begin to merge to create findings that suggest an urgent need to look at how breast cancer screening, identification, and treatment occur for both the majority and minority populations in Kansas.

A variety of stakeholders have specific opportunities to raise the bar in the area of preventive services, and many of these apply to the case of mammography. Below are several ideas to move forward on this front taken from academic literature and the Kansas experience.

A Role for Policy and Public Health

With a grant from the Centers for Disease Control and Prevention which funds the National Breast and Cervical Cancer Screening and Early Detection program, the Kansas Department of Health and Environment (KDHE) runs the Early Detection Works program. Through this program, mammograms and pap smears are provided to approximately 7,000 women ages 40 to 64 annually. The 6,000 mammograms conducted, however, represent only about one-fourth

of the unmet need, with over 27,000 women eligible for service. This year the program cut off enrollment on June 8 due to a shortage of resources. **A well-developed outreach program incorporating lay health advisors goes largely unimplemented, since the demand is already greater than the availability of service. This existing and apparently effective program suffers for lack of adequate funding, most likely resulting in the preventable deaths of Kansans.**

An Opportunity for Office Practice Improvement

A published review of available literature found that organizational interventions, with a focus on system-level changes to encourage screening, were effective in improving mammography screening rates. One study showed that primary care practices which were perceived to have an internal recognition of quality performance and an overall commitment to quality improvement performed higher on breast and cervical cancer screening rates. There is also evidence that racial and ethnic disparities exist in the outcomes of women with breast cancer, in part because of the differences in the rates of use of therapies such as chemotherapy or radiation. Evidence exists that these disparities may be mediated in part by improving the quality of office practice for breast surgeons, specifically, by increasing the scope of discussion of the potential value of adjuvant therapies with eligible patients.

A Single Hospital Makes a Difference

In response to an overwhelming community need, and within the context of the hospital's quality improvement mission, Staten Island University Hospital in New York decided to develop a "breast center" approach to the provision of breast health services. Goals for the initiative were: a) to reduce waiting times for breast imaging services, b) to improve the quality of care, and c) to improve the patient's overall experience.

Over two years, this single institution was able to reduce waiting times for screening mammography from 30 weeks to 3.5 weeks. During the same time period, screening rates of cancer detection increased from 3.2 to 6.3 per 1,000 patients. Contributing factors to these improvements included improved coordination of services, focus on quality outcomes, outreach for government resources, and development of well-trained and dedicated staff.

The Potential for Impact: Congestive Heart Failure and Readmissions

Of all of the quality indicators in the report, Kansas performed most poorly on "percent of heart failure patients given written instructions at discharge," with a rate of 31 percent and a 48th place ranking. This was followed by a 38th place ranking on "Medicare 30-day hospital readmissions as a percent of admissions." Nationally, congestive heart failure is the most common discharge diagnosis among the elderly and up to half will be readmitted within six months of discharge. While the readmissions are not classified by diagnosis, it is likely that these two measures are connected.

Proven Strategies for Improvement

Several reasons for readmissions have been identified. One is that patients may be discharged "quicker and sicker." If there is not support or care after discharge to sustain the care that these patients need, they are at high risk for readmission. An emerging body of literature suggests that another major cause of readmissions results from failure to coordinate care between the outpatient and inpatient settings. Nowhere is this more likely to be true than for congestive heart failure. Fortunately, the literature that is available also offers evidence of successful strategies to improve coordination and reduce the likelihood of readmission. A nurse-delivered patient education session prior to discharge has been observed to result in a 41 percent decrease in re-hospitalization. Systematic reviews of educational interventions coupled with post-discharge patient support have found significant reductions in readmission rates and potential improvements in health outcomes such as survival and quality of life without increasing costs.

Kansas Hospitals Improve

From October 2003 through 2004, as part of ongoing initiatives to impact publicly-reported data in the state of Kansas, the Kansas Foundation for Medical Care (KFMC) brought together 35 Kansas hospitals who volunteered to participate in an interactive learning collaborative to improve hospital care for patients with acute myocardial infarction and heart failure. Among other improvements, participating hospitals demonstrated an average increase from about 30 percent to 50 percent of patients with heart failure receiving written discharge instructions. Since there are 137 hospitals in Kansas, the changes implemented by KFMC were not enough to make a statistically significant impact on the *Scorecard*, but the improvement offers a clear indication

of what could be accomplished if all Kansas hospitals engaged in purposeful efforts to improve performance on this and other quality indicators. Change within Kansas is not only possible, it has been demonstrated.

KDHE Provides a Comprehensive Framework

In 2002, the Office of Health Promotion received funds from CDC to establish the infrastructure for the Kansas Heart Disease and Stroke Prevention Program (KHDSPP), which is devoted to the secondary prevention of cardiovascular disease through detection, treatment and early identification. Supported by these funds, KHDSPP has been building capacity within the state to implement programming for secondary prevention of heart disease and stroke. This past October, they released a comprehensive Kansas Cardiovascular Health State Plan. While the plan does not address the topic of discharge planning specifically, it certainly fits within the framework and is worth consideration. Efforts to move forward in the prevention and treatment of cardiovascular disease and stroke must purposefully address issues of equity and disparities (the mortality rate for blacks from cardiovascular disease is significantly higher than that of whites). The efforts should also reflect our knowledge of the limitations of traditional approaches to professional education and take advantage of demonstrated strategies to engage providers in actively improving the care they provide.

Building on Success: Improving Care in Nursing Homes

The *Scorecard* indicates that Kansas' nursing homes are less likely than those in other states to utilize physical restraints and their high-risk patients are less likely to develop bed sores. These findings suggest that the nursing care in these facilities may be attentive, with adequate staffing to avoid many preventable problems. Why, then, are these same nursing homes associated with a higher-than-average rate of readmission to the hospital for Medicare patients within three months of their initial discharge? The data do not provide an answer. Perhaps the nursing homes are able to achieve these rates because when patients get sick, the nursing homes quickly get them to a hospital. With a low threshold for transfer to a hospital, the nursing homes would maintain their satisfactory nursing ratios and provide excellent care for those clients who remain in their care. An alternate hypothesis would be that the hospitals are discharging patients "quicker and sicker," and thus the nursing homes are unable to care for a substantial portion that

end up being readmitted. Each of these explanations suggests a potential system failure or inappropriate transfer of responsibility.

An alternate "good news" hypothesis also exists. Under this hypothesis, good practices and sufficient and qualified staff hold onto clients until they are quite sick. Thus, those who are actually admitted to the hospital are sicker than admissions in other states. Since the populations being admitted are not comparable, neither are the readmission rates. Perhaps the Kansas rate is appropriate for the actual case mix of the admissions.

The ability to generate these sorts of hypotheses represents the strength of reports such as the *Scorecard*. These alternate hypotheses might be explored using a series of thoughtful analyses of existing data or by the efficient collection of primary data to help to understand whether or not this finding is a problem or a testament to an unusually good system of nursing home care. **The need for further analysis to truly understand the data highlights both strengths and weaknesses of such reports: the ability to "look behind" the indicators in order to identify true opportunities for improvement represents a potential contribution whose benefit is only realized if such "look behind" assessments are thoughtfully undertaken.**

Kansas' Active Involvement in Nursing Home Quality and Improvement

The Kansas Department on Aging is sponsoring the PEAK (Promote Excellent Alternatives in Kansas) Nursing Homes program to promote non-traditional models of care with home environments, a movement known nationally as "culture change." This program recognizes those nursing homes pursuing progressive models of care and provides education on how to institute change and to document the value of innovative change in providing long-term care. This culture change framework addresses strategies for resident control, staff empowerment, home environment and community involvement.

Kansas Foundation for Medical Care Plays Leadership Role in Supporting Quality Improvement in Nursing Homes

The Kansas Foundation for Medical Care (KFMC) has engaged 45 Kansas nursing homes in an ongoing improvement initiative known as the *8th Scope of Work*, a blueprint for federally designated Quality Improvement Organizations (QIO) which outlines a plan for quality

improvement in several areas over the course of three years. KFMC is Kansas' designated QIO. Through monthly site visits, KFMC staff coach the nursing home quality staff in making and measuring changes with the goal of improvements in the areas of chronic pain, physical restraints, depression, and high-risk pressure ulcers. While evaluation data are not yet collected, some facilities are reporting reductions in the use of physical restraints in the range of 50 to 70 percent.

NEXT STEPS: ORGANIZING TO MOVE FORWARD TOGETHER

The *Scorecard* has done a great service by highlighting the role that measurement and reporting can play in serving as a foundation for an ongoing commitment to health and health care improvement. Universally, we see that there is room for improvement. We also see the importance of engaging at multiple levels, advocating for national reform, creating a forum for leadership to discuss planning and executing changes, and supporting local, community, and independent organization efforts to improve health and health care in Kansas.

The *Scorecard* demonstrates that high performance happens where attention is paid to producing high performance. Choosing whether or not to address these issues are distinct decisions with distinct consequences. There should no longer be a sense that "nothing can be done" or "the problem is too big." Components of the problem are being improved throughout the country. **Now is the time for purposeful and deliberate discussion about how to move forward in Kansas.**

Leadership Engagement is Essential

Transformative change and meaningful improvement will not happen without the active participation of senior leaders in public health, health care delivery, and community, purchaser, and industry groups. Leadership functions first and foremost to set the tone and influence others to make the changes necessary to achieve the various improvements to which we aspire. Both within and outside of organizations, successful leadership not only inspires, it focuses. Leadership may allocate resources for measurement, training, or program development. Leadership helps to define a culture that in turn impacts the range of acceptable approaches and helps us answer and address the following questions:

- Is there collaboration and sharing, or do individuals and groups work in isolation from each other?
- Is proprietary data made available for the public good, or does it feed a competitive advantage?
- What are the values that the system seeks to demonstrate?
- Is the equitable provision of services viewed as a priority, or is there a persistent belief that a system can be well-functioning while ignoring those who are vulnerable?
- Will Kansas accept the integration of its future with that of the overall U.S. health system and become a leader in national reform, or sit out such big-picture activities?

There is a distinct opportunity to consider these questions now — to explicitly engage in priority and agenda setting, to invite and accept commitments from disparate stakeholders, to develop what social scientists term a "community of practice" that transcends individual organizations or sectors within the health care system — all with the common goal of improving the health of Kansans.

Evidence exists from multiple sources that leadership matters. Since 2000, the Rhode Island Quality Institute has represented every constituency of health care leadership, as well as health insurance, consumer and public interest. With a very active board, they work collaboratively, come up with innovative solutions, champion changes throughout organizations, and dedicate time, money, and expertise to improve the quality of health care in Rhode Island. In a recent Intensive Care Unit (ICU) collaborative, a decrease in central line infections of 45 percent was documented. When asked the key to the organization's success, CEO and President Laura Adams replied that organizations sent their top leaders to participate. The value of leaders at all levels becoming actively engaged to help develop such a community of practice cannot be overstated. In the Commonwealth Fund's *Study of Effective Practices in Managed Care*, high-performing health plans were found to have enlightened leadership who embrace the synergy between leadership, performance measurement, and a partnership with the clinicians who provide care. *The Scorecard* identifies a need for leadership, management, data, and initiative.

A Structure for Collaboration

Many of the top-performing states on the *Scorecard* are known for a widespread commitment to health care quality and quality improvement. These states often are home to not-for-profit organizations comprised of and funded by a variety of stakeholders that are supporting the public reporting of quality measures as well as quality improvement at a variety of levels of care. Some examples of these follow.

Massachusetts Health Quality Partners

Massachusetts Health Quality Partners (MHQP) is a broad-based coalition of physicians, hospitals, health plans, purchasers, consumers, and government agencies working together to promote improvement in the quality of health care services in Massachusetts. MHQP was first established in 1995 by a group of Massachusetts health care leaders who identified the importance of valid, comparable measures to drive improvement. The MHQP board has identified five strategic areas of focus in support of MHQP's mission: 1) taking a leadership role in building collaboration and consensus around a common quality agenda, 2) aggregating and disseminating comparable performance data, 3) increasing coordination and reducing inefficiencies to improve quality of care delivery, 4) developing and disseminating guidelines and quality improvement tools, and 5) educating providers and consumers in the use of information to support quality improvement.

The *Clinical Quality in Primary Care* report compares medical group performance for measures developed by the National Committee for Quality Assurance (NCQA) to assess the quality of care delivered to members of health plans nationally. The measurement results are based on commercially insured managed care patients covered by five Massachusetts insurers. Massachusetts physicians have improved on six of the eight measures MHQP can trend over the last four years, with cholesterol testing and blood sugar screening for patients with diabetes showing the greatest improvement during this time, followed by well-child visits for teens.[1]

[1] Source: Massachusetts Health Quality Partners Web site, http://www.mhqp.org/aboutus/AboutUs.asp?nav=020000

The Iowa Healthcare Collaborative

The Iowa Healthcare Collaborative (IHC) is a provider-led organization dedicated to promoting a 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 on 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 which aggregates expertise through board composition and collaborative relationships and strives to be non-competitive in approach and representative of the patient voice through all initiatives. IHC is supportive and complementary to other national quality and patient-safety initiatives and works closely with organizations like the Institute for Healthcare Improvement, the National Patient Safety Foundation, the American Hospital Association, and the American Medical Association.

IHC plays 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 the position of leadership — driving clinical progress, accelerating the pace of change, hardwiring clinical improvements, and promoting patient safety. This unique structure has been called a model for other states to achieve engagement and to improve the health of the public.[2]

The Vermont Child Health Improvement Program

The Vermont Child Health Improvement Program (VCHIP) has become a national model of statewide collaboration, supporting clinicians in their efforts to improve care by providing a centralized resource for guidance on the techniques of quality improvement. VCHIP connects academics, public health practitioners, and health care providers with a single goal of improving the system so that all children in Vermont get the best health care possible.

[2] Source: Iowa Healthcare Collaborative Web site, http://www.ihconline.org/aboutus/aboutus.cfm

While they are not directly engaged in public reporting, measurement is at the heart of VCHIPs work. Based at the University of Vermont College of Medicine, VCHIP staff share research, education, and quality improvement expertise with child and adolescent health care professionals across the state.

All 12 Vermont hospitals providing care to newborns and their families participated in the Vermont Hospital Preventive Services Initiative (VHPSI). Hospital improvement teams demonstrated significant improvements in assessment and counseling for sleep position, car safety seat fit, and exposure to tobacco smoke. As a part of the Healthy Development Learning Collaborative, participating practices implemented structured developmental screenings as part of well-child care (100 percent), began performing psychosocial assessments which include screening for domestic violence, substance abuse and maternal depression (50 percent), and are working on systems to improve how they determine and meet parents' information needs.

VCHIP staff has begun consulting and training in other regions and states, to facilitate the development of new multi-stakeholder initiatives dedicated to improvements in child health and development. Recent funding from the Commonwealth Fund will allow them to work with groups in five states, in addition to the seven states with whom they have already collaborated.[3]

Regardless of the forum or the sponsor, engaging multiple stakeholders in a structured conversation is a form of leadership that may lead to the development of common goals and integrated methods.

MOVING FORWARD

While multiple-stakeholder initiatives are attractive, they are but one of a broad menu of approaches that are available. The literature evaluating interventions suggests that context matters, the design and execution of the implementation is consequential, and sometimes outside events can dwarf the impact of well-planned and well-executed interventions. One key interpretation of the *Scorecard* data is that performance is best in states where there appears to be an activation of resources to address these problems. Various stakeholders undertake multiple

[3] Source: Vermont Child Health Improvement Program Web site, http://www.med.uvm.edu/vchip/Downloads /VCHIP_Progress_Report_2005.pdf

initiatives, some coordinated and others not, often with some degree of leadership and organization. Multiple approaches bring in multiple resources, measurement and evaluation inform the process and stimulate mid-course adjustments, and the performance of the overall system improves. In essence, culture and leadership appear to interact in ways that make change possible on a larger scale.

This *Briefing Book* is not intended to be a comprehensive summary of findings or of options. Nonetheless, it is valuable to consider the broad range of possible responses to the needs identified by the *Scorecard*.

Such options include policy changes, which can occur at federal, state, county, local, or regional level, as well as within a given organization. In Kansas, the failure to adequately fund a successful breast cancer screening program demonstrates that level performance is in part a matter of will and prioritization, rather than of knowledge. Once state and federal policies are intertwined, a rational response to these data will build from that recognition.

Some examples of policy initiatives that impact health and health care include actions such as smoking bans, excise taxes that are intended to modify the behavior of smokers, drivers, and drinkers. The New York City Health Department has been a leader in developing nutritional policy, both via its ban on trans fats and through a food labeling regulation. Both California and Massachusetts are implementing broad policy initiatives to enhance access to health care and health insurance because of major policy decisions stemming from broad stakeholder involvement and political leadership. The National Committee for Quality Assurance, the Health Plan Employer Data and Information Set, the Leapfrog Initiative, and a variety of other local and regional purchasing cooperatives have demonstrated how policies, practices, and standards can be impacted by those who purchase care. Advocacy and consumer organizations may play a role by sitting at the table while policy decisions are made.

Both multiple- and single-stakeholder activities can make a big difference. The narratives describe some examples of formal collaboration in Kansas and in the region. Led by the Institute for Healthcare Improvement and its sister organization, the National Initiative for Child Health

Quality Improvement, collaboration has developed a prominent place on the national scene. Informal collaborations also abound. Professional societies are an example where the informal association of professionals can lead to the development of new measures, standards, or practices that have the ability to improve care for specific diseases. While the goal of improving practice and performance levels across the spectrum of diseases is desirable, it should not become an excuse that allows failure to address performance issues that are disease- or population-specific.

A central focus on measurement and evaluation, the importance of developing some common measures, and the desirability of longitudinal measurement both for evaluation and for trends information should be incorporated across strategies. Leadership, culture, the presence or absence of explicit priorities, and political will and commitment all define the context for moving forward.

This list of improvement options suggests just a handful of potential strategies and it recognizes that each stakeholder has the potential to enhance performance on its own, as well as through collaboration. At its finest, health care improvement can be a public-private partnership — a combination of inter-organizational and/or inter-agency collaboration that bridges the efforts of each individual organization or agency, working to improve their piece of the system, with an eye toward a higher and unifying goal.

A single sector cannot be expected to accomplish this alone — but the absence of a partner is not an excuse to discontinue working toward improvement. Sometimes the effect of many small efforts can combine into something much larger. For example, in partnership with the CDC and CMS, a state may develop an immunization registry. The power of that registry to serve citizens, practitioners, and the state are all enhanced when a sufficient number of providers regularly report their data. In a case like this, the recruitment of a sufficient number of individuals can represent a qualitative difference in immunization practice for a state.

A community culture of improvement is not only an external structure, but a bottom-up belief that excellent performance can be designed and assessed as a part of the work that we do every day.

FINAL THOUGHT

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.