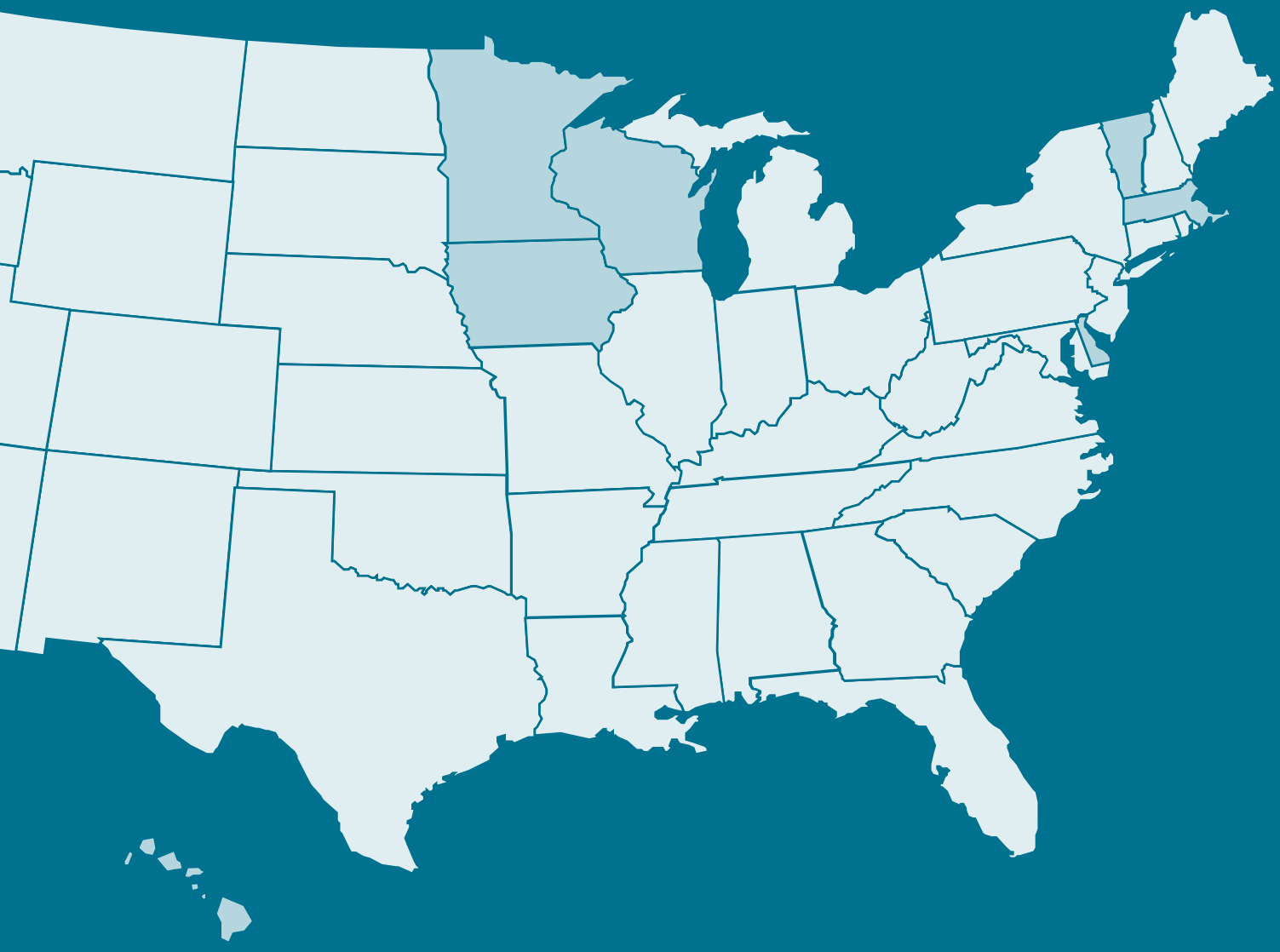
AIMING HIGHER FOR HEALTH SYSTEM PERFORMANCE

A Profile of Seven States That Perform Well on the Commonwealth Fund's 2009 State Scorecard: Overview



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Aiming Higher for Health System Performance: *A Profile of Seven States That Perform Well on the Commonwealth Fund's 2009* State Scorecard: Overview

Greg Moody and Sharon Silow-Carroll
Health Management Associates

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To download the complete report containing all seven state profiles, click here.

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Overview

The 2009 edition of The Commonwealth Fund's *State Scorecard on Health System Performance* identifies wide variation across states in numerous indicators related to access, quality, avoidable hospital use and costs, and healthy lives. *State Scorecard* findings suggest that if middle- and low-performing states were to implement strategies and policies to help bring them to the levels of the highest-performing states, significant cost savings and improved health outcomes could be achieved.

As a companion to the 2009 *State Scorecard*, this report profiles seven state health systems: six that rank among the top quartile of states—Vermont, Hawaii, Iowa, Minnesota, Massachusetts, and Wisconsin—plus Delaware, which was one of the most-improved states (achieving improvement of 5 percent or greater on at least half the scorecard's indicators) from 2007 to 2009. The six leading states also improved substantially since the 2007 *State Scorecard* on many indicators of performance.

In general, the states that ranked in the top quartile in the 2007 *State Scorecard* remain the leaders in 2009, outperforming their peers on multiple indicators (Table 1).[1] These patterns and the findings from the state profiles indicate that public policies plus state and local health care systems can make a difference. Vermont and Massachusetts, for example, have enacted comprehensive reforms to expand coverage and put in place initiatives to improve population health and benchmark providers on quality. Minnesota is a leader in bringing public- and private-sector stakeholders together in collaborative initiatives to improve the overall value of health care—an approach that is gaining traction in other states.

The challenge for all states and for all private-sector health care delivery systems is to learn to use health care resources more effectively and efficiently, in order to realize greater value and greater gains in outcomes. The goal of this report is to showcase insights from high-performing states and identify opportunities for all states to pursue policies and practices that may be reasonably associated with high performance.

Affordable Coverage for All

The seven states profiled in this report have a long history of health system improvement focused on expanding health insurance coverage for uninsured residents. Most experts in these states credit health reforms enacted in the early 1990s as setting the stage for recent coverage expansions and quality gains. All seven profiled states, for example, made significant, early gains in coverage by extending Medicaid benefits to otherwise uninsured residents. The authority for these expansions was granted by the federal government through Medicaid 1115 demonstration waivers and, in most cases, included significant federal financial support.

Health system improvement does not come all at once, but is accumulated over years, sometimes decades, one layer of success building on another. States that want to replicate Massachusetts' precedent setting 2006 reforms, for example, must first understand that earlier reforms in 1985, 1988, 1991, 1996, and 1997 were necessary to put the 2006 reforms within reach. Change on this scale requires persistent focus: the complexities of health care and its many dysfunctions, say the veterans of reform, require ongoing and comprehensive solutions to expand access, improve quality, and control costs.

Shared Values Drive Collaboration

Policymakers in the seven profiled states credit their states' "culture of collaboration" as the critical driver in health system performance. "We trust each other,"

they say, or "We work through our differences to do what is right." In some states, this process is well-organized, like Vermont's Blueprint for Health. In others, like Minnesota, change emerges dynamically from "coalitions of coalitions." But leaders in all of the high-performing states are quick to name the values that set the terms of collaboration—a progressive political tradition in Massachusetts, a commitment to public health in Vermont, an agricultural work ethic in Iowa, and in Delaware it is simply "The Delaware Way."

A Firm Foundation of Transparency and Innovation

States with high-performing health systems have a number of state policies and practices in common. In addition to expanding coverage, recent health reforms in the profiled states have focused on increasing value by improving quality and controlling costs. The most important strategy has been to make health information transparent to consumers and purchasers. The *State Scorecard* documents widespread improvement on selected indicators, especially quality indicators for which there has been a national commitment to reporting performance data and collaborative efforts to improve.

Most of the profiled states support a stand-alone organization with a specific mission to collect and publicly report cost and quality information.[2] In many cases, these organizations were established by physician leaders or hospital systems to improve patient care and today function as a multi-stakeholder forum to align statewide quality improvement and cost control initiatives. These organizations are "on call" to evaluate and adopt emerging best practices, and have put the profiled states among the nation's leaders in establishing patient-centered medical homes, exchanging health information electronically, and experimenting with payment reforms that reward health professionals for the quality rather than the quantity of services provided.

Aiming Higher: A Congruent Set of Policies

States with high-performing health systems work hard to establish a congruent set of policies that make the most of both state and federal resources. States play many roles in the health system: purchasers of coverage for vulnerable populations and their employees; regulators of providers and insurers; advocates for public health; and, increasingly, conveners of and collaborators with other health system stakeholders. State action is also key to improving primary care infrastructures and community-wide systems that facilitate access, improve coordination, and promote effective care.

The seven states profiled in this report show that very high levels of health system performance are achievable and sustainable. Vermont, Hawaii, Iowa, Minnesota, Massachusetts, Wisconsin, and Delaware provide useful and interesting examples of state policies and practices that may be reasonably associated with health system improvement. Across these states, there are common strategies that others may consider: a long-term commitment to reform, encouraging collaboration among multiple stakeholders, leadership to expand health insurance coverage through public programs, transparency of health information, and making sure the state has the capacity to recognize and act on emerging best practices.

Delivery system characteristics also may play a role in supporting an infrastructure of improvement in higher-performing states. The seven states tend to have a greater proportion of hospitals that are part of integrated systems, and their community hospitals are predominantly nonprofit or government-owned (Table 2). Health plan enrollment tends to be more

Table 1. State Scorecard Results: High Performing and Most-Improved States[a]

PERFORMANCE SUMMARY
Overall Scorecard Rank
Number of Indicators in Top Quartile
Number of Indicators in Top 5 States
Number of Indicators Improved by 5% or More

PERFORMANCE ON SCORECARD INDICATORS
Access
Nonelderly adults (ages 18–64) insured
Children (ages 0–17) insured
At-risk adults visited a doctor for routine checkup in the past two years
Adults without a time in the past year when they needed to see a doctor but could not because of cost
Prevention and Treatment
Adults age 50 and older received recommended screening and preventive care
Adult diabetics received recommended preventive care
Children ages 19–35 months received all recommended doses of five key vaccines
Children with both a medical and dental preventive care visit in the past year
Children who received needed mental health care in the past year
Hospitalized patients received recommended care for heart attack, heart failure, and pneumonia
Surgical patients received appropriate care to prevent complications
Home health patients who get better at walking or moving around
Adults with a usual source of care
Children with a medical home
Heart failure patients given written instructions at discharge
Medicare patients whose health care provider always listens, explains, shows respect, and spends enough time with them
Medicare patients giving a best rating for health care received in the past year
High-risk nursing home residents with pressure sores
Long-stay nursing home residents who were physically restrained
Long-stay nursing home residents who have moderate to severe pain
Avoidable Use and Cost
Hospital admissions for pediatric asthma per 100,000 children
Adult asthmatics with an emergency room or urgent care visit in the past year
Medicare hospital admissions for ambulatory care sensitive conditions per 100,000 beneficiaries
Medicare 30-day hospital readmissions as a percent of admissions
Long-stay nursing home residents with a hospital admission
Short-stay nursing home residents with hospital readmission within 30 days
Home health patients with a hospital admission
Hospital Care Intensity Index (US=1.0 in 2001)[b]
Total single premium per enrolled employee at private-sector establishments that offer health insurance
Total Medicare (Parts A & B) reimbursements per enrollee

	Vermont	Hawaii	Iowa	Minnesota	Massachusetts	Wisconsin	Delaware
	1	2	2	4	7	10	14
	22	22	21	25	14	15	13
	8	14	11	11	11	5	8
	14	15	14	15	14	14	17

	US	Vermont		Hawaii		Iowa		Minnesota		Massachusetts		Wisconsin		Delaware	
	Rate	Rate	Rank	Rate	Rank	Rate	Rank	Rate	Rank	Rate	Rank	Rate	Rank	Rate	Rank
	80.0	86.5	10	89.4	2	87.2	6	89.2	3	92.8	1	88.1	4	85.7	12
	89.6	93.4	15	94.9	4	95.0	2	93.5	13	96.8	1	94.2	11	91.7	22
	84.6	84.4	25	84.0	27	85.6	20	88.7	6	91.3	3	84.8	22	91.8	2
	86.6	89.9	16	93.1	1	92.2	4	90.9	7	92.7	2	91.5	5	90.7	9
	42.3	49.3	8	41.4	28	42.9	23	50.8	3	49.5	7	45.3	16	52.5	1
	44.3	55.3	2	49.3	10	48.7	12	66.9	1	na	na	54.3	4	49.0	11
	80.1	79.8	30	87.8	4	80.0	27	84.7	7	83.9	8	79.4	32	81.8	13
	71.6	79.4	7	80.3	6	75.4	13	67.5	38	82.6	2	68.2	35	72.7	20
	60.0	69.3	13	62.8	28	74.5	5	67.0	17	66.6	19	61.4	34	76.9	3
	91.3	94.5	6	87.5	50	94.9	4	93.3	14	91.8	25	93.6	9	92.4	21
	84.6	91.0	3	78.3	51	86.8	20	88.2	12	90.3	6	90.2	7	87.0	17
	40.3	38.8	35	40.5	26	34.8	48	33.8	50	40.9	23	37.9	41	37.3	44
	79.7	86.8	6	85.9	8	84.6	12	78.1	34	88.5	4	85.2	10	89.0	1
	57.5	67.2	3	60.1	27	66.9	4	63.0	14	66.2	5	62.9	16	59.9	28
	74.7	82.3	7	65.4	48	81.6	8	76.6	21	75.1	26	76.2	23	84.2	5
	na	`74.5	24	77.4	4	74.5	24	77.4	4	75.1	13	75.1	13	78.0	1
	na	61.5	21	66.0	6	67.6	3	66.4	4	62.5	17	65.0	9	69.3	1
	12.0	9.4	11	7.6	3	8.0	5	7.7	4	10.9	22	10.1	16	12.3	37
	5.1	2.4	15	2.9	19	1.8	5	2.3	14	4.7	32	1.8	5	1.5	1
	4.4	3.6	14	2.2	3	4.7	30	3.6	14	2.5	4	3.9	19	4.0	21
	164.9	50.2	2	81.0	4	81.0	4	102.2	9	125.5	18	109.1	12	na	na
	17.6	12.4	5	13.1	8	12.3	4	12.6	7	13.7	10	14.5	11	21.6	33
	6,587	4,963	12	4,144	3	5,981	20	4,749	8	7,262	39	5,872	18	5,427	15
	18.4	14.4	6	16.6	15	15.9	10	16.6	15	19.4	37	16.2	12	20.6	45
	19.9	11.3	6	na	na	16.7	21	6.9	1	14.8	17	13.8	12	19.6	27
	21.2	14.3	2	na	na	18.3	17	17.6	14	19.5	21	17.7	15	23.0	39
	31.9	30.0	31	23.5	6	36.1	45	32.7	37	34.1	40	27.7	20	27.3	19
	1.020	0.652	9	1.051	39	0.753	17	0.697	10	0.962	27	0.719	12	1.091	41
	$4,386	$4,900	47	$3,831	2	$4,146	14	$4,432	31	$4,836	44	$4,777	42	$4,733	40
	$8,304	$7,284	17	$5,311	1	$6,572	7	$6,600	9	$9,379	47	$6,978	15	$7,646	25

Table 1. State Scorecard Results: High Performing and Most-Improved States[a] (continued)

PERFORMANCE ON SCORECARD INDICATORS
Healthy Lives
Mortality amenable to health care, deaths per 100,000 population
Infant mortality, deaths per 1,000 live births
Breast cancer deaths per 100,000 female population
Colorectal cancer deaths per 100,000 population
Suicide deaths per 100,000 population
Nonelderly adults (ages 18–64) limited in any activities because of physical, mental, or emotional problems
Adults who smoke
Children ages 10–17 who are overweight or obese

[a] States are shown in order of their ranking on the 2009 *State Scorecard*. Delaware is an example of a state with the most improved performance.
[b] Based on inpatient days and inpatient visits among chronically ill Medicare beneficiaries in last two years of life.
na=not applicable, data value is missing.
Notes: All rates are expressed as percentages unless labeled otherwise. See Appendix B in the State Scorecard Report for data year, source, and definition of each indicator.
Source: Commonwealth Fund 2009 *State Scorecard on Health System Performance*

Table 2. A Snapshot of States with High Performing Health Systems*

Demographics
Resident population in millions, 2008 (a)
Median household income, 2005–2007
Percent of population with income below 200% of federal poverty level, 2006–2007
Health Status
Cancer incidence, age-adjusted rate per 100,000, 2004
Percent of adults who are overweight or obese, 2008
Adult self-reported current asthma prevalence rate, 2007
Percent of adults ever told by a doctor that they have diabetes, 2008
Delivery System Characteristics
Percent of community hospitals that are part of highly integrated systems, 2008 (b)
Percent of community hospitals that are nonprofit or owned by state/local government, 2007 (d)
Market share of top two insurers (percent of commercial HMO/PPO members), 2006 (c)

*States are shown in order of their ranking on the Commonwealth Fund *State Scorecard on Health System Performance*, 2009. Delaware is an example of a state with the most improved performance.
(a) US Census Bureau Resident Population, July 2008: http://www.census.gov/compendia/statab/ranks/rank01.html.
(b) SDI data reported in the Sanofi Aventis Managed Care Digest Series, Hospital/Systems Digest, 2009. Highly integrated systems either own or contract with three or more components of health care delivery including at least one acute-care hospital, at least one physician component, and at least one other component such as a health maintenance organization (HMO), nursing home, home health agency, or surgery center. They also have at least one systemwide contract with a tpayer (e.g., employer, HMO or government entity). Hospitals include short-term, acute-care, nonfederal hospitals in the SDI database.
(c) American Medical Association, Competition in Health Insurance: A comprehensive study of U.S. markets, 2008 update. For states with missing data in 2006, alternate years were utilized to create rankings. Data for Delaware and Wisconsin from 2005. Rankings based on 48 states with available data. US total based on American Medical Association, Competition in Health Insurance, 2007. These data were corrected and updated as of February 22, 2010.
(d) Kaiser State Health Facts: http://statehealthfacts.org/comparebar.jsp?ind=383&cat=8. Community hospitals include nonfederal, short-term general and specialty hospitals whose facilities and services are available to the public. Excludes long term care hospitals, psychiatric hospitals, institutions for the mentally retarded, and alcoholism and other chemical dependency hospitals.
All other data from The Commonwealth Fund *State Scorecard for Health System Performance*, 2009, Exhibit A16.

	US	Vermont		Hawaii		Iowa		Minnesota		Massachusetts		Wisconsin		Delaware	
	Rate	Rate	Rank	Rate	Rank	Rate	Rank	Rate	Rank	Rate	Rank	Rate	Rank	Rate	Rank
	95.6	68.0	3	79.8	19	79.1	18	63.9	1	78.0	17	77.7	15	96.7	30
	6.9	6.5	19	6.6	23	5.4	8	5.1	2	5.1	2	6.5	19	9.0	46
	24.1	20.4	4	19.0	2	21.1	6	22.4	12	23.2	20	22.6	15	23.6	24
	17.5	17.6	22	14.5	3	18.2	29	14.8	4	17.6	22	16.3	11	17.9	27
	10.9	12.2	28	8.3	7	10.9	16	10.3	12	7.2	5	11.5	22	9.6	11
	16.9	17.2	28	12.9	2	14.1	3	15.0	11	16.1	20	14.2	5	18.9	38
	19.4	17.7	12	17.2	6	20.6	33	17.4	8	17.0	5	20.1	26	20.3	29
	31.7	26.8	9	28.5	15	26.5	8	23.1	1	30.1	22	27.9	12	33.1	35

	US	Vermont		Hawaii		Iowa		Minnesota		Massachusetts		Wisconsin		Delaware*	
	Amount	Amount	Rank	Amount	Rank	Amount	Rank	Amount	Rank	Amount	Rank	Amount	Rank	Amount	Rank
	304.1	0.6	49	1.3	42	3.0	30	5.2	21	6.5	14	5.6	20	0.9	45
	$49,901	$51,566	17	$63,164	4	$49,262	24	$57,815	8	$58,286	7	$50,619	19	$54,310	14
	35.8	29.2	9	33.4	24	29.4	10	27.7	4	31.1	14	29.9	12	31.5	17
	458.2	477.3	36	423.6	4	467.0	31	490.5	43	501.7	48	443.1	10	487.5	41
	63.0	58.4	6	57.3	3	64.2	33	62.7	23	58.0	4	63.5	28	63.6	30
	8.2	9.6	46	8.0	17	7.0	5	7.7	11	9.9	48	9.2	39	7.8	13
	8.2	6.4	4	8.2	25	7.0	11	5.9	1	7.1	13	7.2	14	8.2	25
	38.0	46.7	14	22.7	43	28.8	41	47.8	13	46.3	15	59.5	5	50.0	9
	82.2	100.0	1	100.0	1	100.0	1	100.0	1	89.7	21	96.0	13	100.0	1
	36	74	13	99	1	89	5	85	7	72	16	62	31	65	27

concentrated among top plans in the seven states and, while this may limit competition, it also may facilitate efforts to develop coordinated strategies for improvement.

While leading states such as Massachusetts, Minnesota, and Vermont have enacted policy reforms that are extending coverage, promoting community health, and building value-based purchasing strategies through public–private collaboration, this has not been the case in the vast majority of states. In addition to their willingness to persevere in pursuing reforms, some high-performing states may be advantaged by greater resources to support their efforts. A few of the seven profiled states have higher median incomes and lower poverty levels than the national average, while others are closer to the national average (Table 2). Health status exhibits a somewhat mixed picture of higher and lower rates of reported disease prevalence or risk factors both within and across the states profiled.

Lower-performing states, especially states in the bottom quartile, are often challenged by higher rates of disease and poverty, plus high uninsured rates reflecting historic patterns of low employment-based health benefits. Where a large proportion of the population is uninsured, states face a much higher hurdle in seeking to enact comprehensive reform. These historic and geographic disparities across states point to the importance of federal action to raise the floor across all states and create a supportive climate for state innovation and achievement. Encouraging the adoption of systemic improvements will likely require Medicare's participation in state payment initiatives and will require collaborative federal and state efforts to develop the information and shared resources infrastructure necessary to achieve high performance.

The *State Scorecard* shows that all states can aim higher in their health system performance. With rising costs putting pressure on families and businesses alike, it is urgent that states and the federal government join together to take action to enhance value in the health care system and ensure that everyone has the opportunity to participate in it fully. Improving the performance of all states to the levels achieved by the best states could save thousands of lives, improve access and quality of life for millions of people, and reduce costs. In turn, this would free up funds to pay for improved care and expanded insurance coverage—producing a net gain in value from a higher-performing health care system.