

Results from the Commonwealth Fund's State Scorecard on Health System Performance Kansas in comparison to Iowa

Aiming Higher: Results from a State Scorecard on Health System Performance, published by the Commonwealth Fund in June 2007, measures state variation on health system performance using 32 indicators, organized into five key dimensions. The five key dimensions are designed to capture critical aspects of health system performance and include:

- **Access**, including rates of insurance coverage for adults and children and indicators of access and affordability of care.
- **Quality**, including indicators that measure receipt of the “right care,” coordinated care, and patient-centered care.
- **Potentially avoidable use of hospitals and costs of care** including hospital care that might have been prevented with appropriate care and follow-up, and the annual costs of Medicare and private health insurance premiums.
- **Equity** including differences in performance associated with patients' income level, type of insurance, or race or ethnicity.
- **Healthy lives** including indicators that measure the degree to which a state's residents enjoy long and healthy lives.

As part of the assessment process, states were ranked from best to worst on each of the 32 performance indicators. Next, an average was taken of the indicators within each of the five dimensions to determine a state's dimension rank. A state's overall ranking was determined by taking the average of its dimension rankings. This methodology was used to give equal weight to each dimension and equal weight to the indicators within each dimension.

Some Key Findings from the *Aiming Higher Scorecard*

- The top performing states generally ranked high on multiple indicators in each of the five dimensions.
- Many of the top performing states have been leaders in reforming and improving their health systems.
- The states with the best performance in the access dimension are among those with the most expansive eligibility policies for public health insurance coverage.
- The five top-ranked states in the access dimension provide higher-than average public coverage eligibility for parents.
- Differences in uninsured rates for adults and children reflect eligibility criteria for public coverage as well as the extent of private coverage through employers.
- Better access to care and higher rates of insurance are closely associated with better quality.
- Identifying care system practices as well as state policies that promote access to care is essential to improving quality and lowering costs.

SOURCE: *Aiming Higher: Results from a State Scorecard on Health System Performance*, June 2007

Results for Kansas and Iowa

Kansas received an overall ranking of 20, placing it mid level in the second quartile, while Iowa received an overall ranking of 3, placing it in the top quartile. A side by side comparison of how Kansas performed in comparison to Iowa on each of the 32 indicators is illustrated in Attachment 1.

A breakdown of the differences in Kansas' and Iowa's scores on the indicators that were measured by a percentage, and on which Kansas scored below Iowa, follows.

Indicators that Kansas scored 0 – 2 percentage points below Iowa:

- Percent of Medicare patients whose health care provider always listens explains, shows respect, and spends enough time -0.2
- Percent of adults with a usual source of care -0.3
- Percent of children with both medical and preventive care visits -0.9
- Percent of adults who visited a doctor in the past two years -1.0
- Percent of children ages 19-35 months who received all recommended doses of five key vaccines -1.1
- Percent of children (ages 0-17) insured -1.3

Indicators that Kansas scored 2 – 4 percentage points below Iowa:

- Percent of long-stay nursing home residents with a hospital admission* -2.1
- Percent of children with a medical home -2.3
- Percent of adults age 50 and older who received recommended screening and preventive care -2.4
- Percent of adults under age 65 insured -2.6
- Percent of adults without a time when they needed to see a doctor but could not because of cost -3.5
- Percent of hospitalized patients who received recommended care for acute myocardial infarction, congestive heart failure, and pneumonia -3.5
- Percent of home health patients with a hospital admission* -4.2

*Scoring below Iowa on these two indicators resulted in Kansas ranking above Iowa (18 versus 27, and 28 versus 42 respectively) because of the fewer numbers of beneficiaries requiring hospitalization. Even more impressive about these two results, however, is that Kansas is far less institutionalized than Iowa and likely has, by design, a higher needs population at home.

Indicators that Kansas scored 5 or more percentage points below Iowa:

- Percent of adult diabetics who received recommended preventive care -5.7
- Percent of surgical patients who received appropriate timing of antibiotics to prevent infections -6.0
- Percent of children with emotional, behavioral, or developmental problems who received mental health care -6.3
- Percent of heart failure patients given written instructions at discharge -20.0

There were also instances in which Kansas achieved a higher percentage than Iowa on the measured indicator. With the exception of the percent of Medicare patients giving a best rating for health care received (Kansas was ranked 12th while Iowa was ranked 22nd), all other indicators that Kansas scored a higher percentage on resulted in Iowa

achieving a higher ranking than Kansas (e.g., percent of adults under age 65 limited in any activities because of physical, mental, or emotional problems, etc).

Other measures, including indicators used to measure the dimensions of “potential avoidable use of hospital costs of care” and “healthy lives” can be viewed in Attachment I.

Overall Results for Kansas

Kansas did best on the following indicators.

Kansas in the top quartile

Access

- Percent of adults under age 65 insured – Kansas 10th, Iowa 2nd
- Percent of children (ages 0-17) insured – Kansas 11th, Iowa 4th

Quality

- Percent of children ages 19-35 months who received all recommended doses of five key vaccines – Kansas 13th, Iowa 9th
- Percent of adults with a usual source of care – Kansas 11th, Iowa 9th
- Percent of Medicare patients giving a best rating for health care – Kansas 12th, Iowa 22nd
- Percent of nursing home residents who were physically restrained - Kansas 10th, Iowa 3rd

Kansas had the most difficulty on these indicators:

Kansas in or near bottom quartile

Quality

- Percent of heart failure patients given written instructions at discharge – Kansas 48th, Iowa 18th

Avoidable Hospital Uses and Costs

- Medicare 30-day hospital readmissions as a percent of admissions – Kansas 38th, Iowa 3rd

Key Findings as they Relate to Demographic Information

As noted previously, a number of key findings were identified as a result of the *Scorecard* assessment. Although the data set used for the *Scorecard* represents a sampling of the measures that are uniformly available across the states and are therefore difficult to use to gain an understanding of the causes of performance¹, a comparison of Kansas’ and Iowa’s demographics may be helpful (see Attachment 2 for a complete review).

Key finding: The states with the best performance in the access dimension are among those with the most expansive eligibility policies for public health insurance coverage.

¹ Kansas Health Institute (July 2007). *Briefing Book-Aiming Higher: Results from a State Scorecard on Health System Performance*.

Demographic Information: Medicaid eligibility levels by annual income and federal poverty level (FPL) are more generous in Iowa than in Kansas.

- Working parents (77% of FPL in Iowa versus 36% in Kansas)
- Pregnant women (200% of FPL in Iowa versus 150% in Kansas)

Note: The eligibility level for both Kansas' and Iowa's separate SCHIP program is 200% of the FPL, leveling the eligibility criteria for children across the states.²

Key finding: The five top-ranked states in the access dimension provide higher-than-average public coverage eligibility for parents.

Demographic information: See eligibility levels for parents listed above.

Key finding: Differences in uninsured rates for adults and children reflect eligibility criteria for public coverage as well as the extent of private coverage through employers.

Demographic information: More people are insured through their employers in Iowa than in Kansas.

- 59% of the total number of residents in Iowa are insured through their employer
- 57% of the total number of residents in Kansas are insured through their employer

Other demographic factors that are directly tied to a key finding and have a likely impact on health performance outcomes are:

- The percent of people living below the FPL is lower in Iowa than in Kansas (14% versus 16% respectively)
- The percent of people who are near poor (100-199% of the FPL) is lower in Iowa than in Kansas (17% versus 18% respectively)
- The percent of non-poor (200% of the FPL and above) residents living in Iowa is greater than in Kansas (69% of total residents versus 67% respectively)
- There is greater diversity in race/ethnicity in Kansas than in Iowa; Kansas has a minority population 50% larger than Iowa's, as a proportion of the total population
- The median income is slightly higher in Iowa, even though urban areas comprise a lower percentage of the population, suggesting a higher overall standard of living in Iowa
- The percent of Medicaid enrollees enrolled in managed care is greater in Iowa than in Kansas (87% versus 57% respectively)

Key Finding as it relates to Timing of Efforts

Key finding: Many of the top performing states have been leaders in reforming and improving their health systems.

Timing: In 2002, Iowa began exploring a statewide provider-led performance improvement initiative. The Kansas Health Policy Authority was not established until July 1, 2005 and at that time was charged with coordinating health and health care for Kansas.

² Kaiser Family State Health Facts. *Income Eligibility Levels for Children's Separate SCHIP Programs by Annual Incomes and as a Percent of Federal Poverty Level, 2006.*

Iowa

In 2002, the Iowa Hospital Association (IHA) and the Iowa Medical Society (IMS) began exploring joint strategies to improve clinical care in Iowa. During 2003, the IHA and IMS co-founded a collaborative steering committee to explore a statewide provider-led performance improvement initiative. In that same year, the steering committee designed the Iowa Healthcare Collaborative (IHC), establishing its cornerstone principles.

Cornerstones of IHC activity are:

- Align and equip Iowa hospitals and physicians.
- Promote responsible public reporting.
- Engage the community for clinical improvement.
- Raise the standard of care in Iowa.

Examples of initiatives that have been implemented relate to:

- Data and Measurement for Public Reporting (e.g., the *Iowa Report* on quality, patient safety and value to present state-aggregated and hospital specific clinical performance data)
- Education
- Healthcare-Associated Infection
- Medication Safety

The IHC places doctors and nurses in leadership positions – driving clinical progress, accelerating the pace of change, hardwiring clinical improvements, and promoting patient safety. The structure of the IHC has been identified as a model for other states to achieve engagement and to improve the health of the public.

SOURCE: Iowa Healthcare Collaborative www.ihconline.org

Kansas

The Kansas Health Policy Authority (KHPA) was established on July 1, 2005, as a new independent state agency charged with developing a statewide health policy agenda including health care, health promotion components, and health indicators to include baseline and trend data on health care costs.

The creation and implementation of the KHPA was “Phase I” of health reform in Kansas. Phase II began in January 2007 when Governor Kathleen Sebelius asked the legislature and KHPA to partner with her to develop a plan for comprehensive health reform. During the 2007 legislative session, House Substitute for SB 11, an over-arching health reform bill was passed and signed into law by the Governor.

A major component of SB 11 was the mandate for KHPA to deliver health reform options to the Governor and Legislature for enactment by the 2008 Legislature. After many months of reviewing health reform options and meeting with over 1,000 Kansans, the KHPA Board recently voted to recommend to Governor Sebelius and the Kansas Legislature 21 health reform options to achieve health reform in Kansas. The goals targeted in this health reform initiative are:

- to promote personal responsibility
- pay for prevention and promote medical homes, and
- provide and protect affordable health insurance.

Anticipated outcomes of the proposed reform options are:

- Reducing the number of uninsured Kansans to one of the lowest uninsured rates in the United States
- Increasing access to useable health information by all Kansans
- Access to dental health services for low-income pregnant Kansans
- Increasing access to preventive services by Kansans
- Increasing access to person centered medical homes
- Improving detection of early stage disease
- Reducing the level of chronic disease
- Improving health status and quality of life
- Increasing health care cost containment

The anticipated outcomes of these proposed reform options are to elevate the health indicators that provide the framework for the health care system performance evaluation featured in the *Scorecard*.