Executive Summary

Aiming Higher

Results from a State Scorecard on Health System Performance

THE COMMONWEALTH FUND COMMISSION ON A HIGH PERFORMANCE HEALTH SYSTEM

JUNE 2007

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The Commonwealth Fund, among the first private foundations started by a woman philanthropist—Anna M. Harkness—was established in 1918 with the broad charge to enhance the common good.

The mission of The Commonwealth Fund is to promote a high performing health care system that achieves better access, improved quality, and greater efficiency, particularly for society's most vulnerable, including low-income people, the uninsured, minority Americans, young children, and elderly adults.

The Fund carries out this mandate by supporting independent research on health care issues and making grants to improve health care practice and policy. An international program in health policy is designed to stimulate innovative policies and practices in the United States and other industrialized countries.

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TOP LEFT: ROGER CARR
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RESULTS FROM A STATE SCORECARD ON HEALTH SYSTEM PERFORMANCE

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On behalf of the Commonwealth Fund Commission on a High Performance Health System

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ABSTRACT: Developed to follow the *National Scorecard on U.S. Health System Performance*, published in 2006, the *State Scorecard* assesses state variation across key dimensions of health system performance: access, quality, avoidable hospital use and costs, equity, and healthy lives. The findings document wide variation among states and the potential for substantial improvement—in terms of access, quality, costs, and lives—if all states approached levels achieved by the top states. Leading states outperform lagging states on multiple indicators and dimensions; yet, all states have room to improve. The report presents state performance on 32 indicators, with overall rankings as well as ranks on each dimension. The findings underscore the need for federal and state action in key areas to move all states to higher levels of performance and value.

Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and not necessarily those of The Commonwealth Fund or its directors, officers, or staff, or of The Commonwealth Fund Commission on a High Performance Health System or its members. This report, related state tables, and other Fund publications are available online at www.commonwealthfund.org. To learn about new publications when they become available, visit the Fund Web site and register to receive e-mail alerts. Commonwealth Fund pub. no. 1030.

Preface

The Commonwealth Fund Commission on a High Performance Health System is pleased to sponsor this first *State Scorecard on Health System Performance* in the hope that it will help meet the growing need for comparative state health system performance information and contribute to positive action among the states.

In the U.S. federal system, the states maintain significant authority over many health and regulatory policies that influence health system performance and health outcomes. States organize and deliver population health services, regulate health insurance markets, provide Medicaid coverage for the poor and State Children's Health Insurance Program (SCHIP) coverage for low-income children, purchase coverage for their employees and retirees, license and monitor health care providers, and finance charity care for the uninsured. Given these activities and levers, state policymakers across the country are realizing the tremendous opportunity they have to shape and improve health care at the local level for their populations.

In 2006, the Commission published *Why Not the Best? Results from a National Scorecard on U.S. Health System Performance* to comprehensively assess how well the U.S. health system is performing across key indicators of health care outcomes, quality, access, efficiency, and equity. Findings of the *National Scorecard* indicate that America's health system falls far short of achievable benchmarks, especially given the resources the nation invests. Based on these and other data, the Commission believes that transformation of the U.S. health system is urgently needed to achieve optimal health care for all Americans while improving value for society's investment in health care. States and their health delivery systems vary and include models and centers of excellence. In many instances even top-performing states do not reach as high a level as should be achievable—and all have substantial room to improve. Nonetheless, focusing on how top-performing states and organizations achieve high levels of performance will enable the entire country to improve. The *State Scorecard* underscores the need for national as well as state action in key areas to move all states to higher levels of performance and value.

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The rich geographical diversity of the United States is part of its appeal. The diverse performance of the health care system across the U.S., however, is not. People in the United States, regardless of where they live, deserve the best of American health care. The *State Scorecard* is intended to assist states in identifying opportunities to better meet their residents' current and future health needs and enable them to live long and healthy lives. With rising health costs squeezing the budgets of businesses, families, and public programs, there is a pressing need to improve performance and reap greater value from the health system.

The *State Scorecard* offers a framework through which policymakers and other stakeholders can gauge efforts to ensure affordable access to high-quality, efficient, and equitable care. With a goal of focusing on opportunities to improve, the analysis assesses performance relative to what is achievable, based on benchmarks drawn from the range of state health system performance.

Currently, where you live in the United States matters for quality and care experiences. The widely varying performance across states and sharp differences between top and bottom state rates on the 32 indicators included in the *State Scorecard* highlight broad opportunities to improve. If all states approached levels achieved by the top states, the cumulative result would be substantial improvement in terms of access to care, health care quality, reduced costs, and healthier lives.

The analysis of the range of state performance points to five cross-cutting findings:

- There is wide variation among states. This means that the potential exists for the country to do much better.
- Leading states consistently outperform lagging states. The patterns indicate that federal and state policies and local and regional health systems make a difference.
- Across states, better access is closely associated with better quality.
- There are significant opportunities to reduce costs as well as improve access to and quality of care. Higher quality is not associated with higher costs across states.
- All states have substantial room to improve.

Note: This report summarizes results of the *State Scorecard* and presents overall state rankings and rankings on each of the five dimensions of health system performance. Appendices present state-level data for all indicators. *State Scorecard Data Tables* with data and state rankings on the 32 health system indicators and data for all equity comparisons can be downloaded from the Commonwealth Fund Web site at www.commonwealthfund.org. The Web site also provides individual state performance profiles that compare the state to the top state, top five states, and state median rates on all indicators. Also available on the Web site is an analysis of the impact on access, costs, and lives for each state if it were to achieve the top level of performance on each of 11 key indicators. State-specific profiles can be downloaded from the Web site.

HIGHLIGHTS AND KEY FINDINGS

Health care access, quality, cost, and efficiency vary widely across the United States.

The range of performance is often wide across states, with a two- to threefold or greater spread from top to bottom. The variability extends to many of the 32 indicators across five dimensions of health system performance: access; quality; potentially avoidable use of hospitals and costs of care; equity; and the ability to live long and healthy lives (referred to as "healthy lives") (Exhibit 1). Improving performance across the nation to rates achieved by the leading states could save thousands of lives, improve quality of life for millions, and enhance the value gained from our substantial investment in health care.

If all states could approach the low levels of mortality from conditions amenable to care achieved by the top state, nearly 90,000 fewer deaths before the age of 75 would occur annually. If insurance rates nationwide reached that of the top states, the uninsured population would be halved. Matching the performance of the best states on chronic care would enable close to four million more diabetics across the nation to receive basic recommended care and avoid preventable complications, such as renal failure or limb amputation. By matching levels

EXHIBIT 1

List of 32 Indicators in State Scorecard on Health System Performance

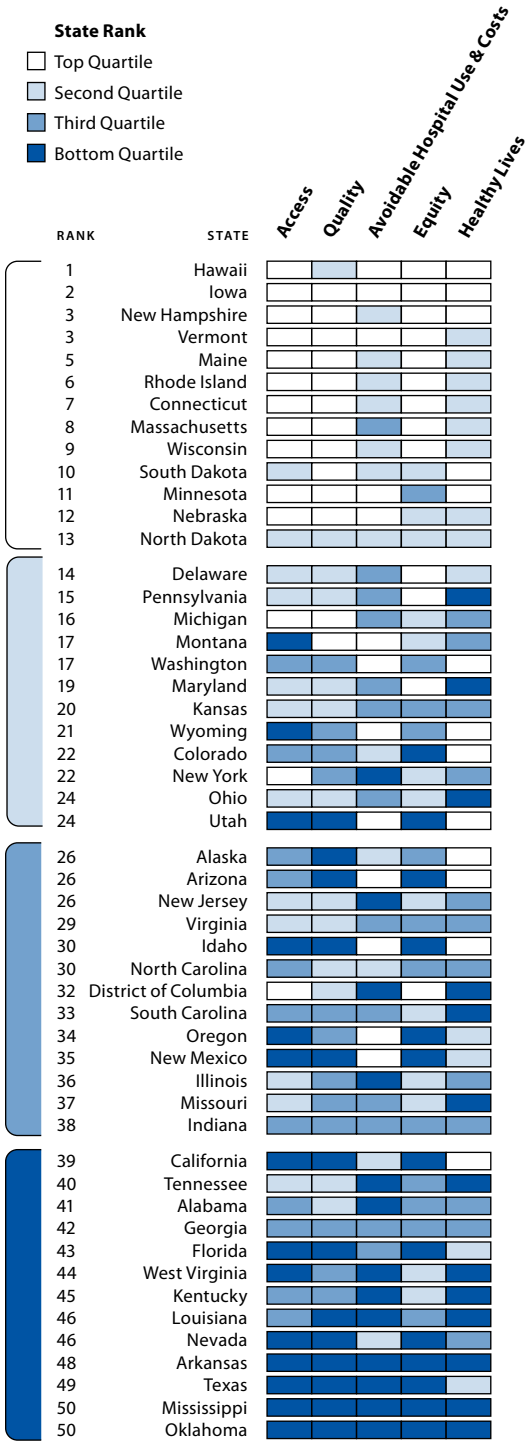
	Year	All States Median	Range of State Performance (Bottom – Top)	Top State
Access				
1. Adults under age 65 insured	2004–2005	81.5	69.6 – 89.0	MN
2. Children insured	2004–2005	91.1	79.8 – 94.9	VT
3. Adults visited a doctor in past two years	2000	83.4	73.9 – 91.5	DC
4. Adults without a time when they needed to see a doctor but could not because of cost	2004	87.2	80.1 – 96.6	HI
Quality				
5. Adults age 50 and older received recommended screening and preventive care	2004	39.7	32.6 – 50.1	MN
6. Adult diabetics received recommended preventive care	2004	42.4	28.7 – 65.4	HI
7. Children ages 19–35 months received all recommended doses of five key vaccines	2005	81.6	66.7 – 93.5	MA
8. Children with both medical and dental preventive care visits	2003	59.2	45.7 – 74.9	MA
9. Children with emotional, behavioral, or developmental problems received mental health care	2003	61.9	43.4 – 77.2	WY
10. Hospitalized patients received recommended care for acute myocardial infarction, congestive heart failure, and pneumonia	2004	83.4	79.0 – 88.4	RI
11. Surgical patients received appropriate timing of antibiotics to prevent infections	2004–2005	69.5	50.0 – 90.0	CT
12. Adults with a usual source of care	2004	81.1	66.3 – 89.4	DE
13. Children with a medical home	2003	47.6	33.8 – 61.0	NH
14. Heart failure patients given written instructions at discharge	2004–2005	49	14 – 67	NJ
15. Medicare patients whose health care provider always listens, explains, shows respect, and spends enough time with them	2003	68.7	63.1 – 74.9	VT
16. Medicare patients giving a best rating for health care received	2003	70.2	61.2 – 74.4	MT
17. High-risk nursing home residents with pressure sores	2004	13.2	19.3 – 7.6	ND
18. Nursing home residents who were physically restrained	2004	6.2	15.9 – 1.9	NE
Potentially Avoidable Use of Hospitals & Costs of Care				
19. Hospital admissions for pediatric asthma per 100,000 children	2002	176.7	314.2 – 54.9	VT
20. Asthmatics with an emergency room or urgent care visit	2001–2004	15.5	29.4 – 9.1	IA
21. Medicare hospital admissions for ambulatory care sensitive conditions per 100,000 beneficiaries	2003	7,278	11,537 – 4,069	HI
22. Medicare 30-day hospital readmission rates	2003	17.6	23.8 – 13.2	ID
23. Long-stay nursing home residents with a hospital admission	2000	16.1	24.9 – 8.3	UT
24. Nursing home residents with a hospital readmission within three months	2000	11.7	17.5 – 6.7	OR
25. Home health patients with a hospital admission	2004	26.9	46.4 – 18.3	UT
26. Total single premium per enrolled employee at private-sector establishments that offer health insurance	2004	$3,706	$4,379 – 3,034	UT
27. Total Medicare (Parts A & B) reimbursements per enrollee	2003	$6,070	$8,076 – 4,530	HI
Healthy Lives				
28. Mortality amenable to health care, deaths per 100,000 population	2002	96.9	160.0 – 70.2	MN
29. Infant mortality, deaths per 1,000 live births	2002	7.1	11.0 – 4.3	ME
30. Breast cancer deaths per 100,000 female population	2002	25.3	34.1 – 16.2	HI
31. Colorectal cancer deaths per 100,000 population	2002	20.0	24.6 – 15.3	UT
32. Adults under age 65 limited in any activities because of physical, mental, or emotional problems	2004	15.3	22.8 – 10.8	DC

Note: All values are expressed as percentages unless labeled otherwise. See Appendices B1 and B2 for data source and definition of each indicator.

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

EXHIBIT 2

State Scorecard Summary of Health System Performance Across Dimensions



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

achieved in the best-performing states, the nation could save billions of dollars a year by reducing potentially preventable hospitalizations or readmissions, and by improving care for frail nursing home residents. If annual per-person costs for Medicare in higher-cost states came down to median rates or those achieved in the lowest quartile of states, the nation would save $22 billion to $38 billion per year. While some savings would be offset by the costs of interventions and insurance coverage expansions, there would be a net gain in value from a higher-performing health care system.

Leading states consistently outperform lagging states on multiple indicators and dimensions.

Thirteen states—Hawaii, Iowa, New Hampshire, Vermont, Maine, Rhode Island, Connecticut, Massachusetts, Wisconsin, South Dakota, Minnesota, Nebraska, and North Dakota—emerge at the top quartile of the overall performance rankings (Exhibit 2). These states generally ranked high on multiple indicators in each of the five dimensions assessed by the *State Scorecard*. Many have been leaders in reforming and improving their health systems and have among the lowest uninsured rates in the nation.

Conversely, the 13 states at the bottom quartile of the overall performance ranking—California, Tennessee, Alabama, Georgia, Florida, West Virginia, Kentucky, Louisiana, Nevada, Arkansas, Texas, Mississippi, and Oklahoma—lag well behind their peers on multiple indicators across dimensions. Uninsured rates for adults and children in these states are well above national averages and more than double those in the quartile of states with the lowest rates. The rates for receipt of recommended preventive care are generally low, and mortality rates from conditions amenable to health care often high.

Health system performance often varies regionally. Across dimensions, states in the Upper Midwest and Northeast often rank in the highest quartile of performance, with those in the lowest quartile concentrated in the South.

States can look to each other for evidence of effective policies and strategies associated with higher performance. For example, in 1974,

Hawaii became the first state to enact legislation requiring employers to provide health insurance to full-time workers; it now ranks first in terms of access to care. For the past decade, Rhode Island has provided incentive payments to Medicaid managed care plans that reach quality targets; it now ranks first on measures of the quality of care. Maine, Massachusetts, and Vermont lead in providing equitable health systems; the three states are recognized for their innovation and leadership on expanding health insurance coverage and benchmarking for quality.

The patterns indicate that federal and state policies plus local and regional health care systems make a difference. Leading states outperform lagging states on multiple indicators that span the dimensions of access, quality, cost, equity, and healthy lives.

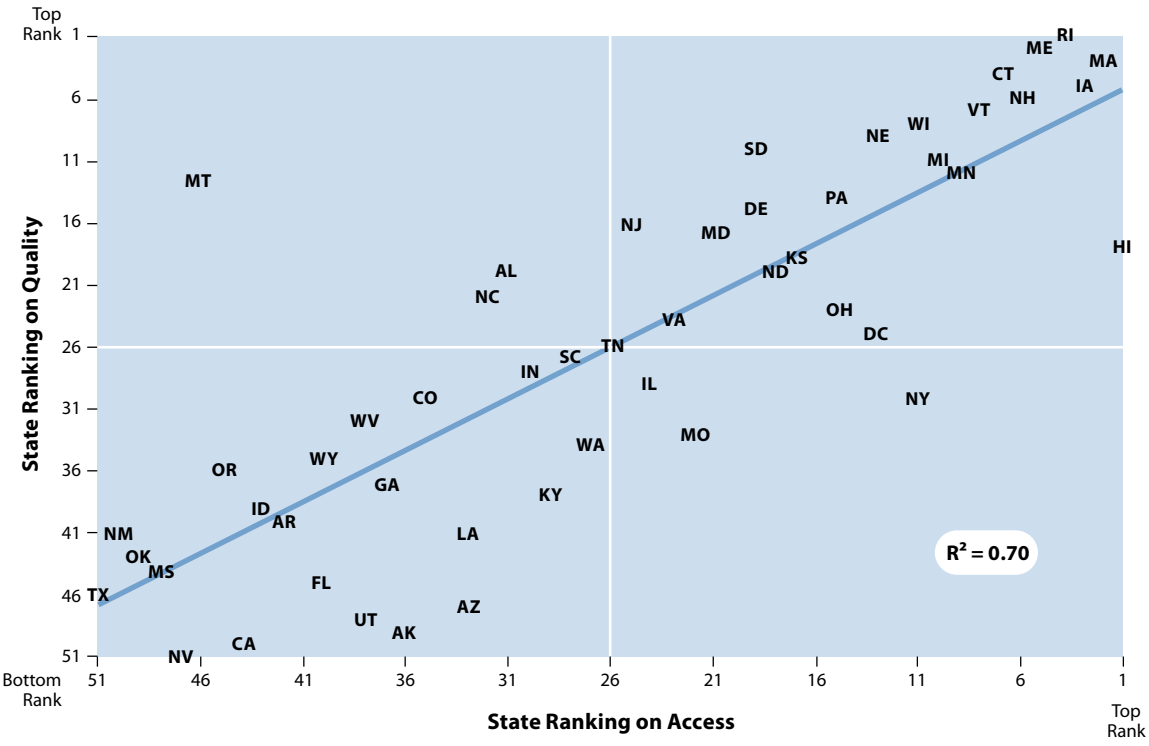
Better access is associated with better quality across states; insurance matters.

Across states, better access to care and higher rates of insurance are closely associated with better quality (Exhibit 3). States with the lowest rates of uninsured residents tend to score highest on measures of preventive and chronic disease care, as well as other quality indicators.

Four of the five leading states in the access dimension—Massachusetts, Iowa, Rhode Island, and Maine—also rank among the top five states in terms of quality. Moreover, states with low quality rankings tend to have high rates of uninsured. This cross-state pattern points to the importance of affordable access as a first step to ensure that patients obtain essential care and receive care that is well coordinated and patient-centered. In states where more people are insured, adults and children are more likely

EXHIBIT 3

State Ranking on Access and Quality Dimensions



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

to have a medical home and receive recommended preventive and chronic care. Identifying care system practices as well as state policies that promote access to care is essential to improving quality and lowering costs.

The number of uninsured children has declined following enactment of federal Medicaid and State Children's Health Insurance Program (SCHIP) expansions for children. Yet, the high and rising rates of uninsured adults put states and the nation at risk as adults lose affordable access and financial security. The deterioration in coverage and the relationship between better coverage and better care point to a pressing need for national action to expand insurance coverage and ensure access to care.

Higher quality does not mean higher costs.

Annual costs of care vary widely across states, with no systematic relationship to insurance coverage or ability to pay as measured by median incomes. Moreover, there is no systematic relationship between the cost of care and quality across states. Some states achieve high quality at lower costs.

States with higher medical costs tend to have higher rates of potentially preventable hospital use, including high rates of readmission within 30 days of discharge and high rates of admission for complications of diabetes, asthma, and other chronic conditions. Reducing the use of expensive hospital care by preventing complications, controlling chronic conditions, and providing effective transitional care following discharge has the potential to improve outcomes and lower costs.

There is room to improve in all states.

All states have substantial room to improve. On some indicators, even the top rates are well below what should be achievable. There are also substantial variations in performance within states.

Among the top-ranked states, each had some indicators in the bottom quartile or bottom half of the performance distribution. Understanding how underlying care system features and population factors contribute to performance variations will help inform efforts to improve.

STATE VARIATION: HIGHLIGHTS BY DIMENSION

Access

- The percent of adults under age 65 who were uninsured in 2004–2005 ranges from a low of 11 percent in Minnesota to a high of 30 percent in Texas. The percent of uninsured children varies fourfold, from 5 percent in Vermont to 20 percent in Texas.
- Over the past five years, the number of states with more than 16 percent of children uninsured declined from 10 to three. In contrast, the number of states with 23 percent or more of adults uninsured increased from four to 12.
- In all but six states, the percent of adults uninsured increased. Notable exceptions include Maine and New York, which have both expanded programs to insure low-income adults.
- Across states, three of four uninsured adults age 50 or older did not receive basic preventive care, including cancer screening. The percent of adults who reported going without care because of costs is up to five times greater in states with high rates of uninsured adults than in states with the lowest uninsured rates.
- The nation would insure 22 million more adults and children if all states moved to the level of coverage provided in the top-performing states.

Quality

- Even in the best states, performance falls far short of optimal standards. The percent of adults age 50 or older receiving all recommended preventive care ranges from a high of 50 percent in Minnesota to 33 percent in Idaho. The percent of diabetics receiving basic preventive care services varies from 65 percent in Hawaii to 29 percent in Mississippi.
- Childhood immunization rates range from 94 percent in Massachusetts to less than 75 percent in the bottom five states. The percent of children with a medical home that helps coordinate care ranges from a high of 61 percent in New Hampshire to less than 40 percent in the bottom 10 states.
- Discharge planning varies markedly. The percent of congestive heart failure patients receiving

complete hospital discharge instructions ranges from 33 percent or less in the bottom five states to 67 percent in New Jersey.
- If all states reached the levels achieved among the top-ranked states, almost nine million more older adults would receive recommended preventive care, and almost four million more diabetics would receive care to help prevent disease complications. Likewise, about 33 million more adults and children would have a usual source of care or medical home to help coordinate care.

Potentially Avoidable Use of Hospitals and Costs of Care

- State rates of hospital admission for childhood asthma range from a low of 55 per 100,000 children in Vermont to more than 300 per 100,000 in South Carolina.
- Rates of potentially preventable hospital admission among Medicare beneficiaries range from more than 10,000 per 100,000 beneficiaries in the five states with the highest rates to less than 5,000 per 100,000 in the five with the lowest rates (Hawaii, Utah, Washington, Alaska, and Oregon).
- Similarly, there is a twofold variation in rates of hospital readmission within 30 days among Medicare beneficiaries (from 24 percent in Louisiana and Nevada to only 13 percent in Vermont and Wyoming) and a threefold range in rates of hospital admission among nursing home residents, from 25 percent (Louisiana) to only 8 percent (Utah).
- High rates of potentially avoidable hospital use and repeat admissions are closely correlated with high costs of care. States with the highest rates of readmission have annual Medicare costs per person 38 percent higher than states with the lowest rates.
- If all states reached the low levels of potentially preventable admissions and readmissions, hospitalizations could be reduced by 30 to 47 percent and save Medicare $2 billion to $5 billion each year. Potential savings would be still greater if the interventions applied to all patients.
- Improving care and developing more efficient care systems have the potential to generate major savings. If annual per-person costs for Medicare in higher-cost states came down to median rates or the lowest quartile, the nation would save $22 billion to $38 billion per year.

Equity

- Equity gaps by income and insurance status on quality indicators exist in most states. The gaps are widest in states that perform poorly overall on quality and access indicators.
- On average, 78 percent of uninsured and 71 percent of low-income adults age 50 and older *did not* receive recommended preventive services. By comparison, 59 percent of insured adults and 54 percent of higher-income adults failed to receive such care.
- The pattern extends to diabetics. On average, 67 percent of low-income diabetics *did not* receive basic care according to guidelines for their condition.
- In some states, equity rankings were low as a result of large disparities among minority groups that comprise relatively small shares of the state population. For example, in Minnesota, indicators of health care quality were often low for a group that included Asian Americans and Native Americans. A focus on these groups would have a high return in reducing health disparities.

Healthy Lives

- There is a twofold range across states in the rate of deaths before age 75 from conditions that might have been prevented with timely and appropriate health care. Potentially preventable death rates in the states with the lowest mortality (Minnesota, Utah, Vermont, Wyoming, and Alaska) are 50 percent below rates in the District of Columbia and states with the highest rates (Tennessee, Arkansas, Louisiana, and Mississippi).
- There are wide differences in this dimension among racial groups. For example, age-standardized death rates for conditions amenable to health care are twice as high for blacks as for whites nationwide (194 versus 94 per 100,000 population). Southern states and some states in the Midwest with large black populations have the greatest racial disparities, with more

than 100 additional deaths per 100,000 black residents above the overall national average. Yet, racial disparities exist even in states with narrower gaps.

- Potentially preventable mortality rates for whites also vary significantly across states, ranging from a low of 67.6 per 100,000 population (Minnesota) to a high of 118.3 (West Virginia). In general, white rates are highest in states with high overall rates.
- If death rates in all states improved to levels achieved by the best state (Minnesota, with 70.2 deaths per 100,000), about 90,000 fewer premature deaths would occur annually.
- Health system performance is only one of many forces that shape health status and longevity. Family history and immigration status can affect state-level population health indicators. Risk factors, such as smoking and obesity, vary across states. Public health policies, including workplace and environmental regulations, are thus critical components for long and healthy lives. The indicators in this dimension are likely to be sensitive to health system performance broadly defined, modifiable through both improved care and public health policies.

SUMMARY AND IMPLICATIONS

The view of health system performance across the nation reveals startlingly wide gaps between leading and lagging states on multiple indicators. The gaps represent illnesses that could have been prevented or better managed, as well as costs that could have been saved or reinvested to improve population health. The *State Scorecard* indicates that we have much to gain as a nation by aiming higher with a coherent set of national and state policies that respond to the urgent need for action.

States play many roles in the health system—as purchasers of public coverage and coverage for their employees, regulators of providers and insurers, advocates for the public health, and, increasingly, conveners and collaborators with other stakeholders. States also can provide a source of public reports on quality and costs. These roles provide potential leverage points to promote better access and quality and to address rising costs.

The findings point to the need for action in the following key areas:

- Universal coverage: This is critical for improving quality and delivering cost-effective care, as well as ensuring access. Federal action as well as state initiatives will be essential for progress nationwide.
- More information to assess performance and identify benchmarks: It takes information to guide and drive change. We need more sophisticated information systems and better information on practices and policies that contribute to high or varying performance.
- Analyses to determine the key factors that contribute to variations: States can use such information to develop evidence-based strategies for improvement.
- National leadership and collaboration across public and private sectors: This is essential for coherent, strategic, and ultimately effective improvement efforts.

Benchmarks set by leading states, as well as exemplary models within the United States and other countries, show that there are broad opportunities to improve and achieve better and more affordable health care. With health costs rising faster than incomes and straining family, business, state, and federal budgets, with access deteriorating, and with startling evidence of variable quality and inefficient care, all states and the nation have much to gain from aiming higher. All states can do better; and all should continually ask, "Why not the best?"

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Joel C. Cantor, Sc.D., is the director of the Center for State Health Policy and professor of Public Policy at Rutgers University. Dr. Cantor's research focuses on issues of health care regulation, financing, and delivery. His recent work includes studies of health insurance market regulation, state health system performance, and access to care for low-income and minority populations. Dr. Cantor has published widely on health policy topics, and serves on the editorial board of the policy journal *Inquiry*. He is a frequent advisor on health policy matters to New Jersey state government and was the 2006 recipient of Rutgers University President's Award for Research in Service to New Jersey. Dr. Cantor received his doctoral degree in health policy and management from the Johns Hopkins Bloomberg School of Public Health.

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