Room for Improvement:

Where Does Ohio's Health Care Quality Rank?

Results from the Commonwealth Fund's
State Scorecard
on
Health System Performance

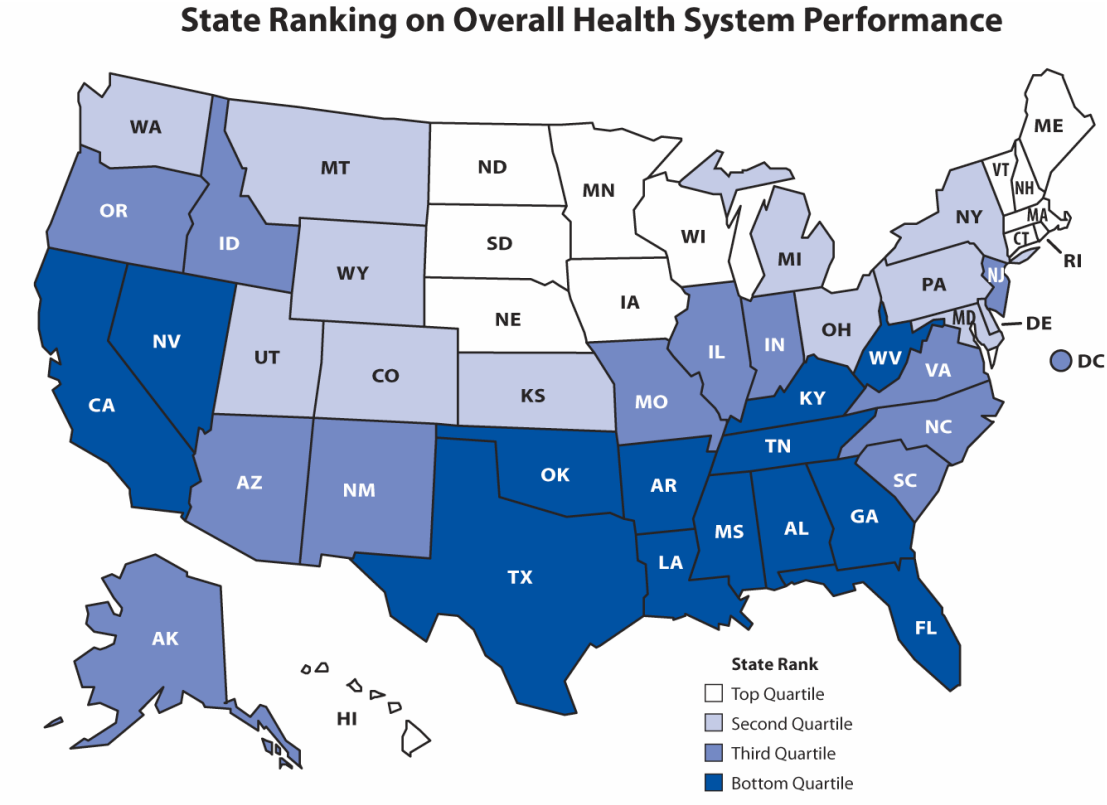
Improving the health and well-being
of all Ohioans through informed
policy decisions

HEALTH POLICY INSTITUTE OF OHIO

INTRODUCTION

The Commonwealth Fund, an independent, private foundation, promotes the creation of a high-performing health care system by supporting independent research on health issues, practice, and policy. In September 2006, the Commonwealth Fund released the *National Scorecard on U.S. Health System Performance*. The *National Scorecard* assesses how well the U.S. is performing across key areas of health care relative to achievable benchmarks. It also points to deficient areas where public and private action is needed — and provides a yardstick against which to measure the success of new policies. Recognizing the influence of state policy on health care system performance, the Commonwealth Fund recently released *Aiming Higher: Results from a State Scorecard on Health System Performance*, which offers a framework to evaluate state health care system performance across five dimensions: access, quality, avoidable hospital use and costs, equity, and healthy lives.

Map 1



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

WHAT THE *SCORECARD* MEASURES

Dimensions and Indicators

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

- **Access** includes rates of insurance coverage for adults and children and indicators of access and affordability of care.

- **Quality** includes indicators that measure three related components: receipt of the "right care," coordinated care, and patient-centered care.

- **Potentially Avoidable Use of Hospitals and Costs of Care** includes indicators of hospital care that might have been prevented with appropriate care and follow-up, as well as the annual costs of Medicare and private health insurance premiums.

- **Equity** includes differences in performance associated with patients' income level, type of insurance, or race and ethnicity.

- **Healthy Lives** includes indicators that measure the degree to which a state's residents enjoy long and healthy lives.

As Map 1 shows, Ohio achieved an overall ranking of 24, placing it in the second quartile of states. Table 1 shows the rankings Ohio achieved in the various performance dimensions and its overall ranking relative to other states.

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

Scorecard Ranking Methodology

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

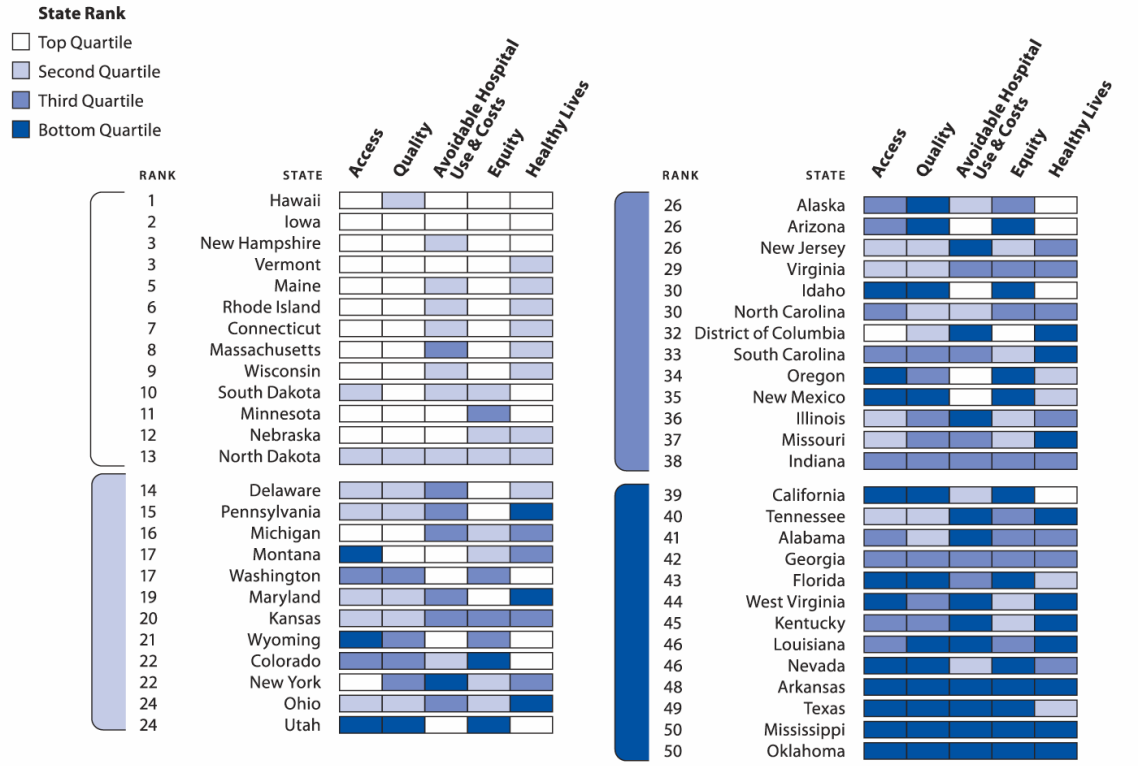
between the most vulnerable subgroup (i.e., low-income, uninsured, or racial/ethnic minority) and the U.S. national average — an absolute standard.

How Ohio Fares

Ohio achieved an overall ranking of 24, placing it in the bottom of the second quartile. As Table 2 illustrates, Ohio scored in the second and third quartiles in 25 of the 32 measures. It achieved top quartile rankings in only five categories and ranked in the bottom quartile in only two.

Table 1

State Scorecard Summary of Health System Performance Across Dimensions



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

Ohio in the Top Quartile

Access

• Percent of adults without time in past year when they needed to see a doctor but could not because of cost — **12th**

Quality

- Percent of children ages 19–35 months received all recommended doses of five key vaccines — **12th**
- Percent of adults with a usual source of care — **11th**
- Percent of children with a medical home — **12th**
- Percent of heart failure patients given written instructions at discharge — **4th**

Ohio in the Bottom Quartile

Avoidable Hospital Use and Costs

- Medicare hospital admissions for ambulatory care sensitive conditions per 100,000 beneficiaries — **42nd**

Healthy Lives

- Breast cancer deaths per 100,000 female population — **47th**

Ohio

Overall rank: 24

Overall and Dimension Ranking

- *Overall: 24*
- *Access: 15*
- *Quality: 23*
- *Avoidable Hospital Use & Costs: 37*
- *Equity: 14*
- *Healthy Lives: 41*

Summary of Indicator Rankings

Total number of indicators: 32
Number of indicators for which the state ranked in the:
Top 5: 1
Top Quartile: 5
2nd Quartile: 6
3rd Quartile: 19
Bottom Quartile: 2
Bottom 5: 1

Table 2

OHIO

Overall and Dimension Ranking	
OVERALL	**24**
Access	15
Quality	23
Avoidable Hospital Use & Costs	37
Equity*	14
Healthy Lives	41

Summary of Indicator Rankings	
Total number of main indicators for this state:	32
Number of indicators for which this state ranked in the:	
Top 5	1
Top Quartile	5
2nd Quartile	6
3rd Quartile	19
Bottom Quartile	2
Bottom 5	1

Dimension and Indicator	Year	State Rate	All States Median Rate	Top 5 States Average Rate	Best State Rate	Rank
ACCESS						**15**
Percent of adults (ages 18–64) insured	2004–2005	84.4	81.5	87.3	89.0	14
Percent of children (ages 0–17) insured	2004–2005	92.0	91.1	94.7	94.9	20
Percent of adults visited a doctor in the past two years	2000	85.2	83.4	89.9	91.5	20
Percent of adults without time in past year when they needed to see a doctor but could not because of cost	2004	89.3	87.2	93.1	96.6	12
QUALITY						**23**
Percent of adults age 50 and older received recommended screening and preventive care	2004	38.1	39.7	48.8	50.1	34
Percent of adult diabetics received recommended preventive care[a]	2004	39.2	42.4	58.5	65.4	35
Percent of children ages 19–35 months received all recommended doses of five key vaccines	2005	84.1	81.6	88.3	93.5	12
Percent of children with both a medical and dental preventive care visit in the past year	2003	61.2	59.2	72.6	74.9	17
Percent of children with emotional, behavioral, or developmental problems received some mental health care in the past year	2003	61.2	61.9	74.2	77.2	29
Percent of hospitalized patients received recommended care for acute myocardial infarction, congestive heart failure, and pneumonia[b]	2004	84.9	83.4	87.8	88.4	17
Percent of surgical patients received appropriate timing of antibiotics to prevent infections	2005	64.5	69.5	82.8	90.0	37
Percent of adults with a usual source of care	2004	84.1	81.1	88.3	89.4	11
Percent of children with a medical home	2003	52.3	47.6	59.7	61.0	12
Percent of heart failure patients given written instructions at discharge	2004–2005	61.0	49.0	63.6	67.0	4
Percent of Medicare patients whose health care provider always listens, explains, shows respect, and spends enough time with them	2003	68.6	68.7	73.2	74.9	30
Percent of Medicare patients giving a best rating for health care received in the past year	2003	70.0	70.2	73.7	74.4	28
Percent of high-risk nursing home residents with pressure sores	2004	13.3	13.2	8.1	7.6	29
Percent of nursing home residents who were physically restrained	2004	7.1	6.2	2.4	1.9	33

OHIO

Dimension and Indicator	Year	State Rate	All States Median Rate	Top 5 States Average Rate	Best State Rate	Rank
AVOIDABLE HOSPITAL USE & COSTS						**37**
Hospital admissions for pediatric asthma per 100,000 children[c]	2002	177.3	176.7	81.3	54.9	18
Percent of asthmatics with an emergency room or urgent care visit in the past year[d]	2001–2004	15.1	15.5	10.8	9.1	17
Medicare hospital admissions for ambulatory care sensitive conditions per 100,000 beneficiaries	2003	8,689	7,278	4,610	4,069	42
Medicare 30-day hospital readmissions as a percent of admissions	2003	18.6	17.6	13.8	13.2	37
Percent of long-stay nursing home residents with a hospital admission[e]	2000	17.7	16.1	8.7	8.3	33
Percent of nursing home residents with hospital readmission within three months[e]	2000	12.0	11.7	7.5	6.7	26
Percent of home health patients with a hospital admission	2004	29.3	26.9	20.1	18.3	36
Total single premium per enrolled employee at private-sector establishments that offer health insurance	2004	3,782	3,706	3,216	3,034	34
Total Medicare (Parts A & B) reimbursements per enrollee	2003	6,470	6,070	4,828	4,530	33
HEALTHY LIVES						**41**
Mortality amenable to health care, deaths per 100,000 population	2002	111.0	96.9	74.1	70.2	35
Infant mortality, deaths per 1,000 live births	2002	7.9	7.1	4.8	4.3	37
Breast cancer deaths per 100,000 female population	2002	28.0	25.3	19.9	16.2	47
Colorectal cancer deaths per 100,000 population	2002	21.1	20.0	16.3	15.3	36
Percent of adults under age 65 limited in any activities because of physical, mental, or emotional problems	2004	15.5	15.3	11.5	10.8	27

[a] Data available for 47 states.
[b] Data available for 50 states.
[c] Data available for 33 states.
[d] Data available for 36 states.
[e] Data available for 48 states.

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

Note: Refer to Appendices B1 and B2 in the *State Scorecard* for indicator descriptions and data sources.

The tables in this document can be found at this link
http://www.commonwealthfund.org/statescorecard/statescorecard_show.htm?doc_id=496083

OHIO: Estimated Impact of Improving State Performance

The *State Scorecard* enables states to compare their performance with those of other states across key indicators of health system performance. It provides states with achievable targets for improvement by assessing each state's performance compared with the best performance attained by a state. By moving toward benchmark levels of health system performance, states could save lives, improve access to and quality of care, and reduce unnecessary spending.

The table below shows the estimated impact if this state's performance improved to the rate of the best-performing state for 11 *Scorecard* indicators. (Refer to this state's individual performance profile to see actual rates.) These examples illustrate only a few important opportunities for improvement in a state. Because some indicators affect the same individuals, these numbers should not be added.

Table 3

Indicator	If OHIO's performance improved to the level of the best-performing state for this indicator, then:	
Insured Adults	327,497	more adults (ages 18–64) would be covered by health insurance (public or private),and therefore would be more likely to receive health care when needed.
Insured Children	80,191	more children (ages 0–17) would be covered by health insurance (public or private),and therefore would be more likely to receive health care when needed.
Adult Preventive Care	409,691	more adults (age 50 and older) would receive recommended preventive care, such as colon cancer screenings, mammograms, pap smears, and flu shots at appropriate ages.
Diabetes Care	177,454	more adults (age 18 and older) with diabetes would receive three recommended services (eye exam, foot exam, and hemoglobin A1c test) to help prevent or delay disease complications.
Childhood Vaccinations	20,305	more children (ages 19–35 months) would be up-to-date on all recommended doses of five key vaccines.
Adults with a Usual Source of Care	451,587	more adults (age 18 and older) would have a usual source of care to help ensure that care is coordinated and accessible when needed.
Children with a Medical Home	244,181	more children (ages 0–17) would have a medical home to help ensure that care is coordinated and accessible when needed.
Preventable Hospital Admissions	54,822 $256,621,000	fewer hospitalizations for ambulatory care sensitive conditions would occur among Medicare beneficiaries (age 65 and older) and would be saved from the reduction in hospitalizations.
Hospital Readmissions	9,794 $93,701,000	fewer hospital readmissions would occur among Medicare beneficiaries (age 65 and older) and would be saved from the reduction in readmissions.
Hospitalization of Nursing Home Residents	7,394 $60,763,000	fewer long-stay nursing home residents would be hospitalized and would be saved from the reduction in hospitalizations.
Mortality Amenable to Health Care	4,495	fewer premature deaths (before age 75) might occur from causes that are potentially treatable or preventable with timely and appropriate health care.

NOTES: Estimates of improvements in state performance were calculated as follows: for each indicator, the difference between the best-performing state's rate and the subject state's rate was multiplied by the applicable subpopulation of individuals in the subject state. (For the readmissions indicator, the difference in rates was multiplied by the applicable number of Medicare hospitalizations in the subject state.) Medicare cost-savings from reduced hospitalizations were calculated using the average cost of the applicable hospitalizations in the subject state. Calculations do not account for potentially interactive effects of indicators (e.g., insurance coverage increases the likelihood of having a usual source of care and receiving preventive care).

For more information, see *Methodology and Sources Used in State Scorecard Impact Calculations*.

What Does The *Scorecard* Mean For Ohio?

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

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

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

• Current measurement strategies are neither sufficient nor perfect. Still, we can conclude that:

- Opportunities for improvement can be found everywhere in the system in every state;
- Although, in general, Ohio performs in the middle of the distribution, these reports identify certain areas of relative strengths and weaknesses; and
- Measurement can be a powerful force in guiding change and defining an agenda to improve system performance.

What Does Poor Health System Performance Cost Ohio?

Amidst discussions about how to measure health system accountability, it is far too easy to forget why we care about doing so in the first place. The *Scorecard* serves to remind us that poor health system performance has real financial and human costs. Table 3 illustrates what could be achieved through a purposeful approach to improving the state's performance in the specific areas highlighted by the *Scorecard*. Note that these are the gains that could be realized in Ohio if our health system performed as well as the systems in top performing states. For example, if the rate of preventable hospitalizations among Medicare beneficiaries in Ohio was the same as that achieved by the top performing states of Hawaii, Utah, Washington, Alaska and Oregon, about 54,000 hospitalizations would be avoided and more than $256 million would be saved each year. Similarly, if we achieved in Ohio the same rate of hospital readmissions among Medicare beneficiaries as the top performing states of Vermont, Wyoming, Iowa, Oregon and Nebraska, we could prevent another 9,700 admissions and save an additional $93 million per year. These are just some of the real costs, both financial and human, of a health system that performs below a level we know is achievable, and in fact is already being achieved in other states.

MOVING FORWARD

One key interpretation of the *Scorecard* data is that performance is best in states that have made a concerted effort to activate resources to address these problems. Examples of successful approaches to improve performance abound. A description of a collaborative approach used in Iowa – a state ranking in the top quartile – is briefly described in the box below

IOWA HEALTHCARE COLLABORATIVE

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

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

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

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

Comprehensive Approach Needed

The *Scorecard* suggests a need for a more comprehensive approach for managing policies and practices. Change can be managed at federal, regional, state, county, local, organizational, and/or population levels. There exists an extensive menu of approaches that range from broad policy changes to organizational practices to the promotion of healthful individual behaviors. Each stakeholder has the potential to enhance performance on its own as well as through collaboration and contribution. While health and performance outcomes are a result of the interaction of many factors, specific stakeholders make important independent contributions to health system performance. Both multi-stakeholder initiatives as well as individual stakeholder activities are necessary to move the system. To be successful, stakeholders must jointly establish priorities, create actionable agendas, and commit to purposeful and effective measurement to assure successful implementation, identify intended and unintended consequences, and reorder priorities.

CONCLUSION

Aiming Higher: Results from a State Scorecard on Health System Performance has the potential to become an important stimulus for state and national efforts to improve health system performance. There are human costs of poor performance and of system failures. People die or suffer needlessly because of inadequate health care services, failed policies, and misplaced priorities. 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 Ohioans.

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