New data track performance of state health systems, offer tools for setting goals and crafting policy

By Kathryn Tormey

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Which states have the highest rates of avoiding preventable deaths? How does the Midwest compare to the nation in providing equitable access to health care?

The most recent edition of a Commonwealth Fund report aims to provide policymakers with the tools to start answering these questions — and look for the best policies for maximizing health system performance.

Information about health indicators has traditionally been measured at the national level. But in “Aiming Higher,” states can learn how their individual health care systems are faring over time, says Cathy Schoen, senior vice president at The Commonwealth Fund and a co-author of the report.

This year’s report looks at 42 indicators in five categories, including changes over five years.

“The basic conclusion is that where you live matters,” Schoen says.

That’s because health care systems are structured differently, depending on state policies governing everything from medical licensing to insurance plans and networks.

Minnesota retained its position as the highest-performing health care system in the nation. Iowa, South Dakota and Wisconsin also placed in the top quartile.

Six states in the Midwest improved or stayed the same in their overall rankings since the 2009 “Aiming Higher” report, while rankings for the five other states in the region (Indiana, Iowa, Kansas, Michigan and North Dakota) declined.

States were evaluated across five categories:

- access/cost (such as insurance coverage and out-of-pocket costs for care);
- prevention/treatment (rates of preventive screenings and measures of quality);
- avoidable hospital use (indicators of hospital use that could have been avoided with effective preventive care);
- healthy lives (such as measures of premature death and health-risk behaviors); and
- equity (differences in performance associated with patient income, race or ethnicity).

Turning data into policy

Schoen says that from time to time, she meets a legislator who is glad to have lots of data about health care — but they’re admittedly unsure how to start using it.

Schoen suggests to lawmakers that they choose a few states that are similar to theirs and see how their own state’s health performance matches up.

Another strategy is to pick a measure and simply think backward to what situation might have led to a particular
outcome. For example, what factors impact whether adults receive a routine physical?

“Then policymakers can develop targeted policies to do better,” she says. “The data can inform action.” Poor rates of preventive care often stem from the cost and availability of care, whether due to uninsurance, workforce shortages in health care or lack of transportation options. And that trend can have far-reaching consequences.

When patients have access to regular primary care, they can be screened for health issues and receive advice on how to take steps toward being healthier. For example, the parent of a child with asthma can learn about the effects that pets, mold and cigarette smoke can have on the disease. That one contact with a physician could have a positive impact on the whole family if, say, the parent quits smoking.

To address issues of access, states can work to increase insurance rates, most notably by expanding Medicaid under the Affordable Care Act (Illinois, Iowa, Michigan, Minnesota, North Dakota and Ohio have done so); but they can also improve access for people who already have insurance. Possible policy solutions include requiring broader insurance networks in Medicaid and state health exchanges or widening the types of care that certain non-physician health professionals can provide — thus freeing up doctors for the most complex care.

**Importance of coordinated care**

One of the top predictors of good outcomes for patients is making sure that different parts of a state’s health care system work well not just alone, but together.

“The medical technology and knowledge might be the same [around the country] about what to do with a person who’s had a hip replacement, but does it all get carried out?” Schoen says. “The large variations among states are usually symptoms of poorly coordinated care.”

For example, when readmission rates are high, states can consider whether hospitals are discharging patients too early or without clear instructions, whether better use of electronic records could prevent harmful drug interactions at home, or whether providers could better communicate follow-up instructions with facilities such as nursing homes.

“Medical homes” can help act as the central location for all of this information about a patient’s care. Minnesota has begun using medical homes in public programs such as Medicaid. Under this arrangement, the state offers certain providers an additional fee for ensuring that all of a beneficiary’s primary and specialty care is in sync. The goal is to avoid duplication, catch health issues early and prevent costly trips to the emergency room. The extra funding is designed to encourage physicians to hire more staff (such as a dietician or exercise specialist), invest in an electronic medical records system, or hold extended hours to serve working patients.
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