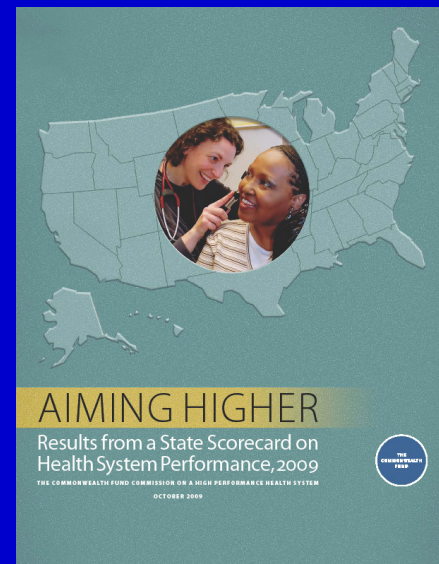


Aiming Higher: New Jersey



Results from the 2009 State Scorecard on Health System Performance

Douglas McCarthy

**Senior Research Advisor, The Commonwealth Fund
President, Issues Research, Inc., Durango, Colo.**

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

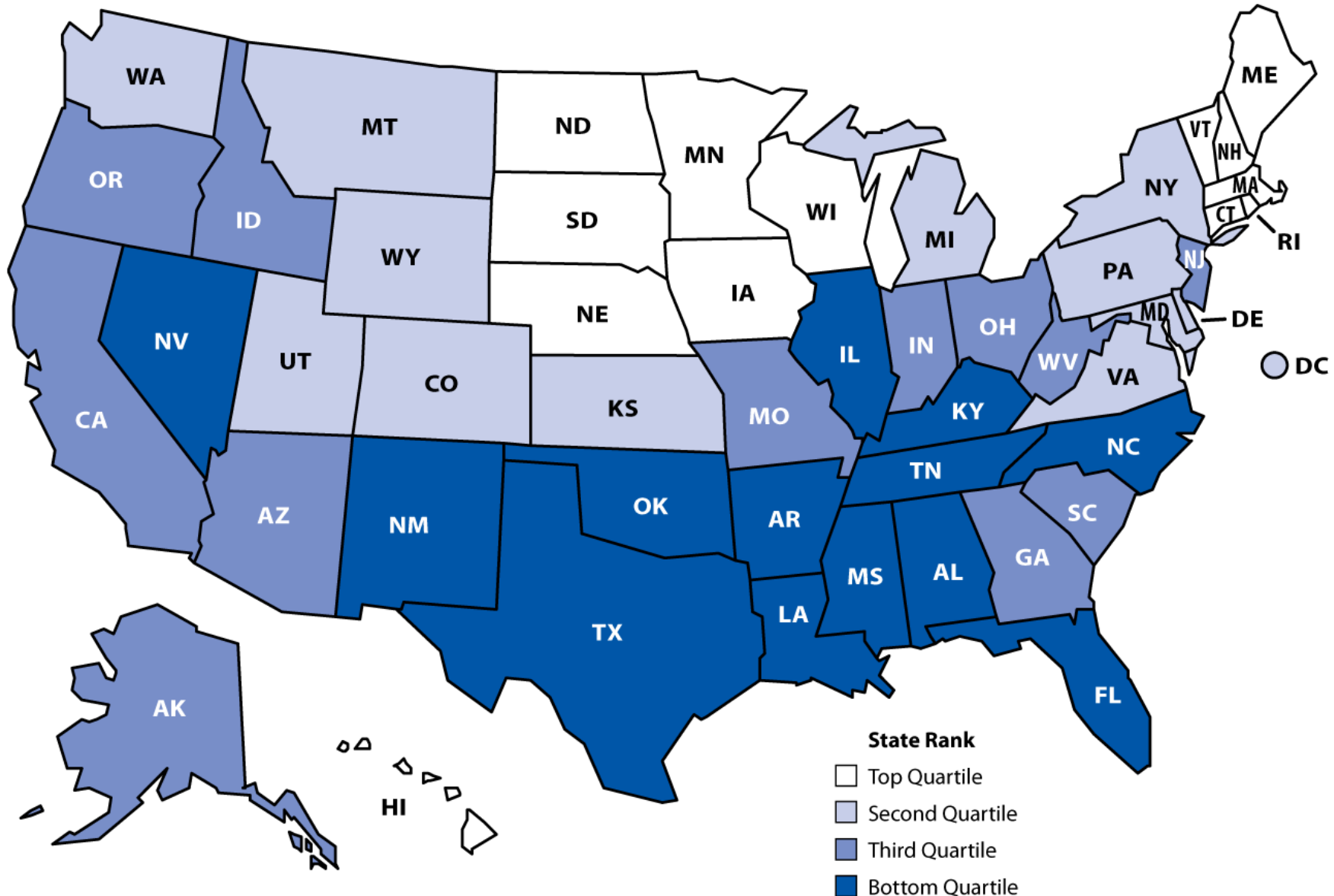
Purpose and Methods

- **Objective: to stimulate discussion and inform national and state policy action**
- **Framework modeled on National Scorecard**
 - **5 dimensions: access; prevention & treatment; avoidable hospital use & costs; equity; and healthy lives**
 - **Provides achievable benchmarks for improvement**
- **Ranks states over two time periods**
 - **Updates set of 38 indicators (6 new); 35 have trend data**
 - **Dimension rank = average of indicator ranks**
 - **Overall rank = average of 5 dimension ranks**
- **Equity measures gaps between vulnerable groups (low-income, uninsured, and non-white) and U.S. average on subset of indicators**

2009 State Scorecard: Key Findings

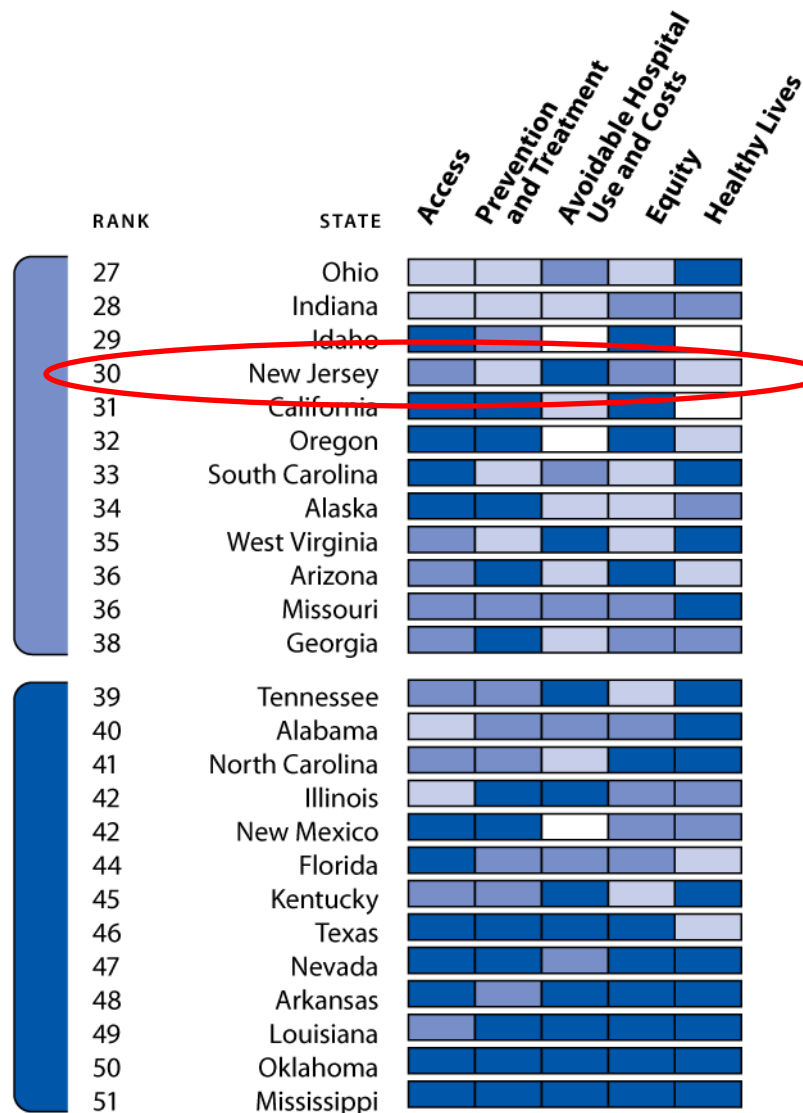
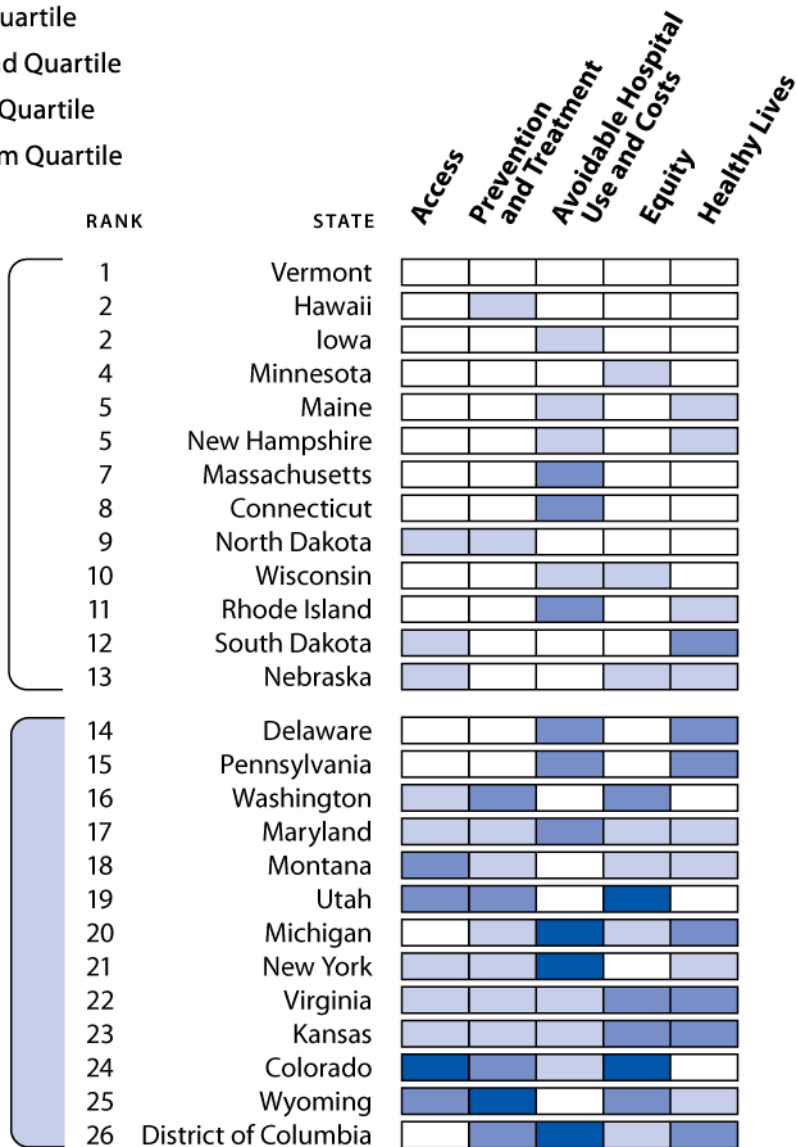
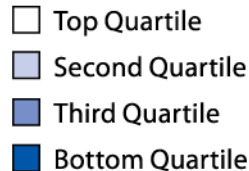
- **Wide variation across states: where you live matters**
 - Top states continue to lead; set new benchmarks
 - Two- to three-fold spread between top and bottom states
- **Losing ground on coverage: federal action needed**
 - Rising rates of uninsured adults
 - Coverage held steady or improved for children
- **Large gains follow national efforts to measure and publicly report performance**
 - Hospital and nursing home/home health quality indicators improved substantially
 - Preventive care and coordination failed to improve
- **Opportunities to improve both quality and costs**
 - Negative trends on hospital readmissions
 - Highest readmission rates in highest cost states
- **Affordability is growing concern: costs rising faster than incomes**

Overall State Ranking 2009



2009 State Scorecard Summary of Health System Performance

State Rank



SUMMARY OF SCORECARD RESULTS FOR NEW JERSEY	Past Rank 2007	Current Rank 2009	Number of Indicators That:		
			Improved by 5% or more	Worsened by 5% or more	Little or No Change
Access	24	27	0	0	4
Prevention & Treatment	13	21	9	2	3
Avoidable Use of Hospitals & Costs of Care	47	48	2	3	4
Equity	20	31	-	-	-
Healthy Lives	24	19	6	1	1
OVERALL	22	30	17	6	12

NOTE: 2007 ranks were revised to include new indicators and match methodology used in 2009.
Trend data were available for 35 of 38 indicators for New Jersey.

SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2009

New Jersey: Relative Strengths & Weakness

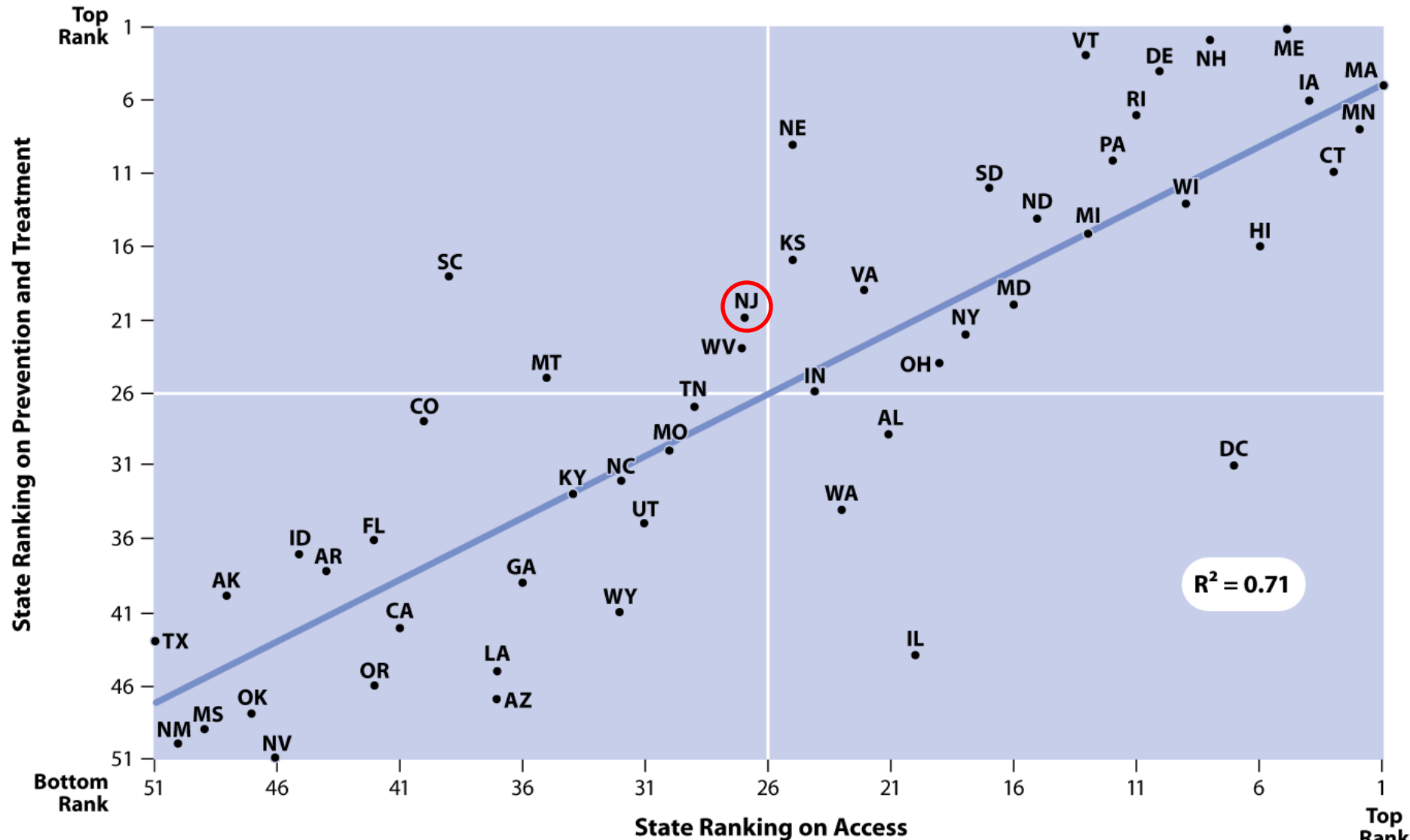
INDICATORS IN TOP QUARTILE

- At-risk adults visited a doctor for routine checkup in past 2 years (8th)
- Children ages 19-35 months received recommended vaccines (12th from 38th)
- Children had both a medical and dental preventive care visit (10th)
- Hospitalized patients received recommended care for heart attack, heart failure, pneumonia (8th)
- Home health patients get better at walking or moving around (6th)
- Long-stay nursing home residents with moderate to severe pain (5th)
- Infant mortality (5th from 10th)
- Suicide deaths (2nd)
- Nonelderly adults with activity limitations due to physical, mental or emotional problems (6th)
- Adult smoking (10th)

INDICATORS IN BOTTOM QUARTILE

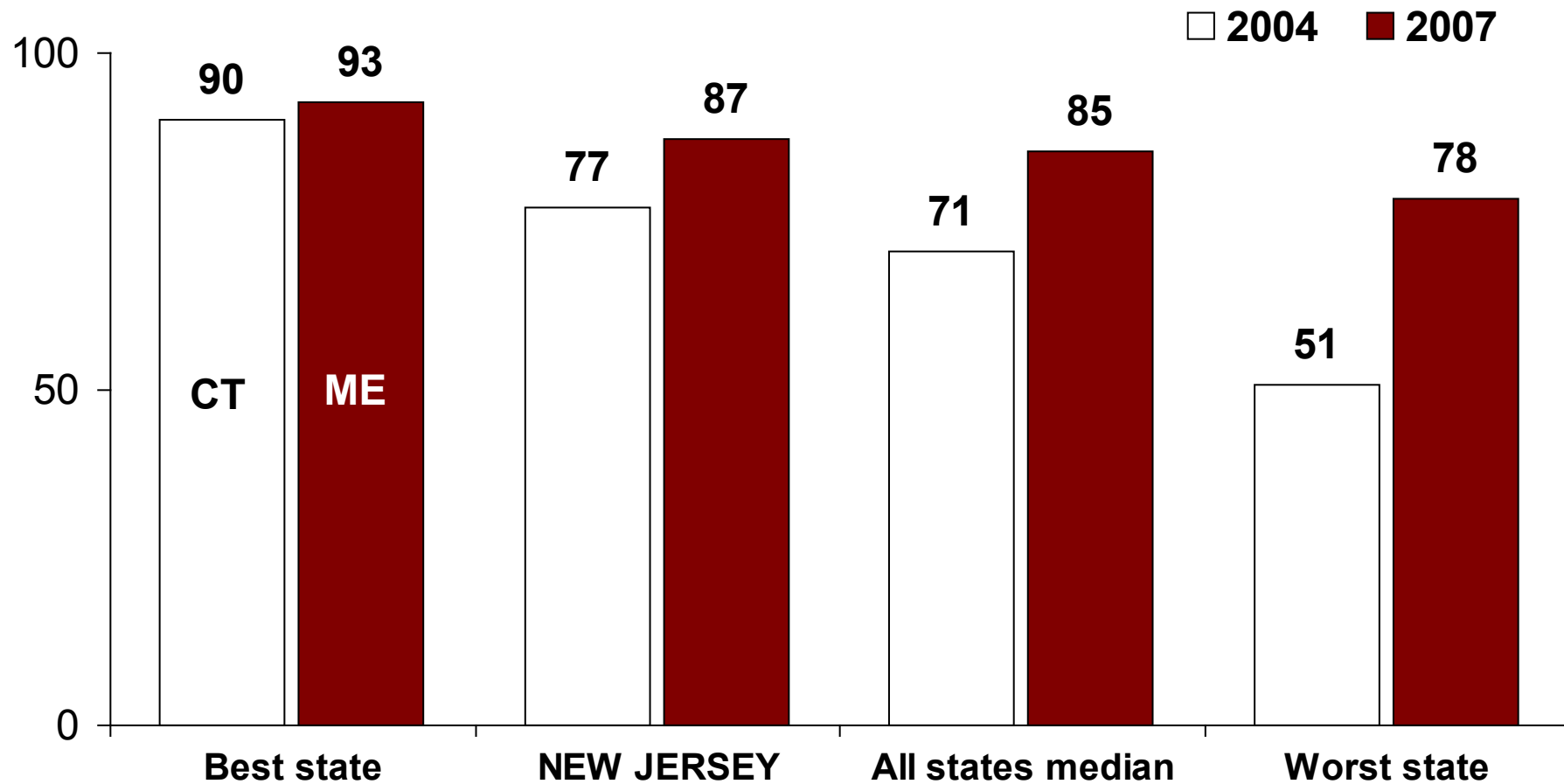
- Children insured (42nd from 35th)
- Children received needed mental health care (41st from 35th)
- Medicare patients giving a best rating for health care received in past year (43rd from 37th)
- High-risk nursing home residents with pressure sores (50th)
- Medicare admissions for ambulatory care sensitive conditions (41st)
- Long-stay nursing home residents with a hospital admission (45th)
- Short-stay nursing home residents with a hospital readmission within 30 days (46th)
- Hospital care intensity: Medicare in last 2 years of life (51st)
- Single employee premiums (43rd) & Medicare reimbursements per enrollee (50th)
- Breast cancer deaths (45th)

State Ranking on Access and Prevention/Treatment Dimensions



Hospital Quality: Prevention of Surgical Complications

Percent of hospitalized adult surgical patients who received appropriate care to prevent complications*



* Data for 2004 is a composite of two clinical indicators; 2007 is a composite of five clinical indicators consisting of original two in 2004 and three new indicators. See Appendix B for description of clinical indicators.

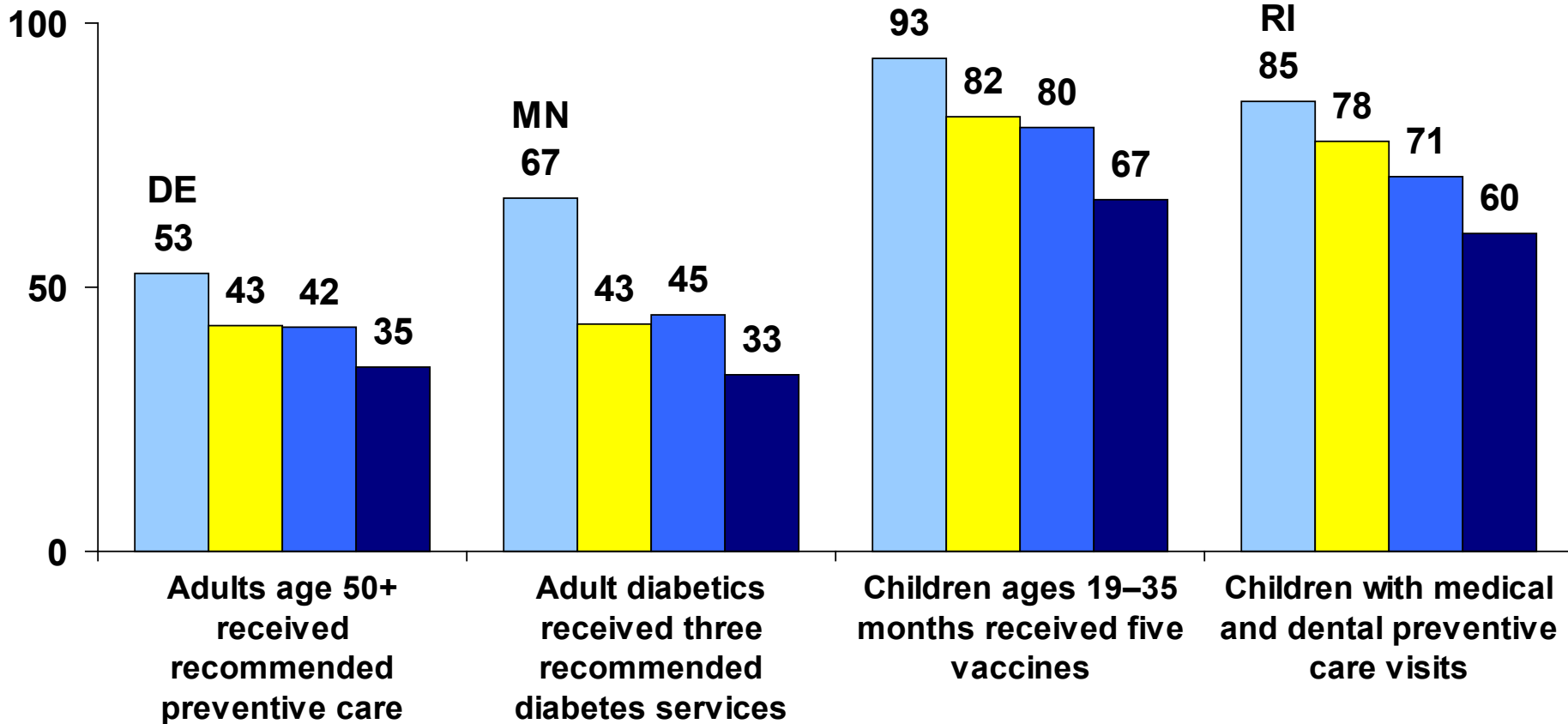
DATA: 2004 and 2007 CMS Hospital Compare

SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2009

Ambulatory Care Quality Indicators

■ Best State
 ■ NEW JERSEY
 ■ All States Median
 ■ Worst State

Percent

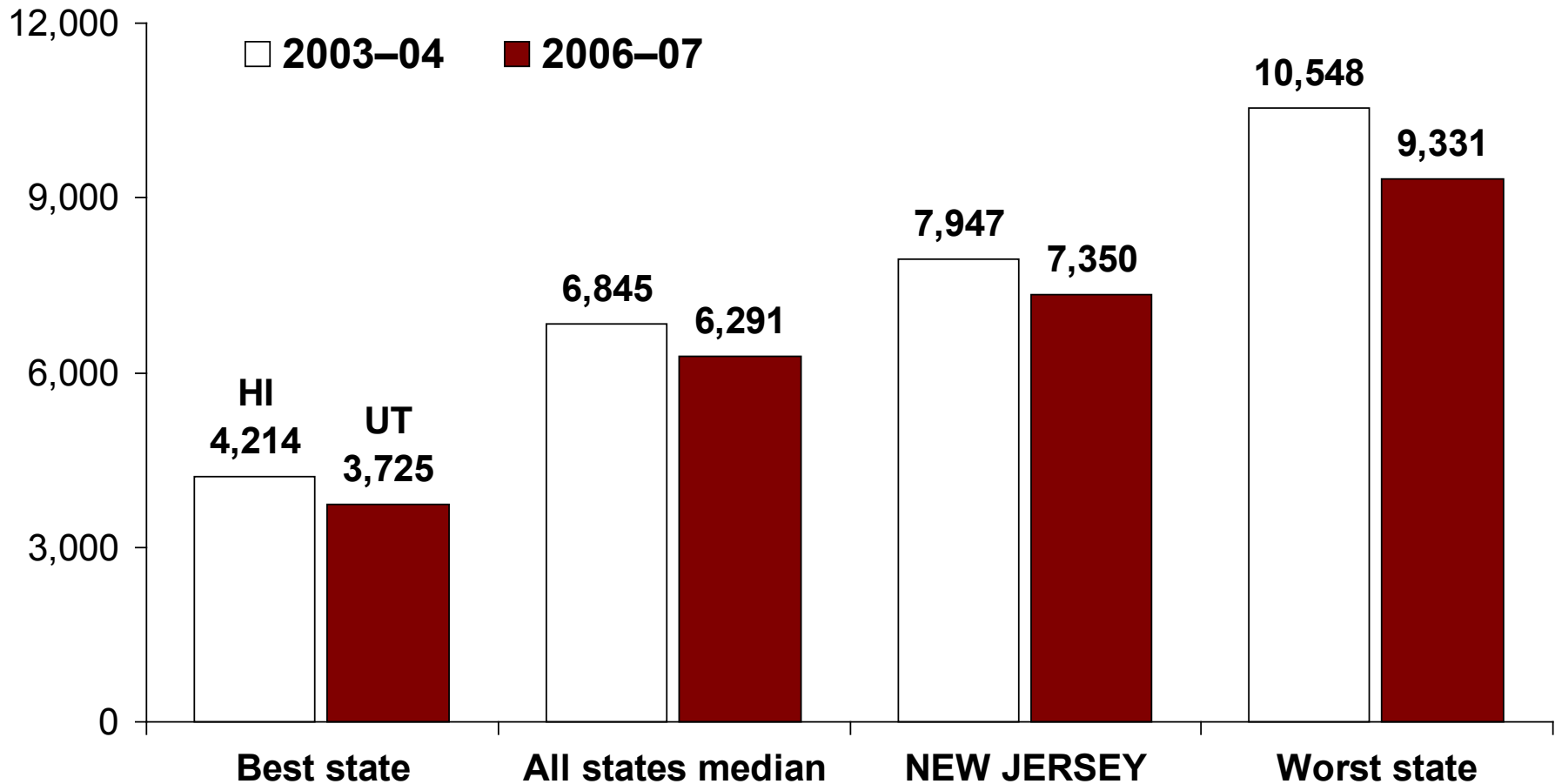


DATA: Adult preventive care—2006 BRFSS; Adult diabetic preventive care—2006-07 BRFSS; Child vaccines—2007 National Immunization Survey; Child medical and dental visits—2007 National Survey of Children's Health

SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2009

Medicare Hospital Admissions for Ambulatory Care Sensitive Conditions

Rate per 100,000 Medicare Beneficiaries*



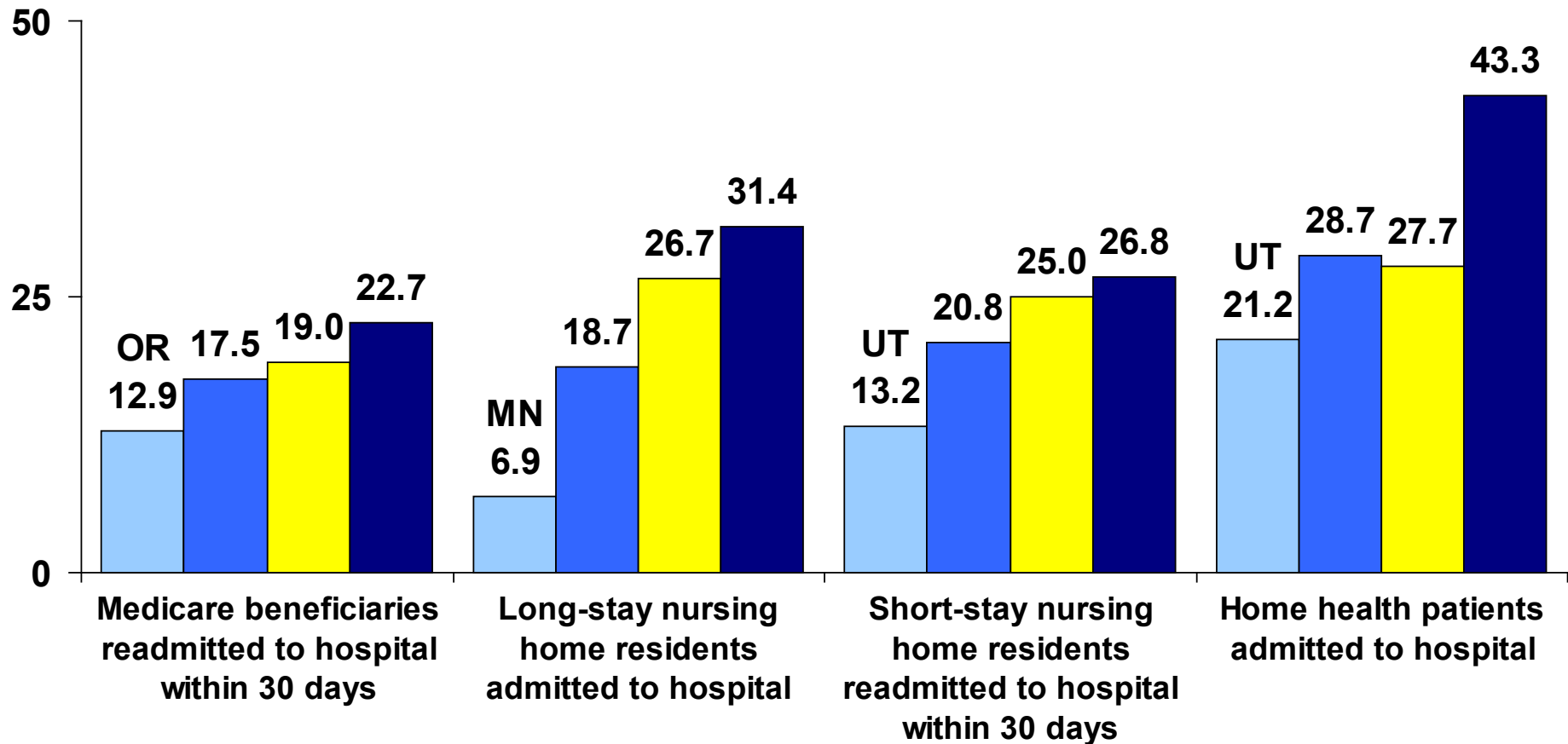
DATA: Medicare 5% SAF Data.

SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2009

Hospital Admissions Indicators

Best State All States Median NEW JERSEY Worst State

Percent



DATA: Medicare readmissions—2006–07 Medicare 5% SAF Data; Nursing home admission and readmissions—2006 Medicare enrollment records and MEDPAR file; Home health admissions—2007 Outcome and Assessment Information Set

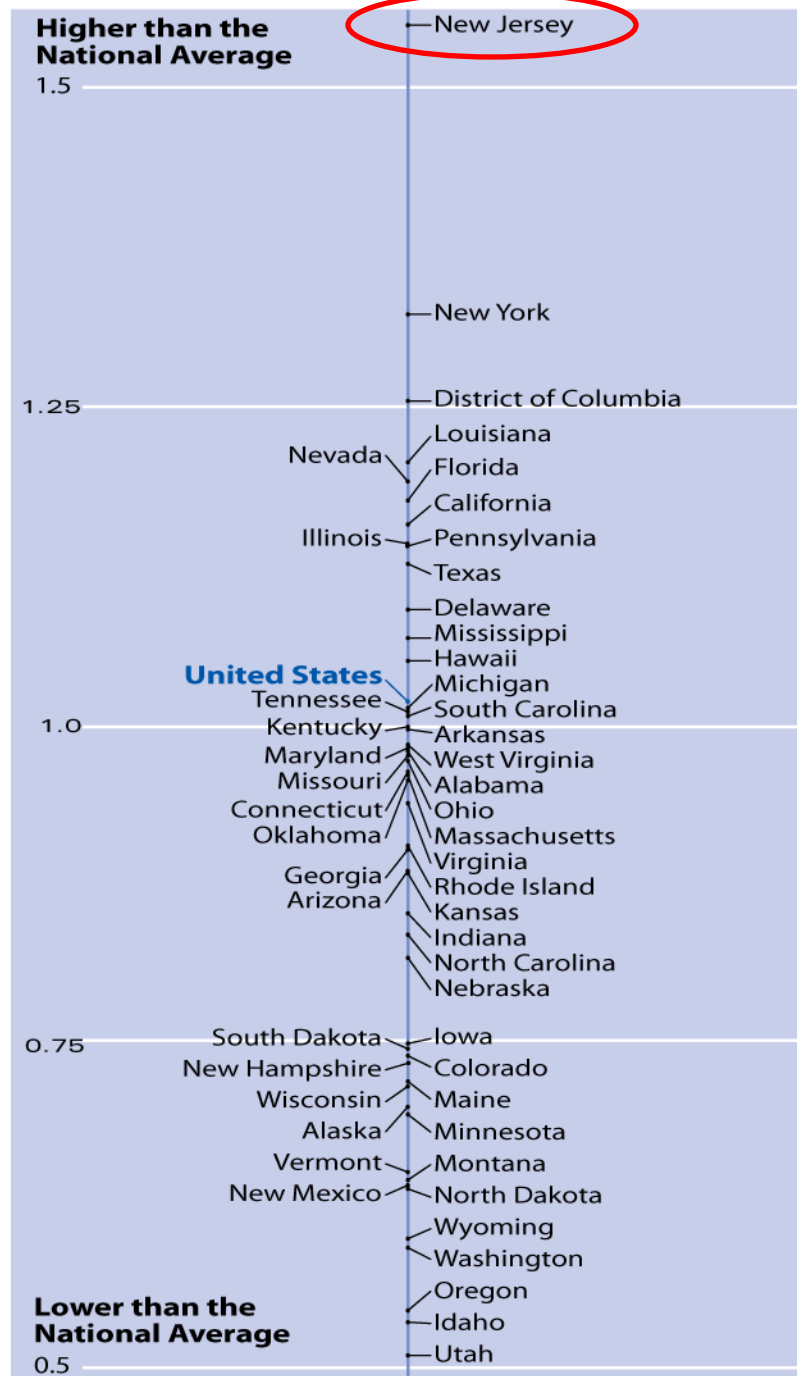
SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2009

State Variation: Hospital Care Intensity Index, 2005

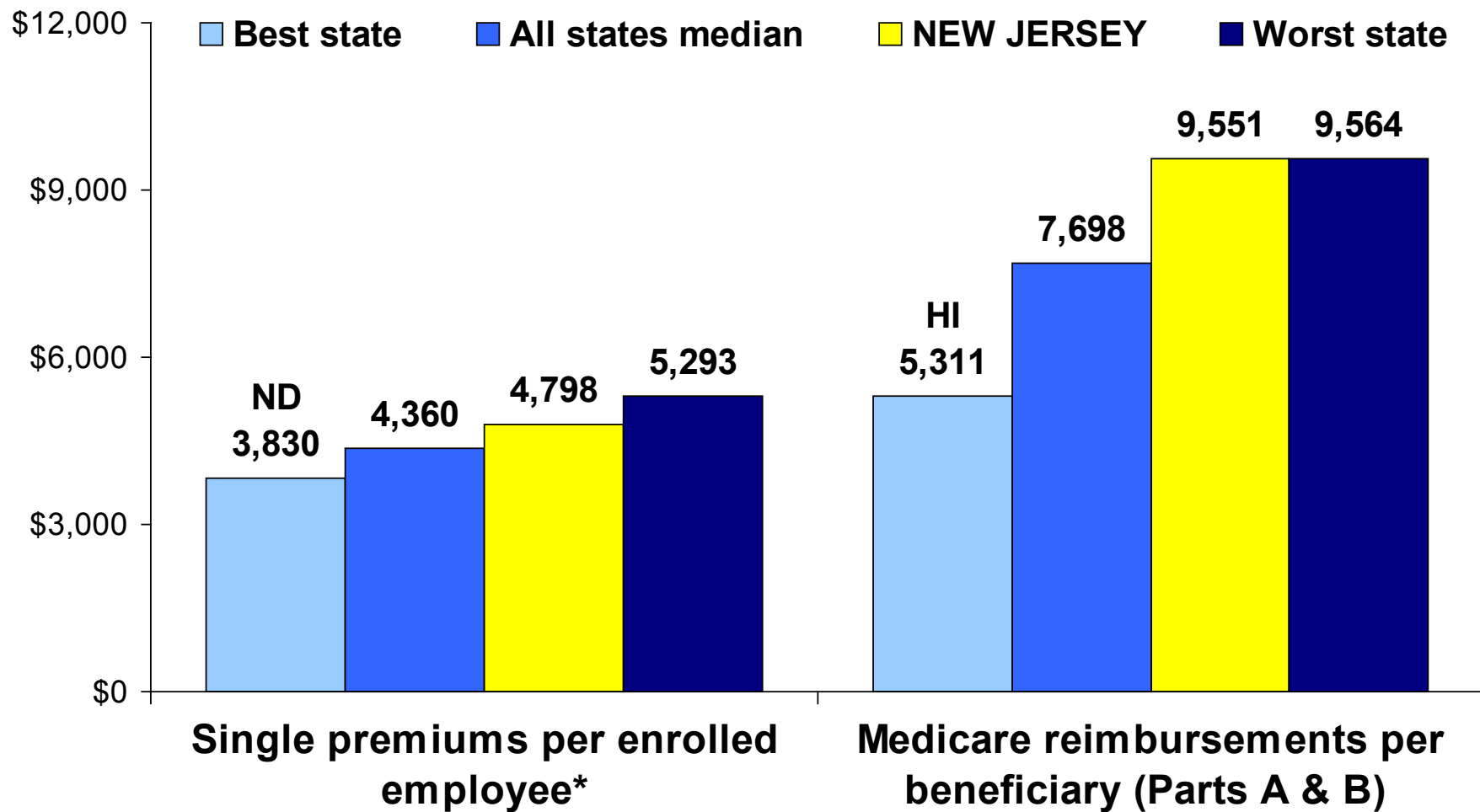
Note: The Hospital Care Intensity Index was calculated as the average of the number of inpatient days by state divided by the national rate and the number of inpatient physician visits by state divided by the national rate, for chronically ill Medicare beneficiaries in the last two years of life. All rates were age-sex-race-illness standardized. The national average was set to 1.0 for the base year 2001, so that ratios in subsequent years reflect the national trend in this composite measure of inpatient utilization.

SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2009

Chronically ill Medicare beneficiaries spent twice as many days in the hospital in New Jersey (25 days) as in Utah (11 days), and they received four times as many inpatient physician visits (61 versus 15) on average during their last two years of life.



Costs of Care

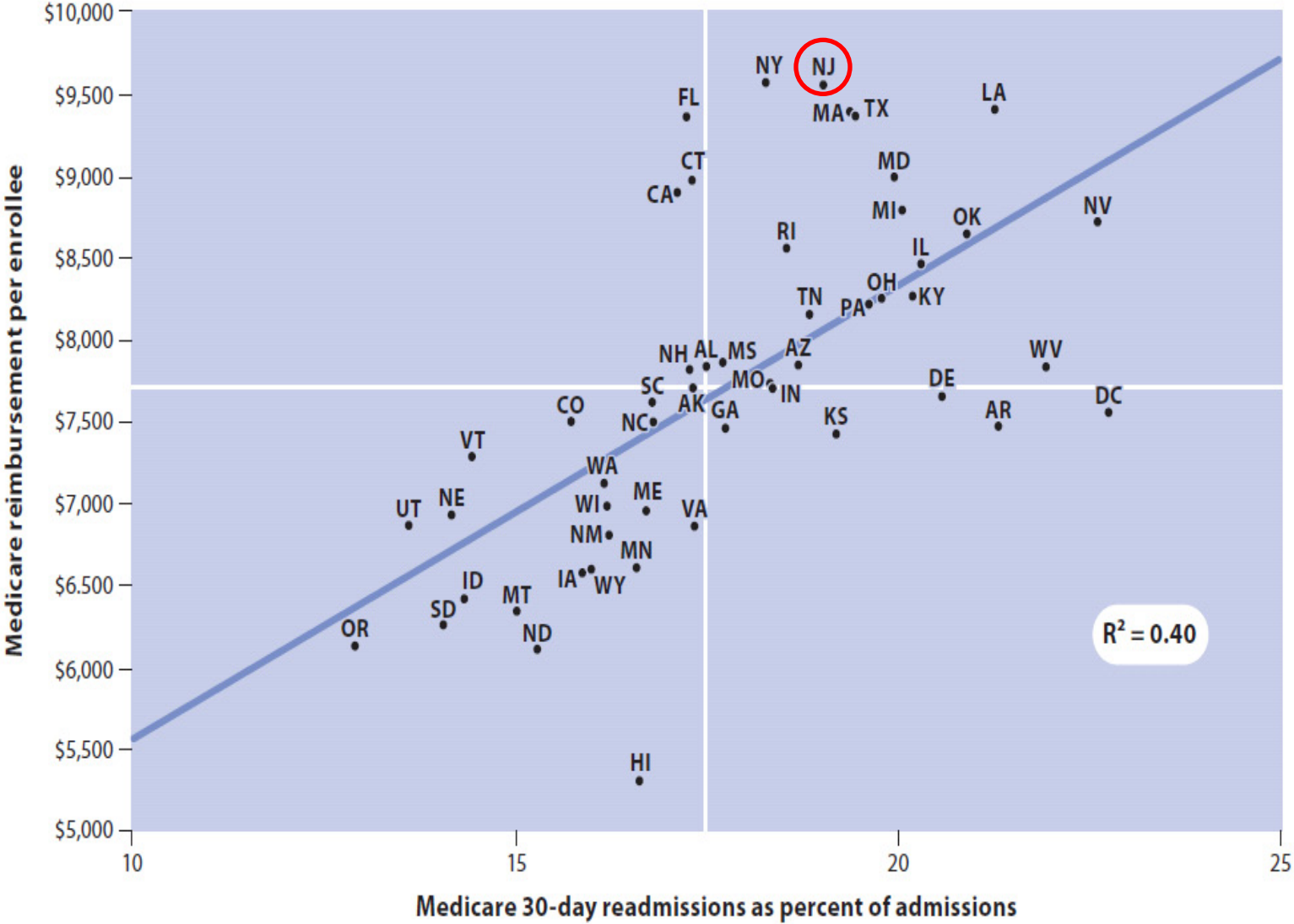


*NOTE: Premiums at private-sector establishments that offer health insurance.

DATA: Medical Expenditure Panel Survey, Insurance Component—2008; Dartmouth Atlas of Health Care—2006.

SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2009

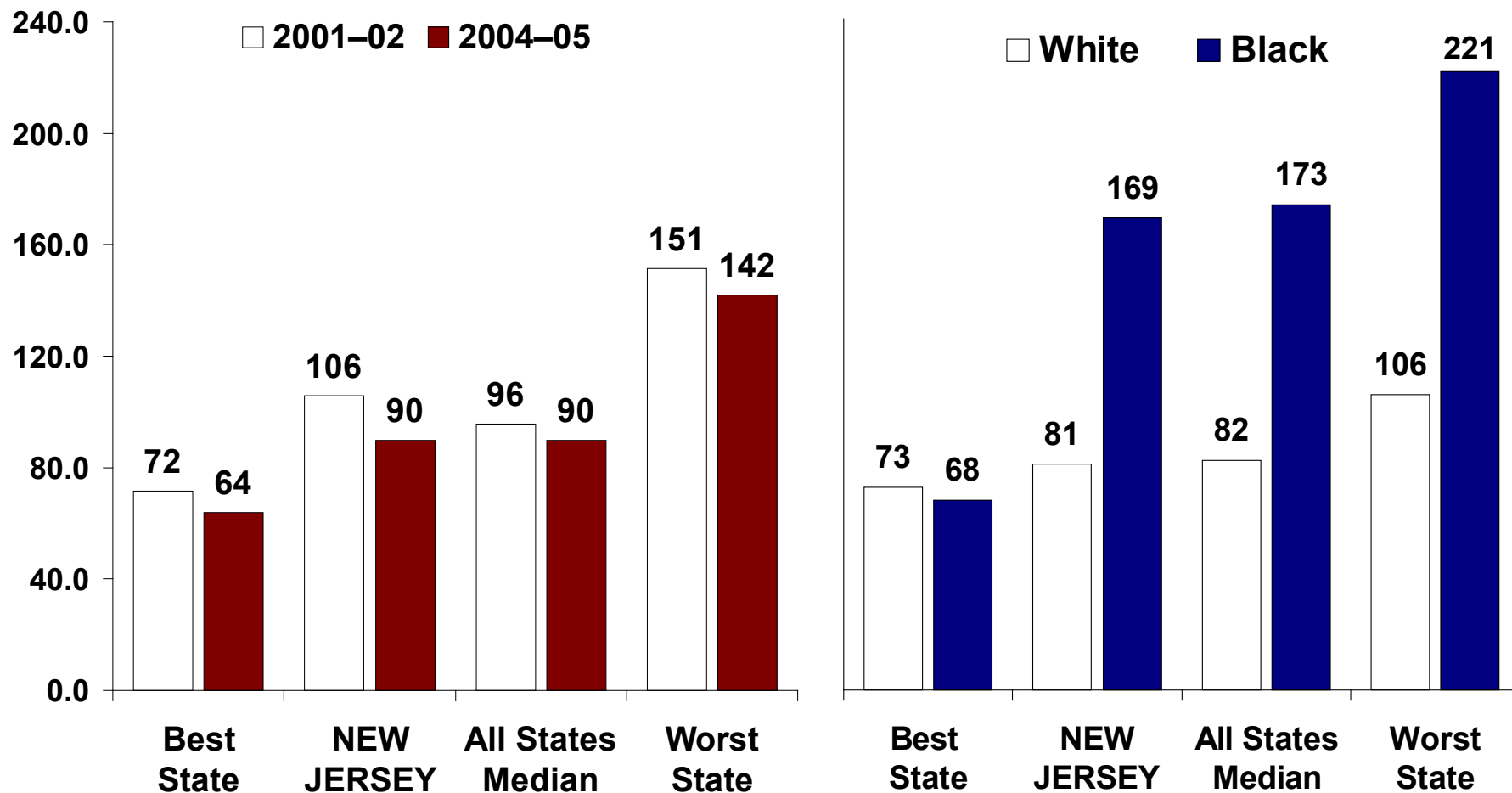
Medicare Cost Per Beneficiary and 30-Day Readmissions by State



DATA: Medicare readmissions—2006–07 Medicare 5% SAF Data; Medicare reimbursement—2006 Dartmouth Atlas of Health Care
 SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2009

Mortality Amenable to Health Care by State

Deaths* per 100,000 Population



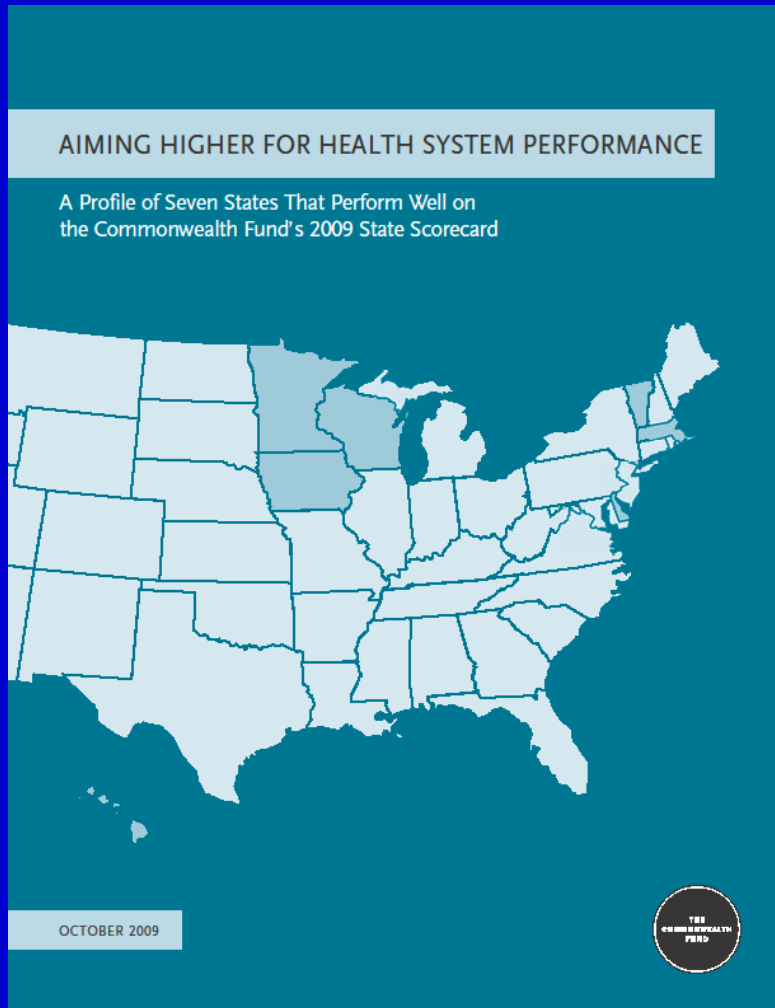
* Age-standardized deaths before age 75 from select causes; includes ischemic heart disease. Data by race available for 44 states.
DATA: Analysis of 2001-02 and 2004-05 CDC Multiple Cause-of-Death data files using Nolte and McKee methodology, *BMJ* 2003.
SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2009

Gains if New Jersey Achieved Top State Performance

- **More people covered:** 621,719 adults and 184,046 children
- **More getting primary care:** 363,716 adults and 257,573 children would have a usual primary care provider or “medical home”
- **More getting recommended preventive care:**
 - 254,680 more adults (age 50+) screened & immunized
 - 144,589 more diabetics treated to prevent complications
 - 18,487 more young children immunized on time
- **Savings from avoided hospital use:**
 - \$270 million from reduced ambulatory care sensitive hospital admissions among Medicare beneficiaries
 - \$134 million from fewer Medicare hospital readmissions
 - \$56 million from fewer hospitalizations of long-state nursing home residents
- **Healthier lives:** 2,455 fewer premature deaths



Lessons from Leading States



- Long-term commitment to reform
- Collaboration among stakeholders
- Leadership to expand coverage
- Transparency of health information
- Capacity to act on emerging best practices

Greg Moody and Sharon Silow-Carroll
Health Management Associates



What Leading States Are Doing to Promote a Higher Performance Health System

- **Promote incentives for improved performance**
 - Value-based purchasing using public employee plan to create collaboration and drive change
 - Multi-payer performance incentives/frameworks
 - Integrated payment models → payment reform
- **Promote better organization, integration, efficiency**
 - Health information exchange; universal standard electronic claims transactions and all-payer data
 - Transitional care after hospital discharge
 - Multi-payer development of primary care medical homes and community-care teams

Value-Based Purchasing: Public Employee Plans

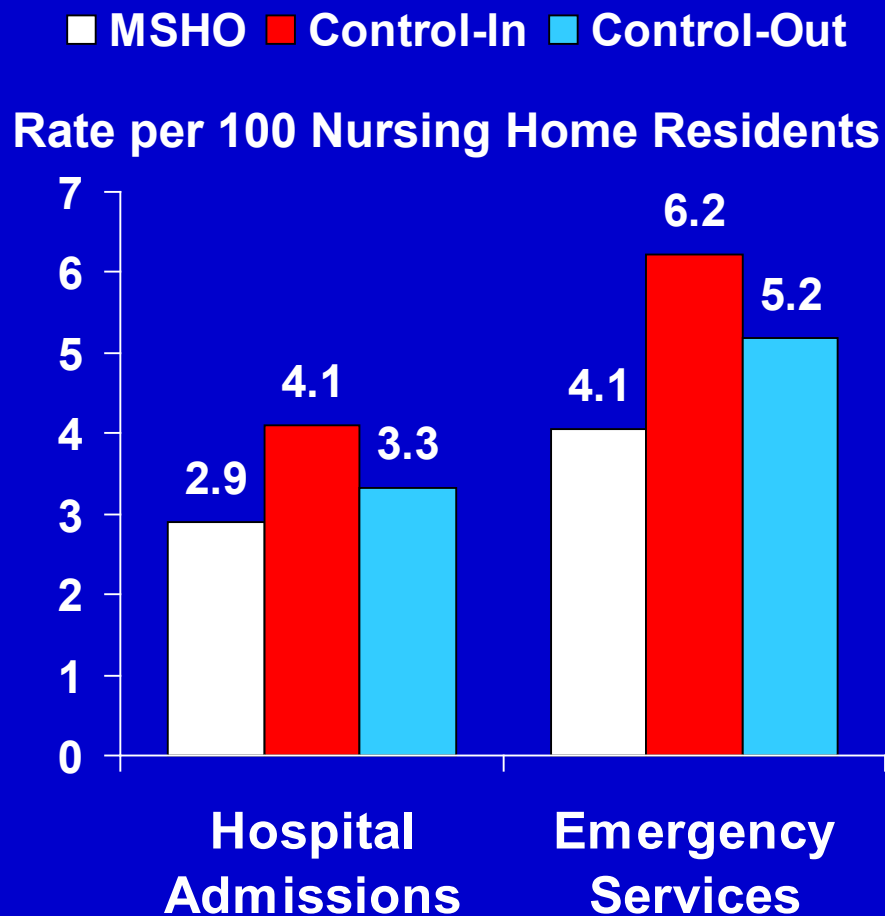
Minnesota Advantage

- Uniform benefits across three participating carriers
- Organizes primary care clinics into four risk-adjusted cost tiers
- Financial incentives to choose lower-cost providers (can change once per month)
- Disease management; reduced copays for participation in health assessment; free health coaching
- Reports performance information (MN Community Measurement)
- Participates in Minnesota “Bridges to Excellence” provider performance incentive program

Maine Employee Health & Benefits

- Patient incentives to select preferred providers using Maine Health Management Coalition’s quality designations
- Preferred hospitals identified on patient safety and clinical quality metrics
- Preferred primary care providers identified on clinical office systems and care for chronic conditions and immunizations
- Phased approach: education for consumers; performance reassessed every 6 months; benchmarks raised over time
- Required legislative waiver from state geographic access standards to institute tiering

Minnesota Senior Health Options: Integrated Care for Dually Eligible Medicaid and Medicare Enrollees



- Dually eligibles: 18% of Medicaid population -> 38% of cost
- Voluntary enrollment – 37,000 seniors living in community and nursing homes (70% of eligibles)
- Nine Medicare Advantage Special Needs Plans – contract with state and blend capitation streams
- Integrates spectrum of care: primary, acute, long-term care
- Pilot sites: 29% lower hospital admissions from nursing homes
- Since 2004: nursing home use down 23% while community services up 48% (100:86 ratio)

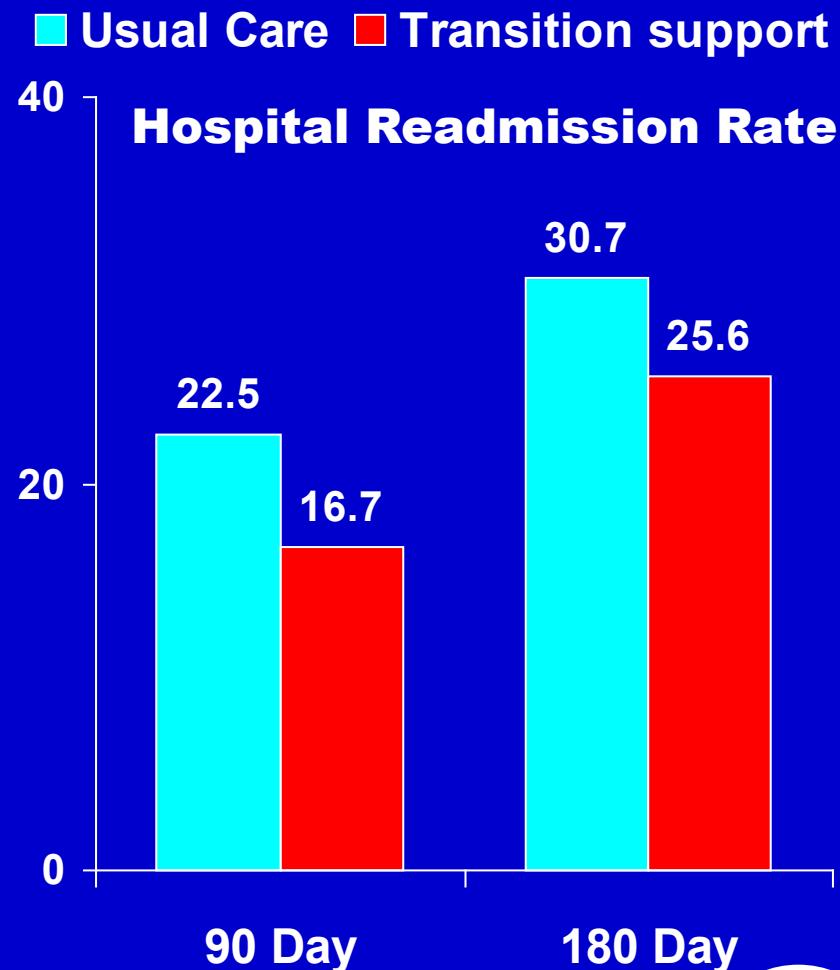
NOTE: Control-In includes residents who were eligible but did not enroll in MSHO; Control-out includes residents in areas where MSHO was not available. Differences between MSHO and controls were statistically significant.

SOURCE: R. Kane et al. "Patterns of utilization for the Minnesota senior health options program," *Journal of the American Geriatrics Society* 2004 52: 2039–44; personal communication with Pam Parker, MN DHS.



Care Transitions: Supporting Frail Patients by Coordinating Care Across Sites of Care

- Care Transition Intervention (University of Colorado)
 - Assistance with medication self-management
 - Personal health record
 - Timely follow-up care and education on “red flags”
 - 25% lower 90-day hospital readmissions
- State of Maine: all hospitals required to assess patients’ perspectives on coordination at hospital discharge using 3-item Care Transition Measure
- STAAR: State Action to Avoid Rehospitalizations Initiative



What Leading States Are Doing to Promote a Higher Performance Health System

- **Use better information to guide and drive improvement**
 - Support common evidence-based guidelines and quality measures to reinforce consistent change
 - Make performance transparent (quality and cost) and help consumers be better users of information
 - Help identify and spread best practices
- **Promote a culture of continuous improvement**
 - Data sharing, tools and technical supports
 - Collaboratives and learning communities
 - Leaders focusing on population health



Selected State-Based Collaborations That Promote Common Evidence, Measurement and Improvement

- **California Integrated Healthcare Association**
- **Colorado Clinical Guidelines Collaborative**
- **Iowa Healthcare Collaborative**
- **Maine Health Management Coalition (along with the Maine Health Data Organization and Maine Quality Forum)**
- **Massachusetts Health Quality Partners and the Massachusetts Health Care Quality and Cost Council**
- **Minnesota Community Measurement and the Institute for Clinical Systems Improvement (ICSI)**
- **Puget Sound Health Alliance**
- **Rhode Island Quality Institute**
- **Vermont Blueprint for Health**
- **Wisconsin Collaborative for Healthcare Quality and Wisconsin Health Information Organization**

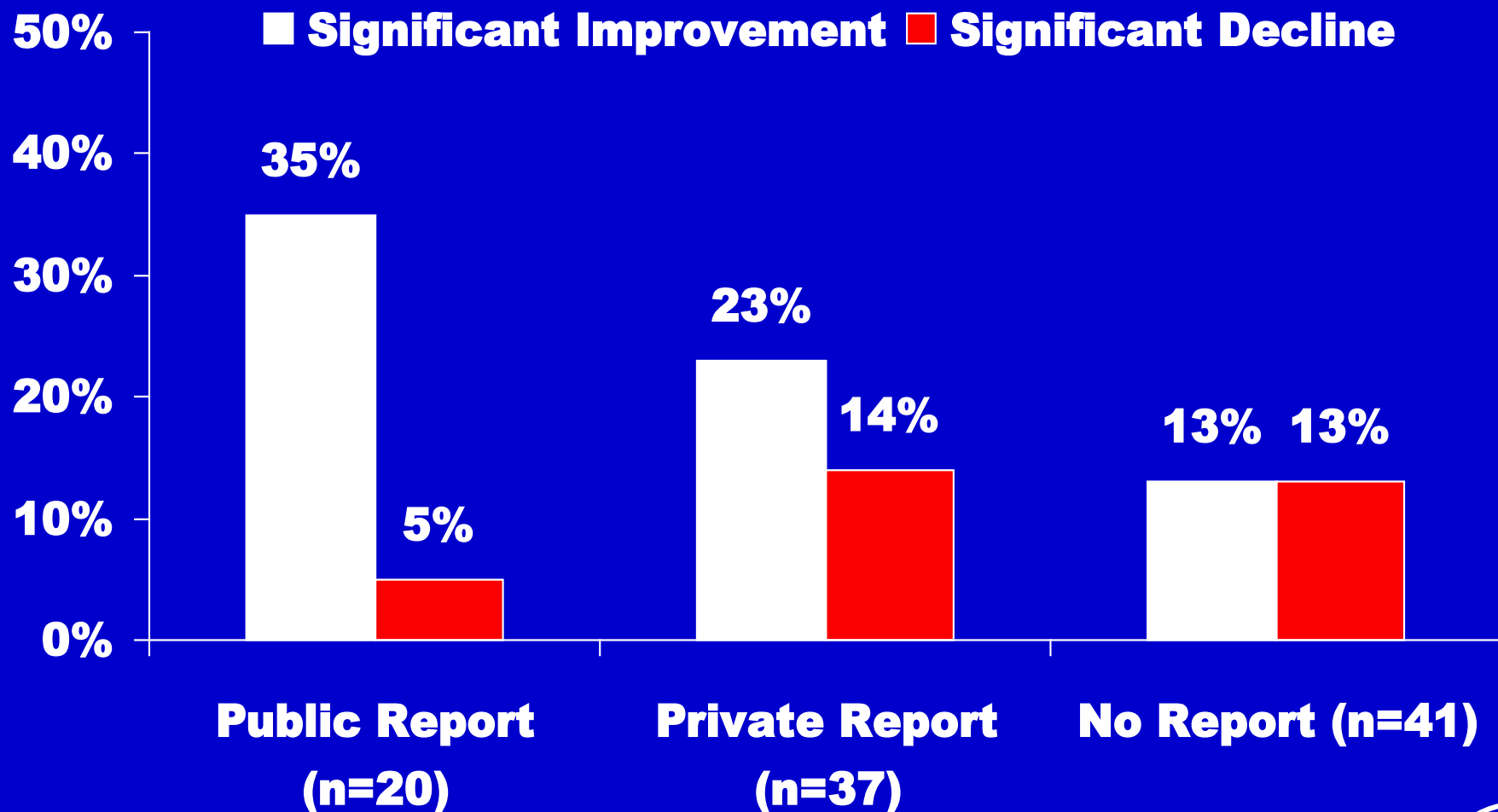
- **Institute for Clinical Systems Improvement (ICSI)**
 - Facilitates collaboration on quality improvement by medical groups, hospitals, and health plans
 - Scientific groundwork: common clinical guidelines; technology assessments; standard order sets; defining baskets of care
 - QI collaboratives: members commit to engage in 4 projects per year (e.g., medical homes, depression screening & treatment)
 - Funded by all six Minnesota health plans
- **Minnesota Community Measurement**
 - Collaboration of health plans, state medical association, medical groups, consumers, and businesses
 - Goals: support quality initiatives of providers and ICSI; reduce reporting-related expenses; report fair, usable, reliable data
 - Report quality and cost for 100 medical practices representing 90% of state residents; used in Minnesota Bridges to Excellence performance incentive program



Coalitions and Collaboratives

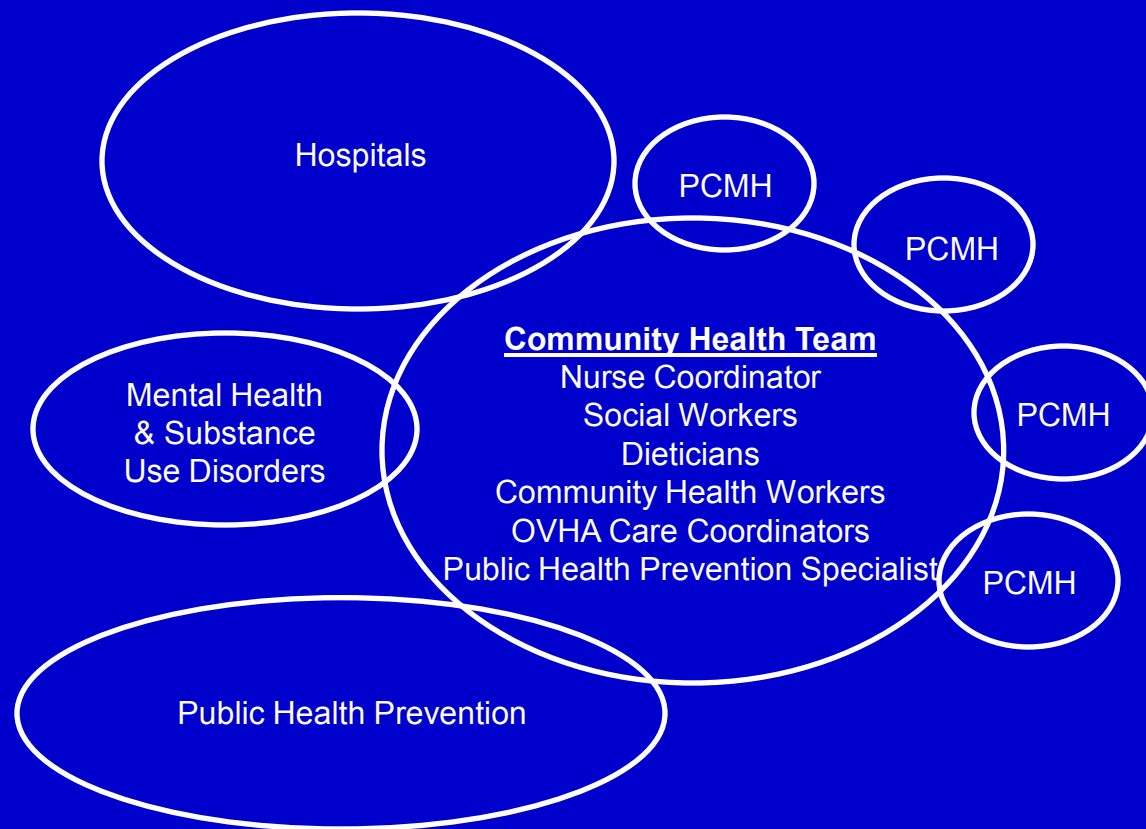
- **Wisconsin Collaborative for Healthcare Quality**
 - Voluntary consortium formed in 2003 – physician groups, hospitals, health plans, employers & labor
 - Develops & publicly reports comparative performance data on physician practices, hospitals & health plans
 - Ambulatory care, IT capacity, patient satisfaction & access – serves as a hub for improvement
- **Wisconsin Health Information Organization**
 - Voluntary multi-stakeholder coalition formed in 2005 funded by member contributions and state physician assessment
 - Creating an "all-payer" repository of claims, pharmacy and lab data; state will add data on costs of publicly paid health care
 - Goal: report on costs (and eventually quality) of care episodes

Wisconsin Hospital Maternity Performance in the Post-Reporting Period (2001-2003)



Source: J.H. Hibbard et al. 2005. Hospital performance reports: impact on quality, market share, and reputation. *Health Affairs* 24:1150-60.

Integrated Pilots *Coordinated Health System*



- Public-private partnership to refocus on prevention and proactive health care
- Scalable community focused interventions: information & tools support patients & providers to successfully manage chronic conditions
- Healthy Living Workshops (state funded; referred by physician); patients report improved health, reduced physician/ER visits
- Medical home pilots with payment incentives from Medicaid & private insurers
- Web-based chronic care patient information system and health information exchange

Conclusion: Aiming Higher

- States play a key role but cannot go it alone; federal action needed to “raise the floor” on performance
- Leading states emphasize access and promote culture of quality and collaboration
- Urgent need for federal and state action that takes a whole-system population perspective and addresses access, quality and cost/efficiency
 - Target primary care and population health
 - Care systems that integrate and coordinate care
 - All states have opportunities to teach & learn



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Also see: Greg Moody and Sharon Silow-Carroll, *Aiming Higher for Health System Performance: A Profile of Seven States that Perform Well on the Commonwealth Fund's State Scorecard*, The Commonwealth Fund, Oct. 2009, www.commonwealthfund.org.



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State Scorecard 2009

This interactive U.S. map draws from [The Commonwealth Fund State Scorecard, 2009](#). Use the map to view state-specific rankings and results compared to benchmarks, and to view the number of lives and dollars each state could save by achieving benchmark levels of performance. Use the tool on the right to select years, performance indicators, and states for comparison and then generate custom, downloadable tables and bar charts. Please send feedback to webeditor@cmwf.org.

change map:

Overall Ranking

Data by State

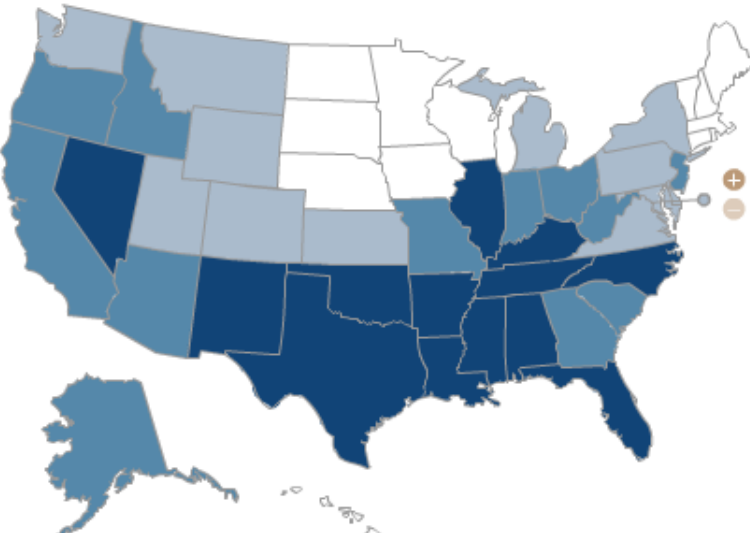
Overall Rank: 2009

1-13

14-26

27-38

39-51



Browse the State Scorecard

Select a State

View

Compare Data Across States

Select a Dimension

Select Scorecard years to compare:

2009

Revised 2007

Select states to compare (All):

Alabama

Kentucky

North Dakota

Alaska

Louisiana

Ohio

Arizona

Maine

Oklahoma

Arkansas

Maryland

Oregon

California

Massachusetts

Pennsylvania

Colorado

Michigan

Rhode Island

Connecticut

Minnesota

South Carolina

Delaware

Mississippi

South Dakota

District of Columbia

Missouri

Tennessee

Florida

Montana

Texas

Georgia

Nebraska

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