Creating a High Performance Health System

Dakota Conference on Rural and Public Health
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To What do these 3 Phrases Refer

“a dangerous path”

“no time to waste”

“collision course”

? Terrorism, Pandemic, Outsourcing U.S. jobs?
They are Observations about Health Care

(Michael Porter, 2006)

Concern is Crystallizing

"The old models of medical care and public health delivery no longer work... the US health care system, both public and private, is in imminent danger of collapse... the public health system is faring even worse than private health care."

(AHA Health Research and Education Trust Sept. 2006)
The overarching mission of a high performance health system is to help everyone, to the extent possible, lead long, healthy, and productive lives.

(Commonwealth Commission)
What do we need to Focus on to be the Best?

A high performance health system is designed to achieve four core goals:

1. high quality, safe care
2. access to care for all people
3. efficient, high value
4. system capacity to improve

Where do we Begin?

To Achieve a High Performance Health System:

• Commit to a clear national strategy.
• Deliver care through models that emphasize coordination and integration.
• Establish and track metrics for health outcomes, quality of care, access, disparities, and efficiency.
Scores: Dimensions of a High Performance Health System

Mortality Amenable to Health Care

Mortality from causes considered amenable to health care is deaths before age 75 that are potentially preventable with timely and appropriate medical care.

(Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006)
Mortality Amenable to Health Care

Mortality from causes considered amenable to health care is deaths before age 75 that are potentially preventable with timely and appropriate medical care.

Deaths per 100,000 population*

<table>
<thead>
<tr>
<th>State</th>
<th>10th</th>
<th>25th</th>
<th>Median</th>
<th>75th</th>
<th>90th</th>
</tr>
</thead>
<tbody>
<tr>
<td>U.S. average</td>
<td>83</td>
<td>84</td>
<td>90</td>
<td>103</td>
<td>119</td>
</tr>
<tr>
<td>North Dakota</td>
<td>110</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

State Variation, 2002

Infant Mortality Rate, 2002

International variation

Infant deaths per 1,000 live births

(Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006)
Infant Mortality Rate, 2002

State variation

<table>
<thead>
<tr>
<th>Infant deaths per 1,000 live births</th>
<th>U.S. average</th>
<th>10th %ile</th>
<th>25th %ile</th>
<th>Median</th>
<th>75th %ile</th>
<th>90th %ile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infant deaths</td>
<td>7.0</td>
<td>6.3</td>
<td>5.3</td>
<td>6.0</td>
<td>7.1</td>
<td>8.1</td>
</tr>
</tbody>
</table>

LONG, HEALTHY & PRODUCTIVE LIVES

Goals for a High Performance Health System

- HIGH QUALITY, SAFE, COMPASSIONATE, COORDINATED CARE
- ACCESS AND EQUITY FOR ALL
- LONG, HEALTHY, AND PRODUCTIVE LIVES
- EFFICIENCY
- CAPACITY FOR SYSTEM AND WORKFORCE INNOVATION AND IMPROVEMENT
States Vary In Quality of Care

2000–2001

Note: State ranking based on 22 Medicare performance measures.


U.S. Adults Receive Half of Recommended Care; Quality Varies Significantly by Medical Condition

Receipt of All Three Recommended Services for Diabetics, by Race/Ethnicity, Family Income, Insurance, and Residence, 2002

Percent of diabetics (ages 18+) who received HbA1c test, retinal exam, and foot exam in past year

- **Total**
  - 53

- **Private**
  - 54

- **Uninsured**
  - 24

- **Urban**
  - 55

- **Rural**
  - 45

* Insurance for people ages 18–64.
** Urban refers to metropolitan area >1 million inhabitants; Rural refers to noncore area <10,000 inhabitants. Data: Medical Expenditure Panel Survey (AHRQ 2005a).

(Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006)

Preventive Care Visits for Children, by Top and Bottom States, Race/Ethnicity, Family Income, and Insurance, 2003

Percent of children (ages <18) received BOTH a medical and dental preventive care visit in past year

- **U.S. average**
  - 59

- **North Dakota**
  - 49

- **Private Insurance**
  - 63

- **Uninsured**
  - 35


(Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006)
Children with a Medical Home, by Top and Bottom States, Race/Ethnicity, Family Income, and Insurance

Percent of children who have a personal doctor or nurse and receive care that is accessible, comprehensive, culturally sensitive, and coordinated*

- Child had 1+ preventive visit in past year; access to specialty care; personal doctor/nurse who usually/always spent enough time and communicated clearly, provided telephone advice or urgent care and followed up after the child’s specialty care visits.

*Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006

Pressure Sores Among High-Risk and Short-Stay Residents in Nursing Facilities

Percent of nursing home residents with pressure sores

By race/ethnicity, 2003

- Data: Nursing Home Minimum Data Set (AHRQ 2005a).
- (Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006)
Medicare Hospital 30-Day Readmission Rates, by Regions, 2003

Rate of hospital readmission within 30 days

<table>
<thead>
<tr>
<th>Regions</th>
<th>National Mean</th>
<th>North Dakota</th>
<th>10th</th>
<th>25th</th>
<th>75th</th>
<th>90th</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>18</td>
<td>16</td>
<td>14</td>
<td>16</td>
<td>20</td>
<td>22</td>
</tr>
</tbody>
</table>

Data: G. Anderson and R. Herbert, Johns Hopkins University analysis of 2003 Medicare Standard Analytical Files 5% Inpatient Data
(Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006)

Patients Reporting Any Error by Number of Doctors Seen in Past Two Years

Percent

<table>
<thead>
<tr>
<th>Countries</th>
<th>1 doctor</th>
<th>4 or more doctors</th>
</tr>
</thead>
<tbody>
<tr>
<td>AUS</td>
<td>12</td>
<td>40</td>
</tr>
<tr>
<td>CAN</td>
<td>15</td>
<td>37</td>
</tr>
<tr>
<td>GER</td>
<td>14</td>
<td>31</td>
</tr>
<tr>
<td>NZ</td>
<td>14</td>
<td>35</td>
</tr>
<tr>
<td>UK</td>
<td>12</td>
<td>28</td>
</tr>
<tr>
<td>US</td>
<td>22</td>
<td>48</td>
</tr>
</tbody>
</table>

2005 Commonwealth Fund International Health Policy Survey
Goals for a High Performance Health System

HIGH QUALITY, SAFE, COMPASSIONATE, COORDINATED CARE

ACCESS AND EQUITY FOR ALL

LONG, HEALTHY, AND PRODUCTIVE LIVES

EFFICIENCY

CAPACITY FOR SYSTEM AND WORKFORCE INNOVATION AND IMPROVEMENT

ACCESS: UNIVERSAL PARTICIPATION

Number of States with High Proportion of Uninsured Adults Ages 18–64 Is Growing

1999–2000

2004–2005


(Source: The Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006)
Uninsured in North Dakota

- 8.2% of North Dakotans are uninsured
- 51,920 people
  - Similar to the population of Bismarck
  - Over 11,000 are children
- Rural more likely to be uninsured

Goals for a High Performance Health System

- High Quality, Safe, Compassionate, Coordinated Care
- Access and Equity for All
- Long, Healthy, and Productive Lives
- Efficiency
- Capacity for System and Workforce Innovation and Improvement
**International Comparison of Spending on Health, 1980–2004**

*Average spending on health per capita (SUS PPP)*

- United States
- Germany
- Canada
- France
- Australia
- United Kingdom

*Total expenditures on health as percent of GDP*

(Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006)

**Efficiency**

*Percentage of National Health Expenditures Spent on Health Administration and Insurance, 2003*

<table>
<thead>
<tr>
<th>Country</th>
<th>2002</th>
<th>1999</th>
<th>2001</th>
</tr>
</thead>
<tbody>
<tr>
<td>France</td>
<td>1.9</td>
<td>2.1</td>
<td>2.1</td>
</tr>
<tr>
<td>Finland</td>
<td>2.6</td>
<td>2.6</td>
<td>2.6</td>
</tr>
<tr>
<td>Japan</td>
<td>3.3</td>
<td>3.3</td>
<td>3.3</td>
</tr>
<tr>
<td>Canada</td>
<td>4.0</td>
<td>4.1</td>
<td>4.2</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>4.8</td>
<td>5.6</td>
<td>7.3</td>
</tr>
<tr>
<td>Netherlands</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Austria</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Australia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Switzerland</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Germany</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>United States</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Includes claims administration, underwriting, marketing, profits, and other administrative costs; based on premiums minus claims expenses for private insurance.*

Data: OECD Health Data 2005.
Source: The Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006
Quality and Costs of Care for Medicare Patients Hospitalized for Heart Attacks, Colon Cancer and Hip Fractures, by Hospital Referral Regions, 2000-2002

Median Relative Resource Use = $25,995

* Indexed to risk-adjusted 1 year survival rate (median = 0.70).
** Risk-adjusted spending on hospital and physician services using standardized national prices.
Data: E. Fisher and D. Staiger, Dartmouth College analysis of data from a 20% national sample of Medicare beneficiaries.
(Source: The Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006)

The Dialogue Has Changed

FROM:
• “Americans have the best health care system in the world”

TO:
• We need to do better
  – We spend more on health care than any other country
  – We need more value for what we are spending
Keys to Transforming the U.S. and North Dakota Health Care System

1. Extend health insurance coverage
2. Safe, effective, and efficient care
3. Ensure coordinated and accessible care for all
4. Increase transparency, reward quality and efficiency
5. Information technology and exchange
6. Workforce for patient-centered and primary care
7. Collaboration among public and private stakeholders

Efforts to Extend Health Insurance Coverage to All

1. Extend Health Insurance Coverage to All
What Are the Most Important Health Care Issues for Presidential and Congressional Action?

<table>
<thead>
<tr>
<th>Percent listing issue as first or second priority:</th>
<th>Total</th>
<th>Less than $50,000</th>
<th>$50,000–$74,999</th>
<th>$75,000 or more</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure that all Americans have adequate, reliable health insurance</td>
<td>52</td>
<td>56</td>
<td>52</td>
<td>50</td>
</tr>
<tr>
<td>Control the rising cost of medical care</td>
<td>37</td>
<td>35</td>
<td>42</td>
<td>39</td>
</tr>
<tr>
<td>Lower the cost of prescription drugs</td>
<td>31</td>
<td>31</td>
<td>27</td>
<td>33</td>
</tr>
<tr>
<td>Ensure that Medicare remains financially sound in the longterm</td>
<td>29</td>
<td>29</td>
<td>32</td>
<td>30</td>
</tr>
<tr>
<td>Improve the quality of nursing homes and long-term care</td>
<td>14</td>
<td>16</td>
<td>15</td>
<td>13</td>
</tr>
<tr>
<td>Reform the medical malpractice system</td>
<td>14</td>
<td>10</td>
<td>12</td>
<td>18</td>
</tr>
<tr>
<td>Reduce the complexity of insurance</td>
<td>12</td>
<td>12</td>
<td>10</td>
<td>10</td>
</tr>
</tbody>
</table>


Pursue Excellence in Provision of Safe, Effective, and Efficient Care

1. Extend Health Insurance Coverage to All

2. Pursue Excellence in Provision of Safe, Effective, and Efficient Care
Perfect Care

- When is performance good enough?
  - For you; for your family
- Near-perfection is attainable even in health care
- The question we all should be asking:
  - How soon can we achieve perfect care?
    - Within our organization
    - Across the entire health care system

Percent of Heart Failure Patients Given Discharge Instructions - Why Not the Best?

Top Hospitals represents the top 10% of hospitals nationwide. Top hospitals achieved a 91% rate or better.

(http://www.hospitalcompare.hhs.gov)
Percent of Pneumonia Patients Given Initial Antibiotic(s) within 4 Hours After Arrival - Why Not the Best?

- Average All Reporting Hospitals: 78%
- Average All Hospitals in North Dakota: 89%
- The same rural North Dakota Hospital: 98%

Top Hospitals represents the top 10% of hospitals nationwide. Top hospitals achieved a 92% rate or better.

Critical Access Hospital Quality in North Dakota

FOCUSING ON:
1. Develop an infrastructure that supports rural hospital efforts to enhance the quality of care provided to rural residents.
2. Position rural hospitals to meet future challenges to the rural health care environment, including quality-based reimbursement.

INVOLVE:
- CAHs, rural non-CAHs, tertiary partners (94% of hospitals participating)
- Center for Rural Health, ND Healthcare Review, Inc., ND Healthcare Association
- ND Department of Health
- CEOs, DONs, QI Coordinators, Tertiary liaisons, Network representatives
- Montana Performance Improvement Network and Billings Clinic

SPONSORED BY:
- ND Small Hospital Improvement Program (SHIP)
- ND Medicare Rural Hospital Flexibility Program (Flex)
Organize the Care System to Ensure Coordinated and Accessible Care for All

1. Extend Health Insurance Coverage to All

2. Pursue Excellence in Provision of Safe, Effective, and Efficient Care

3. Organize the Care System to Ensure Coordinated and Accessible Care for All

Population Centered Care Coordination....
Expand Primary Care and Preventive Services

• Health is better in areas where there are more primary care physicians or more primary care services
• People who receive primary care are healthier
• Costs of care are lower in areas where there are more primary care services
• More primary care is associated with more equitable care


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**Primary Care Score vs. Health Care Expenditures, 1997**

![Graph showing the relationship between primary care score and per capita health care expenditures for different countries in 1997.](Starfield 10/00 IC 1731)
Care Coordination

Base: Have seen a doctor in past 2 years

<table>
<thead>
<tr>
<th>Percent saying in the past 2 years:</th>
<th>AUS</th>
<th>CAN</th>
<th>NZ</th>
<th>UK</th>
<th>US</th>
</tr>
</thead>
<tbody>
<tr>
<td>Test results or records not available at time of appointment</td>
<td>12</td>
<td>14</td>
<td>13</td>
<td>13</td>
<td>17%</td>
</tr>
<tr>
<td>Duplicate tests: doctor ordered test that had already been done</td>
<td>7</td>
<td>6</td>
<td>7</td>
<td>4</td>
<td>14</td>
</tr>
<tr>
<td>Received conflicting information from different doctors</td>
<td>18</td>
<td>14</td>
<td>14</td>
<td>14</td>
<td>18</td>
</tr>
</tbody>
</table>

(Source: 2004 Commonwealth Fund International Health Policy Survey)

Increase Transparency and Reward Quality and Efficiency

1. Extend Health Insurance Coverage to All
2. Pursue Excellence in Provision of Safe, Effective, and Efficient Care
3. Organize the Care System to Ensure Coordinated and Accessible Care for All
4. Increase Transparency and Reward Quality and Efficiency
Medicare/Premier Hospital Quality P4P Demonstration

- First year results = significant improvement; composite score increased -
  - AMI: 87% to 91%
  - Heart Failure: 65% to 74%
  - Pneumonia: 69% to 79%
- Patients receiving better care showed lower mortality (AMI, CHF)
- Cost savings for hospitals (AMI, Pneumonia, CABG) and Medicare

(Source: Premier, “Centers for Medicare and Medicaid Services/Premier Hospital Quality Incentive Demonstration Project: Project Overview and Findings from year One,” April 2006; and Premier, “Exploring the Nexus of Quality and Cost: Methodology and Preliminary Findings,” August 2006.)

Primary Care Doctors’ Reports of Any Financial Incentives Targeted on Quality of Care

*Percent reporting any financial incentive*

*Receive of have potential to receive payment for: clinical care targets, high patient ratings, managing chronic disease/complex needs, preventive care, or QI activities

(Source: 2006 Commonwealth Fund International Health Policy Survey of Primary Care Physicians)
Expand the Use of Information Technology and Exchange

1. Extend Health Insurance Coverage to All
2. Pursue Excellence in Provision of Safe, Effective, and Efficient Care
3. Organize the Care System to Ensure Coordinated and Accessible Care for All
4. Increase Transparency and Reward Quality and Efficiency
5. Expand the Use of Information Technology and Exchange

Electronic Medical Records and Information Systems

- Reduce duplicate tests
- Provide decision support for physicians and patients
- Facilitate “referrals,”
- Reduce medical errors
- Promote better management of chronic conditions and care coordination
  - Registries
  - Performance information
Physicians’ Use of Electronic Medical Records, U.S. Compared with Other Countries, 2000–2001

Percent of physicians

Countries: EU Average, Ireland, Australia*, Greece, United States*, Canada*, Spain, France, Portugal.

* 2000


(Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006)

Primary Care Practices with Advanced Information Capacity

Percent reporting 7 or more out of 14 functions*

Countries: NZ, UK, AUS, NET, GER, US, CAN.

*Count of 14: EMR, EMR access other doctors, outside office, patient; routine use electronic ordering tests, prescriptions, access test results, access hospital records; computer for reminders, Rx alerts, prompt test results; easy to list diagnosis, medications, patients due for care.

(Source: 2006 Commonwealth Fund International Health Policy Survey of Primary Care Physicians)
Payment for telephone call from pt.: 25 DKR or $4 Payment for E-mail from/to pt.: 50 DKR or $8

(Source: I. Johansen, "What Makes a High Performance Health Care System and How Do We Get There? Denmark," Presentation to the Commonwealth Fund International Symposium, November 3, 2005.)

North Dakota Health Information Technology (HIT) Steering Committee

- **Vision** is to implement a statewide health information technology and exchange infrastructure.
- **Mission** is to facilitate the adoption and use of health information technology and exchange to improve healthcare quality, patient safety, and overall efficiency of health care and public health services in North Dakota.
Encourage Leadership and Collaboration Among Public and Private Stakeholders

1. Extend Health Insurance Coverage to All
2. Pursue Excellence in Provision of Safe, Effective, and Efficient Care
3. Organize the Care System to Ensure Coordinated and Accessible Care for All
4. Increase Transparency and Reward Quality and Efficiency
5. Expand the Use of Information Technology and Exchange
6. Develop the Workforce to Foster Patient-Centered and Primary Care
7. Encourage Leadership and Collaboration Among Public and Private Stakeholders

By Engaging…

- Broad-based coalition of clinicians, hospitals, public health, health plans, purchasers, and government agencies

- For example, on a common quality agenda, including shared guidelines and tools, reporting quality measures and patient satisfaction measures
At the State Level…What We Can Do:

Promote:
- evidence-based health care
- effective chronic care management
- transitional care post-hospital discharge
- data transparency and reporting on performance
- practice value-based purchasing
- the use of health information technology
- wellness and healthy living
- access to primary care and preventive services
- simplify and streamline public program eligibility

At the Individual and Organization Level…

What We All Must **STOP** Doing

Protect Our Turf
(there is still a lot of turf to go around)
and work together
Achieve a High Performance Health System:

When excellence in these dimensions is doable -- average isn’t good enough.

Why Not the BEST for North Dakota and the Nation?

For more information contact:
Center for Rural Health
University of North Dakota
School of Medicine and Health Sciences
Grand Forks, ND 58202-9037

Tel: (701) 777-3848
Fax: (701) 777-6779

http://medicine.nodak.edu/crh
Email: mwake@medicine.nodak.edu

Connecting resources and knowledge to strengthen the health of people in rural communities.