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Center for Mississippi Health Policy

HEALTHCARE SYSTEM PERFORMANCE:

MISSISSIPPI INDICATORS AND HEALTHCARE INFRASTRUCTURE

Summary Brief & Policy Proposals

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The Center for Mississippi Health Policy (C4MHP) published Healthcare *System Performance: Mississippi Indicators & Healthcare Infrastructure, Opportunities for Improvement* in May 2022. The report provided an update to the C4MHP's original healthcare system performance report from 2013. This issue brief highlights the 2022 report's findings on the quality and performance of Mississippi healthcare systems and provides program and policy considerations for improvement.

UPDATES FROM CURRENT DATA

At the time of the C4MHP 2013 report, the state's use of hospital care for chronic and preventable conditions was the highest in the nation, while utilization of primary and preventive care was the lowest. These trends in utilization resulted in a higher prevalence of chronic conditions throughout the state and, as hospital care is costlier than primary care, created financial burdens on our healthcare systems. Strategic interventions to address these issues were established and categorized into four dimensions of the healthcare system. Interventions that have focused on provider workforce and payment systems will be highlighted in this brief.

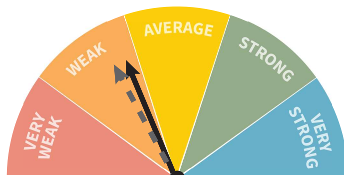
- Provider Workforce
- Performance Measurement
- Payment System Reform
- Service Delivery Models

The Agency for Healthcare Research and Quality (AHRQ)'s annual report, the *National Healthcare Quality and Disparities Report*, includes an overall performance assessment for state health systems. The AHRQ State Snapshots in **Figure 1** show that improvements have been made in Mississippi[1]. For example, **Figure 2** shows that in some areas of the state the 30-Day Hospital Re-admission Rates fell below the national average between 2009 and 2018[2]. However, areas of the state where these rates remain higher than the national average are predominantly low-income communities and communities of color where disparities in health have persisted.

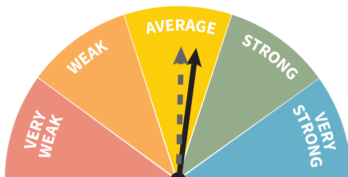
Despite any improvements, Mississippi continues to maintain the worst performing healthcare system in the United States. Reports indicate persistent, major issues with the cost and utilization of services in Mississippi and with preventable hospital re-admissions and admissions due to ambulatory care-sensitive conditions[3]. Several initiatives and programs have been implemented to

FIGURE 1:
AHRQ State Snap Shot

2011*



2019**



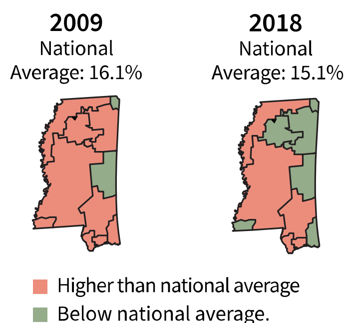
Most Recent Data
Baseline Year

*Based on a composite of 105 measures
**Based on a composite of more than 250 measures

Source: Agency for Healthcare Research & Quality

FIGURE 2:
30 Day Readmission Rates in Mississippi, 2009-2018

2009 National Average: 16.1%
2018 National Average: 15.1%

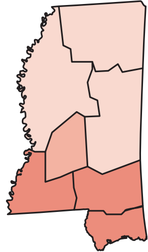


Higher than national average
Below national average.

Source: Dartmouth Atlas of Healthcare

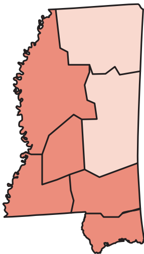
FIGURE 3:
PREVENTABLE HOSPITALIZATIONS FOR CHRONIC CONDITIONS, 2016
PER 100,000 POPULATION

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)



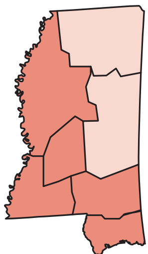
- 311.6 to 407.2
- 411.4 to 544.6
- 549.2 to 2,184.1

CONGESTIVE HEART FAILURE



- 94.5 to 228.5
- 427.3 to 891.2

DIABETES



- 115.3 to 142.2
- 211.7 to 385.1

Source: Statistical Brief #264. Healthcare Cost & Utilization Project. September 2020

address healthcare costs, quality, and access. The state has tested and adopted innovative models for the payment and delivery of services and has enhanced data standards to better monitor and improve the quality and performance of healthcare systems. Coordination of efforts has improved, and the state's approach to the development of strategies has become increasingly comprehensive and collaborative, but there is still significant work to be done and many gaps left to bridge.

CURRENT TRENDS & IMPLICATIONS

In 2020, it was reported that Mississippi had made consistent improvements across the same 16 metrics between 2014 and 2018 – more than most other states. However, throughout this five-year period of notable improvement, overall performance of the state's healthcare systems were consistently the worst when compared to the national standard. Comparing these two points highlights the amount of work it will take to accomplish meaningful change that actively improves our healthcare systems[4].

Trends in the utilization of primary and preventive care are typical indicators for rates of preventable hospitalizations within state healthcare systems because of this type of care's implications on the prevalence and severity of chronic conditions. Data from 2016 shows that Mississippi has the highest rates of potentially preventable hospitalizations for chronic conditions in the United States. In Mississippi, these rates are highest for COPD related conditions, followed by congestive heart failure and diabetes. The regional variations in the rates of preventable hospitalizations, shown in **Figure 3** where darker shades of red indicate higher rates, highlight disparities in the quality of care for chronic conditions throughout Mississippi[5].

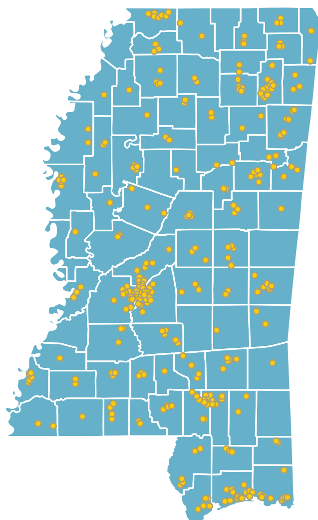
PROGRESS TOWARD IMPROVED OUTCOMES

In 2013, methods and strategies were initiated at national- and state-levels to address health system performance in the areas of healthcare workforce, payment systems, service delivery, and performance measures. Since then, Mississippi strategies have included several efforts to reduce and maintain costs, bolster the provider workforce, and enhance the coordination of care with particular emphasis on general practitioners and the provision of primary and preventive care.

PROVIDER WORKFORCE

Increasing the number of primary care physicians (PCP) has been the focus of efforts for improving the healthcare workforce in Mississippi. In 2012, the legislature passed House Bill 317, establishing the Office of Mississippi Physician Workforce (OMPW). The OMPW was established to oversee workforce

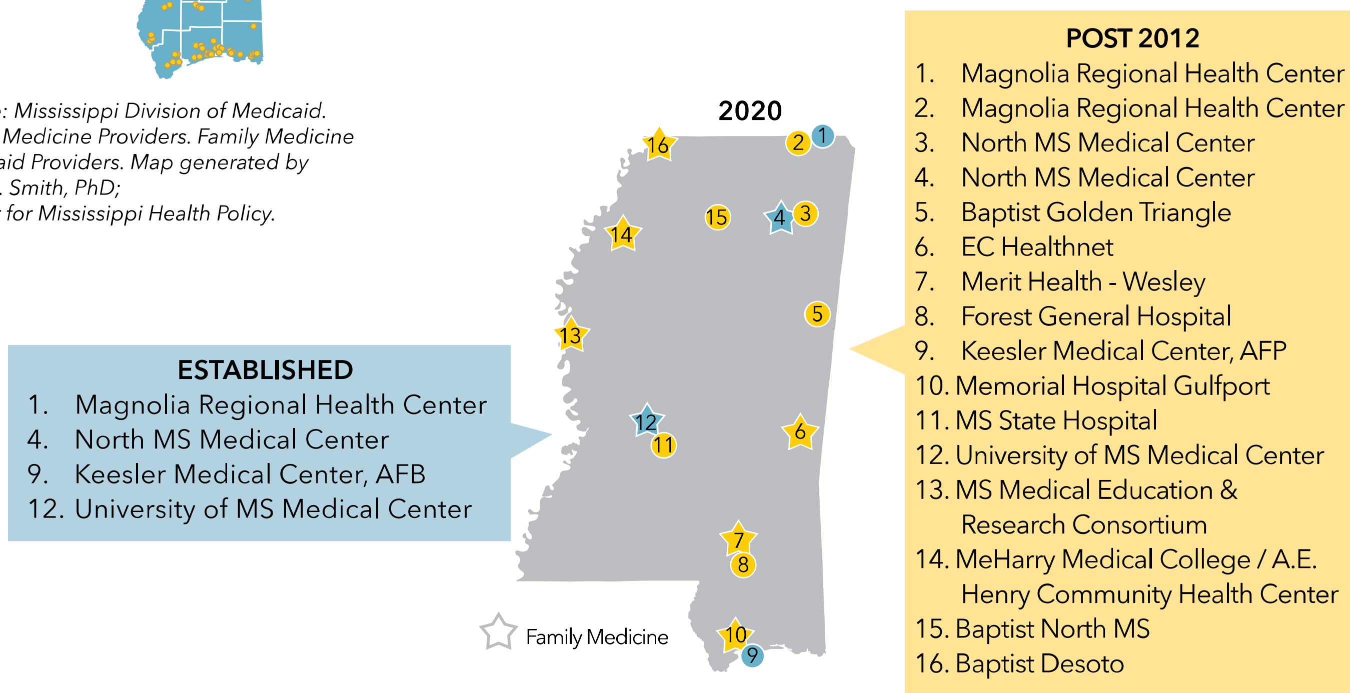
FIGURE 4:
FAMILY MEDICINE MEDICAID PROVIDERS



Source: Mississippi Division of Medicaid. Family Medicine Providers. Family Medicine Medicaid Providers. Map generated by Larry L. Smith, PhD; Center for Mississippi Health Policy.

development and to administer financial support to establish additional accredited graduate medical education (GME) programs in family medicine[6]. Projections from 2012 indicated that an additional 2,100 PCPs would be needed by 2020 for Mississippi to address provider shortages and improve access to primary and preventive services. However, Mississippi had only retained 116 additional PCPs at the end of 2020[7]. The OMPW was successful in the development of additional GME programs throughout the state, however, greater retention of additional PCPs has not been achieved. ***Reforms to payment and delivery systems and provider scopes of practice, as well as expansions to public and private health insurance coverage, will be key to the development of expanded primary care services with greater access and quality.***

FIGURE 5: GRADUATE MEDICAL EDUCATION SITES



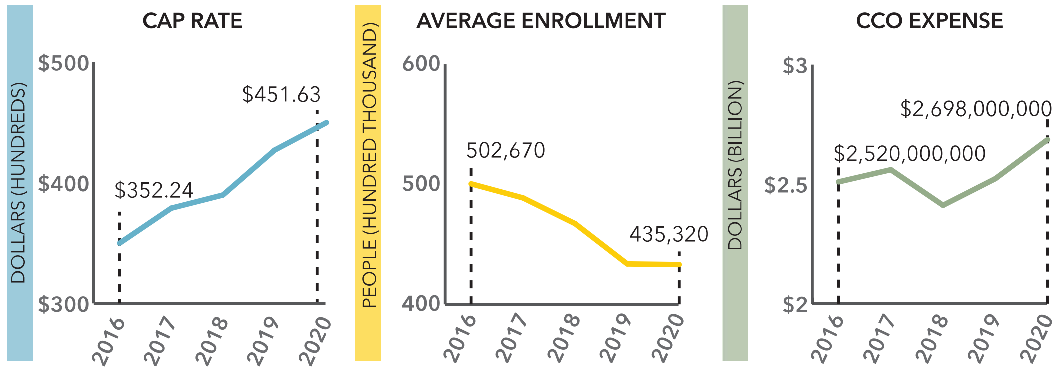
Source: Office of Mississippi Workforce, Director's Report. 2021

PAYMENT SYSTEM REFORM

In conjunction with low concentrations of PCPs, another indicator of poor health system performance are the levels of health expenditures. States with higher rates of healthcare spending per capita tend to have lower quality performance scores. Mississippi worked to address this in 2011 when the Mississippi Division of Medicaid (DOM) implemented the Mississippi Coordinated Access Network (MSCAN) as an effort to improve quality and lower costs[8]. The MSCAN program was expanded in 2016 to cover more people and services and, as a result, expenditures increased by 135%. In 2017, reports were completed on the operational and cost-effectiveness of MSCAN. A report from Navigant Consulting indicated insufficient oversight and monitoring of the program as

well as minimal improvements in select measures, while several other basic health measures had worsened[9]. Another report by Myers & Stauffer highlighted millions of dollars that MSCAN had saved the State of Mississippi between 2011 and 2017[10]. However, because denied or uncovered services are not considered in this analysis, these reported savings do not necessarily translate to reduced costs or improved quality and access. ***Since the expansions to MSCAN in 2016, enrollment continues to drop while expenditures continue to grow.***

FIGURE 6: MSCAN FISCAL ENROLLMENT DATA, 2015-2020



Source: DOM website, MACSTATS, Milliman Actuarial Analysis

POLICY CONSIDERATIONS

Mississippi should continue to focus on the delivery of primary and preventive care throughout the state and begin to consider more innovative models of service delivery. For Mississippi to improve health outcomes and reduce healthcare costs, both local and state leaders should acknowledge and carefully study how the rurality of the state and various determinants of health have led to limited access to care and the disparities that exist throughout the state. Several strategies and state policies exist that address the delivery of care in rural areas and are aimed at reducing the costs of healthcare overall.

Bridge the Provider Shortage Gap

Rural Mississippi presents unique barriers to the delivery of high-quality, affordable care. While chronic conditions and the COVID-19 Pandemic have increased the demand for primary care services, the state continues to struggle with the retention of PCPs in its most underserved areas. Other states have worked to bridge this gap by implementing policies that address scope of practice and incorporate the services of **non-physician providers** such as nurse practitioners (NPs), physician assistants (PAs), as well as midwives, doulas, and community health workers.

While struggling to resolve provider shortages with NPs or PAs, a provider group known as **Community Health Workers** (CHWs)

NON-PHYSICIAN PROVIDERS

Nurse practitioners, clinical nurse specialists, and physician assistants are healthcare providers who practice either in collaboration with or under the supervision of a physician.

COMMUNITY HEALTH WORKERS

Frontline public health workers who are trusted members of and/or have a deep understanding of the community served.

$1.00 INVESTMENT IN COMMUNITY HEALTH WORKERS YIELDS $11.32 RETURN ON INVESTEMENT

Source: Kentucky Homeplace Program ROI Study, Rural Health Information Hub

PERSONAL HEALTH LITERACY

The degree to which individuals have the ability to find, understand, and use information and services to inform health-related decisions and actions for themselves and others.

ORGANIZATIONAL HEALTH LITERACY

The degree to which organizations equitably enable individuals to find, understand, and use information and services to inform health-related decisions and actions for themselves.

have shown to be an impactful and cost-effective alternative. CHWs are defined as "frontline public health workers who are trusted members of and/or have a deep understanding of the community served," and have shown great impacts on improving health outcomes, reducing costs to the state, and linking patients to social services and community resources[11]. CHWs currently practice throughout Mississippi and are typically employed by nonprofits and community organizations. However, these entities lack consistency in the credentialing, monitoring, and funding of CHW services. States have worked to organize their CHW workforce for a greater impact through legislation that establishes or amends the process for certification or licensing, the scope of practice for CHWs, and 21 states have authorized the reimbursement of CHW services through Medicaid or private insurance. With existing state strategies and frameworks, and current federal funding opportunities that provide significant investments toward improving community health and the community health workforce, Mississippi is positioned to develop impactful CHW policies and programs. The Mississippi Legislature could address provider shortages and poor health outcomes in rural areas through policies that organize the CHW workforce and provide funding toward the credentialing, recruitment, and retention of CHWs throughout Mississippi's rural areas and health systems.

Health Education & Literacy

Health literacy involves the extent to which information and services are used to inform health decision-making. Healthy People 2030 define both ***personal health literacy*** and ***organizational health literacy***. With greater personal health literacy, individuals can make more informed health decisions and access the best, most appropriate care they need. Strong organizational health literacy enhances personal health literacy because the information provided by these organizations is easily and equitably accessible. Strong health literacy overall can improve health outcomes and reduce costs, but also streamlines the use and coordination of health care, social services, and community resources[12]. States have recently begun using a Health in All Policies (HiAP) approach to enhance both personal and organizational health literacy. HiAP is, "a collaborative approach to improving the health of all people by incorporating health considerations into decision-making across sectors and policy areas. This approach identifies the ways in which decisions across multiple sectors affect health, and how better health can support the achievement of goals from multiple sectors[13]." ***Consideration for the health impacts of multisector policies has also been key to accomplishing greater health equity and addressing disparities that stem from the determinants of health.***

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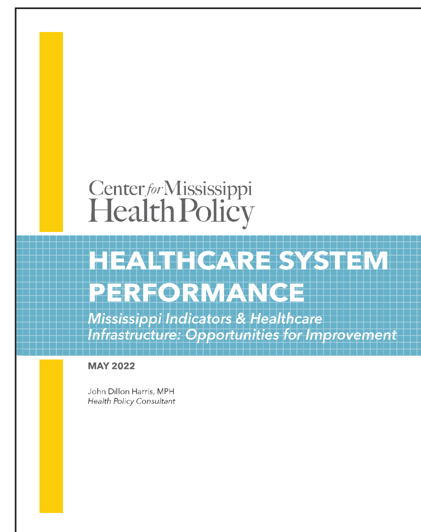

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