VISION OF HEALTH AND HEALTH CARE TRANSFORMED

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Members of the National Committee on Vital and Heath Statistics (NCVHS) Executive Subcommittee: I appreciate the opportunity to speak with you this morning about a vision of health and health care transformed. I am Stephen C. Schoenbaum, M.D., Executive Vice President for Programs at The Commonwealth Fund and Executive Director of the Commonwealth Fund Commission on a High Performance Health System. This Commission, which has been meeting three times yearly since July 2005, has stated that the objective of health care and a health system, for a population and the individuals in it, is to lead to longer, healthier and more productive lives. For health care to make this contribution everyone must have access to it; and the care must be of excellent quality (effective and safe), efficient (without waste of time or resources), and equitable.[1] The Commission has gone further to recommend five key strategies to achieve these outcomes. These are (Exhibit 1):

Exhibit 1. Five Key Strategies for High Performance

1. **Extend affordable health insurance to all**
2. **Align financial incentives to enhance value and achieve savings**
3. **Organize the health care system around the patient to ensure that care is accessible and coordinated**
4. **Meet and raise benchmarks for high-quality, efficient care**
5. **Ensure accountable national leadership and public/private collaboration**

THE COMMONWEALTH FUND

Source: Commission on a High Performance Health System, *A High Performance Health System for the United States: An Ambitious Agenda for the Next President,* The Commonwealth Fund, Nov. 2007.

[1] Commission on a High Performance Health System, *Framework for a High Performance Health System for the United States*, The Commonwealth Fund, Aug. 2006.

- Extend affordable health insurance to all;
- Align financial incentives to enhance value and achieve savings;
- Organize the health care system around the patient to ensure that care is accessible and coordinated;
- Meet and raise benchmarks for high-quality, efficient care; and
- Ensure accountable national leadership and public/private collaboration.[2]

In addition, my colleagues Karen Davis, president of The Commonwealth Fund, Cathy Schoen, and I, back at the turn of the millennium set out a "2020 Vision for a Patient-Centered Health System" that addresses your first question about the critical characteristics and enablers of a safe, patient-centered, high quality health system that optimizes patient outcomes.[3] That vision included the following elements (Exhibit 2):

Exhibit 2. A 2020 Vision for a Patient-Centered Health System

- **Superb access, quality, and safety for all**
- **Patient engagement in care**
- **Clinical information systems that support high-quality care, practice based learning, and quality improvement**
- **Care coordination**
- **Integrated and comprehensive team care**
- **Routine patient feedback to hospitals and physicians**
- **Publicly available information on patient-centered care, clinical quality, efficiency**

THE COMMONWEALTH FUND

Source: K. Davis, C. Schoen, and S. C. Schoenbaum, "A 2020 Vision for American Health Care," *Archives of Internal Medicine,* Dec. 11, 2000 160(22):3357–62.

[2] Commission on a High Performance Health System. *A High Performance Health System for the United States: An Ambitious Agenda for the Next President*, The Commonwealth Fund, Nov. 2007.

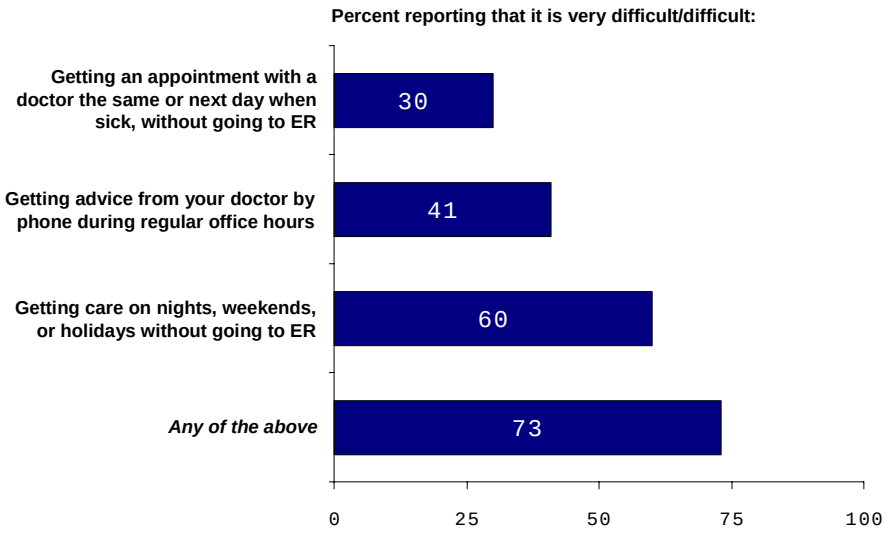
[3] K. Davis, C. Schoen, and S. C. Schoenbaum, "A 2020 Vision for American Health Care," *Archives of Internal Medidine*, Dec. 11, 2000 160(22):3357–62.

- Superb access, quality, and safety for all;
- Patient engagement in care;
- Clinical information systems that support high-quality care, practice based learning, and quality improvement;
- Care coordination;
- Integrated and comprehensive team care;
- Routine patient feedback to hospitals and physicians; and
- Publicly available information on patient-centered care, clinical quality, efficiency

Currently, the majority of adults in the U.S.—73 percent—report having access problems such as getting an appointment with a doctor the same or next day when sick without going to the emergency room—30 percent, getting advice from their doctor by phone during regular office hours—41 percent, or getting care on nights, weekends or holidays without going to the emergency room—60 percent (Exhibit 3).[4] In addition, 47 percent, report problems with coordination of care such as failure to provide important information about their medical history or test results to other doctors or nurses they think should have it, not having test results or medical records available at the time of a scheduled appointment, their physician not receiving a report back from a specialist they had seen, etc (Exhibit 4). Interestingly, roughly 90 percent or more report that it is important or very important to have one place or doctor responsible for primary care and coordinating care, having a place to go on nights and weekends besides the emergency room, having access to their own medical records, and having all of their doctors have access to their medical records when needed (Exhibit 5).

[4] S. K. H. How, A. Shih, J. Lau, and C. Schoen, *Public Views on U.S. Health System Organization: A Call for New Directions*, The Commonwealth Fund, Aug 2008.

Exhibit 3. Access Problems: Three of Four Adults Have Difficulty Getting Timely Access to Their Doctor



Source: Commonwealth Fund Survey of Public Views of the U.S. Health Care System, 2008.

Exhibit 4. Poor Coordination of Care Is Common, Especially if Multiple Doctors Are Involved

	Number of Doctors Seen		
Percent reporting in past two years:	**Any**	**1 to 2**	**3+**
After medical test, no one called or wrote you about results, or you had to call repeatedly to get results	**25**	**23**	**27**
Doctors failed to provide important information about your medical history or test results to other doctors or nurses you think should have it	**21**	**17**	**27**
Test results or medical records were not available at the time of scheduled appointment	**19**	**15**	**24**
Your primary care physician did not receive a report back from a specialist you saw	**15**	**11**	**22**
Your specialist did not receive basic medical information from your primary care doctor	**13**	**10**	**17**
Any of the above	**47**	**41**	**56**

Source: Commonwealth Fund Survey of Public Views of the U.S. Health Care System, 2008.

Exhibit 5. Majority Support More Accessible, Coordinated, and Well-Informed Care

Percent reporting it is very important/important that:	Total: Very important or important	Very important	Important
You have one place/doctor responsible for primary care and coordinating care	91	66	25
On nights and weekends, you have a place to go besides ER	89	58	30
You have easy access to your own medical records	94	68	27
All your doctors have easy access to your medical records	96	72	24
You have information about the quality of care provided by different doctors/hospitals	95	63	32
You have information about the costs of care to you before you actually get care	88	57	31

Note: Subgroups may not sum to total due to rounding.
Source: Commonwealth Fund Survey of Public Views of the U.S. Health Care System, 2008.

Several elements are central to both our personal vision and the Commission's vision of achieving excellent health outcomes and health care for all Americans. They include having:

- A health system that emphasizes primary care and enables each person who wants a primary care clinician to have one;
- Incentives that encourage coordination of care; and
- Robust programs and systems, including appropriate exchange of health information, that support better coordination of care and a variety of other services such as after-hours services.

The Commission on a High Performance Health System recommends "that patient and provider incentives should be aligned to encourage use of effective, evidence-based health services, avoid use of unproven or ineffective care, avoid misuse of services (for example, ineffective services that are sometimes provided at the end of life), and avoid over-utilization, duplication, and waste." In a recent set of papers, my colleagues and I have described how incentives, particularly payment incentives, interact with the way that care is organized and the degree to which caregivers become accountable for

care.[5] We have also argued that new, innovative, Medicare payment policies, including progressively sophisticated ways of paying for bundled care and of paying for performance, could lead the way in transforming the U.S. health system.[6]

With respect to information technology, the Commission on a High Performance Health System has stated, "Sufficient funding and leadership should be committed to achieve universal implementation of interoperable electronic information systems within five years, including electronic health records, electronic billing and claims payment, and provider decision support". The Commission recognizes that in practice, health information technology, used meaningfully, can be instrumental in providing evidence of effectiveness—just-in-time—through decision-support; avoiding duplication and waste through legible and accessible documentation of patient-specific information; and achieving better coordination of care by transfer of appropriate information among providers.

My personal history in health care as a physician, manager, and patient, has led me to believe that "meaningful use" of health information technology can best be realized through implementing systems that have basic functionalities that facilitate the care of patients by physicians, nurses and other providers. These systems need not necessarily be extremely complicated:

In 1981, I began working as a physician and manager at Harvard Community Health Plan in Boston, a staff model HMO that had begun to use a so-called "automated medical record" in 1972. In the era prior to the widespread use of workstations, when inputters entered information from encounter forms,[7] and the output was a dot-matrix printout, it was nonetheless possible to have a medical record with availability in multiple sites and to improve quality of care with appropriately deployed reminders and prompts.[8] Indeed, it was possible beginning in the 1980s for a patient to get care from a primary care clinician in one Harvard Community Health Plan location (there eventually were 14), specialty care at another location, urgent care at night or on the weekends at yet another location, and emergency care if needed in an affiliated Boston-area hospital. The entire record would be available to facilitate the patient's care in each location and document

[5] A. Shih, K. Davis, S. C. Schoenbaum, A. Gauthier, R. Nuzum, and D. McCarthy, *Organizing the U.S. Health Care Delivery System for High Performance*, The Commonwealth Fund, Aug. 2008

[6] S. Guterman, K. Davis, S. C. Schoenbaum, and A. Shih, "Using Medicare Payment Policy to Transform the Health System: A Framework for Improving Performance," *Health Affairs* Web Exclusive, Jan. 27, 2009, w238–w250.

[7] Entries to this record were from coded encounter forms; it was possible for a clinician to enter 160 characters per coded item before it became necessary to dictate; and only 7 percent of encounters resulted in dictation.

[8] S. C. Schoenbaum and G. O. Barnett, "Automated Ambulatory Medical Records Systems: An Orphan Technology," *International Journal of Technology Assessment in Health Care*, Fall 1992 8(4):598–609.

information needed by the next provider. In addition, beginning in the mid-1980s we developed a system of reminders and prompts to improve the provision of needed preventive care for patients in general and diabetic patients in particular. We also developed registries of patients with chronic conditions and provided the information in them to clinicians to enable appropriate follow-up of these patients.[9],[10],[11],[12] By implementing a tracking system for positive test results, it was possible to ensure that follow-up of abnormal tests such as a positive cervical cytology or "pap smear" was virtually 100 percent; and by appropriate programming of a laboratory-result-reporting system, we could provide clinicians with information about the appropriate next step for different types of abnormal pap smears.[13] Furthermore, although the original COSTAR system has now been replaced by an EPIC system, it has been possible to preserve and enhance the database. Today, if I go to the Harvard Vanguard Medical Associates web site, choose the "mychart" function, and provide suitable login information, I have access to portions of my medical records including, for example, my immunization history over the past 25 years. I can also request appointments and prescription renewals.

Many years ago the medical leadership of Harvard Community Health Plan began to establish an annual set of clinical goals—objectives for improvement of clinical care and outcomes that we wanted to achieve. These goals helped drive the "meaningful use" of the available information systems, indeed, helped harness the power of these systems for achieving better outcomes efficiently.

The vision of the Commission on a High Performance Health System and my own personal vision for achieving better health outcomes for the population of this country require having a national leadership that sets performance goals and facilitates the deployment of systems and incentives that will achieve the goals. Failure to have national leadership that establishes goals for performance of our health system—goals which in turn can drive development and use of systems and programs—has been, I believe, a central barrier to having a more effective and efficient health system in this country. The Commission on a High Performance Health System understands that a largely private

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[9] K. O. Murrey, L. K. Gottlieb, and S. C. Schoenbaum, "Ensuring Follow-Up in Ambulatory Care, *Forum* 1992 13(2):6–8.

[10] K. O. Murrey, L. K. Gottlieb, and S. C. Schoenbaum, "Implementing Clinical Guidelines: A Quality Management Approach to Reminder Systems," *Quality Review Bulletin*, Dec. 1992 18(12):423–33.

[11] M. B. Barton and S. C. Schoenbaum, "Improving Influenza Vaccination Performance in an HMO Setting: The Use of Computer-Generated Reminders and Peer Comparison Feedback," *American Journal of Public Health*, May 1990; 80(5):534–36.

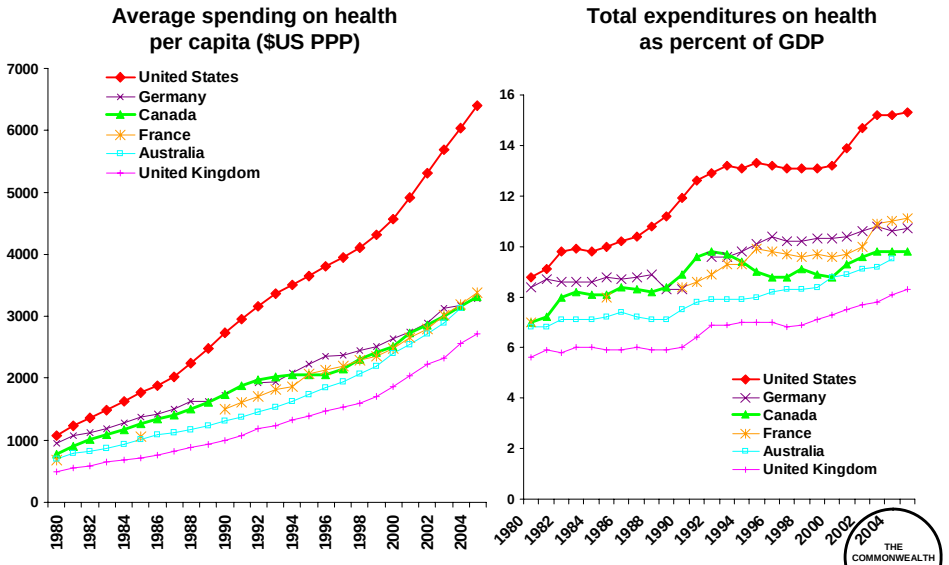
[12] S. C. Schoenbaum, "Implementation of Preventive Services in an HMO Practice," *Journal of General Internal Medicine*, Sept./Oct. 1990 5(5 Suppl.):S123–S127.

[13] S. C. Schoenbaum and L. K. Gottlieb, "Algorithm Based Improvement of Clinical Quality," *British Medical Journal*, Dec. 15, 1990 301(6765):1374–76.

health care system is an important feature of the U.S. health system, a feature that has been associated with an enviable track record of innovation. It also understands that not only do we have the most expensive health system of any developed country (Exhibit 6) but also that performance across our country is significantly poorer than that achieved in several others (Exhibit 7) and that overall performance averages about two-thirds of what can be achieved and varies enormously by where one lives (Exhibits 8, 9, 10).[14],[15] In virtually all other major developed countries, there is national leadership and balancing of the interests of patients with those of providers and insurers (where there are multiple insurers and payers). Despite our spending 17 percent of Gross Domestic Product on health care, and despite government being the single largest payer in this country, national leadership of the health system has been lacking. Starting with national setting of performance goals and ensuring accountable national leadership and public/private collaboration, we are much more likely to use our vast resources meaningfully, effectively, and efficiently.

Thank you!

Exhibit 6. International Comparison of Spending on Health, 1980–2005

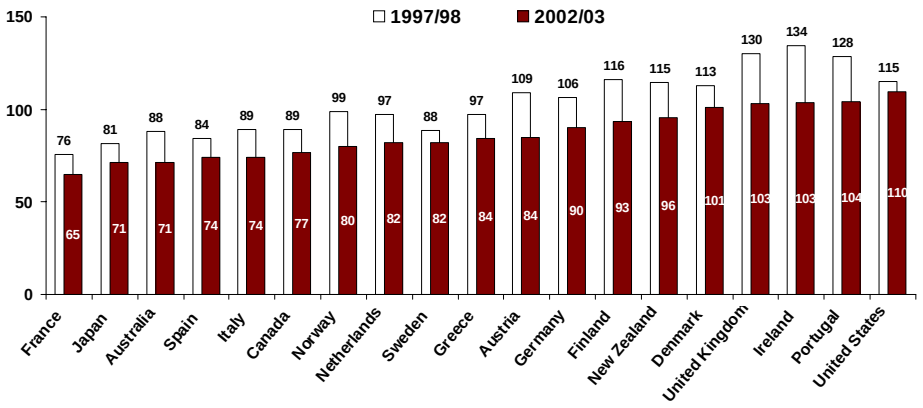


Source: K. Davis, C. Schoen, S. Guterman, T. Shih, S. C. Schoenbaum, and I. Weinbaum, *Slowing the Growth of U.S. Health Care Expenditures: What Are the Options?* The Commonwealth Fund, Jan. 2007, updated with 2007 OECD data.

[14] Commonwealth Fund Commission on a High Performance Health System, *Why Not the Best? Results from the National Scorecard on U.S. Health System Performance, 2008,* The Commonwealth Fund, July 2008.

[15] J. C. Cantor, C. Schoen, D. Belloff, S. K. H. How, and D. McCarthy, *Aiming Higher: Results from a State Scorecard on Health System Performance,* Commonwealth Fund Commission on a High Performance Health System, June 2007.

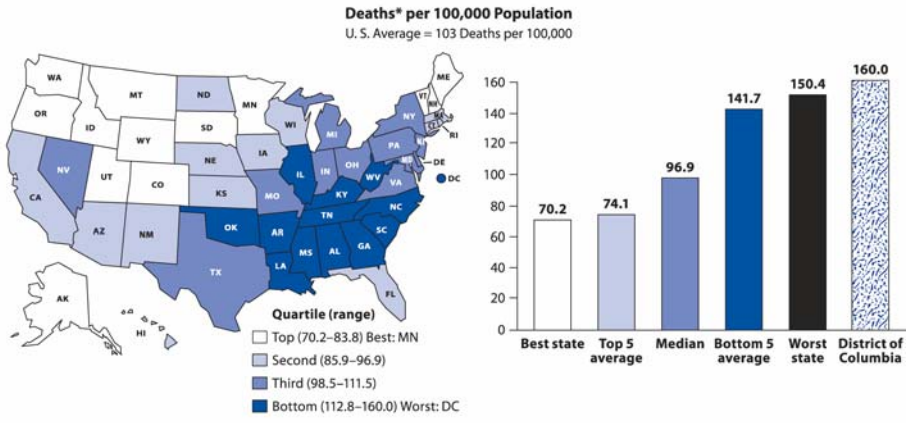
Exhibit 7. Mortality Amenable to Health Care



* Countries' age-standardized death rates before age 75; including ischemic heart disease, diabetes, stroke, and bacterial infections. See report Appendix B for list of all conditions considered amenable to health care in the analysis.
Source: E. Nolte and C. M. McKee, "Measuring the Health of Nations: Updating an Earlier Analysis," *Health Affairs,* Jan./Feb. 2008, 27(1):58–71.Data: Nolte and McKee analysis of World Health Organization mortality files.

HEALTHY LIVES

Exhibit 8.
Mortality Amenable to Health Care by State, 2002

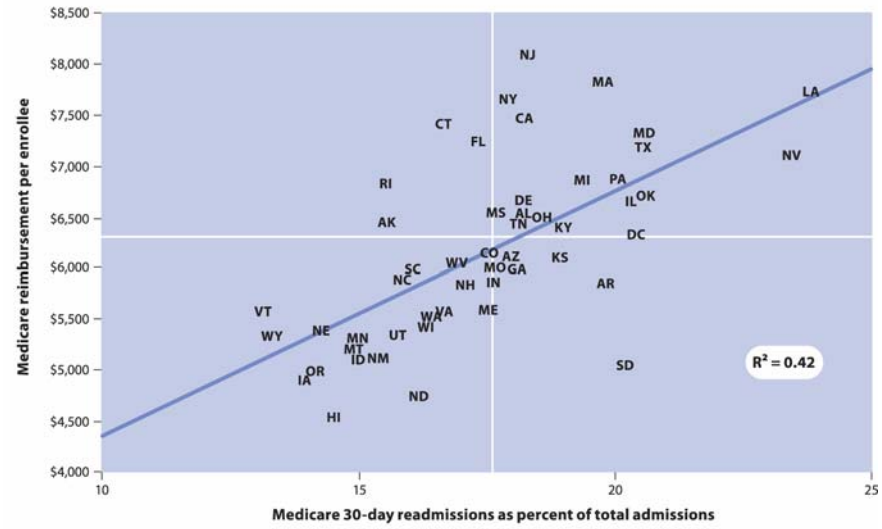


* Age-standardized deaths before age 75 from select causes; includes ischemic heart disease
DATA: Analysis of 2002 CDC Multiple Cause-of-Death data files using Nolte and McKee methodology, *BMJ* 2003.
SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2007

AVOIDABLE HOSPITAL USE AND COSTS

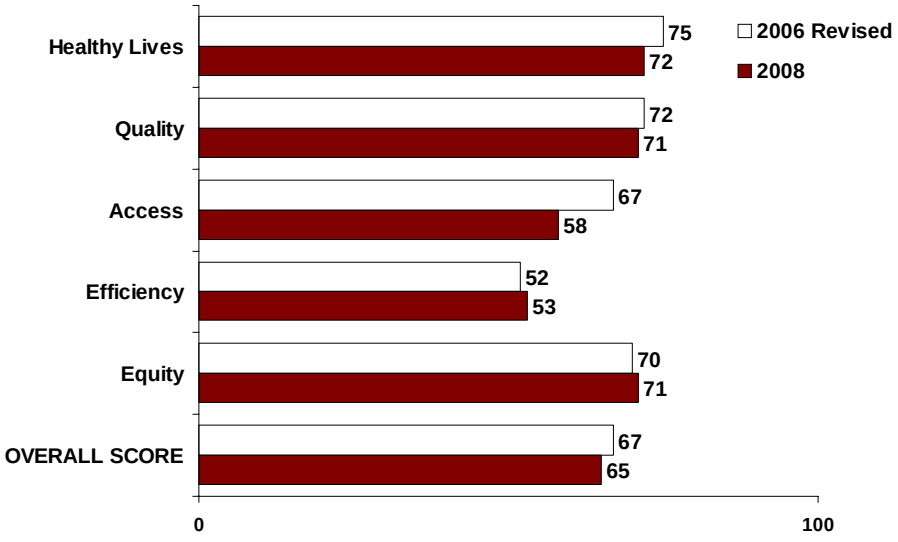
Exhibit 9.

Medicare Reimbursement and 30-Day Readmissions by State, 2003



DATA: Medicare reimbursement – 2003 Dartmouth Atlas of Health Care; Medicare readmissions – 2003 Medicare SAF 5% Inpatient Data
SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2007

Exhibit 10. Scores by Dimensions of a High Performance Health System



Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2008.