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Creating the Framework for High Performing Health Care Organizations

Stephen C. Schoenbaum, MD, MPH

Executive Vice President for Programs

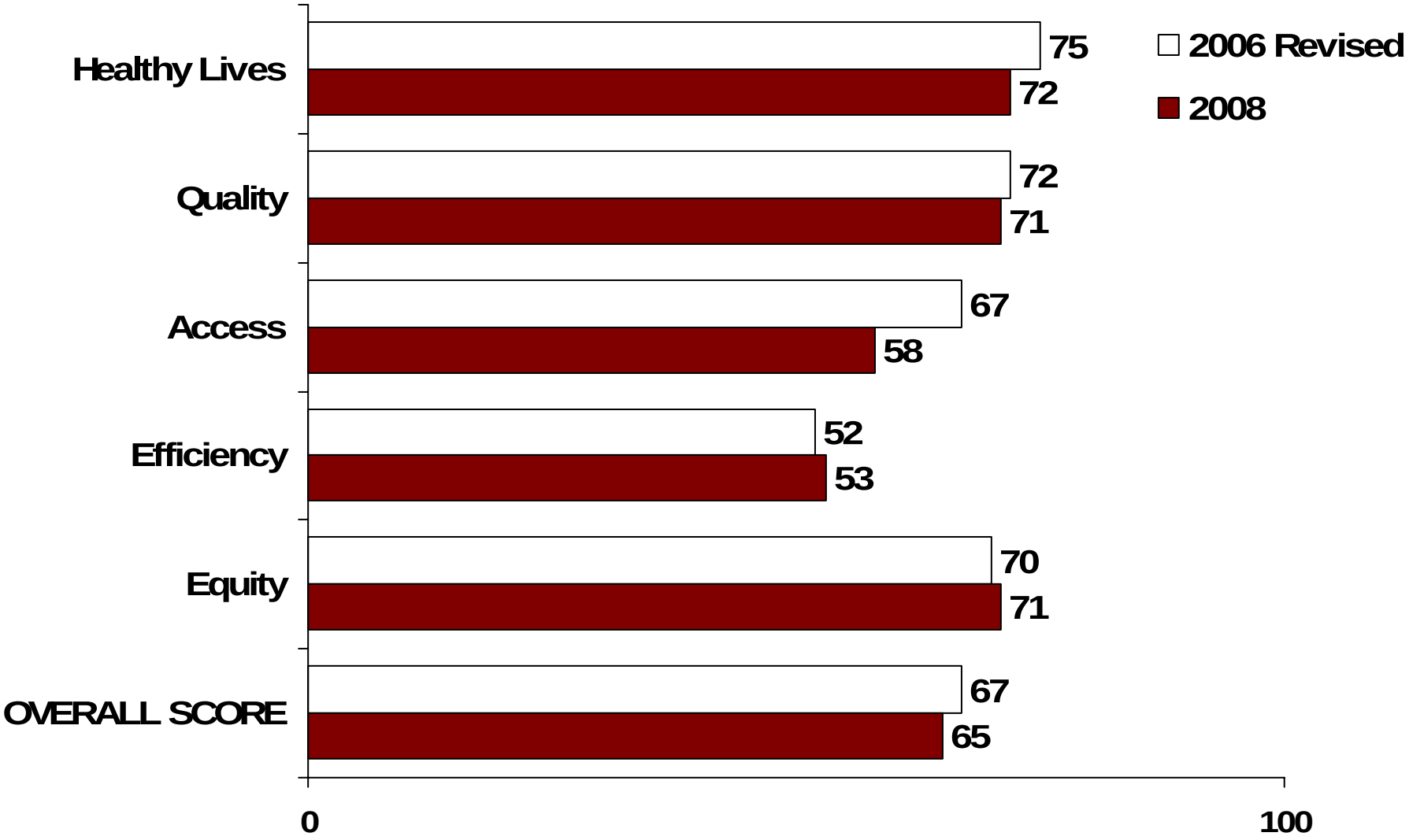
www.commonwealthfund.org

scs@cmwf.org

Public Hearing on Health Care Provider and Payer Costs and Cost Trends

Boston, MA, March 18, 2010

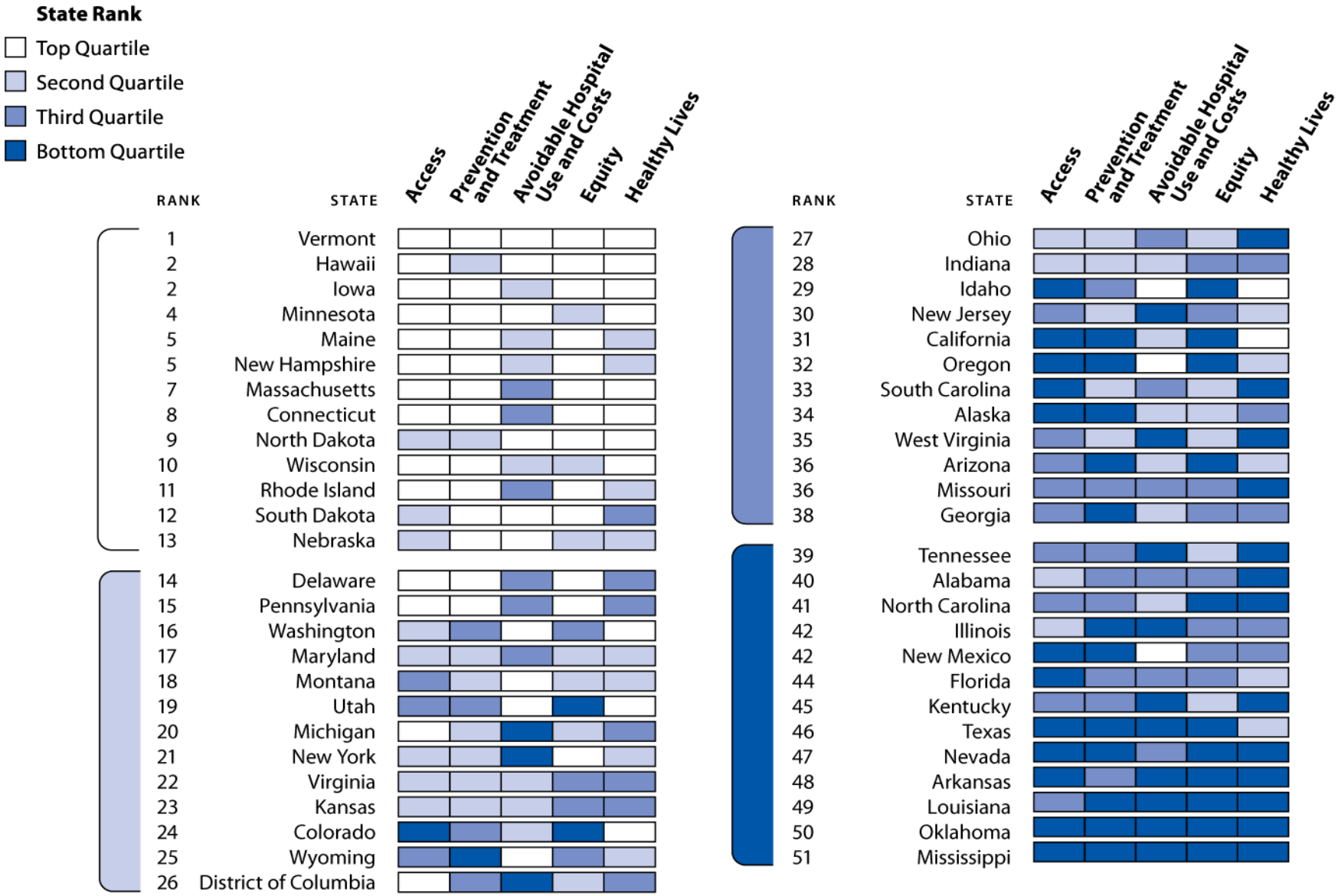
Exhibit 1 - Scores: Dimensions of a High Performance Health System



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

Exhibit 2:

2009 State Scorecard Summary of Health System Performance



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

Exhibit 2A: 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

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, November 2007

Exhibit 3: "Organization" & "Quality" Are Related

- **Large practices perform better than solo/small practices**
  - Large practices are twice as likely to engage in quality improvement and utilize EMRs (Audet et al, 2005)
  - Large practices have lower mortality in heart attack care than solo practices (Ketcham et al, 2007)

- **Integrated Medical Groups perform better than IPAs (Independent Practice Associations)**
  - Integrated medical groups have more IT, more QI (quality improvement) programs, and better clinical performance than IPAs (Mehrota et al, 2006)
  - HMOS that use more group or staff model physician networks have higher performance on composite clinical measures (Gillies et al, 2006)

- **Any network affiliation is better than no affiliation**
  - Although integrated medical groups perform better than IPAs, IPAs are still twice as likely to use effective care management processes than small groups with no IPA affiliation (Rittenhouse et al, 2004)
  - Physician group affiliation with networks is associated with higher quality; impact is greatest among small physician groups (Friedberg et al 2007)

Exhibit 4: “Organization”, Cost & Patient Experience

- **Medical groups can be more efficient**
  - Costs are about 25 percent lower in pre-paid group practices than in other types of health plans, but primary data are old (Chuang et al 2004)
  - Physician-to-population ratio is 22-37 percent below the national rate across 8 large pre-paid group practices (Weiner et al, 2004)

OVERALL CONCLUSION:

“Organization” is an enabler, not a guarantee of higher performance

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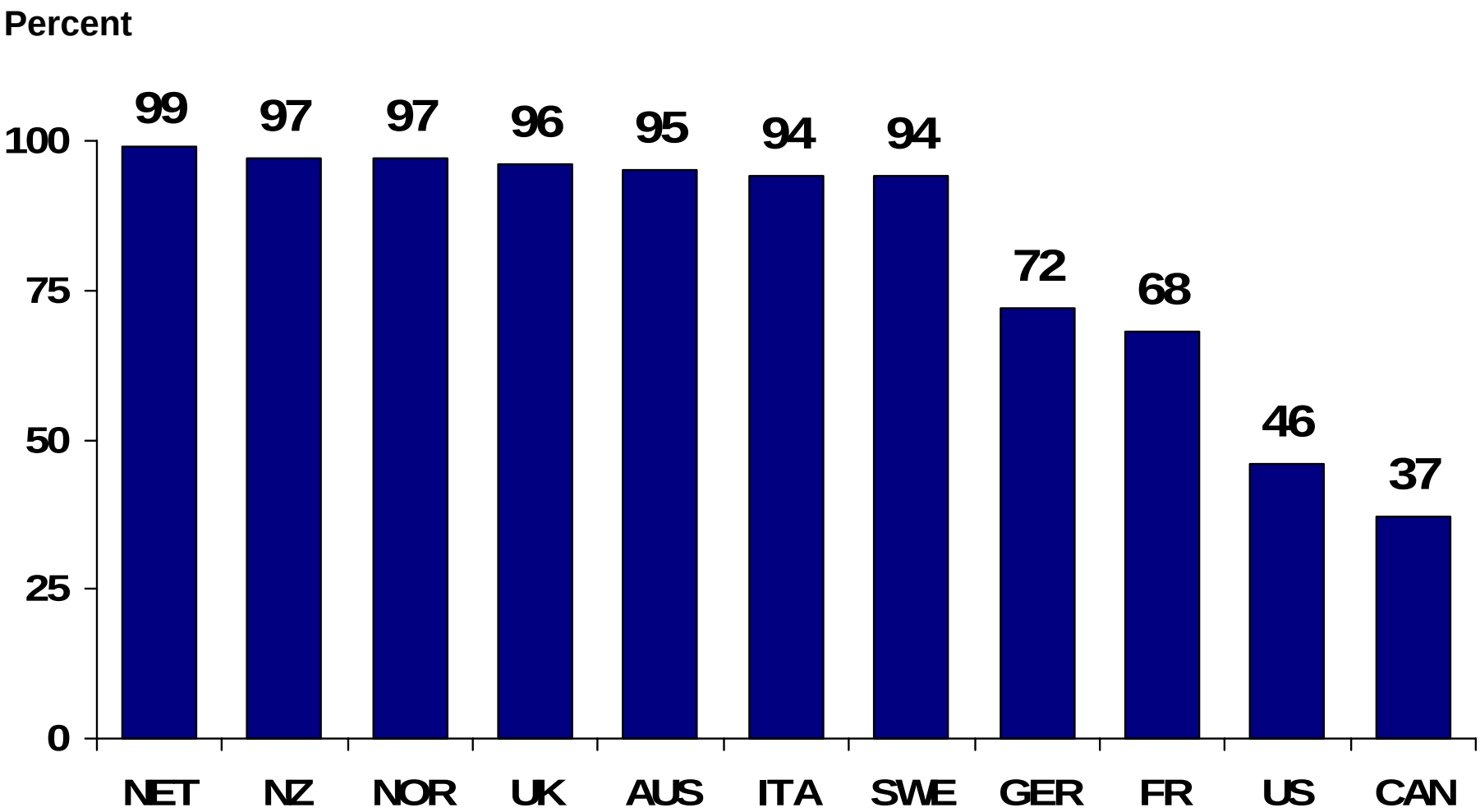
Exhibit 5: Primary Care Doctors Use Electronic Patient Medical Records*



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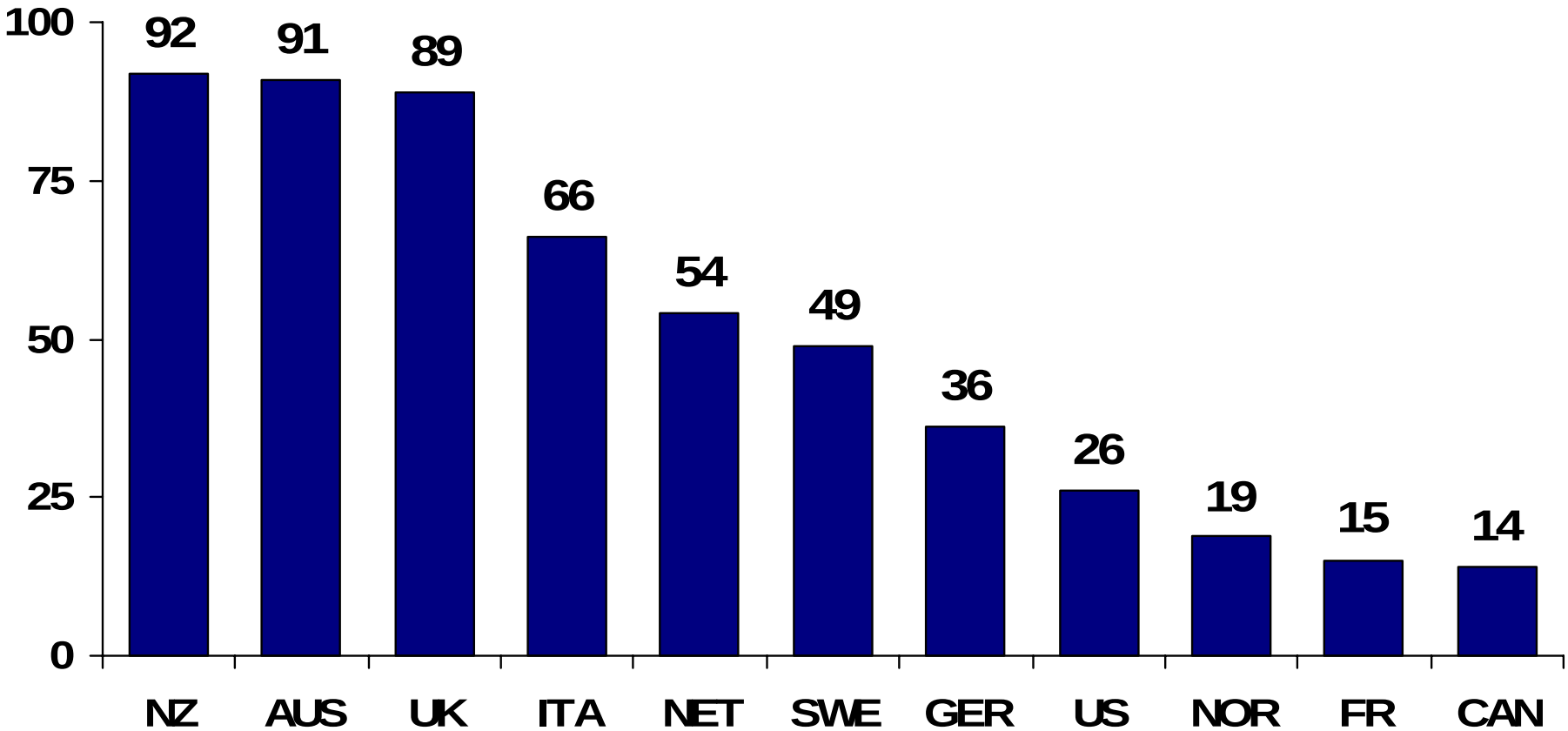
* Not including billing systems.

Source: 2009 Commonwealth Fund International Health Policy Survey of Primary Care Physicians.

Exhibit 6: Practices with Advanced Electronic Health Information Capacity

Percent reporting at least 9 of 14 clinical IT functions*



* Count of 14 functions includes: electronic medical record; electronic prescribing and ordering of tests; electronic access test results, Rx alerts, clinical notes; computerized system for tracking lab tests, guidelines, alerts to provide patients with test results, preventive/follow-up care reminders; and computerized list of patients by diagnosis, medications, due for tests or preventive care.

Source: 2009 Commonwealth Fund International Health Policy Survey of Primary Care Physicians.

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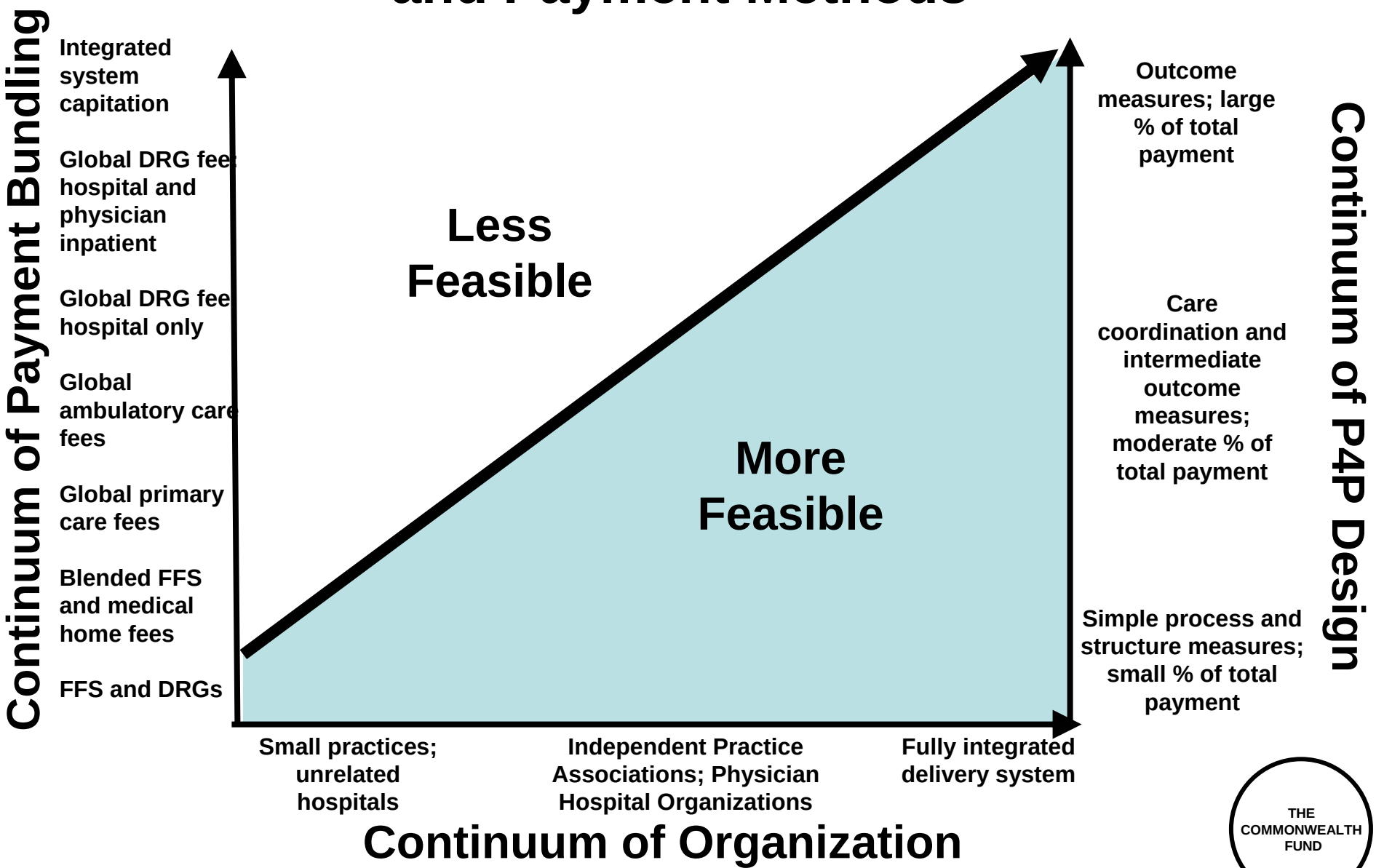
Exhibit 7: The Relationship of Organization Type and Payment Methods



Source: Shih et al, The Commonwealth Fund, August 2008

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Exhibit 8: Fifteen Options that Achieve Savings Cumulative 10-Year Savings

Producing and Using Better Information	
• Promoting Health Information Technology	-$88 billion
• Center for Medical Effectiveness and Health Care Decision-Making	-$368 billion
• Patient Shared Decision-Making	-$9 billion
Promoting Health and Disease Prevention	
• Public Health: Reducing Tobacco Use	-$191 billion
• Public Health: Reducing Obesity	-$283 billion
• Positive Incentives for Health	-$19 billion
Aligning Incentives with Quality and Efficiency	
• Hospital Pay-for-Performance	-$34 billion
• Episode-of-Care Payment	-$229 billion
• Strengthening Primary Care and Care Coordination	-$194 billion
• Limit Federal Tax Exemptions for Premium Contributions	-$131 billion
Correcting Price Signals in the Health Care Market	
• Reset Benchmark Rates for Medicare Advantage Plans	-$50 billion
• Competitive Bidding	-$104 billion
• Negotiated Prescription Drug Prices	-$43 billion
• All-Payer Provider Payment Methods and Rates	-$122 billion
• Limit Payment Updates in High-Cost Areas	-$158 billion

Source: ***Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending*****, Commonwealth Fund, December 2007.**
http://www.commonwealthfund.org/usr_doc/Schoen_bendingthecurve_1080.pdf?section=4039

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Visit the Fund: www.commonwealthfund.org

www.whynotthebest.org

- **WhyNotTheBest.org – a new Commonwealth Fund web site for tracking performance & facilitating performance improvement**
- **Enables users to compare their performance with peers, over time, and against a range of benchmarks (currently hospital data)**
- **Offers case studies of high-performing organizations and improvement tools**

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