



Photo: Roger Carr



Karen Davis

President's Message

2006 ANNUAL REPORT

The Best Health System in the World

With some of the best-equipped hospitals and most highly specialized physicians in the world, it is no wonder that many people believe the U.S. health system is the best on earth. The evidence, however, suggests this confidence is misplaced.

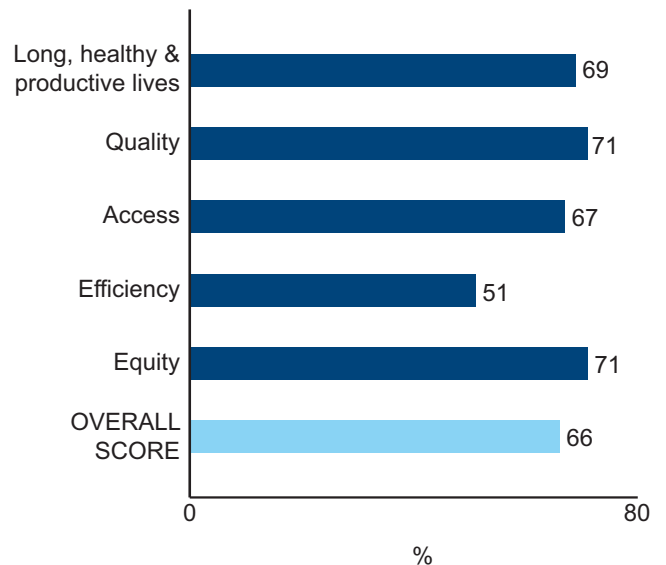
According to the National Scorecard on U.S. Health System Performance, the United States scored just 66 out of 100 when comparing the nation's average performance on three dozen indicators against benchmarks set either within the U.S. or abroad. Given America's high standards—and high spending on health care—that is simply unacceptable.

The national scorecard is the creation of the Commonwealth Fund Commission on a High Performance Health System. Established in July 2005, the Commission seeks to move the nation toward a system of care affording better access, higher quality, and greater efficiency for all members of society, including the most vulnerable. With the release of the scorecard in September 2006, the Commission has made substantial progress in meeting a primary objective—setting realistic benchmarks and targets to track change over time. The coming year will be devoted to a fact-finding process to identify and

analyze promising approaches being used across the country and around the world. Later in its tenure, the Commission will recommend immediate and long-term practical steps and policy measures.

In the sections that follow, I review the scorecard's main findings to highlight where our current health system falls short; discuss the central messages that emerge; and, aided by real examples of high-performance health care, outline a blueprint for change.

Scores: Dimensions of a high performance health system



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

WHAT'S WRONG: A SNAPSHOT

The Commission's scorecard on U.S. health system performance focuses on five core goals:

- Long, healthy, and productive lives;
- High-quality care;
- Access for all;
- Efficient care; and
- Equitable care.

The scorecard's data highlight areas within each category where the U.S. health system currently falls short.

LONG, HEALTHY, AND PRODUCTIVE LIVES

The overriding expectation for a health system is that it ensures the opportunity for a long, healthy, and productive life for everyone. The Commission

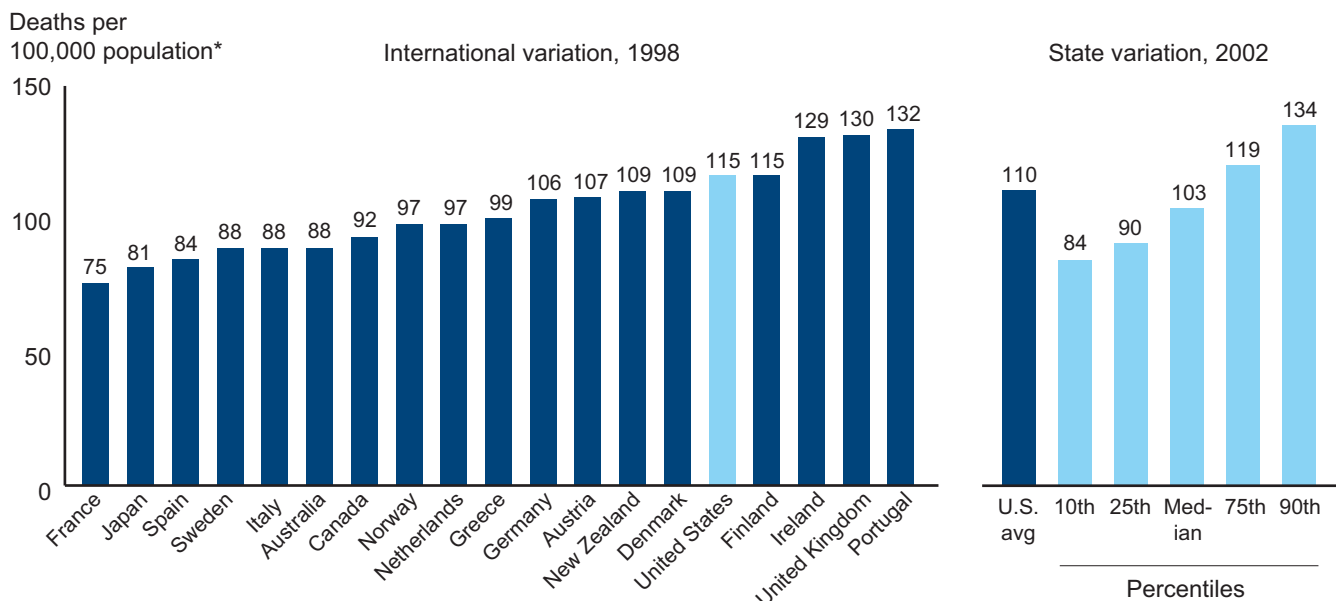
scorecard includes indicators of mortality, healthy life expectancy, and health-related limitations faced by children and adults.

Poorer Health Outcomes, Higher Mortality. Across five indicators of health outcomes, the U.S. scores 69 compared with the benchmark performance of 100. On no indicator of health outcomes is the U.S. the best. The traditional excuse—that the U.S. population is “different”—is not convincing. The indicators were selected to focus on the effect of the health care system, not on health outcomes primarily related to socioeconomic determinants of health or health behaviors such as smoking or diet.

One indicator, for example, focuses on mortality from conditions “amenable to health care”—a measure of death rates before age 75 from diseases and conditions that are preventable or treatable with timely, effective medical care. The U.S. ranked 15th

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



* Countries' age-standardized death rates, ages 0–74; includes ischemic heart disease. Data: International estimates—World Health Organization, WHO mortality database (Nolte and McKee 2003); State estimates—K. Hempstead, Rutgers University using Nolte and McKee methodology. Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006.

out of 19 countries, with a death rate 30 percent higher than France, Japan, and Spain.

Yet hidden in these sobering findings is a glimmer of hope: if all U.S. states performed at the same level as the five best performing states, the U.S. would be on a par with the best countries. Spreading proven best practices from a few pockets of excellence to the entire U.S. health system will be a critical step in improving outcomes.

HIGH-QUALITY CARE

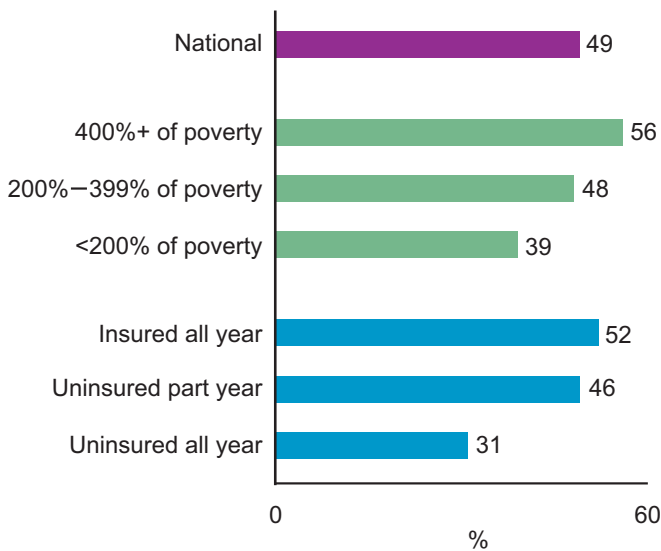
Ensuring that patients get the “right care” and that the care is safe, well-coordinated, and patient-centered is the essential foundation of high-quality care. On 19 indicators capturing these dimensions of care, the U.S. scored an average of 71 out of a possible 100.

Too Little Preventive Care. Slightly less than half of U.S. adults are up-to-date with preventive care recommended by the U.S. Preventive Services Task Force. Not surprisingly, the poor and uninsured figure prominently in this group, but even among adults earning four times the poverty rate, only 56 percent received appropriate preventive care.

Spotty Chronic Care Management. Proper management of chronic conditions is essential to good care, and is an especially important task as the population ages. The good news is that the proportion of the population with their diabetes adequately controlled has improved modestly in the last five years. The bad news is that this varies widely, ranging from 79 percent in the best privately insured plans, to 23 percent in the bottom 10 percent of Medicaid managed care plans.

Receipt of recommended screening and preventive care for adults, by family income and insurance status, 2002

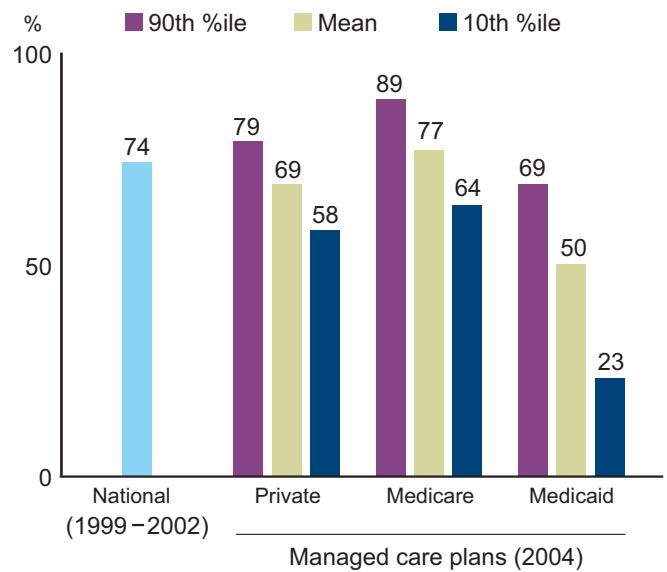
Percent of adults (ages 18+) who received all recommended screening and preventive care within a specific time frame given their age and sex*



* Recommended care includes seven key screening and preventive services: blood pressure, cholesterol, Pap, mammogram, fecal occult blood test or sigmoidoscopy/colonoscopy, and flu shot. Data: B. Mahato, Columbia University analysis of 2002 Medical Expenditure Panel Survey. Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006.

Diabetic adults who have blood glucose levels under fair control, national and managed care plan type

Percent of adults with diagnosed diabetes whose HbA1c level <9.0%



Note: National estimate includes ages 18+ and plan estimates include ages 18–75. Data: National estimate—National Health and Nutrition Examination Survey (AHRQ 2005a); Plan estimates—Health Plan Employer Data and Information Set (NCQA 2005a, 2005b). Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006.

Inadequate Coordination. Coordination of patient care throughout the course of treatment and across various sites of care helps to ensure appropriate follow-up treatment, minimize the risk of error, and prevent complications. But about a third of adults and more than half of all children did not have a medical home with a physician who is easily accessible and a central source of care and referrals to specialists.

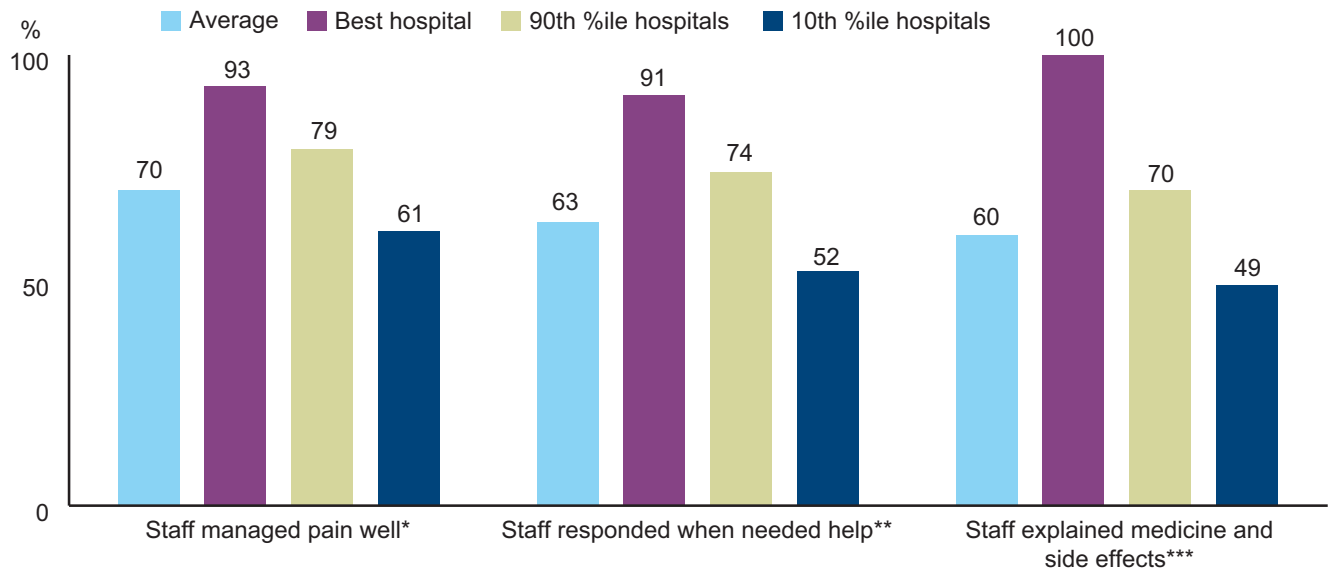
Ensuring coordination of care is especially critical at the time of discharge from a hospital. The Commission's scorecard found that patients with congestive heart failure received written care instructions when discharged only half the time—with a gap of 80 percentage points between the top and bottom 10 percent of hospitals. Failure to manage conditions after discharge can result in trips to the emergency room or rehospitalization, with associated human and financial costs.

Unreliable Care and Processes. More than six years ago, the Institute of Medicine published its landmark report, *To Err Is Human*, calling for implementation of systems to ensure patient safety.¹ Yet, one-third of American patients surveyed in the Fund's 2005 international survey said that in the last two years a medical mistake or a medication or lab test error was made during their care. In order to reach the levels of reliability achieved by the benchmark countries, Germany and the United Kingdom, the U.S. must reduce its error rate by one-third.

Insufficient Focus on Patients' Preferences. Patient-centered care is care delivered with the patient's needs and preferences in mind. When care is both patient-centered and delivered in a timely manner, patients are more likely to adhere to treatment plans, to be fully engaged in care decisions, and to receive better care overall.

Patient-centered hospital care: staff managed pain, responded when needed help, and explained medicines, by hospitals, 2005

Percent of patients reporting "always"



* Patient's pain was well controlled and hospital staff did everything to help with pain.

** Patient got help as soon as wanted after patient pressed call button and in getting to the bathroom/using bedpan.

*** Hospital staff told patient what medicine was for and described possible side effects in a way that patient could understand.

Data: CAHPS Hospital Survey results for 254 hospitals submitting data in 2005. National CAHPS Benchmarking Database.

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

In the mid-1980s, The Commonwealth Fund became one of the pioneers in the patient-centered care movement, calling for regular surveys of hospitalized patients to learn from their experiences with care. Among 254 hospitals voluntarily reporting results in 2005, there was a substantial differential between the top- and bottom-performing groups of hospitals on how well they manage pain, respond when patients press call buttons or need help, or explain medications and possible side effects. In the fall of 2007 the Medicare program will require all hospitals to report standardized patient-centered care survey results.

ACCESS TO CARE

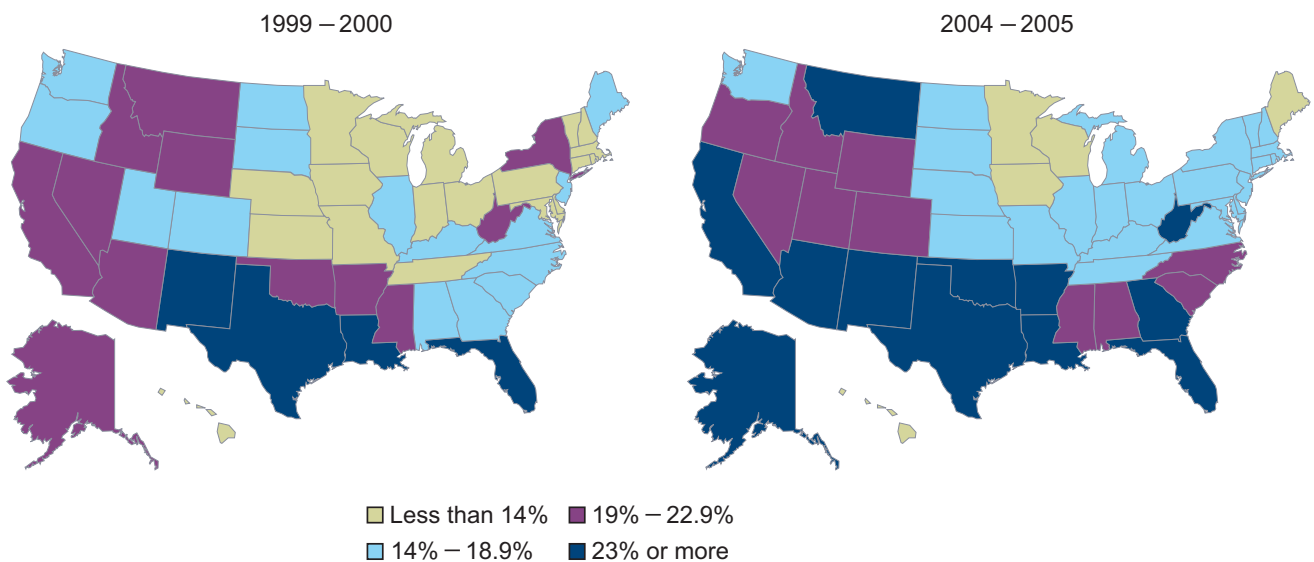
Access to care is a critical hallmark of health system performance. The single most important factor determining whether people can obtain essential health care is whether they have health insurance coverage. The scorecard looks at the percent of the

population that is uninsured or underinsured, patient reports of difficulties obtaining needed care, and measures of affordability of insurance and care for families and employers. On these access indicators the U.S. scored 67 out of a possible 100.

Inadequate Insurance Coverage. In 2005, 46.6 million people were uninsured, 7 million more than in 2000. Because insurance coverage is very unstable and changes as people change jobs or life circumstances, 28 percent of working-age adults are uninsured at some point during the year. Cost pressures have also led employers to limit benefits and require higher deductibles and more cost-sharing by patients. As a result, at least 16 million insured adults are underinsured, and can experience financial difficulties obtaining care.

Rates of uninsured adults varied in 2004–2005 from 30 percent in Texas to 11 percent in Minnesota. By contrast nearly all major industrialized countries provide universal and comprehensive health insurance coverage.

Percent of adults ages 18–64 uninsured by state



Data: Two-year averages 1999–2000 and 2004–2005 from the Census Bureau’s March 2000, 2001 and 2005, 2006 Current Population Surveys. Estimates by the Employee Benefit Research Institute. Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006.

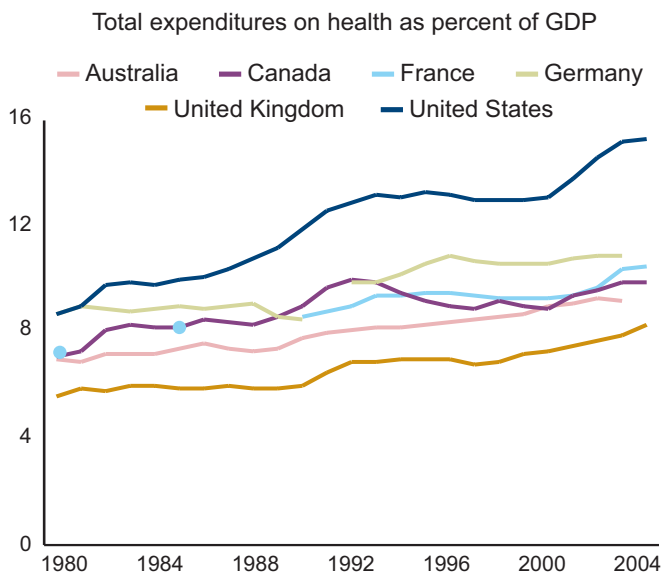
EFFICIENCY

The U.S. spends 16 percent of its gross domestic product on health care—twice as much as the typical industrialized nation, and growth in health spending in recent years has outpaced that of other major countries. On eight efficiency indicators, the Commission scorecard averages 51 out of 100—in other words, average U.S. performance would have to double to reach the best benchmarks.

Overuse, Misuse of Care. Duplication, overuse or inappropriate care—sometimes the result of our fragmented health system—contribute to high costs in the United States. U.S. adults are more likely to report that medical records and test results are not available when needed, and that tests are duplicated or unnecessary. Care that is not evidence-based, such as imaging tests for lower-back pain with no apparent risk factors or signs of serious pathology, adds unnecessarily to costs.

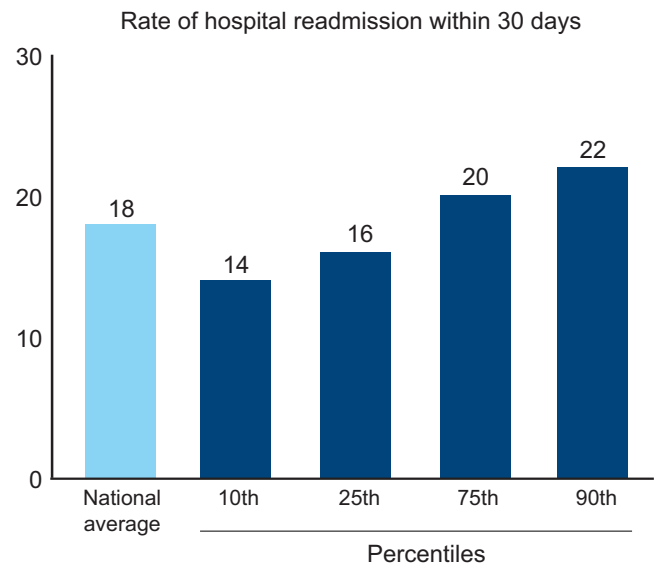
Too Many Admissions and Readmissions. Inadequate access to primary care, whether during regular office hours or after-hours, contributes to expensive visits to the emergency room or admission to the hospital. Americans are more likely to report use of emergency rooms for conditions that could have been treated by a primary care physician, if available. Hospitalization for potentially preventable conditions such as congestive heart failure, diabetes, and pediatric asthma vary two- to four-fold. Bringing national rates of preventable hospitalizations down by 10 percent to 20 percent could save \$4 billion to \$8 billion annually.

International comparison of spending on health, 1980–2004



Data: OECD Health Data 2005 and 2006.
 Note: Data missing for France 1981–84 and 1986–89.
 Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006.

Medicare hospital 30-day readmission rates and associated costs, by hospital referral regions, 2003

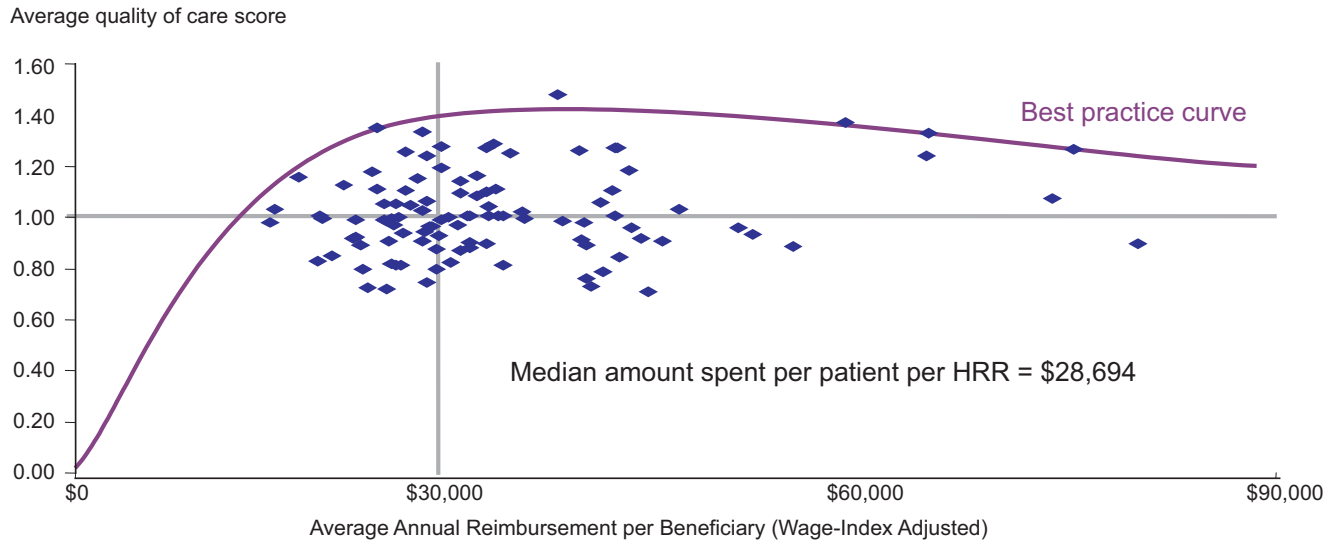


Data: G. Anderson and R. Herbert, Johns Hopkins University analysis of 2003 Medicare Standard Analytical Files (SAF) 5% Inpatient Data. Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006.

Wide Variations in Quality and Cost. Quality and cost vary widely across the U.S., but there is no evidence that higher spending produces higher quality, yielding the strong suggestion that it is possible—paramount, really—to improve quality and reduce cost.

Variation in annual total cost and quality for chronic disease patients

Quality of care* and Medicare spending for beneficiaries with three chronic conditions, by hospital referral region



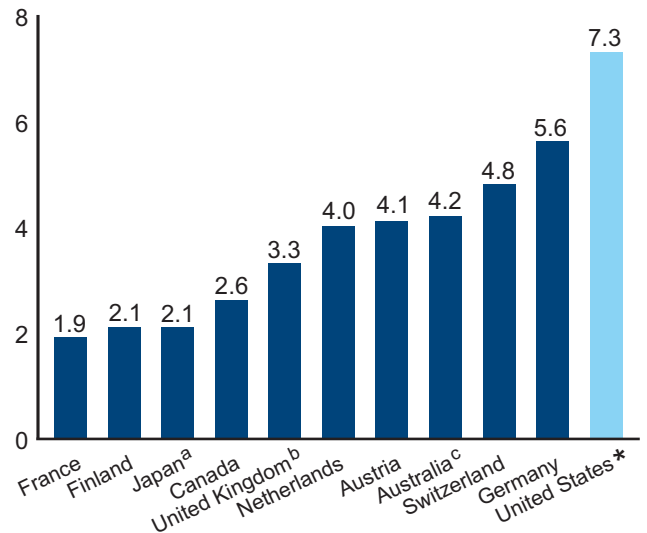
* Based on percent of beneficiaries with three conditions (diabetes, chronic obstructive pulmonary disease, and congestive heart failure) who had a doctor's visit four weeks after hospitalization, a doctor's visit every six months, annual cholesterol test, annual flu shot, annual eye exam, annual HbA1c test, and annual nephrology test.
 Source: G. Anderson and R. Herbert for The Commonwealth Fund, Medicare SAF 5% 2001 data.

For example, data show that if all Medicare patients being treated for heart attacks, hip fractures, or colon cancer received the quality of care delivered by the benchmark regions, Medicare would save an estimated 8,400 lives and \$900 million annually.

High Administrative Costs. Insurance administration costs contribute significantly to the high cost of care in the U.S., without contributing to commensurate gains in quality of care or health outcomes. As a percentage of national health expenditures, U.S. insurance administrative costs are more than three times the rates found in countries with the most integrated insurance systems (France, Finland, and Japan), and 20 to 30 percent higher than those in Germany and Switzerland, two countries where private insurance plays a substantial role. If U.S. administrative costs were on a par with the best countries, we would save \$85 billion a year.

Percentage of national health expenditures spent on health administration and insurance, 2003

Net costs of health administration and health insurance as percent of national health expenditures



^a 2002 ^b 1999 ^c 2001
 * Includes claims administration, underwriting, marketing, profits, and other administrative costs; based on premiums minus claims expenses for private insurance.
 Data: OECD Health Data 2005.
 Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006.

Not Enough Reliance on Information Technology. U.S. physicians lag well behind their counterparts abroad in use of electronic medical records—a key component of health information technology. Fewer than one of five U.S. doctors said they used electronic records, compared with nearly 90 percent in the top two countries.

EQUITY

Despite the fact that our country was founded on the principle of equal opportunity, and that eliminating disparities in health and health care has for years been a national policy priority, there remain significant differences in the care and health outcomes of Americans depending on their insurance coverage, income, and race or ethnicity.

Disparities Based on Income, Insurance, Race and Ethnicity. The average gap in health outcomes, quality, access, and efficiency between uninsured populations and the benchmark insured populations is 34 percent, while the gap between low-income and high-income

groups is 38 percent. Additionally, risk rates are higher for Hispanics and African Americans for being uninsured and for having inadequate access to primary care and preventive care. Widely known is the fact that African American mortality rates are strikingly higher for heart disease, diabetes, and infant mortality.

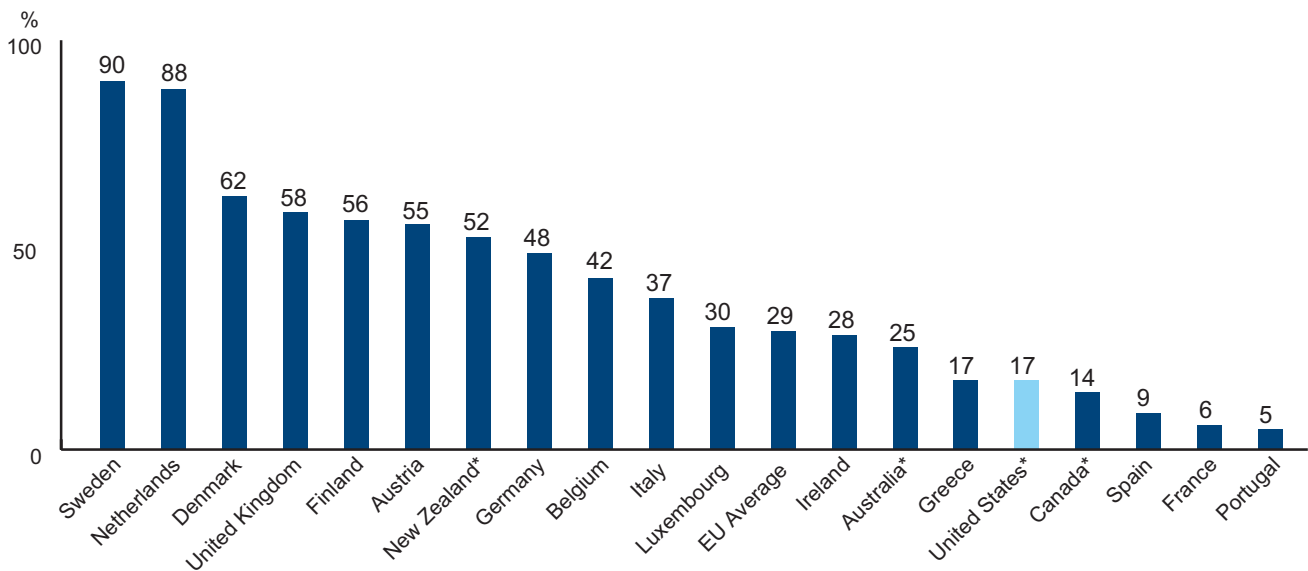
LESSONS FROM THE SCORECARD

The central messages emanating from the scorecard are clear. Whether measured in dollars or human terms, we are paying an unaffordable price for our health system's lackluster performance. In order to address the system's shortcomings, we must:

- *Simultaneously improve access, quality, and efficiency.* These elements are interrelated, and strategies focused on improving only one aspect of care are unlikely to achieve the central goal of long, healthy, productive lives for all Americans. All federal and state health policy proposals and private sector actions

Physicians' use of electronic medical records, U.S. compared with other countries, 2001

Percent of physicians



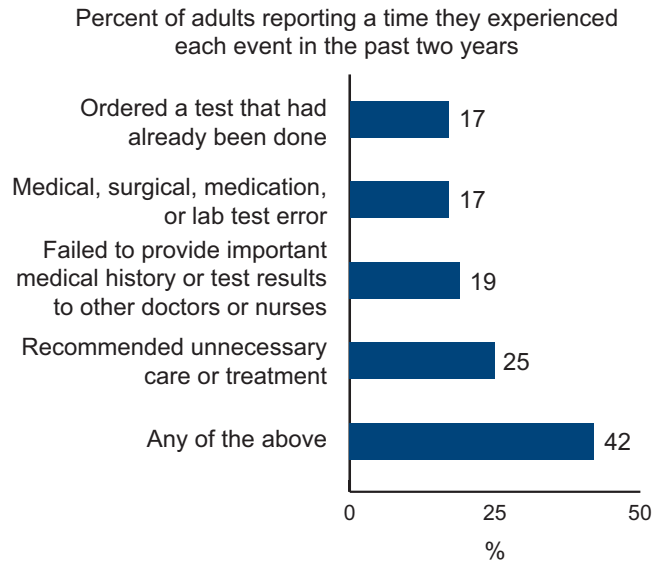
* 2000

Data: 2001 European Union EuroBarometer and 2000 Commonwealth Fund International Health Policy Survey of Physicians (Harris Interactive 2002). Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006.

should be assessed to determine their likely impact on moving us forward as a nation on these core goals.

- *Ensure universal participation in health care and reduce disparities.* The percentage of working-age adults without insurance is up sharply since 2000 despite a growing economy. Loss of comprehensive health insurance coverage puts families and the nation at risk of losing ground on past gains in improved health and workforce productivity.
- *Reduce costs.* There is ample evidence that savings can be generated from improved efficiency in the health care system. Waste and duplication from our fragmented system of coverage and care abound. Widely varying hospital readmission rates from one hospital to another, one city or state to another, suggest that better transitional and follow-up care—and better support for self-care—after hospital discharge can improve quality and lower costs. The challenge is not just identifying and implementing best practices, but redirecting those savings into investments in improved coverage and system capacity to improve performance in the future.
- *Coordinate and integrate care.* Failure to coordinate care for patients over the course of treatment as they see multiple physicians, are hospitalized and rehospitalized, cared for at home by home health aides, or in nursing homes, takes an enormous toll on all fronts. Tests are repeated as records are lost or unavailable when needed. Patients with serious health problems receive conflicting advice and become increasingly frustrated and disaffected as their time and energy are

Inefficient, poorly coordinated, unsafe care
High rates of duplicate tests, medical errors, failures to share information, or times doctors recommended unnecessary care



C. Schoen, S. K. H. How, I. Weinbaum, J. E. Craig, Jr., and K. Davis, *Public Views on Shaping the Future of the U.S. Health System* (New York: The Commonwealth Fund, Aug. 2006).

expended finding their way through a complex and seemingly impersonal health system.

Because our health care system has been slow to invest in the people, research, and infrastructure necessary to catalyze and implement the kind of sweeping change the scorecard calls for, we must also improve our capacity to improve. This will require:

- *A highly motivated health care workforce.* Particularly in the nation’s hospitals and long-term care facilities, high turnover among “front-line” workers, such as nursing home aides—a result of low wages, a lack of benefits, and stressful working conditions—puts the health and quality of life of patients and residents at serious risk. Shortages of primary care physicians, nurses, and other key health personnel further undermine health system performance.

- *More research on evidence-based care and innovative delivery models.* While we spend nearly \$2 trillion on health care, we devote just \$1.5 billion to health systems research, less than \$1 for every \$1,000 in national health care spending.
- *Greater investment in information technology.* Electronic information systems show considerable promise for enhancing efficiency, eliminating duplication and waste, reducing medical errors, assisting physicians, nurses, pharmacists, and other health professionals in delivering the best care, and ensuring that patients are informed, active partners in their care. The U.S. lags behind leading nations in its use of such systems.
- *Improved capacity to measure quality.* Quality is unlikely to be improved if it cannot be measured. The current capacity of the U.S. system to measure and assess performance is fragmented and highly variable. Lack of more integrated data systems across the multiple private and public payers undermines national, state, or regional public or private efforts to assess access, quality, or efficiency of care.

Everyone has a stake and a role to play in transforming the health care system to achieve superior performance.

Armed with the right information and support, patients can take greater responsibility for their health. Physicians, hospitals, and other health care providers can work collaboratively to ensure that patients receive safe, effective, and coordinated care reliably. Insurers and employers can offer coverage that ensures access to essential services and enhances the health and productivity of the workforce, and mobilize their administrative records to provide information useful to patients and providers.

State governments can assess how well the health system performs within their own borders, and pursue the policies of best-performing states that are generating superior results. And the federal government can play a leadership role, ensuring that transparency and accountability in health care become commonplace, that coverage is affordable to all, and that care meets rigorous, evidence-based standards.

WHAT'S RIGHT: A BLUEPRINT FOR CHANGE

Although the task of overhauling our health care system is enormous, benchmark practices, organizations, or even nations offer useful and sometimes inspiring roadmaps to change. Some of the changes these examples suggest will require new policies at the federal or state level. Others rest in the hands of health care leaders who make decisions every day about the way health care is organized, delivered, and financed.

These seven key strategies show great promise for ensuring that the U.S. scorecard in the future will yield truly excellent results.

1. EXPAND HEALTH INSURANCE TO ALL

Case in Point: State of Maine

Surveys of health care opinion leaders and the public consistently show that ensuring that all Americans have adequate, reliable health insurance coverage should be the top health policy priority for Congress and the President.² Yet the gap between that ideal and today's reality remains huge.

Several states—including Maine, Massachusetts, Minnesota, Rhode Island, and Vermont—are leading the way by implementing creative and pragmatic approaches to achieving universal health insurance coverage.³ Strategies that support these efforts include

Positive public views on the need for quality and cost information and payments that reward performance

How important is it to you that: (percent)	Total very or somewhat important	Very important	Somewhat important
You have information about the quality of care provided by different doctors or hospitals	95	77	18
You have information about the costs of care to you BEFORE you actually get the care	91	69	22
Insurance companies identify and reward doctors and hospitals who achieve excellence in the quality and efficiency of care	87	62	25

C. Schoen, S. K. H. How, I. Weinbaum, J. E. Craig, Jr., and K. Davis, *Public Views on Shaping the Future of the U.S. Health System* (New York: The Commonwealth Fund, Aug. 2006).

subsidies, mandates, taxes, public-private partnerships, and policy changes such as raising the age of dependence in parents' health insurance plans.

The State of Maine launched DirigoChoice in January 2005, an affordable insurance product that offers reduced monthly premium rates and deductibles based on income, using a sliding scale up to 300 percent of the poverty level.⁴ Comprehensive benefits include 100 percent coverage of preventive benefits and cash-back incentives for participation in wellness programs. Currently the program insures nearly 13,000 people.

DirigoChoice is part of Dirigo Health, a comprehensive set of reforms enacted with the goal of providing all Maine residents with access to health care by 2009. (Dirigo is Maine's state motto, meaning "I lead.") Dirigo Health aims to do more than insure the poor and subsidize coverage for those who need it. It is designed to contain costs through efforts such as reducing bad debt and

charity care, creating a capital investment fund, exercising tighter oversight on growth and expansion of health care facilities, and providing financial incentives for consumers to choose cost-effective providers. It also aims to improve quality by using information technology, including electronic health records, throughout the state. The new Maine Quality Forum, meanwhile, serves as a clearinghouse of best practices and related health information.

Dirigo Health has been controversial since its inception. It has claimed \$43.7 million savings during its first two years. Under the program's financial structure there is a tax on insurance premiums equal to the savings offset. The Commonwealth Fund is supporting an evaluation of Maine's initiative.

The Fund is also supporting an evaluation of a newer initiative in Massachusetts. We hope to learn from these efforts to make financing coverage a shared responsibility of employers, state and federal government, and individuals. But public policy changes at the national level and increased federal financing are likely to be needed to extend these approaches to states with higher rates of uninsured and more limited ability to fund coverage from local sources. A forthcoming Commonwealth Fund analysis of national health legislative proposals introduced in Congress will lay out a wide range of ideas for consideration.⁵

2. INCREASE TRANSPARENCY AND REPORTING ON QUALITY AND COSTS

Case in Point: Massachusetts Health Quality Partners

Public reporting of information on the performance of health plans and providers can spur improvements in quality and efficiency by helping consumers make more informed decisions and by stimulating providers and health plans to be more accountable for their results.

It can also form the basis for new payment systems that reward providers for excellence and efficiency. Commonwealth Fund surveys indicate that most patients do not have access to the cost and quality information that would enable them to make informed choices, but they very much want access to such information.⁶

Strong public support for well-coordinated care

How important is it to you that: (percent)	Total very or somewhat important	Very important	Somewhat important
You have one place/doctor responsible for primary care and coordinating care	92	75	17
You have easy access to medical records	94	79	15
All your doctors have easy access to your medical records	93	77	16
Care from different doctors is well coordinated	96	79	17

C. Schoen, S. K. H. How, I. Weinbaum, J. E. Craig, Jr., and K. Davis, *Public Views on Shaping the Future of the U.S. Health System* (New York: The Commonwealth Fund, Aug. 2006).

A number of notable initiatives provide purchasers, consumers, and providers themselves with information about quality. The Pennsylvania Health Care Cost Containment Council, or PHC4, an independent state agency created in 1986, is a state-funded initiative to publish comparative data on hospital performance, including costs and complication rates. In 2005 PHC4 was the first organization in the nation to publish data on hospital-acquired infections.

Public reporting of hospital or medical group quality has also advanced in California under the leadership of the Pacific Business Group on Health and the Integrated Healthcare Association, as well as

by state government quality reporting efforts in Minnesota, New Jersey, and New York.

The Wisconsin Collaborative for Healthcare Quality (WCHQ), a voluntary collaborative, develops and publicly reports comparative performance information on physician practices, hospitals, and health plans through an interactive Web-based tool. WCHQ has earned credibility among health care providers because the measures are reported in ways that allow member groups to identify variation by physician practice and target areas for improvement.⁷

With Commonwealth Fund and Robert Wood Johnson Foundation support, Massachusetts Health Quality Partners (MHQP) has publicly released clinical quality data as well as patients' ratings of their experiences with doctors' offices throughout the state.⁸ Data on the clinical performance of primary care physicians are now publicly available at the medical group level in Massachusetts. Formed in 1995, Massachusetts Health Quality Partners gathered information from the state's five largest private health plans on the quality of care provided by 150 medical groups. The coalition then posted these data on its Web site to encourage consumers to search for high-quality providers and guide physicians looking to improve their performance.

This information enables consumers to evaluate the performance of medical groups across 15 measures of clinical quality developed by the National Committee for Quality Assurance as part of the Health Plan Employer Data and Information Set, or HEDIS, as well as patient experiences with their care from physicians. Consumers can search for quality information by physician name and location.

The MHQP coalition, which has worked to engage physicians in the data release process,

recognizes that public disclosure is an essential step in the process of quality improvement. By providing data on physician groups—rather than limiting the release to state performance averages—it is possible to identify variations in care and begin to understand why some groups perform better than others. This year’s report, for example, found significant variation in how well physicians care for patients with depression, those with asthma, and teenagers.

The Commonwealth Fund is also supporting projects to better understand variations in cost and quality across hospitals, medical groups, and geographic areas, and to assist providers and health plans in responding to the increasing availability of comparative data.

3. IMPLEMENT PROVEN QUALITY AND SAFETY IMPROVEMENTS

Case in Point: University of Colorado Health Sciences Center

Substantial gains in health system performance could be achieved if all providers were to adopt the “proven.” These include use of evidence-based medicine, promoting effective chronic care management techniques, “reengineering” delivery within and among provider organizations to improve safety and reliability, and ensuring care coordination across sites of care, especially when transitioning from the hospital to other settings.

The Institute for Healthcare Improvement has been a leader in mobilizing hospitals and other providers to implement proven quality and safety improvements, saving lives and dollars.⁹ Hospitals and health systems throughout the nation have achieved stunning improvements in clinical outcomes and cost reduction by standardizing care

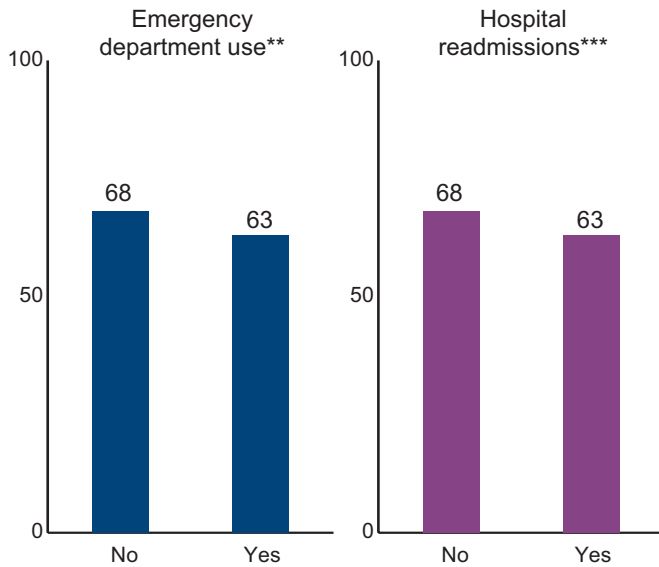
processes based on proven best practices.

Some efforts are institutional, and some are broader. The Pittsburgh Regional Health Initiative is an unusual collaborative of 44 hospitals in southwestern Pennsylvania that works together to improve together. The group shares data, information, ideas, successes, and failures openly, focusing on a wide range of clinical and safety issues. As a result, more than 30 of the region’s hospitals have reduced the incidence of a lethal, hospital-acquired bloodstream infection by 68 percent.¹⁰

A Fund-supported effort by Eric Coleman, M.D., at the University of Colorado Health Sciences Center, is creating more effective forms of “transitional care” for patients returning home from the hospital. The goal is to ensure their care needs are met while avoiding preventable complications and costly rehospitalizations.

Dr. Coleman has worked to develop quality-of-care measures to help pinpoint problems that occur during the transition from one site of care to another. This led to the development of the Care Transitions Measure, which includes a discharge preparation checklist that asks patients to sign off on statements such as: “The hospital staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left the hospital”; and “When I left the hospital, I had a good understanding of the things I was responsible for in managing my health”; and “When I left the hospital, I clearly understood the purpose for taking each of my medications.” The Care Transitions Measure has been adopted by the National Quality Forum as the best measure of care coordination.

In an intervention to improve care coordination at Group Health Cooperative in Seattle, patients receive

Coordinated care across sites of care**Care transition measure scores***

* "When I left the hospital, I had a good understanding of the things I was responsible for in managing my health"; "when I left the hospital, I clearly understood the purpose for taking each of my medications"; "the hospital staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left the hospital".

** $p = 0.01$ *** $p = 0.04$

Source: Adapted from E. A. Coleman, "Windows of Opportunity for Improving Transitional Care," presentation to Commonwealth Fund Commission on a High Performance Health System, Mar. 30, 2006.

tools and are taught skills reinforced by a "transition coach" who follows patients across care settings for the first 30 days following their discharge from the hospital. Dr. Coleman has found that patients who participate are less likely to be readmitted during this time—and even in the six months following discharge.

4. REORGANIZE HEALTH DELIVERY TO EMPHASIZE PATIENT-CENTERED PRIMARY CARE

Case in Point: Denmark

The U.S. is strikingly different from other industrialized countries in one important respect: its relative underinvestment in primary care. The U.S. has a much lower proportion of primary care physicians, and much better financial rewards for specialty care. A review of the literature indicates that better access to

primary care lowers total cost and improves outcomes.¹¹

Reorganizing the U.S. primary care system by moving to a "patient-centered medical home" model of primary care that employs teams of physicians, advanced practice nurses, and other professionals, and an organized system of off-hours care could improve the accessibility, effectiveness, and efficiency of care. A Commonwealth Fund survey of public views of the health system finds strong support for such a reorganization of care.

In Denmark, which has the highest public satisfaction with health care of any country in Europe, primary care is much more accessible than in the U.S.¹² Using a blend of capitation and fee-for-service payment, Denmark ensures that everyone has a primary care physician or "medical home," and generalist physicians typically provide services quickly, often in same-day appointments. An organized off-hours service assures accessible care from physicians 24 hours a day, seven days a week.

An interconnected health information system ensures that the patient's medical home has a complete and up-to-date record of filled prescriptions, lab and imaging results, specialist consultation reports, and hospital discharge information. Patients can e-mail their physician, book appointments, get prescription refills, and review their medication list online. Most importantly, patients are reminded about preventive services. As a result, 94 percent of women now have up-to-date Pap tests, and cervical cancer mortality dropped by 60 percent between 1988 and 2001.¹³

Most countries ensure that patients face no financial barriers to preventive and primary care, while the U.S. has been increasingly moving toward high-deductible health plans. Insurance should be designed to remove, not increase the financial barriers to early preventive and primary care. Public programs

and private insurers could also help improve care coordination by offering enrollees choices of patient-centered medical homes or advanced physician practices that take responsibility for ensuring patients receive accessible care, appropriate preventive care, and ongoing management of chronic conditions, while coordinating their care across different providers.

Payment reform to reward medical homes including a blended system that incorporates features of fee-for-service, monthly per-patient fees, and bonuses for excellence in clinical quality, patient-centered care, and efficiency could make primary care a more rewarding choice of practice.

5. EXPAND THE USE OF INFORMATION TECHNOLOGY

Case in Point: Rhode Island Information Exchange

Progress in improving health system performance will be difficult without widespread use of modern information technology. Electronic health records, decision support for physicians, computerized order entry systems, and patient access to their own medical information can help to reduce costs and improve safety and efficiency. Such systems are costly, and the benefits often accrue to insurers rather than providers who adopt such systems.

A Commonwealth Fund-supported set of case studies of smaller physician practices' adoption of electronic medical records found, however, that even in these settings providers can recover the capital costs of relatively simple systems in two to three years. Some health systems, such as Intermountain Health Care in Utah, Partners HealthCare in Boston, and Geisinger Health System in Pennsylvania, have used decision support systems to guide physicians in ordering expensive imaging tests or suggest lower-cost medications that might be suitable. Kaiser Permanente is rolling out a multi-billion-dollar integrated

electronic medical and health information system that links clinical records with online patient information, the largest civilian EMR project in the U.S.

In order for the health system to maximize benefits from these individual systems, however, innovation must focus on more sophisticated applications and linking all pieces into an interoperable network. For example, if emergency room physicians have access to a patient's history, they may be able to avoid hospitalizing a patient or prescribing inappropriate medications.

A number of states, including New York and Rhode Island, are promoting an "interconnected" health information system. A Fund-supported evaluation of regional information systems in New York will evaluate the costs and benefits of such systems, as well as determine whether benefits accrue primarily to insurers and costs primarily to hospitals.

The Rhode Island Health Information Exchange (HIE) initiative is a public-private effort to allow providers, with their patients' permission, to electronically access important patient health information from a variety of sources. The sharing of data will be phased in, according to the following stages: 1) laboratory data; 2) medication histories; 3) emergency department and hospital discharge summaries, pathology reports, outpatient procedure records, and child health data; and 4) administrative data. The ultimate goals are to:

- Give consumers access to their health information, and enable them to decide when and with whom they want to share it.
- Use patient index functions to allow for unique identification of individual patients and locate where their health information is stored.

- Present data from a variety of sources in an integrated, patient-centered manner using a common interface, such as a portal or local platform.
- Integrate data into electronic health record applications and support the exchange of these data with others, as permitted.
- Provide decision-support capability.
- Aggregate and utilize data for public health purposes, such as population-based analysis, quality improvement, evaluation, bio-surveillance, and research.¹⁴

6. REWARD QUALITY AND EFFICIENCY

Case in Point: New York State

Aligning financial incentives so that health systems, hospitals, and physicians benefit financially from doing the right thing is essential. Our fee-for-service payment system rewards doing more, and rewards providing highly specialized services far more than preventive care or preventing an acute episode for patients with chronic conditions. Payment should be restructured so that providers are reimbursed based on the quality and efficiency of the care they provide.

In New York State, for example, the Department of Health began incorporating quality incentives into the computations of Medicaid managed care capitation rates in 2002. These incentives are tied to performance on 10 quality of care measures and five consumer satisfaction measures. By April 2005, the maximum incentive was 3 percent of the monthly premium. Incentive payments for 2005 totaled \$40 million.

The Commonwealth Fund is supporting a qualitative and quantitative analysis of this incentive plan. Preliminary results indicate that rewarding performance does improve quality. For example, the percentage of women with Medicaid coverage who had appropriate postpartum care rose from 49 percent

in 1996 through 1999—before the quality incentives were in place—to 68 percent in 2003 and 2004, after the incentives were implemented. When surveyed, 80 percent of senior Medicaid managed care plan executives, including CEOs, CMOs, CFOs, and quality improvement directors, said they believe the incentive program has a positive effect on health plan quality.

In September 2006, the Institute of Medicine issued a report evaluating the institution of a pay-for-performance program within Medicare. The report, *Rewarding Provider Performance: Aligning Incentives in Medicine*, recommends pay-for-performance incentives, which reward providers for delivering high-quality care efficiently, as a means of speeding the process of implementing best practices.

Purchasers, both public and private, can improve quality and efficiency by building performance standards into health plan contracts and developing “incentivized” payment systems that reward quality and efficiency in the provision of acute and chronic episodes of care. Fund-supported evaluations of such payment systems have documented at least modest gains in clinical quality when medical groups receive bonuses for higher quality.

The Fund has also assisted by convening participants in Medicare’s physician group practice demonstration to learn from each other about effective practices to both improve quality and control costs.

7. ENCOURAGE PUBLIC-PRIVATE COLLABORATION

Case in Point: Puget Sound Health Alliance

Creating a “culture of high performance” requires a shared vision among all stakeholders. Public and private sectors must work together to achieve this vision. Good collaborative models for improvement can be found where each sector has taken the lead, and more such efforts should be

encouraged. A Fund project is studying collaborations among state or local government, providers, and insurers to improve both quality and efficiency in Minnesota, Washington, and Wisconsin.

In Washington, the Puget Sound Health Alliance is an independent, nonprofit organization composed of employers, physicians, hospitals, consumers, health plans, and other interested parties. The group's aim is to improve care and continuity by developing guidelines for providers, self-management and decision-making tools for patients and consumers, evaluations and reports on quality, and a collaborative approach to quality improvement.

The group seeks to build strong alliances among patients, doctors, hospitals, employers, and health plans to promote health and improve quality and affordability by reducing overuse, underuse, and misuse of health services. In line with this mission, the Alliance has outlined several initiatives:

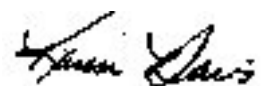
- Develop evidence-based clinical guidelines for diabetes, heart disease, back pain, depression, and pharmaceutical prescribing;
- Produce publicly available reports measuring quality performance of providers in the Puget Sound area, and potentially across the state;
- Encourage greater adoption of health information technology and electronic health records and prescriptions;
- Recommend incentives to encourage improved health and treatment outcomes while simultaneously rewarding quality, affordability, and patient satisfaction; and
- Provide tools for employees on how to manage their health and health care and for employers and unions to support better health.¹⁵

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There is much to learn from these examples, and the need to do so is pressing. While they demonstrate that it is possible to make the kinds of changes required to improve our health care system significantly, they also highlight our greatest challenge: creating a system in which these capabilities and attributes are not isolated, but rather reside together throughout the entire system. The kind of system we desire and deserve will offer consistent and reliable excellence in all its features. This is a lofty but ultimately essential imperative.

The Commonwealth Fund Commission on a High Performance Health System intends to continue examining these and other solutions available to a nation with our exceptional resources and capacity. Learning from pioneers and early adopters is a critical step in the improvement process. Equally important is building the will and the commitment from all stakeholders—purchasers, payers, providers, regulators, government, and patients themselves—to undertake the hard work that major change requires.

It is our hope that the Commission's work will be pivotal in all these tasks. The Commission and The Commonwealth Fund seek not just to expose our system's shortcomings, but to highlight proven strategies to overcome them, and support innovations that may lead to additional solutions. Our ultimate goal is to hasten the day when we can all benefit from a high-performance health system that provides high-quality, accessible, patient-centered care to every patient, every day, everywhere.



NOTES

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