

HEALTH SYSTEM QUALITY AND EFFICIENCY

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Program Goals

The Program on Health System Quality and Efficiency is a major part of The Commonwealth Fund's focus on health care delivery system improvement and innovation. The program's mission is to improve the quality and efficiency of health care in the United States, with special emphasis on fostering greater coordination and accountability among all those involved in the delivery of health care.

The program's work is rooted in the recognition that improvements are most likely to occur when the need for change is understood, measured, and publicly recognized; when providers have the capacity to initiate and sustain change; and when the appropriate incentives are in place. To that end, the program supports projects that:

- assess the capacity of organizations to provide coordinated and efficient population-based care, and help expand that capacity where necessary;
- foster the development and widespread adoption of standard measures for benchmarking the performance of health care organizations over time; and
- promote the use of incentives to improve quality and efficiency in health care.

The program is led by Vice President
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A Private Foundation Working Toward a High Performance Health System

The Issues

The quality and efficiency of American health care is not what it should be. While the basic skill and dedication of the nation's health care providers is not in question, there are nonetheless ample opportunities for improvement in quality, safety, coordination, and patient-centeredness throughout the health care system.

According to The Commonwealth Fund's 2011 [National Scorecard on U.S. Health System Performance](#), as many as 91,000 fewer premature deaths would occur if the United States were to reach the benchmark level of "mortality amenable to health care" achieved by the top-performing country. The relatively poor performance of the U.S. health system, coupled with the nation's standing as the biggest spender on health care in the world, also suggests it is a highly inefficient one. Supporting efforts to increase the value obtained from our health care dollars is one of the Fund's chief goals.

Recent Projects

Redesigning Care for High Performance

Hospitalizations consume nearly one-third of the \$2 trillion spent on health care in the United States. Many of these are readmissions for conditions that could have been prevented had proper discharge planning, education, and postdischarge support been provided for patients. In 2009, the Institute for Healthcare Improvement (IHI), with Commonwealth Fund support, initiated the [State Action on Avoidable Rehospitalizations \(STAAR\)](#), a multipronged effort to help hospitals improve their processes for transitioning discharged patients to other care settings and assist state policymakers and other stakeholders with implementing systemic changes that will sustain improvements. According to a [report in *Health Affairs*](#) (July 7, 2011) that presented early findings from the initiative, the most important rehospitalization-reduction strategies used so far are improving patient education, ensuring timely follow-up with patients after hospital discharge, and creating universal patient transfer or discharge forms. To date nearly 150 STAAR hospitals in three states have joined more than 500 community-based partners, including nursing homes, home health agencies, and physician practices, in the push to improve care transitions.

STAAR is also informing national efforts to reduce rehospitalizations, highlighting the value of collaboration among hospitals and community-based providers for improving care transitions and keeping discharged patients out of the hospital. The initiative has produced a number of how-to guides and other resources—all [available online](#)—to help providers implement best practices for good transitional care.

A concurrent Commonwealth Fund-supported evaluation of STAAR by Pennsylvania State University's Dennis Scanlon, Ph.D., is assessing how well the interventions succeed in reducing hospital readmission rates. The results should hold interest for the Medicare program and other public and provider payers for whom reducing hospitalizations is a priority.

To help hospital leaders get started on a plan for reducing readmissions, a team of experts at the Health Research and Educational Trust (HRET) produced the [Health Care Leader Action Guide to Reduce Avoidable Readmissions](#), with support from both the John A. Hartford Foundation and The Commonwealth Fund. This resource outlines strategies for reducing unplanned readmissions and enables hospitals to estimate the level of effort required for them to implement those strategies.

Accountable Care Systems

As the nation moves toward health care delivery systems that are accountable for the outcomes and health care costs of their patient populations, The Commonwealth Fund is sponsoring efforts intended to ensure the success of this model for achieving coordinated, patient-centered, efficient care. With Fund support, Elliott Fisher, M.D., and colleagues at the Dartmouth Institute for Health Policy and Clinical Practice and the Brookings Institution developed and pilot-tested a "starter set" of health care claims-based measures that could be used both to assess quality of care and to determine payments to accountable care organization (ACO) providers and the shared savings for which they are eligible. In the project's second phase, the team is developing and testing a more advanced set of measures, including clinical outcomes measures and patient-reported measures of care experience and health status. A new [case study series](#) produced by the Dartmouth team examines the progress of four diverse health care organizations—from integrated health systems to a community hospital—as they collaborate with their private-payer partners to become accountable care providers. The cases detail how these institutions, which are all taking part in the Brookings-Dartmouth ACO Pilot Program, formed their ACO partnerships, how they are developing the capacity to manage population health, quality, and costs, and how they are dealing with issues of governance, patient attribution, payment, patient and provider engagement, and benefit design.

For ACOs to succeed, new payment models are needed to foster greater accountability for the quality and cost of patient care. One such model is the Alternative Quality Contract, a global payment system for providers developed by Blue Cross Blue Shield of Massachusetts (BCBS) to replace fee-for-service reimbursement and counter rising health care spending. Under the contract, BCBS pays health care providers a comprehensive payment that covers the entire continuum of a patient's care for a specific illness—including inpatient,

outpatient, rehabilitative, and long-term care, as well as prescription drugs. Providers are eligible for a performance bonus if they meet certain quality targets. With Fund support, Harvard University's Michael Chernew, Ph.D., evaluated spending and quality improvement for BCBS patients whose primary care providers participated in the AQC and did the same for a control group of patients whose providers were not in the AQC.

According to a [study](#) in the *New England Journal of Medicine* coauthored by Chernew, Harvard colleague Zirui Song, and others, medical spending was modestly lower in the AQC's first year, as patients were referred to providers that charged lower fees. Improvements in the quality of adult chronic care and pediatric care were also evident. In another article, published in *Health Affairs*, Robert E. Mechanic, M.B.A., of Brandeis University, together with Chernew and colleagues, described how physician groups in the AQC have begun to [focus on quality improvement](#), reduce their use of expensive sites of care, and coordinate services for high-risk patients.

Meeting and Raising Benchmarks for Quality

Today, nearly 7,500 hospital executives, quality improvement professionals, medical directors, and others use The Commonwealth Fund's online resource for health care quality benchmarking, [WhyNotTheBest.org](#), to compare their organization's performance against their peers, learn from case studies of top performers, and access innovative improvement tools. With an array of custom benchmarks available, users can compare their organization's performance to the leaders and to national and state averages. Recently, the site added two new benchmarks: health system hospitals and non-health system hospitals.

WhyNotTheBest profiles more than 8,000 hospitals and 400 hospital systems on measures of appropriate care processes and outcomes, patient experiences, readmission rates, mortality rates, patient safety and use of resources. The site also reports on the incidence of central line-associated bloodstream infections for more than 1,300 U.S. hospitals, and it serves as a unique source of all-payer data across 12 states. In the past year, the site added an interactive map that enables users to explore performance at the county, hospital referral region, state, and national levels. The performance map will continue to be developed to track accountable care organizations and other emerging integrated systems and communities of care. Additional efforts this year will focus on outreach to new audiences for WhyNotTheBest, such as business coalitions and employers.

Resources such as WhyNotTheBest are essential for improving performance, but they are only as good as the measures for which they report data. Studies have shown that current measures of hospital readmission rates suffer from a lack of consensus over clinical validity,

among other concerns, and that different rehospitalization measures rank hospitals differently. With Commonwealth Fund support, Gerard Anderson, Ph.D., and Stephen Jencks, M.D., are leading a project to define an easily understood, clinically credible measure that will allow for fairer comparisons among states, regions, and hospitals. This work is especially timely, as the Centers for Medicare and Medicaid Services, in addition to private payers, are instituting incentives and penalties based on readmissions for certain preventable medical conditions.

Assessing Providers' Capacity to Improve Care

Mortality rates for people who have experienced an acute myocardial infarction (AMI)—a heart attack—vary substantially across U.S. hospitals, even when researchers adjust for the severity of the condition or other factors like hospital volume, teaching status, and patients' socioeconomic status. With Commonwealth Fund support, Elizabeth Bradley, Ph.D., and her team at Yale University interviewed more than 150 hospital staff members closely involved in AMI care to identify organizational factors that are common to providers with low AMI mortality rates. In a [paper](#) published in *Annals of Internal Medicine* (March 15, 2011), Bradley and her team reported that in the absence of an organizational culture that supports high-quality care, teamwork, and coordination, evidence-based clinical interventions may not be sufficient to improve care and reduce death from AMI. The authors say that hospitals need to set clear goals, secure the engagement of senior management, and establish clear communication and coordination standards.

Access to measures of physician clinical quality remains a challenge. Most commonly used measures—education, board certification, and malpractice history, among others—are mere proxies. With Commonwealth Fund support, researchers from RAND and the University of Pittsburgh, led by Ateev Mehrotra, M.D., used data from a large sample of physicians to examine the relationship between these types of physician characteristics and a range of performance measures. The results of the [study](#), published in the *Archives of Internal Medicine* (Sept. 13, 2010), show that proxy measures are not valid measures of clinical quality, and underscore the need to prioritize expanded public reporting of physician quality data.

Disseminating Best Practices and Innovative Models

Conducting case studies of high-performing provider organizations is an effective way to educate health care stakeholders about best practices for managing chronic diseases, reducing hospitalizations, increasing patient satisfaction, and achieving other important performance goals. A July 2010 Commonwealth Fund [case study series](#) profiled three health care organizations participating in the Institute for Healthcare Improvement's [Triple Aim initiative](#). The series, written by Douglas McCarthy and Sarah Klein, sheds light on how each is partnering with providers and organizing care to improve the

health of its patient population and the experience of care, while also controlling the per capita cost of care. The organizations selected—[CareOregon](#), a nonprofit Medicaid managed health care plan, [Genesys Health System](#), a nonprofit integrated delivery system, and [QuadMed](#), a firm that develops and manages worksite health clinics and wellness programs—represent a diversity of approaches.

Another set of Commonwealth Fund case studies documents advancements in patient safety made in the last five years by four health care organizations that were pioneers in the movement. In the series overview, *Keeping the Commitment: A Progress Report on Four Early Leaders in Patient Safety Improvement*, authors McCarthy and Klein describe how these providers were able to reduce serious events of patient harm, improve the organizational safety climate, and reduce malpractice claims as safety interventions spread from individual hospital units to the entire delivery system—even home health care providers. The case studies describe how the four systems—[Johns Hopkins Medicine](#), [OSF HealthCare](#), [Sentara Healthcare](#), and the [U.S. Department of Veterans Affairs](#)—have deployed new training, coaching, and motivational methods to engage staff in patient safety work; designed tools and systems for minimizing error and maximizing learning; set ambitious goals; and held individual units accountable for their performance.

The Fund is also sponsoring two evaluations focusing on best practices in health care delivery. The first evaluation, led by Geoffrey Lamb, M.D., is examining the Wisconsin Collaborative for Healthcare Quality, one of the U.S. Department of Health and Human Services' designated Chartered Value Exchange Networks and a leader in public reporting and the sharing of best practices. The other is studying shared decision-making in primary care and specialty clinics that are part of the Group Health Cooperative's network in Washington State. Headed by David Arterburn, M.D., the project is assessing the effectiveness of 12 patient-decision aids on the use of elective surgical procedures, total health care utilization, and total costs.

Future Directions

Although the Affordable Care Act encourages the establishment of accountable care organizations, it is not clear how ready health care providers are to participate in them or if they will be able to develop the capabilities to do so. In the first study of its kind, Commonwealth Fund-supported researchers led by Maulik Joshi, Dr.P.H., of the Health Research and Educational Trust will profile U.S. hospitals and health systems for their readiness to be accountable for the continuum of patient care, including their ability to manage financial risk, receive bundled payment, and calculate and distribute shared savings to providers.

Karen Donelan, Sc.D., of Massachusetts General Hospital and Catherine DesRoches, Ph.D., of Mathematica Policy Research will lead a longitudinal national survey to learn about the organizational settings and local health care markets in which physicians practice, as well as their care coordination processes and relationships with other providers, forms of reimbursement, and use of health information technology. Under a Fund grant to the University of Oregon, Jessica Greene, Ph.D., will evaluate the impact of provider payment reforms instituted by Fairview Health Services, an integrated health system in Minnesota that is discarding fee-for-service and replacing it with payment based on quality of care, productivity, patient experience, and cost.

The 17 U.S. communities chosen to participate in the federally authorized Beacon Community Cooperative Agreement Program are currently engaged in efforts to build and strengthen their health information technology infrastructure to achieve improvements in health care quality, cost-efficiency, and the management of community-level population health. With a combination of Commonwealth Fund and federal support, AcademyHealth has launched the Beacon Evaluation and Innovation Network to assist the Beacon Communities in accelerating the identification, documentation, and dissemination of lessons and results of their individual efforts. The network provides an unprecedented opportunity to expand the effectiveness of the program by helping to coordinate and convene evaluators with external experts to address research challenges and maximize opportunities to disseminate evidence.

To apply for a grant from The Commonwealth Fund's
Health System Quality and Efficiency program,
visit [Applicant and Grantee Resources](#).

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