



**CLOSING THE QUALITY CHASM:  
OPPORTUNITIES AND STRATEGIES FOR MOVING TOWARD  
A HIGH PERFORMANCE HEALTH SYSTEM**

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**Invited Testimony**

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**Senate Committee on Health, Education, Labor, and Pensions**

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## EXECUTIVE SUMMARY

As the nation turns to the issue of reforming our health insurance system, it is important simultaneously to address how we organize and deliver health services, to ensure that we are obtaining the best health outcomes for Americans and value for the money we are spending on health care. Unfortunately, the care we receive falls short of the care it is possible to deliver, and the gap is not narrowing. According to the most recent National Scorecard published by the Commonwealth Fund Commission on a High Performance Health System, the U.S. health system scored 65 out of 100 possible points in 2008 on 37 indicators of performance that capture key dimensions of health outcomes, quality, access, equity, and efficiency.

The Scorecard shows that the U.S. is not making consistent progress in reducing the variability of care quality and is failing to keep pace with gains in health outcomes achieved by our industrialized peers.

- The nation now ranks last out of 19 countries on a measure of mortality amenable to medical care, falling from 15th in five years as other countries raised the bar on performance.
- The widening quality chasm is having real effects on real lives—up to 101,000 deaths could be prevented each year if the U.S. raised standards of care to benchmark performance levels achieved abroad.
- While we spend more than twice what other nations spend on health, there is overwhelming evidence of inappropriate care, missed opportunities, and waste within the U.S. health system.

We are fortunate that within our imperfect system there are examples of all the components that, properly organized, reformed, and financed, can enable the nation to provide high-quality, affordable care to every American. Insight into what it takes to achieve high performance is provided by some examples of excellence within the U.S. and around the world:

- The Geisinger Health System, on whose board I am pleased to serve, is a leader in innovation and quality improvement that demonstrates the importance of simultaneously aligning incentives, utilizing electronic health records, and creating policies to encourage coordination of care.
- Denver Health, a comprehensive and integrated medical system that is Colorado's largest health care safety-net provider, has succeeded by promoting a culture of continuous quality improvement and lean efficiency, adopting information technology, and providing organization-wide leadership.
- State initiatives in Iowa and Vermont have achieved better health outcomes and increased access to needed health services by encouraging adoption of the medical home model, disseminating performance information and best practices, and launching focused campaigns to cover young children.

- Regional associations like Massachusetts Health Quality Partners and the Wisconsin Collaborative for Healthcare Quality have been leaders in quality improvement efforts by collecting and disseminating performance data on hospitals and physician groups and educating providers and patients to use that information to facilitate quality improvement activities.
- Denmark and the Netherlands have become international leaders in patient-centered, coordinated care by placing great emphasis on accessible primary care and developing information systems that assist primary care physicians in coordinating health care services.

The specific policies that will both lead to better health outcomes and bend the curve of our nation's unsustainable spending on health revolve around five strategies amenable to action at the federal level:

- Provide affordable health coverage for all;
- Reform provider payment;
- Organize our care delivery systems;
- Invest in a modern health system; and,
- Ensure strong national leadership.

Congress can continue to develop the infrastructure for improving quality by making investments in health information technology and information exchange networks. If the U.S. is serious about closing the quality chasm, it will also need a strong primary care system, which requires fundamental provider payment reform, encouraging all patients to enroll in a patient-centered medical home, and supporting those physician practices with IT and technical assistance in care process design. Funding for comparative effectiveness research and the establishment of a center for comparative effectiveness is also crucial to value-based purchasing and performance improvement initiatives. Finally, the federal government can raise the bar for health system performance by setting explicit goals and priorities for improvement—particularly with regard to the most prevalent chronic conditions, which account for a large majority of health care costs.

By applying these policies collectively, the nation would be able to capture the synergistic benefits of specific changes that, if implemented individually, would yield more modest improvements in quality and less reduction in projected spending trends. The reforms must support providers in their efforts to deliver the best care possible for their patients. Armed with the knowledge that the status quo is no longer acceptable, we have entered a new era ripe with opportunity to close the quality chasm and improve the health and well-being of American families. Working together we can change course—and move the U.S. health system on a path to high performance.

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A HIGH PERFORMANCE HEALTH SYSTEM**

**Karen Davis  
The Commonwealth Fund**

Thank you, Senator Mikulski, for this opportunity to testify on health care quality and delivery system reform in the United States. As the nation turns to the issue of reforming our health insurance system, it is important simultaneously to address how we organize and deliver health services, to ensure that we are obtaining the best health outcomes for Americans and value for the money we are spending on health care.

Unfortunately, the care we receive falls short of the care it is possible to deliver, and the gap is not narrowing. According to the most recent National Scorecard published by the Commonwealth Fund Commission on a High Performance Health System, the U.S. health system scored 65 out of 100 possible points in 2008, on 37 indicators of performance that capture key dimensions of health outcomes, quality, access, equity, and efficiency.<sup>1</sup> This is down slightly from 67 out of 100 in 2006 – we are not on the right path.

The good news is that we no longer simply assert that we have the best health system in the world,<sup>2</sup> and instead are beginning to take a clear-eyed look at how our system performs overall, across states, and in comparison with other countries. We are beginning to have the information that shows where we are gaining ground, and where there are opportunities to improve. Public reporting of data on quality of hospital care and focused campaigns to improve quality are spurring improvement. Many health care professionals and organizations are responding to the challenge and adopting information technology, redesigning care processes, and mobilizing efforts to improve results.

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<sup>1</sup> The 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*, (New York: The Commonwealth Fund, July 2008); C. Schoen, K. Davis, S. K. H. How, and S. C. Schoenbaum, "U.S. Health System Performance: A National Scorecard," *Health Affairs*, November/December 2006; 25(6): w457-w475.

<sup>2</sup> EJ Emanuel, "What Cannot Be Said on Television About Health Care," *JAMA* 2007; 297:2131-2133.

Examples of excellence within the U.S., as well as around the world, demonstrate what can be achieved.

But the U.S. will not have the health system we want for ourselves and our families if the federal government does not lead and implement a series of strategies that taken together can close the quality chasm. These include, most importantly, extending health insurance to all; aligning financial incentives to reward the outcomes we want to achieve; changing the organization and delivery of care to ensure that it is accessible, coordinated, and patient-centered; investing in the infrastructure and support necessary to reach attainable levels of quality and efficiency; and exercising the leadership and collaboration among all parts of the health system necessary to achieve health goals for the nation.

By applying these policies collectively, the nation would be able to capture the synergistic benefits of specific changes that, if implemented individually, would yield more modest improvements in quality and less reduction in projected spending trends. The reforms must support providers in their efforts to deliver the best care possible for their patients. Armed with the knowledge that the status quo is no longer acceptable, we have entered a new era ripe with opportunity to close the quality chasm and improve the health and well-being of American families. Working together we can change course—and move the U.S. health system on a path to high performance.

## **I. Headed in the Wrong Direction: Evidence of a Widening Quality Chasm**

Despite the best efforts of millions of talented and dedicated health care professionals, the U.S. is not making consistent progress in reducing the variability of care quality and is failing to keep pace with gains in health outcomes achieved by our industrialized peers.<sup>3</sup> The nation now ranks last out of 19 countries on a measure of mortality amenable to medical care, falling from 15th in five years as other countries raised the bar on performance.<sup>4</sup> This widening quality chasm is having real effects on real lives—up to 101,000 deaths could be prevented each year if the U.S. raised standards of care to benchmark performance levels achieved abroad.

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<sup>3</sup> Commonwealth Fund Commission, *Ibid.*

<sup>4</sup> E. Nolte and C. McKee, “Measuring The Health Of Nations: Updating An Earlier Analysis,” *Health Affairs*, January/February 2008; 27(1): 58-71.

A focus on preventive care and proper management of chronic disease are key strategies to increase the effectiveness of health care delivery, an area where lack of progress is undermining the nation's efforts to improve quality. While the benefits of prevention are well documented,<sup>5</sup> the national scorecard report found that only half of adults receive all age-appropriate preventive care services such as immunizations, cancer screenings, and blood pressure and cholesterol tests. There was no improvement on this indicator between the 2006 and 2008 scorecards. Meanwhile, troubling variation in chronic disease management is evident across health plans and insurance status despite slight improvements in the control of diabetes and hypertension. A recent National Committee for Quality Assurance study found that eliminating this variance would prevent up to 46,000 premature deaths and save up to \$2.4 billion in medical costs.<sup>6</sup>

Indicators of patient safety are also important measures of overall quality within the health care system. One bright spot is that the United States showed progress on hospital standardized mortality ratios, which declined by 19 percent on the 2008 scorecard from the earlier report. This measure was the focus of a 100,000 Lives campaign led by the Institute for Healthcare Improvement. Other organizations that are working to improve patient safety include the World Health Organization, the Joint Commission National Patient Safety Goals, the Leapfrog Group's Hospital Quality and Safety Survey, the National Surgical Quality Improvement Program, the American Medical Association's National Patient Safety Foundation, and the Center for Disease Control and Prevention's National Health Safety Network.<sup>7</sup>

There also have been gains in acute hospital care for heart attack, heart failure, and pneumonia patients – based on quality metrics reported to Medicare. Yet, gaps in the receipt of recommended care for pneumonia and heart failure were particularly wide, with spreads of 20 to 30 percentage points between the bottom and top 10th percentiles. Standardized federal reporting has shown top hospitals are achieving 100 percent on basic process measures, indicating that full adherence to a set of best practice guidelines is possible. Researchers estimate that if hospitals in the bottom quartile of performance

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<sup>5</sup> T. Kottke et al., "The Comparative Effectiveness of Heart Prevention and Treatment Strategies," *Am J Prev Med* 2009; 36(1): 82-88.

<sup>6</sup> National Committee for Quality Assurance, *The State of Health Care Quality 2008*, (Washington, D.C.: NCQA, 2008).

<sup>7</sup> Commonwealth Fund Commission, *Ibid.*

improved to the level of the top quartile, more than 2,000 deaths could be avoided each year.<sup>8</sup>

Substantial variation was also found among risk-adjusted mortality rates for several serious conditions and risk-adjusted costs for Medicare beneficiaries, demonstrating both inefficiency and a vast quality chasm throughout the country. Updated analysis of Medicare data shows that one-year risk-adjusted mortality rates for heart attacks, hip fractures, and colon cancer varied between 27 and 33 percent among the best- and worst-performing regions, while risk-adjusted cost ranged from \$25,000 to \$30,000. A significant number of those regions with lower risk-adjusted mortality rates also utilized lower total resources, suggesting significant inefficiency among higher spending regions.<sup>9</sup> If all areas of the country achieved the performance levels of the benchmark regions, Medicare could save more than 9,000 lives and reduce annual costs by nearly \$1 billion a year for these three conditions alone.

Providing quality care during a hospital stay and giving appropriate discharge planning, follow-up, and post-acute care can help prevent patients from being readmitted to the hospital, thus improving the patient experience and reducing the total costs of care.<sup>10</sup> However, no improvement in the Medicare 30-day hospital readmission rate was seen in the 2008 scorecard, and regional variation remained stark. Nearly one of five Medicare patients initially hospitalized with one set of selected conditions was readmitted to the hospital within 30 days, with rates in the worst performing regions 50 percent higher than those in the better performing areas of the country. A Medicare Payment Advisory Commission analysis indicates that three-quarters of readmissions may be preventable at a potential savings of \$12 billion a year for Medicare.<sup>11</sup>

The 2008 scorecard also showed increases in the rate of hospitalization and 30-day hospital readmission of nursing home residents, two indicators of poor coordination

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<sup>8</sup> A. Jha et al., "The Inverse Relationship Between Mortality Rates and Performance in the Hospital Quality Alliance Measures," *Health Affairs*, July/August 2007; 26(4): 1104-1110.

<sup>9</sup> E. Fisher, D. Wennberg et al., "The Implications of Regional Variations in Medicare Spending. Part 1: The Content, Quality, and Accessibility of Care," *Annals of Internal Medicine*, February 18, 2003; 138(4): 273-287; E. Fisher, D. Wennberg et al., "The Implications of Regional Variations in Medicare Spending. Part 2: Health Outcomes and Satisfaction with Care," *Annals of Internal Medicine*, February 18, 2003; 138(4): 288-298.

<sup>10</sup> Medicare Payment Advisory Commission, "Payment Policy for Inpatient Readmissions," *Report to the Congress: Promoting Greater Efficiency in Medicare*, (Washington: MedPAC, June 2007).

<sup>11</sup> MedPAC, *Ibid.*

and poor quality for one of the most vulnerable populations within the United States. Nearly one of five nursing home long-stay residents was hospitalized according to the most recent analysis of Medicare claims data, up from 17 percent in the previous study. The frequency of hospitalization and 30-day hospital readmission of nursing home residents increased among both high- and low-performing states.

Rates of potentially preventable hospitalizations for ambulatory care-sensitive (ACS) conditions are another key measure of quality within the U.S. health care system. Widespread variation was again the theme, with two- to four-fold differences across states and hospital referral regions along with associated discrepancies in costs and resource use. At least \$4 billion annually could be saved if these rates fell to benchmark levels.

The 2008 scorecard reported 15 to 24 percentage point differences on important indicators of hospital patient-centered care, including how well staff managed pain, responded when patients pressed a call button, or explained medications and their possible side effects. The best hospitals achieved very high rates of patient ratings on these questions, illustrating that it is possible for hospitals to do much better in meeting patients' needs.

The rate of medical, medication, and lab errors is yet another important quality indicator where the U.S. has failed to keep pace with gains made by benchmark performers in the international community. Nearly one-third of U.S. patients surveyed in 2007 said that, in the last two years, a medical mistake or a medication or lab test error was made during their care. There was little to no improvement on this metric since it was reported in the 2006 scorecard. It would take a 40 percent reduction in the medical, medication, and lab test error rate in the U.S. to reach the low level reported in Germany, the benchmark country.

Aggregate scores on dimensions of care coordination fell between 2006 and 2008, demonstrating that fragmentation and misaligned incentives continue to plague the U.S. health system. The percentage of adults who reported access to a regular source of primary care failed to improve, a particularly disturbing finding given that those who lack a usual source of primary care are more likely to have unmet health care needs and higher

costs of care while being less likely to adhere to treatment and receive preventive care.<sup>12</sup> Differing rates of coordination for hospital patients was similarly distressing, with nearly three-fold variation among high and low performers on the percentage of heart failure patients who received complete written instructions at discharge. Proper coordination of care at the time of hospital discharge helps prevent subsequent complications and readmissions, especially for patients with complex or chronic conditions.<sup>13</sup>

Finally, while studies have shown that expansion of health information technology is a means of facilitating quality reporting and improvement, analysis of the 2006 Commonwealth Fund Survey of Primary Care Physicians demonstrates that the United States falls far behind the Netherlands, New Zealand, the United Kingdom, Australia, and Germany on the utilization and functionality of health IT. The contrast between the United States and the Netherlands is particularly stark, with 98 percent of Dutch primary care physicians reporting the use of electronic medical records compared with only 28 percent of their American counterparts. This general pattern persists when examining the prevalence of other IT functions such as electronic prescribing, decision support, and computerized access to test results.<sup>14</sup>

## II. Impediments in the Current System

In short, the U.S. health care system is plagued by significant variability in quality and is failing to match the gains seen among its industrialized peers. Impediments to improvement include a lack of affordable health coverage for all, a wasteful and inefficient provider payment system, a fragmented and disorganized care delivery system, widespread failure to adopt health information technology, and limited federal oversight and leadership. A recent Commonwealth Fund study found that the U.S. ranked last

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<sup>12</sup> B. Starfield, *Primary Care: Balancing Health Needs, Services, and Technology* (New York: Oxford University Press, 1998).

<sup>13</sup> E. Coleman, "Falling Through the Cracks: Challenges and Opportunities for Improving Transition Care for Persons with Continuous Complex Care Needs," *Journal of the American Geriatrics Society*, April 2003; 51(4): 549-555.

<sup>14</sup> C. Schoen, R. Osborn, P. Trang Huynh, M. Doty, J. Peugh, K. Zapert, "On The Front Lines of Care: Primary Care Doctors' Office Systems, Experiences, and Views in Seven Countries," *Health Affairs*, November/December 2006; 25(6): w555-w571; K. Davis, M. Doty, K. Shea, and K. Stremikis, "Health Information Technology and Physician Perceptions of Quality of Care and Satisfaction," *Health Policy*, forthcoming 2009.

among six industrialized nations on health system performance.<sup>15</sup> Despite spending more than twice what other nations spend on health, there is overwhelming evidence of inappropriate care, missed opportunities, and waste within the U.S. health system.

Lack of affordable health coverage is a proven barrier to obtaining quality care and improving the value of the country's significant expenditure on health services. The U.S. stands alone among its industrialized peers in failing to provide universal coverage, and ranked last among six nations in a recent Commonwealth Fund study on an aggregate measure of health care access.<sup>16</sup> Cost-related problems are widespread, with more than half of respondents to a 2005 survey reporting problems getting recommended tests, treatments, or follow-up care, filling prescriptions, or visiting a doctor when they had medical problems because of cost. Not surprisingly, lack of affordable coverage and the attendant financial barriers to care contributed to underuse of health services among the uninsured, a group much less likely to obtain preventive care, fill prescriptions, and have chronic conditions under control.<sup>17</sup> This phenomenon drives disparities in outcomes, decreases the proportion of the population receiving appropriate primary care to prevent illness, and puts the health of the millions of Americans living with chronic conditions in peril.

Misalignment of financial incentives is also a significant impediment to successful quality improvement in the United States. The 2006 Commonwealth Fund International Health Policy Survey showed that only 30 percent of American primary care physicians received any financial incentive to improve quality, contrasted with their counterparts in the United Kingdom nearly all of whom reported financial bonuses – the result of a bonus system which can account for up to 30 percent of their income based on a broad array of quality measures covering preventive and chronic care and patient experiences.<sup>18</sup> Commonwealth Fund studies have also found the predominance of the fee-for-service payment system in the United States—an arrangement that rewards volume over value—to be a significant barrier to streamlined and more efficient delivery

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<sup>15</sup> K. Davis, C. Schoen, S. C. Schoenbaum, M. M. Doty, A. L. Holmgren, J. L. Kriss, and K. K. Shea, *Mirror, Mirror on the Wall: An International Update on the Comparative Performance of American Health Care*, (New York: The Commonwealth Fund, May 2007).

<sup>16</sup> Davis, "Mirror, Mirror," *Ibid.*

<sup>17</sup> Commonwealth Fund Commission, *Ibid.*

<sup>18</sup> Davis, "Mirror, Mirror," *Ibid.*

models.<sup>19</sup> Analysis has shown that doctors and hospitals practicing in the same community and caring for the same patients have little or no incentive or capacity to connect to one another, contributing to unnecessary duplication of tests and procedures, wasteful deployment of resources, and substandard outcomes.<sup>20</sup>

Fragmentation of the American care delivery system drives low-quality, inappropriate, and inefficient service in a country filled with highly skilled health care professionals. A disjointed mix of private insurers and public programs, each with its own set of rules and payment methods, fuels fragmentation, generating waste and high administrative costs.<sup>21</sup> Moreover, widespread failure to adopt the patient-centered medical home model, especially among community health centers serving low-income and minority patients, has contributed to uneven performance and exacerbated disparities in quality along racial and socioeconomic lines.<sup>22</sup>

Data from high performing health systems across the country show that moving towards more integrated models of care is a proven strategy for increasing quality of care while simultaneously reducing costs and inefficiencies.<sup>23</sup> Over 80 percent of respondents to a recent Commonwealth Fund Health Care Opinion Leaders Survey say that strengthening the primary care system, encouraging care coordination, and facilitating the integration of providers within and across care settings are important steps to improving health system performance.<sup>24</sup>

Substandard outcomes and insufficient value are also driven by insufficient adoption of health information technology (IT) and the absence of information exchange

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<sup>19</sup> K. Stremikis, S. Guterman, and K. Davis, *Health Care Opinion Leaders' Views on Payment System Reform*, (New York: The Commonwealth Fund, November 2008).

<sup>20</sup> MedPAC, "Payment Policy for Inpatient Readmissions," *Ibid.*; D. Grabowski, "Medicare and Medicaid: Conflicting Incentives for Long-Term Care," *Milbank Q.*, December 2007; 85(4): 579-610; T. Bodenheimer, "Coordinating Care—A Perilous Journey Through the Health Care System," *N Engl J Med.*, March 6, 2008; 358(10):1064-1071.

<sup>21</sup> A. Shih, K. Davis, S. Schoenbaum, A. Gauthier, R. Nuzum, and D. McCarthy, *Organizing the U.S. Health Care Delivery System for High Performance*, (New York: The Commonwealth Fund, August 2008).

<sup>22</sup> M. Abrams, "Achieving Person-Centered Primary Care: The Patient-Centered Medical Home," *Invited Testimony, Special Senate Committee on Aging Hearing on "Person-Centered Care: Reforming Services and Bringing Older Citizens Back to the Heart of Society,"* (New York: The Commonwealth Fund, July, 2008).

<sup>23</sup> R. A. Paulus, K. Davis, and G. D. Steele, "Continuous Innovation in Health Care: Implications of the Geisinger Experience," *Health Affairs*, September/October 2008; 27(5): 1235-1245.

<sup>24</sup> K. K. Shea, A. Shih, and K. Davis, *Commonwealth Fund Commission on a High Performance Health System Data Brief: Health Care Opinion Leaders' Views on Health Care Delivery System Reform*, (New York: The Commonwealth Fund, April 2008)

systems. Analysis of the 2006 Commonwealth Fund Survey of Primary Care Physicians demonstrates that the United States has fallen far behind the Netherlands, New Zealand, the United Kingdom, Australia, and Germany on a number of measures related to the utilization of health IT.<sup>25</sup> The contrast between the United States and the Netherlands is particularly stark, with 98 percent of Dutch primary care physicians reporting the use of electronic medical records compared with only 28 percent of their American counterparts. This general pattern persists when examining the prevalence of other IT functions such as electronic prescribing, decision support, and computerized access to test results. A recent Commonwealth Fund-supported study suggests that linking health IT to performance improvement efforts has the potential to both improve the quality of care and significantly reduce costs.<sup>26</sup> If automated decision support was utilized among the 37 million hospital admissions in the U.S. in 2005, facilities across the country would stand to save almost \$20 billion a year.

Finally, limited federal leadership has contributed to uneven application of quality improvement initiatives and widespread variance in health outcomes. To date, federal leaders have not clearly identified national priorities and targets for improvement, and have not implemented a federal system for monitoring and reporting performance on those metrics. Similarly, no federal all-payer database exists for patients who want to know, for example, the survival and complication rate of their surgeon. In the United Kingdom, this type of information is available through the Internet.<sup>27</sup> The U.S. federal government is not currently funding comparative effectiveness research and has not created a national institute to synthesize research, inform benefit design, and guide clinical practice. Such steps have been crucial in value-based purchasing and performance improvement initiatives in other industrialized countries.

### **III. Opportunities and Progress**

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<sup>25</sup> C. Schoen, "On The Front Lines of Care," *Ibid.*

<sup>26</sup> R. Amarasingham et al., "Clinical Information Technologies and Inpatient Outcomes," *Arch Intern Med.* 2009; 169(2):1-7.

<sup>27</sup> K. Davis, *Learning From High Performance Health Systems Around the Globe, Invited Testimony: Senate Health, Education, Labor, and Pensions Committee Hearing*, (New York: The Commonwealth Fund, January 2007).

We are fortunate that within our imperfect health care system are examples of all the components that, properly organized, reformed, and financed, can enable the nation to provide high-quality, affordable care to every American. Systematically applying and disseminating what we know works would help put the U.S. on the path to a high-performance health system.

Several ongoing quality improvement initiatives are contributing to improving performance in hospitals, physician practices, health plans, and public programs in the United States. Over the last 15 years, The Commonwealth Fund has been pleased to support, assess, and disseminate information on a number of efforts to improve quality. It is impossible to give a comprehensive catalog of these efforts, here, but I would like to highlight just a few to give the Committee a sense of the richness of activities underway.

- **Public Awareness.** The Institute of Medicine launched the modern quality movement with its report, *To Err is Human* followed by its report on *The Quality Chasm*.<sup>28</sup>
- **Measurement of Quality.** The National Center for Quality Assurance has been a leader in the development of measures of quality, beginning with a HEDIS set of clinical quality measures, collected and made available at the health plan level. The Agency for HealthCare Quality and Research has added measures of patient experiences with care (CAHPS) to the quality measurement toolkit. Specialty and professional societies have also contributed substantially to the development of an armamentarium of quality measures.
- **Endorsement of Measures.** The National Quality Forum has brought an overarching framework to quality measurement through its endorsement of measures with rigorous standards and its process for expert input.
- **Public Reporting.** The Congress accelerated public reporting of quality information by giving the Medicare program authority to base payment on reporting quality data by hospitals, and more recently by physicians. The

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<sup>28</sup> Institute of Medicine, *To Err is Human: Building a Safer Health System*, (Washington: National Academy Press, 2000); J. Corrigan et al., *Crossing the Quality Chasm: A New Health System for the 21st Century*, (Washington: National Academy Press, 2001).

National Center for Quality Assurance reports on health plan performance on HEDIS clinical quality measures and patient experiences with care (CAHPS). Its annual State of the Nation's Health report is a valuable source of information on quality of care provided to health plan enrollees, including those in commercial, Medicare, and Medicaid health plans. State and regional collaboratives have also led in generating publicly available data on provider performance to be used for three purposes: provider quality improvement, patient choice, and payer rewards.

- **Quality Improvement.** The Institute for HealthCare Improvement has pioneered efforts to improve quality of care through national campaigns and quality improvement breakthrough series. The Medicare Quality Improvement Organizations have provided technical assistance and support to hospitals, physician practices, and nursing homes to improve quality of care. The Commonwealth Fund is striving to make data and tools useful to quality improvement efforts within hospitals available through its WhyNotTheBest.org website.
- **Pay for Performance.** The Leapfrog Group initiated the first major purchaser effort to reward hospitals and other providers who met high standards of quality, and maintains a comprehensive inventory of pay-for-performance initiatives. The Integrated Healthcare Association (IHA) is a statewide leadership group that promotes quality improvement, accountability, and affordability of health care in California, including instituting a system of pay-for-performance to reward medical groups for improving quality, patient experiences, and adoption of health information technology. More than half of state Medicaid programs have elements of paying for performance.<sup>29</sup> Medicare demonstrations including the Hospital Quality Demonstration Initiative and the Physician Group Practice demonstration have implemented and assessed the impact of financial incentives to improve quality.<sup>30</sup>

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<sup>29</sup> K. Kuhmerker and T. Hartman, *Pay-for-Performance in State Medicaid Programs: A Survey of State Medicaid Directors and Programs*, (New York: The Commonwealth Fund, April 2007).

<sup>30</sup> S. Guterman and M. P. Serber, *Enhancing Value in Medicare: Demonstrations and Other Initiatives to Improve the Program*, (New York: The Commonwealth Fund, January 2007).

As a result of these and many other activities, we have made extraordinary progress over the last decade in learning about and improving quality. As noted above, these efforts have borne fruit in improved quality on selected aspects of care that have been the focus of improvement efforts – such as reduced hospital standardized mortality rates which were the focus of the IHI 100,000 Lives Campaign; improved control of chronic conditions which have been reported at the health plan level by NCQA for over a decade; and the Medicare-reported hospital quality measures for heart attacks, congestive heart failure, and pneumonia.

Yet, wide variation in quality and efficiency across states, hospital service areas, and providers persists. Nor is there a systematic all-patient data base that contains the information that would help patients make informed choices. For example, a patient who wants to know the cancer survival rate of cancer centers across the U.S. for his or her form of cancer has no data base to which to turn. A patient who wants to know the survival and complication rates of their surgeon before surgery compared to other surgeons, has no place to turn in most parts of the U.S.

Nonetheless, insight into what it takes to achieve high performance is provided by examples of excellence within the U.S. and around the world. I'd like to highlight some specific examples that point the way to give the Committee a flavor of the innovation that is currently going on. This includes a description of what two health care systems in the U.S. – Geisinger Health System and Denver Health – are doing to achieve high performance; followed by the activities of Iowa and Vermont, two states that score well on the Commonwealth Fund state scorecard; two regional collaboratives which report quality data and work with providers to improve performance – the Massachusetts Health Quality Partners and the Wisconsin Collaborative for Healthcare Quality; and finally health system innovations in the Netherlands and Denmark.

#### **Geisinger Health System and Denver Health**

The Geisinger Health System, on whose board I am pleased to serve, is a leader in innovation and quality improvement – contributing to its ranking in this year's NCQA State of the Nation's Health report in the top five health plans in the nation and top three participating in Medicare. In a September 2008 article in the health policy journal, *Health*

*Affairs*, Geisinger CEO Glenn Steele, M.D., chief innovation officer, Ron Paulus, M.D., and I summarized how Geisinger achieves continuous innovation in health care.<sup>31</sup>

Geisinger is an integrated delivery system in northeastern Pennsylvania with clinical leadership that focuses on value creation, measures innovation returns, and is appropriately rewarded in the market both because it has its own Medicare Advantage plan and because it is participating in the Medicare physician group practice demonstration for Medicare patients not enrolled in plans. Its pilot test of patient-centered medical homes in two primary care group practice sites has reduced hospital admissions of Medicare patients by 20 percent. Its erythropoietin pharmacist-driven care management model for anemia associated with chronic kidney disease resulted in \$3,800/patient/year in drug cost savings. It has redesigned its care process for coronary artery bypass graft surgery (“CABG”) to provide “proven care” and offered insurers a global fee with a “warranty.”

Geisinger’s mission, dedicated innovation and quality improvement units, electronic health information system, and alignment of financial incentives through its own health plan contribute to its record of innovation. Its innovation experience has three implications for national policy: 1) aligning incentives to reward enhanced healthcare value creation; 2) recognizing that electronic health records are absolutely necessary, but not sufficient to create sustainable change in care delivery; and 3) creating policies that encourage greater organization of care delivery and collaboration among payers and providers to foster propagation of innovation that enhances value.

Denver Health, a comprehensive and integrated medical system that is Colorado’s largest health care safety-net provider, has a national reputation as a high-performance organization. Members of The Commonwealth Fund Commission on a High Performance Health System observed Denver Health during a site visit in March 2006, to assess its operation and determine whether it might serve as a model for other public and private health care systems around the country.<sup>32</sup> The Commission concluded that Denver Health is indeed a “learning laboratory.” It has succeeded at providing coordinated care to the community, promoting a culture of continuous quality improvement, adopting new

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<sup>31</sup> Paulus, “Continuous Innovation,” *Ibid.*

<sup>32</sup> R. Nuzum, D. McCarthy, A. Gauthier, and C. Beck, *Denver Health: A High-Performance Public Health Care System*, (New York: The Commonwealth Fund, July 2007).

technology and incorporating it into everyday practice, taking risks and making mid-course corrections, and providing leadership and support to its staff.

Since 2003, Denver Health has transformed itself and created a culture of deliberate improvement. As a result, the organization adopted specific new processes and tools. For example, it systematically applied the principles of "lean manufacturing" based on Toyota's approach to streamlining its operations and eliminating waste. Denver Health has also focused on building its infrastructure for high performance in two important areas: information technology (IT) and workforce. The organization's investment in health-oriented IT, which has totaled \$275 million since 1997, has enabled the establishment of a centralized data warehouse that integrates both clinical and financial data and allows for standardized reporting. A single imaged electronic-record format is used across the entire system so that a patient's information can be retrieved in "real time" by any of his or her providers. To ensure that it has a capable workforce, Denver Health has restructured its hiring practices to recruit and retain the "right people."

While there are many factors contributing to the overall high quality of care that Denver Health provides to its patients, the Commission highlighted several:

- Denver Health is an integrated system, endowed with appropriate tools including an electronic information system and infrastructure to provide coordinated care to the community.
- It has its own Medicaid managed care plan, and state officials have been supportive of policies that permit it to use surpluses from its plan to provide care to a large uninsured and indigent patient population.
- Denver Health promotes a culture of improvement, peopled by dedicated staff. The decisions are data-driven and feedback loops allow for continuous quality improvement. Innovation at Denver Health has strong support at the top.

Geisinger Health System and Denver Health differ in major respects: one is a nonprofit integrated delivery system in a rural area with a disproportionate concentration of elderly Medicare patients; the other is a public integrated delivery system in a large metropolitan area with a disproportionate concentration of low-income uninsured and

Medicaid patients. But both receive at least a portion of their revenues on a “bundled” capitated rate per person enrolled and their public/nonprofit, mission-driven organization leads them to dedicate surpluses gained from eliminating waste and preventing avoidable complications to improving care. They both have invested extensively in health information systems. They have dedicated innovation and quality improvement units that lead the organizations in continuous innovation and improvement. They are led by clinician leaders with a commitment to excellence in patient care, while maintaining fiscal stability of the organization.

### **Iowa and Vermont**

In June 2007 the Commonwealth Fund Commission on a High Performance Health System released a state scorecard on health system performance.<sup>33</sup> This was followed in May 2008 with a child health state scorecard on health system performance. There was wide variation across states on health outcomes, quality, access, equity, and cost. Iowa ranked first on performance of its health system for children and second on the overall state scorecard. Vermont was second on the children’s health scorecard and fourth on the overall scorecard.

Many factors help explain why these states stand out. Both have high rates of health insurance coverage as a result of state Medicaid and SCHIP policies. They rank highly on children and adults cared for in patient-centered medical homes. Both have medical schools with an emphasis on training primary care physicians. And both have a long history of collaboration to promote quality. Both have public health departments that are strongly linked to their communities and that have a mission to serve communities. In both states, public health partners well with Medicaid and with the private sector, especially in terms of outreach to pregnant women and young children.

Iowa has a longstanding commitment to children. In the past decade, the state paid particular attention to the needs of its youngest residents, from birth to age 5. After piloting a variety of early childhood preventive programs in the early 1990s to identify and serve at-risk children and families, the Iowa Legislature established a statewide initiative to fund designated “local empowerment areas” across the state to create local

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<sup>33</sup> 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*, (New York: The Commonwealth Fund, June 2007).

partnerships among clinicians, parents, child care representatives, and educators focused on preventive services. The University of Iowa and a substantial portion of practices in the state have all voluntarily adopted the same EMR system, which is streamlining referral processes.

The Iowa Healthcare Collaborative (IHC) has also been a key means through which the state's healthcare community has come together to improve quality, patient safety, and the value of health care.<sup>34</sup> By focusing on transparency and accountability, sharing performance information and best practices among both health care providers and the general public, the IHC has driven important progress in clinical improvement and empowered patients and families across the state. The collaborative has actively facilitated gains in efficiency by distributing the tools and principles of the Toyota Production System, better known as "Lean," on its website. The group also serves as the Iowa field office, or "node," for IHI's 5 million lives campaign to reduce incidents of medical harm. Further quality improvement efforts include medical home initiatives, establishment of a community advisory council, reduction of healthcare-associated infections, and support of rapid response teams.

The Vermont legislature, in collaboration with public health, Medicaid and the private sector developed a blueprint for health care in Vermont. It builds on the Wagner chronic care model, using measurement and direct support to practices. They have bought into the medical home idea using NCQA criteria. The state is trying to use payment reform to drive quality, and is encouraging adoption of EMR and supporting outreach to help practices implement changes in their micro-processes (appointments, handling messages, tracking laboratory results, creating registries). Also, Medicaid and the health plans have agreed on common measures of quality, which helps the practices focus on a few things, rather than responding to multiple different expectations.

Vermont also has long placed a high priority on children. In 1989, the state enacted the *Dr. Dinosaur* program, which expanded health insurance coverage to children up to age 17 in families earning less than 225 percent of the federal poverty level, as well as pregnant women in families earning less than 200 percent of poverty.

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<sup>34</sup> Iowa Healthcare Collaborative, *2008 Annual Report*, (Des Moines: Iowa Healthcare Collaborative, 2008).

In 2006, Vermont expanded SCHIP income eligibility levels for children in families with incomes up to 300 percent of the federal poverty level. Vermont is also home to the Vermont Child Health Improvement Project (VCHIP), a regional partnership of professional society chapters; the Department of Public Health; the state's Medicaid agency; the University of Vermont's Department of Pediatrics faculty; the Banking, Insurance, Securities and Health Care Administration; and three Vermont managed care organizations. These public and private partners use measurement-based efforts and a systems approach to improve the quality of children's health care. VCHIP shares lessons learned and other findings with public health agencies and policymakers to inform decision-making, enhance services, and target resources. Disease management programs are also being introduced into public insurance plans.

#### **Massachusetts Health Quality Partners and Wisconsin Collaborative for Healthcare Quality**

Commonwealth Fund-sponsored work shows that open sharing of quality performance data through public reporting can be effective as an impetus to quality improvement. Massachusetts Health Quality Partners has been a leader in collecting and disseminating quality data on hospitals and physician groups, and educating providers and patients to use that information to facilitate quality improvement activities.<sup>35</sup> Formed in 1995, Massachusetts Health Quality Partners (MHQP) pioneered the collection and public release of data on patient experiences with hospital care. In the mid-2000s it collected information from the state's five largest private health plans on the quality of care provided by 150 medical groups on 15 measures of clinical quality developed by the National Committee on Quality Assurance (the Health Plan Employer Data and Information Set, or HEDIS).. The coalition then posted this data in 2006 on its Web site to encourage consumers to search for high-quality providers and guide physicians looking to improve their performance.<sup>36</sup> It followed with data on patient experiences with physician care at the medical group level.

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<sup>35</sup> M. W. Friedberg, D. G. Safran, K. L. Coltin et al., "Readiness for the Patient-Centered Medical Home: Structural Capabilities of Massachusetts Primary Care Practices," *Journal of General Internal Medicine*, published online December 3, 2008.

<sup>36</sup> <http://www.mhqp.org>

The Wisconsin Collaborative for Healthcare Quality (WCHQ), founded in 2003, involves physician groups, hospitals, health plans, employers, and labor organizations that want to enhance transparency and promote quality in the health care system.<sup>37</sup> WCHQ publicly reports comparative information on its member physician practices, hospitals, and health plans through an interactive Web-based tool.<sup>38</sup> The 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. WCHQ also developed and unveiled a quadrant analysis to demonstrate the relationship between quality outcomes and risk-adjusted charges. This innovative approach to quantifying the *value* each member hospital provides when caring for patients with specific conditions was developed in response to the business community's desire for a more sophisticated measure of a hospital's efficiency.

#### **Netherlands and Denmark**

A Commonwealth Fund survey of chronically ill adults in eight countries found that the Netherlands consistently outperformed other countries, while the U.S. typically fared worst.<sup>39</sup> The Dutch had the highest satisfaction with their health system, the best access to needed care, the longest relationship with a regular doctor, the easiest time getting a same-day appointment with their doctor, the least difficulty getting care on nights and weekends, the best care coordination and least duplicate tests or missing records, and the lowest reported rates of medical errors – while the U.S. fared worst on all these measures.

The Netherlands has historically had a strong primary care system that requires primary care referrals for specialized care. They have an organized system of off-hours care. Over 90 percent of primary care physicians have electronic medical records. Peer physicians visit and audit each others' practices every three years. They have an advanced system of public reporting of quality.

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<sup>37</sup> A. L. Greer, *Embracing Accountability: Physician Leadership, Public Reporting, and Teamwork in the Wisconsin Collaborative for Healthcare Quality*, (New York: The Commonwealth Fund, June 2008).

<sup>38</sup> <http://wchq.org/Reporting/>

<sup>39</sup> C. Schoen, R. Osborn, S. K. H. How, M. M. Doty, and J. Peugh, "In Chronic Condition: Experiences of Patients with Complex Health Care Needs, in Eight Countries, 2008," *Health Affairs*, January/February 2009; 28(1): w1-w16.

Denmark also places great emphasis on patient-centered primary care, which is highly accessible and has an outstanding information system that assists primary care physicians in coordinating care. Denmark, like most European countries, has a universal health insurance system with no patient cost-sharing for physician or hospital services. Every Dane selects a primary care physician who receives a monthly payment per patient for serving as the patient's medical home, in addition to fees for services provided. Incomes of primary care physicians are slightly higher than those of specialists, who are salaried and employed by hospitals. Patients can easily obtain care on the same day if they are sick or need medical attention, and an organized "off-hours service" provides telephone consultations (for which they are paid a fee) and clinic services on nights and weekends. The patient's own primary care physician receives an e-mail the next day with a record of the off-hours consultation.

All primary care physicians (except a few near retirement) are required to have an electronic medical record system, and 98 percent do. Danish physicians are now paid about \$8 for e-mail consultations with patients, a service that is growing rapidly. The easy accessibility of physician advice by phone or e-mail, and electronic systems for prescriptions and refills cuts down markedly on both physician time and patient time. Primary care physicians save an estimated 50 minutes a day from information systems that simplify their tasks, a return that easily justifies their investment in a practice information technology system.<sup>40</sup>

Primary care physicians prescribe electronically and information systems provide information at the point of prescribing on the lowest cost drug available in a given class. Patients pay the difference if physicians prescribe a more expensive drug. Drug prices are updated automatically every two weeks in physician and pharmacy electronic information systems.

In many ways what the Netherlands and Denmark have done is not remarkable – they emphasize primary care and patients are enrolled with a physician and typically maintain that relationship over a long period of time. Primary care physicians are paid well, they have reasonable working hours since they are supported by off-hours systems

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<sup>40</sup> I. Johansen, "What Makes a High Performance Health Care System and How Do We Get There? Denmark," Presentation to the Commonwealth Fund International Symposium, November 3, 2006.

of care on nights and weekends, and they have information systems that make it possible for them to provide highly coordinated care. They are committed to providing the best quality care for the resources available. Yet, they spend less than half per capita what the U.S. spends. The U.S. has made other choices – a payment system that rewards highly specialized care and procedures, financial barriers that deter patients from seeking care or filling prescriptions written by their physicians to manage their conditions, no organized system of care on nights and weekends other than emergency rooms, lack of investment in health information technology, and inadequate commitment to transparency and quality improvement.

#### **IV. Policy Solutions**

Health care reform is a unique opportunity to transform the U.S. health care system. The Commonwealth Fund Commission on a High Performance Health System has identified five strategies for improving access, quality, and efficiency:

- *Provide affordable health coverage for all.* The most important factor determining the ability to obtain health care is adequate health insurance coverage. The uninsured are much less likely to obtain preventive care. They are much less likely to fill prescriptions and to have their chronic conditions controlled, with the consequence that opportunities are missed to save lives and prevent disability. In Commonwealth Fund international surveys, the U.S. stands out for reported difficulties obtaining needed care. It is time that all Americans receive the security of health care coverage enjoyed by citizens of every other major industrialized country. Providing everyone—regardless of age or employment status—with affordable insurance options, including a comprehensive package of benefits, will enhance access to care. This, in turn, will help reduce disparities in care, increase the proportion of people receiving appropriate primary care to prevent illness, and improve the care and health of millions of Americans living with chronic conditions.
- *Reform provider payment.* Our open-ended fee-for-service payment system must be overhauled to reduce wasteful and ineffective care and to

spur innovations that can save lives and increase the value of our health care dollars. We need to revamp our system for paying health care providers—reform that will reward high-quality care and prudent stewardship of resources, move toward shared provider accountability for the total care of patients, and correct the imbalance in payment whereby specialty care is rewarded more than primary or preventive care.

- *Organize our care delivery systems.* We need to reorganize the delivery of care, moving from our current fragmented system to one where physicians and other care providers are rewarded for banding together into integrated or virtual organizations capable of delivering 21st-century health care. Patients need to have easy access to appropriate care and treatment information, and providers need to be responsive to the needs of all their patients. Providers must also collaborate in delivering high-quality, high-value care, and they should receive the support needed for continuous improvement. Community health centers—a major source of care in many low-income communities—should be assisted in meeting the standards of patient-centered medical homes.
- *Invest in a modern health system.* The U.S. lags behind other countries in the adoption of health information technology and a system of health information exchange. In such a system, patient information would be available to all providers at the point of care, as well as to patients themselves through electronic health record systems, helping to ensure that care is well coordinated. Early investment in the infrastructure of a high performance health system—including information technology, research on comparative effectiveness of drugs, devices, and procedures, data on provider performance on quality and affordability, and a workforce that ensures a team approach to care—is an essential building block.
- *Ensure strong national leadership.* None of the above will be possible if government does not take the lead. The federal government—the nation’s largest purchaser of health care services—has tremendous leverage to

effect changes in coverage, care delivery, and payment. National leadership can encourage the collaboration and coordination among private-sector leaders and government officials that are necessary to set and achieve national goals for a high performance health system. It can also help set priorities and targets for improvement, create a system for monitoring and reporting on performance

### **Information Technology**

Congress has already begun to make important investments in the infrastructure required to improve quality and efficiency in consideration of the economic stimulus package. While some have questioned whether information technology will generate significant health system savings, The Commonwealth Fund report, *Bending the Curve*, put the aggregate system-wide savings of promoting health information technology at \$88 billion over 10 years.<sup>41</sup> The authors estimated that the cost reductions would result from a lower rate of medical errors, more efficient use of diagnostic testing, more effective drug utilization, and decreased provider costs, among other improvements. Additional savings would likely flow from better care coordination among multiple providers—and improved chronic care management—that would lead to a decrease in provider utilization and better health outcomes. Financial benefits accrue to all payers, with investments in health IT estimated to result in substantial cumulative net savings to all levels of government and households over 10 years and cumulative savings to private insurers after 11 years.

A recent Commonwealth Fund-sponsored study of health IT in Texas hospitals led by Ruben Amarasingham of the University of Texas Southwestern Medical Center has shown that hospitals with more advanced information technology capacity have fewer complications and decreased mortality rates.<sup>42</sup> Amarasingham and his colleagues' findings importantly show that utilizing IT to automate test results, order entry, and decision support was not only associated with better quality but also lower average

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<sup>41</sup> C. Schoen, S. Guterman, A. Shih, J. Lau, S. Kasimow, A. Gauthier, and K. Davis, *Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending*, (New York: The Commonwealth Fund, December 2007).

<sup>42</sup> R. Amarasingham, "Clinical Information Technologies," *Ibid.*

adjusted costs for hospital admissions and lower mean hospital costs for a variety of clinical conditions, including heart failure and coronary artery bypass grafting. Computerized decision support was particularly effective at generating savings. Higher degrees of decision support automation were associated with lower average adjusted costs of \$538 for all conditions. If these reductions were realized among the 37 million hospital admissions in the United States in 2005, hospitals across the country would stand to save almost \$20 billion a year.

Modern health care also requires replacing antiquated paper-based medical records with systems that take advantage of modern health information technology. Medicare can do its share by joining with private payers in contributing funds to help those who cannot afford to purchase such technology on their own—especially safety-net clinics and hospitals serving uninsured and low-income patients. It can also create incentives for the adoption of information systems meeting approved standards, and help establish “health information networks” that allow patients and the health professionals that care for them to have all relevant medical information available at their fingertips. While such a change requires upfront investment, it would begin to pay dividends in the future.

### **Primary Care**

If the U.S. is serious about closing the quality chasm, it will need to build a strong primary care system. This will require fundamental provider payment reform, encouraging all patients to enroll with a patient-centered medical home that is accessible and accountable for patient outcomes, and supporting those physician practices with information technology and technical assistance in care process design to improve quality and reliability of care.

One important place to start is to ensure that all the nation’s community health centers meet the standards of a patient-centered medical home, and have the information tools and technical assistance necessary to reach benchmark levels of quality. Work by

staff at the Commonwealth Fund has found that racial/ethnic disparities in access to needed care can be eliminated if patients are enrolled in such systems of care.<sup>43</sup>

### **Comparative Effectiveness**

Medicare, Medicaid, and private insurers can also ensure that the care they cover is based on the best and latest research findings on effectiveness. Insurers should cover all medications, devices, and procedures that have been scientifically shown to improve patient outcomes and quality of life. But insurers also should be prudent purchasers, paying no more for a device or treatment than they would for another that is equally effective. The *Bending the Curve* report estimates that a center on medical effectiveness and health care decision-making could save \$368 billion over 10 years, if insurance benefit design and payment were tied to evidence on cost-effectiveness.

### **Health Goals and Targets for Improvement**

The federal government can also raise the bar for health system performance and help providers get the tools they need to reach the highest attainable levels of performance. This should start with setting explicit goals and priorities for improvement—including a focus on the most prevalent chronic conditions, which account for a large majority of health care costs.

For example, Medicare could join with private insurers and other payers to develop a database that lets providers and the public know how they are doing relative to what is possible. Having reliable comparative data, adjusted for differences in patient characteristics, is the first step along the path to improvement. Such a database should provide timely feedback on how each and every provider—whether health system, hospital, physician, or long-term care facility—is doing on quality and health outcome metrics that are tied to achievable benchmarks. The Commonwealth Fund is helping to support such a tool through its WhyNotTheBest.org Web site with data and tools to improve hospital clinical quality and patients' experiences.

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<sup>43</sup> A. C. Beal, M. M. Doty, S. E. Hernandez, K. K. Shea, and K. Davis, *Closing the Divide: How Medical Homes Promote Equity in Health Care: Results From The Commonwealth Fund 2006 Health Care Quality Survey*, (New York: The Commonwealth Fund, June 2007).

In sum, experience shows that policies to alleviate the quality chasm and improve the performance of our health care system must be multifaceted and mutually reinforcing. Work by the Commonwealth Fund demonstrates that it is not only possible—but critical—to employ strategies that simultaneously improve quality, reduce costs, and increase access for all Americans.

Armed with the knowledge that the status quo is no longer acceptable, we have entered a new era ripe with opportunity to close the quality chasm and improve the health and well-being of American families. Working together we can change course—and move the U.S. health system on a path to high performance.