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

Karen Davis
President
The Commonwealth Fund
One East 75th Street
New York, NY 10021
kd@cmwf.org
www.commonwealthfund.org/

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EXECUTIVE SUMMARY

As the nation turns to the issue of reforming our health insurance system, it is important to address simultaneously how we organize and deliver health services—to ensure that we are obtaining the best possible health outcomes for Americans and the most value for the money we spend 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 in 2008 scored 65 out of 100 possible points on 37 indicators of performance capturing 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 health 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"—in five years falling from 15th, as other countries raised the bar on performance.
- The widening quality chasm is having real effects on people's 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, however, that even within our imperfect system, models exist for each of the components that—if properly organized, reformed, and financed—can enable the nation to provide high-quality, affordable care to every American. The following examples of excellence from across the U.S. and around the world offer insight into what it takes to achieve high performance:

- A leader in innovation and quality improvement, the Geisinger Health System, on whose board I am pleased to serve, 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 the Massachusetts Health Quality Partners and the Wisconsin Collaborative for Healthcare Quality have become leaders in quality improvement by collecting and disseminating performance data on hospitals and

physician groups and by educating providers and patients to use that information to facilitate 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 services.

The specific policies that will both lead to better health outcomes and "bend the curve" of our nation's unsustainable health care spending revolve around five strategies that are 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 fundamentally reforming provider payment, encouraging all patients to enroll in a patient-centered medical home, and supporting physician practices that serve as medical homes with information technology and technical assistance for redesigning care processes. Funding for research on comparative effectiveness and establishing a center for comparative effectiveness are 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 smaller reductions in projected spending. And, to be sure, any reforms must support health care 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 put the U.S. health system on a path to high performance.

CLOSING THE QUALITY CHASM: OPPORTUNITIES AND STRATEGIES FOR MOVING TOWARD 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 U.S. As the nation turns to the issue of reforming our health insurance system, it is important to address simultaneously how we organize and deliver health services—to ensure that we obtain the best health outcomes possible for Americans and the most value from what we spend 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 in 2008 scored 65 out of 100 possible points on 37 indicators of performance capturing key dimensions of health outcomes, quality, access, equity, and efficiency.[1] This is down slightly from the score of 67 achieved in 2006—showing we are not on the right path.

The good news is that we no longer simply assert that the U.S. has the best health system in the world.[2] Instead, we are beginning to take a clear-eyed look at how our system performs overall, across the states, and in comparison with other countries. We are beginning to gather information to show where we are gaining ground and where there are opportunities to improve. Public reporting of data on quality of hospital care and campaigns focused on quality are spurring improvement. Many health care professionals and organizations are responding to the challenge by adopting information technology, redesigning care processes, and mobilizing efforts to improve results. Examples of excellence within the U.S., as well as around the world, demonstrate what can be achieved.

But the nation will not have the health system it wants if the federal government does not lead and implement a series of coordinated strategies to 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

[1] 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.

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

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 a smaller reduction in projected spending. And, to be sure, any reforms must support health care 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 put 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.[3] The nation now ranks last out of 19 countries on a measure of mortality amenable to medical care—in five years falling from 15th, as other countries raised the bar on performance.[4] This widening quality chasm is having real effects on people: up to 101,000 deaths could be prevented each year if the U.S. raised standards of care to benchmark performance levels achieved abroad.

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,[5] the Commonwealth Fund's national scorecard 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 study by the National Committee for Quality Assurance (NCQA) found that

[3] Commonwealth Fund Commission, *Ibid*.

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

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

eliminating this variance would prevent up to 46,000 premature deaths and save up to $2.4 billion in medical costs.[6]

Indicators of patient safety are also important measures of overall quality within the health care system. One bright spot is that the U.S. showed progress on hospital standardized mortality ratios, which declined by 19 percent in two years, according to the 2008 scorecard. This measure was the focus of the 100,000 Lives campaign led by the Institute for Healthcare Improvement (IHI). 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.[7]

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 improved to the level of the top quartile, more than 2,000 deaths could be avoided each year.[8]

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 costs ranged from $25,000 to $30,000. A significant number of regions with lower risk-adjusted mortality rates also utilized lower total resources, suggesting significant inefficiency among higher-spending regions.[9] If all areas of the country achieved the performance levels of the benchmark

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[6] National Committee for Quality Assurance, *The State of Health Care Quality 2008*, (Washington, D.C.: NCQA, 2008).

[7] Commonwealth Fund Commission, *Ibid*.

[8] 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.

[9] 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.

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. This not only improves patients' experiences, but also reduces the total costs of care.[10] 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 regions. 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.[11]

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 and poor quality for one of the most vulnerable populations. 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 high- and low-performing states alike.

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

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

[11] MedPAC, *Ibid.*

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, more likely to incur higher care costs, and less likely to adhere to treatment and receive preventive care.[12] Differing rates of coordination for hospital patients was similarly distressing: there was a 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.[13]

Finally, while studies have shown that expanding the use 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 U.S. is far behind the Netherlands, New Zealand, the United Kingdom, Australia, and Germany on the utilization and functionality of its health information technology (IT). The contrast between the U.S. and 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.[14]

II. Impediments to Improvement in Our 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,

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[12] B. Starfield, *Primary Care: Balancing Health Needs, Services, and Technology* (New York: Oxford University Press, 1998).

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

[14] 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.

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 among six industrialized nations on health system performance.[15] 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.[16] 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 the 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.[17] 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 obstacle to successful quality improvement in the U.S. The 2006 Commonwealth Fund International Health Policy Survey showed that only 30 percent of U.S. primary care physicians received any financial incentive to improve quality, contrasted with their counterparts in the U.K., nearly all of whom reported financial bonuses—the result of a bonus system that can account for up to 30 percent of physician income and is based on a broad array of quality measures covering preventive and chronic care and patient experiences.[18] Commonwealth Fund studies have also found the predominance of the fee-for-service payment system in the U.S.—an arrangement that rewards volume over value—to be a significant barrier to streamlined and more-efficient delivery models.[19] 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; this

[15] 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).

[16] Davis, "Mirror, Mirror," *Ibid.*

[17] Commonwealth Fund Commission, *Ibid*.

[18] Davis, "Mirror, Mirror," *Ibid*.

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

contributes to unnecessary duplication of tests and procedures, wasteful deployment of resources, and substandard outcomes.[20]

Fragmentation of the U.S. health 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.[21] 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.[22]

Data from high-performing health care delivery systems across the country show that moving toward more integrated models of care delivery is a proven strategy for increasing quality of care while simultaneously reducing costs and inefficiencies.[23] Over 80 percent of respondents to a recent Commonwealth Fund Health Care Opinion Leaders Survey said 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.[24]

Substandard outcomes and insufficient value are also driven by insufficient adoption of health information technology (IT) and the absence of information exchange systems, as previously noted. 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.[25] 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

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[20] 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.

[21] 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).

[22] 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).

[23] 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.

[24] 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)

[25] R. Amarasingham et al., "Clinical Information Technologies and Inpatient Outcomes," *Arch Intern Med*. 2009; 169(2):1-7.

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 exits for patients who want to know, for example, the survival and complication rate of their surgeon. In the U.K., this type of information is available through the Internet.[26] 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

We are fortunate that, even within our imperfect health care system, models exist for each of the components that—if properly organized, reformed, and financed—can enable the nation to provide high-quality, affordable care to every American. Systematically applying and disseminating that which 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 U.S. Over the last 15 years, The Commonwealth Fund has been pleased to support, evaluate, 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 under way.

- **Public awareness.** The Institute of Medicine launched the modern quality improvement movement with its report, *To Err is Human,* which was followed by *Crossing the Quality Chasm.*[27]
- **Measurement of quality.** NCQA has been a leader in the development of measures of quality, beginning with a HEDIS (Healthcare Effectiveness Data and Information Set) set of clinical quality measures, collected and made available at the health plan level. The Agency for Healthcare Research and Quality 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.

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[26] 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).

[27] 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).

- **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.** 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. NCQA's annual report, *The State of the Nation's Health,* 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 (IHI) 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 recently launched Web site, WhyNotTheBest.org.
- **Pay-for-performance**. The Leapfrog Group initiated the first major effort by purchasers to reward hospitals and other providers who meet high standards of quality, and it maintains a comprehensive inventory of pay-for-performance initiatives. The Integrated Healthcare Association is a statewide leadership group that promotes quality improvement, accountability, and affordability of health care in California; it institutes 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 pay-for-performance.[28] Medicare's Hospital Quality Demonstration Initiative and Physician Group Practice Demonstration, among others, have implemented and assessed the impact of financial incentives to improve quality.[29]

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, such as reduced hospital standardized mortality rates that were the focus of IHI's 100,000 Lives

[28] 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).

[29] 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).

Campaign, the improved control of chronic conditions 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. Moreover, there is no 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 average survival rate achieved by cancer centers across the U.S. for his or her form of cancer has no database to which to turn. A patient who wants to know the survival and complication rates of their surgeon relative 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; the activities of Iowa and Vermont, two states that score well on the Commonwealth Fund's State Scorecard; two regional collaboratives that report quality data and work with providers to improve performance (the Massachusetts Health Quality Partners and the Wisconsin Collaborative for Healthcare Quality); and 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. In NCQA *State of the Nation's Health* report, Geisinger, an integrated delivery system in northeastern Pennsylvania, ranks among the top five health plans in the nation and top three plans participating in Medicare. In a September 2008 article in *Health Affairs,* the health policy journal, Geisinger CEO Glenn Steele, M.D., chief innovation officer Ron Paulus, M.D., and I summarized how Geisinger achieves continuous innovation in health care.[30] Geisinger's clinical leadership 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 drug cost savings of $3,800 per patient, per year. It has redesigned its care process for coronary artery bypass graft surgery

[30] Paulus, "Continuous Innovation," *Ibid*.

(CABG) to provide "proven care," and it has 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 experience with innovation has three implications for national policy: 1) incentives must be aligned to reward enhanced health care value creation; 2) electronic health records are absolutely necessary, but not sufficient, to create sustainable change in care delivery; and 3) to foster propagation of innovation that enhances value, policies must be created to encourage greater organization of care delivery and collaboration among payers and providers.

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 visit in 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.[31] The Commission concluded that Denver Health is indeed a "learning laboratory," one that has succeeded at providing coordinated care to the community, promoting a culture of continuous quality improvement, adopting new technology and incorporating it into everyday practice, taking risks and making midcourse 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 operations and eliminating waste. Denver Health has also built its infrastructure for high performance in two important areas: information technology and workforce. The organization's investment in health-oriented IT, totaling $275 million since 1997, has enabled the establishment of a centralized data warehouse that integrates 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."

There are many factors contributing to the overall high quality of care that Denver Health provides to its patients. The Commission highlighted the following:

[31] 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).

- 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 and is staffed by dedicated people. 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 that has a concentration of elderly Medicare patients; the other is a public integrated delivery system in a large metropolitan area with a concentration of low-income uninsured and Medicaid patients. But both derive at least a portion of their revenues from a "bundled" capitated rate per enrollee, and their public/nonprofit, mission-driven organization leads them to dedicate surpluses gained from eliminating waste and preventing avoidable complications to improving care. And both have invested extensively in health information systems. Geisinger and Denver Health have dedicated innovation and quality improvement units that lead the organizations in continuous innovation and improvement. Both systems are led by clinician leaders who are committed to excellence in patient care while maintaining fiscal stability.

Iowa and Vermont

In 2007, the Commonwealth Fund Commission on a High Performance Health System released a state scorecard on health system performance.[32] This was followed in 2008 by a child health state scorecard. Both scorecards showed wide variation 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 two states stand out:

- High rates of health insurance coverage, a result of their Medicaid and SCHIP policies;
- A high proportion of children and adults cared for in patient-centered medical homes;
- Medical schools that emphasize training primary care physicians;

[32] 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).

- A long history of collaboration to promote quality;
- Public health departments that have a mission to serve local communities, and that partner 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 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 electronic medical record system, which is streamlining referral processes.

The Iowa Healthcare Collaborative has also been a key means through which the state's health care community has come together to improve quality, patient safety, and the value of health care.[33] By focusing on transparency and accountability and sharing performance information and best practices with health care providers and the general public, the collaborative 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 lean production on its Web site. 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, the establishment of a community advisory council, the reduction of health care–associated infections, and rapid response teams.

The Vermont legislature, in collaboration with the public health department, 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 for practices, and incorporates the medical home concept using NCQA criteria. The state is trying to use payment reform to drive quality and is encouraging adoption of electronic health records 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 physician practices focus on a core areas.

Vermont also has long placed a high priority on children. In 1989, the state enacted the Dr. Dynasaur program, expanding health insurance coverage for children up

[33] Iowa Healthcare Collaborative, *2008 Annual Report*, (Des Moines: Iowa Healthcare Collaborative, 2008).

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 level. In 2006, Vermont expanded SCHIP income eligibility levels for children in families with incomes up to 300 percent of poverty. 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 improving 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 an effective impetus for quality improvement. Massachusetts Health Quality Partners (MHQP) 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.[34] Formed in 1995, MHQP pioneered the collection and public release of data on patient experiences with hospital care. In the middle of this decade, it collected information from the state's five largest private health plans on the quality of care provided by 150 medical groups on 15 HEDIS measures of clinical quality. The coalition then posted these data in 2006 on its Web site—to encourage consumers to search for high-quality providers and guide physicians who are looking to improve their performance.[35] Data on patients' experiences with physician care followed.

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.[36] WCHQ publicly reports comparative information on its member physician practices, hospitals, and health plans through an interactive Web-based tool.[37] The collaborative has

[34] 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.

[35] http://www.mhqp.org

[36] 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).

[37] http://wchq.org/Reporting/

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.[38] 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. Meanwhile, 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. The nation has an organized system of off-hours care. Over 90 percent of its primary care physicians have electronic health records. Peer physicians visit and audit each others' practices every three years. There is an advanced system of public reporting of quality.

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 a 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

[38] 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.

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, along with 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 information technology system.[39]

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. Both countries emphasize primary care; patients are enrolled with a physician and typically maintain that relationship over a long period. Primary care physicians are paid well, they have reasonable working hours (since they are supported by off-hours systems 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, on a per capita basis the two nations spend less than half of what the U.S. spends on health care. The U.S. has made other choices, resulting in a payment system that rewards highly specialized care and procedures; financial barriers that deter patients from seeking care or filling prescriptions for drugs that are intended to manage their conditions; a lack of an organized system of care on nights and weekends, other than emergency rooms; a lack of investment in health information technology; and an inadequate commitment to transparency and quality improvement.

IV. Policy Solutions

Health care reform presents 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.

[39] 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.

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

In consideration of the economic stimulus package, Congress has already begun to make important investments in the infrastructure required to improve quality and efficiency. While some have questioned whether information technology will generate significant health system savings, the Commonwealth Fund report, *Bending the Curve*, put the aggregate systemwide savings of promoting health information technology at $88 billion over 10 years.[40] 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.[41] Amarasingham and his colleagues' findings show that utilizing IT to automate test results, order entry, and decision support is not only associated with better quality but also with lower average adjusted costs for hospital admissions and lower mean hospital costs for a variety of clinical conditions. 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 U.S. 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 IT. 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

[40] 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).

[41] R. Amarasingham, "Clinical Information Technologies," *Ibid.*

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 fundament 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 IT 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.[42]

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

[42] 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).

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 tied to achievable benchmarks. The Commonwealth Fund is supporting such a database through its WhyNotTheBest.org Web site, which has data and tools to improve hospital clinical quality and patients' experiences.

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 possible—and critical—to employ strategies that simultaneously improve health care quality, reduce costs, and increase access to care 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 put the U.S. health system on a path to high performance.

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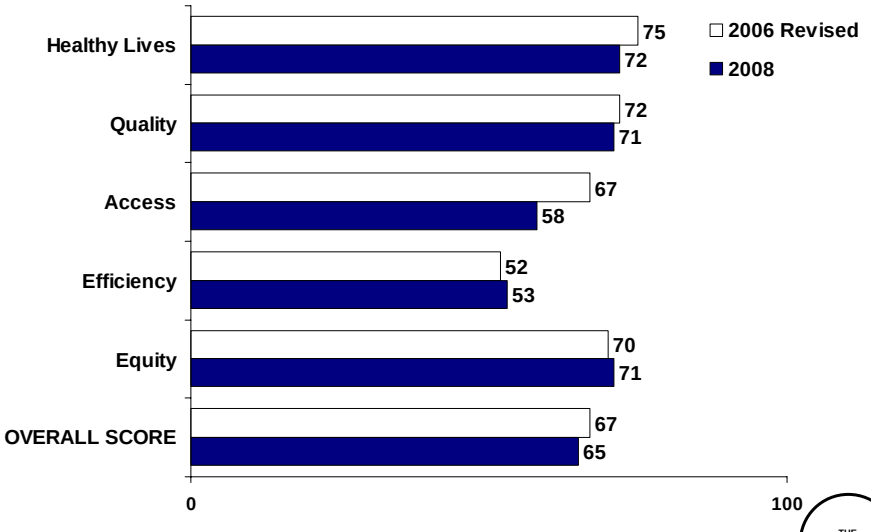
Closing the Quality Chasm: Opportunities and Strategies for Moving Toward a High Performance Health System

Karen Davis
President
The Commonwealth Fund
kd@cmwf.org

Invited Testimony
Senate Committee on Health, Education, Labor, and Pensions
Hearing on
"Crossing the Quality Chasm in Health Care Reform"

January 29, 2009

Scores: Dimensions of a High Performance Health System



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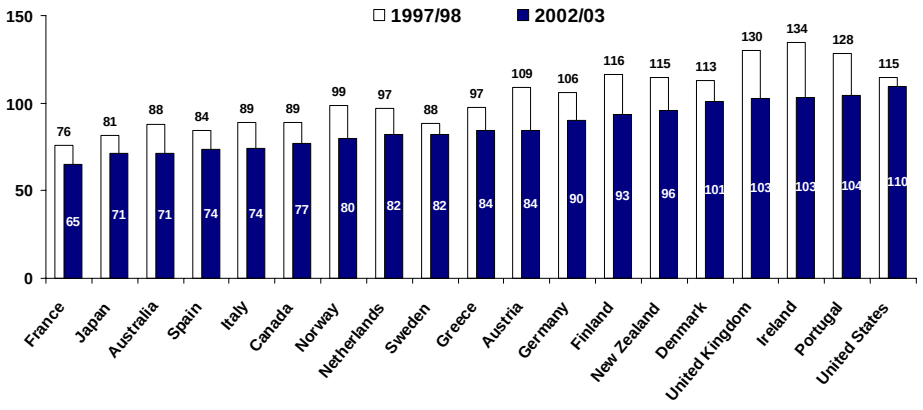
Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2008

2

Headed in the Wrong Direction: Evidence of a Deepening Quality Chasm

Mortality Amenable to Health Care

Deaths per 100,000 population*



* Countries' age-standardized death rates before age 75; including ischemic heart disease, diabetes, stroke, and bacterial infections.
See report Appendix B for list of all conditions considered amenable to health care in the analysis.
Data: E. Nolte and C. M. McKee, London School of Hygiene and Tropical Medicine analysis of World Health Organization mortality files (Nolte and McKee 2008).
Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2008

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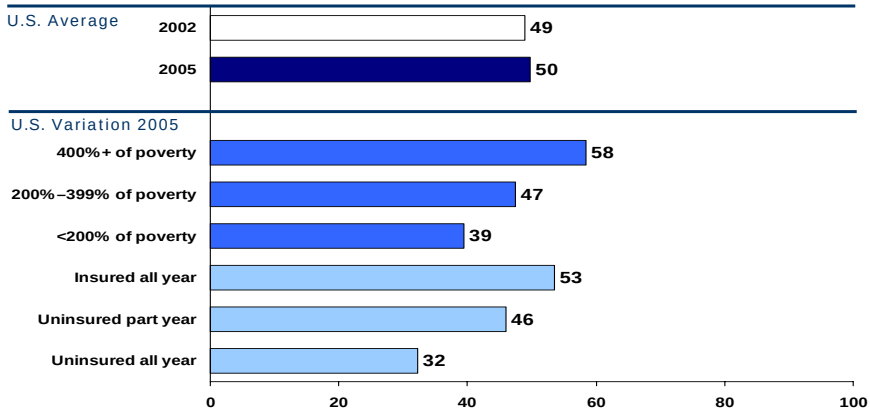
4

Receipt of Recommended Screening and Preventive Care for Adults

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. See report Appendix B for complete description.
Data: B. Mahato, Columbia University analysis of Medical Expenditure Panel Survey.
Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2008

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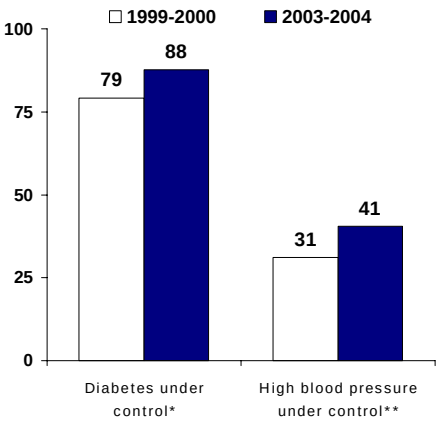
5

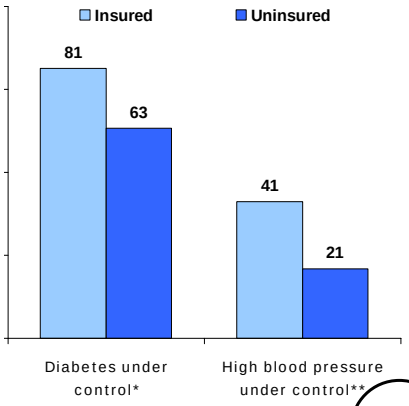
Chronic Disease Under Control: Diabetes and Hypertension

National Average

Percent of adults (age 18+)



By Insurance, 1999-2004



*Refers to diabetic adults whose HbA1c is <9.0 **Refers to hypertensive adults whose blood pressure is <140/90 mmHg.
Data: J. M. McWilliams, Harvard Medical School analysis of National Health and Nutrition Examination Survey.
Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2008

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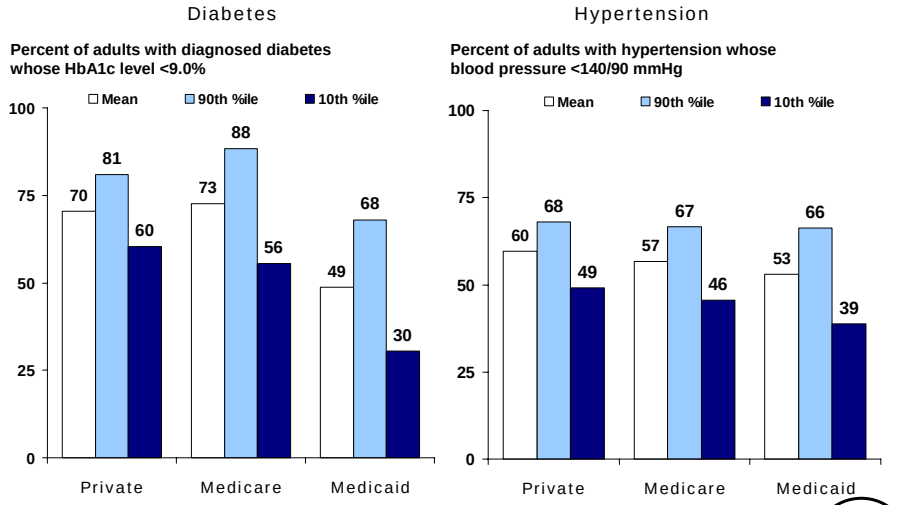
6

Chronic Disease Under Control: Managed Care Plan Distribution, 2006



Note: Diabetes includes ages 18–75; hypertension includes ages 18–85.
Data: Healthcare Effectiveness Data and Information Set (NCQA 2007).

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

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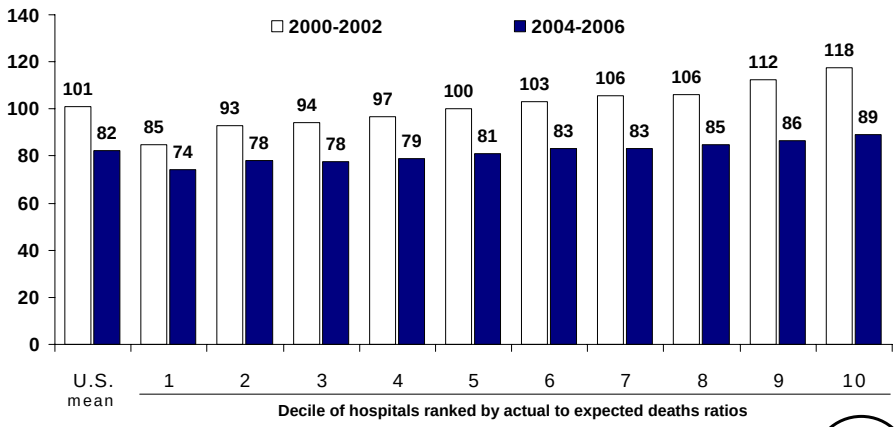
7

Hospital-Standardized Mortality Ratios

Standardized ratios compare actual to expected deaths, risk-adjusted for patient mix and community factors.* Medicare national average for 2000=100



* See report Appendix B for methodology.
Data: B. Jarman analysis of Medicare discharges from 2000 to 2002 and from 2004 to 2006 for conditions leading to 80 percent of all hospital deaths.

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

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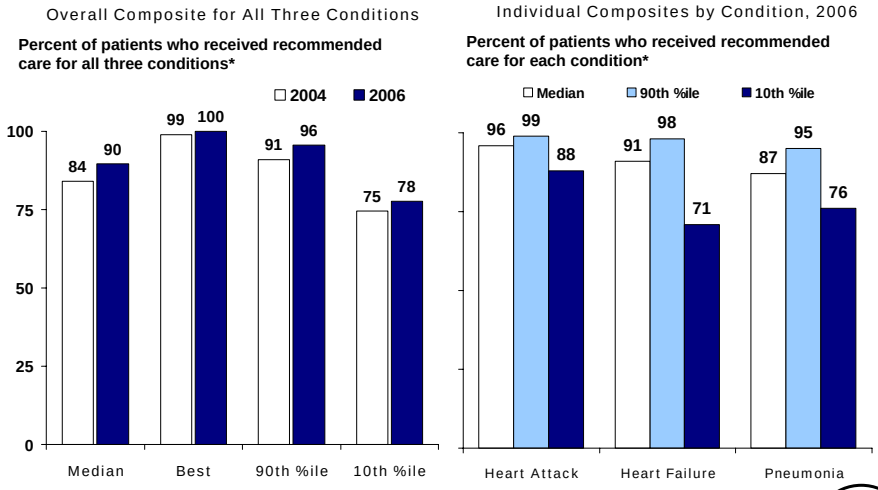
Hospitals: Quality of Care for Heart Attack, Heart Failure, and Pneumonia



* Composite for heart attack care consists of 5 indicators; heart failure care, 2 indicators; and pneumonia care, 3 indicators.
Overall composite consists of all 10 clinical indicators. See report Appendix B for description of clinical indicators.
Data: A. Jha and A. Epstein, Harvard School of Public Health analysis of data from CMS Hospital Compare.
Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2008

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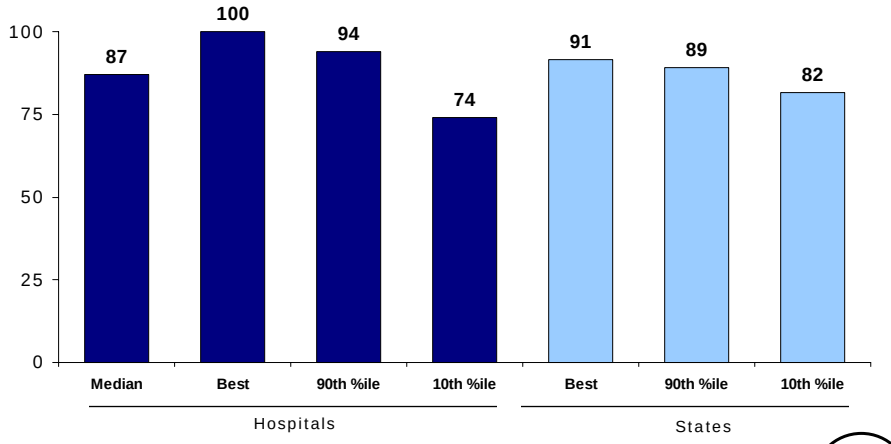
Hospital Quality of Care for Heart Attack, Heart Failure, and Pneumonia: Overall Composite Using Expanded Set of 19 Clinical Indicators*, 2006



*Consists of original 10 "starter set" indicators and 9 new indicators for which data was made available as of December 2006; heart attack care includes 3 new indicators; heart failure care, 2 new indicators; and pneumonia, 4 new indicators)
Data: A. Jha and A. Epstein, Harvard School of Public Health analysis of data from CMS Hospital Compare.
Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2008

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Hospital Quality of Care by Condition: Composites for Heart Attack, Heart Failure, and Pneumonia

		HOSPITALS				STATES		
Percent of patients who received recommended care:		Median	Best	90th percentile	10th percentile	Best	90th percentile	10th percentile
Acute myocardial infarction								
(Original: 5 indicators)								
	2004	**92**	**100**	**98**	**80**	**97**	**96**	**89**
	2006	**96**	**100**	**99**	**88**	**98**	**97**	**93**
(Expanded: 8 indicators*)	**2006**	**95**	**100**	**98**	**87**	**98**	**97**	**92**
Heart failure								
(Original: 2 indicators)								
	2004	**83**	**100**	**94**	**62**	**91**	**89**	**79**
	2006	**91**	**100**	**98**	**71**	**94**	**93**	**81**
(Expanded: 4 indicators*)	**2006**	**83**	**100**	**95**	**61**	**90**	**87**	**75**
Pneumonia								
(Original: 3 indicators)								
	2004	**78**	**99**	**88**	**66**	**82**	**79**	**69**
	2006	**87**	**100**	**95**	**76**	**92**	**91**	**83**
(Expanded: 7 indicators*)	**2006**	**87**	**100**	**94**	**77**	**91**	**90**	**83**

*Consists of original "starter set" indicators and new indicators for which data was made available as of December 2006.
Data: A. Jha and A. Epstein, Harvard School of Public Health analysis of data from CMS Hospital Compare.
Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2008

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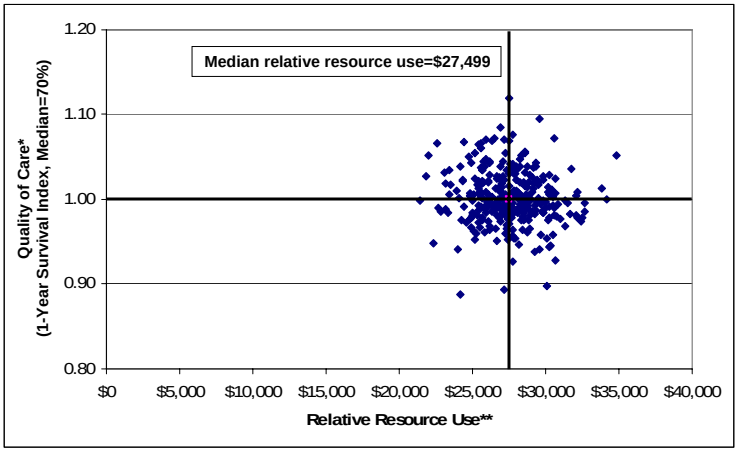
11

Quality and Costs of Care for Medicare Patients Hospitalized for Heart Attacks, Hip Fractures, or Colon Cancer, by Hospital Referral Regions, 2004



* Indexed to risk-adjusted 1-year survival rate (median=0.70).
** Risk-adjusted spending on hospital and physician services using standardized national prices.
Data: E. Fisher, J. Sutherland, and D. Radley, Dartmouth Medical School analysis of data from a 20% national sample of Medicare beneficiaries.
Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2008

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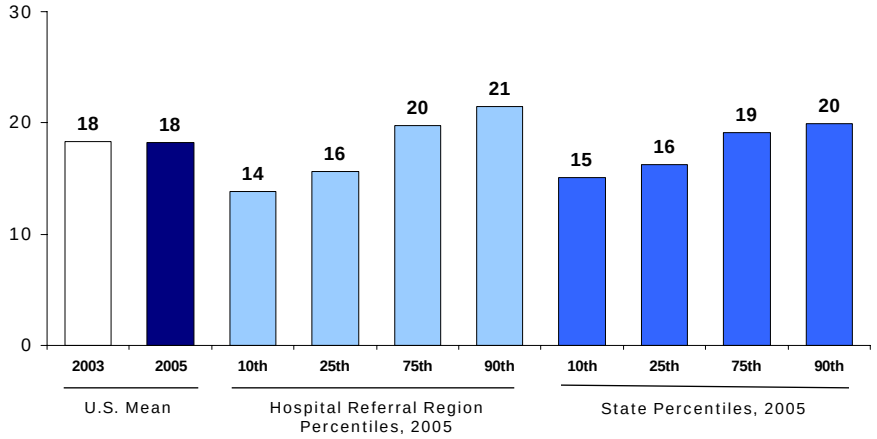
12

Medicare Hospital 30-Day Readmission Rates

Percent of Medicare beneficiaries admitted for one of 31 select conditions who are readmitted within 30 days following discharge*



* See report Appendix B for list of conditions used in the analysis.
Data: G. Anderson and R. Herbert, Johns Hopkins University analysis of Medicare Standard Analytical Files (SAF) 5% Inpatient Data.

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

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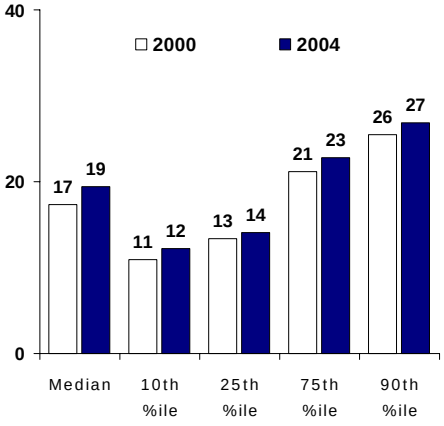
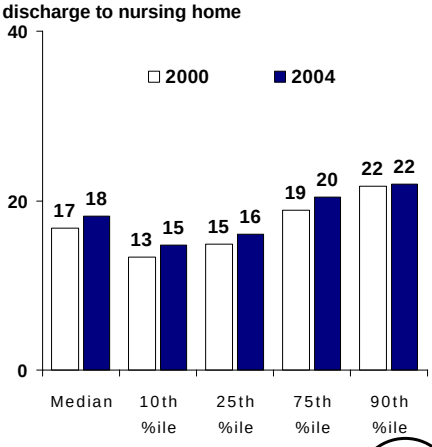
13

Nursing Homes: Hospital Admission and Readmission Rates Among Nursing Home Residents

Percent of long-stay residents with a hospital admission



Percent of short-stay residents re-hospitalized within 30 days of hospital discharge to nursing home



Data: V. Mor, Brown University analysis of Medicare enrollment data and Part A claims data for all Medicare beneficiaries who entered a nursing home and had a Minimum Data Set assessment during 2000 and 2004.

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

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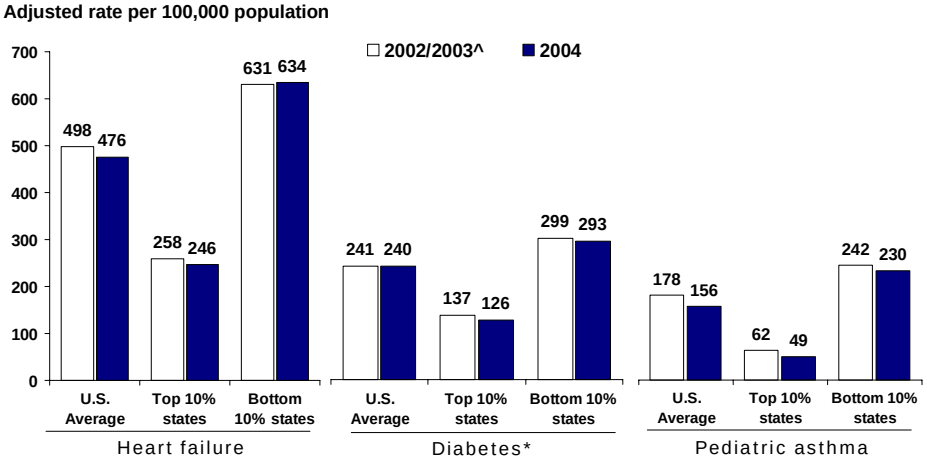
Ambulatory Care–Sensitive (Potentially Preventable) Hospital Admissions for Select Conditions



^ 2002 data for heart failure and diabetes; 2003 data for pediatric asthma. *Combines four diabetes admission measures: uncontrolled, short-term complications, long-term complications, and lower extremity amputations.
Data: National average—Healthcare Cost and Utilization Project, Nationwide Inpatient Sample; State distribution—State Inpatient Databases; not all states participate in HCUP (AHRQ 2005, 2007a).

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

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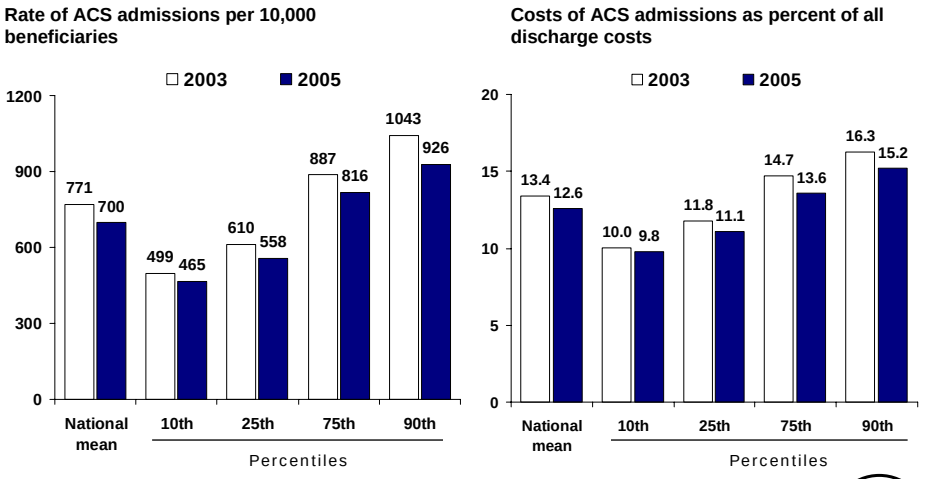
Medicare Admissions for Ambulatory Care–Sensitive Conditions, Rates and Associated Costs, by Hospital Referral Regions



See report Appendix B for complete list of ambulatory care-sensitive conditions used in the analysis.
Data: G. Anderson and R. Herbert, Johns Hopkins University analysis of Medicare Standard Analytical Files (SAF) 5% Inpatient Data.

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

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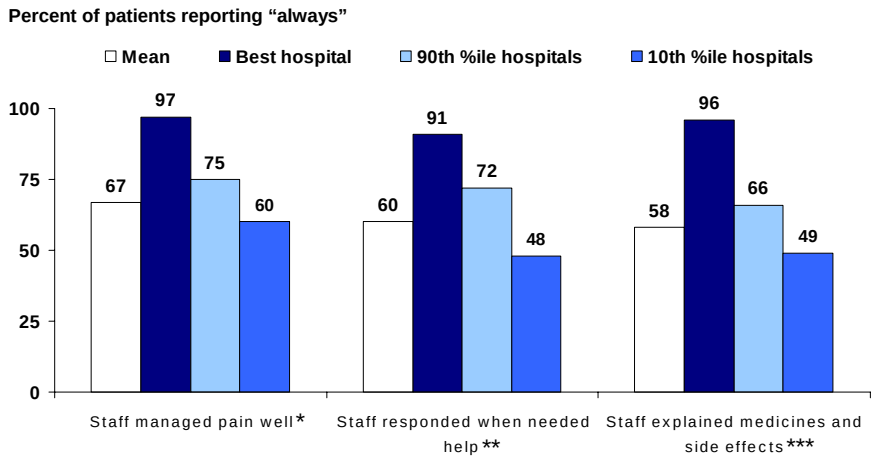
Patient-Centered Hospital Care: Staff Managed Pain, Responded When Needed Help, and Explained Medicines, by Hospitals, 2007



* 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 (Retrieved from CMS Hospital Compare database at http://www.hospitalcompare.hhs.gov).
Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2008

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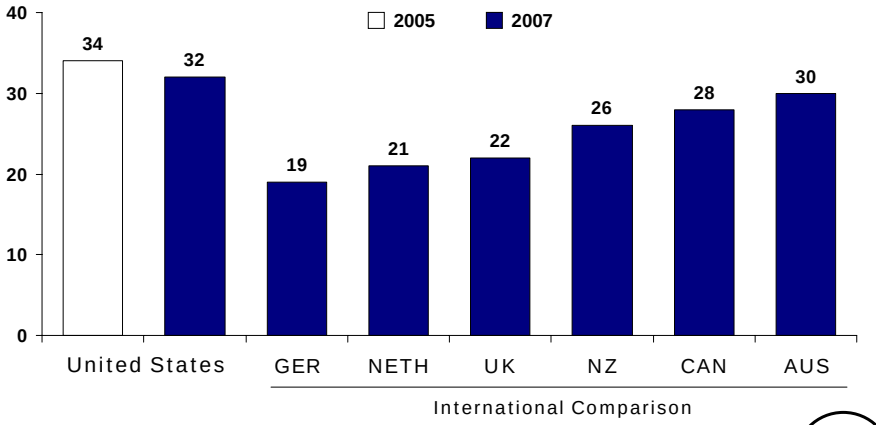
17

Medical, Medication, and Lab Errors, Among Sicker Adults



AUS=Australia; CAN=Canada; GER=Germany; NETH=Netherlands; NZ=New Zealand; UK=United Kingdom.
Data: 2005 and 2007 Commonwealth Fund International Health Policy Survey.

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

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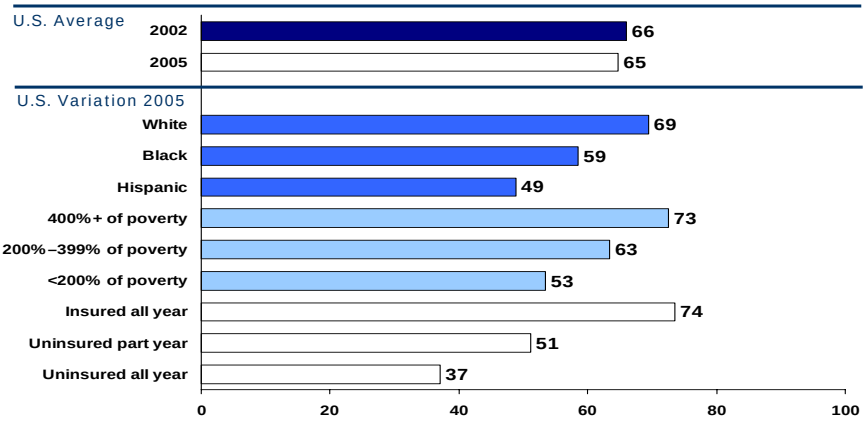
Adults with an Accessible Primary Care Provider

Percent of adults ages 19–64 with an accessible primary care provider*



* An accessible primary care provider is defined as a usual source of care who provides preventive care, care for new and ongoing health problems, referrals, and who is easy to get to.
Data: B. Mahato, Columbia University analysis of Medical Expenditure Panel Survey.

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

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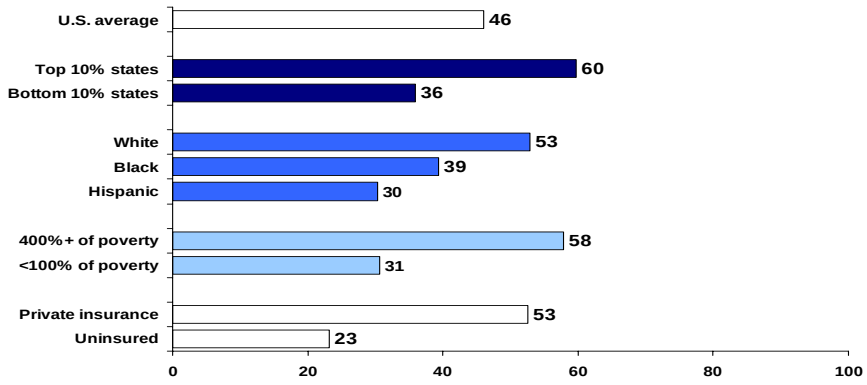
Children with a Medical Home, by Top and Bottom States, Race/Ethnicity, Family Income, and Insurance, 2003

Percent of children who have a personal doctor or nurse and receive care that is accessible, comprehensive, culturally sensitive, and coordinated*



Note: Indicator was not updated due to lack of data. Baseline figures are presented.
* Child had 1+ preventive visit in past year; access to specialty care; personal doctor/nurse who usually/always spent enough time and communicated clearly, provided telephone advice or urgent care and followed up after the child's specialty care visits.
Data: 2003 National Survey of Children's Health (HRSA 2005; retrieved from Data Resource Center for Child and Adolescent Health database at http://www.nschdata.org).
Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2008

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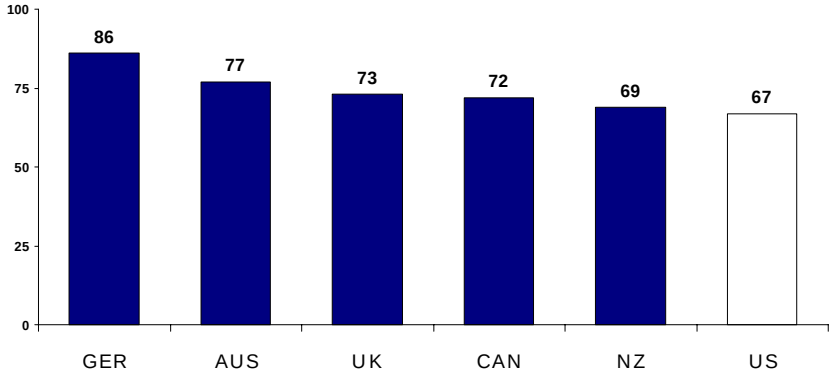
20

Medications Reviewed When Discharged from the Hospital, Among Sicker Adults, 2005

Percent of hospitalized patients with new prescription who reported prior medications were reviewed at discharge



Note: Indicator was not updated due to lack of data. Baseline figures from Scorecard 2006 are presented.
AUS=Australia; CAN=Canada; GER=Germany; NZ=New Zealand; UK=United Kingdom; US=United States.
Data: 2005 Commonwealth Fund International Health Policy Survey.

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

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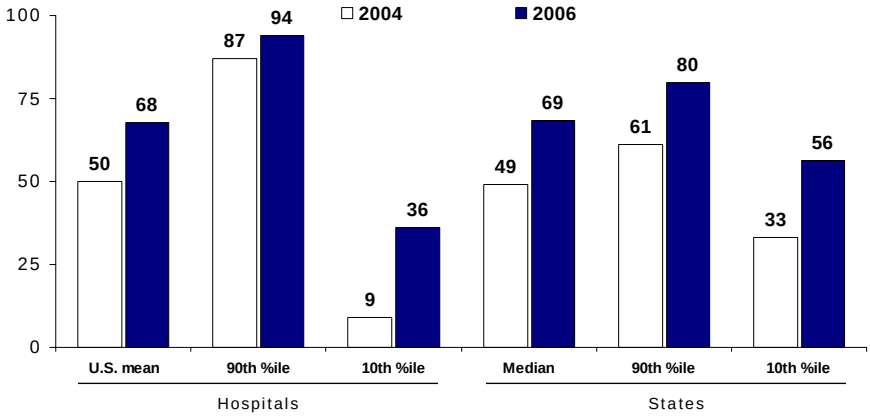
21

Heart Failure Patients Given Complete Written Instructions When Discharged, by Hospitals and States

Percent of heart failure patients discharged home with written instructions*



* Discharge instructions must address all of the following: activity level, diet, discharge medications, follow-up appointment, weight monitoring, and what to do if symptoms worsen.
Data: A. Jha and A. Epstein, Harvard School of Public Health analysis of data from CMS Hospital Compare; State 2004 distribution —Retrieved from CMS Hospital Compare database at http://www.hospitalcompare.hhs.gov.

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

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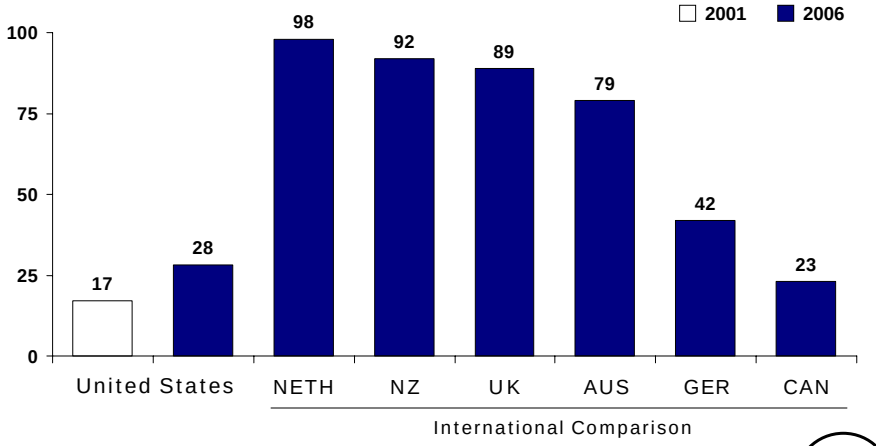
Physicians' Use of Electronic Medical Records

Percent of primary care physicians using electronic medical records



AUS=Australia; CAN=Canada; GER=Germany; NETH=Netherlands; NZ=New Zealand; UK=United Kingdom.
Data: 2001 and 2006 Commonwealth Fund International Health Policy Survey of Physicians.

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

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Impediments in the Current System

Mirror Mirror: US and Canada Fall Behind

Country Rankings	
	1.0-2.66
	2.67-4.33
	4.34-6.0

	AUSTRALIA	CANADA	GERMANY	NEW ZEALAND	UNITED KINGDOM	UNITED STATES
OVERALL RANKING (2007)	3.5	5	2	3.5	1	6
Quality Care	4	6	2.5	2.5	1	5
Right Care	5	6	3	4	2	1
Safe Care	4	5	1	3	2	6
Coordinated Care	3	6	4	2	1	5
Patient-Centered Care	3	6	2	1	4	5
Access	3	5	1	2	4	6
Efficiency	4	5	3	2	1	6
Equity	2	5	4	3	1	6
Long, Healthy, and Productive Lives	1	3	2	4.5	4.5	6
Health Expenditures per Capita, 2004	$2,876*	$3,165	$3,005*	$2,083	$2,546	$6,102

* 2003 data
Source: Calculated by Commonwealth Fund based on the Commonwealth Fund 2004 International Health Policy Survey, the Commonwealth Fund 2005 International Health Policy Survey of Sicker Adults, the 2006 Commonwealth Fund International Health Policy Survey of Primary Care Physicians, and the Commonwealth Fund Commission on a High Performance Health System National Scorecard.
Source: 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, The Commonwealth Fund, May 2007

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Cost-Related Access Problems, Sicker Adults, 2005

Percent in past year due to cost:	AUS	CAN	GER	NZ	UK	US
Did not fill prescription or skipped doses	22	20	14	19	8	40
Had a medical problem but did not visit doctor	18	7	15	29	4	34
Skipped test, treatment or follow-up	20	12	14	21	5	33
Percent who said yes to at least one of the above	34	26	28	38	13	51

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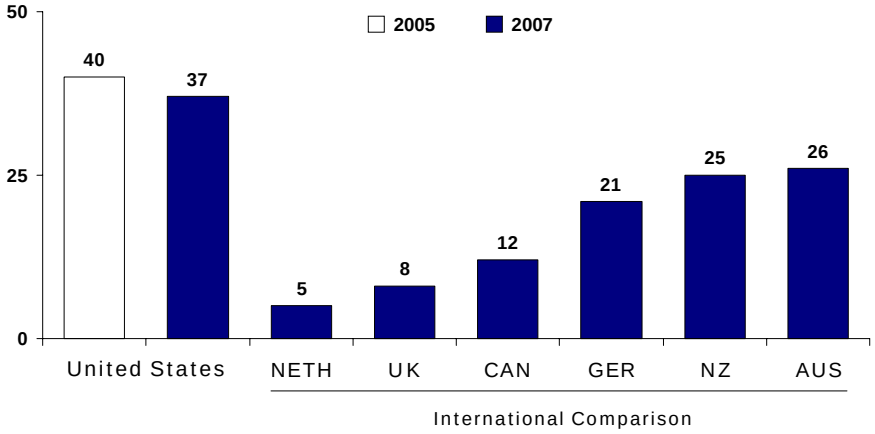
2005 Commonwealth Fund International Health Policy Survey of Sicker Adults

26

Access Problems Because of Costs

Percent of adults who had any of three access problems* in past year because of costs



* Did not get medical care because of cost of doctor's visit, skipped medical test, treatment, or follow-up because of cost, or did not fill Rx or skipped doses because of cost.
AUS=Australia; CAN=Canada; GER=Germany; NETH=Netherlands; NZ=New Zealand; UK=United Kingdom.
Data: 2005 and 2007 Commonwealth Fund International Health Policy Survey.

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

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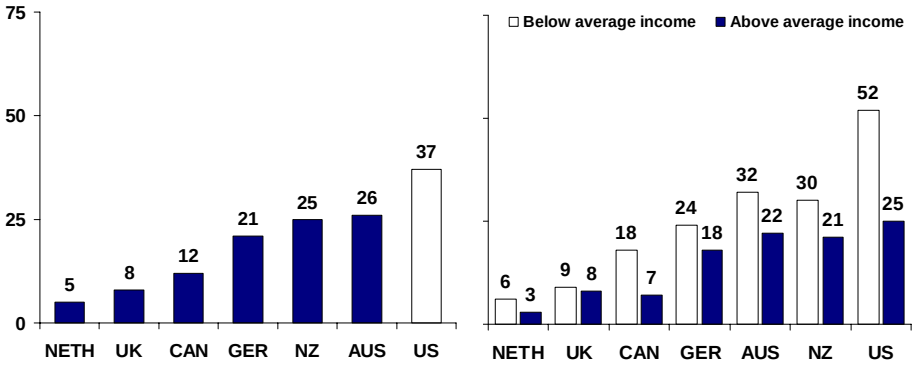
27

Access Problems Because of Costs, By Income, 2007

Percent of adults who had any of three access problems* in past year because of costs



* Did not get medical care because of cost of doctor's visit, skipped medical test, treatment, or follow-up because of cost, or did not fill Rx or skipped doses because of cost.
AUS=Australia; CAN=Canada; GER=Germany; NETH=Netherlands; NZ=New Zealand; UK=United Kingdom; US=United States.
Data: 2007 Commonwealth Fund International Health Policy Survey.
Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2008

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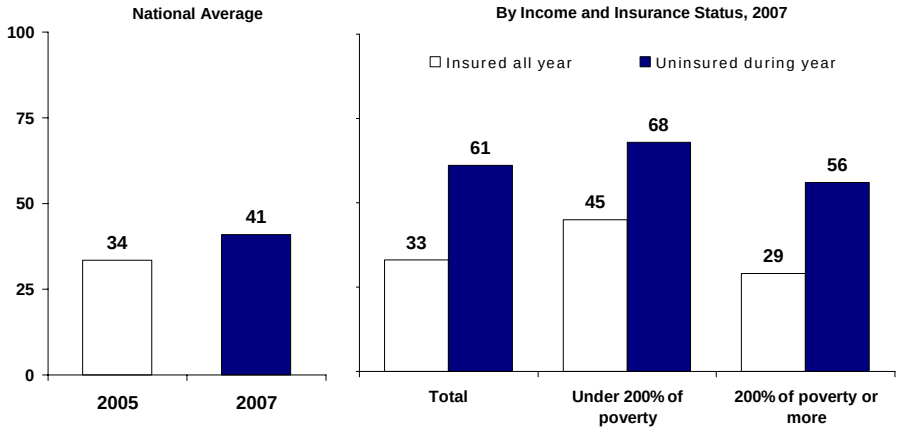
Medical Bill Problems or Medical Debt

Percent of adults (ages 19–64) with any medical bill problem or outstanding debt*



* Problems paying or unable to pay medical bills, contacted by a collection agency for medical bills, had to change way of life to pay bills, or has medical debt being paid off over time.
Data: 2005 and 2007 Commonwealth Fund Biennial Health Insurance Survey.

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

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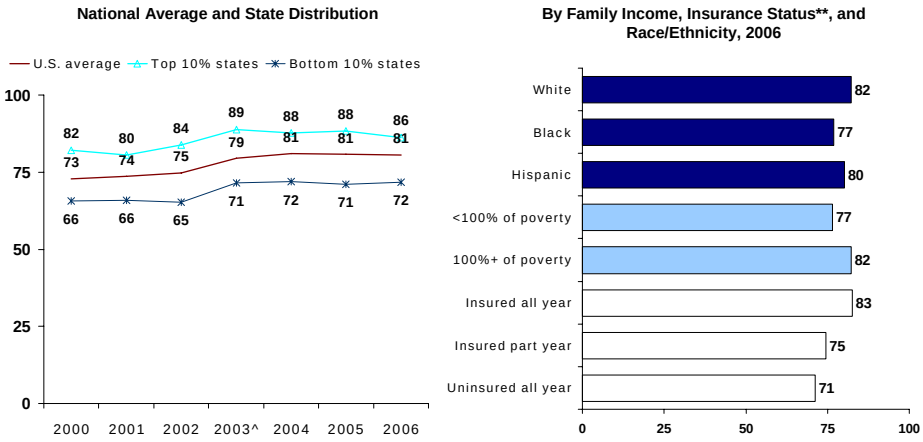
29

Immunizations for Young Children

Percent of children (ages 19–35 months) who received all recommended doses of five key vaccines*



^ Denotes baseline year.
* Recommended vaccines include: 4 doses of diphtheria-tetanus-pertussis (DTP), 3+ doses of polio, 1+ dose of measles-mumps-rubella, 3+doses of Haemophilus influenzae type B, and 3+ doses of hepatitis B vaccine. **Data by insurance was from 2003.
Data: National Immunization Survey (NCHS National Immunization Program, Allred 2007).

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

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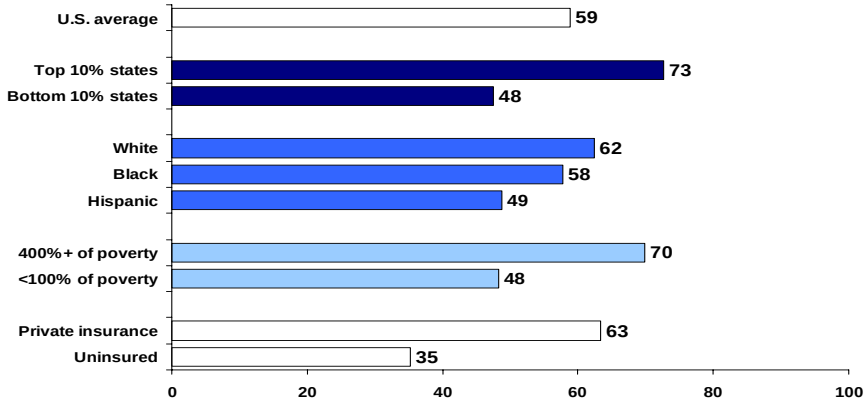
30

Preventive Care Visits for Children, by Top and Bottom States, Race/Ethnicity, Family Income, and Insurance, 2003

Percent of children (ages <18) who received BOTH a medical and dental preventive care visit in past year



Note: Indicator was not updated due to lack of data. Baseline figures from 2006 Scorecard are presented.
Data: 2003 National Survey of Children's Health (HRSA 2005; retrieved from Data Resource Center for Child and Adolescent
Health database at http://www.nschdata.org).

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

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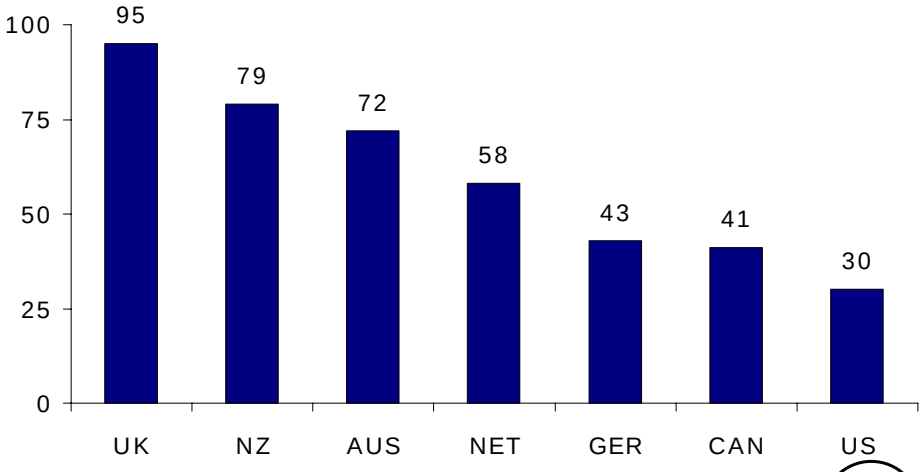
31

Primary Care Doctors' Reports of Any Financial Incentives for Quality of Care Improvement, 2006

Percent of physicians reporting any financial incentive*



***Receive of have potential to receive payment for: clinical care targets, high patient ratings, managing chronic disease/complex needs, preventive care, or QI activities**

Source: 2006 Commonwealth Fund International Health Policy Survey of Primary Care Physicians

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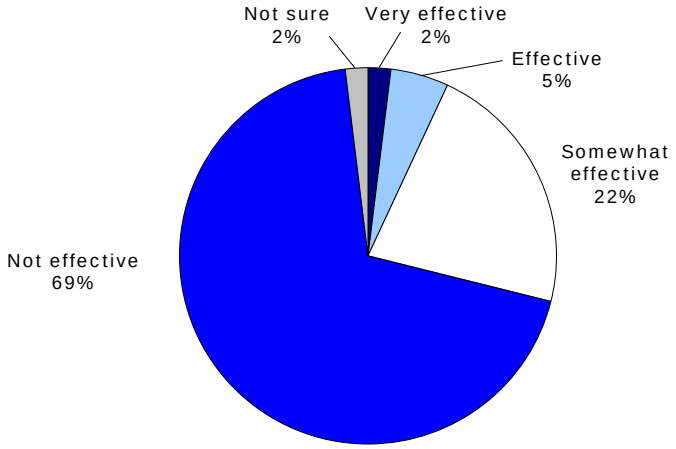
32

More Than Two-Thirds of Opinion Leaders Say Current Payment System Is Not Effective at Encouraging High Quality of Care

"Under the current payment approach, payment is given to each provider for individual services provided to each patient. How effective do you think this payment system is at encouraging high quality and efficient care?"



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Source: Commonwealth Fund Health Care Opinion Leaders Survey, September/October 2008.

33

2006 Fund Quality of Care Survey Indicators of a Medical Home (adults 18–64)

	Total		Percent by Race			
Indicator	Estimated millions	Percent	White	African American	Hispanic	Asian American
Regular doctor or source of care	**142**	**80**	**85**	**79**	**57**	**84**
Among those with a regular doctor or source of care . . .						
Not difficult to contact provider over telephone	**121**	**85**	**88**	**82**	**76**	**84**
Not difficult to get care or medical advice after hours	**92**	**65**	**65**	**69**	**60**	**66**
Doctors' office visits are always or often well organized and running on time	**93**	**66**	**68**	**65**	**60**	**62**
All four indicators of medical home	**47**	**27**	**28**	**34**	**15**	**26**

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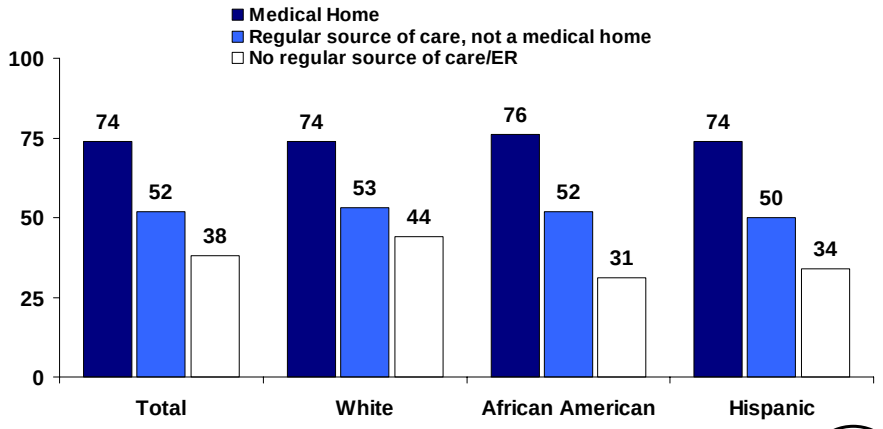
Source: Commonwealth Fund 2006 Health Care Quality Survey.

34

Racial and Ethnic Differences in Getting Needed Medical Care Are Eliminated When Adults Have Medical Homes

Percent of adults 18–64 reporting always getting care they need when they need it



Note: Medical home includes having a regular provider or place of care, reporting no difficulty contacting provider by phone or getting advice and medical care on weekends or evenings, and always or often finding office visits well organized and running on time.
Source: Commonwealth Fund 2006 Health Care Quality Survey.

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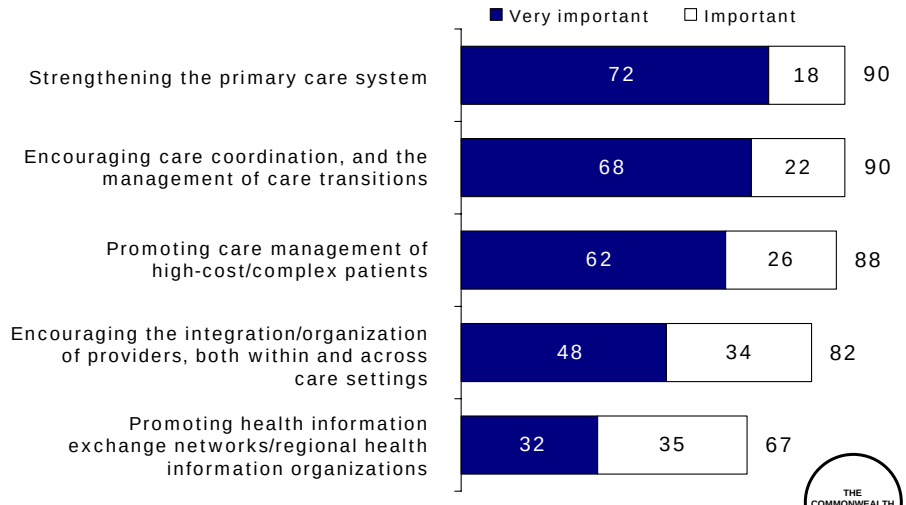
Policy Strategies to Improve Health Care Delivery Organization

"How important do you think each of these are in improving health system performance?"



Source: Commonwealth Fund Health Care Opinion Leaders Survey, April 2008.

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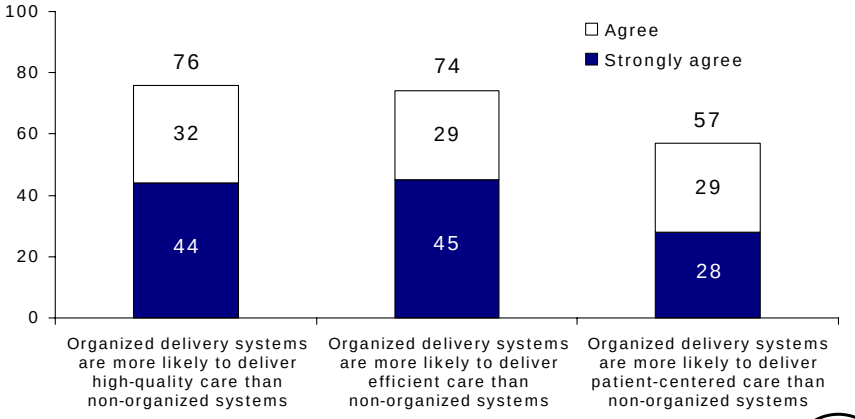
36

Three-Quarters of Health Care Opinion Leaders Think Organized Delivery Systems Are More Likely to Deliver High-Quality and Efficient Care

"Please indicate whether or not you agree with the following statements about organized delivery systems."



Note: Organized delivery system is defined as one which provides enhanced access to care, care coordination, participates in health information exchange, and has hospitals, physician practices, and other providers working together to improve quality and efficiency.
Source: Commonwealth Fund Health Care Opinion Leaders Survey, April 2008.

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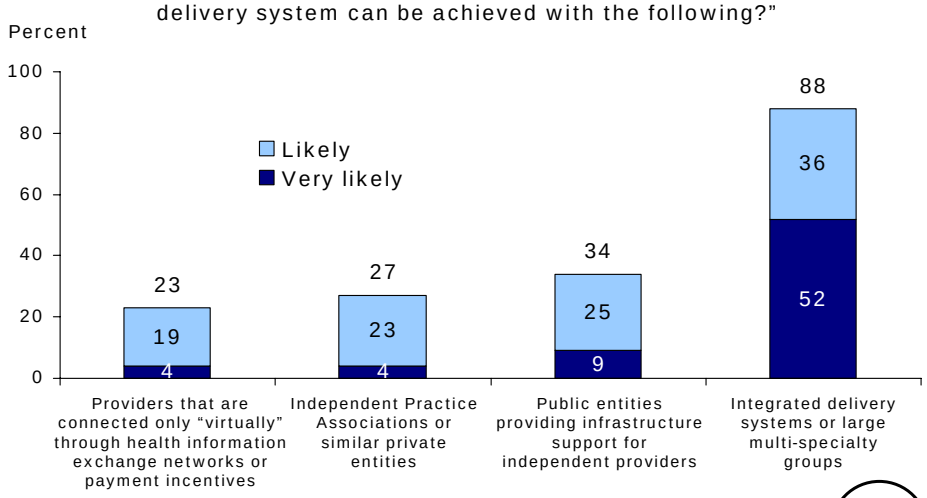
37

Integrated Delivery Systems and Multi-Specialty Group Practices Very Likely to Achieve Organized Delivery Systems

"How likely do you think it is that the results of an organized delivery system can be achieved with the following?"



Note: Organized delivery system is defined as one which provides enhanced access to care, care coordination, participates in health information exchange, and has hospitals, physician practices, and other providers working together to improve quality and efficiency.
Source: Commonwealth Fund Health Care Opinion Leaders Survey, April 2008.

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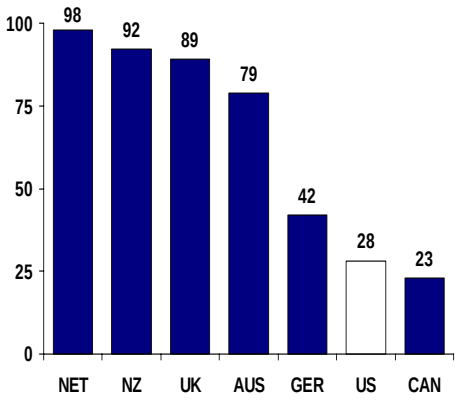
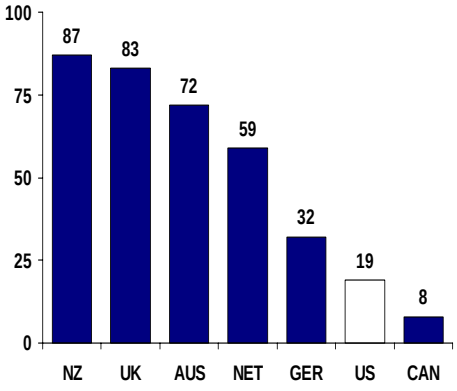
38

Only 28% of U.S. Primary Care Physicians Have Electronic Medical Records; Only 19% Have Advanced IT Capacity

Percent reporting EMR



Percent reporting 7 or more out of 14 functions*



*Count of 14: EMR; EMR access other doctors, outside office, patients; routine use electronic ordering tests, prescriptions; access test results, hospital records; computer for reminders, Rx alerts; prompt tests results; and easy to list diagnosis, medications, patients due for care.

Source: 2006 Commonwealth Fund International Health Policy Survey of Primary Care Physicians.

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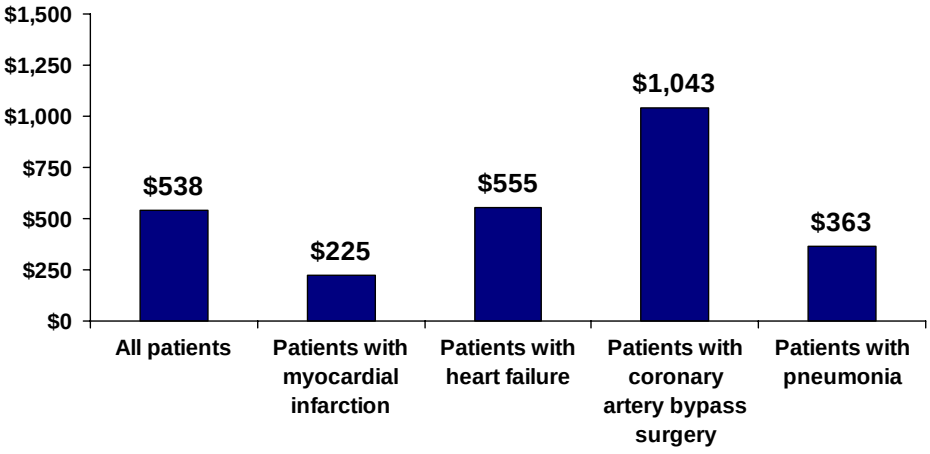
39

Hospitals with Automated Clinical Decision Support Generate Savings

Mean adjusted hospital savings*



* Adjusted for patient complication risk; patient mortality risk; and hospital size, total margin, and ownership. Savings associated with a 10-point increase in Clinical Information Technology Assessment Tool subdomain score.
R. Amarasingham, L. Plantinga, M. Diener-West et al., "Clinical Information Technologies and Inpatients Outcomes: A Multiple Hospital Study," *Archives of Internal Medicine,* Jan. 26, 2009 169(2):1–7.

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British Surgeon Survival and Complication Rates Available on Internet

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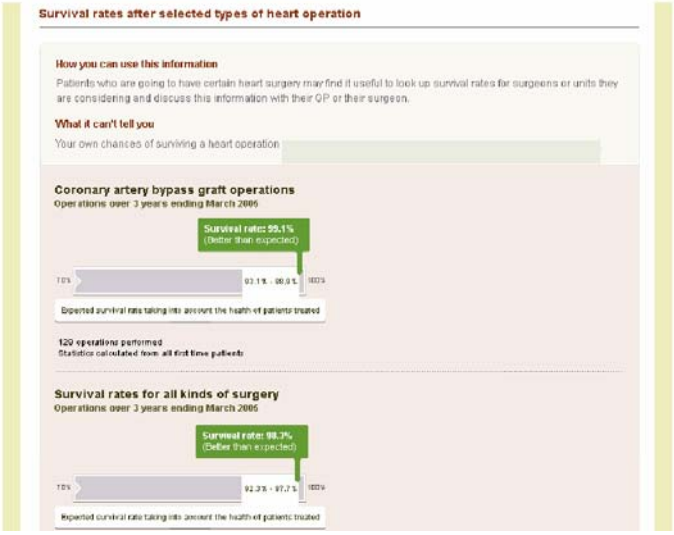
Source: R. Boyle, "National Strategies to Improve Quality and Healthcare Delivery: Heart Disease," Presentation to the Commonwealth Fund International Symposium, November 3, 2005.

British Surgeon Survival and Complication Rates Available on Internet



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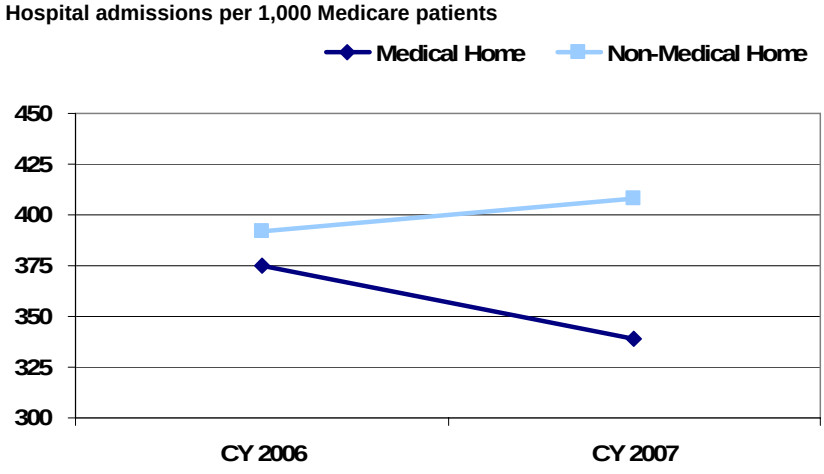
Source: R. Boyle, "National Strategies to Improve Quality and Healthcare Delivery: Heart Disease," Presentation to the Commonwealth Fund International Symposium, November 3, 2005.

Opportunities and Progress

Geisinger Medical Home Sites and Hospital Admissions



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Source: Geisinger Health System, 2008.

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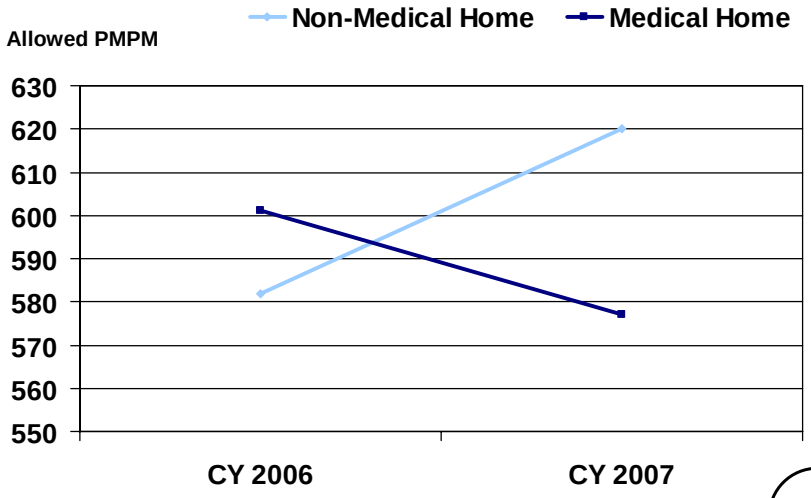
Geisinger Medical Home Pilot Sites Reduce Medical Cost by Four Percent in First Year



Source: G. Steele, "Geisinger Quality – Striving for Perfection," Presentation to The Commonwealth Fund Bipartisan Congressional Health Policy Conference, January 10, 2009.

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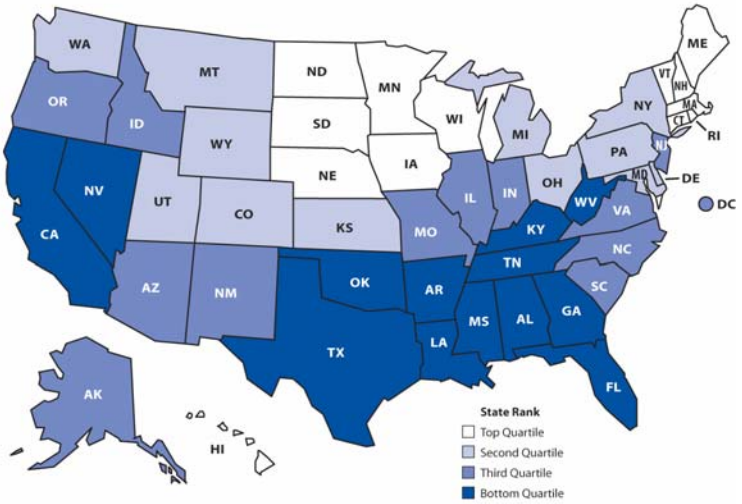
State Rankings on Overall Health System Performance



Source: Commonwealth Fund State Scorecard, 2007.

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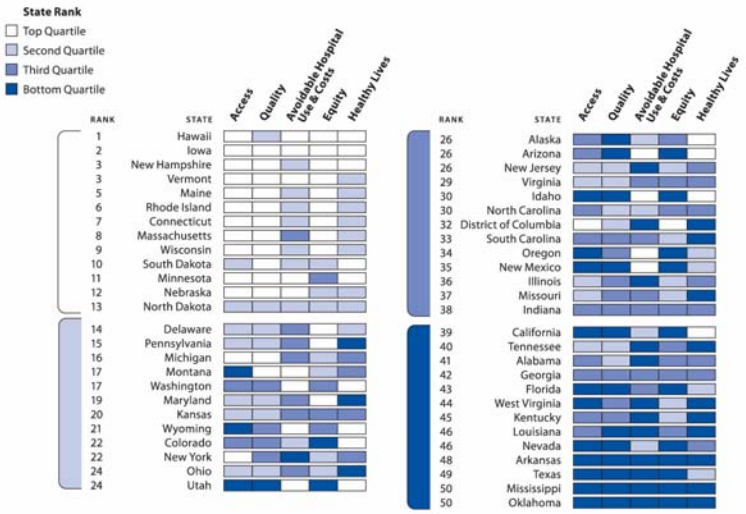
State Scorecard Summary of Health System Performance Across Dimensions



Source: Commonwealth Fund State Scorecard, 2007.

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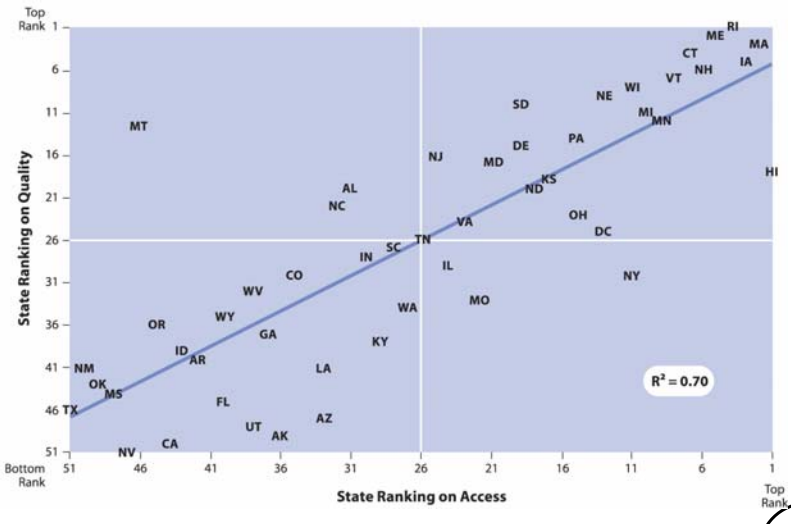
State Ranking on Access and Quality Dimensions



Source: Commonwealth Fund State Scorecard, 2007.

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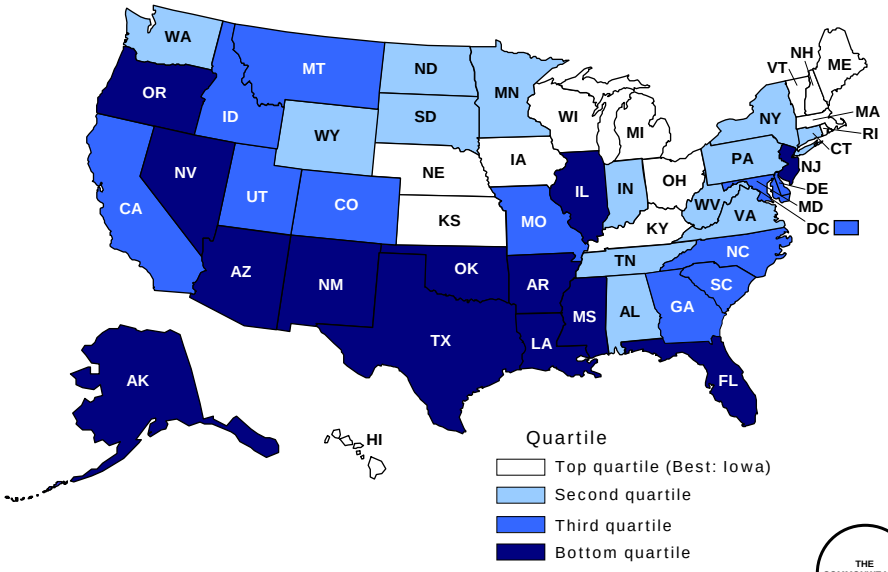
State Ranking on Child Health System Performance



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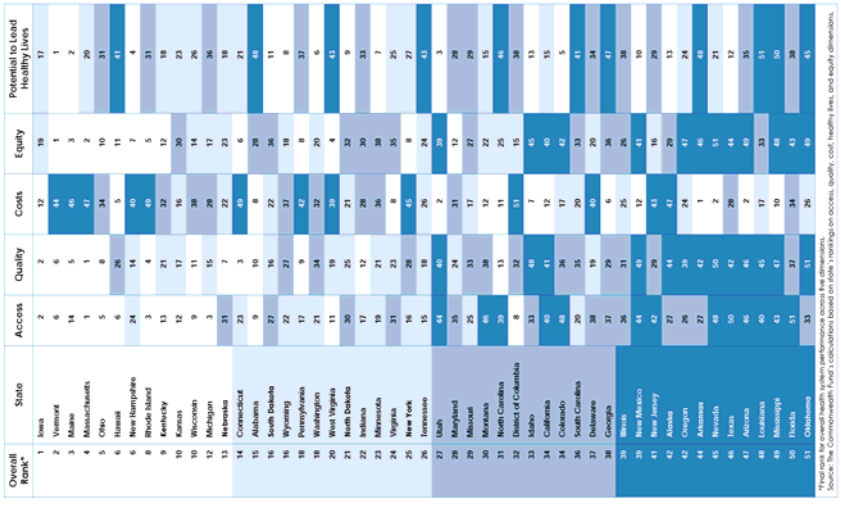
Source: Commonwealth Fund State Scorecard on Child Health System Performance, 2008.

Summary of Variation in Child Health System Performance



Overall Rank*	State	Access	Quality	Costs	Equity	Potential to Lead Healthy Lives
1	Iowa	2	2	12	19	17
2	Vermont	6	6	44	1	1
3	Maine	14	5	46	3	2
4	Massachusetts	1	1	47	2	20
5	Ohio	5	8	34	10	31
6	Hawaii	6	26	5	11	41
6	New Hampshire	24	14	48	7	4
8	Rhode Island	3	4	48	5	31
9	Kentucky	13	21	32	12	18
10	Kansas	12	17	16	30	23
10	Wisconsin	9	11	38	14	26
12	Michigan	3	15	29	17	36
13	Nebraska	31	7	22	23	18
14	Connecticut	23	3	49	6	21
15	Alabama	9	10	8	28	48
16	South Dakota	27	16	22	36	11
16	Wyoming	22	27	37	18	8
18	Pennsylvania	17	9	42	8	37
18	Washington	21	34	32	20	6
20	West Virginia	11	19	39	4	43
21	North Dakota	30	25	21	32	9
22	Indiana	17	12	28	30	33
23	Minnesota	19	21	36	38	7
24	Virginia	31	23	8	35	25
25	New York	16	28	45	8	27
26	Tennessee	15	18	26	24	43
27	Utah	44	40	2	39	3
28	Maryland	35	24	31	12	28
29	Missouri	25	33	17	27	29
30	Montana	46	38	12	22	15
31	North Carolina	39	13	11	25	46
32	District of Columbia	8	32	51	15	38
33	Idaho	33	48	7	45	13
34	California	40	41	12	40	15
34	Colorado	48	42	17	42	5
36	South Carolina	20	36	20	33	41
37	Delaware	38	35	40	20	34
38	Georgia	37	19	6	36	47
39	Illinois	36	31	25	26	38
39	New Mexico	44	49	32	43	10
41	New Jersey	42	29	41	16	29
42	Alaska	27	44	47	29	13
42	Oregon	26	39	24	47	24
44	Arkansas	27	42	1	46	48
45	Nevada	48	50	2	51	21
46	Texas	50	42	29	44	12
47	Arizona	46	46	2	49	35
48	Louisiana	40	45	17	33	51
49	Mississippi	43	47	10	48	50
50	Florida	51	37	34	31	38
51	Oklahoma	33	51	26	49	45

*Final rank for overall health system performance across five dimensions.
Source: The Commonwealth Fund | calculations based on state rankings on access, quality, cost, healthy lives, and equity dimensions.

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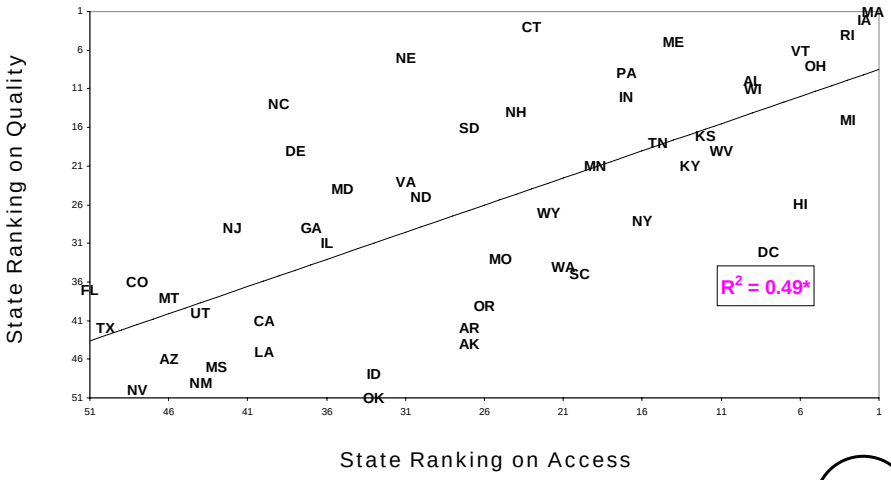
Source: Commonwealth Fund State Scorecard on Child Health System Performance, 2008.

State Ranking on Child Health Access and Quality Dimensions



*p<.05

Source: Commonwealth Fund State Scorecard on Child Health System Performance, 2008.

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Overall Views of the Health Care System in Eight Countries

Base: Adults with any chronic condition

Percent	AUS	CAN	FR	GER	NETH	NZ	UK	US
Only minor changes needed	22	32	41	21	42	29	38	20
Fundamental changes needed	57	50	33	51	46	48	48	46
Rebuild completely	20	16	23	26	9	21	12	33

Data collection: Harris Interactive, Inc.

Source: 2008 Commonwealth Fund International Health Policy Survey of Sicker Adults.

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Cost-Related Access Problems in Past Two Years

Base: Adults with any chronic condition

Percent	AUS	CAN	FR	GER	NETH	NZ	UK	US
Did not fill Rx or skipped doses	20	18	13	12	3	18	7	43
Did not visit a doctor when had a medical problem	21	9	11	15	3	22	4	36
Did not get recommended test, treatment, or follow-up	25	11	13	13	3	18	6	38
Any of the above access problems because of cost	36	25	23	26	7	31	13	54

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Data collection: Harris Interactive, Inc.
Source: 2008 Commonwealth Fund International Health Policy Survey of Sicker Adults.

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Length of Time with Regular Doctor or Place

Base: Adults with any chronic condition

Percent	AUS	CAN	FR	GER	NETH	NZ	UK	US
Has regular doctor or place of care	96	97	99	99	100	98	99	91
With regular doctor or place for five years or more*	58	64	75	79	79	61	73	49

* Base includes those with and without a regular doctor or place of care.

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Data collection: Harris Interactive, Inc.
Source: 2008 Commonwealth Fund International Health Policy Survey of Sicker Adults.

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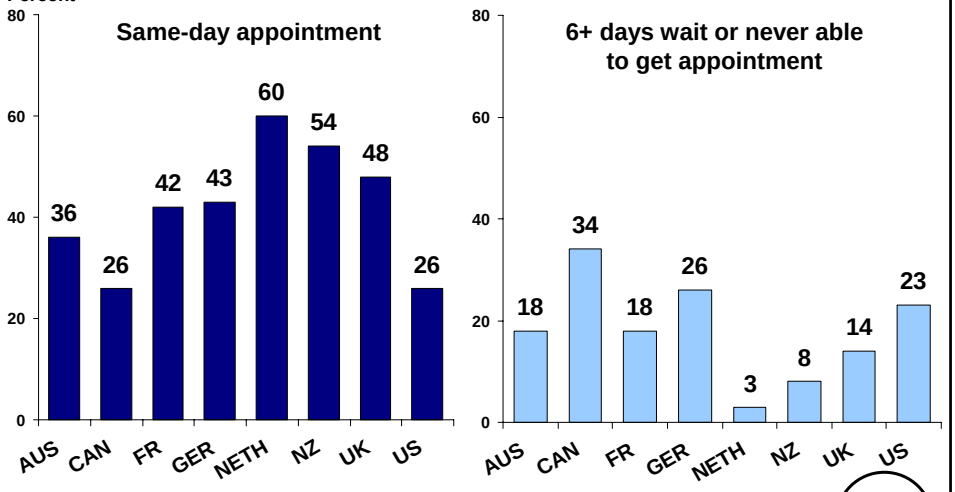
Access to Doctor When Sick or Needed Care

Base: Adults with any chronic condition

Percent



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Data collection: Harris Interactive, Inc.
Source: 2008 Commonwealth Fund International Health Policy Survey of Sicker Adults.

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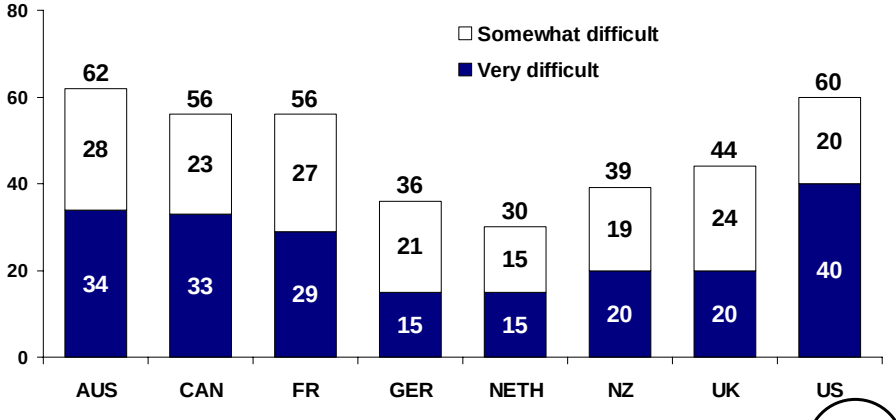
Difficulty Getting Care After Hours Without Going to the Emergency Room

Base: Adults with any chronic condition who needed after-hours care

Percent reported *very/somewhat difficult* getting care on nights, weekends, or holidays without going to ER



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Data collection: Harris Interactive, Inc.
Source: 2008 Commonwealth Fund International Health Policy Survey of Sicker Adults.

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Coordination Problems with Medical Tests or Records in Past Two Years

Base: Adults with any chronic condition

Percent	AUS	CAN	FR	GER	NETH	NZ	UK	US
Test results/records not available at time of appointment	16	19	15	12	11	17	15	24
Duplicate tests: doctors ordered test that had already been done	12	11	10	18	4	10	7	20
Either/both coordination problems	23	25	22	26	14	21	20	34

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Data collection: Harris Interactive, Inc.
Source: 2008 Commonwealth Fund International Health Policy Survey of Sicker Adults.

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Medical, Medication, or Lab Test Errors in Past Two Years

Base: Adults with any chronic condition

Percent	AUS	CAN	FR	GER	NETH	NZ	UK	US
Wrong medication or dose	13	10	8	7	6	13	9	14
Medical mistake in treatment	17	16	8	12	9	15	8	16
Incorrect diagnostic/lab test results*	7	5	3	5	1	3	3	7
Delays in abnormal test results*	13	12	5	5	5	10	8	16
Any medical, medication, or lab errors	29	29	18	19	17	25	20	34

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* Among those who had blood test, x-rays, or other tests.
Data collection: Harris Interactive, Inc.
Source: 2008 Commonwealth Fund International Health Policy Survey of Sicker Adults.

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Policy Solutions

Bending the Curve: Fifteen Options that Achieve Savings Cumulative 10-Year Savings

Producing and Using Better Information

- Promoting Health Information Technology -$88 billion
- Center for Medical Effectiveness and Health Care Decision-Making -$368 billion
- Patient Shared Decision-Making -$9 billion

Promoting Health and Disease Prevention

- Public Health: Reducing Tobacco Use -$191 billion
- Public Health: Reducing Obesity -$283 billion
- Positive Incentives for Health -$19 billion

Aligning Incentives with Quality and Efficiency

- Hospital Pay-for-Performance -$34 billion
- Episode-of-Care Payment -$229 billion
- Strengthening Primary Care and Care Coordination -$194 billion
- Limit Federal Tax Exemptions for Premium Contributions -$131 billion

Correcting Price Signals in the Health Care Market

- Reset Benchmark Rates for Medicare Advantage Plans -$50 billion
- Competitive Bidding -$104 billion
- Negotiated Prescription Drug Prices -$43 billion
- All-Payer Provider Payment Methods and Rates -$122 billion
- Limit Payment Updates in High-Cost Areas -$158 billion

Source: C. Schoen et al., *Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending*, Commonwealth Fund, December 2007.

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Five Key Strategies for High Performance

1. **Extending affordable health insurance to all**
2. **Organizing care around the patient**
3. **Aligning financial incentives to enhance value and achieve savings**
4. **Meeting and raising benchmarks for high-quality, efficient care**
5. **Ensuring accountable national leadership and public/private collaboration**

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

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