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Achieving a High Performance Health System

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President, the Commonwealth Fund

Princeton Conference

May 16, 2003

Princeton Conference: Regional Disparities in Health Spending: Implications for the Private Market and Medicare

- **Lumpkin – Variability associated with poor quality, disparities in care**
- **Wennberg et al. – Health spending varies geographically; underuse of effective care, overuse of supply-sensitive services**
- **Cutler – health spending has contributed to improved health and economic gain; need policies to increase high value, low intensity care; reduce low value, high intensity care; need quality-based payment**
- **Crippen, Lieberman – Willie Sutton principle, focus primarily on high cost beneficiaries**
- **Etheredge -- Health status after age 65 is a function of health status pre-65**

Princeton Conference: Regional Disparities in Health Spending: Implications for the Private Market and Medicare

- **O’Kane – public reporting drives improvement; adopt Value Agenda**
- **Dickey – physician education key; medical extension service**
- **Rowe – some early signs of cost abatement, some things are working**
- **Fox, Marder – under age 65 highly variable as well; hard for employers to lead in reducing variations, delivery system change**
- **Galvin – variation without gold standards not operational; Bridges to Excellence, reward quality; Leapfrog making a difference**
- **Victor Fuchs – important to understand why variations occur before moving to policy solutions; other more pressing policy issues (access, rising costs)**

Princeton Conference: Regional Disparities in Health Spending: Implications for the Private Market and Medicare

- **Altman – Medicare payment policies have moved to pay same prospective price for same service; M+C moving to national payment; FFS no similar rate for per capita spending**
- **Reischauer, MedPAC – proper adjustment narrows variation; unintended consequences of efforts to address variations**
- **Andrea Walsh – ICSI (evidence-based guidelines); measure quality at clinic level; report it; pay for it**
- **Diana Dennett – need stability and certainty in M+C payment; flexibility for innovation; improved regulatory environment**

Princeton Conference: Regional Disparities in Health Spending: Implications for the Private Market and Medicare

- **Bob Berenson – Medicare Purchasing Model – provider eligibility, benefit design, coverage policy, payment policy, technical assistance, beneficiary information and education, paying for performance, collaboration among purchasers, intervene in delivery system**
- **Tom Grissom – geographical politics real; should both move providers to better practices and beneficiaries to better providers**
- **Senator Durenberger – tie payment to quality; start with local innovation, best practices**
- **David Abernethy – move away from political influence on payment; need to reform FFS delivery system**

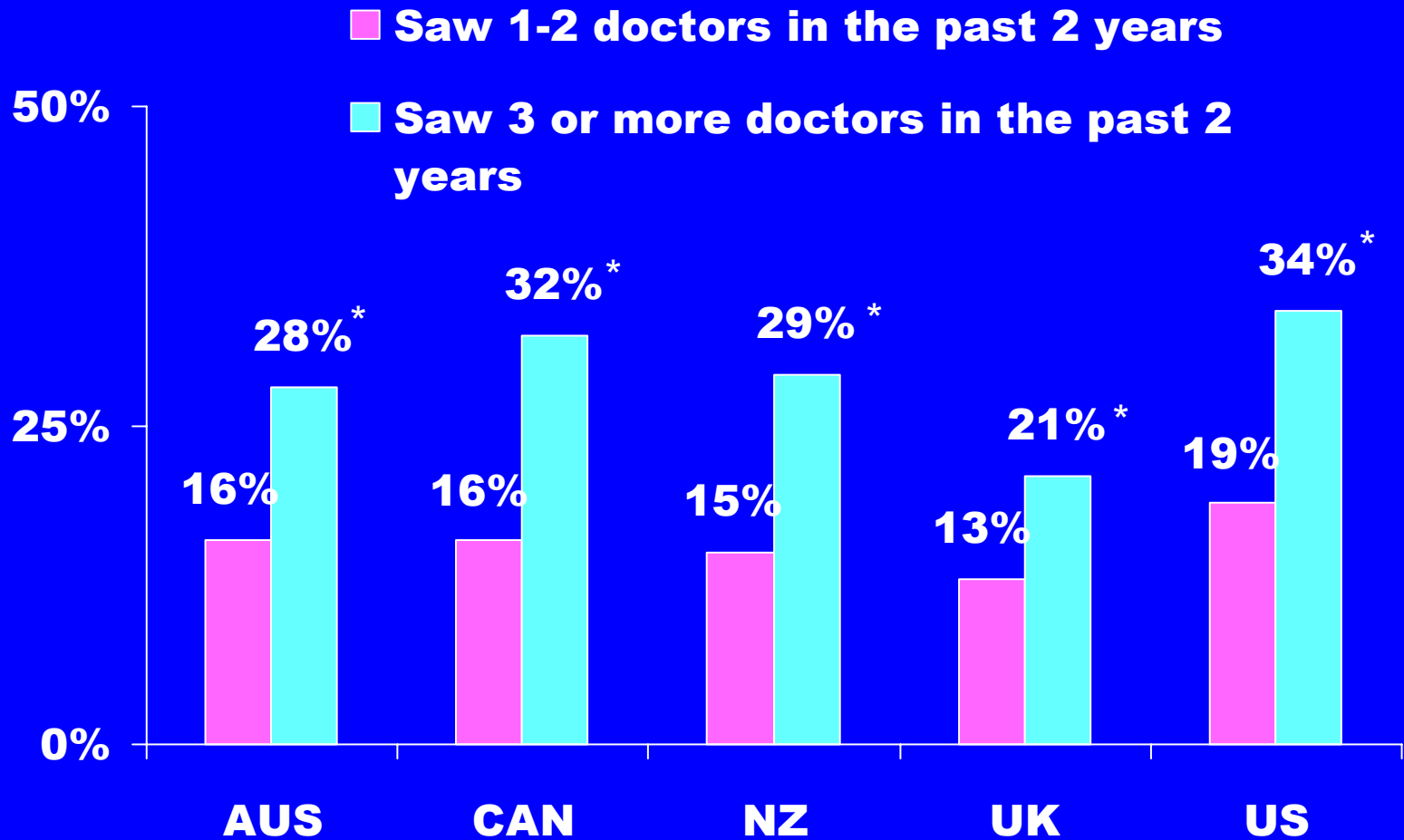
Selected Health System Performance Indicators

	Percent of sicker adults reporting medical errors causing serious problems	Percent of sicker adults reporting not getting medical care due to costs	Health spending per capita, 2000
Australia	13	16	\$2211
Canada	15	9	\$2535
New Zealand	18	26	\$1623
United Kingdom	9	4	\$1763
United States	18	28	\$4631

Source: Commonwealth Fund 2002 International Health Policy Survey of Sicker Adults; R. G. Anderson, U. Reinhardt, P. Hussey, and V. Petrosyan. "It's the Prices, Stupid: Why The United States is So Different from Other Countries." *Health Affairs* May/June 2003.



Percent of Sicker Adults Reporting Medication Error or Medical Mistake in Past 2 Years by Number of Doctors



* Difference between 1-2 doctors and 3 or more doctors significant at $p < .05$

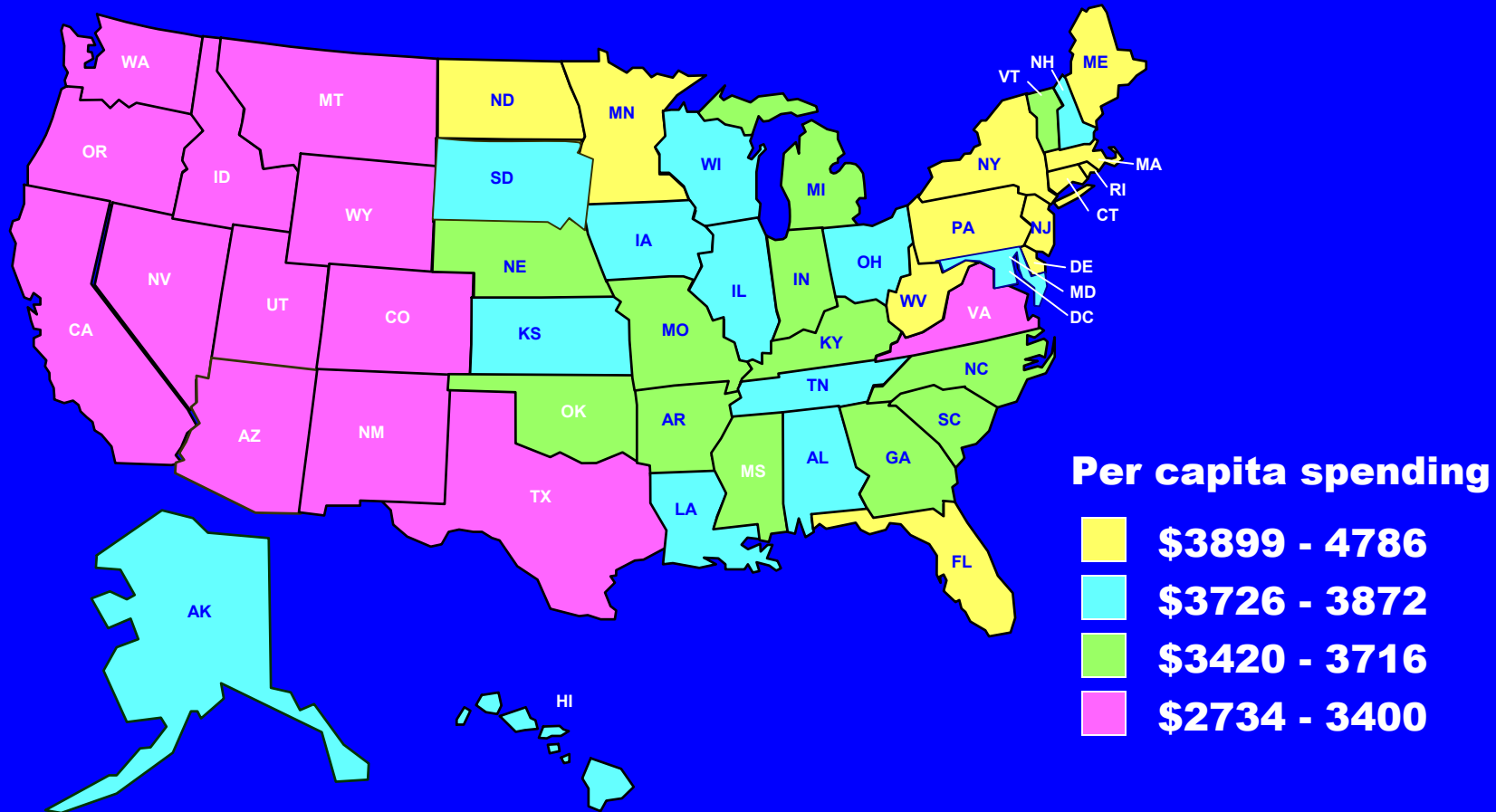
Source: Commonwealth Fund 2002 International Health Policy Survey of Sicker Adults



Geographic Variation in Health Care Costs and Outcomes: What Works to Narrow Differentials?

- **Quality and spending vary geographically – but don't really understand why; need gold standard of what is "right" rate**
- **Both public and private health systems and group practices have shown ability to improve quality and narrow quality variation**
- **Public/private actions can promote quality and efficiency improvement**
- **Medicare policies can promote quality and efficiency improvement**

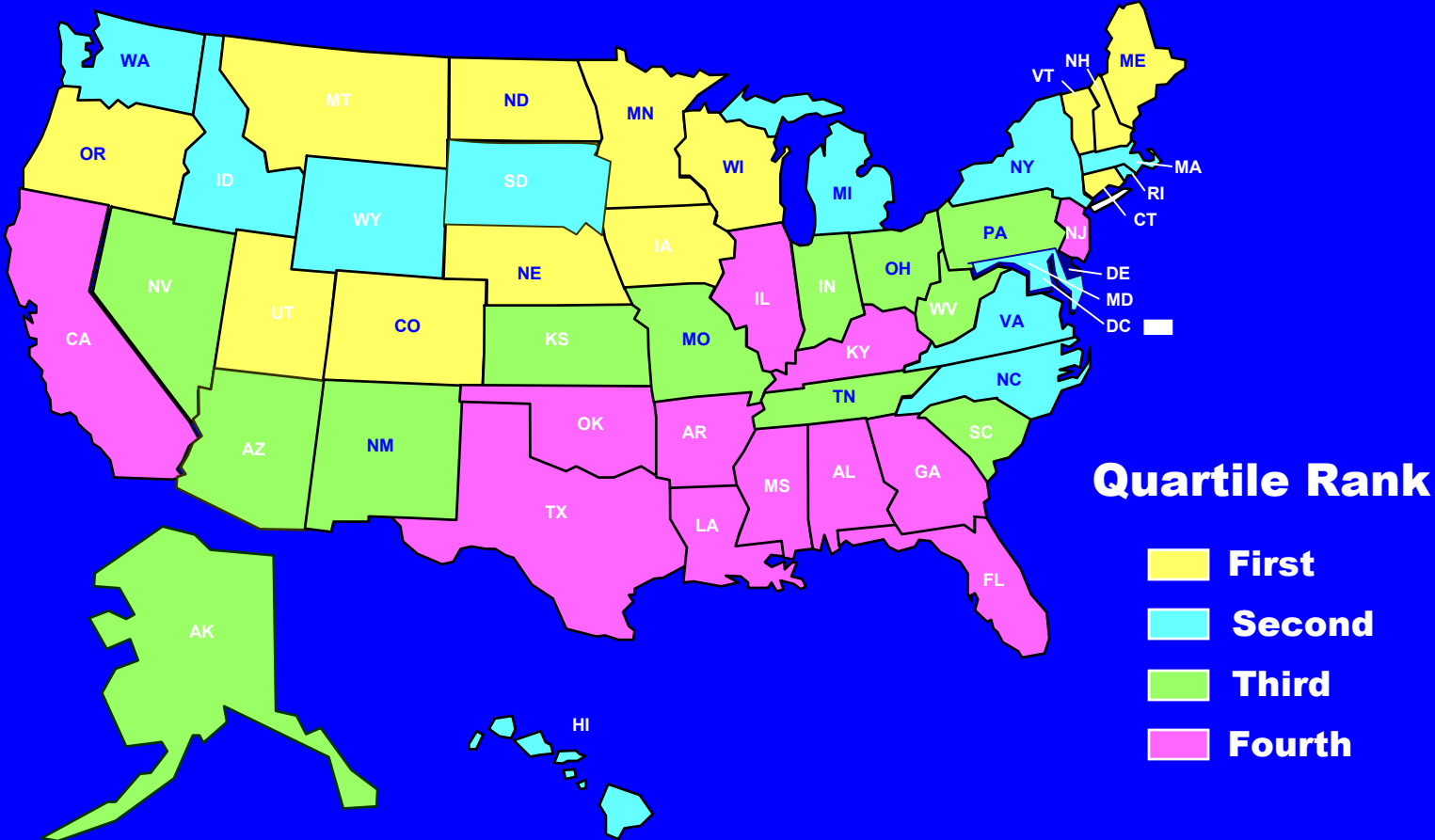
Total Personal Health Care Per Capita Expenditures by State, 1998



Source: National Center for Health Statistics, *Health, United States, 2002*.



State Rank on Provision of Appropriate Care, 2000-2001

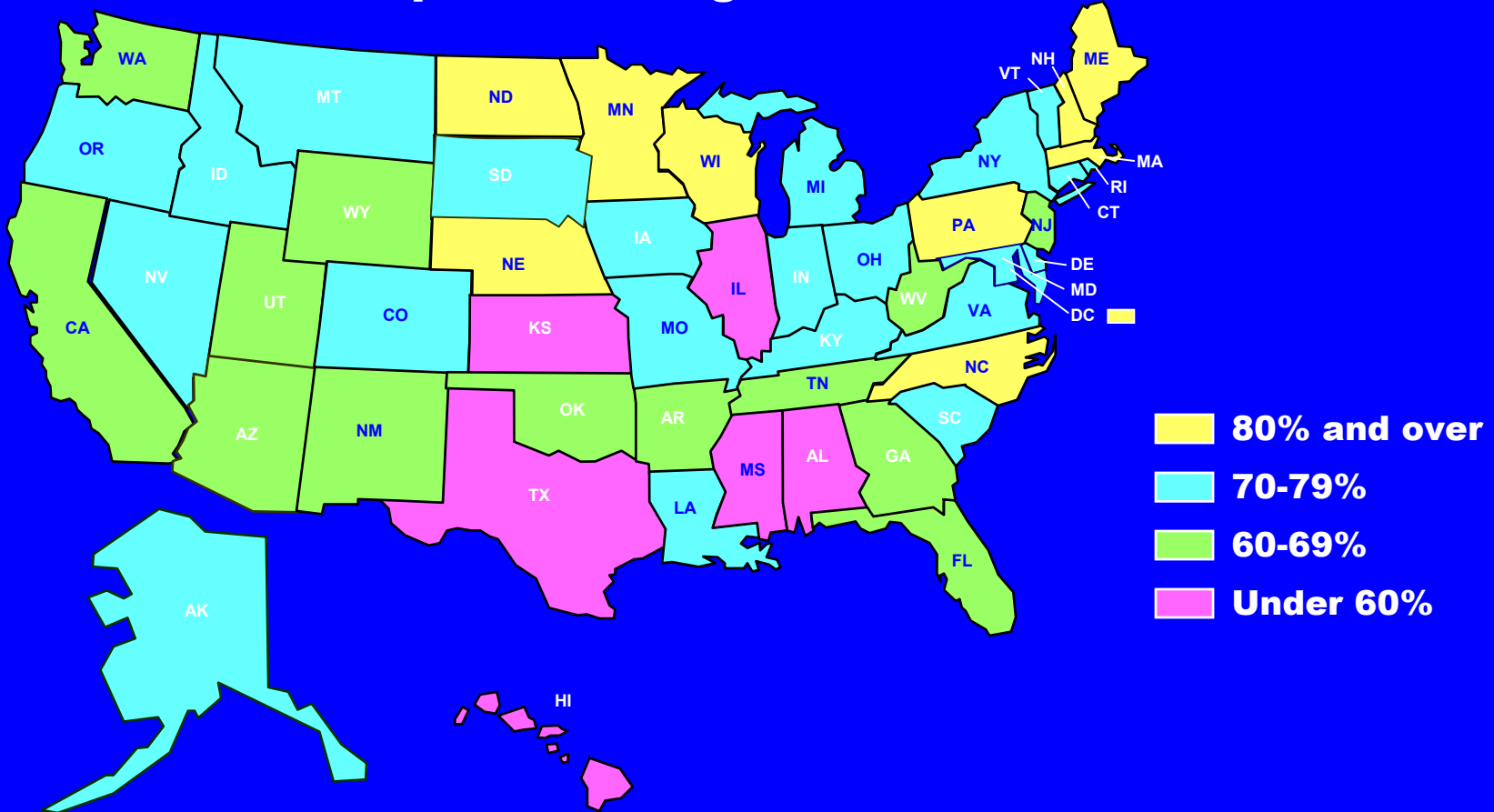


Source: S. Jencks, et al., "Change in the Quality of Medical Care Delivered to Medicare Beneficiaries, 1998-1999 to 2000-2001" JAMA (289) no. 3, 2003, pp 305-312



Medication to Prevent Recurrent Heart Attack

Percent of Medicare heart attack patients prescribed a beta-blocker at hospital discharge when indicated*



Source: S. Leatherman and D. McCarthy, *Quality of Health Care in the United States: A Chartbook* The Commonwealth Fund, 2002. *Ideal candidates are those without contraindications, for whom treatment would almost always be indicated based on clinical guidelines



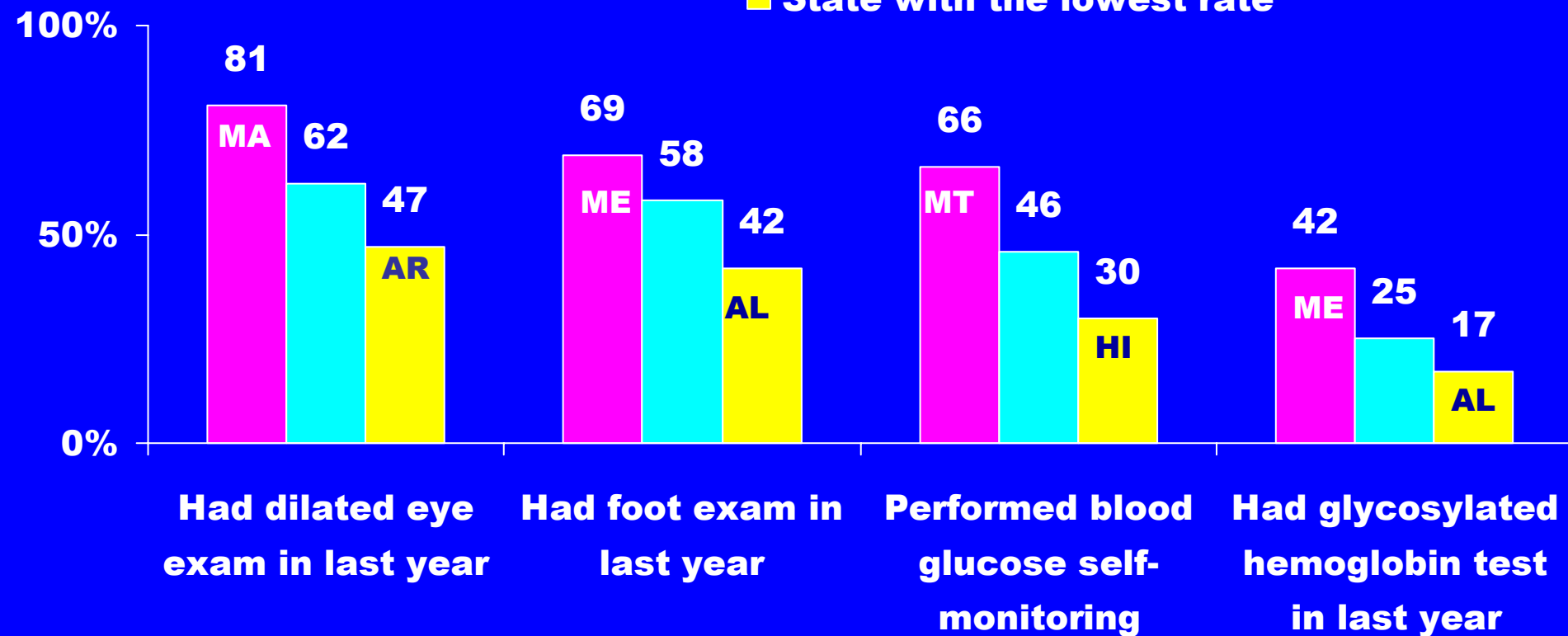
Diabetes Management

■ State with the highest rate

■ U.S. Median

■ State with the lowest rate

Percent of adults with diabetes age 18+



Source: S. Leatherman and D. McCarthy, *Quality of Health Care in the United States: A Chartbook*, The Commonwealth Fund, 2002



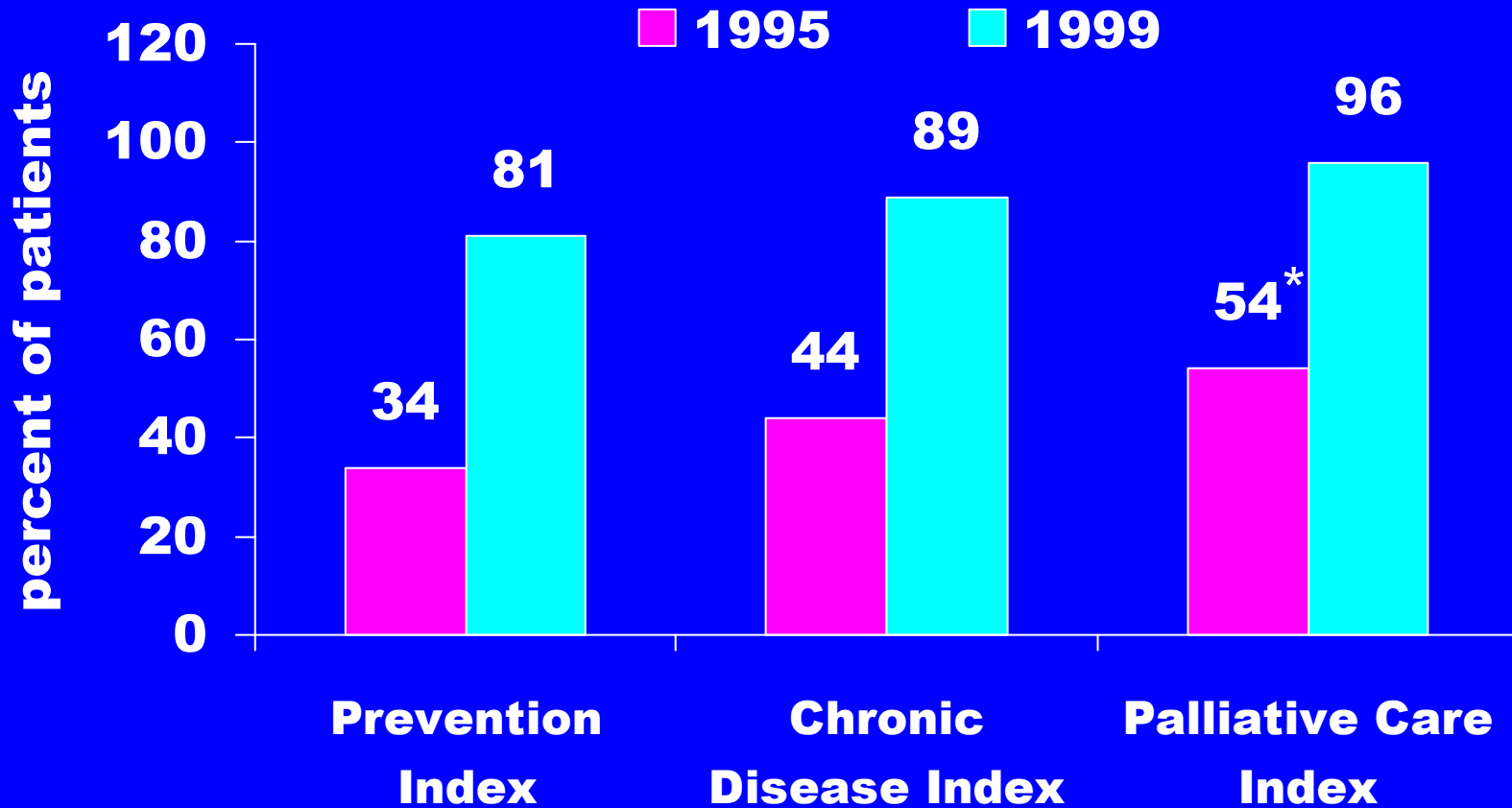
Health Disparities Collaboratives: Outcomes to Date

- **Over 500 community health centers in QI breakthrough collaboratives on diabetes – chronic care model**
- **68,000 patients in chronic disease registry to track/manage care**
- **Improvements in glucose control**
- **Improved management of blood pressure**
- **Increase in patient self management**

D. Stevens, Changing Practice, Changing Lives: Large Scale Improvement in Health Centers Across the Nation. Presentation at IHI National Forum, December, 2002



VA Performance Improvement



* Data from 1997



What Distinguishes Accountable Physician Practices?

CAPP members share some common characteristics:

- **Focus on quality, efficiency, and culture of performance measurement**
- **Focus on professionalism**
- **Continual learning, innovation, and technology readiness**
 - **Deployment of evidence-based practices**
 - **Use of information technology to share information, improve care**

CAPP's early members represent many of the nation's largest and most prestigious medical groups, totaling more than 17,300 physicians.

- **Austin Regional Clinic**
- **The Cleveland Clinic**
- **Duluth Clinic**
- **Geisinger Clinic**
- **Group Health Permanente**
- **HealthCare Partners Medical Group***
- **HealthPartners**
- **Henry Ford Medical Group**
- **The Lahey Clinic**
- **The Nemours Foundation**
- **Palo Alto Medical Foundation***
- **The Permanente Federation***
- **Sharp Rees-Stealy Medical Group***
- **Virginia Mason Clinic**

*CAPP is an affiliate of the AMGA's
American Group Practice Foundation*

*** Founding member**

Source: Council on Accountable Physician Practices



Evidence demonstrates that CAPP practices and other multi-specialty groups deliver higher quality and are more financially efficient

Health Plans delivering the majority of their care through Accountable Physician Practices (APPs) significantly out-performed others. They had:

- **An average of 22% higher HEDIS clinical scores**
 - **Statistically significant, valid regionally and nationally**
- **10% better financial performance per Hewitt's value index**
 - **Adjusted for differences, if known, in plan design, geographic cost differences, enrollee demographics**
- **Satisfaction scores equal to other plans**

Source: Council on Accountable Physician Practices



Policies to Improve Quality and Efficiency

- **Require quality and cost reporting at all levels (individual hospital/health system/physician); performance monitoring**
- **Value based purchasing, quality-based payment, bonus for high quality providers, Centers of Excellence, Centers of Efficiency**
- **Reward and facilitate adoption of IT, EMR**
- **Evidence-based benefits (e.g. frequency of specialist visits, consults); research and demonstrations**
- **Extend and encourage adoption of practice guidelines**

Policies to Improve Quality and Efficiency (con't)

- **Establish networks of providers providing science-based care, better quality, greater efficiency**
- **Consolidation of low-volume providers**
- **Support and promote learning collaboratives to improve quality**
- **Provide funding for demonstrations to improve care (IOM November 2002 report)**

Medicare Policies to Improve Quality and Efficiency

- **Focus on high cost beneficiaries, e.g. screening mechanisms; coordination; profiling and incentives**
- **Medicare could require quality and cost public data reporting as a condition of participation**
- **Medicare could establish quality standards and performance measures for all providers**
- **Medicare could reward high performance physician practices, hospitals, and integrated health delivery systems meeting performance goals**

Medicare Policies to Improve Quality and Efficiency

- **Medicare hospital and physician payment rates could include differential for IT, EMR, CPOE**
- **Medicare could initiate activities to reduce health risks of older adults pre-Medicare; control of diabetes, hypertension; buy-in to Medicare for high risk uninsured**
- **Medicare could screen beneficiaries when enroll in program, identify high risk, provide supplemental benefits for high risk, coordinate care**
- **Coverage policy for high cost elective procedures**
- **QIOs provide technical assistance to improve quality**
- **Medicare could intervene in delivery system, e.g. promote hospitalists**

Acknowledgements

- **Stephen Schoenbaum, M.D., Senior Vice President, Commonwealth Fund**
- **Barbara Cooper, Senior Program Officer for Medicare, Commonwealth Fund**
- **Robert Crane, Kaiser**
- **Jay Crosson, M.D., Permanente**
- **Katie Tenney – production**
- **visit the Fund at:**

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