Models for Achieving the Best Health System in the World

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With some of the best-equipped hospitals and most highly specialized physicians in the world, it is no wonder that many people believe the U.S. health system is the best on earth. Yet, the evidence—including data from the Commission's Scorecard on a High Performance Health System—suggests this confidence is misplaced.

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

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

1. Extend Health Insurance to All
Case in Point: State of Maine
Several states—including Maine, Massachusetts, Minnesota, Rhode Island, and Vermont—are now leading the way by implementing creative and pragmatic approaches to achieving universal health insurance coverage. And it appears that California is following close behind.

Maine took the first step toward universal coverage when it launched DirigoChoice in January 2005. DirigoChoice is an affordable insurance product that offers reduced monthly rates and deductibles based on income, using a sliding scale up to 300 percent of the poverty level. Comprehensive benefits include 100 percent coverage of preventive benefits and cash-back incentives for participation in wellness programs.

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

2. Pursue Excellence in Provision of Safe, Effective, and Efficient Care
Case in Point: University of Colorado Health Sciences Center
Substantial gains in health system performance could be achieved if all providers were to adopt the "proven." These include use of evidence-based medicine, promoting effective chronic care management techniques, prioritizing patient safety, and ensuring care coordination across sites of care, especially when transitioning from the hospital to other settings.

An effort supported by The Commonwealth Fund by Eric Coleman, M.D., at the University of Colorado Health Sciences Center, focuses on creating more effective forms of "transitional care," to help patients care for themselves at home after leaving the hospital, and receive appropriate and timely follow-up care to avoid preventable complications and rehospitalizations.

Dr. Coleman has developed the Care Transitions Intervention, which includes a discharge preparation checklist that asks patients to sign off on statements such as "The hospital staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left the hospital." This statement and two other Care Transition Measures have been adopted by the National Quality Forum as the best measures of care coordination.

At Group Health Cooperative in Seattle, care transitions were identified as part of a larger quality improvement initiative. A "transition coach" worked with patients to prepare them for the change, and followed patients for 30 days after their discharge from the hospital. Dr. Coleman has found that patients who participate are less likely to be readmitted during this time—and even in the six months following discharge.

3. Organize the Care System to Ensure Coordinated and Accessible Care for All
Case in Point: Mount Sinai School of Medicine EXPORT Center
Research demonstrates disparities in health care delivery and status based on race and ethnicity. Mount Sinai Center of Excellence in Partnerships for Community Outreach, Research on Health Disparities, and Training (EXPORT) Center aims to build research capacity targeting underrepresented minority medical faculty and students at Mount Sinai School of Medicine and North General Hospital in New York City. With Fund support, Mark Chassin, M.D., M.P.P., M.P.H., of the EXPORT Center, is conducting a randomized trial to improve care coordination by better ensuring minority women with early breast cancer follow up with recommended treatment after biopsy. Dr. Chassis first showed that minority women are more likely than white women to experience system failures that result in their not receiving treatment. For the intervention, Dr. Chassin designed systems to track patients' care and prompt surgeons to refer women who have not had referrals. He is also documenting rates of underuse before and after implementation of the reminder system, and evaluating reductions in underuse and in system failure.

By addressing the system failures and employing targeted interventions like Mount Sinai's, we can move toward a health system that meets the needs of all Americans, including low-income people, the uninsured, minority Americans, young children, and elderly adults.

4. Develop the Workforce to Foster Patient-Centered and Primary Care
Case in Point: Denmark
The U.S. is strikingly different from other industrialized countries in one important respect: its relative under-investment in patient-centered primary care. The U.S. has a much lower fraction of primary care physicians, and much better financial rewards for specialty care. A review of the literature indicates that better access to primary care lowers total cost and improves outcomes.

In Denmark, which has the highest public satisfaction with health care of any country in Europe, primary care is much more accessible than in the U.S. A blend of capitation and fee-for-service

payments to generalist physicians in Denmark assures that everyone has a primary care physician or "medical home," and generalist physicians typically provide services quickly, often in same-day appointments. An organized off-hours service assures accessible care from physicians 24 hours a day, seven days a week. These medical homes also offer an information system that ensures that the practice has complete and up-to-date records—and remind patients about preventive services.

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

5. Increase Transparency and Reward Quality and Efficiency
Increase Transparency
Case in Point: Massachusetts Health Quality Partners Increase Transparency
Public reporting of information on the performance of health plans and providers can spur improvements in quality and efficiency, by helping consumers make more informed decisions and by stimulating providers and plans to be more accountable for their results. It can also form the basis for new payment systems that reward providers for excellence and efficiency. Commonwealth Fund surveys indicate that most patients do not have access to the cost and quality information that would enable them to make informed choices, but they very much want access to such information.

Yet, a number of notable initiatives provide purchasers, consumers, and providers themselves with information about quality. With Commonwealth Fund and Robert Wood Johnson Foundation support, Massachusetts Health Quality Partners (MHQP) has publicly released clinical quality data as well as patients' ratings of their experiences with doctors' offices throughout the state. In addition, data on the clinical performance of primary care physicians in Massachusetts are now publicly available at the medical group level.

Reward Efficiency
Case in Point: New York State
Along with making quality and patient satisfaction data publicly available, aligning financial incentives so that health systems, hospitals, and physicians benefit financially from doing the right thing is essential. Our fee-for-service payment system rewards doing more, and rewards providing highly specialized services far more than preventive care or preventing an acute episode for patients with chronic conditions. Payment should be restructured so that providers are reimbursed based on the quality and efficiency of the care they provide.

In New York State, for example, the Department of Health began incorporating quality incentives into the computations of Medicaid managed care capitation rates in 2002. These incentives are tied to performance on 10 quality-of-care measures and five consumer satisfaction measures. By April 2005, the maximum incentive was 3 percent of the monthly premium. Incentive payments for 2005 totaled $40 million. The Commonwealth Fund is supporting a qualitative and quantitative analysis of this incentive plan. Preliminary results indicate that rewarding performance does improve quality.

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

A number of states, including Rhode Island, are promoting an interconnected health information system. The Rhode Island Health Information Exchange (HIE) initiative is a public–private effort to allow providers, with their patients' permission, to electronically access important patient health information from a variety of sources. The goals of this project include giving consumers access to their health information, and enabling them to decide when and with whom they want to share it.

7. Encourage Leadership and Collaboration among Public and Private Stakeholders
Case in Point: Puget Sound Health Alliance
Creating a "culture of high performance" requires a shared vision among all stakeholders. Public and private sectors must work together to achieve this vision. In Washington, the Puget Sound Health Alliance is an independent non-profit organization composed of employers, physicians, hospitals, consumers, health plans and other interested parties. The group's aim is to improve care and continuity by developing guidelines for providers, self-management and decision-making tools for patients and consumers, evaluations and reports on quality, and a collaborative approach to quality improvement.

The group seeks to build strong alliances among patients, doctors, hospitals, employers, and health plans to promote health and improve quality and affordability by reducing overuse, underuse, and misuse of health services.

There is much to learn from these examples, and the need to do so is pressing. In 2007, the Commonwealth Fund Commission on a High Performance Health System, and Commonwealth Fund staff and grantees, will continue examining these and other solutions available to a nation with our exceptional resources and capacity.

As always, I'm interested in your feedback. Please e-mail me at kd@cmwf.org.