Performance Improvement in Health Care — Seizing the Moment

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We have an unprecedented opportunity to create a high-performance health system in the United States. Recent statutes, including the Affordable Care Act, the American Recovery and Reinvestment Act, and the Health Information Technology for Economic and Clinical Health Act, provide the federal government with important powers for catalyzing improvement in service delivery. These new powers touch all the critical levers for advancing health system performance: payment policy, organization and infrastructure, public health, and essential information for health care decision making. The national performance-improvement toolbox is now well stocked.

But using that toolbox effectively is enormously challenging. Federal budget deficits and rising health care expenditures create pressures to quickly adopt simple expedients, such as cuts in benefits and provider payments. At the same time, the very number and diversity of available forms of authority, each with its own legal quirks and restrictions, creates huge conceptual and logistic complexity.

So how can the federal government seize this moment to improve health system performance? Without close coordination driven by an overriding vision, the dutiful, line-by-line implementation of each individual program will not create the breakthroughs in performance that are needed to make our health system sustainable. The Commonwealth Fund Commission on a High Performance Health System, which I chair, believes that the government needs a comprehensive, disciplined implementation plan for health system improvement that takes full, thoughtful advantage of its new opportunities.¹

First, the commission believes, government leadership for performance improvement requires clear goals, beginning with concrete cost-containment and quality-improvement targets. The federal government should aim to reduce the rate of increase in national health expenditures per capita to the annual projected growth of the gross domestic product (GDP) per capita plus 0.5 percentage points by 2016 and to maintain that rate through 2021. Achieving this target would reduce national health care expenditures by $893 billion over 10 years and hold health care spending as a share of the GDP in 2021 to 18.9%, as compared with the current projection of 20.1%. The target for health care quality should be to double the annual rate of improvement on the quality metrics tracked by the Agency for Healthcare Research and Quality, from the current 2.3% to 4.6% by 2016.

The guiding vision should also be based on the understanding that performance improvement requires that clinicians and patients be enabled to make better health care decisions by giving them the best available information when and where they need it and making it easy to do the right thing. Clinicians and patients need information about patients’ personal health and health care and about medical evidence relevant to their decisions. Clinicians need environmental supports and financial incentives to choose diagnostic and therapeutic pathways that maximize the value of care. Organizational arrangements must support collaboration, teamwork, and coordination of care.

The federal government can and should facilitate the creation of these conditions, and it should certainly avoid actions that undermine them. But the actual work will fall overwhelmingly to millions of people and institutions in the private and public sectors working together in local communities; they will need to set clear priorities, preferably through a collaborative process that involves states and private-sector...
entities. For both humane and pragmatic reasons, the federal government should start by focusing its robust new forms of authority on improving care for high-cost patients with multiple chronic conditions. Patients with one or more chronic conditions use 96% of home health visits, 93% of prescriptions, and nearly 80% of physician visits and hospital stays — and these sickest patients account for a disproportionate share of U.S. health care expenditures (see graph). Any successful cost-containment effort will have to address their resource utilization. Furthermore, such patients are disproportionately affected by the quality and safety deficits in our health care system and stand to benefit greatly from performance improvements.

The challenge is to find a way to empower providers and patients to rapidly improve the care they offer and receive. Though there is no battle-tested plan for doing so, a logical approach would emphasize three tools and one overall policy strategy.

The tools are improved primary care, payment reform, and better information. Nothing is more important for improving performance in caring for patients with complex conditions than coordinating care and enhancing access during normal office hours, nights, and weekends — precisely the role that good primary care plays in high-performing health systems. Payment reform is essential to enabling providers, and perhaps patients, to participate in the savings that result from reductions in costs and improvements in quality. One stakeholder’s cost is another’s revenue or desired service; to support the reduction of unnecessary or marginally useful services, financial incentives must reward rather than punish such behavior, since it affects all payers, providers, and patients, not just Medicare. And care coordination and cost management depend on having accurate, timely, and actionable information in real time at the point of decision making. The availability and effective use of health information technology are therefore essential to improving health system performance for high-cost patients.

So, what policies are needed to get these tools installed and functioning effectively? Since health care systems are local phenomena, their reform must occur locally. The Commission on a High Performance Health System proposes that the federal government work with other stakeholders to launch a nationwide, community-based initiative as soon as possible to improve the care of high-cost patients with multiple chronic conditions. This program should recruit 50 to 100 geographic areas or health improvement communities (HICs), encompassing a substantial segment of the U.S. population (approaching 60%). The definition of “community” will vary — from a city to a county, a hospital-referral region, a neighborhood, or a state — but to be eligible, a community should have a substantial concentration of high-cost patients.

In return for financial and technical support and regulatory accommodations, such as necessary Medicare and Medicaid waivers, participating communities should involve all or most local payers and providers in community-based accountable care arrangements. Recent research suggests that this type of program could save $184 billion, or about 21% of the $893 billion savings target for national health care expenditures.

Supporting a community-based initiative for high-cost patients would fit within the mandate of the new Center for Medicare and Medicaid Innovation, which has broad authority and $10 billion to undertake new programs to contain Medicare and Medicaid costs while protecting the quality of care. The federal government should also use a range of additional programs and resources to help fundamentally redesign payment, primary care, and information use in participating HICs. HICs should be encouraged to develop innovative gain-sharing payment arrangements that are consistent across public and private payers. Payment redesign should materially improve the revenue, flexibility, and resources available to medical homes in ways that promote and reward the coordination of care by primary care providers for high-cost patients. HICs should be strongly encouraged to have comprehensive health information technology plans for

**Distribution of Health Care Expenditures for the U.S. Population, According to Magnitude of Expenditure, 2009.**

The sickest 10% of patients account for 65% of the health care expenses. Dollar amounts are annual mean expenditures per patient. Data from the 2009 Medical Expenditure Panel Survey, adapted from the Commonwealth Fund.
their communities. In all this work, the Center for Medicare and Medicaid Innovation should provide as much flexibility as possible to HICs, respond rapidly to their needs for federal data, and minimize any regulatory and reporting burdens not vital to ensuring cost containment and quality improvement.

For decades, the United States has seemed powerless to curb excessive health care spending and improve the quality of care. Now, the tools for achieving fundamental reform are in place, but using them requires the federal government and its private and public partners to leave business as usual behind and to create and implement a plan that addresses the root causes of our health care crisis. Our commission believes that the establishment of HICs to transform the care of patients with multiple chronic conditions could provide such a plan. Other approaches may be equally sound. But above all else, we must act.

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##### Sharing the Care to Improve Access to Primary Care

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Gaining prompt access to primary care is a growing concern for all American adults. In Massachusetts, average wait times for new patients to obtain an internal-medicine appointment rose by 82% in the 2 years after health insurance coverage was expanded; current wait times average 36 days for family medicine and 48 days for internal medicine.1 In a 2011 national survey, 57% of patients who were sick and needed medical attention could not obtain access to care promptly, up from 53% in 2006.2

The reason for the access problem is an imbalance between demand for care and capacity to provide care. Demand is growing as the population expands, ages, and faces obesity and diabetes epidemics. Capacity is shrinking as the ratio of adult primary care clinicians (family physicians, general internists, nurse practitioners, and physician assistants) to population drops; this ratio is expected to fall by 9% between 2005 and 2020.3 Even with a dramatic increase in the proportion of U.S. medical students choosing primary care careers, it would take decades to reverse this trend.

The access problem creates a serious dilemma. On the one hand, the deepening shortage of adult primary care clinicians means that panel size — the number of patients cared for by each clinician — will increase. On the other hand, average panel size is already too large, and its further growth will worsen access, compromise quality, and aggravate burnout among primary care clinicians. Clinicians with panel sizes of 2500 patients (the national average is about 2300) would have to spend 18 hours per day to provide excellent chronic and preventive care4 and would require even more hours for acute care and care coordination. Adult primary care as currently organized is not a sustainable enterprise.

The problem becomes clear when we define the relationship between demand and capacity.5 Capacity equals the number of clinician visits per day times the number of working days per year. Demand equals the panel size times the average number of visits per patient per year. If a clinician sees 20 patients per day and works 210 days per year, capacity is 4200 visits per year. If the panel size is 2000 and the average patient sees the clinician 3 times a year, demand is 6000 visits per year — and there’s an intolerable mismatch between capacity and demand. To balance capacity and demand, panel size would need to be reduced to 1400, which would bring demand down to 4200. Panel size also needs to be risk-adjusted, because older and sicker patients require more visits per year; for a geriatric panel requiring an average of 6 visits per year, a reasonable panel size would be 700.

How can primary care respond