



THE
COMMONWEALTH
FUND

Producing Evidence for Better Decision-Making

**Stuart Guterman
Senior Program Director
Program on Medicare's Future
The Commonwealth Fund**

**Medical Technology Leadership Forum
Washington, DC
February 15, 2007**

Overview

- **We need to do things better**
- **What do we need to do differently?**
- **What do we need to know?**
- **How do we get the information we need?**
- **How do we make sure that information is used appropriately?**

We Need to Do Things Better



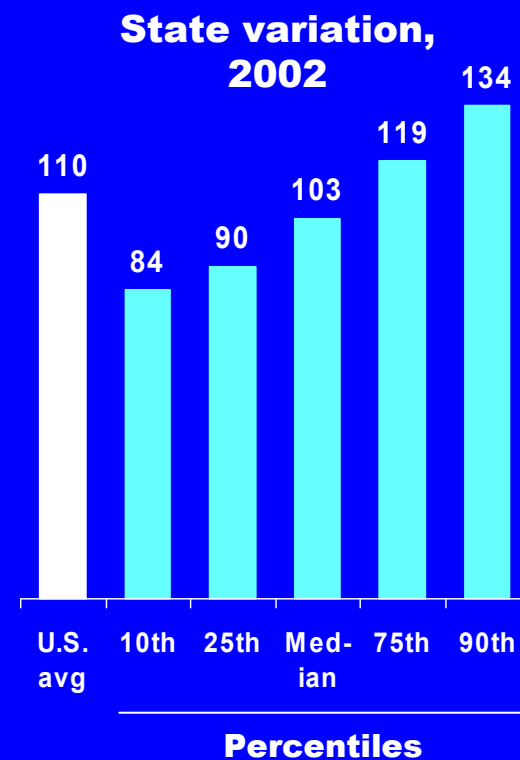
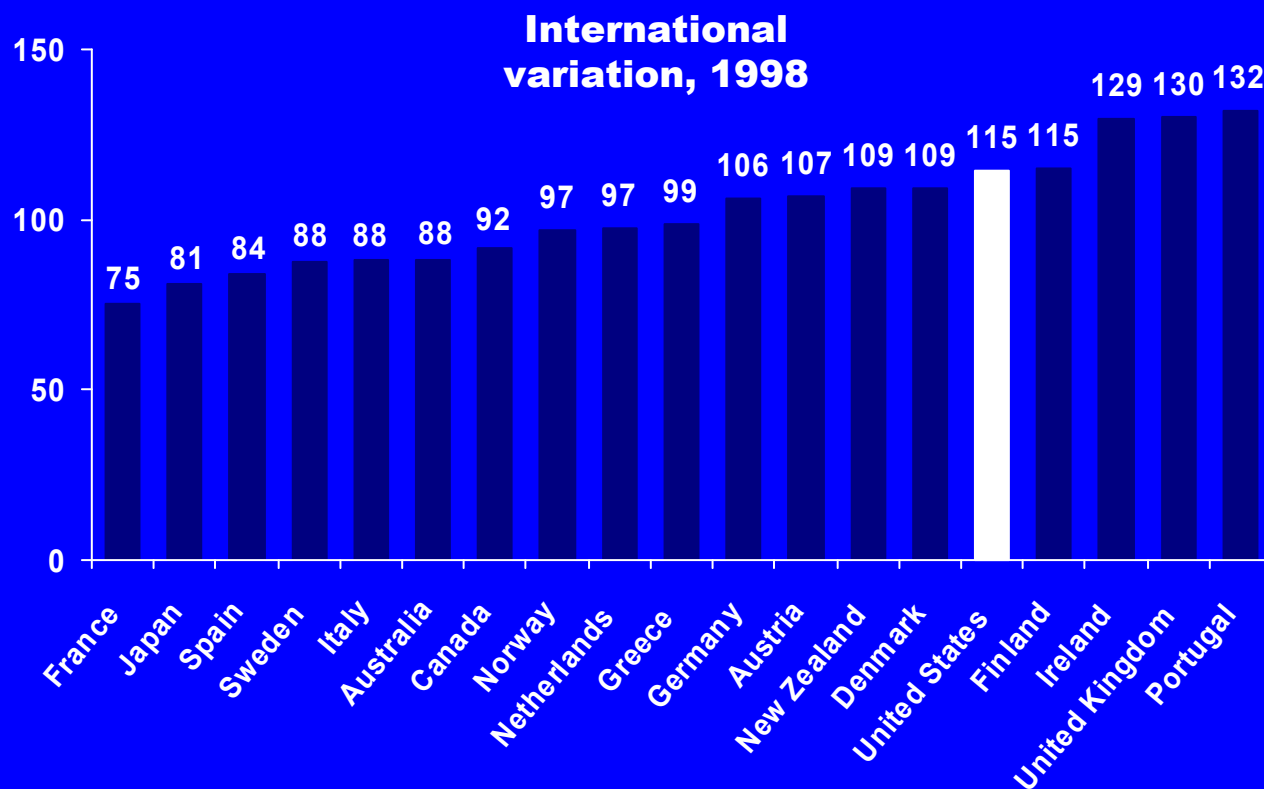
Scores: Dimensions of a High Performance Health System



Mortality Amenable to Health Care

Mortality from causes considered amenable to health care is deaths before age 75 that are potentially preventable with timely and appropriate medical care

Deaths per 100,000 population*

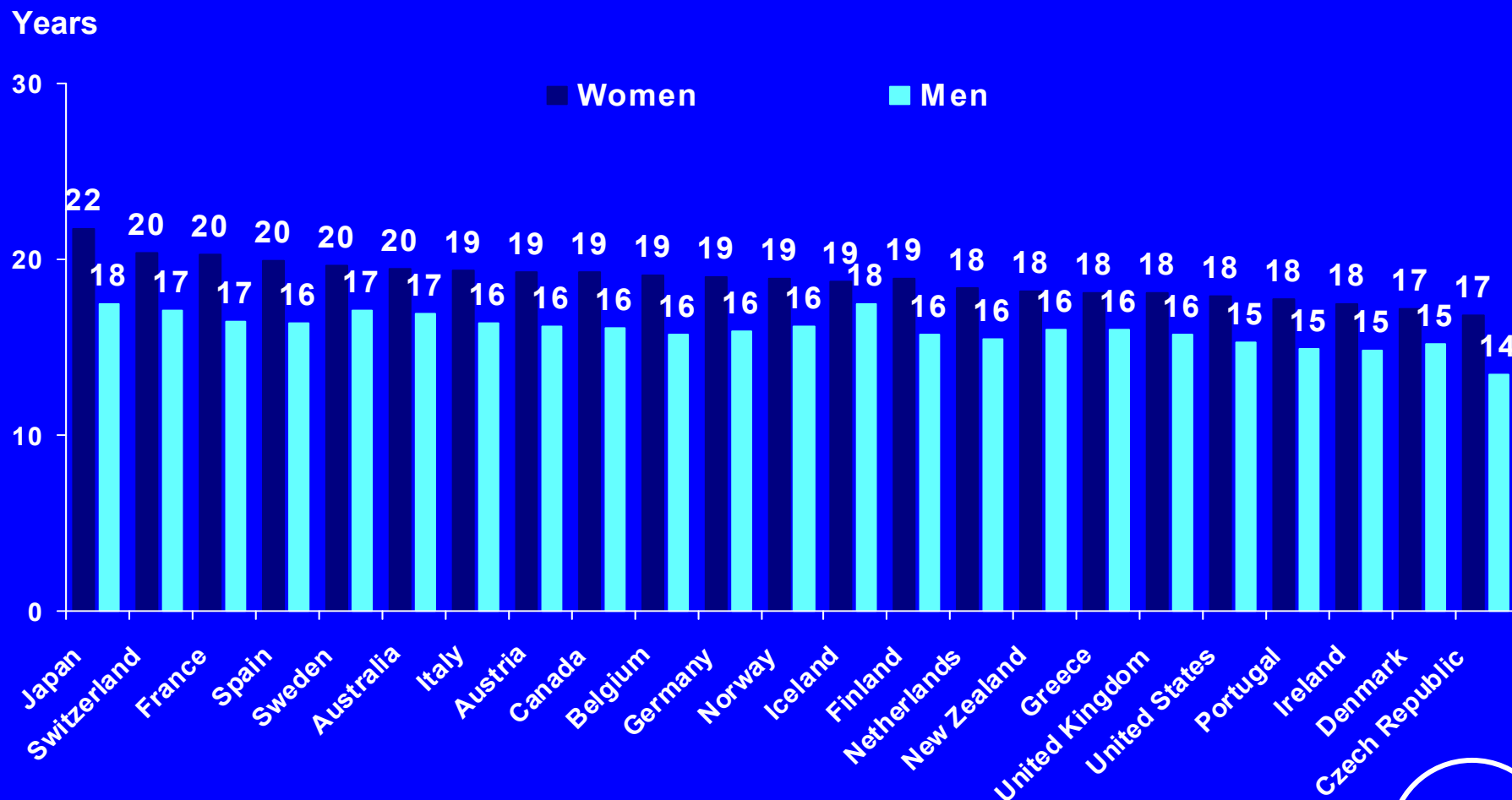


* Countries' age-standardized death rates, ages 0–74; includes ischemic heart disease. See Technical Appendix for list of conditions considered amenable to health care in the analysis. Data: International estimates—World Health Organization, WHO mortality database (Nolte and McKee 2003); State estimates—K. Hempstead, Rutgers University using Nolte and McKee methodology.



Healthy Life Expectancy at Age 60, 2002

Developed by the World Health Organization, healthy life expectancy is based on life expectancy adjusted for time spent in poor health due to disease and/or injury

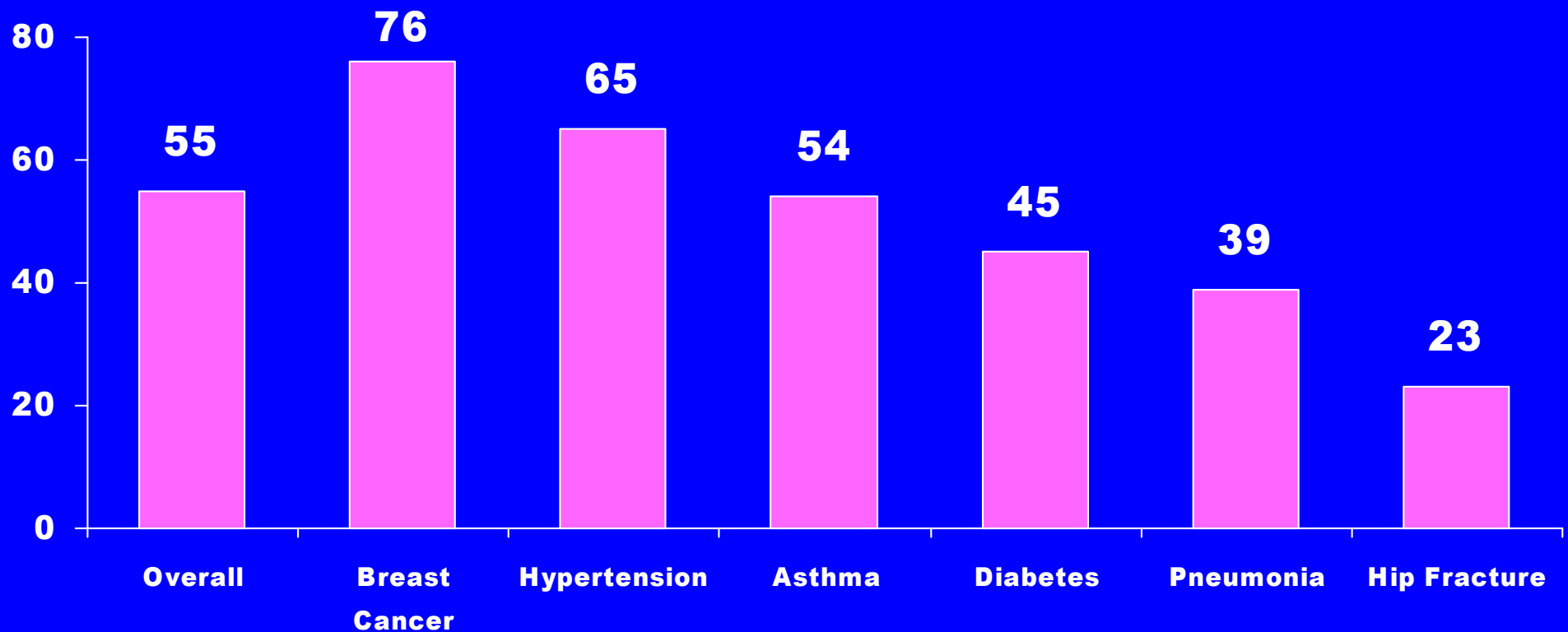


Data: The World Health Report 2003 (WHO 2003, Annex Table 4).



U.S. Adults Receive Only About Half of Recommended Care, and Quality Varies Significantly by Medical Condition

Percent of recommended care received

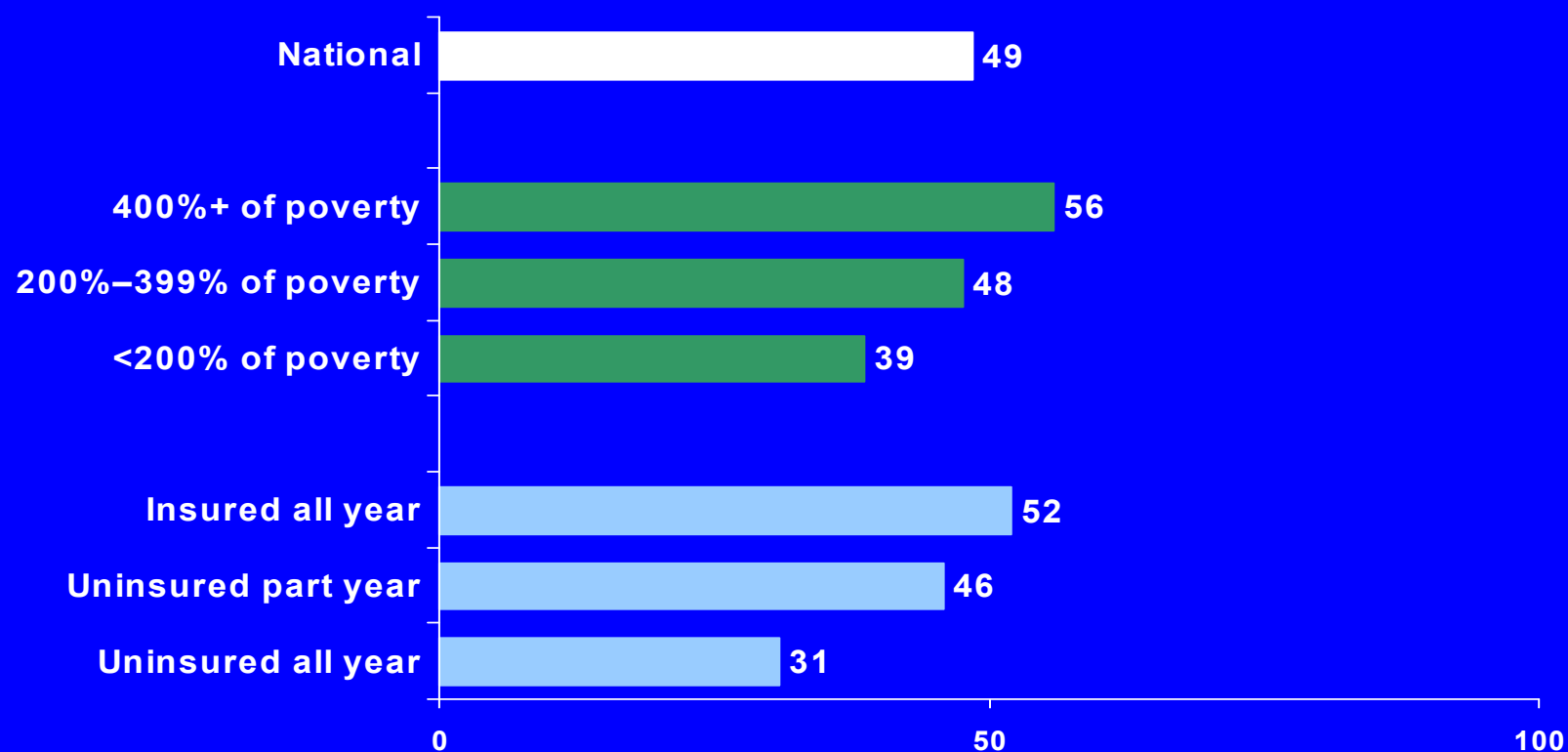


Source: McGlynn et al., "The Quality of Health Care Delivered to Adults in the United States," *The New England Journal of Medicine* (June 26, 2003): 2635–2645.



Receipt of Recommended Screening and Preventive Care for Adults, by Family Income and Insurance Status, 2002

Percent of adults (ages 18+) who received all recommended screening and preventive care within a specific time frame given their age and sex*



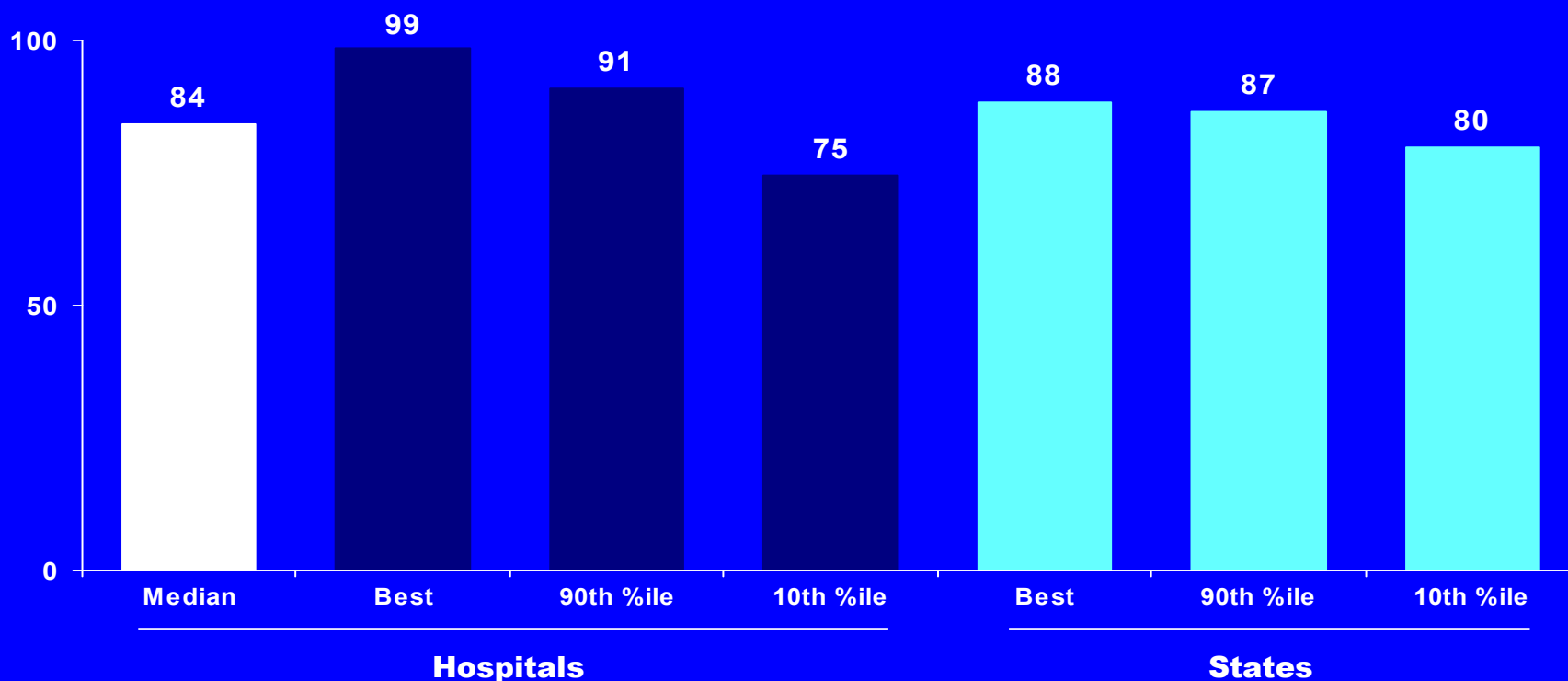
* Recommended care includes seven key screening and preventive services: blood pressure, cholesterol, Pap, mammogram, fecal occult blood test or sigmoidoscopy/colonoscopy, and flu shot. Data: B. Mahato, Columbia University analysis of 2002 Medical Expenditure Panel Survey.



Composite: Hospital Quality of Care for Heart Attack, Heart Failure, and Pneumonia, by Hospitals and States, 2004

This is a composite of ten clinical indicators of the quality of care for acute myocardial infarction (heart attack), congestive heart failure, and pneumonia*

Percent of patients who received recommended care for all three conditions



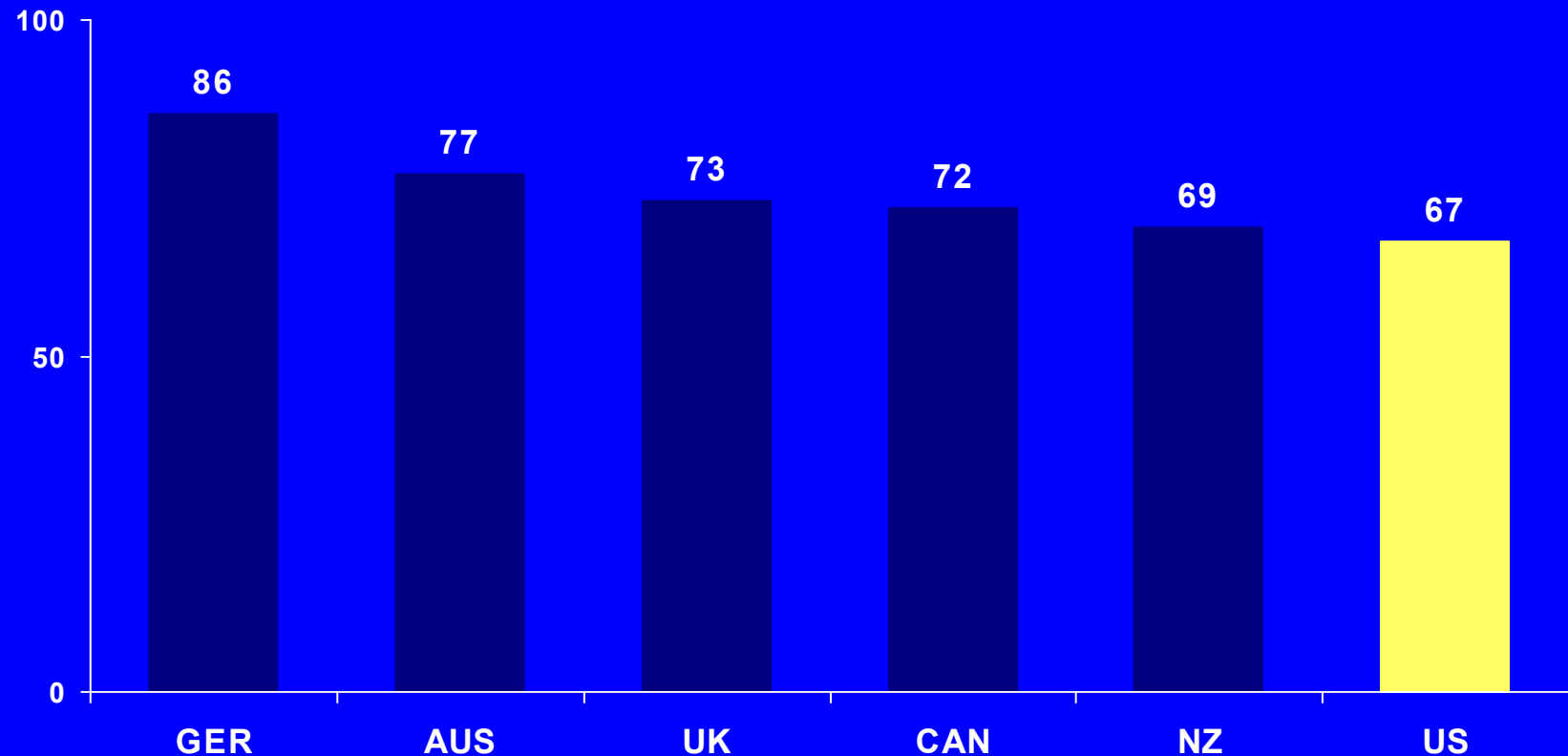
* See following chart for description of ten clinical indicators.

Data: A. Jha and A. Epstein, Harvard University analysis of data from Hospital Quality Alliance national reporting system and CMS Hospital Compare.



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

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

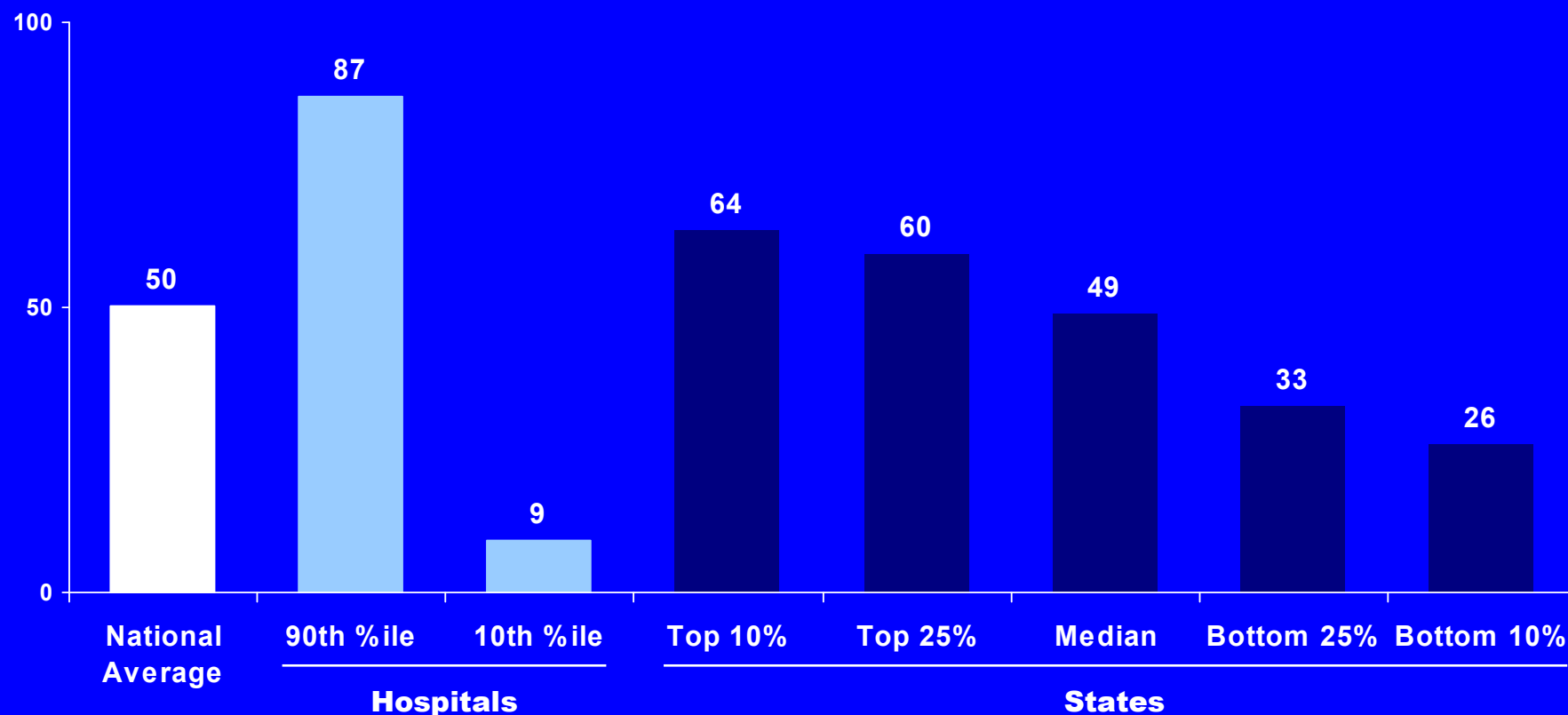


GER=Germany; AUS=Australia; UK=United Kingdom; CAN=Canada; NZ=New Zealand; US=United States.
Data: 2005 Commonwealth Fund International Health Policy Survey of Sicker Adults (Schoen et al. 2005a).



Heart Failure Patients Given Written Instructions or Educational Materials When Discharged, by Hospitals and States, 2004

Percent of heart failure patients discharged home with written instructions or educational material*



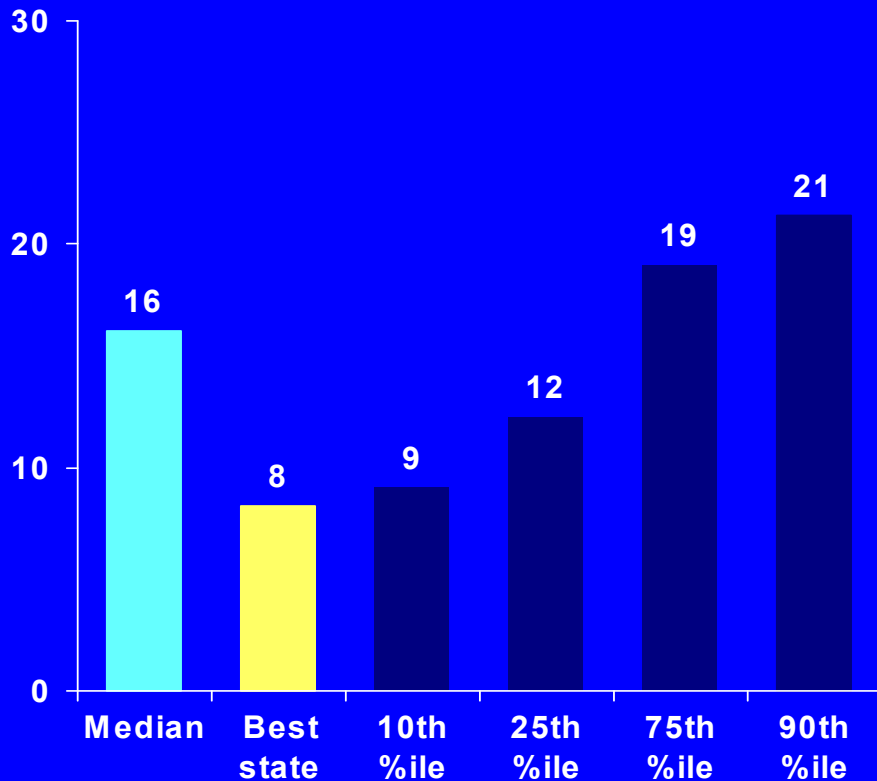
* Discharge instructions must address all of the following: activity level, diet, discharge medications, follow-up appointment, weight monitoring, and what to do if symptoms worsen.

Data: National and hospital estimates—A. Jha and A. Epstein, Harvard University analysis of data from Hospital Quality Alliance national reporting system; State estimates—Retrieved from Hospital Compare database at <http://www.hospitalcompare.hhs.gov>

Nursing Homes: Hospital Admission and Readmission Rates Among Nursing Home Residents, per State, 2000

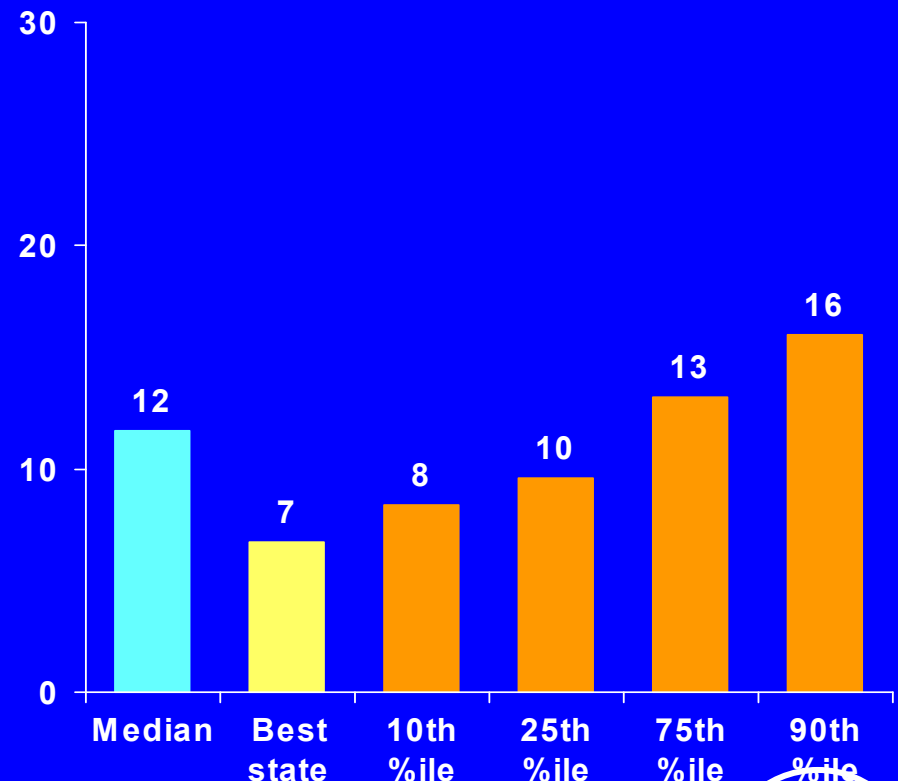
Hospitalization rates

Percent



Re-hospitalization rate (within 3 months of nursing home admission)

Percent

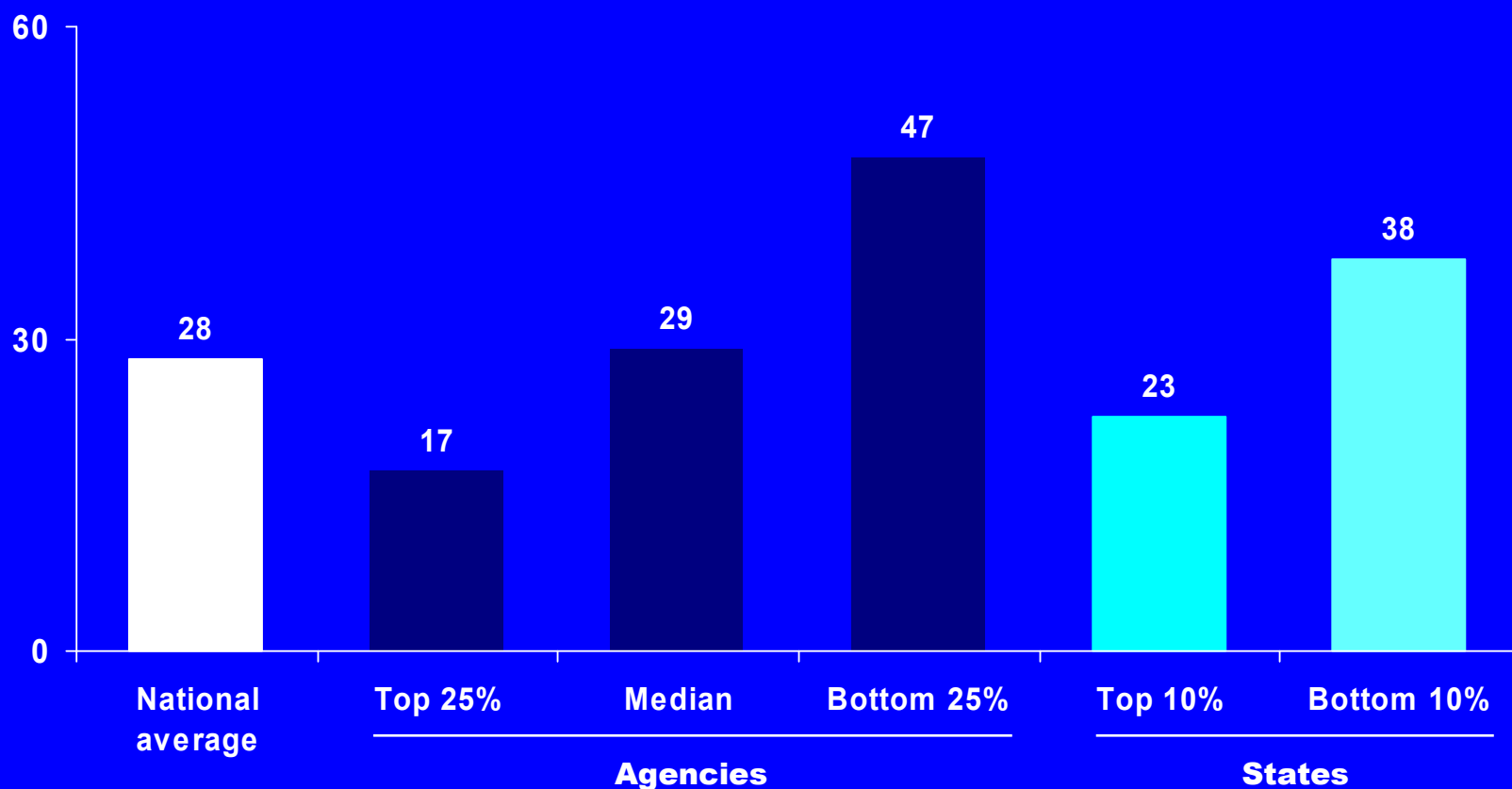


Data: V. Mor, Brown University analysis of Medicare enrollment data and Part A claims data for all Medicare beneficiaries who entered a nursing home and had a Minimum Data Set assessment during 2000.



Home Health Care: Hospital Admissions, by Agencies and States, 2003–2004

Percent of home health episodes that ended with an acute care hospitalization

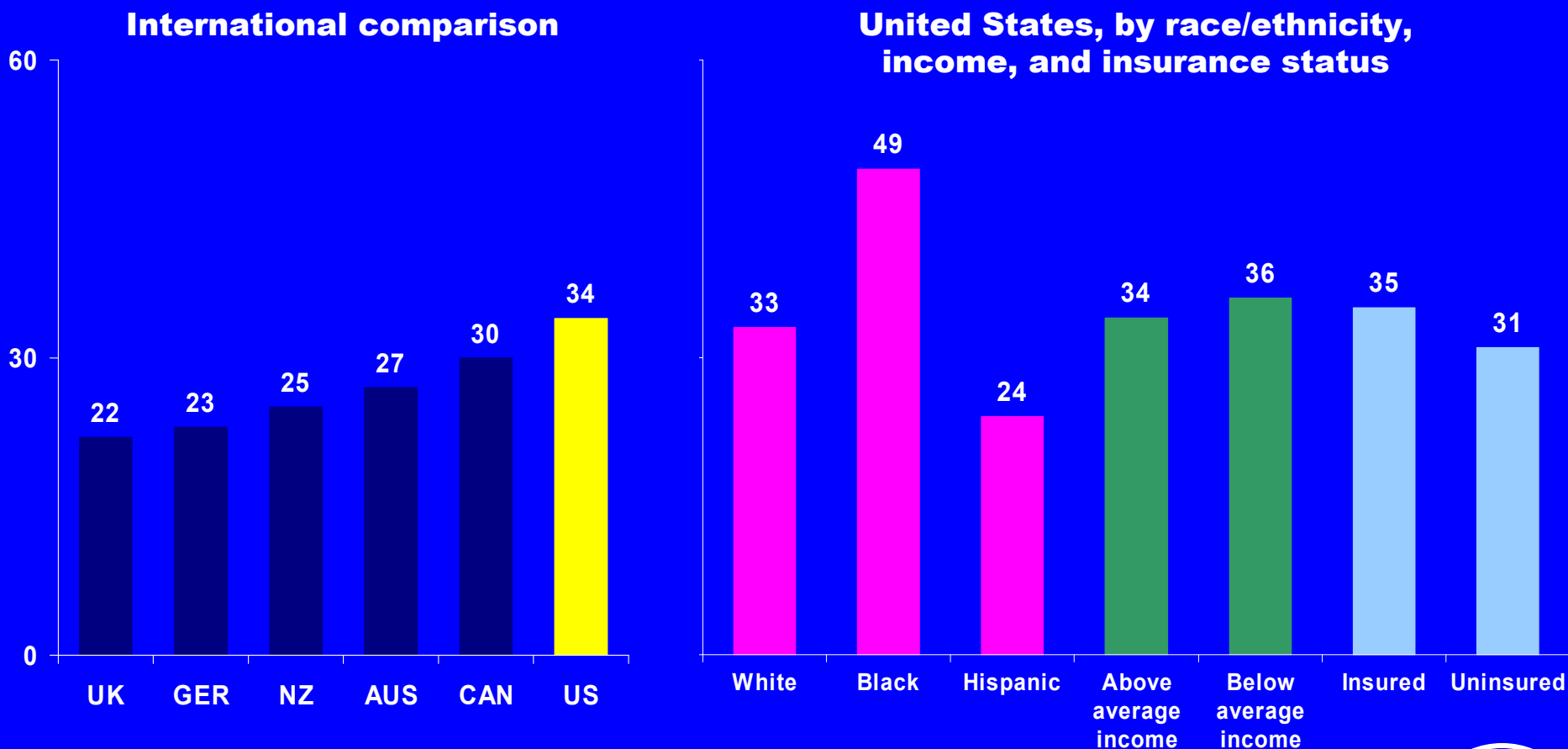


Data: Outcome and Assessment Information Set (Pace et al. 2005).



Medical, Medication, and Lab Errors Among Sicker Adults, 2005

Percent reporting medical mistake, medication error, or lab error in past two years



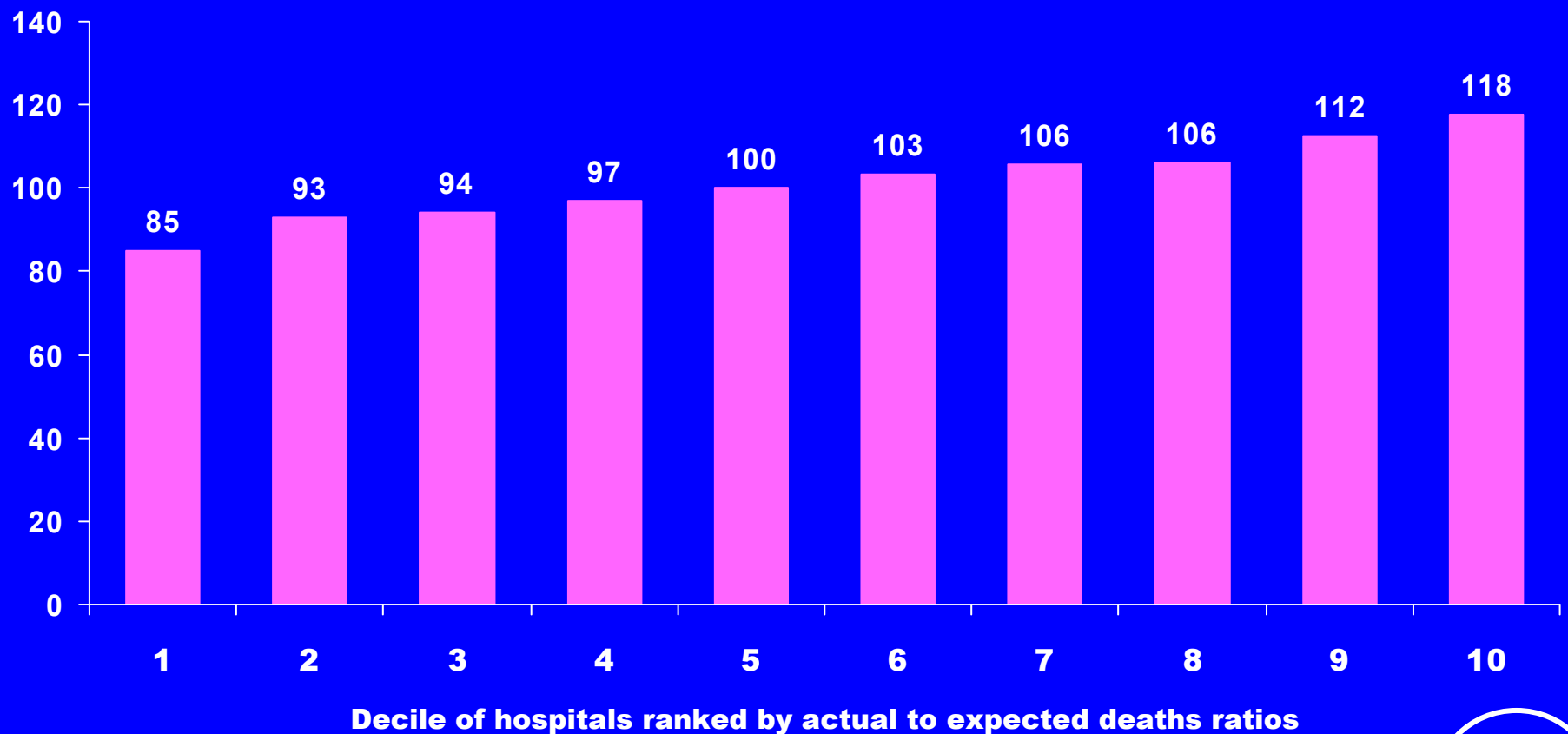
UK=United Kingdom; GER=Germany; NZ=New Zealand; AUS=Australia; CAN=Canada; US=United States.
Data: Analysis of 2005 Commonwealth Fund International Health Policy Survey of Sicker Adults; Schoen et al. 2005a.



Hospital-Standardized Mortality Ratios, 2000–2002

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

Ratio of actual to expected deaths in each decile (x 100)



See Technical Appendix for methodology.

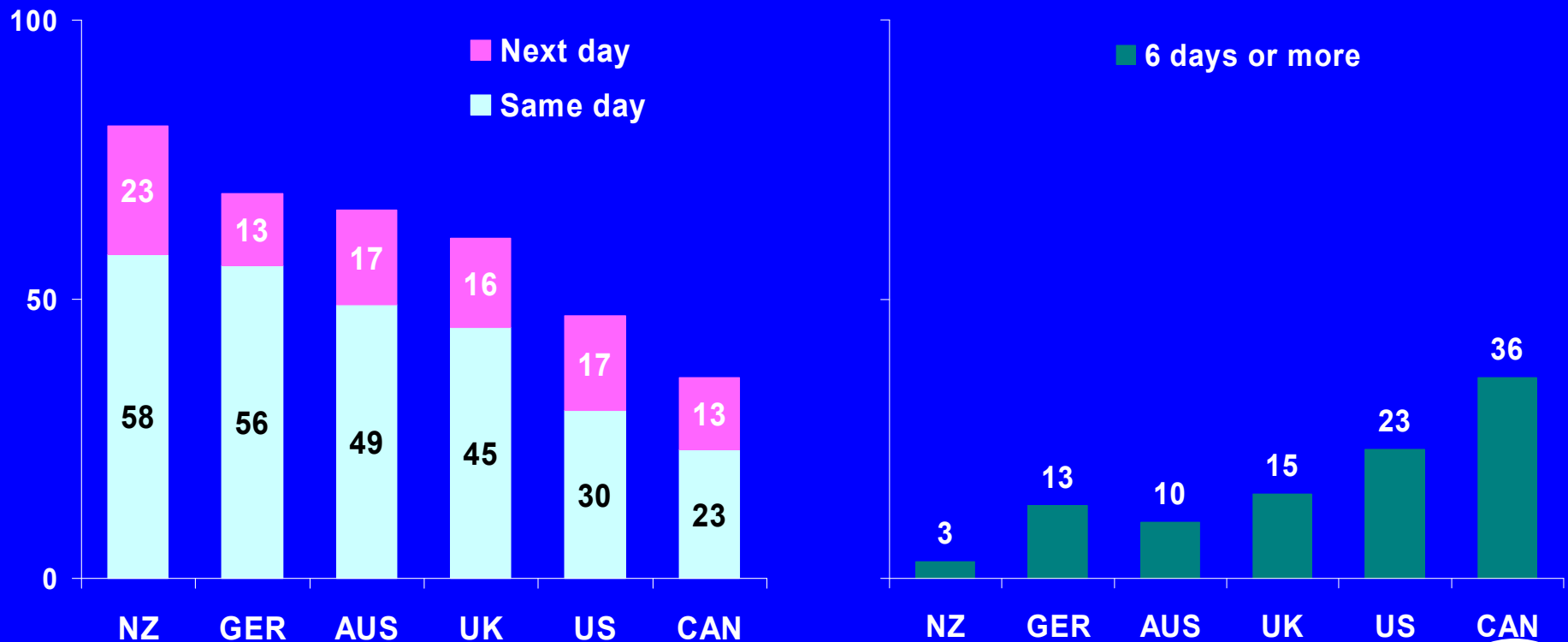
Data: B. Jarman analysis of Medicare discharges from 2000 to 2002 for conditions leading to 80 percent of all hospital deaths



Waiting Time to See Doctor When Sick or Need Medical Attention, Sicker Adults in Six Countries, 2005

Last time you were sick or needed medical attention, how quickly could you get an appointment to see a doctor?

Percent of adults

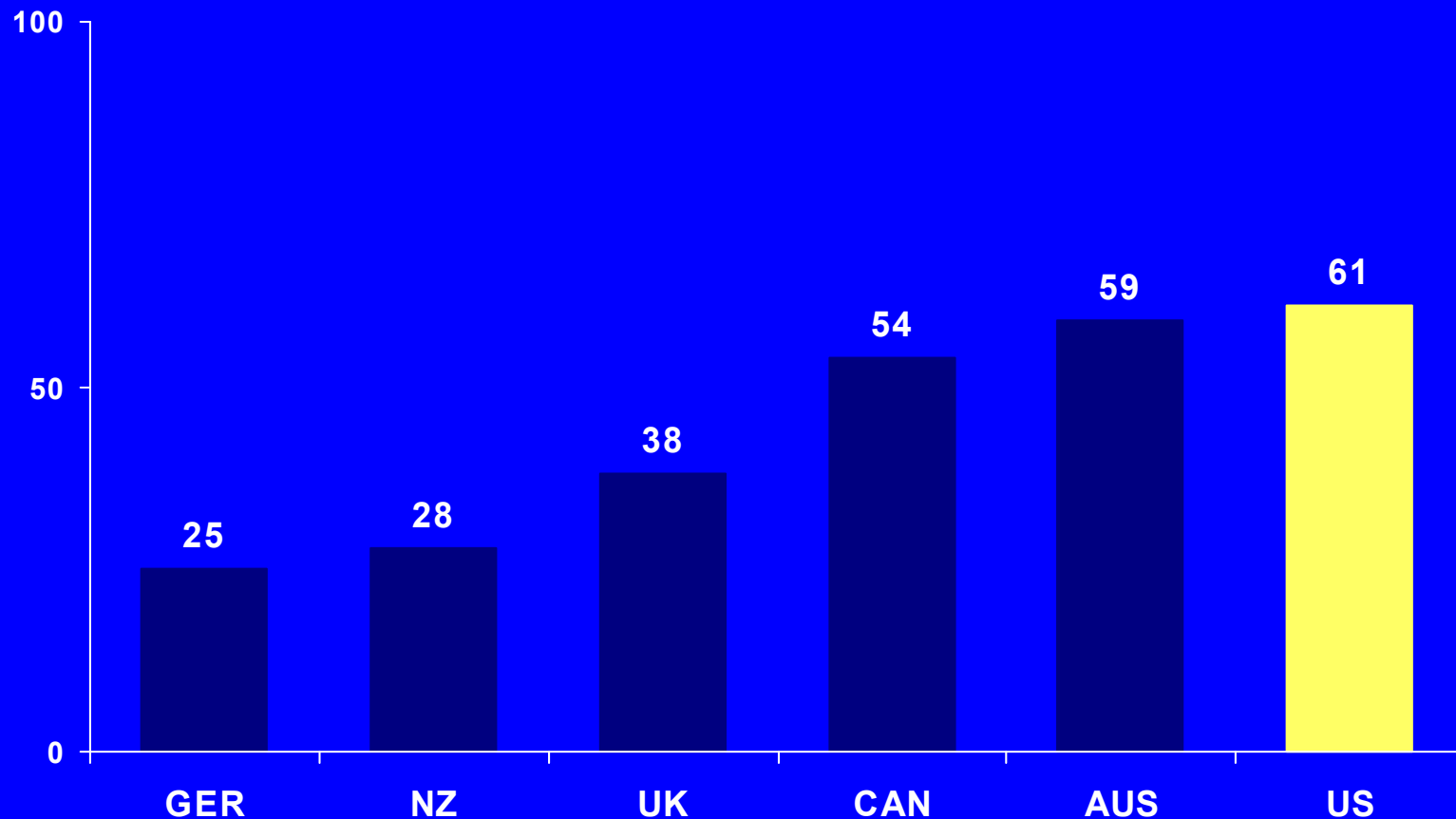


NZ=New Zealand; GER=Germany; AUS=Australia; UK=United Kingdom; US=United States; CAN=Canada.
 Data: 2005 Commonwealth Fund International Health Policy Survey of Sicker Adults (Schoen et al. 2005a).



Difficulty Getting Care on Nights, Weekends, Holidays Without Going to the ER, Among Sicker Adults in Six Countries, 2005

Percent of adults who sought care reporting “very” or “somewhat” difficult

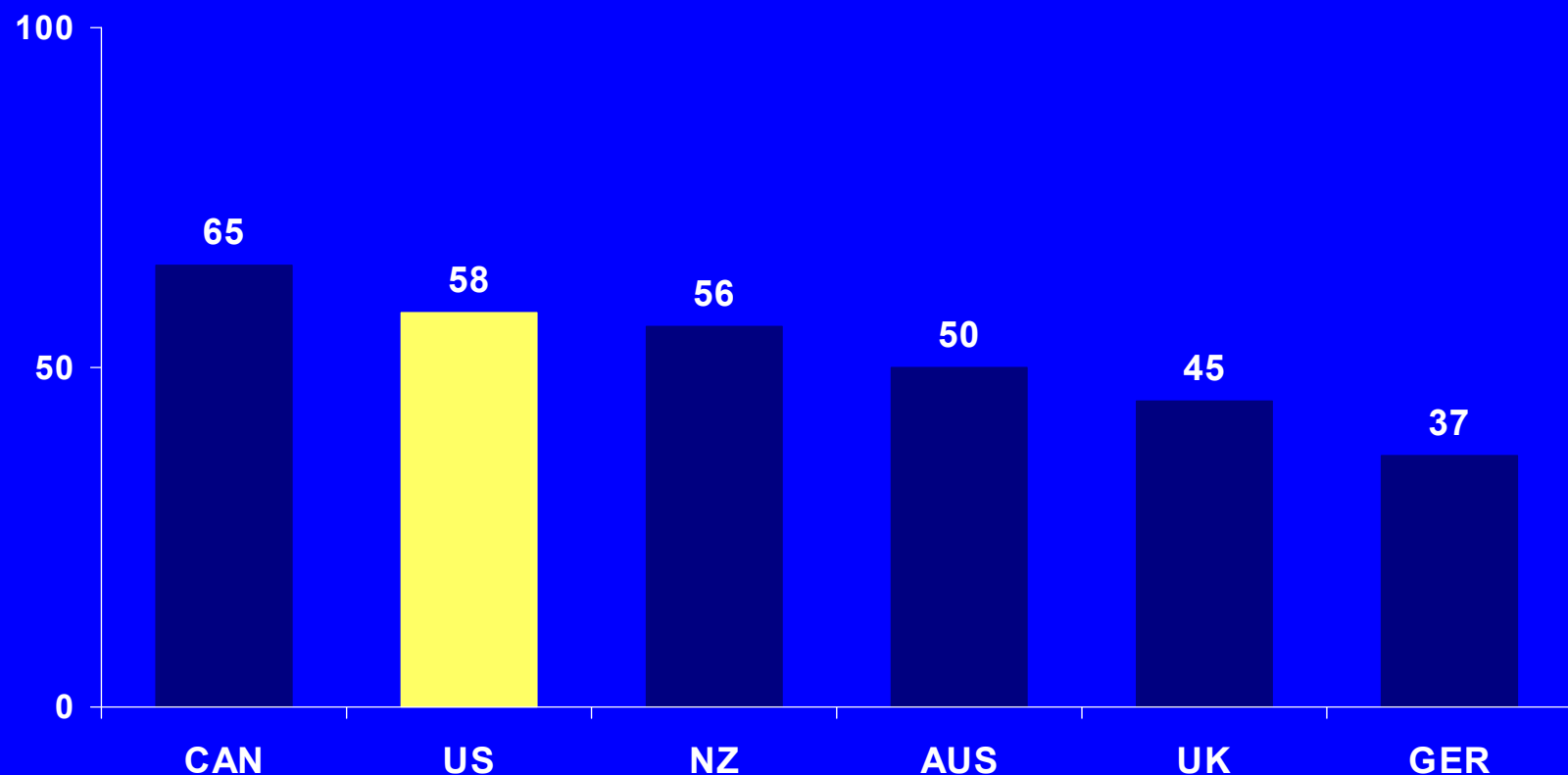


GER=Germany; NZ=New Zealand; UK=United Kingdom; CAN=Canada; AUS=Australia; US=United States.
Data: 2005 Commonwealth Fund International Health Policy Survey of Sicker Adults (Schoen et al. 2005a).



Adults with Chronic Conditions: Receipt of Self-Management Plan in Six Countries, 2005

Percent of adults with chronic conditions* whose doctor gave plan to manage care at home



* Adult reported at least one of six conditions: hypertension, heart disease, diabetes, arthritis, lung problems (asthma, emphysema, etc.), or depression.

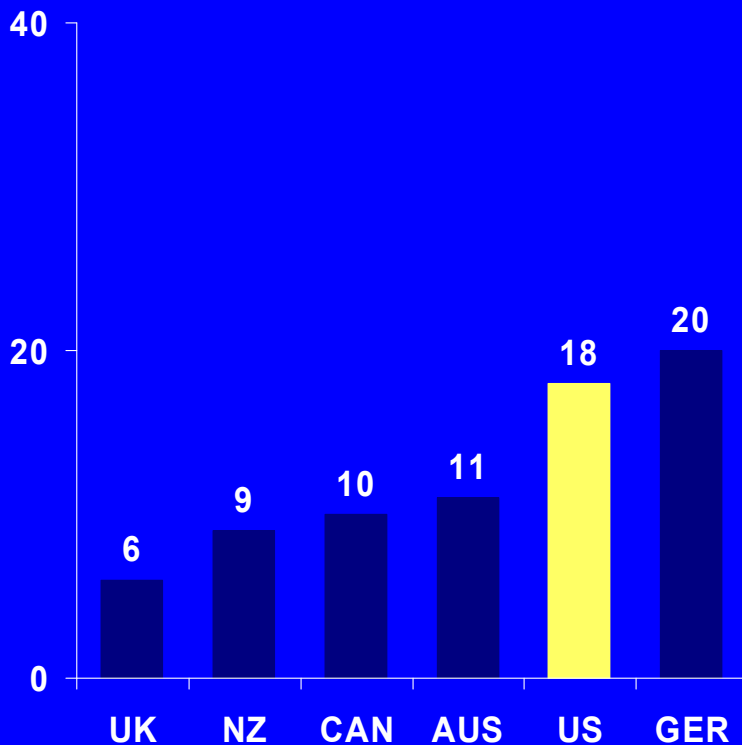
CAN=Canada; US=United States; NZ=New Zealand; AUS=Australia; UK=United Kingdom; GER=Germany.
Data: 2005 Commonwealth Fund International Health Policy Survey of Sicker Adults (Schoen et al. 2005a).



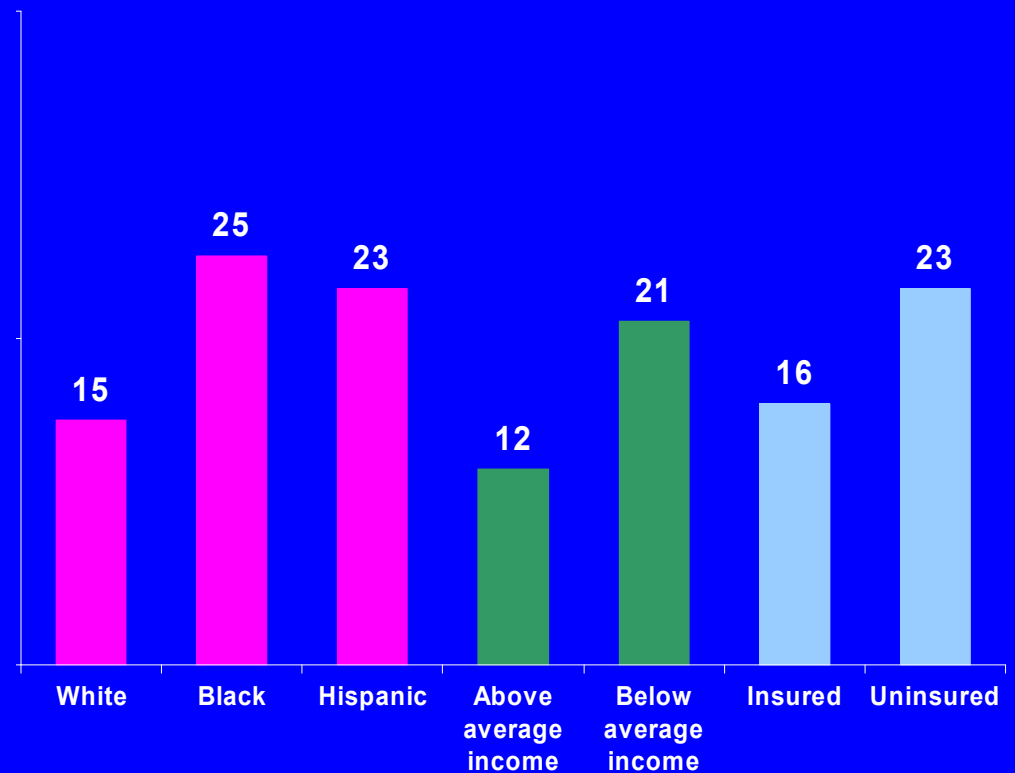
Duplicate Medical Tests, Among Sicker Adults, 2005

Percent reporting that doctor ordered test that had already been done in past two years

International comparison



United States, by race/ethnicity, income, and insurance status

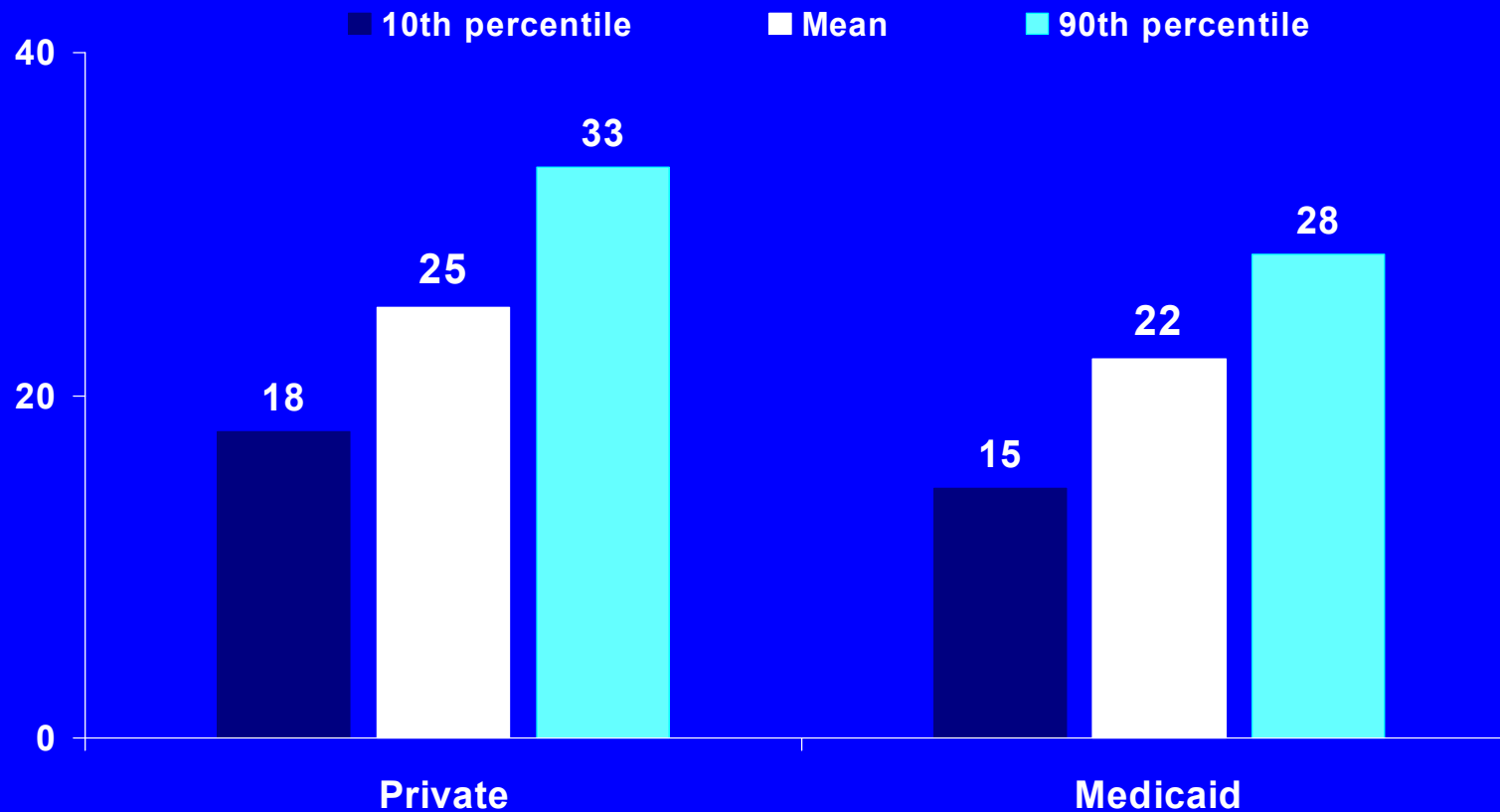


UK=United Kingdom; NZ=New Zealand; CAN=Canada; AUS=Australia; US=United States; GER=Germany.
 Data: Analysis of 2005 Commonwealth Fund International Health Policy Survey of Sicker Adults; Schoen et al. 2005a.



Managed Care Health Plans: Potentially Inappropriate Imaging Studies for Low Back Pain, by Plan Type, 2004

Percent of health plan members (ages 18–50) who received an imaging study within 28 days following an episode of acute low back pain with no risk factors

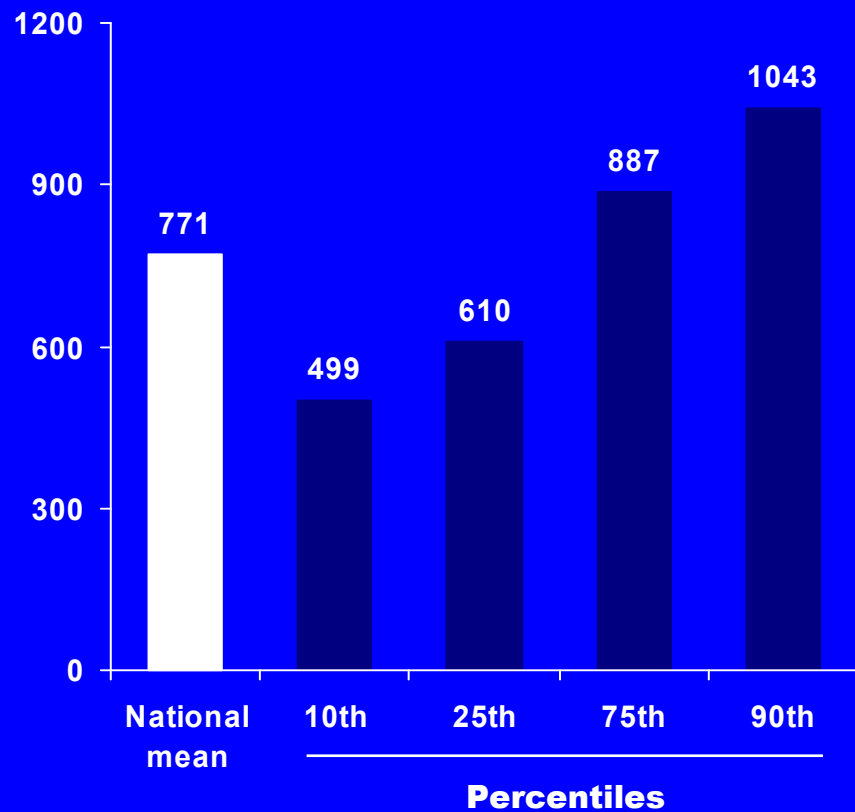


Data: Health Plan Employer Data and Information Set (NCQA 2005a, 2005b).

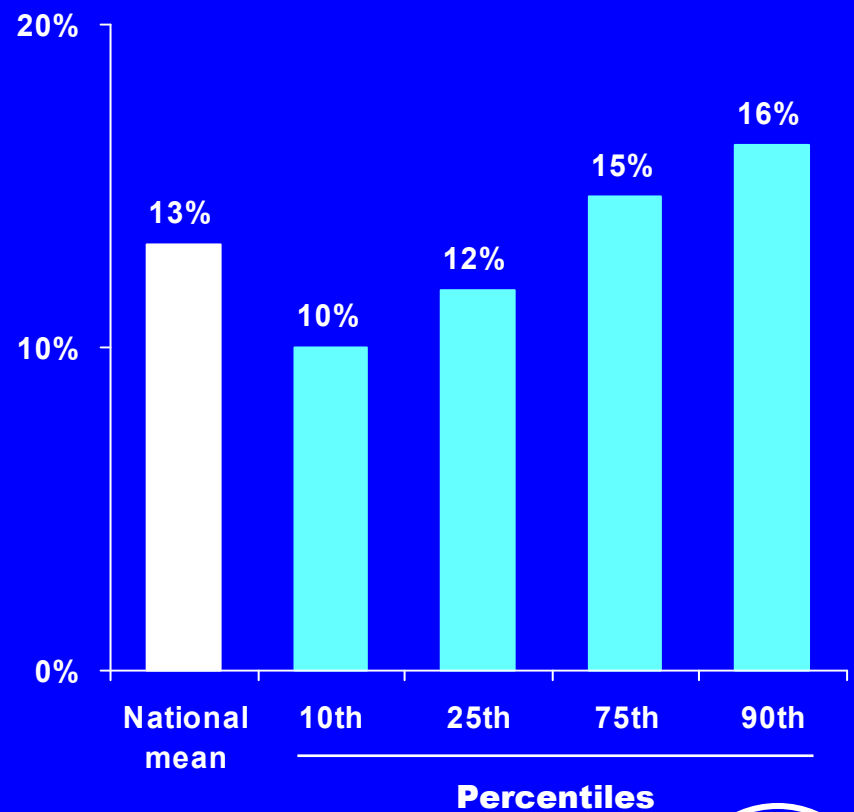


Medicare Discharges for Ambulatory Care Sensitive Conditions, Rates and Associated Costs, by Hospital Referral Regions, 2003

Rate of ACS discharges per 10,000 beneficiaries



Costs of ACS discharges as percent of all discharge costs, average in region groups

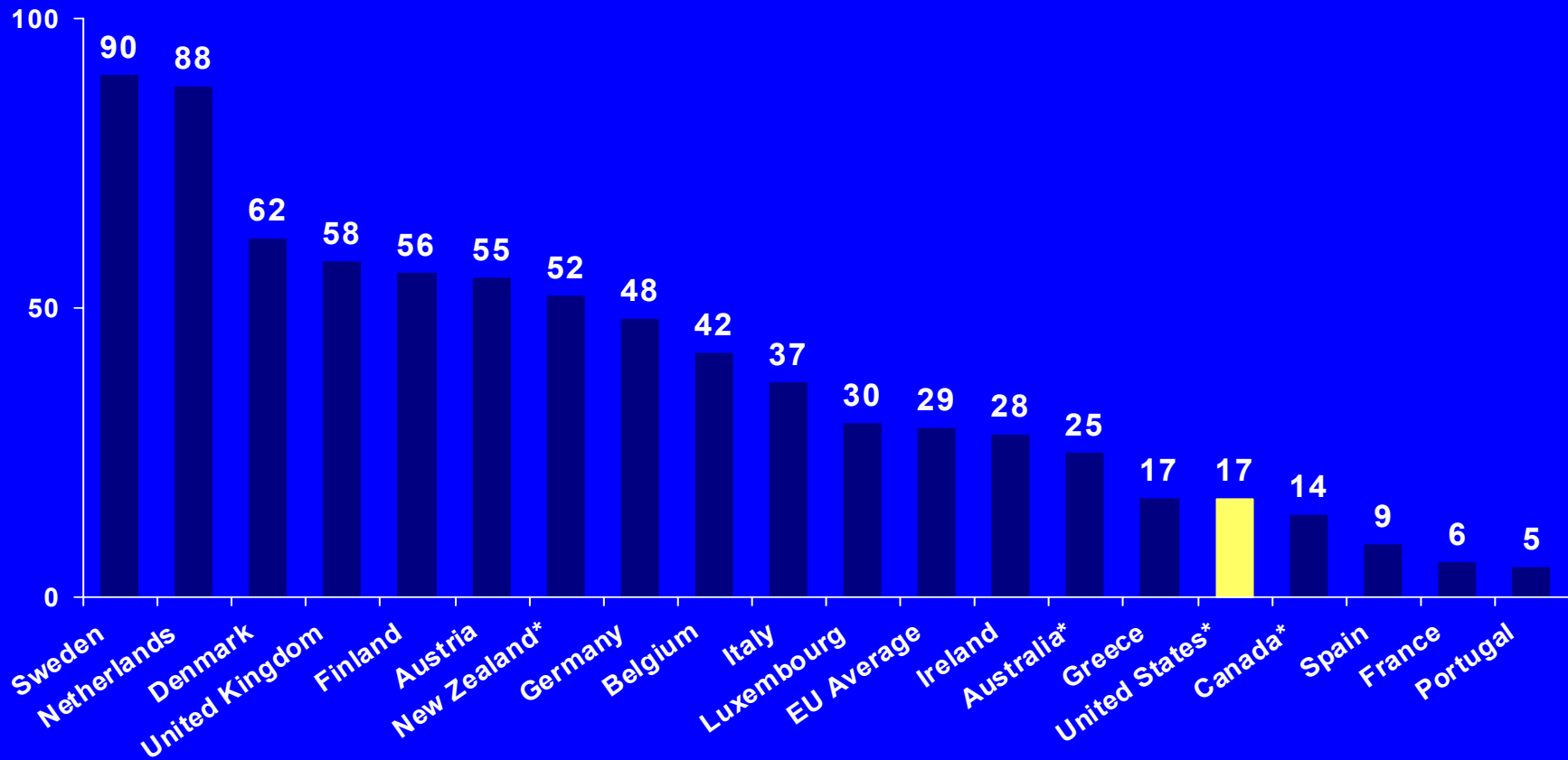


Data: G. Anderson and R. Herbert, Johns Hopkins University analysis of 2003 Medicare Standard Analytical Files (SAF) 5% Inpatient Data.



Physicians' Use of Electronic Medical Records, U.S. Compared with Other Countries, 2001

Percent of physicians

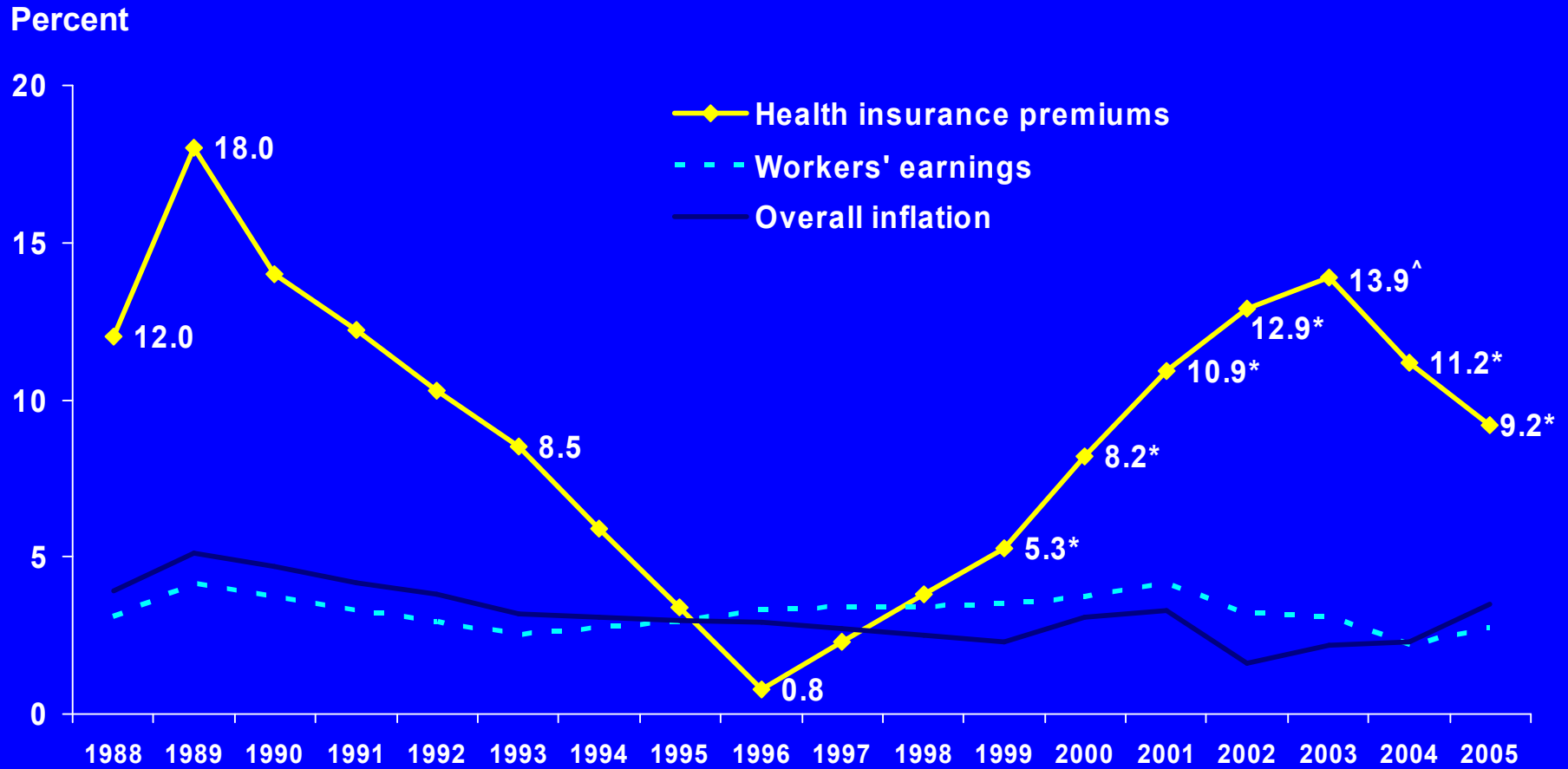


* 2000

Data: 2001 European Union EuroBarometer and 2000 Commonwealth Fund International Health Policy Survey of Physicians (Harris Interactive 2002).



Increases in Health Insurance Premiums Compared with Other Indicators, 1988–2005



* Estimate is statistically different from the previous year shown at $p < 0.05$.

^ Estimate is statistically different from the previous year shown at $p < 0.1$.

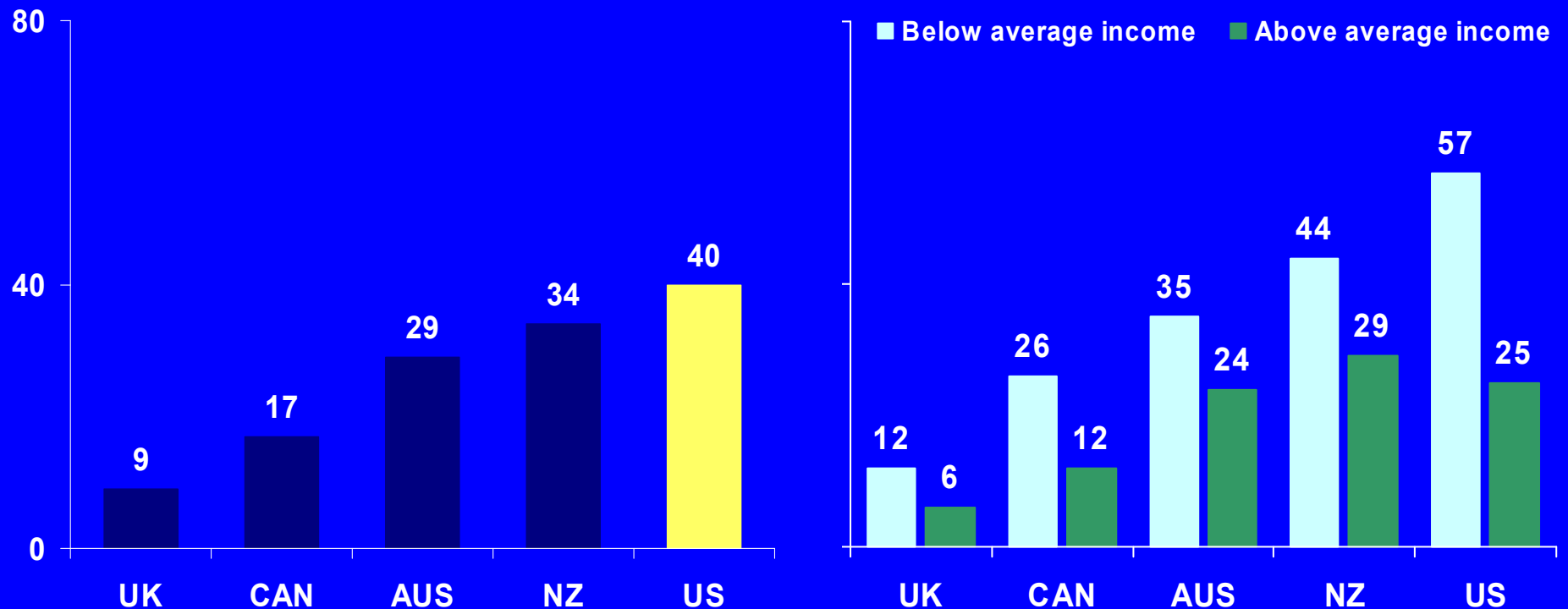
Note: Data on premium increases reflect the cost of health insurance premiums for a family of four. Historical estimates of workers' earnings have been updated to reflect new industry classifications (NAICS).

Data: KFF/HRET Survey of Employer-Sponsored Health Benefits: 2005.



Access Problems Because of Costs in Five Countries, Total and by Income, 2004

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.

UK=United Kingdom; CAN=Canada; AUS=Australia; NZ=New Zealand; US=United States.

Data: 2004 Commonwealth Fund International Health Policy Survey of Adults' Experiences with Primary Care (Schoen et al. 2004; Huynh et al. 2006).



Cost-Related Access Problems, by Race/Ethnicity, Income, and Insurance Status, 2005

Percent of adults (ages 19–64) who had any of four access problems* in past year because of cost



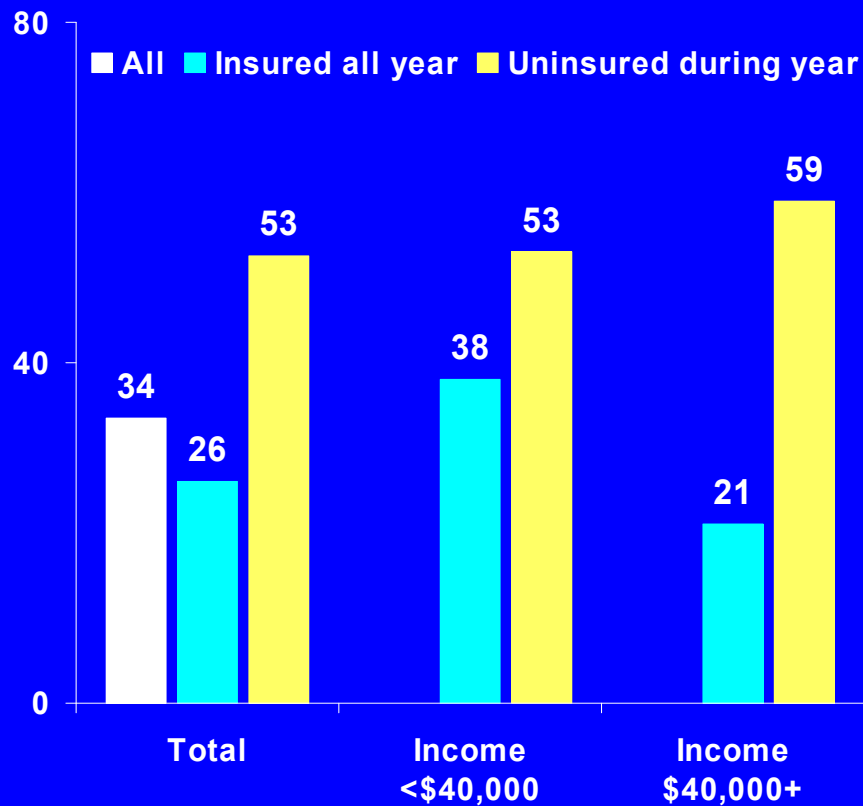
* Did not fill a prescription; skipped recommended medical test, treatment, or follow-up; had a medical problem but did not visit doctor or clinic; or did not see a specialist when needed.
Data: Analysis of 2005 Commonwealth Fund Biennial Health Insurance Survey.



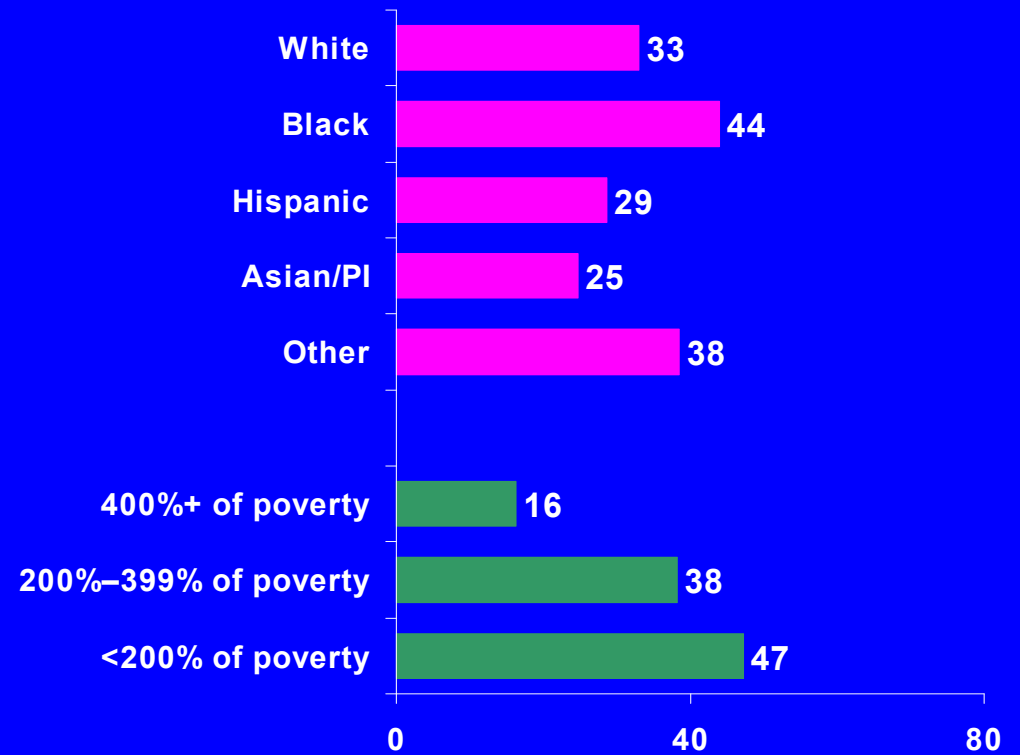
Medical Bill Problems or Accrued Medical Debt, 2005

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

By income and insurance status



By race/ethnicity and income

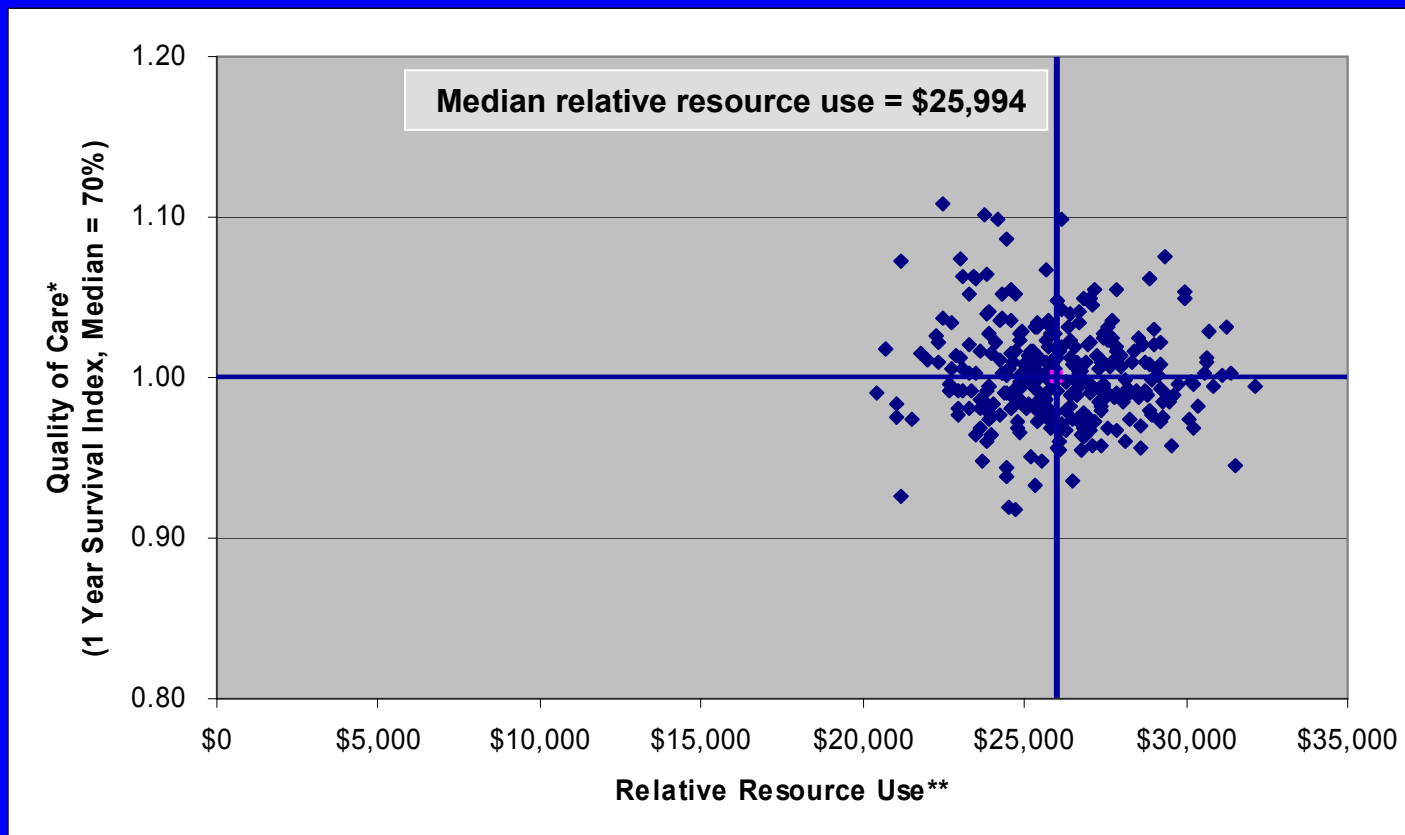


* Problems paying or unable to pay medical bills, contacted by a collection agency for inability to pay medical bills (only), had to change way of life to pay bills, or has medical debt being paid off over time. PI = Pacific Islander.

Data: Analysis of 2005 Commonwealth Fund Biennial Health Insurance Survey; Collins et al. 2006.



Quality and Costs of Care for Medicare Patients Hospitalized for Heart Attacks, Colon Cancer, and Hip Fracture, by Hospital Referral Regions, 2000–2002



* Indexed to risk-adjusted 1 year survival rate (median = 0.70).

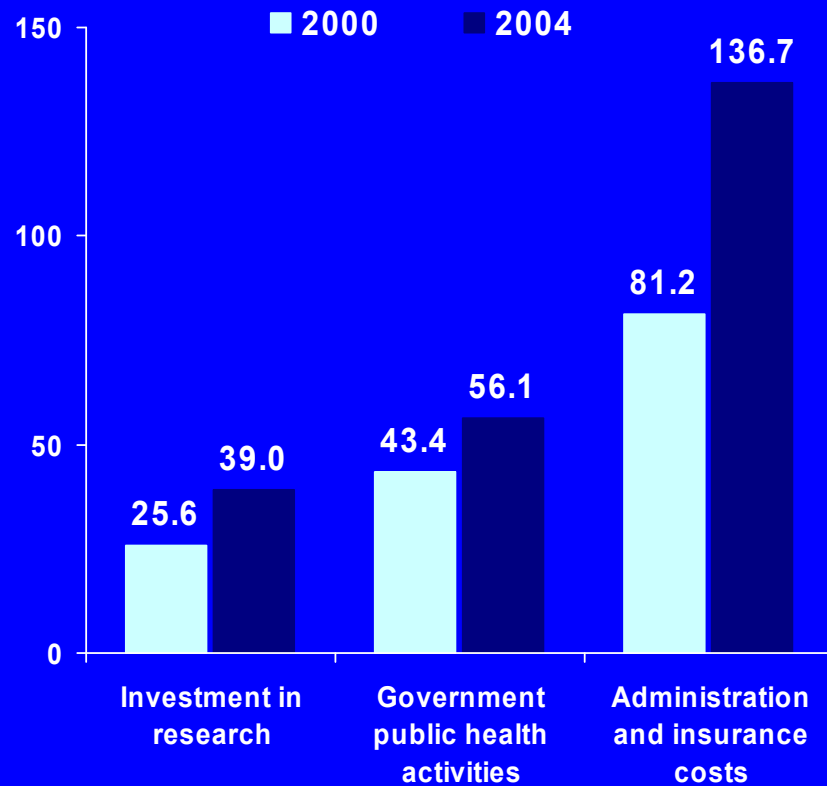
** Risk-adjusted spending on hospital and physician services using standardized national prices.

Data: E. Fisher and D. Staiger, Dartmouth College analysis of data from a 20% national sample of Medicare beneficiaries.

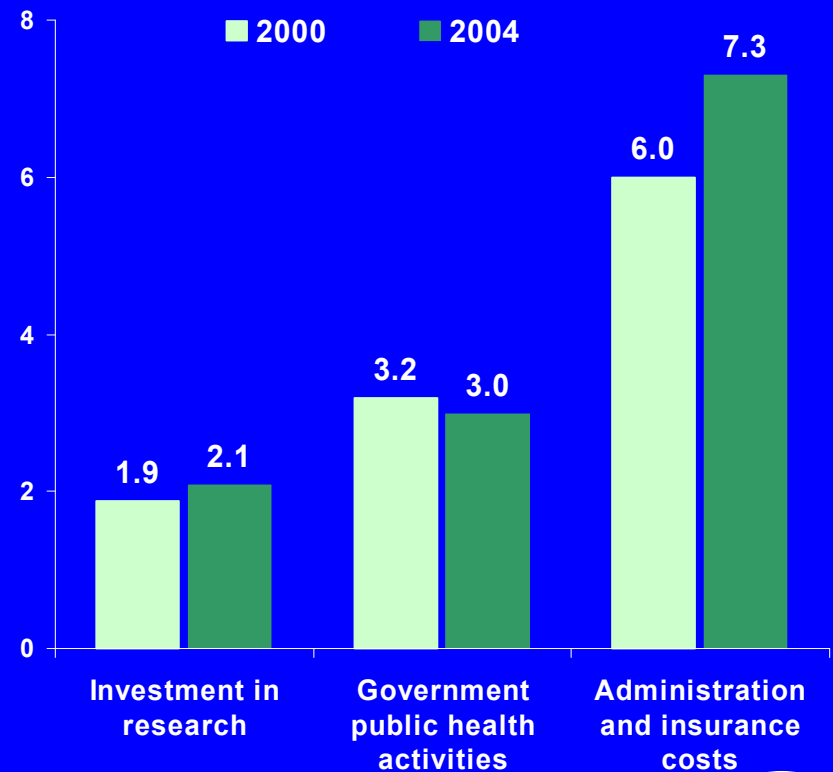


National Health Expenditures Invested in Research and Spent on Public Health Activities Compared with Administration and Insurance Costs, 2000 and 2004

Dollars (in billions)



Percent of national health expenditures



Data: CMS Office of the Actuary, National Health Statistics Group; and U.S. Dept. of Commerce, Bureau of Economic Analysis and U.S. Bureau of the Census (Smith et al. 2006).



What Do We Need to Do Differently?

- **Use the information we have better than we do now**
- **Identify the types of information we need but don't have**
- **Find ways to generate that information**
- **Find ways of injecting that information into the decision-making process**

What Do We Need to Know?

- **What are the benefits and risks of new medical treatments, procedures, and technologies?**
- **Which work best—under which circumstances, for which patients?**
- **What are the costs of the available alternatives?**

How Do We Get the Information We Need?

- **Current approach—decentralized efforts to address the needs of individual segments of the health care sector**
- **Alternative approach—centralized entity to identify, collect, coordinate, generate, and disseminate useful information**

How Do We Get the Information We Need?

- **If we take a centralized approach, should it be:**
 - **Public?**
 - **Private?**
 - **Public/Private collaboration?**
- **What are the pros and cons of each alternative?**

How Do We Make Sure That the Information is Used Appropriately?

- **The biggest challenge: We need to make sure that the information not only is generated and made available, but that it is injected into the decision-making processes of payers, providers, and prospective patients**