

Vision of Health and Health Care Transformed

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Members of the National Committee on Vital and Health Statistics (NCVHS) Executive Subcommittee, I appreciate the opportunity to speak with you this morning about a vision of health and health care transformed. I am Stephen C. Schoenbaum, MD, Executive Vice President for Programs at The Commonwealth Fund and Executive Director of the Commonwealth Fund Commission on a High Performance Health System. This Commission, which has been meeting three times yearly since July, 2005, has stated that the objective of health care for a population and the individuals in it is to lead to longer, healthier and more productive lives and that for health care to make this contribution everyone must have access to the care; and the care itself must be of excellent quality (effective and safe), efficient (without waste of time or resources), and equitable.¹ The Commission has gone further to recommend five key strategies to achieve these outcomes. They are to: Extend affordable health insurance to all; align financial incentives to enhance value and achieve savings; organize the health care system around the patient to ensure that care is accessible and coordinated; meet and raise benchmarks for high-quality, efficient care; and ensure accountable national leadership and public/private collaboration.²

QUESTIONS TO ADDRESS:

- 1. What are the critical characteristics and enablers of a safe, patient-centric, high quality, health-care system that optimizes patient outcomes?**
- 2. What have been the major barriers to system-level improvement in the health care system?**
- 3. How can incentives programs best be structured to support health reform?**

Central to its vision of achieving excellent health outcomes and health care for all Americans is the “meaningful use” of information technology. The Commission has stated, “Sufficient funding and leadership should be committed to achieve universal implementation of interoperable electronic information systems within five years, including electronic health records, electronic billing and claims payment, and provider decision support”. Furthermore, the Commission recommends “that patient and provider incentives should be aligned to encourage use of effective, evidence-based health services, avoid use of unproven or ineffective care, avoid misuse of services (for example, ineffective services that are sometimes provided at the end of life), and avoid overutilization, duplication, and waste.” It recognizes that in practice, health information technology, used meaningfully, can be instrumental in providing evidence of effectiveness, just-in-time, through decision-support; avoid duplication and waste through legible and accessible documentation of patient-specific information; and facilitate better coordination of care by transfer of appropriate information among providers.

My personal history in health care as a physician, manager, and patient, has led me to believe that “meaningful use” of health information technology can best be achieved through implementing systems that have basic functionality that facilitates the care of patients by physicians, nurses and other providers. These systems need not necessarily be extremely complicated. In 1981, I began working as a physician and manager at Harvard Community Health Plan in Boston, a staff model HMO that had begun to use a so-called “automated medical record” in 1972. In the era prior to the widespread use of workstations – entries to this record were primarily from coded encounter forms that allowed a small amount of free text, and the output was primarily a dot-matrix printout – it was nonetheless possible to have a medical record with availability in multiple sites and to improve quality of care with appropriately deployed reminders and prompts.³ Indeed, it was possible beginning in the 1980s for a patient to get care from a primary care clinician in one Harvard Community Health Plan location (there eventually were 14), specialty care at another location, urgent care at night or on the weekends at yet another location, and emergency care if needed in an affiliated Boston-area hospital; and the entire record would be available to facilitate the patient’s care in each location and document information needed by the next provider. In addition,

beginning in the mid-1980s a system of reminders and prompts were developed and used to improve the provision of needed preventive care for patients in general and diabetic patients in particular. Early registries of patients with chronic conditions were developed and provided to clinicians to facilitate appropriate follow-up.^{4, 5, 6, 7} By implementing a tracking system for positive test results, it was possible to ensure that follow-up of abnormal tests such as positive cervical cytology (or “pap smears”) was virtually 100 percent; and by appropriate programming of a laboratory-result-reporting system, it was possible to provide clinicians with information about the appropriate next step for different types of abnormal pap smears.⁸ Furthermore, although the original COSTAR system has now been replaced by an EPIC system, it has been possible to preserve and enhance the database. So, today if I go to the Harvard Vanguard Medical Associates web site and use the “mychart” function, and provide suitable login information, I have access to portions of my medical records including, for example, my immunization history over the past 25 years. I can also request appointments and prescription renewals.

Many years ago the medical leadership of Harvard Community Health Plan began to establish an annual set of clinical goals, objectives for improvement of clinical care and outcomes that it wanted to achieve. These goals helped drive the “meaningful use” of the available information systems. The vision of the Commission on a High Performance Health System and my own personal vision for achieving better health outcomes for the population of this country require having a national leadership that sets performance goals and facilitates the deployment of systems and incentives that will achieve the goals. By knowing what one wants to achieve one not only is more likely to achieve it but also to use resources meaningfully and efficiently.

¹ Commission on a High Performance Health System, *Framework for a High Performance Health System for the United States*, The Commonwealth Fund, August 2006. Available at: http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2006/Aug/Framework%20for%20a%20High%20Performance%20Health%20System%20for%20the%20United%20States/Commission_framework_high_performance_943%20pdf.pdf

² 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. Available at: http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2007/Nov/A%20High%20Performance%20Health%20System%20for%20the%20United%20States%20An%20Ambitious%20Agenda%20for%20the%20Next%20President/Ambitious_Agenda_1075%20pdf.pdf

³ Schoenbaum SC, Barnett GO: Automated ambulatory medical records systems: an orphan technology. *Intl J Technol Assessment in Health Care* 1992; 8(4):598-609.

⁴ Murrey KO, Gottlieb LK, Schoenbaum SC: Ensuring follow-up in ambulatory care. *Forum* 1992; 13(2):6-8.

⁵ Murrey KO, Gottlieb LK, Schoenbaum SC: Implementing clinical guidelines: a quality management approach to reminder systems. *Quality Review Bulletin* 1992;18:423-433.

⁶ Barton MB, Schoenbaum SC: Improving influenza vaccination performance in an HMO setting: The use of computer generated reminders and peer comparison feedback. *Am J Public Health* 1990; 80:534-536.

⁷ Schoenbaum SC: Implementation of preventive services in an HMO Practice. *J General Internal Med* 1990; 5(suppl): S123-S127.

⁸ Schoenbaum SC, Gottlieb LG: Algorithm based clinical quality improvement. *British Medical Journal* 1990; 301:1374-1376.