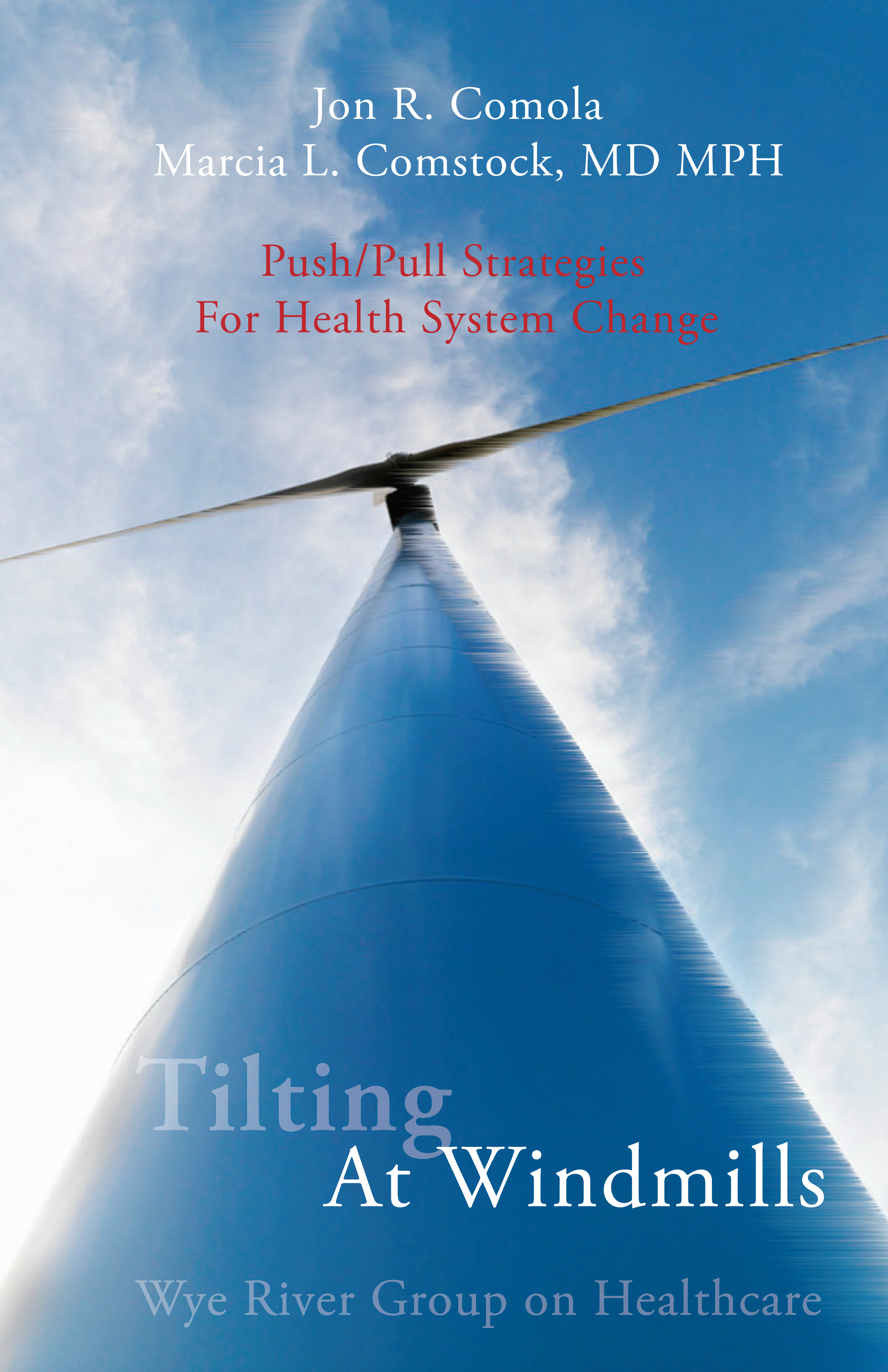

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## Push/Pull Strategies For Health System Change

# Tilting At Windmills

Wye River Group on Healthcare

# Dedication

“ We dedicate this book to those who recognize that designing a healthcare system that better meets everyone’s needs requires first setting aside the politics in favor of collaboration, compromise, and consensus building.”

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# Overview

*"Leaders need first to agree on principles, the guideposts for the debate, in the abstract. Only then can the conversation focus constructively on important medical, ethical, and economic issues." (WRGH,* 2005)

This book has been compiled to describe our success in building a vehicle for implementing broad-scale health policy reform from the ground up. The process we employed enabled community leaders to become architects of national public policy recommendations and to take ownership of them.

It is our hope that by sharing our experience, it will stimulate new thinking among public policy makers, academics, corporate public affairs professionals, health system executives, and elected officials.

Starting from a foundation of values and principles for health policy, synthesized from the views of more than 300 participants in Communities Shaping a Vision for America's 21st Century Health & Healthcare (discussed in Ch V), WRGH facilitated the development of three cornerstone reports for guiding the healthcare debate. These documents include 10 key health policy questions for political candidates; a statement of principles for health policy against which

proposals should be benchmarked (presented in Ch VI); and a robust healthcare reform blueprint, which maps out critical next steps for improving our healthcare system (described in CH VII).

These reports are not the product of a philosophically aligned group hoping to advance a personal or organization agenda. Nor are they derived from an elite group of cloistered thought leaders who emerge to announce their vision of a new world order. What is unique about this work is that it represents the methodical building of a consensus among diverse perspectives. Thoughtfully listening to and learning from informed and experienced leaders is a realistic pathway to addressing the significant shortcomings of our healthcare system, in order to improve the patient experience.

The US healthcare system is a hybrid—neither pure social good nor pure business enterprise. Our citizens' views about healthcare are similarly contradictory and divided. Some individuals view healthcare as a birthright. Others feel it is a privilege. We struggle with finding a balance between our spirit of rugged individualism and the notion of social responsibility. This lack of cultural solidarity has resulted in a patchwork quilt of healthcare financing and delivery models. One thing is clear, however. Healthcare in the U.S. is widely misunderstood.

Over the last 15 years, as healthcare business models have come to mirror other traditional business approaches, wedges have been driven between the disparate interests of healthcare sectors, resulting in misperceptions, lack of trust, and misaligned incentives.

Some of the changes that we need in healthcare have to do with measurable elements, such as incentives, quality metrics, and financing. But an equally important part of the change has to do with social and cultural issues—elements that powerfully influence expectations, preferences, and behavior of individuals and organizations.

In Washington, DC and at the state level, most healthcare trade and professional associations focus on the former very tangible elements. Our work addresses the intersection between tangible improvements and related social dynamics imbedded in culture. We believe that a robust dialogue among diverse healthcare, business, public policy, and consumer stakeholders, designed to explore common values and build trust, is a critical first step in creating a shared vision for national healthcare policy.

Our goal is to promote this new method for engaging health, business, and public sector executives in meaningful dialogue designed to achieve measurable improvements in healthcare system performance, the health of the public, and ultimately, the consumer experience.

Chapter 1

# The Current Landscape

*“If you don’t know where you are going, any road will do.”* This astute comment by Lewis Carroll in Alice in Wonderland is quite relevant to our situation with healthcare today.

According to the CEO of a prominent disease advocacy group, when we talk about the importance of building a shared vision for healthcare, we are highlighting “… *the essence of living in a pluralistic and democratic society… that somehow before you set [health] policies, you get some sense of what the citizens and electorate want.*”

But can we agree on what we are trying to achieve with our healthcare system? Can we agree on what is a better system? Are we looking for some utopian health system, or merely something that is more consistent, cost-effective and equitable than what we have today? Here are some proposed potential “visions” for American healthcare:

> **A** *pluralistic* **system that** *empowers* **patients and demands** *accountability* **from both individuals and the health system, while adequately supporting the needs of the** *disadvantaged*. *(from the WRGH communities initiative).*

> *“Collaborative care”* **with an** *engaged* **patient and a** *partnering* **physician sharing** *expertise*, **as contrasted with “traditional care” with a** *passive* **patient and** *dominant* **physician seeking** *compliance* **with instructions.** *(Thomas Bodenheimer, MD, University of California, San Francisco).*

> *Knowledge-based care: patient centered; system orientation (Institute of Medicine).*

From our work with leaders in Washington and in communities across the country, the vision that seems to resonate with most people is a model based on ***patient-centered healthcare***. This vision rests on the following four cornerstones:

> a sense of community;
> personal responsibility coupled with system accountability;
> leadership that creates a sense of trust; and
> an evolution in the roles of major stakeholders.

Fundamentally, today we have a science-based model created to support the healthcare industry. We need a humanistic-scientific model that is designed to support consumers/patients and an industry working for consumers and patients.

## How did we get here?

How did we get here?

As economist and author JD Kleinke pointed out in his 1999 book “Bleeding Edge; The Business of Healthcare in the New Century,” much of the dissatisfaction we experience with our healthcare system today stems from economics and history.

In a market where consumers don’t pay directly for most healthcare services and providers determine the need for their services, there is little accountability and conflicting incentives. Historical power struggles among physicians, hospitals, and third party payers have fragmented the delivery side of healthcare, making matters worse. As the CEO of a large multi-specialty group practice put it, *“Our current healthcare system exists in random acts of clinical improvement… where each interest group is moving forward in whatever direction it feels is appropriate.”*

> *The core problems we face in health care are unavoidably inter-related.*

For all Americans to be able to reap the benefits of patient-focused, high quality healthcare, we need to fundamentally restructure the organization, delivery and financing of healthcare to align incentives and create a true ***system*** of care. The reality is that the core problems we face—the rising number of uninsured citizens, escalating costs, and widespread quality problems—are unavoidably linked. We cannot adequately address one without considering the impact on the others. Finding the right balance is essential.

So, from a policy perspective, how do we address these serious problems in our country's healthcare system while ensuring we protect and preserve what we all value? The right public policy initiatives can help move us forward by removing barriers that exist, or by creating incentives for development of the right infrastructure.

To accomplish the required transformation in healthcare service and delivery, the roles of all key stakeholders—providers, insurers, and employers—will need to evolve to support a more patient-focused and accountable system. A healthcare system needs to be organized from the perspective of consumers and integrated to create continuity of care. We need a system where quality is integral to healthcare interactions and measurable through improved outcomes. At a minimum, this will require that we align economic incentives and apply basic business principles to healthcare.

> *Access to quality healthcare is too important to be politicized.*

The issue of access to quality healthcare for all Americans is one that is too important to be politicized. We need to work collaboratively to promote a bipartisan approach to solving these problems. Public policy should focus on preserving what currently works and expanding it to those without access, while enabling us to move toward a more satisfying healthcare system—one characterized by individual choice and accountability.

## The New Paradigm:
## Medical Consumerism

This notion of individual choice and accountability has been translated into new models that fall under the rubric of medical consumerism. But what do we mean when we use the term consumerism and apply it to healthcare?

Consumerism is a powerful force that has transformed industries like financial services, telecommunications, travel and entertainment in ways that could hardly have been predicted 15 years ago. It has largely supported the 21st century notion of more choice, lower cost, greater convenience, and higher quality. There is a sense that it is the duty of the system to figure out the equation. This conundrum requires a fundamental shift in how we view the value equation in healthcare. For example, the higher quality, lower cost theory has not yet been proven in healthcare, much to the chagrin of purchasers.

The evidence suggests that, if channeled correctly, consumerism has the potential to radically change our dysfunctional healthcare system and move us toward a much more satisfying system characterized by value, accountability, operational transparency and partnerships. The big question that remains is, will consumerism in healthcare be merely a cost shift or will it lead to a fundamental cultural shift?

> “*Will consumerism in healthcare be merely a cost shift or will it lead to a fundamental cultural shift?*”

Today’s consumerism has redefined expectations and created demand for things that look and feel more like self-service. We pump our own gas. We book our own travel on-line and print boarding passes from our computers at home, and then check our own baggage at the kiosk. We scan and bag our groceries.

On the other end of the service spectrum, busy consumers who can afford it may choose to have fully prepared meals delivered to their door. Consumerism is all about customization and choice! One can only imagine how far it will take us in healthcare.

The Impact on Health

## The Impact on Health Benefits

In some ways, we can look at the current direction in health benefits as part of a natural evolution, or a kind of “back to the future” scenario. Most people realize that employers’ prominent role in healthcare did not occur through some master design. Rather it was a reaction to the wage and price freezes of World War II that allowed employers to recruit workers. However, for this publication, we assume that the political reality suggests that role is not likely to change significantly in the near future. Nearly 160 million people in this country are comfortable with employer-sponsored health benefits, and most surveys suggest these folks are not looking for a major change. Organized labor and some traditional and historically paternalistic corporations are committed to continuing to provide health and retirement benefits, as is the government.

Simplistically speaking, one might consider the progression this way. Between 1945 and 1970, there was a mutuality of interests among insurers, physicians and hospitals. This pact served these stakeholders well by providing a vigorous flow of dollars that enabled scientific progress in medicine and relatively predictable financial security among the parties. In 1964, the Great Society movement swept the country, adding to public expectations and demands with the passage of Medicare and Medicaid legislation.

In the 1970s, tensions began to mount as consumers’ appetite for the latest medical marvels began to outstrip the system’s capacity to cover the costs of care. In response to the cost concerns voiced by employers, in 1974 Congress passed the HMO Act. Initially, managed care seemed to be the answer to the spiraling healthcare cost crisis. It was envisioned to be a dramatic shift, placing an emphasis on prevention and wellness, and channeling patients to high quality, lower cost service providers. We now know that, in most cases, managed care became synonymous with managed cost and little else. The core problem was that managed care overlooked the fact that our science-based model in healthcare is geared to the industry itself--not the consumer. The way the “movement” manifested itself was also incompatible with the American cultural abhorrence of Big Brother and “mother may I.”

> ***Our science-based model in healthcare serves the industry itself--not the consumer.***

In the 1980s and 1990s, employers felt a growing financial pinch. In response, many large employers tried applying business practices to their relationships with the healthcare industry. Strategies included competitive bidding, vendor contracts and supply and demand negotiations. When viewed narrowly, consumerism might also fall under the rubric of a business practice, as it provides a way for employers to predict annual healthcare expenditures and limit their financial risk.

Why Consumerism?

## Why Consumerism?

Why do consumerism’s advocates feel certain this is the right direction? In some ways, it is quite simple. We have tried everything else, and culturally Americans react negatively to any entity that tries to substitute its priorities for those of individuals. There is widespread mistrust of both big government and of corporate interests. In our culture, rugged individualism’s self-determination generally wins over social responsibility and equity.

> ***The ultimate question: Who will control healthcare decisions - bureaucracies or individuals?***

Consumerism may be viewed as the latest attempt to navigate the tensions between limited resources and unlimited expectations. In other words, it is about cost! Ultimately, the health reform debate gets down to a fundamental question: who will control healthcare decisions, bureaucracies or individuals? If we cannot finance ***all*** the services that ***might*** provide ***some*** benefit to ***some*** people, choices have to be made. Who better to make those tough choices than those whose lives are directly affected?

The pluralistic nature of our country also means that there is increasing diversity in health-related attitudes and individual preferences, which can vary within communities and even over the lifespan of a given person. This clearly supports another strong argument that the healthcare system needs to be capable of satisfying individual values, rather than imposing a one-size-fits-all solution upon the population.

Economist Jamie Robinson points out that whatever the approach we choose, it has to recognize that unrealistic and rising expectations, largely driven by the health system's direct-to-consumer advertising, are coming head-to-head with an increasingly elastic definition of "health." More and more "therapies" that have been viewed as cosmetic, optional, or discretionary are coming to be seen by many as essential to our definition of health.

Nevertheless, the jury is still out on the question of whether consumerism, is the right direction for healthcare.

Our findings suggest that the time is right for change. The heaviest impact of healthcare costs on employers will come in the next decade and a half, with some experts anticipating improvement when the Baby Boomers retire. Therefore, there is a window of opportunity opening to engage policymakers, the healthcare industry and the public in a national dialogue. But it won't last!

> *There is a window of opportunity opening--but it won't last!*

Our greatest asset as a society is people–organized people–sharing a common goal and setting priorities to reach that goal. But the public needs to have input. We need to consider the health of the population, while also looking at the health of individuals, in order to get better return from what we spend on our healthcare. We need to identify and learn from models that work.

## Chapter 2

# Politics & Public Policy

Twenty years ago, public policy at the legislative level was cleaner, smoother and simpler from an insider's perspective. When an industry sought to change a regulation or an administrative or statutory law, the task was generally accomplished under the radar screen, out of public view. Often it was not visible to competitors until after the deed was done. But this is not the case today.

In the face of broad, sweeping "sunshine" laws, campaign reform, and sophisticated communication and information systems, things have changed dramatically. It is impossible to conduct any business involving public affairs the old way. With these changes have come new challenges in shaping these processes.

Healthcare, with its complex and often overlapping network of purchasers, payers, providers, and patients, can benefit greatly from political collaboration, but true cooperation is the exception to the rule. Collaboration is not a natural human act. Neither is taking unpredictable risk!

> *"Collaboration is not a natural human act. Neither is taking unpredictable risk!"*

To succeed in influencing public policy as an elected official working inside the process, or as an outside proponent, strong relationships need to be built and leveraged. The need for such relationships puts a premium on the ability to inspire trust and to forge alliances among competing stakeholders. This approach stands in stark contrast to the practices common in the "old days," where influence was most often wielded one on one.

However, certain critical success factors have remained constant. Prerequisites for success include availability of compelling data supporting the desired change, financial resources dedicated to the political process itself, and the ability to create political coalitions or partnerships that embrace and promote the ideas. Success in public policy today depends on the right combination of these elements.

Creating Pathways

## Creating Viable Political Pathways

Politics is often viewed as the art of choosing between two equally unattractive options. In an environment where a slight shift in a law or in a regulation can have broad impact across an industry, an elected official is inclined to tread lightly.

> *"There needs to be a viable political pathway for change, essentially a course of least resistance."*

As we have witnessed many times in healthcare policy debates, good ideas often run headlong into organized political resistance. Public officials often find themselves in a dilemma, caught between their policy objectives and markets that resist change. The need to balance interests among competing constituents can place the elected official at the center of the debate. When the only choice appears to be between a clearly high-risk political move and one which may have unanticipated consequences, most policymakers will elect to do nothing.

To facilitate lasting improvement with high impact, there needs to be a viable political pathway for change, essentially a course of least resistance. Gaining buy-in among diverse interests for a specific change clearly increases the likelihood of adoption. While there are many other strategies that are routinely advanced, this approach is most likely to yield a positive, widely embraceable outcome politically and in the market place.

With all public policy issues, the ultimate test of viability resides with the voting public. However, healthcare presents some unique challenges for policymakers. Many thought leaders believe that the public places unrealistic demands on the healthcare system and generally fails to appreciate the need to contribute individually and collectively. Yet, effective health system reform will require public engagement and individual responsibility. Identifying and implementing policies, strategies and messages that serve to re-shape public behavior without being perceived negatively is a tall order.

## Past Efforts?

## Why did past efforts fail?

A nation that worships the notion of pluralism is unlikely to adopt a one-size-fits-all approach to addressing the shortcomings of the healthcare system. Similarly, vested stakeholders are unlikely to adapt readily to new business models that are unproven and disruptive to the current mode of operation.

> *“A nation that worships the notion of pluralism is unlikely to adopt a one-size-fits-all approach to healthcare reform.”*

For the past 60 years, health reform efforts have shared a common shortcoming. Efforts were built on a national platform using a top-down approach. Generally, healthcare proposals were conceived and developed behind closed doors, then thrust upon unsuspecting purchasers, payers, providers, and the public. People looked at what emerged and found it incomprehensible. Then various interest groups attacked it and it fell apart. Vested stakeholders are unlikely to adapt readily to new business models that are unproven and disruptive to the current mode of operation.

> *“Vested stakeholders are unlikely to adapt readily to new business models that are unproven and disruptive to the current mode of operation.”*

How can we approach healthcare policy differently? Where can the solutions to our healthcare challenges be found? We believe that many answers can be found within our communities. We should adopt the radical notion of a bottom-up approach built on a foundation of practical community experience. (See *www.leadinghealthycommunities.com* for a library of community best practices) While communities differ and need flexibility to design and execute programs tailored to meet residents’ needs, it is possible to identify successful, replicable models of community-based partnerships that are successfully addressing our nation’s healthcare dilemma. As one community leader put it, *“We need flexibility with accountability.”*

In addition, we need to bring the American people together and involve them in discussions of key choices. One individual expressed it this way, *"We need a more civil society. Active citizen participation is not what it needs to be."*

Healthcare leaders need to lead the change. Because each individual and each organization only owns a piece of the problem, no one feels responsible for the whole. Getting leaders to first agree on principles, guideposts for the debate in the abstract, is a prerequisite to constructive conversation, focused on important medical, ethical and economic issues. The CEO of a major trade association put it well: *"In Washington we don't really spend very much time talking about healthcare policy anymore. It's mostly about politics. We don't discuss issues, but there are many controversies that appear on the front page... We find ourselves debating extremes versus finding consensus....Finding the middle ground...and finding the critical path to reform...will be done by good people locally."*

> *We should adopt the radical notion of a "bottom-up" approach built on a foundation of practical community experience.*

If not, the debate will continue to be mired in the details of each parochial agenda, defined within the narrow objectives of each stakeholder. Another trade association CEO added, "Success depends on community leaders. Is it realistic to think that sector competition can be put aside in the name of bettering the health of the community? Does the community have the will?"

To succeed, credible commitments must be made in an environment of mutual trust and respect. Shared incentives must be created where all parties believe they can meet their most important needs.

> *Healthcare leaders need to lead the change. Because each individual and each organization only owns a piece of the problem, no one feels responsible for the whole.*

Read further, and discover the methods we have developed and used successfully to create the necessary neutral environment, gain a broad base of support among competing sectors, maintain momentum, and create community-based collaboration for lasting change – methods that can effectively continue to help move healthcare reform forward.

# Chapter 3

# Public Expectations

A View

## A View From The Pollsters

In 2001, the WRGH invited healthcare pollsters from both sides of the political aisle to share their perspectives on the public's perception of healthcare, and the changes needed to create a more satisfying system for us all.  The chapter text was derived from that meeting discussion and may not reflect the opinion of WRGH.

> *“To move our healthcare system in the right direction we need a charismatic, energetic legislative leader, a general movement that cannot be ignored, or a large, powerful group that decides it wants such change.”*

The pollsters pointed out that everyone interprets healthcare in a personal way. It is perceived by many as a “value.” People view healthcare decisions in a life or death, or at least quality of life, context. As a result, individuals will pay whatever they can to get what they feel they need. If they cannot afford something potentially beneficial, they will feel cheated, perhaps out of years of their life.

> *“The normal model of supply and demand does not work in healthcare. The purchaser is not the consumer and the provider creates the demand and supplies the services.”*

Healthcare, in general, does not follow a normal economic model, as the purchaser of these goods and services is not usually the consumer of them. In addition, the provider of service creates his own demand and then supplies the services.

Further, healthcare and retirement are increasingly intertwined. Healthcare costs become a critical issue when retirement funds are not there, as healthcare is a big part of living comfortably. The concept of health as a security issue emerged strongly post 9/11.

In 1992, forty-five percent (45%) of Americans polled wanted radical change in healthcare. People were worried about healthcare costs and concerned about losing their health insurance because of illness or job loss. Managed care helped to temporarily address the cost issue, and by late 1994, only twenty-two percent (22%) of those polled were advocating for drastic change.

However, the definition began to change as people became sick of managed care restrictions, and in June 1997, thirty seven percent (37%) of the public demanded change that would allow them to once again choose their own doctor. They were tired of insurance bureaucrats making medical decisions. These issues were ones that Congress could do something about, and people wanted Congress to act!

Without Congressional action, the market began to address the excesses of managed care. Unfortunately, by 1999 costs were again spiraling out of control. The number one concern of the public since then has been the surge in healthcare costs, which the public defines as out-of-pocket costs, not the true cost of a healthcare service.

> *The number one concern of the public is healthcare costs, which they define as out-of-pocket costs.*

As a voting issue, this is the most important issue for Congress to address—not the uninsured, the issue cited by most policy experts. Worries about healthcare costs have greater impact than concerns about terrorism, the war, the economy, or education. The fundamental story people tell themselves is that the greed of insurers, pharmaceutical companies, providers and lawyers has compromised the quality of care and driven costs. They do not see it as a problem related to technology, the aging population, or public demands. The public believes that healthcare was once responsive to people's needs and that doctors related to individuals on a personal level. Now they believe think that the "corporate model" of healthcare has compromised the doctor-patient relationship.

Around thirty-three percent (33%) of the public now advocate for significant change, including groups who are disenfranchised by the system and have little political clout, like the poor and minorities. But the very politically powerful group of women voters between the ages of 35-54 is also calling for major change.

But, what do we really mean by "change?" From a partisan perspective, Democrats want big, radical change, but they learned in 1994 that wholesale change of the healthcare system is not likely to be supported by the majority of the voting public. As a result, politicians in both parties are gun shy and want to start small. The "disease of the week" regulation of several years ago was the bridge between Clinton-Care and the Patient's Bill of Rights.

> *Wholesale change of the healthcare system is not likely to be acceptable.*

We need to keep in mind the fundamental disconnect between what people say about dissatisfaction with the system and how satisfied they are personally with their insurance and healthcare. Overall, people are still quite satisfied with their own care, and people do not want to make trade-offs. The consumerism movement in other industries has helped to create the 21st century notion that we can have it all—more choice, lower price, higher quality. Managed care made it worse, because, despite complaints about some aspects of the approach, once people have experienced the comprehensive coverage of managed care, they are resistant to fee-for-service or consumer-directed plans with more cost-sharing.

People perceive they are buying healthcare coverage—they don't see it as insurance—and they want healthcare covered! Candidates sell products, but consumers buy benefits. Politicians are forced to make trade-offs but the public does not believe they are necessary. We may accept some trade-offs in a market sector we do not in a societal sector, and healthcare grew up in a societal model. Also worrisome is the fact that many experts are not so sure that, when given more choice and control, consumers will take responsibility for their healthcare choices.

> *People perceive they are buying healthcare coverage—they don't see it as insurance—and they want healthcare covered!*

We are in dire need of a national debate about equity and economics. No one in the system is really assessing value, and there is a fundamental conflict between our concerns about cost and our demands for choice and freedom. In addition, we are in an upward cycle of our technical and scientific ability, which will have a major impact on cost, values and ethical decisions. How do we begin the debate? This conundrum will require a fundamental shift in how we view the value equation in healthcare.

So as we move toward a system characterized by more consumer empowerment and, importantly, personal responsibility for our health and healthcare, we need to ensure that we do not fundamentally undermine the security of the majority of Americans, or such change will be a political non-starter.

Communication is key. We must test the words we use to describe the concepts. To implement constructive change, it is widely believed that we need to create a new language that resonates with the majority of the American public. We need a language that is culturally palatable—one that trumps politics.

> *We need a new, culturally palatable language to describe healthcare challenges, one that resonates with the public.*

While it is nice to talk about the move from cost to value, in reality, cost is still the driver of change. What other messages and concepts besides cost resonate today? Control and choice are very powerful. For most people, a basic premise of controlling one's own healthcare is the ability to pick one's own doctor. For most people, the definition of a good doctor is one they select themselves. When bureaucrats and cost are in the way, people become resentful.

Quality of care also wins debates. The public views sacrificing quality of care to cover more individuals as an unacceptable trade-off. Portability of health insurance is very important, and media vignettes of pregnant women having to change doctors paint a powerful picture. But at the end of the day, we must convince people that a new concept will help them control the cost of care for it to sell.

Consumers will need a great deal of education if they are to be able to make good choices about healthcare plans and services. Although awareness is increasing, most people do not really understand the concept of health savings accounts, nor the alphabet soup used to describe the various types. We also do not use the right language to talk about tax credits—we talk about them as vehicle, rather than describing what they can help us achieve.

What about Congress? It appears that here, too, education is warranted. In general, individual members are unsophisticated about healthcare. Their knowledge and understanding is largely based on anecdotal and personal experience. Thus, they have little comfort dealing with healthcare issues, although when facing an election year they will confront their discomfort. There is a remarkable gap between what the public says it wants and what politicians recognize and respond to. Currently there is little real pressure to do anything—no mandate. Congress won't pass reform until the market has already shown the way.

*There is a remarkable gap between what the public says it wants and what politicians recognize and respond to.*

What about the future? It appears that there are essentially two competing visions: A government-run, single payer system, which opponents believe will severely stifle innovation. Clearly, this is not what most Americans want. OR a system where individuals with their doctors make decisions, people can keep their providers even if they lose or change jobs, and people have the means, in savings or otherwise, to meet future healthcare needs, catastrophic or routine, without losing sleep or sacrificing other life style desires.

Unfortunately, some experts feel it is likely our system will continue to deteriorate, unless we can find a way to move it in the right direction. This will take a charismatic, energetic legislative leader; a general movement that gets big enough that it cannot be ignored; or a large, powerful group that decides it wants such change. We need to move the debate back into a private sector mode where change can more readily take place. The country wants a contract on healthcare, but we must remember that insurance is just a subset of healthcare. How you pay for it is just a part of the equation and if we keep focusing on the insurance model, we will never have meaningful change, because even a two percent benefit is relevant when it becomes personal!

*Insurance is just a subset of healthcare -- if we keep focusing on the insurance model, we will never have meaningful change.*

Yet change is occurring—there is some self-correction of the market, within current regulatory constraints. People are being offered more choice. We are defining quality in a meaningful way, such as by decreased medical errors. The real question is, can we unleash more competitive forces without doing damage to what we have?

## The Voice of the Public

In December 2004, the Wye River Group on Healthcare commissioned a National Study on Consumer Health Values. The survey, conducted by Harris Interactive, polled a nationally representative sample of 1,000 adults aged 18 and over.

This survey was conducted to augment existing knowledge about consumer attitudes, values, and behaviors related to healthcare. In light of employers' and policymakers' growing interest in consumer-directed healthcare, consumers will likely be facing more responsibility for the costs of and decisions about their healthcare. As consumer-directed health plans become more common, one of the possible challenges for employers and policymakers will be effectively motivating consumers to become more engaged in their healthcare, more committed to prevention and healthy lifestyles, and better informed in order to make choices based on cost and quality information. Given these priorities, it will become even more important to better understand how consumers view their role in healthcare decision-making, what aspects of healthcare they value most, and how they feel about making choices and possibly changing their lifestyles.

# *Key Findings*

> 2/3 say they would become more involved in decision -making, if the healthcare system were easier to navigate.
> BUT over a third would follow their doctor's advice, even if it conflicted with reliable information from another knowledgeable source.
> A large majority of adults say they would be willing to work an extra two or three years in order to ensure that they have enough money to pay for their healthcare in retirement.
> BUT pre-retirees are less willing than younger adults.
> Americans appreciate that there are great differences between the quality of care provided by different hospitals and physicians for serious medical problems.
> BUT consumers are not willing to pay more for access to better-quality hospitals or physicians.
> The public is aware that a healthy lifestyle can improve and/or prevent many medical problems.
> BUT people are generally unwilling to require people with poor lifestyle habits to pay more for their coverage and healthcare.
> The publict believes that corporate profits and "waste" in the system are responsible for the rising costs of healthcare.
> The public is uncomfortable with putting a dollar value on living another year.

An effective approach to getting Americans more involved in healthcare decision-making will need to ensure that the healthcare system is easy to understand and navigate for consumers so that they may become more comfortable using information sources other than those upon which they have traditionally relied. Nearly two in three Americans feel that they would become more involved in decision-making if the healthcare system were easier to navigate. Reflecting a traditional reliance on physicians for making decisions about treatments or selecting specialists or hospitals on their behalf, over a third of consumers say they would still follow their doctor's advice even if it conflicted with reliable information from another knowledgeable source

Given rising healthcare costs and data which shows few Americans are preparing financially for their future healthcare needs, it is significant that a large majority of adults say they would be willing to work an extra two or three years in order to ensure that they have enough money to pay for their healthcare in retirement. However, older adults—including those in their pre-retirement years—are less likely than younger adults to be willing to do so.

When it comes to perceptions about the quality of healthcare, the public holds mixed views. Americans appreciate that there are great differences between the quality of care provided by different hospitals and physicians for serious medical problems. However, they are not willing to pay more for access to better-quality hospitals or physicians. This may relate to the fact that most Americans feel satisfied with their current physicians, and would not change doctors even if cost or other limitations were not an issue. With this in mind, payers will need to use well-designed incentives to drive consumers to higher-quality providers.

Given that care for preventable chronic conditions accounts for a large proportion of all healthcare costs, employers, payers and policy-makers are becoming increasingly interested in motivating Americans to use prevention and lifestyle modification programs in order to decrease their healthcare costs in the long run.

Although Americans are generally aware that a healthy lifestyle can improve and/or prevent many medical problems, they are generally unwilling to require people who are overweight or who do not exercise regularly to pay more for their coverage and care. This suggests that payers should rely on a system of incentives that emphasize rewards for healthy behaviors rather than punishment for unhealthy habits. One possible exception to this rule is smoking, as the public appears more willing to require smokers to pay more for their health insurance and healthcare.

The public believes that corporate profits—especially related to the insurance industry and pharmaceutical companies—and "waste" in the system are responsible for the rising costs of healthcare. Therefore, any actions designed to motivate the public to be more cost-efficient in their use of healthcare would need to overcome this perception.

Also, the public is generally uncomfortable with the important ethical implications of putting a dollar value on living another year, which would force discussions about prioritizing resources for care in the final months of life.

The clear contradictions in these findings, coupled with the earlier view from pollsters, strongly suggest it will take a significant and sustained effort to engage the public in doing their part to improve our population's health, and to address the failures of the current health system.

> *"It will take a significant and sustained effort to engage the public in doing their part to improve our population's health, and to address the failures of the current health system."*

## Chapter 4

# Implementing A New Approach

As discussed in previous chapters, we suggest a different approach to developing public policy in order to better meet our healthcare needs. Rather than focus on a "top-down" approach and look to Washington to solve our problems, we believe that viable solutions to our health system ills can be found by using a "bottom-up" approach, looking to communities for solutions.

*3 principles are intrinsic to the Wye River Process:*

> *Create a neutral environment to engage all relevant stakeholders*
> *Create a shared definition of the problem*
> *Identify opportunities based on a growing consensus*

The Wye River Process

## The Wye River Process

Wye River Group on Healthcare (WRGH) has developed and successfully used an innovative process to bring leaders together to identify common interests and to engage them in constructive dialogue leading to action. The outcome has been effective collaborative partnerships, focused on positive healthcare system change. Through the Wye River Process, we work to translate conflict into collaboration, building on the collective wisdom of diverse leaders. The process results in an enriched understanding among parties, and promotes identification of critical areas of growing consensus.

We have applied our replicable process on behalf of many groups interested in advancing an actionable agenda. WRGH has distinguished itself among healthcare industry leaders as an effective catalyst, by demonstrating our ability to translate the theoretical into the practical. In short, we help move talk into action!

Logistics

## Logistics

A prerequisite for a successful collaborative effort is to create a neutral environment with a highly credible convener. The next step is to realistically evaluate and understand assets and liabilities.

The location for group meetings may seem like a minor issue, however, it is an opportunity to send the right signal. It is important to select a venue that is generally regarded as neutral.

Engagement

## Engagement

Prior to selecting participants, it is crucial to be clear on the purpose of the collaboration. A succinct statement of purpose with an unambiguous motive and well-articulated and generally embraceable set of goals is advantageous. Beginning with objectives that are too specific can have a negative impact on an open process.

Assembling a diverse group of leaders sounds easy. However, it is human nature to tend to select individuals with whom we are most comfortable, those who think and act like us. Developing and communicating a thoughtful, structured selection methodology for invitees is important to a successful outcome. Personal engagement of these leaders sends a clear message of respect and indicates that the planned initiative and their personal involvement is a serious matter.

Given the planned initiative, certain elements may be more or less relevant. For example, is broad diversity of group composition important? Is participation by invitation only desirable?

Meeting Process

## Meeting Process & Content

Here again, certain elements may be critical or merely desirable. Is it important for the group to maintain confidentiality, that is, “what’s said here, stays here?” Is a highly structured dialogue with expert, neutral facilitation needed? Is the goal to ultimately come to agreement on an actionable set of next steps? Answering these questions in advance helps ensure a thoughtful approach to the dialogue and a set of realistic expectations.

It is wise to begin with a relatively brief meeting or conference call, designed to discuss the merits of a collaborative effort and assess the timing. This constructive start can serve to build momentum.

Next, it is crucial that the group reach agreement on a clear definition of “the problem.” It is important for anyone championing an initiative focused on the lofty goal of leadership to go out of the way to demonstrate it is not about a personal agenda. It takes time to get the active support of others and even more time to get them to share ownership of the effort.

Frequently, leaders are anxious to get to the heart of the matter, defined as their solution to the specific issue most important to them. But starting with specific solutions is a sure way to alienate and undermine attempts to establish meaningful, broad, community-based support for the collaborative project.

Set out the ground rules for discussion and seek agreement on the process to be used to begin addressing the issues. A shared definition of HOW agreement will be reached—the APPROACH that will be used—is important to success. Affirm to all involved that their participation does not mean that they endorse the end product in advance. Establishing expectations up front and staying with a well-articulated plan will enhance the likelihood of a successful initiative.

Detailed discussion notes should be taken at each meeting, then shared with participants for their comments, additions and corrections. Capturing the essence of the discussion in writing also adds to the sense of the meeting’s importance.

Action

## Action

Obtaining agreement on potential areas to address is important in shaping the direction of the effort, and in creating a sense of accomplishment. Identifying two or three areas to advance collectively, and prioritizing near term and longer term objectives will help ensure the concerns of each participant are recognized.

The group should work together to delineate key roles and responsibilities of individual participants, as well as organizations. Next, they need to determine the support necessary to accomplish any agreed upon objectives. Each initiative requires specific tools and resources.

The group should come to agreement on a timeline for executing agreed upon actions. Identifying and pursuing several quick wins will help to build and sustain momentum. It is important to identify one credible organization or individual to accept responsibility for ensuring that all participants live up to their commitments. All participants should be comfortable that the party selected is capable and willing to carry out these responsibilities without prejudice.

Communication and documentation of success is necessary to build momentum. As progress is made, consider engaging other community leaders in the on-going process to stimulate their thinking.

The process described is part art and part science. Successful initiatives maintain a balance that ensures meaningful, measurable action is occurring, different agendas are smoothly accommodated, and a sense of pride and belonging is created. These are the cornerstones to effective collaboration. For more information, see the Community Action Guide at ***www.leadinghealthycommunities.com.***

# A Case Study

A Case Study

***“Communities Shaping a Vision for America’s 21st Century Health & Healthcare”***

In July, 2002, Wye River Group on Healthcare (WRGH) lauched a project called “Communities Shaping a Vision for America’s 21st Century Health and Healthcare.” It was sponsored by a cross-section of national trade and professional associations and had bipartisan support.

We felt that the time was right to take a step back and ask healthcare leaders what they believed Americans really want from our healthcare system. Our goal was quite simple. We wanted to learn from local community leaders and citizens the values that guide their thinking about healthcare, and their conclusions about what is working and what needs to be fixed. We hoped to launch conversations in various communities that could jump-start a national dialogue about the fundamental values and principles that Americans want to guide U.S. healthcare policy into the future.

During Phase I, WRGH held a series of Healthcare Leadership Roundtables, or “listening sessions,” in 10 diverse communities around the country. During these roundtable discussions, community healthcare leaders were not asked their views on specific policy issues. Instead, they were asked deeper, more fundamental questions, such as whether there is, or should be, a social contract for healthcare in this country. Participants proved eager to explore these questions, which are rarely asked in the usual forums on healthcare policy.

To our knowledge, the project was unprecedented in its effort to understand how healthcare stakeholders view the values and principles underlying our healthcare system. We used community-based discussions to explore these issues and asked participants to set aside the politics and sector competition that have shaped so much of the healthcare policy debate in this country.

### *General findings*

Compared with the national debate, we found that community discussions were less polarized, less partisan, and more focused on finding practical solutions to the healthcare challenges we face. What we discovered was a surprising degree of interest and willingness at the community level to offer honest viewpoints about important values and principles in healthcare, to bring up frustrations and specific challenges, and to pursue collaborative efforts to address key healthcare issues in their community.

It will come as no surprise that most participants believe we face a major crisis in healthcare that will only get worse if we don’t take definitive action. The good news is that most felt the time is right and there is a window of opportunity to engage policymakers, the healthcare industry and the public in a national dialogue aimed at constructive change. There is a strong sense that healthcare leaders are more motivated than they have been to discuss problems and try to collaborate on solutions.

In general, there was consensus that we lack a meaningful social contract for healthcare. As a result, individuals don’t know what they have a right to expect from the healthcare system, nor do they understand their responsibility to contribute. We must decide as a society what we REALLY want from healthcare. What are the trade-offs? Who is willing to make them?

Leaders agreed that we need to start by carefully defining the problems from the unique perspective of communities before we go pushing a specific approach. Given the pluralistic nature of the country, a one-size-fits-all approach is not likely to be embraced. We also heard that although some policy and financing issues must be addressed at the federal level, there is great faith in the ability of different communities to develop creative approaches that recognize the distinct problems and the specific strengths of each community.

### *Healthcare Leadership Roundtables*

Healthcare Leadership Roundtables were held in ten communities around the country between July 2002 and May 2003. In each community, WRGH assembled a diverse cross-section of public and private stakeholders with detailed knowledge of health and healthcare. They included physician leaders, hospital and health system executives, community and public health officials, pharmaceutical and pharmacy representatives, business leaders, consumer representatives, and government officials. We also worked to ensure that important constituencies such as the elderly, the uninsured, minorities, and people with chronic illnesses were well represented. We believe that, collectively, these leaders have a solid understanding of the health and healthcare challenges communities face.

Each of the roundtables was a three-and-a-half-hour meeting focused on the shared values and principles that should provide the foundation for health policy in this country. In these discussions, we explored participants' views on the social contract for healthcare—both as it currently exists and what they believe it should be. We challenged them to define the attributes of a well-functioning healthcare system and the role that each sector would optimally play in creating and maintaining that system. We asked them to reflect on consumers' expectations of healthcare. We also tried to raise community leaders' sense of themselves as catalysts for positive change in healthcare.

Following each roundtable discussion, a professional writer distilled the comments into a "community profile" highlighting the shared values and principles articulated in each community. Draft versions of the community profiles were distributed to roundtable participants for their comments, corrections and additions prior to being finalized.

Another result of the roundtable discussions was the development of a roster of 20-25 leaders in each community. These advisers from different sectors in each community are willing to help us move closer to addressing issues of common concern in health care. These leaders can be collectively engaged in activities designed to bridge the gap between local concerns and national public policy.

### *Selection of Sites and Participants*

The ten communities in which roundtable discussions were held were carefully chosen to reflect our nation's diversity – not only its diversity of peoples, cultures and values, but also its diversity of healthcare challenges. The selected communities vary by geography and size, ranging from large metropolitan areas to smaller cities and rural communities, and by cultural and ethnic diversity. The communities also represent a range of regulatory environments, from communities in heavily regulated states to those in states with moderate or minimal healthcare regulations. We also selected communities that represent both ends of the spectrum relative to the percentage of uninsured residents.

The final criteria for selection related to healthcare costs and quality, using data from the Dartmouth Atlas of Healthcare and a Health Care Financing Administration (HCFA) study published in The Journal of the American Medical Association (JAMA) in the summer of 2000. We selected communities where healthcare costs per enrollee were much higher than national averages as well as communities where costs were several times lower than national averages. Additionally, some communities were located in states that had been rated very high with regard to quality of care, while others were in the lowest bracket, according to the HCFA study.

Roundtable discussion participants were chosen with equal care. In addition to the chief executive officers and senior executives invited by project sponsors, WRGH recruited a broad cross-section of leaders from each community we visited. Our goal was to balance participation across healthcare sectors and from a public/private perspective, endeavoring to ensure that the consumer voice, reflecting the composition of the community, was represented. With the assistance of our supporting organizations, we were able to reach local healthcare leaders such as public health officials, Medicaid directors, directors of community health centers, representatives from consumer organizations, culturally focused groups and local professional associations, civic thought leaders, and local employers.

### *Site Visits*

WRGH principals traveled to each site four to six weeks in advance of the Healthcare Leadership Roundtable in order to gain a meaningful understanding of the unique cultural aspects and healthcare marketplace dynamics in each community. During the site visit, we met with a broad array of community opinion leaders from virtually every healthcare sector, both public and private, as well as individuals representing key consumer groups. Through a series of one-on-one meetings and interviews, we elicited their concerns and ideas and developed a sense of the local dynamics and cross-sector relationships that shaped each community's approach to healthcare. The one-on-one meetings also helped us identify successful community partnerships that became the basis of our original case studies series, which has been expanded and is intended to provide the opportunity for knowledge transfer among communities and constructive change on the national level.

### *Citizen Voices*

Although this project focused primarily on discussions held at the leadership level in these ten communities, in six of the communities we also conducted informal meetings with groups of local citizens. We wanted to elicit their opinions to balance and supplement the views of their community leaders.

### *Advisory Boards*

Midway through its ten-city tour, the WRGH began to develop a circle of advisers—leaders chosen from different healthcare sectors and communities—to help us develop recommendations and potential next steps in addressing common issues that arose in community discussions. Our intent was to engage these leaders in a process aimed at bridging the gap between local healthcare issues and a broader agenda with national application.

To organize this aspect of the project, we created Advisory

Boards around six healthcare topics: cultural change, access, information infrastructure, incentives, quality, and the role of public health. The advisory board members participated in a series of meetings by telephone aimed at identifying opportunities for focused initiatives to be launched in the communities. The boards each developed a topic-specific report describing the crux of their particular issue and suggesting several potential next steps for collaborative action at the community level. These reports are included here as Appendix A.

### *"Shared Vision" Retreat*

After roundtable discussions were completed in all ten communities and the advisory boards wrapped up their work, the WRGH hosted a multi-day meeting in July 2003, at the Aspen Institute Wye River Conference Center in Maryland. Two key participants from each roundtable discussion and representatives from our sponsoring organizations were invited to participate in a "shared vision" retreat, where draft chapters of the report were reviewed, discussed, and edited.

### *National Summit*

To announce the "shared vision" that arose from this project, WRGH organized a national summit designed to showcase the findings of the 10-city tour and launch a national dialogue on healthcare among the American public, policymakers and healthcare stakeholders. The summit, held in September 2003 in Washington, D.C., provided an opportunity for community and national leaders from all healthcare sectors to share their insights into our healthcare future and to articulate their collaborative goals.

## Chapter 5

# A Community-Based Perspective On Values & Principles For Healthcare Policy

*The Healthcare Leadership Roundtables, hosted by WRGH and described in detail in the previous chapter, created an opportunity for a wealth of frank discussion and unencumbered expression on the state of the U.S. healthcare system and its functionality.*

*In this Chapter, we outline the findings and suggestions/the call to action offered by the roundtable participants. Please note that references made to participants, community leaders, roundtable discussions or discussions, and other similar terms used in this chapter refer specifically to the findings of the Healthcare Leadership Roundtables, or "listening sessions," held during Phase I of the "Communities Shaping a Vision for America's 21st Century Health and Healthcare" project (described in Chapter IV).*

The roundtable discussions revealed a consensus among community leaders that the United States needs to make fundamental changes in its healthcare system. As evidence, these leaders cited mounting problems in healthcare, especially the skyrocketing cost growth that has made healthcare coverage unaffordable for millions of Americans. Rapid escalation in healthcare expenditures is the number one concern that is driving community leaders' interest in comprehensive health system change.

In Jackson, Mississippi, as in many other communities, we heard that "*the crisis is worse now than it was [in the early 1990s]*." In addition to the cost issue, healthcare leaders point to growing problems in healthcare delivery that include:

> over 40 million Americans uninsured at one-time in a year;
> safety net providers who are overwhelmed by increasing demands on their resources;
> workforce shortages;
> widespread quality problems; and
> concerns about how the liability system is affecting access to healthcare.

Not surprisingly, many healthcare leaders convey a sense of urgency when talking about the need to move forward with healthcare system change. They say the problems are severe, pervasive, and likely to worsen unless significant action is taken to address them. *"Time has run out for an incremental approach to healthcare change,"* said a participant in San Antonio.

Our healthcare system is undergoing a period of transition marked by several factors including:

> a growing number of employers moving away from "defined benefit" healthcare coverage to "defined contribution";
> workers being asked to share more of the costs of their care;
> patients demanding more information about their healthcare options and a greater role in decision-making; and
> physicians and nurses facing severe challenges to their morale and their ability to care for patients.

> *"Time has run out for an incremental approach to healthcare change."*

All of these changes, and the increasing cost pressures on healthcare payers, make this a crucial period of transition for American healthcare. But similar to the glass half full/half empty analogy, this period can be viewed either as a moment of crisis or a moment of opportunity.

Community leaders choose to view it as the latter. They say this growing set of healthcare challenges presents a window of opportunity to engage policymakers, the healthcare industry and the public in a national dialogue aimed at constructive change. They say that, as stakeholders, they are more motivated than they have been in a long time to discuss problems and collaborate on solutions. Moreover, the deep concern felt by the healthcare sectors has begun to spread to the public. ***"It is becoming a middle-class consumer crisis,"*** observed a Jackson participant. The public is paying attention, which means that policymakers have a strong incentive to become engaged on the issue of comprehensive health system change.

However, these leaders also warn that the window of opportunity to move forward with thoughtful changes is limited. The window will begin to close once the Baby Boomers start flooding Medicare. It could close even sooner if more employers decide healthcare coverage is unaffordable and stop offering it to their workers. Healthcare leaders say that if there isn't significant progress in the next five to ten years, the problems will become even larger and more intractable, which could prompt a radical shift in U.S. healthcare policy as a last-ditch effort to control cost growth. ***"If we don't consciously make significant change, we are headed inexorably to a government-controlled system,"*** said a participant in Salt Lake City.

> ***"This period can be viewed as a moment of crisis or a moment of opportunity. If we don't make significant changes, we are headed to a government-controlled system."***

The prospect of increased government involvement in healthcare is clearly a lightning rod for disagreement in virtually every community we visited. A large number of participants said they would oppose "government-run healthcare." There was broad agreement that a one-size-fits-all approach is not likely to be embraced in our pluralistic country, ***"where values often differ among communities and across generations,"*** said a Salt Lake City participant.

But some healthcare leaders expressed support for the notion of ***"single-payer healthcare."*** Single-payer supporters seem to share a belief that only a single-payer system can effectively address the inefficiencies and inequities in American healthcare. However, they do not seem to have a shared definition of the term ***"single-payer"*** or a clear sense of how it would achieve their goals.

A few healthcare leaders in various communities said that—like it or not—they believe the U.S. will one day adopt a single-payer approach out of a collective desperation to control costs. Others disagreed. ***"I cannot believe the deliverers and financiers of care would allow us to get national [health] care,"*** said an insurance executive. ***"We will come together before we go over the brink."***

*Values often differ among communities and across generations.*

Community leaders say there is a role for government and one for communities in shaping healthcare. Undoubtedly, healthcare will continue to evolve, even if policymakers refrain from taking an active role in addressing the current problems. But most healthcare leaders say the evolution in healthcare shouldn't be left entirely to the marketplace. ***"Normally our society resolves problems through the market,"*** said a San Diego participant. ***"But this [healthcare] market has a lot of imperfections."*** Therefore, policymakers need to step up and proactively help to define the direction in which we, as a country, want to take our healthcare system.

The first challenge in such an effort would be to decide what Americans should expect from their healthcare system and what they are prepared to actively support. As a healthcare leader in Jackson observed, ***"The problem policy-wise in the U.S. is grasping what health is [to us] as a society. Until we get a handle on what we're trying to achieve, I don't know if we can get a handle on the healthcare system."***

In fact, many of the participants pointed out that the U.S. doesn't even have what can be considered a healthcare ***"system"***. It is a ***"non-system"*** – fragmented, random and complex, they said. ***"Healthcare is not meeting the needs of the 21st century consumer,"*** asserted an Albuquerque participant. ***"There is no integration."*** This lack of coordination in healthcare results in higher costs and lower quality.

*The problem policy-wise in the U.S. is grasping what health is to us as a society. America does not have an agenda for healthcare.*

Healthcare leaders say it is time that Americans come together to talk about what health means to all of us as a society and to start developing a national agenda for healthcare. We need to get clear on what the problems are in healthcare and what kind of solutions we would like to see. A Ft. Lauderdale participant said America needs a vision for healthcare that can be articulated by policymakers and understood by the public. ***"Without a vision, we'll be treading water,"*** he warned. ***"We need a simple message that is visionary."***

Along the same lines, a North Carolina participant observed that, ***"the reality is that America does not have an agenda for healthcare, which should be the driver of the healthcare system.... We have random acts of improvement going on, but there is no overall vision."***

Creating a national vision for healthcare will require the involvement of all healthcare sectors, community leaders and the public, but it starts with courageous political leadership. ***"Unless we have someone who is willing to step forward and very publicly say healthcare is the agenda, I don't think it's going to take place,"*** said a medical group CEO.

For too long the problems in healthcare have been pushed aside in favor of other issues. Leaders in every community agree that now is the time for elected officials to put healthcare at the top of the nation's list of priorities. In the words of one Jackson participant, "If we could declare our healthcare dilemma as a threat to national security, our country would react as it did in Iraq and act to correct it."

The magnitude of the problems that face healthcare today demands that level of attention and focus.

> *“We could declare our healthcare dilemma as a threat to national security.”*

A Social Contract

## A Social Contract for Healthcare

In each of the roundtable discussions held, healthcare leaders were asked, ***“Does our country have a social contract for healthcare?”*** This may sound like a simple question, but it revealed a great deal of uncertainty and disagreement about Americans’ rights and responsibilities as they relate to healthcare. Judging from the response of most participants, the question is not one often discussed in this country, even among healthcare leaders. A typical reply was, ***“What do you mean by a ‘social contract’?”***

A basic definition of a social contract for healthcare is an agreement among citizens that defines the rights and responsibilities of the citizens themselves, their government, and their healthcare system. Under that definition, the U.S. does not have a meaningful social contract for healthcare, according to most participants in our roundtable discussions. Americans do not know what they can and should expect from their healthcare system. Nor do they understand their responsibilities for maintaining the healthcare system. ***“I don’t think the idea of a social contract is in people’s daily consciousness,”*** said a New Hampshire participant. ***“People’s self interest should be more connected to the concept of interdependence.... We need to understand interconnectedness and interdependence.”***

Some participants agreed with the notion that there are multiple social contracts that often conflict with each other and represent a series of ***“warring”*** expectations. Others felt that there are elements of a social contract for healthcare. For example, our country has put in place health insurance and safety net programs to make sure that care is provided to certain populations. The Medicare and Medicaid programs represent a kind of social contract, said some participants. But these programs often fall short of meeting a person’s needs for healthcare and are felt by many to represent more of an entitlement than a social contract. Many leaders point out that healthcare should not be an ***“entitlement”*** as it requires certain responsibilities from individuals as part of a two-way contract.

Furthermore, many also point out that these public programs are underfunded. ***“If a social contract exists, it has a huge hole in it,”*** said a state Medicaid director.

If there is a social contract for healthcare in this country, it is certainly minimal, and poorly articulated. It is only manifested as an expectation that vulnerable people will somehow receive the care they need, particularly in an emergency. Indeed, federal law requires hospital emergency departments to treat anyone regardless of ability to pay. But there is no clear foundation for viewing healthcare as a ***“right”*** that is guaranteed to everyone who lives in the United States. An Albuquerque participant pointed out that ***“from a social justice perspective, we have to acknowledge that our system has not defined healthcare as a human right.”***

The question of whether Americans should have a right to healthcare proved to be very controversial in some communities. A few individuals felt very strongly, for moral reasons, that Americans should have a right to healthcare that is guaranteed by the U.S. Constitution. Some became more specific. *"I'm not sure we have a right to healthcare,"* said a public health official. *"But I'm sure we have a right to health."* Others resisted the idea of healthcare as a right because of the legal obligations that go with establishing rights. In one community, a hospital CEO recommended a middle-ground response to the question: *"Rather than say healthcare is a right, let's say healthcare is a privilege to which everyone should have access."*

> *Our system has not defined healthcare as a human right. Most people do not fully understand that they have a collective responsibility to support and fund the healthcare system.*

A social contract has two sides: rights and responsibilities. In the U.S., both sides are exceedingly fragile. Although Americans have funded Medicare and Medicaid programs through taxes since 1965, healthcare leaders say they don't think most people fully understand that they have a collective responsibility to support and fund the healthcare system on which they depend. While we all want and expect high-quality healthcare, we are not anxious to pay more for it, nor are we enthusiastic about paying for other people's care.

In our society, we have little appreciation of healthcare as a common good that requires substantial pooling of community resources. *"We do need to get the country to understand that with all rights come responsibilities,"* said a New Hampshire participant. *"Everyone has a responsibility for paying for [healthcare],"* said a healthcare attorney. *"We should be asking, what am I willing to give up, and what am I willing to pay for?"*

A North Carolina leader pointed out that, *"In our society, health has such a broad definition that to talk about a social contract is difficult unless we define health and healthcare."* A journalist wondered if it would help to initiate a public conversation about what is a public good. Americans should be asked: *"What's a shared responsibility versus what is personal?"* A health policy expert in another community stated that, *"The reality is that healthcare is both a public good and a private good. Not one or the other. They are blended. The challenge is sorting them out."*

It was suggested in several communities that the public education system could provide a model for viewing healthcare as a right. *"We've reached a consensus that there is universal entitlement to elementary education, but that Harvard and Yale are not for everyone,"* said a San Diego participant. Perhaps there should be universal entitlement to a basic level of healthcare as well, several leaders suggested. But if healthcare is to be universally available, there must be adequate funding for it.

During the roundtable discussions, participants were also asked whether the United States should have a social contract for healthcare and, if so, to describe what it would look like. The general consensus was that we should define more explicitly Americans' rights and responsibilities vis-à-vis the healthcare system but not necessarily codify them in a formal *"contract."* As a Florida healthcare leader put it, *"The social contract needs to be for health, not healthcare. This is going to be a multi-generational effort.... As a country, we haven't embraced health yet as a priority."*

> *Healthcare is both a public good and a private good. The challenge is sorting them out.*

Before the healthcare system can move forward, leaders say, we need to go back to square one and talk about the values and principles that should be the underpinning of our nation's healthcare policy. Both the American public and the healthcare system would certainly benefit from an explicit discussion about the connection between people's self-interest and the public welfare.

But healthcare leaders also recognize that developing this kind of agreement will be difficult. Our country has a long history of conflict between competing political ideals: social equality and fairness on the one hand, versus personal responsibility and self-determination on the other. ***"These are two very powerful belief systems that have endured for more than 200 years,"*** said a medical ethicist. ***"There is no good principle to balance the ideals of social equality and libertarian self-determination."***

***"We can't rush this,"*** said a Portland participant, citing the strong individual rights mentality in this country. While we may not need to reach complete agreement among the American public and policymakers, any reform effort will have little chance of succeeding if these conflicting issues are not openly addressed.

> *There is no good principle to balance the ideals of social equality and libertarian self-determination.*

## Public Expectations

Public Expectations

Community leaders say that discussion of a social contract for healthcare will have to zero in on the issue of expectations. What can Americans reasonably expect from their healthcare system, and what are the trade-offs? So far, there is no clear answer. But there is a feeling among healthcare leaders that the public's current expectations are often out of line with the reality of what the healthcare system is able to deliver. And, in general, the public does not accept the notion of trade-offs when it comes to healthcare.

Community leaders have two main concerns about the public's expectations of the healthcare system. One is that expectations are very high, to the point of being almost unlimited. ***"I think the social contract right now is that people expect everything, everywhere, right now, and for ten dollars,"*** said an insurance company executive. A union official agreed with the statement. Healthcare leaders say consumers seem to feel entitled to the highest quality care available, and at little or no cost to themselves. ***"I see an increasing number of patients who have an almost angry sense of entitlement to healthcare,"*** said a physician. ***"And they think it shouldn't have to cost them anything."*** A leader in San Antonio asserted that, ***"the problem is how to reform an entitlement which has now been passed down to this generation to resolve."***

The other concern community leaders have is that many consumers and patients may fail to appreciate the connection between their personal demands for healthcare and how those demands affect the healthcare system and others dependent on it. Consumers, understandably, tend to be concerned about their individual circumstances, such as whether they have access to quality healthcare at a price they can afford. But they often do not consider how their choices draw on a limited pool of healthcare resources on which other people also rely. Some healthcare leaders point out that in today's system, consumers are not even given the opportunity to consider how their use of healthcare resources affects others. They are not provided with the true cost of various care options.

> *"What can Americans reasonably expect from their healthcare system? What are the trade-offs? The medical delivery system has created unrealistic expectations."*

Community leaders say they recognize that they need to do a better job of communicating to the public that there are limits to what the healthcare system can do. *"Consumers need to understand the rules of the game and the limitations of healthcare,"* said a hospital association executive. *"The medical delivery system has created unrealistic expectations through our marketing."* The public needs a better understanding that when it comes to healthcare, we are all in the same boat and we all have to paddle.

## Defining & Confronting the Problem

The community roundtables' participants agreed that one of the most frustrating obstacles to addressing problems in healthcare is the public's lack of concern. Most individuals, as well as their elected officials, don't seem to appreciate that there are enormous challenges facing the healthcare system or how those challenges undermine not only healthcare but also the economy and society. Consumers may notice their premiums and co-payments going up each year, but they don't see how their own situation ties in to the overall system of healthcare financing and delivery, a system upon which the United States spent 14.1% of the Gross Domestic Product in 2001.

***As a nation, we need to acknowledge the serious problems facing healthcare.***

Healthcare leaders say they would like to see our country confront, head on, the fact that our healthcare system is facing serious problems. This is a fundamental principle on which community healthcare leaders agree. In many areas of the country, healthcare—especially the safety net—is crumbling under the strain of too many demands and not enough resources. The public has to be educated if people are to understand what is at stake, both for the nation and themselves.

There are some hopeful signs that the public wants to engage in healthcare policy. A New Hampshire participant noted that in Montpelier, Vermont (population approximately 8,000), 500 people showed up at a local hospital one night to talk about the healthcare system. *"So people do care,"* he said.

These kinds of efforts are going on in many parts of the country and should be encouraged. Healthcare leaders say that an educated and concerned public would, hopefully, light a fire under its elected representatives to address the problems in healthcare. ***"Fundamentally, you've got to have leadership at the top. That's the President and the Congress, for a start,"*** said a San Diego participant. ***"They have to step up to the plate, make some hard decisions, and communicate that."***

But too many elected officials are not well informed on healthcare policy. ***"The group that really needs educating is our legislators,"*** said a Portland participant. A lot of legislators not only lack information on which to base their health policy decisions, some of them lack any interest in the subject. ***"Our county commissioners couldn't care less if we [public hospitals] live or die,"*** said a public hospital executive. There has to be an effort to educate and engage consumers, including patients, and policymakers on healthcare issues. Not much progress can be made without political leadership and consumer support.

> *There is an urgent need for honest and articulate leadership that demonstrates candor and integrity and focuses on the question of where the nation's healthcare is headed.*

***Healthcare stakeholders must come together to engage the public and find solutions.***

Healthcare stakeholders can play a critical role in educating and engaging the public on healthcare issues, but first they have to be willing to come together and cooperate on a common agenda. Community healthcare leaders say they want their colleagues to understand the value of coming together in the interest of the healthcare system as a whole to develop solutions.

These leaders say that more unites the healthcare sectors than divides them. Yet each sector typically brings its own narrow perspective to policy discussions with the goal of protecting and promoting its own self-interest rather than advancing what would be in the interest of the community.

The healthcare industry has often acted as one of the main obstacles to advancing healthcare reform. ***"We're in a real battleground of special interests,"*** said a North Carolina participant. ***"Year after year, issue after issue, it's the special interests that block change."*** A Mississippi participant agreed: ***"The special interest groups have the loudest voices."***

Admittedly, there is often sharp disagreement within the healthcare industry about where the system should be headed. ***"You get quickly into politics and self-interest,"*** said a Portland participant. ***"There is too much that people have a stake in, and they're not ready to give it up."***

> *Each sector typically brings its own narrow perspective to health policy discussions, rather than advancing what would be in the interest of the community.*

But healthcare leaders in many communities said they want to create an environment that makes it safe for stakeholders to talk about these differences. The scope of the problems facing healthcare demands a greater effort at cooperation, they said. ***“There is a lot of distrust in the system,”*** a Jackson participant acknowledged. ***“But until we understand the perspectives of other sectors, we're going to keep having problems.”***

Almost a decade after the Clinton healthcare reform effort collapsed, healthcare leaders say they would like the various sectors to be able to talk openly and begin moving toward a collective agreement on the future direction of healthcare. But to begin that process, the various healthcare sectors must stop pointing the finger of blame at each other. ***“All stakeholders need to have a voice in the design of the answers and to leave blame outside the door,”*** said a Ft. Lauderdale participant.

We need to launch a national, community-based dialogue about what trade-offs healthcare stakeholders would accept. Quality care should be clearly defined. Providers should be open to moving quality indicators forward and to being evaluated by them. Insurers should allow access to the pricing of healthcare services. Consumers, physicians, hospitals, and insurers need to understand that in healthcare there have to be trade-offs.

## A National Dialogue

A North Carolina physician executive noted that in the last 10 to 15 years there have been two major attempts at initiating broad-based dialogue on healthcare reform. One was in Oregon under the leadership of Governor Kitzhaber. The other was in Washington, with the Clinton plan. A number of participants noted that the two efforts used very different strategies for developing a healthcare reform plan.

Oregon used a very open, “bottom-up” process to develop its policy proposal whereas the Clinton plan was shaped through a relatively closed, top-down process. A number of healthcare leaders in different communities spoke favorably of the Oregon approach, which they said achieved buy-in from the community on some very difficult choices. However, a Washington thought leader pointed out that while Oregon was successful in defining how services paid for by government would be prioritized, the attempt to do this for the state as a whole produced a plan that was voted down.

> ***“We need a new way of talking about values. The place to start is to reacquaint people with their place as part of the community. We've replaced a sense of community about healthcare with a sense of entitlement.”***

Nonetheless, the majority of participants in all communities seemed to agree on the need for a broad and explicit public discourse aimed at developing a national vision for healthcare. A small minority expressed caution. ***“It's hard to get people together and get them on the same page,”*** said a journalism professor. ***“It's important work, but it's hard to get people thinking in new ways.”*** Nevertheless, he said, it's worth trying.

A New Hampshire participant said that in his view, ***“an explicit debate is unnecessary and probably divisive. Sometimes it's better***

***not to state the obvious."*** A Portland participant also expressed concern that if a national dialogue focuses on calling attention to the crisis in healthcare, it could produce ***"a political vortex of blaming. The place to start is to reacquaint people with their place as part of the community."***

If it is to occur, a national dialogue must be initiated at the most basic level by trying to develop a common understanding of Americans' rights and responsibilities vis-à-vis the healthcare system. ***"We need a new way of talking about [values] to better reflect where we are today,"*** said a hospital association executive.

Other advanced industrialized countries that have had this kind of national conversation have benefited from it. But there has been little attempt to really lay healthcare issues on the table for Americans to fully understand and consider, which has left our country without a social contract for healthcare that is well articulated and broadly understood.

As a result, there is a lack of common vision that could act as a counterweight to those forces that tend to act as a barrier to reform. ***"The common thread is that opponents of change are those that have struck the jackpot with the current system,"*** observed a North Carolina attendee. There is difficulty even talking about a common vision for healthcare. ***"I'm concerned that we've lost the ability to have a social discourse,"*** said a Portland participant. ***"It's more about 'me, me, me,' at the national level than about giving."***

There is an urgent need for honest and articulate leadership that demonstrates candor and integrity and focuses on the question of where the nation's healthcare is headed.

### *Discussion should begin at the community level, as well as in Washington.*

Participants in every community said that it is important for national political leaders to put healthcare on the agenda, but they added that people also need to start talking at the state and community level. ***"Healthcare, like politics, is local,"*** said a San Antonio participant. ***"Solutions should be local solutions."*** An insurance executive in Salt Lake City agreed: ***"The grassroots level is where things get done."***

Community-based dialogue offers several advantages. One is that policies determined at the community level are likely to be based on the actual conditions in a community, where people know what works in their area and what doesn't. Americans live in a diverse country where values and priorities differ from one community to another. ***"The genius of this country is innovation and diversity,"*** said a New Hampshire participant. ***"What works in Vermont may not work in Texas."***

> *"Healthcare, like politics, is local."*

Another advantage of the community-based approach is that healthcare sectors are more likely to work together productively within their own communities than they are in the polarizing atmosphere of Washington. ***"There is so much lobbying in Washington that prevents change,"*** in the words of a Ft. Lauderdale participant. But healthcare leaders in a particular community tend to know each other well and are accustomed to working with each other, which provides a foundation of trust and collegiality.

Additionally, a community-based discussion is likely to pull in participation from ***"the grassroots"*** – that is, it is likely to include the consumer voices that need to be heard throughout the process. ***"The effort needs to get out to the grassroots and it needs to reflect grassroots***

***values or it won't be sustainable,"*** said a Ft. Lauderdale participant. Healthcare leaders say they believe consumer and patient voices are too rarely heard at health policy roundtables.

Oregon participants noted that their state has demonstrated that states can achieve health system change by inviting the public into strategic discussions on healthcare policy. By directly involving the public in decisions on how resources should be allocated, the process enhanced the community's sense of having a stake and a voice in its healthcare system.

***The dialogue should include all voices, especially those of consumers and patients.***

Participants said the problems in healthcare require a new kind of conversation—one that brings in a diverse, grassroots perspective and reflects a community's values and priorities. Only then can we get to the kind of healthcare system that people want and are willing to support. The conversation ***"has got to be very broad-based, community-based, with consumer input,"*** said a health system CEO. ***"Healthcare is so personal."*** A North Carolina participant offered that, ***"It has to be an action-oriented dialogue."***

Policymakers need to hear directly from consumers. ***"I don't think we should be the ones deciding what they need,"*** said an Albuquerque participant. ***"That's not to idealize the consumer, but they ought to be the ones dictating what they need."***

The consumer needs to have a voice. ***"We need to get to the 'Oprah' level of dialogue,"*** said a Chicago participant. This level of dialogue includes consumers but also ethicists, clergy, and community leaders that don't have a direct role in healthcare but who can attest to the important role that healthcare plays in society. ***"There is incredible power…in a figure like Cardinal George of Chicago saying, 'We value this.'"***

Transforming

## Transforming the Role of Consumers

Community leaders generally agree that the most important step in moving forward with health system change is a re-examination of the way that consumers function in the healthcare system. Already the healthcare market is evolving in a direction that provides consumers more choice but also requires of them greater responsibility. At the same time, consumers seem to be yearning for more control over their own healthcare. Many are seeking more information about their treatment and provider options.

> ***"To the best of their ability, consumers should assume more stewardship for their healthcare. But, not all consumers want to be 'empowered' or can be."***

Traditionally, consumers have taken a relatively passive role in their healthcare. They've trusted that their doctor will tell them what they need to know. Their choice of health plans and providers has been limited. They've had little information on which to judge the quality of providers that are available to them.

Though consumers didn't create it, this traditional role has unfortunately led to many of the problems in healthcare today, particularly in the area of costs. Many participants say that people are not used to thinking about cost as a factor in their healthcare decisions. Because the current healthcare system does not readily allow consumers and patients to obtain information about actual prices of healthcare services, they have little or no incentive to restrain the cost of their care.

However, some point out that there is an important distinction. While *"consumers,"* individuals on the healthier end of the spectrum, can and should be held accountable for choosing efficient health plans and healthcare services. *"Patients"* on the other hand, are much more reliant on their care providers and others they trust when it comes to decision-making.

Healthcare leaders say many consumers seem to have lost sight of the fact that someone must pay for the care they receive. A New Hampshire participant described this as *"almost a child-like behavior"* – consumers feel entitled to virtually anything, without limit or responsibility.

This concern was echoed at one roundtable discussion after another. *"We've replaced a sense of community about healthcare with a sense of entitlement,"* said an insurance company CEO. *"Too large a percentage of our population believes they can do anything they want, and when they get into trouble the doctors and hospitals will be there to help them,"* said a business leader.

Although many consumers may not be well-informed about their healthcare decisions, providers and other stakeholders share responsibility for our current healthcare climate. *"[We] create expectations by giving antibiotics for upper respiratory tract infections even though it's wrong,"* said a physician. Consumers may feel entitled, but they have been removed, to a large extent, from the decision-making loop. *"To get them back in will be very difficult,"* said a Chicago participant. *"The consumer needs to be re-thought as a focal point,"* added another. A consumer advocate in North Carolina pointed out that, *"I think we need to appreciate the fact that people want to participate in healthcare; they just don't have the opportunity."*

> *"The consumer needs to be re-thought as a focal point."*

Healthcare leaders say they want to move the system in a more patient-centered direction—one that will give individuals more control over their healthcare while also constraining cost growth. This will require that people be given both responsibility for their healthcare and the tools and incentives to make good choices. For example, they will need reliable information about cost and quality, to help them compare providers and participate in shared decision-making *"I think the magic bullet might be consumerism,"* said a Chicago attendee. *"But it's important to look at small steps…."*

### *To the best of their ability, consumers should assume more stewardship for their healthcare.*

There is broad support for more consumer responsibility, but there is also recognition that it needs to be balanced with much more institutional and organizational accountability. In many communities, leaders from different sectors emphasized that efforts to promote *"consumerism"* and personal responsibility must avoid any hint of *"blaming"* individuals for their health conditions. They recognize that there are limits to the responsibility that sick and vulnerable people can assume. *"The individual's responsibility goes only so far,"* said a Chicago participant. *"In a wide range of areas, there are things that individuals*

***are not in charge of, and we have to take that into account."***

A significant number of Americans will continue to rely on the safety net for their care .It's not just the poor or the poorly educated who need the safety net. It's also those who are chronically ill, disabled, or mentally ill, and those who need long-term care. As one New Hampshire participant observed, ***"Lots of choices and information work great for a shopper. But a sick person's world contracts dramatically. So I'm a little skeptical of pushing choices on sick people."*** A healthcare leader in Portland pointed out that, ***"Not all consumers want to be 'empowered' or can be."***

However, most healthcare leaders seem to agree that until consumers understand the economic consequences of their healthcare decisions, they will continue to feel little responsibility for costs. During the past few decades, employer-sponsored managed care plans have increasingly distanced consumers from the true costs of their care. ***"The patient has no idea what the cost of care is,"*** said a San Antonio participant. ***"They know their premium and co-payment, but not the full cost of their care."***

As a result, many consumers believe their benefits package should provide unrestricted access to all forms of healthcare and to all healthcare providers. ***"I think these ideas are in the minds of the public, but it's fantasy,"*** said a Salt Lake City participant. Consumers should recognize that the healthcare system operates under certain financial constraints. They can't all have unlimited access to top-quality healthcare services at little or no cost to themselves. ***"We need to re-introduce the public to the reality of what healthcare costs,"*** said a Portland participant.

In order to facilitate this process, health plans must work to increase transparency, so that consumers and patients can better access financial information about healthcare services. Communities should encourage dialogue about the types of trade-offs that consumers, patients, providers and other healthcare stakeholders would be willing to accept in healthcare services. The definition of ***"quality"*** care and access to that care should be the responsibility of all stakeholders.

The goals of empowering patients and rationalizing utilization are currently driving interest in a concept called ***"shared decision-making,"*** which enables patients to play a greater role in decisions about their own care. Dartmouth studies have found that informed patients who have support in decision-making tend to be more satisfied with their course of treatment. They also tend to choose the option that is most conservative—in other words, the option that is less risky, less invasive, and generally less expensive. This new paradigm of medical decision-making has found growing support in the healthcare communities of northern New England, where it is currently being tested.

### ***People need support, education and incentives to help them make health a priority.***

In community after community, healthcare leaders expressed alarm over the increasing prevalence of chronic illnesses that are related to lifestyle. As a cancer society representative pointed out, ***"thirty percent of cancers are due to behavioral issues."*** The challenge is to get people to change their behaviors before illness develops. ***"If you can get people educated before they have pain and see blood, you can go a long ways,"*** said a Ft. Lauderdale participant.

Healthcare leaders are particularly worried that the number of obese children and adults is rising across the country and so are the chronic conditions—such as diabetes, hypertension and heart disease—that result. They point out that obesity not only affects people's quality of life and longevity, but also leads to enormous and unnecessary costs for the healthcare system. A tremendous amount of resources are being spent to treat illnesses that could have been prevented had those patients made healthier choices.

Given the toll that obesity has taken on our society, something has got to be done to help Americans better manage their weight. This is not easy in a country where unhealthy food is plentiful and cheap and many people lead sedentary lives. *"The popular culture and business interests are going the other way"* by marketing fast food, said a Chicago attendee. *"We have an epidemic of obesity, but McDonald's is super-sizing everything."*

In spite of these challenges, healthcare leaders said there has to be a focused effort to help people maintain a healthy lifestyle. *"We need a national campaign to reach the public on health as a priority,"* said a Ft. Lauderdale participant.

> *Educating patients is something the healthcare system has really ignored. Address behavioral change that is long term.*

*"Educating patients is something the healthcare system has really ignored,"* said a physician. Patients don't know how to care for themselves and stay healthy. Instead, they are bombarded with advertising for pharmaceuticals that seem to fix any condition. *"I spend so much time deprogramming patients from wanting [a drug], which they see on TV every night,"* the physician said.

Several healthcare leaders recommended developing a unified message on the importance of healthy lifestyle choices but tailoring the message to different audiences. *"Address behavioral change that is long term,"* suggested a public health officer. *"And it has to be marketed and targeted."*

Several leaders strongly recommended a particular effort to target children. *"As [the percentage of] chronically ill patients grows, we're really missing the boat on prevention by not getting kids when they're young,"* said a Ft. Lauderdale participant. *"The numbers are rising and I fear where we're headed."*

There was general agreement that health education should be taught in the public schools to a much greater extent than it is now. It was noted that despite the rising numbers of obese and overweight children, physical education classes are often among the first items cut when schools have budget problems. In some states, sex education is not even taught in the public schools. Participants said there is a need to make health a priority in the school curriculum. A community health leader in North Carolina said, *"If we are really going to talk about prevention, we need to talk about what is taught to kids in school."*

Other ideas for promoting health include educating young mothers, improving the nutritional content of school lunches, giving people a certain amount of time off work each day to exercise, and providing wellness programs in the community. In fact, a growing number of community-based organizations offer wellness programs that are tailored to the needs of their members.

Healthcare leaders say they would like to see a broad-based effort aimed at supporting and encouraging people to make healthy choices, but most say it should be done without taking a punitive approach.

There was discussion in some communities about whether consumers should have to pay more for their healthcare if they make choices they know are unhealthy, such as choosing to smoke or to remain 100 pounds overweight. There is some support for charging higher premiums to smokers on the grounds that they are causing themselves serious health conditions that are costly to treat. But most rejected the idea. *“I have a strong reaction to this punishment approach to ill health,”* said a consumer advocate. *“When you look at populations where obesity is most prevalent, it looks like punishing poor people and people of color.”*

Although most healthcare leaders are opposed to using punitive measures to encourage healthier lifestyles, they are open to ideas that provide positive rewards for healthy choices. Many consumer advocates believe that the real focus should be creation of incentives that encourage individuals to engage in processes that reduce health risks, such as compliance with age-appropriate risk reduction behaviors. Participation rather than results should be rewarded, in order to avoid any potential discrimination against individuals who, because of genetic or other factors, are unable to achieve a particular goal.

Restoring

## Restoring Confidence and Trust

During the roundtable discussions, participants were asked what they thought the attributes of a well-functioning healthcare system were. In response, many healthcare leaders said they consider trust, at all levels, to be a fundamental attribute and a value that must be emphasized in healthcare. It is a priority to ensure that people feel confidence in the healthcare system. But many leaders recognize that healthcare institutions have lost much of their credibility with the public. *“We, as an industry, have a big credibility issue,”* said a hospital CEO. Reduced trust in the healthcare system *“pervades what we’re doing,”* said an Oregon participant.

> “*The healthcare industry has a big credibility issue!*”

Unfortunately, patients have good reason to be wary. *“There is a lot of dishonesty in the system,”* said an Albuquerque participant. *“We need to ask ourselves, can our organizations bring more honesty?”* A lack of transparency about quality and price makes it particularly difficult for patients to feel confident they are receiving optimal treatment at a reasonable cost.

Skepticism is also prevalent among employers. *“We in business and I as an individual don’t trust you as an industry,”* said a business CEO. The business community is particularly skeptical of the healthcare system’s willingness to rein in costs. The healthcare community recognizes that many employers don’t trust them. *“Doctors want to be a patient’s advocate,”* said a physician executive in Mississippi. *“But if doctors are unwilling to consider population health, we’ll never control costs.”*

***Patients should be able to understand and trust the healthcare system.***

Right now, many patients do not feel a lot of confidence in their healthcare institutions. One reason is that they don’t think they are getting all the information they need from their providers. They don’t know if their providers are recommending certain kinds of treatment because it is in the patient’s best interest or because of financial incentives.

In addition, consumers are wary of the health insurance industry, particularly when it comes to assisting with quality healthcare decisions. As noted, increased transparency is needed for both the price and quality of services.

There is a lot of confusion. Many consumers find the healthcare system very difficult to understand. Indeed, healthcare is very complex, even for those who are savvy and educated. ***"I can't navigate my own benefits,"*** said a health plan executive. ***"And I'm in the industry!"***

> *A lack of transparency about quality and price makes it difficult for patients to feel confident they are receiving optimal treatment at reasonable cost.*

A number of changes would encourage patients to have greater confidence. One such change would be to provide them with better information about cost and quality throughout the system. Public trust is at an all time low, and without transparency, there can be no trust. ***"There is virtually no transparency in healthcare,"*** said another health plan CEO. ***"People need to be able to determine very quickly whether they are getting good healthcare,"*** said a San Antonio participant. ***"If they can't determine that, they won't be willing to pay for it."*** Currently, there is little reliable data available to patients about physicians, hospitals or health plans.

In many cases it is the healthcare industry that is resisting disclosure, said a Chicago participant. Whenever someone tries to put out data on providers, ***"whoever's ox is gored says the data's no good."*** But without information, patients cannot realistically be expected to make informed choices, and they cannot feel much confidence in their care.

Another critical issue related to confidence is the cultural competence of providers. People who are newly arrived in this country and have limited English proficiency face particular challenges in understanding the healthcare system, which often results in a lack of trust. A lot of immigrants run into problems accessing healthcare because they can't find a provider who is culturally sensitive to their needs. ***"My concern is the growing multicultural population and our inability to reach them,"*** said a healthcare professional in Florida. ***"It costs much more to care for them because they do not understand the system and they face other challenges, like financial needs."*** Another participant in the same meeting said that, ***"immigrants have a different view of accessing healthcare."*** In essence, if they can't find someone they are comfortable with, they will use the ER when they need care.

> *It costs more to care for the growing multicultural population because they do not understand the system and face many other challenges.*

***Patients must be able to trust that their physician is acting in their best interest.***

If patients are to have trust in the healthcare system, they must first have confidence in their own physician. They need to know that their physician is both competent and acting in patients' best interests.

Healthcare leaders say patients should be encouraged to develop strong relationships with their physicians and other healthcare professionals, with minimal interference from outside pressures. ***"Expecting patients to understand their choices without some trust in a practitioner is not realistic,"*** said the president of a state medical society. ***"The physician needs to know a patient over time to really make a good assessment, so continuity of care is essential."***

At the same time, there is recognition that physicians have a responsibility to use evidence-based medicine when treating patients. ***"To simply say 'trust your doctor' is absurd,"*** said a Chicago participant. There have to be practice standards and the standards have to be followed. Some participants say there should be consequences for physicians that do not adhere to evidence-based guidelines.

The integrity of the patient-physician relationship also requires that physicians play a key role as healthcare educators. ***"The central role of the doctor is to teach,"*** said a Chicago participant. ***"To fail to take advantage of that is really to miss a central point."*** But the current financial model does not reimburse doctors for talking with their patients.

> *To simply say "trust your doctor" is absurd!*

Given the enormous benefits of making sure patients are informed, there should be incentives for physicians to educate. They must also be allowed enough time in their schedule to communicate fully with patients and discuss issues such as compliance with prescription medication, treatment options, and preventive care.

***Healthcare professionals should feel confident their work is valued and supported.***

Trust is a two-way street and the healthcare professionals that serve patients should also be able to feel confidence in the healthcare system. They need to feel their work is valued and appropriately compensated. But there is a tremendous crisis of confidence in the healthcare professions these days, participants said. In many places, morale in general is low and frustration high.

Physicians are reporting increased dissatisfaction with the constraints under which they must practice. Feeling squeezed between high malpractice insurance costs and low reimbursement, a growing number are choosing to retire early or switch to other careers. Physicians have been knocked off their pedestal, said a Portland participant. ***"Some of them needed it, but we're paying for it with morale issues."***

There is concern that talented people are becoming less interested in pursuing healthcare careers. It was noted that 20% of surgical residencies went unfilled during the past year. Many communities are facing a shortage of physicians in certain specialties.

A large part of the problem for physicians is liability. In many states, a growing number of physicians can no longer afford their malpractice insurance premiums. Liability costs have made it unaffordable for them to practice. ***"We're punishing the good guys for the sins of the bad guys,"*** said a physician. ***"ER docs are in a horrible quandary."***

In every community we visited, people said government must act on tort reform. ***"The professional liability system is strangling us,"*** said a healthcare leader in Salt Lake City.

It's not only physicians that are experiencing workforce problems. Many communities are even more worried about the nursing shortage than they are about a shortage of physicians. There are just not enough nurses, said participants. Not enough people see nursing, with its heavy workload and other pressures, as an attractive field.

***"Why aren't young people going into nursing and other healthcare jobs?"*** asked a Ft. Lauderdale participant. ***"We need to recognize that all of the players [in the healthcare delivery system] are important in their own right,"*** responded a hospital CEO. ***"We ought to show our appreciation."***

## Spending Money Wisely

> *"We're not talking about where we're going. We're just talking about who's going to pay. Our ability to <u>do</u> is growing much more rapidly than our ability to <u>finance</u>."*

Healthcare leaders recognize that the issue of financing is at the heart of our nation's healthcare crisis. As one San Antonio participant observed, ***"Right now we're not talking about where we're going. We're just talking about who's going to pay."*** A policy expert in San Diego put it this way: ***"Our ability to do is growing much more rapidly than our ability to finance."***

Some participants called for making a larger investment in healthcare, particularly once the baby boomer generation reaches the age of Medicare eligibility and begins driving up the demand for healthcare. ***"What better use of our money is there than healthcare?"*** asked a San Antonio participant.

But others maintain that the U.S. already spends more than enough money on healthcare, noting that the U.S. spends a far higher percentage of its Gross Domestic Product on healthcare than any other country in the world. The problem, they say, is that the dollars are poorly allocated. ***"For the vastly more expensive healthcare in the U.S., we can't demonstrate that we get better outcomes than other advanced, industrialized nations,"*** said a Salt Lake City participant. ***"Before we spend more, we ought to spend more effectively."***

A number of healthcare leaders pointed out that the nation's healthcare system is out of balance with regard to how resources are used. ***"We spend too much and too little,"*** said a healthcare leader in Chicago. In Salt Lake City, we heard that, ***"We're spending what we want to spend. Do we want to decide to spend it differently?"***

There is tremendous waste and over-utilization in some areas and for some people, but there are also many people who are not getting the care they need because they cannot afford it. Eliminating waste and reducing over-utilization are certainly efforts that have the support of the healthcare community. A lot of money could be saved. But these leaders also point out that some areas of the healthcare system—such as public health, mental health and behavioral health—are dangerously under-funded and merit greater investment.

They also point to other areas of the healthcare system that deserve more funding. At the top of the list is addressing the issue of the 40 million or more Americans who are uninsured at any given time. There is broad consensus—but not unanimous agreement—that basic, affordable healthcare should be available and accessible to everyone in the United States. It makes sense not only from a moral standpoint, but also from an economic one.

> *For vastly more expensive healthcare in the U.S., we can't demonstrate that we get better outcomes than other advanced, industrialized nations.*

*It is well worth the money for the U.S. to make basic healthcare available to everyone.*

When participants are asked to name the most critical issues facing healthcare today, the most common response, by far, is *"access,"* meaning that we need to ensure that all people have access to timely and appropriate healthcare and to healthcare coverage.

Over and over again, in every community, healthcare leaders say this is a goal they strongly support. *"A basic level of care should be available to everyone,"* said a San Antonio participant. *"If we want to move forward on healthcare, then we must agree that all people deserve access,"* said a participant in San Diego. *"I don't think single payer will work in our country, but we've got to get the coverage,"* added another in Mississippi.

Many of the leaders mentioned moral reasons for their position in favor of universal coverage. *"The measure of a healthcare system is how it cares for the 'have-nots',"* said the CEO of a community health center. *"So the values there are equity and universality."*

Some healthcare leaders caution that Americans who are insured may not be willing to make significant sacrifices so that others can get healthcare coverage. *"Will the majority of the voting public support giving something up to get everyone covered?"* asked a psychologist. But others countered that all Americans stand to gain from a system of universal coverage, though the general public may not realize it.

> *Community leaders support a basic level of care for everyone. The measure of a healthcare system is how it cares for the 'have-nots.'*

They say it would be money well spent to make sure that all U.S. residents have at least a basic level of healthcare coverage. Universal coverage would allow those who are currently uninsured to access primary and preventive services so that illnesses are detected and treated early on and they could stop relying on expensive emergency room care. *"Coverage means better care and it reduces the cost of care,"* said a state Medicaid director.

They think the argument can be made to voters that lack of coverage for some people threatens the quality of care for everyone. *"More people realize now [than in the early 90s] that the uninsured*

***represent a threat to all of us,"*** said a primary care physician in a community health center.

Once there is agreement on the need for universal access to basic healthcare, the question becomes, what is ***"basic"*** healthcare? Even with universal coverage, there is likely to be a tiered system, although one healthcare leader in New Hampshire strongly objected to the concept. ***"Tiered healthcare exists,"*** he said, ***"But I don't think it should be an accepted assumption."***

Others view it as a given. In fact, one prominent healthcare researcher pointed out that currently, ***"We've got a thousand-fold tiered system in this country [based on geography]."*** A Ft. Lauderdale participant said, ***"We have to recognize that not everyone can have everything, but we all need the basics."*** One in Mississippi said, ***"A lot of people won't like it, having a two-tier system. But I think it's all we can afford."*** However, another participant in that meeting added that ***"basic coverage cannot be two-tiered; physicians need to be required to provide the basic services."***

***Public health infrastructure, prevention and chronic disease management should be funding priorities.***

Another important area of healthcare that deserves a greater investment is public health. In many communities, the public health infrastructure badly needs more resources. ***"There's been a terrible decline in public health capacity,"*** said a healthcare leader in Salt Lake City. ***"The public health system, which is intended to make the healthcare system more effective, is in serious jeopardy,"*** said a San Antonio participant. ***"There are not enough dollars."***

> ***"There has been a terrible decline in public health capacity. We need to incentivize outreach, prevention and early intervention."***

In several communities, participants said there needs to be much more effort put into education, prevention and early intervention, especially for those who are underserved, and that these activities tend to be the function of the public health departments. Again, this would provide a great return on investment by addressing health problems on the front end—or even preventing them—rather than waiting until later when treatment becomes much more expensive. ***"We're patching up people that don't need to be sick in the first place,"*** said a public health professional.

There is a need to put more resources into public health's ability to do consumer outreach. Medically underserved patients often lack basic information about preventing illness and injury. Someone has to be providing education on nutrition and exercise. ***"We need to incentivize outreach, prevention and early intervention,"*** said an Albuquerque participant. ***"Rather than have consumers come to us, let's go to consumers."***

In addition, looking at the demographics of our population, the prevalence of chronic illness and costs associated with its management will continue to grow. Investment in chronic disease management should be a greater priority in the healthcare system.

***Mental and behavioral health should be a greater priority in overall healthcare.***

There is broad agreement among community healthcare leaders that mental health and behavioral health are essential services that need to be integrated into the overall continuum of healthcare. But too often this aspect of healthcare is overlooked and under-valued in the healthcare system. *"Mental health is paid at the level of a step-child,"* said a participant in San Antonio.

Integrating mental and behavioral health services with physical healthcare would have two advantages. First is that it recognizes that these two aspects of healthcare are, in fact, indivisible. There is increasing understanding that mental health and physical health are interrelated. Treating one side of the equation while ignoring the other is inefficient and ineffective.

*"The integration of psychological intervention with physical healthcare, rather than the separation of the two, can save costs and be more effective and more efficient,"* said a San Diego participant. *"Right now we see a bright line between the two."*

The second advantage is that integrating mental and behavioral health into healthcare could have a significant impact on prevention and health promotion. There tend to be psychologically based reasons that people take up smoking or use drugs or let their diabetes spiral out of control. Therefore, mental and behavioral health services can play a key role in reducing these types of unhealthy behaviors that drive up healthcare costs.

> *"Mental and behavioral healthcare are essential services that need to be integrated into the overall continuum of healthcare."*

Doing a better job of integrating mental and behavioral health services into healthcare would also have important benefits for society as a whole. *"Over half of our jail population has severe mental illness,"* said a participant in San Antonio. Many of those who are in jail and have severe mental illness haven't received the mental healthcare they need—either before or during their incarceration.

Healthcare leaders said that it is particularly important to do a better job of making mental healthcare available to children, who often go undiagnosed and untreated for far too long. *"If disorders were dealt with early on, a lot of problems could be prevented,"* said a San Antonio participant.

## *There need to be incentives that encourage the right care at the right time.*

Healthcare leaders say they are frustrated by incentives in the healthcare system that often discourage them from providing the most appropriate and effective care. They say there needs to be a vision of healthcare that aligns incentives correctly so that the right care is delivered in the right place at the right time. *"Incentives get aligned very quickly behind whatever the vision is,"* said a Portland participant. *"If we in this system can get clear on who we're here to serve, I think we can get quickly to aligned incentives."*

*Incentives in the healthcare system often discourage provision of the most appropriate and effective care.*

Healthcare leaders say there should be a vision of healthcare that emphasizes the importance of prevention and education, and then backs it up with incentives to provide those services. *"When you look at the determinants of health—lifestyle, heredity, behavior, medical services—we spend most of our money on medical services and only a sliver on the other factors,"* said a San Diego participant. *"How do we move more money to address the lifestyle and behavioral issues?"*

Preventive care – which everyone acknowledges is important—does not get much support from the incentives structure. *"I would love to put in a system that incentivizes preventive care,"* said a health plan CEO. *"But then I wouldn't have any specialists in my network and no one would buy the product!"*

Excellence in care is not rewarded, say providers. *"The current financing system has no recognition of excellence or even of adequate outcomes,"* said a consumer advocate. Nor is efficiency rewarded. An Albuquerque health system executive agreed. *"We are one of the most efficient states…and the federal government rewards us for that with less funding. Washington should reward us for doing a good job."*

## *There should be more emphasis on coordinating care among providers.*

Perhaps one of the first areas of emphasis ought to be creating a true system of care. A public sector official stated that, *"We can no longer tolerate the randomness of the system. We have enough resources…. We just have to do a better job of allocating them—not from the top-down in a centralized way, but coming from communities."*

There is general agreement that better coordination among providers would reduce inefficiencies in the healthcare delivery system, decrease costs, and improve the quality of care that patients receive. Healthcare leaders say there should be more effort and incentives for providers to integrate healthcare services. Gaps in the continuum of care affect all patients, but particularly those with chronic conditions who rely heavily on the healthcare system and often receive little help navigating among providers.

There are replicable models that have proven successful in helping patients to navigate the health system and receive coordinated care. For example, Dr. Harold Freeman has succeeded in implementing a patient navigator program in the urban setting of Harlem in New York City. This program provides patients a well-connected individual to provide services such as answering questions, ensuring coordinated care, assistance with appointments, transportation and referrals, and helping patients access health insurance.

Many large multi-specialty medical groups are working diligently to integrate data systems to enhance communication among multiple providers and streamline care management, especially for patients with multiple chronic illnesses. One example of innovative thinking and action by such medical groups has been the development of Anceta®, the first national repository of de-identified administrative and clinical data from non-affiliated medical group practices. Anceta® is a subsidiary of the American Medical Group Association and is a comprehensive, longitudinal data warehouse that will provide practitioners opportunity to compare their practices and assist patients in understanding their health status or disease state in the context of other patients with similar demographics and diagnoses.

> *Better coordination among providers would reduce inefficiencies in the healthcare delivery system, decrease costs, and improve the quality of care that patients receive.*

Similarly, the Veterans Administration (VA) has taken a lead in this arena. *"Having worked at the VA as a social worker, I saw a multidisciplinary system of case management,"* said an Albuquerque participant. *"I thought it worked very well for patients. As a patient myself, I don't find that coordination of care."*

## Next Steps

Next Steps

Healthcare leaders say that a public dialogue on all of these issues is important, but it is not enough. Discussion—even if it is broad-based and gets to core issues—will not produce meaningful change unless it leads to action.

These leaders confess to a certain amount of fatigue with healthcare discussions that have not led to any substantive change. The Clinton healthcare plan and its failure are still fresh in the minds of many. *"A lot of us have been in these dialogues before,"* said an Albuquerque participant. *"The question is how we can do it a different way."*

> *Leaders are tired of healthcare discussions that do not lead to substantive change. Success has a lot to do with who is driving the process!*

Turning talk into action should be done very carefully, participants warned. *"The Clinton plan was dead on arrival because the public never had a chance to understand what it was,"* said a healthcare leader in Ft. Lauderdale. Others said the Clinton health plan tried to do too much at once. A Mississippi participant voiced the opinion that *"opposition [to the Clinton plan] was so well organized it was impossible to break through."*

As with any effort to make changes, *"it has a lot to do with who is driving the process,"* a consumer advocate pointed out. Articulate leadership that demonstrates candor and integrity will generate respect for the process and credibility for the outcome. *"We need courage and leaders who have the guts to take on these issues with candor,"* said a physician.

This effort will also require broad-based support from the healthcare community and the public, said participants. *"The healthcare community coming together is the way to sell [the vision],"* said a Mississippi participant. But the public also has to be willing to buy it. *"We have to figure out a way to make change more palatable to people,"* said a healthcare leader in Salt Lake City.

This will be an enormous task. All of the healthcare leaders who participated in these roundtable discussions recognize that fact. But they say the effort must be made. The alternative is to watch our *"non-system"* of healthcare continue to drift into deepening crises marked by unsustainable cost growth, growing numbers of uninsured

Americans, workforce shortages, and diminished access to services.

Community healthcare leaders don’t want to let that happen. Their concerns voiced through these discussions demonstrate their desire for action, and action now.

## Chapter 6

# Turning Talk Into Action

During the second phase of the *"Communities Shaping a Vision for America's 21st Century Health and Healthcare"* project, Wye River Group on Healthcare (WRGH) continued the momentum developed during Phase I to accomplish three objectives:

- Raise awareness and engage the public in constructive dialogue on healthcare challenges;
- Identify and encourage community-based leadership; and
- Create channels to enhance the opportunities for national health policy leaders to gain insight from communities.

As this book is focused on shaping public policy, we will describe efforts undertaken in this vein to address these three issues.

10 Questions

## 10 Questions for Political Candidates & Policymakers

As part of WRGH's efforts to raise awareness and engage the public, as well as to educate those leaders involved in crafting healthcare policy, we worked with healthcare and community leaders across the country prior to the 2004 elections to identify the top issues that candidates for public office should focus on.

The questions that follow represent the best thinking of senior executives from across the spectrum of health and healthcare, including the physician, hospital, insurance, employer, public policy and consumer sectors. In a variety of settings, candidates for public office were asked, formally and informally, to consider these questions as a framework for public policy development and execution. While the issues are complex and have no simple answers, theses questions

highlight the core challenges that our nation, our state and our communities face in responsibly meeting the health and healthcare needs of our citizens.

The many organizations and individuals who endorsed these questions and their value to the healthcare debate collectively called on the candidates and policymakers to promote public discourse on these important issues.

*(1) Our country currently has no shared vision for healthcare policy. Do you believe that such a policy/vision is an important predicate to addressing health system deficiencies, and, if so, how would you go about developing one?*

*(2) Do you believe healthcare is a right or a privilege? Should we have a social contract for healthcare the way we do for education?*

*(3) What policy changes would you support to motivate individuals to assume a greater sense of individual responsibility for health-related decisions? How do we get people to understand there are limited resources and trade-offs have to be made?*

*(4) The healthcare system often lacks clear accountability that would encourage adoption of standards of care and quality improvement. How would you go about aligning financial and personal incentives to optimize outcomes?*

*(5) What steps would you take to address the current fragmentation in healthcare to promote continuity and coordination of care and access to the continuum of quality care, including prevention, mental and oral health services, and long-term and end-of-life care?*

*(6) What role can political leaders play in facilitating a change in emphasis in healthcare from high-end acute care to health promotion and prevention of chronic disease and injury?*

*(7) Currently our country has many citizens who lack access*

*to healthcare services because they cannot afford insurance, are underinsured or face social or cultural barriers. What steps would you take to correct this imbalance?*

*(8) What steps would you take to address the medical liability problem and create a legal environment that fosters openness, disclosure and high quality patient care?*

*(9) What steps would you take to relieve providers of unnecessary administrative and regulatory burdens in order to maximize the percent of healthcare dollars that support direct provision of patient care?*

*(10) What role should government play in advancing science-based medicine and technology and fostering a robust healthcare information infrastructure?*

These questions are as valid today as they were when crafted, as the challenges to our healthcare system have yet to be addressed. In fact, many of the problematic issues continue to get worse.

A Statement

## A Statement of Principles for Health Policy

The next step was to work with community leaders to draft a *"Statement of Principles for Health Policy."* This statement, based on the policy recommendations developed in the first *"Communities"* report, showcased at a National Summit in September 2003, reflects the input of dozens of leaders from around the country, and enjoys diverse and broad support.

*As a prerequisite to developing effective health policy, citizens must be engaged in the creation of a shared vision for American healthcare. Healthy people are vital to the health and well-being of the United States and its economy. Appropriate healthcare is necessary for the well-being of individuals, families, and communities.*

*This Statement of Principles is intended to provide a "benchmark" against which health policy proposals should be evaluated. However, taking into account the sensitivity that surrounds language and the use of terms, certain concepts need to be clarified with regard to the Principles as follows:*

*"Basic" - While the definition of "basic" goes beyond the scope of this document, for this 'Statement of Principles' use it encompasses some elements often "siloed," e.g., mental health, oral health and long-term care.*

*"Choice" - The notion of "choice" does not imply that it is without increased cost to the individual.*

*"Universal Coverage" - The term "universal coverage" does not refer to benefits, rather it refers to financing of care through health insurance and other mechanisms.*

*> Every American should have the ability to access basic high quality, safe, affordable, and culturally appropriate healthcare services. Every American should have choice with regard to the provider of these services, and sound, understandable health information to facilitate good choices.*

*> Every American should have some financial responsibility for the cost of his/her healthcare, consistent with ability to pay, but should have access to financing mechanisms that protect against financial catastrophe and promote optimal health for each individual.*

*> Universal coverage of basic healthcare services and the elimination of health disparities should be a major goal of national health*

*policy. The strengths of the current public-private system should be used in advancing toward this goal.*

- *Every provider should be responsible for practicing according to current standards of care and, in return, should receive fair reimbursement.*
- *Every American should be responsible for taking all reasonable steps to preserve his/her health.*
- *Education about health and the appropriate use of healthcare services should be integral components of the U.S. public educational curricula and our nation's healthcare system in order to promote patient-provider partnerships that maintain and improve individual health.*

We believe that these principles continue to represent a sound basis for decision-making, as they reflect the values of many Americans. Health policymakers should ensure that legislative and regulatory proposals align with the tenets.

# Chapter 7

# Community Leaders’ Blueprint
# For Healthcare Policy

Development

## Development of the Blueprint

> *This blueprint for health reform represents a roadmap for addressing key challenges in healthcare policy.*

Beginning with findings from Communities Shaping a Vision for America’s 21st Century Health and Healthcare, including the shared values and principles, (described in Chapter V), the Advisory Board reports (provided in the Appendix) and 10 Questions for Political Candidates and a Statement of Principles for Health Policy (described in Chapter VI), WRGH and the Foundation for American Health Care Leadership (FAHCL) developed a common platform or ***“blueprint”*** upon which to build public policy recommendations. The resulting work, the ***“‘Community Leaders’ Blueprint for American Health Care Policy,”*** was delivered to the Bush administration and Congress in February 2005.

This blueprint for health reform represents a roadmap for addressing key challenges in healthcare policy. Nearly 150 individuals from across the country contributed their ideas through our community leadership advisory panels, health policy surveys, Internet-based prioritization, and face-to-face meetings in and out of Washington,DC.

The blueprint was developed through a methodical combination of electronic brainstorming and facilitated discussions, and involved direct input from community leaders across the spectrum of health and healthcare, as well as many prominent national thought leaders in public policy.

Many diverse communities were represented, including the 12 involved in Communities Shaping a Vision for American’s 21st Century Health & Healthcare . These communities include Albuquerque, NM; Chicago, IL; Fort Lauderdale, FL; Northern NH and VT; Muncie, IN; Jackson, MS; Portland, OR; Raleigh-Durham, NC; Salt Lake City, UT; San Diego, CA; San Antonio, TX, and Spokane, WA.

The blueprint’s practical recommendations frame a series of actionable steps that can reasonably be advanced within a 4-year time frame. The development process captured 340 ideas and recommendations on a wide range of healthcare public policy issues, such as access, incentives, affordability, public health, quality and public awareness. Once the communities’ work was completed, nationally recognized experts met to set priorities among the community-based recommendations. Brought together, the work of both local and national leadership provided a coherent, largely doable now approach that, absent a nation-wide referendum, provides the clearest statement available of the public’s needs and hopes for a better healthcare system.

> *The blueprint’s practical recommendations frame a series of actionable steps that can reasonably be advanced within a 4-year time frame.*

The Challenge

## The Challenge!

In moving ahead, the challenges clearly identified across the country for our nation's public and private healthcare leaders and policy makers focus on these main actions:

> *Transforming community-generated, priority healthcare reform recommendations into specific, achievable reform objectives;*
> *Developing the partnerships and the legal and regulatory means to accomplish these objectives;*
> *Energizing the necessary political will;*
> *Publicizing an annual report card measuring progress; and, most importantly,*
> *ACTING NOW!*

Blueprint Questions

## Blueprint Questions

The blueprint project approached the issues by asking participants what actions the government, including the President, the administration, and Congress, could take to:

*(1) Facilitate public dialogue about healthcare and engage citizens in taking more responsibility for their health and healthcare decision-making.*

*(2) Help motivate individuals to assume a greater sense of individual responsibility for their health-related decisions.*

*(3) Align incentives for the delivery system to optimize patient outcomes and to provide benefits for which there is no short-term pay off.*

*(4) Address the social, physical, logistical and cultural barriers faced by the uninsured or underinsured.*

*(5) Address the problem of the escalating costs of healthcare services.*

*(6) Promote widespread adoption of standards of care and quality improvement.*

*(7) Address the fragmentation of services to more effectively promote continuity and coordination of care.*

*(8) Advance the utilization of information technology.*

*(9) Advance science-based medicine and accelerate adoption of strategies, technologies and procedures proven to lower costs and/or enhance quality.*

*(10) Begin building an improved public health system.*

*(11) Relieve providers of unnecessary administrative and regulatory burdens to maximize the percentage of healthcare dollars that support direct provision of patient care.*

*(12) Substitute governing mechanisms for the healthcare marketplace that will be less of an impediment than current legal, regulatory and administrative structures.*

*(13) Address medical liability problems by creating a legal environment that fosters openness, disclosure and high quality patient care.*

## Blueprint Themes

Blueprint Themes

> *A dozen general themes were identified by community leaders as absolutely essential ingredients of effective healthcare system reform.*

A dozen general themes underlie the 340 ideas generated during the blueprint process and the 50 ultimate priority recommendations. These themes, identified by the community leaders as absolutely essential ingredients of effective healthcare system reform, include:

> *Recognition and responsiveness to diversity;*
> *Consumers' involvement in their own healthcare decision-making;*
> *Compelling, visible federal and state government leadership;*
> *Coordinated, integrated delivery systems involving all aspects of health and mental healthcare with supporting information systems;*
> *Easily accessible, quality consumer information;*
> *Focus on and accountability for outcomes;*
> *Quality research and emphasis on innovative demonstrations;*
> *Enhanced attention to multiple, complex chronic conditions;*
> *Flexibility in terms of community and/or population specific characteristics and needs;*
> *Utilization of already successful efforts;*
> *Utilization of multiple approaches toward a single objective;*

> *Utilization of multiple incentives to engage stakeholders.*

## Policy Priorities

Policy Priorities

Policymakers have talked about recommendations such as those derived from this project for many years. Conventional wisdom has it that our nation's leadership suffers from healthcare policy fatigue, i.e., serious doubt that we can agree upon a comprehensive solution to the system's problems, compounded by a lack of will to keep trying.

> *Policy change does not need to happen in one sweeping all-encompassing action.*

All who worked on the Blueprint project believe that an effective antidote to healthcare policy fatigue is a package of targeted, short-term, high-leverage reform priorities. Policy change does not need to happen in one sweeping all-encompassing action. Rather, while we wait for an overall solution, incremental healthcare reform successes will improve the nation's health and healthcare and provide the momentum for further change.

Participating community leaders without fail articulated two primary recommendations needed to move forward:

First, they indicated that public and private leadership must agree upon a *compelling vision and goal for health and healthcare.* Harkening back to the Kennedy administration's "man on the moon by…," leaders believe that—guided by the President—the country can rally behind a vision and the steps needed to turn that vision into reality. The leaders believe achievable, measurable objectives and annual reports to the nation are essential among the attendant components of this compelling vision.

Second, the community leaders observed that an essential accompaniment to a compelling vision and goal for health and healthcare is a ***national communications campaign, jointly sponsored by government and the private sector, to engage the public in taking more responsibility for healthy lifestyles and informed healthcare decision making***. Well-researched, key messages are seen as essential components of this national communications campaign.

> *Public and private leadership must agree upon a compelling vision and goal for health and healthcare, one akin to "a man on the moon by…"*

Recommendations

# Blueprint Recommendations

Analysis of the 340 ideas captured and the common themes expressed resulted in 13 distinct categories of healthcare system parameters, which generally tracked with the 13 blueprint questions. The ideas were then grouped, consolidated and integrated under 13 topical areas:

> **Public Awareness**
> **Personal Responsibility**
> **Incentives**
> **Access**
> **Affordability**
> **Quality/Safety**
> **Coordination of Care**
> **Information Technology**
> **Innovation**
> **Public Health**
> **Administrative Simplification**
> **Marketplace Governance**
> **Medical Liability**

Each category, with the specific recommendations that emerged from the process, is discussed below.

**Public Awareness:** Most of the leaders in the study felt that the public does not realistically understand the current dynamics relating to limited healthcare resources, the need for tradeoffs, and the importance of an increased role for individuals in better managing their health. To get the public engaged in helping to address challenges, we will need to create a clear goal, akin to "a man on the moon," and develop a methodical, aggressive campaign to make healthy lifestyle decisions *"cool."* We need a theme, for example, ***"Health is every BODY'S business."*** or ***"Nobody cares about your health as much as you do. Take charge!"***

> *We need an aggressive campaign to make healthy lifestyle decisions "cool."*

There was broad agreement that going "upstream" to reach the younger generation with messages and tools for prevention, will have the most lasting impact. Engaging schools, churches, and social and civic clubs to promote and integrate more information about health and healthcare in their activities will affect kids and parents at same time.

It was suggested that we create a set of national messages, supported and endorsed by a wide range of stakeholders, as part of an overall advertising or public relations campaign. In other words, build a shared vision. We need to spread the word using a broad array of media, including Internet, radio, and TV, and engage community, business, and social leaders to be part of high visibility efforts in their communities.

***Recommendation:***

> Involve younger generations in learning about and taking responsibility for their health and healthcare.

- Develop a kindergarten through grade 12 curriculum teaching personal health responsibility, with components designed to be integrated into other subjects.

**Personal Responsibility:** We found consistent support for more individual responsibility and general agreement that we need to evolve toward a system where consumers have more choice and control. However, it is recognized that disparities resulting from race, ethnicity, income, education, age and health status, must be taken into account. We should not "blame" individuals for their health conditions. The call for more personal responsibility must be balanced with greater institutional accountability.

Some leaders took a no-nonsense approach, stating emphatically that individuals who practice good health habits should directly benefit in lower premiums. Others felt that the prevalence of poor health habits is a societal problem, and as such, all should share the burden, with the "haves" providing significantly for the "have-nots."

There was widespread agreement that we need to emphasize education on healthy lifestyles and wellness, starting with our youth in school. Numerous financial incentives from cigarette, alcohol and fast food taxes, to tax credits and coverage incentives were cited as having potential utility. Transparency of information on price and quality is another "tool" broadly advocated to support good decision-making. Some pointed out that money is a better motivator for episodic users of healthcare; information is more effective for those with chronic disease. Shared decision-making was widely viewed as holding promise for effectively engaging patients in a healthy open exchange that considers treatment options in the context of individual values.

It was wisely suggested that we look outside the healthcare field to determine what works to motivate behavioral change, for example, by considering the success of Sesame Street in educating kids, or how Proctor and Gamble makes soap detergent inspiring. All of these tools and approaches will be needed if we hope to change generations of entrenched behaviors and sustain momentum moving forward. (see ***www.wrgh.org*** 'Broadmor meeting report' for a full discussion of methods to influence behavior).

> *"We should look outside the healthcare field to determine what works to motivate behavioral change."*

***Recommendations:***

\> Improve Medicare/Medicaid access to early prevention and detection.

\> Make good health easier for consumers.

- Increase the transparency of cost and quality information;
- Strengthen initiatives limiting advertising that encourages unhealthy lifestyles;
- Create incentives for positive choices;
- Increase food label size and make the content easier to understand.

\> Offer incentives to encourage physicians to provide annual reports cards to patients based on their agreed-upon objectives.

\> Introduce more flexibility into Medicaid, Medicare and other government plans to make it easier for employers and health plans to financially reward good health decisions.

**Incentives:** One of the fundamental flaws in healthcare emphasized by participants relates to the marked misalignment of incentives for all the major players in the healthcare system—from providers to payers to patients. As a result, our resources are largely spent on treatment of illness, not on keeping people well. An example frequently cited is the amount of resources spent for futile care at the end of life, a practice that distinguishes us from other developed nations.

There was virtually unanimous support for restoring balance in how healthcare resources are allocated and better aligning incentives to support "better health over treatment." However, some were especially concerned about the increasing prevalence of chronic disease and wanted more emphasis on disease management as "tertiary" prevention and disability avoidance. This group worried about moving precipitously in the direction of more resources for primary prevention at the expense of investments in chronic care management.

On the provider side, emphasis was placed on rewarding evidence-based care and outcomes, not on services. The underlying concept was reflected by one participant, who said, ***"We should adopt a model that encourages varying payment for good performance. It is very appropriate in all other industries why not healthcare?"*** Developing models where providers, payers, and patients can share in the savings from prevention, early detection, and better care management was seen as a positive step in aligning incentives.

> *As a result of misalignment of incentives, our resources are largely spent on treatment of illness, not on keeping people well.*

***Recommendations:***

> Seek Office of Management and Budget (OMB) and Congressional Budget Office (CBO) scorings of savings to the healthcare system from providing preventive services.

> Optimize patient outcomes from preventive care by offering benefits for a uniform set of prevention services (based on United States Preventive Service Taskforce Guidelines) and providing consistent reimbursement for these services across all government-based reimbursement programs.

> Develop a methodology for government to share cost savings with providers that accrue from early interventions.

> Optimize outcomes for patients with multiple, complex chronic illnesses by requiring all health related federal agencies to offer cost-effective chronic illness care services for those whom the agencies serve.

> Simplify and standardize oversight requirements for healthcare networks if they establish common intake and assessment procedures, continuity of care policies, and single medical records.

> Fully implement a risk-adjustment system to create a level playing field for providers/payers caring for high-risk patients.
> Emphasize building quality into incentive programs.

- Establish a "no-fault" system to encourage medical error reporting;
- Define quality performance metrics for providers and build them into Medicare and Medicaid reimbursement schemes;
- Reward accountability with models such as system-wide pay for performance;
- Require collection and dissemination of patient outcomes data as a prerequisite for participating in government reimbursement programs;
- Build performance requirements "with teeth" into CMS contracts with providers;
- Require that healthcare organizations receiving government funds disclose provider performance data measured against accepted quality metrics.

**Access**: We learned through the community discussions that access to healthcare, through public or private means, is broadly seen as both socially desirable and economically beneficial. But access is about more than insurance coverage. The problem of access encompasses cultural and logistical elements as well.

Participants emphasized the need for a strong and sustainable safety net to provide for the medically disenfranchised. They also highlighted the importance of equitable healthcare that addresses

> *"Access to healthcare is broadly seen as both socially desirable and economically beneficial."*

Ensuring access to healthcare coverage for all citizens was cited as a top priority. As one leader put it, ***"The government's role is to make access to coverage fair; the role of markets is to make coverage efficient."*** Many felt we should define a "baseline" level of healthcare coverage and ensure a quality product is available to all, using subsidies as necessary. However, participants recognized the challenge inherent in the definition of "basic." Others favored an approach that placed the emphasis on access to a "baseline" of quality services, irrespective of coverage standards or definitions.

Looking at the issue of access from a process perspective, participants demanded greater flexibility in regulations, in the tax code, and with grants and waivers. They want the freedom to craft solutions that meet the unique needs of their community.

***Recommendations:***

> Address medically underserved geographic areas.

- Identify underserved areas and conduct demonstrations to improve access to care in these communities;
- Use telemedicine to extend state-of-the-art care to rural and other underserved communities;
- Offer incentives for providers to work in underserved areas;
- Help fund education for minorities and others to practice in rural areas.

> Increase access to health insurance.

- Offer small employers tax incentives to provide health insurance to their employees;
- Empower states to enroll Medicaid and SCHIP beneficiaries in employer sponsored health plans with government paying employees' share;
- Fund state and local governments for basic preventive and catastrophic care options on a sliding fee basis;
- Ensure stable funding for high risk pools covering up to 50% of annual costs;
- Increase SCHIP eligibility to cover all individuals below poverty.

> Expand funding for federally qualified community health centers.

> Conduct a feasibility study of a universal market-based health insurance model with an individual mandate, subsidies based on income, age and disability status and coordination similar to the Federal Employees Health Benefits Program (FEHBP) and study allowing individuals and employers to buy into FEHBP.

**Affordability:** The issue of financing is at the heart of our nation's healthcare challenges, and affordability is seen as a keystone to greater access and a healthier population. Leaders recognize numerous factors as contributors to the escalation of healthcare costs–expensive technology and pharmaceuticals, demographics, waste and inefficiency, malpractice, and third party reimbursement.

Recommendations for coping with the cost crisis frequently focus on a segment of the cost pie, for example, pharmaceuticals or technology, yet leaders recognize that overall system inefficiencies, including waste and duplication of effort, need to be addressed. Greater transparency of information and accountability for all stakeholders were frequently cited as necessary steps.

While opinions varied on what clearly adds "value" in healthcare today, concerns about appropriate technology assessment prior to introduction into practice were raised by many. Community leaders agree that we need to have better measures to help determine value for

> *The issue of financing is at the heart of our nation's healthcare challenges, and affordability is seen as a keystone to greater access and a healthier population.*

***Recommendations:***

> Place a premium on reducing duplication, service fragmentation and other unnecessary administrative cost producing activities.

> Enhance technology assessment systems stressing the value of the technology prior to making coverage decisions, and ensure more rapid Medicare coverage adjustments in response to clinical trial results.

> Enhance coverage for drugs.

- Direct the Health and Human Services (HHS) Secretary to negotiate large drug discounts for seniors under Medicare through bulk purchasing;
- Fund demonstrations to establish and test systems allowing safe importation of prescription drugs;
- Allow states to expand Medicaid drug discounts to other groups; encourage use of generics and tiered co-pay systems.

> Support programs that make access to alternative providers easier.

- Support enactment of the Medicaid Nursing Incentive Act to increase the number of Advanced Practice nurses.

> Ensure reimbursement rates cover the cost of care to avoid cost shifting.

**Quality/Safety:** *"We need to differentiate between what's done for patients and how it's done,"* said one leader. Participants clearly recognize the importance of consistent quality and standards of care to overall improvement in health outcomes. The problem will be in gaining consensus with regard to specific standards, which currently differ from community to community. Who should decide—payers, purchasers or providers? Another concern relates to the application of a standard of care to a patient with multiple co-morbidities, where "customization" of care frequently results in better outcomes. Some feel it is important to have communities weigh in on standards, to add an element of consumer satisfaction.

> *We need to differentiate between what's done for patients and how it's done.*

***Recommendations:***

> Provide government leadership and leverage its strength as the largest single payer to promote quality by building on the work of the Institute of Medicine (IOM) and HHS.

- Set goals improving Medicare performance in controlling the top 5 chronic diseases and give administrators the flexibility to achieve these goals;
- Encourage the Joint Commission on Accreditation of Healthcare Organizations and others to emphasize performance measurement and quality over process;
- Require providers in government programs to use common standards for patient records and other administrative tasks not yet covered by HIPAA;
- Expand the "NASA" model currently used in the VA Healthcare system to identify, analyze and improve health care practices.

> Develop standards and guidelines for care particularly emphasizing quality measures for complex chronic conditions in the elderly.

- Add to the current pay for performance knowledge base by supporting research; perfect outcomes-based contracting;
- Provide more funding to develop, publish and evaluate rigorous, scientifically-based standards of care;
- Recognize community differences in practice patterns that are explainable in terms of unique community composition and needs;
- Involve communities and professionals in developing standards and guidelines;

- Involve consumer input in developing and applying quality measures;
- Develop a clearinghouse as a resource for clinically-proven guidelines and best practices;
- Facilitate widespread adoption of existing evidence-based clinical protocols in federal programs;
- Educate providers and enforce guidelines by tracking outlier performers.

> Ensure that policies address the quality of what is done for the patient, as well as how it is done.

- Develop standards ensuring that screening, diagnostic tests, treatment, rehabilitative and palliative care services and therapies are safe, cost-effective and reflect the best science available.

**Coordination of Care:** In community discussions across the country, leaders emphasized the increasing importance of better integration and coordination of services. They cited a need for a greater focus on prevention and primary care, public health, behavioral health, and care management for chronic illness. In these discussions, the valuable role that could be played by allied health professionals, such as advanced practice nurses, pharmacists, and others, as well as the importance of integrating social services in a coordinated care model, was frequently mentioned. Similarly, many pointed out the importance of ensuring access to a continuum of care that includes mental and behavioral health and oral healthcare services.

> ***"In a coordinated care model, advanced practice nurses, pharmacists, and social service providers play an important role."***

***Recommendations:***

> Focus on complex, chronic conditions.
- Coordinate disparate federal and state efforts serving people with multiple, complex chronic conditions at local, state and federal levels;
- Research newer models of care delivery and financing that better integrate a continuum of services for these patients;
- Develop new payment methods that reimburse the function of care coordination within Medicare;
- Give each patient a "primary provider" charged with and paid for coordinating their care;
- Use patient navigators and health coaches to help coordinate care for patients' chronic conditions;
- Create a bonus incentive for health systems that sponsor specialty chronic care clinics which achieve specified quality and cost targets;
- Create a complexity adjuster for clinics and physicians who serve a disproportionate share of patients with multiple, complex care needs;
- Simplify record keeping requirements;
- Fund more PACE-like demonstrations.

\> Increase the role of allied health professionals, e.g., advanced practice nurses, geriatric nurse practitioners, pharmacists, social workers.

\> Provide incentives, e.g., loan forgiveness programs, funding the Nurse Reinvestment Act, to increase the number of allied health practitioners within each discipline.

\> Establish a continuity of care requirement for different providers serving the same person.

\> Develop systems to protect consumers from inappropriate and unfair competition among providers while enhancing the ability of related providers to work together to achieve cumulative cost outcomes.

\> Stress models integrating a full spectrum of care.
- Support demonstrations to evaluate the benefits of integrated primary care and mental health services;
- Adopt the Mental Health Commission recommendations to coordinate various funding streams for mental health services at both the state and federal level;
- Stream-line the waiver process for states interested in integrating Medicare and Medicaid financing.

\> Use current legislative authority to adopt care coordination techniques in Medicare and Medicaid.
- Streamline regulations to eliminate conflicts in reporting, record keeping, care planning, admissions, and discharge

- Seek legislation to integrate administration of services for persons dually eligible for Medicare and Medicaid to eliminate duplication and conflicts between programs.

> Seek legislation to integrate administration of services for persons dually eligible for Medicare and Medicaid to eliminate duplication and conflicts between programs.

> Certify "care networks" that demonstrate better continuity, coordination and communication through use of common medical records, team planning, etc.

> Simplify and standardize oversight requirements for health networks that agree to common intake and assessment procedures, continuity of care policies and unified medical records, to enhance care planning across a continuum.

**Information Technology:** The spirit of the community perspective on information technology (IT) is captured by the statement *"we need to avoid letting the perfect be the enemy of the good,"* by getting some initial successes in deploying usable information. While privacy was a concern for some, most saw vast opportunities to employ IT to help convert our "non system" into a system. Promoting and advancing IT is seen as a prerequisite to addressing many of the challenges we face in healthcare.

But there were cautions. IT is not a solution—it is a tool. The ultimate utility of information technology will be largely determined by individual behavior. Community leaders see the greatest impact of IT in its application to electronic medical records, elimination of medical errors, enhancing rural access to services, and reduction of administrative costs. Other potential benefits cited include better collaborative care coordination and better access to healthcare information for consumers to facilitate decision-making.

*"IT is a tool, not a solution."*

Leaders cited standardization, incentives for investment and adoption, funding of pilots and demonstration projects, cultural adaptation by professionals and their institutions, and training of health professionals as critical steps in advancing the use of IT.

***Recommendations:***

> Promote and advance information technology as a tool to address access, affordability, care coordination, quality enhancement, and care for underserved areas.

- Link reimbursement under federal payment systems for capital investments in patient-related technology demonstrating improved patient outcomes in relation to costs;
- Increase funds for and accelerate implementation of E-prescribing regional pilots;
- Develop and require adoption of uniform standards for information to be shared and stored electronically;
- Increase funding for interconnectivity and interoperability demonstrations;
- Provide more grant funding for implementation of telemedicine to rural areas.

> Establish a public/private partnership to develop information technology supporting the continuum of providers needed to meet the care needs of people with multiple, complex chronic conditions.

> Offer incentives for funded entities to capture program utilization and outcomes data in a web-based MIS system that has the ability to upload de-identified (but trackable) information for use by multiple public health entities.

> Require entities funded by the government that have personally identifiable health information in electronic form to make that information available to patients as part of a national network for exchanging health records.

> Encourage investments to facilitate transition to uniform electronic medical records such as tax credits, federal matching, etc.

**Innovation:** Despite the strong cultural support in this country for medical innovation, there is broad recognition that we do not have a clearly defined value proposition for many new technologies and treatments prior to use in care delivery. Similarly, variations in clinical practice drive unnecessary costs on one end of the spectrum. On the other hand, many patients do not receive well-proven interventions.

As a means of advancing some of the recommendations related to innovation and value, many individuals have advocated consideration of the re-creation of an entity similar to the former Office of Technology Assessment (OTA) or one loosely modeled on the National Institute for Clinical Effectiveness (NICE) in the UK. Some also recommend that we re-examine the early work of the Patient Outcome Research Teams (PORTS) with an eye toward the value of that approach in today's environment.

> *We do not have a clearly defined value proposition for many new technologies and treatments prior to use in care delivery.*

***Recommendations:***

> Review the operations of the OTA and the NICE and re-examine the early work of the PORTS to assess the value of these approaches in today's environment.

> Develop thorough, rapid systems that encourage public, private and cross agency collaboration and cooperation to move technologic and treatment innovations from the "bench" to the bedside and provide on-going review of these innovations' utility and relevance.

> Require periodic examination of existing regulations to identify barriers to innovation and make the results of technology assessment transparent, e.g. develop an easily accessible government bulletin board that provides access to results of government-funded research.

> Facilitate research.
- Support collaborative efforts between the government and private payers to develop standards for clinical trial design and reporting;
- Fund research comparing new and existing treatment

protocols—especially pharmaceuticals and medical technologies—to determine the most effective applications for delivery of care;

- Identify two or three national priorities related to reducing chronic disease and disability such as Alzheimer's, diabetes, and depression, and create tax subsidies and awards for demonstrating significant advancements in reducing the societal burden of these chronic illnesses;
- Invest to enhance and expand bioinformatics and nano technology to help translate research more rapidly into practice as outlined in the NIH director's Road Map Initiative;
- Identify and test new models for sharing revenue generated from intellectual property produced by government-sponsored research;
- Increase funding for research on delivery system improvements.

**Public Health:** Public health services need to move up on the national agenda! Public health is inadequately funded, has little presence in medical education, and suffers from a lack of public support and visibility. It also lacks a shared operational vision. Many leaders see it as an untapped asset, one for which there is enormous opportunity, but whose potential is unrealized. To begin to move forward constructively, the Institute of Medicine (IOM) standards on public health should be adopted as national policy and state and local governments should be given support and incentives to meet those standards.

Public health activities vary considerably from state to state and, at times, from community to community. There is strong agreement that there needs to be a better definition of the appropriate role of public health in today's society, with a consistency of activities. Community leaders believe that the Public Health System (PHS) should be streamlined, consolidated, and coordinated at the state, federal, and local levels.

There is a strong sense that public health needs to assume a greater role in public awareness education and coordination, particularly in the areas of health promotion and wellness. The opportunity for public health to provide leadership in school-based health initiatives and in building public/private community partnerships are important examples.

Public health should serve as coordinator of population data collection and interpretation. A robust infrastructure is necessary to support better use of data in the coordination of care for community and population health.

> *"Public health is inadequately funded, has little presence in medical education, and suffers from a lack of public support and visibility."*

***Recommendations:***

> Obtain a consensus on a definition of the appropriate role of public health in today's society.

> Create a stronger public health infrastructure.

- Adopt the IOM standards on public health as national policy and give state and local governments support and incentives to meet these standards;

- Streamline, coordinate, and consolidate the PHS at state, federal, and local levels;
- Emphasize coordination of the PHS's work within the healthcare delivery system;
- Coordinate population data collection and analysis particularly as related to early warning systems;
- Increase funding to programs providing financial support for students enrolled in public health degree programs through mechanisms such as training grants, loan repayments, and service obligations grants;
- Establish an incentive-based federal/state funded system to sustain a public health infrastructure adequate to assure availability of essential public health services in every community.

> Make public health a high priority by developing a national policy to promote awareness of and improvements in public health, e.g., develop a program promoting public health using a model similar to the one developed by the American Cancer Society for its "One Voice Against Cancer" initiative.

> Utilize the public health system in school-based initiatives and public/private partnerships to provide leadership related to health promotion and wellness.

> Establish targeted goals for reducing healthcare costs based on reductions in prevalence and severity of disease and disability and report annually on progress toward these goals.

**Administrative Simplification:** Clearly, there is a relationship between the creation of a robust IT infrastructure and the elimination of paper and instantaneous movement of important information for decision-making. Streamlining Medicare and Medicaid regulations, standardization of forms, codes, billing, and electronic medical records were the ideas most strongly supported by community leaders. However, some felt strongly that use of IT and the Internet should NOT be mandated.

***Recommendations:***

> Direct the Secretary of HHS to streamline and simplify record keeping requirements, eliminate unnecessary rules and regulations that impede providers' ability to offer the right care at the right time in the right place at the right costs, and review all regulations for on-going relevance.

> Create a medical benefits card that can be used within all payment systems and integrated with electronic medical records to allow health plan members to easily transmit eligibility information to each provider and to permit instant claims processing upon authorization by the insurer.

**Marketplace Governance:** Many people feel that the current legal, regulatory, and administrative structures throttling the healthcare market are cumbersome and often an impediment to progress. Alternative governing mechanisms, for example, SEC-like models, healthcare courts, and community health planning models, might be more responsive.

***Recommendations:***

> Stress uniformity of models for setting standards to disclose performance and support models such as those utilized by the National Quality Forum.

> Encourage HHS staff to share information early in the regulatory or guidance design process so that there is ample time to educate staff about how particular regulations will play out in local healthcare systems.

> Encourage health plans and employers to broaden consumer and provider participation in governance issues, e.g., consider using the pharmacy and therapy committee model.

> Revamp federal anti-trust provisions.

**Medical Liability:** Our participants shared the conviction that our current system needs to deal with medical malpractice reform and offered a variety of approaches for consideration. Alternative dispute resolution, limits on contingency fees, voluntary confidential reporting, caps on non-economic damages, and creation of "medical courts" employing experts in medical issues and process were possible approaches that were cited by participants. Although considered important, the general feeling towards medical liability was crystallized by one participant, ***"This issue is really a small piece of the pie, but it really divides the players!"***

> *"While the medical liability issue is really a small piece of the pie, it really divides the players!"*

***Recommendations:***

>Develop processes to expedite legal actions and protect healthcare workers.

- Explore and test use of alternate conflict resolution systems;
- Create specialized health courts that can compensate patients based on a schedule of benefits developed by independent medical experts – i.e., a model similar to workers compensation;
- Test liability protections for workers in emergency rooms and develop evidence-based "safe harbors" to protect workers providing care according to accepted standards.

# Observations on the Role of Government

> *There was general agreement that government involvement is a critical component of a well-functioning healthcare system.*

The Community Leader's Blueprint carefully considered the appropriate role of government. While there was general agreement that government involvement is a critical component of a well-functioning healthcare system, few of the participants in this exercise advocated for a centralized single-payer approach.

As the largest single purchaser of healthcare services, government has a huge stake in how well the healthcare system functions and should leverage its role to promote quality, efficiency and appropriate resource allocation. It should reward the practice of evidence-based medicine, advance quality metrics and fund demonstration projects that pilot new ideas and models designed to improve the overall health of our nation.

As the vehicle for public policy, government should carefully balance social interests. Community leaders emphasized that flexibility should be a hallmark of effective government. They also suggested that existing regulations be periodically re-examined to identify barriers to innovation.

Additionally, it was noted that government may have a third role to play as an effective communicator, making a healthy America synonymous with a strong America.

## Chapter 8

# Six Truths About Tackling Healthcare Challenges

As we strive towards “a better tomorrow” in our nation’s healthcare, it is important to keep in mind the following six truths – *key learnings* – and their relevance to advancing national efforts at health reform. These truths, which encompass important points made in previous chapters and findings from our studies, roundtable meetings, retreats and summits, urgently need to be acted upon if we are to promote the constructive changes in healthcare that our country needs.

## Leadership & Vision

*Truth #1: We need leadership and a vision for health and healthcare.*

Who is in charge? There is no clear national spokesperson for health. Is it the President? The Secretary of Health and Human Services? The Surgeon General?

The sad fact is, the average citizen is unlikely to even know the name of the Surgeon General, who, according to the Health and Human Services Department website, is *“America’s chief health educator, giving Americans the best scientific information available on how to improve their health and reduce the risk of illness and injury.”* No other Surgeon General in recent memory has achieved the public recognition of Dr. C. Everett Koop!

In addition to needing visible leadership, we must decide as a society what we REALLY want from healthcare. Right now, we aren’t talking about where we are going; we are just talking about who is going to pay for it. What are the trade-offs that are needed? Who is willing to make them? These conversations need to begin at the community level.

We don’t seem to recognize the “common good” point of view when it comes to our healthcare. In our society, we have little appreciation of healthcare as a shared resource. The public fails to appreciate how personal demands for healthcare impact the entire healthcare system and others who depend on those limited community resources.

> *“The challenge in healthcare is sorting out what is a shared versus a personal responsibility! Where do we draw the line?”*

Many leaders have suggested that for constructive change to occur, people and communities should view healthcare in a way that is similar to how we view education. By using both educational and healthcare resources wisely, both individuals and communities benefit. Therefore, it is in the interest of the community to ensure quality and equitable allocation. Public safety is another example of a community asset that requires sharing. People are willing to pay for firefighters and police officers to protect them. The reality is that healthcare, like education and public safety, is both a public good and a private good. The challenge in healthcare is sorting out what is a shared versus a personal responsibility! Where do we draw the line?

As one physician leader put it, we need to restore a sense of community interconnectedness and interdependency. We have replaced a sense of community about healthcare with a sense of entitlement. The healthcare industry has helped to fuel this mentality by divorcing people from the cost of care.

## Government's Role

Government's Role

***Truth #2: Government won't solve our healthcare problems.***

> *There is certainly a role for government to play in shaping healthcare—at all levels.*

We need to shift our thinking and recognize that the federal government is not going solve our problems in healthcare. This has been tried for the last 60 years in health policy, that is, trying to find national solutions applied across the board out of Washington DC. Has not worked. People look at what emerges and find it incomprehensible. We need to turn this approach on its head, by bringing the American people together, looking at things differently, and involving them in discussions about key choices.

> *In a pluralistic nation where values and priorities differ from one community to another, and from one generation to another, a one-size-fits-all approach is less likely to be embraced.*

There is certainly a role for government to play in shaping healthcare—at all levels. Most healthcare leaders agree that the necessary evolution in healthcare cannot be left entirely to the marketplace. But there is little chance that the answers to the healthcare crisis are going to come from Washington, where more time is spent talking politics than policy, and in debating extremes rather than finding consensus. In a pluralistic nation where values and priorities differ from one community to another, and from one generation to another, a one-size-fits-all approach is less likely to be embraced. People need to start talking about our healthcare future at the state and community level.

## Communities' Charge

Communities' Charge

*__Truth #3: Communities are the logical place for initiating change.__*

> *Healthcare leaders from different sectors are more likely to work together productively within their own backyard than in the polarizing atmosphere of Washington, DC.*

The old adage "all healthcare is local" remains true today. Although we can and should create replicable models, each community is unique. Policies determined at the community level are more likely to be based on the actual conditions in a community, where people know what will work for them and what will not work. Healthcare leaders from different sectors are more likely to work together productively within their own backyard than in the polarizing atmosphere of Washington, DC. Community-based discussion is much more likely to pull in participation from "the grassroots" and reflect shared community values and priorities.

Leaders in many communities we visited shared one story after another about successful efforts operationalized at the local level, efforts that demonstrate the benefits of local collaboration. Community leaders understand that, at the end of the day, improving the quality of the local environment is in their best interest. The healthcare "pie" is only so big. Sitting down at the table together and working collaboratively in the interest of community health to determine who does what best is a more constructive. Identifying workable solutions that other communities can replicate is an excellent way of creating knowledge transfer and improving health broadly. It is not necessary to reinvent the wheel!

There is general agreement that the best approach is to start by carefully defining problems and priorities from the unique perspective of a community. For example, the problem of access to healthcare does not look the same in Fort Lauderdale, FL as it does in San Diego, CA or Jackson, MS. In some cases, access is defined as a lack of insurance coverage; in other cases it is defined by availability of an appropriate or adequate number of providers. Access may refer to culturally appropriate care or to the logistics of getting to a care provider. Access also implies much better integrated and coordinated services, not just healthcare, but social and community services as well, all of which contribute to a healthier individual and a healthier community.

## Involve ALL Stakeholders

Involve ALL Stakeholders

*__Truth #4: The challenges are too great for the healthcare system alone.__*

> *Singing to the choir does not grow a congregation!*

The image of healthcare today is tarnished. There is a widespread perception that the industry lacks real leadership. To restore trust in the healthcare system, the public needs to see leaders working collaboratively in their best interest. Despite the fact that more unites healthcare stakeholders than divides them, each sector typically brings its own narrow perspective to policy discussions, rather than working to advancing what would be in the best interest of the community. The debate becomes mired in the details of each agenda, which is defined as the narrow objectives of each stakeholder. Healthcare leaders need to stop pointing the finger of blame at each other and cooperate on a common agenda. Each individual or organization only owns a piece, so no one feels responsible for the whole. Industry leaders need to systematically think and plan beyond the fire at their feet. There is a lot of emphasis on innovation in healthcare technology, but what we really need is more innovation in models of care delivery.

> *“Industry leaders need to systematically think and plan beyond the fire at their feet.”*

The “culture” of many organizations has lost touch with their constituencies. Consolidation in healthcare has created significant distance between care givers and those they serve. Healthcare leaders must take special care to ensure their institutional boards reflect the diversity of the community served.

Healthcare organizations rarely lead the kind of change needed because the fundamental metrics they use to assign value do not consider intangibles. The tremendous value created by their own employees is not measured directly. That value does not have a column on the balance sheet!

In that vein, providers can make their services more attractive and more effectively engage the business sector by highlighting healthcare as an economic engine in the community, and by pointing to the relative value of a healthy versus a sick employee.

## Think Health

Think Health

*Truth #5: We need to think HEALTH—not just healthcare.*

> *“The reality is that the greatest challenges we face relate to cultural issues—individual, organizational and societal.”*

We need to examine and methodically address ALL the factors that contribute to the health of an individual and a community: education, the built environment, transportation, in addition to the healthcare system. After all, our common connection is not “healthcare.” It is the improved health of the American people.

Most healthcare leaders and policy experts, as well as the public, tend to focus on concrete issues like financing and access. The reality is that the greatest challenges we face relate to cultural issues—individual, organizational and societal.

While the healthcare delivery system is important to health, it is not the only contributing factor, nor even the most important in creating health. Most healthcare leaders and policy experts, as well as the public, tend to focus on concrete issues like financing and access. The reality is that the greatest challenges we face relate to cultural issues—individual, organizational and societal. If we are going to create change, nationally or at the community level, we have to recognize the fact that radical change in healthcare is intolerable, because it defies the speed of cultural change. And cultural change is a complex social issue that requires multi-faceted solutions to reverse current trends.

> *We need to adopt an ecological mode, where change efforts work on individuals, social environments, physical environments, economics, and policies.*

We know that education creates awareness about appropriate choices, but even combined with behavioral change models, education will not suffice if our end goal is to improve our country's population health. Rather, we need to adopt an ecological mode, where change efforts work on individuals, social environments, physical environments, economics, and policies. To address this crisis, blaming won't work. Personal commitment and community action can.

## Engage the Public

Engage the Public

*Truth #6: We need to get the public actively engaged!*

> *Our health and healthcare are too important for us to leave decisions to others.*

This last "truth" represents the nexus of science and art. It is the component we most often overlook in our quest to improve the healthcare system. The public needs to be involved in discussions and decisions, individually and collectively. Our personal health and our healthcare system are too important for us to leave those decisions to others. Each of us must get engaged in helping to create our own, our families', our friends' and our colleagues' healthcare future!

This requires the art of national leadership - a spokesperson capable of articulating a new vision. And it requires the science of motivating the public to mandate change.

A recent example of a failed attempt to create a public mandate for change was the Citizens' Health Care Working Group (CHCWG). Created by Congress as an amendment to the Medicare Modernization Act of 2003, its purpose was to broadly engage the public in a dialogue on healthcare issues. Instead, it rallied the traditional vested interests in a series of town hall meetings across the country. WRGH principals were engaged to develop a strategic plan for the effort, however, it was largely ignored by the work group. The result was predictable.

> *As members of this society we are a part of a larger picture.*

The importance of public discussion and debate on personal and social issues cannot be overestimated. Active strategies to gather public input on health and healthcare can help reinforce the sense that we are part of something larger than ourselves. Talking about the problems is the first step in moving individuals, families, communities and organizations along a continuum of personal responsibility for helping to make this country's health system more responsive to those it is intended to serve.

The CEO of one of the nation's largest disease advocacy groups put it very well when he said, ***"the essence of living in a pluralistic and democratic society is that somehow before you set policies, you get some sense of what the citizens and electorate want."*** What we want and what each of us is willing to contribute to getting it are the key questions!

## Afterword

# The History & Philosophy of Wye River Group on Healthcare

Wye River Group on Healthcare (WRGH) has served as a non-partisan sounding board and ad hoc advisory panel to state and congressional leadership and business since 1998, quietly vetting many healthcare financing proposals, quality initiatives, and ideas about incentives, infrastructure and other concepts. The organization was legally formalized with its incorporation in June 2001 as a not-for-profit 501c3 organization. Continuing its tradition of focusing on national health policy in Washington, DC, a “macro” perspective, we work with leaders from the executive branch, administrative agencies, congress, and trade and professional associations.

We have convened executive level stakeholders from across the spectrum of business and healthcare, to identify viable public policy pathways that can be collectively advanced through regulatory, administrative, and legislative venues. This “macro” process has primarily focused on Washington stakeholders, but involves community leaders as appropriate.

The Foundation for American Health Care Leadership was launched in January,2004 as an affiliated 501c3 to complement the work of WRGH by capturing and advancing a “micro” perspective from communities. The Foundation provides a neutral venue for community healthcare thought leaders to interact with peers across sectors and across the country.

By drawing on the experience of community leaders, the

Foundation identifies the implications of community learning and advances them upstream. Their collective insight in working through complex issues helps inform state and national public policy making. WRGH and the FAHCL work synergistically, by combining the “‘macro” and the “micro” perspectives on public policy, to advance constructive change. Inclusion of both Washington-based and community-based organizations in our work helps to ensure a balance of the ideological and the practical.

Our objective is to define a common vision for health and healthcare in America, then work to translate that vision into effective institutional response, through public-private collaboration. As catalysts, we raise awareness, broaden perspectives, and bridge gaps between healthcare stakeholders.

## WRGH/FAHCL Today

WRGH/FAHCL Today

Our work today has practical application to the marketplace and public policy. By serving as non-partisan agents, we broker relationships on behalf of individual sectors or organizations that spawn new ideas and partnerships among purchasers, providers, government, payers and patients.

The neutral environment that we create supports intellectual honesty and open discussion and debate. As a result, we are able to facilitate a better understanding of different views, advance compromise and build consensus among competing interests.

Three fundamental principles are intrinsic to our approach:

> to create a neutral environment in order to engage all relevant stakeholders at each stage of the process;

- to create a shared definition of each problem and the language used to describe it; and
- to identify opportunities and draw conclusions based on a growing consensus among participants.

WRGH principals have expertise in law, public policy, medicine, public health, legislative and regulatory compliance, health insurance, public affairs, health policy analysis, and health benefits. This broad experience across business and healthcare related disciplines translates into a clear understanding of the dilemmas facing different healthcare sectors, and the perspectives of individual physicians, hospital CEOs, business leaders, insurance executives, public health officials, and public policy experts.

Coupled with our keen understanding of the complex interdependencies among competing interests, this experience uniquely qualifies us to foster, facilitate, and champion change.

## Core Competencies

Core Competencies

### *Strategic Intelligence*

Strategic intelligence provides important information supporting the ability to successfully analyze an environment and determine the best course of action.  This insight can be applied with customers, competitors, suppliers and regulators. It can enable entities to better understand perceptions about their organization and its products, or to explore alternative approaches to public affairs or business objectives.

WRGH principals help organizations evaluate opportunities in a new space and to develop effective business and public policy strategies. We vet ideas and concepts one-on-one with informed thought leaders and conduct “group brainstorming processes activities to bring focused expertise and diverse viewpoints into the problem-solving venue. These techniques are useful in analyzing complex, multidimensional issues in the public or private marketplace, or the current legislative, regulatory or administrative climate.

### *Facilitating Collaboration*

A fundamental tenet of our philosophy is that collaborative efforts that help “all boats to rise with the tide” are the most effective approach to addressing the myriad challenges that plague healthcare today. We successfully use a methodical process to define and promoting shared agendas across disparate interests. We are skilled at identifying and engaging key stakeholders and creating an environment of trust, which facilitates effective dialogue designed to accomplish interdisciplinary problem solving.

As content experts, we provide informed input and add structure to complex discussions. We believe it is critical to first carefully define the specifics of the issue and achieve consensus on the problem, ensuring that all perspectives are heard and considered. We then discuss opportunities and challenges, and debate the merits of different perspectives. Once a level of agreement is achieved, we advance workable solutions by deliberating on priorities and deciding on action.

### *Linking Interests*

Because the business of healthcare is complex and interdependent, there is high value in identifying, understanding, and leveraging complementary interests. We have garnered the respect of trade and professional associations inside and outside the Capitol Beltway. Therefore, we are able to set a "neutral table," politically and by industry sector. We effectively identify synergies among different interests in both the public and private sectors, creating business and philosophical connections. These connections might be augmented through a new business venture, an alignment on public policy, or the matching of a funding source to a defined need.

By effectively reframing complex issues to enhance understanding, we bring complicated and politically challenging issues before legislative and business audiences. As a result, we help to focus more attention on a specific issue, and highlight relevant and critical dimensions.

### *Program Support & Reporting*

We assist organizations by developing and delivering programs for strategy meetings; policy and practice seminars; collaborative workshops and focus groups; and executive retreats. We also perform executive interviews and topical literature reviews, and develop case studies of replicable best practices.

### *Supporting Your Vision*

For many years, we have applied our skills to benefit both public and private institutions. WRGH principals are sought out by some of our nation's leading healthcare trade and professional associations, and businesses, as well as by governmental entities and foundations. These organizations benefit from our experience and the insights we have gained from executing many collaborative projects and cross-functional dialogues. They value our credibility in providing input into policy development by Congress, federal regulators, and state and municipal leaders.

We welcome the opportunity to work with organizations interested in promoting and leading constructive health system change!

## Appendix

# Advisory Board Reports

Midway through Phase I of Communities Shaping a Vision for America's 21st Century Health and Healthcare, Wye River Group on Healthcare developed a circle of advisers – thought leaders chosen from diverse health care sectors and communities – to help formulate recommendations and potential "next steps" for addressing common issues that arose in the community roundtable discussions.

As a result, we created "advisory boards" around 6 major health care topics: cultural change, access, information infrastructure, incentives, quality, and the role of public health. The reports produced by these advisory boards are included in this section, beginning with the short paper below on cultural change, which we've entitled "Addressing Our Expectations of Health Care."

We begin with this report from the "cultural change" advisory board because it is recognized among our sponsors and participants as the umbrella for all of the other advisory board topics. Cultural change was the constant theme running through all of the advisory board discussions and through all of the community roundtable discussions.

Our notion of cultural change in health care is that in order to address topics such as "access" or "quality", there must be an effort to understand the cultural aspects, at both the organizational and individual level, that affect these issues. Cultural change is critical if comprehensive health system change is to occur. Our findings and recommendations on this subject are detailed below.

Addressing

# Addressing Our Expectations of Healthcare

There is broad agreement across the spectrum of health care stakeholders, including among consumers, that constructive health system change will require us to talk, as a society, about the "culture of entitlement" that pervades health care. This concern about "culture" has no connection to the usual understanding of culture in terms of ethnic heritage or tradition. What we are talking about is the *behavior* of individual consumers, physicians, and health care organizations, and their *expectations* with regard to health care.

Many community leaders share the opinion that changing the culture – i.e., the behavior and expectations – of those who participate in the health care system is one of the most critical tasks that communities can tackle. They say that communities are well-positioned to facilitate and guide transformation of the health care culture from one of entitlement to one of collective responsibility, compassion for others, and conservation of shared health care resources.

We need to be more honest about what the system can and cannot do. Part of the problem is that expectations are fueled by a disconnect between the incredible abilities we have, thanks to medical advances, and our consideration for the cost that goes with these abilities.

It's too narrow to try to change the way the system works by changing individuals one by one. We need to focus on behavior and expectations from the organizational and community perspective.

Clearly, our health care "culture" supports certain elements of our health care system that are self-defeating, inefficient, and ineffective. Once we begin to address these elements, we will be in a better position to work through them collectively.

An important starting point might be to identify the individual elements of our health care "culture" that need to be changed in order to "get from here to there." This task can be facilitated through community dialogue, a media campaign, and education. We need to "seek first to understand" by listening more to each other's ideas and concerns.

The new paradigm needs to focus on empowerment, not blame. We need to support and encourage efforts to take responsibility, while also recognizing that some among us need additional support because, for whatever reason – economic, linguistic, etc. – they cannot assume more responsibility themselves. This requires shifting from a culture of unrealistic expectations to one of taking responsibility for ourselves and recognizing the need to provide care for others. As a society, we must view health care as a precious, finite, shared resource.

We also need to recognize that "the system", including medical training, health system advertising, and financing, has distorted and reinforced certain expectations and behavior among both patients and providers. We need to foster a culture of collaboration among professions.

Already, the system is changing. Consumers are changing, along with their demands and expectations. The opportunity we have is to make sure that this natural evolution reflects our more stable social values. Collectively, we have an opportunity to shape our future and create a more satisfying system through shared responsibility for a mutually defined vision of health and health care.

Below, we describe "next steps" for cultural change. All of the components that we describe here can and will be applied to the Phase II work products that are envisioned for the other 5 advisory boards' recommendations in this section.

## Next Steps

## Next Steps For Communities

***<u>Highly recommended</u>***

- Formalize a Community Healthcare Leadership Board to serve as a catalyst and define a governance process to support, oversee and/or promote the process of change locally.

- Expand the process begun through a series of community forums/dialogues coordinated by each community leader with his/her constituents and local citizens designed to elicit meaningful consideration of the public's views on healthcare values and tradeoffs. This engagement should result in identification of common achievable goals and tangible actions for public and private sectors that should lead to better health system outcomes.

- Identify cultural advisers/cultural navigators in each community to help engage diverse community groups in the discussions of healthcare values.

***<u>Next steps supported by media/PR elements of Phase II</u>***

- Develop brief issue white papers and talking points highlighting the challenges we face and the way a community can meet them, to be used in local speeches to civic groups/social organizations.

- Raise the level of sophistication of local journalists employ when writing about healthcare, through a series of educational briefings by a diverse group of community healthcare leaders.
- Launch a local outreach effort employing media in the constructive education of citizens in healthcare matters and concerns.

***<u>Other considerations</u>***

- Conduct leadership interviews, video/audio taped for distribution in schools, businesses and public policy circles designed to engage the public in community health efforts.
- Conduct "on the street" interviews with citizens, capturing their views on contemporary health and healthcare issues and develop educational tools to encourage the community to get involved in its' collective health.
- Develop and conduct seminars on the importance of self-development and what constitutes personal responsibility and accountability.
- Popularize healthcare through contemporary art and humanities works. Organize contests for healthcare education through poems, letters, plays, short stories, videos, and songs. The themes could reflect the importance of a community approach.
- Augment the oversight of healthcare institutions in such a way as to restore community connectedness by establishing a BOD adjunct comprised of local citizens, lay

and professional, public and private.

***<u>Potential multi-community collaborative project</u>***

- Public safety and public health are useful models to study. Review examples where leaders and institutions communicated with and motivated a change in collective behavior and the culture of the community.
- Consider the de-normalization of tobacco use and the process for successful cessation once addicted, as a general approach to culture change.
- Develop an elementary school-based curriculum designed to educate children about their health and healthcare and motivate them to adopt good health practices.

Access

## Access To Health & Health Care

Americans want to feel confident that they will have access to the health care they need, when they need it. We know that all of us will fall ill at some point in our lives, and a growing number will live with chronic diseases for many years. For all of us, our quality of life depends on our ability to access high-quality health care.

Given the importance of health in our lives, Americans generally agree that everyone should have access to appropriate and effective health care services. In the health care community, there is a broad consensus that all Americans should have access to "rational health care" – health care that is high quality, efficient, evidence-based, and non-wasteful. It is an unfortunate reality in this country that each person's level of access to health care depends in large part on his or her ability to pay for services. However, there is general agreement that our society has an obligation to ensure that everyone has access to at least a basic level of quality health care.

This view is based on certain underlying, reciprocal values. First, society has a moral obligation to ensure that all Americans have access to health care services. Second, there is a moral imperative for individuals to act responsibly in how they use health care services and to ensure, as much as possible, that the services they use are paid for in some way. For example, individuals should purchase health insurance if they can afford it, or enroll in public or private sector programs for which they are eligible.

Discussions about health care access often boil down to the problem of financing. Although most people recognize there are moral grounds for ensuring everyone has access to health care, there is uncertainty about whether our country can afford it. But in recent years health care institutions and others have increasingly pointed out the heavy financial cost, to our society and economy as well as individuals, of *not* ensuring access for everyone to comprehensive and rational health care.

Currently, many people in our society do not have access to rational health care. Millions of Americans lack health insurance coverage, which compromises their ability to access appropriate services – particularly in the areas of primary and preventive health care. Having a system where uninsured people resort to using hospital emergency departments to access non-urgent care is not a solution. Health care leaders have been trying for years to draw attention to the peril associated with using hospital ERs as an all-encompassing health care safety net. We need new strategies to address access issues.

Access problems are not limited to those who lack health insurance. Appropriate access to health care requires more than insurance coverage. It requires adequate numbers and distribution of all necessary primary care and specialty services. It requires a community-based health care infrastructure that delivers, coordinates, and integrates services as needed. And it requires a sustainable means of financing that supports the integration of a continuum of health care services.

Attention should also be paid to the fact that not everyone in the United States comes to health care from the same set of circumstances. Access has logistical, cultural, social and moral components. It requires that "culturally and linguistically competent" providers be conveniently available and willing to meet the needs of different populations. As our country becomes ever more diverse the issue of access to health care involves an increasingly diverse set of challenges. Ensuring access means that health care providers must do more to reach out to people where they live and work and to address the circumstances they present.

We used to think of health care mainly as acute care or trauma care. But now there is greater recognition of the role of primary and preventive care in optimizing a person's quality of life. As a result, chronic illness can be diagnosed and treated at an earlier stage, and chronically ill people can now live for decades *if* they manage their illnesses correctly with access to appropriate and timely health care services, providers, and support. Many people can avoid dying of cancer or heart disease *if* they are screened, diagnosed and treated early. People with mental illness can live a productive and satisfying life *if* they receive early intervention and consistent treatment. Health care now encompasses a much broader spectrum of possibilities than it did years ago. Therefore, access to health care must be viewed in a more comprehensive and systematic way as well.

There is broad agreement that Americans should have access to health care that includes not only acute care and trauma care, but also primary and preventive care, chronic disease management, oral health services and behavioral and mental health care. All of these aspects of care are crucial to optimizing the health and functioning of an individual in society. It would benefit all of us if they were integrated into a rational continuum of care to which every American is assured access.

There is particular concern among the communities we visited about barriers to mental and behavioral health care services. Too often there are disincentives that prevent both insured and uninsured patients from seeking care. There is also not the degree of outreach that is necessary to ensure that everyone receives the mental and behavioral health care they need. This is especially true for children, who often remain undiagnosed and untreated. Ensuring access to health care must mean ensuring access to care that fully integrates mental and behavioral health with physical health.

Another area of growing concern is access to long-term care services. Given the nation's aging population and the increasing numbers of Americans living with multiple chronic illnesses, there is a need to address the problem of access to long-term care and how these services will be financed. Otherwise, patients will continue to bounce around among fragmented health care settings without the coordinated care that meets their needs.

Although there is broad agreement that all Americans deserve access to rational, high-quality health care, this does not mean "one size fits all." Our health care system's pluralism is one of its great strengths; it appropriately reflects our diversity of cultures, generates innovation, and avoids the rigidities and stagnation evident in non-pluralistic systems. National uniformity in health care delivery systems is unachievable, and probably undesirable, in our pluralistic society.

Fortunately, there are many communities around the country that are seeking to improve their residents' access to health care in ways that make sense for *their community*. All communities want their residents to have access to comprehensive, high-quality health care, but there is tremendous variation from one community to the next in the particular needs of their residents and the kind of resources that are available. Embracing community-based solutions and encouraging local innovation has more potential to realistically and effectively address the problem of access to health care than any top-down, uniform approach.

Stimulating

## Stimulating Community-Based Action

Around the country, communities are exploring innovative ways to make rational health care available to all residents in a health-promoting as well as cost-effective manner. In many of these communities, local healthcare organizations – from public health agencies to hospitals to community health clinics – are providing important leadership in efforts to improve access.

In San Diego, CA, more than two dozen local health-related organizations came together in 1995 to form Community Health Improvement Partners (CHIP), a groundbreaking collaborative that assesses local health needs and supports community efforts to expand access to medically underserved populations. The collaborative has become a model of what public-private cooperation can achieve, even in a highly competitive health care environment such as San Diego

County, whose diverse population includes a high percentage of uninsured residents.

In Pittsburgh, PA, a dozen health care and social service agencies came together in 1998 to form the Coordinated Care Network, an umbrella organization that coordinates care for the city's poorest and sickest patients to make sure they have access to the health care services they need. These patients, many of them covered by Medicaid, had been falling thorough the cracks in the safety net and were ending up in hospital emergency rooms, often when it was too late to really help them. Coordinated Care Network has developed an effective outreach and case management program that targets these patients.

These "locally grown" initiatives demonstrate that communities can come together and address the problem of access to care in ways that are effective because they reflect the particular needs of their community and take advantage of the specific resources of their community. Yes, access to health care is a national problem. But as these communities have shown, innovative and effective solutions can often emerge at the local, state or regional level. There appears to be tremendous creativity and dedication to problem solving at the community level, particularly when there is leadership from community health care organizations.

Community decision-making is a strength that can be applied to this problem of ensuring access to health care. A good starting point is a community self-assessment that brings together local leaders in health care and other fields to take an inventory of the community's health care needs and resources.

This community inventory is a tool for identifying gaps in access to health care. It should focus on how health care services look from the perspective of those who use the services, not those who *provide* them. In particular, the inventory should ask how people who are low-income and uninsured, and those who face challenges based on language, literacy, culture or geography, view their ability to access health care in their community. It would also be important to include an evaluation of health care funding streams. Key questions would include: How fragile or secure are each of the funding streams? Is each source of funding appropriate to the objective it is funding? Does funding appropriately reflect priorities?

Once the inventory is complete, the community could come together to discuss how to build on its strengths and to address the gaps and deficiencies in its health care delivery and financing. The inventory would probably suggest the need to reevaluate some roles and examine appropriate accountability, but not to overhaul the entire system. Community leaders could identify areas where inadequate funding leads to gaps in access and request additional targeted funding on that basis. They could also decide to seek more flexibility in funding from all available sources in order to tailor solutions to local needs. It would be up to each community to decide its own path.

An inventory of access points and services could also serve as a starting point for reevaluating service delivery, with an eye toward organizing for more efficient and effective care – from the perspective of patients.

This community self-assessment and decision-making could be a catalyst for change and inspire community leaders to work in partnership to find ways of improving on the status quo. Local planning helps identify disconnects, focuses attention on the problem, and provides a process that can influence the overall direction of public policy. National policymakers should support these kinds of community-based solutions that are intended to meet locally identified needs.

Health Care Financing

# Health Care Financing That Supports Access

As the Institute of Medicine (IoM) and others have pointed out, "we all share a destiny" with regards to health care. The fact that there are millions of Americans who are uninsured does not mean lower health care costs for those who are "appropriately" insured. To the contrary, it means the cost of care for the uninsured is shifted to providers, private payers, and taxpayers. It also means there is a value loss to our society and our economy. People who are uninsured are more likely to have less-than-optimal health status, which negatively affects their quality of life and productivity and causes them to seek care at a more advanced stage of illness and in high-cost settings such as hospital emergency departments.

We need to work constructively toward consensus on how care is to be financed. Today we do not have agreement on the relative appropriate contributions to health care from federal, state and local governments, employers and individuals. This disagreement may be related to the limited capacity of the different financing components and the varying abilities of each to control health care costs.

We must recognize explicitly that current funding is principally derived from employers and government health insurance programs. To the extent that these health care financing systems are serving various populations and are sustainable, we need to capitalize on and expand what is working, while addressing clear deficiencies.

A real barrier to access is the multiplicity of funding streams that have little motivation to integrate to create efficiencies. Financing is fragmented and often leads to a "silo mentality." As a result, one funding source may cut costs in a particular area that it pays for even if it leads to higher overall costs and poorer outcomes. Fragmentation creates the potential for competition for resources, contradictory incentives for improvement, and duplication of efforts. Furthermore, we need to acknowledge the "hydraulics" of the health care system – in other words, the ability of each of the funding streams to exert pressure on the others.

It is often said that a fundamental problem in health care is that access "follows the dollars" rather than being derived from the underlying needs of the population. Health care stakeholders need to work constructively toward a consensus on how health care can be financed to truly support access. This effort will require public/private collaboration and community leadership. It will also require a global view of the costs and benefits of investments in our population's health. Failure to take this global view means that important connections and consequences will be missed as policies are debated.

### ***Re-framing health care service delivery to address gaps in access.***

Regardless of financing mechanisms, the delivery of health care services takes place at the local level, between an individual patient and his or her health care practitioner. There is widespread agreement among the communities we visited that certain changes in health care delivery could directly improve access to health care. These recommendations address not only the way that care is organized, but also the way that cultural and social factors in health care delivery affect access.

First, a primary "health care home" would help ensure that all individuals can access care in an appropriate setting. A "health care home" could be, for example, a primary care practitioner who sees a patient on a consistent basis, knows the patient's medical background, and has a relationship of trust and open communication with the patient. This primary care provider would help ensure access to other primary care, such as oral and behavioral health, and specialty services as needed. If everyone were to have this type of "health care home," they would be much more likely to access timely, appropriate, and cost-effective care.

Second, access to culturally and linguistically competent providers would increase the likelihood that patients of diverse backgrounds are able to access care in a timely manner and in an appropriate setting. Third, coordination of services, especially for patients with multiple chronic illnesses and other vulnerabilities, would ensure that care is well managed, seamless, and covers the range of needed services.

Fourth, a focus on aggressive and effective outreach to underserved populations would enhance the appropriate use of access points. Patient navigator programs have been effective in this regard. And last, there should be an appreciation that the medical encounter is heavily influenced by local practices and acceptable cultural, linguistic and social norms, which are often unique to a community or to a community within that community.

The problem of access is also linked to the issue of quality in health care. Many believe that improving quality and reducing waste in health care delivery will free up substantial resources that could be used to provide health care coverage for all Americans. According to studies by the IoM, the Juran Institute, and the Center for Evaluative Clinical Sciences at Dartmouth, there is significant waste in health care that is caused by a variety of factors: overuse, under-use or misuse of health care services, fraud, greed, defensive medicine, lack of continuity and administrative inefficiencies.

Re-evaluating health care delivery from a systems perspective is likely to yield positive results for both quality and access. Process improvement should become a priority for health care delivery by focusing on the "six sigma" standard used successfully in other sectors of our economy. The issue is discussed further in the Quality Advisory Board report. At the same time that we work to improve healthcare quality we must take steps now ensure that all individuals have broad access to a continuum of health case services that promote the health of individuals and communities.

Creating

## Creating A Broader Definition of "Access"

When discussing the importance of access to health care, we want to remember that the goal – first and foremost – is to optimize the health of individuals and our society. We want to act collectively, as a community, to create a "health-achieving environment" that optimizes each person's ability to maintain and restore his or her personal health.

There are several dimensions to creating this health-achieving environment. One dimension is ensuring access to a comprehensive range of health care services, as has been discussed above. But other dimensions involve public health and personal health. Creating "health" requires looking at the health of the community from a population-based health perspective. It also requires empowering individuals with the knowledge and tools to optimize their own health.

As pointed out in the Healthy People 2010 Initiative, "health literacy" plays a key role in empowering people to self-manage their personal and family health. This "action" term communicates the importance of understanding preventive measures as preconditions for improved health.

There is a need for proactive outreach at the community level to ensure access to services and educate people about their health. Health should be "pushed out" to the public. This is an important role for public health departments and community health workers, also known as "lay educators". This is also something that needs much greater emphasis in the public schools. Comprehensive health education should be considered part of the "access" equation. Children need to learn about what they can do to maintain their own health and access health care.

It is imperative that people understand the importance of doing all they can to maintain their own health and that society support this understanding with a shared ethos that values health. Our society has a moral obligation to ensure access to health care. At the same time, all of us as individuals have an obligation to do what we can to use health care responsibly and judiciously. Health care is a precious resource and it comes at a price. It is up to each of us to be aware of that when we make choices that impact our health.

Public/Private

## A Role For Public/Private Sector Partnerships

Public/private collaboration may hold the key to addressing the problem of health care access. Both the public and private sectors play important and beneficial roles in the U.S. health care system. Therefore, addressing the problems that affect access to health care should be based on constructive collaboration between the two sides.

As the largest purchaser of health care services, the public sector plays a central role in health care financing and a substantial but more limited role in health care delivery. Government also acts as the guarantor of coverage for seniors and low-income families and individuals through Medicare, Medicaid, and the State Children's Health Insurance Program.

In these capacities, federal and state governments can use their collective weight to move the health care system in a direction that expands access to more Americans. Government can start by partnering with private-sector stakeholders to bring clarity to some important questions. How do we define "vulnerable populations" that need special support to access health care? How much support should be provided and in what form? Currently, there is no clear, unified direction on these issues.

Government can collaborate with private health care organizations to create a national vision to guide local communities in their efforts to expand access to health care. Government can also be an agent of change and a facilitator of collaboration between the public and private sectors at the local level. Assuming these roles is not without challenges, especially in light of government's sometimes conflicting roles as facilitator, purchaser and regulator. Nor does this "change agent" role for government reduce or eliminate the responsibilities of other participants in the health care system to foster improved access and quality. Many health system participants have sizable resources, clear responsibilities, and opportunities to implement real changes that can improve patient care and foster broader, systemic changes.

***Next Steps for Communities***

***Highly recommended:***

- Conduct a self-assessment of your community's health care needs and its strengths.
- Gather a diverse group of community and health care leaders – people at the local, regional and state levels who are involved in health care decision-making, including consumer and patient advocates.
- Begin with an assessment of needs. Take an inventory of the services that are currently provided. What are the gaps in access and services? How does health care look from the perspective of patients who are uninsured or face barriers that are linguistic, cultural or geographic?
- Evaluate the funding streams for services. Identify the sources of funding and assess their fragility and potential flexibility. Is the source of funding appropriately matched to the objectives? Are core services "under-prioritized" and subject to volatile funding?
- Reach a joint agreement on how the community will address the gaps in access and other issues identified during the self-assessment. Discuss opportunities to use resources more effectively to ensure broad access to a continuum of services that promote the health of individuals and communities.
- Educate the community about how to access health care and make healthy choices.
- Communities that have already had success in addressing access problems could develop and share a template that provides a roadmap for other communities.
- Assess the level of cultural and linguistic competence of providers in the community, examining the elements of awareness, sensitivity, equity and competence. Identify cultural and linguistic advisers/navigators in each community to help address gaps.

***Other possibilities***

- Generate community support for health policy/governmental action:
- Integrate funding streams from public and private sources in ways that improve access to the full continuum of health care services.
- Encourage local and state governments to be part of the community assessment process and to promote best practices.
- Regionalize health care assets, where possible, so that they don't just stop at state borders.

# Healthcare Quality & Safety

The United States needs a national effort to make dramatic improvements in the quality and safety of health care. According to the Institute of Medicine, a quality movement would cut medical errors and improve health care outcomes. It would also reduce the wide variation in medical practice from place to place. Instead of geography setting the destiny of health care, an indictment leveled by health care researcher Jack Wennberg, high quality should guide health care across the nation.

Industrial quality experts recognize that most effective quality interventions occur as far "up-stream" as possible. Process improvement should become a priority for healthcare education and delivery, for example, through a focus on the "six sigma" standard used successfully in other sectors of our economy. Optimizing safety and quality of health care requires a systems approach that addresses basic issues such as how people learn to take care of themselves and how doctors are trained. But health care is still largely a cottage industry, thus this paper limits itself to considering discrete approaches and interventions that communities can adopt today. Indeed, community-level action may be one of the few ways to make large-scale changes.

Led by health professionals, employers, health plans, and national experts, a fledging health care quality movement can be a guide for communities. It moves beyond medical licensure and litigation as the primary way to protect patients.  Instead, it envisions quality as giving patients the outcome and experience they want while sticking to professional standards for health care. It prompts questions like: do surgical centers meet minimal volumes of surgery which produce consistently good outcomes, and do physicians enable their patients with diabetes to control their blood-sugar levels?

The role for communities in the quality movement is broad. Communities can enable patients to make better, more informed health care choices, establish quality standards that apply to all health professionals regardless of patients' choices, facilitate collaboration among health professionals, protect vulnerable populations who often receive lower quality care, reduce disparities across racial and socio-economic lines, and make it easier for individuals to take control of their own health.

Communities can also help individuals set appropriate expectations about the care they deserve and define new responsibilities for how people care for themselves. People no longer need to be passive patients. Patients will seek higher quality care if they feel engaged in the process. To do so, they must have information relevant to their situation, so they can ask the right questions before choosing a health professional or course of treatment. Communities can encourage both physicians and patients to seek out and use decision-support tools that use evidence-based guidelines for care. Such tools tell doctors and patients if there's scientific evidence to justify a given decision. Without such guidelines, the thousands of medical research articles published every year make it impossible for doctors and patients to keep up with the latest health care research.

Engaging patients in their own care will also accelerate a change in patient expectations that doctors are somehow god-like, beyond reproach, and incapable of making mistakes. Instead of expecting perfection, patients should expect that doctors will aim to recognize, recover, and reduce errors.

Another important benefit to improving quality is cost restraint. That's because medical mistakes are costly and prevention often saves money and lives down the road. Some health care researchers believe that a true high quality health care system would cost 20 to

30 percent less than what we are spending today. Over time, however, higher quality care that produces better health and better value will still cost more. If people see more value in health care than in other areas of consumption, then they should be free to spend more.

An agenda for community action to improve health care quality should focus on three goals: 1) identify how health care safety and quality affects the community and individuals; 2) assess local activities on quality improvement; and 3) start with one quality improvement effort.

### ***Health care quality in a community***

Health care quality is important to us as members of a community. Quality health care makes a community a better place to live. It helps to limit the financial and human toll from wasteful or harmful health care practices. To constructively discuss quality issues, community leaders need a common understanding. The Institute of Medicine (IoM) offers this definition:

***"[Quality is] the degree to which health care services for individuals and populations increase the likelihood of desired outcomes and are consistent with current professional knowledge…Desirable personal outcomes include improvement (and prevention of deterioration) of health status and health-related quality of life, and management of physical and psychological symptoms. Desirable outcomes also include attention to interpersonal aspects of care, such as patients' concerns and expectations, their sense of dignity, their participation in decision making, and in some cases reduced burden on family and caregivers and spiritual well-being."*** (from IoM report Crossing the Quality Chasm).

Some aspects of quality are universal and objective, and some are local and personal. For example, there is a standard of care for people with diabetes (e.g., annual feet and eye exams) set by expert panels assembled by the National Institutes of Health. These panels examined the best available research and heard from top clinical experts. Individual preferences and local factors will (and should) determine how such care is delivered, for instance, in a large, group practice or in a loosely affiliated group of physicians practicing independently.

One of the challenges in using the IOM definition is determining the outcome and experience that patients desire. It is a chicken and egg kind of problem. Patients can't speak as a group to tell doctors what they desire and doctors cannot decide how to measure improvement without knowing what patients desire. Of course, there are some reasonable assumptions that doctors can make. For example, patients do not like to wait for an appointment. But communities can catalyze this process by organizing a dialogue between patients, doctors and other providers about prioritizing a quality agenda.

Fortunately, communities do not have to start from scratch to develop a quality agenda. Many performance-based quality standards have been developed but have not been widely adopted. Most people are not aware of their existence. As communities sort through how to apply nationally developed standards for their local area, they should examine standards developed by groups like the National Quality Forum, Consumer-Purchaser Disclosure Project, NCQA's HEDIS measures; JCAHO's ORYX standards; and the Leapfrog Group. Ideally, communities would have a guide to existing quality standards that can weed out bad health care. Such a compendium would facilitate discussions about how various quality standards work, to whom they apply, the benefits and costs of implementing them, and assessments of their success in driving improvement.

### *Assessing local activities on quality improvement*

Once the importance of quality improvement is understood as a community issue and before a strategy for improvement can take shape, it is important to know what is already happening in a community. For example, many local organizations have established quality improvement partnerships with other sectors that are not widely known.

Other possible sources for local quality improvement efforts include: quality improvement organizations that have evolved from state-based peer review organizations established under Medicare. Public health agencies may have programs for improvement related to specific diseases. Health plans in states like California are cooperating on quality improvement data and incentives. Medical societies and other professional organizations may have taken on specific problems like medical errors.

A local assessment should include a review of existing data. Community level data should be used as much as possible. Physicians and community leaders may not readily accept the reality of heath care quality problems unless they can see it in local data. The data review should cover both overall quality indicators and quality variation in vulnerable populations.

Finally, a local assessment needs to consider capacity and resources to launch and sustain quality improvement efforts. A champion and a realistic potential for improvement are critical for a successful effort.

### *Adopting a quality strategy*

While no community can address all local quality problems, each community can address something. One general approach might be to organize a web-based template that communities could use to develop and implement an improvement strategy. The template would help a community create its own web site focused on its priorities and concerns. The template would include directions to resources. It would be easy to access, easy to use. It would need to be kept current and updated with new information on community health status and other performance indicators. This would enable the community to track its progress. A community could start by picking a single area for quality improvement where the evidence is clear and then aim for 100 percent success.

Some communities are adopting a local quality improvement strategy focused on reducing the burden of a specific disease. Diabetes, stroke, acute myocardial infarction and cancer prevention, screening, and treatment, where guidelines exist, are potential candidates. For example, one goal would be to give aspirin to most heart attack victims. Despite undisputed research on the benefits, physicians 30 percent of the time omit this treatment. Adopting some manageable area of concern could make a significant difference, and also demonstrate that similar efforts are viable for other areas.

For some health care leaders, the problem of simple tasks left undone argues for an aviation safety approach to quality. Checklists similar to what pilots use could be developed for doctors and nurses to ensure the completion of basic tacks. Others, however, believe that while such checklists may be helpful in some areas, they would not account for some essential ingredients needed to successfully care for individual patients. Because of the unique complexity and changing quality of disease patterns and personal preferences, the actual care undertaken is often individualized.

Communities may also choose to focus on a community-wide, integrated approach that combines disclosure of provider performance with incentives from insurers and employers to reward improvement, known as pay for performance. This approach is mentioned in the "Incentives" Advisory Board report.

Another general strategy for a community quality collaborative is to tackle complex issues that are too big for any one segment of the health care system to handle independently. For example, a reliable system for preventing harmful interactions from prescription drugs requires doctors to agree on a common way to enter, transmit, and examine patients' drug records. It also necessitates significant investment in information technology. But which comes first, the standards or the investment? Few doctors would want to make the investment without the standards, and standards cannot become operational without the investments in systems that use the standards. A community agreement upfront can facilitate the development and acceptance of standards as well as the investment in appropriate systems.

In a similar vein, local monitoring of progress on quality standards could do much to reinforce the importance of improvement efforts, but without computer software in physician's offices to track individual patients, it is virtually impossible to track a whole population. And without either the external pressure to improve performance or the opportunity for physicians to have the satisfaction of figuring out what is working in their community, why would doctors invest in computer software?

These barriers to quality improvement are cited in the "Infrastructure" Advisory Board report.

Just what to measure for quality improvement is the conundrum. Some argue that patients' health outcomes should be the focus in order to drive innovation in how the outcome is achieved.

Others believe that the process of care should be measured and periodically updated when new evidence emerges from scientific studies. This is probably a false choice because most existing measures of quality include both process and outcome measures. Outcomes can be too far off to create accountability for quality, and processes can make it harder for providers to change how they do things when new evidence emerges. A careful balancing of the two types is necessary.

Another issue around quality measurement is the extent to which consumers use quality reports. To date, there's not much evidence they use them much. On the other hand, providers do react to quality reports, which have caused improvements even without much consumer involvement.

A final question about quality measurement is which health care entity should be assessed. Measurement of performance against peers is very effective in changing physician practice patterns and standards of performance are applicable to almost every other profession—many being highly regulated. However, many experts point out that health care is increasingly a team effort, and assessing individual physicians, rather than the group or practice, may be counterproductive to facilitating constructive collaboration.

The American Medical Group Association advocates that a balance of ideals can exist by assessing individual physician performance and quality in the context of their practice environ, such as the multi-specialty medical group practice. Results of AMGA's individual member surveys that measure provider satisfaction as well as patient satisfaction have served to stimulate practitioner behavior both for personal improvement but also for the professional enhancement of their group's collaborative capacities in quality care.

Quality is also integrally related to access. Attempting to master one's health is no easy task, and may be impossible - especially once one is injured or stricken by a disease. Family physicians are in no position to act as guides when their main unit of reimbursement is an office visit. Other modes of interaction can be more convenient, effective, and less costly: the telephone, e-mail, drop-in group medical appointments, web-based resources are all tested and cost-effective, satisfying alternatives to the one-on-one visit to the doctor's office. Nurses and physician assistants can often be effective in delivering such services. Finally, patients who see multiple physicians need someone to coordinate their care because no one is paid to do that as part of a typical reimbursement system. Several models of patient navigation have proven effective in this regard. Communities may want to retool the role of physicians in family practice or other specialties so they can coordinate care or encourage the use of health care guides or coaches. Case managers can also be very effective in reducing fragmentation in the system and feedback regarding their work from physicians, patients and families is generally very positive.

Communities also need to consider how issues like medical liability and confidentiality effect quality. In a culture of blame, few are willing to step forward and take responsibility for mistakes. And with systematic errors, it may be difficult, if not impossible, for one individual to do so by his or herself. Instead of disclosing, discussing, and fixing mistakes, the fear of lawsuits can drive problems underground. Communities could establish "health courts," which would employ physicians as impartial experts. Another approach might be to develop patient safety organizations for voluntary and confidential reporting of errors so that providers could police themselves. Federal legislation has been introduced to develop both health courts and patient safety organizations.

Finally, cultural and linguistic competence affects the quality of care at all levels. It can stop a patient from questioning a doctor's decision or even knowing how to deal with a doctor in the first place. Communities can turn such diversity into an advantage by committing to serve everyone equally and engage those who are left out. Patient navigators can help patients who face cultural or language barriers.

Quality improvement cannot occur in a vacuum. It requires cultural acceptance of the approach and the right incentives for stakeholders. For example, quality initiatives with physicians have traditionally focused on passive education or externally imposed "requirements." Collaborative inquiry into current practices and outcomes among physicians is far more likely to succeed. Colleagues talking to one another about what they do and the results that they get is much more effective than pressure from an outside force. Doctors need to become leaders of care instead of acting solely as authorities.

## ***Conclusion***

The science of health care quality improvement is in its nascent stage. Indeed, much work remains for the US Department of Health and Human Services Agency for Healthcare Research and Quality and other research groups. Nonetheless, much of what is already known about quality improvement constitutes a substantial opportunity for action by communities, providers, and individuals.

***Examples of quality collaboration and resources for action:***

- Welcoa provides "well-city" awards.
- "Site Selection" rates communities by health measures.
- *Men's Health* had a story on the healthiest communities for men.
- *Expansion Management* published an article on making health care costs a site selection factor in its February, 2003 issue.
- National resources that have links to local data include *The Dartmouth Atlas* published by the American Hospital Association and the National Association of Health Data Organizations.
- The Department of Health and Human Services is planning a series of demonstration programs for quality improvement based on the recommendations of the Institute of Medicine. In addition, the Robert Wood Johnson Foundation's Rewarding Results project will be providing grants soon to communities to focus on quality areas.
- As a test of "public engagement" to reduce deaths from hearth attacks, the state of New Mexico distributed 500 defibrillators in grocery stores, airports, etc.
- The Northern New England Cardiovascular Disease Study Group, whose success was driven by self-directed exploration and reflection on the process of care, rather than formal physician education.
- Healthcare Collaborative Network – About 20 hospitals, private corporations and government agencies have joined a demonstration project under which they will exchange standardized clinical data in hopes of improving patient care. Initially, New York Presbyterian Hospital, Vanderbilt University Medical Center, Nashville, and Wishard Memorial Hospital, Indianapolis will exchange clinical data among themselves and with the CDC, the CMS, the FDA.

- American Health Quality Association. PROs/Quality Improvement Organizations – Their efforts are largely limited to working through hospitals to reach doctors, but they offer a good source for basic and achievable quality initiatives. http://www.ahqa.org/
- National Quality Forum http://www.qualityforum.org/
- Common Good http://cgood.org/for health courts/
- American Medical Association consortium on quality.
- Federal legislation on health courts and patient safety organizations.
- Institute for Safe Medication Practices.

## ***Next Steps for Communities***

### ***Highly Recommended***

- Develop an agenda for community action to improve health care quality focused on:
- Data collection or surveys to identify how health care safety and quality affects the community and individuals;
- Local activities on quality improvement (hospital, health plan, employer).
- Capacity and resources to launch and sustain quality improvement efforts.

- Selection of one initial quality improvement effort (potential examples in text).
- Create an ‘intellectual exchange’ for physicians to interact peer to peer, either within the community or between communities.

### *Other Consideration*

- Create activities that encourage both physicians and patients to seek out and use decision-support tools that employ evidence-based guidelines for care.
- Collaborate with a local medical school to develop and provide training for medical students and residents in quality principles.

### *Community support for health policy/governmental action*

- Advocate for tying federal/state funding streams to public medical schools to the provision of specific curricula, e.g., quality training. Encouraging quality metrics to be integrated into professional education has precedent, e.g., in some engineering programs.

### *Potential multi-community collaborative projects*

- Consider reviewing national activity to create a shared base of knowledge for the community effort.
- Consider developing a guide to existing quality standards to facilitate discussions about how they work, to whom they apply, the benefits and costs of implementing them, and assessments of their success in driving improvement. Assess applicability for the community.
- Develop a template for communities to use the web to develop and implement an improvement strategy.

# Aligning Incentives In Health Care

Incentives, both positive and negative, are the key driver in most areas of human endeavor. Health care is no exception. Most individuals recognize they have a personal incentive to try to stay healthy and avoid illness. But the absence of value-based behavioral and economic incentives distinguishes health care from nearly every other service industry. Aligning incentives to promote the rational and effective use of health care services is a major challenge.

Standing in the way is an entrenched, third party payer system that separates the consumer of services from the purchaser. In health care insurers pay most of the bills, not patients. As a result, consumers have little incentive to "shop around." Health care providers determine the level and intensity of services that consumers should receive. The results, predictably, are rapid cost growth, frustrated payers, and unengaged consumers.

Cost is not the only concern driving interest in the use of incentives in health care. Incentives can be an important tool for improving the quality of care when used appropriately and can also be used to encourage consumers to avoid unhealthy behaviors. Virtually every area of health care is affected by incentives. Therefore, if we want to change health care, we have to change the incentives.

The movement from a strictly fee-for-service system to one where managed care predominated represented a major effort to shift financial incentives. These two models for health care have very different incentives for providers. Under fee-for-service, payers simply reimburse the providers for services rendered. The more services provided, the more a provider gets paid. There is incentive to treat illness and injury but not to help consumers stay healthy and avoid illness.

The promise of managed care was to shift incentives to encourage providers to maintain patients' health and wellness. But because HMOs typically required only minimal cost sharing at the point of service, managed care achieved little success in connecting patients more directly with the impact of their choices.

It remains a major goal in health care to better align incentives for both consumers *and* providers, including physicians, hospitals, and insurers. We need to create a new "ethos" in health care that will encourage consumers to take responsibility for maintaining their health and the health system to be accountable for providing quality health care. The right incentives for all stakeholders--physicians, hospitals, insurers and consumers--are the key to achieving this goal.

### ***Creating incentives for consumers: Financial tools are some times appropriate.***

In some areas of health care, and for some consumers, financial incentives are an appropriate tool for affecting health care decision-making. For example, financial incentives are appropriate for encouraging a prudent choice of health plan. They can also be used effectively to encourage consumers to choose routine, low-intensity medical care, such as planned interventions, and treatment options that cost less but have been shown to be equally or more effective than higher-cost methods. In some cases, for example, a generic is as effective as a brand-name drug.

However, financial incentives must be carefully evaluated for their potential impact on the basic building blocks of workable insurance. Both healthy and sick individuals must be in the same risk pool in order to assure cross-subsidization. If financial incentives result in healthy individuals purchasing fundamentally different insurance coverage than sick individuals, a viable insurance pool will not be possible.

Similarly, incentives should be structured to encourage individuals to purchase health coverage *before* they face serious medical problems to avoid the problem of individuals refusing to participate in the insurance system while they are healthy, but purchasing insurance coverage when illness strikes.

In discussing the role of financial incentives in affecting consumer choices, it is important to note that not everyone can approach health care from a "consumer perspective." Those who are very ill, for example, should not be considered consumers, but patients. "Consumers" are those individuals on the healthier end of the spectrum who can and should be held accountable for choosing efficient health plans and health care services. Patients, on the other hand, cannot necessarily be expected to make good choices. They are reliant on their care providers and others they trust when it comes to decision-making.

Many health plans and providers are creating new kinds of incentives designed to affect patient choices in a non-punitive manner. For example, in Las Vegas, patients are rewarded if they notify their health plan of their pregnancy in the first trimester. A health plan in California is rewarding patients who complete a Health Risk Assessment (HRA) and engage in activities that reduce their lifestyle-related health risks. These types of financial incentives encourage consumers to assume more responsibility for their health and their health care choices.

Key elements in using financial incentives to engage consumers will include understanding what quality healthcare is, alongside price transparency. Price drives most purchasing decisions in areas other than health care because consumers both know what things cost and are responsible for paying the cost. In health care, consumers have no idea what services cost or what constitutes quality health care. They generally pay little if any of the costs of specific services. At a minimum, price transparency with access to quality health care information would give consumers a way to compare providers on the basis of price. Government agencies, in concert with the private sector, should enable consumers to learn the true cost of services.

The movement toward consumer-directed health care may also help consumers become more sensitive to value in purchasing routine care. However, medical science is complicated, and outcomes are uncertain. Given the potential for serious consequences if "the wrong choice" is made, consumers will need a great deal of help to navigate the health care system effectively.

Another point to consider is that the real costs in health care are in hospitalizations and chronic disease, not in routine care. Therefore, health plans must identify and focus on individuals with risk factors for high-cost care and make sure there are incentives for them to participate in self-care and disease management programs.

Creative Ideas Emerge

## Other Types of Incentives For Consumers: Creative Ideas Emerge

Creating incentives in health care is not about "blaming" or "punishing" individuals for their health status and behavior. Incentives should be focused on empowering people to make good choices for themselves, with the appropriate support and education.

Tangible, community-based support and encouragement can serve as powerful incentives to help people adopt healthier behavior.

In Bladen County, N.C., a homegrown health care outreach and education organization has had a major impact on the health of county residents, particularly in the areas of diabetes and obesity.

Called "Bladen Healthwatch", the organization has created a number of initiatives, including the "Healthwatchers at School" program that started walking campaigns to encourage students to walk during the day near their home, school or church. Schools set up designated walking trails and gave incentives to both teachers and students to participate.

In Philadelphia, the Keystone Mercy Health Plan established the "Health Ministry Program for Women," which provides low-income, African-American women with information about how to access preventive health care services and wellness programs. Workshops are offered in church settings, which provide a welcoming, supportive environment for women to learn about managing stress, controlling diabetes and detecting breast cancer.

Information can be another powerful incentive for consumers. There is a lot that most people don't know about their own health. In a recent survey conducted by the American Cancer Society, only about 1% of those surveyed knew that obesity is a major factor contributing to an individual's risk of dying from cancer. Often, people just don't have the information that would motivate them to make changes.

There needs to be positive, non-punitive incentives that encourage Americans to get educated about their health and to take action on the basis of what they learn. If education is available and accessible, consumers are more likely to use it to make healthy choices.

## *Creating more appropriate incentives for providers: An ongoing challenge.*

The movement toward pay-for-performance and outcome-based payment mechanisms makes sense. There is an urgent need to restructure the payment system in ways that promote continuity and coordination of care and access to the entire continuum of care, including prevention and mental and behavioral health services.

But there continue to be many challenges associated with creating the right financial incentives for providers. Among them are the lack of strong evidence for many medical interventions, the unsophisticated state of performance-based pricing, the failure to identify and pay for quality systematically, and the inability to define rules and mechanisms that align all stakeholder interests financially. There is also cultural resistance by physicians to what is sometimes perceived to be "cook-book medicine." However, having physicians involved in the development of guidelines can go a long way toward facilitating acceptance.

Another challenge is the legacy of the Medicare/Medicaid amendments passed in 1965, which specified that physicians be paid "usual, customary, and reasonable" payments for services but did not provide for the setting and periodic reevaluation of levels of payment for newly developed procedures and treatments. This has led to very high levels of payment for newly developed procedures and services, while old ones are held at much lower levels. As a result, there are powerful financial incentives for providers to perform newer procedures, causing distortions in medical practice.

An additional complication is the need to distinguish between specific services, which generally fall into two categories. Scientifically proven interventions are one, relatively small, category. Even here, we must be cautious, as "proven" interventions may change over time as we learn more. In this situation, the incentive should be for physicians to provide the service. The goal should be to remove disincentives and reduce barriers for patients – for example, by waiving co-payments and ensuring convenient access when it comes to preventive care and immunizations.

In the other category are services for which a "gold standard of treatment" has not been determined and where conservative therapy may have as good an outcome as more aggressive or invasive interventions, which are generally more expensive. Here, incentives are needed to involve the patient in a shared decision-making process focused on ascertaining which treatment is most appropriate for that patient, given his or her preferences and values. An effective process of shared decision-making requires both incentives and decision support information related to costs and relative value.

But given the challenges inherent in creating the right financial incentives for providers, there are other types of incentives that need to be considered. For example, there is broad agreement among providers that reducing the "hassle factor" can be a strong incentive. Eliminating unnecessary paperwork could make a physician's day a lot easier and serve as a major motivator. Similarly, in cases where there are evidence-based, easy-to-use clinical guidelines for care, waiving the approval requirement could serve as a powerful incentive for physicians.

Sometimes merely instituting regular feedback and reporting on performance is enough of an incentive to cause physician "outliers" to change behavior. Some payers provide regular performance feedback to physicians regarding their accomplishment of evidence-based preventive services (primary, secondary and tertiary) in comparison with their peers, and they provide bonuses to those with consistently

better performance. Physicians generally believe they practice good quality medicine. Showing them data that contradicts that belief can be a powerful motivator. But the feedback has to be provided in an easy-to-use fashion and on an ongoing basis.

***<u>Other examples of current initiatives to align incentives:</u>***

- Kaiser Permanente's Care Management Institute is encouraging its network physicians to practice evidence-based medicine by "making the right thing easy to do."
- Multiple entities, including payers, employers, government, patient advocacy associations, etc., have created online, telephonic, and print health decision support services to help consumers make better value and evidence-based purchasing decisions.
- Payers provide episode-of-care payment rates for bundled services, which may include primary care, specialist, laboratory, imaging, pharmacy and surgical services
- Payers offer payment for e-visits, in which physicians confidentially collect information and dispense medical advice to their patients on-line. This could reduce office visits by 30% or more.
- Employers offer health plans that provide incentives for employees to bear more of the costs of discretionary health services while fully covering the costs of evidence-based preventive services.

### *Next Steps for Communities*

### *Highly recommended*

*Request the appropriate government leaders to support incentives by taking certain steps.*

***For example:***

- Urge public sector payers to reward efficient providers who demonstrate good quality indicators with higher payments.
- Make it possible for payers to use the CMS database in "real time" to provide on-going feedback to providers in order to improve patient safety and assess guideline adherence.
- Create Medicaid and Medicare waivers to reward for quality. States and communities can and should serve as laboratories for incentives.
- Urge Medicare to allow providers in high-quality, multi-specialty groups to decide how to structure management around care of chronically ill patients to achieve more efficiency, then decide how reimbursement should be structured.
- Establish standards for information reporting and use public and private sector networks to encourage consumers to fully appreciate the costs of services and educate them about quality health care services.
- Request the federal government consider devising a new system for setting and periodically resetting the payment level under Medicare and Medicaid for physician services, treatments and tests. The level would reflect the training, skill and time required to perform the service. A societal "desirability factor" could also be added, i.e. a higher value for services preventing illness or disability than one for improving cosmetic appearance.
- Communities could work with political leadership to encourage expansion of state-based demonstration projects on IT, case management, patient incentives, etc., and waivers to achieve them.

### *Communities could also:*

- Advance models that would facilitate care coordination, improve outcomes and decrease costs by considering the creation of a patient-centered clinical database between hospitals in each community that would help multiple care professionals track and coordinate efficient and effective interventions. Providers would have appropriate and protected access.
- Work together to devise a national health risk assessment, followed by a national campaign to encourage everyone to adhere to the appropriate risk reduction strategies. There are two aspects to such a strategy. First, the health risk assessment must be based on objective and authoritative evidence and be endorsed by a nationally recognized panel of experts. Next, the physician and consumer must routinely refer and keep track of completing and adhering to desirable health behaviors and actions. It would be critical that scores be kept confidential and that health status not become a barrier to insurance.
- Encourage organizations to consider recommending new

ways to evaluate "technical" interventions, or new ways to apply old methods, e.g., cost-effectiveness analysis.
- Urge provider organizations to create incentives for physicians to be involved in best practices guideline development.

# Information Infrastructure

Information technology has transformed many industries. It has made everything from getting news to investing in the stock market more convenient, less expensive, and ultimately more democratic. In health care, however, it has not been used effectively despite the potential for even greater benefits. After all, health depends on how well individuals, health care professionals and administrators, and public health officials use information.

Information technology can be helpful in health care in many ways. It can help people learn how to deal with health problems as many already do on the Internet. It can help doctors make health care safer, higher quality, and more coordinated by providing timely access to patients' records. It can help doctors make better decisions based on the latest research as it applies to each patient. It can eliminate duplicative lab tests and X-rays that today are lost in thick files. It can reduce simple administrative hassles like verifying a patient's insurance coverage. It can help people make informed choices about their care, their doctor, and their health plan. It can give doctors feedback about the quality of their care and enable employers and insurers to reward higher quality providers. It can help address public health problems like tracking diseases and bioterrorist threats. It can improve research on what works best in health care and on how genetic and environmental factors influence health.

Information technology can make health care more convenient and effective by shifting the locus of care out of the doctor's office and hospital. Imagine how much easier it would be to communicate with your doctor by e-mail to get confidential routine test results and answers to basic questions. If you are trying to stay healthy, caring for a sick child, or dealing with a chronic condition, you are

the primary caregiver and your home or office is where you can receive information to support care needs. The nation needs a health care information infrastructure that is as mobile as its citizens.

There are also critical low-tech components to information infrastructure, for example, lay educators and natural helpers. In many communities, individuals and volunteer organizations step forward to help others get what they need. Sometimes, they assume such a role after a personal struggle with a disease. In other cases, they are in a good position to know how to connect people to the right resources, e.g., a nurse, physician or patient navigator in a small town who knows how to get things done for patients beyond the normal call of duty. The Indian Health Service has, in fact, deliberately cultivated the use of community health representatives. Such people will be increasingly important to those who are not "wired." IT can help create a network to support helpers and deliver information to be used in a socially and culturally palatable format that recognizes the informal aspects of health care.

## *Vision for an Information Infrastructure*

An information infrastructure should be patient-based. It should encourage health care providers and facilities to use IT to keep and analyze patient records and to store them confidentially. It should permit the creation of networks that connect isolated databases in hospitals and elsewhere patient-by-patient. It should enable patients to use their own data to filter information about their health and health care.

An information infrastructure needs to protect patient's privacy and ensure confidential use of information. Patients will not trust an information infrastructure without having safeguards to protect their privacy. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) has safeguards that prevent individual doctors, hospitals, and other institutions from violating patient's privacy and it gives patients access to their own medical records. But it does not give patients control over the creation of networks that link together their medical records that exist in various places.

An information infrastructure should enable getting the right information to the right person at the right time in the right place. In health care many information needs are primarily business or administrative, e.g., processing claims and payments for medical services and gathering, analyzing and reporting of performance measurement data to ensure accountability. Other information needs are more clinical in nature, e.g., electronic medical records, integrated with point of care decision support to enhance decision-making and promote patient safety. There are also patient education needs to enhance consumer choice and self-management and facilitate shared decision-making. Finally, communities need to be able to track illness and monitor community health indices.

In order to meet all of these needs, the creation of an information infrastructure must begin with an accurate and ongoing evaluation of the needs of the end user and the purpose of the information. Building from the user's view is necessary to create a seamless informatics system that will make sense to the end user. Being easy to understand and use is critical for adoption.

### ***Challenges***

Achieving this vision requires an integrated system that moves appropriate information to and from responsible parties in a paperless, electronic system. Yet, there are several key challenges to the creation

of a robust information infrastructure that must be addressed: trust, leadership, standards, incentives and transparency.

The current fragmented system, created within an industry where incentives encourage "siloed" approaches, lacks any systematic cohesiveness. With the exception of multi-specialty groups and integrated systems, physicians generally practice as independent agents interacting with other parts of the system in an ad hoc fashion. Funding streams for programs and institutions are independent, volatile and often fragile. These historical facts suggest information infrastructure lacks a galvanizing agent, but that can change.

One of the biggest challenges is trust. Information is closely guarded in health care, and sharing information raises many fears. Patients may fear losing their job or health insurance if their employer finds out about a health problem. Doctors may fear other doctors stealing their patients or trial lawyers trolling for lawsuits. Hospital departments may fear losing control over their operations under centralized hospital databases.

Trust must be earned, of course, but it can be nurtured through governance. If each group affected by information sharing has a clear and strong voice in determining the use of the information, then they are more likely to trust how it is shared. Establishing governance across institutions is difficult, but communities can be leaders in garnering support.

Government can also play a role in leadership. Government has a vested interested in realizing smooth administration and efficiency. As a payer for approximately 45 percent of all medical services and as a provider of tax subsidies for much of the rest of health care, it can use its leverage to pursue a national strategy, one that is commensurate with the magnitude of the task at hand. Recommended enabling activities include:

- Facilitating and supporting creation of and, when necessary, enforcing national standards for data (including connectivity, security and confidentiality aspects);
- Facilitating development of a national health performance measurement and outcomes database;
- Funding research and demonstration projects;
- Stimulating innovation by creating incentives for IT investments to be made by private institutions or more broadly at the community level (possibly modeled after the 20th century utility or telephone rural coops);
- Functioning as an honest broker in data gathering and dissemination; and
- Convening and coordinating activities.

Supporting the development of standards is a particularly important role for the government because they require investments in creating products that everyone will use but which no single private institution will benefit enough from to pay for the cost of producing them. Standards range from a common language for defining health conditions electronically to rules about measuring, assessing and reporting on quality.

The transparency of health care prices and quality is a critical component of engaging individuals more actively in their own health and health care. Without transparency, individuals cannot understand and evaluate their health care decisions. Some providers urge caution in disclosing less than perfect information, but information about quality will never be perfect. We need to do what we can with what exists and make it better. The Centers for Medicare and Medicaid Services (CMS) is taking steps to release quality indicators about hospitals and nursing homes, and many believe that government can do more to promote transparency at many levels. HIPAA, although a well-intended regulation that is currently driving most of the work on infrastructure, will require that organizations proceed cautiously.

In order to advance transparency, the state and federal regulatory and administrative agencies need to develop standards for disclosure of performance information, help enable the creation of patient records and help to ensure institutions comply with these standards. Standardizing information, release of performance information, setting data and transmission standards are all prerequisites to a high performance health care system.  There is already broad support from the insurance industry for standardization and the enthusiasm of other health care sectors is likely to be enhanced as the appreciation of its value in infrastructure development grows.

Many believe consumers are ready. Others express concern that as we ramp up measurement and launch public debates about the shortcomings of institutions and providers of care, we can expect confusion and uneasiness on the part of individuals, who may want to believe that poor quality and outcomes may happen to others, but not to them. As part of the healing process, patients have a strong need to believe that their physicians and hospital provide appropriate and effective, high quality services. Nonetheless, physicians must begin to transfer ownership of their patient's health to the patients, at least figuratively, if patients are to take more responsibility for their health. In both disclosing information about quality and engendering self-care, both the credibility of the messenger and methods must be trusted.

From the providers' perspective, if feedback on performance is to be accepted and result in appropriate behavior change, the focus should be on improvement, not fault-finding. It is widely believed, however, that if creating an information infrastructure makes it easier for doctors to care for patients, they will willingly give up some control and get "on board." This viewpoint reinforces the importance of designing IT systems to meet the end users' needs, in this case, physicians.

One example of innovative thinking and action in this regard has been the development of Anceta®, the first national repository of de-identified administrative and clinical data from non-affiliated medical group practices. Anceta® is a subsidiary of the American Medical Group Association, an organization whose member groups are some of the largest, most prestigious integrated health care delivery systems in America. The ultimate utility of Anceta® will be to foster greater and more knowledgeable patient-directed influence in the accessibility, quality and cost of his or her own health care. Thus, both the practitioner and the patient can benefit as the end users of this data.

## *Can we learn from other industries?*

Perhaps. Historically, banking was a "cottage industry" not unlike health care. The resistance to transparency and networks for exchanging information was overcome because the industry realized it needed to make transactional services clearer, easier to access, convenient and less expensive. They had to get away from bureaucratic "interventions" that would slowly grind progress to a halt. Today's complex banking infrastructure, e.g., ATM cards, is easy for consumers to use and understand and works across most banking systems. Given the potential benefits to all the stakeholders in health care, especially providers who make it easy to do business with them and who focus on patient needs, champions of infrastructure development and transparency will emerge sooner or later. Communities can grab this opportunity and curb the waste by taking action today.

## *Conclusion*

Currently our "system" is anything but! A well-functioning system uses information to prevent and fix problems even as it continuously updates itself to optimize its functions. Our systems also need inter-disciplinary coordination and more accountability. In addition to a leadership role for communities and government, successful creation of the necessary components of an information infrastructure also depends whether vested stakeholders recognize its value and willingly make the necessary financial and cultural commitments.

## *Resources*

- National Alliance for Health Information Technology http://www.bridgemedical.com/nahit.shtml
- National Patient Safety Foundation http://www.npsf.org/
- Patient Safety Institute http://www.ptsafety.org/
- Crossing the Quality Chasm, IOM report
- US Dept. of Defense, "Reach to Recovery"

## *Next Steps for Communities*

### *Highly recommended*

- Develop and advance programs to educate community health workers and "lay educators," such as patient navigators, to enable other less informed citizens to learn more about their own health and the health of their community and to bridge cultural and linguistic barriers to accessing information.

- Prepare case study vignettes of approaches at the local level that are addressing identified information needs--relative to individuals, the delivery system or the community. The vignettes will outline critical success factors and serve as a vehicle for knowledge transfer among interested parties.

***__Other considerations__***

- Consider advancing a local bond election to fund healthcare infrastructure.
- Create or bestow trust in a third party organization to exchange information across institutions as areas of the country (e.g., as Indianapolis, IN; Santa Barbara, CA, Delaware have done.)

***__Potential multi-community collaborative projects__***

- Examine the progress of public and private initiatives currently underway for local adoption or demonstrations, including the E-Health Initiative, the work of the National Committee for Vital Health Statistics, National Alliance for healthcare information technology (NAHIT), and others.
  Identify the goals of each effort, determine gaps or opportunities for greater collaboration that may serve to accelerate the pace of progress.
- Develop a list of principles framing the infrastructure question and determine appropriate actionable steps to address them. Begin with a review of the NCVHS "National Health Information Infrastructure" white paper.
- Research development of infrastructure in other industries (e.g, banking, utilities, telecommunications, etc) to identify common drivers, incentives, funding streams, governance.
- Develop a white paper to outline the principles, the status of progress being made and recommending enabling activities for government, including financial and regulatory strategies.

***__Community support for health policy/governmental action__***

- Review HIPAA with an eye toward reducing unnecessary requirements especially in view of a more robust information network and infrastructure. New ways to include more stakeholder input and to pilot test standards locally should be considered. Funding for HIPPA compliance should be considered, too.
- Promote research on basic research on information systems to facilitate care and translation of research into practice. AHRQ at $300 million in contrast to the billions at NIH.
- Encourage payers to create incentives for the adoption and use of IT and information networks.
- Re-fashion the way doctors are trained in order to change the more entrenched opposition among doctors to transparency and accountability.
- Address environmental factors that are barriers to change, for example inappropriate medical liability.

- Integrate the use of information in schools as a tool for teaching children about health promotion and disease prevention at the earliest possible age.

# Public Health

Any attempt at comprehensive health system change must start by addressing a fundamental question: How do we achieve "health" as individuals and as a society? The nation's public health system must be recognized as a key part of the answer. Public health performs an essential role as the glue that supports a community's health and health care infrastructure. However, public health's role is often ill-defined, poorly understood, and under-resourced. It is time for communities to re-examine how public health can best be used to support their populations' health needs in the 21st century. Addressing public health problems is one of the most pragmatic means for facilitating community change.

There is no monolithic approach to public health. Traditionally, public health serves certain "core functions", such as tracking community health status and containing disease outbreaks. But there is enormous variation in the range of functions that public health departments perform. For example, in many states, public health delivers a wide array of screening and primary care services to uninsured patients. In some states, public health delivers only a very limited menu of primary care services, such as immunizations and well-baby care. In other states, public health doesn't deliver any primary care at all. As a result of this state-by-state approach, there are 50 different models of public health and 50 different definitions.

One result of such wide variation is a great deal of confusion about just what "public health" is. Some people think of it simply as indigent health care. The public's perceptions of public health's functions are often far narrower than the reality. On the other hand, the Institute of Medicine defines public health in very broad terms, as "***… what we, as a society, do collectively to assure the conditions***

***for people to be healthy***." In most communities, the reality lies somewhere in between. Public health is more targeted than the IoM definition suggests but more comprehensive than much of the public may realize.

There needs to be an effort to redefine public health and its place in our overall health care system. Mark Rothstein, Director of the Institute for Bioethics, Health Policy and Law at the University of Louisville, writes that, "***Greater clarity and consensus on the meaning of public health is likely to lead to more efficient and effective public health interventions as well as increased public and political support for public health activities.***" Bringing "greater clarity and consensus" to public health is an important step communities can take, especially now, when our national security depends more than ever on maintaining a well-functioning public health system.

Unfortunately, there are many communities whose public health systems are falling apart. A recent IoM report on public health in the 21st century cites serious deficiencies in public health, such as lack of workforce training, outdated technology and labs, and ineffective communication networks. It seems that those communities that have the most need for a strong public health infrastructure often have the fewest resources. Public health depends largely on county, state, and federal dollars, which can be pretty fragile funding streams.

It is the position of many community leaders that public-private partnerships could serve a useful role in bolstering a community's public health infrastructure in certain areas. Traditionally, public health has been seen as a purely governmental responsibility, but this mindset may be limiting public health's potential. In considering public health's role in the broader social determinants of health and disease, perhaps it makes sense to view it as a bridge between the public and private sectors involved in health care.

Public health professionals believe that the CDC Office of Public Health Practice should work with health departments, perhaps through the National Association of County Health Officers, on an accreditation process, similar to what the hospitals did voluntarily more than fifteen years ago, to set standards for how the departments work with local healthcare delivery services. This process would help drive improvement and could go a long way toward establishing the appropriate role for and credibility of public health.

Re-Shaping The Role

## Re-Shaping The Role of Public Health In A New Era

Public health leaders can reinvent their mission to better meet the needs of the 21st century. There is a mistaken belief that public health is no longer as necessary or as relevant to Americans' health as it once was because the battle has been won to achieve clean water and good sewage systems. But now our country faces a new set of challenges that underscore that public health still serves a critical function.

During the past two years, public health has assumed a very significant role in national security through its involvement in preparation for bioterrorism and other emerging health threats. Public health, working in concert with the medical community and private health care sector, has taken a leadership role in bioterrorism preparedness. There are also abundant new resources available to public health to address bioterrorism preparedness. This new area of responsibility has required public health to function in new ways and form new partnerships.

For example, in San Antonio, Texas, public health agencies moved quickly after Sept. 11 to come together with local health care providers to form the Regional Emergency Medical Preparedness Steering Committee.

The work done in San Antonio demonstrates that public health can play a vital role by showing leadership in addressing emerging areas of concern. In addition to bioterrorism preparedness and emerging infectious diseases such as SARS, chronic diseases related to lifestyle are a potential area for greater public health involvement. Clearly, public health has an opportunity to reinvent itself and raise its visibility in the community. On the other hand, these new areas of responsibility should not detract from public health's traditional functions.

There is broad agreement on the essential functions of public health, which have been well articulated by the IoM and others. Some key areas include data gathering and analysis; disease prevention, investigation and tracking; monitoring of community health status; health planning; community outreach and engagement; and mobilizing partnerships. Health disparities are also an important focus in public health. However, the IoM found no consensus when it comes to "translating broad statements into effective action," and no shared sense of what the public can and should expect from public health.

As a result, there is little consistency in the organization or content of services, with accountabilities and relationships driven by political expediency rather than policy objectives and capabilities. While no consistent recommendations can be made with regard to how traditional public health services should be organized, there are several caveats that influence the effectiveness of the services. When health departments are organized under the umbrella of "social and health services," coordination may be easier, especially in smaller states or rural regions. However, public health, which benefits society at large, not just the indigent population, may be misinterpreted as another "welfare" program.

Public health's involvement as part of the safety net cannot be eliminated or marginalized. Confusing public health with safety net services and preventive and primary care, including mental health/chemical dependency, runs the risk of relegating public health to a secondary role.

Combining some of these services under one department may be necessary because the same expertise is needed in many cases, but communities should discuss and understand the different roles of the public health system.

Reappraisal of public health must consider the disagreement among public health officials and the public about its role and the distinctions between public health and clinical care and public health and health promotion.

Strengthening Financing

## Strengthening Public Health Financing

However public health is organized, its financing remains a significant challenge. As a critical element of community infrastructure, public health's funding and responsibilities should be clearly articulated. Too often, public health is at the mercy of a political process that threatens its dedicated funding streams. It is the position of many community leaders that public health needs more diverse sources of income.

Public health needs to be financed in a way that maintains the best characteristics of public-private partnerships, building on what the private sector can and will do and ensuring that which is carried by the public sector serves an appropriate public good. The way we currently finance private care may undermine public health financing and collaboration, and vice versa. Just as public health and private health care ought to complement and reinforce one another, some suggest that the dollars spent on medical care and on public health programs should both result in some mutual return on investment. The old distinctions between the funding, the activities, and the results of public health programs and medical care are no longer hard and fast. Therefore, rather than look at the system strictly from an individual perspective, we should consider it within an overall public context.

Much of the work of public health is not linked to a provider encounter, so financing mechanisms need to allow for payment for non-transactional services that promote health, such as epidemiology, surveillance, and environmental health activities. In some places, local health departments only focus on services to which a fee is attached – e.g., immunizations, indigent care or septic tank inspection, at the expense of core public health services. Other service requests are referred to the state health department.

There is a strong sentiment that the health care purchasing role of the government, e.g., the funding of indigent care, must be separated from essential public health services. Organizing Medicaid under the department of public health results in a lack of attention to the multiplicity of important public health programs because of a singular focus on the much higher costs of Medicaid.

### ***Cooperation at the local level for optimum public health***

The current disconnect between public health and the medical community is clearly “unhealthy” and does patients a disservice. We need to get the medical and public health communities back together if we are to make both as effective as possible. Similarly, we need more interdisciplinary collaboration when it comes to other health-related disciplines, such as the oral health and mental health communities.

There needs to be clear delineation of responsibilities for services where there is the potential for overlap. For example, should immunizations be a part of well-baby checks, or a service performed by health departments? It is inefficient and inconvenient to split these two critical pediatric services.

There are also potential problems with regard to categorical programs. Treatment for sexually transmitted diseases and tuberculosis are usually carved out as responsibilities of the health department. But should screening and treatment be part of the “medical home”, with the health department doing contact investigation, tracking, follow-up and outbreak control? Some would argue that when treatment is complicated (as with TB) and follow-up and outreach are critical, public health, which is uniquely good at tracking, should be in control. But collaboration is most effective. There can also be problems in these programs when funding for essential services is combined with patient care dollars. For example, when the price of TB drugs goes up, the health department may feel pressured to reduce nurses.

Some express the view that indigent care is something that should be provided by health departments only until another willing provider can be found. In some cases, however, as cutbacks in other programs are made, the role of public health in creating a model of care delivery that is on the cusp of public health, population health and individual health management becomes important.

Some make a strong argument for a role for public health in chronic disease management. The rationale is that a majority of health care costs are driven by chronic disease, and much of the management of chronic disease goes on outside doctor's office. Possible roles for public health include further development of data registries, with feedback to clinicians; patient education; community support; the development of core indicators for diabetes care; and health tracking, for example, related to asthma. A public health department can play a vital role as a catalyst for change and a convening organization, for example, around chronic care. Public health professionals play a vital role in the continuum of health and health care. They are community-based, can bring communities together, can measure progress and are often viewed as "neutral players". This role also helps ensure that public health will be invited to the table on other issues.

The critical point is not so much which services are deemed appropriate or necessary for a given health department to perform. Rather, dynamics at the local level are problematic and without clarity around roles, a sense of competition, not cooperation, may be created with local hospitals, community and migrant health centers, and private providers.

Moving forward, public health needs much more active engagement from organized medicine. One place to start would be to put a greater emphasis on public health in medical school curricula. Medical students need to be exposed to public health if they are to understand and appreciate its role.

Data Collection

# Data Collection and Analysis: A Role That Is Distinct From Clinical Delivery

Clearly, a primary role of the health department must be to monitor disease trends at the local level and provide that information to communities so that they can set goals and priorities. There is strong support for the notion that, if health departments are involved in clinical delivery, there needs to be a firewall with regard to data. Otherwise, if the health department provides prenatal care and infant death rates increase, for example, there could be a perceived bias in data reporting. In the essential functions of public health, public health departments must be perceived as impartial collectors and analyzers of data.

## *Regionalization*

Consideration should be given to regionalizing some public health functions, similar to the notion of regionalizing trauma districts, and some states are doing this. The CDC criteria for the skills needed for full service health departments should be used. This approach can help to create economies of scale in use of resources. The challenge is explaining the role of public health in a "sound bite." For example, everyone understands the concept of trauma care and only wants the best!

*__Next Steps for Communities__*

*__Highly recommended__*

- Survey public health officials regarding the types of data they collect and the sources of that data. Identify gaps in information that is necessary to create a “community health” profile.
- Establish a “national community dialogue” initiative to determine the optimum role of public health in the 21st century. Consider a series of community meetings that would serve to raise awareness of public health’s function and provide the opportunity to undertake a methodical process of identifying the most important roles for public health from the perspective of the community. Assure that these community perspectives are reflected in public health and medical care incentives for providers and patients. (The definition of “community” is a local issue. In some cases it may reflect only one region of a large city; in a small, rural, or sparsely populated state, the activity may pull from the entire state.)

*__Other steps for consideration__*

- Begin at the community level to identify public health “best practices”, considering the recommendations from the CDC Office of Public Health Practice regarding accreditation. Ensure that criteria are practical and realistic for different practice settings and needs. Catalogue critical success factors embedded in the best practices’ work and reflect these in incentives wherever possible. It is suggested that the community find out which states or communities have begun this process and what results are to date.
- Employ the local public health authority as a governmental “convener” of local, health-related leaders. This role can enhance the authority’s visibility and help to integrate its services into those provided by private sector and others. This activity may need the support of the governor, mayor, county executive, or other elected officials to give it the clout needed.
- Reevaluate current public and private funding streams and assessment of strength or fragility and look for ways to pay for public health services that do not directly relate to an encounter or physician visit, (e.g., surveillance, epidemiology, environmental health activities).

# Jon R. Comola
# Chairman/CEO

Jon Comola serves as Chief Executive Officer and a member of the Board of Directors of Wye River Group on Healthcare. He founded the group in 1997 to champion new solutions and form the basis of support for a new vision for America's healthcare system focused on market-based solutions and public-private partnerships.

Mr. Comola has more than 25 years of experience in health insurance and public affairs. He is skilled at shaping public policy at the state and federal level and has keen insight into the political and healthcare policy environments. For seven years as Vice President, Government Affairs for Blue Cross and Blue Shield of Texas, he was responsible for development and execution of all public strategies on the state and federal levels. Jon has also served as an informal advisor on health care issues to office holders and corporate leaders, counseling them in the development and execution of strategies targeted to achieve business development or political objectives.

As a consultant to the US Chamber of Commerce, he worked with the National Chamber Foundation in developing and marketing several important healthcare initiatives, including the Foundation's successful national Health Care Solutions Summits. This series of regional forums provided the opportunity for a cross-section of community leaders from all healthcare stakeholder groups to come together to discuss and debate issues related to the future of healthcare and highlight community-based partnerships that address access, affordability and quality.

Mr. Comola has helped facilitate development of healthcare stakeholder partnerships and alliances to support evolving roles and advance public policy goals in the current turbulent healthcare environment.

Mr. Comola, is a graduate of the University of Texas, Austin and holds a BA degree in Organizational Communications.

# Marcia L. Comstock, MD, MPH

Marcia L. Comstock, MD MPH, President of Comstock Consulting Group, LLC was a co-incorporator of Wye River Group on Healthcare, Inc. and served as Chief Operating Officer and a member of the Board of Directors from its formal inception in June 2001 until September 2006. She is also co-founder of the Foundation for American Health Care Leadership.

Dr. Comstock is an experienced consultant on national healthcare policy and the evolving roles of healthcare stakeholders. She has worked at the national, state, and local level with public and private sector entities, trade, and professional associations, applying strategic intelligence, 3rd party advocacy and consensus building techniques to identify and advance elements of a common public policy agenda. She has consulted with business leaders on issues such as managed care, health risk management, and environmental health and safety.

From 1998 to 2001, Dr. Comstock served as Fellow, Health Care Policy & Workplace Issues for the National Chamber Foundation, US Chamber of Commerce. She advised the Chamber president and its' members on the impact of proposed health-related legislation and assisted the Chamber in advocating for healthcare, safety, and other regulatory issues of importance to American business. She planned, promoted, and implemented national and regional forums to discuss and debate issues related to access, affordability and quality, and to propose solutions to health system deficiencies.

A Certified Physician Executive and Fellow of the American College of Occupational and Environmental Medicine, Dr Comstock also has extensive experience directing programs in corporate health and productivity enhancement. For 17 years she served as Medical Director, first for AT&T Bell Laboratories, then for Consolidated Rail Corporation. She was consultant to senior management on broad-based economic and humanistic health issues.

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"The authors would like to express sincere appreciation to our Graphic Artist, Lindsey Richey, for her diligence and creativity."

Lindsey Richey
*Graphic Artist*

## In the words of participants in the Wye River Process…….

"These discussions with a cross-section of healthcare leaders have provided valuable insights into our country's healthcare values and how they should shape our healthcare system." *Mark McClellan, MD PhD, Brookings Institution; (former) Administrator, Centers for Medicare & Medicaid Services*

"…the essence of living in a pluralistic and democratic society [is] that somehow before you set [health] policies, you get some sense of what the citizens and electorate want." *John Seffrin, PhD, (former) CEO, American Cancer Society*

"In Washington we don't really spend very much time talking about healthcare policy anymore. It's mostly about politics….We find ourselves debating extremes versus finding consensus…" *Karen Ignagni, President & CEO, AHIP*

"…our healthcare system exists in random acts of clinical improvement… where each interest group is moving forward in whatever direction it feels is appropriate." *Sanford Kurtz, MD, COO Lahey Clinic*

"Like politics, all health care is local. As such, it is fitting that the answers and solutions for the accelerating crisis in healthcare cost and access will come from community innovation." *Martin Hickey, MD MS, SVP Health Care Affairs, Excellus BlueCross BlueShield; (former President & CEO, Lovelace Health Systems)*

"The reality is that health care is both a public good and a private good. Not one or the other…The challenge is sorting them out." *Dave Kendall, Senior Fellow for Health Policy, Progressive Policy Institute*

"A special contribution of [Wye River Group's] work has been the diverse and sustained exploration of the issues with a broad spectrum of healthcare professionals and community leaders….so that the results are free of narrow perspectives and momentary trends. Policymakers… and healthcare organizations all need this kind of balanced, comprehensive, durable foundation on which to base their practical work of implementing useful changes in healthcare."
*Stephen Plume, MD, Professor Emeritus, Dartmouth Medical School*