FOUNDATION FOR AMERICAN HEALTH CARE LEADERSHIP℠

AN AFFILIATE OF WYE RIVER GROUP ON HEALTHCARE

Promoting and Enabling Healthy Choices: Linking the Desire for Health with the Decisions & Tools that Support Health

EXECUTIVE SUMMARY

The Foundation for American Health Care's December 2004 retreat at the Broadmoor in Colorado Springs explored the widening gap between the 'possibilities,' what we can do to maintain our health, and the 'practices,' what many of us are actually doing in our daily lives. Why are things that seem so simple – like eating a healthy diet and getting regular exercise – so difficult for us to practice? What is needed to create a stronger link between our desire for health on the one hand, and making the appropriate choices on the other? How can we ensure that each of us as an individual and as a member of our community has the motivation and the tools to make good decisions about our health and healthcare?

These questions have significant relevance for us as the health care 'system' struggles with managing escalating costs associated with an aging population and the rising prevalence of chronic health conditions. A growing body of literature suggests that the greatest opportunities to improve health outcomes and lower costs lie in the area of behavioral choices and lifestyle. The Broadmoor meeting explored many opportunities in this area.

As a first step, many believe we need to raise public awareness about each person' s ability to influence their own health and well-being, and to educate people about how their personal choices impact the health care system and the available resources upon which we all depend.

The Foundation's June meeting focused on the question *"What is the Economic Value of Health and Healthcare"* and explored each sector' s responsibility to demonstrate value. There was broad agreement that institutions should be accountable, measurable and operationally transparent to the consumer. The system also has a responsibility to ensure that patients have the right incentives and information to be truly engaged in their healthcare. Providers can become partners with patients by offering them the decision-support they need to make healthy choices and better understand their treatment options. Government should serve as a broker of information and as a mechanism to ensure a level playing field.

The Broadmoor retreat then focused on the consumer/patient side of the value equation for health care—how changing individual attitudes and behaviors can enable people to practice good health habits that will help maintain and improve their health. We considered the question of individual engagement by examining potential applications of science, art, social, and cultural dynamics. We discussed marketplace tools and opportunities to optimize our healthcare future from various perspectives--that of employers, providers, government, and consumers--with representatives from across the country, as well as individuals with international expertise. These discussions took place in the context of the implications of future trends.

The Behavioral Change Model

Dr. James Prochaska's keynote speech described the application of the transtheoretical model of behavioral change, illustrating that there is a science to enabling lasting change. He pointed out that the

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mental models of behavioral change that have dominated our society for the past century have been action-oriented models. However, change is a process that unfolds over time, involving progress through a series of stages, from pre-contemplation to contemplation, preparation, action and maintenance. It is highly likely that this is as true for organizations as it is for individuals, a fact that has significant implications for stimulating a positive evolution in the health care system.

Today, it is well known that over 50% of all health care costs are due to behaviors like smoking, alcohol abuse, unhealthy diet, sedentary lifestyles, and stress. But we are not proactively managing these costs! Most primary care takes place at home, and the majority is behavioral.

Dr. Prochaska highlighted the message of small changes. We need to recognize that people are more likely to take steps to address unhealthy lifestyle behaviors if what is asked of them appears to be reasonable, not overwhelming. The stage of readiness of an individual patient can be assessed in five easy questions, so that the behavioral medicine intervention can be matched to their stage. A realistic goal is to help them progress one stage during a brief interaction, by giving them feedback that they aren't aware of in terms of their decision-making about their own behavior and their own health.

To have an unprecedented impact on the major killers and cost drivers of our time, we need to change several of our paradigms. We need to move from a focus on individual patients to populations; from passive reactive to proactive healthcare; from office-based to home-based delivery; from reliance on clinicians to reliance on teams supported by computers; and from addressing single behaviors to multiple behaviors.

Dr. Prochaska also had several recommendations for public policy related to obesity and behavioral change. First, deal with obesity as a multiple behavior change problem and highlight all the benefits to be gained from the behavior change, not just weight loss. Second, he recommended that more home-based programs be available at affordable rates. Finally, and most fundamentally, he recommended that we make unprecedented investments in these strategies, tacitly recognizing their importance.

Developing a Multi-faceted Campaign

Health is an unstoppable political force if we can reach a 'tipping point' by getting everybody—doctors, hospitals, health plans, employers, and patients—on the same page. But that is hard to do! Successful models for health promotion are based on a holistic approach, facilitating both individual responsibility and a supportive environment for change. Yet, most US programs are 'siloed' and focus strongly on individual responsibility for lifestyle changes, with much less attention paid to creating an enabling environment.

Participants expressed the view that leadership should come from government, which can mobilize public and private resources. We need to work to identify the unique capabilities of government agencies and state health departments in working with private sector healthcare organizations and employers, and develop the necessary partnerships to motivate the public. Some suggested the potential benefits of creating a modern version of the old US office of public information to coordinate messages among state and federal agencies on issues of broad public interest.

There is also a huge opportunity with corporations and communities. Both have a major interest in health and wellness for their employees and residents. A healthy member of society is more productive, requires fewer resources, and generally fosters a more positive attitude among his/her peers.

As a start, examples of past campaigns to change behavior should be carefully studied for the critical success factors and lessons learned. Several of these campaigns and community-based models are highlighted in this report. An artful campaign strategy should be considered, tapping into the creative

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marketing techniques perfected by companies in the food/beverage and consumer products industries. We should also harness the collective learning from proven campaigns executed by powerhouse organizations like the disease advocacy groups, American Cancer Society, American Diabetes Association, and American Heart Association. And we should employ the power of art in all its forms as a universal communicator of ideas.

We learned that the campaign should be aimed at the entire population. There is no real 'high risk' group, as most people are doing well at some things and not well at others. Directing efforts on a population basis also raises the likelihood that those who exhibit behaviors we would like to change are getting some social pressure from those who are not engaged in the undesirable behavior.

Health and healthcare are very complex, but messages need to be clear and simple, carefully tailored to different target groups, and delivered using a variety of media. For example, television and radio, journalists, the Internet and the arts, should all be used to reinforce the message. The communication needs to be consistent, encouraging and unavoidable.

Participants strongly agreed with presenters who pointed out that people respond to messages that are human, visual, and aligned with cultural values, social norms and financial incentives. Because we are a society that runs on instant gratification, the tangible and immediate benefits exchange needs to be clear. To make meaningful progress at changing these unhealthy behaviors, it is likely that it will be necessary to move some of our social cultural values, for example, unbridled consumerism, in a different direction. We will need to take advantage of existing strongly held social values and 'higher order' human needs, like the intrinsic desire to belong.

Cultural change to improve health **is** possible, and the most promising setting in which to initiate such change is within the community. Programs need to reach people where they live and work, with tools they can use. Comprehensive programs also need to consider all aspects of living, including education, recreation, safety, urban planning and transportation, all of which impact our health.

Finally, we need to be realistic. As it generally takes 7 to 10 years to fundamentally change culture, we need to appreciate that a public education campaign of six months to two years is not going to be adequate. We need to be ready to invest for the long haul to improve our lifestyle behaviors and ultimately the health of our nation.

The Status of Tools and Information

Participants agreed that patients are the most important source of continuity in their healthcare. Thus, their active involvement, especially in influencing and implementing decisions relating to prevention and early treatment, is crucial to ensuring healthcare quality. A secure, centralized source of patient information, such as an electronic health record, is an essential tool for helping physicians to provide efficient, quality care and patients to track their progress and make important healthcare decisions. Tools and other interventions should be geared to improving patients' readiness to change.

However, to engage consumers/patients, tools must be responsive to the entire array of people affected by the healthcare system, and recognize disparities of disease, socioeconomic status, geography, and racial and ethnic background. Tools need to be appropriate to specific cultures, languages, capacities, skills and health status. They need to be relevant, timely, specific, measurable, geared to the behavior or goal desired, and supported by both positive and negative incentives.

Multiple tools and exposures are necessary, because study results suggest that patients quickly forget much of the information provided during an encounter with their physician. Further, patients must be surrounded with help. They need access to web-based, telephonic, mail, and print communications, as

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well as community advisors and health coaches, to assist them in making healthcare decisions, particularly those involving behavioral change.

One speaker recommended that consumer/patient engagement efforts be focused around the 'Five Vs' : (1) a vision of a healthcare system that is achievable; (2) the values of choice, affordability, personal responsibility, accountability, fairness, dignity, respect and quality; (3) the voice of the consumer/patient; (4) healthcare system changes based on the needs of the system's current victims; and (5) victory that includes a full integration of body, mind and spirit.

There is significant support for the concept of 'information therapy,' which integrates clinical care with condition and treatment specific information. It involves the patient in 'homework' and the healthcare professional in checking patient understanding of information they are getting. Today, few physicians are providing adequate information for patients to use at home to prevent or manage chronic disease.

There are a number of potential barriers to engaging consumers/patients actively in their healthcare. The explosion of complex information and the lack of transparency regarding the cost and quality of available care hinder even those with the best intentions from being fully involved. Recently, some people have expressed concern that health savings accounts could be a barrier to prevention, if consumers focus on saving the money by rolling it over from year to year, reducing the likelihood that they will get important screening tests that could aid early diagnosis. Finally, given our fragmented health care system, developing standards to sort out complexities and using technology to amalgamate and readily distribute important information will take a nationally coordinated effort.

The Status of Shared Decision-Making

There was general agreement among speakers and participants that the politics of healthcare pivots on the doctor-patient relationship. Clearly the quality of communication between physicians and their patients is intrinsic to the overall quality of the relationship.

Physician autonomy, a historical tenet of medical training, was a great strength in yesterday's healthcare environment. But it has become a liability today. Access to information has changed the traditional physician-patient balance. There are a lot of smart patients now. Both the growing demands of these empowered patients and the needs of our complex system mean that a significant transition is needed in the role of physicians, such that they become partners with patients, team leaders and coaches. But data suggests that the compliance rate of the typical physician in working with other health professionals to help patients to adopt a healthier lifestyle is about the same as the compliance behavior of the patients themselves. So we have a lot of work to do on both sides of the doctor-patient equation!

The fundamental challenges for the important process of shared decision-making do not rest on difficult patients or difficult doctors. They rest on difficult relationships. It is very important that patients feel they have a part in making decisions, yet the benefits of shared decision-making are seldom realized today. A study of 1,000 patient encounters involving 3,000 decisions found only 9% of the decisions reflected a limited degree of shared decision-making and not one included all six elements. The element most important to the relationship and to patient compliance, an exploration of the patient's understanding, was noted only 2% of the time.

Effective shared decision-making requires trust, a clinician with good communication skills, time, appropriate incentives, and a larger commitment from the patient and clinician to the value of shared decision-making. Clinicians need to be able to assess the understanding of the patient before providing advice and counsel. They need to build rapport through reflective listening skills and empathetic communication. Patients assume their physician is competent, so the attributes they value most highly are

compassion and a sense of partnership. How a physician presents the 'truth' is crucially important, as there are good ways and bad ways to present the same information to the patient.

Preparing for the Baby Boomers
In this interactive panel discussion, participants learned a good deal about what baby boomers think about aging, what they are doing to prepare, and more importantly what they are NOT doing!

As a society, we are simply not prepared for longevity. We have neither the systems nor the services to take care of the coming wave of seniors, who will face an increasing symptom burden related to chronic illnesses and increasing disability in their later years.

By 2011, the first edge of the baby boomer generation will reach 65, and 76 million boomers will follow. The baby boomers, in general, tell us that aging is not for them. Their bodies might age, but they are healthy and they are never going to get old. Panelists and audience participants agreed that they are largely unwilling to think about the challenges, or opportunities, of aging and believe that a healthy life style now will obviate problems later. Nearly 80% of the boomer generation expects to 'age in place' and continue working at some level.

There are global concerns facing us as the population ages with their needs for significantly more and different health and social services, housing, and economic security being foremost among the challenges. Of all the primary challenges, economic security is the most serious. The financial realities related to the boomers are going to make the need to limit choices and modify behaviors inevitable. Using Prochaska's model we have to gradually bring people along to the inevitability of structural changes. Many people lack an adequate retirement income, and it is not easy to teach people to be financially disciplined. We need to improve population health and lower consumption of resources. But few people seem willing to lesson their demands on the system to free up resources for the less fortunate.

Panelists stressed that they represented only a fraction of the boomers—those who have sufficient economic security to consider options such as retirement and congregate housing. The issues facing those with more limited resources are much more daunting. Among the serious challenges is engaging baby boomers in healthy aging practices and in planning for the years of increasing disability. Health services, in contrast to medical services, and spirituality are key among current boomers' concerns and essential to healthy aging.

Many of the boomers have already experienced the aging process and death with one or both of their parents and want their aging to be fundamentally different. Quality of life concerns will be as important as quantity of life for them.

We have an opportunity to create the kind of environment in which we would like to live as seniors and the services we would like to have available to us. We should begin to create a vision for healthy aging and a vision of a policy and system environment within which healthy aging, as well as increasing chronic illness, can be accommodated effectively.

Integrating Mind and Body
This session focused on what mainstream healthcare can learn from the popularity of a more integrated, mind-body approach to healthcare. For years, consumers have 'gotten it.' They have collectively paid considerable dollars out of their own pockets to get treatments typically labeled as complementary alternative medicine. Yet it is only recently that traditional practitioners have begun to incorporate these practices into a more holistic treatment approach.

Public recognition of the connection between the physical and psychological has been increasing and people are now starting to realize that the six leading causes of death are related to behavior. 97% of the public recognizes the link between good psychological health and good physical health. 79% prefer to see a physician who works collaboratively with a psychologist because it provides more choices and better access to care.

There has been a dramatic increase in the use of CAM by adults and teens and consumer demand has led to an increase in offerings by hospitals and coverage by health plans. Complementary alternative medicine interventions have been effective in appealing to people's willingness to actively engage in their treatment and in facilitating their motivation to change. At the very core of the approach are holistic behavioral lifestyle and mind/body interventions, which, along with diet, exercise, and stress reduction all have a large return on investment. High-tech aggressive interventions yield a smaller return on investment, yet we are investing far more resources there today.

Alternative providers might also provide some solutions to the shortage of traditional providers. CAM practitioners are less expensive to train, their services are generally less costly, and their approach is especially appreciated in multi-cultural communities.

Despite the trends in consumer demand and generally positive outcomes, many physicians still do not support the use of CAM. This attitude contributes to patients' lack of honesty regarding use of such modalities and an increased risk of interactions and side effects.

We need better data on the effectiveness of CAM. Current research isolates interventions and doesn't use an integrated model to evaluate the best application of these modalities in healthcare delivery by multi-disciplinary teams of conventional and CAM practitioners. Speakers suggested that the integration of CAM with mental health and general medical care could be most easily tested in prepaid group practices or in government-run facilities, where the funding is not so fragmented.

NEXT STEPS

In reviewing the richness of the information and insights that emerged from the Broadmoor sessions, we recognized that looking at the value equation from the perspective of consumers and considering how best to promote and engage them in wise health and healthcare decisions is a very broad challenge. The issues are less concrete than considering the value of healthcare interventions and our approach to next steps needs to take this fact into account. We decided that it would be best to explore the options in several areas further, before determining the appropriate role for the Foundation.

We have identified three key topical areas:

1.) Broad-based social marketing and the possibility of a public-private campaign around healthy lifestyles, focused primarily on diet and exercise, to address the obesity epidemic and the associated increase in chronic diseases. Key allies in exploring this option include Oxford Vision 2020, CDC, disease advocacy groups, the food and beverage industry, media, and efforts similar to 'America on the Move'.

2.) Tools and incentives to promote greater engagement. This area should further consider advancements in consumer-directed health benefits and health savings accounts; progress in facilitating physician support of shared decision-making; and advancement in research and implementation of integrative medicine. Key stakeholders include employers, academic medicine, researchers, etc.

3.) Preparing for the baby boomers. This effort should begin with an environmental scan to confirm the 'state of the state' with regard to financial planning, care delivery and community–based models.

In addition, a number of specific policy recommendations emerged from the meeting, several of which are included in our 'Community Leaders Blueprint for Health Care Policy' and will be advanced with the appropriate committee and congressional staff or federal agencies.

Our plan is to invite specific knowledgeable individuals/organizations to participate in a series of conference calls to further identify the most appropriate next steps, if any, in each of these areas. By creating this smaller leadership advisory group we will be better able to discern what is needed and who should do it.

These calls will be summarized, sent to participants for comment, revised, and then shared with all retreat participants for their input. A similar approach proved to be very effective at capturing and distilling broad input during Phase I of the 'Communities Shaping a Vision for America's 21st Century Health & Healthcare' initiative, when we created Advisory Boards on the topics of access, infrastructure, quality, incentives, public health and cultural change.

At a minimum, we believe that the Foundation can serve as a catalyst to promote thinking in this area. We can develop a 'case study' approach, highlighting examples of effective tools and community or worksite-based programs that facilitate the kinds of 'social changes in health behavior' needed to prepare us for a healthier future.

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