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We All Know Why We Must Change: Laying the Groundwork to Bridge Critical Gaps in Health Care



A project of the Harvard School of Public Health *Forces of Change* Program

FORCES OF CHANGE

New Strategies for the Evolving Health Care Marketplace

Edited by: David A. Shore and Christina Thompson Lively

**We All Know Why We Must Change:
Laying the Groundwork to Bridge Critical Gaps in Health Care**

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Harvard School of Public Health
Center for Continuing Professional Education

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Introduction

We are all aware of health care's gaps, and thus we all know why we must change. Though the United States is a leader in health care innovation and spending, our system lags behind other developed countries in life expectancy and quality of care. Poor health is concentrated in specific portions of the population, often among the most disadvantaged. Disparities in health tend to fall along income lines everywhere: the poor generally get sicker and die sooner than the rich. In the United States, however, the gap between the rich and the poor is far wider than in most other developed democracies... and it keeps getting wider!¹

Researchers have conducted many multi-year studies in efforts to understand and address health care's gaps. In March of 2001, the Institute of Medicine released its report, *Crossing the Quality Chasm: A New Health System for the 21st Century*.² Two years after that urgent call to action, Elizabeth McGlynn and her colleagues punctuated the quality gap, reporting that the U.S. health care system delivers evidence-based care to patients a mere 55% of the time.³ For the past 40 years John Wennberg and his colleagues at the Dartmouth Institute for Health Policy and Clinical Practice have documented vast and unwarranted variations in medical practice.⁴ Perhaps one of the more powerful gaps is what Walter Stewart and his colleagues have called the "inferential gap."⁵ An inferential gap exists in two contexts: the nonapplication of relevant existing evidence, and the absence of evidence germane to a particular clinical situation. This gap has enormous implications for evidence-based medicine and consumer-directed health care. Despite years of study and investment, there is little or no evidence that these gaps in health care are shrinking.

Collectively the gaps between what we know and what we do can be framed as gaps between evidence and practice or between bench and bedside. In our own work on *Forces of Change*, we have identified some additional gaps such as the stakeholder collaboration gap and the trust gap. At *Forces*, we seek to help health care leaders bridge the gaps within their organizations.

This collection establishes a common frame of reference as a launching point for our discussions at *Forces of Change*. You will find a discussion of legacy issues such as costs and equity, and a discussion of newer issues including two pieces discussing the need for better information integration. Having identified the problems, we can accelerate the *Forces* experience to move on to what we call "significant learning": active engagement in problem solving, instead of a mere accumulation of facts. Rather than "mind the gaps," we aim to bridge the gaps. Having identified why we must change, we will move quickly to how we can change at *Forces*.

We hope that this review will stimulate thought, dialogue, and insight. I welcome your comments at dshore@hsph.harvard.edu, and hope that you will join us at *Forces of Change*.

David A. Shore, PhD

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Director, Forces of Change Program

Founding Director, Trust Initiative

Harvard School of Public Health

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Eric Winston

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Creating a Successful Health Care Consumer

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Healthways

..there is substantial variation in health care spending per person in different geographic areas — and the places where the most money is spent are not the places where patients get the best quality care.

The Value Gap

U.S. System: Highest Health Care Cost in the World

There is ample evidence that Americans do not receive the value of care indicated by the enormous and growing share of U.S. GDP devoted to health care. The U.S. spends 16% of GDP on health care (well over \$6,000 per person), more than double most other OECD¹ countries, but achieves health outcomes that are in most cases no better and in many cases substantially worse.²

Some of these differences are likely due to differences in health behaviors across countries (with the U.S. obesity rate, for example, triple that of the Netherlands), but even within the U.S., there is substantial variation in health care spending per person in different geographic areas — and the places where the most money is spent are not the places where patients get the best quality care.^{3,4} The parts of the country where Medicare beneficiaries receive the highest quality care are those in which Medicare spends the least per beneficiary. This relationship may be driven by a failure of coordination of care — with more specialist visits producing higher cost but lower quality care. Some estimates suggest that 30% of U.S. health care costs are due to inefficient use of resources (see citations in reference #1).

This high and rising spending on health care poses serious pressures on public and private budgets alike. The Congressional Budget Office estimates that, absent any changes in health policy, the U.S. will spend almost half of GDP on health care in 75 years.⁵ Policy changes that would improve the value of care delivered in the U.S. health system, such as payment, financing, and coverage reforms, could thus reap enormous benefit to the U.S. economy.

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The Equity Gap

Inequity in Health Care and the Implications for the Health Care System

Some researchers suggest that more lives could be saved by eliminating health disparities than by new medical advances in a given length of time.

Inequities in the health care system, based on such factors as socioeconomic status, insurance status, race, and gender, have been well documented. These inequities often have detrimental effects on the populations of patients suffering from them. Although all health care disparities are unacceptable, those in which the differences are not accounted for by insurance status, patient preferences, or clinical need are the most troubling and difficult to understand. Research has shown that regardless of insurance coverage, ethnic minorities are less likely than non-minorities to receive many life-saving therapies.^{1,2} Similarly, women often suffer from unexplained biases when seeking medical care. Some researchers suggest that more lives could be saved by eliminating health disparities than by new medical advances in a given length of time.³

Disparities in Cardiovascular Disease (CVD) are particularly striking because CVD disease is preventable and represents the leading cause of death in the U.S., claiming an estimated 350,000 lives every year.⁴ Minorities are overrepresented in the number of deaths as a result of CVD in relation to the overall population.⁵ Despite patient indications and insurance status, this unexplainable gender and racial treatment imbalance in CVD care continues.⁶ A recent study examining gender and racial differences in the use of implantable cardioverter defibrillator therapy to prevent and treat sudden cardiac death revealed that, among indicated Medicare patients, women and black patients were significantly less likely to receive treatment compared with white males.⁷

It is estimated that by the year 2050, minorities will comprise over 50% of the U.S. population.⁸ Because racial and ethnic minority groups are expected to comprise an increasingly larger proportion of the U.S. population in coming years, the future health of America will be greatly influenced by our success in improving the health of these groups.⁹ We must change the current trend of health care disparities to ensure that all people get the highest possible standard of care, regardless of ethnicity, race, or gender.

Eric Winston

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The lack of coordination and communication by the numerous, overly specialized, and narrowly focused caregivers compromises quality and safety.

The Stakeholder Gap

Stakeholder Issues: Who is in Charge of Coordinating Care Delivery?

Patients increasingly complain about not knowing who is ultimately accountable for coordinating their care. This concern is shared by patients in inpatient settings as well as those who receive care in multiple locations. Patients undergo care and treatment by multiple physicians and other professionals, causing breakdowns in communication, unnecessary confusion, growing distrust, and less than optimum results.

The results of poor coordination by the multiplicity of care deliverers cause waste — the overuse, misuse, and underuse of prescribed medications, tests, and treatments.¹ The severity of this problem will only worsen as the patient population ages and more individuals suffer from multiple complex chronic conditions. The number of individuals with such conditions is expected to reach 81 million by 2020.² The lack of coordination and communication by the numerous, frequently overly specialized and narrowly focused caregivers compromises quality and safety. Patients and their families are increasingly confused and dissatisfied.

This basic care delivery problem requires fundamental and transformative change. A new model of care is clearly needed in which a physician (or other caregiver) is identified as the person who is responsible and accountable for the coordination, communication, and implementation of a plan of care throughout the continuum.

Moving to a system of coordinated care will require that we challenge those who cling to the outmoded idea that physicians work best when they work in isolated fiefdoms and not as part of a team. We must challenge those who put professional prerogative and autonomy ahead of the needs of the patient. We must execute a major cultural change in how we train caregivers, and in how we organize and deliver care.

Michael J. Dowling

President and Chief Executive Officer

North Shore-LIJ Health System

Instructor, Harvard School of Public Health

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The Safety Gap

A Cultural Approach to Safety and Quality

Safety improvement is thwarted by a blame mentality and a failure to provide forums where errors can be safely discussed and root-cause solutions found.

Despite technological advances such as computerized physician order entry and well-publicized quality improvement campaigns in U.S. hospitals, insufficient progress has been made in reducing preventable medical errors. In 2006, for example, the Institute of Medicine found that medication errors continue to harm at least 1.5 million people every year.¹ Safety improvement is thwarted by a blame mentality and a failure to provide forums where errors can be safely discussed, root-cause analyses conducted, and new protocols developed to avoid repetitions of mistakes. Clinicians who might be willing to share knowledge of errors they have made or witnessed say they don't know how to report them and to whom.² Nurses, physicians, and administrators don't even hold the same views on the safety of the care provided by their institutions,³ a disconnect that retards systemic change.

The will to reform may be there, as "patient safety and quality" was cited as the second most important concern of hospital chief executives surveyed recently by the American College of Healthcare Executives.⁴ However, effective solutions have proven elusive. Many analysts view the lack of adoption of electronic medical records by the vast majority of health care organizations as the critical missing link in fostering safer patient care, but growing evidence shows that a culture of safety may be even more important than technology. After all, if the human beings who provide the care and operate the technology aren't working in an environment that promotes patient safety, all the hardware and software in the world won't do much to prevent medical errors. A commitment to safety culture by organizational leadership is key to creating such an environment.

Low-tech changes in care processes and new, blame-free ways of communicating about safety issues offer myriad means to enhance clinical outcomes and decrease preventable errors. A growing number of clinicians are adopting new protocols that take them step by step through what may seem to be pedestrian tasks. These simple changes have had spectacular payoffs in avoided deaths and injuries.⁵ They have also provided strong return on investment that bolster hospitals' bottom lines, not an insignificant factor in an era of declining margins and dwindling reserves.

Adopting a culture of safety is a step every hospital should take as part of its mission to end the continuing tragedy of preventable medical errors.

Melvin F. Hall, PhD

President and Chief Executive Officer

Press Ganey Associates

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Research confirms a current lack of information coordination and alignment.

The Information Gap

We Lack a Coordinated System of Health Care

A lack of coordination across the health care system is creating an environment of tremendous inefficiency and waste. A contributing factor to this problem is the misaligned flow of health care information among health care constituents. Consumers, providers, and payers each hold key information, but the flow of information among these constituents is often limited and fragmented. Among the players in the health care industry, it is payers who have the greatest wealth of information about benefit plans, fund management, provider contracts, care management rules and, increasingly, patient information. But historically, payers have not created value from such information.

The opportunity to create value from payer data is real. Recent case studies illustrate how value-based insurance designs (VBID) can create opportunities to influence behaviors and practices that will lower costs and improve care. VBID, which use payer data to invest in benefits and incentives that change behaviors to reduce health risk, have had positive results on medical cost trend.^{1,2} For VBID to work, however, data from the health plan's core administrative and clinical care management systems must be used to engage other health care constituents and be aligned with their needs.

Research confirms a current lack of information coordination and alignment. For example, a recent health care constituent survey reveals that 88% of providers would like to have access to patient records that extends to all their patients, physicians, and hospitals and the status of all their current medications. Yet, only 29% of payers report that providers are even requesting this kind of access.³ Additionally, 67% of providers say that integration of insurance with provider or hospital management systems would be important, but only 33% of payers acknowledge that providers seek it.⁴

There is a solution to this current lack of coordination and alignment. Payers are ideally positioned to leverage the investments they have already made in core administration and care management systems and to lead the way to a more coordinated health care system. Such a system promises to foster new efficiency and effectiveness across the breadth of health care.

Jeff Margolis

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The Engagement Gap

Employee Engagement is Critical in Today's Health Care Industry

Organizations with higher levels of employee engagement outperform those with low levels of engagement on a number of key financial metrics.

More than a decade of research confirms the strong link between high levels of employee engagement and financial results. Engagement, defined as the willingness and ability to provide discretionary effort on the job, is an intangible but critically important component of the work environment and leadership culture. Engaged employees routinely “go the distance,” freely giving their time, expertise, and energy to their organization because they want to make a difference.

Towers Perrin's research shows that organizations with higher levels of employee engagement outperform those with low levels of engagement on a number of key financial metrics, including operating margin.¹ Our research also shows that highly engaged employees believe they can, and do, impact such key aspects of the business as quality and customer service.

Yet that same research also shows a wide “engagement gap” in virtually all the countries and industries we studied, highlighting what amounts to an untapped source of higher performance for virtually all kinds of organizations. In the health care industry, interestingly, that gap is somewhat smaller than across the U.S. as a whole, in part because the very nature of the industry draws people who want to make a difference in the world and their community through service.

For instance, the engagement score for the U.S. health care industry is 34%, versus 29% for the U.S. as a whole. Still, that means only about a third of health care workers qualify as highly engaged, based on the statistical analysis we do to define engagement levels. Yet, close to 90% of those same employees want to take on challenges, learn new skills, and put discretionary effort into their jobs. This discrepancy between actual and potential engagement and performance on the job is what we call the “engagement gap.”

Significantly, the path to closing this gap isn't powered by a high monetary investment in people. Engagement is not affected by pay levels, or benefits per se, although both remain important to the employment relationship and must be seen as fair and competitive. Rather, the key drivers of engagement are organizational and individual factors which can be produced and leveraged with strategic management.

- A newly published book from Towers Perrin draws on this research and actual company examples, including a hospital system, to explore areas that collectively help shape an environment conducive to high engagement and performance.²

As the industry struggles to manage costs, improve quality, maintain profitability and retain talent, the ability to close the existing engagement gap is more important than ever before. Health care industry executives can examine specific actions required, especially from leaders, to create the conditions required for higher engagement.

Christopher Pinc, PhD
Consultant
Towers Perrin

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The Efficiency Gap

Lack of Health Data Aggregation: The Case for Immediate and Coordinated Action

As the need and opportunities for system transformation grow, the person must be placed at the center of reform.

The current health care system is plagued with waste, error, variance, delay and friction. It is wrought with patient safety issues, inefficient processes, data quality issues, and challenges in research and billing. Care is not coordinated or routinely measured. Significant gaps exist between what care works and what care we receive. Indeed, studies have shown that patients receive recommended care only about half of the time. Such deficits are directly related to health outcomes and preventable deaths.¹

For these and other reasons, we need to transform our health care system. We must create a performance network that starts and ends with the person and is focused on outcomes and appropriateness of care. Absent these reforms, our health care system will continue to underperform.

Areas of Opportunity

Savings and quality improvements are derived from addressing five primary problem areas:

- 1. Health care providers now largely use paper-based records, including patient medical records.** Physicians write orders for diagnostic or therapeutic procedures on paper for others to read and interpret. This process is inefficient, fragmented, and leads to numerous and costly errors and delays. We must automate the health care system to drive improvements in care delivery.
- 2. The standard of care suffers with providers' memory-based decision making.** Unwarranted variance in care and unnecessary waste has been widely documented. Automating the system allows for the benefit of an evidence-based care system to rise.
- 3. The current health care system is too fragmented.** Management of chronic conditions has become a primary challenge of the current health system. In a fragmented environment, care quality has suffered, and there are too many redundant tests and medical errors. These problems of uncoordinated care place an even greater financial burden on the health care system.
- 4. The current, cumbersome transactional system accounts for much of the inefficiency in the health care industry.** Estimates are that 31% of the \$2.3 trillion health care expenditures are consumed with overhead functions.² Most industries would be considered inefficient at one-half of that overhead. Thus, through disruptive innovations in health care commerce, an improvement of just 10% from 31% to 21% overhead costs would result in an annual savings of more than \$230 billion.
- 5. The person is not the primary focus in the current health care model.** Too often the patient is left out of the care model. There is little structure in place to help bring together all elements of a person's care including their social support network. Automation of the health care process should be centered on the person. As information becomes available the person should have access to his or her health data and be compelled to use that information to improve their health status.

Neal Patterson

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The Adherence Gap

Nonadherence to Treatment Causes Unnecessary Burdens on Patients and the Health Care System

The promise of prevention from any treatment requires adherence.

Nonadherence to treatment is a silent epidemic with profound implications for successful health outcomes and financial efficiency on the health care system. Studies have shown that 30–50% of people with long-term prescriptions fail to complete medical recommendations successfully.¹ This lack of adherence denies the patients the preventive or curative benefits of the prescriptions and raises overall costs in the health care system if complications occur.

The World Health Organization defines adherence as “the extent to which a person’s behavior — taking medication, following a diet, and/or executing lifestyle changes, corresponds with agreed recommendations from a health care provider.”² Factors influencing adherence include availability of health care, attributes of the health care team, social support for the patient, and the nature of the condition for treatment of the patient.³ In developed countries, factors that support high adherence include patient engagement, patient satisfaction with their physician, and good physician-patient communication. Factors influencing low adherence include polypharmacy (taking multiple medications), and the need to take prescriptions for chronic conditions.

For those with chronic conditions, medication costs play a role. Medication possession falls with increasing co-payments, indicating that spending caps work to reduce adherence and worsen patient outcomes.⁴ However, cost is not the only factor. Respondents in a recent study blamed nonadherence on issues such as cost savings, side effects, concerns about effectiveness, and most frequently, “I forgot,” with 64% of respondents offering that excuse.⁵ Education and reminders from physicians and nurses can help improve adherence rates, and reinforce the importance of following prescriptions to control chronic conditions.⁶

Chronic diseases requiring medication highlight the implications of nonadherence. Adherence to treatments for the chronic conditions leading to the development of CVD, the top cause of death in the U.S., could save lives and reduce needless costs. In a recent study, researchers prescribed statins to subjects who did not have high cholesterol but did have elevated C-reactive protein. The results indicated that subjects on statins were 50% less likely to suffer a stroke or need angioplasty or bypass surgery, and 20% less likely to die during the study.⁷ The promise of prevention from any treatment requires adherence. Improving adherence rates offers a chance to improve health for patients and to lower costs and burdens on the health care system. In contrast, nonadherence promises both poor health outcomes and unnecessary costs, estimated to be greater than \$100 billion yearly.⁸

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The Quality Gap

Assuring High Quality and Value in Our Health Care is Key

Certainly the problem is not failure to provide the requisite financial resources for delivering high quality care. Americans spend far more per capita on health care than any other country.

If the American health care system is not broken, it certainly has lots of problems. Forty-seven million persons are uninsured¹, 7 million more than in 2000.² Nearly 9 million children remain without coverage.³ Even if you are lucky enough to have health insurance, there are tremendous problems with the quality and safety of care you are likely to receive. For example, only approximately half of hypertensives have their blood pressure controlled.⁴ The landmark study from the RAND Corporation found that on average adult patients got only 55% of indicated care.⁵ The well-publicized Institute of Medicine report showed that medical error, iatrogenic injury, is the eighth leading cause of mortality, responsible for more deaths than breast cancer, motor vehicle accidents, or AIDS.⁶ Disparities in care also abound with minorities and patients of lower socioeconomic status often getting care of lower quality.^{7,8}

Certainly the problem is not failure to provide the requisite financial resources for delivering high quality care. Americans spend far more per capita on health care than any other country. National health expenditures now total more than 2 trillion dollars annually, accounting for 16% of our GDP.⁹ On main street the problem is clearly affordability. Employer-sponsored health coverage premiums for family coverage have nearly doubled since 2000, from \$6,438 to \$12,680 in 2008.¹⁰ These trends show no signs of abating.

Numerous strategies have been proposed or tried to address these shortcomings in health care quality and value. These include public reporting of data on quality performance, financial incentives for higher quality, broader use of information technology, expanded efforts in disease management for patients with chronic illness, promotion of more integrated managed care, efforts to procure better data on the comparative effectiveness of different therapeutic approaches, and recently, improved payments to primary care physicians and increased use of patient-centered medical homes. Many of these strategies have shown promise in different settings, but none of them is a magic bullet.

With President Obama assuming office, it seems more likely now than at any time in the last 15 years that we will see a major effort to expand health insurance coverage. If successful, this would be a substantial benefit to many of those who are currently uninsured. This would also allow us to focus policy attention more fully on our great challenge — assuring the quality and value of our health care.

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American consumers, as a population, are less healthy than previous generations — among the most unhealthy of any developed nation — and costs continue to grow exponentially.

The Consumer Gap

Creating a Successful Health Care Consumer

There are nearly as many definitions of the Consumer Gap in health care as there are segments of the industry. If we take “Consumer Gap” to mean anything that acts as a significant barrier to an individual’s successful entry into, experience with, and equity derived from the traditional health care delivery system, we could identify a number of disparities, from lack of insurance to geography to variances in personal knowledge and education.

All of these gaps, taken individually, get at, but largely do not answer the fundamental questions, “Who are these unsuccessful consumers?” and “At what are they unsuccessful?” From the consumer perspective, with the possible exceptions of the Internal Revenue Service and the criminal justice system, we, as a society, have devised few other institutions as confusing to navigate and as routinely dissatisfying with which to interact than the modern health care system.

From the system’s perspective, there are few mysteries as baffling and impenetrable as the American health care consumer and their seemingly irrational expectations of perpetual good health and world-class medical services anywhere, at any time, for any condition, and for free.

As a nation and an industry, we have acted sporadically and with varying degrees of success over the years to improve outcomes, expand insurance coverage, inform, and make treatment more accessible, equitable, and affordable.¹ Yet, the basic gaps remain. American consumers, as a population, are less healthy than previous generations — among the most unhealthy of any developed nation — and costs continue to grow exponentially.

The threat to the nation posed by those costs, anticipated to be \$4.3 trillion annually by 2017², is so significant we are forced to the paradoxical conclusion that, perhaps, the most successful health care consumer, from a societal perspective, is the consumer that never needs health care at all.”

Such an assumption, while perhaps appearing glib, actually cuts to the heart of the real Consumer Gap in health care, the gap in *well-being*. Closing that gap will require us to answer the question, “How do we, systemically and at scale, move beyond a narrow focus on treatment and management of the sick to a broader focus that encompasses solutions to: keep healthy people healthy, mitigate or eliminate risks associated with modifiable, lifestyle behavior choices, and assure optimized, evidence-based care for the chronically ill?

In other words, how do we keep people healthy for as long as possible, precluding or delaying their entry into traditional health service delivery channels, thereby both reducing their costs and improving their productivity and quality of life?

The definition we choose makes all the difference. At the end of the day, the only truly “successful consumer” is the one who has the knowledge, tools, and support to take the actions and make the choices required to better manage their health across the span of their lifetime. When a consumer enters the system for costly treatment of illness related to modifiable, yet unaddressed lifestyle behaviors and choices, the consumer hasn’t failed. We all have.

Robert E. Stone
Executive Vice President
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From Why We Must Change to How We Will Change: Next Steps to Bridging the Gaps in Health Care

The preceding pages remind the reader of some of the legacy challenges facing health care. These descriptions lay the groundwork for the task ahead. Now we must take the next steps to innovatively develop solutions that address these gaps.

At *Forces of Change*, we will move beyond problem identification directly to actionable solutions that participants can implement at their organizations. We invite you to join the faculty and other thought leaders at *Forces of Change*, where we will move beyond why we must change towards how we will change.

FORCES OF CHANGE

New Strategies for the Evolving Health Care Marketplace

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