

Aligning the Forces of Health Care for Quality and Fairness for All

Risa Lavizzo-Mourey, MD, MBA, president and CEO of the Robert Wood Johnson Foundation (RWJF), delivered Group Health's Eighth Annual Hilde and Bill Birnbaum Endowed Lecture on Benefiting Patients through Health Care Research at the Sheraton Towers in Seattle on November 15, 2007:

I always appreciate the chance to come home to Seattle, especially for an occasion like this one. As much as I love the other places where I've lived and worked, Seattle will always feel like home. Delivering a lecture in honor of great leaders like the Birnbaums makes me feel as if I'm following in the footsteps of giants. And the Birnbaums, along with Group Health, have helped make Seattle the great place it is today—especially for health care.

As a girl, I remember riding my bike through this very neighborhood. Growing up in this city with its great health care institutions helped shape my own career, as a physician and now as a health care philanthropist. I grew up listening to a surgeon and a pediatrician—my parents—debate health care issues at dinner.

As you know, surgeons and pediatricians often represent the North and South Poles of medicine, when it comes to practice and temperament. When you add in the Mars–Venus element—well, it made for pretty interesting conversations at the dinner table.

No doubt, when I count the big influences in my life, those dinner conversations loom large. But there was something about Seattle itself, this place and the people who live and work here, that also shaped my thinking about our health care system, what ails it, and what we all must do to fix it.

Back then, many in the city—and a lot of my parents' patients—worked for one company, Boeing. You know the story. Boeing's always had a reputation for a commitment to quality. Those aeronautical engineers, they just love to solve problems. Something about that problem-solving approach permeated the local culture, and got into our local leaders. Maybe it drizzles down in the rain water.

I know this: Most of the physicians here are homegrown, trained right in this area at one of the world-class hospitals that serve Seattle and the whole region so well. So there's always been a strong sense that when it comes to health care, we're all in this together. I wish we could bottle that feeling and export it elsewhere.

Much about Seattle has changed since my childhood. For one thing, you have added software engineers and Starbucks to the local industry mix. But the medical community that took shape years ago, during my childhood, has maintained its problem-solving attitude.

I believe much of that can be attributed to the Group Health model. Your model used the power of combining peer review, teamwork, and aligning incentives to show that there is another way. Together with similar staff health maintenance organizations like Kaiser Permanente and Harvard Community Health Plan, you showed that alternatives to small private

practices had an important place in the health care landscape. It is that model and spirit that helped shape the character of Seattle's medical community. It's now part of the city's DNA.

It's seen in the attitude that says, we *can* provide high-quality health care to everyone, and we *will*. And we see this attitude reflected in Group Health's approach, and reflected in the work of an astonishingly diverse array of groups within the Puget Sound Health Alliance, and the work of the Seattle Indian Health Board, and the Center for Health Studies. And the outstanding clinics like the Odessa Brown Children's Clinic, which hired my mother as its first medical director many, many years ago.

The mission of the Robert Wood Johnson Foundation is to improve health and health care. In Seattle you are doing just that. So you can understand why I look forward to coming back here again and again, to work with people like Eric Larson, Ed Wagner, Margaret Stanley, Diane Giese, and many of you. All of us at the Foundation are excited that Seattle is showing the way among our Aligning Forces projects. The Puget Sound Health Alliance, which is taking on very ambitious challenges related to public reporting, consumer engagement, and quality improvement. I'll talk more about Aligning Forces, and the next phase of the Foundation's work, in a few minutes.

It is worth noting that Harry Truman, the first president to propose health care reform, was still in office when Group Health was founded in 1947. Sixty years later, we remain confounded by how to deliver high-quality, high-value health care. Almost every administration since Truman's has stared down a major health care reform challenge, only to be thwarted.

So the gains we have made come from the lives of Bill and Hilde Birnbaum and their colleagues who tried to find better models for how a health care system could work in ways that serve everyone's best interests. Right now, we desperately need those solutions. You can see the fault lines from many past health care reform efforts in the current debates around the State Children's Health Insurance Program (SCHIP) and quality. The problems of the past are not getting any better, and almost all Presidential candidates mention issues of cost, access, and quality in their health care proposals.

I am not going to wade into the thicket of today's political debate, but it is obvious why health care is at the top of the domestic agenda.

As you are aware, we spend twice as much per capita on health care than any other industrialized country. One would hope that this high spending would translate into better health care—and better health outcomes. But it doesn't. For many years, the Foundation has supported one of the most illuminating and profound research projects, which shows us just how irrational our health care system is—the Dartmouth Atlas research project. And what this project has consistently revealed is that *more* care does not equal *better* care. In fact, the research reveals that there is no logical reason for why we deliver too much care in some places and not enough care in others.

There are 306 separate Medicare hospital referral regions in the United States—and just as many different levels of Medicare usage and reimbursement. Miami and Seattle are the high and low benchmarks for just how wildly the variations swing from one region to another.

The Dartmouth Atlas puts the variations into stark relief:

- The percentage of Medicare enrollees admitted to intensive care in the last six months of their lives is 61 percent in Miami. In Seattle, it's 33 percent.
- The average number of visits to a specialist during last six months of life in Miami is 27 percent. In Seattle, it's 10 percent.
- The number of specialists allotted for every 1,000 dying patients: Miami, 15; Seattle, 8.

Jack Wennberg, Elliott Fisher, and their colleagues confirm again and again that more hospitals, more doctors, more spending—none of it makes a difference in the effectiveness of care or patient outcomes. *None of it*. In other words—money can't buy quality.

But you might say this is a peculiar Medicare population. So let's move on to another population: our children. Children's health care has been a hot topic this fall because of the SCHIP debate, but then again, it's a constant worry for all of us. I heard this at the dinner table with my parents: Everyone should care about the health of our children, because we understand that on a very basic level, children represent our future.

You may have seen an article in a recent edition of the *New England Journal of Medicine* performed by a Seattleite. With funding from RWJF, Rita Mangione-Smith of the University Washington and Children's Hospital & Regional Medical Center, as well as Beth McGlynn of the RAND Corporation, and colleagues looked at 175 quality measures, from

screening through follow-up care, for 1,500 kids. They found that on average, children received only 46.5 percent of indicated care.

In this study, nearly all of the children had insurance, and more than 80 percent of them had *private* insurance. And yet they only received half of the care that experts recommend children should get: *half!*

Look, folks, I'm not talking about esoteric medical procedures; I'm talking about the basics of primary care. Things that you or I would take for granted for *our* kids or grandkids. Things like regularly measuring kids' height and weight to make sure they're growing properly. We know that health insurance is critical to getting kids access to the care they need. But this study really brought home what we also know: that insurance, by itself, doesn't get us all the way to good care. *Access* and *quality* need to go hand in hand.

Mangione-Smith also pointed out that while we do a great job of treating acute conditions, we do much worse caring for children with chronic conditions. Ninety-two percent of children received the appropriate treatment for upper respiratory infections, but children with asthma get the appropriate care only 46 percent of the time. These chronically ill children are more likely to do poorly in school, more likely to lose out on sports, more likely to miss out on the fun and challenges of childhood.

This is unacceptable.

Moreover, some of the most pressing public health battles are barely being fought at all. Consider that 33 percent of all children and adolescents are overweight or obese. The State of Washington already spends \$1.3 billion to treat adult obesity. Did you see the *Journal of the*

American Medical Association last week? There is growing evidence that the longer you are obese the greater your disability especially from diabetes. Run the numbers on diabetes and hypertension for growing number of children who are overweight or obese. The vitality and productivity of any country depends on the health of its citizens. Put more simply, children are our future. We can't let these problems go on.

So whether you focus on kids or seniors, clearly we have a national crisis in health care, because our populations are not getting what they need despite unprecedented spending. But the crisis doesn't feel as *real* and as *immediate* as it should until you drill down to the people who suffer the effects of the dysfunctional health care industry.

These people are not just the poor and the uninsured, although the evidence clearly establishes that poverty, and lack of access, and even one's racial or ethnic background have major impacts on people's health and health care. But the truth of the matter is *everyone* suffers under the health care system—or lack thereof—that we currently have.

So let me share with you a story about the people behind the curtain, the people who bear the brunt of the things that are seriously wrong with health care today. Because of what I do, people bring me these stories all the time. I repeat: all the time. Colleagues, friends, relatives, and strangers: It doesn't matter. The stories are too *wrong* to not be shared.

Here's one of the latest:

I have a colleague, a well-educated, prosperous woman, my age, with elderly parents. She stunned me when she said that last year was the most stressful year of her life. Why? Well...

This colleague of mine has a strong bond with her parents. Because of what her parents gave her, she in turn feels a strong sense of love and duty to make sure that her parents are well cared for in their advancing years. For those of us who are lucky enough to have had parents who gave us so much during our early years, it sometimes feels wonderful to give something back to them—except when giving back involves the health care system.

In my colleague's situation, Dad, now 90+, was an internist. He is very proud of his past career. He worked in Newark, New Jersey, taking care of poor and very sick patients and making sure they got the best care possible. So he knows in his heart and mind what good care feels like. And now he's facing multiple physical problems as he gets older, he's on an armful of medications, and his daughter—my colleague—wants to make sure *he* gets the best care possible, because it was so much a part of her dad and who he was.

And Mom, who kept the home fort down during my colleague's childhood, is now in the early stages of progressive dementia. Can anyone else in the sandwich generation relate to this story so far?

Here's the thing: Mom and Dad lived in Florida. My colleague lives in Brooklyn, New York. And as their chronic health problems worsened, my colleague wanted to help them get the right care, but trying to do it from a distance was proving to be a very challenging task.

So she did something that probably made perfect sense at the time. She moved Mom and Dad closer. But in the short term, it made matters worse, because their medical records didn't come with them. Their new doctors

didn't have all the history, context, or current information, and my colleague couldn't get the details and information from the former doctors. Despite countless phone calls, e-mails, and letters—and all the tenacity that a high-powered career woman brings to any challenge—all she got was frustration. It was as if a lifetime of medical history disappeared overnight. And to make matters even worse, her father broke his hip a week after the move and experienced a major deterioration of his condition. So my colleague now had more doctors and other settings to deal with. Let's not forget Mom, who doesn't do well alone without her husband of 60+ years.

When these sorts of things happen to us, there is no guide. There is no place to go for definitive answers on where to set the best quality or the best value. And the most frustrating thing is that our health care system—or rather, our *lack* of a truly functional health care system—seems designed to frustrate and overwhelm us, rather than help us get the care the people we love deeply need. My colleague was pushed to the brink over and over again. The pain and stress were written all over her face. And I am sure some of you know someone who has been through a similar hell.

How do we build health care systems where none now exist?

How do we develop systems that truly address the needs of those who deliver health care, those who pay for it, and most important, those who get the care?

I will tell you what we believe needs to happen to answer these questions.

And along the way, I will explain what I think the Robert Wood Johnson Foundation's role is, even though we are not the only player on the field, not by a long shot.

First of all, we need all the different stakeholders—physicians, nurses, consumers, business, and hospitals, to name a few—to acknowledge their particular and unique role is in achieving high-quality health care.

And actually be willing to change the way they do things for the higher goal of better health care.

What do I mean by that? We need physicians and nurses and other health care professionals to commit to improvement. And we believe that part of the commitment needs to include a willingness to measure what they do and learn from those data.

The Robert Wood Johnson Foundation is supporting efforts on both the national and local levels—some of them right here in Seattle—to standardize the way in which we measure and publicly report on quality. And others are also heading in this direction. The U.S. Centers for Medicaid & Medicare Services has launched a number of initiatives, like Hospital Compare, to make health care information more widely available.

As a result of this increased focus on measurement and public reporting, we've heard some rumblings among physician groups that this is a bad thing.

Do you know what? I understand where they're coming from. I may not agree with it, but I understand it. Medicine is getting increasingly hard to

practice. Physicians and nurses are struggling, sometimes in extraordinary ways, to meet the demands of the profession.

In other words, providers are saying, we don't want more bad stuff done to us. We don't want others telling us how to do our job, in a capricious way.

But here's the thing: what if measurement and public reporting were done in the right way? What if measurement and public reporting were done so that physicians and other health care professionals were getting rewarded for delivering the right care, at the right time? What if better health care information could actually help physicians and nurses understand what types of care needs to improve? What if better health care information helped my colleague and people like her more effectively manage their own health care situations, or navigate between different settings and different physicians?

This is what I meant when I stated that different stakeholders have to understand what their role is in achieving quality. And they have to be willing to step out of entrenched perspectives that have helped perpetuate the problems we've got now.

Pacts among stakeholders

When I think of the changes that need to happen, I almost think of them as pacts or promises made and kept between the various stakeholders. For example:

- If the National Quality Forum (NQF) and the Quality Alliance Steering Committee make measurement and public reporting fair and standardized—so that docs in Seattle are not graded differently

from docs in Miami depending on the payer—then physicians must commit to participating in these efforts so that they can actually learn to improve.

- If we, as health care professionals and leaders, believe that improvement *is* possible—and the Foundation has invested in so many programs that have showed us that, improvement is possible—then we must work to demonstrate to others that it's possible, and how to get to high-quality, high-value care.
- If the health care system gets its act together to be patient centered—provide people with clearer sources of information about health care quality, educate them about what they need to know about their own care and treatment, and help make the transitions from one care setting to another--then the patients must take a more active role in managing their care.
- If we help businesses understand that health care can be a value proposition, then they must promise to work more collaboratively with health care systems to get better care for their employees, more value for their dollars, and fairer rewards for doctors, especially primary care doctors.
- If payers learn new mechanisms that help them reward the right kinds of care, not just any care, then they must give health care professionals appropriate rewards, incentives, and tools to deliver good care.

These are all hefty pacts, not to be taken lightly. But I can tell you that the Robert Wood Johnson Foundation is trying, in our own way, to push us all to make good on these pacts.

So what is it, exactly, that we are doing?

After all, we are not a business. We don't pay for health care. We don't run a health care delivery system. We don't provide care like you do at Group Health. We're not government, we don't regulate, so what do we do?

According to Duke University professor Joel Fleischman, who has written extensively on the philanthropic field, foundations, at their best, can: . . . seed a problematic field with research and trials; define clear and achievable goals; devise evidence-based strategies to get us there; recruit the partners needed to get the job done; and help guide society toward that sweet spot on the horizon.

And that is exactly what we are proposing to do with our regional quality approach.

Regional Quality Strategy

Ladies and gentlemen, this [pointing to slide] is the sweet spot right here when quality for a whole region improves. We took the first step toward a Regional Quality Strategy with our national program, Aligning Forces for Quality: The Regional Market Project. Aligning Forces is working with 14 communities on measurement, public reporting, quality improvement, and consumer engagement in outpatient care settings. I can tell you that I wasn't a bit surprised when Seattle ended up being one of the first sites

chosen for the work, under the guidance of the Puget Sound Health Alliance. It seemed in perfect keeping with the city's history and heritage.

The 14 Aligning Forces communities are taking on some very ambitious challenges. But even though the work of the program is far from being complete, the Foundation has decided to forge ahead with our next phase of regional quality work. Because as ambitious as Aligning Forces is, we realized that health care cannot truly be transformed unless you're willing to take on the system as a whole.

For example, what happens when a person experiences a heart attack? In many cases, they'll get rushed to the emergency room. And if we focus just on improving the care in that emergency room, or in that hospital, that's probably better for the patient, but what happens when he or she goes back to their primary care physician? What happens when the patient tries to remember their new multiple medications? What happens when the patient seeks support structures in the community to help her improve diet and exercise?

Let me tell you another story. This story illustrates the success—and the failure—of taking on quality in just one part of the system.

In 2005, we launched a national program called Expecting Success. This program was specifically aimed at improving cardiac care for minority patients in hospitals. Although we had supported a few hospital quality-improvement projects, this was our first effort to engage hospitals serving a high proportion of minority patients and apply standard quality-improvement techniques—like measurement—to a specific area of care in order to reduce disparities.

Nobody likes to talk about disparities, because it forces us to deal with the uncomfortable reality that the care minority patients receive is often lower-quality care than whites receive. Still, we boldly stated that this program was squarely aimed at reducing racial and ethnic disparities in cardiac care. And we had over 100 hospitals apply. We picked 10 of them, ranging from large academic medical centers to small community hospitals. And even though they knew what the program was about, they still clung to strategies to improve quality overall rather than facing the specific challenges of minorities in their own hospital. Hospital after hospital denied that they had racial and ethnic disparities in care, because for the most part they had never looked. They expressed trepidation about the training we offered to help them collect data on patients' race and ethnicity.

The people at these hospitals said to us, "We treat all patients the same." It didn't matter that the Institute of Medicine said otherwise in 2002 with its landmark report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. That report clearly demonstrated that a consistent body of research shows significant variation in the rates of medical procedures by race, even when insurance status, income, age, and severity of conditions are comparable.

Well, the 10 hospitals in Expecting Success didn't think this research applied to them. Then the data came in.

As a condition of the grant, we required these hospitals to measure not only the core measures of quality heart care required by CMS, like percentage of acute myocardial infarction (AMI) patients receiving beta-blockers at discharge, but also a bundled set of measures defined by the

American Heart Association (AHA) as “ideal care.” To meet the latter standard, you’ve got to hit your mark on all counts of heart care.

Lo and behold: they found racial and ethnic differences. They differed from hospital to hospital, but they were there. For example, one hospital found that 83 percent of non-Hispanic patients were receiving discharge instructions after a cardiac episode, compared to 66 percent of Hispanic patients.

I can tell you that lots of well-intentioned health care professionals and executives at these 10 hospitals were walking around for days saying “Holy-moley.”

Now, did these hospitals know exactly why these racial and ethnic gaps were happening? No. But they all embarked on their own exploration of the why. One hospital, with a number of affiliated cardiology practices, found that discharge instructions were not being given to minority patients in a subset of those practices. Another hospital made the seemingly simple discovery that although most of its patients were most comfortable speaking Spanish, patient instructions were available only in English. The hospitals kicked into “fix-it” mode.

Within a couple of years, almost all of the hospitals showed dramatic improvements in heart care. And the racial and ethnic gaps were closing and at the same time the bar is being raised. For example, that first hospital I mentioned before, the one with the 20 percent difference in patients getting discharge instructions? Ninety percent of all patients—Hispanic and non-Hispanic—are now getting discharge instructions after a cardiac episode. And now you hear the staff at these hospitals talking

about disparities as if it's their problem to own and solve—not something to be swept under the carpet, or lost amid the shuffle of the competing pressures that hospital staff cope with.

When I hear about the experiences of this program, I am inspired. I am lucky to be so inspired on an almost-daily basis, because of what I do. I think that this program Expecting Success will yield valuable lessons for other hospitals in other communities. But at the same time, this Expecting Success tells me something about what it will take to truly achieve community-wide change in health care. Why?

Because each of these hospitals, in addition to their inpatient improvement projects, also developed a community-based quality-improvement project. They wanted to test if they could improve care not only inside of hospital walls, but outside of hospital walls as well. And almost all of them wanted to see whether these community demonstration strategies had a positive impact on re-admission rates for heart attacks in their emergency rooms. For example, one hospital proposed a partnership with a community clinic to reach out to physicians about particular patients.

So far, the picture from these interventions is murky. The readmission rates are going up one month and down the next. And the folks running these projects are scratching their heads. What's going on?

I'm not going to claim that I know exactly what's behind these fluctuating readmission rates. But I do know one thing, especially from the Foundation's long, long history in improving the quality of care. We've seen so many projects yield inspiring results. We've seen hospitals and clinics and individual docs tell us that they're doing better. And yet it

doesn't add up. We still get the numbers back that tell us that in this country, getting quality health care is a hit-or-miss proposition. Some places are doing better than others, but no one's got it down.

Why don't the numbers add up?

- Because project accumulation alone doesn't lead to strategic change.
- Because the quality of health care is a composite of a number of influences and forces.
- Because everyone—the payers, the health care professionals, the hospitals, the clinics, the patients, and others—has a role to play.
- And no one entity can achieve transformation. With regard to patients with chronic illness, Ed Wagner has been telling us that for years, and of course most of the care we provide is to patients with chronic illness.
- The Institute of Medicine tells us that trying harder will not work. Rather, changing systems will.

Trying harder will not work; changing systems will.

This is the system we have to change locally.

While we at the Foundation need to continue working on the national front to improve health care quality, we are also going to go deep into communities and support change on the ground. Like politics, health care is national *and* local.

So for the next many years, we will be going even deeper into our regional quality investments. We will ask that communities work on the inpatient and outpatient sides. We will ask that communities pay some attention to care coordination. We will ask that communities pay particular attention to reducing racial and ethnic disparities in care, and emphasizing the roles of nurses and nurse leaders in improving quality.

We intend to make a significant investment so that by 2015, the nation will have 20 targeted regions demonstrating and sustaining high-quality, patient-centered, equitable health care that can be beacons as the health care system continues on its journey to deliver the best. We want anyone in the country who wants to see what health care should look like to be able to go to one of these communities and say “Yes, I see it now.”

So, how do we get from here to there?

- We have to select the 20 regions. This process is underway now, and we’ve invited Seattle and others to apply.
- We need to find ways to deliver the best knowledge, practices, and experiences to our regions. We have to respect the work of local leadership teams, but we also want to share what our other grantees and partners know.
- We’ll make sure research and demonstration projects are aggressive and current.
- We’ll continue to invest in and promote national standards that are based on the best clinical evidence so everyone can feel good about transparency. We will have to use our influence to ensure

that business and payers are involved and that they neither thwart nor drive the process.

- And we always—and I mean always—will keep listening to the voices of the doctors, nurses, administrators, and of course to patients, who will be the real test pilots on this mission.

In any endeavor, the talents and demands and wisdom of others make us better at what we do. In health care, we too often see one another as rivals—for reimbursement, for grants, and so on. What RWJF can do with its philanthropic dollars is to turn these rivalries into collaborations.

Without significant change, the *Quality Chasm* system will remain, and all the things we value about medical practice will be consumed by it, not the patient. Helping patients is why we got into health care in the first place.

That's what I heard at the dinner table.

This generation didn't create this problem, but we are the ones to fix what Harry Truman tried to fix more than 60 years ago. Truman once said something about his own time that speaks just as well to us here today in our time. He said:

[People] make history—and not the other way around.

In periods when there is no leadership, society stands still.

Progress occurs when courageous, skillful leaders *seize* the opportunity to change things for the better.

Truman is right. People *do* make history

People like *us*. People like *you*.

The stakes are high. It's time to transform our health care system into the health care system we need and deserve.

Thank you.