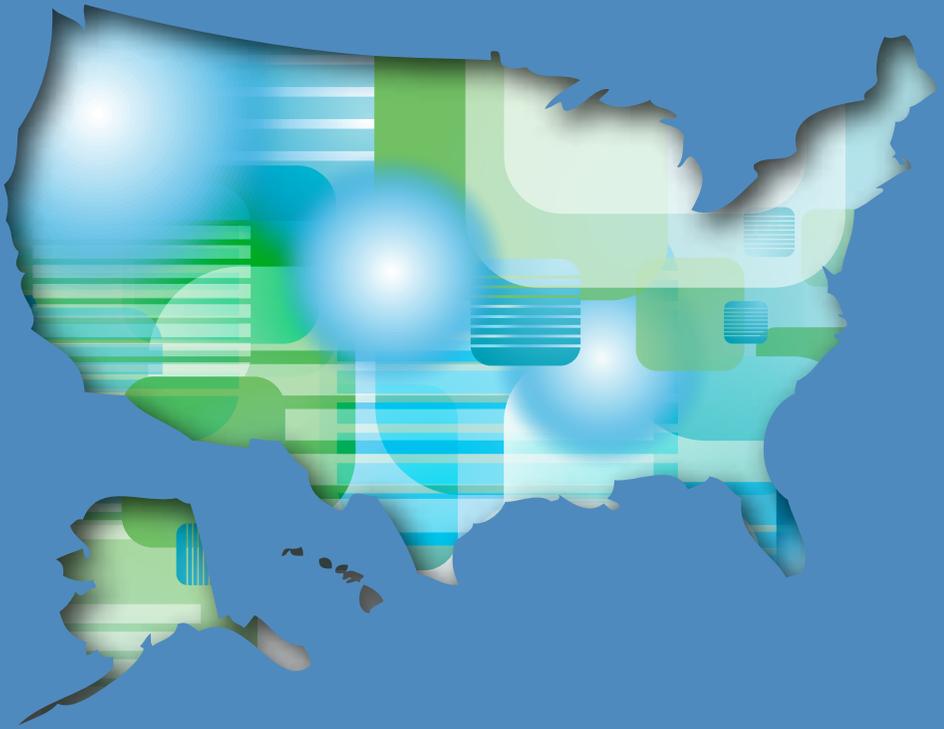


Reinventing Health Care:

The Barriers to Innovation



a publication of the
aspen health stewardship project
the aspen institute

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Much has changed since 2007 when the Aspen Health Stewardship Project was launched to call attention to the uneven quality, staggering inefficiency, and unsustainable expense of the U.S. health care system. These same challenges were top-of-mind when policymakers introduced the Patient Protection and Affordable Care Act in 2010. The law incorporated several recommendations of the Stewardship Project's first report, which stressed the importance of increasing access to care for all Americans and fostering innovation that improves quality and efficiency by turning information about disease and treatments into actionable insight that providers and patients can use to improve health.

Through an expansion of Medicaid and subsidies to make insurance more affordable for individuals and families, the law is projected to reduce the ranks of America's uninsured by 60 percent. It also includes provisions that help individuals with pre-existing conditions gain access to coverage. While the Affordable Care Act expands coverage and introduces a number of measures that may contribute to improved quality and increased efficiency, it will not cure all of the system's ills. Many challenges remain:

- New coverage for the uninsured does not guarantee access, as demonstrated in Massachusetts when the state implemented its program for universal coverage. Shortages of primary care providers in many areas of the country remain a critical barrier to preventive care, shortages that will worsen unless medical students are rewarded for entering primary care fields.
- Inefficiency remains endemic, depriving the system of financial and clinical resources that could fuel quality improvement efforts and preserve the health of Americans.
- Patients still lack access to data and analysis that would enable them to identify providers, health systems, and interventions that produce better or equal outcomes at lower cost.

There is clearly more work to be done. That work is the focus of the Aspen Institute's Health Innovation Project, a new initiative within the Stewardship Project that asks why the American health system is

so breathtakingly innovative in the development of medical treatments and procedures, but so lacking in the innovation that renders clinical discoveries more accessible and affordable. Launched in partnership with WellPoint, Inc., the project explores among other things how health information technology can foster the patient-physician relationship while improving care; how patients can become active participants in the management of their own care; and what is needed for the successful and rapid diffusion of delivery system innovation.

To do that, the project first identifies the primary barriers that stand in the way of creating an ideal health care system. It is a prelude to the project's second report, to be released in 2012, which charts a path to achieving that ideal system.

Acknowledgements

We are grateful to be able to continue promoting the guiding principles of the Stewardship Project in 2012 with the launch of the Health Innovation Project, and on behalf of the Aspen Institute I'd like to thank WellPoint, Inc., for partnering with us in this new endeavor. More specifically, thank you to Sam Nussbaum, M.D., Lisa Latts, M.D., and David Bear of WellPoint, Inc. for their collaborative efforts and enthusiasm in bringing thought leaders together in hopes of promoting innovative strategies in health care delivery.

Furthermore, this paper would not be possible without the tireless efforts of our authors who so graciously have taken many hours out of their busy schedules to participate in various calls and meetings throughout 2011, in addition to presenting at the Congress on Cost Containment. I would like to express gratitude to our contributing authors: Basit Chaudhry, “e-Patient Dave” deBronkart, Carole Roan Gresenz, Joseph Hutter, Anjali Jain, Brent James, Shawn Martin, Lewis Mattison, Daniel Newton, Anthony Nguyen, Brent Parton, Kavita Patel, and Steven Weinberger. Not to be forgotten, many thanks are also due to the others who participated in our first roundtable in April 2011, which helped spark this idea: Susan Dentzer, Keith Lind, Matt Salo, and Grace-Marie Turner.

Finally, I thank my staff and colleagues Katherine Payne and Shayla Nagy for supporting and organizing the behind-the-scenes efforts.

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Reinventing Health Care: The Barriers to Innovation

In many respects, the U.S. health care system is breathtakingly innovative. It produces new technology, medical procedures, and scientific knowledge at a dazzling speed, enabling patients to recover from diseases and injuries once thought incurable or untreatable. As a consequence, the U.S. has one of the highest survival rates for cancers, excels at acute and trauma care, and has produced half of the world's Nobel laureates.^{1,2}

In contrast, innovation of the health care delivery system lags far behind. With the exception of a handful of large, integrated delivery systems that are working to transform the practice of medicine by applying systems science to their clinical operations, most hospitals and physicians are focused on trying to stay afloat, often by maximizing revenues and services, which can lead to care that is inefficient and at times only marginally beneficial.

The lack of innovation in the delivery system costs patients dearly as wide variations in medical practice leave some patients without essential services while subjecting others to costly and unnecessary treatment. Researchers estimate that on average only 54.9 percent of adults get recommended care, even as payers (including employers and state and federal governments) pay twice as much per capita for medical services as other countries.^{3,4} Children fare even worse, getting less than half of the health services recommended by evidence-based standards of pediatric care.⁵

As the cost of health care services continues to escalate, these glaring shortfalls have become less acceptable—prompting a number of forward-thinking health plans, employers, and providers to focus on developing solutions that promote health, eliminate waste, and encourage collaboration among providers to minimize the fragmentation in the system that thwarts effective, efficient care.

The Patient Protection and Affordable Care Act of 2010 attempts to do the same by introducing programs and providing additional funding to support providers as they test new approaches to care, including accountable care organizations, which are designed to reward hospitals and physician groups for working together to eliminate unnecessary tests and services, enhance preventive care, and improve coordination as

patients move between care settings. The law also supports research that compares the effectiveness of different drugs, medical devices, and ways of delivering care to identify those of greatest benefit to patients.

These programs are intended to increase innovation and foster patient care that is more clinically effective. But their overall impact will be limited if they only attract the attention and participation of providers who are highly motivated and have the financial wherewithal and leadership to pursue them. Finding the means to disseminate the models they produce more widely so that their benefits reach the entire U.S. population at a scale that results in meaningful savings is the focus of the Aspen Health Innovation Project.

This project brings together experts whose broad perspectives represent the health care system itself—physicians, health plan leaders, policymakers, health care researchers, and patients—to identify the complex set of financial, cultural, and regulatory barriers that inhibit innovation. The goal of the project is to recommend novel ways of overcoming them. These recommendations are intended to accomplish three important goals:⁶

- Improve the patient experience so that it matches the level of service customers expect from other industries;
- Organize the way providers practice so they can focus on the most critical aspects of care; and
- Save money both to ensure long-term financial sustainability of the system and to continue research on ever-more-effective treatments of the diseases and conditions that still cause great suffering and loss of life.

This summary of the project's preliminary recommendations is a launching point for discussing even more creative ways of overcoming the barriers that stand in the way of creating a delivery system that is coherent, cost-effective, and safe for all.

While innovation in the health care delivery system has not kept pace with innovation in medical science, it has not been for lack of talent. The U.S. health care system is built upon extraordinary human capital: a highly trained and dedicated clinical workforce, a growing army of researchers whose discoveries at the lab bench will one day translate to the bedside, and pharmaceutical and medical device manufacturers whose products have improved the quality of patients' lives in dramatic ways.

What stands in the way of delivery system innovation and its broader diffusion is the fragmented nature of the system itself, which is anchored in its economic organization. One of the greatest impediments is the organizational structure of medical practices. Nearly half of U.S. physicians operate in small practices of less than four that lack the organizational scope, capacity, and diversity of workforce necessary to assume the business risk associated with innovation.⁷

Even in larger practices, financial incentives designed to offset this risk, including payments that reward providers for developing new, more efficient models of care, are often overwhelmed by more powerful, perverse incentives that encourage providers to increase volume rather than clinical effectiveness.

The distribution of physicians into small practices reflects the history of medicine in the U.S., which was formalized as a profession in the 20th century as physicians adopted the role of scientists and began to view patients and their problems through the lenses of physiology and microbiology. Using medical knowledge developed during this period, physicians who operated independently came to be seen as local authorities based on their ability to translate this new and complex information to patients. Unfortunately, the scientific method that produced this knowledge did not extend to the day-to-day practice of medicine. Physicians continued to treat their work as an art form, making medical decisions based on individual experience, judgment and expertise, rather than empirical evidence gathered from large populations of patients using scientific reasoning.

Part of the problem is the nature of medical training. Nearly all physicians-in-training learn to practice under a guild model that encourages them to master skills by observing and emulating clinicians whose methods may or may not reflect existing norms and evidence-based standards of care. These techniques continue to be replicated year after year as these trainees become tomorrow's teachers.

Leaders of medical schools and teaching hospitals tend to perpetuate this model of craftsmanship by not sufficiently integrating medical informatics, epidemiological research, systems engineering, and team-based methods into their curricula. The larger culture helps to reinforce this by viewing the best physicians as those with encyclopedic knowledge and gifted intuition, as epitomized by the television show "House." The end result is a high degree of variation in clinical practice that is detrimental to patients.

To transform the practice of medicine, the U.S. must engage physicians and other providers directly in innovation. A model for doing so already exists in health care systems where providers lead multidisciplinary teams of researchers, health system engineers, and administrators who collectively identify key clinical processes and then develop bottom-up, evidence-based protocols or guidelines that become the organizing principle for care delivery. These protocols are embedded into clinical workflows, and are validated and continually improved at the bedside. They in turn inform everything from staffing decisions, training materials, and educational programming to physical layout and architectural design. And as such they are replacing the proverbial "doctor's pen" as the most powerful force in health care delivery.

The strength of this approach is its ability to organize—rather than simplify—the complexity of medical practice into protocols and procedures that free physicians and other caregivers to focus on the few key variables that most require their professional judgment. Key metrics such as patient outcomes, adverse effects, variance in delivery, and costs are tracked; weaknesses and gaps are discovered; and the guidelines are improved.

The process allows clinicians to tie their efforts to intended consequences and discover whether and why care is diverging from expectations. Over time, variation arising from the physician and at the system level diminishes, and variation arising from the patients themselves increases, resulting in more targeted, efficient, and ultimately more personalized care.

Next generation electronic medical records (EMRs) must develop around these protocols and key clinical processes. This focus is key if EMRs are to help optimize efficiency, care coordination, and quality measurement and reporting.

Ensuring the widespread adoption of new models of care will require demonstrating benefits to patients as well as relative advantages to providers in the form of stable income, convenience, and/or job satisfaction. Gaining the active participation of providers in practice redesign will also require the system and society to address potential concerns that these new methods and organizational structures of delivering care will introduce new legal or regulatory risk, exposing clinicians and health care institutions to litigation or financial penalties.

The U.S. must also address the issue of innovation's cost—particularly for providers in small practices and the nation's hospitals. In 2010, the median operating margin for all U.S. hospitals was 2.75 percent.⁸ Thirty percent of all U.S. hospitals had negative operating margins.⁹ Fortunately, much of the investment required can be had by identifying and eliminating waste.

Finally, to succeed, providers applying systematic approaches to quality improvement need to be equipped with better, more standardized data. A lack of such data and the employment of analytical tools necessary to interpret it now impede those efforts, as do perverse payment systems that reward providers for delivering care even when it is inappropriate.

Overcoming these barriers will require collective effort. The Aspen Health Innovation Project recommends the following:

1. Devise new reimbursement strategies that reward rather than penalize providers for using innovative models of care, especially in communities that already operate in a lean fashion relative to their peers. As an example, payers of all types might consider a multi-tiered model for accountable care organizations, one that allows those that already provide efficient care to receive capitated payments that rise slowly and steadily with the Consumer Price Index, as opposed to more rapidly rising medical inflation. It should also be possible for physician-led and other organizations to become accountable care organizations using a stepwise approach that enables them to take responsibility for an

increasing number of medical conditions (such as congestive heart failure, hypertension, diabetes) or patients with multiple conditions, who account for the greatest percentage of health care spending. Key components of such programs must include risk adjustment for payments and populations, risk mitigation strategies for high-cost patients, and legal safe harbors.

2. Factor innovation into pay-for-performance programs and other funding mechanisms including philanthropic grant making and investments of venture capital—as well as outcomes measures—to raise innovation's importance in the minds of providers. This work must be part of a larger effort to persuade providers that innovation will enable them to offload much of the burdensome complexity of medical practice onto other parts of the system, so that they may focus their knowledge and attention on the most critical variables of their patients' care. Work that facilitates the implementation of innovative models of care delivery should also be factored into promotion decisions in health systems and academia.
3. Incorporate engineers and others with expertise in system science into clinical care settings to design new methods of delivering care—methods that reduce variation and improve workflow and productivity while improving outcomes for patients. Doing so may first require a greater number of universities and medical schools to unite the disciplines of engineering and health sciences. Health care institutions must also devote resources to hiring these professionals.
4. Define the organizational scope, capacity, and size of medical practice necessary to spur innovation and develop strategies to build the technical and financial infrastructure necessary for physicians in small practices to meet expectations for higher performance. These strategies must recognize variation in practice models and practice size, as well as differences in local populations, markets, and contexts of care. The health system must find a way to help these small practices achieve the economies of scale necessary to assume the business risk associated with practice reengineering.

Otherwise, such reengineering, which would allow better tracking of patients' conditions and coordination of care using larger multidisciplinary teams—and other innovations—is unlikely to occur.

5. Design interoperable health information technology systems that link providers—physician groups, hospitals, health systems—and even entire regions to each other to improve care coordination and transitions, and foster transparency of and accountability for process and outcomes measures. Such technology networks will also facilitate epidemiological research and the development of clinical guidelines that improve population health outcomes.
6. The results of quality improvement efforts should inform health policy as well as the clinical research priorities for federal funding. The key metrics that result should constitute the dashboards CEOs, consumer reporting websites, regulators, and policymakers all reference, making measures of performance increasingly transparent to all health care stakeholders: patients, providers, hospitals, industry, and payers. This quality improvement process is how care coordination organizations—accountable care organizations, medical homes, and community health teams—can achieve the outcomes and efficiency society seeks to incentivize through payment reforms.

Although consumers form the axis of the U.S. health delivery system, they are only minimally engaged in determining its focus and its future. Instead, the health care system tends to treat consumers as passive beneficiaries of care, with providers defining a good patient as one who makes few demands and accepts and obeys treatment recommendations without question. Consumers often encourage this unilateral approach to care, assuming erroneously that caregivers will recognize their preferences and needs and act upon them.

As a result, patients often do not ask critical questions about their condition or their plan of care, and leave appointments unable to assess the benefits and risks of different interventions, or even remember what they were told. In a more ideal system, they would be comfortable articulating their needs for information and guidance, without the concern that their demands will upset their relationships with their providers. They would also have the knowledge they need to navigate the delivery system easily, assessing the strengths and weaknesses of providers as well as the full cost of services, so they can traverse the system without fear of unexpected charges or personal harm.

A variety of barriers stand in the way of achieving this ideal. Some are systemic, including a dearth of reliable data and tools for consumers to evaluate providers and determine the cost of their services. Measures now in use rarely capture the variables most relevant to patients such as how quickly a new or existing patient can get an appointment; the likelihood that a given physician will adhere to evidence-based protocols and practice; differential rates of care-associated injuries; or the ability of the provider to communicate in a manner a patient can understand. Finding this information, if it exists at all, is such a challenge that many consumers and the clinicians they turn to as trusted advisors—even the brightest and most Internet savvy—rely instead on word-of-mouth recommendations from peers rather than externally validated sources.

The obstacles to greater consumer engagement are not solely systemic. Barriers arise from consumers themselves, who enter the delivery system with varying levels of education, health knowledge, and decision-making ability. Efforts to improve communication between providers and patients depend on an accurate assessment of these skills, and are further complicated by the delivery system's limited understanding of consumer behavior. Research on consumer preferences and habits so essential to influencing consumer behavior is common in other industries, but it is virtually nonexistent in health care.

Overcoming these obstacles may seem daunting because it appears to require a full-time effort, one neither the consumer nor the provider can afford when burdened by other demands for their time. But it is achievable if the stakeholders that comprise the health system—consumers, physicians, hospitals, health plans, and employers, among many others—share this responsibility. The recommendations of the Aspen Health Innovation Project that follow reflect this expectation.

1. Increase the quality and transparency of performance, safety, and cost data. For patients to find safe, decent care, they must have access to reliable measures that capture multiple dimensions of quality, cost, and access. Without this information, the health care sector will not function as a true market, one in which consumer demand ensures that better products and providers thrive. Developing such measures is not an easy task: they must be individually risk adjusted and be based on large samples to accurately measure outcomes, especially those generated jointly by overlapping teams of health care providers and those influenced by patients themselves, who have different preferences for treatment, capabilities, and support networks.

The complexity associated with assessing physician and hospital performance introduces a number of serious challenges, which health plans, the government, and employers must play the greatest role in addressing. This will ultimately require additional funding to support the development of more refined and standardized measures. (The U.S. Department of Health and Human Services' work to make quality data publicly available will help.¹⁰) They should also play an active role in educating consumers about

key attributes of high-quality care, including evidence of a provider's practice of delivering preventive care, the speed of his or her follow-up on test results, and the frequency with which he or she coordinates care with a patient's other providers. Consumers will also need more information to understand the total expected costs of all services connected to a particular treatment or evaluation. This will help avoid surprises that may deter them from seeking treatment in the future. Physicians and other health care professionals need complete cost data as well, as many may not know the cost of diagnostic tests or treatments that they order.

2. Promote school-based health literacy programs. The nation's educational system should play an expanded role in educating students about the structure and operation of the health care system so that consumers can find and make use of the expertise they seek, understand health plan choices, learn how to navigate an appeals process, how to read a prescription label, and how to find high-quality providers or hospitals. Educating children on these topics will help to educate adults, as knowledge often funnels up to families via children.
3. Enhance trust and communication between consumers and providers. Improving communication among consumers and health care professionals requires providers to recognize that a patient's sense of vulnerability inhibits his or her willingness to articulate needs and preferences. Providers should be mindful of this and elicit this information from patients, either before the patient visit—when his or her needs are most pressing and clear—or at the start of the visit. Medical schools, nursing programs, and other professional training programs play a critical role in teaching providers the communication skills they need to ensure that their messages have been understood, and that they understand patients' concerns. Meanwhile, patients should be encouraged to make use of the following questions (the first four of which were developed by the Patient-Centered Outcomes Research Institute) to facilitate shared decision-making:

- a. Given my personal characteristics, conditions, and preferences, what should I expect will happen to me?
- b. What are my options and what are the benefits and harms of those options?
- c. What can I do to improve the outcomes that are most important to me?
- d. How can the health care system improve my chances of achieving the outcomes I prefer?
- e. How can I connect with other patients like me to share experiences, compare symptoms and treatments, and learn more about my own illness?

Personal health records and full access to the comprehensive medical record may also help streamline patient-provider communication by allowing consumers to communicate their needs and interests in advance. Such records also provide a means for providers to follow-up with patients to ensure treatment recommendations are being followed and respond to questions that may arise after the visit. In the absence of such systems, it is incumbent upon the providers to ensure this post-visit communication occurs. Both financial incentives as well as nonfinancial incentives (such as the incorporation of communication requirements into clinical care guidelines) will help to ensure that this occurs.

4. Increase translation of research findings. As medical information becomes more accessible on the Internet and in other forums, providers will play an increasingly important role in helping consumers understand the significance and relevance of new scientific findings. To expand the body of reliable information, employers, health plans, and state and federal governments should consider funding trusted and neutral intermediaries to translate research findings into plain English and appropriate literacy levels. (Funding to the Agency for Healthcare Research Quality and the recently formed Patient-Centered Outcomes Research Institute illustrates how this can be done.) This is particularly important when research findings or treatment guidelines

are released that conflict with previous recommendations, as recent guidance on mammogram screening did.

5. Support the development of mobile applications that enable consumers to compare the quality of care provided by hospitals and physicians for specific conditions and illnesses.

Accessing Health Information

Many of the innovations now being tested in the U.S. to improve the quality and efficiency of care—including patient-centered medical homes, accountable care organizations, and bundled payment systems—depend heavily on health information technology. The data such systems produce enable providers to identify gaps in care, conduct disease surveillance across communities, and engage in research that leads to more accurate and effective treatment. By linking providers and health systems together, health information technology also reduces waste by eliminating the need for duplicative tests and services.

Despite this, the U.S. has barely tapped its potential. The vision of a highly networked system, organized around personal health records that deliver a patient's entire medical history at the point of care, has gone unrealized outside of a handful of integrated delivery systems that collect and mine patient data for quality improvement purposes. Many of these integrated systems use their electronic records to promote the use of evidence-based guidelines and provide decision-support tools that improve the accuracy of diagnoses and the effectiveness of treatment, but these efforts are too often limited to institutions with the means and foresight to develop such systems. More typically, medical information about patients lies trapped in paper records (nearly 50 percent of U.S. physicians now use no form of an electronic medical record) or is dispersed among multiple providers in electronic medical records that are not structured to allow for in-depth analysis.

The American Recovery and Reinvestment Act of 2009, which provided physicians and hospitals with financial incentives to adopt electronic medical record systems, will surely expand the number of providers who collect patient data, but it does not address the equally important need to facilitate the transfer of data among health systems and providers, which is so critical to increasing coordination of care and reducing waste. This is particularly important in major metropolitan markets where competitive pressures discourage institutions from sharing data with one another.

The Aspen Health Innovation Project offers the following recommendations:

1. Make the transfer of data among providers a priority by encouraging greater standardization in systems and use of open-source technology. In addition to greater standardization, health information technology must also offer more utility to providers. Many existing electronic medical records systems have been developed without the collaboration of clinicians and design engineers with knowledge of care delivery. As a result, the systems are at times unnecessarily complex, creating more work than benefit for doctors and other providers who are pressed for time. Making systems more useful to providers—by easing their workload and increasing their productivity—will greatly enhance provider adoption.
2. Encourage health care providers to leverage disease-specific patient communities and social networking sites as a resource to identify common patient concerns and research priorities. Such sites now provide valuable peer-to-peer support for patients, especially those coping with chronic diseases, but the information they produce is isolated from providers and the health care system more broadly.
3. Make electronic patient portals more appealing and fun to use, so that patients will want to use them to monitor their health status, tailor treatment regimens, and learn new methods for improving their health. One way to do this is to concentrate early design efforts on the features that provide the most convenience to patients, including functions that allow patients to schedule visits. Once consumers become accustomed to using the patient portal as their first point of contact with a provider, they may be drawn to more advanced features, including personalized educational materials and/or the option to enroll in clinical trials using data from their personal health records.
4. Increase efforts to protect the privacy of health information and ensure the integrity of the data. This will encourage consumer trust, and with it, greater use of health information technology systems.

5. Develop automated interfaces between personal health records and electronic medical records. One easy way to do this is establishing certification criteria that assure patient information can be transferred between systems without custom-built interfaces.
6. Catalyze innovation in health information technology using incentive programs. The private sector will likely need to fund these efforts as government grants tend to represent short-term opportunities and are not sustainable as a business model.

- 1 The Guardian, "U.K. Cancer Survival Rates 'Worst in Europe,'" July 2, 2002.
- 2 Of the 609 Nobel laureates listed on the prize's Web site, 293 or 48 percent were affiliated with U.S. institutions. See: http://www.nobelprize.org/nobel_prizes/lists/all/
- 3 E. A. McGlynn, S. M. Asch, J. Adams et al, "The Quality of Health Care Delivered to Adults in the United States," *New England Journal of Medicine*, June 2003 348(26): 2635-45.
- 4 OECD Health Data 2010 (Oct. 2010).
- 5 R. Mangione-Smith, A. H. DeCristofaro, C. M. Setodji et al., "The Quality of Ambulatory Care Delivered to Children in the United States," *New England Journal of Medicine*, Oct. 2007 357(15):1515-23.
- 6 These goals are akin to those of the Institute for Healthcare Improvement's Triple Aim, which fosters programs that simultaneously improve population health and patients' experience of care, while reducing or at least controlling per capita health care costs.
- 7 The percentage of physicians in small practices was drawn from the following article: V. S. Elliott, "Small Practices: Adapting to Survive," *American Medical News*, June 27, 2011. Accessed at <http://www.ama-assn.org/amednews/m/2011/06/27/bsa0627.htm>.
- 8 Thomson Reuters ActionIO Database.
- 9 Trendwatch Chartbook, American Hospital Association. Based upon Avalere Health analysis of American Hospital Association Annual Survey data, 2009, for community hospitals. Accessed at www.aha.org/research/reports/tw/chartbook/2011/table4-1.pdf.
- 10 See www.HealthData.gov and <http://www.healthit.gov/>

About the Health, Biomedical Science and Society Program www.aspeninstitute.org/health

The Aspen Health, Biomedical Science and Society Program is a venue for academic, government and industry leaders to explore critical issues in health care and health policy and how they may affect individual health and that of families, communities, nations and the world. By convening bipartisan, multi-disciplinary forums, the program facilitates the exchange of knowledge and insights among decision-makers and helps to forge networks and other collaborations with the ultimate goal of improving human health.

Through public policy programs and strategic dialogue, including roundtables, policy briefings, conferences and Internet discussion forums, the program seeks to help chart the way forward on issues relating to health and medical science by bringing together the foremost experts in many fields. The program's work routinely incorporates the views of leading scientists, economists, physicians, policymakers, historians, patients and other committed voices in health care and health policy. The program's projects have included the Aspen Health Forum, the Aspen Health Stewardship Project, and the Aspen Task Force on Global Health and Nutrition.

The program's guest speakers include the top names in medicine, biomedical science and policy: Drs. Deepak Chopra, Mehmet Oz, Don Berwick, Peter Agre, J. Michael Bishop, Francis Collins, Sir Richard Feachem, Julie Gerberding, Margaret Hamburg, David Kessler, Tony Fauci, Scott Gottlieb, and Zeke Emmanuel. Additionally, events have also featured "Influentials" such as The Honorable Tom Vilsack, Tom Daschle, Richard Gephardt, John Porter, Tommy Thompson and Billy Tauzin. Other notable speakers include Governor Christie Todd Whitman, Norm Augustine, Jeffrey Sachs, Mary Robinson, Peter Orzag, Ray Suarez, Fred de Sam Lazaro, Esther Dyson, Jeff Kluger, Jim Pinkerton, Shannon Brownlee and Goldie Hawn.

The Aspen Health Stewardship Project. Drawing on the expertise of a diverse group of leaders in health care and health policy, this initiative seeks to inform the national conversation on health care reform and to suffuse related policymaking with non-partisan principles to help drive smart, sustainable improvements in the U.S. health care system.

The Aspen Institute announced the next phase of the Health Stewardship Project at a policy symposium held in Washington, D.C., in November 2010. In this next chapter the Stewardship Project addresses vital next steps in health care reform. Its latest endeavor features a number of forums and events including several regional meetings around the U.S. entitled “Voices from Main Street,” a policy symposium in Washington, D.C., and several invitation-only roundtables with select coalition members, stakeholders, and other key health policymakers. Consistent with the project’s earlier work, the current phase seeks to cultivate top-of-mind awareness of key principles that will drive smart, sustainable improvements in the U.S. health care system with the ultimate aim of converting those principles into policymaking.

The Health Innovation Project. Early in 2011, the Aspen Institute partnered with WellPoint, Inc. to launch the Health Innovation Project, a new initiative within the Stewardship Project that aims to highlight clinical innovations in diverse settings and opportunities for cost containment in the health care system. This inaugural report considers why the American health system is so breathtakingly innovative in the development of medical treatments and procedures, but so lacking in delivery system innovation. The report is intended to spark further discussion of how we can build a world-class system of care delivery, one that brings us closer to translating the Stewardship’s core principles into practice across our nation. A second report will be released later in 2012.

The Aspen Health Forum. Born of the recognition that there is increasing interest in the future of health care, the Aspen Health Forum brings cutting-edge medical science and health care discussions to the public square. It is the world’s only public gathering that offers a lay audience the opportunity to exchange ideas with Nobel laureates, prominent officials from the National Institutes of Health, health care industry leaders, and other top experts in health policy and biomedicine. The next forum will be held at the Aspen Institute campus in Aspen, Colo., in summer 2013.

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