The Care We Need

DRIVING BETTER HEALTH OUTCOMES FOR PEOPLE AND COMMUNITIES
At the beginning of the modern quality movement, the National Quality Forum was founded as a national response to systemic healthcare quality issues. Since the late 1990s, much has been achieved, but many challenges persist. As this report is released, our nation is currently responding to one of the greatest health crises in the last century. During this time, we are reminded that we are one interconnected system of care that performs best when priorities and practices are aligned and coordinated at all levels and across all stakeholders.

The COVID-19 pandemic highlights both the strengths and weaknesses in America’s healthcare delivery system. Prior to the outbreak, many healthcare delivery systems across the country were already embracing a culture of safety, implementing Lean and high-reliability practices, and using robust data-driven quality measurement to drive improvement strategies and better outcomes. However, this is not the norm across all, or even the majority, of the healthcare delivery system. For the health of our communities and the public at large, we need to normalize the processes and practices that reliably deliver safe, appropriate, person-centered care. Now, as the healthcare delivery system faces so many challenges, is the opportunity to do just that.

As a nation, we invest heavily in our delivery system. We lead the world in healthcare spending that exceeds $3.5 trillion per year and approaches one-fifth of our Gross Domestic Product (GDP). Yet, we continue to lag other countries in health outcomes. If we mobilize our resources to support an aligned set of priorities, we should and can expect better health outcomes with the levels of investment in our federal, state, and employer budgets, and consumer spend.¹ The United States can achieve lower rates of medical errors, preventable hospital admissions, and disease burden than comparable countries.²

Together, we must align public and private leadership to propel the quality movement closer to the goals set 20 years ago by the Institute of Medicine in To Err is Human and Crossing the Quality Chasm. Even before the COVID-19 outbreak, the quality community, patients, consumers, and many other stakeholders were frustrated that the nation had not achieved more over the past two decades. Now, especially in the face of the pandemic, we see the importance of coming together to systematically address new and persistent challenges. We are able to align our efforts and mobilize support for solutions to great outcomes in the face of a visible crisis. We need to do this as a norm across our system of care.

True to the mission of the National Quality Forum, we pave the path forward by tapping into our collective expertise and shared commitment to improving the quality of care and outcomes for every person—an objective deeply personal to each and every person, and one of the greatest issues facing our nation. We convened the National Quality Task Force, a highly diverse group of experts, to reflect on promising opportunities to address continuing challenges, as well as emerging issues. Longstanding challenges stem from the flawed fee-for-service payment system, inconsistent cultures of quality and safety, and lack of person-centered care. New issues include obstinate data silos, measure proliferation, and insufficient data and performance transparency. Collectively, these challenges stymie efforts to reduce unacceptably high rates of medical errors. Moreover, they undermine the nation’s

Together we can build on 20 years of concerted effort and progress to make care safe, appropriate, and high value for all people—especially the most vulnerable.

SHANTANU AGRAWAL AND KENNETH W. KIZER
Co-Chairs, National Quality Task Force
The nation has seen significant advances to save lives and avoid harm.

Community by community, person by person, we all want to see our healthcare system consistently work better for every person. We can and need to build on the many great, notable successes to address the challenges that remain. Many of us know what it is like to fight for the comprehensive and connected care people need. For all the people whose stories we do know, there are so many more whose stories go untold.

This report isn’t academic. For every person for whom the system worked well, we need to acknowledge the unseen scores of people for whom it did not. Motivated to make safe, high value care the norm for every person, the Task Force maintained as its North Star the experiences and stories of real people to serve as a call to arms to change the status quo.

These are their stories that, together, we can change.
“Chronic kidney disease affects my whole life, but I’m being treated in different pieces.”

When the doctor told me I had Stage 3 chronic kidney disease, I was also told that I was lucky to learn about it as early as I did. It was a good thing that the family doctor I saw paid attention to my family history of diabetes, noticed my swollen ankles, and asked about my eating habits.

I just thought I’d been on my feet at work too long. I didn’t realize that my diet, or lack thereof, and blood pressure were actually beginning to kill me.

But if I thought I was lucky, I didn’t realize how much and how quickly the diagnosis would change my life.
Living alone, it was more than I could manage, so I moved from the city closer to family. But it was a more remote, quieter area and I no longer had access to the doctor that I had seen on and off over the years.

I didn’t realize how hard it was going to be to find a new doctor that I was comfortable with, much less find a good nephrologist (or any nephrologist!) near me. I’d never even heard of that kind of doctor before. The one I could find gave me different information and advice than my prior doctor. It was hard on me and my family trying to get to all the visits. None of them ever spoke to each other. I had to relay all the information which, even though it was now electronic, seemed even harder to keep track of and make sense of. Despite all the time I spent filling out paperwork for every visit, no one had access to my medications.

Completely overwhelmed and confused, I struggled to make sense of all the information. Because of my move, I could no longer be treated by my prior doctor even with all the advances and the confusing “patient portal” where, I could sometimes message him.

My disease got worse. More complications meant more doctors. It was hard on me and my family trying to get to all the visits. None of them ever spoke to each other. I had to relay all the information which, even though it was now electronic, seemed even harder to keep track of and make sense of. Despite all the time I spent filling out paperwork for every visit, no one had access to my medications.

I had to give up shifts trying to get from appointment to appointment and all I could think about was the wages and tips I was losing filling out similar but different paperwork and telling the same information over and over again. I was terrified that I might forget one medication and have some horrible complication. I was constantly having to ask doctors what they were telling me versus what the other doctor said. Frankly, they seemed just as frustrated not to know what the other was saying or prescribing but didn’t have the time to really address it. They seemed as exhausted as I was.

One day one of my doctors said, “You should have told your other doctor you were taking this medication. He would have never given you that prescription.” That was the last straw. I looked at him and said, “Sorry, I didn’t go to medical school. I work in a diner where the cooks and waiters actually talk to each other.”

How can the whole team—me, my caregivers, my doctors, and nurses—work better together to help me heal?
“Would my son be alive today if his mental health and addiction were treated as a disease?”

Sean was such a good son, really caring towards everyone, but he suffered from anxiety. As he grew older, he began self-medicating and, whether from his genetics or anxiety, was predisposed to addiction. Yet while other kids were embraced by our community for their battles with diseases such as diabetes or cancer, we and Sean felt ashamed about the struggles of his disease. We suffered in silence. It was uncomfortable talking about it with others.

We felt isolated and struggled to heal in a vacuum of support and information.
One drug after another, Sean’s disease took hold until he was addicted to opioids. We stuck by our beloved son going from one program to another. Most of the programs treated Sean as if he was a broken individual, subjecting him to scrubbing toilets with a toothbrush to build character or kicking him out onto the streets if he didn’t comply.

We finally found a treatment center he liked. Unlike the others, this one prescribed suboxone to actually treat the addiction. It was working well, and Sean was smiling again and excited about living a drug-free life. But it didn’t last.

As he transitioned to outpatient treatment, his next psychiatrist didn’t believe in the use of medications to treat addiction. Sean’s medical history didn’t follow him. Scores of NIH-funded research and evidence that we learned about later couldn’t change the doctor’s perspective on the most effective care for our son.

Despite this, Sean was able to stay sober for 12 straight months and getting ready to celebrate his birthday. Then one night, he sat down and wrote us a long letter. He thanked us, said how bad he felt about what he put us through, and how ashamed he was of himself. And then, he committed suicide.

Now we look back and wonder why nobody ever thought to address his anxiety issues during all his addiction treatments. Why couldn’t his care teams follow his medical history to see what was working and what wasn’t? Why is it that physical health conditions like diabetes are treated like a disease to actively manage, but Sean’s mental health was treated like a character flaw?

“How could we have learned more and been better partners with his care teams?”
“Everyone was so busy saving my life, we forgot to think about my quality of life.”

The darkest day of my life wasn’t finding out that I had cancer. It wasn’t leaving career, friends and family to seek treatment at a hospital in another city. It wasn’t the day that doctors told me that I likely wouldn’t survive. No, the darkest day was when I survived, when I was finally released and realized that I had nothing. No job, no husband, no career and no team to help me plan how to get back to life.

The journey all started when my husband and I wanted to have a second child through IVF. A routine blood test showed a high white blood cell count and my doctor insisted on additional tests.
Suddenly, I went from being a career woman trying to have a second child to a cancer patient trying to survive Acute Myeloid Leukemia. We picked up house and home to go to the best place for a bone marrow transplant. Luckily my husband found a job an hour away from the medical center. We agreed that I would take care of myself and the treatments and he would work, take care of our son and take care of me. Jose worked days, drove an hour each way to see me, raised our son, attended to me on my brief stays at home, all while trying to hope and hang on.

The medical care I received was exceptional. I survived against all odds. But we didn’t survive as a family. Everything was falling apart as I was getting better. My husband lost his job. We had no way to support the family and no way to cope with the stress and anxiety we were experiencing. At the moment when I realized I had beaten death, I thought I was better off dead.

Throughout my treatment experience, we were all about the blood counts. But what really counts is the quality of life during and after treatment. Nobody ever checked to see if we were coping, cracking or just checking out. The healthcare system I experienced was good at beating back death, but not at helping me anticipate what else was likely to come and helping me find the resources or tools to get my life back—purpose, employment, dealing with financial stress, or even simple counseling on how to help your husband move from being a caregiver to a husband again.

When you’re finally released from the hospital they say, “Bye, see you for flare-ups and follow-ups.” Job done. Good luck. There has to be something more. I might not have been dead, but I was broken. I mean, when you’re released from prison you at least get a parole officer. Why couldn’t they help me anticipate that? Why couldn’t they tell me where to get the counseling support we obviously needed?

We have to learn how to care for the whole person and help people get back to their whole lives. It’s not just about medical care, but spiritual, emotional, family—everything care—during and after medical treatment.
“Healthier and happier patients will create a healthier and happier healthcare system”

JOAN MAXWELL, PATIENT
IN THE 20 YEARS since seminal efforts such as To Err is Human and Crossing the Quality Chasm launched a national movement to establish safe, high quality care, the field has made important strides in measuring quality and improving patient safety. The country has achieved notable reductions in hospital-acquired infections, fall-related injuries in hospitals, and preventable deaths. These results proved that measuring quality is possible and can have a real impact saving lives. These early efforts also mobilized the quality community to establish a culture that values and expects safe, patient-centered care. Healthcare leaders and systems across the country embrace processes, programs, and improvement priorities designed to consider care and outcomes from the perspective of the patient.

Several exemplar health systems have proven quality is measurable and can be improved. After implementing efforts to prevent avoidable harmful events, Ascension—a large nonprofit healthcare delivery system in the U.S. —reported a total of 57,123 lives saved from 2004 to 2016. Another example is the Essential Hospitals Engagement Network, which reported preventing 4,051 medical errors from 2012 to 2014, at a cost savings of $40 million. Yet, despite the progress, significant work remains to arrive at the point that every person in every community can expect to consistently and predictably receive high quality healthcare. Medical errors are still the third-leading cause of death, after heart disease and cancer, and 250,000 people in the U.S. still die every year from medical errors.

Among U.S. surgeons participating in a recent survey, 8.9 percent reported the belief that they made a major medical error within the last three months, and 1.5 percent believe their error resulted in a patient’s death.

To the frustration of all, medical errors persist, health disparities are rising, healthcare professional well-being is a widespread concern, and healthcare spending is still increasing despite an alarming prevalence of chronic diseases and infant mortality rates. Further, stakeholders—notably consumers—have gained little ground in their ability to make informed decisions with confidence regarding their care based on indicators of quality and value.

These and other shortcomings have been documented widely in reports and the research literature. Most concerning is the lack of an aligned vision and a set of shared priorities to achieve this goal. Together, we can build on 20 years of concerted effort and progress to make care safe, appropriate, and high value for all people—even the most vulnerable.

To achieve this, the National Quality Forum convened almost 100 healthcare executives to identify the highest-yield, actionable opportunities to address persistent barriers, scale proven improvements, and identify innovations to drive value for quality improvement by 2030. This group formed the National Quality Task Force. It assembled regularly over the course of 2019 to identify high impact, actionable steps for the next decade of quality.

The Task Force focused on addressing healthcare quality, safety, value, and experience. In light of active legislative and regulatory efforts and debates, we should note that a few key issues highly concerning to all stakeholders—specifically healthcare pricing and affordability (both services and pharmaceuticals), and coverage—were not included in the scope of the Task Force. These challenges are top of mind for many, notably consumers, when discussing the value of our healthcare delivery system. As efforts continue, the

---

3 Eastman, P. Has anything changed in the 15 years since 'To Err is Human'? Oncology Times. 2016;38(1):17-18.
**FIGURE 1. NATIONAL QUALITY TASK FORCE RECOMMENDATIONS**

**Strategic Objectives**

**Ensuring Appropriate, Safe, Accessible Care**

- Ensure people are consistently and accurately matched to health records across clinicians and settings by implementing a single-person identifier.

**Implementing Seamless Flow of Reliable Data**

- Align the quality enterprise and enable reliable improvement and outcomes analysis by standardizing quality data.

**Paying For Person-Centered Care and Healthy Communities**

- Normalize high value care by adopting population health-based Alternative Payment Models (APMs) as the primary payment model.

**Supporting Activated Consumers**

- Reduce disparities and achieve health equity by developing standard data and interventions to build the evidence base to address social determinants of health (SDOH).

**Achieving Actionable Transparency**

- Create actionable intelligence for consumers by increasing requirements to educate and engage people in healthcare decisions.

**FOUNDATIONAL**

- Ensure advanced technologies improve safe and appropriate outcomes through the use of a technology evaluation framework.

- Expand use of high value care settings by integrating virtual and innovative care modalities throughout the delivery system.

- Improve access to optimal care anywhere by creating pathways to recognize clinical licenses across the country.

- Accelerate adoption of leading practices by highlighting exemplar performers.

- Cultivate a culturally aligned, value-driven workforce by fostering competencies in safe, appropriate, person-centered care.

**ACCELERATORS**
Task Force encourages policymakers to use our vision as a guide to address the unsustainable relationship between the nation’s spending and health outcomes.

The 10-year horizon to make high value care the norm purposely focuses all stakeholders on achievable opportunities. Considering the current and target states of quality, the Task Force acknowledges the enduring relevance of the quality principles described in *Crossing the Quality Chasm*, and advocates for a discrete set of objectives to focus the next decade’s quality priorities.

The Task Force recommendations reflect the shared priorities advocated by the diverse panel. Representing payers, health systems, clinicians, purchasers, patients, consumers, policy, community leaders, and more, the Task Force includes participation from a variety of clinical specialties and geographic regions. Motivated to make care universally safe and effective for every person in every community, the Task Force set five strategic objectives that can be achieved by acting on 10 specific, actionable opportunities.

Delivering high value care requires all players to work as part of one system of care. No one recommendation, no one stakeholder can normalize person-centered, quality care. The recommendations in this report emphasize our interdependent system of care and the importance of shifting from a system optimized to treat the sick, to a system focused on keeping people healthy and well. Progress relies on a collective commitment wherein many leaders embrace their role and ability to influence the drivers of this system change.

The National Quality Task Force calls on all public and private leaders—in policy, public programs, business, and community—to come together, each playing their unique role, to take action on the opportunities identified. We can all move forward together to make sure that within the next 10 years, the healthcare quality movement will see the day when all people consistently and predictably receive the high quality care we need.

**VISION:**

Every person in every community can expect to consistently and predictably receive high quality care by 2030.

**MISSION:**

Identify actionable opportunities to improve alignment across the delivery system to achieve better health outcomes and value for every person.
Acknowledgments

THE NATIONAL QUALITY FORUM would first like to sincerely thank the generous sponsors that contributed to this vital endeavor.

IN ADDITION, WE ARE GRATEFUL for the immense effort and countless hours each committee member dedicated to the Task Force. An enormous thank you goes to the following committee members who contributed their invaluable knowledge and expertise in order to develop the recommendations in this report.

Committee Chairs and Vice Chairs:
Jody Amodeo, BSN
Willis Towers Watson
Susan Dentzer, DHL
Duke-Margolis Center for Health Policy
Cynthia Deyling, MD
Cleveland Clinic
Susan Frampton, PhD
Planetree International
Thomas Lee, MD
Press Ganey
Molly McCarthy, BSN, MBA
Microsoft
David Pryor, MD
Ascension Consulting
Bijan Salehizadeh, MD, MS, MBA
NaviMed Capital
Ronald Walters, MD, MBA, MHA
MD Anderson Cancer Center
Heather Young, PhD, RN, FAAN
UC Davis Betty Irene Moore School of Nursing

Committee Members:
Nasim Afsar, MD, MBA, SFHM
UC Irvine Health
David Asch, MD, MBA
University of Pennsylvania
David Baker, MD, MPH, FACP
The Joint Commission
Alan Balch, PhD
National Patient Advocate Foundation
Edo Banach, JD
National Hospice and Palliative Care Organization (NHPCO)
Mary Barton, MD
National Committee for Quality Assurance (NCQA)
Ivor Benjamin, MD
American Heart Association (AHA)
Binoy Bhansali
Sandbox industries
Leah Binder, MA, MGA
The Leapfrog Group
Laura Blum Meisnere, MA
Heart Rhythm Society
Craig Brammer, MA
Network for Regional Healthcare Improvement (NRHI)
John Branstetter
Patient

Niall Brennan, MPP
Health Care Cost Institute (HCCI)
Jenny Bryant, MBA
Pharmaceutical Research and Manufacturers of America (PhRMA)
Rayna Caplan, MPH
Caravan Health
Marcy Carty, MD, MPH
Cityblock
Lawrence Casalino, MD, MPH, PhD
Cornell
Ceci Connolly
Alliance of Community Health Plans (ACHP)
Patrick Conway, MD
Former Centers for Medicare and Medicaid Services (CMS)
Patrick Courneya, MD
Kaiser Permanente
Don Crane, JD
America’s Physician Groups (APG)
Mark Cunningham-Hill, MD
Northeast Business Group on Health (NEBGH)
Randa Deaton, MA
Kentuckiana Health Collaborative

“Ultimately, the one thing that matters is the patient at the center of everything. The rest of us have the privilege of being participants in the process.”

DAVID PRYOR, MD, ASCENSION CONSULTING
FINALLY, WE WOULD LIKE TO WHOLEHEARTEDLY THANK THE EXPERT ADVISORS who shared indispensable feedback with the Task Force to inform the ultimate direction of the recommendations:

Don Berwick, MD, MPP
Institute for Healthcare Improvement (IHI)

David Blumenthal, MD, MPP
Commonwealth Fund

Peter Briss, MD, MPH
Centers for Disease Control and Prevention (CDC)

Carolyn Clancy, MD
Department of Veterans Affairs (VA)

Mandy Cohen, MD, MPH
North Carolina Department of Health and Human Services

Sanjay Dodamani, MD, MPH
Centers for Medicare and Medicaid Services (CMS)

Katherine Goodrich, MD, MHS
Centers for Medicare and Medicaid Services (CMS)

Aparna Higgins, MA
Duke-Margolis Center for Health Policy

Brent James, MD, MStat
Leavitt Partners

Bob Kocher, MD
Venrock

Elliot Main, MD
California Maternal Quality Care Collaborative

Mark McClellan, MD, PhD
Duke-Margolis Center for Health Policy

Peter Pronovost, MD, PhD
University Hospitals

Michelle Schreiber, MD
Centers for Medicare and Medicaid Services (CMS)

Jonathan Slotkin, MD
Geisinger

Mark Smith, MD, MBA
California Health Foundation

Mary Wakefield, PhD, RN, FAAN
Former Health Resources and Services Administration (HRSA)
Together We Can Make Care Better

LEARN MORE ABOUT THE RECOMMENDATIONS AND EFFORTS YOU CAN SUPPORT TO DRIVE BETTER OUTCOMES FOR PEOPLE AND COMMUNITIES.

www.thecareweneed.org
#careweneed