

Health Care in Franklin County: Readiness and Options for Change



GENERON

Health Care in Franklin County: Readiness and Options for Change

This project stems from a deep concern on the part of some community leaders in Franklin County about the state of health care. In August 2005, these leaders invited Generon Consulting to “*assess our community’s readiness for change to create the conditions necessary to envision and realize health care for all people in Franklin County that is affordable for individuals and sustainable for our community.*” (The sponsors are listed in Appendix A.)

Since August we have spoken in depth with 58 people with differing perspectives on health care in Franklin County: leaders of hospitals, foundations, large and small businesses, and community organizations, as well as politicians, public servants, physicians, and patients. (A list of the interviewees can be found in the Appendix B.) Although our charge was not to assess the health of the system, in the natural course of our conversations we learned a lot about how well people think it is doing. Almost all of those we spoke to describe a system that, although healthy in parts and in many ways superior to health care elsewhere in the country, is as a whole unhealthy and becoming more so.

The first step we took in pursuing our charge was to ask ourselves, how do individuals experience the system? How do they respond to a system that all agree is unhealthy?

A. Current Ways of Experiencing the Health Care System

We found no common view of the system, but rather four distinct perspectives or ways of being in the system. These perspectives are not mutually exclusive. In our interviews, many of you expressed several of these perspectives. But we show them separately to provide a map of this community’s thinking. We have given these perspectives four different names.

Four Current Experiences of Franklin County’s Health Care System[†]



I. "Bureaucracy." We call the first perspective "Bureaucracy" because the voices remind of us those we hear when people describe a system that is complex, wasteful, impersonal, and over which they have little control. When viewing the system from this perspective, one hears confusion, frustration, and resignation. The focus is in survival. It suggests an image of "victim." From this perspective, people feel overwhelmed and in despair. Many who hold this perspective see the system getting worse. At right are quotations from our interviews that illustrate this perspective. (A more complete set of quotations can be found in Appendix C).

II. "Marketplace." From a second perspective people see opportunities for doing better and for winning in a competitive environment. Here there is a shift out of the "victim" mode toward pursuing opportunities for efficiency. There is a sense that getting it right is a question of restructuring incentives and regulating market forces. Some who speak from this perspective are optimistic. However, "Marketplace" allows forms of competition that are not necessarily healthy, leading to outcomes that may be good for individual actors but are suboptimal for the system.

Business Executive

"No one understands what's going on in health care. Everyone is frustrated. Earlier, there used to be people around who at least thought they knew how to fix it. By now they have disappeared."

Patient

"Why does everything need to be so difficult? I needed surgery for an injury which was being covered through worker's comp. It took 13 years to get my surgery. When [a prominent local sports figure] needed the same surgery by the same doctor, he got it immediately. Why?"

Community Leader

"Everyone gets attached to their 'Me, Me, Me.' Everyone lives in an isle."

Patient

"There is a lot of waste because there is no coordinated care. Tests get repeated. Doctors have no incentive to save on healthy people. I get any test I want."

Physician

"I am very much an options person. I hate being trapped."

Public Official

"Small stores can't beat out WAL-MART. Why do we think that small physician practices should survive?"

Community Leader

"The way the system is set up, the hospital whose board I am on has to make itself as good and competitive as it can be. The institutions that have the most community support will prosper. And that's as it should be."

Patient

"Why are the other hospitals trying to close down the surgical hospital? More hospitals make it more competitive. Better for the patient. There was a night and day difference between being treated at a local hospital versus being treated like a real person at the surgical hospital."

Community Leader

"The first criterion used to be: what advances the community? Today it's: how can I advance my business?"

Health Care Executive

"We never did transplants, burns. We were able to thrive on doing high volume tertiary care...But when [others] decided to get into that deal, we had to carve out our own niche by getting in to kidney transplants, burns, high end cancer treatment, robotic surgery and other high end services like that. Not because it was the right thing to do, but to survive."

III. “Jazz Ensemble.” The third perspective differs from the previous two because it focuses more on “what might be” than on “what is.” We give it the name “Jazz Ensemble” because it has a quality of going beyond reacting, to exploring the creation of something new, much in the way a jazz ensemble improvises to create new music. From this perspective one can see and experiment with possibilities. However, like “Marketplace,” the emphasis is at the individual and institutional level. When viewing the system from this perspective, people are in a more self-reflective mode; they are more aware of their own role in the system. They are also more appreciative of and curious about the perspective of others, and therefore are more likely to speak of—and seek out—relationships with others. Here you find people being philosophical about the mindsets that drive behavior affecting the health care system.

IV. “Community.” The last perspective is focused both on the future and on the system as a whole. We call it “Community” because when experiencing the system from this perspective people are able to see beyond their own survival and look to the common good. They are less focused on their own needs and more focused on what serves the community as a whole. People with this orientation sense that there is consensus around a need for radical change. This is a generative stance, open to new possibilities.

Business Executive

“What you see depends on where you are. Every place creates its own reality.”

Public Official

“We were not very good at seeing other things. We got our information from our organization. We read internal documents. There were no external influences or perspectives. We didn’t look outside. We didn’t even know that others had different views and that these different views were passionately held. Looking at it from today I find it fascinating how constrained my own thinking was. I can now see my own ways of looking at things.”

Community Leader

“People tend to expect instant satisfaction and gratification...you search to be happy in an instant...but you are not in peace with yourself if you move so fast...I don’t know why people get out of control...When I am hungry I can hold my hunger for 40 minutes and cook some reasonable food rather than go to a pizza store...How does the habit of instant gratification relate to and limit our thinking about health care?”

Patient

“It takes enormous energy and resources to make the system work. We need consumer-oriented health care. We need to put information in the hands of intelligent patients.”

Health Care Executive

“I can defend the analysis for building three heart hospitals. But is it right? Is it the right thing to do in the context of society?”

Community Leader

“Health care is almost a divine right—especially for children. It is simply unfair that my child should have a better outcome than a poor child.”

Community Leader

“There is a willingness in the wider system to tackle health care. It will take time, energy, and money.”

Public Official

“No one knows what to do, and that creates a lot of room.”

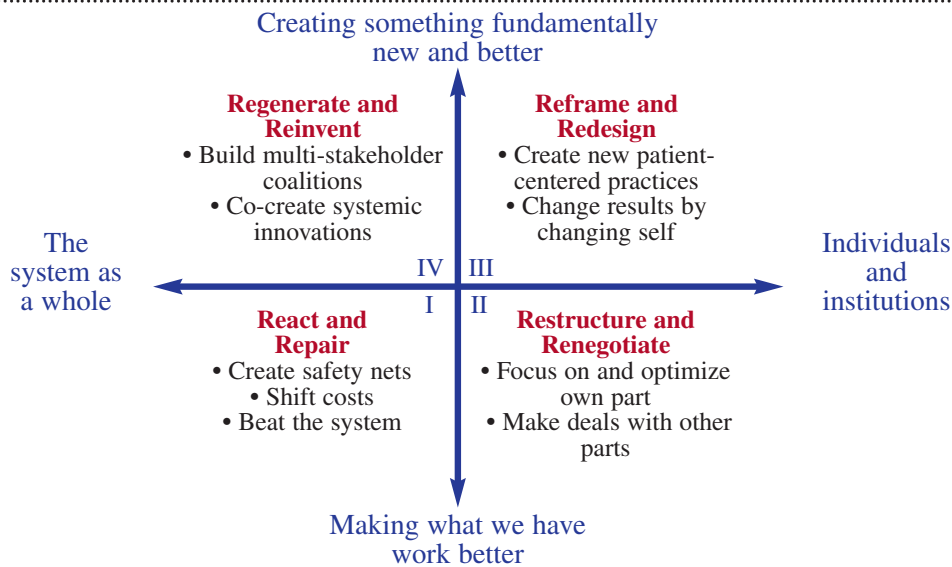
Physician

“[In a dialogue session that I participated in this spring] I could see on a larger scale. It was like experiencing a different way of being that I wasn’t aware of, with everyone receptive to what everyone else was saying. There was a deep feeling of being accepted...A strong bonding happened and an enormous capacity of problem solving evolved within hours...We came up with stimulating ideas, each of which could have produced different ways of existence...It was about collective intelligence...”

B. Current Ways of Acting to Improve the Health Care System

In addition to four ways of experiencing the system, we noticed four related ways of taking action.

Four Strategies for Making the System More Affordable and Sustainable[†]



I. "React and Repair." The first perspective, corresponding to the experience of "Bureaucracy," is one in which people take the system as given and react to it. Although there is some energy for reform in this quadrant, the basic perspective is one of pessimism regarding significant change in the overall system. People acting from this perspective don't see the prospect of significant systemic change and don't feel empowered to do anything major. So they either don't do anything or tend to focus on something small that they can influence. But many are willing to take some steps to keep the system from falling further apart. A few impressive efforts have emerged from this perspective, such as Access HealthColumbus. But they have an inherent limit. Like this example, they do not alter the basic structure of the system, and in fact relieve pressure on other parts of the system, thereby lessening the demand for change.

Community Leader

"The health care system is just like the public school system. Lots of people say that it's broken, but no one is willing to take on changing it—including me."

Health Care Executive

"Even if we all agreed on the changes we needed we don't have the power to do anything. The forces that drive the health care system are beyond our control."

Community Leader

"When you can't figure it out, you ignore it, or you focus on a piece of it."

Physician

"As soon as [an initiative] becomes a solution, it gets overpowered. Access HealthColumbus is a perfect example of this. It's solving a part, but it is not a systemic solution. What happens is that uninsured people who have previously received service at emergency hospital rooms are now being sent to Access, putting even more pressure on the voluntary system. It reinforces the system. Access is a band-aid, though a very good band-aid with a great intention."

II. “Restructure and Renegotiate.” A second strategy for improvement parallels the “Marketplace” perspective. It takes the existing system for granted and tries to optimize it through changes negotiated with other players. Sometimes the innovations can be carried out by individual actors who figure out a better way to compete in the marketplace. This strategy has led to innovations welcomed by some but seen as destructive by others, such as the New Albany Surgical Hospital. Belief here is in the virtue of the marketplace, and the underlying principles of capitalism. This perspective does generate potentially useful innovations and arrangements. But it has clear limits because people remain primarily focused on working within the current system.

III. “Reframe and Redesign.” In contrast to the first two improvement strategies, the third is focused on more fundamental change. However, it remains focused on individuals and institutions rather than the system as a whole. A shift to the customer perspective is characteristic. We saw few examples of this strategy in terms of actual initiatives. It is more evident in shifts in thinking, which, if acted upon, would lead to actions. But we found one example in an initiative at Children’s Hospital to create a coalition against domestic violence.

Physician

“I feel that specialty hospitals with physician ownership are a creative idea.”

Physician

“There is energy and passion in disciplined fighting.”

Community Leader

“The incentives are misaligned. What is good for the patient is not necessarily good for providers; what’s good for physicians is not good for payers, what is good for payers is not good for the government and so on.”

Public Official

“Change to a consumer focus, to an end-user perspective. Have the system emerge from the people it is supposed to serve.”

Physician

“We need a shift from the attitude of ‘being entitled to’ one of ‘things just happen and I won’t be left alone,’ going back to the old family doctor notion.”

Community Leader

“We’ve had some successes. Aetna wanted to look at helping patients receiving IV antibiotic therapy in hospitals. They believed it could be received at home. We did the communication with physicians regarding the circumstance, the opportunity, so patients could receive therapy more effectively for them with less hassle for physician. Costs were reduced; the quality was not comprised; the hassle factor of change minimized.”

Health Care Executive

“Here’s one example of how things can work. Historically there has been lots of interest and many initiatives around child abuse and violence against women. In the last two years, there was a coalition of folks, who created a building to put them in: child assessment/ treatment, police, prosecutors. A coalition against family violence. They had a common data base. They were all coordinating efforts to impact both violence against women and abuse of children. I think it could be national model.”

Community Leader

“In Cambridge, [Mass.] the hospital recognized they needed to collaborate with community to form a community health center. We are far from that here. My vision is that hospitals should go to neighborhood health centers and ask, What can we do?”

IV. “Regenerate and Reinvent.” The fourth improvement strategy takes a whole-system approach. Characteristic of this perspective is the view that you need to go beyond piecemeal reform to transform the whole system. We heard people crying out for solutions of this kind but found no examples.

Business Executive

“We need to explode the whole thing—or at least large parts of it—and build something new. Large social innovation is needed.”

Patient

“If you are too close, you are narrowed down. You need to focus more on the bigger picture and not push your own agenda. You must be willing to cross to the other side of the street.”

Health Care Executive

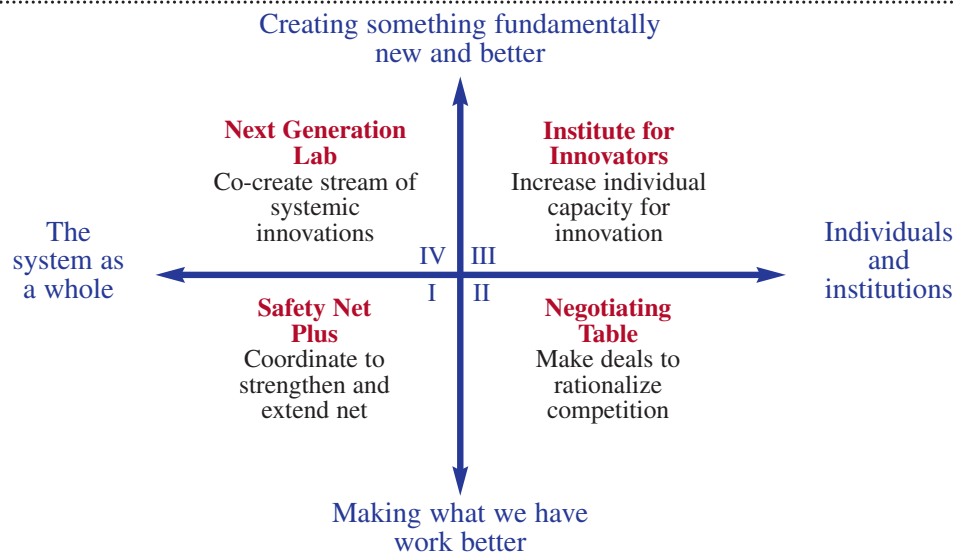
“Having three heart hospitals is irrational; so is two fetal medicine programs. We waste resources and dilute quality. We need to figure out the best way to meet demand as a community, not as individual hospital systems.”

These four strategies are not mutually exclusive. In fact, each transcends and potentially includes the preceding ones. The deeper one goes, the greater the potential to understand and shift the system and the greater the investment required.

C. Four Options for Making the System Work Better

We also see four options for how Franklin County could become more effective at making its health care system work better for everyone. These four ways to strengthen current change efforts—or initiate new efforts—parallel the four existing change strategies. Each of these corresponds to a different level of readiness for change, reflecting increasing gain and risk moving from I to IV. Again, these options are not mutually exclusive; each of them transcends and potentially includes the ones that go before. In our interviews we found energy for each of these approaches. We believe there is potential for a critical mass of people interested in an initiative in each of these areas.

Four New Community-Led Infrastructures For Advancing These Strategies[†]



I. "Safety Net Plus." The first option would continue to take the existing system for granted but look for ways to tighten it up. The objective would be to strengthen and extend the existing safety net, in order to catch people who are falling through the cracks. There is no potential here for transforming the system. However, health care could be provided or improved for some people.

II. "Negotiating Table." A second option reflects a wish to bring rationality to the marketplace through better communication and coordination. By providing a table where some or all stakeholders could communicate and negotiate, it would focus on providing opportunities to resolve conflict and promote collaborative planning. The resulting "ceasefires" could lessen the war of the parts against the whole. Like "Safety Net Plus," this option does not transform the system, but it could improve it.

Public Official

"The obvious thing is: we need to get more money into the system."

Physician

"Why can't we redistribute? No one can have a hold on anything, we all have to give up something."

Patient

"When my mom went to her doctor and asked for the program covering her payment, he said that it didn't exist. But it exists and he didn't know about it. It's about empowering people, and educating the doctors so that you are not in the dark."

Community Leader

"Open Sesame: The cave of health care, the mystery of health care system. I want to know what is behind the doors...Take your responsibility: choose a place to go and stick with it, don't jump from one to other. Get regular care...evaluate your needs. If you have a cold, and you are an adult, don't go to an emergency care room... Guide them about first choice to go."

Business Executive

"The big opportunity in health care is to increase choice and consumerism."

Community Leader

"Do we have an effective way to discuss this stuff? Form a group and put the right people on it. Staff it properly. Present issues, discuss alternatives. Begin to have conversations about solutions. We need answers, ideas, and policy proposals."

Public Official

"We need to take a look at all health systems, do a better job of planning. Each system can decide what it wants to do, but this is where we are going to spend public resources, where they won't duplicate. Why build another cardiac hospital when the need doesn't justify it?"

Community Leader

"[People in Columbus] think they need input from people who have power and money to make things happen. That's their model of change...There is no history of grass roots change. There is a tradition of [particular business-oriented families] as the gatekeepers."

III. "Institute for Innovation." A third option represents a way of putting more energy into existing "Reframe and Redesign" strategies by supporting individuals who want to broaden their perspective, deepen their skills and improve initiatives in which they are engaged. This approach would build the individual capacity of health care leaders in Franklin County. It would help people who are feeling "stuck" examine their own ways of thinking and explore new approaches to their existing initiatives.

IV. "Next Generation Lab." The fourth option would focus on the health care system as a whole, seeking ways to move toward a system serving all citizens that is affordable and sustainable. This option takes nothing for granted. It would aim to regenerate the system by tapping collective intelligence. It would provide a support mechanism for collective action, aiming to generate and implement systemic change initiatives on behalf of the community. Like the "Institute for Innovation," this option would be a training ground for next generation leaders. However, the training would come from direct engagement with a transformation of the system.

Community Leader

"Beyond a small group there is disdain about the current method—the business leader/top-down method. Leadership is also found on sidewalks; we must bring the skyscraper leaders together with the sidewalk leaders. The key is get to the right question, what can we agree on?"

Public Official

"What I see is what I know. What is it that I am not seeing? What is it that needs to be fundamentally questioned? I have to make myself an observer. Where do I need to go, to see newly?"

Business Executive

"We need to build something new—a greenhouse for upstream innovation in health, moving beyond the behavior level. How can knowledge about change from business executives become productive for change in health care?"

Physician

"Patients still need a medical home where they can get care. The continuity is missing. So we're only treating the current symptoms and not the entire patient. We could start small—everyone should have a medical home that they visit at least once every two years."

Business Executive

"The signature opportunity here is: Could Central Ohio be viewed as one of the best places in the world to have health care delivered to you? Where the average age is 105?"

Physician

"We need to have a broader conversation about the health care system—it needs to be a community conversation and a governmental conversation, not one just involving physicians. Nobody is taking the systems view. Nobody can do it by themselves."

Business Executive

"Small groups of committed people exist. The conflict lies in what has to happen. Perhaps this project is the new direction. It's been festering for so long."

Community Leader

"The opening of the three heart hospitals made it clear that our system isn't working properly. Is this really the best use of our community's resources? We have to go up a level and look at this from the balcony. We have to develop a vision and a strategic plan for Columbus' health care system, for how our whole system—not just one institution—can become the best. This is just the kind of coordination that the Partnership did around capital budgeting submissions to the government, which worked brilliantly."

Community Leader

"A new health care system would have to shift the inner focus from Me, Me, Me to a larger place....then you can have access for everybody...then that "everybody" can act responsibly...Why don't you feed your SELF, rather than your Me, Me, Me? It's thinking anew about what it means to be free in this country. Freedom today is bound to the Ego... not to the higher Self...An inner shift from Ego to the higher Self needs to happen."

D. Conclusion and Next Steps

We accepted an invitation to assess the community’s “readiness for change to create the conditions necessary to envision and realize health care for all people in Franklin County that is affordable for individuals and sustainable for our community.” What have we found? We have discovered an almost universally high level of readiness for change, and we present four distinct options for focusing that readiness. These options promise differing levels of potential impact and require corresponding levels of investment. The first two—Safety Net Plus and Negotiating Table—would improve the current system, but would be insufficient for providing sustainable and affordable health care for all. The Institute for Innovation has the potential for effecting deeper change and building leadership capacity. However, the resulting change would not be systemic in nature. The Next Generation Lab has the greatest potential for meeting the more ambitious objective reflected in the charge given to us; it would also require the greatest level of investment. All four approaches would contribute to improving health care in Franklin County, and they are not mutually exclusive. For example, it is possible to embark upon any of the first three options, or any combination, with a view towards effecting discrete changes in the near term, while simultaneously aspiring to shift the health care system as a whole over a longer time frame via the fourth option. We therefore recommend that all four possibilities be explored and that the option or options for which there is a critical mass of support be implemented.

Comparison of the Four Quadrants

	Quadrant I	Quadrant II	Quadrant III	Quadrant IV
Image of the system	Bureaucracy	Marketplace	“Jazz Ensemble”	Community
Attitude	“All I know is that I have to fight (and cheat) in order to survive in this system that I can’t change”	“I know how to win by making make my part work better”	“I realize that what I am doing is not working as well as it could, and that I have to shift my perspective is order to do better”	“We have to work together to build a better system”
Operating mode	Confusion Waste Resignation	Opportunity Differentiation Competition	Reflectivity Dialogue Creativity	Common good Generativity Co-creativity
Approach to dealing with the system	React and Repair	Restructure and Renegotiate	Reframe and Redesign	Regenerate and Reinvent

	Quadrant I	Quadrant II	Quadrant III	Quadrant IV
Strategies	Create safety nets Shift costs Beat the system	Focus on and optimize own part Make deals with other parts	Create new patient-centered practices Change results by changing self	Build multi-stakeholder coalitions Co-create systemic innovations
Level of intervention	Symptoms	Behaviors	Assumptions	Intention
Nature of innovation	No innovation: survive while preserving the status quo of the whole	Technical innovation: improve and preserve the parts	Relational innovation: create new parts by seeing new perspectives, passions, and potentials	Architectural innovation: give birth to a new whole through co-sensing, co-presencing, and co-realizing
Key challenge arising from pursuing this strategy	The system and its rules do not permit everyone to survive, and individual survival strategies exploit and erode the system	Competition leads to fragmentation and a war of the parts against the whole	Downloading truths from the past make it hard to see the possibilities of the future	Holding onto the past and to our own parts make it hard to create a new whole
Relationship to the rules of the game	Need to work around and patch up the rules in order keep self and system alive	Need to renegotiate the rules in order to rationalize the system	Need to access new perspectives on self and others in order to see beyond the rules	Need to access collective intelligence in order to reimagine the rules
Community infrastructure needed to address this challenge and get to the next level	Safety Net Plus	Negotiating Table	Institute for Innovators	Next Generation Lab

	Quadrant I	Quadrant II	Quadrant III	Quadrant IV
Image	A strengthened net to catch the people who fall through the cracks of the existing system	A table where some or all of the stakeholders can sit and negotiate a ceasefire	An institute or greenhouse where formal and informal health care leaders can, through project-based learning, improve their individual capacities for breakthrough innovation	A laboratory where leaders can co-create a next-generation health care system
Objectives	Strengthen, extend, and improve the efficiency of existing safety nets	Increase the rationality and efficiency of the system Resolve conflicts End the war of the parts against the whole	Help individual health care change agents increase their capacity for innovation Build a network of change agents	Invent and implement a stream of systemic innovations Build the community's collective capacity for reinvention
Required players	At least some of the leaders of the existing safety net and emergency response organizations	The principal decision makers in the system—those with the capacity to effect or to block changes in the rules of the game	Each year, a highly diverse class of 24-36 formal and informal leaders of health care systems who are each trying to effect change and who want help to do so more effectively	Each year, a team composed of a microcosm of 24-36 next generation leaders of the system who want to work together to change it, supported by champions from their organizations
Required time by players	One half-day per month for coordination and cooperation meetings	Two days every two months for problem solving and negotiating sessions	12-20 days per year for classroom and field work	Up to 40 days per year for co-sensing, co-presencing, and co-realizing activities

	Quadrant I	Quadrant II	Quadrant III	Quadrant IV
Illustrative precedents	Hospital Care Assurance Program	Informal meetings among hospital CEOs	Institutional and community-wide leadership programs; ELIAS	Sustainable Food Lab
Process	<p>Convene the players</p> <p>Understand current activities and unmet needs</p> <p>Find and implement opportunities to coordinate and collaborate, e.g. shared resources and common policies and practices</p>	<p>Convene the players</p> <p>Agree shared fact base about the problem</p> <p>Develop options to solve the problem</p> <p>Agree preferred options</p> <p>Negotiate new rules and deals</p>	<p>Invite diverse nominations and applications to annual class</p> <p>Learn from each other, stakeholders, teachers, and experts</p> <p>Work on own professional project plus own personal project</p>	<p>Convene an annual lab team that is a microcosm of the relevant system</p> <p>Together build up a deep, shared, new understanding of the current reality of the system</p> <p>Create, test, and institutionalize new realities</p>
Key design question	How to repair the system in the short term without undermining efforts to reform it in the long term?	How top-down/exclusive vs. bottom-up/inclusive should the table be?	How to connect with and differentiate from existing capacity building programs?	Where is the highest-energy entry point to reinvent the system?

Appendix A: Sponsors of the Study

Access HealthColumbus
Columbus Medical Association and Foundation

Osteopathic Heritage Foundations
The Columbus Foundation



Appendix B: Persons Interviewed

Carl Berasi, New Albany Surgical Hospital
Jeff Biehl, Access HealthColumbus
David Blom, OhioHealth
Ed Bope, Physician
Amiee Bowie, Central Community House
Joe Calvaruso, Mount Carmel Health System
Phil Cass, Columbus Medical Association and Foundation
Deborah Chatman, Nursing educator
Barb Colter-Edwards, Ohio Medicaid
Dean Colwell, Physician
Mike Curtin, Dispatch Media Group
Wendy Damron, Patient
Debera Diggs, Communities in Schools
Reed Fraley, Ohio Hospital Association
Keith Goodwin, Children's Hospital
Matt Habash, Columbus City Council
Nora Hesse, Patient
Ben Humphrey, Medical Group of Ohio
Isi Ikharebah, Access HealthColumbus
Janet Jackson, United Way of Central Ohio
Jerry Jurgensen, Nationwide Insurance
Mary Jo Kilroy, Franklin County Board of Commissioners
Peter King, Patient
Doug Kridler, The Columbus Foundation
Renee Lamar, Patient
Maria Carmen Lambea, Latino Empowerment Outreach
Cathy Levine, Universal Health Care Action Network
Teresa Long, Columbus Health Department

Ty Marsh, Columbus Chamber of Commerce
Clifford Mason, Clinton Township Fire Department
John P. McConnell, Worthington Industries
Dorothy McKay, Southside Settlement House
Sabrina McKay, Patient
David Meuse, Stonehenge Financial Holdings
Bob Milbourne, Columbus Partnership
Damon Minter, Southside Initiative
Michael Murnane, Physician
Marc Parnes, Physician
Peter Pavarini, Schottenstein Zox and Dunn
David Powell, Compete Columbus
LeAnn Reat, St. John's Episcopal Church
Dave Regan, Service Employees International Union
Nancy Rini, Columbus Public School Nurses
Rich Rosen, Battelle
Fred Sanfilippo, The Ohio State University
Joe San Filippo, Nationwide Health Plans
Len Schlesinger, Limited Corporation
Juanita Searcy, Patient
Tammie Seay, Access HealthColumbus
Grayce Sills, The Ohio State University
Mari Sunami, South Side Settlement House
Charleta Tavares, Columbus City Council
Greg Thorne, Hilltop Church of God
Rick Vincent, Osteopathic Heritage Foundations
Bruce Wall, Physician
Diane Warren, Katzinger's Deli
Abigail Wexner, Children's Hospital
Donna Woods, Gladden Community House

Appendix C: Additional Quotations from the Interviews

Community Leader

“Thousands in Franklin County are having their lives destroyed because of interaction with the health care system.”

Community Leader

“We are excellent at the high tech Star Wars slice of health care, but fail miserably on preventive care, early interventions.”

Public Official

“75% of money spent goes into 25% of disabled and chronic disease. It’s not about moms and their babies. Long term care is a ticking time bomb. People just don’t realize yet, that Medicare doesn’t pay for long term care, but all of us baby boomers are becoming older. The long term reality of care for the elderly as a vast resource killer has not yet sunk into public consciousness.”

Public Official

“The rate of growth in Medicaid is more than double state revenues.”

Business Executive

“The tipping point has almost been reached when small businesses can’t afford health insurance for their workers. Then what happens?”

Patient

“I had no control over my health care costs—even when I had insurance. I couldn’t control who my doctors brought in as specialists. They didn’t care who was on my plan or who wasn’t. The out-of-pocket expenses were astronomical and I had no control.”

Health Care Executive

“The economic system that compensates health care makes it difficult to change the health care status of this community in near term. The incentives are not aligned.”

Community Leader

“I see a broken cart careening down hill, no one knows how long the hill is, or where the bottom is. And the further down you go, the more speed you get.”

Public Official

“The lack of money makes me do a lot of things that are not good for the system. It’s all reactive and generally not constructive. It’s energy-draining stuff.”

Physician

“A patient of mine has gallstones. She goes to an emergency room at the hospital one night. They do all the x-rays, scans, and testing available. The physicians there don’t know the patients. That makes them do many things that are unnecessary, partly to protect themselves, not the patient. I tell them: why didn’t you call me? I can tell you: I know her very well. I know her parents, her kids. She calls a lot. What she needs is reassurance. I have told this to the doctors at the emergency room. They would still run all the diagnostics.”

Patient

“I don’t know anything...they won’t give me any information!”

Patient

“My experience with health care...is not a positive experience. No one takes any time. Doctors are disengaged in too many cases from dealing with patients. You are shunted off on someone else. I find it hard to make sense of whole thing. You get to an appointment on time, wait for 45 minutes. It’s all predictable. My time is not valuable. The doctor introduces himself as ‘Dr. so and so.’ You don’t get their first name! The presumption is you are inferior.”

Physician

“I am not smart enough to know how to fix the system, but I am smart enough to know that I’m being screwed.”

Physician

“Do you know how I know that the system is dying? My father practiced until he was 75. I won’t last that long. I have three sons. When it came time for them to decide on school, I told them that I would finance their education as long as they didn’t go into medicine. The crisis in health care is so unsettling that my wife and I have questioned whether to continue to stay in Columbus or to leave for greener pastures.”

Community Leader

“We have people horribly sick throughout the system because they haven’t had good preventive care. I know of a case of a woman who couldn’t pay for blood pressure medication. She had four strokes. The fourth killed her. She was an expensive patient, in the hospital for six weeks before she died.”

Community Leader

“I was put in the position of deciding who could and could not get health care. How unfair. There are so many, many things systemically wrong.”

Health Care Executive

“People feel trapped in a health care system that they don’t like.”

Patient

“Hospitals in Columbus are highly competitive—it’s almost cut throat. And it’s not because they are competing to provide care for patients.”

Community Leader

“There is a lot of territorialism. City government and county government are very far apart. They don’t play nicely together in the sandbox.”

Health Care Executive

“The ethic in this community is: ‘Competition is the American way.’We have an inadequate, schizophrenic health care system, which at one level says ‘compete’ and at another says ‘don’t duplicate and be overly expensive’—all with an overlaying bias of ‘we want it.’”

Patient

“We have exactly the health care we deserve. It’s very American. We have a zest for freedom and self-determination. We have allowed a valued piece of society to run amok because of fierce desire for health care at all costs without regard for the resource equation. We want the best. We have compromised all the links to get there. We have the ability to amass resources around the chosen few. Aspen couldn’t exist if Haiti didn’t.”

Patient

“My dad got very sick in Florida. We bring him to Columbus. My general practitioner agrees to completely quarterback my dad’s care. He manages all referrals, talks to me whenever he sees my dad (this was before HIPA), sends him back to Florida. He probably extended his life for three years in a quality way. It was concierge medical care. There was no structure for care coordination in Florida. Here I have access to anything I want—at the personal level—there are no great shortfalls. I can engage with the doctors. I can send my doctor an email on Sunday with all the details of everything I experienced through the week. And then we can have a conversation around it. It’s a partnership.”

Physician

“When I do my job correctly, then patients would not be scared or closed up. I listen with my heart. ... Healing is connecting. Get into the same swing ... it’s not about running another test. Allow for time. Healing needs time.”

Business Executive

“What I want is to make a real contribution; to use my core strengths; to work with a complex set of people; and to bring something into creation that doesn’t exist. The day I realized this was the calmest day in my life.”

Physician

“[People today] don’t know their neighbors. They are less ‘churched.’ They have less support. They are lonely. When you ask what they liked about their experience with the doctor, they tell you that it’s how somebody treated them, or how they got back to them. It’s all about relationship and connection. It’s a group of people they have access to that can help.”

Public Official

“We’re all victims. We don’t feel empowered. People are willing. I have been impressed with how quickly people agree that the system needs fixing.”

Patient

“The current situation of health care reminds me of me giving birth. I started having dry heaves on top of contractions. The doctor said: you are fighting your labor. I feel we are fighting the wrong battles in health care. Can’t get forces together to give birth to a new system if all the forces are pulling in different directions.”

Community Leader

“I used to think that what’s wrong with health care could be fixed with technology. But not any longer. It starts at the core of our society and that’s hard to change.”

Business Executive

“We fail when we fall short of universal health care: providing a basic level of care for everyone. When I grew up, health care was a social good, like K-12 education. Now it’s a commodity like cars and batteries. We mouth both pieties—social good and commodity—and constantly try to navigate between them. My morality says that health care is a social good, but politically Americans say it’s not.”

Community Leader

“There is nothing that occurs to me in my 15 years in Franklin County that makes me optimistic that this can be solved at the county level.”

Physician

“When the system gets too big and complex, you need to make a difference on an individual basis. When I lock the door at night, I know that I have done all I can.”

Community Leader

“The health care system is just like the public school system. Lots of people say that it’s broken, but no one is willing to take on changing it—including me.”

Public Official

“One way of dealing with rate growth in Medicaid double that of state revenues would be to give member vouchers with a fixed amount of money. That shifts the burden of compensating for increasing rates to them. Commercial plans grow by 9–11% per year—there is a big movement to shift that cost problem to the consumer and call it consumer driven care.”

Patient

“People get depressed...they self-medicate through comfort food.”

Health Care Executive

“[Getting people to agree on how to change the system would be] like trying to turn a stampeding cattle herd with one rider, one horse.”

Health Care Executive

“The economic system that compensates health care makes it difficult to change the health care status of this community in near term. The incentives are not aligned.”

Public Official

“Another way would be to bundle purchase power but then let the consumer pick what they want to choose. That’s what’s lacking—better product, lower cost.”

Patient

“I know of a pregnant woman...she didn’t know where to go. There are different numbers for pre-natal care. She was calling 10 times to start pre-natal care...then they put one number, redirecting to “coordinate“ health care access.”

Health Care Executive

“Even if ‘the titans’ were to say ‘This is way it has to be,’ I don’t know if they have ability to drive it through. Having said that, they can create short term victories. People pulled together when hospital closed in South End of Columbus. Maybe if we can find those baby steps.”

Community Leader

“Everyone is doing the right thing in their own space...but no one is looking at the whole.”

Business Executive

“We do not need another talking round. The health care problem is resistant against existing coalition approaches. Need to find a new remedy.”

Public Official

“I was hired to turn the organization around, to change our thinking from “bill payer“ as a gesture of welfare towards paying attention to the consumer and client. The new focus was on the end user, not at our administrative procedures. Why we exist is the consumer; the focus is on people we serve...What is it that people value?”

Business Executive

“The biggest challenge is to live in a changing world without losing focus. We need some core principles to ensure that: respect and trust of people.”

Community Leader

“The marketplace doesn’t solve health care issues. The only way forward is to take it up a level. It won’t be solved by conversations in the health care system.”

Community Leader

“You have to change the whole system. You can’t just tweak one piece. It will destroy itself that way.”

Public Official

“Health care by itself does not improve health. How can we create the conditions to be healthy? I wonder about the importance of health, not health care.”

Public Official

“We have been a primary sponsor of our primary center, before it became federally qualified. It was the only one that got money from the federal government, the east central center, called ECCO. The health department and city of Columbus provided funds to six other centers. ECCO got city money and federal. It fell on hard times. We created an umbrella tying all seven health centers under one organization. They all became FQ centers. We retained ECCO and expanded. The city had put down five million dollars. That was visionary. that the city said we need a consistent system of care throughout Columbus. These FQHC’s would provide consistent care, and we would make them more efficient via bulk buying, rotating physicians, connecting MIS systems.”

Community Leader

“Some people feel that our health care system is really good here in Columbus. ‘Don’t change it. Don’t mess with success.’ A lot of physicians and older people in the community think this way.”

Community Leader

“The insurance companies are making money, so they need to be at the table.”

Public Official

“We need to collapse/integrate public and private sector thinking into entrepreneurial, joint learning about new ways of innovating.”

Health Care Executive

“We as leaders have to transcend the boundaries of our organizations.”

Physician

“I couldn’t live with just treating the sick. I want to keep people healthy. What makes people healthy?”

Public Official

“Get people to know each other, to know what each other is doing. Help them to think differently about what they already know. Have them coach each other in their aspiration to change.”

Physician

“I also realized you can learn so much by talking to one another. Talking to one another cuts cost.”

Community Leader

Being happy or healthy is getting out of your self and helping others. It’s not owning something. Overcoming the nature of humans that you always tend to think of yourself and family. Put yourself on the same level like someone out there.... Next step.... To put yourself behind the other person is not a realistic goal, but at least become on same level, put yourself in their shoes, give yourself another perspective.”

Community Leader

“What enables people to allow them to change the way they believe and act? What are the tools that everyone can use that empowers them to make change? It’s the change in engagement and connectivity. Good nutrition is important, but regional kitchens where people come together to prepare nutritious meals in relationship with others make the difference. Non-health causes people to feel bad. We are disconnected, we feel bad about ourselves. We need to focus on social connectivity. We need to include everyone in the process.”

Physician

“Many things we do, I wonder, isn’t that deciding what the solution is, before we know what the problem is? We design solutions without understanding deeply...we’re doing things wrong, we do them top down, rather from the bottom.”

Public Official

“Teach people how to think differently about what they already know.”

Community Leader

“Are we who have willing to give something up for those that don’t have? Redistribution will only work if the haves feel that they are also gaining. Can we think about health as social connectivity? The haves can gain from the connectivity.”

Community Leader

“The challenge is getting everyone on the same page. To fix it for good, you have to find the root causes. You have to have the right people around the table and have them understand and have the commitment to resolve the issue: period, end of story.”

Community Leader

“We are doing sophisticated and quality work in opposition to the hospital industry because we are given no alternative. We would rather work with them around building a sensible system.”

Health Care Executive

“In the end you want a healthy and educated workforce and a community that people are proud to belong to...health care is an underpinning of that.”

Community Leader

“We need to create coherent action. It would be cheaper and sustainable for all—everyone in the system—need to understand how we are doing this to us. All of us are the problem. So we are all of us part of the solution.”

Business Executive

“When will we reach the tipping point? The electorate is getting more and more concerned. The time is coming—but has it come?—when this issue will get more and more traction. Then we could develop a system by design instead of by default. Columbus politicians could do this. The City Council is progressive, and the County Commissioners would be 3-0 on this. They are out to move the ball down the field, and are willing to engage meaningfully in the art of the possible. If I could play a role in moving this ball down the field, I would. Who wouldn’t be excited!? If Columbus could be a laboratory for demonstrating the art of the possible.”

Health Care Executive

“We need to figure out the best way to meet demand as a community, not as individual hospital systems. We waste resources and dilute quality.”

Physician

“How could we see at a larger scale in our community? How can we unleash collective intelligence in the community?”

Health Care Executive

“In the end you want a healthy and educated workforce and a community that people are proud to belong to...Health care is an underpinning of that.”

Physician

“This community has as good a chance for setting the model as any place that exists...If you are going to plant seeds, you look for a fertile field. For health care delivery change, it would be hard to find a more fertile field than Columbus.”

Business Executive

“My country has to find a way to bring together free markets, capitalism, and socialism.”

Public Official

“40% of the kids in Columbus are in Medicaid. 50% of all kids in Columbus under five years old are living at 200% level of poverty. The right for health care doesn’t go through money. It is for the well-being of the county. It’s for the next generation of the county.”

Health Care Executive

“In the end we need to use the money available together. We need cohesion, an integrated approach. That’s what’s lacking.”

Health Care Executive

“I want my legacy to be “he was a community guy. Not: he fixed it for the doctors.”

Community Leader

“Part of what gives me hope about Columbus is that people are getting health care, even if it’s through a charitable basis. But we need to shift from charity to justice.”

Physician

“I am deeply committed to fixing this system. I would do anything to make it work.”

[†] The underlying four-quadrant model was developed by Otto Scharmer of MIT.