



Robert Wood Johnson Foundation

WOMEN OF IMPACT:

Addressing Health Care's Broken Windows

How women leaders are using collective impact to fix what is broken in health care

By Joanne Conroy, M.D.
with Jennifer J. Salopek
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There's an old Nigerian proverb that says in a moment of crisis, the wise build bridges and the foolish build dams. Our health care system is experiencing a crisis of its own, with patients increasingly feeling marginalized, as if no one is really listening when they are in the hospital or doctors' office, even as they pay ever higher deductibles, co-pays and out-of-pocket costs.

To help build bridges between what patients truly need and what they currently receive, the Women of Impact—an influential group of health care leaders convened by RWJF and supported by the Association of American Medical Colleges—decided to take a hard look at the shortcomings of America's current health care system and offer solutions to make it more patient-focused.

The groups' insights are inspiring and striking, and range from recommending changing the vocabulary physicians use with patients, to creating a more consumer-friendly appointment system. Each idea is designed to help America move from a system built to deliver the most services to patients who can pay for them, to one that truly empowers all patients, while delivering the highest value for each dollar spent.

Now, the Women of Impact will begin the hard work of turning ideas into action. As Americans, we are all in this together and I encourage you to join the effort at www.rwjf.org/womenofimpact.



Risa Lavizzo-Mourey, MD,
is president and CEO of the
Robert Wood Johnson Foundation.

In July 2013, a small group of executive-level women from diverse sectors of the health care industry came together for a unique meeting to articulate their desired personal legacies, and to apply the concept of collective impact to advance those legacies in addressing complex problems in health care.

The group, which has since become known as the Women of Impact, agreed on a shared goal: to realign the health care system to meet the needs of all Americans, recognizing that the people who need care come from all walks of life. They also agreed on a nonpartisan case for change that zeroed in on critical concerns prominent in the national conversation, including:

- Health care costs too much, and Americans aren't getting what they pay for;
- People must have the ability to take charge of their wellness and health care and to exercise the power of choice;
- Health, not sickness should be the focus of care;
- Innovation is vital;
- Health care should be available to everyone when they need it; and
- Now is the time for significant change.

Over the course of three days, the Women of Impact discussed these problems and the prevailing contexts that underlie and reinforce them. For a common frame of reference, the group then drew on Malcolm Gladwell's metaphor of broken windows, i.e. the subtle reinforcing structures of behaviors in the environment that maintain the current context, as a lens through which to examine health care. The group used this frame to identify several of health care's own "broken windows," and agreed to collectively address three especially ripe areas for improvement by leveraging their own experiences, skill sets, and influence.

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The Power of Context: Broken Windows in New York City

*In his best-selling book, *The Tipping Point*, author Malcolm Gladwell describes the often overwhelming power of context: Gladwell argues that for most, if not all situations, current context creates a predictable future, and therefore an awareness of current conditions and circumstances can help individuals and societies understand what is likely to happen next.*

The power of context determines “who shows up on any given day.” Compare and contrast this example: How would a person behave if he or she were sitting in a car and a uniformed state trooper walked up? How would that same person behave if the man who approached had clothes that were in disarray, dirty, and torn? The context (uniformed officer versus unknown, disheveled stranger) determines how people respond and react in any situation. Context acts as a lens through which people see the world, others, and themselves—highlighting some aspects, dimming other aspects, and blanking out still others. It alters the way one sees and feels about a situation and therefore shapes one’s actions. Small changes to one’s environment, that shift context, can have a dramatic impact on behavior.

Broken windows are an example Gladwell leverages of a condition (disrepair in the New York subway as a consequence of vandalism in the 1990s) that creates context (that criminal activity is accepted as unavoidable) that also offers a path to profound change. He draws upon the work of psychologist Philip Zimbardo.

Zimbardo conducted an experiment in which he parked abandoned cars in various locations across the United States. Passersby left them alone—until he broke the windows: then the cars were stripped. Zimbardo’s theory posits that if windows are broken and left unrepaired, people walking by will conclude that no one cares and no one is in charge. Soon, more windows will be broken and the sense of

anarchy will spread. Further, political scientists James Q. Wilson and George L. Kelling argue that minor forms of disorder—graffiti, littering, panhandling, and prostitution—will, if left unaddressed, result in an increase in serious criminal activity: clean up minor disorder, and a reduction in major crime will follow.

Gladwell translated the graffiti, mechanical breakdowns, and literal broken windows of the New York City subway into “broken windows” as a metaphor that further illustrates this power of context. Gladwell posited that fixing these metaphorical broken windows—improving environment or context—could halt or diminish the spread of epidemics, whether literal ones such as malaria or figurative ones such as crime. In fact, this theory was the cornerstone of New York’s approach to dramatically lowering crime in the 1990s by tackling graffiti, subway fare beaters, and other minor criminal infractions. As the idea spread, other city officials focused on the maintenance of public property and an increased police presence on the street to reduce instances of disorder and neglect. They promoted an environment of order and community care by replacing those broken windows, cleaning up graffiti, ensuring that litter was collected, and more. By the end of the nineties, there were 75 percent fewer felonies and the crime rate in the subways plummeted.

We know that New York City did not achieve its success by getting a population transplant, Gladwell writes. No one went out onto the streets to teach every would-be delinquent the difference between right and wrong. There were just as many psychologically damaged and criminally inclined people in the city, but evidently tens of thousands stopped committing crimes. The subtly changed environment of New York created a new basic context in which individuals acted.

Ensuing works, such as Steven Levitt’s *Freakonomics* and others, have analyzed the broken windows theory (debated the drivers) and translated it for use outside the realms of crime and urban culture. Gladwell writes that the theory can be applied to any system as a way of understanding the human reaction to diverse circumstances. New York Mayor Michael Bloomberg’s

effort to improve public and population health citywide by reducing tobacco use, improving food quality, and increasing physical activity through transportation initiatives is another example of the impact of shifting norms and standards that have produced powerful results: The city's adult smoking rate has declined from 21.5 percent in 2002 to 15.5 percent; childhood obesity rates have inched down among schoolchildren; and life expectancy has increased in the city by three years since many of the changes went into play, compared to only 1.8 years in the rest of the country.

It is important to keep in mind that the broken windows theory is less about direct causality than about the fact that nearly all sociological and population-based problems (smoking, drug use, developmental delays in children) are complex, have meaningful consequences, and defy simple or singular solutions. Of course, merely fixing a window does not deter crime. It is deterred by intervening at multiple levels, multiple times over decades, in often subtle ways, changing an entire ecosystem of human actions. The broken window is a symbol of the opportunities for intervention at educational, sociological, political, law enforcement, housing, and financial market levels. It is a metaphor, an easily visualized reminder of current context and our rich potential for impact.

These concepts served as a framework for an impassioned group discussion by the Women of Impact to identify the current context, envision the predictable future, and identify the broken windows of health care that, if repaired, could help create a better future.

A Profound Exploration of Legacy

This is a group of phenomenal women, all of whom have had an impact on their environment. When women come together, there is a bond and a chemistry that unleashes warmth and sharing. We identified some easy short-term deliverables and implemented actions around these. Our initial actions were around amplifying our communications to encourage people who are uninsured to enroll in the health insurance marketplace.

What's next? We haven't figured that out yet. We're seeking to develop messaging that is palatable, not political; that will unite rather than divide. Our target audience is women at all stages of life and eliminating barriers to access for them and the people they care for. I'm at a critical point in my life, and this is a pathway to action.

—**Rhonda Moore Johnson**

*Medical Director
Integrated Clinical Services Division, Highmark*

The Current American Health Care Context

The Women of Impact discussed several elements that comprise the current American health care context, and agreed on the following points:

- Health care in the United States is a network of loosely affiliated small businesses feeding large centralized organizations.
- There is little standardization in health care.
- Health care is focused on treatment, not on prevention; on illness rather than health. It is sick care.
- There is no public consensus about what is really needed to fix health care.
- There is tremendous asymmetry in access to information, and consumers have the least access.
- Privacy trumps all, and sometimes deters the effective dissemination of information.
- Technology is often seen as a solution, but in many cases is only a tool.
- Providers don't apply clinical evidence to changes in practice.
- Physician professional organizations have been powerful reinforcers of the status quo, rather than voices for shifting the conversation to team-based care, quality outcomes, and alternative payment.
- Health care is a massive financial ecosystem, and there are concerns about disrupting it. The reimbursement model is flawed, until recently focusing on volume rather than value.
- There is a culture of rankism in health care that results in an imbalance of power and disempowers patients. Policy makers take a paternalistic approach in deciding what people need, and often consumers are passive about their health.
- Health care has been described as the "third rail" (dangerous, if not deadly) for many leaders in government and industry.
- There is an industry-wide lack of transparency that makes it difficult, if not impossible, for patients to understand the costs of their health care or the value they derive from it.
- People believe that death can be avoided. Combined with the lack of information about costs, decision making becomes emotionally driven.
- Individuals do not "own" their health like they do other parts of their lives.
- Society is torn between focusing on what is best for the collective versus what is best for the individual.
- Society acts as though some patient needs matter less than others.
- Decisions about where health care dollars should be spent on research and treatment for diseases and conditions assign values relative to those diseases and conditions; those that receive less investment typically affect underrepresented population.
- Language is a powerful tool in health care. It can educate or confuse. It can label and insult, or inspire and motivate. The language we use reinforces who we are and what we value.
- The paternalistic structure of health care disempowers people receiving or participating in care.
- There is broad acknowledgement that we want the best outcomes for every individual, but we have knowingly created a system where people repeatedly fall through the cracks. Our unwillingness to address it sends the message that there are ["somebodies"](#) and ["nobodies"](#) in our system, which leads to tremendous disparities in health and health care.

The Predictable Future

The group then discussed what the predictable future would be if there were no changes to the prevailing context, and posited that:

- The nation will continue to spend more money on care that does not improve the quality of our lives despite the wishes of patients and families, while spending in a limited way on well-being;
- Quality and safety will increase to a point, but managing to the bottom line will trump all;
- Health will continue to take a back seat to health care; and
- Consumers will become less empowered and even more disengaged.

In order to work against this predictable future, the group discussed where some promising opportunities to shift the current context might lie and identified three top concerns: 1) the language people use, 2) how health care disempowers people, and 3) how the current system creates disparities. They wondered, “If we were to highlight and change the behaviors that support those contexts, would we then see a measurable change in the important outcomes?” The next step was to translate concerns into “fixable” broken windows.

Health Care’s Broken Windows

Applying the broken windows theory to health care rests on the same assumptions made in New York City: The subtly reinforcing characteristics of the context in which health care is provided can produce positive or negative end results for patient outcomes, for the cost of care, for the health of populations, and the broader impact on society. While it may seem quite obvious that ineffective circumstances produce suboptimal consequences in any system, the degree to which this is true is anything but obvious.

Consider standard physician–patient interactions. Usually, the first interaction a patient has in a clinical

A Sharpened Sense of Purpose

My passion is in making health care work for regular people. I am a plain language advocate. I try to translate, to bridge the gap between medical professionals, policy leaders, and patients.

Some of the Women of Impact won’t have any problem figuring out what their effect on this world will be, but I think about it all the time. The two days we spent working on creating our individual legacies were wonderful, as I don’t have forever and there’s so much more to do. The forum appealed to me because it was an opportunity to sharpen my sense of what motivates me, what to do about it, how I’m going to do it, and making sure it has an impact.

I still believe that the possibilities of what we can do collectively are bigger than what was realized at the forum, but I tend to push harder than most to achieve an ambitious vision.

Together, we just scratched the surface of our potential.

—Diane Stollenwerk

President
StollenWerks Inc

environment involves someone behind a desk asking for proof of insurance or payment up front. While the economic relationship between patient and doctor is an inevitable reality, this immediate requirement to prove economic health before the treatment of physical health emphasizes it, and makes the interaction seem more transactional than personal. The broken window, the marker of dysfunction in the system, is this process.

After paying up, patients participate in the universally loathed waiting room experience. They are warehoused in a room with strangers. The furniture is uncomfortable, the room is too cold, and the magazines are too old. There’s no access to stress relievers, such as food and

drink or fresh air. The only non-anonymous individuals are staff, wearing name tags and identifiable uniforms. The cumulative result of all these negative environmental cues is an uncomfortable and disempowered patient who has yet to receive any diagnosis or treatment at all. This isn't likely to engender a good attitude and a productive perspective.

Then comes the exam room. A patient generally addresses a physician with formality, by title and last name: "Hello, Dr. Doe." (She may not even know the doctor's first name.) The physician may choose to address the patient in equally formal terms, but sometimes will choose to use the patient's first name in an attempt to seem empathetic. That immediate imbalance of formality (and apparent respect) reduces the ease and effectiveness of the interaction from the outset and jeopardizes its shared goal: providing appropriate and satisfactory treatment.

The physician-patient interaction is more complex than forms of address. The patient may have been kept waiting for some time. The doctor will be dressed in business attire, while the patient is in a loose-fitting, revealing, and uncomfortable disposable gown. Most important, the patient is compelled to be present by some concern or condition that requires assistance, whereas the physician is not participating because of some personal vulnerability. These imbalances lead the patient to struggle to express her condition in her own words, and leave her feeling as though she has not adequately communicated her concerns. The physician responds precisely, often tersely, using medical terms that must be translated in order to be comprehensible to the patient. In this context, the ease with which errors and dissatisfaction can result is clear.

These difficult situations are an almost inevitable consequence of the status quo of the health care system, but they result from good intentions. A physician's professional distance is intended to emphasize education and expertise. And indeed, patients value confidence in a physician's professional and rational appraisal of their condition.

The patient-centered medical home and patient- and family-centered care movements have begun to address this challenge. They endeavor to create

healing, empowering environments, eliminate distasteful waiting room experiences, leverage teams, and partner with patients to reinforce prevention and enable self-management. Regardless of these efforts, when the health care system is examined via the broken windows theory, there are many more potential negative behaviors ingrained in current culture and the need for remediation is evident. The example scenario of the imbalance of power between patient and physician and between patient and system exemplifies how seemingly small environmental characteristics can act as broken windows, creating a context in which it seems nobody cares. But the issue extends beyond those isolated moments of awkwardness: It involves the entire health care experience.

For example, patients often must select physicians based on referrals from other physicians, family members, or friends—not on readily available and accessible, objective information about care quality, skill, or performance in managing their specific condition. They make an appointment assuming their insurance will cover most of the cost without having the important coverage conversation first—or even knowing with whom to have that conversation. Finally, in most health care providers' offices, there is little time dedicated to promoting health—what is being reimbursed is management of illness. All incentives focus on delivery of units of care for illness associated with meticulously coded diagnoses, rather than on making an investment in illness prevention.

It is tempting to think that these small inconveniences are not a priority for our overtaxed health care system. However, as the New York subway experiment demonstrated, little improvements can make a dramatic difference. In this case, simple solutions such as providing enough chairs in a waiting room can have a dramatic effect on the mindset of patients. Success can lie in creating an impression that patients are cared for from the outset of their engagement with the practice or system.

Identifying the broken windows and effective interventions in health care is hard work. The Women of Impact participants examined many possibilities¹, and aligned around the following three windows as their agenda for change.

¹ See appendix for full list.

Broken Window #1: Disempowerment

As described in the scenario above, in many cases, patients are disempowered by the imbalance between what they and providers wear, say, and do. Physicians wear white coats; the longer the coat, the more powerful they are. Patients wear gowns that disempower, humiliate, and create a sense of vulnerability. Waiting rooms demonstrate a lack of respect for the value of patients' time. Lack of access to information about cost and quality often makes proactive patient engagement impossible. The disempowerment of patients in the health care system creates downstream inefficiencies in care, and must be remediated.

Broken Window #2: Promotion of Services Over Well-Being

Language and actions pervasive in the health care system communicate that the delivery of services is valued over the promotion of health. Frequently, a patient's first interaction with the health care system is focused on money and record-keeping, not on health or well-being. The system drives relentlessly to see patients in volume and to move them in and out as quickly as possible. When survival of administrative infrastructure trumps health, the perverse incentives become self-perpetuating.

Broken Window #3: Expendability

Through practice and policy, the nation sends the message that some people's needs matter less. Individuals suffering from certain conditions challenge the current system's ability to provide care, and its ability to access whole communities is limited. There is background noise: culture and politics dictate that certain conditions or groups receive superior care. The Women of Impact want to begin the social conversation about whether health care is a right or a privilege, and what responsibility patients bear.

Pushing Personal Boundaries

Our health care system is so fragmented. Fixing one corner feels appealing, but collective impact tries to cut through the fragmentation to make the conversation about the people we're serving. The Women of Impact are a terrific group of women leaders, and I was excited and curious when I received the invitation to attend the Forum.

I had not thought about my personal legacy at all beyond keeping a list of accomplishments on an index card! I'm very left-brained, so the exercise pushed my boundaries and forced me to think about who I am and what I want outside of my work role. I had issues about my recent job transition that I needed to reflect on. Then I had to work through how individual legacies lead to collective impact.

Leadership transcends title or position: That was a key insight for me. I was intrigued by the fact that women in such different roles could coalesce so quickly to set up common aspirations. As for the conversation about current context and the predictable future, we may have been a little too polite. The health care system is a mess for a lot of people.

We quickly learned that the symbolic value of broken windows is easier to grasp than a shared understanding of real issues to fix. Although some of the broken windows we discussed were distracting in a way, it was a worthwhile struggle.

Although it was hard to break away from our real lives for that long, I thought the experience was fantastic. My horizons were expanded, about myself and possibilities for the future. Although I am humbled by the size of our challenges, I left the meeting recharged. I have since come to better appreciate the connection between individual legacy and collective impact, and to feel it profoundly. The kind of impact we're seeking is going to be disruptive.

—Carolyn Clancy

Assistant Deputy Under Secretary for Health for Quality, Safety, and Value
U.S. Veterans Administration

Fixing Broken Windows Through Collective Impact

John Kania and Mark Kramer defined [collective impact](#) as “cross-sector coordination to achieve large-scale social change” in the *Stanford Social Innovation Review* in 2011. In the first of a series of articles on the model, they write that successful collective impact initiatives share five critical elements:

- A common agenda;
- Mutually reinforcing activities;
- Shared measurement systems;
- Continuous communication; and
- Backbone support organizations.

Although evidence of the effectiveness of collective impact is still emerging, successful examples suggest that the model can solve serious, complex social problems by bringing together nonprofits, government, business, and individuals around a common agenda.

The makeup of the Women of Impact group was designed to promote cross-sector coordination, and represent the public and private sectors from a variety of perspectives, including providers, patients, payers, and philanthropists. The group’s common agenda, the broken windows around disempowerment, service promotion, and expendability, was prefaced by agreeing on a case for change and motivated by the articulated individual legacy of each woman.

Mutually Reinforcing Activities

Each forum participant devoted herself to addressing one of the three defined broken windows of health care: disempowerment, promotion of services over wellbeing, and expendability. Each subgroup determined an initial set of activities using the mantra, “Think big. Start small. Act fast.”

Disempowerment. This subgroup is seeking to level the health care playing field to truly empower people to reclaim their health and access to it. The word “patient” does not represent the empowered individual as engaged consumer. At the forum, this conversation revolved around the clothes doctors wear, how they address patients, and how they collect and share information. Creating true patient empowerment requires eliminating these and other behaviors that reduce the agency of individuals in the health care system. Addressing this at a medical school and graduate medical education level was thought to be a natural next step, and aligns with American Council on Graduate Medical Education competencies and national initiatives that measure and monitor patient activation.

The members of this subgroup are reaching out to the Association of American Medical Colleges (AAMC) student and resident members to share the broken windows concept, discuss disempowerment in health care, and solicit their feedback and support. The subgroup plans collaborative efforts to engage like-minded patient advocacy organizations and stakeholder groups around this initiative. Members will seek to place media stories in consumer and senior-focused publications.

The message will look something like this:

“Imagine:

- You make a convenient appointment by phone or email, and know what to expect before you walk into the door (e.g. cost and quality information is available).
- When you arrive, you receive a friendly greeting and a smile. You’re addressed by the correct name.
- Your information is pulled up on a computer and reviewed with you for accuracy.
- You are shown to your room by a pleasant guide.
- You leave feeling that you were taken care of with concern for your comfort and well-being, and respect for your time.

Hotel? No. Health care, the way it should be.”

Promotion of services over wellbeing.

This subgroup is focused on shifting the current context from a delivery system focused on illness to one focused on health, moving from survival to well-being. Its members intend to change language from “patients” to “consumers,” “customers,” and “people.” Other organizations are having similar discussions, including the Department of Defense and the National Prevention Council. And other innovative models such as the [Southcentral Foundation’s Nuka system of care](#) are beginning to make this a reality. Subgroup members are committed to collaborating with other organizations and leveraging collaboration platforms that are already in place, including the Robert Wood Johnson Foundation’s “[Flip the Clinic](#)” project. The group is focusing on early wins by supporting a [Yale–New Haven Hospital project](#) with high school students, sharing collaborations and insight. Team members seek to elevate the national conversation by writing blog posts and well-placed editorials about the pervasive lack of focus on individual and population health. Some of these already have been published, including pieces by [Vineet Arora, M.D.](#), and [Joanne Conroy, M.D.](#)

This group aims to raise awareness in a targeted demographic to change their attitudes and behaviors, and to inspire them to participate in a social movement that embraces health and that enhances and reinforces personal power. The target demographic is teens and young adults, 14 to 28 years old. Although as yet undecided on message, the group is considering the following options. Each is intended to convey messages of choice and empowerment:

- “Every choice you make makes you stronger.”
- “Living with strength and purpose... through mental and physical health”
- “You make choices every day that enhance or diminish your health, strength, and power. Make the right ones.”

Expendability. This subgroup is making an effort to reduce disparities by identifying and remediating the behaviors in the health care environment that communicate that some people are expendable. Its members intend to shed light on those behaviors and eliminate them, replacing them with a value system that communicates that improving the health of all is the goal. Group members actively promoted enrollment in the health insurance exchanges. Through their various and multiple professional, personal, and social networks—through tweets, blog posts, newsletter articles, and other activities—they helped [spread the word](#) about [Healthcare.gov](#) and its importance to uninsured Americans. After all, choice and involvement in securing health insurance is an important first step toward ownership and engagement.

Since then, the group has recognized the need to begin a broader national conversation about whether health care in the United States is a right or a privilege. Although health care may not be an inalienable right, it is a social right, but we have “somebodies” and “nobodies” in our system. This subgroup is considering messages along these lines:

“Doesn’t every child with cancer deserve a chance to live? Doesn’t any 27-year-old injured in a car accident deserve expert care at the closest hospital? Isn’t breast cancer an emergency? If you agree, it is time to join the conversation.”

Group activities are broken down for easier reference in the table below:

Disempowerment

- Begin the conversation with physicians in training at the GME and UME level. Speak to medical students and residents.
- Extend the conversation to specialty societies and other organized medical groups.
- Partner with patient advocacy organizations to achieve convergence and greater impact with messaging.
- Publish in lay and professional literature.
- Connect with researchers who examine how to engage and activate patients.
- Extend messaging to other women's health care leadership groups, legislators, business organizations.
- Track media penetration of message as measurable outcome.

Promotion of Services Over Well-Being

- Work with organizations that already focus on the impact of language (Department of Defense among others) to align goals and activities.
- Work with member organizations to change language in consumer and employee marketing materials.
- Work with the AHA to discuss broader conversation with all providers.

Expendability

- Continue campaign to get people enrolled in health insurance exchanges.
- Write and publish editorials about the gap between aspirational coverage and the impact of policies that deny basic health care to all.

36 Chairs in the Waiting Room

I wasn't familiar with the term "collective impact," but it's what we do here at the Foundation and the Pittsburgh Regional Health Initiative, so I love the term. Getting interesting thinkers together in a room usually leads to a sum greater than the parts. And AAMC could not have assembled a more interesting group of women. Even though I wasn't so keen on the "broken window" solution that we came up with, it was a great intellectual romp. To me, the "johnny" is not the ultimate degradation. I am more concerned about doctors who don't touch their patients or look them in the eye when they come in for an exam.

I'm more concerned about the three dozen chairs in a physician's waiting room. What does that say about patient respect?

Empowerment of the consumer is what WOI is about, so I joined that subgroup. In sum, I never underestimate the importance of networking, of person-to-person interactions among people of like interests and similar perspective. For this reason, I have high expectations for the outcome of WOI.

—**Karen Feinstein**
CEO
Jewish Healthcare Foundation

Shared Measurement Systems

Initial short-term measures of progress will focus on communication and the use and reuse of specific messages including the discussion of the “broken windows” in health care. The group will use content analysis of social and traditional forms of media, web analytics, and primary research through online, mail and/or phone surveys, and may explore using media content analysis with a media tracking system. Secondary measures will include the integration of new social norms into the clinical learning environment for all health care professions. The group is investigating an annual web-based survey of educators, residents, and students to determine the dissemination and integration of key concepts and messages into their clinical learning environments.

More difficult but important to measure will be the longer-term, progressive impact from conversations with patient groups, legislative leaders, employers, and providers, so that they understand the concept of broken windows and join to promote a broad self-examination within health care. The United States runs the risk of being self-satisfied and complacent with its current system of health care. The Women of Impact hope that organizations and individuals will join them on this journey, asking, “What are our broken windows and what would it take to fix them?”

Continuous Communication

Each subgroup meets monthly via conference call and the entire collective convenes via telephone every six weeks. A LinkedIn group was established to facilitate the sharing of information, resources, and support. Additional grant funding is actively being sought to bring the group together in person during each the summer over the next three years. Communications are intended to:

- Further develop the change model;
- Perform credible testing; and
- Achieve broader recognition for the strength of the work, and ultimately, sustained change.

Coalescence Around a Shared Vision

The Women of Impact forum brought together an accomplished group of leaders representing a broad range of backgrounds, experience and context. There was power in the diversity of thought in identifying health care’s “broken windows” and coalescing around approaches to repair the damage. The group identified opportunities to shift and disrupt our current mental models of health care. Through aligned vision and actions, the Women of Impact seek to effect positive change and move us closer to a society in which every person has the opportunity to embrace health and access effective health care.

—Lynne Chafetz

Senior Vice President and General Counsel
Virginia Mason Medical Center

Backbone Support Organizations

The Women of Impact were convened through a generous grant from the [Robert Wood Johnson Foundation](#). Activities during the July forum were facilitated by [Sunergos](#), a global performance consulting firm headquartered in Arlington, Illinois. Their consultants have extensive experience working with female leaders in personal and professional development. The Sunergos process is based on being responsible for the gifts and talents we have and asking, “How will I uniquely contribute these gifts and talents to my community, organization, industry, and the world?” Their program offers participants the opportunity to reflect and begin to answer those questions. Sunergos has worked with the U.S. military to develop a program for female leaders called “Leading with Resiliency and Grace.” It helps military women, both as individuals and in teams, shift the context in which they operate. When participants create a new and empowering context for their lives, they reap many more benefits from the transactional resources that are readily available to them.

Ongoing staff and infrastructure support is being provided by the [Association of American Medical Colleges](#), a not-for-profit organization representing 136 accredited U.S. medical schools and nearly 400 teaching hospitals and health systems. The guiding principles for this collaborative are closely aligned with the AAMC strategic priority of creating a sustainable health care system to which academic medicine can make a unique and important contribution. The AAMC has a successful record of convening diverse stakeholders around complex issues and experience in administering grants in order to support member activities. Over the next few months, a centralized infrastructure with a dedicated staff at the AAMC will be created to help finalize the common agenda, determine shared measurement, and create continuous communication within the group, perpetuated by mutually reinforcing activities among all participants.

Share in the Impact

What can you do?

As an individual: Within or outside the health care industry, you should begin to talk about the things we do that disempower, devalue, or stereotype people in health care—the language we use, what we accept as a “normal inconvenience” in the health care system, and the norms, values and standards you observe as you interact with our health care system. Are the care and those providing it respectful and responsive to your preferences, needs, and values? Are you a partner in that care?

Speak from your experience as a consumer or participant in the health care system. Talk to others. Begin the conversation about what care would look like if the consumers designed the system. An open-source slide deck is under development that anyone can use to guide these conversations and communicate Women of Impact messages in their communities and networks. Access the slide deck and other resources at www.rwjf.org/womenofimpact.

As an organization: Begin the self-examination within your organization. What is the current context of your world and what are the “broken windows”—markers of dysfunction in the system—that you see? These can be behaviors, attitudes, structures, and/or systems that reinforce the current worldview with negative consequences. Once you have identified them, where are there efforts to mitigate these behaviors? Have you addressed them in your organization’s strategic plan? How can you leverage your relationships and networks to continue the conversation outside of your organization? How does this change your perception of what is possible and your potential impact?

Not all social problems are suited for collective impact solutions. Collective impact is best employed for problems that are complex and systemic rather than technical in nature. Collective impact initiatives are currently being employed to address a wide variety of issues around the world, including [education](#), [justice system reform](#), the [environment](#), and [community development](#). The Women of Impact share a deep sense of responsibility and accountability to help strengthen current work on health care's broken windows and use their influence, power, and visibility to effect change.

Change may take the form of many small steps or a few bold initiatives, but they are all tied together by a vision. We want a system where people to have

convenient access for both the necessary care when they are ill, but also preventive, consultative care as they strive to stay healthy. We want providers to be informative and helpful. We want them to translate public information, evidence, and science so we can apply it to our personal decision making. We want our medical records and insurance claims accounts to be understandable and easily accessible from our home computers or handheld devices. We want to be treated as valued customers. We want a health care system that we are proud of, that we view as a critical national investment that will minimize the economic, societal, psychological, and physical burden of disease and illness. Crafting the future of health care should unify us, not divide us.

Appendix

Additional “broken windows” identified by the Women of Impact:

Medical errors. Some group participants suggested that medical errors are broken windows. The environment is sullied when society accepts medical errors as an unavoidable consequence of care, instead of an issue of immediate, pressing concern that every effort should be made to mitigate. “To err is human,” Shakespeare wrote; humans are by nature imperfect. It is the behavior around medical errors that is the reinforcing structure, not the medical error itself.

Provider payment systems. How providers are paid for care is a topic of intense national public debate. Insurance companies, federal and state governments, employers, and policy makers continue to weigh in on the appropriate evolution of the payment structure from fee-for-service to a structure that rewards quality and efficiency. Beneficiaries with high-deductible plans and employers constructing private health exchanges will demand transparency that drives market trajectory. The group agreed that market forces already were beginning to change this conversation.

Medical education about the costs of care. Clinical students are rarely educated about the costs of the treatment decisions they make. This condition has been highlighted by a group of activist residents who felt the need to address the high costs of medical care. They founded an organization, Costs of Care, and partnered with the ABIM Foundation and medical educators at Harvard Medical School and the University of Chicago to create a series of web-based videos to teach medical students about cost consideration. Rather than reinforce the current context that dismisses cost considerations, the nation’s medical education system must encourage future doctors to integrate cost into their conversations with patients.

Patients as passive consumers of health care services. Employers are moving steadily to insurance products that limit their contribution, such as high-deductible plans or private exchanges with a defined

premium contribution for employees. Some have proposed moving retirees to the public exchanges. The rich indemnity plans of the past will be replaced by much leaner offerings that will push a greater percentage of the costs of care to patient, making them financially responsible for their health care choices. Although employer-sponsored insurance historically has been a driver of costs of care, the market is changing in advance of policy or public opinion. This has made patients responsible for navigating the health care system without the tools or information to make informed choices.

Chargemasters. Cost transparency has emerged as a *cause celebre* with the publication of Steven Brill’s *Time* article, [“Bitter Pill: Why Medical Bills Are Killing Us.”](#) Although there is an imperfect understanding about what drives high charges, what is clear is that prices for services have become disconnected from the true costs of delivering care because of opaque internal cross-subsidies. With rising health care costs, the growing numbers of privately insured adults in high-deductible health care plans will demand greater health care price transparency. Health plans, consumer groups, and [state governments](#) are increasingly reporting health care prices. The Women of Impact see price (and quality) transparency as a crucial element of patient empowerment.

Health care disparities. Many of the Women of Impact incorporated addressing health care disparities in their personal legacy statements, as well as identifying them as a significant broken window. Social determinants of health include the socio-economic forces that influence health, including poverty, income inequality, lack of access to affordable and nutritious food, lack of educational and employment opportunities, violence, and racism. Inequities will continue to exist until Americans get serious about acknowledging the social determinants of health and the roles income, education, and access play in the ultimate success of system transformation.