



## Breaking Through the Denial About Health Care Quality in the United States

That Americans get only half of recommended care is not an easy message to deliver—or to receive. A strong communications effort by RAND researchers helped change conventional wisdom and spur new policies to improve quality.

Most Americans have assumed that they receive high quality health care. Yet studies have shown that perceptions of quality often do not line up with reality.

Beginning in 1997, a research team at RAND Corporation led by Elizabeth McGlynn, PhD, assessed the quality of care in a large community-based sample of patients who had made at least one visit to a health care provider in the previous two years. Their goal was to measure the care that was *actually delivered* rather than the care people *thought* they were getting. The Robert Wood Johnson Foundation (RWJF) supported the project as part of its long-term effort to monitor and track changes in the health care system and their impact of quality. See [Program Results Report](#) for more details.

The RAND findings were sobering. In the 12 communities studied, adults were receiving on average 55 percent of recommended care. Children fared even worse, getting 47 percent of recommended care. Where patients lived didn't affect the outcomes very much—and neither did their age, gender, race, income, education, or whether or not they had insurance.

“Frankly, the things we found had been found for decades, but that message had not gotten out beyond a small group of researchers and those who read that research,” said McGlynn, who now directs the Kaiser Permanente Center for Effectiveness and Safety Research. But with the 2001 release of the Institute of Medicine’s report, *Crossing the Quality Chasm*, the time was ripe, McGlynn said, for a

*“For me, publication of research is all about good storytelling. Because if you aren’t convinced there is a problem, there is no motivation to garner resources, time, and attention on fixing the problem.”—Elizabeth McGlynn, PhD, Principal Investigator*

strong dissemination effort designed to “break through the denial about how good quality is in this country.”

Working with Washington-area-based Burness Communications, the RAND team developed the key messages from their findings and a strategy for communicating them. “We thought about publishing several articles at the same time,” McGlynn said, “but the Burness team advised us to spread out the publications. They told us, ‘The media can only get their arms around so much. You will have a more powerful message if you hit it, hit it again, and hit it again.’”

### **Message One: “Quality is Not as Good as You Think”**

Rand’s [first publication](#)<sup>1</sup> in the June 26, 2003 *New England Journal of Medicine* zeroed in on the finding that adults receive 55 percent of recommended care. Burness staff provided training to get the researchers ready to talk to the media. “That was tremendous,” McGlynn said. “RAND has a media group, but [disseminating these findings] required a lot more time and resources than RAND would normally devote to any single study.”

The researchers’ basic message—“Quality is not as good as you think”—generated significant media attention. Original articles appeared in *USA Today*, the *Washington Post*, and the *Wall Street Journal*, and the *New York Times* published an editorial. *ABC World News Tonight* covered the story and the study also was referenced in a 2006 *Time* magazine article.

The message also stuck a chord beyond the United States, McGlynn said. “I’ve talked to people in Europe, Canada, and Australia, and they say that the 55 percent data is the first slide in a lot of slide decks at the country, hospital, and medical group levels being used to motivate people to do something. The study had a tremendous impact—in some ways beyond our wildest dreams.”

### **Message Two: “You’re Not Safe Anywhere”**

The second article detailing how the 12 communities ranked on health care quality did not have as obvious a storyline as the first article. “A classic thing researchers look for is variation,” McGlynn said, “but there wasn’t any. The recommended care delivered ranged from 51 to 59 percent across the 12 communities.”

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<sup>1</sup> McGlynn EA, Asch SM, Adams J, Keesey J, Hicks J, DeCristofaro A and Kerr EA. “The Quality of Health Care Delivered to Adults in the United States.” *New England Journal of Medicine*, 348(27): 2635–2645, June 26, 2003. Available [online](#).

Over dinner at the Tabard Inn in Washington, McGlynn showed the slide with the data to Andy Burness, head of Burness Communications. “I’m not sure we are going to be able to get this published,” she told him. “This is not what journals are looking for.”

Burness perused the slide. “Wow, I look at that and think, ‘You’re not safe anywhere.’ ”

“That became the way we told the community story,” McGlynn said. Published in the 2004 *Health Affairs*, [the article](#)<sup>2</sup> reported that “care was similarly dismal in very different kinds of communities,” McGlynn said. “Even Boston, what you think of as the medical mecca, did not come out on top.”

The report effectively broke down the denial that said, “Well, care may not be very good generally, but that’s not true in *my* community,” according to McGlynn. The researchers found no relationship between quality of care and an array of factors—including the penetration of managed care, the demographics of the community, the economics of the community, the organization delivering the care, and the resources that physicians and nurses had at their disposal.

*“We need to communicate in the language of the people we seek to engage. Stats are important. You need the data. But let’s explain it in language that people can work with.”—Andy Burness, Burness Communications*

Major national newspapers covered the story as well as media outlets in most of the communities reported on in the study. The headline for an article in the *Seattle Post-Intelligencer* said it best: “Seattle: Best of a bad lot.”

“Seattle was at 59 percent, but being on top was not a prize,” McGlynn said. “The range of 51 percent to 59 percent suggested to people that something different was going on. What we know of the economics of health care was not a great predictor of quality.”

### **Message Three: “Everyone Is at Risk of Poor Quality Care”**

The [next article](#)<sup>3</sup>, published in the March 16, 2006 *New England Journal of Medicine*, took aim at yet another level of denial—that patient’s individual characteristics influenced the quality of care they received: “We basically found that everyone is at risk of poor quality care,” McGlynn said.

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<sup>2</sup> Kerr EA, McGlynn EA, Adams J, Keesey J and Asch SM. “Profiling The Quality Of Care In Twelve Communities: Results From The CQI Study.” *Health Affairs*, 23(3): 247–256, 2004. Available [online](#).

<sup>3</sup> Asch SM, Kerr EA, Keesey J, Adams JL, Setodji CM, Malik S and McGlynn EA. “Who Is at Greatest Risk for Receiving Poor-Quality Health Care?” *New England Journal of Medicine*, 354(11): 1147–1156, March 16, 2006. Available [online](#).

Among the findings were some that were controversial. “On the individual analysis, we found that African Americans were getting slightly better care,” McGlynn said. “In trying to get the work published, we not only tortured the data, but tortured the literature to see if we could understand what was going on there.”

The researchers found that most of the previous studies on health care disparities had focused on the big-ticket surgical procedures, such as kidney transplant or open-heart surgery. There had been few large national studies looking at disparities in routine ambulatory care. “We also found that the magnitude of the differences in disparities literature was not enormous—maybe five or 10 percentage points,” McGlynn said. “It wasn’t hard to imagine that you could get a flipped finding given that the differences are not that big.”

“We knew that the findings would not play that well,” McGlynn said, “and Burness helped get us ready for that discussion. We could construct multilevel scores to show things coming out the way you would expect them to come out.

“But the point was, when holding all of those things equal, race itself was not associated with lower performance,” McGlynn said. “I make the point that none of those factors—education, income, insurance, race—necessarily protect you from getting poor quality care. That is the tack we took, but that finding made a lot of people mad.”

#### **Message Four: “Not Even Children Get High Quality Care”**

Findings in the fourth article, published in the October 11, 2007 *New England Journal of Medicine*<sup>4</sup>, were difficult even for the researchers to stomach. On average, children received only 47 percent of the indicated care—lower than the adult average.

Quality varied widely according to type of care: Children received 68 percent of recommended care for acute medical problems, 53 percent of recommended care for chronic medical conditions, and 41 percent of recommended preventive care.

“The lead author, Rita Mangione-Smith, was distraught by the findings,” McGlynn said. “We combed the data to make sure we were getting it right. She was particularly surprised given how scheduled so much of preventive pediatric care is. And yet kids were missing stuff that you not would expect.”

Again, Burness staff helped the researchers prepare to tell the story, “but by then we were developing some skills in that area,” McGlynn said.

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<sup>4</sup> Mangione-Smith R, DeCristofaro AH, Setodji CM, Keeseey J, Klein DJ, Adams JL, Schuster MA, McGlynn EA. “The Quality of Ambulatory Care Delivered to Children in the United States.” *New England Journal of Medicine*, 357(15): 1515–1523, October 11, 2007. Available [online](#).

In a RAND news release, Paul V. Miles, MD, vice president and director of quality and assessment of practice performance for the American Board of Pediatrics, weighed in, noting that the study results “paint the best possible picture” because nearly all the children in the study had health insurance.

“Yet the gaps in quality for children are as great—if not greater—than for adults,” he said. “Clearly, children deserve access to a better health care system.”

Major news services covered the story, including the Associated Press, United Press International, the *Washington Post*, the *Los Angeles Times*, National Public Radio, the *Atlanta Constitution*, the *Syracuse Post-Standard*, and the *Cleveland Plain Dealer*.

## Changing Perceptions

The communications effort around the findings from the RAND study has helped to change conventional wisdom about the quality of care, McGlynn said. Her experience serving on a hospital board provided a potent example. “Early on, the physicians on the medical staff thought, ‘We are doing pretty good here and there must be something wrong with these measures.’ I remember the day the physician who was head of the quality committee turned to me and said, ‘Okay, I get it. We are not doing as well as we think we are or as well as we could. Tell me who has got this figured out.’”

“A lot of places had to go through that journey, almost like the Kubler-Ross stages of grief, to be willing to accept it and move on and do something about it.”

Today in the health policy arena, McGlynn sees a growing willingness to insist on quality measurement. “That has enabled us to think about value based purchasing,” she said. “Policy-makers are realizing that just paying for widgets, pieces of services, does not guarantee that people are going to get the right care.

“Understanding that there is a gap and then looking at how you align financial incentives to insure that people get the care they need has been an evolving policy area,” McGlynn said. “The huge impact of the study was to get peoples’ attention that there was a problem and we needed to be vigilant in measuring how well we were doing and to invest in finding ways to then close the gaps.”

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