Quality 101: Transforming Patient Care

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The national healthcare policy debate has been cast in terms of reforming of the system. I would argue that reforming is an inadequate goal, doomed to failure, and even if should succeed; reformation of the healthcare system will not produce the positive results which are legitimately desired by all participants in the debate. I would argue that if healthcare change is going to improve care, improve the quality of life, cover all Americans, and address the rising cost of care, we must have transformation of the healthcare system and not simple reformation.

Does the distinction between reformation and transformation of the system really make a difference? In order to examine this question, we must define our terms. The definition of "reformation" is "improvement (or an intended improvement) in the existing form or condition of institutions or practices etc.; intended to make a striking change for the better in social or political or religious affairs." Synonyms for "reformation" are "melioration" and "improvement." Another definition states, "The act of reforming, or the state of being reformed; change from worse to better."

On the other hand, "transformation" is defined as, "a marked change in appearance or character, especially for the better." "Metamorphosis," a synonym for "transformation," is the transliteration of a Greek word which is formed by the combination of the word "*morphe*" which means "form," and "*meta*" which means "change." "Metamorphosis" conveys the idea of a "noticeable change in character, appearance, function or condition." Metamorphosis is what happens when a caterpillar morphs into a butterfly.

In function, the distinction between these two concepts as applied to healthcare is that "reformation" comes from pressure from the outside, while "transformation" comes from an essential change of motivation and dynamic from the inside." Anything can be reformed - reshaped, made to conform to an external dimension - if enough pressure is brought to bear.

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Unfortunately, reshaping under pressure can fracture the object being confined to a new space. And, it can do so in such a way as to permanently alter the structural integrity of that which is being reformed. Also, once the external pressure is eliminated, redirected or lessened, the object often returns to its previous shape as nothing has fundamentally changed in its nature.

Being from within, transformation results in change which is not simply reflected in shape, structure, dimension or appearance, but transformation results in a change which is part of the nature of the organization being transformed. The process itself creates a dynamic which is generative, i.e., it not only changes that which is being transformed but it creates within the object of transformation the energy, the will and the necessity of continued and constant change and improvement. Transformation is not dependent upon external pressure but is sustained by an internal drive which is energized by the evolving nature of the organization.

While this may initially appear to be excessively abstract and unwieldy, it really begins to address the methods or tools needed for reformation or for transformation. They are significantly different. The tools of reformation, particularly in healthcare administration are rules, regulations, and restrictions. Reformation is focused upon establishing limits and boundaries rather than realizing possibilities. There is nothing generative - creative - about reformation. In fact, reformation has a "lethal gene" within its structure. That gene is the natural order of an organization, industry or system's ability and will to resist, circumvent and overcome the tools of reformation, requiring new tools, new rules, new regulations and new restrictions. This becomes a vicious cycle. While the nature of the system actually does change, where the goal was reformation, it is most often a dysfunctional change which does not produce the desired results and often makes things worse.

The tools of transformation may actually begin with the same ideals and goals as reformation, but now rather than attempting to impose the changes necessary to achieve those ideals and goals, a transformative process initiates behavioral changes which become self-sustaining, not because of rules, regulations and restrictions but because the images of the desired changes are internalized by the organization which then finds creative and novel ways of achieving those changes.

It is possible for an organization to meet rules, regulations and restrictions perfunctorily without ever experiencing the transformative power which was hoped for by those who fashioned the external pressure for change. In terms of healthcare administration, policy makers can begin reforms by restricting reimbursement for units of work, i.e., they can pay less for office visits or for procedures. While this would hopefully decrease the total cost of care, it would only do so per unit. As more people are added to the public guaranteed healthcare system, the increase in units of care will quickly outstrip any savings from the reduction of the cost of each unit.

Historically, this has proved to be the case. When Medicare was instituted in 1965, projections were made about the increase in cost. In 1995, it was determined that the actual utilization was

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1000% more than the projections. No one had anticipated the appetite for care and the consequent costs which would be created by a system which made access to care universal for those over 65 and which eliminated most financial barriers to the accessing of that care.

Reformation of healthcare promises to decrease the cost of care by improving preventive care, lifestyles and quality of care. This ignores the initial cost of preventive care which has a payoff almost a generation later. It ignores the fact that people still have the right, which they often exercise, to adopt unhealthy lifestyles. Even the President of the United States continues to smoke.

Current proposals for reformation of the healthcare system do nothing to address the fact that the structure of our healthcare system is built upon a "patient" coming to a healthcare provider who is expected to do something "for" the patient. The expectation by the system and by the recipient of care is that something is going to be done "to" or "for" the patient in which process the patient is passive. There is little personal responsibility on the part of the patient for their own healthcare, whether as to content, cost or appropriateness. The healthcare provider is responsible for the health of the patient.

Transformation of healthcare would result in a radical change in relationship between patient and provider. The patient would no longer be a passive recipient of care given by the healthcare system. The patient and provider would become an active team where the provider would cease to be a constable attempting to impose health upon an unwilling or unwitting patient. The collaboration between the patient and the provider would be based on the rational accessing of care. There would no longer be a CAT scan done every time the patient has a headache. There would be a history and physical examination and an appropriate accessing of imaging studies based on need and not desire.

This transformation will require a great deal more communication between patient and provider which would not only take place face-to-face, but by electronic or written means. There was a time when healthcare providers looked askance at patients who wrote down their symptoms. The medical literature called this "*la maladie du petit papier*" or "the malady of the small piece of paper." Patients who came to the office with their symptoms written on a small piece of paper where thought to be neurotic.

No longer is that the case. Providers can read faster than a patient can talk and a well thought out description of symptoms and history is an extremely valuable starting point for accurately recording a patient's history. Many practices with electronic patient records are making it possible for a patient to record their chief complaint, history of present illness and review of systems, before they arrive for an office visit. This increases both the efficiency and the excellence of the medical record and it part of a transformation process in healthcare delivery.

This transformation will require patients becoming much more knowledgeable about their condition than ever before. It will be the fulfillment of Dr. Joslin's dictum, "The person with

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diabetes who knows the most will live the longest." It will require educational tools being made available to the patient in order for them to do self-study. Patients are already undertaking this responsibility as the most common use of the internet is the looking up of health information. It will require a transformative change by providers who will welcome input by the patient to their care rather seeing such input as obstructive.

This transformation will require the patient and the provider to rethink their common prejudice that technology - tests, procedures, and studies - are superior methods of maintaining health and avoiding illness than communication, vigilance and "watchful waiting." Both provider and patient must be committed to evidence-based medicine which has a proven scientific basis for medical-decision making. This transformation will require a community of patients and providers who are committed to science. This will eliminate "provider shopping" by patients who did not get what they want from one provider so they go to another.

This transformation will require the reestablishment of the trust which once existed between provider and patient to be regained. That cannot be done by fiat. It can only be done by the transformation of healthcare in to system which we had fifty to seventy-five years ago. The patient must be absolutely confident that they are the center of care but also they must know that they are principally responsible for their own health. The provider must be an extension of the family. This is the ultimate genius behind the concept of Medical Home and it cannot be achieved by regulations, restrictions and rules.

The transformation will require patient and provider losing their fear of death and surrendering their unspoken idea that death is the ultimate failure of healthcare. Death is a part of life and, in that, it cannot forever be postponed, it must not be seen as the ultimate negative outcome of healthcare delivery. While the foundation of healthcare is that we will do no harm, recognizing the limitations of our abilities and the inevitability of death can lead us to more rational end-of-life healthcare choices.

Public policy can determine whether healthcare is reformed or transformed

First, that policy must acknowledge that governmental policy and private sector policy created the current conditions. Payment by "piece work" put the government's check book in providers' hands. The Providers only benefited; they did not create the system which rewarded over-utilization and expansion of services.

Second, the healthcare system must reward what is valued and what the system wants to promote. In that all of the transformative issues in healthcare are relational rather than technological, the system must promote relationships by rewarding efforts to restore the provider/patient relationship as the basis of care. Even specialist reimbursement should be increased for personal patient management even while the payment for procedures is decreased. The expertise of the specialist benefits patient care without necessarily requiring expensive procedures.

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Third, public policy must place the patient at the center of concern in the healthcare equation, but also must place the patient at the center of responsibility. Patients cannot be allowed to be passive in their care and they cannot transfer their responsibility for their own care to anyone else.

Fourth, healthcare policy must pay for educational medical services but not in such a way as to create a new industry. Providers who create educational opportunities for their patients should be rewarded for doing so.

Fifth, as patients cannot be passive in medical decision making, they cannot be passive in the utilization of resources. No one would argue that a sick person should be denied care unless they can pay for it. However, if a patient continues an activity which adversely affects their healthcare, there should be consequences and those should be partially financial.

Sixth, one side of the healthcare debate argues that improved preventive care will produce dramatic savings in healthcare cost. The other side argues that dramatic decreases in care will be produced by tort reform. Neither is likely to be true. The transformation of healthcare delivery will result in improved preventive care and will result in fewer instances of patient dissatisfaction with their care and/or instances of patient injury, thus decreasing legal actions against providers. Neither, as a primary initiative, will transform healthcare.

Public policy will require some action to make changes in our healthcare system. What is imperative is that those changes which are directed at reforming the system do not ultimately prevent the transforming of the system.

Health IT, as a tool, can be leveraged to transform care delivery and lead to operational, clinical, and financial efficiencies. Meaningful use of health IT is focused on deriving value from the EHR, leading to ability to coordinate care (goal 3 of meaningful use), improve quality, safety, efficiency, and reduce health disparities (goal 1 of meaningful use), and improve population and public health (goal 5 of meaningful use). Health IT is not a panacea, but can provide the glidepath to significant improvements in healthcare utilization, benefiting the patient, the provider, and the system.

References

HIMSS Davies Awards of Excellence – White Papers, Fact Sheets on EHR Implementation and ROI http://www.himss.org/davies/resources.asp

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http://www.himss.org/EconomicStimulus/

Patient Centered Medical Home

1. AHRQ Patient Centered Medical Home Web Site

This Web site provides policymakers and researchers with access to evidence-based resources about the medical home and its potential to transform primary care and improve the quality, safety, efficiency, and effectiveness of U.S. health care.
http://pcmh.ahrq.gov/portal/server.pt/community/pcmh__home/1483

2. Patient Centered Primary Care Collaborative

The PCPCC was created in late 2006, to (1) facilitate improvements in patient-physician relations, and (2) create a more effective and efficient model of healthcare delivery. To achieve these goals, the PCPCC has become one of the major developers and advocates of the patient centered medical home (PCMH) model in America.
http://www.pcpcc.net/

3. National Committee for Quality Assurance

http://www.ncqa.org/

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