
Delivery System Reform From the Inside Out



An alliance of major healthcare organisations publicly committed to partnering with patients is forming under the aegis of the Institute for Healthcare Improvement. In a “Viewpoint” published online in JAMA, the intentions of the Leadership Alliance are outlined, describing how healthcare reform in the US should be led from the “inside out” rather than allowing change to be forced from external (mostly governmental) entities.

While the media has focused on the Affordable Care Act’s extension of coverage to more citizens, another aspect of the reform involves improving the way healthcare is delivered and experienced. The structural changes recently put in place are not sufficient in themselves: meaningful change can only come about when healthcare leaders work with patients, communities, members and workforce to support the three legs of the so-called Triple Aim: better care for individuals, better health for populations and lower per capita costs.

Involving Healthcare Leaders

There are several reasons why healthcare leaders must be directly involved in leading the changes required to achieve the Triple Aim, according to authors Donald M. Berwick, MD, MPP; Derek Feeley, DBA and Saranya Loehrer, MD, MPH. Despite declining readmission rates and better patient safety since the adoption of the Affordable Care Act, there remain widespread challenges to closing the quality chasm.

“Laws, regulations, and payment changes cannot, alone, create health systems that realise the full promise of the Triple Aim. Leaders involved in health care must be actively and directly involved in catalysing change needed to achieve the Triple Aim,” the authors write.

Context Matters

It is important to acknowledge that innovations which succeed in one setting might not have the same impact in others. One example is telemedicine, which has the power to transform care delivery for clinicians, patients and families, but cannot be implemented the same way in rural and urban care settings. The laws and regulations which govern telemedicine, however, can be insensitive to the contextual differences. A properly designed system will depend on local, social, and technical adaptations, the authors assert.

Public Trust and Polarising Politics

When the government or insurance companies make statements about needless care, they are less likely to be accepted by the public than when the messages come from clinicians. Likewise, there is no comparing the patient-clinician relationship to public policy when it comes to teaching patients how to adopt healthier lifestyles. Simply put, politics can prevent real dialogue in public, and that dialogue is what is essential for designing a better healthcare system.

The Leadership Alliance has revised some of the care design principles proposed in the original 2001 Institute of Medicine report, “Crossing the Quality Chasm”. That report suggested six goals for improvement: effectiveness, efficiency, equity, patient-centredness, quality and safety. The expanded list embraced by the Leadership Alliance includes:

- Design and nurture systems that expect and embrace change, in the continual pursuit of improvement.
- Change the balance of power, so that health and well-being can be co-produced in partnership with patients, families, and communities.
- Cultivate and mobilise the pride and joy of the health care workforce.
- Make it easy. Continually reduce waste and all non value-added requirements and activities for patients, families, and clinicians.
- Move knowledge, not people. Exploit all helpful capacities of the modern digital age, and continually substitute better alternatives for visits and institutional stays. Meet people where they are, literally.
- Cooperate and collaborate, above all. Eliminate silos and tear down self-protective institutional and professional boundaries that impede flow and responsiveness.
- Assume abundance. Use all the resources that can help, especially those brought by patients, families, and communities.
- Return the money from health care savings to other public and private purposes. Aim for total health care expenditures at or below 15% of gross domestic product.

Source: JAMA

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