

That Would be You

There was once a great institution...

- Which was seen as being at the top of its peer group,
- for which young people at the start of their careers aspired to work,
- where very complex and special things were done,
- where people from all over the world sought attention,
- whose outcomes were accepted as the best,
- and which was trusted by all.

But then...

- its reputation began to exceed its measurable results,
- greed and conflicts of interest called its judgments into question,
- normal procedures were ignored, creating great risks and, ultimately, great harms,
- catastrophic and occasionally fatal outcomes resulted,

- those supposedly accrediting and watching the institution paid little attention to core deficiencies,

And ...it failed

I am, of course, referring to Bear Stearns. What are you thinking? So, how then, and by whom, will the conclusions that you each just reached be changed? I don't yet know how to change them. But I do know by whom.

That would be you.

The American healthcare enterprise is being inexorably pushed to reconsider its structure, function and accessibility. Its ultimate shape and outcome are unknown and unknowable at this time, but the process is now irreversible. The forces prompting this activity are beyond the control of healthcare providers but they will nonetheless be impacted by them.

Those engaged in these restructuring activities are (and will inevitably be) health policy thought leaders, policy wonks, businessmen and women, economists, attorneys, academic clinicians and systems experts. Restructuring, *writ large*, will be defined in terms of new health delivery systems (such as ACOs, whatever they will be), new sites of service (such as Medical Homes, whatever they will be), and/or new technologies (such as tele-health, whatever that might come to mean.) There is a lot of uncertainty here, isn't there? But one thing is certain: that is the pervasive, unfortunate and inevitable assumption that once redesigned, practitioners and clinicians will know precisely how to adapt to these new environments and alter their behaviors, policies and procedures to extract optimal economic and clinical outcomes from this brave new world.

We know better than that.

As we consider this emerging opportunity enhance the **affordability, safety and clinical outcomes** of the care delivered to our patients, we must not lose sight of the fact all three (**affordability, safety and better outcomes**) are determined not by policy wonks, but by those at the site of care: in a physician's office, clinic, hospital, or outpatient facility. Organizational charts, Venn diagrams and payment innovations will be the sum and substance of the 'reformers'. Yet even if "they" get it right, the clinical skills to necessary to realize the full potential of this brave, new world will be lacking. Who will support the Hyde Park pediatric practice, Buffalo Grove medical home, or Pilsen internal medicine partnership in deciding what each should be doing differently next Monday morning if they are to achieve the goals

envisioned by those who reorganized them? It will not be those “designers” noted above. Who might they be?

They would be you.

So let’s explore how this transformation to a compassionate, competent, safer and more affordable delivery system might occur. Could it be an Accountable Care Organization (ACO)? Maybe, but not likely, based on recent history. It would seem that the acronym “ACO” has been redefined to mean “Another Consulting Opportunity” rather than an “Accountable Care Organization.” When the recent CMS ACO regulations were proposed, it was delivery system CFOs and business organizers who protested the initial financial model. They thought that the rewards were inadequately matched to the risks. Risks to whom? Patients? Certainly not to those who protested and (temporarily, at least) prevailed. I heard no chorus of clinical voices saying “Wait a minute: reducing the 300,000 annual preventable deaths caused by medical errors and hospital acquired infections by only 25% isn’t enough. We can and must do better. Let’s rewrite the regulation” Where were those voices? Who would these people be?

They would be you.

I ask that each of you prepare an ACO owner’s manual entitled “Accountable to Who and for What”

- Keep me safe. Failure to do so means telling my family that: “the operation was a success but the patient died”
- Have access to the knowledge, experience and skills to meet my needs.
- Use them promptly, judiciously and with prudence.
- Know the difference between prolonging my life and prolonging my death.
- If you have a problem with the above, ask me.
- Have the data to prove the above.
- Repeat.

Let me state that a bit differently:

- Don’t hurt me (**safe**)
- Only do what works (**effective**)
- Ask me first (**patient centered**)
- Don’t make me wait (**timely**)
- I need to be able to pay you and feed my family (**efficient**)
- Treat me as you would treat your family (**equitable**)

Sound familiar? It has been 12 years, and precious little progress has been made. And who will guide the evolving delivery system toward these simple, eloquent and 12-year old, unrealized goals.

They, once again, must be you.

To achieve this, a new paradigm is needed. Actually, entire belief systems must be abandoned and replaced by beliefs, systems and practices that put the patient’s needs, rather than the delivery system needs, at their center. This is our greatest challenge. The notion of continuing medical education must be abandoned and replaced by a practical and meaningful infrastructure that demands and provides painless, real-time continual lifetime learning.

- Needs based
- Clinician Sponsored
- Dependent on ABMS Endorsement
- Self Directed

- Monitored and measured
- Directed at Gaps in Knowledge
- Measurement of Impact on Performance
- Real time decision support with on up-to-date practice performance data
- Measurement of impact on patient understanding, adherence and outcomes

Let me cite an example of how critical this is. Patient-Centered Medical Homes are proliferating with high expectation of improved clinical and economic outcomes. They will inevitably become the focus of primary care, however they ultimately evolve. We call them “patient centered, but are they?

While in Seattle last year, I met with a patient who had experienced a year of care in a redefined medical home, one that was created for patients with chronic illness who were supported with dedicated nurses focused on a personal patient relationship. After a 1-year pilot program, the project was terminated.

Doug, a highly educated patient, knowledgeable about his disease, motivated to do the right thing and with a supportive family, had been living with beryliosis, a chronic lung disease for more than 20 years. He reminded me that chronic disease knows neither episodicity nor respite. It travels with the patient. Its home is where the patient is, at the family residence, the work place, travelling, and only very occasionally, at the clinic or hospital.

He also reminded me that most patients are ill-equipped to carry out the responsibility of self management of their chronic disease. Not fully aware of the resources and treatment options available through their health care provider, many patients tend to disregard effective disease management strategies and techniques and fail to step up to the responsibility of effectively managing their condition. The health care system can't do it for them, but can, should (or **must**) help the patients acquire the skills and assume their full share of responsibility.

Doug had previously experienced all of the vicissitudes of the unmanaged health care delivery system and was impressed that the model he had recently encountered was better suited to self-management than more routine models of care. His additional insights, however, were stunning to me. Permit me to paraphrase his thoughts:

- “Living with a chronic illness is like having another full-time job”. First, there is the career-job. Next comes family. Then the house, car and lawn. And finally, the continual responsibility of managing lifestyle and medications to optimize health. The latter is inevitably given the lowest priority.
- No complex full-time job can be undertaken and managed without staff comprising, at least, a **“Deputy Program Manager”**. The myriad details of living with and managing a chronic illness in the context of competing priorities makes the definition of such a role obvious and needed. No such position could realistically be created, but a partially dedicated clinician was able to approximate such a person. It nonetheless fell a bit short.
- Although fairly compulsive about self-management and self-care, frequent calls and reminders were found to be essential for health maintenance. Small, early signs of potential problems were easily subjugated to the pressure of his other three “full-time jobs”, and the prompting and encouragement, as well as the interventions insisted upon by his nurse often precluded significant medical problems.
- Family impact was meaningful. Once the burden of disease oversight was reliably assumed by a knowledgeable healthcare professional, his wife’s burden immediately diminished. Family dynamics improved and the focus of family interaction was entirely on family, rather than “family coping with chronic illness”. This was, perhaps, his most surprising and unexpected benefit of the intensive medical home initiative.

- Frequent, ongoing contact and never-ending risk assessments were valuable and not realistically achievable without dedicated, knowledgeable support.

What stunned me was the notion that, for this patient, the medical home was where he lived, not where his doctor and nurse-manager worked. While current medical home models focus on the physician work environment and strive to create a practice that lends itself to the management of patients in a more cost-effective and patient-centered way, such a model would seem helpful only to those patients with routine problems or episodic health issues. What this patient conveyed (albeit, a study with an n=1) was a far more pressing need: for day-to-day support in dealing with a chronic disease that knows neither episodicity nor respite. It begs us to ask the question of how we define a medical home. Is it: My doctor's office, his team and my illness, or My home, my doctor and our team?

Who must answer this question? Who must address the lack of primary care physician's awareness, skills deficits, resource constraints and payment methodologies to remedy this?

That would be you. That must be you.

The words fall glibly from the lips, even mine. As I exhort you to fix everything, we are all aware that the journey will be difficult steep and often unappreciated. And, as just noted, much of what must be done is uncharted and unrecognized by those who must redefine themselves and unaddressed by those who would certify their competence. There is an inescapable truth: we don't know what we don't know. Large areas of concern remain unrecognized and unaddressed by those who would purport to maintain and renew the knowledge base of our clinicians. Such deficits are not specialty specific. They are unrelated to technical competence. Yet patient harm and unnecessary costs are incurred as a result of these deficits. Among the most significant gaps are;

- How to keep a patient safe wherever he or she might live or be referred;
- How to minimize the risk of a readmission;
- How to manage the diagnostic cascade efficiently and with minimal risk (e.g. radiation exposure) to a patient;
- How to reconcile medications from multiple providers and sources;
- How to seamlessly manage all transitions in care;
- How to coordinate care when many clinicians or institutions are involved;
- How to communicate effectively and multi-directionally between and among primary care physicians and specialty physicians, patients and families, payors and purchasers, pharmacists and other health care professionals (making the practice of medicine a team effort);
- How to integrate other health disciplines into the care of chronically ill patients.

Such learning models are in development with the commitment and involvement of specialty boards, data owners and clinicians. As mentioned, the road will be difficult, steep and often unappreciated. Who must see this through to its inevitable conclusion?

That would be you.

So as we look forward to Monday morning, what will each of you do differently than you did this week? As I enter the years of my life that will inevitably lead to the increasing need for health care, hospitalization and drug treatment, who will keep me safe. Into whose hands must I entrust myself?

Those hands must be yours. Please earn my trust. By Monday morning, if possible.

Thank you and Godspeed on your journeys.

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