

*More Than Old Wine in New Wineskins*REFORM MEANS
TRANSFORMATION

The health care delivery system in the United States obviously is in the throes of a major transformation. Some believe “we are at the beginning of the largest industry transformation in the past century.”¹ This transformation is described in various ways — from provider-centered to patient-centered; from hospital-centric to community-centric; from volume to value; from repair to prevention and early intervention; from a focus on discrete individuals to population health; from disjointed services to coordinated care; and the list goes on.



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It also is spoken of in terms of the Institute for Healthcare Improvement’s “Triple Aim”: Improve the patient experience of care, including quality and satisfaction; improve the health of populations; reduce the per-capita cost of care.

In order to achieve these goals, a great deal of energy, thought, planning, implementation and money are being devoted to creating various delivery mechanisms —

accountable care organizations, patient-centered medical homes, retail clinics, telehealth and telemedicine, among them.

These structures, however, will not be sufficient without an accompanying transformation of the values, beliefs, attitudes and practices that underlie and drive the system. The most ingenious, carefully crafted and appealing delivery mechanisms will most likely fail if all that occurs is a carryover — in other words, if all we do is pour old wine into new wineskins.

But where are the efforts to help medical students, residents, physicians and other health professionals, as well as the general public, begin to think and act differently? The much-needed and much-desired shift to patient-centered care and all it entails could have the unintended side effect of reinforcing some rather common attitudes and behaviors that are in tension with the goals of health care reform.

For example, if U.S. health care really is to shift

its emphasis to population health, prevention, stabilizing chronic conditions and decreasing costs, we surely will need to modify the concept of patient autonomy, perhaps with a sense that we are interrelated and have some responsibilities to others. Similarly, the notions that, when it comes to medical interventions, more is better and we deserve all — as well as the best — that money can buy may need to be abandoned or at least tempered.

In addition, we surely will need to take far more responsibility for our health and our health care than most of us do currently. To do so will require a shift from viewing our health care system as primarily there to fix and repair to viewing it as primarily there to help prevent disease and maintain health.

For some individuals, this will be an easy change in perception — they already are health conscious. But for others, it will require not only a significant change in thinking and behavior, but considerable and ongoing education and coaching.

It is difficult to imagine the hoped-for transformation of the health care delivery system

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succeeding on the basis of American individualism and libertarian tendencies. Instead, success will come from such notions as the individual-in-community, solidarity, the common good, stewardship of resources and fairness in the distribution of resources — but making the shift will be extremely difficult. It will require true conversion. Absent such conversion, we will be pouring old wine into new wineskins.

The general public and patients are not the only ones facing significant disruption in their health-care thinking and behavior. All health care professionals, especially physicians, must change their thinking and behavior too. Patient-centered care design, population health management, a team-based approach to coordinated care across the continuum, care delivered and received beyond the hospital and physician's office and value-based payments instead of fee-for-service all presuppose different ways of thinking and practicing.

In this relationship, patients, too, have responsibilities to caregivers, to themselves and their families, to their communities and to the larger society.

At minimum, it would seem that physicians will need to engage in more and better communication in order to contribute to more informed patient choice and dissuade requests for treatment that is not appropriate to the patient's medical condition. They likely will need to be more conscious of the individual patient as part of a larger whole, meaning treatment regimens and costs must be considered without shortchanging the patient's care.

Physicians also will need to view themselves not solely as an autonomous professional, but also as a member of a team working for the good of the patient and as part of a larger team working to improve population health and curb costs. Depending on the financing system in which they practice, they likely will have new responsibilities to deliver care in alignment with quality measures as well as meet capitation limits, reduce the excessive amount of unnecessary treatment and bend the cost curve.

Clearly, a transformation of our understanding of health care and of delivery mechanisms also will require transformation of the thinking and behaviors of those who are core to the health care system. The health professional-patient relationship will need to be conceived differently in order to accommodate the different roles and responsibilities called for by the Triple Aim.

The Introduction to Part Three of the *Ethical and Religious Directives for Catholic Health Care Services* offers a framework for thinking about and fleshing out what this might look like:

Neither the health care professional nor the patient acts independently of the other; both participate in the healing process. ... The health care professional has the knowledge and experience to pursue the goals of healing, the maintenance of health and the compassionate care of the dying, taking into account the patient's convictions and spiritual needs, and the moral responsibilities of all concerned. The person in need of health care depends on the skill of the health care provider to assist in preserving life and promoting health of body, mind, and spirit. The patient, in turn, has a responsibility to use these physical and mental resources in the service of moral and spiritual goals to the best of his or her ability.²

This passage is striking in the mutuality and the fact of mutual responsibilities that it underscores. In this relationship, patients, too, have responsibilities to caregivers, to themselves and their families, to their communities and to the larger society. Both health care professionals and patients are in this together to achieve and maintain the health and healing of the patient-in-community. It is a collaborative venture.

The very beginning of the *Directives'* Introduction to Part Three identifies some important characteristics of a good health professional-patient relationship.

A person in need of health care and the professional health care provider who accepts that person as a patient enter into a relationship that requires, among other things, mutual respect, trust, honesty and appropriate confidentiality. The resulting free exchange of information must avoid manipulation, intimidation or condescension. Such a re-

relationship enables the patient to disclose personal information needed for effective care and permits the health care provider to use his or her professional competence most effectively to maintain or restore the patient's health.³

Of course, this is only a sketch, a partial description of what should constitute a health professional-patient relationship in the new world of health care delivery. Re-imagining this relationship, however, is as critical as developing the new health care delivery mechanisms in which these relationships will flourish or flounder and which will align with the goals of the Triple Aim or undermine them.

There are some promising signs on at least one side of the equation. There are various efforts across the country to promote "patient activation and engagement."⁴ While these dual terms are variously defined, one proponent describes them this way:

Patient activation emphasizes patient's willingness and ability to take independent actions to manage their health and care. ... This definition equates patient activation with understanding one's role in the care process and having the knowledge, skill, and confidence to manage one's health and care. ...

We use *patient engagement* to denote a broader concept that includes activation; the interventions designed to increase activation; and patients' resulting behavior, such as obtaining preventive care or engaging in regular physical exercise.⁵

There is evidence that patient activation and engagement result in better health outcomes, better health care experiences and lower health care costs. The challenge, of course, is to make activation and engagement happen, especially in patients who may not be so inclined. Again, there is evidence that various interventions by various groups can increase activation levels. There also is evidence that both clinicians' and patients' attitudes can stand in the way of achieving patient

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engagement, further underscoring the need for a transformation of values, beliefs, attitudes and practices.

Such transformations will not occur by chance. They need to be intentional. The challenging question is, how will they come about? Perhaps there is a role here for Catholic health care, maybe in collaboration with communities of faith, and for Catholic medical and nursing schools. The values that need to support a new health care delivery system are, after all, part of our heritage and constitute our core commitments.

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NOTES

1. Tom Main and Adrian Slywotzky, "The Volume-to-Value Revolution: Rebuilding the DNA of Health from the Patient In," www.oliverwyman.com/content/dam/oliverwyman/global/en/files/archive/2013/OW_ENG_HLS_PUBL_Volume_to_Value_Revolution.pdf.
2. United States Conference of Catholic Bishops, "The Professional-Patient Relationship," Part Three, Introduction, *Ethical and Religious Directives for Catholic Health Care Services*, 5th edition (Washington, D.C.: USCCB, 2009).
3. Part Three, Introduction, *Directives*.
4. Almost the entire February 2013 issue of *Health Affairs* is devoted to exploring various dimensions of patient engagement.
5. Judith H. Hibbard and Jessica Greene, "What the Evidence Shows about Patient Activation: Better Health Outcomes and Care Experiences; Fewer Data on Costs," *Health Affairs* 32, no. 2 (February 2013): 207.

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