

# **Better Health Initiative Frequently Asked Questions**

**March 18, 2008**

## **1. What is the Better Health Initiative?**

The Better Health Initiative is deceptively simple. We are healthcare professionals renewing our collective stewardship for health and healthcare in our communities using two strategies: direct discussion among ourselves and others, and direct action toward an improved health system.

The Better Health Initiative is a nationally coordinated and locally-led effort by health professionals to drive more appropriate and rapid healthcare reform. Our goal is to move toward appropriate system design and the wise allocation of resources to deliver improved health and healthcare outcomes and lower costs across our society.

This is an effort by healthcare professionals working directly with other healthcare professional based on two critical and yet deceptively simple strategies – direct dialog between healthcare professionals (physicians in particular), and coordinated testing and action toward improved system design.

First, we actively engage healthcare professionals in reflection and dialogue about the collective imperative that we have to reform healthcare. We do this by using a standardized “Platform” for discussion - the Better Health Initiative Platform which includes a clearly articulated statement of Purpose, Guiding Principles for Healthcare, and Evidence-Based System Design.

Second, we test and deploy real changes in how we work and how we work together - the organized testing and spread of process changes within and between practices and other healthcare organizations in our community. Our goal is intentional and participatory action toward the establishment of coordinated, comprehensive and effective health delivery systems.

These efforts are nationally coordinated because it is important to have a common approach to this work and to learn from our collective efforts. The work is locally led at the state level because each state has a unique set of partners, participants, and circumstances that influence the Better Health Initiative implementation. States develop their own Better Health Initiative leadership building on and learning from the national effort.

## **2. How do I become involved in the Better Health Initiative?**

You can call The Trust for Healthcare Excellence to get our assistance at 503-384-2040. Involvement means developing the appropriate state leadership necessary to launch your own state Better Health Initiative. An example is the Oregon Better Health Initiative.

If you are in the early stages of consideration, The Trust can help you with this. It is important to identify the right individuals and organizations in each state to help lead this process.

If you are in a state that already has a Better Health Initiative, then we recommend that you get involved in your state's effort.

**3. Healthcare improvement and reform efforts are abundant. Why is this different and how would it fit into other work? Is this work competing with other efforts?**

No effort to date has placed such central emphasis on the large scale direct engagement of healthcare professionals, in particular physicians, around stewardship. The Better Health Initiative represents a very critical social process among physicians and other care providers. We believe success in delivery system reform, the building of a genuinely integrated and coordinated care system, requires this social process at the outset to achieve the desired outcome: a coordinated, comprehensive, effective healthcare delivery system grounded in primary care that will improve health in our communities.

Our collective experience suggests that a carefully designed and managed social process that engages and safely challenges physicians and other healthcare professionals is critical at this time.

The Better Health Initiative is by design very synergistic with other local and national efforts, not competitive. Our intent is to help accelerate them.

**4. Are you trying to control the reform process?**

It would be more accurate to say we are trying to accelerate reform using values already shared by almost all healthcare professionals. We are not trying to control the process, but to accelerate it by creating an engaging, respectful, and organized approach.

**5. While you state that the Better Health Initiative is focused on healthcare professionals, it does feel somewhat physician-centric, and certainly an important part of your work is specifically focused on physicians. Why?**

While we acknowledge that a significant part of our effort is in fact and quite appropriately focused on physicians, we are inclusive of all healthcare professionals and stakeholders. However, we do focus strongly on physicians because, in aggregate, physicians need to be better partners with others in our communities who seek similar aims for a reformed health system. Almost all non-physician healthcare professionals and stakeholders agree that it is necessary to get the physician community much more deeply engaged in the reform effort.

We believe that progress in transforming US healthcare will require collaborative, cohesive, participatory, convergent physician leadership and involvement - leadership that is strongly tied to a new level of stewardship for health and healthcare. Everyone recognizes the powerful influence that physicians have and acknowledges their central role in delivering healthcare. Due to their unique role, physicians hold the primary responsibility for applying healthcare resources and therefore should be key stewards of health and healthcare outcomes in partnership with others.

We realize that it will not be easy to move the physician community in a cohesive way, but we believe that it is necessary and possible. To do so, the physician community needs a safe place to address these issues directly with each other, to discuss substantive issues about the nature of our work, the way we organize our work, and the way we work together. Together, physicians must address very challenging issues such as our obligation to our community, our collective stewardship for healthcare resources, and more.

We acknowledge that these are sensitive discussions and we believe that more substantive outcomes will result “behind closed doors” – we believe that physicians need a safe place and safe conditions in which to address these issues directly with each other. We believe that such direct physician-to-physician discussions present the best opportunity for physicians to develop the cohesiveness and trust that will be necessary for us to fundamentally change our work, while being better partners with the wide array of non-physicians who must be involved.

**6. When you talk about reclaiming stewardship for health and healthcare, it sounds like an implication that physicians and other healthcare professionals are responsible for the mess that is healthcare? When exactly did we abandon our "stewardship? Most of us have been working our tails off taking care of patients against enormous system pressure and may resent where you're coming from on this?**

Physicians and other healthcare professionals have historically worked very hard to be advocates and stewards of healthcare for their patients. They fight hard to get people what they need. They have also worked hard to be stewards of their organization – their practice or hospital for example – in the service of patients.

However, the stewardship we are referring to is about overall accountability and safeguarding resources. Healthcare professionals, including physicians, have been quite disconnected from stewardship at the level of the healthcare system and of health in their community. We have failed to exert significant collective stewardship over total costs of care and the overall management of healthcare resources.

Healthcare is very fragmented by profession, by practice, by specialty, by geography, and more. Such fragmentation makes collective stewardship difficult, and we believe that it

will only be through a new form of collective stewardship that we will truly be able to address the challenges that our national healthcare system faces.

Many physicians have viewed stewardship for the health of the broader community as beyond their capacity. Some have viewed population health as “in opposition” to meeting the needs of their individual patients, as in the case of costly care that provides some minimal benefit to an individual, while diverting resources from others. Our goal is to bring many more physicians to view stewardship of “the commons,” the resources that are public and shared by many, as a part of their critical role in society.

**7. When you say evidence-based system design, what do you mean? What evidence and how can a system design be evidence-based?**

There is a tremendous amount of “evidence” on how optimal, cost effective healthcare can and should be delivered. There is evidence at both the system level (how to organize overall resources) and at the practice level (critical components of the medical practice and critical interactions between components of the system). Yes, more can certainly be learned about this, but there is substantive data from both within the US and internationally to give guidance on system design. Elements of effective care delivery systems are in multiple articles across a broad range of literature, and can be applied in an intelligent way to an integrated model, by those with practical experience who can put the pieces together.

In addition to published evidence, the work experience of thousands of healthcare professionals of many stripes, doctors or not, primary care or not, has taught them the value of team-based care where a number of experts in different disciplines contribute to the best care for patients or clients. We have more excuses than we can count for why we “can’t” build such a system of care, and we know we must nonetheless.

**8. What are the implications of the evidence-based system design? I see the diagram, but what does it mean in practical terms?**

To begin, the model explicitly shows integration and communication among the people and entities caring for patients. You will notice there is no provision in the model for an isolated “silo” of services, because the available evidence shows the harm from silo care—the medical errors, unaddressed needs, costly duplications, and diversion of resources from important health priorities. Next, the model places the patient, family, and primary care team at the center. This is not merely symbolic, as it has been in many places for a long time. They are the drivers, coordinators and, yes, the “bosses” of the delivery of care when the chips are down. The roles of all the elements around them (subspecialists, hospitals, ancillary care providers and suppliers of goods) are no less important—but they are explicitly no longer permitted to drive their corner of the universe autonomously, to the detriment of the overall result for the patient and society.

True collaborative, give-and-take collegiality is expected, not merely polite deferential collegiality as we have so long defined it.

**9. Healthcare professionals including physicians are very fragmented and your ability to reach them is limited. How do you propose to address that challenge?**

We will bring healthcare professionals including physicians together through a thoughtful, stepwise building of relationships and consensus, driven by respected leaders within the various professions and specialties. Our early attempts at this tell us that such an approach is feasible and productive.

Bringing healthcare professionals – together within their own profession and together with each other – requires a compelling imperative, a standard thoughtful platform for discussion, planning, a safe environment for direct, honest discussion. We have been impressed with the positive response of physicians thus far and all indications are that other healthcare professionals will respond equally positively. Irrespective of profession, we believe that healthcare professionals, including physicians, know deep down that things are fundamentally wrong in US healthcare and given the right format and framework for discussion and action, they want to be a part of the solution.

**10. I understand the need for discussion among physicians, but moving from them in particular from discussion to true action and system change is hard to imagine. What are your plans for that? What will that look like?**

We believe physicians and other clinicians generally want what is best for both their patients and their community. Many of them now feel frustrated and powerless to influence the dysfunctional system in which they work. The Better Health Initiative provides a venue first for us to think differently together and then to design alternative ways of working with each other before we move to testing those methods.

Once we've built trust in local communities through discussion and relationships, we will move to an action phase of actively testing changes in how physicians and their medical groups work together. Starting small but being clear that our intent is to transform our collective work, we will visibly drive changes in the delivery system together.

We realize that this will be hard work - it will take persistence and it will likely be very uncomfortable for many. Given current levels of scrutiny, physicians and other clinicians are beginning to understand that they will be better off testing and making changes in their systems of themselves before others force them to do so.

**11. You talk about leadership, but obviously not all physicians, other clinicians or stakeholders can, will, or should be leaders. In particular with physicians, how should they respond to this need for leadership?**

For healthcare to move forward, stewardship will require both leadership and active participation by clinicians in particular. The leadership we need is one that will help guide the process without expecting to control it – the leaders will actively engage others to participate in the new system design. We're not asking for blind participation, but rather active, positive participation through the lending of positive support, not opting out, demonstrating support for agreed upon issues, and supporting the testing of new methods of care. We will have to work together in new ways, to participate and support our collective work, to converge around a common platform of belief and action.

We do believe that broad based engagement and participation will be possible, but we'll have to build toward it, starting off with a core group in various communities using local leaders to build involvement and participation.

**12. Within the physician community, do you believe that it is necessary to pit primary care against specialists?**

No, this is not our intent. We do not believe that it is either necessary or desirable to create adversity. We need all physicians and other healthcare professionals involved positively in the work. Our goal is to create a dynamic where physicians are advocating not for themselves but for each other and a better system in which to work. An increasing numbers of non-primary care professionals are speaking about the need to preserve and strengthen the primary care infrastructure. We will work to create a dynamic of mutual support – where physicians are supportive each other and other specialties, not just their own specialty.

**13. If you aren't pitting primary care against specialists, then it is hard to imagine how you are going to make progress – at some point such a confrontation is going to have to occur?**

We don't believe so, and our experience doesn't suggest so. The primary reason that many believe confrontation is necessary is because they have not leveraged the power of conversation and active engagement. Anger, misconceptions, and the lack of trust are always fostered when discussion is lacking. Dialog is the way to dissipate those negative influences.

We in the physician community are already colleagues, and we already work together daily. Dialog, in the right context and within the right framework, is always a more potent driver of change than confrontation. We believe that we can deal with very substantive issues in a positive way, including financial issues, if we do so via direct dialog around a shared imperative, shared values, and a shared vision for where the system needs to go.

**14. Rational healthcare reform will require some physicians to make less money, and those groups will likely resist your efforts. How will you manage that?**

This may or may not be true. We know that we need to leverage the expertise of individuals in very different ways. We know that many physicians and specialties are knowledge resources that are being underused – their current work doesn't maximize their knowledge or skills. We need to rethink how physicians work, and how specialty expertise is applied in the system.

Dialog will help us move toward new ways of thinking and working, while keeping the financing in mind. We expect that everyone will likely be uncomfortable as we move forward, and it is critically important to acknowledge this – but we believe that this dynamic can be managed positively.

**15. What about the payment system? Why don't we address payment system first or much more directly as a part of this work?**

We know that widespread delivery system change cannot proceed without redirection of financing, to support the desired work by doctors and other health professionals. However, for this discussion, we want to avoid having the critical discussion of our stewardship and leadership strategies diverted by arguments over what the payment system should look like, for example single payer versus vouchers versus employer and individual mandates, or the specifics of how we better pay for the work of primary care teams. At this early stage, discussions of the payment system are a diversion from other critical considerations.

So, we acknowledge that the payment system must change, and we are focused on promoting critical characteristics of a payment system that fosters optimal health and healthcare. We invite you to help us define those characteristics, but also ask each of you to resist allowing these important discussions to be diverted by issues of payment reform. It is much too easy for money to become the focus, and thereby create the perception this is just one more self-interested group of professionals concealing greed with high-sounding words.

We also believe that there is a tremendous amount of work that needs to be done within the delivery system before we can settle on more appropriate financing mechanism. Many say “pay us first and then we'll behave differently” but we believe that is a terribly poor expression of leadership. For us, leadership and stewardship will seek to define what the new system should look like first, in iterative steps, before or at least in concert with requests to be paid differently.

Payment change before system change stands many risks, and puts the cart before the horse.

**16. How is the Better Health Initiative going to be financed? If this is a national initiative – being coordinated nationally but implemented locally - what resources are required and how are they supported financially?**

States will pay to participate, and those fees will go to support the national effort. States will need internal resources to manage their statewide Better Health Initiative and the leadership of those statewide initiatives will need to identify that funding.

**17. If this is successful, what concrete differences in the healthcare system will be evident and when will they be evident?**

Primary care will be delivered and supported by local and regional care teams, some integrated within one organization, and some virtual organizations where physicians, midlevel practitioners, pharmacists, social workers, mental health professionals, nurses and others work together across boundaries, delivering team care to those who need it. In the immediate future, this will consist of the rare existing models, with the addition of either funded or bootstrap “grassroots” pilots, wherever fertile ground for development is found.

In the long term, we recognize that financing must support the adoption of the evidence-based delivery system across all communities large and small. Besides the development of funding mechanisms, there will be a lot of local development work, to make practical the concepts of the primary care team in the unlimited variety of settings where those teams are needed. Such an evolutionary process is likely to take decades to reach its full fruition. We’ll never finish unless we get started.