Healthcare executives today are barraged with imperatives. From healthcare reform, looming payment changes, and public reporting requirements for quality and experience measures to meaningful use mandates for health information technology (HIT), medical homes and accountable care organizations (ACOs), leaders face the daunting task of prioritizing and tackling many challenges. Many primary care practices are pursuing medical home and meaningful use certifications—and struggling to meet the criteria, perhaps without a clear design in mind of how to do so. The ACO, which holds out hope for better outcomes and new payment schemes, is driving many organizations to purchase primary care practices in an effort to create integration, even if it is only in financial terms.

How does a thoughtful healthcare executive leverage this opportunity? One idea is to get new “glasses”—bifocals at least, if not trifocals—to promote better “vision” at multiple levels.

The Vision Mechanism
Single-distance eyeglasses are sufficient for eyes that can rapidly adjust their focus to see clearly both up close and at great distances. As we go through life, though, many people’s eyes have difficulty focusing clearly at different distances. Vision operates in much the same way for healthcare.

Healthcare professionals, whether clinical or administrative, are generally very good at focusing on the immediate tasks at hand—the patient in the room with them; the day-to-day functioning of the practice; and the needs of individual patients, families and staff members. In fact, physicians are usually able to provide very detailed descriptions of an astonishing number of individual patients.

But when faced with questions—such as, how many of your patients have diabetes, which patients haven’t been in to see you or been in contact with the practice for over a year, or how many of your patients with high blood pressure have their pressure under control?—the answers are a lot harder to find. Many practices simply do not make that information easily accessible, and opportunities to optimize the care and outcomes for those patient populations are limited to chance encounters initiated by patients. Leadership bifocals and trifocals can enable healthcare organizations to develop a penetrating focus on multiple levels: individual patients and families, the population served and the broader community.

Clear Understanding, Focused View
The key attributes and pertinent skills for successful leadership in healthcare have been described by many distinguished authors, including Jim Reinertsen, Maureen Bisognano and Michael Pugh in the Institute for Healthcare Improvement (IHI) 2008 white paper Seven Leadership Leverage Points for Organization-Level Improvement in Health Care (available at www.ihi.org). With Leverage Point 4, the white paper urges all organizations in the current environment, but especially those that plan to provide primary or accountable care, to put patients and families on the improvement team. To further leadership capacity, I would encourage organizations to develop a deep and comprehensive understanding of both the population served (bifocal) and the way the larger community reflects, understands and serves that population (trifocal).

All of these skills enable leaders to bring focus to middle- and long-distance views of the care provided, creating clarity for the process of developing new ways to deliver on the IHI Triple Aim: the simultaneous optimization of the health of a population, the enhancement of the care experience for those who seek healthcare services and the stabilization or reduction of per capita costs of the healthcare provided.

The most common ways to describe or segment a population include age
bands, insurance status or type, chronic disease diagnoses, preventive services needed and medications. But there are many more. At a recent IHI seminar, “Transforming the Primary Care Practice,” participants brainstormed a total of 32 different ways to look at their practice populations. The Clinical Microsystems Greenbook on Outpatient Primary Care, published by the Trustees of Dartmouth College with Godfrey, Nelson and Batalden at IHI in 2001, recommends a shorter list as an initial assessment of a patient population.

Regardless of the ways chosen to view the population, any redesign of clinical services utterly depends on a firm understanding of the population served, enabling the proper development of care teams (the right mix of staff types and talents) and the tailoring of a care delivery design to particular populations—from chronic disease registries that set the framework for patient reminders, protocols and standing orders to practice processes that innovatively link with community organizations, to health systems co-created with patients. Designing a care system without a focused population view would be like prescribing eyeglasses without the results of an eye examination.

Involve Patients in the Care Team
The combination of understanding your population and community and being willing to include patients and families on the improvement team has the potential to unleash creative healthcare delivery designs. The notion of co-creation of health is a rapidly emerging one, particularly in the United Kingdom. In their publication Red Paper 01—Health: Co-creating Services, published by the U.K.’s Design Council in 2004, Hillary Cottam and Charles Leadbetter state, “Chronic disease presents a new and growing health challenge. … Reform to the health services currently on offer cannot address either the management of chronic diseases or the broader lifestyle issues that might promote better health. We argue for a new approach which we call co-creation since a set of new relationships between users, workers and professionals lies at its heart.”

The fundamental premise is that merely tweaking current systems of care will not yield the improvements we will need to effectively manage the growing burden of an aging population and chronic disease. Acute-care hospitals can manage flare-ups of chronic diseases but are not structured to effectively prevent or mitigate them. Reliance on physicians and health professionals who are visited briefly and intermittently by patients is similarly unlikely to yield the kinds of dramatic improvements we all hope for.

Persons living with chronic diseases possess an enormous wealth of practical knowledge and experience that is largely unacknowledged and dismissed in our current delivery systems. What if healthcare leaders could combine their clear vision of populations and communities with the tremendous practical knowledge of these real experts—people living with chronic conditions—to co-design innovative ways of managing, mitigating and even preventing these conditions?

Expert patients, lay people teaching self-management courses, community health workers and, increasingly, culturally based health workers, or promotores, already exist in some communities. What other new and original resources might we tap if we use our new lenses?

Achieving the Triple Aim
Rising above the current cacophony of leadership imperatives may be the best way for healthcare executives to lead truly transformational change. Merely addressing the requirements of the medical home, as-yet-undefined ACOs and HIT meaningful use will in many instances be an improvement over the current state, but it will be a stifled improvement at best. And chronic disease registries and reliable processes to manage populations are important places to start.

But the power of truly understanding the populations and communities we serve, welcoming the participation and wisdom of patients and families, and actively co-designing the innovative delivery systems of the future may be the best way to ensure we can all achieve the Triple Aim: improved health of populations, an optimal experience of care and a better value for everyone/lower per capita costs. To do so, we must begin with clear, focused vision at all distances. ▲

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