The Friedell Committee for Health System Transformation

Introduction

Over the past several years, it has become clear that Kentuckians are increasingly concerned about health care and their ability to get needed services for themselves, their families, and others in their communities. While specific concerns vary among families and communities, the current fragmented and dysfunctional system does not meet their needs. Health care values are among the most important of those held by Kentuckians, who firmly believe that their health care system must have a strong values base.

This concept of having a set of values-based principles as the foundation of health system transformation in Kentucky was formulated in 2004 by the forerunner of what is now the Friedell Committee. The Committee is a statewide, non-partisan, non-profit, independent, lay-dominated citizens' organization with 40 to 50 members drawn from different backgrounds and areas in the state. Most come from outside the active health professional fields, but some have current connections to health professions or health organizations. However, all serve as individuals and not as representatives of specific organizations or health disciplines.

The mission of the Committee is the transformation of health care for all Kentuckians based on a set of principles and values that have been articulated by the citizens of our Commonwealth, as noted above. We will not conceptualize health care as an economic enterprise; rather, we will think about how we take care of people, how to do it well and then consider its cost. The Committee unequivocally identifies certain pervasive themes that are integrally part of every Principle. These include:

- **Community and its culture**, which profoundly impacts health decisions, behaviors, and expectations
- **Communication,** which must be a central element of professional and system priorities to assure that care is safe and effective, that persons are respected and that transparency and accountability are apparent
- **Education** of individuals and the community to assure full and effective participation of patient, family and community in health decisions, improvement and accountability
- **System development** to assure that all processes and decisions are framed in terms of effectiveness, safety, respect and patient/family/community-centeredness
- **The ultimate goal: All Kentuckians achieve an optimal state of health**

Operationally, the Committee intends to encourage and facilitate constructive change to achieve high performance of the health care infrastructure through three distinct applications of the principles:

1) As benchmarks in evaluating the present health system(s);
2) As foundational elements in the development of a transformed system; and
3) As criteria in the oversight over time of whatever transformed health system is put in place.

It is hoped that others will utilize these principles in similar ways to assess specific health care activities with which they are concerned and to develop systemic solutions to problems which have been identified. We ourselves will work with interested community groups to do this. We hope that, by doing so, people will increasingly recognize that, through their own efforts, they can increase the possibilities for achieving health care in their communities which actually meets their needs. At the same time, by working together we will help policy makers recognize the actions necessary to achieve effective health care in Kentucky.

Core principles

The ten principles put forward by the Committee were derived from several sources (see references) and have been synthesized to reflect the consolidated expressions of Kentuckians for Kentuckians, and a national consensus on the subject. They encompass the Institute of Medicine characteristics of appropriate health care: that it be safe, timely, effective, efficient, patient-centered and equitable. They are presented here as the basis of the Committee's efforts to transform the present health care system.

As noted above, they can be applied in three ways: evaluating the *status quo* of health care and health, as a guide for making changes, and as a tool for determining whether changes have had the desired positive impacts.

Relevant questions have been formulated to clarify each principle and to measure the degree of their application in the transformative process. The principles and questions reflect the Committee's belief that **health care should be organized and provided so that:**

I. Health systems are **accountable to the public** in every aspect of care and resource use.

- Is **transparency** of finance, mission, vision, quality, safety, relationships and processes of care evident for the stakeholders, i.e., patients, families, employees and communities?
- Is **accountability** evident to this same group of stakeholders for the use of resources and for the effectiveness of the processes of care?
- Does the community consciously and intentionally require accountability?
- Is community education being done in a coordinated and comprehensive manner?
- Are outcomes of screening and treatment monitored?
- Are quality parameters measured and reported?
- Are oversight and management procedures effective at all levels of the system?
- Who is responsible for ensuring accountability in all aspects of the system? Is the Board of Health discharging its responsibility for the health of the population?

II. Health systems are responsible for **promoting the health of individuals and populations** throughout the entire life span**.**

- Is general education available for health promotion and disease prevention in all venues and for all literacy populations?
- What is the role of health departments, individual health professionals, hospitals, and voluntary health organizations at state and local levels? Are activities coordinated among these facilities?
- Does the system promote community, environmental and occupational health and safety?
- Are healthy lifestyles promoted throughout the community where people live, work and play?
- Is healthful food available to all?
- Are cooking classes and community gardens available?
- Are there affordable, safe places for exercise? Are exercise, counseling and encouragement available, adequate and correctly structured in schools, for seniors, and throughout the community?

III. **Health professionals and systems are responsible** for providing safe and effective care.

- Is system design focused on effective communication? On a culture of safety and effectiveness?
- Is there assessment of the level of responsibility for providing effective, coordinated, continuous, high-quality care (evidence-based when possible), as well as responsiveness to patient interests by health professionals? Is free and open discussion effectively addressed?
- Do professionals who meet this responsibility receive fair compensation without undue regulatory interference?
- Are health professionals held accountable by the public for practicing in accordance with recognized principles? Is competency assured?

IV. Each individual has **equal access to effective care** without regard to race, gender, culture, geography or socioeconomic status.

- Are requisite health services, including primary care, available in the geographic community?
- Are services located where people need them?
- Is there available and affordable transportation to health services?
- Are services to the appropriate level of care available around the clock?
- Are the services physically accessible for disabled patients?
- Are there cultural or psychological barriers to access? Are they being addressed?
- Are primary care providers readily accessible for all?
- Are community services available to help persons gain access to the system?

- Is assistance available for navigating the system? Does case management enhance access to resources?
- Do governmental, insurance and other regulations or controls enhance or obstruct access to care (e.g., KCHIP, Medicare, Medicaid governmental programs)?
- Are community members aware of and using available services?
- Are communication and education designed to develop appropriate care-seeking choices?
- Are continuity and coordination of care offered?
- Do all community members have a medical home?
- Does all treatment depend on assurance of payment?
- Are similar problems treated similarly without regard to racial, ethnic, and other minority groups or class?
- Above all, does the system provide universal access to effective health care, particularly for disadvantaged populations?

V. Care for each individual is **safe and of** high **quality.**[1]

- Are accepted safety surveys being used to improve safety and develop a culture of safety in all settings of care?
- Are care recipients welcomed and nurtured in such a manner as to assure their participation in safe care?
- Is it clear that services are necessary, that care is evidence-based and that it achieves desired outcomes? Are unnecessary procedures eliminated?
- Is care provided in a timely manner, e.g., manageable waiting times, readily accessible acute and preventive care at convenient hours, prompt response by hospital staff, etc.?
- Is care patient-centered, e.g., are patients and families involved in decisions and treated respectfully?
- Are non-physician members of the interdisciplinary care team involved, e.g., pharmacists, nurses, dietitians, specialty therapists, etc.?
- Does each provider have ready access[2] to all needed information about each patient's care at all times, e.g., through an effective patient data management system?
- Is the necessity for timely care of trauma, cardiac and stroke addressed?
- Does the system foster primary care, oral health, mental health services and other programs required to improve population health? Are the unique safety considerations in behavioral health addressed?

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[1] Institute of Medicine (IOM) definition of quality: "Quality of care is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge." Criteria for assessing quality: Safe, Timely, Effective, Equitable, Efficient, and Patient-centered. (IOM, 2001.)

[2] Access is a prerequisite to quality.

- Are all recipients of care educated to ask questions? Are resources provided to which individuals and families can turn in cases where questions are not clearly and satisfactorily resolved?
- Does the system assure comprehensive access to physical, mental, oral health and primary prevention (e.g., immunizations and reduction of diabetes risk) services?
- Are population health status measures (e.g., mortality rates, incidence of disease, rates of physical activity, etc.) improving?
- Does every setting of care actively coordinate care and provide continuity over time, location and care providers?

VI. The social responsibility to assure that care for each individual is **affordable** is honored**.** Cost must not create a barrier to care nor may individuals be forced to compromise basic needs to afford necessary care.

- How is the care paid for? Public insurance (e.g., Medicare, Medicaid, V.A.)? Private insurance? Other non-insurance support?
- Is financial support limited to specific categories of care?
- Is there support for transportation?
- Is there support for purchasing ancillary care items (e.g., refrigeration, telephone, pharmaceuticals)?
- Does available insurance enable appropriate care, or does it actually restrict care?
- Can patients choose lower cost alternatives?
- Are alternative sources of funding available and well known?
- How are third party payer denials challenged and appealed?
- Are waste, duplication and unnecessary procedures eliminated?
- Are Healthy Community activities and programs employed to reduce costs in the form of unnecessary demands for acute care?
- If individual insurance benefits are lost, does the system respond to prevent lack of access to care?

VII. Care for each individual is **efficient and of high value** to recipient and family.

- Are potentially wasteful procedures addressed (e.g., ineffective and/or excessive diagnostic and therapeutic services, over-utilization of resources, and ultimate costs of denying care)?
- Does the health system actively address issues of financial abuse and performance of unnecessary procedures (e.g., defensive medicine or procedures to enhance reimbursement)?
- Is there a community culture that supports health? Does the public understand the epidemic in our near future resulting from current cultural health behaviors?
- Does each individual/family have “a medical home”?
- Are users of services asked to assess the value they received from care in the system? Are the care assessments aggregated and addressed?

- Are requisite services provided in the most efficient way? If not, what would improve efficiency?
- Is easily understandable information about recommended treatment and self-care provided to patients and families?
- Are services appropriately utilized? E.g., do patients have to use the emergency room for primary care services after hours if lacking a medical home?
- Are services evidence-based?
- Is continuity of care provided?
- Is care coordinated and holistic?
- Is there a sustained focus on disease prevention (primary, secondary and tertiary)?
- Is administrative efficiency achieved at all levels?
- Are health-related resources distributed appropriately (e.g., physical location and level of care)?
- Is preventive care, including immunizations, funded through the health department?
- Can cost(s) of care be accurately assessed for providers, facilities, and other resources?
- Can the immediate and long-term benefits of care be evaluated?
- Does the system test new delivery models?

VIII. Patients and families are treated **with respect.**

- Are patients respected in all interactions with health professionals and their staffs, beginning at the time a patient selects a health practice and extending through interactions in the home, office, hospital or other care facility?
- Do health professionals accept this responsibility?
- Are peer pressures and prevailing cultural norms and expectations considered when individuals are counseled regarding appropriate health behavior?
- Are all facets of health care responsive to the interests if patients, families and communities? For example, is the care recipient empowered and engaged? Are medical regimens clearly understood?
- Are patients, families and communities educated as to expectations and requirements of safe, timely, patient-centered health care?
- How is the patient's experience monitored and improved?
- Is the free exercise of ethical and religious beliefs encouraged and supported?
- Is the public involved and represented at the policy level?

IX. **Patient rights** are clearly expressed and honored.

- Do the rights of choice of provider(s), participation in treatment decisions and access to their records reside with patients?
- Are these rights respected by caregivers?
- Are patient rights to privacy, dignity and compassion honored?

- Is the public educated about their rights when interacting with health care professionals?
- To whom can patients or their families address questions about their rights?
- Is patient-provider confidentiality protected?
- Do individuals have the information necessary for informed decision-making and consent?

X. **Individuals and communities share responsibility** for their health and for the cost of care.
- Are individuals taking personal responsibility for their own health behavior and risks? (e.g., avoiding or quitting tobacco use; avoiding obesity and participating in physical activity; taking part in primary, secondary and tertiary health prevention activities; and adhering to health care recommendations by health care personnel)
- Are individuals accepting the responsibility to understand their rights and to require that they be honored?
- Are costs shared by individuals when possible?
- Are incentives available to promote positive health behaviors? Conversely, are dis-incentives for healthy behaviors being addressed?
- How are patient actions concerning their health lifestyle assessed?
- Do patients accept responsibility for cooperation in screening, diagnosis, treatment and follow-up?
- Is cost-sharing equitable? Does it inhibit access?

A Word in Closing:

Compelling evidence is readily available showing that communities and health professionals, working together, can vastly improve the processes and outcomes of health care, even in the currently dysfunctional U. S. reimbursement and policy environment. The Committee believes that the focused application of a principled approach to transforming health care, going far beyond economic considerations, can lead to dramatic improvement in the health of all Kentuckians.

Such profound change cannot arise from the vested interests currently dominating health policy. Therefore, it must come from the people of the Commonwealth. The **people** of Kentucky must come to believe that health and health care can and must change for the better. They must feel knowledgeable and empowered to require systemic change on the part of their elected policy makers. We must ALL require better performance at the level of both providers of care and policy makers, including a reimbursement policy to foster preventive services and high quality collaborative and coordinated care**.**

The mission of the Friedell Committee, as a body of representative citizens from communities across the state, is to encourage and facilitate the process of shaping an effective, values-based, functional health system for every Kentuckian. As the principles articulated here are applied across Kentucky and refined by experience, we envision increasingly healthy

individuals and communities busily creating social capital. Kentucky can become a shining example for the nation of how health care can and should work for all Americans!

SOURCES/REFERENCES

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