


11-6-2017

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Recommended Citation

Bidwell JL. Push for progress inspired improved outcomes. *J Patient Cent Res Rev*. 2017;4:211-2. doi: [10.17294/2330-0698.1616](https://doi.org/10.17294/2330-0698.1616)

Published quarterly by Midwest-based health system Advocate Aurora Health and indexed in PubMed Central, the Journal of Patient-Centered Research and Reviews (JPCRR) is an open access, peer-reviewed medical journal focused on disseminating scholarly works devoted to improving patient-centered care practices, health outcomes, and the patient experience.

Push for Progress Inspired Improved Outcomes

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When I began a family medicine residency in the late 1990s, the culture of medicine didn't look much like many of my fellow interns. Importantly, we were more diverse, with more women and people of color. More than a few of us had earrings or tattoos and hadn't worn a tie since graduation. But we were proud of our new long white coats. They meant that we could change the world. We had entered the field of medicine to help people who had no voice in society — people who were homeless, people of color, undocumented immigrants, people with limited English proficiency, the LGBTQ community — and chose our training programs accordingly, enticed by organizations that could sponsor free clinics and treat diverse patient populations. While such components were certainly present, we quickly realized that the realities of prevailing practices at that time would present unexpected challenges.

Across the United States, many young physicians struggled with the business side of medicine. Back then, primary care residencies tended to squeeze in underserved care as a rotation or “outreach” activity. Organizationally, the quality of the effort was judged based on the number of people served, the amount of money spent or the number of employees who volunteered more than the impact on patient health. This led to concerns that African American, Latino, homeless, undocumented immigrant or uninsured patients were not receiving an equal standard of care. There was worry that our patients referred for specialty care would be turned away because they could not afford the copay.

The general sense was that the physician's job was to recommend the right process of care, but it was up to the patient to get to the outcome of being healthy. All too frequently these patients left unsatisfied with their care.

As it often does in life, experience proved to be a great teacher. The interns who later became medical directors learned that to truly help patients, one had to learn how to manage budgets to keep the doors open. It also meant attending meetings with executives to share reports from the trenches and also learn the language of business. It wasn't long before this group of idealists switched to sporting conventional haircuts and wearing ties to work every day. While previously little thought was given to good business practices, they started reading literature on quality improvement strategies, Lean methods and balanced scorecards. Indeed, the business world actually seemed to be ahead of the game when it came to using data to drive quality, improve safety and engage employee performance.

At the same time these now not-quite-so-young physicians started to look more like their health systems, health systems started to look a bit more like them. Growing out of sentinel calls to action that surfaced around the turn of the millennium,¹⁻³ use of data registries, population health metrics, Care Management scores and Press Ganey scores took off. The introduction of electronic health records allowed clinics to coordinate care for vulnerable populations across health settings and across health systems. Within the culture of medicine, new language has evolved around social justice and inequalities, enhancing clinical understanding of health disparities, patient



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satisfaction, social determinants of health, precision medicine, consumerism and caregiver well-being.

This evolution speaks to the heightened importance of each individual's health, which resulted in creation of the Triple (improving the health of populations, enhancing the patient experience, reducing cost),⁴ and now Quadruple (improving the work life of caregivers) Aim of Medicine.⁵

Led by such initiatives as the American Hospital Association's Pledge to eliminate health disparities,⁶ innovative and strategic partnerships are forming between health systems and Federally Qualified Health Centers, free clinics, faith communities and community organizations to share data, strategies and resources. Health care organizations now have executive offices of diversity and inclusion, headed by a chief diversity officer. It is expected that a clinic not only have qualified medical interpreters for all patients but that it recruits staff, as much as possible, so that its caregivers and providers reflect the communities served. In Wisconsin, integrated refugee health clinics work in partnership with the state. There is even cooperation among local competitors, as evidenced by Milwaukee's Specialty Access for the Uninsured Program that ensures access to much-needed screening and other procedures.

Most satisfying of all is that underserved care is now integrated into the everyday workflow. This progress occurred because, as health care shifts from a volume-based to value-based world, a health system's ultimate success will depend on how well it takes care of the most vulnerable.

It is becoming clear that health outcomes are affected by more than what happens in an exam room or hospital bed. For example, Housing First initiatives have shown that housing by itself is a cost-effective treatment for both physical health and chronic mental illnesses.⁷ More broadly, ongoing political and economic discussions about the effect of health care quality on the economy, employment, productivity and

gross domestic product have made it imperative that we hold each other accountable for the health of all communities.

When I first entered medicine nearly 20 years ago, practicing "good medicine" did not always mean better outcomes. But new developments — from the language used, to behavior among competitors (who, with increasing frequency, are really collaborators), to how data are stored, tracked and shared — have fundamentally shifted practices. Now, it is expected that providers not only make sure process measures are met but also are responsible for making people's lives better based on clinical outcomes. The world of medicine has steadily shifted its focus to achieving those outcomes in every individual, regardless of the path each person needs to get there.

With everyone working toward that goal, together we can achieve health equity for all.

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