Institute *for* Healthcare Improvement

10 New Rules to Accelerate Healthcare Redesign

Bold aspirations to guide healthcare organizations during an era of reform.

In 2001, the Institute of Medicine's *Crossing the Quality Chasm* report included a framework known as the 10 "simple rules" for guiding the redesign of healthcare delivery in the 21st century. Rules such as "Care is based on continuous healing relationships" and "Safety is a system property" articulate the characteristics of the desired state and encourage healthcare organizations to assess their opportunities for improvement based on current performance.

Although these rules are undoubtedly still relevant, the healthcare landscape has changed significantly since the report was first published almost 15 years ago. Major advances in medicine and technology have tested the ability of providers and systems to keep pace with the need for corresponding care delivery redesign. The acceleration of payment reform, which emphasizes value over volume, has challenged healthcare systems as they transition to managing populations while continuing to operate in a primarily fee-for-service environment. Efforts to achieve the Triple Aim have led to greater appreciation for the need to develop meaningful partnerships with patients and families, and to engage effectively with communities to improve health. Many leaders describe this moment in healthcare as having one foot on the dock and one foot in the canoe. This instability brings up the question: What new rules might provide steadier footing for healthcare organizations during this uncertain transition?

Taking a Closer Look

Recognizing that new aspirations may benefit from guiding principles, the IHI Leadership Alliance, a collaboration of healthcare executives and their teams committed to delivering on the full promise of the Triple Aim by working in partnership with patients, their workforces and communities, has developed and is testing a set of guiding principles or "rules" to help accelerate their progress.

Change the balance of power. Co-produce health and well-being in partnership with patients, families and communities.

Standardize what makes sense. Standardize what is possible to reduce unnecessary variation and increase the time available for individualized care.

Customize to the individual. Contextualize care to an individual's needs, values and preferences, guided by an understanding of what matters to the person in addition to "What's the matter?"

Promote well-being. Focus on outcomes that matter the most to people, appreciating that their health and happiness may not require healthcare.

Create joy in work. Cultivate and mobilize the pride and joy of the healthcare workforce.

Make it easy. Continually reduce waste and all nonvalue-added requirements and activities for patients, families and clinicians.

Move knowledge, not people. Exploit all helpful capacities of modern digital care and continually substitute better alternatives for visits and institutional stays. Meet people where they are, literally.

Collaborate and cooperate. Recognize that the healthcare system is embedded in a network that extends beyond traditional walls. Eliminate siloes and tear down self-protective institutional or professional boundaries that impede flow and responsiveness.

Assume abundance. Use all the assets that can help to optimize the social, economic and physical environment, especially those brought by patients, families and communities.

Return the money. Give the money from healthcare savings to other public and private purposes.

The new rules are not intended to be prescriptive, exhaustive or exclusive of other good ideas. Rather, they are intended to help frame a conversation around shared aspirations for healthcare, more easily identify successes and opportunities for improvement within and across organizations, and counter antiquated notions about seemingly intractable challenges in healthcare with creativity and optimism.

Case Studies in Care Redesign

The new rules have already engendered spirited discussion within and beyond many Alliance member organizations, and have led to a renewed focus and excitement around care redesign. Below are three examples of this enthusiasm.

Bellin Health in Green Bay, Wis., has employed a technique gained from user experience research to *change the balance of power* and more deeply understand how the diagnosis and treatment of gynecological cancer integrates into the everyday ebb and flow of a patient's life over time. Equipped with this information, Bellin has partnered with a number of patients to redesign the organization's gynecology-oncology service line to *standardize what makes sense* and *customize to the individual.* From concerns about finances at the time of diagnosis to anxieties about transitioning between care teams during remission, their efforts seek to address the emerging and evolving issues patients may face throughout their healthcare system journeys.

North Shore–LIJ Health System in New York recently partnered with Project ECHO at the University of New Mexico School of Medicine to explore how to *move knowledge, not people* while delivering much needed care for those with behavioral health conditions. Project ECHO employs a guided practice model and uses video conferencing to connect primary care

providers in rural and underserved areas with an array of specialists via condition-specific virtual clinics. Doing so allows patients to receive high-quality, cost-effective care within their own communities from the providers whom they can most easily access while also *creating joy in work* for primary care and specialty providers.

Charleston (W.Va.) Area Medical Center also has used the new rules to encourage staff to think differently about advancing their current culture of safety efforts. Leaders of the surgical trauma ICU incorporated the new rules to *standardize what makes sense*, *make it easy*, *assume abundance* and *create joy in work* to help improve their approach to pressure ulcer prevention. After the team tested new ways to educate staff, patients and families on the importance of turning patients at defined intervals, team members standardized roles and processes to ensure there was an individual assigned to assist the nurse in turning the patient at identified intervals. In addition, music was incorporated to provide auditory aides. This effort is now being rolled out to other ICUs within CAMC.

The 10 simple rules in the *Crossing the Quality Chasm* report called on clinicians and organizations to think differently about the way they delivered care against the backdrop of high rates of medical harm. The IHI Leadership Alliance added these new rules to raise the ante on what's possible, but they are far from fanciful. Examples abound both within and outside healthcare of radical redesign in operation, with better results for patients, providers and communities.

This enterprise—surfacing, testing and then spreading comprehensive, radical redesign—is not for the timid. Leaders need to be generous with power, seeking to uncover the assets and ambitions of their staff, patients and communities. Leaders need to be curious, eager to seek assistance from others outside their organizations and even outside the healthcare field. And they need to be courageous, committed to finding and testing new ideas and welcoming of not only successes but also failures, which can provide badly needed insights for course corrections and next steps.

The 10 new rules provide ambitious leaders in healthcare with much needed fuel to take a leap. After all, you can't cross a chasm with a few small steps. ▲

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