Doctors Strive to Do Less Harm

By GINA KOLATA

Suffering. The very word made doctors uncomfortable. Medical journals avoided it, instructing authors to say that patients “have’ a disease or complications or side effects rather than ‘suffer’ or ‘suffer from’ them,” said Dr. Thomas H. Lee, the chief medical officer of Press Ganey, a company that surveys hospital patients.

But now, reducing patient suffering — the kind caused not by disease but by medical care itself — has become a medical goal. The effort is driven partly by competition and partly by a realization that suffering, whether from long waits, inadequate explanations or feeling lost in the shuffle, is a real and pressing issue. It is as important, says Dr. Kenneth Sands, the chief quality officer at Harvard’s Beth Israel Deaconess Medical Center in Boston, as injuries, like medication errors or falls, or infections acquired in a hospital. The problem is how to measure it and what to do about it.

Dr. Sands and his colleagues decided to start by asking their own patients what made them suffer.

They found several categories. Communications — for example, a doctor blurting out, “Oh, it looks like you have cancer.” Or losing a valuable, like a wedding

Continued on Page A3

Recent NYT story on how reduction of suffering is becoming a goal around which health care providers are starting to organize themselves.

This is something different than asking every clinician to work hard.

It’s not asking clinicians to be better people.

What is it about, and why is it important?

And how do we accelerate progress?
What is Happening to Us is Historic in Nature

- We have a crisis in the reliability and the coordination of care -- throughout the world

- Irresistible drivers of change include:
  - Medical progress
  - Aging population
  - Global economy

- Challenges for providers and patients:
  - Too many people involved, too much to do, no one with all the information, no one with full accountability
  - Result: Chaos → gaps in quality and safety, inefficiency
  - Patients are afraid not just of their diseases, but of lack of coordination

**Question:** If somehow, magically, health care costs were not a problem, would you say that health care is working just fine?
Our Idealistic Aspirations and Our Business Imperatives Are Converging

- Until recently, providers could get by with hard work and a good brand
  - Get patients in the door
  - Negotiate “cost-plus” contracts
- Today, that approach is a strategy of trying to be the last iceberg to melt
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We are entering a new health care marketplace driven by competition on the “right things”:
  - Meeting patients’ needs
  - Doing so as efficiently as possible

It’s challenging ... but it is better than the alternatives, and it feels right.
A Six Component Framework

THE VALUE-BASED SYSTEM
The strategic agenda for moving to a high-value delivery system has six interdependent elements.

1. ORGANIZE INTO INTEGRATED PRACTICE UNITS (IPUs)
2. MEASURE OUTCOMES AND COSTS FOR EVERY PATIENT
3. MOVE TO BUNDLED PAYMENTS FOR CARE CYCLES
4. INTEGRATE CARE DELIVERY ACROSS SEPARATE FACILITIES
5. EXPAND EXCELLENT SERVICES ACROSS GEOGRAPHY
6. BUILD AN ENABLING INFORMATION TECHNOLOGY PLATFORM

SOURCE: MICHAEL E. PORTER
HBR.ORG
What Do Patients Really Value?

All Patients

- **Recommendation Failure Rate**
  - **15.7%**

Low: Confidence in Provider
- **74.6% Fail to Recommend**
  - **14% of patients**
  - **90% Worked Together Fail to Recommend**
  - **11.4% of patients**
  - **Low: Courtesy 92.8% Fail**
  - **High: Courtesy 78.2% Fail**
  - **Low: Listens Carefully 45.7% Fail**
  - **High: Listens Carefully 24.7% Fail**

High: Confidence in Provider
- **1.9% Fail to Recommend**
  - **5% of patients**
  - **28% Worked Together Fail to Recommend**
  - **2.5% of patients**
  - **Low: Concern for Worries 22.3% Fail**
  - **High: Concern for Worries 6.3% Fail**
  - **Low: Concern for Worries 5.6% Fail**
  - **High: Concern for Worries 0.6% Fail**

- **Low: Worked Together**
  - **90% Fail to Recommend**
  - **3% of patients**
  - **Low: Courtesy 92.8% Fail**
  - **High: Courtesy 78.2% Fail**
  - **Low: Listens Carefully 45.7% Fail**
  - **High: Listens Carefully 24.7% Fail**

- **High: Worked Together**
  - **28% Fail to Recommend**
  - **8% of patients**
  - **Low: Concern for Worries 22.3% Fail**
  - **High: Concern for Worries 6.3% Fail**
  - **Low: Concern for Worries 5.6% Fail**
  - **High: Concern for Worries 0.6% Fail**

8% of patients
- **Low: Worked Together**
  - **11% Fail to Recommend**
  - **72% of patients**
  - **Low: Concern for Worries 22.3% Fail**
  - **High: Concern for Worries 6.3% Fail**
  - **Low: Concern for Worries 5.6% Fail**
  - **High: Concern for Worries 0.6% Fail**
And Now for the Hard Part …

Engaging Doctors in the Health Care Revolution

by Thomas H. Lee and Toby Cosgrove

Despite wondrous advances in medicine and technology, health care regularly fails at the fundamental job of any business: to reliably deliver what its customers need. In the face of ever-increasing complexity, the hard work and best intentions of individual physicians can no longer guarantee efficient, high-quality care. Fixing health care will require a radical transformation, moving from a system organized around individual physicians to a team-based approach focused on patients. Doctors of course must
1. Tradition – e.g., Mayo Dress Code
2. Self-interest – e.g., Performance bonuses
3. Affection – e.g., Peer pressure
4. Shared purpose – e.g., Reducing suffering

- We need to press all four levers.
- But the first lever that must be pressed is creation of Shared Purpose.
- In isolation, any of the other three levers is ineffective or potentially perverse.
- But in pursuit of a shared purpose, all three other levers can be embraced.
My Introduction to “Suffering”

• March 2013 – breakfast with Pat Ryan
• My initial reaction (negative)
• Reaction of my physician colleagues at NEJM (also negative)
• Comment by copy editors that NEJM does not use the word suffering

The Word That Shall Not Be Spoken

Thomas H. Lee, M.D.

During the years when I worked in an academic integrated delivery system, my colleagues and I would frequently discuss patients’ experiences and ways to improve our management of their pain and reduction strategy; from a clinician’s perspective, it was obviously the right thing to do.

So it was a pleasant surprise when I studied the business strategy of a company that assesses patients’ experiences and found the word “suffering” would take some getting used to. I couldn’t remember the last time that my colleagues and I had used that word. “Suffering” made me uncomfortable. I wondered whether it was a tad sensational, a bit too...
Suffering Is Measurable

Mitigatable Suffering Arising from Illness & Treatment:
*Communication gaps, pain management, responsiveness, anxiety*

Avoidable Suffering Arising from Dysfunction:
*Lack of respect, lack of coordination and teamwork, lack of privacy*

<table>
<thead>
<tr>
<th>Measure Description</th>
<th>% Top Box</th>
<th>% Sub-optimal</th>
</tr>
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<tbody>
<tr>
<td>How often did nurses explain things to you in a way you could understand? (HCAHPS)</td>
<td>75.2%</td>
<td>24.8%</td>
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<tr>
<td>During this hospital stay, how often was your pain well controlled? (HCAHPS)</td>
<td>64%</td>
<td>36%</td>
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<tr>
<td>During this hospital stay, after you pressed the call button, how often did you get help as soon as you wanted? (HCAHPS)</td>
<td>64.8%</td>
<td>35.2%</td>
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<tr>
<td>How well did staff address your emotional needs? (PG)</td>
<td>57.5%</td>
<td>42.5%</td>
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<thead>
<tr>
<th>Measure Description</th>
<th>% Top Box</th>
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<tbody>
<tr>
<td>How often did nurses treat you with courtesy and respect? (HCAHPS)</td>
<td>85.8%</td>
<td>14.2%</td>
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<tr>
<td>How well staff worked together to care for you (PG)</td>
<td>70%</td>
<td>30%</td>
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<tr>
<td>Staff concern for your privacy (PG)</td>
<td>68.5%</td>
<td>31.5%</td>
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Appreciative Inquiry as a Tool to Create Shared Purpose

- Focus on positive, not errors
  - *What went right? What characterizes the cases that made us proud?*
- Identify the features that characterize care at its best – and try to make those things happen reliably.
  - *Deconstruct “great care” and focus organization on delivering it.*
- Challenge to leadership:
  - Describe vision for what lies on other side of change underway.
  - Make case that it is potentially good for patients and society, perhaps even great, and more important than the agendas of any of us as individuals.
Prospect Theory and Use of Financial Incentives

Prospect Theory, Kahneman and Tversky, *Econometrica* 1979
<table>
<thead>
<tr>
<th>Likelihood of recommending care provider</th>
<th>Care provider spoke using clear language</th>
<th>Care provider’s explanation of condition/problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.8</td>
<td>4.8</td>
<td>4.8</td>
</tr>
<tr>
<td>My confidence in care provider</td>
<td>Care provider’s effort to include me in decisions</td>
<td>Wait time at clinic</td>
</tr>
<tr>
<td>4.8</td>
<td>4.7</td>
<td>3.6</td>
</tr>
<tr>
<td>Time care provider spent with me</td>
<td>Care provider’s concern for questions &amp; worries</td>
<td>Care provider’s friendliness and courtesy</td>
</tr>
<tr>
<td>4.5</td>
<td>4.7</td>
<td>4.9</td>
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</tbody>
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**Patient Comments**

*Patient comments are gathered from our Press Ganey Patient Satisfaction Survey and displayed in their entirety. Patients are de-identified for confidentiality and patient privacy.*

**UofU Patient August 31, 2014**
Dr Aoki was excellent made us feel very comfortable and confident in the procedure that needed to take place. I would recommend him.

**UofU Patient August 28, 2014**
My boyfriend and I liked Dr. Aoki regarding his manner. Dr. Aoki approach to only doing a revision after further diagnostic injection has been done. Dr. Aoki explanation that he could go in but it is more difficult if not a clearer picture of what is causing pain. Explained hip replacement there is no going back. Dr. Aoki was very humble. Not jumping on doing surgery until further testing which I had already had scheduled from another doctor. Dr. Aoki was very respectful regarding other physician I have seen regarding hip issue. Only huge frustration is Dr. Aoki follow up schedule is so far out. Five weeks until I see him.

**UofU Patient August 25, 2014**
Dr. Aoki was one of the best physician’s I have worked w/ in regard to my daughter. He went above what I expected, waiting for records, keeping us informed and also explaining things in a way that were easily understood. Exceptional physician.

**UofU Patient August 10, 2014**
Brilliant, kind doctor

**UofU Patient August 10, 2014**
Delay in treatment will be lengthy due to my Ins isn't contract. I am pleased they will make an exception and are will to take me to LDS Hospital. I am grateful.
Patient Satisfaction

PROVIDERS AT 99TH %ILE OR ABOVE

*All Facilities Database includes the following
Number of Physicians: 142,411
Number of Patients: 2,783,597

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And the number of dollars that U of Utah physicians have in incentives for improving patient experience is …
And the number of dollars that U of Utah physicians have in incentives for improving patient experience is …

$0$
“Being a professional is doing the things you love to do, on the days you don't feel like doing them.”

-- Julius Irving (“Dr. J”)

Our challenge – can we create a context in which our colleagues live up to their own aspirations for the care we are delivering on every single patient?
Conclusions

- We know what we need to do – organize care for real competition:
  - *Meet patients’ needs – reliably*
  - *Do so efficiently*

- We know how to do it.
  - *Create shared vision*
  - *Measure*
  - *Create and support teams*
  - *Use other Weber models for social action, including transparency*