

TRUST

MEETING OUR MISSION

2003-2012

Transforming health care through research and education



HRET

HEALTH RESEARCH &
EDUCATIONAL TRUST
In Partnership with AHA

TRUST 2012

TEN-YEAR ANNIVERSARY



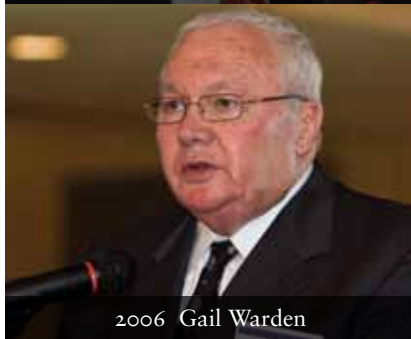
2003 David Lawrence



2004 Don Berwick



2005 Brent James



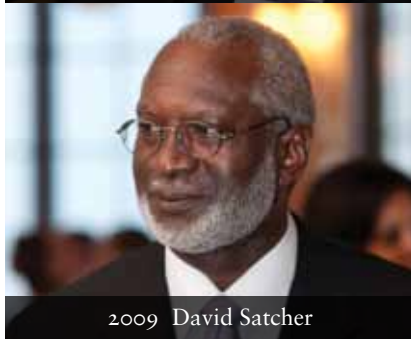
2006 Gail Warden



2007 Janet Corrigan



2008 Bob Brook



2009 David Satcher



2010 Glenn Steele



2011 Atul Gawande



2012 Maureen Bisognano

2003-2012

TRUST MEETING OUR MISSION 2003-2012

IN 2003, the Health Research & Educational Trust established the TRUST Award to honor individuals who have made significant and lasting contributions to health care. TRUST Award recipients share HRET's vision of creating a society of healthy communities—where all individuals reach their highest potential for health—and our mission of transforming health care through research and education.

We have recognized 10 leaders—all visionaries who have made tremendous advances to improve health care quality in policy and practice. Their voices, leadership, and expertise are continually called upon to better guide the field during these exciting yet challenging times. Each one is committed to the rewarding task of improving delivery, quality, and safety and controlling costs—to ultimately transform health care. We are grateful for their inspiration, enduring work, and talents to lead improvement and innovation in the field.

To commemorate the 10th anniversary of the TRUST Award, these leaders have shared insights about what health care has accomplished in the past 10 years, what work still must be done, and what will be required of both seasoned and emerging health care leaders to advance the field over the next 10 years.

Thank you to our TRUST Award recipients for their work, dedication, and vision. I look with great anticipation and optimism toward what we can accomplish in the future, working together to impact health care policy and practice.



Maulik Joshi, DrPH
President, Health Research & Educational Trust
Senior Vice President, American Hospital Association



David Lawrence, MD, MPH, is retired chairman and CEO of Kaiser Foundation Health Plan and Hospitals. Dr. Lawrence continues an active consulting and teaching practice in health care, serves on several public and private company boards, and writes about primary care and integrated care delivery.

DAVID LAWRENCE ON TEAM-BASED CARE

PEOPLE FROM DIFFERENT HEALTH PROFESSIONS SPEND LITTLE TIME TRAINING TOGETHER, if it occurs at all. As a result, the autonomous professional remains the predominant model in health care generally and physician education in particular.

Two things suggest that this could be changing, however. First, new generations of students entering medical school are more comfortable studying and learning together than in my generation and several afterward. Second, about half of entering medical school students are women. Generally, women are socialized to collaborate and may, as a result, work in teams more effectively than men. The combination of age-generational and gender shifts is leading to team-based care more than fundamental changes in medical education itself.

Technology, too, has a salutary impact on team-based care. For example, expansion of the electronic medical record has made clinical information once sequestered in individual doctor's offices more available for collaborative decision making. Doctors still practicing as independent entrepreneurs don't get the benefit of that. But where you see clusters or groups of doctors, you are more likely to see shared information.

Internet availability has given patients and families access to information they didn't have 10 or 20 years ago. This too is an important advance. Although it can be devilish for the doctor, it is a positive move toward team-based care when the patient is better able to participate as a team member in decisions about his or her health. This demystification of information has made it easier for health care professionals to access each other's science, which in turn provides more opportunities to discover where the science overlaps and is complementary.

Ten to 20 years ago, we didn't have many good examples of organizations organized around teams. Today we have many excellent examples from hospitals and health systems of how good care can be when it's designed properly. My advice to administrators and medical leaders is to learn from these organizations and drive your organization to these higher levels of care for patients.

Morally, no one can be an ostrich any longer about the benefits of care that is team-based, patient-centric, coordinated, and integrated. Patients can die or be injured as a result of errors we now know how to prevent. We also know how to provide care that is more effective and timely, more responsive to patients, and less expensive. As caregivers and care system leaders, we are responsible for what happens to our patients if we fail to provide that level of care.



Donald M. Berwick, MD, MPP, is former president and CEO of the Institute for Healthcare Improvement and former administrator of the Centers for Medicare & Medicaid Services.

DON BERWICK ON THE TRIPLE AIM

THE OVERALL REQUIREMENT FOR SUCCESSFUL LEADERSHIP in any industry is to align the work of the organization to meet social need. As the social need changes, then the business model and approach needs to change. So the first and most important requirement of leaders is to correctly identify the need of society that their organization exists to meet.

For health care in the United States today, I think the Triple Aim that IHI—Tom Nolan, John Whittington, and I—first described four or five years ago correctly reflects the social need and that includes focusing on (1) continual improvement of the health care of individuals, (2) continual improvement of the health of populations, and (3) reduction of per capita cost. Organizations contributing to that three-part agenda will more likely thrive in the future. The leader's job is to make the case for needed changes and bring people on to build the will.

In addition to articulating the agenda's importance, leaders need to believe in and increase confidence in the feasibility of achieving it. Some people lack optimism and confidence that they can execute. Leaders who say "we can" or "we will" are going to be much more successful. This, of course, involves the highest level of understanding and cooperation between clinical leaders, executives, and boards.

Though not the happiest circumstance, it is now the case that the ability of health care as a system to thrive in the United States will depend on its ability to achieve affordability. A rhetorical goal for decades, it is now a central strategic imperative. The alternative will be reductions in the ambition of U.S. health care or continual shifting of resources from other important social sectors, public and private, to health care—and either would be unfortunate. The goal of reducing costs through improvement is central to the social need.

We understand efficiency as being customer focused at the extreme level—that every single investment, every single hour used and spent, and every single effort devoted demonstrably meets the need of an external customer that we intend to serve. That provides a powerful platform for defining waste as any activity that doesn't meet need. If one asks how much of what health care is doing meets no need—that is, no aware patient or family would pay for it if they found no value whatsoever—the answer is a very high proportion of activity meets no need. That's the daylight, allowing us to start planned action in health care that in the long run could do what we need, which is to reduce costs by improving the patient experience.

It's an enormous, powerful time for professional leadership—not just for physicians and nurses but for all health care professionals. Leaders can try to batten down the hatches, or they can take the initiative and steer toward the Triple Aim. Professionals who can own this and actually bake the changes in their own work will be leaders. Those who try to preserve the current dysfunctional system might find themselves not only behind the curve but also feeling a bit buffeted by other forces that will insist on the changes. This is a time for leadership, and I'm hopeful that might be possible.



Brent James, MD, MStat, is chief quality officer at Intermountain Health Care.

BRENT JAMES ON BUILDING INFRASTRUCTURE FOR QUALITY

FREDERICK TAYLOR PUBLISHED *Principles of Scientific Management* IN 1911. Within 15 years, any company that couldn't adopt Taylor's methods simply died. Craft-based production, the earlier world's mainstay approach to create products and services, could not begin to compete with the lower-cost, higher-quality products that Taylor's standardized mass assembly production produced.

Taylor also introduced a new vision of the working man. On one side, he placed the thinkers: a handful of college-educated managers and engineers who designed the new work processes. On the other side were those who could only work: often illiterate assembly line workers who were cogs in the production machine. Taylorism embodied top-down command and control. Management was the art of smoothly transferring the thinkers' ideas into the workers' hands, insuring compliance with the instructions given, and of motivating front-line workers—natural malingerers, in Taylor's view—to maximal rates of production.

Thirty years later, W. Edwards Deming transformed Taylor's approach. He first defined the key theoretic structure that made standardized mass assembly production work. To Deming, a "process" was a series of steps designed to convert inputs into a product or service. Deming's logic then followed a series of simple steps: (1) The aim of any company is to satisfy customers;¹ (2) the way that a company satisfies a customer is through a product or service; (3) the company produces that product or service by successfully executing "front-line work processes"; therefore, (4) to be maximally successful, a company should organize all of its activities around value-adding front-line work processes, where "value-adding" is defined by the customer.

Deming called his second major contribution to production theory "fundamental knowledge." It is the idea that there is a difference between theory and reality. Theory is always an abstraction and a simplification. Reality is the devil in the details—the kludges, workarounds, and special circumstances that routinely arise in any work environment. It's the myriad small operational problems that confront front-line workers every day. Thus, the only person who knows how a process really operates is the front-line worker who executes it routinely. By definition, a manager cannot know what's going on. Moving up the management chain gives a broader strategic view, but it also means that the manager detaches from the details of front-line reality. Successful process management and improvement depends critically on fundamental knowledge, which always and only resides in front-line workers.

Deming's approach sparked a second transformation. Once again, productivity surged: quality broadly improved as production costs fell. In internationally competitive manufacturing industries during the 1980s and 1990s, the watchword was "Do Deming or die."

Deming thus became the champion of bottom-up management. Under that model, front-line workers get a new job. Most of the time they do their old job—they execute the processes that produce the products and services upon which the company's success depends. But some of the time they now manage and improve their own work processes. Quality improvement pushes management to the level of the front-line workers, where the fundamental knowledge resides.

¹ Deming had a unique view of the money that a company receives for its products or services: he regarded the amount paid primarily as a very strong direct measure of customer satisfaction.

Quality improvement also redefines the role of the traditional manager. It forces them to become leaders with a primary aim to make their front-line colleagues successful in both their roles. Leaders build infrastructure. They define organizational culture and set a compelling shared vision. They supply the tools, including integrated training, time, improvement coaching, measurement, and resources for front-line process management and improvement. They coordinate the work of front-line teams. They block and tackle, removing institutional barriers to front-line success.² Sometimes they provide a bulwark against outside forces, creating a space in which improvement is possible. In short, quality leaders build infrastructure that “makes it easy to do it right.”

I first met Dr. Deming in 1987. He advised us as we applied his ideas to clinical care. We quickly showed significant improvements in clinical outcomes, usually associated with much lower costs. He heavily edited my monograph describing that experience, *Quality Management for Health Care Delivery*. HRET first published it in 1989, and then republished it in 2005.

As we extended our application of quality improvement in clinical care delivery, we discovered two key infrastructure elements. The first is broadly available, easily accessible, outcomes measurement that feeds back to clinical teams in a learning system. The central issue is effect size. The effects of some interventions are large enough to see with the naked eye. Most, though, require measurement. Measurement represents an organization’s ability to link cause to effect in the context of process management and improvement. Clinicians need that far more than they need most things that we as purported leaders emphasize. I believe our ability to measure clinical outcomes and cost outcomes has been slowly and quietly improving. As people can see clearly what’s happening, without any other force or suasion, they do better.

The second key infrastructure element that we discovered is technically a form of Lean “mass customization.” When we applied that principle within clinical settings, we called the result “shared baseline protocols.”

Any clinician understands that no two patients are quite exactly the same. Different patients are exposed to different pathogens in the environment. Different personal genetics mean different anatomy and physiology, which in turn produces different expression of disease and different individual response to treatment. That means that no treatment protocol perfectly fits any patient. Therefore, we first create evidence-based best treatment protocols. We blend them into clinical workflow, so that their execution doesn’t depend on unreliable human memory. We then demand that our clinicians modify our shared baseline protocols based on individual patient needs. We similarly build measurement systems into the clinical workflows, that track both protocol variations and a full set of clinical, cost, and satisfaction patient outcomes. We feed those data back to the clinical teams to drive learning and improvement. We use the same structure to organize, deploy, and systematically improve clinical knowledge.

Clinicians cannot do this by themselves—it takes a quality organization. I am convinced that the future of care delivery is care organized along these lines—teams of clinicians who come together to use process management tools to deliver patient-centered care. The results to date have been impressive. In area after area, we have been able to show far better clinical results at much lower costs, making effective health care more accessible to more people. We have not yet begun to understand how good we can be for our patients.

² You sometimes must be above a problem within an organization in order to resolve it.



Gail L. Warden is president emeritus of Henry Ford Health System and professor of health management and policy at the University of Michigan School of Public Health.

GAIL WARDEN ON CIVILITY

THE MOST IMPORTANT HIGHLIGHT of the annual TRUST Award reception each year has been the address given by each recipient. Over the past 10 years, the recipients have distinguished themselves by the remarks they have made regarding the role of trust and visionary leadership in improving health care quality and practice.

In my address in 2006, I spoke to the importance of our core issues and the promises we needed to make to our patients, employees, and communities if we wanted them to believe in us and gain their trust. One core issue I did not mention was civility.

Today civility is lacking in our political environment, in our organizations, in our approach to health care reform, and even in our daily lives. Civility is knowing and doing what is right in our relationships with others. Examples are being considerate, being a good listener, lending a hand, going out of one's way, thinking the best, respecting other people's time, accepting and giving praise, respecting others' opinions, acting with politeness, manners, and kindness.

Civility also has to do with having an active interest in the well-being of our communities and a concern for the environment in which we live.

When we really think about civility, we discover that no actions of ours are without consequence, and we must anticipate what these consequences will be. It is about choosing to do the right thing for our family, our community, our profession, and our colleagues.

To promise civility is especially important in a time where too much of our communication is done electronically and through social networking. We need to promise that we will assure that face-to-face communication is not lost in this new world. If we can do that, we will be taking another step toward civility.



Janet Corrigan recently retired from her position as the president and CEO of the National Quality Forum and is now a private consultant.

JANET CORRIGAN ON FOCUSING ON HEALTH, NOT JUST HEALTH CARE

E NORMOUS EFFORTS ARE NOW FOCUSED ON “FIXING” THE HEALTH CARE SYSTEM. Both public and private purchasers are transitioning to value-based payment programs that reward better outcomes and lower costs. The hard work of building more integrated models of care delivery, such as accountable care organizations and medical homes, is well underway. These efforts hold much promise for making care safer and better coordinated and removing waste. But fixing the current health care system alone will not be enough to solve the health care crisis; we must stem the tide of poor health.

The United States is confronting an obesity epidemic of epic proportions. Two-thirds of Americans are overweight or obese, and this includes one in five children under the age of six. Health care costs are a major contributing factor to the national debt, and obesity-related illnesses account for a large share of health care costs. The health care system is poorly prepared to tackle what is perhaps the most significant threat of our times to the health of the population.

Although the health care sector cannot solve the obesity challenge alone, health care leadership will be critical to success. Tackling obesity requires multifaceted interventions at the community and health system levels. At the community level, we must create an environment that encourages healthy lifestyles through public policy and investments that enhance and encourage appropriate exercise and diet. Accomplishing this will require health care leaders in a community to work together to educate others on the role of environmental determinants in obesity and to implement communitywide initiatives to create healthier environments. Health care leaders must serve as catalysts for broader change in their communities.

At the health system level, we must take advantage of every opportunity to engage and support patients in their ongoing efforts to pursue healthy lifestyles. Leadership will be needed to build health systems that focus significant attention on population health in addition to treating disease. All patients should be encouraged to develop and implement wellness plans, and a core responsibility of the health system should be to provide the necessary multidisciplinary supports and tools to patients to maximize outcomes.

We cannot solve the health care cost crisis by focusing solely on “fixing” the health care system. We must focus attention and redirect existing resources on preventing and treating obesity. Doing this requires a new kind of leadership. Leaders who see their responsibility as much about reducing the need for services as providing services to those in need.



Robert H. Brook, MD, ScD, FACP, holds the Distinguished Chair in Health Care Services at the RAND Corporation, where he previously served for 19 years as vice president and director of RAND Health.

BOB BROOK ON CONTROLLING COSTS

WE HAVE FAILED TO CHANGE THE VALUE PROPOSITION of the U.S. health care system in the last 10 years. We spend more money, we have more people uninsured, and we have not improved quality. The next 10 years must be different.

Physicians need to participate in controlling costs. They need to know the cost of what they order. Right now, if you ask how much it costs for nurses to do vital signs in the hospital every two hours as opposed to every 10 minutes, physicians have no idea, and in many cases, nor do hospitals. We need to figure out how to get information in a real-time basis to physicians on the cost of what they order and do. We cannot control costs or improve value if we don't understand what we're spending.

If we know the cost of everything, "cost rounds" need to be done so administrators and physicians can ask: How could we have reduced the cost by 20 percent of this patient's stay in the hospital, stay in the nursing home, or outpatient workup without affecting quality or health? Innovative leaders will not only attend morbidity and mortality conferences but cost rounds as well.

For some situations, explicit algorithms upfront could help physicians decide what to do. If a physician orders an x-ray or a drug and the cost is high, the physician should be able to ask—like shopping on Amazon—is there anything just as good for half the price? Somebody needs to develop apps or tools to make it easy. Eventually there may be a talking wall. The wall will listen to the conversation between the patient and physician and suggest what to do: "I hear you're talking about doing this test; given the patient's symptoms, I suggest this one might be cheaper and better."

In terms of quality, three major problems in health care right now are lack of compliance or adherence to medications in the outpatient area, poor treatment of people when they are sick and in the hospital ICU, and use of procedures and tests that are not needed, on one hand, and not offered when they're needed, on the other hand. The only way to fix these problems is to establish a full partnership between the community and the profession. And I think that will happen.

In the next 10 years, there's a real possibility that we're fundamentally going to change the entire way we approach health care. We will develop a population-based approach for caring for people. We will talk about increased hospitalization rates, increased physician visit rates, and increased nursing home rates as failures of the system. Instead, the community will work together with the profession to keep a population of people healthy.

The model I see is similar to one the military uses when they talk about leaving no one behind on the battlefield. We will develop a culture where communities say: We're not going to leave people around unhealthy. It's our job to determine how to work together with medical personnel to solve the major problems in health care.



David Satcher, MD, PhD, is the director of the Satcher Health Leadership Institute and director of the Center of Excellence on Health Disparities at the Morehouse School of Medicine. Dr. Satcher was the 16th Surgeon General of the United States.

DAVID SATCHER ON LEADERSHIP DEVELOPMENT AND HEALTH CARE EQUITY

LEADERSHIP IS A LEARNING PROCESS. When we stop learning today, we stop leading tomorrow, John F. Kennedy said. At the Satcher Health Leadership Institute, we believe that everybody teaches and everybody learns. We learn from our fellows, from the people in our community health leadership program, and those within our quality parenting program. We're not just teaching; we're learning and sharing. I think leaders need that attitude to be effective.

Leadership occurs at many levels—it's not position dependent. When we create the kind of environments where people are encouraged to contribute, then leadership comes from a lot of different levels. We believe leadership is a team sport. And one of the biggest challenges for leaders is ensuring a team is in place to provide leadership that is consistent with the mission and goals. We try to help our fellows understand and develop in this area: what it means to be part of a team, to develop teams, to promote teams, and not only to share the burden of leadership, which is important, but also to share the rewards of leadership.

Leadership also needs to be mission oriented. Our leadership development program is helping people to develop as leaders in the area of reducing and ultimately eliminating disparities in health. We spend a lot of time discussing issues related to disparities and understanding the nature of disparities, not only in terms of race and ethnicity but also mental health issues.

During the past 10 years, we saw dramatic increases in people having trouble accessing the system for quality health care in the United States. About 13 million people were added to the uninsured rolls. And I don't think we had tremendous progress in outcomes during that time. However, we can take some hope from the fact that the gap in life expectancy between African-Americans and whites is beginning to narrow.

We have made a lot of progress in bringing attention to these issues and putting in place people and programs targeting the reduction of health care disparities. Important advances include the establishment of the National Institute on Minority Health and Health Disparities, NIH research programs, and programs to develop young people for research in this area. Also, incentives outlined in the Affordable Care Act—for primary care and preventive services and for quality rather than volume of care—should benefit people who are in underserved populations and people who have not received the greatest quality of care.

We need a health care system, number one, that provides access for everybody and, number two, focuses most of its resources in primary care and making sure everybody has access to primary care. That includes mental health care because the integration of primary and mental health care is critical for the future. Our health care system also should promote healthy lifestyles—regular physical activity, smoking cessation, and good nutrition. All of these things are critical in reducing and ultimately eliminating disparities in health and health care.

Health care leaders, health care professionals, and hospitals need to develop partnerships with people in the community, business, and education to establish systems of care and provide incentives for keeping all people healthy. The incentives have to be in the right place to get the right outcomes.



Glenn D. Steele, Jr., MD, PhD, is president and CEO of Geisinger Health System.

GLENN STEELE ON INNOVATION

ANY COMPANY, INSTITUTION, OR INDUSTRY WHERE THE LEADERSHIP IS NOT INNOVATING IS ESSENTIALLY DYING. The risk of not innovating is much greater than the risk of innovating. And the usual assumption is when organizations are in extraordinarily difficult circumstances, particularly circumstances that relate to operations and their balance sheet, they have more risk-taking for innovation. I disagree. The time to innovate is when an organization is doing reasonably well. Leaders who are not fundamentally innovating—and I’m not talking about nitty-gritty reaction to everyday operation crises—are likely leading the business into some long-term degeneration.

Whether the organization is a group practice, private practice, or academic setting, the sociology critical to getting consistent change in patient care is applicable. Begin assessing individualized approaches or unjustified variation. After accumulating data, most organizations encounter an “opening up” and realization of the huge amount of variation. It happens even within a relatively tight culture like Geisinger.

Next, allow clinical leaders to reach a consensus of best practice for every step during an episode of care and commit to the enabling technology. Then incrementally move toward achieving 100 percent of the default best practice among 100 percent of the patients. It’s important to allow individual variation by physicians caring for individual patients, but only if it can be justified to their colleagues in real time. Certain justifications are credible but not others. It’s not credible if a caregiver says, “I’m doing it this way because I was taught to do it this way 30 years ago.”

To build a culture of innovation, start with a strategic discussion. It should represent two or three big strategic goals that you’re pushing for over a period of three, four, or five years. Then you’ve got to pay for it. At Geisinger, we’ve done it for our employed positions by putting 20 percent of the total cash compensation aside and using that to pay for something other than productivity. One of those big “somethings” is fundamental innovation.

Caregivers should choose the kind of innovation. Then it’s not only top-down in terms of strategy but also bottom-up in terms of the specific patient care improvement. People should be self-motivated. The organization is trying to pay for it but also trying to energize professional pride. Work to get an early victory, which will create a ripple effect.

The chosen challenge also has to be the right size. If a challenge is important but really below the radar, it’s less likely to turn people on. If it’s too highfalutin and overwhelmingly aspirational, people will not believe it and it will lose credibility. It’s got to be the right-sized challenge with the right packaging.

The number one priority is creating an organization that is healthy enough both sociologically and operationally to move toward fundamental and continuous innovation. Number two is understanding how a particular institution’s structure, market, pedigree, and sociology can be utilized to achieve change and innovation. What’s done at Geisinger is not necessarily appropriate at the University of Chicago or in Boston hospitals. Third, ensure what the CEO does is not dependent upon that CEO’s presence but is institutionalized in a way that will live after the CEO is gone. Ideally, the CEO should be preparing all the time for a successor who will build even more upon these aspirations.



Atul Gawande, MD, MPH, is a general and endocrine surgeon at Brigham and Women's Hospital and has a joint appointment in the Department of Health Policy and Management at the Harvard School of Public Health. He is also lead advisor for the World Health Organization's patient safety programs in surgery and childbirth, and a staff writer for the New Yorker magazine.

ATUL GAWANDE ON END-OF-LIFE CARE

How can we change our approach to end-of-life care and advanced illness planning and management? What can the hospital team do to improve care for patients with advanced illness? As clinicians, we continue treatments long after they provide any benefit and where the harm starts to overwhelm any possibility of benefit. We find it difficult to talk with patients about what to do if their health gets worse. Our job as clinicians has been like shoe sellers: “Do you want the red shoes or blue shoes?” “Do you want the chemotherapy, or do you want to die?” That has been a failed model. But saying “You don’t get the chemotherapy” is not a successful model either.

I’ve been working with experts to understand how to augment clinicians’ capabilities to work successfully with patients as they make decisions. Studies indicate that by discussing patients’ goals and priorities besides living longer, decisions can be phenomenally more successful in reducing suffering and use of therapies that are more harmful than beneficial. There is a period of time when patients are willing to sacrifice time now for time later. But there also comes a time when patients are suffering enough and begin to say, “I want to have a good day now, regardless of what happens later.” Often when you give people a better day now—better pain control and better care—they actually do better for longer. Palliative care focuses on “How do you have the best possible day today?” And we in medicine mostly focus on “I’m going to make you sick and make you hurt now, but it’s for the sake of something later”—which might or might not occur.

How have you changed your approach and interactions with patients who have advanced or terminal illness? The paradigm shift for me was understanding that I need to identify people’s priorities and then design care to meet those priorities—including goals other than trying to live longer. I have started asking my patients: “What is your understanding of how your illness is going? What are your biggest fears and biggest goals if your health gets worse?” I try to understand their priorities so I can make a recommendation. That is very different from saying, “Do you want the surgery or not?” If patients know they don’t have long to live, I can say: if your goals are not to be in institutions, to be mentally alert, and to minimize pain, together we can make a plan that addresses those goals. Maybe surgery is the best chance to help a patient get home and live without pain. Or maybe a particular operation is not.

What support is needed within the medical community to ensure that end-of-life/advanced illness discussions are taking place between patients and their medical team? More is needed than advanced directives. We must create systems that help team members, inside and outside the hospital, know how to effectively ask questions and help patients through this planning. Skill matters in these discussions, and we haven’t learned how to teach it. In my research lab, we’re testing a checklist for a serious illness discussion with patients. We want to determine if physicians trained this way achieve better results with patients—measured by whether patients are more likely to get treatment that matches their wishes at the end of life. For terminally ill patients, we want a highly safe but highly effective approach for planning.



Maureen Bisognano is president and CEO of the Institute for Healthcare Improvement.

MAUREEN BISOGNANO ON PATIENT-CENTERED CARE

What if every patient, in every hospital and clinic across the country, had documented daily goals for what *they* wanted to get from their care?

I had the pleasure of interviewing a patient—Jamie—who had been in and out of the hospital over the last decade with various health problems. After talking about her care, our conversation turned to her job. Jamie is a school teacher, and each year she gets 20 new students. I asked if the students were mostly alike, and she said, “No. They’re all very different.” So I asked how she taught them, given the differences. Jamie explained that she has a simple but successful formula:

1. Huddle with all the students’ prior teachers and map out a history from their point of view.
2. Meet with the family to understand the home context.
3. Meet with the student and set goals for the year, month by month.

These three simple but essential steps, if translated to health care, are exactly what we mean by patient- and family-centered care. Many organizations are starting to implement processes like Jamie’s, but not enough. Another recent experience exemplifies the problem.

A family member of mine was a patient at a hospital here in Boston. As his condition worsened, his care team grew, resulting in decreased coordination and clarity of communication. One doctor told him to take as much pain medication as he needed; another warned him not to take too much. One doctor advised him to walk around a lot; another recommended rest. There were conflicting interpretations of test results, conflicting recommendations about colostomy, and throughout it all, a total absence of post-discharge planning.

We know that care coordination improves outcomes and patient satisfaction, and can reduce costs by shortening length of stay and avoiding complications. I’m encouraged that more and more organizations are following the lead of places like ThedaCare and Gundersen-Lutheran in Wisconsin, both of which have used robust care coordination models for years. But for organizations still struggling with this essential aspect of patient-centered care, I have a suggestion: a whiteboard next to every patient bed. On that whiteboard, write daily (and longer-term) goals with the patient. Develop these goals during multidisciplinary rounds with the care team and the patient or family member.

The whiteboards should include both clinical goals, like lowering blood pressure, and patient-directed goals like the one I heard from my colleague in Saskatchewan, Dr. Susan Shaw. Her patient’s daughter excitedly greeted her one day, showing her a piece of paper on which the mother had written, “My goals: (1) heal this broken body; (2) cut grass.” The patient simply wanted to be healthy enough to mow her lawn. Dr. Shaw noted the inspirational power this wish had on her and her team and the clear direction it gave them about how to plan the patient’s care.

Every patient should have the opportunity to set, understand, and strive for clinical and personal goals. Every clinician should develop these goals by asking the question my colleague Susan Edgman-Levitan proposed: not “What’s the matter?” but “What matters to you?”

Safety Disparities Science Collaboration
Quality Improve
Leadership Customer Partnership
Strategy Evidence Team Vision Process
Cost Systems Transform Education Society
Outcomes Learning Health Patient Innovation
Research Technology Progress Policy Access
Measure Equity Teamwork
Goals Family Mission Efficiency Culture Timely Population
Integration Community Respect Data
Practice Relationships Compassion Organization

HRET

HEALTH RESEARCH &
EDUCATIONAL TRUST
In Partnership with AHA

155 N. Wacker
Chicago, IL 60606
312.422.2600
www.hret.org