Restoring Humanity to Health Care

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ALTHOUGH there is widespread agreement that the US Health Care system needs fundamental change (Schoen et al., 2013), most of the efforts to do so remain small and incremental. For the past decade, I have had the opportunity to work outside many of the usual constraints to redesign and build primary care practices from scratch to create a vision of where we need to go (Fernandopulle, 2013). This quarterly column will share some of the observations and lessons I am learning and, hopefully, help the dialogue on how we collectively can and must change our care delivery system.

Our practices change everything. We start with a different payment model, discarding fee for service entirely and simply get a risk-adjusted primary care capitation rate for our services. This allows us to completely change the conception of our goal—from doing the best we can with each person in front of us to improving the health of a population. To do this, we build a very robust team, with 4 health coaches per doctor drawn from the community to help patients understand and manage their health, integrated mental health, daily huddles to discuss patients who need our help, extensive non–visit-based care, home and hospital visits, and lots of groups to help patients learn from us and each other about their conditions. We have also developed our own information technology platform as we realized that current electronic health records are not built for this very different care model (Fernandopulle & Patel, 2010).

We have shown dramatic improvements in outcomes and drops in total health care costs in practices serving populations as diverse as Boeing employees in Seattle, Washington (Mielstein & Kothari, 2009), Casino workers in Atlantic City, New Jersey, and Las Vegas, Nevada (Agency for Health Research and Quality Innovation Exchange, 2010), and faculty and staff of Dartmouth College in Hanover, New Hampshire. One of the most common questions I get asked is of all the many things we do differently than typical practices, what is the most important in achieving these results? The answer I think is actually quite simple, and yet profound, and is best illustrated by a patient I still remember from our Atlantic City practice.

Her name was Joyce, and I had the pleasure of meeting her when she first came to the practice many years ago. Her hair was disheveled, she arrived late, and her health was a mess—her diabetes and hypertension were way out of control, she was only intermittently taking her medications, her diet was awful, she was in and out of the emergency department, and hadn’t been able to hold down a job. We introduced her to a health coach, cleaned up her medication regimen, and got her started in our program. Six months later I came back to visit the practice, and one of the doctors called me over and said, “Remember Joyce who you met on her first day here—she is back and I want you to see her.”
I walked into the room, and she looked like a new person. Hair was combed, and her clothes were well put together. Her hemoglobin A\textsubscript{1c} level and blood pressure were in control, and she was eating better, taking her medications, was back to work, had not gone to the emergency department in 4 months, and in general had a much more confident look about her. I looked her in the eyes and asked, “Joyce, congratulations—you look great. Can you tell me what we’ve done to help you?”

She thought about it for a moment and replied, “Actually doc it’s quite simple. My health coach and the entire team cared about me, you taught me to care about myself, and I didn’t want to let any of us down.”

What we are really doing is actually quite simple—we are restoring humanity to health care. For millennia patients have been coming to healers to help them, and our only tool was our humanity. Indeed, humanity is what drove many of us to go into the health care in the first place.

However, we are increasingly putting rules and structures in place to make this harder. We have gotten too enamored of our diagnostic and therapeutic technology and have started to turn health care into a series of transactions. Our focus on coding and billing discrete activities has made this worse, and the upcoming ICD-10 (International Classification of Diseases, Tenth Revision) transition and increasing attempts to game CPT (Current Procedural Terminology) coding to compensate for lower rates further exacerbate the problem. Indeed, many of the attempts to help—such as Meaningful Use or Patient-Centered Medical Home certification—further strengthen the focus on transactions and away from the human interaction that is what is truly of value.

So how can we restore humanity to health care? Here are a few lessons we have learned:

1. **Take things away.** Many of our attempts to improve the system involve asking already overworked teams to do more in addition to their current work—answer e-mails, use electronic health records, run groups, etc. There is profound value in taking away useless or marginal work, such as billing and coding. People once asked Michelangelo how he created a beautiful sculpture like the Pieta, and his reply was he simply took a block of stone and chipped away everything that wasn’t the Pieta. We need to remove the many layers of work we have imposed on our health care providers that are not the Pieta and do not add real value to the patient.

2. **Build the right culture.** Much of the focus on care redesign has been around process and technology, but our experience is that by far more important is building the right culture. If you have the right process and technology but the wrong culture, you go nowhere, but if you get the culture right, the rest will fix itself. We have the great advantage of building the right culture from scratch, which primarily means getting the right sort of people on board, with the right attitudes and demeanor. This has much less to do with resumes than personality. Unfortunately, too many people in health care seem to have forgotten that we are in a service industry and that our job is to serve our patients (and not the other way around). To put it bluntly, we have found that to restore humanity to health care, we need to hire the right people and fire the wrong ones.

3. **Think small.** For years, many have argued that physicians need to move into larger group practices in order to improve the quality of care (Casalino et al., 2003). While I agree that one needs the right infrastructure (eg, electronic health records, analytics, improvement methods) to practice optimally, the answer may not be to create larger actual care sites. We have found that there is huge value in keeping the end units small (ie, 2-3 doctors) so that the team can remain small and that everyone can really get to know all the patients. To quote the popular TV show Cheers, a place where “everybody knows your name” makes it much easier to deliver truly human care.
4. The devil is in the details. Most efforts at care redesign focus on the big things—and while these are important, what really makes the difference in service businesses such as health care are the sum of a thousand little things. For instance, we greet our patients by name and offer them a cup of warm tea when they come in to our practices; we always start and end our encounters sitting in real clothes at the same level on real furniture; we decorate our practices more like a bed and breakfast than a chain hotel, with different art and decor for each room; and our teams gather for a cheer when our patients meet their goals such as losing weight or quitting smoking. These may seem small, but it is the sum of lots of these small things that create an environment where patients feel our humanity.

While we have the luxury of starting from scratch by changing the payment model, hiring the right people, and building our own IT system, every practice can take steps to restore humanity to health care. The most important thing is to realize this is important and then figure out what you can do to move in this direction. It may not be as glamorous or fashionable as becoming Patient-Centered Medical Home certified or meeting Meaningful Use criteria, but I believe it will go a longer way to improving health care both for our patients and for ourselves, which of course is what we should be doing in the first place.

REFERENCES


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