Those of us who have worked in the health care world for any length of time have an instinctive aversion to those who claim to have transformative ideas for this sector. Our problem is that we know too much about how hard it is to make even incremental change, much less transformative change. The odds seem stacked against us: The arcane flow of funds among insurers, hospitals, doctors and consumers; the tribalism that separates surgeons from anesthesiologists from radiologists, not to mention the cognitive specialists; and the massive problems of managing patient flows from the ED to the floors and ICUs to post-acute care.

But, every now and then, an idea comes along that has the potential to be transformative. It has to be a good idea: That’s a necessary but not sufficient condition for success. One sufficient condition is that the system has to be motivational for participation by otherwise very busy doctors and nurses. Another sufficient condition is that its implementation is cash-flow positive for the hospitals in which it will be carried out.

In this regard, I think Anthony DiGioia III, MD, and Eve Shapiro are on to something. Like all good ideas, its elegance is its simplicity. But the simplicity is based on the underlying values of well-meaning and hard-working clinicians. Hence, there is a reasonable chance that they will want to try it out. And once they try it out, they may want to keep doing it.

The “something” has two principle parts. Part one borrows from the Lean liturgy, the concept of shadowing. Those of us who have taught and implemented Lean (or Toyota Production System) in hospitals know that a key aspect of training is to ask people to shadow other front-line staff in the hospital, to get a sense of the obstacles those people face when doing their everyday work. After all, it is only by watching work in action that one can find areas of inconvenience and waste, and design experiments to undo the work-arounds that well-meaning people invent to get through the day.

DiGioia and Shapiro take the shadowing concept to its logical home, to have clinicians follow actual patients through their experience in the hospital, to see how our logistical and clinical systems get in the way of a truly patient-centered experience. Some obstacles will be related to direct clinical care, but many will be related to the physical characteristics of our buildings, our staffing models, and the like. Once the clinical team sees what is getting in the way of good care, they can invent experiments to improve the situation. Most enhancements that come out of this design process cost little or no money, and in fact save money.

The second idea is time-driven activity-based costing. The idea is to identify, by and for the clinicians, the true cost drivers in any segment of care delivery and over the full cycle of care. This is a qualitatively different approach from how CFOs measure costs of care, which is basically an exercise in arbitrarily assigning the hospital’s large number of joint and common costs to DRGs to collect payments from insurers. In contrast, here the shadowers record every touchpoint and resource as they occur. Once recorded, those data points are used to help design plans to create sustained change, in a manner that is both patient-centric and cost effective.

This approach laid out by the Patient Centered Value System is thus truly based on creating a learning organization. My late colleague, MIT professor Donald Schoen, described
a learning organization as one that has the potential to transform itself from within. This is a powerful construct, suggesting that sustained change can only be successful if it is driven by those inside a hospital. Well, for those in a hospital to drive change, they need to learn how things work, from the perspective of those being served. For those doctors and nurses to feel a sense of engagement, they have to be the ones to design the improvement experiments, to measure the results (both in terms of patient care and cost), and to be empowered to adopt the changes that work and discard those that do not.

Many recent articles have documented that pay-for-performance reimbursement schemes do not work to improve the quality and efficiency of care. Of course they don’t work. They are not motivational to clinicians and are not based on how work is actually done in hospitals. In contrast, the Patient Centered Value System is based on the natural curiosity and good intentions of clinicians and is designed to capture what’s really going on in the hospitals. Transformative? We’ll see. But it’s the best I've seen in a long time.

*Mr. Levy is former CEO of Beth Israel Deaconess Medical Center, Boston (2002-11). He can be reached at bulletin@acms.org.*

---

**Thank you for your membership in the Allegheny County Medical Society**

The ACMS Membership Committee appreciates your support. Your membership strengthens the society and helps protect our patients.

Please make your medical society stronger by encouraging your colleagues to become members of the ACMS. For information, call the membership department at (412) 321-5030, ext. 110, or email membership@acms.org.