Danny Sands on Physician-Patient Collaboration

A Conversation with David Harlow at HealthBlawg

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David Harlow: This is David Harlow at HealthBlawg, and I'm speaking today with Danny Sands who is on the clinical faculty at Harvard Medical School and co-founder of the Society for Participatory Medicine. Hi, Danny, thanks for joining us today.

Danny Sands: Hey, David nice to be here.

David Harlow: I'm interested in speaking with you today about your view of physician-patient collaboration, how that relates to your work as a clinician, how that triggered your involvement with the Society for Participatory Medicine and other work that you're doing in the medical informatics space. So, for starters I wonder if you could give us a brief introduction to things that are keeping you up at night or things that are interesting to you these days in this space.

Danny Sands: Well, I think that what's really interesting is the way we're changing the way we pay for healthcare. So, as we move from a fee-for-service payment system to a value-based care system it allows us to think differently about things that we've done for so long that really don't make any sense when you step back and think about them and, you know, several of those areas would be like -- Why do we always deliver care in visits? Why is that the best way to take care of people? and if we really want to manage someone's care and help them stay well and get good outcomes and keep costs down, why can't we do this in different ways? How do we keep engagement in between visits, keep people on track with their care plans? How do we partner with patients better? I mean, I think that too often we think about healthcare as a service that we provide, almost like a car wash where patients are going through the healthcare system -- where the patients are the car going through the car wash and they're getting health sprinkled on them. But in fact, there needs to be a partnership there, a partnership model of healthcare where both the patient and the provider are both collaborating and trying to improve the care of that patient. I think that the changes in payment model are going to allow us to be innovative and think in new ways about how we deliver healthcare.

David Harlow: I think it's almost a truism and I've seen graphics showing the iceberg of healthcare and only a tiny percentage of the iceberg is visible above the surface and that sort of represents the face-to-face time with the healthcare system, the office visit, even the time spent in healthcare facilities. So, how do you see the rest of the time being spent? What do you see as potential new tools for making the best use of the rest of the time, the rest of our lives when we're not in the doctor's office and how can we ensure that there is some engagement aside from those ten minutes a year when we're in for the checkup?

Danny Sands: Well, I think that it's an interesting dynamic when we focus on that ten minutes because we try to cram everything into that ten minutes and then as soon as you're out the door, you being the patient and me being the doctor, pretty much I forget about you and you forget about me. That is, you're not engaged in your health and healthcare anymore and I'm not really

involved. It's not my business to reach out to you and check in on you in any way. So, you know we're trying to fit everything into that -- do everything in that visit. So why can't we leverage technology? And we can be really simple about it. I've been doing this for a long time. Let's suppose you have high blood pressure, rather than say okay, I want to see you back in the office in a month to see how this change in your blood pressure medication worked, rather than that I can say, "You know what, a month from now I want you to take several blood pressure measurements on your own and send them to me by email or by secure messaging through the portal." That's kind of a relatively low tech way of thinking about it, but we can be high tech too. We can actually have automated reaching out to patients and getting them to engage and asking them for their information.

David Harlow: So, I've heard two schools of thought among clinicians. One is that I will be interested in receiving some data from my patients in between visits and the other is I don't really want to be bothered. I have a patient who wants to send me every reading from her Fitbit and it doesn't help me. How do you navigate between these two poles, these two extremes? There's some information that's useful, but there is plenty that people want to share with you that are not.

Danny Sands: Yeah, so Jonathan Wald and I, a couple of years ago now, we chaired a technical expert panel on patient-generated health data, and discussed these among many other issues and I think there's an important distinction to be made first of all between solicited and unsolicited patient-generated health information. So, if I'm asking you to send some blood pressure measurement, you know a month from now that's very different from you saying, "you know, maybe I'll just send Dr. Sands every blood pressure measurement I ever get, and my Fitbit data just for good measure." That's a very different thing. Secondly, it's imperative that if we're moving to area which is not just a few blood pressure measurements but it's maybe more data, it's imperative that we have systems that can filter the signal from the noise and can identify important trends and basically pre-digest them with that information and just present to the doctor what is really relevant and important. And then third, this information needs to work within the confines of my workflow. So, if my workflow is an electronic health record, ideally I want this information working with that workflow. So, physicians spend all of their days, pretty much, in the electronic health record and with patients. And if you're going to introduce a whole other flow of information that's not a part of that, that's going to be a big problem for me. So, it's got to work within my work flow. And of course, you know overarching all these issues is that none of these things, I'm never going to care about any of this stuff, if I'm stuck in a fee-for-service model of healthcare.

David Harlow: Sure, so the move from volume to value is a critical part of all of this and we're starting to see that. I know that CMS has said that they're on track with moving Medicare reimbursement to Medicare providers along the path to value-based payment. It's not entirely clear to me what that means, how they're measuring that success, but that's certainly an important issue. We see that here in Boston on a broader scale perhaps than in other parts of the country, but that is happening. I guess another piece of all this is: aside from the individual patient relationship, in the context of a value-based healthcare system, is the idea of using some of these tools to engage in better population health management. I wonder if you could speak to that.

Danny Sands: I think that implicit in this in value-based care is population health management. How do you manage the care of a panel of patients by keeping cost down and keeping quality up? I think one of the ways you can do that is by predictive modeling and hot spotting and focusing expensive resources on the very, very sickest people, maybe even doing house calls. But I think that when you go beyond that sickest 2% of the patients in a panel then you have to do other things. And one of the things you can do is think about the way you deliver healthcare. Does it always have to be in the office? Does it always have to be visit based? Can we use telemedicine? Can we use frequent light touches in between visits to check in on patients and remind them about their care plan and engage them in a dialog? And to be clear I -- although I wrote about this before I joined them, I am the Chief Medical Officer of a company that's doing just that, called Conversa Health.

David Harlow: Great. So I think what you're saying is that there is a combination of tools, a combination of modalities that can be used to reach patients, to reach populations of patients. Do you see this as just sort of an extended trial and error period that we're in, sort of figuring out what works, what works best? Do you expect to see a combination of tools that might work overall or is this going to be very personalized?

Danny Sands: I think that those are really good questions, David. I think that obviously we're going to have to see which things really work to keep costs down and keep quality up. So, which are going to be the best value in the transition of value-based care. It is a very difficult time right now because in most healthcare organizations we have heterogeneous payment for our patients. So, many of them are on fee-for-service and some of them in value-based care of some sort of another and so it's hard from that perspective. And then of course, we've got to figure out which of these modalities really work best. It may be individual -- it may depend on the patient, as you say. So it may be that some patients respond better to some things than to others and it's going to depend on the patient's condition. I think there's a lot that we're going to learn about this transition to value-based care. I'm not sure I have all the answers now. But I will say one thing and this is an important issue I think. We need to engage patients as partners in their healthcare. I think that certainly what we're seeing is that patients, individuals, are now responsible increasingly for the first dollar payment for healthcare services. So that's sort of a step in the right direction. But I think that until patients feel like they really have skin in the game and they're really partners and they're really trying to achieve the same goals that the doctors are in a value-based care contract I think it's going to be very hard to get a lot done. I think, really, that patients need to be partners. We need to have total alignment of goals between the patient and the practice.

David Harlow: Sure. I think that makes sense. We've been talking a fair amount about patient engagement and I guess just to flip the equation for a moment, how do we work on physician engagement? You've identified one problem on that front with dealing with a multiplicity of patients, some of whom were enrolled in value-based plans and some of whom are not. So, the availability of resources might differ from patient to patient. But in an overarching way -- or maybe it's impossible to say that -- how can we better engage physicians in this sort of dialog?

Danny Sands: Yeah. I think that physician engagement or maybe put slightly differently having physicians view healthcare as a collaboration with the patient is really important and that's a concept that you know I've called participatory medicine. So, I think that one aspect of that is getting patients to buy into that model of collaboration but the other is how do get the providers to buy into that. And yeah, payment model is an issue I think but I think that attitude is really a bigger issue and you know changing attitudes is challenging. Changing culture is challenging. I've been speaking to groups of physicians and writing for physicians for very, very long time and it is often challenging to get people to change their entrenched attitudes. One of the goals of the organization that you and I are both members of, the Society for Participatory Medicine, is to do education. Like this is one of our huge initiatives right now is to develop continuing medical education for physicians, to help them understand the benefits and actually how you practice in participatory way. And you know, I'm hoping that we're going to be successful. We're also partnering with physician organizations, and really just trying to change the culture of healthcare. I'm hoping we'll be successful. I don't really think we had that kind of concerted effort before in American medicine. So, we will see what happens. But I'm pretty optimistic that as we develop these educational modules we turn more people on to this. We will change the hearts and minds of physicians.

David Harlow: Great. Do you think that the shift to value-based payment is a necessary part of all of that, of having the physician community being open to this sort of communication, or do you see that as independent but overlapping?

Danny Sands: I think it is a helpful step in the right direction but I'll say that I've been talking about this for a very long time, before there was such a thing as value-based care, and I think there are huge benefits, even to fee-for-service providers from thinking differently about healthcare. It's a harder sell because I think that physicians in total fee-for-service are just kind of heads down, trying to see more patients in less time, and it's very hard for them to lift their heads up and see how ridiculous it all is. But I think the benefits to a fee-for-service provider are first of all joy in practice which is very important and as you know is the--is now talked about is the fourth thing in the Triple Aim or the Quadruple Aim which is joy in practice. So, I think there's that. I think there is also the issue that we physicians want to help people. We want to spend our time doing things that are worthwhile and often we're seeing patients in the office who don't need to be seen. And that's kind of that not utilizing our best skills. What we'd like to do is take care of patients who really need to be seen in the office, who really need that time with us. And in fact, from a fee-for-service perspective, if I'm taking care of a sicker patient, or more complicated patient let's say, I can bill at a higher level for that. So I think that's a benefit, that I can use my schedule better if I find other ways of delivering care, whether it's connecting with patients through secure messaging or through telemedicine or through frequent light touches in between visits, what have you.

David Harlow: Have you seen in your own practice a greater openness to that approach among patients? Do you hear about that from your medical colleagues, or is there resistance on the part of patients? Do people think that this is somehow a shortchanging of their experience?

Danny Sands: That's an important question. Not every patient wants to be an e-patient. Not every patient wants to delve in to participatory medicine. And I believe that patients' willingness

to engage in that way is a function of a number of things. One is culture, you know, what part of the world are they from? How did they grow up? Another is socio-economic status. Another is general literacy, health literacy and then there is sort of this disease state issue which is that if someone is stricken with a serious disease sometimes that's the trigger that they need to really become engaged as an e-patient. In addition, I think there are other sorts of cultural issues which are that some people love to come in to the office. I have, especially, elderly patients, they love to come in and spend 15 minutes with their doctor. It's a high point of their months. But you know not all patients are like that, clearly. My point is that we can't foist this on everybody. We can't make everybody be participatory in this way, but that's okay.

David Harlow: Well, it sounds like there's quite a challenging road ahead both among patients and among some physicians but it sounds like you're working on a number of fronts to educate and enable both patients and physicians.

Danny Sands: Yes, exactly.

David Harlow: Well, thank you very much. I've been speaking with Danny Sands on the clinical faculty of Harvard Medical School and co-founder of the Society for Participatory Medicine. Thank you, Danny, for joining us here on HealthBlawg.

Danny Sands: My pleasure.