Values Can Spread With Same Patterns as Infectious Diseases
Why Strategy Matters Now
Michael E. Porter, Ph.D., and Thomas H. Lee, M.D.

Until recently, most health care organizations could get by without a real strategy, as most businesses understand that term. They didn’t need to worry about how to be different or make painful decisions about what not to do. As long as patients came in the door, they did fine, since fee-for-service contracts covered their costs and a little more.

Success came from operational effectiveness: working hard, employing low-cost methods to provide goods at low prices. To be sure, even low-cost methods can make sense. But they can also lead to the status quo, the easy way out.

What matters is not just being different but differentiating through effective ways to compete in a more competitive world. The focus is on how to be different and on the competitive advantage that is hard to take away.

But that era is ending. Good operational performance remains important, but it is no longer sufficient. The focus is now on being different and creating value that is hard to take away. The former is easier to copy, whereas the latter is much harder.

Basic economics and the market forces that drive them help determine what it is that makes a hospital or health system different from the competition. But the more important question is why. Why will patients buy from you rather than from the competition? Why will employers use you rather than other practices? Why will patients and payers trust you to be their partner in health care?

In a world where business is increasingly about experience, providers must move beyond low-cost service delivery. They must become destination identities, places where patients, employers, and payers want to be. This requires thinking more deeply about the market, the competition, and the ways in which you can add value to the lives of patients, employers, and payers.

The time has come for health care organizations to rethink the meaning of strategy. Strategy is not just about the how; it is about the why as well. And the why is what will determine the long-term success of a health care organization.
What Is Strategy? And What Should It Be?

- Strategy is not the same as Operational Effectiveness

- Strategy boils down to two questions:
  - What are you trying to do for whom?
  - How are you going to be different?
    - *If you are trying to do the same thing for everyone, and do it the same way as everyone else, you will be competing on price alone.*

- Our take:
  - In health care, the overarching goal should be improving *value* for *patients.*
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
Our Idealistic Aspirations and Our Business Imperatives Are Converging

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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.
Things Have Changed Since 2013

- 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 reduce their suffering; 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...
Sixteen Months Later

From New York Times (Page 1, Feb 18, 2015)

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 blurtng 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 Do Patients Really Value?

All Patients
15.7%
Recommendation Failure Rate

Low: Confidence in Provider
74.6% Fail to Recommend

High: Confidence in Provider
1.9% Fail to Recommend

Low: Worked Together
90% Fail to Recommend

High: Worked Together
28% Fail to Recommend

Low: Worked Together
11% Fail to Recommend

High: Worked Together
1% Fail to Recommend

Low: Courtesy
92.8% Fail

High: Courtesy
78.2% Fail

Low: Listens Carefully
45.7% Fail

High: Listens Carefully
24.7% Fail

Low: Listens Carefully
22.3% Fail

High: Listens Carefully
6.3% Fail

Low: Concern for Worries
5.6% Fail

High: Concern for Worries
0.6% Fail

8% of patients
72% of patients

11.4% of patients
2.5% of patients

0.8% of patients
3.4% of patients

2.4% of patients
5.9% of patients

3% of patients
68.4% of patients

High Risk
Low Risk
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

Max Weber’s Four Models for Social Action

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.
Prospect Theory and Use of Financial Incentives

Prospect Theory, Kahneman and Tversky, *Econometria* 1979
Transparency: Screen Shot From University of Utah Find-a-Doctor Site

<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>
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<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>
</table>

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
NURTURE a culture of continuous innovation

HOW DO WE Transform the system?

COMMUNICATE the need for change
DEVELOP your teams
ESTABLISH metrics
ENGAGE physicians, staff, and trainees
EMPOWER front-lines

NUTURE a culture of continuous innovation

Patient Satisfaction

PROVIDERS AT 99TH %ILE OR ABOVE

<table>
<thead>
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<th>Year</th>
<th>% of total providers</th>
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<tbody>
<tr>
<td>2009</td>
<td>1%</td>
</tr>
<tr>
<td>2010</td>
<td>3%</td>
</tr>
<tr>
<td>2011</td>
<td>13%</td>
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<tr>
<td>2012</td>
<td>17%</td>
</tr>
<tr>
<td>2013</td>
<td>25%</td>
</tr>
<tr>
<td>2014</td>
<td>26%</td>
</tr>
</tbody>
</table>

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

© Vivian S. Lee, 2014
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
Conclusions

- Empathic care is not charity – it is strategy
- The goal of every health care organization today is to prepare for a marketplace driven by real competition:
  - *Meet patients’ needs – reliably*
  - *Do so efficiently*
- We know how to do it.
  - *Create shared vision*
  - *Measure*
  - *Create and support teams*
  - *Use financial and non-financial incentives to drive performance*