ECRI Complex Patients Conference
Session 6: Care Outside the Hospital: Maintaining Quality and Safety

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1. *Their complexity...or is it ours*

   Needlessly, dangerously, wastefully, complex systems

2. **Continuity** of care

   “Continuity relationships in all policies” approach

3. Caring *relationships* – crossing boundaries

   Not just length, but depth

4. **Diagnosis** challenges

   Challenges, pitfalls, IT solutions

5. **Conservative** Dx and Rx

   Principles and Preconditions

6. Collateral damage from **War on Drugs**

   Victims of U.S.’s longest and failed drug war

7. Building a *simpler, accessible, efficient, caring* system

   De-complexitizing: single payer quality
1. *Their* complexity...or is it *ours*
Rushed closing of Long Island bridge takes a human toll

By Kevin Cullen | GLOBE COLUMNIST OCTOBER 12, 2014
It was about 4:30 on Wednesday afternoon when the five nurses and six aides working at Andrew House on Long Island got their first inkling that their world, and the world of their patients, some of the most vulnerable people in the city, was about to turn upside down. They were told they had to drive off the island, but would not be allowed to drive back on. No one could drive back on. The bridge linking Long Island to Moon Island and the mainland was suddenly, inexplicably, irreversibly deemed unsafe.
What the heck is that supposed to mean? They could drive off but no one could drive on? They had 60 patients in detox. Who would look after their patients? Who was going to relieve them?

But that was just it: No one was going to relieve them. No one was going to look after their patients, many of whom spend every day with the singular mission of keeping out of reach of a needle. Merri Cunniff, Tracey Briggs, other nurses and aides went into mission mode….needlessly hectic, chaotic hours, while higher-ups gave them the runaround and cops screamed at them to evacuate,… as the dark and the cold set in like a smothering fog.
The idea that suddenly, late in the afternoon on a Wednesday in October 2014, the bridge was too unsafe to use and everybody had to run for their lives like it was the London Blitz makes no sense to anyone — I mean everyone — who works on that island, home to as many as 600 people who are homeless, in recovery, or in transition from prison or some other place where none of us want to be
t

(66) was seen in the BRIGHAM EMERGENCY DEPARTMENT on

Complaint: EXPOSURE
Diagnosis: wet from rain [Uncoded]
Disposition: HOME - ROUTINE
Physician: PATEL, RONAK B, M.D.

ED Provider Note can be seen immediately following this visit. Open LMR and select the patient.

Electronic documentation and other paper-based ED documents can be accessed through scanned documents. With the patient specified you as their Primary Care Physician. If this patient is not yours, please reply to this message indicating the name of the patient’s current provider.

If you are a PCHI or Partners physician and want further information about this patient, please go to the Partners Intranet.

Information in this e-mail is intended only for the person to whom it is addressed. If you believe this e-mail was sent to you in error but does not contain patient information, you can forward it to partners.care+partners.org/complianceline .
Your patient (/66) was seen in the Emergency Department.

Chief Complaint: EXPOSURE
Preliminary Diagnosis: wet from rain [Uncoded]
Disposition: HOME - ROUTINE
ED Physician: PATEL, RONAK B, M.D.

The electronic ED Provider Note can be seen immediately following this email.

The ED RN documentation and other paper-based ED documents can be accessed as well.

This patient specified you as their Primary Care Physician. If this patient is not yours, please reply to this message indicating...
48 y.o. female who is wheelchair bound, morbidly obese, and homeless. She cannot go to local shelters because she is not independent with ADL's (Activities of Daily Living), i.e. showering, toileting, transferring. Patient appears to need nursing home level of care however she recently left xxx Nursing Home against medical advice. I asked patient is she would return to a nursing home if there was a bed available in a different facility, not xxxx. Patient initially said she would consider it but then later said "it's like a death sentence" to go to a nursing home.
Pt. presents to ED triage for the 4th time in the past week and then subsequently refusing treatment. There is no evidence of psychiatric illness such as major depression, (hypo-)mania, psychosis, or delirium though psychopathology cannot be ruled out on this limited assessment. Exam notable for minimal elaboration, regressed behavior, and lack of SI/HI/AVH.

Patient is a 48 y.o. female who returned to BWH E.D. this evening, brought in by Boston EMS, who found her in wheelchair at Brigham Circle in the rain shivering. Patient was evaluated for question of hypothermia and medically cleared for discharge.

Patient is homeless since checking self out of xxx Nursing Home earlier this Fall. Patient has tried staying at Boston area shelters however they are unable to adequately meet her care needs due to limited staffing and lack of CNA’s.
ED Psychiatry Note

Per ED eval, she has not been eating or drinking regularly. She appears amenable to medical hospitalization but changes her mind about this several times during the interview. When asked about the risks of leaving the hospital, she says "they said hypothermia or pneumonia or whatever." She is unable to appreciate the consequences of these illnesses and specifically how they may apply to her. Additionally, she cannot consistently state her preference. Of note, the patient cannot go to local shelters because of her medical needs. She left xxxl nursing AMA though she does not appear to understand the risks involved in decision to leave xxxl without a plan for how her needs would be met. Historical narrative limited due to terse responses and limited engagement.
ED Summary

In summary Pt is a 48 y/o SBW who self discharged herself from a long term care facility over the summer at which time she was effectively wheelchair bound. Since that time she has been in the shelter system however appears to have failed that given that xxx Shelter today indicates to SW they have barred her from their facility after much work to help and support her (offered help to get into a variety of programs), due to her being inappropriate for that level of living. Meanwhile SW also spoke with other local shelters who all feel they are unable to manage her due to being wheelchair bound and unable to independently manage ADLs. At this time also police are unable to help facilitate transportation for her as she would have to transfer independently in to their cars, and she cannot do that. Fallon transportation needs a specific disposition and location, which we do not have. SW met with Pt outside and informed her that there is no destination that we can find for her. She states she is aware of the nighttime drop in center. SW provided the recommendation for her to work with her PCP based supports, such as Laura Shae, to come up with appropriate options.

Patient receives SSI and has Mass Health.
Success Story (mostly)

• 48 y.o. male w/
  – R arm amputation
  – Stroke w/ L leg paralysis
  – Substance use/abuse/”drug seeking”
  – Self mutilation, MRSA arm stump/bone infections
<table>
<thead>
<tr>
<th>Problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>self-mutilation</td>
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<tr>
<td>Hypertension</td>
</tr>
<tr>
<td>Personality disorder</td>
</tr>
<tr>
<td>Alcohol abuse</td>
</tr>
<tr>
<td>Drug abuse - crack cocaine, narcotic</td>
</tr>
<tr>
<td>H/O Cerebrovascular accident - left paraplegia but good left arm fxn</td>
</tr>
<tr>
<td>Methicillin resistant Staphylococcus aureus infection</td>
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<tr>
<td>Chronic pain</td>
</tr>
<tr>
<td>Asthma</td>
</tr>
<tr>
<td>Factitious disorder</td>
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<tr>
<td>Somatoform disorder</td>
</tr>
<tr>
<td>Malingering</td>
</tr>
<tr>
<td>Osteomyelitis</td>
</tr>
<tr>
<td>H/O Myocardial infarction</td>
</tr>
</tbody>
</table>
186 Admissions, ED visits at 6 different Hospitals 2010-2012

Zero in next 15 months
I want to tell you all about something unexpected that happened to me during medical school: I became afraid. Afraid of taking risks.

The good fortune of being a Harvard medical student should have liberated me to pursue my true passions of primary care and community health. Instead, I abandoned these interests for a more traditional, prestigious career path. Deviating from conventional views of success at this point wasn't worth jeopardizing my future.

The question I'll pose today is a simple one: if we, graduates of Harvard Medical School -- the overachievers among overachievers -- cannot find the courage to take risks for ourselves, our patients, our loved ones, how can we reasonably expect anyone else to?
Your patient Mr. XXX is been advised from several employees that he needs to change his insurance since last month. We can no longer take care of him at our hospital. Network Health and Fallon is not one of the insurance that Brigham has a contract with it and I know you are fully aware it and your staff.

Today I spoke to Mr. XXX so I can help him to change plan and decline that he is capable to change it himself. There is two option for him to pick from Masshealth the NHP or PCC plan.

Thanks,
2. Continuity of care

- One last patient
- 54 F major depression, knee arthritis, running... → ran out of unemployment benefits → homeless
Dr. Schiff, this is my final note to you. I want you to know that I have appreciated your...
Dr. Schiff, this is my final note to you as my physician. I want you to know that I have appreciated your services. Dr. Schiff I can't afford the services of Blue Cross/ Blue Shield. I was informed by the Commonwealth of Mass that I am entitled to Health Net.

This is a service that is based on my income and is located through the Whittier Street Health Center. I am informed that I must used their doctor's and the community center.

I want you to know that I'm going to miss your professionalism. Dr. Schiff you are the type of physician that a person in today society needs. By this I mean, you take the time with your patients and you demonstrate the important of care that is needed.

Dr. Schiff, I want you to know that, through all the hurt and pain that I have endured, only you was able to help me understand that Depression is a Sickness that is curable in time.

In closing with my spirituality and you as my primary care taker I will win my battle it's just going to take a little time.
<table>
<thead>
<tr>
<th>Key: gold = best country performance and red = worst country performance</th>
<th>AUS</th>
<th>CAN</th>
<th>GER</th>
<th>NZ</th>
<th>UK</th>
<th>US</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CONTINUITY OF CARE</strong> <em>(higher rates are better)</em></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have regular doctor</td>
<td>92</td>
<td>92</td>
<td>97</td>
<td>94</td>
<td>96</td>
<td>84</td>
</tr>
<tr>
<td><strong>With same doctor 5 years or more</strong> <em>(among those with a regular doctor)</em></td>
<td>61</td>
<td>65</td>
<td>78</td>
<td>61</td>
<td>69</td>
<td>50</td>
</tr>
<tr>
<td><strong>ACCESS PROBLEMS</strong> <em>(lower rates are better)</em></td>
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</tr>
<tr>
<td>Unmet need due to cost in past 2 years <em>(prescription, doctor visit when sick, or test or follow-up recommended by a doctor)</em></td>
<td>34</td>
<td>26</td>
<td>28</td>
<td>38</td>
<td>13</td>
<td>51</td>
</tr>
<tr>
<td>Very difficult to get care on nights, weekends, holidays without going to the ER <em>(among those who sought care)</em></td>
<td>36</td>
<td>29</td>
<td>11</td>
<td>13</td>
<td>22</td>
<td>39</td>
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</tbody>
</table>

Issues In Health Reform: How Changes In Eligibility May Move Millions Back And Forth Between Medicaid And Insurance Exchanges

ABSTRACT The Affordable Care Act will extend health insurance coverage by both expanding Medicaid eligibility and offering premium subsidies for the purchase of private health insurance through state health insurance exchanges. But by definition, eligibility for these programs is sensitive to income and can change over time with fluctuating income and changes in family composition. The law specifies no minimum enrollment period, and subsidy levels will also change as income rises and falls. Using national survey data, we estimate that within six months, more than 35 percent of all adults with family incomes below 200 percent of the federal poverty level will experience a shift in eligibility from Medicaid to an insurance exchange, or the reverse; within a year, 50 percent, or 28 million, will. To minimize the effect on continuity and quality of care, states and the federal government should adopt strategies to reduce the frequency of coverage transitions and to mitigate the disruptions caused by those transitions. Options include establishing a minimum guaranteed eligibility period and “dually certifying” some plans to serve both Medicaid and exchange enrollees.
Income Changes Over Time Among Adults Ages 19–60 With Incomes Initially Under 133 Percent Of The Federal Poverty Level

WHAT HAPPENS TO THOSE WHO START IN THE EXCHANGE?

SOURCE Authors’ analysis of data from the 2004–08 Survey of Income and Program Participation. NOTES N = 12,753. The 133 percent federal poverty level threshold includes an additional 5 percent income disregard, according to the provisions of Medicaid eligibility in the 2010 health reform legislation. In each time frame, only people with monthly income reported for the full survey to that point are included; people who dropped out of the survey at any prior point are excluded.

Sommers Health Affairs 2011
WHAT HAPPENS TO THOSE WHO START OUT OF EXCHANGE?

SOURCE Authors' analysis of data from the 2004–08 Survey of Income and Program Participation. NOTES N = 6,495. The 133 percent federal poverty level threshold includes an additional 5 percent income disregard, according to the provisions of Medicaid eligibility in the 2010 health reform legislation. In each time frame, only people with monthly income reported for the full survey to that point are included; people who dropped out of the survey at any prior point are excluded.
BUILDING HEALTHY COMMUNITIES

By Jason Corburn, Shasa Curl, and Gabino Arredondo

A Health-In-All-Policies Approach Addresses Many Of Richmond, California’s Place-Based Hazards, Stressors

ABSTRACT Poor and minority residents of Richmond, California, have faced a host of place-based hazards and stressors such as pollution, gun violence, and a dearth of economic opportunities, all of which have likely contributed to their poor health outcomes. In this article we describe the city’s efforts to reverse its fortunes by embracing a health-in-all-policies strategy for community development. Starting in 2007, the city organized
How about a “Continuity-in-all policies” approach, litmus test?

- Narrow Networks?
- “Preferred” Providers?
- Managed care – employer plan switched
- Medicaid managed care?
- Differential copays, out of network?
- Employment based private insurance?
- Lose insurance when lose job?
- Mergers, acquisitions?
- A1C P4P?
- Staff/MD burnout, turnover?
Small Primary Care Physician Practices Have Low Rates of Preventable Hospital Admissions

Synopsis

It is often assumed that “bigger is better”–even in the world of health care, where larger physician practices are thought to provide better care. This study, however, turns that notion on its head: it finds that practices with one or two physicians had 33 percent fewer preventable hospital admissions than practices with 10 to 19 physicians, and practices with three to nine physicians had 27 percent fewer admissions.

The Issue

Driven by the Affordable Care Act and private insurance
3. Caring relationships
   Crossing boundaries
It is 5 PM on Friday afternoon. After 2 hours on the telephone trying (and failing) to get her insurance plan to pay for her medication refill, I reached into my pocket and handed the patient $30 so she could fill the prescription. It seemed both kinder and more honest than sending her away saying, “I’m sorry I can’t help you.” While I hardly expected a commendation for such a simple act of kindness, I was completely surprised to find myself being reprimanded for my “unprofessional boundary-crossing behavior” after the resident I was supervising shared this incident with the clinic directors. This allegation of an ethics violation was not only personally painful; it also raised important, controversial, and timely questions about appropriate professional roles.

After more than three decades as a general internist at a Midwest public hospital, I joined the staff of an academic medical center in Boston. While the public hospitals’ patients were predominantly poor and uninsured, the academic center had both a different patient-mix and, to my surprise, a different culture and different norms related to “professional-patient boundaries.” Actions my public hospital colleagues and I regularly took to help needy patients were questioned as inappropriate and unprofessional. Indeed, informal polls I recently conducted at conferences relationships? And will such bounded thinking serve to rationalize abdication of our professional and personal responsibilities to humanely respond to patient suffering and underlying injustices?

While I had rarely paid for a patient’s medication as I did on that Friday afternoon (medications had been free at the public hospital clinic), in this situation it seemed reasonable and appropriate. Various ethics and conflict of interest rules prohibiting physicians from having “financial relationships” with patients may be appropriate when it comes to physicians taking or soliciting money from patients. But what about the propriety of giving money to a needy patient in this particular situation? While other alternatives such as using a special fund might be preferable, when I found that no such fund existed at my hospital (and the drug insurance plan denied coverage due to a technical glitch in the patient’s enrollment), was it wrong to personally help a patient in such a moment of need?

Everything we do in medicine has risks. Whether prescribing a medication or performing surgery, we, in consultation with the patient and family, must weigh potential benefits and risks. When considering reaching out to help patients in need, possible adverse effects should be weighed against the benefit in that particular case.
When Healers Get Too Friendly

By ABIGAIL ZUGER, M.D.

It takes only a moment to step over the line, especially when no one knows exactly where the line is. In my case, it started with a visit from my old friend the activist.

The activist became my patient back in the mid-1990s, when H.I.V. was slowly morphing into a treatable disease. He was young then, with a mop of dark curls — excitable, suspicious and frantic about his health. He was convinced the new drugs were pure synthetic poison, a profit-seeking malevolent conspiracy to enrich the pharmaceutical companies and enrich itself.
When Doctors Give Patients Money

We all hear about “health care costs,” a lumbering behemoth that dominates the news. But it is the smaller amounts, literally the pocket money, that often has the strongest effect on the concrete currency of health. Sometimes doctors find themselves in the position of offering their patients a few dollars to help with a co-pay...
Recently a few of my colleagues were sitting together and one asked if any of us had ever given money to a patient. There was an awkward pause, and then the stories starting coming out — a few dollars for a co-pay, or to help a frail patient take a cab instead of a bus; a bag of food or an extra meal. “How could I not,” one doctor said, “when my patient’s immediate need could be solved by the small change in my coat pocket?”
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<thead>
<tr>
<th></th>
<th>BWH General</th>
<th>BWH Psych Neuro</th>
<th>Cambridge</th>
<th>Tufts</th>
<th>Montfr</th>
<th>BMC</th>
<th>Cook County</th>
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<tbody>
<tr>
<td>Ride Home</td>
<td>17%</td>
<td>25%</td>
<td>44%</td>
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<td>$$ for Med</td>
<td>21%</td>
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<td>62%</td>
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<td>Help Find Job</td>
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<td>33%</td>
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<tr>
<td>Temp Job</td>
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<td>0%</td>
<td>6%</td>
<td>0%</td>
<td>8%</td>
<td>0%</td>
<td>12%</td>
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<td></td>
<td>BWH General</td>
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<td>Ride Home</td>
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<td>88%</td>
<td>73%</td>
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<tr>
<td>$$ for Med</td>
<td>50%</td>
<td>75%</td>
<td>75%</td>
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<td>72%</td>
<td>77%</td>
<td>89%</td>
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<td>Help Find Job</td>
<td>42%</td>
<td>54%</td>
<td>44%</td>
<td>77%</td>
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<td>59%</td>
<td>96%</td>
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<tr>
<td>Temp Job</td>
<td>35%</td>
<td>33%</td>
<td>25%</td>
<td>40%</td>
<td>71%</td>
<td>41%</td>
<td>79%</td>
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</table>
Is there a label/name for what we are talking about?

- Personal relationships w/ patients
- Enhanced caring relationships
- Caring for the “whole person”
- Going the extra mile
- Patient- centered care (“extreme”; “concierge”)
- Extending helping-hand to those most in need
- Crossing boundaries where compelling reasons
- Solidarity beyond charity
- Normal human empathy and compassion
What ‘Patient-Centered’ Should Mean: Confessions Of An Extremist

A seasoned clinician and expert fears the loss of his humanity if he should become a patient.

by Donald M. Berwick

ABSTRACT: “Patient-centeredness” is a dimension of health care quality in its own right, not just because of its connection with other desired aims, like safety and effectiveness. Its proper incorporation into new health care designs will involve some radical, unfamiliar, and disruptive shifts in control and power, out of the hands of those who give care and into the hands of those who receive it. Such a consumerist view of the quality of care, itself, has important differences from the more classical, professionally dominated definitions of “quality.” New designs, like the so-called medical home, should incorporate that change. [Health Affairs 28, no. 4 (2009): w555–w565 (published online 19 May 2009; 10.1377/hlthaff.28.4.w555)]
“You have to meet people halfway”

-Linda Clay Jen Center Orange Team Receptionist Senior Practice Assistant
4. Diagnosis challenges
<table>
<thead>
<tr>
<th>Box 1 Reliable diagnosis: pitfalls and challenges</th>
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<tbody>
<tr>
<td><strong>Challenging disease presentation</strong></td>
</tr>
<tr>
<td>Atypical presentation</td>
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<tr>
<td>Non-specific symptoms and signs</td>
</tr>
<tr>
<td>Unfamiliar/outside specialty</td>
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<tr>
<td>Findings masking/mimicking another diagnosis</td>
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<tr>
<td>Red herring misleading findings</td>
</tr>
<tr>
<td>Rapidly progressive course</td>
</tr>
<tr>
<td>Slowly evolving blunting onset perception</td>
</tr>
<tr>
<td>Deceptively benign course</td>
</tr>
<tr>
<td><strong>Patient factors</strong></td>
</tr>
<tr>
<td>Language/communication barriers</td>
</tr>
<tr>
<td>Signal:noise—patients with multiple other symptoms of inflammation</td>
</tr>
<tr>
<td>Failure to share data (to be forthcoming with symptoms)</td>
</tr>
<tr>
<td>Failure to follow-up</td>
</tr>
<tr>
<td><strong>Testing challenges</strong></td>
</tr>
<tr>
<td>Test not available due geography, access, cost</td>
</tr>
<tr>
<td>Logistical issues in scheduling, performing</td>
</tr>
<tr>
<td>False positive/negative test limitations</td>
</tr>
<tr>
<td>Performance/interpretation failures</td>
</tr>
<tr>
<td>Equivocal results/interpretation</td>
</tr>
<tr>
<td>Test follow-up issues (eg, tracking pending results)</td>
</tr>
</tbody>
</table>

| Stressors                                      |
| Time constraints for clinicians and patients   |
| Discontinuities of care                        |
| Fragmentation of care                          |
| Memory reliance/challenges                     |

| Broader challenges                             |
| Recognition of acuity/severity                 |
| Diagnosis of complications                     |
| Recognition of failure to respond to therapy   |
| Diagnosis of underlying etiologic cause        |
| Recognising misdiagnosis occurrence           |

Schiff  BMJ Qual Safety Health Care 2012
Diagnosis Challenges/Pitfalls/Distractions

• Sorting out signal from noise
  – Chronically ill, mentally ill
  – Pain

• Biases: two tailed errors
  – Nonspecific/”crazy” symptoms = Psych
  – “Ruling out” all organic etiologies 1st

• Failure to recognize
  – New diagnoses
  – Complications of chronic disease
  – Medication adverse reactions/effects
5. Conservative Dx and Rx
Conservative Diagnosis
Selected Principles

• Continuity relationships-knowing the patient
• Time
• Follow-up : new science, safety Net for uncertainty
• Diagnosing what matters
• Appreciating, respecting limits of tests
• Trust: avoiding financial conflicts
• Access, help, consultation
Judicious prescribing is a prerequisite for safe and appropriate medication use. Based on evidence and lessons from recent studies demonstrating problems with widely prescribed medications, we offer a series of principles as a prescription for more cautious and conservative prescribing. These principles urge clinicians to (1) think beyond drugs (consider nondrug therapy, treatable underlying causes, and prevention); (2) practice more strategic prescribing (defer nonurgent drug treatment; avoid unwarranted drug switching; be circumspect about unproven drug uses; and start treatment with only 1 new drug at a time); (3) maintain heightened vigilance regarding adverse effects (suspect drug reactions; be aware of withdrawal syndromes; and educate patients to anticipate reactions); (4) exercise caution and skepticism regarding new drugs (seek out unbiased information; wait until drugs have sufficient time on the market; be skeptical about surrogate rather than true clinical outcomes; avoid stretching indications; avoid seduction by elegant molecular pharmacology; beware of selective drug trial reporting); (5) work with patients for a shared agenda (do not automatically accede to drug requests; consider nonadherence before adding drugs to regimen; avoid restarting previously unsuccessful drug treatment; discontinue treatment with unneeded medications; and respect patients’ reservations about drugs); and (6) consider long-term, broader impacts (weigh long-term outcomes, and recognize that improved systems may outweigh marginal benefits of new drugs).

Published online June 13, 2011.
Principles of Conservative Rx
6 Domains

A. Think beyond drugs
B. Practice more strategic prescribing
C. Heightened vigilance adverse effects
D. Be cautious/skeptical w/ new drugs
E. Work w/ patients for shared agenda
F. Consider long-term, broader impacts

Schiff & Galanter JAMA 2009
Schiff et al Arch Intern Med 2011
# 32 Years Ratings New Drug “Advances”

by Prescrire (1981-2012)

<table>
<thead>
<tr>
<th>Rating</th>
<th>#</th>
<th>%</th>
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<tbody>
<tr>
<td>Bravo</td>
<td>9</td>
<td>0.2%</td>
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<tr>
<td>A real advance</td>
<td>83</td>
<td>2.2%</td>
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<tr>
<td>Offers an advantage</td>
<td>267</td>
<td>7.0%</td>
</tr>
<tr>
<td>Possibly helpful</td>
<td>633</td>
<td>16.7%</td>
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<tr>
<td>Nothing new</td>
<td>2,403</td>
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<tr>
<td>Not acceptable</td>
<td>230</td>
<td>6.1%</td>
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<td>4.5%</td>
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<td><strong>Total</strong></td>
<td><strong>3,796</strong></td>
<td><strong>100</strong></td>
</tr>
<tr>
<td>Variable</td>
<td>Adverse Events</td>
<td>Event Rate</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>----------------</td>
<td>------------</td>
</tr>
<tr>
<td>Total adverse drug events</td>
<td>181</td>
<td>27.4</td>
</tr>
<tr>
<td>Severity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fatal or life-threatening</td>
<td>0</td>
<td>—</td>
</tr>
<tr>
<td>Serious</td>
<td>24 (13)</td>
<td>3.6</td>
</tr>
<tr>
<td>Significant</td>
<td>157 (87)</td>
<td>23.8</td>
</tr>
<tr>
<td>Preventability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ameliorable</td>
<td>51 (28)</td>
<td>7.7</td>
</tr>
<tr>
<td>Preventable</td>
<td>20 (11)</td>
<td>3.0</td>
</tr>
<tr>
<td>Not preventable</td>
<td>110 (61)</td>
<td>16.6</td>
</tr>
<tr>
<td>Serious and preventable</td>
<td>11 (6)</td>
<td>1.7</td>
</tr>
</tbody>
</table>

*Table 3. Rates of Adverse Drug Events.*

Gandhi NEJM 2003
Clinical—Alimentary Tract

Proton-Pump Inhibitor Therapy Induces Acid-Related Symptoms in Healthy Volunteers After Withdrawal of Therapy

TINA REIMER,* BO SØNDERGAARD,* LINDA HILSTED,† and PETER BYTZER*

Department of Medical Gastroenterology, Køge University Hospital, Copenhagen University, and the †Department of Clinical Biochemistry, Rigshospitalet, Copenhagen, Denmark

20 to 33 defined daily doses per 1,000 persons per day. In 2006, approximately 7% of the Danish population was treated with a PPI. Although the incidence of new treatments with PPIs remains stable, the prevalence of long-term treatment is rising. The reasons for the increasing long-term use are not fully understood.

Treatment with PPIs is initiated mainly by primary care physicians, usually as empirical therapy for dyspeptic...
Rebound effect of withdrawing PPI from healthy volunteers
6. Collateral damage from War on Drugs

Complex chronically ill patients have pain, controlled substance issues, stigma, labeling (presumed drug seeking)

Racial Injustice: AA incarceration rates 13X Whites prescribing hassles; furthers care shunning locked into pharmacies lacking adequate supply kicked out of housing lack drug treatment services, access
7. De-complexitizing:
Building a simpler, more accessible, efficient, caring system
Basic Quality Theory

Simplify
- Blame-free culture

Standardize
- Empower workers
- Data, feedback driven

Tame variation
- Continuous process improvement

Remove barriers
- Prevention, anticipation future-oriented

Just-in-time

Pull systems
- Benchmark

Leadership
- Cooperation
Single payer most consistent with quality theory principles & design

- And current system conflicts with best ways to achieve high quality

- Modern Quality Theory/Principles
  - Simplification
  - Standardization
  - Removing barriers
  - Systems thinking rather than blame

Schiff, JAMA 1994
The patient, a powerfully built middle-aged restaurant worker, had awakened one morning with a tight pain in his shoulders that traveled down his right arm. At work, he could barely shrug his shoulders or turn his head. “My arm is paralyzed,” he told his supervisor. The pain persisted, and he noticed a conspicuous weakness in his left arm. He was rushed to the emergency room, where he was examined by a team of specialists.

By PAULINE W. CHEN, M.D.
The Root of Physician Burnout

AUG 27 2012, 9:47 AM ET 41

Incentivizing with money is a self-fulfilling prophecy of cynicism. We must promote compassion, courage, and wisdom among our physicians before we “make a sordid business of this high and sacred calling.”
Burnout of PCPS

Estimates recruitment and replacement costs for individual PCPs -- $470,000 @

Inflation adjusted from
Buchbinder AmJ Managed Care 1999
Off the Hamster Wheel? Qualitative Evaluation of a Payment-Linked Patient-Centered Medical Home (PCMH) Pilot

Asaf Bitton,1,2 Gregory R. Schwartz,1,2 Elizabeth E. Stewart,3 Daniel E. Henderson,4 Carol A. Keohane,1 David W. Bates,1,2,5 and Gordon D. Schiff1,2

1Brigham and Women's Hospital; 2Harvard Medical School; 3American Academy of Family Physicians, National Research Network; 4Columbia University Medical Center; 5Harvard School of Public Health

Context: Many primary care practices are moving toward the patient-centered medical home (PCMH) model and increasingly are offering payment incentives linked to PCMH elements. Developing and evaluating a network of several PCMH pilot projects is an important strategy to promote widespread implementation of PCMH concepts. The aim of this qualitative study was to elicit and probe the perspectives of selected primary care providers about their experiences with the PCMH pilot program.
“They are studying this for economic reasons but I am doing it for other reasons. Though I am not making my bonuses or any more money, I am happier.”

“I have heard about reimbursement changes but don't really know anything about it. We know there is pressure to do better, but we don't really know much more about it than this.”

“More motivating than any bonus is ability to provide more rational high quality care.”

• “Lifestyle is more important than paycheck. I would rather have control over my day
Authors' conclusions: The use of financial incentives to reward PCPs for improving the quality of primary healthcare services is growing. However, there is insufficient evidence to support or not support the use of financial incentives to improve the quality of primary health care. Implementation should proceed with caution and incentive schemes should be more carefully designed before
**Frustrations, hassles, limited options**

**Practice is fun; joy of challenges, learning**

**nelmed; impossible demands**

**Rewarding helping in small, big ways**

**- at/from disagree/able patients**

**Love/relationships with pts/community**

**Everything being dumped on PCP**

**Amazed by pts’ smarts, resilience**

**Irritations: 2x time; late night notes**

**Energized by/catalyzing pts’ resourcefulness**

**Object/penalized performance metric**

**Gratified by appreciation pts, family**

**I/stressed for time; behind**

**Recognized by leadership for efforts**

**Late; family stresses; burnout**

**Time: never enough but find as needed**

**Need help (team, SW, agencies)**

**Privilege for caring for neediest, complex**

**The cog in/ hamster on wheel,**

**Wonderful teamwork, support**

**Waste, wasteful, bureaucratic steps**

**Empowered, engaged, exited, leaders/team**

**Worse every day**

**Continuous improvement**

**by the market**

**Driver- patient needs, profl, caring values**
Global Amnesia: Embracing Fee-For-Non-Service—Again

Cloud U. Himmelstein, MD and Steffie Woolhandler, MD, MPH

University of New York School of Public Health, New York, NY, USA.

We hope that Orwell’s memory hole remains in good repair. As 1984 fans will recall, that appliance incinerated orders of things more conveniently forgotten.

May we need it to cleanse memories of managed care’s driven abuses, so we can proceed, unimpeded by 1984, with accountable care organizations (ACOs) and bundled payment—the linchpin of reforms recommended by the Society of General Internal Medicine (SGIM)’s Clinical Commission on Physician Payment Reform (and published, in this issue of JGIM, by Drs. Ho and Sandy). To support The Commission’s calls for rebalancing compensation for cognitive vs. procedure-related work, proposing the Relative Value Scale Update Committee (RUC) and Medicare’s sustainable growth rate (SGR). But that prescription echoes the 1971 “Health Maintenance Agency” proposal that ushered in the managed care fiasco.

In the end, Americans concluded that fee-for-NON-service was even worse than fee-for-service.

HMOs lived on, but retreated from shifting risk to providers, relying instead on mother-may-I-style cost containment, like pre-authorization.

Now SGIM’s Commission has joined the growing policy bandwagon to reanimate the HMO strategy. There are semantic changes—ACO has replaced HMO, and when insurers drop expensive doctors (e.g. the 1,000-member Yale Medical Group)5, it’s called “network optimization” when reviewers discovered loopholes allowing the denial of transplants.

Physicians were pressured to withhold care, and to hide that pressure from patients; bonuses of up to $150,000 annually were offered to doctors who minimized specialty referrals, inpatient care, etc.3 Our protest of those incentives, and a contract provision forbidding their disclosure (a “gag clause”) led to “delisting”. Award-winning physicians—who often attract unprofitably sick patients—were also delisted. An academic leader admonished physicians: “[We can] no longer tolerate having complex and expensive-to-treat patients encouraged to transfer to our group.”4

In the end, Americans concluded that fee-for-NON-service was even worse than fee-for-service.
Research Shows More Patients Visit Primary Care Doctors than Subspecialists for Complex Chronic Health Conditions

...not primary care medicine, but complex care medicine
AMA Piece Responses/Confessions

Credit card to pay for meds
Regularly paid for pts meds in Bolivia
Buying medical supplies
Pay for motel for homeless patient post d/c
Plane ticket air ambulance for terminal child and father to die with mother
Paying for own patients fistula treatments, labs, and meds in Africa
$1000 to match any special fund I would set up

- Rides home
- Cab rides (“cab fares galore”)
- Subway fare
- Went to gas station w/ patient pay 6 gal of gas
- Driving car home avoid cost hospital parking lot
- Paying parking fines
- Nurses/docs/SW taking care of pet while hospitalized
- “Reverse house calls”-patient comes to MD home
JAMA Piece
Responses/Confessions

• Money for food
• Give cell phone # and wife's cell in case can’t reach him
• Caring for MANY close friends, with house calls 24/7 consultations, weekend drug samples
• Hugs
• Birthday presents and visits
• “Attending funerals, baptisms, wakes, weddings”
• Sharing favorite food dishes and recipes
## Potential Risks

*from extending hand to help needy pts*

<table>
<thead>
<tr>
<th>Practical Problems</th>
<th>Broader Concerns</th>
</tr>
</thead>
<tbody>
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<td>Expect repeated help</td>
<td>• Legal liabilities (car accident)</td>
</tr>
<tr>
<td>Become dependent; impair own resourcefulness</td>
<td>• Injurious to objectivity</td>
</tr>
<tr>
<td>“Divert” $ buy/sell drugs/alcohol</td>
<td>• Potential for privacy violations</td>
</tr>
<tr>
<td>Other pts will expect similar</td>
<td>• Excessive demands prof’s time</td>
</tr>
<tr>
<td>Distracts from medical needs (screening)</td>
<td>• Burnout; over-involvement</td>
</tr>
<tr>
<td>Takes away from care/time of other patients</td>
<td>• Staff dynamics, differing abilities</td>
</tr>
<tr>
<td></td>
<td>• Exploit needy pts, unequal power relationships</td>
</tr>
<tr>
<td></td>
<td>• Transference, coercion, perceived obligation, burden</td>
</tr>
<tr>
<td></td>
<td>• Opens door to sexual relationship</td>
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.....while reducing dissatisfiers (hassles, bureaucracy, pay cuts, clunky IT systems) is an important part of addressing burnout, it’s only half of the equation.

... the key [to combating physician burnout] is promoting professional wholeness, which flows from a full understanding of the real sources of fulfillment
While useful in some respects, the stress-reduction approach addresses only the less important of the two sides of the problem. Reducing stressors in the work environment may offer real benefit... It is like providing symptomatic relief to a patient without ever addressing the underlying disorder or encouraging the development of life habits that foster a positive state of well-being. Instead of merely reducing the bad in medical practice, we need to enhance the good
While useful in some respects, the stress-reduction approach addresses only the less important of the two sides of the problem. Reducing stressors in the work environment may offer real benefit... It is like providing symptomatic relief to a patient without ever addressing the underlying disorder or encouraging the development of life habits that foster a positive state of well-being. Instead of merely reducing the bad in medical practice, we need to enhance the good.
Being a professional means above all professing something, declaring openly in work and life that we stand for something beyond our own narrow self-interest. The more we treat physicians as though they were self-interested money grubbers, the more we de-professionalize them. And a de-professionalized physician is inevitably a demoralized and burnt-out one.
Two strands intertwined DNA

- Collective advocacy for social change
- Personal advocacy helping individual patients
Mirror, Mirror on the Wall

How the Performance of the U.S. Health Care System Compares Internationally

2010 Update
7.1% Annual PCP Turnover Rate in Managed Care (0-53%)

Who still has the worst health system of them all?

In its latest Mirror, Mirror on the Wall Report, published by the US-based Commonwealth Fund, the US healthcare system overall still ranks bottom out of seven countries—as it had done in similar reports in 2004, 2006, and 2007. The Netherlands, which was included for the first time, came first overall. The authors used 74 indicators derived from surveys completed over the past 3 years of more than 27 000 physicians and patients in Australia, Canada, Germany, the Netherlands, New Zealand, the UK, and the USA. These indicators were grouped into five dimensions: quality; access; efficiency; equity; and long, healthy, and productive lives. In all these dimensions, the USA came last or second to last despite spending almost double the amount of money per person than other countries.

Rankings and comparisons, of course, have many problems and limitations. Whereas the WHO effort of of access, equity, and efficiency. And even when only high-income people with health insurance were included, US respondents were more likely than those from other countries to report difficulties obtaining needed care because of costs.

So, the big question is whether President Obama’s landmark Affordable Care Act, which was signed into law a little over 90 days ago, can change the US healthcare system from being fragmented, unaffordable, ineffective (at the population level), and unfair to one that stands up to independent scrutiny in future international comparisons. To mark the first 3 months of the Act, Obama unveiled a Patient’s Bill of Rights under the new legislation on June 22. For example, from September, there can be no more discrimination against children with pre-existing conditions. Lifetime limits or restrictive annual limits of coverage will be...
## Table 2. Multivariable Associations

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Change in Rate (SE) Associated With 10% Higher Provider Turnover</th>
<th>P*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Satisfaction</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High rating of personal doctor</td>
<td>−0.7 (−0.9, −0.5)</td>
<td>.002</td>
</tr>
<tr>
<td>High rating of getting appointment as soon as wanted for routine care</td>
<td>−0.4 (−0.6, −0.2)</td>
<td>.08</td>
</tr>
<tr>
<td>High rating of getting appointment as soon as wanted for illness/injury</td>
<td>−0.8 (−1.0, −0.6)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Wait time in clinic</td>
<td>−0.6 (−0.9, −0.03)</td>
<td>.019</td>
</tr>
<tr>
<td>High rating of provider’s listening skills</td>
<td>−0.6 (−0.7, −0.5)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>High rating of provider’s explanation</td>
<td>−0.5 (−0.6, −0.4)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>High rating of provider’s showing respect</td>
<td>−0.5 (−0.4, −0.6)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>High rating of all healthcare</td>
<td>−0.9 (−1.1, −0.7)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>High rating of health plan</td>
<td>−1.0 (−1.3, −0.7)</td>
<td>.001</td>
</tr>
<tr>
<td><strong>Preventive care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Childhood immunization rate</td>
<td>−1.5 (−2.2, −0.8)</td>
<td>.045</td>
</tr>
<tr>
<td>Rate of well-child visits in the first 15 months</td>
<td>−2.7 (−3.5, −1.9)</td>
<td>.002</td>
</tr>
<tr>
<td>Rate of cholesterol screening management</td>
<td>−1.7 (−2.5, −0.9)</td>
<td>.042</td>
</tr>
<tr>
<td><strong>Diabetes management</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HbA1c control</td>
<td>−2 (−13, 0.9)</td>
<td>.888</td>
</tr>
<tr>
<td>Eye examinations</td>
<td>0.3 (−0.6, 1.2)</td>
<td>.722</td>
</tr>
<tr>
<td>Lipid control</td>
<td>0.2 (−0.6, 1.0)</td>
<td>.750</td>
</tr>
<tr>
<td>Nephropathy</td>
<td>0.1 (−1.0, 1.2)</td>
<td>.905</td>
</tr>
<tr>
<td>Rate of β-blocker treatment</td>
<td>−0.5 (−1.3, 0.3)</td>
<td>.543</td>
</tr>
<tr>
<td>Rate of breast cancer screening</td>
<td>−0.2 (−0.6, 0.2)</td>
<td>.672</td>
</tr>
<tr>
<td>Rate of cervical cancer screening</td>
<td>−1.2 (−1.7, −0.7)</td>
<td>.024</td>
</tr>
</tbody>
</table>
“At every level of staff, there bonusing. Each could get extra 5%; but despite this, we couldn’t get anybody’s attention. It wasn’t motivating at all.”

“We wanted to include nurses in bonus plan, but difficulties arose with nurses’ union; there was a big cultural battle among the nurses. “That person doesn’t deserve to get more than I am getting.”
“Brand broke free and charged Cook again, sweeping him into an animal filled steel tier. The tier balanced for an indecisive moment and then toppled...the doors of the cages swung open. Rats, mice.... guinea pigs moved over the floor in wild panic, squealing as if judgment day had come.

We righted the tiers and replaced the cages; then were faced with the impossible task of sorting the cancerous [and tuberculous] rats and mice... to cover up the evidence of the fight. It was pure guesswork, but we had to try to put the animals back into the correct cages....

Richard Wright _Black Boy_, 1933
experience working in Chicago hospital research lab
Of course, we four black men were much too modest to make our contribution known, but we often wondered what went on in the laboratories after that secret disaster. Was some scientific hypothesis, well on its way to validation...discarded because of unexpected findings? Was some tested principle given a new and strange refinement because of fresh, remarkable evidence?”

Richard Wright Black Boy, 1933
experience working in Chicago hospital research lab
• America’s longest war

• Disastrous consequences

  – Racial injustice 13x (some states 57x) rate of arrest for drug charges

  – Lip service to needs for treatment; most budget goes for criminal justice and military agencies.
    • 90% of those who want treatment can’t get it.
Pharma is U.S. biggest lobbyist

<table>
<thead>
<tr>
<th>Industry</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmaceuticals/Health Products</td>
<td>$2,983,826,387</td>
</tr>
<tr>
<td>Insurance</td>
<td>$2,074,087,821</td>
</tr>
<tr>
<td>Electric Utilities</td>
<td>$1,927,483,692</td>
</tr>
<tr>
<td>Business Associations</td>
<td>$1,721,451,285</td>
</tr>
<tr>
<td>Computers/Internet</td>
<td>$1,652,842,408</td>
</tr>
<tr>
<td>Oil &amp; Gas</td>
<td>$1,618,750,153</td>
</tr>
<tr>
<td>Misc Manufacturing &amp; Distributing</td>
<td>$1,348,865,375</td>
</tr>
<tr>
<td>Education</td>
<td>$1,343,660,432</td>
</tr>
<tr>
<td>TV/Movies/Music</td>
<td>$1,283,422,180</td>
</tr>
<tr>
<td>Hospitals/Nursing Homes</td>
<td>$1,252,889,237</td>
</tr>
<tr>
<td>Securities &amp; Investment</td>
<td>$1,189,809,950</td>
</tr>
<tr>
<td>Civil Servants/Public Officials</td>
<td>$1,163,620,473</td>
</tr>
<tr>
<td>Real Estate</td>
<td>$1,157,962,948</td>
</tr>
<tr>
<td>Health Professionals</td>
<td>$1,130,625,408</td>
</tr>
<tr>
<td>Air Transport</td>
<td>$1,055,737,809</td>
</tr>
</tbody>
</table>

1998-2014
• Complexity- Theirs or ours?
• Manager care 2.0
  – Still undesirable hot potatoes
• Collateral damage in war on drugs
  – Stigma, logistics, harm
  – Chronic ill have pain (back, knee, other)
Unmeasured Cost/Waste

- Hidden
- Shifted/externalized
- Kicked down the road
- Diverted costs
- Misrepresented
- Unmeasured suffering, anxiety cost of pts
must identify, coordinate, facilitate, and manage issues surrounding and shaping those chronic conditions such as lifestyle behaviors, food access, safety, and social, environmental, and economic conditions — also known as social determinants of health. That's not simple, primary care medicine. That’s complex care medicine
• Need for public health approach
  – Prevention
  – Population based
  – Epidemiology – memory and future
  – Human right, social justice
  – International comparisons, modesty
Conservative Prescribing

• Principles (24)

• Preconditions
Conservative Diagnosis
Diagnostic Pitfalls

• Mislabeled psych for organic
• Mistaking drug ADR, withdrawal for psych
• Not giving extra help needed for (e.g.) colonoscopy
• Fragmented care amongst specialists
• Not organizing problem list
• Access hurdles, higher for “noisy” patients
Crossing Boundaries to Help Complex Pts: Violation or Obligation?

- Secret to loving medicine is loving our patients
- Anything that uproots continuity in name of “value,” “efficiency,” “managed,” “preferred,” “team,” care or networks is misguided
Respecting and Loving Patients

- Amazing stories
- Surprising resilience
- Gratifying gratitude/appreciation
- Overwhelming problems surprisingly few and manageable over time
- Sharing connections (music, history)
In the ED multiple times over the past few days.

---Lara Patient: Author:
Electronically Signed by , LICSW Status: Signed Visit Date: 11/01/2014
11/1/2014

SW asked to intervene with Pt after her discharge from BWH ED.
In summary Pt is a 48 y/o SBW who self discharged herself from a long term care facility over the summer at which time she was effectively wheelchair bound. Since that time she has been in the shelter system however appears to have failed that given that Woodsmullen today indicates to SW they have barred her from their facility after much work to help and support her (offered help to get into a variety of programs), due to her being inappropriate for that level of living. Meanwhile SW also spoke with other local shelters who all feel they are unable to manage her due to being wheelchair bound and unable to independently manage ADLs. At this time also police are unable to help facilitate transportation for her as she would have to transfer independently in to their cars, and she cannot do that. Fallon transportation needs a specific disposition and location, which we do not have.

SW spoke with Attending and ED Care Facilitator: At this point Pt's issues are of a social nature due to her previous choices of not working with her previous long term care facility and shelter system staff to come up with more appropriate options. And that her issues are not medical nor rehabilitative and thus the ED does not have options for her as Pt has consistently refused another long term care placement and LTC placement not possible over the weekend. Pt has no medical needs warranting admission, though Pt has historically refused admission anyways.

SW met with Pt outside and informed her that there is no destination that we can find for her. She states she is aware of the nighttime drop in center. SW provided the recommendation for her to work with her PCP based supports, such as Laura Shae, to come up with appropriate options. Likely at least a semi-temporary LTC placement will be necessary to allow for proper planning so she can fully realize her hope of community living (if possible) especially as winter is coming.
• War on drugs 13 x what else

• So many side effects, collateral damage
• “Surreal” night search for bipolar patient missing from facility. Found in parking lot of home depot w/ carload of purchases. I loaded items (potting soil, gravel, more) into my car and delivered to nursing home.
• Another time on a house call, I found an elderly lady severely ill and her sheets a mess from her diarrhea. I sent my wife over to do her laundry.
• William Osler, perhaps the most admired physician in American history, understood well the recipe for demoralization and burnout: "The path is plain before you: always seek your own interests, make of a high and sacred calling a sordid business, and regard your fellow creatures as so many tools of the trade."
Burnout and Satisfaction With Work-Life Balance Among US Physicians Relative to the General US Population

Tait D. Shanafelt, MD; Sonja Boone, MD; Litjen Tan, PhD; Lotte N. Dyrbye, MD, MHPE; Wayne Sotile, PhD; Daniel Satele, BS; Colin P. West, MD, PhD; Jeff Sloan, PhD; Michael R. Oreskovich, MD

Background: Despite extensive data about physician burnout, to our knowledge, no national study has evaluated rates of burnout among US physicians, explored differences by specialty, or compared physicians with US workers in other fields.

Methods: We conducted a national study of burnout in a large sample of US physicians from all specialty disciplines using the American Medical Association Physician Masterfile and surveyed a probability-based sample of the general US population for comparison. Burnout was measured using validated instruments. Satisfaction with work-life balance was explored.

Results: Of 27,276 physicians who received an invitation to participate, 7288 (26.7%) completed surveys. When assessed using the Maslach Burnout Inventory, 45.8% of physicians reported at least 1 symptom of burnout. Substantial differences in burnout were observed by specialty, with the highest rates among physicians at the front line of care access (family medicine, general internal medicine, emergency medicine). Compared with physicians in specialties at the front line of care access, physicians were more likely to have symptoms of burnout (37.9% vs 27.8%) and to be dissatisfied with work-life balance (40.2% vs 23.2%) (P < .001 for both). Highest level of education completed also related to burnout in a pooled multivariate analysis adjusted for age, sex, relationship status, and hours worked per week. Compared with high school graduates, individuals with an MD or DO degree were at increased risk for burnout (odds ratio [OR], 1.36; P < .001), whereas individuals with a bachelor's degree (OR, 0.80; P = .048), master's degree (OR, 0.71; P = .01), or professional or doctoral degree other than an MD or DO degree (OR, 0.64; P = .04) were at lower risk for burnout.

Conclusions: Burnout is more common among physicians than among other US workers. Physicians in specialties at the front line of care access seem to be at greatest risk.

Preconditions for Conservative Rx

• Trusting doctor-patient relationship
• Continuity and good follow-up
• Time to communicate, educate, negotiate
• Quality evidence, trusted reviews on comparative safety and effectiveness
• Electronic tools: lists, CDS, look-up
• Firewalls: to protect conservative culture:
  – Good formularies, drug rep policies
Conservative Rx
24 Principles