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The Aliki Initiative

INNOVATIVE APPROACH TO IMPROVING OUR SKILLS IN PROVIDING PERSONAL HEALTHCARE

The quality of medical care is operator dependent and most physicians are overworked and undereducated in dealing with patients as individuals. Today's guest has an innovative approach to improving our skills and providing personal healthcare. Welcome to the Clinician's Round Table.

I am Dr. Leslie Lundt, your host and with me today is Dr. David Hellmann. Dr. Hellman is the Aliki Perroti Professor of Innovative Medicine, is Vice Dean at Johns Hopkins Bayview Medical Center and is Chairman of its Department of Medicine. He is also an Associate Editor of Medicine and the American Journal of Medicine.

DR. LESLIE LUNDT:

Welcome to ReachMD, Dr. Hellmann.

DR. DAVID HELLMANN:

Thank you so much. Delighted to be here.

DR. LESLIE LUNDT:

Now, tell us about the Aliki initiative at Hopkins.

DR. DAVID HELLMANN:

The Aliki initiative is a new program at Johns Hopkins Bayview that aims to teach our medical students and residents the importance of knowing their patients as individual.

DR. LESLIE LUNDT:

Why is this needed, I mean, don't we all know our patients as individuals.

DR. DAVID HELLMANN:

Well, not according to Americans. There was a poll about 2 years ago put out by Consumer Report, I believe it involved about by 39,000 Americans and the bottom line is that 58% of Americans say their doctor does not know them as a person and they meant their primary care physician. So, there is a lot of evidence, I think, that doctors do not know their patients as individuals.

DR. LESLIE LUNDT:

Now, has there been resistance among the staff to start something this new.

DR. DAVID HELLMANN:

There was, and there was a concern the way that we did this is we focused on one of our inpatient teams and decided that doctors no longer had the gift of time to get to know their patients and the various work rule restriction had focused on the hours that people were working, but not the volume of the patients that doctors were seeing. And, so we decided that we needed to cut in half the number of patients that one of our teams was admitting. So, we did that and we jacked up the opportunities and their expectations for the doctors to know their patients, so you asked about resistance and I think any time you change something in medical education, people get nervous and our house staff were initially worried that if they did not see as many patients would they learn as much. So, that was I think the source of initial resistance.

DR. LESLIE LUNDT:

So, how do you go about cutting in half the workload and still covering what you need to cover in terms of care.

DR. DAVID HELLMANN:

So, the way that we have done this is we have recognized that as a Chairman of Medicine, I am dealing with 2 issues. One issue is educating our doctors and students and for that you really need in my view and in Abraham Flexner's view the same as author of the report in 1910 the change medical education in this country, who emphasized how important it was to know a few people well rather than to I think

he put it, nibble on many. So, I have that obligation to try to get our students and residents a few patients to know really well and then I work for a medical center, which has an economic need of and also there is a community need to deal with a certain volume of patients, so what I've tried to do is to split these 2 things apart and separately deal with medical eduction and separately deal with volume, so what we've done is hire hospitalists to take half of the patients that would normally go to our medical student and house staff team.

DR. LESLIE LUNDT:

So, how do you pay for this.

DR. DAVID HELLMANN:

Yes, that is the more than $60,000 question and that is where Mrs. Perroti has come in. She is a Greek philanthropist, who cares about the kinds of doctors that we are training and was willing to provide a gift that allows us to help pay for this.

DR. LESLIE LUNDT:

Okay, so it has been a long time since I was a house staff, but thinking back into that time, one of my goals was just to get out of the hospital as soon as I can. How do you make sure that the house staff actually spends this increased amount of time with the patients and not just cut out early.

DR. DAVID HELLMANN:

It hasn't been a problem, but we have structured the experience. So, one of things we have done is to both allow and require them to do a very detailed history in the beginning so that when our residents report the social history, really expect to hear about what kind of person this is and what are their

interests, and who have they left behind when they have come into the hospital. So, there is an expectation from the faculty that these histories will be in great detail and secondly, we've structured experiences in which we teach house staff how to do this, and then every patient is called once they leave the hospital, so every internal resident calls their patient after they've left to find out how the transition went, whether they encountered any problems in getting their medications, and then somewhere between 5 and 6 patients each month, the team will actually go to their home or go to their Rehab Center depending on where they have gone and visit with them. We have equipping them with video cameras so that with the patient's permission this can be videotaped, and then the medical students and residents then gleam these experiences and films back and have it reviewed with the rest of their group so that one of the best ways to learn something is to teach something and so they will teach about what they learnt in going to visit the patient and the most striking thing that they have encountered is how commonly they make assumptions about horizontal people that turn out not to be true when they are vertical. So, one person, a 37-year-old guy who has been admitted to our intensive care unit every month for the last year for diabetic ketoacidosis and it had been thought that he was depressed and that he wasn't engaged in his care, and the finally, he was admitted to the Aliki Team and the Aliki Team went to visit him and they found a very different person at home than in the hospital. They found a guy who was smiling, who was engaged, who was actually interested in his healthcare and who had transportation problems, which they were able to solve and he started calling in every morning to report his glucose and had an entirely different experience after they really knew who he was. So, the experience is structured and the doctors, you know, I think that while people do want to have free time, they also want to be a part of something important and I think this is a program that is allowing them to rediscover why they went into Medicine to begin with them. Many of them are loving it and wishing they had even more time to spend.

DR. LESLIE LUNDT:

If you are just joining us, you are listening to the Clinician's Round Table on ReachMD XM-157, the Channel for Medical Professionals. I am Dr. Leslie Lundt, your host and with me today is Dr. David Hellman. We are discussing the Aliki Initiative at Johns Hopkins Bayview Medical Center.

DR. LESLIE LUNDT:

Now Dr. Hellmann, it sounds like right there you've got cost savings potentially if you are keeping

somebody out of the ICU every month.

DR. DAVID HELLMANN:

That is right. We are hoping that this can lead to cost savings and there are variety of ways in which we can do that. Our residents by following our patients and taking with them after they've left the hospital are finding out in a very concrete fashion the cost of medication and there is a lot evidence that if you get to know a patient and provide personalized care that it actually translates into better care. There have been studies in treating patients for hypertension and HIV, which have shown better quality of care outcomes, better compliance if the patients say my doctor knows me as a person.

DR. LESLIE LUNDT:

Now thinking about how life is at Hopkins and the rest of the world, how difficult might this kind of a program be to implement in the rest of the world.

DR. DAVID HELLMANN:

I do not think any change is easy and at the same time, if it turns out that we can show that this personalized care really translates into better care, that patients enjoy it and potentially if it saves money, then I think there is an opportunity for it to be disseminated.

DR. LESLIE LUNDT:

Are you doing any sort of outcomes research to measure the change?

DR. DAVID HELLMANN:

We are. There is a comprehensive research effort behind this, looking at very generalized outcomes to very specific outcomes. Outcomes for example, do patients feel that their doctor knows them, what effect does it have on doctors and rekindling their interest in medicine and particularly in primary care medicine and then very specific items of does this reduce hospitalization, testing, and improve compliance. The Aliki Team went to see a patient who, this was a 60-year-old man who had been admitted for liver disease and ascites 2 months before he was discharged on 5 medications, took none of them, and then was readmitted for what appeared to be refractory ascites, turned out that the one thing that was most important in this man's life was his 15-year-old cocker spaniel and it turned out his dog was on 8 medications and he made sure the dog got each one of these on time. As we talked with him about what happened to lady when he was hospitalized, he realized that lady was not getting the same loving care as when he was home and he said, Oh I get it, if lady were here, she would say take your medicines so you can stay home and take care of me. And, I think that this is yet one more example of illustrating how if you understand the patient as an individual, you can put recommendations in a context that they might understand and care about.

DR. LESLIE LUNDT:

Makes sense now. How long is the program slated to run.

DR. DAVID HELLMANN:

So the program started in October and we currently have funding for 3 years and we are hoping to raise funds to continue it and to expand it. I think this is one of the other important things is that we have enlisted the help of philanthropists and my view is that medicine is a public trust, that we receive more support from the public than any other profession outside of the military and our goal is to try to pay back to society the highest possible dividend and it turns out they are people out there who care about the kinds of doctors we are training and who want to join forces with us in trying to train better doctors.

DR. LESLIE LUNDT:

Well, thank you so much for sharing your program with us today.

DR. DAVID HELLMANN:

Thank you so much.

DR. LESLIE LUNDT:

We have been speaking with Dr. David Hellman, the Aliki Perroti Professor of Innovative Medicine at Johns Hopkins Bayview Medical Center about the new program there, The Aliki Initiative.

I am Dr. Leslie Lundt. You've been listening to the Clinician's Round Table on ReachMD XM-157, the Channel for Medical Professionals. To listen to our on-demand library visit us at reachmd.com. If you register with the promo code "RADIO", you will receive 6 months free streaming to your home or office. If you have questions or comments or suggestions, please call us at 888-MD-XM157. Thank you for listening.

This is Dr. Prabhat Jha, Director for the Center for Global Health Research at The University of Toronto. You are listening to ReachMD XM-157, the Channel for Medical Professionals.