Chapter 5

Socioeconomic Issues Affecting Healthcare Collaboration

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Poorly aligned incentives are tearing healthcare professionals apart. The only low-hanging fruit left on the vine is collaboration based on relationships that are grounded in dialogue, transparency, trust, and the pursuit of mutually compatible, patient-centered goals.

—C. Duane Dauner

[A]Introduction

It is both a curse and a blessing to live in times of rapid change. The curse involves dealing with rapid technological and marketplace change, which makes it necessary but difficult to plan for an uncertain future. As physician and facility reimbursement stagnates or declines, mounting pressures such as regulation; the threat of litigation; consumer pressures; and aging patient, physician, and nursing demographics threaten healthcare professionals' ability to provide high-quality, cost-effective, mission-based services to their communities.

Caught up in the daily siege, with little or no time to reflect, healthcare professionals may find it difficult (to paraphrase an old joke) to find the pony near the manure. Christensen and Stephenson (2005) wrote that the perception of failure and crisis shifts organizations away from consensus and toward command-and-control leadership, which rarely succeeds in the long-term. Healthcare professionals must work smarter by collaborating to create a system that optimizes efficiency and effectiveness for *all* parties.

The blessing of living in an era of disruptive change may lie in the opportunity to rethink the way we care for patients and respond more rapidly to patients' and families' changing wants and needs. In so doing, we can achieve competitive differentiation, increase market share,

improve patient care, and boost patient, employee, and physician retention. The purpose of this chapter is to discuss several current issues in healthcare—poorly aligned incentives, uninsured and underinsured patients, governmental underpayment, workforce shortages, and excessive administrative costs affecting healthcare collaboration—and explore ways that healthcare professionals can improve care and their practice environment by working more interdependently. The following case illustrates the difficulty and the importance of bringing together payers, physicians, hospital executives, insurers, patients, and politicians to have a facilitated discussion of healthcare problems and possible reforms.

[A]Case Presentation

The Pittsburgh Regional Healthcare Initiative (PRHI 2005) began in 1997 when former Treasury Secretary Paul O'Neill and Jewish Healthcare Foundation President Karen Wolk Feinstein assembled a consortium of over forty hospitals, four major insurers, dozens of small and large businesses, and corporate and civic leaders to improve healthcare for patients and ameliorate the financial picture for those who pay for healthcare. Ms. Feinstein announced: "The issue at the time was the cost of healthcare. We wanted to draw attention to the fact that we thought regions didn't have to wait for a national solution to the increasing costs of healthcare but could fashion a solution locally within their own region" (Savary and Crawford-Mason 2006).

Two tors differentiated PRHI from other models:

1. Regional collaboration: PRHI facilitates professionally safe neutral working groups where leaders can share information on improvements rapidly throughout the region across competitive lines. These groups, which form and disband freely according to interest and participation, currently include cardiac surgery, critical care, emergency medicine, chronic conditions, infection control, and long-term care.

2. Perfecting Patient Care™: PRHI, as a community resource, teaches this healthcare adaptation of the Toyota Production System personnel from the executive suite to the front line, demonstrating methods for standardizing work and reducing errors and waste. Beginning in 2006, PRHI's founding organization, the Jewish Healthcare Foundation of Pittsburgh, is awarding grants to physicians in select specialty areas who agree to apply Perfecting Patient Care principles to their work and measure their results.

Results to date include:

- A 63-percent region-wide reduction in bloodstream infections associated with the use of intravenous catheters; these infections carry an approximate 50-percent mortality and $30,000 cost to treat. Several individual hospital units in the region have approached zero central line–associated bloodstream infections, and have sustained that rate for over two years.
- Decreased regional readmissions following coronary artery bypass surgery; pooled regional data revealed a 17-percent readmission rate prior to intervention, largely due to postoperative infection; the 4.7-percent decrease in readmission rate is estimated to have saved the region $1.7 million (PRHI 2005).

[A]Case Analysis

PRHI began with the agreement that the core of every medical endeavor must be the patient's safety and well being, with the provision of the best care every time. Based on this premise, PRHI established regional goals that included:

- Zero medication errors
- Zero nosocomial (healthcare-acquired) infections

- Perfect clinical outcomes, as measured by complications and readmissions, in coronary artery bypass surgery and chronic conditions, such as depression and diabetes

Many healthcare professionals found the concept of perfection insulting and unrealistic, fearing that it would raise expectations and increase clinicians' risk of lawsuits. It took years for clinicians to view the goal from the patient's perspective and ask, "How many errors are allowable?," and "Who would volunteer for a lottery to be harmed or have harm inflicted on family members?" Gradually, the questions moved from accusatory, "Why don't *you* …?**,"** to a systems-based reflection, "What if *we* …," which formed the basis of the Perfecting Patient Care method that sought to improve patient care one encounter at a time (Grunden 2005).

To watch the work at the Pittsburgh VA Healthcare System, where Perfecting Patient Care began, was to see actual system improvements implemented from the ground up rather than by executive decree. Not only did one unit report an 85-percent reduction in the incidence of methicillin-resistant staphylococcus aureus infection, but improvements "leaked out" to other areas in the three-hospital system, where medication delivery improved to a 99-percent on-time rate, for example.

As improvements surfaced, the prevailing mindset changed from, "We can't afford improved quality without higher spending," to "Quality costs less—a lot less!" People learned of the close interrelationships in the processes of care and began to understand how improved collaboration based on empirical change and observation could improve not only the quality of clinical care but also worker safety and satisfaction, efficiency, revenues, and expenses.

Clearly, it takes time for clinical champions to emerge and to learn to ask the right questions. Some groups, like orthopedics, have disbanded, but others like the PRHI cardiac registry, have become powerful forces, uniting competing specialists to pool data in a blinded fashion to

answer questions that single hospitals lack the volume to answer. The model Northern New England Cardiovascular Disease Study Group (2005) has logged data on over 150,000 consecutive procedures since its founding in 1987.

Currently, PRHI is aligning its effort according to the following principles:

- Applying Perfecting Patient Care to transform acute, long-term, and community care settings
- Demonstrating savings that can accrue with providing what the patient needs without error or waste
- Building support among medical specialties to apply lessons from demonstration projects to specialist groups and provider associations
- Transforming reporting, reimbursement, and regulatory systems to focus on activities that make the biggest differences in improving quality, safety, and efficiency

[A]Complex Responsive Processes

Understanding complexity in healthcare may help health professionals make sense of their experience and work more productively together (Cohn 2005). Stacey (2003) proposed the term "complex responsive processes" to describe the way in which communication and power relationships emerge in organizations over time. He felt that formal and informal conversations are important in helping individuals and organizations deal with complexity. This principle underlies the success of the structured dialogue process described in Chapter 1 and creative abrasion in Chapter 2, where scheduled meetings among physicians and hospital leaders became forums for formal and informal conversations that improved communication and hospital processes.

Furthermore, Stacey (2003) wrote that learning inevitably leads to anxiety, because challenges to a person's identity are threatening. People cannot know in advance what patterns of identity they are moving into, which may feel like incompetence and failure. In a social order that prizes knowledge and competence and punishes failure, people can feel ashamed about not knowing. Therefore, the challenge facing organizations in times of rapid change is how to create a safe environment for learning (Stacey 1996). For example, one community hospital hosts interdisciplinary conferences called MLEs, or major learning events, because it found that healthcare professionals are more open to discussing improvement opportunities when they feel that they are in a safe environment for learning.

Interdisciplinary conferences in which all stakeholders are present are key to sustainable healthcare reform (Leape and Berwick 2005). Acknowledging the need for conversations characterized by inquiry rather than advocacy is a prerequisite for sensible action to improve clinical outcomes and maintain economic competitiveness (Garvin and Roberto 2001

We have both an opportunity and a responsibility to move from disaggregated silos to collaboration based on mutual respect, dialogue, transparency, and win-win negotiation. Local successes can lead to progressive improvement and eventually to enlightened public policy, as described in the case presentation.

[B]Disaggregation

"Disaggregation" is a state in which people who need to work interdependently fail to do so because of lack of time, lack of understanding of the context in which they operate, or unwillingness to recognize that their assumptions are not valid. Disaggregation flourishes in an environment of poorly aligned incentives, in which people who make an extra effort to improve patient care are not uniformly recognized or rewarded (Porter and Teisberg 2004);

disaggregation affects every aspect of the provision of healthcare, as described below. Physicians lose time, hospitals lose money, and patients can suffer adverse outcomes (Kohn, Corrigan, and Donaldson 2000, Leape and Berwick 1999).

[B]*Physician Perspectives: A Different Approach to Gainsharing*

Although poorly aligned incentives may have been around for decades, their effects seem more noticeable in the current environment. A cardiac surgeon quipped, "As the portions get smaller, the table manners deteriorate," to express his frustration with being squeezed between stagnant or declining reimbursement and rising expenses, and with feeling that his time and service were less valued than in the past. The deteriorating economic situation leaves healthcare professionals feeling isolated and detached from the implications of their actions and inactions, especially if the only solution to maintaining their incomes involves working harder to see and treat more patients.

Hospitals throughout the United States lose revenue when expenses exceed reimbursement for Medicare inpatients; these losses increase when Medicare patients are allowed to stay over a weekend until their regular physician discharges them. Moreover, keeping patients in the hospital longer than necessary increases the risk of hospital-acquired infections and adverse drug reactions (Leape and Berwick 2005).

Healthcare professionals need to continue to work to change current payment policies and systems of care. If discharge planners at hospitals and receiving facilities such as rehabilitation centers and nursing homes were available to expedite discharges on weekends and holidays, perhaps weekend and holiday discharges might become more routine. Healthcare professionals generally welcome changes that make more effective use of their time if framed in a manner that shows the benefits to them and their patients.

Gainsharing offers an incentive to alter clinical decision making. Although aspects of gainsharing that transfer income to physicians are in their legal infancy (Becker 2005), to date, the authors are not aware of laws that prevent hospital executives from showing practicing physicians what revenue the hospital loses and what funds, for example, could be reinvested in clinical capital budget projects if lengths of stay are reduced. This virtual gainsharing limits both the possibility of audits from the Office of the Inspector General (OIG) and toxic incentives, in which clinicians come to expect annual stipends for patient care improvement efforts (Berwick 1995).

[B]*Administrative Costs: Departmental Silos, Costs of Contracting, and Regulations*

Hospitals are complex organizations in which many people interact, and in the process of that interaction change the context for other participants (Cohn 2005). Organizational charts reflect a more idealized notion of communication than occurs in complex organizations, where effective management requires dotted-line collaboration within areas of influence more than administrative control. Yet, departmental silos, especially in the budgeting process, make collaboration more of a nicety than a necessity (Lambert 2004).

Contracting has not optimized payer-provider collaboration. Despite calls for cost containment, the current system has the opposite effect. The additional costs of rules that do not add value to patient care extend throughout the clinical and administrative sides of the hospital. For example, Kahn et al. (2005) estimated that 20 to 22 percent of the spending on physician and hospital services in California that is paid through private insurance is used for billing and insurance-related functions.

The estimated $470 billion spent per year on administrative expenses subtracts funds that could be used to improve access and care (Woolhandler and Himmelstein 1997). Lewis (2001)

wrote that we could provide care for our nation's uninsured for approximately $190 billion annually; by decreasing time to detection and treatment, this provision might also decrease overall healthcare costs. Similarly, if startup costs for electronic medical records average $15 to 20 million per hospital (Carpenter 2002), computerized medical records might be implemented in U.S. hospitals for approximately $100 billion. If the current system grows more expensive, it will become unsustainable and may limit our options for reform. Already, both industry and labor complain that rising healthcare expenses limit U.S. global competitiveness (Klepper and Salber 2005).

[B]*Additional Perspectives: Governmental Mandates, Education, and Politics*

Other areas where collaboration could improve current problems include:

[C]Medicaid

A combination of federal and state regulations makes more work for caregivers and frequently drives a wedge between healthcare professionals caught between the demands of their practices and a mandate to provide emergency care (Fong 2005).

On-call issues involving care for the uninsured and the underinsured result in conflicts of emergency department physicians against specialists and older members of physician groups against younger members and have resulted in hospitals paying physicians to obtain 24/7 coverage, a service that once was considered an obligation in return for membership on the medical staff. California hospitals paid physicians over $600 million to serve as members of on-call panels in 2005, according to the California HealthcareAssociation (2005).

[C]Assistance for small businesses

Outsourcing healthcare to a larger organization that pools risk needs further encouragement; the purpose of insurance is to gain predictability by spreading losses over large numbers of insured

workers (Feldstein 2005). Such a system might decrease the number of uninsured or underinsured workers and improve overall workers' wellness through timely management of conditions such as hypertension and diabetes (Klepper and Salber 2005, Lee and Zapert 2005).

[C]Increased incentives for employers to augment wellness programs

Researchers are beginning to recognize the benefits of chronic disease management in patients with heart conditions and asthma; why are similar connections not sought for obesity, to limit the number of patients needing future treatment for diabetes, joint destruction, high blood pressure, and kidney failure (Olshansky et al. 2005)?

[C]Education

Future healthcare consumers are inadequately taught how to choose nutritious foods, evaluate health plans, judge quality, and protect their own and their relatives' healthcare safety (Wilson and Sheikh 2002, Lee and Zapert 2005).

[C]Insurers

Efforts to encourage physicians and hospital executives to work more interdependently with insurers could improve systems of care and decrease variation in healthcare utilization (Wennberg et al. 2005).

Payers' report cards on physicians and hospital executives also exacerbate disaggregation by focusing on multiple standards, rather than establishing a uniform rating system that is standard across all payers (Elder and Dovey 2002, Khuri 2005)

[C]Elected officials

Because of the reaction to comprehensive healthcare reform in 1994 and the difficulty of holding individual members accountable for spending decisions, elected officials have chosen to tinker at the edges with self-serving legislation (Fuchs and Emanuel 2005). For

example, Medicare drug coverage increases expenses without providing comparable operational savings or promoting heightened collaboration and shortens the time until our non-system of healthcare becomes bankrupt.

[B]*Workforce Shortages*

The supply of caregivers and allied healthcare professionals is not keeping pace with the demand for hospital care. For example, as of December 2004, hospitals estimated the number of vacant positions for registered nurses was 109,000, approximately 8 percent of all part-time and full-time nursing positions (Steinberg 2006). An increase in the supply of nurses is important to the ability to meet the demands for care. However, from 1995 to 1999, the number of nursing graduates declined 13.6 percent, and the median age of existing nurses rose to over 43 years (AONE 2001). Only 10 percent of the nursing workforce is under 30. Women, who account for 92.8 percent of registered nurses, are 40 percent less likely to enter the nursing profession now than 20 years ago (Dasso and Wilson 2001). Moreover, the number of registered nurses who are no longer working in nursing has risen 22 percent, from 387,000 in 1992 to 494,000 in 2000 (Jaffe 2001).

Raising wages, decreasing education costs, and upgrading the image of nursing are long-term strategies to correct the nursing shortage; however, the impact of these interventions is unlikely to be felt in time to alleviate the growing shortage. Nor is importing nurses from other countries a viable long-term strategy. Instead, improving surgeon-nurse partnerships by managing disruptive physician behavior (Erickson, Warshaw, and Ditomassi 2002) and redesigning work to enable an aging workforce to be more efficient at providing and documenting care, and using revised patient-care algorithms and hand-held or voice-activated technology appear to be promising solutions (AONE 2001).

[A]Conclusion

The present global economic squeeze, poorly aligned incentives that pit groups against each other, and the failure of politicians to undertake systematic healthcare reform inhibit collaboration and add expense to an already overburdened non-system of healthcare. Meetings of all major stakeholders that provide a forum for discussion and sharing rather than blaming can help deal with the complexity in healthcare and improve clinical and financial outcomes.

[A]Key Concepts

- It is time to bring payers, physicians, hospital executives, insurers, patients, and politicians together to have a facilitated discussion of healthcare problems and necessary reforms.
- Understanding complexity and the need for conversations characterized by inquiry rather than advocacy is a prerequisite for sensible action to improve clinical outcomes and maintain economic competitiveness
- Effective dialogue and collaboration are no longer niceties but necessities.
- Reforms must address currently unresolved issues in healthcare: poorly aligned incentives, uninsured and underinsured patients, governmental underpayment, excessive administrative costs, and workforce shortages.

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