

Hospital management reform: a step to healthcare reform

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Abstract

Recent intensive dialogue and debate regarding healthcare reform has led provider administrators to renew their search for “best practices” around the country. Many organizations, particularly hospitals, because of their complexity, are seeking new paradigms that will improve their efficiency and effectiveness regardless of the outcome of the current reform debate. This paper suggest that implementing an organizational change model, specifically, socio-technical systems design, can lead to more teamwork, communications and improved patient service delivery in all areas of hospital operations. Within the STS frame, staff records detailed steps or unit operations in their patient care processes, and then engage physicians in determining what could go wrong in each of these unit operations. Finally, changing what happens or improving the way these steps happen can become a team effort involving both social (people) and technical solutions. The authors acknowledge the extreme difficulty of changing the dominant physician-focused culture which would be the result of such a successful OD intervention.

Keywords: hospital management, healthcare reform

Introduction

The healthcare industry is the subject of intense debate. Forces for and against reform are pitted against each other in an enormous metaphorical field-force analysis. Nowhere is such a debate more intense than on the subject of hospital care, where, coincidentally, the healthcare service provision is most intense.

Hospitals are simultaneously perhaps the most complex of purposeful organizations and they exist in perhaps the most turbulent industry environment. Hospitals constantly deal with life or death matters and must address “customer” needs from customers who are not directly paying for the services they receive. In many cases, the patient-customer is completely unaware of the costs incurred in hospital treatments and procedures. Hospital administrators and managers often have little say in the major decisions made, and the medical service providers rarely are even employees of the organization. Additionally, where in the world do you find constituents with wide status differences co-mingling on a continuous basis: orderly employees, nursing personnel and physicians on the same floor, often in the same room as the patient, at the same time? This situation would be analogous to staffers down to janitors in the board room or presidential suite while a meeting is being consummated. And insurance companies are getting constant reports while lawyers wait to pounce when errors are made.

The above is important to recognize and reflect upon because these frequently dysfunctional organizational patterns illustrate the heart of an issue that healthcare providers as well as managers need to address regardless of health care reforms that may originate with the government. In a nutshell, hospital management must reform and continuously improve the level of teamwork, the quality of relationships within teams and communication dynamics within and amongst organizational teams.

Current Management Practices

Healthcare quality and patient safety are the common mantra of all primary and secondary health care providers. In hospitals, over the years, a variety of models and schemes for hospital interventions and development have been deployed (Friesner, 2009). A typical approach is to hire external consultants to plan and implement organizational change efforts or interventions involving a wide variety of approaches (Hosford, 2008). Using the Malcolm Baldrige Award model, for example, has been a common model in hospital efforts to improve quality. One study of several of such efforts has reported mixed results. Administrators reported that they have made little progress in implementing the Baldrige quality control model or that the effort has not yet “matured” (Hosford, 2008).

Hospitals typically display stagnant, impersonal and historical data on various aspects of hospital performance. In one study examining the effect of change interventions in hospitals, “only 38% of executives believed that their initiatives were successful and only 30% thought these initiatives contributed to the sustained improvement of their organization (Erwin 2009). Also, not surprisingly, initiatives to provide training in teamwork for error reduction efforts did not result in improved outcomes. Changing basic practices in massive, complex healthcare organizations will be especially challenging (Isern and Pung 2007). However, Mohr, Burgess and Young

(2008) suggest that a teamwork culture in a hospital can reduce turnover thus providing cost savings and, perhaps, higher quality service to patients.

Two realities about hospital culture and practices serve to hinder many efforts at a continuous efforts to improve patient healthcare outcomes. First, the status differences among providers, for example, in hospital medical/surgical wards, is often a hindrance to improved quality of service delivery and unit interpersonal communications. Physicians, of course, rightly bear all of the authority and responsibility for patient-related decisions. But physicians, because of this status, are not intimately involved in teaming with other providers when intervention efforts are undertaken. Floor group meetings which are held by provider staff typically do not involve physicians in discussions of individual patient bedside care. When physicians make rounds to attend to patients, usually they first review medical records, view recent test data and other measures, then consult with the patient directly. A nurse or aid is rarely consulted for face-to-face communication and, perhaps surprisingly, the physician rarely reviews nursing notes written in the patient records (Mohr, et al., 2007)

The second hospital cultural factor that may hinder improvement efforts is the variation in techniques or practices caused by variations in maturity of the organization, technology used and, of course, individual differences in personality amongst hospital service providers. Such differences obviously apply to all organizations, their cultures and their practices (Fahey, 2008)

In a hospital, these variations often confound efforts to improve patient quality. First, the traditional model at the floor level is that when an error occurs attention is directed at identifying the cause(s) of the error. This effort, ideally, leads to correction of the error(s). Hopefully, the fix will be communicated to some personnel, but obviously not to others.

When external consultants are used in an organizational development effort, these individuals are rarely familiar with internal processes and procedures. Professionals are left to develop their own improved methods and implement them proactively, unlike the traditional "fix" model. Even threats of legal action and other environmental forces are not stimulating improvement and that the overall picture is one of randomness rather than of enlightened management (Griffin, et al., 2006)

Error Examples for Illustration

To clarify or highlight how current medical practices and culture may negatively affect patient care quality, some examples are perhaps the best illustrators. Patients with serious medical conditions, such as cancer or other diseases that may require surgery, are often in a hospital for several weeks or months due to complications related to the foundational illness or disease process. Patient tests and other measures are undertaken and reported in a standard routine. (Patient records are required in most cases to be kept in paper form. Some facilities also maintain duplicate records electronically.) But, a lengthy stay only increases the probability that a patient medical "error" will occur. All of the events presented below have happened and are not fictitious as observed by the lead author of this paper:

- Patient fluids and weight are monitored but it is not unusual for a patient to gain in excess of 20 pounds before internal communication to the attending physician is executed and an IV is ordered to “fix” the problem. The aide taking the “in and out” urine measures tells the patient’s caregiver, not a nurse or physician.
- Patient’s lungs can gradually collapse partially before more intense respiratory therapy is ordered. Hospital cost control limits such therapy to once per day.
- The result of the above is usually a frightening experience for the patient: a breathing tube is forced down a patient’s throat and their arms are tied to the bedrails so that the patient can not remove the tube.
- If they survive, after a few days, they are given a tracheotomy (another surgery) then placed on a respirator.
- A patient may go into dangerous and life-threatening shock because their white corpuscle count has been allowed to rise over a period of days, even though blood tests are given and test results provided almost daily. Infection control physicians are called in to find out the cause of the problem after the fact...if the patient lives.

Of course, not all hospital stays have the outcomes as described above. Certainly, the cause of these and other negative outcomes can be related to human factors, technology or the catch-all “communication” problems. However, a theme that emerges here is that in each of the cases referenced above dynamics within the existing hospital culture causes the issues and could have been prevented had teamwork and communications been more fluid amongst involved service providers.

The remainder of this paper will suggest a form of management development that will overcome many of the cultural factors hindering improvement in patient quality and safety. More importantly, such an initiative requires the involvement of ALL constituents in the healthcare arena.

Socio-Technical Process Design- Team Driven Improvement

Some old sayings may have some relevance here: first, “we are just too busy chopping wood to sharpen our axes” and “having lost sight of our objective, we re-doubled our efforts”. Teams must engage regularly in process improvement efforts as many TQM advocates have long asserted (Deming, 1989).. Otherwise, they are likely repeating the same mistakes (chopping wood) without reflecting on how to do it better as a team. Also, the objective is patient care quality and safety and without reflection, care becomes its own end.

One such successful team-based program is called socio-technical process design. To explain this seeming jargon, all work processes (patient care, surgery, sandwich factories, car making...) are both social and technical in nature (Jones, 2007). People (the social) provide the movement of information or material (the technical) from input, to processing, and then finally to some output. Christodoulou, Babbalis and Gymnopoulos (2008) note that increasingly the need for teamwork in hospital settings is being recognized even if not sufficiently addressed in current practice.

The generic steps in socio-technical process design include (Jones, 2007)

1. Teams need to take time to document each step or Unit Operation in each process in which they engage. Often, a single person does one process, such as drawing blood. Also, at this stage, a physician need not be involved, but the other medical and non-medical personnel involved should be. A typical process, even sandwich making, may take 30 to 40 steps or unit operations.
2. Display the steps and group or label them, i.e.” bread delivery and preparation.”
3. For each step ask the team “what can go wrong”. These are called “variances” in socio-technical language. (bread is soggy) Stick to things that commonly go wrong.
4. For each variance, brainstorm what can be done to prevent the variance by a technical or social solution. (Humidity can be removed with a machine or the bread could be move to a drier place or device obtained to measure humidity).
5. Make changes to each step focusing on those that are easier to implement or will improve the most or same the most.
6. Use all forms of communication available and even create other communication methods, if necessary, to ensure that the entire team, including the physician in the healthcare case, is aware of and executes the process improvements identified.
7. Review other process or start from Step 1 with the process you just improved.

A natural benefit of this socio-technical process methodology include that employees are always interested in talking about their job. They know their job processes intimately and want to improve them. Also, a facilitator need not be familiar with the technical aspects of the process, only familiarity with the above steps is necessary. Standard formats can be used for each department and process for communication or education purposes. Processes include medical information systems (Berg, 1999) as well as administrative and medical records on paper (Berg & Toussaint, 2003). Finally, process outcomes tend to reinforce the sense of empowerment of workers to communicate key, perhaps life-saving information, to other health care personnel on a timelier basis.

The current effort to create electronic data bases in healthcare provider organizations may be the catalyst towards which hospital management reform moves with more standardization of process and communication, resulting in organizations becoming somewhat redesigned (Olden & McCaughrin, 2007). To implement this move toward electronic data bases requires multi-disciplinary teams to analyze processes. Medical provider personnel as well as technology experts must necessarily be proactively involved in these efforts and the teamwork modality seems ideal for accomplishment of this function (Szydłowski & Smith, 2009)

Medical Examples

Healthcare processes are extremely complex and technical. Many volumes of information are produced in a hospital on a minute-by-minute basis. The usual key issues identified in healthcare, therefore, are how these processes are communicated, particularly if the information is unusual or indicates danger or illness for the patient. Some examples are provided, based on observation and some of the scenarios mentioned above.

- Newly empowered employees now literally put a paper flag on a record which shows an abnormal condition of a patient
- A bulletin board was created to track certain procedures, tests and other care provided to patients. Privacy was maintained since the team developed a code for both names and procedures known only to the team
- A summary form was created for key patient records such as blood count, weight or other data. The form was necessary since a patient could easily develop a 12 inch book thick medical record even after just a few weeks.
- Award and recognition system was developed and implemented with little cost, but were generated by the workers and patients themselves, not physicians or administrative personnel.
- Patients and their relatives or caregivers were give a formatted form or book similar to a diary to document events and episodes not in the record

Conclusion

While the ideas offered here may seem simple and general in nature, if applied, such ideas could energize and empower workers and administrators in the healthcare industry. So much pressure is being placed on the often over-worked professional, that something must be done. A study of the American College of Healthcare Executives indicates much frustration and lack of hope that healthcare can be positively affected in either the financial, performance or turnaround areas (ACHE; 2007). The model suggested here should not be viewed as one step in a re-design of healthcare by a part of an overall organizational change process. The status consciousness currently dominating hospital culture may be somewhat reduced if professionals perceive a more positive outcome for patients. The authors acknowledge the difficulty of bringing significant organizational change to hospitals or for that matter any complex organization. But, a socio-technical systems movement toward greater quality focus, improved teamwork and open, timely communication can only improve the delivery of services in many hospitals and other health care delivery systems.

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