ICU MANAGEMENT & PRACTICE

ICU Volume 6 - Issue 1 - Spring 2006 - Management

Communication with the Administration

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In previous articles in this series, Drs Pauldine and Dorman have discussed communication skills in conflict resolution, and strategies for effective communication in intensive care practice. In this article, the authors focus on how to communicate effectively with administrators.

Clear and effective dialogue is needed between the intensive care team (physicians, nurses and support staff) and the administrative managers of the hospital and healthcare system. Such dialogue is necessary to ensure the efficient function of the healthcare organization. From the perspective of the intensivist, administrative understanding and support is paramount in maintaining the financial and physical resources necessary to provide excellent and safe patient care. From the perspective of the administration, intensive care units represent a significant financial outlay, comprising as much as 30% of the total hospital budget (Bekes et al. 2004). In order to appreciate potential barriers to effective communication between these entities, it is important to understand the culture and general priorities of each and to design strategies and systems to overcome these obstacles when they are present.

Barriers to Communication with Administrators

A number of potential barriers to effective communication exist between clinical providers and administrators. In many situations, the clinicians have no formal business training and may look upon administrative tasks as an unwelcome intrusion into their busy practices. Even when enthusiastic about administrative responsibility, lack of management training and true differences in the language of clinical medicine and business administration may impair meaningful discourse (Atun 2003). A clear understanding of business terms is required for the intensivist team to communicate their needs in a means that allows administration to understand the need, and demonstrates to administration that the intensivist and their team are dedicated to institutional goals. Thus a thorough understanding of fixed and variable costs is required. Furthermore, an appreciation for the context in which these costs exist is also required. For example, the intensivist must understand whether payment is based upon a per-diem basis or bundled into diagnosis-related groups (DRG). Reducing lengthof stay under a per diem payment system may be beneficial in the long term but acutely may lessen cash flow and thus hurt the institution, whereas reductions in length-of-stay under a DRG-like system will immediately contribute positive margin.

The goals of clinicians and administrators are not often aligned. Intensive care clinicians frequently value autonomy of practice, commitment to their patients and specialty while gaining a source of identity from their profession. Administrators are more likely to value a team and committee approach with loyalty to the organization, and tend to identify with their position in the organizational hierarchy (Nowicki and Summers 2002). External pressures including the cost of information technology, new patient technology, and expensive therapies that may not necessarily demonstrate a proven cost savings benefit may further polarize physicians and administrators. Increasing consumerism and access to information on the worldwide web has led to greater expectations from patients and their families. Additionally, escalating malpractice costs, decreasing reimbursement for services, government budget cuts, an aging population, pressure to increase clinical workload and an ever more restrictive policy environment all goals of practitioners and administrators (Rundall et al. 2004). Tension over resource allocation can lead to an environment where administrators are viewed as only being concerned about the bottom line, and clinicians are seen as wasteful of valuable resources. Distrust, alienation and power struggles may result. It is clear that intensive care unit directors are facing an increasing demand for services in an environment of rapidly increasing costs and diminishing resources. In order to create and sustain a positive environment of care and practice for patients and the clinical staff, while contributing to the financial health of the organization as a whole, intensivists and administrators need to remove the barriers to effective communication, seek common ground and work together interdependently.

Improving Communication with Administrators

Strategies to improve communication between clinicians and administrators begin with appreciating the differences in focus and values outlined

above. Formal or informal training in principles of business administration is beneficial for intensivists in bridging the cultural and language gap with managers. Learning to speak in the language of the administration cannot be stressed enough. Understanding the overall goals or mission of the healthcare organization is useful in ensuring that the short-term and long-term plans for intensive care resources are aligned with the vision of senior leadership (Burmahl 2003). The ability to demonstrate and clearly articulate the benefits and return on investment of a wellrun and well-supported intensive care unit can make a strong argument for the provision of responsible leadership and active support of this expensive resource.

Plans to be presented to administration should be researched and prioritized in advance. Recall that communication can be accomplished through a variety of media and formats. Communication can take the form of face-to-face meetings, group encounters, telephone conversations, written correspondence, email, or other printed media such as newsletters. An appreciation and in-depth understanding of your administrator's leadership style and preferred learning style can be extremely helpful. Is live presentation preferred over written communication? If so, does the administration prefer informal presentations or formal briefings with audiovisual aids? Should there be a written follow-up? Is email effectively utilized or is a formal document preferred? Do scheduled meetings at regular intervals meet the need or should meetings be scheduled on an "as needed" basis? Who should request the meeting? Are your communication needs met by existing standing committees? Obviously, the answers may vary with the issues at hand and the culture of the institution. However, the point of tuning in to the right method for the people involved and the question presented is an important one. Finally, these alternate means can be extremely useful, but the value of face-to-face meetings must not be underestimated.

If lines of communication are closed or difficult to access, methods such as structured dialogue can be considered to direct the formulation and presentation of specific plans, by soliciting meaningful input from the clinical staff and administration. Structured dialogue has been recommended as a method for administrators to partner with physicians in a systematic scheduled exchange of information that allows clinicians to be part of the decision-making process, thereby increasing their influence and stake in their professional and economic affairs (Cohn et al. 2005). A series of scheduled meetings with the input of a committee of clinician leaders has been suggested as a format. In order to be successful, the environment must foster cooperation between all of the stakeholders with a commitment to implement the recommendations of the panel. Milestones to measure progress should be implemented. In building trust and strengthening relationships between the intensivist staff and administration, communication techniques such as appreciative inquiry utilize principles that recognize achievement and success, as opposed to dwelling on shortcomings and problems. Such techniques are based on the concepts that people respond to positive reinforcement that strengthens self esteem, shared vision is the engine that drives lasting change, and affirmation and envisioning of goals increases the likelihood that the goals will transform into reality. While it is important for the intensivist to understand administrative styles, goals, and values, communication is clearly a two way street. Administrators send very potent messages through the way they listen, seek to build partnerships with clinical staff, and exhibit willingness to share risk and reward.

Another important area for communication with administrators is in creating an institutional climate of safety. The use of executive walk rounds has been demonstrated to be beneficial in improving nursing attitudes regarding the climate of safety on inpatient units where leadership participated in regular discussions with the providers on the unit (Pronovost et al. 2004; Thomas et al. 2005).

The goal of communication up the administrative chain is for problem solving or resource allocation as it relates to the delivery of services in a particular healthcare organization. However, the importance of communication systems is magnified in times of crisis. Effective and efficient communication between the critical care group and hospital administrators was demonstrated to be of extreme importance during the SARS outbreak in Toronto in 2003. In an assessment of lessons learned from the situation, a recommendation was made for critical care communities to consider existing systems for communication in advance of crisis (Booth and Stewart 2003). This interplay stresses the importance of the relationship between clinicians, their hospital administration and the regional critical care community as a whole.

Intensive care professionals can improve communication with administrators by becoming familiar with their culture, language, values and specific management styles, while using techniques to align goals and build teams. The long-term result of establishing improved communication between clinicians and administrators is in the development of shared perspectives that result in an increase in mutual respect and trust, leading to the most effective and efficient use of intensive care resources.

Published on : Thu, 15 Aug 2013