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Leading Healthcare in Taxing Times: Is There Another Way?

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Key Points

• The economic challenge of providing reliable care to patients requires a radical rethink of what we perceive of healthcare

• The aim should be to move to effective management of disease and the development of a new operating system that allows this move

• This paper examines six key steps to take to ensure that we can restructure healthcare

Introduction

The future of healthcare brings challenges to hospital managers, clinicians and the patients they serve. The growing expense within an era of austerity implies that we need to re-examine the way care is delivered. Change is difficult, as we are inexplicitly bound to a thought process dictated to us by the medical, biomedical and pharmaceutical fraternity. The public is now demanding safe and effective services, and expects us to provide these within the constraints of available funds. In turn we have built up expectations for the clinicians, with new technology and bigger and larger hospital facilities, each burdened by the immense cost of construction and the ongoing cost of maintenance and operations. It is time to step back and reflect on what we are actually trying to do.

I propose six steps to address this problem, based on current best practice. What is really needed is profound and radical change that redirects healthcare in a new direction and takes it to an entirely different level of working and effectiveness.

Key Issues to Address

1. Understanding the change in the needs of the population, now and in the future.
2. Addressing rising cost, as we are spending in the wrong place.
3. Designing services for flow, in order to eliminate artificial variation.

4. Considering the value of care delivered to patients.
5. Changing our leadership style so that it is inclusive and distributive.
6. Developing a compact with clinicians to develop joint solutions to the problems

1. Understanding the Change in the Needs of the Population, Now and in the Future

Life expectancy at birth reaches 80 years across OECD countries, a gain of more than 10 years since 1960 (OECD 2013). Women live almost six years longer than men, averaging 83 years versus 77 years for men. Children who could have died are now teenagers with long-term conditions. People do not have single organ illnesses, and now many have long-term conditions. This implies added complexity, each with the potential of increased cost. At the same time, we have not developed person- centred care, with a move towards health management, as opposed to disease management. Maureen Bisognano (2013) has called for us to "flip health care, moving from a system that does things TO patients to one that works WITH patients to achieve the best results." This in turn is a fundamental shift from asking "what is the matter?" – i.e. a disease oriented approach – to "what matters to you?", a person-centred approach. When we manage hospitals in the current environment this is a challenge, as we often deal with patients who would be better managed in more cost-effective and person-friendly environments. In order to move to the new paradigm we need to rethink how we will plan services, not around the disease, but around the person, who is likely to have more than one chronic problem. This means we need to understand the changing epidemiology of disease, and accept that the models of care based on the diseases of the 20th century simply will not work in the 21st.

Christensen and colleagues (2009) call for a change in the way we deliver care, based on the theory of continual disruption in delivery. Previously, Christensen et al (2000) wrote, "The health care industry today is trying to preserve outmoded institutions. Yet the history of disruptive innovations tells us that those institutions will be replaced, soon enough, with new institutions whose business models are appropriate to the new technologies". This is a call for us to rethink the way we organise healthcare, and to move from the current model to one that is flexible and meets the needs of patients. This does not mean that we do not need hospitals; rather that we must rethink the way we use them. This includes ensuring that we build for the future with paperless systems and the latest IT as standard in all future design.

2. Addressing Rising Cost, as We Are Spending in the Wrong Place

Cost cannot go on rising, so we need to spend wisely. We need to design to decrease cost, and at the same time increasing quality - often referred to as the Triple Aim – how to develop high quality and great patient experience at low cost (Berwick et al, 2008). Emmanuel (2013) suggests that one needs to reinvent healthcare delivery to focus on delivering care to patients with chronic illness. This in turn means avoiding hospitalisation, with more outpatient monitoring and intervention at home. The expressed aim is to decrease emergency department visits. To achieve this one could consider the key elements of the Chronic Care Model (Wagner et al, 2001) that includes decision support and community based activated patients and care teams. The foundation is team-based care coordination between office, hospital, pharmacy and home, with reduction in the use of inappropriate interventions that do not add benefit to the patient.

Reduction of cost can occur if we change priorities as above and stop serving the current paradigm. (Weinstein and Skinner, 2010). The technology that we use needs to be directed at decreasing complexity and cost, rather than adding layers to it. Technology improvements require a change in the way we think, as well as the way we work.

3. Design Services for Flow in Order to Eliminate Artificial Variation

The traditional approach to sorting out the logjams in hospitals has been to try to improve flow through the emergency services, which constantly bump the scheduled patients. Paradoxically, this approach is not the way to go. The most predictable flows of patients in a hospital are the unscheduled patients – they are natural variations and one can predict their flow, unless there is a special cause -such as an epidemic or an accident, etc. The scheduled flow, that the clinicians plan, is the more unpredictable and constitutes the artificial variability of hospital flow. These patients are subject to peaks and troughs, as well as different demands. Though superficially it may seem to be planned, the reality is that most hospital managers have no idea of who will be in the hospital for scheduled care at any one time, nor of the resulting demands on in-hospital services such as radiology, pathology and ICU. The theory of managing operations (IHO, 2014) offers an alternative approach and consists of the following elements:

• One needs to end the competition between scheduled or elective care and acute or unscheduled patient flows. This is achieved by separation of the flow streams.

• The way we organise care consists of artificially created variation in scheduling, with peaks and troughs in the artificial demand that results. Smoothing of the flow in order to eliminate the artificial variation is key to the solution.

• To achieve the best and most costeffective flow one needs to assign separate resources for scheduled and unscheduled patients.

• The patients who are acute need to be seen as per clinical need and in the acute settings. Once the artificial variability has been removed, one can use queuing theory to develop the flow solution.

• Resources for scheduled elective patients are then decided on the concept of maximising patient throughput and minimising unnecessary waits.

This approach turns healthcare into an efficient cost-effective process, which is safer, with patients being in the right bed under the right clinical teams. It does require leadership and constancy of purpose, as it totally changes the current paradigm

4. Considering the Value of the Care Delivered to Patients

The concept of value in healthcare is now centre stage, particularly since the budget for healthcare has become finite. We need to ask whether the care we provide actually does add value. In a review of what type of leadership is required, Swensen et al. (2103) call for a move from a volume-driven approach to one that is more value-driven. With this approach patients are persons who are partners, there is continual focus on waste reduction in service provision, quality is everyone's responsibility, not only that of the quality department, and we move from high cost complex large hospitals to lower cost focused care delivery units. Porter and Lee (2013) have described this value as matching quality with cost, and have recommended integrated care that takes into account the entire patient journey and not parts of it. Both these approaches would change the way we currently run hospitals, managing segments of the patients often in disease-oriented rather than patient-focused delivery units.

5. Changing our Leadership Style to be Inclusive and Distributive

Best and colleagues (2012) studied transformation change, and have suggested that in order to make change meaningful, we need to distribute leadership to the front line. This is what happens in the most successful organisations outside healthcare, and if one looks at the systems that perform well, e.g. Virginia Mason Institute in Seattle (2014), there is an alignment of vision and goals at all levels, and the front line is involved in ensuring safe and effective care takes place. The key elements are:

• Effective distributive leadership, where members of staff in the front line are encouraged to continually improve;

• Data feedback on improvement and performance is given in real time;

• The work of the front line is respected and honoured as they continually improve;

• Engagement of physicians as partners for change is a key component;

• Patients and families are involved from the start, and not as tokens but as real partners.

6. Developing a Compact with Clinicians to Develop Joint Solutions

The final challenge is the need to consider how we will deliver change in the future. Hospital managers are an important part of the process, but they need to work with clinician leaders and clinicians themselves in order to deliver the change. This will require the development of a compact with clinicians and sharing the ownership of the change that is needed (Taitz et al, 2013). This is probably the most difficult of the steps to take, as professional autonomy is a deep-seated cultural facet of the life of a clinician. Yet we need to move to a middle ground where there is joint working towards continual improvement of care from both the clinical and the patients' point of view.

The new environment is possible and we need to work together to redesign the services we provide, rather than to continue working at the solution using old techniques. Hospitals have an important role to play in the future, but we need to continually question how we deliver services so that we get the right care to the patient the first time every time.

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