

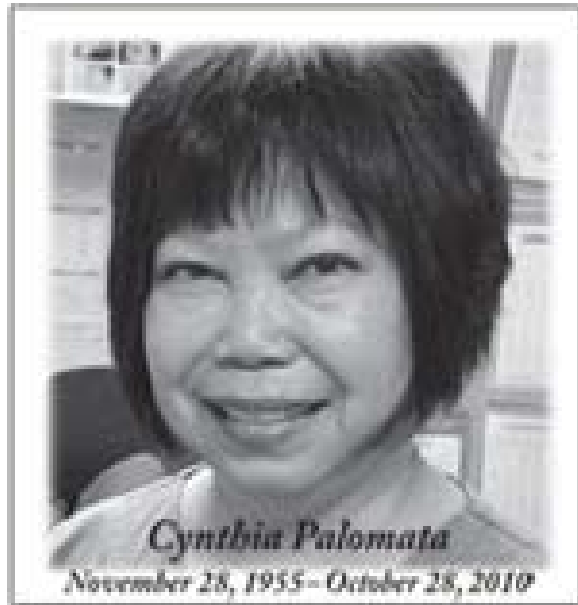


Leadership in Healthcare: Ethical Dilemmas of the New Medicare Influx **Huh?**

Leading Through Conflicts of Delivering
More, Quicker and Better Care for Less

Jim Conway, FACHE
Senior Fellow, Institute for Healthcare Improvement
Adjunct Faculty, Harvard School of Public Health
Member, Comm. Of MA Quality and Cost Council
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Dedication



- To Cynthia Palomata.
Her death in duty, and
for her exceptional
practice in caring for
patients and the public
- To all Contra Costa County
Staff honoring the care,
caring and service you give
every day
 - Health Service
 - Sheriff's Department

Outline

- The New Medicare Influx
- Ethical Dilemmas
- Leadership and Management
- Closing on the Theme of Respect

Ethical Dilemmas of the New Medicare Influx

Conway's Cliff Note View

Reform And The Medicare Influx	Ethical Dilemmas	Leadership and Management
Continual Growth	Effectiveness	At Every Level
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Patient & Family CC	Waste	Teamwork
Coordinated Care	What's Right Is Wrong	Values: Respect

On the National Scene

There is a lot to this
healthcare reform

***...and plenty
happening in
the states too!***

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AMENDMENT NO. _____ Calendar No. _____

Purpose: In the nature of a substitute.

IN THE SENATE OF THE UNITED STATES—111th Cong., 1st Sess.

H. R. 3590

To amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

Referred to the Committee on _____ and
ordered to be printed

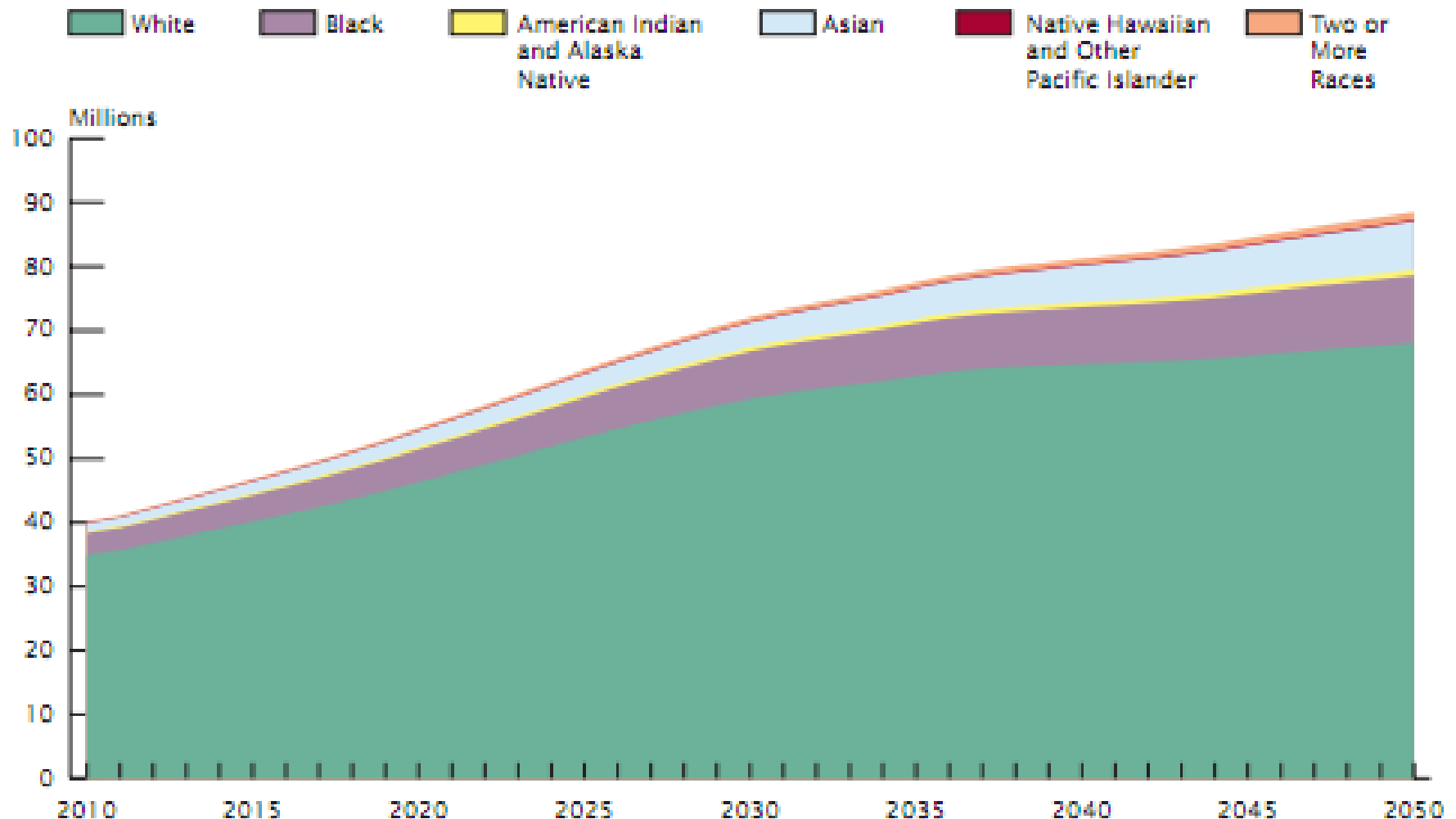
Ordered to lie on the table and to be printed

AMENDMENT IN THE NATURE OF A SUBSTITUTE intended
to be proposed by Mr. REID (for himself, Mr. BAUCUS,
Mr. DODD, and Mr. HARKIN) _____

Viz:

1 Strike all after the enacting clause and insert the fol-
2 lowing:
3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

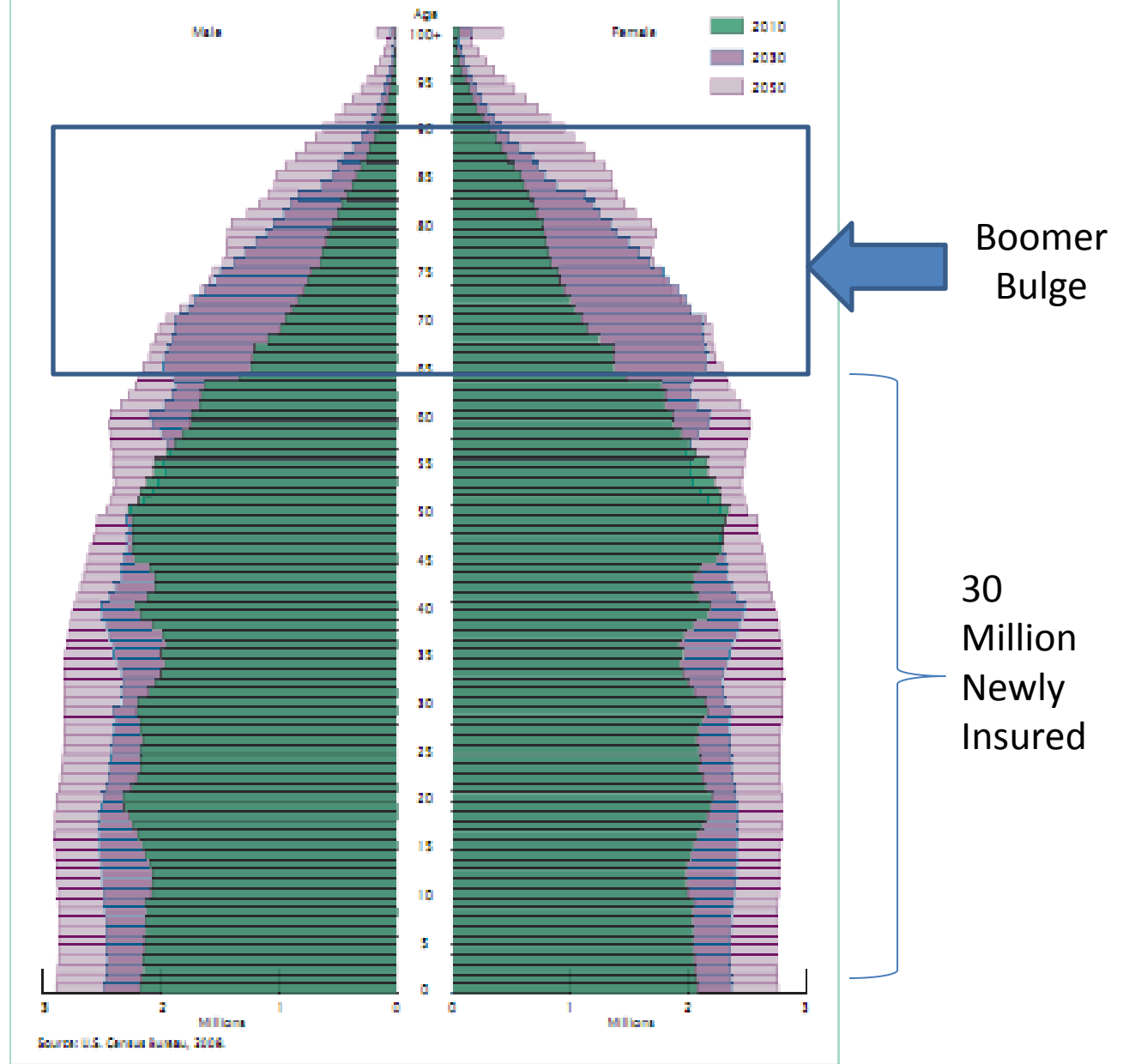
Figure 4.
Projected Population Aged 65 and Over by Race for the United States: 2010 to 2050



Note: Unless otherwise specified, data refer to the population who reported a race alone. Populations for each race group include both Hispanics and non-Hispanics, as Hispanics may be of any race.

Source: U.S. Census Bureau, 2008.

Figure 1.
Age and Sex Structure of the Population for the United States: 2010, 2030, and 2050



Health Reform Priorities

National
Priorities
Partnership

1. Care coordination for chronic disease
2. Overuse
3. Palliative end-of-life care
4. Patient and family engagement
5. Population health
6. Safety

The “Triple Aim”

- Improve Individual Experience
- Improve Population Health
- Control Inflation of Per Capita Costs

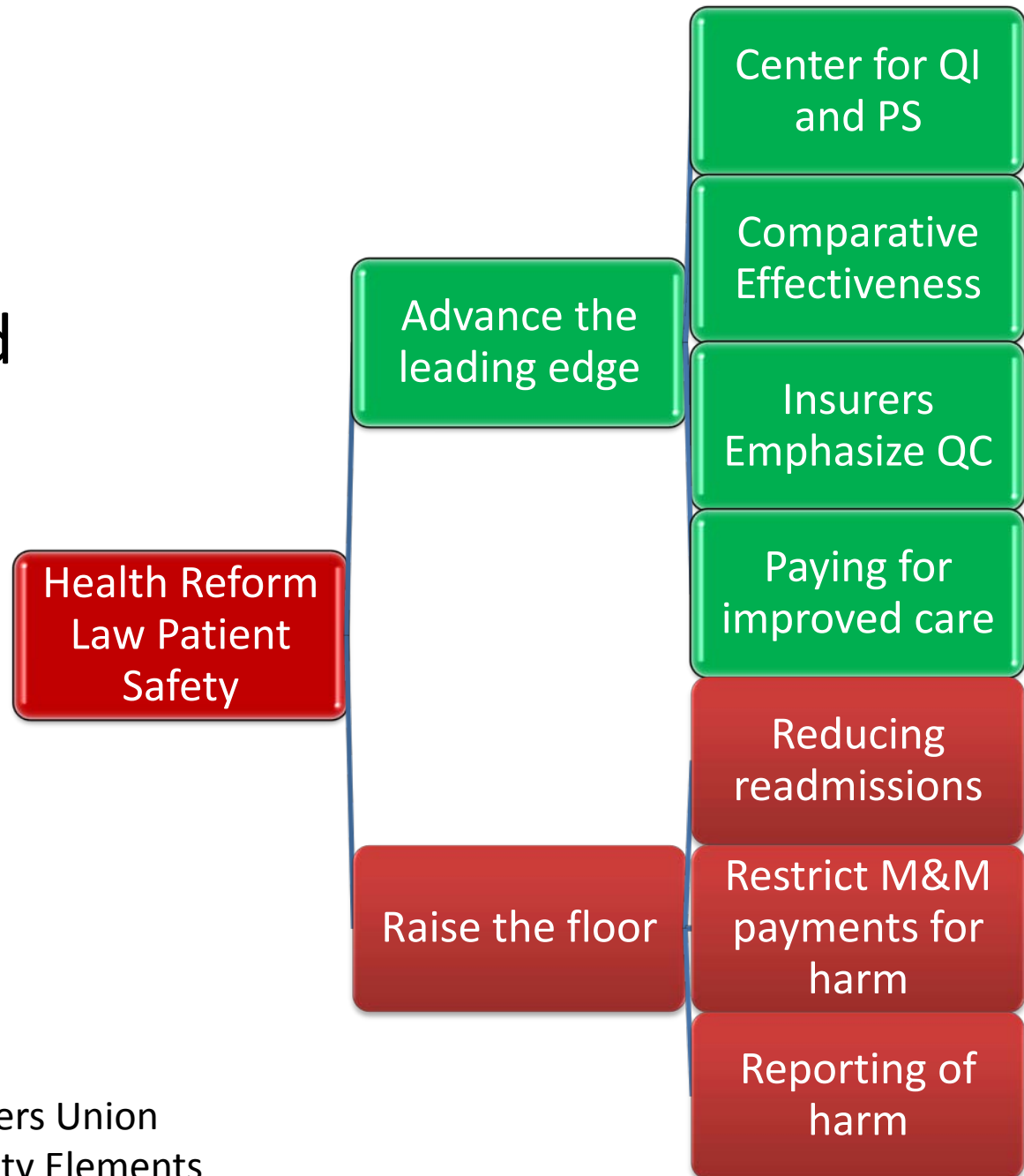


The root of the problem in health care is that the business models of almost all US health care organizations depend on keeping these three aims separate. Society on the other hand needs these three aims optimized (given appropriate weightings on the components) simultaneously.

Tom Nolan, PhD

One View

Patient
Protection and
Affordable
Care Act
(US 2010 Health
Reform)



Adapted from Consumers Union
Analysis of Patient Safety Elements

Pursuing Perfection in Quality and Safety



Jim Reinertsen

Organizations with the Best Outcomes Will Win

- Clinical
- Financial
- Service
- Satisfaction / Experience

The Intersection of Cost and Quality and Service and Satisfaction



Online article and related content
current as of November 2, 2010.

The End of the Quality Improvement Movement: Long Live Improving Value

Robert H. Brook

JAMA. 2010;304(16):1831-1832 (doi:10.1001/jama.2010.1555)

<http://jama.ama-assn.org/cgi/content/full/304/16/1831>

**Safety and secrecy cannot
coexist in complex, tightly
coupled systems; transparency
and safety go together.**

Don Berwick



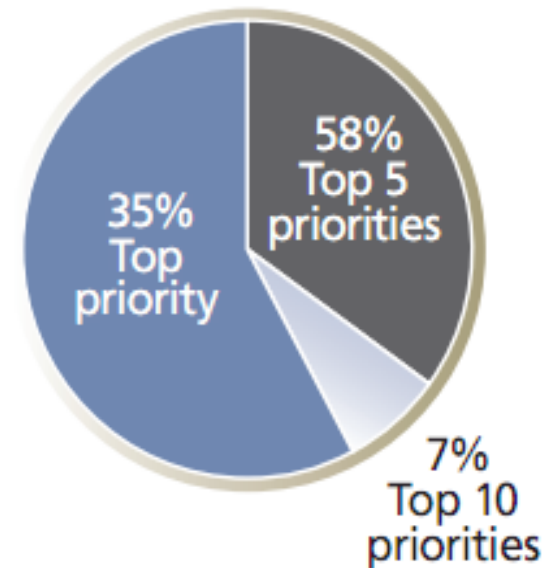
The Time Is Now

If health and/or healthcare is on the table, then the consumer (public, patient, family member) must be at the table, every table.

NOW!

Lucian Leape Institute, 2008

Ninety-three percent of healthcare leaders say patient experience is among their top five priorities.



We're Creating the Health Care *System*

REALLY!
FINALLY!

Massachusetts State Quality Improvement Institute

Massachusetts Strategic Plan for Care Transitions

February, 2010

Alice Bonner, Ph.D, Massachusetts Department of Public Health
Craig D. Schneider, Ph.D, Massachusetts Health Data Consortium
Joel S. Weissman, Ph.D, Executive Office of Health and Human Services

For the Massachusetts Executive Office of Health and Human Services, One Ashburton
Place, 11th Floor, Boston, MA 02114

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Ethics

The study of how to live life well (Beabout & Wennemann)

Principle	Corresponding Duty
Respect	Treat every human being, including yourself, with the respect befitting the dignity and worth of a person
Non-malevolence	Avoid harming people
Benevolence	Promote the well being of others
Integrity	Maintain the personal standards of conduct befitting a professional
Justice	Be fair, treating people equally
Utility	Chose the course of action that produces the greatest benefit to the greatest number of people
Double effect	Make sure that there are no foreseeable bad side effects that are disproportionate with the good of the main effect

The paradox of plenty

What do higher spending regions -- and systems -- get?

Content / Quality of Care^{1,2}

Technical quality worse
No more elective surgery
More hospital stays, visits, specialist use, tests

Health Outcomes^{1,2}

Slightly higher mortality
No better function

Physician's perceptions⁵

Worse communication among physicians
Greater difficulty ensuring continuity of care
Greater difficulty providing high quality care
Greater perception of scarcity

Patient-perceived quality^{1,3}

Lower satisfaction with hospital care
Worse access to primary care

Trends over time⁴

Greater growth in per-capita resource use
Lower gains in survival (following AMI)

(1) Ann Intern Med: 2003; 138: 273-298

(2) Health Affairs web exclusives, October 7, 2004

(3) Health Affairs, web exclusives, Nov 16, 2005

(4) Health Affairs web exclusives, Feb 7, 2006

(5) Ann Intern Med: 2006; 144: 641-649



“What do you mean? Cost has little relationship to charge and charge has little to do with actual payment. Then payment depends on the deal you got, and none of it depends on the quality?”

“I don’t get it.”

Every where we look in our health care system we see tremendous waste. By eliminating waste we improve quality, safety and reduce cost. Isn't that what health care improvement should be all about?

Gary S. Kaplan, MD
Chairman and CEO
Virginia Mason Medical Center

Waste Reduction Targets for National Priorities Partnership*

*A partnership between the National Quality Forum and 28 other organizations

- **Inappropriate medication use**

Targeting inappropriate antibiotic use and polypharmacy (for multiple chronic conditions; of antipsychotics).

- **Unnecessary laboratory tests**

Targeting panels (e.g., thyroid, SMA 20), special testing (e.g., Lyme Disease with regional considerations).

- **Unwarranted maternity care interventions**

Targeting unwarranted cesarean section.

- **Unwarranted diagnostic procedures**

Targeting cardiac computed tomography (non-invasive coronary angiography and coronary calcium scoring), lumbar spine MRI prior to conservative therapy, without red flags, uncomplicated chest/thorax CT screening, bone or joint x-ray prior to conservative therapy, without red flags, chest x-ray, preoperative, on admission, or routine monitoring, endoscopy.

- **Unwarranted procedures**

Targeting spine surgery, percutaneous transluminal coronary angioplasty (PTCA)/Stent, knee/hip replacement, coronary artery bypass graft (CABG), hysterectomy, prostatectomy.

- **Unnecessary consultations**

- **Preventable emergency department visits and hospitalizations**

Targeting potentially preventable emergency department visits, hospital admissions lasting less than 24 hours, and ambulatory care sensitive conditions.

- **Inappropriate non-palliative services at end of life**

Targeting chemotherapy in the last 14 days of life, inappropriate interventional procedures, and more than one ED visit in the last 30 days of life.

- **Potentially harmful preventive services with no benefit**

Targeting BRCA mutation testing for breast and ovarian cancer – female, low risk, CHD: Screening using ECG, ETT, EBCT – adults, low risk, carotid artery stenosis screening – general adult population, cervical cancer screening – female over 65, average risk; female, post-hysterectomy, prostate cancer screening – male over 75 (from the U.S. Preventive Services Task Force D Recommendations List).

“The Billion Dollar U-Turn”

- 17.6% of all Medicare hospitalizations are 30d *rehospitalizations*
 - Accounting for \$15 B in spending in 2004
- Not all rehospitalizations are avoidable, but many are
 - 75% “potentially preventable”
 - Accounts for \$12B in Medicare spending
 - Heart Failure, Pneumonia, COPD, Acute MI lead the medical conditions
 - CABG, PTCA, other vascular procedures lead the surgical conditions
- There is wide intra-state and inter-state variation
 - Medicare 30-day rehospitalization rate varies 13-24% across states



Mark Taylor, *The Billion Dollar U-Turn, Hospitals and Health Networks*, May 2008

MedPAC Report to Congress, *Promoting Greater Efficiency in Medicare*. June 2007

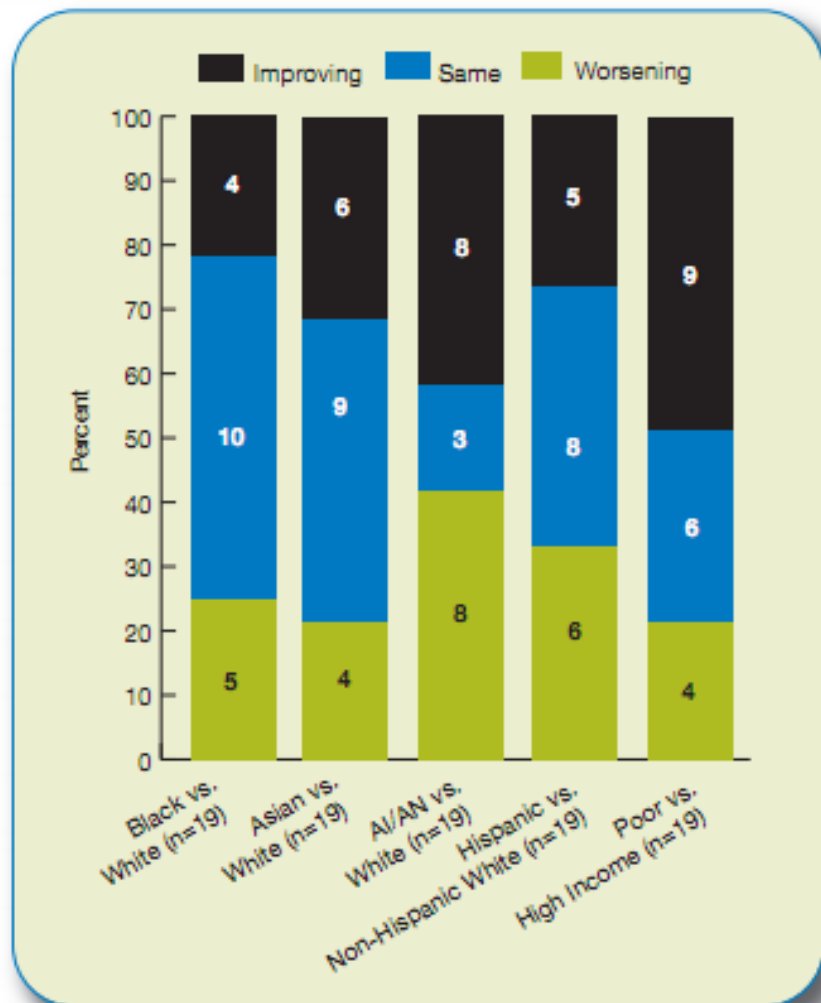
Commonwealth Fund State Scorecard on Health System Performance. October 2009

... a head in the bed is still a good thing. Can I wait a while to do something about readmissions?

*The revenue hit will kill us if
we move now.*

Selected Core Quality Measures

Change Over Time (2000-2002 to 2005-2007)



2009 National Healthcare Disparities Report Themes

- Disparities are common and un-insurance is an important contributor.
- Many disparities are not decreasing.
- Some disparities merit particular attention, especially care for cancer, heart failure, and pneumonia.
- For Blacks, Asians, American Indians / Alaska Natives, Hispanics and poor people, at least 60% of quality of care measures are not improving

Do you have people on your staff
that you wouldn't refer a family
member or friend to?

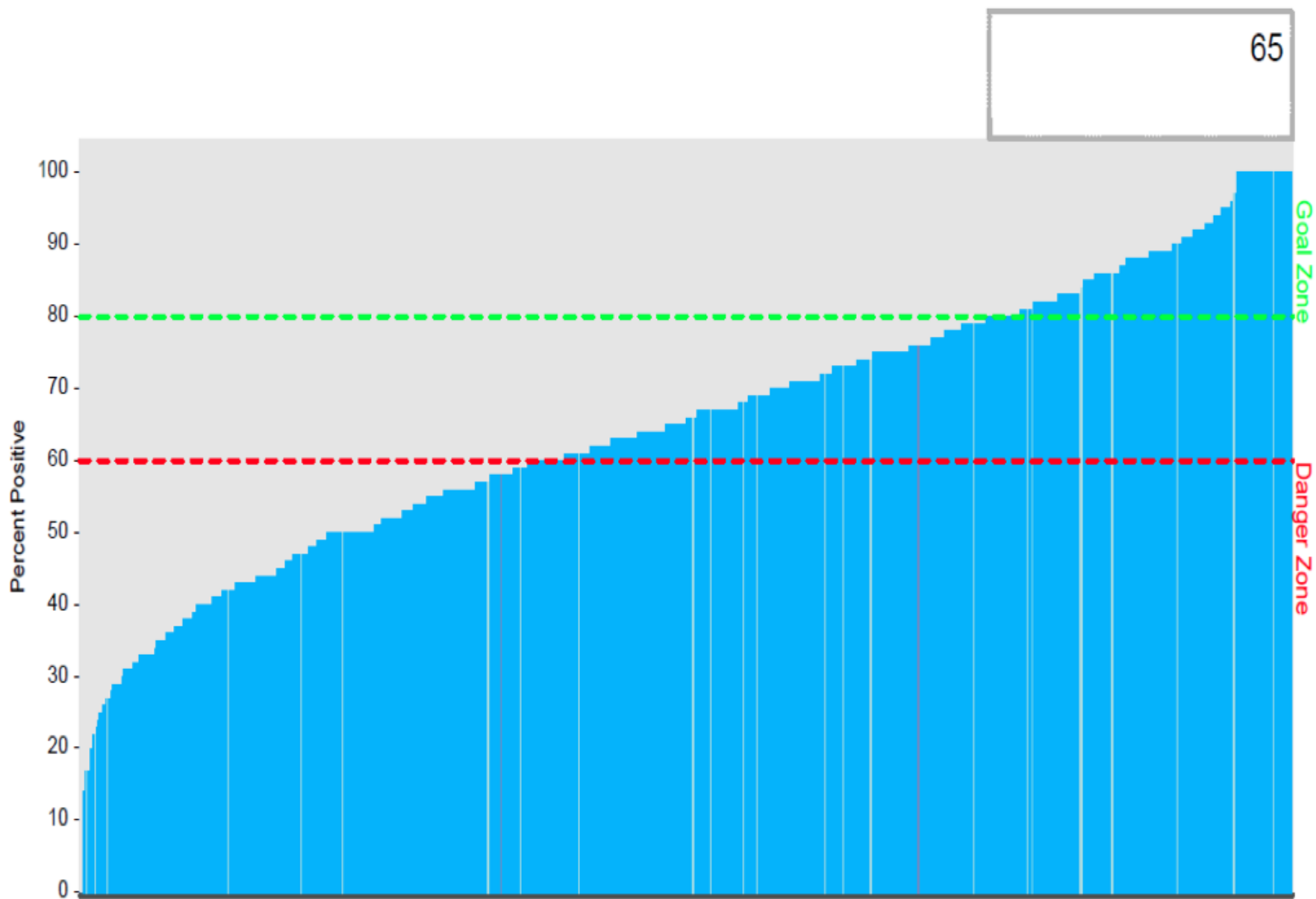
What about that is ok?
What does it take?



How would you describe your
culture?

“Which one?”

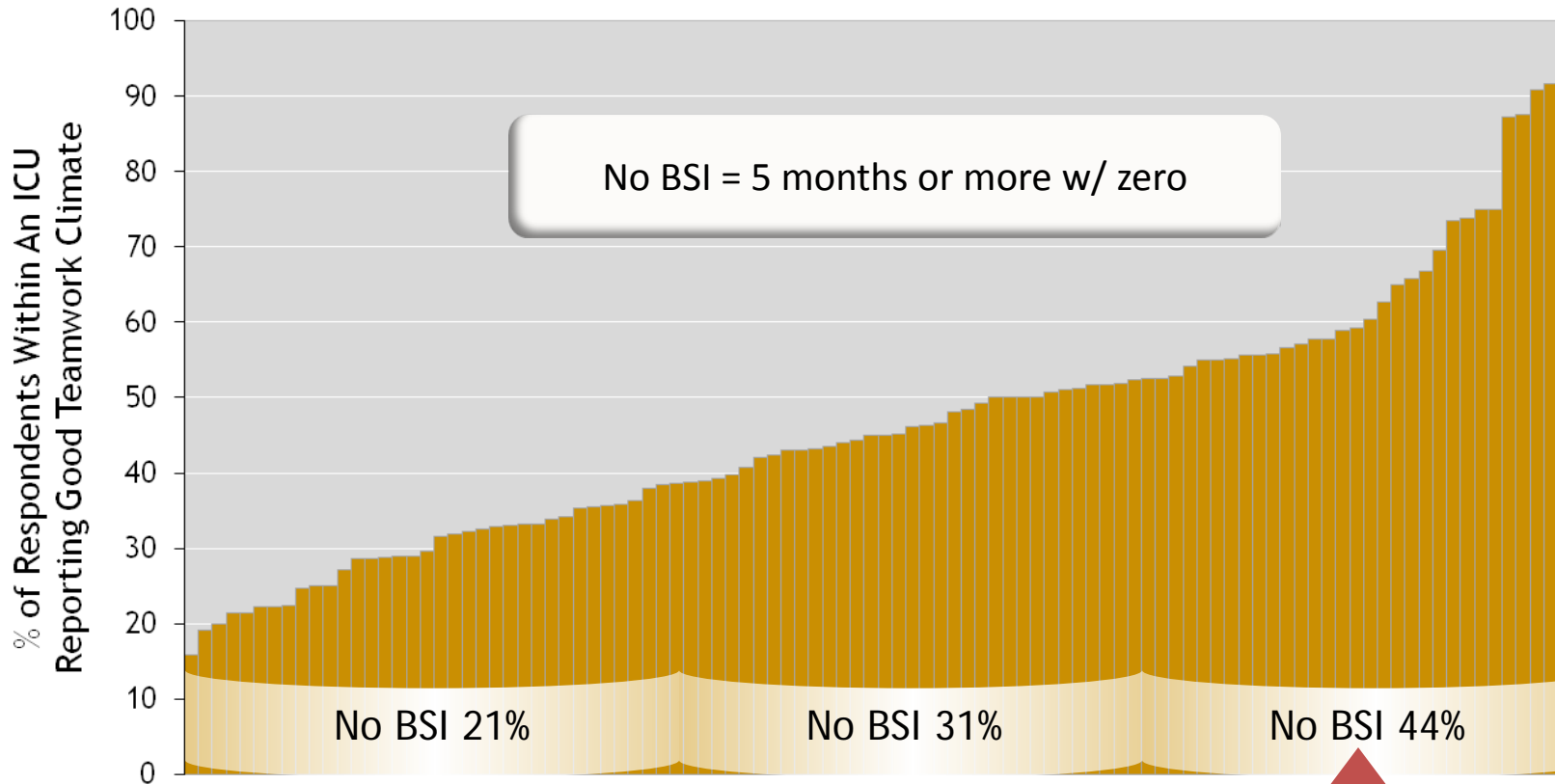
Teamwork Climate



Teamwork Climate across all clinical areas in a system

Courtesy M. Leonard
Pascal Metrics, 2010

Teamwork Climate Across Michigan ICUs



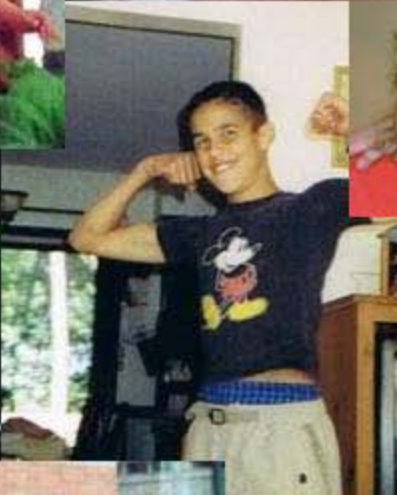
The strongest predictor of clinical excellence: caregivers feel comfortable speaking up if they perceive a problem with patient care

Voices of Families

Enormous Struggles Remain

- ... We watched her die of dehydration...
- ...I was told if I wasn't a better parent, I may have to leave..."
- ...I went to the ED to get someone to help. No one on the unit would listen to me..."
- ...I'm a mother and a nurse... why didn't they listen to me...
- ...The inquest said that if they had paid attention to us, she'd be alive...

Listen to me, trust me, respect me as a partner in care





ADVERSE EVENTS IN HOSPITALS

NATIONAL INCIDENCE: MEDICARE BENEFICIARIES

- An estimated 13.5 percent of hospitalized Medicare beneficiaries experienced adverse events during their hospital stays
 - Projects to an estimated 134,000 Medicare beneficiaries experiencing at least 1 adverse event in hospitals during the 1-month study period.
 - An estimated 1.5 percent of Medicare beneficiaries experienced an event that contributed to their deaths, which projects to 15,000 patients in a month
- An additional 13.5 percent of Medicare beneficiaries experienced events during their hospital stays that resulted in temporary harm.
- Physician reviewers determined that 44 percent of adverse and temporary harm events were clearly or likely preventable
- Hospital care associated with adverse and temporary harm events cost Medicare an estimated \$324 million in October 2008.

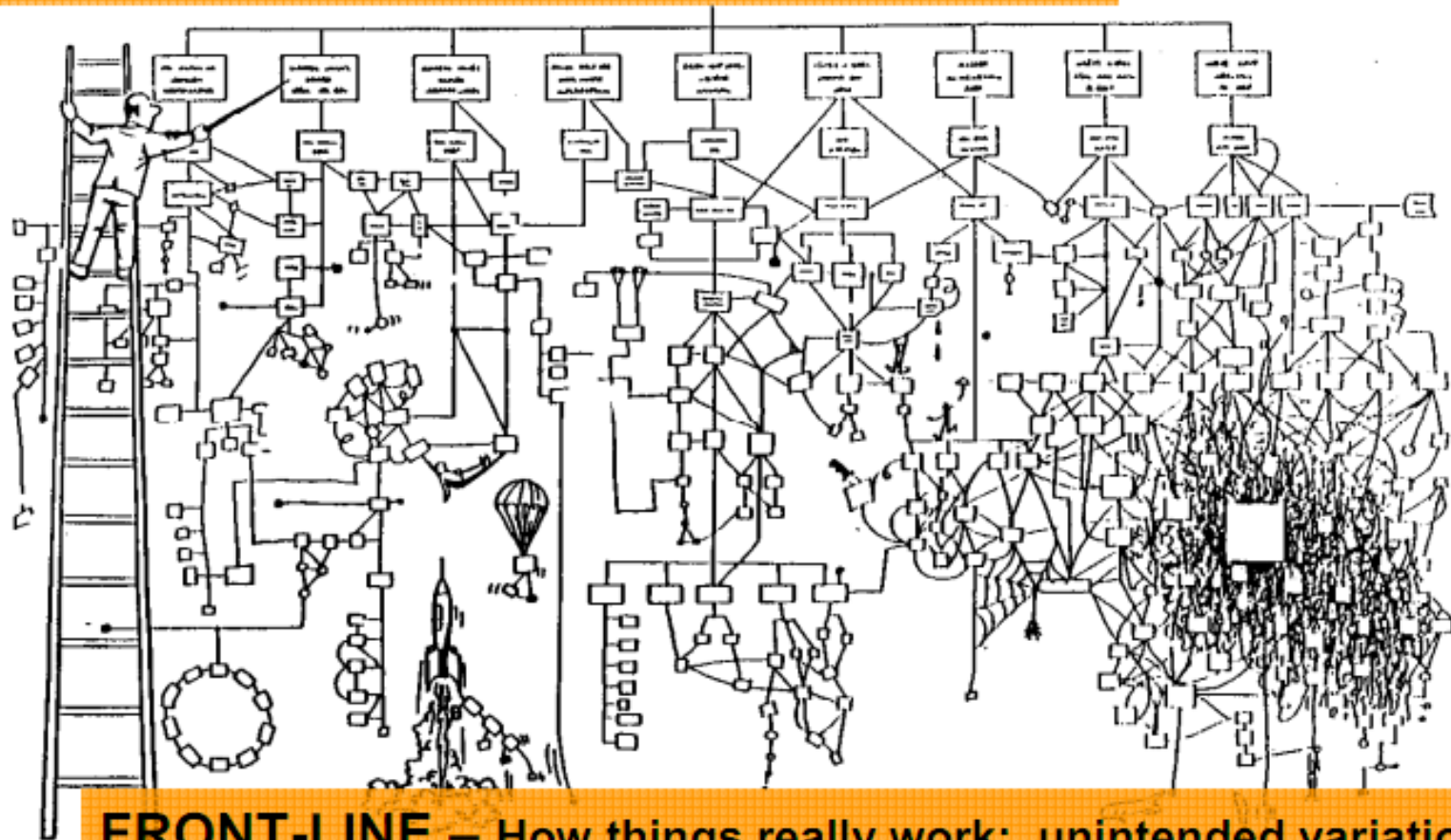
“Every day I come
to work I feel like
I’m sitting at the
bottom of a
waterfall. The stuff
keeps coming and
coming”

Staff RN



...ALL Work is a Process!

LEADER – “How I think things work or should work”



FRONT-LINE – How things really work: unintended variation

Confusion...Conflict...Complexity...Chaos

Rank Your Organizations Top 3 Priorities for the Next 3 Years

What a difference a year can make!	Top 3 2010	Rank	Top 3 2009	Rank
Quality / Patient Safety	40%	1	69%	1
Patient Experience	38%	2	26%	3
Cost Reduction	36%	3	21%	6
MD Recruitment / Retention	30%	4	35%	2
Reimbursement	26%	5	23%	5
Capital Improvement	19%	6	24%	4
Technology	16%	7	13%	9
Care Coordination	14%	8	NA	
New Clinical Procedures	10%	9	11%	10
MD Ventures/Alignment	10%	10	10%	11
Revenue Cycle	10%	11	20%	7

Leadership Characteristics

Where are exceptional outcomes possible?

STRONG LEADER

- Communicates
- Honest
- Visionary
- Respectful
- Sets expectation
- Aligns incentives
- Develops staff
- Visible and approachable
- Optimistic and passionate
- Action oriented
- Knows and empowers people
- Story-teller

WEAK LEADER

- Dishonest
- Insincere
- Absent
- Dictatorial
- Reactive
- Ineffective in meetings
- Selfish and self-centered
- Secretive
- Ignores critical issues
- Under-resources
- Arrogant
- Tunnel vision

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The Leadership Imperative for Quality, Safety and Financial Performance.

April 25, 2010

**Jim Conway, FACHE
Senior Fellow,
Institute for Healthcare Improvement**

**Adjunct Faculty,
Harvard School of Public Health
jconway@hsph.harvard.edu**

What's a Leadership Imperative

- We must ALL improve our performance
 - Experience of care: Quality and Safety
 - Health of the community, city, state, nation
 - Per-capita cost of care
- We must improve it now—urgently
- We must improve systematically
- We must sustain the gains over time
- We are responsible for our outcomes and we should and will be held accountable

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Leadership and Management at Every Level Critical in Improving Quality & Safety

- Governance
- Executive Clinical and Administrative Leadership (C-Suite)
- Senior Directors (Manager of Managers)
- Middle Managers
 - Front line managers, microsystem leaders
- Working supervisors
- Employees and staff (individual contributors and as members of high performance teams)

Patient and Family Centered Care
Personal and Public Engagement

A Powerful Evolution

Do it to me.

Do it for me.

Do it with me.

Martha Hayward
Patient Advocate

Respect

An Overwhelming Message

At the end of the day...
NOTHING is more important

Expectations of Leadership

- Live this core value
- Be the exemplar
 - Model the way, mobilize the effort
- Insist on respectful behavior by others
- Welcome and respond to concerns
- Support staff experiencing disrespectful conduct

IMAGINE THE IMPOSSIBLE

CareSouth: Toward Zero Disparity between White and Non-White Patients

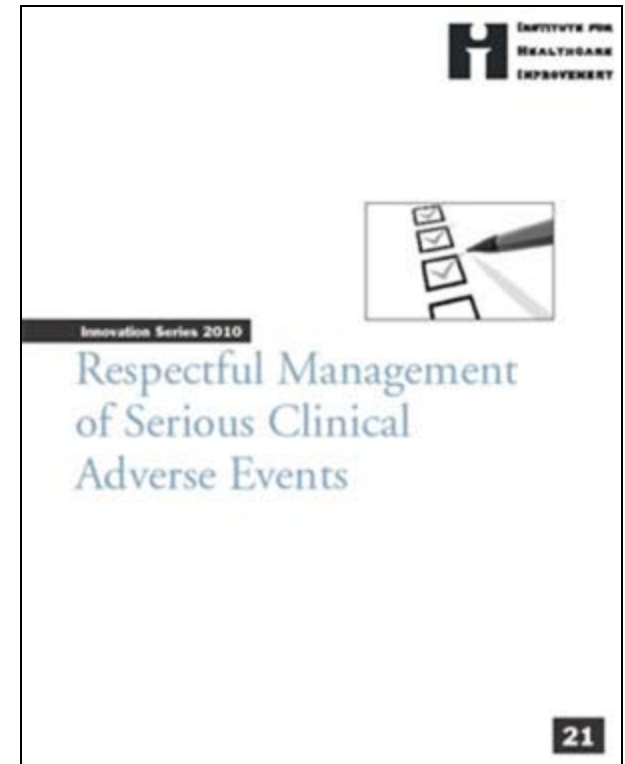
CONDITION	NUMBER OF PATIENTS	CARESOUTH DISPARITY	NATIONAL (OR STATE) DISPARITY
<i>Hypertension</i>	5457	12.1%	130%
<i>Diabetes</i>	2029	9.8%	200%-300%
<i>Depression</i>	1003	-2.2%	50%
<i>Asthma</i>	472	-5.5%	300%

Six Specific Recommendations for Healthcare Executives

1. Know your organizational performance
2. Set bold and measurable aims for your organization and community
3. Prepare patients, families, staff for success
4. Establish systems to support effective care delivery
5. Create measures and accountability to ensure programs are working
6. Remove external barriers

Kabcenell A, Conway J. Honoring Patient Preferences in Advanced Illness: Six Leadership Actions. Healthcare Executive. In Press

In the aftermath of an serious adverse event, the patient, family member, staff, and community all say they were treated with RESPECT.



<http://tinyurl.com/IHIEffectiveCrisisMgmt>

Ethics

The study of how to live life well (Beabout & Wennemann)

Principle	Corresponding Duty
Respect	Treat every human being, including yourself, with the respect befitting the dignity and worth of a person
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Questions and Comments