Health Care Reform: Collaborative Systemic Solutions

By Larry Bridgesmith

As public discourse and political posturing regarding the Affordable Care Act reaches a fever pitch, health care practitioners are asking, “How long must we wait for substantive reform?” The politicization of health care renders the prospect of significant and timely change more illusory by the day. Those providing care at the bedside seem to have gotten lost in the maze of statutory and regulatory “enhancements” to health care protocols. Is health care a constitutional right? Does political intransigence fatally threaten needed improvements in the nation’s health care system? Must meaningful improvement in medical outcomes require governmental involvement?

The complexity of the health care system suggests that no single person or entity can do much to alter the state of the practice of medicine today. As a result, our tendency may be to defer to Washington to address the complicated problems of health care.

However, evidence is building to indicate that when the disciplines involved in the delivery of quality health care learn to collaborate, medical outcomes can be improved, medical costs can be reduced, and patient satisfaction can improve. Multi-disciplinary collaboration may prove more effective in generating health care reform than all government mandated solutions combined.

A small pilot project at St. Joseph’s Medical Center in Phoenix, Arizona serves to illustrate the power of trans-disciplinary collaboration. In early 2011, the preliminary results of a pilot study support the premise that meaningful health care reform is not dependent on Congress, the courts, or constitutional interpretation.1

A 32 bed neurosurgical intensive care unit (“NICU”) at St. Joseph’s had experienced the predictable difficulties when families facing critical care and end of life issues encounter the health system unprepared. Despite the availability of world class neurosurgeons, highly skilled nurses, dedicated clergy, and biomedical ethicists, the St. Joseph NICU staff had experienced more than its share of “exceptional families.”

Exceptional families come in many shapes and sizes. What is common about these challenging consumers of the health care system is their lack of understanding or preparation for the difficult decisions that may need to be made in life threatening medical circumstances. The lack of advanced directives, health care powers of attorney, or any planning for a critical care situation takes these families by surprise. There may be unresolved family issues that complicate decision making for an incapacitated family member. The dreaded “brother from California” who has had little involvement in mother’s care might show up at the bed side and take charge of the crisis contrary to the needs and expectations of others who have been closer to the patient.
Without a designated surrogate, these situations can become unmanageable by the health care team quickly.

At St. Joseph’s, turnover in the NICU had become unsustainable and concerns about patient care and moral distress among health care providers mounted.

In response, a proposed study was developed through the collaborative effort of physicians, nurses, clergy, and hospital administration, including bioethicists. A baseline was established in terms of patient admission demographics including severity, length of stay, duration of intubation, and dismissal outcomes where charted. A comparative study was designed to examine the impact of a single integrated alteration in medical protocol: structured intervention in educating families on critical care, end of life decision making, and resources available to assist.

Based on studies performed by prior researchers, patients and families were questioned about their preparation for advanced directives and surrogacy decision making at the point of admission. St. Joseph personnel further developed an information collection tool for their purposes. As part of that process they helped identify the patient's legally authorized representative (guardian, agent, surrogate or “LAR”). If the patient lacked capacity they helped the LAR understand how he/she would participate in the shared decision making process using either substituted judgment or best interests standards.

A second point of intervention was developed for patients remaining in the NICU after seven days or following 72 hours of ventilator support. At this point, conversations about advanced directives and surrogacy were intentional and specific. Rather than awaiting the inevitable conflict to arise from “difficult families” unprepared for critical care decision making, the St. Joseph NICU staff interjected themselves and facilitated difficult conversations in a very structured and strategic fashion. Interventions were conducted, as was the protocol, on a multi-disciplinary basis. Nurses, physicians, ethicists, social workers, and pastoral care providers were all involved as appropriate to the patient and the patient’s family.

The results of this pilot study were remarkable. Using severity criteria devised to identify the “worst of the worst” cases, the first such 100 patients in each comparative period were analyzed. During the post-intervention study the length of stay declined by 6 days, the period of ventilator support declined by 39 hours, and billed charges declined by $64,000 per patient. Patient satisfaction remained the same. The Medicare case-mix index of 1.7 remained the same reflecting no difference in average case severity.

At a cost of $35,000 for training and protocol development, the 32 bed intensive care unit realized a minimum of $6.2 million savings in billed costs over the second study period in contrast to the first. Otherwise, the data differential between the base period and the post-intervention period was statistically insignificant in terms of release options, morbidity, morality, and similar indicators of medical outcomes. In other words, there was no increase in
patient morbidity or mortality when the base period was compared to the second. Even though length of stay and intubation durations were reduced, there was no degradation in medical outcomes. This was no “death panel.”

Instead, families were assisted in exercising self-determination over their own medical affairs. By learning how to facilitate difficult conversations, the physicians, nurses, clergy, and affiliated services improved health care outcomes. By programmatic and intentional intervention, the resources available to families in crisis were inserted into the medical protocol. This was health care reform at the most fundamental level: the bedside.

This “simple” solution required a complex exercise in trans-disciplinary cooperation. Physicians, nurses, clergy, administration, and bio-ethicists had to both protect their disciplinary integrity and collaborate in a non-traditional fashion. Without creative leadership, cooperative dialog, and conflict management expertise this experiment would have never taken place. The most difficult task of all was learning to listen and incorporate the vision and values of other disciplines into a solution that benefited all.

Conflict resolution principles and strategies do not simply apply to settle cases in litigation. The same skills and practices commonly called “mediation” can be inserted much earlier in the conflict continuum to much greater effect. Lobbyists, lawyers, and lawsuits are not necessary to address the presenting problems of conflict in health care. In fact, the earlier the intervention and less complex the “solution,” the better the medical outcome may prove to be.

We will all watch with a combination of fascination and terror as Heath Care Reform (large letter) takes shape on the national political scene through political posturing, litigation, and legislation. In the meantime, we can all engage in meaningful health care reform (small letter) through trans-disciplinary dialogue much closer to where it matters most: at the bedside.

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