HOSPITAL-PHYSICIAN ALIGNMENT:

THE PAST, PRESENT AND FUTURE

A thesis submitted to the Caspersen School of Graduate Studies

Drew University in partial fulfillment of

the requirements for the degree,

Masters of Medical Humanities

Nicole Lopez-Marin

Drew University

Madison, New Jersey

May 2016

ACKNOWLEDGMENT

My thanks to my advisor, Dr. Scibilia, for his support with both my research and throughout my time in the program. He has shown me that business can have a heart. I also wish to thank Nancy Gross for her endless feedback. There was never a page she wouldn't read or question she wouldn't answer; she is a true teacher and humanitarian. Thanks also to my husband, Drew, for his never-ending love and support. I would have never started the program without his encouragement, and I surely would not have finished. Lastly, I would like to thank my mother, Barbara, who inspired me to enter healthcare and continues to inspire me daily with her passion and accomplishments. My biggest hope is to make all of you proud.

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1 Introduction

1.1 Defining the Problem

This thesis will examine what the history and practice of medicine is, and how, using that knowledge, we can empower everyone to deliver and receive better care. Dr. Paul Kalanithi was a young, talented Neurosurgeon that was faced unexpectedly with Stage IV terminal lung cancer and bravely straddled the line between physician and patient. His experiences, which he wrote about in detail in his memoir, When Breath Becomes Air, raise many questions, but seek to shed light on the real patient experience while also questioning the ethics of medicine and the meaning of life. According to his biography in The Stanford News: "His 'dual citizenship' as a doctor and as a seriously ill patient had taught him that respectful communication is the bedrock of all medicine"[1] (Spector, 2015).

The healthcare system in the United States is demanding, complicated and ever-evolving. The inefficiency of the system economically is disrupting the balance and distracting from the main purpose of healthcare: to serve those who are in need, using humanistic principles such as compassion and empathy, while communicating effectively to provide the best care possible. By re-focusing on these core tenets, we can work smarter as we align goals, behaviors and processes. Given the intimate involvement of both clinicians and administrators on patient care, it would seem as though physicians and hospitals would be aligned; alignment is defined as harmoniously working together, communicating openly to provide the best care for their patients while addressing the challenging landscape of modern healthcare cohesively.

[1]Spector, Roseanne "Stanford Neurosurgeon Writer Paul Kalanithi Dies" Web 4 March 2016 <https://med.stanford.edu/news/all-news/2015/03/stanford-neurosurgeon-writer-paul-kalanithi-dies-at-37.html>

The business of healthcare controls the success of all aspects of the system, be it financial viability, effective care, or hospital-physician relationships. Economic vitality post World War II and better reimbursement meant that physicians had professional authority and hospitals respected the physician's role. Hospital goals and physician goals were aligned and in harmony. Times have changed, and while this was not long ago, merely 50 years past, we have yet to see that happen again. Economics cannot trump patient care considerations. Just as there has been a shift between hospital-physician alignment, there too has been a shift from the hospital as the center of care. Practicing physicians used to refer to the hospital as their homes. There was a sense of loyalty and pride. We need to get back to the era of aligned incentives and efficient reimbursement. The first step is changing the conversation between the hospital, the patient and the physician.

There is a stigma associated with the business of healthcare that hospital administrators are only worried about the bottom line and physicians lack the financial acumen required to make any sort of decisions that extend beyond the clinical. I have witnessed this in my experience as a hospital administrator for a large healthcare system. Hospitals and physicians need each other, and we can accomplish a lot more when we join forces rather than battle. The objective of this thesis is to explain why hospitals and physicians need to align, and how they can align.

Once we look at the times when the healthcare system worked effectively in this country, and why the system isn't working now, we can better understand what needs to happen. In its current state, the patient is suffering as a result of misaligned incentives. The statistics tell us that effective care, or coordinated care, isn't happening. This is examined in more detail in this paper.

There are encouraging signs that quality of care has value. Value based reimbursement ("VBR") and pay for performance ("P4P") payment models are being rolled out in an effort to improve the quality of care rendered. VBR, also called value-based payment, involves paying for quality, taking clinical markers into account and ultimately producing better population-based outcomes[2]. With the VBR payment model, clinicians receive higher pay if they provide high-quality, low-cost care[3]. With P4P payment models, payment systems offer financial rewards to providers who achieve, improve, or exceed their performance on specified quality and cost measures[4]. The idea behind these initiatives is that placing financial incentives on the performance of physicians, hospitals, and the health care system will lead to significant improvement in performance and the care of patients[5]. However, changing behavior is difficult. Rolling out change from the top down will not work.

We are approaching the problem from the wrong direction. Implementing processes, setting goals and thus ultimately changing behavior is working backwards. Rather, we need to change the behavior, set aligned and reasonable goals, and then implement processes. If we do not address the sense of competition that exists between hospitals and physicians, and the lack of harmony, these reforms will never be the panacea we all wish them to be. What will drive improvement? A focus on the patient experience and engagement of physicians will drive improvement.

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[2] Evans, Jim. Transitioning to Value-Based Reimbursement. Executive Insight. Web 26 Apr. 2016. http://healthcare-executive-insight.advanceweb.com/Features/Articles/Transitioning-to-Value-based-Reimbursement.aspx
[3] Westgate, Aubrey. Getting Paid for Value: Defining New Reimbursement Models Web 26 Apr. 2016 http://www.physicianspractice.com/fee-schedule-survey/getting-paid-value-defining-new-reimbursement-models
[4] Health Care Incentives Improvement Institute. Web. 26 Apr. 2016. http://www.hci3.org/thought-leadership/why-incentives-matter/pay-performance/pay-performance-models
[5] Marco, Alan P. "Hit Or Myth?." Physician Executive 35.2 (2009): 34-39. MasterFILE Elite. Web. 1 Mar. 2016.

Assuming the healthcare system requires change, are doctors expected to be agents of change? Are doctors prepared to participate on a collective level to improve care? We know that healthcare quality requires meeting objective standards of humanity. Medical humanism will help doctors become agents of change. Sir William Osler, commonly described as the "Father of Modern Medicine", was a physician and one of the four founding fathers of John Hopkins Hospital. He created the first residency program for specialty training of physicians and was the first to bring students out of lecture halls and for bedside training[6]. Sir Osler stated: "The practice of medicine is an art, not a trade; a calling, not a business; a calling in which your heart will be exercised equally with your head"[7] (The William Osler Papers, 2016). If we consider medicine to be an art, as Sir Osler describes, what is the role for the humanities in the science of medicine?

There is an art of medicine that we see, for example, when a physician counsels a patient. Sir Osler specified that there is one enduring corrective for the practice towards patients, which is grounded by the Golden Rule of Humanity as announced by Confuscious [6th century B.C. philosopher]: "What you do not like when done to yourself, do not do to others"[8] (The Art and Practice of Medical Writing, 1927). Osler also tells us that often the best part of being a physician has nothing to do with potions and powders, but with influence and comfort. We must make sure that we focus on both the business and the art of healing.

This thesis takes a look at physicians and their nature as professionals. Medicine is characterized by a certain level of uncertainty. Does the uncertainty of medical practice limit doctors' ability to engage with systemic healthcare problems? There are doctors, other health

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[6] "The William Osler Papers." Profiles in Science:. National Library of Medicine, n.d. Web. 26 Apr. 2016. <https://profiles.nlm.nih.gov/GF/>.
[7] "The Art and Practice of Medical Writing." *Arch Intern Med Archives of Internal Medicine* 39.3 (1927): 462. Web. 26 Apr. 2016
[8] "The Art and Practice of Medical Writing." *Arch Intern Med Archives of Internal Medicine* 39.3 (1927): 462. Web. 26 Apr. 2016

care professionals, hospital systems and patients; we all fall in at least one of those categories. It is crucial to examine the doctor-patient relationship, how it has evolved, and how focusing on this relationship will shift the patient care continuum towards higher quality. It also behooves us to examine case studies of healthcare organizations that have taken a proactive role in improving their processes to yield improvement in care delivered, supported by empirical evidence.

2 Healthcare Then and Now: Where We Have Been and Where We Are going

2.1 1900 - 1930s: Private Insurance

The relationship between hospitals and physicians hasn't always been so tenuous. When we look at a time one hundred years ago, when healthcare was much simpler, we gain some insight. In the early 1900s, doctors and hospitals saw a greater financial return when a patient had a hospital stay. Patients were sick, they went to the hospital, and everyone got paid, as best they could. There was less bureaucracy and fewer layers of administration and government to navigate. In the early 1900s, physicians saw hospitals as a place to hone their craft. Hospitals became more efficient, and also more expensive. At this time, physicians and hospitals were better aligned and physicians were more involved in management. There was a symbiotic relationship. Additionally, at this time "hospitals were able to focus on happy outcomes"[9] (Accidents of History Created U.S. Health System). As described by Dr. Joel D. Howell in his book "Technology in the Hospital: Transforming Patient Care in the Early Twentieth Century", medical technology was sparse and primitive. A "modern hospital" in the early 1900s was characterized by a laundry room, kitchen, and if they were lucky, a telephone system[10]. Howell describes the transformation of medicine into a science-based discipline during the period between 1900 and 1925 which changed how patients were cared for and how hospitals functioned[11]. The hospitals grew in complexity as well. Howell describes:

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[9] "Accidents Of History Created U.S. Health System." NPR. NPR, n.d. Web. 26 Apr. 2016. <http://www.npr.org/templates/story/story.php?storyId=114045132>.

[10] Howell, Joel D. Technology in the Hospital: Transforming Patient Care in the Early Twentieth Century. Baltimore: Johns Hopkins UP, 1995. Print.

[11] Howell, Joel D. Technology in the Hospital: Transforming Patient Care in the Early Twentieth Century. Baltimore: Johns Hopkins UP, 1995. Print.

> Originally, the patient's room, or more likely the ward, was the place where the patient spent all his or her time, but as hospitals grew in complexity, and technology was introduced, patients were taken during the course of their stay to unfamiliar places such as the x-ray room or the electrocardiography room. Organizational complexity also included the appearance on the hospital staff of persons with specific technical responsibilities[12] (Howell, 1995).

In the early 1900s, health care was virtually unregulated and health insurance, nonexistent. Both physicians and hospitals were unregulated. When patients saw a physician, they paid their modest fees out-of-pocket; patients were more concerned about the income they would lose if illness kept them out of work than about the cost of their medical care[13].

During the 1920s, the cost of medical care rose due to growing demand and higher quality standards for physicians and hospitals. Factors that improved the visibility of hospital included advances in medical technology and tougher licensing criteria. From 1900 to 1930 there was a growing acceptance of medicine as a science, which led to the emergence of hospitals as credible centers for treatment[14]. When the American College of Surgeons was founded in 1913, it was the first body to accredit hospitals[15]. Of the 692 hospitals examined in 1918, only 13 percent received accreditation. By 1932, the percentage accredited had grown to 93 percent of the 1,600 hospitals surveyed[16]. The increase of hospitals examined and accredited from 1918 – 1932 shows their increasing prevalence in the market.

When the Great Depression hit in 1930, the economy suffered. Hospitals and health care providers were not immune. The shift in the economic climate happened suddenly. The statistics tell us that in 1930, the national income was less than half of what it was just a year earlier, in

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[12] Howell, Joel D. Technology in the Hospital: Transforming Patient Care in the Early Twentieth Century. Baltimore: Johns Hopkins UP, 1995. Print.
[13] Moseley III, George B. JD MBA. The U.S. Health Care Non-System, 1908-2008. AMA Journal of Ethics Virtual Mentor. May 2008, Volume 10, Number 5: 324-331. Web.
[14] Moseley III, George B. JD MBA. The U.S. Health Care Non-System, 1908-2008. AMA Journal of Ethics Virtual Mentor. May 2008, Volume 10, Number 5: 324-331. Web.
[15] Affeldt JE. Voluntary accreditation. Proc Acad Polit Sci. 1980;33(4):182-191.
[16] Shryock RH. The Development of Modern Medicine. Madison, WI: University of Wisconsin Press; 1979:348.

1929[17]. When funds are strained, it is not a surprise that healthcare participation should also decrease. Visits to physicians and hospitals decreased since Americans could not pay their bills.

The empty beds lead to a revolution for the private health insurance world. Two companies, which you still recognize today, were created in an effort to address hospital-physician cash flow: Blue Cross and Blue Shield. The American Hospital Association created the Blue Cross plan (hospital coverage) in 1933 and Blue Shield (medical and surgical coverage) in 1939. There was talk of national health insurance proposals at the same time. The discussion came from the need to establish a model to pay for healthcare. The Great Depression put a significant strain on the American population and there was no way to pay for the care that was needed and being delivered. Many Americans had to go without health care and many others could not pay for even part of their medical bills. The government had a responsibility to address the needs of the American people. It appears the government did not realize how profoundly the decisions made at this time would impact healthcare.

During the 1930s, physicians became concerned about proposals for national health insurance and the threat of insurance competition from Blue Cross[18]. Doctors worried that third-party payers would lower their incomes by restricting their ability to set their own fees. In response, physicians established a network of their own insurance plans covering physician services. These plans, known as Blue Shield, preempted the hospital-oriented Blue Cross plans from entering into the primary care sector. Meanwhile, in 1935, the Social Security Act was passed without a health insurance component. The success of the Blue Cross and Blue Shield plans showed commercial insurers that adverse selection could be overcome by focusing on insuring groups of young, healthy, employed workers. As a result the market for health insurance

[17] Medicine and Health in the 1930s: Overview." DISCovering U.S. History. Detroit: Gale, 2003. Student Resources in Context. Web. 22 Feb. 2016.
[18] Leland RG. Prepayment plans for hospital care. JAMA. 1933;100:113-117.

of all kinds increased dramatically during the 1940s, from a total enrollment of 20,662,000 in 1940 to 142,334,000 in 1950[19].

2.2 1940s – 1960s: Hospital at the Center of Healthcare

The Great Depression inadvertently led to the creation of private health insurance, and World War II galvanized the movement. The economy continued to evolve, and the economy during the war was unique. Food rationing and factories were common place. These factories, now producing more and more, tried to attract potential workers with benefits, specifically, health insurance benefits. Wage and price controls prevented employers from using higher salaries to attract workers. Rather than offer higher salaries, they offered benefits like health insurance[20]. In addition, the National Labor Relations Board ruled that health insurance benefits were a legitimate subject of labor-management negotiations. The Internal Revenue Service also determined that employers could deduct the cost of employee health benefits from taxable business income, and employees did not have to include the value of those benefits in calculating their own taxable income. The role of employers as the primary source of health insurance coverage was cemented[21]. By the 1960s 70 percent of the population had private, voluntary health insurance coverage[22]. Americans now bought into the private health insurance model because it was working for them. Or rather, technically, they were working for them, and this became the norm. Either people were employed with jobs and benefits, or they had to look to the government for public coverage- it was one or the other.

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[19] Moseley III, George B. JD MBA. The U.S. Health Care Non-System, 1908-2008. AMA Journal of Ethics Virtual Mentor. May 2008, Volume 10, Number 5: 324-331. Web.
[20] Klein J. For All These Rights: Business, Labor, and the Shaping of America's Public-Private Welfare State. Princeton, NJ: Princeton University Press; 2003:204-257.
[21] Scofea LA. The development and growth of employer-provided health insurance. Mon Labor Rev. 1994;117(3):3-10.
[22] Davidson, Adam. "Accidents Of History Created U.S. Health System." NPR, 22 Oct. 2009. Web. 29 Feb. 2016. <http://www.npr.org/templates/story/story.php?storyId=114045132>.

As private insurance started to gain momentum, from the 1940s up until the 1960s, **t**he popularity of medical specialties after World War II meant the hospital was the center of healthcare. Physician specialization dramatically increased and this greatly impacted the hospital-physician relationship. The rise of physician specialists was one of the biggest shifts of this time period. The TIME Magazine article "One Patient, Too Many Doctors: The Terrible Expense of Overspecialization" explains the rise:

> In 1940, three-quarters of America's physicians were general practitioners. By 1960 specialists outnumbered generalists, and by 1970 only a quarter of doctors counted themselves general practitioners. This increase paralleled an equally dramatic rise in medical expenses, from $3 billion in 1940 to $75 billion in 1970[23] (Jauhar, 2016).

As technology was developing and specialization increased, physicians were tethered to their hospitals. They couldn't be expected to invest in research and have access to the same technology in small private practices. Most practicing physicians spent their time in hospitals or nearby offices[24]. In addition to more advances and increased specializations, Americans received greater levels of medical and preventive care during the 1950s[25]. The specialization of the physicians and the advances made, such as penicillin, inoculations like polio vaccines and diagnostic techniques like x-rays, reinforced the hospital as the nucleus of healthcare. As hospitals became the center of medical care delivery, it became apparent that many communities lacked adequate access to them.

The Hill-Burton Act was passed in 1946 to provide loans and grants for the construction of new hospitals and improvements in the physical plants of existing ones[26]. Over the years many

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[23] Jauhar, Dr. Sandeep, Dr. "One Patient, Too Many Doctors: The Terrible Expense of Overspecialization." TIME Magazine. Web. 29 Feb. 2016.
[24] Medicine and Health in the 1930s: Overview. DISCovering U.S. History. Detroit: Gale, 2003. Student Resources in Context. Web. 29 Feb. 2016.
[25] Fillmore, Randolph. The Evolution of the U.S. Healthcare. Unknown. Document. 17 February 2016.
[26] Brinker PA, Burley W. The Hill-Burton Act: 1948-1954. Rev Econ Stat. 1962;44(2):208-212.

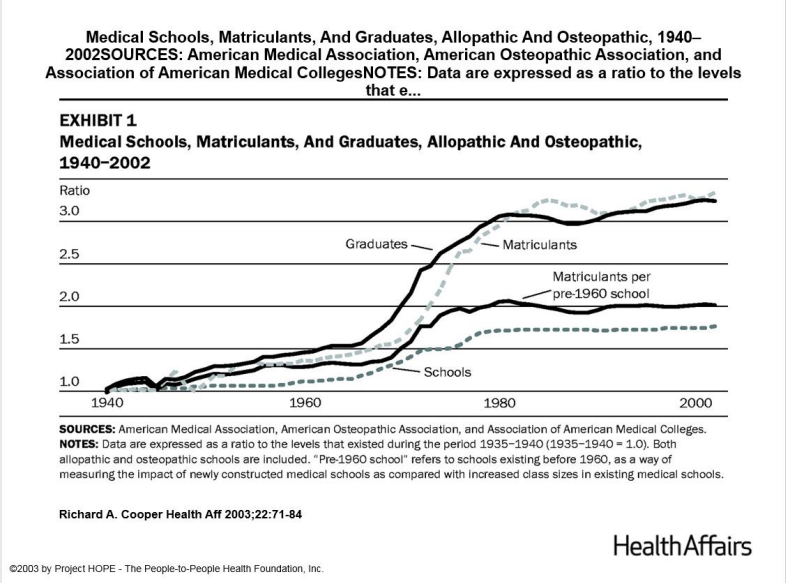
legislative proposals for different approaches to health insurance were introduced and failed. In 1944 President Roosevelt asked Congress for an "Economic Bill of Rights" that included a right to adequate medical care, but this request was never fulfilled. President Truman proposed a national health insurance program that would have created a system covering all Americans, but it was denounced by the AMA and called a "communist plot" by members of Congress[27]. By 1950, national health care expenditures equaled 4.5 percent of the GNP (gross national product) and were continuing to rise[28]. During the 1950s, the price of hospital care doubled, and medical breakthroughs were happening often. Medications became available to treat infections and conditions like glaucoma and arthritis, and the first successful organ transplant was performed in 1954.

2.3 1960s – 1970s: Aligned Incentives: Beginning of the End

By the end of the 1950s, 75 percent of Americans were covered by private health insurance coverage[29]. At this time, physicians were still somewhat independent, they were paid through the fee-for-service delivery model, and hospitals were the center of healthcare. Overall, hospitals and physicians enjoyed a generally productive and harmonious time. The research states that there was a strong sense of professional community and loyalty to the physicians' "medical homes"[30], a term used to describe the allegiance physicians felt to their local hospitals. As more students graduated medical school, hospital medical staff expanded. Growth in the number of medical school graduates in the 1960s and 1970s prompted expansion of hospital

[27] Quadango J. Why the United States has no national health insurance: stakeholder mobilization against the welfare state. J Health Soc Behav. 2004;45
[28] Kristein MM, Arnold CB, Wynder FL. Health economics and preventive care. Science. 1977;195(4277):457-462.
[29] Preskitt, John T. "Health Care Reimbursement: Clemens to Clinton." Proceedings (Baylor University. Medical Center) 21.1 (2008): 40–44. Print.
[30] The Changing Nature of Hospital-Physician Relations" *ACHE* Web 25. Feb. 2016. http://ache.org/pdf/secure/gifts/february10-ListerSagin.pdf

medical staff. In the figure below, one can see that after 1960 there was a steep increase of both medical schools and medical school graduates (see fig. 1):



[31]

Figure 1

As more students matriculated and graduated medical school, the physician workforce grew and most community physicians had at least one hospital affiliation; participation on multiple medical staffs became more common[32]. This was a perfect storm for hospitals and physicians. Specialization was increasing, the number of doctors in the workforce increased, and hospitals were growing with complexity. However, we see that increasing bureaucracies, a result of more government programs and a change to delivery models, required a different type of hospital administrator. Initially, hospital administrators simply served the physicians working in their facilities. As bureaucracy increased, so did the role of the hospital administrator. This is where the tide starts to turn.

[31] Cooper, R. A. "Medical Schools And Their Applicants: An Analysis." *Health Affairs* 22.4 (2003): 71-84. Web.
[32] "The Changing Nature of Hospital-Physician Relations" *ACHE* Web 25. Feb. 2016. http://ache.org/pdf/secure/gifts/february10-ListerSagin.pdf

The literature states that "Administrators in the 1950s through the 1980s rarely needed to confront or challenge physicians and largely deferred to their 'professional authority'"[33] (The Changing Nature of Hospital-Physician Relations). With the increased bureaucracy, the political climate shifted as a result of President Kennedy's assassination in 1960, and with President Johnson taking helm. By 1965, there was a congressional mandate for coverage for those 65 years and older, known as Medicare. It was not nationalized health insurance, but it was a step closer. The American Medical Association (AMA) staunchly opposed the idea of national health insurance. Physicians in leadership positions spoke out about Medicare, saying it was "the most deadly challenge ever faced by the medical profession" [34] and they warned it "would lead to out of control spending" [35]. Specifically, the AMA opposed efforts to nationalize healthcare because they believed it meant physicians would lose their autonomy, be required to work in group practice models and be paid by salary or capitated methods[36]. The loss of physician autonomy has led to a decline in morale. Furthermore, the decline in morale is partially responsible for the decline of the efficacy of American healthcare, and the increase in cost.

2.4 Runaway Healthcare Costs and the Threat to Physician Alignment

Entering the 1960s, the health care system was fiscally unrestrained. There were no external controls on the cost of medical therapies delivered or the resources consumed. There were, by then, more than 700 companies selling health insurance. However, people who were unemployed, like the elderly, were having difficulty paying for it. Realizing that proposals for

[33] "The Changing Nature of Hospital-Physician Relations" *ACHE* Web 25. Feb. 2016. http://ache.org/pdf/secure/gifts/february10-ListerSagin.pdf
[34] Corning PA. The Evolution of Medicare: From Idea to Law [Research Report No. 29, Social Security Administration, Office of Research and Statistics] Washington, DC: Government Printing Office; 1969.
[35] Mahar M. Money-Driven Medicine: The Real Reason Health Care Costs So Much. New York: HarperCollins; 2006.
[36] National Health Insurance—A Brief History of Reform Efforts in the U.S. The Kaiser Family Foundation. Web 25. Apr. 2016 https://kaiserfamilyfoundation.files.wordpress.com/2013/01/7871.pdf

total reform of the system were not working, advocates turned to a more incremental approach. We see the tide start to turn in the mid-1960s. In 1965, Congress created the Medicare and Medicaid programs to provide health care coverage to the elderly and poor[37]. This meant the federal government became the largest single purchaser of health care services, but these two public programs adopted the same reimbursement defects that were found in the private health insurance industry, accelerating the rate of health care price inflation[38].

Inflation of medical costs that followed the initiation of the federal Medicare program challenged hospital-physician alignment. Doctors continued to be paid under the fee-for-service model. At the same time, the government rallied in an effort to rein in healthcare costs. In 1983, Congress passed the Tax Equity and Fiscal Responsibility Act (TEFRA), which instituted a new payment model for hospitals. Using Diagnosis-Related Groups (DRGs), hospitals would be paid a fixed reimbursement for an episode of illness. The goal was to provide incentive for hospitals to control costs. Overall, DRGs and TEFRA were a temporary response to the problem of hospital cost-containment[39].

With TEFRA and DRGs changing the conversation for hospitals, they were left to evaluate their business processes. At the same time, physicians practiced as usual. Unlike the hospitals, they had no economic incentive to evaluate their methods, and they were not motivated to focus on initiatives such as length of stay or utilization. This planted another seed for misalignment between hospitals and physicians. To start, economic incentives were not in sync. Physicians kept practicing as they knew how to, yet we see that hospitals started hiring

[37] Centers for Medicare and Medicaid. Key Milestones in CMS Programs. Web 25. Apr. 2016 http://www.cms.hhs.gov/ History/Downloads/CMSProgramKeyMilestones.pdf.
[38] Moseley III, George B. JD MBA. The U.S. Health Care Non-System, 1908-2008. AMA Journal of Ethics Virtual Mentor. May 2008, Volume 10, Number 5: 324-331. Web.
[39] https://www.princeton.edu/~ota/disk3/1983/8306/830611.PDF Web 25. Apr. 2016

physicians to serve as utilization advisors. The physician advisors' purpose was to "advise" physicians to discharge patients more quickly, and reduce costs[40]. Let us not forget that prior to this shift, hospitals were the center of healthcare delivery. As the discord grew, hospitals began to question the clinical decisions of their physicians and challenge their autonomy. Hospitals felt pressured to cut costs as physicians began to feel scrutinized.

Looking at the history of hospitals and physicians, we see two instances when there were surges of for-profit hospitals acquiring non-profit hospitals. The first occurrence was in the early 1980s, coinciding with TERFA and DRGs. The growth of for-profit hospitals signifies a fundamental shift of health care in the country[41]. The increased pressure to cut costs left hospitals with challenging financial circumstances[42]. The surge ended after changes were made in the Medicare payment guidelines that had inadvertently stimulated for-profit growth[43]. A study conducted in 1999 analyzed thirty-three nonprofit hospitals that converted to for-profit status and fifty for-profit hospitals that converted to nonprofit ownership between 1989 and 1992. The study found that non-profit hospitals that converted to for-profit had significantly lower profit margins than a comparison group of 3,800 hospitals that did not convert[44]. The study added that prior to selling to for-profit purchasers, all the hospitals sampled suffered from varying degrees of economic challenges, including "inability to adapt to the change to prospective reimbursement in the Medicare program, technological change in patient care and the consequent decrease in

[40] "The Changing Nature of Hospital-Physician Relations" ACHE Web 25. Feb. 2016. http://ache.org/pdf/secure/gifts/february10-ListerSagin.pdf
[41] Gray, B. H. 1991. The Profit Motive and Patient Care. Cambridge: Harvard University Press
[42] "The Changing Nature of Hospital-Physician Relations" ACHE Web 25. Feb. 2016. http://ache.org/pdf/secure/gifts/february10-ListerSagin.pdf
[43] Gray, B. H. 1991. The Profit Motive and Patient Care. Cambridge: Harvard University Press
[44] Mark, T. L. 1999. "Analysis of the Rationale For, and Consequences of, Nonprofit and For-Profit Ownership Conversions." Health Services Research, 34 (1): 83–101.

inpatient admissions and length of stay, and the increase in competition that accompanied the introduction of managed care"[45] (Collins, Hadley 2001).

One consequence of these organizational changes was heightened concern on physicians' behalf that finances would trump patient care considerations[46]. Physicians, perceiving that profit margin was now the hospitals' top priority, lost their sense of loyalty to what they once considered their professional home. As some hospitals were bought and sold multiple times to successive investor-owners, the feelings of distrust and misalignment only intensified.

2.5 Popularity of Managed Care: The Final Blow

Managed care is a type of health insurance coverage characterized by contracts with health care providers and medical facilities to provide care for members, or patients, at reduced costs. These contracted providers make up the plan's network, and how much the plan will pay for depends on the network's rules[47]. The development of managed care as the economic model of choice had a significant impact on healthcare delivery in the United States. Physicians were better able to make this transition than hospitals, whereas hospitals were left more vulnerable. Hospitals began to link themselves to physicians in inorganic ways, such as physician practice management companies, and practice acquisitions. For example, in the late 1980s and early

[45] Collins, S. Gray, B.H. Hadley, J. The For-Profit Conversion of Non-Profit Hospitals in the U.S. Health Care System: Eight Case Studies Web. 26 Apr. 2016. <http://www.commonwealthfund.org/~/media/files/publications/fund-report/2001/may/the-for-profit-conversion-of-nonprofit-hospitals-in-the-u-s--health-care-system--eight-case-studies/collins_convstudies_455-pdf.pdf>

[46] "The Changing Nature of Hospital-Physician Relations" ACHE Web 25. Feb. 2016. http://ache.org/pdf/secure/gifts/february10-ListerSagin.pdf

[47] U.S. National Library of Medicine. Web. 26 Apr. 2016 https://www.nlm.nih.gov/medlineplus/managedcare.html

1990s, first-generation physician practice management ("PPM") companies like PhyCor and MedPartners used a model in which the typical management fee consisted of the following[48]:

1. Reimbursement of the PPM's cost of providing the assets and personnel to the practice
2. Profit Share of 15% of the practice's profit before physician compensation
3. Up to 50% of any profits recognized by the practice as a result of new ancillary services financed by the PPM and any "profit" resulting from capitated HMO products. (Guest, Collins 2016).

The physician practice management companies paid for the assets acquired (such as x-ray machines), and, in effect, leased them back to the practice through the management agreement. They also paid the practice a multiple of projected profit shares. A portion of the purchase price was paid at closing, and the balance was typically paid over a two- to three-year period to prevent any decline in physician compensation during onboarding. The assumption of profit growth was initially built on the theory that all healthcare would end up as a capitated model. However, the healthcare delivery system did not evolve to a capitated model. This is just one example of how the hospital-physician relationship changed in response to the times.

Physicians and hospitals were not able to collaborate easily. Most physicians lacked management or leadership training and they were used to having a sense of autonomy with their expertise not typically questioned. Clinicians, ethicists, politicians and others have raised concerns with regards to managed care and the quality care being provided, the physician-patient relationship, and the future of bioethics[49]. The research even has personal accounts written by physicians addressing these concerns[50]; the AMA has issued guidelines on responding to the

[48] Guest, Beth Connor, Collins, Michael E. Is it Time to Resurrect Physician Practice Management Organizations? Web 26. Apr 2016 http://www.healthleadersmedia.com/physician-leaders/it-time-resurrect-physician-practice-management-organizations?page=0%2C1

[49] Zoloth-Dorfman LRubin S The patient as commodity: managed care and the question of ethics. J Clin Ethics. 1995;6339- 357

[50] Scovern H A physician's experiences in a for-profit staff-model HMO. N Engl J Med. 1988;319787- 790

challenges managed care poses to the practicing physician[51]. Studies have addressed the effects of managed care on physician satisfaction,[52] patient satisfaction[53], and patient outcomes[54]. The study findings represented in the tables below show that managed care has negatively impacted physicians (see fig. 2, 3):

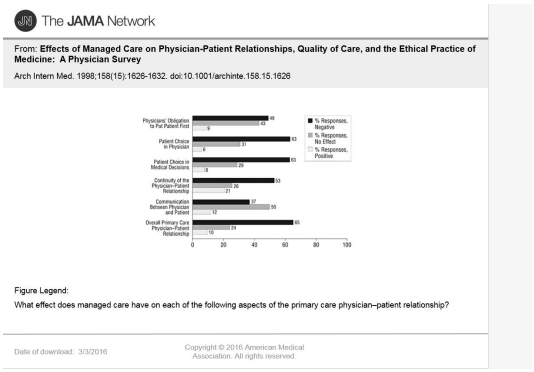


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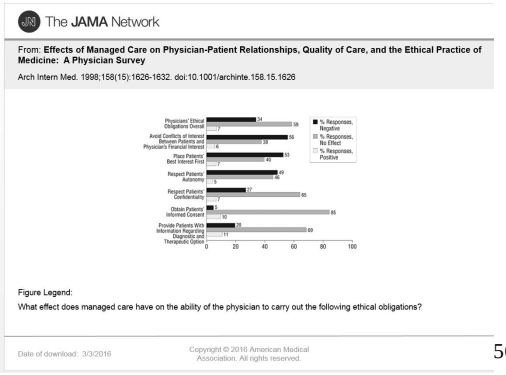
Figure 2



56

Figure 3

[51] American Medical Association Council on Ethical and Judicial Affairs, Ethical issues in health care system reform: the provision of adequate health care. JAMA. 1994;2721056- 1062

[52] Baker LCCantor JC Physician satisfaction under managed care. Health Aff (Millwood). 1993;12258- 270

[53] Knickman JRHughes RGTaylor HBinns KLyons MP Tracking consumers' reactions to the changing health care system. Health Aff (Millwood). 1996;1521- 32

[54] Ware JERogers WHRoss Davies A et al. Comparison of health outcomes at a health maintenance organization with those of fee for service care. Lancet. 1986;11017- 1022

[55] Feldman, Debra S., Dennis H. Novack, and Edward Gracely. "Effects of Managed Care on Physician-Patient Relationships, Quality of Care, and the Ethical Practice of Medicine." Arch Intern Med Archives of Internal Medicine 158.15 (1998): 1626. Web.

[56] Feldman, Debra S., Dennis H. Novack, and Edward Gracely. "Effects of Managed Care on Physician-Patient Relationships, Quality of Care, and the Ethical Practice of Medicine." Arch Intern Med Archives of Internal Medicine 158.15 (1998): 1626. Web.

The research addresses potential conflicts of interest in patient care, as well as challenges for physicians in respecting both their own autonomy and their patients' autonomy. Although the literature questions the impact of some aspect of managed care on the physician-patient relationship and on the ethical obligations of physicians, there is little research that focuses on the physicians' feelings.

2.6 Managed care and the Demise of the Physician-Patient Relationship

Managed care has changed the physician-patient relationship. Prior to the evolution of managed care in the 1990s, the traditional United States health care system was marked by the following features, as detailed by Dranove (2000): "Patients relied on autonomous physicians to act as their agents; patients received complex care from independent, nonprofit hospitals; and insurers did not intervene in medical decision making and reimbursed physicians, hospitals, and other providers on a fee-for-service basis"[57]. The 1990s saw significant health care reform, as managed care grew. For example, "The number of people enrolled in health maintenance organizations (HMOs) doubled in 8 years to 64 million in 1996, and nearly three-fourths of American workers with health insurance receive that coverage in HMOs or other managed care plans"[58]. This significant rise meant that health care was now a competitive marketplace. The insurance plans were no longer working for the physicians and patients. The physicians were working for the HMOs. In the mid-1990s, but the constraints of managed care provoked

[57] Dranove, D. 2000. The evolution of American health care. Princeton, NJ: Princeton University Press. Web.
[58] Afflitto, Lorraine. "Managed Care and its Influence on Physician-Patient Relationship--Implications for Collaborative Practice." Plastic Surgical Nursing 17.4 (1997): 217-8. ProQuest. Web. 14 Mar. 2016.

resistance from patients and physicians, who saw treatment decisions being taken from their hands and their clinical judgment being second-guessed[59].

Having worked for a large managed care organization, the largest in New Jersey, I have seen the managed care strategy; the strategy is to limit or control care options, while simultaneously reducing costs and increasing profit. Part of that managed care strategy is to financially incentivize physicians to limit services and restrict the number of covered procedures under a plan, all while having the authority to make determinations about whether a treatment is medically necessary. This ultimately diminishes the physician's autonomy and limits their decision making. One consequence of this business model is that physicians are expected to quickly respond to these changes in the delivery of care, which is starkly different than models past. These changes impact not only the quality of care the patient receives, but the responsibility of the physician to their patient.

The ideal patient-physician relationship possesses a level of judgment that should not be financially based. The two parameters by which treatment decisions should be made, first and foremost, are the provider's medical expertise and patients' understanding of their illness. Managed care has effectively compromised the physician-patient relationship. There must be a sense of patient autonomy and physician autonomy, and a delicate balance between the two.

In looking at the service of medicine, and the way that physicians are educated and trained, costs are not part of the rubric. Medical students are trained to use their professional judgment and determine the best treatment methods. Cost is not the consideration, nor should it be. The most efficacious treatment is the best treatment, with best treatment being determined

[59] Moseley III, George B. JD MBA. The U.S. Health Care Non-System, 1908-2008. AMA Journal of Ethics Virtual Mentor. May 2008, Volume 10, Number 5: 324-331. Web.

based on the physician's expertise and the patient's understanding. In my experience supporting the Co-Director of Robotic Surgery at Memorial Sloan Kettering, everyone had an understanding that we all shared; the understanding was that every patient should be treated as the only patient and the most important patient. This applied to administrative staff, to mid-levels and to physicians. I remembered this as I answered phones and as I scheduled appointments. I also remembered it as I coordinated pathology reports and scheduled complex surgical procedures. I hope that physicians in every hospital, not just Memorial Sloan Kettering, honor their obligation to the physician-patient relationship. Honoring that obligation means working with the patient to determine the best possible care for that individual. The physician is expected to use their experience, knowledge, peers, continuing education and numerous other sources to decide on a plan of care. The managed care insurance guidelines are not one of the resources they should be expected to use. Restricting a physician and their ability to meet the obligation to the patient violates the understanding of trust and communication that healthcare is built upon. Research suggests that the collective power of physicians has declined because of the more complex and differentiated health care system managed care has created[60].

Managed care impacted hospitals as well, and it is important to keep in mind the focus of this paper: hospital-physician alignment and how the history has shaped the relationship today. Physicians had a certain amount of power and control prior to the rollout of managed care. As we have discussed, physicians felt a loyalty to their hospitals, there was a sense of alignment, and as a result they would steer patients to the hospitals with which they felt allegiance. Hospitals would market to physicians; improved technology, research and teaching were all draws for

[60] Stearns, Cindy A. "How Physicians Lost Out To Managed Care: A Case Study Of Accommodation And Resistance In A Medical Community." Journal Of Medical Humanities 18.4 (1997): 261-271. Academic Search Premier. Web. 14 Mar. 2016.

physicians in the community. Power for the physicians decreased as hospitals increasingly negotiated contracts with HMOs for large numbers of patients, and much more steerage. One report by Cindy Stearns, 1997, details how the first HMO was received by an influential physician in the urban Midwestern region[61]:

> A couple of doctors stood up at meetings and said, "I will resign from whichever hospital signs with Good Health or Total Wellness." Well, that hurts the hospital . . . one was a surgeon whose office was in the hospital and he brought three-fourths of the business there. That is a threat. All told, he didn't resign (Stearns, 1997).

Physicians no longer dictated the terms of their hospital relationships. Hospitals were in a challenging positions as they could not ignore physicians, particularly the physicians that were still directing patients to hospitals and the physicians that maintained a fee-for-service clientele. The top priority became filling the beds for hospitals[62]. With regards to hospital-physician alignment, using contracting and business arrangements, hospitals encouraged the development of HMOs[63], but they also created competition for HMOs by assisting newer physicians and financially backing their private practices. These actions mark a confusing time, where hospitals were trying to fill beds and taking whatever means necessary to do so. Hospitals operated in a contradictory way with their physicians. For the physicians whose practices were being subsidized by the hospitals, they still felt a sense of loyalty. As HMOs grew and the marketplace

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[61] Stearns, Cindy A. "How Physicians Lost Out To Managed Care: A Case Study Of Accommodation And Resistance In A Medical Community." Journal Of Medical Humanities 18.4 (1997): 261-271. Academic Search Premier. Web. 14 Mar. 2016.

[62] Stearns, Cindy A. "How Physicians Lost Out To Managed Care: A Case Study Of Accommodation And Resistance In A Medical Community." Journal Of Medical Humanities 18.4 (1997): 261-271. Academic Search Premier. Web. 14 Mar. 2016.

[63] Stearns, Cindy A. "How Physicians Lost Out To Managed Care: A Case Study Of Accommodation And Resistance In A Medical Community." Journal Of Medical Humanities 18.4 (1997): 261-271. Academic Search Premier. Web. 14 Mar. 2016.

diversified, it became a more competitive place to practice medicine. This made it hard for physicians to trust hospitals, and their goals were not necessarily aligned.

Taking a closer look at the physician-patient relationship, the research tells us of two case studies where the impact managed care had on the physician and patient dynamic (Stearns, 1997):

> Case 1: The first is the case of a woman who, in the presence of a negative mammogram, was diagnosed at age 26 with invasive breast cancer. She had breast conservation surgery (lumpectomy) and the prescribed postoperative radiation therapy. Seven years later, she has decided to have bilateral prophylactic mastectomies because she fears another primary breast cancer and or a recurrence. She sought the advice of a surgeon who, in fulfilling his commitment to explore all treatment options, referred her to our office for reconstructive breast surgery…patient chose a competent surgeon who referred her to a competent specialist. Both surgeons communicated an understanding of her experience of health and illness and clearly discussed all alternative treatment options. They were compassionate and supported her decision. Their intent was to establish a lifelong physician-patient relationship ensuring continuity of care. Neither surgeon is a participant in an HMO or other managed care plan. Their primary directive is patient wellbeing. In this case, the patient's goal and the surgeon's goal are the same. There is no conflict of interest (Stearns, 1997).

In this instance we see a positive relationship between the physician and the patient. We would expect treatment to continue as mutually determined by the patient and the doctor. The surgeons practiced coordination of care, while also considering what the patient wanted and the outcomes she sought to achieve. With this case, the patient was denied benefits by her managed care insurance company on the basis that her surgery was not medically necessary[64]. The physician and patient had a mutually shared objective, which was to minimize the patient's risk of cancer going forward. This case featured a patient that had already endured cancer treatment years prior. She was trying to take a proactive role with regards to her health, and her physicians agreed. She hired an attorney to fight the ruling by the managed care organization, and got

[64] Stearns, Cindy A. "How Physicians Lost Out To Managed Care: A Case Study Of Accommodation And Resistance In A Medical Community." Journal Of Medical Humanities 18.4 (1997): 261-271. Academic Search Premier. Web. 14 Mar. 2016.

approval for the mastectomies but not the reconstruction. This is an example of how the business of medicine impacts the physician-patient relationship. We need to make sure medical ethics still applies.

Another case study, also presented by Stearns, 1997:

> Case 2: The next example will describe an HMO physician-patient relationship. This example documents mistreatment of an individual who required surgical management of an epithelioid sarcoma of the leg. Our patient chose his initial surgeon from a list of HMO providers. Although the surgeon claimed to be competent and the HMO listed him as having expertise in treating tumors of this kind, it was later discovered that he had very little experience with a tumor of this pathology. He operated and the result was inadequate resection of the tumor and improper closure of the wound. The wound later dehisced. This surgeon did not know his own limitations and most likely because of financial conflict of interest and or contractual obligations to the HMO he did not refer the patient to a specialist. Following surgery, this surgeon did not communicate all of the treatment options. Instead, he offered only the option of radiation therapy. Intuitively, our patient did not feel that this was his only option and he sought a second opinion from a surgeon who did not belong to the HMO. He underwent further and complete resection of the tumor and a plastic surgery reconstructive closure of the defect (Stearns, 1997).

The patient in this study if currently disease-free, but if he had followed the advice of the primary surgeon, he would be either dead or dying of disease[65]. With this case study we see a breakdown in physician-patient communication, and we see the lack of coordination of care, and effective treatment. The patient was not entitled to all of his treatment options.

Managed care has taken the value of the "best" treatment away from both the physician and patient, and the patient-physician relationship needs to be restored to the high level of trust that existed before managed care began. The burden of cost control undermines the physician-patient relationship. Patient autonomy and choice can be restricted by insurers, employers and by managed care network providers. The focus on physician productivity limits the time necessary

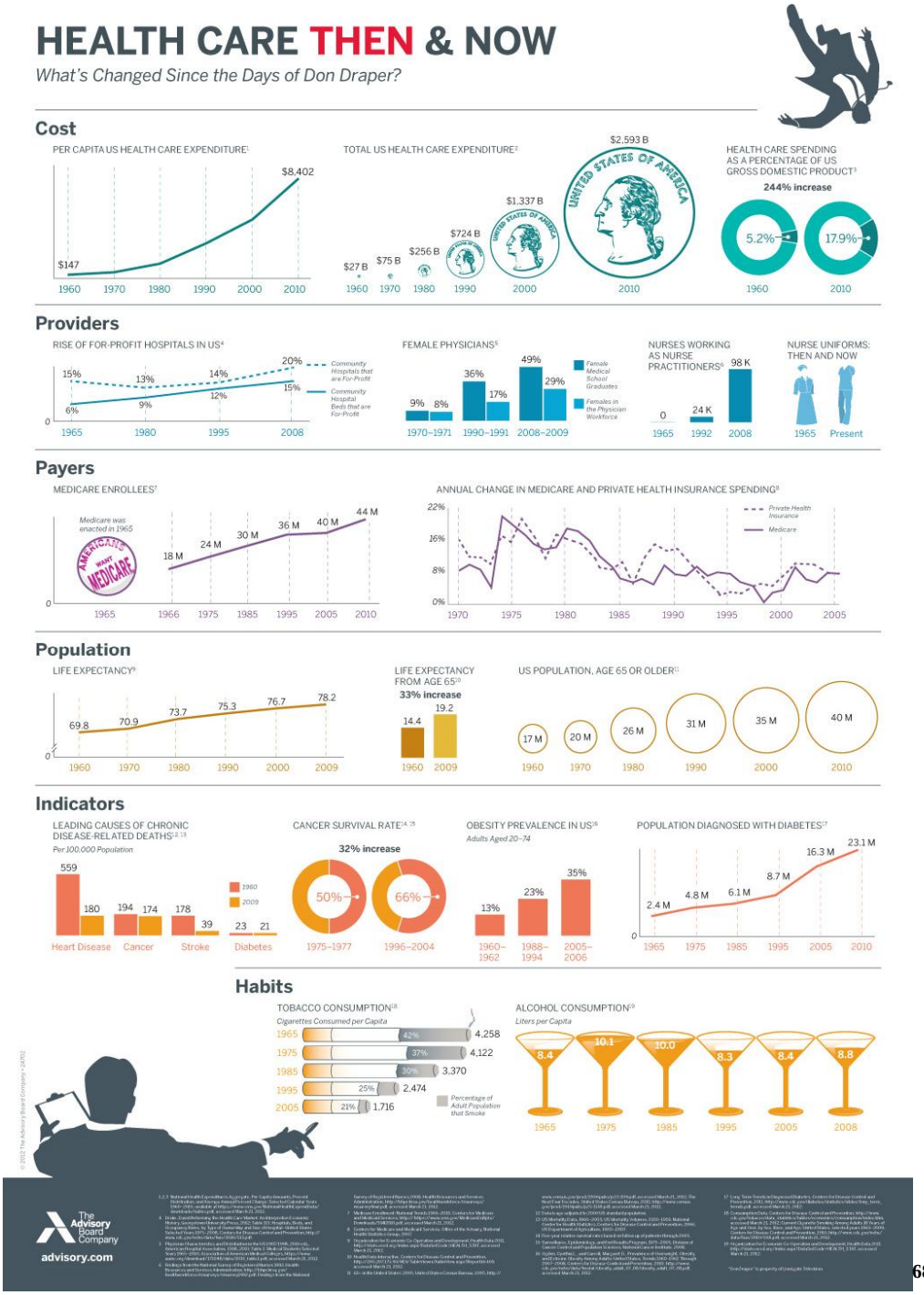
[65] Stearns, Cindy A. "How Physicians Lost Out To Managed Care: A Case Study Of Accommodation And Resistance In A Medical Community." Journal Of Medical Humanities 18.4 (1997): 261-271. Academic Search Premier. Web. 14 Mar. 2016.

for patient communication, and changes to managed care coverage or lower cost insurance plans can greatly disrupt continuity of care in continuity of care[66]. Physician-patient relationship may be an important influence on patients' health outcomes and must be taken into account in light of current changes in the health care delivery system that may place threaten this relationship[67]. Positive physician-patient relationships are essential for effective medical care, which we will examine in more detail later in this analysis. Managed care laid the groundwork for the current state of healthcare and the over-spending we see, with under performance on key performance measures when compared with other healthcare systems globally.

Health Care Then & Now (figure below):

[66] Emanuel, E.J., & Dubler, N.N. (1995). Preserving the physician-patient relationship in the era of managed care. Journal of the American Medical Association, 273, 323-329

[67] Kaplan, Sherrie H., Sheldon Greenfield, and John E. Ware. "Assessing the Effects of Physician-Patient Interactions on the Outcomes of Chronic Disease." *Medical Care* 27.Supplement (1989). Web.



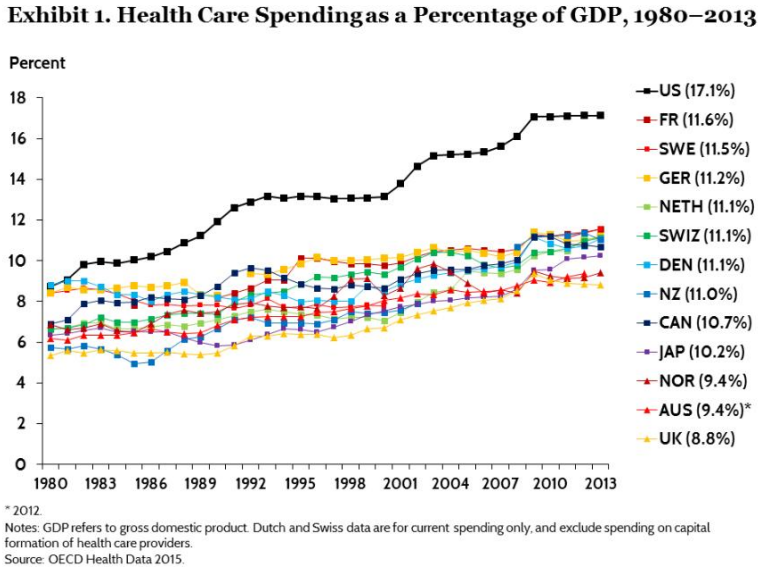
[68]

Figure 4

[68] After Mad Men What Healthcare Has Gained and Lost since 1960 Web 25 Feb 2016 <https://www.advisory.com/daily-briefing/2012/03/22/after-mad-men-what-healthcare-has-gained-and-lost-since-1960s#lightbox>

2.7 Healthcare Now (see fig. 4, above)

Health care in the United States is the most expensive in the world[69]. Despite spending more on health care, Americans tend to have poor health outcomes, including shorter life expectancy and greater prevalence of chronic conditions.[70] With excessive spending, one would think the return on the investment would be better outcomes and a healthier population. Clearly the United States is spending more on health care, rising from 8 percent of the Gross Domestic Product in 2008, to more than double that percentage by 2013 (see fig. 5):



[71]

Figure 5

However, when it comes to critical health outcomes, the U.S. is ranked below many other high-income nations that spend less, such as France, Sweden, Japan and Germany.[72] In

[69] K. Davis, K. Stremikis, C. Schoen, and D. Squires, Mirror, Mirror on the Wall, 2014 Update: How the U.S. Health Care System Compares Internationally, The Commonwealth Fund, June 2014.
[70] D. Squires and C. Anderson, U.S. Health Care from a Global Perspective: Spending, Use of Services, Prices, and Health in 13 Countries, The Commonwealth Fund, October 2015.
[71] D. Squires and C. Anderson, U.S. Health Care from a Global Perspective: Spending, Use of Services, Prices, and Health in 13 Countries, The Commonwealth Fund, October 2015.

conjunction with the health care cost data, it is sobering to look at the table below, which defines the following health outcomes: life expectancy at birth, infant mortality, percentage of population with two or more chronic conditions, obesity rate, percentage of population who are daily smokers and percentage of population aged 65 and over. The United States ranks the worst compared to the other nations listed (see table 1):

Exhibit 9. Select Population Health Outcomes and Risk Factors

	Life exp. at birth, 2013[a]	Infant mortality, per 1,000 live births, 2013[a]	Percent of pop. age 65+ with two or more chronic conditions, 2014[b]	Obesity rate (BMI>30), 2013[a,c]	Percent of pop. (age 15+) who are daily smokers, 2013[a]	Percent of pop. age 65+
Australia	82.2	3.6	54	28.3[e]	12.8	14.4
Canada	81.5[e]	4.8[e]	56	25.8	14.9	15.2
Denmark	80.4	3.5	–	14.2	17.0	17.8
France	82.3	3.6	43	14.5[d]	24.1[d]	17.7
Germany	80.9	3.3	49	23.6	20.9	21.1
Japan	83.4	2.1	–	3.7	19.3	25.1
Netherlands	81.4	3.8	46	11.8	18.5	16.8
New Zealand	81.4	5.2[e]	37	30.6	15.5	14.2
Norway	81.8	2.4	43	10.0[d]	15.0	15.6
Sweden	82.0	2.7	42	11.7	10.7	19.0
Switzerland	82.9	3.9	44	10.3[d]	20.4[d]	17.3
United Kingdom	81.1	3.8	33	24.9	20.0[d]	17.1
United States	78.8	6.1[e]	68	35.3[d]	13.7	14.1
OECD median	81.2	3.5	–	28.3	18.9	17.0

[a] Source: OECD Health Data 2015.
[b] Includes: hypertension or high blood pressure, heart disease, diabetes, lung problems, mental health problems, cancer, and joint pain/arthritis. Source: Commonwealth Fund International Health Policy Survey of Older Adults, 2014.
[c] DEN, FR, NETH, NOR, SWE, and SWIZ based on self-reported data; all other countries based on measured data.
[d] 2012. [e] 2011.

73

Table 1

When it comes to access, efficiency and equity, the United States places last[74] (see table 2):

[72] D. Squires and C. Anderson, U.S. Health Care from a Global Perspective: Spending, Use of Services, Prices, and Health in 13 Countries, The Commonwealth Fund, October 2015.
[73] D. Squires and C. Anderson, U.S. Health Care from a Global Perspective: Spending, Use of Services, Prices, and Health in 13 Countries, The Commonwealth Fund, October 2015
[74] K. Davis, K. Stremikis, C. Schoen, and D. Squires, Mirror, Mirror on the Wall, 2014 Update: How the U.S. Health Care System Compares Internationally, The Commonwealth Fund, June 2014.

EXHIBIT ES-1. OVERALL RANKING

COUNTRY RANKINGS
Top 2*
Middle
Bottom 2*

	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
OVERALL RANKING (2013)	4	10	9	5	5	7	7	3	2	1	11
Quality Care	2	9	8	7	5	4	11	10	3	1	5
Effective Care	4	7	9	6	5	2	11	10	8	1	3
Safe Care	3	10	2	6	7	9	11	5	4	1	7
Coordinated Care	4	8	9	10	5	2	7	11	3	1	6
Patient-Centered Care	5	8	10	7	3	6	11	9	2	1	4
Access	8	9	11	2	4	7	6	4	2	1	9
Cost-Related Problem	9	5	10	4	8	6	3	1	7	1	11
Timeliness of Care	6	11	10	4	2	7	8	9	1	3	5
Efficiency	4	10	8	9	7	3	4	2	6	1	11
Equity	5	9	7	4	8	10	6	1	2	2	11
Healthy Lives	4	8	1	7	5	9	6	2	3	10	11
Health Expenditures/Capita, 2011**	$3,800	$4,522	$4,118	$4,495	$5,099	$3,182	$5,669	$3,925	$5,643	$3,405	$8,508

Notes: * Includes ties. ** Expenditures shown in $US PPP (purchasing power parity); Australian $ data are from 2010.
Source: Calculated by The Commonwealth Fund based on 2011 International Health Policy Survey of Sicker Adults; 2012 International Health Policy Survey of Primary Care Physicians; 2013 International Health Policy Survey; Commonwealth Fund *National Scorecard 2011*; World Health Organization; and Organization for Economic Cooperation and Development, *OECD Health Data, 2013* (Paris: OECD, Nov. 2013).

75

Table 2

With spending the most on health care in the world, and performance ranked lowest amongst our counterparts globally, the divide is undeniable.

This paper looks at the relationship between the hospital, or health care system, and rendering physicians, to see if we can see a means of improving some of the outcomes for which we so poorly rank. In examining the hospital-physician dynamics nationally, we also hope to determine how to improve patient care, based on some of the outcomes. These outcomes include effective care, coordinated care and patient-centered care. Effective care, as defined by the Dartmouth Center for the Evaluative Clinical Sciences, refers to services that are of proven value and have no significant tradeoffs. The benefits of the services "so far outweigh the risks that all patients with specific medical needs should receive them". The services are backed by well-articulated medical theory and strong evidence of efficacy, determined by clinical trials or studies[76]. Coordinated care, or coordination of care is defined as "the deliberate organization of

[75] Davis, K. K. Stremikis, C. Schoen, and D. Squires, Mirror, Mirror on the Wall, 2014 Update: How the U.S. Health Care System Compares Internationally, The Commonwealth Fund, June 2014.
[76]Effective Care: A Dartmouth Atlas Project Topic Brief. Dartmouth Center for the Evaluative Clinical Sciences Web 26. Apr 2016. <http://www.dartmouthatlas.org/downloads/reports/effective_care.pdf>

patient care activities between two or more participants involved in a patient's care to facilitate the appropriate delivery of health care services"[77]. The IOM (Institute of Medicine) defines patient-centered care as: "Providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions"[78].

Patient care in every scenario involves many different parties. We look to clinicians to decide the plan of care, severity of illness, and so forth. At the same time, anyone familiar with contemporary healthcare in this modern age is aware that there are many other factors involved, particularly as it pertains to patient care rendered in the hospital setting. The physicians are on the front line, which leads to subsequent questions. Does the physicians' reach extend beyond the point of care? Meaning, what happens to the patient once they are discharged and resume their daily lives? Who is responsible for the processes and functions of a hospital, and what happens beyond the exam room? The research on health care spending states that physician fees account for only 12 percent of federal health care spending in the United States, and the percentage of spending on physician fees has declined over the past decade[79]. Where is the money being spent on health care actually going, and how can it be used more effectively? How can it be better used to provide patient-centered care, coordination of care and effective care?

One example of the frivolous spending in modern healthcare is detailed by Dr. Elizabeth Dzeng in the blog article "How Much are Misaligned Incentives in Health Care Costing Tax Payers?" Dr. Dzeng, a General Internal Medicine fellow at Johns Hopkins University, saw a patient who had just undergone surgery for an infected artificial shoulder. He was to be

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[77] Reducing Care Fragmentation: A Toolkit for Coordinating Care. (Prepared by Group Health's MacColl Institute for Healthcare Innovation, supported by The Commonwealth Fund), April 2011. Web 26 Apr 2016.
[78] Shaller, Dale. Shaller Consulting c/o The Commonwealth fund. Oct. 2007. Web 26 Apr. 2016. http://www.commonwealthfund.org/usr_doc/Shaller_patient-centeredcarewhatdoesittake_1067.pdf?section=4039
[79] Berry, Daniel J. Drivers Of High US Health Care Costs, Health Affiliate December 2011 vol. 30 no. 12 2457 Web

discharged on intravenous antibiotics three times a day for six weeks[80]. A common treatment, the recommendation was that the patient administer the medication with the help of a home care nurse. The total cost for this treatment was approximately seven-thousand dollars. The social worker informed the patient that Medicare would not pay for home care nurse visits or supplies. However, Medicare would pay for inpatient rehabilitation, which he was eligible for[81]. When presented with the options of paying seven-thousand dollars for home administration of the medication, or nothing out-of-pocket for inpatient rehabilitation, the patient chose inpatient rehabilitation. Financial incentives encouraged the patient to spend zero dollars rather than seven-thousand dollars, meaning Medicare spent an unnecessary added $30,000 on his hospitalization and care[82]. This is one example where misaligned incentives drive both providers and patients to choose the less efficient, more wasteful option. Dr. Dzeng also describes how patients in New York often confided to her how they would call for an ambulance because it was cheaper, with no cost out-of-pocket, as opposed to taking a twenty-dollar cab ride[83]. An ambulance ride in New York City costs the tax payer a base cost of $704 per ride, not including mileage fees. Medicare and Medicaid contribute approximately half of the FDNY's total revenue of $205 million yearly[84] for such services.

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[80] Dzeng, Elizabeth. "How Much Are Misaligned Incentives in Health Care Costing Tax Payers." THCB. Web. 26 Apr. 2016. <http://thehealthcareblog.com/blog/2013/02/23/how-much-are-misaligned-incentives-in-health-care-costing-tax-payers/>.

[81] Dzeng, Elizabeth. "How Much Are Misaligned Incentives in Health Care Costing Tax Payers." THCB. Web. 26 Apr. 2016. <http://thehealthcareblog.com/blog/2013/02/23/how-much-are-misaligned-incentives-in-health-care-costing-tax-payers/>.

[82] Dzeng, Elizabeth. "How Much Are Misaligned Incentives in Health Care Costing Tax Payers." THCB. Web. 26 Apr. 2016. <http://thehealthcareblog.com/blog/2013/02/23/how-much-are-misaligned-incentives-in-health-care-costing-tax-payers/>.

[83] Dzeng, Elizabeth. "How Much Are Misaligned Incentives in Health Care Costing Tax Payers." THCB. Web. 26 Apr. 2016. <http://thehealthcareblog.com/blog/2013/02/23/how-much-are-misaligned-incentives-in-health-care-costing-tax-payers/>.

[84] Holz, Alexander. "Ambulance Costs Increase in NYC." The New York World. N.p., 12 Jan. 2012. Web. 26 Apr. 2016. <http://www.thenewyorkworld.com/2012/01/12/city-readies-sharp-increase-in-ambulance-fees/>.

These situations, outlined above, prove how skewed financial incentives caused by inefficient reimbursement schemes create additional unnecessary costs that are not just wasteful, but also potentially harmful and almost always inconvenient for patients. A study of more than one million Medicare patients suggested that a huge proportion had received care that was simply "a waste"[85]. The researchers called it "low-value care", when in reality it is no-value care[86].

Researchers specifically studied how often people received one of twenty-six tests or treatments that scientific and professional organizations have consistently determined to have no benefit or to be outright harmful[87]:

> Their list included doing an EEG for an uncomplicated headache (EEGs are for diagnosing seizure disorders, not headaches), or doing a CT or MRI scan for low-back pain in patients without any signs of a neurological problem (studies consistently show that scanning such patients adds nothing except cost), or putting a coronary-artery stent in patients with stable cardiac disease (the likelihood of a heart attack or death after five years is unaffected by the stent). In just a single year, the researchers reported, twenty-five to forty-two per cent of Medicare patients received at least one of the twenty-six useless tests and treatments[88] (Gawande, 2015).

The phenomenon of overtesting characterizes modern healthcare. As Dr. Gawande describes:

> The value of any test depends on how likely you are to be having a significant problem in the first place. If you have crushing chest pain and shortness of breath, you start with a high likelihood of having a serious heart condition, and an electrocardiogram has significant value. A heart tracing that doesn't look quite right usually means trouble. When you have no signs or symptoms of heart trouble, an electrocardiogram adds no useful information; a heart tracing that doesn't look quite right is mostly noise. Experts

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[85] Gawande, Atul. "Overkill." *The New Yorker*. The New Yorker, 04 May 2015. Web. 26 Apr. 2016. <http://www.newyorker.com/magazine/2015/05/11/overkill-atul-gawande>.
[86] Gawande, Atul. "Overkill." *The New Yorker*. The New Yorker, 04 May 2015. Web. 26 Apr. 2016. <http://www.newyorker.com/magazine/2015/05/11/overkill-atul-gawande>.
[87] Gawande, Atul. "Overkill." *The New Yorker*. The New Yorker, 04 May 2015. Web. 26 Apr. 2016. <http://www.newyorker.com/magazine/2015/05/11/overkill-atul-gawande>.
[88] Gawande, Atul. "Overkill." *The New Yorker*. The New Yorker, 04 May 2015. Web. 26 Apr. 2016.

> recommend against doing electrocardiograms on healthy people, but millions are done each year, anyway (Gawande, 2015).

Over testing is a widespread problem that undoubtedly stems from a hybrid of greed and defensive medicine. Over testing results in wasteful spending and ineffective care.

3. Understanding the Behavior of Hospitals and Physicians

3.1 Hospital Governance

Hospital administrators, with unique goals and perspectives, yield considerable power for patient care at a higher level. For a hospital as a whole, administrators are responsible for establishing priorities, goals, and carrying out processes that impact the entire community. More so than physicians, hospital administrators are in charge of strategic planning. Typically, hospitals create strategic plans annually. Hospital leadership is usually a blend of management teams, physician representation and community representation[89]. Leadership assesses changes in demographic, regulatory, economic and clinical trends locally and nationally[90]. Operating margins, bed and physician demand, changes in the payer mix, forecasts of outpatient and ancillary activity, comparisons with local hospitals, patient satisfaction and survey results are reviewed[91]. Below, find the "punch list" in every hospital's plan[92]:

- Operating efficiency and cost-reduction, i.e., outsourcing, employee compensation, supply chain economics, et al.
- Physician alignment and clinical integration
- Clinical program innovation and portfolio assessment
- Risk-based contracting and payer relationships, i.e., ACOs, bundled payments
- Strategic partnerships, mergers/acquisition and growth[93] (Keckely, 2016).

Chris Van Gorder is the President and CEO of Scripps Health in San Diego. He explains how his organization ensures adequate input and buy-in when it comes to their strategic planning:

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[89] Keckley, Paul. "Rethinking Hospital Strategy: Time for a Fresh Approach." *Hospital Health Networks RSS*. Web. 26 Apr. 2016. <http://www.hhnmag.com/articles/4618-rethinking-hospital-strategy-time-for-a-fresh-approach>.
[90] Keckley, Paul. "Rethinking Hospital Strategy: Time for a Fresh Approach." *Hospital Health Networks RSS*. Web. 26 Apr. 2016. <http://www.hhnmag.com/articles/4618-rethinking-hospital-strategy-time-for-a-fresh-approach>.
[91] Keckley, Paul. "Rethinking Hospital Strategy: Time for a Fresh Approach." *Hospital Health Networks RSS*. Web. 26 Apr. 2016. <http://www.hhnmag.com/articles/4618-rethinking-hospital-strategy-time-for-a-fresh-approach>.
[92] Keckley, Paul. "Rethinking Hospital Strategy: Time for a Fresh Approach." *Hospital Health Networks RSS*. Web. 26 Apr. 2016. <http://www.hhnmag.com/articles/4618-rethinking-hospital-strategy-time-for-a-fresh-approach>.
[93] Keckley, Paul. "Rethinking Hospital Strategy: Time for a Fresh Approach." *Hospital Health Networks RSS*. Web. 26 Apr. 2016. <http://www.hhnmag.com/articles/4618-rethinking-hospital-strategy-time-for-a-fresh-approach>.

> At Scripps Health, we engage all of our constituents in open dialogue in a variety of forums. Examples include a workshop for the 300 plus graduates of our monthly Leadership Academy for front-line managers, a Physician Leadership Cabinet for all of our hospital chiefs and vice-chiefs, and our Employee 100 Group (front-line employees). Once a month, we also talk to our board about not only what we're doing, but what we should be doing. In addition, we go to each of our clinical care lines and get feedback from their specific viewpoints. All of that input goes to our strategic-planning team and the senior executive team, which holds an annual retreat to look at our past and current performance and what we need to do for the future. In tandem with the planning is a process of continuous alignment and education, in which our leadership ensures that the organization is continually adjusting to the marketplace. I actually spend most of my time teaching in the organization-and learning about what's going on in the medical specialties, digital medicine, pharmacology, and technology areas that we'll need to invest in[94] (Healthcare Strategic Planning, 2016).

This is an example of how an organization leads both bottom-up and top-down. Some examples of "bottom-up" measures include speaking with front-line employees about their experiences, and engaging front line managers. Based on what Mr. Van Gorder states, communication is open and works both ways, in that the clinicians and employees communicate to the Board, and the Board communicates with the community and the hospital employees.

It would be great if every healthcare organization approached strategy like Scripps Health does. In reality, the divide between the spending and performance of the United States healthcare system mirrors the divide between physicians and hospital administration. Physicians and healthcare administrators are at best working in parallel, rather than collaboratively. According to research, there is a distinct divide between physicians and administration[95], due to misaligned goals, and poor infrastructure[96]. Hospital structures tend to be complicated and bogged down by bureaucracy. Change is slow to happen due to the many layers of organization. For this reason, I

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[94] "Healthcare Strategic Planning in Today's Dynamic Environment." Healthcare Strategic Planning in Today's Dynamic Environment. Web. 26 Apr. 2016. <http://www.hfma.org/Leadership/Archives/2015/Summer/Healthcare_Strategic_Planning_in_Today_s_Dynamic_Environment/>.

[95] Zidel, Thomas. Developing Physician Leaders for Successful Clinical Integration. Chicago, IL, USA: ACHE Management Series, 2013. ProQuest ebrary. Web. 19 February 2016.

[96] Zidel, Thomas. Developing Physician Leaders for Successful Clinical Integration. Chicago, IL, USA: ACHE Management Series, 2013. ProQuest ebrary. Web. 19 February 2016.

believe change is discouraged. There is a significant lack of awareness on both the physicians' part and the administrations' part.

The structures governing a hospital or health care system are complicated and complex; often they are not built upon a good exchange between physicians and leadership[97]. Take for instance, the hospital medical staff. The trend is that medical staffs do not seem to be appointed or organized using a degree of planning or approval[98]. Medical staff alignment will be explored in more detail in the forthcoming discussion. Research on medical staff organization tells us that for the medical staff, tenure of office may not be defined, with no conscious effort to get leadership to work harmoniously due to a lack of motive and training[99]. The lack of alignment in the governance of medical staffs is one example of the politics and bureaucracy that exists, particularly with physician leadership and hospitals. These complex, multi-faceted organizations lack the awareness and tools to work harmoniously, and thus the desire to cooperate, in order to evaluate their physician relationships.

Hospital board members and executives do not fully understand the difficult economic pressures faced by physicians. In many cases they are not educated about these issues, alienating physician participation because of the lack of understanding of the challenges they face. An effective hospital board has been shown to be related to high hospital financial performance[100]. Typically the board of trustees has six core financial responsibilities: (1) to specify financial objectives, (2) to review and align the management financial plan with stated objectives, (3) to

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[97] Zidel, Thomas. Developing Physician Leaders for Successful Clinical Integration. Chicago, IL, USA: ACHE Management Series, 2013. ProQuest ebrary. Web. 19 February 2016.
[98] HOSPITAL ORGANIZATION. Journal of the American Medical Association. 2000; 284(16):2029. doi:10.1001/jama.284.16.2029.
[99] HOSPITAL ORGANIZATION. Journal of the American Medical Association. 2000; 284(16):2029. doi:10.1001/jama.284.16.2029.
[100] Alexander JA, Lee SD. Does governance matter? Board configuration and performance in not-for-profit hospitals. The Milbank Q. 2006;84:733.

enhance creditworthiness, (4) to ensure capital is effectively allocated, (5) to monitor financial performance, and (6) to verify financial statements [101]. In a survey of community hospitals both Chief Executive Officers and trustees indicated that financial aspects of organizational performance received the most attention during board meetings[102] as financial performance is the criteria most commonly used to evaluate hospitals and CEOs of hospitals[103].

The board members need to be willing to listen to and work with physicians in order to provide a positive outcome. It is important to identify key objectives that affect both the board and physicians, strengthening the working relationship between the two through open communication. Effort must be made to recognize physicians' goals and work to align these with hospital practices in order to encourage the two parties to work together. Despite differences in mindset and direction, and despite the factors that can disrupt the hospital/physician relationship, one single critical thing binds both hospitals and physicians, and has the potential to bring them together - a joint commitment to service, quality, patient safety and patient loyalty. This is the centerpiece of creating meaningful hospital/medical staff alignment. While hospitals and physicians may disagree, or find themselves at odds on many things and in many areas, the commitment to providing the right care in the right way at the right time, in the safest manner and with the highest level of quality will always be at the heart of what hospitals and physicians are all about.

Hospital leaders must place importance on the establishment of a culture of collaboration, cooperation and the opportunities with mutual self-interest. The organization needs to support

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[101] Pointer DD, Orlikoff JE. Getting to Great: Principles of Health Care Organization Governance. Jossey-Bass; San Francisco, CA, U.S.A.: 2002.
[102] Margolin FS, Hawkins S, Alexander JA, Prybil L. Hospital Governance: Initial Summary Report of 2005 Survey of CEOs and Board Chairs. Health Research & Educational Trust; Chicago, IL, U.S.A.: 2006.
[103] Prybil LP, Peterson PR, Price J, Levey S, Kruempel D, Brezinski P. Governance in High-Performing Organizations: A Comparative Study of Governing Boards in Not-for-Profit Hospitals. Health Research & Educational Trust; Chicago, IL, U.S.A.: 2005. pp. 4–23.

alignment culturally. They will be unable to do so if they do not take an honest inventory of what goals and motivators the medical staff and hospitals currently have. Managed care established different reimbursement plans for hospitals and doctors with purpose. As hospital care has become more complex and sophisticated, outcomes and efficiency are increasingly linked to the quality of teamwork[104].

3.2 Why Align? What's the Point?

Addressing the need for improved physician relationships is easier said than done, and the literature states that physician engagement is one of the most difficult aspects when managing physicians[105]. The economic piece many organizations focus on is but one aspect of the hospital-physician relationship. True engagement and ultimately alignment of both parties relies on more than dollars and cents. The hospitals and physicians that band together to work smarter will find fortitude and longevity. Most important, research tells us their patients win[106].

Patient care is at the center of the issue of hospital and physician interdependence. Administrators managing hospital processes, and physicians trying to provide effective and coordinated care, are not recognizing their full potential. As a result, patient care suffers. Those making decisions about healthcare at the highest level, particularly in government, have rolled out a new movement of reimbursement and healthcare delivery that emphasizes value over volume. While this is discussed further, the take away is that as healthcare reform is happening,

[104] The Walker Company, BoardBrief: Building Constructive Hospital/Medical Staff Relationships and Alignment Web 26 Apr. 2016 https://www.mnhospitals.org/Portals/0/Documents/Trustees/briefs-resources/hospital-medical-staff-relationships.pdf
[105] Thomas, J.R. The Dynamins of Physician Alignment MedSynergies Web 26 Apr. 2016 <http://medsynergies.com/dynamics-of-physician-alignment>
[106] Thomas, J.R. The Dynamins of Physician Alignment MedSynergies Web 26 Apr. 2016 <http://medsynergies.com/dynamics-of-physician-alignment>

quality requirements and new delivery models are guiding everything[107]. In fact, the presence of physicians is growing within hospital leadership. Reports state that approximately 5 percent of hospital leaders are physicians, and that number is rising as health systems move towards value-based care[108]. With systemic changes in healthcare, and a movement for improved quality and increasing value of care rendered, hospital leadership will be increasingly impacted by physicians, and physicians will play a larger role. One executive had the following comment, regarding the climate of change:

> 'The decade we're in is probably going to lead to the greatest amount of change that's been experienced for the last hundred years in health care,' said Dean Grüner, MD, president and CEO of ThedaCare Inc., and a board member of the ThedaCare Center for Healthcare Value in Appleton, WI.[109] (Insight Magazine, 2013).

Hospitals have to question if they want to accomplish the following goals: higher quality, consistent safety, streamline efficiency and value-based care. To weather the changes coming down the pike for healthcare in this country, the answer will have to be yes.

If the answer is yes, then physician leadership will be the key to achieving these goals. The literature tells us the shift from volume to value based care, a focus on wellness, the redesign of both clinical care models and financial payment models present opportunity for hospitals and physicians to align. The progressive nature of these changes already happening have begun rewarding health care systems for clinical excellence and coordinated care[110]. For the reasons outlined, hospital systems need physician leaders, and physician leaders need administration. Revenue is being scrutinized more rigorously, which means hospital administrators are expected

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[107] Zidel, Thomas. Developing Physician Leaders for Successful Clinical Integration. Chicago, IL, USA: ACHE Management Series, 2013. ProQuest ebrary. Web. 19 February 2016.
[108] Angood, Peter, and Susan Birk. "The Value Of Physician Leadership." Physician Executive 40.3 (2014): 6-22. MasterFILE Elite. Web. 24 Feb. 2016.
[109] Insight Magazine WJ, January 29, 2013 http://www.youtube.com/watch? v=70xC SLeoBgc
[110] Angood, Peter, and Susan Birk. "The Value Of Physician Leadership." Physician Executive 40.3 (2014): 6-22. MasterFILE Elite. Web. 24 Feb. 2016.

to make decisions about processes that appear to be financial in nature, but ultimately impact the clinical care a hospital provides. The study *Physician Leaders and Hospital Performance: Is There An Association*, found that overall hospital quality scores are 25 percent higher when doctors run hospitals[111]. Physicians that serve as motivators and can successfully implement change will be in high demand as hospitals are being judged by their medical performance rather than operational acumen[112]. The reason why alignment is worth the investment is because clinical performance is recognized and rewarded financially, and therefore needs to drive operations.

This is not to say that the financial aspects of running a hospital are without merit or not important. It is to say that the issue of financial health is multi-factorial. More engagement and a sense of partnership between hospitals and physicians will result in better coordination of care while maintaining a healthy financial status[113]. Recent market changes have significantly stressed the economic relationship between hospitals and physicians. However, we cannot be short sighted and approach the issue from the viewpoint that financial success is most important. 72 percent of hospital executives surveyed by the American College of Healthcare Executives ("ACHE") said they would align more closely with physicians "to reap rewards for care coordination, better quality, patient safety, and lower costs"[114]. The benefits of hospital-physician alignment improve the bottom line and benefit the patients. The past, focused on volume based reimbursement, created clinical activities segmented from management and administration. The

[111] Goodall AH. Physician-leaders and hospital performance: Is there an association? Social Science & Medicine, Elsevier, vol. 73(4), 535-539, August 2011.
[112] Angood, Peter, and Susan Birk. "The Value Of Physician Leadership." Physician Executive 40.3 (2014): 6-22. MasterFILE Elite. Web. 24 Feb. 2016.
[113] Lovrien, Kate, and Luke Peterson. "Hospital-Physician Alignment Making the Relationship Work." Healthcare Financial Management 65.12 (2011): 72,6, 78. ProQuest. Web. 19 Feb. 2016.
[114] 1 hospital-physician alignment the 1990s versus now Harbeck, Clayton. Healthcare Financial Management65.4 (Apr 2011): 48-52.

future of health care rests on patient-centered care. The focus is not only better health, but rather better health at a lower cost. Hospitals will not be able to embrace this change without their physicians on board. With industry changes spawning the need for new relationships in healthcare delivery, hospitals and physicians should aligning to create patient-care solutions. A complete continuum of patient care will provide an advantage to those who choose to align[115]. As healthcare costs continue to swell, administration, physicians, and patients will be forced to align or be left behind.

Healthcare is changing because it is broken. Patients are generally dissatisfied with the health care system's access, cost, and quality[116]. In 2008, the Commonwealth Fund Commission conducted a survey on more than 1,000 adults to determine the general experience and views on the United State's health care. 80 percent of those surveyed agreed that the health system needs either fundamental change or complete rebuilding[117]. The public believes the American healthcare system is in need of an overhaul. Those working in healthcare share that opinion. The clinical workforce in our nation's hospitals finds frustration in their work environment on a daily basis, and cites frequent and recurring patient safety issues[118]. The lack of alignment, or the fragmented nature of our delivery system is a fundamental contributor to the poor overall performance of the United States health care system[119]. The Commonwealth Fund identifies the following issues with the healthcare delivery system:

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[115] Thomas, John R. "Hospital-Physician Alignment no Decision is a Decision." Healthcare Financial Management 63.12 (2009): 76-80. ProQuest. Web. 19 Feb. 2016.
[116] How SK, Shih A, Lau J, Schoen C. Public Views on U.S. Health System Organization: A Call for New Directions.Commonwealth Fund; August 2008
[117] S. K. H. How, A. Shih, J. Lau, and C. Schoen, Public Views on U.S. Health System Organization: A Call for New Directions, The Commonwealth Fund, August 2008.
[118] Weber, D. Unethical Business Practices in US Health Care Alarm Physician Leaders.The Physician Executive; 2005; 31(2): 6-11.
[119] A. Shih, K. Davis, S. Schoenbaum, A. Gauthier, R. Nuzum, and D. McCarthy, Organizing the U.S. Health Care Delivery System for High Performance, The Commonwealth Fund, August 2008.

> Patients and families navigate unassisted across different providers and care settings, fostering frustrating and dangerous patient experiences; poor communication and lack of clear accountability for a patient among multiple providers lead to medical errors, waste, and duplication; the absence of peer accountability, quality improvement infrastructure, and clinical information systems foster poor overall quality of care; and high-cost, intensive medical intervention is rewarded over higher-value primary care, including preventive medicine and the management of chronic illness[120] (Commonwealth Fund).

In order to address these shortcomings, as they were identified in the article *Organizing the U.S. Health Care Delivery System for High Performance*, it is important to recognize we are all working on the same team. Additional studies state that "Leadership is a critical factor in the success of delivery systems"[121]. The delivery system is desperate for change and improved leadership is the key to these changes. Many are drawn to healthcare, as a field, because it is dynamic and rapidly changing. Adjustments are constantly being made, often times driven by private-sector changes and government. Being responsive to these changes requires teamwork and leadership that is effective at implementing change, while being able to quickly respond.

3.3 Medical Staff Leadership

This section of the thesis examines how to improve hospital and physician alignment. The first step to improving alignment between hospitals and physicians is focusing on medical staff alignment. Hospital-medical staff alignment is defined an agreement between hospital governance and the medical staff around a common commitment and a common strategic direction for achieving common objectives[122]. It creates the development of meaningful, value-

[120] A. Shih, K. Davis, S. Schoenbaum, A. Gauthier, R. Nuzum, and D. McCarthy, Organizing the U.S. Health Care Delivery System for High Performance, The Commonwealth Fund, August 2008.
[121] A. Shih, K. Davis, S. Schoenbaum, A. Gauthier, R. Nuzum, and D. McCarthy, Organizing the U.S. Health Care Delivery System for High Performance, The Commonwealth Fund, August 2008.
[122] The Walker Company, BoardBrief: Building Constructive Hospital/Medical Staff Relationships and Alignment Web 26 Apr. 2016 https://www.mnhospitals.org/Portals/0/Documents/Trustees/briefs-resources/hospital-medical-staff-relationships.pdf

driven economic integration that meets the needs of both the hospital and its physicians[123]. Hospitals and medical staffs often have unique perspectives and different cultures, which leads to disconnect between the two. The hospital-medical staff relationship should be a trusting partnership, where both the medical staff and hospital work closely together to provide quality care for patients. There are actions that hospital governance and physician leaders can take to improve alignment to build a high functioning, strong hospital-medical staff dynamic.

The first factor we have to recognize is that hospitals and physicians have different financial needs and pressures. For example, there is visible misalignment of hospital and physician financial incentives. Admission and discharge decisions are generally made by physicians and not under the immediate control of the hospital. In addition, physicians have the primary role in determining what resources are utilized within the hospital through the ordering of diagnostic tests, consulting other physicians, or moving patients to different levels of care, such as admitting from the Emergency Room or moving patients to the Intensive Care Unit. Yet the hospital is financially liable for many of these decisions and currently has few tools at its disposal to address overutilization of resources by physicians. The New Jersey Commission on Rationalizing Health Care Resources Commission heard a presentation from a consultant where costs for similar risk patients with a similar diagnosis varied by a magnitude of five depending on the physician caring for the patient within a given hospital[124]. We must recognize that the physicians' use of resources in the hospital setting is not under the hospital leadership's control. Lack of awareness to different financial interests can lead to conflict. It is important for hospitals

[123] The Walker Company, BoardBrief: Building Constructive Hospital/Medical Staff Relationships and Alignment Web 26 Apr. 2016 https://www.mnhospitals.org/Portals/0/Documents/Trustees/briefs-resources/hospital-medical-staff-relationships.pdf

[124] New Jersey Department of Health. Web. 26 Apr. 2016. <http://www.nj.gov/health/rhc/documents/interim_report.pdf>.

to take a look at their culture, and understand how the financial pressures differ, as well as where they may overlap.

Secondly, hospitals and physicians do not always share the same goals, nor do they share the same strategies. Hospital strategy tends to be high-level, broad, and involves more community initiatives whereas physician strategy are smaller scale, focused on individual patients and the development of the physicians' medical practices. Hospitals are governed by boards, are responsive to community concerns, and maintain direct reporting control only over their employees, which is primarily administrative staff, nurses and mid-level providers. Historically, few physicians were employed by hospitals, so hospital administrators traditionally sought to create appealing practice environments for doctors who brought in the patients and consequently brought in the revenue that came from filling their beds. In this setting, hospitals lacked the need and desire to actively manage physicians. There were few initiatives to organize their work, promote teamwork, or create systems that pushed quality or safety too aggressively, especially since some such initiatives threatened physician autonomy[125]. Hospitals also lacked the skills to do so.

Statistically, the office-based practitioner does not play a prevalent role within the medical staff at hospitals. The primary care physician or general practitioner that spends less than a few hours a week seeing patients in the hospital cannot be expected to lead hospital quality initiatives or motivate the hospital to create better systems. The average physician lacks the time to participate in hospital committees or emergency department call schedules. Historically, this kind of physician participation was at the core of the medical staff–hospital

[125] The Walker Company, BoardBrief: Building Constructive Hospital/Medical Staff Relationships and Alignment Web 26 Apr. 2016 https://www.mnhospitals.org/Portals/0/Documents/Trustees/briefs-resources/hospital-medical-staff-relationships.pdf

relationships[126]. General Practitioners seldom go to the hospital to see their patients, and Hospitalists seldom leave the hospital. Hospitalists are specialists that are dedicated strictly to the care of admitted patients, with their core expertise being the management of the clinical problems of acutely ill, hospitalized patients[127]. We will not be able to deliver coordinated care in a system where the medical staff is fragmented.

In some select cases, the financial incentives between these physicians and the hospital may be aligned. For example, about two-thirds of Hospitalist groups in the United States receive support from hospitals[128], often to make up the difference between the money they can generate through professional fees for direct care and the costs of their call shifts. In many cases, the physicians are employed by the hospital itself, but even if they are not, the presence of these support payments creates an alignment of incentives. Physicians who receive 30 percent of their income from their hospitals can be counted on to enthusiastically participate in hospital-based quality or cost reduction initiatives because they are more invested.

There are many issues at play, such as community-health issues, nursing shortages, constant reform to improve quality and safety, and the implementation of electronic medical records (EMR). Take for instance, the implementation of EMR. Less than a decade ago, nine out of ten doctors in the U.S. updated their patients' records by hand and stored them as manual charts. By the end of 2014, 83% of physicians nationwide used EMR[129]. This is but one example of seismic change that hospitals and physicians have to adapt to. In some settings, successful

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[126] The Walker Company, BoardBrief: Building Constructive Hospital/Medical Staff Relationships and Alignment Web 26 Apr. 2016 https://www.mnhospitals.org/Portals/0/Documents/Trustees/briefs-resources/hospital-medical-staff-relationships.pdf

[127] Society of Hospital Medicine Web 26 Apr. 2016 http://www.hospitalmedicine.org/Web/About_SHM/Hospitalist_Definition/About_SHM/Industry/Hospital_Medicine_Hospital_Definition.aspx?hkey=fb083d78-95b8-4539-9c5b-58d4424877aa

[128] The Walker Company, BoardBrief: Building Constructive Hospital/Medical Staff Relationships and Alignment Web 26 Apr. 2016 https://www.mnhospitals.org/Portals/0/Documents/Trustees/briefs-resources/hospital-medical-staff-relationships.pdf

[129] Shay, Ryan. Practice Fusion Blog. Web. 26 Apr. 2016 <http://www.practicefusion.com/blog/ehr-adoption-rates/>

collaboration is facilitated by a hospital culture that links the medical staff and the hospital, even if the physicians aren't employees. High-functioning hospitals are characterized by leaders who managed to engage their physicians. As listed in US News Annual Best Hospitals list, the top 15 hospitals, or the "Honor Roll" is as follows:

US News 2015-16 Honor Roll (U.S. News & World Report)[130]

1. Massachusetts General Hospital, Boston
2. Mayo Clinic, Rochester, Minnesota
3. (tie) Johns Hopkins Hospital, Baltimore
3. (tie) UCLA Medical Center, Los Angeles
5. Cleveland Clinic
6. Brigham and Women's Hospital, Boston
7. New York-Presbyterian University Hospital of Columbia and Cornell, New York
8. UCSF Medical Center, San Francisco
9. Hospitals of the University of Pennsylvania-Penn Presbyterian, Philadelphia
10. Barnes-Jewish Hospital/Washington University, St. Louis
11. Northwestern Memorial Hospital, Chicago
12. NYU Langone Medical Center, New York
13. UPMC-University of Pittsburgh Medical Center
14. Duke University Hospital, Durham, North Carolina
15. Stanford Health-Stanford Hospital, Stanford, California

The hospitals listed above qualified for a spot on the Honor Roll by ranking at or near the top in six or more specialties. Overall, hospitals were given a number between 0 and 100 based on four categories: reputation, patient survival, patient safety, and care-related factors (including the amount of nurses and patient related services.) The last three categories, all of which related directly to a patient's positive or negative outcome with the hospital, comprised 72.5 percent of the weight determining if a hospital was highly ranked[131].

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[130] "U.S. News & World Report Releases 2015–16 Best Hospitals." US News. U.S.News & World Report, n.d. Web. 26 Apr. 2016. <http://www.usnews.com/info/blogs/press-room/2015/07/21/us-news-releases-201516-best-hospitals>.

[131] Venosa, Ali. "These Are The Best Hospitals In America For 2015-2016." Medical Daily. N.p., 22 July 2015. Web. 26 Apr. 2016. <http://www.medicaldaily.com/us-news-hospital-rankings-these-are-best-hospitals-america-2015-2016-344152>.

We consistently see top performing hospitals characterized by leaders who are excellent communicators and top physician executives who could serve as bridges between hospital administrators and medical staff. Organizations that have consistently reinforced the idea of a shared purpose rank high on the list. Mayo Clinic is one example of leadership and shared purpose working to drive the organization forward. Their promise that "the needs of the patient come first" is effective because they establish an organizational purpose rather than setting fragmented goals[132]. The research states that organization initiatives such as those set by Mayo Clinic Health System, and other successful hospitals have three features in common: "they are unequivocally focused on patients, they acknowledge that the status quo is inadequate and must change, and they affirm that group action is needed to pursue the shared goal"[133]. The Cleveland Clinic operates under a similar paradigm, but we see that they use media tools to reinforce their message of shared purpose[134]. For example, they created an "empathy" video that served as a poignant reminder to physicians of the need for empathy and compassion. At the start, the video was internal, meant to encourage their more than 40,000 employees to be more empathetic. The same video was shown at a State of the Clinic address at a conference, and the video was then shared nationally using social media. The video put an emotional face on empathy, but also met the three criteria for organizational initiative by focusing on patients, addressing a need for change and affirming that group action is required to bring about the change.

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[132] Lee, Thomas, Dr, and Dr. Toby Cosgrove. "Engaging Doctors in the Health Care Revolution." *Harvard Business Review*. N.p., 01 June 2014. Web. 26 Apr. 2016. <https://hbr.org/2014/06/engaging-doctors-in-the-health-care-revolution>.

[133] Lee, Thomas, Dr, and Toby Cosgrove. "Engaging Doctors in the Health Care Revolution." *Harvard Business Review*. N.p., 01 June 2014. Web. 26 Apr. 2016. <https://hbr.org/2014/06/engaging-doctors-in-the-health-care-revolution>.

[134] Lee, Thomas, Dr, and Toby Cosgrove. "Engaging Doctors in the Health Care Revolution." *Harvard Business Review*. N.p., 01 June 2014. Web. 26 Apr. 2016. <https://hbr.org/2014/06/engaging-doctors-in-the-health-care-revolution>.

With competent and visible leadership, physicians will feel they can trust their organization and may be more inclined to forfeit some autonomy in order to drive forward quality and safety initiatives. Conversely, a lack of trust can significantly impact hospital-physician alignment. When physicians become unhappy with their experience with a hospital, they may become competitors, refusing to become employed by the hospital and instead leading their own practices. The Affordable Care Act has increased the complexity of operating a medical practice, but physicians are weary of the hospital and health system relationship, preferring practice autonomy to hospital governance and local politics[135]. Although both hospital executives and physicians believe in treating patients with quality care, each may have its own vision as to how to execute that goal. A lack of trust will only continue to negatively affect relationships between hospital leaders and the medical staff. In order to create a meaningful partnership for patient care, both physicians and hospital leaders must move beyond individual competition to build better collaborative relationships and improve alignment. The changing health care environment continues to strain physicians as they experience a loss of autonomy, rising malpractice costs, increased administrative responsibilities, competition, regulatory requirements, and tighter reimbursement.

Physicians have been trained and socialized to be fiercely independent. The art of medicine is a service that requires personal judgement. In the past, doctors' income came directly from patients or their insurance plans; the hospital was simply the workshop in which they practiced their craft. Although doctors wanted hospitals that were pleasant and conducive to high-quality care, the pressures they brought to bear on hospitals reflected their independence and ability to vote with their feet. Since neither physicians nor hospitals saw differential pay or

[135] Cheung-Larevy, Karen. "Interview: Competition to Employ Physicians Heats up." *FierceHealthcare*. N.p., n.d. Web. 26 Apr. 2016. <http://www.fiercehealthcare.com/story/interview-competition-employ-physicians-heats/2012-02-09>.

volume based on quality, such pressures generally focused on making it easy to get patients in, on widespread access to the technology needed to practice modern medicine, and on easily available, well-trained, and appropriately respectful support staff.

4. Changing Behavior

4.1 Incorporating Humanities to Improve Communication

I have identified how poorly the United States ranks globally with regards to patient outcomes. In particular, efficacy of care, coordination of care and the physician-patient relationship is ranked below average[136]. There are numerous published studies that address the need for physicians to improve their communication skills. This includes developing the ability to interpret and respond appropriately to what patients say. There is increased pressure to improve outcomes, as a result of payment model reform, while increasing productivity and maintaining patient volume. The healthcare culture sends physicians a mixed message: you will be rushed and may be discouraged, while you are asked to be more compassionate and spend more time listening to your patient[137]. In 2010, a national survey conducted with doctors and hospitalized patients finds that effective communication often is sorely lacking. The survey results should be a call to action. According to the survey, only 48% of patients said they were always involved in decisions about their treatment, and 29% of patients didn't know who was in charge of their case while they were in the hospital[138]. As George Bernard Shaw states, "The single biggest problem in communication is the illusion that it has taken place"[139].

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[136] Weise, Elizabeth. "Survey Finds Gap in Doctor-patient Communication - USATODAY.com." Survey Finds Gap in Doctor-patient Communication Web. 26 Apr. 2016. <http://usatoday30.usatoday.com/yourlife/health/healthcare/studies/2010-12-06-1Adoctalks06_ST_N.htm>.

[137] Bub, B. The patient's lament: hidden key to effective communication: how to recognise and transform *Med Humanities 2004;30:2 63-69 doi:10.1136/jmh.2004.000164*

[138] Weise, Elizabeth. "Survey Finds Gap in Doctor-patient Communication - USATODAY.com." Survey Finds Gap in Doctor-patient Communication Web. 26 Apr. 2016.

[139] Gossart, Heather. "Communication- "The Single Biggest Problem with Communication Is the Illusion That It Has Taken Place." (George Bernard Shaw) | NCEA." *Communication- "The Single Biggest Problem with Communication Is the Illusion That It Has Taken Place." (George Bernard Shaw) | NCEA*. Web. 26 Apr. 2016. <http://www.ncea.org/department-news/communication-single-biggest-problem-communication-illusion-it-has-taken-place>.

The solution to the dilemma of more compassion with less time, is to get back to the basics. As I stated earlier, and as quoted by Dr. Paul Kalinithi, good communication is the bedrock of medicine. Hospital administrators need physicians, and physicians need hospital administrators. By aligning the Medical Staff and the Hospital, we can drive forward the quality of care that is being rendered[140]. At the same time, we need to focus on what is happening bedside with the patient. How can we improve the patient experience? I assert, we can improve the experience of both the patient and the physician using narrative medicine and medical humanities.

81 percent of patients and 71 percent of doctors agreed communication made a difference in whether a patient lives or dies, according to a survey of 500 doctors and 800 patients[141] reviewed by USA Today. Physicians need to do two things as it pertains to patient stories and improving communication. First, they need to recognize that the patient's story deserves to be heard and it has intrinsic value. Secondly, the patients' treatment extends beyond their medical chart. The patient story can reveal additional information, or truths, that may alter diagnosis and care plans. By honoring each individual story and by applying the knowledge gained through the study of narrative, we can find the most efficient route to the understanding of her chief concern and the correct diagnosis of his or her chief complaint.[142] This will improve efficacy of care. Hospitals need to accept the value of the individual story and the patient-physician relationship as well. That is where medical staff- hospital alignment will facilitate the cultural change.

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[140] Schleifer, Ronald, and Vannatta, Jerry. Chief Concern of Medicine : The Integration of the Medical Humanities and Narrative Knowledge into Medical Practices. Ann Arbor, MI, USA: University of Michigan Press, 2013. ProQuest ebrary. Web. 1 April 2016.

[141] Weise, Elizabeth. "Survey Finds Gap in Doctor-patient Communication - USATODAY.com." Survey Finds Gap in Doctor-patient Communication Web. 26 Apr. 2016.

[142] Schleifer, Ronald, and Vannatta, Jerry. Chief Concern of Medicine: The Integration of the Medical Humanities and Narrative Knowledge into Medical Practices. Ann Arbor, MI, USA: University of Michigan Press, 2013. ProQuest ebrary. Web. 1 April 2016

We reviewed how the economics of medicine has changed over the past century. The epidemiological aspects of healthcare have changed as well. Current-day illness and disease has significantly changed from 100 years ago. The paradigm of sickness is very different than the days of cholera and black plague. Life expectancy and morbidity have changed what patients need from their physicians. Dealing with chronic disease rather than widespread illnesses, as we did in the past, brings a whole host of other issues. According to the Center for Disease Control ("CDC"), the leading causes of death and disability in the United States are chronic disease.

Chronic diseases and conditions, such as heart disease, stroke, cancer, type 2 diabetes, obesity, and arthritis "are among the most common, costly, and preventable of all health problems"[143]. Physicians are expected to lead the patient in dealing with the management of chronic illness. This means active treatment with medication, recurring visits to a physician and/or medical team. These conditions can be complex, requiring the understanding of a patients' daily habits and lifestyle and may require the physician to provide suggestions for behavioral modification or counseling. It requires the development of a healing doctor/patient partnership. The future of healthcare is contingent upon the management of chronic disease and the physician-patient relationship. When we ask why the United States is the most expensive healthcare system in the world, the key is chronic illness: 86 percent of all health care spending in 2010 was for people with one or more chronic medical conditions[144]. How well equipped are physicians to deal with the complex issues that come with patients suffering from chronic illness?

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[143] Chronic Disease Overview." *Centers for Disease Control and Prevention*. Centers for Disease Control and Prevention, 23 Feb. 2016. Web. 26 Apr. 2016. <http://www.cdc.gov/chronicdisease/overview/>.
[144] Chronic Disease Overview." *Centers for Disease Control and Prevention*. Centers for Disease Control and Prevention, 23 Feb. 2016. Web. 26 Apr. 2016. <http://www.cdc.gov/chronicdisease/overview/>.

The patient narrative is extremely important as it pertains to chronic illness and lifestyle choices. Do physicians value the patient narrative? Are they comfortable understanding and perhaps modifying a patient's behavior or lifestyle? The training for these skills is lacking, and with increased pressure to be financially productive, hospitals and healthcare have become increasingly impersonal. Patients commonly complain that physicians do not spend enough time with them, do not listen to them, and do not understand them[145]. The research tells us that patients have reason to complain. In one study, only 17% of patients classified as clinically anxious and only 6% of those classified as clinically depressed were perceived as such by their oncologists[146]. In another, physicians responded positively to patient clues about their emotional state in only 38% of surgical cases and 21% in primary care settings[147].

Undoubtedly, physicians are asked to keep pace with a rapidly evolving healthcare system. Some of those major concerns are pressures of managed care, over-regulation and loss of autonomy[148]. Physicians in turn lament their many losses in the healthcare revolution and the pressures of managed care, over-regulation, and the pace of practice that allows insufficient time to spend with patients. This incessant complaining has been described by Brouilette as the "physician moaning syndrome"[149]. Doctors commiserate and complain about their own sense of "chronic fatigue, depression, and loss of self-esteem"[150]. We know that patients don't feel heard, and physicians are dissatisfied as well. How do we improve the quality of doctor/patient

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[145] Schleifer, Ronald, and Vannatta, Jerry. Chief Concern of Medicine : The Integration of the Medical Humanities and Narrative Knowledge into Medical Practices. Ann Arbor, MI, USA: University of Michigan Press, 2013. ProQuest ebrary. Web. 1 April 2016

[146] Newell S , Sanson-Fisher RW, Bonaventura A. How well do medical oncologists' perceptions reflect their patients' reported physical and psychosocial problems? Data from a survey of five oncologists. Cancer 1998;83:1640–51.

[147] Levinson W , Gorawara-Bhat R, Lamb J. A study of patient clues and physician responses in primary care and surgical settings. JAMA2000;284:1021–7

[148] Brouillette J . Physician moaning syndrome. Journal of the Florida Medical Association 1996;83:139.

[149] Brouillette J . Physician moaning syndrome. Journal of the Florida Medical Association 1996;83:139.

[150] Brouillette J . Physician moaning syndrome. Journal of the Florida Medical Association 1996;83:139.

communication so that patients feel adequately listened to and understood, without adding an additional time burden to physicians? The answer is that it is not necessarily the amount of time, but what physicians are doing with that time with their patient that will make a difference. We must equip physicians with the support of their hospitals and communities to learn how to listen.

In order to improve the physician-patient experience, the value of the patient narrative needs to be recognized. Physicians need to know what to listen for, how to understand the significance of what they are hearing, and ultimately, how to respond in a productive way. How do they change how they care for their patients as a result of wat they learn? We wouldn't expect our doctor to diagnose a heart problem without listening to our heart. If the doctor knows what to listen for, and what to do when they hear different responses, they can then use their judgement and act accordingly. However, a high percentage of physicians report greatly inadequate training in psychotherapy and communication skills[151]. As it pertains to the hospital setting, while the majority of mental health care is provided in the primary care setting[152], depression is frequently encountered in all practice settings, particularly in the elderly[153]. In a survey of oncologists, 74% of whom reported breaking bad news to patients in excess of five times a month, only 7.8% had any formal training in techniques of responding to patient emotions[154]. If or when physicians learn these communication skills, the statistics tell us it is not all for naught. Chances are, they will need to use them.

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[151] Swanson J . Family physicians' approach to psychotherapy and counseling. Perceptions and practices. Can Fam Physician 1994;40:53–8.
[152] De Gruy F . Mental health care in the primary care setting: a paradigm problem. Families Systems & Health1997;15:3–23.
[153] Meldon S , Emerman C, Shubert D, et al. Depression in geriatric ED patients: prevalence and recognition. Ann Emerg Med 1997;30:141–5.
[154] Baile W , Buckman R, Lenzi R, et al. SPIKES—a six step protocol for delivering bad news: application to the patient with cancer. Oncologist 2000;5:302–11.

We can respond by changing the culture to reinforce that listening in medicine is not an act of kindness stemming from compassion, but rather an essential clinical skill that is both a science and an art. The hospital system and administrators in leadership need to recognize the value of this communication. That is the only way it will be cultural transformation. Let us not forget, good communication is the bedrock of medicine. Osler stated: "Care more particularly for the individual patient than for the special features of the disease"[155]. If hospital leadership can work with their physicians to clarify and simplify communication concepts and provide tools for diagnosis and treatment so that the average physician is empowered to listen and counsel efficiently and effectively[156], we will all benefit. The impact will be significant.

4.2 Medical Humanities in Hospital Culture: Parallel Charts, Schwartz Center Rounds,

We need to look at improving the physician-patient relationship. The reason why we need to look at that relationship is because the relationship between a patient and their doctor greatly determines both treatment outcomes and a patient's satisfaction with his/her care[157]. Patients want a personal relationship with their doctor, good communication and empathy[158]. Saultz and Lauchner have shown an association between patients who generally see the same doctor and better outcomes, better preventive care and fewer hospitalizations[159]. Little et.al. demonstrated that a personal relationship between patient and doctor and a feeling of partnership led to patients

[155]"The Art and Practice of Medical Writing." *Arch Intern Med Archives of Internal Medicine* 39.3 (1927): 462. Web. 26 Apr. 2016

[156] Baile W , Buckman R, Lenzi R, et al. SPIKES—a six step protocol for delivering bad news: application to the patient with cancer. Oncologist 2000;5:302–11.

[157] Rickert, James. "Patient-Centered Care: What It Means And How To Get There." Health Affairs. N.p., n.d. Web. 26 Apr. 2016. <http://healthaffairs.org/blog/2012/01/24/patient-centered-care-what-it-means-and-how-to-get-there/>.

[158] Rickert, James. "Patient-Centered Care: What It Means And How To Get There." *Health Affairs*. N.p., n.d. Web. 26 Apr. 2016. <http://healthaffairs.org/blog/2012/01/24/patient-centered-care-what-it-means-and-how-to-get-there/>.

[159] Saultz JW1, Lochner J. Interpersonal continuity of care and care outcomes: a critical review. American Journal of Fam Med. 2005 Mar-Apr;3(2):159-66.

who were more satisfied, more enabled, and had a lower symptom burden and lower rates of referral[160]. The Institute of Medicine, in its 2001 report Crossing the Quality Chasm: A New Health System for the 21st Century, highlighted patient-centered care as an area for the development of quality measures[161]. Medical centers nationwide have incorporated patient-centered modalities in their delivery systems[162]. In academic medical centers, we see that patient-centered care has raised the awareness of the interactions between the humanities and medicine[163]. The goal is to define the roles of patient-centered medicine and the medical humanities in the hospital environment, to establish the shared values between the medical humanities and patient-centered care, and to use medical humanities as a teaching tool for patient-centered care.

As defined by Baylor University, Medical Humanities is the following:

> An interdisciplinary and interprofessional approach to investigating and understanding the profound effects of illness and disease on patients, health professionals, and the social worlds in which they live and work. In contrast to the medical sciences, the medical humanities - which include narrative medicine, history of medicine, culture studies, science and technology studies, medical anthropology, ethics, economics, philosophy and the arts (literature, film, visual art) - focus more on meaning making than measurement[164] (Baylor University).

The University of Toronto medical school created a guideline of fifteen steps to introduce a medical humanities curriculum to their facility. This plan in particular led to the granting of official status to their "Program in Narrative and Healthcare Humanities" at the University of

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[160] Little Paul, Everitt Hazel, Williamson Ian, Warner Greg, Moore Michael, Gould Clare et al. Observational study of effect of patient centredness and positive approach on outcomes of general practice consultations BMJ 2001; 323 :908

[161] Nazario RJ1.J Hosp Med. 2009 Oct;4(8):512-4. doi: 10.1002/jhm.480. Medical humanities as tools for the teaching of patient-centered care.

[162] Nazario RJ1.J Hosp Med. 2009 Oct;4(8):512-4. doi: 10.1002/jhm.480. Medical humanities as tools for the teaching of patient-centered care.

[163] Nazario RJ1.J Hosp Med. 2009 Oct;4(8):512-4. doi: 10.1002/jhm.480. Medical humanities as tools for the teaching of patient-centered care.

[164] "Baylor University || Medical Humanities." *Medical Humanities*. Web. 26 Apr. 2016. <http://www.baylor.edu/medical_humanities/>.

Toronto[165]. The first step in their guideline is to start with a hospital-based initiative and make sure colleagues and administrators know about the work. Hold monthly, inter-disciplinary lunchtime meetings with engaging speakers tackling different, interesting subject matter[166]. For example, this particular program used a variety of presenters, including a toxicologist discussing poison in opera, and a nurse with dance background that addressed the need for movement for children in hospital. The nurse taught the group how getting children to move might impact hospital design. A social worker offered training for mindfulness in the hospital setting. The program stresses that activities and presentations should be offered broadly. The goal is to foster interaction and participation. They suggest inviting students and faculty from both health and arts disciplines, and advertising events. Participants can fill out evaluations of the sessions, with the evaluations used to continually improve the sessions. This is one example of how this curriculum can be implemented.

Dr. Rita Charon, Professor of Clinical Medicine and Director of the Program in Narrative Medicine at the Columbia University College of Physicians and Surgeons, has created a program in narrative medicine where medical students and clinicians take their clinical experiences and create narratives that reflect not only their points of view but also that of their patients.[167] Dr. Charon believes that personal narrative can change the way a doctor thinks about his or her patients, and themselves. Students and doctors are encouraged to write about clinical experiences that may not necessarily be appropriate in the medical record. It is focused on moving beyond the chart and detailing all the other aspects of an interaction- the emotions and the story of both

[165] "How to Grow a Healthcare Humanities Program: 15 Steps For Success In Harsh Economic Times |." N.p., n.d. Web. 26 Apr. 2016. <http://medhum.med.nyu.edu/blog/?p=220>.
[166] "How to Grow a Healthcare Humanities Program: 15 Steps For Success In Harsh Economic Times |." N.p., n.d. Web. 26 Apr. 2016. <http://medhum.med.nyu.edu/blog/?p=220>.
[167] U.S. National Library of Medicine. Dr. Rita Charon (video transcript) Bethesda, MD: US. National Library of Medicine; Web Apr 26 2016 http://www.nlm.nih.gov/changingthefaceofmedicine/video/58_1_trans.html.

the clinical scenario and the patient. “The experience is intended to expose unique dimensions of patient care” (Charon, 2010).

With narrative reflective practice, one exercise has medical students write, share, and collaboratively using what Charon[168] calls “parallel charts” of their experiences. Dr. Charon works from a narrative view of experience in which people both live and tell stories of their lives. In parallel charts, students, residents and attending physicians write those things that are critical to the care of their patient that do not belong in the hospital chart but have to be written somewhere. I have participated in parallel charts session at Overlook Medical Center (OMC) and Morristown Memorial Hospital. At OMC, Internal Medicine residents write parallel charts, and participate in small-group sessions to review the charts. Based on my experience, it is a valuable reflective practice that can be at times emotional. The value lies in having the physician identify an experience, think about it, and deeply dive into the care of their patient that otherwise may not happen. The value also lies in sharing these experiences, in hearing them and reacting to them. The process of this reflective narrative practice allows each physician/student to tell his/her story in a parallel chart, which becomes a starting point for the group’s shared narrative inquiry[169]. The sessions seem simple and straightforward. However, they accomplish more than one might realize. When writing and sharing parallel charts, the groups receive guidance and support from a physician leader and a medical humanities professional. Sharing the experiences helps the resident, the peers and perhaps even the facilitators. The lesson learned here is a departure for their typical focus on clinical knowledge, skill-based knowledge. The experience shapes their physician identity.

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[168] Clandinin, Jean, Marie Thérèse Cave, and Andrew Cave. “Narrative Reflective Practice in Medical Education for Residents: Composing Shifting Identities.” *Advances in Medical Education and Practice* 2 (2011): 1–7. *PMC*. Web. 1 Apr. 2016.

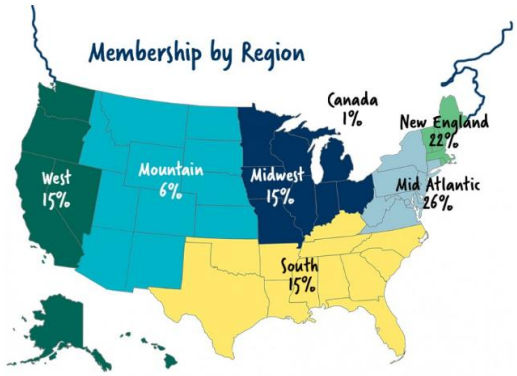
[169] Clandinin DJ, Connelly FM. Narrative Inquiry: Experience and Story in Qualitative Research. San Francisco, CA: Jossey-Bass; 2000.

Narrative medicine imports terms form literature and translates them to the physician-patient relationship. The focus is not on the outcome, the treatment or diagnosis; the focus is the story. Dr. Charon describes communication skills as "narrative competence", and tells us that listening is a skill that can be taught through narrative study much like anatomy can be taught from an anatomy textbook. This practice is a lesson-plan for active listening and for good communication.

Schwartz Center Rounds ("SCR") is another way the hospital can support their providers and foster a sense of compassion, while encouraging an effective physician-patient relationship. It is easy to forget the amount of stress physicians and those in the hospital that are caring for patients, and their families, endure. People being treating in the hospital are often suffering, in pain, or may be dying. We ask clinicians to draw on reserves of empathy and compassion on a regular basis. SCR are an interdisciplinary approach to patient-centered communication, teamwork and support[170]. Staff may begin to feel stressed, or depressed, or even suffer from burnout, which makes having empathy or providing compassionate care a challenge. It is easy for the hospital to ask the physicians and staff to listen better, and do more with their patients. However, framework needs to be put into place that supports these efforts as well. Culturally, how can a hospital recognize, value and support what physicians do?

SCR is a national program, currently taking place at 250 hospitals nationwide[171]. The graphic below shows the demographic distribution of Schwartz Center Rounds across the country (see fig. 6):

[170] Lown BA, Manning C. (2010) The Schwartz Center Rounds: evaluation of an interdisciplinary approach to enhancing patient-centered communication, teamwork, and provider support. *Academic Medicine* 85(6):1073-1081.
[171] Schwartz Center Rounds Session, Overlook Medical Center, February 10, 2016



172

Figure 6

As this thesis examines the history of healthcare and where healthcare is now, we try to plan for a future of healthcare in this nation where patients receive effective, coordinated and compassionate care, and providers are supported by their organizations to do so. The SCR credo is built upon the same idea: providing support to caregivers who can ensure patients receive compassionate care. The goal of the SCR is to "ensure that compassionate care is fundamental to the design of healthcare systems, the delivery of care, the measurement of quality and outcomes, and the education of all healthcare professionals"[173].

The Schwartz Center is led by a medical director, Beth Lown, MD, and a steering committee of renowned educators, researchers and policymakers from across North America[174]. They actively work to develop recommendations on how to implement, measure and reward

[172]"Schwartz Center Members | The Schwartz Center for Compassionate Healthcare." The Schwartz Center for Compassionate HealthcareWeb. 26 Apr. 2016. <http://www.theschwartzcenter.org/join-us/become-member/schwartz-center-members/>.
[173] "Schwartz Center Members | The Schwartz Center for Compassionate Healthcare." *The Schwartz Center for Compassionate Healthcare*. Web. 26 Apr. 2016. <http://www.theschwartzcenter.org/join-us/become-member/schwartz-center-members/>.
[174]"Schwartz Center Members | The Schwartz Center for Compassionate Healthcare." *The Schwartz Center for Compassionate Healthcare*. Web. 26 Apr. 2016. <http://www.theschwartzcenter.org/join-us/become-member/schwartz-center-members/>.

compassionate care across all healthcare settings and systems[175]. Their goal is to start a national conversation about the importance of compassionate healthcare and how to create compassionate care practices and systems that are successful and sustainable while also addressing education, measurement and research. Medical Director Dr. Beth Lown, stated "There is an urgency to this work. We have a window of opportunity as the nation's attention focuses on healthcare. We can and must build systems that promote health and provide compassionate care. The well-being of each and every one of us, our loved ones and the American public depends on it". Just as good communication is the bedrock of medicine, so too is providing compassionate care.

The Journal of the Royal Society of Medicine conducted a survey to determine whether SCR could transfer from the United States clinical setting to the United Kingdom's setting, and if it would achieve a similar impact. The study, conducted in 2012, used 41 qualitative interviews with context provided by additional quantitative research[176]. The study conducted Schwartz Center Rounds at two sites, both sites being hospitals providing acute care. SCR were held over the course of a year, with ten rounds conducted. The rounds were attended by 1250 staff, and held in the same format as the rounds held in the United States.

The study found that participants perceived SCR as having personal benefit, influence on relationships with colleagues and in teams, and wider effects on the organization. Those attending SCR generally appreciated the opportunities afforded to talk through difficult cases and to learn how others managed their difficulties and coped with stress. The fact that SCR focused on feelings, and not on practical issues or problem-solving, was generally valued. A large

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[175] "Schwartz Center Members | The Schwartz Center for Compassionate Healthcare." *The Schwartz Center for Compassionate Healthcare*Web. 26 Apr. 2016. <http://www.theschwartzcenter.org/join-us/become-member/schwartz-center-members/>.

[176] Goodrich, Joanna. "Supporting Hospital Staff to Provide Compassionate Care: Do Schwartz Center Rounds Work in English Hospitals?" *Journal of the Royal Society of Medicine* 105.3 (2012): 117–122. *PMC*. Web. 26 Apr. 2016.

number of interviewees (both clinicians and non-clinicians) felt that the SCR were helpful in increasing respect, empathy and understanding between staff. A greater appreciation of how other people felt about their work also seemed to contribute to a greater potential for multidisciplinary working, including amongst people and teams who had not necessarily worked together in the past. What better way to improve coordination of care?

At a higher level, the feedback also explained how participants changed their views of the hospital overall. The study details the following findings[177]: there was some feeling that the SCR made the hospital environment less hierarchical by providing a forum where people could meet and discuss as equals, with recognition for the similar feelings that people in different roles and at different levels of seniority shared. SCR was seen as having the potential to underpin and support an organization's strategic vision. SCR could support the organization in its quest for improving the experience of both staff and patients by offering support rather than reacting to behavior with punishments or rewards. SCR were seen as instrumental in building and supporting shared values on which the strategic vision was based. This was most important in relation to building a caring organization, and one in which it was permissible to speak openly.

Some of the comments from participants, found below:

> People have found it really helpful. It has given people a focal point to talk about their roles. It can be brutalizing to be compassionate all the time. (Organizing committee, site 2, phase 2)…I really appreciated the language. You hear words used you don't normally hear such as anger, guilt, shame and frustration. They are obviously there, but there is no outlet for them. (Participant, site 2, phase 2)… People are taking the concerns of staff seriously – opening ourselves to hear what people are struggling with. And in the context of mid-Staffs – staff are expressing things, and the Rounds are a sign that it is safe to

[177] Goodrich, Joanna. "Supporting Hospital Staff to Provide Compassionate Care: Do Schwartz Center Rounds Work in English Hospitals?" *Journal of the Royal Society of Medicine* 105.3 (2012): 117–122. *PMC*. Web. 26 Apr. 2016.

> speak. It is all very well to say we have an open culture, but this demonstrates that value[178] (Organizing Committee, Site 1, Phase 2).

The Goodman Research Group conducted a retrospective survey of 256 caregivers at six sites where SCR had existed for more than 3 years. According to the study, caregivers who participated in SCR reported increased insight into the non-clinical aspects of patient care, improved teamwork among co-workers and greater support for their efforts to provide patient care[179]. The issues discussed at SCR can provide needed support and help to answer or consider some of the more difficult situations caregivers face on a daily basis. For example, how do you differentiate between family-centered care and interference? Is culturally competent care possible when communication is a problem? How can you provide compassionate care when a parent or spouse is not on the same page, or not receptive? How do you decide treatment, use your judgement and provide compassionate care when patient's beliefs conflict with traditional medical care? It is the duty of the hospital and the community to support caregivers so that we may all experience better outcomes, more compassionate care and improved communication.

4.3 Leadership Studies, Physician Surveys (CEO surveys)

We need to understand how the healthcare system has evolved to what it is today as we put processes in place that support compassionate care and improved communication. We need less spending with better results. We also need to consider what the leaders in healthcare are telling us about healthcare today. They have sage advice and can help us with their insight and experiences.

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[178] Goodrich, Joanna. “Supporting Hospital Staff to Provide Compassionate Care: Do Schwartz Center Rounds Work in English Hospitals?” *Journal of the Royal Society of Medicine* 105.3 (2012): 117–122. *PMC*. Web. 26 Apr. 2016.

[179] "Schwartz Center Rounds." Department of Oncology, Montefiore Medical Center. Web. 26 Apr. 2016. <http://www.montefiore.org/schwartz-center-rounds>.

Current health statistics tell us the United States will soon be a majority-minority country as estimates say more than 50% of the population will be made up of traditional minorities[180] by the year 2020. At the same time, most hospitals aren't taking the necessary steps to meet those patients' needs, to the detriment of their communities and their bottom lines[181]. Mr. Ram Raju, President and CEO of New York City Health and Hospitals Corporation explains, "Unfortunately, the health care delivery system for many decades has not really understood the cultural competency issues"[182]. He provided an example from his days as a CMO, when clinicians were focused on lowering the diabetes rate among the large West Indian population in the community[183]. They couldn't seem to get the patients' diabetes under control. Mr. Raju explained: "We kept giving them the same diabetic diet, and the West Indian population's staple food was rice." No treatment plan or medication was going to change the cultural eating habits of this community. "So we started cooking and teaching people how to cook the diabetic food with the same food they used, the ethnic food," Mr.Raju said. "You can give [patients] a lot of insurance, we can open clinics all open the place," Mr. Raju added. "Unless you understand the backgrounds of the cultures, the food habits, and how they interact with the health care system," and the respect with which they need to be treated, "we will not get the outcome we desire in our country.[184]" This also reinforces the idea that hospitals and physicians need to be adept at dealing with chronic disease and the issues that accompany chronic disease in diverse populations, as previously mentioned. The way disease has changed the nation needs to carry through to the

[180] "CEO: What Hospitals Don't Understand about the Patients of the Future." *The Advisory Board Company*. Web. 26 Apr. 2016. <https://www.advisory.com/daily-briefing/2015/10/09/patients-of-the-future>.
[181] "CEO: What Hospitals Don't Understand about the Patients of the Future." *The Advisory Board Company*. Web. 26 Apr. 2016. <https://www.advisory.com/daily-briefing/2015/10/09/patients-of-the-future>.
[182] "CEO: What Hospitals Don't Understand about the Patients of the Future." *The Advisory Board Company*. Web. 26 Apr. 2016. <https://www.advisory.com/daily-briefing/2015/10/09/patients-of-the-future>.
[183] "CEO: What Hospitals Don't Understand about the Patients of the Future." *The Advisory Board Company*. Web. 26 Apr. 2016. <https://www.advisory.com/daily-briefing/2015/10/09/patients-of-the-future>.
[184] "CEO: What Hospitals Don't Understand about the Patients of the Future." *The Advisory Board Company*. Web. 26 Apr. 2016. <https://www.advisory.com/daily-briefing/2015/10/09/patients-of-the-future>.

hospitals so the community can receive more effective care. Healthcare providers need to meet patients where they are, rather than expecting patients to meet their clinicians where they are. Perhaps the middle ground is the sweet spot. Cultural competency and compromise is needed to get there. Cultural competence is defined as a set of congruent behaviors, attitudes, and policies that come together in a system, agency or among professionals and enable that system, agency or those professions to work effectively in cross-cultural situations[185]. The examples mentioned previously address issues of cultural competence in healthcare.

Many organizations are facing acute challenges to delivering culturally competent care today. The article “Patients of the Future” by the Advisory Board, tells us that Mr. Raju stresses understanding cultural beliefs of different patient populations is critical[186]. The article further explains, to help existing staff deliver culturally competent care, leaders need to take a two-pronged approach. First, they need to ensure house-wide cultural education is as effective as possible. There's a big difference between providing diversity training where staff feel like they're simply "checking a box" to complete a requirement during orientation—and training that helps them examine their own biases. Second, leaders need to provide resources to ensure culturally competent care. Resources can include readily available interpretation services, or cultural “cheat sheets”[187].

Another Hospital leader, Ralph Muller, CEO of the University of Pennsylvania Health System explains how physicians think[188]: “Doctors think systematically about disease, but they

[185]"NCCC: Curricula Enhancement Module Series." NCCC: Curricula Enhancement Module Series. Web. 26 Apr. 2016. <http://www.nccccurricula.info/culturalcompetence.html>.
[186] "CEO: What Hospitals Don't Understand about the Patients of the Future." *The Advisory Board Company*. Web. 26 Apr. 2016. <https://www.advisory.com/daily-briefing/2015/10/09/patients-of-the-future>.
[187] "CEO: What Hospitals Don't Understand about the Patients of the Future." *The Advisory Board Company*. Web. 26 Apr. 2016. <https://www.advisory.com/daily-briefing/2015/10/09/patients-of-the-future>.
[188] "What Health Care CEOs Told Us in 2015." *The Advisory Board Company*. Web. 26 Apr. 2016. <https://www.advisory.com/daily-briefing/2015/12/23/ceo-interviews>.

don't think systematically about patient populations. That skill set is closer to what economists and political scientists do, whether it's looking at heat maps or referral patterns. I believe in the value of bringing the social sciences and medicine together"[189]. John Henning Schumann, a physician and interim president of the University of Oklahoma, commented on the same. Instead of memorization,[190] which is increasingly difficult given that the volume of medical knowledge is estimated to double every four years, aspiring doctors should be taught to think critically, Schumann says: "Students should be taught and evaluated on their ability to find, assess, and synthesize knowledge. And they should be educated in teams to help prepare them for what goes on in the real world"[191]. Medical education should also emphasize the social determinants of health, Schumann says. That means educating doctors on the role "poverty, housing, nutrition, and other factors" play in a person's overall health. Schumann says it took him years in the field to understand how integral such factors can be to treating a patient. He states: "It took more than a decade for me to learn to ask patients about hunger. I found out that many of the people I've cared for suffer from food insecurity—not knowing where their next meal will come from". Emphasizing social factors may confuse some who see medicine as a strictly science-based discipline, Schumann acknowledges[192]. However, he points to a budding movement in the medical community to elevate such factors as evidence that progress is indeed possible. Schumann says medical education is on the cusp of a more socially conscious era. Now,

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[189] "What Health Care CEOs Told Us in 2015." *The Advisory Board Company*. Web. 26 Apr. 2016. <https://www.advisory.com/daily-briefing/2015/12/23/ceo-interviews>.
[190] "Should Med Students Really Memorize the Krebs Cycle? The Case for a Curriculum Revamp." *The Advisory Board Company*. N.p., n.d. Web. 26 Apr. 2016. <https://www.advisory.com/daily-briefing/2015/04/28/krebs-cycle-revamp>.
[191] "Should Med Students Really Memorize the Krebs Cycle? The Case for a Curriculum Revamp." *The Advisory Board Company*. N.p., n.d. Web. 26 Apr. 2016. <https://www.advisory.com/daily-briefing/2015/04/28/krebs-cycle-revamp>.
[192] "Should Med Students Really Memorize the Krebs Cycle? The Case for a Curriculum Revamp." *The Advisory Board Company*. N.p., n.d. Web. 26 Apr. 2016. <https://www.advisory.com/daily-briefing/2015/04/28/krebs-cycle-revamp>.

Schumann's biggest question is: "What will replace the Krebs Cycle in the medical education pantheon?" the biomedical model of medical education is out of date and should be replaced with a focus on critical thinking and socially conscious health care.

Different leaders at respective healthcare systems have unique perspectives but the research finds a recurring theme. The recurring theme is the focus on improving quality and reducing costs[193]. Potential compromises to Medicare reimbursements, the Center for Medicaid and Medicare (CMS) audits and reduced operating costs rank among the top concerns for community hospitals in a survey of more than 330 hospital CEOs[194]. Leaders find themselves trying to do more with less, according to the report by the American College of Healthcare Executives. Trying to simultaneously reduce costs and improve quality is proving to be a complicated task, says Deborah Bowen, ACHE president and CEO. Financial challenges, healthcare reform implementation, government mandates and patient quality and safety topped the list of woes hospital leaders faced in the list of 10 areas of concerns. The top priorities for respondents within the area of patient safety and quality, included: the engagement of physicians in improving the culture (73%); redesigning care processes (61%) and the shift from fee-for-service to value-payment structures (56%). Within each of these 10 issues, respondents identified specific concerns facing their hospitals. Following are those concerns in order of mention for the top three issues identified in the survey[195] (see table 3):

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[193] Rice, Sabriya. "'Challenging Times' for Hospital Leaders, ACHE Says." *Modern Healthcare*. Web. 26 Apr. 2016. <http://www.modernhealthcare.com/article/20150110/NEWS/301099960>.
[194] Rice, Sabriya. "'Challenging Times' for Hospital Leaders, ACHE Says." *Modern Healthcare*. Web. 26 Apr. 2016. <http://www.modernhealthcare.com/article/20150110/NEWS/301099960>.
[195] "Research & Resources." *Top Issues Confronting Hospitals*. Web. 26 Apr. 2016. <https://www.ache.org/pubs/research/ceoissues.cfm>.

Patient safety and quality (n = 350)[1]	
Engaging physicians in improving the culture of quality/safety	66%
Engaging physicians in reducing clinically unnecessary tests and procedures	60%
Redesigning care processes	59%
Pay for performance	46%
Public reporting of outcomes data (including being transparent, fairness of measures, reporting burden)	41%
Redesigning work environment to reduce errors	39%
Leapfrog demands (i.e., computerized physician order entry, ICU staffing by trained intensivists, etc.)	37%
Compliance with accrediting organizations (e.g., Joint Commission, NCQA)	26%
Medication errors	25%
Other	n = 1

[1] If number of respondents is fewer than 50, only numbers are provided.

196

Table 3

The research says that unlike politicians or the public, the leaders of America's leading hospitals and health systems are optimistic about reform (see figure below). We see that 65 percent indicated that by 2020, they believe the healthcare system as a whole will be somewhat or significantly better than it is today[197]. 93 percent predicted that the quality of care provided by their own health system would improve[198]. This is probably related to efforts to diminish hospital acquired conditions, medication errors, and unnecessary re-admissions, as encouraged by financial penalties in the Affordable Care Act[199] (see fig. 7).

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[196] Research & Resources." *Top Issues Confronting Hospitals*. Web. 26 Apr. 2016. <https://www.ache.org/pubs/research/ceoissues.cfm>.

[197] Steinmetz, Andrew. "Health Care Reform: Views From The Hospital Executive Suite." *Health Affairs*. 18 Dec. 2013. Web. 26 Apr. 2016. <http://healthaffairs.org/blog/2013/12/18/health-care-reform-views-from-the-hospital-executive-suite/>.

[198] Steinmetz, Andrew. "Health Care Reform: Views From The Hospital Executive Suite." *Health Affairs*. 18 Dec. 2013. Web. 26 Apr. 2016. <http://healthaffairs.org/blog/2013/12/18/health-care-reform-views-from-the-hospital-executive-suite/>.

[199] Steinmetz, Andrew. "Health Care Reform: Views From The Hospital Executive Suite." *Health Affairs*. 18 Dec. 2013. Web. 26 Apr. 2016. <http://healthaffairs.org/blog/2013/12/18/health-care-reform-views-from-the-hospital-executive-suite/>.

FIGURES (Click to enlarge):

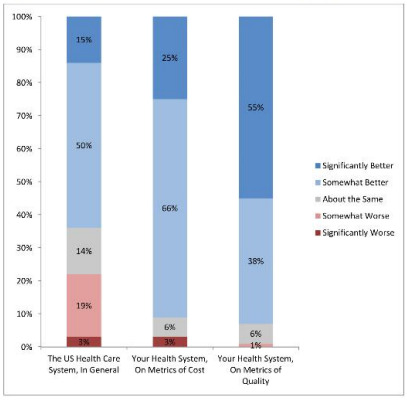
Figure 1. Hospital Executives' Views of the Future of the Health Care System

Questions

As a result of the passage of the Affordable Care Act and the Supreme Court's ruling on its constitutionality, by 2020, do you believe the US health care system will be…?

As a result of the passage of the Affordable Care Act and the Supreme Court's ruling on its constitutionality, by 2020, on metrics of quality, do you believe your health system will be…?

As a result of the passage of the Affordable Care Act and the Supreme Court's ruling on its constitutionality, by 2020, on metrics of cost, do you believe your health system will be…?



200

Figure 7

While care transformation continues to lead the list of concerns for hospital and health system executives, this year two of the top four topics relate to patients' non-clinical needs, according to The Advisory Board Company's Annual Health Care CEO Survey. Specifically, meeting consumer expectations and patient engagement made notable moves up the list[201]. Nearly half (47%) of executive respondents indicated that they were extremely interested in addressing the challenge of rising consumer expectations for service. Additionally, 45% of hospital and health system executives said they were extremely interested in identifying patient engagement strategies. "Health systems are facing a push toward consumerization, fueled by more patient financial accountability, as well as the push to population heath and managing the

[200] Steinmetz, Andrew. "Health Care Reform: Views From The Hospital Executive Suite." *Health Affairs*. 18 Dec. 2013. Web. 26 Apr. 2016. <http://healthaffairs.org/blog/2013/12/18/health-care-reform-views-from-the-hospital-executive-suite/>.

[201] Survey Finds Hospital Executives Increasing Focus on Patient Expectations and Engagement." *Survey Finds Hospital Executives Increasing Focus on Patient Expectations and Engagement*. N.p., n.d. Web. 26 Apr. 2016. <http://www.prnewswire.com/news-releases/survey-finds-hospital-executives-increasing-focus-on-patient-expectations-and-engagement-300245424.html>.

total cost of care," said Lisa Bielamowicz, MD, Chief Medical Officer and Executive Director, Research and Insights at The Advisory Board Company. "Health systems are seeking strategies that bring together these potentially conflicting market forces". The future of medicine is focused on patient engagement and the patient experience.

Research from The Advisory Board Company asked executives about their level of concern for 25 topics, ranging from reducing drug costs to mergers and acquisitions. The top five areas of interest to hospital and health system executives are:

1. Engaging physicians in minimizing clinical variation (53%);
2. Redesigning health system services for population health (52%);
3. Meeting rising consumer expectations for service (47%);
4. Patient engagement strategies (45%); and
5. Controlling avoidable utilization (44%)[202]

The research says: "The Centers for Medicare and Medicaid Services' accelerating transition to alternative payment models is driving providers to redefine their business models," said Chas Roades, Chief Research Officer at The Advisory Board Company. "The Annual CEO Survey shows that hospital and health system executives are embracing strategies like population health to help make shift from treating patients to preventing illness" (Advisory Board Company, 2015).

Please note, for its Annual Health Care CEO Survey, The Advisory Board Company surveyed 209 C-suite executive members in December 2015. The firm's membership includes some of the largest and most progressive hospitals and health systems in the United States. Survey questions are based on the Advisory Board's more than 10,000 annual research interviews with health care executives[203].

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[202] Survey Finds Hospital Executives Increasing Focus on Patient Expectations and Engagement." Survey Finds Hospital Executives Increasing Focus on Patient Expectations and Engagement. N.p., n.d. Web. 26 Apr. 2016. <http://www.prnewswire.com/news-releases/survey-finds-hospital-executives-increasing-focus-on-patient-expectations-and-engagement-300245424.html>.

[203] Survey Finds Hospital Executives Increasing Focus on Patient Expectations and Engagement." Survey Finds Hospital Executives Increasing Focus on Patient Expectations and Engagement. N.p., n.d. Web. 26 Apr. 2016.

4.4 Case Studies (Geisinger Health System, Cleveland Clinic, Mayo Clinic Health System)

Rapid change within the healthcare industry demands strong leadership within healthcare institutions, and multi-hospital healthcare systems present particular leadership challenges due to their size and complexity[204]. Ideally, healthcare organizations provide strong employee development and training for all levels of employees[205]. While innovation is something most hospitals tackle one way or another, some healthcare systems have instilled innovation as a cultural norm. One example is Geisinger Health System, featured in the Becker's Hospital Review. Geisinger has developed a culture of innovation. In fact, some of their most notable achievements which include closing care gaps, improving medication adherence, and using bundles for chronic disease- came from round-table conversations. The article mentions that healthcare experts state the ease with which people can innovate is based on the organization's talent development and whether leaders are system thinkers. The clinical staff may innovate individually or on a smaller scale with the goal of improving care. Often times these efforts are done in spite of an organization's structure, incentives or decision making processes rather than the organization supporting the efforts.

The research identifies a few things innovative organizations do differently. According to Scott Anthony, writer for the Harvard Business Review, organizations that innovate have to recognize that business is built to scale yesterday's model, not discover tomorrow's. This requires the first step: leadership must be clear that innovation is an organizational value and

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<http://www.prnewswire.com/news-releases/survey-finds-hospital-executives-increasing-focus-on-patient-expectations-and-engagement-300245424.html>.

[204] McAlearney, Anne Scheck. "Executive Leadership Development In U.S. Health Systems: Exploring the Evidence Final Report." *ACHE* Web. 26 Apr. 2016. <https://www.ache.org/pubs/research/McAlearney_HMRA_Report.pdf>.

[205] McAlearney, Anne Scheck. "Executive Leadership Development In U.S. Health Systems: Exploring the Evidence Final Report." *ACHE* Web. 26 Apr. 2016. <https://www.ache.org/pubs/research/McAlearney_HMRA_Report.pdf>.

discipline. A culture of discipline is not merely built on rhetoric. Leaders have to be personally involved; by developing and training their talent, an organization can be empowered while reinforcing the commitment to innovation. Innovation resembles investment.

Another step towards innovating requires “system thinking”. CEOs or other leaders that are system thinkers recognize the connection between health outcomes, clinic operational changes and how we get people to think differently. Innovative CEOs address all components of the hospital. Implementation is approached from diverse viewpoints. When an organization supports innovation, people can think independently knowing that they are expected to brainstorm and encouraged to share. Leadership knows when to relinquish control.

Furthermore, the article adds that true transformation starts with a deep understanding of the problem and a formalized process to execute ideas. Take cost reductions as an example. You cannot merely decide one day to implement a new process for cost reduction. Rather, you have to change the operating structure, culture and strategic vision so people understand it at every level. Changes are transformational. Hospitals ahead of the curve know that healthcare reform was as platform to have transformational discussions for all of healthcare.

Geisinger believes that innovation makes life easier in the long run, and innovation is not seen as work. Invention and creativity are seen as things that simplify work and improve patient outcomes. Geisinger aims to change their care delivery so that quality and patient satisfaction are promoted, but burdens are also eliminated. One example of their innovation is the development of Open Notes. Patients can read their medical records or physician notes in their entirety through online portals. They were one of the first health systems to provide this access back in 2013. It has added transparency but it has also appealed to patients invested in their own care that may review the notes and contact their providers to address any errors or concerns.

In November of 2015 Geisinger announced that it was going to start offering a money-back guarantee to patients who receive care at one of their facilities. The initiative made news last year Feinberg made news last year when he announced a pilot program where Geisinger patients who didn't like the way they were treated could use an app to name the amount of a refund. Geisinger CEO Dr. Feinberg stated "We need to be disruptive to move the practice of providing great patient experience forward and so the decision was made to give unsatisfied patients their money back." Dr. Feinberg's innovation approach to the patient-experience is inspiring. Modern Healthcare is quoted as saying "[Dr. Feinberg has] doubled-down on the system's approach emphasizing the patient experience, telling Modern Healthcare last year that "we want to take patient-centeredness to the next level ... We want to make our transitions in care remarkably smooth. We want patients to understand their bill"[206]. This is an example that proves a proactive approach to transformation and innovation will truly drive healthcare forward.

The Cleveland Clinic is another organization that has transformed their culture. They created a culture of engagement in an effort to improve employee engagement and patient satisfaction. One of the major focuses of their efforts was creating an engaged workforce. This was not limited to physicians, as they tried to establish a culture where everyone plays a part in providing better care and creating a better patient experience. Prior to the more formal transformation, Cleveland Clinic was regarded as a center for medical excellence and controlled costs. It was highly regarded as one of the best systems in the country. The efforts Cleveland Clinic made, which will be detailed, suggests organizations can improve customer experience

[206] Wenner, David "Doc Who Began Refunds for Geisinger Patients Treated Rudely Named among Most Influential." PennLive.com. 08 Apr. 2016. Web. 26 Apr. 2016. <http://www.pennlive.com/news/2016/04/central_pa_doc_who_proposed_re.html>.

without compromising their traditional strengths. This should be reassuring not only for healthcare organizations, but any organization trying to do what they do well, just better.

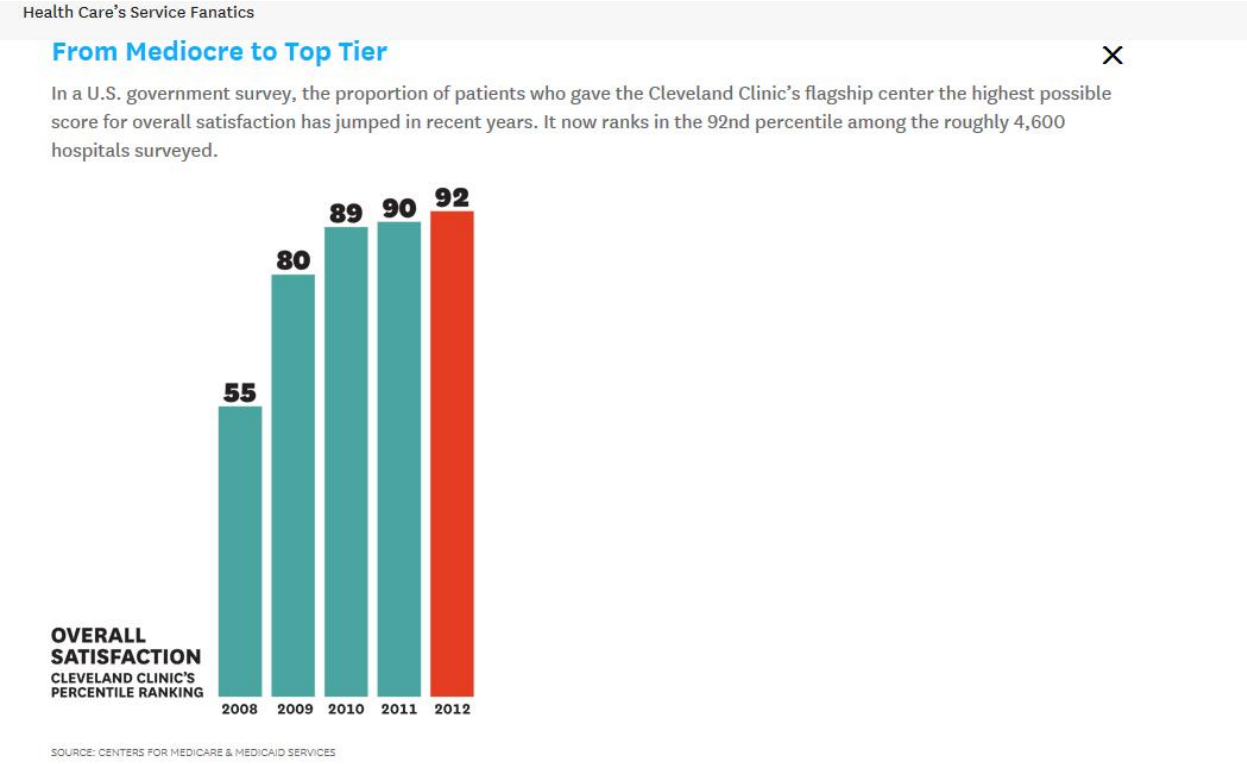
The Harvard Business Review explains how the Cleveland Clinic transformed their culture in the article “Health Care’s Service Fanatics”. The title alone reminds us that health care is a service industry, something we may forget. The first thing the Cleveland Clinic did was establish patient experience as a strategic priority. The issue was identified and broken down in a way that employees were engaged. For example, they spelled out the problems with patient experience in a systematic, sustained way. For the physicians that were focused on medical outcomes, this helped them to recognize that patient dissatisfaction is a real issue. They also felt that all employees, from housekeeping staff to administrators, play a role in fixing the problem.

Once the Clinic determined patient experience was the issue, they took inventory of what their starting point was. They conducted surveys and studies, and solicited patients’ input. This helped them to not only grasp how deeply the issues were rooted, but also gave them an understanding of patients’ needs. The Clinic allocated time, staff and money to these efforts. I believe this proves they were really invested in making a change for the better. They set out to develop and implement processes, create metrics and monitor performance so the organization could improve. They also communicated with prospective patients about expectations for their time spent at the hospital.

At first, the physicians expressed fears about conflict between the focus on patient experience and those medical outcomes they tended to be hyper-focused on. They were afraid the patient-experience initiative would conflict with efforts to maintain high quality and safety standards and to further reduce costs. However, this did not prove to be true. The opposite happened: “During the transformation the Clinic rose dramatically in the University

HealthSystem Consortium's rankings of 97 academic medical centers on quality and safety. Its efficiency in delivering care improved as well". The physicians' fears were understandable. For most of the Clinic's history, they were focused solely on medical outcomes. The Clinic repeatedly ranked among the top five US hospitals for overall quality of care. Other areas of patient experience that typically go overlooked were- experiences such as making appointments, clear discharge instructions, and addressing fears or concerns during their stay.

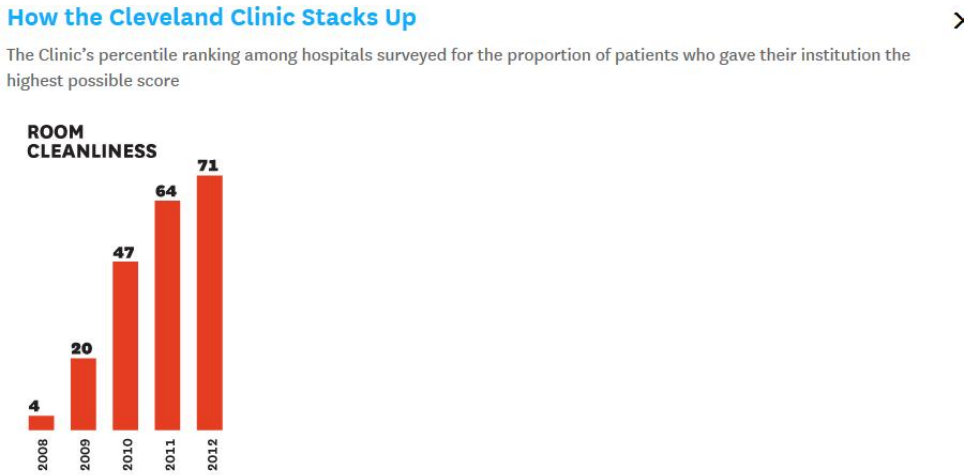
Changes in the field of healthcare that impacted all hospitals impacted the Clinic, too. In 2008 the CMS (Center for Medicare and Medicaid Services) made satisfaction surveys and quality of care data public online in an effort to add transparency, encouraging consumers to make informed decisions about their healthcare, and encouraging hospitals to improve. This was just the start. In 2013, CMS accounts that $1 billion in Medicare payments to hospitals would be contingent upon performance in these areas; that amount would double by 2017. The CMS satisfaction scores are based on randomly selected patients' responses to questions, post discharge. The charts below show how the Cleveland Clinic dramatically improved their scores (see fig. 8- 16):



[207]

Figure 8

Other specific areas, not typically considered when medical outcomes are the organizational focus, dramatically improved:



[208]*Figure 9*

[207] Merlino, James, and Anath Raman. "Health Care's Service Fanatics." Harvard Business Review. 01 May 2013. Web. 26 Apr. 2016. <https://hbr.org/2013/05/health-cares-service-fanatics>.

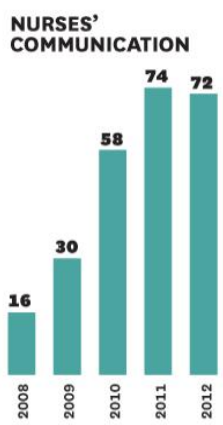


Figure 10

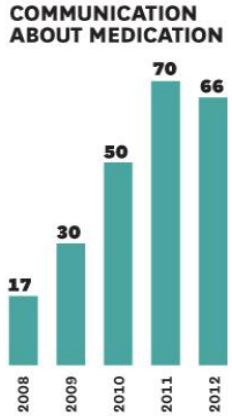


Figure 11

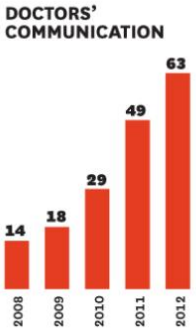


Figure 12

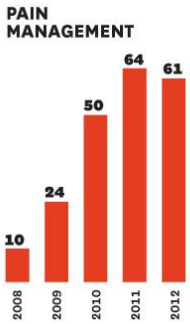


Figure 13

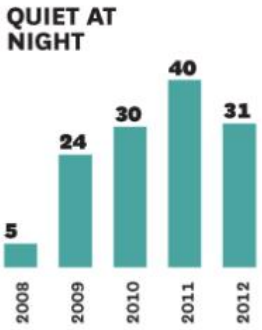


Figure 14

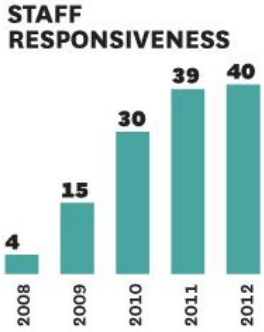


Figure 15

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[208] Merlino, James, and Anath Raman. "Health Care's Service Fanatics." Harvard Business Review. 01 May 2013. Web. 26 Apr. 2016. <https://hbr.org/2013/05/health-cares-service-fanatics>.

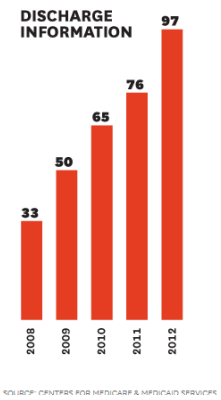

Figure 16

The leadership notes, in the Harvard Business School article, that patients were coming to the center for clinical excellence, but they didn't like them very much. Cleveland Clinic CEO Toby Cosgrove explains that the Clinic recognized they couldn't continue to count on medical excellence to drive patients. In this new era of healthcare, patient experience trumped medical excellence.

Mr. Cosgrove had an interesting dilemma when leading the change. How did he get physicians on board, many of whom are "superstars" in their field? The Cleveland Clinic has a reputation and name-recognition which meant that many patients came to the center for these superstars, and getting the clinical talent to "salute and obey" would be challenging. He needed someone that could strike a balance between understanding the challenges of delivering patient experience and focusing on medical outcomes with credibility in the field. He addressed this by creating a Chief Experience Officer, Dr. James Merlino. The Office of Patient Experience has a $9.2 million annual budget and 112 staff members.

The undertaking was no small task. Doctors and nurses typically focus on performing procedures and treatments and often fail to explain them fully and in terms patients can

understand. The Clinic's caregivers were no different. Ignorance and cost pressures presented two other obstacles. Employees at most hospitals are unaware of CMS scores or don't believe they matter all that much, and they don't understand how to improve the patient experience. Employees became aware of CMS scores but that was just the first step. Know that everyone knows the scores, how do you change them?

The Cleveland Clinic made understanding the Patient and their needs a top priority. Since everyone plays a role in a patient's experience, each employee needs to understand what their responsibility is with regards to improvement. The Clinic defined the patient experience as "Everyone and everything people encountered from the time they decided to go to the Clinic until they were discharged"[209]. The effort to improve it became known as "managing the 360"[210]. The Clinic conducted two large studies to ascertain exactly what the patients want and need. The studies revealed interesting results. The studies revealed more about what patients want, beyond empathy and understanding. The results said that patients wanted better communication; patients want information about what is going on in their environment and about the plan of care, even with routine or minute activities[211]. As anyone that has been a patient in the hospital knows, sometimes mundane tasks that the clinical team may not give much consideration can seem more frightening and anxiety-provoking to a patient that doesn't expect them or know why they are being done. In addition, patients said they wanted better coordination of their care. The results said the following:

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[209] Merlino, James, and Anath Raman. "Health Care's Service Fanatics." Harvard Business Review. 01 May 2013. Web. 26 Apr. 2016. <https://hbr.org/2013/05/health-cares-service-fanatics>.
[210] Merlino, James, and Anath Raman. "Health Care's Service Fanatics." Harvard Business Review. 01 May 2013. Web. 26 Apr. 2016. <https://hbr.org/2013/05/health-cares-service-fanatics>.
[211] Merlino, James, and Anath Raman. "Health Care's Service Fanatics." Harvard Business Review. 01 May 2013. Web. 26 Apr. 2016. <https://hbr.org/2013/05/health-cares-service-fanatics>.

> When nurses and doctors did not communicate with one another, patients were left feeling that no one was taking responsibility for them. The studies also revealed that patients often used proxies in their ratings: If the room was dirty, for example, they might take it as a sign that the hospital delivered poor care. Another striking finding was the importance of doctors' and nurses' demeanor. Patients tended to be more satisfied when their caregivers were happy. It wasn't that they craved interactions with happy employees; rather, they believed that if their caregivers were unhappy, it meant either that the patient was doing something to make them feel that way or that something was going on that they did not want to reveal[212] (Merlino, Cosgrove 2013).

Something physicians and all hospital workers need to remember: patients don't want to be here. It is often an emotional experience, with feelings of fear, terror, confusion and almost always anxiety. The core of patient experience is being reassured that the people taking care of you really understand and really care about what you are going through[213]. Families feel the same way[214]. The results the studies Cleveland Clinic found I believe are indicative of most patients' experiences and feelings.

The relationship between the physician and patient has significant value. At the same time, the research tells us the hospital experience is very broad and we cannot have tunnel-vision: all interactions are important. When I worked as a Hospital Administrator, this was stressed by the executives. We should be eager and willing to help lost patients find their way. We wouldn't just point the patients in the right direction, we made sure to take them to the final destination, even if it was the parking garage or a building on the other side of campus. You don't realize how impactful a helping hand can be, even if you are not a physician and just merely doing an act of kindness.

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[212] Merlino, James, and Anath Raman. "Health Care's Service Fanatics." Harvard Business Review. 01 May 2013. Web. 26 Apr. 2016. <https://hbr.org/2013/05/health-cares-service-fanatics>.
[213] Merlino, James, and Anath Raman. "Health Care's Service Fanatics." Harvard Business Review. 01 May 2013. Web. 26 Apr. 2016. <https://hbr.org/2013/05/health-cares-service-fanatics>.
[214] Merlino, James, and Anath Raman. "Health Care's Service Fanatics." Harvard Business Review. 01 May 2013. Web. 26 Apr. 2016. <https://hbr.org/2013/05/health-cares-service-fanatics>.

The Cleveland Clinic tried to study how many people a patient typically encounters, The Chief Experience Officer asked a patient to keep a journal of everyone who cared for her during her five-day stay. It turned out that there were eight doctors, 60 nurses, and so many others (phlebotomists, environmental service workers, transporters, food workers, and house staff) that the patient lost track. Few of her 120 hours at the Clinic were spent with physicians. Moreover, her journal did not even take into account employees in nonclinical areas, such as billing, marketing, parking, and food operations—people who did not interact directly with her but might have had a big impact on her stay. The takeaway was that all employees are caregivers, and that the doctor-centric relationship should be replaced by a caregiver-centric one.

A study conducted by the Joint Commission published in the Journal for Quality and Patient Safety found that patients can have between 5 and 8.5 number of room entries per hour, depending on the patient population, isolation status and unit type (see table 4):

Published in final edited form as:
Jt Comm J Qual Patient Saf. 2012 Dec; 38(12): 560–565.

Table 1

Entries into Patients' Rooms by Patient Population, Isolation Status, and Unit Type

	Patient Population		Isolation Status		Unit Type		Total
	Adults	Children	Any Isolation	No Isolation	Intensive Care	General Medical/Surgical	
Total patient hours observed	120.4	371.0	223.9	267.5	200.6	290.8	491.4
Total number of room entries per hour*	5.0 (0–26.4)	8.5 (1.0–28.0)	5.0 (0–28.0)	6.0 (0–26.4)	6.0 (0–28.0)	6.0 (0–20.6)	5.5 (0–28.0)
Number of different people entering room per hour*	3.0 (0–18.0)	3.5 (0.5–9.0)	3.0 (0–11.0)	4.0 (0–18.0)	3.5 (0–18.0)	3.5 (0–11.3)	3.5 (0–18.0)
Minutes spent in room by each individual*	3.0 (1.0–124.0)	3.0 (1.0–120.0)	3.0 (1–124.0)	3.0 (1–120.0)	3.0 (1–120.0)	3.0 (1–124.0)	3.0 (1–124.0)

*Data presented are median (range).

215

Table 4

[215] Cohen, Bevin et al. "Frequency of Patient Contact with Health Care Personnel and Visitors: Implications for Infection Prevention." Joint Commission journal on quality and patient safety / Joint Commission Resources 38.12 (2012): 560–565. Print.

The Clinic also found value in letting patients know before they got to the hospital what to expect while they were there. Outreach included printed materials and interactive online videos that described the hospital environment. The materials also educated patients about pain management and how to communicate with providers. In addition, Dr. Merlino realized that the Clinic could enlist patients' help in improving the hospital experience and showed us that patients can be a difference maker in their own care. They started to rely more heavily on patients to identify problems and improve processes[216]. The Clinic now asks patients to report rooms that have not been cleaned properly and to routinely ask caregivers if they have washed their hands[217].

If nothing else, the work the Cleveland Clinic has committed to tells us that even small changes can have large impact. When processes are designed empathically, they can enhance patients' experiences even as they reduce costs[218]. Hospital leaders may believe that they cannot justify the kinds of programs described. CMS's linking of Medicare reimbursement to patient satisfaction should help convince them otherwise and should prove there is real value in the patient experience. There is value in better care. People should also learn that changing culture and processes to improve the patient experience can lead to substantial improvements in safety and quality[219]. In this modern era of healthcare, a patient-centered approach to care, which

[216] Merlino, James, and Anath Raman. "Health Care's Service Fanatics." Harvard Business Review. 01 May 2013. Web. 26 Apr. 2016. <https://hbr.org/2013/05/health-cares-service-fanatics>.
[217] Merlino, James, and Anath Raman. "Health Care's Service Fanatics." Harvard Business Review. 01 May 2013. Web. 26 Apr. 2016. <https://hbr.org/2013/05/health-cares-service-fanatics>.
[218] Merlino, James, and Anath Raman. "Health Care's Service Fanatics." Harvard Business Review. 01 May 2013. Web. 26 Apr. 2016. <https://hbr.org/2013/05/health-cares-service-fanatics>.
[219] Merlino, James, and Anath Raman. "Health Care's Service Fanatics." Harvard Business Review. 01 May 2013. Web. 26 Apr. 2016. <https://hbr.org/2013/05/health-cares-service-fanatics>.

includes giving patients an outstanding experience, is not an option; it's a necessity[220]. We all play a role, no matter how large or small.

Another aspect of the business of healthcare, which will impact hospital-physician alignment in the future is physician compensation. The future of healthcare sees physician compensation tied to quality. A study conducted by Sullivan, Cotter and Associates, Inc. (Sullivan Cotter) explains the movement of incentivizing physicians to be better aligned with quality initiatives, and the Mayo Clinic provides a valuable case study for how the plan works in action. As the health care industry continues to shift its focus from volume to value, compensation arrangements are following suit. The *Provider Performance Incentive Survey* from Sullivan Cotter focuses exclusively on non-productivity measures for physicians. Conducted in 2014, information was collected from more than 30 large multi-specialty medical groups and health systems who were ahead of the curve in incorporating quality measures into their provider incentive plans. These organizations reported on more than 20 specialties and provided details on over 350 different performance measures. The results showed that one-third of these organizations have more than 10% of compensation associated with value- and quality-based performance measures. As Brad Vaudrey, Managing Principal of Sullivan Cotter explains:

> Value-based compensation and payment arrangements continue to evolve as the focus on rewarding value over volume is increasing. In the next five years, we expect approximately 80% of organizations to have more than 10% of physician compensation tied to quality measures, a large percentage of which will be 'at risk'. Understanding these upward trends in value-based incentive measures are key to aligning provider pay and performance[221]

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[220] Merlino, James, and Anath Raman. "Health Care's Service Fanatics." Harvard Business Review. 01 May 2013. Web. 26 Apr. 2016. <https://hbr.org/2013/05/health-cares-service-fanatics>.

[221] "One-Third of Early Adopters Have More Than 10% of Provider Compensation Tied to Quality - Sullivan Cotter." Sullivan Cotter. 16 Nov. 2015. Web. 26 Apr. 2016. <https://www.sullivancotter.com/one-third-of-early-adopters-have-more-than-10-of-provider-compensation-tied-to-quality/>.

Organizations reported that primary care specialties such as Internal Medicine and Family Medicine, at 94 percent and 90 percent respectively, are among those with the highest percentage of quality measures integrated into their compensation plans, as reported. Dr. Jeff Weisz, Managing Principal and Consulting Physician, Sullivan Cotter, explains:

> The demand for delivering value-based care is central to the health care debate. Organizations are transitioning from fee-for-service, volume-based productivity measures to delivering the highest quality care, the best patient experience, and a more affordable health care product by incorporating more value-based measures into their provider performance incentive plans[222] (Sullivan Cotter and Associates).

Mayo Clinic Health System (MCHS) proves that even small incentives are enough to steer physicians toward value. This reinforces the idea that small, consistent changes can yield large results. The looming question in this era of healthcare is how to align with physicians and incentivize them to drive value-based initiatives. The response of top-performing health systems to the challenge of aligning physicians can provide valuable insights that can inform many organizations' efforts; MCHS is one such organization.

In 2014, MCHS implemented a new physician compensation model designed to align physician performance with the organization's strategic goals to achieve integrated, value-based patient care[223]. MCHS developed value-focused physician compensation plan as part of a larger initiative aimed at system wide clinical integration. The plan uses three value-based metrics: patient outcomes, patient safety, and patient experience[224]. These measures would determine five percent of a physician's compensation.

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[222] "One-Third of Early Adopters Have More Than 10% of Provider Compensation Tied to Quality - Sullivan Cotter." Sullivan Cotter. 16 Nov. 2015. Web. 26 Apr. 2016. <https://www.sullivancotter.com/one-third-of-early-adopters-have-more-than-10-of-provider-compensation-tied-to-quality/>.

[223] [223] Bunkers, B., Koch, M., McDonough, B., and Whited, B., "Aligning Physician Compensation with Strategic Goals," Healthcare Financial Management, July 2014. Web 26 Apr. 2016. < https://www.sullivancotter.com/wp-content/uploads/2016/03/Value-Based-Physician-Compensation-final-hfm-Magazine.pdf>

[224] [224] Bunkers, B., Koch, M., McDonough, B., and Whited, B., "Aligning Physician Compensation with

This new transformational model would align with evolving payment models in which value, not volume of care, is rewarded. Thus resulting in accessible, higher-quality care, at lower cost for a better patient experience. To develop the plan, a ten member physician compensation standardization advisory group formed to study best practices of other medical groups, gather input, and developed the framework[225]. The new compensation model would measure physician productivity within their practices, while value-based metrics would be gradually incorporated into physician compensation. Experience has shown that it is critical for physicians to receive accurate data and agreed upon metrics to motivate improved performance. The underlying question in the transition to value-based incentives was whether a relatively small amount of risk would be enough to engage physicians in implementing value-based care practices. The five-percent at-risk compensation was not seen as a large percentage. The developers at MCHS were not sure if five-percent would be enough to encourage physician buy-in.

Results were obtained for one year prior to rollout, where results were gathered and "shadowed". They would serve as a baseline for the next year. As part of the change management process, the framework involved devising an implementation schedule, creating a solid leadership/governance structure, forming comprehensive communication strategies, developing an information system to manage the data, and setting up considerable support systems to help physicians understand the changes[226]. If MCHS leaders had simply changed the

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Strategic Goals," Healthcare Financial Management, July 2014. Web 26 Apr. 2016. < https://www.sullivancotter.com/wp-content/uploads/2016/03/Value-Based-Physician-Compensation-final-hfm-Magazine.pdf>

[225] [225] Bunkers, B., Koch, M., McDonough, B., and Whited, B., "Aligning Physician Compensation with Strategic Goals," Healthcare Financial Management, July 2014. Web 26 Apr. 2016. < https://www.sullivancotter.com/wp-content/uploads/2016/03/Value-Based-Physician-Compensation-final-hfm-Magazine.pdf>

[226] [226] Bunkers, B., Koch, M., McDonough, B., and Whited, B., "Aligning Physician Compensation with Strategic Goals," Healthcare Financial Management, July 2014. Web 26 Apr. 2016. < https://www.sullivancotter.com/wp-content/uploads/2016/03/Value-Based-Physician-Compensation-final-hfm-Magazine.pdf>

compensation plan without attaining physician buy-in, the significant performance improvement that was achieved would likely have been elusive[227]. Key elements of the change management process included the following.

> Methodical rollout of program with full leadership support.
> Multi-faceted communication strategy.
> Data transparency and frequent reporting.
> Robust physician performance management tools.
> Substantial physician support.[228]

Compensation plans are both part of an organization's culture and reflective of the current market forces. While every healthcare system is unique, the MCHS case study provides a framework for compensation redesign that is part of a larger change management process, carefully developed to earn physicians' trust and acceptance and aligned with the organization's strategic goals to help achieve the ultimate objective: high-quality, cost effective care.

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[227] [227] Bunkers, B., Koch, M., McDonough, B., and Whited, B., "Aligning Physician Compensation with Strategic Goals," Healthcare Financial Management, July 2014. Web 26 Apr. 2016. < https://www.sullivancotter.com/wp-content/uploads/2016/03/Value-Based-Physician-Compensation-final-hfm-Magazine.pdf>

[228] Bunkers, B., Koch, M., McDonough, B., and Whited, B., "Aligning Physician Compensation with Strategic Goals," Healthcare Financial Management, July 2014. Web 26 Apr. 2016. < https://www.sullivancotter.com/wp-content/uploads/2016/03/Value-Based-Physician-Compensation-final-hfm-Magazine.pdf>

5. Conclusion

Healthcare is quickly and constantly changing. We need to make sure as healthcare professionals we change with it. The United States is on the brink of national health reform. We know that highly engaged employees and physicians lead to improved teamwork, coordination of care and patient outcomes. We need to make sure hospitals do not layer new initiatives on antiquated practices and operations. The environment of healthcare, specifically in the hospital setting, needs to change to meet the goal: higher quality, more cost-effective care for all. With the same thinking, the environment needs to work for us, not against us. Innovation needs to be instilled as a cultural norm. We see the best organizations in our nation establish a connection between innovation system-wide and the individual patient. Innovation is fully supported from the top-down.

When times were simpler, organizational processes weren't as complicated because they didn't have to be. One hundred years ago, doctors were bedside and patients payed what they could at the time of service. Technology was primitive. There was also no regulation of financial payments. As quality standards rose for both physicians and hospitals, so did regulation; so did the costs.

Health insurance changed the conversation. Doctors fought against nationalized health insurance, fearing it would rob them of autonomy. By 1950, one hundred and fifty million people were enrolled with health insurance coverage and the hospital was the center of healthcare. At one time, physicians and hospitals were harmonious. More medical students enrolled and graduated, and medical staff participation increased. Hospitals didn't challenge physicians, yet, and we see that the health care system was unrestrained. However, inflation of medical costs after the institution of federal Medicare programs threatened hospital-physician alignment.

Managed care had many negative effects on healthcare, specifically patient relationships and quality of care. Treatment decisions were no longer in the patient's full control, and clinical judgment was not entirely in the physicians' control. The ideal relationship between a patient and physician shouldn't be financially based but rather based on the physician's clinical expertise and the patient's understanding of their health. Both the physician and patient must experience a sense of autonomy. The collective power of physicians has declined and the hospitals have been focused on filling beds. Currently we see the most spending on healthcare in the world, with the lowest performance when compared to other high-income nations. The divide between the spending and performance of the United States healthcare system mirrors the divide between physicians and hospital administration; the divide between stems from misaligned goals and poor infrastructure.

Research shows physicians and employees drive patient experience and quality of care. The most successful organizations are dedicated to improving the patient experience and engaging their physicians. The research also proves that a hospital's ability to create a culture of engagement has significant financial implications. Engagement impacts the patients' perception of their care, and the quality of the care they receive. The same measures of care are tied to CMS reimbursement rates. Ultimately, a hospital's survival is contingent upon its ability to engage and retain its physicians.

The alignment of hospitals and physicians will be even more crucial in the future as reform supports the shift from the volume of care provided to the value of care provided. An increasing number of Americans are seeking medical care and enrolling in Medicaid and Medicare. Currently we see that 75 percent of healthcare costs nationally are attributed to chronic disease while only 12 percent of costs are attributed to physician fees.

There are several tools hospitals can use to improve communication with physicians. Using improved communication and showing organizational support will allow the hospital to move toward physician alignment. Everyone will benefit, most notably the patient. The physicians and the hospital have a vested interest to provide cost-effective, quality care. Doing so will keep the hospitals in business and keep the healthcare system afloat. Hospital-physician alignment lets patients benefit from coordinated care across multiple settings to meet the communal goal of quality patient care. As the health care industry shifts to a payment model where compensation and reimbursement is tied to results for quality, access and efficiency, alignment is necessary.

When baseline performance levels are met, hospitals and physicians will benefit from shared savings—and to achieve those levels, aligning the actions of the provider group is essential. When performance levels are not met, hospitals and physicians will be at risk for reduced payment, no payment or exclusion from a provider network. However, today the historical basis for a working relationship between physicians and hospitals has broken down due to increased competition aimed at offsetting increasing reimbursement cuts. This breakdown, coupled with the increasing demands for quality, efficiency, coordination and the payment changes outlined in healthcare reform, has left many organizations wondering how they can encourage physician-hospital alignment.

Investing in collaborative partnerships requires understanding the needs of both parties and the use of a variety of strategies to meet those needs and to align the hospital and its physicians. Given that the success of the hospital's mission depends on physician alignment, it is crucial that hospital administrators consider a need framework. Making progress toward the goal of better alignment and requires that organizations understand the elements of alignment and

how various strategies such as parallel charts and Schwartz Grand Rounds can positively impact these elements. The future of healthcare is leading to a great dependency on medical humanities in the organizational culture, and physician compensation tied to patient quality measures.

Dr. Ross Donaldson is the Director of the Emergency Medicine Global Health Program at the Harbor-UCLA Medical Center and holds appointments in the UCLA Schools of Medicine and Public Health. He has been featured on CNN, BBC, NPR, and other media outlets. As Dr. Ross Donaldson eloquently stated in his book, The Lassa Ward: One Man's Fight Against One of the World's Deadliest Diseases:

> Seeing modern health care from the other side, I can say that it is clearly not set up for the patient. It is frequently a poor arrangement for doctors as well, but that does not mitigate how little the system accounts for the patient's best interest. Just when you are at your weakest and least able to make all the phone calls, traverse the maze of insurance, and plead for health-care referrals is that one time when you have to — your life may depend on it[229] (Donaldson, 2009).

Our lives all depend on valuing the patient's best interest and supporting our physicians to do so.

[229] Donaldson, Ross I. The Lassa Ward: One Man's Fight against One of the World's Deadliest Diseases. New York: St. Martin's, 2009.

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May 2016
VITA

Nicole Lopez-Marin

Born Brooklyn, New York, March 20, 1986

Parents: Raymond Lopez and Barbara Lopez

Educational Institutions:

School	Place	Degree	Date
Staten Island Academy	Staten Island, NY	High School	6/2004
Drew University	Madison, NJ	Bachelor of Arts	5/2008
Drew University	Madison, NJ	Masters	5/2016