Engaging managers and clinicians in DRG based outcome analysis

Pieter Degeling
Deconstructing the topic

What do we mean by:
- Engaging clinicians?
- Outcomes?
What do we mean by “engaging”

- Clinicians as objects:
  - How can we *engage* clinicians? (that is):
    - attract, charm, cajole, convince
    - induce, entice, allure, tempt

- Clinicians as subjects:
  - How will we know that clinicians are *engaged*? (that is):
    - acknowledge, (accept, endorse, affirm, agree with) the benefit of,
    - voluntarily and routinely undertake (embark on, venture into, take upon themselves)

- Clinician & Manager as conjoint subjects
  - How will we know that clinicians and managers are *mutually engaged*?
    - All of the above but with unity of purpose and reciprocal regard and respect,
Outcomes

- Outcomes or Outputs?
- What sorts of outcomes?
  - Clinical outcomes
  - Patient experience outcomes
  - Resource usage/cost outcomes
  - Process outcomes
  - System’s outcomes
DRGs: A language for clinician and management engagement?

- Effective communication is the most serious problem facing the health care system

- Accordingly, regulators and managers must build a language to physicians that:
  - merges medical and financial information and
  - makes it possible to:
    - trace the relationship between physicians’ decisions and effects on cost
    - frame valid questions to deal equitably with issues of effectiveness, quality and efficiency in patient care

- DRGs are base building blocks for developing such as a language

Fetter et al 1980:34
Conceptions of Language

Language as socially embedded vernacular

Language usage as representation

Language as technically derived classification system

Language usage as cultural performance

Silverman 1993
Lee: 1991
Language characteristics of DRGs

Language as socially embedded vernacular

Language usage as representation

Language of DRGs

Language as technically derived classification system

Language of care

Language usage as cultural performance
Implications of these different conceptions of language become clear when we consider:

- differences in the cultures of medicine, nursing and management

- and how these cultural differences are reflected in how these professional groups evaluated DRGs
Culture
Basic Assumptions
Legitimating Ideology

Key
Colour = Visible Traits
White = Masked Traits

Rules, Practices and Artefacts
Attitudes, Values and Personal Identity
Levels of culture

- Rules and practices enacted in the course of:
  - resource allocation
  - social control
  - conflict management and resolution
  - social integration
  - socialisation

- Shared attitudes, values and beliefs that are embodied in action in ways that:
  - makes social interaction possible and
  - Materialises and reinforces personal identity

- Basic assumptions and legitimating ideology:
  - about the way the world is and/or ought to be,
  - that are regarded as natural and necessary truths in society,
  - that set the agendas within which action can take place and
  - set the limits of actors personal identity
Findings from an ethnographic study of hospitals

Degeling 1994
Questionnaire design

Respondents views on:

- acute health care issues
- strategies for addressing hospital resource issues
- their professional autonomy
- scope and limits of their accountability
- causes of clinical practice variation
- factors affecting their clinical practice
- interconnections between the clinical and resource dimensions of care
- forms of knowledge which should be used in setting clinical standards
- management models appropriate for improving the overall performance of clinical units
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## Summary of Professional Cultures

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<td>Recognise interconnections between clinical and resource dimensions of care</td>
<td>+/-</td>
<td>+</td>
<td>+</td>
<td>+/-</td>
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<tr>
<td>Balance professional with transparent autonomy and accountability</td>
<td>-</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+/-</td>
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<tr>
<td>Support the systematisation of clinical work</td>
<td>-</td>
<td>-</td>
<td>+/-</td>
<td>+</td>
<td>+/-</td>
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<tr>
<td>Accept the power sharing implications of multidisciplinary teams</td>
<td>-</td>
<td>-</td>
<td>+/-</td>
<td>+</td>
<td>+</td>
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Study Findings

- differences between respondents best explained by their occupational background

- these differences occur on four dimensions, two of which explain 91% of the variances
The Two Dimensions were:

- personalized vs rational and socially abstracted approaches to clinical work organization
- individualistic vs collective concepts of clinical work performance
Professional Subcultures Across Country Comparison

Systematised concepts of clinical work

Emphasis on financial realism and transparent accountability

Individualistic concepts of clinical work

Emphasis on clinical purism and opaque accountability

Degeling et al 2006
### Stability of professional ‘archetypes’

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Culture based evaluations of DRGs
Conceptions of Language

- Language as socially embedded vernacular
- Language usage as cultural performance
- Language of care
- Language of DRGs
- Language usage as representation
- Language as technically derived classification system
# Culture based evaluations of DRGs

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<th>NC</th>
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<tbody>
<tr>
<td>Inappropriately lump patients with different needs</td>
<td>++</td>
<td>0</td>
<td>-</td>
<td>-</td>
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<tr>
<td>Cannot keep up with rapid changes in medical technology and treatments</td>
<td>+</td>
<td>+</td>
<td>-</td>
<td>-</td>
<td>0</td>
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<tr>
<td>Derived information is effective for evaluating the quality of patient care</td>
<td>-</td>
<td>-</td>
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<td>+</td>
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<tr>
<td>Increase hospital efficiency</td>
<td>0</td>
<td>+</td>
<td>++</td>
<td>++</td>
<td>+</td>
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<tr>
<td>Increase the control of lay managers over clinical staff</td>
<td>+++</td>
<td>0</td>
<td>+</td>
<td>0</td>
<td>+</td>
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<tr>
<td>Increase hospital administrative costs</td>
<td>++</td>
<td>+</td>
<td>0</td>
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Degeling, Black, Palmer & Walters: 1995
Some Evidence of Culture Change
Evidence of cultural shifts among medical managers

Emphasis on financial realism and transparent accountability

Systematised concepts of clinical work

Individualistic concepts of clinical work

Emphasis on clinical purism and Opaque accountability
Some other evidence on emerging changes in medical culture suggest that room for manoeuvre on clinical work focussed management may be increasing.
Assessment of propositions that clinical practice should *not* take account of resource constraints

Positive = Disagree with proposition

Negative = Agree with proposition

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<tr>
<th>Year</th>
<th>Doctor</th>
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<th>Manager</th>
<th>Nurse Manager</th>
<th>Nurse</th>
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Assessment of practices that would facilitate the systematisation of clinical work

- Negative = Support practices
- Positive = Reject practices

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<tr>
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<tr>
<td>Nurse Manager</td>
<td>-0.8</td>
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<tr>
<td>Nurse</td>
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Assessment of a model of clinical unit management that underwrites medical ascendancy and emphasises management role in resource acquisition

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<tr>
<td>Negative</td>
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<tr>
<td>Support model</td>
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<td>Reject model</td>
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<td>Mean factor score</td>
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Legend:
- Doctor
- Doctor Manager
- Manager
- Nurse Manager
- Nurse

Positive = Support model
Negative = Reject model
Assessment of models of clinical unit management that emphasise the manager’s role in bringing about improvement oriented team building

Mean factor score

-0.6
-0.4
-0.2
0.0
0.2
0.4
0.6

England 1995
England 2002
2004

Negative = Support model
Positive = Reject model
These (albeit preliminary) indications of shifts in medical and nursing culture suggest emerging mutations in the vernaculars of clinical professions.
Clinical-product focused structures and processes as media for enacting culture change

- Clinical/Resource interconnections
- Transparent Accountability
- Clinical Product focussed Management System
- Power-shared based multidisciplinary teams
- Clinical work systemisation
What can and needs to be done to institutionalize this to the benefit of engaging clinicians?
Internal and external contributory factors

Clinical production focused regulatory structures

Clinical production focused payment systems

Method for Systematising Clinical Production

Cost

Quality Indicators

Care Pathways

Variance Review

Outcome Indicators

Clinical Product focused organisation structure

Intermediate Products

Final Products

Clinical Product focused accountability structure

Hospital Management Board

Surgical Division Clinical Production Council

Orthopaedics Unit

Hip Replacement Type 1

Hip Replacement Type 2

Facture Type 1

Facture Type 2

Redundancy for Naturalizing Clinical-Product focused talk
Conceptions of Language

- Language as socially embedded vernacular
- Language usage as cultural performance
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- Language usage as representation
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- Language as technically derived classification system
If and when we achieve this we will have:

- Institutionalized the vocabulary and grammar of casemix, as well as the values and meanings incorporated in it.

- Naturalized clinician use and engagement with casemix methodologies and thinking and

- They will be in a position to join with managers in using it for both output and outcome analysis.