Managed Care in an Un-Managed World

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By now most everyone is familiar with at least one tale of a managed care nightmare scenario. Some poor patient was shuffled through a seemingly uncaring, unsympathetic and unresponsive healthcare system, which did everything but care. Truly the only word to describe the fate of patients who suffer needlessly is tragic. But the truth is that for every so-called horror story there are countless patients who otherwise receive good medical treatment and have good outcomes, although they may well feel mistreated. And it is this "mistreated" population of patients where most of our effort should probably focus.

Who are the mistreated patients? First, a working definition of a mistreated patient: a mistreated patient is one who receives appropriate medical treatment while simultaneously being ignored and/or stripped of their human-ness. The mistreated patient is you, me, and anyone who waited in the wrong line, hit a dead end on a voice mail screen or simply became overwhelmed and frustrated at a health care system that did not seem to care about the individual person. The mistreated patient is probably the average patient in many managed care systems.

Why are patients mistreated? Rarely does one suggest that doctors, nurses, and administrators purposely mistreat patients. In fact most doctors, nurses, and administrators would argue very forcefully that they are doing all they can to ensure that patients are not mistreated. Having said that, why do patients continue to feel mistreated in these managed care systems? Are not these very doctors, nurses, administrators the ones who are precisely in a position to ensure positive outcomes? The short answer is

yes and no. Yes, every individual in a health care delivery system is in a position to control how they interact and react with a patient. No, individuals in a healthcare delivery system cannot change policy, break rules or short-circuit management goals. And that duality seems to sum up the frustrations of doctors, nurses, and administrators in today's un-managed world of managed care. And that perhaps is why the patients are frustrated and feeling mistreated. It seems that while policy makers are trying to manage care within the confines of some theoretical box, with neatly drawn lines, the rest of us in the real un-managed world are trying to cope with conflicting goals, changing policy objectives, and of course, an infinite demand for care in a world of finite resources.

Since roughly the early 1990's as managed care become more and more of a national phenomenon, health policy experts would speak of the managed care triad: access, cost and quality. Often times the word choice would also enter the discussion as a fourth variable. In any case, the point of the experts was that for the people who are delivering healthcare in a managed care world they must understand that their patients could only have two or three of the four variables, but never all four. And so the challenge was to define which patients within our served population wanted which of those variables, knowing that we could never offer all four. The guidance given seemed very clear. We went back home to our offices, sat down with the doctors, administrators, and the bean counters and simply developed a few product lines, usually an economy model, a standard plan, and a luxury model and then priced and marketed the three products accordingly. Life is good. Everyone should be happy.

However a funny thing happened. We ran into patients who said in no uncertain terms that they will have access, choice, cost and quality, or at least we think that's what

we heard. And in many ways the patients and the people delivering healthcare have been shouting at each other ever since, with neither side likely ever having heard the other. Fear and mistrust soon followed, ending with a negotiated stalemate of sorts. There was no one particularly happy; several were particularly unhappy.

How did we get to such a place so quickly, from an idea that at first seemed to have so much promise? Blaming the patient has always been a very satisfying, if not shortsighted answer for many people. Patients expect too much, they should be held accountable for their health behaviors, they need to be made to understand why they cannot have quality, access and choice all at a low cost. Who could argue with that? All those statements most would agree, have a kernel of truth in them. Yet it also demonstrates what has been clearly wrong about the implementation side of most managed care programs.

The principles of managed care work. Empirical data have shown time and again that equal or better care is delivered in managed care settings at a lower cost when compared to the traditional fee for service plans. Saving money is a good thing. But what is not a good thing is to leave the patient in the lurch; to leave the patient feeling mistreated, to leave the patient adrift in a system that the patient cannot successfully navigate on his or her own. Yet, that is precisely what we have been asking patients to do; to navigate the managed care world on their own. To make matters worse, the people that do managed care - doctors, nurses, administrators - are trying to manage the un-manageable: patients. Many of the people who do manage care feel that the patient is as just described: an ever demanding, unrelenting consumer of healthcare resources. They

believe this because that's what managed care has taught them. And because the patient is this way, we must manage the patient; we must manage the un-manageable!

There should be no sense of blasphemy in saying that patients are indeed at times unreasonable, lead unhealthy lifestyles, or are quite simply unrelenting consumers with insatiable appetites for healthcare. That is the reality of the un-managed world. What is blasphemy is fooling ourselves that we can manage the un-manageable. However, if we use as our starting point the notion that we take each patient as we find them, we can redefine how we implement the managed care model. A patient who approaches the healthcare system by definition needs something. By definition the healthcare system is in place to address that need. The trick then will be to find ways to identify the needs, find a definition of that need that both patient and healthcare system agree upon, and then meet the need.

Clearly the most difficult step is to find agreement on what is meant by a particular need. When a patient says she wants choice, the administrator immediately hears: I want my own doctor who is also a non-network, high cost provider. When the patient hears the managed care company say no, you must go to this clinic and see this doctor, the patient immediately hears: The managed care company will not allow me to choose my own doctor. I have no choice. But often times what the patient really means is I want a doctor like my doctor, a doctor who knows my name, or who doesn't make me feel like he is in a hurry. Often times with just a small amount of effort and yes, some compromise, everyone can get what they really wanted in the first place.

But how do we do that? If it is so simple why has it not been done? Well, in many cases it is being done, usually at a very localized level, using for example, nurse

case-managers. Often times case managers intervene well before small problems become big problems. This of course, is nothing new or extraordinary. It does however point out that the change in patient behavior happens only at a human one-on-one level. Quite opposite from the corporate up on high, top-down, bureaucratic model of implementing a policy. Quite opposite of trying to manage the un-manageable.

Which points to the three main areas in which many organizations and leaders have failed in implementing managed care. First, they have failed in recognizing the role that all the individual players in the managed care healthcare delivery system play. From not only doctors and nurses, but Red Cross volunteers, food service personnel, parking lot cashiers - ***everyone*** who has the potential to positively or negatively influence a patient experiencing managed care. Second, they have failed to recognize the need to educate ***everyone*** in an organization about their role in shaping and influencing the opinions of patients. Third, they have failed to recognize that the patient must be taken as a given in his or her present form. Some patients are more compliant than others, some more flexible, some more demanding. But all patients are uniform in only one way: they uniformly will not tolerate cookie-cutter treatment. They are too smart, too experienced, and too undeserving of such treatment. By recognizing these three points, managed care managers could free themselves from their current theoretical box of access, choice, cost, and quality, and truly begin to impart real change and real improvement.

The importance of recognizing the role and the contributions that everyone makes within a managed care organization cannot be overemphasized. The most carefully crafted marketing plan, the slickest public relations blitz, the sweetest-smelling flowers in the lobby – all these attempts at satisfying patients will absolutely fail before the patient

ever walks in the door if everyone in the organization is not part of the healthcare delivery process. All it takes is for a pateint to overhear a security guard at the front door making some cutting remark about the facility or its staff to a friend or co-worker, for that patient to lose all trust and any sense of respect for that managed care organization.

Yet no one ever seems to think it's important to educate a security guard of all people, on the inner workings of managed care. No one thinks to teach the guard the organization's business strategy for success, the organization's goals, and most importantly, how the guard himself can help the organization meet those goals. Yet individuals like a security guard can very much set the tone for everything that the patient experiences, favorably or unfavorably, from that moment forward.

Imagine for a moment the same guard who attended a thirty-minute training session, which explained very briefly the mechanics of managed care. In that session the guard hears about the ethics of managed care, how managed care saves resources and maximizes the health benefits to the greater population. Imagine if someone took the time to answer the guard's questions about managed care. Imagine now a guard who greets that friend or neighbor and expresses a confidence and a belief in his managed care organization. Unreasonable, not cost-effective, not practical? Absolutely not. Implementing such a program would put actions behind words, and would have a benefit far greater and much more enduring than any vase of cut flowers or piped in music.

Finally, we have the patient. We cannot change him or her. Nor should we ever try. Of course I don't mean we should not practice preventive medicine. We should discourage smoking and encourage exercise. But to try and change a patient's fundamental beliefs, change something that is to them very personal and individual in an

impersonal way, through a mass media, one size fits all program is not only foolhardy, but in a very serious way borders on unethical. Unethical because it demonstrates a level of uncaring if not arrogance that patients will immediately recognize and rebel against.

Here again, we return to this very basic notion of treating patients as individuals. Talking to patients and listening very carefully at what they say would amaze many policy makers. Patients will tell us their definition of access, choice, cost and quality if we are willing to listen. Surprisingly, most patients understand and embrace the principles of managed care. Their definitions of access, choice, cost and quality are more often than not more austere than the most jaded gatekeeper would have. Moreover, many patients want to carry their own weight so to speak, and not burden the system. But often times it's not the message, but the messenger that will make patients feel disenfranchised. When the messenger is a managed care organization that is trying to shoehorn a one size fits all message into the hearts and minds of thousands of individual patients, surely the messenger will fail. Rather than one huge messenger, the successful organizations will train and develop and cultivate everyone in the organization to become messengers. Only by creating thousands and thousands of one-on-one interactions at a human level will managed care organizations succeed. Only by having thousands and thousands of one-on-one interactions will mutually agreeable definitions of access, choice, cost and quality be achieved.

Managed care will not improve itself or the delivery of healthcare in a dramatic way. It will improve as small changes and small agreements are made at the individual level - individual employees in healthcare working with individual patients. Small, incremental policy changes are what will carry the day, not broad sweeping programs.

Steady, but gentle pressure is what it takes. Unfortunately such yeoman's work is neither easy nor glamorous. Chief Executive Officer's, elected officials and policy makers no doubt want quicker fixes. There are none. Carrying out the day-in, day-out drudgery of educating staff and patients is extraordinarily difficult. Gaining and maintaining momentum is extremely hard work. Implementing deliberate change in an organization by identifying the formal and informal leaders is just one of the many important and tiny steps that must be taken to move forward. Ribbon cuttings and press releases alone will not work. Persistent action, effective and constant communication, and especially fulfilled promises, will be the benchmarks by which patients and staff measure the sincerity of a managed care organization's intent and integrity. Managed care can and does work. We only now need to put the managed care managers to work.