[music]

Geri Amori, PhD, ARM, DFASHRM, CPHRM: Hello, everyone, and welcome to *Healthcare Perspectives 360*, a podcast dedicated to exploring contemporary healthcare issues from multiple perspectives. I'm Geri Amori, and today I'm joined by Marisha Burden, MD, the division head of hospital medicine and Professor of Medicine at the University of Colorado School of Medicine, and recipient of the Society for Hospital Medicine Award of Excellence in Clinical Leadership for Physicians. As a working hospitalist, her interest is in building a thriving workforce and building clinical staffing models that drive outstanding patient and institutional outcomes.

I'm also joined by Susan Dorr Goold, MD, Professor of Internal Medicine as well as Professor of Health Management and Policy at the University of Michigan School of Public Health. Dr. Goold has a special interest in public health policy and ethics and is a practicing primary care physician.

I'm also joined by Gina Symczak, patient and family advisor serving on the council of HOMERuN, the Hospital Medicine Reengineering Network. Gina has been an active member of patient and family advisory councils at the University of California San Franciso, and a representative on patient-centered initiatives for national organizations since 2012. Her service follows a career in marketing and brand strategy in the consumer packaged goods industry.

I'm also joined by Luci Leykum, MD, affiliate professor of medicine, Dell Medical School at the University of Texas Health Science Center, and a general internist, as well as a health services research investigator focusing on assessing and improving healthcare system function.

Welcome to our panelists, and welcome to our audience. Today, we're talking about the effects of administrative decisions. Those are the decisions made by healthcare systems – boards, local boards, and administrators – on the care received by patients.

It's tempting to think about decisions made by leadership, including boards of directors, or the C-suite, and even high-level directors and VPs, being specifically about the business of medicine. Decisions include directives about budgets, equipment and supplies, locations of operations, and formularies. Purchasing of new practices, buildings and maintenance, shuttle buses, and even benefits.

Closer to patient care, there are decisions about staffing, and vacation time, and opportunities for training, and where to store supply items that may be used by staff. And in many, many ways, these things feel incidental to the active diagnosis and treatment of illness. But they all work together.

According to O'Donnell, who coined the term administrative harm in 2022, more decisions are being made by people very far from patients, and there's no accountability, especially compared to physicians. He calls these adminogenic injuries, a play on the term iatrogenic injury. That was a mouthful.

Susan, I'd like to ask you the first question today. From your health policy and management perspective, what are your thoughts about the statistics quoted by Lazarus in *KevinMD* that I'm about to give you? Despite the significant expenditure on healthcare, the US overall Global Health Security Index score in 2023 was 73.3 out of 100 points. This made us ranking 69 out of 167 total countries rated and is even unfavorable compared to many third-world countries. The US has the lowest life expectancy among large, wealthy countries, while it far outspends its peers on healthcare. And then he goes on to say these poor rankings are partly a result of administrative harm, or what some refer to as management malpractice. More funds are diverted to maintaining an inefficient administrative infrastructure, and less money for actual healthcare. This feels like quite an indictment to me. Do you think this is true, and do you think they're just inflammatory statements? Or what do you think?

Susan Goold, MD, MHSA, MA: It's definitely true that, on average, the US spends at least 50% more than other wealthy countries on healthcare, and we're the only wealthy country, by the way, that doesn't have universal coverage. So where does the high spending come from? Utilization of care really isn't different. It's prices, and those prices often refer to outpatient and inpatient care and lots of other things. Those prices reflect the administrative cost of our supposedly free market healthcare system, okay? It's not really a free market, but that's what it's supposed to be based on.

We have so many different payers, and each one of them has different rules and regulations and prior authorization requirements. I don't have time to look up the rules for obesity medicines for all of them, so we have somebody whose job in our office is to do that. So we're spending money on that instead of spending the money on the medicines or other things. And, yes, our outcomes as a country – life expectancy, maternal and fetal health, rates of chronic disease – worse than most other well-off countries. Mississippi, West Virginia have life expectancy that's worse than Bangladesh.

Amori: Wow. Okay. Well, that's something to think about. Marisha, you published a study in *JAMA Internal Medicine*, in 2024, and in that you reported a stunning statistic regarding your respondents personal beliefs about the effect of patients by administrative harm. Can you tell us what you found?

Marisha Burden, MD, MBA, SFHM: Absolutely. So in our study, we set out to understand how not only frontline clinicians, but also leaders, had experienced administrative harm. And what we found was both striking and concerning. First, 85% of respondents said administrative harm affects patient care at least somewhat to a great extent. And to me, that alone should raise red flags for any organization whose mission statement centers on patient safety and quality. Yet despite this level of impact, only 38% of participants felt empowered to speak up and raise concerns about administrative decisions that they believed could cause harm.

And this mismatch of high harm-low voice to me is deeply troubling. And these numbers matter not just for clinicians, but I believe for the public. Patients deserve to know that some of the risks that they face in the healthcare system come not from clinical errors alone, but from this invisible layer of administrative choices that shape staffing, processes and policies, and how resources are allocated. And when clinicians and other healthcare workers feel powerless to challenge these

choices – voiceless sometimes – both patient safety and workforce wellbeing suffer. And our findings really highlight it is time to bring administrative accountability to the same spotlight that we have for clinical accountability.

Amori: That sounds really important. Luci, what do you feel are some of the impacts of administrative harm on patients?

Luci K. Leykum, MD, MBA, MSc: Yeah, they're everywhere. Administrative decisions influence all aspects of care delivery, so the impacts of administrative harm could be felt anywhere in the system, from not having enough staff, to poor documentation of the care that's occurring to bottlenecks. And you might think about these as really being unintended consequences of decisions. Decision makers often have legitimate reasons why they're making some of these decisions, they're often financial, and they're just not anticipating the impact on care at the frontline. And because they don't have that direct channel to the clinicians, they don't understand what those consequences are.

And there's so many, but I do want to mention two specifically. The first is access to care. When operational decisions are made that lead to bottlenecks or delays, people might wait longer for the care that they need, right? They might wait longer for that test, they might not get the care at all. And then the second is errors. So when we make changes to how people work, some of the safeguards and processes that they rely on to make sure things are done quickly and safely get disrupted. And because these disruptions are unexpected, they don't even know to look out for them.

And I just want to tie into something Marisha just said. From a research perspective, we do a lot to make sure our research is safe, right? There's all types of human subjects' protections. And I've always thought it was so interesting and ironic that an administrator can change processes in how healthcare is delivered, and there's not really a whole lot of oversight of that decision-making in terms of making sure that the impacts are going to be okay.

Amori: That's really interesting, we ought to have an Institutional Review Board for administrative decisions when they decide to change suppliers or change… That's a good idea. Okay, that's unique.

Gina, thinking about your personal experience. Have you heard patients talk about, or have you personally had an experience that you might call administrative harm, and if so would you be willing to talk about it?

Gina Symczak: Absolutely, and I think I have a good example of the unintended consequences of an administrative decision. I got a call one day from an unidentified phone number, and I thought it was spam, so I didn't pick it up. The number called me back three times. So I finally picked up, ready to give them a piece of my mind. But as it turns out, it was a clinic calling me, because I was the emergency contact for a good friend of mine who was a patient of theirs. He had just had a blood test, and they were trying to urgently reach him because his potassium level was dangerously high. I called him to relay the message, and he picked up my call immediately because he knew it was me. He said that he, too, had received multiple calls from an unidentified

caller, but he ignored them the same way that I did. He went to the emergency room immediately.

My friend could have died because some administrator had made a decision, or simply an oversight, when setting up a phone system for the clinic, without ensuring that their outbound calls were identified as coming from them. That administrator will never know the consequences of their decision, because there's no feedback loop for that kind of administrative harm. They would never have been held accountable if, in fact, the outcome had been different, and that's really scary and really sad.

Amori: That is. And actually, that could have ended up as patient-blaming. They would have said, well, the patient never picked up the phone call, right, never even looking at the fact that they contributed to the patient not picking up the phone call.

Symczak: Exactly.

Amori: A scary example. Susan, apart from the belief that Americans believe we have the best healthcare. As we've heard earlier, it is the most expensive with not the greatest results. Is it just us losing a competition, or are we morally or ethically failing our citizens in some way? And do we have an ethical obligation to address administrative harm?

Goold: Yes. And one of the reasons is that healthcare and public health, both, use shared resources, whether those resources are coming from the government, Medicare, or from premiums being put into a private health insurance, for instance. Those are still shared resources, and then they need to be used to meet the needs of a certain population of people. But we have a moral obligation to use those resources wisely and fairly.

Amori: Marisha, from a hospital clinician perspective, what is my obligation if I perceive administrative harm affecting a specific patient? Can I do anything?

Burden: This is such an important question, Geri. Recognizing and reporting harm is challenging, whether it be in the clinical or administrative setting. And right now, most of our infrastructure is designed to detect and prevent clinical errors, not the upstream administrative decisions that lead to some of these errors and bring harm. The reality is that healthcare workers are already overwhelmed, so expecting busy clinicians or other team members of the workforce to take on more reporting responsibilities probably isn't the full solution, as it can feel like one more thing to do. And yet it's really critically important.

First, I think we have to make it easy and safe to flag administrative harm with clear, quick ways to report concerns without fear of blame or retaliation, and this could be through anonymous channels or simple ways to share during regular team meetings, such as huddles or staff meetings. And you can also implement this feedback loop or assessment in the clinical case reviews that we do around clinical care, to try to identify if there are any structural or process-related issues that led to an error or harm, and how those structures and processes came to be.

Second, organizations need to be more proactive, and actually study and assess the impact of their own decisions, just as we do with clinical treatments – are our staffing models safe, do our workflows help or hinder care? Do the policies actually protect patients and staff, or is it just a check box? And then third, leaders have to foster transparency and psychologically safe environments to foster that culture of giving that feedback.

Amori: All right. So Luci, I'm going to ask you a similar question, but kind of the flip-side of it. From the perspective of system interface with clinicians, if I as a clinician perceive that a specific patient is being adversely affected significantly in their care, what can I do?

Leykum: I think there's at least three avenues that clinicians could pursue really in real time. So the first is going through their own sort of chain of command, or their own set of resources to their supervisor, or another person in a leadership position, who can not only help them navigate that situation, but also pass on the feedback to higher levels of the organization. The second is, I think, what Marisha was talking about, in terms of really leveraging the incident reporting systems that every health system has to have. And her point about making these systems as easy to use as possible so that busy clinicians don't feel like, you know, it's such a hassle to use it. But these are important, because they get widely reviewed at the organizational level. If leaders see patterns, they'll be able to identify them early and take action.

And then I think the third way is through the avenues that directly support patients and families, so including patient advocates. I have involved advocates in care of people when I was concerned that things weren't moving in the best direction, and I found that to be very useful.

Amori: Good. So, Gina, if you as a patient are being treated for something, and your healthcare provider notes a barrier to your care that's administrative, what is your expectation of that provider and the system?

Symczak: When there's a barrier to care, I think that patients expect the provider, the person they perceive as both the subject expert and the intermediary, to be their advocate and their partner to help them find a creative solution. And I think the patients, who let's remember are the paying customers here, deserve an obvious and accessible channel of communication in the administrative system that they can count on to be responsive to their needs.

Amori: Okay. We're sitting in a virtual conference room here, and it looks like Susan wants to say something. You want to pipe in here?

Goold: Yeah. I just want to say in response to Luci's comments about what to do. Besides the organization you're working in, professional organizations can be useful for putting the pressure on different large organizations. And frankly, I've sent messages to the Center for Medicaid and Medicare Services about ridiculous time-wasting things that I'm required to do. I don't know where it goes or what happens with it, but the more of us who do it, the better.

Amori: Okay. I like that, an activist perspective. Good for you and thank you for doing that. I guess we're getting ready to wrap up here, so I need you to keep it to two sentences if you can. But if there's one thing that you would like our listeners today to take away about the impact of

administrative harm on patient care, what would that be? Okay? So, Marisha, what would you like to leave our listeners with?

Burden: Sure. If we want truly safe, sustainable care, we have to stop treating administrative harm as just the way things are, and instead we have to start naming it, measuring it, and addressing it.

Amori: Thank you. Gina, what about you, what would you want people to take away?

Symczak: Administration's a complex matrix or web, with the power to either support or further entangle up the experience for both the provider, and the patient, and the patient's care partners.

Amori: Okay, good, that's a good thing to remember as well. Susan, what would you like people to remember about this?

Goold: Well, administrative requirements are worse because of our complicated "free market" system, there's multiple payers and each payer has different plans, etc., etc. And the time required to take care of administrative requirements takes time and money away from actually things that improve health.

Amori: Okay. Boy, that's important. And finally, Luci.

Leykum: Yes, thank you. I would say reporting systems are such important mechanisms for getting information from the frontlines to people making decisions, so clinicians, patients, and families should have a very low threshold for utilizing them. I say that even recognizing that it's often one more thing for them to do.

Amori: Understood. Well, I've learned a lot today. I've learned a lot about the fact that this is a big apple, and we all need to take the bites out of it that we can and push back as much as we can from our individual perspectives. And I'd like to thank our incredibly insightful panelists for being here with us today. I've learned a lot, I hope our audience has learned a lot. So I want to thank you, and I want to thank our audience for being here. And I'm looking forward to seeing all of you back here again the next time we have a *Perspectives 360*.

[music]