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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, MBA, SFHM, 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.

Also with us today is Susan Dorr Goold, MD, MHSA, MA, 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.

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 Francisco, 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.

And finally, Luci Leykum, MD, MBA, MSc, affiliate professor of medicine at the 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.

We have a star-filled panel today. So welcome to our panel and welcome to everyone. Today, we're going to talk about a term that has been gaining attention in the last few years, administrative harm. The effect of administrative decisions on patient care is not a new concept, there has been a tacit recognition that decisions made upstream of the patient can affect patient care and outcomes. Mostly, those of us who work in risk management thought about administrative effects on care in terms of quality of supplies, or storage distance of supplies from patient care sites or staffing levels. However, more recently there's been a broader recognition that all administrative decisions ultimately affect care, and perhaps there are ways to reconcile the need for administrative watchfulness with impact on care.

So administrative harm has been described by our own panelists, Drs. Burden and Leykum in an edition of *STAT News*, in 2024, as being the negative impact on patients and healthcare providers caused by bureaucratic processes, policies, or inefficiencies within the healthcare system. "It directly influences patient care and outcomes, professional practice, and organizational efficiencies. It is pervasive and can come from any level of leadership, from administrative leaders as well as clinical leaders."

According to Dr. Walter O'Donnell, who originally coined the term, administrative harm can be classified as an error or shortcoming in one of what he calls the 5 S's of administrative domains in healthcare. Those 5 S's are: systems, staff, stuff, space, and spirit. Dr. Dr. Burden, may I call you Marisha?

Marisha Burden, MD, MBA, SFHM: Yes.

Amori: Thank you. Marisha, can you please give us some real legitimate examples of administrative harm?

Burden: Absolutely, Geri. And thanks for having us, really excited to be here today. Administrative harm happens when decisions made far from the bedside create obstacles for both patients and healthcare workers alike. And as you mentioned, it can come from administrative professionals, clinical leaders,

informal leaders, anyone with decision making authority. And I think what's telling is there are several articles that can help us understand some of the examples. Drs. Zhang and Leong in *The Quiet Epidemic* highlight burdensome administrative hurdles that patients must overcome to receive necessary medications, and they describe a constant cycle of prior authorizations, long waiting periods, frequent denials. And in some cases, the patient actually has to suffer harm before they can get a specific type of medication, the one they described I believe was a gastrointestinal bleed.

Dr. O'Donnell described another case where a smoking cessation program was cancelled by an administrative scalpel, as he describes it, where a nationally acclaimed program that had helped patients have a higher quit rate by 50 to 70%, it was just cancelled and many patients probably had subsequent bad outcomes. But the list goes on. Unrealistic patient workloads, delays in being able to discharge a patient based on arbitrary number of days in the hospital which can lead to deconditioning, immobilization, and potentially infections that you can acquire in the hospital. So, so many examples. I'll pause, though, because I could keep going on.

Amori: Well, we're going to come back to you, Marisha. In the meantime, Dr. Goold, or may I call you Susan?

Susan Goold, MD, MHSA, MA: Yes, of course.

Amori: Thank you. Susan, can you give us some additional outpatient examples? And also, I often hear older patients, because I've worked with older patients, feeling like healthcare is cold and impersonal now. I don't hear younger people having the same expectation of personalized care that older patients might. Is this a generational thing, are younger people more comfortable with the transactional process? Or is all this concern about administrative burden or administrative harm nothing to them, or is the shifting of care moving away from the individual? What do you think?

Goold: Well, your first question, some examples of administrative harm in the outpatient setting. Prior authorization is also a big problem there. Can I say the weight loss medications are a huge source of that right now? But also some really simple things, like faxed orders for homecare and durable medical equipment that must be ink signed by a primary care provider, alerts in the electronic medical record to maximize revenue basically so that we just document comorbid conditions like diabetes, or depression, or whatever. Click, click, click, click. In other words, okay?

Regarding the generational differences, really I think all patients prefer better communication and personal care. I think we know that patients tend to think that doctors do too much testing, and prescribe too many medicines, and don't listen enough. I don't think that really varies by generation. I think there is a little bit of a shift in focus from individual to the population in the sense that we're paying a little more attention to population health, or sort of measures of covered lives health and that sort of thing; that is, how are all of your patients doing in terms of blood pressure control, or diabetes control.

But first, we should care about blood pressure control for those who aren't coming in. Okay? So if we really care about population health, it's not just the patients coming in to see the doctors, okay, but also that the administrative metrics for that, like how many people's A1C is less than 7, they're not arbitrary but they don't recognize the importance of individual patient circumstances. Like if I can get somebody who's A1C is 14 down to 10, that's a huge win, but it doesn't count as quality.

Amori: Got it. Thank you. I'm going to have another question for you soon. In the meantime, Miss Symczak. Gina. May I call you Gina?

Gina Symczak: Sure.

Amori: When I was a kid and I went to see a doctor in his office, where his wife was the receptionist and he had a nurse, and that was it. And I recognize that was a long time ago. So what is your knowledge about the patient encounter, what patients encounter now? How do patients feel about the balance of staffing?

Symczak: Well, basically what patients encounter now in their healthcare delivery is layers, layers of people that don't seem to be connected. So, for example, protective office staff screening doctor phone calls. Off-site or outsourced back office support staff. Nurse support lines and “advocates” offered by their insurer, not their physician. Hospitalists who don’t know them as well as their primary care doctor. And phone trees, lots and lots of phone trees. And patients as a result are feeling stressed, they’re feeling the resulting stress of these things. They’re more administratively burdened, their physicians have less time for them, and there are fewer doctors because many are leaving practices for more manageable lifestyles.

So, the bottom line is it’s incredibly frustrating and tiring for people who are feeling sick, or scared, or both, to have to work their way through these disconnected layers and to manage multiple aspects of their healthcare on their own. And lastly, it also contributes to their growing lack of trust in healthcare. At a vulnerable point in your life, how can you trust someone you don't know or who is not perceived to be on your side?

Amori: That’s a really good question. So I think that leads us on to the question I’d like to ask Dr. Leykum. May I call you Luci, please?

Luci K. Leykum, MD, MBA, MSc: Please.

Amori: All right, thank you. Luci, what do you feel is contributing to all of this; I mean, this doesn’t sound pretty. So what do you think is doing it?

Leykum: Well, there's a lot of factors, but one of them is that there's a lot of consolidation in healthcare. As practices and hospitals merge or are acquired by each other, you get the development of these larger and larger healthcare delivery systems. And in fact, at this point, almost three-quarters of physicians in the US are employed rather than working in their own practices. So you have these larger and larger systems where you have decision-makers that are farther and farther from the front lines, and that real-time communication and feedback becomes just harder and harder to accomplish.

And Gina just spoke to this from the patient perspective, but it impacts the clinicians, as well, because frontline clinicians have much less ability to provide insight into decision-making. And the people making those decisions have less opportunity to see and hear the impact of those decisions on care. So it makes the negative impacts of decisions really hard to address. So the upshot is that clinicians feel much less agency in terms of their ability to influence their daily work, and then they’re dealing with these impacts, often negative impacts, of decisions that they didn’t make.

Amori: Okay, thank you. So Marisha, building on that. How does this administrative harm manifest? Doctors are feeling it, but how does it show itself?

Burden: Yeah, great question, Geri. Administrative harm doesn't always look like traditional medical harm, like a surgical error or a medication mistake or a misdiagnosis, but it can certainly lead to those outcomes. Administrative harm is often more hidden and systemic. And I'll use an example from a loved one in my family who had known invasive squamous cell cancer, was awaiting surgery, got pretty sick –

swelling. Had to go to the emergency room, got a CT scan, and the clinician was so overloaded it was clear they didn't even have time to check their chart.

They come back and tell the family that they're concerned about invasive melanoma based on a quick CT scan read. Wasn't melanoma at all. But the emotional harm was real for my family. This is exactly how administrative harm shows up – rushed care, unnecessary fear by patients, and avoidable mistakes. Shows up in the daily friction points that clinicians face, not enough resources and less hoops to jump through just to get tests or follow-up care approved, and organizational initiatives that just check a box without truly improving care.

Amori: Wow, that's a hard one. Gina, just a few weeks ago I was looking at the 2022 and 2024 Gallup polls, their reports on healthcare. Marisha just talking about how it shows up, but I was wondering what the public thought. So I looked at those Gallup polls, and I was trying to figure out who the public thinks is responsible for healthcare access, and who they think should run it. And both reports solidly showed the public believes the government is responsible to ensure that patients have access to care. Where it differed was, though, in whether it should be a government entity running healthcare or a private entity running healthcare, like what would make it work better? But I see that both of those have lots of paperwork, and we're already experiencing administrative harm. So whose fault do you think, or from the patient's perspective, is administrative harm? Is it individual organizations, the government? What do you think?

Symczak: Geri, I think it's hard to generalize and place blame on institutions as a whole. Administrative harms are almost by definition faceless, nameless, and far upstream, as Luci was just speaking to. Because they're not often patient-facing, it seems that it could be hard for administrative decision-makers to remember the humanity of the situation, and it's hard for patients to know who the decision-maker is. Is the provider, is it the insurance company, is it one department or another department? I think administrative harms can really be considered the fault of individuals in all of the systems, people, people who do their jobs but who have lost touch with the people impacted by their decisions.

Amori: That makes it really hard to fix. But, yeah, okay. So, Susan, let me ask you a question here. We know that most healthcare in the US is now delivered by large systems, which by definition are going to be more depersonalized, right? Systems have supposed economies of scale, but they also have detailed processes. And have we sacrificed compassion in healthcare for bigness in healthcare? Is this an ethical problem, a policy problem, both? What do you think?

Goold: Definitely both. So my first question is where do the economies of scale come from? Do they come from bargaining to get cheaper prices on drugs and equipment? To get cheaper prices from providers, or to get them to see more patients in less time? To streamline administrative expenses and tasks? That's possible. I don't think we have to sacrifice compassion with bigness.

For example, we have an AI scribe that allows me to talk to patients face-to-face, and that will sort of create at least a drafted note of that doctor/patient encounter. That's actually an improvement over me typing while I'm trying to talk to a patient. On the other hand, if you have rules, hard and fast rules about appointment times and things that lack flexibility, that can hurt patients.

I want to raise the issue when you talk about bigness of private equity purchases of healthcare organizations. Hospitals and medical practices, which has really grown from 75 deals in 2012 to 400 and some in 2021. Private equity firms prioritize short-term profits so they can turn around and sell something. And we know from research – Luci can probably weigh in on this too – that private equity has effects on the workforce, on quality, on access, and simple things like where do you locate an office or a practice, what kind of after-hours nurse or on-call support do you have? So, we need investment that prioritizes long-term outcomes, but short term.

Amori: That's a really good point. And that leads me to Luci. In addition to the many large administrative decisions made daily by systems, there are multiple small administrative decisions made daily by closer leaders, like managers and supervisors. And how do these contribute to administrative harm?

Leykum: Yeah. It may seem like these small, daily decisions shouldn't have much impact on care delivery, but they actually really can. And, in fact, these small decisions often have surprisingly big impacts as they sort of ripple across the system, and they're downstream effects ripple across the system. And one of my favorite, or unfavorite, examples from a hospital I worked in had to do with the MRI. They had one machine. These machines are expensive, so they shared it between the hospital and some of the outpatient clinics in the same building. Someone on the outpatient side thought it would be a great idea to just add one more appointment a day to prevent this backlog from growing on the ambulatory side, without realizing that the impact that it would have on the hospitalized patients waiting for the MRI could be profound. And so we saw this really actually quick impact in terms of people waiting for tests, and length of stay utilization, and ED crowding from one appointment a day on an MRI scan.

Amori: Wow! Okay. We're coming to the top of our program here today, but there's one question that I always like to ask our panelists. If there was one thing that you can say in two sentences or less that you would like our listeners to take away about what is administrative harm, understanding administrative harm, what would those two sentences be? What is it you would want anyone who heard us today to think about? So I'm going to call on each of you, and I guess I'd like to start with Marisha.

Burden: Sure. We're obsessed with identifying and preventing harm in the clinical space, things like infections, falls, medication errors. But we almost never address the administrative harm with the same urgency. Yet administrative harm is just as real. It delays care, erodes trust, burns out clinicians, and contributes to outcomes we would never tolerate if it were tied to a clinical error. Thus, we have to start measuring and redesigning the systems that creates this harm.

Amori: Excellent. Thank you so much, Marisha. Dr. Goold, what are your two sentences about what you want people to remember?

Goold: I want people to remember that administrative requirements come at a cost, a financial one, yes, but perhaps more importantly, definitely more importantly, a cost of time with and for patients. If your doctor has to spend an hour filling out forms for your homecare orders that have already been decided upon, but now they just have to be signed over and over again, that's an hour they can't spend trying to figure out what's causing your pain, or what the diagnosis is.

Amori: Thank you, and you're right. Gina, what are your thoughts, what are your two sentences about what you want our listeners, any listeners to think about?

Symczak: What I'd like them to remember is that having patients top of mind, treating them with empathy and attention to detail when you work in healthcare administration doesn't necessarily add time or cost to any project. You can have administrative watchfulness but just don't lose sight of the patients who are your ultimate consumers.

Amori: Thank you. And finally, Luci, what would you want our listeners to remember about what is administrative harm, understanding it?

Leykum: Yeah. I think it's really important for people to understand that there's this larger policy and political context that impacts how care is paid for, and that context in turn drives a lot of this health

system leader decision-making. So for all of us, we all can and should ensure that our voices are out there and heard in these other arenas.

Amori: That's a very profound way to end our discussion today. I want to say this has been an amazing discussion, it's given me food for thought, and I'm sure it will for our listeners too. So I'd like to thank our panelists for being here today, and I'd like to thank our audience for being here today. We hope you found this valuable, and we look forward to seeing you again in our next episode of *Perspectives 360*. Thanks for joining us.

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