

CHAPTER 1

Introduction to Health Care Systems

“Everything must be made as simple as possible.
But not simpler.”

—Albert Einstein

Welcome to *Lead, Drive, and Thrive in the System*, a book about how nurses can lead from any position or level in the system. Leading, driving, and thriving in any system is a very operational, tactical, and thoughtful process. Throughout this book, I will refer to the “system,” by which I mean any system involved, directly or indirectly, in health care. This could include (but is not limited to) an individual department or facility, academia, government, health insurers, e-commerce, and large multistate horizontally or vertically integrated organizations.

The integration could consist of only hospitals, only clinics, only home care agencies, only nursing homes, only pharmacies, and so on, as well as any combination of all the above. Everything and everyone is connected and part of a system.

Chapter 1 will introduce health care systems, collaboration, change, and why a system needs all its members to work together. By the end of the chapter, I hope you will start to see things a little differently than when you started this book! Many concepts in this chapter will be expounded later in this book.

What Is Leading, Driving, and Thriving in the System?

All nurses are leaders regardless of role, position, or educational level. A clinical, direct-care RN leads by providing care as part of the interdisciplinary team, most importantly through the professional role of care coordinator and patient advocate. Additionally, the nurse delegates tasks to others on the care team and may take part in shared leadership. Through those activities, the clinical RN is leading in the part of the system where that RN has responsibility and accountability.

The nurse manager is also a leader. It is not the formal management tasks that make them a leader but their ability to lead change at both higher and lower levels in the system. Regardless of your role as a nurse, all RNs and advanced practice RNs (APRNs) have a professional responsibility to lead.

The responsibility to lead is founded in the American Nurses Association (ANA) *Code of Ethics for Nurses*, which states, “The nurse’s primary commitment is the patient, whether an individual, family, group, community, or population” (ANA, 2015). Nurses can have many commitments or loyalties beyond their patient, including loyalty to their employer. This can and does create conflicts for nurses. However, it is important to remember that the nurse–patient relationship is the primary commitment, which supersedes the nurse–employer relationship. This is

A CONSIDERATION FOR SYSTEMS THINKING

In my faculty role, one of my favorite system assignments was to have each student use a mind-mapping software to demonstrate the connections between a local individual-level health

quality outcome and the clinician, unit, facility, city/county, state, national, and global-level influences. Regardless of where you are, we are truly a system of systems.

A CONSIDERATION FOR SYSTEMS THINKING

Leadership versus Management

Leadership and management are not the same concept and can actually be mutually exclusive. A leader is not necessarily a manager, and a manager is not necessarily a leader.

“In this chaotic world, we need leaders. But we don’t need bosses. We need leaders to help us develop the clear identity that lights the dark moments of confusion” (Wheatley, 2006, p. 131).

one of many reasons why the public has voted through the Gallop Poll that nursing is the most trusted profession for over the past 20 years.

The *Code of Ethics for Nurses* does not say “the staff nurse’s primary commitment,” but “the nurses.” This means that regardless of your role, manager, executive, APRN, or staff nurse, your primary commitment is the patient. As a member of the profession and as a nurse, your primary commitment is the patient, regardless of the role you hold, which is the reason the system even exists. If you have a role in nursing as a nurse manager, director, or CNO/CNE, you are automatically given additional responsibilities as you lead in the system; however, the patient is still your primary commitment.

There will be further discussion about different RN and APRN roles related to leading in the system in chapter 6.

Definition of Nursing

This book can be used by nurses and those in other health care disciplines as well. That being said, this book focuses on the role of the professional nurse, so it is appropriate to ensure a standard definition of nursing before continuing. In this book, we will use the ANA definition of nursing.

As per the ANA’s Scope and Standards of Nursing Practice (2021), nursing is defined as follows:

Nursing integrates the art and science of caring and focuses on the protection, promotion, and optimization of health and human functioning; prevention of illness and injury; facilitation of healing; and alleviation of suffering through compassionate presence. Nursing is the diagnosis and treatment of human responses and advocacy in the care of individuals, families, groups, communities, and populations in recognition of the connection of all humanity. (p. 1)

Maybe your organization has its own definition of nursing. We will discuss later in chapter 2 the importance of standardization, but for now, the importance of using a standard definition of nursing is so that all nurses can communicate clearly as one nursing voice. There is an important premise in standardization, and clearly many issues exist in our current health care system due to our reluctance to standardize and desire to personalize things.

To underscore the importance of evidence-based standardization, I will borrow a phrase Lucian Leape, MD, used at a quality conference in 2014: *Autonomy Nuts*.

As a former health policy analysis and professor, he stated that autonomy nuts are people who are familiar with the standards and evidence but choose to ignore them in favor of their own way of doing things. There is a time and place for autonomy, as this concept is vital to the role of the professional RN, but there is also a time and place to support standardized definitions, language, and processes! Standardization can improve our ability to communicate more effectively the outcomes of our work, as it allows us all to work from the same page. Effective communication is vital when you are leading in the system.

A First Look at Systems

Typically, when people think of a health care system, words such as “bureaucratic,” “hierarchical,” “complex,” and “slow” often come to mind.

All of these can be true but it does not mean it has to stifle innovation. And while we may not like hierarchy, complexity, and bureaucracy, they can and do serve a purpose. I believe that the connotation of these words tends to be negative, mostly because people do not know how to navigate and negotiate effectively or have the patience needed to see change through to the end. Once we hit the first barrier, we attach negative feelings to the system. To lead in a system, any system, nurses must know the ins and outs of an organization, the internal and external inputs that influence and mold it, and that anyone can make a difference for change. It is through the bureaucracy and partnering with others that we understand how to most effectively impact the complexity and interrelatedness of the system.

Systems are defined in more detail in chapter 3. However, as an introduction, there are a few ways to think about systems. You should think of systems not only

DEFINITIONS FOR SYSTEMS THINKING

I use the word “practice” throughout the book when referring to work. I find it to be a professional view of nursing as opposed to calling it work, which implies a task-based job. Saying that someone “practices” is not limited to direct-care RNs or APRNs. Educators, leaders, case managers, researchers, and other RNs also have a “practice.” For

example, an educator practices education and a nurse leader practices leadership. So when I say “practice” anywhere in the book, think about your “work” or “job” through the lens of a professional. I encourage you to use the word “practice” from now on instead of saying “job” or “work.” It may feel odd at first, but words are powerful and words change cultures.

as a set of levels but also as a worldview, or a mental model of the world and reality. Systems can also be open or closed. Open systems interact with the world around it, whereas closed do not. Health care is an open system.

When it comes to thinking about levels in a system, James Miller (1978) stated that systems exist at eight “nested” hierarchical levels, which include the cell, organ, organism, group, organization, community, society, and supranational system. Each level works within and between other levels and has its own perspective and specific role to accomplish, neither of which is necessarily better than the other. In this book, we focus on the latter six levels: organism (person), group, organization, community, society (national), and supranational system (global).

Each for their own!

In any organization, individuals at any level may think they have it the hardest or that they need to “fight for their resources.” That somehow, their shift/team/unit/department is not being given the resources needed on purpose. This belief, which is due in part to the culture and management practices of an organization, can lead to the belief that everyone needs to fend for themselves.

While our health care system does continue to grow in costs, it may not feel like additional money or resources are making it downstream or to the lowest level. However, asking for more is not always the best way to achieve what is needed. Is there a way to rearrange what we already use differently, more effectively?

As socially responsible nurses, we cannot afford to let the US health care system continuously increase spending unchecked. We all need to be a part of rethinking how to spend the money that is already spent in health care! Why? Statista (2022) states that 19.7 percent of our gross domestic product (GDP) in the United States was spent on health care in 2020, with the highest spending among developed countries. GDP is an important measure within the US and across countries when it comes to comparing expenditures. GDP is the total monetary value of all goods and services produced in a country at a given time. This is not government spending or tax dollars alone.

DEFINITIONS FOR SYSTEMS THINKING

System: “A set of components that work together for the overall objective of the whole” (Haines, 1998, p. VI)

Real Organization: “A dense network of interdependent relationships” (Wheatley, 2006, p. 144)

For comparison of US health care spending against other areas, for instance, the US budget for the Department of Defense amounted to 3.3 percent of GDP in 2021 (US Congressional Budget Office, 2022) and 3.1 percent of GDP for elementary and secondary public schools' expenditures in 2018 (National Science Foundation [NSF], 2021). US health care spending is estimated to continue to grow to 24.8 percent by 2050 (IHME, 2020). So, the takeaway is the more we spend in one area, the less we must spend in another (or go into debt).

Therein lies the dilemma. If we spend more in health care, what and where do we spend less? And, if we spend more, how much and where? Who gets it? What area or industry is it taken from? Our health care system is an integral part of the lives of everyone in the US. Spending more requires trade-offs. How do we improve our health care system when we already spend more per capita than any other country? All good questions. We need to rethink our system at each level. As we make changes in our health care system, whether in our unit or department, organization, or national policy, we all need to change our own perspectives and take into consideration all other perspectives.

Belonging to a System

While the system may now seem even more daunting, there are numerous benefits to being part of a system. Depending on where you practice, whether at a higher level such as the corporate office (table 1.1) or lower level such as a department in an organization (table 1.2), these issues will vary. The often-quoted idiom “Can’t see the forest for the trees,” as well as the opposite, “Can’t see the trees for the forest,” is a good metaphor to understand the positive and negative aspects of being within varying levels of a system. Anyone can fall victim to losing the larger picture, or the details, within a situation.

Change: It Starts with You

How can one change their perspective from *everyone for themselves* to *everyone for our patients and communities*? I know someone is saying, “I fight for myself so that I can give the patients what they deserve!” Fair. But, if we are going to lead change so that we can deliver on the quintuple aim of improving health, improving care experience, reducing the cost of care, advancing health equity, and attaining joy at work (Nundy et al., 2022), we need to think about the system and everyone.

If we are going to lead change so that we can deliver care better in the future as our health care system changes, how can you think differently so that you can still

Table 1.1. Benefits and Potential Issues Practicing at the Corporate Level

BENEFITS	POTENTIAL ISSUES
Stay focused on larger issue	Lose sight of local issues and details
Become and visualize the interconnection across multiple organizations	Have more superficial relationships in lieu of local personal ones
Understand and see strategic plans and visions with greater clarity	Lose sight of how higher-level planning may negatively affect lower levels

Table 1.2. Benefits and Potential Issues Practicing at the Department Level

BENEFITS	POTENTIAL ISSUES
See how end results impact patients and staff directly	Perceived lack of power to make changes that may positively affect staff and patients
Able to visualize and change details	May not understand how localized slight changes could negatively impact policies
Have closer relationships with individuals at closest point of care to patient	May not see the aggregated impact of decisions

advocate and provide for your patients while working as a team? We are all responsible for decreasing the cost of health care in the US.

One way to change your perspective is to start with trust. Trust first that everyone you work with is there for the good of the patient and that everyone's goal is the same. They just may have a different way of getting there. We all have had a different journey and experiences that have given us different perspectives. It is not bad or good, simply different. We all look at situations and events and interpret what other people say and do, comparing it to our own set of past experiences, our culture, faith, values, and so on. These things all helped us to form our beliefs about ourselves, about others, and about the world in which we live. The meaning we give events, the way we make sense of our world, is based upon our set of core beliefs. This set of core beliefs is different for each person. So, seek to understand differences first and build trust upon that!

Sister Facilities

I have worked in multiple health care systems. One of the best lessons I took away from them was how you referred to or “saw” the other organizations in your system.

Often, I would hear people refer to other hospitals, clinics, or home care agencies that were part of “them” in a very negative, patronizing manner—preferring to call

their organization the flagship or another label suggesting that the organization was somehow better than the others. This continues the “us versus them” attitude. I heard things like “We do things best,” or “They never meet budget,” or worse yet: “I wouldn’t take my family members there for care.” How does this affect the organization’s culture, and what does this say about the person who is making the comment? If you want to have a successful health care system, you cannot have an “us versus them” mentality. We have to be here for the patients and all communities. How do we create and support one another so that our patients and communities are the ones who benefit? One of the better ways of solving this issue is to refer to other entities in your system as family. I and others use the term “sister facilities.” We all know that we might have a crazy sister or relative in our family, but we will adamantly defend and support them. Thinking of your system as a family begins the change into a culture of cooperation and togetherness rather than one of abuse.

Holding Companies and Operating Companies

In a health care system, it is important to know which type of business entity you are: holding, operating, or even a combination of the two. This plays out in a whole host of things later in this book, so I will just explain the difference here quickly. The fundamental difference is the structure of management and interactions of each separate entity or organization with the parent company. A holding company or system “holds” an organization, which means that it does not control day-to-day operations or activities and that its interest lies in owning assets or obtaining profits from the company it holds. The held company can do its own thing, as long as it continues to make money for the larger holding company or system. Here, you may find it easier to make change happen faster as each individual facility does not need to work necessarily with other sister facilities to agree on a policy or purchasing the same brand of equipment, for instance.

On the other side is an operating company, a more cohesive system in this case. These companies handle all their own day-to-day operations in addition to the assets and profits. Here, organizations prefer standardizing products, policies, and practice standards across many entities, so change will be much more complex. The theory is that standardization of products and policies leads to cost savings with bulk purchases (i.e., medical supplies, pharmaceuticals).

In a holding company, you may have more competition between each other or see little value in collaborating, whereas in an operating company, you will have

more collaboration and a greater value is placed on standardization of operating processes.

Competition versus Collaboration

Regardless of the type of health care system, there is competition. Your sister facilities may try to outdo one another on patient outcomes, for instance, and a little competition could be good for everyone, patients and staff. However, how you structure the incentives can have a profound impact on the outcomes of your own organization. While you may not get a bonus or incentive in your role, it is

EXPERIENCE FROM THE FIELD

Collaborating within a Health Care System

I recently taught a class for a diverse group of health care executives on Collaborating for Outstanding Results. We talked about the silos that existed in their hospitals and organizations. Then we talked about how to remove the barriers to create trust and build solid relationships. Silos arise when a leader thinks he or she is better than others and wants more resources devoted to their unit, department, or hospital, rather than looking at what is best for the greater good. Competition for scarce resources pits these leaders against each other. Team members in a silo focus internally rather than seeing the whole organization as part of their team. As competition for resources intensifies, essentials like information may be withheld, causing problems in other departments.

Which is recognized, reinforced, and rewarded by your organizational culture: competition or collaboration? Are you willing to confront high performers who lead silos to indicate that their behavior needs to change?

It takes tremendous effort to break down a silo and build trust and collaboration. One of the most effective ways is for the senior leadership to create one or more goals that require the various teams, disciplines, or facilities to work together. Then the reward structure needs to be changed to reward everyone for achieving the common goal, rather than for working toward their competing individual priorities. Several health care organizations have created a systemwide goal of improved patient satisfaction and said that if the metric is reached, all employees receive a bonus or reward. This means that even those who do not have direct patient care are more inclined to support the caregivers to achieve the desired outcome. This generated success and moved the organization closer to a common vision. How can you create common goals that encourage everyone to work together?

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important to understand how this process may work in your organization. The tricky thing is that this is usually not discussed outside of management levels.

One might be able to obtain the information from the strategic plan and how outcomes are structured as well as goal thresholds. If you are in a system that gives yearly bonuses based on performance measures, how are they given? Is the individual's bonus based on their own individual facility or on department performance, or is your individual bonus based on all of the system entities meeting the goals? How does each of those scenarios play out related to competition and collaboration?

I have worked in systems that gave bonuses in both ways. In the system that gave bonuses based on individual facility performance, the goal for everyone was to focus on their own facility and ensure they meet their goals. You might not really care if the other facilities were not making their goals. You might even pride yourself in thinking or saying you are better than another facility. But is that good for any patient? In the system where you only get your bonus if all facilities meet their goals, the focus is 180 degrees different! If your facility is doing great on patient satisfaction scores and another facility is not, that one facility is placing everyone at risk for losing their bonus. So, guess what? People will want to help each other, share learnings, and offer suggestions. Do they need the ability of a particular staff member? Do they lack resources or a program? People are more likely to try to help and more likely to ask for help from the organizations that are doing well. No one wants to be the organization that brings everyone down.

If the organization is offering bonus/incentives, it is usually considered part of the total compensation of the employee. Here, the base salary may be less, while offering a larger bonus/incentive, for a grand larger total to incentivize the individual to meet the organization's goals. I have also worked in organizations that do not offer or believe in management bonuses or incentives. In this type of organization, the salary is much higher, with the belief that if the money issue is off the table, then everyone will be more focused on meeting the goals together.

Health Care as Cottage Industry

At one end of the spectrum in health care is a small collection of well-functioning health care systems, and on the other end is the traditional cottage industry of solo or small-group practices and facilities. Our current health care system has evolved some from its roots as a cottage industry when health care was practiced and managed at a local level (Mercado, 2020), particularly over the past decade. A

cottage industry “is essentially a group of nonintegrated, dedicated artisans who eschew standardization” (Swensen et al., 2010). These solo practices represent “a collection of autonomous professionals providing largely self-defined expert care within organizational, payment, and regulatory environments involving conflicting incentives, goals, and objectives” (Shortell & Schmittiel, 2004, p. 52). Industry experts thought that after the enactment of Medicare in 1965 and, more recently, the Patient Protection and Affordable Care Act of 2010, cost savings and care improvements would materialize faster, forcing the US health care system away from a cottage industry. Unfortunately, this has not been the case, as evidenced by care that is not adaptive to those with chronic illnesses, unsustainable costs, and failure to deliver basic care (Wasson, 2019).

Although other non-health care industries have transformed themselves using tools such as standardization of value-generating processes, performance measurement, and the transparent reporting of quality, the application of these tools to health care is still controversial. Such fears include the loss of autonomy as providers move to “cookbook medicine.” However, appropriate standardization is not a loss of professional autonomy, a misinformed focus on the wrong care, or a loss of individual attention and personal touch in care delivery. The application of improvement tools is not only essential to modernizing care delivery but also the key to preserving the values to which our current system aspires (Swensen et al., 2010). Managed care was supposed to bridge the gap between quality and cost reduction, but that did not transpire (Sinnot et al., 2020). The state and federal government, which is the largest payer of health care, is using its size to pursue value-based payments through organized systems such as accountable care organizations and patient-centered medical homes (Sinnott et al., 2020).

Growing evidence highlights the dangers of continuing to operate as a cottage industry. Fragmentation of care has led to suboptimal performance. The gap between established science and current practice is wide.

The transformation from cottage industry to postindustrial care will be facilitated by combining the following three elements: standardizing care, measuring performance, and transparent reporting (Swensen et al., 2010).

The cottage industry concept does not only apply to physician practices. The multiple small home health agencies in your town, each with a small patient census, may also be engaging in this ideology. Even a large single hospital that is not a part of a system can be thought of as a cottage industry participant. Most other types of business do not function within their industry as a stand-alone, as they may not

EXPERIENCE FROM THE FIELD

Us versus Them

How can you effectively lead in a large health care system? When I started my health care career, I was hired as the organizational development and learning director, part of the administration team to work at a large hospital that had been winning the organization's Best of the Best awards frequently. I was told during the interview process that the senior leadership team considered themselves "mavericks" and that they liked to figure out what needed to be done and do it to achieve corporate and patient goals. The system often lagged behind them or did not really approve of their actions, but they were tolerated because results were achieved. I was part of this "us" getting things done and making a difference.

After two years, I had the opportunity to help open a new state-of-the-art hospital within the same system. When I joined that team, the senior leader made clear that "We may not always agree with what corporate tells us but we do what they say, we toe the line." Hmm, two very different examples of "us versus them," rebellious versus compliant, but I was still a part of the "us" getting things done and making a difference.

Fast forward three years and I am reassigned to the corporate office. Now my focus is on system leadership development, change management, and

process improvement. Now I am "them." I changed locations and crossed the line from "us" to "them." Where are my loyalties?

This experience at once enabled me to restructure some key change management efforts by creating cross-functional teams from multiple facilities to problem solve. Whether tackling the challenges of a new performance management system or improving the matrix management reporting structure or the cardiac catheter lab process flow, each team consisted of leaders and front-line staff at various levels coming from large and small hospitals, located in rural and urban areas. Everyone's voice needed to be heard. We thought through the necessary changes and then created a new process for the whole. Occasionally, we also needed to create a process variation, based on the needs of a facility, on size, or on resources. This enabled us to achieve better outcomes and greater consistency and minimized the facilities or departments creating a "workaround" as soon as the process was implemented. Getting people to address a common problem together to achieve a workable solution brought pride and camaraderie. It tore down some of the silos and distrust that existed and generated better solutions.

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survive competition. For instance, there are only a handful of computer companies and computer operating systems (i.e., Microsoft Windows, Apple MacOS, Linux). This is because smaller companies merge with others or are acquired to better position themselves to compete in the marketplace and improve efficiencies. The health care industry, from physicians' offices to hospitals to electronic health record vendors, needs to become more efficient to help reduce the amount of waste in health care as we cannot sustain the current growth.

Common Goal: The Patients

The one thing we all have in common is the patient. It is important to remember that as we lead in the system. We want to lead our health care system to changes that will positively impact our patients, families, and our own lives professionally. Creating a patient-centered health care system will break down silos and bring collaboration to our future systems.

Key Points

- The goals of an Accountable Care Organization (ACO) are to coordinate patient care, provide the right care at the right time, avoid unnecessary duplication of services, and prevent medical errors.
- All nurses are leaders regardless of role, position, or educational level.
- To lead in any system, nurses must know the ins and outs of an organization, the internal and external forces that can mold it, and that anyone can make a difference for change.
- We are all responsible for providing efficient and effective quality care while managing the cost of health care in the United States.
- Align incentives for collaboration, not competition.
- Fragmentation makes it more difficult to transform the industry; we should strive for appropriate standardization.