

Healthcare Project Management in the New Economy

“The health care sector has many stakeholders, each with an agenda. Often, these players have substantial resources and the power to influence public policy and opinion by attacking or helping the innovator.”

- Regina Herzlinger, Ph.D., Harvard Business Review, May 2006, p. 60

Abstract

Public health care spending in the United States is expected to have its largest single-year increase in 2009. Once the recession starts to ease next year, there should be an upturn in both private and public health care spending. Starting in 2010, private health care spending is expected to rise by 4.2 percent. By 2018 health care spending is projected to reach \$4.4 trillion - - accounting for 20.3 percent of the U.S. gross domestic product (GDP). Costs need to be controlled to ensure that health care is affordable for everyone. This paper explores what is unique about Medical and Healthcare Project Management in general and particularly in the new economy.

Introduction

One of the most daunting problems facing healthcare projects is the management of stakeholders. Healthcare projects involve competing stakeholder interests. For example, there are highly educated doctors with embedded opinions about how processes should work, equipment and materials producers (e.g. pharmaceutical companies) who have huge sunk investments in their products and are desperate to recover these costs and turn a profit prior to patent expiry, and insurance companies constantly struggling to determine what to reimburse, how to cover, who to cover, and how to attract and retain the most profitable individuals.

The debate over healthcare innovation has focused on the issue of how to enable consumer-driven innovation. In this space, some argue that a consumer-driven solution is absolutely necessary (Herzlinger 2006). Meanwhile, others see consumer control as an impediment to successful innovation due to poor design of consumer involvement as well as technical incapacity of consumers to understand the complexities and needs of delivering care (Richmond et al. 2005; Walker 2006). Both sides of this argument agree that stakeholder management needs special emphasis in healthcare innovation projects.

To understand the special characteristics and needs of stakeholder management in healthcare industry projects in the new economy, we begin by examining the healthcare *economy as it relates to stakeholders*. Specifically, we ask how value is created by different stakeholders in this industry. As we show in this paper, this is a particularly important concern for healthcare Project Management, due to the large number of competing stakes with legitimate claims on control even when they are not sponsoring projects. We suggest that Organizational Project Management (OPM) techniques can aid in addressing the heightened needs for stakeholder management and engagement.

The latter half of this paper presents a unified model for understanding healthcare stakeholder influence and relationships in new economy projects. We illustrate the application of the model with examples from our work in the healthcare industry.

Healthcare Project Stakeholders and Value

Some argue that the value chain for the healthcare industry includes five major categories of organizations / stakeholders, namely, payers, fiscal intermediaries, providers, purchasers, and producers (Burns 2002). Payers include individuals and businesses as well as government organizations. Fiscal intermediaries include insurers, HMOs, and pharmacy benefit managers. Providers include hospitals, integrated delivery networks, and individual clinics and physician practices. Purchasers include groups who aggregate healthcare products and services for distribution. Producers create drugs and devices used in healthcare practice. For the sake of understanding and managing pressures on Project Management, we may think of four major stakeholders: payers, producers, providers and fiscal intermediaries. The purchasers are often producers as well. For example, a majority of McKesson's revenue comes from purchasing and distributing pharmaceuticals even though many people consider them a healthcare IT producer¹.

Historically, these four stakeholders did not all exist. Even until the 1940s, there were mostly payers and providers, producers and fiscal intermediaries came later (Richmond et al. 2005) (Figure 1). The point of a value chain is to understand who benefits from whose economic contribution and where the most concentrated economic value exists (i.e. to the right of the chain). Based on this macro-economic view of the basic relationships among healthcare stakeholders, fiscal intermediaries hold the most economic power and control. They are in a position to decide whether medical devices will be reimbursed as well as amounts of reimbursement for various procedures. As such, they can dictate how much payers pay, what providers provide, and what is economical for producers to produce. Producers come in second in this analysis. Provided fiscal intermediaries are willing to pay for their devices and drugs, they can use that information to compel providers to provide. The providers are next, as they can determine to the payers whether they need follow-up visits or further testing, etc. The payers, individuals and organizations, are at the mercy of the other stakeholders. A project would need to be careful to accommodate its upstream stakeholders and would especially benefit from carefully managing the ones further to the right.

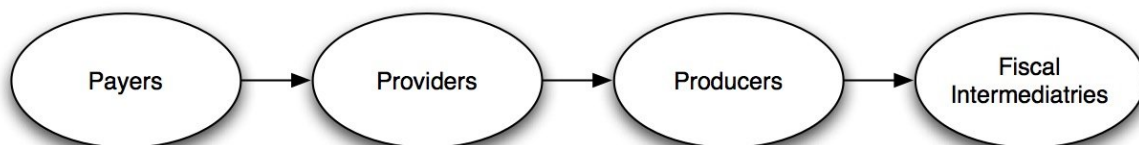


Figure 1 Macro-economic Healthcare Value Chain

Unfortunately, in the case of healthcare, the value chain alone is inadequate to understand the relationships among the stakeholders and major issues in managing them. Healthcare is somewhat unique as an industry due to the transparency of consumer utility in the

¹ Data received from an interview with a former McKesson manager, May 2009.

products and services consumed. The utility chain produces a very different view of who has control over changes.

Healthcare Project Stakeholders and Utility

The principle of utility, as Jeremy Bentham put it in 1776, is “the greatest happiness for the greatest number of people.” In micro-economics, utility refers to the relative value a person gets out of something they do or something they purchase. Among several alternative items to fit the same need, a rational person will choose to purchase the one that gives the most utility. In practice, people each have differing understandings of utility for most goods. Thus, one person may get a lot of utility out of buying and driving a BMW car while another would much rather have a pick-up truck. Since their utility from the products is not comparable, we would not expect generalized agreement about the amount of utility represented by each car. In many areas of healthcare, utility *is comparable*. This leads to an important reverse utility chain in healthcare that impacts project stakeholder management (Figure 2).

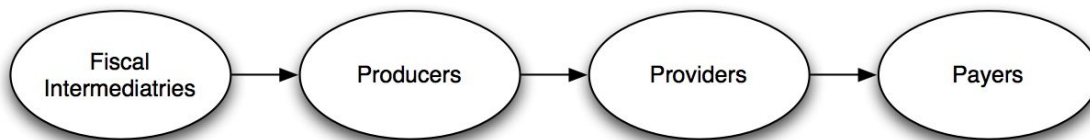


Figure 2 Micro-economic Healthcare Utility Chain

In many healthcare settings, the ultimate impact of products and services may lead to saving a life. Relative to other industries, such as autos, retail, energy, or high tech, the *individual utility* people receive from treatment for many common ailments *is comparable in healthcare*. The statisticians refer to these comparable utility units as quality of life years or QALYs (eg. Cohen et al. 2008). What does this imply? Ultimately, utility trumps macro-economic value when you ask an individual payer to judge multiple alternatives. For any given product or service, this gives the payers control over which services and products they get as well as a way to demand of fiscal intermediaries that high-utility but costly treatments be covered by insurance. The same can be said of the providers. They can be heard invoking best medical judgment in their practice. For example, they may prescribe drugs or devices that were not originally intended for a given treatment if they judge that it will improve health outcomes (utility) regardless of cost. Indeed, their ethics compel them to treat patients without concern for cost for most ailments (elective procedures excluded).

In the utility chain we see that utility is condensed at its highest in the payers. The governments, individuals and organizations who receive healthy and productive family and work life (QALYs) gain the most utility. The utility chain produces fights for control against the economic value chain. A healthcare project manager also needs to consider the utility each stakeholder will gain from his or her project and whether they will exercise positive or negative utility-based control over upstream stakeholders. We believe the most useful way to consider these competing forces is together.

Stakeholder Value and Control for Healthcare Projects

The figure below represents the layout of stakeholders and their basic involvement (relationships) in our healthcare system at present (Figure 3).

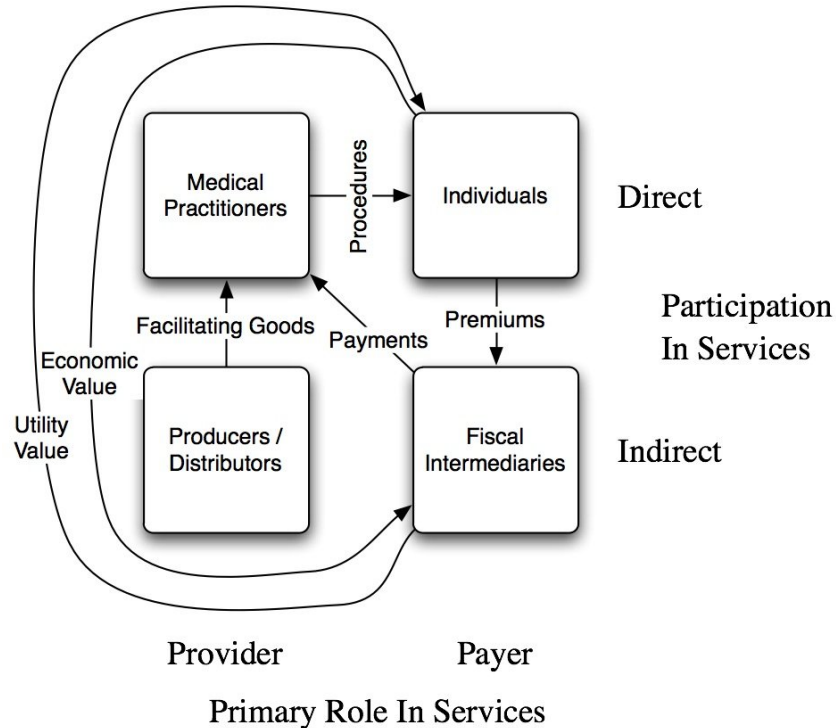


Figure 3 Current U.S. Healthcare System Stakeholders and Their Basic Relationships

Notice that even though there is a direct connection between the fiscal intermediaries and the producers / distributors in terms of economic value, in practice, they do not interact on an industry services level. The absence of direct relationship where economic value is supposed to have continuity implies a problematic disjoint. Producers / distributors are likely to engage in investments more oriented to targeting the medical practitioners than meeting the needs of the fiscal intermediaries. Since the practitioners make money on procedures, there would be little motivation for medical practitioners to invest in any devices, drugs or materials that would erode the economic value (cost) of procedures. Subsequently, the individuals would demand the new procedures enabled by new devices, drugs, and materials, and their premiums would go up. The fiscal intermediaries exercise control in this system through management of reimbursement and premiums, perhaps limiting or denying access to payment or increasing premiums.

The consequence of this behavior in terms of utility is equally problematic. The ultimate healthcare utility is extension of healthy living. The utility chain is broken in that the intermediaries should be the ones overseeing the best ways to extend healthy living *at the lowest cost*. In their absence, drug companies, device manufacturers, and distributors market their goods in this role. Their marketing and funding frames doctors' understanding of utility and influences their choices in procedures even if the doctors intend to remain systematic and independent (Breggin 1994).

Solutions and Examples

Within the past year, both authors have been involved in healthcare projects and healthcare Project Management with each of the types of stakeholders at the core of the US healthcare system. In this section, we share some of our insights on how better Project Management organization can enable these projects through improved stakeholder management.

Let's begin with an example of a project hosted by a provider. One author recently managed a project with a regional health provider with more than 15 locations (clinics and hospitals). The provider had had problems prioritizing project ideas and deciding how to evaluate on-going efforts and wanted to improve its ability to strategically plan and execute innovation projects. Initial analysis of the control and status systems for these projects revealed that key drivers of strategic value for the organization were: 1) quality of care and 2) ability to attract specialty business (market leader positions). Interestingly, capital projects run through this business unit were not systematically screened for key strategic criteria. No metrics relating the value of a project relative to the strategic criteria nor stakeholders were published anywhere that other managers could view them when considering the projects. Applying the framework presented earlier, we can see that both drivers relate solely to the relationship between providers and individuals (providing procedures).

There were no formalized criteria related to the management of facilitating goods nor the management of reimbursement, though the practitioners at the provider agreed these were major areas of concern with opportunity for innovation. In other words, the projects were prioritized based on their ability to deliver the ultimate utility in the healthcare system and to collect the most basic economic value. From an organizational perspective, the organization would benefit from including the producers and fiscal intermediaries' stakes and relationships in their capital projects planning and prioritization efforts, as these stakeholders not only have key insight into possible changes that would improve efficiencies (since they are further down they economic value chains), they are also interested in improving the health utility of the system.

The solution in this case focused on standardizing the criteria for project evaluation during project chartering decisions and status reporting during implementation so that they represented the value offered by all four stakeholders. Additional phases will implement transparency of these criteria so that stakeholders can understand why projects are being implemented and how they are impacted positively. This will solve a central problem facing the host division, which was that stakeholders were agitating for their own projects and could not be convinced of the merit of other ideas due to lack of visibility into the project statuses and impact on the stakeholders in the provider's network.

Visibility into the utility of healthcare services has known positive impacts on improving quality. For example, for several years the Centers for Medicare and Medicaid has required reporting of measurement success rates for full reimbursement of several major procedures including treatment of heart failure, pneumonia, and several types of surgery.

Visibility into these metrics around delivery of procedures has led to improved healthcare quality.² Transparent public reporting on www.hospitalcompare.hhs.gov has been a key to making sure consumers have choices based on perceived quality and hospitals are kept honest. In other words, one experiment bringing visibility into one of the key value chains for one of the main relationships in U.S. healthcare has improved quality. That leaves seven other existing relationships and value areas available for innovation. Transparency of outcome data to individuals aligns medical practitioners and individuals in their understanding of the utility of the procedures relationship (Figure 3), and it implies that bringing organization and transparency to the process of improving healthcare outcomes will aid in innovation and improvement not only in the existing relationships within the healthcare industry but also in the areas where relationships should be formed (i.e. between fiscal intermediaries and producers / distributors). Fortunately, there is guidance on how to systematically affect organizational innovation while achieving transparency that aligns stakeholders; it occurs in the area of Organizational Project Management (OPM).

The Role of Organizational Project Management

We make the assumption that projects are the key means through which organizations undertake major innovation efforts. Whether addressing the ways that consumers buy and use health care, using technology to develop new products and treatments or otherwise improve care, or generating new business models that integrate economic value chains and utility value chains, in practice these activities can be reduced to two main functions of any organization: 1) choosing the right projects that advance the organization's strategic intent, and 2) delivering those projects successfully, consistently, and predictably. Activity one is characterized as Portfolio Management, and activity two is characterized as Program and Project Management. These two activities are described by the Project Management Institute, the main professional association for Project Management in the U.S., as the discipline of Organizational Project Management (OPM) in the Organizational Project Management Maturity Model (OPM3®).

Using OPM3®, organizations intentionally improve Organizational Project Management. How OPM systems are instantiated is unique to each organization, but the intention and methods common to all OPM3® implementations develop capable processes through standardization, measurement, control, and continuous improvement of processes.

Significant opportunities exist to incentivize healthcare industry organizations to carry out this agenda in innovative ways. For example, economic and utilitarian opportunities could be generated by producers to co-evolve Portfolio Management activities with fiscal intermediaries in service to individuals, i.e. in ways that change the relationship between producers and individuals, which does not exist today aside from direct marketing of certain products (e.g. drugs) by producers to individuals.

² According to analyses reported by the Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services, <http://www.ahrq.gov/>. Data also received in an interview with Ann L. Lovejoy, Healthcare Program Leader, Creative Intermedia, LLC.

Likewise, organizations can be incentivized to carry out Program and Project Management activities in ways that address both economic and utility interests. We see this in the reporting of surgery outcomes tied to reimbursement by the Centers for Medicare and Medicaid and subsequent improvement in care quality by providers as mentioned in the previous section. Standardizing and measuring processes in specific ways can cause the intended behavior.

Ultimately, to address the tension between economic and utility value chains, organizations must be motivated to implement Portfolio and Program/Project Management in new ways. They must be motivated to implement Portfolio Management to address all four stakeholders when they are identifying, selecting, and prioritizing investments. They must be motivated to implement Program/Project Management in ways that cause the intended behavior of balancing economic and utilitarian interests. To do this, business leaders could self-organize, or more likely, government could legislate the use of OPM3® in specific ways that enable auditing and certification of stakeholder management regulations. Such an approach is already applied to software practices where vendors serving government projects and many major organizational IT projects are required to have a certain level of capability according to the Software Engineering Institute's maturity model. Moreover, OPM3® could be combined with the framework outlined in this paper, and then used as a mechanism for prequalifying organizations for government funding in health care reform and stimulus package allocation decisions.

We have seen application of a structured approach to Organizational Project Management help ensure effective stakeholder management in healthcare organizations. It does so by making the process of selecting and delivering projects transparent as well as equitable. Healthcare innovation in the new economy is complex. It does involve multiple stakeholders who are each likely to have substantial power to influence any innovation or change effort. They must be convinced of the necessity and value of any innovation so that they will contribute their efforts to the change and not work against it. Applying OPM with OPM3® and the healthcare stakeholder framework from this paper offers a major opportunity for improving healthcare innovation success.

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