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**SERVICE LINE MANAGEMENT: DOES THIS
MANAGEMENT STRUCTURE MEET THE NEEDS OF
THE HOSPITAL STAFF AND BENEFICIARY COMMUNITY AT
MARTIN ARMY COMMUNITY HOSPITAL**

Graduate Management Project
to the Faculty of
Baylor University
In Partial Fulfillment of the
Requirements for the Degree
of
Master of Health Administration
by
Captain James L. Rosengren, MS

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ABSTRACT

Army medical treatment facilities (MTF's) need a functional, understandable clinical administration program. Access to health care providers, and potentially the delivery of quality health care, can be degraded without a viable program. A clinical administrative structure must be implemented that fulfills the expectations of the staff and ultimately meets the needs of the beneficiary community.

The need for clinical administration in Army MTF's has always existed. Multiple structures for clinical administration programs have been designed over time, changing primarily to meet current trends in the health care system. At Martin Army Community Hospital, different approaches to clinical administration have been implemented, and currently, service line management (SLM) is the structure utilized. Service line management has demonstrated to be an ineffective and inefficient type of management

program. Clearly, a clinical administration change is necessary--necessary for staff morale, efficiency, effectiveness, and enhanced productivity.

At MACH, confusion reins over two critical issues of SLM: how does the system work, and who is the ultimate decision maker. This study recommends a new structure--through systems analysis, structured interviews, and participant observation--that meets the needs and expectations of the staff of Martin Army Community Hospital.

I. INTRODUCTION

Conditions Which Prompted the Study

Clinical administration in Army medical treatment facilities (MTF) differs from facility to facility. Oftentimes initiatives are established based on personalities present, not on the needs of the system. One can look at various Army MTF's and find clinical administration established under the supervision of a clinical support division (CSD), clinical service administrator (CSA), floor management, departmental administration, or service (product) line management (SLM).

Guidance from U.S. Army Health Services Command (HSC) allows for the hospital commander's discretion in establishing the makeup of clinical administration. The clinical administration staff can work directly for the Deputy Commander for Administration (DCA) or the Deputy Commander for Clinical Services (DCCS), again at the discretion of the hospital commander (HSC Regulation, Number 10-1, Organizations and Functions Policy, 1986).

Regardless of the type of management program implemented, the goal or mission of clinical

administration is to provide administrative management support to all clinical elements of the hospital and supporting clinics.

Martin Army Community Hospital (MACH) has migrated through multiple initiatives in the clinical administration of the hospital. One goal inherent in each management style was that access to care and the quality of care would not degradate as a result of the clinical service management style that was implemented.

In the past, MACH has utilized centralized management, decentralized management, matrix management, and currently is employing SLM. Initial planning for implementing SLM was accomplished via a working group that included members from nursing, administration, and the clinical staff. The hospital commander, desiring to employ this management style prior to his retirement in June 1990 and before the hospital was ready for the transition, directed the hospital to convert to SLM in May 1990. Current hospital staff, many of whom were assigned to MACH during the transition, are convinced that the push, or rush, to implement SLM was done without the thorough and final staff coordination required for success, and

without adequate training for the staff. Distribution of resources and voids in total conversion insofar as ratings of personnel and departmental fiscal management are concerned appear to have hampered the success of SLM.

The overall environment in which the healthcare system operates is changing at an ever-increasing pace. The military healthcare system is changing rapidly, primarily in concert with cost-saving/cost-reduction initiatives. The traditional military organizational structure found in Army hospitals does not optimize the potential to adapt to the rapidly changing environment facing Army hospitals today. Management challenges of today, or in the near future, will be provided by programs such as PRIMUS, CHAMPUS Partnership, DRG's, Ambulatory Surgery, Catchment Area Management, Coordinated Care, and Gateway to Health Care. Proactive administrative management of these and other management initiatives must occur in an effective, timely, and coordinated fashion; however, this is not the case at Martin Army Community Hospital.

Throughout the hospital, confusion reigns over two critical issues concerning administrative

management in the clinical arena: How does this system work?, and Who is the ultimate decision maker? A recent hospital strategic planning conference amplified these concerns. The MACH command element and staff are convinced that successful administration of the clinical elements is essential to the accomplishment of present and future health care missions.

Statement of the Management Problem

The problem of this study was to assess the effectiveness of the clinical administration program, specifically, Service Line Management, and to offer alternatives to develop the most effective system for the provision of administrative support to the clinical departments.

Review of the Literature

The need for clinical administration in Army MTF's has always existed. Multiple means of how to best accomplish this need for clinical administration have been designed over time, and are still being brainstormed today.

Russell C. Coile, Jr., President of Health Forecasting Group, advises that health care administration in the civilian sector changes to meet

current and future trends (1990). The period of the 1970's was predicated on cost reimbursement, competition dominated the period of the 1980's, and the 1990's will see managed care dictate management styles. To survive in each of these eras, health care administrators adapted the management and administration of their hospitals, primarily the aspect of clinical administration, to meet the needs of the community and to stay financially competitive.

Military hospitals have not had to adapt to this changing and difficult environment which is prevalent in civilian hospitals. As a general rule, Army MTF's have never had to be concerned with cost reimbursement, competition, or managed care (Robert H. Buker, personal communication, 7 January 1991). Even so, the styles of management have changed, specifically in the arena of clinical administration. Today's military healthcare community is concerned with and confronted by fiscal constraint and the development of coordinated (managed) care, but that is not the focus for this study.

Peter Drucker stated in Hospital Forum (1979) that the hospital is the most complex human organization we have ever attempted to manage.

Directly due to this complexity, matrix management is becoming the desired form of management because both vertical and horizontal coordination exist. Departmentalization creates a vertical or hierarchical structure, or a formal chain of command. Simultaneously, an overlapping horizontal or lateral structure allows for coordination across departments though patient care teams (Neuhouser, 1972). Staff are required to report both to linking managers and to superiors in formal chains of command. They, in essence, are then supervised by two managers or "bosses" who share equal responsibility in evaluating their performance. If this situation exists, in theory the staff will respond to the different concerns/demands of each supervisor, internally providing the general management perspective required for integration (Kimberly, Leatt, & Shortell, 1983). Resultantly, health care administrators must be well versed in both participatory and hierarchical styles of management. They must be capable of maintaining differentiation through departmental lines and integrating specialized activities at the same time (Neuhauser, 1972).

Decentralization is a management style that distributes responsibility and authority to semi-independent decision units, while exercising carefully devised controls to make sure that all separate decision units are working towards the same result or goal. Health care institutions, specifically hospitals, lend themselves well to decentralization since they have many areas where efficiency can be improved and cost savings realized. Decentralized management encourages department chiefs to individually manage their work areas. Where this is not practiced, managers tend to rely on the supervisor for direction and decision, usually for the simplest of issues (Laliberty, 1988).

Many military organizations tend not to promote decentralized management. Traditionally, decisions are made at higher levels in the military system, specifically in hospitals. Decisions in areas of budget, personnel hiring, equipment acquisition, and rewards/recognition are usually made at the very highest of the management ladder. Inherent in military managers, specifically officers, is the tendency to take few risks. Risk-taking is oftentimes associated with failure, and in today's climate, the

smallest mistake can cost a person his career. So, a dichotomy exists--and a dilemma developed. Should decision making authority and responsibility be powered-down to the lowest level?; and if responsibility is given, should the manager take the necessary risks and chance failure, or go with the status quo? At MACH, different approaches to clinical administration have been implemented over the years, utilizing every possible management structure; they include decentralized, centralized, and service line management. The current management style is SLM; however, it is not adequately meeting the needs of the hospital. Since this is the management philosophy currently being utilized, a review of SLM is in order.

Service or product (names are interchangeable) line management is a concept that originated in the manufacturing industry. Yano-Fong (1988) reports that SLM was first introduced in 1928 by Procter and Gamble to market their new product, Lava soap. By the mid-1960's, Yano-Fong reports that 84% of the large manufacturing companies adopted this business/management technique to compete successfully in their rapidly changing environments.

Historically, hospitals have been organized and managed along functional lines; there was not a focus on costs of production or the elements of production. The change in the healthcare industry towards profits and losses, as well as competition, has changed the management focus of many administrators. By the mid-1980's, SLM had been overwhelmingly selected by hospital leaders as one vehicle required for becoming market-driven, improving competitive position, and increasing profitability (Cole and Brown, 1988).

Service line management is defined as products or services that are related to each other by such factors as the type of need they satisfy, the way they are used, the customers who buy them, the mechanisms through which they are marketed, and even their price range (Bird, 1988). Specifically, Bird defines product or service as anything that can be offered to the market for attention, acquisition, or consumption. The end result is that a product or service is whatever will fulfill a specific need, want, or desire. Theoretically, service line management is an approach to business that focuses on marketing a particular brand or product rather than on other business functions, such as production, finance, or

personnel (Lukacs, 1987). Further, the product being marketed is viewed as a profit center; this encompasses start-up costs with implementing the product, overall sales, and associated profits and losses.

Fottler and Repasky (1988) suggest that SLM is a modification to the organizational structure of the hospital as a direct result of a declining inpatient volume, prospective payment systems, and increasing competition for both inpatient and outpatient revenue; the end product being the very problematic survival of the hospital.

In the late 1980's hospital inpatient volume rose while profits fell, dispelling the myth that there was a necessary relationship between activity and profitability in the U.S. hospital industry (Coile, 1990). In fact, one could juxtapose that if occupancy rises again, so, in fact, may losses. Because of this shift, the pressure on department heads and program directors to become small business operators and entrepreneurs is tremendous. Most are untrained for SLM and many lack critical business and marketing skills to make their individual product line successful. Specifically, Therese Droste (1988)

states that successful SLM involves the shifting of personnel, budgeting, and marketing to a service, or product line manager. Fottler and Repasky (1988) agree with this shifting of responsibilities, but unequivocally include strategy formulation, coordination of all resources, monitoring of production, and measuring the results, all done under the management of a single administrator.

Hospitals (Droste, 1988) states that the concept of SLM is oftentimes misunderstood and, in some cases, 'has fallen victim to interhospital turf battles' (p. 30). Successful implementation of SLM requires a reorganization of the hospital's management, providing timely, uniform structure, thereby treating medical departments and separate services as individual profit centers.

A health care economics report by Alden Solovy (1989) stated that the health care industry's attempt to practice SLM as practiced in business and industry was not successful. The specific reason cited was that decisions about profitability are often less important than issues of hospital regulation and mission.

The problem of defining a hospital's 'product,' according to Gregory A. Bird (1988), appears to stem from the hospital's service orientation. Resistance is seen from both professional staffs and hospital administrators, mainly for two reasons: first, health care professionals feel that labeling health care as a product is alien and even demeaning; and secondly, the factor of appointment of the service line manager, oftentimes a personality-driven decision, affects the system development of the service line.

In the health care community, hospitals have tended to be product-oriented and focused on producing services as opposed to servicing markets (Zelman and McLaughlin, 1990). Because of the marketing connotation associated with SLM, most military hospitals have not seen the need to integrate SLM. Finding a patient population to utilize the services available at military healthcare facilities is not a problem for administrators, which is the opposite of the situation faced by civilian healthcare administrators.

Not only have military hospitals had an abundance of patients which made the need for marketing in the truest of definitions unneeded, but there has been a

shortage of clinical professional personnel since the abolishment of the draft in the mid-1970's. The concept of SLM is a physician, nurse, and administrator working in harmony towards a common goal in the management and administration of the specific department or service concerned. The implementation of SLM must be cognizant of the resources available for complete integration of this concept. A look at available resources is necessary.

Unilaterally, civilian and military hospitals have been afflicted with nursing personnel shortages for years. Patient acuity has increased (personal communication, D. Gordon, R.N., 14 January 1991), and the volume of administrative/clerical tasks required on nursing units has equally expanded. As far back as 1968, Zimmerman in Hospital Progress reported that 25% of nursing supervisors' and head nurses' time was spent on non-nursing management activities. All personnel in health care agree that in the past 23 years, the requirement for documentation, as mandated by the Joint Commission on Accreditation of Healthcare Organizations, has dramatically increased, thus impacting significantly on the available patient care time of these nursing supervisors. There is no

argument that nurses have, inherent in their jobs, required administrative responsibilities, but none that require more than 25% of their productive time! Further, the availability of nurses, both registered and licensed practical nurses, is diminishing. Civilian Personnel Offices throughout the Department of Defense have difficulty recruiting needed nurses (personal communication, G. Backman, 21 January 1991). The concept of SLM could significantly exacerbate this already critical nursing shortage by demanding more administrative time away from patient care.

When one explores the administrative responsibilities of physicians versus their responsibilities to provide patient care, one finds it can be overwhelming. Physicians in military hospitals have complained for years that their time is improperly utilized. Recent testimony before the United States House of Representatives' Armed Services Subcommittee on Military Personnel and Compensation focused on a survey of 1,500 of the approximately 9,600 military physicians on active duty which sought information on their attitudes and opinions of military medicine. Some of the more stirring results are: 41% cited inadequate numbers of health care

support personnel as being among the top three factors which would influence a decision on their part to leave the service; 86% cited extreme shortages of clerks, receptionists, and secretaries; 76% stated there were significant shortages in corpsmen and orderlies; and 74% stated there were drastic shortages in nurses, both registered and licensed practical (Baine, 1989). Further, the Department of Defense conducted a study in 1989 that amplified physician disenchantment with the quantity of clinical (79%) and clerical support (84%). Many felt they ended up doing routine administrative work, such as filling out laboratory and x-ray requests, escorting patients, making telephone calls, looking for patient charts/records, and ordering equipment and supplies.

This finding was supported by a United States General Accounting Office report that examined the extent to which military physicians performed administrative and clerical tasks. Such tasks included typing, filing, answering the telephone, retrieving medical records, completing laboratory slips, and performing reception duties--all in lieu of treating patients. The report concluded that the administrative personnel shortage problem has been a

cause for concern among military physicians for many years. There is no argument that physician performance of administrative and clerical tasks detracts from clinical practice time--time with patients--thus negatively affecting productivity and jeopardizing access to care and quality of care. The report concluded that the effects of any actions taken to address this problem, such as the reallocation of administrative and clerical duties from health care providers to administrators, are likely to be realized over the long term (United States, 1989).

The last of the triad of resources necessary to effectively (by-the-book) implement SLM is the administrator. In most military hospitals, but specifically MACH, there is a lack of requirements and authorizations for administrators. Even if the requirements were authorized, Brigadier General Ron Blanck stated in a speech at Fort Benning, Georgia (20 April 1991) that the Army Medical Service Corps would see cuts in personnel ranging from 5,300 to 3,800 in the next several years. This action would seem to diminish the availability of departmental administrators, although not eliminate the possibility totally. Positions could be civilianized should

officer acquisitions prove unsuccessful (personal communication, G. Backman, 19 April 1991).

The administrator position creates the least of problems or confusion for the accomplishment of departmental/service administration.

Army MTF's have utilized various organizational structures over the years. In 1977, the Ambulatory Patient Care Model #18 was revised to establish a Clinical Support Division (CSD). The purpose was to relieve physicians of administrative responsibilities that detracted from the provision of primary patient care. With this model, a clinical support division was created whose intent was to maximize the effectiveness of all administrative personnel supporting clinical elements by placing them under centralized management/supervision (United States). This model has since been replaced by guidance in Health Services Command Regulation 40-5 (1987) that restated the duties and responsibilities of the CSD, whose function it is to relieve health care providers of those administrative tasks that detract from time with the patient. Multiple hospitals still use this system today. Many facilities, such as Brooke Army Medical Center, use departmental administrators with a

decentralized Clinical Support Division. Here, the Chief, CSD assumes the title of clinical services administrator (personal communication, M. Leggette, 13 February 1991). At Walter Reed Army Medical Center, clinical administration is accomplished by using floor managers (personal communication, M. Rowbotham, 13 February 1991). Various adaptations to clinical administrative management occur regularly throughout Health Services Command; however, to date, MACH is the only facility to attempt SLM.

At MACH, the implementation of SLM was initiated without the staff's complete understanding of the theory, structure, and process inherent in this management philosophy. Even so, a directive for initial implementation was given. The result has been a disruption in clinical administration that has the clinical staff and administrators shaking their heads in dismay, confusion, and bewilderment. This paper will focus on the development of clinical administration for Martin Army Community Hospital, Fort Benning, Georgia.

Purpose of the Study

The purpose of this study was to identify the weaknesses of service line management employed at

Martin Army Community Hospital and thereby structure a clinical administrative program that meets the needs of the hospital staff and ultimately the beneficiary community by lessening the administrative burden placed upon primary care providers and primary care support personnel.

II. METHOD AND PROCEDURES

At the direction of the hospital commander, information was collected from staff members via multiple vehicles to determine whether or not SLM at MACH meets the needs and expectations of the staff, and ultimately the patient community. The reliability and validity of information collected was difficult to determine, primarily due to the emotion this topic elicited; however, information gathered and responses to same-type questions from department chiefs were extremely similar. I considered expert reliability to be very strong. Inter-rater reliability was also very high as same and similar questions were asked at different times, in different settings, to the same individuals, and the responses were the same.

Strictly qualitative methods were utilized, i.e., systems analysis, structured interviews, and participant observation. Several structured interview questionnaires were developed (Appendices A-B). The sequence of events for accomplishing the project was as follows:

1. A review of the literature was completed.

2. A review of the current administrative clinical support structure was observed and evaluated.

3. Observations were made as to how various hospitals, military and civilian, administratively supported the clinical operations of their respective facilities.

4. Each MACH department chief was questioned/interviewed to determine his/her satisfaction with SLM, administrative distractions that reduced patient care time, and recommendations for improvement of SLM or the development of a different form of administrative support (Appendix A).

5. Key staff members, clinicians and administrators, officers and noncommissioned officers, civilian employees, and junior enlisted soldiers participated in the same type of interview as the department chiefs (Appendix B).

6. Interviews were conducted with the members of the Executive Staff concerning their perceptions of SLM. Additionally, several prominent health care administrators within the Army Medical Department were consulted.

Using the systems analysis case study approach, the preliminary investigation revealed that a problem

with the administration of the clinical services existed. The Commander and DCA directed that a detailed investigation be conducted, with a specific focus on the potential need for restructuring the administrative aspect of the clinical support division, the evaluation of possible courses of action, and a recommendation of a final course of action that would best meet the needs of MACH.

III. RESULTS AND DISCUSSION

Findings

The design and implementation of a clinical administrative structure that supports the clinical staff and subsequently the beneficiaries are much in need. The Commander, DCA, DCCS, and Chief, Department of Nursing (C, DON) of MACH fully recognize that the current approach to administering the clinical aspects of the hospital is inadequate. A new structure will enhance staff morale, promote efficiency throughout the entire medical facility, and further the command's desire for expedient and easy access to care--all done under the umbrella of the highest quality of health care for the beneficiary community.

The current design of SLM was preordained to fail. It was never fully implemented, primarily, according to a majority of the staff interviewed, due to the Medical Department Activities (MEDDAC) change of command (new command emphasis) and the impact of Operations Desert Shield/Storm. Further, the structure required to achieve success for SLM was never fully supported by the previous DCCS, and the increased detailed communication (a quality assurance

benefit) usually inspired by SLM never transpired. This was exacerbated by the majority of the clinical department chiefs lack of management and leadership experience.

Overall, the maturity of the organization required to support SLM does not exist. There is little argument from most members of the clinical staff that the current approach to clinical administration has led to staff and potentially patient frustration, a decrease in continuity of administration in medical departments and separate services, and, overall, a question of efficiency from a financial perspective. It should be noted that no one has questioned the overall quality of care once a patient has been able to enter the healthcare system, or once the clinicians have been given the resources to provide the required care and treatment.

The potential gain to the command is unquantifiable. What is known from current observations and interviews, insofar as redesign is concerned, is the following: efficiency will improve; morale will improve; productivity will improve, thus improving access to providers; communication will greatly improve; middle-management, having input into

clinical operations, will be cemented, i.e., departments will have the ability to manage; there will be close integration of the critical members of the departments' clinical/management teams--with the ultimate focus being teamwork; and a clearer line of authority will exist from the executive office to the first-line managers, with decisions being made at the lowest level possible.

Overview

Service line management has become an easy catchword for so many different organizational approaches that some consider it in danger of trivialization. Warnings are being given against 'use of the term and introduction of the concept by its initials' (Zelman and Parham, 1990, p.29). It is my belief that this is the case at Martin Army Community Hospital. A review of the intent of SLM is that first and foremost, it should be rooted in the corporate management strategy, and secondly, SLM implies an intention to focus on specific services and markets. Again, my belief is that neither of these occurred at Martin Army Community Hospital. The results of this case study strongly demonstrate that change must occur in the way administrative support is rendered to the

clinical departments and services. However, let me regress and set the stage so that the results and pending discussion fall in place.

Clinical Support Division

The Clinical Support Division (CSD) at MACH has undergone several reorganizations in the past several years. Additionally, a majority of the key and critical management positions have seen two and sometimes three different individuals assigned to them during this period of time.

Prior to February 10, 1990, (the date the hospital commander approved the implementation of SLM) MACH was organized under the traditional CSD concept employed by a majority of hospitals throughout HSC (Figure 1). In individual interviews and in several group sessions, staff who were assigned to MACH during this period of time essentially gave supporting comments to the structure and support rendered by the CSD. The negative connotations were that this structure was reactive rather than proactive; that department chiefs had to 'hope' that their needs were prioritized first for support and action; and that department chiefs did not rate any of the administrative support personnel. It is important

to note that there were no strong dissenters of the traditional CSD organization that significantly impacted on the decision to change to SLM.

The segue from this centralized CSD to SLM was done, as stated in the decision paper implementing SLM, to "keep pace with the changing health care system." Service line management was predicted to cause major impact on the operations of the CSD. The idea was that CSD would be dissolved as a centrally operating entity and would be replaced by the creation of a decentralized administrative support system, such as that found in Army Medical Centers. The triad model SLM was based on was contingent on the success, compatibility, and effort of the three main points in the management team, i.e., physician, nurse, and administrator (Figure 2). With this concept, six service line management teams were developed (Figure 3). The only constant with this change insofar as the CSD organization was concerned was that centralized/decentralized appointment personnel and the library personnel continued to report to the C. CSD.

Service Line Management Concept

In discussing SLM with the current department chiefs and various key staff members, the focus always came back to the why and how the new management philosophy should be implemented. It is essential to know what these people think and feel about SLM. It has become an extremely emotional issue because, "in a nutshell, it has not worked, was never supported with personnel and physical space, and is not liked," so stated a spokesman in one of the group sessions.

It is imperative to look at the comments generated by the questionnaires. For simplicity, I have merged the comments and eliminated identity. There were no dramatic differences with the answers regardless of whom I talked with, clinical or administrative. Over 100 individuals were interviewed, many from the same department. I show below the common, most frequent answers.

1. Where do you work?

Department of Medicine, Department of Family Practice, Department of Surgery, Department of Nursing, Resource Management Division, Logistics Division, Department of Pathology, Department of

Psychiatry, Preventive Medicine Service, Department of Radiology, Clinical Support Division, and hospital headquarters.

2. What is Service Line Management?

The most frequent answers were: I don't know, I sure wish someone would explain it; Some new management thing; A mess; How we do business here; A great concept in clinical management that has never worked or supported me; and What we went to when we got rid of the primary and specialty support branches.

3. Does SLM support your administrative needs?

The most frequent answers were: A strong no; Sometimes; If I force it to; Totally unresponsive system; and Yes.

4. Is the current system of SLM adequate?

The most frequent answers were: No; Totally inadequate; Has ability; Needs to be fine-tuned; Can never work; and Yes.

5. How can SLM be improved?

The most frequent answers were: Get rid of it; Go back to the old system; Give me rating authority; Let me run my department; Get C, CSD out of the day-to-day management of the administrator; Give us control of finances and personnel resources; Give

incentives to departments to do better; It needs to be reorganized; It can never be improved; and Doesn't belong in the military.

6. If you are a physician/clinician, how much time do you spend doing administrative, or non-patient care functions?

The most frequent responses were: 30-50%; 75-85%; 10-15%; None; and It seems like all my work is administrative.

7. How much time should a physician/clinician spend accomplishing administrative requirements?

The most frequent answers were: 10% or less; Less than 15%; As much time as needed; It varies depending on what the command wants; and Difficult to tell because I have never had adequate administrative support to would allow me to be freed-up.

8. How would you restructure the Clinical Support Division or the administrative support rendered the clinical departments and services?

The most frequent answers were: To give the department chief complete control with rating authority; Go back to the old way; Get rid of CSD like the medical centers did; and Make it fair--give each department the same assets.

9. Would you make any changes in staff alignment or reporting/rating relationships?

The most frequent answers were: Let the people who work in the specific departments be rated by that department chief; Get rid of centralized control/supervision of central appointment clerks; and Let people, regardless of specialty, who work on the clinical side of the house be rated strictly by the clinical side of the house.

Analysis

It is not difficult to tell from the above that overwhelming negativism exists about SLM; clearly, change needs to be made. Before I generate recommendations, let me offer why I think the above comments were so strongly unsupportive of the current administrative support to the clinical departments and services.

It is my opinion that the previous leadership of the hospital was preoccupied with being on the cutting edge of management styles and philosophies. The feelings of many staff members support this; many go further to say that SLM was started so that MACH had a new buzzword the command could dangle in front of HSC

and other MEDDAC's. I generally support this because there was no dedicated support provided for implementing SLM other than by name. One needs to review the assumptions the command made when deciding to implement SLM. I will list the assumptions made and follow them by providing comments generated in the interview process.

1. Assumption: The physical colocation of medical, nursing, and administrative staff members will result in better coordination of actions and, therefore, increase productivity through faster and higher quality decision making.

Comments: Not all of the six SLM teams were ever fully staffed. As a result, with the abolishment of the dedicated centralized CSD, many departments found they had less support than ever before. Coordination was made more difficult with the loss of assets, primarily administrative officers and noncommissioned officers (NCO). Finally, decision making slowed down; in fact, in many respects it came to a standstill due to the fact that no one was in charge. The triad concept was that all three members were equal, with equal say in the resolution of issues. Physicians found their patient productivity

declined because they were spending more time doing routine administrative work, i.e., efficiency reports, awards, typing, and filing, and they were having to arbitrate departmental disputes in the hospital headquarters.

2. Assumption: Any efforts to change the organizational structure of the MEDDAC at the departmental level will require considerable time to obtain approval from higher headquarters and may put the entire project at risk of disapproval due to territorial or parochial considerations.

Comments: Many felt that the command was taking the easy way out by not addressing the difficult issue of, "Who is in charge?"

Organizational structure can change without having a dramatic affect on the efficiency report rating chain, primarily within Department of Nursing, which is what most feel is underwritten in this assumption. Nursing staff members can still rate and senior rate, but physicians can intermediate rate or provide letters of input to the OER. This assumption was viewed as military bureaucracy at its finest.

3. Assumption: Any new, improved organizational relationships should be designed to have minimal

impact on current departmental organizational structure and rating schemes.

Comments: This was viewed as the singular largest fault. i.e., change the name, shuffle a few bodies, but not place into practice what you say you will. A major question is, "How can you go to a triad style of management, with no one person in charge, and expect no impact on the current departmental organizational structure?" There was significant impact on the departments where SLM was implemented and on supporting departments, such as nursing.

4. Assumption: There are no additional resources available to implement service line management.

Comments: This assumption was true, there were no new assets brought on board to support SLM. That is why it is failing, "It takes money to make money." This is the reason why three of the departments implemented SLM and why three did not. The most common staff shortage was of the administrator and NCO.

5. Assumption: There will be space available to accomplish any recommended relocations.

Comments: Space is always a problem, and relocating all of the triad assets into one location proved to be difficult. One team moved portions of its assets three times, finally giving up the attempt to colocate. Space was viewed as the least of our problems for the successful implementation of SLM.

6. Other factors that weighed on the decision process were also critical. First, no department chief was included in the working group to formulate SLM, nor were they included on the coordination line for comments/concurrence of the decision paper; in other words, this concept and the ultimate decision were top-driven. Secondly, facilitation of departmental collaboration and coordination of efforts via SLM did not easily occur. Again, the lack of rating authority created functional control problems. Lastly, a most critical issue is that the centralized CSD did not go away with SLM as initially projected. The C, CSD maintained supervisory control, rating responsibility, and daily tasking of work control over the departmental administrators. Many of these tasking followed the old functional lines of the preexisting CSD.

7. Administratively, no proactive attempt has been made to give responsibility for fiscal and workload accountability, personnel hiring, ancillary services utilization, i.e., laboratory, x-ray, or pharmacy utilization management, to the existing SLM teams.

Based on the comments generated by the interview and sensing session process, only one conclusion can be drawn.

IV. CONCLUSION

Service line management has been nothing short of a failure since its inception at Martin Army Community Hospital. The efficiency and effectiveness promised with thorough and complete implementation of this management concept never came to fruition. Unhesitatingly, I strongly advocate that a change in the structure for administrative support to the clinical departments be implemented. Under the current leadership, we have begun to move forward, to be proactive, to query and investigate the difficult and complex issues, and to allow subordinates the latitude necessary to work to the extremes of their abilities and desires. The "hanging noose" has been taken down; workers are no longer threatened by the results of failure, but motivated by the attempt to excel. Now, however, it is equally imperative that the entire MEDDAC staff redirect their efforts towards accomplishing the goals of the organization. The narrow mind-set and myopic vision displayed by leaders at all levels of the organization must broaden with greater depth and agility if any change in administrative support is to be successful.

Contributing Factors for Change

Four basic factors contribute to the challenge of providing optimum administrative support at Martin Army Community Hospital. First, the range and complexity of clinical missions continue to change rapidly, most of them expanding (especially with Gateway to Health Care), while administrative capabilities have not mirrored the change or examined the immediate demands of the future.

Secondly, there is a widespread perception that even given the limited resources in today's environment, administrative support is still not functioning as well as it could at MACH.

Thirdly, even though the concept of SLM is new in the health care community, the management employed by the SLM system is layered, bureaucratic, unresponsive, lacks decision making authority and responsibility, and functions as designed in the 1970's via Ambulatory Patient Care (APC) Model #18. Changes in technology, resource flow, workforce availability, and hospital practice patterns have not been able to impact on, or cultivate a significant change in the administrative 'working' structure.

Lastly, the demands of the 1990's will present even greater changes in the structure, process, and technologies used to provide and manage the health care delivery system. Again, Gateway to Health Care will force these changes, primarily as we move to a capitation funding system, with the emphasis moving to out-patient care and wellness, a dramatic change from the days of in-patient care and sickness.

Why Restructure?

A critical and essential precept of Total Quality Management is the emphasis on listening to the customer. In the case of MACH administrative support, the customer is the clinical staff being supported--and to many clinicians, the major factor preventing productivity increases is administrative support. It is clear that restructuring will not solve all of the problems encountered in providing optimal administrative support to the clinical departments and services, but it must be considered in light of the changes witnessed in the health care delivery system which have occurred or will soon occur. Further, once again, our staff is telling us that it is time to try something new.

If we are to hold department chiefs responsible for the efficiency, effectiveness, and productivity of their respective operations, then restructure of administrative support to clinical departments is warranted. If workload and productivity are to drive resource allocation in terms of dollars, personnel, space, and major equipment purchases, then restructure is warranted on an equitable basis.

If change is to be successful, then the structure must be modified to reflect clinical needs, and the behaviors of the staff modified to improve administrative and clinical interactions. Territorialism at all levels, among all specialties, in all corners of the hospital, must be abolished. We no longer can accept the mind-set that the hospital operates with two halves; one being the clinical side-of-the-house and the other being the administrative side-of-the-house. The precept that the problem at hand is 'your problem' must be changed. Any problem that impacts on the ability of any portion of the hospital to propel itself forward, to meet and surpass its mission, is a problem owned by every member of the Martin Army Community Hospital staff.

V. RECOMMENDATIONS

Overview

The structure emplaced to administratively support the clinical departments must be molded to meet the needs of the hospital, not designed based on the personalities of the current staff. It is desired that with each changing of the guard that a new structure will not have to be designed and implemented. One must examine, however, the maturity of the organization, current and future, to ensure it is capable of successfully working within the structure created. A complex structure, staffed by junior, inexperienced staff is destined for failure. Skill level, not individual personalities is of paramount importance. Every department chief interviewed in the course of the research paper agreed in principle to the primary course of action presented below.

Factors considered in making this recommendation include major issues such as, the potential for the dramatic improvement in staff morale, patient access to appointments, and ultimately, productivity. Additionally, this study was charged with being

sensitive to issues of rating chains, space, authority, responsibility, nursing involvement, enlisted support, and communication. Positive changes identified will impact significantly on the decisions concerning budgeting, personnel hiring, major equipment purchases, and space allocation. Clearly a change must be made. A redesign of the system currently in place must be initiated that satisfies the total and complete needs for clinical administration.

The current DCCS and C, CSD are most positive and proactive in discussing the redesign/restructure of SLM. Their willingness to broach this topic so openly demonstrates that they possess a vision for the future and very much want to enjoy harmony, efficiency, and effectiveness with the administration of the clinical services. Without their openness to address this issue head-on, no change would be possible, simply because they strongly share the initial brunt of any redesign.

Course of Action

1. The Clinical Support Division should be dissolved. The C,CSD assumes the title of Clinical Services Administrator (CSA). Working directly for

the DCCS, the CSA would be directly responsible for input into major and minor equipment purchases, continuing health education temporary duty/travel, space allocation, civilian grading structure, quality assurance (QA), and risk management. Additionally, he would monitor workload, productivity, budget implementation and utilization, and staffing. These are not limiting duties and responsibilities and can be easily adjusted; they are however, a compendium of responsibilities of most CSAs at medical centers. Functions which would report directly to the CSA would be:

- QA
- Credentials
- Medical Library
- Patient Affairs/Patient Assistance (not community relations)
- Central appointments
- Secretary

2. Current administrative service line managers would assume the title of departmental administrators, working directly for the physician department chief. It is desired that the rater be the department chief

and the senior rater be the CSA. Should the rank of the incumbent department chief be greater than the CSA, then merely reverse them and let the CSA rate and the department chief senior rate. Both **must** be in the direct rating chain, but day-to-day control, supervision, and assignment of duties and responsibilities must rest singularly with the department chief.

3. The department secretary must support the needs and demands of both the department chief and the department administrator. If the department is operating efficiently and correctly, the initiator of the majority of work for the secretary would be the department administrator. Ideally, the administrator would rate the secretary (this single issue would probably create the most discussion and emotion).

4. There must be an NCO to assist in the administration of the departments, primarily when supervising the subordinate services and clinics. The current nursing NCO only assists where nursing is involved. This is unacceptable; the duties of this individual would have to be expanded. A shortage of

administrative NCO's has been long-lived and is not likely to be resolved in the near-future. The nursing NCO must assume the responsibility as departmental NCOIC, working for the administrator. He should be rated by the administrator and endorsed by the nursing supervisor. Again, this is an emotional issue, primarily because it is change. But, empires must be toppled and we must work with the resources we have. The wealth must be shared. Should this action be seen as a show stopper, I would let nursing rate and the department administrator endorse. A major reason given for not allowing these actions to occur is the need for soldier specific training and counseling. I state that this can still happen with the above changes. All employees must be counseled, not just NCOs. Secondly, if the hospital command sergeant major has an adequate and efficient enlisted training program, training will not be an issue.

5. All clinic or service NCOIC's must work for the department NCOIC. The obvious following of the chain of command/supervision must occur.

6. Appointment clerks must work for the respective clinic/service/ward where they work. Day-to-day supervision of the employee necessitates that the actual supervisor become the clinic/service/ward NCOIC.

7. Nurses--the toughest issue is the last one. People I talked to from in and out of the hospital felt that this is the most bureaucratic, personnel-wasteful, layered department in Health Services Command. Civilian facilities I visited can not believe our nursing organization. It is clear that nurses must work for nurses--they are the check and balance of the hospital. However, they can be intermediate rated by the department chief or, at a minimum, have an official letter of input from the department chief accompany the OER. Most department chiefs do not have a major problem with the nurse rating; they do, however, want the nurses to work closer with the department. There is a sense of Department of Nursing protectionism for nurses that is impacting on efficiency. This must be recognized and changed

There is no new fancy organization chart to present. In fact, we modified the current structure (figure 4). Where the CSD currently exists has been replaced by the CSA and his staff, administrators fall directly under the department chief, and nursing essentially remains the same.

Analysis of Course of Action

The single, most critical issue we must ask is, "Will the above changes make us better?" I believe they will. What was missing the most with SLM was that autonomy to run/manage the department never occurred, no one person was in charge, there were multiple bosses, departments were not staffed appropriately, and education of implementers and users of the system never happened. This recommended change clearly has someone in charge--the physician department chief. The administrator clearly works for the department chief, not CSD. The department chief has some influence in the nursing OER, and of critical importance, the NCO has expanded and broadened responsibilities.

This system will allow for many of the same outcomes desired under SLM. It will need work and training to make it successful, but the system can be easily implemented. Some departmental managed issues are (not inclusive):

1. Budget development, management, and execution
2. Pharmacy budget, by drug, by physician
3. Supply utilization
4. Ancillary services utilization, such as laboratory, radiology, and other referral services
5. Personnel utilization, to include overtime utilization, hiring, and lay-offs
6. Productivity and physician efficiency patterns
7. Incentives for improved efficiency

What is the Cost?

The singularly most difficult decision to be made is to accept that change must be made. Secondly, the leadership must address head-on, not skirt, the issues of reporting, evaluations, and rating chains. Thirdly, some money must be spent. Administrators must be hired for each department. There cannot be a

shared administrator that attempts to service the needs of each department. Our current system displays that this has been unsuccessful. Departments that should have an administrator are:

1. Family Practice and Community Medicine
2. Medicine
3. Nursing 4. Psychiatry
5. Surgery
6. Radiology

There will be a need to civilianized three of these positions. Current requirements do not authorize six military department administrators. The current job description for the civilian administrator in Department of Medicine will suffice for the creation of the new positions. The Department of Pathology and the Preventive Medicine Service have adequate assets to administratively manage their respective areas.

The decision to change administrative structure rests with the executive body, and ultimately with the hospital commander. This study should be instrumental in recommending a course of action to be employed throughout MACH, one which will unquestionably support the needs of the staff and those of the beneficiary community. Notwithstanding the fact that

the medical environment is unstable because of the evolution of Gateway to Health Care, Wisconsin Physician Services developing a Preferred Provider Organization, and the return of many clinical staff members from the war in Southwest Asia, change should not be delayed. Modifications will need to occur as the environment changes. Such adjustments would be difficult if not impossible to accomplish with SLM; however, modifications would be simplified with the recommended course of action.

In years past, there has been little doubt that Army hospitals have had difficulty in designing an administrative process or structure that met the clinical needs of the hospital, independent of individual personalities. It is hoped that use of this analysis and implementation of the recommendations will save MACH valuable time and resources over the coming months and years, particularly as Gateway to Health Care becomes a reality.

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APPENDIX A

Interview questions for chiefs of departments and their key staff.

1. Where do you work?
2. What is Service Line Management?
3. Does SLM support your administrative needs?
4. Is the current system of SLM adequate?
5. How can SLM be improved?
6. If you are a physician/clinician, how much time do you spend doing administrative, or non-patient care functions?
7. How much time should a physician/clinician spend accomplishing administrative requirements?

8. How would you restructure the Clinical Support Division, or the administrative support rendered the clinical departments and services?

9. Would you make any changes in staff alignment or reporting/rating relationships?

APPENDIX B

Interview questions for key staff members, clinicians and administrators, officers, and noncommissioned officers, civilian employees, and junior enlisted soldiers.

1. Where do you work?
2. What is Service Line Management?
3. Does SLM support the administrative needs where you work?
4. Is the current system of SLM adequate?
5. How can SLM be improved?
6. If you are a physician, how much time do you spend doing administrative, or non-patient care functions?
7. Do you spend more time than you feel necessary or acceptable completing administrative requirements?

8. How would you restructure the Clinical Support Division or the administrative support rendered the clinical departments and services?

9. Would you make any changes in staff alignment or reporting/rating relationships?

Figure 1

TRADITIONAL CLINICAL SUPPORT DIVISION
HEALTH SERVICES COMMAND

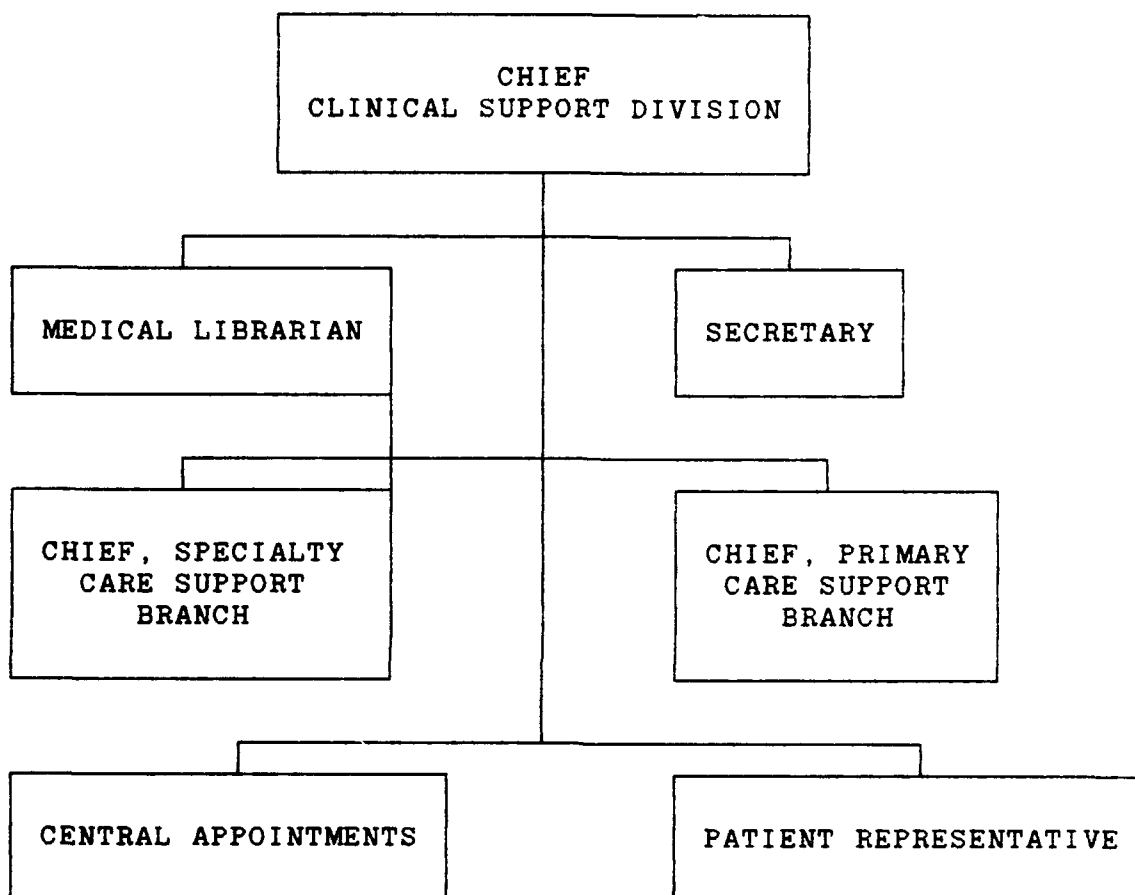
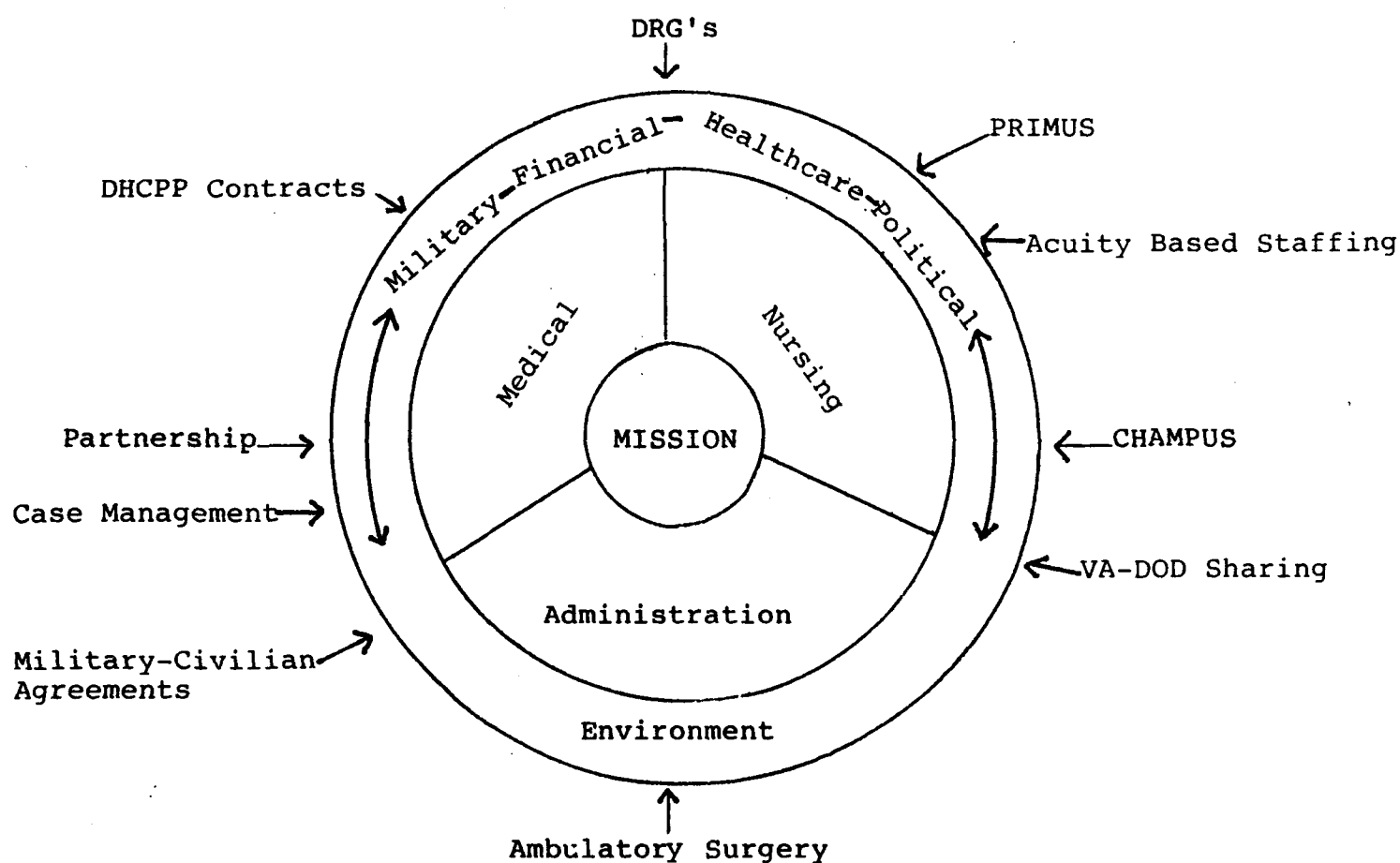


Figure 2
SERVICE LINE MANAGEMENT TEAM
TRIAD* MODEL



*TRIAD: A union or group of three, especially three closely related persons, beings, or things. (Webster's 7th New Collegiate Dictionary)

Figure 3

SERVICE LINE MANAGEMENT TEAMS

Surgical Management Team

Medical Management Team

Family Practice
Management Team

Maternal/Child Health
Management Team

Mental Health/ADAPCP
Management Team

Preventive Medicine/
Community Health
Management Team

Figure 4

MODIFICATION TO TRADITIONAL
CLINICAL SUPPORT DIVISION