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Types and Structures of Health Services Organizations and Health Systems

Learning Objectives

- Identify the elements of the HSO triad and compare their roles and relationships
- Compare and contrast the services delivery roles of types of HSOs prominent in healthcare
- Draw and explain the organizational structures of various types of HSOs
- Understand the structure and role of health systems with emphasis on governance
- Conceptualize the relationships between HSOs and the public health system
- Comprehend the environmental forces affecting HSOs and HSs

Discussion Questions

1. *Identify the typical legal status of various types of HSOs. Why are HSOs almost always organized as corporations? (Refer to Chapter 4.)*

Typical legal status for HSOs includes general partnership, limited partnership, LLC, and corporation (not for profit or for profit). Physicians and other types of licensed independent practitioners (LIPs) may organize professional corporations, often designated by *PC* or *Ltd.*

General partnerships are uncommon and should be considered an undesirable legal form for an HSO. State law gives limited partnerships some of the attributes of a corporation. Limited partners have limited legal liability; general partners have unlimited liability. LLCs have the advantage of financial liability that is limited to the investments of the owners/stockholders (limited liability) and advantageous tax treatment.

The corporation is a legal form that offers several advantages: limited liability, continuity of existence, transferability of ownership, and ability to raise capital. Limited liability is considered among the most important advantages. Organizations chartered as not-for-profit corporations under state law enjoy tax advantages that are substantially enhanced if the corporation is qualified under the Internal Revenue Code as a 501(c)(3) tax-exempt organization. State and federal law may offer tax and other advantages to not-for-profit organizations as well.

2. *Describe the generic roles and activities of the GB, management, and PSO triad in HSOs/HSs.*

The GB

- Develops and approves organization mission, vision, general policies, and long-range plans
- Approves strategies to achieve objectives that are formulated by senior-level management
- Monitors implementation of strategy and policy
- Monitors financial performance and approves capital expenditures
- Recruits, hires, and evaluates the CEO
- In general, monitors the quality of care
- Gives final approval to PSO appointments and clinical privileges
- Provides a link to the community and service area

Management

- Implements policy
- Develops the strategic plan
- Reports through the CEO to the GB about progress in achieving goals/objectives
- Advises the GB (through the CEO) as to potential new policies and organization direction
- Specifically monitors quality of care and implements continuous quality improvement (CQI)

- Prepares and monitors budgets
- Manages departments and activities to attain organization objectives
- Provides a liaison between the GB and the PSO

The PSO

- Has various degrees of self-governance through its bylaws, and rules and regulations
- Monitors quality of care
- Develops and enforces rules and regulations for clinical services
- Participates with management and the GB in long-range and strategic planning
- Is generally integrated into management and GB activities
- Has roles and activities that are similar whether the HSO is organized for profit or not for profit

3. *Most types of HSOs have physicians and other LIPs whose credentials are reviewed before their membership in the PSO is approved and clinical privileges are delineated. Describe the credentialing process. How does it differ for an acute care hospital, a nursing facility, and an independent practice association–model HMO? Why?*

The steps and content of the credentialing process depend on whether the LIP is making an initial application or is reapplying for PSO membership and privileges. Initial application involves a background check, including personal and professional references, all educational experiences and preparation, state license, specialty board status, malpractice insurance coverage and policy limits, health status, Drug Enforcement Administration (DEA) registration, applied training, and continuing education, as well as a query to the data bank that was established by the Health Care Quality Improvement Act of 1986.

Reapplication includes checking state license, malpractice insurance coverage and policy limits, DEA registration, health status, continuing education, and the data bank, with the critical addition of a review of clinical performance. This includes performance at the HSO granting privileges, determined by reviewing data developed through quality assessment and risk management activities. It is good practice for HSOs to require LIPs to provide information about their clinical practices at other HSOs. Use of outside sources is essential when LIPs have too few patients at an HSO to adequately judge the quality of care provided there. Outside information (added to information from the HSO) helps the HSO determine what clinical activities (privileges) the LIP will be allowed to undertake. The acid test is that clinical activities must be consistent with demonstrated current competence. In summary, the typical steps in the credentialing process are as follows:

- The applicant applies or reapplies.
- The required information is obtained by the HSO.
- The file is reviewed by the clinical department in which the LIP will be appointed.
- The file is sent to the PSO credentials committee.
- Information from quality assessment activities and other sources is used to judge performance.

- The file is sent to the PSO executive committee after the credentials committee review and recommendation.
- A recommendation for appointment and range of privileges is sent to the GB professional staff committee.
- The GB professional staff committee recommendation is sent to the GB for final review and approval.

The LIP has the burden of demonstrating competence. No assumptions should be made.

Credentialing should be done at all HSOs in which LIPs practice, and the basic process is the same in acute care hospitals, nursing facilities, and independent practice association (IPA)-model HMOs. HSs may have one process for member HSOs. Credentialing is most formal in acute care hospitals and least formal in nursing facilities. Some HSOs rely on the fact that an LIP has privileges at an acute care hospital and do not have their own credentialing processes. Unless they have full access to hospital data about performance and quality of care, this credentialing process is inadequate. In addition, all HSOs must monitor the performance of LIPs who provide services in them. Increasingly broad legal liability makes reliance on the credentialing processes of other HSOs/HSs undesirable. More important, however, it is not good management practice and is likely not to serve the best interests of the patient.

4. What are the functions of a general acute care hospital?

The functions of an acute care hospital are diagnosing and treating the sick and injured, preventing illness and promoting health, educating health services workers, and undertaking clinical and administrative research. Other functions of an acute care hospital include a community health resource, a health center, and a health services coordinator and organizer.

5. How does the typical general acute care hospital differ organizationally from the usual bureaucratic form? Why? Are these differences necessary?

This question is designed to differentiate the bureaucratic form found in business organizations from those in HSOs, especially acute care hospitals. Usually there is a triad of the GB, senior-level management, and PSO in an acute care hospital. The relationship between the GB and the PSO is often unclear and not a typical exercise of line authority—even though the GB ultimately appoints the members of the PSO and approves their clinical privileges. Clearer lines are found between the CEO and the GB. Special expertise, especially in the PSO, results in shared authority. This differs from the usual bureaucratic form, which has clear lines of authority and reporting relationships.

Historically, it was thought that the triad was necessary because the work done by LIPs, primarily physicians, was too complex and technical for GB members to understand and judge. The complexities and technical nature of their work are even greater now, but GBs have an undisputed ethical and legal responsibility to monitor what happens in the hospital and other HSOs. GBs have increasingly developed the expertise, resources, and data systems to enable them to effectively monitor the quality of clinical care.

The differences between the hospital organization and the usual bureaucratic form are likely to continue in the near term. Long-term changes are likely to include a less independent PSO as more physicians are employed by the HSO.

6. How does the organizational structure of a nursing facility differ from that of a general acute care hospital? Relate these differences to the ease or difficulty of managing each.

The typical organizational structure of a nursing facility and an acute care hospital can be compared as follows:

Nursing facility

Flat organization
Possibly organized as sole proprietorships
Probable absence of a PSO
Few departments
Few specialized staff

Hospital

Tall organization
Organized as either corporations with GB
or limited partnerships with no GB
PSO, always
Numerous departments
Specialized staff of many types

In theory, nursing facilities are typically less complex and should be easier to manage. Such comparisons are highly fact dependent, however.

7. How can relationships between members of the typical PSO (or physicians and other LIPs, if there is no PSO) and management be improved to enhance organizational effectiveness? Why is this important?

Relationships between members of the PSO and management can be improved in several ways (with most of the burden in this regard appropriately falling on management):

- Maintain openness with members of the PSO
- Involve PSO members in all major management committees
- Involve PSO members in the GB and its committees
- Develop a team and a teamwork attitude with PSO members
- Gain and hold the trust of PSO members
- Demonstrate competence and resolve problems affecting clinical activities (on the part of management)
- Develop a partnership with PSO leadership to work in the best interests of the PSO

The text describes how hospitals that involve physicians in management are more effective and efficient. It is likely that such findings can be generalized to HSOs of all types. Successful HSO managers never forget that it is the clinical orders of LIPs, especially physicians, that initiate the conversion of resources into patient services. LIPs are indispensable to HSOs.

8. Federal reimbursement for medical services provided in several types of HSOs was referenced in this chapter. Identify why federal reimbursement is important and the implications it has for managing these HSOs.

Federal reimbursement is important because most HSOs are heavily dependent on direct (Medicare) or indirect (Medicaid) federal payments. Despite the inadequacy of such payments, especially from Medicaid, they do help cover overhead and, at the margin, may more than cover the costs of services. Data presented in Chapter 1 show that the federal share of national health expenditures has risen each decade since the 1960s, a trend that is likely to continue. Recent changes in federal health policy and other likely future changes will accelerate the trend toward greater federal government financing and participation, such as more efforts to control expenditures. The implications of increased federal government financing and participation include the following:

- Likelihood of reduced reimbursement
- Greater direct and indirect regulation of activities
- Need for more effective management

- Need for greater integration of the PSO into the HSO
- Need for improved relationships with the PSO
- Emphasis on managed care and HSOs as preferred providers
- Emphasis on outpatient services
- Emphasis on early release from acute services and use of nonhospital HSOs
- More bankruptcies of marginal HSOs
- Pressures to integrate/affiliate to survive
- Need for not-for-profits to engage in fund-raising to finance capital expenditures

9. What are the key roles of public health organizations at the state and local levels?

Within the public health system, there are many organizations, often units of the federal government, such as the Food and Drug Administration (www.fda.gov) and the Centers for Disease Control and Prevention (www.cdc.gov). States have health departments such as the Virginia Department of Health (<http://www.vdh.virginia.gov/>). Similarly, many cities, counties, and other local levels of government maintain more than 3,000¹ local health departments. An example of a local unit is the Allegheny County Health Department (www.achd.net).

According to the CDC's web site (<http://www.cdc.gov/nphsp/essentialservices.html>), public health can be viewed as a set of "Essential Services" that provide a working definition of public health and a guiding framework for the responsibilities of local public health systems:²

1. Monitor health status to identify and solve community health problems
2. Diagnose and investigate health problems and health hazards in the community
3. Inform, educate, and empower people about health issues
4. Mobilize community partnerships and action to identify and solve health problems
5. Develop policies and plans that support individual and community health efforts
6. Enforce laws and regulations that protect health and ensure safety
7. Link people to needed personal health services and assure the provision of healthcare when otherwise unavailable
8. Assure [a] competent public and personal healthcare workforce
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services
10. Research for new insights and innovative solutions to health problems

10. Discuss governance in HSs.

The most basic governance issue in HSs is whether governance is centralized or decentralized. The centralized governance structure model, sometimes referred to as a corporate or system board model, centralizes governance control in a single GB that exercises direct control over all component HSOs in the system (see Figures 2.2 and 2.5). Component HSOs may have advisory bodies, but these bodies have no legal authority or fiduciary duty; there is only one GB for the HS.

A second model, the decentralized governance structure, sometimes referred to as the parent holding company model, decentralizes governance control and shares it among the system GB and separate subordinate GBs, often at the level of component HSOs or entities (see Figure 2.10). A key responsibility of the system GB in a decentralized governance structure is oversight and coordination of subordinate GBs.

In decentralized HSs, subordinate boards can be structured along organizational, regional, or functional lines. In a decentralized HS that structures its subordinate boards organization-

ally, as is shown in Figure 2.10, there is a system board, and each component HSO of the HS is overseen by its own GB. When subordinate boards are structured regionally, each subordinate board oversees a particular market or geographic region in which the HS operates. When subordinate boards are structured functionally, each oversees groupings of system components that perform similar functions (i.e., physician groups, hospitals, insurance companies). Figure 2.11 shows systems in which subordinate boards are structured regionally or functionally.

In both independent HSOs and HSs, those who govern have five responsibilities to which they must attend, albeit differently, if they are to fulfill their obligations to stakeholders, including the owners or shareholders in for-profit situations.³ First, GBs are responsible for formulating organizational ends. That is, they are responsible for establishing a mission and vision for the HSO/HS, from which associated organizational objectives are derived. Second, GBs have a responsibility to ensure suitable performance of senior-level managers. Third, GBs are ultimately responsible for the quality of care provided. GBs also bear responsibility in a fourth area, the finances and financial performance of their HSOs/HSs. The fifth area of GB responsibility is for self. That is, those who govern are responsible for doing so in an effective and efficient manner. Fulfilling this responsibility includes establishing and maintaining appropriate bylaws to guide the governance process, selecting GB members who can serve the HSO/HS well and seeing that they do, and ensuring that processes for evaluating GB performance and for member development are in place and properly functioning.

Case Study 1

The Clinical Staff

This case study highlights the adversarial relationship between managers and clinicians in HSOs. The case is set in a hospital, but similar problems often occur in other types of HSOs as well. There is a natural tension between managers, who are responsible for entire HSOs/HSs or large parts of them, and clinicians, who focus on one patient at a time. This tension is not necessarily reduced even if the managers involved are trained in medicine or another clinical area.

1. How should you respond to the president of the PSO?

You should state that such a view is outdated and inconsistent with the cooperation and integration of management and clinical staff that are needed to efficiently deliver high-quality services.

2. What arguments should you use to support your position?

Possible arguments to support your position include the following:

- Delivering high-quality health services requires integrating administrative and clinical activities.
- Artificial barriers between administration and clinical activities lead to suspicion and lack of cooperation.
- Distinctions have a negative effect on team building and CQI efforts.
- The GB, through the CEO, is accountable for the quality of medical care, and this requires that management and clinical staff work together.
- It is in the clinical staff's interests to work with management to improve processes and the support they receive.

3. *Sketch an outline showing the appropriate relationship among the GB, CEO, and PSO.*

An appropriate relationship between members of the triad would perform as follows:

- Develop an open relationship among the PSO and the GB and managers. Caution: some PSO members may be involved in activities that compete with the HSO. This makes an open relationship problematic.
- Involve PSO members in all major management committees
- Have PSO members on the GB and its committees
- Attempt to develop a collegial team and positive attitude toward teamwork with PSO members
- Gain and hold the trust of PSO members

In addition, management must evidence competence and act as a resource for clinical problems and activities of PSO members and must develop a partnership with PSO leadership to work in the best interests of the PSO. Management and the PSO must perceive each other as a resource.

Case Study 2

The Role of the Healthcare Executive in a Change in Organizational Ownership or Control⁴

1. *In addition to the roles of CEOs and other senior-level managers in HSOs/HSs during a change in organizational ownership or control, what role should their GBs and PSOs play?*

It is important to remember that the GB bears overall responsibility for the HSO/HS. Thus it is necessary for the GB to be deeply involved in determining strategic direction with help from the CEO. As noted in the text, the GB performs many functions: appointing and maintaining effective relationships with the CEO; establishing the organization's mission and monitoring progress toward its accomplishment; approving and monitoring the strategic plan and annual budget; ensuring the quality of care by approving quality goals and monitoring progress toward them; and monitoring overall performance of the HSO/HS.

Historically, PSO members have had little involvement in management and governance decision making, including decisions regarding changing ownership or control of the HSO/HS. The exception has been clinical managers and PSO officers. In the past decade, however, the value of their participation has been recognized, and PSO members have become more involved in management decision making. Such interactions are good practice and are strongly recommended by accrediting bodies such as The Joint Commission.

PSO members can be integrated into an HSO's/HS's management structure in several ways: They may join PSO management and GB committees; managers may ask them for advice formally and informally; and those who manage clinical departments or units are part of the management team and should be treated as such.

A useful way to discuss the roles of all three parts of the triad (GB, management, and PSO) is to note their primary generic roles and activities as outlined in the response to Discussion Question 2.

2. *Why is it important for senior-level managers in HSOs/HSs to have governance competence when they are involved in changes in organizational ownership?*

The knowledge and associated skills of governance competence are important for senior-level managers for three reasons (discussed more fully in Chapter 5):

1. Most senior-level managers participate directly in the governance function as members of their organization's or system's GB. The vast majority of HSOs include their CEOs on their GBs. CEOs of HSs are almost universally included. These managers participate in the governance decisions regarding consolidation, merger, acquisition, and affiliation.
2. At the strategic apex, it is difficult to separate what occurs under the rubric of governance from what occurs in the context of strategic management. Consequently, effective senior-level managers must be knowledgeable about management and governance. This is certainly the case when important strategic decisions such as those involved in consolidations, mergers, acquisitions, or affiliations are being considered.
3. Senior-level managers can assist those with direct governance responsibilities to do a better job by providing information, resources, training, and development programs. Several suggestions in the guidelines outline a role for senior-level managers in assisting members of the GB in these decisions, including establishing a code of conduct and the specific criteria for use in proposals involving changes in ownership or control of the organization, the identification of financial incentives that may influence the decisions for all involved in them, and actions that are related to the creation of foundations as a result of ownership or control changes.

Case Study 3

Public Health and the Health Services Delivery System

1. Why are HSOs/HSs in the personal health services and public health domains so different?

Their focus and methods are complementary, but divergent.

Limited diagnosis and treatment services may be available at a public health entity; its real niche, however, is the "prepathogenic period," which is the period before a disease agent or illness manifests itself in the human being. Public health services also focus on groups of persons, using a communitywide setting. This compares with the typical HSO, which focuses on individuals in ambulatory, inpatient, home, or mobile settings.

For example, groups of healthy persons are targeted for *preventive* and *health promotion* services offered by health departments. Examples include screening persons in malls for high blood pressure; vaccinating children for polio, diphtheria, and other childhood diseases; fluoridating the public water supply to prevent dental caries; quarantining dogs for rabies after they bite human beings; and preparing public service announcements about the risks of failing to use automobile seat belts. Local health departments use their regulatory authority to provide *protective* services that include inspecting food establishments for safe food handling, elevator maintenance and safety, and the safety of radiation sources, such as x-ray machines. These services seek to keep workers and the public well.

Personal health services focus on the sick and treat, rehabilitate, and assist persons to maintain their highest possible level of functioning. In addition, however, acute care hospitals engage in health promotion, screening, and disease prevention by conducting vaccination programs and educating the public. This emphasis will increase as more attention is paid to population health. The main emphasis, however, is diagnosing and treating those who are the worried well or who are ill. Historically, public health aimed at diminishing the likelihood or

extent of epidemics. Public health uses the “epidemiologic model,” studies the natural history of a communicable disease or other threats to health such as accidents and suicides, and tries to intervene before the problem occurs.

People want to live where disease and death rates are low, but also in a place that has hospitals and other “pathogenic period” services available. A health system with continuity of care needs both.

2. What are the implications of these differences for society?

Society tends to view the needs of the sick with more compassion than the needs of the well. The funding of personal services and public health services follows this perception. Indeed, there is logic to it as well. If acute services were not available, it is likely that a life would be lost. It is important to bear in mind that even the worst epidemics do not kill all those affected. Henrik Blum’s model is shown in Figure 1.1. It contrasts the importance of factors other than acute care services as they influence health and well-being. It is useful to draw the students’ attention to this depiction. Factors such as lifestyle cannot be easily influenced by public health, personal health services, or government. Nor is it likely that Americans would accept the level of indoctrination and control needed to force persons to engage in health-positive behavior, rather than health-risky behavior, if that is their preference. Such a loss of free choice carries a high cost in terms of personal liberty. Thus it is almost certain that risk-taking and unhealthy lifestyle choices will continue to be made, and society will do the best it can to save persons from themselves. Health education has proven only partially effective in that persons engage in risky behavior even though they are aware of the potential harm to their health and well-being. In a sense this view is not illogical. Not all who engage in high-risk behavior are afflicted by the condition that may result. Statistical probabilities are only that—probabilities, not certainties.

3. How can their roles be more complementary?

Communication and continuity must be enhanced; and role interfaces such as referrals must be improved. When screening identifies someone who requires follow-up, there should be a referral network that facilitates further treatment. When a physician or ED diagnoses a reportable communicable disease, this information should be provided quickly to the health department for follow-up, case finding, and/or treatment.

Biological and nuclear threats require the expertise of the public health community, and its authority to quarantine and isolate must be coordinated with personal health services provided by hospitals and physicians offices.

As technology increases the productivity and effectiveness of healthcare organizations, the availability of health information, with proper safeguards to privacy, must be enhanced. In addition, there are newly emerging diseases that were rare or nonexistent only a few decades ago. Drug-resistant bacteria, AIDS, West Nile encephalitis, hantaviruses, and the like will cause new threats, and their prevention and treatment will be enhanced by coordinated population and personal healthcare delivery.

Case Study 4

Board Effectiveness⁵

Students are directed to respond to the following two questions regarding each of the 10 statements posed in the case:

- 1. What pitfall (problem or issue) is this statement designed to identify?*
- 2. What steps should be taken to ensure that the pitfall (problem or issue) does not arise and hamper board effectiveness?*

The pitfalls and preventive measures for each of the 10 statements are as follows:

- Statement 1.* The pitfall is that the board might not consider issues from the perspective of all relevant constituencies. This pitfall can be avoided by inclusion of relevant constituencies on the board.
- Statement 2.* The pitfall is that the board might not remember the HSO's/HS's mission in its decisions. This pitfall can be avoided by continuous attention to mission and by questioning all board decisions in the context of their fit with the mission.
- Statements 3 and 4.* The pitfall is that the board will become bogged down in details addressed in its committees and by management and will fail to make key strategic decisions. This pitfall can be avoided by leaving detailed decisions to appropriate committees or management, with board oversight, and paying attention to key strategic issues.
- Statement 5.* The pitfall is that the board will fail to remove dysfunctional members. This pitfall can be avoided by development and use of a clearly articulated process for removal.
- Statement 6.* The pitfall is that board members will not know what is expected of them and may not perform up to full potential. This pitfall can be avoided by development and use of appropriate performance standards.
- Statement 7.* The pitfall is that the massive amount of work facing the typical board will not be appropriately divided among functioning committees so that it can all be properly done. This pitfall can be avoided by a comprehensive committee structure and by effective functioning of the committees.
- Statement 8.* The pitfall is that the roles expected to be played by each board, trustee, and board officer will not be clearly specified, reducing their effectiveness. This pitfall can be avoided by the use of carefully developed job descriptions in educating board members as to role and as criteria in evaluating their performance.
- Statements 9 and 10.* The pitfall is that board members will not be thoroughly oriented to their roles and to the governance culture nor receive appropriate continuing education necessary to fulfill their roles. This pitfall can be avoided by effective orientation programs and continuing education and evaluation processes in which board members actively participate.
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Additional Case Study 1: The Emergency Department

This case suggests the dynamics among various clinical managers in HSOs/HSs and how different agendas may be present. The problems described here typify those that would be found in a complex HSO such as a hospital. Establishing artificial boundaries for staffing and unnecessarily complicated reporting and matrix relationships should be avoided. A key skill for nonclinical managers is understanding such dynamics and getting past the smoke and rhetoric to identify the underlying issues in a situation.

You are the CEO of Holbrook Hospital, which has an active emergency department (ED) with more than 60,000 visits annually. Historically, the department has been organized like that of most hospital EDs. Nursing staff report to nursing service; registration clerks, cashiers, and other clerks report to the admissions department; security officers report to the security

department; residents who provide medical services report to various chiefs of departments such as internal medicine and surgery; and the crisis intervention social workers report to the department of social services.

You have just employed a full-time salaried physician as ED director. He has informed you that changes must be made if he is to do the job properly. The basic change is that all nursing service employees must report to him instead of nursing service. He has considerable experience in emergency medicine and has told you that this change will help employees feel a greater esprit de corps because they would be in one department rather than dividing their loyalties between the ED and their "home" departments. The director believes that this change will promote efficiency, boost morale, and facilitate coordinating work in the ED.

The director of nursing service is not pleased with the proposal. She has told you that, if the change is approved, the ED director should not expect nursing service to provide staff, even in an emergency. For example, if an ED nurse does not report because of illness, the ED director will have to call in other ED nurses, rather than expect nursing service to move nurses from elsewhere in the hospital. At present, when ED needs more nurses because of absenteeism or sudden increased activity, nurses are pulled from various floors.

The director of nursing also pointed out that, in the past, nursing service, with help from the human resources department, has been responsible for recruiting and training ED nursing staff. If the change is made, she thinks the ED director should be responsible for these activities as well.

Currently, operating room (OR) nurses report to nursing service even though a salaried chief of surgery heads the department. The same is true in the intensive care unit (ICU), where nurses report to nursing service even though a salaried physician is head of the ICU. These physicians are unconcerned that nursing employees report to nursing service because they retain responsibility for directing the nurses' professional activities.

1. Why does the ED director want nursing staff to have a line relationship to him?

There are several possible reasons why the ED director would want a line relationship with nursing personnel:

- Control
- Responsiveness
- No intervening loyalties or ties
- Potential for more specialization and improved skills
- Authority to hire, fire, and discipline
- Power or personal aggrandizement
- One-upmanship with the director of nursing

2. What advantages and disadvantages would this line relationship have when compared with the pattern in the OR and the ICU?

The advantages of a line relationship include the following:

- Control
- Responsiveness
- Dedicated staff with potential for better skills/training
- Elimination of the confusion of dual lines of reporting
- A higher quality nursing team

The disadvantages of a line relationship include the following:

- Lack of flexibility
- Potential staffing problems

- Additional compartmentalization of the hospital
- Lack of “float” nursing staff available during peak demand in the ED
- Potential pay inequity
- Higher staffing costs

3. *Will this change accomplish the things the ED director claims (better esprit de corps, efficiency, morale, coordination)? Why? Why not?*

Better esprit de corps depends on the current stability in ED staffing. If it is relatively stable, dedicated staffing is not likely to improve esprit de corps. The change may or may not improve ED efficiency, and it is measured by variables such as absenteeism, staffing level, and availability of specialized ED staff. Given that the ED is likely to staff for peak demand and that it cannot get float staff from elsewhere in the hospital, dedicated staffing is likely to decrease overall hospital efficiency. Morale is similar to esprit de corps, but it is neither as clearly evidenced nor as enthusiastically shown. Improvement in morale will depend on whether the ED director is able to build a team with ED staff. It is likely that coordination will be improved, especially if staffing is sufficient to meet peak demand. If not, and the hospital nursing department does not provide the ED with float staff, agency nurses will have to be obtained. In that case, coordination will decline.

4. *What decision should you as CEO make? Why?*

Responses will include approving, disapproving, or deferring the ED director's request. Given the facts, the request should be denied because hospitalwide consistency is maintained, and efficiency is likely to be greater. Other arguments in favor are likely to be unpersuasive.

Additional Case Study 2: The Right Thing to Do⁶

This case suggests the issues that arise in allocating resources in HSOs/HSs. The specific question concerns establishing an inpatient hospice unit, but it could as easily be a new activity such as home health care or a new physical plant or equipment. In a sense, this is a type of diversification, and it is important that discussion include the total impact on the organization. Establishing a hospice unit has ethical and legal dimensions as well, and these should receive considerable attention in the discussion.

Mr. Sterling, CEO of University Hospital, leaned back in his chair and contemplated the document in his hands with mild disbelief. The “Executive Summary of the Hospice Inpatient Unit Feasibility Study” was concise and emphatic. All committee members had individually summarized their reasons for recommending establishment of a discrete inpatient hospice unit at the hospital. The summary also noted that, if the hospital or its physicians failed to provide or disclose the hospice option to terminally ill patients, such action might constitute a harm that could be unethical or illegal. Failing to inform terminally ill patients about the option of hospice, whether located in or out of the hospital, was unacceptable to the committee.

Professional perspectives included the following:

- *Hospital legal counsel.* Failing to disclose the hospice option may be a tort in negligence because it fails to meet the duty owed by physicians to inform patients of alternative forms of treatment. It could also be actionable as a breach of physicians' fiduciary duty to give patients information that is in their best interests to know.
- *Hospital physician–ethicist.* Failing to disclose the hospice option could be judged as manipulating information, an external constraint on autonomous decision making. Failing to seek the greater balance of good over harm for the patient, as seen by the patient, is unethical.
- *Member of GB, known as board of trustees.* Institutional policies and mission statements affirm the patient's right to self-determination. University Hospital is in an academic health center and well positioned for hospice care. Interorganizational relationships

offer well-developed referral patterns; patient volume is sufficient to fill a hospice unit; and the trustees take pride in community perceptions that the hospital, and their role in it, is to provide innovative medical and nonmedical care.

- *Physician director, ICU.* On reflection, recent increases in ethics consultations for ICU patients and their families were largely seen to be attributable to the many terminally ill patients inappropriately referred to the ICU. Availability of an in-house hospice as a resource for patients, families, and physicians would reduce inappropriate referrals.

Mr. Sterling considered the recommendations. From his viewpoint, there was financial risk in creating a discrete inpatient hospice unit, as well as in changing from income-generating, high-technology care to low-technology, palliative care with a possible reduction in reimbursement. However, he also realized that, even if the hospice lost money, benefits might outweigh losses: As part of the hospital, the hospice would provide charitable or altruistic services to the community, thereby justifying its valuable tax-exempt status.

Mr. Sterling realized that he had an opportunity to do something that made sense medically, reduced legal risks, and met high ethical standards. He wondered, however, about the economic implications for the hospital and for some PSO members, especially those who treated many terminally ill patients. What was the right thing to do?

1. *A large academic health center might be able to invest in an inpatient hospice unit. Could a medium-size community hospital do so? What are the implications of enhanced fund-raising and/or public relations in this decision?*

Medium-size community hospitals could develop inpatient hospice units that might have advantages over those in an academic health center. Community hospitals have lower costs, and reimbursement would come closer to covering the cost of hospice than it would in an academic health center. Also, patients in community hospitals are drawn locally and have a personal interest in the types and quality of care that they might receive. An important consideration is that hospice care is palliative. Therefore, it requires very little technology, uses volunteers (which reduces paid staffing), and has few overhead costs.

Anecdotal evidence suggests that hospitals with hospice programs attract favorable public attention; generate significant community support, as evidenced by volunteers and fund-raising; and receive contributions for these programs.

2. *Even if a hospital lost money on an inpatient hospice unit, how would it contribute to the system, and what noneconomic factors are important? Can an HSO overlook the ethical and legal implications of disclosing this option to terminally ill patients?*

Voluntary, not-for-profit community hospitals are likely to be tax-exempt, in part because of the benefits they provide to their communities, even if care is fully reimbursed. An HSO/HS losing money on an inpatient hospice unit could cite this as an example of the charitable care and community benefit it provides, thereby partly justifying its valuable tax-exempt status. Inpatient hospice in teaching hospitals enriches the environment to which students in the health professions are exposed. A hospice unit could provide a teaching opportunity to give students experience and greater comfort with dying patients. Finally, hospitals find it advantageous to be perceived as “full service,” and availability of inpatient hospice adds to the scope of services.

The physician-ethicist noted that failing to discuss the hospice alternative could be informational manipulation that constrains autonomous decision making. Patient autonomy, or self-determination, may be enhanced in several ways. The federal Patient Self-Determination Act requires health services providers to inform patients in writing about their rights under state law to make decisions about the medical care they will accept or forgo. Advance directives provide instructions to caregivers from people who at a later point may lack the capacity to make medical decisions. By providing information about hospice, HSOs/HSs meet patients' rights to self-determination and act legally, responsibly, and ethically toward people with terminal illnesses.

3. *Would your decision be different if ethical, legal, and medical factors supported establishing an inpatient hospice unit but a number of physicians saw it as an economic threat to their practices?*

Establishing an inpatient hospice unit is complicated if physicians on the PSO view it as an economic threat. This may happen initially because they fear losing terminally ill patients to other physicians; however, physicians may continue caring for their patients in hospice. Notably, hospice may include medical treatment, such as surgery, that supports palliative care. The purpose of treatment distinguishes hospice from conventional medical care. Physicians must understand that hospice is an extension of medical care and a further resource available when conventional, curative medicine is ineffective or inappropriate. For dying patients, the effect of treatment on disease is not paramount; it is the effect of treatment on the patient that is important, and patients must be assisted in choosing treatment that best reflects their beliefs and values.

Additional Case Study 3: Which Hat Are You Wearing?

As this case study notes, combining the positions of chairman of the board and chief executive officer is common in for-profit corporate America. Doing so in health services raises important issues, especially in not-for-profit HSOs. Students will know differences in roles of governance and management after analyzing this case study.

Abby Milroy has been the CEO of Ocean Cove Hospital and Medical Center for almost 10 years. Milroy has been very effective. She is trusted by the board of trustees (BOT) and has been given wide latitude in decision making, including regarding capital expenditures. The chair of the BOT is more than 80 years of age and has served as chair for more than 2 decades. He and Milroy have an excellent working relationship and they often socialize.

When the chair told Milroy he was planning to retire, Milroy decided to approach him with a proposal to combine the positions of chair of the BOT and CEO into one; she would be the first incumbent of that position. Milroy emphasized that the corporate, for-profit world has long used the model she is proposing. It has inherent decision-making efficiencies and offers a much better bridge to connect senior management and governance. If approved, Milroy's new title would be chair of the board and CEO of Ocean Cove Hospital and Medical Center. In that capacity she would preside at BOT meetings and have the authority that the BOT bylaws give the current chair. In addition, Milroy would function as the CEO of the organization and direct the activities of managers and staff.

The current chair of the BOT reacted favorably to the proposal; he agreed to speak to the board about it. His informal meeting with other board members produced a mixed response. The current chair decided to consider the proposal further; since his retirement was not imminent, he had time to think before a formal decision by the BOT would be necessary.

1. *Identify and compare the functions of the CEO and senior management with those of the BOT.*

Pages 72–73 of the text detail the responsibilities and functions of the CEO. Those of the BOT are detailed on pp. 66–67. In summary, the BOT (governance) determines the “right thing” (mission [strategic direction]), and the CEO (and subordinate managers) determines the “right way” (implementation [tactics]).

2. *Identify several reasons why a CEO would also want to be chair of the BOT.*

- a. Eases decision making
- b. Diminishes need for consultation and group decision making

- c. Provides immediate/shorter decision-making cycle(s)
- d. Reduces oversight of performance and questions/second-guessing
- e. The combined responsibilities enhance the person's leadership position
- f. Psychological and political rewards for the incumbent of the combined positions
- g. May justify a high salary because of increased responsibilities

3. *Identify several reasons why members of the BOT might find the proposal problematic.*

- a. Diminishes importance of board
- b. Reduces the role of board members
- c. Concentrates too much power in the CEO and other hospital managers
- d. Diminishes the influence of the community connection with the HSO
- e. Lessens accountability of CEO and management to the not-for-profit corporation
- f. Combining CEO and governance creates corporate model that is ill-fitted to not-for-profit field

4. *What reasons might members of the community served by Ocean Cove Hospital have to object to the proposal? Or to support the proposal?*

Reasons community members might object to proposal:

- a. Diminishes or risks potential loss of link with community input
- b. Lessens opportunity to participate in establishing hospital's mission/strategies
- c. Creates greater potential for CEO/management missteps/mischief because oversight is lacking
- d. Results in more of an appearance of a for-profit business, which may diminish charitable focus
- e. Takes some of the "community" out of community hospital

Reasons community members might support proposal:

- a. Possibility of greater efficiency through more rapid decision making
- b. Ability to attract higher quality CEO/management because of increased independence
- c. Potential for more direct access to CEO/management without having to go through a board
- d. Higher levels of entrepreneurship because governance is not moderating activity
- e. Potential to function like the real businesses that hospitals are in fact

Notes

1. Barton, Phoebe L. *Understanding the U.S. Health Services System*, 2nd ed., 85. Chicago: Health Administration Press, 2003.
2. Centers for Disease Control and Prevention. "The Public Health System and the 10 Essential Public Health Services." <http://www.cdc.gov/nphsp/essentialservices.html>, retrieved January 4, 2014.
3. Pointer, Dennis D., Jeffrey A. Alexander, and Howard S. Zuckerman. "Loosening the Gordian Knot of Governance in Integrated Health Care Delivery Systems." *Frontiers of Health Services Management* 11 (Spring 1995): 3–37.
4. From *The Role of the Healthcare Executive in a Change in Organizational Ownership or Control: Consolidations, Mergers, Acquisitions, Affiliations, Divestitures, or Closures*. Chicago: American College of Healthcare Executives, November 2005. Reprinted with permission of the American College of Healthcare Executives.
5. From Orlikoff, James E., and Mary K. Totten. "Systems Thinking in Governance." *Trustee* 52 (January 1999 [workbook insert]): 4; reprinted by permission.
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