

“I guess the biggest gripe I have is with Smith, head of centralized photocopying. Sometimes it takes 10 minutes to convince Smith that the reproduction job is hospital business and is important. Smith really seems to like the authority. Anyway, take this isometric drawing I have here; I bet Smith will think it’s my 6-year-old daughter’s homework assignment. I wonder how long it will take me to convince Smith it is job related.”

“Want some more coffee?” asked Snook.

Questions

1. What is the focus of control in this situation?
2. What dysfunctional results have occurred from centralizing photocopying?

Case Study 3

Barriers to an Effective QI Effort

District Hospital is a 260-bed, public, general acute care hospital owned by a special tax district. Its service area includes five communities with a total population of 180,000 in a southeastern coastal state in one of the nation’s fastest-growing counties. It is one of three hospitals owned by the special tax district. The seven other hospitals in District Hospital’s general service area make the environment highly competitive.

District Hospital has a wide range of services and the active medical staff of 527 represents most specialties. The emergency department (ED) is a major source of admissions. Last year, 26,153 patients visited the ED and 3,745, or 14.3%, were admitted. This was 42% of total hospital admissions. Some admissions were sent to the ED by private physicians and some came by ambulance, but most were self-referred.

The hospital chief executive officer, W.G. Lester, noted that the number of visits to the ED was decreasing. Over a 3-year period, they had declined from a high of 29,345 to the current low of 26,153. Only part of this reduction seemed attributable to competition. Lester was also concerned about an increasing number of complaints concerning the quality of ED services. The complaints related to waiting time, poor attitudes of physicians, and questions about the quality of care. Investigation found that many complaints were justified, but the causes of these problems were difficult to discern.

Registered nurses (RNs) employed in the ED want a larger role in triaging and treating patients, but the dominance of ED physicians limits the RNs' duties and frustrates other staff, as well. This is manifested among RN staff by high turnover, low morale, and difficulty in recruitment and retention.

Another factor is the emergency medical technician (EMT) program started in the county a few years ago. The EMTs are an important community medical resource and are very influential in deciding the hospital to which patients in ambulances will be transported. It will be necessary for District Hospital, through the ED physicians, to participate actively in training and managing the EMT program if District Hospital is to receive its share of emergency patients. ED physicians have refused to participate in teaching or directing the program, however. In fact, they often alienate the EMTs.

Lester is concerned, too, that the position of full-time director of emergency medicine at District Hospital has been vacant for 4 years. Residency programs in emergency medicine are producing physicians who are seeking positions with higher salaries and better working conditions than those available at District Hospital.

There has been little turnover among the six physicians who staff the ED; they include one general surgeon (retired from private practice), two internists, and three non-U.S.-trained medical graduates with specialties in family practice. The ED physicians seem to lack a clear commitment to District Hospital. All of them contract separately with the hospital to provide ED services. District Hospital bills ED patients and collects the physicians' fees: moneys above the guaranteed minimum are paid to them

pro rata. They participate in District Hospital's fringe benefits and are covered by its professional liability insurance policy.

One ED physician, Dr. Balck (the retired surgeon), recognizes the progress being made nationally in emergency medicine. She made several unsuccessful attempts to move District Hospital in the same direction. With great effort, she instituted programs on intradepartmental education and mandatory attendance at approved courses in emergency medicine. Quality-related activities, however, are done perfunctorily. Also, she has tried to obtain full recognition of the ED and its work by other members of the PSO.

The members of the PSO seem satisfied with the situation. Its executive committee does not understand the changing status of emergency medicine. As evidence of its unwillingness to grant full recognition to the department, the PSO has consistently denied the ED's requests for full departmental status.

Questions

1. Use the problem-solving methodology described in Chapter 6 to define the problem facing Lester. Which alternative solution should be implemented? Why?
2. Describe the relationship between inpatient census and ED admissions. Outline a strategy to educate the members of the ED physician staff as to the relationship and importance of the ED to the financial good health of District Hospital.
3. Use the principles of CQI from Chapters 7 and 8 to outline a basic effort to improve quality in the ED.
4. Analyze the role of the EMTs and their relationship with District Hospital. What should be the role of ED physicians and staff at District Hospital in terms of educating the EMTs? What are the negative aspects of this educational activity? Is there a potential conflict of interest?

5. Identify some control measures that could be used by Lester.

Case Study 4

State Allocation Decisions—Centralize or Decentralize¹¹⁶

The 50 states vary in how much control of operations and funding is delegated to city and county health departments. In Ohio, for instance, the state health department provides very little funding for local health departments and provides little direction as to how they manage public health programs for the state.

In Kentucky, each local health department is generously supported by the state health department and is expected to be its agent in managing programs such as family planning, health education, and well-baby clinics. However, numerous “strings” come with the money in Kentucky. Unlike in Ohio, the Kentucky state health department dictates the local health department’s accounting systems, restaurant inspection fee structure, septic tank exception, employee health insurance benefits, and many other decisions that would be left to the local health departments in Ohio.

Still another type of state–local arrangement is that in Virginia. Local health departments in Virginia are staffed solely with state employees and are operated exclusively by policies set in the state capital.

These varied relationships raise a classic management question: centralization or decentralization of operational authority. Each approach has significant advantages and disadvantages. For example, some managers prefer the clarity and fairness of centralized systems. Others want policy setting to be more flexible and responsive—keeping it as close to the delivery site and its clients as possible.