Continuing Education

Management in the Current Health Care Environment

Howard W. Schwartz

University of Minnesota Hospital, Minneapolis, Minnesota

This is the second article in a four-part series on management. Upon completion of this article, the reader will understand: 1) the external forces affecting the health care industry; 2) the current challenges of health care management; 3) competition in the health care marketplace; 4) the current staffing crisis in medical imaging; and 5) future trends in health care management.

Whether the result of strategic planning or external forces, change within the health care industry will remain a fundamental reality in the daily operation of our professional lives as medical imaging managers. There is no looking back to simpler days when traditional fee-for-service insurance programs, manageable government spending, and static technology governed a slower, more predictable health care environment. The information revolution coupled with its corollary rise in the pace of technological change and medical advancement, continues to impact against rapidly constrained resources and an ever-aging adult population. Health care administration today must embrace these external realities and consciously manage creative strategies in order for our industry to successfully meet our patients' needs well into the 21st century.

The role and function of management in health care has changed dramatically over the past decade, primarily due to economic and social forces external to the health care industry. Department administrators are now expected to possess necessary management education in addition to the hospital's traditional reliance on technical skill and experience. These changes in managerial expectations are creating temporary shifts in the labor market for health care managers. Concurrently, the rapidly approaching shortage in technical staffing stands to become the most significant challenge facing health care management now and into the year 2000.

For reprints contact: Howard W. Schwartz, MBA, FAHRA, University of Minnesota Hospital, 420 Delaware St., S.E., Minneapolis, MN 55455.

CHALLENGES IN HEALTH CARE MANAGEMENT

Of major significance in this decade has been the development of a three-volume health care industry analysis entitled, *The Health Policy Agenda for the American People* (*1*). Guided by a 37-member Steering Committee representing allied health professionals, business, consumers, dentists, hospital administrators, insurance providers, nurses, physicians, the pharmaceutical industry, and state and federal government, this agenda reflects concensus on the issues and objectives confronting the health care system in the United States. Seven policy areas are addressed in the agenda: supplying the professionals, providing the technology and facilities, organizing the resources, communicating health information, ensuring quality, paying the bill, and preparing for the future through research. These seven focii summarily represent *the* health care management challenge today and serve to define the criteria by which our industry will succeed or fail in the future.

How health care institutions will be managed in light of this *Agenda* is the fundamental basis underlying our ability to successfully define and meet these challenges. Perhaps more important than the organizational structures which have traditionally governed institutional operations, the basic skills of the health care manager are undergoing constant evaluation and evolution. Therefore, reliance on technical competence and experience, alone, which has served our industry well over the past seventy-five years, is no longer sufficient (*2*).

An informal survey recently conducted among the leadership of the American Healthcare Radiology Administrators (AHRA) indicates several critical management skill areas which must be enhanced in order to meet future administrative expectations. In the accounting/budgeting area, greater attention needs to be paid to such subjects as gross-to-net reimbursement analysis, volume and revenue projections, procedure microcosting, budget justification, and managerial data acquisition and analysis. Stronger capital asset manage-

ment acumen is required in the areas of long range capital planning, analyzing capital replacement alternatives, managing the capital purchases, and prolonging useful capital life. Consequently, facilities planning skills must encompass the technical aspects of design and construction, space design and utilization planning, forecasting demands for space, as well as project budgeting and specification.

Health care managers must also be well versed on a variety of legal issues including regulation, risk management, professional liability, records maintenance, patient confidentiality, and the full array of contract arrangements such as joint ventures, entitlements and the like. New emphases on marketing now require familiarity with developing a marketing plan, product development and differentiation, customer relations, outreach and networking, as well as managing internal marketing of ideas to CEOs, directors, physicians and institutional staff.

On the operations side, managers must be competent in such areas as automation and information systems management, organizational politics, the art of negotiating, as well as organizational alternatives. However, it is believed that the greatest demand for increased operations management skill rests in the area of human resource management. Increased emphasis on maximizing available staff, recruitment and retention, and staff development require a keen understanding of contemporary labor issues and staffing plan alternatives in light of current manpower shortages in the medical imaging specialties.

This shift from technical competence to managerial competence can certainly be expanded to encompass all health care managers today. The underlying assumption is that the challenges facing health care administration and, thus, the skills required to meet these challenges are no different than those confronting any other industry in America. When economic times are good, even inadequately prepared managers can ride a positive trend line. However, the converse is not necessarily true. While it may have been easier, for instance, to blame deregulation and recession for the recent upheaval in the airline industry, the facts more accurately suggest that the airline industry was simply not managerially prepared to meet these external challenges (*2*). Bankruptcies and corporate reorganizations resulted with devastating effects in the short run. However, once the initial shake-down had occurred, a rejuvenated airline industry emerged with a stronger emphasis on consumerism, operational economics, and market definition (*2*).

The health care industry would be best served if management acknowledged the historical experience of others who have faced similar economic and social forces. Implicit in this acceptance is for our industry to both seek out managers who currently possess the necessary skills to creatively address the challenges identified in the *Agenda* and provide incentives for current health care managers at all levels to pursue the appropriate continuing education necessary to acquire those skills. Costs inherent in supporting continuing management education for onsite administrative staff ought to be weighed against orientation and training costs associated with bringing on prospective managerial employees. Ironically, many institutions are cutting back on continuing management education support at a time when the demand for excellence in management has never been greater.

COMPETITION IN THE HEALTH CARE MARKETPLACE

One of the most interesting outgrowths of contemporary health care industry change has been the full-blown emergence of competition among health care providers (*3*). No matter which major American metropolis one visits, you will undoubtedly be greeted by billboards, media ads and insurance promotions touting the benefits and advantages of one health care provider over another. In economic terms, this type of monopolistic competition has awakened a heightened sense of product differentiation in what had been traditionally perceived as a relatively undifferentiated industry (*3*).

It would be simplistic to assume that competition among health care providers is a phenomenon of this decade. In fact, competition has always existed where institutions competed for patient referrals in order to meet capacity and financial objectives. Managing the needs of the referring physician and providing for the care of our patients had been our basic consumer orientation. However, with the advent of managed-care organizations outside the traditional hospital environment in the 1970s coupled with the emergence of innovative reimbursement programs in the 1980s, competition for patients and referring physicians took on an entirely new dimension. In concert with this new emphasis on market coupled with the changing management style and skills required to meet the market, competition for effective health care managers was not far behind.

There may be an interesting phenomenon emerging within the health care management profession directly relating to the intensity of market changes thrust on our industry. A recent survey conducted by the Association of Executive Search Consultants indicates that the number of searches for general management positions in the United States has increased 10% from the first quarter of 1988 (*4*). While no statistics currently exist as to what portion of these searches pertain to health care (or at what levels), a cursory scanning of position changes noted in such industry publications as *Hospitals* certainly reinforces the notion that health care management opportunities are turning over at an increasing rate.

This may be the result of four concurrent career movements taking place. According to information garnered from the informal AHRA survey, first, and most obvious, is the increasing demand for nontraditional health care management skills in such areas as marketing, information management, managed-care contract development, fund raising, and industry partnerships. Second, and perhaps equally significant, is an apparent outmigration of seasoned health care managers who

find little, if any, career satisfaction in the new managerial demands being placed upon them (*5*).

A third and somewhat less visible career pattern may be reflected in the lateral mobility of health care managers seeking a more stable administrative opportunity. Such career shifts are most certainly a response to a combination of factors. In addition to the realization that certain hospitals will simply not survive current changes in our industry, such management turnover is also a function of disagreement with reactionary strategies for institutional survival promulgated by senior administrative staff (*6*). Staffing cuts, budget freezes and other short-term operational responses to financial dilemmas lacking long-term vision would be sufficient cause for any frustrated department head to seek employment in a less reactive environment. Regardless of the cause, competition for good management jobs in the health care field is being fueled by dissatisfaction with short-sighted, sometimes desperate administrative policies lacking strategic vision (*7*).

Changing job requirements reflect yet another important dimension to the changing career competition equation. As indicated earlier, technical competence at one time was a sufficient basis for promotion to department level management positions. A technologist who aspired to head an imaging department was allowed a series of promotional opportunities eventually leading to the senior spot. Senior management, on the other hand, required baccalaureate- or graduate school-level education as a minimum qualification, preferably (if not exclusively) in health care management.

It is now becoming evidently clear that traditional career paths are being replaced with new management structures. Accordingly, competition for department head positions is accentuated by demands for both management and technical competence. In the medical imaging arena, professional certification and experience were sufficient background for appointment to the radiology administrator position. Today, many recruitment advertisements found in such publications as the *AHRA Announcement* call for baccalaureate or master's level education in business along with demonstrated technical proficiency. For example, a substantive comparison of the minimum job requirements for positions advertised in the *AHRA Announcement* was conducted between two years' worth of issues: January–December 1983 and January–December 1988. Of significance was that the advertisements for radiology administrators posted in 1983 generally required AART certification and experience. However, advertisements placed in the 1988 issues placed greater emphasis on baccalaureate and master's level education with secondary emphasis (or no emphasis) on certification. Of course, technologist training is more essential for the smaller institutions as opposed to the large ones; however, the interest in management education is still as strong. This trend is presumably in recognition of the advanced management skills now required to successfully manage an imaging department. Accordingly, the AHRA is noting an increase in the number of its members now possessing business degrees at the undergraduate and graduate levels, as compared to five years ago. Personal communications with various AHRA members clearly indicate that their pursuit of an advanced management education was primarily for the purpose of staying competitive in the health care career environment.

THE NEW HEALTH CARE CONSUMERISM

Ever since Ralph Nader launched his attacks on the automobile industry, and Tom Peters and Bob Waterman focused on quality and service as the future of American industrial excellence, consumerism has been recognized as a dominant force in the American economy (*8*). Whereas the referring physician had been the traditional consumer in health care, our industry has been forced to expand our customer awareness to include third party payors, health maintenance organizations (HMOs), preferred provider organizations (PPOs), large corporate employers, and of course, our patients.

In many respects, no fundamental area of our industry has been more greatly impacted by the current health care consumerism than in the hands-on patient care arena. From a hospital administrative perspective, we have always been aware of patient complaints regarding long waits, rude and disinterested employees, poor patient education regarding complex and often painful procedures, and inadequate facilities. Presumably, the new health care consumerism prompted by the government-supported emergence of HMOs, PPOs, prospective payment, price discounting, and facilities marketing was an incentive to correct the insensitivities of our industry while concurrently dropping the price of our services (*8*).

However, it did not take long for the emergence of Medicare prospective payment and similar managed-care reimbursement programs to generate a corollary rise in the public's concern regarding the potential absence of quality in their care (*8*). Summarily, publicized reductions in health care costs and the methods employed to achieve them may have unfortunately translated into a perceived reduction in the quality of patient services (*9*). In 1984, the Joint Commission on Accreditation of Health Care Organizations (JCAHO) responded to these consumer perceptions by revising their focus away from process, and redirecting the hospital's attention toward quality and patient service (*9*). Health care consumerism had been officially acknowledged and recognized within the hospital accreditation framework.

At the department management level, consumerism has moved well beyond quality assurance and JCAHO accreditation oversight. For purposes of differentiating their products, health care institutions are engaging in a variety of patient relations programs designed to identify patient care services needing improvement as perceived by the patient (*8*). These same institutions are now vying for a greater number of satisfied outpatients in order to offset the decline in inpatient days allowed. The shift to outpatient services has also reinforced the need for health care institutions to better serve the patient as customer. Whereas the inpatient generally uses all services provided inhouse, the outpatient has substantially greater flexibility as to which health care services will be utilized, and where they will be provided. Consequently,

greater emphasis is now being placed on customer service and satisfaction, aesthetic facilities, improved turnaround times for physician communications, enhanced patient amenities such as convenient parking and attractive cafeteria services, plus a wide variety of other consumer issues.

STAFFING CONCERNS IN MEDICAL IMAGING

While there may be a perceived increase in the number of health care managers looking for progressive administrative opportunities, quite the opposite is true with respect to the availability of technologist staff. Early in 1987, representatives from seventeen societies and associations allied with the medical imaging and radiation/oncology specialties came together to assess current and future trends in staffing. Adopting five focii for study, the Summit on Manpower continues today to explore the means by which a perceived staffing shortage can be validated and acted upon before these concerns reach crisis proportions. In a study recently conducted by the AHRA on behalf of the Summit on Manpower,* a significant number of hospitals throughout the United States reported experiencing increased and disparate difficulties in filling vacant positions for radiologic technologists, diagnostic medical sonographers, radiation oncology technologists, and nuclear medicine technologists. Supported by documentation provided by the American Hospital Association and others, the Summit's data indicate that potential shortages may be realized throughout the health care industry by the year 2000.

How administration responds at the department head and senior management levels to this labor shortage problem may signify the difference between future financial success and failure. Health care's traditional reliance on profit margins from medical imaging to fund other cost center staff positions may be in serious jeopardy if a full complement of technical staff is not available to meet projected demand for medical imaging services. Referring physicians will be left with little choice but to send their patients to departments able to handle the most immediate scheduling requirements. Since inpatients' needs must be met on a shortened stay basis as a result of prospective payment constraints, timely outpatient procedure scheduling will suffer due to decreased staff availability. Given the current profitability of outpatient services not reimbursed prospectively, decreased volume in this area will have a critical effect on overall institutional revenues.

While hospitals had been seeking methods for reducing staff positions in medical imaging, this labor market shortage may eventually push demand well beyond the availability of supply. Management efforts to enhance staffing recruitment incentives currently have revolved around upward adjustments in salaries and benefits, provision of recruitment bonuses and perquisites, and recruitment of credentialed health care personnel willing to return to the workplace on a temporary or flexible basis. Consequently, labor costs associated with these recruitment incentive programs may rise faster than inflation and thus create a new set of problems for our industry in addition to the ongoing concern regarding overstaffing in a prospective payment environment.

HEALTH CARE MANAGEMENT IN THE NEXT CENTURY

Much has happened over the past two decades, forcing significant changes on the management of our health care system and institutions, alike. Health care administration at both the department head and senior staff levels is evolving in response to these challenges. This is reflected in an increased emphasis on entry-level management skills in accounting/budgeting, capital asset and facilities planning, legal issues, marketing, and human resource management, in addition to continued reliance on technical competence and experience.

It is generally believed that rapid technological change and the advanced aging of our general population will continue to adversely impact the cost of health care services while the dollars available for reimbursement will continue to decline. Staffing shortages will grow in severity at a time when consumers will demand more in the delivery of health care services. New medical procedures will be developed to join an already impressive array of health care programs available in this country (*7*).

While it may be sheer folly to predict the future in the midst of these present challenges, one absolute certainty emerges. The success of the health care industry will be totally dependent on the availability of astute, dedicated managers committed to the basic values which have always sustained us: the welfare of our patients and access to our services. As medical imaging and therapy administrators, we can play an ever increasing role in shaping our industry's adherence to these values. Our calling as health care professionals has never been greater.

NOTE

* Publication of the findings from Manpower Summits I and II currently are in production by AHRA Publishing, P.O. Box 334, Sudbury, MA 01776 and will be available for general distribution in May 1989. Copies of specific data cited are available from the author.

REFERENCES

1. American Medical Association. *The Health Policy Agenda for the American People*, Vol. 1. Chicago: 1987:1–29.

2. Schwartz HW. New directions in radiology management. Presentation at the AHRA Western Region Annual Meeting, Phoenix, AZ, May 18, 1988.

3. Schwartz HW. Quality assurance/utilization review: Challenging the successful radiologic practice. Presentation at the Radiologic Society of North America, Chicago, IL, December 3, 1987.

4. Anonymous. Middle managers, victims of the '80s, making a comeback. *Minneapolis Star Tribune* 1988 Nov 6:1D.

5. Schwartz HW. Radiology's unrewarded partner. *Radiology Management* 1986;8(1):9.

6. Schwartz HW. The staffing dilemma. *Radiology Management* 1987:9(1):22–25.

7. Schwartz HW. New directions in diagnostic imaging: Venture into change and opportunity. *Radiology Management* 1987;9(2):45–48.

8. Schwartz HW. Utilization review in diagnostic imaging: Can quality be cost-effective? *Radiology Management* 1987;9(3):40–45.

9. Affeldt J. Foreward. In: *Accreditation Manual for Hospitals, 1984*. Chicago: Joint Commission on Accreditation of Health Care; 1984.

MANAGEMENT IN THE CURRENT HEALTH CARE ENVIRONMENT

For each of the following questions, select the best answers. Then circle the number on the reader service card that corresponds to the answer you have selected. Keep a record of your responses so that you can compare them with the correct answers, which will be published in the next issue of the *Journal.*

A. *In the current health care environment, relying on technical competence and experience is no longer sufficient.*
101. True
102. False

B. *The greatest demand for increased operations management skills is in the area of:*
103. automation.
104. human resources.
105. information systems.

C. *The "Health Policy Agenda for the American People" proposes criteria by which the health care industry will succeed or fail in the future.*
106. True
107. False

D. *Policy areas addressed in the "Agenda" are:*
108. research.
109. communicating health information,
110. staffing.
111. all of the above.

E. *Competition for patients has become a major factor in management strategy with the emergence of:*
112. nonhospital based health care organizations.
113. innovative reimbursement programs.
114. 112 and 113

F. *In recent years, the search for general management positions in health care has:*
115. increased.
116. decreased.

G. *When recruiting for managerial positions, health care institutions are searching for:*
117. technical competence.
118. advanced degrees.
119. business degrees.
120. all of the above.

H. *Consumerism plays an important role in the health care environment of recent times.*
121. True
122. False

I. *Health care consumerism has become:*
123. a minor focus of hospitals.
124. the major cause of the staffing current crisis.
125. part of the institution's accreditation framework.

J. *The JCAHO _____ revised their focus from process towards quality.*
126. has not
127. has

K. *The availability of health care professionals is:*
128. increasing.
129. decreasing.

L. *Management efforts to enhance recruitment efforts are:*
130. higher salaries.
131. recruitment bonuses.
132. flexible or temporary hours.
133. all of the above.

M. *In the future, staffing shortages will grow while demand for services:*
134. decreases due to aging of the general population.
135. increases due to aging of the general population.
136. decreases while available reimbursement dollars decline.

Your answers to the above questions should be returned on a reader service card (found in the back of the *Journal*) no later than September 1, 1989. Remember to supply your name and address in the space provided on the card; also, write your VOICE number after your name. Your VOICE number appears on the upper left hand corner of your *Journal* mailing label. No credit can be recorded without it. A 70% correct response rate is required to receive 0.1 CEU credit for this article. Members participating in this continuing education activity will receive documentation on their VOICE transcript, which is issued in March of each year. Nonmembers may request verification of their participation but do not receive credit.

Answers to CE Article Tests, March 1989

The Continuing Education article in the March 1989 issue, "DRGs and PPS—Their Effect on Hospitals," by Mark R. Gavens was accompanied by a CE article test. The correct answers are:

A. 103	D. 110	G. 118	J. 126	M. 135
B. 106	E. 114	H. 121	K. 130	N. 140
C. 107	F. 117	I. 124	L. 133	O. 142

The answers to the CE article test on "Gallium Imaging in Acquired Immunodeficiency Syndrome" by William G. Spies are:

A. 145	D. 159	G. 166	J. 176	M. 187
B. 150	E. 160	H. 169	K. 179	N. 189
C. 152	F. 162	I. 174	L. 183	