Take Charge: Managing Six Transformations In Health Care Delivery

Changes occurring in the health care industry are substantive and constitute a paradigm shift. Nurse managers can participate in shaping the health care organization of the future by understanding six critical areas of transformation and their driving forces.

The political environment of health care organizations has been tumultuous over the past several years. In anticipation of health care reform legislation and as a response to payer pressures, health care organizations are making fundamental changes in their structure and business lines. The revolutionary nature of these changes constitutes a paradigm shift (Kuhn, 1962), rather than an adaptation to changing markets.

Regardless of whether Congress passes comprehensive health care reform legislation, the paradigm shift in the health care industry will continue in varying degrees. By understanding critical areas of transformation, nurse managers can influence the direction of these transformations.

We identify six transformations that constitute a paradigm shift in health care delivery. The changes are interconnected, although each is discussed separately. These transformations are the change from: (a) the person-as-customer to the population-as-customer; (b) illness care to wellness care; (c) revenue management to cost management; (d) autonomy of professionals to interdependence of professionals; (e) patient as nonconsumer of cost and quality information, to patient as consumer of cost and quality information; and (f) continuity of provider to continuity of information. Issues for nursing management related to each transformation, and ways in which nurse managers might shape the direction and nature of the transformations are discussed.

Understanding the Momentum

The paradigm shift in health care delivery is occurring and will continue regardless of whether health care reform legislation is passed. Nurse managers and administrators can participate in directing the course of this paradigm shift. Two theoretical perspectives are useful to understand the momentum of the paradigm shift and how to participate in shaping the transformation.

One momentum for change occurs because organizations are active creators of the anticipated future, not merely responders or adapters to environmental changes. By anticipating the future, organizations act in ways that create the "anticipated future" (Weick, 1979).
Another momentum for change occurs because some organizations, often referred to as “first movers,” act before others by creating new structures and business arrangements. Institutional theory (Meyer & Rowan, 1977) suggests that these risk-taking organizations, when successful, legitimize new organizational forms and processes that then gain wide acceptance. In this way, they shape the environment of other organizations. Organizations that are not among the early actors will face legitimacy problems, with an associated loss of resources, if they do not also adopt the new institutionalized organizational forms and processes (Arndt & Bigelow, 1992).

Together enactment and institutionalization are forces that create momentum for the paradigm shift that is occurring in the health care industry. For example, during the 1992 presidential campaign, health care reform was put on the national agenda. Across the nation, health care executives and professionals observed, or were involved in, many discussions about the future role of health care providers. Possible new payment arrangements, and new strategies for controlling costs. Within months, hospital systems had “caught merger mania” (Greene & Lutz, 1994). Although the President’s plan had not been fully specified, health care executives anticipated that certain specific changes would occur, and acted accordingly. Actions taken by health care organizations, in effect, created the anticipated reform of the health care environment. These organizations enacted (Weick, 1979) and continue to enact a new environment for health care delivery. Once some health care organizations had taken successful action, others followed suit. Changing perceptions of what organizational forms and processes are appropriate are causing slower-acting organizations to change (to be legitimized) as predicted by institutional theory (Arndt & Bigelow, 1992; Meyer & Rowan, 1977).

Understanding gained from enactment and institutionalization theory can be used by nurse managers to create the health care organization of the future. For each of the six transformations that constitute the paradigm shift in health care, nurse managers can create new environments or establish new organizational forms that will put their organization in a leading, rather than following, position.

#1. From Person-As-Customer To Population-As-Customer

Health services are being provided to large groups of individuals, usually defined by employers, through managed care or capitated contracts. The steady increase in the rate of enrollment into managed care organizations over the past 10 years (Kenkel, 1994; Wholey, Christianson, & Sanchez, 1992) is indicative of the change to population-as-customer. The Health Securities Act would make managed care a universal concept for financing and delivering health care. Although it is not yet legislated, health care organizations are positioning themselves in health care markets to provide services to as many individuals as possible within a population (community, locality, or region), albeit to boost operating margins (Greene & Lutz, 1994).

Management issues. The majority of any population is well, and yet, within a population a great diversity and range of severity of health problems exist. Managers must understand this diversity and be prepared to address it effectively, as well as develop incentives to promote health. Also, when estimating capitation rates, managers will need to accurately reflect both the wellness potential and the illness potential of the population. To predict and address the population’s health needs and health behaviors, health service managers and providers will need to understand epidemiologic and social demographic data and trends. Understanding population characteristics for the purposes of program development, pricing, and marketing will have greater salience for managerial decision making.

Directing the shift to population focus. Shaping the transformation to population as customer can be fostered by nurses through two approaches. One approach focuses on nurse managers’ involvement in negotiating managed care contracts. The exploitation of nurses can be used to identify target populations with which to negotiate contracts for providing health care. Detailed information defining nursing services and their costs and outcomes can be used by contract negotiators in obtaining profitable yet competitive contracts. With a few strong demonstrations by early risk takers, nurse involvement in contracting for services could become the norm and legitimized within the structures of health care organizations.

The second approach focuses on enacting new populations for the health care organization. Nurses can engage in community action and assist the disenfranchised, such as Medicaid populations, small businesses, and the uninsured, to form ad hoc alliances and assist them to negoti-
ate for health services. In this way, the nurse manager is enacting an environment in which all populations are potential customers.

#2. From Illness Care to Wellness Care

When health care organizations take responsibility for a population's health under a capitation payment system, the financial incentive shifts from inducing customers to use expensive services to inducing them not to use expensive services. As a result, hospitals have become more involved in health promotion programs (Coile, 1994) and ambulatory care. From a managerial perspective, promotion of healthy lifestyles is a means to reduce demand for expensive, acute care services (Grundberg, 1994). Programs specifically designed to improve the overall health of a community will become routine for managed care organizations (“Capitation Could Make,” 1994).

Management issues. With the shift to population-as-customer, health problems with social etiologies (lack of housing, inadequate nutrition, family violence) will become more obvious and salient to health care organizations because those problems may hamper the goal of keeping customers healthy. Researchers have repeatedly demonstrated correlations between health status and social problems (Conger, Lorenz, Elder, Simons, & Ge, 1993; Lobel, Dunkel-Schetter, & Scrimshaw, 1992). Having the population-as-customer leads to the need to address underlying social etiologies of many health problems within the customer population.

The change to wellness care also necessitates redefining the health service, particularly with regard to health promotion, disease prevention, social interventions, and public health. Historically, health departments, almost invisible entities, have played a role in maintaining the health of the population through programs that have specific preventive foci. Health care organizations may find it strategically sound to provide the population-as-customer with traditional public health services, particularly control of communicable diseases and environmental hazards. Health services managers will increasingly face issues inherent in collaborating with health departments to provide such services to their customers.

In addition, the change to wellness care requires restructuring the illness care organization into a wellness care system, inclusive of early, preventive interventions by primary care providers. Restructuring the organization for wellness care encompasses downsizing acute care facilities and upsizing primary care facilities and providers. One issue for managers is whether the health care organization ought be organized around traditional medical specialty care that is illness focused, or around primary care that is population-based and wellness care focused. Another restructuring issue is whether to provide services through a network of providers (such as IPAs and PPOs), or a network of health care organizations (such as Columbia/HCA). Regardless of the network type, with primary care as the central health care service, new structures among providers throughout the networks will be needed.

Defining the change to wellness. Changing the health care system into a wellness care system requires that managers be visionary and foster changes in shared cognition (Daft & Weick, 1984) of organizational members, particularly regarding the meaning of health and health care. Using knowledge from nursing, nurse managers can reinforce the change to wellness through actions that will establish new operational definitions of health and wellness for the customer and organization that are population-focused.

Nurse managers can plan and develop services based on a wellness-care model. Specific wellness care services can be defined by matching existing or new business lines of the organization with the diversity of existing and potential health concerns and problems of the customer population. Acting to create wellness care business lines for new populations is one strategy for establishing new institutionalized norms of what constitutes wellness care.

One radical approach to redefining the core services is to consider that wellness care includes the prevention of health problems through social intervention. For nurse managers, at issue is the level of responsibility that the health care organization will assume for resolving key social problems affecting the health of its customer populations. If the health care organization embraces a broad spectrum of wellness care, then another issue for managers will be learning to either compete or collaborate with existing community social service agencies for federal or other grants to fund social interventions and programs. By taking the initiative to engage in these negotiations, nurses can establish this activity as a norm for health care organizations.
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#3. From Revenue Management to Cost Management

A health care organization, or more likely a network of organizations, that accepts responsibility for providing care to a population under a capitated financial arrangement, also accepts financial responsibility for all services provided to the population. Logically, then, managers' attention turns to costs across an episode of care, or, more consistent with a wellness focus, costs across a lifetime of health care.

Management issues. Managers and providers will no longer be rewarded for generating revenues. Such revenue generation, beyond the attainment of managed care contracts, will not exist. The cash generators of yesterday, especially hospitals, become enormous cost centers, and the balance of power among providers in all segments of the delivery system changes. According to Shortell, Gillies, Anderson, Mitchell, and Morgan (1993), historically, hospitals generated the most cash flow in the health care system. However, "today's 'cash cows' may well become tomorrow's 'dogs,' and continued investment in them to the exclusion of newly emerging priorities could bring down the entire system" (p. 453).

A salient management issue will be the development of ways to reward managers and providers for performance and actions other than revenue generation. Although nursing services in acute care settings primarily have been cost centers, for years nurse executives have debated the advantages and prestige associated with the nursing department as revenue center versus cost center. Thus, nurse executives have years of experience and a wealth of knowledge to lead health care organizations in planning low-cost, high-quality care.

The hospital chief executive officer (CEO) will no longer be at the pinnacle of health care management. A study of integrated health care systems conducted by Shortell et al. (1993) demonstrated that the hospital CEO position could be eliminated by moving the CEO responsibility to system-wide performance with rewards for performance of the whole system. Health services managers, however, will face the difficult challenge of changing the role of the hospital from being the center of an illness care system with a goal of maximizing revenue generation, to being a support service in a wellness care system with a goal of minimizing costs, namely those resulting from use of acute care services.

Directing the shift to cost management. When the cost of care across an episode of illness, or across a lifetime, is the focus, the delivery system, not a department or service entity, is the unit of consideration. Issues will surface concerning how to reward managers for their performance in their departments or divisions while meeting the system goals of the health care organization. All health services will be cost centers and nurse executives can use their expertise to provide the leadership needed to develop new reward systems. Shortell et al. (1993) suggested several strategies for creating new management incentives. Instead of rewards for keeping inpatient beds filled, managers could be rewarded for integrating care across settings so that "patients are treated at the point in the continuum of care where the most value is added (i.e., cost/benefit)" (Shortell et al., 1993, p. 452). Implementing these and other innovative reward systems creates organizational structures through which cost, not revenue, is managed.

Entirely new marketing strategies will emerge that induce individuals to engage in healthy lifestyles. This is necessary to reduce the financial risk to the managed care organization. Nurses can forge partnerships with health clubs, fitness trainers, and nutritionists that may emerge as institutionalized components of health care provided by the managed care organization as incentives for population fitness.

#4. From Autonomy of Professionals to Interdependence of Professionals

One hallmark of professionalism has been autonomy (Light & Levine, 1988), whether institutional, administrative, or operational (Raelin, 1989). Operational autonomy, the freedom in choice and performance of tasks to accomplish a goal, has been synonymous with health professionals, especially physicians. Numerous factors (O'Connor & Lanning, 1992), including the change toward managed health care systems, have resulted in decreased autonomy of health professionals.

Concurrent with the decrease of physician autonomy, managers in health care organizations are experiencing decreased autonomy as they are required to act interdependently with workers. The shift toward interdependence of managers and workers is evident in the rise of the quality improvement movement in health care, and the rise of shared governance in nursing in the late 1980s (Conte, Barhyte, & Christman, 1987). With the change to interdependence, physicians, other health care pro-
professionals, and managers are making fewer decisions without involving key stakeholders. Including the patient and the population. This is a fundamental change from the traditional notion of professionally dominated organizations (Fogel, 1989). Individual and organizational autonomy are being supplanted by interdependence in meeting both patient care and financial goals.

Management issues. The shift toward interdependence of professionals brings a set of issues for management: coordinating the interdependencies, and identifying and fostering interdependencies that result in new synergies. Thompson’s (1965) three types of interdependence—pooled, sequential, reciprocal—focus on relationships among those doing the work, and has been a cornerstone of management science. With the change to interdependence among professionals, managers, and patients, a fourth type of interdependence is emerging within health care organizations. This fourth type of interdependence, that we will name consensual, reflects the values of an information society and consumerism. Consensual interdependence is the negotiated agreement among those doing the work and the customer regarding what needs to be done and how, and is consistent with viewing the patient as a member of the organization (Mills, 1986). Managers will face exponential challenges in tracking, understanding, and modifying the four types of interdependencies, especially in highly complex health care organizations of the future.

The increased interaction among interdependent professionals will be accompanied by more opportunities for conflict and managers will need to be skilled in conflict resolution. Finally, managers will need creative team building skills to develop and administer strategies for moving themselves and others up the learning curve of the shift to interdependence.

Directing the shift to interdependence. By identifying and maximizing synergies related to interdependencies among professionals and customers, the nurse manager can create additional synergies that enhance health care and the financial viability of the organization. To actualize potentially beneficial synergies will require incentives for teamwork, collaboration, and communication. New reward systems must be reconciled with the need for autonomy and traditional roles of professionals. Such incentives will institutionalize interdependence and the focus on synergies.

In addition, consensual interdependence will require new forms of information exchange within the provider-patient relationship, both at the individual and population level. In a wellness care system it will become apparent that dictating a treatment regimen that customers are not happy with, and won’t follow, will not meet the goals of either the organization or the customer. Managers must develop mechanisms by which health professionals can engage in creative planning with patients that is less “giving” of information, and more “sharing” of information. Through consensual interdependence, the customer, the health professional, and the manager may negotiate a course of action that will produce a more favorable outcome for the patient and the health care organization. In this way consensual interdependence is akin to demand management (Lynch, 1993). Nurse leaders in health care can establish mechanisms for consensual interdependence and thereby set this as a norm in health care. These same mechanisms will serve to create the expectation on the part of the consumer and professional for interdependence, and on the part of managers for synergies.

#5. From Continuity of Provider to Continuity of Information

Historically, continuity of care has been accomplished by trying to maintain the same care provider across temporal and physical boundaries. In a nursing unit, for example, primary nurses assure continuity by being available across shift boundaries on a 24-hour basis and, when patients are re-admitted, they are assigned to the same nurse. General practice physicians assure continuity by following patients across physical boundaries between their offices and hospitals. Through continuity of provider, the patient receives continuity of care in as much as a provider possesses personal and clinical knowledge of the patient. Continuity occurs because providers cross the temporal or physical boundaries and bring with them knowledge about the patient.

The meaning and operationalization of continuity will change and become predicated upon having complete, accurate, and timely information that moves with, or preferably ahead of, the patient. Managed care organizations cannot totally rely on providers to assure continuity. Continuity, when based on providers, is fallible, as is evident in duplicated diagnostic tests and procedures in many traditional health care organizations. In a managed care organization, a patient may see many
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providers in different locations during an episode of illness. For this reason, continuity based on providers becomes too costly for managed care organizations. Therefore, the shift to continuity based on information is occurring.

Continuity of information requires sophisticated information systems. The information systems developed to date primarily serve the information needs of an individual provider or group, such as the primary care physician, or the needs within a department, such as a hospital accounting department. Few information systems have effectively integrated clinical and financial information about an individual patient for an entire episode of illness, let alone about a population for the lifetime of each member of that population.

Management issues. Managers must have adequate information systems to understand populations, predict and manage costs and outcomes (Morrisey, 1994), and to synergize the efforts of interdependent providers and organizations. To effectively serve the population as customer, managers require information about populations' health risks and needs, as well as those for the individuals within a population. This information must be in a form such that managers can obtain descriptions of populations' health and accurately predict future use of health services. Such analysis enables managers to negotiate capitated contracts (as discussed earlier) that cover expected costs for the managed care organization and desired outcomes for the population.

Person-based information is also required, however. As a person moves through the managed care organization, it is essential that the information unique to that person is readily accessible by any health professional providing care to that person. Interdependence among departments or branches of a managed care organization necessitates having information systems that transmit clinical and financial data, "on time," and across geographic boundaries. Information systems must make readily available to providers the data needed to avoid duplication of diagnostic testing, treatments, and followup efforts.

Because each provider, department, and branch of a managed care organization is a cost center, information systems are needed to track practice patterns and clinical and financial outcomes for each provider within the managed care organization. Managers must keep costs in line with the capitated contracts and this requires having timely and accurate information about costs and service outcomes for the customer population. Cost information about a specific patient, or a specific department will not be as useful to managers' decision making as information about the whole managed care organization.

Directing the shift to information continuity. Planning as though an information continuity existed contributes to creating information continuity as a future environment for decision making, and is necessary to design the system. Therefore, nurse managers should plan and develop health care services and packages as though continuous patient information was available. Although it may take several years to achieve information continuity, identifying the information needs through the planning process can stimulate the health care organization to expedite developing the information systems.

Another approach is to use innovative strategies to establish continuity of information as an institutional norm. For example, providers can communicate quickly through an electronic medium, and more expensive and time consuming face-to-face encounters can be reserved for complex situations requiring high media richness (Daft & Lengel, 1986). Before patients begin to carry a card with a computer chip containing their total health and illness records, organizational structures can be established for updating records during each service encounter, and for thinking of the information node as the patient, rather than the provider. Managers can use these and other information systems innovations to foster synergies that result from interdependence among providers and patients.

#6. From Patient as Nonconsumer of Cost and Quality Information, to Patient as Consumer of Cost and Quality Information

In the old paradigm, health services managers assumed that consumers, both payers and patients, had minimal interest in or knowledge about the services they received. For example, individuals knew that their insurance covered 80% of their health care cost. Thus, they generally did not ask questions about providers or what services were available through this coverage. Those questions were postponed until a health need arose. In the new paradigm, however, payers and patients want information about the package of services available to them, the quality of those services, and the per-capita price of those services because they pay up-front for a health care package and what is in a health care package can vary substantially among managed
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care organizations. When customers, whether individuals or populations, choose a plan, they are choosing the set of services and providers before there is a need for those services.

With the option of selecting a preferred set of services and providers, customers will be more concerned about the quality of the services provided. In the old paradigm, quality information was not readily available from providers or organizations nor was much effort assigned to measurement and analysis of quality data. Since the first publication of the Health Care Financing Administration mortality data for hospitals in 1986 (Fleming, Hicks, & Bailey, 1995), patients and payers have become increasingly savvy in their demands for and knowledge of health care. With the shift to consumption of health and quality information, sophisticated mechanisms for measuring and publishing such data will be necessary. In a wellness-care system, information will be centered around patients' involvement in planning care (consensual interdependence), maintaining wellness, and use of services (cost management).

Management issues. Management issues that arise with the change to patients as information consumers may be the most difficult issues for managers. Effective management of this shift will require a change in the balance of power among payers, patients, and providers, and new kinds of relationships among them. Three management issues require attention.

First, managers and health professionals will no longer be able to assume that they already know what customers need or want. When customers use health information they realize that the doctor may not know best.

Second, managers will need specific and detailed information about the content, processes, and outcomes of care in their health care organization. This information will be necessary not only for managerial decision making, but for presentation to consumers. Women, for example, may want to know their prenatal care options (content), the organization's rate of cesarean-sections (processes), and the rate of low birthweight infants (outcomes) before choosing a managed care organization. Men may want to know their options for heart "health" care (content), the system's rate of bypass surgery (processes), and the rates of mortality and morbidity due to heart disease (outcomes). The customer population will want information about a health care organization's ability to make positive changes in a population's health status. Managers will be responsible for knowing and developing techniques to present the variety of information that can be used to inform consumer groups about an organization's performance.

Third, managers can more successfully compete for health care contracts by sharing quality and cost data with customers and negotiators. Those who contract for services on behalf of the population customer will want access to data regarding the quality of services provided and outcomes experienced by other populations.

Directing information consumption. Nurses can foster the shift to patient as consumer of health information by anticipating the information needs of individuals and populations. For example, high use of primary health care services is often the result of a lack of self-care information for treating minor illnesses such as colds (Lynch, 1993). Managers can increase the population's access to self-care information through printed materials, videos, and dial-a-nurse phone services. Nurses have been at the forefront of patient education for many years and can use that expertise to get information to individual patients earlier in the course of an illness or at optimal times for prevention. Another approach to increasing information consumption is to infuse the population with information on illness prevention and health promotion so that patients have the information for developing high levels of health with low demand on services.

An alternative approach is to forge new relationships with payers, employers, providers, and patients. Nurse managers will have to listen to payers and patients about what information they want and need, and to health professionals about what is possible. A series of negotiations may be required to create alliances among payers (who also may be employers), patients, and providers. For example, we will see managers and health professionals going to employers and employee representatives to engage in a dialogue about health care relationships based on available quality and cost information.

Nurse managers are in an excellent position to develop the databases necessary to demonstrate what services nurses provide, how they influence a population's health, and at what cost. Clear and simple communication of such data will be critical to negotiating managed care contracts that include nursing services. Thus, nurse managers can take leadership in developing the appropriate techniques to effectively present the variety of information that consumer groups will use to make
judgments about the health care organization's performance. The customer population will want, in particular, information about a health care organization's ability to make positive changes in a population's health status.

Conclusion

The health care industry is changing radically. The six transformations described are just beginning, but the power of enactment and institutionalization will ensure that the changes continue and result in a paradigm change in health care. For managers, it is not a question of if the changes will occur, but what are the best courses of action and how can nurse managers participate in directing the transformations. Nurse managers are able to enact health care reform, without any legislation, and create, with vision and commitment, a healthy future for the people of this nation.$

REFERENCES


Dual Graduate Degree in Nursing/Business

Johns Hopkins University's School of Nursing and School of Continuing Studies have joined forces to offer a new part-time dual master's degree program in nursing management and business. The new MS in nursing/MS in business program aims to prepare nurses to successfully manage nursing services and integrated health services. For more information, contact Pat Wafer at (410) 290-1260; wafer_p@jhuums.hcf.jhu.edu

Nurse Executive Survey

According to a study of nurse executives by the American Organization of Nurse Executives: The average base salary nationwide is $91,800, up from $77,670 in 1990: 60% of nurse executives report to the CEO and 32% to the COO; 91% are females, down from 95% in 1990: 40% expect to be in health care but in a new position after 5 years; almost all expect to become a CEO or COO.