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REORGANIZATION OF A HOSPITAL IN ENSURING SURVIVAL

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A Project  
Presented to the  
Faculty of  
California State University,  
San Bernardino

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In Partial Fulfillment  
of the Requirements for the Degree  
Masters of Arts  
in  
Special Major

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by  
Evelyn Chidinma Nwaomah

June 1988

REORGANIZATION OF A HOSPITAL IN ENSURING SURVIVAL

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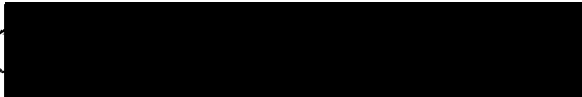
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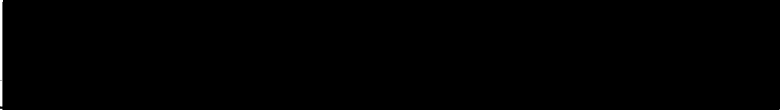
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## ABSTRACT

The ability to coordinate an organized, quality delivery of healthcare system result in effective and efficient patient care. This paper details a brief history of a hospital operating at a loss due to pressures of economic and political forces. This paper also analyzed four projects: First project involved staffing patterns for counselors in hospital or chemical dependency unit. Second project explored utilization of Certified Registered Nurse Anesthetist in rural areas. Third project analyzed criteria for surgery team in rural area with special concern on liability insurance coverage for Nurse Anesthetist. The last project involved master price charge system and a brief discussion of internal control.

REORGANIZATION OF A HOSPITAL IN  
ENSURING SURVIVAL

INTRODUCTION

A brief history of the hospital that pioneered my administrative experience will help increase our understanding of the nature of reorganization of a hospital.

Mountains Community Hospital Lake Arrowhead started as Santa Anita Hospital operated by the Sisters of St. Joseph of Orange. This hospital was opened in 1951 as a 37-bed hospital with eight nurses. The community that it serves saw the hospital as an emergency facility rather than an organization with full ability to coordinate organized quality delivery of efficient and effective patient care. The hospital was operating at a loss due to pressures of economic and political forces in the hospital's business environment. Therefore, survival was questionable. The Sisters of St. Joseph announced that they could no longer operate the hospital.

The mountain community at this time realized that they could suddenly be cut off without an adequate health care facility. The community therefore purchased the hospital. A new hospital leadership with a different focus was emerged. This new hospital was named Community Corporation, a non-profit organization governed by



community leaders. A non-profit hospital is defined as,

A hospital which is a corporation which turns its profits back into the hospital and has a non-taxable status. It is usually community owned or owned by a church or society or other services minded organization (Timmreck, 1982).

The mission of Community Corporation was to purchase and operate the hospital for the benefit of all people living in the mountain communities. The total purchase price was \$530,000.00 with a down payment of \$180,000.00 raised by these dedicated business and community leaders (Personnel Policy Manual, 1987).

To ensure survivability the next step taken was to raise sufficient funds to meet the notes and operating deficits. A fund raising dinner featuring many celebrities was held. One hundred local citizens pledged one thousand dollars or more to assist in the operation of the hospital. Their names are listed on a plaque located in the lobby of Mountains Community Hospital Lake Arrowhead.

The hospital went into operation May, 1965. Under a new governing structure and with a commitment from the community in November 1967 the community voted for the hospital to become a district hospital, and assumed a new name San Bernardino Mountains Community Hospital District.

Hospital districts are governmental subdivisions established for the purpose of supporting and administering hospitals through the power of taxation of the population in the district (Timmreck 1987).

The hospitals are governed by a board of directors elected by the district residents. This makes the district independent of city, county or state government. Hospital district form of a health care organization are seen mainly in Texas and California.

Under the new name San Bernardino Mountains Community Hospital District, the community leased out the hospital. Westworld Community Health Care, Inc. signed a 30 year lease agreement with the District Board of Directors and assumed management in September, 1984. Due to changing reimbursement and competitive dynamics resulting in new incentives and constraints, Westworld Community Health Care Inc. filed bankruptcy in June 1987. The District Board of Directors assumed interim management upon an agreement with the trustee. In a desperate move to keep the hospital open a plea to several major healthcare organizations was made. The management of the hospital was then contracted by the San Bernardino County Hospital. In November 1987, the District Board of Directors regained control of the hospital by purchasing the assets from Westworld Community Health Care Incorporation (1987).

#### CURRENT ORGANIZATIONAL STRUCTURE AND OPERATION

My Administrative Residency started January 4, 1988 under Mrs. Shirley McCarty, R.N. acting Administrator.

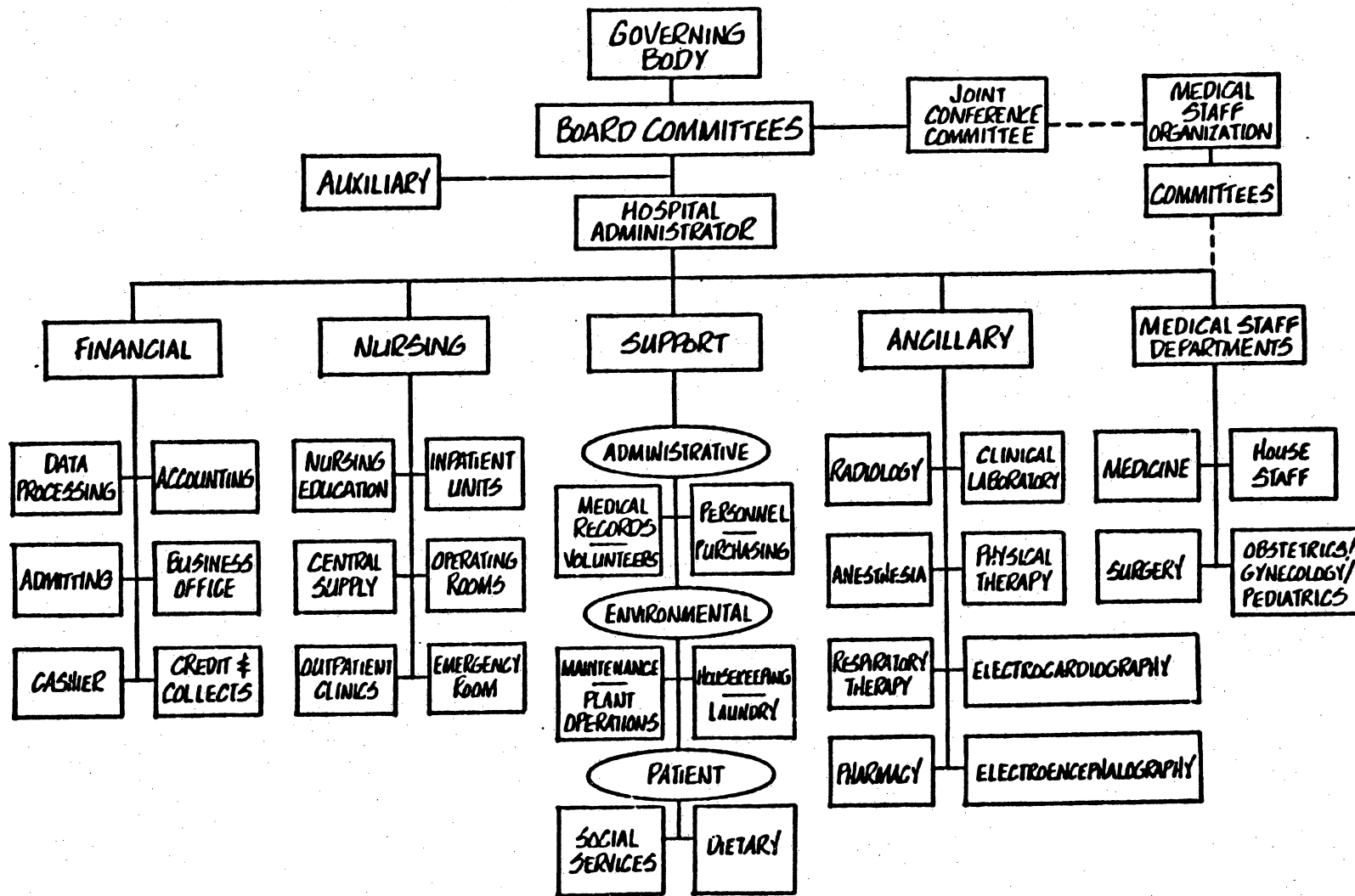
(See organizational charts, Figure 1, A Typical Hospital Organizational Chart; Figure 2, the current Mountain Community Hospital Lake Arrowhead Organizational Chart.)

The governing body of the organization is generally referred to as the board of governors, board of trustees of board of directors. The board delegates its authority to the administrator, chief executive officer, director, or president of the hospital. The administrator generally has associate administrators, assistant administrators, or administrative assistants that handle operational aspects of the day to day functioning of the hospital. In the department or functional organization of the hospital, there are at least four major types of functions: (1) Nursing functions, (2) ancillary or professional services, (3) business or fiscal functions and, (4) support services. Please see charts.

Although an organization chart serves a purpose, it has some limitations. One limitation as stated by Snook, (1981), is that it does not include hospital's informal organization and physicians are not showing formal authority relationship. This of course confirms why hospitals have not effectively lowered physician's autonomy but rather foster many of the hospital resources to the medical staffs.

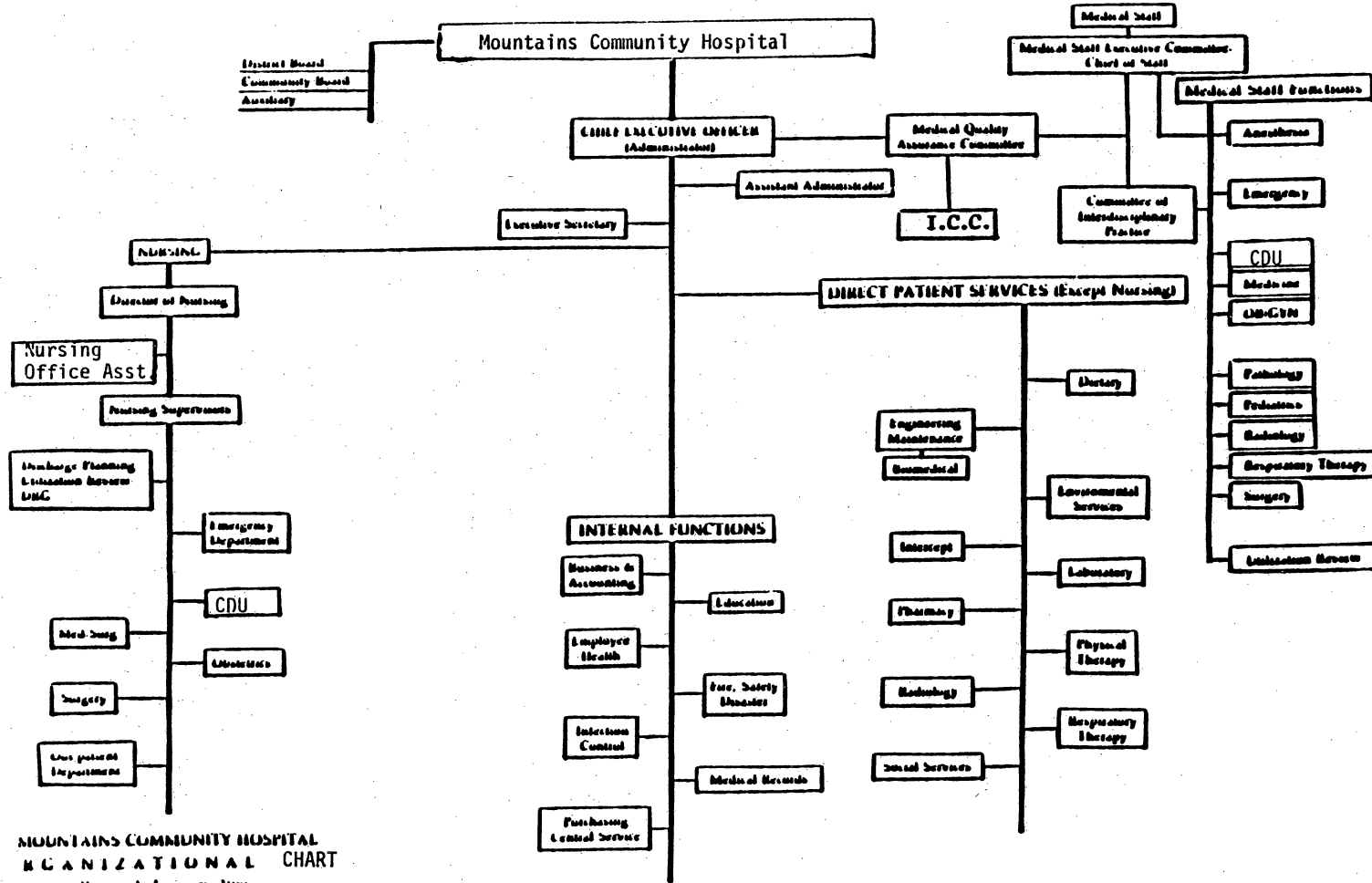
The hospital is a complex organization between three

Figure 1 A Typical Hospital Organization Chart



5

Figure 2



major sources of power: (1) the board, (2) the administrator and (3) the medical staff. The main organizational units that enable the medical staff to relate formally to the board are the staff's executive committee and board's joint conference committee.

According to Snook (1981), for an effectively organized institution, the board of trustees, the Chief Executive Officer or CEO, and the physicians must all understand who is assigned to what responsibly, understand the players and the roles that are important for survival. Most important, hospitals should determine what programs they should offer and what program they know best to offer.

Organizations are infused with purpose and meaning only through imagination and will of people by acts of leadership. As Chandler (1962), emphasized, organization design and structure must follow from and be subservient to strategy-human purposes formulated into organizational goals. It is by these revitalizing aspects of leadership that organizations remain useful tools, not stultifying masters. In such instances, organizations undergo a process of adaptation and "institutionalization." Shortell and Kaluzny (1983), indicate that organization take on values, commitments, goals, and repertoires of action that are considered important for their own sake. Leadership is responsible for guiding this process of institutionaliza-

tion. This task involves making "critical decisions" concerning the development and maintenance of the institution:

1. The leader must define the role and mission of the organization. This includes both assessing the organization's internal and external commitments and determining goals in light of these commitments.
2. The leader must enact a social structure that embodies the key values and commitments of the organization. That is, the design of the organization must be adapted to its goals.
3. The leader must defend the institutional integrity of the organization. That is, the leader must legitimate the organization's values and distinctive competencies before the external public and the organization's members.
4. Finally, the leader must regulate internal rivalries by reaching an accommodation between organizational goals and group interests (Shortell & Kaluzny, 1983).

With the reorganization of Mountains Community Hospital Lake Arrowhead, the hospital became involved in the following programs: 37 acute care hospital beds with 24 hour emergency service. Fourteen of these beds are used

for treatment of chemically dependent patients, surgery services with two surgery suites, a labor and delivery room and an alternate birthing room, x-ray, laboratory, respiratory therapy and blood gas laboratory services. There is a heliport with helicopter ambulance service, a fire department hot-line communication system and direct communication capabilities via radio with the County Medical Center Emergency Services San Bernardino. The hospital also provide meals-on-wheels to the senior citizens in the community.

As indicated early, the basic purpose of an organization is the fulfillment of its mission statement which outlines the organization's philosophy, values, and goals. The organization's success in producing quality goods and services that are valued by the community it serves is contingent upon the effectiveness of four organizational structures as indicated by Robert L. Veninga: (1) the formal structure which outlines the hierarchical responsibilities of departments and individuals; (2) the informal structure which include the networks of relationships supported by tacit values that control the quality and quantity of the work; (3) the political structure which has vested within it power that is used in support or defiance of explicit organizational goals; and (4) the financial structure which supports the



organization's activities (Veninga, 1982).

Keith Davis (1977), stated that both the formal and the informal structure are necessary for group activity, just as two blades are essential to make a pair of scissors workable. Together, formal and informal organizations constitute the social system of work groups. The informal structure is a powerful influence upon productivity and job satisfaction.

Clayton Reeser and Marvin Loper (1978), note in regards to political structure;

Organizations are political systems, whatever else organizations may be (problem solving instruments, sociotechnical systems, reward systems, and so on). All it means is that organizations operate by setting goals, distributing authority, and setting a stage for the exercise of power.

The concept of power has been described by Bertrand (1938), as;

...the fundamental concept in social science ....in the same sense in which energy is the fundamental concept in physics. Leaders are often instructed to 'walk softly yet carry a big stick' - a prescription that tries to meld two seemingly incongruent axioms (Bertrand, 1938).

We tend to admire power in others, yet we resent it if it is utilized against us in a capricious manner. If we are to achieve our own goals we must possess power, yet most feel reluctant to tell others that their goal is to possess

power. One definition of power is "the ability to affect and control anything that is of value to others." Politics therefore, is the complex of intuitive and deliberative strategies through which power is acquired and manipulated (Veninga, 1982).

The financial structure focus our mind in the magnitude of the organization's resources, the predictability and stability of those resources, and the process by which budgets are established. Veninga (1982), indicated that one way to examine the financial culture of an organization is to analyze the master budget, the operating budget, and the process by which allocations are made to departments. It is also important to determine how financial adjustments are made if unforeseen events necessitate a change. He continued by defining master budget and operating budget.

Master budget is sometimes referred to as the balance sheet budget. It is a forecast of expected financial status as of the last day of the budget period, usually the close of the fiscal year (Veninga, 1982).

The forecast usually will show whether the organization is making a profit, breaking even, or incurring a deficit. If the organization is in a profit or surplus position, and if this occurs on a yearly basis, it is important to know how such surpluses are expended. Some institutions will place their surpluses in a high-interest-earning bank account

designed for future operating needs. The operating budget is;

The revenue and expense budget. It gives information on labor costs (salary and fringe benefits), material and supply costs, and indirect cost (such as utilities, maintenance, and insurance). As the name implies, operating budgets describe how the operations of the organization are financially supported. The operating budget identifies precisely the amount of money allocated to each department and the name of the person who is responsible for managing departmental resources. (Veninga, 1982).

The budgeting process is usually carried out through a budget officer sometimes referred to as the comptroller or the financial officer. Usually the financial officer has a staff of individuals who are trained in financial management. They are responsible for keeping a detailed accounting of all revenues and expenditures including preparing the payroll. This, of course, is one of the day to day problems identified in Mountains Community Hospital Lake Arrowhead and will be discussed later.

In order to understand the Mountains Community Hospital organization's culture, it is important to examine reorganization criteria. In reorganization it simply means change is instituted by the management to improve operations efficiency, as a response to pressures of economic and political forces in the business environment. Change is essential to life but there are limits on one's

adaptability. Joseph L. Massie and John Douglas indicate that, if the organization does not adapt to its environment, it may die a slow death. On the other hand, if it innovates with new ideas, programs, and services, a period of growth may be imminent (Massie & Douglas, 1977). Organizational cancer usually begins in a small way. It is often located in a philosophical perspective that the organization can continue doing what it has in the past and can ignore those who are demanding reform and change. By ignoring legitimate needs, the organization allows the cancer to spread, making it less and less able to creatively respond to the needs of constituents. In its weakened state it may recognize that it may be too late to respond, particularly if other organizations have exerted leadership in meeting consumer need. This was stressed by Veninga, he continued by sayings that, the quickest way of determining whether an administrator understands that organizations have a life cycle is to ask one penetrating question: Where will this organization be five years from now? If that question cannot be answered or if it is not even being addressed, the probability is great that an evolutionary approach to change is being practiced (Veninga, 1982).

Blake and Mouton indicate another approach to initiating organizations change, which they called

REVOLUTION. The primary goal of a revolution is to change the status quo. This usually takes place when it has been concluded that the existing leadership is so corrupt, decayed, or ineffective that the organization can no longer tolerate the existing order (Blake & Mouton, 1972). The primary objective of revolutionary change is to clean house of old policies, old patterns of reward and punishment, and those who hold powerful positions. One of the acts of revolutionaries is to render existing leadership impotent. Looking back in history, when the revolution took place in Iran, the Shah's generals were executed; when revolutionaries took over the government of Liberia, the president was killed. On an organizational level, the new guard will "eliminate" the existing leaders by terminating their employment or by assigning them a benign role. One major purpose of revolutionary change is to establish a new order as quickly as possible. The changes that take place through revolutionary tactics are dramatic and may result in either positive or negative results. On the positive side long-standing problems might be resolved. If the old leadership was incompetent there is the possibility that the new will be effective. Negative effects may outweigh the positive benefits. The end result of a revolution is merely to shift old powers to new leaders rather than to make the enterprise more responsive to an altruistic goal.

Sometimes revolutionaries have difficulty separating what is good for the enterprise from what is good for them personally. Their personal ambitions become so enmeshed in new organizational priorities that they find it difficult to objectively analyze what needs to be done (Veninga, 1982).

Richard J. Oszustowicz (1988) state criteria for reorganization:

1. Improves cash flow for the corporation.
2. Generates increased capital for future growth.
3. Facilitates diversification into new services or entry into new markets.
4. Provides access to greater market share.
5. Reduces cost payer penalties.
6. Reduces unnecessary certificate of need review.
7. Eliminates unnecessary rate review.
8. Improves management effectiveness.
9. Improves service to patients.
10. Permits corporation to compete more effectively on price.
11. Improves credit rating of corporation.
12. Increases organizational flexibility.

## PROBLEMS IDENTIFIED

The greatest day to day problems identified during my residency were centered around the following:

1. Inability to market services and products.
2. Reimbursement and monitoring system.
3. Inability to ensure adequate internal control.
4. Nonutilization of facility and services or the need to increase volume.
5. Financial viability.
6. Lack of communication between hospital or management and doctors.

As administrative resident, I was very fortunate to undertake the following projects:

1. Developed staffing pattern for counselors in Chemical Dependency Unit.
2. Conducted survey involving utilization of Certified Registered Nurse Anesthesiologist and their functions in pre-anesthesia evaluation.
3. Conducted survey on liability insurance criteria for surgery team coverage in rural area.
4. Assisted the accounting department to formulate master price charge system list for the hospital.

My discussion will include these four projects and internal control.

STAFFING PATTERNS FOR  
COUNSELORS IN HOSPITAL SETTING OR  
CHEMICAL DEPENDENCY UNIT

PURPOSE

To measure productivity of counselors in hospitals and their services in outcome/output, cost-efficiency/cost-effectiveness or cost benefit terms. This study will provide understanding of the amount of time counselors typically spend with hospitalized patients and stimulate scrutiny of the way in which staff are allocated relative to occupied beds.

GENERAL INFORMATION

An administrative resident in Mountains Community Hospital, I was asked to investigate staffing patterns of counselors in the Chemical Dependency Unit. The unit bed size is fourteen (14) with three (3) out-patient beds. Total patient capacity, 17. The number of counselors on staff, nine with 3.5 nursing hours per day on average. The bed capacity of this hospital as mentioned earlier is 37 with the following sections or service locations: Medical/Surgical, Obstetrics/Gynecology and Chemical Dependent Unit. It was also indicated that the hospital has a MSW counselor on staff which was not included in the number given previously. Due to the size of the hospital



and limited representativeness of trained counselors, I decided to collect sample from five other hospitals with similar service area. Sample size, 16 counselors or social workers, 8 trained at the master's level and 8 at the baccalaureate level. This sample is believed to be representative of this six hospital's caseload during fall and winter period.

#### LITERATURE REVIEW

The major area of concern are demographics, educational background, skill and knowledge, caseload descriptors, service activity and primary clinical functions. Krell and Rosenberg, indicated that 55-60 percent of patients in hospitals need psycho-social intervention. Social workers or counselors give 60-70 percent direct service time to patients for a 60-bed acute medical/surgical unit, two MSWs and one BSW are needed. For high risk groups, one MSW for each 25 beds where the MSW is involved in the primary delivery of psychotherapy. For psychiatry, two MSWs for 24 beds when this is a shared responsibility (Krell & Rosenberg, 1983).

Productivity is generally defined as output per worker's hour, where output refers to the department's products. In a hospital counseling department one of the major "products" is services to patients. As stated by

Coulton and Keller (1985), it takes more time and effort to serve some patients than others. Therefore, understanding the factors that determine the amount of professional time expended with and in behalf of different patients can point toward a system for classifying patients or services into categories that reflect the expenditure of resources they require.

#### METHODOLOGY

Survey of six hospitals with similar programs or service area. Interviews were conducted with hospital counselors and 100 randomly selected patients were also interviewed in three methods of operationalizing psychosocial acuity was used in the questionnaire. One is based on the number of psychosocial problems a patient presents and are addressed by the counselor. A second method of conceptualizing psycho-social acuity is to incorporate the concept of social risk. Third, or last approach will be to show the degree to which individuals use the resources.

Decision criteria for statistical significance was set at  $\alpha = 0.05$ . Data analyzed using nonparametric methods to avoid any assumption regarding underlying distribution of counselor's productivity and staff allocation relative to occupied beds in the hospital. Data were aggregated in

tables. Counselor time expenditure, by type of services, counselor's time expenditure by patient's hospital location, percentage of time spent in different job activities by level of training and percentage of caseload by level of training.

#### RESEARCH QUESTIONS USED

1. What is your area of location within the hospital?
2. How do patients find out about types of counseling or services?
3. What are the ways or method used to attract patients to seek counseling?
4. What criteria do patients use in selecting a counseling activity?
5. Do the counselors seek the patient out in their individual patient room?
6. What are physicians' attitudes and beliefs about counselors?
7. Do physicians recognize the psycho-social component as important in care?
8. Do physicians control the entry or exclusion of counselor's services for patients?
9. Can counselor himself identify the population he will serve?

10. What is the nature of the population served: ethnicity, socio-economic background, race, culture?
11. What is the mix of patient's illnesses?
12. What is the sophistication of patients and family about counselor?
13. What is your daily activity program like?
14. How far is the counselor's office to the patient room area?
15. What percentage of patients effectively respond to therapy and for how long?
16. What percentage of those who have to go through additional counseling sections select the same counselor?
17. What are your source of payment?
18. What is your current or proposed level of staffing, the size of the support staff, the organization of the department? How many trained and untrained?
19. What is the order of priorities, the sanctions regarding case entry and pick-up?
20. What is the orientations of hospital administrators towards counselors?

#### HYPOTHESIS DEVELOPING THUS

1. Location of the patient within the hospital or

particular unit affect counselor's time.

Null hypothesis states, there is no association between location of patient within the hospital and counselor's time.

2. Patient's awareness of availability of counseling services is influenced by severity of their social problems.

Null hypothesis states, there is no association between patient's awareness of counseling services and the severity of their social problems.

Alternative hypothesis states, there is an association between patient's awareness of counseling services and the severity of their social problems.

3. Counselor's awareness of patient's individual needs prevents prolonged counseling time.

Null hypothesis states, there is no association between counselor's awareness or identification of patient's individual need and counseling time.

Alternative hypothesis states, there is an association between counselor's awareness or identification of patient's individual need and counseling time.

4. The quality of daily activity program of the counselor reflect an effective staffing plan or support.

Null hypothesis states, there is no association

between quality of daily activity program and the effectiveness of staffing plan or support.

Alternative hypothesis states, there is an association between the quality of daily activity program and the effectiveness of staffing plan or support.

5. The number of functions provided by counseling department relate directly to the size of the staff required.

Null hypothesis states, there is no association between number of functions provided by counseling department relate directly to the size of the staff required.

Alternative hypothesis states, there is an association between number of functions provided by counseling department and size of the staff required.

6. High risk factors, such as low socio-economic background, age of the patient, severity of illness require more counseling time.

Null hypothesis states, there is no association between high risk factors such as low socio-economic background, age, severity of illness and counseling time.

Alternative hypothesis states, there is an association between high risk factors, such as low socio-economic background, age, severity of illness and counseling time.

7. Educational level of counselor is perceived as

high level of knowledge and clinical functions.

Null hypothesis states, there is no association between educational level of counselor and level of knowledge and clinical functions.

8. Counseling department is more likely to expand in hospitals where officials (administrators) perceive them to be relevant to practical needs of the hospital.

Null hypothesis states, there is no association between the size of the department of counseling and administration's orientation towards the counselor.

Alternative hypothesis states, there is an association between the size of the department of counseling and administration's orientation toward the counselor.

FINDINGS BY CATEGORY

TABLE 1

Counselor Services Received by Patients

Service	(N = 100)	
	Number	Percentage
Screening	35	35
Assessment	100	100
Discharge Planning	100	100
Crisis Intervention	25	25
Agency Referral	55	55
Psychosocial Intervention	72	70

TABLE II

Counselor Time Expenditure by Type of Service

Service	1-5	>15 minutes
Screening	10	25
Assessment	7	43
Discharge Planning	10	90
Crisis Intervention	15	40
Agency Referral	15	55
Psychosocial Intervention	12	60
<b>TOTAL</b>	<b>62</b>	<b>413</b>

TABLE III

Counselor Time Expenditure by Patient's Hospital Location

Location	Counselor's Work Time Expended	
	1-5	>15 minutes
Medical Unit	15	30
Surgical Unit	10	50
Critical Care Unit	15	90
Specialty Unit	15	60
Obstetrics/Gynecology	12	25
<b>TOTAL</b>	<b>67</b>	<b>255</b>



TABLE IV

Summary of Patient's Characteristics  
(N = 100)

Characteristics	Number	Percentage
<b>Sex</b>		
Male	46	46
Female	54	54
<b>Race</b>		
White	72	72
Black	28	28
<b>Source of Payment</b>		
Medicare Only	25	25
Medicare and Insurance	6	6
Medicare and Medical	30	30
Medical/General Relief	1	1
Private Insurance	34	34
Other	4	4
<b>Hospital Location</b>		
Medical	30	30
Surgical	24	24
Obstetrics/Gynecology	12	12
Chemical/Dependency Unit	34	34
<b>Ability to Perform Activities of Daily Living:</b>		
Excellent	20	20
Good	5	5
Mildly Impaired	30	30
Moderately Impaired	25	25
Severely Impaired	20	20
<b>Social Resources</b>		
Excellent	16	16
Good	73	73
Fair	9	9
None	2	2

TABLE V

Percentage of Time Spent in Different  
Job Activities by Level of Training

Job Activity	MSW	BSW	Non Trained
<b>Diagnostic Assessment</b>			
Intake Interviews	25	75	0
Diagnostic Assessment	60	40	0
Social/Family Assessment	30	70	0
Clinical Charting	15	85	0
<b>Treatment Services</b>			
Treatment Planning	15	85	0
Psychotherapy	75	25	0
Play Therapy	15	85	0
Activities Therapy	20	80	0
Crisis Intervention	20	80	0
Clinical Charting	10	90	0
Staffing	90	10	0
Clinical Supervision	60	40	0
<b>Medical Services</b>			
Reviewing Medications	85	15	0
Monitoring Signs/Symptoms	80	20	0
<b>Client Support Services</b>			
Referring to External Agencies	15	85	0
Monitoring Progress	15	85	0
Conducting Home Visits	60	40	0
Advocacy	15	85	0
Case Finding	10	90	0
Obtaining Social Service			
Benefits	80	20	0
Making Family Contacts	60	40	0
<b>Administrative Support Services</b>			
Management of Agency or Staff	70	28	2
Program Administration	30	68	2
Program Planning Evaluation	80	20	0
Providing Supervision	20	80	2
<b>Consultation and Education Services</b>			
Schools	80	20	0
Law Enforcement/Corrections	80	20	0
Self-Help Groups	30	68	2
Industry	80	20	0

## RESULTS

The results demonstrated very considerable variation. Patient's characteristics of the 100 study subjects are presented in Table IV. The majority of the sample consisted of older, white females on a medical service. The mean age of the patient - 66. Most were discharged to their own homes and were moderately impaired in physical activities. The average length of stay (ALOS) was 21 days which is substantially higher than the 8.7 days that was the average length of stay for all adult patients in the hospital. All patients received an assessment (See Table I). The average length of time counselors spent working with and in behalf of patients was about 5.6 hours. As can be seen in Table III, the time expenditure in behalf of patients differed among patients in various locations within the hospital. Similarly, the average time required differed, depending on which counseling services the patient received, with discharge planning being the most time-consuming service (See Table II).

With level of training there is considerable involvement in a range of services (See Table V). There are some interesting differences between the roles that the three groups performed. MSWs treat the more acute clients, BSWs serve more generalists functions and treat the more chronically disabled clients. Under administrative support

services and consultation and education, there were indication of use of untrained persons. This was seen in two hospitals with Chemical Dependency Units (Mountains Community Hospital and San Bernardino Community Hospital Care Unit).

#### DISCUSSION

In conclusion, the analysis of this survey may highlight differences in level of quality of care for the patient, and also the marketing focus of the hospital. Overall, the mission statement of the organization has a greater part. Therefore, I recommend the use of the following formula as indicated by George I. Krell (1983).

$$\frac{\text{Number of Beds} \times \% \text{ of Patients to be served}}{\text{Staff Caseload Ratios by Functions Carried}} = \# \text{ of Staff Needed}$$

28% for (1 to 200 beds)  
34% for (201 to 500 beds)  
40% for (501 plus beds)

1 to 13 Functions = 1 staff to 35 Cases  
14 to 18 Functions = 1 staff to 25 Cases  
18 plus Functions = 1 staff to 15 Cases  
(Krell & Rosenberg, 1983)

SURVEY INVOLVING UTILIZATION OF CERTIFIED  
REGISTERED NURSE ANESTHETIST

PURPOSE

This project is to explore what other hospitals in the rural areas are doing in regards to utilization of Certified Registered Nurse Anesthetist for preanesthesia evaluation instead of a physician.

GENERAL INFORMATION

Mountains Community Hospital Lake Arrowhead was cited for using Nurse Anesthetist for preanesthesia evaluation instead of a physician as a deficiency by Joint Commission on Accreditation of Hospital in 1986. The situation was reviewed by the state inspector who accepted that the surgeon on the case should document and sign pre-operative note on the patient which states that the patient is considered to be ready for surgery. The surgeons on this ground began to question their liability. The hospital has an MD Anesthesiologist on staff but he is not available for all surgeries. Therefore, utilization of nurse anesthetist became appropriate.

Furrow, Johnson, Jost and Schwartz (1987), state: The medical practice health care professionals acting within the scope of their own licensure from sanctions against the unauthorized practice of medicine. These professions

include nursing, which is licensed under state nursing practice acts and it includes nurse-anesthetists.

#### METHODOLOGY

Telephone survey of ten hospitals in California were conducted and interviews were done with the Medical Records Supervisors and the Surgery Department of the following hospitals:

1. Barstow Community Hospital (56 beds)
2. Bear Valley Community Hospital (28 beds)
3. Calexico Hospital (34 beds)
4. Coalinga District Hospital (26 beds)
5. Hi-Desert Medical Center (56 beds)
6. Palo Verde Hospital (55 beds)
7. Needles-Desert Communities Hospital (39 beds)
8. San Gorgonion Pass Memorial Hospital (68 beds)
9. Santa Ynez Valley Hospital (30 beds)
10. Victor Valley Community Hospital (28 beds)

#### RESULT

These hospitals indicate using Certified Registered Nurse Anesthetists for documenting findings of pre-operative evaluation and the attending physician or surgeon on the case co-sign on the document that the patient is clear for surgery. Barstow Community Hospital and Victor Valley

Community Hospital indicated having some controversy with surgeons questioning their liability. Therefore, MD Anesthesiologist does pre-operative notes when necessary. Chart review is performed monthly by the Surgery/ Anesthesia Committee of the above hospital including that of Mountains Community Hospital Lake Arrowhead to ensure and promote quality in patient care.

LIABILITY INSURANCE COMPANY'S CRITERIA FOR  
SURGERY TEAM COVERAGE IN RURAL AREA

PURPOSE

To find out liability insurance criteria for surgery team in rural area. Specially concerned with Nurse Anesthetist coverage.

METHODOLOGY

Telephone survey of following insurance companies were conducted through the underwriting department.

1. Southern California Physician Insurance Exchange (SCPIE).
2. The Doctors California Company.
3. Norcal Mutual Insurance Company.

RESULT

Surgery criteria for rural areas are the same as that

of urban areas. These insurance companies insure Certified Registered Nurse Anesthetist through their employer. It is assumed that Certified registered Nurse Anesthetist does not practice independently. But practices under a MD Anesthesiologists supervision.

## MASTER PRICE CHARGE SYSTEM

### LIST FOR THE HOSPITAL

#### PURPOSE

To provide a standard costing model that will better estimate the cost of the product line.

#### GENERAL INFORMATION

It was noted that there was no uniformity in the charge system used throughout the hospital. The patient's bills contained the total charges and the portions for certain types of items such as intravenous solutions differ when used in the emergency room compared to the wards or units. Charges were recorded when received in the financial or accounting office, not when they were generated. Thus, manual extraction of the charges was necessary. There were errors resulting from manual extraction because of an oversight in the part of the biller.



## LITERATURE REVIEW

The continually rising costs for medical care have been cited as the reason for instituting major changes in medical care financing that now have an impact upon the delivery of care. The primary concern of the medical community is that cost containment, if poorly introduced could reduce access to care, as well as the quality of care, yet this might not achieve true cost savings. Stern and Epstein (1985) stated,

Proponents of the diagnosis - related group (DRG system) believe that it will solve many of the ills now attributed to cost-based reimbursement. In his report to Congress, former Secretary of Health and Human Services, Richard Schweiker, suggested that a DRG based system will provide hospitals with an incentive to improve efficiency, will establish medicare as a prudent buyer of hospital services, will reduce the administrative burden on hospitals, and will assure beneficiary access to quality health care.

The shift from traditional cost based reimbursement to a prospective payment system has increased the importance of understanding the cost implications of health care managers' decisions. Also, the risk imposed by poor cost control or inappropriate use of resources has shifted from the third-party payer to the provider of health services. The use of capitation rates requires the provider to estimate the total cost from different tests, services and procedures. Cost management and cost estimation are response to these changes in the health care organization.

Cost estimation requires an understanding of costing concepts and cost behavior. Cooper and Suver (1988) explained,

Cost determination refers primarily to separating costs into direct and indirect patient categories and into fixed and variable categories. Direct patient costs are costs that are directly traceable to a patient care unit such as inpatient costs laboratory, radiology, and pharmacy. Indirect costs refer to all other costs of the institution or health care provider that have not been included in the direct cost categories. Fixed costs represent an accounting definition for costs that do not vary with changes in the volume of patient care provided. This volume measure could be expressed in patient days, operating procedures, laboratory tests or radiology procedure. Variable costs are defined as those costs that can be expected to vary directly with the volume of services provided. Examples include the medical supplies used in inpatient service, reagents used in laboratory tests, or film used in radiology procedures.

## SAMPLE COST CATEGORIES

### DIRECT COSTS

Inpatient  
Variable (medical supplies)  
Fixed (beds, rooms, supervision)  
(salaries)  
  
Laboratory  
Variable (reagents)  
  
Fixed (equipment, supervision)  
  
Radiology  
Maintenance  
Variable (film, developer)  
Fixed (equipment, supervision)  
  
Pharmacy  
Variable (drugs, supplies)  
Fixed (supervision, depreciation)

### INDIRECT COSTS

Administrative  
Variable  
(supplies)  
Fixed  
  
Housekeeping  
Variable  
(cleaning  
supplies)  
Fixed  
(salaries)  
  
Plant  
  
Variable  
(supplies)  
Fixed  
(depreciation)  
  
Dietary  
Variable  
(food)  
Fixed  
(equipment)

(Copper & Suver, 1988)

Thakur, English and Hoffman (1986) also categorized cost items and administrative measures.

Cost Items Factor	Possible Administrative Measures
Wages and Salaries	<ol style="list-style-type: none"> <li>1. Effective manpower scheduling</li> <li>2. FTE Reduction</li> <li>3. Employ Part-Time Personnel</li> <li>4. No COLA, only merit raise</li> </ol>
Benefits	<ol style="list-style-type: none"> <li>1. Renegotiation of packages</li> <li>2. Performance based compensation</li> <li>3. Gradual reduction of benefits</li> </ol>
Contractual Gaps (Collected less than billed)	<ol style="list-style-type: none"> <li>1. "Good" business manager</li> <li>2. More aggressive Debt collection</li> <li>3. Good marketing strategies</li> <li>4. Rerouting of indigents</li> </ol>
Equipment	<ol style="list-style-type: none"> <li>1. Closer monitoring of physician's</li> <li>2. Requests for equipment and better maintenance</li> <li>3. Improved depreciation policy</li> <li>4. Employee education regarding proper maintenance</li> </ol>
Supplies and Utilities	<ol style="list-style-type: none"> <li>1. "Good" Pharmacists</li> <li>2. Bulk buying and combined buying with others</li> <li>3. Facilitate energy efficiency by providing incentives to departments</li> </ol>

(Thakur, English & Hoffman, 1986)

The control of these measures was found to be typically between 80 percent to 100 percent (that is, the amount of internal control which the hospital has over expenditures.

#### METHODOLOGY

Master charge list of Mountains Community Hospital under the operation of Westworld Community Healthcare Inc. with a cost survey of ten hospitals in the Inland Empire, put up by Hospital Council of Southern California was used for analysis. The survey identified the following: Highest Charge, Average Charge, Median Charge, Lowest Charge and the percentage different between high and low. Unfortunately, this project was unable to be completed due to the threat of closing the hospital. The issue of closure will be addressed in the conclusion of this paper.

#### INTERNAL CONTROL

The operation and utilization of hospital is the issue today. Hospitals have been swept along on a wave of change, reaching to new pricing, market and competitive demands, and for the most part doing their best to survive. In 1987, experts are saying that hospital will continue to see declines in census and utilization of traditional services, payments that will not keep pace with inflation

or the increased intensity of services provided, and more uninsured or under-insured patients whose care can drain hospitals almost to the breaking point. For hospitals, as stated by Sandrick, "The cumulative effect will be threats to profitability and cash flow, and for the community, limited access to care." He went on to say,

Board members must make sure assets are being properly managed and are yielding the maximum amount based on the risk the organization is willing to take (Herkimer, 1978).

Internal control therefore has a part to play in safeguarding the assets of the institution or organization. Weygandt, Kieso, and Kell (1987) define internal control thus: Internal control is the plan of the organization and all of the related methods and measures adopted within a business to:

1. Safeguard its assets from employee theft, robbery, and unauthorized use.
2. Enhance the accuracy and reliability of its accounting data by reducing the risk of errors in the accounting process.
3. Promote operational efficiency through employee training programs and quality control incentives.
4. Encourage adherence to prescribed managerial policies through periodic review and evaluation of employee performance.

Control can be viewed as a process by which an organization sets up procedures designed to help it obtain and utilize resources as effectively, efficiently, and economically as possible. Control is said to be most effective when only one person is responsible for a given task. Mountains Community Hospital employees are a dedicated group of employees. Each of the employees have more than one function or division of work.

Weygandt, Kieso and Kell (1987) indicate a principle known as "segregation of duty." This principle is indispensable in a system of internal control. They went on by stating that,

...the rationale for segregation of duty is that the work of one employee should, without a duplication of effort, provide a reliable basis for evaluating the work of another employee.

The responsibility for related activities should be assigned to different individuals and the responsibility for establishing the accountability for an asset should be separate from the physical custody of that asset.

Most important of all, it should be recognized that the human element is an important factor in every system of internal control. A good system can become ineffective as a result of employee fatigue, carelessness, and indifference. For example, a billing clerk may not bother to check "master charge list" to verify price, but may just

"fudge" a price off-hand. Herkimer concluded that,

...for employees to be committed to controlling costs and protecting the organization's assets, they must perceive that management has a commitment to those concepts as well. This commitment should be in actions as well as words (Herkimer 1978).

#### HOSPITAL SURVIVAL OR CLOSURE

The dilemma facing Mountains Community Hospital Lake Arrowhead at this point in time, May 1, 1988, is can it remain open? The fate of the hospital is in the hands of a Los Angeles bankruptcy trustee who gave the hospital a 15 day notice due for closure from May 1, 1988 to May 15, 1988. And plans to auction all medical equipment on May 16, 1988 to help pay the debts of the former operator of the hospital (Westworld Community Healthcare Inc.). Series of open board meetings involving board members, employees and community members are held every week. On May 9, 1988, the board conveyed that bankruptcy trustee granted the hospital an extra week -- until May 22, 1988 for closing. Another open-board meeting was called on May 18, 1988, and the board disclosed that the bankruptcy trustee extended the closing date to June 17, 1988.

It is mentioned that there are about five interested parties willing to pay-off the equipment cost and lease the hospital. All offers' terms and conditions remain confidential at this time.



## CONCLUSION

My experience in Mountains Community Hospital Lake Arrowhead is very enriching. The concept of reorganization in order to ensure survival require effective communication between the board of trustees, administrator, physicians and the employee. The board of trustees must grapple with the fundamental question of whether the hospital's mission is to meet the health care needs of the community or to maximize the facilities operating supplies. When the trustees, administrator, physicians and employee work concurrently to decide on major decisions, effectiveness, timeliness, and precision of the decision making process is enhanced. Also effective problem solving by the administrator can significantly contribute to the development of individual board members. This can deepen everyone's understanding of the issues involved, and will eventually improve communication by building trust and strength within the organization of the hospital.

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