Decentralizing Healthcare Delivery in Kenya: Transforming Public Hospitals into Autonomous Institutions

A Hospital Operations Manual

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INTRODUCTION

In recent years it has become very difficult for many developing countries to afford the social contract they hold with their citizens for healthcare. A substantial portion of the budget that is allocated for health care services is expended in supporting the physical plant and equipment of hospitals and other health care facilities. In addition, the productivity of public owned and operated health care facilities is not as high as it could be. Consequently, as annual budgets are exhausted, supplies run short, essential facility repairs are not made, equipment is not maintained or purchased, morale among staff suffers, and the quality of services declines.

Theoretically, if the Ministry of Health and its public health provider organizations were not burdened with stifling bureaucracies, bloated workforces, deteriorating and antiquated facilities and equipment, escalating costs and alike, their budget allotment would be more effective in funding the delivery of quality healthcare. This is the dilemma in which the Ministry of Health in Kenya found itself. In general, the central ministry knows the right thing to do, but it is unable to do right things right.

One solution, and a significant development, was the "fee-for-service" policy introduced in 1989, which allowed hospitals to charge patients for services, commonly referred to in public hospitals as "cost sharing." Because the government was unable to continue unlimited free care to its citizens, the rationale for this policy was due to:

- Insufficient budget allocation
- Rising costs of health care
- Increasing population
- Increasing complex burden of disease (malaria, typhoid, cholera, HIV AIDS)

Hospitals were able to retain and control the cost sharing monies collected to assist with cost recovery. The program has been very successful, and in light of the ongoing reductions in government allocations, without this program many hospitals would have drastically cut back on services or gone out of business.

Another solution to this dilemma is decentralization of health care delivery by transforming public health care facilities into autonomous institutions. Decentralization then becomes a key enabler for improving hospital performance. The rationale for decentralization:

- Improving communication and reducing administrative bureaucracy and thereby improving government's responsiveness to local health care needs
- Enhancing effectiveness and efficiency of management by allowing greater discretion
- Increasing the role of the local community in ensuring governance while operating outside the day-to-day control of the MoH, but with the physical assets owned by the MoH and operating under MoH policy, framework, and protection

Reforms that accompany autonomy, like managerial and budgetary reforms, cost sharing, etc., which enable financial and managerial autonomy and accountability, are likely to create mechanisms for functional/operational budgeting, information systems, etc. which may lead to greater efficiency. If decentralization and institutional autonomy could be accomplished the following benefits may be accrued:

- Operating costs could be reduced
- Management would be motivated to upgrade skills and productivity of staff

- Productivity, quality of services and organizational capacity could be enhanced through staff development/training programs
- Reduced administrative complexity, enhanced effectiveness of management, improved decision making, communications, clinical outcomes and patient and staff satisfaction by reengineering and restructuring the operating organization

Decentralized decision making will be enhanced in six main areas:

- Strategic management
- Financial management
- Human resources management
- Procurement of supplies and equipment
- Administration
- Clinical governance(medical staff organization)

Autonomy can be expected to lead to a transfer of authority from the central government/ministry to the hospital board and administration. Vested with more authority, board and administration can be expected to be better able to respond to the needs of the local community. This should lead to greater community participation (may be effected by a community advisory committee of the board), particularly for community input in decisions by the hospital for meeting community health care needs, thereby leading to greater acceptance and satisfaction by the community.
Autonomy will lead to gains in efficiency if the board and management are sufficiently motivated to bring about the necessary changes. One way of bringing about motivation is through incentive structures. In the absence of appropriate incentives, the potential benefits of autonomy may not be fully realized.

Greater autonomy can be expected to bring improvements in quality of care. Autonomy, when accompanied by incentives and consumer responsiveness, greater responsibility, and accountability can be expected to lead to:

- optimum employment of medical personnel
- improvement of medical records
- better clinical testing facilities
- increased availability of drugs and supplies
- better infection control procedures
- greater levels of cleanliness
- changes in attitudes and behavior of administration and medical staff
- more punctual attendance and productivity of staff

All of these affect quality of care and patient and staff satisfaction.

By transferring decision-making authority and, most important, control of resources to local public health care institutions, effective and efficient independent operations can be achieved at the provincial and local level. The MoH can then divest itself of direct care responsibility, eliminate units in the ministry, and orient itself more to a planning, policy, budgeting, and/or contracting role.

Hospital Autonomy: Some General Propositions
Dictionary Definition: Autonomy- " the quality or state of being self-governing, existing or capable of existing independently"

- Hospital autonomy is a relative not an absolute concept
- Even private hospitals are not truly autonomous- they are also subject to government regulation
- The issue is one of "degree of autonomy rather than an absolute autonomous state"
- Implicit in the definition of autonomous hospitals- ones that are ,"at least partially, self-governing, self-directing, and self-financing"
- What is relevant and important is the effect of the degree of autonomy on the performance of the hospital – to the extent that it promotes positive outcomes and reduces negative outcomes
- Autonomy does not automatically enhance performance
- Autonomy is not synonymous with privatization- an autonomous hospital can exist just as easily under government ownership, as under private ownership
- Equity, quality, and patient satisfaction are indicators to measure the outcomes of hospital autonomy

A key factor in the design of this concept is that hospitals will be granted a different organizational status (semi-autonomous or parastatal) than they had as part of the regular Ministry of Health (MoH) system. A decentralized autonomous system results in the central government delegating operational responsibility to the local hospital governing board. The new status is to feature enhanced management authority with respect to personnel administration and budget administration such that there will be incentives for more efficient performance and more discretion by management to achieve it. This is a key concept because decentralization will be relying in good part on these enhanced incentives and authorities to drive improved organizational efficiency and quality of outputs if hospitals are to succeed with substantial cost recovery.

An Autonomous Hospital Is An Institution :

- Constituted, in Kenya, under the Public Health Act, and accountable to the community, and with authority to enter into contractual relationships, and operating under Ministry of Health supervision. It needs to be emphasized that the successful conversion to autonomous status rests with having the legal framework in place which supports full control of the hospital by its local board, and commitment of the board.
- Responsible to the Ministry of Health for adhering to the appropriate functions for autonomous public hospitals as part of a coherent Kenya health services system and meeting the basic minimum standards for its technical and administrative functions.
- Operating under a general memorandum of administrative agreement defining the operational relationship between the Ministry of Health and the autonomous hospital as described in the "New Board Members Handbook" to ensure orientation of the board to its roles, responsibilities, and powers of authority. This framework includes the requirement of regular reporting and monitoring of certain indicators of performance.
  These guidelines, along with the increased and visible accountability to the community, can be expected to lead to efficiency gains and improvements in patient satisfaction and quality of patient care.
- Primarily responsible for the provision of curative care services, but also providing promotive and preventive health care services.
- Financed through a system of vertical block grants and/or transfers from the Government Treasurery, and locally generated revenue (in that order of importance)

with clear and transparent lines of authority both within the hospital and between the hospital, its board, and the Ministry.
- Able to retain operating surpluses and be fully responsible for all hospital resources and openly and transparently accounting for all resources regardless of source.
- Whose employees/staff are either: a) autonomous hospital employees; b) civil servants on secondment to the autonomous hospital; or c) full civil servant status during the transitional phase
- Governed by a Hospital Governing Board and administratively managed by a Chief Executive Officer/Administrator/Medical Superintendent who is responsible for implementing the board's directives and for representing the board in the operations of the organization

I. LAUNCHING THE CONCEPT

The Concept of Hospital Autonomy

The Ministry of Health in Kenya, to make the government's budget allotment more effective in funding the delivery of quality health care to the citizens of Kenya, has adopted one solution; the decentralization of public hospitals into *autonomous* institutions. This includes transferring decision-making authority and control of resources to the local institution. Implementing autonomy is at least as much a political as a technical exercise.

The autonomous hospital offers general community health care services for inpatients, outpatients and emergency/casualty care on a fee-for-service basis. Hospital operational costs are recovered from patient fees (called cost sharing or cost recovery), social insurance, business contracts, and government grants (usually considered a subsidy for those patients that can not pay or are exempt).

In thinking in particular terms about implementation during the start-up phase, the hospital must achieve improvements in its performance and quality in order to successfully market its product/services, enhance the hospital's reputation, and earn the anticipated substantial revenue necessary to recover operating costs. But the revenues to be earned in this way are a necessary condition for putting in place improved operating systems (reengineering) and qualified staff required to provide quality services efficiently. These conditions represent, in general, principles of good business whether or not the hospital is to become autonomous. Quality and patient satisfaction are measurable indicators of hospital autonomy.

Main Benefits of Autonomy for Hospital Managers:

- Increased flexibility
- Control over administration and finances
- Initiative
- Creativity
- Results orientation

Main Benefits of Autonomy for MOH Officials

- The way for ending enormous subsidies to public hospitals
- A buffer against public criticism over the public hospitals' performance

MOH Officials and Hospital Managers Agree

- Autonomy would augment the hospital's resources, and improve efficiency and performance
- A panacea for all that is wrong with the functioning of the health care system in general and tertiary hospitals in particular

Potential Points of Conflict between the MOH and Hospital:

- Ministries of Health and Finance tend to think of the hospitals as an extension of the government- ignoring the autonomy of the hospital
- Hospital management long used to the protection of the government and its style of functioning, have either rather opportunistically, tended to assert their independence, or have fallen back on the government cushion

Critically important-

- The government's responsibility begins, not ends, with the promulgation of a law or policy legislation
- Effective government-to-institution coordination and collaboration
- Adequate planning- both government and hospital must invest in planning and preparation for the transition to autonomy
- New and creative management structures and processes are required

Consumers of Hospital Services

- Do not think autonomy will lead to improvements in the quality of care and public accountability
- Autonomy will lead to higher fees without improvement in the quality of services

Stakeholders have such a divergent conception of autonomy and what it implies that –

- There is a tendency to overstate the benefits of autonomy, and
- Understate the problems

II. MOVING THE PROCESS FORWARD FROM CONCEPTION TO IMPLEMENTATION

The following paragraphs describe, in brief, operating standards for consideration. The areas represented are not intended to be all inclusive, but rather a guideline or framework for improving hospital performance. Performance is what is done and how well its done to provide health care. The effect of an organization's performance of these functions is reflected in patient outcomes and in the cost of its services.

Mission of an Autonomous Hospital

The mission of an autonomous hospital is to provide comprehensive health care services- both high quality and relevant to community needs- in the most efficient manner possible within available resources

Hospital Governing Board

An autonomous hospital must have its own governing board to oversee the operations of the hospital and be accountable to the community it serves. (See Appendix A- Model Board Bylaws)

What does the board do? Those responsible for governance establish policy, promote performance improvement, and provide for organizational management and planning.

Core Roles:

- Policy formulation- direction and expectations of management and medical staff
- Decision making- based on policy
- Oversight- ensures accountability

Core Responsibilities:

- Setting the direction- formulating vision, mission and key goals
- Ensuring high levels of executive management performance
- Achieving quality goals- ensuring the quality of patient care
- Ensuring the hospital's financial health- protecting and enhancing resources
- Assume responsibility for itself- its own effective and efficient performance

Hospital Management

The chief executive officer/administrator is selected by the governing board and is responsible for operating the hospital according to the authority conferred by the governing board. The chief executive officer working with management, clinical, and administrative staff provides for a well-managed hospital with clear lines of responsibility and accountability within departments and between departments and administration. Specific chief executive officer responsibilities include:

- Establishing effective operations
- Establishing information and support systems

- Recruiting and maintaining staff
- Conserving physical and financial assets

The hospital leadership should provide for institutional planning, a critical element in the implementation phase. Planning includes defining the vision, mission, and values for the hospital, assessing the internal and external environment, and creating the strategic, operational, programmatic, and other plans and policies to achieve the vision and mission. (See Appendix B- "Guide to Strategic Planning")

Accounting and Financial Management

During this start-up period the hospital requires the necessary financial resources to implement organizational reengineering of its operating systems to improve performance and quality and to get up to speed. One possible feasible response to this need will come in the form of MoH subsidies commonly called "block grants". The block grant amount will be given as "unrestricted funds" by the MoH to offset the free healthcare (includes waivers/exemptions) provided by the hospital to the citizens of Kenya, thereby fulfilling the government's moral and social obligation to the medically indigent. These unrestricted funds would replace the present budget for recurrent expenditures.

An accrual-based accounting system needs to be in place with the development of a hospital "chart of accounts" for the proper allocation of operating costs and revenue to operating departments or services. The initial year's budget will include the recurrent budget from the government- including full funding of the hospital staff. The hospital will develop its operating and capital budgets, and report monthly to management and board the organization's performance to budget with variances explained.

Revenue generation for both inpatient and outpatient services is under the responsibility of the finance and accounting department for cash-paying and non-cash and insured patients. Hospital service fees/charge determination is the responsibility of the finance and accounting department with review and approval by hospital management and board. Payment waivers for the poor and categories of patients exempt from payment of fees are the responsibility of hospital management (See Appendix C- "Guidelines for Determining Ability to Pay")

It is highly recommended that the hospital computerize the finance and accounting system and include integration of patient registration software to form a very basic management information system. The objective is to collect and analyze aggregate data to support patient care and operations (See Appendix D- "Installation of Hospital Cash Registers and Model Monthly Management Reports")

Autonomous hospitals are encouraged to develop and implement costing of services exercise to learn the true and full cost of service provision prior to setting fees. In public hospitals, it is suggested, while fees for general ward services should approximate costs, fees in amenity or special wards should exceed costs. Service fees charged to the poor may be below cost and waived in part or totally.

Each service department is ultimately accountable for the cash value of services rendered in that department. Each department is a "cost center" with inputs and outputs and revenue (volume x

fee). The total cash revenue should be traceable to each revenue center comparing expected revenue with actual, and departments held accountable for any variance.

All cash collections should be done openly and receipted, and all revenue accounted for and banked the same day.

Contracting and Contract Management

In general, contracting can be an effective method of extending services to increase revenue, focusing on core business, or improving organizational performance.

As hospital organizations pursue opportunities that promote autonomization, increased operational efficiency and quality of services***, contracting out*** is increasingly becoming a strategy of choice. The top five tactical reasons for contracting out are:

- Resources not available internally
- Function difficult to manage or out of control
- Reduce or control operating costs
- Make capital funds available
- Cash infusion

(See Appendix E- "Guidelines for Contracting Out Services")

Before moving forward, hospital management should consider- do we have adequate skills in developing request for proposal, bidding, awarding bids, managing and evaluating contract compliance? Contracting out is not a response to short term situations- it must be integrated with the hospital's long-term strategy.

Contracting in may be considered when the hospital wishes to bid on a contract to provide services in its primary target area. Before considering such contracts, the hospital should answer these questions:

- By entering into a service contract, will the hospital dilute its prime mission of providing curative services to the primary target population?
- Is there potential for diverting funds from our core business?
- Has adequate cost analysis been done to assure that services can be provided at contracted price?
- Does the hospital have adequate skills in proposal writing, bidding, and managing service contracts?

However, contracting is not always appropriate and decisions to operate in a contract mode should be carefully considered. It would not be a good decision to contract in, for example, laundry services when your equipment and staff cannot effectively meet the demand, and in the end the customer pulls out of the contract for reasons of the hospital's non performance. Only market what you do very well, and have the capability to fully meet contract provisions. Once you lose the business it is very difficult to get it back, including the hospital's reputation.

Human Resources Management

Management of human resources focuses on identifying and providing the right number of competent staff to meet the needs of patients served by the hospital. Also, the department

coordinates ongoing assessing, maintaining and improving staff competence, and promoting self-development and learning. Where the autonomous hospital employs regular, salaried staff, it follows the general government labor rules with respect to acquisition, discipline and termination of staff. A very important difference, however, is that the hospital is allowed a number of options with respect to overtime pay, merit pay, and the like (not allowed to regular MoH facilities) such that rates of pay can be very substantially increased to reward superior performance. Also, the hospital is free to contract on the open market for the services of all staff managers, nurses, doctors and technicians. Under such contracts, the hospital has a free hand to negotiate terms and conditions of employment, salary and wage schedules, and personnel policies and procedures.

Nursing Services Organization

Regardless of the organization's structure there is a nurse executive, qualified by advanced education and management experience who has the authority and responsibility to address the following four core functions:

- Developing organization-wide patient care programs, policies, and procedures that describe how patients' nursing care needs or patient populations receiving nursing care are assessed, evaluated, and met (standards of nursing practice)
- Developing and implementing the organization's plans for providing nursing care to those patients requiring nursing care (nursing standards of patient care)
- Implementing an effective, ongoing program to measure, assess, and improve the quality of nursing care delivered to patients
- Participating with governing board, management, medical staff, and other clinical leaders in the organization's decision-making structures and processes

The Medical Staff Organization

Hospitals are dynamic ever-changing institutions that are organized and committed to maintaining and improving the community's health and quality of life. The medical staff, hospital board, and executive management share interdependent leadership roles in guiding hospitals to meet this responsibility, as well as accountability for the health status of the community. In order for the medical staff to be accountable to the board for the quality of medical care provided in the hospital, it must function within an organized framework.

The medical staff develops and adopts bylaws and rules and regulations to establish a framework for self-governance of medical staff activities and accountability to the governing board. This ensures that physicians will practice within an organized department and that departments will have appointed leaders who report to a chief of staff or medical director. Members of the medical staff are involved in activities to measure, assess, and improve clinical performance. Therefore, it is important that physicians, through the medical staff organization, become an integral part of the hospital's governance and management processes. The overall goal of the functional medical staff organization is: a) enhance the quality of patient care; b) maximize clinical performance; c) maximize professional learning; d) maximize effective communication.

To effect these goals the medical staff will: a) conduct monitoring and evaluation of patient care; b) evaluate physicians credentials for staff appointment and reappointment; c) evaluate professional performance and clinical competency of physician members and physician applicants for staff appointment. The purpose, structure, roles and responsibilities of the medical

staff organization are contained in the Staff Bylaws, Rules and Regulations (See Appendix F- "Model Medical Staff Bylaws).

Pharmacy Services

While medications are often essential to patient care, their use and handling entail risks which must be managed. These standards address medication:

- Selection, procurement, and storage
- Prescribing or ordering
- Administration
- Monitoring effects on the patient

A list of medications that are always available within the organization is maintained. Medication selection is a collaborative process that considers patient need and safety as well as economics. Suggested criteria for selection may include the following:

- Need, given the diseases and conditions treated
- Effectiveness – toxicity, efficacy, therapeutic equivalence
- Risks – adverse drug reactions, potential for error in prescribing, preparation, dispensing and administration
- Acquisition costs and cost impact

The hospital will adhere to law, professional licensure, and practice standards governing the safe operation of pharmacy services.

Purchasing, Stores and Distribution (Materials Management)

Materials management is an integrated system of functions and departments responsible for getting materials from the point of origin (manufacturer) to the point of use and ultimate disposition. The objective of materials management is to provide the right items, in the right quantity, to the right place, at the right time, for the right (lowest total) cost.

The second largest single component of operating expenses after salaries and benefits is supplies. The scope of services of the materials management function include:

- Purchasing
- Receiving
- Storing supplies
- Managing/controlling inventory
- Distributing and transporting products and supplies to users

The interrelated nature of the components of materials management supports the argument for centralizing purchasing. Simplification of communications; continuity of approach and systems; cross-utilization of personnel, space, and equipment; and other related functions are enhanced when under the responsibility and accountability of one manager. (See Appendix G- "Guidelines for a Hospital Supplies Management System")

Quality Assessment and Improvement

- Quality assessment and improvement activities should be organized around the flow of patient care and be coordinated across disciplines and departments- they are integrated concepts forming the framework of the hospital's "Quality Improvement Plan"

- Performance is best improved by focusing on systems and processes rather than on individuals
- Quality improvement cannot succeed without the commitment and involvement of the organization's leaders; clinical and managerial
- Education and training are essential
- Quality has a customer focus- both internal and external

Quality improvement activities occur for governance, management, nursing, support services, clinical functions, and medical staff. The hospital measures, assesses, and improves care/service, and key processes in the areas below:

- Leadership
- Credentials
- Improvement of processes and functions
- Information management- financial reports
- Sentinel events evaluation (things that go wrong)
- Infection control- surveillance, prevention, and control of infection
- Operative and other invasive procedures
- Blood usage
- Pharmacy and therapeutics review
- Drug usage
- Medical record review
- Safety management
- Appropriateness of admission and continued hospitalization
- Treatment of patients
- Customer complaint review
- Patient and family education
- Patient satisfaction surveys
- Staff attitude surveys

(See Appendix H- "Guide to Quality Assurance")

III. A BASIC MODEL APPROACH TO HOSPITAL AUTONOMIZATION

Phase I of the approach is the operational assessment of the hospital organization to determine feasibility for achieving institutional autonomy. If Phase I results indicate a high probability of success can be achieved, then Phase II- Implementation would be executed. The model is based on field experience in other countries, and direct collaboration and coordination with the MoH and the target hospital throughout its evolution.

This model was developed and implemented as a pilot in the Coast Provincial General Hospital, Mombasa, Kenya. Coast General is a 600 bed tertiary care teaching hospital, in operation over 50 years serving the community of Mombasa town and Coast Province with an estimated catchment area population in excess of 500,000.

Operational Assessment – Phase I

To prepare the hospital for this transformation the following framework, consisting of nine synergistic modules or tasks, was developed.

Module #1 Hospital Performance Assessment – on-site interviews with management, small group meetings with staff and medical staff leadership, a review of various operating data, and tour of facilities. Generally, information was collected to document:

- Scope of services
- Organizational structure
- Hospital and patient care environment, strengths and weaknesses
- Staffing levels- manpower needs
- Medical staff profile
- Utilization of services, patient activity
- Financial overview- budget, revenue, expenses
- Status of facilities and equipment

(See Appendix I- "Hospital Assessment Tool")

The assessment findings are analyzed to determine appropriate options, which result in an "Action Plan". The Action Plan is an outline and/or description of activities, roles and responsibilities utilized to develop consensus and define responsibilities for the achievement and/or completion of a project. The overall purpose of the Action Plan is to successfully plan, design and implement dramatic improvements in organizational performance and quality of services to meet stakeholder's expectations.

Conversion Planning – Phase II

This process is a step by step methodology developed to move the public hospital from its current position to the new level of institutional autonomy.

There are eight (8) modules of this conversion process:

Module #2 Public Relations – establish internal and external support, e.g., at Coast General, introduction of cash registers and their benefit to hospital and patients; laying of the foundation stone for the new construction of a replacement maternity unit, and plans for major renovations of facilities to demonstrate visible improvements.

Module #3 Reengineering – the fundamental rethinking and radical redesign of business and operating systems to cause dramatic improvements in organizational performance, costs, quality of services, and patient satisfaction. These expectations are rooted in the following premises that quality costs less, and current systems limit quality. Redesigning the organizational architecture to increase information flow and to facilitate decision-making is one of the important and basic components of reengineering. **Improving "organization performance" helps to continuously improve patient health outcomes.**

Module #4 Training – Orienting, Training, and Educating Staff

An orientation process is necessary for all staff that provides initial job training and information and assesses the staff's ability to fulfill specified responsibilities. The process familiarizes staff members with their jobs and with the work environment before the staff begins patient care or other activities. In this way, the process promotes safe and effective job performance. The hospital director of human resources usually is responsible for coordinating the development of a master training plan based on a list of hospital-wide operational requirements (needs assessment). This includes board, management, and staff. In general, five training modules are identified to meet expected outcomes for both senior and middle management:

- Management Theory/Team Building
- Motivational Theory/Communication Skills
- Planning and Goal Setting
- Financial Skills/Budgeting
- Customer Relations

(See Appendix J- "Guidelines for Management Development Program")

Module #5 Management Information System – assess data gathering and handling systems needs to improve manual and automated processes in a basic package designed to improve budgeting, planning, reporting, analysis, communication, and decision making. (See Appendix K- "Guide for IT System")

Module #6 Facilities Engineering and Equipment Management – develop a plan that includes a preventive maintenance program, and a process that defines problems and develops and documents corrective actions.

Module #7 Additional Module(s) – the need for an additional module(s) will be evaluated based on the initial assessment(module #1)- for example:

- Finance and accounting system
- Quality improvement program, infection control, general safety
- Materials management system- centralized purchasing, stock control of drugs and supplies, and distribution
- Human Resources- policies and procedures, staffing levels, job descriptions, compensation schedule, and staff development plan
- Patient intake system- accessibility to services, reception, wayfinding
- Clinical resources management system/Care Management- implementation of admission criteria, extended stay review, appropriateness of ancillary services (lab, x-ray), and clinical pathways (an optimal sequencing and timing of interventions by physicians, nurses, and other staff for a particular diagnosis or procedure, designed to better utilize resources, maximize quality of care, and minimize delays. The key measurable benefits possible are:
  - Reduction in cost per case (by specific diagnosis)
  - Reduction in length of stay per case
  - Improvement in clinical outcomes
  - Improvement in patient satisfaction
  - Improvement in staff satisfaction

Module #8 Business Plan – a detailed financial plan used as the foundation for transforming the hospital into an autonomous institution. It draws information from modules 1-8. (See Appendix L- "Guidelines for Developing a Hospital Business Plan)

Module #9 Feasibility Analysis – an overall analysis of the information and data flowing from each of the modules, particularly the business plan

The objective of the analysis is to determine if autonomization has an acceptable probability of success, and can the constraints to overall success of the effort be overcome. If the analysis indicates a high probability of success, then a decision can be made to proceed to the *implementation* phase.

Implementation: The Reengineering Process – Phase III

Implementation Strategies: Organizational Improvement Goals

1. **Restructure / Redesign Organization**
   - Organizational structure can be more optimally configured to reengineering results- de-layering management, i.e., smaller, flatter organization structure is better- no more than four levels of management anywhere in the organization, and no less than six personnel reporting to each manager (see Appendix M- "Hospital Operating Organization Model")
   - High employee involvement
   - Organizational characteristics: governance, management, finance, clinical, support
   - Consider management consolidations
   - Managers can be selected according to new skill set needs
   - Facilitate responsiveness- support small groups, build coordination and accountability
   - The board expects significant changes in staffing levels to regain financial stability
   - New structure to be reviewed and approved by administration and board
   - May be best not to alter management structure until the analyses and strategies are formulated

NOTE: Various management tasks performed at hospitals require specific types of knowledge and skills. It is the chief executive officer's responsibility to analyze the work the organization must do to fulfill its purpose. People with the right knowledge, competencies, and management skills must be found for each job or the job will not be done as well. This can limit the organization's potential success, especially in implementing the reengineering strategies, and will build frustration for the job-holder and those affected by the job not being done.

To improve the match between people and responsibilities, the chief executive officer must judge which alternative works best: replacing the people; improving their knowledge, competencies, and skills; or redefining the job.

2. Orientation and Training

- Board of Trustees – hospital orientation, member roles and responsibilities-
- Management – roles and responsibilities, supervisory skills
- Staff Development – do needs assessment, customer relations

3. Organize Systems - Reengineering Tasks- based on the Phase I Assessment

3.1 Design and Implement Financial Management Information System

- Budgeting
- Expenditure planning
- Patient registration
- Allocation of operating costs
- Revenue and cash enhancement strategies
- Management reports

3.2 Design and Implement Human Resources Management System

- Staffing levels
- Policies and procedures
- Compensation schedule

3.3 Design and Implement Materials Management System

- Centralized purchasing – drugs and supplies- use standardization committees
- Stock control and distribution system

3.4 Design and Implement Patient Intake System

- Improve patient and visitor accessibility to services
- Signage/Wayfinding
- Reception
- Patient escort

3.5 Design and Implement Functional Nursing Service Organization

- Implement nursing management structure to actively provide direction, support and assistance to staff nurses
- Update nursing standards of patient care to improve quality of care, patient and staff satisfaction
- Assign staffing levels, job descriptions, and a program for continuing education
- Implement committees for nursing care, quality assurance, infection control

3.6 Design and Implement Clinical Resource Management System

- Clinical protocols/pathways: the best physician and nurse practices are selected to create an optimal diagnostic and treatment path that provides superior care and minimal expenses- select high volume/high cost cases/diagnosis as a start, but not more than four. These will give the biggest gain. This requires high involvement of physicians in the development and implementation.
- Admission criteria to avoid inappropriate hospital admissions
- Appropriateness of continued stay and use of ancillaries (lab, x-ray…)
- Develop and implement a functional medical staff organization (see Appendix F- "Model Medical Staff Bylaws")

4. Prepare the Organization for Change

4.1 Design and implement information program for board and staff

- Anticipate questions
- Communicate the rationale, use data
- Communicate the Action Plan- implementation strategies with time lines

4.2 Establish Reengineering Management Procedures

- Role/responsibility of Project Coordinator
- Role/responsibility of Steering Committee
- Role/responsibility of Implementation Committees

5. Develop Performance Indicators (quality and patient satisfaction)

5.1 Expected outcomes (Targets/Goals)

- Increase in revenues
- Improved clinical outcomes – e.g., decrease in average length of stay
- Decreased ancillary turnaround times
- Increased nurses time with inpatients
- Patient and family satisfaction- patient surveys and community household survey helpful to establish a benchmark for improvement in services

5.2 Critical success factors

- Customer friendly service, accessible, fast, timely
- Significant cost recovery
- Cost containment
- Quality improvement

5.3 Consistently monitor expected outcomes (Goals)

- Develop mechanisms for measuring outcomes
- Establish benchmarks and do regular monitoring, tracking, and reporting

6. Update Communications Plan

6.1 Communicate results to staff

- Employee meetings
- Hospital newsletters
- One-on-One by management

7. Facilitators in Reengineering

- Clarity and consistency of vision
- Communication- a key ingredient
- Board and management support
- Physician involvement

8. Barriers to Reengineering

- Lack of vision/purpose
- Inadequate preparation/training
- Inadequate communication and feedback
- Inconsistent support/involvement
- Inadequate measurement mechanisms
- Inadequate physician involvement
- Inadequate authority/responsibilities
- The inverse of most barriers could be considered facilitators to the process

CONCLUSIONS

Early in the process of implementation, five vital elements stand out as critical for the hospital's successful transition to institutional autonomy:

- Hospital boards need clear and unambiguous guidelines on the role, functions, and powers of the board, which do not contravene the basic principles of autonomy, and which do not have inherent contradictions. This is a precursor to decentralization.
- Board members- appropriate selection, orientation and training
- The early selection and training of both senior and mid level managers
- Development of a "Hospital Strategic Plan" with collaboration of board, management and medical staff leadership
- The urgent need to increase revenue

During the assessment Phase I it became clear that there was a wide variance between the potential revenue for services volume and the actual cash being collected. One the other hand the major cause for shortage of supplies and drugs was given as gross insufficient revenue to purchase supplies (shortage of basic patient care supplies and essential drug items), and services (maintenance- equipment out of service- x-ray). The financial management information system proposed in paragraph 3.1, page 15, was decided that too much time would be required to develop, purchase, install the system, and train staff to correct the immediate need for revenue. So, in the interest of the urgent need and time factors, a point-of-sale (cash registers) system similar to those found in general retail establishments in the community was installed at 5 cash collection points. This system would replace the existing manual collection and receipt procedure. Transparency and accountability greatly improved from the time the units became operational in August 1998. Similarly, a substantial increase in revenue collection resulted and without any remarkable change in patient volumes. Within a 2 year period the cash collections increased from a monthly total of 1.6 million Kenya Schillings to 5.8 million. This increase in monthly cash collections resulted in marked improvement in availability of supplies, drugs, services, and satisfaction of patients and staff. In addition, improvements in hospital grounds and renovations of physical facilities was implemented. These changes for the better were also perceived by the community as improvements in quality of services. (See Appendix D - "Installing Hospital Cash Registers: A Case Study")

Also, during the implementation Phase III, we became concerned about the organization inertia and malaise when it came to follow through on the reengineering strategies for improvement. Even to revisit the Action Plan and its rationale and to re review with management did not result in significant changes for the better. It became clear that the implementation phase would require more time and effort than originally anticipated, and a lot of "hand-holding." As a result of field testing this model the following points are identified as some of the major inherent problems of a public hospital transitioning to autonomous status:

CONSTRAINTS TO EFFECTIVE DELIVERY OF THE TECHNICAL ASSISTANCE

1. **A lack of hospital control of its human resources (control remained at MOH)**
   - **Lack of continuity of staff, particularly managerial**
   - **Handicapped by current ineffective system for corrective action/discipline and performance-based incentives**
     - **there are individuals in responsible positions that hold similar positions in other hospital organizations as a result of the government system and low pay**

2. **An organizational culture which, in general, lacks motivation, responsibility, accountability, and does not foster support for promoting the organization and focusing on the patient/client.**

3. **The lack of a committed middle management group to quality improvement, problem solving, and team building.**

Successful implementation of the concept is demonstrated by enhancement of the availability, accessibility, quality, patient and staff satisfaction, and sustainability of hospital services.

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