ONKOLOGIE

Clinical Information · Klinische Information

Onkologie 2010;33:331–336
DOI: 10.1159/000313867

Published online: May 11, 2010

Chief Medical Clinic Manager of a University OB/GYN Clinic – An Innovative Job Description as Management Response for Increase of Profitability, Quality of Care, and Physicians' Freedom of Action

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Key Words
Clinic management · Change management · Resource management · Cost transparency · Adjustment of care to reimbursement

Summary
Leadership structures in German clinics are adjusting parallel to DRG (diagnose-related groups)-induced economic reorientation of the health care system. A Chief Medical Clinic Manager (CMCM) is a new job description and an innovative approach to combine medical competence and business economics at the operational level of care. The ideal qualification is a medical specialist in the clinical field with practical experience in patient care and leadership as well as in hospital economics and quality control. A CMCM is placed at a superior level in the clinic, with authorizing competence for the entire physician team. Main tasks are cost transparency within the clinic, organizational development by structured processes, and financial and strategic controlling of all business aspects. A CMCM induces change management and financial adjustment of care to reimbursement with maintaining the standard of care. In cooperation with the director of the clinic, a CMCM develops a vision for clinic development, an investment strategy, and a business plan. The success parameters are positive operative results of the clinic, cost-covering care, increased investment rate, employee satisfaction, and implementation of innovations in research and therapy. A CMCM thereby increases financial and organizational freedom of action at the clinic level in a non-profit public health care system.

Schlüsselwörter
Klinikmanagement · Veränderungsmanagement · Ressourcenmanagement · Kostentransparenz · Leistungsanpassung an Erstattung

Zusammenfassung
Führungsstrukturen in deutschen Kliniken verändern sich parallel zu der von der DRG (diagnose-related groups)-Einführung forcierten wirtschaftlicheren Neuausrichtung des Gesundheitssystems. Ein Leitender Ärztlicher Klinikmanager (LÄKM) ist ein neues Berufsbild und ein innovativer Ansatz, um medizinische und betriebswirtschaftliche Kompetenz im Klinikalltag zu verbinden. Die ideale Qualifikation ist ein Facharzt aus demselben Fachgebiet mit praktischer Erfahrung in Patientenbetreuung wie Mitarbeiterführung, Krankenhausbetriebswirtschaft und Qualitätssicherung. Ein LÄKM ist als Stabsstelle in der Klinik hoch angesiedelt, mit Weisungsbefugnis gegenüber allen ärztlichen Mitarbeitern. Die Kernaufgaben sind Kostentransparenz innerhalb der Klinik, die Organisationsentwicklung mittels strukturierter Prozesse sowie finanzielles und strategisches Controlling aller betriebswirtschaftlichen Aspekte. Ein LÄKM führt Veränderungsprozesse und Anpassung von medizinischen Leistungen an die Erstattung ein, mit dem Ziel der Aufrechterhaltung des Versorgungsstandards. In Zusammenarbeit mit dem Klinikdirektor entwickelt der LÄKM eine Perspektive für die Klinik, die Investmentstrategie und den Geschäftsplan. Die Erfolgsparameter sind ein positives Betriebsergebnis, kostendeckende Patientenversorgung, ansteigende Investitionen, Mitarbeiterzufriedenheit sowie Einführung von Innovationen in Forschung und Therapie. Ein LÄKM erhöht dadurch die finanzielle und organisatorische Handlungsfreiheit innerhalb der Klinik in einem nicht auf Gewinn ausgerichteten öffentlichen Gesundheitssystem.

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Introduction

Any health care system and its spectrum of performance, productivity, and effectiveness are defined by the country's specific legal, social, and economic base and background. Generally, the country's government body defines the value of health care for a society by supplying the adequate and reasonable resources available. But often compromises have to be made between optimal and financially possible health care. Therefore, demands for optimal health care on the one side and limitation of costs on the other have to be weighted and balanced. From the German as well as the European perspective, this seems to be necessary because non- or under-regulated health care systems would soon increase and exceed reasonable health care spending and finally get out of financial control as can be seen in the USA. Germany therefore has defined the amount of care and limitations of health care spending and regulations in its social law book [1] and by regulating or supporting institutions like the Federal Ministry of Health (BMG), the Federal Joint Commission (G-BA), the Institute for Quality and Economic Efficiency in the Health Care System (IQWiG), and others. To limit increase of health care spending, German politicians have over the last decades regularly implemented a new health care reform every few years. In such an attempt, the German Diagnose-Related Groups (G-DRG) system was successively implemented over a 6-year period starting in 2004. Based on average on a cross section of about 10% of German hospitals and their calculations from the actual costs of resources used for most entities, a flat rate for each entity is defined which is paid to all German clinics irrespective of the actual individual costs. Since all hospitals are paid irrespective of their level of care, which is a severe financial problem for universities as maximum providers of care [2], economic aspects like business expenses and actual costs of providing care are increasingly influencing patient care. All clinic-individual costs have to be calculated and made transparent within the institution to be used for cost steering by physicians in diagnostics and therapy. Finally, each clinic has to identify its specific costs for care and adjust it to the government-defined fixed prices of care [3]. This cost-to-reimbursement shaping is a challenge since many hospitals lack organization structure, cost transparency, and horizontal communication to adjust to this. However, in the context of quality-certified breast units, it was recently shown that at guideline-based quality of care level the provider is not adequately reimbursed for the actual costs of treatment within the DRG system [4], in general [5] as well as at the single cost level [6]. Therefore, cost transparency at the operational level is mandatory to influence costs of care and adjust cost to reimbursement for each single main entity and their DRG. Physicians traditionally still feel obligated to care for patients only, irrespective of costs and reimbursement policies. To address and solve this problem in an ongoing change management process, German clinics have to integrate physicians into the DRG-induced economic reorientation of the health care system. The current administration system of many public hospitals is struggling with the necessary changes due to old-fashioned, rather slow and ineffective clinic-internal information and communication structures leading often to losses which have to be compensated by the clinic owner. One possibility is the privatization of public hospitals which has happened over the last years at a remarkable rate [7]. An alternative is to solve the problem within the institution by remaining independent from stakeholders' return on investment interests and regain freedom of action as physicians regarding medical and organizational aspects [8]. The concept and successful implementation of such a new leadership structure in the form of a Chief Medical Clinic Manager (CMCM) in an obstetrics and gynecology (OB/GYN) clinic of a German university as a possible approach and solution is outlined and discussed in the following.

Increasing Organizational and Economic Problems of German Hospitals

In the past, a clinic director was primarily responsible for classic clinical patient care. With an economically evolving health care system, multiple organizational and economic tasks have been added over time for which medical school or residency are not preparing at all. An increasing number of duties regarding administration, documentation, certification, controlling, and business economics lead to an unsolvable overload, difficult for the physician in charge to fulfill parallel to clinical patient care. To follow constantly changing costs and comprehensive DRG reimbursement rules and legal policies, medical Right-Coding, and economical optimization of case management in increasingly elaborate and complex health care systems, a specialist is required to unite all these requirements at the clinic level. Data for cost steering is often not at hand in clinics but only in the hospitals' administration, and may be non-existing, imprecise, compressed, non-verifiable, or unreliable. Therefore, as a consequence, steering and influencing treatment processes as well as the related costs is hardly possible. Still, German hospitals often work segmented and are structured in a way that there is only a limited flow of information – especially on costs – to those who are able to influence them. Missing integration of the diversity of health care-related information into the treatment process is dominating. The entire process of patient care with documentation, coding, billing, cost-reimbursement analysis is fragmented and placed between different personal responsibilities and department structures. Also, potential abuse of the system by patients can not be instantly identified and eliminated because feedback systems, e.g. from the debtor management back to the clinic for patients not paying their bills, are often missing. At least in public hospitals – unsurprisingly even at the uni-

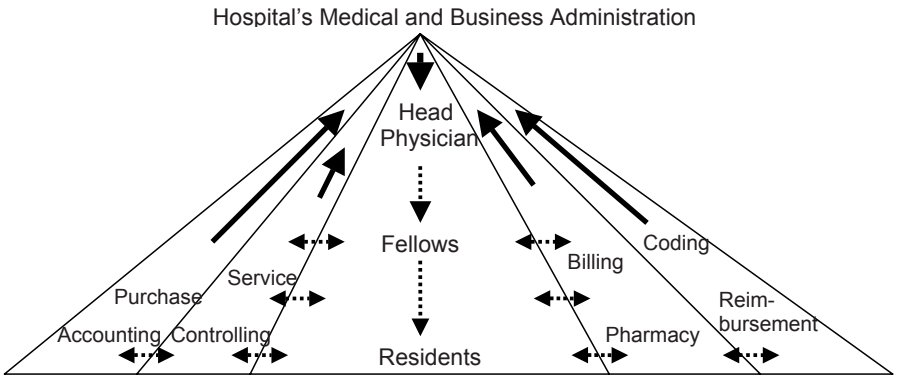

Fig. 1. Hierarchy pyramid of segmented flow of information in hospitals. Arrows represent flow of data and information (black = existing flow of information, dotted = missing flow of information).

versity level – there is no rational economic overall responsibility covering the entire process of health care. Additionally, there can be conflicts of economic interest between a single clinic and the overall hospital administration which should be addressed and solved. The separation of administration and medical care supports communication problems, missing horizontal communication and flow of information, and is set against optimizing costs and processes (fig. 1). To date, hospital administration staff does not effectively reach clinicians and is either not or only to a limited degree able to influence costs and induce necessary cost-driven adjustments among physicians. At the present time, the conventional non-privatized German hospital system does not cover adequately the necessary interphase between medicine and hospital economics. New leadership structure and competence have to be developed accordingly [9–11]. From the authors' experience, this position should be a clinic manager with competence in medicine and administration placed within the clinic and at the level of cost decisions, as an approach to anticipate these problems [12]. The concept of a clinic-based physician manager to integrate and solve economic aspects at the clinic level as described here is new. A search in the database MEDLINE on April 3rd 2010 revealed that there are only n = 15 publications with the key word 'clinic manager' and only n = 28 publications with 'clinical manager' listed. This confirms that economic and organizational aspects have not been a focus in medical publishing so far. However, among these publications, the professional group of nurses seems to have addressed some aspects of clinic management at a much earlier stage [13–15].

Definition of Chief Medical Clinic Manager

A CMCM is a new job description for Germany and an innovative approach to combine medical competence and business economics at the operational level of medical care. The position of CMCM is at the interphase between medicine and economics, a 'Trojan horse' in a positive sense with administrative thinking and targets within the medical environment to influence and affect costs right where they occur. This position is a management response to the need of changing structures in the German health care system [12]. It is intended to be groundbreaking in the quest for integration of economic and business aspects into treatment processes. This concept has been developed and proven to be successful over several years at a German university OB/GYN clinic.

Qualification and Competence

Preferable qualifications for the position of CMCM include a medical specialist from within the clinical field (OB/GYN consultant) with practical experience in patient care and leadership as well as in hospital economics and quality control. Medical school (MD), a scientific approach and methods (PhD), and a further degree in business or hospital economics (MBA) are the base for acceptance by both physicians and controllers and administration. Full specialist training verifies in-depth understanding of medical care. Hospital administration knowledge and quality management experience avoids a narrow-minded view just from a cost perspective, and leadership training supplies the tools and improves acceptance of the message. Knowledge of international health care systems and solutions are desired. Soft skills for a CMCM are leadership personality, ability to motivate and integrate medical staff and the entire hospital team, identification of win-win situations and ability to define tasks and priorities with quantification and transparency of results, as well as communication skills with adequate self-marketing of results.

Positioning of a Chief Medical Clinic Manager

As a staff position, a CMCM is primarily placed at a superior level next to the clinic director to whom he/she is reporting, but at the same time he/she operates in-line regarding economic aspects with authorizing competence for the entire physician team. The CMCM is integrated in the medical staff and participates in daily routine, especially meetings and shift

Table 1. Possible tasks for a Chief Medical Clinic Manager

n	Task	Target	Tools
1	cost transparency	increase of cost awareness	price lists for material expenses, internal clinic services, monthly cost reports
2	pharmaceutical management	cost reduction of medication for inpatients	monthly medication cost reports, active oncologic cost management
3	material costs	cost reduction of materials for inpatients	monthly cost reports
4	horizontal communication	improved and faster communication	scheduled routine communication with integration of all clinic aspects
5	cost-covering patient care	adjustment of costs of diagnostic and therapy to reimbursement	analysis of top-DRGs and the clinic-specific cost structure, talks with clinic leaders, active identification of less costly alternatives
6	adjustment to DRG system	length of stay according to DRG requirements, reduction of DRG outliers	length of stay-report, print-out lists for rounds, monthly reports with analysis
7	identification of cost drivers	reduction, shifting, and elimination of costs	analysis of monthly clinic reports
8	optimizing reimbursement	cost-covering reimbursement	models of reimbursement alternatives. reorganization of patient flow and pathways
9	correct coding	elimination of potential costly coding mistakes	clinic internal education, accurate and complete documentation for correct coding, integration of coding knowledge at physician level
10	strategic controlling	increased understanding and prospective steering	analysis of monthly clinic business report and all data
11	flow of information	steering by complete information	monthly reports and clinic data
12	increasing quality of care	improvement of service at or above guideline standard	identification of processes which reduce costs and simultaneously improve care

DRG = Diagnose-Related Groups.

changes; however, the position is unusual because of the unique combination of multiple qualifications. Although qualified as an OB/GYN specialist, it is generally an unsolvable ethical conflict to be responsible for patients and request best care irrespective of cost and to be in the economic position and supply best care at minimal costs at the same time [16]. Therefore, the CMCM should refrain from being involved in daily medical decisions and indications, and be mainly responsible for financial, informational, and organizational aspects, but should intervene and use his direction rights where essential or even survival-relevant cost aspects from the clinic's point are involved. Due to the aim of this position, a CMCM should represent the clinic in all internal commissions and workgroups relevant for or focusing on costs, organizational, and financial aspects.

Tasks of a Chief Medical Clinic Manager

The tasks of a CMCM are defined by each clinic's individual and specific needs and structure deficiencies, and have to be adjusted accordingly. The main problems have to be identified, ranked, and prioritized (table 1). In the initial phase, central contact partners have to be identified, e.g. in administration, controlling, purchase, and clinical pharmacy. Clinic internal information has to be screened for use for cost steering, structured information necessary on a monthly basis has to be defined, and a continuous flow of information has to be negotiated and installed. With these data, the tools have to be developed and adjusted and have to be combined in close feedback with the head of the clinic for the strategic orientation of the clinic and development of the future perspective. Yearly business plans assure defined targets and allow repeated benchmarking at defined time intervals. A CMCM should constantly inform, address, and discuss financial conflicts within the medical team including nurses, midwives, operating room (OR) staff, etc., and find solutions without lowering quality and standard of care. Main tasks are cost transparency within the clinic, organizational development by structured processes, and financial and strategic controlling of all business aspects. A valuable target for quick wins is in general the clinic's pharmaceutical budget which can be optimized through introduction of a cost model for chemotherapy [17, 18], a pharmaceutical budget to be reduced by over 75%

Table 2. Examples for a clinic manager's project-related savings or saving potentials at a university OB/GYN clinic

Projects	Savings or potential, €/year	Ref.
Oncologic cost management	approx. 900,000	[17–20]
Monthly pharmaceutical cost report	approx. 42,000 at one ward	[24, 25]
Clinical study management	> 100,000	[23]
Off-label use management	> 100,000	[21]
Clinical pharmacist at ward	approx. 25,000[a]	[28]
Implant cost management	approx. 85,000	[29]
Right-Coding	≤ 500,000	–[b]
DRG outlier (below minimum stay)	≤ 550,000	–[b]

[a]Breaking even for additional costs at a higher quality of care level.
[b]Unpublished data.

within 2 years [19, 20], addressing the problem of expensive innovative pharmacological substances [21], comparing costs between different chemo-regimens [22], and finally solving the problem of under-reimbursed clinical study costs [23]. A monthly report about costs and progress is supporting the target of cost-conscious resource consumption [24, 25]. A CMCM thereby induces change management. Important tasks are positive reinforcement to the team, feedback about results, increasing motivation to participate in the changing process, implementing continuous education about internal organization, the large spectrum of legal and financial aspects (SGB V, DRGs, MDK, NUBs, ZEs, AMR, Right-Coding, pharmaceutical regress, etc.). The CMCM serves as guidance towards cost covering patient care at maximum quality of care level. The development of financial or educational incentives supports this process and allows the staff to participate in the economic success.

Advantages of Hospital Economics – From 'Inside' to 'On-Site'

Usual attempts to influence physicians' cost decisions from the hospitals' administration level have shown limited results. To reach and influence the daily resource = cost decisions by physicians, input and influence can only be given at the daily operational level of care. The approach of a CMCM within the physicians' team allows implementing basic economic rules and influencing cost decisions on-site. A CMCM can help and encourage physicians caught in the dilemma of costs and ethics to stay within the financial limits but actively identify and distinguish between ethically necessary quality of care and desirable but unfunded convenience or unfunded expansion of medical service. Since physicians are better in addressing the patients' needs than business experts, physicians have to implement cost consciousness unless they are willing to give up and accept economic advice from the outside. This additional knowledge increases the control over the entire process as well as costs and the physicians' competence and freedom of action.

Negligence of this development has within the last decade lead to the fact that about 30% of German hospitals have been privatized and sold from public ownership to private companies [7]. The main reason for this is that repeated losses incurred by the hospitals can not be covered by the public anymore. But privatization is not necessary if public hospital administrations were able to act and adjust costs. However, from the physicians' point of view, the sale to private health care companies is neither the solution [26] nor an alternative to take over the responsibility for costs of resources used for heath care. Private companies implement strategies and a more sufficient controlling which public hospitals could do just as well if they really wanted to and tried. This would have several advantages for public hospitals, such as reinvestment of the shareholders' 5–10% dividend and profit margin in improved patient care [27], clinic infrastructure and quality measures [28], work conditions, etc. At the same time, physicians remain responsible and influential in the hospital for the necessary professional freedom of action and formal arrangement of the hospital setting.

Cost and Return on Investment for a CMCM

At the present time, the comprehensive medical and administrative education, high competence, and several amplifying qualifications of a CMCM can not be adequately remunerated by standard hospital physician tariffs. Innovative non-tariff contracts which can reflect personal effort and engagement offer a better alternative but are not possible in a variety of German hospitals for general structural reasons. The financial outcome and potential gains from a variety of previous projects are listed in table 2. From this previous experience in two German OB/GYN clinics at university level, the return on investment for a clinic-based CMCM is – depending on the economic maturation of the institution – at least a minimum of threefold and, as proven over many years, can be realistically up to ten times the salary over time, making it at the present time an excellent investment for economic improvement from within a clinic at the level of care.

Success Targets of a CMCM and the Perspective

The success parameter of a CMCM are positive operative results of the clinic, cost covering care, increased investment rates, employee satisfaction, and implementation of innovations in research and therapy. The time frame is depending on the clinic's basic conditions but first results should be reached and become significant within 1–2 years. The success is primarily depending on economic maturation of the organization, the information transparency reached, and – most importantly – the motivation of the physicians and entire medical team to implement these changes towards a more economic patient care.

Conclusion

A CMCM is a new management response to a changing health care system in Germany. As a system optimizer he/she acts at the interphase between medicine and administration. Inside the clinic, at the level of care, a CMCM is able to influence resource costs, hospital structures, and clinic processes according to legal, financial, and quality aspects. A CMCM thereby increases financial and organizational professional freedom of action in a non-profit health care system.

Conflict of Interest

The authors declare no conflict of interest.

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