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A readiness model for implementation of Program Management.

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A READINESS MODEL

FOR IMPLEMENTATION OF

PROGRAM MANAGEMENT

by

Pauline J. Brandes

A Thesis

Submitted to the Faculty of Graduate Studies and Research

through the Faculty of Business Administration

in Partial Fulfillment of the Requirements for

the Degree of Master of Business Administration at the

University of Windsor

Windsor, Ontario, Canada

1996

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ABSTRACT

Driven by spiraling costs and the increasing demands of consumers. workers and funding bodies. change is an ongoing and inevitable condition in the health care industry. Traditional structures. high professional differentiation and provider-centred processes have resulted in an inefficient system that requires radical change to meet the new demands of the environment and the market place. The literature on the shift towards decentralized organizational models such as Program Management. was reviewed. A Readiness Model was developed based upon the critical factors for successful implementation of Program Management as identified in the literature. A two part field study was then conducted in a multidivisional community hospital. Results confirmed that the critical factors identified in the literature were also viewed as critical factors in the study setting. Correlational analysis indicated a positive relationship between the perceived degree of development of the critical factors and the perceived success of implementation of Program Management. In the hospital studied. results for perceived readiness and perceived success ranked the hospital divisions highest to lowest for Rehabilitation. Regional Children's Centre. Long Term Care and Acute Care. The most important factors were perceived to be interdisciplinary teamwork. a philosophy of client-centred care. and shared vision and values. The results suggested a model incorporating the concept of the critical factors with the concept of the team-based organization. Self directed teams must be supported by the critical factors as they develop processes to deliver client-centred care to specific program populations. The Readiness Model may be used by healthcare organizations to evaluate the level of development of critical factors and to target areas requiring further development in order to facilitate successful implementation of decentralized structures.

DEDICATION

This thesis is dedicated to my husband. Bob. and to my daughter, Jesse. I could not have accomplished this task without their love. support and understanding. Over the years of part time MBA work. Bob willingly assumed more than his fair share of running our household. Jesse understood when I was not available to play as often as we both would have liked but she always offered her bright smile to cheer me up.

ACKNOWLEDGEMENTS

TABLE OF CONTENTS

TABLE OF CONTENTS

TABLE OF CONTENTS

TABLE OF CONTENTS

List of Tables

List of Figures

CHAPTER 1 : INTRODUCTION

1.1 The Changing Environment of Health Care

Fueled by increasing deficits in Federal and Provincial budgets, hospitals are facing dramatic funding cuts. Budget reductions of approximately 18% have been announced for local hospitals over the next three years. This follows several years of funding frozen at level rates while costs for items such as utilities, supplies, technology, benefits, and pay equity continued to increase and other sources of revenue such as preferred room rates also decreased. The cuts are being initiated at the end of three years of a social contract salary freeze, when healthcare workers are expecting compensation increases.

Traditionally, hospitals have been reimbursed for what they spend overall but the Canadian system is shifting towards the United States model of a prospective case-based payment system. They will be paid for what they do and ultimately for the outcomes that should be achieved (Mackenzie, 1992). However, in Canada, roles and bed numbers will be prescribed based upon Ministry directives for rationalization of services within communities and an increasing trend towards regionalization of health care planning and governance. Mergers, multifacility management, alliances, consortiums, networks and other forms of partnering are occurring with increasing frequency in order to leverage resources, exploit efficiencies and create integrated systems of health care (Insight Information Inc., 1995).

The other major impact on hospital funding derives from the shift in emphasis from in-patient to outpatient, community and home care services. In Windsor-Essex, the reconfiguration plan for the local health care system directed that the twenty two million dollars projected to result from consolidation of the hospital sector would be reinvested in community based care (Essex County District Health Council, 1994).

In addition to this financially driven need for reform based on increasing efficiency, a second impetus for transformation of health care delivery arises from the changing perspectives of the consumer and the healthcare worker.

Consumers demand more input into the healthcare system and into their own care. They expect high quality, convenient access, better coordination and more accountability from the system. Today's more knowledgeable consumers are no longer satisfied with care delivered within the frame of reference that the professional knows what's best. "People want to share the responsibilities of their treatment, to work together with their physicians, rather than being passive recipients of their care" (Orr, 1987, p. 3). Most health care organizations have therefore moved to a client centred philosophy of care. This term originated in the 1940's to refer to a new approach in psychotherapy that emphasized a more active client role in the therapeutic process (Gage, 1994).

At the same time, the healthcare workforce is also better educated and seeks increased input, involvement, participation and responsibility level in their worklife. These values foster empowerment of all personnel to respond to the needs of the patient rather than to the routine of the system (Eubanks, 1991). Staff empowerment and involvement has been labeled 'shared governance' by some professional groups such as nursing, and is becoming an industry standard. In the traditional structure, health care workers perform duties as assigned by their manager, who is held responsible for the department's outputs. Employees are afraid or unwilling to perform any duty beyond their stated job description or what they perceive the manager wants them to do. On the other hand, shared governance joins responsibility with accountability to enable health care workers to plan, manage and execute care activities as required for the benefit of the client. Within this philosophy, healthcare workers work for the patient and not for their supervisor. This

2

means that as employees become more empowered. managers must move from a control to a leadership role. The general trend is toward more democratic institutions. and away from traditional hierarchical forms of organizations (Leatt et al, 1994).

Shared governance or staff empowerment. along with the philosophy of client centred care. will drive changes in the way that healthcare is delivered. Client centred care will mean the development of services that meet patient needs as patients perceive them. not as professionals or hospitals do (Kosta, 1990).

As funding levels decrease and consumers and workers demand more accountability and input. the system is struggling to find strategies to reduce costs while maintaining quality and accessibility and meeting the needs of employees. This rapidly changing environment demands a shift in thinking, a fundamental reform. a new structure (Mang, 1995; Shackleton & Gage, 1995).

CHAPTER 2 : LITERATURE REVIEW

2.1 Traditional Hospital Structure

Organizational structures in hospitals have not changed substantially since early in the twentieth century. Their functional-hierarchical structures are based on the industrial reductionist model of F. Taylor with high worker specialization and division of labour. Following the lead of medicine and driven by the specialization of knowledge, skills and technology, individual allied health provider groups have, over time, laid claim to discrete aspects of the care process. This has promoted profession-based service differentiation (Wakefield et al, 1994). Each professional addresses one aspect of the needs of the patient, just as each factory worker performs one aspect of the assembly process (Gage, 1994). Therefore, workers cannot appreciate the big picture and often do not know the overall status of the patient's treatment.

With each profession based differentiation, new departments were established, resulting in management structures organized vertically into 'chimneys' of functional departments such as nursing, physiotherapy, respiratory therapy.

"This structure reflects how hospitals budget, manage productivity, ensure quality and report performance. This approach makes it more difficult to manage the total costs of care received by patients and/or to manage in relation to patient outcomes and results. Management concerns are more likely to focus on the outputs of each autonomous functional department" (Stuart & Sherrard, 1987, p.53).

As noted by Hamilton (1993), rewards are also based on individual or department performance which may encourage shifting of costs to other departments rather than on improving processes for the organization as a whole. Under traditional structure, clinical disciplines often become focused on turf protection. Care becomes more discipline focused than patient focused and no one is held accountable for the totality of care received by a patient. The resulting fragmentation of processes, lack of continuity and

lack of accountability leads to reduced quality and high costs of resource utilization. There is duplication and waste at the interface between separate services. In addition, hospitals maintain multiple layers of hierarchy, centralized decision making authority, a centralized approach to information flow and bureaucratic processes. This structure is based upon feeding the needs of the system rather than meeting the needs of the patients or workers. It leads to slow decision making, staff frustration and reduced responsiveness to the needs of the clients or to the changing environment. In a medium sized hospital, there are seven to nine layers of management between the caregivers and the CEO and up to 300 job descriptions. Large amounts of time are spent in documentation, scheduling, transporting patients between services and waiting time. Only 16-35% of caregiver time is spent on direct patient care (Moffitt, 1993: Christensen & Bender, 1994; Brider, 1992; Curtin, 1994; Lathrop, 1992). This has distinguished the traditional hospital as one of the most inefficient organizational models in existence.

Clearly, a fundamental shift in thinking is required to move from how best to provide a wide variety of independent services to how to combine individual service components into an effective and integrated health care experience (Wakefield et al, 1994). More efficient and more flexible structures are required to remove layers of decision making, to foster staff empowerment at the level of direct care, and to foster the principles of client centred care. If care is to be truly client-centred, then it must be delivered through interdisciplinary teams that coordinate all aspects of care for the patient and are able to make clinical decisions at the point of caregiver patient interface. "Addressing the needs of the patient comprehensively required the building of a multidisciplinary team which could put aside individual and department loyalties to focus on the well being of the patient" (Spitzer-Lehman & Yahn, 1992, p. 30). The client and family must also be involved in care decisions and interventions must be based on client specific goals and desired outcomes.

2.2 Decentralized. Client Centred Models of Delivery

Several examples of decentralized. client-centred delivery models have emerged in hospitals over the last twenty years. These include Product Line Management. Matrix Management. Program Management and the Client-Focused Care Model.

2.2.1 Product Line Management

Product Line Management uses a small business approach to plan. manage and market a distinct clinical service or department within a larger institution (Christensen & Bender. 1994). One of the pioneers in this model was John Hopkins Hospital in the United States (U.S.) where the hospital became a holding company for various clinical specialty units (Stuart & Sherrard. 1987). One of the main thrusts of this organizational model popular in U.S. hospitals in the mid seventies. was to control expenses by placing responsibility for costs in the hands of physicians. since most costs of hospital care result from their decisions. This model commonly used management teams comprised of a Physician Chief. an Administrator and a Nursing Director responsible for all components associated with the service including marketing of the line for each specialty unit. Each unit could purchase services such as housekeeping from the main hospital or from an outside provider (Heyssel et al. 1984). This model was highly physician driven. emphasized marketing of the line. and required that resource allocation be based on a product's ability to generate Return on Investment.

Problems arise in application of these principles to the healthcare system. particularly in the Canadian context. Physicians in Canada are reimbursed on a fee for service basis through billing the Ministry of Health for the services rendered to patients. This sets up a disincentive to allocate time towards administrative activities. Also. as noted by Bowers and Taylor (1990). resource allocation decisions in hospitals have rarely been based upon

6

measure of profit. even in the U.S. The emphasis on marketing in Program Line Management is more compatible with the competitive. volume driven model in the United States where 'service packages or products' are marketed to respond to specific market demands. In Canada. healthcare is delivered on the principle of universal access under government funding. In addition. the historical development of health care has resulted in a mixed focus on populations such as paediatrics. specialty diseases such as cancer and treatment modalities such as surgery. According to Zelman et al (1990). and to Bowers & Taylor (1990). this makes it difficult to reach agreement on what constitutes a 'product' and to develop mutually exclusive product line categories.

Product Line Management has been implemented in a few Canadian hospitals in specialty services such as oncology but in reviewing the literature. Wodinsky et al (1988) found few published examples of successful functioning of this model in health care. In most cases. it has been superimposed over the existing functional organizational structure and product line managers do not have direct authority over the staff assigned to their program. These managers must therefore rely upon the cooperation of functional managers in order to achieve their business goals under such a matrix arrangement. Wodinsky cites two hospitals in Canada including Kingston General Hospital and Sunnybrook Medical Centre. The Kingston model as described. is really an evolution towards case mix groups and the Sunnybrook Centre was in early stages of an evolution towards a Program Management Model.

2.2.2 Matrix Management

The literature on Matrix Management highlights the problems inherent in the dual reporting structure that results from superimposing project or program teams over the functional department structure. Employees are responsible to their discipline head as well as to the project or program manager. Allcorn (1990) states that matrix management

7

in the hospital setting is based upon the need to balance the resources held within functional specialties with the needs of programs for those specialty services. The specific balance of authority varies widely along a continuum from a functionally oriented matrix at one end and a program oriented matrix at the other. In the former, the program manager's role is limited to coordinating the work of employees from various specialty departments who take direction from their functional managers. In the latter, the Program Manager has direct control over the workflow and the personnel assigned to the program, and the functional managers are limited to addressing discipline specific professional issues. There is little evidence that Matrix Management works (Knight, 1976). Problems include ambiguity, employee stress, power/authority mismatch and time coordination costs (Allcorn, 1990; Bartlett & Ghoshal, 1990; Lawrence et al. 1977; Kolodny, 1979).

By the end of the eighties, many Canadian hospitals had begun to move towards the Program focus end of the continuum and to reorganize under Program Management Models.

2.2.3 Program Management

Unlike Product Line Management's emphasis on service packages, Program Management focuses on sets of activities directed at groupings of common patient care needs. These groupings may be on the basis of population group (geriatrics), disease (cancer), medical specialty (surgery), client needs (rehabilitation) or type of service (inpatient) (Leatt et al. 1994). The full range of resources and caregivers required by these groupings is assigned to the program and are accountable to the Program Manager, rather than to the discipline heads (Gillies et al. 1993). This ensures a greater degree of accountability for the set of services any patient uses and is compatible with the Quality movement dominating healthcare in the late eighties and early nineties. The premise is that the hospital should

8

be organized around the needs of clients rather than around the needs of the system or the needs of providers. Decision making and responsibility for the quality of care should be decentralized to the level of front line care. This philosophy of client-centred care as well as the principles of interdisciplinary team collaboration. outcome-focused, goal-oriented care and evidence-based practice are fundamental to program management (Leatt et al. 1994). The integration of clinical and management decisions at the program level facilitates a more comprehensive consideration of the implications of the decision. It also ensures a greater degree of accountability for effective use of resources. cost control. positive client outcomes and quality of care (Baptiste, 1993). Decision making at the point of care delivery should increase flexibility and increase the speed of response (Meeks. 1994). Stuart & Sherrard (1987) agree that efforts to ensure best patient outcomes are enhanced by the Program Management approach through integration of decision making of the various functional specialists. It also ensures that the most appropriate mix of services to meet the patient's needs are organized in a single centre of response for the total care provided for the patient.

"Program Management is not an easy concept to implement as it requires a change in management style and requires an evolutionary approach to implementation" (Harber & Eni. 1989. p. 38). Canadian hospitals are increasingly adopting Program Management but they are doing so using variations to suit the specific mission. size, level of complexity. range of services and environment of each facility (Leatt et al. 1994; Baptiste. 1993; Harber & Eni. 1989; Monaghan et al. 1992). The specific grouping of services into programs varies, but Stuart & Sherrard (1987) advocate that the definition of hospital programs should be based upon consideration of what management entities are most suitable for ensuring an effective and practical management structure. They note that each major Program may have several programme components and each component will include a number of service elements. For example, a Cardiac Program may include

9

program components of cardiac rehabilitation. cardiac surgery and cardiac assessment with the assessment including service elements such as radiology and stress testing.

The benefits and advantages of Program Management cited in the literature (Leatt et al. 1994; Stuart & Sherrard. 1987; Monaghan et al. 1992) include:

- smaller units focused on the bottom line of care and cost containment
- facilitation of outcome measurement : the extent to which the health of specific patient groups has been influenced by the services provided
- better strategic planning
- increased commitment and innovation within program teams
- opportunities for external linkages resulting from clear program identities
- better resource allocation based on needs of program client group
- better cost containment
- reduced turf protection
- facilitation of interdisciplinary approaches to care
- streamlining of management hierarchy
- greater accountability for the overall quality of care

Complete program organization is often more theoretical than practical. as there will always be some centralization due to technology. specialization and economies of scale (Leatt et al. 1994). Most hospitals have implemented modified or partial designs that retain some functional elements and selected centralized services such as housekeeping and food services. However, some hospitals have adopted complete models with full integration of functional specialties into the programs and costing of all resources. services and activities to the programs. They have adopted a 'client-focused care' approach.

2.2.4 Client-Focused Care Model

This approach is a highly evolved form of Program Management. It utilizes a fundamental reengineering of the organizational structure and patient care processes to increase the amount of direct care, to decrease the number of providers that come into contact with the patient and to minimize movement of the patient. This is accomplished by bringing all services closer to the patient through adaptation of the environment by creating satellite services such as lab, pharmacy and X-ray on each unit. Process reengineering, job redesign and multiskilling are used to simplify procedures and to create a core work team to perform as many functions as possible on the unit (Brider, 1992; Lumsden, 1993; Jirsch, 1993; Eubanks, 1991; Spitzer-Lehman & Yahn, 1992; Townsend, 1993; Kosta, 1990; Rondeau, 1995; Mang, 1995; Wakefield et al. 1994). This approach requires high implementation costs. Bishop Memorial Hospital however, reported that cost benefits exceeded the conversion cost of 1.3 million dollars and that productivity as measured by direct care hours/day increased from 7.5 to 12 (Moffit, 1993). This highly complete Program Model has been limited in Canada although some aspects of process reengineering, work redesign and multiskilling are being utilized in many hospitals to enhance their chosen design. An example of multiskilling has been implemented at Sunnybrook Health Sciences Centre in Toronto, where a position of service assistant was created to combine six unionized job roles including dietary aide, orderly, porter, unit aide, health care aid, and helper (Marshall, 1995). This multiskilling is expected to reduce the support service management infrastructure cost by as much as $500,000 (Carmichael, 1994). A multiskilled position of support service representative was also established at Peel Memorial Hospital in 1993 (Harber, 1994).

11

2.3 Experiences in Implementation of Program Management

The variations being tried in Program Management and the factors to be considered in implementing the new model are underlined by specific case studies of implementation in Canadian hospitals (Leatt et al. 1994).

One of the first hospitals to initiate a Program Management Model in 1985 was the Health Sciences Centre in Winnipeg . They established six major clinical programs with a mix of advisory, decision making and coordinating committees but retained functional staffing control. Harber & Eni (1989), noted that the committee structure created a long process for accomplishing program goals. They emphasized the importance of top leadership. commitment at all levels of the organization and clear roles and responsibilities to effect such change successfully.

Rather than a committee structure. Sunnybrook Health Sciences Centre in Toronto has evolved a co-leadership structure in their decentralized model developed in several waves since 1988. Each of three major clinical units is under the co-leadership of a Physician and a Nurse Director with care delivered by semi-autonomous teams. A service chief was designated for each professional discipline to maintain standards of care and professional identity and multiskilling was initiated in the position of service assistant. This centre found that frequent communication using a variety of mediums was a critical factor requiring emphasis during implementation (Ellis & Closson. 1994; MacTavish & Norton. 1995; MacTavish et al. 1995).

Peel Memorial Hospital further contributed to the list of factors important for successful implementation of decentralized models. A review in 1991 identified issues in the implementation process: lack of understanding of the rationale for implementing program

management, lack of skills such as problem solving and consensus building, lack of information system support, role conflicts between program managers and functional managers, lack of support for professional standards, degree of centralization and physician involvement. Based on this information, the new CEO initiated a process of renewal that decentralized professional accountabilities to the program level and established a Professional Advisory Committee with discipline directors to ensure professional accountability and standards of care. One of the strengths supporting the renewal was the fact that there was an organizational culture that supported teamwork. Increased education and communication strategies as well as a transition team were utilized during the renewal process. By 1993, staff were reporting increased quality of patient care, increased team cohesiveness and increased decision making quality, accountability and productivity (Harber, 1994). This supports the positive effect on implementation resulting from attention to specific factors such as the need for education and communication.

McMaster University Medical Centre in Hamilton began to develop a clinical program management structure in 1990. They experienced similar issues in implementation as those reported at Peel Memorial Hospital (Baptiste, 1993). According to Baptiste, areas of difficulty included : lack of role clarity particularly for former discipline heads resulting in power struggles and staff confusion, gaps in shared decision making, and lack of shared vision and corporate identity. However, she notes that after two years, the new model has proven to be successful in terms of fiscal management, setting of priorities for service delivery, as well as team interaction and involvement.

In a 1990 reorganization to support Program Management, the Hospital for Sick Children in Toronto also recognized education as a key factor for success. Special education sessions were held during implementation to focus on program management philosophy

13

and change management principles. They also developed program budget models to capture all program costs prior to the change. Evaluation after three years considered program management to be a success due to a corporate culture that included top management commitment, physician involvement, education. communication, encouragement of collaboration. effective information and budget models as well as multidisciplinary teamwork (Leatt et al. 1994).

Women's College Hospital also reported that the move to a Program Management model has been successful in allowing the hospital to achieve service targets and savings within programs as well as increasing staff involvement in decision making. As in other hospitals, early commitment and vision of the CEO were highlighted as important to success (Ross. 1994). One of the implementation issues was ensuring continued voice for professional nursing issues and maintenance of nursing standards as the functional department was dismantled. The hospital established a Professional Advisory Committee to respond to these needs. Other difficulties encountered were cross-program competition and loss of flexibility in transferring resources (Macleod. 1994).

The importance of education and training was again highlighted in implementation of Program Management at St. Peter's Hospital in Hamilton. Gilbert (1994), noted that extensive leadership educational programs were key in training the Primary Care Coordinators for their roles in managing the ten interdisciplinary programs established. Each Primary Care Coordinator is responsible for coordinating the team and ensuring that assessment. planning. implementation and evaluation of wholistic patient care is achieved. They facilitate interactions and events with the patient to deliver care that focuses on the patient and his/her choices and goals. Harber & Eni (1989) have also emphasized the importance of training and education to define roles & responsibilities. and to develop skills such as team building, negotiation, and coaching. They state that

14

"the key to successful Program Management may rest with the Program Manager" (p. 12).
Once again. communication strategies. defining a role for directors of professional services and development of program oriented information and financial systems were seen as other key issues in implementation at St. Peter's (Bain et al. 1994).

Learning from the experience of other hospitals, Markham Stouffville Hospital, located north of Toronto, implemented a program management structure which would provide discipline based support outside of a functional departmental structure at the onset. They also emphasized communication of the change process and the use of the Concerns Based Adoption Model for change management as key elements in implementation. The new Program Management structure has resulted in increased teamwork. better flow to patient care. decentralized decision making, faster response times and increased empowerment and involvement of staff (Bruner & Barker. 1994).

In its initial implementation of Program Management, West Park Hospital in Toronto initiated a pilot project in three of it's six program areas in 1991. Due to the pressures of maintaining parallel structures however. it spread the model to the other programs before the end of the pilot (Monaghan et al, 1992: Morris et al. 1994). Each program was managed by a service director and a medical program director but a professional standards and issues committee was established to monitor standards and provide a forum for professional issues. A unique feature of the model was restructuring of the board along program committee lines. External consultants were used to develop an evaluation of Program Management and they state that the evaluation provides evidence to support the overall validity of the program management structure (Morris et al. 1994).

In their article on Homewood Health Centre in Guelph, Pond & Herne (1994), emphasize that preparation and planning are key factors for successful implementation. They also

15

emphasize the need to manage the change process. to educate staff, and to deal with the resistance that occurs. In particular, professional issues and fears must be addressed. roles must be clarified and strong leadership and top support must be in place. Evaluation after three years noted better control over costs, budgets and allocation of resources. empowerment and commitment of staff, improved decision making, improved customer satisfaction, increased physician involvement and improved communication.

To date then. the Canadian hospitals implementing a Program Management model have identified a number of common factors that have affected their success. These factors include the following:

- top management support
- shared vision and values
- a client-centred philosophy
- interdisciplinary team culture of trust and collaboration
- clear roles and responsibilities
- good communication and education/training strategies
- attention to the professional needs of healthcare workers
- strong program leaders
- use of change management strategies
- the development of information and financial systems as well as performance appraisal systems to support the program organization

2.4 Evaluation of Success of Program Management

There is still a lack of empirical support to indicate that Program Management is a more efficient and effective means of delivering health care services (Pond & Herne. 1994). "The possibility of making causal links between a change in organizational design and hospital performance in relation to costs. utilization, quality or medical outcomes is

16

especially difficult in a rapidly changing environment" (Leatt et al. 1994, p87). As discussed in section 2.3 above, most of the hospitals that were implementing Program Management were also undergoing simultaneous changes such as mergers. Also, there were no effective monitoring systems in place. Hospitals reporting on their change to Program Management have reported it to be a positive change overall and that it is a process of continuing evolution and improvement (Leatt et al. 1994).

The West Park evaluation study (Morris et al, 1994) indicated that most staff perceived program management as a positive change and that few would revert to the previous structure. It determined that the new structure offered better, more coordinated delivery of services. Findings were based upon surveys, interviews and focus groups with staff, residents, physicians and management in Oct. 1991 and again in March 1992 (Morris et al. 1994). Most hospitals reported that patient satisfaction was maintained with Homewood Health Centre reporting improved satisfaction (Pond & Herne, 1994). In general, the hospitals reporting in Leatt (1994) believed that as a result of the change to program management, decision making had been speeded up, there was increased staff involvement and commitment, and it was easier to achieve quality care through the interdisciplinary team model. The cases were not specific about whether savings had resulted but several did report that senior management positions were eliminated. In many cases, the development of compatible information systems to measure costs, workload and quality were implemented after the changes in organizational structure and therefore, monitoring of performance may be more possible in the future.

However, limitations of the new structure have also been identified. Professional staff at Westpark perceived a decrease in the amount of time available for direct care as a result of increased team meeting time. Secondly, due to small numbers of certain professionals, cross-program staffing is often necessary to provide the required specialty expertise to all

programs. This has a negative impact on the individual's ability to function in a variety of interdisciplinary teams and to deal with multiple demands which may affect job satisfaction. This is a particular issue for new graduates. A related professional issue arises from the fact that the common practise of rotating staff through various programs for professional development and retention purposes is not compatible with consistent discipline coverage in a program and may compromise achievement of program goals (Harber & Eni, 1989). Split assignments also create complex payroll and financial accounting demands to allocate staff time across programs. A third issue results from the fact that functional managers are no longer responsible for assigning staff across the corporation : flexibility is reduced for dealing with sick, vacation and vacancy issues (Monaghan, Macleod, Pond & Herne, 1994). Also, professional associations and training programs have been slow to embrace the concept of program management and many still require supervision by a discipline specific supervisor. Another limitation stems from the flattening of the hierarchy since it results in reduced opportunity for career advancement. The fifth issue of financial compensation for lost clinical time for physicians has not been resolved and this has continued to limit involvement of physicians in the new structure (Monaghan et al, 1994). Lastly, most hospitals have not had the level of funds available to implement technology to support the information requirements to make good decisions within the program structure. The importance of an efficient information infrastructure has been emphasized by Harber & Eni (1989); Morris et al (1994); Harber & Miller (1994). The latter state that the information in a Program Management environment should be current rather than retrospective, specifically focused on the product and correctly aligned for the organizational structure. In addition, the program format is in conflict with the reporting format of the Ministry of Health that still requires information reported by department.

The West Park consultant's study confirmed the anecdotal information reported by other hospitals regarding factors that were viewed as important in maximizing the success of implementation despite these longer term limitations. These included honest, timely communication, commitment from senior management, shared direction and values, the need to work with professional groups inside and professional associations outside the hospital to address professional concerns when centralized discipline specific departments are eliminated, the need to maximize the time that staff have available for direct patient care, development of interdisciplinary philosophy and teamwork skills, strong leadership skills for program directors and the necessity for strong program-based information and finance systems.

2.5 Principles of Change Management

Despite the reported successes in moving from a traditional structure to Program Management, hospitals such as West Park reported that they underestimated the degree of resistance to the change process and in particular, the level of attachment that staff felt for the functional line organizational structure. Meeks (1994) has also noted that professional staff have been the most threatened in the shift to Program Management as many have felt that their profession would be devalued by reporting to a Program Manager who was not of their discipline. Hospitals have relied heavily upon the professionalism of their staff, and in many instances have been able to provide excellent care despite inefficient systems only because of the dedication of their staff. Therefore, this is a significant issue in the implementation of Program Management. As Ellis & Closson (1994) discussed, staff identified with their profession as part of their own personal identity and were very threatened by the loss of their historical identity with a professional department. Hospitals have responded to these professional concerns in a variety of ways including the establishment of Professional Advisory Councils or new roles for functional managers as clinical experts .

19

Given the magnitude of change involved in moving to Program Management, the risks involved in large scale reorganization, and the degree of resistance that hospitals encountered, attention to the general principles of change management is warranted.

Flaherty (1979) argued that in today's society, change is no longer the exception but the norm. Managing change more systematically will assume increasingly critical importance. As outlined by Marks (1994), Kurt Lewin developed a three step model for change management that has been widely used in a number of sectors. He has labeled the first stage unfreezing of current practices and procedures. This is followed by a changing phase in which redevelopment occurs to be culminated by a stage of refreezing when the new processes and desired behaviours are reinforced. Bridges (1980, 1991), discusses change management in the context of the need to manage *transition*, the psychological process people must go through to come to terms with the new order. This involves an initial stage of ending or letting go of the old order and the old way of doing things. Both Bridges and Connor (1993), emphasize that this should include appreciation of the past. It is also necessary to acknowledge and manage resistance to the change (Cross et al. 1992; Bryant, 1979). Ending is followed by a neutral stage in the gap between old and new. Bridges notes this as a stage where great innovation, experimentation and creativity is possible if staff are encouraged and supported. The final stage of new beginning is when the new way of doing things becomes established. Institutionalization of the new order is necessary to ensure that the change endures and that people do not revert to the old way of doing things. A number of authors note that this requires that new expectations, new procedures, rewards and structures reinforce the new behaviours required and that the necessary resources are provided (Moss-Kanter, 1983; Beer et al. 1990; Bridges, 1991). According to Cauthorne-Lindstrom and Tracy (1992, p.92), "the first requirement for successful large-scale change is a clear **vision** of what the change

20

will look like. In the absence of a clear vision, the change process will flounder and fail, as a variety of people attempt to achieve different and frequently incompatible pictures of how things should be (p. 61)." Bartlett and Ghoshal (1990) also emphasize the importance of building a shared vision and continually reinforcing, elaborating and interpreting the core vision to keep it from becoming abstract or obsolete.

In order to sell the vision to the rest of the organization, there must be **total commitment from the top**. Bard (1994), notes that the CEO must be visibly behind the change and senior executives must contribute their time and enthusiasm to impress the merits of change upon all employees.

Another key element in successful change management is **communication**. Senior management must ensure consistent, frequent communication throughout all stages of the change process. Argenti (1992), underlines the need for a coherent corporate communication strategy that includes analysis of the relevant constituency groups and the appropriate messages. Symbolic events can have value far beyond the day and Moss-Kanter (1983), sees magnifying power in using recursiveness throughout the process to demonstrate the desired principles and behaviours. Initial communication efforts should clearly communicate the need for change; this need must be felt throughout the organization in order to facilitate buy-in from the workforce. Connor (1993), actually advocates orchestrating "pain messages" as the first step in developing organizational commitment to change. A credible vision of the future and a clear plan for getting there should also be communicated to all levels in the organization. If this is not done, people will see no need to let go of the old or will get stuck in the neutral zone of change with no incentive to accept the discomfort of developing new behaviours. In the health care setting, it is essential to communicate to workers how they and the people that they serve will benefit by the change. This is particularly important in an industry where mergers

21

and downsizing have resulted in disruption in work routine, lay offs, and staff anxiety and frustration. In order to support change, health care workers must understand why it is required and they must perceive that the change will result in increased efficiency, quality of care and increased job satisfaction.

Organizational members who support the change can be utilized as **Champions** to play an important role in communication and in generating enthusiasm among others (Cauthorne-Lindstrom & Tracy, 1992). Connors (1993) uses the term sponsors to denote those with the power to sanction and legitimize change and he describes a cascading sponsorship to constantly reinforce the importance of change as it moves through the organization.

Involvement of the people who must implement the change is also a critical element for successful change as discussed in the literature. Moss-Kanter (1983) notes the importance of engaging employees in problem solving and in remaining constantly aware of the needs of employees when decisions are made that affect the workplace. She states that in a stable environment, companies can ignore people and just require them to fit into the system but in a changing environment, organizations must relearn the importance of people. Many other authors have expanded upon the importance of involvement of employees given the profile of the modern workforce as higher educated and more demanding of input into their work life. If workers are not involved, informed and educated about the change, they may become mired in maladaptive response to the stress and uncertainty of a transition (Marks, 1994).

The following are ten commandments of implementing change as discussed by Todd Jick in his 1993 book on managing change.

- analyze the organization and it's need for change
- create a shared vision and common direction
- separate from the past
- create a sense of urgency
- support a strong leader role
- line up political sponsorship
- craft an implementation plan
- develop enabling structures
- communicate, involve people, and be honest
- reinforce and institutionalize change.

These commandments sum up many of the ideas discussed in the literature on change management and would apply to the type of radical change in organizational structure being investigated in this study.

CHAPTER 3 : THEORETICAL FRAMEWORK

3.1 Study Rationale

As discussed in chapter 1. the Canadian healthcare system is undergoing radical change in response to an increasingly complex and uncertain environment. As funding levels decrease. workers demand more democratic workplaces and consumers demand more accountability. the system is struggling to reduce costs and involve workers while maintaining quality and accessibility of care.

In response to this rapidly changing environment, hospitals are shifting to decentralized. client centred models of care delivery as outlined in chapter 2. An increasing number are moving to a Program Management model using variations to suit their specific environments. The literature suggests that the specific form of Program Management chosen is less crucial to successful implementation than the degree of development of a number of critical factors.

This information was used to develop a Readiness Model based on these critical factors. See **Figure 2**. A two stage study was then conducted in a multidivisional community hospital in order to validate the model and to examine the correlation between the critical factors and successful implementation of Program Management.

3.2 Conceptual Framework

The conceptual framework for the study is presented in **Figure 1.**

3.2.1 Factors Driving Change

As discussed fully in chapter 1, a number of forces in the healthcare industry are contributing to a complex, turbulent environment and are driving change away from the traditional hospital structure. As shown, the Ministry of Health directives put increased

24

Figure 1
Conceptual Framework

Factors Driving Change

Complex, Turbulent Environment
- ↓ funds
- ↑ costs
- expanding technology
- changing workforce
- ↑ public demand for Quality and Service Continuum
- change in industry standards / values
  - ↪ client-centred
  - ↪ shared governance
  - ↪ team approaches
  - ↪ outcome orientation
- * MOH directives
  - ↪ rationalization
  - ↪ regionalization
  - ↪ shift to outpatient
  - ↪ consumer driven
  - ↪ accountabilities / case costing
- Local Reconfiguration

* MOH = Ministry of Health

Internal Context

Complex, Turbulent Environment
- merger
- multidivisional
- multisite
- new construction
- relocations and program shifts
- traditional, functional hierarchical organization
- divisional differences in structure & development

Decision to Implement P.M. *

Varied Time Lines For Divisions

Implementation

Development of Critical Factors
- client-centred culture
- process capability
- education and training
- professional issues strategy
- change management strategy

Successful Outcome

Indicators of Successful Implementation of P.M.
- integration of care
- interdisciplinary team work
- client-centred focus
- involvement client / family
- staff involvement in decision making
- outcome focus
- goal focus
- Quality of Care
- efficiency in use of resources
- professional stds maintained

** P.M. = Program Management

25

emphasis on rationalization of resources to reduce duplication of services, staff, and equipment between community hospitals and agencies. They also emphasize regional planning of services and a shifting of funding from inpatient to outpatient and community services. While the resources of individual hospitals decrease. costs continue to increase for technology and operations. At the same time, increased accountability is demanded by the Ministry, the consumers and the workforce. In general, hospitals are expected to maintain quality and accessibility despite increasing demands and dwindling resources. This situation drives the need for a shift to a more efficient system that is client-centred, outcome-oriented and team-focused. At the local level, activity aimed at reconfiguration of the healthcare system has been ongoing over the past five years and this has had major impact on the internal context of the hospital setting of this study.

3.2.2 Internal Context

A major result of the local reconfiguration planning was the consolidation of the four city hospitals into two corporations. The hospital under study. Windsor Regional Hospital. was incorporated in December 1994 as a result of a merger between the Windsor Western Hospital Centre and the Metropolitan General Hospital. This created a multisite. multidivisional hospital corporation with 731 inpatient beds, a range of outpatient and community services and a staff of 2.306. The internal context is complex and turbulent. There have been department consolidations between sites and complete relocation of programs/services from one site to the other. As expected. the merger. consolidation activity, and the mixing of two cultures has resulted in numerous issues. These include staff anxiety, decline in morale, turf struggles and union issues. To date most downsizing has been absorbed through attrition and early retirements although there has been job loss and turnover within the middle management group.

The internal context also included new construction and the complex issues associated with moving the staff and clients of the Regional Children's Centre and the Long Term Care Centre from old buildings to new ones on the Western site. These moves occurred in June 1995. In a further move in June 1996, 76 chronic care patients were moved from the Metropolitan to the Western campus.

Another major impact on the internal environment was the preparation for an Accreditation of the hospital to be conducted in December 1996.In keeping with the new standards, accreditation committees were established in for each major Program and for support services . These committees mixed staff from both campuses in an interdisciplinary context and required the commitment of a great deal of time and energy.

3.2.3 Decision to Implement Program Management

In June 1995. Windsor Regional Hospital made the corporate decision to organize under a Program Management Model. However, the various divisions would be at different stages in implementation of the model. The Regional Children's Centre (RCC), had adopted a program model prior to 1990 and the Rehabilitation Services Division was historically organized along a program model in it's specialty programme areas. The Long Term Care (LTC) Division began evolution towards program management as part of the planning for the move in June 1995. The Acute Care Division was organized under a traditional functional model and encompassed a varied range of services. In June 1995. these areas were organized into four Programs: Women's and Children Program. Surgery Oncology Program. Critical Care Program and Medicine Mental Health Program.

3.2.4 Implementation

As illustrated in the literature, the decision to implement Program Management necessitates the development of a number of critical factors to facilitate that implementation. These are discussed in the following section on the Readiness Model.

In addition, general change management strategies are also important to successful implementation of Program Management or any other new organizational structure. This includes a need for comprehensive communication strategy that establishes the need for change and keeps all levels of the organization informed throughout the change process. Support from the top is another key issue in change management. In the case of a hospital, the support of the physician group as well as the management group is important in facilitating change and acting as champions to create 'buy-in' throughout the organization.

3.2.5 Successful Outcome

Indicators of successful implementation are based upon the philosophy and key principles of Program Management. Program Management should result in increased integration of care through increased interdisciplinary teamwork. Care should be goal-oriented and outcome-focused. There should be increased focus on client needs (client-centred) and increased involvement of the client/family. Decision making should be decentralized to the point of action and should reflect team input. The overall result should be increased quality of care and increased efficiency in the use of resources as the full range of professional expertise required by the client group is responsible to the program. At the same time, the system must ensure that standards of care are maintained (Leatt et al, 1994).

3.3 Readiness Model for Successful Implementation of Program Management

The model shown in **Figure 2** shows the critical factors for successful implementation of Program Management. The model may be used by a health care facility to evaluate its readiness for a change from a traditional structure to a Program Management structure. The success of Program Management will be related to the degree of development of the critical factors in addition to the organization's use of change management principles. The critical factors have been grouped into four subcomponents based on face validity: Client-Centred Culture, Process Capability, Education and Training and Professional Issues Strategy.

3.3.1 Client Centred Culture

Marszalek-Gaucher and Coffey (1990) have stated that cultural change lies at the heart of successful transformations in health care organizations. Cultures characterized by consistency, organization wide consensus and clarity have been found to lead to greater effectiveness. Nystrom (1993) studied culture in health care organizations and found that people who work in a strong culture feel more committed and that culture affects the important outcomes in the organization. Findings by Carman et al (1996) showing that culture played a pivotal role in successful implementation of continuous quality improvement (CQI) programs are relevant to this study as CQI shares common philosophical aspects with Program Management. Both require a culture that embraces a client-centred focus, high staff and client involvement, teamwork, goal orientation, outcome-focus, and tolerance of risk taking that will support change, innovation and decentralized decision making. These elements are fundamental cultural elements to underpin the philosophy of Program Management. The interdisciplinary nature of the teamwork inherent to Program Management requires development of a culture of collaboration, respect and trust as professionals with a variety of skills are brought together to plan and deliver integrated, quality plans of care for special populations.

29

Figure 2
Readiness Model

Process Capability

- decentralized decision making
- flatter hierarchy
- information systems
- care and support processes
- integrative mechanisms
- performance / reward system
- risk management / QM

Client-Centered Culture

- shared vision and values
- client-centered philosophy
- interdisciplinary teamwork
- staff empowerment
- collaboration / trust / respect
- staff participation / involvement
- shared decision making
- quality focused
- outcome focused
- tolerance of risk taking

Successful Implementation of Program Management

Professional Issues Strategy

- professional standards
- unions / professional organizations
- roles and identity
- peer support
- quality of work life
- professional development

Education and Training

- program management philosophy
- client-centered care
- new structures and procedures
- new roles and responsibilities
- staff skills and behaviours
- staff attitudes
- new skills / roles for leaders

30

Empowerment of team members and shared decision making are other essential cultural elements for successful program management. As emphasized by Bartlett and Ghoshal (1990), taking the time to develop shared corporate beliefs/norms and a strong culture is essential to establishing corporate change : it enables all employees to concentrate their efforts in the same direction.

3.3.2 Process Capability

In 1983, Moss-Kanter pointed out that in resource lean times, the domain for innovation shifts towards managerial procedures and organizational practices. In order to make program management work, processes of care as well as support systems must enable, rather than hinder. client-centred care and must minimize waste and rework. As noted by Curtin (1994). unless hospitals reengineer their processes to eliminate wasted time, workers will be overburdened and will have less time for direct care activities. Furthermore, processes and procedures should be designed from the basis of needs as defined by the client group. Decentralized decision making is essential to building a responsive system in which decisions can be made quickly at the front line level of activity in order to react flexibly to the environment. This requires a flattening of the traditional hierarchy in hospitals and a move away from centralized control and lengthy bureaucratic approval procedures. The development of integrative mechanisms is also important to encourage fluidity of boundaries. free flow of ideas between areas, lateral relationships and coordination of effort. Otherwise, there is a danger that the new programs will become isolated 'chimneys' like the old functional areas did under traditional structure.

The health care management literature indicates that in most cases, there has been poor development of the infrastructure to support decentralized care delivery models. Some

31

organizations made clinical performance improvements but failed to achieve significant savings because they failed to change the technology to support the new system (Bergman, 1994). Clarke (1994) goes further in stating that "old systems can frequently be a drag on the ability of the organization to move forward with changes : they just don't 'fit' anymore" (p. 91). Harber and Miller (1994) note that in particular, Program Management results in a complex, highly information-dependent operational environment. Other authors such as Stuart and Sherrard (1987) agree that information systems are essential to support program management functions such as human resources, quality improvement, risk management, cost and productivity and that this information must be geared to reporting on the program level rather than the functional department level. In terms of costs, this can provide the potential for program management to control costs per patient group. Unfortunately, Canadian hospitals still lag behind industries of similar financial scale in investing in information systems. According to Harber and Miller (1994), hospitals devote only $2^{o}o$ to $4^{o}o$ of their annual budgets for this purpose compared to $10^{o}o$ allocations in banking, retailing and insurance. This is a significant dilemma. Hospital funding is decreasing, which further limits investment in information technology and yet hospitals such as West Park have found that the effectiveness of Program Management depends largely on an efficient information infrastructure (Morris et al, 1994).

Reward and performance evaluation systems must also be revamped to support the new model in order to reinforce the new behaviours required under Program Management and to discourage the tendency to drift back to traditional behaviours and roles.

3.3.3 Training and Education
Any change process requires education of those affected about the need for the change, new structures, procedures and behaviours as well as new roles and responsibilities. Lack

of clear understanding of roles and responsibilities was cited as an issue in several of the hospitals that had moved to a Program Management Model as outlined in section 2.3.

Boston and Vestal (1994) contend that communication and education of staff should begin well before implementation of change as staff require time to acquire new competencies and skills. Program Management does require a number of particular skills, behaviours and attitudes. The interdisciplinary nature of the model requires team and interpersonal skills such as collaboration, consultation, problem solving, consensus-building, negotiation, constructive criticism and active listening. It is also essential that teams members develop a shared understanding of the philosophy of program management and client-centred care and that positive attitudes of cooperation, trust and respect are fostered. Program managers must learn new skills in team building and must shift from a role of controlling and monitoring to one of facilitating, coaching and leading. They must also learn principles of change management in order to effectively assist staff in dealing with uncertainty and resistance. Sherer (1995), profiled a successful change process in a U.S. hospital which was largely attributed to a significant training and development process provided to staff prior to the change. A similar process involving a two day educational program in another U.S. hospital was specifically targeted on multidisciplinary context, client-centred care concepts, team-building, change theory and creativity (Kennedy and Crowell, 1995).

3.3.4 Professional Issues Strategy

The health care setting is particularly vulnerable to problems related to professional identity and autonomy. The system has been heavily dependent upon the enormous professional devotion of practitioners who have been trained to be autonomous professionals and to make independent decisions on a case by case basis. These professionals have high loyalty and attachment to their professional disciplines from

which they derive a sense of identity, peer support and status. Accordingly, hospitals that have moved to decentralized models emphasizing interdisciplinary teams rather than functional departments have found that the dissolution of department structures leaves a void and creates issues requiring attention. Kennedy and Crowell (1995) state that "we needed to address their professional identities, give them opportunities for input into patient operations, meet their educational needs and assure quality improvement activity" (p. 10). Hospitals have responded to the professional issue by setting up a variety of structures to preserve professional voice (Schneller & Ott, 1996) and ensure quality monitoring. These have included special roles for clinical leads or discipline heads as well as committees with representative from each discipline, e.g., Professional Advisory Committee, Clinical Resource and Standards Team, Professional Affairs Committees.

Other potential professional issues are related to team roles. Interdisciplinary teams are composed of a variety of special expertise that should complement rather than duplicate other members in order to deliver the most comprehensive and integrated care possible. As these integrated processes are developed, issues arise regarding core or lead professional competencies and areas of overlap. Also, the traditional, informal hierarchy which gives more power to some disciplines than to others increases the possibility of conflict and can create apprehension about reporting to a program manager from a different clinical background. Collaboration, negotiation, mutual respect, flexibility and teamwork are required to manage these issues and to address the interprofessional competition (turf wars) that can result. According to Lumsden (1993), nursing has experienced particular difficulty with ambiguity about their role in some patient-focused systems. In addressing this same issue, Boston and Vestal (1994) underline the need to shift nursing ideals from a nursing care focus to meeting the broader organizational goals. The goals of all individual workers should be congruent with those of the organization.

Peer support and professional standards can become a particular issue on teams where there is only one of a particular discipline. Individuals may feel isolated from others in their profession and cut off from input from them. In situations where one individual is assigned across multiple programs, issues arise in dealing with the complexities of scheduling and in meeting the different demands and expectations of each team. Other issues affecting quality of work life include the fact that rotation through a variety of assignments may be desired by the professional but is not compatible with program needs. This is a major consideration for new graduates who require ongoing training and supervision. Professional organizations and unions if present, are important influences for health care workers and their involvement and support in a change process is important to success. As advocates for workers and for quality care. these bodies are likely to support change to decentralized models if they see the potential benefits for clients and for the worklife of their members. Professional associations have been slow to endorse Program Management although they have strongly endorsed client-centred care. At issue is the need for preservation of professional standards of care through a functional discipline head. As discussed above. this can be ensured without the need for traditional department structure as long as the organization is committed to a strategy to address professional issues and to ensure an avenue for " professional voice".

3.4 Hypotheses
The following hypotheses are based upon the readiness model and will be tested in the study.

Hypothesis 1
The critical factors for success as identified in the literature and included in the Readiness Model (Figure 2) are applicable to the study setting.

Hypothesis 2
There will be a relationship between the perceived degree of readiness (as measured on Questionnaire 4) and the perceived level of success in implementation of Program Management (as measured on Questionnaire 5 and on a general question rating success).

Hypothesis 3
The greater the perceived degree of development of a subcomponent of readiness, the greater the overall perceived readiness score.

Hypothesis 4
The greater the perceived degree of development of a client centred culture, the greater will be the perceived success of implementation of Program Management.

Hypothesis 5
The greater the perceived degree of development of process capability, the greater will be the perceived success of implementation of Program Management.

Hypothesis 6
The greater the perceived amount of education/training provided regarding Program Management, the greater will be the perceived success of implementation of Program Management.

Hypothesis 7
The greater the perceived degree of development of mechanisms to address professional issues, the greater will be the perceived success of implementation of Program Management.

Hypothesis 8
To what extent do perceived degree of culture, education/training, process capability and attention to professional issues predict perceived successful implementation of Program Management?

Hypothesis 9
The majority of health care workers would not recommend return to a traditional, functional organizational structure.

Hypothesis 10
Perceived degree of Readiness varies significantly by Division.

Hypothesis 11
Perceived Success of implementation of Program Management varies significantly by Division.

CHAPTER 4 : METHODOLOGY

4.1 Study Overview

Part A The first part of the study was exploratory to attempt to validate the critical factors for successful implementation of Program Management identified in the literature and to confirm their applicability to the study setting.

Part B

The second part of the study was a correlational study to explore the relationship between the perceived degree of development of the critical readiness factors and the perceived success of implementation of Program Management in four divisions of a Community hospital.

4.2 Study Setting

Windsor Regional Hospital is a multisite. multidivisional community hospital with 731 beds and a staff of 2,306 . There are two main campuses offering a wide variety of inpatient and outpatient services. The current corporation was formed in December 1994 as the result of a merger between Metropolitan General Hospital located midtown (Met Campus) and Windsor Western Hospital Centre located on the west side (Western Campus). Following a decision in June 1995 to organize around Program Management . the Divisions and Programs outlined below became part of the new structure.

Rehabilitation Division

This Division is also a Program under the new structure. It encompasses specialty interdisciplinary programmes as well as a full range of functional departments for rehabilitation disciplines such as physiotherapy that assign staff to other Programs across the corporation. As most Rehabilitation services were centred at the Western campus, this division/program was marginally impacted by the merger. Only the interdisciplinary programmes were included in the study and these were: the Inpatient Regional Rehabilitation Unit, the Day Hospital, Geriatric Assessment Consultation (GAP) and the

Acute Injuries Rehabilitation and Evaluation Centre (AIREC). These specialty areas have historically been organized around a program model with interdisciplinary teams focusing on providing integrated plans of care to their target populations.

Regional Children's Centre Division (RCC)

This division is located in a free standing building on the Western campus and although it is part of the Windsor Regional Hospital Centre. it is funded by the Ministry of Community and Social Services rather than by the Ministry of Health. RCC is a children's mental health centre which serves children and adolescents and their families experiencing adaptive behavioural/social/emotional problems. The centre was reorganized along program lines in the mid 1980s and services are delivered through interdisciplinary programme teams including intake, preadolescent. adolescent. neurodevelopmental. milieu and modified day program. The merger had no effect on the operations of this division.

Long Term Care Division

This division encompasses a Long Term Care Program (LTC) and a Chronic Care Program. The chronic care area was not included in the study as it was in the process of relocation during the time frame of the study. The LTC Program is located in a free standing building. the Malden Park Continuing Care Centre. located on the Western Campus. The program moved into this new building in June 1995 and this involved moving patients and staff from two other buildings. The centre houses 225 residential beds divided into the four specialty groupings of Young Disabled Adult. Disabled Adult. Cognitively Impaired Ambulatory Adult and Cognitively Mobility Impaired Adult. Programme teams are interdisciplinary. The merger had little effect on the day to day operations of this program.

Acute Care Division

This division encompasses four major Programs including Critical Care, Surgery/Oncology. Medicine/Mental Health and Women's and Children's Services. As all

of these programs except Women's and Children's had services at both campuses. they were most highly impacted by the merger. A major focus of activity has been on planning for consolidation of all Acute Care services at the Met campus. This has involved integration of policies and procedures as well as mixing of staff, space planning and shifting of beds between campuses. The opportunity to focus on the development of a program philosophy and interdisciplinary team approaches has therefore been limited. Another focus of activity since the winter of 1995 has been preparation for an Accreditation to occur in December 1996. While this introduced another complexity to the changing system, it did trigger the formation of multidisciplinary care teams for each area. Only Surgery/Oncology and Critical Care programs were included in the study.

Management Structure

Windsor Regional Hospital is headed by a CEO and a senior management team of five Vice Presidents, one Assistant Vice President and two Executive Directors.

The Rehabilitation Program and the four Acute Care Programs are under the administration of the Vice President of Programs. A Program Director is responsible for the overall direction and development of each Program. Specialty programmes or units within each Program are managed by Program or Unit Managers. The Rehabilitation Division/Program has had consistent leadership over the past five years. The current Program Director was the manager for the division under the old structure. The Critical Care and Surgery/Oncology Programs within the Acute Care Division have had the consistent leadership of a Program Director and an Acting Program Director through most of the past year. The Medicine/Mental Health Program has had consistent leadership for only parts of the program and the Women's and Children's Program did not recruit a Program Director until spring 1996.

The LTC Division is under the administration of an Executive Director and a Program Director is responsible for overall direction of the LTC Program. Each of the four specialty programmes in the Malden Park Centre are managed by Program Managers and this leadership has been consistent over the past fourteen months.

RCC 's administrative structure includes an Executive Director. an Assistant Executive Director and a team of Directors for each programme area. The leadership of RCC has been consistent for a number of years.

4.3 Measurement Tools

4.3.1 Questionnaire 1 : Identification of Critical Factors

This interview questionnaire consisted of three open ended questions concerning the respondent's opinion about the critical factors related to successful implementation of Program Management and the degree of development of the factors as well as barriers to success in their area of assignment. Completion time was approximately 15 minutes. See Appendix B.

4.3.2 Questionnaire 2 : Rating of Importance of Critical Factors

This self-administered questionnaire consisted of 30 items rated on a five point Likert scale with 5 being most important and 1 being least. The items were critical factors for success as identified in the literature and as included in the Readiness Model of this study. Completion time was approximately 5 minutes. See Appendix C.

The initial version of this questionnaire was developed as a four point scale of very important. moderately important, mildly important and not important. Based on the first administration of the tool. the scale was revised to the final Likert scale to provide more information.

4.3.3 Questionnaire 3 : Qualitative Description of Divisions

This semi-structured interview questionnaire consisted of 13 questions designed to elicit a description of the culture, team activities, educational activities , decision making and professional supervision mechanisms in the respondent's area of assignment. Six of the questions had fixed response alternatives and these were presented verbally as well as written on cards. See Appendix D.

4.3.4 Questionnaire 4 : Perceived Readiness Scale

This is a self-administered questionnaire with a total of 30 items clustered into four subcomponents on the basis of face validity and matching the Readiness Model shown in Figure 2. Each item represents a critical factor in successful implementation of Program Management as identified from the literature and confirmed to be applicable for the study setting through Questionnaires 1 and 2. The subcomponent of Client-Centred Culture included ten (10) items, Process Capability and Education/Training both included seven (7). while Professional Issues Strategy included six (6). See Appendix E. The response scale consisted of five fixed alternatives representing the perceived degree of development of each factor : highly. partially. minimally. undeveloped and unsure. A draft of questionnaire 4 was pretested on a front-line staff member and a manager. This resulted in expansion of the response scale from yes/no/somewhat to the five part scale. Minor language changes were also made for clarification.

4.3.5. Questionnaire 5 - Perceived Success of Implementation of Program Management

This questionnaire is a self-administered scale with a total of 19 items based upon expected indicators of successful implementation of Program Management as noted from the literature and as presented in the conceptual framework in Figure 1, and the readiness model in Figure 2. See Appendix F. The response scale consisted of five alternatives :

strongly agree, agree, neither agree or disagree, disagree and strongly disagree. A draft of questionnaire 5 was pretested on a line staff and a manager. This resulted in minor changes in the language of some items and deletion of one item.

4.3.6 General Questions

Two general questions were presented on the same sheet as Questionnaire 5. One question asked respondents to rate the overall success of Program Management in their area as High, Medium or Low. A second question asked respondents if they would recommend returning to the traditional, functional departmental structure.

4.3.7 Open Question and Open Interviews

An open comment area was included on the same sheet as Questionnaire 5 to elicit spontaneous qualitative data. See Bottom of Appendix F. Unstructured interviews were conducted with two line staff who had experience in two divisions , Rehabilitation Acute Care and Rehabilitation/LTC to discuss their perceptions of the relative degree of development of the critical readiness factors and the relative success of Program Management in the three areas.

4.3.8 Validity and Reliability

The measurement tools used in the study were non standardized but the items used in the tools and in the proposed model draw face validity from the literature. There was high congruency between questionnaires 1 and 2, indicating convergent validity. Table 3 indicates a moderately high correlation (.65), significant at the .01 level, between the two measures of success used in the study : a single overall question with a high, medium, low rating and Questionnaire 5 using a Likert scale. This also demonstrates convergent validity. Questionnaires 3, 4 and 5 showed predictive validity in differentiating between the four divisions in the study. As shown in Appendices G and H, the Cronbach's Alpha

for Questionnaire 4 and Questionnaire 5 are high with low variance if items are omitted. This indicates high inter-item consistency reliability. Also, the subcomponents of Questionnaire 4 were positively correlated with the total questionnaire.

4.3.9 Study Bias

Robinson and Thorne (1988) have recommended the immersion of the researcher in a study setting as a means of obtaining meaningful, in depth data. In this case, the researcher is the Program Director for one of the divisions under study, namely the Rehabilitation Division. This was an advantage in terms of a high level of access and trust in addition to intimate knowledge of the system and of the culture under study. However, the disadvantage is that familiarity creates potential for bias and vested interest. Unlike field studies with the aim of evaluating programs and making recommendations for continuation, this study held no such threats or vested interest for the researcher. The main focus of the study was correlational rather than evaluative. Although the respondents knew the identity of the researcher, the questionnaire responses were anonymous and the researcher does not directly supervise the work of the respondents (except for four of the managers). Triangulation was used in sampling across all levels of the organization from line staff to senior management and in utilizing multiple measures of both quantitative and qualitative nature to corroborate information and reduce bias. Also, the intentions of the researcher were made explicit to all respondents. Only two individuals declined to participate in the study.

4.4 Sample Selection And Data Collection
4.4.1 Part A : Exploratory Study

4.4.1.1 Sample Selection

Fourteen (14) key informants were selected from across the corporation. They represented all levels of staffing including Senior Administrators, Program Directors,

Program Managers. professional line staff and support staff. They were drawn from all divisions and their experience at Windsor Regional Hospital ranged from 3 months to 25 years. Key informants were selected on the basis of their expertise and knowledge regarding management models, program management, services of the corporation and culture of the organization.

4.4.1.2 Data Collection Method

Interview Questionnaire 1 (Q1 - Appendix B) was administered in a one to one interview using open-ended questions and follow up probes as required. Prior to the beginning of the interview all participants were informed about the general purpose of the activity as part of a thesis study. Participants were assured of confidentiality and anonymity of their responses. All responses were recorded by the author in long hand format.

Immediately following completion of Q1. Questionnaire 2 was self administered by participants with the author present but engaged in adding notations to the narratives of Q1. The format of the questionnaire was a fixed alternative Likert scale. Only 13 of the 14 questionnaires were included in the results as the scale for the questionnaire was changed after the first administration and the initial questionnaire served as a pilot for the questionnaire format.

4.4.2 PART B : Correlational Study

4.4.2.1 Sample Selection for Questionnaires 4 and 5

A total of 151 participants completed both Questionnaire 4 (Q4) on critical readiness factors and Questionnaire 5 (Q5) on success of implementation of program management. The sample included 42 participants from the Rehabilitation Division. 47 from the RCC Division, 32 from the LTC Division and 30 from the Acute Care Division.

For Rehabilitation, only team members from the interdisciplinary specialty programmes of AIREC, Day Hospital, Geriatric Assessment and Inpatient Rehabilitation Unit were included. The disciplines represented were occupational therapy, physiotherapy, speech/language pathology, psychology, clinical nutrition, nursing and social work.

In RCC, all programme teams were sampled and the disciplines represented were social work, neuropsychology, psychology, education and child and youth workers.

In LTC, all four programme teams were sampled and this included representatives from nursing, clinical nutrition, occupational therapy, physiotherapy, staff education, social work, psychology, recreational therapy and speech language pathology. Audiology and chiropody are available on a consult basis and were not included in sampling. Only one of the twelve physicians involved in the centre was present during data gathering.

In the Acute Care Division there was the lack of consistent leadership for all areas as recruitment for Program Directors was ongoing. Therefore, only areas that had consistent leadership for most of the past year, had some teaming experience and had formed committees for accreditation were included in the study. These included the Emergency Room Services , Coronary Care , Surgery and Oncology groups. Team members included in the sample represented nursing, medicine, respiratory therapy, physiotherapy, pastoral care, social work and pharmacy.

4.4.2.2 Data Collection Methods for Questionnaires 4 and 5

The Questionnaires were self administered with fixed alternative Likert scale responses and an average administration time of 15 minutes. Questionnaire 5 also contained an open comment area and a general question rating success of program management and one on preference to return to a traditional structure. See Appendices E and F.

Most questionnaires were completed in group meetings. These were programme team meetings or accreditation care team meetings. Due to vacations and other absences, fifteen participants completed the questionnaires on an individual basis with the author present. All participants were provided with the letter of explanation (Appendix A) and were assured of confidentiality and anonymity. Responses were collected with the face letter shielding the responses. Participants were also verbally instructed as follows :

- complete the questions on the basis of the current status in your area of assignment

- on Questionnaire 4, management information systems refers to the type of month end reports accessed by managers, e.g., sick time, hours worked . =admissions, =discharges

- hierarchy refers to the number of layers between front line staff and the top decision maker. A flatter hierarchy would have fewer layers for approvals.

- read instructions for Questionnaire 5 as Program Management facilitates instead of has facilitated if this is the only structure you've worked in

4.4.2.3 Sample Selection for Questionnaire 3

Questionnaire 3 was administered to a total of 24 participants chosen on the basis of experience with the programmes and the culture. They included Program Directors, Program Managers and line staff including 7 from Rehabilitation, 2 from RCC, 10 from LTC and 5 from Acute Care. The initial sampling plan was for 5 participants per division. However, this was not feasible in RCC due to scheduling issues but the two obtained were highly consistent with each other and with the quantitative data for that division. The sample for Rehabilitation was increased based on availability and the number was increased to 10 for LTC based on an emerging pattern of polarized responses in that division.

4.4.2.4 Data Collection Methods for Questionnaire 3

The questionnaire was administered verbally on an individual basis with the author recording the responses by hand except in one circumstance where the respondent filled out the form himself while others were in the room. The participants were given the cover letter and provided with assurances of confidentiality and anonymity.

4.4.2.5 Sample Selection and Data Collection Methods for General Questions

The same 151 respondents for questionnaires 4 and 5 completed the general question section on the same sheet as questionnaire 5.

4.4.2.6 Sample Selection and Data Collection Methods for Open Question and Interviews

The open comment question was included on questionnaire 5. which was presented to 151 participants. Forty-seven persons made comments. Open interviews were conducted with two staff members who had experience in two divisions : Rehabilitation/Acute Care and Rehabilitation/LTC. Responses were recorded in longhand by the author.

4.5 DATA ANALYSIS METHODS

Questionnaire 1 Identification of Critical Factors

The responses were coded according to the key shown in Appendix I. The coding was designed to match the language for the factors in Questionnaire 2 and on the readiness model in order to relate the two sets of information. The number of spontaneous mentions of each code item were counted and displayed in **Table 1.**

Questionnaire 2 : Rating of Importance of Critical Factors

The information for each respondent on this measure was entered into an SPSS database to allow for analysis. The mean rating was obtained for each critical factor as well as the percent responses for each rating.

Questionnaire 3

The qualitative information obtained on this interview questionnaire was summarized by subcomponent and by division as shown in **Tables 15**.

Questionnaire 4 : Perceived Readiness Scale

The response scale consisting of the five fixed alternatives of highly, partially, minimally, undeveloped and unsure were assigned scores of 4,3,2,1,0 respectively to allow for quantitative analysis of the four subcomponent scores and the total readiness score for all thirty responses. The information for each respondent on this measure was entered into an SPSS database to allow for analysis.

Questionnaire 5 : Perceived Success Of Implementation of Program Management

The response scale consisting of the five alternatives strongly agree, agree, neither agree or disagree, disagree and strongly disagree were assigned scores of 5,4,3,2,1, respectively and a total success rating score was obtained for the 19 items. The information for each respondent on this measure was entered into an SPSS database to allow for analysis.

The data for Questionnaires 4 and 5 was analyzed by total sample and by division. Analysis included means, standard deviation, Pearson correlations, frequency distributions, regression, ANOVA and Scheffe statistics.

General Questions

For the general success question, the high, medium, low ratings were assigned scores of 3.2.1 respectively for the purposes of analysis. For the question on return to a traditional structure, responses of Yes were assigned a score of 1 . No a score of 2 and unsure a score of 0. Higher response scores would then reflect a desire to retain the new Program Management structure. The information for each respondent on these questions was entered into an SPSS database to allow for analysis.

Open Comment Question, question 2 and 3 of Q1 and Open Interviews

The qualitative information obtained on these tools was summarized into a composite picture of each Division as shown in **Table 16.**

CHAPTER 5 : RESULTS

5.1 Part A. Exploratory Study to Confirm Critical Readiness Factors
Total Sample = 14 Key Informants

Hypothesis 1
The critical factors identified in the literature will be applicable to the study setting.

Table 1 shows the responses to the open ended interview question =1 on Questionnaire 1 asking "what factors or conditions do you see as critical in making Program Management work?" The need for solid Interdisciplinary Teamwork was mentioned most frequently. Shared Vision and Values as well as Management Support of Program Management (PM) were mentioned second most often followed by development of a Client-Centred Philosophy (CCP) and Education about PM. CCP and teamwork. Team principles of Collaboration, Respect and Trust were also mentioned frequently as well as Staff Involvement and Empowerment. These results are in good agreement with the responses obtained from the same informants on Questionnaire =2. using a self administered Likert scale. See **Table 2**. All factors listed in the questionnaire were perceived as important with only three scoring below 4 on the 5 point scale.: revision of documentation formats. revised performance evaluations. support of unions. Factors with the highest mean rating were Interdisciplinary Team Approaches, Shared Vision & Values, Management Support of PM, Client Centred Philosophy, Shared Decision Making, Commitment of Sr. Management and Collaboration & Trust.

Hypothesis 1 is supported.

Table 1

FACTOR	# *	OBSERVATIONS
Interdisciplinary Teamwork	25	interdisciplinary teamwork and team principles of support, respect & collaboration were seen as essential
		these were noted as positives in RCC & Rehab areas but LTC and Acute Care areas require development to move from a nursing to an interdisciplinary team focus
Shared Vision & Values	15	a well understood, well communicated, corporate vision and implementation plan was seen as critical in setting a common direction and shared focus
Management Support	15	visible support of Program Management and leadership from senior management was seen as important to develop organizational readiness to move to a new model i.e., to move from a functional to a program focus
Client-Centred Philosophy	12	informants noted that the culture must be focused on meeting the needs of the client and that processes & procedures should be designed to meet these needs
Education & Training	12	education was seen as important in establishing an understanding of Program Management. Client-Centred Care. Interdisciplinary Teamwork & Roles/Responsibilities
Collaboration. Trust. Respect	10	these principles were seen as important within and between teams
Staff Involvement and Empowerment	9	it was seen as important to involve the line caregivers
Roles & Responsibilities	8	clear roles & responsibilities were seen as important in terms of reporting relationships, accountability, staff comfort and professional identity/contributions
		clarity of roles for Program & Functional Managers was noted as particularly problematic/stressful in LTC
Communication	8	more required, consistency
Decentralized Decisions	7	decisions at the program team level
Professional Issues	7	role identity on interdisciplinary teams, territorial issues need for discipline links & monitoring standards of care
Policies & Procedures	7	clarity rquired
Integrating Mechanisms	5	between internal areas & externaL agencies
Positive Attitudes/Buy In	5	staff attitudes and support for change
Focus on Processes	4	e.g., intake/referral, assessment, treatment, discharge
Tolerance Risk Taking	4	willingness to try something new

* number of spontaneous mentions by key informants

Table 2

Importance Rating of Critical Factors by Key Informants (N=13)

ITEM on Questionnaire #2	Mean	5	4	3	2	1
8 Interdisciplinary Team Approaches	4.85	85%	15%			
3 Shared Vision & Values	4.77	85%	8%	8%		
27 Management Support of Program Mgmt	4.77	85%	8%	8%		
4 Client Centred Philosophy	4.69	69%	31%			
6 Shared Decision Making	4.69	69%	31%			
2 Commitment of Sr. Management	4.69	77%	15%	8%		
14 Collaboration and Trust	4.69	77%	15%	8%		
9 Effective Corporate Communication	4.62	77%	8%	15%		
5 Effective Information Systems	4.62	77%	8%	15%		
25 Tolerance of Risk Taking	4.62	77%	8%	15%		
20 Empowerment of Staff	4.62	69%	23%	8%		
1 Staff Participation & Involvement	4.62	62%	39%			
26 Understanding of Client Centred Care	4.62	62%	39%			
13 Strong Program Leaders	4.54	62%	31%	8%		
22 Staff Skill in Teamwork. Prob. Solving	4.54	62%	31%	8%		
11 Decentralized Decision Making	4.46	69%	23%			
12 Clear Roles & Responsibilities	4.46	62%	23%	15%		
24 Positive Staff Attitudes	4.46	62%	23%	15%		
28 Physician Support of Program Mgmt	4.31	62%	23%		15%	
15 Ongoing Education & Training	4.31	62%	8%	31%		
16 Avenues to Address Prof. Issues	4.23	54%	31%		15%	
29 Info. on Need & Reasons for Change	4.23	46%	39%	8%	8%	
17 Program Management Champions	4.15	46%	39%	8%		
18 Fin & Stat Systems for Programs	4.15	39%	39%	23%		
23 Flatter Hierarchy	4.08	39%	46%	8%		
19 Change Management Activities	4.00	39%	31%	23%	8%	
10 Support of Professional Groups	4.00	54%		39%	8%	
21 Revised Documentation Formats	3.92	31%	46%	8%	15%	
30 Revised Performance Eval System	3.54	23%	23%	39%	15%	
7 Support of Unions	3.31	23%	23%	31%	8%	

5.2 Part B. Correlational Study to explore the relationship between the degree of development of critical readiness factors and success of implementation of Program Management.

5.2.1 TOTAL SAMPLE RESULTS (N=151)

Hypothesis 2
There will be a relationship between the perceived degree of readiness (as measured on Q 4) and the perceived level of success in implementation of Program Management (as measured on Q 5 and a single question rating success).

Table 3 shows the means, standard deviations, and Pearson correlations for Q 4-Total. the subcomponents of Q4 (culture, education and training, professional issues and process capability), Q 5-Total. and a single general question asking participants to rate the overall success of program management .

Table 3
Means. SDs & Pearson Correlations for Q4. Q5 and Success Question

			Pearson Correlations						
	Mean	**S.D.**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
1. Q4-Total	85.86	15.54	1	0.78	0.81	0.81	0.74	0.72	0.61
2. Q4 Culture	33.19	5.04		1	0.51	0.55	0.35	0.63	0.52
3. Q4 Process Cap	16.57	5.41			1	0.50	0.48	0.54	0.46
4. Q4 Ed'n & Training	18.97	4.85				1	0.53	0.62	0.47
5. Q4 Professional Iss.	17.50	4.29					1	0.43	0.34
6. Q5 - Total	69.71	12.45						1	0.65
7. Success Rating of PM	2.07	0.77							1

Note. All correlations are significant at the 01 level (2 tailed)

The correlation between Questionnaire 4 and Questionnaire 5 is moderately high at 0.72 and is significant at the .01 level. The correlation between Q4 and the single success rating question is 0.61. also significant at .01.

Hypothesis 2 is supported.

Hypothesis 3
The greater the perceived degree of development of a subcomponent of readiness. the greater the overall perceived readiness score.

As shown in **Table 3**. the correlations between the subcomponents and overall readiness (Q4-Total) were 0.81. 0.81. 0.81 and 0.74 for culture, process capability, education and training, and professional issues strategy respectively. All were significant at the .01 level.

Hypothesis 3 is supported.

Hypothesis 4
The greater the perceived degree of development of a client centred culture. the greater will be the perceived success of implementation of Program Management.

Hypothesis 5
The greater the perceived degree of development of process capability, the greater will be the perceived success of implementation of Program Management.

Hypothesis 6
The greater the perceived amount of education/training provided regarding Program Management and related topics. the greater will be the perceived success of implementation of Program Management.

Hypothesis 7
The greater the perceived degree of development of strategies to address professional issues, the greater will be the perceived success of implementation of Program Management.

Table 3 also illustrates that the subcomponents of Questionnaire 4 (perceived readiness), correlated with Questionnaire 5 (perceived success) at levels of 0.63 for culture. 0.62 for education/training, 0.54 for process capability and 0.43 for professional issues.

Correlations of the subcomponents with the single success rating question were 0.52. 0.47. 0.46, and 0.34 . All correlations were significant at the .01 level.

Hypotheses 4, 5, 6 and 7 are supported.

Hypothesis 8

The perceived degree of development of Client-Centred Culture, Process Capability, Education/Training, and a Professional Issues Strategy predict perceived successful implementation of Program Management .

Table 4

Regression Analysis for Questionnaire 5/Questionnaire4

Dep. Var	Ind. Variable	R	R Square	Std Error	F	Sig.
Q5 - Total	Q4 - Total	0.72	0.52	8.64	132.3	0.00
Q5 - Total	Constant	0.74	0.54	8.51	35.84	0.002
	Q4 Culture					0.001
	Q4 Process Cap.					0.028
	Q4 Ed'n & Training					0.001
	Q4 Profes. Issues					0.363

As shown in **Table 4**, the results of an analysis regressing the perceived readiness questionnaire (Q4) against perceived success of implementation of Program Management (Q5) indicates that 52% of the variance in successful implementation is significantly explained by the readiness variable. Consistent with this, the table also indicates that the four subcomponents of Q4 taken together significantly explain 54% of the variance of successful implementation of program management. However, at the individual sub-component level, results for culture and education/training are highly significant, process capability is significant at the .028 level but the professional issues strategy is not significant in explaining variance in overall success of implementation of program management.

Hypothesis 8 is supported for all subcomponents except the Professional Issues Strategy. Perceived degree of development of client-centred culture, process capability, and education/training predict perceived success of implementation of Program Management. Perceived degree of development of a strategy to address professional issues did not predict perceived success of implementation.

Hypothesis 9

The majority of health care workers would not recommend return to a traditional. functional organizational structure.

Table 5

Response to Return to Traditional Structure

Responses	Frequency	Percent
YES = 1	26	17
NO = 2	113	78
Unsure = 0	5	3.3
Need Both	1	0.7
Mean	**S.D.**	**Var.**
1.76	0.52	0.27

Table 5 shows the response to a question asking respondents whether or not they would return to the more traditional functional department structure. Overall, 78% of the staff responding would not return to the traditional structure, i.e., would retain the new structure, and only 18% would return to the functional organization. This is consistent with the responses obtained in a study at West Park Hospital as documented in chapter 2 part 2.3. However, 40% of the respondents in the Acute Care Division recommended return to the old traditional structure.

Hypothesis 9 is supported.

Item Analysis on Questionnaire 4 and Questionnaire 5

Table 6 shows the mean, variance and standard deviation for each item on Q4 (perceived readiness) rated on an interval scale of 0–4. The highest mean score (3.63) and lowest variance (.56) was obtained on item Client-Centred Culture. Items Interdisciplinary Teamwork, Collaboration and Quality Focus, also have high mean scores. The lowest mean score is Financial Reports by Program. Variance is high on items related to process capability including Financial Reports, Quality Management, Information Systems. This

reflects the fact that line staff tended to code unsure on these items and management staff coded them as partially or minimally developed. Performance Evaluations. Discipline Specific Supervision also show high variance.

Table 6

Mean, Std. Dev., Variance for Items on Q 4

Item	Valid #	Mean	SD	Var.
Client-Centred Culture	151	3.63	0.56	0.31
Interdisciplinary Teamwork	150	3.61	0.65	0.43
Collaboration	150	3.58	0.59	0.35
Quality Focused Culture	150	3.45	0.66	0.44
Staff Particip'n & Involvmt	151	3.39	0.74	0.55
Outcome Focused Culture	151	3.25	0.80	0.64
Opportunity Peer Contact	151	3.15	1.08	1.17
Shared Vision & Values	151	3.13	0.88	0.78
Culture Trust & Respect	149	3.11	0.79	0.63
Shared Decision Making	150	3.09	0.79	0.62
Maintain Profess'l Standards	151	3.07	0.94	0.88
Contact Profess'l Organiz'ns.	151	3.02	1.04	1.09
Ed'n- Client Centred Care	151	3.00	0.95	0.91
Clear Roles/Responsibilities	151	2.87	0.90	0.81
Linkages internal/external	151	2.84	1.00	1.00
Discipline specific Supervis'n	147	2.77	1.31	1.71
Communic'n with Unions	150	2.76	1.23	1.51
Strong Program Leader Skills	151	2.75	0.99	0.99
New Skills & Attitudes	151	2.75	1.00	1.00
Professional Development	150	2.73	0.99	0.99
Tolerance Risk Taking	148	2.74	0.96	0.93
Ed'n re Multidisciplinary	151	2.73	0.93	0.87
Decentralized Dec'n Making	146	2.60	1.06	1.12
Ed'n -Dealing with Change	151	2.50	1.04	1.08
Perf. Evals by Program	150	2.47	1.33	1.78
Flat Hierarchy	149	2.40	1.12	1.26
Ed'n- Program Managment	151	2.38	0.99	0.98
Quality Mgm't by Program	150	2.33	1.46	2.14
Info System by Program	147	2.33	1.36	1.84
Financial Reports by Program	150	1.71	1.58	2.49

Table 7 shows the mean, variance and standard deviation for each item on Q5 (perceived success) on an interval scale of 1-5. The highest mean score (4.23) was obtained on the item Increased Focus on Client Needs. Other high score items include Increased Focus on the Client as a Whole Person and Increased Interaction Between Disciplines. The lowest score and a high variance was obtained on Increased Speed of Decisions. Other low mean/high variance items included Increased Time for Direct Care, Increased Staff Satisfaction, and Decreased Discipline Turf Conflicts.

Table 7

Mean, Std. Dev., Variance for Items on Q 5

Item	Valid #	Mean	SD	Var.
Focus on Client Needs	149	4.23	0.83	0.69
Focus on Whole Client	150	4.13	0.85	0.72
Increased Team Inter'n	151	4.03	0.90	0.82
Involvement Client/Family	150	3.99	0.89	0.80
Interdisciplinary Teamwk	150	3.92	0.91	0.83
Clinical Dec'n Making	150	3.89	0.86	0.73
Staff Participation	150	3.87	0.91	0.82
Meet Program Goals	151	3.87	0.91	0.84
Quality of Care	149	3.85	1.00	1.00
Integrated Care Planning	150	3.83	0.91	0.83
Maintain Professnl Stds	151	3.77	0.94	0.89
Improved Pt. Outcomes	150	3.75	0.77	0.59
Increased Client Satisf'n	151	3.66	0.83	0.69
Increasd Control Resrces	150	3.48	0.96	0.92
Meet Professnl Needs	151	3.38	1.05	1.10
Incr. Direct Care Time	151	3.14	1.21	1.45
Incr. Staff Satisfaction	151	3.09	1.13	1.28
Decr. Turf Conflicts	151	3.07	1.12	1.25
Incr Speed Decisions	150	2.89	1.03	1.06

5.2.2 BETWEEN DIVISION RESULTS

Hypothesis 10

The perceived degree of Readiness varies significantly by Division.

Table 8

Results of ANOVA (one way) for Between Group Comparisons
on Questionnaire 4 and Questionnaire 5

Division	Questionnaire 4				Questionnaire 5			
	Mean	S.D.	F	Sig.	Mean	S.D.	F	Sig.
RCC	89.26	11.88			73.44	11.01		
Rehab.	94.24	13.09			75.29	10.19		
LTC	81.00	16.98			67.56	11.09		
Acute Care	72.50	12.45			58.03	10.68		
Between Grp			14.70	0.00			17.35	0.00

Table 8 shows the means, standard deviations and ANOVA results for the four divisions on Questionnaire 4. The Rehabilitation Division shows the highest mean followed by RCC, LTC and Acute Care. The variance for LTC is the highest. The ANOVA shows significant difference between the four groups on Questionnaire 4 (Perceived Readiness).

Table 9 shows the Scheffe analysis of where the differences occur. The mean for Rehabilitation is significantly different from LTC and Acute Care but not from RCC. Acute Care is significantly different from RCC and Rehabilitation but not from LTC. LTC is only significantly different from Rehabilitation.

Table 9

Scheffe Analysis for Q4 by Division

1-Division	2-Division	Mn Diff. 1-2	Std. Err.	Sig.
RCC	Rehab	-4.97	3.04	0.447
	LTC	8.26	3.28	0.101
	Acute Care	16.76*	3.47	0.000
Rehab	RCC	4.97	3.04	0.447
	LTC	13.24*	3.35	0.002
	Acute Care	21.74*	3.54	0.000
LTC	RCC	-8.26	3.28	0.101
	Rehab	-13.24*	3.35	0.002
	Acute Care	8.50	3.75	0.167
Acute Care	RCC	16.76*	3.47	0.000
	Rehab	-21.74*	3.54	0.000
	LTC	-8.5000	3.75	0.167

* significant at .05 level

59

Table 10 shows the ANOVA results for the four divisions on each of the subcomponents of Q4. The results indicate significant difference between the four means at a .01 level for culture. process capability and education and at the .023 level for professional issues.

Table 10

Results of ANOVA (one way) for Between Group Comparisons
on Subcomponents of Questionnaire 4 (Q4)

Subcomponents	df	Mean Sq.	F	Sig.
Client-Centred Culture	3	361.08	19.94	0.000
Process Capabilities	3	161.95	6.15	0.001
Education & Training	3	180.43	8.88	0.000
Professional Issues	3	57.34	3.26	0.023

The Scheffe analyses shown in **Table 11** shows clustering of Rehabilitation and RCC in terms of client-centred culture with these two being significantly different from Acute Care and LTC. For Process Capability and for Education and Training, Acute Care is significantly different from RCC. and from Rehabilitation. On Professional Issues Strategy, the only significant difference is between Rehabilitation and Acute Care.

Table 11

Results of Scheffe Analysis on Means for Subcomponents of Q4

Division	Client-Centred Culture		Process Capability	Education & Training	Professional Issues
	LTC	Acute Care	Acute Care	Acute Care	Acute Care
Rehabilitation	4.66	7.65	4.58	5.53	3.01
RCC	3.07	6.06	3.92	3.62	not significant

Note. Mean differences significant at the .05 level

See **Figure 3** for comparison of the means for Q4 by Division.

60

Figure 3

Questionnaire Means by Division

Figure 3. Questionnaire Means by Division
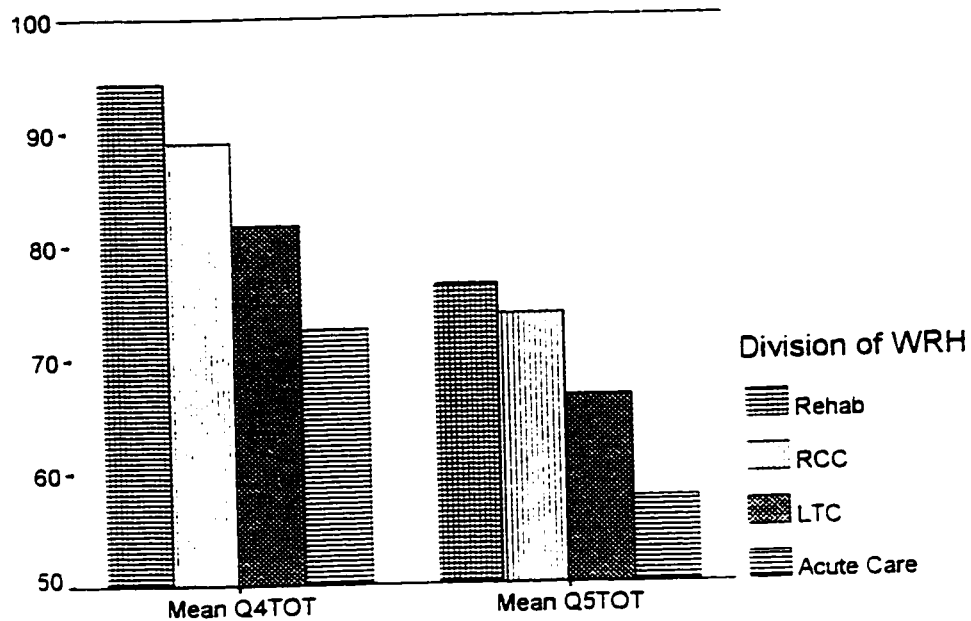
Hypothesis 10 is partially supported. The most significant differences between divisions in perceived degree of readiness were between Acute Care and Rehabilitation and between Acute Care and RCC. In terms of the subcomponents. Rehabilitation and RCC were significantly different from Acute Care and LTC in terms of development of client-centred culture. For Process capability and Education Training Strategy. Acute Care was significantly different from both Rehabilitation and RCC. For Professional Issues the only significant difference is between Acute Care and Rehabilitation.

Subcomponent and Item Analysis for Questionnaire 4 (Perceived Readiness)

As illustrated in **Figure 4.** the rank order of highest to lowest means for each

subcomponent of Questionnaire 4 were consistent with the overall means :

Rehabilitation. RCC. LTC and Acute Care.

Perceived Subcomponent Development/Div'n
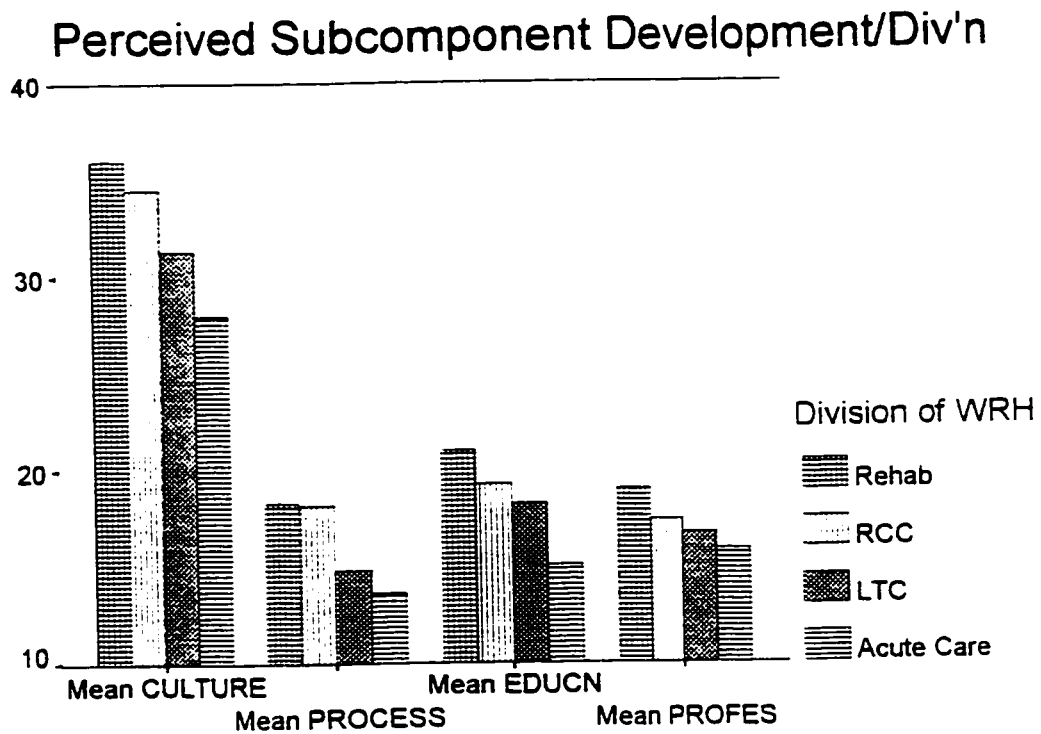
Table 12 shows between group comparisons on mean scores for the subcomponents of Questionnaire 4 as well as rating frequencies for Q4 and correlations between Q4 and Q5. The **percentage frequency** of items rated unsure. undeveloped and minimally developed was on the order of twice as high for the LTC and Acute Care divisions compared to the Rehabilitation and RCC divisions. Partially Developed was the most frequent rating in all divisions except Rehabilitation where Highly Developed was the most frequent rating. Mechanisms for discipline peer contact was more of an issue relative to other subfactors in the Acute Care Division. **Correlation between Q4 and Q5** was significant in all divisions except for Acute Care and the degree of correlation was less in LTC than in Rehabilitation and RCC.

There were six items on Q4 that were rated as Highly Developed by fifty percent (50%) or more of the total sample of participants. These included:

1. Interdisciplinary Teamwork Encouraged   66.9%
2. Client Centred Culture   68.7%
3. Collaboration Encouraged   63.3%
4. Quality Focused Culture   54.0%
5. Staff Participation & Involvement   51.7%
6. Mechanism for Contact with Peers   51.0%

The first five items were clustered under the Culture subcomponent and the sixth under Professional Issues. These items as well as all scored as **Highly Developed by 50% or more** are shown in **Table 12** by Program. Interdisciplinary Teamwork, Client-Centred Care and Collaboration were identified as Highly Developed by more than 50% of the respondents in the Rehabilitation. RCC and LTC programs. In LTC. Mechanism for Contact with Peers was the only other item above 50%. In Rehabilitation.. Staff Participation and Involvement was also very highly rated and a total of 15 of the 30 items were rated highly developed by 50% or more respondents. Six items for RCC and four items for LTC were rated as highly developed by 50% or greater respondents.

Table 12

Between Group Comparisons on Questionnaire 4 (Q 4)

Mean Scores	Rehab	RCC	LTC	Acute	Total Sample
Q4 - Total Score	94.24	89.26	81.00	72.5	85.86
Q4 - Culture SubScore	36.05	34.46	31.39	28.4	33.19
Q4 - Process Capability SubScore	18.44	17.77	14.93	13.86	16.57
Q4 - Education/Training SubScore	21.17	19.26	18.81	15.63	18.97
Q4 - Professional Issues SubScore	19.08	17.54	16.83	16.07	17.5
Correlation Q4 & Q5	0.70*	0.72*	0.57*	0.35	0.72*

Frequency of Ratings					
Unsure = 0	4.9 %	6.1 %	6.6 %	6.9 %	
Undeveloped = 1	3.3 %	4.2 %	7.1 %	9.7 %	
Minimally Developed = 2	9.3 %	14.6 %	20.8 %	30.6 %	
Partially Developed = 3	35.4 %	39.1 %	43.0%	39.1 %	
Highly Developed = 4	47.0%	36.0%	28.2 %	13.6 %	

Items Rated Highly Developed >50%					
1. Interdisciplinary Team Focus	90.2 %	70.2 %	65.6 %	40.0 %	68.7 %
2. Client Centred Culture	83.3 %	85.1 %	53.1 %	30.0 %	66.9 %
3. Collaboration Encouraged	76.2 %	80.9 %	53.1 %	27.6 %	63.3 %
4. Quality Focus	68.3 %	68.1 %	37.5 %	30.0 %	54.0 %
5. Staff Participation & Involvement	83.3 %	44.7 %	46.9 %	23.3 %	51.7 %
6. Mechanism for Peer Contact	59.5 %	51.1 %	53.1 %	36.7 %	51.0 %

Outcome Focused	61.9 %	55.3 %			
Shared Vision & Values	59.5 %				
Shared Decision Making	59.5 %				
Discipline Specific Supervision	55.0 %				
Education-Client Centred Care	54.8 %				
Quality Management by Program	52.4 %				
Atmosphere of Trust & Respect	50.0 %				
Linkages Internal & External	50.0 %				
Maintenance of Professional Standard:	50.0 %				

* significant at the .05 level

64

Hypothesis 11

Perceived Success of implementation of Program Management varies significantly by Division

As shown in **Table 8**, the means for the four divisions on Q5 are ranked in the same order high to low as for Q4. The ANOVA indicates significant difference between the four means. The Scheffe analysis in **Table 13**, indicates that Acute Care is significantly different from the other three divisions in terms of perceived success of implementation. LTC is significantly different from Rehabilitation and Acute Care but not from RCC. Rehabilitation is significantly different from LTC and Acute Care but not from RCC. RCC is significantly different only from Acute Care.

Hypothesis 11 is therefore, partially supported.

See **Figure 3** for comparison of the means for Q5 by Division.

Table 13

Scheffe Analysis for Q 5 by Division

1-Div	2-Div	Mean Diff. 1-2	Std. Err	Sig.
RCC	Rehabilitation	-1.85	3.04	0.447
	LTC	5.89	3.28	0.101
	Acute Care	15.41*	3.47	0.000
Rehab	RCC	1.85	3.04	0.447
	LTC	7.74*	3.35	0.002
	Acute Care	17.26*	3.54	0.000
LTC	RCC	-5.88	3.28	0.101
	Rehabilitation	-7.74*	3.35	0.002
	Acute Care	9.52*	3.75	0.167
Acute Care	RCC	-15.41*	3.47	0.000
	Rehabilitation	-17.26*	3.54	0.000
	LTC	-9.52*	3.75	0.167

* mean difference significant at the .05 level

Item Analysis for Questionnaire 5 (Perceived Success)

As shown in **Table 14**, the percentage of items on Q5 scored as Strongly Agree (5) and Agree (4), indicating higher success in implementation of program management, were highest for Rehab. followed by RCC, LTC and Acute Care. Conversely, ratings of Neither (3), Disagree (2) and Strongly Disagree (1), indicating lower success, were more frequent for Acute Care and LTC. These results are consistent with those for Q 4. Table 14 also shows the items with a mean score of 4 or greater. For the overall sample these included three items : <u>Increased Focus on Client Needs, Increased Focus on the Client as a Whole Person</u>, and <u>Increased Interaction Between Disciplines</u>. Acute Care mean scores were all below 4 but the three highest scores were consistent with the three highest for the sample. Rehab. and RCC programs both scored above 4 on the three top sample items but each also scored at or above four on an additional 6 items. The LTC division scored above 4 on the top two items but not for <u>Increased Interaction Between the Disciplines</u>. The score for <u>Increased Involvement of Clients/Families</u> was however, above 4 for LTC.

Table 14
<u>Between Group Comparisons on Questionnaire 5 (Q 5)</u>

Q5 Response Categories	Rehab	RCC	LTC	ACUTE
Strongly Agree = 5	34.1 %	29.1 %	17.2 %	5.9 %
Agree = 4	40.8 %	40.3 %	37.9 %	31.7 %
Neither = 3	16.3 %	21.0 %	27.7 %	36.4 %
Disagree = 2	7.6 %	8.6 %	13.6 %	22.6 %
Strongly Disagree = 1	1.2 %	1.1 %	3.7 %	3.3 %
Q5 Items with Means Over 4.00				
Increased Focus on Client Needs	4.52	4.45	4.17	**3.53**
Increased Focus on Client as Whole	4.45	4.28	4.09	**3.47**
Increased Interact'n between Disciplines	4.40	4.11	**3.94**	**3.5**
Increased Quality of Care/Service	4.32	4.17		
Increased Staff Participation in Decisions	4.26			
Improved Interdisciplinary Teamwork	4.26	4.00		
Increased Involvement of Client/Family	4.21	4.19	4.06	
Improved Integrated Care Planning	4.21	4.15		
Improved Clinical Decision Making	4.07	4.19		
Increased Ability to Meet Program Goals		4.19		
Success of Program Management - General Question				
Mean Rating	2.45	2.30	1.75	1.53
High = 3	50.0 %	46.8 %	18.8 %	3.3 %
Medium = 2	45.2 %	36.2 %	37.5 %	46.7 %
Low = 1	4.8 %	17%	43.8 %	50.0 %

Analysis of General Success Rating Question

Table 14 also shows the breakdown of responses to a general question asking

respondents to rate the overall success of implementation of Program Management in

their program as High. Medium or Low. The highest number of responses for Rehab and

for RCC were high but RCC had triple the number of low ratings as Rehab. Both LTC

and Acute Care had the highest number of ratings in the low range but LTC had five

times more in the high category compared to Acute Care. This results in an overall

ranking from high to low of Rehab. RCC. LTC and Acute Care which is consistent with

the results on Questionnaires 5 and 4. Summary ratings may be interpreted as High-

Medium for RCC and Rehabilitation and Low-Medium for LTC and Acute Care. The

correlation between the general question and Q5 was significant at the .01 level for

Rehab and at the .05 level for the other three divisions. See **Figure 5** and **Figure 6.**

Mean Success & Mean Retain New Structure
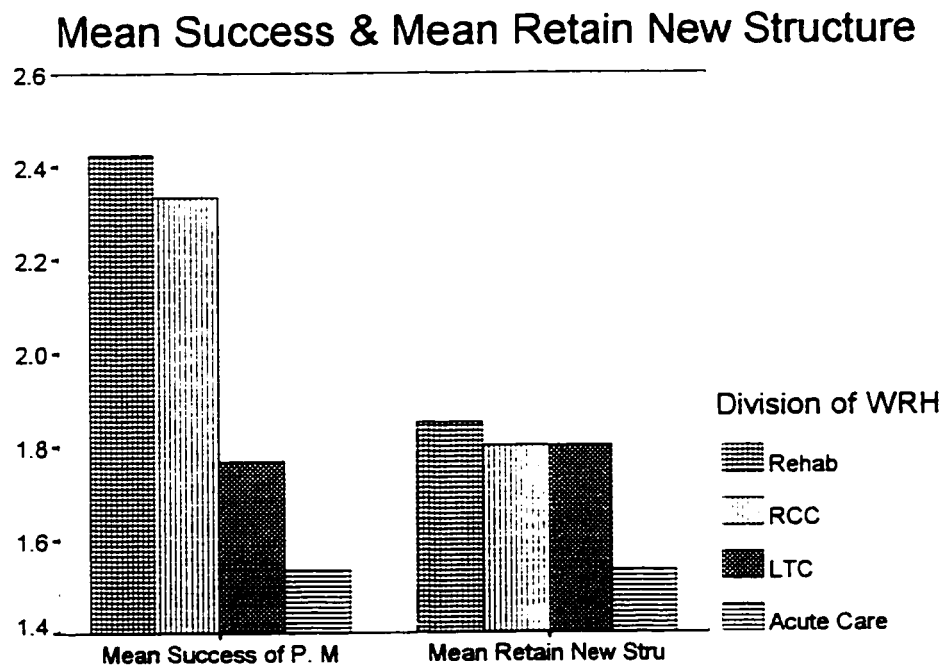
Figure 6

Success Rating by Division
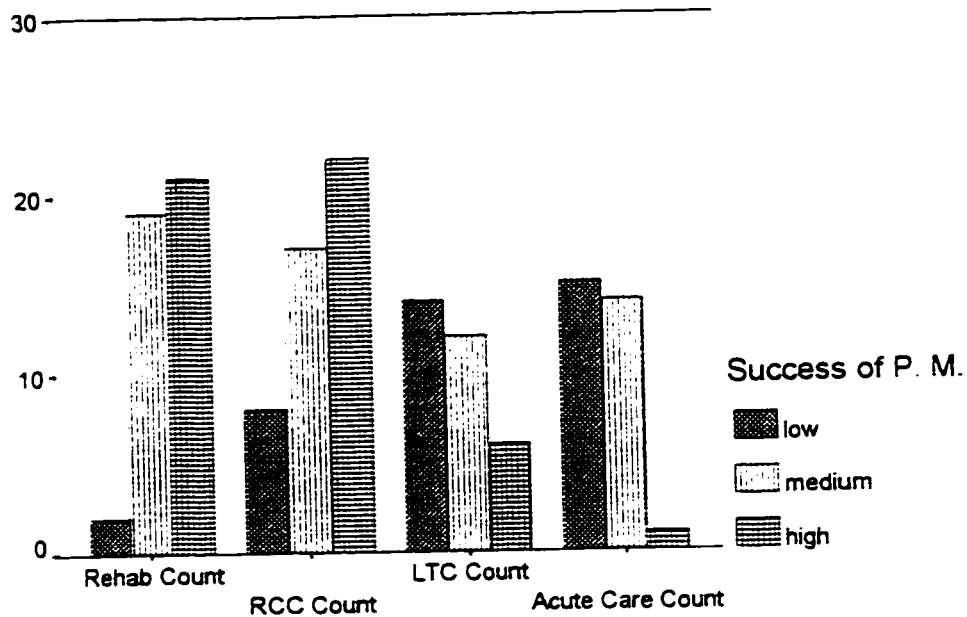
5.2.3 Qualitative Results

Table 15 summarizes qualitative comments regarding the status of development of the Critical Readiness factors by subcomponent and by division as obtained on Questionnaire 3. Descriptions by respondents (N=24) are generally consistent with the quantitative data obtained on Questionnaire 4 and Questionnaire 5 except that qualitative comments would separate LTC further from RCC's more highly developed status. See discussion.

A composite of qualitative comments received on questions 2 and 3 of interview Questionnaire =1, an open comment area on Q5 and two in depth interviews with line staff with experience in both LTC.Rehab and Rehab/Acute Care are summarized in Table16 (Total: N=58). The overall picture is consistent with the quantitative results obtained on Q4 and Q5, except for LTC. Again, qualitative comments would separate LTC further from RCC's more highly developed systems and more successful program

68

management, particularly interdisciplinary team functioning. Key readiness factors and Program Management were perceived as highly to moderately developed in Rehab and well developed in RCC. LTC was seen as not well developed but improving and Acute Care was seen as being poorly developed and in the beginning stages only. See discussion.

Table 15

Comments by Key Informants Regarding Status of Critical Factors by Division

C C Culture	Process Capability	Educ'n & Training	Professional Issues
RCC (N=2) Consultative Multidisciplinary Flexible to Meet Client Needs Client/Family/Community Focus Staff Input as Appropriate Very Busy	Manager gets info & feeds back to staff as appropriate Ongoing improvement of service processes Multiple communication methods Mod awareness of management information systems by staff	Ongoing through team interaction & case collaboration Workshops in specific topics	Professional roles are respected Clinical supervision meets needs Contact with peers in RCC & hospital Occasional turf issues seem related to a few individuals
REHABILITATION (N=7) Client Centred Client/Family Involvement Interdisciplinary Team Approach High staff input into decisions Collaborative. Team Directed Outcome Oriented Trust & Respect	Frequent team interaction aids in keeping process tight High degree of communication Mod. awareness of management information systems by staff	Education ongoing as part of team process Strong Program Leaders	Discipline specific supervision meets needs Contact with discipline peers is adequate Occasional turf issues seem related to a few individuals

LTC (N = 10)
No clear philosophy
Stressful. Tense. Frustrating
Sense of little input or voice
Resident focus not consistent
Medical/nursing driven
More interaction between
    disciplines
Interdisciplinary concept has a
    long way to go but improving
	Systems Problems had to be overcome after move (1 yr)
	
	Communication is poor (3), is better (1), is good (2)
	
	Few processes/ policies in place
	
	Inconsistent demands/ program
	
	Some awareness of management information systems
		Some education provided but low understanding of program management model
		
		Lack of clear understanding of roles leads to stress
		
		Education on Program Management would have been useful prior to move
			Roles are unclear with regards to Program Managers vs Functional
			
			Level of involvement varies for functional supervisors
			
			Some territorial issues
			
			Non nursing disciplines feel minimally involved
			
			Assignments across >1 program

ACUTE CARE (N =5) Little understanding of PM model Patient welfare now considered Not interdisciplinary yet. starting Medicine/nursing driven Always did teamwork in nursing Negative environment. hostile No philosophy, mission direction Sense of floundering	Communication is lacking Decisions made by small groups without reps all disciplines Functional areas dispersed but no processes for program mgmt Min awareness of management information systems	Some education provided re PM interdisciplinary teamwork etc Low understanding of PM interdisciplinary, client centred Lack of understanding about changes in roles/responsibilities No real sense of "Program"	Adversarial attitudes Non nursing disciplines feel uninvolved & isolated Non nursing areas still operating as functional depts

70

Table 16

Comments on Development & Success of Program Management Obtained on #2 & #3 of Questionnaire 1, Open Comments on Q5 and Open Interviews

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Rehabilitation Program (N = 12)

factors are highly to moderately well developed, concept is continually evolving

there is good understanding of what Program Management is and how it works

Program Management works very well and is beneficial to the client/family

Program Management encourages interdisciplinary teamwork and collaboration

Program Management is the best model but need to ensure professional contact

    Problems/Barriers

        some professional turf issues, need to constantly review lead roles

        changes in managers for the inpatient unit

        some matrix issues between program managers/functional areas

RCC Program (N = 12)

factors are well developed, the process is evolutionary

Program Management is a philosophical fit with their industry segment

training & staff Involvement were key in the beginning stages

Program Management is central to successful intervention

Program Management is the only system worth having in human services

Program Management has a high Interdisciplinary Focus

    Problems/Barriers

        can be professionally isolating for smaller disciplines

        power imbalance on some teams

        some turf issues related to role blurring

        centralized decision making by Director's Group

        not enough time for communication & education

LTC Program (N = 14)

Program Management is not well developed, long way to go but improving

lack of shared understanding of Program Management, a lot of confusion

lack of clear vision, values, roles & responsibilities, inconsistent support

still highly nursing focused

Program Management has high potential as it's client focused

    problems/barriers

        poor understanding of scope of practice for non nursing disciplines

        system problems over last year - physical plant

        no clear vision, values, roles (esp. for managers)

        high stress & time pressures

        part time or shared staff across programs

Acute Care Program (N = 20)

Program Management is poorly developed, long way to go, but has potential

just starting, still a functional focus really, still highly nursing focused

low understanding of Program Management, low commitment

adversarial atmosphere, poor communication

excellent concept but difficult to implement in climate of control

    problems/barriers

        lack of clear understanding, vision, values, roles

        independent pockets of action with no collaboration

        still too nursing driven

        less time for direct care due to meetings, poor communication

CHAPTER 6 : DISCUSSION

Driven by spiraling costs and the changing demands of consumers. workers and funding bodies, there is no question that change is an ongoing and inevitable condition in the health care industry. Traditional structures. high professional differentiation and provider centred processes have resulted in an inefficient system that requires radical change to meet the new demands of the environment and the market place.

Given these drivers and the overall business direction towards customer focused service. the philosophy of client-centred care will be an enduring standard rather than a passing trend in system change. The literature documents widespread adoption of this philosophy and the results of this study confirm its importance. although different organizational structures have been chosen to deliver it. An increasing number of Canadian hospitals have embraced a Program Management model. The specific clusterings of services into programs. the specific management structures chosen, and the degree of decentralization of functional departments, services have varied widely. The literature suggests however. that the success of implementation has been more dependent upon the development of a number of critical factors than upon the specific structure chosen.

The results of the exploratory part of this study confirmed that the key factors identified in the literature were also viewed as important and applicable by the key informants in the study setting. This provides support to the readiness factors included in the model in Figure 2. All factors presented were felt to be important but those identified as most important were Interdisciplinary Teamwork, Shared Vision & Values, Management Support, Client-Centred Philosophy and Education and Training about program management, teamwork and related topics. The importance placed on shared vision/ values and management support is consistent with general change management theory.

In the proposed readiness model, successful implementation of Program Management is dependent upon the degree of development of the critical factors which are clustered into four subcomponents : Client-Centred Culture, Process Capability, Education and Training and Professional Issues Strategy. Study results confirm a significant correlation between the perceived readiness measure (Questionnaire 4) and the perceived success measures (Questionnaire 5 and a success rating question).

In terms of the subcomponents of Client-Centred Culture, Process Capability, Education and Training and Professional Issues Strategy, all were significantly correlated with perceived success of implementation but the relationship was highest for Culture and weakest for Professional Issues Strategy. The inclusion of a mix of management and unionized line staff in the sample may be a contributing factor to the weaker emphasis on professional issues strategy but due to anonymity of responses, confirmation is not possible. Qualitative interview information seems to support this partial explanation. Further explanation may lie in the variability across divisions in terms of the attention directed towards development of mechanisms to address issues such as discipline specific supervision. The presence of such mechanisms that fit the program model showed high variation across the corporation but was a particular issue in Acute Care and LTC. For Acute Care, this may explain in part, the higher number of staff who would prefer to return to the more traditional, functional structure (Figure 5). The literature and the qualitative comments in this study suggest that Professional Issues may indeed be viewed as what Pearce and Osmond (1996) have labeled as access leverage points or 'ALPs'. These are critical aspects of the culture that can aid but sometimes impede organizational change efforts. Given the established reliance on professionalism in health care, attention to a professional issues strategy could provide leverage in terms of establishing the required support for decentralized models and minimizing resistance to change, particularly if the support of unions and professional groups is demonstrated.

The total sample results for Questionnaire 4 indicate that factors most highly developed across the corporation are Client-Centred Culture and Interdisciplinary Teamwork. The qualitative information is consistent with this : almost all respondents felt that they had become more client focused in their care delivery. Some demonstrated a sophisticated grasp of the concepts associated with a culture of client-centred care and other comments reflected the basic philosophy that "we are all here to meet the client's needs". Financial information reports and other information processes were not viewed as well developed. Reports are not yet formatted to the program model in all areas and problems with accuracy, timeliness and comprehensiveness were reported across all divisions. Many line staff were not informed about management reports , or if they were, they did not reflect it in their responses on the questionnaire or the questionnaire items were not clear.

The total sample results for Questionnaire 5 indicate the highest perceived success scores on Increased Focus on Client Needs , Increased Focus on the Client as a Whole Person and Increased Interaction between Disciplines. These results are congruent with the results of Questionnaire 4 since they are the expected outcomes of increased development of a client-centred culture and interdisciplinary teamwork. Low success scores were obtained on speed of decisions , increased time for direct care , increased staff satisfaction and decreased turf conflicts. These results are reflective of a system in development . Decision making has not yet been decentralized to match the model and increased time is being required for team and organizational meetings. (The accreditation process also required staff time for meetings over the past six months). An increase in turf conflicts is an expected state as staff begin to attempt to work in more interdisciplinary team approaches and to establish their roles on the teams. Staff satisfaction then, might be expected to be lower during this period of adjustment and in light of the added dimension of the merger, construction and moves. These items also showed high variance which may reflect individual staff responses to change as well as

the differences across divisions. Qualitative data indicates that these issues are particularly prevalent in Acute Care and also in LTC but less relevant to the RCC and Rehabilitation divisions.

The perceived degree of readiness did differ highest to lowest across the four divisions studied : Rehabilitation, RCC, LTC and Acute Care. Multiple comparison analysis resulted in a cluster of Rehabilitation with RCC , LTC with RCC and LTC with Acute Care. Overall, readiness factors were rated unsure, undeveloped and minimally developed on the order of twice as often for LTC and Acute Care as opposed to RCC and Rehabilitation. Ranking of results for the four divisions at the level of the subcomponents was consistent with the overall readiness scores. Multiple comparison analysis indicated that Rehabilitation and RCC were significantly different from LTC and Acute Care on the Client-Centred Culture subcomponent. For Process Capability, LTC was clustered with Rehabilitation and RCC in one grouping and with Acute Care in another. Rehabilitation, RCC and LTC formed one cluster with Acute Care being significantly different from RCC and Rehabilitation on the subcomponent for Education and Training. On Professional Issues, the only significant difference was between Rehabilitation and Acute Care.. This likely reflects Acute Care's lack of approaches to include and address the interests of non nursing disciplines and the relatively well evolved interdisciplinary team processes in Rehabilitation. These results are generally consistent with the qualitative responses. Rehabilitation and RCC have been evolving program management over a number of years and both have well developed missions and client-centred cultures. Both have strong interdisciplinary team focus and processes. Some interprofessional issues were identified but these were at a fairly high level of sophistication or were related to particular individuals. This emphasizes however, the need for continuing review and attention to role clarity within the team context even when team approaches are well established as in these two divisions. On Questionnaire 4,

the Rehabilitation Division had 15 of the 30 items scored as highly developed by 50 % or more of the respondents. RCC scored higher on collaboration and slightly higher on client-centred culture. LTC results fell between RCC and Acute Care and this was also congruent with qualitative comments reflecting a middle stage of development characterized by inconsistency and confusion. Staff in LTC have received some education and have some understanding of Program Management. There is not however, a shared understanding or a clear sense of the roles and responsibilities under the new model. They have not yet operationalized the model into effective interdisciplinary processes to create a consistent experience that will enable staff to internalize and institutionalize program management principles. This was evident in the polarized responses received where some staff felt that communication and interdisciplinary processes were going extremely well and others reported that communication was completely lacking and that teams were still highly nursing driven. Results however, must be viewed in light of the move to a new building with merging of staff from different areas and the stress created by problems with the new physical plant. Acute Care was viewed as being in the very early stages of learning about Program Management. In fact, this may not have even been at a threshold level for valid testing. This was the only Division for which the correlation between results on Questionnaires 4 and 5 was not significant. Forty percent (40%) of the Acute Care respondents preferred to return to the traditional structure as opposed to only eighteen percent (18%) of the total sample.

Perceived success of implementation of Program Management was ranked in the same order as readiness : Rehabilitation. RCC. LTC and Acute Care. Acute Care was significantly different from the other three divisions. Again, LTC is in the middle position being significantly different from Rehabilitation and from Acute Care but not from RCC. This is somewhat discrepant from the qualitative reports indicating that RCC

was perceived to be more successful. Results on the general question rating success as high. medium. low placed RCC at a High - Medium level and LTC at Low - Medium. These results are more consistent with the qualitative comments. The discrepancy may be related to the non-standardized measurement tool used and/or to the polarized responses obtained in LTC. Also. LTC staff indicated that certain aspects of care and operations had improved a great deal. This improving picture may have been reflected in Questionnaire 5 but the general question may have captured the overall perception.

Regression analysis indicated that over 50% of the variation in perceived successful implementation was explained by the readiness variable. Other variables affecting success may include staff morale. effects of the merger. moves. constructions as well as leadership and the amount of time that Program Management has been in practice. In the current study. the Rehabilitation Division and the Regional Children's Centre (RCC) displayed the highest levels of success. They have been operating along program lines for the longest periods compared to the Long Term Care and Acute Care Divisions. The time variable must be considered in the context of depth of development of the critical factors. That is. while it takes time to develop culture. skills and processes that support successful program management. effort must be expended towards their development or any amount of time will not result in success. Composition of care teams may also be an important moderating variable which is largely dictated by the nature of the services provided. In Rehabilitation services. teams are usually smaller and are composed of a wide variety of professional disciplines. RCC teams are also smaller with fewer disciplines involved. most with a mental health focus in their training. LTC and Acute Care deal primarily with inpatient hospital populations and are therefore more heavily weighted with nursing staff. The difficulty in shifting from a medical/nursing focus to an interdisciplinary focus was identified as a problem that will require a greater commitment of time and training in these divisions.

CHAPTER 7 : SUMMARY AND IMPLICATIONS OF STUDY

7.1 Summary

This study supports the hypothesis that attention to the development of critical readiness factors can enhance perceived success of implementation of Program Management. Given the high stakes involved in a transition from a traditional structure to a Program Management approach, hospitals must consider and plan such changes carefully. Time spent in preparation can ensure best fit in the choice of structure design, minimize organizational resistance and facilitate more enduring change. The model proposed in this study may assist health care organizations in evaluating their readiness for change and in targeting areas requiring attention to facilitate successful organizational transition to a decentralized model.

7.2 IMPLICATIONS OF STUDY

Using the premise that it makes sense to organize around the work, health care organizations should focus their reorganization around the patient/client care program. It is the quality of this care by which consumers will judge the hospital. The accepted industry standard that such care will be delivered by interdisciplinary teams within a client-centred care philosophy was supported by the results of this study. With the two factors interdisciplinary teamwork and client-centred philosophy as the basis of the delivery system, a new model emerges that targets organizational change efforts on the development of **high performance teams** that can deliver quality, client-centred care to specific client groups. These program/unit teams may then be organizationally clustered into larger Programs based on the client groups served by the organization as a whole.

78

Self-directed or self-managed work teams have been proclaimed as the wave of the future and their use is spreading rapidly from the manufacturing to the service sector. According to Fisher (1993), team-centred organizations have reported improvements of 30-50% in the key organizational measures. Team based organizational design in health care has been supported by Hamilton (1993) and by Eubanks (1991) who stated that " it is the management of clinical processes by collaborative multidisciplinary teams that will offer critical breakthroughs in health care (p. 26). Peters (1992) has predicted that teams will become the basic work unit in moving to truly collaborative systems of work.

Fisher (1993) views self-directed teams as "the most advanced form of worker empowerment" and he further states that " empowerment is potentially as profound a change in contemporary organizations as the first industrial revolution was at the turn of the century " (p. 3). He contends that empowerment allows employees to assume many of the traditional management responsibilities as they take direction from the work itself and from a clear vision and set of guiding principles rather than from a supervisor. Lawler (1988) and Peters (1992) agree that shared principles and values can act as a compass to guide behaviour and encourage appropriate situation specific responses.

This is consistent with the trend to downsize middle management and to extend the span of control but it requires extensive training for team leaders as well as team members. Leaders must learn to assume a long-term , interdisciplinary perspective rather than a task-oriented perspective. They must learn how to coach. to negotiate. to communicate. to network and to manage inter and intra-team processes. Team members must learn interdependence, respect for other disciplines and collaboration in pooling their talents to accomplish the common goal of providing quality programming to their client group.

In a **team based organizational design**, teams build and evolve processes based upon the needs of the client group , team capabilities and available resources. According to Brown (1993), given the same common core values, healthcare teams will develop different approaches, structures and solutions to problems. This creativity could be encouraged and used as a springboard for inter-team learning. As teams become the organizational units accountable for performance, superior performance will rely heavily on the **commitment**, not merely the compliance, of team members. Commitment models emphasize the advantages of a committed workforce that focuses on what needs to be done rather than the prescribed thing to do (Lawler,1988). Mackenzie (1991), and Herbert (1981) note that commitment and performance are enhanced when there is goal congruency between the individual and the organization. This is an advantage in healthcare. since most healthcare workers take pride in their professional identity and in the provision of quality care. As Walton (1985) has written. not all workers wish to be empowered. Those who want only to put in their eight hours and go home may have become conditioned by a culture of hierarchy and control. It is essential to re-energize these individuals through a common. compelling vision and by soliciting their involvement. Beer et al (1990) contend that the most effective way to change behaviour is to put people into a new context that imposes new roles. responsibilities and relationships on them. The establishment of interdisciplinary teams and team processes imposes such roles and collaborative relationships. This forces new behaviours and attitudes provided that training is offered for the new skills required. On the other hand, an impressive organizational structure on paper will not result in change if the training and new role expectations are not reinforced.

In the healthcare setting, each person's perception of service depends much more on individual excellence than it does in manufacturing (Jirsch, p. 30). The 'moments of truth' are the provider/consumer interactions at the interface of care delivery. Staff behaviour

and attitude have critical impact on consumer perception of quality (Drummond, 1992). Therefore, individual healthcare workers must be committed to excellence. Teams and their individual members must be empowered to make decisions at the level that will affect consumer perceptions about the organization. As noted above, true empowerment and decentralization of decision-making have wide ramifications that may not be fully appreciated when organizations decide to move to decentralized models.

At the same time that the focus is on team building and individual commitment, it is essential to support the individual's professional identity and to nurture the unique expertise that they bring to the team. As discipline specific departments are phased out, opportunities for peer interaction must be provided and mechanisms to ensure professional voice as well as standards of practice must be developed . This can be accomplished in a variety of ways. Maintenance of roles, albeit different roles, for clinical heads is one way and the establishment of committees such as Professional Affairs is another avenue. Collaborative dialogue with professional groups and unions is also recommended to develop shared solutions to issues.

Once program unit care teams develop processes, it is essential that support services and procedures are developed that enhance rather than impede these processes. Teams require timely information at the level of the program or care unit for appropriate feedback and decision-making. The concept of self-directed teams can be applied to support teams as well as to care teams.

CHAPTER 8 : LIMITATIONS and RECOMMENDATIONS

8.1 Limitations of the Study

The measures utilized in the study were self-report measures. As they were dependent upon the judgment and opinions of respondents, they measured perceived readiness and perceived success of implementation. Such measures however, have gained acceptance in psychological research. "The advantages of using human judgment as a means of measurement are generally thought to outweigh the disadvantages" (Blalock, 1974, p. 159). People know what they feel and consequently can give meaningful reports about subjective states of mind. Furthermore, how people feel dictates how they behave.

The fixed response format utilized in questionnaires 3,4 and 5 of this study cannot provide all of the possible response alternatives. The format can also cause respondents to fall into a response set as they strive to appear consistent (Kidder & Judd. 1986). The likelihood of this tendency increases when the questionnaire is lengthy. In this study, the questionnaires were relatively short in length and a fixed response set was not apparent from examination of the results.

The scope of the study did not include direct observation of program teams in daily activity or examination of secondary documents such as care plans and minutes of meetings. Future research could include such methods to corroborate information received in self-report measures. The study design included only minimal pretesting of measurement tools. More extensive piloting of the tools would have resulted in a number of additional changes to simplify the language and to investigate some areas in greater depth. For the question on return to a traditional structure, a question on the reasons for recommending return to that structure would have provided useful information. On questionnaire 4, addition of specific questions to investigate process capability at the team level would have added information to the model. Addition of an open question to

Questionnaire 5 could have gathered information about what critical factors staff felt were required to make Program Management work.

Use of a preceptor to administer the questionnaires may have reduced the possibility for perceived bias by the author. However, as the author's activities are well known in the hospital, any attempts to conceal her identity may have had other negative effects.

The study was conducted during a period when employee morale and commitment, were being affected by mergers, relocations, and the uncertainty associated with consolidation and downsizing. As such pressures and changes are ongoing in the healthcare industry, it is not possible to control these variables. The data gathering for the study was, however, compressed into one month in order to collect data from all four divisions during the same time frame and within the same relative climate.

8.2 Recommendations for Future Research.

The following recommendations are made for future research.

1. A follow up study to track further development of critical factors and success of Program Management in the Acute Care and LTC divisions would provide a more complete picture of the course of shifting to a decentralized model in areas that are traditionally medical/nursing driven.

2. Further factor analysis of the critical readiness factors may yield other subcomponent groupings.

3. Further field studies to test and develop critical pathways for implementation of decentralized models would be useful for organizations considering a change.

4. As health care organizations continue to move to new models of service delivery, tracking of outcomes is essential to evaluate their effectiveness. This should include measures such as client satisfaction, changes in health and functional status, average

length of stay in hospital, and productivity. Since there has been a lack of outcome measures to provide baseline data, comparisons will be difficult. The development of more sophisticated Information Systems geared to the new organizational designs will be required to provide information for evaluation purposes.

8.3 Recommendations for a Team Based Organizational Model

A team based organizational model is recommended for health care organizations, including the setting for this study. The team provides a more concrete level around which to organize and on which to focus educational activities. It is easier for staff to focus at the level of their everyday work experience and more difficult to conceptualize at the level of the larger Program. Once teams develop processes and operationalize them, the underlying concepts can be experienced, internalized and institutionalized.

A team focus is applicable within Program Management or other decentralized structures. The critical readiness factors clustered in this study into the four subcomponents of Client-Centred Care, Process Capability, Education and Training and Professional Issues Strategy are highly relevant to a team based organizational design. The critical factors provide the underlying support for effective team development and functioning. This support is important during the implementation phase as well as during phases of ongoing operation of the chosen model.

A model is presented in **Figure 7** that incorporates the concept of the critical readiness factors with the concept of the team based organizational model. Self directed care teams are developed and are supported by the four readiness subcomponents. The teams develop relationships and processes to deliver quality, client-centred care through individual and team commitment to specific client groups. The focus is then on building up a high performance organization rather than simply on installing a new structure.

84

Figure 7
Team Based Organizational Model

SELF DIRECTED CARE TEAMS

Shared Culture (Client-Centred)

Process Capability

Education and Training

Professional Issues Strategy

Processes

QUALITY CLIENT CENTRED CARE

team and individual commitment

CLIENT GROUP
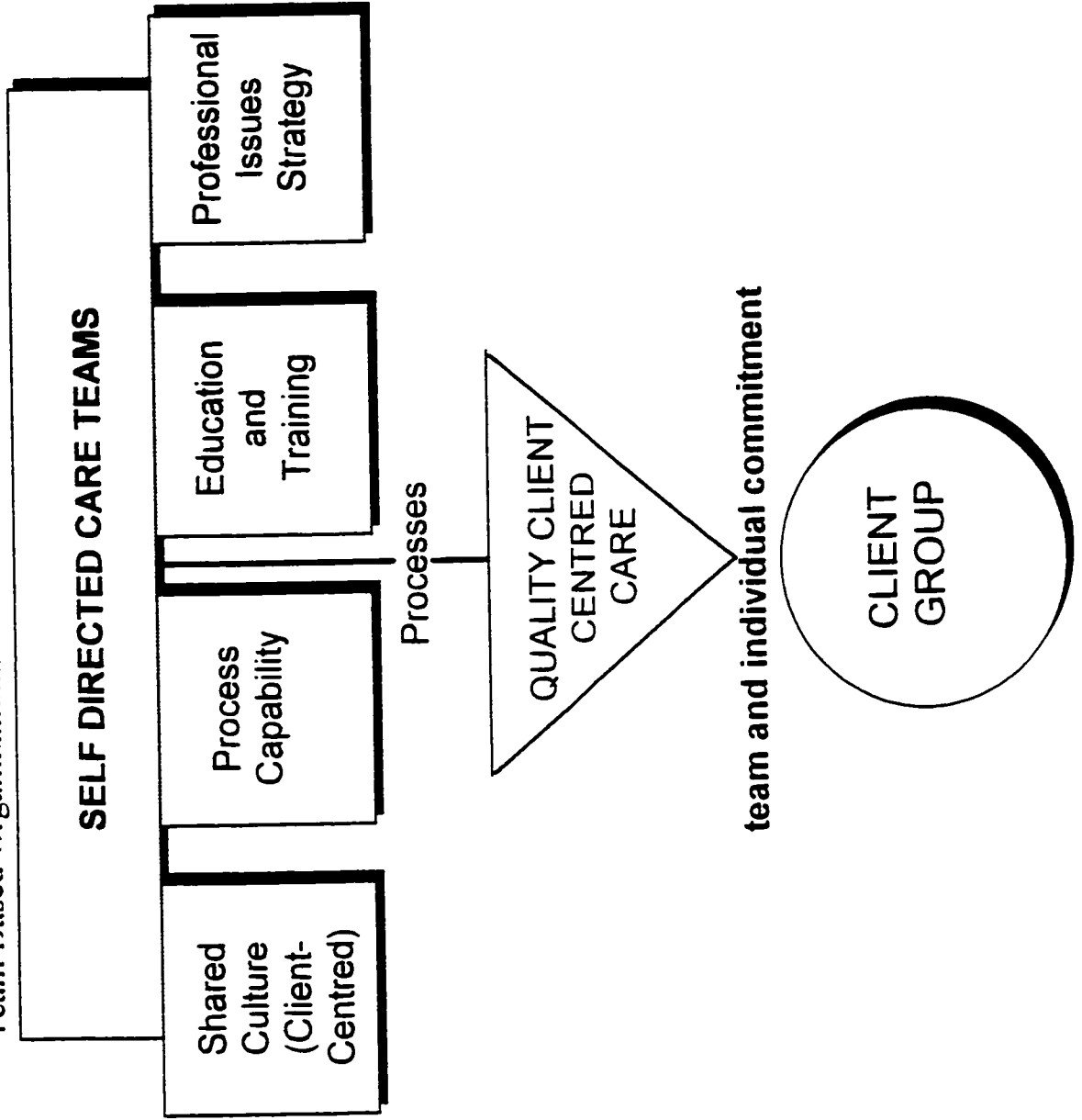
APPENDIX A

Letter of Explanation to Participants

Dear Colleague,

Hello, my name is Pauline Brandes from Rehab. Services. I am conducting brief interviews as part of my Master's thesis on Program Management. Although I have approval from senior management for this activity, I am conducting this research independently as part of my MBA program at the University.

The interview will take approximately twenty (20) minutes of your time. You will not sign your name or be identified in any way. The results are completely anonymous.

There are no right or wrong answers. I am interested in your honest, personal opinion.

I would like to thank you for your assistance by buying you a cup of coffee, tea, juice. Please use the attached voucher in the cafeteria at either the Western, the Met or the Malden Park campus.

Many Thanks,

_____

Pauline J. Brandes

APPENDIX B

Interview Questionnaire 1: Identification of Critical Factors

1   What factors or conditions do you see as critical in making program management work?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

2.   How well developed are these factors or conditions?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

3.   What have the greatest challenges been in implementing Program Management?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

APPENDIX C

Questionnaire 2: Rating of Importance of Critical Factors

Please mark factors in terms of importance by circling a score for each on a scale of 1 to 5
(5) is most important and (1) is least important

	Most				Least
1. Involvement and Participation of staff	5	4	3	2	1
2. Commitment of Senior Management	5	4	3	2	1
3. Shared Vision and Values	5	4	3	2	1
4. Client Centered Philosophy	5	4	3	2	1
5. Effective Information Systems	5	4	3	2	1
6. Shared Decision Making	5	4	3	2	1
7. Support of Unions	5	4	3	2	1
8. Interdisciplinary Team Approaches	5	4	3	2	1
9. Effective Corporate Communication	5	4	3	2	1
10. Support of Professional Groups	5	4	3	2	1
11. Decentralized Decision Making	5	4	3	2	1
12. Clear Roles and Responsibilities	5	4	3	2	1
13. Strong Program Leaders	5	4	3	2	1
14. Collaboration and Trust	5	4	3	2	1
15. Ongoing Education and Training	5	4	3	2	1
16. Avenues to Address Professional Issues	5	4	3	2	1
17. Program Management Champions	5	4	3	2	1
18. Finance & Stats Systems geared to Program	5	4	3	2	1
19. Change Management Activities	5	4	3	2	1
20. Empowerment of Line Staff	5	4	3	2	1
21. Revised Documentation Formats	5	4	3	2	1
22. Staff Skills in Team Work, Problem Solving	5	4	3	2	1
23. Flatter Hierarchy	5	4	3	2	1
24. Positive Staff Attitudes	5	4	3	2	1
25. Tolerance of Risk Taking	5	4	3	2	1
26. Understanding of Client Centred Care	5	4	3	2	1
27. Management Support of Program Mgmt	5	4	3	2	1
28. Physician Support of Program Mgmt	5	4	3	2	1
29. Information on Need & Reasons for Change	5	4	3	2	1
30. Revised Performance Evaluation System	5	4	3	2	1

Thank You

88

APPENDIX D

Questionnaire 3 : Qualitative Descriptions of Divisions

1 How would you describe the culture in your daily work environment? i.e.. philosophy. values. ways of doing things

_____
_____
_____
_____
_____
_____
_____
_____
_____
____

2. What is your program's mission? What is it's vision?

_____
_____
_____
_____
_____
_____

3 a) How much education and training has been is provided about program management. multidisciplinary team work. client centred care. outcome measurement?

Ongoing ___ Frequent ___ Occasional ___ Never ___

b) What educational activities have you been involved in this year?

_____
_____
_____
_____

c) How was/is this provided? Check all that apply
- staff meetings _____
- presentations _____
- workshops _____
- informal discussion _____
- as examples occur _____
- other _____

4 Do you work in an interdisciplinary team?   Most of the Time _____
                                                      Occasionally _____
                                                      Never _____

5 Describe the team activities you are involved in.

_____
_____

APPENDIX D CONTINUED

6 Describe team interactions

_____
_____

7 How clear are roles and responsibilities?

Very Clear _____ Moderately Clear _____ Unclear _____ Unsure _____

8.a) How often do staff participate and become involved in program decisions?

Always ___ Most of the Time ___ Occasionally ___ Never ___ Unsure ___

b) How are most decisions made?

_____
_____

9 How are professional issues addressed ? e.g., professional standards. supervision, peer contact.

_____
_____
_____
_____

10 How does your program link up with other areas in the hospital?

_____
_____
_____
_____

11.a) What type of management information do you receive? (if applicable)

_____
_____
_____

b) How useful is it?   Very ___ Moderately ___ Somewhat ___ Not Useful ___ Unsure ___

12.a) What approval processes are in place ?

_____
_____

b) How effective are they? Very ___ Moderately ___ Somewhat ___ Not Effective ___ Unsure ___

13 If you have any comments you'd like to make . please do so

_____
_____
_____
_____

Thank You

APPENDIX E

Questionnaire 4 : Perceived Readiness Scale

Please rate the following in terms of **how well** they are **developed** in your program. Please circle one choice per statement.

Culture (philosophy, values, a way of doing things)

Is it client centred?	Highly	Partially	Minimally	Undeveloped	Unsure
Is it outcome focused?	Highly	Partially	Minimally	Undeveloped	Unsure
Is it quality focused?	Highly	Partially	Minimally	Undeveloped	Unsure
Is collaboration encouraged?	Highly	Partially	Minimally	Undeveloped	Unsure
Is there shared vision and values?	Highly	Partially	Minimally	Undeveloped	Unsure
Is interdisciplinary teamwork encouraged?	Highly	Partially	Minimally	Undeveloped	Unsure
Is shared decision making shared?	Highly	Partially	Minimally	Undeveloped	Unsure
Is there tolerance of risk taking?	Highly	Partially	Minimally	Undeveloped	Unsure
Is there staff participation & involvement?	Highly	Partially	Minimally	Undeveloped	Unsure
Is there an atmosphere of trust and respect?	Highly	Partially	Minimally	Undeveloped	Unsure

Process Capability

Are management information systems program specific?	Highly	Partially	Minimally	Undeveloped	Unsure
Are there links with other hospital & outside areas?	Highly	Partially	Minimally	Undeveloped	Unsure
Is the hierarchy flat and flexible?	Highly	Partially	Minimally	Undeveloped	Unsure
Is decision making decentralized?	Highly	Partially	Minimally	Undeveloped	Unsure
Are accounting & financial reports organized by program?	Highly	Partially	Minimally	Undeveloped	Unsure
Do performance evaluations reflect a program focus?	Highly	Partially	Minimally	Undeveloped	Unsure
Are Quality Management activities program specific?	Highly	Partially	Minimally	Undeveloped	Unsure

91

Please rate the following in terms of **how well** they are **developed** in your program. Please circle one choice per statement.

Education and Training

Has education been provided about multidisciplinary approaches?	Highly	Partially	Minimally	Undeveloped	Unsure
Has education been provided about client centred care?	Highly	Partially	Minimally	Undeveloped	Unsure
Has education been provided about dealing with change?	Highly	Partially	Minimally	Undeveloped	Unsure
Has education been provided about program management?	Highly	Partially	Minimally	Undeveloped	Unsure
Have roles and responsibilities been made clear?	Highly	Partially	Minimally	Undeveloped	Unsure
Have strong program leader skills been developed?	Highly	Partially	Minimally	Undeveloped	Unsure
Have staff assisted in developing new skills and attitudes?	Highly	Partially	Minimally	Undeveloped	Unsure

Professional Issues Strategy

Is there a mechanism for contact with peers in your discipline?	Highly	Partially	Minimally	Undeveloped	Unsure
Is there opportunity for continued professional development?	Highly	Partially	Minimally	Undeveloped	Unsure
Is there a mechanism for discipline specific supervision?	Highly	Partially	Minimally	Undeveloped	Unsure
Is there a way to ensure that professional standards are maintained?	Highly	Partially	Minimally	Undeveloped	Unsure
Is there contact with professional organizations?	Highly	Partially	Minimally	Undeveloped	Unsure
Is there communication with relevant unions?	Highly	Partially	Minimally	Undeveloped	Unsure

Thank You

APPENDIX F

Questionnaire 5 : Perceived Success of Implementation of Program Management

Instructions

Consider the current structure for program management used in your area of assignment

Please circle   **SA** = Strongly Agree

           A = Agree.

           N = Neither Agree or Disagree

           D = Disagree

           SD = Strongly Disagree

Program Management has facilitated :

1.	improved clinical decision making	SA	A	N	D	SD
2.	increased quality of care/service	SA	A	N	D	SD
3.	increased staff participation in program decisions	SA	A	N	D	SD
4.	increased focus on client needs	SA	A	N	D	SD
5.	increased ability to meet program goals	SA	A	N	D	SD
6.	increased involvement of client/family	SA	A	N	D	SD
7.	decreased discipline and turf conflicts	SA	A	N	D	SD
8.	increased focus on the client as a whole person	SA	A	N	D	SD
9.	increased interaction between disciplines	SA	A	N	D	SD
10	increased speed of administrative decisions	SA	A	N	D	SD
11	improved client outcomes	SA	A	N	D	SD
12.	increased client satisfaction	SA	A	N	D	SD
13	maintaining professional standards of practice	SA	A	N	D	SD
14	improved interdisciplinary team work	SA	A	N	D	SD
15	increased control over program resources	SA	A	N	D	SD
16	increased staff satisfaction	SA	A	N	D	SD
17	increased time in direct patient care	SA	A	N	D	SD
18	improved integrated care planning	SA	A	N	D	SD
19	meeting my professional needs	SA	A	N	D	SD

GENERAL QUESTIONS

How would you rate the success of Program Management in your area? Low__ Medium__ High__

Would you recommend a return to a more traditional organization based on services or departments. e.g.. nursing. physiotherapy?   Yes__ No__

If you have any comments you'd like to make. please do so

_____

_____

_____

_____

_____

_____

_____

Thank You.

APPENDIX G

Reliability Coefficient for Q4 -Cronbach's Alpha

N of Cases = 133.0

Item Means		Mean	Minimum	Maximum	Range	Max/Min	Variance
		2.9619	1.6842	3.6316	1.9474	2.1563	.2005

R E L I A B I L I T Y   A N A L Y S I S   -   S C A L E   (A L P H A)

Item-total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Squared Multiple Correlation	Alpha if Item Deleted
Q1	82.2256	233.9942	.4260	.5031	.8979
Q2	82.5865	229.7292	.4623	.4572	.8968
Q3	82.4060	230.6672	.5246	.4915	.8964
Q4	82.2857	229.9481	.6113	.6424	.8957
Q5	82.7068	228.0119	.5009	.6324	.8961
Q6	82.2556	230.7069	.5179	.5696	.8965
Q7	82.7519	232.3243	.3730	.4971	.8981
Q8	83.1129	222.8432	.6109	.5163	.8940
Q9	82.4361	229.7781	.5334	.6315	.8962
Q10	82.7519	227.7940	.5581	.6029	.8955
Q11	83.5414	222.4623	.4267	.4813	.8979
Q12	83.0075	226.5378	.4486	.4866	.8968
Q13	83.4286	228.4437	.3625	.4029	.8985
Q14	83.2105	226.6523	.4318	.4698	.8971
Q15	84.1729	221.9471	.3656	.4019	.9005
Q16	83.4286	220.2316	.4845	.3321	.8964
Q17	83.5639	220.3993	.4447	.5271	.8977
Q18	83.1729	228.0229	.4500	.5330	.8968
Q19	82.9098	225.9312	.5170	.5485	.8957
Q20	83.4060	223.7581	.5288	.6189	.8953
Q21	83.5038	225.3731	.4966	.4832	.8959
Q22	82.9699	227.5597	.4849	.5469	.8963
Q23	83.1429	222.1537	.5997	.6026	.8940
Q24	83.1429	221.8203	.6160	.5615	.8937
Q25	82.6992	225.8028	.4434	.3663	.8969
Q26	83.1504	227.7954	.4314	.4147	.8971
Q27	83.0902	222.7191	.4343	.4846	.8976
Q28	82.7970	225.9206	.5201	.5523	.8956
Q29	82.8797	229.3642	.3386	.4117	.8989
Q30	83.1203	226.5157	.3632	.4075	.8989

Reliability Coefficients   30 items

Alpha =   .8998   Standardized item alpha =   .9115

APPENDIX H

Reliability Coefficient for Q5 - Cronbach's Alpha

Statistics for	Mean	Variance	Std Dev	N of Variables
Scale	69.7113	154.9870	12.4494	19

Item Means	Mean	Minimum	Maximum	Range	Max/Min	Variance
	3.6690	2.8944	4.2254	1.3310	1.4599	.1491

Item Variances	Mean	Minimum	Maximum	Range	Max/Min	Variance
	.9019	.5836	1.4306	.8470	2.4513	.0512

R E L I A B I L I T Y   A N A L Y S I S   -   S C A L E   (A L P H A)

Item-total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Squared Multiple Correlation	Alpha if Item Deleted
S1	65.8451	140.7276	.6691	.5394	.9354
S2	65.8732	136.7781	.7349	.6597	.9339
S3	65.8380	140.8176	.6149	.5234	.9362
S4	65.4859	141.9963	.6304	.7182	.9361
S5	65.8451	139.0397	.7193	.6383	.9344
S6	65.7324	141.7009	.5919	.6022	.9367
S7	66.6338	137.0848	.6281	.5599	.9363
S8	65.5915	141.9029	.6135	.6717	.9363
S9	65.6831	140.9982	.6176	.6236	.9362
S10	66.8169	140.0372	.5701	.4693	.9373
S11	65.9859	141.6877	.6992	.6945	.9351
S12	66.0704	139.9525	.7163	.6992	.9346
S13	65.9577	140.8776	.6044	.5243	.9364
S14	65.8099	140.3820	.6333	.6172	.9359
S15	66.2254	141.5659	.5582	.4348	.9373
S16	66.6268	134.1789	.7486	.6902	.9336
S17	66.5845	136.4432	.6124	.5628	.9369
S18	65.8662	138.4430	.7415	.6456	.9340
S19	66.3310	137.3010	.6891	.5973	.9348

Reliability Coefficients   19 items

Alpha =   .9369   Standardized item alpha =   .9405

95

CODING KEY for Questionnaire 1

A - Positive Attitudes
AS - Adequate staffing, manageable workload
BI - Buy In
C - Communication
CCP - Client Centred Philosophy/Culture
Ch - Readiness for Change, Willingness to Change
Coll - Collaboration, Respect, Trust
Com - Commitment
Cul - Client Centred Culture
D - Decentralized Decision Making
Doc - Documentation
Ed - Education & Training
Emp - Empowerment
EP - Evolving Process
F - Flexibility
Info - Information
IM - Integrating Mechanisms, Links between areas or outside agencies
MS - Management Support
P - Professional Issues
PO - Process Orientation
Q - Quality Orientation
L - Strong Program Leaders, new skills for Program Management
    Team Supporting Manager, not Discipline Supporting
RSK - Risk Taking
SI - Staff Participation & Involvement
R&R - Clear roles & responsibilities, clear direction on roles, clear
    accountabilities
Res - Respect, Trust
S&P - Structures & Procedures, clear directions on how things are done,
    who reports to   who, policies & procedures, infrastructure
ShD - Shared decision making
T - Teamwork
Union - Union buy in
V - Shared Vision & Values

REFERENCES

Allcorn. S. (1990). Using matrix organization to manage health care delivery organizations. Hospital and Health Service Administration, 35:4, Winter . 575-590.

Argenti. P. (1992). Corporate communication. U.S.A: R. Irwin Inc.

Bain. J. Farrell. J. Fawcett. S.. Gilbert. S.. Meeks. J. & Purdell-Lewis. G. (1994). **Program management at St. Peter's Hospital** in Program Management and Beyond. Leatt. P.. Lemieux-Charles. L.. Aird. C. 75-84.

Baptiste. S. (1993). **Clinical programme management: a model of promise?** CJOT, Vol. 60, No. 4, October. 200-205.

Bard. M. (1994). **Reinventing health care delivery.** Hospital & Health Services Administration. Vol. 39. No. 3. Fall. 378-385.

Bartlett. C.. Ghoshal. S. (1990). **Matrix management: not a structure. a frame of mind.** Harvard Business Review. July - August. 397-402.

Becker-Reems. E. (1994). **Self managed work teams in health care organizations.** Boston: American Hospitals Pubs. Inc.

Beer. M.. Eisenstat. A. & Spector. B. (1990). **Why change programs don't produce change.** Harvard Business Review. Nov - Dec. 159-166.

Bergman. R. (1994). **Reengineering healthcare.** Hospital & Health Networks, Vol. 68. No. 3. Feb.. 28-36.

Blalock. H. (1974). Measurement in Social Sciences. Chicago: Aldine Pubs. Co.

Blancett. S. (1994). **Self managed teams : The reality and the promise.** Health Care Supervisor. 12 (4). 48-55.

Bolton. C.. Gordon. J. (1994). **Re-engineering : A prescription for hospitals.** Healthcare Management Forum. Vol. 7. No. 2. Summer. 51-55.

Boston. C.. Vestal. K. (1994). **Work transformation: Why the new health care imperative must focus on both people and processes.** Hospitals & Health Networks, Vol. 68. #7, April. 50-54.

Bowers. M.. Taylor. J. (1990). **Product line management in hospitals : An exploratory study of managing change.** Hospital & Health Services Administration, 35 (3), 365-375.

Brider. P. (1992). **Focused care.** American Journal of Nursing, September. 27-33.

Bridges. W. (1980). Transitions. Don Mill. Ontario: Addison - Wesley Publishing Co.

Bridges. W. (1988). Surviving Corporate Transitions. New York: Doubleday.

Bridges. W. (1991). Managing transitions: making the most of change. Don Mills. Ontario: Addison - Wesley Publishing Co.

Brown. T. (1993). **The new science of leadership.** Industry Week. 242. no. 2. 15-22.

Bryant. D. (1979). **The psychology of resistance to change.** Management Services, March. 9-10.

Bruner. J.. Barker. J. (1994). **Program management at Markham Stouffville Hospital** in Program Management and Beyond. Leatt. P.. Lemieux-Charles. L.. Aird. C. 29-36.

Budgen. C. M. (1987). **Modelling: A method for program development.** JONA, Vol. 17. No. 12. December. 19-26.

Burdett. J. (1992). **A template for organizational development.** Business Quarterly, Summer. 35-41

Carman. J.. Shortell. S.. Foster. R.. Hughes. E.. Boerstler. H.. O'Brien. J.. & O'Connor. E. (1996). **Keys for successful implementation of total quality management in hospitals.** Health Care Management Review, 21 (1). 48-60.

Carmichael. D. (1994). **Business process reengineering: A remedy for health care.** Healthcare Management Forum, Winter, 44-55.

Cauthorne-Lindstrom. C.. Tracy. T. (1992). **Organizational change from the "mom & pop" perspective.** JONA, Vol. 22. No. 7. (8). July. Aug. 61-64.

Chilton. H. (1995). **Partners in practice: Redirecting the winds of change.** CJOT. Vol. 62. No. 4. October. 183-187.

Christensen. P.. Bender. L. (1994). **Models of nursing care in a changing environment: Current challenges and future directions.** Orthopaedic Nursing, Vol.13. No. 2. March April. 64-70.

Clarke, L. (1992). The essence of change. Toronto: A. Buckley ed.. Prentice Hall.

Connor. D. (1993). Managing at the speed of change. New York: Villard Books.

Cross. K.. Feather. J.. & Lynch. R. (1993). Corporate Renaissance.

Curtin. L. (1994). **Restructuring: what works - And what does not.** Nursing Management. October. 7-8.

Deutsch. N. (1994). **Hospital corridors program management: For better or worse?** Pharmacy News. January . 27.

Drummond. H. (1992). The Quality Movement. New Jersey: London Nichols Pubs.

Ellis. P.. Closson. T. (1994). **Realigning around the patient: the application of restructuring and process reengineering at Sunnybrook Health Science Centre** in Program Management and Beyond. Leatt. P. Lemieux-Charles. L.. Aird, C.. 55-66.

Essex County District Health Council. (1994). The Final Report of the Steering Committee on Health Care Reorganization. March.

Eubanks. P. (1991). **Restructuring care: patient focus is key to innovation.** Hospitals. Aug.. 26-33.

Fisher. K. (1993). **Leading self directed work teams.** New York: McGraw-Hill Inc.

Flaherty. T. (1979). Managing change : today's challenge to management. New York: Neller Pub. Co.

Fountain, M. (1993). **Key roles and issues of the multidisciplinary team.** Seminars in Oncology Nursing. Vol. 9. No. 1. February. 25-31.

Gage, M. (1994). **The patient- driven interdisciplinary care plan.** JONA. Vol. 24. No. 4. April. 26-35.

Gilbert. S. (1994). **Bedside nurses gain new role.** Registered Nurse. Aril. May. 33.

Gillies, R., Shortell. S.. Anderson. D.. Mitchell. J. & Morgan. K. (1993). **Conceptualizing and measuring integration : findings from the health systems integration study.** Hospital & Health Services Administration. 38 (4). 467-489.

Griffith, J. (1994). **Reengineering healthcare : management systems for survivors.** Hospital & Health Services Administration, 39:4, Winter. 451-469.

Hamilton, J. (1993). **Toppling the power of the pyramid : team based restructuring for TQM, patient centred care** Hospitals. 67. 40–41.

Harber, B. (1994). **Program management at Peel Memorial Hospital** in Program Management and Beyond, Leatt. P. Lemieux-Charles, L., Aird,C. 17-28.

Harber, B., Godwin, R. & Eni, G. (1989). **Issues for consideration in the establishment of a program management structure.** Healthcare Management Forum. 38 Fall. 6-13.

Harber, B., Miller, S. (1994). **Program management and health care informatics: refining relationships.** Healthcare Management Forum. Vol. 7. No. 4. Winter. 28-35.

Henderson, J., Williams, J. (1991). **The people side of patient care redesign.** Health Care Forum Journal. 34 (4). 44–49.

Herbert, T. (1981). **Congruence model** OB Readings and Cases. New York: Macmillan Pubs. Inc., N.Y. 16-30.

Heyssel, R., Gaintner, J., Kues, L., Jones, A., & Lipstein, S. (1984). **Special report : decentralized management in a teaching hospital.** New England Journal of Medicine, 310. 220. 1477-1480.

Hutchison, P. (1994). **Program management at the Hospital for Sick Children** in Program Management and Beyond, Leatt. P. Lemieux-Charles, L., Aird,C. 37–42.

Jacques, E. (1990). **In praise of hierarchy.** Harvard Business Review, January - February. 127-133.

Jick, T. (1993). Managing Change. Boston Mass.: R. Irwin Inc.

Jirsch, D. (1993). **Patient-focused care : The systematic implications of change.** Healthcare Management Forum. Vol. 6. No. 4. Winter. 27-32.

Johnson, J., Olesinski, N. (1995). **Program evaluation - Key to success.** JONA, Vol. 25. No. 1. January. 53-60.

Kennedy T., Crowell, D. (1995). **The whole hospital model.** PFCA Review, Summer. 7-13.

Kidder, L., Judd, C. (1986). Research Methods in Social Relations. Toronto: Holt, Rhinehart & Winston.

Kolodny, H. (1979). **Evolution to a matrix organization.** Academy of Management Review, 4 (4). 543-553.

Kosta, M. (1990). **Patient centred care: can your hospital afford to have It?** Hospitals, 64, Nov., 48-54.

Knight, K. (1976). **Matrix organization : A review.** Journal of Management Studies 13, No. 2, 111-130.

Lamkin, L. (1993). **Assessment, development, and evaluation of cancer programs.** Seminars in Oncology Nursing, Vol. 9, No. 1, February, 17-21.

Lathrop, J. (1992). **The patient-focused hospital.** Health Care Forum Journal, May-June, 76-78.

Lawler, E. (1988). **Substitutes for hierarchy.** Organizational Dynamics, Summer, 4-15.

Lawrence, P., Kolodny, H., & Davis, S. (1977). **The human side of the matrix.** Organizational Dynamics, 6 (1), 43-61.

Leatt, P. (1988). **Management partnerships : A reaction.** Hospital & Health Network, Vol. 1, No. 2, 21-24.

Leatt, P., Lemieux-Charles, L., & Aird, C. (1994). **Program management: introduction and overview.** Program Management and Beyond, (Chapter One). Canadian College of Health Service Executives, Ottawa, Ontario.

Lewin, K. (1948). Resolving Social Conflicts. New York : Harper Row.

Lumsden, K. (1993). **Putting patients first: hospitals work to define patient centred care.** Hospitals, Vol. 67, No. 3, Feb., 14-26.

MacDonald, S. (1993). **Organizational approaches to cancer program development.** Seminars in Oncology Nursing, Vol. 9, No. 1, Feb., 8-16.

Mackenzie, K. (1991). The Organizational Hologram : The Effective Management of Organizational Change. Boston: Awer Academic Pubs.

Mackenzie, T., Reynolds, D., & Greenaway-Coates, A. (1992). **Hospital reimbursement in Alberta : outcome management is on the way.** Healthcare Management Forum, 5 (4), 21-27.

Macleod, W. (1994). **Program Management at Women's College Hospital** in Program Management and Beyond, Leatt, P. Lemieux-Charles, L., Aird, C., 11-16.

MacTavish, M., Norton, P. (1995). **Redesign of a health sciences centre : reflections on co-leadership.** Healthcare Management Forum, Volume 8, No. 4, 45-48.

101

MacTavish. M.. Norton. P.. & Glouberman. S. (1995). **New management structures at Sunnybrook Health Science Centre: identifying patient groupings** Healthcare Management Forum, Volume 8. No. 2, 29-31.

Mang. A. (1995). **Implementation strategies in patient focused care.** Hospital and Health Service Administration, 40:30, Fall. 426-435.

Marks. M (1994). From Turmoil to Triumph. Don Mills Ont.: Maxwell Macmillan Can. Inc.

Marshall. K. (1995). **Multiskilling - re-engineering work process.** Healthcare Management Forum. Vol. 8. No. 2. Summer. 32-36.

Marszalek-Gaucher. E.. Coffey. R. (1990). **Transforming healthcare organizations : How to achieve and sustain organizational excellence.** San Francisco. California: Jossey-Bass.

Meeks. J. (1994). **Transition from Department to Program.** Paper presented Sheraton Hamilton Hotel. November

Moffitt. K. (1993). **Patient-focused care : Key principles to restructuring.** Hospitals & Health Services Administration. 38:4. Winter. 509-521.

Monaghan. B.. Alton. L.. & Allen. D. (1992). **Transition to program management.** Leadership. (33 - 37).September October. 33-37

Monaghan. B.. Alton. L.. & Wojtak. A. (1994). **Program Management at West Park Hospital** in Program Management and Beyond, Leatt. P. Lemieux-Charles. L.. Aird. C.. 43-54.

Morris. R.. Stuart. N., Monoghan. B.. & Alton. L. (1994). **An evaluation of program management: the West Park Hospital experience.** Healthcare Management Forum, Vol. 7. No. 2. Summer. 29-37.

Moss - Kanter. R. (1993). The Change Masters, New York: Simon & Schuster.

Nystrom. P. (1993). **Organizational cultures, strategies and commitments in health care organizations.** Health Care Management Review, 18(1). 43-49.

Orr. R. (1987). **A new design for modern healthcare : the planetree project.** World Hospital, 23. (3:4). 38-40.

Pearce. B.. Osmond. P. (1996). **Metaphors for change : The ALPS model of change management.** Organizational Dynamics, Winter, 23-37.
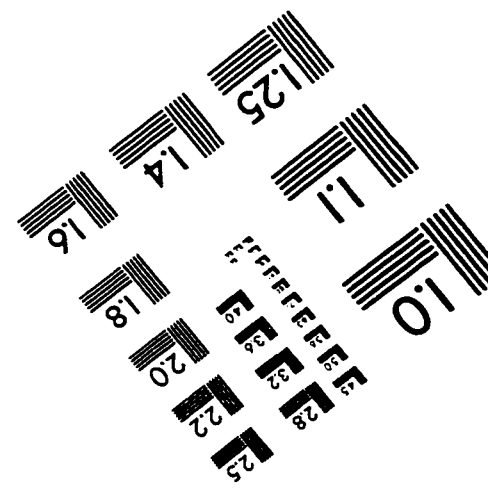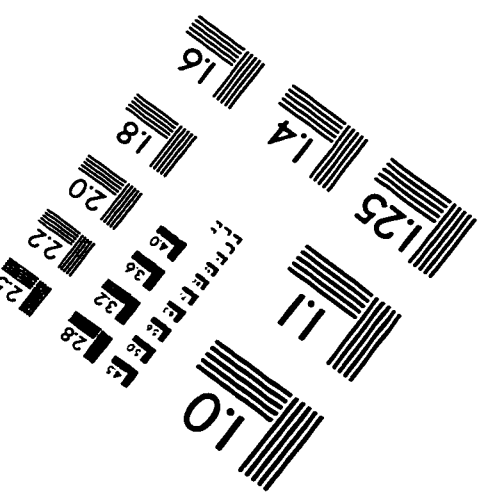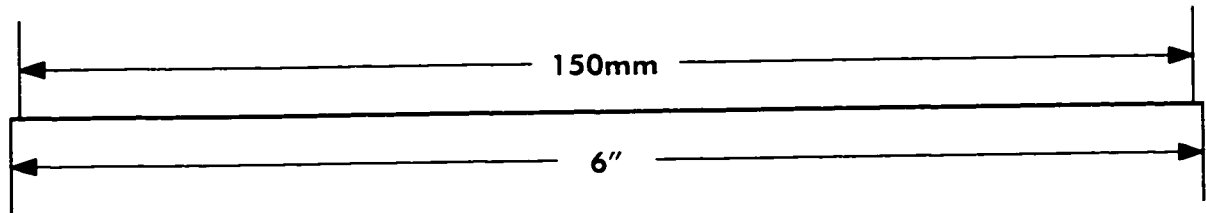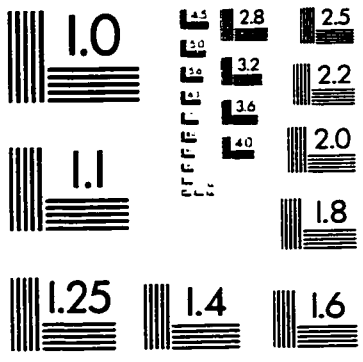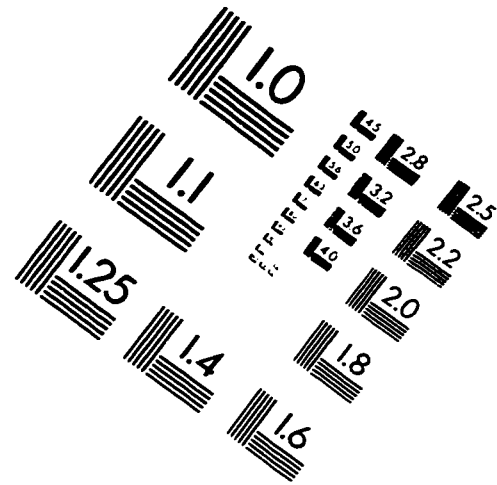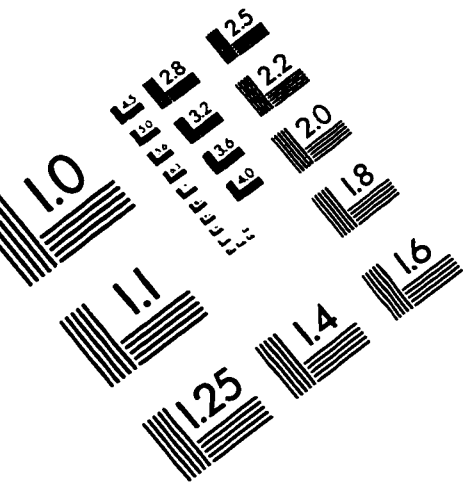
Peters. T. (1992). **Liberation management, necessary disorganization for the nanosecond nineties**. New York: Alfred Knopf.

Pond. R., Herne. J. (1994). **Program management at Homewood Health Centre** in Program Management and Beyond Leatt. P. Lemieux-Charles. L.. Aird. C.. 67-74.

Pike. W. (1995). Leading the transition. New York: Quality Resources.

Robinson. C.. Thorne. S. (1991). **Dilemmas of ethics and validity in qualitative nursing research**. The Canadian Journal of Nursing Research. 20 (1), 65-76.

Robinson. N. (1991). **A patient-centred framework for restructuring care**. JONA. Vol. 21. No. 9. Sept., 29-34.

Rondeau. K. (1995). **Designing the private-centred care organization**. Canadian Health Care Management, April, 50-52.

Ross. E. (1994). **A new voice for staff nurses**. Registered Nurse. June-July. 12-13.

Schneller. E.. Ott. J. (1996). **Contemporary models of change in the health professions**. Hospitals & Health Services Administration . Vol. 41. =1. Spring. 121-136.

Shackleton. T.. Gage. M. (1995). **Strategic planning: positioning occupations to be proactive in the new health care paradigm**. CJOT. Vol. 62. No. 4. October. 188-196.

Shapiro. I. (1993). **Is there an auditor in the house?** Report on Business Magazine. November. 86-101.

Sherer, J. (1995). **Managing chaos**. Hospital & Health Services Network, Vol. 69. No. 4. Feb.. 22-29.

Smith, B. (1994). **Self managed teams : the reality and the promise**. Health Care Supervisor. 12 (4). 48-55.

Spitzer-Lehman. R.. Yahn, K. (1992). **Patient needs drive an integrated approach to care**. Nursing Management. August. 30-33.

Stevens, R. (1990). **The hospital as a social institution: New fashioned for the 90's**. Address at the American Hospital Association. Annual Meeting. July.

Stevens. G. (1991). The strategic health care manager : Mastering essential leadership skills. San Francisco: N. Jossey Bass Inc. Pubs.

Stuart, N., Sherrard, H., Price Waterhous. (1987). **Managing hospitals from a program perspective.** Health Management Forum, Spring, 53 - 63.

Townsend, M. (1993). **Patient-focused care : Is It for your hospital?** Nursing Management, Vol. 24.No. 9, Sept., 74-80.

VanPelt, G. (1985). **Program management and matrix reporting.** Hospitals, December, 83 - 84.

Wakefield, D., Cyphert, S., Murray, J., Uden-Holman, T., Hendryx, M., Wakefield, B. & Helms, C. (1994). **Understanding patient-centred care in the context of total quality management and continuous quality improvement.** Journal on Quality Improvement, Vol. 20, No. 3, March, 152-161.

Walton, R. (1985). **From control to commitment in the workplace.** Harvard Business Review, March, April, 77-82.

Wells, D. (1991). **Getting together: Administrative and clerical teamwork creates a geriatric care program for the hospital.** Forum, Spring, 3 - 8.

Wodinsky, H., Egan, D., & Markel, F. (1988). **Product line management in oncology : a Canadian experience.** Hospital & Health Services Administration, 33 (2), 221-225.

Woodend, R., Cluett, B. (1992). **Implementing the vision.** Hospital-Community Psychiatry, 4th quarter, 16 - 20.

Zelman, W., Parham, D. (1990). **Strategic, operational, and marketing concerns of product line management in health care.** Health Care Management Review, 15 (1), 29-35.

VITA AUCTORIS

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IMAGE EVALUATION
TEST TARGET (QA-3)