The Dynamic Environment of Health Care

CHAPTER OBJECTIVES

- Describe the healthcare environment as it has evolved since the middle to late 1960s with attention to the dynamic interplay of key factors.
- Examine megatrends in the healthcare environment with attention to:
  - ❍ Client characteristics
  - ❍ Professional practitioners and caregivers
  - ❍ Healthcare marketplace and settings
  - ❍ Applicable laws, regulations, and standards
  - ❍ Impact of technology
  - ❍ Privacy and security considerations
  - ❍ Financing of health care
  - ❍ Social and cultural factors
- Identify the role set of the healthcare practitioner as manager.
- Review the classic functions of the manager.
- Define and differentiate between management as an art and a science.
- Conceptualize the characteristics of an effective manager.

THE DYNAMIC ENVIRONMENT OF HEALTH CARE

The contemporary healthcare environment is a dynamic one, combining enduring patterns of practice with evolving ones to meet challenges and opportunities of changing times. The healthcare organization is a highly visible one in most communities. It is a fixture with deep roots in the social, religious, fraternal, and civic fabric of the society. It is a major economic force, accounting for approximately

one-sixth of the national economy. In some local settings, the healthcare organization is one of the major employers, with the local economy tied to this sector. The image of the hospital is anchored in personal lives: it is the place of major life events, including birth and death, and episodes of care throughout one's life. Families recount the stories of "remember the time when we all rushed to the hospital …" and similar recollections. The hospital is anchored in the popular culture as a common frame of reference. People express, in ordinary terms, their stereotypic reference to the healthcare setting: "He works up at the hospital," "Oh yes, we made another trip to the emergency room," or "I have a doctor's appointment." Popular media also uses similar references; television shows regularly feature dramatic scenes in the acute care hospital, with the physician as an almost universally visible presence. Care is often depicted as happening in the emergency department.

On closer examination, one recognizes that, in fact, many changes have occurred in the healthcare environment. The traditional hospital remains an important hub of care but with many levels of care and physical locations. The physician continues to hold a major place on the healthcare team, but there has been a steady increase in the development and use of other practitioners (e.g., nurse midwife, physical therapist as independent agent, physician assistant) to complement and augment the physician's role. A casual conversation reflects such change; a person is just as likely to go to the mall to get a brief physical examination at a walk-in, franchised clinic as he or she would be to go to the traditional physician's office. One might get an annual "flu" shot at the grocery store or smoking cessation counseling from the pharmacist at a commercial drug store. One might have an appointment for care with a nurse practitioner instead of a physician. Instead of using an emergency service at a hospital, one might receive health care at an urgent care service or clinic.

Although the setting and practitioners have developed and changed, the underlying theme remains: how to provide health care that is the best, most effective, accessible, and affordable, in a stable yet flexible delivery system. This is the enduring goal.

Those who manage healthcare organizations monitor trends and issues associated with the healthcare delivery system in order to reach this goal. Thus, a manager seeks to have thorough awareness and knowledge of the interplay of the dynamic forces. It is useful, therefore, to follow a systematic approach to identify, monitor, and respond to changes in the healthcare environment. The following template provides such a systematic approach. The starting point is the client/patient/recipient of care. This is followed in turn by considerations of the professional practitioners and caregivers; healthcare market place and settings; applicable laws, regulations, and standards; impact of technology; privacy and security considerations; financing; and social-cultural factors.

CLIENT/PATIENT CHARACTERISTICS

The demographic patterns of the overall population have a direct impact on the healthcare organization. For example, the increase in the number of older people requires more facilities and personnel specializing in care of this group, such as continuing care, skilled nursing care, and home care.

Clinical conditions associated with aging also lead to the development of specialty programs such as Alzheimer's disease and memory care, cardiac and stroke rehabilitation, and wellness programs to promote healthy aging. At the other end of the age spectrum, attention to neonatal care, healthy growth and development, and preventive care are points of focus. Particular attention is given to adolescents and young adults who engage in contact sports, where concussion, permanent brain injury, fractures, and sprains are common. In all age groups, there is a rising rate of obesity; type 2 diabetes; and addictions to substances, such as heroin, opioids, methadone, and assorted "street drugs."

Diseases and illnesses are, of course, an ever-present consideration. Some diseases seem to have been conquered and eliminated through timely intervention. Some recur after long periods of absence. Tuberculosis, polio, smallpox, and pertussis are examples of successes in disease management and prevention. Sometimes, however, new strains may develop or compliance with immunization mandates may decrease so that these types of communicable diseases reappear.

Decades of use of antibacterial medicines has given rise to superbugs, resistant to the usual treatment. Another element of concern is the appearance of an almost unknown disease entity (e.g., Ebola or a pandemic agent). New clinical conditions may also arise within certain age groups, necessitating fresh approaches to their care. By way of example, consider the rise in autism and childhood obesity.

Other characteristics of the client/patient population reflect patterns of usage and the associated costs of care. The identification of superusers—patients who have high readmission rates and/or longer than average lengths of stay or more complications—gives providers an insight into practices needing improvement (e.g., better discharge planning or increased patient education). The geographic region that constitutes the general catchment area of the facility should be analyzed to identify health conditions common to the area. Examples include rural farm regions, with associated injuries and illnesses; heavy industry, with work-related injuries; and winter resort areas, with injuries resulting from strenuous outdoor activity (e.g., fractures from skiing injuries).

TRENDS RELATING TO PRACTITIONERS AND CAREGIVERS

The trends and issues relating to practitioners and caregivers cluster around the continuing expansion of scope of practice, with the related increase in education and credentialing. The traditional attending physician role has given way to the inpatient physician, the hospitalist. The one-to-one physician–patient role set continues to shift from solo practice to group practice and team coverage. Licensed, credentialed nonphysician practitioners continue to augment the care provided by the physician. These physician-extenders often specialize—for example, the physical therapist in sports-related care, the occupational therapist in autism programs, the nurse practitioner in wellness care for the frail elderly, the nurse midwife, the nurse case manager in transition care, and the physician assistant in emergency care. Educational requirements include advanced degrees in the designated field.

There is a related shift in the practice settings for these various practitioners. The move away from inpatient-based care leads to an increase in independent practice. Sometimes the franchise model is favored over self-employment. Regional and national franchises provide a turnkey practice environment with the additional benefits of a management support division.

The Family as Caregiver

Although the provision of care by family members is a practice that long predates formal healthcare models, these caregivers are the focus of renewed attention. As shorter stays for inpatient care, or subacute care to reduce inpatient care, become the norm, the role of the family caretaker intensifies. The patient care plan, with emphasis on the discharge plan, necessarily includes instruction to family members about such elements as medication regimen, wound care, infection prevention, and injection processes. If the patient does not have a family member who is able to assist in these ways, or if the patient (often a frail, elderly person) lives alone, coordination of services with a community agency or commercial company is needed. This gives rise to related issues. Can family members be reimbursed by insurance providers? If so, what is needed by way of documentation and billing? And there is yet another related issue: how can employers assist workers to meet the demands of work as well as help the family member? Practices such as flexible work hours and unpaid leave become both desirable and necessary elements.

Changes in Management Support Services

Behind the scenes, there is the wide network of management support services within the healthcare organization. The trend toward specialization increases within these ranks, with new job categories being developed in response to related trends. With regard to finances and reimbursement, chief financial officers (or similar administrators) augment their teams with clinical reimbursement auditors, coding and billing compliance officers, physician coder-educators, and certified medical coders. The regulatory standards manager specializes in coordinating the many compliance factors flowing from laws, regulations, and standards. The chief information officer augments that role with specialized teams, including nurse informaticians, clinical information specialists, and information technology experts.

Patterns of Care

Improvements in patient care services, the utilization of advanced technologies such as telemedicine, and the financial pressures to reduce the length of stay for inpatient care have resulted in shorter stays, more transitional care, and (possibly) a higher readmission rate. To offset a high readmission rate, additional attention is given to the discharge plan. The increased use of the observation unit in the emergency department also helps reduce admission and readmission rate. These issues and trends lead to a discussion of the healthcare setting.

THE HEALTHCARE SETTING: FORMAL ORGANIZATIONAL PATTERNS AND LEVELS OF CARE

Each healthcare setting has a distinct pattern of organization and offers specific levels of care. Characteristics include ownership and sponsorship, nonprofit or for-profit corporate status, and distinct levels of care. These elements are specified in the license to operate as well as in the corporate charter. Ownership and sponsorship often reflect deep ties to the immediate community. A sector of the community, such as a fraternal organization, a religious association, or an academic institution, developed and funded the original hospital or clinic, almost always as nonprofit because of their own nonprofit status. These organizations purchased the land, had the buildings erected and equipped, and provided continued supplemental funding for the enterprise. Federal, state, city, and county units of government also own and sponsor certain facilities (e.g., facilities for veterans, state behavioral care facilities, county residential programs for the intellectually disabled). For-profit ownership and sponsorship include owner-investor hospital and clinic chains; long-term care facilities; franchise operations for specialty care (e.g., eye care, rehabilitation centers, retail clinics in drugstores and big-box retailer stores). Over the past several decades, sponsorship by religious or fraternal organizations has diminished, with the resulting sale of these healthcare facilities to other entities. The original name is often retained because it is a familiar and respected designation in the community.

Provider Growth: Mergers, Joint Ventures, and Collaborative Partnerships

Healthcare organizations periodically change or augment their service offerings, with a resulting change in corporate structure. This restructuring may take the form of a merger, a joint venture, or a collaborative partnership. Why do healthcare organizations seek restructuring? The reasons are several:

- The desire to express an overall value of promoting comprehensive, readily accessible care by shoring up smaller community-based facilities, keeping them from closure
- The need for improved efficiencies resulting from centralized administrative practices such as financial and health information resource streamlining or public relations and marketing intensification
- The desire and/or need to penetrate new markets to attract additional clients
- The desire and/or need to increase size so as to have greater clout in negotiations with managed care providers who tend to bypass smaller entities

As cost-containment pressure began to grow, providers—primarily hospitals—initially moved into mergers mostly to secure economies of scale and other operating efficiencies and sometimes for reasons as basic as survival. The growth and expansion of managed care plans provided further incentive

to merge among hospitals, which seems to have inspired health plan mergers in return. Each time a significant merger occurs, one side gains more leverage in negotiating contracts. The larger the managed care plan, the greater the clout in negotiating with hospitals and physicians and vice versa.

Clarification of Terms

The term *merger* is used to describe the blending of two or more corporate entities to create one new organization with one licensure and one provider number for reimbursement purposes. One central board of trustees or directors is created, usually with representation from each of the merged facilities. Debts and assets are combined. For example, suppose a university medical center buys a smaller community-based hospital. Ownership and control is now shifted to the new organization. Sometimes the names of the original facilities are retained as part of public relations and marketing, as when a community group or religious-affiliated group has great loyalty and ties to the organization. Alternatively, a combined name is used, such as Mayfair Hospital of the University Medical System.

The *joint venture* differs from a merger in that each organization retains its own standing as a specific legal/corporate entity. A joint venture or affiliation is a formal agreement between or among member facilities to officially coordinate and share one or more activities. Ownership and control of each party remains distinct, but binding agreements, beneficial to all parties, are developed. Shared activities typically include managed care negotiations, group purchasing discounts, staff development and education offerings, and shared management services. Each organization keeps its own name with the addition of some reference to its affiliated status, as in the title: Port Martin Hospital, an affiliate of Vincent Medical Center.

A *collaborative partnership* is another interorganizational arrangement. As with the joint venture, each organization retains its own standing as a specific legal–corporate entity. The purpose of the collaborative partnership is to draw on the mutually beneficial resources of each party for a specific time period associated with the completion of agreed-on projects. An example from research illustrates this point: a university's neuroscience and psychology departments and a hospital pediatric service combine research efforts in the area of autism. A formal letter of agreement or mutual understanding is exchanged, outlining the essential aspects of the cooperative arrangement.

Such restructuring efforts, especially the formal merger, are preceded by mutual due diligence reviews in which operational, financial, and legal issues are assessed. Federal regulations and state licensing requirements must be followed. Details of the impact of the restructuring on operational levels are considered, with each manager providing reports; statistics; contractual information, leases (as of equipment); and staffing arrangements, including independent contractors and outsourced work.

In the instance of a full merger, practical considerations constitute major points of focus. Examples include redesigning forms, merging the master patient index and record system into one new system, merging finance and billing processes, and officially discharging and readmitting patients when the legally binding merger has taken place.

Present-day mergers and joint ventures can have a pronounced effect on the health professional entering a management position. Consider the example of a laboratory manager who must now oversee a geographically divided service because a two-hospital merger results in this person's having responsibility in two sites that are miles apart. There is far more to consider in managing a split department than in managing a single-site operation. The manager's job is made all the more difficult. Overall, however, mergers, joint ventures, and collaborative partnerships are an opportunity for the professional-as-manager with greatly increased responsibility and accountability and a role of increasing complexity.

Range of Service and Levels of Care

One of the most distinguishing features of a specific healthcare organization is the range of service, along with levels of care. This feature identifies the organization as a particular kind of organization, explicitly defined in its license to operate (e.g., an acute care hospital, an adult day care center, a hospice). An organization may offer many different services, both inpatient and outpatient. The range of service and levels of care are part of the overall definition of the organization; the specific types of care are delineated. Groups such as the American Hospital Association (AHA), The Joint Commission (TJC) and similar associations, and various designated federal and/or state agencies, define types and levels of care. Thus, a hospital might develop its range of services at an advanced level, with a variety of specialty services, to meet the definition of tertiary care. A small, rural hospital might seek to meet the basic standards for a critical access facility, capitalizing on the flexibility such designation permits.

Clinics vary in their range of service from the relatively small, walk-in clinic, to more complex services such as an urgent care clinic or specialty clinic associated with a hospital. In this latter arrangement, the inpatient service coordinates care with its companion outpatient clinic. Examples include surgery, cardiac care, and prenatal and postnatal care.

Another way of noting the variety of care services is to group organizations by client characteristics and treatment needs: geriatric behavioral care, rapid treatment for drug-dependent clients, women's health, comprehensive cancer care, sports medicine, hospice care, and intensive day treatment for at-risk youth. Care of frail, elderly people has been and is a growth industry because of the simple fact of demographics—the increasing numbers of older individuals. The variety of levels of care include independent living units; personal care assistance, including secured units for dementia care; skilled nursing care; and comprehensive continuing care facilities. Adult day care programs augment residential care.

Further details about the range of care can be found by identifying the organization's place in the overall continuum of care. For the purposes of this discussion, the acute care, inpatient facility will be placed at the center, with the continuum of care segmented as subacute and postacute, although it should be noted that not all care involves inpatient admission. Thus, an organization might tailor its services to support transitional care, either temporary or permanent care, with a postacute

rehabilitation center, a long-term nursing care center, and assisted living and secured personal care for frail elderly people. The current emphasis on reducing readmission rates for inpatient care gives new impetus to the development and/or expansion of these types of services. A traditional nursing home, specializing in "balance of life" care of frail, elderly people, might restructure its programs to add posthospitalization care, with the expectation that the length of stay will be weeks or (a few) months—not indeterminate and permanent. Home care programs have increased in prominence because of their place in the sequence of care. Shortened inpatient stays, outpatient same-day surgery, transitional care from hospital to nursing home to the patient's personal residence intensify the need for home care by nurses, along with a variety of other caregivers (e.g., health aides, homemaker aides).

Hospice care represents a model of service that utilizes several levels of care. Care of the terminally ill (regardless of age) is rendered in the home, in the hospital when needed, and in a nursing care facility. A hospice might be owned and sponsored by an inpatient facility or operate as a stand-alone organization. One way to describe hospice care is this: the hospice program follows the patient and family as they move through the various changes in location.

In the continuing search for the best care, with flexibility and affordability, there has been renewed interest in domiciliary care for the elderly or developmentally disabled. The underlying idea is a return to home-like, individual care provided by paid caregivers, often in a patient's own homes. Some states have active programs to increase the number and quality of such arrangements, along with active plans to decrease the number of nursing home beds.

The group home for adolescents or developmentally disabled people continues to be an area of change. The movement is away from large, institutional-based care to very small units (e.g., four to six clients in a family-like group home).

LAWS, REGULATIONS, AND ACCREDITING STANDARDS

Laws, regulations, and accrediting standards are a major consideration in the delivery of health care. They affect every aspect of the healthcare system. The sheer volume of such requirements, some of which are in contradiction to others, has increased to the point that most organizations have a formally designated compliance officer. This high-level manager, assigned to the chief executive division, has the responsibility of assessing compliance with current requirements, monitoring proposed changes, and helping departments and services prepare for upcoming changes. Other responsibilities of this officer include the preparation of required reports and studies, the coordination of site visits, and the preparation of any follow-up action or plan of correction. In addition, this officer provides liaison with the Board of Trustee's corporate compliance committee. Managers at the operational level work closely with this office in order to comply—indeed excel—at meeting all requirements.

The operational level managers, while assisted by the compliance office, must take the initiative on their own to ensure that day-to-day practices and systems are in order. A systematic review of laws, regulations, and standards facilitates this practice. A manager can sort through the thicket of requirements by analyzing them in terms of several features:

- Setting. Licensure laws at the state level authorize the owner/sponsors to offer specific types of care (e.g., acute care hospital, behavioral care facility, rehabilitation center). The definitions and requirements in this fundamental law are the starting point, for without meeting this set of binding elements, the organization would not be permitted to function. Changes in program offerings, including expansion, termination, or sale, trigger an update in licensure status.
- Patient/client group. Certain issues concerning definition of the patient/client must be considered: when does the relationship begin; who is eligible for certain programs of care; what aspects of reimbursement for care apply; who may consent for care; and what, if any, special provisions attach to certain patient groups (e.g., any patients needing protective care).
- Professional practitioners and the support staff. Professional practitioners are required to have a license to practice. Both the individual and the organization's officials must be mindful of the necessity of meeting this set of rules. In addition to this requirement, there are many laws and regulations governing working conditions, hours and rates of pay, and nondiscrimination.
- Systems requirements. Specific aspects of the administrative and support systems are often laid out in detail, including time frames; requirements for record development and retention; and review processes relating to patient care, safety, and privacy. Required documentation of care is delineated in terms of content and time (e.g., development of plan of care, discharge plan, medication profile, restraint usage).

The sources of law are both state and federal governments. In addition to these, local units of government, such as counties and cities, have laws that apply to most or all formal organizations in their geographic jurisdiction. The usual ones are fire and safety codes, zoning regulations, environmental requirements, and traffic controls.

Regulations Stemming from Laws

The usual practice in lawmaking is this: the basic law is developed and passed, with the lawmakers recognizing that further details will be needed. The specific law usually indicates which government department or agency is invested with this rule making power. Healthcare providers are most familiar with the Department of Health and Human Services (DHHS) and its Centers for Medicare and Medicaid Services (CMS—formerly the Health Care Financing Administration) division that has the authority to develop Medicare rules and regulations. Other current "headliner" laws and companion regulations include the Health Information Technology for Economic and Clinical Health Act (HITECH), the Health Insurance Portability and Accountability Act (HIPAA) of 1996, and the Patient Protection and Affordable Care Act (PPACA) of 2010.

Accrediting Standards

Although these standards or elements of performance are not required as such, most healthcare facilities seek to meet them and have official recognition by an appropriate accrediting agency. Some of the usual nationwide accrediting bodies are TJC, Continuing Care Accreditation Commission, and the Accrediting Commission for Health Care.

Within the accrediting process for the overall facility, there are additional criteria for certain programs, with the resulting assurance of quality care. By way of example, TJC has a gold seal of approval rating for rehabilitation services. It also has disease-specific care certification.

Professional Association Standards and Guidelines

Professional associations develop standards of practice and related guidelines in their area of expertise. These guidelines reflect best practices and provide practical methods of developing and implementing operational level systems. In addition to the practical aspect of meeting such optional standards, there is prestige value associated with gaining recognition by outside groups. Receiving magnet designation from the American Nurses' Credentialing Center illustrates this dual benefit.

Sources of Information about Requirements

Managers face a challenge in trying to keep up to date regarding the many requirements. They must take a proactive stand, especially for those aspects relating to their department or service.

One's professional association is a reliable source of timely and thorough information. The umbrella organizations such as the AHA monitor current and prospective issues and make the information readily available. A useful practice for managers to adopt is the regular monitoring of the *Federal Register* for federal regulations, and the companion publication at state level. These agencies publish agenda listings on a periodic basis (e.g., annually, semiannually) to alert the public about probable new regulations. This is augmented by an official Notice of Proposed Rulemaking about a specific topic.

Government agencies, public and private "think tanks," and other associations prepare position papers; national, state, or regional health initiatives proposals; and similar plans. Healthy People 2020 or the DHHS's national health goals or a state governor's long-range plan are examples of readily available documents to alert managers of trends and issues.

THE IMPACT OF TECHNOLOGY

A survey of any health discipline would readily provide examples of the impact of technology. New treatment modalities emerge. For example, specialty care is taken to the patient (e.g., bedside anesthesia, mobile vans with chemotherapy, portable diagnostic equipment). There is rapid and constant adoption of computerized devices. Several areas of interest are highlighted here to illustrate the trends and issues of a high-tech world and its implications for healthcare delivery.

eHealth and Virtual Health

This segment of health care has several names: eHealth, Virtual Health, and Digital Connectivity. The eVisit, wherein patient and provider communicate by means of technological interaction instead of face-to-face, in an office, has become commonplace. *Telemedicine* or *telehealth* is a broader and slightly older term, reflecting the same kind of interaction. Both methods utilize video conferencing, telephone systems, and computers. The eVisit by the patient with the clinician is a particularly good method for patients who are in rural areas without easy access to their primary care provider; it is useful in the same way for the homebound patient without transportation or whose chronic illness is exacerbated by going outside the home. Virtual counseling is another example of this kind of care; the sufferer of posttraumatic stress disorder or depression might find easier access to interventions and care because it is readily available through technology. Also, the eVisit is a useful alternative when inclement weather makes travel to on-site care unwise or impossible. In addition, remote monitoring provides real-time feedback to providers and patients, allowing them to make more timely interventions when indicated. Common applications include monitoring heart-related conditions, diabetes, and pulmonary hypertension.

Teleconferencing provides clinicians with ready access to specialists in another setting, thus providing the patient and care team with expert advice and avoiding the transfer of the patient. The telestroke program exemplifies this type of interaction where time is of the essence. The popular use of apps for self-monitoring, both for a clinical condition as well as wellness, provides clients and caregivers with some baseline information about a client's ongoing condition. The user can set up reminders about medication use, blood sugar levels, or blood pressure monitoring. Diet and exercise information can be tracked. Coupled with popular web searches for health information (e.g., getting a "second opinion" from a Web site), the consumer of health care generates his or her own personal health record.

The Personal Health Record

This is not a new concept. Conscientious individuals routinely keep important health documents, including immunization records, summaries of episodes of care, and their own tracking notes about a chronic condition. What is new is the increased computerization of such notes. With the emphasis on developing and maintaining an electronic health record system, healthcare organizations encourage the incorporation of client-generated portfolios and the official documentation from healthcare providers into a comprehensive document. Patients' rights to access and receive a copy of their health records has been well established and is encouraged. This is a gradual change from the days when there was limited or no routine access. The *personal health record* (PHR) does not replace the legal record of the healthcare provider—the PHR is developed and maintained by the patient/client and the official record by the provider. There is a related trend: having the patient access the ongoing, official record through electronic systems. Providers make this possible through the development of secure portal access to the information and encourage its use through patient

education about the process. Information includes access to test results, discharge instructions, procedure information, and similar data. The goal is to increase patients' involvement in their own care. The electronic health record is more fully discussed in the chapter on the challenges of change in the healthcare system.

Data Warehousing and Data Mining

As the electronic data capture and retention and manipulation increases, so does the sheer volume of data. These electronic measures incorporate and enhance the more historical methods of the hard copy record, decentralized indexes and registries, and special studies. *Data warehousing* refers to the centralized depository of data collected from most or all aspects of the organization (e.g., patient demographics, financial/billing transactions, clinical decision making) gathered into one consistent computerized format. Easy connectivity to national and international data bases (e.g., National Library of Medicine, Medicare Providers Analysis and Review) is yet another feature of this process. *Data mining* is the analysis and extraction of data to find meaningful facts and trends for real-time interventions in clinical decision-making support, studies and oversight review of administrative and clinical practice by designated review groups, budget support, and related data usage. Trend analysis and predictive indicators (e.g., injury prediction outcomes in pediatric emergencies or predictions of impending arrhythmia and sudden death, mortality predictions) are readily available to clinicians. Data mining is also a business; a medical center, with its fast compilation of core data and specialty data elements, may sell nonidentifiable patient data to pharmaceutical, medical device, and biotech industries.

Translational Medicine

With the ready availability of support data, clinicians seek to more effectively and rapidly complete the cycle of bench to bedside to bench. Translational medicine emerges as an area of intensified interest, with hospitals coordinating these efforts through a clinical innovation office headed by a physician with an appropriate support staff. This strengthens both research capabilities and clinical practice.

The Health Information Exchange

The electronic health record enhances patient care within the organization because of its real-time, comprehensive features. But what of the situations in which care is given in more than one setting? The release of information process, using traditional hard copy or even electronic transmission, usually starts after the patient is admitted. Why not develop systems of interchange of information, regardless of the point of care? Such a system would facilitate communication among providers, reduce the number of unneeded tests, and provide a more comprehensive review of patients' past and ongoing care. Technology supports this concept; the electronic movement of health-related information is available. The coordinated efforts to make this a reality have led to the development of regional health information exchange of patient-consented information.

Privacy and Security Issues

The positive aspects of technology as applied to health care are clear. But along with these positive benefits, there arise new concerns for privacy and security issues. Hackers can access and even destroy computerized data bases. Identify theft, including medical identity, is an increasing problem for individuals and organizations. Consequently, safeguards are increased to secure the data, yet keep it easily accessible by legitimate users. There is a growing body of laws and regulations relating to these issues, foremost of which is HIPAA, mandating a variety of controls and practices to ensure patient privacy is protected. A more detailed discussion of this law and its requirements is in the chapter on the challenge of change.

Informatics Standards and Common Language

The goals of data sharing in support of patient care are generally well accepted, with active implementation of systems. To make this effective, there is the continuing need for interoperability of systems along with informatics standards and common language. These efforts include the development of standard vocabulary and classification systems, such as the National Library of Medicine's Unified Medical Language System as well as the standards developed by the Institute of Electrical and Electronic Engineers and the Health Level-7 standards. HIPAA regulations requires uniform protocols for electronic transactions for both format and content of data capture and transmission. The development of a national healthcare information infrastructure has the support of key advocates who support the development and implementation of national standards.

The Virtual Enterprise

The concept of the virtual enterprise has emerged as a result of available technology in both the for-profit and nonprofit sectors. Organizations develop contractual partnerships with independent companies and individuals who provide goods and services. Instead of on-site departments, services, or units, or direct employer–employee relationships, organizations outsource many functions. By way of example, consider the contemporary health information department that has outsourced several functions: transcription, billing and coding support, release of information, and document storage and retrieval. Another example, drawn from a direct patient care program, is reflected in a chronic disease management service within a home health agency. The home health agency coordinates services from other health providers who remain independent agents. This trend is so common that, in job descriptions and want ads, the job location is noted as to on-site or virtual as the setting.

REIMBURSEMENT AND PATTERNS OF PAYMENT

Patterns of payment for health care have changed in response to social, political, and economic pressures. Hospitals and clinics have deep historical roots in charitable, not-for-profit models; along

with this early approach to care there was also the fee-for-service approach as patients made payments directly to practitioners.

Health insurance programs, both nonprofit such as Blue Cross and Blue Shield and commercial insurance plans, emerged in the 1930s as partners in the payment for healthcare services. The form of insurance that many of these early plans offered was frequently referred to as "hospitalization" insurance; it covered costs when one was hospitalized, but the majority of early plans did not cover common ancillary services such as visits to physicians.

The 1960s saw the introduction of federally funded care with the creation of Medicare coverage for the elderly and Medicaid, essentially a welfare program, to provide coverage for low-income persons and the indigent. Medicare and Medicaid were established by the same federal legislation but they differ as sources of payment. Medicare reimbursement is fully federal, but Medicaid reimbursement is shared, with 50% coming from the federal government and the remaining 50% split between state and county. In some instances, the second 50% is split evenly between state and county and in some the split is different (e.g., 34% state and 16% county).

Concern for healthcare costs has been gathering momentum since the 1960s, as have efforts to control or reduce these costs. Costs clearly took a leap upward immediately following the introduction of Medicare and Medicaid; however, Medicare and Medicaid are not the sole cause of the cost escalation. Rather, costs have been driven up by a complex combination of forces that include the aforementioned programs and other government undertakings, private not-for-profit and commercial insurers, changes in medical practice and advancements in technology, proliferation of medical specialties, increases in physician fees, advances in pharmaceuticals, overexpansion of the country's hospital system, economic improvements in the lot of healthcare workers, and the desires and demands of the public. These and other forces have kept healthcare costs rising at a rate that has outpaced overall inflation two- or threefold in some years.

As concern for healthcare costs has spread, so have attempts to control costs without adversely affecting quality or hindering access. The final two decades of the 1900s and the beginning of this century have seen some significant dollar-driven phenomena that are dramatically changing the face of healthcare delivery. Specifically, these include the following:

- The rise of competition among providers in an industry that was long considered essentially devoid of competition
- Changes in the structure of care delivery, such as system shrinkage as hospitals decertify beds; an increase in hospital closures, mergers, and other affiliations that catalyzed the growth of healthcare systems; and the proliferation of independent specialty practices
- The advent and growth and expansion of managed care

In one way or another, most modern societal concerns for health care relate directly to cost or, in some instances, to issues of access to health care, which in turn translate directly into concern for cost. Massive change in health care has become a way of life, and dollars are the principal driver of this change.

THE MANAGED CARE ERA

The Managed Care "Solution" and the Beginning of Restricted Access

Aside from technological advances, most of what has occurred in recent years in the organization of healthcare delivery, and payment has been driven by concern for costs. Changes have been driven by the desire to stem alarming cost increases and, in some instances, to reduce costs overall. These efforts have been variously focused. Government and insurers have acted on the healthcare money supply, essentially forcing providers to find ways of operating on less money than they think they require. Provider organizations have taken steps to adjust expenditures to fall within the financial limitations they face. These steps have included closures, downsizing, formation of systems to take advantage of economies of scale, and otherwise seeking ways of delivering care more economically and efficiently. In this cost-conscious environment, managed care evolved.

Managed care, consisting of a number of practices intended to reduce costs and improve quality, seemed, at least in concept, to offer workable solutions to the problem of providing reasonable access to quality care at an affordable cost. Managed care included economic incentives for physicians and patients, programs for reviewing the medical necessity of specific services, increased beneficiary cost-sharing, controls on hospital inpatient admissions and lengths of stay, cost-sharing incentives for outpatient surgery, selective contracting with providers, and management of high-cost cases.

The most commonly encountered form of managed care is the health maintenance organization (HMO). The HMO concept was initially proposed in the 1960s when healthcare costs began to increase all out of proportion to other costs and so-called "normal" inflation following the introduction of Medicare and Medicaid. The HMO was formally promoted as a remedy for rising healthcare costs by the Health Maintenance Organization Act of 1973. The full title of this legislation is "An Act to amend the Public Health Service Act to provide assistance and encouragement for the establishment and expansion of health maintenance organizations, and for other purposes." From today's perspective it is interesting to note that in implementing the HMO Act, it was necessary to override laws in place in a number of states that actually forbade the establishment of such entities.

The HMO Act provided for grants and loans to be used for starting or expanding HMOs. Preempting state restrictions on the establishment and operation of federally qualified HMOs, it required employers with 25 or more employees to offer federally certified HMO options if they already offered traditional health insurance to employees. (It did not require employers to offer health insurance if they did not already do so.) To become federally certified, an HMO had to offer a comprehensive package of specific benefits, be available to a broadly representative population on an equitable basis, be available at the same or lower cost than traditional insurance coverage, and provide for increased participation by consumers. Portions of the HMO Act have been amended several times since its initial passage, most notably by HIPAA.

Specifically, an HMO is a managed care plan that incorporates financing and delivery of a defined set of healthcare services to persons who are enrolled in a service network.

For the first time in the history of American health care, the introduction of managed care placed significant restrictions on the use of services. The public was introduced to the concept of the primary care physician as the "gatekeeper" to control access to specialists and various other services. Formerly, an insured individual could go to a specialist at will, and insurance would usually pay for the service. But with the gatekeeper in place, a subscriber's visits to a specialist were covered only if the patient was properly referred by the primary care physician. Subscribers who went to specialists without referral suddenly found themselves billed for the entire cost of the specialists.

By placing restrictions on the services that would be paid for and under what circumstances they could be accessed, managed care plans exerted control over some health insurance premium costs for employers and subscribers. In return for controlled costs, users had to accept limitations on their choice of physicians, having to choose from among those who agreed to participate in a given plan and accept that plan's payments, accept limitations on what services would be available to them, and, in most instances, agree to pay specified deductibles and copayments.

Managed care organizations and governmental payers brought pressure to bear on hospitals as well. Hospitals and physicians were encouraged to reduce the length of hospital stays, reduce the use of most ancillary services, and meet more medical needs on an outpatient basis. Review processes were established, and hospitals were penalized financially if their costs were determined to be "too high" or their inpatient stays "too long." Eventually, payment became linked to a standard or target length of stay so that a given diagnosis was compensated at a predetermined amount regardless of how long the patient was hospitalized.

As managed care organizations grew larger and stronger, they began to negotiate with hospitals concerning the use of their services. Various plans negotiated contracts with hospitals that would provide the best price breaks for the plan's patients, and price competition between and among providers became a reality.

By the end of the 1900s, approximately 160 million Americans were enrolled in managed care plans, encompassing what many thought to be the majority of people who were suitable for managed care. In-and-out participation of some groups, such as the younger aging (people in their 60s or so) and Medicaid patients, was anticipated. However, the bulk of people on whom managed care plans could best make their money were supposedly already enrolled. But managed care continued to grow in a manner essentially consistent with the growth of the population overall. According to the trade association America's Health Insurance Plans, approximately 90% of insured Americans were enrolled in plans with some form of managed care by 2007,[1] and total participation today continues at or near this 90% level.

Much of the movement into managed care was driven by corporate employers attempting to contain healthcare benefit costs. However, during this same period of growing managed care enrollment, the number of managed care plans experiencing financial problems also increased steadily.

It appears that managed care was able to slow the rate of health insurance premium increases throughout most of the 1990s. However, early in the first decade of the 2000s, the cost of insurance coverage again began climbing at an alarming rate. The increase continued; it was reported in 2005 that health insurance premiums would increase in some areas by more than 12% for 2006, making 2006 the fifth straight year of double-digit premium increases for many.[2] This grim prediction for 2006 was fulfilled, and the trend has continued, with increases for most years since then averaging in excess of 10%.

By the end of the 1990s, it appeared that the majority of average middle-class subscribers had reached a negative consensus about managed care. This caused some damage to the political viability of for-profit managed care, and it hurt managed care overall. Indeed, it seemed increasingly likely that managed care might not be financially affordable in the long run.

The year 2000 was especially grim for the relationship between managed care plans and Medicare. As a result of decisions made during that year, nearly a million beneficiaries from 464 counties in 34 states lost their coverage on January 1, 2001, when 118 HMOs withdrew from Medicare. In addition, many of the plans that remained in Medicare increased premiums and reduced benefits in response to what were described as continually rising costs and the effects of cuts in reimbursement rates. In December 2000, Congress voted to allocate billions of additional dollars to Medicare HMOs, supposedly to reduce premiums or increase benefits to subscribers. However, wording of the legislation also allowed HMOs to pay more to their networks of hospitals and healthcare professionals, thus consuming the majority of the additional funds. As a result, only 4 of the 118 HMOs that had withdrawn returned to Medicare.

Managed care organizations and elements of government brought additional pressure to bear on hospitals. Hospitals and physicians were encouraged to reduce the length of hospital stays, cut back on the use of ancillary services, and meet more medical needs on an outpatient basis. Review processes were established such that hospitals were penalized financially if their costs were determined to be too high or their inpatient stays too long. Eventually payment became linked to a standard, or target, length of stay so that any given diagnosis was compensated at a specific amount regardless of how long the patient was hospitalized.

As they grew larger, managed care organizations began to deal directly with hospitals, negotiating the use of their services. As various plans contracted with hospitals that would give the best price breaks for the plan's patients, price competition between and among providers became a factor to be considered.

It is reasonable to say that although managed care provided cost-saving benefits at least for a time, it is evident that managed care plans have not been able to sustain their promises of delivering efficient and cost-effective care. An aging population, newer and more expensive technologies, newer and higher priced prescription drugs, new federal and state mandates, and pressure from healthcare providers for higher fees have essentially wiped out the savings from managed care for employers and subscribers alike. It is likely, however, that without managed care, costs and cost

increases would be even more pronounced than at present. Essentially the managed care model became a permanent and common feature in the coordination of and payment for care.

The Balanced Budget Act of 1997

The Balanced Budget Act (BBA) of 1997 is worthy of mention in this discussion of managed care. This act was adopted in part because of: the increased fiscal pressure caused by the growth of Medicare payments, concern over Medicare overpayments, the desire for more rational payment methods, and a stated wish to offer beneficiaries greater choice. By mandating that federal revenues and federal expenditures be balanced each fiscal year, the BBA fundamentally altered the rules of fiscal policy making in the United States.[3] (It perhaps need not be said that the mandate to balance the federal budget has been dramatically overridden in many years since then.) A balanced budget would of course be sensible, but it was the manner in which budget balancing was implemented that forced disproportionate reductions in healthcare reimbursement. In terms of its overall effects, the BBA became the most significant piece of healthcare legislation since Medicare and Medicaid were established in 1965.[4]

The reductions required to balance the budget were not taken uniformly from all elements of the budget. More than half of the federal budget—specifically the very large piece of the budget, including Department of Defense spending, Social Security, and interest on the federal debt—was insulated from cuts, meaning that the entire balancing reduction would have to come from the remaining portion (less than half) of the budget. Medicare had some time earlier become a significantly large third-party payer for healthcare services, so as a direct result of the BBA, drastic cuts occurred in Medicare reimbursement, therefore affecting the income of healthcare providers.

Some degree of relief from the BBA arrived in the form of the Balanced Budget Refinement Act (BBRA) of 1999, arising perhaps out of recognition that the act itself went too far in reducing reimbursements. When the BBRA became law, it suspended the cap that had been placed on outpatient rehabilitation services and paved the way for the design of a new payment mechanism. Regardless of these positive steps, however, the BBA brought some irreversible consequences to healthcare providers.

WHO IS REALLY PAYING THE BILLS?

Payment for health care flows from a number of sources, some major and well known and some less recognizable and relatively specialized. A number of these sources can be grouped together under the heading of "government," the largest being, of course, Medicare and Medicaid. Yet in addition to Medicare and Medicaid, there are other government programs that reimburse for health care at both state and federal levels. There are, for example, specific programs for providing health services to the dependents and survivors of military personnel and there is the health care for former military personnel provided by the hospital system of the Veterans Administration. Also under "government" are a number of state programs including, for example, Workers' Ccompensation, which

pays for health care for sick or injured workers as well as compensating for lost income. Many of the states also have unique programs designed to serve certain specific population segments (e.g., *Healthy New York* programs in New York State).

Next, outside of government programs, various programs can be gathered under the heading of *private insurance*. This collection of payers includes not-for-profit entities such as Blue Cross–Blue Shield, commercial (for-profit) insurance companies, and the many HMOs that comprise a large proportion of payers. These entities just named interlock to a considerable extent; for example, many managed care programs are operated by not-for-profits such as Blue Cross and Blue Shield, which also administer insurance programs designed to supplement Medicare benefits.

Much health care delivered by the HMOs and other insurers subjects users to deductibles and copays, making patients and families payers to a considerable extent. (A "deductible" is a designated amount a patient must pay before certain coverage kicks in, and a "copay"—common to essentially all programs to some extent—is a designated portion of the cost of a specific service that must be borne by the patient.)

Some larger organizations have essentially entered into the health insurance business by self-insuring for their employees. Practical (and permissible) for only sizable organizations with sufficient financial capability, these self-insurers pay their employees' claims directly using, in most instances, an administrative claim service to handle the transactions. However, most self-insurers also carry additional coverage against the possibility of catastrophic claims.

However, getting down to absolute basics, it is the population at large that pays for health care through taxes, through insurance premiums, and out of their own pockets.

Related Considerations

A number of additional programs or practices in place or under active consideration affect payment for health care. To enumerate just a few:

Reference pricing is the concept under which a patient's plan pays 100% of costs within one's network and the patient pays 100% of costs incurred outside of the network. Reference pricing also allows insurers and employers to place a dollar limit on what the plan pays for expensive procedures, potentially resulting in some large medical bills for patients. Presently it is believed that CMS may ban reference pricing.

Regional pricing is another concept that has come under consideration in some quarters. In its simplest form, this is pricing that has its basis in the economy of a specified geographic area, suggesting that the same service may cost more in a "wealthier" region than in a "poorer" area.

Although still evolving, the concept of the *medical home* offers financial incentives for providers to focus on the quality of patient outcomes rather than the volume of services provided. The medical home can be a physical or virtual network of providers; the keys to its success are said to be information technology and payment reform. The medical home is designed around patient needs and aims to improve access to care and improve communication in what is promoted as an

innovative approach to delivering comprehensive patient-centered preventive and primary care. The PPACA contains provisions that support use of the medical home model including new payment policies.

In addition, the financial and practical advantages of membership in the *health network* subject to its coordination of the provision of care and payment for care are addressed to some extent in the PPACA.

Built into the formal reimbursement methods of the principal programs and organizations that pay for healthcare services are numerous requirements and conditions the purpose of which is *cost containment*. For example, there is the routine review for *preventable readmission within 30 days* under which some amount of reimbursement may be denied if a particular readmission within that time frame is considered not medically necessary. There is also the increased use of temporary admission to an *observation unit* rather than to a *formal inpatient unit*, reacting to the knowledge that the former, often associated with the emergency department, is less costly than a regular hospital admission and does not unnecessarily tie up a bed in an acute care unit.

Another practice that serves both coordination of patient care and cost containment is the concept of *bundling for continuum of care*, involving discharge planning and coordination of posthospital care, recognizing that acute hospital care is but one step in addressing a patient's needs and that complete recovery requires organized posthospital follow-up to ensure return to health and to minimize the chances of readmission.

A fairly long-standing practice relating to both quality of care and cost containment is *utilization review*. Here hospital discharges are examined in detail to identify unnecessary treatments, excessive lengths of stay, and quality issues, with the intent of potentially improving quality of care while containing costs.

In general, virtually all of the reimbursement practices of the payers for health care have built-in rules, regulations, and requirements that place limits on certain practices (e.g., limiting length of hospital stays for specific diagnoses) and attendant penalties in the form of reduced or denied reimbursement.

REIMBURSEMENT SYSTEM WEAKNESSES

It holds generally true that the larger and more complex a system or program, the greater the chances of error and the more opportunity there is for misuse or mistreatment of the process itself. The overall healthcare reimbursement structure is both large and complex. There are many chances for the occurrence of honest errors, and there are many opportunities for deliberate fraud and abuse. Here are a few examples:

- "Upcoding," a process that occurs when someone submits the diagnosis-related group (DRG) code for a higher reimbursement level than what the actual case should receive (e.g., entering the code for "appendectomy with complications" in place of "routine appendectomy)

- Double billing or false billing by providers, perhaps billing twice for certain procedures, or—rather common among fraud cases—billing for services never rendered
- Billing for more service than was rendered, as in billing for more treatment than actually was provided and billing payers for appointments that patients had actually canceled (consider the case of the provider who actually billed as much as 33 hours for a single date)
- Billing for services that are actually not covered under the prevailing reimbursement mechanism
- "Double dipping" in Medicaid programs by individuals using addresses in two states and collecting benefits from both for the same care

All manner of medical providers have been involved in fleecing, or attempting to fleece, the reimbursement system: physicians, dentists, pharmacists, physical therapists and other individual providers, as well as individuals working in institutional settings and falsifying records as in "upcoding" and claiming reimbursement for services not rendered. Reimbursement structures are generally large and complex, and there is undoubtedly the feeling among some providers that what they are doing will never be detected or that their practices will never be examined in detail (similar to the attitude of the individual who feels that "the Internal Revenue Service will never audit *me*"). Yet numerous providers have lost their livelihoods when caught committing fraud or otherwise abusing the system.

Fraud and abuse constitute significant problems for present reimbursement mechanisms, and constant vigilance and regular monitoring are required to keep them in check. It is likely that any complex, multilayered system can be "gamed" in some way, and thanks to Medicare and Medicaid and all else that has risen around the major payers, healthcare reimbursement is and will likely present opportunities for fraud and abuse capable of continually siphoning off an eye-opening percentage of the healthcare dollar.

SOCIAL AND ETHICAL FACTORS

The use of technology, privacy concerns, and continuing issues related to healthcare availability and financing give rise to new debates about social and ethical factors. These norms have always been a part of the healthcare ethos, but from time to time, more urgent considerations are required. As noted above, a technological breakthrough occasions such renewed interest. At another time, a new legislative mandate, such as the Patient Self-Determination Act, brings about fresh consideration of enduring concerns. Increased sensitivity to patient or consumer wishes is yet another source of attentiveness to social and ethical issues. For example, the increased use by patients of alternative therapies and interventions has reopened the question about proper integration of nontraditional care with the more standardized modes. The debate reaches into the questions of reimbursement as well; healthcare plans are increasingly approving some alternative or complementary intervention as reimbursable costs. Another ethical issue stemming from healthcare financing stems from a new

practice: the embedded nurse, one who is an employee of the insurance company but assigned to the direct care team within a healthcare facility. Whose agent is this employee? What ethical dilemmas does this worker face? Do patients know that their care is being rendered by one whose assignment includes cost effectiveness as a direct part of his or her work? Rationing of health care is yet another area of continuing discussion, including "quality-adjusted remaining years" indicators and "complete lives" measures. Finally, the use of marijuana for medical purposes showcases another example of societal norms shifting to greater acceptance of such substances.

Ethical considerations such as the these result in the increased use of the ethics review committee, the institutional review board, and similar clinical and administrative review groups.

THE ROLE SET OF THE HEALTHCARE PRACTITIONER AS MANAGER

The dynamic setting of healthcare organizations constitutes the environment of the manager, specifically the healthcare practitioner as manager. Often unseen by the patient or the public, the managers of departments and services work behind the scenes to support direct patient care interactions. In this specialized environment of a healthcare organization, qualified professional practitioners may assume the role of unit supervisors, project managers, or department heads. The role may emerge gradually as the numbers of patients increase, as the number and type of services expand, and as specialization occurs within a profession. The role of manager begins to emerge as budget preparations need to be made, job descriptions need to be updated and refined, and staffing patterns need to be reassessed and expanded.

For example, a physical therapy staff specialist may develop a successful program for patients with spinal cord injuries. As the practitioner most directly involved in the work, this individual may be given full administrative responsibility for that program. Alternatively, an occupational therapist may find that a small program in home care flourishes and is subsequently made into a specialized division. Again, this credentialed practitioner in a healthcare profession may be given a managerial role. Practitioners who develop their own independent practices assume the role of manager for their business enterprises. The role of the practitioner as manager is reinforced further by various legal, regulatory, and accrediting agencies, which often require chiefs of service or department heads to be qualified practitioners in their distinct disciplines.

Classic Management Functions

The healthcare practitioner–manager engages in traditional management activities—the circle of actions in which each component (e.g., planning, decision making) leads to the next. These activities are a mix of routine, repeated activities of an ongoing nature, along with periodic major activities such as preparation for and participating in accreditation processes, or major projects such as a complete systems overhaul. Figure 1–1 illustrates the interrelationships of management functions. Table 1–1 provides examples of daily activities of the professional practitioner as manager.
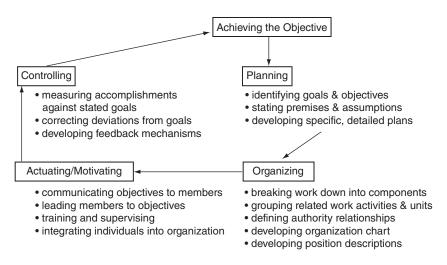
FIGURE 1–1 Interrelationship of Management Functions

Management functions typically include the following:

- Planning: the selection of objectives, the establishment of goals, and the factual determination of the existing situation and the desired future state
- Decision making: part of the planning process in that a commitment to one of the several alternatives (decisions) must be made. Others may assist in planning, but decision making is the privilege and burden of managers. Decision making includes the development of alternatives, conscious choice, and commitment.

Table 1–1 The Chief of Service as Manager: Example of Daily Activities

Activity	Management Function Reflected
Readjust staffing pattern for the day because of employee absenteeism	Staffing
Review cases with staff, encouraging staff members to assume greater responsibility	Controlling
	Planning
	Leading/motivating/actuating
Counsel employee with habitual lateness problem	Controlling
	Leading/motivating/actuating
Present departmental quality assurance plan for approval of Risk Management/ Quality Assurance Committee	Planning
	Leadership
Conduct research to improve treatment techniques	Planning
	Leadership
Dialogue with third-party reimbursement manager about coverage for innovative services leadership	Planning

- Organizing: the design of a pattern of roles and relationships that contribute to the goal. Roles are assigned, authority and responsibility are determined, and provision is made for coordination. Organization typically involves the development of the organization chart, job descriptions, and statements of work flow.
- Staffing: the determination of personnel needs and the selection, orientation, training, and continuing evaluation of the individuals who hold the required positions identified in the organizing process
- Directing or actuating: the provision of guidance and leadership so that the work performed is goal oriented. It is the exercise of the manager's influence as well asthe process of teaching, coaching, and motivating workers.
- Controlling: the determination of what is being accomplished, the assessment of performance as it relates to the accomplishment of the organizational goals, and the initiation of corrective actions. In contemporary management practice, the larger concepts of performance improvement and total quality management include controlling.

MANAGEMENT AS AN ART AND A SCIENCE

Management has been defined as the process of getting things done through and with people. It is the planning and directing of effort and the organizing and employing of resources (both human and material) to accomplish some predetermined objective. Management is both an art and a science. Especially in its early years of development at the turn of the 20th century, management's scientific aspects were emphasized. This scientific approach included and continues to include research and studies about the most efficient methods, leadership styles, and patterns of organization. However, management science tends to lack the distinct characteristics of an exact discipline, such as chemistry or mathematics. A more intuitive and nuanced set of elements reflect management as an art as well as a science. One speaks of the art of leadership and motivation. One relies on intuition and experience in situation of conflict or crisis.

Managers seek to combine the best of both approaches, striving to become *effective* managers.

Characteristics of an Effective Manager

The classic functions of a manager have been noted in the previous section. The highlighting of the characteristics of the effective manager augment this role set. Five major characteristics of effective managers are:

1. They know the internal structure and characteristics of their organization:
   - Its overall mission
   - Its client characteristics and needs

❍ Its specific products or services offered to meet these needs

❍ Its specific setting or combination of settings and formal organizational category (e.g., acute care, freestanding clinic)

❍ Its specific laws, regulations, and accrediting standard applicable to each type of health-care unit

2. They know the internal and external dynamics of their organization:

❍ The organization's strengths

❍ The challenges to its survival

❍ The areas requiring adaptation and innovation

❍ Its life cycle

❍ Its network of internal and external relationships

❍ Its survival strategies

3. They lead and motivate the workforce by doing the following:

❍ Developing and maintaining a positive workplace environment

❍ Reducing conflict

❍ Increasing worker satisfaction through training and ongoing development and the provision of proper wage and benefits

❍ Maintaining effective communication

4. They engage in the search for excellence through continuous quality improvement.

5. They remain aware of and respond to the following:

❍ Trends (e.g., changes in technology, patterns of reimbursement, social issues)

❍ The challenge of change and the necessity of being a change agent and a leader

The manger's responsibility to identify and respond to change is the focus of the following chapter.

EXERCISE: BECOMING A SPLIT-DEPARTMENT MANAGER

Imagine that you are the manager of a department organized to provide service in your chosen profession. In other words, if your career is medical laboratory technology, you are a laboratory manager; if your field is physical therapy, you manage physical therapy or rehabilitation services; and so on. You are employed by a 60-bed rural hospital, an institution sufficiently small that you represent the only level of management within your function (unless your profession is nursing, in which case there will be perhaps two or three levels of management). This means that unless you are a first-line manager in nursing (e.g., head nurse), you report directly to administration.

You have been in your position for about 2 years. Following some stressful early months, you are beginning to feel that you have your job under control most of the time.

A possibility that for years had been talked about and argued throughout the local community, the merger of your hospital with a similar but larger institution (90 beds) about 10 miles away, recently became a reality. One of the initial major changes undertaken by the new corporate entity was realignment of the management structure. In addition to placing the new corporate entity under a single chief executive officer, the realignment included, for most activities, bringing each function under a single manager. Between the merger date and the present, most department managers have been involved in the unpleasant process of competing against their counterparts for the single manager position.

You are the successful candidate, the survivor. Effective next Monday, you will be running a combined department in two locations consisting of more than twice the number of employees you have been accustomed to supervising.

Instructions

Generate a list of the ways in which you believe your responsibilities and the tasks you perform are likely to change because of the merger and your resulting new role. *Hint:* It may be helpful to make lists of what you imagine to be the circumstances before and after your appointment. For example, two obvious points of comparison involve the number of employees (which implies many necessary tasks) and the travel inherent in the job. See how long a list you are able to generate.

If possible (e.g., within a class or discussion group), after individual lists have been generated, bring several people together, combine their lists with yours, and see if a group process can further expand the list.

Also, address the following questions:

1. What does this split-department situation do to your efficiency as a manager, and how can you compensate for this change?
2. On which specific management skill should the newly appointed split-department manager be concentrating?

NOTES

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