SECTION I

Planning for Improvement

As discussed in Introduction: Managing for Quality and Performance (Chapter 1), management involves four sets of activities or functions: planning, organizing, facilitating, and controlling. This book adds an emphasis on using each management function to improve the organization. Each management function is covered in a section of the book. Planning for Improvement (Section I) covers competencies (knowledge, skills, attitudes, and values) related to managers' responsibility to plan ahead to improve their units and organizations.

The Policy Context for Management (Chapter 2) describes the interdependence between managing and public policy in the health sector. Strategic Planning (Chapter 3) describes tools and resources for organizational and community-wide planning. Marketing Health (Chapter 4) shows how health organizations can use marketing and media to shape their plans and messages and to meet their organizational missions. Preparing for Emergencies (Chapter 5) covers the critical area of preparing for emergencies, a planning responsibility of all health organizations.

Competencies commonly used by health organization managers can be identified by inspecting competency frameworks developed by professional associations of educators and practitioners. The Association of Schools of Public Health (ASPH) has compiled an inventory of core competencies expected of graduates of Master of Public Health (MPH) degree programs (Association of Schools of Public Health 2010). The Healthcare Leadership Alliance (HLA) is a consortium of professional organizations with more than 140,000 members across the major health care management sectors. A compilation of the HLA member competency frameworks is available (Healthcare Leadership Alliance 2010).

Planning for Improvement (Section I) contributes to strengthening six competencies in the ASPH competency framework for Health Policy and Management:

- Identify the main components and issues of the organization, financing, and delivery of health services and public health systems in the United States.
- Discuss the policy process for improving the health status of populations.
- Apply principles of strategic planning and marketing to public health.
- Communicate health policy and management issues using appropriate channels and technologies.
- Explain methods of ensuring community health safety and preparedness.
- Apply "systems thinking" for resolving organizational problems.

Planning for Improvement (Section I) also contains material related to selected ASPH competencies from three cross-cutting domains: Program Planning, Systems Thinking, and Communication and Informatics. From the HLA competency framework, Planning for Improvement (Section I) emphasizes the competency domain of Knowledge of the Health Care Environment, as well as the competency cluster of Strategic Planning and Marketing from within the competency domain Business Skills and Knowledge.

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CHAPTER 2

The Policy Context for Management

CHAPTER OBJECTIVES

After reading this chapter, readers will:

- Understand the interdependence of health management and public policy.
- Be able to describe the US governmental policy-making process.
- Understand key distinctive features of health policy in the United States.
- Be able to identify key policy issues relevant to health management.

CHAPTER SUMMARY

Laws and regulations affecting health organizations are diverse and plentiful in the United States, at the local, state, and federal levels. Managers of health organizations are responsible for assuring that their organizations and units comply with laws and regulations. Proactive managers keep informed of likely changes in relevant laws, regulations, and other expressions of health policy. Managers should understand the legislative process so that they can participate in it and anticipate changes in public policies. Key health policies affecting health organizations include policies on access to services and reimbursement of services, health information technology support and security, emergency preparedness,

quality improvement, prevention, and health promotion. Performance-driven health organizations seek to shape health policies so that quality and value are motivated and rewarded.

CASE STUDY

Sandra and Madeline were introduced at one of the new employee orientation sessions. They began a dialogue over lunch that day.

"The new owners have given us the task of purchasing an electronic health record system," said Sandra. "The CEO reminded me to acquire a system that is the least expensive for the organization to purchase and operate."

Madeline responded, "That is a reasonable goal, but the CEO has a financial background and is not familiar with electronic record systems in health. I think we have a responsibility to ensure that any system that we install is fully compatible with all laboratories, offices, diagnostic centers, and billing operations here as well as being able to import and export data to insurance carriers and health providers in this part of the state."

"That is a tall order, but I agree with you," replied Sandra. "What do you think should be our next step?"

While Madeline thinks, what advice would you offer?

INTRODUCTION

Management inside of organizations is undertaken within the larger context of laws and regulations governing commerce in the United States. *Laws* are rules developed and approved by legislative bodies and enforceable in the courts. *Regulations* are rules developed by governmental agencies or by private organizations that have been assigned authority by the government, usually to enact the provisions of laws. Still more rules are established by discretionary decisions of administrative agencies of the government, because all situations cannot be covered by laws and regulations. For example, the federal government's Centers for Medicare and Medicaid Services (CMS) makes eligibility and reimbursement decisions for the highly complex Medicare health insurance program; those decisions essentially become rules.

Compliance with laws and regulations is a prominent task in larger and complex organizations, and management is responsible for ensuring that employees are aware of and follow relevant laws and regulations. Larger health organizations retain compliance managers and legal counsel to assist in compliance management. For example, management of human resources is subject to a host of laws

and regulations. Financial laws and regulations govern financial reporting. In this chapter, the focus is on laws and regulations that are specific to the health sector.

The concept of health policy is broader than laws and regulations. *Health policy* refers to the principles and activities guiding the allocation of resources that affect the health of patients and populations. Health policy is heavily influenced by the laws and regulations formulated and implemented by governmental units. In addition to governmental action, private organizations affect health policy in the United States. For example, hospitals must be accredited by The Joint Commission (a private organization) or another similar accrediting body in order to receive federal funds from Medicaid and Medicare. In addition, the decisions made by large private insurance companies regarding reimbursement of specific health services shape health policy. Private nonprofit organizations, as well as private for-profit organizations, are highly involved in formulation of US health policy.

Managers can benefit from an understanding of how health policy is formulated. The process of policy formulation is outlined, with an emphasis on governmental action.

THE POLICY-MAKING PROCESS

Governmental policy making in the United States occurs at three major levels: federal, state, and local. Two principles undergird the policy-making process: federalism and the separation of powers. *Federalism* refers to the sharing of power between states and the national government. States are granted authority by the US Constitution to establish laws that protect the public's health and welfare. States license health practitioners, health delivery organizations, and health insurance plans, for example. Federalism explains why managing in a health organization in one state may differ from managing in a health organization in another. As an example, for-profit hospitals are banned in the state of Minnesota, but not in most other US states. Federalism also means that states are free to delegate powers to local and county governments, which they have done in most states for many public health services. Despite such delegation, the organization of public health services still varies substantially across states.

The second principle, *separation of powers*, divides government into three branches: the judiciary (courts); the executive, including the President at the national level and governors and mayors at the state and local levels; and the legislative, including the Senate and the House of Representatives at the national level and similar entities at the state level. Allocating power among the three branches in an equitable manner is referred to as the system of checks and balances. The legislative branch has

authority to safeguard the public health, which includes such areas as waste and water management, vaccination requirements, and emergency preparedness. The legislative branch also has authority to shape the delivery of and payment for health services, although the limits of that authority have been disputed, for example, by challenges to the Patient Protection and Affordable Care Act of 2010 (discussed in more detail later in this chapter). The judicial branch enforces laws made by the legislative branch, with criminal and civil sanctions and adjudication of legal disputes, for example, between providers and patients or insurance companies and patients. The judicial branch decides whether legislation is consistent with principles in the US Constitution. The executive branch proposes and implements legislation and regulations that flow from legislation.

The Legislative Branch

At the national level in the United States, laws originate in the US House of Representatives or the Senate. Laws approved by the House or Senate move to the other body. If identical bills are approved, the law moves to the President for approval or veto. If the bills are not identical, a conference committee comprised of members from the House and Senate constructs a compromise bill, which is then processed through the two bodies. A two-thirds vote of the legislative branch (House and Senate) can override a Presidential veto. Similar processes guide most state legislatures.

Health organizations and their interest groups, such as professional associations, can be directly involved in proposing legislation and participating in hearings on health laws. Large health organizations and associations frequently employ communications or lobbying specialists to engage in this activity. Key groups in the legislative process are the committees of the US House and Senate that process health laws under consideration. The Senate Finance Committee and the House Committee on Ways and Means, which have jurisdiction over Medicare and Medicaid legislation (described in more detail later in this chapter), are two key committees. Legislative committees often hold public hearings on controversial proposals. The hearings give health organizations opportunity for input. Similar processes at the community and state levels provide opportunities for influence on state and local laws as well.

Influencing the Policy Process

To further influence public policy in the health care arena, managers can develop or participate in coalitions of like-minded individuals and advocate for their

viewpoints before, during, and after the legislative process. Longest (2010) suggests five stages at which public policy can be influenced:

1. Agenda setting stage
2. Legislation development stage
3. Rulemaking stage
4. Policy operation stage
5. Policy modification stage

To help establish agendas, managers can urge their organizations to define and document problems, develop and evaluate solutions, and lobby politicians. Members of health organizations can participate in drafting legislation and testifying at legislative hearings. At the rulemaking stage, health organizations can provide formal comments on draft rules and serve on rulemaking advisory bodies. At the policy operation stage, health organizations can share their knowledge and concerns with policy implementers. Finally, managers and others, including consumers of health organization services, can document the case for modifying laws and regulations through communication to government of their experiences and evaluations of laws and regulations.

DISTINCTIVE FEATURES OF US HEALTH POLICY

In the United States, the government is less involved in the direct provision of health services than any other industrialized country in the world (Greenwald 2010; Jonas, Goldsteen, and Goldsteen 2007). Health care workers are less likely to be employed by the government. Managers in health organizations may work in a variety of settings, including private nonprofit, private for-profit, and public (including local, county, state, or federal government; Veterans Administration; and armed forces). If managers cross organizational settings in their careers, they must be prepared to adapt their style and knowledge base to the different settings.

In contrast to most national health systems, no central agency governs the US health system. Further, there is no universal access to health care. The existence of multiple sources of payment for health services increases administrative costs to the US system. Countervailing forces struggle to promote their own interests in the political arena. The major forces are typically identified as government, large private employers, labor, insurance companies, physicians, and hospitals (Shi and Singh 2008). Gaining consensus to change the system in fundamental ways is very difficult. As a result, most changes in health policy are incremental and fragmented.

Decentralization and fragmentation of health policies in the United States do not mean that health organizations are unregulated. In fact, many health organizations complain that they are overregulated through micromanagement in the form of laws and regulations that add to organizational costs and sometimes conflict with each other. For example, government is heavily involved in regulation due to the financing of health services through the Medicare and Medicaid programs. Medicare, established in 1965, finances medical care for persons age 65 and older, certain permanently disabled workers and their dependents, and persons with end-stage renal disease. Medicare is a critical factor in the financial condition of many health organizations, because it accounts for 20% of national health expenditures (US Department of Health and Human Services 2011). Medicaid, also established in 1965, funds medical care for some of the poor who qualify for eligibility, based on state criteria. Medicaid funding is shared by the national and state governments. Medicaid accounts for 15% of national health expenditures (US Department of Health and Human Services 2011). Both Medicare and Medicaid are in a precarious financial condition. Managers in health organizations that depend on those sources must be attuned to the need for increased efficiency in services to recipients.

Government also funds a wide array of health research, training of health workers, and a variety of direct delivery services, such as the Veterans Health Administration. The Department of Health and Human Services, which includes the Centers for Disease Control and Prevention and the Agency for Healthcare Research and Quality, is the largest of the governmental departments administering health-related laws at the national level. At the state level (in most states), a state board of health oversees public health services, including vital statistics, public health laboratories, communicable disease control, environmental sanitation, maternal and child health, and public health education. In most states, local health departments implement many of these services.

KEY HEALTH POLICIES AFFECTING MANAGEMENT

As already noted, organizational activities are subject to many laws that regulate financial reporting and human resources. Legislation has been enacted to regulate organizations that provide programs and services that are related to health. This section reviews policies that are specific to the health sector, focusing on those that impact the ability of health organizations to improve the quality of their programs and services and increase their value to consumers and clients.

Health Information Technology Support and Security

Health information technology has been targeted by recent legislation designed to modify existing policies and practices. These efforts have been driven by the slow adoption of information technology by organizations in the health sector and the fragmented delivery system in the United States. Health care service providers have begun to implement a wide range of different brands of information systems. Information systems are often selected for their financial advantage to the purchasing organization rather than considering their utility to customers, clients, or patients. A consequence of this approach is that individuals who use different provider organizations often do not have integrated health records.

To address these issues, recent changes in health policies have supported investment in information technology and standardization of the diverse technologies so that they can be interconnected. A National Coordinator for Health Information Technology was mandated by the Health Information Technology for Economic and Clinical Health Act (HITECH Act). This legislation was included in the American Recovery and Reinvestment Act (ARRA) of 2009. The Office of the National Coordinator is responsible for promoting a nationwide health information technology infrastructure that improves health quality and reduces costs. The ARRA also authorized nearly $20 billion over 5 years to assist physicians in adopting electronic health record (EHR) technology. Beginning in 2015, physicians not using EHRs will be penalized in their Medicare payments.

Privacy and security of health data are of critical concern to US health policy, again related to the many different sources of health information already in existence. The Health Insurance Portability and Accountability Act (HIPAA) of 1996 set standards for the security of certain protected health information. Health care providers and supportive personnel in a variety of settings now receive training on enforcement of the HIPAA guidelines. Privacy and security continue to be critical national policy issues in implementation of a health information technology infrastructure.

Access to Health Services

As noted earlier, the federal Medicare health insurance program and the joint federal–state Medicaid health insurance program have served elderly and disadvantaged populations for decades in the United States. A major expansion in the federal role in access to health services occurred in 2010, with the Patient Protection and Affordable Care Act. The law unfolds over the 2010–2014 period. The constitutionality of the law is being challenged in the courts as this book is written, with undetermined outcome.

Immediate effects of the Patient Protection and Affordable Care Act include a prohibition on denial of health insurance coverage for children due to preexisting conditions and requirements for full coverage of selected preventive services in health insurance plans. Later effects include an individual mandate for health insurance—individuals not covered by government insurance programs must maintain health insurance or pay a penalty. Access to affordable insurance will be increased through the use of health insurance exchanges operating in each state. Minimum standards for health insurance policies will be introduced. The law also funds a major expansion of Community Health Centers, which largely serve inner city poor populations, and increases payment levels to rural health care providers. Providers (primarily hospitals and clinicians) are given incentives to join in community-based accountable care organizations (ACOs). ACOs are integrated groups of providers responsible to care for a population of Medicare enrollees who are rewarded for reducing costs and improving quality.

Quality Improvement

US health policy is strongly behind efforts to improve the quality of health services, with increased expectations that health organizations will report and enhance the quality and value of their services. This trend is demonstrated by several provisions of the Patient Protection and Affordable Care Act. This legislation requires increased linkages between Medicare payments and quality outcomes. The Act establishes a Patient-Centered Outcomes Research Institute that is independent from the government. The Institute will examine the relative effectiveness of different medical treatments. The HITECH Act requires physicians to document clinical quality measures.

As of 2008, 26 states had enacted mandatory reporting laws requiring provider organizations to report instances of serious adverse events that occurred in hospitals on an annual basis (US Department of Health and Human Services 2008). In most states, root cause analysis is required to develop action plans for preventing similar events.

A movement to accredit public health departments, formally launched in 2011, is another example of the growing inclusion of quality improvement in US health policy. The Public Health Accreditation Board is dedicated to advancing the continuous quality improvement of state, local, tribal, and territorial public health departments.

Emergency Preparedness

Government is heavily involved in health policy for emergency preparedness. At the national level, the US Department of Homeland Security, established by the

Homeland Security Act of 2002, and one of its units, the Federal Emergency Management Agency, develop and deploy national strategies for prevention and response to emergencies, including terrorist attacks and natural disasters. States and many localities have similar emergency preparedness units, and health managers should be familiar with their organization's responsibilities to the community, state, and federal governments during emergencies.

Prevention and Health Promotion

US health policy has gradually increased recognition of the importance of prevention and health promotion. Building on the Healthy People initiatives, which set national health goals for 1990, 2000, 2010, and 2020, the Patient Protection and Affordable Care Act of 2010 creates a $15 billion Prevention and Public Health Fund and a council to develop and promote stronger national prevention, health promotion, and public health strategies. As already noted, the Act also creates requirements for health insurance plans to cover selected preventive services.

Another area of growing health policy concern is health disparities. *Health disparities* are population-specific differences in health. Many different populations are affected by disparities including racial and ethnic minorities, residents of rural areas, women, children, the elderly, and persons with disabilities. The Minority Health and Health Disparities Research and Education Act of 2000 authorized several US Department of Health and Human Services programs to address disparities. The Patient Protection and Affordable Care Act of 2010 expands services to low-income populations, broadens initiatives to increase racial and ethnic diversity in the health care professions, and strengthens cultural competency training for health care providers.

CONCLUSION

Informed and involved managers will not be surprised by most changes in US health policy. Changes in health policy reflect the fragmented, pluralistic structure of the health system in the United States. Incremental shifts toward health information technology support and security, increased access to services, quality and value improvement, emergency preparedness, and prevention and health promotion are long-term policy trends that provide opportunities for many health organizations. Managers familiar with the policy context of health management can better position their units and organizations for coming changes in health policies, take advantage of new service markets, and comply with laws and regulations.

Systems Thinking about the Policy Context for Management

Most health organizations tackle complex challenges to improve patient or population health. The health challenges inevitably have a health policy component, creating long-term interdependence between health organizations and health policies. As health policies change, so do the roles of organizations.

A good example of this connectedness over time is the health challenge of tobacco control. For several decades in the United States in the 1900s, tobacco control was not viewed as a salient health policy issue. Individualistic values and the American free enterprise economic system combined to limit the creation of policy interventions to control the use of tobacco. Tobacco users were free to make their own choices to use tobacco, and tobacco manufacturers were free to pursue profit.

Eventually, accumulating research on the negative health effects of tobacco on users and the harmful impact of secondhand smoke on nonusers, along with the huge cost of tobacco-induced illness to health insurance programs, altered health policy to promote decreased use. Individual-level interventions such as telephone quit lines and nicotine substitutes emerged. Community-level and population-level interventions, including bans on smoking in public places, higher taxes on tobacco products, and warning labels on tobacco products, were implemented. Successful suits against tobacco companies by state governments reflected changing health policy and resulted in large endowments for tobacco use prevention campaigns and research. Over time, a multitude of stakeholder organizations emerged, including government (e.g., the National Cancer Institute, Centers for Disease Control and Prevention) and private organizations (e.g., Robert Wood Johnson Foundation, American Cancer Society, Campaign for Tobacco-Free Kids).

As a whole system, the changes in tobacco health policy reflect the interdependence of private nonprofit organizations, researchers, government, consumers, and product manufacturers. Whole systems thinking about tobacco control involves reducing duplication of effort among disparate programs, encouraging multipartner efforts, developing better evidence on the effectiveness of tobacco control efforts, and integrating research and practice (National Cancer Institute 2007). The whole systems approach to tobacco control is a constructive attempt to address the pluralistic and fragmented health system, the incremental nature of policy change, and the complexity of most health challenges.

CASE STUDY RESOLUTION

Returning to the discussion about electronic health record systems, Madeline began to speak. "Financial efficiency is important, but, in my opinion, customers or clients should come first. If we opt for efficiency, the organization and owners benefit. If we install a system that can interact with other electronic health systems in the region, our costs will be marginally greater. However, the people that we serve will benefit. The increase in customer satisfaction and goodwill should more than offset the extra cost. The federal government has recognized the value of integrated record systems, too. We should check into that."

"I agree," replied Sandra.

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- **Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009:** http://www.hhs.gov/recovery/reports/plans/onc_hit.pdf
- **Healthy People:** http://www.healthypeople.gov/2020/default.aspx
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- **Homeland Security Act of 2002:** http://www.dhs.gov/xabout/laws/law_regulation_rule_0011.shtm
- **National Academy for State Health Policy:** www.nashp.org/
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