Joan Gratto Liebler
Charles R. McConnell

Management Principles

for Health Professionals

EIGHTH EDITION

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This Eighth Edition is dedicated to the memory of Charles R. (Chuck) McConnell.

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Preface

This book is intended for healthcare professionals who regularly perform the classic functions of a manager as part of their job duties—planning, organizing, decision making, staffing, leading or directing, communicating, and motivating—yet have not had extensive management training. Healthcare practitioners may exercise these functions on a continuing basis in their roles as department directors or unit supervisors, or they may participate in only a few of these traditional functions, such as training and development of unit staff. In any case, knowledge of management theory is an essential element in professional training, because no single function is ever addressed independently of all others. Individuals who are trained in management theory but do not have healthcare experience will find an abundance of examples linking theory to the healthcare environment. A wide variety of settings are reflected in the many examples provided.

In this book, emphasis is placed on definitions of terms, clarification of concepts, and, in some cases, highly detailed explanations of processes and concepts. The examples reflect typical practices in the healthcare setting. However, all examples are fictitious and none are intended as legal, financial, or accreditation advice.

Every author must decide what material to include and what level of detail to provide. We have been guided by experience gained in the classroom, as well as in many training and development workshops for healthcare practitioners. Three basic objectives determined the final selection and development of material:

1. *Acquaint the healthcare practitioner with management concepts essential to the understanding of the organizational environment within which the functions of the manager are performed.* Some material challenges assumptions about such concepts as power, authority, influence, and leadership. Some of the discussions focus on relatively new concepts such as social media use, cultural proficiency and diversity training, changes in credentialing, and job duties of both professional and technical support personnel. Practitioners must keep abreast of developing trends in management, guarding against being "the last to know."
2. *Provide a base for further study of management concepts.* Therefore, the classic literature in the field is cited, major theorists are noted, and terms are defined, especially where there is a divergence of opinion in management literature. We all stand on the shoulders of the management "giants" who paved the way in the field; a return to original sources is encouraged.
3. *Provide sufficient detail in selected areas to enable the practitioner to apply the concepts in day-to-day situations.* Several tools of planning and control, such as budget preparation and justification, training design, project management, special reports (e.g., the annual report, a strategic plan, a due diligence assessment, a consultant's report), and labor union contracts, are explained in detail.

We have attempted to provide enough information to make it possible for the reader to use these tools with ease at their basic level. It is the authors' hope that the readers will contribute to the literature and practice of healthcare management as they grow in their professional practice and management roles. We are grateful to our many colleagues who have journeyed with us over the years and shared their ideas with us.

Joan Gratto Liebler
Charles R. McConnell

It is with regret that Joan Gratto Liebler and Jones & Bartlett Learning note the passing of Charles R. McConnell in late 2019.

About the Authors

Joan Gratto Liebler, MA, MPA, is Professor Emerita, Health Information Management, Temple University, Philadelphia, Pennsylvania. She has more than 40 years of professional experience in teaching and research in healthcare settings. In addition to teaching, her work and consulting experience include engagement with community health centers; behavioral health settings, schools, industrial clinics, prisons; and long-term care, acute care, and hospice facilities. She has also been an active participant in area-wide healthcare planning, end-of-life care coalitions, and area-wide emergency and disaster planning.

Ms. Liebler is also the author of *Medical Records: Policies and Guidelines* and has authored numerous journal articles and contributed chapters relating to health information management.

Ms. Liebler holds the degrees of Master of Public Administration, Temple University, Philadelphia, PA, and Master of Arts (concentration in Medical Ethics), St. Charles Borromeo Seminary, Philadelphia, Pennsylvania.

Charles R. McConnell, MBA, CM, led a successful career as an independent healthcare management and human resources consultant and freelance writer specializing in business, management, and human resources topics. For 11 years he was active as a management engineering consultant with the Management and Planning Services (MAPS) division of the Hospital Association of New York State (HANYS), and he later spent 18 years as a hospital human resources manager. As author, coauthor, and anthology editor, he published more than 30 books and contributed several hundred articles to various publications. For 40 years, he was editor of the quarterly professional journal *The Health Care Manager.*

Mr. McConnell received a Master of Business Administration and a Bachelor of Science degree in Engineering from the State University of New York at Buffalo.

What's New in the *Eighth Edition*

Management Principles for Health Professionals, Eighth Edition, continues to present foundational principles of management in the context of contemporary healthcare. The *Eighth Edition* reflects current issues and trends, linking them to basic principles. The corporate culture as an over-arching ethos is identified and then applied to various management functions; new and continuing legislative and accrediting mandates are included. Throughout the chapters, telemedicine and eHealth, the impact of technology, social media issues, and changes relating to reimbursement are noted as pervasive themes. A variety of formats are used to present material; these formats include the content of a topic, and provide examples of methods of presentation for use in training and workshops. Two major reference tools are presented and developed throughout the text: The Manager's Wheel Book and The Management Reference Portfolio.

Examples and exhibits have been updated to reflect a wide variety of settings and clients. Settings include the traditional inpatient hospital and related specialty clinics; expanded use of ER and observation units/clinical decision units; rehabilitation services, both inpatient and outpatient; expanded use of adult day care centers for respite/vacation care; expanded use of homecare, supported by telemedicine. Some other examples include such varied settings as truck stop dispensaries, industrial health correction care, and programs for the homeless population.

Changing aspects of job content are noted, including the development of the nurse navigator role; "always on" and required or expected availability; technological skills requirements,

Specific Chapter Updates

Chapter 1, "The Dynamic Environment of Health Care," presents a template for analyzing megatrends in health care including telemedicine and eHealth, increasing use of technology, "Here Come the Robots," retainer-fee and concierge care, respite and vacation care of elderly, ER care by appointment, medical cost sharing, Accountable Care Organizations, in-network care. A major new feature is the Manager's Wheel Book, its content and uses.

Chapter 2, "The Challenge of Change," includes six examples of major change, followed by an analysis of the incremental changes associated with each. Suggested quality assurance analysis relating to HIPAA compliance and advance directive practices are provided. Interoperability features of EHR and data degrading issues are noted. ACA is updated. A template for analyzing health insurance proposals is included.

Chapter 3, "Organizational Adaptation and Survival," includes expanded discussion of issues such as: when clients become adversaries, how to reach remote clients and expand client base, changes in practitioners' roles, with emphasis on the nurse navigator as a counter-balance to bureaucratic features of large organizations. The corporate culture as an over-arching ethos is discussed in detail. To link theory and practice, a detailed analysis of life cycle concepts with the related survival strategies is presented. The concept of the Management Reference Portfolio is introduced. "Know Your Organization" is presented, using the manager's wheel book as an analytical tool.

Chapter 4, "Leadership and the Manager," features sections on "Growing in the Leadership Role" and "Enhancing One's Career Path." These include a data-driven review process for a manager's self-evaluation and for aligning one's career path with the goals of the organization. Excerpts from the manager's wheel book are included to reflect leadership and career development activities.

Chapter 5, "Planning and Decision Making," adds material reflecting the corporate culture as a primary factor in these processes. Examples for assessing planning constraints and factors include settings and client characteristics in traditional settings as well as adult day care/respite care centers, correction care, truck stop dispensaries, and healthcare outreach programs for the homeless population. Additional examples of mission

and core values are included. Policy excerpts include Institutional Review Board consent practices. Decision-making discussion includes assessment of degree of impact and probability. Detailed use of the after-action-review and the analysis of unanticipated outcomes are described as means for evaluating decisions.

Chapter 6, "Organizing and Staffing," includes analysis of organizational structure as centralized vs. decentralized, "tall," or "flat" models. Succession plans are described; clarification of employee status relating to contractual and temporary workers is given; classifications as essential and non-essential, "always on" availability requirements, and flextime options are described. Additional elements and wording of job descriptions are given. The consultant report reflects several current issues in long-term care: increased use of respite/vacation care; bullying and the incident report requirements; pain management and opioid use; pros and cons of documenting a spiritual history; indicators of social isolation; changing patterns of length of stay. The use of telehealth/eHealth and the personal health record are also included.

Chapter 7, "Committees and Teams," includes an exposition of the over-all context for committee and team development. The corporate culture is given particular attention regarding committees and teams and the values of cooperation, transparency, corporate compliance, safety and security, and outreach initiatives. Guidelines for group deliberation are given, and then illustrated in the after-action review of a major disaster. The manager's wheel book entries relating to committee and team activity are reviewed.

Chapter 8, "Budget Planning and Implementation" are presented within the context of the corporate culture, plus laws, regulations and standards for fiscal planning. An in-depth discussion of shared responsibilities is given, with emphasis on board of trustee's root decisions. These include balancing "safety net" commitment, cost-shifting impact, and debt limits. Identification of new elements in billing is noted (e.g., charges associated with eVisits and other telemedicine interactions). A budget reference portfolio and additional budget justification statements are included. Examples of budget auditing findings are noted.

Chapter 9, "Training and Development: The Backbone of Motivation and Retention," reflects the corporate culture values of success and excellence. Orientation topics include clarification about employees being "always on" and modified operations schedules requirements and expectations. Orientation also includes expanded discussion of social media and internet use. The topic of sexual harassment is presented in a Frequently Asked Questions format, thus giving both the content of this topic and an example of a training method.

Chapter 10, "Adaptation, Motivation, and Conflict Management," includes additional examples of the sources of conflict; the conflict model is applied in detail to Whistleblower activity. Union trends and issues are noted, including concerns about the increased use of robots in replacing workers; the effects of the Supreme Court JANUS decision are described.

Chapter 11, "Communication: The Glue that Binds Us Together," provides information about social media and e-mail, texting, and instant messaging through an analysis of policy and practices, with particular emphasis on limits on management's prerogatives. Methods for enhancing communication effectiveness are noted, including the SBAR format.

Chapter 12, "Comprehensive Planning and Accountability Documentation," relates planning and review documents to the corporate culture and values of accountability, transparency, and shared responsibility. The standard reports have updated entries reflecting "By the Numbers" reporting; telemedicine and eHealth; the personal health record; closure of a facility details. A Plan of Correction as a mandated response to licensure or accreditation reviews is included. Excerpts from the manager's wheel book are given to illustrate the usefulness of these factual support materials for writing accurate reports.

Chapter 13, "Quality Improvement and Control Processes," has new material about the characteristics of a thriving organization. A variety of quality improvement topics are suggested, including readmission within 30 days, focused review of over/underuse of services, patterns of use regarding inpatient admissions from ER and Observation Unit, pain management, and opioid use.

Chapter 14, "Human Resources Management: A Line Manager's Perspective," includes aspects of online and social media recruiting; using the manager's wheel book to identify significant activity to include in employee evaluation; processes associated with both voluntary and involuntary separation from the organization. Particular emphasis is given to the work environment: hostile or supportive and practices that foster one or the other environment.

Chapter 15, "Day-to-Day Management for the Health Professional-as-Manager," provides additional material for self-assessment, career development and the review of personal and professional goals, and the necessity for aligning these with the organization's goals. The final appendix includes a complete wheel book for comprehensive analysis of the role and functions of the middle manager.

CHAPTER 1

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 and the related competencies.
- Introduce the concept of The Manager's Wheel Book, its content, and uses.
- 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 the 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 a freestanding clinic or an urgent care service at a shopping mall. Within the emergency service setting there are changes: emergency service care by appointment. In this instance, the patient (or caregiver) arranges an arrival time and waits at home until the designated time. The purposes of this reservation process are reducing wait time in the emergency room (ER) and enhancing the general comfort of the patient in their home setting. Careful assessment is needed when using this approach; a patient might delay seeking care because they do not realize the seriousness of their condition. Another innovation in health care is that of boutique care, also called retainer-fee care or concierge care. The patient and primary care physician enter into a retainer arrangement, with the patient paying an annual fee for overall care; the physician agrees to limit the number of patients to increase a more personalized approach, decrease waiting times, and increase availability. Some practices charge additional fees for certain tests and services.

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. These topics and trends are discussed more fully in the subsequent chapters.

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." Medical marijuana use has become an acceptable element in pain management care, although there continues to be questions about conflict of federal versus state law about the legalization of this substance.

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, measles, mumps, 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 or 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 in high risk pregnancy care, the nurse case manager in transition care, the nurse navigator in coordinating discharge plans and after-care training, 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. Long-term care facilities and adult day care centers have adopted programs for respite care to provide relief for family caregivers as well as to give frail elderly a variety of care.

If a 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, including home care and telemedicine services. 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 challenged). For-profit ownership and sponsorship include owner–investor hospital and clinic chains, long-term care facilities, and 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? There are several reasons:

- 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 being responsible for 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 (a Centers for Medicare and Medicaid Services designation), capitalizing on the flexibility such designation requires.

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 includes 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 post-acute, 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 post-acute rehabilitation center, a long-term nursing care center, and assisted living and secured personal care for frail, elderly people. The continuing 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, and 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 challenged persons 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; 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, now commonly referred to as the Affordable Care Act (ACA).

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, the Commission on Accreditation of Rehabilitation Facilities (CARF), 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 an additional 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 the 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. The DHHS's national health goals

or a state governor's long-range plans 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 and 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 website), the consumer of health care generates his or her own personal health record (PHR).

Here Come the Robots

Robotic technology is a growing one in most sectors, including health care; these technologies have had gradual implementation and have become a fixture, with greater use anticipated. Examples include transport and delivery of supplies; mixing and dispensing medications; surgical applications, especially in highly delicate care, such as eye surgery. Devices such as a robotic arm enhance care in rehabilitation units. For some aspects of robot utilization (e.g., transport and delivery), a cost savings tends to result, thus offsetting the cost of robot with reduced costs relating to personnel. There is, of course, some loss of personalization and this is a drawback; a caregiver picks up on both subtle and overt changes in a patient during routine care and in the conversational exchange; a patient often expresses important information such as an increase in discomfort or pain that would not be conveyed in the robotic intervention. This observational opportunity is lost in the high tech approach.

The Personal Health Record

The PHR 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. Fitness application data and various self-testing (such as do-it-yourself EKG monitoring) have become common. 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 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 increase, 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. Identifying 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 require 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, 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 whether the setting is on-site or virtual.

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; in others, the split is unequal (e.g., 34% state and 16% county).

Concern for healthcare costs has gathered 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 20th century 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 one of the principal drivers of this change.

The Managed Care Era

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

Aside from technological advances, much 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 has 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 20th century, 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.

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.

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 gradual unfolding of the ACA, with its increased premiums, added to this trend. The average middle-class subscribers and the public in general 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.

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.

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.

Managed care groups as well as voluntary groups sometimes work together to achieve cost savings and improve coordination of care under such programs as CMS's accountable care organizations (ACO's). By working together within a designation region, these groups reduce cost by sharing information that, in turn, reduces duplicate testing, increases wellness care, and prevents medical errors. If cost savings are realized, Medicare returns a portion of the savings to the ACO's providers.

There have been on-going initiatives to develop programs to coordinate care and share the costs. In addition to those already discussed, there is an alternative to managed care, namely, the medical cost-sharing model. These organizations are somewhat like insurers, but are not, generally, regulated as such. They are usually sponsored by some non-profit group as a service to their members. The members who join the medical cost-sharing program agree to pay a specified amount into a general pool of money to pay the medical bills of members. When a member incurs medical costs (of a specified category), he or she submits the bill to his or her cost-sharing group, which then pays the bill. In order to keep costs down, the cost-sharing group has eligibility requirements. These include members' agreement to avoid high-risk behaviors (e.g., no smoking). Failure to comply with these requirements would result in non-payment by the cost-sharing organization.

The Annual Congressional Budget Allocations

During the formulations and passage of the annual federal budget, additional requirements affecting managed care, Medicare and Medicaid, and other reimbursement program are developed. Some requirements are reduced or eliminated. The process is both a political one and a practical one: the allocation of funds must be incorporated into an overall budget, with mandatory federal debt limits. The political overlay reflects a variety of attempts to respond to

constituency concerns. Thus, it is an annual process requiring careful attention by the healthcare reimbursement community. State-level budget processes require similar monitoring and input.

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 Workers' Compensation, which pays for health care for sick or injured workers whose condition results from job-related conditions. The programs includes compensation for lost income. Many of the states also have unique programs designed to serve certain specific population segments. In addition to 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:

- Network designation is the concept under which a patient's plan pays up to 100% of costs within one's network and the patient pays 100% of costs incurred outside of the network. Usually insurers and employers place a dollar limit on what the plan pays for expensive procedures, potentially resulting in some large medical bills for patients. Certain problems arise with out-of-network care; a patient does not always know that the provider or facility is not part of the network. For instance, in an emergency or accident, the patient is taken to the nearest facility which may not be in the network. The patient often is unable to participate in the decision due to their condition, or the patient's condition requires immediate care, regardless of network considerations.
- 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 on the volume of services provided. The medical home can be a physical or virtual network of providers; the keys to its success are related to 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 ACA contains provisions that support use of the medical home model, including new payment policies.
- 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. This involves discharge planning and coordination of posthospital care and recognizes that acute hospital care is but one step in addressing a patient's needs. The continuum of care model recognizes 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. 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 generally holds 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:

- 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 was actually 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 in a single day)
- 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
- Stringent efforts to combat fraud and abuse include both internal and external audits of reimbursement and the documentation to support claims.

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 previously, 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 in 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 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 and Essential Competencies

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.

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.

Figure 1–1 Interrelationship of Management Functions.

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	Planning Leadership

- 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.
- 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 as the 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.

Essential competencies and characteristics of an effective manager are discussed in the next section.

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 augments this role set; they reflect the essential competencies of a manager. 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 standards applicable to each type of healthcare 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 wages 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.

The Manager's Wheel Book

This concept is drawn from the maritime world. The captain of the ship holds the primary position of authority, plans the course, directs the crew, and makes necessary adjustments to the course. To accomplish these activities, a captain's log, the wheel book, is maintained. It contains factual information: distances travelled, weather conditions, supplies obtained, information about unplanned events. If someone had to take the captain's place in an emergency, the wheel book entries would provide immediate information for use by the person replacing the captain. As the responsibility holders for their departments, managers could use a similar concept, a manager's wheel book, showing simple, factual entries by date. Its uses are several:

1. As a quick reference to recall date and action, such as when renewal of vendor contract occurred
2. Planning: comparing a plan to actual performance (e.g., budget preparation, planning long range initiatives)
3. Identify orientation and training needs
4. Orienting a clinical affiliation student to the role of manager and aspects of the particular setting
5. Preparing major reports such as the annual report
6. Preparing employee evaluations by reviewing the past year's critical incidents
7. Preparing policy and procedure updates
8. Analysis of one's duties, activities, and preparing one's self-evaluation

The wheel book contents, reflecting one or several years, help managers identify trends and separate out the one or two situations from those that have moved beyond a popular trend into enduring elements. It also helps a manager in those challenging moments when one might be tempted to make an emotional response: "Why is this always happening in your unit?" "That vendor never delivers on time!" These might surface as quick responses to a pressing situation, but a quick check through the daily log does not support the momentary impression.

Of primary importance is its use to assist others who might need to take over, such as in an emergency and/or a manager's unavailability due to leave of absence, illness, vacation, or conference attendance.

An Excerpt for a Manager's Wheel Book

The log is a simple one: date; activity; note column

Additional examples of entries are given throughout this text, illustrating its use and content.

Date	Activity	Notes
April 17	Reviewed vacation coverage plan for July–August	
	Monthly meeting with peer group; discussed ICD-11 status	
	Met with Supply Chain assistant director about reducing variety of brand-specific supplies	

Date	Activity	Notes
	Employee (*N*)—end of probationary period; completed HR documents to move employee from probationary to full status	
	Annual evaluation reports—preliminary preparation; reviewed January–March weather-related closure; critical incident response; availability	
	Met with HR department re: current status of March 17 whistleblower report	
	Unplanned visit from colleagues from neighboring state	
	False alarm—fire alarm in remote storage area	
	Unexpected resignation notice from assistant director	

A comprehensive wheel book example is provided at the end of the final chapter.

A manager's day is often a mix of planned activity (e.g., a monthly meeting, completion of personnel forms) with the unplanned occurences (e.g., unplanned visit from colleagues, fire alarm). Notice that it is not a TO DO list; the log contains what did happen. It will be the basis of a TO DO list, but the emphasis is the capture of day-to-day activity. Many of the entries will be a repeat of early ones. In maritime language, "Continuing as Before" was a common phrase to indicate that no new events occurred and the ship was proceeding on course. In this adaptation of the wheel book, a manager would not take a short cut to entries lest this lead to a loss of background information. Seemingly repetitious entries (e.g., certain regular meetings, employee matters) are common; they reflect a stable, routine, well-ordered environment. The entries need not be long; brief notation is sufficient.

Format of Wheel Book

One might want to choose to simply add this type of information to one's calendar. Meetings, for example, are already listed. A prompt column for TO DO is often included on business calendars. Personal information is often listed in one's calendar. Using the existing personal/business calendar might seem convenient, but there is a drawback to this method: when the manager leaves, or is temporarily unavailable, the information in personal/desk calendar goes with him or her. The wheel book and simple logging of date and activity of what actually happened are a straightforward alternative.

The log entries do not show details; the related documents serve that purpose (e.g., minutes of meeting, completed evaluation form, equipment inventory and specifications file).

Along with the Manager's Reference Portfolio (discussed in Chapter 3), the Manager's Wheel Book provides a useful source of information about planned, seasonal, and ordinary activity along with the unplanned events that make up a manager's work.

CHAPTER 2

The Challenge of Change

CHAPTER OBJECTIVES

- Identify the impact of change on organizational life.
- Identify the manager's role as change agent.
- Review examples of successful change.
- Examine a major change having ongoing impact.
- Describe the organizational change process.
- Identify specific strategies for dealing with resistance to change.

The Impact of Change

Change in the healthcare environment is continuous and challenging; the trends and issues in the healthcare setting reflect the reality in every stage of the life cycle of the organization, as well as in its attendant survival strategies. Trends and issues intensify, becoming mandates for change in patient care, setting, and administrative support. This affects workers at all levels. Such changes consume financial and administrative resources; they have the potential of draining emotional and physical energy away from primary goals. Thus, the managers accept the role of change agent, seeking to stabilize the organization in the face of change.

The Manager as Change Agent

Managers, as the visible leaders of their units, assume the function of change agents. This change agent role involves moving the trend or issue from challenge to stable and routine. This is accomplished in several ways:

- Mediating imposed change through adjusting patterns of practice, staffing, and administrative routines
- Monitoring horizon events through active assessment of trends and issues
- Creating a change-ready environment
- Taking the lead in accepting change

Review of Successful Change

Managers foster a change-ready environment by reminding the work group of successful changes. This raises the comfort level of the group and provides insight into strategies for achieving desired outcomes. Six examples are provided here to illustrate the process of successful change, along with ongoing responses. They reflect the move from major, rapid change to incremental, continuous adjustment.

- Year 2000 (Y2K): change as opportunity
- Patient Self-Determination Act (PSDA): routinization of change
- Health Insurance Portability and Accountability Act (HIPAA): extensive change via legislation

- Electronic health records: proactive change
- Economic and market forces: anticipatory readiness through organizational restructuring
- Disruption in personal circumstances: revitalization through career development

Change as Opportunity: Y2K

Recall the transition to the new century: Y2K. The phrase alone reminds us of successful responses to an inevitable change. It also reminds us of the pre-Y2K concerns about technology-dependent systems: would they work? Faced with the possibility of massive systems failure, managers carefully defined the characteristics of this anticipated change:

1. A definitive event with an exact timetable
2. Well known ahead of time (3- or 4-year run-up)
3. Unknowns or uncertainty mixed with known technical aspects: which systems might fail, what would the resulting impact be (e.g., failure of power grids, communication disruption, financial infrastructure chaos)

During the run-up to Y2K, managers assessed the potential impact and planned accordingly. Furthermore, many managers seized the opportunity to make even bigger changes. When the cost of upgrading some existing systems was compared with adopting new systems, managers chose to spend the money and time on a comprehensive overhaul.

Funding such a major project became part of the challenge. Many chose a combination of borrowing, along with "bare bones" budgets, with deferred maintenance and elimination of discretionary projects (e.g., refurbishing) to meet this need. The end result in many organizations was the adoption of new, well-integrated computerized systems. This overall plan of upgrading was supplemented with contingency planning closer to the December 31, 1999, deadline. Managers took such practical steps as:

- Eliminating all backlogs (e.g., coding, billing, transcription)
- Preregistering selected patient groups (e.g., prenatal care patients)
- Obtaining and warehousing extra supplies
- Adjusting staffing patterns for the eve of Y2K and the days immediately following it, with workers available and trained to carry out manual backup for critical functions

Managers also took the opportunity to review and update the emergency preparedness and disaster plans for the healthcare organization. Again, the anticipated Y2K change was the catalytic agent for renewed efforts in these areas. Y2K came and ran its course; this major change was absorbed with relative ease because of careful planning. Two decades later, some of the issues remain because the nature of the basic concern remains. Is it time for a complete overhaul of the technology system? Is incremental change no longer effective? The threats to the system from electromagnetic pulse impact failure of the power grid, or disasters are ongoing concerns, requiring ongoing monitoring and incremental change.

The Routinization of Change: The Patient Self-Determination Act of 1990

End-of-life care and related decisions have always been a part of the healthcare environment. However, technological change (e.g., advances in life support systems) along with definitive court cases (e.g., *Quinlan, Cruzan*, *Conroy*) led to a renewed interest in these issues. This interest, in turn, resulted in the passage of the PSDA, which had implications for patient care as well as the administrative support systems.

The response to this change was orderly and timely because the healthcare providers and the administrative teams assessed the change in a systematic manner. This strategy of absorbing change through rapid routinization into existing modes of practice included the following:

1. Outreach to clients or patients and their families, along with the public at large, to provide information and guidance about healthcare proxies, advance directives, and living wills. Information about support services such as social service, chaplaincy, and hospice care was included as part of the regular client/patient education programs.
2. Review and update of do not resuscitate (DNR) orders and related protocols for full or selected therapeutic efforts.
3. Review of plan of care protocols for "balance of life" admissions.
4. Increased emphasis on spiritual and psychological considerations of patients and families, with documentation through values history or similar assessments.
5. Renewed involvement of the ethics committee of the medical staff to provide the healthcare practitioner, patient, and family with guidance. The committee also adopted review protocols to assess patterns of compliance with advance directives and end-of-life care.
6. Documentation and related administrative processes augmented to reflect the details of this

sequence of care (e.g., documentation that an advance directive was made, movement of the document with the patient as he or she changed location, flagging the chart to indicate the presence of the directive). Existing policies and procedures were updated to reflect these additional practices.

The changes stemming from the PSDA were easily managed through systematic review and adjustment of existing, well-established routines. However, there is a potential downside to routinizing change: the changes might become so well accepted that they are more or less ignored. For example, the living will become just another piece of paper or data entry, checked off as being available but not truly part of the care plan. A thorough quality assurance or improvement review of actual practice relating to advance directives highlights the need for ongoing attention to this issue. As a practical matter, there remains a need to ensure the availability of the official advance directive. If a patient is receiving care from more than one healthcare professional, and/or hospital or clinic, the patient usually needs to give each provider an official copy, not a photocopy, or at least indicate that he or she has an official directive and where it is located. However, without the document per se, the provider can only proceed with generally accepted treatment protocols. In an emergency episode, and even in planned encounters, patients rarely carry an advance directive. In a similar situation, that of a patient traveling from their home state to another state (e.g., on business or personal matters), the advance directive may not apply. Even with interstate compact agreements, this issue is still not settled.

At a more basic level, a patient might ask for a sample form to fill in. Unless one is consulting a lawyer, one might accept the simplified check-list version, completing it as part of an intake process while sitting in a waiting area. There is the possibility of inadvertently checking the wrong box, not understanding the terminology, or simply leaving most options unchecked. Finally, there is the remote possibility of someone else later on altering the document by changing the checkmark—checkoff lists are easily altered. There is a need for continued education of the general public as well as patients about this important topic. The original impetus to adopt advance directives has lessened somewhat. The larger cultural and ethical aspects of life-and-death issues currently focus on assisted suicide.

Because response to legislated change is often required, it is useful to examine yet another such mandate. A consideration of HIPAA reflects a different dynamic in the organizational process of responding to new requirements.

Extensive Change via Legislation: Health Insurance Portability and Accountability Act of 1996

This act, known commonly by the acronym HIPAA (Public Law Number 104 of the 191st Congress) (PL 104-191), was enacted in 1996. When it was a newly passed law, its most visible portion was broadly described by the name of the law, addressing primarily "portability" of employee health insurance.

The intent of HIPAA was to enable workers to change jobs without fear of losing healthcare coverage. It enabled workers to move from one employer's plan to another's without gaps in coverage and without encountering restrictions based on preexisting conditions. It specified that a worker could move from plan to plan without disruption of coverage.

At first, many healthcare managers were not concerned with HIPAA. Human resources managers became most aware of the new law because it concerned their benefits plans, but the burden of notification was borne mostly by the employers' health insurance carriers, so there was little to do other than answering employees' questions. For many managers, the employer had no concerns about HIPAA beyond ensuring health insurance portability. Additional clarifications and guidelines have been promulgated over the years, resulting in routine, incremental change. For example, employer-sponsored wellness programs have gained popularity; does HIPAA apply? Yes, if the program is part of the employer-sponsored group health plan. The employer may not access workers' information about participation in, or details of, wellness program results even though the employer pays for the program.

Managers continue to respond to the ongoing mandates of this law, consisting of five sections: titles I, II, III, IV, and V.

Title II in the Spotlight

Titles I, III, IV, and V of HIPAA deal with employee health insurance, promoting medical savings accounts, and setting standards for covering long-term care. Title II is the section driving most HIPAA-related change. This section is called "Preventing Health Care Fraud and Abuse, Administrative Simplification, and Medical Liability Reform" under the standard regulatory term *Administrative Simplification*.

Administrative Simplification includes several requirements designated for implementation at differing times. Compliance with the Privacy Rule, the most

contentious part of HIPAA, was required by April 14, 2003. Compliance with the Transactions and Code Sets (TCS) Rule was required by October 16, 2003, and the Security Rule was set for implementation in April 2005. The Centers for Medicare and Medicaid Services have issued, and continue to issue, a wide variety of rules and guidelines, with managers implementing these routinely. HIPAA has become a fixed feature in healthcare systems.

Controversy over the intent versus the reality of HIPAA involves the Privacy Rule. In trying to strike a balance between the accessibility of personal health information by those who truly need it and matters of patient privacy, portions of HIPAA have created considerable work and expense for healthcare providers and organizations that do business with them, not to mention creating inconvenience and frustration for patients and others.

The Continuing Privacy Controversy

Reactions to the Privacy Rule have been numerous. Patients and their advocates claimed that these new requirements were forcing a choice between access to medical care and control of their personal medical information. Government, however, claimed that the rules would successfully balance patient privacy against the needs of the healthcare industry for information for research promoting public health objectives and improving the quality of care.

When HIPAA's privacy regulations first received widespread exposure, hospitals, insurers, health maintenance organizations, and others claimed that the Privacy Rule would impose costly new burdens on the industry. At the same time, Congress was claiming that HIPAA's protections were immensely popular with consumers. Consumer advocates hailed the Privacy Rule as a major step toward comprehensive standards for medical privacy while suggesting that it did not go far enough.

To comply with the Privacy Rule, affected organizations were required to

- Publish policies and procedures addressing the handling of patient medical information
- Train employees in the proper handling of protected health information
- Monitor compliance with all requirements for handling protected health information
- Maintain documented proof that all pertinent requirements for information handling requirements are fulfilled

The HIPAA privacy requirements has caused frustration for patients and others. For example, a spouse who has to help obtain a referral or follow up on a test result cannot do so without the signed authorization of the patient (unless the patient is a minor). Anyone other than a minor or a legally incapable or incapacitated individual must give written permission for anyone else to receive any of his or her personal medical information.

There are a number of instances in which personal medical information can be used without patient consent. These instances, along with all patients' rights concerning personal medical information, must be delineated in the Privacy Notice that every provider organization must provide to every patient.

Effects on an Organization

All healthcare plans and providers must comply with HIPAA. Provider organizations include physicians' and dentists' offices; hospitals, nursing homes, and hospices; home health providers; clinical laboratories; imaging services; pharmacies, clinics, and free-standing surgical centers and urgent care centers. In addition, such organizations include any other entities that provide health-related services to individuals. Also required to comply are other organizations that serve the direct providers of health care (e.g., billing services and medical equipment dealers). All affected organizations must

- Protect patient information from unauthorized use or distribution and from malfeasance and misuse
- Implement specific data formats and code sets for consistency of information processing and preservation
- Set up audit mechanisms to safeguard against fraud and abuse

All subcontractors, suppliers, or others coming into contact with protected patient information are also required to comply with the HIPAA Privacy Rule. In addition, all arrangements with such entities must define the acceptable uses of patient information.

Depending on organization size and structure, compliance with the HIPAA Privacy Rule could involve several departments (as in a mid-size to large hospital), a few people (as in a small hospital or nursing home), or a single person (as in a small medical office). Overall, whether compliance is accomplished by separate departments or just a person or two, compliance can involve a number of activities, including information technology, health information management, social services, finance, administration, and ancillary or supporting services.

The necessary changes have been numerous and have added to the workload in every affected area.

Providers routinely obtain written consent from patients or their legal representatives for the use or disclosure of information in their medical records, as had been the standard practice. However, renewed attention has been focused on release of information practices. Also, providers are now legally required to disclose when patient information has been improperly accessed or disclosed.

The Privacy Rule created a widespread need for healthcare providers to revise their systems to protect patient information and combat misuse and abuse. Providers now must protect patient information in all forms, implement specific data formats and code sets, monitor compliance within their organizations, implement appropriate policies and procedures, provide training all in HIPAA's privacy requirements, and require the organization's outside business partners to return or destroy protected information once it is no longer needed. Also, it is not enough simply to do everything that is supposed to be done: there are also a number of documentation requirements as well. Even a provider organization's telecommuting or home-based program must be HIPAA compliant.

Physical Layout Considerations

The HIPAA Privacy Rule has necessitated changes in physical arrangements to ensure that no one other than the patient and caregiver or other legitimately involved person knows the nature of the patient's problem—or even, for that matter, that the specific individual is a patient. Medical orders or information about an individual's condition must be conveyed with a guarantee of privacy. Numerous organizations had to move desks or workstations, erect privacy partitions, provide soundproofing, and make other alterations so that no one other than those who are legally entitled to hear may overhear what passes between patient or representative and a legitimately concerned party. As with the advance directive topic, a quality assurance/improvement study about this aspect of privacy might yield information about unintended breaches. Consider the common situation of check-in at the reception area of a physician's office or clinic. Or even a pharmacy. The receptionist asks for name, date of birth, and reason for visit/whom are you seeing, or what medication are you obtaining. This transaction often occurs within hearing distance of others in the waiting area or, in the case of a commercial pharmacy, at the cash register area. While further intake assessment is done in properly arranged locations, the check-in/check-out area might not meet privacy requirements.

The Privacy Official

Every healthcare provider organization must have a person designated to oversee HIPAA compliance. In a large organization, this position could be filled by a full-time HIPAA coordinator. In a small organization, such as a medical office, the task might be an additional responsibility of the office manager. This person must monitor all aspects of compliance and ensure that appropriate policies and procedures are maintained and kept current. Professional associations, including the American Health Information Management Association (AHIMA), have developed detailed position descriptions and guidelines for privacy officers.

The Department Manager and HIPAA

Depending on the nature of a department's activity, HIPAA's requirements could significantly affect the manager's role. For example, health information management must be concerned with the release of information. A manager within information technology or information systems will be significantly concerned with the Security Rule because of its relevance for information stored or transmitted electronically.

As with other laws affecting the workplace, there is much more to compliance with HIPAA than simply putting policies, procedures, and systems in place. Some HIPAA regulations are complex, and in the most heavily affected areas of an organization, considerable training can be required. Also, HIPAA necessitates some training for most staff regardless of department; any person who comes into contact with protected patient information must receive privacy training. As a consequence, most managers will be both trainees and trainers, learning HIPAA's privacy requirements, remaining up to date, and communicating them to employees.

Some HIPAA requirements continue to be amplified, and it is clear that the law's basic privacy requirements are here to stay in one form or another. Privacy rules will continue to affect every physician, patient, hospital, pharmacy, healthcare provider, and all other entities having contact with patient medical information in any form. The American Recovery and Reinvestment Act of 2009 and the related Health Information Technology for Economic and Clinical Health Act amplify privacy practices, with particular emphasis on breach notification. The breach notification provisions include detailed regulations touching on the following issues:

- Notification of individuals if there is significant risk of financial, reputational, or other harm

- Time frames and manner of notification
- Tracking and reporting
- Internal compliance monitoring systems

As an unexpected positive outcome of HIPAA-related actions, the health information management environment has been primed to undertake major efforts in expanding electronic health records.

A Study in Proactive Change: Electronic Health Records

Implementation of electronic health records reflects a proactive approach to change. The application of technology to enhance the creation and use of healthcare information has been a welcome advance. The migration from hard copy records and systems to automated ones represents change, both incremental and rapid. Data gathering and analysis via punched cards in the early 1960s was a precursor of advances to come. As the country became accustomed to electronic capture, exchange, and use of information as a result of the new technology (the credit card—easy to use, easy to carry), smart cards with embedded personal health information were a highlight in the early 1970s. Why not apply the same idea to one's personal information? Applications of smart cards in the late 1980s included patient's use of interactive behavioral healthcare protocols. Throughout this period, automated and outsourced administrative processes were adopted readily. The Y2K events occasioned a thorough review of systems. Advances in technology, plus related legislation in favor of electronic health records, have resulted in rapid change and a cascade of changes. Note, by way of example, the adoption of Health Level-7 standards, the creation of a national health information technology coordinator and the national health information technology plan, and such specific legislation as the Medical Modernization Act and its mandates concerning electronic prescription systems.

The electronic health record incentive program provided an additional catalyst for the adoption of this massive system change. Yes, the technology is continually evolving, but the underlying principle is enduring: quality health information for use in patient care, research, and administrative support. Legislative mandates requiring universal adoption of electronic health records further reinforce this ongoing professional mission.

Health information practitioners have taken leadership roles in their workplaces and through their national association, AHIMA, along with its state component organizations. A strategy for proactive engagement with these changes was developed and continues to be applied as the migration from hard copy to electronic information systems unfolds. The overall strategy has six features:

1. Individual initiative within the workplace
2. Advocacy in the public arena
3. Partnership with key stakeholders
4. Outreach to clients and patients
5. Continual adjustments to information systems
6. Reassessment of health information management job roles and credentialing

Individual Initiative

Within the workplace, individual health information managers have steadily adopted computer technology to support basic operations. Workflow and processes have been gradually converted over time, including automated master patient indexes, coding and reimbursement processes, digital imaging, and speech recognition dictation. Internal administrative systems have served as building blocks for the expansion of computerized systems to include electronic health records. Although individual initiative continues to be an important facet of this transition, fostering change through advocacy has been primarily an organized group effort through the national association, AHIMA.

Advocacy in the Public Arena

External forces, particularly law and regulation, are affecting the process of developing electronic health records. It is essential, then, that professional practitioners help shape the debate, contributing their knowledge and expertise through organized efforts. Regular interaction with lawmakers and regulatory agency officials has been central to this process. Participation in work groups, task forces, and special initiatives has been steady. Landmark events bear the imprint of such involvement, including the Centers for Disease Control and Prevention's Public Health Information Network to implement the Consolidated Health Informatics standards, the Public Health Data Standards Consortium, the Department of Health and Human Services (DHHS), the American Health Information Community and its initiatives toward creating a national health information network, and the Certification Commission for Healthcare Information Technology.

Partnerships with Key Stakeholders

The health information profession has long been the authoritative source of practice standards. With the

advent of electronic health records, many of the questions that have arisen are variations of issues with which health information management practitioners have successfully dealt. Those experiences have prepared these practitioners to offer guidance in such areas as documentation content and standardization, authentication of documentation, informed consent, accuracy of patient information, access and authorized use of data, and data security.

AHIMA has developed a series of position papers, statements of best practices, and guidelines for these and related topics. This organization has strengthened its efforts through partnership with key stakeholders, as the following examples demonstrate

- American Health Information Community (DHHS): standards for electronic health data
- American Medical Informatics Association: data standards
- Medical Group Management Association: performance improvements and need for consistent data standards
- National Library of Medicine: data mapping (e.g., Systematized Nomenclature of Medicine and International Classification of Disease interface)
- American Society for Testing and Materials and its committee on health informatics: core data elements and definitions
- Corporate partner industry briefings: cosponsored exchange sessions
- As major initiatives move forward with the implementation of the EHR, AHIMA has partnered with governmental and private groups to develop guidelines regarding the interoperability of systems. Issues relating to digital degrading over time (an unknown factor) also constitute areas of common interest. Some of the organizations are Work group for Electronic Data Exchange (WEDI), The Institute of Electrical and Electronic Engineers and their continuing project on Health Level–7 standards, The American Medical Informatics Association, and the CMS's guidelines on Promoting Interoperability Program. IT vendors associations also constitute active participants.
- Regional Health Information Exchanges (RHIE) provide coordination among healthcare providers (e.g., physicians, hospitals, nursing homes) who enter into an agreement to share electronic health records among the RHIE. Having obtained patient consent to share information in this manner helps to foster rapid access to their information, avoid duplication of testing, and enhance coordination of care. AHIMA members participate in RHIE activities and help promulgate its benefits through patient education regarding consent for release of information.

Through these and similar outreach efforts, AHIMA makes available valuable guidance to those involved in adopting electronic health records.

Another major initiative by AHIMA has been the move toward open membership. In recognition of the important partnership with information technology specialists, clinicians, and others with a shared interest in health information, as well as to foster even greater teamwork, the AHIMA members voted to eliminate associate membership, moving this group into the active membership category. An open, inclusive membership provides additional strength to the association in its efforts to support the electronic health record initiative.

Outreach to Clients and Patients

Consumers are an important partner in the effective use of electronic health records. AHIMA has developed an initiative to raise public awareness of these personal health records. As part of this initiative, individual health information practitioners, using AHIMA-created presentations, interact at local and regional levels with consumer groups such as local chambers of commerce, health fair coordinators, and specialty support groups (e.g., cancer support groups). Presentations and articles by health information management professionals concerning the health information exchange or "how to" explanations about accessing an electronic health record for one's personal use have fostered patient engagement in this unfolding endeavor.

An important adjunct to this outreach is advocacy. Clients and patients must continue to have trust in the process of revealing their personal information fully and truthfully during healthcare interactions. AHIMA continues to press for specific protective legislation with a nondiscrimination focus: protect the patient from any discriminatory action stemming from documented information about patient care encounters.

Continual Adjustments to Information Systems

In summary, electronic health record initiatives reflect the best in proactive involvement by managers in facing major change. As the transition from paper to electronic records continues, AHIMA has provided position papers, best practices guidelines, and training materials including document imaging to link paper

documents to electronic health records, along with retention guidelines for postscanning management of data; "copy and paste" guidelines; making corrections, amendments, and deletions to ensure record integrity; the definition of the legal record; and e-discovery rules under federal rules of civil procedures. The transition to fully electronic records has not been accomplished. The sheer cost of a complete changeover is a prohibitive factor; however, incremental change continues. Smaller organizations such as a physician's and dentist's office might choose to continue the hybrid system until there is a natural migration to the EHR as new patients enter the system. Inpatient facilities continue to use short-form summaries, such as a discharge binder or an expanded SBAR form to facilitate the exchange of information when a patient is moved to another unit or transferred to another facility.

Reassessing Health Information Management Job Roles and Credentialing

The changing landscape of health information management job roles and functions has produced associations that periodically review this work. Such evaluation has become a more urgent priority as attention to the need to reassess both traditional jobs as well as emerging ones. Logical steps have included identifying the new configuration of jobs and role sets, identifying the associated knowledge and competencies, and developing and expanding the educational preparatory levels (associate, bachelor's, and master's degrees, as well as graduate certificate in healthcare informatics). The credentialing process has also been expanded to include new categories of specialization (e.g., Certified Documentation Improvement Practitioner, Certification in Healthcare Privacy and Security).

Economic and Market Forces: Anticipatory Readiness Through Organizational Restructuring

Sometimes an organization as a whole faces severe circumstances caused by economic and market forces. Consider the situation of a facility offering two levels of care for frail, elderly people: personal care and assisted living. This facility opened 40 years ago and has been in the same physical building since then. It has had a history of modest but steady success. An analysis of the balance sheet reflected breakeven points for 11 of the 40 years and 14 years of modest profit. Only the first few years showed yearly losses, primarily because of startup costs. Then, most recently, there was a 5-year run of steady loss and increased debt, due to increased competition in local market and to the need for expensive renovations to the 40-year old physical facility. Decreasing reimbursement rates from third-party payers added to this erosion of revenue.

To reverse this trend, the management team undertook the process of preparing the organization to survive and thrive in a new era. The team restructured the organization. It also anticipated probable changes in state law, including those leading to a decrease in skilled care beds through a buy-back provision. Decreased reimbursement for this level of care gave the organization an additional reason to convert some units to increase the size of its dementia care service. Assisted living care was discontinued. The assisted living building was converted to additional personal care and respite care, plus an adult day care center with respite care included. Telemedicine access was added to the day care component, thus providing clients easily accessible communication with physicians and other healthcare providers. Tele-appointments became an attractive feature of the center. Hours of care were expanded to cover 6:30 A.M. through 7:00 P.M., and weekend and holiday hours were offered. Comprehensive home care services, using a contractual provider, rounded out the reconfigured services. Through all of these efforts, the organization emerged from its threatened state and became a leading provider in its geographic region.

Disruption in Personal Circumstances: Revitalization Through Career Development

The individual is certainly not immune to the pressure of change. Consider the situation of the health information professional whose family circumstances require increased income over the next several years. This credentialed practitioner had been working part-time as a coding specialist in a community hospital. There were no anticipated resignations in the department management team, and internal advancement was unlikely. Furthermore, this woman needed to remain in the region for family reasons. Recognizing the constraints in her situation, she made and implemented a plan for advancement. First, she utilized the AHIMA career development and self-assessment program to identify competencies needing upgrading. While continuing to work, she undertook master's degree studies in health informatics and participated in several projects. These projects included research

in correctional facilities, juvenile detention centers, and protective service agencies. Through this health information professional's involvement in local civic activity, an opportunity developed for her to work in first local, and then regional, correctional facilities. She worked first as a part-time consultant and then as the full-time director of the health information department. Both her personal and professional goals were met.

Using the foregoing examples as background, let us now consider the theoretical aspects of organizational change.

Change and Resistance to Change

Change is inevitable, but change can also be chaotic and painful. Alfred North Whitehead once said, "The art of progress is to preserve order amid change and to preserve change amid order." That statement captures the essence of change and its effects on all of life. Much change is beneficial, even necessary, but change is often upsetting and unsettling and thus must be controlled. For good or ill, change is inevitable. So, too, is resistance to change inevitable.

This section addresses the inevitability of change, including how, as individuals, we tend to deal with change and how, as managers, we can deal with employee resistance to change. In discussing this topic, it is necessary to look at individual attitudes toward change, those of both managers and employees alike, because resistance is a human reaction that can arise in anyone regardless of organizational position. In other words, the manager who is expected to be a change agent and supportive of inevitable change may initially experience feelings of resistance equivalent to those of the employee. It is also necessary to consider how to meet change when it occurs and how to make change work.

The Collision of Constancy and Change

Up until a few decades ago, an individual could adopt a career and with few exceptions expect to remain in that career for a lifetime. The effects of the knowledge explosion and the Industrial Revolution that preceded it, however, included changes that rendered some occupations obsolete or changed them dramatically. Occupations that had existed for several generations all but vanished as machines took over work that had long been done by hand. Entire industries disappeared. For example, whaling, once an economic mainstay of the northeastern United States, shriveled and died as petroleum products replaced whale oil. Many individuals have seen their jobs and careers disappear as a consequence of change that continues to accelerate to this day.

Those working in the delivery of health care have seen and are seeing new medical technologies arise to either replace or augment existing technologies, in some instances making it necessary for workers to learn new skills or seek new occupations. Some individuals still working in diagnostic imaging were first employed when imaging was entirely X-ray; they have seen the addition of the computerized axial tomography (CAT) scan, magnetic resonance imaging (MRI), positron emission tomography (PET) scan, and other technologies. One technologist who had been employed in a hospital laboratory for 30 years observed that more than 80% of the tests she performed on a routine basis did not exist when she first entered the field. People have been conditioned by centuries of change to desire constancy or near-constancy. That, plus a natural tendency to seek equilibrium with the surroundings, conditions many people to be automatic resisters of change. They are continually attempting to preserve equilibrium with the environment, and whenever it is disturbed, they tend to take steps to reestablish that equilibrium—to return to a "comfort zone." Certainly not all people behave in the same manner, but it is likely that most people seek equilibrium with their surroundings and tend to equate security with constancy. Indeed, security was once likely to be found in adopting an occupation and doing it well for life or in remaining a loyal employee of one organization for life. No longer, however, is there security in constancy; rather, today's security, to the extent that it may exist, lies in flexibility and adaptability.

The Roots of Resistance

The principal cause of most resistance to change is the disturbance of the previously mentioned equilibrium. Resistance will, of course, be influenced considerably by one's knowledge of where a given change is coming from. It is unlikely that a person will resist a change with which he or she wholeheartedly agrees or one that is his or her own idea to begin with. The person does not resist such a change because it is welcome and, therefore, does not threaten one's equilibrium. Thus, it is not change itself that people resist but rather *being changed*—being made to change by forces or circumstances outside of themselves.

A secondary major cause of resistance lies in the inability of people to mentally conceive of certain possibilities or think beyond the boundaries of what they presently know or believe. The limitations imposed by what people know and what they believe can provide significant barriers to creativity and progress. Ideas that are today deemed revolutionary were not originally welcomed with open minds. Many people we have come to think of as innovators and visionaries were, in their day, regarded as dreamers, charlatans, or crackpots. Here are four examples.

1. Barely 2 months before the Wright brothers flew, a noted scientist publicly explained why a heavier-than-air flying machine could never work. However, the brothers went ahead and flew anyway; they had an advantage in not knowing "it couldn't be done."
2. A device called a "telephone" was branded a fraud, with an "expert" proclaiming that even if it were possible to transmit human voice over wires, the device would have no practical value.
3. When television was new, the head of a major Hollywood studio proclaimed that people would soon get tired of staring at a plywood box every night.
4. Even in the field of medicine, change has often been thought impossible: in 1837, leading British surgeon Sir John Erichson stated that the abdomen, the chest, and the brain would "forever be shut from the intrusion of the wise and humane surgeon." Note as well that many people alive today once thought that surgery on a living heart would never be possible.

To a considerable extent, then, the roots of resistance to change are within human beings themselves.

Primary Causes of Resistance

Concerning change that occurs in the workplace, people tend to be thrown off balance by changes that are thrust on them and especially by the way in which many of these changes are introduced. Common sources of change in the work organization occur in many areas:

- Organizational structure, when departments are altered or interdepartmental relationships or management reporting relationships are changed, including the changes that result from merger, affiliation, or system formation
- Management, whether in a department, a division, or an entire organization
- Product or service lines, as services are added, dropped, or altered significantly
- Introduction of new technology, bringing with it new equipment that employees must learn to use
- Job restructuring, altering the duties of particular jobs, such as combining jobs that were formerly separate
- Methods and procedures, requiring workers to learn new ways of doing their jobs
- The organization's policies, especially personnel policies affecting terms and conditions of employment

Consider how much—or perhaps how little—control the average rank-and-file employee or the typical department manager can exert over the foregoing changes. In most instances, the individual is essentially powerless. Managers and some employees might perhaps have a voice in restructuring jobs and altering methods and procedures, and perhaps they might be involved in selecting or recommending new equipment, but chances are they have little or no voice in the decisions necessitating such changes. It is doubtful that many employees or managers below the level of executive management have any influence on changes in products or services. And concerning the remainder of the major sources of change described—significant sources of stress and resistance for managers and employees alike—rank-and-file employees and their department managers are powerless.

Organizational Changes

Depending on the extent of reorganization, structural changes within a healthcare organization, such as combining departments or groups or realigning departments under different executives, can engender ill feelings and generate considerable resistance. Most department managers and their employees are well aware that reorganizing under any name—reengineering or downsizing—often means that some people will lose their jobs, so fear and insecurity and thus resistance increase while productivity inevitably decreases. Even more likely to upset employees are the changes accompanying merger or other form of affiliation, acquisition by a larger organization, or health system formation.

Management Changes

Changes in management are among the most potentially upsetting changes employees can experience. The stress of a management change, and thus the resistance to it, is concentrated within the hierarchy beneath the management position that is turning over; therefore, a change in department manager will affect primarily that department, whereas a change in

chief executive officer will affect the entire organization. A change in management almost always involves exchanging a known quantity for a complete or partial unknown, and it is fear and apprehension concerning the unknown that causes most initial resistance to management changes.

Policy Changes

Major changes in the policies of the organization, especially personnel policies affecting terms and conditions of employment, are likely to spark a certain amount of employee resistance, especially if employees perceive they are losing something. In these years of fiscal belt-tightening, it is not uncommon to see, for example, employers in health care and elsewhere shifting an increasing portion of ever-growing health insurance costs to employees, or reducing the corporate contribution to defined-contribution retirement plans or other investment plans, or reducing the sick-time benefit and combining the remainder with vacation and personal time in "paid time off" plans. Such policy changes have inspired so much resistance for some employers that they have become major issues in union organizing campaigns and labor contract negotiations.

Many Causes

Resistance can occur anywhere, resulting from almost any change within an organization, often arising in situations that no one had thought would prompt any objections. Times of relative turmoil in health care, with all of the fallout of "merger mania" and all of the cost-reducing and cost-saving pressures brought to bear on the healthcare delivery system, finds the healthcare worker—and the healthcare manager as well—working in an environment of intensifying change and an eroding sense of security.

Meeting Change Head-On

The healthcare department manager is in a uniquely difficult position relative to change that has an impact on the healthcare organization. As an employee, the manager is just as affected by change as the rank-and-file employees and is just as likely to feel helpless, demoralized, and resistant. Yet it is up to the manager to try to minimize the negative reactions of the work group and attempt to raise employee morale and ensure continued productivity. If the manager openly projects doom, gloom, and resistance, the staff will be all the more likely to become more deeply mired in doom, gloom, and resistance themselves, ensuring that morale and productivity both suffer. It can be a most difficult role for the manager to function as "cheerleader" when there seems to be nothing to cheer about. Yet the manager must make a conscious effort to rise above all the negative thinking. Succeeding at doing so is largely a matter of attitude, including the willingness to take a moderate amount of risk.

Flexibility and Adaptability

As noted, people can no longer find security in constancy, maintaining loyalty to the same ideas, concepts, and institutions for life. Rather, security, to whatever extent it exists today, is more likely found in flexibility and adaptability. The manager who remains rooted in place, with a fixed set of ideas and an unchanging concept of the job, will not be particularly successful; however, the manager who can move about, who can flex and adapt as circumstances change, stands a much greater chance of success. Also, to enhance the department's chances of success in adjusting to changing circumstances, the manager must be a role model for flexibility and adaptability.

A department manager may be able to help some employees increase their flexibility by instituting cross-training wherever possible. For cross-training to be effective, it is necessary that there be a number of employees distributed across multiple jobs of approximately the same skill or grade level; thus, it is not possible in every department. When cross-training is possible, however, there are benefits for employee, department, and organization alike. With people trained in multiple activities, coverage for vacations and other absences is more readily accomplished, employees get the advantages of task variety, and employees may become more secure during times of readjustment by being capable of moving into certain other jobs, already trained and competent.

A Matter of Control

The department manager who becomes caught up in a sea of change should immediately learn the difference between what can be controlled and what cannot be controlled. Much energy is wasted in trying to control that which is uncontrollable. For example, a manager may be greatly stressed about an impending merger and subsequent combination of departments, but there is nothing that the manager can do about it; it will happen whether he or she wishes it or not.

Stress as a response to change, both real and impending, is an emotional reaction. An important early step in gaining a measure of control over one's circumstances is learning to control one's emotions.

A person may have little or no control over the changes themselves; however, he or she has complete control over how one's *response* to the changes.

Fortunately, there are usually a few factors that the individual department manager can control to some extent. Reorganizing or reengineering frequently results in the need to combine positions and restructure a number of jobs—that is, change job descriptions, assignments, crew or team sizes, equipment, or later services. These actions usually entail changes in methods and procedures, changes that can be determined in detail within the department by the manager, often with the participation of the employees.

Addressing Resistance with Employees

A manager responsible for implementing change has three available avenues along which to approach employees regarding a specific change. The manager can (1) simply tell them what to do, (2) convince them of the necessity for doing it, or (3) involve them in planning for the change.

Tell Them

The use of specific orders or commands is one of the hallmarks of the autocratic or authoritarian leader. The boss is the boss, a giver of orders who either makes a decision and orders its implementation or relays without expansion or clarification the mandate from above.

The authoritarian approach is sometimes necessary; occasionally, it is the only option available under urgent or completely unanticipated circumstances. However, in most situations the "tell-them" approach is the approach most likely to generate resistance, so it should be used in only those rare instances when it is the only means available.

Convince Them

In most instances, including those in which the change in question is an absolute mandate from top management, the individual manager has room for explanation and persuasion. At the very least, there is the opportunity to try making each employee aware of the reasons for the change and the necessity for its implementation. It may be necessary for the manager to champion the cause of something clearly distasteful to all concerned (except, most likely, to those mandating compliance) because it may be good for the institution overall or good for patients, or even perhaps because it is mandated by new government regulations. The employees may not like what they are called on to do, but they are more likely to respond as needed if they know and understand why the change must be implemented.

The employees deserve all the information available, and this information often serves the manager well because it can remove the shadow of the unknown from the employees and thus lessen their resistance. Few, if any, changes cannot be approached by this means. The authoritarian "tell-them" approach should be reserved as a last resort to be used on those occasions when employees clearly cannot be "sold" on the change.

Involve Them

Whenever possible, and especially if it affects the way they do their assigned jobs, employees should become involved in shaping the details of any particular change. It has been repeatedly demonstrated that employees are far more likely to understand and comply when they have a voice in determining the form and substance of the change. For example, if new equipment is under consideration and there is sufficient lead time, it is helpful to obtain the input of the people who will have to work with the equipment once it is in place. This sort of involvement not only enhances employee cooperation but often leads to a better decision because of the perspective of the people doing the hands-on work. When expansion or remodeling will change the characteristics of the department, employee input in the planning stages will bring the workers' perspective into determining optimal layout and work flow. Through involvement, change can become a positive force. Employees will be more likely to comply because they own part of the change; in effect, a piece of it is their idea.

There is another potential benefit to involvement as well: employee knowledge of the details of the work in ways the manager may never have. The manager supervises a number of tasks, some of which he or she may have once done personally. However, the employees regularly perform in hands-on fashion the tasks the manager only oversees. Thus, the employees usually know the details of the work far better than the manager and are in a better position to provide the basis for positive change in task performance.

The numerous sources of management advice that promote the value of employee involvement are correct. The participative and consultative approaches to management are the best ways of getting things done through employees. The most effective ways of reducing or removing the fear of the unknown make full use of communication and involvement.

Guidelines for Effective Management of Change

To secure employee cooperation and participation and successfully manage change in the workplace, it is necessary for the manager to take the following steps:

- *Plan thoroughly*. Fully evaluate the potential change and examine all implications of its potential impact on the department and the total organization.
- *Communicate fully*. Completely communicate the change, starting early, ensuring that the employees are not taken by surprise. This should ideally be two-way communication, preparing the way for employees' involvement by soliciting their comments or suggestions.
- *Convince employees*. As necessary, take steps to sell employees on the value and benefits of the proposed change. When possible, appeal to employees' self-interest, letting them know how they stand to benefit from the change and how it might make their work easier.
- *Involve employees when possible*. It is not possible to completely involve employees in all matters, but involvement is nevertheless possible on many occasions. Be especially aware of the value of employees as a source of job knowledge, and tap this source not only for the acceptance of change but also for the development of improvements.
- *Monitor implementation*. As with the implementation of any decision, monitor the implementation of any change until the new way is established as part of the accepted work pattern. A new work method, dependent for its success on willing adoption by individual employees, can be introduced in a burst of enthusiasm. Do not let it die of its own weight as the novelty wears off and old habits return. New habits are not easily formed, and the employees need all the help the manager can furnish through conscientious follow-up.

True Resistance

Resistance to change will never be completely eliminated. People possess differing degrees of flexibility and exhibit varying degrees of acceptance of ideas that are not purely their own. However, involvement helps, and the manager will eventually discover, if not already having done so, that most employees are willing to cooperate and genuinely want to contribute. Beyond involvement, however, continuing communication is the key. Full knowledge and understanding of what is happening and why it is happening are the strongest forces the manager can bring to bear on the problems of resistance to change. Ultimately, one will discover that it is not change that people resist so much as they resist *being changed*.

In addition to applying the foregoing strategies, managers facilitate their response to change by

1. Recommitting to the full spectrum of their role through a review of the enduring functions of the manager
2. Remaining attentive to
   - Developments in the history of management and the ways in which managers adjusted their focus from time to time
   - Shifts in organizational life from informal to formal, stable organizational patterns
   - Opportunities for building a strong network of internal and external relationships

One More Challenge: The Patient Protection and Affordable Care Act of 2010

The major legislation known as the Patient Protection and Affordable Care Act of 2010 (PPAC), more commonly referred to as the Affordable Care Act (ACA), affects the healthcare system at all levels. Middle managers often need to use the strategies described in this chapter to deal with the massive changes associated with this legislation focusing on the provision of affordable care and healthcare reform. They need to take into account the political aspects of the legislation's passage, which has led to further amendments, deletions, and changes in its implementation time frame. The federal mandates, in turn, generated companion state-level legislation. More than 100 regulatory agencies, boards, and councils are empowered to issue guidelines and mandatory regulations. The designated time frame for the implementation of the federal law was from 2010 to 2018. Thus, there has been an almost decade-long period of sustained change, with continuing change being a regular feature going forward.

The manager who has a positive attitude will more easily respond to these challenges than one who is resistant. Flexibility, creativity, and attentiveness to the unfolding mandates—these traits will serve the manager well. A commitment to factual analysis will

lead the manager to develop a system for monitoring the details of this law. For guidance, the manager should turn to trusted sources, such as professional associations—especially these organizations' legislative divisions, which monitor primary documents such as federal and state regulation publications. The manager might partner with several peers in the work setting to study the unfolding mandates and share insight about their impact.

Following is a suggested template for use in tracking these changes. A few examples are included under the headings as a starter.

- Impact on the organizational setting
  - Increase in community health centers
  - Development of independence-at-home programs
  - Creation of community-based transition programs for Medicare patients at high risk for readmission to acute care
  - Phasing out of physician-owned specialty hospitals
  - Increase in use of observation units as a bridge between emergency care and admission/readmission to inpatient care
- Patterns of care
  - Increase in use of outcome measurement for clinical effectiveness research
  - Implementation of wellness programs and preventive care (e.g., smoking cessation counseling)
  - Wellness care incentives
  - Increased emphasis on coordination of care for all stages of care, with particular attention to discharge planning and reduction of preventable readmission within 30 days
  - Creation of medical homes or health homes programs (i.e., a decentralized coordinator of care) for chronic illness care. (*Note*: The term *homes* is not used to denote a place to live; in this context, it means the primary caregiver who coordinates various aspects of care including referrals to specialists.) The expanded role of the nurse navigator as coordinator of posthospital care is associated with the medical home or medical hub concept.
- Practitioners
  - Increased funding for training
  - Increased utilization of physician assistants and nurse practitioners
  - Increased roles for pharmacists in direct counseling of patients concerning medication management
- Clients
  - Increased numbers as individuals come under new health insurance coverage
  - Surge in demand for specific services as coverage for these services unfolds (e.g., free annual physical examination)
  - Increased need for client education about the details of coverage and the time frames associated with various benefits (e.g., preexisting conditions coverage and its limits)
  - Increased need to capture eligibility data (e.g., income levels, prescription medication expenses for the benefit period, Medicare or Medicaid coverage)
  - Increased sensitivity to patients' concerns about their coverage and their continued access to care. This involves the development of trusted adviser contacts who assist clients with their understanding of their eligibility for, and coverage options, with regard to healthcare insurance plans
- Employees
  - Need for timely information about changes in health insurance coverage, copayments, and deductibles
  - Need for annual information (on W-2 forms) about the dollar value of the health insurance fringe benefit
  - Concern for job security when the organizational setting changes
  - Questions about job rotation (e.g., if mergers occur or if community-based programs are developed, will the employee be obliged to rotate among various geographic locations?)
  - Need for more frequent continuing education (e.g., intake processing and health insurance questions)
- Specific systems impact
  - Budget adjustments to include resources for more frequent continuing education
  - Increase in fraud detection processes
  - Increase in patient-centered outcomes standards research and studies
  - Increase in monitoring of discharge planning, coordination of care, readmission rates, and supportive rationale

A Template for Assessing Health Insurance Proposals

Health insurance proposals will be offered with predictable regularity such as during national election candidate selection. Associations involved in healthcare provision will continue their efforts at health insurance reform. In assessing proposals, and their potential impact on the managers' responsibilities and concerns, a useful template to follow is this.

1. *Extent of coverage*: inpatient care; outpatient care both hospital-sponsored and free-standing; telemedicine/e-health interactions; long-term care, rehabilitation, hospice, home care; comprehensive coverage from prenatal to end of life; catastrophic care only
2. *Method of financing*: general taxation; payroll tax, similar to Social Security; tax credits; surcharge on natural resources; luxury tax; copayments and deductibles
3. *Federal-state government relationship*: Worker Compensation model; Medicare-Medicaid model
4. *Relationship to existing programs*: all phased out completely and replaced with an entirely new system; building on/expanding and coordination with existing programs such as private insurance, managed care, medical sharing groups, and county and city hospitals and clinics; Medicare and Medicaid
5. *Methods of review and control*: utilization review; quality monitoring; financial audits; healthcare planning agencies, with approval/disapproval power; cost-containment requirements; uniform billing
6. *Organizational form to administer the over-all program*: existing framework (e.g., DHHS, or CMS); government-sponsored HMO; the public utility model with franchises and licensure and rate-control features; public corporation

The manager constantly attends to change, meets it through managing the organization through its life cycle, uses strategies for organizational adaptation and survival, and strengthens the organization's relationships with key constituents and stakeholders. These concepts are discussed in subsequent chapters.