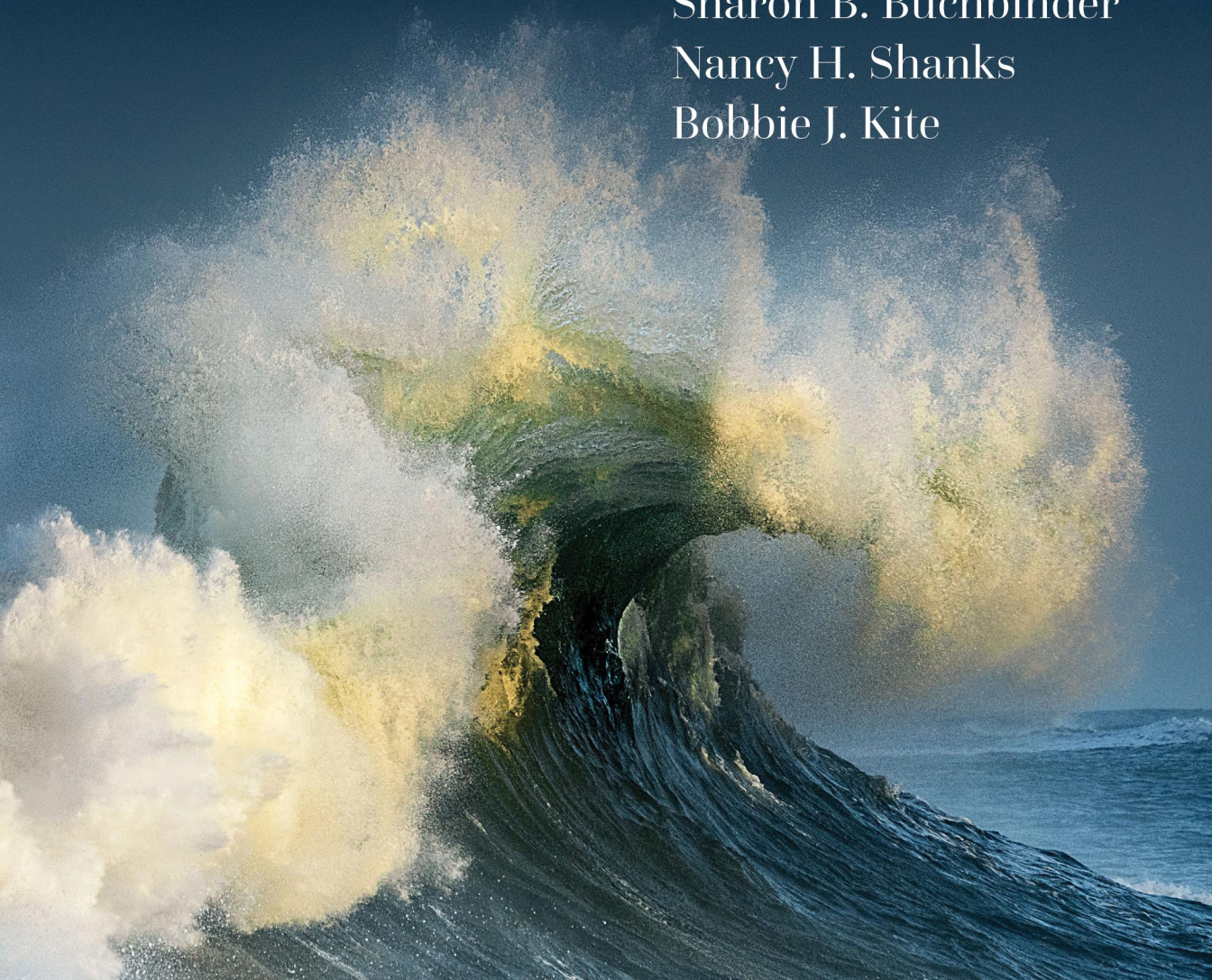
FOURTH EDITION

INTRODUCTION TO Health Care Management

Sharon B. Buchbinder
Nancy H. Shanks
Bobbie J. Kite



FOURTH EDITION

INTRODUCTION TO Health Care Management

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We dedicate this book to our loving spouses,
Dale Buchbinder, Rick Shanks, and Casey Kite—
Who coached, collaborated, and coerced us to
"FINISH THE FOURTH EDITION!"

Contents

Foreword

Effective learning occurs when students are engaged and inspired. Effective teaching creates the environment for engagement and inspiring thought. *Introduction to Health Care Management, fourth edition,* is a comprehensive text that covers essential content material and provides an extensive variety of cases to stimulate thought. The revisions in this edition are timely and extend the learning that is possible about the health care industry. Students and instructors will benefit from the expertise shared in this text.

Health care is complex, and management of its delivery entails a breadth and depth of knowledge, skill, and ability. The responsibility of implementing service, coordinating those providing it, and ensuring the quality of care is the mantle of the health care manager. It is imperative that both the clinical and business aspects of service and patient care are understood and closely monitored. Leaders rely on the knowledge and skill of competent managers to make informed decisions. Management requires a deep understanding of multiple functions and processes while also leading people from a variety of disciplines in a multitude of roles. Mentorship of managers is part of the developmental process of leaders. A good foundation for health care management is the start of lifelong learning and career development.

The knowledge of management science with an interdisciplinary foundation is needed to succeed in the ever-changing health care industry. The demand for health care coverage is constantly in the news. Working with teams of professionals to provide quality care that is cost-effective is an ongoing challenge for health care managers. This text lays the groundwork of a health care management curriculum; other courses may add depth and can benefit from the breadth of the cases in this text.

Population health, community well-being, and medical care delivery are growing fields where excellent management makes a difference. Management responsibility of care extends outside the walls of an organization. One is now managing the health of the population they serve. The continuum of care includes collaboration across various service modalities. This text is not just hospital-based and includes settings that span the continuum of care. The span of specialty care from obstetrics to gerontology takes coordination to ensure that it is safe, timely, efficient, effective, equitable, and patient-centered, the aims of the Institute of Medicine. The aging of a population that wants to remain independent is changing all aspects of health care, especially long-term care. From pre-conception and birth to end of life and death, health care management is all-encompassing.

To be successful as a manager one needs to focus on creating the right culture. In an environment of new, disruptive technologies, communication is critically important for people to keep learning and experimenting with new knowledge, products, and processes. Keeping up with a culture of change and innovation while building on a traditional foundation takes skill and diligence. In addition, disparities that exist must be acknowledged and addressed. The new edition of this text

incorporates information management that will help to invest in culture. Good, constant, and credible communication takes skilled managers to accomplish. A positive and productive culture is dependent on open and transparent communication.

A manager needs to be prepared for any eventuality. Planning for disasters and emergencies is much more than fire or air raid drills or having an evacuation plan. Extreme weather, mass shootings, chemical and biological exposures, infectious disease outbreaks, and ED diversion, for example, are all too common occurrences. Communities and health care institutions are more vulnerable when panic or chaos is the initial reaction. Plans that are known, practiced, and updated are the hallmark of a well-positioned organization if or when the no longer unexpected happens. The new edition of this text helps instructors further develop student competence in strategy and planning.

The text is already a classic and serves as a reference for many who learned from early editions. It is a resource for faculty as well as a foundational text for practitioners transitioning to supervisory roles. Each new edition builds on the prior and is improved with new contributions.

Exceptional management is all about being able to tell stories. A story engages, and to be memorable is inspirational. The authors of this text are master story crafters. Drs. Buchbinder, Shanks, and Kite and their contributors have woven together a comprehensive yet concise guidebook for an entry level manager. Whether new to health care, or an experienced clinician transitioning to management, the content is clear, and the stories resonate. This text is so readable because it tells stories and urges the reader to solve cases with the intent to teach the learner to create their own stories by managing complex situations.

When the last page is read, and the cover is closed—or the eBook is shut down—the theories and cases within will serve as the underpinning for the stories to be told by the next generation of health care managers.

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Preface

The fourth edition of *Introduction to Health Care Management* is driven by our continuing desire to have an excellent text that meets the needs of the health care management field, health care management educators, and students enrolled in health care management programs around the world. The inspiration for the first edition of this book came over a good cup of coffee and a deep-seated unhappiness with the texts available in 2004. This edition builds on the strengths of the first three editions and is based an ongoing conversation with end users—instructors and students—from all types of higher education institutions and all types of delivery modalities. Whether your institution is a traditional "bricks and mortar" school or a fully online one, this book and its ancillary materials are formatted for your ease of use and adoption.

For this edition, many of the same master teachers and researchers with expertise in each topic revised and updated their chapters. A third editor, Bobbie Kite, joined the Buchbinder/Shanks team for this new edition in an effort to bring greater knowledge of several increasingly important areas in the health field, bringing expertise in health information systems and population health. Several other new contributors stepped forward to revise several chapters and write completely new cases for this text. This was the result of our listening to you, our readers and users. With a track record of more than 12 years in the field, we learned exactly what did or did not work in the classrooms and online, so we further enhanced and refined our student- and professor-friendly text. We are grateful to all our authors for their insightful, well-written chapters and our abundant, realistic case studies.

As before, this text will be useful to a wide variety of students and programs. Undergraduate students in health care management, nursing, public health, nutrition, athletic training, and allied health programs will find the writing to be engaging. In addition, students in graduate programs in discipline-specific areas, such as business administration, nursing, pharmacy, occupational therapy, public administration, and public health will find the materials both theory-based and readily applicable to real-world settings. With a combined five decades of experience in higher education, we know first and foremost that teaching and learning are *not* solo sports, but a team effort—a *contact* sport. There must be a give-and-take between the students and the instructors for deep learning to take place. This text uses active learning methods to achieve this goal. Along with lively writing and content critical for a foundation in health care management, this new edition continues to provide realistic information that can be applied immediately to the real world of health care management. In addition to revised and updated chapters from the prior edition, there are learning objectives, discussion questions, and case studies included for each chapter, with additional instructors' resources online and Instructor's Case Guides for each case study. PowerPoint slides, test bank items, and research sources are also included for each chapter, as well as an updated glossary.

A sample syllabus is also provided. Specifically, this edition contains:

- Significantly revised chapters on quality improvement, health information systems and technologies, law and ethics, and health care regulation and compliance.
- Revisions and updates have been made to all chapters, including current data and recent additions to the literature.
- There is continued emphasis on research that is on-going in each of the areas of health care.
- The chapter on emerging issues in health care management that was new to the third edition has been updated in some areas and revised in other areas to include the following topics: re-emerging outbreaks, vaccine preventable diseases, and deaths; violence in health care settings; mental illness, substance use disorders, and federal legislation; and emergency and disaster management.
- There are 42 cases or exercises in the last chapter; 34 are new for this edition with a wider variety of settings than in our previous edition. Six exercises focus on a variety of topics, including reviving the art of letter writing, addressing gun violence as a public health issue, addressing the opioid epidemic as a public health problem, addressing politics and policy, how to write an email, and how to do informational interviewing. The cases cover a wide variety of settings and an assortment of health care management topics. At the end of each chapter in the text, at least one specific case study and/or exercise is identified and linked to the content of that chapter. Many chapters have multiple cases.
- Case guides for these cases are again included in the online materials for this edition. These will be beneficial to instructors as they evaluate student performance and will enable professors at every level of experience to hit the ground running on that first day of classes.
- The test banks for each chapter have been totally revised, providing larger pools of questions and addressing our concerns that answers to the previous test banks could be purchased online.

Never underestimate the power of a good cup of joe. We hope you enjoy this book as much as we enjoyed revising it. May your classroom and online discussions be filled with active learning experiences, may your teaching be filled with good humor and fun, and may your coffee cup always be full.

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Acknowledgments

This fourth edition is the result of what has now been a 15-year process involving many of the leaders in excellence in undergraduate health care management education. We continue to be deeply grateful to the Association of University Programs in Health Administration (AUPHA) faculty, members, and staff for all the support, both in time and expertise, in developing the proposal for this text, and for providing us with excellent feedback for each edition.

More than 20 authors have made this contributed text a one-of-a-kind book. Not only are our authors expert teachers and practitioners in their disciplines and research niches, they are also practiced teachers and mentors. As we read each chapter and case study, we could hear the voices of each author. It has been a privilege and honor to work with each and every one of them: Rachael Akshar, Trina Armstrong, Mark Arvisais, Brooke Barclay, Jodie Bell, Ellen Breckenridge, Dale Buchbinder, Robert Casanova, Susan Casciani, Donna Cox, Stephen Duarte, Matthew Dyer, Anna Kayes, Jihan Mahmoud, Sheila McGinnis, Lea Nolan, Lou Rubino, Sharon Saracino, Nancy Sayre, Jon Thompson, and Stephanie Williams.

And, finally, and never too often, we thank our spouses, Dale Buchbinder, Rick Shanks, and Casey Kite who listened to long telephone conversations about the book's revisions, trailed us to meetings and dinners, and served us wine with our whines. We love you and could not have done this without you.

About the Editors

Sharon B. Buchbinder, RN, PhD, is currently Professor and Program Coordinator of the MS in Healthcare Management Program at Stevenson University in Stevenson, Maryland. Prior to this she was professor and chair of the Department of Health Science at Towson University and president of the American Hospital Management Group Corporation, MASA Healthcare Co, a health care management education and health care delivery organization based in Owings Mills, Maryland. For more than four decades, Dr. Buchbinder has worked in many aspects of health care as a clinician, researcher, association executive, and academic. With a PhD in public health from the University of Illinois School of Public Health, she brings this blend of real-world experience and theoretical constructs to undergraduate and graduate face-to-face and online classrooms, where she is constantly reminded of how important good teaching really is. She is past chair of the Board of the Association of University Programs in Health Administration (AUPHA) and coauthor of the Bugbee-Falk Award-winning *Career Opportunities in Health Care Management: Perspectives from the Field.* Dr. Buchbinder also coauthored *Cases in Health Care Management* with Nancy Shanks and Dale Buchbinder.

Nancy H. Shanks, PhD, has extensive experience in the health care field. For 12 years, she worked as a health services researcher and health policy analyst and later served as the executive director of a grant-making, fundraising foundation that was associated with a large multihospital system in Denver. This was followed by more than 20 years as a health care administration educator at Metropolitan State University of Denver, where she has taught a variety of undergraduate courses in health services management, organization, research, human resources management, strategic management, and law. Dr. Shanks developed the first online health care management course at Metropolitan State and was instrumental in moving the HCM undergraduate degree online. She is currently an Emeritus Professor of Health Care Management, after serving as chair of the Department of Health Professions for 7 years and as an affiliate faculty member for 5 years. Dr. Shanks's research interests have focused on health policy issues, such as providing access to health care for the uninsured.

Bobbie Kite, PhD, MHS is currently the Academic Director of the Healthcare Management program, and an Associate Professor at the University of Denver. Prior to the University of Denver, Dr. Kite was at The Ohio State University Wexner Medical Center, where she served as a postdoctoral fellow for the National Library of Medicine and then as a Clinical Assistant Professor in the field of Biomedical Informatics and a consultant with The Ohio State University Health Plan. With an avid interest in teaching, community collaboration, and research, Dr. Kite has a passion for teaching and also maintains her research focused on population health. Before entering the field of biomedical informatics, Dr. Kite earned her doctorate degree in Public Health from the University of Texas Health Science Center, with minors in epidemiology and health policy. She also holds a Master's in Health Science with a focus on emergency and disaster management.

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CHAPTER 1

An Overview of Health Care Management

Jon M. Thompson,
Sharon B. Buchbinder,
Nancy H. Shanks, and
Bobbie Kite

LEARNING OBJECTIVES

By the end of this chapter, the student will be able to:

Define health care management and the role of the health care manager;
Differentiate among the functions, roles, and responsibilities of health care managers;
Compare and contrast the key competencies of health care managers; and,
Identify current areas of research in health care management.

Introduction

Any introductory text in health care management must clearly define the profession of health care management and discuss the major functions, roles, responsibilities, and competencies for health care managers. These topics are the focus of this chapter. Health care management is a growing profession with increasing opportunities in both direct care and non–direct care settings. As defined by Buchbinder and Thompson (2010), **direct care settings** are "those organizations that provide care directly to a patient, resident or client who seeks services from the organization" (pp. 33–34). Direct care organizations include inpatient care settings such as general community hospitals and specialty hospitals; behavioral and substance abuse treatment centers; outpatient facilities including physician, dentist, and chiropractic practices; clinics; ambulatory care and urgent care settings; laboratories; imaging; and long-stay facilities such as residential treatment centers,

group homes for people with disabilities, nursing homes, and assisted living facilities. **Non–direct care settings** are not directly involved in providing care to persons needing health services, but rather support the care of individuals through products and services made available to direct care settings. Traditional non–direct care settings include durable medical equipment suppliers, medical device sales, health care accountants and auditors, compliance officers, marketing firms, medical billing and revenue recovery companies, pharmaceutical and health insurance companies—including state, local, and federal ones—nutrition and fitness firms, big data analytic and population health management companies, consulting firms, and associations. Alternative non–direct care settings now include using consumer items and companies for nutrition tracking, wearable devices, and personal coaching. As population health continues to expand, the line between the health care delivery systems and the health industry increasingly blurs. What sets these alternative non–direct care companies apart is the difference in billing. Where in traditional non–direct care settings, billing is still very tied to insurance, alternative non–direct care companies are mostly self-pay with only some services being covered by traditional insurance.

Per the Bureau of Labor Statistics (BLS, 2017):

> Employment in the health care and social assistance sector is projected to add nearly 4.0 million jobs by 2026, about one-third of all new jobs. The share of health care and social assistance employment is projected to increase from 12.2 percent in 2016 to 13.8 percent in 2026, becoming the largest major sector in 2026 (p. 4, para. 1).

FIGURE 1-1 illustrates these projections in relations to other industries.

"Employment of healthcare occupations is projected to grow 18 percent from 2016 to 2026 adding about 2.4 million new jobs. This projected growth is mainly due to an aging population, leading to greater demand for healthcare services" (BLS, 2018a, Para. 1). The Bureau of Labor Statistics (2018b) indicates health care management, specifically, is one of the fastest-growing occupations within health care occupations, due to the expansion and diversification of the health care industry. The BLS projects that employment of medical and health services managers is expected to grow 21% from 2016 to 2026, faster than the average for all occupations (BLS, 2018b). As can be seen in **FIGURE 1-2**, the fastest growth is in health care support occupations.

Health care managers are expected to be needed in both inpatient and outpatient care facilities, with the greatest growth in managerial positions occurring in outpatient centers, clinics, and physician practices. In addition, as the line between the health care delivery systems and the health industry continues to blur, the scope for health care managers increases. Hospitals, too, will experience a large number of managerial jobs because of the hospital sector's large size. In addition, many new roles will grow out of the continuous changes in the health care system itself, jobs for which we don't even have titles at this time—because health care organizations don't know they will need them. Many of these opportunities will be in integrated health systems, where health facilities have affiliated or merged to create a continuum of care. Moreover, these estimates do not reflect the significant growth in managerial positions in non–direct care settings delineated above. These non–direct care settings provide significant assistance to direct care organizations, and since the number of direct care managerial positions is expected to increase significantly, it is expected that growth will also occur in managerial positions in non–direct care settings.

Health care management is the profession that provides leadership and direction to organizations that deliver personal and consumer health services and to divisions,

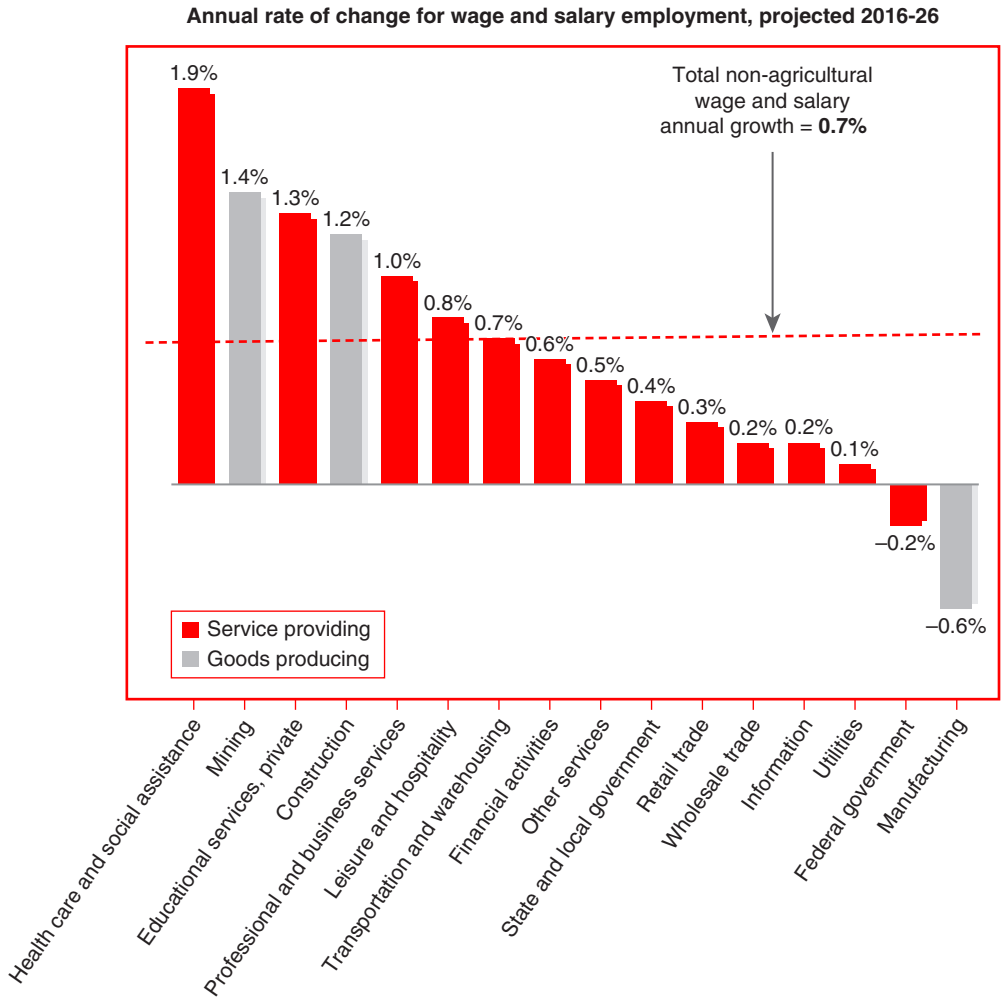

FIGURE 1-1 Projected Percent Change in Industry Employment, 2016–26

Source: Bureau of Labor Statistics. (2017, October 24). Employment projections, 2016–2026. News release.

departments, units, or services within those organizations; those organizations will include the direct care settings, as well as traditional and alternative non–direct care settings listed above. Like other professions, health care management is characterized by formal education and training, common values, specialized knowledge and skills, professional development, credentialing, and continuing education. Health care management provides significant rewards and personal satisfaction for those who want to make a difference in the lives of others. This chapter gives a comprehensive overview of health care management as a profession. Understanding the roles, responsibilities, and functions carried out by health care managers is important for those individuals considering the field to make informed decisions about the "fit." This chapter provides a discussion of key management roles, responsibilities, and functions, as well as management positions at different levels within health care organizations. In addition, descriptions of supervisory level, mid-level, and senior management positions within different organizations are provided.

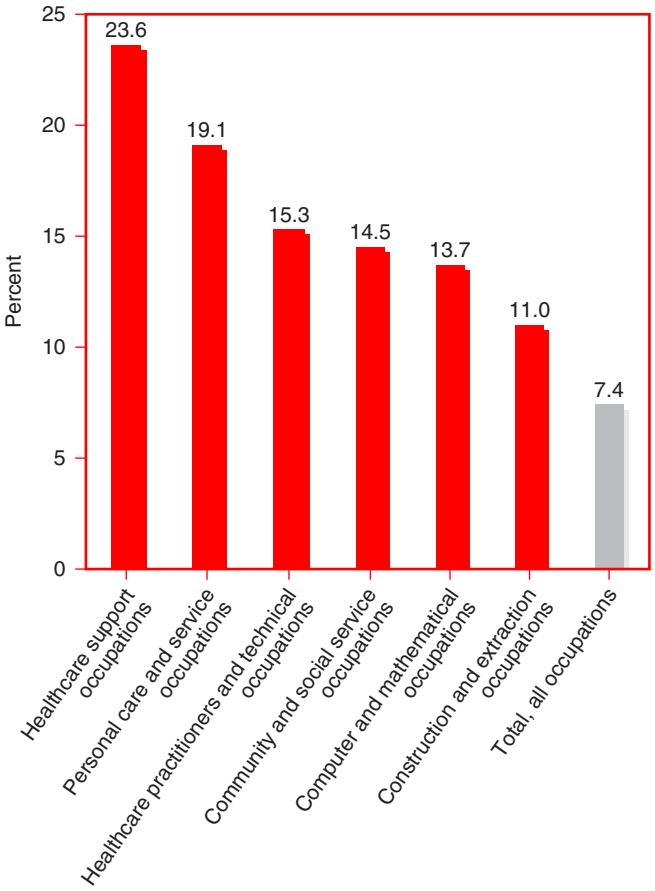

FIGURE 1-2 Projected Percent Change, by Select Occupational Groups, 2016–26

Source: Bureau of Labor Statistics. (2017, October 24). Employment projections, 2016–2026. News release.

The Need for Managers and Their Perspectives

Health care organizations are complex and dynamic. Whether these organizations are health care delivery or consumer driven, their nature requires that managers provide leadership, as well as the supervision and coordination of employees. Organizations were created to achieve goals beyond the capacity of any single individual. In health care organizations, the scope and complexity of tasks carried out in provision of services are so great that individual staff operating on their own could not get the job done. Moreover, the necessary tasks in producing services in large health care organizations require the coordination of many highly specialized disciplines that must work together seamlessly. Managers are needed to ensure organizational tasks are carried out in the best way possible to achieve organizational goals and that appropriate resources, including financial and human resources, are adequate to support the organization. This is true of smaller consumer driven health care organizations, as well.

Health care managers are appointed to positions of authority, where they shape the organization by making important decisions.

Such decisions relate, for example, to recruitment and development of staff, acquisition of technology, service additions and reductions, and allocation and spending of financial resources. Decisions made by health care managers not only focus on ensuring that the patient receives the most appropriate, timely, and effective services possible, but also address achievement of performance targets that are desired by the manager. Ultimately, decisions made by an individual manager impact the organization's overall performance. When thinking about the population health and consumer industry, this is especially important due to the influence a health care manager can have on strategy and collaboration.

Health care in the U.S. is provided across a continuum of care, from cradle to grave and from home to hospice, with individual patients moving on, off, and/or along the continuum as they have needs for care. **TABLE 1-1** is an overview of this complex system, showing education/research, suppliers, insurers, providers, payers, and government in their siloes, underscoring the difficulties inherent in interconnecting these disparate entities that form our health care system. The provider column in this table is not exhaustive. There are many other places where people receive health care, including but not limited to, mobile facilities, retailers such as department stores and pharmacies, and wellness and fitness centers. The individual pieces of the health care continuum puzzle do not always fit together well, which makes connecting these pieces a complicated, complex, and challenging job for health care managers.

Within provider settings, managers must consider two domains as they carry out various tasks and make decisions (Thompson, 2007). These domains are termed external and internal domains (see **TABLE 1-2**). The **external domain** refers to the influences, resources, and activities that exist outside the boundary of the organization but that significantly affect the organization. These factors include community needs, population characteristics, and reimbursement from commercial insurers, as well as government plans, such as the Children's Health Insurance Plans (CHIP), Medicare, and Medicaid. The **internal domain** refers to those areas of focus that managers need to address on a daily basis, such as ensuring the appropriate number and types of staff, financial performance, and quality of care. These internal areas reflect the operation of the organization where the manager has the most control. Keeping the dual perspective requires significant balance and effort on the part of management in order to make good decisions.

Management: Definition, Functions, and Competencies

As discussed earlier, management is needed to support and coordinate the services provided within health care organizations. **Management** has been defined as the process, comprised of social and technical functions and activities, occurring within organizations for the purpose of accomplishing predetermined objectives through human and other resources (Longest, Rakich, & Darr, 2000). Implicit in the definition is that managers work through and with other people, carrying out technical and interpersonal activities to achieve the desired objectives of the organization. Others have stated that a manager is anyone in the organization who supports and is responsible for the work performance of one or more other persons (Lombardi & Schermerhorn, 2007).

While most beginning students of health care management tend to focus on the role of the senior manager or lead administrator of an organization, it should be realized that management occurs through many others who may not have "manager" in their position title. Examples of some of these managerial positions in health care organizations include supervisor, coordinator, and director, among others (see **TABLE 1-3**). These levels of managerial control are discussed in more detail in the next section.

TABLE 1-1 The Complexity of Health Care Delivery

Education/Research	Suppliers	Insurers	Providers	Payers	Government
Medical schools Dental schools Nursing programs Physician assistant programs Nurse practitioner programs Physical therapy, occupational therapy, speech therapy programs Research organizations Private foundations U.S. Public Health Service (Agency for Healthcare Research and Quality, Agency for Toxic Substances and Disease Registry, Centers for Disease Control and Prevention, Food and Drug Administration, Health Resources and Services Administration, Indian Health Service, National Institutes of Health, Substance Abuse and Mental Health Services Administration) Professional associations Trade associations	Pharmaceutical companies Multipurpose suppliers Biotechnology companies	Managed care plans Blue Cross/ Blue Shield plans Commercial insurers Self-insured employers Medicare Medicaid Veterans Affairs Tricare	***Preventive Care*** Health departments ***Primary Care*** Physician offices Community health centers Dentists Nonphysician providers ***Subacute Care*** Subacute care facilities Ambulatory surgery centers ***Acute Care*** Hospitals ***Auxiliary Services*** Pharmacists Diagnostic clinics X-ray units Suppliers of medical equipment ***Rehabilitative Services*** Home health agencies Rehabilitation centers Skilled nursing facilities ***Continuing Care*** Nursing homes ***End-of-Life Care*** Hospices ***Integrated*** Managed care organizations Integrated networks	Blue Cross/ Blue Shield plans Commercial insurers Employers Third-party administrators State agencies	Public insurance financing Health regulations Health policy Research funding Public health

Source: Shi, L. & Singh, D.A. (2019). Delivering Health Care in America, 7th ed., p. 3.

TABLE 1-2 Domains of Health Services Administration

External	Internal
Community demographics/need	Staffing
Licensure	Budgeting
Accreditation	Quality services
Regulations	Patient satisfaction
Stakeholder demands	Physician relations
Competitors	Financial performance
Medicare and Medicaid	Technology acquisition
Managed care organizations/insurers	New service development

Source: Thompson, J. M. (2007). Health services administration. In S. Chisolm (Ed.), The health professions: Trends and opportunities in U.S. health care (357–372). Sudbury, MA: Jones and Bartlett.

TABLE 1-3 Managerial Positions, by Organizational Setting

Organizational Setting	Examples of Managerial Positions
Physician practice	Practice Manager
	Director of Medical Records
	Supervisor, Billing Office
Nursing home	Administrator
	Manager, Business Office
	Director, Food Services
	Admissions Coordinator
	Supervisor, Environmental Services

(*continues*)

TABLE 1-3 Managerial Positions, by Organizational Setting *(continued)*

Hospital	Chief Executive Officer
	Vice President, Marketing
	Clinical Nurse Manager
	Director, Revenue Management
	Supervisor, Maintenance
Non–direct Care Settings	Director, Consumer Experience
	Director, Operations

Managers implement six management functions as they carry out the process of management (Longest et al., 2000):

Planning: This function requires the manager to set a direction and determine what needs to be accomplished. It means setting priorities and determining performance targets.

Organizing: This management function refers to the overall design of the organization or the specific division, unit, or service for which the manager is responsible. Furthermore, it means designating reporting relationships and intentional patterns of interaction. Determining positions, teamwork assignments, and distribution of authority and responsibility are critical components of this function.

Staffing: This function refers to acquiring and retaining human resources. It also refers to developing and maintaining the workforce through various strategies and tactics.

Controlling: This function refers to monitoring staff activities and performance and taking the appropriate actions for corrective action to increase performance.

Directing: The focus in this function is on initiating action in the organization through effective leadership and motivation of, and communication with, subordinates.

Decision making: This function is critical to all of the aforementioned management functions and means making effective decisions based on consideration of benefits and the drawbacks of alternatives.

In order to effectively carry out these functions, the manager needs to possess several key competencies. Katz (1974) identified key competencies of the effective manager, including conceptual, technical, and interpersonal skills. The term **competency** refers to a state in which an individual has the requisite or adequate ability or qualities to perform certain functions (Ross, Wenzel, & Mitlyng, 2002). These are defined as follows:

Conceptual skills are those skills that involve the ability to critically analyze and solve complex problems. Examples: a manager conducts an analysis of the best way to provide a service or determines a strategy to reduce patient complaints regarding food service.

Technical skills are those skills that reflect expertise or ability to perform a specific work task. Examples: a manager develops and implements a new incentive compensation program for staff or designs and implements modifications to a computer-based staffing model.

Interpersonal skills are those skills that enable a manager to communicate and work well with other individuals, regardless of whether they are peers, supervisors, or subordinates. Examples: a manager counsels an employee whose performance is below expectation or communicates to subordinates the desired performance level for a service for the next fiscal year.

Management Positions: The Control in the Organizational Hierarchy

Management positions within health care organizations are not confined to the top level; because of the size and complexity of many health care organizations, management positions are found throughout the organization. Management positions exist at the lower, middle, and upper levels; the upper level is referred to as senior management. The hierarchy of management means that authority, or power, is delegated downward in the organization, and lower-level managers have less authority than higher-level managers, whose scope of responsibility is much greater. For example, a vice president of Patient Care Services in a hospital may be in charge of several different functional areas, such as nursing, diagnostic imaging services, and laboratory services; in contrast, a director of Quality Management—a lower-level position—has responsibility for functions such as patient or product safety and quality. Furthermore, a supervisor within the Environmental Services department may have responsibility for only a small housekeeping staff, whose work is critical, but confined to a defined area of the organization. Some managerial positions, such as those discussed previously, are **line manager** positions because the manager supervises other employees; other managerial positions are **staff manager** positions because they carry out work and advise their bosses, but they do not routinely supervise others. Managerial positions also vary in terms of required education, expertise, or experience. Some positions require extensive knowledge of many substantive areas and significant working experience, and other positions are more appropriate for entry-level managers who have limited or no experience.

The most common organizational structure for health care organizations is a **functional organizational structure**, whose key characteristic is a pyramid-shaped hierarchy that defines the functions carried out and the key management positions assigned to those functions (see **FIGURE 1-3**). The size and complexity of the specific health services organization will dictate the particular structure. For example, larger organizations—such as large community hospitals, hospital systems, and academic medical centers—will likely have deep vertical structures reflecting varying levels of administrative control for the organization. This structure is necessary due to the large scope of services provided and the corresponding vast array of administrative and support services that are needed to enable the delivery of clinical services. Other characteristics associated with this functional structure include a strict chain of command and line of reporting, which ensure communication and assignment and evaluation of tasks are carried out in a linear command and control environment. This structure offers key advantages, such as specific divisions of labor and clear lines of reporting and accountability. Smaller organizations, such as

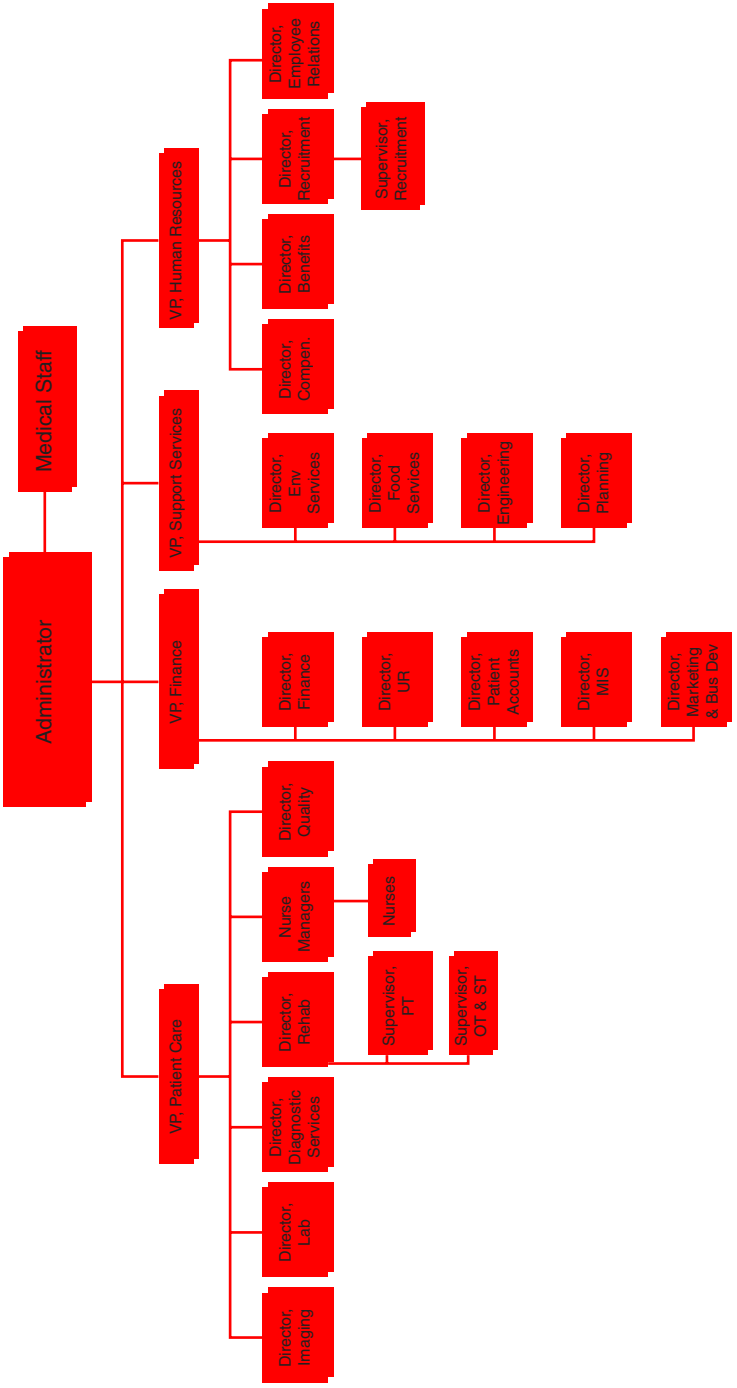

FIGURE 1-3 Functional Organization Structure

consulting firms and non–direct care population health companies, will have flatter organizational structures with one person in charge of all staff, cutting out layers of middle management—and costs.

Other administrative structures have been adopted by health care organizations, usually in combination with a functional structure. These include matrix, or team-based, models and service line management models. The **matrix model** recognizes that a strict functional structure may limit the organization's flexibility to carry out the work, and that the expertise of other disciplines is needed on a continuous basis. An example of the matrix method is when functional staff, such as nursing and rehabilitation personnel, are assigned to a specific program, such as geriatrics, and they report for programmatic purposes to the program director of the geriatrics department. Another example is when clinical and administrative staff are assigned to a team investigating new services that is headed by a marketing or business development manager. In both of these examples, management would lead staff who traditionally are not under their direct administrative control. Advantages of this structure include improved lateral communication and coordination of services, as well as pooled knowledge.

In **service line management**, a manager is appointed to head a specific clinical service line and has responsibility and accountability for staffing, direct supervision of staff, resource acquisition, budget, and financial control associated with the array of services provided under that service line. Typical examples of service lines include cardiology, oncology (cancer), women's services, physical rehabilitation, and behavioral health (mental health). Service lines can be established within a single organization or may cut across affiliated organizations, such as within a hospital system where services are provided at several different affiliated facilities (Boblitz & Thompson, 2005). Some facilities have found that the service line management model for selected clinical services has resulted in many benefits, such as lower costs, higher quality of care, and greater patient satisfaction, compared to other management models (Duffy & Lemieux, 1995). The service line management model is usually implemented within an organization in conjunction with a functional structure, as the organization may choose to give special emphasis and additional resources to one or a few services lines. In non–direct care population health companies, service lines might be centered around technology such as the ability to have consumer wearable devices pass along data to health care delivery systems or between members of certain organizations.

Focus of Management: Self, Unit/Team, and Organization

Effective health care management involves exercising professional judgment and skills and carrying out the aforementioned managerial functions at three levels: self, unit/team, and organization-wide. First and foremost, individual managers must be able to effectively manage themselves. This means managing time, information, space, and materials; being responsive and following through with peers, supervisors, and clients; maintaining a positive attitude and high motivation; and keeping a current understanding of management techniques and substantive issues of health care management. Drucker (2005) suggests that managing yourself also involves knowing your strengths, how you perform, your values, where you belong, and what you can contribute, as well as taking responsibility for your relationships. Managing yourself also means developing and applying appropriate technical, interpersonal, and conceptual skills and competencies and being comfortable with

them, in order to be able to effectively move to the next level—that of supervising others.

The second focus of management is the unit/team level. The expertise of the manager at this level involves managing others in terms of effectively completing the work. Compared to medicine and nursing, health care management is a young discipline. The University of Chicago founded the first program in health administration in 1934 under the leadership of Michael M. Davis, who had a PhD in sociology. Davis recognized that there was no formal training for hospital managers and that an interdisciplinary program of education was needed. Envisioning the role of the health care manager as both a business and social role, he utilized the expertise of medical, social service administration, and business faculty to create an interdisciplinary model that has been replicated repeatedly across the U.S. and throughout the world (University of Chicago School of Social Service Administration, n.d.). Schools with a degree in health care management or administration were originally all master's degree programs, geared to preparing hospital administrators. Now, in addition to master's degrees, there are baccalaureate and doctoral programs in health care management. More jobs in health care management are being created outside of hospital settings than within (BLS, 2018). Increasing specialization of health care, burgeoning allied health care disciplines, a diversity of health care organizations, greater variety in jobs, higher expectations for health care outcomes, and demanding consumers mean that health care organizations must be able to respond appropriately, effectively, and efficiently. Interdisciplinary teams and teamwork provide the mechanism for improved responses to these demands. No matter your job title, you will be working in teams. Since there is little formal training in most professional programs in how to work in teams, it would behoove you to obtain education and training in this competency as early in your career as possible.

Regardless of whether you are a senior manager, mid-level manager, or supervisor, you will be "supervising" others as expected in your assigned role. This responsibility includes assigning work tasks, reviewing and modifying of assignments, monitoring and reviewing individual performance, and carrying out the management functions described earlier to ensure excellent delivery of services. This focal area is where the actual work gets done. Performance reflects the interaction of the manager and the employee, and it is incumbent on the manager to do what is needed to shape the performance of individual employees. The focus of management at this echelon recognizes the task interdependencies among staff and the close coordination that is needed to ensure that work gets completed efficiently and effectively.

The third management focus is at the organizational or interorganizational level. This focal area reflects the fact that managers must work together as part of the larger organization or multiple organizations to ensure organization-wide or collaborative performance and organizational viability. In other words, the success of the organization or collaboration depends upon the success of its individual parts, and effective collaboration and teamwork are needed to ensure that this occurs. The range of clinical and nonclinical activities that occur within a health care organization requires that managers who head individual units work closely with other unit managers to provide services. Sharing of information, collaboration, and communication are essential for success. The hierarchy looks to the contribution of each supervised unit as it pertains to the whole. Individual managers' contributions to the overall performance of the organization—in terms of various performance measures such as cost, quality, satisfaction, and access—are important and measured.

Role of the Manager in Establishing and Maintaining Organizational Culture

Every organization has a distinct culture, known as the beliefs, attitudes, and behavior that are shared among organizational members. **Organizational culture** is commonly defined as the character, personality, and experience of organizational life, i.e., what the organization really "is" (Scott, Mannion, Davies, & Marshall, 2003). Culture prescribes the way things are done, and is defined, shaped, and reinforced by the management team. All managers play a role in establishing the culture of a health care organization, and in taking the necessary leadership action to sustain, and in some cases change, the culture. Culture is shaped by the values, mission, and vision for the organization. **Values** are principles the organization believes in and shape the organization's purpose, goals, and day-to-day behaviors. Adopted values provide the foundation for the organization's activities and include such principles as respect, quality service, and innovation. The **mission** of the organization is its fundamental purpose, or what the organization seeks to achieve. The **vision** of the organization specifies the desired future state for the organization and reflects what the organization wants to be known and recognized for in the future. Statements of values, mission, and vision result from the organizational strategic planning process. These statements are communicated widely throughout the organization and to the community and shape organizational strategic and operational actions. Increasingly, organizations are establishing codes of conduct or **standards of behavior** that all employees must follow (Studer, 2003). These standards of behavior align with the values, mission, and vision. The role of managers in the oversight of standards of behavior is critical in several respects: for setting expectations for staff behavior, modelling the behavior, measuring staff performance, and improving staff performance. Mid-level and lower-level managers are instrumental to organization-wide adoption and embracing of the culture as they communicate desired behaviors and reinforce culture through modelling expectations through their own behaviors. In addition to culture, health care managers are also becoming more involved in marketing and branding of health care organizations (Ellis, 2018). For example, a value of customer service or patient focus requires that managers ensure proper levels of service by their employees via clarifying expectations and providing internal customer service to their own staff and other managers. Furthermore, managers can measure and evaluate employee compliance with organizational values and standards of behavior by reviewing employee performance and working with staff to improve performance. Performance evaluation will be explored in a later chapter in this text.

Role of the Manager in Talent Management

In order to effectively master the focal areas of management and carry out the required management functions, management must have the requisite number and types of highly motivated employees. From a strategic perspective, health care organizations compete for labor, and it is commonly accepted today that high-performing health care organizations are dependent upon individual human performance, as discussed further in Chapter 12. Many observers have advocated for health care organizations to view their employees as strategic assets who can create a competitive advantage (Becker, Huselid, & Ulrich, 2001). Therefore, the human resources management

function has been replaced in many health care organizations with **talent management**. The focus has shifted to securing and retaining the talent needed to do the job in the best way, rather than simply filling a role (Huselid, Beatty, & Becker, 2005). As a result, managers are now focusing on effectively managing talent and workforce issues because of the link to organizational performance (Griffith, 2009).

Beyond recruitment, managers are concerned about developing and retaining those staff who are excellent performers. Many health care organizations are creating high-involvement organizations that identify and meet employee needs through their jobs and the larger organizational work setting (Becker et al., 2001). As the frequency of organizational moves in career trajectory increases, it's becoming more important to maximize the experience of employees as their average time with an organization before moving on has grown shorter (Deloitte, 2018). One of the critical responsibilities of managers in talent management is promoting **employee engagement**, which describes the motivation and commitment of staff to contribute to the organization. There are several strategies used by managers to develop and sustain employee engagement, as well as to develop and maintain excellent performers. These include formal methods such as offering training programs; providing leadership development programs; identifying employee needs and measuring employee satisfaction through engagement surveys; providing continuing education, especially for clinical and technical fields; and enabling job enrichment. In addition, managers use informal methods such as conducting periodic employee reviews, soliciting employee feedback, conducting rounds and employee huddles, offering employee suggestion programs, and other methods of managing employee relations and engagement. These topics are explored in more detail in in Chapter 2.

Role of the Manager in Strategic Planning and Strategy Development

As part of the planning function, managers play a key role in determining the future of the organization through the strategic planning process. This process enables the leadership of the organization to determine the direction of the organization. **Strategic planning** is the process of identifying a desired future state for an organization and a means to achieve it. Through an ongoing analysis of the organization's operating environment, matched against its own internal capabilities, an organization's leadership is able to identify strategies that will drive the organization from its present condition to that desired future state. The delivery of health care services is not a static process; advances in medical science and technology combined with continuous quality improvement efforts and consumerism that overlap across disciplines are forever changing the way we deliver care. Health care managers and clinicians must continually adapt to this changing environment in our quest to provide optimal care to patients. In essence, health care organizations need to be learning organizations which continually fold lessons back into strategic planning.

This process is typically carried out on an annual basis, with appropriate updating and revision of the strategic plan. The manager's role in this process is critical for several reasons. First, managers have unique knowledge of patient needs, services, and industry trends specific to their area of responsibility that are important to consider in the strategic planning process. Second, participation in the planning process is important so that the manager can be an advocate for his or her department or function, in terms of setting organizational goals, strategies, and implementation plans. Also, managers play a key role in determining

implementation plans with realistic input on staffing, resources, and accountability, as well as monitoring strategy implementation and progress. Strategic planning is addressed in detail in Chapter 5.

Role of the Manager in Ensuring High Performance

At the end of the day, the role of managers is to ensure that the units, services, divisions, or organizations they lead achieve high performance. What exactly is meant by high performance? To understand performance, one has to appreciate the value of setting and meeting goals and objectives for the unit/service and organization as a whole, in terms of the work that is being carried out. Goals and objectives are desired end points for activity and reflect strategic and operational directions for the organization. They are specific, measurable, meaningful, and time oriented. Goals and objectives for individual units should reflect the overarching needs and expectations of the organization as a whole because, as the reader will recall, all entities are working together to achieve high levels of overall organizational performance. Studer (2003) views the organization as needing to be results oriented, with identified pillars of excellence as a framework for the specific goals of the organization. These pillars are people (employees, patients, and physicians), service, quality, finance, and growth. Griffith (2000) refers to high-performing organizations as being championship organizations—that is, they expect to perform well on different yet meaningful measures of performance. Griffith further defines the "championship processes" and the need to develop performance measures in each of the following: governance and strategic management; clinical quality, including customer satisfaction; clinical organization (caregivers); financial planning; planning and marketing; information services; human resources; and plant and supplies. For each championship process, the organization should establish measures of desired performance that will guide the organization. Examples of measures include medication errors, surgical complications, patient satisfaction, staff turnover rates, employee satisfaction, market share, profit margin, and revenue growth, among others. In turn, respective divisions, units, and services will set targets and carry out activities to address key performance processes. The manager's job, ultimately, is to ensure these targets are met by carrying out the previously discussed management functions. A control process for managers has been advanced by Ginter, Swayne, and Duncan (2002) that describes five key steps in the performance management process: set objectives, measure performance, compare performance with objectives, determine reasons for deviation, and take corrective action. Management's job is to ensure that performance is maintained or, if below expectations, improved.

Stakeholders, including, but not limited to insurers, state and federal governments, and consumer advocacy groups, are expecting, and in many cases demanding, acceptable levels of performance in health care organizations. These groups want to make sure that services are provided in a safe, convenient, low-cost, and high-quality environment. For example, The Joint Commission (formerly JCAHO) has set minimum standards for health care facilities operations that ensure quality, the National Committee for Quality Assurance (NCQA) has set standards for measuring performance of health plans and recognizing health care organizations as Patient-Centered Medical Homes, and the Centers for Medicare and Medicaid Services (CMS) has established websites that report hospital and nursing home performance along a number of critical dimensions. In addition, CMS has provided

incentives to health care organizations by paying for performance on measures of clinical care and not paying for care resulting from **never events**, i.e., shocking health outcomes that should never occur in a health care setting such as wrong site surgery (e.g., the wrong leg) or hospital-acquired infections (Agency for Healthcare Research and Quality, n.d.). Health insurers also have implemented pay-for-performance programs for health care organizations based on various quality and customer service measures.

In addition to meeting the reporting requirements of the aforementioned organizations, many health care organizations today use varying methods of measuring and reporting the performance measurement process. Common methods include developing and using dashboards or balanced scorecards that allow for a quick interpretation of organizational performance across a number of key measures (Curtright, Stolp-Smith, & Edell, 2000; Pieper, 2005). Senior administration uses these methods to measure and communicate performance on the total organization to the governing board and other critical constituents. Other managers use these methods at the division, unit, or service level to profile its performance. In turn, these measures are also used to evaluate managers' performance and are considered in decisions by the manager's boss regarding compensation adjustments, promotions, increased or reduced responsibility, training and development, and, if necessary, termination or reassignment.

Role of the Manager in Ensuring a Positive Patient Experience

Fundamentally, direct care organizations help patients suffering from illness and injury, who are in many cases, anxious and vulnerable. These organizations have increasingly recognized that service quality—customer service—is required, and allows the organization to be competitive in the way services are provided. All managers need to focus on the customer service to the patient, even those who do not supervise patient services, because their support functions contribute to the overall patient experience. It is the manager's role to ensure that a positive patient experience occurs.

Traditionally, quality of care has been defined as the quality of the clinical care provided. While noted as important, service quality or customer service was viewed as secondary. In the past decade, industry thinking on customer service has shifted dramatically, given the Triple Aim framework advanced by the Institute for Healthcare Improvement. **The Triple Aim** advocates health system improvements that address three dimensions: reducing the per capita cost of care, improving the health of populations, and improving the patient experience of care (Institute for Healthcare Improvement, 2018). With the shift to value-based performance, Medicare and commercial insurers are now paying for care on the basis of clinical quality *and* patient perceptions of care and customer service, through the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey scores. As a result, hospitals have mounted increased efforts to provide for excellent service experiences; hospitals are paying closer attention to overall patient perceptions and satisfaction, by closely monitoring patient satisfaction, quickly addressing patient concerns and complaints, and improving processes. Many large hospitals and health systems have created the position of Vice President of Service Excellence, or Chief Patient Experience Officer (Manary, Staelin, Kosel, Schulman, & Glickman, 2014). This manager's role is to create organizational-wide strategy and programs to improve and sustain the patient experience.

The **patient experience** is defined as "the sum of all interactions, shaped by an organization's culture, that influence patient

perceptions across the continuum of care" (Beryl Institute, 2018, para.1). To ensure a positive patient experience, managers first need to understand the organizational processes of providing care and support services, and the interactions of the patient with the organization. Many managers have chosen to establish patient journeys and graphically portray them as **patient journey maps** that depict the steps in receiving care from the perspective of the patient and the patient's family (Trebble, Hansi, Hydes, Smith, & Baker, 2010). Such maps portray all interactions and touchpoints between the patient and the organization. Second, managers need to understand the needs and expectations of patients. Patients want to be informed, respected, supported, and treated in a courteous and friendly way with empathy and compassion. On the technical care side, patients want appropriate and timely care, provided in the right way and at the right time. To the degree that these needs and expectations are met, patients tend to view their experience positively. Finally, managers need to focus on and improve the physical environment of care, which promotes access, comfort, and convenience for patients (Birkelien, 2017).

By assessing the experience through the patient journey maps, and noting discrepancies where the patient experience has failed or flows inefficiently based upon expectations and the physical environment, organizations can begin to identify improvement opportunities and set priorities for enhancing the patient experience. This can be done with quality improvement teams or through Lean management or Six Sigma initiatives (these concepts are discussed in more detail in Chapter 7). Such improvements to the patient experience can also be identified and addressed through formal employee suggestion programs, meetings with staff, daily or weekly huddles, and other scheduled feedback sessions with staff, review of complaints and grievances, and observations made through manager rounding with staff. Improvements can be made and monitored through initiatives such as changing care processes, implementing staff training, providing feedback through employee evaluations, and encouraging professional development.

Role of the Manager in Leadership Development and Succession Planning

Because health care organizations are complex and experience challenges from internal and external environments, the need for leadership skills of managers at all levels of the organization has become paramount. Successful organizations that demonstrate high operational performance depend on strong leaders (Squazzo, 2009). Senior executives have a primary role in ensuring managers throughout the organization have the knowledge and skills to provide effective leadership to achieve desired levels of organizational performance. Senior management also plays a key role in succession planning to ensure vacancies at mid- and upper levels of the organization due to retirements, departures, and promotions are filled with capable leaders. Therefore, key responsibilities of managers are to develop future leaders through leadership development initiatives and to engage in succession planning.

Leadership development programs are broadly comprised of several specific organizational services that are offered to enhance leadership competencies and skills of managerial staff in health care organizations. **Leadership development** is defined as educational interventions and skill-building activities designed to improve the leadership capabilities of individuals (Kim & Thompson, 2012; McAlearney, 2005). Such initiatives not only serve to increase leadership skills and behaviors, but also ensure stability within organizational talent and culture through career advancement and succession planning (Burt, 2005). In order to embrace leadership development, managers

provide technical and psychological support to the staff through a range of leadership development activities:

Leadership development program: Training and leadership development on a variety of required topics, through a formally designated program, using structured learning and competency-based assessment using various formats, media, and locations (Kim & Thompson, 2012).

Courses on leadership and management: Didactic training through specific courses offered face-to-face, online, or in hybrid form (Garman, 2010; Kim & Thompson, 2012).

Mentoring: Formal methods used by the organization for matching aspiring leaders with mid-level and senior executives to assist in their learning, as well as professional and personal growth (Garman, 2010; Landry & Bewley, 2010).

Personal development coaching: Usually reserved for upper-level executives; these formal organizational efforts assist in improving performance by shaping attitudes and behavior and focusing on personal skills development (Garman, 2010; Scott, 2009).

Job enlargement: The offering of expanded responsibilities, developmental assignments, and special projects to individuals to cultivate leadership skills for advancement within the organization (Fernandez-Araoz, 2014; Garman, 2010; Landry & Bewley, 2010).

360-degree performance feedback: A multisource feedback approach where an individual staff member or manager receives an assessment of performance from several key individuals (e.g., peers, superiors, other managers, and subordinates) regarding performance and opportunities for improvement (Garman, 2010; Landry & Bewley, 2010).

Leadership development programs have shown positive results. For example, health systems report benefits such as improvement of skills and quality of the workforce, enhancing organizational efficiency in educational activities, and reducing staff turnover and related expenses when leadership training is tied to organization-wide strategic priorities (McAlearney, 2005). In addition, hospitals with leadership development programs have been found to have higher volumes of patients, higher occupancy, higher net patient revenue, and higher total profit margin when compared to hospitals without these programs (Thompson & Kim, 2013). Studies have also shown that leadership development programs in health systems are related to greater focus on employee growth and development, improved employee retention, and greater focus on organizational strategic priorities (McAlearney, 2010). Finally, within a single health system, a leadership development program led to greater market share, reduced employee turnover, and improved core quality measures (Ogden, 2007). However, one of the key drawbacks to leadership development programs is the cost of developing and operating the programs and the participants' time investments (Squazzo, 2009).

Due to the competitive nature of health care organizations and the need for highly motivated and skilled employees, managers are faced with the challenge of **succession planning** for their organizations. Succession planning refers to the concept of taking actions to ensure staff can move up in management roles within the organization to replace those managers who retire or move to other opportunities in other organizations. Succession planning has most recently been emphasized at the senior level of organizations, in part due to the large number of retirements that are anticipated from Baby Boomer chief executive officers (CEOs) (Burt, 2005). To continue the emphasis on high performance within health care organizations, CEOs and other senior managers are interested in finding and

nurturing leadership talent within their organizations who can assume the responsibility and carry forward the important work of these organizations.

Health care organizations are currently engaged in several practices to address leadership succession needs. First, mentoring programs for junior management that includes the participation of senior management have been advocated as a good way to prepare future health care leaders (Rollins, 2003). Mentoring studies show that mentors view their efforts as helpful to the organization (Finley, Ivanitskaya, & Kennedy, 2007). Some observers suggest having many mentors is essential to capturing the necessary scope of expertise, experience, interest, and contacts to maximize professional growth (Broscio & Scherer, 2003). Mentoring middle-level managers for success as they transition to their current positions is also helpful in preparing those managers for future executive leadership roles (Kubica, 2008).

A second method of succession planning is through formal leadership development programs. These programs are intended to identify management potential throughout an organization by targeting specific skill sets of individuals and assessing their match to specific jobs, such as vice president or chief operating officer (COO). One way to implement this is through talent reviews, which, when done annually, help create a pool of existing staff who may be excellent candidates for further leadership development and skill strengthening through the establishment of development plans. Formal programs that are being established by many health care organizations focus on high-potential people (Burt, 2005). Thompson and Kim (2013) found that 48% of community hospitals offered a leadership development program, and McAlearney (2010) reported that about 50% of hospital systems nationwide had an executive-level leadership development program. However, many health care organizations have developed programs that address leadership development at all levels of the organization, not just the executive level, and require all managers to participate in these programs to strengthen their managerial and leadership skills and to contribute to organizational performance.

Role of the Manager in Innovation and Change Management

Due to the pace of change in the health care and services industry and the complexity of the variety of health-related organizations, the manager plays a significant role in leading innovation and spearheading change management. Health care and service organizations cannot remain static. The environmental forces discussed earlier in this chapter strongly point to the need for organizations to respond and adapt to these external influences. In addition, achieving and maintaining high performance outcomes or results is dependent on making improvements to the organizational structure and processes. Moreover, managers are encouraged to embrace innovation to identify creative ways to improve service and provide care effectively and efficiently.

Innovation and change management are intricately related, but different, competencies. Hamel (2007) describes management innovation and operational innovation. **Management innovation** addresses the organization's management processes as the practices and routines that determine how the work of management gets conducted on a daily basis. These include such practices as internal communications, employment assessment, project management, and training and development. In contrast, **operational innovation** addresses the organization's business processes. In the health care setting, these include processes such as customer service, procurement of supplies and supply chain changes, care coordination across staff, and development and use of clinical procedures and practices. Some operational

innovation is structural in nature and involves acquisition of information and clinical products, such as electronic medical/health records, or a new device or procedure, such as robotic surgery or new medications (Staren, Braun, & Denny, 2010). There are specific skills needed by managers to be innovators in management. These skills include thinking creatively about ways to proactively change operational and management practices to improve the organization. It also involves a willingness to test these innovative practices and assess their impact. Also, a manager must facilitate recruitment and development of employees who embrace creativity and innovation. Having innovative clinical and administrative staff is critical to implementing operational innovation. A culture of innovation depends upon staff who are generating ideas for operational innovation, and the manager is a linchpin in establishing a culture of innovation that supports idea generation. Recent studies of innovative and creative companies found that leaders should rely on all staff collaborating by helping one another and engaging in a dynamic process of seeking and giving feedback, ideas, and assistance (Amabile, Fisher, & Pillemer, 2014). Several barriers to innovation have been identified. These barriers include lack of an innovation culture that supports idea generation, lack of leadership in innovation efforts, and high costs of making innovative changes (Harrington & Voehl, 2010). In addition, formal rules and regulations, professional standards, and administrative policies may all work against innovation (Dhar, Griffin, Hollin, & Kachnowski, 2012). Finally, daily priorities and inertia reflecting the status quo that cause managers to focus on routines and day-to-day tasks limit staff ability to be creative, engage in discovery, and generate ideas (Dhar et al., 2012).

Organizational change, or **change management**, is related to but different from innovation. Organizational change is a structured management approach to improving the organization and its performance. Knowledge of performance gaps is a necessary prerequisite to change management, and managers must routinely assess their operational activities and performance and make adjustments in the work structure and processes to improve performance (Thompson, 2010). Managing organizational change has become a significant responsibility of managers and a key competency for health care managers (Buchbinder & Thompson, 2010). Managing the change process within health care organizations is critical because appropriately and systematically managing change can result in improved organizational performance. However, change is difficult and the change process creates both staff resistance and support for a change.

A process model of change management has been suggested by Longest et al. (2000). This rational, problem-based model identifies four key steps in systematically understanding and managing the change process: (1) identification of the need for change, (2) planning for implementing the change, (3) implementing the change, and (4) evaluating the change.

There are several key management competencies that health care managers need to possess to effectively manage change within their organizations. Thompson (2010) suggests that managers:

- Embrace change and be a change agent;
- Employ a change management process;
- Effectively address support and resistance to change;
- Use change management to make the organization innovative and successful in the future; and,
- Recruit staff and succession plan with change management in mind.

Role of the Manager in Health Care Policy

As noted earlier in this chapter, managers must consider both their external and internal domains as they carry out management functions and tasks. One of the critical areas for

managing the external world is to be knowledgeable about health policy matters under consideration at the state and federal levels that affect health care organizations and health care delivery. This is particularly true for senior-level managers. This awareness is necessary to influence policy in positive ways that will help the organization and limit any adverse impacts. Staying current with health care policy discussions, participating in deliberations of health policy, and providing input where possible will allow health care management voices to be heard. Because health care is such a popular yet controversial topic in the U.S. today, continuing changes in health care delivery are likely to emanate from the legislative and policy processes at the state and federal levels. For example, the Patient Protection and Affordable Care Act (ACA), signed into law in 2010 as a major health care reform initiative, has had significant implications for health care organizations in terms of patient volumes, reimbursement for previously uninsured patients, and the movement to improve population health and develop value-based purchasing. However, legislative changes have been made to this law at the federal level that will impact health care organizations in the future. The possible legislative changes to the ACA are discussed further in Chapter 9. Other recent federal policy changes include cuts in Medicare reimbursement and increases in reporting requirements. State legislative changes across the country affect reimbursement under Medicaid and the Children's Health Insurance Program, licensure of facilities and staff, certificate of need rules for capital expenditures and facility and service expansions, and state requirements on mandated health benefits and modified reimbursements for insured individuals that affect services offered by health care organizations.

In order to understand and influence health policy, managers must strive to keep their knowledge current. This can be accomplished through targeted personal learning, networking with colleagues within and outside of their organizations, and participating in professional associations, such as the American College of Healthcare Executives and the Medical Group Management Association. These organizations, and many others, monitor health policy discussions and advocate for their associations' interests at the state and federal levels. Knowledge gained through these efforts can be helpful in shaping health policy in accordance with the desires of health care managers.

Opportunities for Research on Health Care Management

Two key focal areas are the subject of current research in health care management: best practices of managers and leaders, and leader behaviors. The best practices of managers and leaders in ensuring organizational performance has been the focus of work by McAlearney, Robbins, Garman, and Song (2013) and Garman, McAlearney, Harrison, Song, and McHugh (2011). The best practices identified by these researchers include staff engagement, staff acquisition and development, staff frontline empowerment, and leadership alignment and development.

The second focal area of recent research has examined the behaviors of successful CEOs and leadership behaviors in high-performing hospitals. Botelho, Powell, Kincaid, and Wang (2017) identified the following behaviors of successful CEOs: decision-making with speed and conviction, with input from multiple points of view; engaging for impact, by gaining buy-in from stakeholders; adapting proactively by focusing on the long term and taking advantage of changes; and delivering consistent results by following through on commitments. Wagner (2018) examined top performing hospitals and found several key leadership practices that are instrumental in creating a culture of caring: huddling for

patient safety and quality; empowering staff to take action; engaging with employees through rewards, recognition, and idea solicitation for improvement; and aligning staff personal values with organizational mission.

Understanding leader practices in developing their staff and preparing lower-level managers for leadership roles has been a common research focus. Leadership development programs have been examined in terms of their structure and impact. McAlearney (2008) surveyed health care organizations and key informants to determine the availability of leadership development programs and their role in improving quality and efficiency, and found these programs enhanced the skills and quality of the workforce, improved efficiency in educational development, and reduced staff turnover. A study of high-performing health organizations found various practices are used to develop leaders internally, including talent reviews to identify candidates for upward movement, career development planning, job rotations, and developmental assignments (McHugh, Garman, McAlearney, Song, & Harrison, 2010). In addition, a 2010 study examined leadership development in health and non-health care organizations and found best practices included 360-degree performance evaluation, mentoring, coaching, and experiential learning (National Center for Healthcare Leadership, 2010). A study of U.S. health systems found about half of health systems offered a leadership development program and also found that leadership development initiatives helped the systems focus on employee growth and development and improved employee retention (McAlearney, 2010). As noted earlier in this chapter, some recent studies have examined the characteristics of leadership development programs in hospitals, finding correlations of programs with size, urban location, and not-for-profit ownership status (Kim & Thompson, 2012; Thompson & Kim, 2013). A new area of management research is the participation of early careerists in leadership development programs, and recent evidence shows that some leadership development activities are of more interest to staff than others (Thompson & Temple, 2015). A number of important areas of management research exist today, and include looking at the effect of leadership development training on specific decision making by managers, career progression due to participation in leadership development, and the impact of collaboration among staff on firm innovation and performance (Amabile, Fisher, & Pillemer, 2014).

Conclusion

The profession of health care management is challenging yet rewarding, and requires persons in managerial positions at all levels of the organization to possess sound conceptual, technical, and interpersonal skills to carry out the necessary managerial functions of planning, organizing, staffing, directing, controlling, and decision making. In addition, managers must maintain a dual perspective where they understand the external and internal domains of their organization and the need for development at the self, unit/team, and organization levels. Opportunities exist for managerial talent at all levels of a health care organization, including supervisory, middle-management, and senior-management levels. The role of manager is critical to ensuring a high level of organizational performance, and managers are also instrumental in establishing and maintaining organizational culture, talent recruitment and retention, strategic planning and strategy development, ensuring a positive patient experience, leadership development and succession planning, innovation and change management, and shaping health care policy.

Discussion Questions

1. Define health care management and health care managers.
2. Differentiate between traditional and alternative non–direct care settings and give examples of each.

3. Delineate the functions carried out by health care managers and give an example of a task in each function.
4. Explain why interpersonal skills are important in health care management.
5. Compare and contrast three models of organizational design.
6. Why is the health care manager's role in ensuring high performance so critical? Explain.
7. Why has the "patient experience" become an important focal point for health care managers? Explain.
8. Characterize the health care manager's role in change management and assess the extent to which this has an impact on the success of the change process.
9. Describe the internal and external role of health care managers in the health industry.

CASES AND EXERCISES IN CHAPTER 18 THAT ARE RELATED TO THIS CHAPTER INCLUDE:

Improving Patient Experience
Exercises for Reviving the Art of Letter Writing
How to Write an Email with Five Exercises
Informational Interviewing Exercise

Case guides are available in the online Instructor's Materials.

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CHAPTER 2

Leadership

Louis Rubino

LEARNING OBJECTIVES

By the end of this chapter, the student will be able to:

- Distinguish between leadership and management;
- Summarize the history of leadership in the U.S. from the 1920s to contemporary times;
- Compare and contrast leadership styles, competencies, and protocols;
- Summarize old and new governance trends;
- Analyze key barriers and challenges to successful leadership;
- Provide a rationale for why health care leaders have a greater need for ethical behavior;
- Explore important new initiatives requiring health care leaders' engagement;
- Synthesize leadership directions of the future; and,
- Discuss special research issues related to leadership.

Leadership vs. Management

In any business setting, there must be **leaders** as well as **managers**. But are these the same people? Not necessarily. There are leaders who are good managers and there are managers who are good leaders, but usually neither case is the norm. In health care, this is especially important to recognize because of the need for both. Health care is unique in that it is a service industry that depends on a large number of highly trained personnel as well as trade workers. Whatever the setting, be it a hospital, a long-term care facility, an ambulatory care center, a medical device company, an insurance company, an accountable care organization, or some other health care entity, leaders as well as managers are needed to keep the organization moving in a forward direction and, at the same time, maintain current operations. This is done by leading and managing its people and assuring good business practices.

Leaders usually take a focus that is more external, whereas the focus of managers is more internal. Even though they need to be sure their health care facility is operating

properly, leaders tend to spend the majority of their time communicating and aligning with outside groups that can benefit their organizations (partners, community, vendors) or influence them (government, public agencies, media). See **FIGURE 2-1**. There is crossover between leaders and managers across the various areas, though a distinction remains for certain duties and responsibilities.

Usually the top person in the organization (e.g., Chief Executive Officer, Administrator, Director) has full and ultimate accountability. This type of leader may be dictated by the current conditions faced by the organization. A more **strategic leader**, who defines purpose and vision and aligns people, processes, and values, may be needed. Or, a **network leader**, who could connect people across disciplines, organizational departments, and regions, may be essential. Whichever type surfaces, there will be several managers reporting to this person, all of whom have various **functional responsibilities** for different areas of the organization (e.g., Chief Nursing Executive, Physician Director, Chief Experience Officer). These managers can certainly be leaders in their own areas, but their focus will be more internal within the organization's operations. They are the **operational leaders** of the organization. Together, these three types of leaders/followers produce an interdependent leadership system, a team which will prove more high performing in the current health care field (Maccoby, Norman, Norman, & Margolies, 2013).

Leaders have a particular set of competencies that require more forward thinking than those of managers. Leaders need to establish a **mission** and set a **vision** or direction for the organization. They need to be able to motivate their employees, as well as other stakeholders, so the business continues to exist and, hopefully, thrive in periods of change. No industry is as dynamic as health care, with rapid change occurring due to the complexity of the

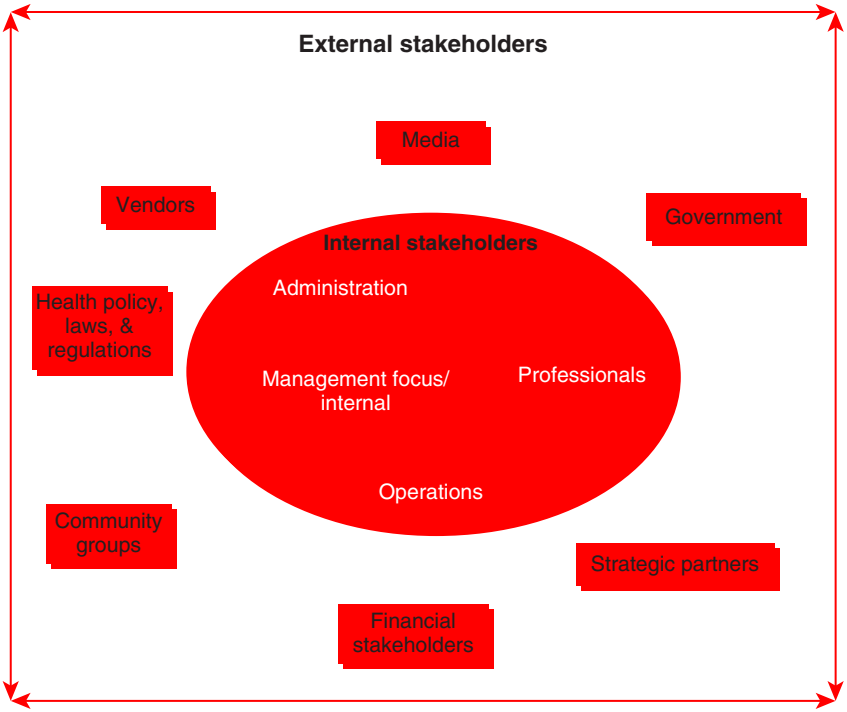

FIGURE 2-1 Leadership and Management Focus

system and government regulations. Leaders are needed to keep the entity on course and to maneuver around obstacles, like a captain commanding his ship at sea. Managers must tend to the business at hand and make sure the staff is following proper procedures and meeting established targets and goals. They need a different set of competencies. See **TABLE 2-1**.

History of Leadership in the U.S.

Leaders have been around since the beginning of man. We think of the strongest male becoming the leader of a caveman clan. In Plato's time, the Greeks began to talk about the concept of leadership and acknowledged the political system as critical for leaders to emerge in a society. In Germany during the late 19th century, Sigmund Freud described leadership as unconscious exhibited behavior; later, Max Weber identified how leadership is present in a bureaucracy through assigned roles. Formal leadership studies in the U.S., though, have only been around for the last 100 years (Sibbet, 1997).

We can look at the decades spanning the 20th century to see how leadership theories evolved, placing their center of attention on certain key components at different times (Northouse, 2019). These emphases often matched or were adapted from the changes occurring in society.

With the industrialization of the U.S. in the 1920s, productivity was of paramount importance. Scientific management was introduced, and researchers tried to determine which characteristics were identified with the most effective leaders based on their units having high productivity. The **Great Man Theory** was developed out of the idea that certain traits determined good leadership. The traits that were recognized as necessary for effective leaders were ones that were already inherent in the person, such as being male, being tall, being strong, and even being Caucasian. Even the idea that "you either got it or you don't" was supported by this theory, the notion being that a good leader had charisma. Behaviors were not considered important in determining what made a good leader. This theory discouraged anyone who did not have the specified traits from aspiring to a leadership position.

TABLE 2-1 Leadership vs. Management Competencies

Leadership Competencies	Management Competencies
Establishing mission	Staffing personnel
Setting vision/direction	Assuring patient-centered practices
Motivating stakeholders	Controlling resources
Being an effective spokesperson	Supervising the service provided
Determining strategies for the future	Overseeing adherence to regulations
Transforming the organization	Counseling/developing employees
Networking	Managing operations

Fortunately, after two decades, businesses realized leadership could be enhanced through certain conscious acts, and researchers began to study which behaviors would produce better results. Resources were in short supply due to World War II, and leaders were needed who could truly produce good results. This was the beginning of the **Style Approach to Leadership**. Rather than looking at only the characteristics of the leader, researchers started to recognize the importance of two types of behaviors in successful leadership: completing tasks and creating good relationships. This theory states leaders have differing degrees of concern over each of these behaviors, and the best leaders would be fully attentive to both.

In the 1960s, American society had a renewed emphasis on helping all of its people and began a series of social programs that still remain today. The two that impact health care directly, by providing essential services, are Medicare for the elderly (age 65 and over) and the disabled and Medicaid for the indigent population. The **Situational Approach to Leadership** then came into prominence and supported this national concern. This set of theories focused on the leader changing his or her behavior in certain situations in order to meet the needs of subordinates. This would imply a very fluid leadership process whereby one can adapt one's actions to an employee's needs at any given time.

Not much later, researchers believed perhaps leaders should not have to change how they behaved in a work setting, but instead the appropriate leaders should be selected from the very beginning. This is the **Contingency Theory of Leadership** and was very popular in the 1970s. Under this theory, the focus was on both the leader's style as well as the situation in which the leader worked, thus building upon the two earlier theories. This approach was further developed by what is known as the **Path–Goal Theory of Leadership**. This theory still placed its attention on the leader's style and the work situation (subordinate characteristics and work task structure) but also recognized the importance of setting goals for employees. The leader was expected to remove any obstacles in order to provide the support necessary for them to achieve those goals.

In the later 1970s, the U.S. was coming out of the Vietnam War, in which many of its citizens did not think the country should have been involved. More concern was expressed over relationships as the society became more psychologically attuned to how people felt. The **Leader–Member Exchange Theory** evolved over the concern that leadership was being defined by the leader, the follower, and the context. This new way of looking at leadership focused on the interactions that occur between the leaders and the followers. This theory claimed leaders could be more effective if they developed better relationships with their subordinates through high-quality exchanges.

After Vietnam and a series of weak political leaders, Americans were looking for people to take charge who could really make a difference. Charismatic leaders came back into vogue, as demonstrated by the support shown to President Ronald Reagan, an actor turned politician. Unlike the Great Man Theory earlier in the century, this time the leader had to have certain skills to transform the organization through inspirational, motivational efforts. Leadership was not centered upon transactional processes that tied rewards or corrective actions to performance. Rather, the **transformational leader** could significantly change an organization through its people by raising their consciousness, empowering them, and then providing the nurturing needed as they produced the results desired.

In the late 1980s, the U.S. started to look more globally for ways to have better production. Total Quality Management became a popular concept and arose from researchers studying Japanese principles of managing production lines. In the health care setting, this was embraced through a process still used today called Continuous Quality Improvement

or Performance Improvement. In the decade to follow, leaders assigned subordinates to a series of work groups in order to focus on a particular area of production. Attention was placed on developing the team for higher level functioning and on how a leader could create a work environment that could improve the performance of the team. Individual team members were expendable, and the team entity was all-important.

We have entered the 21st century with some of the greatest leadership challenges ever in the health care field. Critical personnel shortages, limited resources, and increased governmental regulations provide an environment that yearns for leaders who are attentive to the organization and its people, yet can still address the big picture. Several of today's leadership models relate well to the dynamism of the health care field and are presented here. Looking at these models, there seems to be a consistent pattern of self-aware leaders who are concerned for their employees and understand the importance of meaningful work. As we entered the 2000s, leaders needed to use **Adaptive Leadership** to create flexible organizations able to meet the relentless succession of challenges faced in health care and elsewhere (Heifetz, Grashow, & Linsky, 2009). Plus, today's astute health care leaders recognize the importance of considering the global environment, as health care wrestles with international issues that impact us locally, such as outsourcing services, medical tourism, and over-the-border drug purchases, giving rise to the **global leader**. See **TABLE 2-2**.

Contemporary Models

Today's health care industry does not prescribe any one type of leadership model. Many leaders are successful drawing from a variety of traditional and contemporary models. It is

TABLE 2-2 Leadership Theories in the U.S.

Period of Time	Leadership Theory	Leadership Focus
1920s and 1930s	Great Man	Having certain inherent traits
1940s and 1950s	Style Approach	Task completion and developing relationships
1960s	Situational Approach	Needs of the subordinates
Early 1970s	Contingency and Path–Goal	Both style and situation
Late 1970s	Leader–Member Exchange	Interactions between leader and subordinate
1980s	Transformational Approach	Raise consciousness and empower followers
1990s	Team Leadership	Team performance and development
2000s	Adaptive Leadership	Build capacity to thrive in a new reality
2010s	Global Leader	Recognizing the impact of globalization for their industry

wise for the leadership student, as well as the practitioner, to become familiar with the various contemporary models so they can be utilized when appropriate. See **TABLE 2-3**.

Emotional Intelligence (EI)

Emotional intelligence (EI) is a concept made famous by Daniel Goleman in the late 1990s. It suggests that there are certain skills (**intrapersonal and interpersonal**) that a person needs to be well adjusted in today's world. These skills include **self-awareness** (having a deep understanding of one's emotions, strengths, weaknesses, needs, and drives), **self-regulation** (a propensity for reflection, an ability to adapt to changes, the power to say no to impulsive urges), **self-motivation** (being driven to achieve, being passionate about one's profession, enjoying challenges), **empathy** or **social awareness** (thoughtfully considering others' feelings when interacting), and **social skills** (moving people in the direction you desire by your ability to interact effectively) (Freshman & Rubino, 2002). See **TABLE 2-4**.

EI, when applied to leadership, suggests a more caring, confident, enthusiastic boss who can establish good relations with workers. Researchers have shown that EI can distinguish outstanding leaders and strong organizational performance (Goleman, 1998). For health care as an industry and for health care managers, this seems like a good fit, especially during times of change (Delmatoff & Lazarus, 2014).

Emotional intelligence is broadly endorsed as a leadership development strategy in health care and it is widely believed it can be learned, practiced and improved over time (Mintz & Stoller, 2014). Now, many organizations use selection criteria that include the ability of a person to effectively relate to others thus validating the importance of a health care leader having emotional intelligence (Dye & Lee, 2016). In fact, emotional intelligence is considered one of the top ten most desirable job skills in the *Future of Jobs Report 2018* from the World Economic Forum (World Economic Forum, 2018).

Authentic Leadership

The central focus of **authentic leadership** is that people will want to naturally associate with someone who is following their internal compass of true purpose (George & Sims, 2007). Leaders who follow this model are ones who know their authentic selves, define their values

TABLE 2-3 Contemporary Leadership Models

Model	Leadership Application
Emotional Intelligence	Tools to be well-adjusted leader
Authentic Leadership	Follows internal compass of true purpose
Servant Leadership	Desire to serve others
Resilient Leadership	Builds inner strength and perseverance
Discursive Leadership	Practices negotiated communication
Emerging Leadership	Continual learners and developers

TABLE 2-4 Emotional Intelligence's Application to Health Care Leadership

EI Dimension	Definition	Leadership Application
Self-Awareness	A deep understanding of one's emotions and drives	Knowing if your values are congruent with the organization's
Self-Regulation	Adaptability to changes and control over impulses	Considering ethics of giving bribes to doctors
Self-Motivation	Ability to enjoy challenges and being passionate toward work	Being optimistic even when census is low
Empathy	Social awareness skill, putting yourself in another's shoes	Setting a patient-centered vision for the organization
Social Skills	Supportive communication skills, abilities to influence and inspire	Having an excellent rapport with the board

and leadership principles, understand what motivates them, build a strong support team, and stay grounded by integrating all aspects of their lives. Authentic leaders have attributes such as confidence, hope, optimism, resilience, high levels of integrity, and positive values (Brown & Gardner, 2007). Assessments given to leaders in a variety of international locations have provided the evidence-based knowledge that there is a correlation between authentic leadership and positive outcomes based on supervisor-rated performance (Walumbwa, Avolio, Gardner, Wernsing, & Peterson, 2008).

Servant Leadership

Many people view health care as a very special type of work. Individuals usually work in this setting because they want to help people. **Servant leadership** applies this concept to top administration's ability to lead, acknowledging that a health care leader is largely motivated by a desire to serve others. This leadership model breaks down the typical organizational hierarchy and professes the belief of building a community within an organization in which everyone contributes to the greater whole. A servant leader is highly collaborative and gives credit to others generously. This leader is sensitive to what motivates others and empowers all to win with shared goals and vision. Servant leaders use personal trust and respect to build bridges and use persuasion rather than positional authority to foster cooperation. This model works especially well in a not-for-profit setting, since it continues the mission of fulfilling the community's needs rather than the organization's (Ledbetter, Banks, & Greenhalgh, 2016; Swearingen & Liberman, 2004). Sometimes, the servant leader has a **spiritual leadership** focus. This does not necessarily imply a certain set of religious beliefs, but emphasizes ethics, values, relationship skills, and the promotion of balance between work and self (Wolf, 2004).

Resilient Leadership

Being a health care leader is an exciting yet challenging job. Much stress is placed on the executive and it takes a strong, **resilient leader** to overcome these pressures, bounce back, and

keep the organization moving forward. Everyday practices can be stressful enough, but in today's society, a health care leader must also have to contend with the possibility of unforeseen crises and emergencies which arise from man-made as well as environmental attacks. Certain resilience-building practices can be used by the leader to build inner strength and perseverance (Wicks & Buck, 2013). A self-care protocol that includes self-awareness, alone time, mindfulness, and keeping a healthy perspective can be essential to not only leaders but also to coach their team members to avoid burnout and foster high staff morale. A health care leader has a responsibility to build organizational resilience by playing a central role in fostering resilient practices (Bowen, 2018).

Discursive Leadership

Good communication is critical for health care leaders. Much has been written about communication strategies which can increase the leader's ability to influence and motivate people (Walston, 2017). This occurs at various levels; interpersonal, inter-group, intra-group, organizational, and external. A new leadership theory, entitled **discursive**, presents leadership as being created through communication practices that are negotiated between the leader and follower (Northouse, 2019).

The Emerging Health Care Leader

Students of health administration do not become successful leaders overnight. It usually takes years of study and experience to become comfortable and proficient in the role. A basic foundation is necessary before a leader can emerge and certain strategies can be applied to help an individual build and grow their career (Baedke & Lamberton, 2015). Some of these include paying attention to one's character, examining self-discipline, cultivating your personal brand, and constant networking. The best leaders are ones who are continually learning and using this new knowledge to further their development as a leader in today's changing health care world.

Leadership Styles

Models give us a broad understanding of someone's leadership philosophy. Styles demonstrate a particular type of leadership behavior that is consistently used. Various authors have attempted to explain different leadership styles (Northouse, 2018; Studer, 2008). Some styles are more appropriate to use with certain health care workers, depending on their education, training, competence, motivation, experience, and personal needs. The environment must also be considered when deciding which style is the best fit.

In a **coercive leadership style** power is used to get a desired response from a follower. This very directive format should probably not be used unless the leader is dealing with a very problematic subordinate or is in an emergency situation and needs immediate action. In health care settings over longer periods of time, three other leadership styles could be used more effectively: **participative**, **pacesetting**, and **coaching**.

Many health care workers are highly trained, specialized individuals who know much more about their area of expertise than their supervisor. Take the generally trained chief operating officers of a hospital who have several department managers (e.g., Imaging, Health Information Systems, Engineering) reporting to them. These managers will respond better and be more productive if the leader is participative in style. Asking these managers for their input and giving them a voice in making decisions will let them know they are respected and valued.

In a pacesetting style, leaders set high performance standards for their followers. This is very effective when the employees are self-motivated and highly competent—e.g., research scientists or intensive care nurses. A coaching style is recommended for the very top personnel in an organization. With this style, leaders focus on the