HSPM Study Guide: 1
October 10/17

Chapter1: Health Care Settings

Direct Care Settings: provide care to a patient, resident or client who seeks services from the organization.
Non-Direct Care Settings: are not directly involved in providing care to persons needing health services, but rather support the care of individuals through product and services made available to direct care settings.
Health Care Management: is the profession that provides leadership and direction to organizations that deliver personal health searches and to divisions, departments and units or strives within those organizations.

External Domains: Refers to the influences, resources and activities that exist outside the boundary of the organization but that significantly affect the organization.

Management:

1. Planning
2. Organizing
3. Staffing
4. Controlling
5. Directing
6. Decision making

Competency: refers to a state in which an individual has the requisite or adequate ability or qualities t perform certain functions

- -Conceptual Skills
- -Technical Skills
- -Interpersonal Skills

Matrix Model:
Recognizes that a strict functional structure may limit the organization's flexibility to carryout the work and that the expertise of other disciplines is needed on a continuous basis.

Leadership Development:
-Courses on leadership and management
-Mentoring
-Personal development coaching
-Job Enlargement
-360-degree Performance Feedback

Chapter 2: Leadership: Leaders as well as Managers

Types of Leaders:

1. Strategic Leader: purpose and vision and aligns people, processes and values may be needed.
    1. Within an organization
    2. Defines purpose/vision
    3. EX: CEO
2. Network Leader: who could connect people, processes and values may need needed.
    1. Relationships
    2. Connects people across disciplines, departments, and regions

3. Operational Leader: managers that focus will be more internal within the organization's operations.
    1. Day to day task
    2. Organizational operations, can be formal
    3. EX: CIO (chief of information officer)

Historical Models of Leadership

Great Man Theory:

-1st formal theory.
- "Born a Leader" mentality.
- 1920s/30s, white, male, strong

Style Approach:

-Leaders have 2 behaviors: complete task, create relationships.
-Not fixed traits
-This theory states leaders have differing degrees of concern over each of these behaviors-but the best leaders would give equal attention to both.

Situational Approach:

-Leader changes their behavior based on the situation.
-Adaptable to people and environment
-implies a very fluid leadership process whereby one can adapt one's actions to an employee's needs at any given time.

Contingency Theory:

-Very popular in the 1970s
-Leader's style and situation
-combination of situational and style approach
-abilities alone aren't enough.

Path-Goal Theory:

-Depends on satisfaction, motivation, and performance of his or her subordinates
-Reach goals
-Goals of organization

Transformational Leader:

-Role model, inspirational, motivational.
-Teams, create a vision to inspire change
-Nurturing needed as they produce results desired.

Leader-Member Exchange Theory:

-Leadership was being defined by the leader, the follower and connect.
-New way of looking at leadership through: interaction that occur between leaders and followers.
-This theory claimed more leaders could be more effective if they developed better relationships with their subordinates through high-quality changes.

Adaptive Leadership:

-Self-aware leaders who are concerned for their employees and understand the importance of meaningful work.
-Create flexible organizations to meet the relentless succession of challenges faced in health care and elsewhere.

Contemporary Models of Leadership

Emotional Intelligence: 4 Domains

1. Self awareness: emotional
2. Social awareness: empathy
3. Self Management: transparency
4. Relationship Management: developing others

Authentic Leadership: people will want to naturally associate with someone who is following their internal compass of true purpose. They define their values and leadership principles, understand what motivates them, build a strong support team and stay grounded by integrating all aspects of their lives.

Diversity Leadership: being self-aware of social tensions between groups, differences and similarities. The environment must be assessed so goals can be set that embrace the concept of diversity work for the organization.

Servant Leadership: inspire and help others. Also known as the "Ghandi Approach." Applies this concept to top administrations ability to lead, acknowledging that health care leader is largely motivated hierarchy and professes the belief in building a community within the organization.

Resilient Leadership: do not bounce back, bounce FORWARD! Keeps the organization moving forward, with inner strength and perseverance.

Leadership Styles:

1. Coercive: demanding, power based style. Directive format should not be used unless the leader is dealing with very problematic subordinate or is in an emergency situation.
2. Participative: input, allowing decision making improvement
3. Pace-Setting: setting high performance standards and numbers
4. Coaching: personal development

Chapter 3: Management and Motivation

Employee Engagement
-one of the most disliked business jargon terms.

Towers Watsons:
-how well employees understand roles
-how much passion they bring
-how willing they're investing discretionary effort (above and beyond) to preform your tasks

Engagement Valable to:
-Happier= working harder, making companies more money

Culture of engagement -> emotional state -> behaviors of engagement -> business benefits -> profits

Challenges in employee engagement in healthcare:

-technology
-dedication and energy
-compassion

Motivation and Engagement: "Why employees are engaged"

Intrinsic	VS	**Extrinsic**
Internal Benefits to you		Outside benefits to you
Motivation within you, do what you love/want to do		Given something/ incentives Salary/bonus/benefits

Maslow's Heiarchy of Needs
Self-actualization (smallest)
Esteem
Love/belonging
Society
Physiological (biggest)

Herzberg 2 Factor Theory ('03) (these things can mix)
Hygienes: lower level motivations working conditions, salary.
Motivators: higher-level factors, achievement and recognition.

McGregor's Theory X and Theory Y
-Based on work of Herzburg
-Theory X: managers view people as unmotivated, managers focus on hygiene.
-Theory Y: managers assist employees in achieving higher level motivators.

McClelland's Acquired Needs Theory (1985)
-Needs required throughout life, learned-not innate
-3 Types of needs:

1. Achievement: desire for success
   Reachable goals.
2. Affiliation: desire for relationships
   Cooperative environment.
3. Power: desire for power, authority over others.
   Power Seekers.

Organizational Behavior
-Emotion attitude, thoughts drives behavior.
-Thinking drives behavior

1. Fill information, maximizing your value.
2. Max benefits
3. Based on objective facts
4. Affinity
5. In group bias
6. Halo/Horn affect

(#1-3: rational thinking)

Bias

1. Availability: refers to the judging the importance of information because it is easy to recall examples.
2. Over Confidence: widespread tendency to overestimate the accuracy of our won judgments, so we act upon opinion or institution without people are highly confident their conclusions are right when in reality, they are wrong.

3. Confirmation: means we unconsciously and selectively notice information that simply confirms out existing beliefs.

Bias is NOT discrimination

Typer of Research on Bias in Healthcare
1. Developing the problem
2. Test solutions

Healthcare Marketing
-Customer: do not know
-Marketing: activity
-Marketing Plan: written document the serves to guide marketing initiatives across organization. Part of a broader strategic plan.

Development of a Marketing strategy can be viewed at three main levels:
1. Core strategy
2. Competitive positioning
3. Implantation of the strategy

MIX 4P's: (1-4)
4. Product: item/service, satisfies customer needs
5. Price: amount paid, do not set prices
6. Place: where services is developed
7. Promotion: marketing communications (balance of advertising, PR, message strategy).

Segmentation Targeting Positioning: STP
Segmentation: process of dividing total market into groups (place-geographical, psychographic personality traits), demographic ages & gender, Behavioral (brand, loyalty, etc)

Target: is the segment beneficial.
-Discernible: how segments are different
-Accessible: how segment can be accessed have marketing communications produced by form.
-Measurable: can be segment be qualified and size determined

Target Markets: undifferentiated, differentiated, niche.
Position: how to position a product/service in relation to others in the minds of customers

Quality of Health Care:
-Degree to which health services for individuals for populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.
    -Effective: achieving health outcomes. "Right Treatment."
    -Efficient: "Are things done right?" Payer, policy, desired health outcomes for populations.

Donabedian (1966):
1. Structure
2. Process
3. Outcome

-Technical Management: focuses on the clinical performance of health care providers
-Interpersonal relationships: managed by technical management, underscores the coproduction of care by both providers and patients.
-Amenities of care: speak to the patient's interest in being treated in comfortable, clean surroundings
-Ethical principles guiding care: speak to the provider's ethical conduct in delivering care and his/her furthering societal and organizational well being.

1. Underuse: a failure to provide a service whose benefit is greater than its risk.
2. Overuse: quality problem, occurs when a health service is provided when it outweighs its benefits.
3. Misuse: occurs when the right service is provided badly and avoidable complication reduces and benefit the patient receives.

Continuous quality improvement: to meet or exceed customer expectations.

CQI: 5 Dementions:
1. Process focus: factors that create variation in process will influence quality of care.
2. Customer focus: "delight in the customer."
3. Data-based decision making: make decisions visiting data.
4. Employee empowerment: individuals who work in an area are involved in the CQI, not just a manager telling employees what to do and how to do their job.
5. Organizational scope/impact: impacts across level and priorities.

FOCUS/PDCA
F: Find- identify a process problem.
O: Organize- put together team to work on process
C: Clarify- use techniques to clarify the problems. Flow charting.
U: Understand- measure and collect data to document the problem.
S: Select: identify process improvements for implementation.

FOCUS/**PDCA**
P: Plan- create implantation plan into taking the process to the next level.
D: Do- implement/test new processes
C: Check- evaluate measures used to asses outcomes
A: Act- continuation or not of new processes.

Six Sigma: DMAIC:
Data Driven Quality

D: Define- launch teams
M: Measure- document processes
A: Analyze- look at data
I: Improve- generate solutions
C: Control- control the process

Fishbone Diagram: Exploring root causes for undesirable effects
Drawn Below