CHAPTER 1

THE WORK OF MANAGERS IN HEALTH PROGRAMS

LEARNING OBJECTIVES

After reading this chapter, you should be able to:

- Define health, health programs, and management
- Understand the core and facilitative activities of managers' work
- Understand the roles managers play as they do management work
- Appreciate the underlying competencies demonstrated by managers in doing management work
- Understand the importance of applying well-developed personal ethical standards in doing management work

Much of the pursuit of health occurs through a variety of health programs. For example, when a young adult with type 2 diabetes leads an active and productive life, her health improvements may well be attributed to a program that helps her understand the disease and take an active role in controlling it. When the federal Center for Medicare and Medicaid Innovation established the Innovation Advisors Program, supporting individuals who test and refine new models to drive health delivery system reform, improvements in the delivery system were made more likely (Centers for Medicare and Medicaid Services 2014). When a county health department mounts a project to enroll children in an innovative insurance plan, the impact on those children may be felt throughout a lifetime of better health.

One of the distinguishing characteristics of successful programs is how well their managers perform. This book is about the work program managers do. This chapter provides an overview of management work in health programs, as well as some key definitions and concepts, all of which serve as a framework for navigating the remainder of the book. Management work is described in terms of a set of core activities managers undertake in performing their work—developing/strategizing, designing, and leading—and a set of facilitative activities that also are important to management work—communicating, decision making, managing quality, marketing, and evaluating.

As a backdrop for considering management work, it is important to know that three distinct types of work occur in health programs (Charns and Gittell 2006). Direct work entails the actual provision of services or creation of products by participants in a program. This type of work is done by counselors, nurses, therapists, physicians,

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health educators, and others who form what Mintzberg (1992) classically termed the "operating core" of a program.

A second type of work done in health programs is support work. This work is a necessary adjuvant to the direct work. In health programs, participants performing support work are involved in such activities as fund-raising and development; recruiting patients for a clinical trial; providing legal counsel; or providing marketing, public relations accounting, or financial services for a program.

The third type of work done in health programs is management work. This work involves establishing—often with the direct involvement of others—the mission and objectives a program is intended to achieve, and creating the circumstances through which the direct work, aided by support work, can lead to the accomplishment of that mission and fulfillment of objectives.

An example will clarify the different types of work. A manager may establish one of the objectives of a program as enrolling one thousand children in an innovative insurance plan. The establishment of this objective is management work, as is the training of program participants to help parents or guardians enroll children. The act of enrolling children in the plan is some of the direct work of the program. The manager may also arrange for publicity surrounding the plan to increase awareness and encourage enrollment. The provision of publicity is support work, although arranging for the publicity is management work.

As we will see in this chapter, one useful way to assess and study management work is in terms of the activities managers engage in as they do this work. Often in the management literature the term *functions* is used instead of *activities* (Daft 2014; Marquis and Huston 2012). I will generally use the term activities, although the two words are interchangeable in this context. I will also discuss the roles that managers play in performing their work, as well as the competencies needed to do management work well.

Key Definitions

Before considering management work in more depth, it is useful to establish several key definitions to describe health and health determinants, health programs, and program management.

Health and Health Determinants

The World Health Organization (www.who.int/en/) has provided a long-standing definition of ***health*** as the "state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity" (World

Health Organization 1948, 100). The state of health in human beings is a function of ***health determinants***, which are a "range of personal, social, economic, and environmental factors that influence health" at both the individual level and the population level (U.S. Department of Health and Human Services 2014). The wide variety of determinants means that health programs have an enormous range of possible foci.

Health determinants for individuals or populations include the physical environments in which people live and work; their behaviors; and their biology (genetic makeup, family history, and physical and mental health problems acquired during life). Health determinants also include a host of social factors, which include economic circumstances; one's socioeconomic position in society; income distribution; discrimination based on race or ethnicity, gender, sexual orientation, or some other characteristic; as well as the availability of social networks and social support. Finally, the health services to which people have access also are health determinants (U.S. Department of Health and Human Services 2014). Health programs can be focused on any of these determinants, as well as on combinations of them.

Health Programs

A ***program*** is generally defined as an organizational unit intended to accomplish one or more objectives through a plan of action that describes what work is to be done, by whom, when, and how, as well as what resources will be used. Programs are embedded in organizations and exist to be of benefit to the larger host organization. Figure 1.1 depicts a program embedded in a host health services organization.

Host organizations can be very large, involving thousands of participants. Expansive integrated health systems, large foundations, agencies of the federal government, or state health departments, for example, are large organizations that house numerous health programs. Interestingly, even though programs are typically much smaller than such organizations, they are in fact themselves organizations. Therefore, another way to define programs is as organizations, albeit usually small ones. They are organizations in that they meet the standard definition of an organization: groups of people and other resources formally associated with each other through intentionally designed patterns of relationships to pursue desired results. Wholey, Hatry, and Newcomer (2010, 5) defined a program as "a set of resources and activities directed toward one or more common goals, typically under the direction of a single manager or management team." Because health programs are embedded within larger organizations, it is useful to think of these programs as organizations within organizations.

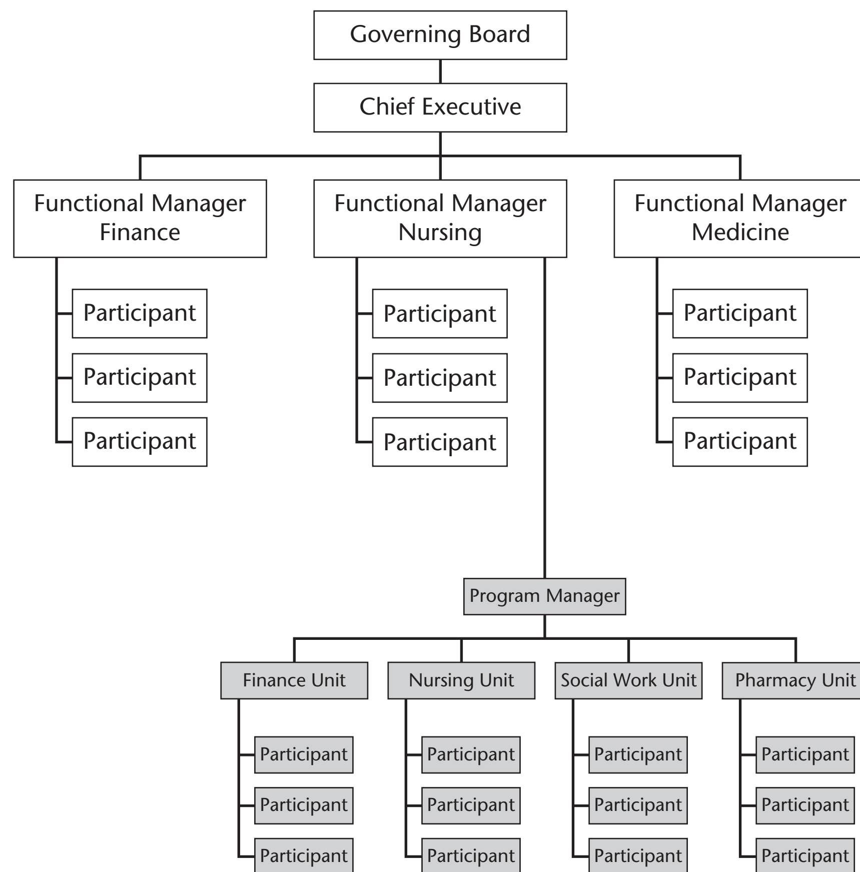

Figure 1.1 An Organization Design Depicting a Program Embedded in a Host Health Services Organization

Programs that pertain to any of the determinants of health noted earlier are by definition ***health programs***. Thus health programs address some aspect of the physical environments in which people live and work, their behaviors, their biology, the social factors that affect them, or the health services they receive.

The terms *programs* and *projects* are sometimes used interchangeably, although they do not refer to the same things. The differences between programs and projects are rather subjective and pertain mostly to scope and longevity. Some people view projects as subsets of programs. For example, the Project Management Institute (2013, 165) views a program as a "group of related projects." The institute defines a project as "a temporary endeavor undertaken to create a unique product, service, or result" (168). In this view, projects are smaller and more focused than programs. In addition, projects are typically more time limited. That is, a project has a predetermined life

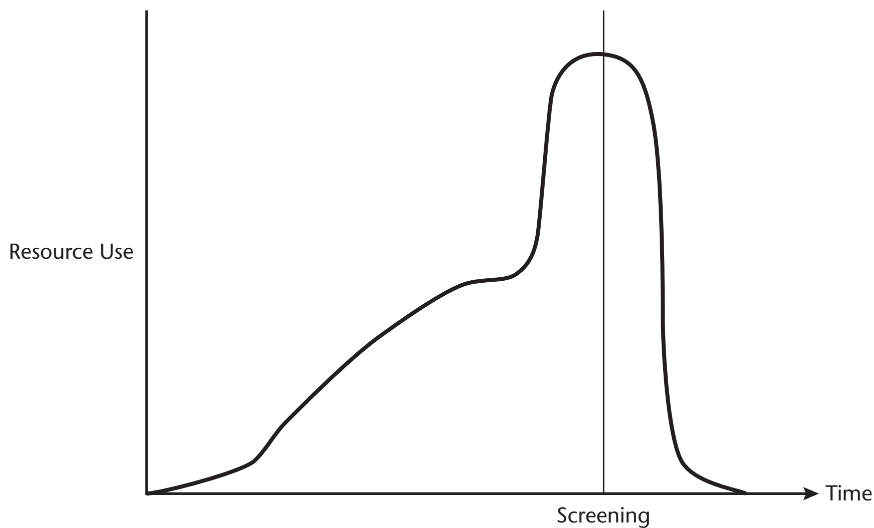

Figure 1.2 A Project's Life Cycle

cycle, and a program may have a more indeterminate life cycle. The duration of a project is scheduled at its beginning, although some run for a longer or shorter duration than originally planned because of changing circumstances.

Figure 1.2 graphically depicts a project's life cycle. Assume that the project is intended to involve conducting diabetes screenings at an annual health fair. The curve reflects the consumption of human, financial, and material resources during the life cycle of the project. A gradual buildup of activity during which arrangements are made for the conduct of the screenings precedes the peak of activity when the actual conduct of the screenings occurs, and the peak is followed immediately by the project's conclusion and termination.

Examples of Health Programs and Projects

Examples of health programs include those in cancer care, cardiac rehabilitation, data and statistics, geriatrics, health education, home care, palliative care, prevention, health promotion, research and development, substance abuse, wellness, and women's health. Less obvious examples of health programs include housing programs, job training programs, or programs to clean up the physical environment, as well as programs aimed at reducing ignorance, illiteracy, discrimination, or poverty. These less obvious examples are also health programs because they address one or another health determinant. Appendix A provides a brief description of a health program, the Global Health Program, embedded in a host organization, the Bill and Melinda Gates Foundation.

Examples of health projects include research or demonstration projects pertaining to a health determinant, as well as projects to promote seat belt use, healthier eating, or safe sex practices. Projects also may be designed to achieve some specific physical or intellectual purpose within a host program or organization, such as designing and equipping a laboratory, training a staff in a new protocol or to use some new technology, designing an information system, or developing a strategic plan or a new accounting system. Appendix B provides a brief overview of a health project, the Mass General Care Management Project, which. involves testing ways to improve coordination of care for Medicare patients.

Program Management

The definition of ***program management*** begins with a generic definition of ***management***, and there are many. Daft (2014, 6), for example, defined management in any organizational setting as "the attainment of organizational goals in an effective and efficient manner through planning, organizing, leading, and controlling organizational resources." In another source, management is defined as "the process, composed of interrelated social and technical functions and activities, occurring within a formal organizational setting for the purpose of helping establish objectives and accomplishing the predetermined objectives through the use of human and other resources" (Longest and Darr 2014, 255).

Building on these and other similar generic definitions of management, and in light of the earlier discussion of management work in terms of the activities of managers, program management is here defined as the activities through which the mission and objectives of a program are established and pursued by means of various processes using human and other resources.

Managers, when doing management work, often with the help of other participants in a program or in the organization in which it is embedded, seek to accomplish the following tasks:

- Analyzing variables in the program's external environment, assessing their importance and relevance, and responding to them appropriately
- Determining the program's mission and objectives
- Assembling the resources necessary to achieve the desired results
- Determining the processes necessary to accomplish the mission and objectives, and ensuring that the processes are carried out effectively and efficiently
- Leading others in contributing to accomplishment of the mission and objectives

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The Work of Program Managers in Terms of Core and Facilitative Activities

In performing ***management work***, managers engage in an interrelated set of activities and play a variety of interconnected roles, both of which are facilitated by possession and use of certain competencies. All three perspectives on management work are considered in this chapter. Subsequently, the book itself is organized around the activities that program managers engage in as they manage. These activities are divided into a set of core activities and a set of facilitative activities that together constitute program management work.

Throughout this chapter and in the more in-depth discussions that follow in the book, the descriptions of, and prescriptions and recommendations pertaining to, the activities in which program managers engage reflect as much as possible evidence-based management, also known as EBMgt (Briner, Denyer, and Rousseau 2009; Kovner, Fine, and D'Aquila 2009; Rousseau 2014), or the more specific evidence-based health services management, also known as EBHSM (Kovner and Rundall 2006). The practice of management is not as evidence based as it should be, although it is moving in this direction. In essence, practicing evidence-based management means that managers, like clinicians practicing evidence-based medicine, ground their professional work in empirical evidence from management research (Walshe and Rundall 2001).

Core Activities in Program Management Work

All health program managers engage in three ***core management activities*** as they perform management work: developing/strategizing, designing, and leading. This conceptualization of management work is similar to one developed by Zuckerman and Dowling (1997), although it extends their conceptualization and applies it specifically to managing health programs. In performing these core activities, managers also engage in other activities that facilitate and support accomplishment of the core activities. These facilitative activities are briefly discussed later in this chapter, and a subsequent chapter is devoted to each of them. The core developing/strategizing, designing, and leading activities of program management work are modeled in Figure 1.3, and are discussed briefly in the following subsections as an introduction to the more detailed discussions of these activities in subsequent chapters.

All managers perform these core activities regardless of their hierarchical level in an organizational setting. There are of course differences

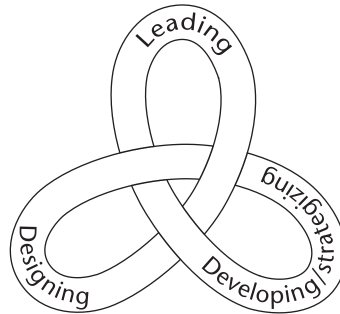

Figure 1.3 Model of the Core Activities in Program Management Work

between the work of managers at the level of programs and the work of the president or chief executive officer (CEO) of a large host organization. But the work of managers at both, and other, levels can be considered in terms of this set of core activities.

In considering management work in terms of these activities, it is convenient to separate them so that each can be discussed independently; but management work should not be viewed as a series of separate activities sequentially performed. In practice, a manager performs these activities simultaneously, not sequentially, and as part of an interdependent mosaic of activities. The separation of management activities is necessary for the purposes of our discussion, but it is an artificial treatment of the reality of managing.

Developing/Strategizing

Programs come into existence because someone develops them and strategizes their future. Developing a program initially simply means conceptualizing the program as a vehicle for delivering services or products that may succeed in the marketplace. In ongoing programs, development pertains to improving established services or products or to expanding a program's portfolio of services or products. Development triggers strategizing, which is the work that managers do as they establish or revise the specific mission and objectives of a program and plan the means of achieving them.

Although the relative degree of the work's complexity may vary, managers of all programs engage in ***developing/strategizing*** as part of performing their management work. This activity not only results in decisions about the existence, revision, purpose, and direction of programs but also helps managers adapt their programs to the challenges and opportunities presented by continuously and often turbulently changing external environments (Ginter, Duncan, and Swayne 2013).

The aim of developing/strategizing is to achieve an integrated set of direct, support, and management work sufficient to establish and achieve the results envisioned for a program. Effective developing/strategizing lays the foundation for designing effective relationships among people and other resources that are necessary to achieve desired results. It also provides the blueprint managers use in leading others in contributing to their achievement.

There are a number of reasons why developing/strategizing activities are so crucial to the success of health programs. Perhaps none is more important than the simple fact that developing/strategizing focuses attention on desired results. When done well, developing/strategizing activities yield statements of intended results, expressed as a mission and objectives, and help conceptualize the means through which these can be achieved. In this way, developing/strategizing contributes to the coordination and integration of the actions of all participants in a program toward shared purposes.

Another reason why developing/strategizing is important in ongoing programs is that it helps offset the pervasive uncertainty that health programs face. When managers anticipate the future and plan for contingencies that can be imagined or foreseen, they greatly reduce the possibility of being caught unprepared. Uncertainty cannot be eliminated, but it can be prepared for through developing/strategizing. Conditions of uncertainty require that programs be adaptable and flexible, which makes developing/strategizing a critical core activity in management work.

A third reason why developing/strategizing is important is that it enhances efficiency and effectiveness. By performing this activity, a manager facilitates the substitution of coordinated and integrated effort in place of random activity, controlled flow of work in place of uneven flow, and careful decisions in place of snap judgments. Growing pressure for health programs to be operated efficiently and effectively increases the importance and value of developing/strategizing as a core management activity.

Finally, developing/strategizing in health programs is important because it facilitates managers' efforts to assess and control results. Controlling relies on comparing actual results with predetermined, desired results and taking corrective action when actual results do not match desired results. Good strategizing yields statements of desired results against which actual results can be compared.

Control techniques are based on the same basic elements, regardless of whether quality, cost, participant or patient/customer satisfaction, or some other variable is being controlled. Controlling, wherever it occurs, involves four steps: (1) establishing desired results, (2) measuring performance, (3)

comparing actual results with desired results, and (4) correcting deviations from desired results when they occur. As will be seen later on, the facilitative activity of evaluating is important to effective control.

Designing

Designing is the work managers do when establishing and changing the intentional patterns of relationships among human and other resources within a program and when establishing and changing the relationship of the program to its external environment, including to the larger organizational home in which it is embedded.

Designing activity permits a manager to establish an organizational structure for a program. This includes assembling the necessary inputs or resources for a program. Because human resources are key resources in all programs, the designation of individual positions and the aggregation or clustering of these positions into the work groups, teams, or other subunits of a program is a critical aspect of a manager's designing activity. The number and type of individual positions are typically determined by how a program's work is divided and specialized.

In larger programs, the designing activity may also include clustering work groups into divisions or other units, such as separate smaller projects, as well as determining how the various work groups and clusters of work groups are integrated and coordinated. A key part of designing is relating a program to its larger organizational home. For example, a program embedded in a county health department must fit within the context of that department. A program manager in such a setting reports to a superior in the larger organizational home, and in doing so makes certain that the program's mission and objectives are consistent with and supportive of those of the department in which it is embedded.

The pattern of relationships among the human and other resources that results from the designing activity forms the organization design of a program. Remember that a program is a type of organization. Further, staffing involves the specific activities of attracting and retaining people to occupy the positions in an organization design, and is thus a vital part of organizing a program.

In practice, an organization design proceeds from individual positions through a clustering of positions into work groups, which may serve as subunits of a program or may be the entire program. In the larger organizational home of a program, clustering of work groups also forms the organization design of the organization's departments and its larger subdivisions. Clustering eventually produces an entire organizational

structure and perhaps even a system comprising interconnected organizations.

Successful designs in health programs, as well as in larger organizations, depend on appropriate distributions of authority and responsibility as the program or organization is built up through the successive rounds of clustering. Authority is primarily the power one derives from occupying a position in an organization design. Responsibility can be thought of as the obligation to execute work, whether it is direct, support, or management work. Every participant in a program has responsibility as a result of his or her position. The source of responsibility is one's organizational superior. By delegating responsibility to an organizational subordinate, the superior creates a relationship between superior and subordinate that is based on obligation.

Effective organization designs achieve a balance between authority and responsibility. When responsibility is given to a participant, that person must also be given the necessary authority to make commitments, use resources, and perform the actions needed to fulfill the responsibility.

Depending on the circumstances of a program, a challenge for its design can stem from the degree of coordination required among participants. There is a correlation between the degree to which a program's work is divided and the need for attention to coordination among participants. The more differentiated the work is, the more important—and often the more difficult—the coordination task is likely to be. For example, a large, comprehensive program in women's health would involve many different people—managers, physicians, nurses, and counselors, for example—each performing highly differentiated work, making coordination quite challenging.

In addition, the direct, support, and management work in most programs are highly interdependent. This condition of functional interdependence makes achieving coordination an important aspect of the organization design of a program.

Another key to successful health program organization designs is the inclusion of features that minimize and resolve conflict among participants. Individuals participating in a program may perceive the program's mission or objectives differently, or may favor various pathways to their achievement. Conflict can occur between and among any of the various participants in a program, as well as with others outside the program.

Conflict involving two or more individuals within a program, as well as conflict between a program and its organizational home or one or more other entities, may arise. In fact, both forms of conflict should be anticipated, and can be addressed at least partially through the organization design. Even

such low levels of conflict as those evidenced by participants who dislike other participants or have difficulty getting along with others can reduce performance in a program. Thus, the prevention or resolution of conflict is an important aspect of successful organization designs.

Leading

The work that managers do when influencing other participants to contribute to the performance of a program is ***leading***. No matter how well a manager develops/strategizes and designs, a program's success also depends on the manager's effectively leading.

In leading the other participants in a program, the manager seeks to instill in them a shared understanding of the program's mission and objectives, and to stimulate determined and sustained efforts to achieve them. As leaders, managers focus on the various decisions and actions that affect a program, including those intended to ensure its survival and overall well-being.

Leading successfully in any setting is challenging. It is especially so in settings such as health programs, where leaders must satisfy diverse constituencies. It is necessary to take into account not only the often-heterogeneous needs and preferences of a program's patients/customers but also the needs and preferences of other participants. Only rarely are the needs and preferences of all participants in a program in complete harmony.

As Figure 1.3 illustrates, the core activities of managers are interrelated. Leading is not done in isolation from designing and developing/strategizing. How well managers engage in one of the core activities affects their performance of the others. In addition to undertaking these core activities of management work, managers engage in a number of other activities that facilitate and support their performance of the core activities. These facilitative activities are examined next, when we consider a more complete model of the activities that make up management work.

Facilitative Activities in Program Management Work

Managers routinely engage in decision making and communicating as they perform the core activities of developing/strategizing, designing, and leading. Increasingly, they also engage in managing quality and marketing, and evaluating is a common activity in most programs. Thus, Figure 1.3 can be expanded into a more complete model of the activities performed in management work as a manager seeks to ensure the success of a program.

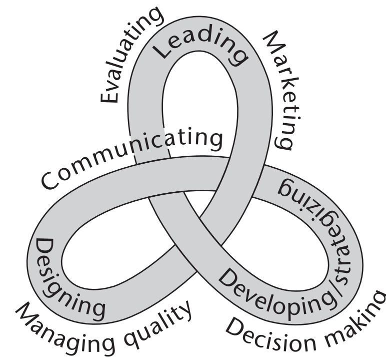

Figure 1.4 Model of the Core and Facilitative Activities in Program Management Work

Figure 1.4 shows the ***facilitative management activities*** of decision making, communicating, managing quality, marketing, and evaluating intertwined with the core activities involved in management work.

Decision Making

Decision making permeates all management work. Performance of the core activities of management work requires extensive ***decision making***, as does performance of the other facilitative activities. Managers make decisions when they establish desired results through developing/strategizing or when they make alterations in a program's organization design. In fact, not only are designs subject to change, but all management work is performed in a dynamic context that requires continual decision making to modify such variables as missions and objectives as well as the means to accomplish them through tasks, technologies, and people.

Decision making is simply making a choice between two or more alternatives (DuBrin 2012; Dunn 2010). The myriad decisions that program managers face can be divided into two subsets: problem-solving decisions and opportunistic decisions. Problem-solving decisions are made to solve existing or anticipated problems. Opportunistic decisions are typically sporadic and arise with opportunities to reshape or advance accomplishment of a program's mission and objectives.

Communicating

Just as decision-making activities permeate all management work, ***communicating*** is also ubiquitous in facilitating a manager's performance of the core activities of developing/strategizing, designing, and leading (Adler and Elmhorst 2012). For example, managers who can effectively articulate and

communicate their ideas and preferences have a distinct advantage in leading a program's participants. Communicating with participants is vital if they are to be involved in establishing and changing the program's organization design; and the design's details must be effectively communicated if those affected by the design are to understand it. Communicating is essential in establishing strategies for a program and in sharing the strategies with stakeholders—individuals inside as well as individuals, groups, and other organizations outside the program with significant interests in it.

Communicating involves senders (individuals, groups, or organizations) conveying ideas, intentions, and information to receivers (also individuals, groups, or organizations). Communication is effective when receivers understand ideas, intentions, or information as senders intend. Managers must be concerned with communication in two contexts: (1) communicating with a program's internal stakeholders, and (2) facilitating communication between the program and other stakeholders in its external environment.

Managing Quality

In successfully managing health programs, managers are heavily involved in ***managing quality***. Not only is quality obviously important to those for whom services are provided, but also it is important to the people who work in programs. For example, it has been shown that working in an environment characterized by efforts to continuously improve quality yields higher levels of work satisfaction among participants (Berlowitz et al. 2003).

In a widely used definition, the Institute of Medicine (IOM; 1990, 128–129) defined quality as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge." In addition to this definition of quality, the IOM (2001) also established six aims for quality improvement, saying that health care should be all of the following: safe, effective, patient centered, timely, efficient, and equitable.

The IOM's definition of quality and the six aims for quality improvement apply equally well to programs intended to serve individuals and those aimed at populations. Paying specific attention to population-based public health programs, the U.S. Department of Health and Human Services (2008) has developed the *Consensus Statement on Quality in the Public Health System,* in which quality in public health is defined as "the degree to which policies, programs, services, and research for the population increase desired health outcomes and conditions in which the population can be

healthy" (1). The consensus statement also includes nine characteristics of quality in public health as follows (1):

- *Population-centered:* protecting and promoting healthy conditions and the health for the entire population
- *Equitable:* working to achieve health equity
- *Proactive:* formulating policies and sustainable practices in a timely manner, while mobilizing rapidly to address new and emerging threats and vulnerabilities
- *Health promoting:* ensuring policies and strategies that advance safe practices by providers and the population and increase the probability of positive health behaviors and outcomes
- *Risk-reducing:* diminishing adverse environmental and social events by implementing policies and strategies to reduce the probability of preventable injuries and illness or other negative outcomes
- *Vigilant:* intensifying practices and enacting policies to support enhancements to surveillance activities (e.g., technology, standardization, systems thinking/modeling)
- *Transparent:* ensuring openness in the delivery of services and practices with particular emphasis on valid, reliable, accessible, timely, and meaningful data that is readily available to stakeholders, including the public
- *Effective:* justifying investments by utilizing evidence, science, and best practices to achieve optimal results in areas of greatest need
- *Efficient:* understanding costs and benefits of public health interventions and to facilitate the optimal utilization of resources to achieve desired outcomes

In what we will call a total quality (TQ) approach in this book, managers are guided by the application of the three interrelated components as they seek to manage quality in a program: (1) focusing on the patients/customers of the program, (2) striving for continuous improvement, and (3) teamwork (Dean and Bowen 1994). Patient/customer focus means identifying what a program's patients/customers need and want, and then developing and delivering services that satisfy those needs and wants. Continuous improvement means making a commitment to ongoing efforts to examine the processes through which services are provided, in search of better ways to provide them. Teamwork is emphasized in a TQ approach because quality is a collective responsibility of all those involved in a program.

Marketing

The boundary between a program and its external environment is important territory for its manager. A manager can use ***marketing*** to effectively cross this boundary. Marketing is a facilitative management activity through which human and social needs can be identified and met (Kotler and Keller 2012). The purpose of marketing is to bring about voluntary exchanges with others outside a program so that the program's mission and objectives can be achieved. Others in the external environment that can be reached through marketing activities include potential patients/customers for a program's services, as well as others who can influence them. Engaging in exchanges with patients/customers is critical to the success of most programs, especially when services for sale are offered.

Successful programs also engage in voluntary exchanges with physicians and other health services providers who are positioned to refer patients/customers, and with insurers and health plans that may permit or limit use of a program's services by their subscribers or members. Similarly, voluntary exchanges are made with the organization in which a program is embedded, with potential employees, and perhaps with donors and volunteers. All of these exchanges are supported and facilitated through marketing.

Evaluating

In essence, when program managers engage in ***evaluating***, they are collecting and analyzing information about a program or some aspect of a program as a basis for making decisions about the program (McNamara 2014). Program evaluation has been defined as "the application of systematic methods to address questions about program operations and results" (Wholey, Hatry, and Newcomer 2010, 5–6).

Managers engage in evaluating activities for a number of reasons, including the following: (1) to improve the overall performance of their programs, (2) to demonstrate accountability to stakeholders and justify the use of resources, (3) to demonstrate the effectiveness of their programs in terms of accomplishing missions and objectives, and (4) to demonstrate the effectiveness of specific interventions undertaken by programs.

There are many types of evaluations. Some are conducted during the development or ongoing implementation of a program, with the intent to improve the program. Other evaluations focus on the end results achieved by a program and are used to make decisions about the future of the program, including its continuation, termination, or major modification.

It is important to emphasize the interdependence among the full set of activities shown in Figure 1.4, including the core activities of management work (developing/strategizing, designing, and leading) and the facilitative activities of decision making, communicating, managing quality, marketing, and evaluating. Although it is convenient to separate these activities for purposes of discussion or description, the danger in doing so is that it may seem that managing is a series of separate activities, perhaps carried out in a particular sequence. In practice, managers do not perform the activities separately—and certainly not in a fixed sequence.

In addition to considering management work in terms of the activities described earlier, it is useful to consider this work in terms of the roles that managers play as they perform management work as well as the competencies that underpin program management work. These perspectives are described in the following sections.

Roles Played by Program Managers: The Mintzberg Model

Although it was conducted decades ago and did not focus specifically on health program managers, a historically important study of management work has direct applicability to the work of contemporary health program managers. In this seminal work, Mintzberg (1973, 1975) observed a sample of managers over a period of time, recorded and analyzed what they did, and concluded that management work can be described meaningfully in terms of three categories of interrelated ***roles*** that all managers play. Thus, another way to examine the work of managers is to think about the different roles they play.

Roles are the typical or customary sets of behaviors that accompany particular positions. Teachers play identifiable roles in schools, quarterbacks play defined roles on football teams, conductors play clear-cut roles in orchestras, and managers play roles as they perform management work. Mintzberg concluded that managers, simply because they are managers, must adopt certain patterns of behavior when doing management work.

He saw the work of managers in terms of three broad categories of roles—interpersonal, informational, and decisional—with each category comprising a number of separate and distinct roles as summarized in Figure 1.5.

Interpersonal Roles

In Mintzberg's (1973) view, all managers play interpersonal roles as figureheads, influencers or leaders, and liaisons. The figurehead role is played as

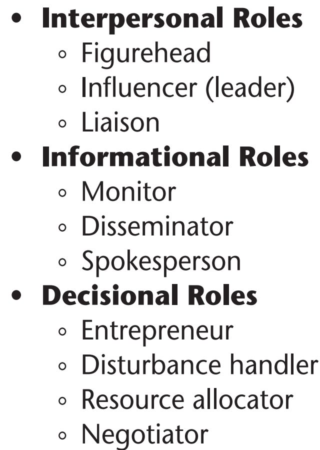

Figure 1.5 The Manager's Roles

managers engage in ceremonial and symbolic activities, such as presiding over the opening of an additional site for a program or giving a speech to a graduating class of speech pathology students. Managers play the role of influencer or leader when they seek to inspire others or to help motivate them to higher levels of performance, or when they set an example through their own behavior. The liaison role involves making formal and informal contact with those inside a given program as well as with external stakeholders. Managers usually play the liaison role to establish relationships that will help them achieve a program's mission and objectives.

Informational Roles

As Figure 1.5 illustrates, Mintzberg (1973) also ascribes a category of informational roles to managers, whereby they serve as monitors, disseminators, and spokespeople. In taking on the monitor role, managers gather information from their networks of contacts (including those established in playing the liaison role), filter the information, evaluate it, and choose how to act as a result of the information. The disseminator role grows out of access to information and managers' ability to choose what to do with the information they obtain. In dissemination, managers have many choices about whom inside and outside a program they route information to. The third informational role, that of spokesperson, is related to managers' figurehead role. As spokespeople, managers communicate information about a program to internal and external stakeholders.

Decisional Roles

The third category of roles managers play in Mintzberg's (1973) model, decisional roles, includes entrepreneur, disturbance handler, resource allocator, and negotiator roles. In the entrepreneur role, managers function as initiators and designers of changes intended to improve performance in a program. When playing this role, managers are acting as change agents. In the disturbance handler role, managers decide how to handle a wide variety of disturbances that arise as they carry out their daily work routines. A program manager may face disturbances created by participants, by a regulatory agency, or by the actions of a competitor. Even a heavy snowfall that makes it impossible for key participants to come to work can be a significant disturbance. The ability to handle disturbances is an important determinant of managerial success.

In playing the resource allocator role, a manager must allocate human and other resources across alternative uses. As resources become more constrained, decisions about resource allocation become more difficult and more important. In the negotiator role, managers interact and bargain with participants, suppliers, regulators, patients/customers, and others who have some relationship to a given program. Negotiating includes deciding what objectives or outcomes to seek through negotiation, as well as deciding what techniques will be used in conducting any negotiations.

The Gestalt of Program Managers' Roles

The ten managerial roles shown in Figure 1.5 cannot really be neatly separated. In practice, they are closely intertwined into a gestalt—an integrated whole. Management work is not merely a summation of these ten roles; it is much more. When the interconnected roles are each played well, the result is synergistic. Being a good negotiator makes a manager a better disturbance handler. Playing the informational roles effectively improves performance in the decisional roles, because managers will have better information on which to base their decisions.

Most, if not all, of the activities in which managers engage as they manage their programs can be categorized into one or more of the core or facilitative activities depicted in Figure 1.4. Similarly, the roles they play are comprehensively depicted in Figure 1.5. Descriptions of these activities and roles say very little, however, about the competencies needed to perform the activities or play the roles well. Another important element in getting a sense of what management work entails is therefore to understand the competencies successful managers possess.

Competencies That Underpin Program Management Work

A ***competency*** is "a cluster of related skills, knowledge, and ability (sometimes referred to by the acronym SKA) that: 1) affect a major part of one's job, 2) correlate with performance on the job, 3) can be measured against well accepted standards, and 4) can be improved by training and development" (Parry 1996, 48). A similar definition of a competency is "a cluster of related abilities, commitments, knowledge, and skills that enable a person (or an organization) to act effectively in a job or situation" (BusinessDictionary 2014). The competencies required of effective managers provide another useful way to consider program management work.

The earliest studies of management competencies were conducted to investigate the skills needed by managers. For example, decades ago Katz (1974) identified three types of skills that effective managers use: technical, conceptual, and human or interpersonal skills. The technical skills of managers, like the technical skills of physical therapists or nurses, are apparent as they do their work. A manager's work in counseling a participant in a program about performance, or developing a budget, requires technical skills. Human or interpersonal skills contribute to managers' ability to get along with other people, to understand them, and to lead them in the workplace. Conceptual skills reflect managers' ability to visualize mentally all the complex interrelationships that exist in the workplace. For example, relationships exist between a program and other departments or units in its organizational home. Relationships also exist between a program and components of its larger external environment. Conceptual skills permit managers to understand how the various factors in particular situations fit together and interact with one another. Conceptual skills are clearly reflected in the appropriateness and usefulness of a program's organization design.

More recently, the Katz model of skills required of managers has been broadened into a larger set of competencies (Longest and Darr 2014). In this newer model, the competencies that are useful to program managers are (1) conceptual, (2) technical (managerial and clinical), (3) interpersonal and collaborative, (4) policy, and (5) commercial. Each is discussed in the following subsections.

Conceptual Competence

In all settings, managers must be able to envision the place and role of a given program within its larger context. This may mean envisioning its place

and role in the larger society, as well as in the organizational home in which it is embedded. This competency also allows managers to visualize the complex interrelationships in the workplace—relationships among participants in a program, as well as relationships between the program and other units of its host organization or external entities with which it interacts.

In short, adequate conceptual competence allows managers to identify, understand, and interact with a program's myriad external and internal stakeholders. Conceptual competence also enhances managers' ability to comprehend the culture and historically developed values, beliefs, and norms present in a program, and to visualize its future.

Technical (Managerial and Clinical) Competence

The cluster of knowledge and associated skills that make up technical competence pertains to management work as well as to the direct work performed in a program. In health programs, direct work often involves clinical activities, such as conducting a health education session, performing a screening test, conducting a physical therapy session, or counseling a patient about nutrition. The technical aspects of management work, such as planning for a new service or facility or developing a program budget, are also crucial to a program's success. Knowledge and relevant skills in using or applying the knowledge in both clinical and management areas constitute technical competence for health program managers.

Interpersonal and Collaborative Competence

An important ingredient in managerial success is the cluster of knowledge and related skills pertaining to human interactions and relations by which managers lead others in pursuit of a program's mission and objectives. For example, a survey of managers in ambulatory health services settings intended to determine competencies most important to success in management performance found that interpersonal skills rated highest (Hudak et al. 1997). Interpersonal competence incorporates knowledge and skills useful in effectively interacting with others. It enables managers both to help participants achieve higher levels of motivation and to handle conflicts among participants.

The key elements of traditional interpersonal competence expand considerably when programs must interact with other organizational entities. This requires collaborative competence, which facilitates synergistic interaction between a program and various other organizational units. Collaborative competence is exercised, for example, when two programs are successfully merged, or when a joint venture among programs is created

and operated to better serve a particular population. This competency relies on a manager's ability to build trust between a program and other organizational units, and to effectively form partnerships with other units to achieve certain purposes. It also is reflected in the manager's ability to build effective coalitions and alliances.

Policy Competence

Policy competence, defined as the dual ability to accurately assess the impact of public policies on the performance of a program and to influence public policymaking at state and federal levels (Longest 2010), is an increasingly important area of competence for program managers. Managers can influence public policy at many points in the policymaking process. For example, they can help define problems that policies might address, they can help create solutions to the problems, or they can help establish the political circumstances necessary to advance solutions through the policymaking process (Kingdon 2010).

Program managers are often in an excellent position to have firsthand knowledge about particular health problems because they deal with them daily. And by permitting a program to serve as a demonstration site for assessing possible solutions, they can play an important role in identifying feasible solutions to problems.

Based on their knowledge and expertise in addressing particular health issues, managers can participate in drafting legislative proposals and testify at legislative hearings. They can also influence the rule-making process. Procedurally, rules are made to guide the implementation of public policies. The process of rule making is designed to include input in the form of formal comments on proposed rules from those who will be affected by them.

Commercial Competence

In any setting, commercial competence refers to managers' ability to establish and operate value-creating situations in which economic exchanges between buyers and sellers occur. Value in services produced by health programs has a specific meaning, and it requires that buyers and sellers think about both quality and price. Value is quality divided by price. Today, managers of health programs are being challenged at unprecedented levels to deliver value, which is created when services have more quality attributes desired by buyers than do the services of competitors, or when services can be provided with a comparable set of quality attributes at a lower price compared to the services of competitors (Burns, Bradley, and

Weiner 2012). The commercial success of health programs may be essential for their survival, requiring managers to possess commercial competence.

Managers' Use of Different Mixes of Competencies

All managers need the full set of competencies—conceptual, technical (managerial and clinical), interpersonal and collaborative, policy, and commercial—to perform management work effectively. Not all managers use the various competencies to the same degree, however, or in the same mix. For example, the management work that takes place in a very large program providing health education services could require three different levels of management and three different mixes of competencies. The program manager would be vitally concerned about the overall performance of the program and how it fit within its larger environment. If this program were housed in a hospital, for example, the manager would be concerned about how the program fit into the total picture of the hospital and its plans, including how the program might grow in the future. Such concerns would require a heavy dependence on conceptual, policy, and commercial competencies.

The large health education program might have major subdivisions—such as one focusing on services offered to individual clients and another focusing on offering services to employers for their employees—each with its own division director. These middle-level managers would rely more on their technical (managerial and clinical) competence and their interpersonal and collaborative competencies than on conceptual, policy, or commercial competencies, although like all managers they would use all the competencies to a degree. In this program the division managers would spend much of their time troubleshooting the health education services provided by their respective divisions of the program and might be constantly required to make decisions based on technical knowledge.

In contrast to the program manager and the two division directors, a health educator who is the account manager in charge of a team of educators providing a single employer with services might use a considerable amount of technical (managerial and clinical) competence, because in addition to being a first-level manager, or supervisor of direct work, this individual would have to provide health education services. This manager, more than either the program manager or the division directors, would also be required to use interpersonal and collaborative competence on the job, because almost all of this person's work would involve direct contact with the other educators on the team. The variation in the mixes of these five types of competencies used in management work can be seen in Figure 1.6.

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Program Manager
Conceptual
Technical (managerial and clinical)
Interpersonal and collaborative
Policy
Commercial

Division Director
Conceptual
Technical (managerial and clinical)
Interpersonal and collaborative
Policy
Commercial

Account Manager
Conceptual
Technical (managerial and clinical)
Interpersonal and collaborative
Policy
Commercial

Figure 1.6 Relative Mixes of Competencies Needed for Effective Management Work in a Large Program

The work of program managers has been viewed from the perspective of the activities managers engage in as they do their work (see Figure 1.4), from the perspective of the managerial roles they play in doing management work (see Figure 1.5), and from the perspective of the competencies needed to perform this work well (see Figure 1.6). Each perspective contributes to an understanding of program management work. In addition, it is important to consider the ethical aspects of management work.

Managing Health Programs Ethically

The beginning of an appreciation for the extent to which ethics affects management work rests in the recognition that all decisions and actions in health programs include ethical dimensions, whether they are clinical or management decisions, or some combination of these. Managers, if they are to behave ethically, must first recognize ethical issues, and then act on them.

Managers routinely make decisions and perform actions that have consequences for their programs, as well as for these programs' internal and external stakeholders. As a foundation for their decisions and actions, managers need well-developed personal ***ethical standards***. These standards must be applied in the context of the philosophy and culture of a given program, as well as in the context of the philosophy and culture of the

organization in which the program is embedded. Compatibility between the personal ethical standards of managers and those of the programs and organizations within which they work is important, and both sets of standards should be built on four key ethics principles: respect for persons, justice, beneficence, and nonmaleficence.

Respect for Persons

The principle of respect for persons has four elements: autonomy of persons, truth telling, confidentiality, and fidelity. The concept of autonomy recognizes that individuals have the right to their own beliefs and values, and that they have the right to make the decisions and choices that further those beliefs and values. Specifically, autonomy pertains to individuals' right to independent self-determination in regard to how they live their lives; it also pertains to the rights of individuals concerning what happens to them in health care situations.

In health programs, honoring the autonomy of patients/customers means not only following their wishes about their care but also letting them be involved in their care to the extent that they choose to be. It also means that when its patients/customers either are children or are adults with diminished competence due to a physical or mental condition, a program has special procedures to allow for surrogate decision making or substituted judgments.

The principle of respect for persons is especially important in regard to its effect on consent and the use of confidential patient information in health programs. Respect for persons as autonomous beings implies honesty in relationships with them. Closely related to honesty in such relationships is the element of confidentiality. Confidences broken will impair the performance of management work.

A third element of respect for persons is fidelity. This means doing one's duty and keeping one's word. Fidelity is often equated with promise keeping. When managers tell the truth, honor confidences, and keep promises, they are behaving in an ethically sound manner.

Decisions and actions that reflect the principle of respect for persons can sometimes be better understood in contrast to those reflecting its opposite—paternalism. Paternalism means that one thinks one knows what is best for someone else. Decisions and actions guided by a preference for autonomy limit paternalism. One of the most vivid examples of the application of this principle in health care is the 1990 Patient Self-Determination Act (PL 101-508). This public policy is designed to uphold individuals' right to make decisions concerning their health care, including the

right to accept or refuse treatment and the right to formulate advance directives concerning their care. These directives are a means by which competent individuals give instructions about their health care that are to be implemented at some later date, should they lack the capacity to make these decisions. In concept, this policy allows people to exercise their right to autonomy in advance of a time when they might no longer be able to actively exercise that right.

Justice

A second principle of significant ethical importance to managers and their work in programs is justice. The concept of justice has a direct impact on management work because justice, in the context of ethics, is defined as fairness (Rawls and Kelly 2001). The principle of justice also includes the concept of desert: justice is done when a person receives that which he or she deserves (Beauchamp and Childress 2012). The key ethical question in many of the decisions and actions of managers, deriving from attention to the principle of justice, is, of course, what is fair in this situation?

The principle of justice provides the underpinnings for many ethically sound decisions and actions concerning the allocation of resources. Decisions about resource allocation that adhere closely to the principle of justice are made under the provisions of a morally defensible system rather than being arbitrary or capricious. The application of justice in making decisions in health programs, as well as in other settings, is in part ensured by the existence of the legal system, which serves as an appeals mechanism for those who believe they have been done an injustice.

Beneficence and Nonmaleficence

Two other ethics principles that are of direct relevance to managers in health programs are beneficence and nonmaleficence. Beneficence means acting with charity and kindness. This principle is incorporated into acts through which services or products are provided that are beneficial to people, including the services of health programs. The principle of beneficence also includes, however, the more complex concept of balancing benefits and harms, which may require using the relative costs and benefits of alternative decisions and actions as one basis on which to choose from among alternatives.

The growing emphasis on cost-effectiveness in health care will increasingly bring into play the principle of beneficence in the conduct of management work in health programs. Managers who are guided by the principle of beneficence feel a positive duty to contribute to the welfare of

patients/customers. This inclination is rooted in the Hippocratic tradition and has a long and noble history in the health professions and in health services settings, including health programs.

Nonmaleficence, a principle with deep roots in medical ethics, is exemplified in the dictum "Primum non nocere," or "First, do no harm." Managers who are guided by the principle of nonmaleficence try to make decisions that minimize harm. Harm can be mental as well as physical, and it can be caused through such acts as violating the privacy of patients/customers. Whereas beneficence is a positive duty involving taking action to do good, nonmaleficence involves refraining from doing something that harms. The principles of beneficence and nonmaleficence are reflected in actions and decisions involving the assurance of the quality of the services of a program, and in managers' exercise of their fiduciary duties, their use of confidential information, and their resolution of conflicts of interest.

Supporting Ethical Behavior in Health Programs

Health programs by nature routinely involve people providing health services. In these situations, the service providers face a set of ethical obligations that stem from their roles as health professionals. These obligations may be summarized as follows:

- *Obligations between professionals and patients/customers.* As fiduciaries for their patients/customers, professionals must be honest, candid, competent, loyal, fair, and discreet in these relationships.
- *Obligations to third parties.* In many health programs, other people or organizations (for example, parents or other family members, employers, teachers, or insurance plans) have interests in the professional-patient/customer relationship. The ethical issues that arise from these obligations usually have to do with confidentiality and the protection of privacy. These issues also often involve compliance with laws, such as the Health Insurance Portability and Accountability Act (HIPAA). They may also involve responding to court orders. HIPAA includes privacy provisions that generally limit the use or disclosure of protected health information to a minimum necessary standard. It also gives patients the right to see and receive copies of their records, request amendments to their records, and learn details about disclosures of their records.
- *Obligations between professionals and their employers.* Obligations exist between professionals and the health programs that employ them. Ethical issues that arise from these obligations involve due process,

confidentiality, and professional support. Professionals, as participants in programs, have obligations to their employers that include being honest, candid, competent, loyal, fair, and discreet.

- *Obligations to the profession.* The professionals that work in health programs have obligations to their profession that include advancing knowledge, reforming the profession, and respecting the profession.

A number of codes of ethics have been developed for individual professions, as well as for various health services organizations. For example, the American Hospital Association has produced a prototype code of ethics for hospitals. It includes sections on the community roles and responsibilities of these institutions, on patient care therein, and on organizational conduct. The American Public Health Association has produced a code of ethics to guide the practice of public health. The American Association for Health Education offers a code of ethics for health educators. The American Medical Association adopted the first version of its *Principles of Medical Ethics* at its founding in 1847. The American Nurses Association has developed a code for nurses. The American College of Healthcare Executives provides a code of ethics to guide its members. Similarly, other health professions have developed codes. In fact, a code of ethics is a hallmark of any profession. Beyond these codes, many individual health services organizations develop their own. Such codes often provide very visible evidence of the commitment of organizations to ethical behavior; programs embedded in such organizations are also expected to follow these codes of ethics.

In addition to relying on codes of ethics developed by others, participants can follow the guidelines of a program-specific code of ethics. Program managers can support ethical behavior in other ways as well, such as by developing a culture or climate that minimizes ethical ambiguity and continuously reminds participants to make ethical decisions and take ethical actions (Martin and Cullen 2006). Ethical climates "influence both decision making and behavioral responses to ethical dilemmas, which then go on to be reflected in various work outcomes" (Simha and Cullen 2012, 20–21).

Managers can also reward ethical behavior and create a climate in which people are free to challenge standards or practices they consider unethical. Finally, managers can encourage ethical behavior by providing training in applied ethics to increase awareness of the ethical dimensions of decisions and actions, encourage critical evaluations of values and priorities, and help program participants integrate ethics considerations into their decisions and actions.

Managers and the Success of Programs

In concluding this introductory chapter, it is important to emphasize the significant impact that managers can have on their programs. The manager, more than anyone or anything else, establishes a program's work climate. A work climate is defined as comprising "the shared perceptions of procedures, policies, and practices [of a program], both formal and informal" (Simha and Cullen 2012, 20). Work climates are known to influence the behaviors of program participants to a great degree (Tsai and Huang 2008).

Health programs are not random groups of people assembled by chance interactions. Instead, they are consciously formed for the purpose of achieving a mission and specific objectives. From this fact stems the overarching purpose of all program management work, which is to facilitate the achievement of a program's intended results—that is, to accomplish its mission and fulfill its objectives.

The contributions managers make to the degree to which desired results are successfully achieved can be measured along many dimensions. Measuring managers' contributions to success may involve measuring a program's results in terms of counts of services and productivity levels, the quality of services, and patient/customer satisfaction. For example, the number of services rendered can be counted and compared to established targets. Productivity can be measured in terms of resources used per unit of service. The quality of the services provided by a program can be measured in terms of clinical outcomes achieved, as well as in terms of process measures (such as adherence to protocols) and input measures (such as the credentials of staff). Patient/customer satisfaction levels can be measured by surveys, and by loyalty demonstrated by continued use of services. Success can also be measured through such outcomes as changes in the attitudes, behaviors, health status, or level of functioning of patients/customers. Finally, managers' contributions can be measured in terms of the impact of a program on the overall health status of a community.

There is no universally accepted formula by which managers maximize their contributions to program effectiveness. There is, however, a correlation between a program's success and how well its manager performs the core activities of developing/strategizing, designing, and leading. Similarly, the manner in which a manager makes decisions, communicates, manages quality, markets the program, and evaluates the program has a direct bearing on success.

There is also a correlation between how well managers play their interpersonal, informational, and decisional roles and the level of performance a program attains. Similarly, it matters to performance whether or not a program's manager possesses and uses appropriate conceptual, technical

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(managerial and clinical), interpersonal and collaborative, policy, and commercial competencies. Effective managers, by creating conditions that are conducive to superior performance, make vital and unique contributions to the programs they manage. The remaining chapters in this book are intended to help program managers maximize their contributions to successful programs.

Summary

Definitions of health, health programs, and program management are provided in this chapter. Following the World Health Organization's (1948) view, health is defined as the "state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity." Health is discussed as a function of a number of health determinants, which for individuals or for populations include the physical environments in which people live and work; their behaviors; and their biology (genetic makeup, family history, and physical and mental health problems acquired during life). Health determinants also include a host of social factors, such as economic circumstances; one's socioeconomic position in society; income distribution; discrimination based on race or ethnicity, gender, sexual orientation, or some other characteristic; and the availability of social networks and social support. Further, the health services to which people have access also are health determinants. The variety of health determinants means that health programs can have a wide array of foci.

The work of health program managers is considered in terms of the core activities in which all managers engage as they do management work: developing/strategizing, designing, and leading. Consideration of this work is extended also to include the facilitative activities of management work: decision making, communicating, managing quality, marketing, and evaluating. The entire set of core and facilitative activities in management work is modeled graphically in Figure 1.4.

As an adjunct to the discussion of the activities in management work, Mintzberg's model of the roles that managers play in doing management work is also presented. Figure 1.5 summarizes these roles in interpersonal, informational, and decisional categories. There is also a discussion of the conceptual, technical (managerial and clinical), interpersonal and collaborative, policy, and commercial competencies necessary to manage health programs well.

The chapter acknowledges the growing impact that ethics considerations have on all actions and decisions in health programs in both the clinical and managerial spheres of activity. The ethics principles of respect for persons, justice, beneficence, and nonmaleficence are discussed as the basis for the construction of personal ethical standards for managers.

REVIEW QUESTIONS

1. Define health, health programs, and program management.
2. Discuss how the determinants of health shape the focus of health programs.
3. Briefly describe the core activities of management work.
4. Briefly describe the facilitative activities of management work.
5. Discuss the Mintzberg model of the roles managers play in doing their work.
6. Discuss the competencies that are useful to managers in performing their work, including the different mixes of competencies that would be appropriate in different circumstances.
7. Why is it important for managers to develop personal ethical standards? Discuss the principles on which such standards should be based.
8. Discuss the overall contributions managers make to the success of the health programs they manage.

KEY TERMS AND CONCEPTS

communicating
competency
core management activities
decision making
designing
developing/strategizing
ethical standards
evaluating
facilitative management activities
health
health determinants
health programs
leading
management
management work
managing quality
marketing
program
program management
roles

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