

## EMERGING INFLUENCES IN HEALTHCARE

“Don’t follow trends. Start trends.”  
—Frank Capra

### Chapter Objectives

After you have studied this chapter, you should be able to do the following:

1. Recognize the many forces affecting healthcare and healthcare management today.
2. Apply traditional management principles to address a rapidly changing healthcare environment.

### The Force of Change

At the beginning of this book, we discussed the manager’s role in the planning process. Planning for the future requires a combination of reflection on the past and anticipation of what is coming, both short and long term, in the years ahead. Managers in the years to come will deal with tremendous change as the healthcare industry reforms its mission. The industry is in a state of flux as a result of mergers, publicized patient safety ratings, closures, regulations, technology leaps, staffing shortages, and an informed consumer base with high demand for positive outcomes. Our staff members also will be concerned with threats from terrorist groups, personal financial constraints, and agitation among our residents. All of these issues, and many more, affect how a supervisor manages his department, structures his workplace, motivates his staff, and achieves his goals.

This chapter examines a variety of issues on the horizon and highlights those most likely to present management challenges. Up until now, the book has discussed relatively traditional approaches to the roles of management—planning, organizing, staffing, influencing, and controlling. The successful supervisor must take the theories explored throughout this book and apply them to the new challenges ahead. For our tenth edition, we discuss some challenges for the future during a time of healthcare reform. They relate to the areas of occupation and workforce, consumer involvement and satisfaction, technology and medicine, economics and regulation, communication, and quality of care.

## Changing Occupations and Workforce

Some experts believe that more than 2 billion jobs will disappear by 2030 (Frey 2014). But at the same time, new and different work will need to be done. Just as the 1985 Apple LaserWriter revolutionized desktop publishing, the 2010 MakerBot Thing-O-Matic 3D printer has given us desktop manufacturing. Automation is no longer the domain of the few, and the sooner the technology spreads across industries, the quicker everyone will participate (Frey 2014).

Such drastic workforce changes are nothing new. According to the US Census Bureau, the United States had 2,076,000 railroad workers in 1920; today they number only 113,800 (US Bureau of Labor Statistics 2014b). Conversely, today we have 325,800 medical technicians; in 1910 there were none (US Bureau of Labor Statistics 2014b). As the United States became more industrialized, some occupations were reduced or eliminated, and others were created.

Looking ahead, aging baby boomers will place a strain on the health-care system. Of today's 50-year-old women, 40 percent will live to be 100. Although healthcare professionals are specializing in many areas, geriatrics is not one of them. The United States will need an estimated 36,000 geriatricians by 2030, but it has fewer than 7,200 today (American Geriatrics Society 2015). Fewer than half (41 percent) of US medical schools have a structured geriatrics curriculum (Geriatrics Workforce Policy Studies Center 2008).

The situation concerning geriatricians is not unusual; there are staff shortages in almost every category of healthcare worker. The World Health Organization (2013) reported a worldwide shortage of 7.2 million healthcare workers, and it expects that number to increase to 12.9 million by 2035. A growing shortage of primary care physicians has caused many healthcare organizations to reconsider, and expand, the roles of nurse practitioners and physician assistants (Weldon 2014). In some states, pharmacists are being recruited to take on duties traditionally performed by physicians. An article in *Healthcare Finance News* described a recent California law that allows pharmacists with advanced licensure to perform patient assessments, order and analyze drug therapy tests, and take part in the evaluation and management of diseases and health conditions (Mosquera 2014). Nurse practitioners, physician assistants, and pharmacists are all being called on to fill the gap left by physicians who are retiring, reducing their patient load, or choosing to leave the field.

Because of a growing number of nursing school graduates, the United States is expected to have an excess of 340,000 registered nurses by 2025 (US Department of Health and Human Services et al. 2014). Supply is expected to outpace demand for dietitians and respiratory therapists as well (HRSA 2015). However, shortages are expected for many other healthcare professionals. The Health Resources and Services Administration (HRSA 2015) reports that, by 2025, demand will grow by 24 percent for nuclear medicine technicians and

radiology technicians and by 22 percent for medical and clinical laboratory technologists and technicians. Hospitals nationwide have reported vacancy rates of 18 percent for radiology technicians, 12 percent for laboratory technologists, and 9 percent for housekeeping and maintenance staff.

Every healthcare worker is an integral part of the larger system. When a shortage exists in any area, organization-wide management must adjust existing processes and resources to meet the demand for high-quality patient care. Recruiting staff and, especially, attracting new graduates will continue to be a challenge. College students are not entering the healthcare profession in strong numbers, possibly because of the high caseloads, 24/7 demands, or lure of other, less stressful options available to today's youth. Management needs to aggressively promote healthcare careers and provide work site considerations that address the negative aspects of the job. Competition for much-needed workers is likely to intensify with healthcare's trend toward globalization; managers looking to fill staffing voids may find themselves competing not just with other healthcare employers in their region but also with employers worldwide (Fried 2009).

Thomas Frey, a futurist, predicts new positions will emerge in such fields as senior living, "bio-factories," and extreme innovation; some of the job titles he forecasts include legacist, aging specialist, memorial designer, memory augmentation therapist, clone rancher, gene sequencer, and amnesia surgeon (Frey 2014). We need only look at the shifts we mentioned earlier for railroad workers and medical technologists to recognize that these titles may be only one or two decades away.

Looking to the more immediate future, healthcare jobs are changing in other ways. Organizations are figuratively tearing down walls as paperless environments evolve and electronic health information is made readily available to both caregivers and healthcare support staff. Such access supports the growth in telecommuting opportunities for staff not involved in hands-on patient care—for instance, staff in such areas as patient billing and coding, data collection, utilization review and case management, and finance. Staff from these areas who need to be on-site may be blended into new departments or support groups. For example, some individuals serving consumers with patient-portal questions may be consolidated with those who previously worked in health information management. The new blended support group may be known as *personal information access services*.

Although somewhat behind other industries, healthcare has begun to adopt the *project management professional* (PMP) position. When an organization has many initiatives occurring simultaneously, a PMP provides the skills and organization to keep each project on track and helps make all participants aware of their assignments, the project's goals, and the organization's achievements. The PMP draws up a plan for a project, assembles the team (often from more than one functional area), decides how to allocate resources,

schedules the work, watches the budget, solves problems, and does a lot of other things as well. The position carries a large responsibility, even when the project is modest in scope (Harvard Business Review 2014, 5). The PMP shepherds participants through four phases of the project (Harvard Business Review 2014, 6–7):

1. **Planning:** The problem is defined, the stakeholders are identified, goals are established, and resources needed to meet the goals are projected. Goals are set according to the acronym SMART: They should be specific, measurable, action oriented, realistic, and time limited (or specific, measurable, attainable, result oriented, and time limited).
2. **Buildup:** The team is assembled, tasks are delineated, the schedule is developed, and the budget is confirmed. The initial kickoff meeting occurs during this phase. Ensuring that team members have the required skills and experience and work well in groups is vital.
3. **Implementation:** The project is in process during this phase. Team members are accomplishing their assigned tasks, meetings are being held, regular reports are issued to stakeholders, and the schedule and budget are being monitored. Unexpected issues (e.g., a team member leaves, a vendor delays delivery) are arising.
4. **Closeout:** The project is complete. Handoff to the responsible party occurs during this phase, and lessons are documented in a final report.

The PMP coordinates the entire project and in doing so is responsible for ensuring that the scope of the project is completed within the defined budget and schedule. Supervisors will find that additional education in the concepts of project management will benefit them in a variety of ways. They will be more effective when conducting meetings, preparing budgets, developing goals for themselves and subordinates, and managing departmental and interdepartmental process improvement activities.

## Changing Consumers and Satisfaction

Additional challenges relate to the changing nature of healthcare consumers. The baby boomers have entered their 60s and will continue to be the most powerful segment of consumers. They also are well educated, technology savvy, and demanding of service. Many are taking care of their aging parents and overseeing healthcare delivered to that generation. In addition to the baby boomers is a new universe of insureds who enrolled in the Affordable Care Act (Obamacare) programs. Individuals who formerly may have been treated under a provider's charity care provision now have insurance and may be more vocal about the services received.

Ensuring customer satisfaction with the services a healthcare organization's staff and facility provide is paramount in tying the boomers and newly insureds to the facility for future care. Staff training in customer service techniques must be a component of every orientation program. A patient may see 50 different hospital employees during treatment and interact with four or more at a physician or outpatient setting. Today's healthcare workforce is made up of employees from at least three generations, each of which has its own characteristics concerning work ethic, regard for authority, and expectations (Reese 2014). If these diverse employees do not communicate and collaborate effectively with one another, the patient's concerns and desires will not be accurately transmitted to the next caregiver. Miscommunication and inconsistent care will define the patient's experience. Although face-to-face skills are important, training in telephone and e-mail communication and etiquette should not be ignored. A training program should also include skill building in the psychology that governs upset-customer behavior, strategies for successful customer encounters, effective cross-generational and cross-cultural communication techniques, and the understanding of attitudes and actions.

Customers are seeking "quality care" (see Exhibit 29.1), for which each individual has her own definition. Today's consumer is much more health conscious and "health literate" than the consumer of past years. Websites offer abundant health information and facility-specific comparative data to the public; no longer must individuals rely on the physician office visit to learn about their conditions or to determine at which hospital to be treated. Customers today—patients as well as their relatives—are living in a fast-paced world, and also a litigious one. They expect answers and explanations that they can understand, and they expect them now. Delays of any kind may be perceived as maneuvers to hide information, leaving consumers potentially angry and certainly dissatisfied. The Veterans Affairs (VA) scandal in 2014, involving excessive delays in scheduling for treatment, contributed to many

---

"Patients aren't basing their decisions on medical technology or the adequacy of staffing on a nursing station. They base their decisions on things they feel qualified to judge: the room; the food; how hard it was to find a parking place; whether or not the people are smiling and friendly; the admission process; the questions they are asked and the answers they get to their questions. Those things do not necessarily have anything to do with the quality of medical care, but they are the way that healthcare providers are being evaluated.

"It seems that the new healthcare consumers simply assume that members of the healthcare fraternity will do their best to cure their ills and fix what is broken. They evaluate care and base their buying decision on the way they are treated. In a sense, it's not the care, it's the *caring*, that new consumers have on their minds."

—Dawn M. Gideon

**EXHIBIT 29.1**  
What Is  
the New  
Healthcare  
Consumer  
Looking For?

---

Source: Used with permission from Transition Management Group.

consumers losing faith and trust in the healthcare industry, and in the VA system in particular.

In 2013, journalist Steven Brill gained widespread attention with his *TIME* magazine article “Bitter Pill: Why Medical Bills Are Killing Us,” which explored the high cost of healthcare, the role of chargemasters, and how hospitals profit from the lack of transparency in the system (*Becker's Hospital Review* 2013; Brill 2013). Since the article was published, many states that had not previously required price transparency have begun doing so. Additional efforts to inform customers about institution and physician quality have come from entities such as the Centers for Medicare & Medicaid Services (CMS), through its Hospital and Physician Compare databases; Healthgrades; and the Leapfrog Group. Such efforts have increased transparency of service outcomes and led to the development of comprehensive benchmarking and performance measurement programs. CMS has been releasing data on frequently billed inpatient and outpatient services for hospitals and physician payments from pharmaceutical companies.

One trend that might facilitate patient satisfaction with the healthcare delivery system is the growth of the **medical home** model. This model permits closer interaction with primary care providers, which may increase patient compliance with physician directives and possibly improve outcomes. The medical home has been described as “a model or philosophy of primary care that is patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety” (Patient-Centered Primary Care Collaborative 2014). It has become widely accepted as a model for the organization and delivery of primary care, and as a philosophy driving providers and care teams. The medical home is not a “final destination,” but rather a “model for achieving primary care excellence so that care is received in the right place, at the right time, and in the manner that best suits a patient’s needs” (Patient-Centered Primary Care Collaborative 2014).

Healthcare facilities can further demonstrate their commitment to quality and customer satisfaction by addressing disease outcomes, participating in community health projects, and surveying consumers. Those providers who are less proactive in these matters will be pressured to change; the government is requiring them to address patient outcomes with the reporting of the CMS Core Measures, patient safety initiatives, and physician-quality measures, the results of which will affect reimbursement. Organizations are encouraged to participate in quality-measurement efforts such as the Malcolm Baldrige National Quality Award program. The Baldrige criteria provide a framework for an established culture and processes that will produce quality outcomes and be repeatable to sustain quality results consistently (Cohen 2008). Leaders within their departments should proactively seek to make critical decisions that will help ensure services are delivered at the highest quality level.

**medical home**

A model and philosophy for primary care organization and delivery. It emphasizes safe, high-quality care that is patient centered, accessible, comprehensive, and team based.

As for employees, the old adage “seeing is believing” may work for or against a healthcare organization. Employees who see and believe that resources are being properly channeled toward replacing and updating technology, hiring qualified workers, and staffing patient care areas at the appropriate level will feel more positive about the quality of care delivered in their institution. These staff will promote to friends and neighbors the advances the organization is making in technology, patient satisfaction, outcomes, and other crucial areas. On the other hand, employees who are disgruntled about any of these issues might discuss with friends and neighbors the management shortfalls, pointing to medication errors, unexpected deaths, safety issues, and so forth. Supervisors must seriously consider employee concerns and recognize that they serve as a barometer of consumer satisfaction with the organization.

## Changing Technology and Medicine

A new wave of technology and medicine is on the horizon. Cloning, genetic mapping, and tissue engineering are creating the potential to design humans in the future. Imaging technology has advanced to the stage where surgeons are using microinstrumentation to correct defects in the unborn fetus. An emerging industry of “genetaceuticals” is combining genetic research and drug therapies. Ideas that would have been considered radical thinking in the past may soon become ordinary; in two decades or less, the use of stem cells to treat conditions such as spinal cord damage, multiple sclerosis, Alzheimer’s disease, and baldness may be commonplace. Already there are robotic demonstrations helping individuals with spinal cord damage to ambulate (Niu et al. 2014).

Myoelectric sensors will read impulses from nerves to trigger movements and actions of prosthetic devices. Spring-like mechanical struts in prosthetic legs allow them to outperform their biological counterparts, and complex electronic knees and feet contain narrow artificial intelligence (Saenz 2009b). The design of prosthetic arms and hands has made great strides with robotic advancements such as Deka’s Luke Arm. Dean Kamen, inventor of the Segway scooter and head of Deka, helped design the arm to meet the needs of modern amputees; with pads under the feet and attachments to the shoulder, it is said to function “like a complex video game” (Saenz 2009c). Consider also the rehabilitative advantages that Ambient Corporation’s Audeo device, which reads nerve impulses in the neck to help people speak and even control an electronic wheelchair, will provide for people suffering from diseases such as amyotrophic lateral sclerosis (ALS, or Lou Gehrig’s disease) or for athletes who sustain spinal cord injuries (Saenz 2009a). These and other new technologies will change the way physical and occupational therapists teach their patients to adapt to paralysis or the loss of a limb.

Prosthetic limbs are also becoming less expensive and easier to obtain through the use of 3D printing devices, thanks in part to efforts at the University of Toronto, Rochester Institute of Technology, and Johns Hopkins Medicine (Braga 2014). And the impact of 3D printing does not stop at prosthetic limbs. Following a breakthrough by US and Australian researchers, scientists, who in the past had been able to “print” types of human tissue with a 3D printer, can now make that tissue survive on its own. This breakthrough brings science one step closer to printing sustainable living organs (Davey 2014).

Numerous other innovations offer glimpses of the future. GPS (Global Positioning System) personal tracking devices can now be used to track toddlers or adults with Alzheimer's, and military medics have adopted similar technologies to remotely track soldiers' body temperature, heart rate, EKG (electrocardiogram) readings, and stress or dehydration levels (Yu 2012). The medical alert systems that have been around for decades have switched from landline connectivity to far more sophisticated communications networks. Exmobaby infant pajamas have sensors that send vital signs and information about the baby's “emotional state” to parents' mobile devices (Yu 2012). Wearable devices such as Fitbit wristbands, which monitor health conditions and wellness activities, have become increasingly popular. These devices are able to transmit data to one's computer or personal health record. The Institute for Health Studies estimated sales of wearable health-monitoring units in 2014 at roughly 50 million, with more than 180 million predicted to sell in 2018 (O'Riordan 2014).

Access to specialists will be facilitated by electronic health records (EHRs), telemedicine, health information exchanges, and other technology. Telehealth depends on sophisticated information systems that cut across campuses and geography and provide immediate access to critical patient care information and healthcare guidance from specialists around the world.<sup>1</sup> Many experts believe that, a decade from now, patients may not need to leave their homes for primary medical care. However, to take advantage of telemedicine, especially in underserved areas, regulators and insurers must loosen the limitations on its use. Nearly 30 states do not allow reimbursement for video visits, thereby preventing doctors from practicing telemedicine. Medicare and Medicaid will reimburse doctors in some video treatment situations, but some insurance companies still resist (O'Donnell 2014).

Future medical care will involve remote connections to home computers or health-monitoring devices, and it will use sources currently in homes to analyze a patient's bodily functions. For instance, Japan's Intelligence Toilet II, created by Toto, has shown that a toilet can effectively record and analyze important data, such as weight, body mass index, blood pressure, and blood sugar levels. This information can be sent to the patient's computer and can help him, with the guidance of a physician, monitor health and detect certain medical conditions. Graphs on the patient's computer can show, for example,

whether glucose levels and urine temperatures have fluctuated. Such information can help people with diabetes time their insulin shots and women track their hormone levels (Saenz 2009d).

Firms such as the biotechnology company Theranos are reducing the need for vials of blood when a pinprick portion will do for many common tests. By providing access to more convenient, less painful, and cheaper blood tests, Theranos is helping consumers comply with physician-ordered testing and at the same time take a more active role in monitoring and maintaining their health (Auletta 2014). Consumers are also directing and monitoring their own health with automated glucose monitors, blood pressure gauges, and body sensor scales. Developments such as the recent Novartis-Google partnership to create a new contact lens that will measure blood sugar levels will further facilitate consumer-controlled health management (O’Riordan 2014).

Health information exchanges will support biosurveillance monitoring to identify suspicious complaint patterns in localized areas; the identification of patterns might signal the need for further investigation or help report a disease outbreak or bioterrorism event. Some experts believe the deployment of biosurveillance networks is a precursor to a national health information network (Goedert 2007); data reporting for such a network would satisfy the American Recovery and Reinvestment Act’s (ARRA) meaningful use criteria, which providers must satisfy to obtain and retain funding for EHR systems.

Times have changed from the days when physicians believed they “knew it all.” Many now seek advice from consultants and have online access to the latest findings on drugs, treatments, and other medical advances. As patient needs become more complex, advanced medical knowledge, including human understanding and published data, and diagnostic equipment must be linked with sophisticated technology systems.

Robotics in the operating room and rolling along hospital corridors have become a reality. Robotic systems for delivering medications, food service trays, and materials for the lab, pharmacy, and central supply, and for removing trash, will replace the need for humans to do these tasks. Using robots to disinfect patient rooms, emergency departments, and operating rooms and to decontaminate and sterilize surgical instruments will be beneficial, and it will reduce the risks highlighted in recent Ebola incidents. Robots work 24 hours a day, 7 days a week, and they require no sick or vacation time. The need for file clerks, technicians, and couriers will diminish. Management will need to decide if people in these roles will be displaced, retrained, or terminated. Surgeons have acclimated to the use of robots in the operating room. They no longer need to touch the patient during heart bypass surgery; according to reports, the surgery with robotics is easier for the surgeon to perform and less traumatic for the patient to experience (Lanfranco et al. 2004). Still, even though robotics have been used for invasive procedures for more than 15 years, concerns remain about complications and malfunctions (Rabin 2013).

**medical tourism**

The practice of seeking medical care in a foreign country because of cost savings, quality, expertise, or other reasons.

Factors other than technological advancement are also driving changes in medicine. As healthcare costs in the United States continue to rise, patients, with the encouragement of their insurance firms, are seeking high-quality healthcare services overseas. This practice, known as **medical tourism**, led an estimated 900,000 Americans to travel abroad for care in 2013. In countries across the globe, hospitals and physicians are demonstrating proficiency and quality equal to those available in Europe and North America; at the same time, their prices represent substantial savings to the medical tourist (Pocius 2014). This phenomenon poses a unique challenge to US health systems. United-Health Group, which insures more than 70 million Americans, has moved to make Bumrungrad International Hospital in Bangkok an in-network facility. Aetna bought the overseas insurer Goodhealth Worldwide because Aetna saw globalized surgery as “an important emerging trend” (*Upstart Business Journal* 2009). Medical tourism also appeals to foreign patients seeking specialty care available in the United States. New forms of telemedicine will enable broader application of virtual medical tourism.

As organizations seek to attract international patients, supervisors will need to make sure that their staffs can communicate with foreign patients and understand those patients' cultural characteristics (Fried 2009). At the same time, supervisors who are managing technology will require staff to be technologically proficient. Fortunately, many of today's workers (members of generations X and Y) have grown up during a time when technology was prevalent and do not fear using it. Patient information is available electronically both within a healthcare organization and through information exchanges among associated healthcare organizations, facilitating patient care in a healthcare system, across a region, and across oceans. Access authorization to patient information will be facilitated with ATM-like devices to accommodate our mobile customers.

Security will be heightened because of the accessibility of sensitive data. Thus, we should expect higher surveillance levels, more rigorous card-access systems, biometrics, and other approaches to control who has access to what, when, and where. One biometric method, for instance, involves identifying patients through the use of palm scanning, which can assist in uncovering patient identity theft as well as misuse of payer insurance cards. Some employees and patients may find biometric approaches invasive, distasteful, or possibly in conflict with their religious or cultural mores. The supervisor will need to address these concerns.

## Changing Economic and Regulatory Environment

Effects of the Affordable Care Act (ACA) have been highlighted throughout this book, and the ACA is certain to have a major impact on efforts to balance declining reimbursement against the rising cost of care for underinsured and

uninsured populations. Healthcare managers will need to modify bad-debt and charity care policies to address the high deductibles present in the ACA policy offerings for patients, and managers will also need to recognize that high-deductible plans will likely affect the employed staff. Understanding that employees may face financial challenges associated with their own healthcare encounters will be important.

Adding to the reimbursement dilemma are various regulatory changes. The self-reporting of hospital-acquired conditions (HACs), for instance, will result in lower or no reimbursement for treatment of HACs. This regulation has prompted changes in patient care protocols, additional surveillance of patients who are prone to injury (e.g., the elderly), and new precautionary measures prior to surgery and other procedures. Other challenges involve incentives and penalties related to the readmission of patients within 30 days of discharge and the requirement that patients be admitted as inpatients only after the physician testifies to the anticipated need for the patient to stay overnight through two midnights. These measures may require providers to monitor discharged patients' compliance with medications and other therapies and to ensure that physician documentation clearly and completely reflects the conditions for which each patient is being treated.

Payer initiatives, higher deductibles under the ACA, some states' unwillingness to expand Medicaid coverage, Medicare's cuts in reimbursement, minimum-wage increases, redefinition of full-time work for insurance coverage purposes, and other competing priorities have placed many healthcare entities and providers in a serious cash crunch. As a result, layoffs are commonplace.

Another significant change related to healthcare economics is the October 2015 implementation of the International Classification of Diseases, Tenth Edition (ICD-10), coding system update. The ICD-10 is the first major coding classification change in the United States in more than 30 years. It will provide payers and government agencies with much more specificity on the conditions being treated, to identify HACs and epidemiological concerns. It will also facilitate payers' ability to profile providers, to gauge outcome performance, and to adjust reimbursement based on those outcomes. Finally, the ICD-10's coding details complement the data needs of accountable care organizations (ACOs). ACOs are encouraged to develop provider networks that cover the entire continuum of care, so that payments for an entire episode of care can be made to a single healthcare entity that will have the responsibility of paying other providers that participated in the episode.

The prevalence of ACO arrangements is paving the way for closed networks of providers at all levels that are tied to a single healthcare facility or network of facilities, with the ability to collaborate to develop protocols that will result in better patient outcomes and services delivered at a lower cost. Healthcare providers will no longer gauge their effectiveness by *how much* they did but rather by *how well* they did. Payments will be bundled to include

all providers during an episode of care and will be driven by outcomes management, placing the primary care physician in the driver's seat to oversee all services for her patient. Such changes will require managers to educate their staff on documentation requirements, accurate data entry, data analysis, and, of course, continuous process improvements affecting patient outcomes. Failure to achieve progressive improvements in patient outcomes and demonstrate successful performance for 30-plus quality measures will result in reimbursement penalties similar to those imposed on many facilities today for readmissions.

Mergers, once thought to be the cure-all for providing cost-effective healthcare to a region, have had relatively high failure rates in major cities. Instead of reducing costs, mergers have often created a new layer of management, resulting in increased and often nondirect patient care costs. For instance, the 1997 merger of the University of California, San Francisco, and Stanford University medical centers added nearly 1,000 employees to the combined organization. This new layer was seen by some as nothing more than additional bureaucracy stifling the actual delivery of healthcare, and the merger was soon dissolved. However, JP Morgan Chase & Co. has forecast a new wave of consolidations that will eliminate weaker facilities and create large, multistate systems. Such systems would be able to withstand regional economic crises on the strength of their diversity, rationalize capital spending with systemwide service line planning, and strategically offer clinical programs to achieve market share (Bush 2009).

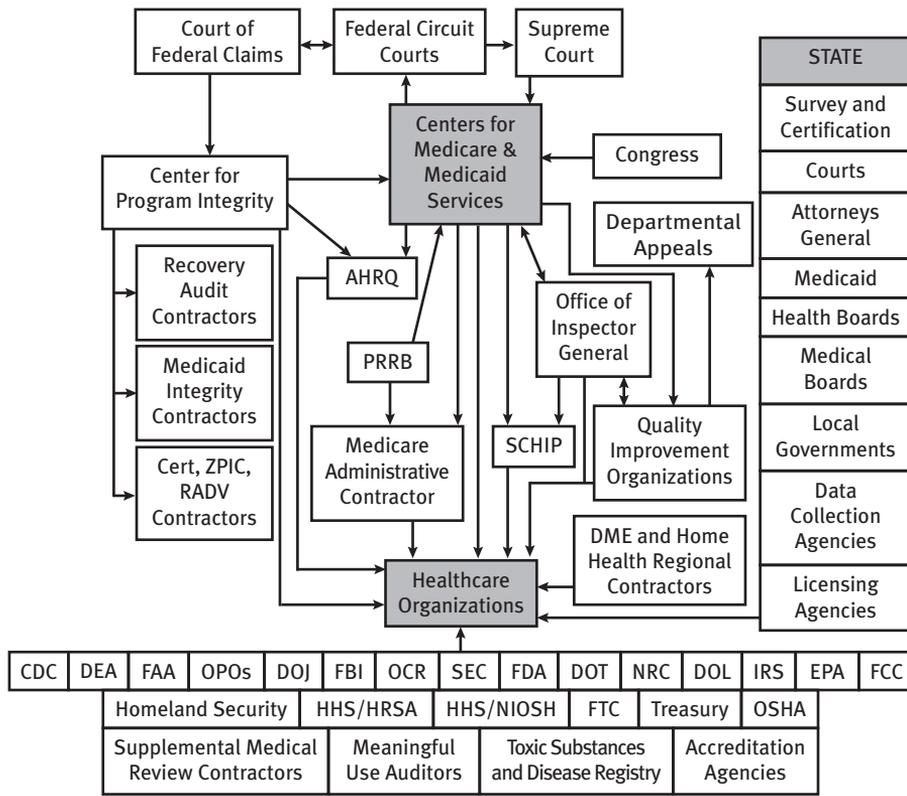
Outsourcing has continued to gain acceptance among healthcare organizations. When mergers failed to yield the cost savings anticipated, payers increasingly outsourced to both domestic and offshore parties. Services commonly outsourced include claims processing, utilization management, collections, transcription, radiology exam reading, coding, and information systems management.

As mergers, closures, and outsourcing occur, supervisors will have to respond to grapevine rumors predicting budget cuts and downsizing and other staff apprehensions. Morale is likely to deteriorate. As discussed in previous chapters, incorporating regular, truthful, and complete communication into the culture will be imperative. A culture in which staff are encouraged to voice their concerns will serve as a buffer between employees and a union organizer—an important function at a time when healthcare union membership is growing. Listening and empathizing will be a supervisor's best attributes. The first-line supervisor will be the agent who will make sense of, unite, and transmit the organization's culture (Valentino 2004).

## Changing Policies and Oversight

The number of organizations that play some part in regulating healthcare is astonishing. Exhibit 29.2 identifies many of these groups, but it does not

**EXHIBIT 29.2**  
Who Regulates Hospitals?



Source: Adapted from *AHA News*, Vol. 36, No. 21, May 29, 2000, © 2000, by Health Forum, Inc.

include those that healthcare facilities voluntarily invite to evaluate their activities, such as the National Committee for Quality Assurance, the International Organization for Standardization, the Malcolm Baldrige National Quality Award program, and the Healthcare Facilities Accreditation Program. It also does not reflect newer entities such as Recovery Audit Contractors, Medicare Administrative Contractors, Medicaid Integrity Contractors, the Office for Civil Rights, and other review agencies. Many of these same organizations and others monitor physician practices and other ambulatory healthcare organizations.

Supervisors will continue to implement security, privacy, and safety measures; error prevention; documentation enhancement; and process improvement in compliance with the many regulations imposed on healthcare organizations. Furthermore, they likely will need to do so with fewer staff. Delegation and team empowerment will no longer be optional; they will be necessities for tomorrow’s managers trying to fulfill requirements in this regulated environment.

Among the healthcare regulations mentioned in earlier chapters, those included in ARRA might have the most far-reaching impact. The act provides funding for the advancement of EHRs and imposes penalties for organizations that lack them or fail to demonstrate **meaningful use**. ARRA also provides for

**meaningful use**  
A phrase used to describe the ability of a healthcare organization or provider to demonstrate its effective use of one or more electronic health record systems to capture and report specific criteria-based data.

educational programs to enhance the health information technology skills of the healthcare workforce, heightens awareness of privacy and security measures and increases penalties for violating them, expands the role of consumers in their healthcare choices, and increases the amount of data about patients and providers that will be accessible to the federal and state governments.

As organizations have worked to implement EHRs, many have found that these systems detract from the personal experience between the clinician and his patient and are not as easy to navigate as some paper records. Furthermore, the standard formats and terminology built into the system can create difficulties in distinguishing one patient from another. Many physicians have complained that use of the EHR for various tasks often takes more time rather than less (Billings 2014). This extra time means fewer patients are seen in the day and less income is received, thus encouraging physicians to shift away from independent practice and seek employee status with healthcare organizations.

Accompanying EHRs is the increase in data that are available for organizations to massage and dive into for strategic planning, clinical protocol development, outcomes measurement, and other business and research activities. Meaningful use ties together many disparate healthcare initiatives, including The Joint Commission documentation requirements, regional health information exchange, chronic care coordination, payment models, electronic prescribing, physician quality measures, ACOs, patient-centered medical homes, payer population management, personal health records, patient safety guidelines, and medication reconciliation.

With such vast amounts of data residing in external databases, legacy systems, and EHRs, the term *Big Data* has surfaced. **Big Data** consists of structured and unstructured data that have the potential to be mined with sophisticated computer applications to create forecasts, to identify trends, to facilitate reporting to regulatory and accrediting agencies, and to bolster business intelligence activities. Business analytics departments and positions managing Big Data are becoming prevalent in many healthcare systems.

Beyond ARRA are a variety of bills and amendments looming that, if passed, will affect the way supervisors direct their staff (see Chapter 25). Some measures will increase demands for pricing transparency, requiring healthcare organizations to publicly post their charges for services. Immigration status monitoring will be heightened, with the federal government's E-Verify program allowing organizations to check an employee's status. Recent rulings by the National Labor Relations Board—recognizing the employee's presumptive right to use an employer's e-mail systems to communicate about workplace issues and requiring the almost-immediate response from employers to an election petition—will change how managers act and address union-related issues.

Accountability of tax-exempt healthcare entities for providing services to those who cannot pay will continue with expanded disclosure requirements. Governmental and private insurer audits of services to uncover fraud and

### Big Data

The vast collection of structured and unstructured information, including that residing in various databases and electronic health records, that may be mined for various forecasting, reporting, and analytic purposes.

payments for unnecessary care will increase due to the demonstrated results of the Recovery Audit Contractors for Medicare and the Medicaid Integrity Contractors. Beyond the requirements of the Deficit Reduction Act enacted in 2006, mandates likely will surface that require management to repeatedly remind employees, medical staff, and contractors of their obligation to report any billing or service improprieties, which in turn may encourage employees or others to become whistle-blowers to seek qui tam compensation. Department managers will be responsible for keeping administration informed of any regulatory changes that will affect departments or the organization, as well as for increasing staff communication and feedback so that employees know the supervisors are acting on the issues identified.

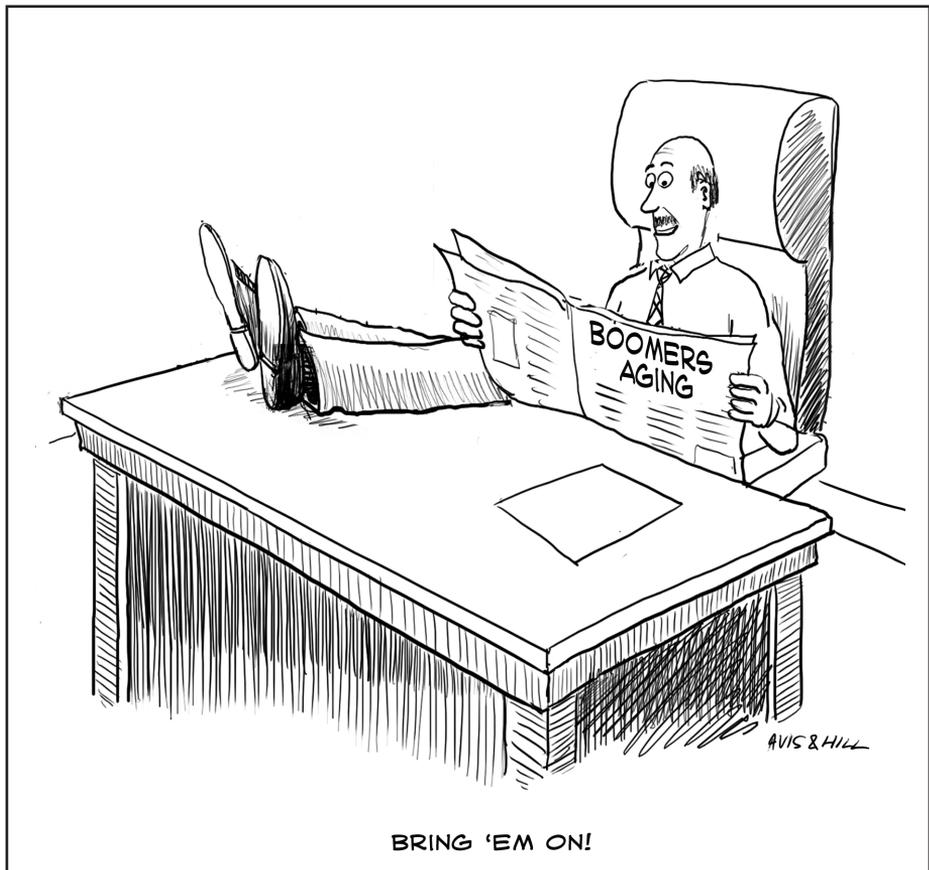
Finally, the Health Insurance Portability and Accountability Act (HIPAA) and breaches of it—which increased 138 percent from 2012 to 2013 (McCann 2014)—continue to be key issues in healthcare management. The exposure of sensitive personal information has occurred not only in healthcare but in major retailers throughout the United States and allegedly by foreign countries as well. Community Health Systems, one of the largest hospital organizations in the country, reported that Chinese hackers gained access to its computer network and compromised the data of nearly 4.5 million patients. Such a large data breach highlighted the seriousness of healthcare’s cybersecurity issues (Definitive Healthcare 2014). Managers must be absolute in the reinforcement of privacy measures, implementation of security protections, education of their workforce, and application of sanctions.

## Changing Staff Issues

Goldsmith (2007) predicts a “workforce tsunami” in healthcare’s future, meaning that critical workforce shortages will cause catastrophic gaps in care. His prediction has merit, as the US healthcare system, long powered by baby boomers, is aging. The average age of registered nurses is 50 (American Nurses Association 2014), 72 percent of physicians are aged 40 or older, and the average age of all physicians is 54 (Physicians Foundation 2012). Finally, the entire senior management cadre of most hospitals and health systems is nearing retirement. This human resources crisis is not cyclical, and incremental productivity improvements will not close the gap. Managers must focus on retention of skilled employees, and they should consider redesigning jobs to keep older workers. Such redesign efforts should strive to reduce stress and turnover while allowing “chronologically gifted” individuals sufficient time for leisure and family obligations.

Specialization will continue as the evolution in healthcare delivery and payment affects leadership, talent, and organizational structures. According to a recent study, some of the emerging position titles now being used in

## HOSPITAL LAND



healthcare organizations include *chief population health manager*, *vice president of cost containment*, *chief clinical transformation officer*, and *chief patient engagement officer* (Pennic 2014). A relatively new title in nursing is *clinical nurse leader* (CNL). CNLs are master's-prepared nurses who assume accountability for healthcare outcomes for a specific group of clients through application of research-based information to design, implement, and evaluate client care plans (Begun, Tornabeni, and White 2006). Other fields are following suit. As new positions are created, promising individuals in your teams are likely to apply and secure these new opportunities.

As discussed earlier in the book, younger (generation Y) workers are likely to seek positions with greater flexibility—such as those with fewer working hours and more telecommuting—to accommodate personal, community service, and social needs and interests. They may also have concerns about safety and security, particularly in light of recent news stories of shooting sprees at healthcare facilities. Such concerns may lead more managers to consider tailoring work and work settings to align with employees' life interests. However,

such flexible work approaches obviously cannot be used for all healthcare staff, because someone must provide the direct hands-on care for patients. Recruiting and retaining staff for less flexible bedside and facility-based positions are thus likely to become more difficult than before. To help in these areas, supervisors may need to involve their patient care staff in rethinking how work is done. They might turn to audio and video conferencing and conduct “what-if” brainstorming scenarios with staff to build a patient care environment that is more efficient and effective, and also more rewarding to the staff. Borrowing models from other industries will help identify options that fit in healthcare.

Workforce diversity will create unique situations involving language, communication, and cultural differences. An employee might have difficulty knowing what is expected of her if she does not speak the same language as her supervisor, both metaphorically and literally. Similar frustrations may arise if patients find they cannot communicate with healthcare providers in a language that is mutually understood. Supervisors may need to send staff members to special training courses to teach them to speak, read, and write in English. Meanwhile, the diversified labor pool may prove to be advantageous, as workers with different language skills provide an alternative to hiring translators to meet the needs of patients who speak languages other than English.

Coworker dating issues and accommodations for people with disabilities may surface as additional challenges for frontline supervisors. With people spending the bulk of their time at work, it is not surprising that Cupid may set up shop in your department. Some human resources departments now require that a “love contract” be executed to provide guidelines for dating or romantically involved coworkers, especially those in executive-level positions (Ritter 2009; Gardner 2008). Americans with Disabilities Act modifications in 2008 broadened the definition of and offered greater protection to individuals with disabilities. Managers will likely see an increase in employees’ requests for workplace accommodations and a potential spike in litigation (Ritter and Alkhas 2009).

Other challenges confronting supervisors involve employee safety programs and disaster plans. The United States has been hit with a number of disasters over the past decade, many of which seemed nearly impossible to anticipate. Tornado outbreaks that almost never would have ventured out of the Midwest have now confronted the Northeast. Flooding in drought-stricken states such as California has ripped away buildings in landslides. Ice storms and freak snowstorms brought usually warm cities such as Atlanta to a standstill in 2014. Managers must always consider “what’s next” and build multifaceted contingency plans not just for labor resources but also for emergency power, communication methods, food, and pharmaceutical and medical supplies. They must brace for deadly infectious outbreaks, mass casualties, terrorism, and, simply, the unexpected.

Gun violence in the workplace remains a concern, especially as gun sales rose after late 2012. Some observers have linked the surge in sales to that year's Sandy Hook school shooting in Newtown, Connecticut, which stoked fears that the federal government could tighten access to firearms; others have attributed it to increased concerns about terrorism and crime during difficult economic times (David 2014; Ritter and Rosenberg 2009). Healthcare management must also seek to minimize injuries and accidents of various types. Rush University Medical Center took noteworthy action to improve worker safety at the construction site of its new facility that opened in Chicago in 2012. Through a collaboration with the Occupational Safety and Health Administration, Rush saw a 78 percent decrease in the rate of construction worker injury during the program's first year (Kehoe 2012).

Finally, ethics, ethical issues, and ethical compliance will continue to be a central focus for administration. Employees, boards, and the public will expect the highest ethical conduct from healthcare leaders and employees, and patients will be encouraged to report any action they consider to be to the contrary. Supervisors should monitor their ethical position regularly to be able to answer the question, "Why shouldn't we do what is right and moral?" Ethical dilemmas can trigger widespread media attention and emotional public response. You may recall debates about the Terri Schiavo case, in which family members, healthcare providers, and the public battled over her right to life or death, and discussions about the controversial use of fertility treatments in the birth of octuplets to Nadya Suleman, a single, unemployed woman who already had six young children. Debates continue over such issues as end-of-life care for children, patients' rights to physician-assisted suicide, decisions on who should receive an organ for transplant or an experimental drug for a fatal disease, vaccination requirements, and the progress of stem cell research. Dilemmas will surface more frequently as technology, rather than human organs, keeps people alive longer, and debates will be complicated by struggles between right-to-life and right-to-die activist groups. Supervisors must seek to understand these issues and the burdens they place on people who serve patients directly. Guiding staff effectively through these challenges will be paramount.

## Changing Communication Methods

In recent years, the use of social networking websites has exploded. People constantly share news, events, photos, and commentary over Facebook, Twitter, and other sites. Retailers and businesses seek a presence on these sites to coax purchases, groom fellowship, and meet customers where they are. Political campaigns use the sites to secure donations and get their messages out to

generation X and Y members. Blogs continue to be popular. Many people find great satisfaction from sites that allow them to state their positions on topics, share information with others, and link to others with similar preferences. For management, however, use of these sites by staff can represent a loss of productivity, especially if employees check routinely during work hours for updates from friends. Additionally, blogs can create public relations nightmares if disgruntled employees post their perceptions of a change and then others—often readers from throughout the world—jump in to voice their opinions.

Social media, when used effectively, can benefit hospitals through increased revenue, employee recruitment, and higher customer satisfaction. A study published in the *Journal of Healthcare Management* found that 72 percent of adults who use the Internet, and 70 percent of hospitals, engage in social media activity. Hospitals, however, largely use Facebook as a dissemination strategy to educate consumers rather than as a way to actively engage consumers. The study concludes that healthcare facilities have failed to use social networking effectively and thus far have missed an opportunity to enhance customer service, improve quality of care, and build loyalty (Richter, Muhlestein, and Wilks 2014). Clearly, communication approaches supported by these technologies differ from those used in the past, with less face-to-face interaction and visual feedback, but their benefits should not be underestimated.

## Changing Cost Structure and Focus

Healthcare has struggled with the rising costs of talented labor, of state-of-the-art technology, and of new facilities to meet changing population demographics and demands for access. To deal with the rising costs, labor considered nonessential has been eliminated, perks have been cut, debt has grown, and prices have been increased; yet at the same time, many healthcare facilities have become more palatial and extravagant. The American public and Congress continue to voice concern with the cost of healthcare. When six- and seven-figure executive salaries are published in the local business news and a neighbor's spouse has been laid off from the hospital's housekeeping or security staff, local residents question the effective use of funds that should be used for treating patients.

One of the features of the ACO model, discussed in various parts of this book, is risk-based payment. When healthcare networks find that a substantial portion of their revenue is performance or risk based, they must be able to assess the populations they serve and redesign their approach to promote **population health**—that is, the health outcomes of a group of individuals, including the distribution of such outcomes within the group (Kindig and Stoddart 2003). Rather than building services around caring for illnesses, successful ACOs

**population health**  
The health outcomes of a group of individuals and the distribution of such outcomes within the group.

and provider networks will build programs to keep populations healthy—or at least promote healthy regimens, minimized health risks, smaller chances of unexpected deterioration, and reduced likelihood of inpatient admission. Such an approach is evident, for instance, when a healthcare organization chooses to self-fund its employees' health insurance. With population health objectives, the need for inpatient beds, including long-term care beds, will be expected to decline, and finance professionals are allocating their capital budgets accordingly. The use of patient-centered medical homes, as discussed earlier, and home care is anticipated to grow, even for complex conditions such as cancer, organ failure, and dementia. This change also suggests that managers will need to consider staffing patterns that include employees who work not at the healthcare organization but rather at patients' homes.

Success in population health management depends on data that can be massaged to find relationships between treatment modalities and outcomes; to predict the onset of disease; to identify, monitor, and address the health needs of patients served; to identify pockets in the service area that are underserved; to track and trend provider performance; and to measure healthspan, not lifespan. These analyses will be among the many duties of the *chief population health manager* position mentioned earlier. Reimbursement rewards will be bestowed on those provider organizations that cost-effectively manage their populations and experience positive outcomes.

Errors are not intentional. They may be the result of lack of orientation, absence of processes that provide for the second check, haste, excessive workloads, and leadership that fails to put in place quality-control mechanisms. One of the additional readings suggested in this book—a 2006 article by van den Heuvel, Bogers, Does, van Dijk, and Berg listed at the end of Chapter 14—discusses the value of quality. Does high-quality care cost any more than poor-quality care? One answer may be that high-quality care ultimately costs less because errors add cost to healthcare. Regardless, the patient's experience is the priority. Patients have choices. Whatever their healthcare need, they want us to do “it” better and at a lower cost.

If organizations fail to put quality first, consumers find out when they review the organizations' publicly displayed performance profiles, such as those in CMS's Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) and the Leapfrog Group's Hospital Safety Scores. HCAHPS is based on patient surveys and includes such questions as whether you would recommend this hospital to family members, whether you were treated with courtesy and respect by your physicians and nurses, and whether your identity was confirmed before being given medications. The Hospital Safety Scores are derived from hospital data, and they compare healthcare organizations based on patient care errors, injuries, accidents, and infections.

Improving performance will require collaboration from the entire health-care team to find more efficient protocols, more effective tools (e.g., prostheses, drugs, diagnostic tests), and more patient-friendly communication approaches. For more than a quarter century, the Malcolm Baldrige National Quality Award has set the gold standard for organizational excellence. The “journey” to apply for the award has been described as “a strategic diagnostic analysis” of the organization’s leadership systems (Goonan and Muzikowski 2008). Healthcare providers must deploy their limited resources to conduct such an analysis—at the department level and at the overall organization level—to improve care for patients and simultaneously enhance the organization’s bottom line.

Achieving these goals will require collaboration, trust, and mutual respect between clinicians and organizational leadership (Boehler et al. 2009). Otherwise, costs will continue to rise, and regulators will force organizations to address the costs. Management’s overall approach must encourage participation. An approach known as the “uncommon leader” method, championed by Clay Sherman, requires employees to look at operations and suggest ideas for improvements in four categories: best people, high quality, low cost, and customer satisfaction. Most employees want to make a difference where they work, and this is their opportunity to do it. If employees at all levels continue to step up, organizations can survive reimbursement cuts and other economic challenges (Thrall 2009). As David Walker, former US comptroller general, said, “It’s better to control your own destiny. It’s better to try to make changes proactively and on your own initiative rather than to be forced to change based upon rules that are dictated by others” (Clarke 2009).

## A Final Word

In his 2015 incoming address as chairman of the American College of Healthcare Executives, Richard D. Cordova, FACHE, president and CEO of Children’s Hospital Los Angeles, offered ten lessons that significantly affected his career:

1. Engage early in networking with others in your field, and engage a mentor who can help you see the road ahead and prepare for the journey.
2. Be a lifelong learner, to better position yourself to anticipate change and use it to succeed.
3. Recognize that everything is temporary. Change is not only expected but also accelerating. Embracing change rather than fearing it is crucial to positioning your organization for success.

4. Reinvent yourself. Anticipate changes in your professional life, and be prepared to reinvent yourself.
5. Be kind to your body. Physical and mental health breed success in the workplace. Remember, *you* set the example for your employees. Get out from behind your desk. Never forget your team members love to see you.
6. You're only as good as your team. Admitting your weaknesses takes courage, but doing so means you can surround yourself with people who complete you.
7. Lead from your heart, and make decisions based on values you hold close. Kindness and caring never go out of style.
8. Culture counts and is the force behind the successful implementation of a strategic plan.
9. Put family first. Beyond your professional life, the consistent group of supporters you get to keep with you is your family. Make sure you make time for them.
10. Paint your own picture. As you begin your management career, you will likely be following the vision of your boss and organization. But at some point, you will realize you have enough experience and know-how to create your own vision. Think about the picture you want to paint for your organization. That's where the fun begins. It's also where you'll need to grab hold of your courage.

*Source:* Adapted from American College of Healthcare Executives (2015).

Supervisors have a challenging job in any industry but particularly in healthcare, where the product of the organization can result in life or death. Appendix 29.1 explores some of the pitfalls common to new supervisors and offers valuable advice for avoiding them. In the years ahead, our dynamic industry will require the leadership skills to reinvent a better, more efficient, more effective, and more trustworthy healthcare experience for patients, staff, and providers. May you be successful in your career.

## Note

1. In 2015, the Mercy Health System opened a virtual care center in Chesterfield, Missouri. Approximately 300 physicians, nurses, researchers, and support staff were expected to provide 24/7 care over audio, video, and data connections to Mercy's hundreds of locations

and extend primary care into places such as nursing homes and patients' homes. The virtual care center—believed to be the first of its kind—will use remote monitoring technologies.

## Additional Reading

Society for Healthcare Strategy & Market Development. 2015. *Futurescan 2015: Healthcare Trends and Implications 2015–2020*. Chicago: Society for Healthcare Strategy & Market Development of the American Hospital Association and Health Administration Press.

## Appendix 29.1

### First-Time Management Blunders

by Danny Pancho

It's a heady feeling to finally get that new title, but fresh-faced managers will do well to bone up on the skills set and mind frame crucial to a successful transition from being one of the boys to becoming The Boss.

So you have finally gained that much-coveted position—you are now a manager. But if you think you have it made, think again. Like Humpty Dumpty, many a new manager has suffered a great fall, largely due to missteps and miscues in climbing the high wall of success.

So how do you avoid becoming one of the casualties of managerial unpreparedness? How do you ensure a smooth and successful transition? Here are a few tips:

Think like a manager. Many dewy managers encounter transition difficulties because they retain their rank-and-file mentality. They should be prepared to make the necessary mindset switches to cope with the higher responsibilities.

- Have the perspective of an eagle, not an ant. See the forest, not the trees—Your thinking should now take on a broader perspective. Evaluate the effect of your actions or decisions not only on your unit, but on the whole organization. Your problem solving approach should now be strategic rather than merely straightforward. (You'll learn that sometimes, it may be necessary to lose a battle to win the war.) You should begin steering a course along the company's vision.
- Analyze deeply if you have the time, but decide quickly when needed—One weakness of new managerial appointees, especially those fresh from graduate business school, is a tendency to be wishy-washy. After going through endless case studies in school, they have become so good at analyzing situations that they tend to develop analysis paralysis. They cannot decide without first making a thorough study. A manager must have enough self-confidence to size up situations quickly, and then, even with the barest of information available, make hard and fast decisions when called for. You must learn to develop your "gut feel" and to rely on it at crunch time.
- Think ahead: Be proactive, not reactive—Often, new managers are so afraid of failure that they defer making risky decisions, waiting instead for things to come to a head and then reacting to them. A good manager is one who trains himself or herself to look ahead, weigh all possible scenarios, decide on the most probable outcome and proact accordingly.
- Be organizationally aware—Understand how the organization works—its systems, situations, pressures, culture, etc.—and how these factors combine to influence your unit. Also, study how your own unit impacts on the other components of the organization.

A newly promoted purchasing manager I once knew paid a dear price for not heeding this advice. To win his subordinates over, he solicited assistance from the suppliers in treating them to an excursion. His objective was laudable, but his method was questionable. He violated the organization's stand against soliciting from suppliers and stirred envy in other departments. The resulting fallout was so bad that he had to leave the company.

Behave like a manager. Another managerial pitfall is failing to act appropriately. You should know that, as a manager, you are a company role model, expected to act in a certain manner reflective of your stature in the organization.

- Integrity is very important—As a role model, you must maintain and promote social, ethical and organizational norms in conducting your internal and external business activities. Bear in mind that you now represent the company inside and outside its walls, and how you behave reflects on the company.
- Be a leader, not a boss—A few years back, I encountered a situation where the Engineering Department, once performing well, suddenly became a problem area. It turned out that the people had a beef against the newly promoted engineering manager. Some of their feedback: “Mabuti pa noong `bisor siya, ang bait. Nang maging manager, naging mayabang!” “Grabe maka-utos. Ororada! Pag di agad nasunod, nagagalit.” (“It was better when he was supervisor. As manager, he has become swellheaded!” “He’s too bossy. He wants things done at once, and gets angry otherwise.”)

Several coaching sessions with the manager and a teambuilding workshop with his staff were conducted, and the situation was rectified.

To be an effective manager, you should be a leader, not a boss. You must earn your subordinates' respect, not demand it. You must also delegate properly rather than give orders. You must be sensitive to their needs and assist them when the situation demands it. And most of all, develop them to be better employees, because your success depends on their success.

Work like a manager. Your new post will necessitate a change in work style and a sturdy stomach to withstand the increased pressure.

- Observe flexible work hours—A manager cannot afford to be tardy or even knock off early. Otherwise, you will have a difficult time enforcing time discipline among your subordinates.  
Also, do not observe a regular “eight-to-five” routine simply because you are not paid overtime. Remember that your performance is no longer measured in work hours, but in work output. Oftentimes, this calls for putting in long and hard hours, especially if you have deadlines to meet.
- Learn to live under pressure and to avoid burnout—The major reason why the engineering manager mentioned earlier developed staff problems was his difficulty in coping with pressure. He wanted to prove himself so badly that he took on more jobs than he could possibly handle, and the demands of these simply overwhelmed him. As a result, he vented his exasperation on his hapless subordinates.

Learn to prioritize your tasks based on their perceived importance to the organization or, equally important, to your boss. Tackle the big ones immediately and try to squeeze in the small tasks afterward. If you fill a container with sand, there is no way you can add the pebbles and stones anymore. But put in the stones first, and you can push the pebbles between the gaps, and then squeeze sand into whatever gaps still remain.

Master the art of pacing yourself and conserving your energy for the long grind ahead. It is useless to expend all your energy at the start, only to falter at the end because you've run out of gas.

Finally, learn to handle pressure. You should be able to tolerate stress and relieve it in a manner acceptable to the people around you. There are many articles and self-help books that can teach you how to do this.

- Be tenacious but resilient—As a manager, you should be determined to succeed. Stay on course until you have achieved your objective, or until it is no longer reasonably attainable. However, be resilient as well. You are not Superman and should expect some disappointments and failures along the way. But you should be able to handle these setbacks well and maintain your effectiveness.

There are many more expectations from you as a manager than can be mentioned in this article. Your success will depend on how well you cope with these expectations. Most important, however, is that you learn to think out of the employee box and acknowledge that you still have a lot to learn to become an effective manager. Adopt this frame of mind, and you are halfway there.

*Source:* Courtesy of JobStreet.com Philippines, Inc.