Health Policy & Management
CPH Exam Review Session

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Background:
Certified in Public Health (CPH) Exam

- The intent of this 75 minute review session is to assist PHS Officers from a wide range of agencies and disciplines with an opportunity to take the Certified Public Health (CPH) exam through the National Board of Public Health Examiners (NBPHE). As a "pilot" program, this test can be taken by PHS Officers at a reduced cost during the month of October 2015.
- In an effort to assist those PHS Officers interested in obtaining this certification, a total of 8 weekly, 75-minute review sessions will be led. In addition, these sessions will have additional review materials, resources, and "homework"" in which the goal is to assist the officer in being prepared to test for this for the CPH exam.
- Please visit the following website if you are interested in the Certified in Public Health (CPH) Exam through the National Board of Public Health Examiners (NBPHE) under this pilot program for the month of October 2015. At this website you will also have access to information on the pilot project (ie: target population) and resources to begin to prepare you for examination:

www.nbphe.org

For questions please email LCDR Evelyn Seel at Evelyn.Seel@hhs.gov

or CDR Harvey Ball at Harvey.Ball@hhs.gov

Exam Competencies

- Identify main components & issues of the organization, financing, & delivery of health services & public health systems in the US
- Describe legal & ethical bases for public health & health services
- Explain methods of ensuring community health safety & preparedness
- Discuss policy process for improving health status of populations
- Apply principles of program planning, development, budgeting, management, & evaluation in organizational & community initiatives

Exam Competencies (cont.)

- Apply principles of strategic planning & marketing to public health
- Apply quality & performance improvement concepts to address organizations performance issues
- Apply “systems thinking” for resolving organizational problems
- Communicate health policy & management issues using appropriate channels & technologies
- Demonstrate leadership skills for building partnerships

Evolution of U.S. Public Health System

- Battling Epidemics (before 1850)
- Building state and local infrastructure (1850-1949)
- Filling gaps in medical care delivery (1950-2000)
- Preparing for and responding to community health threats (2001-today)

- Before 1850 the focus was infectious disease control
    - Treatments based on wisdom passed down through an apprenticeship system rather than scientific evidence.
    - Primary focus on protecting public from infectious diseases introduced by travelers (which included inspecting ships at harbors)
    - Infectious diseases, like yellow fever or cholera were introduced to the US from other countries, which then spread from city to city. In response the federal government created the Marine Hospital System in 1798 (later became USPHS)
- Mid-nineteenth century
    - Medical science advances expanded the availability of public health efforts to control the spread of infectious disease
    - Safer vaccines, smallpox for example, enabled widespread immunization
    - Identification of microbes led to a sanitary awakening resulting in a focus on improved social and environmental conditions, like sewage disposal. These efforts improved population health.
    - In 1870 – John Maynard Woodworth transformed the Marine Hospital System from a loose network of locally controlled hospitals into a centrally controlled administration. U.S. Public Health Service Commissioned Corps – brought significant progress in population health.
    - 1887 – Marine Hospital System started the Hygienic Laboratory to research microbes causing infectious disease – later became National Institutes of Health
    - 1906 – FDA was created to regulate medication quality and labeling.
    - 1912 – the Marine Hospital System was given the responsibility for controlling

spread of disease among civilian population – so the name changed to USPHS

- 1918 – federal government started giving grants to states for public health services.

Before 1850 : Battling Epidemics

- Treatments based on wisdom
- Infectious disease prevention
- Travelers were the primary carrier
- Ship inspections and quarantine of persons suspected of carrying contagious disease
- Marine Hospital System (MHS) created

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Evolution of Health Care Services

- Flexnor Report from 1910
- Emergence of hospitals
  - Almshouses
  - Pesthouses
- Hill-Burton Act of 1946

- Late 19th and early 20th century
  - Change in medical practice prompted by a Carnegie Foundation report released in 1910 – commonly known as the Flexnor report – evaluated the quality of medical education in the US and Canada
  - In the late 18th century and early 19th century the majority of hospitals emerged from almshouses and pesthouses (financed through charitable giving and local government funds)
    - Almshouses provided food and shelter to poor individuals and had an infirmary to isolate the ill
    - Pesthouses were used to quarantine people with contagious illness
    - In the late 19th century, these houses evolved into public hospitals. These hospitals served the poor and those without family. Charitable and religious organizations also established hospitals for the poor. Voluntary hospitals, financed through donations, emerged as well and served individuals from all classes of society
  - # of hospitals grew rapidly because of the Hill-Burton Act of 1946 – which provided federal matching funds for community hospitals
    - Hospitals built with this funding had to provide care regardless of a patient's ability to pay

Health Care Financing

- In 2010, US spent 17.4% of GDP on health care
- Rank 37th in the industrialized world
- Medical advances & professionalization of medicine
- Employer Sponsored Insurance

- In 2010, US spent 17.4% of GDP on health care – more than any other country (kff.org)
- Only 2.8% of national health expenditures went to public health programs
- Medical advances & professionalization of medicine led to an increased demand for medical care & increased health care costs
- Employer sponsored insurance (ESI) system was established during WWII in response to wage and price controls and a tight labor market.
    - In 1954, IRS declared premiums for employer-sponsored health insurance are not taxable as income
    - In 2008, 60% of Americans had ESI, paid for with before-tax dollars.
- In 1948, President Truman proposed a single national health insurance system for all Americans. AMA defeated this effort and created the "socialized medicine" label
- In 1965, federal government passed Medicare and Medicaid.
- Next expansion of public health insurance didn't occur until the 1990's – State Children's Health Insurance Program (SCHIP)

Public Financing of Health Care

- Medicare (Title XIX of the Social Security Act)
- Medicaid (Title XVIII of the Social Security Act)
- State Children's Health Insurance Program (Title XXI of the Social Security Act)
- Affordable Care Act

- Largest publicly funded health programs
- The Affordable Care Act was passed by Congress and then signed into law by the President on March 23, 2010. On June 28, 2012 the Supreme Court rendered a final decision to uphold the health care law.
    - The Affordable Care Act puts consumers back in charge of their health care. Under the law, a new "Patient's Bill of Rights" gives the American people the stability and flexibility they need to make informed choices about their health.
        - Coverage
            - Ends Pre-Existing Condition Exclusions for Children: Health plans can no longer limit or deny benefits to children under 19 due to a pre-existing condition.
            - Keeps Young Adults Covered: If you are under 26, you may be eligible to be covered under your parent's health plan.
            - Ends Arbitrary Withdrawals of Insurance Coverage: Insurers can no longer cancel your coverage just because you made an honest mistake.
            - Guarantees Your Right to Appeal: You now have the right to ask that your plan reconsider its denial of payment.
        - Costs
            - Ends Lifetime Limits on Coverage: Lifetime limits on most benefits are banned for all new health insurance plans.
            - Reviews Premium Increases: Insurance companies must now publicly justify any unreasonable rate hikes.

    - Helps You Get the Most from Your Premium Dollars: Your premium dollars must be spent primarily on health care – not administrative costs.
- Care
    - Covers Preventive Care at No Cost to You: You may be eligible for recommended preventive health services. No copayment.
    - Protects Your Choice of Doctors: Choose the primary care doctor you want from your plan's network.
    - Removes Insurance Company Barriers to Emergency Services: You can seek emergency care at a hospital outside of your health plan's network.

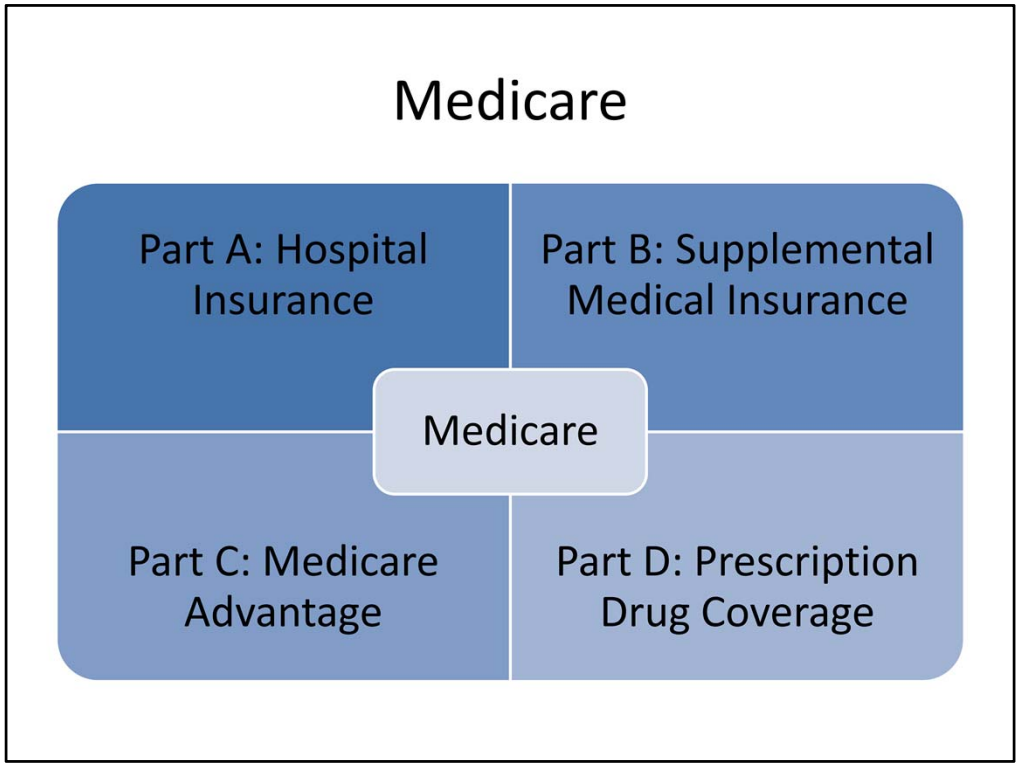
Medicare

- For the elderly & people with disabilities
- Funded through payroll taxes, general revenue, & premiums
- Covers ~45 million people & consumes ~14% of the federal budget
- Four parts to Medicare
  - Parts A, B, C, D

- Federal health program for the elderly and people with disabilities
- Funded through payroll taxes, general revenue and premiums
- Benefits and services are consistent across the country
- Medicare covers ~45 million people and consumes 14% of the federal budget
- To be eligible for Medicare an individual or his/her spouse has to contribute to Medicare for 10 years or pay monthly premiums to buy-in to the program. Beneficiaries must be age 65 or older, disabled and entitled to social security benefits (after a 2-year waiting period), or have end stage renal disease.
- Medicare eligibility is not based on income or assets.
- 4 parts to Medicare:
  - Medicare Part A: known as hospital insurance
    - Covers inpatient hospital care, skilled nursing, and hospice.
    - It is financed through mandatory payroll taxes levied on the employer and employee.
  - Medicare Part B: known as Supplemental Medical Insurance
    - Covers outpatient services, including physician care.
    - This is a voluntary program financed through premiums and general tax revenue.
  - Medicare Part C: known as Medicare Advantage
    - Provides alternatives to traditional Medicare. Beneficiaries can choose from a # of health maintenance organizations, preferred provider organizations, or private fee-for-service plans.
    - The plans are financed by payments from Medicare & may require an

additional premium. In exchange, these plans can provide additional benefits not covered by traditional Medicare.

- Medicare Part D: provides prescription drug coverage
    - Was established by the Medicare Prescription Drug Improvement and Modernization Act of 2003 & implemented in 2006
    - Voluntary program. Enrollees can choose between a stand-alone plan for prescriptions or a Medicare Advantage plan that provides prescription drug benefits
    - Premiums are subsidized for low-income beneficiaries



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        - Voluntary program, **however, those who chose to obtain Part D at a later date will incur a late enrollment penalty (LEP) unless they have previous employer group drug coverage or coverage from a spouse**).

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Medicaid

- Joint federal-state program
- Provides health care for low income people
- Does not cover all individuals with incomes below the federal poverty line
- Administered by state governments

- Joint federal-state program provides health care for low income people
- In 2006, covered 59 million people (15% of the population) & had total expenditure of $269 billion
- Administered by state governments, federal government provides matching funds to states on an open-ended basis
    - Amount of matching funds varies from 50% -76% depending on the state's ability to raise tax revenue.
- Eligibility used to be focused on welfare recipients but with the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 – separated Medicaid eligibility from welfare eligibility
- Parents with dependent children, pregnant women, & individuals who are aged, blind or disabled are Medicaid eligible if they meet the income and assets tests.
- Medicaid doesn't cover all individuals with incomes below the federal poverty level.
- The federal government sets broad criteria and each state can choose to include optional services & population groups
- Changes from ACA: http://www.medicaid.gov/affordablecareact/affordable-care-act.html

State Children's Health Insurance Program (SCHIP)

- Passed into law in 1997
- Every state has an approved SCHIP plan, some states include waivers to cover parents of children receiving benefits
- Funded from discretionary spending & must be reauthorized

- Passed into law in 1997
    - SCHIP was the largest expansion of taxpayer-funded health insurance coverage for children in the US since Medicaid began in the 1960s
- SCHIP provides broad federal guidelines but gives the states flexibility in designing their eligibility requirements and policies
- Each state has an approved SCHIP plan. Some states have used waivers of SCHIP statutory provisions to cover parents of children receiving benefits
- In 2006, SCHIP covered 6.6 million children
- Even though SCHIP expands health insurance access to more low income children, many uninsured children have incomes above the 200% federal poverty level and don't qualify
- SCHIP is funded from discretionary spending and must be reauthorized
- Legislation to expand SCHIP was vetoed twice during the Bush Administration and approved in 2009 by the Obama Administration

Affordable Care Act

- The Affordable Care Act was passed by Congress and then signed into law by the President on March 23, 2010.
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- The Marketplace (federal exchange): www.healthcare.gov

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Legal Framework for Public Health

- Public health system in the U.S. consists of state & local public health agencies working with the federal government.
- Over the last century, the majority of public health services are delivered by local and state public health agencies and a large part of the funding is federal.

- States develop public health infrastructure where it didn't exist (like rural areas), and formally delegated authority over many public health functions to local governments.
- Local public health agencies are responsible to state government for the effective execution of public health functions.

Health Policy

- Health policy is the aggregate of decisions by governments & other stakeholders that determine the allocation of resources & services that affect the health of the population.

- Health policy reflects the principles, priorities and values of decision makers and key stakeholders.
- The goals of health policy are targeted at the determinants of health. The determinants of health are:
    - Social (socioeconomic factors of the organization of health services)
    - Behavioral (health related behaviors)
    - Environmental (built environment)
    - Biological/physical (age, genetics, …)
- Policy analysis is the systematic investigation of policy alternatives based on the assembly of evidence for or against each alternative. The policy analysis involves both problem and solution analysis. Quantitative and qualitative information is included in policy analysis.

Health Policy

- Policy development process:
  1. Agenda setting
  2. Policy formulation
  3. Policy adoption
  4. Implementation
  5. Administration
  6. Consequences
  7. Evaluation

- The policy development processes involves six stages:
  1. Setting the agenda – problems are put on the agenda by various sources (political influence is a necessary factor). Mass media can also be an influence as the issues is brought to the public's attention.
  2. Policy formation – once a problem is on the agenda then policy makers begin generating possible solutions. The solutions could be developed by political staffers, but usually they are generated by special interest groups who care about the problem and advocate for specific solutions.
  3. Policy adoption – where policies are enacted. This is the highest-profile stage and gets the most media attention and public scrutiny.
  4. Implementation – involves the development of rules & regulations that determine how the policy will work in reality. The executive branch of government is the lead government body in this stage, and it may take several years to complete. This stage can involve federal, state, and local governments as well as public comment.
  5. Administration – running the programs as spelled out in the rules & regulations. The rules & regulations continue to be refined based on feedback for policy experts & organizations responsible for program or service delivery.
  6. Consequences – Hopefully better effects on the population. New or related problems arise.
  7. Evaluation – added stage. Assessing whether the policy achieved its goals. This part is usually ignored. Political influence from elected officials and special interest groups can derail evaluation or hinder the dissemination of results.

Management

- Process of coordinating & organizing people & resources to achieve organizational goals.
- Basic functions include:
  - Planning
  - Organizing
  - Leading
  - Controlling

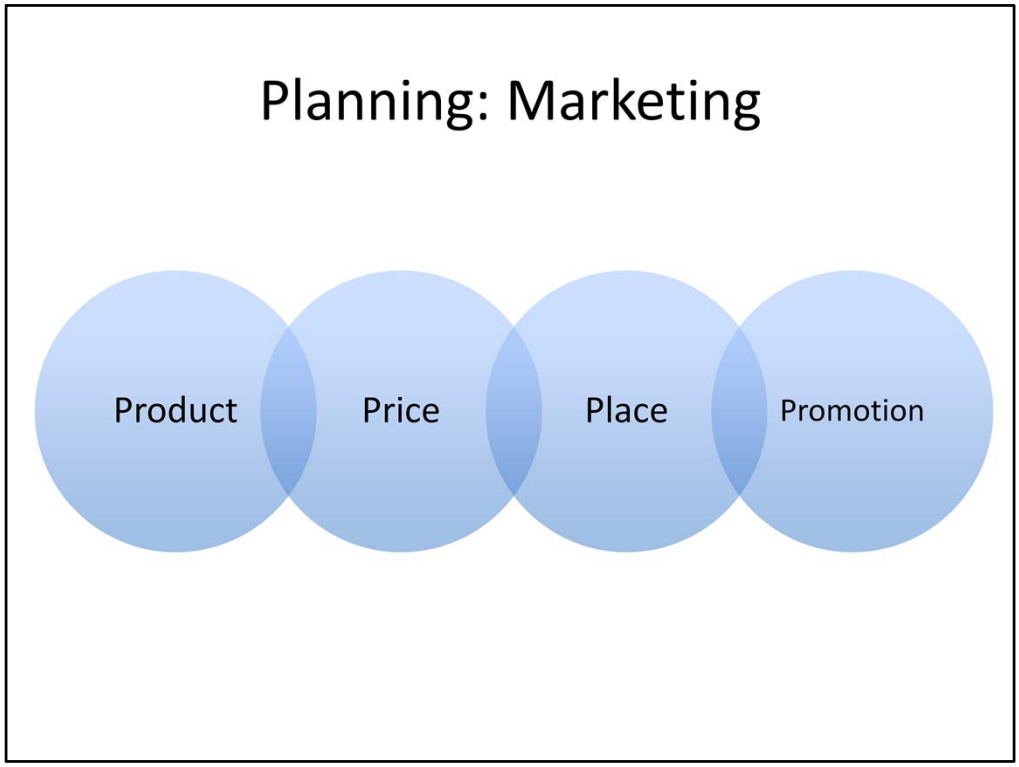
- Process of coordinating & organizing people & resources to achieve organizational goals.
- Basic functions include:
  - Planning – ongoing process of developing the organizations' vision, mission and goals and how to accomplish the goals.
    - Strategic planning
    - Marketing
    - Communication planning
  - Organizing
  - Leading
    - Leadership
    - Motivation
  - Controlling
    - Financial management
    - Quality assurance

Planning: Strategic Planning

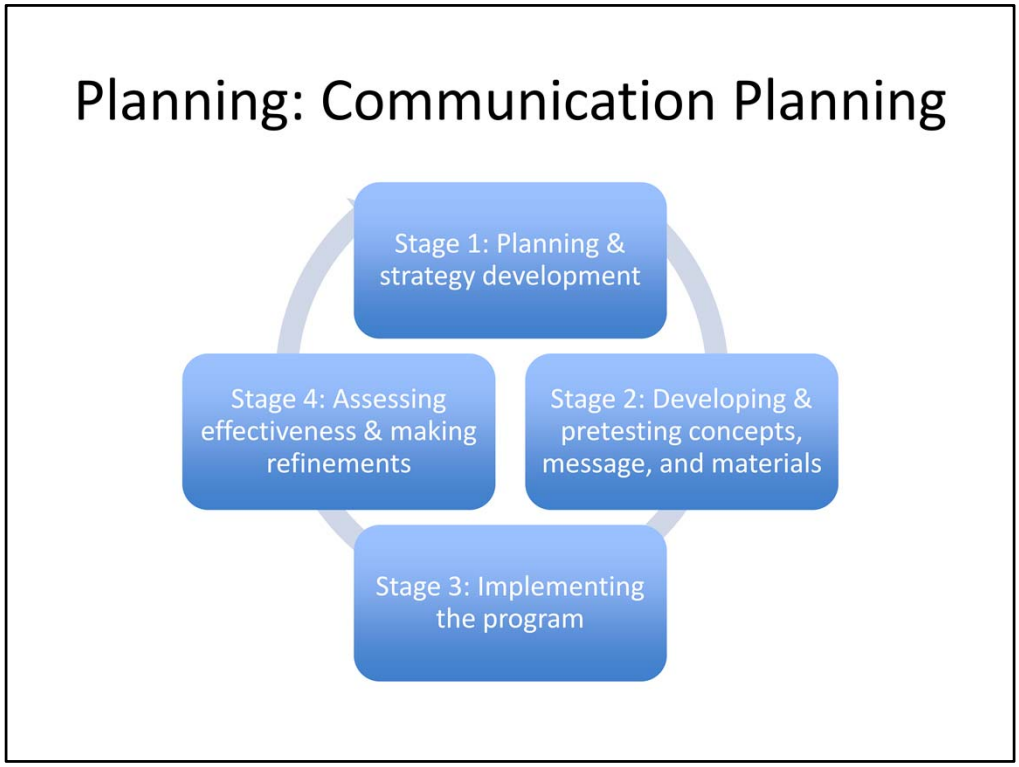
- Strategic Planning
  - Environmental Scan
  - Strategy formulation
  - Strategy implementation
  - Evaluation

- Strategic planning – process of determining where the organization wants to be in the future and how it is going to get there. This must be a proactive and ongoing process.
    - Environmental scan – SWOT (strengths, weaknesses, opportunities, threats) analysis is an assessment of the organizations' internal SWOT.
        - Internal strengths & weaknesses are identified by assessing the organization's services, core capabilities, and performance on past strategic plans.
        - External opportunities & threats are identified using PEST (Political, Economic, Social, Technical) analysis by analyzing the environment that can affect the organization's future performance.
    - Strategy formulation – the organization formulates potential strategic objectives based on the organization's mission, vision, and values and the results of the environmental scan. Selected strategic objectives should be prioritized, clear, focused, and doable.
    - Strategy implementation – involves developing a tactical and implementation plan.
        - Tactical plan breaks down the strategic plan into specific, short-term actions and plans and assigns responsibility for specific areas. An effective tactical plan needs flexibility for unplanned events.
        - Implementation plan outlines the process for communicating the strategic plan to employees and getting employee buy-in to the strategic plan.
    - Evaluation – of the implementation of the strategic plan to ensure that the

organization is following the strategic plan and identify any areas that need adjustments.



- Marketing in public health is the process of creating, communicating, & delivering health information, services, & Interventions using consumer-centered approaches with the goal of protecting & promoting the health of diverse populations
- The marketing plan is based on the marketing mix – integration of the four P's
    - Product: product or service used by consumers
    - Price: monetary and non-monetary costs to consumers
    - Place: distribution channels and locations where consumers can obtain product or service
    - Promotion: direct communication, publicity, and advertising about the product or service with the goal of generating a positive customer response



- The National Institute of Cancer has developed a 4 stage process for developing an effective communication plan.
    1. Planning and strategy development – focuses on developing a plan for communicating with the public
        - Identify the goal of the communication plan
        - Describe the specific objectives
        - Identify who you want to communicate your message to
        - Learn about the target audience (beliefs, actions, demographics, …)
        - Write a communication plan outlining the activities & partnerships as well as evaluation criteria and a baseline survey for outcome evaluation
    2. Developing and pretesting concepts, messages, and materials – focuses on developing the message to be communicated
        - Brainstorm to generate possible messages & asses how well they achieve the goals & are appropriate for the target audience
        - Identify channels & sources that will effectively reach intended audience
        - Determine the best time to reach the audience
        - Pretest selected messages
        - Pretest messages with intended audience
        - Revise messages and materials based on feedback from pre-testing
    3. Implementing the program
        - Executing the communication plan
        - Communicating with partners and the media

    - Begin evaluating the communication plan & making necessary adjustments
1. Assessing the effectiveness and making refinements – focuses on assessing the effectiveness and refining the strategies
    - Assessing whether the communication plan achieved objectives
    - Identify changes that would increase the communication plan's effectiveness.

Organizing

- Organizing is concerned with ensuring that the necessary resources are available and appropriately configured to meet the organization's mission and vision.
- Includes human resources functions.

- Organizing is concerned with ensuring that the necessary resources are available and appropriately configured to meet the organization's mission and vision.
- Systems theory, which views organizations as complex systems functioning with broader environment, provides a useful approach for understanding the organizing function within public health organizations. A system has various inputs which are put through processes to produce outputs. Continued feedback between parts of the system ensures that they remain focused on the organization's goals
    - Inputs for public health organizations include:
        - Human resources, funding, scientific evidence, and facilities
    - Core processes within public health agencies include the 10 essential functions performed by public health professionals:
        - Monitoring, diagnosing & investigating, informing & educating, mobilizing, developing policies & plans, enforcement, creating linkages, assurance, evaluation, and research.
- Human resources is the organizational function responsible for implementing strategies & policies related to management of individuals. Basic functions of HR are:
    - Staffing management – identifying, recruiting, and retaining employees needed to support the organization's activities
    - Training and development – concerned with improving performance of individuals and groups in organizational settings
    - Compensation and benefits – combination of direct and indirect compensation employers provide to attract, recognize, and retain employees.
    - Employee relations – employer-employee relationship, employee performance,

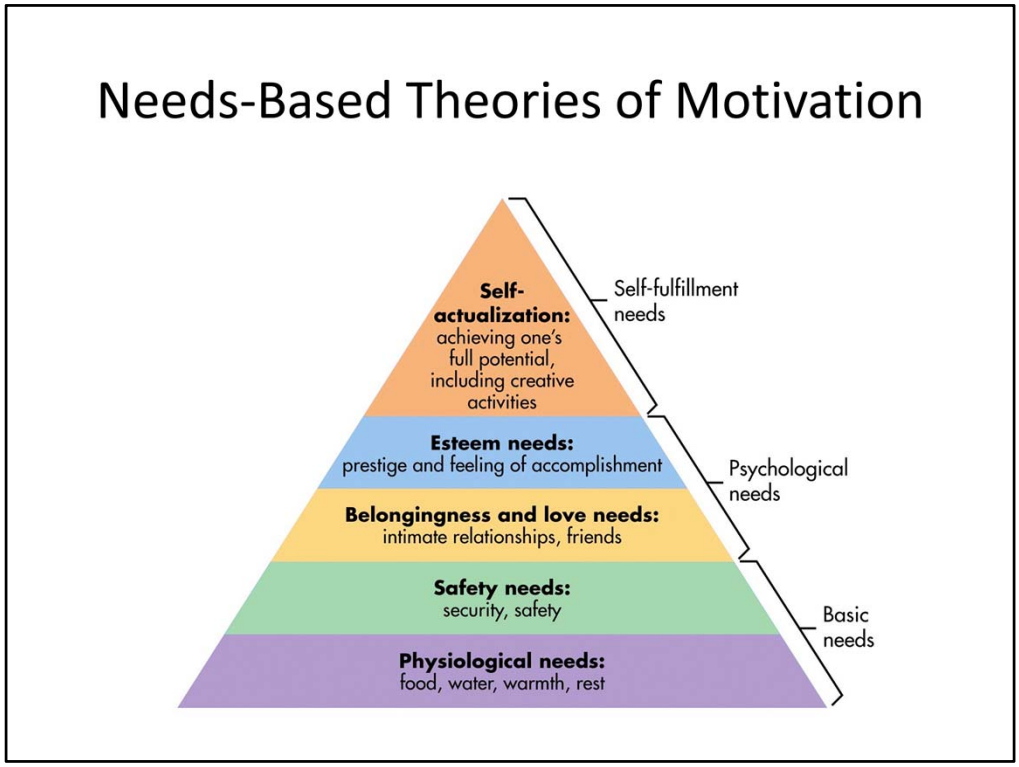
communications, compliance with federal, state, and local laws and regulations and resolving workplace disputes.

- Labor relations – concerned with terms and conditions of employment, legally protected activities, unfair labor & management practices, collective bargaining, …

Leadership

- Leading involves setting direction for the organization and influencing people to follow that direction.
- Leadership is defined many ways – viewed as specific traits or characteristics, certain skills & knowledge, or as a process emphasizing social interaction and relationships.
- Leadership styles
    - Transactional leadership – assumes that employees only perform work because they are rewarded. This style gets work done, but doesn't generate strong work relationships nor motivating work environments in the long term.
    - Autocratic leadership – an extreme form of transactional leadership, exerts absolute power over employees. Most people resent this leadership style so leads to high absenteeism and turnover, but this can be effective for routine and unskilled jobs.
    - Bureaucratic leadership – insist that employees follow rules and procedures precisely. This style is appropriate for work involving serious safety risks or a high likelihood of failure.
    - Charismatic leadership – generates enthusiasm and inspires employees to higher levels of achievement. Leadership void is created when these leaders leave the organization
    - Democratic or participative leadership – involve employees in the decision-making process, but final decision rests with leader. Engenders greater job satisfaction and helps employees develop their skills. Employees feel more empowered which increases motivation. This approach works with team work and when quality > efficiency.

- Laissez-faire leadership – “leave it be” in French, leave team members to work on their own. This style is effective with the leader monitors and communicated information on performance to employees. Most appropriate for very experienced and skilled employees who are self-starters.
- Relationship-oriented leadership – focus largely on organizing, supporting, and developing their employees. Encourages good teamwork and creative collaboration.
- Servant leadership – informal leader at any level of the organization who leads by meeting team needs. Often involves others in the decision making process. This approach is effective where values are important and the servant leader gains power on the basis of their values and ideals.
- Transformational leadership – inspires employees to share in his or her vision for the organization. “true leadership”: because leaders are enthusiastic and innovative which motivates the employees. They may need to rely on others to attend to details and control function.



- Motivation is the act of influencing an individual to take a desired course of acting.
    - Intrinsic motivation – arises from rewards inherent in accomplishing a task or activity itself. Leaders can influence an employee's level of intrinsic motivation through job redesign, improving work conditions, and offering a range of incentives. Intrinsic is more effective, but is harder to influence
    - Extrinsic motivation – arises from external rewards and can be influenced through monetary rewards.
- Needs-based theories of motivation
    - Maslow's Hierarchy of Needs – 1954 theorized that individuals are motivated by a hierarchy of needs progressing from subsistence-level needs to self-actualization.
        - Five levels are: physiological needs (food, water, …), safety needs (shelter, employment, access to health care), belonging needs (desire for social contact, friendship, support), esteem needs (status, recognition, positive regard), self-actualization needs (desire for achievement, personal growth, autonomy). Once an individual satisfies the lower-level needs, the individual becomes motivated to fulfill the next level.
    - Alderfer's Existence, Relatedness, Growth (ERG) Theory – Alderfer drew on Maslow's hierarchal theory, but he argued that an individual can move forward and backward through the levels of motivations. He reduced the level of needs to 3 – existence (Maslow's physiological and safety needs), relatedness (social need), growth (need for self-esteem and self-actualization)
    - Herzberg's Two Factor Theory – separate factors lead to job satisfaction

(motivators) and job dissatisfaction (hygiene factors).
    - Job satisfaction comes from intrinsic motivators – such as the level of challenge and responsibility of a job and the opportunity for personal growth
    - Job dissatisfaction comes from hygiene factors – salary, job security, …
- McClelland's Acquired Needs Theory – needs are learned and developed as a result of one's life experiences. 3 types of needs:
    - The needs for achievement – emphasizes the desires for success, for mastering tasks, and for attaining goals
    - The needs for affiliation – focuses on the desire for relationships and associations with others
    - Need for power – relates to desires for, responsibility for, control of, and authority over others
- Skinner's Reinforcement Theory – postulates that 4 types of reinforcement (operant conditioning) influence an individual's behavior, but doesn't take into account the higher level of cognition that occurs in humans:
    - Positive reinforcement – providing rewards for desired behaviors
    - Negative reinforcement or avoidance – providing rewards for avoiding undesirable behaviors
    - Positive Punishment – negative consequences for undesirable behaviors
    - Negative Punishment – removal of rewards for undesirable behavior

Intrinsic Motivation Theories

- Intrinsic motivation theories – address the internal thought processes and perceptions that affect motivation
    - Adam's Equity Theory – argues that motivation is determined by how equitably an employee perceives he/she is treated in comparison to others in the organization
    - Expectancy Theory – employees motivation is a function of the employee's belief that:
        - Putting more effort into the job will result in better performance
        - Better job performance will be rewarded
        - The predicted rewards are valuable
    - Locke's Goal Setting Theory – argues that individuals are motivated to improve their performance when given challenging and specific goals. Employees must be interested in attaining the goal and adopting the goal as their own.
    - McGregor's XY Theory
        - Theory X – assumes that employees naturally dislike work and avoid responsibility, so they must be compelled to perform
        - Theory Y – assumes that employees are naturally motivated and committed, managers can help employees achieve their full potential by providing opportunities for personal growth and development through challenging and interesting work
    - Attribution Theory – people tend to ascribe an explanation to another's behavior. Our perceptions influence whether we attribute the behavior to the person's personality traits or to the circumstances in which it occurred.

Controlling

- Financial management
  - Accounting
  - Financial management
- Quality assurance

- Control function is systematic process of measuring performance and taking corrective action to ensure that organizational goals are met. Key aspects of control function:
  1. Determining appropriate performance areas or control units
  2. Determining what constitutes satisfactory performance
- Two key control functions:
  1. Financial management – the process of providing oversight of the healthcare organization's daily financial operations, as well as planning the organization's long-range financial direction. Two primary functions are 1. accounting (reporting of financial transactions) 2. financial management
     - Income statement – revenues and expense details of an organization over a specific period of time
     - Balance sheet – detailed financial assets, liabilities, equities of an organization at a specific time
     - Cash flow statement – forecast of cash inflow, outflow, and net lending or borrowing for a period of time
     - Budgeting – the process of converting the goals and objectives into financial terms.
     - Retrospective reimbursement – amount reimbursed is determined after service delivery (aka fee for service)
     - Prospective reimbursement – method of reimbursement determined before service is provided and based on contractual arrangements between provider and payer
     - Unit of service reimbursement – provider is reimbursed a pre-

determined fee for each unit of service (visit, procedure, …)

- Bundled payments – fixed amount is paid and to be shared by all providers
- Capitation – health plans pay providers a fixed amount per enrollee per moth in exchange for a contractually specified set of services in the future. Payment is received whether patient uses services or not.
- Medicare reimbursement methods – uses prospective reimbursement methods. Payments is a fixed amount per admission and per diagnosis.

1. Quality assurance – focuses on eliminating defects or errors. Sets a threshold for average acceptable quality and strives to achieve that level.
    - Quality improvement – aka continuous quality improvement (CQI), it begins by investigating potential causes of error, identifying remedial measures that address the source of error, implementing the process improvement and evaluating the results.
    - Total quality management – customer focus, continuous improvement, and teamwork

Public Health Emergency Preparedness

- Federal coordination
- National Incident Management System (NIMS)
- Incident Command Systems (ICS)

- Public health emergency preparedness and response efforts endeavor to prevent epidemics and the spread of disease, protect against environmental hazards, prevent injuries, promote healthy behaviors, and assure the quality and accessibility of health services.
- Effective preparedness and response rely on coordinated efforts in surveillance, epidemiological investigation and analysis, laboratory investigation and analysis, intervention, risk communication, preparedness planning, and community-wide response.
- Preparedness planning is a health policy & management activity that relies on input of all other core public health functions
- Effective emergency preparedness planning includes monitoring available response resources, establishing action protocols, simulating emergency events to improve readiness, training public & private sector personnel, assessing communication capabilities, and maintaining relationships with partner organizations to improve coordination.
- At the national level, emergency preparedness is coordinated through Department of Homeland Security (DHS), but the public health response to emergencies is the responsibility of DHHS including CDC, HRSA, FDA, NIH. ASPR sets policy and coordinates the emergency preparedness and response across DHHS.
- NIMS – established in 2003 to assure greater consistency of emergency management systems. DHS is responsible for developing and implementing NIMS. In 2004, compatibility with NIMS is a condition of all federal grants awarded for emergency preparedness.

- ICS – is widely used to effectively facilitate decision making in emergencies. Key components of ICS are:
    - Common terminology – common names are used for personnel, equipment, and facilities
    - Modular organization – “top down” – each is staffed with designated incident commander and other functions as needed
    - Integrated communications – redundant two-way communications are used
    - Unified Command structure – necessary when multiple agencies or jurisdictions are involved
    - Consolidated action plans – written plans that include specific goals, objectives, and support activities
    - Manageable span of control – between 3-7 subordinates are assigned to one supervisor
    - Designated incident facilities – command post where operations are directed
    - Comprehensive resource management – maximizes resources use and consolidates control

QUESTIONS?