

Chapter 1

LEADERSHIP DIMENSIONS AND PROCESSES

Learning objectives

After reading this chapter, the learner will be able to:

- Identify the flow of the revenue cycle in your facility
- Discuss the foreign language of finance

Today's nurse manager

There is no question that in today's healthcare environment the role of the nurse manager is very different than it was 25 years ago. Back then, nurse managers were referred to as "head nurses" and were responsible for leading their area or unit in a much different capacity than is expected today. Head nurses were primarily responsible for providing patient care and running the unit and were often considered working supervisors. Fast forward to the present and the term head nurse is virtually extinct.

This is not to say that the duties of head nurses no longer exist; on the contrary, they have multiplied. Now you find those responsible for overseeing the same tasks as head nurses donning titles such as nurse managers, directors, coordinators, and service-line leaders, with each title dependent on the hospital in which they work.

These leaders, regardless of their titles, are responsible for managing and guiding their units 24 hours a day, seven days a week. Nowadays, additional skills beyond the clinical base are necessary to do the job. This book will discuss and explain one of the necessary skills for the successful nurse manager: financial management.

Responsibilities

The authority and responsibilities of nurse managers differ from organization to organization. However, there are some core competencies that consistently are required of you. Interpersonal skills, resource management, time management, communication skills, and a clinical background are all part of the nurse manager's repertoire.

Some of the essential functions expected of the nurse manager include the following:

- Develop a practical annual budget for a unit or department that includes volume, revenue, personnel, supplies, and capital equipment
- Give weekly or monthly reports of budgetary variances to your supervisor and review end-of-year data with the finance department and the chief nurse executive (CNE)
- Ensure proper, efficient operations and monitor trends regarding staff, material, and supply usage
- Communicate fiscal management expectations and outcomes to your staff and other stakeholders

Education and training

The majority of the nurse manager's education focuses on clinical nursing. Because you have picked up this book, it's safe to assume that you are just one of the many clinically proficient staff nurses who have been promoted to nurse manager without any formal or informal business or financial experience or training. This side of nurse managing likely causes the most strife and warrants the most education.

Whether you go out and get this training or your hospital makes it available to you, learning the skills necessary to be a manager is vital to your career. To become a successful financial

manager, you must know and learn tasks such as creating and presenting budgets, reading financial statements, and managing the financial aspects of the units.

Of course, this is not to say that you should forsake your clinical training. On the contrary, use it to your fullest advantage. As a nurse with business acumen and finance knowledge, you will carry a particularly important position, because you can inject your clinical knowledge into the budgeting process. By doing so, you help ensure that patients continue to get safe, quality care even when budget cuts must be made. To do so, begin by learning what makes the financial hearts of hospitals and healthcare organizations tick.

This is a business

Now that you are a financial manager, the main point to remember is that hospitals and other healthcare organizations are businesses. And for businesses to be successful, they must make a profit on the goods or services they offer or sell.

Many hospitals are not-for-profit. Such organizations generally use earnings to construct new buildings, provide raises for staff, or buy new equipment. For-profit hospitals essentially spend their earnings on the same things; however, they have the additional expense of paying back shareholders.

As with every business, there are certain politics that dictate hospitals' operations. Therefore, you, as a financial manager, must understand the politics behind healthcare economics.

The politics of healthcare economics

Many factors affect the cost of healthcare today. Both nationally and at the state level, the number of people who are uninsured or underinsured is on the rise. More than 47 million people went without health insurance in 2006, including 8.7 million children, according to data released by the United States Census Bureau in 2007.

The state of the economy plays a large role in increasing healthcare costs. During rough economic times, many consumers must make the harsh decision of whether to put food on the table or pay for healthcare. As you can imagine, many neglect their health until they are ill, entering the healthcare system through the emergency department, which increases costs significantly.

Another major factor in increasing healthcare costs is the overall shortage of healthcare workers in the nation—particularly RNs. When hospitals have high RN vacancy rates, they must resort to alternatives such as using costly contract/agency staff and offering incentive programs such as sign-on bonuses. They also use traveling nurses, those on a minimum 13-week assignment, to fill open slots within hospitals at a higher rate of pay. These actions are short-term solutions and significantly increase hospital expenditures.

Technology and pharmaceuticals

The cost of technology plays a major role in the cost of healthcare, and there has been an explosion of available technology in the past 20 years. The more technology that is available, the more there is a need for specialists to run the technology. Hospitals, competing for the best physicians to come on staff to attract more patients, buy expensive technologies.

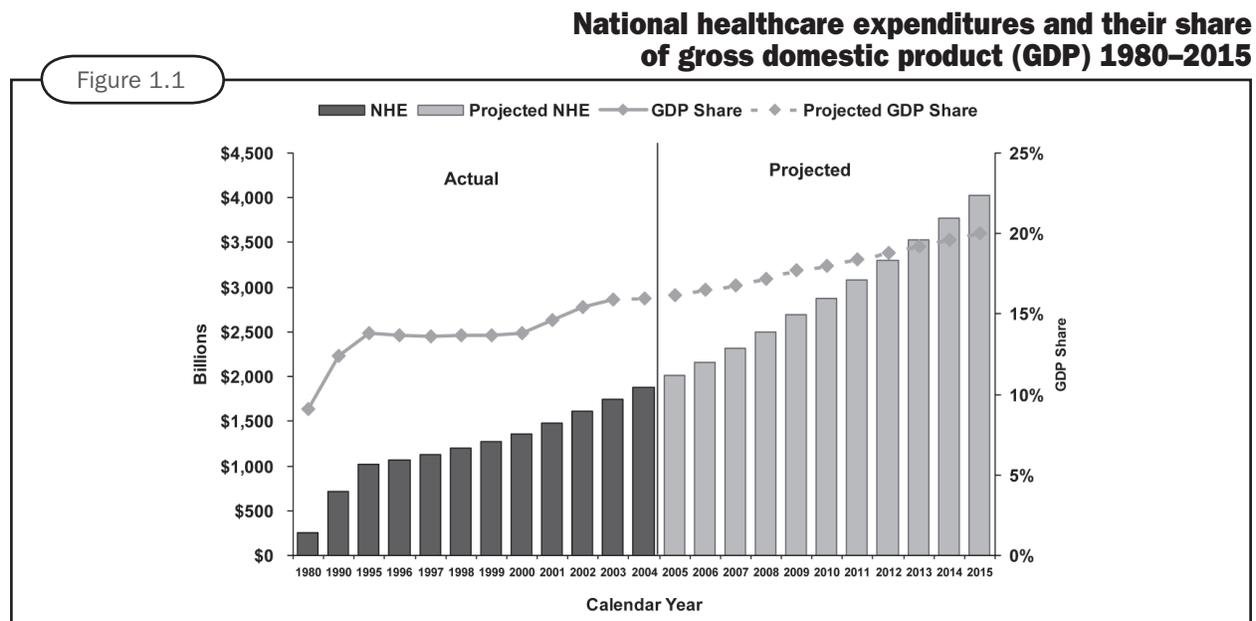
In the past, hospitals were paid by the various health insurers each time a procedure was performed with new equipment. Today, with managed care and diagnosis-related groups (DRGs), procedures are not reimbursed separately; rather, the hospital receives a flat-rate reimbursement, thus increasing the costs of healthcare.

Hospitals feel it is necessary to have the most current technology to attract patients and physicians, but it can be costly. In addition, with increased litigation in the industry, physicians are more apt to order pricey, high-tech tests to ensure they have covered all bases to avoid a lawsuit. They essentially order tests for the benefit of the medical record, not for the patient.

The number of new medications developed in the pharmaceutical industry has skyrocketed over the past 20 years, thus increasing the cost of healthcare. As these drugs are available and used by physicians, it adds to the costs of patient care. This is because the costs to develop, test, and approve new medications are high, and it can take years before a medication reaches the marketplace. When the medication is finally available to the public, manufacturers must charge enough to cover these costs and pay their stockholders, who expect to see a return on their investment. The price of drugs does not drop significantly until companies begin to sell generic versions of a high-priced drug (National Coalition on Health Care 2007).

Healthcare spending

Understanding how the United States spends its money on healthcare and how it relates to the gross domestic product (GDP) is important. Figure 1.1 from the Centers for Medicare & Medicaid Services (CMS), Office of the Actuary, National Health Statistics Group 2007, shows the national health expenditures and their share of the GDP, 1980–2015. This information provides a big-picture perspective of how expensive healthcare is—and is becoming! National health spending is projected to increase as a share of GDP over the next decade.



Source: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group 2007. "An overview of the U.S. Health Care System Chart Book." Available from www.cms.gov.

Resources are limited, reimbursement is decreasing, and it has become imperative that nurse leaders control and/or manage costs on their units.

This big-picture perspective affects healthcare costs on a national scale. Each state has its own challenges and issues, and reimbursement by payer type may differ. In 2005, healthcare spending in the United States reached \$2 trillion, and that amount is projected to reach \$2.9 trillion in 2009 (National Coalition on Health Care 2007).

As the baby boomer generation ages, approximately 77 million people will begin to use healthcare services, and we can expect the related healthcare costs to continue to skyrocket.

The financial reimbursement breakdown

Prior to 1983, hospitals were reimbursed for the services they provided by insurance companies or directly by the patient. This included such expenditures as room charges, nursing care, ancillary services, medications, procedures, linen, food, etc. Bills were sent to the insurance company or patients. This system depended heavily on the nursing department and ancillary services. Cost containment was not an issue: The more hospitals charged, the more revenue they brought in. Management decisions such as the amount of staff or resources were essentially no-brainers because reimbursement was so healthy. Costs were shifted to insurance companies and patients while hospitals enjoyed healthy financial statements.

However, after 1983, Medicare diagnosis-related groups (see p. 4) drastically changed hospital operations. DRGs categorize patient care by characteristics, such as diagnosis, treatment, age, and sex, to estimate patients' approximate length of stay (LOS) and use of hospital resources. DRGs are based on the prospective payment system (PPS), which determines the amount hospitals can charge (hospitals cannot charge for all costs incurred for patient care).

Under PPS, hospitals could no longer charge for costs they incurred. Rather, their reimbursement relied on predetermined prices set by the DRG. Because of this shift in reimbursement practices, many hospitals began providing patients with the lowest level of care possible to control costs. With approximately 700 DRG categories, hospitals are paid a flat-rate reimbursement on the discharge diagnosis regardless of the patient's LOS, tests, procedures, or the supplies used. As a financial manager, you must know how much it costs your hospital to care for patients per day because the reimbursement may not cover the cost of care. Also, depending on the percentage of Medicare patients admitted and cared for, the hospital's bottom line can be negatively affected.

Other payers followed suit, and in the mid to late 1980s, insurance companies also began paying hospitals differently. As mentioned before, insurance companies were billed for services rendered, for which they would pay the hospital. Today, these important third-party payers no longer reimburse hospitals for services rendered: Rather, they base reimbursement on negotiated rates, contracts, and outcomes. These payers often constitute the majority of revenue for hospitals. Some methods of reimbursement from insurers include reimbursing a percentage of the charges, or a "per diem rate." The per diem rate is a negotiated rate that the hospital receives

for reimbursement regardless of the actual amount for services rendered. A healthy payer mix composed of primarily third-party payers has a great effect on organizations' financial health. Hospitals with a large percentage of Medicare patients need to make an extra effort to control costs; however, there are times when Medicare actually pays more than some of the hospital-negotiated contracts.

Another significant payer is Medicaid, the state health insurance program for the medically indigent. Under Medicaid, services paid vary from state to state. Reimbursement is often paid at a flat rate.

Changes in 2008

Beginning in October 2008, CMS has announced that Medicare will stop paying for eight reasonably preventable hospital-acquired conditions. This ruling is primarily due to the increasing concentration by payers on quality, patient safety, and hospital performance. CMS has established eight conditions in which the presence of complications and co-morbidities, should they occur during the hospital stay, will no longer lead to a higher DRG payment. The eight conditions are as follows:

- Object left in patient during surgery
- Air embolism
- Blood incompatibility
- Catheter-associated urinary tract infection
- Pressure ulcer
- Vascular catheter-associated infection
- Mediastinitis after coronary artery bypass graft
- Hospital-acquired injury, which includes fractures, dislocations, intercranial injuries, crushing injuries, and burns

As a manager, it is important to continually educate and monitor staff to ensure competency in all areas of responsibility. As you can see from these changes, mistakes can be costly.

Managed care

With the passage of the Health Maintenance Organization Act of 1973, alternative prepaid health plans began cropping up around the nation. By the mid 1980s, "managed care" entered the healthcare arena, and hospitals were forced to adapt to a new reimbursement method.

Managed care refers to the entire spectrum of available alternatives to the traditional fee-for-service mechanism used for provider reimbursement. It is a system that manages or controls healthcare costs by carefully monitoring resource utilization and, therefore, shifting the financial risk to hospitals. In other words, managed care puts the burden of managing costs on hospitals by expecting them to control the use of resources in order for them to receive optimal reimbursement rather than having third-party payers, such as the patient or insurance company, pay for services rendered.

Remembering the various abbreviations for the following managed care plans can be confusing, as there are many. For instance, there are HMOs, IPAs, PPOs—and the list goes on.

HMO

The most common form of managed care is the health maintenance organization (HMO). There are two types of HMOs:

1. The group model, in which physicians are actually employed by the HMO
2. The individual practitioner association (IPA) model, in which physicians maintain a private practice while serving both HMO and non-HMO patients

With both models, a population of patients, or “members,” is enrolled for a prepaid fee known as the capitation charge. HMOs focus on preventive care with the ultimate goal of keeping members healthy and out of the hospital. The fewer services members use, the more money the HMO gets to keep. For these programs, a low census is a good sign. In fact, many organizations with capitated contracts have outpatient clinics, and they put health and wellness programs in place to keep patients out of hospital beds and only admit patients when absolutely necessary. Hospitals are then left to figure out creative, innovative ways to provide quality patient care at the lowest cost possible.

IPA

In the IPA model, a group of privately practicing physicians join together to form a coalition that offers managed health organizations a full spectrum of services. These physicians continue to treat patients with third-party payers while serving HMO members. This model is highly controversial, as it raises many ethical questions regarding issues such as the average length of time physicians spend with HMO patients vs. other patients and the number of diagnostic

tests physicians request for their HMO patients. These questions arise because in this model, the more resources physicians use, the less they are paid.

PPO

The preferred provider organization (PPO) is a negotiated arrangement between providers and third-party payers. When a physician joins the organization, he or she agrees to abide by the rules and standards within the PPO’s reimbursement structure.

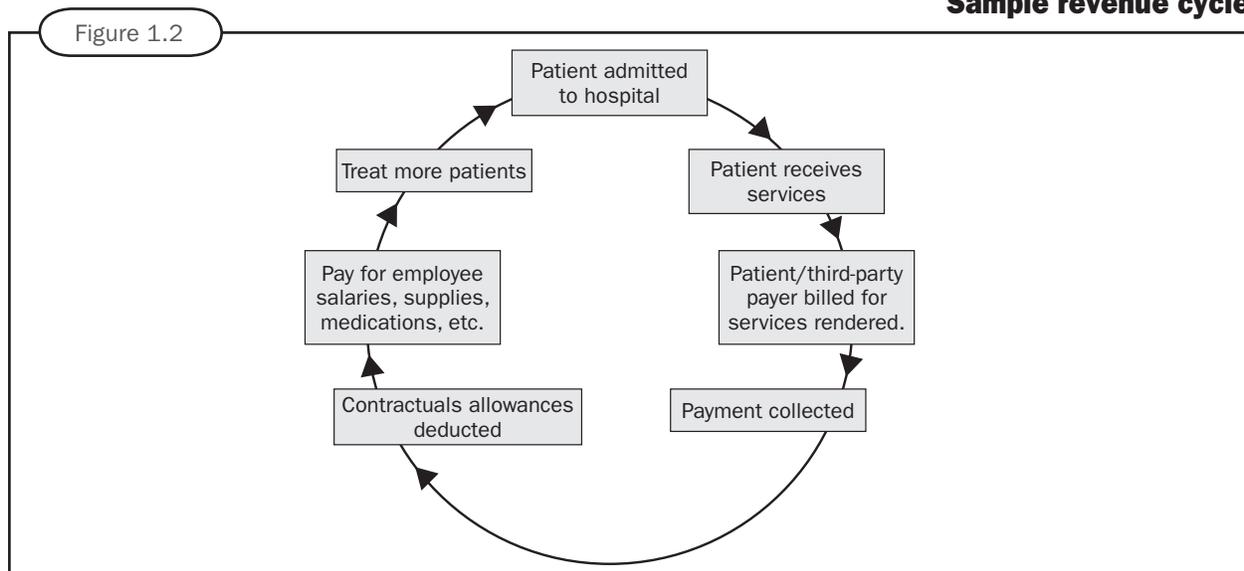
The bigger picture

As a financial manager, you should always keep the big picture in mind. For instance, even though you do not have control over the payer mix admitted to your unit, you need to know your hospital’s payer mix. The payer mix may differ dramatically depending on your facility’s geographic location. For instance, a large urban teaching hospital will likely have more uninsured patients than a small, suburban community hospital. Each patient-care unit is its own business, and as the nurse manager, you are the chief operating officer of that unit. Knowing the payer mix makeup, or how your hospital is reimbursed, helps you understand why LOS is so important and how using fewer resources equates to increased profit for the hospital.

Understanding the flow of revenue cycle in your facility

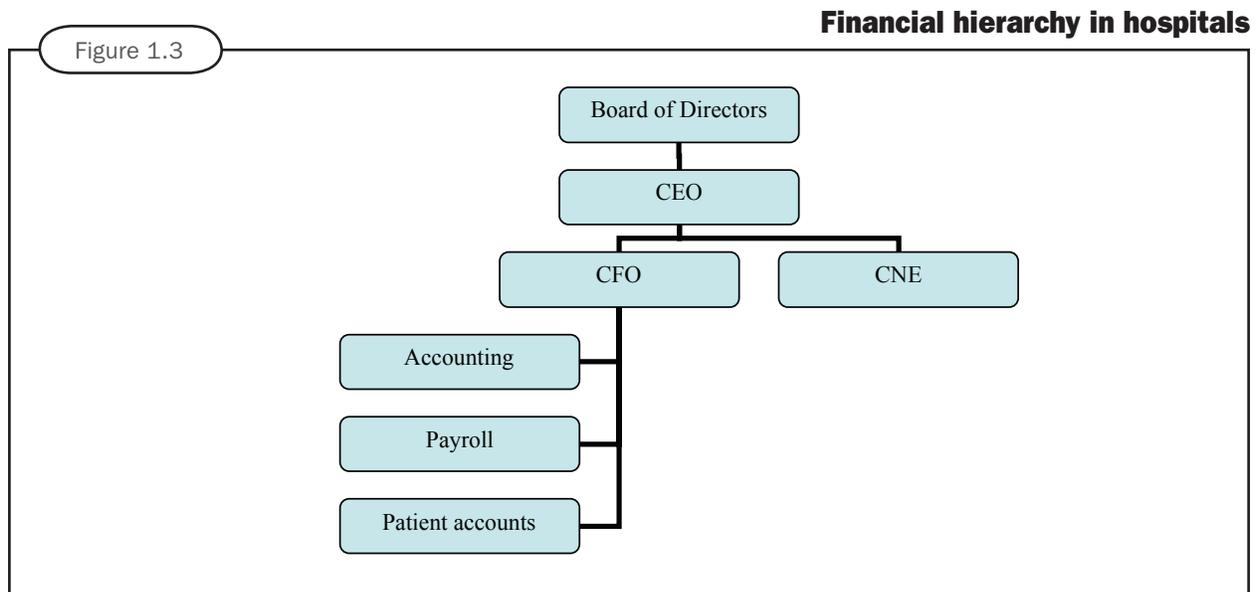
As nurse manager, you must have a basic understanding of how revenues flow into and out of the hospital. Figure 1.2 shows a typical revenue cycle.

Sample revenue cycle



Hospital hierarchy

In addition to understanding how revenue circulates throughout your hospital, it is also imperative that you know how professional power flows. Power flows are particularly important for nurse managers to know and understand because you deal with and present budgets to the financial experts within your organization. To get a better understanding of the typical financial hierarchy in hospitals, review Figure 1.3.



The governing board or board of directors is held accountable for the organization's financial performance and therefore has final approval of the budget. Board members are usually local business and community leaders who are not hospital employees. As the governing board, they empower the chief executive officer (CEO) to be responsible for the hospital's management, according to The Joint Commission's (formerly JCAHO) management standard. The CEO, in turn, empowers his or her administrative team to manage the organization's daily operations.

The chief financial officer (CFO) or vice president of finance heads the department and he or she handles all of the hospital's financial operations. CFOs are employees of the hospital.

In the past, the CFO developed the budgets for each unit and presented them to the CNE. The CNE would then present that budget to his or her direct reports (i.e., nursing directors and managers). Today, most CNEs serve at the same level as CFOs and are expected to have

the necessary financial and business skills to perform this expanded role. Likewise, nurse managers are now responsible for learning and understanding the tasks related to the financial aspects of their departments—including budget development—for which they are held accountable. In fact, The Joint Commission requires managers to be involved in the budgeting process.

The finance department includes the accounting, payroll, and patient accounting divisions. The finance department manages the financial resources (i.e., cash, investments, and accounts receivable) of the hospital. This department or division is responsible for the following functions:

- Financial planning and auditing
- Accounting services
- Reimbursement and fiscal projects
- Data processing
- Patient financial services

Interdepartmental communication

As nurse manager, hone your skills in communicating effectively with other departments. This is important because departments outside of nursing or outside of the cost center—the cost center being any department that accumulates costs—often affect your unit’s business. For example, the nursing unit may be charged for biomedical services performed on unit equipment for preventive maintenance. As nurse manager, you must know the cost and timing of such services so you can keep track of the money in your department’s budget.

You must establish strong relationships not only with vendors and other clinical departments but also with the finance department. Engaging the finance department in the actual activities and services of your unit and maintaining healthy relationships with that team enables conversations to flow freely among units, allowing each department to express its needs. Waiting until your formal budget presentation is not a good time to negotiate what your unit needs.

Learning the foreign language of finance

In nursing school, nurses are taught a vocabulary specific to the profession. To the untrained ear, this nursing language can seem confusing. It’s the same with finance and accounting

professionals: They use only their own terminology to communicate. Learn the language of finance to make your job easier and help you gain the respect of finance personnel.

Figure 1.4 lists some of the financial acronyms and abbreviations commonly used in hospitals.

Figure 1.4

Glossary of key acronyms and terms

ADC: average daily census	Patient day: an admitted patient in a hospital bed at midnight
ALOS: average length of stay	PPO: preferred provider organization
Assets: liabilities + equity	Productive: actual time worked
CPUOS: cost per unit of service	Productivity: output/input
Expenses: costs	PTO: paid time off
FTE: full-time equivalent	ROI: return on investment
Gross revenue: charges	RVU: relative value unit
HMO: health maintenance organization	SWB: salary, wages, and benefits
HPPD: hours per patient day	UOS: unit of service
Liabilities: financial obligations or debt	Volume: number of patients, tests, visits, procedures, etc.
LOS: length of stay	
Nonproductive: nonworked time	

We will discuss each of these terms at length in Chapters 1 and 3.

UOS: A unit of service, or UOS, is the specific item the organization produces and delivers to its customers. For instance, the UOS in nursing departments is typically an admitted patient who is in the hospital bed at midnight. In ancillary departments, such as respiratory therapy, laboratory, and radiology, UOSs may be the number of treatments, tests, or doses given to a patient. As nurse manager, you may be responsible for managing both inpatient and outpatient areas as well as supervising an ancillary service. Therefore, it's important that you know how UOSs are measured. In the nursing example, the admitted patient in a hospital bed at midnight (the UOS) is the measurement. In ancillary departments, each procedure, depending on its complexity, is assigned a relative value unit (RVU). For instance, with respiratory therapy, setting up oxygen may count as one RVU, whereas checking a ventilator may be allocated three RVUs.

ADC: The average daily census (ADC) is the number of admitted patients (inpatients) on any given day. However, depending on a hospital's operation, this may include observation patients. To determine the ADC you divide the number of patient days in a given period by the number

of days in that period. For example, in a nursing unit that is budgeted to use 7,500 UOSs per year, divide the number of UOSs by the number of days in a year (365) to find out the ADC. So, $7,500 \div 365 = 20.55$ average patients on the unit per day.

ALOS: The average length of stay (ALOS) is the average number of days patients spent in the hospital. Find this by dividing the number of patient days in a given period by the number of discharges in that period. For example, if your unit experienced 180 patient days and 50 discharges in one week, your ALOS would be 3.6 ($180 \div 50 = 3.6$). Therefore, your patients stay in your unit for an average of 3.6 days.

CPUOS: The cost per UOS (CPUOS) is defined as the total cost of salaries divided by the units of service. You can use this financial measurement for any expense that occurs on the unit, but it is primarily used for salaries. To calculate salary CPUOS, take the total worked hours by staff and multiply it by the hourly rate. Then divide that amount by the UOS for that unit. For example, if the total salaries were \$102,000 and the UOS were 660 for the month, then the total CPUOS would be \$154.55 ($\$102,000 \div 660 = \154.55) for worked hours. You can also calculate the total CPUOS by adding in the non-worked hours. The breakdown of these two categories will be explained in a later chapter.

FTE: A full-time equivalent (FTE) is the equivalent of one full-time employee working for one year. This is generally calculated as 40 hours per week for 52 weeks or as a total of 2,080 paid hours per year. This includes both productive and nonproductive (i.e., vacation, sick, holiday) time. For example, two employees working half-time for one year equal one FTE. To calculate FTE, multiply the length of the shifts by the number of days worked. Then divide the total by 40 hours, the number of hours worked by a full-time employee. For example, if a nurse works three eight-hour shifts per week, the FTE would be 0.6 ($8 \times 3 = 24 \div 40 = 0.6$).

Volume: The term “volume” refers to the number of patients admitted or in the bed at midnight; the number of treatments, tests, or procedures patients undergo, and the number of meals served, etc.

Productivity: Simply stated, productivity is output divided by input. Productivity rates measure the input required for a unit of output. When put into practice in hospitals, productivity is the number of staff who were used—either by hours or dollars—divided by the number of

UOS used (i.e., midnight census on inpatient units). By comparing the actual staffing hours with the staffing hours required—while taking patient acuity levels into consideration—you can determine the standard productivity measure used in hospitals.

These terms and acronyms are some of the basics used in hospitals today. Incorporate them into your daily vocabulary. Understanding these terms—and how they fit into the big picture—will enable you to be more efficient and productive in your role.

BONUS TOOLS



You will find a financial terminology cheat sheet and the top five survival skills every manager should know on the CD-ROM accompanying this book.

'Talking the talk' scenario

Review the following scenario and think about the correct and incorrect ways to handle the situation:

New nurse manager Carey Carrington runs a busy telemetry unit. The unit is particularly difficult to manage because it has 85 staff members and an ADC of 26 patients. Patients are constantly transferring in and out of the unit.

Each week, Carey's productivity report reflects a large variance toward the beginning of the week, but her unit's midnight census has remained consistent. When reviewing the previous month's staffing reports and admission/discharge/transfer data, Carey found that an average of 20 new patients flowed through the unit during the same 12-hour period every Tuesday. She discovered that the patients were not captured in the midnight census.

Carey is scheduled to meet with her supervisor in the morning. What should she say?

Incorrect: "Tuesdays are really busy on the unit; we are always short-staffed and some of my nurses are threatening to quit. I need to hire another nurse. Can you please sign this hiring form so I can take it to HR and begin advertising?"

Correct: "After collecting data and observing the unit for the past 90 days, I have found that as a result of the cardiac catheterization lab scheduling, we take on an average of five extra cases each Tuesday. Along with the added cases, the intensive care unit census is running to capacity. Therefore, we have turned over an average of 20 patients every Tuesday for the past three months. And although our productivity reports show an ADC of 26, we are actually caring for 46 patients over the course of the day.

"I would like approval to increase staffing on Tuesdays, and I will modify the schedule accordingly. Currently, we are reducing staff on Fridays because of the lowered census, which will help maintain the overall budgeted HPPD. I will explain the variances each month on the variance report. I anticipate the overall CPUOS to remain the same."

