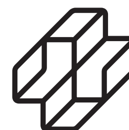
Business essentials for nurse leaders

March 2009

The Business of Caring



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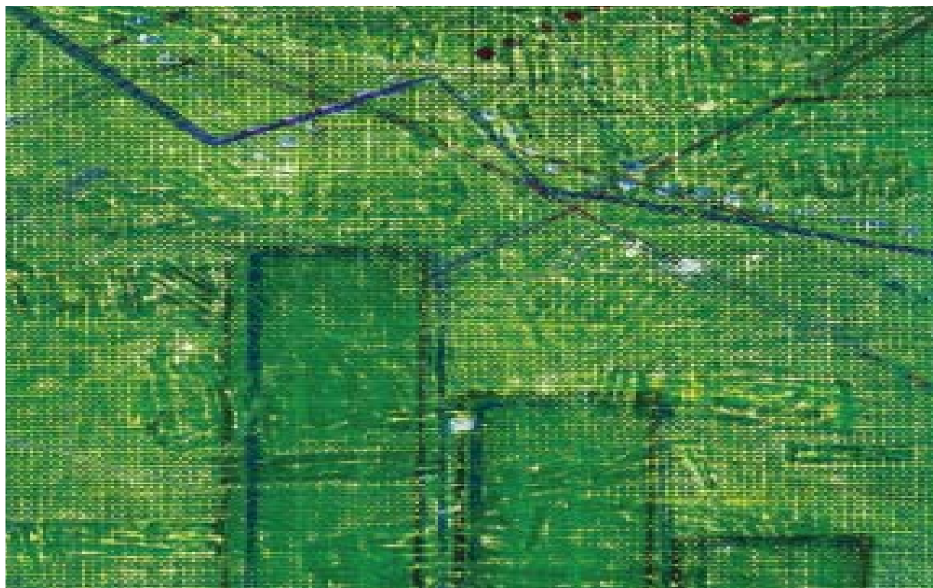
Unit-Level Scorecards
Helping Managers Monitor Operations



Leaders at St. Joseph Health System of Lexington, Ky., wanted their nurses to be more business-minded. Specifically, nurse managers needed a better way to analyze their unit functions and make sure that their daily operations fit their goals. Since 2003, the system has used a six-item dashboard or scorecard—appropriately called a "six-pack"—that helps motivate nurses to be more efficient and accountable on key measures like labor costs, volume, and productivity. → →

INSIDE THIS ISSUE

RAC: What Medicare's New Audit Program Means for Nurses 4

Case Studies: Reducing Premium Labor Costs 6

Managing a Merger 7

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COMING IN APRIL

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 continued from page 1

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Putting a unit-level dashboard together at St. Joseph Health System required a productive partnership between nursing and finance with the goal of making clinical leaders more business-savvy. “It is important to share the same focus regardless of which discipline we represent,” says Gary Ermers, CFO.

A Visual Aid

Nursing and finance developed a simple scorecard that department managers use to track key areas:

> Department volume, trended monthly
> Total department costs—full-time equivalents (FTEs) and supplies
> Patient satisfaction
> Turnover, including the number and percentage of nurses
> Percentage of premium labor used, such as overtime, agency, and pool usage (the target for overtime is less than 2 percent of labor costs)
> Productivity measured in hours per patient day (HPPD), tracked every two weeks

Each month, a nursing secretary pulls data from different hospital reports into a spreadsheet to create the dashboards. The result is a one-page visual that compares the actual results in these six areas for the current and previous fiscal years (see the exhibit on page 3).

With timely data on these measures, clinical managers can make real-time changes in how they run their departments. For example, they can look at variances in supply costs and ensure that supplies are properly assigned to their departments. Or they might look for dips in patient satisfaction and make necessary changes.

Partnering on Productivity

Using the six pack reports to improve productivity—without affecting other measures—has been a major goal. “We wanted to take a balanced approach when looking at these parameters, so that we could see if changes in labor productivity had an impact on other measures such as patient satisfaction or turnover,” says Chris Mays, RN, MSN, chief nursing executive and chief operating officer at St. Joseph Hospital and St. Joseph East.

The measures are interrelated. For example, if a unit has 8 percent overtime for several pay periods, what is the impact on turnover?

Keeping nurse managers focused on business issues is important in a heavily managed care market like central Kentucky, where St. Joseph is located. Productivity measures like HPPD provide a picture of how many resources are required to achieve a result. HPPD is a reflection of total staff hours worked (by nurses, managers, and secretaries) divided by unit census. In health care, missing productivity targets can have serious financial implications. For example, a unit with an HPPD target of 9.0 may stand to lose thousands of dollars if it runs over budget by just a few percentage points.

Biweekly reporting of HPPD helps eliminate confusion over monthly accruals, which can skew productivity numbers, according to Mays. “By changing the tracking of HPPD to be per pay period, we have a consistent 14-day period that we count the hours worked per employee and we have an accurate reflection of the workload and the productivity for that department.”

Enlisting Financial Assistance

When setting productivity targets for each unit, hospitals can look at benchmarks from national standards or state hospital associations. They also may review the experience level of nurses on the unit. Units staffed with more seasoned nurses can run leaner than areas staffed primarily with new graduates, says Mays.

To develop the proper metrics for each unit at St. Joseph, nursing leaders collaborated with the finance team. They realized that some units required a more sophisticated approach depending on their patient acuity and case mix.

For example, leaders needed to develop a blended target for HPPD for one medical-surgical unit serving bariatric and orthopedic patients. They assessed the average patient day for their bariatric patients and orthopedic patients, and combined the weighted averages for a blended target.

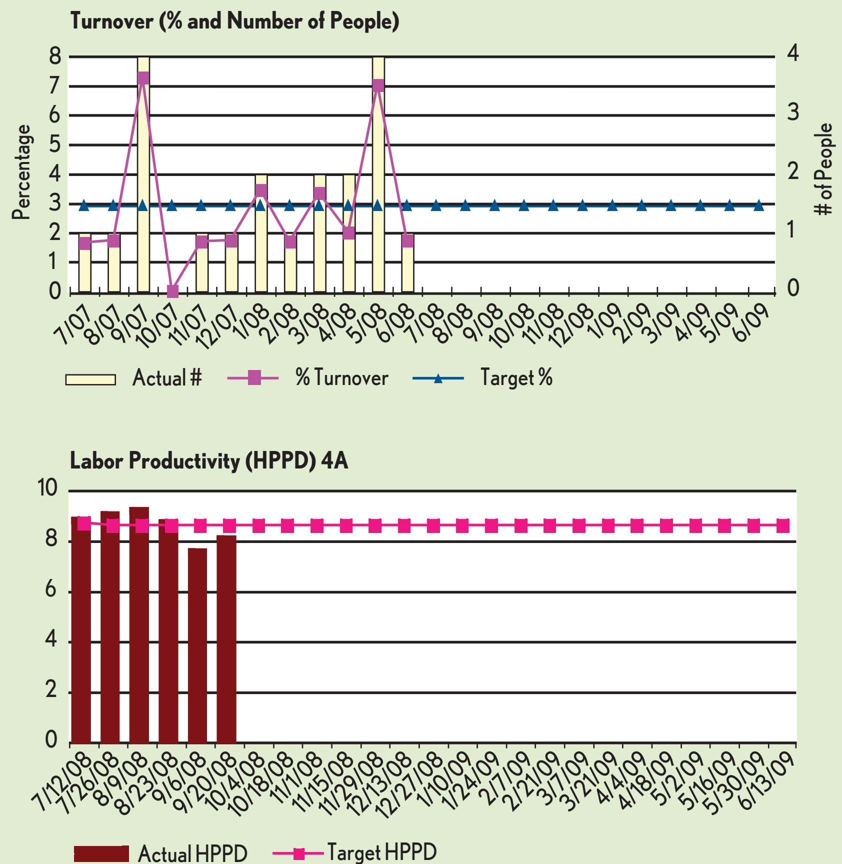
Maintain Accountability Monthly

Each month, nurse managers review the six-pack reports for variances, comparing actual results to targets in the six areas for the current and previous fiscal year. After receiving the monthly reports, nurse managers have 10 days to develop an action plan to address any variances. The action plans must outline three steps that they can take to improve their metrics in the next 30 days. Then, the managers present their action plans at the monthly management team meetings.

"At first, nurses were intimidated to share their data in front of their peers," says Mays. "But nurses now realize that it's an opportunity to share ideas with 40 of their peers." Each manager presents for about two minutes, so meetings are usually completed within two hours. All executives, including finance and other members of the executive suite, may attend.

The six-pack reports, combined with monthly meetings and action plans to address variances, have helped nurse managers develop—and share—ideas for improvement. "The focus is not on what happened, but what they can do," Mays says. For example, periodically, the six-pack meeting may have a specific focus around opportunities to improve patient satisfaction. The departments that are exceeding their patient satisfaction targets will generate ideas to assist the group by offering best practices, such as intentional hourly rounding, which is proven effective in increasing patient satisfaction.

Excerpt from St. Joseph's Six-Pack Scorecard



Source: St. Joseph Health System, Lexington, Ky.

Working together, nursing and finance at St. Joseph developed a simple scorecard that nursing managers can use to track six key areas in their departments. Only two areas of the scorecard (labor productivity and turnover) are pictured here. The full six-pack also reports monthly data on department volume, total department costs, patient satisfaction, and percentage of premium labor used.

Impressive Results

Since the implementation of the reports and monthly meetings, St. Joseph Hospital and Saint Joseph East has had a reduction in HPPD from 248.34 in 2005 to 241.58 in 2008. They have also seen the following results:

- An increase in annual average daily census from 287 in 2003 to 326 in 2008
- Steady improvement in patient satisfaction, from about 8.6 to 9.11 out of a 10-point scale (which is greater than the 90th percentile)
- A 2 percent reduction in RN turnover

"Nurses have to know their data better now more than ever," says Mays. In other words, if they aren't asking the questions, they may not be able to find the answers.

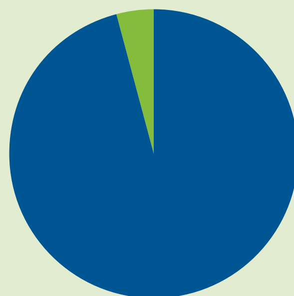
Chris Mays, RN, MSN, was interviewed for this article. Mays is the chief nursing executive, chief operation officer, St. Joseph Hospital and St. Joseph East in Lexington, Ky. (maysch@sjhlex.org).

RAC: What Medicare's New Audit Program Means for Nurses

If you hear the term "RAC audit" in the hospital corridor, expect to see a furrowed brow. After a demonstration project in six states (California, Florida, New York, Massachusetts, South Carolina, and Arizona), the federal government's recovery audit contractor (RAC) program is now rolling out across the nation, with the goal of operating in every state by 2010.

The RAC program's goal: to sniff out billions of dollars that hospitals owe to the Centers for Medicare and Medicaid Services (CMS). Meeting the demands of a RAC audit can pose an extreme burden on a hospital—and the financial consequences can be severe. That's why all nurse managers need to understand how to help their hospitals prepare for and, if necessary, respond to the RAC program.

Identifying Errors in Payment

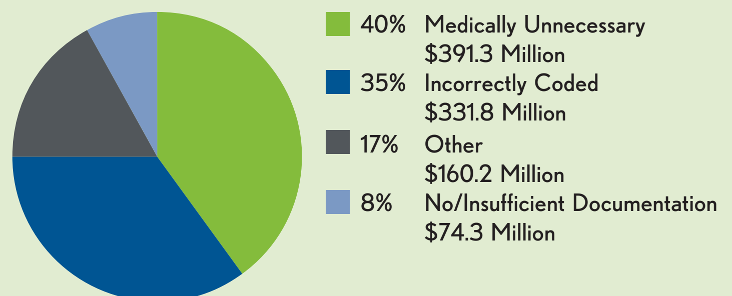


96% Overpayments

4% Underpayments

Most instances of improper payment identified by RACs were in the government favor—amounting to a recoupment of $828.3 million. Approximately 96 percent of the improper payments identified by the RACs in 2007 were overpayments collected from healthcare providers. The remaining 4 percent were underpayments repaid to healthcare providers.

Where Did RACs Find Overpayment?



40% Medically Unnecessary $391.3 Million

35% Incorrectly Coded $331.8 Million

17% Other $160.2 Million

8% No/Insufficient Documentation $74.3 Million

Top services identified with overpayments by RACs for inpatient hospitals included:

> Surgical procedures in wrong setting (medically unnecessary)
> Excisional debridement (incorrectly coded)
> Cardiac defibrillator implant in wrong setting (medically unnecessary)
> Treatment for heart failure and shock in wrong setting (medically unnecessary)
> Respiratory system diagnoses with ventilator support (incorrectly coded)

Source: Centers for Medicare & Medicaid Services, *The Medicare Recovery Audit Contract (RAC) Program: An Evaluation of the 3-Year Demonstration*, June 2008. Percentages reflect cumulative data through 3/27/08. Claim RACs only. Based on self-reports by the claim RACs.

A Burdensome Process

RAC auditors use software programs to look for patterns in Medicare claims that help identify hospitals at which inappropriate claims are waiting to be discovered. The auditors also request copies of medical records so they can look at patient charts in detail. One Florida hospital had to provide 2,200 records to the RAC auditor over a two-year period—or between 10 and 250 records a month (*Readying for the RACS: What You Should Know*, HFMA, March 2009).

During the demonstration project, healthcare providers frequently disagreed with the auditors' decisions and filed appeals to prove their case. In fact, 22 percent of all decisions were appealed. The RAC program includes four levels of appeal. But, in the end, only 7.6 percent of the auditors' claims were overturned, according to CMS.

How Can Nurse Managers Help?

Kathy Zaharias, RN, MBA, a principal at Milliman, Inc., says clinical documentation specialists, bedside nurses, and case managers—and especially ED nurses and case managers—can help their hospitals avoid RAC claims by:

- Identifying insufficient physician documentation
- Ensuring that physician documentation supports admission
- Documenting pressure ulcer stage codes, which may be used in conjunction with the physician's documentation
- Documenting body mass index in obesity cases in conjunction with the physician's documentation

In addition, because staff education is so important to avoiding or defending RAC claims, nurse executives must provide proper training on several topics.

- Necessary documentation for accurate coding
- Observation versus inpatient status
- Inpatient level-of-care requirements (for example, as related to rehabilitation)
- Importance of prompting physicians to document appropriately
- RAC response time frames

A Note to Subscribers

The Business of Caring Will Soon Be ... Free

Beginning this summer, all nurses will be able to access *The Business of Caring* electronically at www.hfma.org/boc—for free. The last print issue of *The Business of Caring* will be the May 2009 issue. After that, we will publish the newsletter in electronic format only on a quarterly basis. Anyone who visits the web site will be able to access the newsletter.

Why the Change?

By providing open access to *The Business of Caring*, we will make it possible for many more nurse managers and executives to learn successful strategies and tactics for navigating the business side of health care.

HFMA and AONE launched *The Business of Caring* in 2006 to encourage more collaboration among nurses and finance. Both associations see this relationship as key if hospitals are going to successfully provide safe, high-quality care and control costs. Quality care requires sufficient staffing and equipment. Nurse leaders need to know how to talk to finance about these investments. Controlling costs requires improving clinical processes—and that requires the full participation of nurses and finance.

The more nurse leaders who have tools and strategies for accomplishing these vital goals, the better.

Your Subscription

If your current subscription to *The Business of Caring* extends past May 2009 (the last printed issue), then you will automatically start receiving another related newsletter—*Healthcare Cost Containment*—in June. This bimonthly newsletter (www.hfma.org/hcc) provides how-to strategies and expert advice for rooting out inefficiencies, rework, and waste without harming quality.

You will continue receiving *Healthcare Cost Containment* until your subscription to *The Business of Caring* expires—plus an additional three issues as our gift to you. In addition, you will receive an email alert from us every time we post new content to *The Business of Caring* web site (if we have your email address on record).

If you have any questions about this arrangement, please contact our Member Services department at 1-800-252-4362, ext 2.

Reducing Premium Labor Costs

Plugging holes in your staffing schedule with agency nurses or overtime hours may temporally solve one problem. But this expensive solution is bound to cause your labor budget to leak red. Nursing leaders from two hospitals tell how they are scheduling nurses more efficiently and filling open shifts without resorting to costly alternatives.

Case Study 1: Improving Staff Forecasting

by Kristie Huff and Kristi McMillan

By developing processes for forecasting nurse staffing needs, Lee Memorial Health System (LMHS) was able to save more than $11 million in one year alone. The savings are due to the elimination of agency nurses, as of May 2008.

The Roots of the Problem

Back in 2000, the number of agency nurses with 13-week contracts hit a historical peak at LMHS. Following the 2006 acquisition of two area hospitals, 350 travelers were on the combined payroll at the system's five acute care facilities. Each traveler cost the health system twice as much as a staff nurse.

One of the major factors was that nursing directors overstaffed their units, fearing last-minute sick calls and spikes in census.

Predicting Demand, Beds, and Staff

To tackle the problem, leaders at LMHS created a forecasting tool that would help directors predict staffing needs by day and shift. With such a model, nursing leaders could determine their staffing needs and use in-house PRN nurses from the system's centralized staffing department to fill "holes" in a more efficient way.

LMHS chose a model that uses census points, or forecasted admissions. Census points are derived from using actual census figures and applying current and historical trends to determine the following month's census—by shift, by day of the week, and by unit.

Here's how it works: The operations improvement team collects census data from about 50 units at the five hospitals and plugs these data into spreadsheets, which generate frequency distribution models. Census points serve as "targets" for unit directors. Eighty percent of the time, a unit should be at—or under—its census point within a calendar month. For example, if a unit's census point is 30, the unit is estimated to be at 30 or fewer patients, 80 percent of the time. Twenty percent of the time, the unit is expected to be above 30. Unit directors need a plan to flex their staffing up during high census times.

Kristie Huff, RN, MSN, is system director for resource management and staffing, Lee Memorial Health System, Fort Myers, Fla. (kristie.huff@leememorial.org). Kristi McMillan is operations improvement coach, Lee Memorial Health System (kristi.mcmillan@leememorial.org).

Read longer, more detailed versions of these case studies at www.hfma.org/boc.

Case Study 2: Giving Staff Incentives to Fill Shifts

by Kathryn Raethel and Deborah Crist-Grundman

Finding resources to fill open nursing shifts is an ongoing concern for many healthcare organizations. To address the issue, Castle Medical Center of Kailua, Hawaii, implemented an incentive program in 2006. The online program matches nurses and other employees with open shifts.

Contract Labor Slashed

To date, more than 450 hospital employees have signed up to use the program, with greater than 60 percent actively requesting to fill open shifts. Thirty-seven percent of shifts have been filled by staff self selecting to work outside their home nursing unit.

In the first 18 months of the program, the hospital achieved the following results:

- A 93 percent reduction in external contract agency use
- A reduction in total incentive liability costs to only $15 per day
- A 54 percent reduction in the staff vacancy rate

Point-Based Rewards

One feature that captured Castle Medical Center's interest was the ability to provide point-based rewards to staff for filling shifts, whereby an employee collects points for participating in the program that could be redeemed for various merchandise and rewards.

Kathryn Raethel RN, MHA, CNAA, FACHE, is vice president of patient care services, Castle Medical Center, Kailua, Hawaii (RaetheKA@ah.org). Deborah Crist-Grundman is executive strategist, Concerro, Inc., San Diego (dcrist-grundman@concerro.com).

By Kathleen D. Sanford, RN, MA, DBA, FACHE

Managing a Merger

Preparation and communication can help make the transition smooth.

My hospital is preparing to merge with another hospital across town. How can I help ease this transition for my nursing staff—and for myself?

Sanford: The announcement of a merger is bound to cause some unease among staff. To help them through the transition, you should try to understand your employees' concerns. Most likely, their primary concerns will be whether they will keep their jobs and what the culture of the new organization will be like.

Job Changes

It is true that, following a merger, some jobs will be cut. However, nurses usually have the opportunity to work for the merged organization, as they are still needed to care for patients. So unless patient census falls or a service is closed, nursing staff jobs are probably going to be available.

Management jobs, on the other hand, are more at risk in a merger—this means that your job may undergo some significant changes. So when a merger is announced, as a manager, you need to make some decisions. Do you want to keep this same job in a new organization? Do you want to take this opportunity to take a new position in the organization—or work somewhere else altogether?

If you would like to keep your position, find out which service lines the merged organization is intending to keep, and at which hospital they will be offered. The answer will be a good indicator of leadership's plans for your position.

Whether you want to keep your current job or move within the organization, you should let leadership know of your interest. Then dust off your resume and add any new education you have obtained, any writing or speaking you have done, and any new accomplishments. When applying for a job within their own organizations, many managers make the mistake of thinking, "They already know me." This may be the case, but summarizing your recent accomplishments will help leaders see your true qualifications. Be sure to emphasize the value that you will bring to the new organization, just as you would if you were coming from the outside.

If you end up leaving the organization, remember that nursing skills can make you valuable in other types of jobs. When a hospital I once worked at had a reduction in force, many of the nurses and nurse managers who were laid off ended up in other roles; for example, one became a school nurse, and another began teaching university nursing students.

Culture Change

If you're merging with another hospital in town, it will feel strange to be working with an organization that was previously a competitor. Therefore, both groups should be sure to focus on how the new culture will support high-quality patient care. Working toward this common goal will help the staff learn to work as a single team.

You can play a vital role in the development of this new culture. Think about which parts of your culture work best and are most valuable to patients and staff, and be sure to talk to leadership about how to ensure that they are not lost when the two cultures come together.

Kathleen D. Sanford, RN, MA, DBA, FACHE, is past president of the board of directors of the AONE and senior vice president and CNO of Catholic Health Initiatives. Do you have a question for Kathleen? Send it to kathyaone06@yahoo.com.

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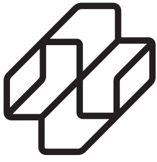

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