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Seeking Out Good Data for Business Decisions

Let's say you want to justify the need for a palliative care program. Or perhaps you would like to learn more about your unit's patient volumes. Where can you start? How can you obtain the financial and operational data you need to understand a staffing situation or see how a clinical improvement will affect your organization's bottom line?

"Many nurse leaders know they are impacting costs when they reduce vent days or length of stay," says Pamela Thompson, MS, RN, FAAN, CEO, American Organization of Nurse Executives. "They are very good at talking about the clinical improvement, but now they need to translate that into financial numbers."

The first stop for business data is almost always finance, say seasoned nurse leaders. Depending on the project, you may also need to seek data from other sources, including materials management, risk management, business development, marketing, and vendors. But your finance contact can often help you identify where to go for data and then help you crunch the necessary numbers.

"It's important to set up a strong relationship with one person in finance," says Sue Sandberg, RN, MBA, vice president, Com-

munity Health Network, Indianapolis, Ind. "The finance representative and nursing leader will each learn more of the other's area of expertise. Growth and trust will develop on both sides. Asking questions and seeking assistance will become easier as a result."

Below is some specific advice on how to come up with the data you need for business decisions.

Digging Up Better Staffing Data

The Issue: Nurse leaders at many hospitals get plenty of data from finance. But that's often the problem—they get too much data and very little useful information, says Kathy White, RN, MS, healthcare executive consultant. The budget or operational report may be dense with numbers related to labor costs and patient volumes, but these numbers may not help nurse leaders uncover, for example, why patient volumes

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don't match reality or whether charges are being properly captured. "Usually there's too much information so nobody is looking at anything," says White.

Potential Tactic: Before offering a solution, White emphasizes what nurse managers should not do: Don't try to create your own special report based on the data you receive from finance. "What clinical people tend to do is keep all these logs to explain why their numbers [patient volumes or FTE hours] are different than the financials. It causes undo stress for everyone involved by taking the team off focus, which results in wasting precious time in solving or improving the issues you are addressing."

Instead, nursing executives need to work with finance to develop an operations or productivity report that is truly useful. The exact makeup of this report will depend on nurse leaders' needs. White typically requests a biweekly productivity summary report that rolls up every single cost that each particular nurse executive or manager is responsible for. (A CNO's report would show all hospital costs; a unit manager's would only show his unit's costs). White requests that these reports show actual costs versus budgeted, worked versus paid hours, and worked versus paid dollars per unit of service.

"Out of these reports, you can begin to methodically request existing reports that you now view as valuable, as well as identify the development of other reports that will help all involved," says White. For example, in response to a bed capacity issue, one nurse leader at Community Health Network worked with finance to develop a special report on patients' length of stay by physician, says Sandberg. "She was then able to meet individually with doctors to say, 'You know, I'm under fixed reimbursement for this. Do you realize that your patient is staying x number of days versus our average patient who is staying y number of days? Help me understand this.'

"If you see an opportunity to reduce costs from medications or supplies, then you want to do that as much as you can because waste is benefiting nobody. But the opportunity cost for bringing in additional patients dwarfs the amount that you could save by reducing medication or supply costs."

What she found was that the physicians didn't realize we were under DRG payments for those cases. They thought we were under a percent of charges."

☑ Determining the Value of Clinical Improvements

The Issue: A nurse manager wants to "sell" a palliative care program to her hospital governing body and CEO. The quality-of-care benefits from end-of-life care are well documented. But she needs to come up with a financial rationale. Similar programs have reduced length of stay on the ICU. But will that translate into saved costs or additional revenue—and, if so, how much?

Potential Tactic: Turn your clinical improvement project into a story, says Ken Smithson, MD, vice president of research, VHA Inc., Irving, Texas. "You basically have to say, 'Okay, we're going to do x , and that's going to result in y '. Once you've come up with that story, then you could start to say, 'All right, what are the economic consequences of this particular intervention?'"

To develop your story, White advises gathering a team of "good thinkers"—which usually includes a finance person, a physician, and a staff nurse—for a meeting, says White. Then, get the clinicians talking about "what they want and why they want it." Let's say the clinicians are seeking funding for a telemetry unit. "The finance

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Determining Return on Investment

Do you want to acquire a magnetic resonance imaging scanner? Or add a nursing position to improve patient flow through the emergency department? Be prepared to answer the question: “What’s the return on investment?” Asking for the ROI is just another way of saying, “Is it really worth the money?” It is a question finance managers like to ask—and can help you answer.

ROI estimates are often used to evaluate various potential projects. Theoretically, the project with the largest estimated ROI gets the thumbs up. In the real world, however, other factors—such as physician preferences, quality of care, and operating costs—may carry more weight than ROI.

ROI Formula

When someone asks about ROI, they want to know the amount of profit from an investment, expressed as a percentage of the total project cost. For example, if a \$100 investment generates \$10 in income, the ROI is 10 percent. However, few real-life ROI calculations are so simple.

The following formula can be used to determine ROI:

$$\text{Revenue from the Initiative} \div \text{Total Cost of the Asset}^* = \text{ROI}$$

* Total cost of the asset refers to all the costs related to the initiative, including equipment costs, space renovation costs, staff costs, interest on any money borrowed to finance the project, etc.

Hospital finance departments may use more technical formulas to determine the ROI of various projects and initiatives.

What Does a Good ROI Look Like?

Average ROI for all hospital assets*

Type of hospital	Median	90th percentile
Urban hospitals	10.00%	18.60%
Rural hospitals	9.50%	15.60%
Teaching hospitals	9.80%	16.90%
Non-teaching hospitals	9.80%	19.40%
System affiliated hospitals	10.90%	23.80%
Non-system affiliated hospitals	9.00%	15.10%

* Calculated based on 2005 data from more than 1,500 hospitals; 90th percentile figures show ROI for top-performing hospitals.

Source: 2007 Almanac of Hospital Financial and Operating Indicators, Ingenix ©2007. Reprinted with permission.

CFOs track the ROI of all hospital assets—from the land that the hospital owns to the patient beds and everything in between—as one measure of financial strength. As these numbers show, average ROI rates vary, depending on a hospital’s geographic location and other factors. Knowing a hospital’s overall ROI helps a nurse leader understand the expectation the CFO may have when new initiatives are proposed.

ROI Is Used for Making Investment Decisions

If a nursing leader wants to add capacity to an existing service (for example, add another cath lab), then ROI may be a critical factor in making a decision on whether to proceed.

Step 1. Start by asking the hospital CFO what return—10 percent or more—would not be unusual—would be required to win approval from top management and the board of directors.

Step 2. Work with an architect, contractor, and equipment vendors to estimate construction and equipment costs. Look to the finance department for estimated labor, supplies, and other operating costs, based on the experience in the existing cath lab.

Step 3. Knowing all the costs and the minimum ROI, work with finance to calculate how much revenue the new cath lab must generate to be economically feasible. How many procedures—and at what charge to the patient—will it take to hit that number?

Step 4. If the procedures must be priced significantly more than competitors are charging—and the ROI expectations are not negotiable—costs will have to be decreased before the project can fly.

Partner with Finance

Nurse leaders should not go it alone when determining whether a particular project is worth the cost. Ask a finance manager which calculation is most appropriate for the initiative that you are proposing—and go to the cost accountant to get the specific numbers (for example, interest expense) that plug into the formula. Nursing-friendly software programs are available to calculate ROI but, in many hospitals, a member of the finance department will do the calculation for you.

ROI Is Used to Make the Case for Clinical Improvements

Not every piece of equipment generates a fat ROI, and everyone knows it. Say a nurse manager wants to buy bili lights for the neonatal nursery.

Working with a vendor, the nurse leader can learn how much the equipment will cost, plus maintenance and supply expenses. Then, she should check with the hospital's managed care officer to learn how much the hospital will be paid for the service—and calculate an estimated ROI.

The ROI number may be low—or even negative—meaning bili lights are a money-losing proposition. This does not mean that buying the lights is a bad decision. Rather, armed with ROI information, a nurse executive knows that she must use a cost-benefit analysis to advocate for the purchase (see the definition of cost-benefit analysis below). She can point out the intangible benefits, such as parent or physician satisfaction, to make the case for bili lights.

Important Measures of Success—Other than ROI

The term ROI is used as shorthand for many “is it worth it?” calculations. Technically, however, ROI is most appropriate when evaluating the purchase of capital assets, such as buildings, property, or equipment that have a useful life beyond the year they are purchased. If a nurse executive is considering a new hire or an improvement initiative, other calculations are typically used. Here are some other financial measures to know.

Cost-benefit analysis: A popular tool for making financial decisions, cost-benefit analysis compares the costs and benefits of a particular service or initiative. Ideally, all costs and benefits are expressed in terms of dollars. In health care this is not always possible because “human lives saved” might be among the benefits. Thus, think of cost-benefit analysis as a concept of weighing costs versus benefits when some benefits cannot be reduced to dollars.

Consider a situation in which a nurse executive is

trying to unclog a chronically overcrowded emergency department without adding space. One possible solution: add an ED admitting nurse. The nurse in this position would prepare patient assessments and start paperwork, making it easier for floor nurses to accept new patients.

The costs of adding a new position—such as salary, benefits, and recruitment expenses—are easy to calculate. But sizing up the benefits is not. If adding this position would reduce ambulance diversion hours, allowing more patients to be admitted to the hospital, that is a benefit. By working with the finance department, a nurse executive can estimate the financial worth of these and other potential benefits.

Non-financial benefits should also be considered. Although difficult to measure in monetary terms, eliminating long ED waits is likely to improve patient satisfaction and word-of-mouth advertising. That benefit does not fit neatly into the equation, but it could fit nicely into the nurse leader's pre-

sentation when she makes the case for adding a new staff member.

Payback period: The length of time for cash coming in from an investment to equal the amount of cash originally spent. Let's say a hospital buys new imaging technology, and more patients start choosing the hospital for diagnostic tests. Within 10 months, the hospital has brought in enough extra revenue to cover the costs of the imaging equipment. In this example, the payback period is 10 months.

Break-even point: The point at which payments from insurers, the government, and patients match the money spent on labor, supplies, and other expenses. The break-even point is frequently calculated in terms of patient volume. How many scans does an MRI unit need to perform in order to be financially self-sufficient? If the revenue generated by 500 scans covers the cost of operating the unit, it has reached its break-even point.

What Have You Done to Improve Patient Throughput in the Emergency Department?

Once every minute in the United States, an emergency patient is diverted from a full emergency department to one that is farther away (Institute of Medicine). The problem is unnerving, even to veteran nursing directors who have seen it all. There are, of course, the serious patient care issues to consider. There is also the cost. A study conducted at Oregon Science & Health University in Portland found that every hour spent on ambulance diversion cost the hospital \$1,086 in lost revenue from ambulance patients, who typically generate higher charges than other patients (Annals of Emergency Medicine, December 2006)

Adding more ED beds to prevent diversion may not be an option for every hospital—the cost of building more space and adding beds to an ED averages about \$1 million per bed. What else works? We asked healthcare leaders at three hospitals to explain some of their tactics for tackling crowded EDs. They have not yet solved the issue. But they are slowly working toward answers.

Case Study 1

Boarding ED Patients in Acute Care Hallways

The ED at New York's Stony Brook University Hospital was originally built in the 1970s to handle about 24,000 visits a year. By the 1990s, the hospital's ED volumes were nearly triple that amount.

So in 2000, the 405-bed hospital adopted a "full capacity protocol," also known as an "adopt-a-boarder" program. Per the protocol, patients awaiting admission are transferred to beds in acute care hallways when the ED is no longer able to treat patients in a timely manner. No more than two boarders are added to any unit.

"When patients go to the hallway on the floor where they will be admitted, the

experts in their care actually start their care. But downstairs, they are still just waiting," says Carolyn Santora, MS, RN, CNAA-BC, associate director for cardiac trauma and emergency services at Stony Brook University Hospital.

In the first year after the protocol was implemented, ED patient satisfaction increased from the bottom percentile to the 80th percentile, while inpatient satisfaction held steady. The new approach has also impacted length of stay. A study conducted at Stony Brook found that the average length of stay is 0.8 days shorter when patients are moved to an inpatient hallway, compared with an ED hallway. A 2002 study by the Health Care Advisory Board found that reducing LOS by one day is equivalent to adding 49 new beds in a typical 300-bed hospital.

Nurse-to-Patient Ratios Affected—but Not Severely

In the first year, the hospital found that "full capacity" was sometimes a relative term. More than one-quarter of patients who were slated to board in an inpatient hallway actually got a bed right away. Another 25 percent of patients spent less than an hour in a hallway. Inpatient nurse-to-patient ratios did increase for some nurses, though they never increased beyond a 7-to-1 ratio.

Over the years, the hospital has liberalized the policy so that the medical director no longer needs to approve when the protocol is set in motion. Only the bed coordinator needs to be notified by the ED.

Policy Defines Boarder Patients

The hospital's updated policy also simplifies patient priorities for hall bed placement:

- > Patients with minimal to moderate risk factor co-morbidity are the first to be considered.
- > Adults can be considered for a pediatric bed, if available.

Patients who are excluded from a hall bed include:

- > Those requiring the intermediate care unit or the ICU
- > Patients on ventilators
- > Those requiring negative pressure room placement
- > Patients requiring 4 L or greater of oxygen
- > Those who require suction
- > Those who are incontinent

The policy also maps out steps that staff must take to make hallway patients more comfortable, such as giving them a nurse call device and providing privacy screens.

A 23-week study at Stony Brook found that approximately half of all patients admitted to the hospital qualify for placement in acute care hallways when regular inpatient beds are not available.

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Despite the program's success, Santora concedes that a full capacity protocol is not a cure for the problem. As she says, "Your real goal should be that a patient never winds up in a hallway, so you need to keep working on the patient flow issues in your institution."

Carolyn Santora, MS, RN, CNAA-BC, is associate director for cardiac trauma and emergency services at Stony Brook University Hospital in Stony Brook, N.Y. (carolyn.santora@stonybrook.edu). Stony Brook's full capacity protocols are published online at www.hospitalovercrowding.com.

Case Study 2 Increasing ICU Capacity

"More research is showing that ED overcrowding is not a problem about getting patients in the front door, but getting them out the back door—in other words, out of the ED," says K. John McConnell, PhD, a health economist and research assistant professor at Oregon Health & Science University in Portland.

Some hospitals like OHSU are trying the tactic of increasing ICU capacity. Prior to August 2002, the hospital was on diversion approximately 47 percent of the time. But when the 400-bed hospital increased its staffed ICU beds from 47 to 67, diversion decreased 63 percent—from an average of 307 to 114 hours per month. In addition, the hospital received an additional 68 patients per month and gained \$175,000 in monthly revenues from ambulance patients over about 15 months.

Does the Additional Revenue Justify the Costs?

Many hospitals would welcome the additional revenue OHSU gained from decreasing diversions. Yet the gain only represented a 0.4 percent increase in total monthly revenues of \$46 million. Such a modest increase might not be enough to motivate many hospitals to add additional ICU beds or look at other strategies to tackle the diversion problem, McConnell says.

"Hospitals have to weigh those revenues against the opportunity cost [potential lost profits] of keeping a bed open to avoid diversion," he adds. They must also consider the operating costs of an available bed, which includes the cost of nursing.

The way hospitals are currently paid for services is part of the problem, McConnell says. "[Currently,] the incentives are there for the hospital to prioritize non-emergency patients over emergency patients, because non-emergency patients are easier to manage and they are prescreened with estimated revenues," he says. "A policy response to that is to restructure payments

Other Solutions to ED Clogging

- > Create a patient flow team that has support from upper management.
- > Use a bed control office to manage outflow from the ED.
- > Hire hospitalists in the ED, or improve physician staffing.
- > Consider using a charge nurse with admission, discharge, and transfer duties to help process pending discharges.
- > Add a clinical decision unit, or observation unit, to channel ED patients (for example, those requiring rapid rule-outs of chest pain), and to determine which ED patients require admission.
- > Adjust elective surgery booking to take advantage of slower OR times and spread schedules more evenly over the week.
- > Review housekeeping policies that can slow turnaround time throughout the hospital.
- > Creating a discharge lounge for patients awaiting medication or transportation.
- > Add FTEs to the transport team.
- > Establish a community-wide task force to look at ED diversion and capacity issues.
- > Use formal quality improvement methods to establish objectives and track results.
- > Add centralized processes, such as physician order entry.

"When patients go to the hallway on the floor where they will be admitted, the experts in their care actually start their care. But downstairs, they are still just waiting."

to hospitals so that they are rewarded for having decreased length of stay in the ED. This gives hospitals the incentive to keep those beds open."

Even More ICU Beds Needed Now

How has the ICU expansion affected throughput in the ED? "Not as much as we had hoped," says Judi Huffman, MS, RN, division director for emergency, trauma, orthopedics, and neurology. "We had very successful surgeon recruitment, and as a result, the percentage of our OR growth—specifically surgical cases—was greater than anticipated. So we have continued to need additional beds."

OSHU's experience emphasizes the continually changing—and organizationwide—nature of the ED diversion issue. To accommodate the extra surgical load, the hospital has budgeted for the FTEs to add six more ICU beds this spring. "We hope that, with the addition of these beds, we will have a greater downstream effect on the ED than we have had to date," Huffman adds.

Judi Huffman, MS, RN, is division director for emergency, trauma, orthopedics, and neurology at Oregon Health & Science University, Portland, Ore. (huffmanju@ohsu.edu) K. John McConnell, PhD, is a health economist and a research assistant professor at Oregon Health & Science University. (mcconnjo@ohsu)

Case Study 3 Tracking ED Patients with Technology

Until October 2004, a white board was the only tool that ED registrars used to track

patients arriving at Virtua Health's four New Jersey EDs. But Virtua has since automated the process using an emergency department information system that combines triage, tracking, and reporting functions.

The system gives staff a snapshot of what's happening in the ED—including the patients' acuity level, who is treating the patients, and how long patients have been waiting. It also helps staff prioritize patients—for example, it alerts nurses and physicians when lab findings come back abnormal. The system uses color-coding to identify how patients are triaged using the five-level triage system: orange means high-acuity patients, while red is the highest acuity.

Fine-Tuning the System

In January 2007, Virtua West Jersey Hospital Voorhees was the last of the system's EDs to go live with the nursing assessment record component of its EDIS system. All staff—including weekend Baylor nurses—were required to attend four hours of training ahead of time. Virtua's IS team cloaked personal information on real patient charts so nurses could practice using the system. At the time of launch, the IS team and software representatives were there to help staff.

Janice Quay, RN, BSN, nursing director at the Virtua Voorhees ED, reports few glitches so far. But they are still ironing out some reporting issues. "We found that it is more efficient for nurses to complete charts in real time," Quay says. "That way the chart is up-to-date before the patient leaves."

Another change took place in February 2005, when the EDs implemented their "Quick Reg" system. During this expedited registration, the patient is greeted upon arrival to the ED. That staff member collects the patient's basic personal data, such as name and social security number, for identification purposes and the reason for

the visit. "From a data perspective, this is when you are starting the clock," Quay says. "Many quality indicators, such as care of the pneumonia patient, are measured from the arrival time. Therefore, capturing this information accurately is key to our compliance."

Fast Track and Swing Beds

Leaders at Virtua Voorhees recognize that ED overcrowding is a hospitalwide problem. Changes in hospital census and ED triage level status set off a chain of protocols, which begins with a page to all managers throughout the house. "If we are at a level red, our [ED] wait times have hit the four-hour mark. Our protocols include putting a physician assistant in the [ED] waiting room, instituting treatment protocols, and getting additional supplies from housekeeping, dietary, and other departments as needed," she says. The thought is that when you are functioning at a level red, all hands are on deck. The ancillary departments call in to see what additional resources are needed. This eliminates the need for ED staff to call other hospital staff for support.

Of the ED's 34 beds, four are dedicated to fast track and another four can "swing" to a higher acuity as needed. The hospital also can flip eight to 10 of its post-partum

"More research is showing that ED overcrowding is not a problem about getting patients in the front door, but getting them out the back door—in other words, out of the ED."

obstetric unit beds to med-surg beds as the need arises.

Building an Ideal ED for the Future

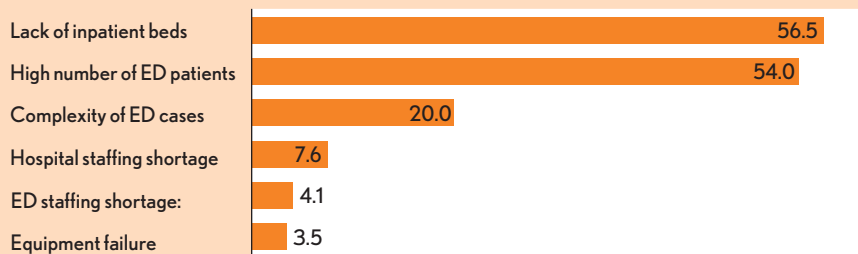
Long-term, Virtua Health hopes to further improve throughput issues by redesigning its EDs. Over the next 10 to 15 years, the health organization will have two new state-of-the-art regional medical centers in Voorhees Township and Mount Holly.

Quay is leading the team responsible for planning the ED on its new campus. "We went into the project looking at automation tools and how we could bring the tools to the nurses," she says. Part of the new technology will include electronic tablets that give ED nurses the option of charting information at the bedside. ☞

Janice Quay, RN, BSN, is nursing director for the Virtua Voorhees emergency department, Virtua Health, Voorhees, N.J. (jqay@virtua.org)

Why Are Hospitals Having to Divert ED Patients?

Mean percentage of ambulance diversion hours by reasons of diversion, 2003-04:



Source: *Staffing, Capacity, and Ambulance Diversion in Emergency Departments: United States, 2003-04*. Centers for Disease Control and Prevention, National Center for Health Statistics, September 27, 2006. Visit www.cdc.gov/nchs for the full report.

Between 40 to 50 percent of hospital emergency departments reported overcrowding between 2003 and 2004, according to a recent CDC report. About one-third of hospitals had to divert an ambulance to another ED in the last year because of overcrowding or staffing shortages in the ED. Besides the lost revenue, overcrowding is associated with longer patient waiting and treatment times.

Delivering a Negative Performance Review

Properly handled, a negative performance review can produce positive change.

How do I give someone a negative performance review? I really want this person to change her behavior, but I don't want to hurt her feelings or put her on the defensive.

Sanford: Whenever you talk to staff about a performance concern, you need to be hard on the issues but soft on the people. This means that you need to focus on how they need to change their work practices in order to help the department and organization meet its goals and to maintain a high level of patient care. Keep the conversation on how their behaviors need to be changed, not on them as people. Also, be specific about which behaviors need changing.

For example, if the employee has a habit of coming to work late, discuss how this lateness affects the organization—for example, it delays necessary patient care duties and prevents outgoing staffers from leaving on time. But avoid theorizing about the cause of the tardiness. Do not say things

like, “I don't think you care enough about this job” or “You need different child care arrangements.” Those are emotional issues that detract from the primary problem.

In general, you should never wait until the annual review to tell someone that he or she needs to work on something. Performance reviews usually should not include any surprises. However, when you obtain feedback from others as you develop a person's review, you may uncover some performance problems that you were unaware of, because someone didn't have the courage or time to say something sooner. In these cases, don't disregard this information simply because it never came up earlier.

After you present your concerns to the staff people under review and provide opportunities for them to offer feedback, discuss how you can help that person change. Part of your job as manager is to help your staff be successful, so work together

to set specific objectives for improvement, and then make a plan to get together again in the future to discuss his or her progress.

For instance, if a staff person has been making patient care-related errors, perhaps he or she needs some additional training or education. In that case, during the performance review, determine a date by which the individual must participate in such training and set a specific goal for improvement. For example, a nurse who isn't completing all of his or her patient assessments each day could be given the objective of completing all assessments before the end of his or her daily shift. In addition, set dates that the employee's patient charts will be reviewed to check on his or her progress (such as the 15th of each month), and then select a date that you both will meet again to discuss whether the objective has been met. ☞

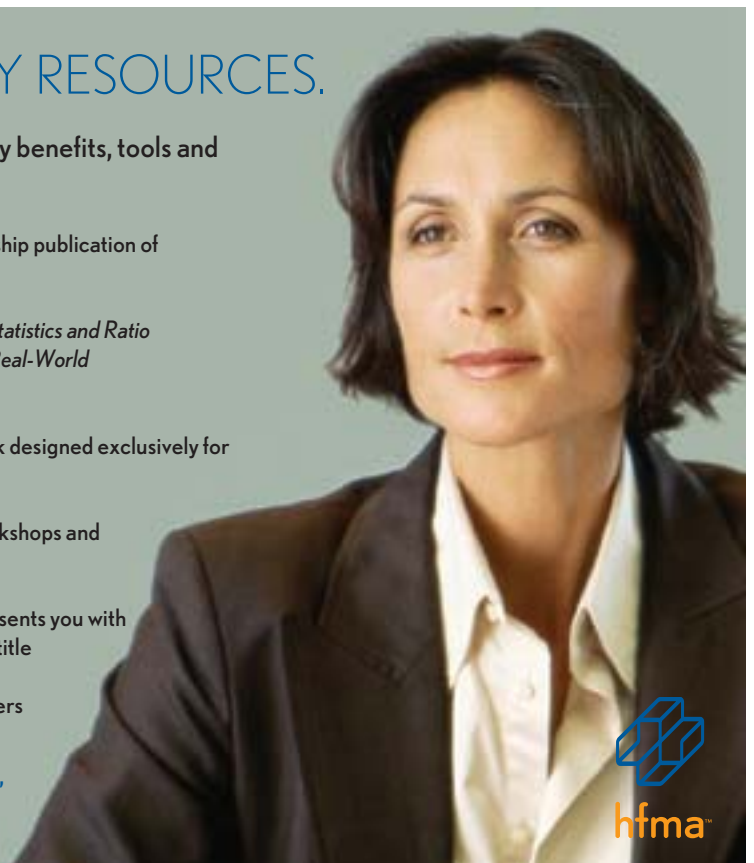
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An illustration of a hospital emergency department at night. The building is lit up, and a large sign above the entrance reads "EMERGENCY" with a red cross. A digital sign above the entrance displays "CURRENT WAIT TIME 3 HOURS". Several smaller signs on the building indicate "BED EMPTY SINCE" followed by times: "5 A.M.", "7 P.M.", and "2 A.M.". A group of people is standing in a line outside the entrance, waiting.

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Using Excel® to Sort Data and Identify Trends

The Challenge: Karen Ramirez, a nurse executive who oversees a total of 60 nurses in three separate units, would like to be able to create “snapshots” of her staff. She wants to quickly see, for example, how many of her nurses are currently working toward advanced degrees, or the average tenure of the nurses within a particular unit.

This type of information is, of course, available from her hospital’s human resources department. But Karen wants to be able to manipulate the data herself so she can quickly review different scenarios as she develops individual plans for recruiting and retaining nursing staff on each unit. How can Karen maintain this information in an easily accessible, easy-to-use database?

The Solution: Karen realizes that Microsoft® Excel® has a “sort” function that would allow her to view data on her nursing

staff in a variety of configurations. To begin, she asks human resources to generate an Excel file that includes the names of all of her nursing staff, along with various information such as their birth dates, degrees, certifications (for example, RN, LPN), start dates, and the unit in which they work.

After she opens the Excel document, Karen sorts the data by following these steps:

- > She clicks on a data cell within her spreadsheet. Then, she clicks on the “Data” menu at the top of the window, and selects “Sort.”
- > A “Sort” pop-up window appears. Karen can choose to sort the data by three variables at once. In this case, she would like to see which unit has the highest number of nurses in school. She wants to use this data to determine the need for an on-site BSN completion program. So, she chooses to sort by unit (in the “Sort by” menu) and then by graduation date (in the

“Then by” menu).

- > She selects “Ascending” to see the data sorted from beginning to end (for example, A to Z or 1 to 10). If she had wanted to see the data in reverse order, she could have selected “Descending.”

The Result: Karen can now easily review data on her staff and make more effective plans for recruitment and retention. For instance, she found that more than half of the nurses in her ICU were working toward or had already obtained additional degrees. Karen determined that she needs to develop a customized plan for this unit that focuses on strategies beyond the on-site BSN program. She is also going to recognize this unit as having the highest percentage of “internal students” in the division. ☞

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Nursing Staff Data—by Unit and Advanced Degrees

Last Name	First Name	Certification	DOB	Start Date	Unit	Date on unit	In School	Grad Date
Johnson	Darlene	RN	5/9/1948	2/4/1971	ICU	10/18/1992	N	
Jackson	Tina	RN, MBA	1/6/1972	3/6/1999	ICU	9/4/2001	N	
Krakowski	Lisa	RN	11/17/1954	7/6/2006	ICU	7/6/2006	Y (BSN)	5/07
Christianson	Diane	RN	9/16/1969	10/12/1994	ICU	12/1/1996	Y (BSN)	1/08
Sullivan	Mary	RN, BSN	3/1/1953	2/2/1976	ICU	10/11/1980	Y (BSN)	5/07
Christopher	James	LPN	4/15/1955	1/15/1986	OB	1/15/1986	N	
Smith	Paula	RN, MSN	4/21/1957	7/7/1977	OB	7/7/1977	N	
Forrest	Rose	LPN	9/29/1981	4/13/2004	OB	4/13/2004	Y (RN)	5/07
Greene	Delores	LPN	6/12/1959	9/12/1987	PACU	10/31/1992	N	
Schneider	Kathleen	RN, BSN	1/3/1983	7/1/2004	PACU	12/10/2005	N	
Williams	Matt	RN	7/12/1972	6/30/1983	PACU	7/4/2005	Y (BSN)	5/07

Using the “Sort” function in Microsoft Excel® allows you to organize data in a spreadsheet according to select variables. For example, this sample spreadsheet was sorted to see which nurses on each unit were working toward another degree.

person will hear things like, 'I have too many patients in the ED,' 'We have patient flow issues, 'Everybody's in the ICU,'" says White. "The nurse manager's job is to work with that finance manager to translate the clinicians' descriptions into data points that help justify the project. For example, how many patients is the hospital turning away? What was the impact on the cardiac program? Have we had to turn down any surgeries?"

Try to think big when exploring financial justifications for a clinical improvement, says Smithson. "The real brass ring is if you can translate your project into shortened length of stay *and* additional revenue," he says. "If you see an opportunity to reduce costs from medications or supplies, then you want to do that as much as you can because waste is benefiting nobody. But the opportunity cost for bringing in additional patients dwarfs the amount that you could save by reducing medication or supply costs."

Nursing executives need to work with finance to develop an operations or productivity report that is truly useful.

What about the palliative care example cited above? By working closely with end-of-life patients and their families, palliative care staff can discharge many of these patients to a hospice, or move them out of critical care to a lower level of care at the hospital. As a result, additional ICU beds often open up.

But don't get too excited yet. "Opening up beds, by itself, means virtually nothing from a financial standpoint," says Smithson. "I've always said that focusing on cutting length of stay by one day isn't the right objective, since the last day in the hospital isn't the most expensive day when it comes to resource utilization, and hospitals have to pay fixed costs, such as salaries and utilities, whether a patient is in a bed or not. In addition, many patients use up the major-

ity of expensive supplies during their first days in the hospital, meaning chopping off a day at the end is not going to save much."

"However, by reducing length of stay, you open the opportunity to get another paying patient in that bed," Smithson says. You then need to find what kind of patient that is likely to be (a Medicare patient, a per diem patient)—and what the hospital is likely to get paid for that patient's care.

"That's where you need to sit down with the finance people," Smithson says. "They can say, 'Well, on average, we think it's going to be this type of patient based on your unit's history.' Then, the finance people can help you put together a pro forma, which will show the potential benefits of the palliative care program."

(For more on this topic, you can read "Building a Business Case for Clinical Quality" in the December 2006 *hfm* magazine. An excerpt of this article is posted at www.hfma.org.)

Business News for Clinicians

Turning Auto Workers into RNs

Michigan hospitals and universities are using layoffs in the depressed auto industry to their advantage by enticing unemployed workers to consider accelerated nursing programs, reports *The Detroit News*. Oakland University has teamed with the Henry Ford Health System to create a fast-track nursing program specifically for unemployed Ford Motor Company workers. For those without a college degree, the program is three years, and those who already have a degree can earn a nursing degree in a year.

The hospitals are hoping not only to help solve their nursing shortage but also to train new healthcare employees in the culture and practices of their institutions right from the start.

Circulatory Disorders Top Causes for Hospitalization

Circulatory diseases accounted for one out of every six hospital stays—the most prevalent reason for hospitalization in 2004 with the exception of pregnancy and childbirth, according to the Agency for Healthcare Research and Quality. Coronary atherosclerosis was the most common circulatory disease requiring hospitalization (3.1 percent of all admissions), followed by congestive heart failure (2.9 percent of admissions). Here are some other findings:

- > More patients died in the hospital with circulatory diseases (3.3 percent) than all other patients.
- > The average cost per hospitalization for circulatory diseases was 41 percent higher than for other conditions (\$10,800 versus \$7,700).

Patient-Centered Case Management Cuts Admissions by 38%

A novel patient-centered case management program designed for those with late-stage illnesses—mostly cancer—resulted in a 38 percent decrease in hospital admissions, according to a study in *The American Journal of Managed Care*. The case management approach also reduced costs by more than \$18,000 per patient, and garnered high satisfaction rates among patients.

Survival rates were the same as a control group that received usual case management. After accounting for the additional cost of the program, the return on investment was 2:1.

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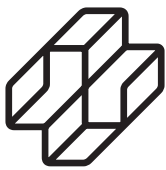
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