Nursing VOICE

Hospital Finances

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Healthcare's Doomsday Overstated

The hospital industry is one of the largest industries in the country. So large in fact that the Commerce Department reports healthcare expenses will amount to nearly 13 percent of the gross national product (GNP) by year end.

Parallel to the growth in expenses are tremendous pressures from the community and government to control costs.

In an effort to accomplish this, government bodies have passed major legislation. The largest impact on the hospital industry was The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), PF 97-248. It had the most far-reaching effects on the Medicare program of any legislation since the original act passed in 1975. TEFRA introduced the prospective payment system (PPS).

The PPS changes the method of payment to hospitals from the cost per case method of allowable costs to one of payment computed prospectively (before the service is delivered).

The formula for payment is adjusted for diagnostic groups (DRGs), for certain clinical characteristics of the patient, for hospital, region, wage levels and other pertinent factors. The PPS method is complicated and overwhelming because of all the adjustments that are made. Basically, however, payment is determined by applying the weight of the proper DRG category to a base Medicare rate plus adjustments.

SCOTT DORNBLASER

MaryLou Patari, RN, Pediatrics (right), discusses young Chelsea's progress with her mother, MaryLou Danish. It is patients like Chelsea who benefit from the tough budget decisions that must be made in order to guarantee our patients continued quality care.

Today, hospitals depend on payments from "third parties" as one of their major sources of revenue. Many hospitals realize a substantial percentage of their revenue from the Medicare system. Because of this dependency, the government, as a third party payer through the use of the PPS, has a profound impact on the financial stability or instability, if you will, of the hospital industry.

The greatest impact of the prospective payment system on hospitals has been a yearly decline in revenues. It has been very clear that levels of reimbursement have not kept pace with rising costs.

This substantial decline in revenues gives rise to changes necessary to remain solvent. These changes include mergers, integration into larger organizations, increasing utilization of outpatient services, greater awareness of appropriate lengths of stay and increased preadmission testing.

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The Allentown Hospital— Lehigh Valley Hospital Center
A HealthEast Hospital

Financial Strength Insures Future

(EDITOR'S NOTE: The article below is an extensive interview with Vaughn C. Gower, senior vice president and chief financial officer of TAH—LVHC).

Q. What motivates us financially? Aren't we not for profit?

A. The financial picture of any non-profit institution must be viewed in terms of its purpose or mission. Our hospital belongs to the community and must be here forever because the community will always need healthcare.

The hospital directors (or trustees) are the community's assigned leaders. Their role is to ensure that the institution provides healthcare to meet the community's needs today and in the future.

The managers and staff are here to carry out that responsibility. Our job is to ensure the institution's well-being, now and in the future. It's as if you, as an individual, were to prepare not only for your own retirement, but also had the responsibility to provide for your heirs as well.

Vaughn C. Gower

Q: What does this mean in terms of a hospital budget?

A: We must think of financial strength in terms of manageable debt and worthy assets, just as with any individual's or business's budget. Our assets are primarily a partially modern physical plant and cash reserves. Cash reserves are used to keep the physical plant modern, protecting that asset for the community, and to provide a buffer against unforeseen events. Therefore, we'll meet our responsibility to the community if we have financial strength.

Q: What kind of "unforeseen" things do you mean?

A: One thing the last decade has taught us is that the healthcare environment is very fragile and unpredictable. Much of our reimbursement (or income) is dependent upon government programs (Medicare and Medicaid). An example of the "unforeseen" might be that the government cuts back on funds to pay for Medicare and Medical Assistance patients.

Calamitous world events could lead to economic disruption which could lead to a reduction of Medicare or Medicaid payments. Then the entire burden of caring for the poor and uninsured would rest upon the community and be provided through its hospitals.

Another example might be a medical catastrophe. Certainly, the pressures metropolitan hospitals are feeling related to the care of AIDS patients tells us this is not as far-fetched as we might once have believed.

Q: How do we meet our objectives to fulfill our community responsibility?

A: That's where our annual plan comes in. We establish our priorities and goals, as an institution, as departments, and as individuals.

Our operating budget must be geared to cash flow and cash flow starts with the income statement, which is why there is so much pressure on the operating margin. This is where the pressures related to reimbursements have become so much more severe.

When we look at the use of cash, we must always come back to our objectives or plans which are developed to meet our community responsibility. So we invest some cash from our earnings in our facilities, save some for future investment in our facilities or unforeseen events, or pay back the people who have lent us money which was also used to modernize our facilities and develop programs to provide modern healthcare.

Q. What would happen if we lost sight of our community responsibility?

A. Well, if we didn't remember the important responsibility of being here forever, we could fall victim to short-term thinking. Our budgets and plans could contract and we could spend insufficient time worrying about our continued viability.

The major challenge is that the environment keeps changing. The conditions under which we strive to carry out our community responsibility keep changing. Therefore, our responses have to keep changing as well. I thank goodness for the constancy of our community responsibility. That, at the least,

doesn't change and provides a clear vision for us to focus on.

Q. What role do you see the government assuming in resolving some of the issues facing healthcare providers?

A. The government's role will be determined by the powerful effect the federal budget deficit plays in all decisions. In addition, because the economies of the world's nations are inextricably linked, we are more than ever affected by world events. This leads to greater uncertainty and volatility.

We should not believe there is such a thing as a "health plan" at the Federal level. We will only have narrow, locally-driven health initiatives to improve the health status of people in the region and community. We cannot count on the government; state and national responses will continue to be too random. Therefore, the community, through its hospital, needs to assume responsibility.

Q. Do you think nationalization of the healthcare system will play a role in minimizing today's healthcare crisis?

A. A nationalized health plan would be a political decision that's made; but, if it happens, it will occur as a random response in the regular turbulence of politics and economic events.

Some view nationalization as an improvement since dealing effectively with the real issues seems impossible. The problem truly is one of resources; there are not enough resources to satisfy all our desires — in healthcare or anywhere else.

Some will propose a change in the delivery and payment systems, which is what nationalization involves, rather than deal with the resource issues. It will occur if its proponents can convince enough legislators that the resource inputs will be less under a nationalized plan.

Q. What role do you see each individual playing in this pretty dismal picture of healthcare economics?

A. Remember our story about cash. Our actions must support our purpose or mission. On an individual basis the income statement is the one thing we can do something about. Only if we succeed at the level of the income statement can we achieve the vision.

'We should not believe that there is a health plan at the federal level. The community, through its hospital, assumes this responsibility.'

Individuals should focus on manpower and product usage. At the individual level most savings seem infinitesimal given the scope of the overall institution's budget. But cumulatively each savings becomes very important because of the size of the organization. Blue-pad or linen savings on one unit may seem insignificant until multiplied by 55 units. We need dozens of these improvements all the time to keep ourselves at today's relative position.

While supply usage is important, supplies only account for 20 percent of our operating expenses. Since 60 percent of our total operating expenses come from salary and fringe benefit costs, it is three times more effective to focus on people costs.

We must improve how we work with patients and with each other. We face the choice of either improving or maintaining our patient care requirements. We must constantly improve how we do things and evaluate the usefulness of what we do or be in a position of having to provide less for patients because resources do not grow as fast as the cost of what we do today or would like to do in the future.

Q. Is this where Total Quality Management comes into play?

A. Yes, we must find ways to make changes in order to respond to the pressures in our changing environment at TAH—LVHC. Our approach to do that is Total Quality Management; it's our investment, an insurance policy that we will be able to fulfill our mission in the future. My concern is with hospitals who aren't even trying to find alternatives. I don't know if they'll survive in the long run.

Q. What specific circumstances have caused our financial picture at TAH—LVHC to become more fragile during the past year?

A. Our operating margin has been declining since Fiscal Year 1985 at a level of about $1,000,000 or about four-tenths of 1 percent in Fiscal Year 1990. Early in that period, the primary problem was very low payment increases from government programs in contrast with higher than inflation cost increases.

Last fiscal year our rate of cost increase was improved thanks to an excellent effort throughout the hospital. However, our revenues from commercial insurers declined dramatically as those payees were very assertive about reducing the length of stay for the patients they insure. This length of stay change is very important since commercial insurance pays for services as they're incurred; a lower length of stay produces less revenue for the hospital without a similar reduction of expenses.

Elisabeth Williamson, RN
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Budget's Bad Rap Undeserved

Most nurses have the luxury of little regard to unit budgets and the sense of competition felt in big business. But along with decentralization, head nurses now have a much better idea of how the budget works. Hopefully, as we move forward, so will most staff nurses.

The mysterious "budget" often receives a bad rap. It is known to be a consumer of head nurse time, keeping him/her from making unit improvements. It is the given reason the nurses "work short." It is the instrument of distributing resources, yet, may prevent availability of staff and equipment. It is a monster whose body resides in Finance, as tentacles wind through Purchasing, CPD, Pharmacy, Radiology, Laboratory and nursing units: facets belonging to an upper management committee, the chief financial officer (CFO), the division administrator, head nurses, and staff, to name a few!

Planning is the prerogative of upper management. It makes its plan known to middle management. The head nurse is asked for input. Head nurses formulate any challenge or input and submit them via their administrator to upper management.

Decisions are made about whether or not to make proposed changes, in view of the needs of the whole hospital. Perhaps there will be opportunities to hire more people or start new programs. Perhaps there will be no allowance for growth in expenditures. Will there be changes in the next fiscal year which will impact the plan? Can the need for more personnel or equipment be demonstrated? Should one unit's needs be considered above another's if there is not enough money for everything? Does the bit of the budget proposed for the unit reflect performances/changes from last year? Is it a good plan, in my opinion?

This process, from my perspective, has been simplified over the last four years. The change has been from an eight-hour day or more spent preparing the budget to a few scattered hours. Head nurses involved with large equipment purchases, common in the OR, or in new programs have a more complex budget to manage.

Monitoring the budget is another activity with which all head nurses are acquainted. It involves sifting through numerous reports to determine if the activity of the unit is accurately represented. Among these are the monthly budget report, the CPD report, the pharmacy report, two labor distribution summary reports, the unit period detail report and the cost accounting report.

Some reports are brief; others involve what seems like a ream of computer paper! Mostly, I look for "outlyers." Are staff that I don't recognize charged to the unit? Did the unit pay for 10,000 gauze pads instead of the 100 actually ordered and used? Did the unit buy one typewriter and inadvertently get charged for two?

When I'm satisfied that the report reflects the unit's performance, I turn my attention to an examination of portions of the budget that vary from the projection for that month. I attempt to answer the questions of why, and what can be done to bring those problematic areas in line for the upcoming months. Actually, this requires some creativity and is, for me, the most interesting facet of my work with the budget.

I like to remember that it isn't the budget that is responsible for scarce resources. It's only the tool that fits the finite assets of a system to its infinite needs.

Carole Moretz, RN
6T (TAH)

SCOTT DORNBLASER

Sharon Smetzer, RN, head nurse of NICU, prepares her monthly budget report.

ANSWER KEY

Across:
5. Special Care Unit
6. Adolescent Psych
11. Short Procedure
17. MedEvac
18. Seven C
19. ACU
21. PCCU
22. PACU
23. TCU
24. Five B

Down:
1.Six A
2. Six C
3. OR
4. OTU
5. Shock Trauma Unit
7. Emergency Center
8. TOHU
9. Post Anesthesia
10. Operating Room
12. Open Heart Unit
13. CNS Unit
14. Dialysis Center
15. Emergency Dept.
16.Five C
20. Four C
21. PD Unit

Computers Increase Efficiency

In the past five to 10 years, almost every industry has explored the advantages of computerization. Most have introduced some form of computer technology.

As an example, take a shopping trip to Sears. You find your catalog order by using a touch-screen system. Your bank uses computers to process the check you write to pay for your purchase. Finally, after a long day of shopping, a clerk punches your fast-food order into a small computer to transmit the order to the cook.

Computers. . . They seem to be everywhere, helping people do their jobs more easily. . . except in healthcare. Only recently has the healthcare industry begun to take advantage of existing computer technology to facilitate patient care.

Only recently have manufacturers begun to design computer systems specifically geared to healthcare and to direct patient care. Of the 3,037 community hospitals in the United States with more than 100 beds, 57.5 percent use some form of computerized patient care system, but only 1.4 percent of those hospitals greater than 300 beds use bedside terminals.[1]

The healthcare industry recognizes that hospitals, too, can enjoy the benefits of computerization. Laboratories, pharmacies, admitting and central supply departments have been among the first areas to explore automation.

Now, hospitals all over the country are defining their requirements and explaining their needs to the vendors of computerized patient care systems. The investment in a patient care management system is increasingly seen as yielding resource management efficiency in all departments, including nursing.

Like everyone else in healthcare, nurses are taking a tremendous interest in computers. Responsible for coordinating patient care, nurses must process large amounts of complex clinical data, manage the appropriate utilization of patient care resources and communicate with other healthcare personnel throughout the hospital. Most research finds nurses spending 30 to 60 percent of their time communicating and documenting.[2]

Many studies indicate that this burden, which removes nurses from direct patient contact, contributes to nurses' frustration and dissatisfaction. Clearly automation has the potential to benefit nurses. Patient care can be better coordinated among caregivers when multiple uses are able to access information about patients simultaneously.

Improvements in time management can be achieved through use of worklists, computerized care plans, standardized documentation, etc. In addition, the use of computers can help nurses build a consistent body of knowledge, leading to the further development of the profession.[3]

Specific uses for computers which have been identified in the literature include: documenting nursing assessments and careplans, providing medication worklists and assisting with drug calculations, scheduling diagnostic tests and reporting the results of diagnostic tests. Administrative functions include: determining patient acuity, staffing and collecting data for quality assurance activities.

With all of these advantages in mind, an information services strategic plan is being implemented at TAH—LVHC. The process of selecting a system to meet the hospital's needs began earlier this year. To date, several steps have been completed:

1. Recognition of the need and commitment to investigate systems.

2. Identification of system needs and specification of requirements. Four task forces have been involved in the development of these documents.

3. Examination of the reliability and experience of vendors.

This fall, vendor products were examined more closely. Unit staff and task force members had the opportunity to evaluate four different products.

This is certainly an exciting time for healthcare and how we care for our patients. Next time you order that burger or stop at a "MAC" machine, think about how you do your job and how a computer might help you do it better.

(1) Herring, D., Rochman, R. 1990. A closer look at bedside terminals. Nursing Management. 21(7): 54-61

(2) Korpman, R. 1984. Patient care information systems: looking to the future. Part 2: the impending revolution. Software in Healthcare. 2: 26-30.

(3) Zielstorff, R., McHugh, M., Clinton, J. 1988. Computer Design Criteria: For Systems that Support the Nursing Process. American Nurses Association.

Jan Stahler, RN
Nursing Administration

SCOTT DORNBLASER

Reviewing the latest computer capabilities to facilitate patient care are (from left) Diane Popovich, RN, Emergency (TAH); Beverly Snyder, RN, Emergency (LVHC); Kathy Crane, representative of TDS, a computer vendor; and Cathy Knudsen, RN, ACU (LVHC).

Caring Is The Greatest Gift

TOM AMICO

Retired nurses Josephine Ritz, RN (right), and Helen Barnes, RN (center), admire one of the Friends of Nursing prizes with Enid Littlehales, RN, a nurse at TAH—LVHC.

The 6,000 hospitals in the United States are in the midst of a magnificent transformation of who gets healthcare, how it is paid for and how it is managed. These times are exciting, but also very chaotic and demanding.

Planning for the future is almost an academic exercise in futility when the major variables are sure to be altered. However, emerging from this unsure vision of what tomorrow holds, philanthropy seems to be capturing increasing attention in the marketplace. The reason, I believe, is two-fold:

1. No hospital or college in the United States has either achieved nor sustained a level of exceptional quality without philanthropy. Simply stated, patients paying the bills and students paying tuition cover only the bare bones operational costs.

2. Dollar for dollar, professional fund raising provides a better return on investment than other healthcare financing techniques.

There are three ways to acquire financing for hospitals.

1. Debt Financing, i.e., borrow the money from some source, usually bonds which people and organizations purchase. The cost of debt financing ultimately, however, is usually about $2 to $3 for every $1 of net capital.

2. Operations Financing, i.e., manage the hospital so that there is something left over after expenses. However, even in the best managed healthcare institutions, administration would have to spend at least .95 cents or more to acquire $1 of net capital.

3. Finally, there is philanthropy which, depending on the level of sophistication, may bring in $1 of net capital at a cost of only .15 or .20 cents.

Today, many of the hospitals in the United States are still not involved in philanthropy on a full-time, professional basis. Most hospitals are content with special events, direct mail campaigns and payroll deduction programs.

These same institutions also find themselves struggling every five years or so when major capital expenditures must be made to renovate or construct new pieces of the physical plant.

Naturally, to accomplish the capital make over, a fund-raising campaign is launched — usually with success. Then a long, "dry spell" of scant fund-raising activity occurs until another capital need arises.

This process of fund raising is something akin to saving for retirement on an episodic, ill-defined basis. Little ongoing cultivation of prospects is undertaken and all capital fund raising is usually cash intensive over a short pledge period, leaving potential major deferred gifts unsolicited.

No one wants to discuss estate plans or life insurance gifts during a capital campaign to build a new wing on a hospital. Thus, some of the largest possible gift commitments never are made.

Full-time professional fund raising in support of the hospital's long-range clinical and facilities plan is the only efficient and effective way to insure fiscal vibrancy. Gift solicitation should be for immediate, as well as long-term needs, including endowment.

Philanthropy supplements and augments existing hospital budgets. Gifts acquired help to make extra things happen in a hospital setting that would otherwise not be possible.

The real key to fund-raising success is through a team approach. Everyone in the hospital family must believe and accept that he is directly or indirectly involved in fund raising for their respective clinical departments.

Professional fund raisers depend on nurses and doctors to confidentially refer names of possible contributors. The fund raisers handle all the communication, including setting up the appropriate funds for a specific department. Funds can be earmarked for research, education, equipment purchase, lectures, etc. Most funds are named by the donors and expenditures are made by personnel in the respective clinical department.

For more information please call 778-7990.

Michael F. Luck, PhD
Vice President, Development

Speaking Out

Effective, Efficient Care Increases Quality, Decreases Costs

By William W. Frailey, MD
Vice President, Medical Affairs

The two underlying characteristics of good patient care are effectiveness and efficiency. The hospital's goal is to develop a program that can be said to "do the right thing, the right way, the first time." Effectiveness allows us to continue to evaluate the care of the patient and improve the quality by which it is delivered on an ongoing basis.

Efficiency allows us to deliver that ever-increasing quality of care in a manner which is affordable. The accomplishment of these goals will allow the hospital to continue to deliver the outstanding care for which it is known and at the same time address society's concerns about controlling the cost of that care.

In order to monitor the development and implementation to accomplish the goal of effective and efficient use of the hospital's resources, a quality improvement team under the chairmanship of Samuel Huston was developed. This committee's other members are Vaughn Gower, senior vice president for finance; Mary Ann Keyes, senior vice president for nursing; John Salventi, vice president for administration; Bruce Gresh of the planning department of HealthEast, and myself.

The committee has met on a periodic basis to oversee and guide the process. There has also been a number of meetings with presentations to the medical staff and the nursing leadership group in order to begin the education process that will be necessary.

One major implementation step is the creation of Resource Utilization Management teams. These teams consist of a Utilization Review Coordinator and one or more Discharge Planners, who are assigned geographically to a floor or specialty on a regular basis. This allows them to become known to the physicians and nurses practicing in those specialties.

Their job is the continued review of the need for acute care and to facilitate discharge planning so that such plans are in place when the patient is ready for discharge. These teams will be working with the nurses on the units in order to identify potential utilization and discharge management problems. The goal is, with the proper coordination between the Resource Utilization Management Teams and the staff nurses, that problems can be anticipated and appropriately planned for without a crisis arising.

'This linkage between the Resource Utilization Management Teams and the staff nurses is absolutely critical to the success to the program.'

This linkage between the Resource Utilization Management Teams and the staff nurses is absolutely critical to the success to the program. It is frequently the staff nurse who picks up the first clues that there may be problems in placement or after care of the patient. Communication of this information to the Resource Utilization Management Team is key to having an appropriately prepared utilization and discharge plan.

The Resource Utilization Management Teams will be set up so all units will be covered. It is our hope that all patients will be reviewed and screened for potential problems in order to maximize the effectiveness and efficiency of the delivery of care and the adequacy of the discharge planning process.

More specifically, a group has been formed to look at DRG 110, which is peripheral vascular surgery. This DRG was selected because it is a relatively homogeneous group of patients largely located in one geographical area and under the care of a smaller group of attending physicians. It is felt that these characteristics would allow the use of this DRG to build the model for a "time line management system." This committee, made up of nurses, physicians and utilization review personnel, along with significant support from Information Services, is in the process of thoroughly analyzing the way that we care for patients in this DRG.

This analysis consists of what needs to be done, what are the key steps in the patient's care, in what order should they occur, and how long does it take to process the patient from admission through discharge. This information can then be overlaid onto what we believe might be a more effective and efficient method of care.

As a result, a time line will be established. This will allow the physicians, the nurses and the Resource Utilization Management Team to understand on an ongoing basis whether the patient is passing through the system in an uncomplicated fashion or whether difficulties have arisen which can and should be addressed. It is hoped that this model can be transferred to other DRGs.

A better and objective understanding of how patients flow through any DRG will allow us to adjust that DRG to maximize effective and efficient care and at the same time reduce the cost.

Continued from Page One

Doomsday

As you may know, we at The Allentown Hospital—Lehigh Valley Hospital Center have experienced many of these changes. So, what then, does the future hold for the financial "instability" of the hospital industry?

As Tim Porter-O'Grady states, the future is a mixed bag of information that carries generally some pretty depressing times for the foreseeable future. Porter-O'Grady continues to say that the challenge more often than not is the notion that the healthcare industry must settle for surviving unfriendly waters in increasingly tight times.

Russell C. Coile Jr., a healthcare consultant and futurist, says that America's healthcare industry is crunched between the "rock" of labor shortages and rising costs and the "hard place" of lower per-unit reimbursement.

Coile's report is based on a survey of The HealthCare Forum's nationwide panel of 500 healthcare experts. The highlights of his report conclude that hospitals should brace themselves for more years of financial pressure. It will not end before 1991-92.

It is clear that hospitals will need to rely on "non-operating" revenues, ambulatory care and other non-inpatient revenues and philanthropy to keep them in the black.

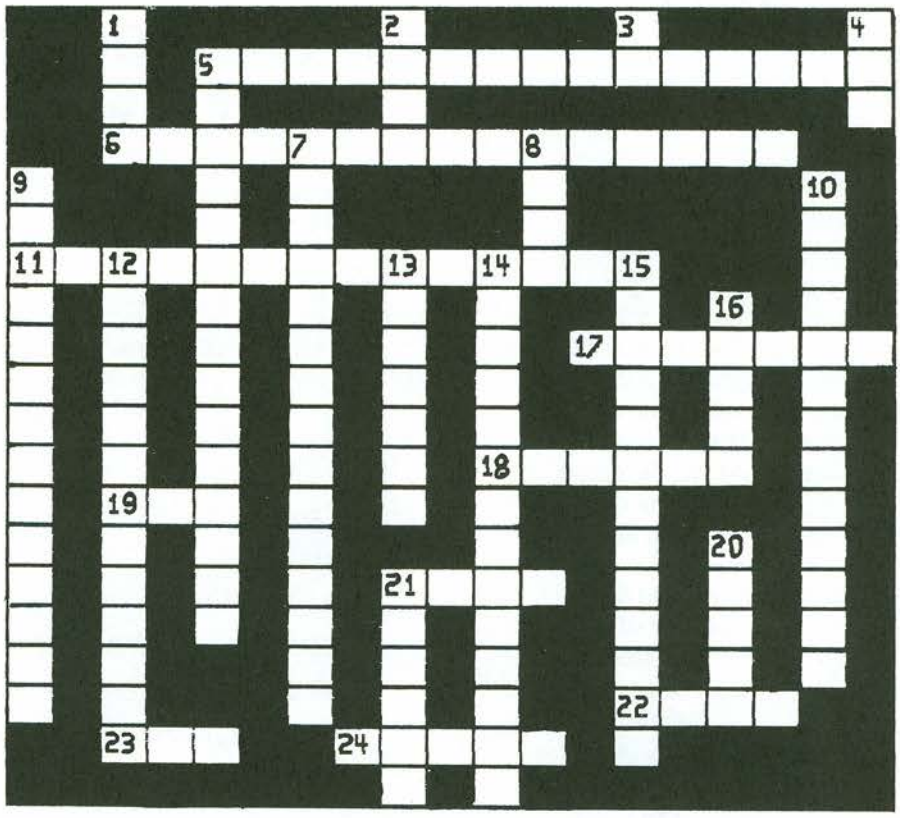
Although all of this sounds bleak, there is some encouraging news on the horizon. Financial performance did decline in 1987-88, but in some regions of the country the decline was not nearly as sharp when compared to the previous two years.

A declining number of hospital executives believe that the once forecasted "doomsday" closures of hospitals may have been overstated. Many hospitals will become integrated into larger organizations as opposed to disappearing.

Some experts contend that the hospital recession is nearing an end and that there will be better days ahead for hospitals. Let's hope they're correct.

Jack Schwab, RN
TCU (TAH site)

Test Your Hospital I.Q.



ACROSS

5. 14 bed critical care unit; wide variety of patients (LVHC)
6. Family-centered 11-bed unit for 12 to 18 year olds (TAH)
11. One-day surgery unit; gives the most pre-ops (LVHC)
17. Flying team of nurse, medic and pilot (LVHC)
18. GIMS (general internal medicine service); has mostly elderly patients (LVHC)
19. Cares for pre-surgery IABP, cardiac cath and evolving MI patients (LVHC)
21. Unit for ventricular mapping patients (LVHC)
22. Provides immediate post-anesthesia care including children; 24-hour staff (TAH)
23. General/cardiac stepdown unit with 50 percent patient turnover each day (TAH)
24. General surgical unit whose patients have the most IVs (LVHC)

DOWN

1. This unit has a patient census of zero (LVHC)
2. This floor gives the most chemotherapy; has oncology and urology patients (LVHC)
3. Unit to need perfusion unit most frequently (LVHC)
4. Outpatient chemotherapy unit; used to be ambulatory surgery (TAH)
5. Code Red ETA; 1 min often called for this unit (LVHC)
7. Provides rape exams, poison control and general emergency care (TAH)
8. Open heart stepdown unit (LVHC)
9. Recovers patients after surgeries ranging from joints to the aorta (LVHC)
10. Place for surgery for gynecology, pediatric, renal and neonatal patients (TAH)
12. Zipper patients (LVHC)
13. Provides care for head injury or spinal cord injury patients (LVHC)
14. Provides 350 dialysis treatments per month (TAH)
15. First unit to evaluate Medivac patients (LVHC)
16. Orthopedic unit which sends the most patients to physical therapy (LVHC)
20. Cardiology unit; unit to make the most moves (LVHC)
21. Provides outpatient peritoneal dialysis, dialysis teaching and renal clinic (TAH)

Anne Brown, RN
TAH Recovery Room