the NURSE MANAGER'S GUIDE to BUDGETING & FINANCE

3rd ED.

US $34.95

Nurses focus on the art and science of caregiving, but nurse managers are faced with the economic reality of patient-staffing ratios, budgets, reports, and accounting. Acronyms such as FTEs and ADCs can feel like a foreign language, but thankfully, help is available.

Updated to include details about key legislation that affects budgeting, *The Nurse Manager's Guide to Budgeting and Finance,* 3rd Edition, provides practical tools, tips, and strategies for running a unit that were not taught in nursing school:

- **NEW:** Reimbursement in other practice settings, such as primary care offices, urgent care centers, same-day surgery centers, and long-term facilities
- **NEW:** Expanded coverage of the Quality and Safety Education for Nurses (QSEN) competencies for graduate nursing education and their relationship to budgeting and finance
- **NEW:** Fiduciary responsibility of boards and the difference between a system network board and a hospital board
- Operating and capital budget development and planning for the year
- Formulas and calculations for full-time employee hours, variances, and benefit costs
- Explanation of financial statements, budgets, and reimbursement documents
- The relationship between high reliability organizations (HROs) and finance/budgets
- Differences between not-for-profit and for-profit institutions

"I truly wish I'd had Dr. Rundio's book as a reference early in my career, not only for myself, but as a resource for nurse leader colleagues!"

-Valerie S. Hardy-Sprenkle, MPH, RN, NEA-BC, FACHE (R)
Vice President of Acute Care Nursing Practice (retired), Wellspan, and Vice President/Chief Nursing Officer (retired), WellSpan York Hospital

ABOUT THE AUTHOR

Al Rundio, PhD, DNP, RN, APRN, NEA-BC, FNAP, FIAAN, FAAN, is an experienced clinician, administrator, and educator. He is a Clinical Professor of Nursing at Drexel University's College of Nursing and Health Professions in Philadelphia, PA, USA. He is the former Vice President of Nursing/CNO at Shore Medical Center in Somers Point, NJ, USA, and a member of the board of trustees of Inspira Health System.

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THIRD EDITION

Al Rundio, PhD, DNP, RN, APRN, NEA-BC, FNAP, FAAN

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Copy Editor: Todd Lothery
Proofreader: Jane Palmer

About the Author

Al Rundio, PhD, DNP, RN, APRN, NEA-BC, FNAP, FAAN, is an experienced clinician, administrator, and educator. He is a Clinical Professor of Nursing at Drexel University's College of Nursing and Health Professions in Philadelphia, Pennsylvania. He is the former Vice President of Nursing/CNO at Shore Medical Center in Somers Point, New Jersey. He is a member of the board of trustees of Inspira Health System in New Jersey. Rundio currently practices part-time as a nurse practitioner in a residential addiction treatment center. He is the immediate Past President of the International Nurses Society on Addictions.

Rundio is the coauthor of the first, second, and third editions of *Nurse Executive Review and Resource Manual*, published by the American Nurses Credentialing Center. He is the coeditor and author of *The Doctor of Nursing Practice and the Nurse Executive Role*, published by Lippincott Williams & Wilkins. He is the editor of *Nurse Management & Executive Practice*, also published by Lippincott Williams & Wilkins. He is the coeditor-in-chief of the *Journal of Interprofessional Education and Practice*. He is a popular speaker on nurse management and leadership topics. He presents nurse executive review courses to assist nurses in preparation for the nurse executive certification board examinations.

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Foreword

Although the title of Dr. Rundio's latest book includes the words "Nurse Manager," this essential resource is a must-read for all nursing leaders. That has never been truer than now, as over the past year we all found ourselves navigating unchartered waters. Nurse leaders wear many hats and are responsible for the smooth and efficient operation of their unit, for nurse recruitment and retention, and for staff and patient satisfaction, all while dealing with often limited financial resources. The financial principles in this book provide a strong foundation for nurse leaders to design and implement a solid budget. As the book unfolds, there are tricks of the trade that break down the complexities of financial challenges and equip leaders with the tools to defend the budget and advocate for valuable resources for staff.

Nursing is the heart and soul of healthcare. Now more than ever, leaders must ensure that they have the necessary knowledge and resources to sit at the financial table and speak the same language as the "financial wizards." Nursing knowledge is a valuable commodity whether at the bedside or in the boardroom. Though most of us are more comfortable at the bedside, the newest edition of Al Rundio's invaluable book expands our knowledge of hospital boards, reimbursement, and legislation, as well as the impact of a well-crafted budget for high reliability organizations (HROs) and the pivotal roles that nursing leaders play.

Dr. Rundio has a gift. He is able to break down the complexities of finance and put them in "nurse speak." Give yourself a gift and arm yourself with this important resource. I am confident you will treasure his book, whether you are a novice or seasoned leader.

–AnnMarie Papa, DNP, RN, CEN, NE-BC, FAEN, FAAN
Vice President & Chief Nursing Officer
Einstein Medical Center Montgomery
East Norriton, Pennsylvania

"Everything that can be counted does not necessarily count; everything that counts cannot necessarily be counted."

–Albert Einstein, theoretical physicist, 1879–1955

Introduction

Many nurses become nurse managers as the next necessary step to advance in their careers. Some form a desire to contribute to nurses and nursing within their organization. Often, though, nurses find themselves in a management position without the tools and skills needed to do the job effectively.

As revenue decreases in most healthcare facilities, more pressure is placed on nurse managers to manage the organization's resources—both human capital and supplies—more judiciously. Suddenly, they need to understand words and phrases like *productivity* and *staffing to census*. To manage the organization's resources more wisely, nurse managers must be armed with the necessary tools to do the job well. After all, healthcare is a business.

Nurse managers must possess some basic knowledge about budgeting and finance. The reality is that nurse managers manage their own business (the nursing unit) within the organization. With decreasing revenue streams, nurse managers must manage their units so that actual expenses equal budgeted expenses, or they must be able to justify variances and take corrective

action where needed. Nurse managers must also be familiar with certain types of budget reports, how to interpret these reports, and, most importantly, how to take action to control the results. All this can be difficult for many nurse managers.

This book is written with the nurse manager at the unit level and above for any healthcare organization in mind. It's a handbook that is intended to be used on the job for the effective management of the organization's finances. It is also intended to share with nurse managers concepts that can be implemented in management so they become more effective at managing the resources of the organization. Finally, this book will assist any nursing manager pursuing certification as a nurse executive.

Healthcare in the United States—where this book's primary audience practices—is different from that of many other countries, especially those with a national single-payer health plan. The US has numerous insurance products on the market. According to the Kaiser Family Foundation (2020), 57% of firms offered health benefits, and 90% of Americans worked at a firm that offered health benefits to at least some workers in 2019. Some individuals purchase an entire insurance product on their own. Older adults and certain patient populations—such as dialysis patients—receive Medicare. Low-income people may qualify for Medicaid. The Children's Health Insurance Program provides low-cost health coverage to children in families that earn too much money to qualify for Medicaid. Medicare and Medicaid are the two federal programs for healthcare insurance. The Patient Protection and Affordable Care Act (ACA) of 2010 has assisted millions more individuals with health insurance through the health insurance marketplace.

In the US, healthcare costs continue to rise. Many of these costs relate to unnecessary tests and procedures. Insured Americans are experiencing tighter controls from insurance plans, where second and third opinions for certain elective procedures may be required and where certain medications need approval from the insurance company.

NOTE

Although the US system does have financial problems, it's not the only one. National single-payer systems also have financial problems—sometimes equal to or greater than those in the US. A free-market system, like the one in the US, creates competition, which can lower rates as well as add services and products.

Nearly 30 million Americans were uninsured in 2019 (Congressional Budget Office, 2020). The ACA has helped address this problem by making insurance exchanges available and assessing financial penalties if an uninsured person does not purchase health insurance. (Since its passage, there have been many challenges to this act. The federal government no longer assesses financial penalties for uninsured persons. Some state governments do, however.) Those without health insurance might not seek healthcare when needed and might not seek primary care for the prevention of illness. This is obviously a problem. However, another problem is created as more Americans obtain health insurance: There are not enough primary care providers to serve them all. Thus, long delays to access health services will most likely be the end result.

This reality places advanced practice nurses in a pivotal position to become the primary care providers of the nation—a notion promoted by the American Academy of Medicine (formerly the Institute of Medicine), whose 2010 report *The Future of Nursing* calls for all nurses to function at their full scope of practice. (A new report will be available in the very near future and will likely repeat this call.)

The uniqueness of healthcare reimbursement in the US and the fact that we are the most industrialized country in the world that does not provide universal healthcare to all citizens mean nurse managers must balance cost with quality. To effectively do this, nurse managers must understand the basic concepts of budgeting. These are the essence of this book for the nurse manager.

The third edition of the *Nurse Manager's Guide to Budgeting & Finance* takes a deeper dive into the nursing budget than the first two editions. New information includes reimbursement in other practice settings such as primary care offices, urgent care centers, same-day surgery centers, and long-term facilities, including nursing homes and assisted living facilities. This new edition also expands coverage of the Quality and Safety Education for Nurses (QSEN) competencies for graduate nursing education and their relationship to budgeting and finance. It adds more information on boards, including the difference between a system network board and a hospital board.

Chapters in this book cover the following key information:

- **Chapter 1** covers the budgeting process for nurse managers and its relationship to patient care. It contains information on not-for-profit and for-profit hospitals and other healthcare systems and care settings. It discusses what a budget is, the benefits of budgeting, and the integral nature of budgeting. Finally, it includes an interview with a nurse manager of an emergency department.
- **Chapter 2** covers a significant amount of material on the political history of healthcare and an overview of healthcare reimbursement in the US, including reimbursement for long-term care. It discusses the role of policy in healthcare reimbursement and the importance of reimbursement. Finally, it touches on the effect of the COVID-19 pandemic on healthcare.
- **Chapter 3** discusses assets, liability, and equity and defines several other basic accounting terms. Responsibility center budgeting is also discussed, followed by forms of budgets, historical budgets, operating budgets, and capital budgets. Finally, it covers the importance of strategic vision and mission and the cash basis of accounting.
- **Chapter 4** covers the steps of the budget-development workflow, including collecting data, planning services, planning activities, implementing the plan, monitoring the budget, and taking corrective action when

necessary. It also discusses management's role in budgeting and inventory management. Finally, it includes an interview with a chief nursing officer, with a focus on how the COVID-19 pandemic has affected nursing.

- **Chapter 5** takes a deeper dive into key concepts in the development of an operating budget. It covers key metrics, discusses expenses, and illustrates how to calculate employee-related costs. It discusses outpatient reimbursement. It debunks various budgeting myths. Finally, it includes an interview with the chief financial officer of a hospital system.
- **Chapter 6** covers budgeting for major movable equipment and for fixed assets. It provides examples of capital expenses. It explains why you need to develop a capital budget and how to do it. Finally, it discusses the importance of including a contingency line in capital budgets.
- In **Chapter 7**, readers learn how to conduct variance analysis, calculate variances, assess efficiency and cost variances, and avoid negative cost variances.
- In **Chapter 8**, you'll find a discussion of types of budget reports and several examples of staff reports, including a new report on nursing salary variances.
- **Chapter 9** discusses the need for healthcare reform and includes updated information on the ACA of 2010 (including major challenges to this act). Hospital mergers, closures, strategic partnering, and global caps are also discussed.
- **Chapter 10** explains what governing boards are (including the differences between a health system network board and a hospital board) and identifies their responsibilities. It defines conflicts of interest, cites common mistakes made by governing boards, and discusses the role of nurses on governing boards. It then shifts to a discussion of specialty organizations: what they are, how their governing boards work, and how they develop budgets.

- **Chapter 11** has been expanded to cover the Quality and Safety Education for Nurses (QSEN) program. It also discusses incentivizing quality (for example, by using value-based incentives), the role of nursing in improving quality, quality and population health, assessing home-care quality, and high-reliability organizations.
- **Chapter 12** discusses the importance of getting politically involved, knowing what types of insurance plans reimburse your organization, developing strategic relationships with key individuals in your organization, speaking the language of finance, practicing finance, and embracing change.

Case examples and interviews have been added to a number of the chapters to further demonstrate the concepts being presented. These should assist you in mastering the principles of budgeting and finance.

If you're ready to improve your ability to successfully manage a nursing unit or department, or to simply gain a better understanding of budgeting and finance in healthcare, read on!

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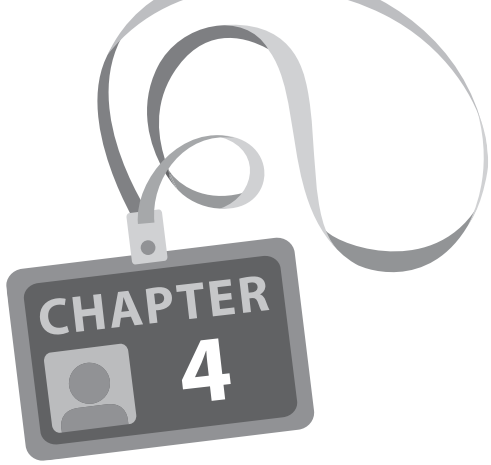

Budget Development

Nurse managers set goals and design the budget—usually in collaboration with the finance department—for their own responsibility center or nursing unit. After the budget has been developed and updated, it is submitted for approval to administration and ultimately to the board of directors. After the budget is approved and the fiscal year begins, the organization must deliver the planned services and programs.

The budgeting process is ongoing and dynamic and should provide feedback. This is essential in managing the budget. The budget-development workflow involves the following steps:

1. Collecting relevant data
2. Planning services
3. Planning activities
4. Implementing the plan
5. Monitoring the budget
6. Taking corrective measures when necessary

NOTE

Spreadsheets, typically in Microsoft Excel, are used to calculate all budget components at the unit level.

Step 1: Collecting Relevant Data

A critical task in creating a budget is collecting relevant data. The finance department ultimately collects this data but does so in collaboration with the nurse manager to create a functional budget. This includes the following information:

- **Services offered:** This data is collected by the nurse manager, who has the most insight into services currently on offer and those that will be offered in the future. For example, a nurse manager might plan to increase bed capacity in an underused nursing unit in response to an increase in the census in the past year and the knowledge that an additional surgeon will be coming on staff, which will increase volume even more.
- **Patient mix/case mix:** This pertains to the complexity of care. Generally, the more complex the case, the higher the reimbursement. The finance department of every hospital and skilled nursing facility calculates an overall case-mix index. The higher the number, the higher the reimbursement level.
- **Payer mix:** This number, also calculated by the finance department, reflects patient demographics. For example, suppose the payer mix indicates that 50% of the patients of a healthcare facility are below the age of 65 and have managed care insurance. Generally, for such patients, the length of stay is shorter and reimbursement is higher than for Medicare patients. Now suppose the payer mix indicates that 70% of a facility's patients are over 65 and that their primary insurance is

Medicare. For these patients, the length of stay will typically be longer and reimbursement lower than for patients with commercial insurance.

- **Acuity index:** This is a numeric calculation that considers the acuity of each patient in a given nursing unit to predict the level of staffing required. It used to be that the nurse manager or charge nurse on each shift assessed each patient in the unit and assigned a numeric acuity level to each one to calculate the acuity index. Because these were subjective assessments, however, the index was almost always inaccurate, typically predicting the need for huge increases in staffing that the organization could not afford. Today, most facilities use computerized systems, which are significantly more accurate.

NOTE

Many facilities do not use acuity systems. Instead, predictions for average, minimum, and maximum staffing requirements are based on census information, the type of nursing unit, and data from organizations that report hours of nursing per patient per patient day—for example, a state's hospital association.

In addition, the following data should be gathered:

- Hours provided per patient day
- Standards of care
- Plans for changes in services provided
- Plans for changes in resource utilization

All this information can be gleaned from the following data sources:

- **Historical information:** This data is composed of the prior years' history of operational performance found in budget reports. Information such as patient days, average length of stay, nursing hours per patient day, staff overtime, and so on are reviewed from prior years to make budget projections for the upcoming year.

Historical Budgets

From my experience speaking around the country, I've learned that most facilities see historical budgeting as a vital component of planning the next fiscal year's budget. When I was a Chief Nursing Officer (CNO), the finance department always provided me with useful historical information—usually from the previous four or five years—whenever I was planning the next year's budget. Reviewing data from previous years, I could quickly identify patterns and trends—for example, whether admissions or the average patient length of stay was increasing, decreasing, or remaining level, and whether there had been practice changes that drive patient length of stay—for example, when total hip replacements changed from an average length of stay of 15 days to one day. One of the data elements that I really homed in on was the nursing hours of care per patient day.

It is often sensible to review historical data from a shorter time period when major paradigm shifts in healthcare reimbursement occur. For example, in my state, New Jersey, all private insurance companies used to reimburse for acute inpatient hospital care using the DRG system. Then in 1992, the governor deregulated the healthcare insurance reimbursement industry in our state. This meant that from 1992 on, insurance companies negotiated rates individually with each hospital or hospital system. It also cleared the way for managed care. Afterward, anyone looking at historical data for New Jersey could clearly see a difference in average length of stay, admissions, and nursing hours per patient day. When we prepared budgets for 1993 and 1994, information prior to 1992 was suddenly rather outdated. It just did not make sense to track back too many years until the new system stabilized.

- **Statistical reports/prior year reports:** Statistical reports record one year of operations in an organization. After the year is up, a statistical report becomes a prior year report—part of the organization's history. In organizations that do historical budgeting, the finance department and the nurse manager refer to prior year reports when creating the budget for the next fiscal year.
- **Industry trends:** An example of an industry trend is a change in technology. For example, some orthopaedic total hip replacements now take an anterior approach, with the patient discharged the next day rather than enduring a three-day hospital stay. This affects reimbursement. Another example is the use of percutaneous cardiac interventions rather than coronary bypass surgeries in myocardial infarction patients. Other industry trends could relate to things happening in politics, such as decreasing reimbursement in the Medicare or Medicaid programs.

NOTE

Nurses must be attuned to what the federal government does with federal insurance programs, as well as what their state government does with Medicaid, charity care, and other state-managed programs.

- **Organizational goals and objectives:** These are developed by the top administration and are generally communicated to staff through department directors and administrators. Nurse managers formulate their own goals and objectives, which must be aligned with the overall organizational goals and objectives.

Understanding the Chart of Accounts

During the budget-creation process, the financial department will create a chart of accounts. This is a list of income (revenue), expense (what the business spends), liability (what the business owes), and asset (what the business owns) accounts used in maintaining their books in a general ledger.

The chart of accounts is set up by finance at the start of the business. Reference numbers are used to help classify the accounts by type. For example, in a hospital, each nursing unit will have a reference number. The chart organizes and tracks all business activities. Reports can then be easily generated in a logical sequence to track the financial history and progress of the business.

The chart of accounts does the following:

- It provides a format for the financial structure of the budget so that all expenses and revenues can be tracked and recorded.
- It structures the recording and reporting of activities (revenue and expense).
- It organizes the information.
- It identifies the various areas of responsibility and the types of transactions that occur in each.

I think of a chart of accounts as being like my household budget. In my household budget, which I place in columns in a tabular format, I list all my revenue—that is, the income I make from my primary job, my work as a nurse practitioner, consulting, etc. I then list all my expense items—for example, my mortgage, car payment, electricity costs, gas costs, credit card bills, and other expense items. Each column includes total amounts—for example, my total income from all that I do and my total expenses.

There are some differences between a chart of accounts and a household budget. I recently paid off the mortgage for my house, so I no longer need to list the mortgage amount as an expense. However, even though my home is an asset, I don't list it as such in my household budget. In contrast, a chart of accounts for a business would list the value of any fully owned assets—for example, physical plants. The chart of accounts would also list any liabilities.

Most nurse managers neither see nor prepare charts of accounts. Doing so is an accounting function of the finance department. However, it is important for nurse managers to know these exist and what they are for.

Step 2: Planning Services

The nursing department is generally aware of what types of services will be rendered in the next fiscal year. However, although the finance department may be aware of large projects, it might not be cognizant of every type of service that will be rendered.

If you are planning a new service for the next fiscal budget, this must be communicated to the finance department. For example, suppose a nurse manager in an emergency department is planning to launch a fast-track service to accommodate minor emergencies more efficiently. Because this new service will require additional staffing, the budget will have to be formulated with it in mind. That is, all associated costs, as well as projected volume and revenue, will need to be accounted for in the budget. It's crucial that the finance department be aware of this.

It is imperative that nurse executives work effectively with the individuals in their organization who control the purse strings. This is why I always cultivated an ongoing relationship with the finance department wherever I worked. I met biweekly with the budget manager, who also met with all of my managers on a biweekly basis. In addition, during budget-preparation

time, the budget manager met individually with my managers to plan the next fiscal year's budget. The purpose of all these meetings was to review current finance reports and to communicate current and future activities and planning.

There will almost always be budget surprises during a fiscal year. These, too, must be communicated to finance. Here's an example from my own experience: Back when laparoscopic surgery was in its infancy, some of our medical staff trained on the procedure and decided they wanted to implement it mid–budget year. This involved some costs—for example, the purchase of new equipment for the operating room. These weren't huge, but they were unplanned. I communicated this to the finance department, the chief financial officer (CFO), and the chief executive officer (CEO). I explained that equipping ourselves to perform these surgeries would increase revenue in the long run and that we would lose market share if we did not do it now. We then as a united group sold this to the board of directors, who approved the purchase of the equipment for the implementation of this new procedure.

With mid–budget year requests, it's critical to really analyze what is being requested. Ask yourself these questions:

- Can it wait until the next fiscal year?
- Will we lose market share if we delay purchase or implementation?
- What are the overall costs?
- Do the costs outweigh the benefits?
- Will revenue increase?

Step 3: Planning Activities

An example of an activity is a treatment offered by a department. New activities must be accounted for in the budget. For example, when tissue plasminogen activator (TPA) became available to treat myocardial infarction patients in emergency departments, nurse managers were aware of this, but

individuals in the finance department likely were not. This was a problem, because TPA cost approximately $2,000 per treatment. So, if the emergency department treated 2,000 myocardial infarction patients every year, and 75% of these patients could receive TPA, the cost would be upwards of $3 million. If the nurse manager failed to make finance aware of this new treatment and the associated costs, there would be a significant negative budget variance. Finance would also need to see if insurance would reimburse this new treatment. You can see why the nurse manager is critical to planning activities for the budget!

Defending Your Proposals

Often, creating a budget involves defending what you have proposed. This goes for nurse managers, too. Defending what you are proposing is a give-and-take process, based on the available resources of the organization.

One of the more challenging proposals to justify is a new nursing position or role. Take the role of clinical nurse specialist on a nursing unit. There is no doubt in my mind that a good clinical nurse specialist improves care and mentors and motivates nursing staff to excel. I hired my first clinical specialist in maternal-child health. This person was a dynamo who really improved care in this area. My vision was to have a clinical nurse specialist for every major service—neuro, critical care, operating room, etc. Each year, I would add a new clinical nurse specialist position to the budget. I had to justify this, but I used concrete outcome measurement data from the clinical specialists in the role. This provided data that enabled me to get approval on these positions.

In any case, it's generally true that when estimating the staffing and dollars needed to deliver care, the nursing department's figure will be higher than the finance group's. So, nursing and finance must come to agreement on the budget before presenting it to administration.

Having these two departments in agreement becomes an item of defense if the CEO does not approve the budget as submitted.

Speaking of the CEO, he or she will most likely question certain budgeted items. The item questioned most often is the care hours provided per patient day because these hours convert to staffed hours. Usually, nursing attempts to increase the hours. Care hours provided should be in alignment with the complexity of the cases and the acuity system used (if any).

Your best bet is to prepare for and anticipate such questions and to back up your answers with data. For example, if you predict more care hours due to an increased census, demonstrate with data:

- How the census has increased during the past year
- What percent occupancy your unit was, and for how long
- How this trend will continue into the foreseeable future

Finance can help you with this.

Step 4: Implementing the Plan

After upper-level administration and the board of directors approve the budget plan, the nurse manager implements it. Implementing the plan means providing the services. It's what occurs on a day-to-day basis with the provision of care to patients. Often, the process of implementing the budget plan will be similar from year to year. Sometimes, however, it might entail the enactment of new services or treatments.

NOTE

During the implementation process, budgeted expenses and revenue are compared to actual expenses and revenue.

Step 5: Monitoring the Budget

The budget must be monitored. Monitoring the budget involves the following:

- Routinely generating accurate financial reports
- Using these financial reports to compare actual revenue and expenses to budgeted revenue and expenses and identify variances
- Conducting variance analysis to examine variances in cost, efficiency, and volume

NOTE

Chapter 8 discusses various types of budget reports.

Who does what may vary from organization to organization. For example, the finance department usually generates reports, while the nurse manager typically identifies variances and conducts variance analysis. However, this might not always be the case.

Variance analysis is especially critical whenever there is a deficit—that is, when actual expenses exceed budgeted expenses or actual revenue is less than budgeted revenue. This is so that the nurse manager can determine exactly what is causing the problem. Armed with this knowledge, the nurse manager can take corrective action in the next budget cycle.

Step 6: Taking Corrective Measures When Necessary

Goals set forth in the budget may need to be modified depending on performance. A change in the types and levels of services and the resources used may also be required. To illustrate, recall the TPA example from earlier in

this chapter. Suppose that everything is going well with the administration of TPA and that the first quarter budget report is right on target. Now suppose that new evidence emerges during the second quarter that demonstrates that patients with an acute myocardial infarction should be treated promptly in a cath lab so that percutaneous cardiac interventions can be performed—for example, an angioplasty with stent placement. This evidence drives the decision to immediately begin triaging patients right to the cardiac cath lab instead of administering TPA in the emergency department. So, because fewer patients will receive TPA in the emergency department, that department will need to reduce its projected costs and revenue accordingly. Similarly, because the cath lab will see *more* patients, it will need to adjust its budget to account for more staffing and on-call shifts.

Management's Role in Budgeting

In terms of budgeting, management responsibilities are broken down as follows:

- **Department head:** Each department head or nurse manager is responsible for confirming the detailed operating expense budget for his or her department (cost center), consistent with organizational goals and objectives.
- **Director of budget:** The director of budget ensures that all budget forms are properly prepared and that data is accumulated within the specified timetable.
- **Vice presidents:** Vice presidents are responsible for the establishment of the basic annual budget formulation parameters. They assimilate departmental budgets into an organizational master budget consistent with organizational goals and objectives.
- **President/CEO:** The president or CEO has overall responsibility for the formulation and execution of the organization's budget. The president ensures consistency between the budget and divisional goals and objectives.

- **Finance committee and board of trustees:** These bodies are responsible for the review and approval of the completed operating budget.

In a healthcare setting, department heads and nurse managers are involved with some of the most critical functions in budgetary planning and the control process. They serve as the link between the plans of administration and the performance of the institution's workforce. If they fail to achieve the objectives and goals of the budget, the desired results will not be achieved.

Spotting a Dysfunctional Budget

Managers consider a budget to be dysfunctional when it is seen to be:

- **Rigid:** Some fiscal departments are very conservative. So, when the budget is created for the next year, it is more or less set in stone, or rigid. Even if variances are identified and explained, the budget will not change.
- **Externally imposed:** In some organizations, the budget is externally imposed by a higher administrative person—for example, a director of nursing. In one scenario, this person completes the budget with the finance budget manager and simply hands it down to nurse managers without their input. In another scenario, the nurse manager has an opportunity to offer input—for example, calling for more staffing—but higher administration determines that his request is not feasible. The nurse manager must then manage within the confines of the budget provided.
- **Interfering with interdepartmental/intradepartmental cooperation and communication:** Departmental cooperation and communication can suffer when one department receives more in the budget than another department. For example, suppose the nurse manager puts in a request in the capital budget for a new automatic blood pressure machine but it is denied.

Now suppose the radiology department puts in a request for a new CT scanner and it is approved. The CT scanner is in the million-dollar range. The automatic blood pressure machine is in the thousand-dollar range. The nurse manager's working relationship with the radiology director suffers because of this.

- **A tool for which managers are held accountable but do not have the authority to control:** Often, the nurse manager is held accountable for the budget but is not given the authority to control it. For example, in my first management job, I never saw the budget, nor did I ever see budget reports. Still, two years into the job, I was reprimanded for using too much overtime. Essentially, I was held accountable for the overtime, but because I had no access to the necessary reports, I had no authority to really manage it!

Inventory Management

In a healthcare setting, inventory management involves overseeing and controlling the ordering, storage, and use of supplies needed for the provision of care. A healthcare organization's inventory is one of its major assets.

Inventory is an investment that is tied up until the item is used. It also costs money to store, track, and insure inventory. Mismanagement of inventories can create significant financial problems for a healthcare entity, resulting in inventory excess or an inventory shortage.

NOTE

Hospitals and other healthcare organizations require that a lot of inventory be kept on hand for daily use. The amount kept available is based on prior history and projected volumes for an upcoming fiscal cycle.

Successful inventory management involves creating a purchasing plan that ensures that items are available when they are needed—but that neither too much nor too little is purchased—and keeping track of existing inventory and its use. Two common inventory-management methods are as follows:

- **Just-in-time ordering:** With this method, companies plan to receive items as they are needed rather than maintaining high inventory levels. Waiting to order a very expensive and rarely used surgical device until a patient schedules a procedure that requires it is an example of just-in-time ordering.
- **Materials requiring planning:** With this method, companies schedule material deliveries based on projected forecasts.

Inventory management also includes rotating stock, checking stock for outdated or near-outdated supplies, and making certain that supplies are on hand when needed.

One area in a hospital with particularly high inventory costs is the operating room. In most operating rooms, there is a procedure card for each type of surgical procedure. This card lists all the inventory items required for a procedure. Hospitals often design their informatics system so that when a nurse pulls the inventory for a procedure (based on the procedure card), the system automatically bills the patient's account and orders replacement inventory. This ensures that the correct amount of inventory is on hand and that the correct party is billed for the inventory. It also controls costs because excessive inventory is not maintained; items are replaced only when they are used.

The Importance of Paying Vendors

One Friday afternoon, knowing that Friday evenings often brought numerous trauma patients to the facility, the nurse manager at a busy inner-city emergency department checked the supply room for lactated Ringer's solution. After an extensive search, the nurse manager concluded that there were no bags of lactated Ringer's solution on the shelf.

The nurse manager called the central processing department that stocked supplies to ask why there was no lactated Ringer's solution. The answer was that they had run out of it. Upon further questioning, the nurse manager learned that the hospital was experiencing financial difficulty and had not been paying its vendors. The vendor that supplied the lactated Ringer's solution would not send more bags of it until payment was received.

Healthcare organizations that fail to pay vendors for inventory place the organization in jeopardy, as eventually the vendor will stop providing supplies. Vendor disputes like these *must* be addressed before a situation like this one unfolds. A well-functioning purchasing department would never allow such an event to occur. Vendors must be paid in a timely manner—especially for critical supplies. Imagine what would happen if the company that supplied the hospital's oxygen was not paid, and no oxygen was delivered!

The key is to negotiate reasonable charges. This can be done in several ways. One way is to explore how many companies make or distribute a particular item and obtain price quotes from all of them. Another is to work with multiple hospitals in a network to obtain a lower group price.

In this example, the emergency department in question was part of a two-hospital system, and fortunately, the other hospital had extra lactated Ringer's solution on hand to share. In an emergency, however, other crystalloid solutions, such as normal saline solution, could have been used.

Contingency Management

Contingency management is a management approach that involves identifying potential threats and vulnerabilities and implementing countermeasures to limit their impact should they occur (Nordmeyer, n.d.). The COVID-19 pandemic has clearly demonstrated the importance of continency management with regard to the supply chain.

One hospital I know took contingency management extremely seriously from the beginning of the pandemic. This hospital assembled key individuals

to form an oversight committee, which met daily out of a command center in the hospital. The committee turned to the organization's informatics department to obtain key metrics and statistics to perform predictive analytics. It also called for daily inventory checks. Finally, it worked with its state's department of health, which updated incident rates daily. As a result, this organization has had enough personal protective equipment, patient care equipment (such as ventilators, ED beds, and ICU beds), and so on, available at all times.

This committee also paid close attention to the vaccine trials. Four months before the FDA approved the Pfizer vaccine, the committee predicted that this would likely be the first vaccine approved and purchased the sub-zero refrigerators needed to store it. Again, this was *four months* before vaccine approval!

This story demonstrates what predictive analytics and a proactive organization can accomplish.

Interview With a Chief Nursing Officer

This nursing executive is the corporate VP of a three-hospital system, which is itself part of a larger healthcare system in the Philadelphia area. I posed a series of questions that were pertinent to gaining a better understanding of nursing operations in a hospital system.

Q. ***What is the average nurse staffing in your organization?***

A. Staffing in this system is as follows:

- One nurse to four to five patients (when it exceeds five patients, staff can feel it)
- One nursing assistant to eight to 12 patients
- One safety associate sitter for one-to-one observations (for example, with suicide ideation)

Q. ***What is the nursing management structure in your organization?***

A. The system uses a lean management structure, with one manager to 35 staff reports. (The industry standard is one manager to 17 staff reports; this keeps finance off of nursing, as management-wise, nursing is very lean.)

Q. ***Does your organization use an acuity system to determine nurse staffing levels?***

A. No acuity system is used. Minimum, maximum, and average staffing ratios are defined.

One nursing unit created an algorithm for assignments. It looked at data from nursing, patient and nursing satisfaction, geography, breaks, and where supplies were located on the nursing unit. They then assigned staffing accordingly. This created great staff satisfaction, as they were in control of their situation.

Q. ***How is the nursing budget developed?***

A. The budget is developed as far down as the unit level. Every nurse manager meets with the CNO and the financial representative for nursing. Having one financial representative for nursing has been the most effective strategy. To address variances, the financial representative contacts the nurse manager or vice versa. This has created greater accountability for the nurse manager. For example, one nurse manager recognized that the use of infant formula had increased but volume had not. An investigation ensued, which revealed that infant formula was being stolen by employees at the hospital's loading dock.

Q. *What impact has COVID-19 had on the organization?*

A. With regard to COVID-19:

- Staff are tested only if there is an exposure. They are then quarantined for 14 days or until a negative test result is obtained.
- Flex staffing was implemented.
- More staff were hired into a float pool so they could be reassigned to other nursing units where they are competent.
- The organization has had to access local, national, and global supply chains.
- The organization is now preparing for the next phase of the pandemic and stockpiling supplies.
- The organization has seen an increase in patients and staff with depression, anxiety, PTSD, and substance use disorders. Increased anxiety among the children of staff members has also been observed.
- The pandemic has resulted in increased early retirements. (One retiree stated, "It just is not worth coming to work and being stressed.") Nurses are leaving the profession earlier than their retirement age. There were three retirements during the summer months, which was unusual, as most nurses retire sometime in December.

Summary

This chapter discussed the following:

- Step 1: Collecting relevant data
- Step 2: Planning services
- Step 3: Planning activities
- Step 4: Implementing the plan
- Step 5: Monitoring the budget
- Step 6: Taking corrective measures when necessary
- Management's role in budgeting
- Inventory management

Reference

Nordmeyer, B. (n.d.). What is contingency management in a business? *Chron*. https://smallbusiness.chron.com/contingency-management-business-23285.html

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NOTE: Page references with an *f* are figures; Page references with a *t* are tables.