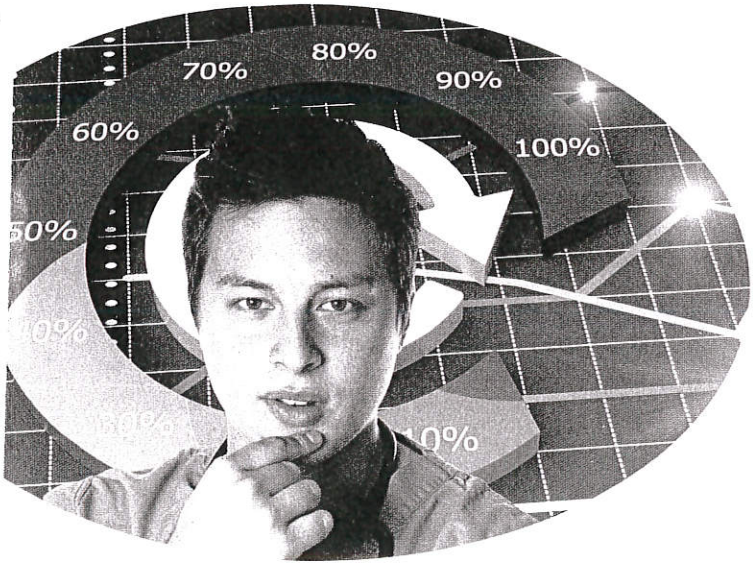
Budgets - Part 1

The business of caring: What every nurse should know about cutting costs

By Rose Sherman, EdD, RN, NEA-BC, FAAN

KATE PETERSON, an intensive care unit (ICU) director, starts her monthly staff meeting with sobering news: "Our hospital is losing money despite the increase in patient volume," she states. "Reimbursement for care has been declining, and we're seeing more uninsured patients who can't pay their bills. So our unit's request for new monitors has been put on hold for this year. And we'll need to carefully watch our staffing, overtime, and use of supplies. We're all in this together. I need your help and creative ideas to help reduce our expenditures."



Announcements like this are being made in nursing staff meetings across the United States. Like it or not, health care is a business—one that's under tremendous pressure to cut costs. Healthcare costs in the United States have skyrocketed to an average of $8,000+ per person each year. Left unchecked, they could rise to $13,000+ per person by 2018.

The phrase "No money, no mission" is sometimes overused. But sound financial management is important in all healthcare environments, whether for profit, not for profit, or publicly financed. To advocate successfully for the resources needed to staff and operate their units, nurses need to become more financially savvy and increase their understanding of healthcare costs.

Learn how you can help make a difference in your unit budget.

Who pays for care?

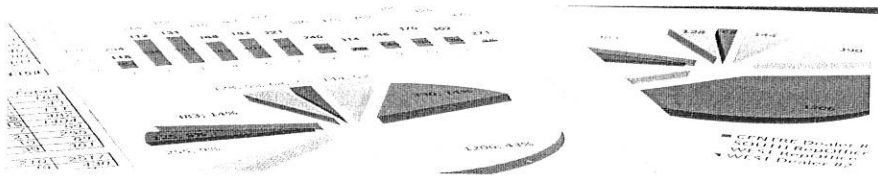
Payment for health care in the United States is a complex web involving insurance companies, government agencies, and out-of-pocket payments by consumers. More than half of healthcare costs are paid by private insurers or individuals. The federal government is the single biggest payer, through Medicare, Medicaid, and the Department of Veterans Affairs.

Some healthcare costs aren't paid at all, due to lack of an adequate healthcare safety net. Currently, 47 million people in the United States lack health insurance. Many go without preventive care, but everyone is entitled to (costly) emergency care under the Emergency Medical Treatment and Active Labor Act regardless of their ability to pay. If no further changes are made to the Affordable Care Act (ACA), coverage will expand to 32 million of the currently uninsured population. A large percentage of these persons will be insured under expanded state Medicaid programs. While this should help reduce the amount of unreimbursed care, significant changes are coming in the payment structure that will affect hospitals and other care providers as insurers attempt to decrease healthcare costs.

Trend toward pay for performance

Recent discussion of healthcare reform has focused on how costs can be reduced. Historically, healthcare providers and hospitals have been paid based on the volume of care they provide. But with the ACA, this system is changing. Payment incentives are moving away from a volume basis toward a greater focus on value of services and health outcomes, including fewer hospitalizations. A 2011 report to Congress titled National Strategy for Quality Improvement in Health Care stated that the overall goal for healthcare is "to ensure that all patients are provided with the right care, at the right time, in the right setting, every time."

These changes are putting more pressure on nurse



leaders and other managers to increase efficiency while improving quality and patient outcomes. Reimbursement will be tied more closely to performance on various care measures (including the patient experience)—many of which are nurse-sensitive. The value-based trend in hospital reimbursement will benefit from nursing support.

Outcomes and the bottom line

As a nurse, you need to understand how patient care outcomes affect your employer's financial bottom line. For example, starting in 2013, more than 2,000 U.S. hospitals will lose Medicare reimbursement money because too many of their patients are being readmitted within 30 days of discharge. Also, certain types of patient situations are now considered "never" events—events that shouldn't happen during a hospital stay, such as pressure ulcers, falls, and hospital-acquired infections. Hospitals are no longer being reimbursed for care related to these events.

Are hospitals being targeted unfairly? Perhaps, but a key part of the healthcare financing puzzle is how dollars are being spent. Hospital care is the single biggest spending category (31%) of the healthcare dollar pie. Not surprisingly, when cuts are proposed, this big-ticket item is eyed first. In our opening scenario, Kate Peterson is wise to educate her staff about what's happening to their hospital financially and how it will affect their unit. When you understand the nuts and bolts of budgets at the unit level, you're more motivated and involved in reducing costs. Each nursing unit is part of the larger organization, which depends on qualified nurses to manage the business and understand the bigger picture.

Items in a unit budget

A budget is an annual plan that includes the organization's goals and objectives, lists all planned expenses and revenues, and guides the organization on the best use of human and material resources. Budgetary planning promotes use of the best methods to achieve financial objectives while ensuring patients receive high-quality, cost-effective services. During budgetary planning, expense and revenue projections are reviewed and compared. If they're not in balance, the budget is reviewed to seek ways to reduce expenses without impairing the services that support revenues.

Healthcare organizations use various types of budgets, including operating budgets and capital budgets, to plan and monitor their financial status. (See *What's in a capital budget?*) The *operating budget* is especially relevant to nurses because they're closest to the patients and know what's needed to provide appropriate care and services on a daily basis. Each nursing unit is considered a cost center and has an operating budget, whose major components are revenues and expenses. The operating budget monitors anticipated day-to-day activities, resources, personnel, and supplies—typically over a 1-year period.

Revenue is based on charges. It's the money the organization receives for patient visits, procedures, and inpatient hospitalizations from Medicare, Medicaid, private insurers, or patients themselves. Of course, not all charges are paid in the full amount. Some may be discounted depending on the payer. Many insurers pay a flat rate per day for an inpatient hospital stay. For a nursing unit, budget revenues are projected from the total number of days patients spend on the unit or the average daily census. As Kate Peterson pointed out to her staff, during these challenging times, a hospital might be losing revenue even if a unit has a full census. Be aware that nursing services aren't considered revenue-producing; instead, they're included in overall room and board charges.

Expenses include the cost of nursing staff, activities, supplies, and other items used to run the nursing unit. An operating budget has two main types of expenses: employment costs and non-salary expenses.

- *Employment costs* (the largest part of the unit budget) include salaries and wages for hospital employees and contract staff, including overtime, shift differentials, holidays, orientation, education, in-service sessions, and benefits.
- *Non-salary expenses* include medical supplies used for patient care (such as I.V. tubing and dressings), pharmacy costs for stock medications and syringes, office supplies, equipment rentals (such as copy ma-

What's in a capital budget?

Usually separate from the operating budget, the capital budget is a projection of the planned costs of major purchases, including equipment, maintenance, renovations, and new construction. Each capital budget item is listed as the price of the item or project, along with the duration of its expected use.

Organizations use a designated point (such as $500 or $1,000) as the cutoff point above which an item belongs in the capital budget rather than the operating budget. Capital budgeting has gotten more difficult as healthcare technology has become more complex and costly. During tough times, requests for capital items are more likely to be denied. The chief financial officer must analyze each item's financial implications to determine if the hospital will have a sufficient number of patients needing procedures related to that item, and if reimbursement for these procedures will pay for the cost of the new item. Any needed renovations, supplies, and staff required to operate the equipment and care for patients also must be taken into account when deciding on capital equipment purchases.

chines), repairs and maintenance of equipment used on the unit, and staff travel for educational purposes.

How nurses can help reduce healthcare costs

After a unit budget is approved, it must be monitored continuously to ensure expenses stay within projected budgetary limits. The nursing manager gets feedback on actual expenses—data that show any discrepancies between budgetary projections and actual results; these are called variances. Unit managers work to modify expenses and thus correct variances, ensuring that each department stays within budget for the year and expenses are controlled.

Nursing is the largest professional group in the hospital—and usually the most expensive. As a nurse, you can play an important role in helping reduce costs. Based on the unit census and patient acuity, a targeted number of hours per patient day (HPPD) is designated. When nursing hours exceed the HPPD needed by patients, nurse managers typically are required to submit a report explaining the reason. Nurses can help make a difference in their unit budgets by not overstaffing their unit when they are in charge, avoiding excessive use of unscheduled leave that could require overtime, and monitoring the use of supplies.

With declining healthcare reimbursement and growing numbers of patients unable to pay for their health care, nurses are expected to do more with less. Meeting this challenge will take innovative thinking and involvement of all staff. The business of caring is perhaps more important today than ever. Your involvement, interest, and support can help ensure patients receive high-quality care, and can go a long way toward promoting your organization's healthy financial future. ✶

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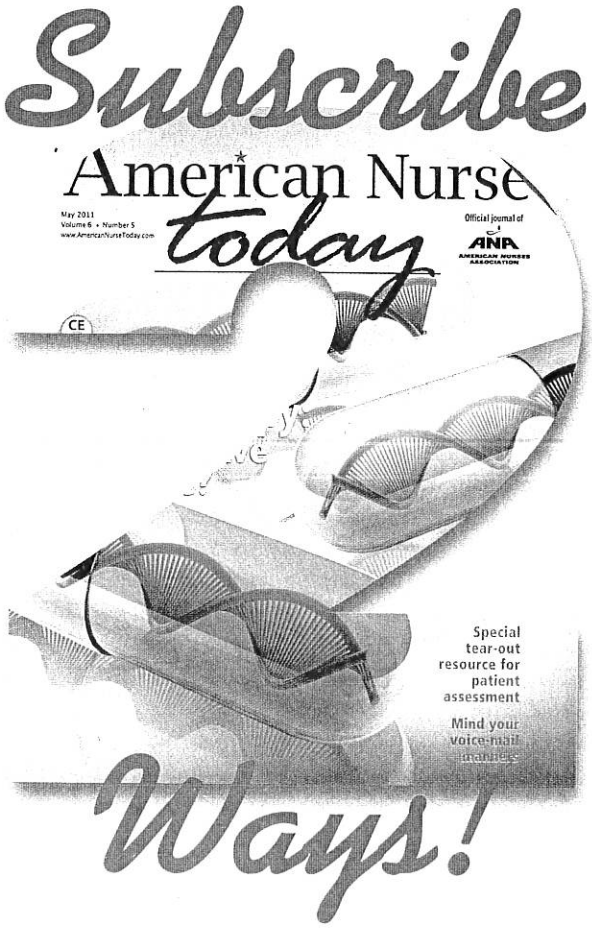

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Does evidence-based nursing increase ROI?

(Return on Investment)

Part 1
Budgets

By Marita MacKinnon Schifalacqua, MSN, RN, NEA-BC, FAAN; Sr. Maurita Soukup, MSN, RN, PhD; Wanda Kelley, MSN, RN-BC; and Alison Rich Mason, BA, BSN, RN

CATHOLIC HEALTH INITIATIVES (CHI) is committed to improving the patient and family experience through evidence-based practices (EBP) and other effective improvement strategies. Based in Englewood, Colorado, CHI is the third largest not-for-profit healthcare system in the United States, with more than 70 hospitals and 30,000 nurses.

Our EBP program aims to bring evidence-based care to the patient using systemwide standards of care, toolkits, education, organizational-level engagement, and metrics for determining clinical and fiscal impact. The program includes four clinical metrics and one financial metric for cost-of-care avoidance related to reducing preventable adverse events for which the Centers for Medicare & Medicaid Services no longer reimburses healthcare costs.

This article describes CHI's cost-of-care metric for five healthcare-acquired conditions (HACs)—catheter-associated urinary tract infections, methicillin-resistant *Staphylococcus aureus* infections, *Clostridium difficile* infections, surgical "never" events, and patient falls. Our metric calculates cost savings when an HAC is avoided. Developed and successfully implemented within 18 months, this initiative serves as an organizational- and system-level vehicle for evaluating costs avoided by implementing specific care bundles for HAC prevention.

To help prevent surgical "never" events, CHI implemented the World Health Organization's surgical checklist and recommended practices of the Association of periOperative Registered Nurses to reduce complications and death rates in patients undergoing surgery across a diverse group of hospitals. CHI also implemented a care bundle to prevent healthcare-associated infections, based on established guidelines from national sources, such as the National Healthcare Safety Network of the Centers for Disease Control and Prevention.

Cost avoidance plus cost savings

The Institute for Healthcare Improvement uses the term "dark green dollars" when quality-improvement initiatives yield cost savings that can be tracked to the bottom line through both cost avoidance and cost savings. At CHI, the average cost of each incident type was established during the planning phase of our initiative through an extensive review of empirical literature on cost averages associated with each HAC. This allowed us to establish a benchmark cost to gauge the return on investment (ROI) realized through cost avoidance. (See *Costs for each healthcare-acquired condition.*)

> Implementation of five care bundles decreased healthcare-acquired conditions by 30%.

Advancing understanding of data

Our cost-of-care calculator tool allows local and system-level users to understand the contributions of nurses and other caregivers to EBP, specific to care bundles and estimated cost avoidance when these bundles are used. Data transparency advances clinicians' understanding of nurse-sensitive measures linked to ROI methodology and accountability.

Costs for each healthcare-acquired condition

This table shows costs per event for five healthcare-acquired conditions (HACs) for which Catholic Health Initiatives implemented care bundles. When a range was reported, the lower figure was used to calculate estimated cost avoidance. This is important when interpreting findings, because estimated cost avoidance represents an underestimate, not an overestimate.

HAC	Estimated cost of care
Catheter-associated urinary tract infection	$758 per infection
Clostridium difficile infection	$5,042 per infection
Methicillin-resistant *Staphylococcus aureus* infection	$6,400 per infection
Patient fall	$4,233 per fall occurrence
Surgical "never" event	$62,000 per event

Created with Excel Workbook, our cost-of-care metric was designed to measure organizational- and system-level estimated cost-avoidance costs by volume-of-event occurrences during baseline and measurement periods. In the metric, the volume of baseline-period event occurrences is multiplied by the estimated cost associated with one event occurrence, followed by subtraction of data for the measurement period.

HAC occurrences are reported quarterly using agreed-on formulas. The general formula for calculating cost-avoidance costs incorporates the numerator divided by the denominator, along with rate definitions and calculations for specific outcome metrics. (For detailed formulas used with each care bundle, see *Formulas for calculating event occurrences.*) At CHI, total system findings between the baseline and measurement periods for each of five care bundles implemented showed a 30% decrease in HACs, yielding an overall estimated cost avoidance of more than $8 million aggregated for fiscal year 2010.

CHI's cost-of-care metric supports a culture of safety and nursing's contribution to creating healthcare value. It focuses on the role of event prevention in improving patient outcomes during hospitalization, and links prevention with fiscal metrics in determining estimated cost avoidance. A synopsis of clinical outcome improvement and estimated cost avoidance provides compelling evidence that connects EBP to financial metrics. ✶

Formulas for calculating event occurrences

This table summarizes formulas used to calculate event occurrences for five care bundles implemented at Catholic Health Initiatives. The general formula for calculating cost-avoidance costs incorporates the numerator divided by the denominator; the result is converted to a rate for specific outcome metrics. (The surgical "never" event rate simply reflects the number of occurrences and is not formula-based.)

Care bundle	Formula
Catheter-associated urinary tract infections (CAUTIs)	Numerator: number of patients with healthcare-acquired CAUTIs Denominator: total number of patient days x 1000
Clostridium difficile infections (CDIs)	Numerator: number of patients with CDIs Denominator: total number of patient days x 10,000
Methicillin- resistant *Staphylococcus aureus* (MRSA) infections	Numerator: number of patients with MRSA infections Denominator: total number of patient days x 1000
Patient falls	Numerator: total number of falls in acute-care settings Denominator: total number of patient days x 1000
Surgical "never" events	Number of surgeries with documented adverse events (no formula used)

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