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The CNO/CFO Partnership: Navigating the Changing Landscape

Executive Summary

- With increasing pressure to cut costs, both real and immediate, and those forecasted and anticipated, the partnership and collaboration between nursing and finance will continue to take on new challenges.
- This partnership has historically been strained and does not always come easy due to differences in focus, different priorities, and inadequate communication, listening, and hearing.
- That needs to change and a strong CNO-CFO partnership is needed.
- Nursing leaders need to understand and appreciate the financial constraints and balance them with expected outcomes, and financial leaders need to understand and appreciate the core clinical business and what gaps in care mean to the financial viability of the organization and to patient outcomes.
- One health system developed a platform for change and is dedicated to the hard work involved in continuously working on those partnerships so when it comes to patient quality, safety, and financial performance, nursing and finance leaders are well positioned for future health care challenges.

MANAGING THE BUSINESS OF health care delivery requires an appreciation for the complexity of how care is delivered and how it is financed. No two people know the inherent challenges of this interface between finance and quality/safety considerations better than the chiefs of nursing and finance. A critical aspect of their roles is aligning the financial and care processes.

There are great examples of strong collaboration between chief nursing officers (CNOs) and chief financial officers (CFOs). Spectrum Health in Grand Rapids, MI, and Yavapai Regional Medical Center in Prescott, AZ, stand out as two exemplars in the literature (Brennan, Hinson & Taylor, 2008; Hudson-Thrall, 2007). At Spectrum Health, which staffs nearly 1,000 beds with an annual operating budget of $1.2 bilion, Shawn Ulreich, CNO, and Joseph Fifer, CFO, maintain that better cooperation and collaboration translate into better financials. At Yavapai Regional, finance and nursing departments view it as their responsibility to work as a team, not as adversaries.

Despite these positive examples, Hudson-Thrall (2007) states financial executives too often live and breathe balance sheets and operating margins, while nurse leaders are steeped in clinical care indicators. In 2005 the Healthcare Financial Management Association (HFMA) held a series of focus groups and found the relationship between nursing and finance at many hospitals was cordial but cold at best, and, at worst, downright adversarial. According to Richard Clarke, HFMA president and chief executive officer of HFMA, "Finance folks talked about nurses that would ask for budget allocations without a business case, and referred to nurses' 'faulty math.' Nurses would say, 'Finance only talks to us when they have to cut dollars,' and that finance managers simply didn't understand the dynamics of running a patient care unit" (Hudson-Thrall, 2007).

As a goal at Main Line Health

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(MLH), the senior vice president/chief nursing officer (SVP/CNO) and executive vice president/chief financial officer (EVP/CFO) recognized the need to collaborate and work together to deliver the right amount of care at the bedside... not too much and not too little, each and every day. As seasoned senior health care leaders, we know firsthand the benefits of a positive CNO-CFO partnership as well as the potential hardships associated with a negative one. Everyone, most importantly the patients and the nurses, who care for them, benefit from a strong nursing-finance partnership and collaboration.

An organization-wide journey over the past 3 years, which focused on close examination of the care delivery system and the financial resources needed to support it, is described. The skills, trust, and determination to obtain results that have brought us closer to the goal of getting our staffing "just right" are discussed. Delivering the right amount of care is critical to achieve the strategic goals of patient safety and quality care. From the beginning we recognized this is a team sport and neither nursing nor finance could succeed independently. To achieve success, we pledged partnership.

Even with our initial success, we recognize that as we move forward in uncertain times, the real test of that partnership is whether it will be preserved, and perhaps even thrive, when the going gets tough and the funding gets tight – the very situation health care executives find themselves in today. Having this solid relationship as a foundation is key to finding solutions in a new health care world.

The Main Line Health Case Study

Main Line Health is suburban Philadelphia's most comprehensive health care provider, offering a full range of medical, surgical, obstetric, pediatric, psychiatric, and emergency services. At the core of MLH are four of the region's most respected acute care hospitals – Bryn Mawr, Lankenau, Paoli, and Riddle – as well as a nationally recognized provider of rehabilitative medicine, Bryn Mawr Rehab Hospital. MLH is especially recognized for cardiac, orthopedic, oncology, rehabilitation, women's clinical services, and trauma.

MLH has 1,168 licensed beds, over 10,000 employees, and 1,900 physicians, making it one of the largest employers in southeastern Pennsylvania. MLH is the recipient of numerous awards, including the nation's top 100 Most Wired Hospitals and Health Systems, one of the Best Places to Work in Pennsylvania by the *Philadelphia Business Journal*, and one of the Best Places to Work in Healthcare by *Modern Healthcare*. Three of the MLH hospitals – Bryn Mawr, Lankenau, and Paoli – were awarded Magnet® designation by the American Nurses Credentialing Center in 2005 and in 2010. Riddle and Bryn Mawr Rehab hospitals are currently on the Magnet journey.

In 2006, a full-time CNO position was established for the five hospitals. This replaced the individual who had assumed CNO responsibilities for the prior 7 years in addition to being the president of Paoli Hospital. After the initial Magnet designation in 2005, the incoming CEO, who was experienced with Magnet organizations, recognized the need for ramping up the organizational commitment to nursing leadership on a full-time scale.

The MLH organizational structure is a combination of direct and matrix reporting relationships. Each hospital is headed by a president who reports directly to the MLH President and CEO. Each hospital has a nursing vice president (NVP) who reports directly to the respective hospital president and has a "dotted line" relationship to the MLH SVP/CNO, Nancy Valentine. In contrast, the director of finance at each hospital reports directly to the MLH EVP/CFO and has a "dotted line" relationship to the respective hospital's president. Both the SVP/CNO and EVP/CFO report directly to the MLH President and CEO. The difference in reporting relationships did not make a substantive difference in the work of developing the strategic partnership between nursing and finance. However, the role of CNO as influencer required bringing all parties together in the spirit of collaboration for outcomes, independent of formal reporting relationships.

MLH nursing budgets are developed at each hospital and are based on MLH system-level targets. The budget development process includes the president, NVP, and hospital-based director of finance in collaboration with the EVP/CFO. The SVP/CNO's role has evolved over the past 4 years. The SVP/CNO has been the nursing driver for building a standardized approach for developing and managing staffing system wide. To support this, a system-level director of nursing resources, Kathleen Wolf, provides nurse manager education and technical assistance to meet the budgeted targets. Creating solutions together has resulted in a shift from the individual entity to system solutions. This case study is based on how the system approach was organized.

The Devil Is in the Details

In March 2007, the MLH SVP/CNO was asked by the MLH President and CEO, Jack Lynch, and the EVP/CFO, Mike Buongiorno, to examine variations in nursing budgets and spending at each of the MLH hospitals and to work toward a common approach. Collectively, nursing costs across the system were over budget. The reasons for the variance were unclear. To assist with the analysis the SVP/CNO engaged a consultant, Karen Kirby, with a strong foundation in nursing administration and finance to quantify and define the key contributors of

budget variances by hospital.

When all the FY '07 data were reported in August of that year, nursing financial and productivity data for each of the MLH acute care hospitals – Bryn Mawr, Lankenau, Paoli, and Riddle – were examined. Key elements reviewed were the total variance in salary expense against budget at each hospital and the causes of the variance, including variances in budgeted to actual patient days, variances in budgeted to actual paid and worked hours per patient day, variances in budgeted to actual salary rates per hour, and variances in budgeted to actual nonproductive time. Each of these variables was also compared across the hospitals by unit type, including intensive care unit, telemetry, medical/surgical, and perinatal services. The case mix index (CMI) at each hospital also was considered to see if it contributed to spending differences.

Collectively, the four acute care hospitals ended FY '07 over budget by $7.1 million, or 6.4%, with individual hospital variances ranging from 1.9% to 7.8%. Reasons for the variances differed among the hospitals and included nonproductive time being budgeted too low, salary rate per hour below or above budget, patient days higher than budgeted, and not hitting the budgeted hours per patient day (HPPD). At the conclusion of this assessment there was agreement between nursing and finance that additional steps were needed to improve and standardize nursing financial management across MLH. It was clear this work would require close collaboration between nursing and finance. To achieve that goal, the SVP/CNO and EVP/CFO served as executive sponsors on a project conducted over 3 years, in three phases using a framework of creating and achieving best practices through building consensus.

Phase I: MLH Nursing Financial Best Practices

MLH works on a July 1 to June 30 fiscal year. The financial best practices project was launched in January 2008, at the beginning of the FY '09 budget development cycle. The expectation was that new nursing budgets would be developed for FY '09 by the end of March to go into effect July 1, 2008.

The overall goal of this project was to develop consistent, equitable, and credible nursing service budgets and monitoring tools that meet the patient care and financial objectives at all MLH hospitals and ensure budget compliance. The MLH president and CEO was clear that quality patient care objectives were the basis for the financial objectives. The objectives for this phase were:

1. To establish benchmarks for nursing hours per unit of service and staff mix that are consistent and accepted by nursing, executive management, and finance at all MLH hospitals.
2. To establish mechanisms for consistently budgeting and capturing *all* units of service within the MLH hospitals, including patient days, ambulatory visits, observation days, OR cases, ED visits, L&D cases, PACU visits, etc.
3. To develop efficient, effective, and credible tools for budget development, budget monitoring, and regular variance reporting across all MLH hospitals.
4. To improve the nursing service budget development and monitoring process by establishing three well-defined nursing budget categories – direct, indirect, and nonproductive – all of which are developed and monitored differently.
5. To develop consistent and credible standards for what is included in indirect full-time equivalents (FTE) at each MLH hospital, to include nurse managers, unit secretary, and other elements acceptable to all stakeholders.
6. To develop consistent and credible standards for determining nonproductive requirements at each MLH hospital, to include paid time off (vacation, holiday, and sick time), orientation, and staff education.

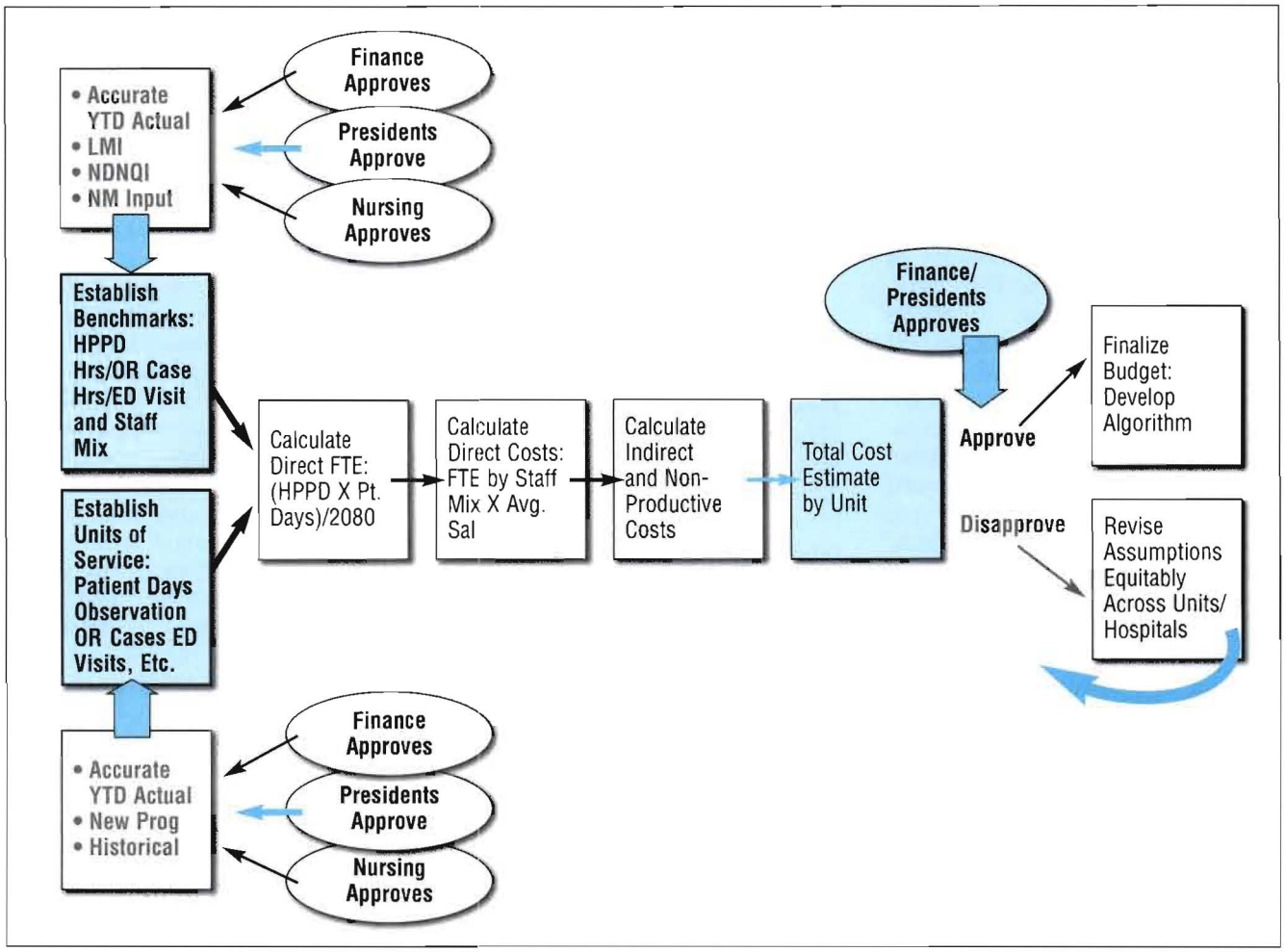
The initial meeting included the consultant, who had the responsibility for coordinating the effort with representatives from across finance and nursing. The purpose of the first meeting was to discuss the budgeting process and data available from finance to assist in developing budgets.

Since day-to-day compliance with meeting budget compliance is the responsibility of the nurse managers in concert with their respective directors, a directors' work group was established with one to two nursing directors and the director of finance from each hospital, along with the consultant and others from corporate finance. The consultant led this group in setting agendas, leading meetings, gathering best practices data and benchmarks, conducting analysis, and documenting recommendations. This working group took all recommendations to the hospital NVPs for input and approval and ultimately to the SVP/CNO and EVP/CFO for their approval and presentation to the hospital presidents. The approval process approved by hospital presidents is illustrated in Figure 1.

During the initial phase, the two steps that required the most time and effort were the definition and categorization of direct, indirect, and nonproductive time and the development of benchmarks for direct HPPD. Definitions for direct, indirect, and nonproductive FTEs were established as follows:

- *Direct FTE* includes all staff members who spend at least 50% time in direct patient care and who are replaced when

Figure 1.
MLH Nursing Financial Best Practices Project – 2008



not available – typically all RNs and patient care technicians. It also includes charge nurses and any licensed practical nurses and nursing assistants. *Direct FTE will be determined based on budgeted patient days (or cases) and budgeted hours per patient day (or case). Direct FTE will vary throughout the budget year based on actual patient days (or cases) only. The budgeted hours per patient day (or case) will remain constant unless a change in patient acuity can be demonstrated and is appropriately approved.*

- *Indirect FTEs* include nurse managers, unit secretaries, coordinators, and any other staff members who spend less than 50% time in direct patient care and who are not replaced when not available.
- *Nonproductive FTE* includes vacation, sick, and holiday time, as well as orientation, and staff meeting and education time. It was acknowledged that it would be preferable to include orientation, meetings, and education time in *Indirect FTE* to reflect that it is productive time but this would have required major changes to the MLH payroll system.

The CFO requested a review of FTE categories for all MLH nursing jobs to indicate which were direct and indirect so time would be captured appropriately for budget monitoring. Another decision that required careful consideration and debate within the directors' working group was categorizing sitters (1:1 staff), particularly because their use was growing. It was ultimately agreed sitters would *not* be included in direct FTEs. Sitters would be captured in a separate cost center because patients still required other caregivers, and sitter (1:1) utilization would be reported by nursing unit. Nurse managers would be held accountable for controlling this cost.

In this phase, setting staffing benchmarks were limited to ICU,

Table 1.
MLH Nursing Benchmarks (2009)

Unit Type	DHPPD	RN %	Patients per RN	Patients per Tech
Med-Surg	7.5-7.9	60-65	4.7-5.3	7.6-9.1
Telemetry	8.3-8.5	65-70	4.0-4.6	8.1-10.0
Step Down	8.6-9.0	70-75	3.6-4.0	8.9-11.2
CCU	13-15	85-90	1.8-2.2	10.7-18.5
ICU	15-17	85-90	1.6-1.9	9.4-16.0

telemetry, and medical/surgical units. Perinatal services, emergency departments, and perioperative areas were delayed due to budgeting time constraints. The process of benchmarking was particularly difficult without the availability of patient acuity data to help determine differences in patient needs on similar units at each of the hospitals. Although each of the hospitals had access to the Labor Management Institute survey of nursing hours data (Suby, 2008) survey findings were not used consistently or in the same way by the hospitals. Likewise, Lankenau, Bryn Mawr, and Paoli Hospitals had National Database of Nursing Quality Indicators (NDNQI) data but findings were questioned because of significant differences in the units reporting into the same category. Most notably, units reporting as step down in NDNQI ranged from true step-down units with very acute patients coming from ICUs to units similar to medical/surgical units except for telemetry.

Benchmarks for direct hours per patient day (DHPPD) and staff mix were ultimately agreed upon after extensive discussion, review of multiple national and local benchmarks, and consensus building within the directors' working group. A range for each metric was established to allow flexibility for differences in acuity at each hospital. Table 1 shows the agreed upon benchmarks.

Once the benchmarks were established, the DHPPD and staff mix were budgeted for each nursing unit, and staffing algorithms were put into Excel spreadsheets to quickly calculate the number and level of staff required by census level. Nurse managers were instructed that staffing algorithms were guidelines for daily staffing purposes. If patient acuity warranted adding staff on a particular day or shift, that should be done, provided staffing was reduced on lower acuity days to meet targets each pay period.

Phase II: MLH Nursing Financial Best Practices

The goal of this phase, which started upon completion of the FY '09 budget, was to ensure appropriate budget implementation and monitoring. The first step was to provide a 1-day workshop for nurse managers to provide a clear understanding of how their budget was developed, how to implement it, and how to monitor it effectively and provide appropriate variance reports. These workshops were also attended by members of the finance departments at each hospital. The program was well received with high evaluation scores, particularly when directors of finance attended and actively participated. The goal of the educational session was to strengthen the nursing-finance partnership at each hospital, create cross-sharing of goals system wide, and develop common language and understanding.

Simultaneous with implementing the FY '09 budget, the Advisory Board Company's *Nursing Compass* system was introduced to provide nurse managers daily workload management and productivity data. The system was started at one MLH hospital – Bryn Mawr – where both the NVP and director of finance showed a strong commitment to collaboration and maximizing *Nursing Compass*. The *Compass* implementation, however, took longer than anticipated. By December 2008, it was clear a short-term solution was needed by nursing and finance to examine variances by nursing unit bi-weekly. This was prompted by the fact that as of October, 5 months into FY '09, patient days were below budget and nursing expenditures were 5% over budget. Although DHPPD were being managed close to budget, the use of nonproductive time and overtime was high.

In December 2008, the MLH "flash report" was launched by the EVP/CFO to provide management with a basic tool that could assess accountabilities by nursing departments. The consultant developed the flash report template, and the finance directors refined it to be applicable to MLH. Each hospital had its own flash report showing direct and indirect HPPD by pay period and year to date (YTD) compared to budget targets. The report also showed current pay period and YTD average daily census and its favorable or unfavorable target FTE by nursing unit, shown in Table 2. Hospital-specific data were wrapped into a comprehensive MLH flash report that showed all nursing units grouped by specialty (neonatal intensive care unit, ICU, step down, medical-surgical, and other), shown in Table 3. At the close of FY '09, total nursing FTEs were over target by 1.4%, a marked improvement over prior years. The partnership was making a difference.

During this phase, the FY '10 nursing budget was developed. Regular meetings were held with the directors' working group to review progress and set FY '10

Table 2.
Hospital Report

	Worked Hours Per Patient Day						Average Daily Census		FTE Variances	
Direct Hours per Patient Day	FY11 Target	FYE 6/30/10	Pay Ending 4/30/11	Actual YTD	YTD Variance	YTD % Variance	Pay Period ADC	YTD ADC	Pay Period FTE	YTD FTE Variance
Psych Unit	6.00	6.02	6.36	5.81	0.19	3.17%	17.50	18.14	(1.10)	0.60
Pediatrics	9.60	10.81	13.36	10.44	(0.84)	-8.75%	4.57	6.57	(3.01)	(0.97)
Neontatal ICU	10.30	10.21	9.81	10.83	(0.53)	-5.15%	14.14	10.44	1.21	(0.97)
Telemetry	8.30	8.74	8.45	8.57	(0.27)	-3.25%	26.36	24.77	(0.69)	(1.17)
CCU	14.20	13.75	13.85	13.75	0.45	3.17%	12.00	10.09	0.73	0.79
ICU	16.00	15.96	15.55	15.78	0.22	1.38%	13.43	13.28	1.06	0.51
Med/Surg	7.50	7.86	7.60	7.63	(0.13)	-1.73%	22.79	21.96	(0.40)	(0.50)
Step Down/Tele	8.80	9.13	8.87	8.84	(0.04)	-0.45%	39.36	38.34	(0.48)	(0.27)
Med/Surg	7.50	7.62	7.30	7.50	0.00	0.00%	29.07	25.92	1.02	0.00
Med/Surg	7.50	8.56	7.26	7.48	0.02	0.27%	20.36	17.87	0.86	0.06
Telemetry	8.40	8.78	8.44	8.43	(0.03)	-0.36%	17.21	16.49	(0.12)	(0.09)
							216.79	203.87	(0.92)	(2.01)
									-0.3%	-0.6%
Indirect Hours per Patient Day										
Psych Unit	1.90	1.73	1.45	1.69	0.21	11.05%	17.50	18.14	1.38	0.67
Pediatrics	3.10	2.11	2.34	1.56	1.54	49.68%	4.57	6.57	0.61	1.77
Neontatal ICU	1.60	1.53	1.29	1.52	0.08	5.00%	14.14	10.44	0.77	0.15
Telemetry	1.00	0.83	0.74	0.75	0.25	25.00%	26.36	24.77	1.20	1.08
CCU	2.40	1.83	1.49	2.10	0.30	12.50%	12.00	10.09	1.91	0.53
ICU	1.80	1.76	1.59	1.53	0.27	15.00%	13.43	13.28	0.49	0.63
Med/Surg	1.20	0.93	0.76	0.99	0.21	17.50%	22.79	21.96	1.75	0.81
Step Down/Tele	1.00	0.97	0.85	0.88	0.12	12.00%	39.36	38.34	1.03	0.81
Med/Surg	1.40	1.35	0.88	1.09	0.31	22.14%	29.07	25.92	2.65	1.41
Med/Surg	1.10	1.12	0.99	1.10	0.00	0.00	20.36	17.87	0.39	0.00
Telemetry	1.50	1.25	1.35	1.34	0.16	10.67%	17.21	16.49	0.45	0.46
							216.79	203.87	12.63	8.32
									23.7%	16.4%
Total Productive Hours per Patient Day										
Psych Unit	7.90	7.75	7.81	7.50	0.40	5.06%	17.50	18.14	0.28	1.27
Pediatrics	12.70	12.92	15.70	12.00	0.70	5.51%	4.57	6.57	(2.40)	0.80
Neontatal ICU	11.90	11.74	11.10	12.35	(0.45)	-3.78%	14.14	10.44	1.98	(0.82)
Telemetry	9.30	9.57	9.19	9.32	(0.02)	-0.22%	26.36	24.77	0.51	(0.09)
CCU	16.60	15.58	15.34	15.85	0.75	4.52%	12.00	10.09	2.64	1.32
ICU	17.80	17.72	17.14	17.31	0.49	2.75%	13.43	13.28	1.55	1.14
Med/Surg	8.70	8.79	8.36	8.62	0.08	0.92%	22.79	21.96	1.35	0.31
Step Down/Tele	9.80	10.10	9.72	9.72	0.08	0.82%	39.36	38.34	0.55	0.54
Med/Surg	8.90	8.97	8.18	8.59	0.31	3.48%	29.07	25.92	3.67	1.41
Med/Surg	8.60	9.68	8.25	8.58	0.02	0.23%	20.36	17.87	1.25	0.06
Telemetry	9.90	10.03	9.79	9.77	0.13	1.31%	17.21	16.49	0.33	0.37
							216.79	203.87	11.71	6.31

Table 3.
System Report

	Worked Hours Per Patient Day						Average Daily Census		FTE Variances	
Direct Hours per Patient Day	FY11 Target	FYE 6/30/10	Pay Ending 4/30/11	Actual YTD	YTD Variance	YTD % Variance	Pay Period ADC	YTD ADC	Pay Period FTE	YTD FTE Variance
Neonatal ICU										
LMC	10.30	10.06	9.92	10.61	(0.31)	-3.01%	14.50	12.85	0.96	(0.70)
BMH	10.30	10.21	9.81	10.83	(0.53)	-5.15%	14.14	10.44	1.21	(0.97)
PH	15.50	12.60	15.46	12.88	2.62	16.90%	2.93	3.63	0.02	1.66
RMH	15.50	12.62	16.39	15.66	(0.16)	-1.03%	2.21	2.57	(0.34)	(0.07)
							33.78	29.49	1.85	(0.08)
Critical Care										
LMC CCU	16.70	16.29	19.33	16.83	(0.13)	-0.78%	8.64	11.00	(3.98)	(0.25)
LMC SICU	16.30	16.55	17.07	16.63	(0.33)	-2.02%	12.21	13.45	(1.65)	(0.78)
BMH CCU	14.20	13.75	13.85	13.75	0.45	3.17%	12.00	10.09	0.73	0.79
BMH ICU	16.00	15.96	15.55	15.78	0.22	1.38%	13.43	13.28	1.06	0.51
PH ICU	16.30	15.61	15.51	15.47	0.83	5.09%	11.79	11.26	1.63	1.64
RMH ICU	15.00	14.25	13.71	14.23	0.77	5.13%	8.64	10.71	1.95	1.44
							66.71	69.79	(0.26)	3.35
Step Down/ Telemetry										
LMC - 2 South	9.00	9.24	9.18	9.15	(0.15)	-1.67%	21.36	22.81	(0.67)	(0.60)
LMC – Step Down	9.00	8.68	9.26	8.89	0.11	1.22%	21.00	28.49	(0.96)	0.55
LMC - 2 Onc	8.50	8.52	8.62	8.47	0.03	0.35%	16.86	23.40	(0.35)	0.12
LMC - 1 SW	8.30	8.57	8.59	8.58	(0.28)	-3.37%	20.71	21.60	(1.05)	(1.06)
LMC - 3 R	8.30	8.87	9.01	8.80	(0.50)	-6.02%	6.79	8.74	(0.84)	(0.76)
LMC - 1 South	8.30	8.49	8.63	8.66	(0.36)	-4.34%	21.29	22.01	(1.23)	(1.39)
BMH - 5C	8.80	9.13	8.87	8.84	(0.04)	-0.45%	39.36	38.34	(0.48)	(0.27)
BMH - 6A	8.40	8.78	8.44	8.43	(0.03)	-0.36%	17.21	16.49	(0.12)	(0.09)
BMH - Telemetry 2	8.30	8.74	8.45	8.57	(0.27)	-3.25%	26.36	24.77	(0.69)	(1.17)
PH - 3 East	8.30	8.28	7.67	7.82	0.48	5.78%	28.57	26.65	3.15	2.24
PH - PCP 3A	8.30	8.66	7.82	8.16	0.14	1.69%	27.86	27.87	2.34	0.68
PH - Step Down	9.00	9.21	9.46	9.52	(0.52)	-5.78%	12.00	11.59	(0.97)	(1.05)
RMH - 2 North	8.80	9.04	9.21	8.72	0.08	0.91%	14.07	13.92	(1.01)	0.19
RMH - 2 East	8.50	8.23	8.31	8.58	(0.08)	-0.94%	14.64	13.87	0.49	(0.19)
RMH - Telemetry 2	9.00	9.11	8.92	9.14	(0.14)	-1.56%	15.57	15.47	0.22	(0.38)
							303.65	316.02	(2.17)	(3.18)
Med-Surg										
LMC - 2 Southwest	7.50	7.46	7.92	7.52	(0.02)	-0.27%	21.29	25.40	(1.56)	(0.09)
LMC - 3 Southwest	7.50	7.36	8.07	7.59	(0.09)	-1.20%	25.21	21.52	(2.51)	(0.34)
BMH - 6C	7.50	7.86	7.60	7.63	(0.13)	-1.73%	22.79	21.96	(0.40)	(0.50)
BMH - 3B	7.50	7.62	7.30	7.50	0.00	0.00%	29.07	25.92	1.02	0.00
BMH - 3C	7.50	8.56	7.26	7.48	0.02	0.27%	20.36	17.87	0.86	0.06
PH - PCP 4A	7.50	7.99	7.72	7.56	(0.06)	-0.80%	25.64	23.79	(0.99)	(0.25)
PH - PCP 4B	7.50	7.62	7.35	7.42	0.08	1.07%	25.00	24.66	0.66	0.35
RMH - 4 W Ortho	8.60	9.03	9.04	8.72	(0.12)	-1.40%	9.93	11.82	(0.76)	(0.25)
RMH - 4 South	7.60	7.71	7.86	7.70	(0.10)	-1.32%	25.14	23.68	(1.14)	(0.41)
RMH - 4 East	7.50	7.46	7.32	7.34	0.16	2.13%	17.21	16.31	0.54	0.46
RMH - 4C West	7.50	7.47	7.42	7.52	(0.02)	-0.27%	16.07	15.56	0.22	(0.05)
							241.71	229.70	(4.76)	(1.39)
Other										
BMH – Psych Unit	6.00	6.02	6.36	5.81	0.19	3.17%	17.50	18.14	(1.10)	0.60
BMH - Pediatrics	9.60	10.81	13.36	10.44	(0.84)	-8.75%	4.57	6.57	(3.01)	(0.97)
LMC - TCC	5.70	5.91	5.69	5.70	0.00	0.00%	19.79	19.85	0.03	0.00
RMH - TCC	5.70	6.68	6.02	6.07	(0.37)	-6.49%	18.14	8.58	(1.02)	(0.56)
BMRH - Oak Unit	6.80	6.33	6.70	6.44	0.36	5.29%	40.14	42.85	0.70	2.70
BMRH - Spruce	6.40	6.15	6.39	6.32	0.08	1.25%	36.71	37.71	0.06	0.53
BMRH - Maple Unit	8.00	7.78	7.81	7.89	0.11	1.38%	36.21	35.22	1.20	0.68
BMRH - Birch Unit	6.50	6.51	0.00	7.16	(0.66)	-10.15%	0.14	4.89	0.16	(0.56)
							173.20	182.75	(2.98)	2.56
							Total FTE Variance		(8.32)	1.26

benchmarks. Several units' DHPPD targets were adjusted modestly to reflect the addition of a trauma service at Paoli Hospital and higher acuity on telemetry units. The flash report continued to be used by nursing and finance, as well as hospital presidents. Nursing and finance at Bryn Mawr had more fully implemented *Nursing Compass* and used it to track DHPPD. *Nursing Compass* provides daily snapshots of activity and allows for immediate course correction in real time. At the system level, however, target achievement continued to be monitored using the flash report. At the close of FY '10, financial management against target continued to improve, and the year-end total FTE variance was less than 1%.

Phase III: Main Line Health Financial Management

This phase of the project included three pieces of work:

1. Develop benchmarks for those areas not previously benchmarked, including perinatal services (labor/delivery, postpartum, and nursery), perioperative services (OR and PACU), and the emergency department. This involved many meetings between an expanded group of nurse consultants and representatives from each hospital grouped by clinical area. Historic data and national benchmarks were reviewed, differences in practice at each hospital were discussed, and ultimately consensus was reached on benchmarks. Finance was instrumental in providing necessary data and reviewed progress regularly.
2. Develop a charter and bylaws for a Nurse Staffing Council consistent with proposed staffing legislation in Pennsylvania. Several bills were introduced in both the Pennsylvania Senate and House of Representatives for staffing ratios even more stringent than those in California. MLH nursing leadership considered it prudent to demonstrate definitive steps were being taken to get broad input from all levels of nursing staff into the staffing and budgeting process.
3. Develop a request for proposal (RFP) and evaluate patient acuity/classification systems. Nurse consultants met with nurse managers, nursing staff, and a host of others across the organization to hear their views on acuity systems. Nursing staff and managers all wanted more data but they also made it clear they did not want to take the time to implement an acuity system if it was not going to be used to adjust staffing. After these meetings, the nurse consultants prepared an RFP and coordinated the demonstration of seven patient acuity systems for MLH nurse leaders. Ultimately three systems were identified as warranting further examination pending approval to purchase a system.

MLH used a patient acuity system in years past, but like many other hospitals across the country, discontinued it due to reliability and validity issues and the nursing time needed to capture data. More recently, however, there was evidence significant improvements had been made in patient classification systems, which MLH wanted to evaluate – particularly those where patient acuity could be captured from nursing documentation. There was also a belief that if changes were made in the patient care delivery system, it was important to have more information on current patient needs and nurse workload.

Of particular interest during the evaluation of patient classification systems, it was learned several nursing units had informal programs for rating patients as "heavy, moderate, or light" for purposes of making assignments. But one unit, a large multispecialty unit at Bryn Mawr Hospital, developed its own patient classification system that was more detailed. Staff on this unit expressed dissatisfaction with inequity of patient assignments due to a broad range of acuity levels in their patient population. They used their patient classification tool to make more equitable assignments, and they are beginning to track the data to determine trends in acuity. This unit has demonstrated that using this tool improved both patient and staff satisfaction as evidenced by increases in Press Ganey/HCAHPS and their employee Gallup survey post implementation.

MLH Current State and Lessons Learned

As MLH closed FY '11 on June 30, 2011, the most significant outcomes are a result of continuous communication, transparency, education, and instilling accountability. For example, nurse managers are involved daily with rigorous and timely budget monitoring and are projected to end the fiscal year under targeted FTEs. Nurse managers have engaged their staff in this effort through education about the importance of their role in the use of resources and managing staffing. Through algorithm building, nurse managers have made the process transparent to staff and engaged them in the management of the cost structure and with a greater sensitivity to the need to eliminate waste.

Finance directors have a greater appreciation and respect for what nurses do and the challenges involved in both the delivery of care and the human resource aspects of managing upsizing and downsizing as census and work demands fluctuate on an hourly basis. Many of the tactics developed to analyze staffing are now being used in other departments to replicate the success in nursing.

The use of a consultant to

facilitate the project proved invaluable. Providing the structure and the processes as well as expert facilitation skills to keep the project focused, the consultant served as a neutral voice in discussion and had the needed expertise and respect of nursing administration and finance.

Some challenges are ongoing. For example, Bryn Mawr Hospital had the most significant improvement in meeting budget targets with nursing and finance both crediting it to the use of *Nursing Compass* and bi-weekly productivity review meetings with nurse managers. However, after 3 years of *Nursing Compass* development and implementation and a thorough discussion of its utility and value to the organization, the decision was made to discontinue it due to lack of consensus among all MLH hospitals. Those not in favor of retaining the tool cited the cost of continuing it, believing the existing tools coupled with increased manager accountability would achieve the desired outcome.

Staying true to the standards set requires discipline. One of the lessons learned was if hospital-based presidents and finance staff operate differently and set different standards at each hospital it is extremely difficult, if not impossible, to maintain nursing standards. Therefore, MLH is updating all stakeholders regularly recognizing financial pressures can continuously challenge set standards.

Another lesson learned was establishing evidence-based staffing standards across a system is challenging for multiple reasons. First, each organization has its own routines, culture, and priorities. Bringing five different leaders together to establish consensus required patience and time to address all concerns. Changing staffing patterns and setting standards of accountability required education, oversight, and an emphasis of getting business and quality of care goals in balance. Although difficult, the 3 years invested in this project yielded a more balanced budget and a more cohesive management team in both nursing and finance as well as defining how to manage change as a coordinated system rather than as five separate entities; thus setting the stage and providing a template for how other projects and programs will be managed. In terms of dollars and cents, savings were realized over the 3 years of the project; however, for the first 2 years, the focus was primarily on developing a decision support process. As savings were calculated for FY '10/'11 (year 3), they totaled $2 million with $1.3 million in productivity savings and $700,000 in reduced sitter utilization across the five hospitals.

Progress was made in level setting the staffing approach across MLH, but questions were raised about the validity of the benchmarks. With threats of decreased revenue on the horizon, health care providers are challenged to address the dilemma: How can we afford to increase patient safety while maintaining budget neutrality? MLH EVP/CFO relates, "If you have patient safety and quality, the financial performance will fall in line." The challenge will be achieving these outcomes in a radically changing environment.

When the Going Gets Tough, The Tough Get Going

With increasing pressure to cut costs, both real and immediate, and those forecasted and anticipated, the partnership and collaboration between nursing and finance will continue to take on new challenges.

Understanding how the work of nurses contributes to outcomes will need to be addressed with a new lens. It will be critical to revamp the way we deliver care across the continuum. When nurses are asked what they would want to give up doing, the answer is often silence. It is difficult to ask people who are doing a complex job that requires intense focus and time management skills to think about how to "work smarter, not harder." Another opportunity is how technology investments are leveraged to work smarter not harder. Simply adding technology to speed up or document old work patterns is not useful in achieving the goal of efficiency balanced with effectiveness

These are the times when a strong CNO-CFO partnership is needed most. Funding cuts will require innovative changes in the way care is delivered and that does not happen overnight. It takes careful planning, resources, support, experimentation, and strong partnerships among nursing, financial, administrative, and medical leadership.

Malloch and Porter-O'Grady (2010) put forward an exceptional roadmap for creating a new model of care. They acknowledge change of this kind is not easy. It involves defining in specific and quantifiable terms the work of nurses and what can happen if there is not enough of that work. When nursing is absent it is not just about medications not being given or dressings not being changed, it is about patients not being monitored, failure to rescue, condition changes not being communicated, patient knowledge not being improved, lack of coordination, and much more. There also needs to be an understanding that nursing work is nonlinear. There are overlaps in work or multi-tasking; interruptions from other caregivers, patients, and families; and unpredictable patient priorities like pain, elimination, and nutrition (Malloch & Porter-O'Grady, 2010).

Change must include identifying and eliminating non-value added work, creating the most productive context and work environment, providing technology and support systems, maximizing the contributions of each level of

caregiver, and increasing the teamwork among caregivers. An effective way of identifying value-added work is viewing all care through the eyes of the patient and family. DiGioia, Lorenz, Greenhouse, Bertoty, and Rocks (2010) describe a patient-centered model of care that improved quality metrics without increasing costs. It required shadowing patients and families through care experiences and care flow mapping. This work takes time but it is needed to make sustainable change that meets the needs and expectations of patients and families.

Shrinking resources and the growing (and very appropriate) focus on quality patient outcomes necessitate fundamental change in how care is provided. Change requires cooperation, collaboration, and partnerships; one of the most fundamental being between nursing and finance. Together, nursing and finance address the core business and how it is financed. This partnership has historically been strained and does not always come easy due to differences in focus, different priorities, and inadequate communication, listening, and hearing. That needs to change. Nursing leaders need to understand and appreciate the financial constraints and balance them with expected outcomes, and financial leaders need to understand and appreciate the core clinical business and what gaps in care mean to the financial viability of the organization and to patient outcomes. And, all of that requires strong partnerships. MLH made a wise strategic move 3 years ago to develop a platform for change and is dedicated to the hard work involved in continuously working on those partnerships. When it comes to patient quality, safety, and financial performance, nursing and finance leaders are well positioned for future health care challenges. **$**

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NURSING ECONOMIC$ DATA BANK

Health Care Quality Gaps and Disparities Persist in Every State

States are seeing improvements in health care quality, but disparities for their minority and low-income residents persist, according to the *2010 State Snapshots*, released by the Agency for Healthcare Research and Quality (AHRQ).

New Hampshire, Minnesota, Maine, Massachusetts, and Rhode Island showed the greatest overall performance improvement in 2010. The five states with the smallest overall performance improvement were Kentucky, Louisiana, New Mexico, Oklahoma, and Texas. As in previous years, AHRQ's *2010 State Snapshots* show that no state does well or poorly on all quality measures.

The 2010 State Snapshots, an interactive Web-based tool, show whether a state has improved or worsened on specific health care quality measures. For each state and the District of Columbia, this tool features an individual performance summary of more than 100 measures, such as preventing pressure sores, screening for diabetes-related foot problems, and giving recommended care to patients with pneumonia. To access the *2010 State Snapshots*, go to http://statesnapshots.ahrq.gov/

Acceptance of 'Smart' Intravenous Infusion Pumps Is Growing Among Nurses, but Challenges Remain

A new study of nurses' experiences with "smart" IV pumps finds that their acceptance is growing. However, challenges remain with regard to implementing these pumps in the health care setting and dealing with technical performance issues. The researchers surveyed nurses attending training sessions on smart IV pumps prior to their implementation at a large medical center.

Nurses were surveyed again via e-mail at 6 weeks after the pumps were actively in use on the floors and then again at 1 year. Nurses expressed positive perceptions of the smart IV pumps on the pre-implementation and 6-week post-implementation surveys. These positive perceptions increased significantly after 1 year of use. This was particularly true when it came to the perceived efficiency of these pumps. Such improvements were not observed, however, regarding nurses' experiences with the pump's implementation process and technical performance. Nurses cited problems with the usefulness of information received about the pump's implementation as well as clarity of the training materials. Even after 1 year, perceptions regarding the pump's noise and reliability did not improve. See the full report in Carayon, P. et al. (2010). Nurses' acceptance of smart IV pump technology. *International Journal of Medical Informatics, 79,* 401-411.