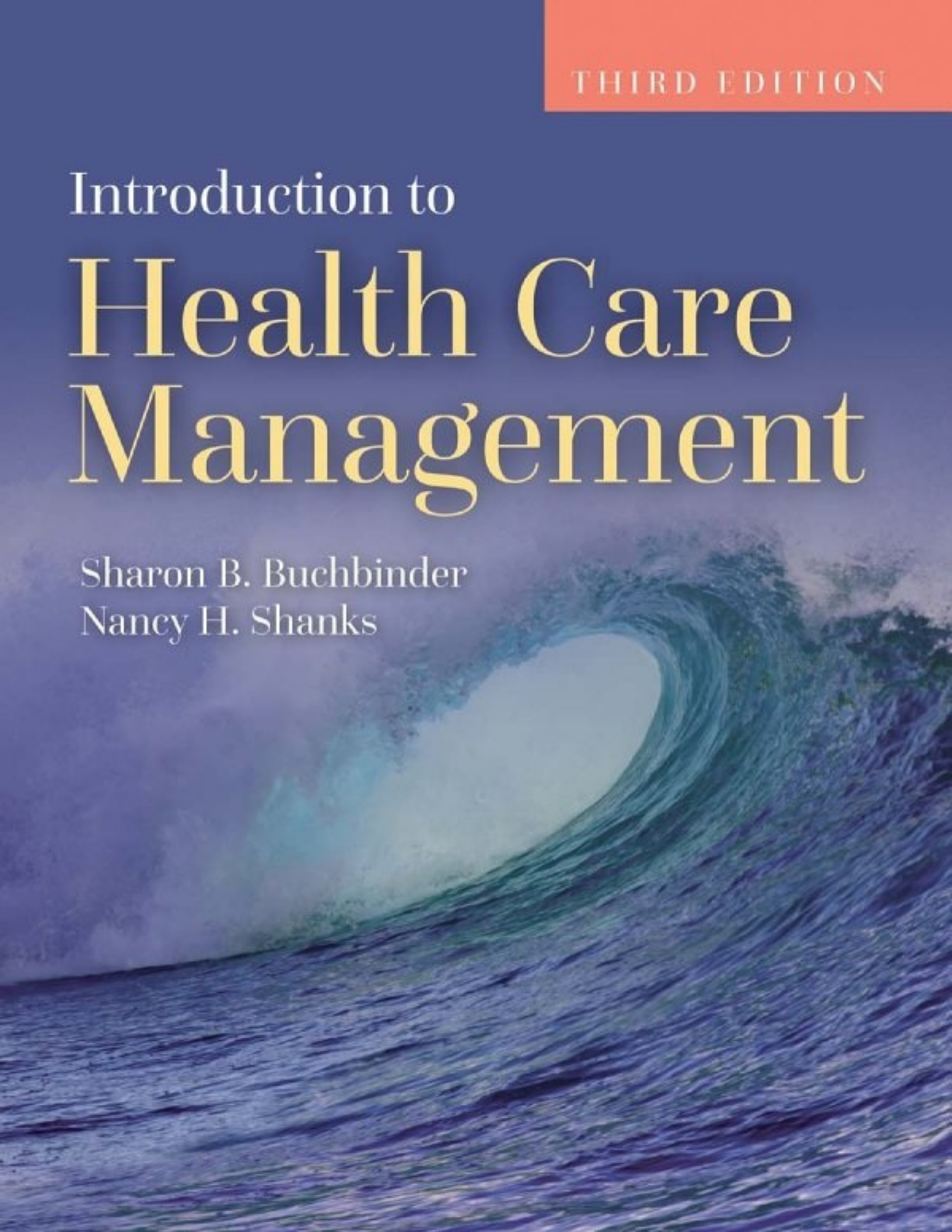
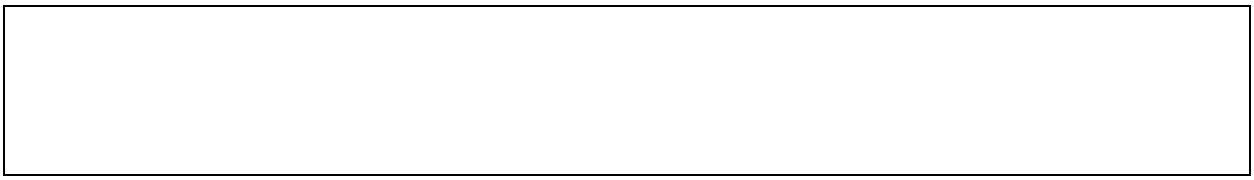
THIRD EDITION

Introduction to Health Care Management

Sharon B. Buchbinder
Nancy H. Shanks



JONES & BARTLETT
LEARNING



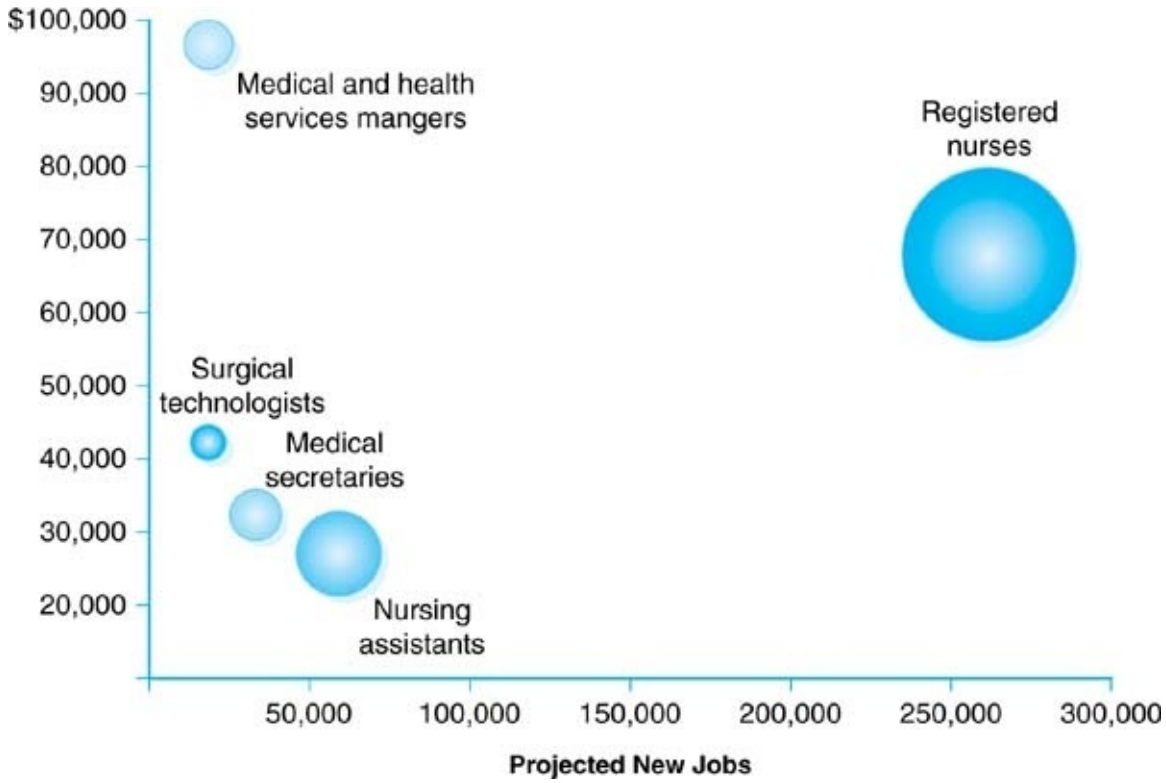

$100,000
90,000
80,000
70,000
60,000
50,000
40,000
30,000
20,000
Medical and health services mangers
Registered nurses
Surgical technologists
Medical secretaries
Nursing assistants
50,000
100,000
150,000
200,000
250,000
300,000
Projected New Jobs

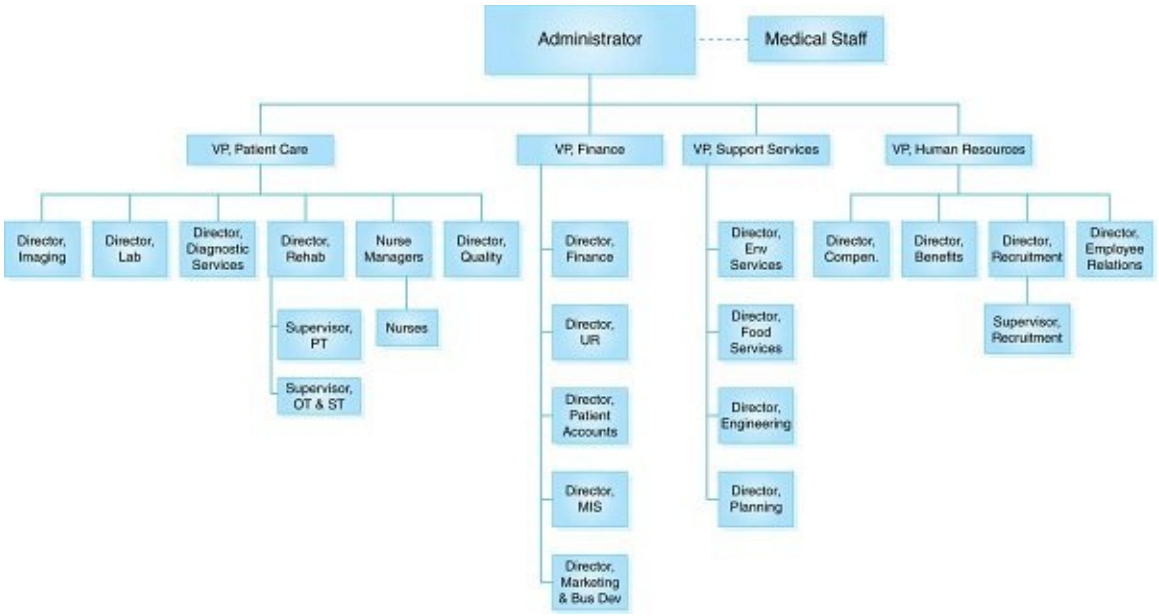
TABLE 1-1 Domains of Health Services Administration

External	Internal
Community demographics/need	Staffing
Licensure	Budgeting
Accreditation	Quality services
Regulations	Patient satisfaction
Stakeholder demands	Physician relations
Competitors	Financial performance
Medicare and Medicaid	Technology acquisition
Managed care organizations/insurers	New service development

Source: Thompson, 2007.

TABLE 1-2 Managerial Positions, by Organizational Setting

Organizational Setting	Examples of Managerial Positions
Physician practice	Practice Manager
	Director of Medical Records
	Supervisor, Billing Office
Nursing home	Administrator
	Manager, Business Office
	Director, Food Services
	Admissions Coordinator
	Supervisor, Environmental Services
Hospital	Chief Executive Officer
	Vice President, Marketing
	Clinical Nurse Manager
	Director, Revenue Management
	Supervisor, Maintenance


Administrator
Medical Staff
VP, Patient Care
VP, Finance
VP, Support Services
VP, Human Resources
Director, Imaging
Director, Lab
Director, Diagnostic Services
Director, Rehab
Nurse Managers
Director, Quality
Supervisor, PT
Supervisor, OT & ST
Nurses
Director, Finance
Director, UR
Director, Patient Accounts
Director, MIS
Director, Marketing & Bus Dev
Director, Env Services
Director, Food Services
Director, Engineering
Director, Planning
Director, Compen.
Director, Benefits
Director, Recruitment
Director, Employee Relations
Supervisor, Recruitment


External Stakeholders
Media
Vendors
Government
Internal Stakeholders
Administration
Health Policy, Laws, & Regulations
Management Focus/ Internal
Professionals
Operations
Community Groups
Strategic Partners
Financial Stakeholders

TABLE 2-1 Leadership vs. Management Competencies

Leadership Competencies	Management Competencies
Establishing mission	Staffing personnel
Setting vision/direction	Assuring patient-centered practices
Motivating stakeholders	Controlling resources
Being an effective spokesperson	Supervising the service provided
Determining strategies for the future	Overseeing adherence to regulations
Transforming the organization	Counseling/developing employees
Networking	Managing operations

TABLE 2-2 Leadership Theories in the U.S.

Period of Time	Leadership Theory	Leadership Focus
1920s and 1930s	Great Man	Having certain inherent traits
1940s and 1950s	Style Approach	Task completion and developing relationships
1960s	Situational Approach	Needs of the subordinates
Early 1970s	Contingency and Path-Goal	Both style and situation
Late 1970s	Leader-Member Exchange	Interactions between leader and subordinate
1980s	Transformational Approach	Raise consciousness and empower followers
1990s	Team Leadership	Team performance and development
2000s	Adaptive Leadership	Build capacity to thrive in a new reality
2010s	Global Leader	Recognizing the impact of globalization for their industry

TABLE 2-3 Contemporary Leadership Models

Model	Leadership Application
Emotional Intelligence	Tools to be well adjusted leader
Authentic Leadership	Follows internal compass of true purpose
Diversity Leadership	Culturally competent leader
Servant Leadership	Desire to serve others
Spirituality Leadership	Supports finding meaning
Resilient Leadership	Build inner strength and perseverance
Emerging Leadership	Continual learners and developers

TABLE 2-4 Emotional Intelligence's Application to Health Care Leadership

EI Dimension	Definition	Leadership Application
Self-Awareness	A deep understanding of one's emotions and drives	Knowing if your values are congruent with the organization's
Self-Regulation	Adaptability to changes and control over impulses	Considering ethics of giving bribes to doctors
Motivation	Ability to enjoy challenges and being passionate toward work	Being optimistic even when census is low
Empathy	Social awareness skill, putting yourself in another's shoes	Setting a patient-centered vision for the organization
Social Skills	Supportive communication skills, abilities to influence and inspire	Having an excellent rapport with the board

TABLE 2-5 Leadership Styles for Health Care Personnel

Style	Definition	Application
Coercive	Demanding and power based	Problematic employees
Participative	Soliciting input and allowing decision making	Most followers
Pacesetting	Setting high performance standards	Highly competent
Coaching	Focus on personal development	Top level

TABLE 2-6 Leadership Domains and Competencies

Domain: Functional and Technical Competencies:

- Knowledge of business/business acumen
- Strategic vision
- Decision making and decision quality
- Managerial ethics and values
- Problem solving
- Change management/dealing with ambiguity
- Systems thinking
- Governance

Domain: Self-Development and Self-Understanding Competencies:

- Self-awareness and self-confidence
- Self-regulation and personal responsibility
- Honesty and integrity
- Lifelong learning
- Motivation/drive to achieve
- Empathy and compassion
- Flexibility
- Perseverance
- Work/life balance

Domain: Interpersonal Competencies:

- Communication
- Motivating
- Empowerment of subordinates
- Management of group process
- Conflict management and resolution
- Negotiation
- Formal presentations
- Social interaction

Domain: Organizational Competencies:

- Organizational design
- Team building
- Priority setting
- Political savvy
- Managing and measuring performance
- Developing others
- Human resources
- Community and external resources
- Managing culture/diversity

Hilberman, D. (Ed.), The 2004 ACHE-AUPHA Pedagogy Enhancement Work Group. June 2005.

TABLE 2-7 Key Leadership Protocols

1. Professionalism
2. Reciprocal trust and respect
3. Confident, optimistic, and passionate
4. Being visible
5. Open communicator
6. Risk taker/entrepreneur
7. Admitting fault
8. Balancing being a motivator, vision-setter, analyzer, and task-master

TABLE 2-8 Health Care Governance Trends

Function	Old Way	New Trend
Size of board	Larger	Smaller (average 13 people)
Membership	Many members from within the organization	More balance of members within and outside the organization
Conflicts of interest	Some present, not disclosed	Must be disclosed but prefer none
Meetings	Voluminous detailed information presented	Strategic information and trends presented
Evaluations	If done, not taken too seriously	Taken seriously to identify issues and correct
Focus	Competence of individual providers	Focus on functioning of the system
Leadership	Fiduciary and strategic responsibilities	Generative source of reframing priorities
Goal	Keep stable	Manage change

TABLE 2-9 Key Health Care Leadership Barriers and Challenges

1. Laws and regulations (Barrier)
2. Physicians (Challenge)
3. New technology (Barrier)
4. Culture of safety (Challenge)
5. Value-based purchasing (Challenge)
6. Women in top leadership positions (Barrier)

TABLE 2-10 American College of Healthcare Executives Code of Ethics

Responsible Area	Sample Guidelines
To the profession	Comply with laws Avoid any conflicts of interest Respect confidences
To the patients or others served	Prevent discrimination Safeguard patient confidentiality Have process to evaluate quality of care
To the organization	Proper resource allocation Improve standards of management Prevent fraud and abuse within
To the employees	Allow free expression Ensure a safe workplace environment Follow nondiscrimination policies
To the community and society	Work to meet the needs of the community Provide appropriate access to services Advocate for healthy society
To report violations of the code	Healthcare executive–supplier interactions Decisions near the end of life Impaired healthcare executives

TABLE 2-11 Professional Associations

Name	Acronym	Targeted Career	Website
American College of Healthcare Executives	ACHE	Health administrators	www.ache.org
Healthcare Financial Management Association	HFMA	Health care chief financial officers	www.hfma.org
Association for University Programs in Health Administration	AUPHA	Health administration education program directors	www.aupha.org
Medical Group Management Association	MGMA	Medical group administrators	www.mgma.org
American College of Health Care Administrators	ACHCA	Long-term care administrators	www.achca.org
American Academy of Nursing	AAN	Nurse leaders	www.aannet.org
American College of Physician Executives	ACPE	Physician leaders	www.acpe.org
National Association of Health Services Executives	NAHSE	Black health care leaders	www.nahse.org
National Forum for Latino Healthcare Executives	NFLHE	Latino health care leaders	www.nflhe.org
Asian Health Care Leaders Association	AHCLA	Asian health care leaders	www.asianhealth careleaders.org
Rainbow Healthcare Leaders Association	RHLA	LGBT (lesbian, gay, bi-sexual, transgender) health care leaders	www.RHLA.org

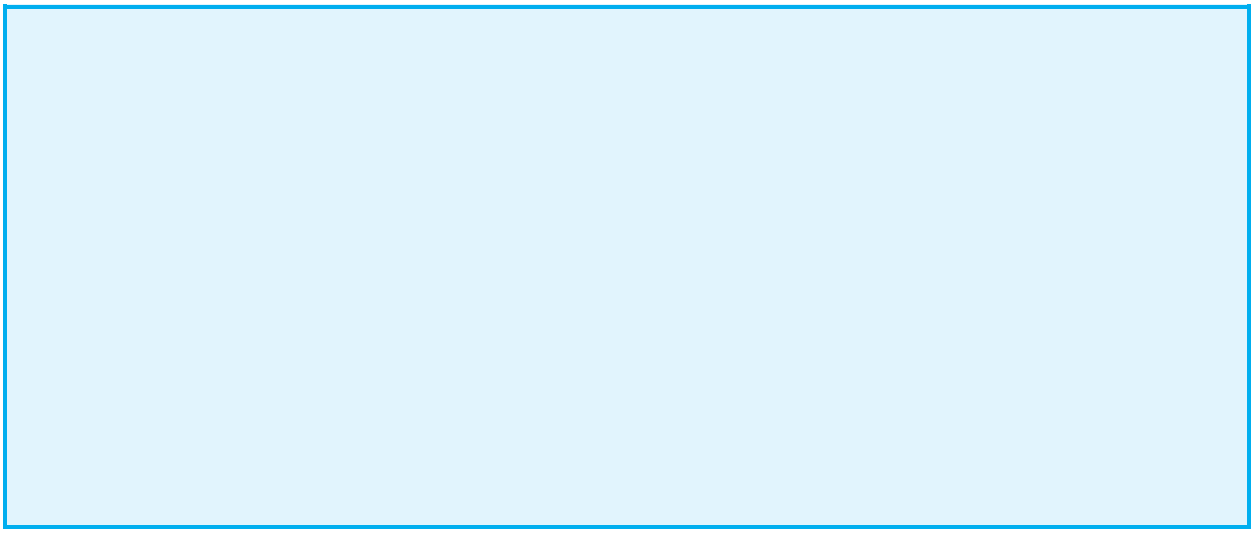
-
-
-
-

TABLE 3-1 Generation Characteristics and Motivational Preferences

Generation	Traditionalist	Baby Boomers	Generation X	Generation Y	Generation Z
Born:	Before 1945	1946–1964	1965–1978	1979–1995	Born after 1995
Cohort size	27 million	76 million	60 million	88 million	20 million
Nickname	Silent Generation/ Matures	Boomers/ Woodstock Generation	Gen Xers	Millennials	Linksters/New Silent Generation
Workplace characteristics	Respectful of authority Value duty and sacrifice Value accountability and practical experience Strong work ethic with emphasis on timeliness and productivity Strong interpersonal skills Value academic credentials Accept limited resources Loyal to employer and expect loyalty in return	Individuality Driven by goals for success Measure work ethic in hours worked and financial rewards Believe in teamwork Emphasize relationship building Expect loyalty from coworkers Career equals identity A democratic approach Competitive	Self-reliant Highly educated Questioning Risk-averse Most loyal employees Want open communication Respect production over tenure Value control of their time Invest loyalty in a person, not in an organization	Image conscious Need constant feedback and reinforcement Idealist Team-oriented Want open communication Search for an individual who will help them achieve their goals Search for ways to shed stress Racial and ethnic identification of reduced importance Organized and prefer structure	Results-focused Tech savvy, yet struggle with face-to-face communications Value structure, routine, and predictability Prefer clear, direct job descriptions/ duties, and expectations Strong work ethic Leaders in online collaboration Strong ability to multitask High entrepreneurial attributes
Motivational preferences	Loyalty Hierarchical structure	Work for managers who treat them as equals	Genuine and informal managers	Value instant gratification	Search for and value ways to improve the world they live in (community service-oriented)

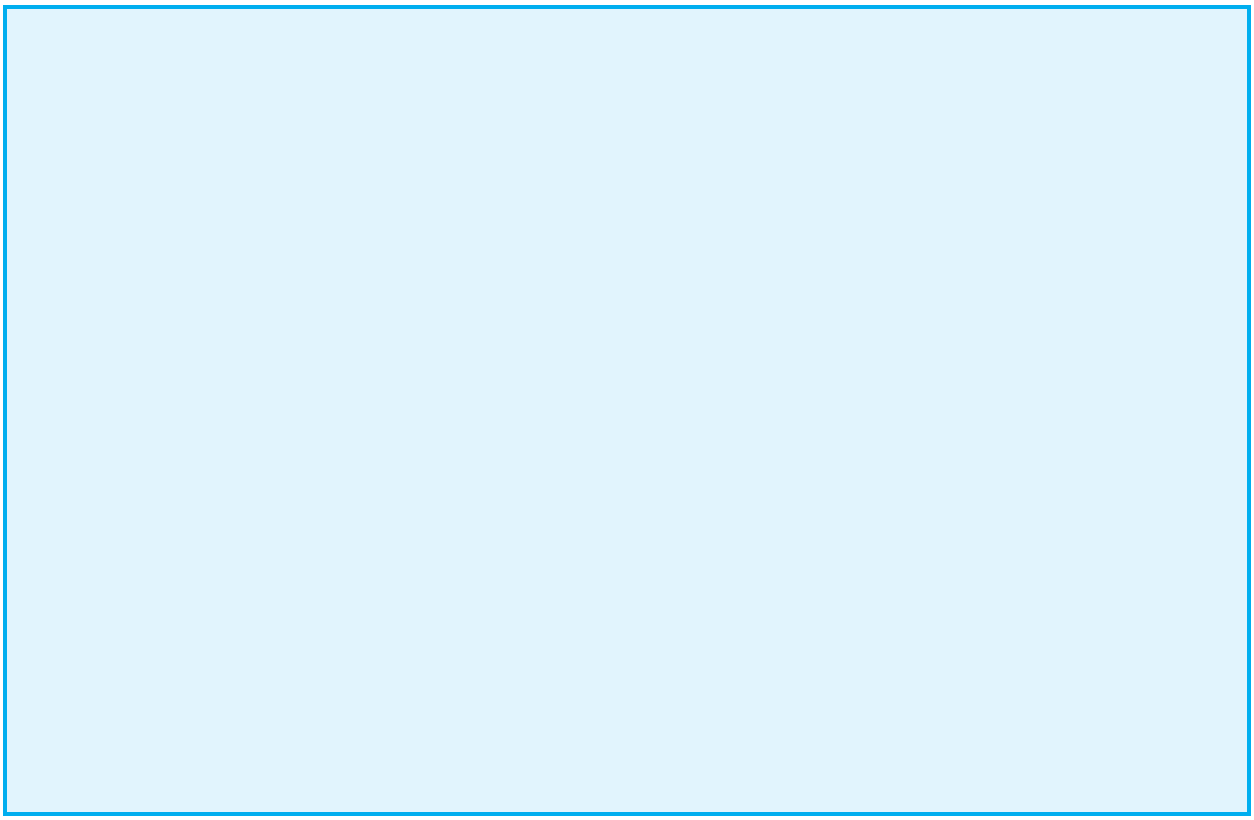
	Status Rewards based on promotion and job tenure Recognition of hard work and work ethic	Assurance that they are making a difference Work-life balance	Training and growth opportunities Flexibility Work deadlines, but with freedom and flexibility on how to reach those deadlines Results-oriented	Collaborative and positive interactions Achievement-oriented Coaching and support focused Personal fulfillment in job	Prefer management practices and workspaces that best support their needs Appreciation of collaboration tools Regular and consistent feedback Rewards that are consistent and tied to specific performance goals

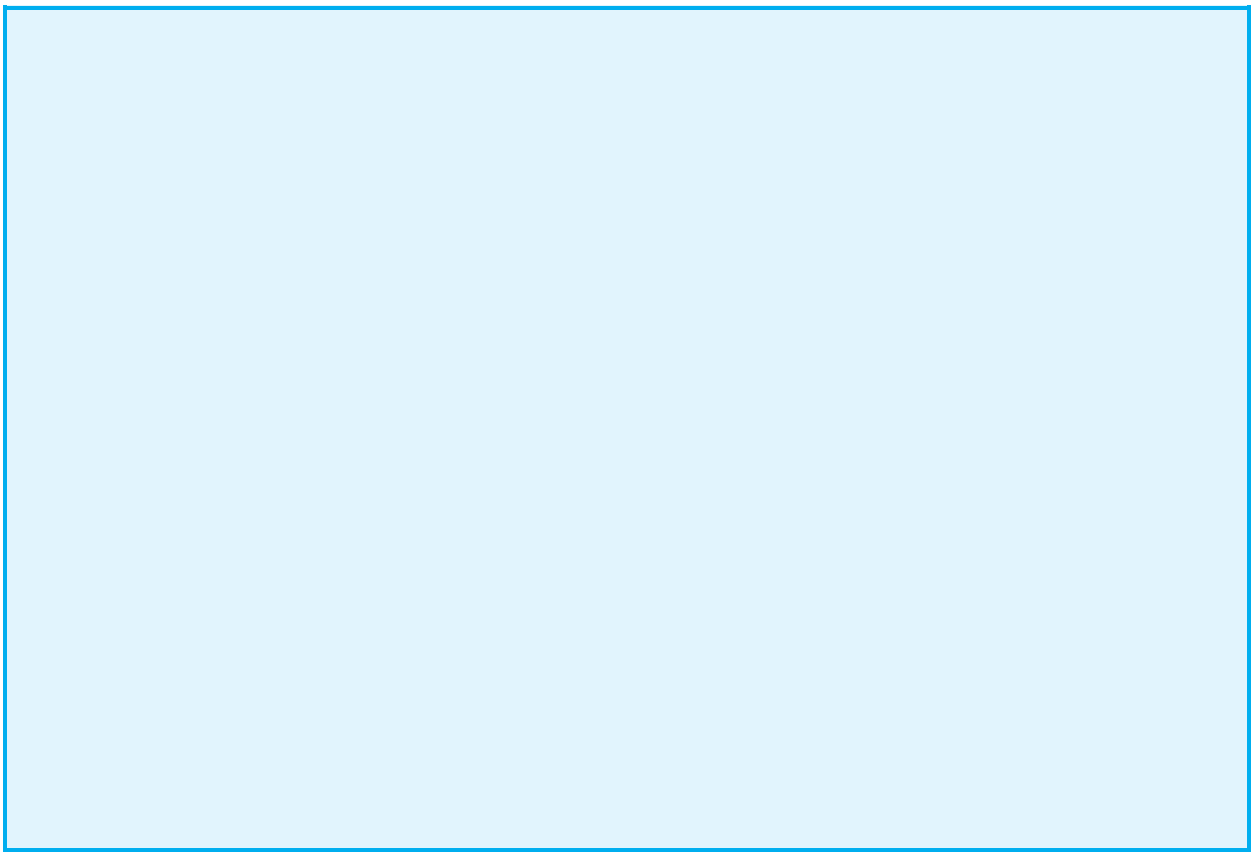
-
-
-

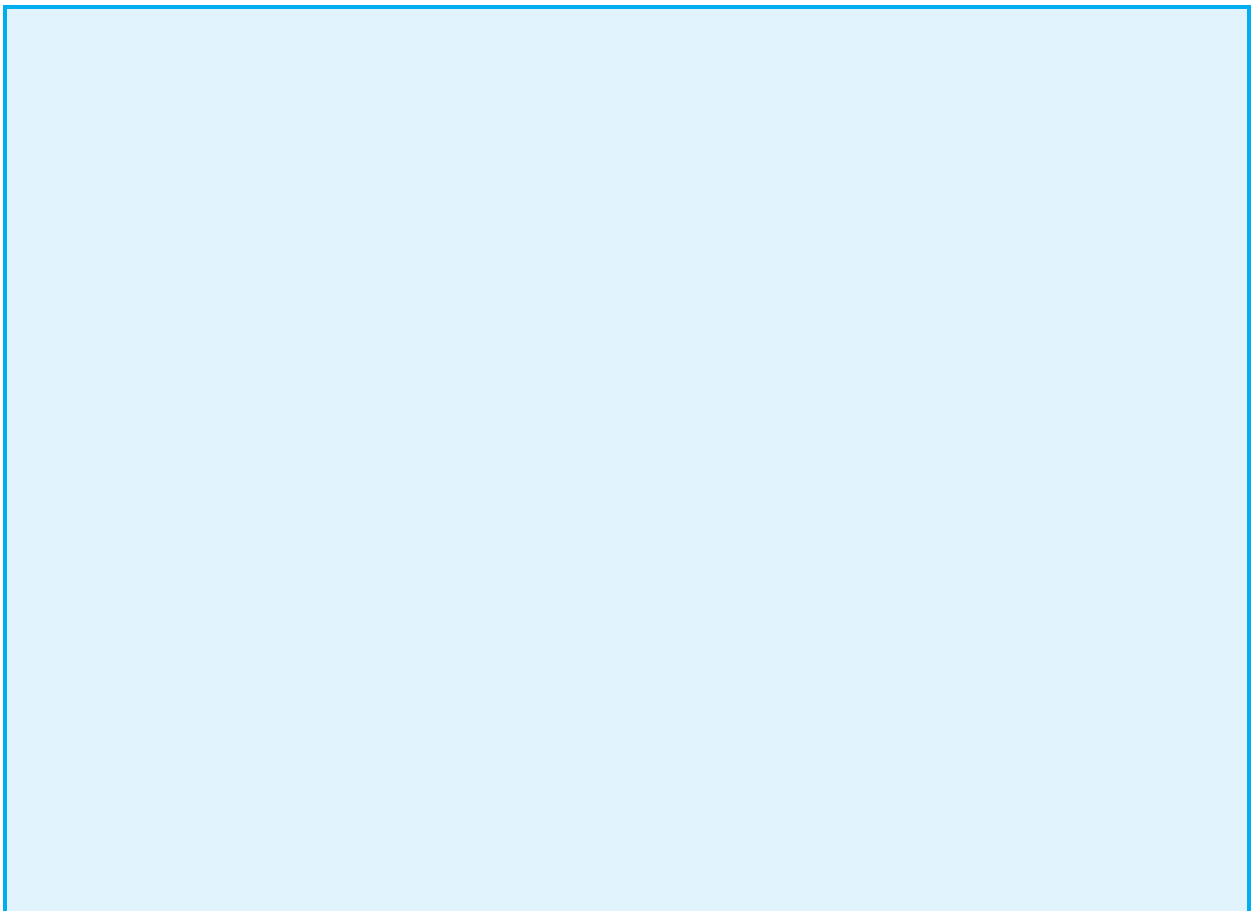


-
-
-
-
-
-
-
-
-

-
-
-
-
-

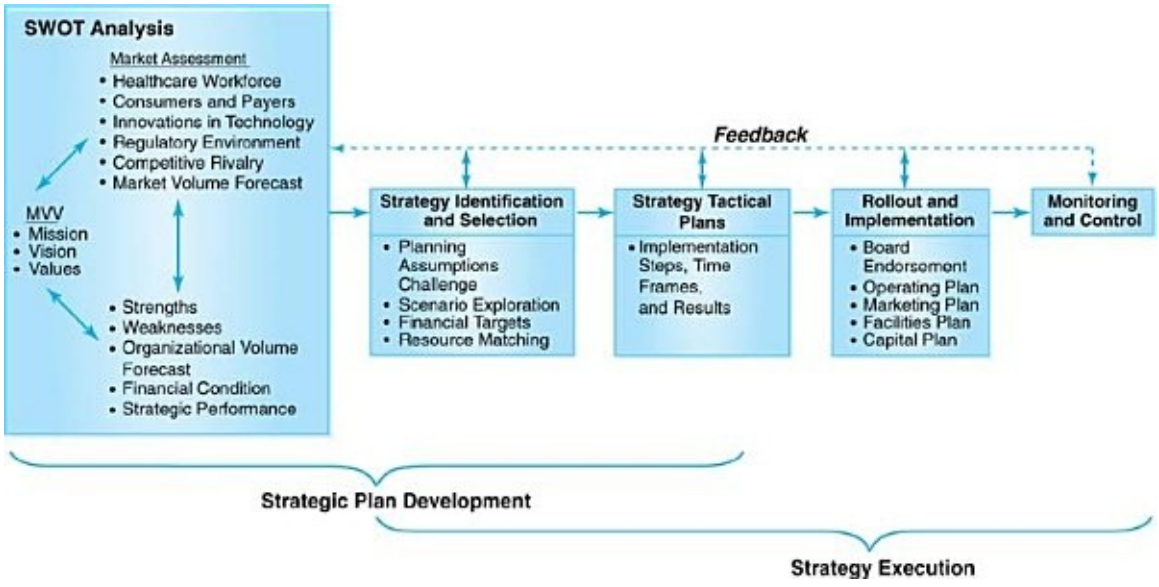






-
-
-
-
-
-
-
-

-
-
-
-


SWOT Analysis
Market Assessment
• Healthcare Workforce
• Consumers and Payers
• Innovations in Technology
• Regulatory Environment
• Competitive Rivalry
• Market Volume Forecast
MVV
• Mission
• Vision
• Values
• Strengths
• Weaknesses
• Organizational Volume Forecast
• Financial Condition
• Strategic Performance
Feedback
Strategy Identification and Selection
• Planning Assumptions Challenge
• Scenario Exploration
• Financial Targets
• Resource Matching
Strategy Tactical Plans
• Implementation Steps, Time Frames, and Results
Rollout and Implementation
• Board Endorsement
• Operating Plan
• Marketing Plan
• Facilities Plan
• Capital Plan
Monitoring and Control
Strategic Plan Development
Strategy Execution

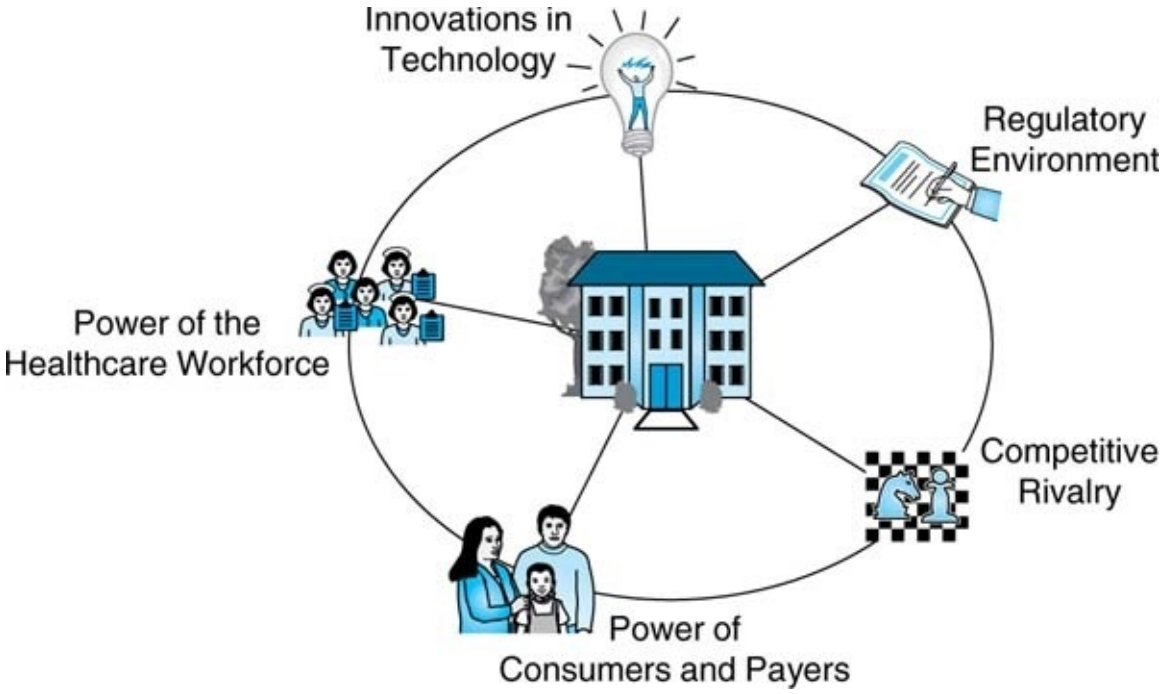

Innovations in Technology
Regulatory Environment
Power of the Healthcare Workforce
Competitive Rivalry
Power of Consumers and Payers

TABLE 5-1 Data Collection Methods

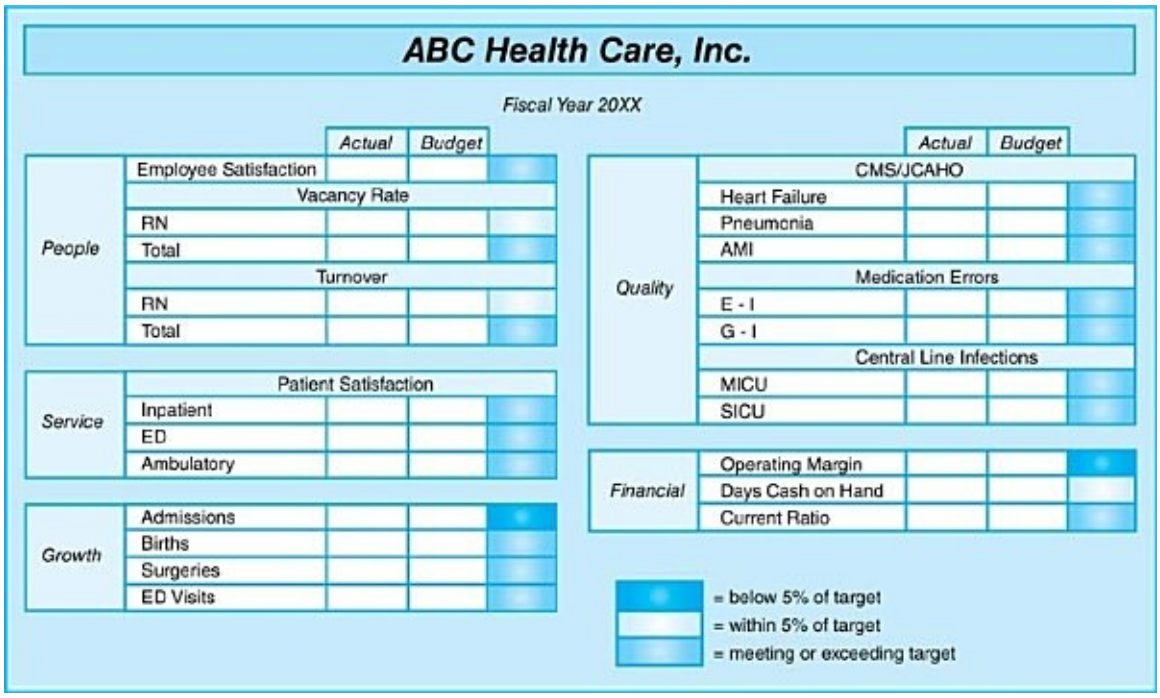
	Pros	Cons
Interviews	■ opportunity to clarify responses ■ encourages free thinking ■ can ensure representative sample	■ time-consuming ■ potential for interviewer bias ■ open answers difficult to analyze
Focus Groups	■ opportunity to clarify responses ■ allows for relatively large sample ■ can be economically efficient	■ potential for groupthink ■ open answers difficult to analyze
Surveys	■ effective way to obtain large sample ■ standardized answers allow for easier analysis no interviewer bias	■ can be expensive ■ lag time for responses ■ potential for low response rate

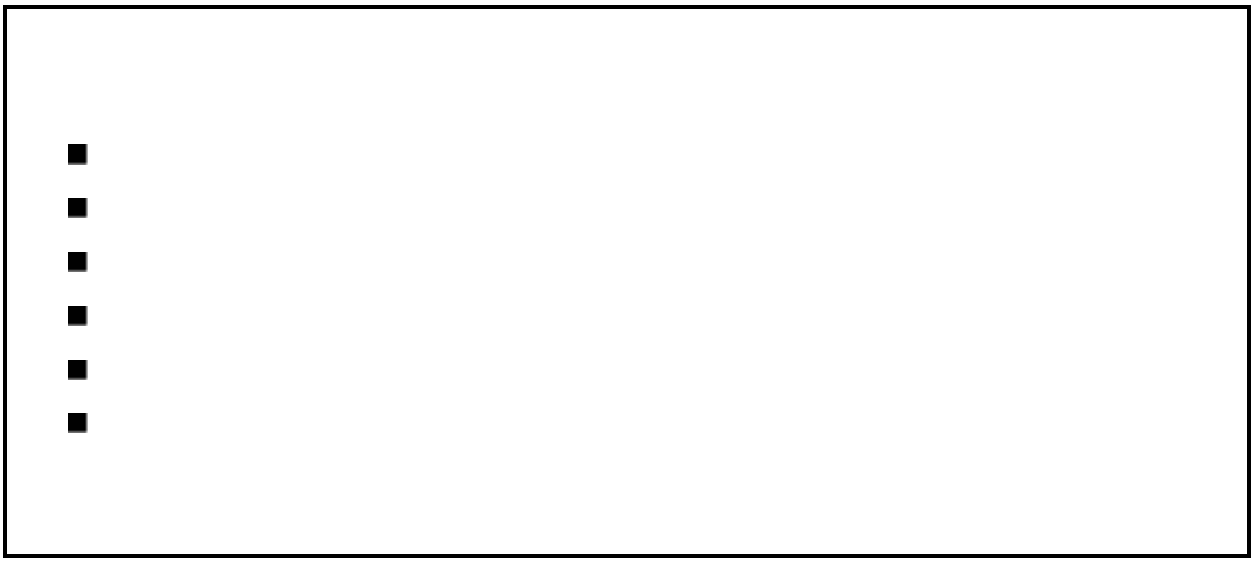
TABLE 5-2 Successful Strategies

Successful Strategies
■ Are focused on the desired future state
■ Align internal capabilities with market opportunities and threats
■ Provide or sustain a competitive advantage for the organization
■ Are funded and resourced long term

TABLE 5-3 Tactical Plan Template

Goal	Key Actions	Target Completion Date	Resources Required	Dependencies	Revenue Projection	Success Metric


ABC Health Care, Inc.
Fiscal Year 20XX
Actual
Budget
People
Employee Satisfaction
Vacancy Rate
RN
Total
Turnover
RN
Total
Service
Patient Satisfaction
Inpatient
ED
Ambulatory
Growth
Admissions
Births
Surgeries
ED Visits
Quality
CMS/JCAHO
Heart Failure
Pneumonia
AMI
Medication Errors
E - I
G - I
Central Line Infections
MICU
SICU
Financial
Operating Margin
Days Cash on Hand
Current Ratio
= below 5% of target
= within 5% of target
= meeting or exceeding target




Health Care Organization
Production Orientation
Activities focused on achieving organizational goals through product and clinical quality.
Marketing Concept Adoption: Low
Sales Orientation
Activities focused on achieving organizational goals by generating volume and filling beds.
Marketing Concept Adoption: Moderate
Marketing Orientation
Activities focused on achieving organizational goals by identifying health care needs, creating, communicating, and delivering value.
Marketing Concept Adoption: High


Key Stakeholders
• Customers
• Board of Directors
• Suppliers
• Physicians
• Employers
• Society at Large
Controllable Variables
• Product
• Price
• Promotion
• Place
Organizations
Uncontrollable Environment
• Political
• Economic
• Social and Cultural
• Technological
• Regulatory
• Competitive

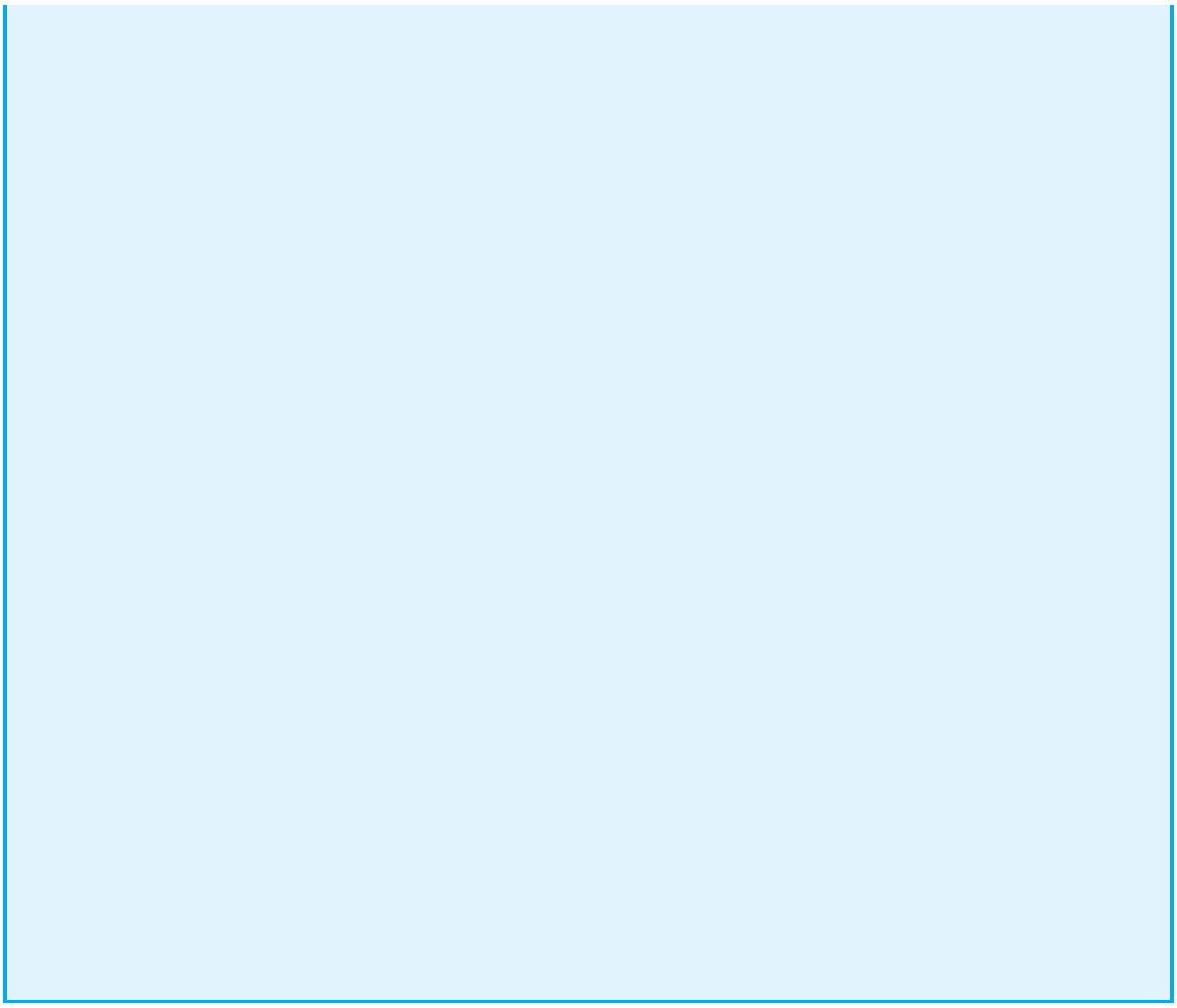

Organization Purpose
Industry Analysis
Core Strategy
Organization Analysis
Target Market
Competitive Positioning
Differential Advantage
Evaluation and Control
Implementation
Continuous Improvement
Marketing Mix

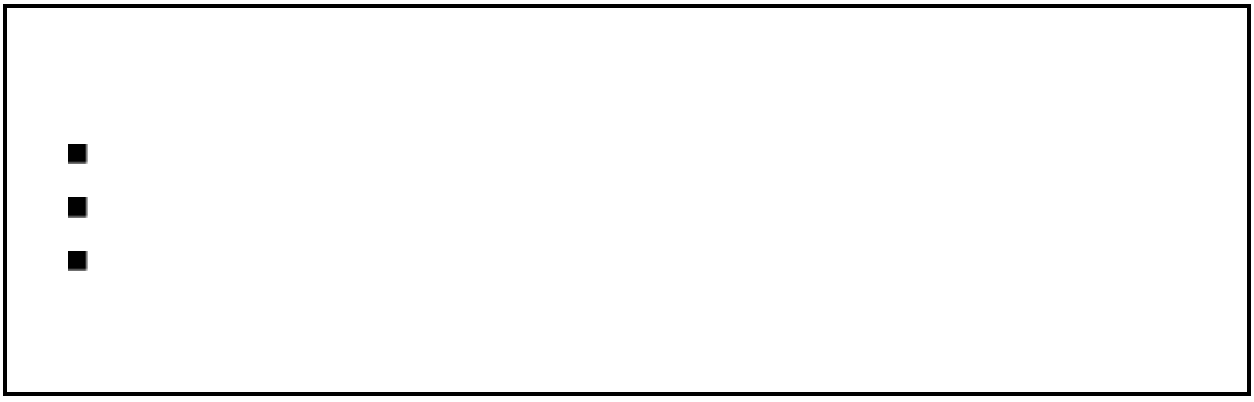
TABLE 6-1 Segmentation Broad Categories, Variables, and Indicative Examples

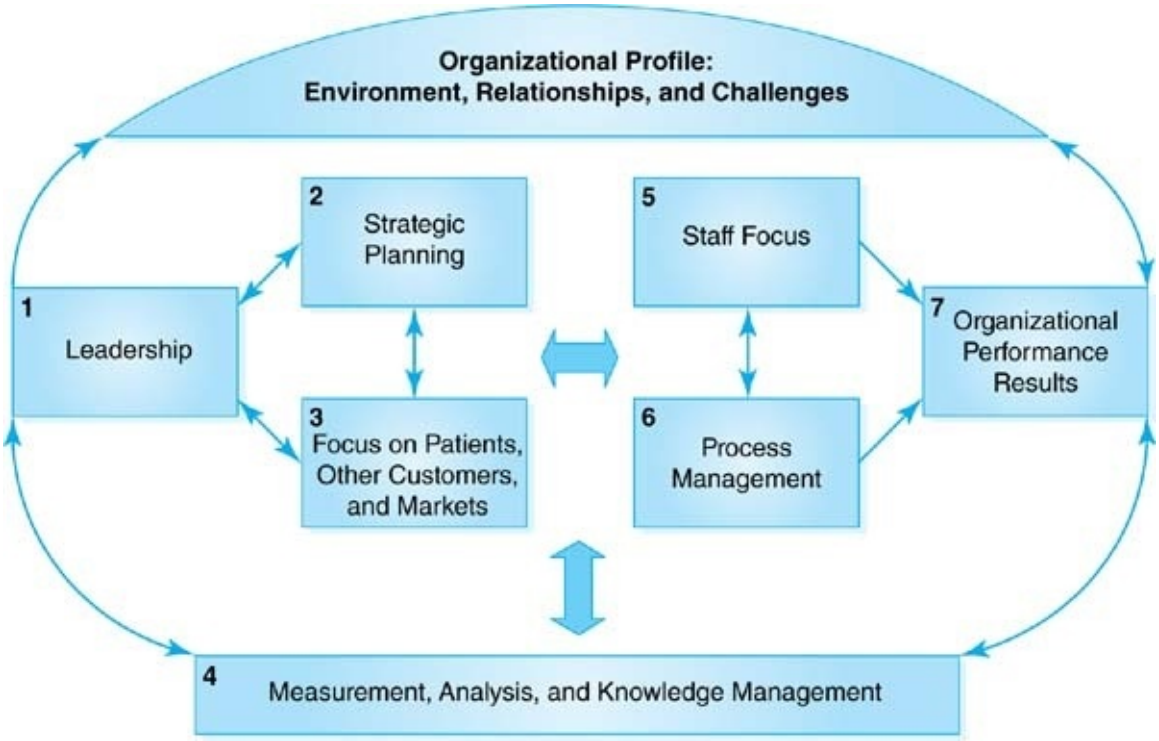
Category	Variables	Example(s)
Demographic	Age; Gender; Ethnicity and race; Country of origin; Education; Occupation; Income; Generation; Life cycle stage	Changing U.S. demographics offer new opportunities to target retiring and aspiring retiree segments. A long-term care facility might develop a communications plan to reach seniors 55 and older.
Geographic	State; City; County; Urban; Rural	Marketing food products typically varies by region and geographic segmentation. Because tastes and preferences differ, recipes, packaging and promotion are different for many parts of the country.
Psychographic	Values; Lifestyle; Personality; Motivation; Self-efficacy; Attitudes	Four groups of distinct health information–seeking orientations were found to be significantly associated with certain prevention-related attitudes and behaviors. Using a research screening instrument, respondents were segmented into four psychographic consumer segments—*independent actives, doctor-dependent actives, independent passives*, and *doctor-dependent passives* (Wolff et al., 2010).
Situational	Life events	Health insurance firms use situational segmentation to reach employed and unemployed segments. Segment examples include: (1) employer-based health insurance coverage, (2) Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage for 18 months after job termination, and (3) individual health plans beyond COBRA.
Behavioral	Usage rates; Tech-savvy users	In the midst of a recession and in a state with the highest unemployment rate in the nation in 2009, the Henry Ford Health System in Detroit led local competitors in inpatient growth, with a 7.4% increase in admissions over the previous year. Of the 8,201 new admissions, the seven-hospital system segmented the customer base to reach Internet users through social media and other online tools (Glenn, 2010).

TABLE 6-2 Consumer Decision-Making Process

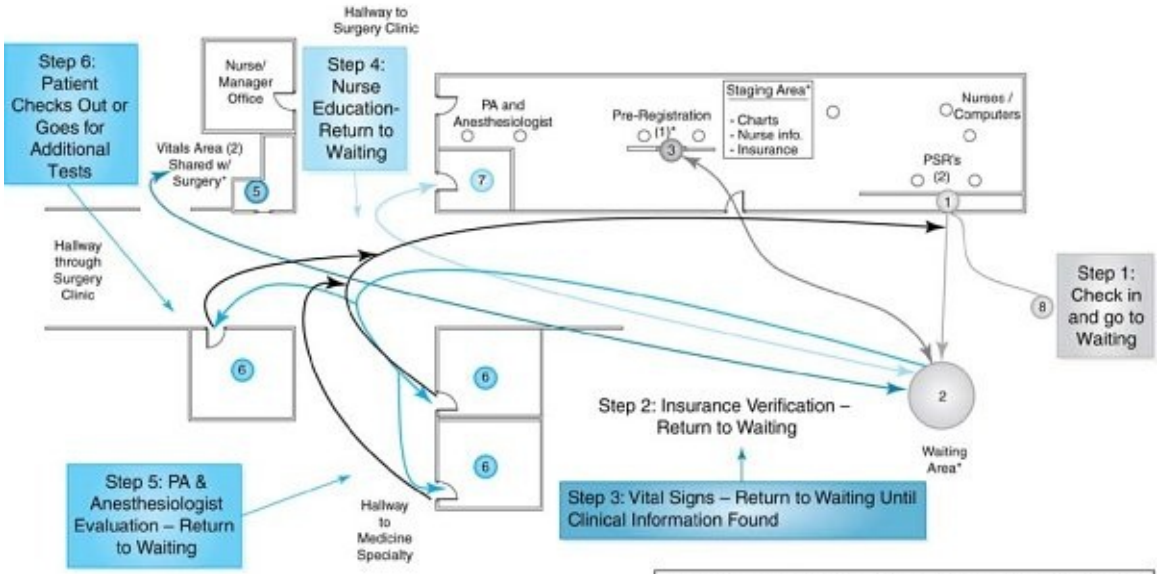
Stage	Definition
I. Problem Recognition	The health consumer recognizes a difference between an actual and desired state. The individual or group is motivated to reach the desired state. For example, a person may feel that he or she is overweight and wishes to reach a specific weight goal.
II. Internal Search	The consumer searches internal memory to find a solution to the problem. The person may remember a previous experience such as dieting that may or may not have led to solving the problem.
III. External Search	If the problem cannot be solved through an internal search, the health consumer is likely to seek external information that may lead to a solution. The health consumer might consult with family and friends, consult with a physician, or search the Internet or any number of external sources.
IV. Alternative Evaluation	In the fourth stage of the decision-making process, the consumer evaluates the various alternatives to arrive at a solution.
V. Purchase	The fifth stage involves the purchase by selecting the health product, service, or idea. For example, an individual might decide that gastric bypass surgery is the most viable solution.
VI. Post-Purchase Evaluation	In the final stage, the consumer evaluates his or her choice. Generally speaking, in a high-involvement purchase decision with several equally attractive alternatives, the consumer may experience cognitive dissonance, a state of anxiety where there is uncertainty about the selection.



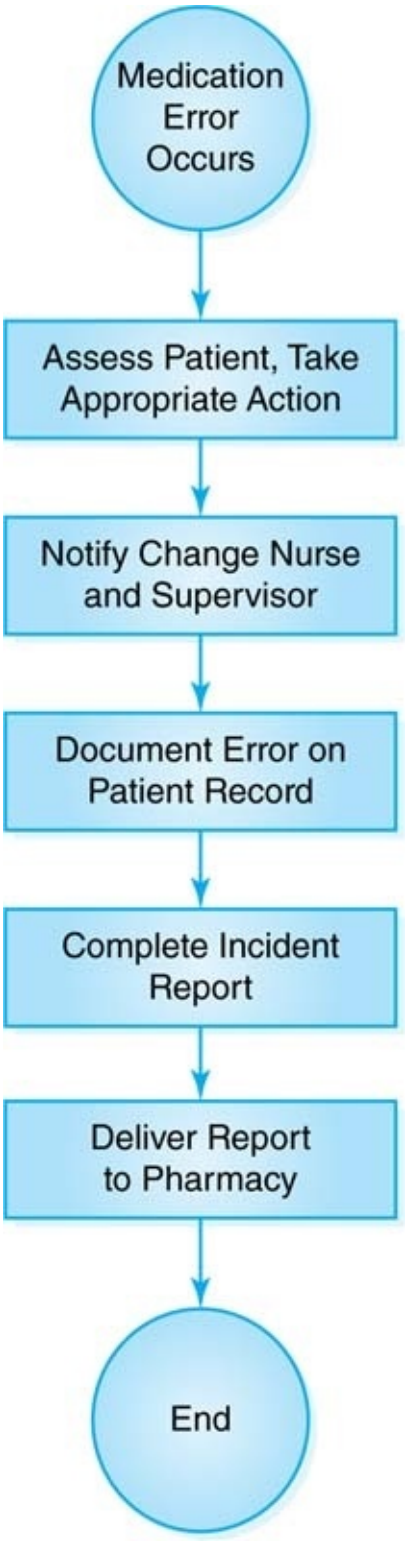


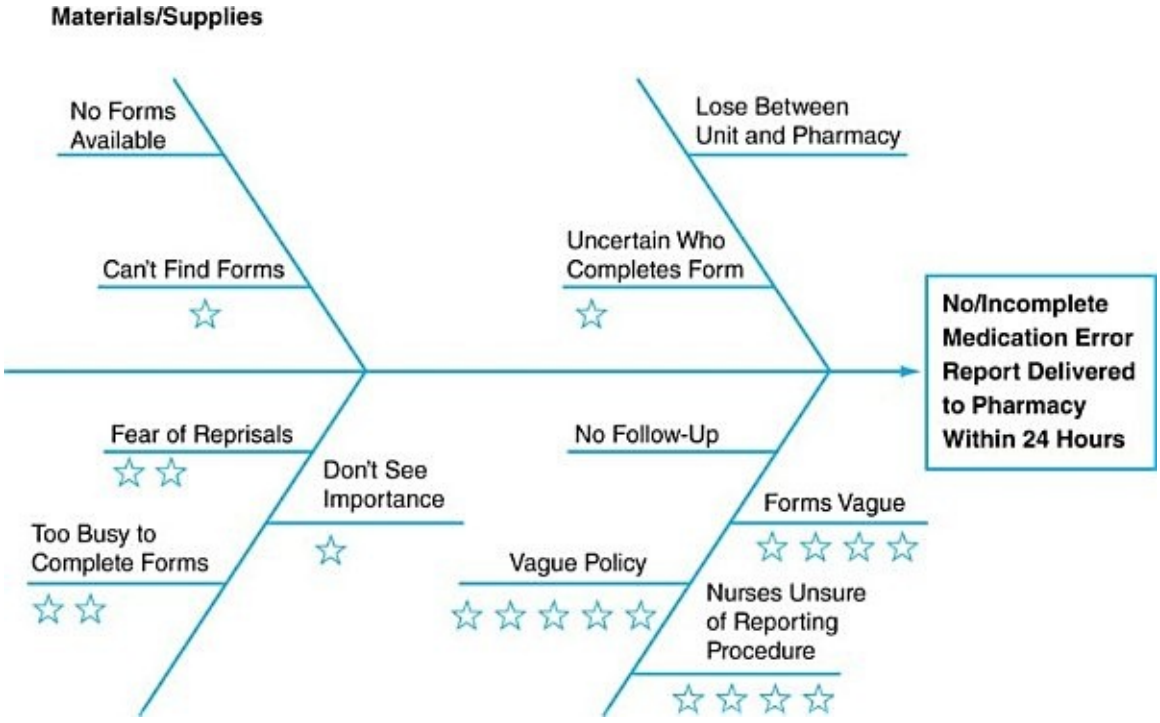

Organizational Profile:
Environment, Relationships, and Challenges
1
Leadership
2
Strategic Planning
3
Focus on Patients, Other Customers, and Markets
4
Measurement, Analysis, and Knowledge Management
5
Staff Focus
6
Process Management
7
Organizational Performance Results

Spaghetti Diagram of
of Pre-Procedural Clinic Patient Movement



Note: Excessive movement, Patients may return to waiting area due to delays between steps 3, 4 and 5. Within- and between-day variation


Medication Error Occurs
Assess Patient, Take Appropriate Action
Notify Change Nurse and Supervisor
Document Error on Patient Record
Complete Incident Report
Deliver Report to Pharmacy
End


Materials/Supplies
No Forms Available
Can't Find Forms
Fear of Reprisals
Too Busy to Complete Forms
Don't See Importance
Lose Between Unit and Pharmacy
Uncertain Who Completes Form
No Follow-Up
Forms Vague
Vague Policy
Nurses Unsure of Reporting Procedure
No/Incomplete Medication Error Report Delivered to Pharmacy Within 24 Hours

-
-
-
-

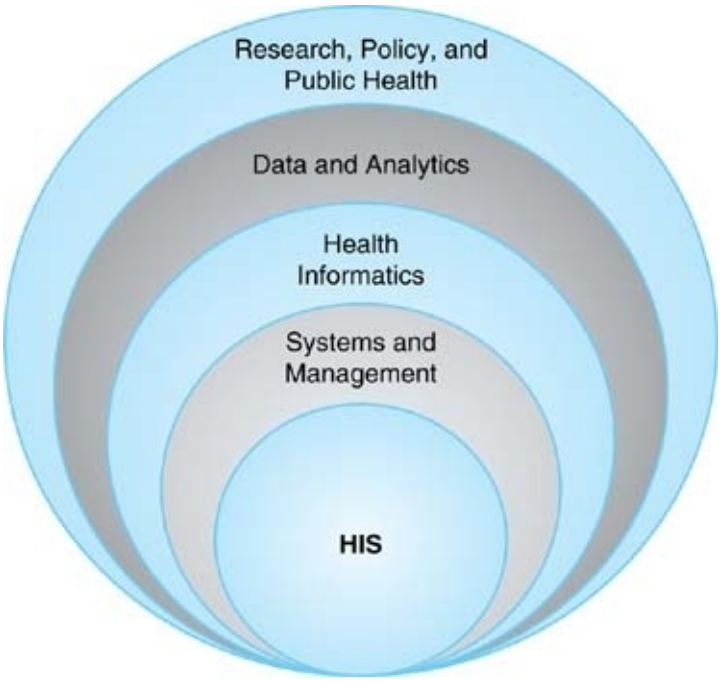

Research, Policy, and
Public Health
Data and Analytics
Health
Informatics
Systems and
Management
HIS

TABLE 8-1 Examples of Typical Clinical Systems in Hospitals

Clinical System Name	Clinical System Function	Primary User(s)
Laboratory System	Tracks lab order and results	Laboratory department
Radiology System	Tracks radiology orders and results	Radiology department
Pharmacy System	Tracks medication orders including when dispensed	Pharmacy department
Clinical Data Repository (CDR)	Storage of all clinical data	Clinicians
Computerized Provider Order Entry (CPOE)	Electronic ordering of all orders for a patient by a provider such as a physician, pharmacist, or advanced practitioner	Providers
Nursing/Clinical Documentation	Online documentation of the care of patients by nursing, physical therapy, respiratory therapy, etc.	Nurses, therapists
Clinical Decision Support System (CDSS)	Alerts that indicate potentially harmful situations for patients	Physicians, pharmacists, nurses
Picture Archiving and Communications System (PACS)	System that stores actual digital imaging of radiology, cardiology, and other studies	Physicians

EMR Adoption Model[SM]	
Stage	Cumulative Capabilities
Stage 7	Complete EMR; CCD transactions to share data; Data warehousing; Data continuity with ED, ambulatory, OP
Stage 6	Physician documentation (structured templates), full CDSS (variance & compliance), full R-PACS
Stage 5	Closed loop medication administration
Stage 4	CPOE, Clinical Decision Support (clinical protocols)
Stage 3	Nursing/clinical documentation (flow sheets), CDSS (error checking), PACS available outside Radiology
Stage 2	CDR, Controlled Medical Vocabulary, CDS, may have Document Imaging; HIE capable
Stage 1	Ancillaries—Lab, Rad, Pharmacy—All Installed
Stage 0	All Three Ancillaries Not Installed

TABLE 8-2 Comparison of 2008 to 2015 EMRAM Scores for American Hospitals

EMRAM Stage	2008 Q4	2010 Q4	2014 Q4	2015 Q1
Stage 7	0.3%	1.0%	3.6%	3.7%
Stage 6	0.5%	3.2%	17.9%	22.2%
Stage 5	2.5%	4.5%	32.8%	30.8%
Stage 4	2.5%	10.5%	14.0%	13.6%
Stage 3	35.7%	49.0%	21.0%	19.7%
Stage 2	31.4%	7.1%	5.1%	4.3%
Stage 1	11.5%	7.1%	2.0%	2.2%
Stage 0	15.6%	11.5%	3.7%	3.5%
Total hospitals	5,168	5,281	5,467	5,462

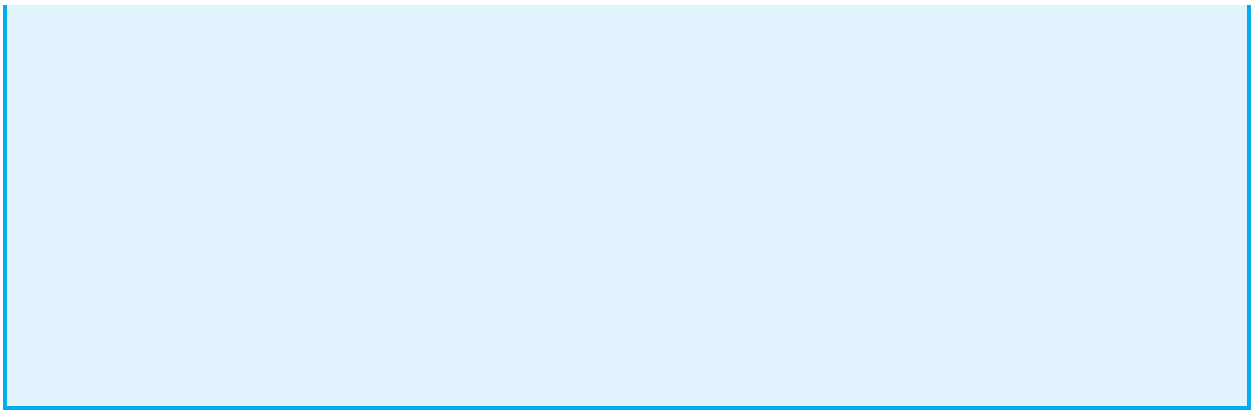
Courtesy of HIMSS ANALYTICS

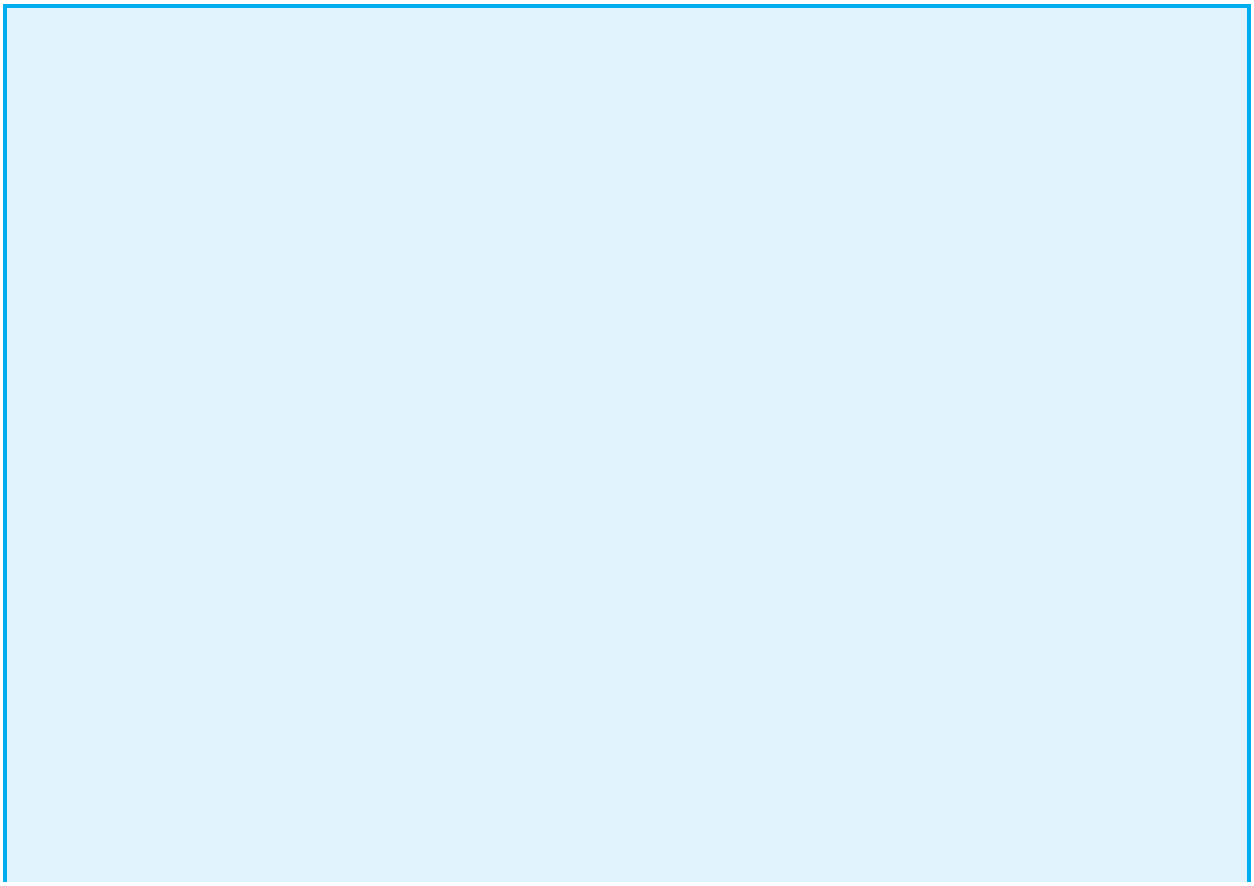
-
-

-
-
-
-
-

-
-
-
-

-
-
-
-
-





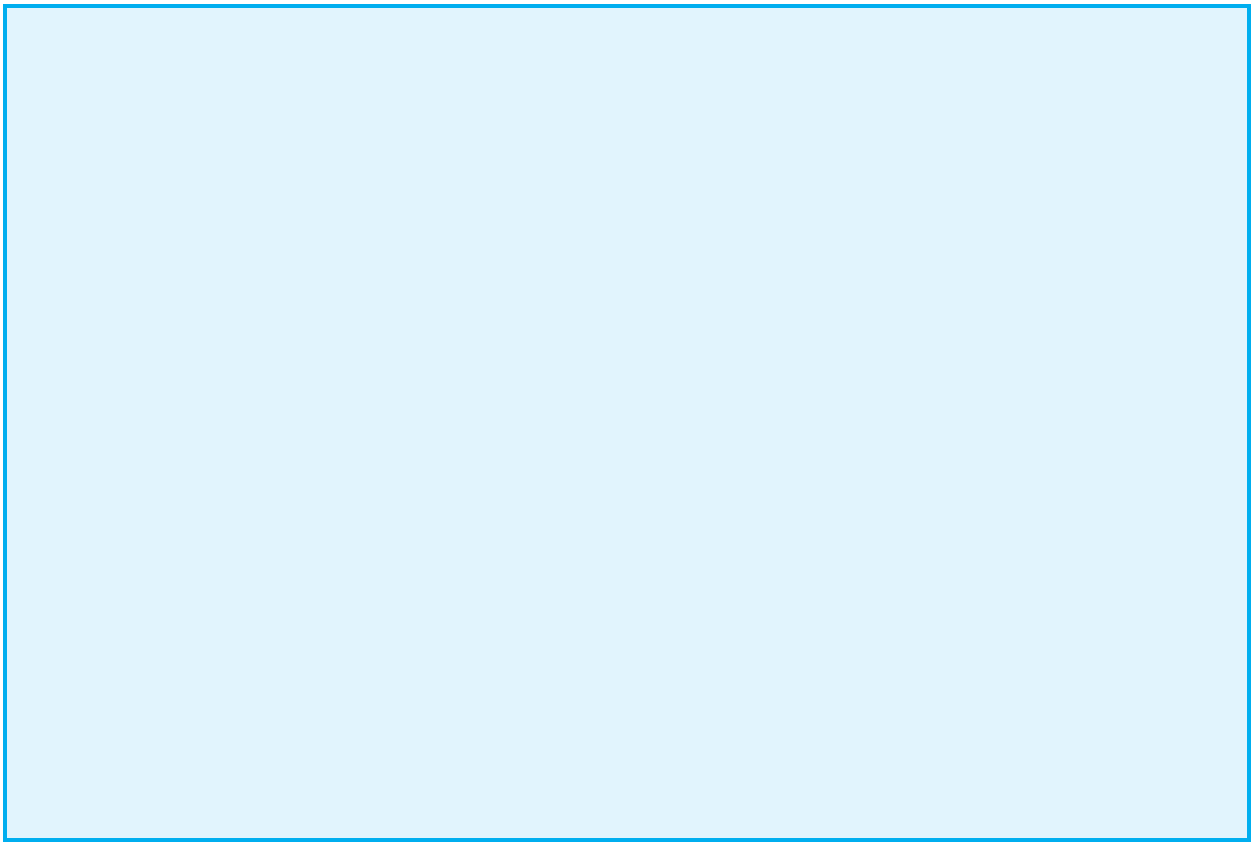


TABLE 9-1 2013 National Health Spending by Type of Expenditure

Expenditure Type	Amount (in billions)
Hospital care	936.9
Physician and clinical services	586.7
Other professional, dental, and personal care services	191.2
Other health, residential and personal care*	148.2
Prescription drugs	271.1
Durable medical equipment and other nondurable medical products	98.9
Nursing home and home health care	235.6
Government administration	37.0
Net cost of health insurance	173.6
Public health activities	75.4
Research	43.6
Structures and equipment	117.9
TOTAL	$2,919.1

Source: CMS, 2014a.

*Includes health-related spending for Children's Health Insurance Program (CHIP) Titles XIX and XXI, Department of Defense, and Department of Veterans Affairs.

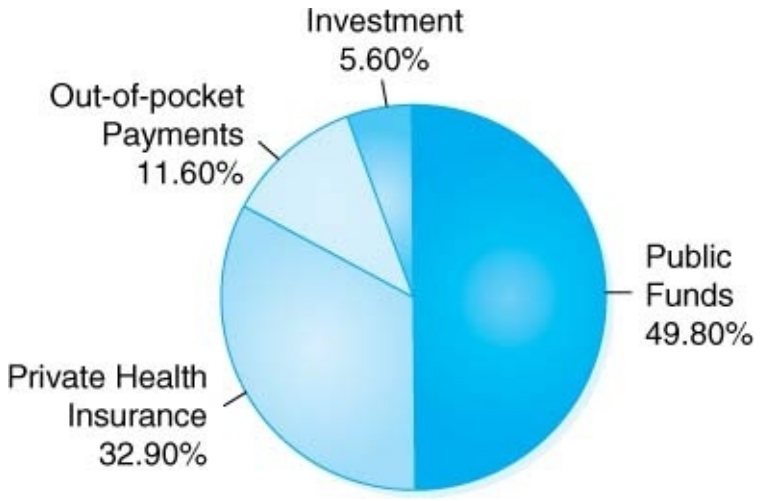

Investment
5.60%
Out-of-pocket
Payments
11.60%
Public
Funds
49.80%
Private Health
Insurance
32.90%

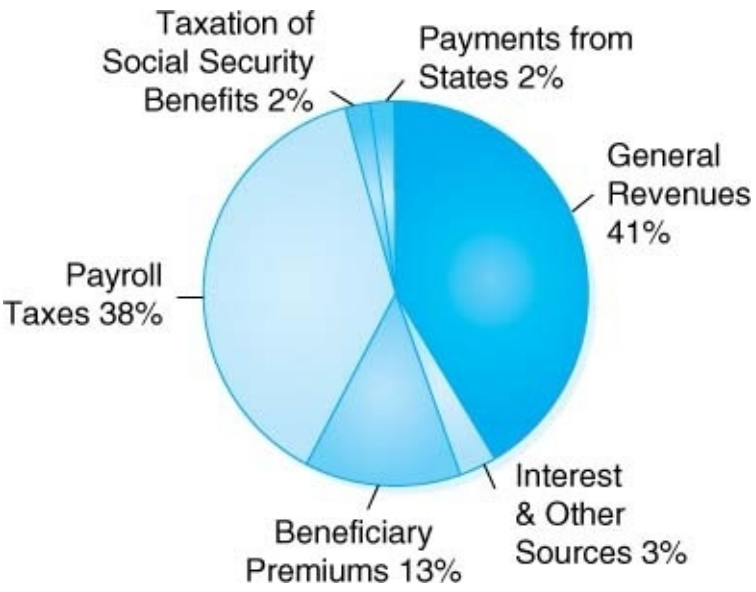
TABLE 9-2 Health Plan Enrollment by Type of Plan, 1988–2014

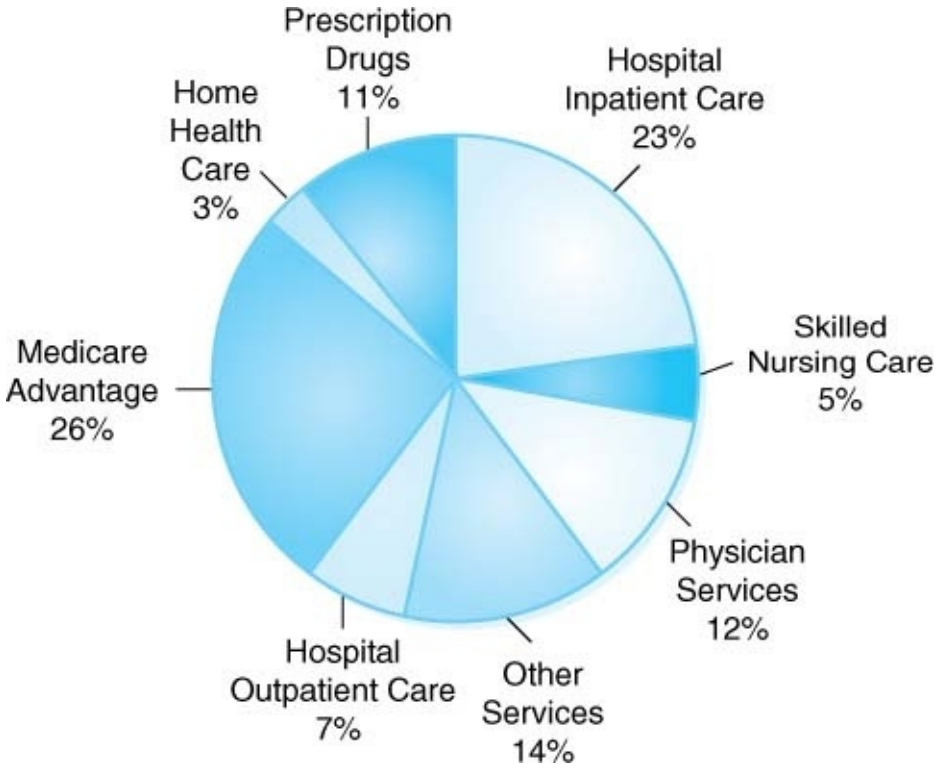
Type of Plan	1988	1993	1998	2003	2008	2013	2014
Conventional	73%	46%	14%	5%	2%	<1%	<1%
HMO	16%	21%	27%	24%	20%	14%	13%
PPO	11%	26%	35%	54%	58%	57%	58%
POS	0%	7%	24%	17%	12%	8%	8%
HDHP/SO	0%	0%	0%	0%	8%	20%	20%

Data from: Kaiser Family Foundation and Health Research and Educational Trust, 2014.

TABLE 9-3 Comparison of Insurance Plan Characteristics

	Indemnity Plans	Health Maintenance Organizations (HMOs)	Preferred Provider Organizations (PPOs)	Point-of-Service Plans (POSs)	High-Deductible Health Plans (HDHPs)
Access to Care	Unlimited	Limited and controlled; may require waiting for care	Unlimited	Unlimited	Unlimited
Geographic Limitations	None	Limited to geographic regions served by HMO, except in emergencies	Unlimited	Unlimited	Unlimited
Choice of Provider	Unlimited	Limited to in-network providers	Unlimited, but pay less when preferred (in-network) providers used	Can go out of network, but pay more	Unlimited
Access to Specialists	Unlimited	Limited; need referral from gatekeeper for some services	Unlimited; can self-refer	Unlimited; may self-refer out of plan at a higher cost	Unlimited
Utilization Restrictions	None	Limitations may be imposed on certain services	Mostly unlimited; plan may place annual dollar or visit limits	Mostly unlimited; plan may place annual dollar or visit limits	Unlimited
Deductibles/ Copayments	Both typically must be met	No deductibles/small copays	Deductibles and copays required	Deductibles and copays required	High deductibles required
Coinsurance	Required	None	Required	Required for services received out of plan	None
Quality Issues	Likely to be high	May be lower, if patients have to wait for care	Likely to be high	Likely to be high, if patient gets second opinions	Likely to be high
Paperwork	Insured must complete to get reimbursed	Minimal; billing only needed on a small number of procedures	Excessive	Moderate for out-of-plan services	Minimal, unless catastrophic incident occurs
Administrative Costs	Moderately high	Low; controlled by not having to bill for most services	High; uncontrolled	Moderate to high	Low
Management of Costs	Costs difficult to manage; plans are cost inducing	Costs are known and can be managed	Costs are difficult to manage; costs are based on utilization	Costs are partially known for in-plan care; out-of-plan care is less known	Patients manage expenditures, unless catastrophic incident occurs


Taxation of
Social Security
Benefits 2%
Payments from
States 2%
General
Revenues
41%
Payroll
Taxes 38%
Interest
& Other
Sources 3%
Beneficiary
Premiums 13%


Prescription Drugs 11%
Hospital Inpatient Care 23%
Home Health Care 3%
Skilled Nursing Care 5%
Medicare Advantage 26%
Physician Services 12%
Hospital Outpatient Care 7%
Other Services 14%

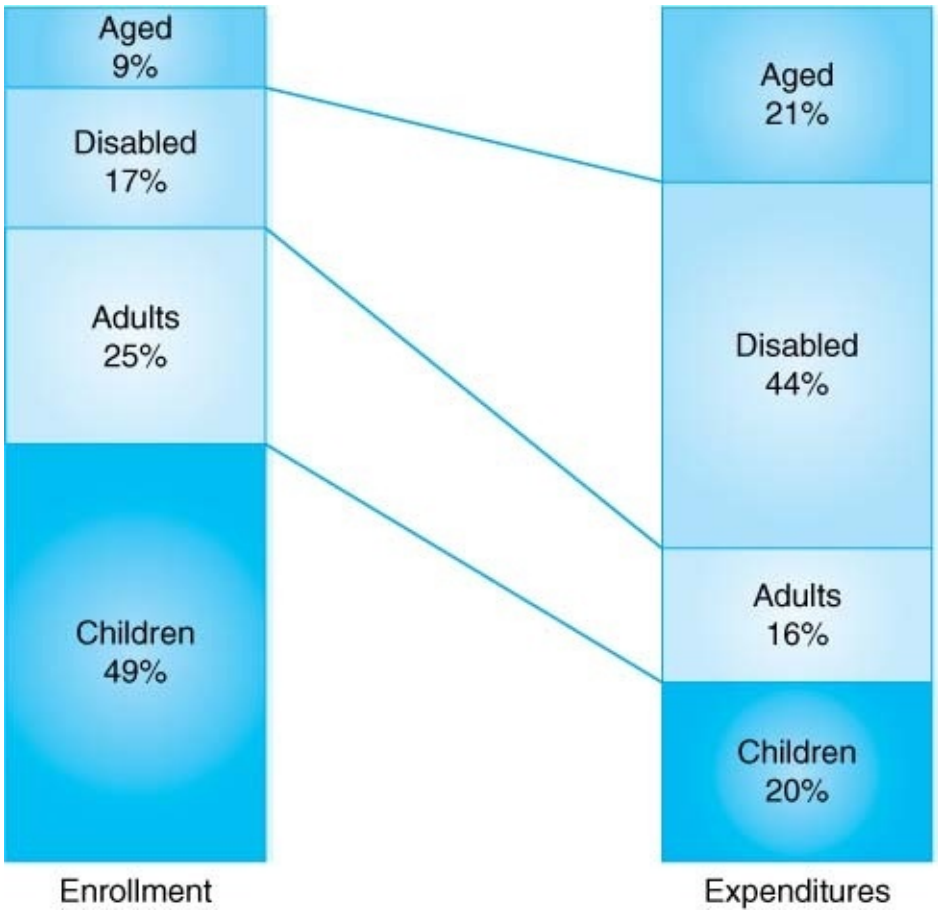

Aged
9%
Disabled
17%
Adults
25%
Children
49%
Enrollment
Aged
21%
Disabled
44%
Adults
16%
Children
20%
Expenditures

TABLE 9-4 VA Enrollment Categories (Abbreviated Explanation)

Category 1: Service-connected (SC) veterans—50% or more disabled

Category 2: SC veterans—30–40% disabled

Category 3: SC 10–20%; former prisoners of war; Purple Heart recipients

Category 4: Vets receiving aid and attendance allowance or catastrophically disabled

Category 5: Low-income SC veterans with 0% disability and non-SC vets; vets receiving VA pension; vets eligible for Medicaid

Category 6: WWI vets; Mexican Border War vets; compensable SC vets with 0% disability; vets seeking care for herbicide exposure (Vietnam); vets exposed to ionizing radiation; vets with Gulf War illness; vets who participated in Project SHAD

Category 7: Vets with income above a certain limit and below the HUD geographic index who agree to pay copays for services

Category 8: Same as Category 7 except above the HUD geographic index

Source: U.S. Department of Veterans Affairs, 2009b.

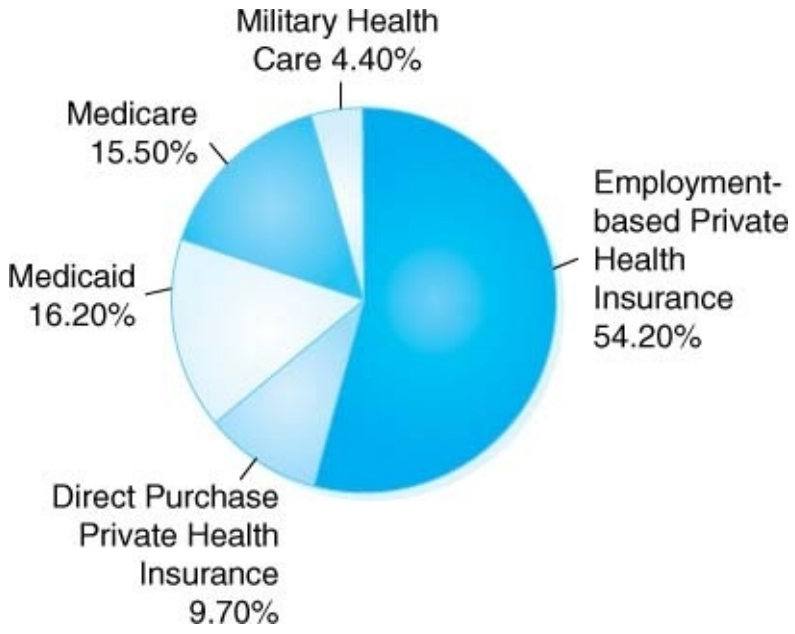
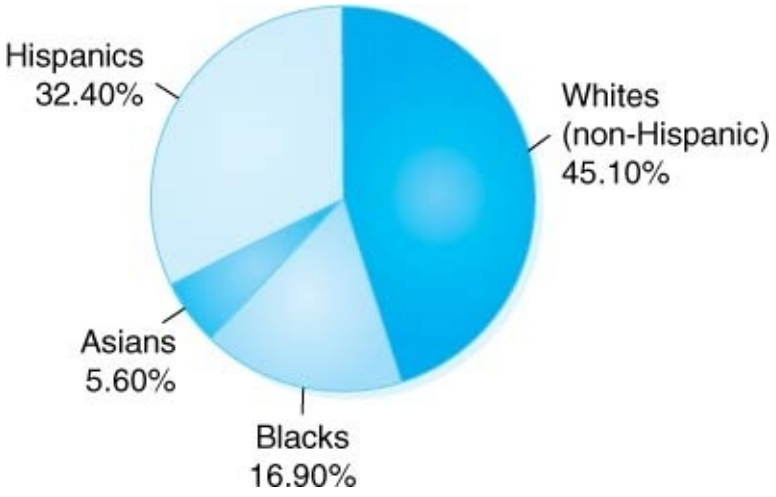

Military Health Care 4.40%
Medicare 15.50%
Medicaid 16.20%
Direct Purchase Private Health Insurance 9.70%
Employment-based Private Health Insurance 54.20%

TABLE 9-5 Premiums Paid by Employees and Employers by Type of Plan, 2014

Type of Plan	Employee Contribution	Employer Contribution	Total Premium
Individual coverage			
All plans	$1,081	$4,944	$6,025
HMO	$1,182	$5,041	$6,223
PPO	$1,134	$5,082	$6,217
POS	$984	$5,182	$6,166
HDHP/SO	$905	$4,394	$5,299
Family coverage			
All plans	$4,823	$12,011	$16,834
HMO	$5,254	$12,129	$17,383
PPO	$4,877	$12,456	$17,333
POS	$4,849	$11,188	$16,037
HDHP/SO	$4,385	$11,016	$15,401

Data from: Kaiser Family Foundation and the Health Research and Educational Trust, 2014, p. 2.


Hispanics
32.40%
Whites
(non-Hispanic)
45.10%
Asians
5.60%
Blacks
16.90%

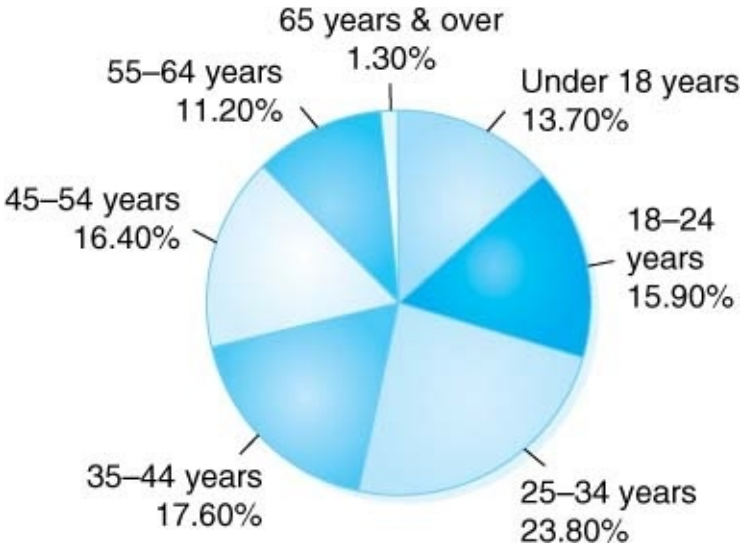

65 years & over
1.30%
55–64 years
11.20%
Under 18 years
13.70%
45–54 years
16.40%
18–24
years
15.90%
35–44 years
17.60%
25–34 years
23.80%

TABLE 10-1 Comparison of For-Profit and Not-for-Profit Organizations

For-Profit	Not-for-Profit
Serve private interests	Serve public or community interests
Pay federal and state income taxes on profits, state and local sales taxes, and property taxes	Are exempt from taxes; health care organizations receive 501(c)(3) designation if they meet federal IRS criteria
Must file an annual for-profit tax return	Must file the IRS 990 annual corporate tax return, including a community services benefits report
Are motivated by profit, with income benefitting individuals	Revenues cannot benefit individuals, beyond payment of reasonable salaries
Must pay business fees	Are exempt from paying most business fees and licenses
Must adhere to taxable bond yields	Can access tax-exempt bond markets to raise capital
May participate in political campaigns and influence legislation	May not participate in political campaigns or influence legislation
Able to issue stock to raise capital and offer stock options to recruit and retain staff	May not issue stock or offer stock options to staff
Have limited obligation to provide indigent care	Must provide designated amounts of community benefit, including indigent care

TABLE 10-2 Frequently Utilized Methods of Classifying Costs

METHOD	CLASSIFICATION	EXAMPLE
By behavior	**Fixed costs**—stay the same in relation to changes in volume of services	Electricity for lighting
	Variable costs—change directly in relation to changes in volume	Number of sutures used to close incisions
	Semivariable costs—partially fixed and partially variable	Labor costs are the same for patients 1–8; then with The Joint Commission standards, need another RN to take care of the ninth person
By traceability	**Direct costs**—can be traced to a particular patient, product, or service	Gauze pads used in dressing a wound
	Indirect costs (overhead)—cannot be traced to a particular patient or service	Amount of water used during a typical hospital stay
	Full costs—both direct costs and indirect costs	Treatments provided plus utilities used
By decision-making capability	**Controllable costs**—under the manager's influence	Wages of certified nursing assistants (CNAs) per shift
	Uncontrollable costs—cannot be controlled by the manager	Upper administrative hours allocated to department
	Sunk costs—already incurred and cannot be influenced further	Cost of insurance paid in advance
	Opportunity costs—proceeds lost by rejecting alternatives	No purchase of X-ray machine if money spent on new ultrasound machine

TABLE 10-3 Hospital Departmental Involvement in Managing Accounts Receivable

Department	AR Involvement
Contracts	Relationships and contract negotiation with third-party payers
Admissions/registration	Precertification, preadmission, insurance verification
Patient care unit (nursing, lab, radiology, rehab, etc.)	Documentation capture, charge capture for services rendered
Medical records	Coding, utilization review, QA (quality assurance audits)
Billing	Bill preparation, billing audits
Compliance	Fraud and abuse internal audits
Collections	Collection policy and procedures, financial counseling, third-party, and self-pay follow-up
Legal	Contracts, litigation policy, federal regulations, patient rights

TABLE 10-4 Inventory Management Techniques

FIFO Example

Date	Purchased	Sold	Balance
August 3			200 @ $10 = $2,000
August 9		100 @ $10 = $1,000	100 @ 10 = 1,000
August 11	300 @ $11 = $3,300		100 @ 10 = 1,000
			300 @ 11 = 3,300
August 12		100 @ 10 = 1,000	200 @ 11 = 2,200
		100 @ 11 = 1,100	
August 20	50 @ 14 = 700		200 @ 11 = 2,200
			50 @ 14 = 700
August 26		200 @ 11 = 2,200	50 @ 14 = 700
August 29	200 @ 12 = 2,400		50 @ 14 = 700
			200 @ 12 = 2,400
Total August 30	550 $ 6,400	500 $ 5,300	250 $ 3,100
2,000 + 6,400 − 5,300 − 3,100 = 0			

IIFO Example

Date	Purchased	Sold	Balance
August 3			200 @ $10 = $2,000
August 9		100 @ $10 = $1,000	100 @ 10 = 1,000
August 11	300 @ $11 = $3,300		100 @ 10 = 1,000
			300 @ 11 = 3,300
August 12		200 @ 11 = 2,200	100 @ 10 = 1,000
			100 @ 11 = 1,100
August 20	50 @ 14 = 700		100 @ 10 = 1,000
			100 @ 11 = 1,100
			50 @ 14 = 700
August 26		50 @ 14 = 700	
		100 @ 11 = 1,100	
		50 @ 10 = 500	50 @ 10 = 500
August 29	200 @ 12 = 2,400		50 @ 10 = 500
			200 @ 12 = 2,400
Total August 30	550 $ 6,400	500 $ 5,500	250 $ 2,900
2,000 + 6,400 − 5,500 − 2,900 = 0			

Weighted-Average Example

Date	Purchased	Sold	Balance
August 3			200 @ $10 = $2,000
August 9		100 @ $ 10 = $1,000	100 @ 10 = 1,000
August 11	300 @ $11 = $3,300		400 @ 10.75 = 4,300
August 12		200 @ 10.75 = 2,150	200 @ 10.75 = 2,150
August 20	50 @ 14 = 700		250 @ 11.40 = 2,850
August 26		200 @ 11.40 = 2,280	50 @ 11.40 = 570
August 29	200 @ 12 = 2,400		250 @ 11.88 = 2.970
Total August 30	550 $ 6,400	500 $ 5,430	250 $ 2,970

2,000 + 6,400 − 5,430 − 2,970 = 0

-
-
-
-
-

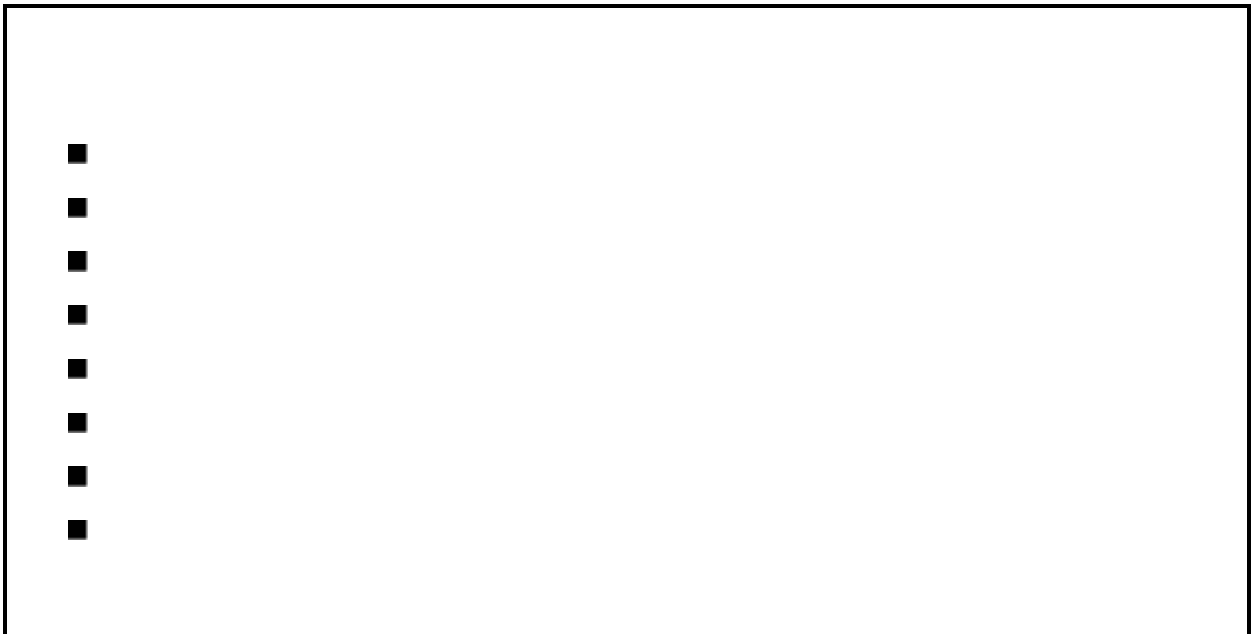


TABLE 12-1 Environmental Forces and Impacts on Human Resources Management

Force	Impact
Declining reimbursement	Less resources to recruit, compensate, and develop workforce
Declining supply of workers	Shortage of skilled workers, changes in recruiting and staffing specialized services, lower satisfaction of workers
Increasing population need	Increased volumes of patients and workload for HSOs
Increasing competition among HSOs	Competition for health care workers and pressure for higher wages
External pressure on HSOs	HR must ensure high performance in HSO for accountability and performance

TABLE 12-2 Projected Growth in Health Care Occupations Employment, 2012–2022

Occupation	Total Employment, 2012	Projected Total Employment, 2022	Difference (percentage)	Median Annual Earnings in 2012
Physician Assistants	86,700	120,000	33,300 (38%)	$90,930
Physical Therapists	204,200	277,700	73,500 (36%)	$79,860
Physicians and Surgeons	691,400	814,700	123,300 (18%)	$187,200
Registered Nurses	2,711,500	3,238,300	526,800 (19%)	$65,470
Medical and Health Services Managers	315,500	388,800	73,300 (23%)	$88,580

Bureau of Labor Statistics, 2014.

TABLE 12-3 Human Resources Functions

Function	Related Tasks
Workforce Planning/Recruitment	Job analysis
	Manpower planning
	Job descriptions
	Recruitment, selection, negotiation, and hiring
	Orientation
Employee Retention	Employee relations and engagement
	Training and development
	Compensation and benefits
	Employee assistance programs
	Assessing performance
	Labor relations
	Leadership development
	Employee suggestion programs

TABLE 12-4 Key Federal Legislation Affecting Human Resources Management

1935	**National Labor Relations Act** (as amended in 1974). Provides for bargaining units and collective bargaining in hospitals and health services organizations.
1938	**Fair Labor Standards Act** (as amended many times). Employees who are nonexempt from minimum wage and overtime provisions must be paid minimum wage and time and a half for hours beyond 40 hours per week. Special provisions for health services organizations.
1963	**Equal Pay Act**. Prohibits discrepancies in pay between men and women who perform the same job.
1964	**Civil Rights Act** (as amended many times). Prohibits discrimination in screening, hiring, and promotion of individuals based on gender, color, religion, or national origin (Title VII).
1967	**Age Discrimination in Employment Act**. Prohibits employment discrimination against employees age 40 and older.
1970	**Occupational Safety and Health Act**. Requires employers to maintain a safe workplace and adhere to standards specific to health care employers.
1973	**Rehabilitation Act**. Protects the rights of handicapped people (physically or mentally impaired) and protects them from discrimination.
1974	**Employee Retirement Income Security Act (ERISA)**. Grants protection to employees for retirement benefits to which they are entitled.
1978	**Pregnancy Discrimination Act**. Requires employers to consider pregnancy a "medical condition" and prohibits exclusion of pregnancy in benefits and leave policies.
1986	**Consolidated Omnibus Budget Reconciliation Act (COBRA)**. Gives employees and their families the right to continue health insurance coverage for a limited time due to various circumstances such as termination, layoff, death, reduction in hours worked per week, and divorce.
1986	**Immigration Reform and Control Act.** Establishes penalties for employers who knowingly hire illegal aliens.
1987	**Worker Adjustment and Retraining Notification Act**. Requires employers who will make a mass layoff or plant closing to give 60 days' advance notice to affected employees.
1989	**Whistleblower Protection Act**. Protects employees who report employer misconduct or wrongdoing with respect to compliance with federal and state law.
1990	**Americans with Disabilities Act (ADA)**. Gives people with physical and mental disabilities access to public services and requires employers to provide reasonable accommodation for applicants and employees.
1993	**Family and Medical Leave Act (FMLA)**. Permits employees in organizations to take up to 12 weeks of unpaid leave each year for family or medical reasons.
2003	**Health Insurance Portability and Accountability Act (HIPAA)**. Affords employee protection from outside access to personal health information and limits employers' ability to use employee health information under health insurance plans.
2010	**Patient Protection and Affordable Care Act (PPACA or ACA)**. Enacts various health insurance reforms, including requiring employers to offer coverage, prohibiting denial of coverage/claims based on preexisting conditions, and extending insurance coverage for dependent children to age 26.

Data from: Busse, 2005; Kaiser Family Foundation, 2010; Lehr, McLean, & Smith, 1998; U.S. Department of Labor, 2006.

BON SECOURS HEALTH CORPORATION
St. Francis Medical Center

POSITION DESCRIPTION

TITLE: Environmental Services Aide **JOB CODE: 950**
DEPARTMENT: Environmental Services
REPORTS TO: **FLSA: Non-exempt**

I. GENERAL PURPOSE OF POSITION:

The primary responsibility of this position is to perform cleaning tasks to maintain designated areas in a clean, safe, orderly and attractive manner. The employee is expected to follow detailed instructions and/or written task schedules to accomplish assigned duties. This position serves all populations of visitors, employees, physicians and patients.

II. EMPLOYMENT QUALIFICATIONS:

1. Ability to communicate and interpret assignments issued through a computerized paging system.
2. Dependability and flexibility demonstrated through previous work or school history.
3. Previous housekeeping work experience preferred.

III. ESSENTIAL JOB FUNCTIONS:

1. Communicates all hospital-related issues to Supervisor.
2. Performs the duties necessary to maintain the sanitary conditions of the hospital, including routine cleaning and maintenance of all floor types.
3. Prepares patient rooms for new admissions through the proper utilization of the Bedtracking® system. (LoginILogout)
4. Cleans and sanitizes isolation rooms and other contaminated areas following written techniques appropriate for that type of isolation (i.e., tuberculosis, HIV, hepatitis).
5. Performs general cleaning tasks using the 7 Steps process.
6. Follows hospital policy regarding storage and security of housekeeping chemicals.
7. Accurately uses Bedtracking® system to meet departmental response and cleaning time standards.
8. Responsible for the use and care of equipment and other hospital property. Maintains equipment by proper cleaning and storage; reports dangerous or broken equipment to team leader. Makes sure EVS cart is clean, box locks, and wringer free of lint.
9. Understands basic safety procedures. (RACE, PASS, MSDS, etc.)

IV. OTHER JOB EXPECTATIONS:

1. Actively participates in the hospital's Continuing Educational Improvement programs (i.e., Essential Skills, Safety Fairs, etc.)
2. Assists in the orientation of new employees in departmental methods and procedures.
3. Responds to unusual occurrences such as flood, spillage, etc.

V. WORKING CONDITIONS:

Works in all areas of the hospital and off-site properties. May be exposed to hazardous chemicals, but potential for harm is limited, if safety precautions are followed.

The individual performing this job may reasonably come into contact with human blood and other potentially infectious materials. The individual in this position is required to exercise universal precautions, use personal protective equipment and devices, when necessary, and learn the policies concerning infection control.

VI. BON SECOURS MISSION, VALUES, CUSTOMER ORIENTATION AND CONTINUOUS QUALITY IMPROVEMENT FOCUS:

It is the responsibility of all employees to learn and utilize continuous quality improvement principles in their daily work.

All employees are responsible for extending the mission and values of the Sisters of Bon Secours by understanding each customer, treating each patient, staff member, and community member in a dignified manner with respect, kindness, and understanding, and subscribing to the organization's commitment to quality and service.

VII. APPROVALS DATE

Department Manager

Administration _____

Human Resources

The above statements are intended to describe the nature and level of work being done by individuals assigned to this classification and are not to be construed as an exhaustive list of all job duties. This document does not create an employment contract, and employment with Bon Secours Richmond Health System is "at will".

TABLE 12-5 Responsibilities of HR Staff and Line Managers in Recruitment

HR Staff Person
Prepares position description
Prices jobs
Prepares advertisements/recruitment materials
Keeps track of applicants/maintains HR Information System
Checks applicant references
Maintains personnel files
Narrows candidate pool
Line Manager
Clarifies job function/provides input into position description
Interviews candidates
Ranks candidates
Selects candidate
Negotiates with candidate
Hires candidate

Management Summary Form

Confidential

Development Level:
1 = Performs below standard
2 = Inconsistently meets the standard
3 = Consistently meets the standard
4 = Frequently exceeds the standard
5 = Consistently exceeds the standard

_____ Annual Review
_____ Other

(For the initial review, please use the "Introductory Performance Review" Form)

Instructions: The Performance Improvement Plan is a tool designed to assist in managing, developing and reviewing an employee's effectiveness and efficiency. It also provides a common understanding of job expectations for present and future performance review periods. ***Please note all supporting comments on the Development Plan.***

I. Values (includes integration of Quest for Excellence Behaviors) *(see page 6-7 of the Process Guide)*

		Developmental Level				
		1	2	3	4	5
A.	Respect - commitment to treat people well (e.g., responsive - returns calls/emails). Justice - supporting and protecting the rights of all people. Integrity - honest in dealings (e.g., honors commitments, keeps promises). Compassion - experiencing empathy with another's life situation.					
B.	Stewardship - responsible use of Bon Secours resources (e.g., consistently on time). Innovation - creating or managing new ideas, methods, processes and/or technologies. Quality - continuous improvement of service; involved in Gallup/Quest planning. Growth - developing and improving services and promoting self-renewal; completion of previous year's Development Plan. (e.g., thinks "Big Picture").	1	2	3	4	5

Average Developmental Level for Section I (A + B/2)**:**

II. Leadership Competencies (see page 10-14 of the Process Guide)

	Developmental Level				
Change Management & Organization Development - planning & designing change strategies as needed; integrating individual dev. & organizational dev. into strategies.	1	2	3	4	5
Communication & Interpersonal Skills - listening & responding in constructive manner; promoting understanding while building productive working relationships.	1	2	3	4	5
Critical Thinking - examining underlying causes & determining best course of action.	1	2	3	4	5
Human Resource Development - facilitating others to achieve professional dev. goals.	1	2	3	4	5
Planning & Strategic Direction Setting - determining shape of present & future job environment; efficiently maintaining & improving practices; setting direction for dept./org.; **developing Gallup Impact, PRC, Quest for Excellence Plans.**	1	2	3	4	5
Promotion of Mission & Values - setting an example by integrating org. standards into day-to-day functions; guiding others to a common Mission & Vision.	1	2	3	4	5
Self-Knowledge & Insight - using personal understanding to promote positive self-change.	1	2	3	4	5
Team Building - promoting teamwork to accomplish dept./org. objectives.	1	2	3	4	5
Proficiency in Field - subject matter expert in field; resource to others.	1	2	3	4	5

Average Developmental Level for Section II (Sum of 9 Leadership Competency Dev. Levels/9)**:**

III. Essential Job Functions

(This section is determined by the Job Description and will vary with the Position being evaluated)

Average Developmental Level for Section III:

Overall Average: *(Average Level for Section I x .5) + (Average Level for Section II x .25) + (Average Level for Section III x .25)*

Development Plan

Name: _____

Facility & Dept.: _____

The Purpose of the Development Plan is to aid in the process of developing specific skills and behaviors. The Plan is reviewed and finalized during the performance review meeting. At a minimum, progress toward reaching agreed-upon goals should be discussed once during the year. ***This form must be completed by each employee and returned prior to the performance review.***

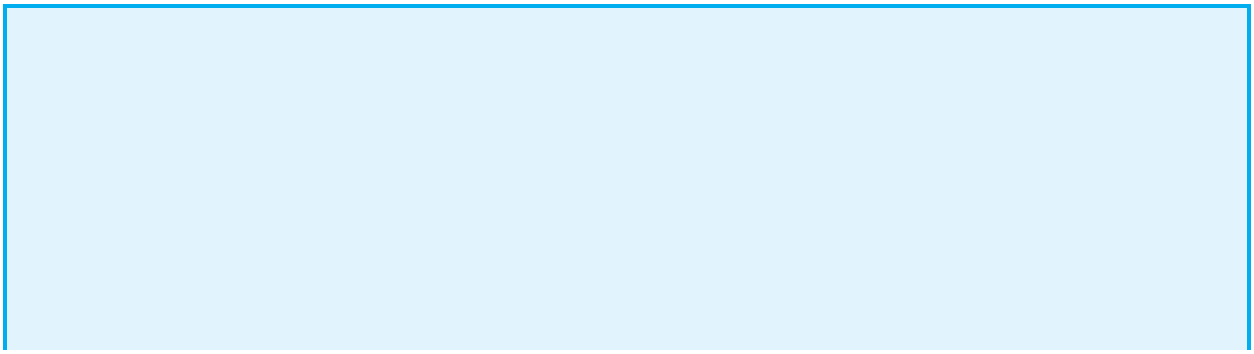
1 **Previous Objectives, Goals, and Accomplishments.** Review learning and development objectives, goals, and accomplishments achieved since last performance review; include knowledge and skill strengths used to accomplish objectives and goals.

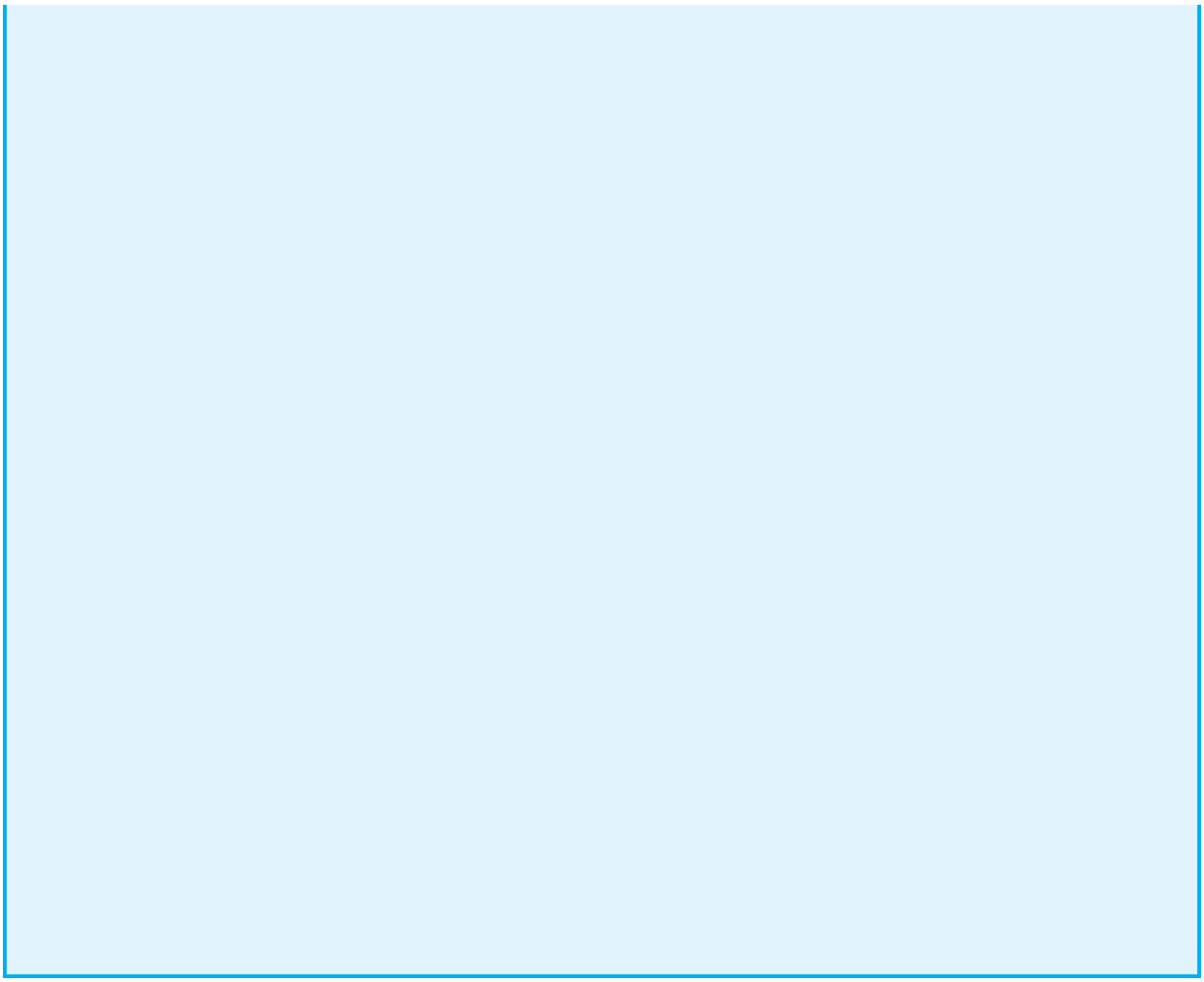
2 **New Objectives and Goals.** Identify new learning and development objectives and goals for the coming year, which include addressing opportunities for growth. Include issues, which may need to be addressed and opportunities needed to successfully implement, including implementation of Quest/Team Player improvements.

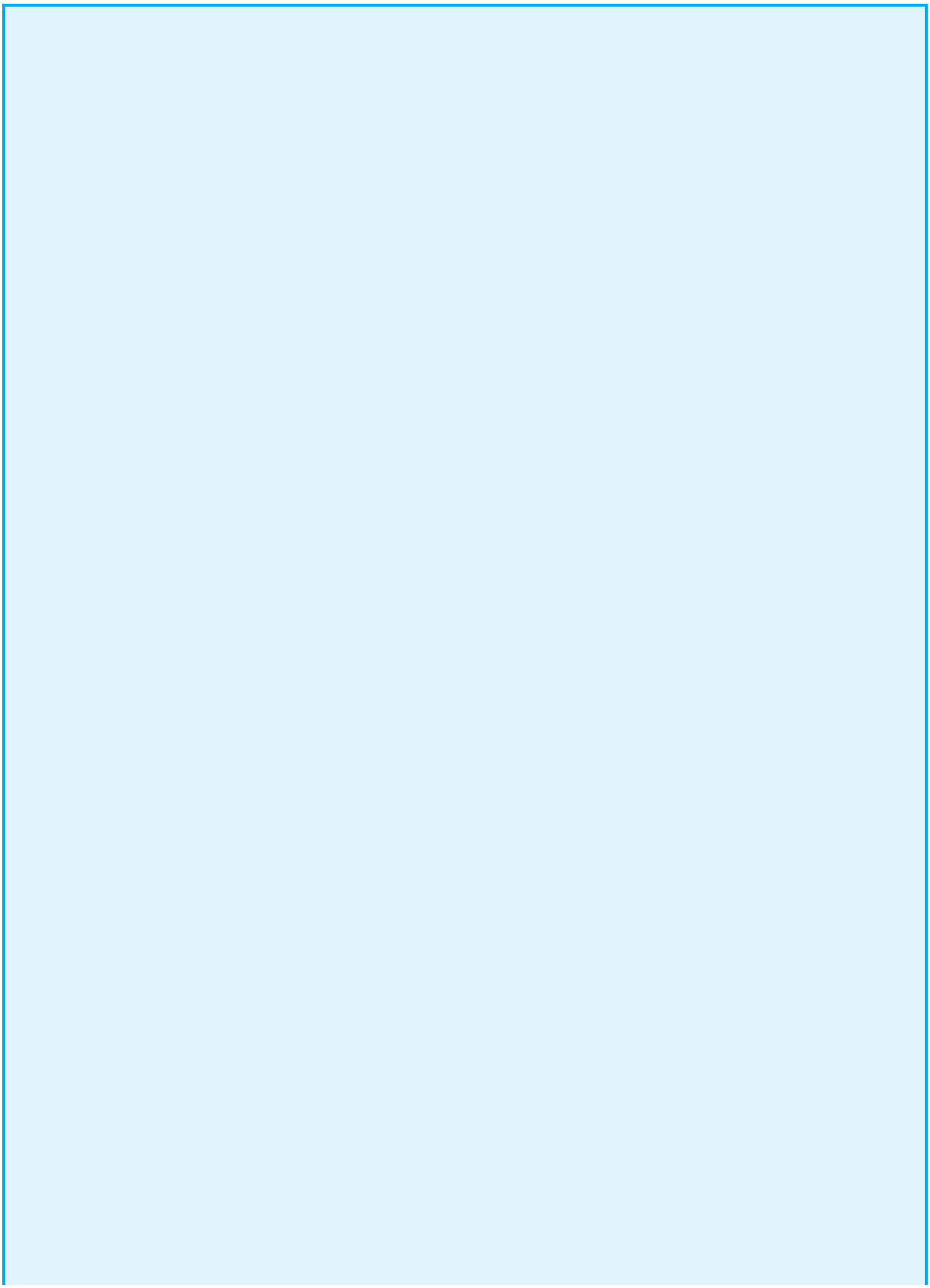
3 **Employee and/or Manager's Comments.** Additional comments may be made on a separate sheet of paper and attached to this form.

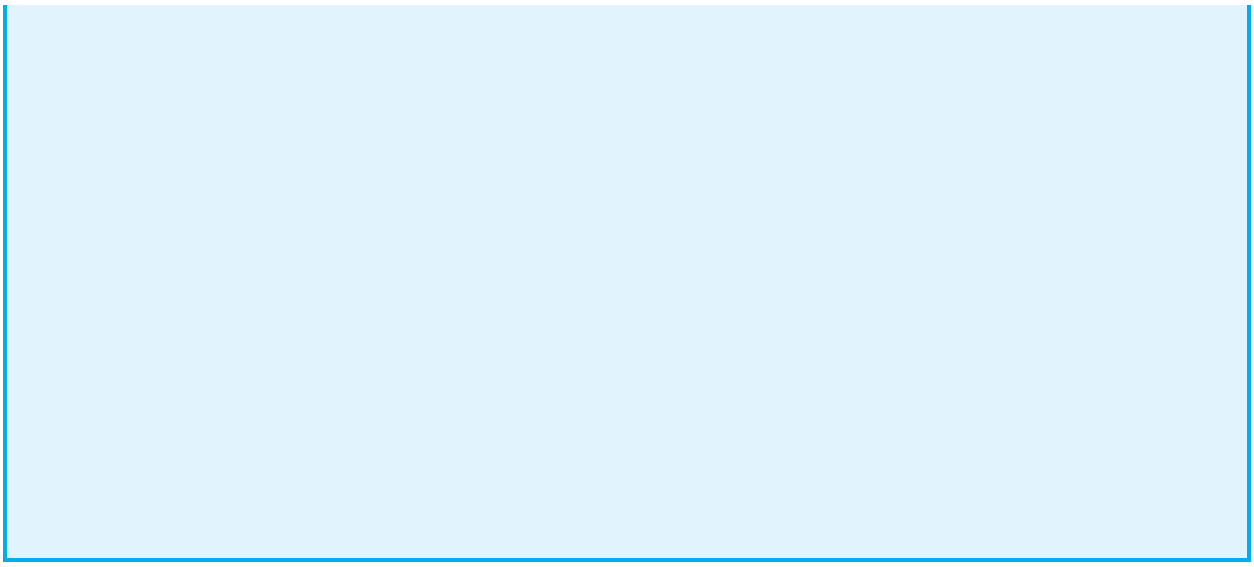
-
-
-
-
-
-
-

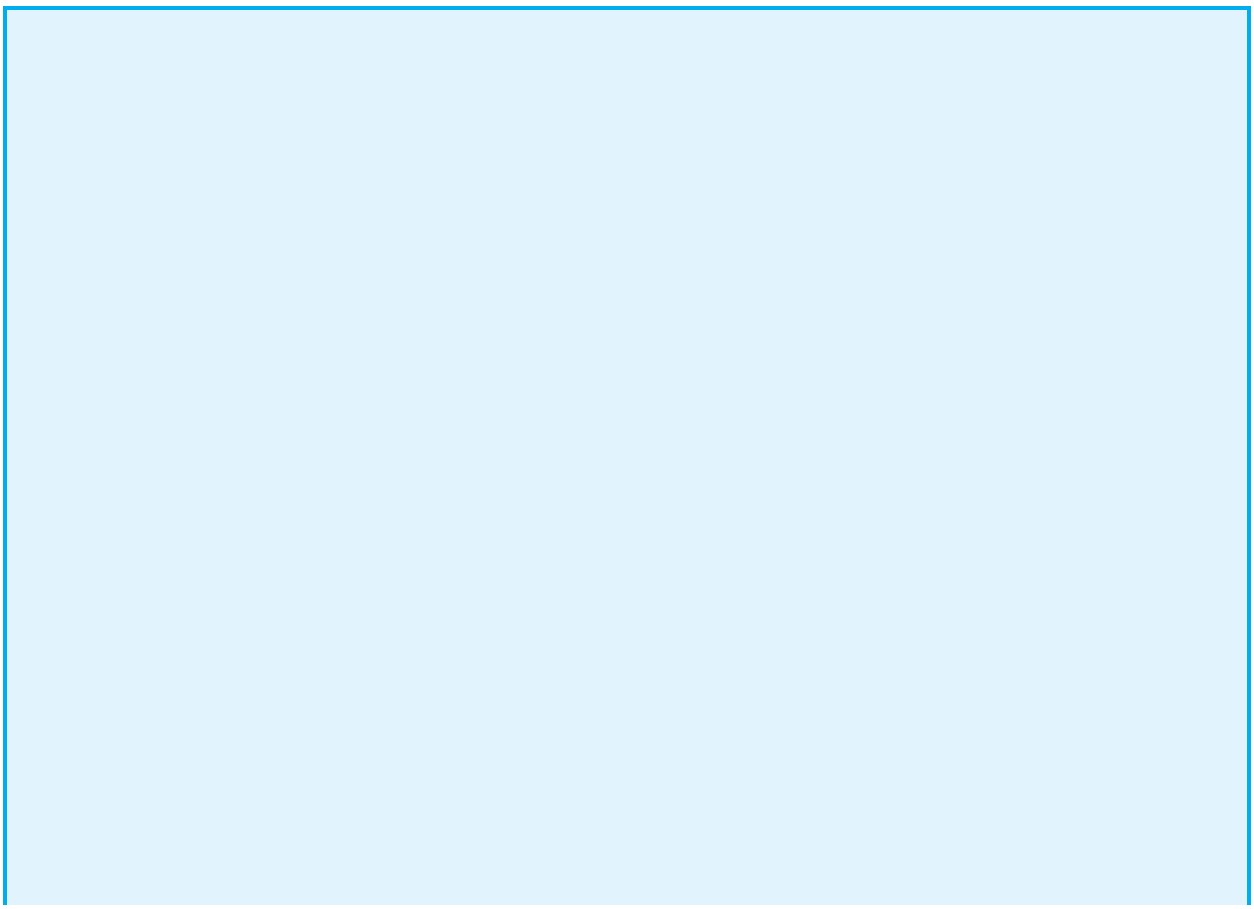
-
-
-
-

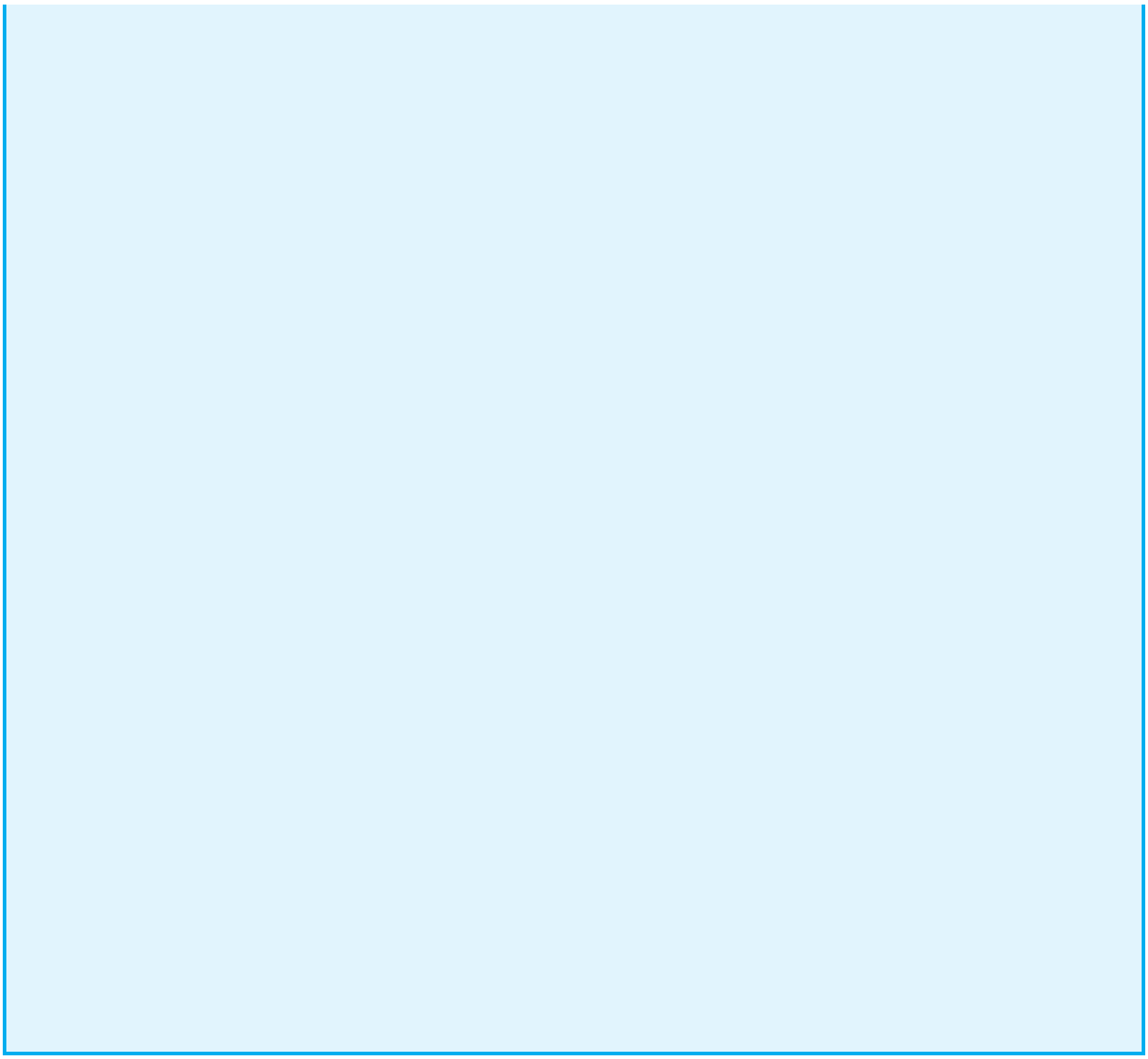


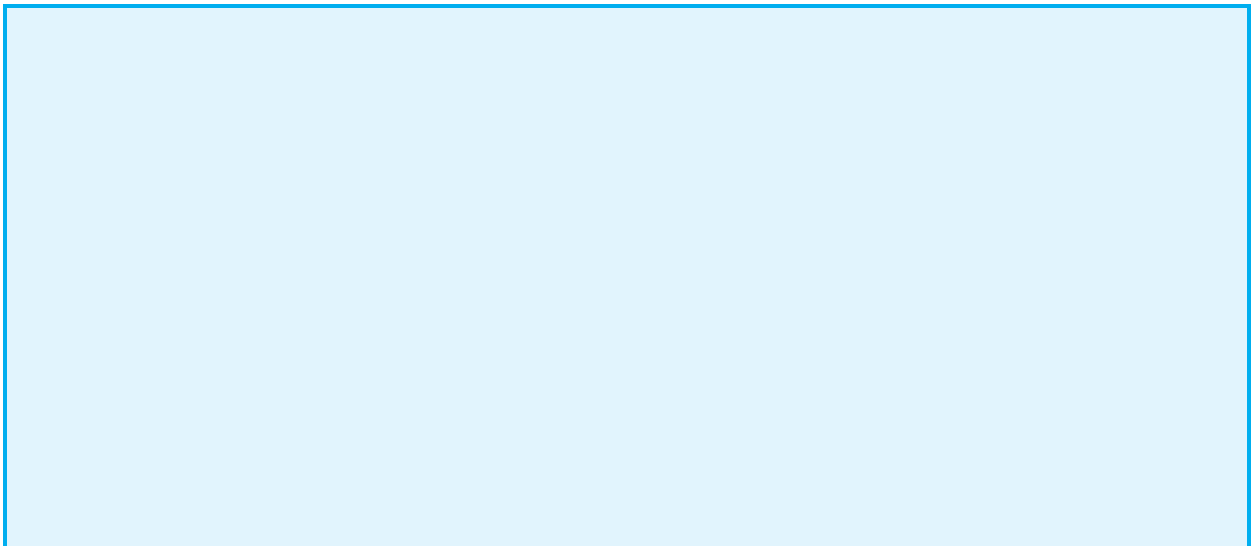




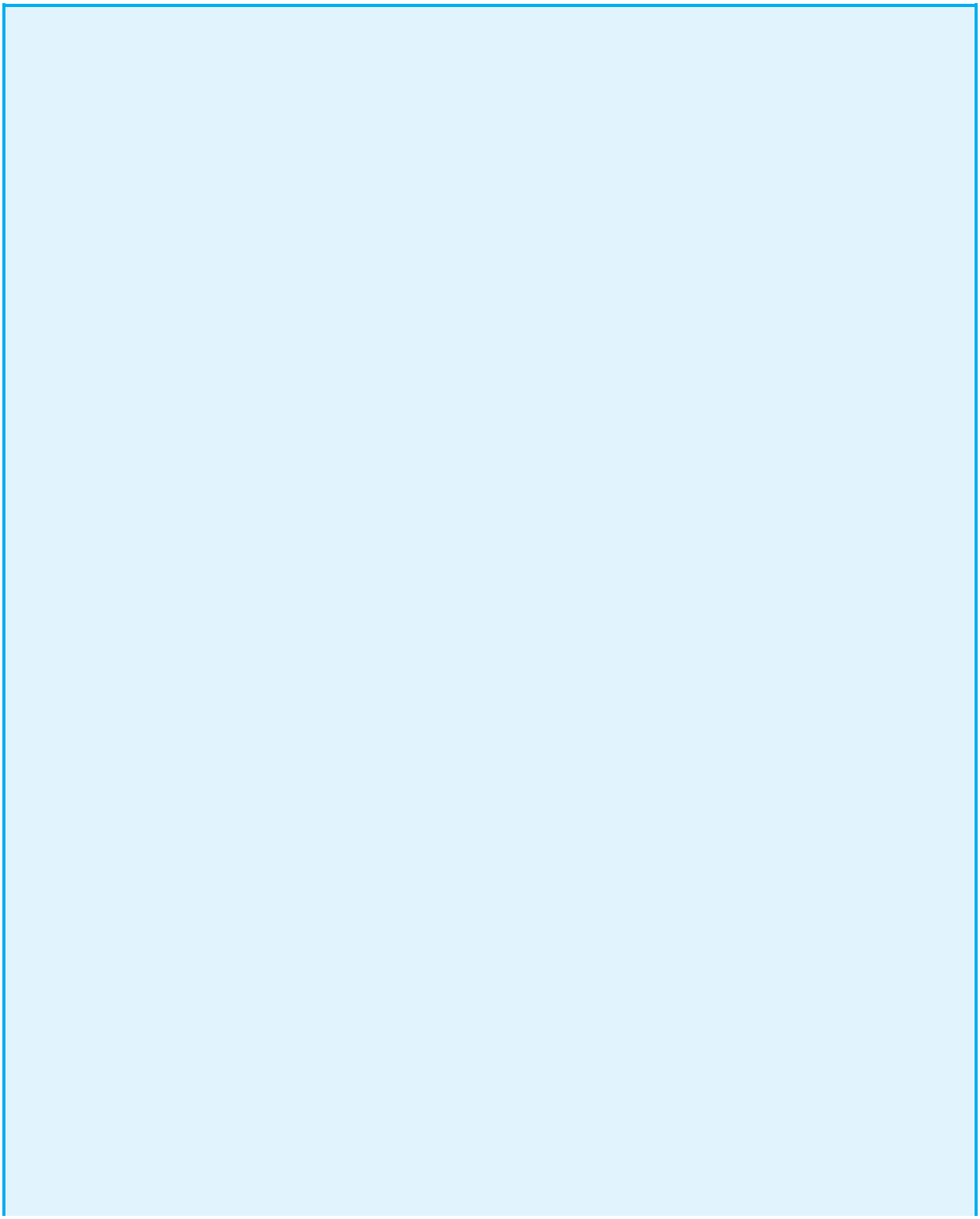








-
-
-
-
-
-
-



The purpose of Team XYZ is to _____ **<goals>** _____.

Our deadline for solving this problem is _____ **<date>** _____.

The team will meet _____ **<number of times or frequency of meetings>** _____.

Representatives from each affected area have been asked to serve on Team XYZ.

Those representatives are: _____ **<List names of team members>** _____

Team members will:

- Attend all team sessions, unless there is an emergency;
- Prepare for each session;
- Listen to each other with respect:
- Work collaboratively to identify and meet session goals;
- Be an active participant in group discussions;
- Keep an open mind, be willing to modify opinions or conclusions to keep the project moving forward;
- Present ideas concisely;
- Be considerate and tactful when participating in group discussions;
- Submit/delegate work on time and fulfill responsibilities as agreed; and
- Work actively to achieve group consensus on issues and problems.

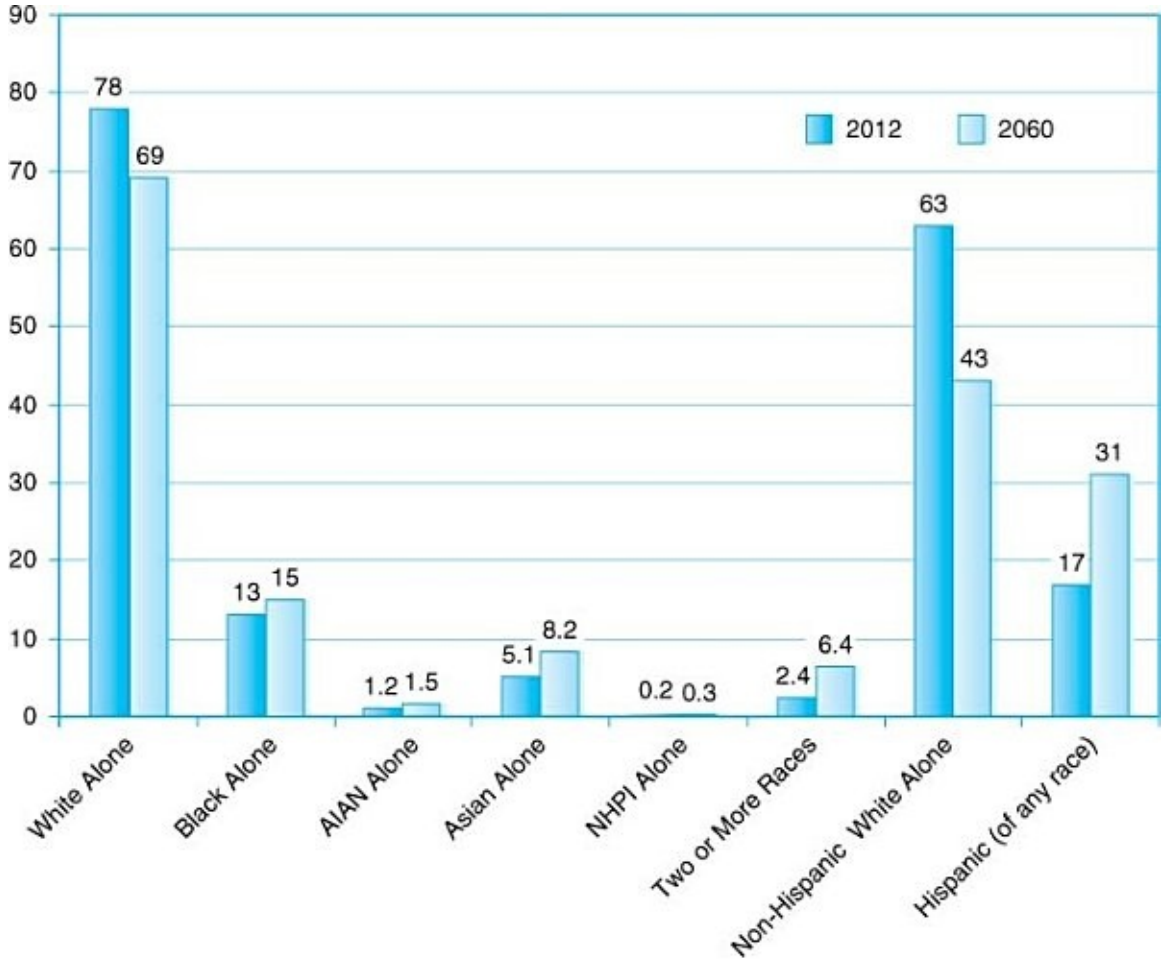
By _____ **<deadline>** _____, Team XYZ will have the following outcomes:*

- Reports of proceedings, data analyses, recommendations, and an evaluation plan for implementation of the recommendations.

Note: The Leader of Team XYZ is responsible for presentation of this report, with all team members present, if possible, to the administration for review and approval.

**Interim deadlines may be needed, so consider those as you discuss these guidelines.*

-
-
-
-
-
-



AIAN = American Indian and Alaska Native; NHPI = Native Hawaiian and Other Pacific Islander

TABLE 14-1 National Standards on Culturally and Linguistically Appropriate Services (CLAS)

Principal Standard:

1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Governance, Leadership, and Workforce:

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.

3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.

4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance:

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.

6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.

7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.

8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability:

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.

10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.

11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.

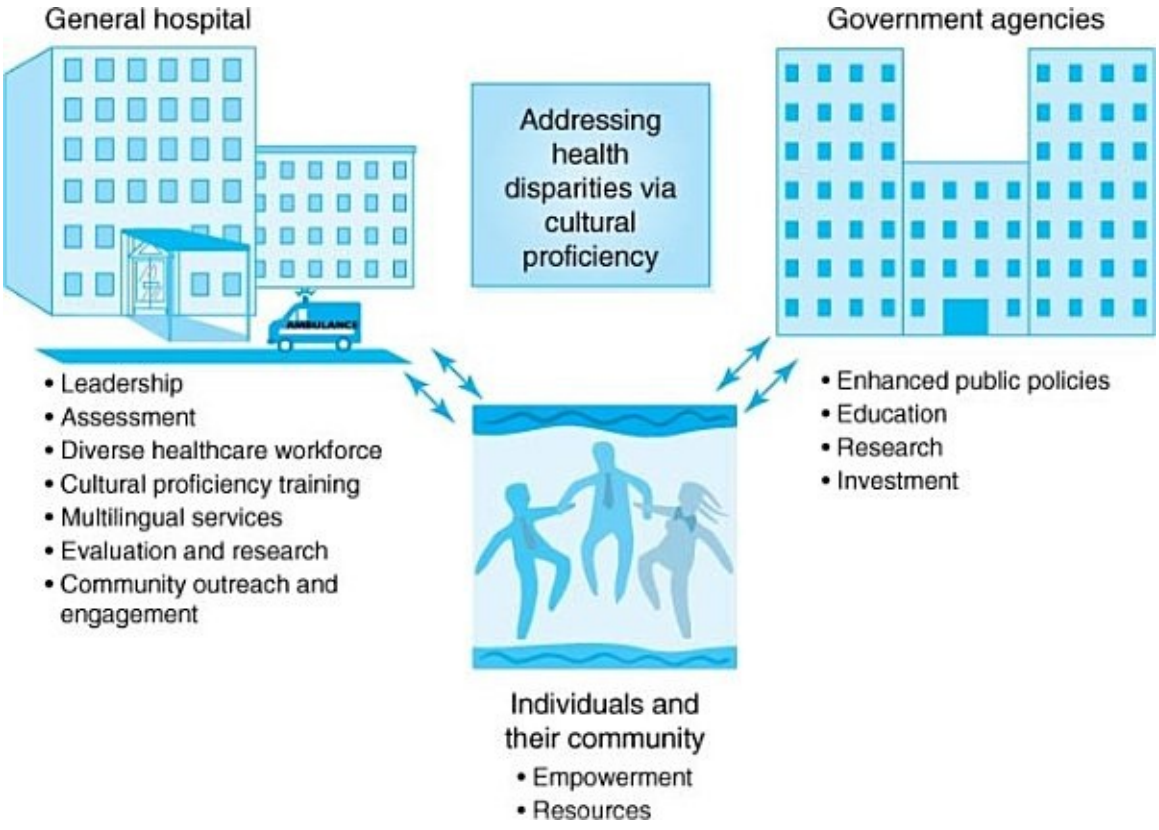
12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.

13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.

14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.

15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

Office of Minority Health, n.d. Retrieved from http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53


General hospital
Government agencies
Addressing health disparities via cultural proficiency
• Leadership
• Assessment
• Diverse healthcare workforce
• Cultural proficiency training
• Multilingual services
• Evaluation and research
• Community outreach and engagement
• Enhanced public policies
• Education
• Research
• Investment
Individuals and their community
• Empowerment
• Resources

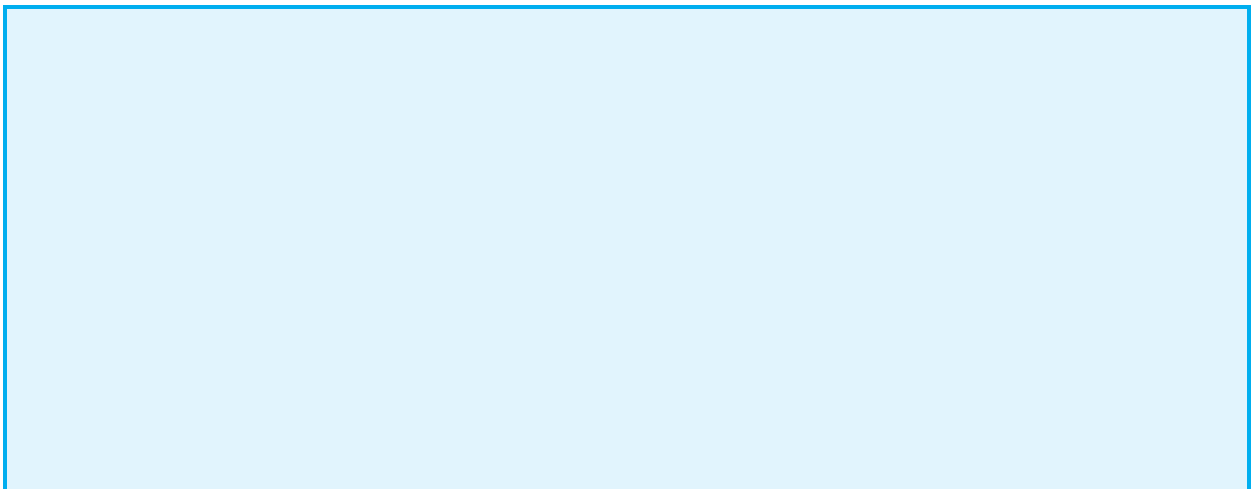


TABLE 15-1 Legal and Ethical Comparison

LEGAL	ETHICAL
Action is required by law.	No legal requirements to act, but professional organizations may require it.
Legal consequences may occur if no action is taken.	Censure by the governing body may occur if unethical behavior occurs.
Many professionals have a duty to report based on law, that is, physicians, nurses, social workers, and so on.	Ethics oftentimes helps to define the duty of care owed to a patient by a professional caregiver.
Results from numerous areas of law such as rules of professional responsibility, legislative action, court rulings, and so on.	Standards are defined by governing bodies that license professionals.
Individuals may face criminal sanctions if they deviate from the law.	Violation of standards may result in loss of license or professional privileges.

TABLE 15-2 Overlap of Legal and Ethical Activities

	Is it legal?		
Is it ethical?	Yes	Uncertain	No

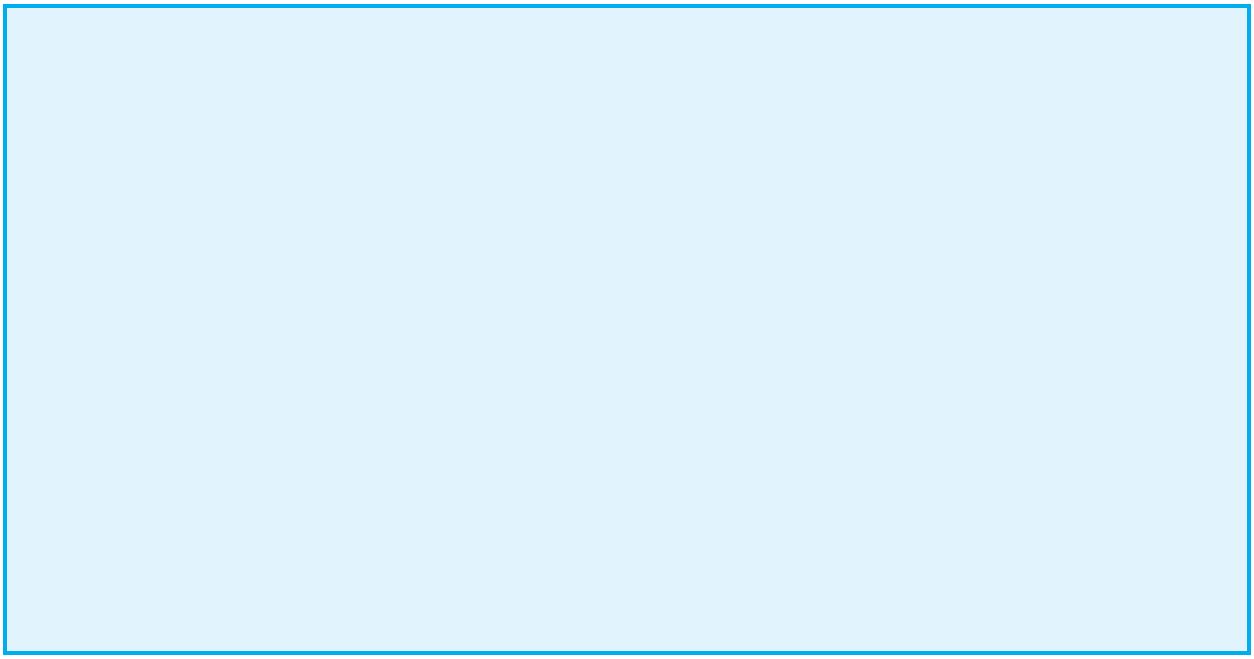


TABLE 15-3 Health Care Regulatory and Accrediting Agencies

Regulatory/Accrediting Agency	Type	Charge/Web Link
The Joint Commission (TJC)	Independent, Not-for-profit	Accredits and certifies health care organizations. http://www.jointcommission.org/default.aspx
The National Committee on Quality Assurance (NCQA)	Independent, Not-for-profit	Accredits and sets standards for health plans. http://www.ncqa.org/
Agency for Healthcare Research and Quality (AHRQ)	U.S. Government Agency (DHHS)	Performs research to improve health care quality. http://www.ahrq.gov
Centers for Disease Control and Prevention (CDC)	U.S. Government Public Health Agency	Focuses on safety and health threats both foreign and domestic. http://www.cdc.gov
Department of Health and Human Services (DHHS)	U.S. Government Agency	Provides essential health and human services, and oversees many of the federal agencies listed here. http://www.hhs.gov
Food and Drug Administration (FDA)	U.S. Government Agency	Protects public health by ensuring the safety of human and veterinary pharmaceuticals. http://www.fda.gov
Centers for Medicare and Medicaid Services (CMS)	U.S. Government Agency (HHS)	Administers the Medicare program and assists states with the Medicaid program. http://www.cms.gov
Occupational Safety and Health Administration (OSHA)	U.S. Government Agency	Assures safe and healthy work conditions. https://www.osha.gov
Accreditation Commission for Health Care (ACHC)	Independent, private organization	Accreditation to improve business operations and the quality of health care. http://www.achc.org
United States Agency for Toxic Substance and Disease Registry (ATSDR)	U.S. Government Agency	Performs public health assessments on environmental hazards. http://www.atsdr.cdc.gov

TABLE 15-4 Contract and Tort Law

CONTRACT	TORT
Duties are determined by the parties who are privy to the contract	Duties are determined by law
Parties are known as those that have been contracted with	Parties are generally unknown
Consented to	Individuals do not consent
No legal action for the contract itself	Legal action is available
The damages awarded are not for the contract itself, only for the particular breach that occurred	Damages are awarded and are the only remedy
Damages are normally determined by the writing contained in the contract; in other words, the intent of the contracting parties will determine the legal remedy	Damages are normally decided by a judge or jury that makes a decision based on the evidence

-
-
-
-
-
-

TABLE 16-1 Criminal Disclosure Provisions

ACT	FUNCTION
Criminal-Disclosure Provisions of the Social Security Act	a) Provider must disclose overpayments so that the government can initiate collection efforts. b) Imposes penalties for failure to disclose such payment information. c) Disclosure may provide a defense if the government attempts to collect. d) Provider liability includes: Felony offense Up to $25,000 fine Up to five years in jail
False Claims Act	a) Federal government's primary civil remedy for fraudulent claims. b) Providers who make improper claims are fined $5,500–$11,000 per claim. c) The Act is also applied to improper billing, claims for services not rendered, unnecessary services, misrepresenting credentials, and substandard quality of care.
Emergency Medical Treatment and Active Labor Act (EMTALA)	a) Requires all Medicare and Medicaid hospitals with an emergency department to provide appropriate medical screening to all seeking emergency care. b) Often referred to as the anti-dumping law because it prohibits hospitals from transferring an emergency patient to another hospital because of an inability to pay.

Data from: Cleverley & Cameron, 2007, pp. 75–77.

TABLE 16-2 Antitrust Acts

ACT	FUNCTION
Sherman Antitrust Act	a) Applies to agreements that unreasonably restrain trade. These include, but are not limited to: price fixing, boycotting other organizations, dividing market territories, and using coercive tactics with the intent to harm or injure another party.
	b) Applies to virtually all businesses in the country, including health care.
Clayton Act	a) Prohibits mergers and acquisitions that may lessen competition.
	b) Unlike the Sherman Act, the Clayton Act only imposes civil penalties.
Federal Trade Commission Act	a) Prohibits unfair methods of competition. This may include techniques such as larger businesses using their size to gain lower prices from suppliers and suppliers giving discounts to larger companies without providing the same for smaller ones.

Data from: Cleverley & Camerson, 2007, pp. 78 and 82.

TABLE 16-3 Stark Laws

STARK I	STARK II
Enacted to deal with physician self-referrals.	Expanded Stark I laws.
Often referred to as the Ethics in Patient Referrals Act.	Any amounts billed illegally must be refunded.
Makes it illegal for a physician to make a Medicare-financed referral to an organization in which he or she or a family member has a financial interest.	Applies to Medicaid services as well as Medicare.
Also prohibits billings by a laboratory for services provided pursuant to illegal referrals.	Knowingly billing or failing to make a refund is subject to a civil fine of $15,000 per item billed.

Furrow et al., 2004, p. 1033.

TABLE 16-4 Effective Compliance Program Essentials

ELEMENT	REQUIREMENT
1) Written policies, procedures, and standards of conduct.	These must speak to the organization's commitment to comply with all applicable federal and state standards.
2) Designation of a compliance officer.	Sponsor must have: a) compliance officer in place b) compliance committee in place c) established protocol for overview d) compliance officer if responsible for fraud and abuse program
3) Training and education.	Must have a training and education program in place.
4) Effective lines of communication throughout the organization.	Sponsor must have: a) organized lines of communication to effectively provide information as it pertains to compliance issues b) mechanisms are in place for capturing concerns and risks
5) Enforcement procedures.	Must enforce standards through disciplinary guidelines.
6) Procedures for effective internal monitoring and auditing.	These requirements are as follows: a) must have a monitoring and auditing program b) must monitor and audit contractors c) must allow CMS to audit financial records d) must allow the federal government to perform an onsite audit e) contractors must allow CMS access to their records
7) Procedures for corrective action.	The organization must ensure: a) prompt response to violations b) appropriate corrective action is taken
8) Fraud and abuse plan must be in place.	Must have a plan in place to detect and prevent fraud and abuse.

TABLE 17-1 Diseases by Cases and Deaths in the U.S. and Globally

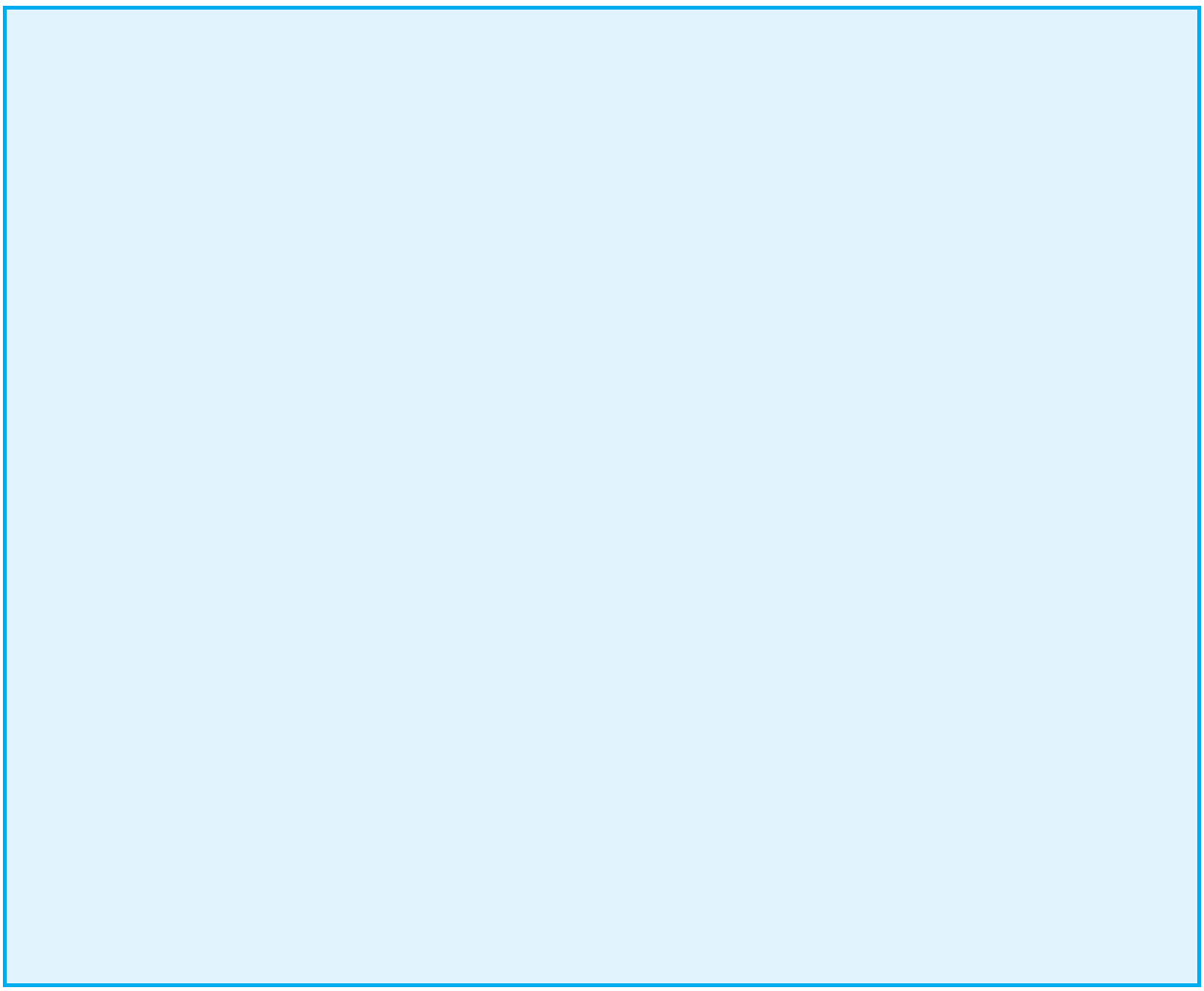
Disease	Cases in U.S.	Global Cases and Deaths
Measles	173 cases, 21 states and District of Columbia 5 outbreaks in 2015[a]	In 2013, 145,700 deaths; About 400 deaths every day, or 16 deaths every hour.[b]
Pertussis	10,000–40,000 cases each year; 10–20 children's deaths[c]	16 million cases in 2008; 195,000 children's deaths[d]
Polio	None; free of disease for 30 years due to vaccine.[e]	416 reported cases in 2013; One in 200 infections leads to irreversible paralysis. Of those, 5% to 10% die when their breathing muscles become immobilized[f]
Influenza	98,680 cases 2014/15[g] 125 pediatric deaths in U.S., 90% unvaccinated[h]	250,000 to 500,000 deaths (all ages)[h]
Ebola virus	4 cases, 1 death[i]	10 countries; 20,272 cases; 7,953 deaths[i]

[a]CDC,2015d
[b]WHO, 2015
[c]CDC, 2013b
[d]WHO, 2011
[e]CDC, 2014
[f]WHO, 2014
[g]CDC, 2015
[h]CDC, 2015b
[i]WaveWeb, 2015

TABLE 17-2 The Push and Pull of Human Trafficking

Push Factors of Human Trafficking	Pull Factors of Human Trafficking
Poverty, low educational levels, patriarchy; High birth rate → low value of human life; Street children unsupervised by parents; Runaways and abused children susceptible; Destabilization of governments (e.g., Syria, Iraq, Soviet Union, Latin America, Africa); Rise of organized crime from former soldiers and enforcers (Russian mob, MS-13); and Natural disasters leave women and children unprotected.	Demand for sex in areas with large numbers of unmarried men (mining, agricultural); Sex tourism, demand for children both male and female; Demand for compliant soldiers (<12 years); Demand for cheap labor (global competition), domestic servants, agricultural workers; Criminal demand for children for begging; and Demand for babies and body parts.

Data from: International Labour Organization, 2012; Polaris.org, 2015; Shelley, 2010.



-
-
-
-
-
-
-
-
-

-
-

-
-
-
-
-
-
-
-
-

	A Level	B Level	C Level	D Level
Introduction (10 pts)	The section introduction: • Was well organized • Smoothly pulled the reader into the topic • Presented the main focus of the case study section • Included adequate content • Was written for the correct audience	The section introduction had one limitation: • Disorganized • Not smooth • Did not present the main focus of the case study section • Too detailed or too sketchy • Rocky first sentences	The section introduction had two of these limitations: • Disorganized • Not smooth • Did not present the main focus of the case study section • Too detailed or too sketchy • Rocky first sentences	The section introduction had three or more limitations listed at left or required major changes.
Content (20 pts)	The content of the case study section: • Was clear • Had a unified focus • Focused on important information • Adequately explained concepts • Was correct	The content of the case study section had one of these limitations: • Hard to understand • Included irrelevant or too much detailed information • Failed to explain concepts • Had a disjointed focus • Incorrect information	The content of the case study section had two of these limitations: • Hard to understand • Included irrelevant or too much detailed information • Failed to explain concepts • Had a disjointed focus • Incorrect information	The content of the case study section was not clearly written and difficult to understand OR had three or more limitations listed at left.
Paragraph organization (20 pts)	Paragraphs in the case study section: • Had clear topic sentences • Were about a single topic • Were organized at the paragraph level • Had transitions from one paragraph to another	Paragraphs in the case study section had one of these limitations: • Poor topic sentences • Run-on paragraphs or paragraphs were too brief • Lacked organization within the paragraph • Lacked transitions from one paragraph to another	Paragraphs in the case study section had two of these limitations: • Poor topic sentences • Run-on paragraphs or paragraphs were too brief • Lacked organization within the paragraph • Lacked transitions from one paragraph to another	Paragraphs in the case study section had three or more of the limitations at left.
Case study section organization (20 pts)	The case study section's organization: • Was easy to follow • Was presented in a logical manner • Integrated information • Summarized information when needed • Used headers	The case study section had one of the following limitations: • Organization was not logical • Information was not consistently integrated together • Information was not summarized when needed • Headers were missing	The case study section had two of the following limitations: • Organization was not logical • Information was not consistently integrated together • Information was not summarized when needed • Headers were missing	The case study section was disorganized and illogical OR had three or more of the limitations listed at left.
Writing style (10 pts)	The style of writing is professional • Easy to understand • Uses appropriate vocabulary • Shows mature syntax style	Writing is affected by one of the following limitations: • Jargon • Wordiness • Redundant phrasing • Awkward syntax structures • Choppy sentences • Run-on sentences • Incorrect use of vocabulary	Writing is affected by two of the following limitations: • Vocabulary jargon • Wordiness • Redundant phrasing • Awkward syntax structures • Choppy sentences • Run-on sentences • Incorrect use of vocabulary	Writing is affected by three or more limitations occurring three or more times.
Writing mechanics (10 pts)	The case study section is free of spelling, grammar, and punctuation errors.	The case study section has fewer than 5 errors in spelling, grammar, or punctuation.	The case study section has 6–10 errors in spelling, grammar, or punctuation.	The case study section has more than 10 errors in spelling, grammar, or punctuation.
APA (10 pts)	All APA rules are followed for citations, numbers, quotes, references, headers, etc.	The case study section has fewer than 5 APA rule errors.	The case study section has 6–10 APA rule errors.	The case study section has more than 10 APA rule errors.

PEER EVALUATION CRITERIA FOR CASE STUDY PRESENTATIONS SCORING SHEET	
Presentation Title and Author's Name	**Your Name**
Use a scale of 1 to 10, where 1 is poor and 10 is excellent. **(You must explain any scores below 3 and above 8.)**	
How well did the presenter:	**Points**
Indicate the purpose of the presentation and its relevance to the course?	0
Ensure the presentation was relevant to the current state of health care?	0
Demonstrate knowledge about the *case study*?	0
Contribute to peer knowledge?	0
Use proper grammar, punctuation, and vocabulary?	0
Adhere to length constraints (*10 slides maximum*, excluding references)?	0
Use current references and cite properly in presentation?	0
Provide appropriate main points?	0
Use legible fonts with appropriate colors/background and clip art?	0
Accomplish the stated objectives?	0
TOTAL	0
Comments	

CONFIDENTIAL TEAMMATE EVALUATION CRITERIA			
Use a scale of 1 to 10, where 1 is poor and 10 is excellent. (Do NOT evaluate yourself.)			
How well did your teammates:	**Name**	**Name**	**Name**
Attend all team sessions?	0	0	0
Prepare for each session?	0	0	0
Work collaboratively to identify and meet session goals?	0	0	0
Actively participate in group discussions?	0	0	0
Keep an open mind or modify opinions or conclusions to keep the project moving?	0	0	0
Present ideas concisely?	0	0	0
Submit assigned work on time?	0	0	0
Interact with teammates in a respectful, considerate, and tactful manner?	0	0	0
Fulfill responsibilities as agreed?	0	0	0
Work actively to achieve group consensus on issues/problems?	0	0	0
TOTAL	0	0	0
Would you be willing to work with this teammate again on another team? (YES or NO)			
(You must evaluate ALL teammates and explain any scores below 3 and above 8.)			

May 26, 2014

1. Event forms for submission: (to Project Manager)
2. **First meeting of each month**: Financial reports (Admin Asst)
   a. CATCH budget
   b. Whole Kids budget
3. **Second meeting of each month**: Contacts and hours reports (Project Mgr and Admin Asst)
4. Website Review
5. PEPS Update:
   a. New placements for Fall 2014—applications due 5/27
6. DeFeo's Tomato Sauce samples:
   a. pH testing needs to be done by 6/12
   b. recipe nutrient analysis done by 6/20
7. Health Assess:
   a. Appoint scheduling needed for softball team
8. Tracking Magaram Center Projects/Activities
   a. Can we develop a written policy and instructions for how this is done so we have training materials?
9. CPHIZ:
   a. Contract for Dr. Barrack Gardner
   b. Program Evaluation: Lindsey Marx
10. Lactation Affinity Group—Graduate student to oversee project on behalf of MMC

Activity Reporting Form

Marilyn Magaram Center for Food Science Nutrition and Dietetics

Date of Project Feb 25, 2015 Project Duration 3 Months

Project Name Healthy Kids Garden Grant

Project Location Northridge, CA # of Contacts 4514

Event Description

Summarize the event in about 5 sentences.

A program that helps children learn about planting, growing, and harvesting fresh whole foods while at school. Provides education to help prevent and/or curb obesity, and gives children the tools to take what they have learned home in hopes that they start their own gardens.

Attach a flyer as appropriate

Speaker John Doe

Community Partners Acme Food Products, Ace Global Foods, Salad-To-Go.

Total number of volunteers including yourself		Total Number of PEPs		MMC Staff	
Total number of volunteer hours		Total Number of PEP Hours		MMC Staff Hours	

Please list ALL of the volunteers present on the back side of this page

Signature _____

Please turn in this evaluation to the MMC SQ 120

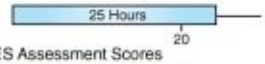
magaram.center@csun.edu

818/677-3102

Marilyn Magaram Center
2014–2015 Program of Work Dashboard

Goal 1: Education
Promote the professional growth and development of faculty, students, and professionals in the fields of nutrition and food science.

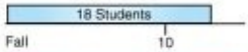
Continuing Education

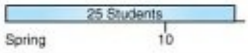


CES Assessment Scores

CES Speakers: John Doe

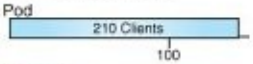
Professional Experience Program Participants



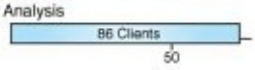


Goal 2: Community
Provide education related to food science, nutrition, health and wellbeing to diverse communities.

Bod Pod



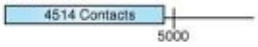
Diet Analysis



Recipe Contracts 3 / 2

Acme Food Products, Ace Global Foods, Salad-To-Go

MMC Contacts



Goal 3: Scholarly Projects
Pursue scholarly projects in the fields of nutrition and food science.

Grants: Healthy Kids Garden Grant
Federal USA Grant

Published Materials:

Graduate Students: 4 / 2

Joan Adams, Bob Gonzalez, Ed White, Doris Smith.

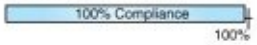
Professional Presentations: 2 Submitted, Pending Approval

Actions:

Goal 4: Community Alliances
Form (and maintain) alliances with professional organizations and community agencies.

Alliances

PEP Evaluations



Goal 5: Viability
Ensure the long-term viability of the Center.

Administrative Grants: Intramural Grant

Grants: Associated Students
Special Earmark

Donor Tours: 1 / 2

Potential Donor Jones

Assessment Committee Meetings:
October 28, 2014; February 10, 2015

Operational Budget Balance $2,369,301

Revenue Increase: ~4.5%

Marilyn Magaram Center
for Food Science Nutrition and Dietetics

Updated Feb 25, 2015
Presented at March 2015 Advisory Board Meeting

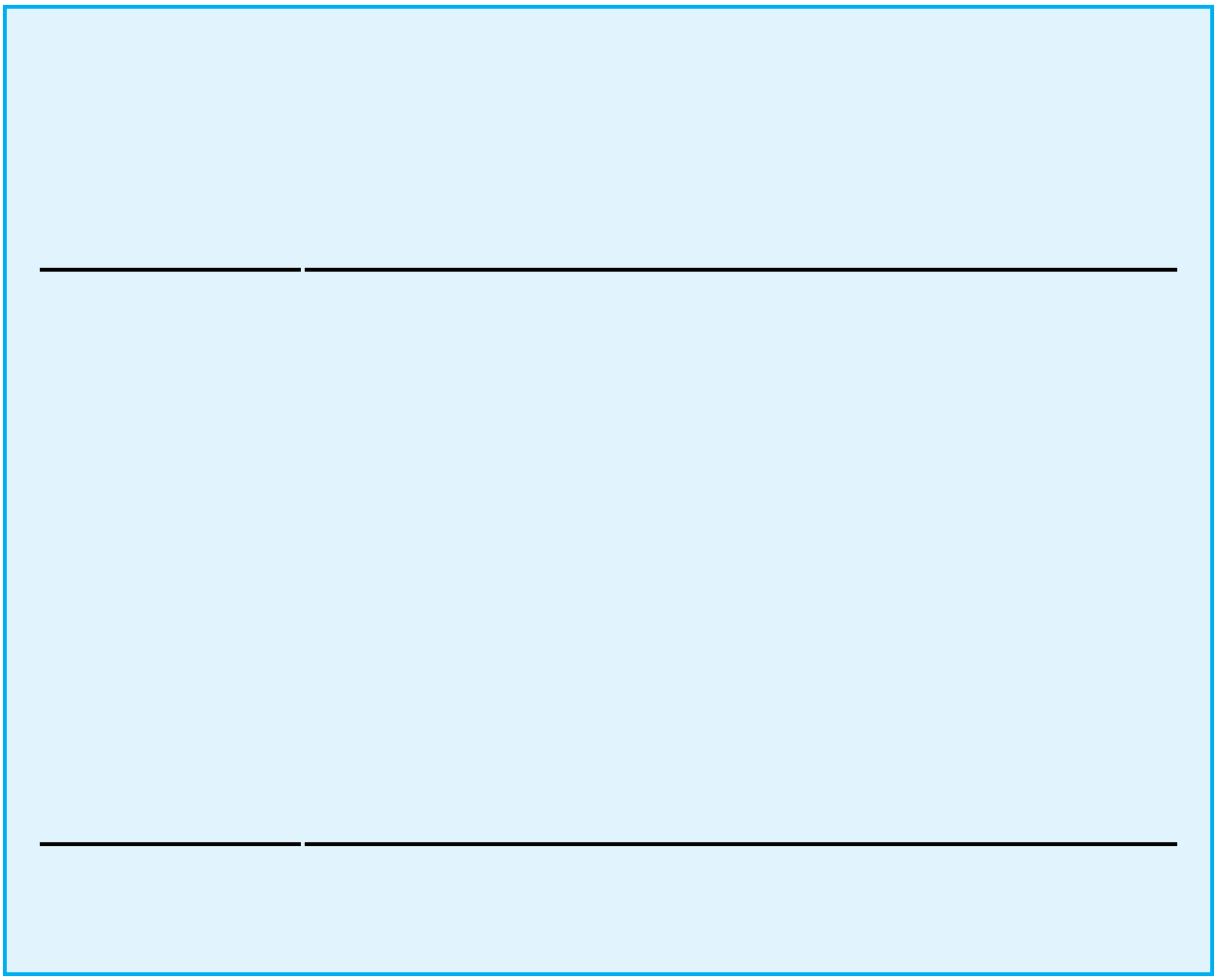
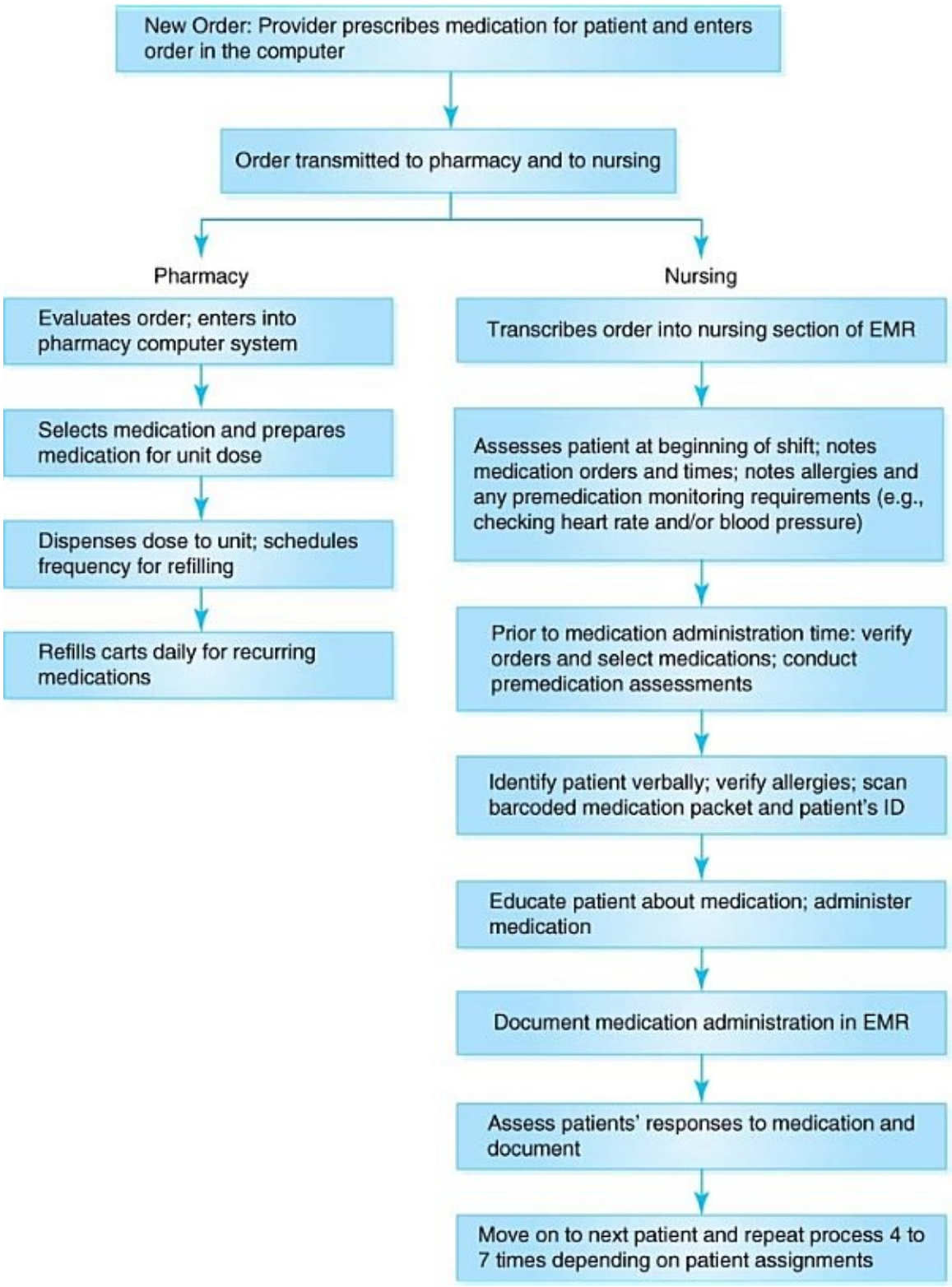
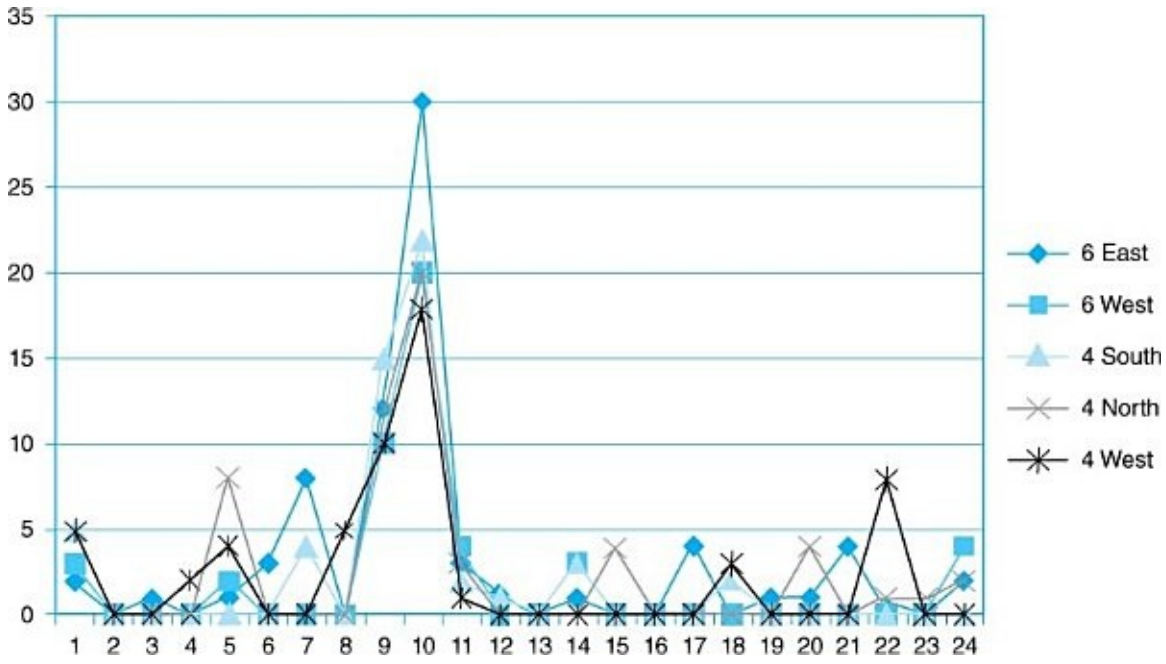


TABLE 18-1 Madison Community Hospital Hand Hygiene Compliance Observation Data

	Number of Staff Observed	Number Sanitizing Hands	Percentage Sanitizing Hands
2 North	15	8	53%
2 South	18	12	67%
2 East	16	6	38%
3 North	19	10	53%
3 South	13	7	54%
3 East	15	6	40%
4 North	18	9	50%
4 South	17	7	41%
4 East	14	6	43%
Total	145	71	49%


New Order: Provider prescribes medication for patient and enters order in the computer
Order transmitted to pharmacy and to nursing
Pharmacy
Evaluates order; enters into pharmacy computer system
Selects medication and prepares medication for unit dose
Dispenses dose to unit; schedules frequency for refilling
Refills carts daily for recurring medications
Nursing
Transcribes order into nursing section of EMR
Assesses patient at beginning of shift; notes medication orders and times; notes allergies and any premedication monitoring requirements (e.g., checking heart rate and/or blood pressure)
Prior to medication administration time: verify orders and select medications; conduct premedication assessments
Identify patient verbally; verify allergies; scan barcoded medication packet and patient's ID
Educate patient about medication; administer medication
Document medication administration in EMR
Assess patients' responses to medication and document
Move on to next patient and repeat process 4 to 7 times depending on patient assignments


35
30
25
20
15
10
5
0
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24
6 East
6 West
4 South
4 North
4 West