

American College of Healthcare Executives

Reference Manual

**For the ACHE
Board of Governors Examination
in Healthcare Management**

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ADDENDUM

The following updated documents can be found in the About ACHE section of ache.org.

Ethical Policy Statements

Ethics Self-Assessment

Code of Ethics

Bylaws

Regulations Governing Admission, Advancement and Recertification

Chapter I

The Board of Governors

Examination in Healthcare Management

General Comments

Considerable change in the healthcare delivery system over the last several years has resulted in a broader ACHE membership base in terms of age, education, employment and career path. The Board of Governors Exam must be fair and equitable to candidates from these diverse backgrounds. It must meet stringent educational testing standards to make sure that it is current and valid. To ensure that the Exam is valid, current and fair, it is revised annually.

The revision process ensures that the credentialing program is fair to candidates from a wide variety of healthcare management settings. A professional examination service is retained to assist the Examinations Committee with the development of the new Exam. In addition, content experts in each of the 10 knowledge areas are contracted to develop new exam questions. The result is a carefully structured, fair and valid examination that addresses the needs of healthcare managers from a wide variety of backgrounds and settings.

The Board of Governors Examination in Healthcare Management is a six-hour, 250-question examination consisting of 200 scored questions and 50 pretest, multiple-choice questions, covering general knowledge of management principles in 10 healthcare knowledge areas.

Exam Administration

Exam Registration Form

As soon as your application for advancement to Fellow is authorized, you may complete an Exam registration form, which serves to notify ACHE of your intent to take the Exam and to start the registration process. The Exam registration form is available to download on our Web site ache.org. After you have studied and are ready to take the exam you should mail the form to ACHE.

Which Exam Site Should You Select?

Several factors should be considered when selecting from among your Examination options. Geographic location and travel expense are probably the biggest considerations. With this in mind, ACHE has designed the Board of Governors Examination so that affiliates will be able to take it in their own communities. The Examination is offered at Prometric testing centers across the country. Once authorized to take the Exam, you will be able to schedule your computer-based Exam at your convenience.

The paper-and-pencil Exam will continue to be offered once a year during ACHE's annual Congress on Healthcare Leadership in March for those candidates who prefer that method of testing.

Cancellation Policy

If you need to cancel your Exam registration with Prometric, please follow Prometric's cancellation policy. **You will be assessed a cancellation fee equal to the Examination fee if you fail to provide notice of cancellation to Prometric according to their cancellation policy. You have 90 days from the date on your confirmation letter to take the Exam.**

Arrival Time on Exam Day

Prometric will provide you with arrival time information for the computer-based Exam.

Rules of the Exam Room

Prometric will inform you of the rules of the testing centers upon registration.

Length of the Exam

Currently, the Exam is four hours. Beginning August 2008 the time may increase due to the addition of more questions.

Exam Development and Scoring

Exam Development

ACHE cares about the validity, reliability and credibility of the Board of Governors Exam. Healthcare management experts spend 6 to 10 months annually engaged in a careful, deliberate process as they develop the Exam for the current year.

Each year, the Examinations Committee reviews the outline of the Exam to make sure that it is up-to-date with current healthcare management trends and issues. When the Committee identifies a need to write new Exam questions, ACHE Fellows offer assistance. Experts in health insurance, healthcare law and other disciplines also provide guidance. Working within the parameters developed by professional testing consultants, the Examinations Committee and other credentialed ACHE affiliates then construct multiple-choice questions covering specific knowledge areas. Requirements are strict as every question must be based on an identifiable published authority.

As writers submit questions, ACHE judges how appropriate they are for the Examination. Those questions that pass this initial evaluation are then entered into the formal question review process, where a panel of experts reviews the questions. After the panel gives its approval, the questions are edited and reviewed by a professional consultant and then filed into a question bank for future use. The Examinations Committee pilot tests the items stored in the bank to ensure validity and reliability.

Additionally, ACHE's professional exam consultants regularly analyze the performance of the exam questions. From this analysis, the questions that appear to be obsolete or produce statistically poor results are dropped from the question bank.

To ensure a timely, workable and useful Examination, ACHE repeats this extended process at the end of each Examination year.

Exam Scoring

Scores are currently derived on a criterion-referenced basis; that is, candidates are measured against a predetermined standard of performance, rather than being compared with other candidates.

Notification of Results

ACHE annual Exam cycle begins at Congress each year. After the Congress Exam, results are sent to ACHE's testing consultant for analysis and pass point setting. This analysis takes approximately eight weeks to complete. Therefore, scores are not available between March and April. If you take the paper-and-pencil Exam at Congress in March, you will be notified in 8-10 weeks. If you take the Exam at a computerized testing center, you will receive your Exam results immediately at the testing center.

Exam Retakes

If you do not pass the Exam at the computerized site, you will receive a computerized analysis informing you of how you performed in each knowledge area. A percentage correct is noted next to each area. This information may be used to study those weak areas.

You must have an authorized Fellow application on file with ACHE before you may retake the Exam.

When you schedule to retake the Exam, there will be a \$200 retake fee. This fee is due before you retake the Exam.

Chapter II

Preparing for the Exam

The Exam

Overview

The Exam begins with a short biographical data questionnaire that takes less than five minutes to complete. The Exam currently consists of 170 questions. Beginning with the paper-and-pencil Exam at Congress 2008 the Exam will consist of a six-hour, 250 multiple choice question Examination consisting of 200 scored questions and 50 pretest questions. The computerized version of the Exam will have the 250 questions beginning August 2008. A candidate's score is based on the number of scored questions on the Examination. The pretest questions do not affect a candidate's score.

Pretest questions are included in order to evaluate them for possible use as scored questions on future Examinations. The pretest questions are placed throughout the examination and cannot be identified during the Examination.

Each multiple-choice question has four possible answers, but only one is correct. A candidate's reported score on the written Exam equals the total number of correct responses. Therefore, it is to your advantage to answer every question even when uncertain of the correct answer. There is no penalty for incorrect answers. No credit is given for questions with more than one response.

Definitions for the 10 knowledge areas are found on the next few pages, followed by information on the exam outline. There is a review of the knowledge areas that includes an overview of each knowledge area followed by a list of specific knowledges required in each area. It is suggested that you thoroughly review and understand the subject matter outlined in each knowledge area section.

Definition of Knowledge Areas

The knowledge areas identified as pivotal for the practice of healthcare management are defined below.

Governance and Organizational Structure

This area deals with the development and analysis of the organizational structure and with delineating responsibility, authority and accountability at all levels of the organization. Functions include the development and implementation of policies and procedures for the governance process.

Human Resources

This area pertains to assessing the need for and the supply of professional and other personnel. Functions include recruitment, selection, training, compensation and evaluation of such personnel and how to examine ways of evaluating productivity and monitoring accountability for results.

Finance

This area covers the planning, development, establishment, analysis and assessment of financial management processes for an organization's capital, budget, accounting and related reporting systems.

Healthcare Technology and Information Management

This area covers management information and clinical information systems such as finding computer-based support for management, assessing how current technologies and major innovations are changing the way healthcare executives manage, using information systems for short- and long-range planning, using clinical information systems and acquiring information systems.

Quality and Performance Improvement

This area concentrates on the development, implementation and evaluation of organizational accountability, including TQM/CQI programs, quality assessment and assurance philosophies, policies, programs and procedures.

Laws and Regulations

This area covers identifying and interpreting the impact of government regulations and law on the organization; identifying the need for and working with others to develop new regulations and laws; investigating, monitoring, documenting and enforcing existing statutes; and maintaining communication and cooperation with both public and private organizations.

Professionalism and Ethics

This area focuses on the development, monitoring and maintenance of procedures to ensure that the needs of professional staff are met.

Ethics includes identifying, monitoring and disseminating codes of professional conduct; understanding the implications of ethical decisions, providing procedures to monitor standards of behavior within the organization; and determining, maintaining and monitoring accountability procedures.

Healthcare

This area focuses a broad range of organizations and professions involved in the delivery of healthcare. Included are managed care models, healthcare trends and ancillary services provided.

Management

This area covers general management principles (planning, organizing, directing and controlling) to address overall organizational objectives.

Business

This area pertains to specific functions/concepts of the organization (e.g., marketing, business planning, strategic planning).

Exam Outline

The Exam is composed of a 170-question, multiple-choice generic core Exam assessing the candidate's general knowledge in each of 10 healthcare knowledge areas. Beginning August 2008 there will be 250 questions. Questions are developed based on knowledge statements that have been derived from a validation study completed by a representative sample of members of the profession.

The knowledge statements under each of the following knowledge areas represent the specifications for which the Exam questions were constructed. One to three questions were developed for each of the statements. Therefore, by becoming familiar with these knowledge statements, you will get a general overview of the content of the test questions.

Generic Core – 170 Questions (Exam Before August 2008)

<u>KNOWLEDGE AREA</u>	<u>PERCENTAGE</u>	<u># OF QUESTIONS</u>
Governance and Organizational Structure	6%	10
<ol style="list-style-type: none"> 1. Governance theory (e.g., mission and values, relationships with board of directors) 2. Governance structure (e.g., bylaws, articles of incorporation, fiduciary responsibilities) 3. Medical staff relationship to governing body and facility operation 4. Legislative issues and advocacy processes 		
Human Resources	11%	19
<ol style="list-style-type: none"> 5. Performance management systems (e.g., performance-based evaluation, rewards system, disciplinary policies and procedures) 6. Recruitment techniques 7. Selection techniques (e.g., interviews) 8. Labor relations strategies 9. Staffing methodologies and productivity management (e.g., acuity-based staffing, flexible staffing, fixed staffing) 10. Employee satisfaction measurement and improvement techniques 11. Motivational techniques 		
Finance	10%	17
<ol style="list-style-type: none"> 12. Basic accounting principles (e.g., accounts receivable, cash flow) 13. Financial management and financial analysis principles (e.g., balance sheets, income and cash flow statements, ratio analysis) 14. Operating budget principles (e.g., fixed vs. flexible, zero-based) 15. Capital budgeting principles 16. Reimbursement techniques 17. Fundamental productivity measures (e.g., hours per patient day, cost per patient day, units of service per man hour, PMPM) 		
Healthcare Technology and Information Management	7%	12
<ol style="list-style-type: none"> 18. The role and function of information technology in operations 19. The changes in information systems and technology trends 20. Security requirement for information management (e.g., HIPAA) 21. Information technology (e.g., e-commerce, Internet, intranet) 		
Quality and Performance Improvement	11%	19
<ol style="list-style-type: none"> 22. Benchmarking techniques 23. Medical staff peer review and disciplinary processes) 		

24. Risk management principles and programs (e.g., insurance, education, safety, injury management, patient complaint)		
25. Performance and process improvement (e.g., CQI, TQM, QA/QI)		
26. Customer satisfaction principles and tools		
27. Clinical pathways and disease management		
28. Utilization review and management regulations		
Laws and Regulations	10%	17
29. Human resources laws and regulations (e.g., labor law, wage and hour, FMLA, FLSA, EEOC, ERISA, workers compensation)		
30. Confidentiality principles and laws (e.g., credentialing, intellectual property, peer review)		
31. Corporate compliance laws and regulations (e.g., physician recruitment, billing and coding practices, antitrust, conflict of interest, EMTALA)		
Professionalism and Ethics	8%	13
32. Professional codes of ethical behavior (e.g., ACHE, Hippocratic Oath, AMA)		
33. Patients rights and responsibilities		
34. Ethics committees' roles, structure and functions		
35. Cultural and spiritual diversity for patients and staff as they relate to healthcare needs		
36. Conflict of interest situations as defined by organizational bylaws, policies and procedures		
Healthcare	14%	24
37. Healthcare and medical terminology		
38. Healthcare trends		
39. Managed care models, structures, and environment (e.g., group, staff, IPA, PPO)		
40. The acute-care sector		
41. The ambulatory-care sector		
42. The interaction and integration among healthcare sectors		
43. Ancillary services (e.g., lab, radiology, therapies)		
44. Nursing, physicians and allied health professionals roles		
Management	11%	19
45. Implementation planning (e.g., operational plan, management plan)		
46. Contingency planning (e.g., emergency preparedness)		
47. Organizational (systems) theory and structuring (e.g., span of control, chain of command, interrelationships of organizational units)		
48. Management functions (e.g., planning, organizing, directing, controlling)		
49. Leadership styles/techniques		
50. Mediation, negotiation and dispute resolution techniques		

Business	12%	20
51. Basic statistical analysis		
52. Strategic planning principles		
53. Basic business contracts (e.g., legal and financial implications)		
54. Marketing principles and tools (e.g., market analysis, market research, sales, advertising)		
55. Techniques for business plan development and implementation		
56. Principles of public and community relations		
57. The functions of organizational policies and procedures		

**Healthcare Executive Board of Governors' Exam Test Blueprint
Beginning August 2008**

<u>Knowledge Areas</u>	<u>Weight on Test</u>	<u># of Questions</u>
<i>Category 01: Financial Knowledges</i>	10%	20
K1: Basic accounting principles (e.g., accounts receivable, cash flow, chart of accounts, GAAP)		
K2: Financial management and financial analysis principles (e.g., balance sheets, income & cash flow statements, ratio analysis)		
K3: Operating budget principles (e.g., fixed vs. flexible, zero-based, variance analysis)		
K4: Capital budgeting principles		
K5: Reimbursement methodologies and ramifications		
K6: Fundamental productivity measures (e.g., hours per patient day, cost per patient day, units of service per man hour)		
K7: Controls and auditing principles		
K8: Capital funding sources		
K9: Revenue generation		
 <i>Category 02: Management Knowledges</i>	 15%	 30
K10: Implementation planning (e.g., operational plan, management plan)		
K11: Contingency planning (e.g., emergency preparedness and response)		
K12: Organizational systems theory and structuring (e.g., span of control, chain of command, interrelationships of organizational units)		
K13: Management functions (e.g., planning, organizing, directing, controlling)		
K14: Leadership theory and situational applications		
K15: Team building techniques		

<u>Knowledge Areas</u>	<u>Weight on Test</u>	<u># of Questions</u>
K16: Mediation, negotiation, and dispute resolution techniques		
K17: Potential impacts and consequences of decision making in situations both internal and external		
K18: How an organizations culture impacts its effectiveness		
K19: Analyze and evaluate information to support a decision or recommendation		
K20: Distinguish relevant from irrelevant information		
K21: Integrate information from various sources to make decisions or recommendations		
<i>Category 03: Business Knowledges</i>	10%	20
K23: Strategic planning principles (e.g., scenario planning, forecasting, etc)		
K24: Basic business contracts (e.g., legal and financial implications)		
K25: Marketing principles and tools (e.g., market analysis, market research, sales, advertising)		
K26: Techniques for business plan development, implementation and assessment		
K27: Principles of public affairs and community relations		
K28: The functions of organizational policies and procedures		
K29: Socioeconomic environment in which the organization functions		
<i>Category 04: Healthcare Knowledges</i>	18%	36
K30: Healthcare and medical terminology		
K31: Healthcare trends		

<u>Knowledge Areas</u>	<u>Weight on Test</u>	<u># of Questions</u>
K32: Managed care models, structures and environment (e.g., group, staff, IPA, PPO)		
K33: Health care sectors (e.g., acute care, ambulatory care, post-acute, public health, long-term)		
K34: The interdependency, integration and competition among healthcare sectors		
K35: Ancillary services (e.g., lab, radiology, therapies)		
K36: Physicians roles		
K37: Implications of community standards of care		
K38: Evidence-based management practice		
K39: Staff perspective in organizational settings (e.g., frame of reference by discipline and role; orientation)		
K40: Healthcare economics		
K41: The interrelationships among access, quality, cost, resource allocation, accountability and community		
K42: Nurse and allied health professionals scope of practice		
K43: Support services (e.g., plant operations, materials management, supply chain management, hospitality services)		
K44: The patient perspective (e.g., cultural differences, expectations)		
<i>Category 5: Laws and Regulations</i>	8%	16
K45: Human resources laws and regulations (e.g., labor law, wage and hour, FMLA, FLSA, EEOC, ERISA, workers compensation)		
K46: Confidentiality principles and laws		
K47: Corporate compliance laws and regulations (e.g., physician contracts, billing and coding practices, antitrust, conflict of interest, EMTALA, Stark, fraud and abuse, anti-kickback, tax status)		

<u>Knowledge Areas</u>	<u>Weight on Test</u>	<u># of Questions</u>
K48: Medicare/Medicaid/Third Party payment regulations		
K49: Inspection and accrediting standards, regulations and organizations (e.g., JCAHO/NCQA, OSHA, FDA, NRC, CDC)		
K50: Patients’ rights laws and regulations (e.g., organ donation, HIPAA, medical records, access to care, advance directives, durable power of attorney, involuntary commitments)		
<i>Category 6: Human Resources</i>	11%	22
K51: Performance management systems (e.g., performance-based evaluation, rewards systems, disciplinary policies and procedures)		
K52: Recruitment and retention techniques		
K53: Selection techniques		
K54: Labor relations strategies and tactics		
K55: Staffing methodologies and productivity management (e.g., acuity based staffing, flexible staffing, fixed staffing)		
K56: Employee satisfaction measurement and improvement techniques		
K57: Employee motivational techniques		
K58: Compensation and benefits practices		
K59: Worker safety, security and employee health issues (e.g., OSHA; workplace violence)		
K60: Conflict resolution and grievance procedures		
<i>Category 7: Governance and Organizational Structure</i>	5%	10
K61: Governance theory (e.g., mission and values, relationships with board of directors, roles of governing board and management)		
K62: Governance structure (e.g., bylaws, articles of incorporation, fiduciary responsibilities)		

<u>Knowledge Areas</u>	<u>Weight on Test</u>	<u># of Questions</u>
K63: Medical staff structure and its relationship to governing body and facility operation (e.g., credentialing, privileging and disciplinary process)		
K64: Public policy matters and legislative and advocacy processes		
<i>Category 8: Healthcare Technology and Information Management</i>	5%	10
K65: The role and function of information technology in operations		
K66: Technology trends and clinical applications		
K67: Technology security requirements (e.g., re: HIPAA, local governmental and organizational policies)		
K68: Health informatics (e.g., data/equipment inter-operability standards, decision support)		
K69: Information systems continuity (e.g., disaster planning, recovery, backup, sabotage, natural disasters)		
K70: Information systems planning and implementation (e.g., service architecture; technology lifecycles; obsolescence)		
<i>Category 9: Quality and Performance</i>	10%	20
K71: Benchmarking techniques		
K72: Medical staff peer review		
K73: Risk management principles and programs (e.g., insurance, education, safety, injury management, patient complaint, patient and staff security)		
K74: Performance and process improvement		
K75: Customer satisfaction principles and tools		
K76: Clinical methodologies (e.g., clinical pathways, evidence-based medicine, population health, pay for performance)		
K77: Utilization review		
K78: National quality initiatives including patient safety		

<u>Knowledge Areas</u>	<u>Weight on Test</u>	<u># of Questions</u>
<i>Category 10: Professionalism and Ethics</i>	8%	16
K79: Professional codes of ethical behavior (e.g., ACHE, Hippocratic Oath, AMA)		
K80: Patients' rights and responsibilities		
K81: Ethics committees roles, structure and functions		
K82: Cultural and spiritual diversity for patients and staff as they relate to healthcare needs		
K83: Conflict of interest situations as defined by organizational bylaws, policies and procedures		
K84: Professional norms and behaviors		
K85: Consequences of unethical actions		
K86: Ethical implications of human-subject research		
Total Questions	100%	200

Chapter III

Review of Exam Knowledge Areas

Governance and Organizational Structure

Governance

Governance is defined as a shared process of top-level organizational leadership, policy making and decision making. Although the governing board has the ultimate authority and accountability, the CEO, senior management and clinical leaders are also involved in top-level functions. Thus, governance is not a “board only” activity, but rather an interdependent partnership of leaders.¹ It is the function that holds management and the organization accountable for its actions and that helps provide management with overall strategic direction in guiding the organization’s activities.²

Purpose of the Governing Board

The governing board is accountable to the stakeholders of the organization and must attempt to identify and carry out their wishes as effectively as possible. There are clear differences in governing boards depending on whether the organization is for-profit or nonprofit. In for-profit organizations success is measured by profitability. Board members, usually called directors, are compensated for their efforts and are usually given financial incentives for success. Directors select among opportunities and negotiate solutions with other stakeholders that maximize profits. In a nonprofit organization, the owners are the members of the community served. Nonprofit board members are generally not compensated for their efforts.³

Governing boards may also have relationships with other hospital systems, or academic, governmental or multihospital systems. With these relationships comes the potential for sharing board members across organizations or a smaller organization adopting policies promulgated by the larger organization. Regardless of the type of ownership and control, the following is a list of essential board functions:

1. Selecting and working with the CEO.
2. Establishing the mission, vision and long-range plan.
3. Approving strategies and an annual budget.
4. Maintaining the quality of care.
5. Monitoring results for compliance to goals, laws and regulations. ⁴

Composition of the Governing Board

The composition of the board differs by type of ownership. Governing board members, typically called Trustees, of not-for-profit organizations are usually selected from members of the community served. Business and community leaders who have special skills are commonly chosen. For-profit organizations draw members from stockholders (owners), physicians, and, to a lesser extent, from the same groups as nonprofit boards.

Much of the governing board's work is done by committee. Standing committees may include executive, professional staff, human resources, quality improvement, finance, audit, planning, public relations and development, investment, capital equipment and expenditure and nomination.

The executive committee may act on behalf of the full board in emergencies and its officers usually include the board chair, vice chair, secretary and treasurer. It is considered the most powerful of the board committees and may receive reports from other committees, monitor policy implementation and provide interim decision making.

Relationship to the CEO

One of the governing board's responsibilities is to recruit, select and evaluate the CEO. The CEO assembles and organizes resources and develops the systems to carry out programs and policies approved by the governing board.

The CEO's performance should be assessed regularly by the governing board. Performance is best measured against predetermined objective standards mutually identified and accepted by the CEO and governing board. Employment contracts for CEOs are increasingly common in healthcare organizations. These contracts set the terms of employment, including severance, and may contain periodically updated performance standards.

The Triad

The governing board delegates authority to the CEO, who acts as its agent and exercises that authority to achieve organizational objectives.⁵ Since most healthcare delivery organizations have a medical/professional staff, governance becomes more complex. The CEO, governing board and professional staff are known as a triad. The three entities are also sometimes referred to as the "three-legged stool."

Effective governance begins with excellent communication between the board chairman, CEO and medical staff president and how, jointly, they approach the challenges of the healthcare organization.

Board Chairmen: The desirability of communication between the board chairman and CEO cannot be over stated. "Board Chairs have the potential to affect virtually every aspect of their institution positively...the best CEO-chair relationships are characterized by honest, candid, two-way dialogue and mutual respect."⁶ Perhaps the most important functions of the board include ensuring the quality of healthcare provided, developing a strategic plan, evaluating the

CEO's performance, being an advocate for the hospital and evaluating its own performance.

CEOs: Many hospital CEOs in the United States have an employment contract and those who do typically have two-year contracts. They typically spend an average of 7 ½ hours per week on board related activities.⁷ Many hospital CEOs are voting members of their boards, especially in larger organizations

Medical Staff Presidents: A survey by the American Medical Association and Ernst & Young LLP found that 81 percent of hospital respondents and 72 percent of system respondents had voting physician members on their board; roughly a third of both groups had a least three voting physician members.⁸ Nearly all medical staff presidents would agree that a major part of their jobs is to represent the medical staff to administration and to the board, but they are also expected to provide medical staff expertise and perspective in both quality and credentialing.

Reports to the Board

Reports to the board need to present measures of the processes and performance areas that are most critical to the organization's mission, vision and strategic and operational goals. These measurements are frequently reported indicators of the organization's key strategic initiatives and critical processes. Reports generally include the following major topics: financial position, revenues and costs, clinical quality and appropriateness review, service volumes and environmental changes and progress reports on ad hoc committees and ongoing projects.⁹

Increasingly, boards are also informed of quality outcome measurements, ratings and comparisons that may be reported through the media. Many, but not all, of these measurements are provided to the board prior to communitywide dissemination.

Reports should also include evidence of how well the organization performed in meeting its own expectations. Reported measures should include established expectations, tolerance limits of variation and highlighting of variance that exceeds those limits. This is not necessarily the same information as presented to management (e.g., it may be simplified), and it does not have to be the same as similar organizations (that may have different missions and financial constraints). Reports on these measures are generally made in aggregate since board members have limited time to review information and have global, not technical, expertise.

Board's Function Regarding Quality of Care

The board has the ultimate responsibility for quality of care in the organization. The board relies on peer review to carry out this function for credentialed clinical staff. The clinical staff should conduct peer review; management should ensure this is not too costly and should contract for peer review with external agencies, if needed. Increasingly, quality profiles, comparisons and ratings are being reported in the media. Hospital boards and medical staffs should be aware and actively participate and report on quality initiatives required by governmental agencies and improvement initiatives sponsored by organizations such as the Institute for Healthcare Improvement.

Setting the Organization's Mission, Vision and Values

The mission of an organization is the most central agreement among the stakeholders, and it tends to be the most permanent. It establishes the specific purposes of the organization. ¹⁰

Responsibility for the mission statement rests almost exclusively with the governing board and specifies the community served and services offered. The mission, vision and values are a central educational device, prominently displayed and periodically reviewed by large numbers of associates to promote

consensus and commitment. It is the underlying foundation for stakeholder discussions that support both the statements and their acceptance throughout the organization.¹¹ The mission is the foundation for all organization planning and is not frequently changed.

The vision is focused on the future—what the organization hopes to achieve further in the future. While a vision does not necessarily change the mission of the organization, it does provide a road map representing the long-term direction the organization hopes to take to accomplish its mission. A vision can be stated in terms of growth, organizational alignment and financial security or of many potential achievements. Together, these statements represent the most central focus of the owners and the threshold for all subsequent planning decisions. Revisions to the mission and vision statements require formal board action.

Implementing Policies and Procedures

A key element in the governance process is the development of policies. Policies are officially expressed or implied guidelines for behavior, decision making and thinking within the organization. They help organizations attain objectives and, thus, must be consistent with the organization's mission.

Procedures are guides to action. Unlike policies—which are guidelines to behavior, decision making and thinking—procedures guide actions for specific situations. Formal procedures give directions to employees in performing their duties.

General policies apply to the entire organization and are formulated by senior management. Procedures generally apply to a specific unit or department and are formulated by department managers, so long as they are consistent with general policy. Effective boards set and monitor the system for making policy decisions.¹²

Endnotes

¹ Bader, B.S. "CQI progress reports: The dashboard approach provides a better way to keep boards informed about quality." *Healthcare Executive*, September/October 1993, 8-11.

² Shortell, S.M. and Kaluzny, A.D. *Health care management: Organization design and behavior* (5th Ed.), Clifton Park, NY: Thompson-Delmar Learning. 2006

³ Griffith, J.R. and White, K.R. *The Well-Managed Healthcare Organization* (6th Ed.), Chicago: Health Administration Press. 2007.

⁴ Griffith and White, 2007, p. 65.

⁵ Rakich, Longest and Darr, Chapter 7.

⁶ Trustee, June 2006, p. 14-17.

⁷ The Governance Institute's Research Poll Results, Odds and Ends, June 2006 [poll from 125 responses].

⁸ Tyler and Biggs, 2001, p. 63.

⁹ Tyler and Biggs, 2001, p. 63.

¹⁰ Griffith and White, 2007, p. 45.

¹¹ Griffith and White, 2007, p. 70.

¹² Rakich, Longest and Darr, Chapter 7.

Study Guidelines

- Understand the role of committees within healthcare organizations including: executive, finance and budget, audit, nominating and evaluating, planning, quality improvement, ad hoc committees.
- Understand the board's role in developing mission, vision and values.
- Understand the board's role in establishing a long-range strategic plan.
- Understand the board's role in establishing policy.
- Understand the board's role in healthcare advocacy.
- Understand the board's role in hiring and evaluating the CEO.
- Understand the functions of the CEO.

- Understand the components of an organization's bylaws.
- Know typical board membership of for-profit and not-for-profit organizations.
- Understand the relationship between the CEO and the board.
- Understand the role of the board in setting the organization's mission statement and establishing the long-range plan.
- Understand transparency in health care.
- Understand the rules for operating as a tax-exempt organization.

Human Resources

Healthcare organizations, like most other service organizations, are very labor intensive. The production and consumption of services occur simultaneously and the interaction between caregivers and care-receivers is an integral part of the service delivery process. The critical role that human resources plays in health services delivery requires that healthcare executives direct attention toward planning and coordinating a variety of activities to ensure that the highest possible quality of care is provided quickly and efficiently.

Human Resources Management

One major responsibility of healthcare executives is ensuring that qualified, motivated personnel are available to perform the tasks needed for the organization to accomplish its mission. In this regard, executives must be sure that plans have been developed to identify the number and types of personnel required to staff the services the organization will provide. They also must take responsibility for seeing that the typical human resources functions of recruitment and selection, training and development, performance appraisal and compensation, and retention are being performed effectively. To accomplish this, executives should have a basic understanding of these functions and their relationship to other organizational processes.

Broadly speaking, executives are responsible for ensuring that the organization develops and promotes its human resources philosophy through the operating policies and structure of the organization in a manner that encourages motivation and commitment. Thus, executives need to be aware of methods available to increase motivation such as job design, appropriate allocation of decision-making responsibilities, management training and reward systems. The role of employee involvement programs in this area should be clearly understood.

Major reform movements in the healthcare field and the trend toward organizational restructuring have forced many organizations to downsize their operations. Executives should be aware of alternative strategies for downsizing and the role of outplacement services in this process.

Interaction With Professionals

The responsibilities of healthcare executives for human resources activities extend far beyond the typical areas normally associated with personnel functions within an organization. They must also be concerned with the interaction of the organization and its affiliated medical/professional staff. The executives must be cognizant of the processes used for providing staff privileges to professionals and must ensure that appropriate processes are being used by their organization.

Healthcare executives must be prepared to handle matters of dispute amongst major groups within the organization as well as the professional staff and others. Therefore, they must understand different types of conflict and be able to apply appropriate conflict management techniques. In addition, they need to understand the principles of negotiation and how these principles are applied to improve the negotiation process.

Evaluation of Managers

Executives should be aware of the benefits of using performance appraisal systems in evaluating managerial competencies. This information is useful not only in making retention and compensation decisions, but also in identifying internal managers who have the potential for advancement to higher-level positions.

Teamwork

Healthcare executives must be able to promote teamwork of groups at all levels of the organization. Work groups are an integral component of healthcare organizations and provide the context through which most of the work is performed. Well-managed work groups can be very productive, while poorly managed groups can cause significant internal problems. Executives need to understand factors that affect work group cohesion and performance. They should also understand situations that may increase intergroup and intragroup conflict. Executives should be aware of the strategies available for reducing conflict and be able to apply the strategy appropriate for a specific situation.

Productivity

Given the highly competitive healthcare market and increasing emphasis on cost control and efficiency of service delivery, healthcare executives must be able to evaluate productivity at all organizational levels. They must understand basic approaches to measuring productivity and encouraging productive behaviors by employees.

Legal Compliance

Healthcare organizations operate within two broad classes of laws that constrain the management of human resources. The first set of laws is designed to protect employees in the workplace. Executives must be conversant with federal and state statutes developed to prohibit discrimination in the workplace and to ensure individual employment rights. Federal standards on industrial safety represent another area requiring attention. Compensation and employee benefits are also subject to regulations that must be clearly understood.

The second set of laws is designed to regulate the behavior of employers and employees in collective bargaining situations. Executives should understand the

process of negotiating a labor relations agreement. They should understand collective bargaining strategy, the importance of “good faith” bargaining and components of grievances procedures and arbitration processes under a union contract.

Study Guidelines

- Understand how to plan for the numbers and types of personnel needed by the organization.
- Understand basic human resources functions of recruitment and selection, training and development, performance appraisal and compensation and retention.
- Identify methods to influence the motivational levels of employees.
- Identify alternative strategies for downsizing.
- Describe the role of outplacement services in downsizing.
- Understand the processes used for approving staff privileges for professionals.
- Ensure that appropriate processes for granting staff privileges are used.
- Understand different types of conflict.
- Understand how to apply appropriate conflict management techniques.
- Identify the principles of negotiation.
- Understand how to apply negotiation principles to improve the negotiation process.
- Understand the role of performance appraisal systems in evaluating managers.
- Understand methods available for identifying internal managers with potential for advancement.
- Describe factors that affect work group cohesion and performance.
- Identify factors that increase intergroup and intragroup conflict.
- Describe strategies available for reducing conflict and apply the strategy appropriate for the situation.
- Understand basic approaches for measuring productivity.
- Describe methods for encouraging productive behaviors by employees.

- Understand federal statutes that prohibit workplace discrimination and ensure individual employment rights.
- Understand regulations on employee compensation and benefits.
- Understand collective bargaining strategy and the importance of “good faith” bargaining.
- Describe components of grievance procedures and arbitration processes under a union contract.

Finance

The successful achievement of organizational objectives is facilitated by a consistent and competent team effort from all members of a management staff. Most corporate success stories, whether in a for-profit or nonprofit context, include a team of people who contribute their individual expertise, effectively interact with one another, and are able to maximize their energies toward the pursuit of commonly accepted objectives.¹

Because of the importance of financial viability to almost every aspect of the organization's operations, competent financial management is necessary for effective and efficient hospital operations. Previously, financial management was associated with the complex and technical world of accounting and the historical record keeping of the organization's performance. It was viewed as a specialized area delegated to a single individual who was separate and apart from general management and operations. This has changed dramatically. Financial management has become an integral component of total management. Financial managers have moved into senior roles within healthcare organizations, and other senior managers have found a need to become familiar with basic financial concepts.²

The basic concepts of healthcare finance are usually found in three academic disciplines: financial accounting, managerial accounting and financial management.

Financial accounting involves the basic accounting functions of data entry, transaction analysis and the preparation and interpretation of financial statements for internal managers and external stakeholders.

Managerial accounting focuses on the *internal* uses of accounting information for decision making. Managerial accounting techniques include cost identification

and cost/volume/profit models. Management accounting should provide information that will improve the efficiency and effectiveness of the use of economic resources.

Financial management primarily focuses on assets management with an emphasis on cash flow analysis, i.e., working capital, the capital structure composition, risk and cost of various amounts of debt and equity sources, the capital budgeting process, time value of money techniques and financial feasibility studies.

Note: Each of these three areas will be covered separately but it is important to stress that the coverage will be a brief review only of the major concepts and techniques. The reader is encouraged to review current texts in the area to obtain a more detailed discussion of the topics.

Financial Accounting

Financial Statements

One of the primary outputs of a financial accounting system should be a set of financial statements that have been prepared in accordance with Generally Accepted Accounting Principles (GAAP), which are provided by the Financial Accounting Standards Board (FASB) and the American Institute of Certified Public Accountants (AICPA). A second major output should be financial (cost) information that is required by management for decision making. The internal information does not have to comply with GAAP, although in most cases it will. However, the system should be flexible enough to provide cost information to managers in a variety of ways including past summaries, present studies and future estimations. The data must be flexible enough to be individualized by products/outputs, cost centers and product lines. In the remainder of this section, we will concentrate on the financial statements.

The three basic financial statements are:

- balance sheet
- income statement (statement of revenue and expenses)
- statement of cash flows

The *balance sheet* presents the financial position of the organization at a *point in time*—usually at the end of a fiscal year. The values assigned to the assets are accounting values and do not necessarily reflect market values. The balance sheet is usually prepared in accordance with GAAP. The major components of the balance sheet are historical cost convention, accrual and “going concern.”

Under the historical cost convention, the asset values are typically based on the value assigned at the time of purchase (the price paid). The accrual component focuses on a matching of the revenues earned and expenses incurred to provide those services, not when the cash flow actually occurs. The “going concern” concept reflects the fact that the values assigned to the assets are based on the premise that the organization will continue to perform the same type of mission, i.e., health services in the case of a hospital.

The basic structure of the balance sheet is to present assets in order of liquidity and liabilities in order of payment. In addition, the value of the assets must be equal to the claims of the capital supplier. TABLE 1 illustrates this basic structure.

TABLE 1

TOTAL ASSETS	=	TOTAL DEBT AND EQUITY
<i>Including:</i>		<i>Including:</i>
Current Assets		Current Liabilities
Assets Limited as to Use		Long-Term Liabilities
Tangible Assets		Equity/Net Worth/Funds Balance
Intangible Assets		

The structure does not imply that the liabilities are discharged by the offsetting asset base. Rather, it is important to stress that all capital suppliers need to be paid in cash, and this implies that all of the assets need to be converted to cash when the liability is due. The structure of the balance sheet also indicates that the equity/net worth/fund balance capital sources are exposed to the most financial risk since they are last in line to be paid.

The *income statement* (statement of revenues and expenses) reports the revenues and expenses of the organization *over a period of time*. The bottom line of the income statement is captured in the equity section of the balance sheet. It is usually prepared in accordance with GAAP, which requires the use of the accrual basis of accounting for recognition of revenues and expenses. This means the revenues and expenses reported include the value of services provided regardless of whether cash has been received; expenses include cash expenses such as salaries and noncash expenses such as depreciation, amortization and bad debt expense. The noncash expenses reflect accounting allocations of previous capital investment decisions and the amount of revenues that have been billed but will probably not be collected in full.

It is important to stress that charity care is not shown as an expense or deduction under the revised accounting rules. Charity care and other deductions from

revenue such as allowance accounts and discounts are shown in the footnotes of the financial statements.

The structure of the income statement is shown in FIGURE 1.

FIGURE 1 INCOME STATEMENT
(Statement of Revenues and Expenses)

REVENUES	
Net Revenues from Patient Services	\$xxxx
Other Operating Revenue	\$xxxx

Total Revenues	\$xxxx
 EXPENSES	
Operating Expenses	\$xxxx

INCOME (LOSS) FROM OPERATIONS	\$xxxx
	=====
 Nonoperating Gains (Losses)	 \$xxxx

NET REVENUES AND GAINS IN EXCESS OF (LESS THAN) EXPENSES AND LOSSES	\$xxxx
	=====

The *statement of cash flows* uses information from balance sheet and income statements to develop a cash flow statement that explains changes in cash flows resulting from three activities:

- Operating
- Investing
- Financing

This statement is usually prepared in accordance with GAAP.

To summarize:

- The statement of cash flows converts net income based on the accrual basis of accounting to a cash basis by adding noncash expenses back to the reported net income.
- It identifies cash flows from providing services, investing activities and financing activities.

Ratio Analysis

A primary financial tool used to assess the financial condition of an organization is called ratio analysis. The categories of ratios are:

Liquidity	ability to meet short-term obligations
Operating	use of assets and management performance
Debt	long-term survivability
Profit	management performance and ability to meet long-term obligations

For managed care organizations, two ratios are generally monitored very closely to assess performance. The two ratios are:

$$\text{Medical Claims Expense Ratio} = \frac{\text{Total Medical Claims Expense}}{\text{Premium Revenue}}$$

$$\text{Administrative Expense Ratio} = \frac{\text{Nonhealth Service Expenses}}{\text{Total Operating Revenue}}$$

These ratios focus on the two major categories of expense and how they relate to the premium dollar.

Management Accounting

The primary focus of management accounting is the determination of the cost of a particular decision. It is important to stress that the word “cost” is ambiguous and its meaning depends on the type of decision being made.

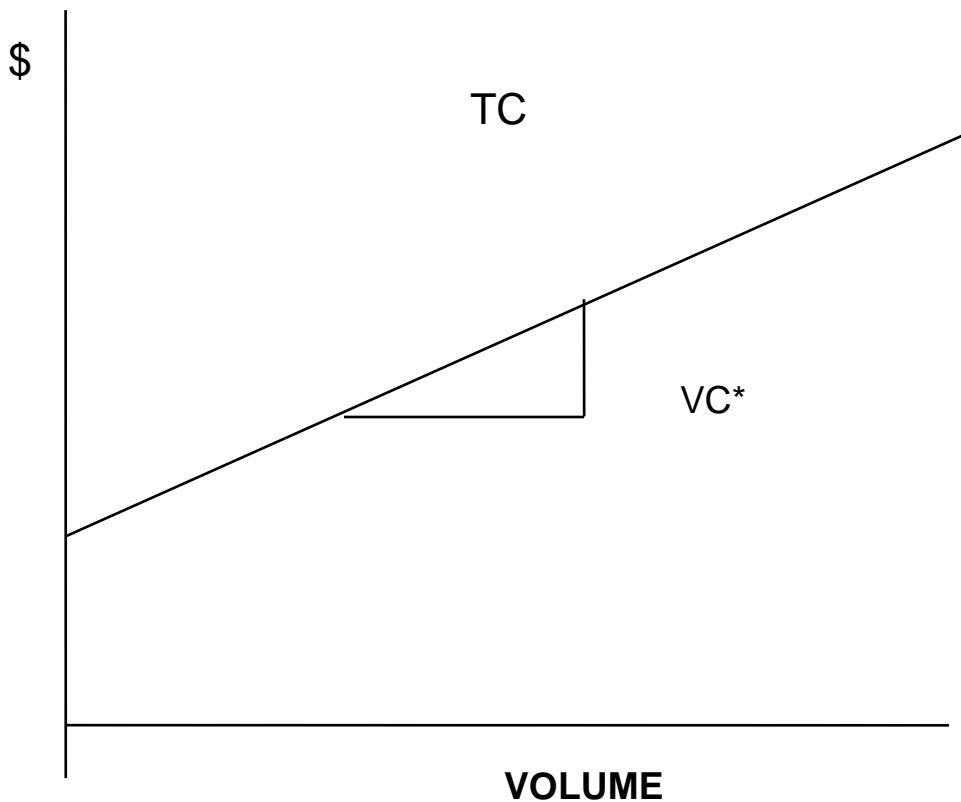
The types of decisions requiring cost information are:

- Pricing decisions
 - short-range
 - long-range
- Capital investment
- Discontinuance/sales value
- Performance evaluation

Most pricing decisions require a separation of the cost data into two categories:

Fixed Costs (FC)	Do not vary directly with volume of activity (changed only by management decisions, i.e., salaried personnel)
Variable Costs (VC)	Vary directly with volume of activity (i.e., fee for service activity)

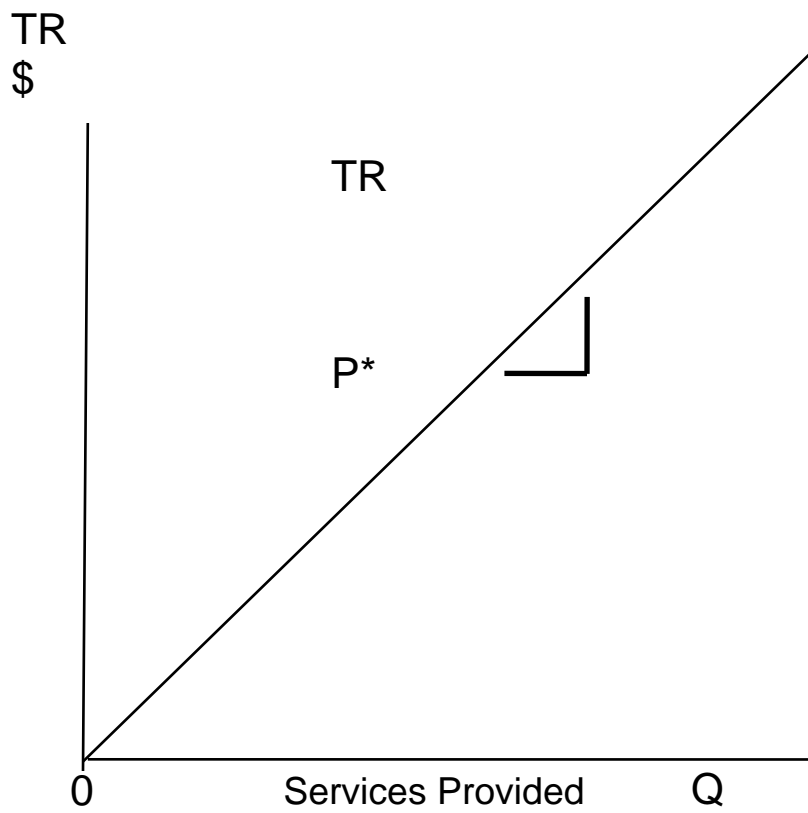
Both are influenced by the volume of the activity measure being selected. In graphical format, the total costs of a health provider can be presented as in FIGURE 2, when the slope of the total cost curve is a function of the variable costs per unit.

FIGURE 2 THE TOTAL COST CURVE

* VC = variable cost per unit

If we add a revenue function that is basically a price-times-quantity relationship, then the slope of the total revenue curve in a fee-for-service environment is the price billed for the services provided. FIGURE 3 captures this relationship.

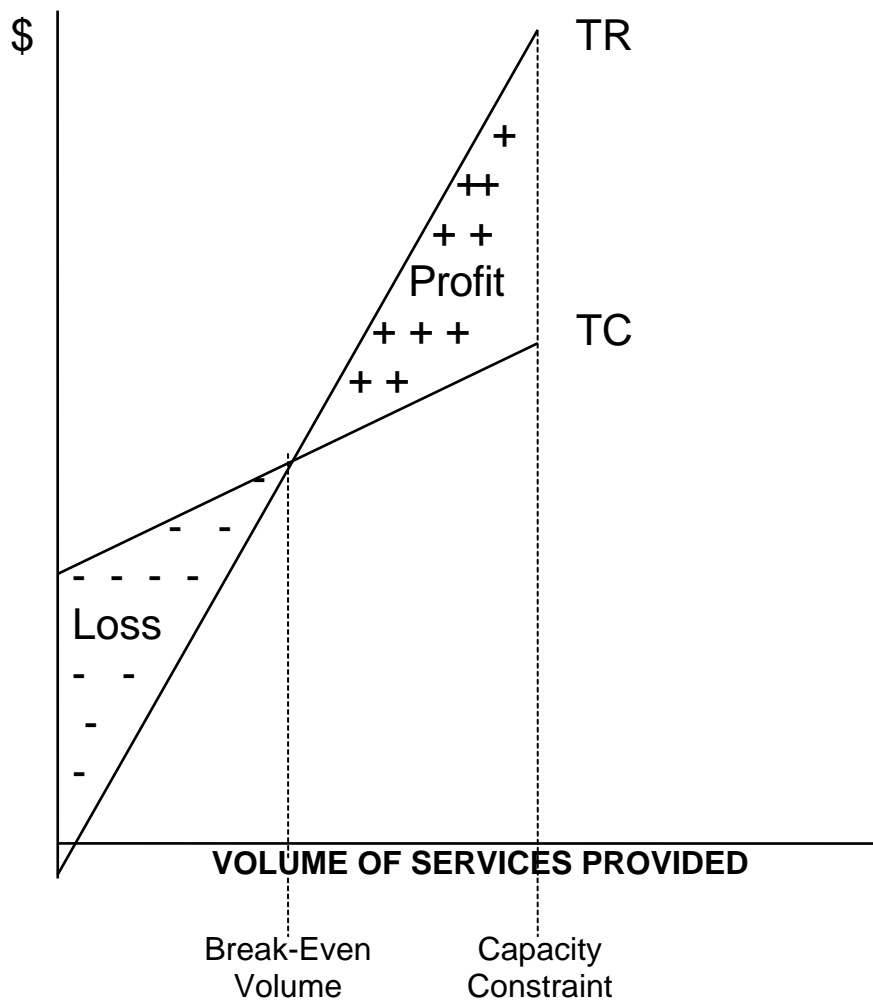
FIGURE 3 TOTAL REVENUE IN A FEE FOR SERVICE ENVIRONMENT



*P = Price Billed for Services Provided

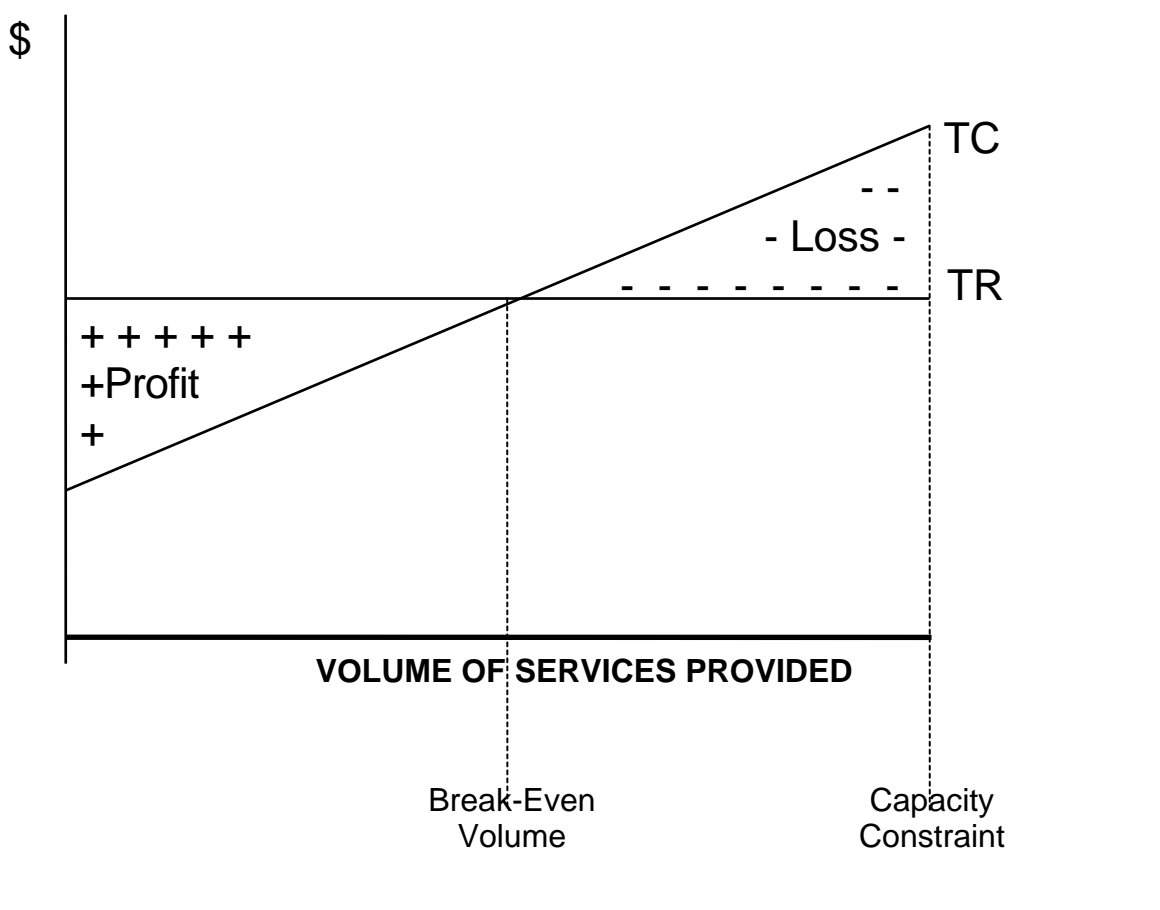
In a managed care capitated environment, as contrasted with a fee for service environment, the diagnosis of the impact of volume on profitability can be illustrated, as shown in FIGURE 4 and FIGURE 5.

FIGURE 4 COST-VOLUME-PROFIT MODELS UNDER A FEE-FOR-SERVICE FORMAT



Under a capitated form of reimbursement, the total amount of reimbursement is a function of the number of subscribers, not the volume of services provided. Once the coverage period starts, the number of subscribers is fixed; therefore, the total revenue curve is flat (i.e., does not increase with volume, as indicated in FIGURE 5).

FIGURE 5 COST-VOLUME-PROFIT MODELS UNDER A CAPITATED METHOD OF PAYMENT



The financial incentives are reversed from a fee-for-service environment, and utilization review switches from an over-utilization to an under-utilization perspective.

Total cost behavior primarily deals with budgeting, performance measurement and other strategic/operational decisions. When we are concerned with pricing decisions, we must consider per-unit costing concepts. Basically, all per-unit costs are averages. As illustrated in FIGURE 6, one obtains per-unit costs by dividing total costs by a volume measure.

FIGURE 6 “PER-UNIT” VS. “TOTAL COST” DECISIONS

Total Cost = Total Fixed Cost + Total Variable Costs

Per-Unit Costs Are Averages

$$\text{Per - Unit Costs} = \frac{\text{TFC}}{\text{Q}} + \frac{\text{TVC}}{\text{Q}}$$

It is important to stress that whenever you have fixed costs, you can not determine per-unit costs without specifying a volume of output.

Contribution Margin Approach

The relationship between fixed and variable costs and profit can also be expressed in terms of the contribution margin approach:

$$\begin{aligned} \text{Contribution Margin} &= \text{Price after Discounts} - \text{Variable Cost Per Unit} \\ \text{CM} &= P - VC_U \end{aligned}$$

The relationship between contribution margin and the income statement covered in the financial accounting section is illustrated in FIGURE 7.

FIGURE 7 COMPUTATION OF BREAK-EVEN POINT

Given: \$20	Average revenue per patient visit after discount	
<u>- 8</u>	Average variable cost per patient visit	
\$12	Contribution margin (CM) per patient visit	

Total fixed costs (TFC): \$240,000

$$\text{BEQ} = \frac{\text{TFC}}{\text{contribution margin}} = \frac{\$240,000}{12}$$

This can easily be proven by the following financial statement:

Total revenue	(20,000 x \$20)		= \$400,000
Total variable costs	(20,000 x \$8)		= <u>160,000</u>
Total contribution margin	(20,000 x \$12)		= \$240,000
Total fixed costs			= <u>240,000</u>
Excess of revenue over expenses			= <u>\$ 0</u>

Additional contribution formulas are shown in FIGURE 8.

FIGURE 8 EQUATIONS

QUANTITY EQUATION (M = 0)

$$Q = \frac{TFC}{CM}$$

QUANTITY EQUATION (M > 0)

$$Q = \frac{TFC + M^*}{CM}$$

RATE-SETTING EQUATION (Q is given)

$$P = \frac{TFC + TVC + M}{CM}$$

$$P = VCU + \frac{TFC + M}{Q}$$

* M = Margin or Profit

Basically, the contribution margin approach can be used to determine break-even points/profit, quantity, prices and cost categories.

Allocation Process

Another major factor in the determination of per-unit costs is the allocation process. Basically, all costs must be included in the costs of the revenue-producing services. In the allocation process, variable costs can be traced

directly to the output of the department, but fixed costs must be *allocated* to the output of the department. It is important to stress that *allocation is a subjective process*. Organizations will have different cost allocations based on the following decisions:

- Allocation method
- Allocation base
- Responsibility centers
- Depreciation method

To summarize, the cost process requires that you:

- Define cost centers (both support and service)
- Determine direct costs of support and service centers
- Allocate support center cost to service centers to determine total costs
- Determine unit costs by dividing total center costs by number of units provided

Because of the subjective nature of the costing process, performance measurement requires categorizing information in a different manner. A basic concept of performance evaluation is that individuals should only be measured by costs they control or significantly influence, i.e., direct costs.

Costs for Performance Measurement

Costs for performance measurement are categorized as following:

Direct Costs	Costs that can be traced to a service, organizational unit or individual provider/manager
Indirect Costs	Costs that <i>must be allocated</i> to services, organizational units or individual providers/managers

A key aspect of effective performance measurement is to organize the activities of the provider in the responsibility centers. The basic responsibility centers are:

- Cost (expense) center inputs only measured
- Revenue center outputs only measured
- Profit center inputs and outputs measured
- Investment center inputs and outputs measured in relation to amount of investment

Budgeting Systems

The type of responsibility center has an important impact on the type of budgeting system to be used. A major premise of the budgeting system is that it should focus on *outputs* not inputs.

Only the investment center or profit center approach provides output information. In the cost center, inputs are used that can be interpreted thusly: If you spend your budgeted amount, you are performing satisfactorily. A revenue center approach basically says that only outputs are important and the costs of achieving them are not relevant to the manager. As a goal, the budgeting process should be designed to allow the following to be measured:

Effectiveness	The accomplishment of the organizational objectives
Efficiency	The measurement of resources consumed to outputs achieved

From a more general focus, a budget should accomplish the following:

- Control activities
- Coordinate activities
- Communicate important objectives
- Motivate personnel
- Measure results

Three types of budgeting systems are typically used with healthcare providers:

- Incremental
- Program
- Zero base

TABLE 2 illustrates the processes, strengths, and weaknesses of each approach.

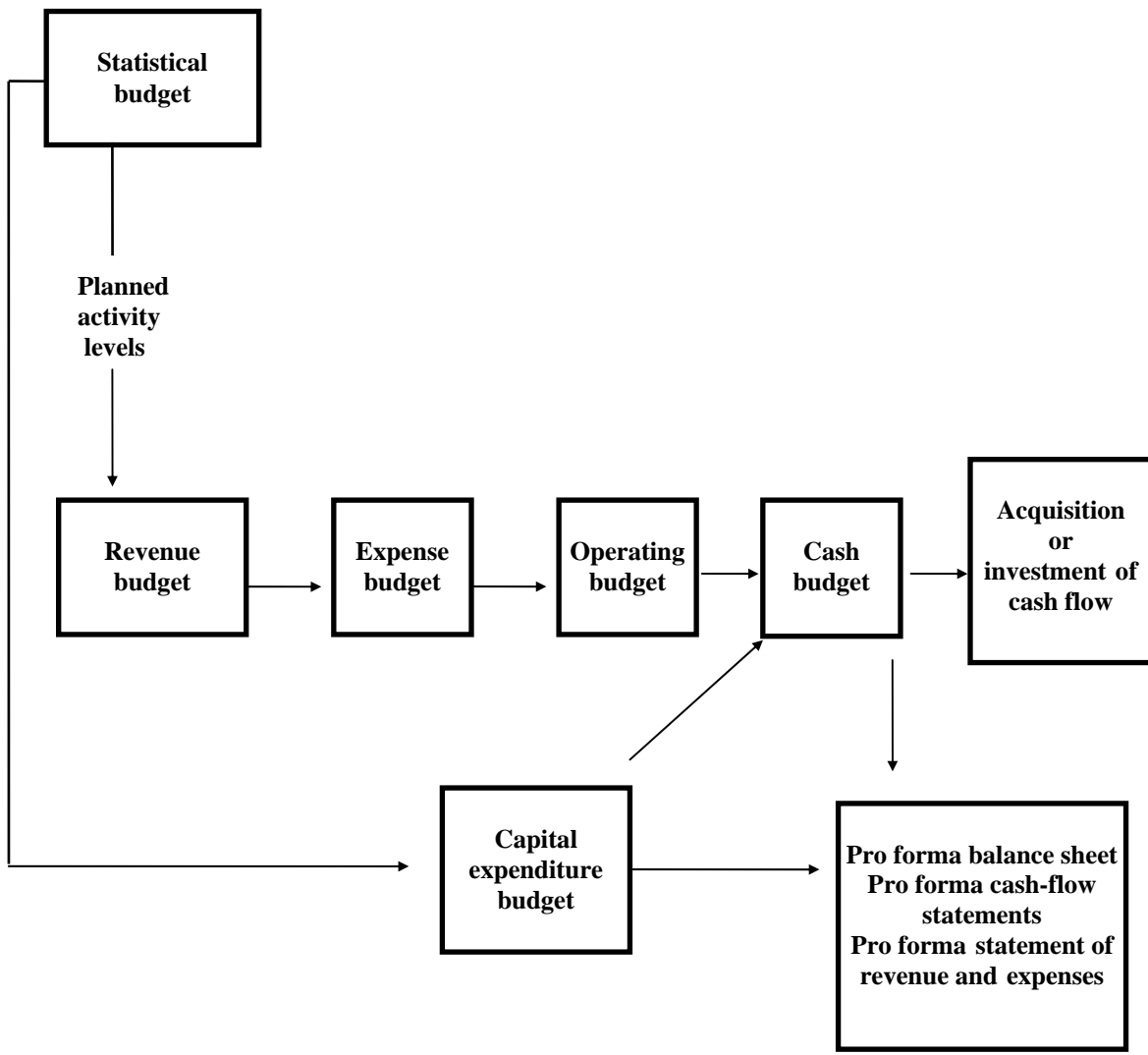
TABLE 2 BUDGETING TECHNIQUES, PROCESSES, STRENGTHS AND WEAKNESSES

Technique	Incremental	Program	Zero-Base Budgeting	Standard-Cost Budgeting
Processes	<p>Last year's actuals are starting point</p> <p>Amounts added for inflation, new programs</p>	<p>Outputs (programs) to be achieved are costed and benefits evaluated</p>	<p>Activities to be completed are broken into small decision packages by supervisors and then ranked by management</p>	<p>Requires development of what activities "should cost" for given output and quality levels using time and motion studies and detailed cost data</p>
Strengths	<p>Budgeting is by responsibility center</p> <p>Easy to do</p>	<p>Focuses on outputs</p> <p>Includes input/output comparisons</p>	<p>Starts from zero each year</p> <p>All dollars requested must be justified</p> <p>Involves lower levels of management</p> <p>Provides a priority ranking of activities proposed to be accomplished</p> <p>Combines inputs with outputs</p>	<p>Provides goals for supervisors to meet</p> <p>Requires involvement of supervisors, technicians and financial personnel</p> <p>Focuses on currently attainable efficiency</p>
Weaknesses	<p>Assumes last year's amount was right</p> <p>Subject to arbitrary costs</p> <p>Focuses on inputs</p>	<p>Does not align with responsibility centers</p> <p>Difficult to assign responsibility when more than one cost center is involved</p>	<p>Lengthy process</p> <p>Lower-level supervisors are not trained to complete decision packages</p> <p>Impossible from a practical point of view to start from zero</p>	<p>Reliable cost data typically not available</p> <p>Lengthy process</p> <p>Standards need to be updated frequently</p>

Operating Budget Cycle

Finally, a summary of the operating budget cycle is illustrated in FIGURE 9.

FIGURE 9 THE OPERATING BUDGET CYCLE



Financial Management

Financial management focuses on ensuring that the capital requirements of the organization are met. These capital requirements can be expressed as:

- Costs of doing business
- Costs of staying in business
- Costs of changing business
- Returns to suppliers of capital

Most of the capital requirements can be determined through the accounting system; however, financial management depends on recognizing the difference between accounting costs and economic costs and requires that both be included in the decision process.

Accounting Costs

Accounting costs are outputs of the accounting system and are usually determined in accordance with GAAP. Accounting break-even occurs when revenues equal expenses. Economic costs typically reflect current market value. Economic break-even includes a return to all suppliers of capital and requires that total financial requirements be met.

Most major financial management decisions involve capital investment types of decisions, i.e., funds are expended now for future gains. Capital investment decisions focus on cash flows rather than on accounting flows. They are basically economic decisions.

Economic Decisions

Economic decisions require an understanding of the following cost categories:

- Opportunity costs
 - Benefits given up by not selecting next best alternative (costs typically not shown on the financial statements)
- Incremental (marginal) costs
 - Out-of-pocket costs that will change if and only if a decision is made (determined from special studies)
- Sunk costs
 - Costs not changed by the decision under consideration (basically accounting costs)

Management Decisions

There are two major management decisions in capital investment decisions:

- Sources of capital
 - Where did we get it?
 - What is the cost?
- Uses of capital
 - How did we use it?
 - What are the returns?

The amount and timing of the cash flows adjusted for the time value of money is the measurement focus.

Sources of Capital

The sources of capital in the capital structure decision can come from two sources:

- Equity (or fund balance)
 - Contributed capital
 - Retained earnings
- Debt
 - Short-term (trade credit)
 - Long-term (notes, bonds, leasing)

As the amount of debt increases, the risk to the lender increases and higher interest rates follow. To maintain a stable risk profile in the capital structure, then, increased use of debt requires that additional equity also be obtained to keep the relative amounts of each source within board-established limits.

One way to measure the costs of various services of capital and the impact of the capital structure is the use of a weighted average cost of capital model (WACC). In the WACC approach, the relative amount of debt and equity in the capital structure and the cost of each source in the marketplace are used to determine the weighted cost, as illustrated in FIGURE 10.

FIGURE 10 COSTING OF SOURCES**Weighted Average Model**

<u>Capital Source</u>	<u>Optimum Percentage</u>	x	<u>Cost</u>	=	<u>Weighted Cost</u>
Short-term debt	10	x	0	=	0
Long-term debt	30	x	10	=	3
Equity	60	x	12	=	72
Weighted Average Cost of Capital:					10.2%

Capital Investment Decisions

Typical decisions requiring the use of capital investment techniques are:

- Equipment (purchase or divestiture)
- People (hiring and firing)
- Interest-bearing instruments
- Repurchase of debt instruments
- Programs (initiating/terminating)

Inputs required to determine the rate of return on the capital investment decisions include:

- Cash flows (inflows and outflows)
- Economic life
- Discount rate (cost of capital)
- Impact of taxation and/or cost-based reimbursement

The discount rate used to determine the discount factor can be determined from the weighted average cost of capital or alternative methods, which are explained in any of the referenced texts.

Evaluation Techniques

The evaluation techniques used in the analysis of capital investment decisions can be separated into two categories: economic evaluation techniques and accounting evaluation techniques.

Economic Evaluation Techniques (adjusted for the time value of money)

Net Present Value (NPV):	The difference between the discounted cash inflows and discounted cash outflows over the life of the investment.
Internal Rate of Return (IRR):	The discount rate, which, when used to discount a series of cash inflows and outflows, makes the NPV of those cash flows equal to zero.

Accounting Evaluation Techniques (not adjusted for the time value of money)

Accounting Rate of Return:	The average increase in income reported on the financial statement divided by the total or average investment.
Pay Back:	The amount of time it takes to recover the cash outflows of the investment from the cash inflows.

Calculations using all four techniques are shown in FIGURE 11.

FIGURE 11 TWO CAPITAL INVESTMENT PROJECTS

Diagnostic Equipment	Project A	Project B
Cost, including installation	\$ 60,000	\$ 55,000
Est. annual labor cost savings	\$ 20,000	\$ 16,000
Est. economic life	5 years	5 years
Tax rate	40%	40%
Cost of capital	15%	15%
Incremental cash inflows	\$ 20,000	\$ 16,000
Depreciation expense	<u>\$ 12,000</u>	<u>\$ 11,000</u>
Taxable income before taxes	\$ 8,000	\$ 5,000
Taxes 40%	- <u>\$ 3,200</u>	- <u>\$ 2,000</u>
Net income after taxes	\$ 4,800	\$ 3,000
Accounting rate of return (before taxes)	13.33%	9.01%
Accounting rate of return (after taxes)	8.00%	5.45%
Payback	3 years	3.4375 years
Net present value:		
Year 0 cash outflow	\$ 60,000	\$ 55,000
Year 1-5 inflows before taxes	\$ 20,000	\$ 16,000
Year 1-5 inflows after taxes	\$ 16,800	\$ 14,000
Factor for inflows (15%)	3.352	3.352
Present value of inflows before taxes	\$ 67,040	\$ 53,632
Present value of inflows after taxes	\$ 56,314	\$ 46,928
Internal rate of return before taxes	19.86%	13.95%
Internal rate of return after taxes	10.92%	8.62%

Endnotes

¹Berman, Kukla, and Weeks. Page 2.

Study Guidelines

- Understand managerial factors in controlling accounts receivable.
- Understand the elements in providing credit, including routing credit and collection costs, carrying costs and delinquency costs.
- Understand the basics of investment decision making, including:
 - Concept of capital rationing
 - Use of discount rates
 - Elements of financial risk
 - Use of the cost/benefit index in evaluating capital investments
 - How net present value (NPV) is used in investment decisions
- Know the uses of time value of money techniques, discounted cash flow (DCF) and NPV techniques.
- Understand how the following are used in integrating the strategic and financial plan:
 - Growth rate of assets
 - Debt capacity
 - Profitability objectives
- Understand the uses of the following budgeting techniques:
 - Zero-based
 - Incremental
 - Flexible
 - Program
- Understand the concepts of cash flow and operating margin.
- Understand the following reimbursement methods:
 - Per diem
 - DRG
 - Capitated

Cost-based

- Understand the difference between community rating and experience rating.
- Know the difference between the income statement, statement of cash flows and the balance sheet.
- Understand the concepts of financial leverage, growth rate and contribution margin.
- Understand the relationship of the cash budget to the revenue, expense and capital budgets.
- Be familiar with the methods of cost-finding, including:
 - Step-down
 - Direct apportionment
 - Double apportionment
 - Multiple apportionment
- Be familiar with the various depreciation methods, including:
 - Declining balance
 - Straight-line
 - Allowable cost
 - Sum of the years in digits
- Understand how the financial ratios are used, including:

Liquidity measures	current ratio, acid test ratio, collection period
Activities ratios	total asset turnover, inventory turnover, fixed asset turnover ratio
Operating margin	operating margin, return on assets
Capital structure	long-term debt to fixed assets, long-term debt to equity, debt to service ratio

Healthcare Technology and Information Management

The healthcare field is in a period of great change characterized by more involved and knowledgeable consumers, demands for cost containment and quality improvement from consumers and payors and a resultant development of provider networks through mergers, acquisitions and joint ventures. Information is an essential resource for strategic management and delivery of high-quality patient care in this complex environment. Effective use of information does not just happen. The process of information systems planning, design and implementation requires effective information resource management within the healthcare organization.

Development of Information Systems

Four basic management principles should guide the development of information systems in healthcare organizations:

- Treat information as an essential institutional resource that must be carefully managed.
- Obtain top executive support for information systems planning and development.
- Employ a user-driven focus in the information systems planning and project development process.
- Begin with a strategic information systems plan that links information system priorities to the strategic goals and objectives of the organization.

Information Systems Planning

Information systems planning should be guided by a management information systems steering committee with representation from administration, medical staff, major system users and the information systems department of the

organization. The planning committee should not be dominated by technical specialists.

The strategic information systems plan should establish goals and objectives linked to organizational priorities. The plan will specify priorities for individual computer applications and resources required for systems development and implementation. An important element of planning is specification of requirements for system integration; this is the ability of individual computer applications to share information and communicate electronically with one another.

Role of the Chief Information Officer

Many healthcare organizations, particularly larger ones, have employed a chief information officer (CIO) to guide the information systems planning process. The CIO should be a member of the executive management team who understands the processes of strategic planning and management. One of the most important responsibilities of the CIO is to serve as an advisor to the executive management team on the effective use of information for management and patient care support. The CIO would oversee organizational units responsible for information systems and telecommunications.

The development of individual information systems in a healthcare organization should begin with analysis of functional requirements. Representatives from departments who will use the proposed new system should be heavily involved in specifying these functions. Systems analysis will result in process improvements even if a decision is made not to proceed with installation of a computerized system.

Evaluation of Vendors

In recent years, most healthcare organizations have chosen to obtain commercial software from vendors for implementing systems rather than writing computer programs with in-house staff. The vendor evaluation and selection process must be carefully managed and must always begin with a detailed statement of system requirements, as described above. In evaluating software packages, it is essential to obtain information on system performance directly from other healthcare organizations that are using the product under consideration.

After proposals from vendors have been evaluated, negotiations with the vendor of first choice should be carried out. The CIO or other administrator responsible for information management should head the negotiating team. The negotiating team should be kept small and should include legal counsel and representatives from the financial office of the organization. Standard vendor contracts should not be considered since the contract terms are designed to favor the vendor in the negotiations. The request for proposals (RFP) includes detailed system specifications and should be included as part of the contract. All aspects of an information system should be evaluated by a thorough system test prior to final acceptance from the vendor.

All operational systems should be periodically evaluated by the CIO or other person designated by the chief executive officer. Evaluation helps ensure that original system objectives are being realized efficiently.

Categories of Information Systems

There are three general categories of information systems used in healthcare organizations:

- Clinical
- Administrative/financial

- Decision support for strategic management

Clinical Information Systems

Clinical information systems have taken on increased importance both for improvement of patient care quality and cost control purposes. In 1991, a committee of the Institute of Medicine (IOM) recommended that work begin on the development of a national system of computerized patient records.

Clinical systems support medical records storage and retrieval, medical instrumentation, computer-aided diagnosis and treatment planning, nursing care, clinical education and research. Many hospitals are now providing electronic linkages to computers in physician offices to offer access to clinical data and establish closer bonds with physicians on the medical staff. Several hospitals are using bedside or point-of-care terminal devices to facilitate direct entry of patient information at the source and reduce clerical time spent by nursing personnel. A promising new technology on the horizon, but one that is not yet fully operational, is voice recognition. These systems, when perfected, will allow direct voice input of data into clinical data files, thus helping to overcome a major barrier to system utilization by physicians and other patient care personnel.

Administrative/Financial Information Systems

Administrative/financial information systems include payroll, human resources and materials management; patient, general and cost accounting; facilities management and scheduling systems; and office automation. Increases in managed care contracting give additional priority to the development of good financial systems in the organization.

Decision Support Systems

Decision support systems are designed to provide information for strategic planning and decision making. Information on physician practice and referral patterns, patient satisfaction, net revenue by product or service line and other key indicators can be produced by such systems if executives are actively involved in defining requirements.

Data Security

Protecting confidentiality of information is an important design criterion for healthcare information systems, particularly those dealing with patient data. Data security must include management policies and procedures linked to technical system controls such as password identification, terminal interlocks, and logs of users for retrospective auditing.

Integrated Delivery Systems and Managed Care

Provider networks developed through mergers, acquisitions and joint ventures require electronic communications among network members. Enterprisewide information systems and data warehouses are being developed to meet this need. It will not be necessary that all organizations in a network use the same computer hardware and software, although some consolidation of systems may be desirable. Standard data communications protocols such as Health Level Seven (HL7) will be needed to facilitate information exchange within and across organizations in the network. Careful analysis of the business, clinical and operating requirements of the network will drive the development of network systems.

Managed care contracting places a priority on financial forecasting and modeling by healthcare organizations. The need to measure outcomes and continuously improve service and patient care quality will continue. Outcomes assessment requires good information on costs, quality and access to services. Healthcare organizations will be seeking the lowest cost treatment protocols that have been

shown to have at least equal medical effectiveness to other available treatment modalities.

Executive managers must take direct responsibility to ensure that information is used effectively in their organizations. Information is essential for strategic planning, cost control, productivity management, continuous quality improvement and evaluation of programs and services. Information systems must be user-driven rather than technology-driven if they are to succeed. The intelligent use of information for health services management does not just happen. Rather, the chief executive officer must take responsibility to see that it occurs in a systematic and carefully planned manner.

Study Guidelines

- Understand the purposes of automated information systems.
- Review basic approaches for measuring productivity.
- Understand factors in guiding the development of information services, including the planning process.
- Know how to measure the performance of the management information system.
- Understand the role of outside contractors in establishing a management information system.
- Understand the process for selecting an information system vendor.
- Understand the role of the management information systems steering committee.
- Understand the need for electronic data interchange as a result of managed care expansion and the development of integrated delivery systems

Quality and Performance Improvement

This area addresses the development, implementation and evaluation of organizational accountability for quality care and services. It considers some of the historic philosophical elements of quality and their more contemporary use. Government and business initiatives regarding transparency and quality comparisons are also addressed.

“The American healthcare delivery system is in need of fundamental change.” This opening line in the preface to the IOM’s report, *Crossing the Quality Chasm: A New Health System for the 21st Century* (2001, p. ix) sounded a clarion call for improving quality. Along with the previous IOM report, *To Err Is Human* (1999), they share a perspective of how healthcare had not lived up to its potential and a refocusing on quality was due. Major questions left in the wake of these reports include, “*How do we improve quality?*” And “*How do we know that we’ve improved?*” The demand healthcare quality to improve has never been louder or more insistent.

Quality Comparisons & Demands

Healthcare costs money. Large businesses spend a considerable amount of money providing some portion of the payment for their employees’ healthcare services. A comparison of costs and outcomes across the nation has shown that they are not uniform and not predictable. In an effort to improve predictability, some businesses have joined to create organizations such as the Leapfrog Group, an organization representing close to 40 million people, to mandate certain processes be initiated to improve quality for their constituents. Other organizations such as the Centers for Medicare and Medicaid Services (CMS) and The Joint Commission are monitoring specific clinical outcomes and comparing hospital-specific information on the Internet. These sets of measures represent measurement of a core group that will undoubtedly expand.

CMS initiatives make clear that the future of pay-for-performance programs in healthcare is the direction they're going. The idea is simply to reward hospitals that show improvement in specific areas compared to other hospitals. The reward can come in the form of getting the entire Medicare payment or getting additional money from hospitals that were penalized and didn't show improvement. One area where pay-for-performance may be used is in measuring customer satisfaction with the Consumer Assessment of Healthcare Providers and Systems Hospital Survey (H-CAHPS), mandated by CMS. This survey instrument will be used to collect and compare self-reported patient satisfaction along certain parameters. The data also will be available on the CMS's hospital compare Web site for public consumption. It is presumed that hospitals unable to improve scores will be financially penalized.

The Institute for Healthcare Improvement (IHI) has made a huge impact in healthcare quality by providing leadership in determining and disseminating best practices. They have championed programs encouraging hospitals to find and use evidence-based practices, including a program to reduce preventable deaths and to reduce the number of people harmed in the course of their treatment. Their program of encouraging nursing staff to call a rapid-response team if they feel their patient is deteriorating is an innovation copied by The Joint Commission in their 2008 patient safety goals.

Transparency is a term that is increasingly being used in healthcare. It refers to the ability to judge care, costs and satisfaction from outside the organization by viewing published elements that paint a picture of supposed competency. The more transparent the data and information are the better consumers and stakeholders will be able to compare and make decisions regarding care. Information in support of transparency is available through CMS, The Joint Commission, IHI and soon will be through H-CAHPS information.

Quality Improvement

Current performance improvement processes may have a departmental focus. They also may compare performance from one healthcare organization to another, or to a national measurement of best performance. Continuous Quality Improvement (CQI) is a phrase used in healthcare literature and as working terminology to describe a reiterative process of not accepting the status quo as sufficient. CQI suggests a system focus in reducing unnecessary variation in processes such as delivery of medications, delivery of supplies or completing patient bills. Although recognizing that otherwise capable individuals cannot succeed in a poorly functioning system, it is necessary to provide data to show how systems are constituted—how they work and whether the variability of a system can be reduced to better assure stable processes. Understanding that mistakes happen for many reasons and are not necessarily the fault of any one person, errors in manufacture, delivery and administration can occur because of poorly designed or inadequately functioning processes.

There is an interconnectivity of processes and systems; as one part of a system is improved, the relationship or functioning between parts of the system can also be improved as a result.

CQI tools can be considered *process* or *statistical tools* that allow for analysis, measurement, and improvement. Improving processes is appropriate in comparing evidence of compliance with medical quality standards, financial management, cost control, customer satisfaction results, use of supplies and many others. Rather than only analyzing with historic data, as quality assessment processes, performance improvement processes chart routes for future improvement and measure success in implementation. While improvement has been used to improve clinical practices, it is equally useful in improving nonclinical processes and systems as well.

Process-Oriented Thinking

The reiterative process of improving stems from a philosophy that suggests quality is not something attained but rather continually sought. Like any organizational philosophy, quality will permeate an organization only if top administrative understanding, agreement and adherence occur. Essential quality improvement elements come from authors such as Deming, Juran, Crosby, Ishikawa and others. Success in the application of this philosophy has been used by Motorola, GE, and Toyota, and is being widely adapted into healthcare organizations as well. Certain themes include the following:

- Decisions are based on data. Data that are properly collected eliminate much of the potentially emotional subjectivity inherent in poor decisions based on intuition, or other decisions.
- Decisions are guided by embracing a philosophy suggesting that better decisions can be made with proper analysis, and individuals succeed when allowed to participate in decision making.
- Serving and pleasing the customer are paramount to survival. Customers may be defined as anyone affected by an organization's actions. Insight from the customer is more important than the organization's perception of what the customer should recognize. An organization must ask their customers for feedback regarding their products or services and then act to improve customer satisfaction.
- Progress is measurable. Improvements in services should be compared to customer expectations to achieve goals. Information resulting from these

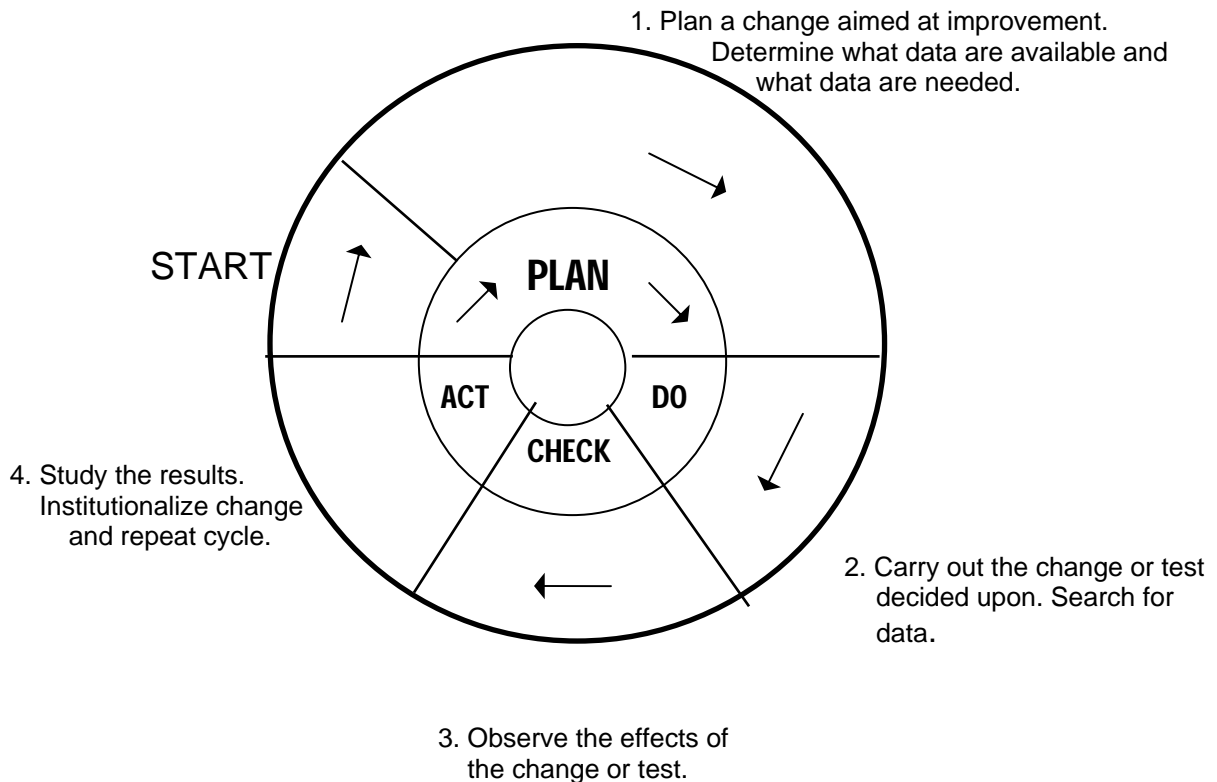
improvements should be shared within the organization in support of the philosophy and initiative.

- Quality tools are available to improve the reliability of collecting data. Traditional tools include run charts, flow diagrams, fish diagrams and Pareto charts. More sophisticated data collection tools also exist, but these are easily understood at every level of an organization.
- Empowerment and fear are mutually exclusive. Employees cannot openly participate in performance improvement activities if they fear retaliation or ridicule as a result of offering suggestions for improvement.

CQI is a thoughtful, purposeful philosophy that may require managers to relinquish historic individualistic control of decisions and replace it with an empowered multidisciplinary team. Use of the Deming wheel, as a process, may be critical in focusing on reducing variation in a continuous process to eliminate unnecessary variation and improve care and support services.

FIGURE 12

The Plan-Do-Check-Act Cycle



Many organizations begin implementation with training related to basic statistical concepts—how to flowchart a process that creates a *picture* of the process, which is altered as improvements occur. Use of control charts can help in demonstrating where variation exists. As variation is reduced, the quality of the product or service offered becomes more consistent and customer satisfaction improves.

Risk Management

Risk management is an important aspect of healthcare management. Risk management and CQI can be used together to identify areas for improvement since risk may be involved in parallel, complementary paths. Risk management reduces the exposure of the organization, legally and financially, while CQI improves processes that may have been poorly designed, and as a result increase risk to the patient. In some organizations, the risk management function overlaps or is included with the corporate compliance function.

Risk Management and Medical Records

Accurate medical records are very important in risk management. Ownership of the medical record rests with the hospital or with the physician who keeps patient records. The owner of the record thus has the right of physical possession and control. Neither the patient nor an authorized representative has the right to physical possession of original medical records. Instead of delivering the entire original record to a newly chosen physician or hospital, the physician or hospital that owns the record may transfer a copy. The hospital or physician has a legal obligation to make available to the receiving physician or hospital all information that is necessary for the care of the patient.

The Joint Commission has set standards for maintaining medical records. The record must contain sufficient information to identify the patient and to support the diagnosis and treatment, and it must furnish adequate documentation of results. The Joint Commission standards require that the medical history, diagnostic and therapeutic orders, all reports, consultations, tests, progress notes and clinical resume are entered and signed by the attending physician. Failure to maintain complete, accurate and current records have adverse effects for defendants in malpractice litigation.

To meet the demands of the changing healthcare environment, managers must develop expanded measures of quality improvement processes and outcomes to supplement traditional indicators of quality assessment and risk management. Risk management and quality improvement initiatives should be deeply seated in the organization as complementary paths for improving patient care and assuring safety.

Endnotes

Institute of Medicine. *Crossing the quality chasm: A new health system for the 21st century*. Washington, D.C.: National Academy Press. 2001

Institute of Medicine. *To Err Is Human*. Washington, D.C.: National Academy Press. 1999.

H-CAHPS www.cms.hhs.gov/HospitalQualityInits/

Institute for Healthcare Improvement www.ihl.org

Leapfrog Group www.leapfroggroup.org

The Joint Commission www.jointcommission.org

Study Guidelines

- Understand the philosophy and application of CQI in the healthcare setting for clinical and supportive processes and systems.
- Understand the function of a Quality Council or Performance Improvement Council.
- Understand the concept of transparency for comparative quality data and public reporting.
- Understand comparative quality outcomes and their effect in the public domain.
- Understand pay-for-performance initiatives and their potential impact for Medicare payments.
- Understand customer satisfaction surveys, including H-CAHPS, and the application of pay-for-performance for improving customer satisfaction.
- Know what the basic tools used in CQI are, including:
Flowcharts, Control charts, Cause-and-effect diagrams, Histograms, Check sheets, Pareto charts, Scatter diagrams.

- Understand the uses of critical paths in surgical and medical diagnoses and the use of evidence-based information.
- Understand the quality outcome goals related to the Institute for Healthcare Improvement in assessing and encouraging clinical and process improvements, and their reporting.
- Understand the philosophy and initiatives of business organizations such as the Leapfrog Group and their outcomes reporting.
- Understand what Six Sigma means as a health care improvement philosophy.
- Understand the role of patient/employee safety as a quality function.
- Know what the Health Plan Employer Data and Information Set (HEDIS) is.
- Know what the Malcolm Baldrige National Quality Award is and how it relates to healthcare organizations.
- Understand the importance of keeping a written record of quality assurance activities.
- Understand the Joint Commission patient safety standards.
- Understand the Joint Commission quality improvement core outcomes reporting and promulgation.
- Understand the CMS quality outcomes initiatives and reporting.
- Understand the rights of patients in planning their own care.
- Understand the Joint Commission standards for withholding life-sustaining care.
- Know the laws and the Joint Commission standards for maintaining and documenting medical records.

Laws and Regulations

Questions in the area of government regulations and law relate to the many ways healthcare organizations and professionals are affected by legal principles and government policies. These questions test one's knowledge of the effects of government policy on healthcare operations; the opportunities for and restrictions on lobbying activities and other contact with government officials; implementation of laws pertaining to healthcare; the legal responsibilities and liabilities of organizations and professionals; identification of restraint-of-trade situations; and identification of healthcare-related fraud and abuse.

“Law is a system of principles and rules devised by organized society for the purpose of controlling human conduct.”¹ And the effects of law—whether from constitutional, statutory, judicial or administrative sources—are all-pervasive in the field of healthcare. For this reason, healthcare executives must be somewhat familiar with trends and pitfalls in such legal fields as criminal law, contracts, antitrust, negligence, fraud and abuse, taxation, administrative law, the law of corporations, environmental regulation and numerous other areas.

Contracts

Although the executive need not be a lawyer, he or she must have sufficient knowledge of these fields to understand where the legal rocks and shoals are located, how to navigate around them and when to obtain the services of an experienced attorney.

For example, in the area of contracts, basic principles teach that private agreements give rise to certain duties that are enforceable in a public forum (the court system). Any physician-patient or institution-patient relationship is founded in contract: The patient requests treatment and the provider agrees to provide it in return for payment. Although these points usually are only implied rather than

expressed, they are the essential elements of a contract and they establish certain legally enforceable duties and expectations of which the healthcare executive must be aware.

There also are contractual aspects to the relationship between a healthcare organization and its physicians, nurses, other employees, suppliers, payors and the government. A basic understanding of the effects of contract law and of the means of supervising contractual relationships is essential for proper management.

Corporation Law

In a similar vein, corporation law imposes on healthcare organizations certain duties, limitations, and responsibilities. Because a corporation has a charter from the state, it receives certain benefits such as perpetual existence, legal personality and a “corporate veil” that shields the individuals who created it and those who operate it. On the other hand, a corporation is the subject of numerous legal obligations in the form of government licensure, regulation and oversight merely by virtue of its corporate status (let alone any healthcare-related obligations). The requirements of corporation law are an essential starting point for any healthcare executive.

Criminal Law

Criminal law is a less obvious but nevertheless important field of inquiry. Various criminal penalties can be imposed for actions relating to healthcare operations. It is not unheard of for healthcare personnel to be prosecuted and convicted for crimes such as assault, false imprisonment, violation of civil rights, defamation (libel and slander), environmental pollution and even murder (witness the recent but thus far unsuccessful prosecutions of Dr. Kevorkian in Michigan).

Negligence

Much more commonly healthcare personnel become involved in cases alleging negligence—violation of some proven “standard of care” or failure to exercise due care under the circumstances. The most obvious examples are cases of alleged medical malpractice against physicians, but the ingenuity of plaintiffs’ counsel in asserting grounds for negligence knows no bounds. Although most healthcare organizations were once protected by the doctrine of “charitable immunity,” they and/or their employees today can face tort liability for allegations such as failure to:

- Determine the qualifications of a physician prior to granting or renewing staff privileges.
- Monitor the qualifications of nurses and other healthcare workers.
- Maintain and implement adequate institutional policies.
- Follow the organization’s own bylaws.
- Maintain adequate facilities and equipment.
- Comply with “anti-dumping” laws regarding emergency room patients.
- Supervise the performance of contractors (including hired physicians).
- Maintain appropriate peer review and quality assurance functions.
- Prevent the unauthorized disclosure of information from patient records.
- Protect patients from healthcare workers who carry communicable or infectious diseases.
- Protect the identities of AIDS and substance abuse patients.
- Follow standard orders and protocols.
- Inform the patient or family when injuries result from known deviations from the standard of care.
- Counsel persons regarding known or knowable genetic conditions that would affect their children.

Below are only a few of the innovative types of tort law (negligence) cases that have been litigated in recent years. The need for healthcare executives to be aware of the pitfalls in this area cannot be overstated.

Fraud and Abuse

Healthcare executives must understand the standards of federal and state fraud and abuse laws, which prohibit false claims, “kickbacks” for referrals of Medicare patients, various kinds of physician self-referrals and similar activities. There are many ways those laws can be unwittingly breached and violations can result in huge penalties. (For example, each mailing of a bill containing “DRG creep” is a separate violation punishable by a fine of up to \$10,000 and expulsion from the Medicare program.) It is therefore imperative that healthcare leaders have at least a working knowledge of the requirements of these statutes and their implementing regulations.

Antitrust Law

It also is difficult to overstate the importance of issues relating to antitrust law and their application to the healthcare field. Once exempted from antitrust statutes because of their “learned profession” status, physicians and healthcare organizations now must consider that they are subject to antitrust laws of both the federal and state governments. This fact presents significant legal and operational concerns as healthcare reform takes hold: The incentives of antitrust law (to preserve and promote competition) seem counter to the policy imperatives of healthcare reform (to promote efficiency, lower cost and reduce duplication of services).

Healthcare executives who engage in business deals such as mergers, consolidations, acquisitions, reduction of services and joint ventures may unwittingly find themselves the subject of litigation brought by the U.S.

Department of Justice, the Federal Trade Commission and/or a state antitrust agency. These cases are especially troublesome because they take years to litigate, cost millions of dollars to defend and, if lost, can cost millions more in damages and penalties.

Tax Laws

The tax status of healthcare organizations is a matter of interest to executives for a number of reasons. For one thing, if the organization wishes to be a tax-exempt entity under state or federal law, it must comply with the tax laws' limitations and requirements regarding lobbying activities, political campaigning, community benefits, charitable purpose, private inurement, unrelated business income, etc. Unwitting failure to comply with the various arcane standards of the tax laws can result in a loss of tax-exempt status and millions of dollars to the bottom line.

Informed Consent

Healthcare executives need a working knowledge of legal standards in other areas as well. For example, various laws place obligations on a healthcare organization regarding admission to and discharge from the facility. In this regard, executives must be generally aware of the requirements of such diverse laws as the "Hill-Burton Act," the Emergency Medical Treatment and Active Labor Act and laws relating to involuntary commitment of mentally ill persons. They must have a general knowledge of the requirements for informed consent, the circumstances when consent can be refused and the procedures needed to secure and document informed consent. They need to understand the legal aspects of medical records: their form and contents, standards for retention/disposal, rights of ownership and control, and their use as evidence in litigation.

They also need to know about legal principles affecting consent for treatment of incompetent adults, young minor children, mature minors, pregnant minors, and seriously ill newborns whose parents refuse to consent to care. Depending on the policies of the organization with which they work, healthcare executives may need to know the state of the law regarding abortion, sterilization, euthanasia, genetic therapies and other procedures having religious or ethical overtones. They need to know about the organization's potential liability for "wrongful life" or "wrongful birth."

In short, it is essential that healthcare executives gain a certain familiarity with law and the legal system because law is one of the most common threads in the fabric of the healthcare system today. Virtually every decision made and every action taken by healthcare personnel has legal implications, and all such decisions and actions are explicitly or implicitly based on some legal principle.

Having emphasized the importance of the subject, however, we must also admit that many healthcare executives find the topic frustrating. Law is not an exact science. It has none of the precision of mathematics nor the empiricism of such a discipline as medicine. It is a "social science," and its imprecision can be frustrating.

Yet the uncertainty and flexibility of the law are what give it its strength and its appeal. It is based on a set of general rules that must be applied to the infinite variety of human behavior. The basic principles have evolved over centuries of experience, and they continue to change to meet the emerging needs of society. Thus, the courts not only determine the facts of a particular situation, apply a legal principle and determine the outcome as though some sort of sociological calculus existed, but they also interpret those fundamental doctrines and adapt them in light of changing times.

Endnote

¹Southwick, A.F. *The Law of Hospital and Health Care Administration* (2nd ed.). Chicago: Health Administration Press, 1988. Page 3.

Study Guidelines

- Identify regulations and government policies that affect healthcare organizations.
- Understand the medical/legal aspects of patient care, including the release of patient information.
- Understand antitrust regulations as they apply to the merger, consolidation or acquisition of competitor healthcare organizations.
- Understand the basics of congressional procedures and how legislation is proposed and enacted.
- Know which activities tax-exempt organizations cannot legally engage in.
- Understand the requirements of federal fraud and abuse laws.
- Know what constitutes violation of antitrust laws for healthcare organizations.
- Know the legal requirements for the maintenance of patient records, including length of time that they must be retained by the organization and the release of information contained within medical records.
- Understand the legal status of the physician-patient relationship and informed consent.
- Know what constitutes sexual harassment and the legal requirements for investigating it.
- Understand the liability of healthcare organizations regarding the actions of the medical staff.
- Know the rights of AIDS patients in medical treatment.
- Understand that the “Notice of Proposed Rulemaking,” issued by the Department of Health and Human Services, provides a process for public input into a regulating body’s decision making.
- Know the legal status of a corporation when considered a “person.”

- Know the requirements of the Americans with Disabilities Act as it relates to healthcare organizations.
- Know what legal factors are important in securing informed patient consent.

Professionalism and Ethics

The field of healthcare management became rooted in the United States when graduate education and a professional organization for healthcare managers were both established in the early 1930s. From its founding in 1933, when it was known as the American College of Hospital Administrators, to the present, the American College of Healthcare Executives (ACHE) has been a leader in establishing the profession of healthcare management. Generic hallmarks of professions include a public service orientation, self-regulation, a Code of Ethics and expectations such as assuring competence of members through continuing professional education. Additional important hallmarks for health services executives and the health professions include samaritanism and charity. Such hallmarks and expectations can be found in ACHE's *Code of Ethics* (see Addendum). *Ethical Policy Statements* have also been developed by ACHE to address specific concerns of healthcare executives (see Addendum).

Philosophers define ethics as the formal study of morality. Sociologists see ethics as the mores, customs and behavior found in a culture. For physicians, ethics means meeting the expectations of their profession and society and acting in certain ways toward patients. Healthcare executives should view ethics as a special charge and responsibility to the patient, client or others served; the organization and its personnel; themselves and the profession; and ultimately, but less directly, to society. Healthcare executives must develop a personal ethic to provide a frame of reference when they confront ethical problems.

Professional Codes

Codes of ethics usually identify the expected level of performance as well as the strivings of the profession. ACHE's *Code of Ethics* was first published in 1939, and there have been several iterations since. A major revision of the *Code* was adopted in 1987, and the *Code* is reviewed and updated annually. A primary and contextual focus of the *Code* is protecting and furthering the interests of the patient, client or others served. Special attention is given to such issues as responsibility to those served by the organization, obligations to the profession and the organization, roles in providing health services to the community and to those in need of services and conflicts of interest. The *Code* encompasses the concept of moral agency (although the *Code* currently uses "advocate" rather than "agency"), which holds that healthcare executives are morally accountable for the implications of their malfeasance, nonfeasance and misfeasance. ACHE affiliates are obliged to bring to the attention to the ACHE Ethics Committee any information that reasonably causes them to believe there has been an infraction of the *Code*. Alleged infractions of the *Code* are reviewed by the Ethics Committee, with the help of other elements of the ACHE governance structure. The Ethics Committee makes a recommendation to the Board of Governors, which has final authority. The *Code* includes appeals and reviews, which provide for substantive and procedural due process.

Because of their size and prominence, the American Medical Association (AMA) and the American Nurses Association (ANA) have codes of ethics that are among the most important of any clinical professional organizations. The first *AMA Principles of Medical Ethics* were based on the work of a 19th century English physician, Sir Thomas Percival. Subsequent revisions continue to incorporate portions of the Hippocratic philosophy governing physician-patient relationships. The *Principles* were last revised in 1980. That iteration moved away from the previous emphasis on benefits and harms and adopted the language of rights and responsibilities. The *AMA Principles* direct members to

“strive to expose those physicians deficient in character or competence, or who engage in fraud or deception.” Similarly, ACHE affiliates are expected to report members who are reasonably believed to have violated the *Code of Ethics*.

The philosophy of the ANA’s *Code for Nurses* is that the goal of nursing is to support the client’s responsibility and self-determination to the greatest extent possible. Specific provisions set out the relationships among nurses, and with nursing, clients, employers and the public. Nurses, too, are expected to act when healthcare and safety are affected by the incompetent, unethical or illegal practice of any person.

Professionals meet their obligations to themselves and to those they serve only when self-regulation is effective. Codes of ethics must be sufficiently precise so that guidance is meaningful, both to the members of professional groups and societies and to those who are charged with enforcing the code. Codes of ethics must be living documents that provide meaningful guidance to individuals who want to do the right thing, but who are uncertain as to what that is. In this regard, education is an important factor, and education about its ethical code and expectations should be part of any continuing executive development program undertaken by a profession.

Patient Rights and Responsibilities

Two moral philosophies are especially important as a context for solving ethical problems. The first, utilitarianism, is a type of teleology (*telos* is Greek for “end”) that measures the ends or results produced by a certain action; the action producing the greatest good is that which is morally correct. The second philosophy is deontology (*deon* is Greek for “duty”), which is based on duty; there are right and wrong actions, regardless of the end produced by that action. These philosophies (and others such as natural law, virtue ethics and the ethics of care) are derived four principles that can be used to guide healthcare

executives in developing a personal ethic: respect for persons, which incorporates autonomy, confidentiality, fidelity (promise keeping) and truth telling, beneficence, nonmaleficence and justice. These principles should permeate an organization's philosophy and should be reflected in its mission statement and other written expressions of values, including the organization's ethical policy statements. These principles should be reflected in all of the policies, procedures and rules used by the organization. Similarly, these principles should be part of the healthcare executive's personal ethics, as well as part of all decision making.

Institutional ethics committees (IECs) are found in most healthcare organizations. IECs are interdisciplinary and provide advice, consultation, education and analysis for physicians, patients, staff and healthcare executives. Initially, IECs focused on biomedical ethical issues, but problems of administrative ethics are an appropriate area of involvement. Healthcare executives have a role in solving biomedical ethical problems—just as clinicians have a role in solving administrative ethical problems—because decision making in either area affects the other professional group and because there is evidence that the quality of problem solving is enhanced when the two groups work together. The IEC is a way for them to contribute to higher-quality results when ethical problems arise.

Two specialized types of ethics committees are likely to be found in acute-care hospitals. Infant care review committees (ICRCs) were established in response to the Federal Child Abuse Amendments of 1984. For infants with life-threatening conditions ICRCs (1) educate hospital personnel and families of disabled infants; (2) recommend institutional policies and guidelines as to withholding medically indicated treatment; and (3) offer counsel and review in such cases. The regulations also make recommendations as to membership and administration of ICRCs. Another specialized kind of ethics committee is the institutional review board (IRB). IRBs that meet the requirements of the Department of Health and Human Services and other federal and state agencies are required in various types of research. The function of an IRB is to prospectively review proposed

research that involves human subjects to determine whether research subjects will be at risk of harm and to ensure that legally effective informed consent will be obtained. Qualifying IRBs are expected to have specific membership and engage in identified activities.

Healthcare organizations engage in a wide range of research. Clinical trials are primarily done in academic health centers and other teaching hospitals. Similarly, research to improve the practice of management tends to be done in larger hospitals and HMOs. The use of previously collected data and survey research (questionnaires) is one way in which the practice of management is evaluated. It is increasingly common to conduct telephone surveys of customers (patients/clients) to identify satisfaction levels and to pinpoint areas of dissatisfaction. There are outcome measures (indicators) that alert healthcare executives about potential problems and areas where improvement in performance should occur.

Patient bills of rights suggest appropriate ethical relationships between the patient and the organization and its employees. Titles vary, but bills of rights have been published by organizations such as the American Hospital Association (AHA), the Joint Commission and the U.S. Department of Veterans Affairs. Some are more paternalistic than others, but they all emphasize maximization of patient autonomy while recognizing the needs of the health services organization. Recognized, too, are the responsibilities of patients in the care process.

Trade associations such as the AHA, the American Healthcare Association (long-term care), the American Association of Homes and Services for the Aging and the American Association of Health Plans have issued statements or guidelines that set out expectations for ethical conduct and relationships with the community, and those served, and organizational conduct in general. These statements of ethical conduct are different from the patient bill of rights described above. For example, the AHA addresses informed consent, confidentiality and

mechanisms to resolve conflicting values and ethical dilemmas among patients and families, medical staff, employees, the organization and the community. Members are expected to accommodate the religious and social beliefs and customs of patients whenever possible.

Cultural and Spiritual Diversity

The past several decades have witnessed much greater attention to cultural and spiritual diversity. These changes have resulted from a greater sensitivity to the presence of various ethnic and cultural groups in the United States. Some of this attention has been reflected in federal law, such as the Equal Employment Opportunity Commission and similar laws in various states. Such laws provide a legal framework in which employment and other relationships (as well as their “ethic”) are judged. These and similar laws also create protected classes of persons against whom it is illegal to discriminate. Thus, unlawful discrimination, sexual harassment, intimate or romantic relationships in the workplace, sexual orientation, affirmative action and diversity programs all raise ethical (and oftentimes legal) issues that the organization must address if it is to act ethically.

Health services organizations and their managers are expected to obey the law as a minimum level of performance. In addition, however, they should be especially aware of the special needs of groups and individuals, whether the relationship is one of service, employment, or in the general conduct of business. It is important to stress there is no belief that the organization’s legally compliant value system as expressed in its statement of organizational philosophy or other guiding principles must be breached to meet the demands of patients, clients or others served, or of employees. This position is generally accepted by the courts for private (nongovernmental) corporations, but governmental facilities may not enforce theologically based positions since this constitutes an unconstitutional establishment of religion. Thus, governmental facilities provide services that nongovernmental facilities may not be forced to provide.

Cultural sensitivity and awareness is especially important for organizations attempting to deliver services to diverse populations. For example, various cultures and religions have widely differing views of illness, dying and death. These views determine the roles and reactions not only of the patient but also of family and friends, as well as what is seen as the appropriate role of the organization and care providers. Organizations that have ethnically and culturally diverse staff can draw on them as resources in such situations.

Conflicts of Interest

Conflicts of interest are a common and insidious problem in organizations of all types. The health services field has not been immune from them despite the attention devoted to the problem in ACHE's *Code of Ethics*, professional publications and the popular press. To paraphrase the poet Carl Sandburg, it is not fog but conflicts of interest that come on little cat feet. Their stealth and furtiveness make them a bane to managers who must be continually on alert lest they be ensnared.

A conflict of interest occurs when one has conflicting duties or responsibilities and meeting one of them makes it impossible to meet the other. The classic example occurs when a decision maker (a manager or corporate director) is also a decision maker for an organization with which business is done. Often, the potential conflict of interest becomes an actual conflict of interest because the decision maker cannot meet the duty of fidelity (loyalty) to both organizations when a decision that affects both is needed.

ACHE's *Code* notes that the line between acceptable and unacceptable behavior is often one of degree. ACHE affiliates are expected to accept no gift or benefit "offered with the express or implied expectation of influencing a management decision." This pragmatic view recognizes that the normal conduct of business

creates relationships that contain a duality of interests with the potential for conflicts of interest. It is difficult, however, to imagine situations where the expectation is other than to influence managerial decision making.

A number of actions and activities can help healthcare executives and their organizations avoid conflicts of interest or minimize their effect if they have already occurred. Awareness of the potential for conflicts of interests in all decisions and relationships and consciously seeking to avoid situations where they can occur—prevention—is the most useful approach. Once conflicts have developed, managers must disclose their presence to higher authority and remove themselves from a position of decision making. In addition, the organization can assist employees who may receive gratuities from sales representatives and drug detailers by developing appropriate policies. Gratuities should be defined as including gifts of all kinds, meals and entertainment. A policy that no gratuities can be accepted is the cleanest and clearest approach and leaves nothing to the potential recipient's judgment. Again, as with most aspects of leadership, it is the responsibility of senior management to set the example in terms of conflicts of interest.

Study Guidelines

- Learn the specific expectations found in ACHE's *Code of Ethics*
- Become generally knowledgeable about the codes of other major medical professional groups
- Know the rights and responsibilities of patients
- Learn the types and functions of various types of committees that deal with ethical issues
- Understand the concept of conflict of interest and be able to apply it in operational settings

Healthcare

The complex nature of the healthcare field is both daunting and exhilarating to those who hold positions of leadership in it. Healthcare straddles science, commerce and many other aspects of human behavior and draws on several different bodies of knowledge. Executives in the field are expected to be conversant in the content and terminology of several disciplines to communicate and collaborate with the diverse mix of clinical and administrative personnel found in healthcare organizations. Breadth of knowledge and versatility in its application are core competencies for the successful healthcare leader. The rapid pace of technological and policy change adds to the challenge of attempting to stay current and well versed in a broad array of issues.

Health and Medical Care

The traditional healthcare delivery system has been in many respects been a “sickness system” that has focused on clinical interventions that respond to needs presented by patients seeking treatment. Clinical care providers have been at the core of these systems, and it has been essential for managers to be able to work with and coordinate the efforts of many different types of clinicians. Managers need to understand the nature of medical work including its terminology, the skills and activities of physicians and other professionals, and ways to create settings and arrangements that support and extend the efforts of clinical work. Additionally, as an appreciation for the scarcity of limited resources in healthcare has grown, executives are expected to become even more directly involved in resource management and allocation decisions. In all of these activities, understanding healthcare and medical terminology is an essential ingredient to success.

Many recent efforts have focused on re-orienting the attention of healthcare systems more toward health, health promotion and disease prevention. Likewise,

increased attention is being placed on making healthcare organizations more responsive to their patients/customers and engaging in activities that empower patients/customers to play a more active role in their own healthcare. Healthcare executives have unique management and education roles in creating organizations and environments that facilitate constructive interaction between clinical professionals and increasingly better-informed consumers. Raising levels of understanding and finding new ways to promote communication between clinicians and their patients will be a major task in the years ahead.

Professionals—Roles, Responsibilities and Relationships

The high degree of specialization found in clinical work and the extensive education and training needed for persons in the healthcare field have contributed to a very strong sense of professionalism. Executives need detailed knowledge of the types of healthcare professional positions, the range of educational preparation they require, licensure and other regulatory requirements that affect their occupations and the professional associations in which many of them participate and have staunch loyalty. In addition, the complicated interrelationships among professionals are very important to understand because of their clinical, legal and economic implications. The rigid hierarchy and division of labor found in medical practice and sustained by legislation and regulation are nearly unique to the health field. Few fields of management have so many potential interprofessional or interoccupational conflicts, and healthcare managers must be sensitive and attentive to these relationships and rivalries.

Working with professionals brings another dimension to healthcare management because they typically expect a relatively high degree of autonomy to enable them to care for their patients as they see fit. Consequently, professionals often rely more heavily on peer input and consultation than on formal organizational authority relationships. What makes this even more challenging is that physicians

in particular typically are affiliated with organizations as independent contractors, not as employees, and they may also be affiliated with competitor organizations.

Healthcare Delivery—A Continuum Perspective

There are many different ways to look at the component parts of healthcare delivery and how they fit together. One of these is to consider healthcare services as a continuum ranging from acute, curative care, to long-term rehabilitative or custodial care, to palliative care for persons at the end of life. Within the acute, curative system, it is common to define care delivery by the site or location of the services such as outpatient (ambulatory) or inpatient (institutional) care. Ambulatory care may be an alternative or a prelude to acute inpatient care and is delivered in community-based settings ranging from home to physician offices to clinic-based settings or in outpatient or emergency departments of hospitals. Acute inpatient care is rendered in hospitals that reflect wide variation on many dimensions including size, service complexity and specialization, medical staff membership and ownership. An impressive range of ancillary services including laboratory, radiology and other therapies are offered in both ambulatory and inpatient settings, sometimes within existing provider organizations such as hospitals or on a freestanding basis.

Technological developments, economic considerations and patient preferences have contributed to a substantial shift of treatment away from traditional inpatient settings. But in many respects the full-service hospital remains at the center of the acute care universe. Hospitals do face growing competition from alternative sites of care and have engaged in a variety of strategic responses including joint ventures, development of satellite facilities, purchase of freestanding organizations including physician practices and other maneuvers. New clinical and information technological advances have also facilitated delivery of care in patient homes and other noninstitutional locations. In response, more acute-care

providers have become actively engaged in sub- or post-acute care services to complement their traditional activities.

The overall increase in spending in the healthcare sector has encouraged many firms and entrepreneurs to seek emerging investment opportunities in health and medical care. Some of them believe that traditional delivery systems have not been very efficient or focused in their efforts, or they have attempted to satisfy too many constituencies. Growth in some single medical specialty groups or specialized facilities reflects a belief that “focus factories” or highly specialized providers can provide better value than full-service providers. Others have attempted to reorganize or to manage more effectively existing components of the field such as physician practices that have large defied pressures to become more “corporatized.” While many of these efforts have not, as yet, proven to be very successful, they have contributed to greater diversity in the types of organizations found in healthcare and added new challenges for healthcare leaders.

Delivery Systems and Nonsystems—Fitting the Pieces Together

A continuing debate about the healthcare field in the United States is whether it is a system or a nonsystem. In fact, it is probably best characterized as a conglomeration of multiple systems that vary greatly in their degree of completeness or integration. The 1990s witnessed two parallel, and at times converging, trends of horizontal integration and vertical integration that created both more and larger systems of hospitals (horizontally linked). However, hospitals typically faltered when they tried to link vertically with other providers up and down the continuum of care. Efforts to purchase or manage practices, acquire and manage post-acute providers, and expand into insurance or managed care products were generally not very successful for hospitals that now seem intent on returning to their core acute-care services.

A major force expected to promote and produce more integrated care delivery and more completely developed health system was the rise of managed care. Strongly advocated by purchasers of health benefits, managed care models like health maintenance organizations (HMOs) and preferred provider organizations (PPOs) grew dramatically from the mid-1980s till the end of the 1990s before leveling off. Through organizing provider networks to render care to enrolled persons and using these enrolled persons as the basis for negotiating price discounts and other terms with providers, HMOs and PPOs hoped to provide benefit packages at a lower cost that could be done through traditional indemnity insurance products. These organizations also attempted to promote more aggressive care management and encouraged providers of care to become more efficient, namely to use fewer resources to produce the same outcomes. In the case of HMOs, use of risk-based compensation arrangements like capitation payments with individual physicians or groups of providers were employed to try to change behavior and encourage more cost-conscious provision of services.

For several years, managed care organizations were apparently successful in slowing the rate of healthcare cost increases and promoting improved operating efficiency among some acute-care providers. But in recent years, HMOs and PPOs have lost traction in cost containment. In some cases, this is because new technology and pharmaceutical products have affected the amount and types of services being demanded. It also appears that success among hospitals and physicians to consolidate and mobilize their negotiation leverage has forced managed care organizations to increase payments substantially. In response to consumer and provider dissatisfaction, there has been more government intervention to influence how managed care organizations behave that may be constraining their ability to contain costs. Finally, it appears that much of the healthcare system has proven not to be as changeable or malleable as expected, and thus managed care organizations have been unable to engineer permanent changes in the healthcare sector.

Trends—The Certainty of Uncertainty

In many respects, the perplexing managed care experience underscores the most demanding feature of the healthcare field—the unceasing need to try to stay current. Not only does clinical medical knowledge grow continually with significant implications for medical technology and practice, but the influence of continuous change in the policy and financing environments compounds the uncertainty. Change in one area sets in motion trends and developments that provoke reactions and responses in other areas. Within many, if not most, healthcare organizations, the healthcare executive is expected to be the one individual who is attuning to and up-to-date on external developments and to be astute about how these developments may affect the organization. Tracking change and translating it into meaningful information for others will remain one of the enduring responsibilities of the successful healthcare leader.

Study Guidelines

- Develop a general working knowledge of basic medical terminology.
- Know the key components of healthcare delivery systems.
- Understand the roles and relationship of the principal professionals involved in healthcare delivery.
- Know the general education and training requirements for major healthcare professions and occupation.
- Know the primary professional associations with which healthcare professionals are affiliated.
- Understand the principal types of healthcare delivery settings in which inpatient and ambulatory care is delivered.
- Understand the differences in ownership, mission, service specialization and other important features among hospitals.
- Understand how and why hospitals and health systems have engaged in vertical and horizontal integration in recent years.

- Know how different types of ambulatory care settings differ in structure and operations.
- Understand some of the varied configurations for physician practice arrangements.
- Know the major types of managed care organizations and the products they offer.
- Understand how managed products and contracting arrangements differ across models.
- Understand how purchaser and consumer preferences have shaped managed care markets and how preferences may be changing over time.
- Know how managed care organizations may differ in terms of ownership and affiliations.
- Understand how consumerism is affecting healthcare organizations and professionals.

Management

Management is a process that is composed of interrelated social and technical functions and activities. It occurs in a formal organizational setting and is undertaken for the purpose of accomplishing predetermined objectives through the use of human and other resources. Senior managers, in concert with managers at various levels, establish organizational objectives, and all in the organization work to achieve them. Management's work includes providing an organizational context within which direct and support work can be performed effectively and preparing an organization to deal with the threats and opportunities in its external environment. Managers at all levels shape organizational values and culture by their decisions and through leading by example (modeling), even though senior managers usually have the clearest and most direct effect. The organization's overall performance is evidence of their efforts. Regardless of hierarchical level, managers throughout an organization engage in the same basic, generic functions, even though decisions made at senior levels have the most dramatic result on the organization.

Management Functions and Decision Making

The five management functions of planning, organizing, controlling, directing and staffing are brought to life and connected by decision making, which is itself a subset of the essential process for managers that is known as problem solving. Little that managers at all levels in an organization do falls outside the purview of the five management functions. Management theorists and practitioners may have chosen one or two functions as most important, but this is not borne out normatively. When one considers the full range of what managers do (or should do) as they perform their work, concentrating on a few to the exclusion or diminution of the others invariably causes problems for the organization.

Decision making is an inherent activity of managers, and they make decisions within and among the five management functions. Decision making is part of the process of problem solving, which also includes problem analysis. Performance of the management functions and the decision making of problem solving should be evaluated using explicit and measurable criteria. In addition to engaging in the five management functions, managers must use specific skills, play various roles and show that they possess a number of competencies.

Managers Managing and Leaders Leading

Some theorists and academicians distinguish managers and leaders, based on a view that managing is more caretaking and maintaining status quo (transactional) whereas leading is more visionary and dynamic (transformational). That distinction may be more important pedagogically than in practical application, however, especially at the organization's operating level. Senior managers must ensure effective current organizational activities **and** ensure that an organization's future is envisioned and transform the organization, as needed.

As they work to achieve organizational objectives, managers use technical, conceptual and interpersonal skills. These skills are used in different proportions, depending on the manager's task and hierarchical level. Usually, senior managers make greater use of conceptual skills, whereas middle- and entry-level managers tend to have a more even mix of the three.

Mintzberg's research found that managers have different roles, the general categories of which include interpersonal, informational and decisional. Each may be segmented. As examples, the interpersonal role includes figurehead and influencer, informational includes monitor and spokesperson and the decisional role includes entrepreneur and negotiator. Successful managers integrate these various roles and are likely to engage in them without making a clear distinction.

Another way to understand managers' work is to identify their competencies, some of which are found in categorizations discussed above. Conceptual, technical managerial/clinical, interpersonal/collaborative, political, commercial and governance competencies are used in different proportions by managers at various levels of the organization.

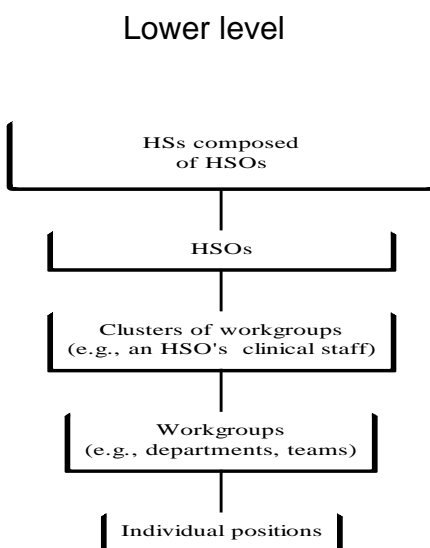
Leaders are able to exercise leadership behavior that influences followers' behavior to achieve objectives because they have authority or power. Various sources of power have been identified: legitimate (formal), reward, coercive, expert and referent. These sources of power are more likely to be complementary than mutually exclusive. Effective leaders understand the risks and benefits of using each kind of power and try to use it appropriately. Some researchers have identified leader traits (e.g., assertive, cooperative, decisive, dependable) and skills (e.g., intelligent, conceptually skilled, creative, persuasive) as a way to explain leader success. Others have focused on leader styles; for example, Likert's continuum of leadership effectiveness spans autocratic, benevolent, consultative and participative/democratic.

An approach asserting that traits, behaviors and styles alone are inadequate to explain leader success is called situational or contingency theory. Here, the hypothesis is that certain actions or responses (behavior/styles) in some situations lead to success, while their use in other situations causes failure. Incorporating situational factors or contingencies into the analyses of leader styles made them more sophisticated and enhanced their usability. Many of the efforts to analyze leaders and the reasons for their success overlap, but they all contribute to understanding managers qua leaders.

Designing Formal Organizations

The organizing function, which encompasses the design (and redesign) of organizations, has its genesis in the planning function. Senior managers and, depending on the scope of decisions being made, the governing body are concerned with broad aspects of organizing such as authority and responsibility relationships, departmentation, and coordination and relationships of components whether within an organization or among the elements in a system of organizations.

FIGURE 13 LEVELS OF ORGANIZATION DESIGN IN HEALTH SERVICES ORGANIZATIONS AND HEALTH SYSTEMS



Adapted from Longest, Beaufort B. Jr., Jonathon S. Rakich, and Kurt Darr. *Managing Health Services Organizations and Systems*. Baltimore: Health Professions Press, 2000, page 112.

Operational managers are concerned with individual positions, aggregations of individual positions into workgroups and clusters of workgroups. The work of

classical management theorists like Weber, Fayol and Barnard established a theoretical basis for organizational design in the late 19th and early 20th centuries. Their concepts of division of work, authority and responsibility relationships, departmentation, span of control and coordination have been complemented by contemporary theorists. FIGURE 13 shows levels of organization design.

“Organization” within an Organization

The formal organizational structure that managers design and implement provides important information about the planned interrelationships among its various elements. Within the formal structure, however, is the informal organization, which describes the numerous interpersonal relationships that develop outside the formal relationships established in the formal organization and that reflect the wishes and preferences of people who work in the organization. The informal organization is characterized by dynamic behavior and activity patterns that occur within the formal organization structure of people working together. Combined, the formal and informal organizations are the actual organization. Managers ignore either at their peril.

Strategic and Operational Planning

Strategic planning addresses the longer-term direction and goals selected by the organization through its governance and management in order to accomplish its goals. Strategic planning may also be called strategic management, which suggests the broader, more dynamic concept of fully integrated management and planning. An extension of strategic planning that seeks to affect the external environment is strategic issues management (SIM). SIM is a systematic process that proactively influences the external environment so that it is more favorable to the organization rather than reacting to events after they occur.

Operational planning focuses on the direction and activities of individual units and departments of the organization. The operational plan must be coordinated with and is subordinate to the strategic plan. FIGURE 14 shows the general characteristics of strategic and operational planning.

FIGURE 14 PLANNING CHARACTERISTICS

Type of Planning	Scope	Time Frame of Planning	Who Plans	Approach to Planning
Strategic Planning - organization mission, vision, values - organization objectives - organization strategies - general policies	Broad	Long Range	Senior-level managers (governing body)	Developmental-incremental Proactive-reactive
Operational Planning - department (sub) objectives - operational programs - operational policies	Narrow	Short term	Middle-level managers (first-line managers)	Developmental-incremental Proactive-reactive

Adapted from Longest, Beaufort B., Jr., Jonathon S. Rakich, and Kurt Darr. *Managing Health Services Organizations and Systems*. Baltimore: Health Professions Press, 2000, page 349.

Contingency Planning in Health Services Organizations

In their work, managers face a large number of unknowns. Planning that anticipates these unknowns, mitigates their potential negative implications for the organization and, if possible, turns them into an economic or competitive advantage is called contingency planning. The best-known example of contingency planning for hospitals is disaster planning, where hospitals plan for the demands placed on them in a mass casualty situation. In addition to external disasters, contingency planning for disasters should address the possibility of an internal disaster that might be caused, for example, by an earthquake that damages the building or a sudden outbreak of food poisoning that incapacitates a large number of clinical staff.

Contingency planning should also address interruption of utilities such as water, electricity and natural gas. Standby electrical generators quickly become inoperable if they are located in basements that fill with water during a flood or hurricane. Such debacles are damaging to the health services organization because they prevent it from meeting its obligations to patients or others served and they raise significant questions as to the quality of management.

Managers as Negotiators

Successful managers are effective negotiators. The art of negotiating or bargaining applies to all internal or external transactions in which the parties decide what they will give and what they want to get. Negotiation is often characterized as win-win (cooperative) in which either parties benefit or win-lose (competitive) if one party prevails at the expense of the other. W. Edwards Deming argued that the result of win-lose negotiations is really lose-lose—both parties lose.

Most negotiating in organizations is informal, e.g., two managers agree to change how their departments coordinate activities. The result of these negotiations may be reflected in a memorandum, thus adding a level of formality. The most common type of formal negotiating occurs when contracts are negotiated (and usually signed) between or among parties who seek mutual benefit from the legal relationship that results. These contracts may be for the purchase of goods or services that an organization uses as input to achieve its objectives or they may bind organizations horizontally or vertically in health systems from which they hope to benefit.

Typically, there are two sources of conflict in negotiating. The first is how the resources are to be divided—the money, goods, or services that are to be exchanged for what consideration. The second is resolving the psychological dynamics and satisfying the personal motivations of the negotiators in the organizations involved. The latter source of conflict is known as the intangibles of negotiation and can include variables such as the ego involvement of appearing to win or lose, competing effectively or cooperating fairly. The intangibles of negotiating are often the most difficult to understand and resolve.

Nonjudicial Means of Resolving Disputes

When disputes arise in health services organizations, legal action should be the last resort. There are far more efficient (and lower cost) ways to settle disputes, whether they involve contracts, employment, patient or visitor injury or clinical privileges. The methods that can be used to settle disputes other than by recourse to the legal system are known as alternative dispute resolution (ADR). ADR has been widely used for decades to resolve commercial disputes, and it is becoming more common in the health services field. ADR is private, inexpensive and efficient—attributes that are especially important to health services organizations.

ADR includes binding and nonbinding arbitration (which may be voluntary or involuntary), mediation, mini trials, neutral fact finding and variations of these mechanisms. Each mechanism or variation has qualities that make it best for use in resolving a certain type of dispute. For example, mediation is especially useful when the parties want to maintain a continuing relationship. Binding arbitration is contractually required by some health plans to resolve disputes involving alleged medical malpractice and other disputes with enrollees. There are private organizations that provide panels of arbitrators, mediators and other experts in ADR. Negotiation is not part of the ADR lexicon, but it is the technique managers should use in a first effort to resolve any dispute.

Study Guidelines

- Understand the management functions and their link to decision making.
- Know various management skills, roles, styles and contingency (situational) leadership theories.
- Comprehend the concepts of designing and redesigning formal organizations.
- Differentiate the formal and informal organization and how each can aid in achieving objectives.
- Distinguish strategic and operational planning and know their elements and processes.
- Understand contingency planning and its application in health services organizations.
- Know the uses of negotiation and how managers use their skills as negotiators.
- Understand alternative dispute resolution and the roles of mediation and arbitration.

Business

Basic Statistical Analysis

Statistical analysis provides the empirical tools to make sound decisions. Most basic of these are measures of central tendency: the median and mean. The median is that number above and below which 50 percent of scores fall. The mean refers to the arithmetic average of all scores. The mode is the most common or frequent score or number. To evaluate more completely any group of data, it is important to have some expression of the spread of scores within that group. This spread or distribution of scores is commonly called variability. A range of scores shows the distance between the highest and lowest score in the group; however, variability of scores is best represented by the standard deviation around the mean. Another tool is the control chart. It allows one to monitor, control and improve process performance by examining variation over time. The control chart will show the process mean (centerline) and the fluctuation or variation of data. Upper and lower control limits are set to indicate “statistical control” wherein normal variation is expected. Points outside the control limits may indicate problems that should be studied. One final tool to consider is that of regression analysis. This technique uses a mathematical equation to show the relationship between sets of data or variables. This relationship is depicted by a regression line that, when extended out into the future, can be used for health planning (e.g., forecasting of patient demand).

Strategic Planning Principles

Planning has been defined by Longest, Rakich and Darr as “anticipating the future, assessing present conditions and making decisions concerning organizational direction, programs and resource deployment.” Strategic planning now is viewed more appropriately as “strategic management” in that planning must be integrated with other management functions (i.e., organizing, directing,

controlling, staffing and decision making). Hence, current strategic planning processes usually consist of the phases and elements outlined below:

I. Assessment

- A. Review or establishment of vision, mission, values and guiding principles
- B. External assessment of market, competition demographics, environmental conditions and technology as well as determination of customer or stakeholder needs and expectations
- C. Internal assessment of strengths and weaknesses of the organization, including its financial status

II. Planning

- A. Development of a plan based on the assessment. The plan would include goals, specific objectives, metrics to assess success in reaching goals and objectives, and a delineation of resources needed to accomplish goals and objectives
- B. Enhancement of the plan using the principle of “catch all” whereby drafts of the plan are reviewed by all major departments and services

III. Implementation

- A. Leaders establish the organizational culture, communication, rewards system, support structures and policies to ensure that the plan is effectively implemented
- B. Departments develop their own plans based on the organization’s strategic plan
- C. Cross-functional teams are established, if necessary, to plan and implement major systems change across the organization
- D. Individuals are held accountable for the implementation of plan

IV. Evaluation and Continuous Improvement

- A. Measurement of results of plan against goals and objectives
- B. Evaluation or analysis of results

C. Change/modification of plan based on the analysis of results

Basic Business Contracts

Contracts occur in a variety of situations (e.g., to purchase supplies, equipment or services). Longest, Rakich, and Darr define a contract as “an agreement between two or more parties that identifies rights and obligations.” The authors also identify four elements of a valid contract: (1) an agreement is reached after an offer is accepted, (2) there is consideration or something of value in the agreement, (3) the agreement is reached by parties who have the legal capacity to contract and (4) the contract’s objective/purpose is lawful. When a party does not perform certain performance requirements of the contract, a breach of contract can occur, usually resulting in a remedy (e.g., money damages) for the aggrieved party. Breaches can be avoided through careful drafting and negotiating of contract provisions.

Marketing Principles and Tools

Marketing is critical to the ongoing survival and competitive advantage of the healthcare organization. The most widely accepted definition of marketing comes from the American Marketing Association, which states that marketing is the “process of planning and executing the conception, pricing, promotion and distribution of ideas, goods and services to create exchanges that satisfy individual and organizational objectives.” Marketing usually begins with defining key customer groups (market segmentation) and determining customer needs, expectations and buying behavior. Segmentation analysis can be done through analysis of socio-demographic variables such as age, gender, ethnicity and geographic location. In addition, a situational assessment is made often through a SWOT analysis that examines strengths and weaknesses of the organization as well as opportunities and threats in the current or future environment. Studies of market share, brand loyalty and brand recognition are now regularly done to

better understand the competitive position of the organization as well as what changes may be needed in promotion or advertising. Modifications in product strategy are often based on a portfolio analysis in which different service lines are evaluated with regard to their profitability, consistency with organizational goals and competitive position in the marketplace.

Business Plan Development and Implementation

A business plan is used as a vital communications and planning tool to channel efforts for a particular project or initiative. A business planning process enables a standardized process for market and data-driven comparisons of existing and proposed programs. Arista Associates suggests that the business planning process include four steps: (1) assess your current situation, (2) decide what you want to accomplish by drafting your objectives, (3) ensure all have input into the process and (4) discuss whether your business planning process is meeting objectives. The actual business planning document should include a thorough description of the project, situation, target market and objectives. In addition, the plan must include the specific steps needed to accomplish the project or program along with a timetable (milestones) for implementation. All costs relevant for the project should be delineated (operational, capital, or other resources needed), and the financial impact of the project should be shown (e.g., through a break-even analysis, net present value, etc.). Finally, the business plan should include an evaluation component that shows how the outcome of the project will be measured (e.g., utilization, revenue, expenses).

Public and Community Relations

As the healthcare marketplace becomes increasingly competitive, the community's or public's perception can be a major factor in the survival of the

healthcare organization. Any loss of support from the community will mean fewer patients, volunteers and donor support. To enhance public image, Chyna identifies several strategies: (1) focus on personal interaction (improving the day-to-day interactions between patients and caregivers), (2) enhance employee morale (paying attention to job satisfaction issues so that employees have a positive attitude about their jobs that, in turn, is conveyed to patients), (3) connect with the community (e.g., conducting health education programs at community sites, having a dedicated hotline for patients to express their concerns and holding public forums where community members can interact with organization leaders) and (4) work with the media (e.g., sending out regular news releases and newsletters, or having members of the media sit on advisory panels). Finally, reputation and public relations can be enhanced by providing culturally sensitive care. This would mean knowing and clearly understanding the demographics and culture of the different communities served, ensuring a culturally diverse staff and providing an interpreter service and translated materials.

Organizational Policies and Procedures

Policies and procedures provide ongoing guidance for members of the organization. Policies are intended to help organizations reach their objectives; hence they must be consistent with and support the organization's mission, goals and objectives. Policies are of two types: general and operational. General policies apply to the entire organization, whereas operational policies pertain to a specific unit, department or service. Procedures, on the other hand, are used to define specific actions for organizational members. They usually come in the form of a sequence of steps to complete a task. Examples of these are procedures for admitting or discharging patients or ordering supplies. Good policies have a number of characteristics: (1) They are consistent with larger organizational objectives, (2) Their impact is well thought out before they are formalized, (3) They are flexible so they can be applied in typical as well as unique situations, (4) They are ethical and legal, and reflect the values of the organization, (5) They must be clear and understood and (6) They must be consistent with each other.

Chapter IV

Study Hints and Mock Questions

Study Hints and Practical Tips

Your overall performance on the Exam will be better if you follow these tips:

- 1) Be sure to read each question carefully.
- 2) Read all responses for each question before selecting an answer.
- 3) Mark one answer. The computer scoring routine recognizes one, and only one, correct answer.
- 4) There is no penalty for guessing, so answer every question.
- 5) Skip difficult questions and return to them later.
- 6) Do not go back and change answers; your first “hunch” is most often correct.
- 7) Evaluate questions from a general healthcare management perspective. The correct response will apply equally to all healthcare organizations regardless of type, size or location.
- 8) Remember that the Exam is national in scope and is not defined in terms of individual states and their laws or regulations.
- 9) The most inclusive answer is usually the correct response. However, if the question includes a qualifier (words such as *except* or *least*, generally printed in italics), then the most specific answer is usually the correct choice.

- 10) Write in the test booklet if you feel it will help you. This can be useful if you:
 - Circle key words in each question.
 - Cross off poor answers to help you focus on the best answer.

- 11) If you want to return to a question on the computerized exam, you may “mark” it. The computer will keep track of your “marked” questions, and you may return to them.

- 12) Do not become discouraged by difficult or complex questions. If the question confuses you, it will probably confuse other examinees as well. The Exam pass point is set with the expectation that candidates will score higher on some areas than in others. This is a general knowledge Exam, and you are not expected to be an expert in every area.

Mock Questions and Key Word Indicators

Following are 20 mock questions. The correct answer is in bold and an explanation of the correct answer follows each question. These questions give very good examples of key words to look for when responding to questions.

1. In a dispute between two staff physicians, the **primary** role of the chief executive officer is to:
 1. ask a representative of the governing authority to mediate the dispute.
 2. avoid any involvement in the dispute.
 3. meet with both parties as soon as the problem is identified.
 4. **request the appropriate chief(s) of service to investigate and report back.**

Answer 4 is correct. This question requires knowledge of the CEO's role in mediating disputes and the reporting relationships within a healthcare facility. The staff physicians report to the chief(s) of service who, in return, report to the CEO.

2. Environmental changes, including shifts in public attitudes, community health needs, provider practices and actions of competing institutions, may alter a healthcare institution's direction. Healthcare executives could be forced to:
 1. reduce levels of patient care to the level of payments received.
 2. **scrutinize all new ventures from a variety of perspectives, including financial, environmental, ethical and quality of care.**
 3. eliminate patient-care programs that do not pay for themselves.
 4. place ceilings on those financial categories of patients that pay less than full operating costs.

Answer 2 is a proactive response and it is the most inclusive answer. It provides a variety of perspectives that must be considered when changing a healthcare institution's direction.

3. As a result of the Health Care Financing Administration's action to **reimburse** healthcare facilities on a **prospective basis**, action taken in healthcare facilities today is **best** described by the statement that:
 1. governing authorities and physicians are investigating new ways of developing sources of income through joint ventures.
 2. **managers and physicians are collaborating in revising medical protocol and in restraining excessive use of tests and procedures.**
 3. managers are increasing their marketing efforts to garner more support for new admissions from the medical community.
 4. physicians are reviewing new methods of caring for their patients that could result in a reduced length of stay.

Answer 2 is the correct response because it most effectively addresses the point of the question. Key words are **reimburse**, **prospective basis** and **best**. Since reimbursement will be a predesignated amount, revenue is enhanced when ancillary services are restrained. The other responses may result in additional revenue, but not in relation to reimbursement on a prospective basis.

4. Committees are an important management tool **primarily** because:
 1. **they provide a mechanism for reconciling differing opinions and facilitating decision making.**
 2. they are the only way of providing for intrastaff communication.
 3. they keep staff up to date on new professional developments.
 4. they ensure self-expression and participation by staff.

Answer 1 is the correct response because it is the most inclusive and proactive. The key word in this question is **primarily**. While up-to-date information regarding professional developments, self-expression and participation may be goals in the formation of committees, it is not their primary function.

5. Which one of the following classifications or groups of financial ratios would be most useful as a guide to **long-range financial viability** of an organization in undertaking **facility replacement**?
 1. **leverage ratios**
 2. profitability ratios
 3. liquidity ratios
 4. composition ratios

Answer 1 is correct. The question requires a basic knowledge of finance. The key words are **long-range financial viability** related to **facility replacement**. Leverage ratios give an indication of the facility's long-range financial viability and the amount of cash available for undertaking facility replacement.

6. The **primary** purpose of the quality assurance (QA)/risk management program is to:
1. comply with licensure and accreditation standards as required by state and federal legislation.
 2. monitor medical staff practices control the increases in malpractice rates.
 3. identify potential problems that will keep the hospital from becoming a party to litigation.
 4. **monitor, control and direct the institution's efforts toward achieving delivery of the optimal level of care.**

Answer 4 is correct because the **primary** purpose of a quality assurance program is the delivery of the **optimal level of care**. The other responses are secondary to the purpose of having a QA program. Remember that in a healthcare facility, patient care comes first.

7. The administrator's relationship with the board of directors should be one in which the administrator:
1. minimizes board involvement in any operational issues.
 2. **draws upon skills of board members in facilitating appropriate discussion and decision making.**
 3. identifies those topics with which the board should involve itself.
 4. serves as the functionary for implementing all board of directors' decisions.

Answer 2 is correct because it is a proactive response. The key word is **facilitating**. The administrator's role is to facilitate the board discussion and decision making. Answer 4 may be correct, but only after answer 2 is accomplished.

8. In consultation with the board, the administrator has decided that an effort must be made to increase the level of involvement among management personnel in quality assessment and assurance. Which one of the following options is **most likely** to achieve the desired results?
1. Send all key management personnel to quality assessment workshops over the next year.
 2. Delegate quality assessment functions in question to the medical records committee.
 3. Delegate quality assessment education functions to the utilization review coordinator.
 4. **Develop an in-house program using trained key personnel for presenting and discussing quality assurance and its implications for the organization.**

Answer 4 is correct. The key word is **develop**. Answers 2 and 3 can be immediately disqualified because results are less likely to be achieved through **delegation**. Answer 4 is the most inclusive and proactive answer.

9. A healthcare facility can **best meet** its **social and economic** goals by:
1. **developing a realistic and coordinated approach to long-range planning.**
 2. devoting most of its efforts to the development of efficient operational practices.
 3. having a good public relations program, which will focus the facility in the community.
 4. providing all reimbursable services desired by the community.

Answer 1 is correct. Key words are **best meet** and **social and economic**. Both social and economic goals are met through the long-range planning process. Also, the key word in the answer is **developing**. The other responses may meet

some goals, but the *best* way to meet goals is through developing an approach. Again, this is a much more proactive response.

10. The governing body of a healthcare institution meets its responsibility for the quality of patient care by:
1. delegating accountability for patient care to the committee appointed by the governing body, which provides a formal administrative liaison between the governing body, the administration and the medical/professional staff.
 2. delegating to the chief executive officer the responsibility for developing criteria for making certain that an effective medical/professional audit is carried out.
 3. **establishing, maintaining and supporting through the medical/professional staff and management staff an ongoing program of review and evaluation of patient/client care and action on findings.**
 4. establishing an effective system for utilization review, medical/professional audit activities and credentialing of the medical/professional staff.

Answer 3 is the correct response. Answers 1 and 2 can be immediately disqualified because responsibility is not met through delegating. Answer 4 can be eliminated because it only addresses some of the activities that could be used in meeting quality assurance requirements. Answer 3 is much more inclusive. Key words are **establishing, maintaining** and **supporting**. Also, answer 3 is the only response that suggests follow up on the program through **review, evaluation** and **action** on the findings.

11. With growing frequency, employees who have been dismissed are resorting to lawsuits for redress. In such cases, the court may find in favor of the plaintiff if the employer dismissed that plaintiff:
1. for cause, but without using progressive discipline.
 2. **without cause.**
 3. before the end of the plaintiff's probationary period.
 4. for union-organizing activities.

Answer 2 is correct. The question requires a basic knowledge of human resources issues. Courts are increasingly finding in favor of employees who are dismissed without cause.

12. Accreditation requires documentation of regular meetings that include representatives of the governing authority, management and medical staff leadership. Standards require that the meetings be conducted:
1. **semiannually.**
 2. for discussion purposes only.
 3. **by parties affected by the standards.**
 4. for handling disciplinary matters regarding clinical privileges of physicians.

Both 1 and 3 are correct. This is a case in which the Examinations Committee has decided to allow two correct answers, after reviewing the test statistical results. The question has been deleted from future versions of the examination because the Examinations Committee strives to include questions that have only one correct answer. Usually, two to three test questions are double-keyed as correct. This practice is to your advantage because it increases your chances of getting the question right. If you encounter a question that has two obviously correct answers, you should choose only one response, but do not become frustrated with the question. The chances are now two in four that you got it right.

This question requires a general knowledge of JCAHO standards, which require that such meetings be conducted semiannually by all parties affected by the standards.

13. The evaluation of senior management is best administered:
1. **when criteria are established and known to both parties.**
 2. on a scheduled periodic basis.
 3. after consultation of the executive committee of the board.
 4. in conjunction with a salary adjustment.

Answer 1 is correct. The question requires a basic knowledge of human resources issues. Performance evaluations are most effective when the evaluator and manager have established criteria before the evaluation.

14. Investor-owned healthcare systems are usually distinct from nonprofit systems because:
1. investor-owned healthcare systems provide no uncompensated care.
 2. members of the medical staff of investor-owned healthcare systems may use any healthcare facility owned by the corporation.
 3. **investor-owned healthcare systems consolidate balance sheets.**
 4. local boards have governing authority.

Answer 3 is correct. This question requires knowledge of the forms of ownership and the differences between them.

15. What age group will consume the greatest per capita healthcare resources in the 21st century?
1. **75 years and over**
 2. 65-74 years
 3. 45-64 years
 4. 0-1 year

Answer 1 is correct. The fastest-growing age group that will consume the most healthcare resources is the “oldest” of the elderly.

16. To survive the turbulent and revolutionary changes facing the healthcare field, executives must manage internal, external and interface stakeholders better. To do so, these executives must:
1. minimally satisfy the needs of marginal stakeholders while maximally satisfying the needs of key stakeholders.
 2. **establish goals for relationships with current and potential stakeholders as part of an effective strategic management process.**
 3. identify stakeholders who are involved in the local community healthcare delivery system.
 4. react to the demands of the stakeholders so that their expectations can be met.

Answer 2 is correct. This question requires knowledge of the term *stakeholders*. Also, **establish** is a key word because it makes answer 2 the most proactive response. Answers 1, 3 and 4 contain less active words.

17. After determining your own management strengths and weaknesses, the most effective method for follow up is to:

1. seek out educational offerings specific to your identified needs.
2. attend short courses that address current industry issues.
3. read current trade journals.
4. **create a developmental plan with goals and time frames.**

Answer 4 is the correct answer because it involves establishing a plan with goals and time frames and is much more proactive compared to the other responses.

18. The **major** purpose of the code of ethics for members of a healthcare executive's association is to:
1. enhance the image of the healthcare management profession.
 2. **set forth standards of ethical behavior for healthcare executives.**
 3. set ethical guidelines for the advancement of members within the organization.
 4. provide a forum for dialogue on healthcare policy issues.

Answer 2 is correct. A code of ethics sets guidelines and standards for behavior (not for advancement, as in answer 3). Answers 1 and 3 may happen as a result of having a code of ethics, but they are not the **major** purpose.

19. In the planning of construction, modernization and alteration programs, **fixed** equipment:
1. is not shown in construction documents if it is owner-provided and installed by the vendor.
 2. includes equipment with quick-disconnect connections to utilities.
 3. consists of major technical equipment.
 4. **is usually included as part of the construction contract.**

Answer 4 is correct. The question requires a basic knowledge of plant and facility management. The key word is **fixed** equipment, which should be included in construction contracts.

20. A well-developed marketing plan will include all of the following, **except**:
1. staffing considerations.
 2. competitive analysis.
 3. **quality-of-care considerations.**
 4. pricing considerations.

Answer 3 is correct. While quality-of-care issues are a concern of healthcare administrators, they are not the tools used in marketing.

Additional Questions

1. The interpretation of the healthcare organization's role with respect to healthcare values would require:
 1. Establishing corporate goals and major institutional policies.
 2. Ensuring that the community served by the facility is well informed about the organization's goals and performance.
 3. **Developing a mission statement indicating the organization's fundamental purpose or reason for existence, in order to guide organizational behavior.**
 4. Creating a corporate vision of the organization's governing authority.

2. Which one of the following statements is in accordance with the principle of delegation?
 1. The executive who subscribes to the principle of delegation knows what he/she wants to accomplish and exercises control over the work schedule of subordinates.
 2. An executive explains how he/she wants things done and points out how the subordinate's contribution fits into the overall plan.
 3. A successful executive gives instructions, telling subordinates exactly how and in what sequence things should be done.
 4. **In applying the principle of delegation, an executive makes relatively few decisions personally and frames orders in broad general terms.**

3. Before submission of the annual business plan to the governing authority, the plan should be developed by:
 1. Recommendations from the finance committee, on the basis of its estimate of income for the budget year.
 2. The heads of the profit centers, considering each center's anticipated revenues and expenses, with the CEO collating.
 3. **Key executives, after receiving recommendations from the heads of operating divisions.**
 4. The heads of the operating divisions, with the CEO collating.

4. Most products and services enter a period of decline. Unless compelling reasons prevail, continuing a declining product or service is costly because:
 1. Increased turnover of personnel will occur.
 2. Continuation will set an undesirable precedent concerned with maintaining the status quo.
 3. **The program will consume a disproportionate amount of management time and delay the search for a replacement.**
 4. The organization will be perceived as being insensitive to the marketplace.

5. Once a marketing research problem has been identified, the researcher's next step is to:
 1. Conduct a literature search.
 2. Conduct focus groups and collect data.
 3. **Specify information needs.**
 4. Design a data-collection instrument.

6. A key concept for marketing healthcare is to:
 1. Maximize the customer's participation in the selling process.
 2. Advertise and promote existing services
 3. **Adapt services to the customer's needs.**
 4. Emphasize specialization.

7. Performance rating scales—the oldest and most widely used performance appraisal procedures—are of two general types: the continuous scale and the:
 1. Equitable scale.
 2. **Discrete scale.**
 3. Field rating.
 4. Behaviorally anchored rating.

8. A successful healthcare organization usually has a unique and well-articulated company philosophy that presents a clear picture of the organization's objectives, norms and values. Employee motivation to support this philosophy would be greatest when the company:
 1. Maintains a program that provides employees with a wide variety of social, cultural and recreational activities.
 2. Emphasizes financial rewards, including strong employee benefits.
 3. **Provides a training program that is well communicated, understood by employees and enforced by executive management.**
 4. Continues a major effort to articulate employee rights in such areas as grievances, affirmative action, and human rights issues.

9. One of the techniques most frequently used in industry to aid management in interpreting a firm's balance sheet is computation of the "acid-test ratio," which is the ratio of:
 1. Current assets to current liabilities.
 2. Total assets to total liabilities.
 3. Cash to short-term debt.
 4. **Cash, marketable securities and accounts receivable to current liabilities.**

10. The primary reason for the decision to move from a freestanding voluntary facility to an investor-owned healthcare organization is:
 1. Economy of scale.
 2. **Access to the equity market.**
 3. Access to patients.
 4. Improved visibility in the community.

11. The purchasing/receiving process is often the weak link in a healthcare organization's internal control of its inventory. Which one of the following is standard procedure in preventing problems in this area?
1. The organization should utilize a decentralized process for the control receiving.
 2. Consolidation of receiving and storeroom functions will decrease the possibility of collusion.
 3. Review of the process by the internal auditor should be done on a routine basis.
 4. **The principle of dual receiving accountability as a prerequisite for invoice payment should be enforced.**
12. Following the completion of a strategic plan and of program development activities, the healthcare facility may find it necessary to alter its physical capacity, to correct code violations, and to improve functional configuration. To achieve these objectives, the healthcare facility should:
1. Identify accreditation requirements.
 2. Identify growth plans for patient, ancillary and support departments.
 3. **Prepare a master facility plan.**
 4. Prepare a physical facilities assessment.
13. The primary purpose of a planning task force for a management information system (MIS) is to:
1. Make recommendations to the governing authority.
 2. **Gather information on data needs in order to effectively evaluate vendors.**
 3. Reduce the necessity for user feedback.
 4. Implement the MIS system of the facility.

14. Compatibility between data-processing units is necessary except when:
1. The costs of individual systems are less than the cost of an integrated system.
 2. Technological advances are so rapid that obsolescence occurs within a few years.
 3. Constraints on available space restrict the size of the units that can be installed.
 4. **The information involved is used for a discrete freestanding activity.**
15. Accident rates among personnel continue to rise and are distributed among all departments. What would be your best initial action in finding a comprehensive solution to this problem?
1. **Form a safety committee of key personnel to review reports of all accidents and make recommendations for corrections.**
 2. Require each department head to analyze his/her department's accidents in order to determine the causes and find methods of corrections.
 3. Institute a safety education program by departments.
 4. Recommend that the personnel committee formulate an effective accident-prevention program.
16. If a physician abuses a patient in the healthcare organization, initial corrective action should be taken by the:
1. Chief of staff.
 2. **Chief of service (department chairman).**
 3. Nursing unit supervisor.
 4. Chief executive officer.

17. The most useful way for a healthcare organization to deal with outside regulatory and credentialing bodies is to:
1. Identify opportunities to influence political outcomes.
 2. **Regularly maintain both formal and informal relationships with these agencies.**
 3. Deal with these agencies only in written form so as to have a clear paper trail for subsequent review and analysis.
 4. Provide only the minimum amount of information required to comply with the regulations of the agency.
18. The cultural climate of an organization affects its recruiting procedure because:
1. It reduces employee turnover and absenteeism.
 2. **Organizations seek applicants whose attitudes, values and goals are consistent with those of the organization.**
 3. Applicants who cannot support a given culture will be unwilling to work for that organization.
 4. Applicants look only to organizations that portray a positive cultural climate.
19. Which of the following bodies has the final accountability for the formulation of policies and procedures concerning professional responsibilities within the healthcare organization?
1. Chief executive and senior management.
 2. Medical executive committee.
 3. **Governing authority.**
 4. Quality assurance committee.

20. The volume that would be realized if each prospective consumer were to purchase a specified amount of a particular service during a defined future time frame is called:
1. A sales forecast.
 2. A market forecast.
 3. Operational capacity.
 4. **Market potential.**
21. As an internal control method, a budget is most commonly used to:
1. Allow managers to control expenditures in the current year and to justify increases in future budgets.
 2. Provide feedback concerning operational expenditures to the governing authority and to allow management to satisfy the governing authority's requirements of accountability.
 3. **Serve as a numerical specification of plans and to function as a standard of control against which results can be compared.**
 4. Allow management to monitor operational expenditures and to justify future requests for decreased or increased expenditures to rate-setting agencies.
22. Which of the following is the proper term for the healthcare facility development plan?
1. Land use plan.
 2. Functional plan.
 3. **Master site plan.**
 4. Strategic plan.
23. The management accountability of a senior executive can best be determined by a formal evaluation of performance if the:
1. Governing authority receives copies of the evaluation.
 2. **Performance objectives are discussed and agreed upon at the time of employment.**
 3. Review is conducted annually.
 4. Review is conducted by a committee.

24. Materials management can best be defined as a system of effective:
1. Purchasing of materials at the lowest possible cost.
 2. Distribution of materials on a scheduled basis.
 - 3. Allocation of materials.**
 4. Control of inventories.
25. The purpose of debt-service coverage is to:
1. Determine the payout period.
 2. Determine the rating of the bonds.
 - 3. Protect the investor.**
 4. Establish the rate structure for patient services.
26. When facility maintenance is deferred, which of the following outcomes is predictable?
- 1. Higher costs.**
 2. Lower costs.
 3. Deferred risk.
 4. Higher liability exposure.
27. The major purpose of a code of ethics for members of a healthcare executives association is to:
- 1. Provide guidance to members in their own professional conduct.**
 2. Increase public understanding of the professional association.
 3. Provide a framework for disciplining members when necessary.
 4. Provide a framework for annually evaluating professional performance.
28. Effective facilities maintenance depends on:
1. Life-cycle planning of equipment.
 2. An up-to-date inventory of equipment parts for replacement.
 3. A periodic update of a preventive maintenance schedule.
 - 4. Maintaining facilities on a preventive schedule.**

29. When a member of the medical/professional staff requires disciplinary action, it is the ultimate responsibility of the:
1. CEO of the healthcare organization.
 - 2. Governing authority.**
 3. Medical director or chief of staff.
 4. Chief of the clinical service (department chairman).
30. Temporary working capital needs should be financed through:
1. Leasing of equipment.
 - 2. Short-term debt.**
 3. Equity financing.
 4. Accounts receivable.
31. Which of the following rules applies to the purchase of major diagnostic or treatment equipment?
1. Physician input is required by the accrediting body.
 2. Competitive bidding is required by government programs.
 3. The decision should be based on equipment depreciation schedules.
 - 4. Funds should be allocated annually in accordance with the organization's capital schedule.**
32. The principal advantage for an inpatient facility to affiliate with a geriatric-care program is that such an arrangement:
- 1. Provides for a continuum of care for patients.**
 2. Permits patients to receive care in the home settings.
 3. Requires less skilled personnel to provide the care.
 4. Is less costly to the patient.
33. Quality of patient care can best be measured by:
1. Carefully constructed written reports comparing different time periods.
 2. A review of incident reports.
 3. Reviewing the minutes of the medical/professional executive committee.
 - 4. A combination of statistical reports and direct supervision of patient care.**

34. The thrust of antitrust legislation as applied to the healthcare field is to:
1. Contain costs.
 2. Contain rising costs of independent single unit hospital.
 3. Monitor the scope of health services provided in a given area.
 4. **Protect the public's economic interest.**
35. A hospice may be described as a/an:
1. Intermediate-care facility.
 2. Extended-care facility that specializes in the treatment of the chronically ill.
 3. **Facility where terminally ill patients can receive special attention.**
 4. Interrelated group of healthcare services.
36. Which one of the following is the most important element of communication in contract management?
1. Negotiating.
 2. Controlling.
 3. Directing.
 4. **Feedback.**
37. To obtain the most objective evaluation of state-of-the-art computer technology, the healthcare executive should ultimately:
1. Survey local computer users.
 2. Undertake a literature search.
 3. Rely upon the in-house management information systems committee.
 4. **Utilize outside experts.**
38. The primary function of an extended-care unit is to provide:
1. **Post-acute care services in a rehabilitation-oriented environment.**
 2. Self-care facilities for ambulatory patients.
 3. Additional facilities for geriatric cases.
 4. More intensive nursing care for chronically ill patients.

39. Which one of the following conditions must be met for human subjects to be used in a medical research program?
1. No suitable animal model exists for use instead of people.
 2. The research program has been approved by the medical staff.
 3. The research program has been approved by the governing authority.
 4. **Risks should be clearly explained in understandable language to each individual subject.**
40. In developing a health promotion program for marketing to business, the most important factor is:
1. Generation of sufficient additional revenue to justify potential risk.
 2. **Development of a high-quality product to serve the needs and interests of the clientele.**
 3. Enhancement of the institution's image within the community.
 4. Achievement of institutional goals and missions by helping to ensure good health
41. Controlling the costs of accounts receivable is heavily affected by:
1. **The time or length of the payment cycle.**
 2. The dollar amount of credit granted to individuals.
 3. The total dollar amount of receivables carried on the books.
 4. Working capital management.
42. When a healthcare organization's goal conflict with the stated position of a professional society, the professional individual's responsibility is to:
1. **Make known the stance of the profession and reconcile the divergent positions.**
 2. Enlist the support of professional colleagues to alter the organization's position.
 3. Support the professional society's position.
 4. Support the organization's position.

43. At this time of restriction and complexity in the healthcare environment, the process of strategic planning for the healthcare organization requires the organization to develop a plan that:
- 1. Responds to the healthcare needs of the community.**
 2. Meets the needs of its service area population.
 3. Is coordinated with medical staff interests.
 4. Gives high priority to marketing.
44. In achieving the goals of an organization, the most important management practice is:
1. Allowing the line managers to determine their own goals.
 - 2. Applying goals uniformly at all organizational levels.**
 3. Holding operational-level meetings to compare objectives.
 4. Establishing organizational objectives based on the goals of the management teams.
45. All of the following are essential components of strategic planning except:
1. The corporate mission statement.
 - 2. Timetables for activity completion.**
 3. Competitive analysis.
 4. Assessment of the external environment.
46. When data are scarce, the best method of forecasting is to use:
1. Computer-based simulation methods.
 2. Time series analysis.
 3. Econometric forecasting.
 - 4. Qualitative techniques.**

47. Operational planning can be correctly defined as:
1. A function of establishing the annual budget by accumulating departmental information.
 2. **The process by which short-range objectives and actions are established and implemented in accordance with the strategic plan.**
 3. An annual process of developing, evaluating and implementing goals based on community needs.
 4. Determining the major types of services offered based on profit margins.
48. Decisions concerning the development of alternative modes of service delivery are generally made upon recommendations of:
1. The market research director to the CEO.
 2. Community leaders to the CEO.
 3. **The CEO to the governing authority.**
 4. The medical/professional staff to the governing authority.
49. One of the best ways to determine the total market size and the share of each competitor in that market is to:
1. Survey the opinions of the sales force or the medical/professional staff.
 2. **Survey a stratified sample of patients/clients.**
 3. Hire a consultant.
 4. Estimate the production capacity of each competitor.
50. Short-range planning is enhanced if a strategic plan has been adopted because:
1. Potential programs can be eliminated easily if not part of the strategic plan.
 2. Use of space has already been determined.
 3. **A frame of reference is already in place.**
 4. Operational problems can be quickly resolved.

51. In the field of healthcare services, which of the following trends has significantly increased the need to develop more comprehensive and more systematic credentialing processes in healthcare facilities?
1. The increased number of independent healthcare practitioners.
 2. The expansion of governmental regulations covering the operation of healthcare facilities.
 3. The growth of ambulatory healthcare services.
 4. **The growth of liability of healthcare facilities for malpractice by health practitioners.**
52. Which of the following activities can best help identify the most efficient staffing patterns for a healthcare organization?
1. **Periodic job-analysis to determine productivity levels.**
 2. Review of industry standards by region.
 3. Desk audit of job descriptions.
 4. Frequent on-site visits to work locations.
53. In a sound human resources program, the primary purpose of the job classification system is to:
1. Develop position descriptions for employees.
 2. Establish a total wage and salary administration program.
 3. **Rank jobs by kind and level of work performed.**
 4. Define an effective organizational structure.
54. Which of the following statements best defines increased productivity?
1. An increase in productivity occurs when the number of units of service rendered in a given year increases over the number rendered in the previous year.
 2. An increase in productivity occurs when an increase occurs in the volume or number of units of service rendered.
 3. **An increase in productivity occurs when a reduction occurs in the ratio of hours worked to the number of units of service rendered.**
 4. An increase in productivity occurs when an increase occurs in the revenue from a given number of full-time equivalent employees.

55. Which of the following is the depreciation method that best recognizes changes in the general purchasing power of the dollar and/or changes in the replacement cost of specific assets?
1. Declining-balance depreciation.
 2. Straight-line depreciation.
 - 3. Price-level depreciation.**
 4. Sum of the years' digits depreciation
56. When third-party policies and programs impede the healthcare facility's fiscal capacity to renovate and model its plant as routinely scheduled, the healthcare facility—to protect itself—should first:
- 1. Delay capital improvements until funds are available.**
 2. Reduce the level of operating services.
 3. Limit the number of admissions from selected third-party payment sources.
 4. Resort to the regulatory agency to obtain a waiver.
57. The method referred to as value analysis is used in inventory control activities to:
1. Make adequate substitutions for requisitioned items.
 2. Reduce the quantity of items issued to the various departments.
 - 3. Reduce cost without impairing functional efficiency.**
 4. Relate quantity and quality of items.
58. When a computer system is being used for business records, confidentiality is most effectively maintained by:
1. Periodic reviews by the internal auditor.
 2. Monitoring the activities of those employees who operate computer services.
 - 3. Restricting access to the information system.**
 4. Restricting access to the computer area.

59. To evaluate changes in levels of revenue and expenses as a result of changes occurring during the year, management can:
1. Use a “step-down” method.
 - 2. Use the contribution margin approach to budgeting.**
 3. Use the capital approach to budgeting.
 4. Project existing trends forward for one year.
60. Under generally accepted accounting standards, bad debts are reported as a/an:
- 1. Operating expense.**
 2. Deduction from net revenue.
 3. Contractual allowance.
 4. Deduction from gross revenue.
61. A case-mix cost allocation system that identifies costs associated with final (as opposed to intermediate) outputs provides:
- 1. Managers with more accurate information about true costs and thus improve their ability to control.**
 2. Managers with a systems device to deal with the problem of human resources allocation.
 3. Auditors with a better understanding of the financial status of the institution in a relationship to agreed-upon goals and objective.
 4. Governing authorities with better insight into the future growth and development of healthcare facilities.
62. Formation of a sound inventory control system depends upon:
1. Aging by item according to first-in/first-out protocols.
 2. Meeting demand and maximizing turnover.
 3. Maintaining sound fiscal controls based on utilization.
 - 4. Meeting demand and minimizing inventory cost.**
63. A management information system task force to plan for system design and implementation should, first of all, include:

1. Medical records, financial management, nursing service.
 - 2. Managers of appropriate healthcare organization departments.**
 3. Information systems consultant, CEO, financial management.
 4. Governing authority, medical staff, nursing service.
64. Because quality of care is a primary concern, an effective information system must include:
- 1. Objective and subjective reporting methods, incorporating peer judgments about patient care.**
 2. Preparation and evaluation of statistical and financial reports, on a regular basis.
 3. Weekly reports regarding census data and cost per occupied bed.
 4. A monthly comparison of actual expenses to budgeted expenses on a line-item basis.
65. The sole purpose of the medical/professional staff organization is to:
1. Meet accreditation standards.
 2. Review the standards of patient care.
 3. Review the credentials of physicians applying for membership.
 - 4. Safeguard patient safety.**
66. Incident reports should be initiated by:
- 1. A member of the medical/professional staff or by any employee.**
 2. Any person with direct patient-care responsibilities.
 3. The department director or supervisor.
 4. The risk manager/quality assurance coordinator.
67. The establishment of an appropriate credentialing procedure for members of the medical/professional staff should ultimately be a decision of the:
1. Entire medical/professional staff.
 2. Credentials committee.
 - 3. Governing authority.**
 4. Medical/professional executive committee.

68. The governing authority of a healthcare facility can terminate the privileges of any member of the medical/professional staff:
- 1. At any time, if it follows its own adopted procedures.**
 2. At any time, with or without due process.
 3. Only if termination is recommended by the medical/professional executive committee.
 4. Only if termination is recommended by the medical/professional staff.
69. It is important for the CEO of a healthcare organization to represent the the organization at state and regional associations and to other organizations in the community because:
1. The organization's spokesman is the person who is most knowledgeable about the organization.
 2. The CEO can use the opportunity to explore external threats to the organization.
 - 3. These activities develop exchange relationships and are therefore crucial to the organization.**
 4. Consumer surveys indicate that, within the community, the CEO is the most visible spokesman for the organization.
70. What population factor is currently having the greatest impact on healthcare organization?
1. Ethnic composition.
 2. Economic status.
 3. Geographic distribution.
 - 4. Age cohort.**
71. To work effectively with the media, healthcare executives must:
1. Be accessible at all times to the media.
 - 2. Increase their knowledge of and sensitivity to the media's function.**
 3. Employ a public relations officer to control the release of all information.
 - 4. Issue press releases on a timely basis.**

Chapter V

Sample Test and Answers With Solutions

The following questions were either written for the Board of Governors Examination or were previously used in the Examination.

Sample Test—100 Questions

1. CEO compensation should be based on:
 1. the compensation arrangements with the prior CEO.
 2. executive compensation in local corporations with similar gross revenues.
 3. present salary plus cost-of-living adjustment.
 4. what the institution would have to pay for a similarly prepared person if that person were employed elsewhere.

2. An essential function of the governing board is to:
 1. approve the mission, vision and long-range plan.
 2. focus on strategic planning.
 3. prepare the operating plan.
 4. review performance of departmental activities.

3. The key to enhancing board effectiveness is:
 1. getting the right people to serve on the board.
 2. supporting and selecting the right CEO.
 3. orienting and training the CEO.
 4. organizing the board's work.

4. Members of the medical staff are eligible for full membership on the governing board in the same manner as other individuals:
 1. when not legally prohibited.
 2. when they do not actively practice in the organization.
 3. when they are not full-time employees.
 4. if they are not foreign nationals.

5. The chief executive officer:
 1. is a member of the board.
 2. represents the board internally and externally.
 3. is not a member of the board
 4. has a contract with the board.

6. Regarding the budget, the board:
 1. does not use the budget exercise as a way to improve quality and productivity.
 2. gets involved in preparing budgets for all operational units.
 3. decides which personnel are needed in top management.
 4. establishes guidelines and makes final choices among competing opportunities.

7. The individual or group responsible for establishing policy, maintaining quality of care and providing for institutional management planning is the:
 1. chief operating officer.
 2. medical staff executive committee.
 3. governing body.
 4. chief executive officer.

8. A correct statement regarding trustees serving as fiduciaries is that they can:
 1. be indicted for alleged theft of facility funds and the improper expenditure of facility funds for personal reasons.
 2. be released from responsibility by giving the audit committee final authority in high-risk areas of financial matters, without any action by the whole board.
 3. be held personally liable for wrongful acts or omissions by corporate officers or co-trustees by virtue of their position as trustees.
 4. waive their fiduciary responsibility as a community organization.

9. Ultimate responsibility for the mission statement rests with the:
 1. CEO and medical staff.
 2. governing board.
 3. community and CEO.
 4. chief executive.

10. A key reason for choosing board members is because:
 1. other board members want to listen to their opinions.
 2. of what they can do for the organization.
 3. they have high status in the community.
 4. physicians will listen to them.

11. The bylaws of healthcare organizations should include which of the following?
 1. Committee scope and function
 2. The privileges of the medical staff
 3. The names of the stockholders in the organization
 4. Composition of the governing board, committees and officers

12. Successful approaches to strategic planning include:
 1. a well-written mission statement, long-range plan and fiscal plan plus the history and discussion surrounding them.
 2. avoidance of high-risk decisions.
 3. not paying attention to the competitor's activity.
 4. using rules and past experience as a guide to future action.

13. The primary challenge facing a prospector is:
 1. protecting and increasing current service (product) or market share through technical efficiency, cost improvements or differentiation strategies.
 2. managing diversification successfully, to guard against expanding too rapidly or into areas where they have little knowledge.
 3. managing simultaneously the difficult task of pursuing new markets and services while avoiding erosion of current services in existing markets.
 4. creating stability by sticking with a strategic plan long enough to accumulate experience and to develop consistent leadership, avoiding random diversification efforts.

14. In the introductory stage of the product life cycle:
 1. The introductory stage can be very short.
 2. The introductory stage can be very long.
 3. sales or revenue growth is slow.
 4. all of the above.

15. The primary task of marketing is to:
 1. bring about voluntary and involuntary exchanges of values.
 2. attract new advertisers.
 3. bring about voluntary exchanges of values.
 4. advertise new and existing services.

16. It would be incorrect to say that:
1. an organization's image is a function of all that the organization has done as well as what it has attempted to communicate.
 2. people's images of an organization always reflect their true attitudes toward the organization.
 3. an organization's image is largely the result of public relations, advertising, selling and communication efforts.
 4. responsibility for the creation of the organization's image does not lie merely with the marketer.
17. It is important to understand the consumer adoption process because:
1. the organization may be able to convince the consumer to pass over the awareness, interest and evaluation stages, moving directly to trial.
 2. it is important to have the communications plan for the new product/service address the late majority and laggards as well as the innovators.
 3. word of mouth and personal influence play little to no role in the consumer adoption process.
 4. people differ significantly in their likelihood to try a new product/service, a factor that should affect an organization's communications plans for its new product/service.
18. All of the following are methods used to forecast future demand *except*:
1. target buyer intention surveys.
 2. performance of an environmental assessment.
 3. estimation of a competitor's current customer base.
 4. estimate of future demand by "middlemen."
19. Which of the following can be used to establish marketing budgets?
1. The affordable method
 2. Objective and task method
 3. Competitive-based method
 4. All of the above

20. All of the following statements are true *except* that:
1. much of the art of forecasting relies on the opinions of experts.
 2. forecasting, if correctly performed relying on technological forecasting approaches, is an exact science.
 3. forecasting includes applying the rates of anticipated future change to the current status to predict the future.
 4. qualitative data are often used in developing assumptions on which quantitative forecasting can be constructed.
21. Which of the following environmental assumptions for the next decade is *not* reasonable?
1. Cost containment pressures will continue to be a dominant factor in the delivery of health services.
 2. There will be decreased morbidity (substance abuse, violence, accidents, etc.) due to increased marketing efforts and technological advances.
 3. Continued growth in new technologies will focus on cost-saving technologies that move care from inpatient settings to out-of-hospital settings.
 4. There will be continuing efforts to measure and assure quality of healthcare services.
22. Of the four following advertising media, which potentially has the maximum selectivity in reaching defined target audiences?
1. Local radio
 2. Direct mail
 3. Network TV
 4. Outdoor advertising
23. The major value of job analysis is that it is:
1. used to establish wage levels.
 2. the best method for identifying the need for employees.
 3. the cornerstone of human resources management activities.
 4. valid for a long period of time.

24. Comparative methods of performance appraisal that compare one manager to another to determine performance ratings:
1. are solely based on desired organizational outcomes.
 2. are time consuming and useful only for relatively small groups of employees.
 3. are objective measures of performance.
 4. require the use of only one rater to achieve consistency of measurement.
25. A system for providing reward for improvement in productivity should:
1. be group-based to reinforce teamwork and cooperation.
 2. focus on nonfinancial rewards only.
 3. be integrated into the organization's employee appraisal system.
 4. focus on both nonfinancial and financial rewards.
26. Vertical job enlargement:
1. gives individual workers responsibility for control of decision making over task-related decisions.
 2. has been universally accepted by all employees.
 3. must involve supervisor and subordinate in a participative process.
 4. expands an individual's job by assigning additional steps in the production process.
27. A stop-gap measure that a health service executive might use to manage intergroup conflict, which allows people to cool down and regain perspective, is:
1. smoothing.
 2. bargaining.
 3. integrative problem solving.
 4. appealing to super ordinate goals.
28. Work groups informally govern the amount and quality of work of individuals within the group through:
1. performance norms.
 2. behavior norms.
 3. standard operating procedures.
 4. job descriptions.

29. As a minimum, an organization demonstrates “good faith” in collective bargaining with a union by:
1. appointing a representative who may not have the power to negotiate agreements to meet with the union.
 2. rejecting union proposals without having to offer counterproposals.
 3. bargaining individually with employees or offering them individual contracts even though bargaining has been requested by the majority representative.
 4. receiving union proposals and meeting with the union from time to time to discuss the proposals.
30. Large, multidisciplinary work groups with health services organizations are likely to suffer from:
1. “groupthink,” when individuals strive toward harmony and unanimity at the expense of good decision making.
 2. “free-riding,” when individuals can benefit from the work of the group without making a suitable contribution.
 3. “risky shift,” when individuals ignore potentially dangerous outcomes and choose high-risk alternatives.
 4. “behavioral transference,” when the values and norms of other work groups are discounted.
31. The major benefit of the integrative dimension of negotiation over the distributive dimension is that the:
1. value of the Best Alternative to a Negotiated Agreement is increased.
 2. value of the Best Alternative to a Negotiated Agreement is decreased.
 3. complexity of the negotiation process is simplified.
 4. amount of resources to be distributed is increased, allowing both parties to reach their reservation prices.
32. As managerial vacancies occur, the availability of well-trained individuals who understand the organization’s mission, values, culture and strategy is enhanced by:
1. the use of an executive search firm to fill managerial vacancies.
 2. rotation of managerial responsibilities among the organization’s executives.
 3. the use of an effective succession planning program.
 4. uniform management development programs for midlevel and senior-level managers.

33. Capital rationing in the investment decision process refers to the:
1. decision on which of the proposed capital projects will be funded.
 2. decision on the total amount of funds available for capital projects.
 3. decision on the financial merits of each proposal.
 4. decision on the amount of funds to be borrowed for capital projects.
34. A positive net present value indicates that the investment has a rate of return:
1. higher than the discount rate used in the calculation.
 2. lower than the discount rate used in the calculation.
 3. equal to the discount rate used in the calculation.
 4. equal to the accounting profit averaged over the life of the investment.
35. For information on net cash flows from providing health services for a specific time frame, the decision maker should use the:
1. statement of cash flows.
 2. income statement.
 3. balance sheet.
 4. statement of retained earnings.
36. Memorial Hospital offers a screening test as a public service for \$0.50 per test. Variable costs per unit are \$0.32. Fixed costs are \$43,200 per month for the department performing the test. It is the only test done by this special department. The break-even point in tests is:
1. 240,000 tests.
 2. 172,800 tests.
 3. 135,000 tests.
 4. 86,400 tests.
37. The most important factor in the success of the organizational internal control system is the:
1. selection of the internal auditor.
 2. selection of the CEO.
 3. selection of certified public accountants for the internal auditor functions.
 4. selection of the audit committee of the board.

38. Hampton Outpatient Clinic budgeted revenue from flu vaccinations at \$20 per shot. Fixed costs total \$5 per unit based on 4,000 shots and remain unchanged within a relevant range of 1,500 shots to 6,500 shots. Variable costs are \$10 per shot. After total revenue was budgeted at \$70,000, the clinic received a request from the local school district for flu vaccinations for its 1,000 students at a reasonable cost. If Hampton Clinic wants to increase operating income by \$2,000, what should Hampton charge for the additional shots?
1. The variable costs plus the incremental profit margin per shot.
 2. The average cost per shot plus the per-unit profit.
 3. The fixed costs per shot plus the variable costs.
 4. The variable costs plus the per-unit fixed cost per shot.
39. Financial risk is an element in capital investment decisions and is determined by:
1. the riskiness of the firm to the equity holders, assuming no debt financing is used.
 2. the additional risk placed on the firm when debt financing is used.
 3. the risk inherent in the firm's beta coefficient as determined by industry levels.
 4. the total riskiness of the firm's return on assets (ROA) and its market portfolio.
40. The asset turnover ratio is useful in measuring managerial performance because it indicates the:
1. amount of resources required to generate a dollar of revenue.
 2. profitability per dollar of revenue.
 3. effectiveness of capital structure decisions.
 4. effective use of current assets.
41. A weighted average cost of capital is the:
1. accounting cost to the organization of producing all required returns to capital.
 2. economic cost to the organization of producing all required returns to capital.
 3. weighted average required rate of return adjusted downward in accordance with Generally Accepted Accounting Principles.
 4. correct discount rate for valuing the total cash flows received by equity suppliers.
42. In general, the net present value calculations assume:

1. the discount rate is constant over the life of the decision.
 2. the organization is a for-profit entity.
 3. future cash flows are known with certainty.
 4. borrowing and lending rates are equal with each period.
43. The difference between an accounting break-even point and an economic break-even point is that:
1. the economic breakeven point provides the required rate of return to all suppliers of capital to the provider.
 2. the economic breakeven point does not recognize expense categories.
 3. the accounting breakeven point provides for total financial requirements.
 4. there is no difference.
44. Under the capitation, the risks of overutilization are shifted to the:
1. patient receiving the health services.
 2. provider of the health services.
 3. third-party payors.
 4. health insurance company.
45. Which of the following ratios would be used to estimate cash flow for a specific time period?
1.
$$\frac{\text{Receivable balance}}{\text{Average daily revenues for period}}$$
 2.
$$\frac{\text{Net accounts receivable}}{\text{Gross accounts receivable}}$$
 3.
$$\frac{\text{Cash collected during period}}{\text{Revenues for period}}$$
 4.
$$\frac{\text{Deduction from revenue}}{\text{Gross revenue for period}}$$

46. In developing workload measurements for estimating manpower requirements for budget preparation, the analyst should first:
1. develop relative value units for each cost center.
 2. predict payor mix for the budget year.
 3. determine available staff for each department.
 4. forecast total admissions activity levels and patient days.
47. Under Generally Accepted Accounting Principles, bad debts are reported as a/an:
1. deduction from net revenue.
 2. operating expense.
 3. contractual allowance.
 4. deduction from gross revenue.
48. A technique used to shorten the in-house processing time of the accounts receivable cycle is a:
1. "lock-box" agreement.
 2. line of credit arrangement.
 3. minimum balance arrangement.
 4. shortened write-off date.
49. Which of the following best describes a plan for the development of a facility's physical plant?
1. a set of completed plans and specifications for all of the changes to be made to the physical plant.
 2. a projection of the cash flow for plant-related projects.
 3. a listing of the changes, sequence and costs to meet projected capacity requirements.
 4. a financial feasibility study of funding alternatives for plant development.
50. In planning to purchase new equipment, a healthcare facility should always be sure:
1. to speak with all suppliers and ask for presentations by suppliers.
 2. the purchase is part of the facility's capital plan.
 3. to take the lowest bid.
 4. to take the recommendation of the medical director.

51. The selection of a major item of equipment should be:
1. guided by a selection group composed of the users and maintainers of that equipment.
 2. made by the medical director of the department.
 3. the sole choice of the administrator.
 4. the decision of the board of directors.
52. An effective plan for equipment maintenance is:
1. ensured by having all replacement parts in stock.
 2. determined when the equipment is installed and need not be changed.
 3. based on manufacturer's recommendations and facility experience with the equipment.
 4. ensured by having a computer-based preventive maintenance system.
53. To assess the effectiveness of its maintenance program, a health facility should:
1. review the costs of maintenance activities.
 2. send satisfaction questionnaires to user departments.
 3. monitor an established set of performance measures on a periodic basis.
 4. have an outside consultant review the program.
54. The organization's strategic plan, accreditation and licensing requirements and the need to improve functional efficiency may indicate the need for a building program. To develop a program that best meets these needs, the healthcare organization should:
1. interview medical staff for suggestions.
 2. interview department managers regarding planned growth.
 3. interview board members.
 4. prepare a master facility plan.
55. The master facility plan for development of a healthcare organization's physical plant should be based on:
1. the suggestions of medical staff for clinical service expansion.
 2. the facility's strategic plan and volume projections.
 3. recommendations from licensing and accrediting bodies.
 4. the architect's drawings.

56. A facility maintenance program will be most effective if:
1. requests for service are satisfied promptly.
 2. reliability, safety and efficient operation guide the plan's design.
 3. system failures occur very rarely.
 4. backup plans exist for every major system.
57. The plan for maintenance of the physical plant should emphasize:
1. customer satisfaction.
 2. minimal downtime for equipment.
 3. preventive maintenance.
 4. rapid response to problems.
58. One of the major elements of a master plan for information systems development in a healthcare organization is:
1. a request-for-proposal (RFP) from vendors.
 2. a list of specifications for computer programs.
 3. the setting of individual computer applications.
 4. a list of specifications for computer hardware installation and maintenance.
59. An information system contract for a healthcare organization should be drafted by:
1. an independent management consultant.
 2. the vendor who will supply the system.
 3. the organization's legal counsel.
 4. technical staff from the organization and the vendor working together.
60. To compete for managed care contracts, healthcare providers must be able to provide data to managed care organizations on:
1. costs and quality of services provided.
 2. medical technology employed in the delivery of care.
 3. efficiency of internal operations.
 4. number of personnel employed in the organization.

61. The chief information officer for a healthcare organization should supervise the following functions in the organization:
1. information systems and telecommunications.
 2. mix of services provided.
 3. utilization review and risk management.
 4. clinical engineering programs.
62. An important management principle that should guide the planning, design and implementation of information systems for healthcare organizations is:
1. always buy the newest system available to avoid technical obsolescence.
 2. leave all decisions about information technology to technical specialists.
 3. employ consultants to set priorities for system development.
 4. treat information as an essential institutional resource.
63. Membership of the healthcare information systems steering committee should comprise:
1. the chief executive officer, chief information officer, selected major user departments and chair of the governing board.
 2. representatives of administration, physician leadership, information systems management and major user departments.
 3. the chief information officer and senior systems analysts.
 4. the chief information officer and outside technical consultants.
64. The most important factor influencing specifications for individual information systems in healthcare organizations should be:
1. standard reports generated.
 2. user requirements.
 3. the cost of the systems.
 4. vendor service capabilities.
65. Of the following, the most important task in evaluating vendor information system products is:
1. reviewing technical journals.
 2. attending vendor product demonstrations.
 3. talking directly with others who have used the products you are considering.
 4. attending computer trade shows and conferences.

66. As healthcare networks develop, the level of information systems consolidation should be driven by:
1. the desires and needs of managed care and other payors.
 2. the business, clinical and operating requirements of the emerging organization.
 3. the desires of the largest organizations in the network.
 4. plans to use common computer hardware throughout the network.
67. Information systems needed for financial planning and control in healthcare organizations include:
1. patient registration, admissions, discharges and transfers.
 2. outpatient and emergency room scheduling.
 3. budgeting, cost accounting, case-mix analysis and financial modeling.
 4. order entry and results reporting.
68. Outcomes assessment required by managed care will require more advanced clinical information systems, such as:
1. computerized protocols to aid in diagnosis and treatment planning.
 2. computerized patient registration.
 3. entry of laboratory and radiology orders from computer terminals.
 4. processing of medical records abstracts.
69. With respect to the processes by which healthcare organizations maintain the confidentiality, security and integrity of the medical record, all of the following statements are true *except*:
1. the original medical record of a patient being transferred from one healthcare organization to another may accompany the patient to the new organization.
 2. healthcare organizations must have a mechanism to preserve the confidentiality of data/information identified as sensitive.
 3. the organization must have a mechanism to safeguard records against loss, destruction, tampering and unauthorized access or use.
 4. written policies must require that medical records may be removed from the organization's jurisdiction only in accordance with a court order, subpoena or statute.

70. All of the following are commonly recognized to be a right of each patient *except* the right to:
1. receive considerate and respectful care.
 2. access protective services.
 3. communicate with a caregiver in the language of the patient's choosing.
 4. be informed about and participate in decisions regarding their care.
71. All of the following statements about documentation in the medical record are true *except*:
1. verbal orders must be authorized by the practitioner within a time frame to be defined by the medical staff.
 2. verbal orders can only be accepted by registered nurses.
 3. authentication may be made by actual written signatures, initials, rubber stamp signatures, or computer "signatures."
 4. that entries must be authenticated by the actual author only.
72. Current Joint Commission guidelines regarding the design of new patient care processes include all of the following *except*:
1. the design is clinically up-to-date.
 2. the design is based on the organization's mission, vision, values and plans.
 3. the design meets the needs and expectations of key constituents.
 4. the design team includes physicians or their designees.
73. Current Joint Commission guidelines regarding measurement (the collection of data) include all of the following *except*:
1. the data collection processes should be consistent with those of the Joint Commission's "10-step method" for quality assessment.
 2. the data should identify opportunities for possible improvement of existing processes.
 3. the organization must collect data about the appropriateness of admissions and hospital stays.
 4. the organization must collect data on patient care processes that are high risk, high volume and problem prone.

74. Which of the following is a false statement?
- Guidelines produced by the Agency for Health Care Policy and Research:
1. have been shown to decrease healthcare costs.
 2. rarely need to be revised.
 3. provide starting points for managing individual patients.
 4. have been shown to improve the quality of care.
75. Which of the following statements about the Malcolm Baldrige National Quality Award is true?
1. Service organizations have won the award as often as manufacturing organizations.
 2. Healthcare organizations were able to receive the award beginning in 1996.
 3. Each year, there are winners in the manufacturing, service and small business categories.
 4. Regulatory compliance constitutes an essential prerequisite to winning the award.
76. Which of the following statements *most* accurately describes the, Health Plan Employer Data and Information Set (HEDIS)?
1. HEDIS indicators can easily be adopted for use by acute-care hospitals.
 2. HEDIS quality indicators evaluate preventive services, prenatal care, acute and chronic illness and mental health and substance abuse programs.
 3. HEDIS was developed primarily to meet the needs of patients and their families.
 4. financial performance has no bearing on HEDIS indicators.
77. The governing authority assures itself about the quality of care by:
1. holding the CEO of the health facility accountable.
 2. making the president of the medical/professional staff an *ex officio* member of the governing authority.
 3. approving the process and then following up regularly and continuously to see that it is being used.
 4. reviewing tabulated results of incidence reports.

78. A nonlegitimate reason to release information from a patient's medical record is when:
1. subpoenaed by a court order.
 2. requested by the spouse or next of kin.
 3. the patient becomes incompetent.
 4. reporting statistics for a research project.
79. In the past, hospitals have been less effective in lobbying than physicians because:
1. legislators like physicians more.
 2. physicians have better lobbyists.
 3. the law prevents hospitals from lobbying.
 4. hospitals don't vote.
80. In general, courts exhibit what attitude regarding controversies over medical staff privileges?
1. Human lives are at stake and the courts must intervene to protect physicians' rights to save those lives.
 2. If the decision were supported by reasonable evidence, courts will not substitute their judgment for that of the hospital board.
 3. Hospitals must not be permitted to interfere with the doctor-patient relationship.
 4. Courts may not entertain suits regarding medical staff privileges.
81. Under federal law, whenever a patient comes to a hospital emergency department with an emergency condition:
1. with few exceptions, the patient's ability to pay may be considered in determining whether to provide treatment.
 2. with few exceptions, the patient's condition must be stabilized before he/she is transferred or discharged.
 3. a police officer may be asked to authorize treatment.
 4. the hospital has no duty to treat the person if he/she is not a patient or a member of the medical staff.

82. In considering applications for medical staff privileges, hospitals receive reports from a U.S. Government clearinghouse on malpractice payments and adverse medical staff and licensure actions. In general, these reports have had which effect?
1. Reports have rarely led hospitals to make privileging decisions they would not have made otherwise.
 2. Reports have been timely and helpful and have reduced the complexity of the privileging process.
 3. Had they not received the reports, most hospitals' privileging decisions would usually have been different.
 4. Hospitals usually receive significant information that neither the practitioner involved nor any other sources had provided.
83. Which of the following statements best summarizes the prevailing legal standard used to judge the actions of members of a nonprofit healthcare organization's governing board?
1. They must act in good faith, with reasonable care, and with the best interests of the corporation in mind.
 2. They must exercise the same high level of fiduciary duty as is applied to the trustees of a trust.
 3. They must avoid gross negligence and willful misconduct.
 4. They are immune from personal liability.
84. Which of the following is the clear trend regarding a hospital's liability for the actions of members of its medical staff?
1. The hospital may be held liable for a physician's negligence even though the physician is an "independent contractor."
 2. Hospitals are not liable for such actions because they are simply physical sites where patients receive treatment from privately retained physicians.
 3. Courts are becoming more reluctant to impose liability on hospitals for the negligence of physicians who use their facilities.
 4. The hospital is liable only if the physician is an employee.

85. A joint venture laboratory owned by a hospital and physicians on its medical staff would probably be in violation of fraud and abuse laws if it were to:
1. market its services to both investors and noninvestors.
 2. offer ownership shares at the same price to referrers and nonreferrers.
 3. require investors to refer business to it.
 4. base its profit distributions on the amount of capital contributed, not on referrals.
86. The principal reason for small and midsized employers to join buyers cooperatives is to enable them to:
1. drop coverage from existing insurers.
 2. gain leverage to obtain prices similar to large employers.
 3. negotiate directly with physicians and hospitals.
 4. lobby government agencies for more protection from insurers.
87. The development of preferred provider organizations was originally intended to:
1. guarantee that hospitals maintain their occupancies.
 2. promote networks that would evolve into multihospital systems.
 3. offer an alternative to the health maintenance organization.
 4. force high-priced hospitals out of local markets via discounts.
88. An important reason for a hospital and its medical staff to explore the development of physician-hospital organizations is to:
1. permit contracting with plans that want to buy both hospital and physician services.
 2. begin development of a hospital-based health maintenance organization.
 3. eliminate poor-performing physicians from the organization.
 4. provide a way to put all physicians on salary.
89. Insurance companies and other payors have introduced preadmission certification for elective hospital stays in order to:
1. cause physicians to reconsider need for service.
 2. facilitate communication between hospitals and the attending physician.
 3. establish clinical necessity prior to service.
 4. encourage the patient to obtain a second opinion.

90. Healthcare organizations encourage their employees to contribute to the United Way and other community groups primarily because these agencies:
1. promote the image of the healthcare organization.
 2. provide funds to support many community services.
 3. will return funds to the healthcare organization.
 4. have healthcare organization executives on their boards.
91. Healthcare facilities serving disabled populations might wish to systematically review concerns by:
1. adding specific questions to patient satisfaction instruments.
 2. consulting periodically with advocacy groups.
 3. reviewing patient complaints raised by disabled individuals.
 4. reviewing their compliance with the Americans with Disabilities Act.
92. Which one of the following characteristics differentiates a multihospital system from a network or alliance?
1. the geographic distribution of its members
 2. the corporate structure
 3. vertical integration
 4. horizontal integration
93. When an acute healthcare facility is part of a parent-subsiary type corporation, that facility typically is:
1. the parent corporation.
 2. a holding company.
 3. a member of the association.
 4. the subsidiary.
94. Two independent healthcare organizations interested in discussing a joint venture to initiate a cancer treatment program would be wise to initially consult with their legal counsel to determine if their:
1. liability is equal even though disproportionately owned.
 2. financial gains or losses can be shared unequally.
 3. discussions might violate antitrust statutes.
 4. current facilities can accommodate the program.

95. The healthcare executive with opposing duties (obligations)—meeting one of which makes it impossible to meet the other—has a:
1. conflict of interest.
 2. management ethical dilemma.
 3. need for a consultant.
 4. situation that is impossible.
96. The best way to describe health fairs, screening programs and smoking cessation classes provided by healthcare organizations is that they are:
1. attempts to create demand for services.
 2. necessary for most third-party reimbursement.
 3. desirable, but superfluous activities.
 4. community education programs.
97. The ethical precepts (organizational philosophy) that guide an organization's activities are found in a variety of sources that are:
1. reflected in everyday actions.
 2. the sole province of senior management.
 3. part of the governing body's formal actions.
 4. written and unwritten.
98. The most common and useful ways to overcome resistance to change in organizations are:
1. education and communication.
 2. manipulation and co-optation.
 3. committees and task forces.
 4. inspirational leadership and managerial skill.
99. Coordination among governance, management and professional staff is a major problem for most healthcare organizations. A common way to solve the problem of coordination is to:
1. provide a local area network to leaders of each group using personal computers.
 2. have overlapping membership on committees that are part of each group.
 3. have quarterly meeting where issues of concern to the groups are discussed.
 4. provide copies of memoranda and policy statements to leaders of each group.

100. In efforts to encourage licensed clinical staff to engage in continuing education, healthcare executives are given substantial assistance by the fact that these professionals:
1. are encouraged by significant peer pressure.
 2. must meet requirements of their certifying group.
 3. are often interested in opportunities to transfer.
 4. must meet malpractice law continuing education standards.

Answer Key/Solutions

1. **Correct Answer: 4**
2. **Correct Answer: 1**
3. **Correct Answer: 4**
4. **Correct Answer: 1**
5. **Correct Answer: 2**
6. **Correct Answer: 4**
7. **Correct Answer: 3**
8. **Correct Answer: 1**
9. **Correct Answer: 2**
10. **Correct Answer: 2**
11. **Correct Answer: 4**
12. **Correct Answer: 1**
13. **Correct Answer: 2**
14. **Correct Answer: 4**
15. **Correct Answer: 3**
16. **Correct Answer: 3**
17. **Correct Answer: 4**
18. **Correct Answer: 3**
19. **Correct Answer: 4**
20. **Correct Answer: 2**
21. **Correct Answer: 2**
22. **Correct Answer: 2**

- 23. **Correct Answer: 3**
- 24. **Correct Answer: 2**
- 25. **Correct Answer: 4**
- 26. **Correct Answer: 3**
- 27. **Correct Answer: 1**
- 28. **Correct Answer: 1**
- 29. **Correct Answer: 4**
- 30. **Correct Answer: 2**
- 31. **Correct Answer: 4**
- 32. **Correct Answer: 3**
- 33. **Correct Answer: 1**
- 34. **Correct Answer: 1**
- 35. **Correct Answer: 1**
- 36. **Correct Answer: 1**
- 37. **Correct Answer: 1**
- 38. **Correct Answer: 1**
- 39. **Correct Answer: 2**
- 40. **Correct Answer: 1**
- 41. **Correct Answer: 2**
- 42. **Correct Answer: 4**
- 43. **Correct Answer: 1**
- 44. **Correct Answer: 2**
- 45. **Correct Answer: 3**

- 46. **Correct Answer: 4**
- 47. **Correct Answer: 2**
- 48. **Correct Answer: 1**
- 49. **Correct Answer: 3**
- 50. **Correct Answer: 2**
- 51. **Correct Answer: 1**
- 52. **Correct Answer: 3**
- 53. **Correct Answer: 3**
- 54. **Correct Answer: 4**
- 55. **Correct Answer: 2**
- 56. **Correct Answer: 2**
- 57. **Correct Answer: 3**
- 58. **Correct Answer: 3**
- 59. **Correct Answer: 3**
- 60. **Correct Answer: 1**
- 61. **Correct Answer: 1**
- 62. **Correct Answer: 4**
- 63. **Correct Answer: 2**
- 64. **Correct Answer: 2**
- 65. **Correct Answer: 3**
- 66. **Correct Answer: 2**
- 67. **Correct Answer: 3**

- 68. **Correct Answer: 1**
- 69. **Correct Answer: 1**
- 70. **Correct Answer: 3**
- 71. **Correct Answer: 2**
- 72. **Correct Answer: 4**
- 73. **Correct Answer: 1**
- 74. **Correct Answer: 2**
- 75. **Correct Answer: 2**
- 76. **Correct Answer: 2**
- 77. **Correct Answer: 3**
- 78. **Correct Answer: 2**
- 79. **Correct Answer: 4**
- 80. **Correct Answer: 2**
- 81. **Correct Answer: 2**
- 82. **Correct Answer: 1**
- 83. **Correct Answer: 1**
- 84. **Correct Answer: 1**
- 85. **Correct Answer: 3**
- 86. **Correct Answer: 2**
- 87. **Correct Answer: 3**
- 88. **Correct Answer: 1**
- 89. **Correct Answer: 3**

- 90. Correct Answer: 2**
- 91. Correct Answer: 1**
- 92. Correct Answer: 2**
- 93. Correct Answer: 4**
- 94. Correct Answer: 3**
- 95. Correct Answer: 1**
- 96. Correct Answer: 4**
- 97. Correct Answer: 4**
- 98. Correct Answer: 1**
- 99. Correct Answer: 2**
- 100. Correct Answer: 2**

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