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Abstract

Productivity initiatives are often defeated when we approach the effort strictly as a finance project. Since the central purpose of most health care organizations is not financial, this approach fails, leaving all parties frustrated. A prime symptom of this breakdown is the lack of budget discipline and strict accountability that is sadly the norm in most organizations. Finance wants savings, security, and lasting prosperity, while clinicians want sufficient labor resources to do what's right by their patients. Can't both objectives be accomplished? Through honest collaboration, defining and working to meet mutual goals, knowledge can be shared, learning can be facilitated, and a consensus built for all stakeholders, department by department. The result is that managers feel more in control, enjoy more autonomy, and are satisfied that their requirements are met, while administration produces a culture of accountability to performance standards.

Finance professionals are often accused by clinicians and non-financial administrators of living in their own world, speaking their own incomprehensible insider jargon, and failing to appreciate the caregiver perspective and tradition. It's all about the money, they might say of Finance. So why do they put up with it? They need the cash.

Clinicians seem to imagine they work in a fantasy world of unlimited resources, without any financial constraints, speaking a peculiar medical dialect with shorthand symbols. They don't appreciate the critical role of Finance in assuring that the health care enterprise is able to buy equipment, build facilities, and pay the employees. It doesn't just happen by itself. It seems like Finance is constantly struggling with Clinical to balance patients with profit. So why does Finance put up with it? They need the patients.

Finance professionals may have a certain degree of power to drive constructive change, but they cannot do it alone. They need to collaborate with their clinical and technical managers. Finance and Clinical belong together; each cannot exist without the other. A healthcare organization with only clinicians would soon bankrupt itself. A healthcare organization with only Finance would have no purpose. They are each a part of the same team, and must learn to collaborate. There is probably no area of healthcare administration where this native inability to act as a team clashes more than in the annual budget exercise. For it is here that heartless Finance valiantly attempts to restrain the wildly spending, undisciplined clinicians so that the enterprise remains solvent, or even improves its financial performance. And it is here that noble clinicians oppose the stingy and heartless finance team for the sake of its patients, unwitting pawns in this life and death game. It's as if Finance and Clinical come from different planets, unable or unwilling to join forces to achieve mutual ends. Finance tries to achieve its purposes, and Clinical theirs, in a zero-sum game in which no gains can be had except at someone's loss.

Can't We All Just Get Along?

Many hospital administrations have foisted unnecessarily complex, excessively detailed, over-engineered monitoring systems upon clinicians. They are billed as a "tool" that somehow helps managers. When real managers are asked their opinion, however, there is no enthusiasm for this tool they've been given. Such systems serve as a report card, helping administration to identify who has been bad and who has been good. Yet the more detailed and more frequent the monitoring, the less useful it is to administration. It's a paradox, but more frequency and detail introduces complexity and highlights random variation that confounds understanding. Nurse managers, for example, aren't against monitoring systems as such—after all, they use staffing grids every day—but they don't need anyone riding herd on them or second-guessing their shift-by-shift staffing decisions. That's their job, and Finance needs to let them do it. The whole area of productivity management needs to be cleaned up for the sake of simplicity, understanding, and acceptance.

More sophisticated software and hardware is not the answer. Collaboration is the real solution. Once we abandon the management vs. worker, clinician vs. non-clinician, budget cop vs. violator models of engagement, effective collaboration is not just possible, but entirely realistic and expected.

With real collaboration, no one party can dictate a certain outcome or force compliance to a final position. It doesn't mean that senior management loses the prerogative to make choices, but it does mean that those choices are informed and shaped by those who are party to it.

The strange thing is this: real collaboration can be very simple to achieve. How can Finance discover what clinicians really want? Just ask them. Don't pronounce judgment, and don't tell them that what they want is impossibly unrealistic. Instead, ask them how what they want could work in the current business environment. Would it speed up patient throughput, or slow it down? Would it cost more, or would the proposal save money downstream? Increase or decrease revenue? More patients or fewer patients? Get them to think through the business implications, and don't be surprised when their thinking and that of Finance starts to converge. If an idea looks promising on paper, and the concept is sound, why not help the clinicians flesh out their plans? That's collaboration.

How can finance professionals pick up the operating knowledge they need to collaborate successfully with those with whom they are working? Just ask them. Volunteer. Ask the nurse manager if she needs some help on the floor for an afternoon. Ask the radiology manager if he could use an extra hand to help register patents for a day and learn the process first-hand. Ask the surgery director for a personal tour and observe the operation. Doing this not only increases Finance's knowledge and effectiveness, it vastly improves trust. Taking the time to learn, and not direct or compel, makes Finance a critical part of the clinical team, not an enforcer on the outside looking in. That's collaboration.

Collaborate? Collaborate on What?

Let's take the labor budget as a good example. Finance often assumes that its budgets and its proscriptions will be rigorously adhered to, as if routine budget discipline were a thing of the past, and that everyone will obey. Too often, Finance tries to force better productivity by employing budget cuts, hiring freezes, and layoffs, hoping that clinicians will somehow figure it all out. Or Finance gives clinical managers some complex reports, hoping that act will accomplish something dramatic. None of these methods works.

In the real world, managers complain that budgets are arbitrary, capricious, and don't reflect reality. There is no "ownership" and no commitment. Is it any surprise that budget discipline is missing in action? What's wrong with this model? No collaboration.

The typical labor budget process begins with collecting the last six months or so of all department's hours, wages, and workload statistics (if any). Hours and wages are divided into numerous skill mix categories and job classes, and then further subdivided into fixed and variable categories. In the world of the budget, it seems that some people, some of the time, are intimately connected with the work of a unit, whether that be patients, treatments, visits, days, or procedures, and some are not—except when they are replaced while on vacation (or not). Some people working in a department aren't really connected to others in the same department who care for patients, but they work there anyway.

Next, employees who are involved with patients are divided by the numbers of those patients, while the other group of employees in the same department is set off by themselves, adrift without a tether to any patients, as it were. Volume is forecasted, the ratio of those "connected" to patients is multiplied by the forecasted volume, and then the "unconnected" are added back in, without regard to how many "connected employees" and patients there are, or will be.

Thus, every worker is placed into one of several job categories, matched against patient volume (or not), and next year's total labor is calculated for each department. But managers don't really care about this. They only look at the budget total, the layers of ratios and other mathematical minutia beyond their customary set of job skills. If the budget is higher than what they currently have, they press hard to hire up quickly. If the budget is less than what they currently run at, they make an appeal to senior management to change the budget, or they ignore it (more or less) over the course of the next year. If they can get away with ignoring it for the first six months or so, the cost "overrun" will form the base for the next year's budget.

If the reader can follow all this, he or she is not a typical clinical manager, but a finance professional, and the audience (aka customers) has been left behind in their "ignorance." Mathematical perfection might have been achieved, but it will amount to little. The audience doesn't understand what it is that they're supposed to do, the math is too difficult to follow, and they end up ignoring it, hoping to be left alone to do their jobs.

This is the "machine" approach. It doesn't rely upon messy collaboration but upon control. This programmed approach works well for machines, but the actual behavior of human beings working in a service industry like healthcare is difficult, even impossible, to model precisely. Machines lack motivation; they either work or fail, but people aren't so simple. How do organizations attend to the human factor so often missing in finance work? Why should clinicians support patient growth and financial objectives? Why should people enthusiastically contribute—not merely attend meetings and sit there, inert, but eagerly collaborate? What's in it for them and their patients? How can Finance persuade managers not to hope that its productivity efforts will blow over and die through utter indifference?

Now Let's Act as a Team

What would the budget process look like if it were truly collaborative?

First, the process would be designed to meet the "customers" where they are, not where Finance wishes they would be. Clinical managers are hired primarily for having strong technical expertise in their field and the ability to coordinate the work of others, and not their financial acumen. That, after all, is a good thing for the patients. Clinicians do not have, and never will have, the skills of a good financial analyst. The reverse is also true—a financial analyst will never have the skills of a fine clinician. They are different jobs, each with their own purpose.

Second, the new budgeting process would allow and encourage managers to succeed, not set them up for failure. No one wants to write negative variance reports all year long based upon unrealistic assumptions.

Third, the new collaborative process would meet organizational objectives, while still allowing individuals to realize their personal and professional goals. If the organization benefits from the outstanding contributions of a dedicated and talented manager, it seems fitting that the manager should somehow benefit from giving his or her best.

The new budget process would begin by collaborating with clinicians to discover the workload measures that best define their mission, patients, or purpose. Nothing would be ruled out. The ability to collect automated figures would have no bearing on finding and using the right measure. Visits, treatments, procedures, and exams would be weighted to adjust for service intensity, so that no manager was ever hurt or helped by something out of his or her control. If the midnight census on a nursing unit was not representative of nursing workload, then all the census levels could be summed, and different levels of patients on the unit could even be weighted for service intensity. A budget analyst would be eager to assist and spend the time and effort required to ensure that clinicians were satisfied that they had identified the best driver of workload. To strengthen accountability, clinical managers, not Finance, would choose the measure to be adopted. The budget analyst would be an internal consultant, a partner and a guide, offering advice and expertise, not a budget cop.

Next, Finance would work with clinicians to find the hours per unit and costs per unit that reflect reality as it exists today—not a labor standard derived from an unknown department in an nameless hospital—but one from their own history, tailored to their unique operation. In a spirit of true partnership, Finance would guarantee to clinicians that their labor standards would only change if there were a change in operations, technology, function, or purpose. Finance and Administration would stop trying to whittle away at what was so painstakingly worked out together, thereby undermining trust, and destroying any future hope of working in concert. If managers needed help to achieve their goals, Finance would be generous and prompt with its expertise. Finance would no longer pretend to be interested in forcing managers to write lame negative variance reports that no one reads. Instead, it would collaborate with managers to ensure that each of them succeeds. Finance would be a valued member of the clinical team.

The organization would provide very simple monitoring reports, without the excessive detail and unnecessary frequency that so confounds understanding among the very people who are its intended audience of users. Rather than aiming for ultimate control, Finance would abandon complexity and offer a simplified, realistic system that managers could understand and accept. Since clinicians are busy people with important jobs, Finance would respect that, and wouldn't burden them with more than one side of one page. How would Finance know that managers really understood these new, simplified reports? It would ask them. It would design the system around the manager's specifications, and then check for understanding, revising the design as needed.

Instead of micromanaging and second-guessing department managers, Administration would give them new authority to manage their units as they saw fit—provided they met standard. Administration would remove any obstacles that stood in the way of having managers make operating decisions that enhance productivity and accountability.

Instead of trying to cascade a host of top-level organizational goals down to departments that have no control over the outcome, the focus would be on what each manager could accomplish within his or her scope of influence, and reward outstanding results handsomely. Administration would try to transform all of its managers into star performers by giving them sizable incentives to achieve department-specific outcomes that the organization highly values. It would seek to unleash talent, drive, and dedication.

Collaboration Changes Company Culture

The collaborative method differs from the traditional command-and-control system by giving those whom it affects a direct say in shaping the operating environment and structure. The collaborative management style tends to be decentralized, building from the ground up, rather than dictated from the top down. It encourages reasonable people to find agreement by working together on already existing common principles. It empowers, not restricts, rewarding creativity and entrepreneurship, and not punishing such desirable qualities. Collaborative management grants the freedom to question and make genuine operational improvements, relying on self-control, not on external control from above. Ultimately, if Finance wants true collaboration, and desires to change company culture for the better, it must change itself first.