Care CEUs

Continuing Education for Nursing Home Administrators

Financial and Expense Management

Introduction

In the current health care climate, financial and expense management is paramount to the success of a health care organization. The questions is, how can nursing home and assisted living administrators effectively manage the finances and expenses of their health care organization? This course will answer that very question, while providing financial and expense management recommendations that may be used by nursing home and assisted living administrators to ensure the financial future of their health care organization.

Section 1: Group Purchasing Organizations (GPOs)

A health care administrator is tasked with managing the finances and expenses of a nursing home. The health care administrator begins by reviewing the budget, resident population, staffing needs, and the impact of the coronavirus disease 2019 (COVID-19) pandemic. After some consideration, the health care administrator asks a colleague the following question: how can nursing home and assisted living administrators effectively manage the finances and expenses of their health care organization? In the current health care climate, the aforementioned question is a common one. Fortunately, the answer to the aforementioned question is rather straightforward. Health care administrators can effectively manage the finances and expenses of their health care organization by incorporating the five essential elements of effective financial and expense management for health care organizations into the cultural, executive, and directional structure of their health care organization. With that in mind, this section of the course will review the first essential element of financial and expense management for health care organizations, which is to utilize group purchasing organizations (GPO)s, when appropriate. The information found within this section of the course was derived from materials provided by the American Medical Association unless, otherwise, specified (American Medical Association, 2019).

What is a group purchasing organization (GPO)?

The term group purchasing organization (GPO) may refer to an organization that negotiates prices for drugs, devices, and other medical products and services on behalf of health care providers/organizations (e.g., nursing homes).

Health care administrators should note that the main purpose of a GPO is to enhance the quality of the services delivered and lower health care providers'/organizations' operating costs by reducing transaction costs and negotiating lower prices for supplies.

How does a GPO typically work to save health care organizations money?

A GPO typically works to save health care organizations money by negotiating contracts between medical supply and service vendors and health care providers/organizations, which reduces transaction costs, and, ultimately, provides health care providers/ organizations lower prices for needed supplies.

How do GPOs impact the health care system?

Research indicates that GPOs deliver billions in cost savings every year to the health care system.

Health care administrators should note the following: a recent analysis of Medicare claims data by health care economists found that GPOs reduced health care costs by up to $55 billion annually, and up to $864 billion over 10 years; the Federal Trade Commission Chairman found that health care organizations can save 10% to 18% by buying through GPOs.

How is a GPO typically financed?

A GPO is typically financed, at least in part, by vendor fees.

Are health care providers/organizations and suppliers required to use GPOs?

No, the use of a GPO is voluntary.

How many GPOs exist in the U.S.?

There are more than 600 GPOs operating in the U.S. (e.g., Premier Inc., MedAssets, and Intalere).

How do U.S. laws and regulations apply to GPOs and the use of GPOs, and what are related considerations regarding GPOs?

Anti-kickback statutes and related "safe harbor" regulations typically apply to GPOs (note: the term kickback may refer to a misappropriation of funds that enriches a person and/or an organization) (U.S. Department of Health and Human Services, 2021).

The anti-kickback statute (AKS) may refer to a criminal law that prohibits the knowing and willful payment of "remuneration" to induce or reward patient referrals or the generation of business involving any item or service payable by the Federal health care programs (e.g., drugs, supplies, or health care services for Medicare or Medicaid patients). Remuneration includes anything of value and can take many forms besides cash, such as free rent, expensive hotel stays and meals, and excessive compensation for medical directorships or consultancies. In some industries, it is acceptable to reward those who refer business to individuals. However, in the Federal health care programs, paying for referrals is a crime**.** The statute covers the payers of kickbacks-those who offer or pay remuneration- as well as the recipients of kickbacks-those who solicit or receive remuneration. Each party's intent is a key element of their liability under the AKS (U.S. Department of Health and Human Services, 2021).

Criminal penalties and administrative sanctions for violating the AKS include fines, jail terms, and exclusion from participation in the Federal health care programs. Under the CMPL, physicians who pay or accept kickbacks also face penalties of up to $50,000 per kickback plus three times the amount of the remuneration (U.S. Department of Health and Human Services, 2021).

Safe harbors protect certain payment and business practices that could otherwise implicate the AKS from criminal and civil prosecution. To be protected by a safe harbor, an arrangement must fit squarely in the safe harbor and satisfy all of its requirements. Some safe harbors address personal services and rental agreements, investments in ambulatory surgical centers, and payments to bona fide employees (U.S. Department of Health and Human Services, 2021).

The federal anti-kickback statute provides criminal penalties for individuals or entities that knowingly and willfully offer, pay, solicit, or receive remuneration to induce business reimbursed under the Medicare or state health care programs. The Secretary of the U.S. Department of Health and Human Services (HHS) delegated authority over the anti-kickback statute to the HHS Office of Inspector General (OIG) (U.S. Department of Health and Human Services, 2021).

This provision is extremely broad. The types of remuneration covered specifically include kickbacks, bribes, and rebates made directly or indirectly, overtly or covertly, or in cash or in kind. In addition, prohibited conduct includes not only remuneration intended to induce referrals of patients, but also intended to induce the purchasing, leasing, ordering, or arranging for any good, facility, service, or item paid for by Medicare or state health care programs (U.S. Department of Health and Human Services, 2021).

Because of the broad reach of the statute, concern was expressed that some relatively innocuous commercial arrangements were covered by the statute and, therefore, potentially subject to criminal prosecution. In response, Congress provides statutory exceptions from illegal remuneration where the anti-kickback statute does not apply. In addition, Congress specifically required the development and promulgation of regulations, the so-called safe harbor provisions, that would specify various payment and business practices that would not be treated as criminal offenses under the anti-kickback statute, even though they may potentially be capable of inducing referrals of business under federal health care programs. In authorizing HHS to protect certain arrangements and payment practices under the anti-kickback statute, Congress intended that the safe harbor regulations be updated periodically to reflect changing business practices and technologies in the health care industry (U.S. Department of Health and Human Services, 2021).

Accordingly, the legal framework governing the anti-kickback statute includes both statutory exceptions and regulatory safe harbors. The federal government considers the statutory exceptions and regulatory safe harbors as co-terminus, meaning that they cover the same conduct and the regulatory safe harbor is implementing the statutory safe harbor. Industry and the provider community have argued that they are distinct, separate protections. For example, a provider could receive protection under the statutory exception for discounts even if the arrangement would not fit within the counterpart regulatory safe harbor. Whether the protections are co-terminus or distinct is an open legal question that depends on the legal precedent of case law in each federal circuit (if a circuit has considered this specific issue) (American Medical Association, 2019).

With GPOs, congress enacted section 9321 of the Omnibus Budget Reconciliation Act of 1986, which excludes from the definition of “remuneration” certain fees paid by vendors to GPOs from prosecution under the anti-kickback statute. According to the legislative history, Congress believed that GPOs could help reduce health care costs for the government and private sector organizations alike by enabling a group of purchasers to obtain substantial volume discounts on the prices they are charged (American Medical Association, 2019).

In 1991, OIG issued a final rule implementing a GPO safe harbor to apply to payments from vendors to entities authorized to act as a GPO for individuals or entities who are furnishing Medicare or Medicaid services; the proposed safe harbor required a written

agreement between the GPO and the individual or organization that specifies the amounts vendors will pay the GPO (American Medical Association, 2019).

To qualify for protection under the GPO safe harbor, a GPO must have a written agreement with each individual or organization for which items or services are furnished. That agreement must either provide that participating vendors from which the individual or organization will purchase goods or services will pay a fee to the GPO of three percent or less of the purchase price of the goods or services provided by that vendor or, in the event the fee paid to the GPO is not fixed at three percent or less of the purchase price of the goods or services, specify the amount (or if not known, the maximum amount) the GPO will be paid by each vendor (American Medical Association, 2019).

Where the organization that receives the goods or services from the vendor is a health care provider of services, the GPO must disclose in writing to the organization at least annually, and to the Secretary upon request, the amount received from each vendor with respect to purchases made by or on behalf of the entity. As explained in the preamble to the final regulations, the safe harbor is not intended to protect fees to arrange for referrals or recommendations within a single entity. Therefore, the safe harbor provides that "Group Purchasing Organization" means an entity authorized to act as a purchasing agent for a group of individuals or organizations who are furnishing services for which payment may be made in whole or in part under Medicare, Medicaid, or other federal health care programs, and who are neither wholly owned by the GPO nor subsidiaries of a parent corporation that wholly owns the GPO (either directly or through another wholly owned entity) (American Medical Association, 2019).

If a GPO meets the above requirements, it fits within the GPO safe harbor and its administrative fees will not be subject to criminal prosecution under the anti-kickback statute (note: these administrative fees may cover a variety of services) (American Medical Association, 2019).

The discount statutory exception applies to arrangements where there is a discount or other reduction in price that was obtained by a provider or other organization when such discounts are properly disclosed and reflected in the costs for which reimbursement could be claimed; Congress included the discount exception to ensure that the practice of discounting in the normal course of business transactions would not be deemed illegal(American Medical Association, 2019).

The regulatory discount safe harbor exempts from the definition of remuneration discounts on items or services for which the federal government may pay and certain disclosure requirements are met; a discount means a reduction in the amount a buyer is charged for an item or service based on an arms-length transaction; in addition, rebates are also covered under the discount safe harbor to mean an amount that is described in writing at the time of the purchase but is not paid at the time of sale; the safe harbor also specifically excludes from the definition of a discount cash or cash-equivalents (except for rebates in the form of a check); certain swapping arrangements (e.g., induce purchasing one good for another good); exempted remuneration from other safe harbors (e.g., warranties); and other remuneration, in cash or in kind not explicitly described by the safe harbor (American Medical Association, 2019).

The regulatory safe harbor disclosure requirements vary based on the type of entity - buyer; seller - in the discount arrangement; moreover, a buyer's disclosure requirements depend on whether the entity is acting under a risk contract; reports costs on a cost report; or submits a claim or a request for payment is submitted for the discounted item or service and payment may be made, in whole or in part, under Medicare, Medicaid, or other federal health care programs (American Medical Association, 2019).

A GPO's up-front discount is covered by the statutory exception and the regulatory safe harbor if properly disclosed, and it will not be subject to criminal prosecution under the anti-kickback statute(American Medical Association, 2019).

This safe harbor protects certain payments made by a principal to an agent as compensation for the agent's services; protection applies only if certain standards are met that limit the opportunity to provide financial incentives in exchange for referrals; these standards include that aggregate compensation is set in advance, consistent with fair market value in an arms-length transaction, and not determined in a manner that takes into account the volume or value of any referrals or business generated between the parties (American Medical Association, 2019).

If a GPO offers additional services that go beyond the administration fees (i.e., direct charges to the provider-members), the GPO may be able to structure such fees under the personal services safe harbor and receive protection from criminal prosecution under the AKS (American Medical Association, 2019).

The OIG's only formal pronouncement on PBMs and the GPO regulatory Safe Harbor is found in sub-regulatory guidance: Compliance Program Guidance for Pharmaceutical Manufacturers issued in 2003; any rebates or other payments by drug manufacturers to

PBMs that are based on the PBM's customers' purchases potentially implicate the anti-kickback statute; protection is available by structuring such arrangements to fit in the GPO safe harbor; that safe harbor requires, among other things, that the payments be authorized in advance by the PBM's customer and that all amounts actually paid to the PBM on account of the customer's purchases be disclosed in writing at least annually to the customer and to HHS upon request; in addition, Medicare Part D sponsors and other entities that provide PBM services are required to report various data elements to CMS; the statute specifies that this data is confidential and generally must not be disclosed by the government or by a plan receiving the information (American Medical Association, 2019).

The OIG potentially extended the GPO regulatory Safe Harbor, which is meant to cover administrative fees, to include "any rebates or other payments; thus, PBMs can argue that fees and rebates have protection under the GPO Safe Harbor; however, PBMs would attempt to fit non-administrative fees within different safe harbors first and then potentially rely on GPO Safe Harbor as a backstop (American Medical Association, 2019).

On February 6, 2019, HHS issued a proposed rule to amend the safe harbor regulations concerning discounts; HHS is proposing to disallow these traditional discount/rebate arrangements for plan sponsors under Part D and Medicaid Managed Care Organizations and attempt to instead pass any price concession directly to the beneficiary at the point-of-sale of the drug; they are proposing changes to the anti-kickback safe harbor regulation concerning discounts; under the proposal, CMS would eliminate the current safe harbor protections for discounts paid by manufacturers directly to plan sponsors and PBMs; HHS also proposes the creation of two new safe harbor protections: protection for reductions in price at the point-of-sale and protection for fixed fees paid to PBMs for services rendered to manufacturers.

All GPO contracts are voluntary and the product of market negotiations; hospitals and other health care providers are generally not required to only contract with one GPO and may belong to multiple GPOs; vendors are not required to contract with GPOs and health care providers are not required to use the contracts negotiated by GPOs with their vendors; while GPOs may negotiate sole-source contracts, providers are generally not required to purchase through their GPO contracts but can instead purchase supplies off contract by negotiating their own prices directly with suppliers; in economic models, on-contract prices are not necessarily the lowest available; off-contract prices are sometimes lower; however, off-contract prices could be lower than on-contract prices

because of the presence of the GPO; without the GPO, the off-contract price could potentially be higher (American Medical Association, 2019).

Section 1 Summary

The first essential element of financial and expense management for health care organizations is to utilize GPOs, when appropriate. GPOs may refer to organizations that negotiate prices for drugs, devices, and other medical products and services on behalf of health care providers/organizations (e.g., nursing homes). Health care administrators should note that the main purpose of a GPO is to enhance the quality of the services delivered and lower health care providers'/organizations' operating costs by reducing transaction costs and negotiating lower prices for supplies.

Section 1 Key Concepts

- The first essential element of financial and expense management for health care organizations is to utilize GPOs, when appropriate.
- The main purpose of a GPO is to enhance the quality of the services delivered and lower health care providers'/organizations' operating costs by reducing transaction costs and negotiating lower prices for supplies.
- A GPO typically works to save health care organizations money by negotiating contracts between medical supply and service vendors and health care providers/organizations.
- The use of a GPO is voluntary.
- Anti-kickback statutes and related "safe harbor" regulations typically apply to GPOs.

Section 1 Key Terms

Group purchasing organization (GPO) - an organization that negotiates prices for drugs, devices, and other medical products and services on behalf of health care providers/organizations

Kickback - a misappropriation of funds that enriches a person and/or an organization (U.S. Department of Health and Human Services, 2021)

Anti-kickback statute (AKS) - a criminal law that prohibits the knowing and willful payment of remuneration to induce or reward patient referrals or the generation of

business involving any item or service payable by the Federal health care programs (U.S. Department of Health and Human Services, 2021)

Discount (within the context of a safe harbor) - a reduction in the amount a buyer is charged for an item or service based on an arms-length transaction

Section 1 Personal Reflection Question

How can health care administrators utilize GPOs to help manage the finances and expenses of their health care organization?

Section 2: Employee Retention

Consistently losing employees can be extremely costly for a health care organization. Therefore, the second essential element of financial and expense management for health care organizations is employee retention and preventing employee turnover (note: employee turnover may refer to the number or percentage of employees who leave an organization). Health care administers can work to retain employees and prevent employee turnover by incorporating the essential elements of employee retention into the cultural, executive, and directional structure of their health care organization. The essential elements of employee retention include the following: effective communication, effective employee grievance resolution, effective employee staffing, reducing employee stress, and employee safety. This section of the course will review the aforementioned essential elements of employee retention, while providing recommendations for their implementation.

Effective Communication

It has been argued that effective communication is absolutely essential to employee retention. Therefore, health care administrators should work to establish effective communication within their health care organization. Specific information regarding effective communication may be found below. The information found below was derived from materials provided by the Harvard Public Health Review, unless, otherwise, specified (Ratna, 2019).

What is communication?

Communication may refer to the process of transmitting information and messages from one individual or party to another individual or party in order to obtain meaning and a common understanding.

Effective communication occurs when information and messages are adequately transmitted, received, and understood.

Health care administrators should note that communication may be verbal or nonverbal. Verbal communication may refer to the use of sounds and/or words to transmit information/messages (e.g., one individual says "hello" to another individual; one individual says "yes" or "no" to another individual). Nonverbal communication may refer to the use of gestures, facial expressions, eye contact, body language, posture, and/or other means that do not involve sounds and/or words to transmit information/messages (e.g., one individual gives another individual the "thumbs up" to indicate satisfaction and/or approval). Health care administrators should also note that exchanges between individuals or parties may include both verbal and nonverbal communication.

What is the communication process?

The communication process may refer to the exchange of information and messages from a sender, through a selected channel, to a receiver.

What are the key elements of the communication process?

As previously alluded to, the key elements of the communication process include the following: sender, channel, and receiver. Additional elements of the communication process include: encoding, decoding, and feedback. Specific information regarding the aforementioned key elements of the communication process may be found below.

- **Sender** - the sender, in the context of the communication process, may refer to the individual or party who initiates communication by using sounds, words, gestures, facial expressions, tones of voice, eye contact, body language, posture, and/or other means to transmit a message (i.e., the source that originates a message).
- **Channel** - the channel, in the context of the communication process, may refer to the medium which is used to carry communication (e.g., verbal messages, nonverbal cues, written words, numbers, and symbols).
- **Receiver** - the receiver, in the context of the communication process, may refer to the individual or party to whom a message is sent (i.e., the audience).
- **Encode** - the process of selecting sounds, words, gestures, facial expressions, tones of voice, eye contact methods, body language, postures, and/or other means to generate a message.

- **Decode** - the process of receiving, interpreting, and attempting to understand an encoded message in order to obtain meaningful information.
- **Feedback** - a receiver's response to a sender's message (i.e., a receiver sends a message to a sender).

What are the essential steps involved in the communication process?

The essential steps involved in the communication process include the following:

1. A sender has a desire to convey an idea or concept via a message
2. A sender encodes an idea or concept into a message
3. A sender transmits a message via a channel
4. A receiver takes in the message sent by the sender
5. The receiver decodes the message
6. The receiver provides feedback to the sender

Health care administrators should note that noise may interfere with the previously highlighted steps and, ultimately, with the communication process. Noise, in the context of communication, may refer to anything that distorts or disrupts a message and/or the communication process. Health care administrators should also note that noise can act as a barrier to effective communication. Specific types of noise include the following: physical noise, physiological noise, psychological noise, and semantic noise. Specific information regarding the aforementioned types of noise may be found below.

- **Physical noise** - physical noise may refer to external or environmental stimulus that acts as a distraction (e.g., excessive talking, screaming, and loud music).
- **Physiological noise** - physiological noise may refer to a distraction related to physiological functions (e.g., hunger, thirst, and fatigue).
- **Psychological noise** - psychological noise may refer to preconceived notions (e.g., reputations, biases, and assumptions) that interfere with the encoding and decoding process.
- **Semantic noise** - semantic noise may refer to a disturbance that occurs in the transmission of a message that interferes with the interpretation of a message due the ambiguity of chosen sounds, words, gestures, facial expressions, tones of

voice, eye contact methods, body language, postures, and/or other means of communication.

What is interpersonal communication?

Interpersonal communication may refer to an exchange of information and messages between two or more individuals or parties.

Health care administrators should note that interpersonal communication may occur in both personal and professional settings.

How may communication flow during interpersonal communication?

During interpersonal communication, communication typically flows in one direction or in two directions. Specific information regarding the possible directions of communication may be found below.

- **One-way communication** - one-way communication occurs when information/a message is sent in only one direction, from sender to receiver. Health care administrators should note that, typically, one-way communication is used to inform, persuade, or command.
- **Two-way communication** - two-way communication occurs when information is transmitted and flows freely among individuals and parties (i.e., information is sent in a back and forth manner between individuals or parties). Health care administrators should note that two-way communication is essential to establishing a shared understanding among individuals or parties.

What is organizational communication?

Organizational communication, in the context of this course, may refer to the process of sending and receiving information/messages among interrelated individuals within a given organization, such as a health care facility.

Examples of organizational communication within a health care facility may include the following: a health care manager gives instructions to a health care professional; two health care professionals discuss a patient's medications; a health care professional provides education to a group of health care professionals; a health care professional writes another health care professional a note regarding a patient; health care professionals exchange emails regarding specific interventions.

How does communication typically move or flow within an organization?

Communication typically moves or flows, within an organization, in a vertical and/or a horizontal manner.

- **Vertical communication** - vertical communication, within the context of organizational communication, may refer to the flow of communication between individuals associated with the same organization who are on different levels of the organization's hierarchy. Health care administrators should note that vertical communication may flow in a downwards or upwards manner. Downward communication occurs when organizational leaders or managers share information with lower-level employees (e.g., a nurse manager gives a nurse instructions). Upward communication occurs when lower-level employees share information with organizational leaders or managers (e.g., a health care professional informs a health care manager of a safety hazard). Health care administrators should also note that vertical communication is essential to creating and maintaining a shared understanding between organizational leaders, managers, and employees.
- **Horizontal communication** - horizontal communication, within the context of organizational communication, may refer to the flow of communication between individuals and/or departments that are on the same level of a given organization (e.g., a health care manager provides information to another health care manager; an intensive care nurse provides another intensive care nurse with relevant patient information). Health care administrators should note that horizontal communication may be an essential element to effective teamwork within a given health care facility.

Health care administrators should note that communication may also flow into and out of an organization. For example, during a health care emergency, such as a pandemic, information may flow into a health care facility from government officials, while information about health care may flow out of a health care facility to specific government officials.

Why is effective communication important to employee retention and, ultimately, health care?

Effective communication is important to employee retention and, ultimately, health care for a variety of different reasons including the following: promotes safe and effective

health care; promotes and fosters medical error prevention; creates the potential to optimize patient care; and promotes effective teamwork. Specific information on the aforementioned reasons why effective communication is important to employee retention and, ultimately, health care may be found below. The information found below was derived from materials provided by the Joint Commission (Joint Commission, 2021).

- **Promotes safe and effective health care** - first and foremost, effective communication can help health care professionals administer safe and effective health care. Essentially, effective communication can help health care professionals transmit and receive vital patient information essential to health care such as the following: patient vital signs, patient lab results, patient medication information, patient symptoms, and patient disease states. Health care administrators should note the following: health care professionals are more likely to work or continue to work for a health care organization that promotes safe and effective health care.

- **Medical error prevention** - the term medical error may refer to a preventable adverse effect of care that may or may not be evident or causes harm to a patient. In an ideal health care climate, medical errors would not occur - however, the simple truth of the matter is that they often do occur. That being the case, health care administrators should note that effective communication can help prevent medical errors from occurring. For example, proper medication labeling, adequate alarm systems, and patient education can be methods to communicate key information that can help prevent medical errors from occurring. Health care administrators should also note the following: the prevention of medical errors can help prevent situations that may lead to the loss of an employee (e.g., a health care professional chooses to resign from a health care organization where medical errors are prevalent and are contributing to increasing patient mortality and morbidity rates).

- **Creates the potential to optimize patient care** - by helping to promote safe and effective health care and by reducing medical errors from occurring, effective communication can, ultimately, create the potential to optimize patient care. Health care administrators should note that working to optimize patient care may contribute to employee satisfaction, and thus, employee retention.

- **Promotes effective teamwork** - communication is an essential element of effective teamwork. Within the team setting, communication can be used to allow individuals to understand their roles, set goals, transmit and receive points

of interest, provide status reports, share knowledge, make adjustments, and, ultimately, achieve desired results. In essence, in a health care setting, effective communication can help health care professionals work as a cohesive unit to ensure patients receive the care they need. Health care administrators should note that effective teamwork can help health care professionals create bonds that may impact employee satisfaction, and thus, employee retention.

- **Health care professional employee satisfaction** - to build on the previous point of interest, effective communication between fellow health care professionals can lead to the formation of personal and professional relationships that have the potential to bring health care professionals satisfaction regarding their health care organization. Health care professionals should note the following: employee satisfaction may refer to an employee's perceived level of contentment related to his or her place of employment; employee satisfaction can promote employee retention.

Effective Employee Grievance Resolution

A grievance, as it pertains to a professional setting, may refer to a matter of concern regarding a potential violation of work-related rights, which is formally submitted, without fear of retaliation, and requires a formal response. With that said, unresolved grievances may lead to employee dissatisfaction, law suits, government intervention, and, ultimately, to the loss of an employee(s). Therefore, health care administrators should work to effectively resolve grievances, within a health care organization, in order to retain employees. Health care administrators can work to effectively resolve grievances, within a health care organization, by adopting a grievance resolution process. An example of a grievance resolution process may be found below. Health care administrators may use the example found below or a similar, organizational specific grievance resolution process to help resolve grievances with their health care organization.

Example Grievance Resolution Process

- **Step 1:** Encourage employees to share concerns and to seek grievance resolution - health care administrators should ensure that all health care facility staff and management encourage employees to share their concerns and to seek grievance resolution (note: the first step towards resolving employee grievances begins well before a formal employee grievance is even submitted). In essence, the first step to resolving employee grievances is to make sure existing employee grievance

policies and procedures help establish a professional culture where the voicing of employee concerns and grievances is welcomed by the health care organization and resolved quickly to avoid grievance escalation.

- **Step 2:** Designate an employee(s) to head or manage the grievance resolution process - every health care organization should have a designated employee(s) to head/manage the process of resolving formal employee grievances. Typically, the designated employee heads/manages the grievance resolution process from beginning to end (i.e., the designated employee handles the grievance resolution process from the time a formal employee grievance is submitted until the time the formal employee grievance is officially resolved). The designated employee may also serve as a contact individual for the employee who submitted the formal employee grievance. Establishing a contact individual for employees during the grievance resolution process can help foster effective communication, which is often essential to the grievance resolution process.

- **Step 3:** Acknowledge the receipt of a formal employee grievance - if a formal employee grievance is submitted, the health care organization should acknowledge, in some fashion, that the formal employee grievance was received. Doing so can inform the employee, who submitted the formal employee grievance, that the formal employee grievance resolution process has been initiated. Additionally, it can indirectly or directly inform the employee that his or her formal employee grievance, in some way, has been heard. The simple truth of the matter is, that when individuals have a concern or grievance, they want to be heard by those in a position to resolve or alleviate the concern or grievance. By letting the employee know his or her formal employee grievance was received, it can let the employee know he or she is being heard by those who can work to resolve the grievance. Furthermore, acknowledging the receipt of a formal employee grievance can potentially help avoid or prevent grievance escalation. Often, when individuals feel like their concerns or grievances are not listened to or heard, they escalate the process of voicing their concerns or grievances until they are heard. When individuals escalate the process of voicing their concerns or grievances until they are heard, negative results can occur such as: additional grievances, disruptions, disturbances, and intense arguments, all of which should be avoided in the health care setting due to their potential to negatively impact patient care. Thus, by acknowledging the receipt of a formal employee grievance, health care organizations can let their employees know they are being heard and potentially avoid grievance escalation.

- **Step 4:** Gather information - once the receipt of a formal employee grievance is acknowledged, those responsible for managing the employee grievance resolution process should begin gathering relevant information. Information regarding a grievance may come from many different sources including: the employees involved in the grievance, other employees not directly involved in the grievance, additional witnesses, organizations' policies, as well as state and federal laws. With that said, health care administrators should note that objectivity is necessary when gathering information.

- **Step 5:** Document the process of employee grievance resolution - the employee grievance resolution process should be documented (i.e., the formal grievance, any employee statements, any information relating to grievance resolution or the grievance decision/the health care organization's formal decision regarding a submitted grievance should be officially documented). Documentation can provide information to employees regarding the grievance resolution process and the health care organization's formal decision. Documentation can also prove to be valuable if any state, federal, or attorney intervention, regarding a grievance, occurs.

- **Step 6:** Formulate a decision - once all relevant information has been gathered and documented, a formal decision regarding an employee grievance must, eventually, be made. Health care administrators should note that formal decisions regarding an employee grievance must be made within the designated time line specified in their organization's employee grievance policies and procedures (e.g., if an organization's employee grievance policies and procedures specify that an official decision regarding an employee grievance must be reached 15 - 30 days after the formal submission of the employee grievance then the decision should be reached within the aforementioned time period).

- **Step 7:** Follow up with the employee(s) involved in a grievance - once an organization reaches an official decision regarding a grievance, the organization should formally follow up with the employee who submitted the grievance and any employees involved in the grievance (i.e., an organization should provide the employee(s) involved in a grievance with documentation).

Effective Employee Staffing

Effective employee staffing can be vital to employee retention, especially in the wake of the COVID-19 pandemic (note: effective employee staffing, in the modern health care

system, occurs when all required schedules and open shifts are filled with consideration for employee satisfaction; employee satisfaction may refer to an employee's perceived level of contentment related to his or her place of employment). That said, there are a variety of different strategies or models that may be used to effectively staff employees. One model, in particular, that is currently standing out among other staffing models as an effective means to staff employees and promote employee retention is known as the collaborative staffing model. Specific information regarding the collaborative staffing model may be found below. The information found below was derived from materials provided by the American Association of Critical-Care Nurses (American Association of Critical-Care Nurses, 2018).

- The collaborative staffing model may refer to an employee staffing model that encourages and allows health care managers and health care professionals to work together to create schedules and/or fill required open shifts across a health care organization.
- The collaborative staffing model helps remove the traditional hierarchical structure of a health care organization that may not be relevant in the modern era of health care.
- In order for the collaborative staffing model to be effective, health care organizations must have a means for health care professionals to view and fill schedules/open shifts.
- In order for the collaborative staffing model to be effective, health care organizations must have a means for health care professionals to communicate information regarding schedules/open shifts.
- In order for the collaborative staffing model to be effective, health care organizations must establish channels for effective horizontal communication.
- The collaborative staffing model can help reduce some of the scheduling burden for health care managers, while providing them additional time to focus on other vital issues or concerns.
- The collaborative staffing model can help health care organizations fill schedules/ open shifts to help meet the demands of the COVID-19 pandemic.
- The collaborative staffing model can help foster professional teamwork, which in turn could help health care professionals create professional bonds that may impact employee retention.

- The collaborative staffing model can help increase employee satisfaction. Health care administrators should note the following: some of the most cited reasons why health care professionals leave health care organizations are centered around scheduling issues and low employee satisfaction; the collaborative staffing model can help health care organizations address the aforementioned reasons why health care professionals leave health care organizations.

Reducing Employee Stress

In order to help reduce employee stress, health care administrators must possess insight into stress. Specific information regarding stress and the effects of stress may be found below. The information found below was derived from materials provided by the CDC unless, otherwise, specified (CDC, 2020).

- Stress may refer to a factor that causes emotional, physical, or psychological tension.
- Stress can be related to a "negative" event such as an accident, as well as a "positive" event such as a promotion.
- Stress may also arise from a significant life event such as: divorce, moving, school graduation, and new employment (note: a significant life event may refer to any major shift in an individual's life).
- Signs/symptoms of stress include the following:
    - Disbelief and shock
    - Tension and irritability
    - Fear and anxiety about the future
    - Difficulty making decisions
    - Feeling numb
    - Loss of interest in normal activities
    - Loss of appetite
    - Nightmares and recurring thoughts about an event
    - Anger

    - Increased use of alcohol and drugs
    - Sadness and other symptoms of depression
    - Feeling powerless
    - Crying
    - Sleep problems
    - Headaches
    - Back pains
    - Stomach problems
    - Trouble concentrating
- Stress can play a role in the development of the following: headaches, high blood pressure, heart disease, diabetes, skin conditions, asthma, arthritis, depression, anxiety, substance abuse, and burn-out.
- Stress is related to burn-out.
- Burn-out may refer to a syndrome conceptualized as resulting from chronic workplace stress that has not been successfully managed (World Health Organization [WHO], 2019). Health care professionals should note that burn-out is characterized by the following three dimensions: feelings of energy depletion or exhaustion; increased mental distance from one's job, or feelings of negativism or cynicism related to one's job; and reduced professional efficacy (WHO, 2019). Health care professionals should also note that burn-out should be avoided because it can lead to suboptimal patient care, employee turnover, and workplace violence (WHO, 2019).
- Health care administrators can help prevent/limit stress and related burn-out by the following means: taking designated breaks, developing schedules that allow for consecutive days off, limiting work hours (when applicable), taking vacation time, engaging in exercise, yoga, tai chi, and/or meditation, connecting socially, and taking part in support groups.

Employee Safety

Lastly, and perhaps most important to employee retention is employee safety. Quite simply put, if a health care professional does not feel safe while working in his or her health care facility, then the health care professional will not continue to work in his or her health care facility. Thus, health care organizations should ensure their health care facility is safe for all employees. To ensure a health care facility is safe for all employees, health care administrators and health care organizations should consider the laws included in the Occupational Safety and Health Act of 1970 (OSH Act). The Occupational Safety and Health Act of 1970 (OSH Act) may refer to the group of labor laws that govern the federal law of occupational health and safety in the private sector and federal government in the U. S. Specific information regarding the OSH Act may be found below. The information found below was derived from materials provided by the United States Department of Labor (United States Department of Labor, 2021).

- The OSH Act was passed to prevent workers from being killed or otherwise harmed at work.
- The OSH Act requires employers to provide their employees with working conditions that are free of known dangers.
- The OSH Act created the Occupational Safety and Health Administration (OSHA), which sets and enforces protective workplace safety and health standards.
- The OSH Act gives workers the right to safe and healthful working conditions. It is the duty of employers to provide workplaces that are free of known dangers that could harm their employees. This law also gives workers important rights to participate in activities to ensure their protection from job hazards.
- The OSH Act states that employers have the responsibility to provide a safe workplace. Employers must provide their employees with a workplace that does not have serious hazards and must follow all OSHA safety and health standards.
- The OSH Act states that employers must inform workers about hazards through training, labels, alarms, color-coded systems, chemical information sheets, and other methods.
- The OSH Act states that employers must train workers in a language and vocabulary they can understand.

- The OSH Act states that employers must keep accurate records of work-related injuries and illnesses.
- The OSH Act states that employers must perform tests in the workplace, such as air sampling, required by some OSHA standards.
- The OSH Act states that employers must provide hearing exams or other medical tests required by OSHA standards.
- The OSH Act states that employers must post OSHA citations and injury and illness data where workers can see them.
- - The OSH Act states that employers must notify OSHA within eight hours of a workplace fatality or within 24 hours of any work-related inpatient hospitalization, amputation, or loss of an eye.
- The OSH Act states that employers must not retaliate against workers for using their rights under the law, including their right to report a work-related injury or illness.
- The OSH Act states that employers must comply with the General Duty Clause of the OSH Act. This clause requires employers to keep their workplaces free of serious recognized hazards and is generally cited when no specific OSHA standard applies to the hazard.
- The OSH Act states that employers must provide most protective equipment free of charge. Employers are responsible for knowing when protective equipment is needed. Examples of protective equipment include: respirators, goggles, and gloves.
- OSHA gives workers and their representatives the right to see information that employers collect on hazards in the workplace. Workers have the right to know what hazards are present in the workplace and how to protect themselves. Additionally, the Hazard Communication standard, known as the “right-to-know” standard, requires employers to inform and train workers about hazardous chemicals and substances in the workplace.
- Many OSHA standards require employers to run tests of the workplace environment to find out if their workers are being exposed to harmful levels of hazardous substances such as lead or asbestos, or high levels of noise or

radiation. These types of tests are called exposure monitoring. OSHA gives workers the right to get the results of these tests.

- OSHA conducts on-site inspections of worksites to enforce the OSHA law that protects workers and their rights. On-site inspections can be triggered by a worker complaint of a potential workplace hazard or violation.
- Workers and their representatives have the right to ask for an inspection without OSHA telling their employer who filed the complaint. It is a violation of the OSH Act for an employer to fire, demote, transfer or retaliate in any way against a worker for filing a complaint or using other OSHA rights.
- When the OSHA area director determines that there has been a violation of OSHA standards, regulations, or other requirements, the area director issues a citation and notification of proposed penalty to an employer (typically following an inspection).
- A citation includes a description of the violation and the date by when the corrective actions must be taken. Depending on the situation, OSHA can classify a violation as serious, willful, or repeat. The employer can also be cited for failing to correct a violation for which it has already been cited. Employers must post a copy of a citation in the workplace where employees will see it.
- Workers and employers can contest citations once they are issued to the employer. Workers may only contest the amount of time the employer is given to correct the hazard. Workers or their representatives must file a notice of contest with the OSHA area office within 15 days of the issuance of a citation.
- Employers have the right to challenge whether there is a violation, how the violation is classified, the amount of any penalty, what the employer must do to correct the violation and how long they have to fix it. Workers or their representatives may participate in this appeals process by electing “party status.” This is done by filing a written notice with the Occupational Safety and Health Review Commission (OSHRC).
- The OSHRC hears appeals of OSHA citations. They are an independent agency separate from the Department of Labor.
- The OSHA area director evaluates complaints from employees or their representatives according to the procedures defined in the OSHA Field Operations

Manual. If the area director decides not to inspect the workplace, he or she will send a letter to the complainant explaining the decision and the reasons for it.

- OSHA will inform complainants that they have the right to request a review of the decision by the OSHA regional administrator. Similarly, in the event that OSHA decides not to issue a citation after an inspection, employees have a right to further clarification from the area director and an informal review by the regional administrator.

- The OSH Act prohibits employers from retaliating against their employees for using their rights under the OSH Act. These rights include filing an OSHA complaint, participating in an inspection or talking to the inspector, seeking access to employer exposure and injury records, raising a safety or health issue with the employer, or any other workers' rights described above. Protection from retaliation means that an employer cannot punish workers by taking "adverse action," such as firing or laying off.

- If an employee has been retaliated against for using their rights, they must file a complaint with OSHA within 30 calendar days from the date the retaliatory decision has been both made and communicated to the employee (the worker). Following a complaint, OSHA will contact the complainant and conduct an interview to determine whether an investigation is necessary.

- If the evidence shows that the employee has been retaliated against for exercising safety and health rights, OSHA will ask the employer to restore that worker's job, earnings, and benefits. If the employer refuses, OSHA may take the employer to court.

- Employees may file a complaint with OSHA concerning a hazardous working condition at any time. However, an employee should not leave the worksite merely because he or she has filed a complaint. If the condition clearly presents a risk of death or serious physical harm, there is not sufficient time for OSHA to inspect, and, where possible, an employee has brought the condition to the attention of his or her employer, an employee may have a legal right to refuse to work in a situation in which you would be exposed to the hazard.

- If a worker, with no reasonable alternative, refuses in good faith to expose himself or herself to a dangerous condition, he or she would be protected from subsequent retaliation. The condition must be of such a nature that a reasonable person would conclude that there is a real danger of death or serious harm and

that there is not enough time to contact OSHA and for OSHA to inspect. Where possible, the employee must have also sought from his employer, and been unable to obtain, a correction of the condition.

- Since passage of the OSH Act in 1970, Congress has expanded OSHA's whistleblower protection authority to protect workers from retaliation under federal law. These laws protect employees who report violations of various workplace safety, airline, commercial motor carrier, consumer product, environmental, financial reform, health care reform, nuclear, pipeline, public transportation agency, railroad, maritime and securities laws. Complaints must be reported to OSHA within set timeframes following the retaliatory action, as prescribed by each law.
- Health care administrators should note the following: OSHA offers cooperative programs under which businesses, labor groups and other organizations can work cooperatively with OSHA; the OSHA Strategic Partnerships (OSP) provide the opportunity for OSHA to partner with employers, workers, professional or trade associations, labor organizations, and/or other interested stakeholders; through the Alliance Program, OSHA works with groups to develop compliance assistance tools and resources to share with workers and employers, and educate workers and employers about their rights and responsibilities.

Section 2 Summary

Health care administrators should work to retain employees. Health care administrators can work to retain employees by incorporating the essential elements of employee retention into the cultural, executive, and directional structure of their health care organization. The essential elements of employee retention include the following: effective communication, effective employee grievance resolution, effective employee staffing, reducing employee stress, and employee safety.

Section 2 Key Concepts

- The second essential element of financial and expense management for health care organizations is employee retention and working to prevent employee turnover.
- The essential elements of employee retention include the following: effective communication, effective employee grievance resolution, effective employee staffing, reducing employee stress, and employee safety.

- Effective communication occurs when information and messages are adequately transmitted, received, and understood.
- Health care administrators can work to effectively resolve grievances, within a health care organization, by adopting a grievance resolution process.
- Effective employee staffing, in the modern health care system, occurs when all required schedules and open shifts are filled with consideration for employee satisfaction.
- The collaborative staffing model can be an effective means to staff employees and promote employee retention.
- In order to help reduce employee stress, health care administrators must possess insight into stress; the signs/symptoms of stress include the following: disbelief and shock; tension and irritability; fear and anxiety about the future; difficulty making decisions; feeling numb; loss of interest in normal activities; loss of appetite; nightmares and recurring thoughts about an event; anger; increased use of alcohol and drugs; sadness and other symptoms of depression; feeling powerless; crying; sleep problems; headaches; back pains; stomach problems; trouble concentrating.
- Stress is related to burn-out.
- To ensure a health care facility is safe for all employees, health care administrators and health care organizations should consider the laws included in the OSH Act.

Section 2 Key Terms

Employee turnover - the number or percentage of employees who leave an organization

Communication - the process of transmitting information and messages from one individual or party to another individual or party in order to obtain meaning and a common understanding

Verbal communication - the use of sounds and/or words to transmit information/ messages

Nonverbal communication - the use of gestures, facial expressions, eye contact, body language, posture, and/or other means that do not involve sounds and/or words to transmit information/messages

Communication process - the exchange of information and messages from a sender, through a selected channel, to a receiver

Sender (within the context of the communication process) - the individual or party who initiates communication by using sounds, words, gestures, facial expressions, tones of voice, eye contact, body language, posture, or other means to transmit a message; the source that originates a message

Channel (within the context of the communication process) - the medium which is used to carry communication

Receiver (within the context of the communication process) - the individual or party to whom a message is sent; the audience

Encode - the process of selecting sounds, words, gestures, facial expressions, tones of voice, eye contact methods, body language, postures, and/or other means to generate a message

Decode - the process of receiving, interpreting, and attempting to understand an encoded message in order to obtain meaningful information

Feedback - a receiver's response to a sender's message

Noise (within the context of communication) - anything that distorts or disrupts a message and/or the communication process

Physical noise - external or environmental stimulus that acts as a distraction

Physiological noise - a distraction related to physiological function(s)

Psychological noise - preconceived notions

Semantic noise - a disturbance that occurs in the transmission of a message that interferes with the interpretation of a message due the ambiguity of chosen sounds, words, gestures, facial expressions, tones of voice, eye contact methods, body language, postures, and/or other means of communication

Interpersonal communication - an exchange of information and messages between two or more individuals or parties

Organizational communication (within the context of this course) - the process of sending and receiving information/messages among interrelated individuals within a given organization such as a health care facility

Vertical communication (within the context of organizational communication) - the flow of communication between individuals associated with the same organization who are on different levels of the organization's hierarchy

Horizontal communication (within the context of organizational communication) - the flow of communication between individuals and/or departments that are on the same level of a given organization

Medical error - a preventable adverse effect of care that may or may not be evident or causes harm to a patient

Employee satisfaction - an employee's perceived level of contentment related to his or her place of employment

Grievance (as it pertains to a professional setting) - a matter of concern regarding a potential violation of work-related rights, which is formally submitted, without fear of retaliation, and requires a formal response

Employee satisfaction - an employee's perceived level of contentment related to his or her place of employment

Collaborative staffing model - an employee staffing model that encourages and allows health care managers and health care professionals to work together to create schedules and/or fill required open shifts across a health care organization

Stress - a factor that causes emotional, physical, or psychological tension

Significant life event - any major shift in an individual's life

Burn-out - a syndrome conceptualized as resulting from chronic workplace stress that has not been successfully managed (WHO, 2019)

Occupational Safety and Health Act of 1970 (OSH Act) - the group of labor laws that govern the federal law of occupational health and safety in the private sector and federal government in the U. S.

Section 2 Personal Reflection Question

How can health care administrators effectively incorporate the essential elements of employee retention into the cultural, executive, and directional structure of their health care organization?

Section 3: Grants and Federal Funding Opportunities

The third essential element of financial and expense management for health care organizations is to actively seek grants and federal funding opportunities, which may be used to help financially support health care organizations and/or older adult residents (note: the term older adult may refer to an individual 65 years or older). With that in mind, this section of the course will review grants and federal funding opportunities that may be used to help financially support health care organizations and/or older adult residents. The information found within this section of the course was derived from materials provided by the U.S. government unless, otherwise, specified (Centers for Medicare and Medicaid Services, 2021; U.S. Department of Housing and Urban Development, 2021; U.S. Department of Veterans Affairs, 2020).

Civil Money Penalty (CMP) Funds

A civil money penalty (CMP) is a monetary penalty the Centers for Medicare and Medicaid Services (CMS) may impose against nursing homes for either the number of days or for each instance a nursing home is not in substantial compliance with one or more Medicare and Medicaid participation requirements for long-term care facilities. A portion of CMPs collected from nursing homes are returned to the states in which CMPs are imposed. State CMP funds may be reinvested to support activities that benefit nursing home residents and that protect or improve their quality of care or quality of life.

CMP funds may be used for (but not limited to) the following:

- Assistance to support and protect residents of a facility that closes or is decertified
- Time-limited expenses incurred in the process of relocating residents to home and community-based settings or another facility when a facility is closed or downsized pursuant to an agreement with the state Medicaid agency
- Projects that support resident and family councils and other consumer involvement in assuring quality care in facilities
- Facility improvement initiatives, such as joint training of facility staff and surveyors, or technical assistance for facilities implementing quality assurance and performance improvement programs.

Any organization, association, and university (e.g., Quality Improvement Organization, health care organizations, providers, associations, and advocacy groups) may apply for funding under this grant opportunity. A maximum of one application may be submitted per organization/association/university.

The application process for CMP funds is determined by the state in which the nursing home is located. The process for each state may differ, and some states have their own applications for CMP funds. Applicants should use their state-specific application and instructions, if applicable.

Applicants must consider current CMP state activities and other Partnership activities being implemented and clearly articulate how this activity will enhance and build on, not supplant current activities and be implemented with a regional and/or national scope.

When CMP funds are requested for educational purposes, the organization involved must also include the following: anticipated number of attendees; target audience; timeline for implementation and plan and sustainability. Representatives from any group requesting funding, or representatives who are in situations where a conflict of interest exists, must disqualify themselves from making recommendations.

CMP funds may not be used to pay entities to perform functions which they are already paid by State, Federal or other sources. CMP funds, for example may not be used to enlarge an existing appropriation or statutory purpose that is substantially the same as the CMP project.

Assisted Living Conversion Program (ALCP)

The Assisted Living Conversion Program (ALCP) provides private, nonprofit owners of eligible developments with a grant to convert some or all of the dwelling units in the project into an assisted living facility or service-enriched housing (SEH) for elderly residents aging in place. An assisted living facility must be licensed and regulated by the State (or if there is no State law providing such licensing and regulation, by the municipality or other subdivision in which the facility is located). Service-Enriched Housing is housing that accommodates the provision of services to older adult residents who need assistance with activities of daily living in order to live independently.

The ALCP indicates the following: assisted living facilities are designed to accommodate frail older adults and people with disabilities who can live independently, but need assistance with activities of daily living (e.g., assistance with eating, bathing, grooming, dressing and home management activities); assisted living facilities must provide

support services such as personal care, transportation, meals, housekeeping, and laundry.

Typical funding will cover basic physical conversion of existing project units, common and services space. The ALCP provides funding for the physical costs of converting some or all of the units of an eligible development into an assisted living facility or SEH, including the unit configuration, common and services space and any necessary remodeling, consistent with HUD or the State's statute/regulations (whichever is more stringent). Assisted living facilities or SEH must have sufficient community space to accommodate provisions of meals and supportive services.

Funding for the supportive services does not come from HUD but must be coordinated by the owners or residents, either directly or through a third party. Supportive services may include Medicaid services and programs provided by the State, an Area Agency on Aging, Money Follows the Person funds, State Home Health Care programs, State Assisted Living Services funds, Congregate Housing Services Program funds, Service Coordinator funds, or similar programs.

Eligible projects must be owned by a private, nonprofit entity, and designated primarily for occupancy by older adult persons. Projects must have completed final closing and must have been in occupancy for at least five years from the date of the HUD approved form HUD-92485 (Permission to Occupy Project Mortgage). Eligible projects may only receive one grant award per fiscal year.

Eligible projects must also qualify as one of the following:

- Section 202 direct loan projects with or without Section 8 rental assistance;
- Section 202 capital advance projects receiving rental assistance under their Project Rental Assistance Contract (PRAC);
- Section 515 rural housing projects receiving Section 8 rental assistance;
- Other projects receiving Section 8 project-based rental assistance;
- Projects subsidized with Section 221(d)(3) below-market interest mortgage; or
- Projects assisted under Section 236 of the National Housing Act.

For an assisted living facility - eligible residents who meet the admissions/discharge requirements as established for assisted living by State and local licensing, or HUD frailty requirements under 24 CFR891.205 if more stringent, the residents must be able to live

independently but need assistance with activities of daily living (e.g., assistance with eating, bathing, grooming, dressing and home management activities).

Applicants must submit an application for funding, in response to the Notice of Funding Availability (NOFA) published on www.grants.gov each fiscal year that funds are available.

The aforementioned program is authorized under Section 202b of the Housing Act of 1959, as amended by the Section 202 Supportive Housing for the Elderly Act of 2010. HUD's Office of Multifamily Housing is responsible for administering the Assisted Living Conversion Program. For more information, please contact your local HUD office.

Housing Choice Vouchers Program

The HUD Housing Choice Vouchers Program is designed to allow people with low incomes the opportunity to live in safe, affordable housing. Through the Housing Choice Vouchers Program, recipients can choose any public or private housing that accepts Housing Choice Vouchers, including assisted living facilities (note: public housing authorities run the program).

The participant is free to choose any housing that meets the requirements of the program and is not limited to units located in subsidized housing projects.

Housing choice vouchers are administered locally by public housing agencies(PHAs). The PHAs receive federal funds from the U.S. Department of Housing and Urban Development (HUD) to administer the voucher program.

Eligibility for a housing voucher is determined by the PHA based on the total annual gross income and family size and is limited to US citizens and specified categories of non-citizens who have eligible immigration status. In general, the family's income may not exceed 50 percent of the median income for the county or metropolitan area in which the family chooses to live. By law, a PHA must provide 75 percent of its voucher to applicants whose incomes do not exceed 30 percent of the area median income. Median income levels are published by HUD and vary by location. The PHA serving an individual's community can provide individuals with the income limits for the area and family size.

Individuals can contact their local authority to apply. If local PHAs do not participate in the program, individuals can contact another PHA in a different area to apply.

During the application process, the PHA will collect information on family income, assets, and family composition. The PHA will verify this information with other local agencies, employers and banks, and will use the information to determine program eligibility and the amount of the housing assistance payment.

The demand for housing assistance, often, exceeds the limited resources available to HUD and the local housing agencies, long waiting periods are common (note: a PHA may close its waiting list when it has more families on the list than can be assisted in the near future).

PHAs may establish local preferences for selecting applicants from its waiting list. For example, PHAs may give a preference to a family who is homeless or living in substandard housing; paying more than 50 percent of its income for rent; or involuntarily displaced. Families who qualify for any such local preferences move ahead of other families on the list who do not qualify for any preference. Each PHA has the discretion to establish local preferences to reflect the housing needs and priorities of its particular community.

The housing choice voucher program places the choice of housing in the hands of the individual family. A very low-income family is selected by the PHA to participate is encouraged to consider several housing choices to secure the best housing for the family needs. A housing voucher holder is advised of the unit size for which it is eligible based on family size and composition.

The housing unit selected by the family must meet an acceptable level of health and safety before the PHA can approve the unit. When the voucher holder finds a unit that it wishes to occupy and reaches an agreement with the landlord over the lease terms, the PHA must inspect the dwelling and determine that the rent requested is reasonable.

The PHA determines a payment standard that is the amount generally needed to rent a moderately-priced dwelling unit in the local housing market and that is used to calculate the amount of housing assistance a family will receive. However, the payment standard does not limit and does not affect the amount of rent an individual may charge or the family may pay. A family which receives a housing voucher can select a unit with a rent that is below or above the payment standard. The housing voucher family must pay 30 percent of its monthly adjusted gross income for rent and utilities, and if the unit rent is greater than the payment standard the family is required to pay the additional amount. By law, whenever a family moves to a new unit where the rent exceeds the payment

standard, the family may not pay more than 40 percent of its adjusted monthly income for rent.

The PHA calculates the maximum amount of housing assistance allowable. The maximum housing assistance is generally the lesser of the payment standard minus 30 percent of the family's monthly adjusted income or the gross rent for the unit minus 30 percent of monthly adjusted income.

A family's/individual's housing needs change over time with changes in family size, job locations, and for other reasons. The housing choice voucher program is designed to allow families to move without the loss of housing assistance. Moves are permissible as long as the family notifies the PHA ahead of time, terminates its existing lease within the lease provisions, and finds acceptable alternate housing.

Under the voucher program, new voucher-holders may choose a unit anywhere in the United States if the family lived in the jurisdiction of the PHA issuing the voucher when the family applied for assistance. Those new voucher-holders not living in the jurisdiction of the PHA at the time the family applied for housing assistance must initially lease a unit within that jurisdiction for the first twelve months of assistance. A family that wishes to move to another PHA's jurisdiction must consult with the PHA that currently administers its housing assistance to verify the procedures for moving.

The role of the landlord in the voucher program is to provide decent, safe, and sanitary housing to a tenant at a reasonable rent. The dwelling unit must pass the program's housing quality standards and be maintained up to those standards as long as the owner receives housing assistance payments. In addition, the landlord is expected to provide the services agreed to as part of the lease signed with the tenant and the contract signed with the PHA.

To cover the cost of the program, HUD provides funds to allow PHAs to make housing assistance payments on behalf of the families. HUD also pays the PHA a fee for the costs of administering the program. When additional funds become available to assist new families, HUD invites PHAs to submit applications for funds for additional housing vouchers. Applications are then reviewed and funds awarded to the selected PHAs on a competitive basis. HUD monitors PHA administration of the program to ensure program rules are properly followed.

Multifamily Housing Projects Designated for Occupancy

The Multifamily Housing Projects Designated for Occupancy is managed by the Housing and Urban Development Program, which helps provide grants to assisted living facilities in need of all types of emergency maintenance help in order to stay open. Individual facilities may receive up to $500,000.

To be eligible, facilities must meet the following criteria:

- Must be in compliance with Loan Agreement, Capital Advance Agreement, Regulatory Agreement, Housing Assistance Payment Contract, Project Rental Assistance Contract, Rent Supplement or LMSA Contract, or any other HUD grant or contract document.
- Must be in compliance with all fair housing and civil rights laws, statutes, regulations, and executive orders enumerated in 24 CFR 5.105(a)as applicable.

Assistance is limited to those projects with emergency problems that are of such a magnitude that the problem poses an immediate threat to the quality of life of the tenants and the continuation of the existing problem could potentially result in an evacuation of the tenants or long-term tenant displacement unless the repairs are made.

To apply individuals should submit a complete application, in accordance with requirements of the notice published in the Federal Register. HUD staff will review each application to determine whether the application meets the requirements of the notice.

At the end of the review process, facilities will be either recommended for funding or rejected. If an application meets all program eligibility requirements after completion of the review, the local Multifamily Hub Director will forward a recommendation for funding to HUD Headquarters.

Veterans' Programs

Veterans may be eligible for assistance to pay for assisted living facilities and nursing homes (note: the term veteran may refer to any individual who served in the active military, naval, or air service, and who was discharged or released under conditions other than dishonorable).

Veterans may receive assistance to pay for the following: Veterans Affairs (VA) nursing centers, state-owned and -managed centers that provide full-time care for veterans, and non-VA nursing homes.

Veterans may be eligible for assistance if they meet the following criteria found below.

- They are signed up for VA health care.
- The VA concludes that veterans need a specific service to help with their ongoing treatment and personal care.
- The service (or space in the care setting) is available.

Veterans may apply for services through the U.S. Department of Veterans Affairs. When applying veterans will need the information found below.

- Social Security numbers for the veteran, spouse, and qualified dependents.
- Military discharge papers (DD214 or other separation documents).
- Insurance card information for all insurance companies that cover the veteran, including any coverage provided through a spouse or significant other (note: this includes Medicare, private insurance, or insurance from employer).
- Gross household income from the previous calendar year for the veteran, spouse, and dependents. (note: this includes income from a job and any other sources; gross household income is income before taxes and any other deductions).
- Deductible expenses for the past year (note: this includes certain health care and education costs).

Section 3 Summary

The third essential element of financial and expense management for health care organizations is to actively seek grants and federal funding opportunities, which may be used to help financially support health care organizations and/or older adult residents. Grants and federal funding opportunities that may be used to help financially support health care organizations and/or older adult residents include the following: CMP funds, ALCP grants, funding related to the Housing Choice Vouchers Program, funding related to Multifamily Housing Projects Designated for Occupancy, and veterans-related programs. Health care administers should note that additional information and

applications for the aforementioned grants/federal funding opportunities may be found on related government websites.

Section 3 Key Concepts

- The third essential element of financial and expense management for health care organizations is to actively seek grants and federal funding opportunities, which may be used to help financially support health care organizations and/or older adult residents.
- Grants and federal funding opportunities that may be used to help financially support health care organizations and/or older adult residents include the following: CMP funds, ALCP grants, funding related to the Housing Choice Vouchers Program, funding related to Multifamily Housing Projects Designated for Occupancy, and veterans-related programs.

Section 3 Key Terms

Older adult - an individual 65 years or older

Civil Money Penalty (CMP) - a monetary penalty the CMS may impose against nursing homes for either the number of days or for each instance a nursing home is not in substantial compliance with one or more Medicare and Medicaid participation requirements for long-term care facilities

Service-Enriched Housing - housing that accommodates the provision of services to older adult residents who need assistance with activities of daily living in order to live independently

Veteran - any individual who served in the active military, naval, or air service, and who was discharged or released under conditions other than dishonorable

Gross household income - income before taxes and any other deductions

Section 3 Personal Reflection Question

How can health care administrators obtain and utilize grants and federal funding opportunities to help financially support their health care organization?

Section 4: COVID-19-Related Relief Funds

In the wake of the coronavirus disease 2019 (COVID-19) pandemic, the U.S. government released COVID-19-related relief funding for health care organizations (note: coronavirus disease 2019 [COVID-19] may refer to a respiratory illness that can spread from person to person that is caused by a virus known as the severe acute respiratory syndrome coronavirus 2 [SARS-CoV-2)]). Therefore, in the current COVID-19 impacted health care climate, the forth essential element of financial and expense management for health care organizations is to obtain applicable COVID-19-related relief funds from the U.S. government. This section of the course will review COVID-19-related relief funding opportunities provide by the U.S. government. The information found within this section of the course was derived from materials provided by the U.S. government unless, otherwise, specified (U.S. Congress, 2021; U.S. Department of Health and Human Services, 2021).

The Coronavirus Aid, Relief, and Economic Security Act (CARES Act)

The Coronavirus Aid, Relief, and Economic Security Act (CARES Act) may refer to the economic stimulus bill passed by the 116th U.S. Congress and signed into law by President Donald Trump on March 27, 2020, in response to the economic impact of the COVID-19 pandemic in the U. S.

The CARES Act created a $175 billion Provider Relief Fund, with approximately $21 billion of that reserved for health care/nursing facilities.

Part 1 of the CARES Act requires the Secretary of Health and Human Services (HHS) to enter into an agreement with the National Academies of Sciences, Engineering, and Medicine to examine and report on the security of the U.S. medical product supply chain, including assessing and evaluating the dependence of the U.S. on critical drugs and devices sourced or manufactured outside of the U.S., and to provide recommendations.

Part 1 of the CARES Act requires the Strategic National Stockpile to include personal protective equipment, ancillary medical supplies, and supplies required for administering drugs, vaccines and other biological products, medical devices, and diagnostic tests.

Part 1 of the CARES Act amends the Public Health Service Act to include a respiratory protective device (e.g., masks, respirators), approved by the National Institute for Occupational Safety and Health and that the Secretary determines to be a priority for

use during a public health emergency, to be a covered countermeasure, conferring permanent liability protection for manufacturers.

Part 1 of the CARES Act amends the Federal Food, Drug, and Cosmetic Act to require the Secretary of HHS to prioritize expedited review and inspections if there is or is likely to be a shortage of a drug that is life-supporting, life-sustaining, or intended to prevent or treat a debilitating disease or condition.

Part 1 of the CARES Act provides for additional reporting requirements when drug manufacturing interruption or discontinuation occurs and is likely to lead to a meaningful disruption when the drug or ingredient is critical to the public health during a public health emergency. Requires: disclosure of reasons for the discontinuation or interruption, and if an active pharmaceutical ingredient is a reason for, or risk factor in, such interruption, the source of the active ingredient and any known alternative sources; whether any associated device is a reason for, or a risk factor in interruption; the expected duration of the interruption; and such other information as the Secretary may require. Manufacturers of drugs, ingredients, or associated devices facing discontinuation or limitation shall develop, maintain, and implement, as appropriate, a redundancy risk management plan that identifies and evaluates risks to the supply of the drug, subject to inspection and copying by the Secretary. Secretary to provide regular reporting on current drug shortage lists. Provides certain exemptions for biological products not necessary to protect the public health. Provisions take effect 180 days after enactment.

Part 1 of the CARES Act provides that certain manufacturers of devices deemed critical to public health during a public health emergency provide notice of manufacturing discontinuation or interruption impacting supply. Provides that the secretary shall report on such disturbances. Exceptions for reporting if Secretary determines such disclosure would adversely affect the public health (e.g. increasing possibility of unnecessary over purchase). Provides expedited review processes for devices that could help mitigate or prevent such shortages.

Part 2 of the CARES Act amends the Families First Coronavirus Response Act to require coverage (without cost-sharing or other cost-containment measures) of a test for the detection of SARS–CoV–2 or the diagnosis of the virus that causes COVID–19 if: the test has received an Emergency Use Authorization (EUA) from the FDA; the developer has requested or intends to request EUA (until such request is denied or withdrawn); or the test has been developed in and authorized by a State that has notified HHS of its

intention to review such test; or other test that the Secretary determines appropriate in guidance.

Part 2 of the CARES Act amends requirement under the Families First Coronavirus Response Act (for private plans to cover coronavirus test) to address balance billing. During the emergency period, the amendment requires group health plans and issuers to reimburse providers for a test for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19 as follows:

- If the provider participates in the plan network, the plan shall pay the contracted in-network rate
- If the provider is out-of-network, the plan shall either negotiate a price with the provider, or the plan shall reimburse the provider in an amount equal to the cash price that the provider lists on a public internet website
- During the emergency period, a provider of such diagnostic testing shall post the cash price for such test on its public website. A civil money penalty of up to $300 can be imposed by the Secretary of HHS for each day a provider is out of compliance with this requirement.

Part 2 of the CARES Act requires group health plans and individual health insurance policies to cover any qualifying coronavirus preventive service, including a vaccine, without cost-sharing no later than 15 days after it is recommended for such coverage by the US Preventive Services Task Force (USPSTF) with an A or B rating or by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention. Under current law, plans have up to 1 year following such recommendations to implement coverage.

Part 2 of the CARES Act provides supplemental awards of $1.32 billion in FY 2020 for health centers for the detection of SARS-CoV-2 or the prevention, diagnosis, and treatment of COVID-19.

Part 2 of the CARES Act amends the Public Health Service Act to authorize to be appropriated $29 million for each of fiscal years 2021 through 2025 for the telehealth network grant program, which awards eligible entities for projects which demonstrate telehealth technologies can be used in rural areas and medically underserved areas (note: telehealth may refer to the use of electronic information and telecommunication technologies to support and promote long-distance clinical health care, patient and professional health-related education, public health, and health administration). Extends

the grant award period from 4 years to 5 years. Eliminates grants for telehealth resource centers. Cuts requirement that the Secretary of HHS establish terms and conditions of grants, maximum amounts of grants, and publish a notice of application requirements. Eliminates the requirement that grantees be non-profits. Removes requirement that states establish a health care provider reciprocity agreement.

Part 2 of the CARES Act amends the Public Health Service Act to reauthorize grant programs to strengthen rural community health, to authorize to be appropriated $79.5 million for each of fiscal years 2021 through 2025, extending the grant award period from 3 years to 5 years. Removes the requirement that grantees be a rural public or nonprofit and broadens eligibility to include any entity with experience serving (or capacity to serve) rural underserved populations. Grants may be for basic healthcare services rather than limited to essential healthcare services. Adds focus on community engagement during rural healthcare services. Includes activities related to care coordination, chronic disease management, and improving patient health outcomes in requirements for small health care provider quality improvement grants.

Part 2 of the CARES Act amends the Public Health Service Act to provide for a Ready Reserve Corp in times of public health emergencies, in addition to national emergencies.

Part 2 of the CARES Act protects health care professionals from liability under Federal or State law for any harm caused by an act or omission in the provision of health care services during the COVID-19 public health emergency so long as health care services in response to the public health emergency are performed in a volunteer capacity and the act or omission occurs in the course of providing health care services within the scope of the license, registration, or certification and in good faith. Protections do not apply if harm was caused by an act or omission of willful or criminal misconduct, gross, negligence, reckless misconduct, or a conscious flagrant indifference to the rights or safety of the individual harmed or if rendered under the influence of alcohol or an intoxicating drug. Provision takes effect upon enactment of Act and is in effect for the length of the COVD-19 public health emergency.

Part 2 of the CARES Act states that during any portion of the COVID-19 public health emergency, the Secretary of HHS shall allow any state or area agency on aging to transfer no more than 100% of funds to address the needs of the area served, specifically funds for either a) making available comprehensive programs which include a full range of health, education, and supportive services to older citizens, b) special consideration for older citizens with special needs (especially those with the greatest social or economic need) in planning such programs, c) reducing hunger and food insecurity, d) promoting

the health and well-being of older individuals by assisting such individuals to gain access to nutrition, other disease prevention, health promotion services.

Part 2 of the CARES Act states that the Secretary of Labor may allow individuals participating in community service activities as established under title V of the Older Americans Act of 1965 to extend their participation in the program past the period established in law if the Secretary determines such extension is appropriate due to the COVID-19 public health emergency. If it is necessary to respond to the additional administrative needs to respond to the COVID–19 public health emergency, the Secretary may also increase the amount available to pay the authorized administrative costs for a project, not to exceed 20% of the grant.

Part 2 of the CARES Act amends the Public Health Service Act to authorize to be appropriated funding for each of fiscal years 2021 through 2025 for health care professions workforce programs and allows more grant funding to be used for training of health care workers in rural and underserved areas, prioritizing the fields of substance use, geriatrics health.

Part 2 of the CARES Act directs Secretary of HHS to lead the development of and reporting for a plan on health care workforce issues that establishes performance measures, identifies gaps in workforce, and recommends strategies for filling gaps.

Part 2 of the CARES Act amends the Public Health Service Act to establish education and training programs related to geriatrics. Geriatrics Workforce Enhancement Program: Directs the Secretary to award grants, contracts, or cooperative agreements to a variety of entities including, health professions schools, schools of nursing, nursing centers, academic health centers, State or local governments, and other appropriate public or private nonprofit entities to establish or operate Geriatrics Workforce Enhancement Programs that meet the following requirements:

- Award supports the training of health professionals in geriatrics, including traineeships or fellowships.
- Activities conducted include clinical training on providing integrated geriatrics and primary care; interprofessional training to practitioners from multiple disciplines including training on the provision of care to older adults; establishing or maintaining training-related community-based programs for older adults and caregivers to improve health outcomes for older adults; providing education on Alzheimer’s disease and related dementias.

- Grant length does not exceed 5 years.
- When awarding the grants, Secretary should prioritize certain applicants, such as those with programs or activities that are expected to substantially benefit rural or medically underserved populations of older adults, and give special consideration to those that provide services in areas with a shortage of geriatric workforce professionals.

The CARES Act states Geriatrics Academic Career Awards directs the Secretary to establish a program to provide geriatric academic career awards to a variety of entities including, health professions schools, schools of nursing, nursing centers, academic health centers, State or local governments, and other appropriate public or private nonprofit entities applying on behalf of eligible individuals to promote the career development of academic geriatricians or other academic geriatrics health professionals. The amount of an award shall be at least $75,000 for fiscal year 2021, increasing by CPI for future years. The Secretary should not make awards longer than a period of 5 years.

The CARES Act reauthorizes and amends Title VIII of the Public Health Service Act on nurse workforce training programs. Alters definitions of eligible entities and programs for nursing workforce grants. Authorizes to be appropriated $137,837,000 for each of fiscal years 2021 through 2025 for grants for nurse education and training programs, nursing workforce diversity, and nurse retention and $117,135,000 for each of fiscal years 2021 through 2025 for student loan funds with schools of nursing. Updates reporting requirements on nurse loan repayment program.

The CARES Act clarifies that dollar caps on emergency paid family leave benefits in the Families First Act are per employee. The Families First Act requires employers to provide 12 weeks of emergency family leave paid at two-thirds the employee's regular pay, up to $200/day and $10,000 in aggregate, when the employee's child's school or place of care is closed as a result of coronavirus.

The CARES Act clarifies that the dollar caps on emergency paid sick leave benefits in the Families First Act are per employee. An employer shall not be required to pay more than either:

- $511 per day and $5,110 in the aggregate for each employee, when the employee is taking leave to care for themselves for reasons related to COVID-19.
- $200 per day and $2,000 in the aggregate for each employee, when the employee is taking leave to provide caregiving for an individual impacted by COVID-19.

The CARES Act provides that tax credits for employers providing emergency paid sick and/or family leave, as provided in the Families First Act, are advanceable. Adds that the Secretary of the Treasury shall make regulations that permit advancement of tax credits.

The CARES Act amends ERISA to expand the circumstances under which the Secretary of the DOL may postpone certain ERISA filing deadlines to include a public health emergency, as declared by the Secretary of HHS.

The CARES Act amends ERISA and the Internal Revenue Code to include in its definition of a cooperative and small employer charity pension plans that as of Jan. 1, 2020, were a 501(c)(3), were in existence since 1938, that conduct medical research through grant making, and whose primary exempt purpose is to provide services with respect to mothers and children. Amendments apply to plan years beginning after Dec. 31, 2018.

Subtitle D of the CARES Act states the following: for plan years beginning on or before Dec. 31, 2021, allows high-deductible health plans with a health savings account (HSA) to cover telehealth services prior to a patient reaching the deductible.

Subtitle D of the CARES Act waives the requirement that patients of an Inpatient Rehabilitation Facility (IRF) receive at least 15 hours of therapy a week (3 hours of therapy per day, 5 days per week).

Sec. 3713. of the CARES Act states the following: medicare, including traditional Medicare and Medicare Advantage plans, will cover any COVID-19 vaccine (that is licensed under section 351 of the Public Health Service Act) and its administration under Medicare Part B. Medicare beneficiaries will not pay cost sharing for the vaccine or its administration (typically many services under Part B are subject to a deductible and 20% coinsurance).

The CARES Act requires Medicare prescription drug plans and Medicare Advantage drug plans to permit Part D plan enrollees to obtain a 90-day supply of a covered Part D drug (even if the drug is subject to cost and utilization management, medication therapy management, or other such programs) during the COVID-19 emergency period.

The CARES Act clarifies the definition of “uninsured individuals” who are eligible for Medicaid-covered COVID-19 testing and testing-related services with 100% federal matching funds in the new optional pathway created by the Families First Coronavirus Response Act. Specifically, the bill clarifies that adults in non-expansion states who would be eligible for the ACA Medicaid expansion if the expansion was adopted by their state do qualify as “uninsured individuals” eligible in the new pathway. Also provides

that “uninsured individuals” eligible in the new pathway include those eligible for Medicaid in pathways for TB-infection, breast or cervical cancer, optional family planning services, medically needy/spend down (only if they receive a limited benefit package that is less than minimum essential coverage).

The CARES Act states the following: the Families First Coronavirus Response Act added COVID-19 testing products to the mandatory Medicaid lab services benefit and also exempts these tests from cost-sharing. This bill removes the requirement that these testing products be FDA-approved to be covered and exempt from cost-sharing in Medicaid.

The CARES Act states the Families First Coronavirus Response Act provides a 6.2 percentage point increase in federal matching funds for Medicaid enrollees (other than ACA expansion adults) during the 1135 emergency period, provided that states meet certain conditions. One of these conditions is that states may not impose premiums higher than those in effect on 1/1/20. This bill provides a limited exception, allowing states to receive the enhanced federal matching funds during the 30-day period after the CARES Act becomes law, even if the state has a premium higher than what was in effect on 1/1/20, provided that the higher premium was in effect on the date that the CARES Act became law.

The CARES Act states amends the FD&C Act by adding a section to change current regulations, permitting FDA to reform the approval process for certain nonprescription (i.e., over-the-counter or OTC) drugs deemed “to be generally recognized as safe and effective”(GRASE) by implementing an administrative (rather than full rulemaking) approval process. OTC drugs not considered to be GRASE or with unacceptable indications (i.e. category II drugs) are deemed new and require a new drug application. Also includes an exclusivity provision for innovative drugs meeting certain conditions and a future GAO study on impact of exclusivity provisions.

The CARES Act allocates $25,000,000 in funding for “distance Learning, Telemedicine, and Broadband Program” to prevent, prepare for, and respond to coronavirus, domestically or internationally, for telemedicine and distance learning services in rural areas (note: aforementioned funds to remain available until expended).

The CARES Act allocates $80,000,000 for “salaries and expenses” to prevent, prepare for, and respond to coronavirus, domestically or internationally, including funds for the development of necessary medical countermeasures and vaccines, advanced manufacturing for medical products, the monitoring of medical product supply chains,

and related administrative activities (note: aforementioned funds to remain available until expended).

The CARES Act allocates $45,000,000,000 for an additional amount for “Disaster Relief Fund,” which is used by FEMA to fund federal disaster response and assist nonfederal levels of government that have had their capacity to deal with major disasters and emergencies overwhelmed. It can support a range of eligible efforts, including medical response.

The CARES Act allocates $4,300,000,000 for an additional amount for “CDC-Wide Activities and Program Support” to prevent, prepare for, and respond to coronavirus, domestically or internationally (note: aforementioned funds to remain available until Sept. 30, 2024).

The CARES Act allocates $103,400,000 for an additional amount for “National Heart, Lung, and Blood Institute” to prevent, prepare for, and respond to coronavirus, domestically or internationally (note: aforementioned funds to remain available until Sept. 30, 2024).

The CARES Act allocates $200,000,000 to the Centers for Medicare & Medicaid Services (CMS) for an additional amount for “Program Management” to prevent, prepare for, and respond to coronavirus, domestically and internationally (note: aforementioned funds to remain available until Sept. 30, 2023).

The CARES Act allocates $2,800,000 for an additional amount for the “Armed Forces Retirement Home Trust Fund” to prevent, prepare for, and respond to coronavirus by supporting increased healthcare, security, and food services personnel expenses, including the personal protective equipment they need, as well as necessary supplies and equipment at the Armed Forces Retirement Homes in Washington, D.C. and Gulfport, Mississippi, which will help minimize the spread of coronavirus among residents.

The CARES Act allows funds to be used to enter into contracts with individuals for the provision of personal services to prevent, prepare for, and respond to coronavirus, within the United States and abroad; such individuals may not be deemed U.S. employees.

The CARES Act allows funds provided under this title to the heading “Department of Health and Human Services” may be transferred to, and merged with, other appropriation accounts under the headings “Centers for Disease Control and

Prevention," "Public Health and Social Services Emergency Fund," "Administration for Children and Families," "Administration for Community Living," and "National Institutes of Health" to prevent, prepare for, and respond to coronavirus following consultation with the Office of Management and Budget (providing congressional notification 10 days in advance of any such transfer).

American Rescue Plan and Provider Relief Fund

In addition to funding and resources provided by the CARES Act, additional funding is now available for health care organizations.

In late 2021, the Biden-Harris administration announced that the U.S. Department of Health and Human Services (HHS), through the Health Resources and Services Administration (HRSA), is making $25.5 billion in new funding available for health care providers affected by the COVID-19 pandemic.

The funding includes $8.5 billion in American Rescue Plan (ARP) resources for providers who serve rural Medicaid or Medicare patients, and an additional $17 billion for Provider Relief Fund (PRF) Phase 4 for a broad range of providers who can document revenue loss and expenses associated with the pandemic.

ARP Rural is intended to help address the disproportionate impact COVID-19 is having on rural communities and rural health care providers; funding will be available to providers who serve patients in these communities. Eligible applicants can apply for the ARP Rural funds through the same Application and Attestation Portal that is available to apply for the Phase 4 General Distribution. Providers will apply for both programs in a single application. In order to be considered for an ARP Rural payment, applicants must include any billing Tax Identification (TIN) owned by the applicant. ARP Rural payments will be determined based on the amount and type of Medicare and Medicaid services provided by billing TINs to rural beneficiaries. Applicants do not need to verify whether their beneficiaries live in an area that meets the definition of rural.

Qualified providers of health care, services, and support may receive Provider Relief Fund payments for health care-related expenses or lost revenues due to coronavirus. These distributions do not need to be repaid to the US government, assuming providers comply with the terms and conditions.

According the U.S. government, the funding will be used to help health care providers who have endured demanding workloads and significant financial strains amidst the

pandemic; the funding will be distributed with a focus on equity, to ensure providers who serve the most vulnerable communities will receive the support they need.

Consistent with the requirements included in the Coronavirus Response and Relief Supplemental Appropriations Act of 2020, PRF Phase 4 payments will be based on providers' lost revenues and expenditures between July 1, 2020, and March 31, 2021. As part of the Biden-Harris Administration's ongoing commitment to equity, and to support providers with the most need, PRF Phase 4 will reimburse smaller providers - who tend to operate on thin margins and often serve vulnerable or isolated communities - for their lost revenues and COVID-19 expenses at a higher rate compared to larger providers. PRF Phase 4 will also include bonus payments for providers who serve Medicaid and/or Medicare patients, who tend to be lower income and have greater and more complex medical needs. HRSA will price these bonus payments at the generally higher Medicare rates to ensure equity for those serving low-income individuals, individuals with disabilities, and older adults.

HRSA will make ARP rural payments to providers based on the amount of Medicaid and/or Medicare services they provide to patients who live in rural areas as defined by the HHS Federal Office of Rural Health Policy. As rural providers serve a disproportionate number of Medicaid patients who often have disproportionately greater and more complex medical needs, many rural communities have been hit particularly hard by the pandemic. Accordingly, ARP rural payments will also generally be based on Medicare reimbursement rates.

In order to expedite and streamline the application process and minimize administrative burdens, providers will apply for both programs in a single application. HRSA will use existing Medicaid and Medicare claims data in calculating payments. To help ensure that these provider relief funds are used for patient care, PRF recipients will be required to notify the HHS Secretary of any merger with, or acquisition of, another health care provider during the period in which they can use the payments. Providers who report a merger or acquisition may be more likely to be audited to confirm their funds were used for coronavirus-related costs, consistent with an overall risk-based audit strategy.

To be eligible to apply for the Phase 4 General Distribution, the applicant must meet all of the following requirements:

- Must fall into one of the following categories:
- Must have either directly billed, or owns (on the application date) an included subsidiary that has directly billed, their state/territory Medicaid program (fee-for

service or managed care) for health care-related services during the period of January 1, 2019 to December 31, 2020; or

- Must be a dental service provider who has either directly billed, or owns (on the application date) an included subsidiary that has directly billed, health insurance companies or patients for oral health care-related services during the period of January 1, 2019 to December 31, 2020;
- Must have either directly billed, or owns (on the application date) an included subsidiary that has directly billed, Medicare fee-for-service (Parts A and/or B) or Medicare Advantage (Part C) for health care-related services during the period of January 1, 2019 to December 31, 2020;
- Must be a state-licensed/certified assisted living facility on or before December 31, 2020;
- Must be a behavioral health provider who has either directly billed, or owns (on the application date) an included subsidiary that has directly billed, health insurance companies or patients for health care-related services during the period of January 1, 2019 to December 31, 2020;
- Must have received a prior Targeted Distribution payment.
- Must have either (i) filed a federal income tax return for fiscal years 2018, 2019, or 2020, or (ii) be an entity exempt from the requirement to file a federal income tax return and have no beneficial owner that is required to file a federal income tax return (e.g. a state-owned hospital or health care clinic); and
- Must have provided patient care after January 31, 2020; and
- Must not have permanently ceased providing patient care directly, or indirectly through included subsidiaries; and
- If the applicant is an individual that was providing patient care, have gross receipts or sales from providing patient care reported on Form 1040, Schedule C, Line 1, excluding income reported on a W-2 as a (statutory) employee.

In accordance with the statutory requirements, to be eligible to apply for ARP Rural Payments, the applicant or at least one subsidiary TINs must be:

- A rural health clinic as defined in section 1861(aa)(2) of the Social Security Act; or

- A provider treated as located in a rural area pursuant to section 1886(d)(8)(E), such as critical access hospitals; or
- A provider or supplier that:
- Has directly billed for health care-related services between January 1, 2019 and September 30, 2020:
- Medicare fee-for-service (Parts A and/or B);
- Medicare Advantage (Part C)
- Their state/territory Medicaid program (fee-for service or managed care); or
- Their state/territory Children's Health Insurance Program (CHIP); and
- Operates in or serves patients living in the HHS Federal Office of Rural Health Policy's (FORHP) definition of a rural area:
- All non-Metro counties;
- All Census Tracts within a Metropolitan county that have a Rural-Urban Commuting Area (RUCA) code of 4-10. The RUCA codes allow the identification of rural Census Tracts in Metropolitan counties;
- 132 large area census tracts with RUCA codes 2 or 3. These tracts are at least 400 square miles in area with a population density of no more than 35 people per square mile; and
- 295 outlying Metropolitan counties with no Urbanized Area population.

Payments from both programs can be used for lost revenues or eligible expenses incurred dating back to from Jan. 1, 2020 which are not obligated to be reimbursed from another funding source.

Phase 4 General Distribution: Consistent with the requirements included in the December appropriations bill, PRF Phase 4 payments will be based on providers' changes in operating revenues and expenses from July 1, 2020 to March 31, 2021. Phase 4 will also include new elements specifically focused on equity, including reimbursing smaller providers for their changes in operating revenues and expenses at a higher rate compared to larger providers, and bonus payments based on the amount of services providers furnish to Medicaid/CHIP and Medicare beneficiaries.

- Approximately 75% of the Phase 4 allocation will be used for Base Payments, which are a percentage of a provider's change in quarterly operating revenues and expenses.
- Provider size categories (Small, Medium, and Large) will be based on annual net patient care revenues, and will be established after the close of the Phase 4 application.
- Large providers will receive a Base Payment amount that is a percentage of the change in their quarterly operating revenues and expenses.
- Base Payments for medium and small providers will include the same percentage of the change in their quarterly operating revenues and expenses plus a scaled supplement, with small providers receiving the greatest amount.
- No provider will receive a Base Payment that exceeds 100% of their change in quarterly operating revenues and expenses.
- Approximately 25% of the Phase 4 allocation will be put towards bonus payments.
- Bonus payments will be based on the amount and type of services provided to Medicaid and Medicare beneficiaries from January 1, 2019 through September 30, 2020.
- HHS will price Medicaid claims data at Medicare rates, with some limited exceptions for some services provided predominantly in Medicaid.
- ARP Rural Distribution: HHS will make payments to providers based on the amount and type of Medicare and Medicaid services provided to rural beneficiaries from January 1, 2019 through September 30, 2020.
- HHS will price Medicaid claims data at Medicare rates, with some limited exceptions for some services provided predominantly in Medicaid.
- Eligible billing TINs that have at least one Medicaid or Medicare claim for a rural beneficiary will receive a minimum payment of $500.

Section 4 Summary

The U.S. government released COVID-19-related relief funds for health care organizations. Therefore, in the current COVID-19 impacted health care climate, the

fourth essential element of financial and expense management for health care organizations is to obtain applicable COVID-19-related relief funding from the U.S. government. Health care administers should note that additional information and/or applications for COVID-19-related relief funding, associated with the CARES Act, ARP, and PRF Phase 4, may be found on related government websites.

Section 4 Key Concepts

- The forth essential element of financial and expense management for health care organizations is to obtain applicable COVID-19-related relief funds from the U.S. government.
- The CARES Act created a $175 billion Provider Relief Fund; approximately $21 billion of the $175 billion Provider Relief Fund was reserved for health care/ nursing facilities.
- In late 2021, the Biden-Harris administration announced that the U.S. Department of Health and Human Services (HHS), through the Health Resources and Services Administration (HRSA), is making $25.5 billion in new funding available for health care providers affected by the COVID-19 pandemic.
- The funding includes $8.5 billion in ARP resources for providers who serve rural Medicaid or Medicare patients, and an additional $17 billion for PRF Phase 4 for a broad range of providers who can document revenue loss and expenses associated with the pandemic.

Section 4 Key Terms

Coronavirus disease 2019 (COVID-19) - a respiratory illness that can spread from person to person that is caused by a virus known as the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)

Coronavirus Aid, Relief, and Economic Security Act (CARES Act) - the economic stimulus bill passed by the 116th U.S. Congress and signed into law by President Donald Trump on March 27, 2020, in response to the economic impact of the COVID-19 pandemic in the U. S.

Telehealth - the use of electronic information and telecommunication technologies to support and promote long-distance clinical health care, patient and professional health-related education, public health, and health administration

Section 4 Personal Reflection Question

How can COVID-19-related relief funds help a specific health care organization?

Section 5: Financial and Expense Management Recommendations

The fifth and final essential element of financial and expense management for health care organizations is to follow related recommendations. This section of the course will review financial and expense management recommendations.

Financial and Expense Management Recommendations

- **Maintain a budget** - first and foremost, health care administrators should maintain a budget. A budget may refer to a financial plan for a defined period of time (e.g., 12 months). When determining a budget, health care administrators should consider the short-term and long-term goals of their health care organization (e.g., staffing; obtaining health care equipment; renovations). Health care administrators should note that budgets should include staffing needs per resident (e.g., the number of nurses required for the total resident population of a health care facility/per day).
- **Consider laws and regulations related to required staffing needs** - to build on the previous recommendation, health care administrators should consider laws and regulations related to required staffing needs. Examples of such laws/regulations may be found below. The information found below was derived from materials provided by the Florida senate (Florida senate, 2021).
    - For each facility a minimum weekly average of certified nursing assistant and licensed nursing staffing combined of 3.6 hours of direct care per resident per day.
    - A minimum certified nursing assistant staffing of 2.5 hours of direct care per resident per day. A facility may not staff below one certified nursing assistant per 20 residents.
    - A minimum licensed nursing staffing of 1.0 hour of direct care per resident per day. A facility may not staff below one licensed nurse per 40 residents.

- Nursing assistants employed under related laws may be included in computing the staffing ratio for certified nursing assistants if their job responsibilities include only nursing-assistant-related duties.
- Each nursing home facility must document compliance with staffing standards as required, and post daily the names of staff on duty for the benefit of facility residents and the public.
- The agency shall recognize the use of licensed nurses for compliance with minimum staffing requirements for certified nursing assistants if the nursing home facility otherwise meets the minimum staffing requirements for licensed nurses and the licensed nurses are performing the duties of a certified nursing assistant. Unless otherwise approved by the agency, licensed nurses counted toward the minimum staffing requirements for certified nursing assistants must exclusively perform the duties of a certified nursing assistant for the entire shift and not also be counted toward the minimum staffing requirements for licensed nurses. If the agency approved a facility's request to use a licensed nurse to perform both licensed nursing and certified nursing assistant duties, the facility must allocate the amount of staff time specifically spent on certified nursing assistant duties for the purpose of documenting compliance with minimum staffing requirements for certified and licensed nursing staff. The hours of a licensed nurse with dual job responsibilities may not be counted twice.
- Non-nursing staff providing eating assistance to residents shall not count toward compliance with minimum staffing standards.
- Licensed practical nurses who are providing nursing services in nursing home facilities may supervise the activities of other licensed practical nurses, certified nursing assistants, and other unlicensed personnel providing services in such facilities in accordance with rules adopted by the Board of Nursing.

- **Monitor employee overtime** - employee overtime may refer to hours worked over 40 hours in a workweek. Employee overtime may be an essential component of staffing, and may be necessary to meet the requirements of related laws and regulations. With that said, health care administrators should monitor employee overtime to ensure overtime costs do not negatively impact health care

organizations' budgets. When considering and monitoring overtime, health care administrators should note federal overtime laws and regulations. Specific information regarding federal overtime laws and regulations may be found below. The information found below was derived from materials provided by the U.S. Department of Labor (U.S. Department of Labor, 2021).

- The federal overtime provisions are contained in the Fair Labor Standards Act (FLSA). Unless exempt, employees covered by the Act must receive overtime pay for hours worked over 40 in a workweek at a rate not less than time and one-half their regular rates of pay. There is no limit in the Act on the number of hours employees aged 16 and older may work in any workweek. The Act does not require overtime pay for work on Saturdays, Sundays, holidays, or regular days of rest, unless overtime is worked on such days.

- The Act applies on a workweek basis. An employee's workweek is a fixed and regularly recurring period of 168 hours - seven consecutive 24-hour periods. It need not coincide with the calendar week, but may begin on any day and at any hour of the day. Different workweeks may be established for different employees or groups of employees. Averaging of hours over two or more weeks is not permitted.

- Normally, overtime pay earned in a particular workweek must be paid on the regular pay day for the pay period in which the wages were earned.

- On December 12, 2019, the U.S. Department of Labor announced a Final Rule that will allow employers to offer perks and benefits to their employees.

- On September 24, 2019, the U.S. Department of Labor announced a final rule to make 1.3 million American workers eligible for overtime pay.

- On May 18, 2020, the U.S. Department of Labor announced a final rule to withdraw the partial lists of establishments that lack or may have a “retail concept” under the Fair Labor Standards Act.

- On May 20, 2020, the U.S. Department of Labor announced a final rule that allows employers to pay bonuses or other incentive-based pay to salaried, nonexempt employees whose hours vary from week to week. The final rule clarifies that payments in addition to the fixed salary are

compatible with the use of the fluctuating workweek method under the Fair Labor Standards Act (FLSA).

- The aforementioned final rule adds language to 29 CFR 778.114(a) to expressly state that employers can pay bonuses, premium payments, or other additional pay, such as commissions and hazard pay, to employees compensated using the fluctuating workweek method of compensation. The rule also states that such supplemental payments must be included in the calculation of the regular rate unless they are excludable under FLSA sections 7(e)(1)–(8)). The rule grants employers greater flexibility to provide bonuses or other additional compensation to nonexempt employees whose hours vary from week to week, and eliminates any disincentive for employers to pay additional bonus or premium payments to such employees; addresses the divergent views expressed by the Department and courts - and even among courts - that have created legal uncertainty for employers regarding the compatibility of various types of supplemental pay with the fluctuating workweek method; adds examples to 29 CFR 778.114(b) to illustrate these principles where an employer pays an employee, in addition to a fixed salary (1) a nightshift differential and (2) a productivity bonus; revises the rule in a non-substantive way to make it easier to read, so employers will be able to better understand the fluctuating workweek method; revised 29 CFR 778.114(a) lists each of the requirements for using the fluctuating workweek method, and duplicative text is removed from revised 29 CFR 778.114(c); changes the title of the regulation from “Fixed salary for fluctuating hours” to “Fluctuating Workweek Method of Computing Overtime.”

- Registered nurses who are paid on an hourly basis should receive overtime pay. However, registered nurses who are registered by the appropriate State examining board generally meet the duties requirements for the learned professional exemption and, if paid on a salary basis of at least $684 per week, may be classified as exempt.

- Licensed practical nurses and other similar health care employees, however, generally do not qualify as exempt learned professionals, regardless of work experience and training, because possession of a specialized advanced academic degree is not a standard prerequisite for entry into such occupations, and are entitled to overtime pay.

- **Review financial statements** - it is often argued that financial statements are vital to effective financial and expense management because financial statements provide invaluable insight into an organization's performance, potential, and available financial resources (note: a financial statement may refer to the official record of the financial activities and position of an individual or organization). Therefore, health care administers should consistently review their health care organization's financial statements. Health care administrators should note the following key elements of a financial statement: a balance sheet, an income statement, and cash flow statement. Specific information on the aforementioned key elements of a financial statement may be found below.

    - **Balance sheet** - a balance sheet may refer to a summary of an individual's or organization's finances. Health care administrators should note that a balance sheet may provide information on an organization's assets and/or liabilities. Health care administrators should also note the following: an asset may refer to any resource owned or controlled by an individual or organization that may provide value or benefit to the controlling individual or organization; a liability may refer to any resource that is owed by one individual or organization to another individual or organization.

    - **Income statement** - an income statement may refer to a summary of an organization's income and expenditures (i.e., an income statement provides a snapshot of the money coming in and going out of an organization). Health care administers should note that an income statement typically presents the financial results of an organization for a stated period of time (e.g., 12 months).

    - **Cash flow statement** - a cash flow statement may refer to a financial statement that shows how changes in balance sheet accounts and income affect cash and the availability of cash. Health care administrators should be sure to analyze/pay particular attention to cash flow statements. Health care administrators should note that cash flow may be especially relevant and important during times of economic instability, such as the economic instability related to the COVID-19 pandemic.

- **Assess short-term and long-term assets** - to build on the previous recommendation, health care administrators should consistently assess short-term and long-term assets. A short-term asset may refer to any resource that is held for a year or less; a resource that may be converted into cash within a year

or less (e.g., cash; inventory; prepaid expenses). A long-term asset may refer to any resource that is held for more than a year; a fixed resource (e.g., land). Health care administrators should note that consistently assessing short-term and long-term assets may be especially relevant and important during times of economic instability, such as the economic instability related to the COVID-19 pandemic.

- **Set financial goals** - setting financial goals can be a powerful tool to help effectively manage the finances and expenses of a health care organization. Essentially, financial goals can give individuals direction, let individuals know what needs to be done, and provide individuals with information on what is required. When setting goals, health care administrators should consider the following elements of goal setting: identify the intent or purpose of the goal; determine if the goal is a short-term or long-term goal; determine the time-line for the goal; develop a plan to meet the goal; inform individuals about the goal and related concepts; ensure individuals have what they require to accomplish the goal; follow up with individuals to assess progress; make required adjustments to the goal, as needed; recognize if and when the goal is completed; express gratitude to those individuals who helped achieved the goal. Health care administrators should note the following: when individuals from the workforce are working to achieve desired goals, health care administrators should effectively communicate with relevant individuals and/or parties to help motivate them to maximize their efforts to accomplish the desired goal; effective communication occurs when information and messages are adequately transmitted, received, and understood.

- **Work to achieve employee satisfaction** - it has been argued that employee satisfaction is one of the major driving forces behind employee retention and employee turnover prevention (note: employee satisfaction may refer to an employee's perceived level of contentment related to his or her place of employment). Thus, health care administers should work to achieve employee satisfaction among a health care organization's workforce to effectively manage a health care organization's finances and expenses. Health care administrators can work to achieve employee satisfaction by incorporating many or all of the following recommendations into the cultural, executive, and directional structure of their health care organization.

- **Treat employees like individuals** - health care administrators should treat an employee like he or she is an individual. Treating an employee like he or she is an individual can help health care administrators identify the specific influences,

characteristics, benefits, limitations, and ultimately, motivations of each employee. Health care administrators should note that treating an employee like he or she is an individual can help maximize the workforce motivation process, and the professional impact of each individual, as well as help improve employee satisfaction.

- **Provide positive feedback** - positive feedback, with the context of communication, may refer to a form of communication that recognizes an individual's success, achievements, and/or hard work. Positive feedback often motivates individuals to do their best, as well as helps establish employee satisfaction. Therefore, health care administrators should provide positive feedback to help prevent employee turnover. Health care administrators should note the following examples of positive feedback: "Excellent work today;" "You did a great job helping patients today;" "I appreciate all of your hard work;" "Your effort is really making a difference;" "Your effort is helping to improve patient care."

- **Utilize positive reinforcement** - to build on the previous recommendation, health care administrators should utilize positive reinforcement when attempting to establish, improve, and maintain employee satisfaction. Positive reinforcement, with the context of communication, may refer to a communication exchange or response that encourages a constructive or beneficial action or behavior. In essence, positive reinforcement can be used by health care administrators to inspire or motivate individuals to repeat constructive, beneficial, and/or productive behavior. For example, if a health care professional goes above and beyond the minimum effort to improve upon patient care, positive reinforcement can be used to motivate the health care professional to continue to go above and beyond the minimum effort to improve upon patient care. Health care administrators should note the following examples of positive reinforcement: simply saying thank you to an individual from the workforce, verbal praise, and recommending a peer or colleague for an intra-organizational employee recognition award.

- **Express gratitude** - gratitude can be a powerful motivational tool and a means for health care administrators to prevent employee turnover. Therefore, health care administrators should express gratitude to employees, when applicable. Specific information regarding gratitude may be found below. The information found

below was derived from materials provided by Positive Psychology unless, otherwise, specified (Chowdhury, 2021).

- Gratitude may refer to a state of thankfulness or appreciation for receiving what is meaningful to oneself; the act of showing appreciation.
- The following is an example of gratitude that may be observed in health care settings: Health Care Professional A has questions regarding a medication; Health Care Professional A asks Health Care Professional B about the medication in question; Health Care Professional B provides Health Care Professional A with important information about the medication in question; Health Care Professional A is thankful for the information. Health Care Professional A says "Thank you" to Health Care Professional B. In return, Health Care Professional B replies, "You're welcome" to Health Care Professional A.
- The following is an example of gratitude that may be observed in health care settings: over the past four weeks Health Care Professional C has been working extra hours and filling in for other health care professionals who have been unable to work due to illness. Health Care Professional C's manager recognizes Health Care Professional C for the extra effort. Health Care Professional C appreciates the recognition.
- Research indicates that gratitude is associated with happiness, well-being, and motivation. Essentially, gratitude can impact optimism, empathy, and self-esteem, all of which can affect happiness, well-being, and motivation (i.e., improved optimism, empathy, and self-esteem can lead to happiness, well-being, and, ultimately, to increased motivation and satisfaction).
- Optimism may refer to hopefulness and/or confidence regarding future endeavors and/or outcomes. Often gratitude can improve optimism by increasing an individual's positivity, vigor, energy, and interest in working diligently to achieve desired outcomes.
- Empathy may refer to the ability to understand another individual's feelings and/or emotions. Expressing gratitude can open up an individual's emotional expression, perception, and ability to view situations from other individuals' perspectives. Once an individual is capable of emotional expression, perception, and possesses the ability to view situations from

other individuals' perspectives, he or she is more likely to experience empathy.

- Self-esteem may refer to confidence in one's own abilities; self-respect. Expressing gratitude and receiving expressions of gratitude can build and improve self-esteem.
- Evidence suggests that gratitude can impact interpersonal relationships. Essentially, gratitude can help individuals create interpersonal bonds, which in turn can foster individuals' ability to forge and improve upon interpersonal relationships. Health care administrators should note that gratitude's impact on interpersonal relationships can help forge and improve upon personal and professional relationships, which in turn could impact motivation and employee satisfaction.
- Gratitude can promote effective communication, which in turn could impact motivation and employee satisfaction (note: effective communication occurs when information and messages are adequately transmitted, received, and understood).
- Gratitude can potentially limit and prevent stress. Gratitude's impact on stress is related to its effects on optimism, empathy, and self-esteem. As previously mentioned, gratitude can improve optimism, empathy, and self-esteem, which in turn can reduce and prevent stress (i.e., when individuals have increased levels of optimism, empathy, and self-esteem they experience less stress). Health care administrators should note that stress can impact motivation and employee satisfaction. Health care administrators should also note that individuals are more likely to become motivated/satisfied when they are not stressed.
- Due to gratitude's impact on stress, gratitude can help prevent/limit burn-out (note: burn-out may refer to a syndrome conceptualized as resulting from chronic workplace stress that has not been successfully managed) (WHO, 2019).
- Gratitude can potentially improve an individual's mood, which in turn could impact motivation and employee satisfaction.

    - Health care administrators should work to express gratitude on a daily basis, when applicable (e.g., say "thank you" to individuals from the workforce).

- **Work to establish and maintain a culture of gratitude within a health care organization** - a culture of gratitude can help motivate individuals and improve employee satisfaction, which in turn can help prevent employee turnover. Therefore, health care administrators should work to establish and maintain a culture of gratitude within a health care organization. A culture of gratitude is one where expressions of gratitude are freely exchanged among individuals (i.e., a culture of gratitude is one where individuals adequately express and receive gratitude). The key to a culture of gratitude is acknowledgement. Acknowledgement, as it relates to establishing and maintaining a culture of gratitude, can include three key elements.

  The first element of acknowledgement, as it relates to establishing and maintaining a culture of gratitude, is to recognize other health care professionals who adhere to the major ethic principles of health care, meet their job requirements, and promote the administration of safe and effective health care. Health care administrators can show their recognition to health care professionals who adhere to the major ethic principles of health care, meet their job requirements, and promote the administration of safe and effective health care by simply saying, "Thank you" to a health care professional after he or she completes a task, and/or by pointing out something positive a health care professional did and then thanking him or her for it (e.g., you did a good job making that patient feel comfortable, thank you; you did a great job administering medications to patients today, thank you).

  The second element of acknowledgement, as it relates to establishing and maintaining a culture of gratitude, is to recognize health care professionals who go above and beyond their duties and responsibilities as health care professionals (e.g., a health care professional works extra hours to cover shifts for other health care professionals unable to work; a health care professional continues to work past the completion of his or her shift to help a fellow health care professional complete a task; a health care professional continues to work past the completion of his or her shift to help out a patient). Health care administrators can show their appreciation to specific health care professionals who go above and beyond their duties and responsibilities as health care professionals by simply saying, "Thank

you" to a health care professional after he or she goes above and beyond their duties and responsibilities, and/or by pointing out what a health care professional did to go above and beyond his or her duties and responsibilities and then thanking him or her for it (e.g., I noticed you stayed late yesterday to speak to patients about their medications, thank you). Health care administrators should note the following: health care administrators can recognize health care professionals who go above and beyond their duties and responsibilities as health care professionals via formal, internal channels that highlight specific individuals and what they did to receive recognition and acknowledgement (e.g., an internal, monthly health care organizational bulletin that highlights employees who positively contributed to the health care organization, made a positive difference in patient care, developed a new innovative policy or procedure that promotes safe, efficient, and effective health care, acted extraordinarily while caring for a patient, and/or, simply, acted in a manner consistent with going above and beyond required duties and responsibilities as a health care professional).

The third, and perhaps the most important, element of acknowledgement, as it relates to establishing and maintaining a culture of gratitude, is to recognize and accept expressions of gratitude when they are offered. This last element of acknowledgement builds on the previous two elements and requires individuals to be cognizant of expressions of gratitude when they are offered and to mentally take in or openly welcome expressions of gratitude from other individuals. Health care administrators can become cognizant of expressions of gratitude when they are offered and mentally take in or openly welcome expressions of gratitude from other individuals by effectively communicating with others, engaging in active listening, and by simply saying, "You're welcome" after someone says "Thank you." With this last element of acknowledgement in mind, health care administrators should note that gratitude can perpetuate gratitude, and thus, firmly establish and maintain a culture of gratitude within a health care organization (i.e., gratitude, especially when it is recognized and accepted, can lead to more gratitude).

- **Allow for and encourage professional autonomy** - professional autonomy may refer to any allowance that enables an employee to complete a task with little to no interruption or interference. Professional autonomy is another example of a powerful tool that can be used to help establish, improve, and maintain employee satisfaction. When allowing for professional autonomy, health care administrators should consider the following elements of professional autonomy: give

individuals space and freedom, professional trust, professional independence, professional accountability, the authority to make decisions, effective communication, organization, support, and avoid micromanagement. Specific information regarding the aforementioned elements of professional autonomy may be found below.

- **Give individuals space and freedom** - giving individuals space and freedom is absolutely essential to professional autonomy. It has been argued, that without giving individuals space and freedom there can truly be no professional autonomy. Therefore, health care administrators should allow individuals from the workforce the space and freedom to work independently, at times, to complete tasks, collaborate with peers, and work to optimize patient care. Health care administrators should note the following: giving individuals space and freedom often means allowing individuals to work with little to no interruption or interference from other individuals, which may disrupt an individual's ability to complete a task or required duty.

- **Professional trust** - professional trust is also absolutely essential to professional autonomy. Health care administrators and organizational leaders must trust in their employees' abilities to complete tasks and required duties. Without professional trust there can be no professional autonomy. Health care administrators should note the following: health care administrators should work to establish trust with health care professionals. Health care administrators should also note the following methods to effectively establish trust with other health care organizational leaders and health care professionals: complete tasks when they are assigned, meet deadlines, consistently show up to work on time, assist peers and colleges, remain honest, follow health care organization policies and procedures, work to improve patient safety, work to improve patient care, and act professionally.

- **Professional independence** - professional independence may refer to the ability of an individual to work safely and effectively on his or her own with little to no direct supervision or management. Health care administrators should cultivate their professional independence if they would like to or prefer to work autonomously. Health care administrators should note the following: health care organizational leaders and health care professionals

are more likely to extend professional autonomy to health care administrators and health care professionals who exhibit professional independence.

- **Professional accountability** - professional accountability may refer to the act of taking responsibility for the failure or success of an action, project, or task taken or completed in a professional setting. If a health care professional would like to work autonomously then he or she should take professional accountability for his or her actions. Health care administrators should note the following: professional accountability often requires commitment to professional oaths, codes, scopes of practice, and/or standards of practice.

- **The authority to make decisions** - often, the success of professional autonomy rests on an individual's authority to make his or her own decisions. If an individual is truly given professional autonomy he or she should possess, at least some, authority to make decisions. Health care administrators should note the following: authority to make decisions can empower individuals to take on more responsibility, and grant them the professional confidence to accept and complete difficult professional challenges.

- **Effective communication** - effective communication is often the foundation for professional autonomy. Individuals from every level of a health care organization must be able to effectively communicate in order for professional autonomy to be effective. Health care administrators and health care organizational leaders must be able to communicate vital health care-related information to health care professional employees, and health care professional employees must be able to effectively communicate vital health care-related information to health care administrators and health care organizational leaders. Health care administrators should note the following: in order for communication to be effective, within the context of professional autonomy, health care administrators and health care professional employees must remain approachable, open, and receptive to communication.

- **Organization** - for the individual health care professional granted professional autonomy, he or she must be organized. Essentially, the individual health care professional given professional autonomy should be

organized enough to efficiently and effectively complete assigned tasks, duties, and responsibilities within the given time frame. Health care administrators should note that time management is often essential to organization in a professional setting.

- **Support** - individual health care professionals granted professional autonomy may require support, at times, to efficiently and effectively complete assigned tasks, duties, and responsibilities. Support should be extended when required. Health care administrators should note that support may come in the form of assistance from other health care professionals, health care-related resources (e.g., meeting space and/or personal computers), and effective intra-organizational communication.

- **Avoid micromanagement** - finally, micromanagement should be avoided. Micromanagement, within the context of a professional organization, may refer to a management style that exhibits excessive control over employees and their professional actions. Health care administrators should note the following: professional autonomy can motivate and ignite individuals' desire to self-start, work independently, take on responsibilities and tasks, complete tasks, accept accountability, communicate effectively, maximize efforts, and optimize patient care, while micromanagement can have the opposite effects; micromanagement can professionally suffocate individuals, and potentially decrease individuals' desire to self-start, work independently, take on responsibilities and tasks, complete tasks, accept accountability, communicate effectively, maximize efforts, and optimize patient care; micromanagement often decrease, stifles, suppress, and/or extinguishes motivation and employee satisfaction.

- **Embrace integrity** - lastly, and perhaps most importantly, health care administrators should embrace integrity. Integrity may refer to the consistent inclusion of honesty, morals, and values into daily actions and behavior. Integrity can be vital to the process of establishing, improving, and maintaining employee satisfaction. Essentially, integrity can help build trust and respect, which in turn can help health care administrators effectively establish, improve, and maintain employee satisfaction. Examples of how health care administrators can incorporate and display integrity in the workplace may be found below.

- **Embrace honesty** - honesty is often the foundation of integrity. Thus, when one is attempting to act with integrity, one first has to be honest with him or herself and others.
- **Embrace shared morals and values** - much like with honesty, when one is attempting to act with integrity, one has to embrace shared morals and values.
- **Embrace transparency** - transparency, within the context of health care, may refer to an open and honest method of transmitting information regarding operating practices and patient care. Within a health care organization transparency can foster trust, honesty, effective communication, teamwork, responsibility, accountability, and, subsequently, employee satisfaction. Health care administrators can embrace transparency in health care organizations by the following means: utilize direct and honest communication; establish open door policies for health care professionals; provide individuals from the workforce with organizational updates.
- **Consistently showing up to work on time** - consistently showing up to work on time may not be an action that comes to mind when considering integrity. However, consistently showing up to work on time can be a very simple and straightforward way to incorporate/display integrity in the workplace. Essentially, consistently showing up to work on time sends the message that one respects other individuals' time, while consistently showing up late to work sends the message that one does not respect other individuals' time. Sending the message that one does not respect other individuals' time can undermine a health care administrator's ability to effectively establish, improve, and maintain employee satisfaction. Thus, health care administrators should make every effort to show up to work on time.
- **Do not waste other individuals' time** - to build on the previous recommendation, health care administrators should not waste other individuals' time. Much like with the previous integrity recommendation, wasting other individuals' time sends the message that one does not respect other individuals' time; sending the message that one does not respect other individuals' time can undermine a health care administrator's ability to effectively establish, improve, and maintain

employee satisfaction. Health care administrators should note the following examples of how one can waste other individuals' time: excessive talking about personal matters that may be irrelevant to health care, making personal calls, sending personal text messages, engaging in personal social media interactions, taking excessively long breaks (e.g., taking a break which exceeds the allotted time), causing distractions, causing disorganization, running disorganized meetings, deliberately moving in a slow manner, failing to engage in relevant training, and refusing to follow specific instructions.

- **Follow health care organization policies and procedures** - following related health care organization policies and procedures can show others that one is attempting to follow directions, pursue education, and create commonality among peers and colleagues. Attempting to follow directions, pursue education, and create commonality among peers and colleagues can help health care administrators effectively establish, improve, and maintain employee satisfaction.

- **Be professional** - finally, acting in a professional manner can go a long way when attempting to incorporate/display integrity in the workplace. Examples of how a health care administrator can act in a professional manner include the following: remain calm, especially in the face of a challenge or adversity; follow directions; listen to others; refrain from using excessive profanity and/or crude language; remain educated and up to date on relevant health care-related information; respect other individual's privacy; do not inject unnecessary personal information or "drama" into professional dynamics; refrain from injecting oneself into other individuals' personal "drama" or personal social dynamics; do not engage in personal social media interactions that may lead to conflict in the workplace; work to efficiently and effectively resolve workplace grievances; follow health care-related laws and guidelines (e.g., the Health Insurance Portability and Accountability Act of 1996 [HIPAA]); follow related scopes of practice; adhere to relevant standards of practice (note: the term scope of practice may refer to a description of services qualified health care professionals are deemed competent to perform and permitted to undertake under the terms of their professional license; the term standards of practice may refer to a statement of duties or specific guidelines for a health care professional). Health care administrators should note that acting in a

professional manner can help health care administrators ``lead by example'' to, ultimately, help prevent employee turnover and effectively manage their health care organization's finances and expenses.

Section 5 Summary

The fifth and final essential element of financial and expense management for health care organizations is to follow financial and expense management recommendations. Financial and expense management recommendations include the following: maintain a budget; consider laws and regulations related to required staffing needs; monitor employee overtime; review financial statements; assess short-term and long-term assets; set financial goals; work to achieve employee satisfaction; treat employees like individuals; provide positive feedback; utilize positive reinforcement; express gratitude; work to establish and maintain a culture of gratitude within a health care organization; allow for and encourage professional autonomy; embrace integrity.

Section 5 Key Concepts

- The fifth essential element of financial and expense management for health care organizations is to follow financial and expense management recommendations.

Section 5 Key Terms

Budget - a financial plan for a defined period of time

Employee overtime - hours worked over 40 hours in a workweek

Financial statement - the official record of the financial activities and position of an individual or organization

Balance sheet - a summary of an individual's or organization's finances

Asset - any resource owned or controlled by an individual or organization that may provide value or benefit to the controlling individual or organization

Liability - any resource that is owed by one individual or organization to another individual or organization

Income statement - a summary of an organization's income and expenditures

Cash flow statement - a financial statement that shows how changes in balance sheet accounts and income affect cash and the availability of cash

Short-term asset - any resource that is held for a year or less; a resource that may be converted into cash within a year or less

Long-term asset - any resource that is held for more than a year; a fixed resource

Positive feedback (with the context of communication) - a form of communication that recognizes an individual's success, achievements, and/or hard work

Positive reinforcement (with the context of communication) - a communication exchange or response that encourages a constructive or beneficial action or behavior

Gratitude - a state of thankfulness or appreciation for receiving what is meaningful to oneself; the act of showing appreciation

Optimism - hopefulness and/or confidence regarding future endeavors and/or outcomes

Empathy - the ability to understand another individual's feelings and/or emotions

Self-esteem - confidence in one's own abilities; self-respect

Professional autonomy - any allowance that enables an employee to complete a task with little to no interruption or interference

Professional independence - the ability of an individual to work safely and effectively on his or her own with little to no direct supervision or management

Professional accountability - the act of taking responsibility for the failure or success of an action, project, or task taken or completed in a professional setting

Micromanagement (within the context of a professional organization) - a management style the exhibits excessive control over employees and their professional actions

Integrity - the consistent inclusion of honesty, morals, and values into daily actions and behavior

Transparency (within the context of health care) - an open an honest method of transmitting information regarding operating practices and patient care

Scope of practice - a description of services qualified health care professionals are deemed competent to perform and permitted to undertake under the terms of their professional license

Standards of practice - a statement of duties or specific guidelines for a health care professional

Section 5 Personal Reflection Question

How can health care administrators use the above recommendations to effectively manage the finances and expenses of their health care organization?

Conclusion

In the current health care climate, financial and expense management is paramount to the success of a health care organization. Health care administrators can effectively manage the finances and expenses of their health care organization by incorporating the following five essential elements of financial and expense management for health care organizations into the cultural, executive, and directional structure of their health care organization: utilize GPOs, when appropriate; employee retention and working to prevent employee turnover; actively seek grants and federal funding that may be used to help financially support health care organizations and/or older adult residents; obtain applicable COVID-19-related relief funds from the U.S. government; and follow financial and expense management recommendations.

References

American Association of Critical-Care Nurses. (2018, September). AACN guiding principles for appropriate staffing. https://www.aacn.org/policy-and-advocacy/guiding-principles-for-staffing

American Medical Association. (2019). Report of the council on medical service. https://www.ama-assn.org/system/files/2019-07/a19-cms-report-8.pdf

Centers for Disease Control and Prevention. (2020, December 16). Dealing with Stress. https://www.cdc.gov/injury/features/dealing-with-stress/index.html

Centers for Medicare and Medicaid Services. (2021). Civil money penalty reinvestment program. https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/LTC-CMP-Reinvestment

Chowdhury, M.R. (2021, May 26). The neuroscience of gratitude and how it affects anxiety & grief. Positive Psychology. https://positivepsychology.com/neuroscience-of-gratitude/

Florida Senate. (2021). 2013 Florida statutes. https://www.flsenate.gov/laws/statutes/2013/400.23

Joint Commission. (2021). Hospital: 2021 national patient safety goals. www.jointcommission.org/standards/national-patient-safety-goals/hospital-2020-national-patient-safety-goals/

Ratna, H. (2019). The importance of effective communication in healthcare practice. Harvard Public Health Review, 23.

U.S. Congress. (2021). CARES Act. https://www.congress.gov/bill/116th-congress/house-bill/748/text

U.S. Department of Health and Human Services. (2021, November 23). Biden-Harris administration begins distributing American Rescue Plan Rural funding to support providers impacted by pandemic. https://www.hhs.gov/about/news/2021/11/23/biden-admin-begins-distributing-arp-prf-support-to-providers-impacted-by-pandemic.html

U.S. Department of Health and Human Services. (2021). Fraud and Abuse laws. https://oig.hhs.gov/compliance/physician-education/fraud-abuse-laws/

U.S. Department of Housing and Urban Development. (2021). Assisted living conversion program (ALCP). https://www.hud.gov/program_offices/housing/mfh/progdesc/alcp

U.S. Department of Housing and Urban Development. (2021). Housing choice vouchers fact sheet.https://www.hud.gov/program_offices/public_indian_housing/programs/hcv/about/fact_sheet

U.S. Department of Labor. (2021). Fact sheet #17N: Nurses and the part 541 exemptions under the Fair Labor Standards Act (FLSA). https://www.dol.gov/agencies/whd/fact-sheets/17n-overtime-nurses

U.S. Department of Labor. (2021). OSH act of 1970. https://www.osha.gov/laws-regs/oshact/toc

U.S. Department of Labor. (2021). Overtime pay. https://www.dol.gov/agencies/whd/overtime

U.S. Department of Veterans Affairs. (2020, April 30). VA nursing homes, assisted living, and home health care. https://www.va.gov/health-care/about-va-health-benefits/long-term-care/

World Health Organization. (2019, May 28). Burn-out an occupational phenomenon: International classification of diseases. https://www.who.int/news/item/28-05-2019-burn-out-an-occupational-phenomenon-international-classification-of-diseases