Overview of Strategic Planning

The environment in which organizations and programs providing services to children with special health care needs operate is characterized by continuous change. Major forces of change include advances in genetics and biotechnology, rising health care costs, and empowered consumers expecting increased participation in health care and access to new treatments and interventions. Pressure for greater accountability and evidence-based practice in health care is also increasing. These forces will likely continue a systemic trend toward ambulatory, outpatient, and post-acute care as well as new models of service delivery with Internet and e-health featured prominently as effective mechanisms of outreach and knowledge transfer.

These and other future changes pose major planning challenges for health care organizations and programs providing services for children with special health care needs. How can health care leaders (health administrators and clinicians) deal with the emerging external forces that will shape the climate in which their organizations and programs operate? Dealing with rapid, complex, often discontinuous change requires leadership and management tools to cope with the ever-changing environment. Hence, a process is needed to renew the organization, revamp products and services, change strategies, policies, rules, and procedures, and reconsider the mission, vision and values. Strategic planning has become the health care leaders' primary tool to anticipate and cope with various external forces and position and adapt their organizations to take advantage of emerging opportunities while avoiding external threats so their organization can survive and grow.

Strategic Planning Definition

Strategic planning is the organizational process for identifying the desired future and developing decision guidelines regarding how the organization will logically and consistently relate to its external environment over time. Thus, the result of the strategic planning process is a plan or strategy. The term strategy has three related meanings. First, strategy is viewed as a pattern for decisions concerning the positioning of the organization within its environment. Strategy also may be viewed as the "behavior" of the organization. Consistency of behavior is "driven" by common organizational purposes, values, and goals. Extensive analysis of external forces shapes these values and goals that will influence organizational behavior and suggest "what the organization should do." Strategic behavior is additionally influenced by the internal capabilities of the organization and represents "what the organization can do." Finally, these values and goals often result from considerable analysis by organizational leaders and indicate "what the organization wants to do" in light of environmental opportunities and threats and organizational strengths and weaknesses.

Strategic Planning Process

Strategic planning is comprised of a set of steps for the organization's leadership to review together and confirm/revise its mission and vision, reach consensus on the desired future of the organization, and develop decision rules to achieve that future. Basic components of the strategic planning decision process include: 1) situational analysis, 2) strategy formulation, and 3) planning implementation of the strategy.

Situation Analysis

Analyzing and understanding the situation is accomplished by three separate strategic thinking activities: 1) external environmental analysis, 2) internal environmental analysis, and 3) directional strategies. The interaction and results of these activities form the bases for development of strategy. First, situational analysis means obtaining current information on the external climate, analyzing these data and sensing emerging changes in the future external climate, then assessing implications of these trends for the health care industry and the organization. The external environmental analysis will suggest "what the organization should do." Strategy is also influenced by internal resources, competencies, and capabilities of the organization and represents "what the organization can do." Finally, strategy is driven by the organization's directional strategies. Directional strategies include the "mission" statement describing the organization's purpose. The mission statement defines the organization's overarching purpose and shared values that will guide the organization's members in performing their work to fulfill its purpose. Also, the mission communicates the essence of the organization to people inside and outside the organization. Whereas the mission statement summarizes the what, how, and why of the organization's work, "vision" defines a gap between the present and some future state and what success will look like. Directional strategies indicate "what the organization wants to do." Together, these forces are essential input to strategy formulation. These components of the situation analysis are not mutually exclusive but overlap, interact with, and influence one another.

Strategy Formulation

Whereas situational analysis involves extensive gathering, classifying, analyzing, and understanding of information; strategy formulation involves decision making that uses situational knowledge to reaffirm or adapt the organization's mission and vision as well as makes choices regarding components of the strategy that will define "how" they will achieve their mission and vision. Other components of strategy represent choices regarding: 1) Markets or population groups it will target and how the organization will reach the targeted populations. 2) Products/services/solutions the organization will offer. 3) How the organization positions or differentiates its product and/or service offerings in the market. 4) How the organization designs and manages its clinical/business processes across the value chain. The value chain is comprised of the core processes that encompass the patient value-adding work of the organization. 5) How the organization configures its resources. 5) Activities in the value chain the organization will perform

itself and activities it will outsource to outside partners. 6) How the organization will capture retained earnings or profits.

Strategy Implementation

The strategic formulation planning process defines where the organization wants to go; the implementation plan defines who (people) is going to get the organization there and the implementation path for the people. Strategy implementation involves putting the strategies to work by engaging the organization's people in setting implementation goals, objectives, action steps, and outcome measures that link the strategic process to the organization's operating processes. The implementation plan centers on developing action plans, including necessary activity and resource trade-offs between short-term objectives and long-term goals, and assigning people. Finally, the implementation plan should include agreement and accountability from all participants, establishing follow-through measures to make sure people are meeting their commitments to bring the strategy to fruition.

Marketing Overview

The American Marketing Association defines **marketing** as the process of planning and executing conception, pricing, promotion and distribution of ideas, goods and services to create exchanges that satisfy individual and organizational objectives. Marketing is an integral part of the economy that helps to identify, develop and bring products, services and ideas to producers, intermediaries and end users.

Marketing is often discussed as having four components: product, price, place and promotion. The term **product** refers to a wide range of things. Of course, there are materials goods like pharmaceuticals, cars and books that are all considered products. In the early 1900's the definition of product was limited to such material items. However, as the economy grew and products became more sophisticated, it became clear that service were an important part of the product. For example, instead of just buying a car, marketers became aware that the competency of the car vendor and the on-going relationship he/she had with the customer was bundled together in the customer's mind with the car itself. So, the term product expanded to encompass not only the durable item but also the service associated with it. Eventually, the term product came to be used for purchases that were comprised of only services, like legal counseling. The next big step in broadening the definition of marketing came when marketing was used to focus the dissemination of ideas. So, campaigns like "Buckle Up for Safety," or "get prenatal care" or "Vote for Proposition 3" were honed by marketers. As this evolution occurred, the term product expanded once again to include ideas. As things stand today, the term product refers to material goods, services, ideas or any combination of these. To drawn an example from care for children with special needs, a pediatric dental clinic provides a *product* that includes the dental *services*, the *material goods* the clinic may send home with the family for in-home care and the *ideas* of appropriate dental hygiene and follow-up.

Price is a term that everyone is familiar with when it is applied in a context that refers to money. Marketers expand the definition of price to include costs to one's self image, time spent on acquiring/using the product, costs associated in integrating the product into one's life and so on. So, a very inexpensive car may have a low price, but it may challenge the buyer's self image as an up-and-coming individual and may require him to change the garage he uses for car maintenance. As a result, price is a broad term that covers all that the buyer is asked to give up in order to acquire the product. In the case of children with special needs, parents who are sent for genetic counseling have to pay a price that includes threats to their self-concept when they are confronted with the knowledge that they are carriers of a particular genetic anomaly.

Place is also a very broad term that covers the location at which the customer acquires or uses the product. It also encompasses the routes or channels through which the product moves to the end user. In the example of a head of lettuce, the most obvious component of place is the grocery store the consumer uses. But, place also reflects the decision that the lettuce grower made in choosing to sell through a national chain as opposed to a

roadside stand, to restaurants, or to foodservice providers. Place is a very important consideration, in part, because it is very difficult to change. For example, in the case of children with special needs, the place component of a specialist in child psychiatry includes the office out of which she practices (i.e., its location, its décor, its signage, etc.), the building in which she is located (i.e., the parking availability, its geographic location, the hours it is open for appointments), and the health plans she accepts. The health plans are included because they act like a road that allows the end user to move towards her, and if the road is blocked, the end user cannot get to her place of work. If the physician changes her geographic location, or even the health plans she accepts, the ability to "get to" her product may change dramatically.

Promotion is another extremely broad term having four categories itself: *advertising*, *publicity*, sales *promotion*, and *promotion* (here promotion is used as a catchall term meaning not one of the other three categories). All forms of promotion are ways that the provider communicates with end users or other decision makers who are involved in the acquisition of a product. Advertising is paid for, mass-market communication. So, a campaign to inform parents about the importance of vaccines is advertising if the Health Department pays to run these pieces on air or in the paper. If the Health Department does not have to pay for this communication, if instead the TV or newspaper runs a feature piece that emphasizes the message for free, then this is called publicity. Sales promotion, or personal selling, is characterized by having face-to-face communication. This form of promotion is usually necessary if the product is complex and if the buyer needs to have more of a personal connection to feel comfortable with the purchase. Sales promotion is the most time consuming and expensive (on a per person reached basis) type of communication. Life insurance was traditionally sold through personal selling, although the internet is now making inroads. The upside of using the internet for buying life insurance is that the costs to the company are lower (because they do not employ a sales staff), and so the cost savings are passed along by lower premiums for life insurance. The downside of using the internet is that consumers are asked to make a potentially complex decision without the access to an informed sales agent to discuss or explain the product. To see the role of relationship in health care, consider how although health care is generally seen as a collaborative model in which the provider and the patient (or her family) make decisions jointly, there are situations in which the patient (or her family) may resist a particular message. For example, perhaps the psychological price of accepting a diagnosis is too high for the patient/family to initially accept the message. In this situation, providers would continue to use persuasive communication to inform the patient/family about the diagnosis. Using the example of the family that is not yet ready to accept a diagnosis, it is clear that several visits spread over time will be needed for the provider and the family to make a joint decision that is acceptable to all. The final category, promotion, is used to capture all the communication efforts that do not fit in the category of advertising, publicity or sales promotion. Pens or magnets with a clinic name and phone number are examples of the category "promotion" within the broader term promotion.

In addition to the areas of product, price, place and promotion, there are some other central ideas in marketing. One is the concept of a **target market**. This is the group of

customers for whom a product is developed and marketed towards. So, for example, Lucky brand blue jeans are targeted towards young adults who are interested in being fashionable and trendy. They are not targeted to the newly retired baby boomer. Targeting is accomplished in part by effective **positioning** of a product. Positioning is how one thinks about a product. For example, Volvo is positioned as a safe car; it is not positioned as the perfect vehicle for baby boomers that need a mid-life crisis car. Marketing **intermediaries** are all the middle men, or vendors, that help move the product from the manufacturer to the end user. The intermediaries can influence the product's positioning and the efficacy of its target marketing. For example, most consumers would not find a high-end position of a consumer product credible if it were to be sold through a discount vendor (e.g., would the average consumer pay thousand of dollars for a wedding dress bought through K-Mart?).

Marketers make a broad distinction between **products that are marketed by businesses to consumers**, sometimes referred to as B-2-C, (e.g., the grocery store that sells to you, or a vitamin manufacturer that sells to you) and **products that are sold from one business to another**, sometimes call B-2-B, (e.g., Proctor and Gamble sells Tide to your local grocery store, or a vitamin manufacturer sells vitamins to another manufacturer that puts them into enriched flour). The sorts of consumer purchases we make on a daily basis usually involve fewer decision makers, often only the adults in the household, or maybe even just the primary shopper. On the other hand, businesses usually have more complex buying decisions. The person who uses a drill press in the plant is rarely the one that negotiates with a drill press producer, and the negotiator is usually not the same person that does the day-to-day processing of outstanding orders. Because the buying process is different between B-2-C and B-2-B the promotion process is usually different. In general, more advertising is used when selling to consumers and more sales promotion is used when selling to other businesses.

Marketers are also involved in developing new products. The field of **marketing research** is dedicated to providing information that can be used to guide marketing decisions. Marketing research can be broken into two main approaches. The first is **quantitative research**, which, as its name suggests, is involved with numbers and statistical analysis. Most quantitative research gathers data from surveys. The second approach is **qualitative research**. This type of research is "softer", relying on techniques such as focus groups, interviews, observation and the like. Qualitative research usually has fewer respondents but may gather more detailed information from each one. Quantitative research usually gathers information on many people but the depth of each piece of data is limited.

Health care providers are engaged in marketing every day whether they realize it or not. Every effort to educate patients is a form of marketing in which ideas are being communicated in a persuasive way. Each time a patient is asked to sacrifice time or energy to do a certain task, such as exercises at home between appointments, the provider is asking the patient to pay a price in exchange for a benefit. Family groups that advocate for their children use marketing to clarify their messages and the means that they will use to communicate them. Marketing is much more than TV ads or telemarketing!

Marketing, done effectively, allows for clear communication, effective messages and the delivery of high quality products.

Overview of Operations Management

Operations Management involves the planning, scheduling, and control of activities that transform inputs into finished goods and services.

For organizations providing specialized health services to children, the success of the management of the operations impacts directly on the ability of that organization to deliver services of a certain quality standard in the quantity and timeliness that meets the needs of the consumers of the services.

Successful planning for the management of the operations of any business must be carefully aligned with the strategic and financial planning functions. It is critical for operations planning to be in sync with strategic planning because the management of operations involves determining the tasks and technology needed to fulfill strategic objectives, deciding how to acquire the resources and design the facilities these tasks require, and measuring service delivery to gauge the ability of the operations to reach intended targets.

Primary activities of operations management include job design, scheduling, materials management, capacity management, facilities management, and quality management. In this article each of these activities will be outlined in the context of planning the operations of a human service organization. Key operations management concepts are **bolded** for identification purposes.

Operations Management in Health Care/Human Service Organizations

One reality that distinguishes operations management for the human service industry versus the manufacturing sector is that services can not be **inventoried**. Health services must be provided "**on demand**" to the consumer. This lack of inventory presents serious implications for the management of a service organization because of the increased need to plan carefully to ensure that appropriate services are available when needed. Not only is health care service provision vulnerable to **cyclical variation** due to calendar events such as holidays or the commencement of school, but health services must be available in the event of **unanticipated circumstances** such as an outbreak of a communicable disease.

Therefore, **scheduling** for normal operations as well as for times of **unusual demand** generates the need to build a system where personnel are responsive to the need to **increase capacity**. Public health care planners often refer to this ability to react to times of unanticipated increased demand as **surge capacity**.

Capacity management is a major operations consideration and the following three capacity-related areas are particularly important for planning: **materials management**, **technology use**, and the use of **capital**.

In order to have materials available to provide services in a timely manner the materials need to be **identified, ordered, purchased, inventoried,** and **stored**. In addition, there must be an efficient **means of access** to and a **consistent supply** of these items which indicates that the **flow of materials** needs to be documented and analyzed. Oftentimes the demand for a material or set of materials for a specific service is related to the demand for materials for another related service and these variants need to be considered in planning the **distribution** of the materials. For example, a well-visit has different implications than a visit for a specific medical intervention and these implications may include a need for materials such as vaccines, lab testing supplies, or assistive technology.

The term "**technology**" not only encompasses the items commonly thought to be technological such as diagnostic equipment and computer systems. In operations management **technology** refers also to **human technology** because of the contribution of the expertise of the individuals who work in the organization. Recently the concept of **technology** has been broadened further to include **systems** where practical application of knowledge for the prevention, diagnosis, and treatment of disease occurs.

Management decisions regarding the **acquisition of technology** have to be carefully made with consideration of the financial status of the organization. The **use of capital** in any business requires an assessment of current needs and projections of future needs. This is why operations decisions must be made in cooperation with the financial planning strategies.

Related to capacity management is the operation and location of the facilities that house the service delivery. The facilities must be large enough to accommodate the work that must be done and designed to facilitate **efficient** service delivery. For example, improvements in emergency room capacity can be achieved by a redesign of the operations—including **scheduling**, **facilities**, and **job design**. In a 2004 article in the *Boston Globe*[1] entitled "Emergency Room Recovery", Boston Medical Center's success at reducing waiting in its emergency room by the use of operations management strategies is described.

Ideally, human service facilities are located near to customers. However, in cases where customers may live some distance from facilities, operational strategies can be implemented to make services accessible such as parking and the design of waiting and visiting areas.

Job design is an especially important operations function in the health care industry because health care involves high **labor intensity**, a high **level of interaction** with the customer, and the services delivered are highly **specialized** to customer needs. These three factors make thoughtful job design in a human service organization particularly important because of the increased negative consequences of job turnover and error.

[1] Reference: http://www.boston.com/globe/search/stories/reprints/emergencyroom070804.html

Properly designing jobs for individuals or groups means specifying WHAT is to be done, HOW it is to be done, and WHY it is to be done. The answers to these queries on the operations side should reflect the organization's mission and strategic plans and include the design of the facilities or work environment to facilitate the use of technology for completing the work. The design of the work environment to include the interface of human and machine technology is often referred to as **ergonomics**.

Finally, **quality management** activities are vitally important for the success of operations management. There are a variety of approaches to the assessment of quality and to the use of data for improving operations but most organizations recognize the need for a system of **continuous quality improvement**. Ideally, the continuous quality improvement system would catch errors and track data that provides information to make adjustments in the system. In order to learn more about specific issues relating to service quality and the ability of the organization to meet strategic objectives, specific data collection practices are often implemented such as **customer satisfaction surveys**, **outcomes measurement** on specific treatment variables, **or impact measurement** on individuals, families, or the community.

Unfortunately there is less opportunity to correct quality problems in human service delivery than in manufacturing. Moreover, the costs of assessing quality is high due to the need to measure constructs which are difficult to operationalize such as "courtesy", "attention", and "participation in treatment". Quality improvement data collection also means attention to the development of ethical and credible data collection strategies from customers, including primary and secondary service recipients. It is also recommended to apply what has been learned from **evidence-based medicine** and from research into the **best practices** for the type of services being delivered.

In conclusion, much of operations management involves determining what needs to be done and how much effort/resources it will take. There are often a number of trade-offs that should be considered such as **specialization** versus **expansion** of job tasks. It is of paramount importance for the central operations functions of job design, scheduling, capacity management, facilities management, and quality management to be closely aligned with the strategic objectives of the organization and to be cooperative with the financial realities and projections for organizational growth and improvement.

Financial Management Overview
Health Services & Applications to Neurodevelopmental Disabilities & Related Disorders in Children

The health care sector of our economy is growing rapidly in both size and complexity. Understanding the financial and economic implications of decision making has become one of the most critical areas encountered by health care decision makers. Knowledge paired with successful decision making can lead to a viable operation capable of providing needed health care services. Unsuccessful decision making often leads to financial failure. The role of financial information in rounding out the professional's perspective cannot be overstated.

Compared with most businesses, health care organizations are financially complex. Not only do they provide a large number of specific services, but also their individual services often have different effective prices structures. Services may be bundled in different ways to determine prices, according to extant agreements with specific payers. One customer [patient] may pay on a cost basis while another may pay based on self pay criteria. Prices may be determined prospectively or may be **capitated** for broad scopes of care. This variation in payment patterns or reimbursement creates problems in the establishment of prices for products and services. Indeed, the revenue function of a typical health care entity is usually much more complex than that of a comparably sized non-health care business. Further, organizations within different segments of the health care industry are affected by changes in payment arrangements in different ways.

Health care entities also depend heavily on a very limited number of key clients for most of their **operating costs**. The largest client is often the federal or the state government. Doing business with these governmental agencies involve a significant amount of reporting to ensure compliance and adherence to government regulations. Moreover, since the federal government is such a large purchaser of services, a thorough understanding of the nature and implications of the Medicare and Medicaid payment system's rules and regulations is a must for effective management practices.

Health care organizations can have vastly different **revenue structures** depending on which segments of the health care industry in which they are active. Government commands enormous influence as a purchaser of health care services and maintains complex payment systems. The **Managed Care** arena is an evolving payment mechanism that also must be critically analyzed and understood. Health plans have historically paid providers, doctors and hospitals on a **fee-for-service** basis. The health plan then assumed the risk for all **utilization variances**, whereas, the provider assumed the risk for production, being able to provide services at cost less than negotiated prices. **HMOs** and other managed care organizations are also trying to shift utilization risk to providers by capitating payment to them.

Capitation payment systems require the providers to know much more about the populations that they are obligated to provides services to and to do a much better job of

forecasting. Pricing under a capitated payment system is easy to conceptualize but difficult to implement because most providers have little experience with utilization variation in a covered population.

Regardless of whether a health care service is for profit or not-for-profit, both types of health care organizations must be able to cover their costs or the services will not survive. Generating more revenue, or income, than what it costs to provide those services is also a worthy goal, regardless of non-profit status. If a not-for-profit health care service generates a "profit" (i.e., takes in more revenues than it expends), the organization can put those resources back into the program for improvements or to meet increasing costs. The costs of doing business, whether it is health care or something else, usually involves a combination of **fixed costs** which are independent of volume of goods and services produced, such as salary for employees or equipment, and **variable costs**, which are goods or materials whose consumption is related to the volume or number of goods and services produced. The components are typically referred to as the "**cost structure**" of an organization. In the case of health care, the services or products of this sector are typically referred to as volume, visits, or utilization. Because the ability to survive as a health care provider organization is dependent upon an organization's capacity to balance costs and revenues, it is critically important for not only managers and budget analysts to understand the basic tools of financial management, but also for clinicians to understand these concepts and their role in the cost structure and revenue generation processes. It is a fundamental requirement of leaders within an organization to assure the fiscal "health" of a company or organization, and thus, leaders of clinical programs must also have a command of financial management tools to assure good financial health.

Analyzing cost structures typically involves identifying **fixed costs** of salary and benefits of health care providers, facilities, debt service, and equipment. Fixed costs for the most part do not change within a fiscal year, and the organization is committed to paying out those costs whether one or 1000 patients are seen. Thus, to meet fixed costs there is an incentive to generate volume. **Variable costs** will vary, or change, as a function of patient volume. For example, laundry and food service charges in a hospital will vary depending on number of admissions and length of admissions. Both fixed and variable are referred to as direct costs. **Indirect costs** include the cost of administrative and overhead types of services that may be shared by a number of other clinical program areas or units, such as payroll, information services, billing, and housekeeping, but some portion of those costs must be borne equitably by each of the service units who make use of those shared services.

Generating revenue involves not only offering services that are attractive and responsive to customer needs, but also assuring adequate patient mix to secure reimbursement, managing timely billing, raising non-patient revenue based income, and effectively managing to maximize efficiencies that save the organization and the consumer money. **Analyzing utilization**, **revenues, and cost recovery** can also help a health care organization identify strengths and weaknesses and gaps in revenue generation, and can also contribute to **pricing** of services. Many health care organizations function as "price takers," meaning that they take the reimbursement

provided by third party payers for particular services. Analysis of utilization and revenues based on prices set by the insurers is often all that is needed to project revenues under different volume scenarios. However, when new services are offered, establishing prices (i.e., becoming a "price setter" instead of "price taker") may require the use of other types of analytic tools which may be based upon the actual costs of providing the service (based on the "cost structure") and the presence or absence of discounts or a profit targets. A **cost-volume-profit analysis** and **break-even analysis** are two financial management tools that allow managers to explore the impact of alternative assumptions about costs, prices, and volume on its capacity to provide a particular service. This type of information can help managers "evaluate future courses of action regarding prices and the introduction of new services." (Source: Louis Gapenski, *Health Care Finance.* Foundation of the American College of Health Care Executives, 2005).

Budgeting is also an important management tool that enables administrators to establish operational goals to keep costs in balance. Oftentimes a budget is set based upon previous year's experience, and significant variations can occur in the current year from the previous year's experience. If, for example, volume of visits is significantly lower than projected for a given period, there can be cost savings in variable costs, but fixed costs must be met regardless. Using c-v-p analysis in the budgeting process can allow administrators to develop a range of cost estimates based on volume and set volume targets to keep costs manageable. Use of the **balance sheet** (which provides a real time summary of costs/expenditures and cash flow) to monitor costs and revenues on an ongoing basis throughout the year is also an excellent tool to support the fiscal health of a health care organization and enables timely responses revenue or expense problems that might emerge.

Internal fiscal controls are employed in health care settings to assure accountability of the funds being generated (revenues) and being expended (payouts for salary, supplies, equipment, debt service, etc). Internal fiscal controls, such as payroll analysis and accounting audits, help managers identify any unusual outflows of cash or other inappropriate use of funds, and help avoid billing errors that could lead to costly and embarrassing fraud investigations.

Beyond using financial tools to effectively manage a health care service, financial analysis is a necessary component to any **business plan**. Analysis of market conditions is essential to predicting the potential of a new or expanded service, product, or line of business to cover its costs and/or make a profit, but this analysis cannot be complete until there is a full understanding of costs under various market scenarios, or projected volume of sales or services. Thus, all of the tools of financial management described above would prove useful when incorporated in business planning for new services. This type of analyses can gain the confidence of potential investors, whether they are financial investors, grant makers, academic administrators, or chief financial officers of health care organizations, all of whom will evaluate the merits of various proposals based on not just the need for the service, but is fiscal soundness as well.

The ability to manage financial decision-making requires an understanding of various terms. Below are listed common finance and budgeting terms and definitions of health services that will be invaluable in the professional's consideration of financial issues in care delivery for children with special health care needs.

Third-party payers-insurers from which a large proportion of the health service industry receives its revenues. Third-party payers are classified as private insurers (Blue Cross/Blue Shield, commercial, and self insurers) and public insurers (Medicare and Medicaid).

Revenues-monies collected or expected to be collected by an organization from the provision of patient services.

Expenses- economic costs associated with the provision of services.

Reimbursement-payment methods used to reimburse providers. Payment methods fall into two major classifications**: fee-for-service** and **capitation**.

Fee-for-Service-a payment method of which many variations exist and is based on the greater the amount of services provided, the higher the amount of reimbursement.

Capitation-a payment method in which a fixed payment is made to providers for each enrollee regardless of the amount of services provided. Providers receive a specific amount in advance to care for specific health care needs of a defined population over a specific period. Providers are usually paid on a "per-member–per-month" basis (PMPM).

A **capitated provider** assumes the risk of caring for the covered population for the PMPM amount. The capitation dollars are derived from premiums paid by enrollees.

Prospective Payment System-The rates paid by the payers are determined by the payer before the service is provided. For example, per procedure, per diagnosis, or per diem. This system is used by Medicare to reimburse providers a set amount based on the patient's DRG (Diagnosis-related group).

Managed Care- various arrangements made that are designed to control health care costs through monitoring, prescribing, or proscribing the provision of healthcare to a patient population, for example, an **HMO**. Managed care plans provide both the insurance function and the provision of healthcare services.

Health Maintenance Organization (HMO)-Entities that receive premium payments from enrollees with the understanding that the HMO is financially responsible for all predefined health care required by its enrollees for a specified period of time. The healthcare is provided through the HMO's provider network.

Preferred provider organization (PPO)- An independent provider or provider network pre-selected by the payer to provide a specific service or range of services at predetermined (usually discounted) rates to the payer's covered members.

Utilization review-used to ensure that services rendered are appropriate and needed.

Usage Variance-the dollar amount caused by excess utilization.

Negotiated charges-allow for discounts for billed charges. Some HMO's and PPO's can negotiate discounts ranging from 20 to 30 percent or more of charges billed to them because of the large number of patients that they bring to a provider.