Glossary

Academic medical centers—Similar to community not-for-profit facilities, academic medical centers are generally organized as tax-exempt under Internal Revenue Service regulations (501 (c)(3)). Their primary purpose is to provide community benefit through various programs and services. Access to capital is mainly through donations (which are usually tax-deductible to the donor), bonds and other debt instruments, and efficient operations. A major part of their mission is teaching new health-care professionals and funding research. These additional activities carry a higher cost structure, which is often partly offset by other funding sources such as grants, state legislative funding, and so forth.

Accounting methods—The three basic accounting methods used by health-care organizations are cash basis, accrual basis, and fund accounting.

Accrual basis accounting—Used for most businesses, this method seeks to "accrue" revenues and expenses to the proper period in which they are earned.

Activity matrix—A matrix of prioritized activities, resources, and costs for pharmacy services to be delivered in an institution.

Acuity—A measure of severity of illness.

Administrative data—Payment, cost, and activity data generated anytime a patient has an encounter with a provider or facility when reimbursement is sought for those services.

Administrative fees—Fees paid by the hospital for its membership to belong to a GPO and to access the contracts the GPO offers, or fees paid by the manufacturer or supplier of the product. Administrative fees typically range from 1 to 3 percent of the purchase price of the product, and they must be disclosed in an agreement between the GPO and each participating member.

Advance beneficiary notice (ABN)—A written notice (on form CMS-R-131) given to a patient before that patient receives items or services, notifying the patient that Medicare may deny payment for that specific procedure or treatment, and that the patient will be personally responsible for full payment if Medicare denies payment. The ABN explains alternative treatment options, quality-of-life issues, and the patient's obligation to pay for the therapy if the claim is not approved by CMS. The ABN must be signed by the physician providing services and by the patient. The patient must disclose any coverage or financial assistance from secondary insurance providers, medication assistance programs, patient assistance programs, or charities.

Ambulatory payment classification (APC)—The APC outpatient prospective payment system (OPPS) is a reimbursement method that categorizes outpatient visits into groups according to clinical characteristics, typical resource use, costs associated with the diagnoses, and procedures performed. An APC is a diagnostic classification analogous to an outpatient diagnosis–related group.

Balance sheet—Lists assets owned by the organization on the left side of the report, and the liabilities owed and the equity of the organization on the right side of the report. Assets must equal liabilities plus equity (or net assets).

Benchmarking—The continuous process of measuring products, services, and practices against the company's toughest competitors, or against those companies identified as industry leaders, so as to find and implement best practice.

Board of trustees—All hospital operations are governed by a board of trustees that commonly consists of members of the hospital's senior management team and representatives from the medical staff and the community.

Budget—A plan for future expenses and revenue, typically over a 12-month period. A budget does not represent the actual amount of money available to be spent, but is a plan based on history and on an understanding of the future. The pharmacy budget is designed to be a thoughtful, data-driven forecast of future expenses and revenue, and a yardstick for measuring financial performance over the course of the financial year.

Budget variance—The difference between the budgeted amount and the actual amount spent for a period. Variances can be described as positive

(expenses lower than forecast; revenues higher than forecast) or negative (expenses higher than forecast; revenues lower than forecast). Variances can also be absolute: the total actual amount is higher irrespective of volume, or volume-adjusted.

Bundled contracts—Contracts for multiple products produced by a single manufacturer. This type of contract is usually anchored by a key product in a competitive market, along with several other products for which the manufacturer has competition from other suppliers.

Business plan—A document with a standard format and structure that clearly explains the what, why, when, who, and how of the project. It is a comprehensive explanation of the opportunity, the people involved, the money required to implement the plan, where the resources will come from, and what financial results the opportunity is likely to produce.

Capital budget—Typically comprises items that cost more than a fixed threshold amount (e.g., an expense greater than $5,000) and that have a useful life greater than a specified number of years (e.g., five years). Capital expense budgets are typically set several years in advance. Pharmacy examples include installing new IV admixture hoods, remodeling a pharmacy, or building a new pharmacy satellite.

Case mix index (CMI)—Indicator of acuity to recognize the additional cost and resources required to care for more seriously ill patients.

Cash-basis accounting—Recognizes income and expense only when cash is received or disbursed. It ignores liabilities for purchases made but not yet received, and for assets earned but not yet collected. Cash-basis accounting is typically limited to individuals or small community organizations.

Centers for Medicare and Medicaid Services (CMS)—A federal agency in the US Department of Health and Human Services (DHHS) that administers the Medicare program and works with state governments to administer Medicaid and the State Children's Health Insurance Program (SCHIP). CMS establishes program policies in accordance with congressional mandates through regulations, transmittals, and directives to fiscal intermediaries.

Clinical decision-support system (CDSS)—A centralized data warehouse to analyze combined administrative, clinical, and financial data.

Community-based (or not-for-profit) facilities—Generally organized as tax-exempt under Internal Revenue Service regulations (501(c)(3)). Such facilities provide community benefits through various programs and services, and they are funded mainly through donations, bonds, other debt instruments, and efficient operations.

Compensation philosophy—A pay and benefit structure and philosophy developed to attract, retain, and motivate employees, while allocating available funds in the most effective manner.

Competitive environment analysis—Research report that includes an overview of the pharmacy's competitors, their nature, the number, and their advantages and vulnerabilities. This research also considers the overall size of the market in terms of gross dollars and net profits, clients and customers, and growth trends over the past three to ten years. The analysis should include any external or internal trends that would affect the potential for success or failure, as well as how this proposed venture would succeed in such an environment.

Continuing education—Instruction that is beyond the requirements for entry into a profession. Continuing education may include courses, programs, or organized learning experiences.

Continuous Quality Improvement (CQI)—A management philosophy that asserts that most things can be improved upon. CQI is an approach to quality that builds upon traditional quality assurance methods by emphasizing the organization and systems. CQI emphasizes process improvement and supports the use of objective data to assess and improve processes.

Contract purchase—Purchases made through membership in a GPO.

Contribution margin—The amount by which total departmental revenue exceeds total departmental expenses.

Cost accounting system—(or cost-allocating system, or decision-support system) A process that uses information from the hospital's general ledger system applied to individual patient accounts from the hospital's billing system to perform detailed

data analysis. Used to allocate the hospital's total cost to the patient database with no comparisons to budget, or a standard cost.

Cost-containment plan—Documents areas in which targeted interventions may improve quality and reduce cost.

Data element—A reported metric (e.g., volume statistic, expense, revenue, etc.) within a productivity monitoring system.

Delphi process—A structured process for collecting and compiling knowledge and developing consensus in a group through a series of questionnaires with a feedback process through which agreed-upon values are developed with the help of a facilitator.

Departmental outsourcing—The outsourcing of the management of the entire pharmacy department.

Diagnosis related group (DRG)—A system used by Medicare to classify inpatient hospital services in which hospitals are paid a fixed rate for specific diagnoses. A DRG is expected to have consistent hospital resource use. DRGs were developed for Medicare as part of the prospective payment system. A DRG is assigned based on diagnoses, procedures, age, sex, and the presence of complications or comorbidities.

Direct expenses—Expenses that can be clearly identified as having been incurred in the operation of a department of the hospital.

Direct time study—A series of direct observations of a task to determine the average time required to complete the task and to assign a standard deviation to the average measurement.

Disproportionate share hospital (DSH) program pricing—(or 340(b) drug pricing program) A federal program for eligible safety net providers that gives discounts on the cost of pharmaceuticals; typically, to qualify for 340(b) pricing, a hospital must provide care to a certain percentage (>11.75%) of low-income individuals.

Earnings Before Interest, Deductions, Taxes and Amortization (EBIDTA)—Net revenue less operating expenses equals earnings before depreciation, interest, taxes, and amortization (EBIDTA for for-profit reporting) or the excess of revenues over expenses (for not-for-profit reporting).

Expense—A payment made by the health system to others for value received. Pharmacy expenses can be divided into three categories: supplies, human resources, and other expenses.

Fiscal intermediaries—(FI) Fiscal intermediaries are regional and state Medicare contractors that provide reimbursement review and medical coverage review. Medicare fiscal intermediaries are private insurance companies that serve as the federal government's agents in the administration of the Medicare program, including the payment of claims.

Fiscal services—The collective name for a number of different departments often led by the chief financial officer. Fiscal services can sometimes simply refer to the accounting department.

Fixed expenses—Expenses that do not fluctuate as volumes in the hospital change. Examples include the monthly lease payment for office space or equipment and core staffing levels in some revenue-producing departments and such overhead departments as administration, human resources, and fiscal services.

Flexible budget—An interactive budget that adjusts the static budget based on the actual volume and mix for a period of time.

For-profit facilities—Generally organized as taxable entities. Besides their organizational mission, their primary focus is on generating a return for the shareholder or owner(s). Access to capital is mainly through the sale of stock, debt instruments, and efficient operations.

FTE—A full-time equivalent employee, computed by dividing the number of man-hours for the period by the number of man-hours a full-time employee would be paid for that period.

Functional outsourcing—The outsourcing of a specific function within the pharmacy, such as nuclear radiopharmaceuticals, intravenous compounding, clinical services, packaging services, and after-hours order entry.

Fund accounting—Typically used by governmental entities and academic medical centers, fund accounting establishes specific funds for a variety of uses, such as the equipment replacement fund and the general fund. The general fund serves as the operating fund for the entity.

Gap analysis structured method—Used to document the difference between where a particular department or process is versus where it should be.

Gross revenue—The total amount of revenue billed, based on the established charging structure.

Group purchasing organizations (GPOs)—Organizations whose primary service is developing purchasing contracts for product and nonlabor service agreements that their membership can access. By pooling the purchases of their member hospitals, GPOs can negotiate lower prices from suppliers and manufacturers.

HCPCS coding—The process of organizing data into meaningful categories for analysis. The HCPCS code set is one of the standard code sets used for this purpose. The HCPCS is organized into two principal subsystems, referred to as level I and level II of the HCPCS. Level I of the HCPCS comprises the CPT (current procedural terminology), a numeric coding system maintained by the American Medical Association (AMA). The CPT is a uniform coding system comprising descriptive terms and identifying codes used primarily to identify medical services and procedures. Level II of the HCPCS is a standardized coding system used primarily to identify products, supplies, and services not included in the CPT codes.

High-priority medications—A list of 60 to 80 drug products that represent as much as 80 percent of total annual medication expenditures. *Compare* **Low-priority medications.**

Home infusion center pharmacies—Specialized pharmacies that primarily mix, prepare, and dispense infusions, injections, and other products for use in the home and in other ambulatory settings.

Hospital profit box—A hospital financial model that focuses on the income statement.

Human intellectual capital (HIC)—The value of the collective experience, wisdom, education, and other factors that represent an institution's population.

Human resource expenses—Consist of the salary and benefit costs for pharmacists, pharmacy technicians, pharmacy managers, and others.

ICD-9-CM classification system—The International Classification of Diseases, ninth revision, clinical modification (ICD-9-CM) is a coding system based on the World Health Organization's ninth revision, International Classification of Diseases (ICD-9). ICD-9-CM is the official system of assigning codes to diagnoses and procedures associated with hospital care in the United States. The ICD-9-CM is designed for the classification of morbidity and mortality information for statistical purposes, for the indexing of records, and for ease of data storage and retrieval. The ICD-9-CM classification for diagnoses and injuries is grouped into 17 chapters that are typically arranged by body systems. These codes can be up to five digits in length, permitting detailed descriptions.

Implementation plan—A plan with a timetable indicating key milestones.

Income statement—(or operating statement, or statement of revenues and expenses) Reports financial performance of the organization for a designated period of time. It details revenues earned and related expenses incurred in the operation of the organization.

Indirect expenses—Expenses such as employee benefits, or depreciation, that are similar in nature to revenue deductions in that they require an allocation to be made.

Institutional review board (IRB)—An institutional review board (IRB) is a committee formally designated to monitor, review, and approve biomedical and behavioral research involving humans. The IRB focuses on the protection of the rights and welfare of research subjects.

Integrated delivery networks (IDNs)—Networks of facilities and providers, usually anchored by one or two large hospitals (many times teaching hospitals), and several smaller community or rural hospitals, clinics, and other alternate sites of care, that work together to provide care to a specific market or geographic area.

Intermediate Product (IP)—Represents the standard costs associated with dispensing one unit of a drug. These costs include all resources of the institution related directly and indirectly to the drug.

Internal benchmarking—(i.e., internal productivity monitoring) A process of measuring current department performance against performance over time, comparing current and future

department performance against prior department performance.

Key indicators—List of performance measures used to monitor changes in financial operations over time; reviewed at least annually to be sure that the reports and ratios focus on the current main issues.

Letters of commitment (LOCs)—Letters that the pharmaceutical supplier requires the provider to sign in order to access the program. LOCs may be managed by the GPO to track membership enrollment in the program, or by the pharmaceutical supplier, in which case the GPO may not be able to reliably track which members have enrolled in the program.

Local coverage determinations (LCDs)—(or local medical review policies) A local coverage determination (LCD), as established by Section 522 of the Benefits Improvement and Protection Act, is a decision by a fiscal intermediary whether to cover a particular service on an intermediary-wide or carrier-wide basis in accordance with Section 1862(a)(1)(A) of the Social Security Act (i.e., a determination as to whether the service is reasonable and necessary).

Long-term care pharmacy—A pharmacy designed specifically to meet the needs of those in long-term care. Most medications administered in such a pharmacy are oral dosage forms, and the remaining comprise injections and infusions.

Lost charges—Patient-chargeable items for which pharmacy appears to have provided a dose through the first dose process or cart fill, when a second replacement dose is requested by nursing because the initial dispensed dose cannot be located. The replacement dose is then billed back to the HCO for chargeback to the department in which the loss occurred.

Low-priority medications—A large number of medications that represent a small proportion of the entire medication budget. *Compare* **High-priority medications.**

Mail-service pharmacy—A pharmacy that mails drugs to patients. Such a pharmacy is often a cost-saving alternative to the traditional retail pharmacy.

Managed care—A highly competitive arena in which the primary strategy is to offer a comprehensive bundle of health-care services for a set fee over a specific amount of time, using principles of health management and financial control. Managed care is a risk-based business and a form of insurance.

Market competitive clause—A clause that often exists in generic pharmaceutical contracts to allow for price reductions if competitors within the generic class offer a lower price to GPO members.

Market—Group of customers with a set of common characteristics, who want to buy the service.

Marketing plan—A plan to inform potential customers of the new service and ongoing marketing efforts. A marketing plan should include an overall strategy and may include tactics for each target group. Collateral materials and media should be described to provide additional insight on how the new service will be promoted. The plan should include a schedule for introducing the new service and for promoting, as well as a general plan for tracking results of the marketing effort.

Medicaid Program—Title XIX of the Social Security Act is a Federal/State entitlement program that pays for medical assistance for certain individuals and families with low incomes and resources. This program, known as Medicaid, became law in 1965 as a cooperative venture jointly funded by federal and state governments to assist states in furnishing medical assistance to eligible needy persons. Medicaid is the largest source of funding for medical and health-related services for America's poorest people.

Medicare Coverage Advisory Committee (MCAC)—The MCAC reviews and evaluates medical literature, reviews technical assessments, and examines data and information on the effectiveness and appropriateness of medical items and services covered or eligible for coverage under Medicare. The MCAC is also responsible for advising on the scope of medical coverage provided and for the rationale for clinical decisions, as well as for recommending the compendia that are used to support medical decisions.

Medicare Program—A Federal entitlement program that provides access to and pays for medical care for people age 65 or older, for people under age 65 with certain disabilities, and for people of all ages with end-stage renal disease.

Medicare Prospective Payment System (MPPS)—The MPPS was introduced by the federal government in October, 1983, as a way to change hospital behavior through financial incentives that encourage more cost-efficient management of medical care. Under PPS, hospitals are paid a predetermined rate for each Medicare admission. Each patient is classified into a diagnosis-related group (DRG) on the basis of clinical information. Except for certain patients with exceptionally high costs (called outliers), the hospital is paid a flat rate for the DRG, regardless of the actual services provided. MPPS introduced the fixed-price payer into the hospital profit box.

Medicare's limited income subsidy (LIS) benefit—Federal assistance that can increase a patient's cost savings by paying part of his or her monthly premium, annual deductibles, and monthly prescription copayments under the Medicare Part D program. This extra assistance can be worth as much as $3700 annually for an individual patient.

Medication budget—The health system's plan for medication expenditures during the budget period. The medication budget is the sum of the high-priority, new medication, nonformulary, and low-priority budget components, minus the savings identified in the cost-containment plan.

Medication therapy management services (MTMS)—Services provided by the pharmacy, which optimize therapeutic care (including managing and monitoring drug therapy in patients receiving treatment for cancer or chronic conditions such as asthma and diabetes, consulting with patients and their families on the proper use of medication, conducting wellness and disease prevention programs to improve public health, and overseeing medication use in a variety of settings, such as home care settings, hospitals, ambulatory care settings, long-term care facilities, clinics, and intensive care units).

Minibid—A bid conducted for a specific drug or contract if the awarded supplier decides it cannot continue to be price competitive.

Monthly operating statement—A monthly accounting of expenses and revenues prepared by the finance department. The monthly operating statement details the pharmacy's performance against revenue, expense, workload, and additional selected indicators.

Net revenue—Gross revenue less deductions for negotiated discounts, mandated contractual adjustments, and the write-off for charity care. It is the real measure of the revenue earned by the hospital.

Nonacute care facility—Medical treatment facility that does not address urgent or severe needs. A nonacute care facility may include physician offices, retail pharmacies, clinics, long-term care facilities, home care agencies, and other alternate sites of care.

Noncontract purchase—Occurs when a pharmaceutical purchase is made though neither the GPO nor an individual member contract.

Nonformulary agents—Those drugs not found on a hospital or health plan's approved drug list; such drugs may not be covered or may result in a higher copayment.

Normalization—A movement or transfer of reported costs, volumes, and hours from one department to another for the purpose of assuring that those data are reported and combined in the same way by each participating hospital. Normalizations are meant to allocate specific expenses into the most appropriate operational department across all organizations, and they thus enable more accurate comparisons among dissimilar organizations.

Off contract purchase—Occurs when the member hospital does not purchase through the GPO agreement but through an individual contract with the supplier or another GPO or distributor agreement with the supplier.

Operating budget—A forecast of the daily expenses required to operate the pharmacy, including labor, drugs, supplies, and other support below the capital expense threshold.

Operational benchmarking—(also commonly referred to as external benchmarking and external productivity monitoring) A system whereby hospitals submit department-level data (usually on a quarterly cycle) into a vendor-managed financial and operational comparative database to compare departmental operational and financial performance to peer organizations.

Order management—Everything the pharmacy does to understand, translate, perfect, and prepare the physician's order for fulfillment. Order entry, or order review, usually comprises a large part of this process.

Outlier payments—Provisions within the Medicare Act provide for Medicare payments for cases that incur extraordinarily high costs (outliers). These payments are made to Medicare-participating hospitals in addition to the basic prospective payments.

Outsourcing—A contract between a health system and an outside company to provide pharmaceutical services or management.

Overhead—Cost of the indirect services that support the pharmacy, but are not directly paid by the pharmacy. These include housekeeping, heat and air-conditioning, electricity, health system administration, health system purchasing, information systems support, human resources, finance, and others.

Patient assistance programs (PAP)—Patient assistance programs are run by pharmaceutical companies to provide free medications to people who cannot afford to buy their medicine. PAPs provide opportunities for individuals with no insurance or prescription coverage to receive low-cost or free pharmaceuticals.

Patronage fees—The portion of the administrative fees returned to a GPO's membership each year. Most GPOs subtract operating expenses from the administrative fees and return the remainder of the fees to their membership each year. The percentage returned to the member hospitals varies among GPOs.

Pay-for-performance (P4P)—Compensation for high-quality care, based on established quality indicators.

Peer group—A grouping of like hospitals or hospital departments.

Per diem rate—Fixed-price per patient day; most favored payment methodology of health insurers.

Per member per month (PMPM)—A fixed payment per month that is received for providing services to a member.

Percentile—A relative ranking of performance versus a compare (peer) group. In operational benchmarking, percentiles range from 0 to 100 percent, and better performance is typically signified by a lower percentile ranking.

Performance agreements—Contract agreements designed to reward hospitals for increased use of a specific product within a therapeutic class. Performance agreements typically have multiple tiers, each of which is associated with a product price. Tiers are differentiated based on a market share percentage scale, the total number of units purchased, the total of dollars spent, or a combination of these attributes. The price a member pays for a contracted product decreases as the market share percentage for the product increases, the total units purchased increase, or the total dollars spent increase. Performance agreement calculation of market share is usually based on a market basket of competitive products, whereby the contracted product usage is divided by overall usage of all other products in the market basket.

Pharmacy informatics—The effective acquisition, storage, organization, analysis, management, and use of information in the delivery of pharmaceutical care and the delivery of optimal medication-related patient care and health outcomes.

Prescription drug benefit—A contract that defines the benefits, including formulary coverage, co-pays, deductibles, and caps according to the specifications of the employer, who is picking up most of the expenditures. The prescription drug benefit portion is often defined by the plan and priced on a per member per month (PMPM) basis.

Procedure analysis report—Depicts the current price, current month and year-to-date volumes, and gross charges for each procedure code in the pharmacy and includes departmental totals of volumes and revenue. (PS ref: chapter 2, page 10, para 1)

Productivity ratio—A measure of productivity (output/input). Productivity ratios are often divided into *labor productivity ratios* (e.g., hours worked or paid per unit of output, hours worked per 100 orders processed, doses dispensed per hour worked) and *cost-based productivity ratios* (e.g., expense per unit of output, drug cost per 100 orders processed, total pharmacy cost per patient discharge).

Rebates—A percentage of the total purchase cost of the product returned to the purchaser. Rebates are meant as an incentive to purchase more product. Rebates are also used to hide the actual price of the product either from the pharmacy distributor or from other competitors.

Regulatory environment investigation—Research such as a regulatory environment investigation considers the unique regulatory issues associated with the pharmacy business. Such research must be thorough and is as important to success as any other financial factor in the project evaluation.

Reimbursement analysis—A research report that considers the reimbursement issues unique to the business venture, outlining any advantages, leverage, or limitations to be considered. The reimbursement analysis should include a realistic appraisal of how reimbursement issues will affect the project and its chances for success. Strategies for maximizing any advantages and for dealing with the challenges should be a part of this research, and they should become a fundamental component of the final business plan.

Relative value unit (RVU)—Depending on the cost type, this RVU can be the actual cost per unit, labor minutes per unit, or a weighting factor that helps distribute the cost accordingly.

Replacement cost—The resources and monies expended to replace a separated employee. These resources include the cost of identifying and attracting applicants, conducting screening interviews, testing or other assessment of competency, preemployment administrative expenses, travel and moving expenses, and recruitment or other incentive payments.

Responsibility accounting—Responsibility reports show the department manager his or her responsibility in the financial picture. The report presents *only* those items that the manager is, or should be, directly responsible for in his or her department. The most common responsibility accounting report is the monthly department operations report.

Retail pharmacy—A community pharmacy in which drugs are sold to patients.

Return on investment (ROI)—A structured calculation of the operating cost and revenue changes that the health system will incur with the new capital expense. ROI calculations are often stated in the number of months or years that a capital purchase takes to pay back its purchase cost.

Revenue—Money received for products or services provided to customers. Pharmacy revenues consist primarily of patient charges, which may arise from doses administered in an inpatient setting or from prescriptions dispensed in an outpatient setting.

Reverse auction—A bid process where multiple suppliers bid for a contract through an electronic auction process. Through the auction process, the price is driven down rather than driven up (hence the term *reverse auction*).

Salary accrual—An estimate of the amount of salary and wage expense incurred between the end of the last pay period of the month and the end of the month used to properly match expenses to revenue.

Self-reporting—Relies on staff to document the amount of time required to perform an activity. Self-reporting studies are best conducted in situations of low to moderate activity volume with easily definable start and stop times with little variation in activity interpretability.

Specialty pharmacy—A pharmacy that stocks, prepares, and dispenses drugs to patients, primarily to those in the home or in other outpatient settings. The drugs dispensed are limited in number, but they tend to be expensive, and they frequently require administration by self-injection. These drugs are often not routinely stocked in a neighborhood pharmacy.

Staff development—A structured development plan created between the staff member and the department manager to improve performance. Staff development is another plan for the career growth of particular individuals within the department. Formal education may be included, such as the Master of Business Administration (MBA) or other specialized education programs. In some organizations, a formal mentoring program may be available for managers or for peak performers who wish to advance.

Staffing plan—A plan that creates an optimal relationship between the available resources (hours of pharmacist and technician work time) and the coverage hours and activities of the pharmacy

and that seeks to achieve the greatest utility and output while meeting the human needs of staff. The basis for a staffing plan includes the scope of services of the pharmacy, practice standards and regulatory requirements, the leverage provided by the skills and competencies of the pharmacy staff, the capabilities of automation and technology, and an understanding and acknowledgement of the support needs at practice interfaces with physicians, nurses, and others who work in the medication use process.

Standard cost accounting, product costing—Process of determining the price of a product by examining the various expenses accumulated in the development and sale of that product.

Statement of cash flows—Final financial statement. It identifies the sources and uses of cash in the organization. The statement must tie to the cash balance reported on the balance sheet.

Statement of owner's equity or fund balance—Provides a detailed account of the equity balance at the beginning and end of the reporting period. The net income or loss (excess of revenues over expenses, in the case of a not-for-profit organization) is often the most significant transaction. Net income increases equity on the balance sheet; net losses decrease equity.

Static budget—Snapshot of expected costs; not adjusted or altered after the budget is submitted.

Stepwise analysis—Method of variance analysis that lines up all the factors being analyzed, starting with all factors at their budgeted level. At each step in the analysis, one of the factors is shown at its actual level rather than at its budgeted level.

Stop loss provision—Contract provisions in which additional payments to the hospital are generated from the insurer when an individual admission reaches a certain charge level (similar to outlier payments). These additional payments can take any form (per diem, case rate, percentage of charges), with percentage of charges being preferred by the hospital financial manager.

Strategic plan—A document describing the resources required, the costs incurred, and the benefits realized in acquiring those resources to achieve long-term goals.

Strategic pricing—A pricing method that analyzes each procedure code by payer source (charge-based or cost-based). Strategic pricing places as much of a price increase as is possible on procedures with high usage by charge-based payers and as little as possible on procedures with a high usage by cost-based payers generating a higher net return for the hospital.

SWOT (strengths, weaknesses, opportunities, and threats) analysis—A structured strategic planning method that results in a report that enables the pharmacy to evaluate how to enhance strengths, mitigate or eliminate a weakness, and capitalize on an opportunity, and that helps the hospital plan how to deal with threats.

Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)—Changed the Medicare program from a cost-based payer to a fixed-price payer for inpatient acute care admissions, leaving outpatient, physical rehabilitation, transplant, and behavioral health services as cost-based payers. TEFRA resulted in the implementation of the Medicare prospective payment system and introduced the fixed-price payer. Under TEFRA, hospitals in the same geographic area are all paid the same base rate for each admission. This base rate is then multiplied by the program-determined cost weight for the DRG to determine the actual payment by Medicare to the hospital.

Therapeutic interchange—To modify the market share of drugs in a specific therapeutic class by moving market share toward one product in a class by deeming products therapeutically equivalent to the medication prescribed. Examples of therapeutic categories in which interchange programs may be considered include antiemetics, antimicrobials, and erythropoietic growth factors.

Time standard—The mean time required to perform a task.

Variable expenses—Expenses that fluctuate as volumes in the hospital change. Pharmacy drug cost is an example of a variable expense—the more patients the hospital has, generally the higher the total drug cost, and the fewer patients a hospital has, the lower the drug cost.

Variance—Differences between the budget and actual expense expressed in absolute dollars and as percentage differences.

Volume budget—The number of admissions, patient days, CMI, outpatient visits, emergency

department visits, and other activities for the budget year; prepared by the CFO.

Volume indicator—The frequency with which activities occur, often reported as a mean frequency when nonautomated sources are used to provide the frequency.

Weighting—A method used to recombine a department's varied work outputs equitably to produce a single figure that represents the department's entire output. Weighting can also be defined as a measure of time to perform one unit of each department output.

Work sampling—A method to estimate the percent of time that staff spend on various activities; an indirect method of establishing time requirements. The work sampling method of measurement is best for measuring the relative frequency of all tasks staff perform, and for measuring intermittent activities that are not closely structured in time, that occur infrequently, and for which data would thus require an inordinate amount of time to collect through direct observation.

Workload unit—A unit of measure to monitor financial performance. On the inpatient side patient days, number of admissions, and number of discharges are common measures. On the outpatient side patient visits, such as emergency room or clinic visits, are common indicators. For those organizations that provide traditional retail prescription services, prescription volume is also a common measure.

Technical terms outlining the function of Medicare, Medicaid and other reimbursement and financial functions of the Department of Health and Human Services and the Centers for Medicare and Medicaid Services (CMS) were researched and validated at the time of publication. Readers are referred to these web sites to ensure that their understanding of the terms, and that use and function of these terms are current. Web Sites: www.cms.hhs.gov, www.cdc.gov, www.hhs.gov, www.medicare.gov.