Shedding Light on Hidden Costs

More savings in labor, supply chain than you know

By John M. Buell

What if you learned you could add 1 percent or more to your bottom line each year for the next three years without compromising the quality of care your organization delivers? Would you do it? Of course you would.

For many hospitals, nearly 80 percent of costs are consumed between labor and the supply chain. And with the median operating margin for nonprofit acute-care hospitals at 2 percent, reducing and better managing expenses can significantly boost the bottom line.

Financial expert Steven H. Berger, CPA, FACHE, FHFMA, president, Healthcare Insights LLC, Libertyville, Ill., says labor and supply chain are two major expense areas that can be examined to reduce costs. Labor by far is the largest bucket to attack and should be addressed first; however, there is waste in the supply chain with some estimates putting it at as much as 30 percent.

Shedding Light on Hidden Costs

More savings in labor, supply chain than you know

Before attempting to better manage labor and supply chain expenses, hospital leaders should first determine whether their department managers understand a basic management principle: the money earned and money spent. The unfortunate reality, says Berger, is that many hospital managers don't know how to effectively apply this principle.

"There are many managers who weren't trained to be managers," says Berger. "They were the best radiology technician or the best floor nurse who was promoted into management. This is very common. And if they received any training prior to their promotion, it was usually just a few hours' worth, which is not even close to the amount of training that is needed."

Compounding the situation, according to Berger, is that many hospital leaders don't hold their managers accountable to the financial goals the board of directors establishes and approves annually. This is borne out in informal surveys Berger has conducted during the past 12 years in classes he teaches for ACHE and the Healthcare Financial Management Association. The surveys consistently reveal that only 2 percent of hospitals will terminate nonperforming managers, despite goals that are consistently missed.

"Without consequences (demotion or termination), the financial goals have very little chance of being met," he says.

Assuming you have competent and accountable managers in place, below are seven specific and basic steps hospital leadership can implement to help control expenses in the areas of labor and supply chain costs, according to Berger:

1. Determine the key financial (or performance) indicators that the organization needs to achieve.
2. Set goals around these indicators (using reputable benchmarking outcomes).
3. Create action plans to achieve these goals.
4. Implement the action plans.
5. Monitor the results of the implementation.
6. Communicate the results back to the affected parties (usually managers and directors).
7. Develop and implement consequences (both positive and negative) depending on the results.

Labor Costs

When managing labor costs, the key financial indicator is your organization's labor compensation ratio, which is determined by dividing salaries, wages, fringe benefits and contract labor costs by total net revenue.

The median labor compensation ratio for nonprofit acute-care hospitals in 2010 was 50.2 percent, according to Fitch Ratings, which provides the world's credit markets with independent and prospective credit opinions, research and data. A labor compensation ratio under 50.2 percent is considered better than 50 percent of the sampled hospitals, notes Berger, and yet well-managed hospitals have labor compensation ratios at about 40 percent. HCA, the largest hospital system in the United States, has a labor compensation ratio of 40 percent, according to Berger.

The point is that if a for-profit system like HCA can consistently have a labor compensation ratio near or at 40 percent, your hospital can move forward to reach toward the same results.

With your financial indicator—labor compensation ratio—known, the next step is setting a goal around the indicator. If your labor compensation ratio is 55 percent, have a goal to reduce that amount 1 or 2 percent per year.

"For every percentage point you take off the labor compensation ratio, you put that number back onto your bottom line," says Berger.

The median operating margin for nonprofit hospitals rated by Fitch Ratings in 2010 was 2.8 percent. "That is a poor operating margin for any organization, let alone a hospital," says Berger. "If you are a hospital with an annual budget of $100 million and you reduce your labor compensation ratio by just 1 percent, that's $1 million that is added to your bottom line."

Reducing Labor Rates

With your labor compensation ratio known and a new ratio goal

established, organizations should then create and implement a multi-year action plan, which typically involves lowering labor rates and improving labor productivity, the two key components of the labor compensation ratio. The easier of the two to address is reducing labor rates, says Berger, and one of the major reasons for high labor rates is overtime expenses, particularly overtime paid to nurses.

"The problem isn't with the base rates nurses are paid," says Berger. "The issue is organizations are paying too much for overtime. Let's say, for example, you are paying a nurse a base rate of $30 per hour, which means when you pay her overtime you're paying time and a half, which is a 50 percent premium. But many hospitals use agencies, or contract labor, to cover overtime, which shoots the labor rate to as much as $90 per hour—a 200 percent premium."

To understand your labor costs you have to know what your labor rate is, according to Berger. "It has been my experience that many hospitals don't even recognize it as being an element of their labor costs," he says. "You have to know and then manage the labor rate, which begins with having standards and tools in place on a shift-by-shift basis so that you can hire into positions to minimize your use of overtime and agency labor. Once you do this, you are starting to get to a winning combination."

Organizations that effectively manage their labor rates hire more part timers, notes Berger. "When I tell that to hospital leaders, they say, 'That's not possible. Those part-time workers aren't out there.' But I tell them that there are hospitals that are doing this, many of which changed their hiring model to accommodate part-time staff," says Berger. "There's no doubt there are labor shortages. There are shortages in nursing and clinical tech positions, but hospitals can lure in part timers."

> "Without consequences (demotion or termination), the financial goals have very little chance of being met."
>
> —Steven H. Berger, CPA, FACHE, FHFMA
> Healthcare Insights LLC

Increasing Labor Productivity

Every job code in each department should include a standardized way to measure productivity, says Berger. But few hospitals do this. "In my unscientific surveys, when I ask executives if they have standards associated with productivity and ways to measure it, about 40 percent of the hands go up," he says. "When I ask if they have *effective* productivity measures and standards in place, only 10 percent raise their hands. With that said, if productivity measures are a key element of the labor compensation ratio and only 10 percent of hospitals have an effective productivity measure in place, it will be extremely difficult for hospitals to improve their financial positions."

Putting a Labor Plan Into Practice

Albert Lea (Minn.) Medical Center–Mayo Health System is a community-based, regional medical center, offering 237 beds of care in a variety of disciplines with more than 1,200 employees. In the first quarter of 2008, the medical center's operating margin was slightly more than 5 percent. Its financial situation was good, but "unremarkable." Within one month, however, the organization lost 10 percent of its medical staff, which created patient access issues and compromised the hospital's surgical coverage.

"We were in the midst of a major campus renovation and expansion project," says Stephen C. Waldhoff, FACHE, chief administrative officer. "We were starting to see red ink, but we did not have a plan to respond to this issue. This was a crisis for us."

A plan was developed to help the hospital better manage its expenses and

overall operations. That plan included creating a vision for the organization, with its guiding principle that patient needs come first, the hospital's bottom line second. Built on top of that, Albert Lea Medical Center leaders set goals to be more transparent in their decision-making process and establish a commitment to employment integrity. "We also wanted to lead by example and not by edict," says Waldhoff. "We wanted to build a culture of trust."

The hospital's economic recovery plan included four areas: decreasing labor costs, improving processes, enhancing revenue and managing the culture of the hospital. Labor costs were addressed first.

At the low point of its financial crisis, Albert Lea Medical Center's labor compensation ratio surpassed the 50.1 percent Fitch-rated median for nonprofit acute-care hospitals. But within a year of implementing its economic recovery plan, the ratio fell below that benchmark and has consistently remained there. In addition, the organization's financial strategy has saved $4.9 million annually.

"Our economic recovery plan provided more than a one-time savings but savings that accrue from one year to the next," says Waldhoff.

To better manage its labor costs, the medical center focused on two areas: labor rates and productivity. The organization implemented a software package that allowed staff to manage overtime on a real-time basis. "We didn't have to wait until the end of the pay period to see how we were doing," says Waldhoff. "Managers were now expected to manage their overtime on a per-shift basis, and mutually agreed-upon goals between senior leaders and managers were set."

Another step the medical center took to reduce labor costs was delaying giving staff technical pay adjustments, which is one of two components to the organization's wage and salary administration program. The other is merit raises.

"We also postponed giving leadership their wage adjustment," says Waldhoff. "And we eliminated all temporary staff and stopped using agency staff. That was part of a broader strategy to preserve work for staff in our organization."

On the labor productivity side, Albert Lea Medical Center established specific productivity indices for each department. "We did this so that we knew exactly the level of staffing that we would need in any given department," says Waldhoff. "We then identified by department where we were overstaffed. In addition, as attrition occurred we would not replace those employees."

Also, part of the plan to lower labor costs included implementing a flexible budget based on workload units specific to any given department so that a cost per unit of service or revenue per unit of service was established. "This gave us a more accurate picture of our revenue and expenses on some kind of a metric basis," says Waldhoff. "This is part of our strategy to be a more data-driven organization."

> "Our economic recovery plan provided more than a one-time savings but savings that accrue from one year to the next."
>
> —Stephen C. Waldhoff, FACHE
> Albert Lea (Minn.) Medical Center–Mayo Health System

In addition, a biweekly income and expense statement was introduced to give managers information two weeks earlier. "We were accustomed to waiting until the end of an accounting period before we got expense statements, but now managers can make timelier decisions," says Waldhoff.

Once Albert Lea Medical Center's labor costs were reduced, the organization focused its attention on increasing revenue, enhancing processes and

managing the hospital's culture, which included providing regular communication updates to staff on the economic recovery plan's progress.

"We developed a mantra of weathering the storm," says Waldhoff. "The updates were a way to keep the end point in sight, sustaining the organization."

Managing Supply Chain Expenses

Healthcare Insight's Berger suggests hospitals can use the same seven-point plan discussed earlier to manage their supply chain expenses as they do their labor expenses, beginning again with identifying the key financial indicator that needs addressing. With the supply chain, that would be the supply chain ratio, which is determined by dividing total supply expenses by total net revenue. The ratio for nonprofit, Fitch-rated (as well as Moody's Investor Services and Standard & Poor's) hospitals is between 16 and 19 percent, with well-managed for-profit hospitals at between 12 to 13 percent. "Which means there is ample room to lower supply chain expenses," he says. "The supply chain is complex, and the more complex, the more opportunity for inefficiencies."

Other experts say there is far more room for expense reduction in the supply chain than healthcare leaders realize. Jamie C. Kowalski, FACHE, president of Jamie Kowalski Consulting, Milwaukee, says total annual expenses on the supply chain are approaching, and in some hospitals exceeding, 50 percent of total hospital annual expenses, when evaluating the supply chain via activity-based costs/cost accounting methods. This definition of the supply chain includes all consumable supplies plus all the full and partial days spent by non-supply chain staff doing supply chain tasks—often at the expense of doing other things such as taking care of patients.

Kowalski says the message to healthcare executives is supply chain costs are more than they realize, and they need to look at the supply chain as a strategic part of their business.

"If you are dealing with an element that is 50 percent of your expenditures, if this is not a strategic element, I don't know what is," he says.

Physician Preference Items

Much of the supply chain's complexity comes from ordering physician preference items (PPI), according to Berger. "The ability to manage physicians' ordering patterns creates the biggest opportunity for savings," he says.

A key element in managing PPI effectively is identifying product cost variability and communicating that back to physicians, says Frank D. Kilzer, vice president of Material and Facility Resources, St. Alexius Medical Center, Bismarck, N.D.

"Let's say you have a group of physicians using a particular item and another group using a different item to treat the same ailment," says Kilzer. "But we know there is significant cost variability between the products, unknown to the physicians. They think they are doing fine price wise and patient outcome wise, but by making physicians aware of what the costs are for products they are using and comparing that (anonymously) to what their peers are using, it gives them a benchmark for their practice and whether there is a differentiating factor in patient outcomes."

Kilzer says physicians support St. Alexius Medical Center's efforts to show what they are purchasing compared to their competitors. When the data is revealed, physicians are identified by letters—A, B, C, D, etc.—and each physician only knows his or her own letter. "They look at the data and say 'I know which letter is me, and I didn't know this (product and price variability with same patient outcome) was happening.' They are competitive and don't want to be seen as an outlier," says Kilzer.

In addition, factoring in the illness severity can lead to lower PPI costs, says Kilzer. "So not only are you looking at cost for caring for a specific patient population, but you are sorting that by the acuity level of that patient group such as hip or knee replacement," he says. "Some patients come in with more comorbidities that will have an impact on what the total cost of care might be, and you need to factor that in

so you are not penalizing someone because you have a patient or patients involved in your data that were outliers to the normal case mix acuity."

Value Analysis

Another strategy hospitals use to manage expenses in the supply chain and save money is a team approach to product value analysis, says Peter A. Stille, president, Strategic Sourcing Results, Chicago.

"In the past, hospitals had a products committee that was chaired by the head of materials management and influenced, for example, by infection control," says Stille. "But now hospitals are using a multidisciplined approach in which you see the committee led and participated in at the executive level."

Lancaster (Pa.) General Hospital saved $10 million in its first year using a multidiscipline-team approach to its product value analysis, which it began using two years ago. In the past, one team was responsible for analyzing products, but now nine teams, ranging from surgical services to human resources departments, review products and determine the negotiating tactics to use with suppliers. Representatives from each team collectively report to a value analysis steering committee that consists of the departments' senior vice president, other senior executives and physician representatives who are responsible for removing any roadblocks to the teams' purchasing decisions. In addition, the organization's COO is the champion of the entire value analysis process.

"The advantage of our new value analysis approach is that supply chain ownership is on the departments," says Ken Collins, vice president, Materials Management, Lancaster General Hospital. "Materials management provides oversight and financial data for the products departments are looking at."

After the second year of using the new value analysis process, an additional $10.2 million was saved, and the teams are proposing another $10 million in savings for the upcoming fiscal year, says Collins.

Kowalski says Lancaster General's value analysis process has an added benefit—providing senior-level executives with more visibility into the supply chain. "By giving them visibility, they will have a better feel for how the hospital's supply chain is doing and make better informed decisions if problems arise," he says.

Adds Kilzer: "The role of materials management has expanded over the years to be much broader today where it's everyone's role to ensure the organization is being efficient and effective with the supplies flowing throughout. And the only way to do that is to be as transparent as you can with the data and be sure everyone knows what products they are using and what they are costing the organization."

Healthcare Insight's Berger says what expense management in labor and the supply chain comes down to is setting goals around what leadership believes are the most important outcomes and then continuing to set higher goals.

"Leadership has to make sure managers are aware of their goals and that they will be held accountable for achieving them," says Berger. "If managers don't meet their goals, then leadership has to find new managers. And they need to do it in a short period of time—months, not years."

John M. Buell is a writer with Healthcare Executive.

Ask the Expert

Have a question on this topic? Continue the discussion on the ACHE Message Board. Steven H. Berger, CPA, FACHE, FHFMA, president, Healthcare Insights LLC, Libertyville, Ill., will take your questions on ACHE's Message Board from Jan. 1 to Jan. 31. Responses will be posted each Monday. Visit **ache.org/MessageBoard** to post your question and view his response. When you post your question, please title the subject "HE Mag/Jan/Feb/LaborSupply [question here]."