Managing Productivity in the Critical Access Hospital

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The Need for Change

Industry trends are creating a need for health care organizations to change the way they operate and to be more efficient and eliminate waste.

Demand for Quality
Increasing Cost
Increasing Demand
Increasing Need for Transparency
Increasing Use of Technology

Need for Change

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Demand for Quality

- US health care ranks 37th in the world for quality
- Medical errors account for 44,000 - 98,000 deaths
- Pay for performance and national quality rankings will have significant impact on reimbursement

Demand for Quality
Increasing Cost
Increasing Demand
Increasing Need for Transparency
Increasing Use of Technology

Increasing Cost

- US ranks 1st in the world for highest cost of healthcare
- The rising number of uninsured are increasing the cost of bad debt and charity care
- Expenses related to the treatment of chronic conditions continues to rise

Demand for Quality
Increasing Cost
Increasing Demand
Increasing Need for Transparency
Increasing Use of Technology

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Increasing Demand

- Physician and nursing workforce shortages continue to plague rural communities
- An aging population will increase the demand and utilization of facility resources
- Increases in chronic illness are requiring increased use of preventative medicine

Increasing Need for Transparency

- Consumers are demanding increased product and pricing transparency (e.g., cost and quality data on physicians, hospitals)
- With greater "skin in the game", consumers are taking a larger role in making health care decisions and requiring information
- Pay for performance and national quality rankings will have significant impact on reimbursement
Increasing Use of Technology

- HIT use is changing the way health care information is captured and delivered
- Government incentives are making HIT use an imperative
- Processes are being reviewed to capture the efficiencies of the new HIT standards

Current State of Healthcare

- 1% operating margin (or less)
- Lack of direction due to the unknown
- Managers have a superficial understanding of the financial model for the organization
- Productivity levels fall short of the benchmark standards
- Lack of meaningful data
Success in the Future

- Increased operating margins
- Improved direction
- Improved working knowledge of both the financial and clinical model of the organization
- Internal and external benchmarking used to monitor productivity
- Staff have access to data and believe they have input into work processes

Improved Profitability

- Increased market share
- Improved patient management / efficiency
  - Appropriate services rendered
  - Appropriate resources expended
Improved Profitability

- Future profitability will be determined on ability to:
  - Increase gross revenues
    - Increased Market Share
  - Decreased cost to beneficiaries
    - Improved coordination of care
    - Improved efficiency

Change in Direction

- Current state
  - Rewarded for volume
  - No penalty or reward for quality
  - Opportunities for cost containment
Change in Direction

• Future State
  • Better rewards for
    • Higher market share
    • Lower intensity and volume of services
  • Penalties and rewards for quality
  • Increased focus on cost containment

Use of Benchmarks

• Benchmarking is the process of measuring an organization’s internal processes then identifying, understanding and adapting outstanding practices from other organizations considered to be “best in class”.

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Use of Benchmarks

- Benchmarking is the process of comparing the business processes and performance metrics including cost, cycle time, productivity, or quality to another that is widely considered to be and industry standard benchmark or best practice.

Use of Benchmarks

- Benchmarking is most often used to measure performance using a specific indicator
- This results in a metric of performance that is then compared to others
- Must accept that benchmarks are not perfect!
Benchmarks

- Two types of benchmarks
  - Internal—created with your own data
    - Allows for monitoring internal trends
    - Lacks external focus
  - External—created using outside data sources
    - Difficulties in comparisons

Benchmarks

- Used alone, benchmarks can result in decisions that are not realistic
  - Not just a number used to reduce staff
- Benchmarks assume an ability to gather data consistently
- Benchmarks often contain a large range or assume all organizations are the same
  - Must assure “apples to apples” comparison
Benchmarks

- Benchmarks are *not* averages
- Benchmarks *ARE* best practices

“If you are ‘average’ are you the best of the worst, or worst of the best?”
# Methods for Implementing Benchmarks

- Assign accountability
- Establish baselines
- Set targets for improvement
- Innovate, create value
- Implement changes
- Monitor and measure progress
  - Weekly or daily

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# Understanding the Financial Model

- Clinical leaders need to be financial leaders
  - Will create challenges and opportunities
  - Organizations will provide financial training to clinicians
    - Productivity relates to costs
    - Costs relate to profits
    - Impact of market share
  - Clinical champions will need to be identified
  - This will be a challenge to both the clinical and financial leaders in the organization
Operations Improvement

- Payments to our facilities will not continue to grow at historical levels.
- In order to be more financially solvent, we are forced to look internally at our costs
  - Largest Expense – Salary and Benefits
  - Second Largest Expense - Supplies
- Fortunately we can manage these costs (i.e. variable vs. fixed costs)

Expense Breakdown

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaries, wages &amp; benefits</td>
<td>45% - 55%</td>
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<tr>
<td>Supplies</td>
<td>15% - 22%</td>
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<tr>
<td>Purchased services</td>
<td>10% - 15%</td>
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<tr>
<td>Professional fees</td>
<td>5% - 7%</td>
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<tr>
<td>Depreciation</td>
<td>6% - 8%</td>
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<tr>
<td>Interest</td>
<td>5% - 8%</td>
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<tr>
<td>Bad Debts</td>
<td>2% - 4%</td>
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<tr>
<td>Other</td>
<td>5% - 7%</td>
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</table>
Operations Improvement

- Upwards of 75-80% of the total costs are in the labor and supplies
- The questions that need to be asked are:
  1) Can we survive into the future with this level of costs?
  2) What can we do as an organization to control these variable costs?

Labor Costs

- For most organizations, the biggest single labor cost is in the clinical areas
- This is also the area we see as having the biggest opportunity for improvement
Labor Costs

• So why is that....?
  • We often plan for the “what if…”
  • If we have to choose, it’s better to be over-staffed than under-staffed
  • We lack an understanding of the financial impact of always being slightly over-staffed
  • Our model for staffing is often inefficient from the start
  • Our focus is on “care” and not “care and cost”
  • Managers are often not held accountable for cost overruns (at least not to a level that has an impact)

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Labor Costs

• So why is that....?
  • If we use benchmarks or monitor productivity, we often only look at them on a quarterly or annual basis
  • We promote the best clinicians versus best managers to levels of leadership?
Summary of Opportunity Savings & Cost

A summary of the potential savings and cost for the opportunities identified is as follows:

<table>
<thead>
<tr>
<th>Department</th>
<th>Opportunity</th>
<th>2011 Savings (Cost)</th>
<th>Net Impact After Cost Report Considerations</th>
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<tbody>
<tr>
<td>Nursing Administration</td>
<td>Staffing efficiency</td>
<td>$200,679</td>
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<td>Med/Surg, OB, swingbed</td>
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<td>$439,921</td>
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<td>$1,987,383</td>
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Sample Staffing Plan

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<td>HOUR TOTAL</td>
<td>48</td>
<td>60</td>
<td>72</td>
<td>96</td>
<td>128</td>
<td>136</td>
<td>152</td>
<td>168</td>
<td>192</td>
<td>216</td>
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<td>264</td>
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**Staffing Up vs Staffing Down Model**

“Staffing up” model versus “Staffing down”.

- **Staffing down model**: Baseline level of staffing.
  - Workload—goes up and down over time.

- **Staffing up model**: Baseline level of staffing.
  - Staffing up based on workload.

**Key points of the “staffing up” model:**

- Baseline staffing is set at 65-75% of the average workload.
- Staffing plan is based on benchmark standards of 8-10 hours/patient day (combined med/surg, swingbed, ICU and observation).
- There is an understanding that the workload goes up and down over time, whether that be day-to-day, week-to-week, month-to-month, etc.
- The staffing plan incorporates a contingency plan for how staffing will be increased. This could include employing part-time help that could work extra shifts, flex-time staff available as needed, having designated paid on-call staff, etc.
- The primary premise of the “staffing up” model is that the baseline level of staffing is always in place, and staff is added to the baseline based on benchmark standards and a staffing plan.
- As workload increases, the staffing increases accordingly, based on an established benchmark standard.

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**Impact of Improved Productivity**

<table>
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<tr>
<th>Year</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>MDS, rising, etc. days</td>
<td>5,390</td>
<td>4,741</td>
<td>4,756</td>
</tr>
<tr>
<td>Production hours</td>
<td>61,947</td>
<td>54,140</td>
<td>62,492</td>
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<tr>
<td>Hours per patient day</td>
<td>11.73</td>
<td>12.05</td>
<td>11.14</td>
</tr>
<tr>
<td>Benchmark</td>
<td>9.95</td>
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</table>

- Actual Hours over Benchmark: 35,991
- Potential Savings: $643,406

*Assumes average salary of $39.16 with benefits at 33.6% of salary cost.

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Impact of Improved Productivity

- Effective management of labor hours improves the financial outcomes significantly
- Accomplishing this result requires being knowledgeable about productivity and staffing
- Studies have shown that as efficiency and productivity improve, the quality and value also are directly proportionate

Impact of Improved Productivity

- Will need to address shifting staffing needs in the organization
  - Increases
    - Medical Home
    - Preventative Services
    - Patient Navigation
  - Decreases
    - Inpatient Services
  - Some staff may choose not to make the transition
Physician Productivity

- Must first understand physician demand
  - Helps support physician productivity expectations
  - How many physicians of each area of expertise do you need in your service area versus how many are providing services in the market
    - Research number of existing providers
    - Utilize benchmarks based on populations
  - Some markets do have too many providers
    - Difficult to maintain productivity levels if supply exceeds demand
    - Increase market share?
    - Decrease number of providers?

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Physician Productivity

- Strategies to improve productivity
  - Proper mix of providers
  - Strong support team
    - Marketing
    - Scheduling
    - Nursing
    - Ancillary
  - Compensation based on incentives

Access to Data

- Limited data availability in the past
- Increased need for data in the future
  - Quality
  - Cost
    - Incentives
    - Benchmarks
  - Market Share
Access Data

• Timeliness of Data
  • Quarterly and Annually is not enough
    • Monthly
    • Weekly
    • Daily

Preparation for the Future

• Identify direction
  • Increased market share
  • Improved coordination of care
  • Decreased costs
• Identify clinical “champions”
• Utilize benchmarks to develop staffing plans
  • Establish accountability
  • Utilize a “staffing up” model versus “staffing down”
• Develop dashboards that provide real-time feedback
Questions??

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