

Labor Management: A Model for the Future

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Introduction

Managing labor resources is more critical than ever in the current healthcare environment, characterized by:

- A shortage of nursing and technical labor
- Declining payments
- Prospective payment for outpatient as well as inpatient services
- “Price-led costing”

This presentation will focus on models for managing labor costs.

Outline

I. Planning for a Productivity System

- Anne Farmer, TriNet

II. Productivity Systems and Their Benefits

- Larry Murray, Kronos

Outline: Part I

Planning involves answering several questions:

- I. What are the organization's needs for productivity reporting/labor management?
- II. What types of systems are available for productivity reporting?
- III. What approach should we take in developing labor standards?
- IV. What are other decisions that need to be made before going forward?



Determine goals

To figure out what your productivity/labor management solution will look like, determine your organization's goals for labor management:

- Manage skill mix?
- Manage use of overtime and agency?
- Manage fluctuations in volume?
- Get information to managers on a more timely basis?



Designing the System

First, determine the type of tool you need.

Traditional systems offer:

- Budget variance reporting
- Position control
- Scheduling/staffing



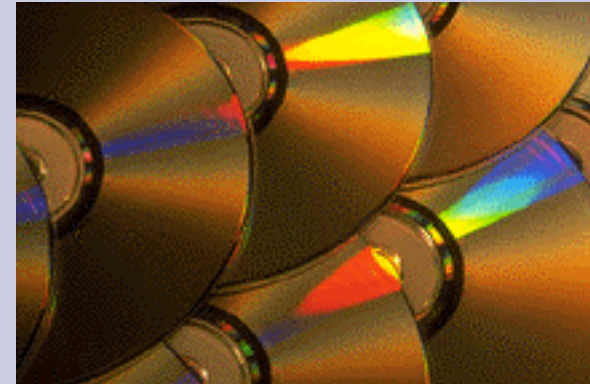
Productivity systems go a few steps further:

- Adjust for volume
- Incorporate procedure-level standards
- Provide valuable detail
- Offer other analytical tools such as exception reporting

(More on this later, in Part II.....)

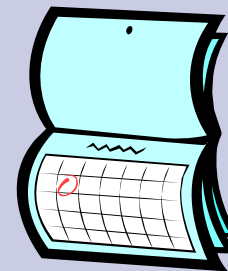
Types of productivity systems

- Decision Support systems:
 - McKesson (HBOC)
 - Eclipsys (TSI)
 - Avega (HCm)
 - KREG
- Labor Decision Support systems:
 - KRONOS
- Productivity systems with benchmarking:
 - MECON
 - CHIPS
 - HBSI
- Homegrown (spreadsheet or data base package)



Designing the System

- Determine the necessary frequency:
 - Monthly (Senior Management)
 - Biweekly (Department Managers)
 - Weekly (Department Managers)
 - Daily? (Nursing)

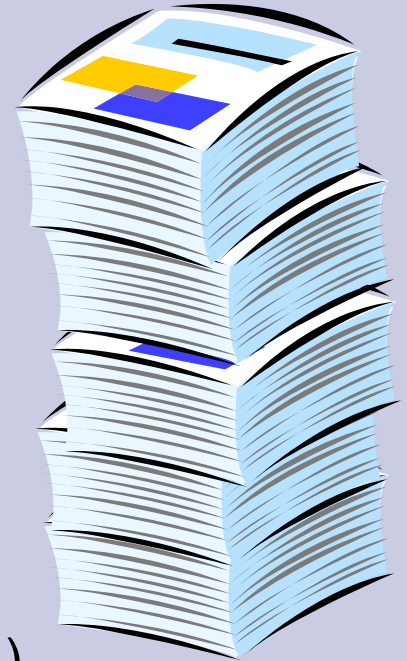


If adjusting for volume: Can we get volume data on a biweekly or weekly basis?

(More on this later, in Part II.....)

Designing the System (cont.)

- Determine the necessary level of detail:
 - Position detail:
 - General ledger accounts
 - Jobcode (more detailed)
 - Type of pay
 - Productive vs. nonproductive only
 - Paytype (overtime, agency, holiday overtime, etc.)



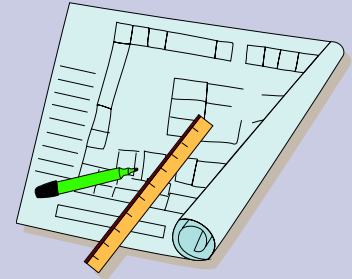
Getting Started: An Approach

- Begin with an examination of the department's performance over the past several years.
 - Ignore comparison to budget for this, since budgets are adjusted annually
- Define the unit of service.
- Initially, ignore fixed vs. variable and look at hours per unit over time.
 - Focus on productive time only
- Rank the departments into several groups:
 - Losing ground
 - Holding steady
 - Gaining
 - New programs



A Work Plan

1. Conduct an initial assessment of departments (see previous page).
2. Develop a plan for education, and conduct orientation for department managers.
3. Determine unit of service/cost driver for each department.
4. Develop fixed/variable assumptions.
5. Develop productivity standards.
6. Design reports.
7. Review data requirements, and develop interfaces as necessary.
8. Build model, and run “test” reports. Correct any problems.
9. Distribute reports, and get managers to use the information!



Defining Units of Service

- Department volume statistic
 - Visits, treatments, tests, etc.
- Overhead statistic
 - Patient meals, lbs laundry, etc.
- Global statistic
 - Use for certain overhead departments without a clear “output” or cost driver
 - Purpose: relates size of the department to the size of the organization
 - Example: adjusted patient days
- Cost accounting standards/RVU's
 - Defined at charge code level
 - Benefit: accounts for mix of services within a department



Key factor: Buy-in from the department manager!

Developing Standards

- Departmental standards
 - Historical trends
 - Published standards, or other benchmarks
 - Standards inherent in the budget
 - Variable hours / budget units
- Procedure level (“micro”):
 - Published standards (e.g. Respiratory Therapy, Radiology Workload Units)
 - – Estimation by department managers/supervisors
 - Activity-based costing (“ABC”) approach
 - Engineered standards (time studies, work sampling)



Standards Worksheet

Department: ICU

<u>Productive Hours by Category</u>	<u>Budget Hours</u>	<u>Fixed %</u>	<u>Fixed Hours</u>	<u>Variable %</u>	<u>Variable Hours</u>	<u>Variable Hours/Unit</u>
6010 Mgmt & Supervision	525	100%	525	0%	-	
6020 Techs and Specialists	500	82%	411	18%	89	0.031
6030 RN	13,093	30%	3,929	70%	9,164	3.171
6050 Aides and Orderlies	1,647	30%	493	70%	1,154	0.399
6165 Cash In's	<u>700</u>	<u>100%</u>	<u>700</u>	<u>0%</u>	<u>-</u>	
TOTAL HOURS	16,465	37%	6,058	63%	10,407	3.601
STATISTICS:						
DAYS + OBSERVATION	2,890					

Standards: Micro

If cost accounting standards will be used, it is important to ensure that the standards are consistent with current required labor. (If the standards tell you that you need 20 FTE's in the department, and you only have 10, there's a problem!)

How can this be addressed?

Plan A: Adjust the standards:

What we call “standards” may have been developed as RVU's, for the primary purpose of patient costing. Now, we're taking them a step further to use for productivity analysis. Solution: work with the departments to adjust, or....

Plan B: Use as “RVU's”:

- Use the existing standards purely as RVU's. Develop a target hours/RVU for each department. Use the RVU values each month when adjusting for volume.

Standards: Department Strategies

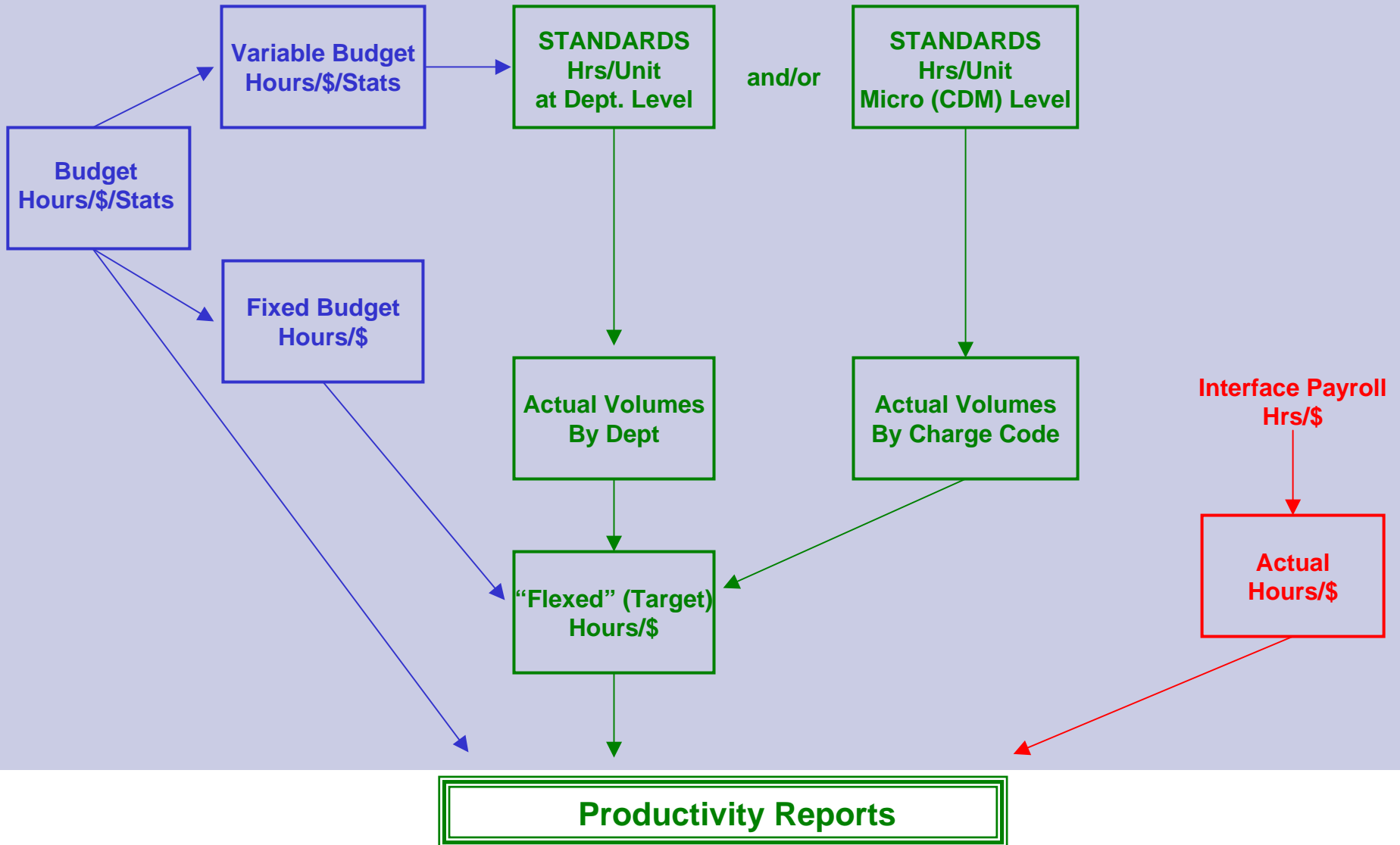
- Nursing
 - Acuity systems
 - Careplans
 - Case-mix adjusted patient days
- Pharmacy
 - PharmaTrend labor categories
- Surgery
 - Use information from O.R. system to develop minutes per type of case (orthopedic, cardiac, etc.)
- Emergency Department
 - Incorporate E&M codes (vs. hours/E.D. visit)
 - Use APC rates or RBRVS weights as RVU's, allocate budget hrs over “weighted” volumes

Productivity Reporting Model

Budget

Target

Actual



To benchmark or not?

CON

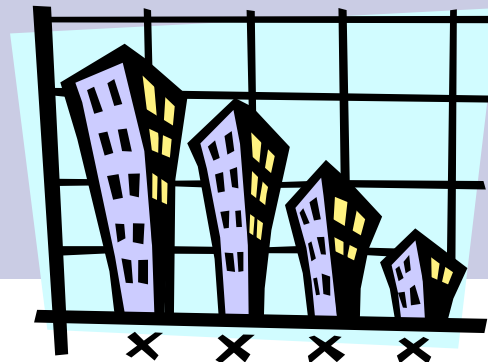
“Before reliable productivity standards are in place, the hospital should avoid external benchmarking. Such attempts usually end in failure if the hospital has not first established the discipline necessary for meeting productivity standards. Comparing its productivity with that of other hospitals requires the hospital to conduct complex analyses aimed at equating different types of patients, distinct medical practices, conflicting traditions, special tasks and so forth. Such a complex analysis can prove to be a formidable obstacle to achieving initial improvement.”

Paul A. Fogel, “Achieving Superior Productivity”, Healthcare Financial Management, August 2000 (p. 51-52)

To benchmark or not?

PRO

- Obtain an awareness of “best practices”.
- Even if it’s not entirely trusted, if several benchmarks from different sources paint the same picture, this can show a direction you need to take.



Benchmark Report Example: M/S Nursing Unit

* PRODUCTIVE HOURS *

Budget	4,222
Required	4,419
Actual	4,881
Productivity Variance	462
Productivity % (Req./Act.)	90.53%

* NONPRODUCTIVE HOURS *

Budget	621
Actual	780
% of Productive (Actual)	15.98%
Required (Req Prod Hrs x %)	706
Variance	74

* TOTAL HOURS *

Budget	4,843
Required	5,125
Actual	5,661
Variance	536

* STATISTICS *

ACUITY HRS	3,629
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* BENCHMARK COMPARISON *

Benchmark Statistic	
PATIENT DAYS	551
Benchmark Ratio	10.274
Benchmark	
6.6-7.3 Pd Hrs per Patient Day	

Productivity Analysis

*Benchmark section
(uses different statistic)*

Pitfalls to avoid

- Overly complicated system that isn't understood by the managers.
- Too many manual steps to produce reports. (Automate! Automate! Automate!).
- Reports do not meet the needs of managers at various levels.
- Overlooking the importance of education.



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