The Economics of labor in Not-for-profit healthcare, 2008

Prepared 11/15/2008

Purpose of the Report

With shrinking reimbursements, aging workforces and creeping acuity, reducing expenses is fast becoming a required leadership competency. As a result, each year since 2005, Workforce Prescriptions has compared data on nearly 1300 not-for-profit adult acute hospitals in order to better understand the impacts of labor costs on overall financial performance. Hospitals studied, each report between 100 and 1043 <u>staffed</u> beds and are non-government, not-for-profit facilities who update their publicly reported data by 11/01 of each year (MedPAR, OPPS, Cost reports, CMS and other publicly reported data). In 2006, 1043 hospitals were sampled in 2007, 1292 and in 2008, 1271. To ensure data integrity, the same hospitals were sampled each year with the addition of two categories of smaller hospitals in 2007.

Workforce Prescriptions then completes deep internal audits on a sampling of them (24 in 2007, 28 in 2008) in order to gain a better understanding of the factors impacting changes in labor costs.

General Trends

- Once again, year-over-year growth in net revenue per bed lagged labor growth
- For the second time in 3 years, labor as a percentage of net revenue held firm (instead of rising)
- Nursing productivity (the number of nursing hours utilized for each adjusted patient day) improved dramatically
- "Premium pay" as a component of labor continued its upward trend in-spite of productivity improvements

	2006	2007	2008	Annual Change
Premium pay as a % of Net revenue	4.8%	5.6%	6.9%	22.5%
Premium pay as a % of Gross labor (with benefits)	11.8%	13.2%	13.7%	4.0%
Recap % of Net Rev	2.50%	2.79%	2.31%	-17.2%
Labor/Net Rev	51.2%	51.1%	51.0%	-0.2%
Nursing Productivity (nursing hours/Adj Pat Day)	10.9	11.3	8.14	-28.0%
Labor /staffed bed (160-1000 beds)	$372,804	$379,204	$391,595	3.3%
Revenue /staffed bed (160-1000 beds)	$742,390	$762,773	$784,130	2.8%

Specific Findings

- Growth in net revenue per staffed bed (2.8% in 2008) is no longer staying ahead of growth in labor and is creating an adverse impact on financial results (even as nursing labor hours have declined) - resulting in the cost per hour of that labor rising.
- There has been a marked increase in the use of overtime, agency and other "premium" components of labor.
- "Productivity Improvements" have hospital staff working harder than ever to meet volume and acuity needs.

Data by facility size

Over time, we have recognized that facilities of disparate size experience unique challenges in labor. In small facilities, the % of fixed labor resources is less than in large facilities where 24 hour infrastructure requirements and deeper layers of management infrastructure create heavier relative burdens. As a result, we compare organizations of similar size in order to ensure the equity of operating conditions.

Workforce Prescriptions calculates a "Pay Practice IQ" for each studied facility. This algorythm adjusts for cost of living/cost of labor, payor and volume differences and then compares the efficiency of labor dollars spent in meeting volume needs.

Bed Size	Labor/Net Revenue	Pay IQ	2007 Recapture % of Net Revenue	2008 Recapture % of Net Revenue	Yr-over-yr Change in Recapture	N
801-1043	56.3%	115.3	2.6%	2.3%	-11.7%	25
601-700	50.1%	109.0	2.3%	2.2%	-4.8%	45
551-600	51.4%	108.9	2.7%	2.3%	-13.5%	32
701-800	48.5%	108.5	2.4%	2.3%	-4.7%	39
426-450	51.3%	107.9	2.7%	2.4%	-10.0%	38
226-250	51.4%	106.5	2.9%	2.7%	-5.3%	89
151-175	51.4%	105.6	2.9%	2.8%	-3.2%	101
501-550	49.7%	105.6	2.6%	2.7%	1.9%	37
376-400	54.6%	105.3	3.0%	3.0%	0.2%	45
301-325	51.2%	105.1	2.7%	2.8%	2.2%	62
National Ave	51.0%	105.1	2.8%	2.31%		1271
451-500	51.0%	104.9	2.6%	2.8%	8.2%	47
326-350	49.3%	104.7	2.8%	2.7%	-1.9%	64
276-300	50.9%	104.4	2.8%	2.7%	-4.7%	74
176-200	51.6%	104.3	2.9%	2.8%	-2.6%	127
401-425	50.3%	104.3	2.7%	2.5%	-6.0%	44
351-375	50.4%	103.7	2.7%	2.7%	-1.8%	62
251-275	50.6%	103.4	2.8%	2.8%	-1.6%	80
201-225	51.3%	103.3	2.8%	2.8%	0.2%	103
126-150	51.5%	103.1	3.0%	2.9%	-2.9%	97
100-125	48.0%	102.1	2.9%	2.9%	0.0%	48
70-99	51.0%	101.2	NA	3.5%	NA	12

Labor/Net Revenue
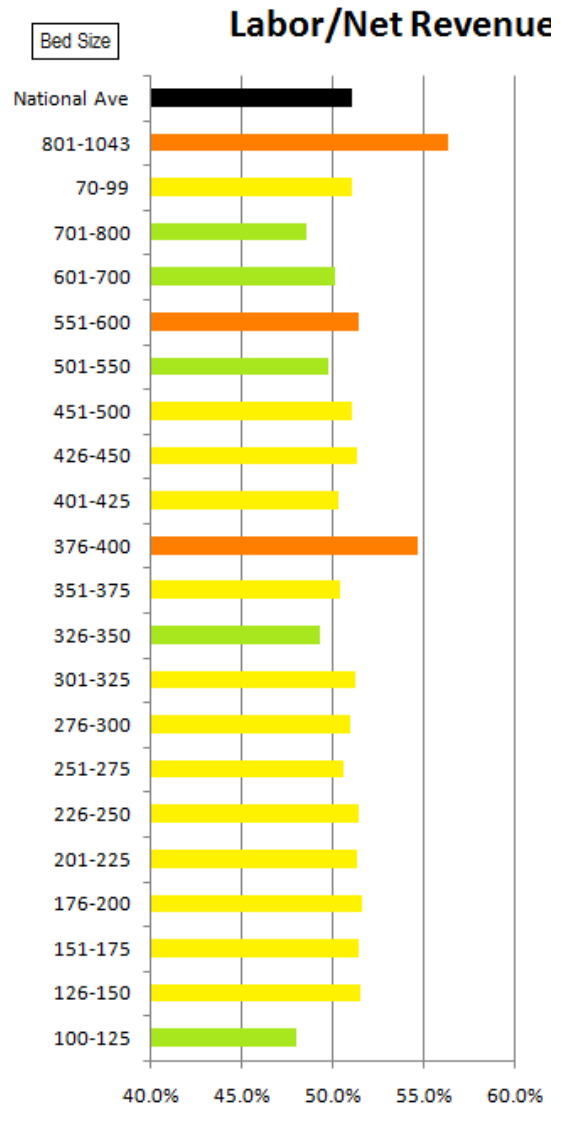
Based on indepth onsite audits and recapture programs completed in 2008, Workforce Prescriptions has been able to assess which components of labor spend are "reducable" without requiring FTE cuts. Both calculations for each category appear above (by facility bed size):

There are 2 groups that are suffering:

Hospitals with beds between 70 & 150
Hospitals with beds between 201 & 225

There is 1 group that is doing better than ave:

Hospitals with beds above 551

Performance by state pointed to clear regional market trends. Knowing that the Pay IQ calculation adjusts for differences in reimbursement rates (private, Medicare and Medicaid), acuity and cost of living/cost of labor, it is interesting to note that the gap in labor performance is widening as some states improve their performance while others have slipped:

Mitigating Factors to changes in year-over-year labor performance of states

- Several States saw their Labor/Net revenue and Pay IQ drop. This occurs when enhancements to revenue outpace increases in labor costs. The pay IQ number reflects efficiency in labor utilization even when ratios like "labor/net revenue" appear to have improved (IE labor costs can be rising but are masked by higher revenue).
- The overall hospital workforce has continued to age (mean of 44.2 yrs in 2008 of audited facilities). Aging workforces tend to have heightened tenure driving up the cost of non-productive labor components (PTO, Sick leave, vacation, etc . . .)
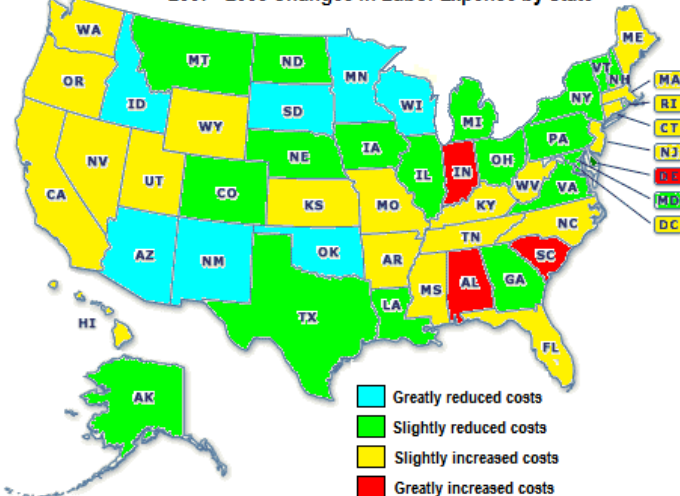
Summary findings of changes in labor costs in 2008

Knowing "what" is occurring is only half of the battle. Understanding "why" and more importantly "what to do about it" are the other half. All organizations audited (onsite audits included detailed payroll data analysis, staff & leader interviews and custom surveys) reported the following as reasons for escalation in labor costs:

- Labor costs on a per hour of care basis have risen.
- "Premium Pay" is the fastest rising component of paid labor.
- Current productivity measures are masking rising hourly costs (often productivity is measured as hours/FTE's per adjusted patient day instead of as cost-per-hour-per adjusted patient day).
- Workforce flexibility is diminishing as workforce age rises. As a result, staff scheduling is becoming increasingly complex.
- 72% of audited hospitals have reduced FTE's to combat rising labor expense.
- Productivity (output per hour of labor) is increasing yet cost per hour of that labor are rising.
- All audited facilities are struggling with a slight fall-off in volumes.

State	2006 Labor/Net Revenue	2007 Labor/Net Revenue	2008 Labor/Net Revenue	2008 Pay IQ	Yr-over-yr Labor/Net Rev
SD	51.5%	55.5%	47.9%	98.6	-13.8%
ID	52.1%	54.2%	47.9%	106.0	-11.6%
MN	53.8%	58.8%	53.3%	112.4	-9.4%
AZ	48.1%	49.0%	46.2%	103.9	-5.6%
NM	55.1%	48.2%	45.8%	108.5	-5.0%
WI	49.3%	53.9%	51.5%	112.4	-4.5%
OK	46.5%	47.1%	45.0%	97.3	-4.5%
CO	43.2%	46.9%	45.2%	102.0	-3.6%
VA	45.1%	47.3%	45.7%	100.5	-3.3%
IA	50.3%	50.4%	49.0%	99.9	-2.7%
VT	50.3%	52.2%	50.8%	123.4	-2.7%
IL	49.3%	47.9%	46.6%	101.4	-2.7%
GA	47.8%	47.9%	47.1%	98.0	-1.8%
MT	47.9%	49.0%	48.1%	105.6	-1.8%
NH	48.1%	49.6%	48.8%	114.1	-1.7%
PA	48.6%	50.3%	49.5%	101.9	-1.6%
MD	49.9%	52.0%	51.2%	108.0	-1.4%
MI	53.2%	52.0%	51.3%	107.9	-1.4%
AK	No Data	54.8%	54.1%	112.9	-1.2%
NE	47.5%	47.2%	46.8%	102.7	-0.8%
TX	45.8%	44.3%	44.0%	96.4	-0.8%
KY	46.2%	47.5%	47.2%	99.0	-0.6%
OH	48.3%	48.1%	47.9%	100.5	-0.4%
ND	54.2%	54.5%	54.3%	110.8	-0.3%
NY	65.2%	64.0%	63.9%	109.9	-0.2%
LA	44.9%	47.5%	47.5%	99.5	-0.1%
CT	58.3%	57.5%	57.5%	118.0	0.0%
WA	48.9%	47.8%	47.8%	112.4	0.0%
MA	58.8%	59.5%	59.5%	123.8	0.1%
TN	44.0%	44.5%	44.6%	96.9	0.2%
WV	47.6%	47.5%	47.7%	98.4	0.4%
ME	50.6%	50.2%	50.4%	109.5	0.5%
KS	46.1%	45.9%	46.2%	100.6	0.7%
RI	61.2%	60.4%	60.9%	120.5	0.8%
NJ	56.8%	57.8%	58.3%	109.5	0.8%
CA	53.4%	51.7%	52.1%	106.1	0.8%
NC	49.3%	49.8%	50.7%	104.7	1.8%
MO	48.1%	49.2%	50.1%	103.6	1.9%
UT	49.6%	50.9%	51.9%	106.5	1.9%
WY	44.3%	44.1%	45.1%	104.6	2.3%
AR	43.7%	45.7%	46.8%	96.8	2.3%
MS	43.7%	39.6%	40.5%	92.8	2.4%
FL	47.7%	45.8%	46.9%	98.4	2.4%
NV	44.4%	43.4%	44.5%	100.9	2.4%
OR	55.0%	53.6%	55.0%	122.4	2.6%
DC	51.3%	50.6%	52.1%	109.3	3.0%
HI	No Data	52.6%	54.6%	103.5	3.8%
DE	66.1%	49.2%	51.2%	104.7	4.1%
AL	47.1%	43.4%	45.6%	94.9	5.2%
SC	48.0%	45.3%	48.4%	98.9	6.8%
IN	47.7%	49.2%	55.2%	105.6	12.3%

2007 - 2008 Changes in Labor Expense by State

- Greatly reduced costs
- Slightly reduced costs
- Slightly increased costs
- Greatly increased costs

Big Winners & Losers . . .

Big Winners:
South Dakota, Idaho, Minnesota & Arizona who each drove their labor costs as a % of net revenue DOWN by over 4%!

Big Losers:
Delaware, Alabama, South Carolina & Indiana who each saw their labor costs (as a % of net revenue) INCREASE by over 4%

Nursing Productivity

In 2008, nursing, like most workforce components came under increasing pressure to improve productivity. Often rather than "do things differently" in order to improve productivity, many organizations attempted to "do things the same but with fewer resources".

Nursing does have productivity opportunities. In organizations with clean processes, 24X7 inpatient care departments are able to provide quality care with as little as 4.3 worked hours per adjusted patient day (including management, unit secretaries, etc . . .). In organizations who struggled with efficient processes for care delivery, the labor utilization number can reach as high as 20.4 worked hours per adjusted patient day.

The disparity in these numbers forced us to begin surveying nursing workforces in both high and low performing organizations to determine the cause for the gap. The data made clear that nursing productivity is most greatly impacted by just a few key process differences. A survey of 1894 bedside nurses in organizations with lower productivity illustrates these differences clearly:

- *In less productive organizations, shopping/hunting for equipment consumes an average of 40.38 minutes per nurse per shift of productive labor.*

- *In less productive organizations, completing redundant paperwork consumes an average of 57.41 minutes per nurse per shift of productive labor.*

- *All together, these two challenges consume 16.2% of ALL bedside nursing labor (some nurses work 12 hour shifts and others 8).*

Care Efficiency Survey	
Messiest Hand-offs:	N=1894
Between one nursing department department and another	60.18%
Most important change to make to improve hand-offs:	
Communication/respect/teamwork(hand-offs, shift change, staff, patients)	36.80%
Making departments accountable from one dept. to another	19.05%
Better processes & routines (what to do, where to go, timely manner, your own unit)	11.84%
Other people's jobs that nursing does regularly:	
Hunting for equipment that isn't available/serviced	63.17%
Stocking supplies	29.46%
When patients most often experience delays:	
During the admission process	41.23%
During the administration of care	38.96%
During the last 24 hours of their stay	19.81%
Do patients know "what is coming next"?	
Sometimes	51.89%
No	28.54%
Top dissatisfier's for nurses:	
Supply Issues - Not being able to find equipment/supplies	59.41%
Supply Issues - Having to restock equipment and supplies	35.07%
Teamwork issues - Someone else isn't doing their job	21.88%
Most "hunted" equipment	
Wheelchairs	71.38%
IV Poles	34.56%
IV Therapy Infusion Pumps	34.38%
Pillows	31.69%
Process Waste	97.79
Minutes per nurse/per shift hunting for equipment	40.38
Minutes per nurse/per shift spent completing redundant paperwork	57.41
Minutes recaptured per nurse per shift by addressing these two issues	71.61

Notes of Interest

The most "hunted for" pieces of equipment in 2008:
- #1 Wheelchairs
- #2 IV Poles
- #3 IV Therapy Infusion Pumps
- #4 Pillows

Top Dissatisfier's for nurses in 2008:
- #1 Not being able to find needed equipment or supplies
- #2 Having to re-stock equipment and supplies
- #3 Having to do someone else's job

Care Efficiency issues in 2008:
- #1 38.96% of nurses reported that patients most often experienced delays DURING the administration of care
- #2 80.43% of nurses reported that patients either DON'T KNOW what's coming next or only "sometimes" know what is coming next

Avoidable Days

One of the easiest ways to reduce labor dependence is by reducing daily census without reducing revenue. To do this, high performing organizations have developed processes to attack the "sources" of avoidable days that lower performing organizations have not or have not been effective in implementing.

In order to discover the root cause of these differences in performance, we surveyed hundreds of Case Management nurses about the sources and costs of avoidable days.

- *In struggling organizations, an average of 44.9% of avoidable days can be reduced with minimal changes in process at the case management level. This amount equaled 1332 days per year (in facilities with an average staffed bed size of 283). 1332 days per year equates to a daily census reduction of 3.65 patients (1332/365).*

- *Struggling organizations create an average of 10.47 avoidable days per bed per year, 4.70 of them being classified as "easily remediated" by high performing organizations.*

- *The greatest contributors to difficulty in addressing avoidable days was the size, charter and organization of case management (& the involvement of a physician leader).*

Source of Excess Days (16 hospitals)	N=179	TTL Days/YR	Cntrlble Days
Misc Issues: Backlog in case management prevented timely discharge planning	2.8%		11.9%
Misc Issues: Not medically stable for discharge	6.4%		
Misc Issues: Lack of insurance authorization for post-acute services/facilities	4.2%		
Misc Issues: Necessary tests/procedures not completed	4.9%		
	18.2%	540	351
Cooperation issues: Patient need could be met at another facility but patient/family will not allow referral	3.3%		7.2%
Cooperation issues: Patient/Family slow to select discharge care option	4.0%		
Cooperation issues: Difficult to reach/find family at key decision points	3.6%		
Cooperation issues: Patient/Family uncooperative/indecisive regarding procedures and tests	3.2%		
Cooperation issues: Family unwilling/unable to take patient home on discharge date	3.9%		
Cooperation issues: Physician Issues: Physician is slow to write orders, no plan documented	6.3%		
	24.3%	722	213
Physician Issues: Physician has had inadequate communication with patient/family about patient's care	5.6%		6.0%
Physician Issues: Physicians performing consults are slow to provide assessment/treatment	5.0%		
Physician Issues: Day of discharge is unclear (surprise)	6.0%		
	16.7%	495	179
LTC/SNF Issues: Local market does not have enough LTC/SNF beds available	4.9%		19.8%
LTC/SNF Issues: Process of placement to LTC/SNF is difficult/cumbersome (financial/legal issues)	4.7%		
LTC/SNF Issues: Local market does not have enough specialty beds available in LTC/SNF facilities	5.4%		
LTC/SNF Issues: There are clinical financial issues for patient at LTC/SNF (cost of meds & equipment)	4.7%		
LTC/SNF Issues: Day of discharge is on weekend and facility will not accept	5.9%		
LTC/SNF Issues: Physician does not write orders early enough - facility unable to accept patient on primary date	5.4%		
LTC/SNF Issues: Patient/Family chooses unavailable/un-matching facilities	3.9%		
	34.9%	1034	588
DME/HH Issues: Local market does not have enough DME/HH services	2.1%		3.8%
DME/HH Issues: Unclear whether patient would need post acute care until very late in stay	3.8%		
	5.9%	174	112
Case Management reported excess days per month 247		2964	1332
Total % of controllable days		44.9%	

Notes of Interest

The labor savings associated with reducing "avoidable days" can be calculated many ways
(this sample uses a hospital with 26,771 patient days per year who identified 2190 avoidable days that they could reduce)

Census translation
= **6 patients** per calendar day (2190/365) . . . census drop of 6 patients per day (8.2%)

FTE reduction translation
=16.68 FTE's reduced JUST IN NURSING (2,190 reduced days *15.8 nursing hours per patient day – current labor use per day)
=4.17 FTE's reduced in ancillary and support departments (2,190 reduced days * 3.95 hours per patient day – current labor use per day)
=20.85 FTE's

Labor $ reduction translation
=$1,238,437.20 JUST IN NURSING (34,691 hours/16.68 FTE's * $35.70 - ave rate of $30/hr + 19% bene's)
=$ 237,396.43 IN all other labor reductions (8,764 hours/4.17 FTE's *$27.37 – ave rate of $23/hr + 19% bene's)
=$1,475,883.63

LOS translation
= 4.7 days (2008 YTD average)
= 4.3 days (2008 average – 8.2%)
= **9.3 hour savings** (8.2% of 4.7 days)

2008 Root Causes of Labor Waste

Challenges in Scheduling

The difficulty and complexity of roster development, shifting volumes, skill mix issues, productivity requirements, non-productive use, changes in acuity and call-outs all conspire to make managing a staff schedule abhorrent and time consuming.

The result is 18-22% labor waste for departments who fail to master this activity.

When a manager is forced to both call and cancel staff, they ultimately default to playing "lets make a deal" in order to guarantee coverage.

We surveyed 159 nursing departments in order to more fully understand why scheduling is growing as a contributor to labor waste.

Coverage Challenges	# Depts	%	
Departments that reported having holes in every schedule inspite of attempts to balance it	63	39.6%	
Departments that reported having holes in most schedules inspite of attempts to balance it	24	15.1%	
Departments that reported never or almost never having holes in schedules	72	45.3%	100%

Roster Challenges	# Depts	%
Departments that reported having the wrong mix of FT & PT to fill schedules	55	34.6%
Departments that reported having staff who reduced their FTE status just to receive more premium pay	50	31.4%
Departments that reported staff consistently work short	147	92.5%
Departments that reported both calling and canceling staff in the same schedule	105	65.7%

Succession Planning	# Depts	%	
Departments that reported less than 10% of their staff plan to retire in the next 5 years	5	3.1%	
Departments that reported between 10 & 30% of their staff plan to retire in the next 5 years	9	5.7%	
Departments that reported more than 30% of their staff plan to retire in the next 5 years	145	91.2%	100%

Causes of Premium Pay Use (OT, Bonuses, Agency, etc . . .)	# Depts	%	
Departments that reported that staff are using more premium pay because the organization incents its use	58	36.5%	
Departments that reported staff are using more premium pay because of a difficult work enviornment (hazzard pay)	24	15.1%	
Departments that reported staff are using more premium pay because compensation levels are too low	77	48.4%	100%

The proof of false assumptions	# Depts	%
Departments that reported their staff with be MORE upset with being canceled on a scheduled shift than being called in on a day off	112	70.6%
Departments that reported the #1 cause of holes in schedules was vacancies	82	51.6%

The impact of Scheduling	# Depts	%	N=
Departments that reported the #1 cause of holes in schedules was difficulty managing all the variables of scheduling	77	48.4%	159
Departments that reported they could get more labor out of their existing staff if they could offer each of them a "perfect schedule"	109	68.6%	

- *39.6% of department report having holes in EVERY schedule in spite of their best efforts to balance and fill them.*

- *34.6% of departments report not having the right mix of full and part-time staff to meet changes in volume/acuity. Detailed roster audits of these 159 departments showed that 73.4% of them actually had the wrong roster mix to accommodate volume swings.*

- *36.5% of departments report that their policies actually incentivize staff to withhold labor in order to receive heightened premium pay.*

N = 159 Nursing Depts.

	FT	#	PT		SR	#	JR
	5%	3	95%		5%	8	95%
	15%	5	85%		15%	12	85%
	25%	2	75%		25%	15	75%
	35%	4	65%		35%	5	65%
	45%	1	55%		45%	7	55%
	50%	6	50%		50%	19	50%
	55%	5	45%		55%	3	45%
	60%	10	40%		60%	7	40%
	65%	7	35%		65%	7	35%
	70%	14	30%		70%	11	30%
	75%	24	25%		75%	12	25%
	80%	11	20%		80%	5	20%
	85%	19	15%		85%	9	15%
	90%	23	10%		90%	12	10%
	95%	12	5%		95%	13	5%
	100%	13	0%		100%	14	0%
Average	73.8%	159	26.2%	Average	60.5%	159	39.5%
Target	60%		40%	Target	55%		45%
Ave Deviation	-23.1%	117	34.6%	Ave Deviation	-10.1%	116	12.3%
Depts with significant deviation	73.6%				73.0%		

Notes of Interest

- **Shift differentials** have become disconnected from which shifts are actually the hardest to fill: (see graph to right)
  - Friday evenings are now 73.6% harder to fill than weekdays
  - Friday nights are now 72.7% harder to fill than weekdays
  - Weekend days are now easier to fill than either evenings or nights on Friday

- **Staff turnover** due to retirement will soon be a major contributor to vacancies
  - 91.2% of departments reported that MORE than 30% of their staff plan to retire in the next 5 years
  - 73.0% of departments do not have a healthy mix of senior and junior level staff (senior was described as "able to work independently without being surprised")

- **Scheduling Impact**
  - 48.4% of departments reported that holes in schedules were caused primarily by challenges in managing the variables of scheduling and not by vacancies
  - 68.6% of departments reported that they could get more productive labor out of their existing staff if they could just give them the schedules that they wanted

Shift	Staffing Difficulty	
Friday Evenings	73.6%	% harder to staff than weekdays
Friday Nights	72.7%	
Weekend Evenings	68.5%	
Weekend Nights	68.1%	
Weekend Days	35.5%	
Weekday Nights	30.5%	
Weekday Evenings	29.2%	
Weekdays	0	

N=159 (Nursing depts)

N= 159 Nursing Departments

	M	T	W	Th	Fri	S	Su
Days							
Eve's							
Nights							

Non Strategic HR

Unlike other industries, healthcare often views HR as a "non-revenue producing" function. A natural result of this is HR's inability to effect the processes that drive labor waste.

In an attempt to understand this, we engaged 85 senior leadership teams in a survey that evaluated HR in 43 different areas and in driving 9 key hospital outcomes.

This survey of 425 individuals clearly illustrates why certain not-for-profit hospitals struggle to reduce labor waste.

- HR performs best in "personnel" level activities.

- HR struggles most with the purposeful creation of outcomes in the larger workforce.

- HR performs at a marginal level in traditional organizational development activities.

Notes of Interest

Outcomes most impacted by HR in 2008:
- #1 Reducing vacancies
- #2 Stabilizing the nursing workforce
- #3 Developing managers
- #4 Improving employee engagement

Highest evaluated HR competencies in 2008:
- #1 Benefits enrollment & administration
- #2 Pre-employment credentialing
- #3 Offer & acceptance generation
- #4 Orientation & on-boarding
- #5 Benefit optimization & design

Lowest evaluated HR competencies in 2008:
- #1 Succession Planning
- #2 Job competency gap assessment
- #3 Career counseling
- #4 Identifying top performers
- #5 Exit interviewing/turnover analysis

N=85

Hiring/staffing/recruiting	6.4
Identification & tracking of vacancies	6.5
Development of applicant pools	5.8
Development of staffing strategies	5.0
Pre-interview screening for trait and behavior matching	5.7
Hiring process management & facilitation	6.5
Pre-employment credentialing	7.3
Offer and acceptance generation	7.2
Orientation and onboarding	7.1

Assessment/Selection	5.1
Identification of "top performers" in each job family	4.8
The development of pre-employment screening tools	5.6
Monitoring/reporting of hiring outcomes	4.9

Compensation & Benefits	6.5
Compensation alignment and design	6.4
Benefit optimization and design	7.1
Compensation & benefit education and support	6.6
Policy design	6.4
Measurement & governance of policies	5.8
Policy review and updating	6.1
Compliance and liability mitigation	7.0

Communication & Retention	5.7
Propagating leadership vision	6.0
Engaging the workforce to org. vision & values	5.8
Assisting leaders in gaining access to "discretionary effort"	5.3

Workforce & Succession Planning	5.1
Succession Planning	4.6
Developmental Planning	5.1
Leadership Development	5.6
Workforce/Manpower Planning	5.2

Employee Relations	5.6
Workforce preference/engagement surveying	5.5
Performance coaching	5.6
Behavior and competency remediation	5.8
Career counseling	4.8
Performance management	5.8
Crisis intervention	7.1
Exit interviewing/turnover analysis	4.9

Training & Development	5.0
Job competency gap assessment	4.8
General cirriculum design	4.9
Stand up training	5.2

Automation & Process	6.5
Hiring process efficiency & automation	5.8
Benefits enrollment and administration	7.7
Leave management optimization	5.9

HR's purposeful creation of outcomes:	4.9
Improvements in throughput	5.1
Alignment of models of care	4.4
Reduction in premium pay utilization	4.8
Reduction in turnover	5.1
Reduction in vacancies	5.7
Stabilization of the nursing workforce	5.4
Improving employee engagement	5.2
Developing Managers	5.2
Assisting with challenges in physician relationships	3.6

Poor	0-4.0
Marginal	4.1-6
Good	6.1-8
Outstanding	8.1-10

Meta Areas (Sorted)	Score
Compensation & Benefits	6.5
Automation & Process	6.5
Hiring/staffing/recruiting	6.4
Communication & Retention	5.7
Employee Relations	5.6
Workforce & Succession Planning	5.1
Assessment/Selection	5.1
Training & Development	5.0
HR's purposeful creation of outcomes:	4.9

Top Scoring	Score
Benefits enrollment and administration	7.7
Pre-employment credentialing	7.3
Offer and acceptance generation	7.2
Orientation and onboarding	7.1
Benefit optimization and design	7.1
Crisis intervention	7.1
Compliance and liability mitigation	7.0
Compensation & benefit education and support	6.6
Hiring process management & facilitation	6.5
Identification & tracking of vacancies	6.5

Bottom Scoring	Score
Succession Planning	4.6
Job competency gap assessment	4.8
Career counseling	4.8
Identification of "top performers" in each job family	4.8
Exit interviewing/turnover analysis	4.9
Monitoring/reporting of hiring outcomes	4.9
General cirriculum design	4.9
Development of staffing strategies	5.0
Developmental Planning	5.1
Workforce/Manpower Planning	5.2

N = 85
Senior Leadership
Teams
CEO, CFO, COO,
CNO, CMO
425 participants

Across America, facilities audited were actively pursuing labor expense reductions as a means of improving overall financial performance (yet many noted that their larger issues were actually rooted in known revenue challenges). Those that pursued FTE reductions as their primary method of reducing labor costs in 2008 discovered that:

- Turnover/hiring/orientation costs and the use of premium pay all rose following FTE reductions
- Employee engagement and access to productive labor fell following FTE reductions
- Productivity fell following FTE reductions

Organizations that were most successful in reducing labor costs pursued operational opportunities such as:

- Reducing "avoidable days" (thereby reducing the need for labor)
- Improving scheduling practices (modeling & administering) to reduce instances of "let's make a deal"
- Improving the ability of recruiters and reducing time-to-fill
- Developing tighter policies for the governance of time-keeping, scheduling & premium pay practices
- Expanding the use of clusters and other variable workforce strategies
- Improving roster mix with a heightened focus on job sharing, PT, per-diem and pool recruitment for both nursing and departments outside of nursing
- By converting productivity measures to "cost per hour" of labor vs. "# of hours" of labor

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Successes - Results of efforts to improve labor performance

The organizations that participated in onsite audits all shared one compelling desire: To drive down labor costs WITHOUT disenfranchising the workforce or compromising quality of care. What is most valuable to share is that all 28 organizations audited were able to drive down labor costs. Below are the results of their efforts:

- Those that pursued FTE reductions identified an average of $2,545,322 (.93% of Net Revenue) in annual savings opportunities
- Those that pursued operational efficiencies identified an average of $6,598,808 (2.4% of Net Revenue) in annual savings
- Those that pursued operational efficiencies had the greatest reduction in Agency and "premium program" usage (24.1% of total spend in those areas).
- Even high performing hospitals (those with efficient use of labor) were able to drive down labor costs through the reduction of avoidable days and use of "premium pay" programs.

	Beds	Pay IQ	Total Recapture	Recapture % of Revenue	
Georgia Hospital	358	101.5	$ 7,251,348	2.0%	Top quartile
Central PA Hospital	627	108.7	$12,128,775	2.1%	
Connecticut Hospital	132	116.1	$ 2,387,360	2.3%	2nd quartile
Central Michigan Hospital	511	106.0	$ 9,425,555	2.3%	
Western Michigan Hospital	351	103.7	$ 6,458,221	2.4%	
South Florida Hospital	354	102.9	$ 6,544,053	2.4%	
Upstate NY Hospital	435	106.9	$ 7,731,289	2.5%	3rd quartile
Central NJ Hospital	170	100.4	$ 3,110,329	2.5%	
Central Florida Hospital	364	102.2	$ 6,460,762	2.6%	Bottom quartile
Southern NJ Hospital	416	100.8	$ 7,374,993	2.7%	
Mid Atlantic Hospital	218	100.8	$ 3,714,199	2.9%	
Average Annual Recapture			$ 6,598,808	2.4%	
Cummulative Annual Recapture			$72,586,885		

Of the 11 organizations participating in detailed audits during Q2 and Q3 of 2008, all were able to identify methods for significantly reducing labor costs by focusing on key operational competencies in the areas of labor waste detailed in preceding pages.

Conclusions

The primary lesson learned in 2008 is that there ARE opportunities for improvements in labor costs/reductions in labor waste that don't require draconian FTE reductions or the eliminations of programs by mandate. In a majority of organizations we audited (28/28), premium pay had grown to become an expected component of core compensation and therefore an entitlement. All productivity improvements that had been made were undermined by a heightened used of such compensation. As the number of available bodies was reduced, the amount of premium pay provided by managers increased as they struggled to get smaller workforces to provide coverage. Since Premium compensation (OT, Bonuses, Agency, etc . . .) represents an average of 6.9% of net revenue and 13.7% of gross labor in not-for-profit hospitals in 2008, addressing it has become a chief concern of industry leaders.

About Workforce Prescriptions

Workforce Prescriptions is an "evidence based" consulting firm headquartered in Hudson, FL that provides assistance to organizations desiring to: enhance their revenue opportunities, reduce their cost of labor, reduce their length of stay or to improve their human resource & recruiting practices. Workforce prescriptions focuses primarily in the not for profit sector of healthcare in order to ""assist those organizations whose own mission requires them to take extraordinary risks in order to ensure access to quality healthcare".

Workforce Prescriptions can be contacted at (888) 343-8403 or online at http://www.workforcerx.org

About the "Pay Practice Audit"

Workforce Prescriptions launched its detailed "Pay Practice Audit" service in August of 2006 in support of its annual report "The economics of labor in healthcare". If you would be interested in discovering more about how you can participate in an audit, please visit our website at http://www.workforcerx.org/ContactUs.php and click on the link, "Audit Brochure".

About the "Pay Practice IQ"

Each year, Workforce Prescriptions creates an "every hospital" from scrubbed data. It then factors differences in reimbursement and cost of living for each market of the country and creates template facilities for each zip code family (first 2 digits of the zip code). It then overlays actual facility performance (volumes, case types, costs, revenue, labor, etc . .) to the appropriate zip code template and evaluates the efficiency of labor cost utilization. The Pay IQ algorithm then assigns an "IQ" score to each facility based on how effectively it used its labor expenses. IQ's range from 182 (Einstein level genius at labor cost efficiency) to 84.7 (smarter than Forrest Gump, but needing some direction). Each November/December Workforce Prescriptions publishes the Pay IQ of all 1271 hospitals in its involuntary study group along with "algorithmically calculated labor cost reduction estimates" on our website!