ACHIEVING SUPERIOR PRODUCTIVITY
Hospitals need to analyze, develop, and implement realistic, effective productivity standards. The first step in a productivity analysis is to collect performance data for each hospital department. A workload measure should be assigned to every department. Comparing historical performance data for each department highlights problem areas. Gaining executive commitment and department manager acceptance is essential to productivity-improvement initiatives.

Even in departments that experience a change in function, historical data can be used to monitor performance and determine where improvement is needed. A weighting system can be employed to capture historical data and establish a standard against which to measure future performance.

BY PAUL A. FOGEL, MBA

Because labor is the largest expense in healthcare organizations, hospitals that want to reduce costs need to focus on reducing labor expense. The industry trend is to use highly sophisticated productivity measurement systems to gather, calculate, and report data to control costs. Some newer systems can compute cost and hourly productivity targets for every shift of every day to help hospitals maintain cost-effective staffing levels.

Although well intentioned, such systems do not achieve cost reduction; in fact, the opposite usually occurs. Because these systems are too complex to be clearly understood by most hospital department managers, the managers cannot meet the standards projected by the productivity system. A simple, logical, and rational approach is needed.

Realistic goals of productivity management include scaling back warranted staff expansion, establishing reasonable staffing levels, and preventing unwarranted staffing increases in the future. To achieve these goals, hospitals need to create achievable productivity standards and hold department managers accountable for meeting those standards.

ANALYZING PRODUCTIVITY

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.

A productivity analysis should begin with an examination of each department’s performance over the past several years. This historical benchmarking provides a foundation against which to evaluate current performance. At this point, analysts should ignore whether the departments met their budgeted productivity targets. Because budgets are adjusted annually, it is possible for a department to meet its budget target and yet have a worse record of performance than it had the previous year.

Next, a unit of service, or workload measure, should be assigned to every department, including departments whose staffing does not normally change with fluctuations in work volume. In most cases, the unit of service will be an actual product or featured service of the department, such as patient days, visits, procedures, or treatments.

If it is not possible to easily quantify the unit of service, the size of the department (based on total hours and total wages) can be related to the size of the hospital to provide a measure of the department’s growth compared with the hospital’s growth. For example, for a fixed administrative department with several full-time salaried positions, the department’s total number of worked hours should be divided by the number of hospital-adjusted discharges per day and the ratio over time compared.

Existing workload units should be used, but if these measures are illogical or unacceptable to the department managers, the hospital should use different measures. A manager, for example, might not accept a unit of service that is obsolete or no longer describes the department’s
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product. After an acceptable unit of service has been chosen, the same unit of service should be used consistently for each department being reviewed to facilitate reasonable comparisons, department by department, over several years.

For each department, hours-per-unit data should be compared with hours-per-unit data from the previous year, without distinguishing between fixed and variable costs, to calculate whether the department's productivity improved or worsened. Then, the gain or loss in productivity should be multiplied by current workload volumes, at current salary rates, for each year. The results will illustrate the impact of changing productivity for the years studied, in both hours and wages.

For example, if a nursing department's hours worked per patient day in 1999 increased from 1998—indicating lower productivity—the increase should be multiplied by the number of patient days in 1999 to find the total number of excess hours worked. Then these hours should be multiplied by department average hourly wages in 1999. The result shows the financial impact of a department's declining productivity on the hospital. Performing this calculation for every hospital department will show the total financial impact of productivity changes on the hospital.

A nursing unit analysis is depicted in Exhibit 1. By dividing productive hours and productive wages into the department workload volume (the number of patient days), the nursing unit can determine productivity changes over a three-year period (see sidebar, page 51). This nursing unit experienced a productivity improvement of $37,761 in 1998 over 1997, but a $93,348 loss in 1999. The goal is to reverse this loss.

The data used in the calculations are for productive, or worked, hours and wages only. To assess total paid labor costs, about 12 percent would be added to wage expense to cover vacation, sick, and holiday pay and an additional 20 percent would be added for benefits, increasing labor expense by about one-third. It is important to calculate total paid labor costs to determine potential savings to the hospital.

For most hospitals, it is best to use productive (rather than paid) hours and wages when establishing new standards because these measures are controllable by managers. Vacation, sick, and holiday pay and benefits vary with employee longevity and other factors, making it unfeasible to apply a uniform standard to the department.

The next step in analyzing productivity is to list hospital departments in descending order of financial performance. Placing the worst performers at the top of the list draws attention to the departments that need special attention. All of the departments should be subdivided into one of the following four categories:

- Losing Ground (departments whose productivity has worsened);
- Holding Steady (departments whose productivity remained roughly the same over the period);
- Gaining (departments whose productivity has improved); and
- New Programs and Other (eg, start-ups, grant and research programs).

The New Programs and Other category is used to exclude start-ups and other departments that should be immune from comparison with historical data. New programs have not had sufficient time to establish stable patient volumes, much less determine appropriate staffing in relation to workload. "Other" might include grant or temporary programs for which cost cutting does not apply.

<table>
<thead>
<tr>
<th>Unit of Service</th>
<th>Total Hours and Wages</th>
<th>Per Unit of Service*</th>
<th>Effect of Productivity Change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Workload Volume</td>
<td>Productive Hours</td>
<td>Productive Dollars†</td>
</tr>
<tr>
<td>1997 Patient Days</td>
<td>2,806</td>
<td>34,500</td>
<td>$1,060,486</td>
</tr>
<tr>
<td>1998 Patient Days</td>
<td>2,942</td>
<td>34,936</td>
<td>$1,067,652</td>
</tr>
<tr>
<td>1999 Patient Days</td>
<td>3,015</td>
<td>38,713</td>
<td>$1,241,986</td>
</tr>
<tr>
<td>Three-Year Performance</td>
<td>8,763</td>
<td>108,149</td>
<td>$3,370,124</td>
</tr>
</tbody>
</table>

* These numbers are ratios and do not sum.
† Wages (excluding bonuses).
‡ 0.9 more hours worked per patient day in 1999.
§ 1.0 more hours worked per patient day in 1999 over 1997 patient days.
$ 2,910.60 hours times 1999 average hourly wages, including temporary worker and registry (productive dollars divided by productive hours).
The goal of productivity analysis is to assess the benefit to the hospital if departments in the Losing Ground category returned to the level of performance they had achieved previously.

Hospitals that have multiple nursing units treating the same or similar types of patients can use internal benchmarking data to improve productivity. These hospitals can identify the most efficient in-house unit, using its standard of performance for other units of its type as best-practice benchmarks for the other units to achieve.

One of the pitfalls of using internal benchmarking is the difficulty in comparing functions. For example, several nursing units treating the same, or similar, types of patients could be compared, but the tasks within each unit could differ markedly. One unit might deliver meal trays, while the others do not. One unit might do blood draws, whereas another has this task done by laboratory personnel. For this reason, it is sometimes best to perform this analysis later on.

IMPLEMENTING CHANGES

When the analysis is completed, the project manager should meet individually with each department manager to review the results of the productivity analysis and seek the department manager’s acceptance to use historical data as a guide when staffing for current workload volume. Discussing productivity improvement on an individual department basis not only helps overcome resistance to change, but also provides an opportunity to explain each manager’s role in achieving productivity goals and to learn more about the department’s operations.

If the hospital does not have staff with the appropriate expertise to conduct a productivity analysis objectively and implement changes based on the results, outside expertise should be sought. A consultant should be paired with a member of finance or management engineering to ensure continuity after recommended changes are implemented. Such pairing also helps the consultant learn how the hospital operates.

It will take a medium-sized hospital about three months to go through the analytical process, engage in discussions with the managers, and commence implementation. The same person or small group should meet with each manager throughout the entire process to ensure that a consistent message and relevant information are presented. The emphasis should be on a successful result.

It is realistic to expect productivity initiatives to encounter objections from department managers. Senior managers need to understand that the goal of productivity improvement is to reclaim lost productivity. Department managers need to be supported during the process and believe that senior management knows they are capable of achieving productivity-improvement goals. For department managers to accept accountability, they must be given full authority. Department managers should be given complete responsibility for managing their costs if lasting performance improvement is to be gained. Individual responsibility and accountability are created through this process. Breaking down bureaucracy and eliminating the practice of making excuses and placing blame ultimately is of great importance in ensuring productivity improvement.

ACCOUNTING FOR FUNCTIONAL CHANGE

In general, if a department’s mission, service mix, or functions have changed, its historical performance may be of little or no help in conducting a productivity analysis. In such cases, healthcare organizations normally use current performance to establish productivity standards for the future. Although this method will not yield immediate savings, it helps establish a foundation for maintaining performance.

Some types of historical data sometimes can be used as a guide, however, for departments whose functions have changed. For example, consider a general

<table>
<thead>
<tr>
<th>How to Do the Calculations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Productive Hours per Unit of Service</strong>: Productive hours (hours worked per patient day) divided by workload volume.</td>
</tr>
<tr>
<td><strong>Productive Dollars per Unit of Service</strong>: Productive dollars (wages, excluding benefits, per patient day) divided by workload volume.</td>
</tr>
<tr>
<td><strong>Effect of Productivity Change—Productive Hours</strong>: Current year’s productive hours per unit of service minus the previous year’s productive hours per unit of service, multiplied by current year workload volume.</td>
</tr>
<tr>
<td><strong>Effect of Productivity Change—Productive Dollars</strong>: Productive hours in the Effect of Productivity Change—Productive Hours column multiplied by average hourly wages (including temporary worker and registry). Total productive dollars divided by total productive hours equals average hourly wages.</td>
</tr>
</tbody>
</table>
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medical/surgical unit that converts to a mixed unit. From one year to the next, the patient acuity level has increased. The likelihood that the patient mix will continue to change over time is high.

To keep pace with expected changes in acuity, many hospitals create an acuity measure for each patient type. Such weighting systems often are used for radiology, respiratory therapy, and other departments whose service demands vary widely depending on the procedure. Using an automated tracking system to track actual days (or procedures) by patient type simplifies monitoring, because the productivity impact of varying patient types is factored out. In this way, it is easier to spot trends that require corrective action.

CONCLUSION

Hospitals need to be committed to the new productivity system as a vital element in the effort to control costs. Once productivity standards are in place and managers have committed to the concepts and measurement methods, attention should be directed to maintaining these new standards. Hospitals need to decide who has primary responsibility for meeting these standards and prescribe the manner in which they should be held accountable. There should be clearly defined consequences for poor management as well as incentives for superior performance. Without incentives and consequences policies in place and enforced, efforts to improve productivity will be ineffective.

ABOUT THE AUTHOR

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