

Cost-Containment and Cost-Management Strategies

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The leadership and boards of trustees of all healthcare organizations are the ultimate stewards of the limited resources available to best meet community needs. The strategic planning process leads the organization down a clear path of setting priorities, making choices, and taking action. The day a new cancer center opens or the latest technology arrives is an exciting one for the community.

After the ribbon cutting, these new programs become the responsibility of the hospital's service line directors or clinical managers. Their staffing is based on projections and other assumptions that may or may not be on point but have a direct impact on the operations and finances of the organization.

As part of normal decision making for a hospital's new initiatives, a payer mix and revenue stream were predicted. Now two significant environmental events have made projections more uncertain and put aggressive cost management on center stage: the economic downturn and payment reform.

The economic downturn affecting hospitals began in the fall of 2008. Its broad impact on the organization was described by Goldberg and Petasnick (2010):

With credit markets drying up, unemployment rising, consumer confidence eroding, and employee morale shaken, healthcare system executives had their hands full. The combined result of the turmoil made the old adage "cash is king" truer than ever. As consumers pulled back and individuals lost health insurance, hospitals experienced losses in volume for elective, nonemergent healthcare. Financial operating results suffered. Meanwhile, losses in investment values eliminated the safety net reserves created by nonoperating income. Many hospitals and healthcare systems were forced to consider or enact layoffs and postpone or cancel capital-intensive projects. All were required to rethink their strategic plans.

Because of the economic downturn and high unemployment, which led to income declines and individuals losing job-based healthcare coverage, Medicaid enrollment is projected to increase 10.5 percent in fiscal 2010.

When you couple this with significant declines in state and federal revenue, there is a shortfall in meeting financial obligations. Not surprisingly, Medicaid cost containment is being put into place. Thirty-two states plan to reduce or freeze provider payments in fiscal 2010 and 48 states will do so in 2011 (National Governors Association 2010).

With the passage of healthcare reform—the Patient Protection and Affordable Care Act signed into law March 23, 2010—major expansions to cover the uninsured are scheduled to take place on January 1, 2014. Though this brings clarity to

elements of longer-term financial planning for the uninsured, the underinsured, and those with bad debt, payment reform means there will be trade-offs. Anticipated provider cuts in the next few years means there will be no surge in revenue in 2014. The difficult economy has created an environment where this need is well understood by the stakeholders. As a result, patients and employees know the financial challenges their hospitals face.

One outcome of the act is the intense interest in cost-containment and cost-management strategies. Much of this interest is driven by the need to achieve an organization-established financial goal and bridge the gap when requests and planned expenditures exceed available funds. However, cost management has grown far beyond the purview of finance as payment reform initiatives have an impact on quality and process improvement and now carry financial rewards or penalties. Pertinent examples include payment denial for readmission of certain diagnoses within 30 days of discharge and bonus payments for early adoption of electronic health records (U.S. Congress 2010, 2009).

Beyond making internal comparisons of performance to budget, flexing resources to meet changing patient volumes and requirements, and comparing one's organization to similar institutions and available databases, how does one manage cost? It all starts with tools and programs such as labor resource benchmarking and analysis of the management span of control.

In practice, benchmarking is a nonstandardized term. For most, benchmarking means some kind of comparison, such as an organization benchmarking itself to a best-practice organization:

1. Benchmarking is a process where our results are compared to a database of *similar institutions*.
2. Benchmarking is where our organization tracks and compares to *itself*.
3. Benchmarking is where our organization is compared to a performance standard set by an *outside organization*.

Cost management depends on staffing management decisions, which are best supported by benchmark process number three. Typically, 60 percent of a hospital's expense is labor, with a majority of that expense in nursing. In many organizations this process is driven by operations or finance and is an intricate part of ongoing management and focus of the dashboard. The benchmarking described in number three should not be a one-time process, but rather should be done by an outside organization on an ongoing basis.

Many hospitals appear to have bloated management ranks based on analysis of title, pay grade, or who attends manager meetings. Although it is common in finance or IT to find individuals who are called *manager* or *director* and who manage programs and not staff, in other departments managers should have direct reports to earn this designation.

Span-of-control studies have concluded that, based on hospital organizational charts and position title, too many managers often do not have enough staff

reporting to them. This finding is based strictly on job titles and organization charts. When the actual job is examined and defined, benchmarking experts often find it is not a management-level position, and if it is reclassified the hospital's span of control falls within the correct range. As a staff retention strategy, titles have inflated over time to justify pay levels for key staff doing jobs that the normal pay grade system in human resources do not recognize. This organizational behavior leads to too many management layers within the organization.

Norwood Hospital in Massachusetts is a 264-bed facility with a full range of patient care services, including its Small Miracles Family Birthing Center, a modern emergency department, up-to-date radiation oncology services, extensive endoscopic services, advanced laparoscopic and neurological surgery, and a cardiac catheterization lab. The hospital provides exceptional care to the more than 300,000 people in Norwood and 16 surrounding communities. It is located in the competitive Boston market.

A new era began when Norwood Hospital became Caritas Norwood Hospital in 1997 after acquisition by Caritas Christi Health Care, the second-largest health-care system in New England. In 2009, the official name was changed to Norwood Hospital, A Caritas Family Hospital. In a recently announced precedent-setting deal, Caritas Christi Health Care was purchased by Cerberus Capital Management, a private equity firm.

With operating margins typically a bit above or below breakeven each year, cost management has always been a priority. Norwood Hospital focuses on these key principles for its departments, service lines, and managers:

- Create an environment of transparency where the information is shared and comments and questions are encouraged.
- Create an environment where the managers are expected to achieve or exceed their goals, such as clinical and patient excellence and performance, and take steps to flex staff and other resources to meet the demands of changing volume.
- Provide the managers with timely data, including custom-developed labor benchmarks, revised and updated by consultants on site with continued outside periodic review, so the productivity goals and expectations are clear.

Managers benefit from access to state-of-the-art productivity information and the ability to compare data and experiences with other peer hospitals in the Caritas Christi Health Care system. Those comparisons can be particularly helpful; they are done in a system framework—system groups of health information management directors or patient care executives—and one-on-one. This analysis leads to managers who have the information, tools, and resources to manage their areas and perform to expectations. As a result of using this information:

- Managers are expected to achieve staff targets and control overtime, use of per diems, and agency personnel, or to identify why these factors aren't controlled and develop an action plan for solutions.

- Managers see other managers' results and can question why they are not achieving their benchmarks. A spirited discussion ensues through e-mail and other exchanges. A sense of community is created for management, yet accountability is still the focus. Poor performance has ramifications.

Here are some examples of how Norwood Hospital has increased productivity:

- Early enabling of EMR technology in a community setting
- Use of value engineering, better workflow, and systems flow in redesigned areas such as the emergency department
- Use of external customized productivity benchmarks to measure and monitor labor resources

Norwood Hospital also has conducted a span-of-control project to identify the need for management or staff reductions if overages are identified. To achieve continued success, these reviews have to establish the baseline benchmarks. Benchmarks are then refreshed as new programs and technology are implemented. Without this refreshing, FTE creep—an increase in full-time-equivalent staff because leadership won't deny unjustified FTE requests—can occur.

At Norwood Hospital and the Caritas Christi Health Care system, the expectation is to provide the highest quality patient care with dignity; with all the changes coming to healthcare, meeting that expectation will continue to be a financial challenge. System functions such as finance, human resources, and IT are consolidated and centrally located. Functions are outsourced as appropriate. It is not a one-size-fits-all system strategy, and it recognizes the need for local management input and control on specific issues.

So many cost-containment strategies exist that each one could have its own article devoted to it. However, if an organization wants the most benefit in the shortest time frame, it should concentrate on performing an on-site labor resource benchmarking and a span-of-control analysis.

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