

Hospital Strategies for Process-Based Cost Reduction



Facing mounting financial pressures and a payment system increasingly focused on quality of care over volume, hospitals are realizing that traditional cost-containment efforts directed at line-item cuts in labor and supply purchase prices are neither sufficient nor effective long term. To create sustainable levels of improvement, hospitals need to approach cost reduction from a more strategic viewpoint and change processes of care so they can better utilize resources and capture efficiencies.

Following such an approach isn't easy. All too often, process-based cost-management initiatives fall victim to inadequate goals, poor understanding of progress, and insufficient physician and executive support.

With this in mind, the following report focuses on ways hospitals are structuring their decision making to avoid these common pitfalls and various strategies for uniting clinical and financial leadership to create and support cost-effective process change.

The Need for Process-Focused Cost Management

Formal examination of cost management processes is becoming increasingly important to hospitals and health systems for a number of reasons. Optimizing financial performance is key as the industry struggles with the effects of a continued weak economy, including a rise in the number of self-pay; stagnant or declining revenue from outpatient services as consumers with high-deductible health plans put off elective care; and reduced Medicaid payments as state governments wrestle with massive budget deficits.¹ At the same time, demands on capital remain high as organizations seek achieve electronic health record meaningful use and deal with the ongoing need to invest in facility upgrades or expansion.

For the past several years, cost-containment efforts have concentrated largely on traditional targets, such as supply costs and labor. For the most part, hospitals have been trimming supply costs by negotiating lower prices and more advantageous contracts, standardizing product choices, engaging physicians in supply-chain projects, and holding departmental managers accountable for supply costs and

savings. Labor reductions have focused on reducing staff, reducing contributions to retirement plans, and freezing or cutting salaries.

These avenues for cost control are narrowing, however. As leadership has gathered the "low-hanging fruit" with intense scrutiny of line items, the need for more substantial, year-over-year savings continues. As a result, healthcare executives are focusing increasingly on process reengineering. More than 80 percent of HFMA Healthcare Financial Pulse survey respondents believe process improvement will be a core cost-management strategy for the foreseeable future.²

Payment change is a key factor driving hospitals' need for a more sophisticated approach to cost management. Hospitals have always pushed for efficiency while supporting patient safety and clinical quality, but with payment change, these efforts have taken on new levels of financial urgency. Quality and patient satisfaction are being factored into Medicare payment, while private payers are pushing for performance- and risk-based payment structures, capitated contracts, and pay-for-performance incentives. In this environment, reducing expense is not enough. Leadership also needs to ensure these efforts support delivery of high-quality care.

As hospitals adapt to these process-focused, value-driven shifts in cost management, key will be developing the right structures for collaborative decision making, setting priorities, tracking improvement, and creating widespread systems of accountability.

Decision Making

Cost control should no longer be considered a unilateral function of the administrative or financial side of an organization. It should factor in both clinical and financial processes and their linkages so cost cutting can streamline service delivery without compromising quality. Cost management decisions should therefore rely on input from financial and clinical leadership.

At University of Alabama (UAB) Hospital, Birmingham, one of the top 20 largest academic medical centers in the United States, leadership has aligned strategic and business imperatives with the organization's pillar goals of quality, satisfaction, and finance.

The organization's three- to five-year strategic financial forecast projects anticipated growth and determines the related timing with which efficiency gains need to be realized. "Key leadership, which includes the CEO and the board, establishes the strategic plan," says CFO Mary Beth Briscoe. "We evaluate market share and anticipated changes in payment to determine the magnitude of required operational improvements. From this strategic overview, we develop more tactical plans to achieve the improvements within our three pillar goals."

For key initiatives, University Hospital first forms an oversight or executive committee with members from various disciplines, which includes nursing, medical staff, finance, and operations. This committee provides perspective on the effects of any changes in policies and practices and identifies any potential fallout or unintended consequences.

Critical initiatives utilize a project management framework and are led by appropriate clinical and non-clinical leadership. An executive steering committee may include clinical chairs and department heads. "This is the key strategic committee that reviews and evaluates all recommendations and determines the optimal implementation plan," says Briscoe. "Their charge is to ensure that all perspectives are considered, identify barriers to change, provide guidance on eliminating or mitigating those barriers, identify alternatives, and execute change."

Members of this group are carefully selected. "To be successful, all stakeholders must have a representative in the process," says Briscoe. "We choose strategic, broad thinkers—people who can think longitudinally across the process and the organization and who have influence to affect process change."

The group is committed to ensuring process changes do not compromise clinical outcomes, safety, or satisfaction for the sake of cost reduction and that the net impact of any process change is beneficial to the hospital and patients. "It is only at this point, once the organization has gathered the correct information, assessed the alternatives, and evaluated the impact on cost, quality, and satisfaction, that it is ready to implement change," notes Briscoe.

Setting Priorities

With limited resources and seemingly endless competing options, hospitals face intense pressure in identifying which value-driving initiatives are best to pursue.

Focusing on highest potential return. A common method of setting priorities for cost control is to target areas that are expected to produce the greatest overall financial benefit. Denver Health and Hospital Authority, an integrated, safety-net healthcare delivery network and largest provider of health services to uninsured and Medicaid patients in Colorado, has used this approach effectively.

The health system's structured approach to process improvement and cost control is grounded on Lean principles. Lean revolves around the elimination of waste in routine processes of care by identifying the root causes for waste, meaningfully involving employees in process improvement, removing silos, providing rapid initial results, and rooting lessons learned in organizational culture.

"Since we adopted Lean in 2005, we have been applying a more rigorous way of looking at cost to make changes that are logical and that eliminate waste but that do not impact quality in a negative way," says CFO Peg Burnette.

Lean focuses on value streams, or the steps associated with major organizational processes. Since the transition to Lean, Denver Health has selected 16 value streams, including revenue cycle, managed care, pharmacy, laboratory, supply chain, perioperative care, and human resources.

Value streams are chosen on the basis of their impact on cost or revenue. Improvement in the revenue cycle value stream, for example, has huge financial potential. With a total of \$1.5 billion in gross charges, even half of a percentage improvement in Denver Health's collection rate adds \$7.5 million in net revenue.

A centralized, separate Lean Systems Improvement department sets savings targets for each value stream and spearheads rapid improvement events (RIEs), four-day improvement projects that apply Lean tools to improve specific aspects of a value stream. For the revenue cycle value stream alone, 52 RIEs have instituted process changes in

financial counseling, denial management, denials prevention, self-pay collections, late charges, and authorizations. RIEs yielded \$29 million in additional revenue from the revenue cycle. RIEs for all value streams produced \$54 million in positive financial benefit in the form of increased revenue or decreased cost for 2011, which was \$26 million more than the organization's goal for the year.

The Lean department also offers a Black Belt program to train middle managers in Lean techniques. The program has certified more than 200 middle managers at Denver Health as Lean Black Belts, with each one expected to generate \$30,000 in cost reduction or revenue enhancement each year. Among their cost-saving accomplishments are a \$110,000 reduction in expenses associated with use of inpatient inhalers over a six-month period, a \$457,000 drop in supply costs for hospital engineering, and a \$35,000 savings in office supplies for environmental health services. As of Dec. 31, 2011, RIEs and Black Belt projects produced nearly \$144 million in cost savings and revenue.

Leveraging small successes for bigger wins. Some operational areas are particularly ripe for cost control. An annual survey of hospital executives by Surgical Information Systems found that 78 percent were considering or planning projects in 2012 that would reduce perioperative costs. That figure represents a 34 percent increase in cost-cutting programs in the operating room (OR) since 2010.³

But bringing these kinds of cost-cutting programs to fruition can be difficult. "For example, if you identify a process within perioperative services that may reduce cost by \$500,000, consideration must be given to the number of stakeholders involved, time for completion, and amount of collaboration involved in ensuring measurable success," says UAB Hospital's Briscoe. As can be expected, organizations often find that the larger the project, the more difficult it tends to be to gain buy-in to the change or the more sophisticated the actions needed to realize improvement potential.

Briscoe believes it is important for an organization to devote time, at least at first, to projects that are likely to succeed. Although these "easy wins" may be limited in size or scope, they can set the framework and working relationship for future process improvement. As Briscoe explains: "A small change in one part of an organizational process may seem

diminutive, however, it may be the building block for the group to gain the momentum and camaraderie necessary for it to tackle more challenging and critical components of the process and larger goals."

By building a track record with smaller project successes, members demonstrate an ability to build teamwork, gain trust, and execute change. "Ultimately, these same individuals, or others working in the same framework, garner organizational support due to the foundation of trust they have built in the approach to process evaluation as well as the management and implementation of the process change," Briscoe adds.

One area where applying this approach has been particularly effective is in the active engagement of Supply Chain in clinical and other nontraditional areas. "Supply Chain brings an alternative perspective to process review," explains Bob Taylor, AVP Supply Chain. "Because Supply Chain is focused and oriented on the development of efficient processes, we frequently ask questions and provide alternatives to identify and eliminate nonvalue-added activities."

Tracking Progress

Also important is continuous monitoring of process change. Organizations need a reliable way to determine whether they are achieving the results they are seeking. The right decision support is critical for examining the impact of cost reduction and process reengineering. As the focus on value of care increases, many organizations are finding need for more advanced business intelligence to provide insight into the effects of cost cutting on operations, quality of care, and patient satisfaction.

At Coshocton County Memorial Hospital, a 56-bed hospital in Coshocton, Ohio, leadership is upgrading the information management system to improve clinical and financial data capture and reporting.

"The system that we used for the past 15 years is limited in its reporting capabilities, says CEO Robert Miller. "Some of the more detailed and analytical techniques have not been available to us. By changing computer systems, we will be providing our managers with quantifiable information so they can make better and more timely decisions on processes to meet patient needs."

In a January 2011 HFMA Value Project survey, 79 percent of 116 executives surveyed noted that they do not measure or manage to metrics when it comes to cost of waste in care processes. Only one-third had business intelligence supporting activity-based costing to allocate indirect and overhead costs to departments, procedures, or activities.⁴

Structuring for project management. Of course, technology is not a panacea. Hospitals and health systems still need the right structures and processes in place to keep a close eye on how their projects directed at process change are progressing. At UAB Hospital, once a process initiative is determined, the oversight of the project varies depending on the magnitude of the change and the breadth of stakeholders impacted. The organization is informed of project status and results through various communication methods. Information permeates throughout the organization through Management Forum updates, newsletters, and standing committee updates, notes Briscoe. “We report on which initiatives are moving forward to the executive steering committee, which includes key leadership of the organization,” she says. “If projects are not meeting established timelines, we identify the barriers and determine what steps should be taken to move the initiative forward.”

Benchmarking costs and operations. Benchmarking with peers is also an important tool for tracking progress of initiatives. Benchmarking not only provides performance context, but also can aid discovery of improvement opportunity and help in identifying the right performance targets.

Denver Health is a member of University HealthSystem Consortium’s Operational Data Base program, which obtains comparative operational data from 124 academic medical centers and affiliated hospitals to identify high-level performance in supply chain management.

The UHC data base gathers the total supply expense (excluding drugs) or case mix index-weighted adjusted diagnosis, at least two department supply expense measures, and/or operating margin percentage to provide a snapshot of overall supply utilization as well as supply utilization specific to cardiology, surgical services, and inpatient medications.

Denver Health, the top-performing public hospital in the UHC program for 2011, regularly tracks these types of supply data from 104 clinical departments, and it tallies the number

of departments whose performance matches the UHC 25th percentile. Sixty-eight departments are currently meeting that target, compared with only 43 when Denver Health joined the UHC program in 2007, says Denver Health financial analyst Christy Hardy.

Benchmarking has been an effective driver of performance, says Hardy. “Any department that is not meeting the 25th UHC percentile target will have to develop an action plan and review it with us quarterly,” she explains.

Managers of departments that consistently have subpar performance are encouraged to contact their counterparts in the program’s high-performing facilities to learn more about what they are doing differently, says Michael O’Malley, associate CFO. As an example, one medical/surgical unit that had been underperforming learned that its high-performing peers had processes in place so charge nurses would routinely accept patients. “A simple observation such as this helped them recognize the level of benefit associated with having additional RNs on the floor,” O’Malley explains.

Quarterly benchmarking is fueling a cost-management initiative for 2012. “Personnel costs are about 63 percent of our total operating margin,” says CFO Burnette. “We are comparing ourselves with peers to identify potential opportunities associated with how we’re staffing, scheduling, and using over-time and ‘flex’ personnel, such as intermittent and outside temp agency staffing. That’s one of our organization’s top priority initiatives for this year.”

Managing Accountability

Driving—and maintaining—successes requires strong systems of accountability. To this end, organizations need the right organizational culture, incentives, role definitions, and performance metrics in place.

To ensure a culture of accountability for process changes at UAB, the hospital begins with education to various groups that explains why changes are being evaluated and implemented. “It’s important to frame how initiatives will support our three pillar goals,” Briscoe says.

UAB Hospital then ties the discussion to specific, transparent metrics. “Whatever metrics you want to move, be it number of handoffs, cost per unit, or quality outcomes, you keep them in front of the organization so all appropriate staff

are informed as to whether defined targets are being met," she says.

To further reinforce the importance of improving various processes that impact quality, cost, and satisfaction, the hospital has implemented a Sharing in Success program. This program ties a financial reward for all employees with the organization's ability to achieve metric-based results.

At Denver Health, the organization has benefited by examining role definition for accountability. As an example, when Denver Health analyzed the processes associated with supply chain management, it soon realized that it could streamline and improve supply-chain efficiencies by handing departmental decision making over to materials management. "Whereas most hospitals have clinicians involved in the supply chain at all levels, we started to embed materials management staff in each area to help set inventory levels, reduce excess inventory, help with supply chain reordering systems, and automate the process wherever possible," says Philip Pettigrew, director of materials management.

Over the past four years, Denver Health has gradually eliminated clinicians from departmental management of the supply chain and put in a supply chain expert to handle the reordering processes and inventories. Materials managers now handle 95 percent of the pharmaceutical inventory of the hospital.

Physicians bought into the change because they can still maintain control over their preferred items. "Anything related to physician preference involves physician committees in the negotiation of those particular contracts," Pettigrew says. "Physicians at Denver Health are employees, so they support the mission and the overall objectives of what we are trying to accomplish. They work in concert with us to negotiate the very lowest possible prices, standardize use of products, and consolidate products with appropriate suppliers and vendors."

Denver Health also depends heavily on metric-based performance goals to maintain systems of accountability. In the past, Denver Health addressed supply chain costs as most hospitals do—by negotiating the lowest possible prices for products. Health system leaders soon realized that the supply chain involved more than the supply expense as

it appears on expense and revenue statements. "We started focusing on the overall efficiency of the systems—the dollars that we spend on supply expenses as well as the cost of inventory and the labor involved in ordering products, inventorying products, and paying the bills," Pettigrew says.

As a result, the organization developed its own performance metric along these lines and developed systems of accountability around it. The standard measurement tool used in supply chain management—the supply cost per patient day or equivalent discharge—did not reflect the efficiency of the system. So Denver Health created the product department index (PDI), which measures the effectiveness and efficiency of the entire product management operation, from requisition to purchase order to invoice to electronic fund transfer, as well as overall inventory control management.

PDIs are computed for 83 departments in the hospital and used to monitor improvement. Based on a department's PDI, individual department action plans have been developed with the department managers that streamline the number of vendors of products and look at the overall contract that needs to be negotiated. The action plans specify who is responsible for each action item and are reviewed quarterly. "By monitoring the PDI, we determine what has improved and what areas need additional work," he says.

Positioning Your Organization for Success

When looking to build value-driving, process-based efficiencies and cost reductions at their own organizations, healthcare executives should consider the following advice.

Demonstrate commitment to value at an executive level.

Process-based cost management programs are two-way streets. To be successful, they require commitment from top executives as well as line staff. "It is absolutely key that you have alignment of all the stakeholders—clinicians, employees, physicians, and administrative staff," says Briscoe. "Everyone has to be committed to the same purpose."

Denver Health's Burnette agrees. "It is important to engage both clinical and nonclinical staff in projects and to have a team of executives and the leadership of the organization that looks at the projects regularly," she says.

TIPS FOR TRANSFORMING YOUR APPROACH TO COST REDUCTION

Angela Zotos, partner, Ernst & Young Health Care Advisory Services, discusses key strategies hospitals should take when seeking financial performance improvement that aligns with the industry's drive to enhance value of care.

Q We hear people talk about transformative cost reduction. What does that really mean?

A What we are seeing in the marketplace is a sea change in how organizations approach improvement, in terms of reflecting new reimbursement paradigms, greater transparency, and deeper collaboration between payers and providers. As hospitals seek to succeed under new quality- and outcomes-based constructs—versus the traditional encounter-based fee-for-service remuneration—they are finding they need to fundamentally change the way they do business while demonstrating three fundamentals: leadership, focus, and accountability. Several actions can aid organizations during this transformation:

Recognize the elevated importance of effective governance.

Leadership must be proactive, and it must model and foster transparency and two-way communication. Commitment to performance initiatives has to start at the top, and senior management must be visible and unwavering in driving organizational change. Also, it's important to recognize that even though the tone and direction of initiatives should come from senior executives, the successful execution of initiatives will be driven by joint clinical and administrative project teams. As such, healthcare executives are encouraged to identify clinical champions within their organizations, because respected surgeons, physicians, and nurses must work alongside CEOs and CFOs to drive the necessary changes toward quality improvement all the way to the bedside.

Leverage organizational strengths and use data to bring realism to the need for improvement and progress made.

Executive teams should direct a laser-like focus on the people

and operations that represent core strengths as they seek to implement change. These strengths should serve as a foundation for change.

It's also important to recognize that sustainable change generally is best achieved in an incremental fashion. Leadership should set a reasonable time frame for reaching targets and look for front-load, quick wins. When organizations can celebrate wins along the way, it builds momentum and signals the reality of the effort.

Also, keep the project rooted in objective results and data to identify real success and demonstrate value while rewarding departments and areas who are early adopters. People may argue with ideas, but they will have difficulty challenging tangible, transparent results.

Create a culture that sustains results. One of the most prevalent difficulties with cost-reduction initiatives is the ability to sustain results. Too often, cost reduction is a slash-and-burn downsizing effort with unsustainable staffing levels eventually returning to normal and little to no sustainable benefit to the business. By realigning the business around financial incentives that have the patient's best interest at heart, people have a compelling reason to change and to re-engineer the business. Adopting risk-based controls around results and progress will enhance transparency, and it allows executives to be alerted to any erosion of benefits or a slippage to old business practices. Drawing on today's data and analytics to deliver on-demand monitoring of key clinical, financial, and operational metrics can help ensure top-to-bottom accountability.

Source: Ernst & Young.

Build transparency around performance metrics. The success of these types of programs also hinges on clear and transparent metrics. “Staff want to do the right thing anyway to keep the mission of the organization going, but they also need to know how they are going to be held accountable,” says Burnette.

To protect the organization from unintended consequences on quality or satisfaction, it should monitor process changes consistently and with rigor. “Metrics must be hard-wired into all reporting and management systems to expeditiously identify areas of immediate focus for correction and improvement,” says Briscoe.

Continually energize staff around cost. Miller, with Coshocton County Memorial Hospital, notes that hospitals need to continue to keep a close eye on line-item expense. For example, in the past year, his organization has entered into a new eight-facility group purchasing agreement that will allow the hospital to continue buying from the same vendors but obtain better-tiered pricing. The hospital has also decreased the cost of benefits to employees and closely contained wage increases.

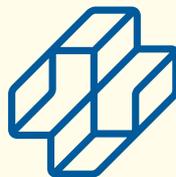
But, he notes, it’s just as important to create urgency around the need to examine process-based efficiencies and value. “With payment systems changing from the way we used to do business for so many years, we will have to change the mind-set of most people in health care, especially at the line level,” he says. “This shift in perspective won’t be easy. However, it’s crucial for us to build awareness that we need to look at new ways to provide services even more efficiently than we ever have in the past.”

Endnotes

- ¹ *HFMA’s Healthcare Financial Pulse*, Healthcare Financial Management Association, February 2010.
- ² *Ibid.*
- ³ Surgical Information Services, Survey reveals 78% of healthcare executives prioritizing perioperative cost reduction efforts. Surgical Information Services, Nov 17, 2011.
- ⁴ *Building Value-Driving Capabilities: Business Intelligence*, HFMA Value Project Report, Healthcare Financial Management Association, January 2012.



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