By Will Mahone, Diane Barlow, and Bob Davis

# Case Study: Mobilizing Performance Management Disciplines

*If you doubt that controlling labor costs is a strategic initiative, consider the case of Halifax Regional Medical Center (HRMC) in Roanoke Rapids, N.C., where a midsize, rural hospital overcame obsolete management practices, weak financial systems, and difficult demographics to reach profitability in nine months.*

The turnaround was the result of adopting recommended productivity improvement plans, performance management approaches, and cross-functional systems innovation. Underlying these changes was a robust process to build credibility and trust, train managers in flexible staffing techniques, and create timely reporting.

### A Step-by-Step Approach

HRMC is located in a fairly rural area and suffers from wide census swings; demographics constrain volume and top line growth. When the new CEO came on board in December 2005, he soon discovered serious financial problems, including weak financial systems that masked pending losses and made information retrieval difficult.

Managers had varying levels of experience but were functioning in a culture of silos, fixed staff positions (regardless of volume), and top-down decision making. They had not been provided any specific training in labor performance management. Moreover, the critical CFO position was vacant.

With the help of a consultant, a specialist in operations improvement committed to developing manager buy-in and lasting results, the CEO and his team went to work.

*Step 1: Assess operational performance.* Assessment was the first step. Both quantitative analysis and executive interviews were used to identify areas of potential opportunity and understand the root causes blocking higher profitability. The findings indicated that productivity was a major issue and needed to be the major priority. (Nonsalary costs were largely in line with independent sources of comparative data, and the revenue cycle had various issues that could be put on hold during a CFO search.)

The difference between Halifax baseline productivity and best practice exceeded 10 percent. The interviews highlighted a number of reasons for the gap, including, in addition to those listed above, process barriers and a lack of accountability. To succeed, the improvement process would need to seek resolution of these underlying issues at every stage.

*Step 2: Mobilize senior management.* Mobilizing senior management to actively sponsor productivity management was essential. There was a concerted effort to get each vice president to truly engage, beginning with transparent review of assessment findings. The CEO led the way in sponsoring a new way of staffing, in which productivity was measured frequently, managers helped each other, and staff was adjusted with volume shifts; each vice president reinforced the message with his or her direct reports.

With a global improvement goal of "the right staff for current workload while assuring that quality and service don't suffer," the executive team finalized interim staff productivity targets for each cost center. A summary productivity indicator was also added to the top management balanced scorecard. Key to reaching the targets was consistent monitoring, using biweekly reporting. The target for the emergency department, for example, was set at 2.0 worked hours/visit.

*Step 3: Engage managers.* Next came an ownership-building process with each manager, designed to resolve productivity roadblocks. This involved listening to the managers' challenges, expanding assessment findings, building credibility for benchmarks, and sharing ideas during a series of meetings.

Significant time and effort was spent with individual managers to build action plans tailored to their particular needs. They were taught performance management techniques, and received help in defining process improvement initiatives and clarifying their cross-functional needs to top management. No target was set without an achievable plan for both internal initiatives and support needed from others. For many, the attainment of top quartile performance was phased over two or more years; often targets were conditional on matching commitments from senior management for overarching system innovation.

All managers began receiving timely, biweekly productivity reports that incorporated interim targets and highlighted both progress and emerging issues. Functions with highly variable workload (e.g., inpatient nursing, diagnostic imaging) developed daily or even per shift mechanisms to adjust staffing to need. The reports then served to confirm their success and encourage continuous improvement.

Diagnostic imaging provides one example of positive change that occurred through

## Improving Productivity in Diagnostic Imaging

A relatively new manager in the diagnostic imaging at Halifax Regional Medical Center faced a culture of inflexibility and complacency, with department productivity 20 percent to 35 percent below the comparative benchmark, depending on the modality. During action planning coaching, the project team worked with each manager to establish a phased series of interim targets and develop key drivers for improvement.

**Excerpt from Action Plan for Diagnostic Imaging**

<table>
<tr><td colspan="8">Halifax Action Plan Cover Sheet</td></tr>
<tr><td colspan="4">Department or function: Diagnostic imaging<br>Top Five Issues to Resolve:</td><td colspan="4" rowspan="4">Accountable managers: Bill ___ V2: April 20, 2006<br>Goal and Potential Benefits<br>Improve facility and staff utilization and hence:<br>1. Lower cost/case<br>2. Capacity for growing volume in specialties</td></tr>
<tr><td>1</td><td colspan="3">Low productivity across five cost centers</td></tr>
<tr><td>2</td><td colspan="3">Uneven utilization among modalities</td></tr>
<tr><td>3</td><td colspan="3">Resistance to change; prior culture and habits</td></tr>
<tr><td colspan="4">Measures to Track Progress:</td><td>Baseline</td><td>Target</td><td colspan="2">Comments</td></tr>
<tr><td>1</td><td colspan="3">Staff productivity</td><td>74%</td><td>95%</td><td colspan="2">Interim target 87% within 9 months</td></tr>
<tr><td colspan="4">Key Milestones</td><td>Target Date</td><td>On Time?</td><td>% Cmp'l.</td><td>Comments</td></tr>
<tr><td>1</td><td colspan="3">Implement voluntary time off (VTO) program</td><td>15-Jul</td><td></td><td></td><td></td></tr>
<tr><td>2</td><td colspan="3">Extend cross training and cross certification across modalities</td><td>1-Sep</td><td></td><td></td><td></td></tr>
<tr><td colspan="2">Steps</td><td colspan="5">Action Plan Initiatives and Tasks Worksheet</td><td>Page ___of___</td></tr>
<tr><td>Main</td><td>Sub</td><td>What: Actions Required</td><td>Who</td><td>When</td><td colspan="2">How (resources required)</td><td>Notes</td></tr>
<tr><td>1</td><td colspan="2">Create forecasting methods to finetune daily staffing</td><td>Bill</td><td>15-May</td><td colspan="2">Coaching from Bruce ___</td><td></td></tr>
<tr><td></td><td>1.1</td><td>Review day of week and hourly patterns</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td>1.2</td><td>Evaluate add-ons and no shows patterns</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>2</td><td colspan="2">Work with Administration to finalize VTO Policy</td><td>Bill</td><td></td><td colspan="3">HR signoff on plans using VHS and/or without pay</td></tr>
<tr><td></td><td>2.1</td><td>Confirm process to cancel next day shifts or send home</td><td></td><td>1-May</td><td colspan="3">Senior management assure consistent with other departments</td></tr>
<tr><td></td><td>2.2</td><td>Communicate with staff positive reasons, process</td><td></td><td>15-May</td><td></td><td></td><td>Goal – avoid layoffs</td></tr>
<tr><td></td><td>2.3</td><td>Implement and monitor pilot 2-week impacts</td><td></td><td>1-Jun</td><td></td><td></td><td></td></tr>
<tr><td>3</td><td colspan="2">Combine and consolidate jobs across modalities</td><td>Bill</td><td>15-Jul</td><td></td><td></td><td></td></tr>
<tr><td></td><td>3.1</td><td>Shift support staff hours from underutilized specialties</td><td></td><td></td><td></td><td></td><td></td></tr>
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Gradually, productivity rose. The department met the interim target within six months and was exceeding the benchmark in a year and a half. Actions included the following:

> Convincing staff there would be no layoffs if everyone did their part, and reinforcing the urgency and organizational vision.

> Creating a voluntary time-off program tied closely to workload forecasting. This enabled the department to call off workers in advance of scheduled shifts during lull periods. Analysis of work patterns also allowed managers to fine-tune shift schedules

> Extending cross-certification of technicians in additional modalities and cross-training support staff (eliminating silos and the insular culture they had created).

> Shifting all workers to a 38-hour work week and restructuring jobs as attrition reduced staff.

> Seeking coaching from more experienced managers and enrolling in management courses.

> Monitoring staff morale, patient satisfaction scores, and other indicators to assure ongoing quality.

this process (see the sidebar on page 14 for details).

*Step 4: Empower chief implementation officer.* A major ingredient for success was identifying and positioning a trusted senior executive—the vice president for clinical and support operations, as it turned out—to serve as chief implementation officer to shepherd the fledgling program. Chief among the officer's functions is reinforcing manager ownership in improvement processes and outcomes.

The chief implementation officer is responsible for:

> Consistently monitoring biweekly productivity

> Offering assistance to managers and/or their vice presidents who are struggling

> Promoting progress

> Bringing issues to top management meetings

> Monitoring daily global volume statistics and issuing alerts as required

> Interpreting productivity data and upcoming possibilities for FTE right-sizing during budgeting.

The chief implementation officer and the consultant teamed up again after one full year to refine targets in line with the new fiscal year budget and to bolster training. Efforts at cross-functional cooperation and mobilizing top management support were renewed, especially for sensitive initiatives that might provoke physician resistance. Small staff increases were recommended for functions with large outpatient volume growth and a few targets were eased to reflect minimum staffing in small care units. Such actions further built credibility and respect for the program among clinical managers.

*Step 5: Manage outcomes.* Actually a parallel rather than a sequential effort, managing outcomes and building accountability was the collective responsibility of all vice presidents, led by the CEO. Again, this was a major culture change from top-down budgeting and decision making and inflexible staffing. However, creating biweekly productivity reports and incorporating monthly budget status reviews began to create momentum, and manager training and coaching in how to improve performance continued to reinforce the process.

The new CFO has been working closely with the CEO and other vice presidents to directly tie productivity expectations to each new operating budget, thus aligning the processes of meeting budgets and hitting the biweekly productivity targets. Had there been a CFO from day one, that individual would have been an active sponsor for change and a participant in target setting, as well as a leader in strengthening financial systems.

## Results

Profitability has been sustained for two years, and FTEs per adjusted occupied bed (FTE/AOB) continues to improve (see the exhibit below).

As important, performance management has become a way of daily life: Halifax has achieved sustained gains with stronger real-time managers and improved cross-functional processes. Specifically:

> FTE levels have dropped, despite moderate increases in volume, and FTE/AOB were reduced by more than 12 percent.

> HRMC has avoided layoffs; managers controlled overtime, used attrition, and reduced contract labor to reach interim targets in about nine months. This strategy avoided the rumors and fear that can drive off good people.

> Managers own the standards and interim targets; they are becoming proficient at the disciplines needed to manage variable workload.

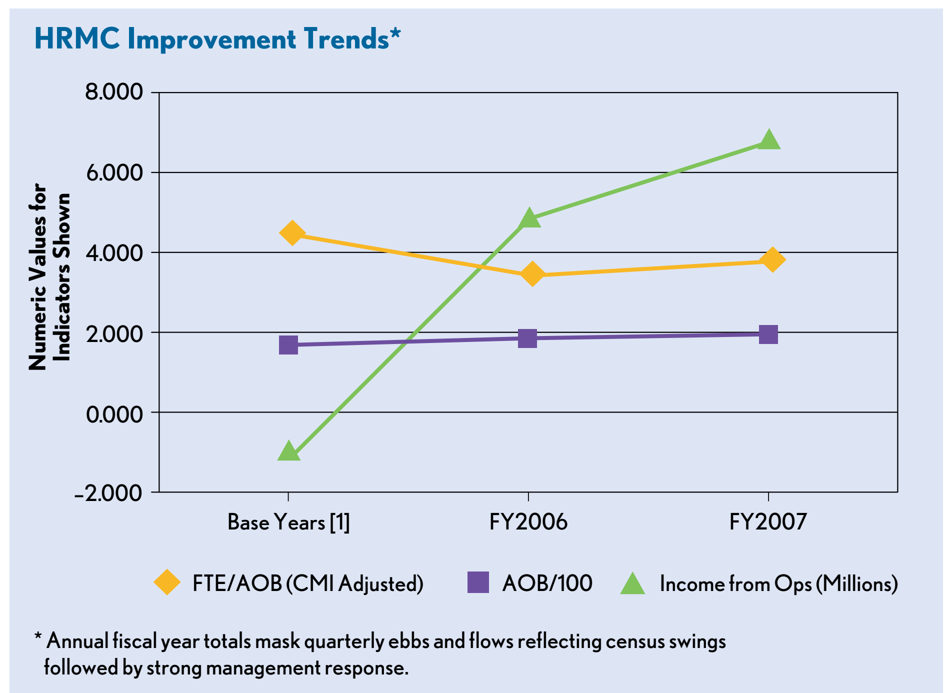
At the same time, HRMC is achieving high marks on Centers for Medicare and Medicaid Services quality measures.

## Lessons Learned

Along the way, the CEO and his team absorbed some valuable lessons, including the following:

> Persuading managers that they can improve quality and simultaneously boost productivity into the top quartile of similar hospitals is critical to success.

**HRMC Improvement Trends***




* Annual fiscal year totals mask quarterly ebbs and flows reflecting census swings followed by strong management response.

- Only manager development coupled with process improvement can provide balanced gains.
- Even with CEO sponsorship, it was more difficult to get uniform participation—especially to sustain the gains—in some clinical areas. These tended to be areas with "up through the ranks" managers and/or strong physician influences, which needed extra top management attention.
- "Flexing down" from inflated fixed staffs is tough. It is far easier to pare down core staffing to below average workloads, then arrange for supplemental staff (part-timers, selective overtime, float pools) to cover peaks.
- Consultants must have the ability to communicate and form relationships with mid-level managers, build credibility, define ambitious targets, and teach the managers how to create an action plan that achieves its targets over a defined period of time.
- Number crunching is not enough. Both consultants and internal champions must listen, understand specific issues, negotiate interim targets and timing, and advocate for cross-functional support to individual managers. Often this requires breaking down silos.

Perhaps most important, Halifax Regional Medical Center learned that most hospitals cannot hope to reverse financial losses without managing labor, which often represents 50 percent of total expense.

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