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April 2010

Healthcare Cost Containment

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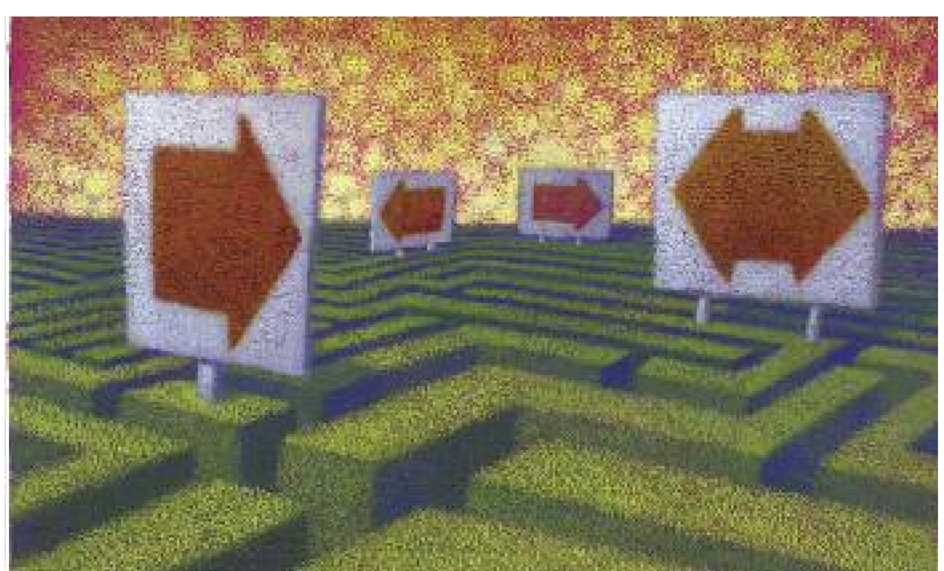
A More Logical Way to Distribute Supplies



How does a health system reduce its warehousing/distribution system costs for medical surgical supplies? For the University of Michigan Health System, eliminating the warehouse was the answer. Learn how the University of Michigan Health System is saving $800,000 on warehousing/distribution costs for medical/surgical supplies. ➜ ➜

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When looking for a better way to manage medical surgical supplies, the University of Michigan Health System (UMHS), Ann Arbor, turned to a model called logical unit of measure, an advanced, just-in-time process that moves the supply closer to the end user. The process reduces costs associated with handling supplies as well as the need for warehousing space.

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Healthcare Cost Containment is published bimonthly by the Healthcare Financial Management Association, Two Westbrook Corporate Center, Suite 700, Westchester, IL 60154.

Presorted standard postage paid in Chicago, IL 60607.

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Volume 2, Number 6

Subscriptions are $95 for HFMA members and $125 for other individuals and organizations. To subscribe, call 1-800-252-HFMA, ext 2.

Healthcare Cost Containment is indexed with Hospital and Health Administration Index and the HealthSTAR database.

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ISSN 1945-6360

Traditionally, the UMHS warehouse is stocked with $1.6 million in product. The health system expects to reduce the cost of warehousing those supplies by $800,000 over the next three years through a combination of reduced inventory and labor, says UMHS director of materiel services Frank Krupansky.

Removing the Touch Points

One of the main challenges in managing supply distribution at UMHS is its size. The 866-staffed-bed facility has about 10,000 lines of products in its item master, Krupansky says. That means a lot of supplies are being shuffled around.

"We were turning inventory roughly 45 times a year. When you think about the activity that we had flowing through this warehouse, we were essentially ordering product every day, putting it on the shelf, taking it off the shelf, and delivering it. We said, 'There has got to be a better way for us to do this,'" Krupansky says.

With the implementation of UMHS's logical unit of measure program, the inpatient units, rather than the warehouse, have become the logical place to store supplies.

Under the old process, stockkeepers used handheld computer devices to inventory supplies on the units, making sure they were in line with established par levels, Krupansky explains. Those data were then synced with the hospital's inventory management system, which

Tips for Success

Implementing a logical unit of measure model for distributing supplies requires sufficient planning and collaboration from various areas. Here are a few tips for making the change run smoothly.

Spend the time to do it right. Don't try to implement a change in your warehousing/distribution system in just a few months and then try to solve problems on the run. Plan your steps and test those steps before going live.

Document your processes. Document all the steps required to procure, purchase, receive, warehouse, and distribute supplies. For example: How is receiving product handled? How does introducing a new product affect the flow of the process? What if a product needs to be substituted? How is changing an item handled? Documenting such steps helps to create a model for how the new process should work, without having to add resources or complexity.

Establish a strong relationship with your distributor. If your distributor isn't delivering supplies on time, or you're having other problems with this vendor, implementing a logical unit of measure program isn't going to solve these problems. Make sure the vendor's operations, such as whether someone is available at all hours to accept orders, fits in with your planned distribution changes.

Use technology. Some type of computer system is needed to eliminate the human touch points and instead send and receive communication, such as purchase orders and receipts, electronically with the distributor. Homegrown computer systems or manual inventory management systems would make implementing a logical unit of measure program extremely difficult.

Involve the end-user. Analyzing facts and figures alone isn't enough to uncover opportunities for improvement. Supply chain customers, such as nurses and technicians, can offer invaluable feedback in such areas as critical need for certain items or how difference seasons affect PAR levels. Make this on-the-job experience part of the planning process.

created a pick plan. At the warehouse, stockkeepers would pick the necessary supplies and deliver them to the storage rooms on the units.

Under the logical unit of measure process, supplies are not warehoused, but delivered directly from the distributor to the patient care areas. Inventories are still conducted using handheld devices; however, when the data are synced with the hospital's inventory management system, the system sends the specific unit's needed order, rather than a bulk order of items, directly to the distributor Krupansky explains. The distributor then picks and delivers the supplies in totes labeled for the specific unit to the hospital's dock, and materiel services staff pick up and deliver the supplies to patient units.

"You bypass that whole warehouse process," Krupansky says.

In addition to reducing costs, Krupansky says the health system's logical unit of measure program is allowing materiel services to provide an enhanced level of service to caregivers who need supplies at their fingertips, not in a storage room. Patients prefer private rooms, and as hospitals work toward meeting this need, nursing units have become more spread out. This means caregivers are traveling a longer distance to supply rooms.

"The motto that we go by is, 'A product is most valuable when it's there and ready for you to use.' If a product is down the hall in a supply room, it's not as valuable as if it's right there at the bedside," Krupansky says.

Materiel services staff have, therefore, begun to provide point-of-use stocking to small mobile carts and nurse servers (small closets typically located outside patient rooms) for such common items as gauze, tape, and specimen collection supplies. By providing this substocking service, material services is able to better manage the product and provide caregivers with standardized and consistent service, Krupansky says.

Process Changes Required Collaboration

UMHS is implementing its logical unit of measure program in three phases. During the first phase, begun last November, logical unit of measure was implemented on inpatient floors. During the second and third phases, scheduled for later this year, the process will be implemented in diagnostic areas, such as the catheterization lab, and in ambulatory areas, such as clinics.

Although the concept of reducing the amount of warehoused supplies is pretty simple, planning for such a change in the distribution process took more than a year and required collaboration from a number of hospital departments, such as accounts payable, contracts and procurement, transactional purchasing, nursing, value analysis, and IT as well as the distributor, says Derek Huntman, warehouse manager for materiel services.

"We had to work with a lot of different departments to make this successful," he says. "We actually drew a pyramid diagram showing how all the departments have to work together."

Huntman says a lot of time was spent working with IT to switch the procurement ordering system from one that created internal purchase orders to one in which orders were sent directly from the procurement module to the distributor. Huntman says this meant going from sending a couple of purchase orders a day to the supply distributor to sending several hundred, a number that will increase as logical unit of measure is implemented throughout more units.

Additional Benefits: Improved Efficiency and Satisfaction

Because supplies are no longer delivered in bulk, but packaged in small quantities appropriate for use in patient rooms, some of the cost savings will be offset by increased distribution costs, Krupansky says. However, improved efficiency and staff satisfaction have been added benefits.

With its logical unit of measure model, UMHS has not only reduced the amount of space needed to store medical surgical supplies at the 9,500-square-foot warehouse, but also has eliminated the need for a warehouse at the new women's and children's hospital facility, set to open in 2012. Krupansky says the health system realized in the design phase that a warehouse is not the most cost-efficient use of space.

"Warehousing isn't the primary role in health care," Krupansky says.

The freed-up space at the existing warehouse is being used to expand the department for instrument sterilization, he says.

Krupansky says the materiel services staff like the change because they spend less time picking product in the warehouse and more time ensuring each room has the necessary supplies. The new distribution system is also a hit with nurses and other clinicians, who didn't even realize when LUM went into effect on their unit, Krupansky says.

"On the units where we have implemented it, the change has been essentially invisible to the customer," he says. "That's good. It should have been invisible."

Clinical-Finance Teams Identify Cost Savings in APR-DRGs

By transforming its approach to quality improvement and cost reduction, Bon Secours Richmond Health System has achieved success in both.

At most hospitals, finance staff and clinical staff work in silos—separated by their respective tasks and objectives. However, at Bon Secours Richmond Health System in Virginia, finance professionals and clinicians have worked together to break these silos down, partnering with each other on the shared goal of improving quality and reducing costs.

Bon Secours initiated a clinical transformation program in 2006 to bring finance staff together with clinicians to improve quality and reduce costs, says Melinda Hancock, vice president of strategic finance for Bon Secours Richmond, part of Bon Secours Health System in Marriottsville, Md. In FY09, Bon Secours Richmond, which has four acute-care hospitals, 850 beds, and annual revenue of $1.1 billion, saved $8.4 million through the CT initiative.

"We were doing a really good job on efforts to improve quality and reduce costs before the focused attention on clinical transformation, but I think now we're taking our efforts to a different level," Hancock says.

Taking a Closer Look

The idea behind Bon Secours' clinical transformation program was to pair clinical and financial skills to uncover variance, determine best practices, and quantify any potential cost savings that may result from implementing those practices, Hancock says.

The program is overseen by a multidisciplinary team that includes administrators, finance staff, service line leaders, physicians, and nursing executives. This steering committee drives the efforts of 14 teams, or learning communities, centered at Bon Secours' Virginia hospitals. These communities work together to identify variances by reviewing costs per case and other benchmarking data across the seven hospitals in Virginia (Bon Secours Hampton Roads has three acute-care hospitals) as well as against peer groups. The communities compare internal practices against common evidence-based protocols.

Each team is charged with uncovering variance in a particular clinical area, such as intensive care or cardiology. Like the project steering committee, each team includes a finance leader, physician leader, and clinical leader.

In 2009, clinical transformation teams were responsible for tracking the cost per case for the top 20 all patient refined DRGs (APR-DRGs) across the Virginia hospitals. Each team reviewed variations in length of stay and costs, including components such as imaging, supply, and nurse labor expenses. After studying the data, the team proposed a best practice and offered a roadmap for how to meet it for the designated APR-DRG.

Clinical and Financial Roles in Achieving Cost Savings

By evaluating the clinical impact of a proposed change in care practice, physician and nurse leaders play critical roles in the process. "They really help drive the change in the delivery of care," Hancock says.

These leaders use their clinical knowledge and familiarity with care processes to determine how to roll out any proposed changes in a care process. If a clinical transformation team comes up with a set of best practices for treating pneumonia, for example, the physicians and nurses then determine whether it's possible to

Lessons Learned

Melinda Hancock, vice president of strategic finance for Bon Secours Richmond Health System in Virginia, shares what she's learned so far in implementing the system's clinical transformation program.

Use benchmarking wisely. If a benchmark seems too high or too low, review it carefully. When benchmarking the cost of urinary tract infections (UTIs), Hancock found a national average of $2,500 that was quoted in a presentation; upon further investigation, she determined that the benchmark took two other studies and averaged them, creating an average of the average. Instead, Hancock used data from within the entire Bon Secours system to benchmark the cost of UTIs.

Stay out of "the weeds." Spending too much time and resources in quantifying dollars spent on a particular procedure or the cost of a specific treatment or supply can be wasteful and unnecessary, Hancock says. Balance the time and intensity of the effort with the objective.

Involve physicians from the beginning of a cost savings initiative. When embarking upon a systemwide strategy that has the potential to involve a change in the delivery of care, physician input is critical. Strong physician leaders can make the strategy easier to implement—and ultimately, more successful.

make any or all of those changes that may have to take place in the care process.

One of the roles of the finance leader is to quantify the potential cost savings that would result from a change in care practice.

For example, Hancock benchmarked the average cost to treat a urinary tract infection (UTI) related to catheter use at $643. Reductions in incident rates for UTIs could then be quantified. Hancock offers examples of savings at two system hospitals where clinical transformation has been fully implemented:

> In 2008, Memorial Regional Medical Center reduced its incident rate for UTIs to 1.66 per month. The targeted incident rate was 4.73, and the baseline set by the Centers for Disease Control and Prevention is five per month. The savings: $17,000.

> Also in 2008, St. Mary's Hospital reduced its UTI rate to 1.51, besting both the targeted rate, 3.18, and the CDC's baseline, 3.5. The savings: $20,000.

> Hancock and her team also used evidence-based medicine to reduce the number of screws being used in pediatric scoliosis cases. St. Mary's saved $397,000 in 2009 not only by reducing the costs of screws, but also by reducing the rate of infection, which increases as the numbers of screws increases, Hancock says.

Future Savings

Hancock says costs savings will deepen when the health system begins using a new clinical information system, scheduled to begin this month (April). Reducing variations in care practices will foster the creation of order sets, or protocols of care, that can then be input into the Bon Secours' electronic health record (EHR) system, she says. Nurses will then be able to follow these protocols in uncomplicated cases, such as hip implant cases, rather than calling in a physician.

The EHR system also will allow for access to patient records across the entire continuum of care. Currently, records are gathered from various sources. Having all the clinical information in one place will open up even more opportunities for reducing variances in quality and, in turn, costs, Hancock says.

"At the end of the day, it's about perfect patient care. And, it's about providing it consistently, every time," she says.

By Jacob J. Groenewold

Evaluating the Value of Supplies Can Help Reduce Costs, Improve Efficiency

At Wake Forest University Baptist Medical Center, based in Winston-Salem, N.C., evidence-based evaluations of supplies allow the medical center to examine not only a product's costs, but also how the product contributes to greater efficiency, increased revenue, and better patient outcomes.

For example, Wake Forest used an evidence-based approach to evaluate a robotic-assist device that one surgeon believed would significantly reduce the time needed for procedures. Upon evaluation, Wake Forest determined that the surgeon could reduce total operating room time per case by 33 percent using the robotic-assist device. This would allow the surgeon to perform nearly one additional case per day—generating additional revenue that would more than offset the device's price.

In another instance, an orthopedic surgeon requested an evaluation of a coagulator cutting device designed to eliminate postoperative blood transfusions. Within six months, the orthopedic surgeon was able to completely reduce blood transfusions for total knee replacement cases and reduce blood transfusions for total hip replacement patients by 83 percent.

Key to the initiatives: quality data, a collegial culture, and regular and consistent communications.

"We are a metric-driven organization," says Sallie Simpson, director of materials management at North Carolina Baptist Hospital of Wake Forest University Baptist Medical Center. "Our physicians and clinicians are open to trying new things as long as we can give them simple, quality data on the benefits of making such changes."

How can your organization engage physicians and clinicians in evaluating the value of supplies? Wake Forest offers these tips.

Collaboration and Commitment

Evidence-based evaluation of hospital supplies requires the cooperation and active involvement of multiple departments, committees, and individuals.

For materials managers, one of the keys to fostering collaboration is earning clinicians' respect by demonstrating a deep understanding of what they do and how they work. Three members of Wake Forest's materials management team have clinical backgrounds. "We can pick up the phone and talk to clinicians on their level," Simpson says.

The materials management team often collaborates with attending nurses to identify physician champions for various supply chain initiatives. More than a dozen Wake Forest physicians participate in or co-chair value analysis committees. Some have become effective, hands-on leaders in negotiating advantageous vendor contracts.

Standardizing on Price, Not Product

One of Wake Forest Baptist's supply chain management goals is to increase standardization across the hospital, health sciences center, and the integrated healthcare system.

For hip and knee implants, the hospital's strategy was to standardize on price, since its seven joint surgeons were each using different vendors. All seven surgeons helped set a realistic capped price and agreed to not use any supplier that did not comply with the pricing cap. All the vendors renewed their contracts under these new terms, saving Wake Forest more than $800,000 during the first year of the initiative.

Simpson offers these tips for engaging physicians in evidence-based supply evaluations.

Be selective in choosing physicians for leadership roles. The most highly skilled or knowledgeable individuals aren't always the best leaders. Choose physicians who have good business sense, are influential with their peers, and are excellent communicators.

Accommodate physicians' needs and keep them informed. Set meetings to fit their schedules and always respond immediately to any problems, real or perceived. Ask for their advice, encourage dissent, and give them credit for their accomplishments.

Provide accurate, concise data. Make sure data are current, accurate, and easy to understand. Data should also be easy to obtain and specific to the issue under discussion.

Establish clearly defined processes for new product requests. Use electronic forms that make it easy for physicians to submit requests.

Jacob J. Groenewold is vice president, supply chain, University HealthSystem Consortium, Oakbrook, Ill. (groenewold@uhc.edu).

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By Doug Schwieger

Careful Management of Freight Costs Can Deliver Surprising Savings

A freight management program can help hospitals significantly reduce supply expenses.

With so many areas to scrutinize for cost-saving opportunities, there may be one in particular that is easy to overlook: freight expenses.

Freight expenses often comprise 1 to 2 percent of a hospital's annual direct supply spend—costing the hospital about $1,000 per year, per bed. Because many suppliers add an upcharge for freight and pass this cost on to hospitals, it's also likely that hospitals have seen their freight expenses steadily increase over the past few years.

The good news is that by implementing a comprehensive freight management program, a hospital can dramatically reduce its freight costs—and keep them in check, year after year.

Arkansas Children's Hospital in Little Rock, Ark., saves approximately $120,000 in freight costs each year from the transactional discounts it receives from its freight management program. Fifty-eight percent of the hospital's suppliers participate in its freight management program, and more than 65 percent of direct manufacturer shipments are delivered using its discounted shipping rate. Additionally, Arkansas Children's Hospital reduced its cost-per-pack from $23 in 2005 to $15 in 2009.

By focusing on improved transaction rates, program utilization, mode optimization, and channel optimization, **Adventist Health, based in Roseville, Calif.**—which operates 17 acute care facilities in four states—has been able to reduce its average "cost per package" from $23 in 2005 to $19 in 2009. That translates into an average annual savings of $370,000 per year.

Health Management Associates, which operates 56 hospitals in 15 states throughout the Southwest and Southeast, has reduced its cost per pack from $18 in 2005 to $13 in 2009. This has translated into nearly $700,000 in annual freight savings each year since.

Gaining Control of Freight Costs

The supply chain distribution channel is often the most cost-effective way to order higher volume products, effectively eliminating freight costs from the overall cost of receiving hospital supplies. But physician preference items—especially those used in the operating room, catheterization lab, interventional radiology, central store, and clinical lab—usually must be ordered directly from the manufacturer, partly because of the variable nature of demand and utilization of these items, and partly due to the high cost associated with maintaining hospital inventories of these products.

There are ways to significantly reduce the freight costs associated with the purchase of physician preference items. The following are steps a hospital should consider.

Focus on cost per package. When analyzing freight expenses, focus on the total cost of purchasing and receiving each product. Take into account any savings the hospital may be receiving through improved transaction rates, program utilization, mode optimization, and channel optimization (see the sidebar below).

Analyzing the Benefits of Third-Party Freight Management

Considering a partnership with a freight management company? There are three key ways third-party freight management can help hospitals reduce their freight management costs.

Transactional discounts. Freight management companies offer discounts on all inbound and outbound shipments. They consolidate the direct shipping needs of hundreds of customers and negotiate industry-best transaction rates with a carrier such as Fed Ex or UPS. They also provide hospitals with a third-party Fed Ex or UPS account number that staff can use on all incoming and outbound shipments. An effective freight management partner should also help the hospital encourage as many suppliers as possible to enroll to use this third-party account number when sending shipments.

Mode optimization. On average, express deliveries cost 420 percent more than ground shipments. A freight management company can help hospital staff understand how to use the best shipping "mode" to get the products they need, when they need them, at the best cost. For example, a freight management partner should help staff understand when to select "ground" delivery instead of "next day air"—at less than a quarter of the cost.

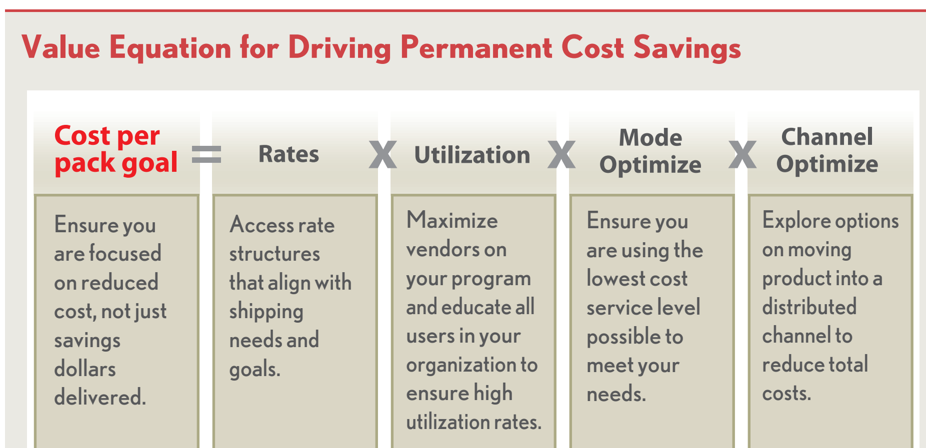
Supply chain optimization. A freight management partner with distribution experience can leverage 'demand planning' to help the hospital improve ordering patterns to reduce costly, unused inventory—particularly for higher-priced items. A distribution partner also can recommend products that could be more cost-effectively ordered through a distribution channel rather than directly from the manufacturer—without affecting product availability.

Don't allow manufacturers to bury freight charges into the overall product cost. Freight charges should always be listed as a separate line item to allow the hospital's finance team to analyze freight costs. The more detailed the invoice, the better. Beware of supplier promises of "free freight." When a line item for freight charges is not included on an invoice, chances are the costs have been included in the cost of the product.

If the hospital is participating in a freight management program, contractually require the hospital's suppliers to participate as well. The more suppliers agree to use a hospital's third-party account number in shipping supplies, the higher the savings.

Commit to staff education to ensure adherence. Staff participation in a hospital's freight management program is key to the hospital's ability to reap savings. When participating in a freight management program, train staff to consistently use the correct account number for shipping the items to the hospital when ordering products directly from the manufacturer. Be sure to regularly share the cost savings from this initiative with staff so they will better understand the importance of adhering to the hospital's freight management practices.

Value Equation for Driving Permanent Cost Savings



Compare the hospital's performance in a freight management program with the performance of its peers. Once the organization has established a freight management program, benchmark its performance against that of similar hospitals. This will help the organization identify opportunities for improvement.

Doug Schwieger is director of marketing, Cardinal Health's OptiFreight freight management service, Dublin, Ohio (Doug.Schwieger@cardinalhealth.com).

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By ChrysMarie Suby

Controlling Overtime Through Position Control

The most effective position control reports should enable hospitals to reduce overtime in nursing units. Here are examples of good, better, and best position control reports—and 17 criteria for improving the value of these reports for your organization.

It has long been thought that the only purpose for a position control report was to serve as the "hiring plan" for the unit and an organization's human resources department. However, when position control is used to translate a unit's budget into the defined scheduling requirements for the unit, the report takes on greater importance in ensuring staffing for safe patient outcomes.

The Labor Management Institute (LMI) analyzed 7,196 patient care units surveyed between 2003 and 2007, examining a number of staffing variables in relation to patient outcomes ("Labor Management Institute Findings Regarding OT & Position Control," *PSS™ Perspectives in Staffing and Scheduling*, November/December 2007). The analysis revealed that overtime was lower in organizations that fully implemented and regularly used position control to guide the assignment of work shifts than in organizations that had no position control or poorly used position control. Additionally, overtime elevated above 5 percent of total worked hours per pay period was associated with increased medical errors and patient falls.

How can organizations use position control reports to decrease overtime on nursing units? The following are strategies to consider.

What Makes a Good Position Control Report?

Position control reports are often created in Microsoft Excel®, but templates may be included in your organization's human resource, finance, or scheduling/staffing software systems. It's important for clinical directors to share position control reports with finance to help control overtime costs.

At a minimum, position control management should address filled and open positions compared with hired and actual FTE positions. Position control that is limited to these four elements acts as a vacancy report to guide hiring FTEs, but often lacks a relationship to shifts or shift length.

A *good* position control report identifies open and filled positions and correlates these positions to target scheduling requirements for specific shifts (see the exhibit below). In addition, it includes:

> References to the budgeted FTEs by skill mix (e.g., RN, LPN, NA
> Positions by job codes or skill mix for the direct and indirect caregivers

The *best* position control reports include the two criteria previously listed under good position control management plus:

> Budgeted dollars for FTE positions
> Hire dates for employees in filled positions, to track issues around seniority
> Designation for full-time, part-time, and per diem/casual status to help the manager quickly assess the actual versus optimum or budgeted full-time/part-time rotation plan
> A position control numbering schema that allows for "loaning" positions to other units for some period of time (For example, a diabetic educator position for the diabetes education program is put on hold, but the FTE is "loaned" to a medical/surgical unit where most diabetic and endocrinology patients are admitted.)

The best position control reports are online, in real time, and are automatically updated by a software system (as opposed to updates by the manager, or financial analyst) to reflect timely changes in work agreements, job codes, skill-mix assignments, dates of hire, or unit-transfer assignment dates to

Definition: Position Control Report

A position control report or tool can help managers create an accurate inventory of current and future human resource requirements, assess vacancy rates, and improve hiring and scheduling practices (www.premierinc.com).

Example of a "Good" Position Control Report for ABC—Cardiac Unit

Shift	Skill Mix	Job Code	Budget Position	Filled Position	Variance	Employee Name
Day	RN	NX 913	1.0 FTE	1.0 FTE	0.0	A. Smith
	RN	NX 913	1.0 FTE	1.0 FTE	0.0	B. Smith
	RN	NX 913	1.0 FTE	0.9 FTE	0.1	C. Smith
	RN	NX 913	1.0 FTE	0.8 FTE	0.2	D. Smith
	RN	NX 913	1.0 FTE	1.0 FTE	0.0	E. Smith
	PCT	TC 214	1.0 FTE	1.0 FTE	0.0	S. Smith
	PCT	TC 214	1.0 FTE	1.0 FTE	0.0	S. Smith
	PCT	TC 214	1.0 FTE	1.0 FTE	0.0	S. Smith
Total			**8.0 FTE**	**7.7 FTE**	**0.3 FTE**	

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recognize seniority issues and length of time to fill positions.

The very best position control reports will provide a comparison of the budgeted positions with the actual worked schedules and workload requirements so that managers can determine whether hired staff are working the shifts to which they are budgeted, or whether they are self-scheduled to their shifts of preference. The best position control reports also will identify actual and budget workload, overtime and supplemental staffing used during the selected time period, actual to budget dollars, and average time to fill positions.

Best Practices for Position Control

The Labor Management Institute recommends the following criteria be used to evaluate whether an organization is meeting best practices for position control. In reviewing these criteria, consider whether the necessary criteria are provided to evaluate the organization's position control practices. Human resources, finance, and nursing leadership should work together to supply any criteria that may be missing.

Position control reports should:

- Be based on budgeted FTEs
- Include filled and unfilled positions (vacant FTEs)
- Include the category of staff or skill mix by direct caregiver groups (e.g., RN, LPN, NA) and indirect caregiver groups (e.g., manager, secretary)
- Include date of hire, for seniority tracking
- Identify positions as full-time, part-time, and per diem/casual
- Allow positions to be distributed by shifts (days, afternoons, and nights)
- Allow positions to be distributed on weekends
- Compare budgeted positions with filled positions
- Compare agency/traveler hours by shift with budgeted positions
- Compare actual and budgeted census or other workload for the reporting period
- Compare budgeted, hired, and actual dollars for the survey period
- Identify the time to hire positions in months by skill mix
- Be managed by the unit manager
- Be shared by the organization's human resources department as a unit's hiring plan
- Be shared with finance for FTE management
- Is integrated to and updated automatically by HR, payroll, and workload information
- Provides reports that have been updated from integrated system data

Good position control helps us strengthen our financial skills so that we can identify the sources for our FTE deficits and monitor scheduling practices to ensure that staff are scheduling and working the shifts for which they are budgeted. We have long known the importance of position control but now we know that good position control management will help control for overtime that contributes to adverse patient outcomes.

ChrysMarie Suby, RN, MS, is an international healthcare consultant; president/CEO of the Labor Management Institute, which publishes the PSS™ Annual Survey of Hours Report©; and editor of the newsletter *Perspectives of Staffing and Scheduling*© (c.suby@lminstitute.com).

Example of a "Best" Position Control Report for ABC—Orthopedic Unit

Shift	Position #	Skill Mix	Job Code	Budget Dollars	Budget FTE	Filled FTE	FT/PT or PD	Var	Hire Date	Employee Name
Day	0602.RN.1	RN	NX913	$88,514	1.0	1.0	FT	0.0	04-10-2000	AS
	0602.RN.2	RN	NX913	$83,724	1.0	1.0	FT	0.0	03-15-1999	BS
	0602.RN.3	RN	NX913	$74,848	1.0	0.9	FT	0.1	11-20-2001	CS
	0602.RN.4	RN	NX913	$82,410	1.0	0.8	FT	0.2	01-04-2002	DS
	0602.RN.5	RN	NX913	$68,582	1.0	1.0	FT	0.0	02-18-2005	ES
Subtotal				**$398,078**	**5.0**	**4.7**	**4 FT**	**0.3**		
							1 PT			
							0 PD			
	0602.PCT.1	PCT	TC 214	$34,409	1.0	1.0	FT	0.0	07-12-2007	FS
	0602.PCT.2	PCT	TC 214	$34,509	1.0	1.0	FT	0.0	08-14-2003	GS
	0602.PCT.3	PCT	TC 214	$34,509	1.0	1.0	FT	0.0	05-23-2004	HS
Subtotal				**$103,427**	**3.0**	**3.0**	**3 FT**	**0.0**		
							0 PT			
							0 PD			
Total				**$501,505**	**8.0**	**7.7**	**7 FT**	**0.3**		
							1 PT			
							0 PD			

The Best Way to Cut Your Healthcare Supply Chain Costs is to Start with the **Leaders and Best**

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When you consider that supply chain operations constitute 30 to 40 percent of healthcare costs, second only to personnel costs*, even small efforts to improve efficiency and reduce waste can have a significant impact on an organization's bottom line. UM's Lean Supply Chain for Healthcare program draws upon years of experience by U-M faculty and medical center staff addressing key issues such as:

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In addition to real-world case studies, participants can witness Lean practices in action at the University Hospital and visit a distribution center to learn more about the logistics between the hospital and the their major medical supplier.

* Based on figures from ROI—Resource Organization and Innovation, an operating division of the Sisters of Mercy Health System.

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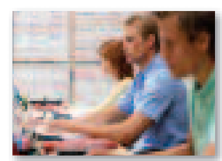

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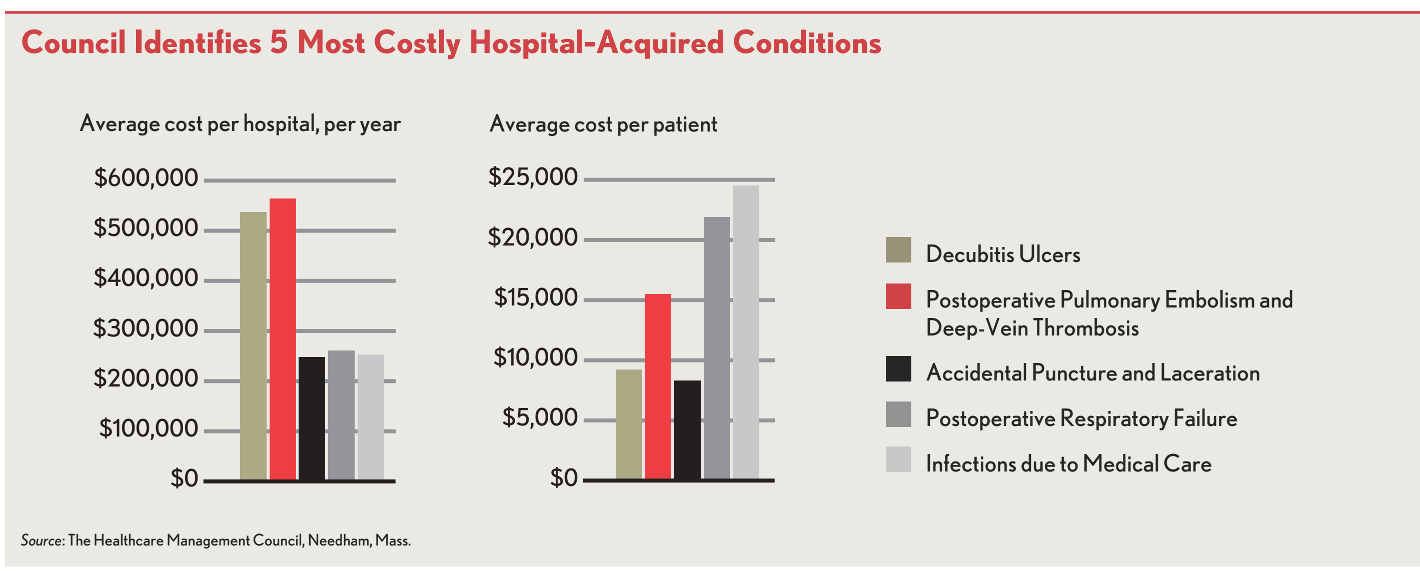

Source: The Healthcare Management Council, Needham, Mass.

Reducing Surgical Site and MRSA Infections at Centra Health

Centra Health, based in Lynchburg, Va., reduced surgical-site and methicillin-resistant Staphylococcus aureus (MRSA) infections by changing the product used for cleaning patient's skin before surgery (both at home, the night before surgery, and in the hospital, before the procedure). The initiative has significantly reduced the health system's overall surgical-site infection rates and more specifically, MRSA surgical site infection rates—and has saved an average of $25,000 for each incidence that has been avoided.

1. For years, Centra Health used a body lotion soap product to clean patients' skin prior to surgery—a product that patients would rinse off after use. But the health system's rate of surgical-site and MRSA surgical-site infections was higher than desired.

2. Centra Health sought to reduce its rate of surgical-site and MRSA surgical-site infections by switching to Chlorhexidine impregnated cloths to clean patients' skin before surgery.

3. The health system initiated a three-month pilot program for Chlorhexidine cloth use in December 2008. Staff and patients were trained on proper use.

4. Patients pat their skin with the cloths an hour after bathing the night before surgery. The cloths are used again prior to surgery.

5. When Centra Health experienced a reduction in surgical-site and MRSA surgical-site infections during the pilot program, the initiative was implemented systemwide.

6. By third quarter 2009, the initiative had reduced the health system's overall surgical site infection rate by 37 percent and its MRSA surgical-site infection rate by 58 percent—and saved, on average, more than $25,000 for each incidence that was avoided.

7. The cost of the new product is $20,000 more per year than the former product, an expense the health system recoups in just one avoided surgical-site or MRSA infection.

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Mark Donaldson, BSc, RPh, PharmD, FASHP

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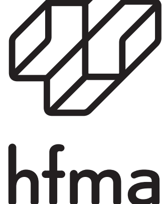

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