transforming labor-management practices through real-time analytics

Catholic Health Partners used real-time reporting and metrics to enhance its workforce performance, saving $13.5 million in operating costs.

When it comes to the cost of inpatient health care, few line items attract more attention than labor. Depending on their mission, structure, and staffing needs, some health systems find that workforce costs can surpass 60 percent of their total operating expenses. And with payers and regulators intensifying their focus on controlling expenses in every area of health care, a health system’s ability to optimally manage its large and diverse workforce is taking on increasing importance.

Unfortunately, improving labor management isn’t simply a tactical matter of paying greater attention. Hospitals and health systems struggle with the challenge because it’s an exceedingly complex task to balance competing and conflicting goals. Lean, highly productive staffing strategies can lower costs, but they also can lead to undesirable consequences, including shortfalls in coverage, unplanned overtime, greater burdens on staff, and, ultimately, a negative impact on the quality of care. Conversely, overstaffing translates into unnecessary expenses, budget overruns, and idle staff.

So how can a health system improve its labor management practices through optimized staffing levels and controlled costs while preserving or enhancing the quality of care?

It’s all about the data. The ability to accurately analyze—in real time—labor resources across different locations, units, shifts, skill levels, and other dimensions can directly translate into lower labor costs without any negative impact on continually improving patient care.

At Cincinnati–based Catholic Health Partners (CHP), productivity management systems, analytics, and revamped processes were used to enhance workforce performance with real-time reporting and metrics. As a result, the organization saved more than $8 million in annual labor costs in 2009.

To view some reports that are available through real-time analytics, go to www.kronos.com.
In early 2010, premium labor expenses declined 8.4 percent, saving an additional $3.1 million in agency costs and $2.4 million in overtime labor. This $13.5 million improvement in operating costs all occurred within a health system that ranked in Thomson Reuters’ Top 10 list of U.S. health systems based on clinical performance.

**Eliminating the “Black Box”**

With more than 100 organizations—including 24 hospitals, 15 senior living communities, five hospice programs, and eight home health agencies, and an insurance plan in Ohio and Kentucky, CHP is one of the largest not-for-profit health systems in the United States. And with more than 32,000 associates providing highly rated health care to millions of people each year, CHP has one of the largest labor-management challenges in health care.

In 2008, CHP’s executive team and board of trustees initiated a thorough review of the data, systems, and processes for managing labor and productivity. The team concluded that, without a strategic productivity objective and revamped processes, the data would take the initiative only so far.

Until that point, labor management was largely a centralized function at CHP. Benchmarking and productivity analyses were controlled by a 17-person operation in the Toledo office, which monitored productivity at a high level using basic metrics and targets that were largely dictated in a top-down fashion to various facilities and departments. CHP wasn’t focusing enough on process improvements—only on end-of-period targets and “lagging measures” without regard for how those targets could be achieved.

Without standardized definitions or consistent measurements—or even a centralized enterprise database—there was a lot of organizational resistance to the productivity management processes. For instance, the organization lacked consensus on what, exactly, constitutes a “patient day.” Different regions viewed patient day in parochial terms. The perception emerged that labor management was a black-box process that fomented feelings of fear and mistrust—fear of missing a target and a lack of trust in the process. Instead of holding conversations, CHP was issuing mandates.

By contrast, across the organization, CHP had excellent managers and executives—seasoned professionals with many different perspectives on healthcare financial performance—who were motivated instead to create a culture of accountability. But without standardization and appropriate and consistent enforcement, the health system wasn’t able to meet that objective. The fact is, holding leaders accountable to metrics and performance measures that are ill-defined and not transparent is an unfair way to evaluate their ability to manage a workforce.

**A Commitment to Transparency**

In response to this grassroots resistance, CHP’s senior leaders commissioned a new and broad productivity management initiative to transform the labor picture and drive new cost savings. The program was initially conceived to develop and implement strategies to promote more efficient use of CHP’s human resources. Essentially, the goal was to decentralize the responsibility for productivity management across 24 hospitals while still centrally managing CHP’s benchmarking and metrics. Among the key goals were to:

- Monitor CHP’s acute-care related labor expenses of $1.15 billion
- Analyze data and collaborate with regional leaders to identify opportunities for improvement by comparing labor performance with that of peers and best practices
- Evaluate staffing models and provide innovative solutions to achieve top-quartile performance compared with external peers
- Facilitate transparency of workforce-related data to all regional leaders
- Implement and maintain the CHP labor management systems, including time and attendance, labor analytics, advanced scheduling, and benchmarking software
- Advise regions regarding staffing strategies, skill mix, workload volume management, reduction of incremental overtime, and other workforce initiatives
To gain greater buy-in to benchmarking, the peer selection and vetting process was redesigned. Using the peers in our subscribed database, we selected them using several key filter criteria, e.g., volume, CMI (to align acuity), similar cohort with each hospital related to open heart, Level I or II trauma, and critical access. Our 24 hospitals were aligned with approximately 172 peers. Regional CFOs and COOs were provided all the filter data and were encouraged to vet their peers to ensure their hospitals were similar in nature. Once the vetting process occurred, the assigned peers were finalized. Once that process is completed, the departmental benchmarks are assigned in a similar fashion. All of this information is posted on the CHP intranet for executives, directors, and managers to view. Annual webinars are offered to explain the process and answer questions from participants. In 2011, more than 400 leaders participated in these webinars.

Building on the lessons of earlier initiatives meant that CHP had to make a systemic commitment to transparency. The health system needed to open up that black box and involve stakeholders in defining terms, buying into some shared accountability, and generally accepting more responsibility for the labor-management outcomes—steps they were eager to take. For the first 18 months, a team of executives from IT, financial planning, human resources, nursing, and operations held bi-monthly meetings to put everything on the table and begin the transition from centralized control of labor productivity to a decentralized coordination. One of the keys was the use of an internal advisory board (CHP’s workforce strategy committee) and external consultants to help CHP fully understand the benchmarking process. This approach helped remove bias and emotion from the process and gave the benchmark results a far higher level of credibility.

CHP’s workforce strategy committee is composed of regional representatives such as COO, vice president of finance, regional and hospital CEO, human resources executive, and CNO. The committee is co-chaired by the CHP vice president of workforce management and one of the regional CEOs. The participants are reviewed each year by the co-chairs to be sure there is consistent representation from the regions and corporate office.

Without question, the biggest change CHP contemplated was the movement from a centralized productivity management system that streamed all data to one team to a decentralized one in which each CHP region would be responsible for its own data and results. Executives at each region wanted this greater level of control of their productivity tools and data, which would allow each location to fully use and manage its data (within the organization’s centrally established reporting standards). Local responsibility for the reports would allow executives in each region to obtain a more comprehensive picture of labor costs by facility and empower them to take ownership for changes that increase productivity and lower costs.

CHP also met with external benchmarking consultants, and implemented standardized definitions for all units of service. The result was a set of aggregated findings, which CHP compiled in a summary document to be disseminated organizationwide by the workforce strategy committee to secure formal buy-in across the organization.

Next, CHP started to execute that vision—to transition from a productivity system to a total labor management process. That transition necessitated a heavy commitment in IT and involvement from the CIO and some IT staff. CHP used labor cost management software tools to better understand the true nature of the expense base and identify the areas where it could achieve the maximum improvements. This effort involved enhancing communication and coordination using existing software tools (including web-based dashboards), providing new desktop reports for front-line managers (a new paradigm for CHP), promoting the use of daily reporting across the organization, and other changes.

Finally, CHP developed management-level programs to educate senior staff on the use and content of labor reports so that they could derive the greatest value from them.
A Rich Enterprise Database
The heart of CHP’s efforts is the enterprise database that delivers all labor management information in a standard form that the health system can share with the regions. Those local managers can use the data to make corrections to their labor practices, such as improving management of variances within the pay period before it becomes a budget issue at the end of several pay periods.

Perhaps the most impactful and influential report that CHP created is the Variance Summary Report, which shows how each facility and department is performing. It displays each facility’s run-rate (current and projected annualized labor expenses) and identifies departments that are not hitting their agreed-upon targets. CHP starts with the benchmarks or unit target and then uses a workforce analytics software to get complete information about which way the trends are pointed, how long each trend has been occurring, and other insights.

It’s important to keep in mind that budgeting and target-setting are performed on the regional level. Regional executives can follow their own processes and incorporate appropriate variation. Of course, the budgeting isn’t completed in isolation. The vice president of workforce management serves as the subject matter expert along with the corporate director of workforce analytics and participates in the annual budget-planning process with all regions. This participation helps ensure alignment with the regional CFOs in terms of their total labor budget submission. The CHP target is top-quartile performance in labor expense per case mix index-adjusted discharge by hospital, so if CHP sees unusual instances that might merit more attention, it can bring those forward for further discussion.

In CHP’s database, the rate experience (defined by what was budgeted for rate/hour versus what the actual rate is running) can be viewed. CHP’s workforce management corporate director of analytics can see if a manager is applying inappropriate rates and contact the regional CFO or decision-support director if those significantly deviate from the actual rate in the database.

Auditing is conducted at the enterprise level between the regional workforce coordinator and the designated workforce senior analyst, so there is a process of review that nonetheless avoids the levels of resentment that were experienced earlier.

Although CHP’s home office allows local control, it still has expectations for premium and contract labor and overtime. When teams set the benchmarks, they do so in a way where they can transparently compare with peer units and organizations—and that transparency creates a beneficial collaborative effect and a peer-pressure governance mechanism as well. The results for all CHP facilities are shared with divisional and regional finance leaders as well as CEOs, COOs, and the workforce strategy committee.

Catholic Health Partners Labor Management Strategy
CHP’s goal was to design, implement, and support a process to foster continuous labor improvement over time. The scope of its process has included:
- Integrate/measure quality
- Create continuous change
- Establish clear targets and expectations for quality and cost using objective, granular measures
- Measure to those targets
- Promote transparency
- Implement mechanisms to monitor performance
- Own the process and be accountable for results
- Gain support from leadership team

Improving by Millions of Dollars
CHP’s senior management’s expectations for this multiyear initiative were quite high. They charged the productivity management initiative team with keeping key labor metrics for all facilities in the top quartile when compared with their peers. What’s more, the team needed to distribute out the responsibility and accountability for that performance to the individual facilities; they own those benchmarks and the productivity results. CHP believes that the process is unique among healthcare systems of its size and footprint.
In just three years, most of CHP’s facilities’ performance has reached that targeted quartile level. That has happened because CHP has created the culture it sought to foster—where transparency and collaboration drive the organization to feasible gains in how it allocates and funds the most important resource: its skilled labor.

Previously, CHP focused on department benchmarks at the regional level. Now, however, it is looking at labor for each facility, as well as the logical cohorts for each facility. For instance, a facility’s leadership team might see “soft” spots in a department’s staffing and call for more clinicians to shift from a less-busy unit to the understaffed department. These decisions are best left to local leaders, who now have the necessary data aligned with transparent objectives.

And it’s paying significant dividends. The millions of dollars of savings that are being achieved are coming from across the board—from numerous different departments and units in virtually all facilities. In 2011, premium labor—a metric CHP monitors carefully—constituted 3.25 percent of salaries. This next year, CHP has set expectations to 3 percent to meet its benchmark target.

CHP has a longstanding partnership with a third-party vendor to manage relationships with various contract labor firms across all regions. This new process and data analysis showed some inconsistent contracts and rates with different providers, presenting an attractive opportunity to standardize and streamline contract-labor relationships.

Ultimately, labor-management initiatives hinge on real-time analysis of standardized data, distributed authority through transparent processes, and an aggregation of information from multiple sources, such as payroll, labor measurements (e.g., registrations and patient days), billing, and time and attendance. Using the analytics software to analyze this centralized enterprise warehouse of information has been transformative for CHP.

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