Using Predictive Modeling to Trim Nurse Staffing Costs

By Laura Ramos Hegwer

An Illinois hospital is saving $2.1 million in annual labor costs, thanks to new staffing processes and a scheduling tool that uses predictive modeling.
Having too few—or too many—nurses on the schedule can be costly for hospitals. With advances in IT and analytics, nursing and finance leaders can analyze the data they collect from multiple software systems to better manage their valuable nursing resources.

That is what leaders are doing at the University of Illinois Hospital & Health Sciences System (UI Health), which budgets $94 million each year for inpatient nursing and has 1,000 FTEs. For years, nurse managers at the 495-bed Chicago hospital had been struggling with last-minute staffing needs that led to an overreliance on high-cost overtime resources. In fact, actual overtime use was triple the budgeted amount. Other staffing challenges included an increase in retirements and the fact that union contracts prevented unit managers from sending nurses home due to a low patient census.

Today, nurse staffing runs much more efficiently, thanks to two improvements:

- The adoption of a scheduling tool that uses predictive modeling to help managers determine appropriate staffing.
- The implementation of a decentralized staffing model for flex nurses that gives managers more control at the front line.

Putting Predictive Modeling in Action

Widely used in the financial industry and other business areas, predictive modeling is a process that uses statistics and historical data to forecast the likelihood of a future event.

At UI Health, nurse leaders have implemented a third-party scheduling tool that uses predictive modeling. The tool uses an algorithm that allows managers to anticipate nurse staffing needs based on current utilization and trend data, says Beena Peters, RN, MS, FACHE, associate director of nursing, nursing finance decision support.

“The system looks at both historical data and real-time patient census data to predict the level of staffing required,” Peters says. Specifically, the system calculates workload hours by shift for each unit using:

- Volumes
- A patient acuity score
- Workload time averages for any potential admission, discharge, or transfer, based on historic data from the previous six weeks
- Average length of stay (LOS) based on the previous year’s volume data

Tips for Re-Engineering Nurse Staffing to Reduce Costs

Create a detailed project plan to help anticipate the resources needed. Although the vendor had suggested that UI Health hire 1.0 to 1.5 FTEs to implement the predictive modeling tool, nursing leaders thought that would not be necessary. Ultimately, not having a detailed project plan at the start and not having enough resources slowed down the implementation, which took about three years—about twice as long as they expected, according to UI Health. “You will find faults in your processes, and it takes time to fix those problems.”

Take a critical look at your census data. UI Health’s census data revealed that nursing leaders were staffing up at the wrong times. Admissions from the emergency department were highest from 2 p.m. to 2 a.m., yet there were fewer nurses scheduled during the evening shift. In addition, census data revealed that most unit admissions from the OR occurred between 11 a.m. and 3 p.m. To address these issues, nursing leaders changed their core coverage to better match patient care needs throughout the day.

Gain buy-in at every level, from senior leaders to front-line staff. For example, nursing leaders at UI Health invited flex pool nurses to meetings to offer their insights on decentralizing the flex pool.

Update your scheduling policies and procedures before you implement new processes. Having a written document that requires all managers to use the new scheduling system fosters participation across the organization.

Use business associates wisely. UI Health employs business associates—non-nurses with office management or other business skills—on some of its units to free up nurse managers from time-consuming tasks like scheduling. This allows nurses to focus on clinical duties.
The predictive modeling process is fully automated. “The only thing the nurse has to do is validate that the number of scheduled employees and the predicted discharge time for patients on the unit are correct,” Mathew says.

To date, the model has been 88 percent accurate in building its 36-hour target, a figure that nursing leaders say still leaves some room for improvement.

Smaller organizations do not have to implement the same type of system to do the same work, Mathew and Peters say. A spreadsheet, using the same predictive modeling principles, would also provide the ability to organize data and use it to efficiently allocate resources.

Decentralizing Flex Nurse Staffing
In addition to using the new scheduling
tool, nursing leaders at UI Health took the bold step of decentralizing their flex pool to help decrease overtime usage. Previously, flex nurses were located in one flex pool, but now the pool is divided among the hospital’s three divisions: medical-surgical, critical care, and women’s and children’s health services.

Under the new model, flex nurses are part of the unit roster, and unit managers are responsible for managing them. Previously, the centralized nursing resource office oversaw flex staffing.

One of the key benefits of decentralizing staffing of flex nurses is that it allows nursing leaders to be proactive—rather than reactive—in managing variable staffing needs, Peters says. Unit managers have more control over staffing to manage changes in census, patient acuity, and staff call-ins. “Previously, charge nurses would call the centralized nursing resource office and ask for two or three flex nurses. But now, they take more ownership of the process,” Peters says.

To improve resource utilization among the units in each division, charge nurses host “huddles” to discuss their staffing issues. If a unit is overscheduled, a charge nurse can “float” a nurse or two to an understaffed unit.

Nursing leaders piloted the model in the hospital’s labor and delivery and mother-baby units for about six months. The new model cut the two units’ overtime hours by more than 22 percent and also increased staff satisfaction. “Nurses are happier because they can pre-plan their staffing so they are not scrambling to staff their units that day,” Peters says.

Since implementing the model, all flex nurses have been decentralized, and the hospital has hired additional flex nurses. For example, the neonatal intensive care unit (NICU) hired 16 flex nurses to help address the unit’s high variability in census. The model is working well in the NICU, Peters says. But other units with high variability are still working to find the right staffing balance. Part of the challenge is that a fluctuating census makes it difficult to anticipate when additional nurses might be needed.

Another challenge is determining where to place flex nurses who worked in different areas, such as medical-surgical and step-down units, prior to decentralization.

**A Better Bottom Line**

Peters says it took about 18 months to implement the new scheduling tool and the decentralization of the flex pool. As a result of these changes, UI Health has saved $2.1 million in annual labor costs. Approximately $1.5 million of that savings is due to decreases in overtime, while the remaining savings are attributed to a shift from overtime usage to flex usage.

In addition to containing costs, the new tool and processes have helped nursing leaders take control of their staffing and deal with variability head on. According to Peters, “The changes have given us more confidence in staffing. The next step is improving skill mix to match benchmarks.” Specifically, nursing leaders plan to address the overstaffing of RNs and the understaffing of nurse technicians on some units by filling nurse technician vacancies and reviewing staff roles and responsibilities.

Laura Ramos Hegwer is a freelance writer and editor based in Lake Bluff, Ill. (laurahegwer@comcast.net).

**Interviewed for this article:** Beena E. Mathew, MHA, financial analyst and planner specialist, University of Illinois Hospital & Health Sciences System, Chicago (bemathew@uic.edu).

Beena Peters, RN, MS, FACHE, associate director of nursing, nursing finance decision support, University of Illinois Hospital & Health Sciences System, Chicago (bpeters@uic.edu).

This article is based on interviews and a presentation at the American College of Healthcare Executives Congress in March 2013.
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A Medical Home Investment Achieves a Double-Digit ROI

In the first six months of a value-based commercial contract, Bon Secours Virginia Medical Group achieved a 35 percent reduction in readmissions and is $1.8 million below projected spend. Meanwhile, the medical home’s volumes and capacity have increased.

Over the last several years, Bon Secours Virginia Medical Group (BSVMG) has transformed into a patient-centered medical home (PCMH) that embraces population health management. Part of the Bon Secours Virginia Health System, the BSVMG multi-specialty practice has more than 100 locations in the Richmond, Va., area. The group’s 475 employed providers—45 percent of whom are primary care providers (PCPs)—serve more than 500,000 patients each year.

BSVMG’s care transformation has involved reengineering primary care practices, integrating new population health technologies into workflows, and engaging patients in their care. When BSVMG implemented these changes, it took a leap of faith—acting on the hope that payers would come to the practice if it built a viable model. Although it took a few years, payers did respond. BSVMG was selected as an early participant in the Medicare Shared Savings Program. It also has value-based contracts with two commercial payers—CIGNA and Anthem—and is in negotiations with several more.

After shouldering the expense of its medical home project for the first few years, BSVMG is now poised to reap the rewards of its investment. Results include reduced readmissions (along with the associated costs), and greater revenues for both the practice and the health system.

Improving Capacity
BSVMG’s medical home initiative began as a pilot in June 2010. Since then, 11 BSVMG practices have been recognized as patient-centered medical homes by the National Committee for Quality Assurance.

One of the main objectives was to improve capacity, or increase the size of patient panels. Physicians, including cardiologists, now share responsibility for patient care with other team members, allowing physicians to focus on patients who truly require their attention. To facilitate this process, BSVMG has embedded nurse navigators into the primary care team. These nurse navigators are registered nurses (RNs) who are board-certified case managers or are actively working toward certification. BSVMG currently has 37 nurse navigators managing care across 25 locations and is actively recruiting 30 more this year.

Each nurse navigator is assigned a panel of approximately 150 high-risk patients. The navigator cultivates a personal relationship with each patient, usually through multiple phone contacts. Because navigators are embedded in the group practice, they can spend time with these patients to conduct care assessments and planning and provide education.

The number of clinical tasks performed by physicians has been reduced because the navigators—and all team members—operate at their maximum level of competency and license. This has made it possible for PCPs to increase the size of their patient panels without overburdening themselves or sacrificing quality. Panels have increased, with a cap on primary care of 2,500 patients per month and total new patient growth capped at approximately 8,000 patients per month.

Although the cost of adding so many nurse navigators is significant, the cost is now covered under various value-based contracts. CIGNA currently gives BSVMG a per-member-per-month (PMPM) adjustment for care coordination. Anthem pays a care coordination fee and will change to PMPM in the coming year.

Building Population Health Capabilities
An important aspect of BSVMG’s strategy is health IT, which enables the care team to efficiently manage population health.

Enterprise EHRs. As a first step, BSVMG implemented an ambulatory EHR system at every practice in the group. The care team built a registry within the EHR that could identify high-risk and high-utilization patients based on data, such as number of medications or frequent visits to the emergency department. However, the organization recognized the need for a more robust, scalable patient registry solution.

Population-wide patient registry. Consequently, BSVMG implemented an automated population health
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management (PHM) platform. The software integrates with the EHR and aggregates all data into a population-wide registry. BSVMG staff can now perform various types of analytics, such as stratifying patients by risk to determine which patients are most likely to be readmitted. Care teams can also drill down into the data to monitor the health status of specific patients, such as those who are living with diabetes, so they can deliver timely and appropriate care interventions.

**Automating Patient Engagement**

The medical group’s care teams also use the PHM system to automate select patient outreach functions. Whatever the targeted protocol—whether compiling information about patients with diabetes, identifying patients who were recently discharged from the hospital, or pinpointing those who may need a screening test—the system identifies patients who are due for recommended care and notifies them through automated outbound messaging. The care team then tracks patient responses in the PHM system and monitors whether they actually come in for the necessary appointment. Any high-risk patients identified in this process are flagged and referred to nurse navigators for follow-up.

A significant priority for BSVMG has been reducing 30-day readmissions. The medical group uses the PHM software’s outreach system to identify discharged patients, link them to a PCP, and pinpoint patients who are at high risk for readmission. Flagged patients are then called within 24 to 72 hours to reinforce discharge instructions, make sure their medications are reconciled, and schedule an appointment at the PCP’s office within five to 10 days of discharge.

Using the automated PHM platform for patient outreach, BSVMG generated an average of approximately 40,000 unique patient visits per year—all for preventive, follow-up, or acute care. The visit system to identify discharged patients, link them to a PCP, and pinpoint patients who are at high risk for readmission. Flagged patients are then called within 24 to 72 hours to reinforce discharge instructions, make sure their medications are reconciled, and schedule an appointment at the PCP’s office within five to 10 days of discharge.

Using the automated PHM platform for patient outreach, BSVMG generated an average of approximately 40,000 unique patient visits per year—all for preventive, follow-up, or acute care. These visits generated more than $2 million in revenue for the organization and an ROI on technology of approximately 5 to 1.

Another strategy for increasing patient engagement is employing the EHR’s personal health record (PHR), which allows patients to view clinical results and communicate conveniently with their care provider. The organization relies on physicians and staff to encourage PHR use by helping patients sign up during office visits.

**Navigating the Transition to Value**

Because of BSVMG’s patient outreach and the intervention of nurse navigators, the 30-day readmission rate for patients in the group’s medical homes has consistently been below 2 percent for the last two years, in comparison with an average rate of 6 percent (ranging up to 17 percent in some cases) before the implementation of the PCMH. The impact on readmissions for one practice is shown in the exhibit below.

Another indicator of success: BSVMG’s patient engagement scores in 2012 were in the 97th percentile.

BSVMG has also attained many of its quality targets. However, the group needs to slightly improve gap-in-care metrics, the various HEDIS metrics used to evaluate performance in outcomes management. Claims-based outcome measurement is very difficult and error prone—subject to coding error as well as physical data entry and handling error. Once BSVMG reaches these gap-in-care targets, it will qualify for an additional gainsharing reward from CIGNA, a development that will bring a projected annual savings of $4 million.

**Bridging the Gap**

Overall, BSVMG is bridging the gap between value-based care and the fee-for-service (FFS) model. This transition is often a difficult one, requiring significant upfront investment before seeing any financial reward. By practicing population health management to drive patient volume for chronic and recommended care, BSVMG has both improved quality and increased revenues.

<table>
<thead>
<tr>
<th>Month and Year</th>
<th>Number of Patients Tracked</th>
<th>Number of Patients Readmitted in 30 Days</th>
<th>Readmission Rate</th>
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<tbody>
<tr>
<td>January 2013</td>
<td>41</td>
<td>7</td>
<td>17.07%</td>
</tr>
<tr>
<td>February 2013</td>
<td>48</td>
<td>5</td>
<td>10.42%</td>
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<tr>
<td>March 2013*</td>
<td>52</td>
<td>5</td>
<td>9.62%</td>
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<tr>
<td>April 2013</td>
<td>53</td>
<td>2</td>
<td>3.77%</td>
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*Nurse navigators started mid-month.

Source: BSVMG. Used with permission.

Robert Fortini, RN, PNP, is vice president and chief clinical officer, Bon Secours Virginia Medical Group, Richmond, Va. (Robert_Fortini@bshsi.org).
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Effective Cost Management Requires Pushing Through Execution Barriers

To realize sustainable results, hospitals and health systems first must identify and overcome the obstacles that have prevented them from achieving or maintaining past cost reduction goals.

Many hospitals and health systems are looking for new and exciting approaches to cost reduction. But perhaps they need not look too far afield. Common barriers can significantly compromise successful cost reduction, often allowing eliminated costs to creep back into operations.

Cost reduction should not be viewed as a short-term fix; long-term, sustainable cost transformation is needed. The first step is to reflect on past cost reduction efforts, and have honest dialogue about the roadblocks that prevented those efforts from achieving planned results.

Leadership teams routinely make dozens of decisions and non-decisions, producing unintended consequences that can limit the effectiveness of such initiatives. One example is focusing on finding new cost reduction strategies without first analyzing past successes and failures. Identifying and addressing historically problematic decision points strengthens an organization’s capacity to overcome future execution barriers and achieve lasting results, while also improving transparency.

Differentiating Avoidance from Reduction
Focusing on activity-centered cost avoidance, rather than true cost reduction, is a common barrier to the achievement of cost reduction targets. Knowing the difference is essential. For example, a large tertiary medical center may decide to absorb a 20 percent increase in respiratory therapy volume without adding staff. Increases in productivity would result, according to conventional, activity-based workload measures. This approach may avoid adding staffing costs, but it does not reduce existing hospital costs.

Methodologies for measuring cost and productivity, both for individual departments and systemwide, should be aligned with cost reduction goals. To do this, a strong understanding of cost drivers should be developed. A common assumption in evaluating surgery departments, for example, is that costs are driven primarily by patient volume. In fact, experience shows that growth in patient volume does not necessarily lead to a proportionate growth in costs—capacity does. If a department routinely staffs for 12 operating rooms (ORs) to support volume expectations, regardless of fluctuations in actual patient volumes, costs are higher than if staffing levels were to flex according to volume. While many organizations seek to staff according to demand, there often is a significant gap between a hospital’s OR staffing capacity and actual patient cases.

Aligning Targets with Goals
Another common execution barrier is the adoption of benchmarks which, when achieved, would fail to produce the targeted financial improvement. There often is strong motivation to adopt benchmarks that may cast departments and the organization in a favorable light. When this motivation biases the cost reduction effort, it will lead to the adoption of bad benchmarks, which can be worse than having no benchmarks at all.

For example, a small community hospital providing open heart surgery decided to benchmark itself against other organizations that performed open heart surgeries. In doing so, the hospital compared itself to much larger and more complex hospitals, with greater resources, and more service lines. This decision allowed management to interpret favorable benchmark comparisons as indicators of relative efficiency and cost-effectiveness, despite mounting financial losses.

In this case, adoption of non-comparable benchmarks made it difficult to focus on real opportunities to reduce costs that more realistic benchmarking would have revealed.

Goal achievement also can be hampered if an organization overemphasizes gaining buy-in from department managers in setting targets and budgets. Senior management must be willing to identify targets based on required levels of performance before knowing how those goals will be achieved. Once established, senior managers must enable department managers to develop plans to achieve the targets. Trying to gain consensus on targets upfront can be time consuming and result in a lengthy negotiation process that diverts energy and time from the needed execution of a cost reduction plan.

Leaders should recognize the execution expertise that already exists within their organizations. They should foster a culture that is demanding, but that also enables middle managers to effect change and encourages progress through accountability. For this to occur, senior management first should recognize that department managers are the most qualified to determine how best to achieve targets.

Strengthening Organizational Capacity
Strengthening the organization’s capacity to produce lasting results should inform every step of an organization’s cost management strategy.

To achieve these goals, organizations should ensure the following are a defined part of the process:
- Establishment of a strategic and financial context for the cost reduction effort
- Quick quantification of targets that are aligned with financial performance
- Alignment of resources with targets and plans
- Definition of performance measures focused on clinical and financial ROI, as well as total costs
- Unwavering discipline to move from improvement opportunities to results

A results-driven approach to cost reduction requires that organizations have top-down leadership in the setting and oversight of cost targets, coordinated with bottom-up planning and execution of cost reduction strategies. Cost initiatives provide an excellent platform to grow the leadership skills and capacity needed to push through execution barriers and achieve significant and sustainable results.

Brian Channon is a senior vice president and head of strategic cost management services at Kaufman Hall, Skokie, Ill. (bchannon@kaufmanhall.com).
A Safety Net System Launches a Lean Approach to Sustainable Performance Improvement

A comprehensive quality improvement and cost reduction initiative at a public Texas health system has generated more than $16.2 million in cost savings to date, helping to position the organization for a value-oriented marketplace.

University Health System, a San Antonio, Texas-based, safety-net provider and academic medical center, undertook a thorough operational self-review in anticipation of revenue reductions associated with impending state and federal payment cuts. In 2011, when these changes threatened to stall the system’s growth momentum, it launched a multi-pronged, comprehensive initiative that is strengthening both its fiscal health and its ability to deliver high-quality care to residents of South Texas.

Managing supply expense. Supplies were assigned to one of three categories: > Physician preference items > Clinically sensitive items > Commodity or non-clinically sensitive items

Specific methodologies—anchored by data-driven processes—were then applied to each category to identify opportunities and correctly analyze all University Health System expenditures. Supply expense initiatives included obtaining better pricing as well as reinforcing accurate pricing, increasing understanding and compliance with existing supplier contracts, and engaging physicians to standardize supplies and decrease utilization of expensive supplies.

Improving clinical resource utilization and standardization. A proven physician engagement methodology was adopted that focused on clinical practices and utilization, as well as price. A database platform was used to conduct a comparative analysis of variables, including reimbursement, supply cost, utilization, and clinical resource data. The database platform helps manage supply costs by evaluating metrics such as contract compliance and utilization and by normalizing the data in the item file, thereby helping to eliminate duplicate items and standardize nomenclature.

Physicians then participated in an analytical review process to share their insights on cost drivers and assess savings opportunities. The goal was to maintain high-quality patient outcomes while gaining consensus on opportunities to standardize and improve clinical resource utilization.

Although the clinical resource utilization project is still in the beginning phases, these initiatives have produced new savings and efficiencies in areas such as laboratory, radiology, and the operating room, resulting in savings of more than $140,000 for University Health System. This physician engagement-driven approach typically results in savings of 5 percent to 20 percent of implant expenses.

340B drug discount program. Several initiatives related to the ongoing 340B program were conducted, including a compliance evaluation and identification of revenue enhancement opportunities. The program enabled the system to reach more eligible patients and provide more comprehensive services. The compliance review allowed University Health System to improve compliance with 340B program requirements, thereby minimizing the risks of fines or potential loss of the program. This has resulted in increased revenues.

Purchased services. A typical health system may spend 15 percent of operating expense on purchased services. University Health System evaluated total expenses across operational functions and support services, such as insurance, parking and transportation costs, use of referral lab testing, transcription cost management, and standard maintenance contracts. By leveraging a national purchased services program that provided industry best practices and national
Throughout the process, University Health System worked with executive management and physician teams to build and improve upon several care models to ensure that patients are admitted to the appropriate care setting and receive the highest quality care. Below are four examples from the initiative.

**Length of stay.** One of the Lean initiatives focused on reducing length of stay (LOS) in trauma units. A thorough analysis was conducted to identify communication breakdowns and inefficiencies that led to potential increases in length of stay. Case managers, nurses, physical therapists, and physicians worked together to improve communications among team members. Specifically, they implemented patient rounding twice a day, thereby doubling opportunities for dialogue among provider team members about a patient’s discharge. Additionally, at the point of admission, the organization posted the estimated length of stay for the patient based on the patient’s admitting diagnosis and the geometric length of stay for the particular DRG. These counter measures led to time savings and eventually shorter hospital stays for patients. This focused approach to process improvement has created new opportunities for University Health System employees to make the right work easier to do, with improved quality and reduced cost.

**Care improvements for patients receiving oxygen and other ventilatory support.** A new nursing protocol related to oxygen use was developed, resulting in more than $24,000 in savings and improved quality of care. In looking at ventilator-associated pneumonia, University Health System is evaluating opportunities for improvement ranging from physician documentation to new endotracheal tubes. A unit-based dashboard is being designed to develop real-time alerts and logic tracking to improve quality of care and patient outcomes related to this condition.

**Dialysis.** The health system is also in the process of developing a continuum-of-care model related to hemodialysis. The goal of the model is to evaluate charge capture, improve care transitions, and encourage other adjustments to physician practices to achieve greater efficiencies.

**Medication management.** University Health System also engaged in a Lean initiative targeting medication management. Teams of pharmacy personnel and nurses examined workflow between the two groups to identify problems and potential solutions. This provided an opportunity for nurses to visit the pharmacy—many for the first time—and meet the pharmacists, gaining an understanding of their workload and staffing patterns. Likewise, pharmacy staff had a chance to visit nursing units and observe nurses’ work patterns. Nurses identified opportunities to change pharmacy processes to improve efficiency. As a result, pharmacy personnel get medications to the nurses faster, reducing wait time and trips to the pharmacy. Ultimately, the improved process frees more of nurses’ time for direct patient care.

**Striding Forward**

During the first year of the initiative, University Health System made great strides in improving clinical and financial performance. Average LOS decreased by 0.4 days, which is significant in the academic medical center environment, with its higher case and service mix. Overall supply expenses tracked per adjusted discharge declined by 3.5 percent over previous year levels. These financial and operational improvements have enabled University Health System to continue a

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**Labor.** Labor costs are the highest expense category for most healthcare organizations. Staffing appropriately amid fluctuating patient volume and acuity has traditionally been a financial and liability pain point. University Health System’s workforce optimization initiatives focused on agency rate reduction, productivity benchmarking, and staffing ratio optimization. A centralized staffing office was created to standardize online requisition and fulfillment of all agency staff. By enhancing organizational visibility of labor spend, University Health System was better positioned to validate compliance with contract terms and rates and simplify staffing processes. The result was more than $2.4 million in workforce savings and labor reduction costs.

**Re-engineering Clinical Processes Through Lean**

In the first 11 months of the initiative, 16 rapid improvement programs were launched. The programs involved more than 100 employees and targeted both clinical and operational areas.

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**Construction projects.** This initiative focused on using national benchmarking and contracting support services, as well as cloud-based technology, to gain enhanced visibility and financial control over construction projects. To date, capital expenditure savings on major construction projects, as well as replacement capital, have totaled more than $3.7 million. University Health System enhanced organizational visibility of capital expenditure savings on major construction projects, as well as replacement capital, and found additional savings in capital purchases, on top of lowered costs for equipment and build-
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growth strategy designed to better serve patients in South Texas. Its medical home service model has been expanded, a new six-story campus clinical pavilion was recently opened, and construction is underway on a million-square-foot addition to the main hospital. To sustain that improvement, the system plans to continue driving adoption of best practices that produce more predictable cost and quality outcomes, thereby reducing its cost structure and improving patient care.

Peggy Deming is executive vice president and CFO, University Health System, San Antonio, Texas, and a member of HFMA’s South Texas Chapter ( peggy.deming@uhs-sa.com ).

Charles Hagood is senior vice president, Advisory Solutions, MedAssets, Nashville, Tenn., and a member of HFMA’s Tennessee Chapter ( charles.hagood@medassets.com ).

Dan Piro is president, Advisory Solutions, MedAssets, Centennial, Colo., and a member of HFMA’s Colorado Chapter ( dpiro@medassets.com ).

Supply Chain Management

By Lori Webb, Tom Watson, and Katie Regan

Discount Strategies You Should Be Pursuing—But Are You?

Navigating capital purchases requires knowledge of vendor tactics and business savvy. Obtaining the best discount is not just about negotiating with sales representatives or using clever strategies, however. Often, optimizing results involves preparation before the actual discussion takes place.

<table>
<thead>
<tr>
<th>General Negotiating Principles</th>
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<tbody>
<tr>
<td><strong>Align key players.</strong>&lt;br&gt;Strive for team solidarity, which is essential to maximize price negotiations.&lt;br&gt;Seek strategic alignment among department directors, purchasing managers, chief administrators, and key physicians.&lt;br&gt;Avoid a situation that allows a vendor to cultivate a relationship outside of the team that could undermine negotiating goals.</td>
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<tr>
<td><strong>Keep your cards close to the vest.</strong>&lt;br&gt;Don’t divulge too much information or key details about your organization’s circumstances to the sales representative.</td>
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<td><strong>Collaborate, within limits.</strong>&lt;br&gt;Seek to work with vendors who recognize the importance of transparency and collaboration in the healthcare industry.&lt;br&gt;Engage in competitive quoting to attain higher discounts.</td>
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<td><strong>Know what you want.</strong>&lt;br&gt;Ensure that internal stakeholders are clearly aligned in the difference between the clinical “must haves” and “nice-to-haves.”&lt;br&gt;Adhere to the RFI/RFP (request for information/proposal) process to prevent over-buying or under-buying based on a great sales presentation or getting too focused on the lowest price.&lt;br&gt;Use the RFI/RFP process to ensure that the vendor provides the level of detail needed to clearly understand the product offerings and to identify opportunities for discussion, consideration, and further negotiation.</td>
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<td><strong>Know your sales rep.</strong>&lt;br&gt;Be aware that unlike a rookie, an experienced sales rep can recognize when a sale is on the line and may be able to expedite management approval for higher discount percentages.</td>
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<thead>
<tr>
<th>Specific Discount and Negotiation Strategies</th>
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<tr>
<td><strong>Do not be taken in by promotions.</strong>&lt;br&gt;Know the vendor’s history of pricing and promotional offers.&lt;br&gt;Realize that promotional offers with supposedly strict deadlines are often “renewed” multiple times.&lt;br&gt;Understand that promotions often include better incentives than those offered through group purchasing organization contracts.</td>
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By Lori Webb, Tom Watson, and Katie Regan
| **Take advantage of end-of-year deals.** | ✓ Realize that vendors are usually more willing to deal on price, options, and other special considerations at the end of the quarter or fiscal year end.  
✓ Potential additional discount: 3 to 5 percent |
| **Consider switching vendors.** | ✓ Consider replacing an existing vendor—this provides leverage as the new vendor will often be aggressive in pricing to win a “take-away” from an incumbent vendor.  
✓ Understand that, conversely, vendors who fear being replaced will be more determined to retain existing customers. |
| **Consider combining purchases.** | ✓ Plan equipment purchases strategically by internally aligning multi-system or multi-departmental purchases together when possible.  
✓ Coordinate your capital budget to identify and leverage opportunities.  
✓ Do not accept vendor claims that discounting on equipment sold under another business line is not permitted.  
✓ Potential additional discount: 3 to 5 percent |
| **Be strategic about consumables.** | ✓ Learn about options for technologies that use consumables, such as pulse oximetry and cardiac output monitors. Some models require consumables that are proprietary, while others can use a third-party consumable at a lower cost.  
✓ Know that a consumable commitment may allow you to shift some or all of your capital expense to an operational expense.  
It is essential to evaluate your consumable cost before capital expense is included.  
✓ Use a reliable source to benchmark your costs with comparable organizations that have similar volumes.  
✓ Be wary of volume commitments that may not be achievable or sustainable. Savings can quickly dissipate if consumables go unused. |
| **Evaluate soft-dollar considerations.** | ✓ Bring soft dollars (e.g., the cost of peripherals such as training and product warranties) into vendor negotiations to yield additional savings for benefits that you would have to pay for but typically cost the vendor little or nothing.  
✓ Use this tactic to gain leverage during final steps of a negotiation. |
| **Negotiate point-of-sale service contracts.** | ✓ Negotiate the service support contract at the point of sale when you have the most leverage.  
✓ Seek a multiple-year service contract as these are typically priced lower.  
✓ Plan to pay multiple-year contracts on a yearly basis.  
✓ Seek the option to change contract coverage levels depending on the performance of your system or renegotiate price depending on quality of service.  
✓ Potential savings: 1 to 3 percent. |
| **Negotiate your discount before trade-in credits.** | ✓ Realize that discounts may be artificially inflated when the trade-in allowance is included in the net selling price.  
✓ Be sure your sales representative discloses the net selling price apart from any trade-in amounts.  
✓ Know the fair market value of equipment being traded in. |
| **Use industry reviews as leverage.** | ✓ Familiarize yourself with industry reviews from research companies to gain leverage and let the vendor know you have done your homework. |
| **Skip the onsite demo.** | ✓ If users have experience with a particular system or platform, some vendors will offer a “no-demo” discount.  
✓ “No-demo” discounts percentages will vary based on technology. |

Lori Webb is a clinical analyst (lori.webb@mdbuyline.com), Tom Watson is a senior clinical analyst (tom.watson@mdbuyline.com), and Katie Regan is a clinical publishing analyst (katie.regan@mdbuyline.com) at MD Buyline, Dallas.
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