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About FYA

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With every issue, FYA provides insights into the topics that concern healthcare leaders today and the challenges that will be faced in the near future.

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"FTE Creep"

By Dorothy (Dolly) Bellhouse

Let's look at a case study. Facing significant budget shortfalls, the management team at Neptune Valley Hospital (NVH) worked hard to keep operating while it eliminated positions and froze open positions. Before any recruiting occurred, the CEO or COO had to review and sign off.

Unfortunately those tactics were short-lived and they eventually hired an outside consulting firm specializing in productivity. The consultants gave the hospital the data on which departments were running "fat" compared to national benchmarks and then, they faced the reality of where they would have to cut. They crafted an early retirement package and targeted reductions in force. They tried to "protect" the direct patient care areas by lessening the cuts (on a percentage basis) there and increasing the cuts in non-clinical areas. No one was left out. Senior managers lost their administrative assistants and some of their directors. It was tough, but they knew what they had to do and as the saying goes, the "tough got going."

The problem was that cuts are hard to sustain. Although the clinical areas had been "protected," they now had less help from non-clinical support departments and consequently had to pick up the slack. Even though NVH management said that it would do without certain things because the support wouldn't be there to provide typical reports or turn around special projects, etc., that never came to fruition. There were less people to do the work, but the work didn't change. For NVH management, that meant even longer days. They all had worked upwards of 70-80 hours a week when the situation demanded it, but doing that month after month took its toll. NVH directors and mid-level managers would see their leaders scurrying from meeting to meeting heads down (hoping they wouldn't see someone in the hall that would give them another problem to fix or ask about a yet uncompleted project) and grabbing sandwiches to take to the next meeting. No one ever saw NVH senior management in the cafeteria sitting down talking with employees – there just wasn't time.

The good news is that the outlook was better at the next NVH budget cycle. And then it started. Some departments requested more FTEs because their revenue was up. Others made a case that they had been understaffed before the cuts and with positions frozen, they weren't delivering the service management expected. Others wanted to expand services, so, of course, they needed more people.

Not every FTE request was granted, yet many were. NVH management could justify that the departments that were making their numbers could

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"FTE Creep" (Continued...)

add an FTE or two, Adding staff in service areas that were favorably reimbursed made sense. However, those departments that were struggling to meet their budgets, running overtime, etc., were denied their requested positions. They were in stage one FTE creep, but didn't know it.

Many of us have seen this cycle. Sure enough, less than three years later, NVH management was facing the same challenges all over again. The hospital was running over budget and FTEs had steadily crept up over the prior two years. NVH management did not want to freeze positions and cut again, but it felt it had no other options.

NVH may have been right at that point, but what could they have done differently? Or better yet, how should they proceed now?

FTE reductions are rarely sustainable. Why is that? Although NVH management made reductions according to productivity and benchmark data, the work never changed. Even some senior executives added director positions back in as soon as the budget looked more favorable because work was backlogged.

Productivity and benchmark data are just places to start. How do you really know an area has the staff it needs? Toyota and other innovative companies would suggest that the only way to really know is to get a deep understanding of the work. And the way to get a deep understanding of the work is to observe it. There is no substitute for direct observation. When staff and executives learn about the work through observation, they begin to see redundancies, unnecessary steps and possibilities for improvements. The staffs know the work best and, if given the support, will experiment with lots of innovative approaches to improve their work. Wouldn't it be great if those NVH areas making their numbers could handle even more volume without adding staff? Wouldn't it be good to know that those areas that weren't making their numbers really did need more staff to eliminate overtime and agency

costs? I'm certain that NVH senior management would rather be facing the challenge of how to re-tool some of its good employees to provide services to other areas so that no one lost his or her job.

One closing word of caution here – truly understanding the work at your organization and building the capability of your people to innovate and experiment is an investment. It occurs by addressing one, often small, problem at a time. The results are cumulative, not a quick fix. NVH can build resiliency to face future challenges and continue to grow by investing in its most valuable resource – its people. The key is to just start.

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About



FYA - For Your Advantage is brought to you by TrendLeader Connections. The function of TrendLeader Connections is producing educational materials and seminars that help healthcare executives differentiate between fads and trends; and making connections with "Trend Leaders" within the healthcare industry.

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More Red Ink for Hospitals?

By Rick Kneipper, Chief Administrative Officer and Co-Founder of PHNS

We're all aware of the increasingly relentless financial pressures on hospitals in the U.S., yet most hospital execs have found ways to continue to operate despite the pressures. But according to a study summarized in an April 30 article, this year, in *The Wall Street Journal*, it's going to get way worse:

"More than half of U.S. hospitals aren't seeing enough patients to provide sufficient revenue to fund operations and are 'teetering on the brink of insolvency' or already are insolvent..."

The study's findings confirm what lots of hospital execs believe – it's going to get a lot worse financially for hospitals before it gets better:

- 2,044 hospitals do not earn a profit on patient care;
- An additional 744 hospitals earn less than they need to fund day-to-day operations and to make the most basic capital expenditures such as facility repairs; and
- Hospitals' capital expenditures are underfunded by about \$10-\$20 billion because they are using those dollars to fund operations.

The study was done by restructuring firm Alvarez & Marsal, which studied 3,861 of the approximately 4,900 short-term, acute-care hospitals in the U.S.

"We're seeing hospital insolvencies and hospital bankruptcies – it's a heyday right now...we're going to see more bankruptcies this year than last year." according to George Pillari, a managing director of Alvarez & Marsal who was quoted in the article.

The article refers to what the rating agencies have called the "haves" and the "have nots" among hospitals – the "haves" are a "top tier" of about 500 to 1,000

hospitals that are consistently profitable, have excellent credit ratings and claim a substantial share of the market, and the "have nots" are "everybody else." And as the "have nots" continue to face increasing financial problems, that puts a bigger squeeze on all hospitals. For example, the article quotes Pillari as stating that "lenders that last year were willing to finance a hospital at an amount that was five to six times its cash flow are now making loans only in amounts that are double or triple cash flow."

The article states that the major reasons for hospitals' financial problems include the following:

- too many hospitals with too many beds and too few patients, and as occupancy levels decline, the cost of care continues to rise;
- the decline in rates of reimbursement from Medicare and Medicaid; and
- rocketing numbers of uninsured patients.

In the meanwhile, the financial plight of U.S. hospitals is about to get worse – e.g., President Bush's FY09 budget proposes a \$182 billion cut in Medicare over the next five years and a \$17.4 billion cut in Medicaid.

It's sad to say, but maybe more insolvencies, bankruptcies and closings of hospitals will finally convince our elected representatives "inside the Beltway" to get serious for once and for all about making the major structural changes that are necessary in order to ensure the continuing financial viability of our U.S. hospital system. What do you think?

I would like to hear your comments.
Send them to:
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Nothing Beats Nothing

The 32 students entering a new medical school later this year, run by the Cleveland Clinic, will be offered a tuition-free education. The Cleveland Clinic will use funds from its endowment and hospital operations to pay the \$43,500 individual tuition bill.

The new school is the Cleveland Clinic Lerner College of Medicine of Case Western Reserve University.

The executive dean of the college, Dr. Andrew Fishleder, said the intention is to free students from the feeling that they have to choose high-paying specialties to pay off the average medical school debt of \$160,000. With tuition relief, it is hoped that students will choose academic and research oriented medicine, toward which the Clinic program is geared.

Interest in academic medicine has been relatively flat for about a decade, hovering around 15 percent according to a yearly survey of incoming students. That number fell to 9.4 percent in 2007 according to Gwen Garrison, director of student and applicant studies at the Association of American Medical Colleges. In clinical practice, family-doctors in 2006-07 earned an average \$161,000 a year; radiologists earned \$380,000, according to the healthcare search firm Merritt, Hawkins & Associates. In the academic world, median base compensation for family practice is \$140,038, orthopedic surgery \$205,904 and radiology \$272,737, according to the Medical Group Management Association.

The Clinic's college is a five-year program – a year longer than most schools – to complete a medical degree and a master's-level thesis. The Clinic will provide students a \$23,000-stipend during the fifth year when the students are typically involved in research projects and aren't required to pay tuition.

The college will award all incoming students full scholarships to cover their estimated \$43,500 tuition. Students will still have to pay for living expenses, fees, equipment and books – estimated at \$21,800.

While this is the first medical school in the U. S. to forgo tuition for all students, other schools are working to ease the financial burden. Some have reduced tuition costs substantially for those students who want to practice in fields that are lower-paying, but greatly needed, such as geriatrics and family medicine.

The Mayo Medical School has had a generous scholarship program for the past 20 years that enabled about 60 percent of the students to attend tuition free. The 50 students starting Mayo this summer will each get \$25,000 to use towards tuition of \$29,200. Students also get \$2,000 to \$5,000 a year more based on need, said David Dahlen, director of student financial aide at Mayo, based in Rochester, MN.

The University of Central Florida in Orlando will open its college of medicine next year. It announced that its entry class of 40 students will pay no tuition – and have their living expenses paid for during the four-year program.

Yale University is increasing financial aid and Harvard University recently announced plans to eliminate the \$12,500 family contribution expected for medical students in those families with incomes of under \$120,000.

Even with the high costs of a medical education, new schools are opening and established schools are expanding their class sizes to help offset an anticipated future shortage of doctors.

About



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