

# Controlling Costs in Census-Driven Staffing



*Integrated labor management tools put time and money back on the hospital's side.*

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by Kerry Kerlin

Rush North Shore Medical Center, a 265-bed hospital in Skokie, Ill., is unique in that we experience unusually high weekly census fluctuations of up to 50 percent. Such wide swings in patient needs can make it very challenging to staff appropriately while controlling labor costs. In the past, when the census surged, managers would scramble to meet staffing needs, relying primarily on their manually maintained lists of on-call and otherwise available staff. These lists, however, did not keep track of vital information, such as which staff members had already accrued maximum overtime for the period or which staffers had not yet worked their scheduled hours for the period.

The organization asked managers to both maintain appropriate staffing levels and control labor costs, yet managers did not have the necessary tools to meet this critical goal. In response to these challenges, we replaced our manual timekeeping and scheduling processes with integrated systems. By giving departmental managers and executive leaders the tools to monitor trends and respond in real time to staffing needs, we are better able respond to sharp, frequent census changes, maintain optimal staffing levels for patients and contain labor costs.

## Tools Empower Managers

Like most hospitals, labor costs are Rush North Shore Medical Center's single largest expense. As a result, our leaders want to deploy staff members as efficiently as possible while improving the quality of patient care. To that end, the hospital has stressed individual accountability by pursuing initiatives like Six Sigma and Continuous Improvement techniques, all of which emphasize the concrete definition of challenges and goal setting as well as clearly designated accountability.

Yet because the hospital's timekeeping and scheduling processes were manual, clinical managers weren't fully aware of the consequences of their actions in these areas. Procedures varied from department to department, and because there was no central monitoring of payroll and staffing procedures, informal policies and processes took hold across the hospital. With the lack of consistency across hospital operations, it was difficult for hospital leaders to get a clear picture of how efficiently each department was handling its timekeeping and scheduling. The processing of early clock-ins, for example, tended to vary across departments. This meant that the organization ran the risk of unexpectedly seeing its labor costs balloon because staff would be paid for clocking in, say, 15 minutes early. When such practices became widespread, over time, the costs could be substantial.

When Rush North Shore Medical Center first considered automating some of its labor resource management processes, the initial goal was simply to automate timekeeping. We wanted to standardize the hospital's payroll policies and apply them uniformly across the organization. Automated timekeeping would also play an important role in developing accountability for labor costs. But when we considered the full range of labor-related challenges facing the hospital, we concluded that without addressing scheduling, the hospital would most likely continue to struggle with labor costs. Given the wide weekly swings in patient census, we determined that if scheduling processes remained separate from timekeeping, it would be difficult to deliver adequate staffing levels while optimizing our labor resources.

## Applications Reach Every Staff Member

We selected an integrated time and attendance and staffing and scheduling application. We anticipated integration would make payroll and scheduling information available in real time and improve our capacity to manage staffing needs and expenses. We also expected to benefit from deploying these financial systems prior to implementing an electronic medical record or other clinical system. Because timekeeping and scheduling systems touch everyone in the organization, we viewed the deployment as a good way to introduce staff to automated applications while helping them to learn how to participate in and benefit from such changes.

With the new system, employees now clock in using a wall-mounted touch-screen unit that they can also use to access such information as their hours worked, benefits information and personal time-off balances. They can also use the system to self-schedule and swap shifts. Managers can access the new system over an intranet inside the hospital or from outside the facility over a secure Internet connection, and scheduling is now an automated process, rather than one that's performed manually using pencil and paper. Managers now have ready access each employee's hours worked, overtime accrued, credentials, contact information, seniority and languages spoken. This kind of information ensures optimal staffing for each shift. In the payroll department, processing is now automated, replacing the manual data entry that was once required; payroll functions are now performed in a fraction of the time and with much greater accuracy.

The vast majority of staff adopted the new procedures readily and quickly appreciated the improvements they offered, including improved availability of information to employees, reduced paperwork for managers, and enhanced administrative efficiency for managers and payroll staff. At first, a small number of employees were unhappy with the new, more formalized procedures for clocking in. Previously, those procedures varied widely by department, but we were able to placate them by demonstrating the widespread variances in timekeeping and scheduling practices and how these inefficiencies affected patient care and revenues.

We implemented the timekeeping application, then the scheduling tool, both in phased deployments. Prior to deploying the timekeeping system, we identified all regularly occurring payroll rules, such as premiums for certain kinds of duty, overtime pay, differentials based on department and on-call pay. We then formalized corresponding rules in the new system. Then, in the first six months of use, we identified the remaining payroll scenarios and addressed them. Deploying the scheduling application was a more complex process due to the wide variances in scheduling formats from department to department, all of which had to be reconciled. In total, our phased implementation process for both applications took about a year.

### **Agency, Overtime Expenses Reduced**

The timekeeping and scheduling systems have generated substantial results. Clinical managers have embraced the applications by responding more quickly and cost-efficiently to our census fluctuations. The systems have enabled us to reduce our use of agency nurses substantially, because the applications guide managers to identify available nurses to fill unexpected needs. When managers need to fill shifts, the system provides a filtered list of every staff member available for that shift, based on necessary qualifications, credentials and hours worked so far in the period. Thanks in part to the information provided in these filtered lists, we have seen a 1 to 2 percent decrease in overtime hours, which makes an important contribution to our fiscal health.

For budgeting and monitoring their performance against their annual budgets, the integrated tools help managers accommodate payroll increases and policy changes. To track trends over time, managers can run reports that indicate areas trending well and areas in need of attention. Hospital leaders, meanwhile, incorporate data from these systems into a Six Sigma dashboard that gives a high-level overview of performance. For example, when reporting indicated a consistent rise in overtime over four pay periods, we used these applications to drill down to specific problem areas. When some managers were not considering hours worked when filling shifts to account for surges in census, we could make the necessary corrections and reduce our overtime to less than the original levels.

The hospital's time and attendance and scheduling systems have had the added value of generating the kind of data that inspires trust from staff. When we relied on manual scheduling, it was very challenging to ask a clinical manager to alter staffing procedures, because it was easy for him or her to argue that the specific circumstances in that department justified variances. Now that we can show managers the complete staffing picture in a compact, understandable format, we can convince them to make changes. Like so many areas in health care, accurate, real-time data tell the most compelling stories.



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