

Benchmarking FTEs Is Not Enough

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www.garrickhyde.com

Abstract

Healthcare analysts must be very careful when benchmarking hospital FTEs because of a peer's potential to outsource some or many labor functions. In hospital departmental benchmarking, measuring total departmental expenses is much more accurate and meaningful than measuring FTE productivity.

Hospital department managers have long looked at their employee headcount as the primary indicator of both departmental cost and efficiency. Benchmarking fulltime-equivalent employees (FTEs) is popular because the measure is relatively simple to track and comparative benchmarks abound. In fact, two of the most widespread metrics in the hospital industry are *hospital FTEs per adjusted occupied bed* and *hospital FTEs per adjusted patient day*. Examining FTE productivity is undoubtedly an important indicator of department efficiency. However, benchmarking FTEs without simultaneously examining departmental costs can result in a grossly inaccurate representation of a department's efficiency.

In any type of benchmarking, one must be very careful when comparing FTEs because of a peer (i.e., benchmark) hospital's potential to outsource some or many labor functions. FTE data usually include only hospital employees—while excluding the time and expense of additional labor performed under agreements for outsourced purchased services or professional fees.

Here's a hypothetical example of this principle of comparing FTEs inaccurately: Lynne is the laboratory director at Happy Valley Hospital. She keeps detailed records on the hours worked by her staff of technicians and clerks. She also maintains detailed statistics on the number of tests her staff performs. She is interested in benchmarking the productivity of her department to lab departments in other hospitals, so she contacts her friend Yeng, who runs the lab at Pleasant Hill Hospital in a neighboring community. The two directors agree to share data on their staff's number of FTE hours worked per lab test. The benchmarking exercise disappoints Lynne because she discovers that her staff has more worked hours per lab test than Yeng's staff, meaning Lynne's staff does fewer tests per hour and is therefore less efficient. What Lynne and Yeng do not know about each other's data is that Lynne's staff performs all the tests in their lab, while Yeng outsources 30 percent of his lab tests to an outside agency. Yeng's statistics reflect *all* the tests going through the lab (even the outsourced ones), even though his staff only performed 70 percent of these tests. No wonder his staff's FTE hours worked per lab test are lower than Lynne's!

In departmental benchmarking, measuring total departmental expenses is much more accurate than measuring FTE productivity. Measuring total expenses is more accurate because the cost of employee labor and outsourced labor are all included together. If Lynne and Yeng had benchmarked their total costs instead of worked hours, they would have compared Lynne's labor expenses to Yeng's labor *and* purchased service expenses—plus whatever expenses both laboratories incur for supplies, employee benefits, equipment depreciation, etc. Using this total expense metric, Lynne may show a *lower* total expense per test than Yeng (assuming Yeng's cost of outsourcing lab work is greater than doing it in-house).

Trends in hospital expenses show that outsourcing labor through purchased services and professional fees is on the rise. **Table 1** shows a snapshot of expenses for all California hospitals, broken out by expense

type. In the five-year period from 1994 to 1999, the combined expenses of purchased services and professional fees rose 3.4 percent (as a percentage of total expenses), while the combined expenses of salaries and benefits conversely fell 3.1 percent.

Table 1

<i>Expense Type</i>	<i>1994 Percent of Total</i>	<i>1999 Percent of Total</i>
Productive Salaries	39.9 %	38.1 %
Benefits & Nonproductive Salaries	13.7	12.4
Supplies	15.5	16.5
Purchased Services	10.5	13.4
Nonphysician Professional Fees	2.8	3.3
Depreciation	5.2	5.3
Leases/Rentals	1.9	1.7
Physician Professional Fees	1.9	1.9
Other Expenses	8.6	7.5
	100.0 %	100.0 %

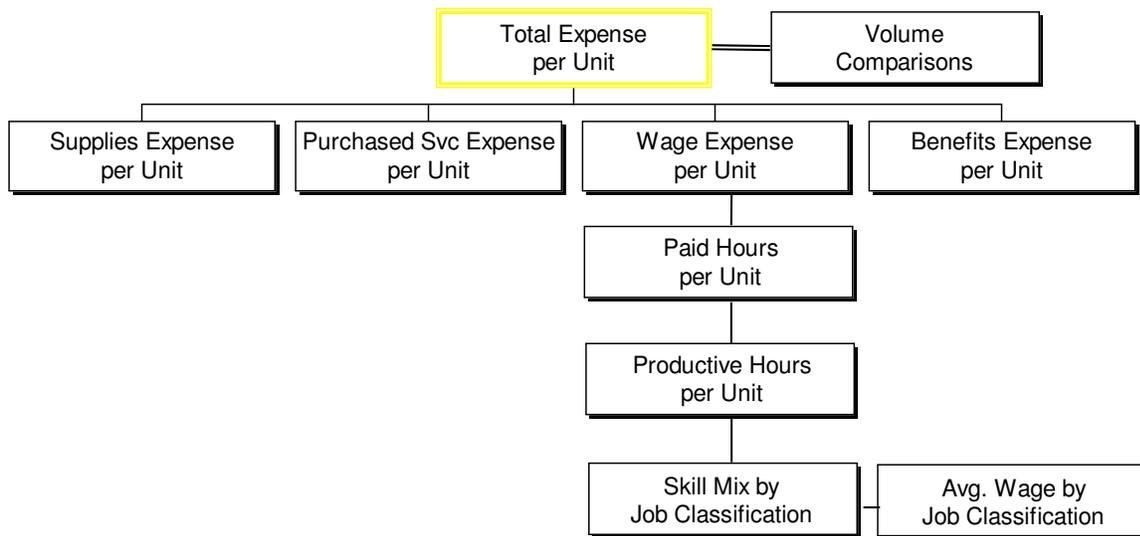
Source: California OSHPD Financial Data, Fiscal Years 1994 and 1999.

In **Table 1**, purchased services include purchased medical services (such as laboratory or CT Scan services), dietary and laundry services, repair and maintenance services, medical school contracts, management services, collection agencies, and other purchased services. Nonphysician professional fees include professional fees paid to nonphysician medical personnel, registry nurses, consultants, legal firms, audit firms, other contracted personnel, and other professional fees. Fees paid to physicians or residents are excluded from this category. The category for physician professional fees includes physician expenses supported by the hospital for activities that do not involve direct patient care, such as research, medical education, supervision, and administration. Fees paid to physicians or residents for direct patient care are excluded from departmental expenses in **Table 1**.

Examining a random hospital department offers further proof of the significance of outsourced labor on departmental expenses. In a sample of 247 California urban, acute-care, nonspecialty hospitals, expense data for the housekeeping department show that 66 of the 247 hospitals have purchased-service and professional-fee expenses that are greater than 20 percent of the department's total expenses. These 66 hospitals use a significant amount of outsourced labor, even though they still have their own housekeeping FTEs as well. Benchmarking FTEs instead of total expenses in the housekeeping department of these hospitals would prove erroneous—if not disastrous.

The approach of benchmarking a department's total expenses *first* will eliminate the accounting differences of using hospital employees versus outsourced labor. If a department shows an unfavorable variance to benchmarks at the total-expense level, then the next step is to determine which specific expense types are driving the total expense variance. Analysis of productive wages, benefits, supplies,

purchased services, and professional fees will pinpoint the specific problem areas. The chart below shows the hierarchical relationship between analyses, from top (do this analysis first) to bottom (do this last).



Examining paid and productive hours is appropriate if variances are discovered from the total expense and wage expense analyses. Delving further into skill-mix and wage-rate analyses will provide an important understanding of whether high wage expenses are attributable to too many hours, a “rich” skill-mix, or high wage rates. Benchmarking FTE productivity is a good endeavor—it’s just not enough.

Biographical Sketch

Garrick Hyde has worked as a management consultant to the healthcare industry for the past 17 years. He founded Garrick Hyde Consulting in 1995, specializing in benchmarking services for hospitals. Through hospital departmental benchmarking, Garrick has identified cumulative cost savings of \$2.18 billion for all client hospitals.

Prior to founding GHC, Garrick worked in the Performance Improvement consulting practices at both Ernst & Young and APM Management Consultants (now CSC Healthcare). He also led the Data Analytics practice at Performance Logic and designed educational software for IBM.

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