Trends in the Use of Contract Labor among Hospitals

A study by:

Paul Shoemaker
President and CEO
American Hospital Directory, Inc.
www.ahd.com

Douglas H. Howell
Senior Vice President, Organization and Performance
Norton Healthcare, Inc.
www.nortonhealthcare.com

July 21, 2005

ahd.com
AMERICAN HOSPITAL DIRECTORY

Trends in the Use of Contract Labor among Hospitals

Summary

Personnel expense typically consumes more than half of a hospital's operating revenue. This expense includes the use of contract labor to supplement scarce resources such as nurses. Over a recent seven-year period the use of such contract labor in short term acute care hospitals has increased from 1.4% of personnel expense in 1997 to 3.8% in 2003. This trend may indicate that hospitals are substituting more expensive contract labor for salaried staff. Most recent data indicate, however, that the rate of increase may have subsided.

Since contract labor is more expensive, reversing the trend may be a significant opportunity to reduce personnel expense. Nationwide, short term acute care hospitals in the United States currently spend more than $7.8 billion per year on contract labor. Since rates paid for contract labor are often twice what staff employees are paid, the opportunity for improvement in staffing costs may approximate $3.9 billion.

This study was first published on August 20, 2004 and covered time periods through 2002. The study is now being updated to cover periods through 2003 and to provide preliminary data for 2004. The update also refines the definition of contract labor to exclude home office costs, physician services, and other labor costs not typically considered as contract labor. Please see attachment A for details. It examines Medicare cost report data and provides comparative information that can be used to identify opportunities to reduce staffing costs. It also provides a case study of how an integrated healthcare system achieved remarkable reductions in personnel expense by more closely managing the use the contract labor.

Background

Health care delivery is a labor-intensive process involving a wide range of clinical skills. In short-term general and specialty hospitals personnel expense typically represents about half of operating revenue. Recruiting and retaining the right mix of qualified personnel has always been a challenge and has become even more difficult in recent years. The available workforce is diminishing as experienced workers age and as fewer young people enter health careers.

In the face of this skilled labor shortage, solutions are rare and complex. Financial incentives for workers are not always possible because of economic pressures on hospitals. In an aging workforce with competitive dynamics, more workers want flexibility in the hours and times that they work. Quality health care delivery requires adequate levels of qualified staffing that generally cannot be safely reduced, substituted with less skilled personnel, or replaced by technology.

During recent years hospitals have been challenged to reduce expenses in response to declining revenues. Restrictions in reimbursement from Medicare and Medicaid have been relentless and the proliferation of managed care and contractual discounts has dramatically reduced payments in most major markets. Because of these pressures, most hospitals have trimmed operations and staffing to the point where any personnel vacancies are problematic. The situation is sometimes critical. As a result, many hospital executives today feel that shortages of qualified personnel are among their chief concerns.

Using contracted staffing is an obvious solution to temporary shortages in the workforce. When the use of contracted staffing becomes widespread and continuous, however, the increased costs can be significant.

This study focuses on trends in personnel expense and the use of contract labor. It also provides comparative information for hospitals that may wish to examine their own operations. Lastly, a brief case study is presented of one hospital system that achieved remarkable savings through an innovative approach for resolving its high costs of contract labor.

The Data

This study is based on Medicare cost report data for hospital fiscal years ending in 1997 through 2004. Data for years prior to 1997 are not readily available from federal sources. Data for 2004 are preliminary since they are not yet available for most hospitals.

Hospitals that participate in Medicare are required to submit annual financial reports that detail their operations. These reports are subsequently made available in electronic form by the Centers for Medicare and Medicaid Services (CMS). The Healthcare Cost Report Information System (HCRIS) dataset contains data elements from the most recent version (i.e. as submitted, settled, or reopened) of each cost report filed since federal fiscal year 1996.

Though hospitals that participate in Medicare are legally required to submit accurate and timely cost reports, data are sometimes incorrect or incomplete. 1,114 cost reports were excluded from the study because of missing revenue data and an additional 15 were excluded due to missing salary data. Medicare cost report data for hospitals in Puerto Rico, Guam, and the Virgin Islands were excluded due to differences in wage rates and other operational factors.

Trends in Personnel Expense and Contract Labor Usage

For purposes of this study, total personnel expense is defined as the sum of salary expense, benefits, and contract labor. Though some hospitals appear to combine the cost of benefits in the salary expense reported, the practice does not interfere with the calculation of total personnel expense as defined.

Personnel expense excludes home office costs, physician services, and other labor costs that are neither salary expense nor typically considered as contract labor. Please see Attachment A for details.

As shown in Table 1, the use of contract labor is most prevalent in short term acute care hospitals. The rate of use does not seem to be increasing for any other types except long term hospitals for which contract labor represented less than 1% of overall personnel expense during 1997-2000 but has been 1.1%, 1.7%, 2.1%, and 4.3% during 2001 through 2004 (preliminary), respectively. (Please see Attachment B for details).

Table 1 –Personnel Expense and Contract Labor By Type of Facility During 2003 ($millions)

Type of Facility	Number Facilities	Salary Expense	Contract Labor	Fringe Benefits	Operating Revenue[1]	Personnel Expense[2]	Contract Labor[3]
Childrens	51	$4,668	$11	$433	$10,208	50.1%	0.2%
Critical Access	770	$2,881	$10	$519	$6,408	53.2%	0.3%
Long Term	295	$2,310	$57	$371	$5,323	51.4%	2.1%
Other	16	$17	$0	$1	$17	108.4%	0.0%
Psychiatric	345	$3,854	$4	$447	$5,086	84.7%	0.1%
Rehabilitation	218	$1,714	$26	$290	$3,872	52.4%	1.3%
Short Term	4,059	$172,646	$7,777	$26,964	$426,523	48.6%	3.8%
TOTALS	5,754	$188,090	$7,885	$29,024	$457,436	49.2%	3.5%

Notes: [1]Total operating revenue is the net patient revenue after contractual allowances and discounts.
[2]Personnel expense as a percent of operating revenue
[3]Contract labor as a percent of personnel expense

This study focuses on short term acute care hospitals. Total personnel expense for such hospitals has averaged about 48.8% of total operating revenue during the period 1997 – 2003. During this same period, however, contract labor expense as a percentage of total personnel expense increased 167.2%.

Table 2 – Trends in Personnel Expense and Contract Labor (short term hospitals)

Hospital Fiscal Years	Number of Hospitals	Personnel Expense as percentage of Total Operating Revenue	Contract Labor as percentage of Total Personnel Expense
1997	5,034	48.8%	1.4%
1998	4,992	49.0%	1.7%
1999	4,959	49.3%	1.9%
2000	4,754	48.4%	2.3%
2001	4,565	48.7%	3.0%
2002	4,243	48.9%	3.7%
2003	4,059	48.6%	3.8%

There are several factors that might influence levels of personnel expense. These include ownership, size, and intensity of services. In order to test the influence of these factors on short term acute care hospitals, several analyses were conducted.

Effects of Ownership / Type of Control

Staffing and management practices may differ among hospitals according to ownership or type of control. For example, a hospital that is operated for profit may be more aggressive in managing staffing levels. Table 3 examines the effects of ownership:

Table 3 –Personnel Expense and Contract Labor By Type of Control During 2003 ($millions)

Type of Control (Short Term Hospitals)	Number Facilities	Salary Expense	Contract Labor	Fringe Benefits	Operating Revenue[1]	Personnel Expense[2]	Contract Labor[3]
Governmental	805	$28,938	$1,166	$4,132	$62,423	54.8%	3.4%
Proprietary (For Profit)	875	$18,523	$1,472	$2,298	$57,397	38.8%	6.6%
Voluntary (Not For Profit)	2,379	$125,185	$5,139	$20,534	$306,703	49.2%	3.4%
TOTALS	4,059	$172,646	$7,777	$26,964	$426,523	48.6%	3.8%

Notes: [1]Total operating revenue is the net patient revenue after contractual allowances and discounts.
[2]Personnel expense as a percent of operating revenue
[3]Contract labor as a percent of personnel expense

Even though proprietary hospitals seem to have the highest use of contract labor, their overall personnel expense is considerably less than voluntary or government operated hospitals. This may indicate that the use of contract labor is higher when staffing levels are more aggressively managed.

Effects of Hospital Size

In order to measure the effects of hospital size, all hospitals were ranked by total operating revenue and then divided into five equivalently sized groups ranging from the lowest revenues (first quintile) to the highest revenues (fifth quintile).

Table 4 – Personnel Expense and Contract Labor By Short-Term Hospital Size During 2003 ($millions)

Quintile	Highest Revenue	Number Facilities	Salary Expense	Contract Labor	Fringe Benefits	Operating Revenue[1]	Personnel Expense[2]	Contract Labor[3]
1	$16.2	812	$3,225	$160	$522	$6,886	56.7%	4.1%
2	$37.3	812	$8,897	$392	$1,554	$21,181	51.2%	3.6%
3	$77.6	812	$18,095	$759	$3,084	$44,887	48.9%	3.5%
4	$161.2	812	$36,507	$1,755	$6,442	$92,061	48.6%	3.9%
5	$1,995.2	811	$105,922	$4,712	$15,362	$261,508	48.2%	3.7%
TOTAL		4,059	$172,646	$7,777	$26,964	$426,523	48.6%	3.8%

Notes: [1]Total operating revenue is the net patient revenue after contractual allowances and discounts.
[2]Personnel expense as a percent of operating revenue
[3]Contract labor as a percent of personnel expense

There appear to be economies of scale in personnel expense. Personnel expense as a percentage of operating revenue declines as operating revenues increase. There does not, however, appear to be a relationship between hospital size and the use of contract labor.

Effects of Service Intensity

The Medicare case mix index (CMI) for federal fiscal year 2003 was used to rank hospitals according to the intensity of services provided. All hospitals were ranked according to their CMI and then divided into five equivalently-sized groups with the lowest CMIs in the first quintile and the highest CMIs in the fifth quintile.

Table 5 – Personnel Expense and Contract Labor for Short Term Hospitals By CMI During 2003 ($millions)

Quintile	Highest CMI	Number Facilities	Salary Expense	Contract Labor	Fringe Benefits	Operating Revenue[1]	Personnel Expense[2]	Contract Labor[3]
1	1.0519	804	$6,091	$225	$1,057	$12,840	57.4%	3.1%
2	1.1804	804	$14,008	$551	$2,460	$32,331	52.6%	3.2%
3	1.2909	804	$25,524	$1,037	$4,917	$62,159	50.6%	3.3%
4	1.4918	805	$43,638	$2,333	$7,357	$106,290	50.2%	[5]4.4%
5	2.9737	805	$83,266	$3,628	$11,154	$212,603	46.1%	3.7%
N/A[4]		37	$119	$3	$19	$300	47.1%	2.1%
TOTAL		4,059	$172,646	$7,777	$26,964	$426,523	48.6%	3.8%

Notes: [1]Total operating revenue is the net patient revenue after contractual allowances and discounts.
[2]Personnel expense as a percent of operating revenue
[3]Contract labor as a percent of personnel expense
[4]CMI data not available for 37 hospitals (e.g. certain specialty and governmental hospitals)
[5]When one hospital with remarkably high contract labor is removed, the percentage is reduced to 3.6%

Personnel expense as a percentage of operating revenue declined as the intensity of services increased. This is most likely due to the higher revenues generated by more intense services. This may also indicate economies of scale in larger hospitals.

In contrast, however, contract labor expense increased as the intensity of services increased. The more specialized skills associated with more intense services may result in a greater need for contract labor, as do the more complex workplace issues surrounding more intense care levels. Since hospitals with more intense services are most often located in larger cities, there may also be more competitive labor markets for those hospitals. (The unexpectedly high percentage of contract labor for quintile 4 resulted from a remarkably high contract expense of 85.4% in one hospital. When this single hospital is removed the contract labor expense for remaining hospitals in the quintile is 3.6%.).

It is difficult to separate the issues of size and intensity since larger hospitals typically offer more intense services. Not surprisingly, data for the two are similar. Both tables are presented, however, since some smaller specialty hospitals (e.g. cardiac, surgical, etc.) have high intensities.

Conclusions

Personnel expense typically consumes more than half of a hospital's operating revenue. During the five-year period from 1997 to 2003 personnel expense as a percentage of operating revenue remained around 48.8%. Contract labor as a percentage of total personnel expense, however, increased steadily from 1.4% to 3.8%. This trend may indicate that hospitals are substituting more expensive contract labor for salaried staff. Data for most recent periods, however, may indicate that the rate of increase has subsided.

Since contract labor is more expensive than salaried staff, reversing this trend may be a significant opportunity to reduce personnel expense. Nationwide, short term acute care hospitals spent more than $7.8 billion on contract labor in 2003. This may indicate a savings opportunity of up to $3.9 billion if the use of contract labor use can be curtailed.

Attachment B provides annual statistics for each hospital type so that hospitals can compare their own personnel costs with that of their peers. Short term hospitals can use the tables within the study for comparisons based on factors such as ownership, size, and intensity of services. It is especially noteworthy that the lower personnel costs measured for proprietary hospitals may indicate opportunities for other types of hospitals to reduce their personnel costs.

Attachment C is a case study describing the innovative approach used by Norton Healthcare in Louisville, Kentucky to reduce their high costs of contract labor. Their experience illustrates the significant improvements that may be possible.

Attachment A

Components of Other Labor Expense By Type of Facility During 2003

This study was first published on August 20, 2004 and covered time periods through 2002. The study is now being updated to cover periods through 2003 and to provide preliminary data for 2004. The update also refines the definition of contract labor to exclude home office costs (e.g. mobile nursing staff), physician services, and other labor costs that were included in the prior study but not typically considered as *controllable* contract labor costs. This refined definition of contract labor includes only those amounts reported by hospitals on Medicare cost report worksheet S, Part II, line 9.

The following table details the components of other labor expense and is followed by instructions followed by hospitals in preparing their cost reports:

Table 1 –Components of Other Labor Expense By Type of Facility During 2003 ($millions)

Worksheet S, Part II	Contract Labor	Contract Phy	Teaching Phy	Home Off Salary	Home Off Phy	Home Off Teach Phy	TOTAL
(line numbers)	(9)	(10)	(10.01)	(11)	(12)	(12.01)	(12.01)
Childrens	$11.4	$0.0	$0.0	$4.3	$0.0	$0.0	$15.7
Critical Access	$10.0	$3.7	$0.0	$8.0	$0.0	$0.0	$21.8
Long Term	$57.2	$21.3	$0.0	$41.7	$0.0	$0.0	$120.2
Other	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Psychiatric	$4.0	$1.0	$0.0	$3.2	$0.4	$0.0	$8.5
Rehabilitation	$25.5	$14.6	$0.0	$3.6	$0.0	$0.0	$43.7
Short Term	$7,777.3	$1,485.3	$1,097.7	$8,294.7	$137.4	$190.3	$18,982.8
TOTAL	$7,885.3	$1,526.0	$1,097.7	$8,355.4	$137.9	$190.3	$19,192.8
Percent Total	41.1%	8.0%	5.7%	43.5%	0.7%	1.0%	

3605.2 FORM CMS-2552-96 05-04

3605.2 Part II - Hospital Wage Index Information.--This worksheet provides for the collection of hospital wage data which is needed to update the hospital wage index applied to the labor-related portion of the national average standardized amounts of the prospective payment system. It is important for hospitals to ensure that the data reported on Worksheet S-3, Parts II and III are accurate. Beginning October 1, 1993, the wage index must be updated annually. (See §1886(d)(3)(E) of the Act.) Congress also indicated that any revised wage index must exclude data for wages incurred in furnishing SNF services. Complete this worksheet for §1886(d) hospitals, any hospital with a PPS subprovider (except psychiatric, LTC, or rehabilitation), or any hospital that would be subject to PPS if not granted a waiver.

NOTE: Any line reference for Worksheets A and A-6 includes all subscripts of that line.

Column 1

Line 9--Enter the amount paid for services furnished under contract, rather than by employees, for direct patient care, and management services as defined below. DO NOT include cost for equipment, supplies, travel expenses, and other miscellaneous or overhead items. Do not include costs applicable to excluded areas reported on line 8 and 8.01 Include costs for contract CRNA and intern and resident services (these costs are also to be reported on lines 2 and 6 respectively).

Components of Other Labor Expense By Type of Facility During 2003
(continued)

For cost reporting periods beginning before October 1, 2000, DO NOT include costs for pharmacy and laboratory services furnished under contract and subscript this line to report these costs on line 9.01 and 9.02 respectively (10/97). For cost reporting periods beginning on or after October 1, 2000, DO NOT uses lines 9.01 and 9.02, but include on line 9 contract pharmacy and laboratory wage costs as defined below in lines 9.01 and 9.02.

Direct patient care services include nursing, diagnostic, therapeutic, and rehabilitative services Report only personnel costs associated with these contracts. DO NOT apply the guidelines for contracted therapy services under §1861(v)(5) of the Act and 42 CFR 413.106. Eliminate all supplies, travel expenses, and other miscellaneous items. Direct patient care contracted labor, for purposes of this worksheet, DOES NOT include the following: services paid under Part B: (e.g., physician clinical services, physician assistant services), management and consultant contracts, billing services, legal and accounting services, clinical psychologist and clinical social worker services, housekeeping services, security personnel, planning contracts, independent financial audits, or any other service not directly related to patient care.

Include the amount paid for **management services**, as defined below, furnished under contract rather than by employees. Report only those personnel costs associated with the contract. Eliminate all supplies, travel expenses, and other miscellaneous items. Contract management is limited to the personnel costs for those individuals who are working at the hospital facility in the capacity of chief executive officer, chief operating officer, chief financial officer, or nursing administrator. The titles given to these individuals may vary from the titles indicated above. However, the individual should be performing those duties customarily given these positions.

For purposes of this worksheet, contract management services DO NOT include the following: other management or administrative services, physician Part A services, consultative services, clerical and billing services, legal and accounting services, unmet physician guarantees, physician services, planning contracts, independent financial audits, or any services other than the management contracts listed above. Per instructions on the Form CMS-339, submit to your intermediary the following: for direct patient care, pharmacy and laboratory contracts, the types of services, wages, and associated hours; for management contracts, the aggregate wages and hours (10/00).

If you have no contracts for direct patient care or management services as defined above, enter a zero in column 1. If you are unable to accurately determine the number of hours associated with contracted labor, enter a zero in column 1.

Line 10--Enter from your records the amount paid under contract (as defined on line 9) for Part A physician services, excluding teaching physician services. Subscript this line and report Part A teaching physicians under contract on line 10.01. DO NOT include contract I & R services (to be included on line 6) (10/97). DO NOT include the costs for Part A physician services from the home office allocation and/or from related organizations (to be reported on line 12). Also, DO NOT include Part A physician contracts for any of the management positions reported on line 9.

Line 11--Enter the salaries and wage-related costs (as defined on lines 13 and 14) paid to personnel who are affiliated with a home office and/or related organization, who provide services to the hospital, and whose salaries are not included on Worksheet A, column 1. In addition, add the home office/related organization salaries included on line 7 and the associated wage-related costs. This figure must be based on recognized methods of allocating an individual's home office/related organization salary to the hospital. If no home office/related organization exists or if you cannot accurately determine the hours associated with the home office/related organization salaries that are allocated to the hospital, then enter a zero in column 1. All costs for any related organization must be shown as the cost to the related organization.

NOTE: Do not include any costs for Part A physician services from the home office allocation and/or related organizations. These amounts are reported on line 12.

If a wage related cost associated with the home office is not "core" (as described in Part I of Exhibit 7 of the Form-CMS -339) and is not a category included in "other" wage related costs on line 14 (see Part II of Exhibit 7 of Form CMS-339 and line 14 instructions below), the cost cannot be included on line 11. For example, if a hospital's employee parking cost does not meet the criteria for inclusion as a wage-related cost on line 14, any parking cost associated with home office staff cannot be included on line 11 (10/97).

Line 12--Enter from your records the salaries and wage-related costs for Part A physician services, excluding teaching physician Part A services from the home office allocation and/or related organizations. Subscript this line and report separately on line 12.01 the salaries and wage-related costs for Part A teaching physicians from the home office allocation and/or related organizations (10/97).

Attachment B

Trends in Personnel Expense and the Use of Contract Labor By Type of Facility ($millions)

Childrens

Year	Count	Salary Expense	Contract Labor	Fringe Benefits	Operating Revenue	Personnel Expense	Contract Labor
1997	46	$2,855	$0	$229	$5,895	52.3%	0.0%
1998	46	$3,000	$1	$219	$6,113	52.7%	0.0%
1999	44	$3,061	$2	$223	$6,506	50.5%	0.1%
2000	45	$3,330	$2	$256	$6,942	51.7%	0.1%
2001	47	$3,681	$18	$283	$7,994	49.8%	0.5%
2002	49	$4,288	$14	$367	$9,165	50.9%	0.3%
2003	51	$4,668	$11	$433	$10,208	50.1%	0.2%
2004	23	$2,036	$1	$234	$3,912	58.1%	0.0%
TOTAL	351	$26,919	$50	$2,243	$56,736	51.5%	0.2%

Critical Access

Year	Count	Salary Expense	Contract Labor	Fringe Benefits	Operating Revenue	Personnel Expense	Contract Labor
1997	41	$58	$0	$9	$94	70.9%	0.2%
1998	39	$63	$0	$9	$106	68.9%	0.3%
1999	62	$96	$0	$14	$182	60.3%	0.2%
2000	229	$366	$4	$53	$737	57.4%	1.0%
2001	444	$1,038	$16	$155	$2,282	53.0%	1.3%
2002	647	$1,975	$14	$336	$4,404	52.8%	0.6%
2003	770	$2,881	$10	$519	$6,408	53.2%	0.3%
2004	506	$2,075	$6	$404	$4,718	52.7%	0.3%
TOTAL	2,738	$8,553	$51	$1,499	$18,931	53.4%	0.5%

Long Term

Year	Count	Salary Expense	Contract Labor	Fringe Benefits	Operating Revenue	Personnel Expense	Contract Labor
1997	211	$1,845	$1	$254	$3,492	60.1%	0.1%
1998	232	$1,610	$3	$227	$3,371	54.6%	0.2%
1999	216	$1,800	$12	$261	$3,878	53.5%	0.6%
2000	232	$1,889	$20	$254	$3,851	56.2%	0.9%
2001	261	$2,342	$30	$335	$4,586	59.0%	1.1%
2002	273	$2,260	$44	$323	$4,820	54.5%	1.7%
2003	295	$2,310	$57	$371	$5,323	51.4%	2.1%
2004	242	$2,013	$106	$347	$4,725	52.2%	4.3%
TOTAL	1,962	$16,069	$273	$2,372	$34,046	55.0%	1.5%

Trends in Personnel Expense and the Use of Contract Labor By Type of Facility ($millions)
(continued)

Other

Year	Count	Salary Expense	Contract Labor	Fringe Benefits	Operating Revenue	Personnel Expense	Contract Labor
1997	33	$30	$0	$3	$39	84.5%	0.0%
1998	31	$30	$0	$3	$39	83.8%	0.0%
1999	32	$33	$0	$4	$43	85.5%	0.0%
2000	17	$15	$0	$1	$15	109.2%	0.0%
2001	15	$14	$0	$1	$13	114.4%	0.0%
2002	16	$17	$0	$1	$16	107.5%	0.0%
2003	16	$17	$0	$1	$17	108.4%	0.0%
2004	5	$4	$0	$0	$4	97.9%	0.0%
TOTAL	165	$160	$0	$14	$187	93.1%	0.0%

Psychiatric

Year	Count	Salary Expense	Contract Labor	Fringe Benefits	Operating Revenue	Personnel Expense	Contract Labor
1997	556	$3,849	$1	$342	$5,136	81.6%	0.0%
1998	483	$3,772	$0	$358	$5,222	79.1%	0.0%
1999	455	$3,938	$0	$347	$5,148	83.2%	0.0%
2000	422	$3,960	$2	$321	$4,804	89.1%	0.0%
2001	366	$3,963	$3	$397	$4,971	87.8%	0.1%
2002	352	$4,054	$4	$417	$5,104	87.7%	0.1%
2003	345	$3,854	$4	$447	$5,086	84.7%	0.1%
2004	206	$2,914	$2	$350	$3,444	94.8%	0.0%
TOTAL	3,185	$30,304	$16	$2,978	$38,916	85.6%	0.0%

Rehabilitation

Year	Count	Salary Expense	Contract Labor	Fringe Benefits	Operating Revenue	Personnel Expense	Contract Labor
1997	197	$1,499	$0	$174	$3,226	51.9%	0.0%
1998	198	$1,472	$1	$181	$3,092	53.5%	0.1%
1999	190	$1,467	$1	$184	$3,119	53.0%	0.0%
2000	191	$1,524	$1	$211	$3,278	53.0%	0.1%
2001	260	$1,822	$1	$265	$3,944	52.9%	0.1%
2002	207	$1,642	$21	$257	$3,755	51.1%	1.1%
2003	218	$1,714	$26	$290	$3,872	52.4%	1.3%
2004	89	$815	$5	$131	$1,654	57.5%	0.6%
TOTAL	1,550	$11,954	$56	$1,693	$25,940	52.8%	0.4%

Trends in Personnel Expense and the Use of Contract Labor By Type of Facility ($millions) (continued)

Short Term Acute Care

Year	Count	Salary Expense	Contract Labor	Fringe Benefits	Operating Revenue	Personnel Expense	Contract Labor
1997	5,034	$127,459	$2,067	$17,729	$301,536	48.8%	1.4%
1998	4,992	$133,950	$2,584	$18,401	$316,395	49.0%	1.7%
1999	4,959	$140,180	$3,150	$19,190	$329,882	49.3%	1.9%
2000	4,754	$145,859	$3,923	$19,893	$350,471	48.4%	2.3%
2001	4,565	$154,978	$5,538	$21,475	$373,941	48.7%	3.0%
2002	4,243	$164,455	$7,180	$24,262	$400,906	48.9%	3.7%
2003	4,059	$172,646	$7,777	$26,964	$426,523	48.6%	3.8%
2004	2,138	$95,175	$3,819	$14,773	$239,445	47.5%	3.4%
TOTAL	34,744	$1,134,700	$36,038	$162,687	$2,739,099	48.7%	2.7%

Notes:
[1]Total operating revenue is the net patient revenue after contractual allowances and discounts.
[2]Personnel expense as a percent of operating revenue
[3]Contract labor as a percent of personnel expense

Attachment C

Case Study: Norton Healthcare Recaptures Clinical Workforce

With a national health care workforce crisis in full bloom, it's no surprise that health care organizations find themselves at the mercy of clinical temporary staffing agencies for a substantial portion of their clinical workforce. Nationally, about 3.8% of healthcare's total labor dollars for acute care hospitals are spent on contract labor, totaling some $7.8 billion dollars in 2003 alone. Since typically half of those dollars are "incremental", that is the price paid to agencies over and above normal staff wages, the national cost of this dilemma may approach $3.9 billion annually.

Norton Healthcare, an integrated health care network in Louisville, KY, found themselves in that predicament several years ago, with contract labor spending increasing annually to a run rate of $16 million annually by mid-2002. Previous efforts to limit or control “agency use” had failed as the system’s volumes grew and patient acuity continued to rise.

In mid-2002, Norton had had enough. They simply didn’t have $8 million dollars to pay agencies for staff that should be working for the system. A small group of HR and clinical leaders convened to develop a solution to this out-of-control practice. The intent of that group was to recapture the flexible workforce that Norton was “renting” from agencies.

In two weeks, the group crafted what became known as the Premium Labor Action Plan, and set a goal of eliminating 95% of contract labor by June 30, 2003. The plan consisted of a focused effort to weed out contract labor in the 20% of nursing units (and ancillary areas) that research had shown were causing 80% of the system’s contract labor use. A task force of HR and clinical managers was formed, who developed partnerships, created manager and unit incentives and laid out individual strategies by unit to convert or eliminate traveling nurses, per diem agency use and other contract employees on those targeted units.

This Plan received unanimous support from senior management and was implemented in September, 2002, via a widespread announcement of the purpose and goals for the group. Biweekly tracking was developed and shared across the system’s seven hospitals to track success, identify problems and award incentives to units that had earned them by meeting interim goals that were set monthly.

Norton’s efforts over the past several years built an impressive recruiting machine, including a very successful employee referral program, and a focused direct mail capability. These and other elements of Norton’s 2000-2005 Workforce Development Plan put the system ahead of their competition in vacancy rates, but contract labor had continued to grow.

In the first thirty days of PLAP, agency use began to decline across the system. By the end of 2002, Norton was ahead of all targets and began to pay out incentives to managers and units. Ironically, all the incentive dollars were used to improve conditions on the units, rather than funding parties or individual needs, which further accelerated the progress of the plan.

Over the next several months, progress against PLAP goals continued, in spite of a major clinical systems implementation, winter census spikes and intense competition for nurses in the local market. In

June, 2003, Norton used fewer than 1,000 hours of contract labor in a pay period for the first time in years. At the system's peak in mid-2002, they were using more than 14,000 hours of agency per pay period.

Norton's use of contract labor has continued to decline over the intervening months, as proof that the results were permanent. Thus far through May of 2005, the system's combined use of clinical contract labor in five hospitals was 268 hours, costing less than $4,000, with significantly increased patient volumes.

The impact of this effort on the system has been a reduction of $9 million annually in labor costs, plus the added benefit of knowing that Norton employees provide all of the nursing care in the system's hospitals. The reaction of physicians and patients has been gratifying, as has the confidence that comes from meeting an "impossible" goal.

Attachment D
About the Authors

Douglas H. Howell
Senior Vice President, Organization and Performance
Assistant to the President
Norton Healthcare

Doug Howell currently serves as senior vice president-organization and performance and assistant to the President for Norton Healthcare. Mr. Howell is responsible for human resources, management and leadership development, organizational development and all support services for Norton Healthcare and its operating facilities. In addition, Mr. Howell serves as assistant to the President, coordinating a number of operational, strategic and organization improvement initiatives for the system.

Prior to assuming his current role, Mr. Howell was Vice President, Human Resources for Norton Healthcare, a position he assumed in October, 1999. His background also includes serving as Chief Operation Officer of MetriCor, Inc., a health information consulting firm and The American Hospital Directory, an internet-based hospital data service. He previously spent fifteen years with Humana, Inc. in both human resources and operations roles.

Mr. Howell received his B.S. in Commerce from University of Louisville and did graduate work in business administration and psychology. He has served the community as board member of several community organizations, including the Louisville Urban league, the Private Industry Council and the Spalding University School of Nursing Advisory Council.

Norton Healthcare
Norton Healthcare is the Louisville, KY area's leading hospital and health care system (45 percent market share) and third largest employer. The not-for-profit system -- the largest in Kentucky and rated one of the top 100 integrated health care delivery systems in the country -- includes five hospitals, five Immediate Care Centers, 27 physician practices, 9,400 employees and 2,000 physicians. Norton's broad range of services includes special areas of emphasis in heart care, cancer care, women's services, pediatrics, orthopedics and spine surgery.

About the Authors
(continued)

Paul Shoemaker, FACHE
President and CEO
American Hospital Directory, Inc.

Paul Shoemaker is founder, president and chief executive officer of American Hospital Directory, Inc., an Internet service that provides hospital information from public and private data sources. He is also president of Cost Report Data Resources, LLC, an Internet service that provides online access to Medicare cost reports filed by hospitals.

His professional experience includes sixteen years with Humana Inc. where he served as Vice President of Prospective Payment Systems. He was a co-founder and president of MetriCor Inc., a consulting company specializing in patient medical record coding and management. He has authored numerous professional articles related to health information and is a frequent public speaker. His professional career has centered on the collection, management and analysis of health care information. He has extensive experience in the use of such information for health policy analysis, strategic planning and operational management.

He is a Fellow of the American College of Healthcare Executives and active in numerous professional organizations such as the Healthcare Financial Management Association (HFMA). Paul is a graduate of the University of Kentucky and a Certified Computing Professional (CCP). He is active in the community and is currently on the Boards of Directors of the Louisville Youth Orchestra and New Performing Arts.

About American Hospital Directory

The American Hospital Directory (www.ahd.com) has been providing the operating details of virtually every hospital in the United States as a free on-line service since September 1997. On-line reports describe a hospital's general characteristics, services provided, financial information, volumes, average lengths of stay, average charges and much more. The free service is provided to over 5,000 users each day. AHD also offers more detailed subscription services and custom data reporting for those who need it.
.