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Gainsharing: A Powerful and Proven Method for Improving Hospital Productivity and Quality

In health care today, with so many hospitals watching their profit margins dwindle or disappear entirely, a dollar saved is worth more than a dollar earned; it may be worth dozens. This is why hospitals across the nation are exploring every conceivable way to save money, including headcount reductions, reorganizations, technological redeployment, capital restructuring—the list goes on and on. Such an environment of severe cost containment takes a toll on everyone involved, from managers, employees, and boards of directors to investors, shareholders, and even patients.

The flurry of cost-cutting activity set in motion with the advent of diagnostic related groups (DRGs) has been with us now for more than five years, and managers are weary. Yet they continue to face one simple reality: cut costs or go broke.

Employees have it as bad as or worse than their managers. So many hospitals have experienced dramatic staff reductions that the ones laid off may be the lucky ones. Those remaining not only toil under the specter of further cutbacks but also are being asked to accomplish more with less—less staff, less supplies, less money.

The industry is in a Darwinian crisis. Hospitals are closing at an alarming rate, and the National Committee for Quality Health Care predicts that 40 percent of the nation's hospitals may close by 2000.¹ Several chapters in this edition discuss the myriad approaches and interventions intended to stem this attrition. Here we will discuss one in particular—*gainsharing*.

To some, gainsharing is a retreat, “old wine in a new bottle.” To most, however, it is one of the last win-win propositions left in human resources management. In this chapter we will describe gainsharing and its history, discuss how it is implemented in a hospital setting, and dispel some of the myths that have developed around it.

WHAT IS GAINSHARING?

Gainsharing is an organizational program designed to improve productivity, enhance quality, and reduce cost. The benefits that accrue from these improvements are then shared in cash with the employees who produced them.

Gainsharing is a group incentive program with the emphasis on teamwork. Furthermore, gainsharing is intended to capture the numerous small savings that collectively add up to substantial savings. And what's more, gainsharing creates an environment for sustained, continual improvements.

The concept of gainsharing is simple. First, the hospital calculates its historic rates of productivity (and, where measurable, quality). Then, new targets are set. If performance reaches the new targets, the hospital and its employees share the monetary gains. Because it involves money that the hospital otherwise would not have saved or earned, the program is self-funding. In this sense, it is a win-win program for both the hospital and its employees.

Although gainsharing has only recently come to the attention of many hospital managers, the concept is not new. Prototype Scanlon plans appeared in the late 1930s and Rucker plans in the early 1940s. In fact, six major forms of gainsharing are currently in use in the United States: Scanlon plans, Rucker plans, Improshare plans, productivity and waste bonus programs, combined work-group/plantwide plans, and standard hour plans. Each type has its own philosophy, approach, structure, measurement system, and provisions for employee involvement. The six major types are thoroughly discussed and documented in the literature so we will not rehash them here (see Suggested Reading list). In practice, most programs are highly eclectic, borrowing features freely from the various

types and adding a measure of creativity to fit the specific organization.

HOW IS GAINSHARING IMPLEMENTED IN A HOSPITAL SETTING?

The optimal way to implement gainsharing depends entirely on the needs and conditions of the hospital. Therefore, be wary of canned approaches. Gainsharing touches so many hospital employees that a flawed design and/or implementation could deal a blow to the organization from which it may not soon recover.

There is, however, a proven process for successfully designing a gainsharing plan. That process involves the following eight steps:

1. buy-in
2. assessment
3. design
4. review/acceptance
5. preparation/training of supervisors
6. program introduction
7. monitoring
8. revision

We will explore each of these steps in detail on the following pages, but first a few observations are in order.

One Size Does Not Fit All

Unfortunately, many human resources programs in health care suffer from the “me too” syndrome. That is, what has proven to work well in one organization is copied by another. Frequently, this understandable desire to not “reinvent the wheel” backfires because of

- a program design that doesn’t fit with the needs and circumstances of the institution
- weak implementation and buy-in

Thus, our first key message is this: *one size does not fit all*. In fact, gainsharing programs usually fail when a proper assessment does not precede a well-tailored design and an effective implementation.

Don’t Overdesign

For some reason, gainsharing programs seem more susceptible to overdesign than do other types of programs. We at Hay are frequently called in to “induce labor” on plans that have been gestating in design committees for years. Why does it take so long? Probably because the idea of giving employees

cash for doing their jobs better creates a strong desire to avoid giveaways. This keeps designers searching for every possible contingency. The result can be debilitating. The message is clear: *don’t overdesign*. In gainsharing, as in most change-oriented employee involvement programs, an “80–20” rule applies: If you spend 80 percent of your time and money designing the program and 20 percent implementing it, you will almost surely fail. However, if you spend 20 percent of your time designing and 80 percent implementing, you stand a much better chance for success. Thus, it is imperative to keep the program simple, but not simplistic.

There are two ways to keep the gainsharing design process going smoothly. First, it is important to create an awareness of the cost of *not* implementing gainsharing. Consider the following. If a hospital has a controllable expense budget of \$150 million dollars, a 2-percent savings (a conservative estimate of what’s achievable) equals \$3 million dollars. Even after paying 50 percent of this savings to employees, it is costing the hospital \$30,000 every week it waits to implement a gainsharing program. Second, developing a systematic approach to the design process assures hospital management that all contingencies have been covered and that nothing has been overlooked.

Let’s consider such an approach, one step at a time.

Step 1. Buy-In

Gainsharing benefits from extensive administrative and physician buy-in from the start. Administrators want assurances that the program is not a giveaway. Physicians want assurances that employees will not sacrifice quality care. In the early stages these assurances can usually be accomplished with a few meetings to clarify objectives and approaches. Later on there will need to be further meetings and discussions on specific design elements.

Achieving this early buy-in provides the requisite senior management team that is committed to the program. Other influential constituencies, like the board of directors and corporate staff, also need to be exposed to the idea of gainsharing early on to secure their support.

Step 2. Assessment

An effective predesign assessment is critical to a successful gainsharing program. Not every hospital is ready for gainsharing, and not all gainsharing programs are alike. Gainsharing in a hospital that is not ready can be counterproductive. Remember, once the program is implemented, employees will have high expectations of receiving a payout. If the system breaks down and they receive none, they will probably be very frustrated and disappointed.

To avoid this potential setback, all hospitals should assess their overall gainsharing readiness. Hay management consultants have developed a four-part diagnostic process that pro-

vides a comprehensive assessment of a hospital's gainsharing readiness. The four elements of the diagnostic are

1. management interviews
2. gainsharing readiness audit
3. employee focus groups
4. systems review

The result of the overall assessment process is rarely a "go-no go" decision. Rather, it produces a plan for strengthening any weak spots before proceeding. The elements of the various assessment approaches are described below. As you read them, remember that each provides a different perspective on overall readiness.

Management Interviews

Management interviews serve the dual purpose of testing management readiness and gaining acceptance. These interviews center around perceived hindrances and obstructions that could impede a successful gainsharing implementation. They provide a firsthand impression of the "personality" and values of the hospital, as expressed through its management. These interviews provide an ideal setting to test and corroborate initial design hypotheses for further discussion in employee focus groups. Management interviews are usually held one on one, and the discussions are confidential. The results from all the interviews are normally condensed into a brief report to management that includes feedback on all aspects of the overall assessment process.

Gainsharing Readiness Audit

Hay management consultants have created a standardized questionnaire of over 100 items designed to assess employee attitudes and management culture in 11 critical areas. This survey provides a powerful analytical tool for assessing a hospital's gainsharing readiness and prescribing the best design and implementation strategy to meet each hospital's unique needs. Tailored to each hospital's specific situation, it is administered either to all employees or to a statistically meaningful sample. The specific factors are defined in Table 18-1.

While all factors in the gainsharing readiness audit provide important and useful insights, Supervisory Capability and Trust tend to correlate most closely with ultimate program success. We discuss this correlation more fully later in the sections on design and implementation.

Hay's gainsharing readiness audit is different from other employee attitude surveys in one important respect: it is supported by a data base of the collected responses from each hospital. This data base is used to help hospitals determine the relative favorability of their responses. From this we can produce a profile of hospitals that have successfully implemented gainsharing and compare it to any individual hospital. We can also use the data base to help assess the readiness of individual departments, as Figure 18-1 illustrates.

Employee Focus Groups

Employee focus groups permit the testing of hypotheses about employee reactions to special design considerations. By engaging 10–15 employees in discussions on the critical issues that have arisen in the other phases of the assessment process, one can sample both the employee reaction and the depth of emotions generated by these issues. This enables the design team to gauge how various approaches are likely to be received by the employees once the program is implemented. The composition of focus groups is critical to their value and success. As a general rule we don't mix managers and their subordinates or levels within the organization because this tends to obstruct candor. In addition, it is desirable to have both homogeneous and heterogeneous groups by function. A typical hospital's functional groupings for employee focus groups might look like this.

- nursing supervisors
- clinical (non-nursing) supervisors
- administrative supervisors
- mixed supervisors
- nursing staff
- clinical (non-nursing) staff
- administrative staff
- mixed staff

Decisions on focus group composition and participation are very important and must be carefully planned so as not to skew the results, create false expectations on the part of the participants, or insult important individuals/groups not chosen to participate. During focus groups, every effort is made to assure confidentiality. Participation in an employee focus group is voluntary, and individuals should not be asked to identify themselves. Notes are usually taken, but direct quotes should be avoided. Such sessions are best conducted by neutral third parties, but representatives of the hospital often sit in on one or several meetings to help interpret comments. Like the findings for the management interviews, focus group results are provided to management, the Design Task Force, and focus group participants, but care must be taken not to breach confidences or identify individuals.

Systems Review

A complete review of the hospital's relevant operational and management systems early on in the design process is important and necessary. It helps ascertain whether the hospital has the systems and measurement capability necessary to support gainsharing. When certain capabilities are lacking, the early warning allows the program to be postponed until correction or additions can be made. The types of systems reviewed are

- *Productivity measurement systems.* Here one checks for the presence of historical baselines; the accuracy, reliability, and timeliness of the information; the ability to flex

Table 18-1 Factors Considered in the Gainsharing Readiness Audit

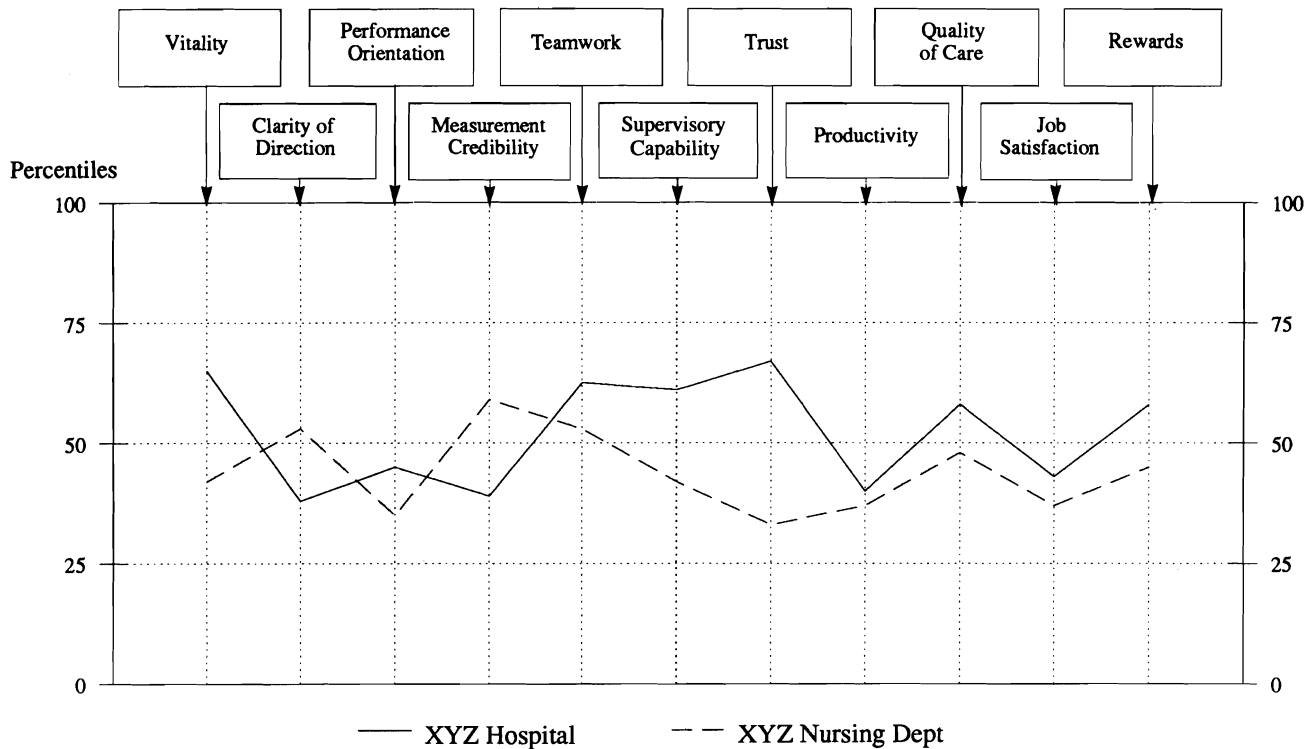
<i>Factor</i>	<i>Definition</i>
1. Organizational Vitality	The overall place and sense of urgency exhibited by the organization as indicated by the venturesomeness of goals, the timeliness of decision making, the responsiveness to change, the degree of innovation, and the orientation toward risk taking
2. Clarity of Direction	The extent to which goals provide a useful context for daily action/decision making and are thoughtfully planned, well defined, clearly communicated, and well understood
3. Performance Orientation	The extent to which individuals are encouraged to stretch toward demanding goals, are held personally accountable for results, and understand what's expected of them
4. Measurement Credibility	The extent to which current measurement systems (i.e., budgets, revenue reports, performance appraisals, productivity reports) are perceived as being accurate, timely, complete, fairly compiled, and a true reflection of actual accomplishments
5. Teamwork	The degree to which employees work well together and need to work well together; the overall extent to which organizational integration, inter- and intradepartmental cooperation, lateral communication, and open discussion are used constructively to resolve conflict
6. Supervisory Capability	How well supervisors are perceived as knowing their job, holding people accountable for performance, treating employees fairly, providing timely and appropriate feedback, responding to problems, encouraging suggestions for improvements, recognizing and appreciating good work, and rewarding superior performance
7. Trust	The overall level of trust that employees have in the organization and their management with regard to reliability of information, level of commitment to employees, and willingness to provide directions
8. Productivity	The extent to which individuals feel that their job equipment and systems are designed to achieve the desired results, that they personally contribute to the results in their area, and that they are working at peak efficiency and productivity
9. Quality of Care	The extent to which the organization delivers high-quality health care, encourages employees to focus on providing high-quality care, and provides employees with the necessary resources, direction, and support to accomplish this goal; the degree to which employees judge their work to be of high quality
10. Job Satisfaction	The extent to which individuals find their jobs challenging and interesting, feel their jobs make good use of their skills and abilities, and are provided with sufficient information, authority, and discretion to do their jobs effectively
11. Rewards	Employees' overall satisfaction with current compensation and benefits policies and practices, their level of understanding of programs, and the extent to which nonmonetary rewards are provided and valued

for census, acuity, and severity; the usefulness of the measures; the amount, extent, and nature of employee impact on what is being measured; and the way reports are formatted and used by management.

- *Financial measurement systems.* Here, again, one looks at the accuracy, reliability, and timeliness of the information; its sensitivity to patient and staffing variations; the ability to extract controllable costs; and the presence of historical baselines linked to a coherent budgeting process.
- *Quality measurement systems.* In order to assure that productivity gains are not made at the expense of quality, it is essential for the hospital to develop a means for tracking and measuring the quality of its care. Here one is concerned with the types of measures used and how they are used on short- and long-term bases to monitor and control quality.
- *Performance management systems.* Since gainsharing is a group rather than an individual incentive program, it is

important to understand the hospital's philosophies, programs, and practices with respect to rewarding individual performance in order to reinforce them, not undermine or contradict them. In addition, one must fully understand the nature of the other systems in use to motivate individuals in order to make sure that gainsharing does not force individuals to make choices between their own interest and the interest of the group.

- *Compensation systems.* Gainsharing programs are greatly affected by employee perceptions of the other compensation approaches in the hospital. In hospitals where the pay is perceived as high, gainsharing may be viewed with indifference by employees who are content with their pay. In hospitals where the pay is perceived as low, gainsharing can be viewed either positively as a way to supplement income or negatively as a way to get people to work harder without guaranteeing them any more money. In order to manage employee expectations about gainsharing, it is important to understand the equity and competitiveness of the overall pay program.



*Represents normative data base of over 200 U.S. hospitals

This illustration highlights an interesting and important relationship between employee perceptions of trust and the credibility of productivity/quality/performance measurement systems. Below are types of implications that emerge.

- Given XYZ Hospital's reservoir of trust and relative lack of measurement credibility, the hospital does not need to overspecify measures and targets, and it is well positioned to make midcourse adjustments.
- However, the dangerously low "trust" levels in the nursing department probably call for a separate nursing program that clearly specifies measures, targets, and payout opportunities and that is intensively communicated to assure that the program is understood and accepted.

Figure 18-1 Gainsharing Readiness Audit—Illustrative Departmental Comparison

- *Other employee involvement systems.* Many hospitals have a variety of employee involvement programs, some of which could conflict with gainsharing. Examples of such programs include employee suggestion box programs, perfect quality programs, patient complaint programs, and productivity enhancement schemes. In general, such programs are a plus and contribute to an overall environment that is favorable toward gainsharing. On the other hand, employees will want to know how all the various programs fit together. The Gainsharing Design Team must be aware of the various issues that could arise in order to deal constructively with any conflicts that occur.

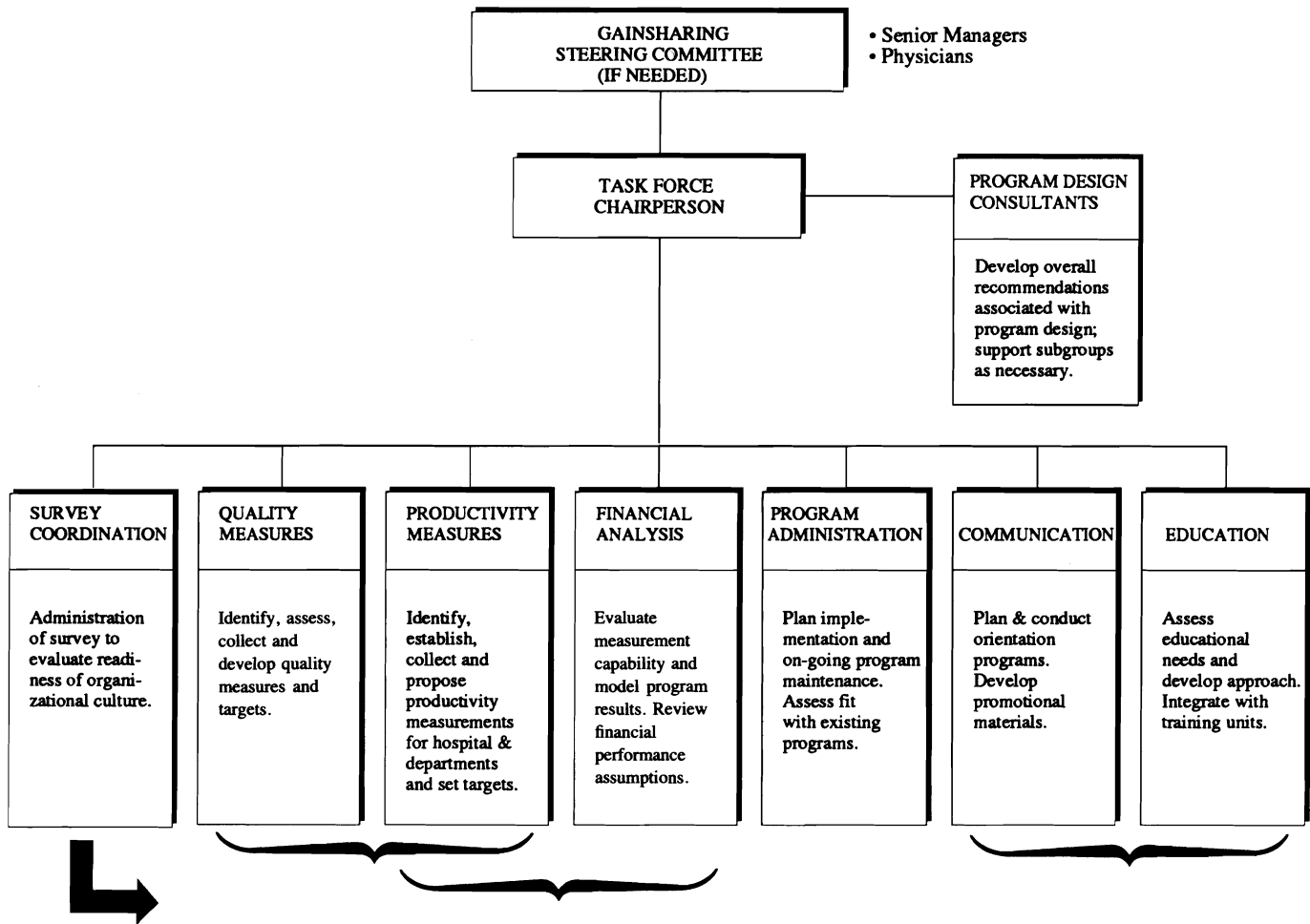
Step 3. Design

Before delving into the specific considerations of the actual gainsharing design, it may be helpful to describe the makeup of a typical design team. This team usually takes the form of a

large task force out of which several smaller sub-task forces are created. Figure 18-2 shows the organization and responsibilities of a typical task force.

The Gainsharing Task Force usually involves from 5 to 15 individuals, the majority of whom are at the department head level and above (with some employee participation recommended). Members should represent both line and staff functions from all participating units or facilities. Furthermore, at least one physician representative should serve on this task force to convey physician concerns and represent their interests. Such a broad-based, multidisciplinary design task force helps secure additional buy-in and incorporates specific knowledge and expertise about the hospital's systems and processes. Members of the task force should be recognized leaders in the organization. It is particularly important to involve those key managers who are skeptical of or concerned about the program in order to secure their early support.

A key role in the task force is that of the task force chairperson. Far from being a figurehead, this person is essential to ultimate program success. The chairperson serves as the or-



Note: Brackets indicate groups that are frequently combined. Arrow indicates that members of this group typically serve on other groups when tasks are completed.

Figure 18-2 Gainsharing Task Force

organization's principal gainsharing proponent and fulfills these important roles.

- consensus builder
- information conduit
- coordinator
- custodian of the organization's mission and values
- link to the steering committee

The chairperson not only needs to be committed to the program's success, but also should be action oriented and well regarded throughout the organization. Without this individual, gainsharing may never materialize.

The Gainsharing Design Task Force usually reports to a steering committee and/or the organization's senior management group. In smaller organizations, the steering committee is replaced by the CEO. The senior management/steering committee role is to review and approve the final design.

Members of the steering committee are usually senior managers and physicians who are typically not eligible to participate directly in the plan. As such, they are best positioned to assess the plan objectively.

In Figure 18-2 the brackets indicate subgroups that are frequently combined. The arrow under Survey Coordination indicates that members of this subgroup typically serve on other subgroups when the gainsharing readiness audit is complete. During the design process the emphases are on the Quality, Productivity, and Financial Analysis subgroups. Thus, there is a temptation to postpone forming the other subgroups (i.e., Program Administration, Communication, and Education) until later when they are needed. This is a mistake. If members of these subgroups are to be ready when called on, they must understand the issues underpinning the design decisions.

The roles and accountabilities of the principal design subtask forces are described below.

Quality Sub-Task Force

As mentioned earlier, a hospital gainsharing program must not overlook the quality of care. Preserving or enhancing the quality of care must be the overriding concern of the development process. It is the specific job of the Quality Sub-Task Force to assure that this is accomplished. This is done typically using the following steps:

- Inventory the existing quality measurement systems.
- Assess the quality and effectiveness of existing quality measures in terms of
 1. coverage (patients, MDs, clerical departments, staff departments)
 2. accuracy
 3. reliability
 4. availability of historical data
 5. timeliness
 6. understandability/clarity
 7. methods of communication
- Document significant quality measures that are lacking.
- Recommend one or two appropriate quality measures for each department.
 1. one clinical (if possible)
 2. one perceptible (if possible)
- Consider potential department clusters to share a single measure.
- Recommend three to five appropriate total-hospital-quality measures.
- Propose preliminary threshold quality levels for all measures.

Members of the Quality Sub-Task Force usually work closely both with members of the hospital Quality Assurance Department and with other department heads, especially when recommending departmental quality measures and standards.

Financial Analysis and Productivity Measure Sub-Task Forces

These groups are considered together because their activities are so closely related. The purposes of these groups are to

- establish hospital and departmental productivity measures and targets
- evaluate the hospital's measurement capability and model program results based on financial performance assumptions

Activities undertaken by these groups usually involve some combination of the following steps:

- Inventory existing productivity measurement, budgeting, and/or cost accounting systems.

- Assess the effectiveness of existing productivity measurement systems in terms of
 1. accuracy
 2. flexibility needed to accommodate shifts in volume
 3. reliability
 4. relevance to the gainsharing program
 5. availability of historical data
 6. difficulty in achieving targets
 7. level of employee impact/control on measures
 8. difficulty in measuring/tracking
 9. level of use/understanding at the department head/supervisory level
- Document significant measures that are lacking.
- Recommend one or two appropriate measures for each department or cluster of departments.
- Recommend total hospital measures (if applicable).
- Propose preliminary threshold productivity levels for all measures.
- Model payout scenarios under various performance criteria.

As with the Quality Sub-Task Force, members of the Productivity Sub-Task Force work frequently and closely with others, including financial analysts, management engineers, and department heads.

Now that we have discussed the makeup of the Gainsharing Design Team, let's look at the following specific design elements:

- eligibility
- measures
- payouts
- hospital/employee share

Eligibility

Options as to which employees should participate in the gainsharing program are many and varied. Most hospitals choose to involve all employees, but other options include

- All employees who have passed normal probation
- All full-time employees
- All regular employees
- All nonmanagement employees
- All nonexempt employees
- Selected departments or facilities (pilot programs)

The ultimate decision is usually based on the program's purpose and the employees' eligibility in other similar programs. Because part-time employees make up such a large part of most hospitals' staffs and because their productivity is so important to overall hospital success, they are typically eligible to participate in the gainsharing program.

Measures

We discussed how measures are determined above. Let us now look at examples of the types of measures that are used. (See Table 18-2.)

Be careful not to use too many measures. Doing so will make it difficult for employees to focus on what's important. We recommend that no more than three qualifiers be used for each department and that all departments have at least one of each type (quality and productivity).

Once the actual measures are selected, how are they used? Table 18-3 presents the two major options available for a gainsharing plan that includes both quality and productivity measures. Typically, Option 1 is selected for hospitalwide programs because determining payouts at the total hospital level minimizes departmental rivalry, cost shifting, and sub-

optimizing at the department level. Under this option, each department must achieve set productivity and quality standards in order for employees in that department to be eligible to receive a payout. The size of the payout is determined by overall hospital performance. Quality standards are also frequently set at the total hospital level, but many hospitals feel this is unnecessary if quality is adequately monitored at the departmental level.

It is worthwhile noting that in very sophisticated gainsharing programs, one or more of the qualifiers are replaced by modifiers that vary the payout based on a comparison of the level of performance with the standards, rather than simply turning the payout on or off.

If a hospital chooses to focus its gainsharing plan on quality, it can determine the payout on that basis instead. This is problematic, however, because of the difficulties associated

Table 18-2 Gainsharing Measures

	<i>Hospitalwide</i>	<i>Departmental</i>							
Productivity/ Cost Measures	<table border="0"> <tr> <td style="border: 1px solid black; padding: 5px;">Targeted Costs</td> <td style="padding: 0 10px;">-</td> <td style="border: 1px solid black; padding: 5px;">Actual Costs</td> <td style="padding: 0 10px;">=</td> <td style="border: 1px solid black; padding: 5px;">Savings</td> </tr> </table>	Targeted Costs	-	Actual Costs	=	Savings	Cost per Unit of Service Cost per Test Cost per Discharge Cost per Square Foot Cost per FTE Cost per Admission Cost per Visit Cost per RVU Net Bad Debt Receivable Days		
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	Net Adjusted Revenues	-	Actual Costs	=	Operating Surplus				
	<table border="0"> <tr> <td style="border: 1px solid black; padding: 5px;">Targeted Cost per Patient</td> <td style="padding: 0 10px;">-</td> <td style="border: 1px solid black; padding: 5px;">Actual Cost per Patient</td> <td style="padding: 0 10px;">×</td> <td style="border: 1px solid black; padding: 5px;">Patient Day</td> <td style="padding: 0 10px;">=</td> <td style="border: 1px solid black; padding: 5px;">Savings</td> </tr> </table>	Targeted Cost per Patient	-	Actual Cost per Patient	×	Patient Day		=	Savings
	Targeted Cost per Patient	-	Actual Cost per Patient	×	Patient Day	=		Savings	
<table border="0"> <tr> <td style="border: 1px solid black; padding: 5px;">Reimbursement for DRG Inlier Activities</td> <td style="padding: 0 10px;">-</td> <td style="border: 1px solid black; padding: 5px;">Actual Costs</td> <td style="padding: 0 10px;">=</td> <td style="border: 1px solid black; padding: 5px;">Savings</td> </tr> </table>	Reimbursement for DRG Inlier Activities	-	Actual Costs	=	Savings				
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$\frac{\text{Output}}{\text{Input}}$	=	$\frac{\text{Aggregate Units of Service}}{\text{Human Resources Cost}}$	=	Human Resources Productivity Index					
Quality Measures	Joint Commission Accreditation Board of Directors' Approval Physician Satisfaction Index Overall Patient Satisfaction Index	Patient Satisfaction Index Performance of Safety Checks Completing Treatment Plans Postoperative Complications (Therapies) Tests Ordered But Not Done Call Backs or Re-do's Breakage and Waste Documentation Completeness and Timeliness							

Table 18-3 Use of Gainsharing Measures

		<i>Hospitalwide</i>	<i>Departmental</i>
OPTION 1	Productivity	Determiner	Qualifier
	Quality	Qualifier	Qualifier
		<i>Hospitalwide</i>	<i>Departmental</i>
OPTION 2	Productivity	Qualifier	Qualifier
	Quality	Determiner	Determiner

Determiner: determines the size of the actual payout
 Qualifier: establishes who will be eligible to receive a payout

with valuing the savings that result from quality improvements.

Payouts

Like eligibility, there are numerous options for both the frequency and the method for allocating the gainsharing payout. For motivational reasons, payouts should be made as frequently as possible, provided that doing so doesn't place unreasonable burdens on the payroll system. We recommend payouts at least quarterly. Some hospitals pay bimonthly or even monthly. Pay annually or semiannually only if you must. If possible, make the payout in a separate check to highlight its special nature. Some hospitals choose to send checks only once a year, but to provide more frequent reports that indicate how each individual is faring. In our view there is no substitute for cash in hand to motivate and stimulate involvement. Furthermore, if you are going to calculate individual earning reports, most of the work is already done, and you might as well cut the check.

Most hospitals debate whether payouts should be equal in size for all eligible (qualifying) employees or whether they should vary depending on salary. (Equal share payouts are usually based on hours worked in order to allow for part-time employees.) The basic formula for each type of calculation appears below.

$$\text{Equal Shares: } \frac{\text{Total employee share (\$)}}{\text{Total hours worked}} = \text{Share per Hour}$$

$$\text{Individual hours worked in period} \times \text{Share per hour} = \text{Individual Employee Share}$$

$$\text{Unequal Shares: } \frac{\text{Total employee share (\$)}}{\text{Total payroll for period}} = \text{Payout Percentage}$$

$$\text{Individual earnings for period} \times \text{Payout percentage} = \text{Individual Employee Share}$$

The choice is made based on whom you consider gainsharing to be intended to motivate. If you believe that gainsharing is intended to reward lower-level employees, equal shares would be appropriate. If, on the other hand, you feel that the ultimate success of gainsharing rests with the commitment of supervisors, managers, and other professionals to make it work, you may consider it unfair for all employees to receive the same dollar share.

In our view, this is not such a difficult choice. Since the amount of money required to motivate a higher-level employee, such as a pharmacist, is different from the amount required to motivate a lower-level employee, such as a pot washer, offering equal shares will overcompensate the lower-level employee and not motivate the higher-level employee. This is a particularly undesirable outcome when you consider that successful gainsharing programs depend on the support and participation of department heads and supervisors and often put the most pressure on these individuals.

Hospital/Employee Share

There is range of options for dividing gainsharing savings between the hospital and the employees. Most hospitals opt for a 50-50 split because of its apparent fairness. The split does not have to be equal, however. Some hospitals have even decided to institute a three-way split with the final third going to charity. The decision is based on the hospital's philosophy and the type of message it wishes to pass to its employees.

The actual split, however, is less important than whether or not the hospital chooses to hold some of the employees' payout in reserve as insurance against overpayment. Overpayment can occur when payouts are made more frequently than once a year. The risk when increasing payout frequency is that superior performance early in the year could result in large payouts, but a later reversal could find the employees owing the hospital money. To avoid this, we recommend that 10 or 20 percent of the employee share be held in reserve against down periods and paid out at the end of the year if a positive balance remains.

This concludes the discussion of the major decisions that are made during the design phase of the program. There are, of course, numerous smaller considerations that go beyond the scope of this chapter. Examples include overtime treatment, capital expenditures, and major unplanned investments.

Step 4. Review/Acceptance

The preliminary design, once completed, usually is returned to the Steering Committee for review and approval. The Steering Committee will probably be most concerned about the accuracy and flexibility of the measures and the mechanisms that control for extenuating circumstances (e.g., to avoid payouts when the hospital is performing poorly). The design is usually finalized jointly in these meetings between the Steering Committee and the Design Task Force.

Step 5. Preparation/Training of Supervisors

Supervisory resistance to gainsharing occurs in varying degrees in almost all hospitals. Supervisors must be taught the skills and behaviors they will need in order to flourish in the new environment gainsharing represents. Examples of these skills and behaviors include

- openness to change
- willingness to admit errors
- confidence in the abilities of others
- willingness to allow the free flow of information

These valuable qualities do not suddenly appear when you decide to implement a gainsharing program. On the contrary, introducing a gainsharing program often produces the opposite result—supervisory intransigence. Supervisors who feel that they have been made vulnerable through exposure to subordinates’ challenges and that they appear weaker to higher management may respond with passive nonsupport, or even subtle or overt sabotage of the gainsharing program.

To counter this tendency, the Education Sub-Task Force must be prepared to address the specific improvement that was identified during the gainsharing readiness audit and the employee focus groups. Approaches that can be used include

- training supervisors in participatory management
- encouraging supervisors with the correct skills to assume leadership roles in training others

- employing outside facilitators to conduct interactive sessions to enhance supervisory skills

Step 6. Program Introduction

The importance of this phase to the ultimate success of the gainsharing program can scarcely be overemphasized. As with any employee involvement program, getting it off to a good start is critical. The Communication Sub-Task Force is accountable for managing this effort. Its job is to create early momentum. By making use of the task force approach described earlier, the Communication Sub-Task Force members will have a reserve of trained, knowledgeable, involved people who can help get the message out.

Early on, employees will desire a great deal of information about the new program. Don’t get caught unprepared. Make a plan that identifies all the audiences and what information they need. A sample draft of a communication plan appears in Table 18-4.

Communications should do more than merely describe the mechanics of the program; they should also include ideas and suggestions about how gains are made. Furthermore, visible top-management commitment is most important at this time. In the critical early days employees will be looking for tangible signs that gainsharing is not a passing fancy or a management whim, but a program to which all levels of management are committed.

The best communication approach is a multimedia one involving special events with posters, slide shows, video

Table 18-4 Communication Plan

<i>Audiences</i>	<i>Objectives</i>	<i>Messages</i>	<i>Media</i>	<i>Success Factors</i>	<i>Timing</i>	<i>Responsibilities</i>
• All employees	• Find out what’s in it for me • Determine how it works	• Improves quality • Supports mission • Enhances justice and fairness	• Memos • Newsletters			
• Management/supervisors	• Determine how it works • Overcome resistance	• Sustains business success • Rewards success	• Training materials • Glossary • Charts/graphs			
• Physicians	• Improve quality of care	• Improves quality of care	• Newsletters • Meetings			
• Special committees	• Show progress & results		• Memos • Newsletters			
• Corporate parent	• Communicate results		• Memos • Newsletters • Meetings			
• Task force members	• Provide updates and show progress		• Memos • Newsletters			

tapes, buttons, whatever is customary for your organization. Extensive use should be made of posters and charts that clearly display progress on a frequent basis. Ideally, every department will have two charts (one for productivity and one for quality) posted in a visible public area, and a similar chart should be displayed in the cafeteria showing the total hospital measure(s). Don't skimp here. Do a sharp, professional job, and the returns will cover the investment many times over.

Step 7. Monitoring

Once the gainsharing program is designed, announced, and in effect, performance and results must be monitored. This is the job of the Program Administration Sub-Task Force. Mechanisms for this monitoring should be in place prior to implementing the program. This monitoring should occur both at the total hospital level (if payments will be based on total hospital performance) and at the department level.

Step 8. Revision

The perfect gainsharing program has yet to be created on the first try. Even the best design needs to be tuned after it is implemented. We have found it useful to reconvene the entire Design Task Force monthly at the outset to discuss any necessary revisions. In all likelihood there will be questions about the measures that require judgment and forgiveness. It is preferable to offer forgiveness on a temporary basis, rather than making midyear changes to measures or the standards. The Design Task Force may need to secure guidance from the Steering Committee regarding which revisions they are free to make and which will need the Steering Committee's review and approval. In our experience, it takes an entire plan cycle (usually one year) to iron out most of the bugs.

WHY DO GAINSHARING PLANS FAIL?

Although the majority of thoughtfully designed and conscientiously implemented hospital gainsharing plans succeed, some do occasionally fail. The reasons for this failure include

- lack of top management commitment
- recalcitrance from first-line supervisors
- excessive complexity
- lack of employee trust in management
- unattainable goals
- poor communications
- inappropriate culture and management style
- inadequate management training
- lack of employee involvement in program design and implementation

With so many pitfalls, why do any hospitals attempt such a plan? Because gainsharing mines the hospital's last untapped resources: the enthusiasm, creativity, and commitment of its employees.

WHAT IS THE RESULT?

For the health care gainsharing programs in place, first-year productivity increases are averaging around 12 percent.* Subsequent years' increases are less, but still significant. The first-year gainsharing results reported by one 375-bed, not-for-profit community hospital are telling.

- Overall productivity increased 9 percent, yielding cost savings of almost \$2 million.
- Cost per adjusted admission was reduced 6 percent from the previous year's level.
- Supply and expense costs per admission were reduced 3 percent.
- Quality of care improved, according to surveys, physician surveys, and clinical data.
- Employee commitment and motivation improved significantly.
- Employees' gainsharing awards averaged 5 percent of their annual salaries.

As you can see from these statistics, gainsharing results can be dramatic. Perhaps the most striking result is the size of the payout (5 percent). In an economy with relatively low inflation, it is possible for gainsharing rewards to meet or exceed an employee's normal raise. This is particularly important in light of the pressures on hospitals to recruit and retain scarce talent in an environment of severe cost sensitivity.

CONCLUSION

Many health care managers are somewhat uncomfortable with incentive and bonus programs that traditionally work well in other industries. But merely sticking to the basic knitting of quality care is not enough to survive in these turbulent times. Managers must attend to the financial viability of their institution and work to involve their employees in the effort. Only the collective energy, creativity, and commitment of all employees will assure success.

Gainsharing can and does help. It is a proven technique for helping employees feel like and behave like shareholders in the organization. Gainsharing's track record both inside and outside of health care is impressive. There is considerable risk, however, to both managers and employees, given Gainsharing's visibility and impact. If well designed and implemented,

*Source of data is recently completed gainsharing program designed by and implemented in conjunction with the authors.

gainsharing will contribute to improved hospital performance. If poorly designed and implemented, it could damage the morale of the organization.

Remember our two basic themes to improve your organization's chances of producing a successful program.

1. *One size does not fit all.* Tailor the program to fit your hospital's needs and circumstances.
2. *Don't overdesign.* Keep the program as simple (not simplistic) and understandable as possible.

If you do these things, you will have a program that induces managers to run their departments as if they were their own businesses. If they don't, their employees will remind them that they should.

NOTE

1. "The Year in Review," *Hospitals*, December 20, 1988.

SUGGESTED READINGS

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