

How to Make the Safe Patient Handling Financial Case

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*Senior Director,
 Risk Management Loss Control & Education*



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Ed Hall is the Senior Director for Risk Management at Stanford University Medical Center. Ed has more than 18 years of diverse loss control and safety management experience, with an emphasis in managing worker safety risks in healthcare and industrial sectors. He has spent more than 10 years in the Safe Patient Handling arena and participated in developing the business case for over 30 hospitals. Ed is recognized for his leadership in implementing innovative loss control risk management programs resulting in dramatic and immediate savings. In 2010 Ed was recognized as Innovator of the Year by Risk and Insurance as well as receiving the Responsible Leader Award.

Ed's expertise focuses on utilizing quantifiable data to identify risk reduction objectives and opportunities which result in significant returns on investment.

Ed received a BS in Fire and Safety Engineering, an MS in Loss Prevention and Safety from Eastern Kentucky University and is a Certified Safety Professional as well as a Certified Safe Patient Handling Professional.

Edward Hall MS, CSP, CSPHP
 Senior Director, Risk Management Controls and Education



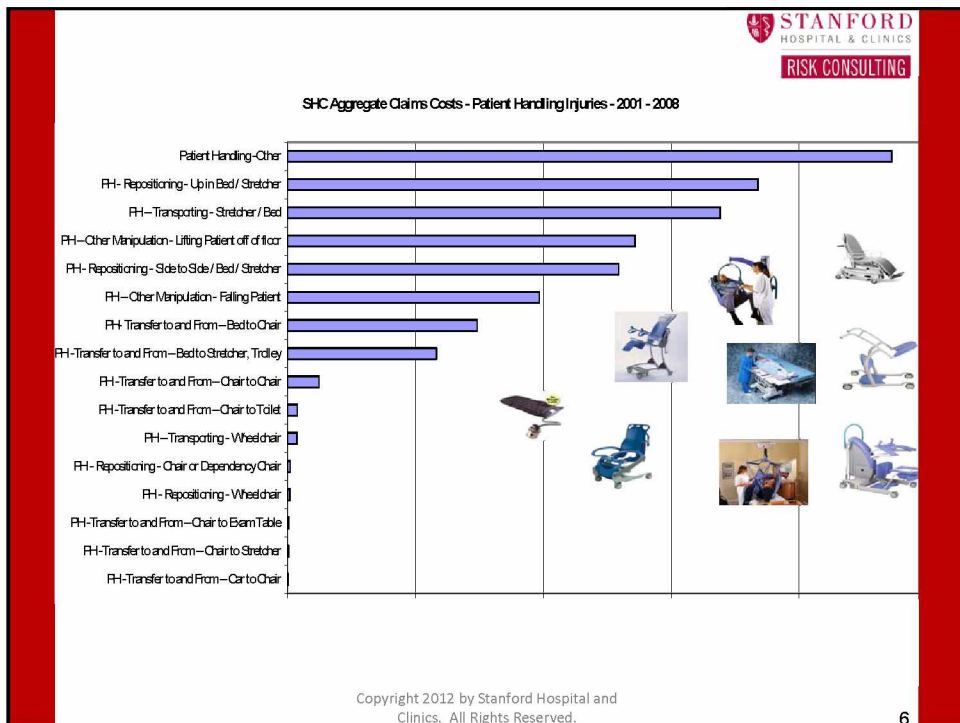
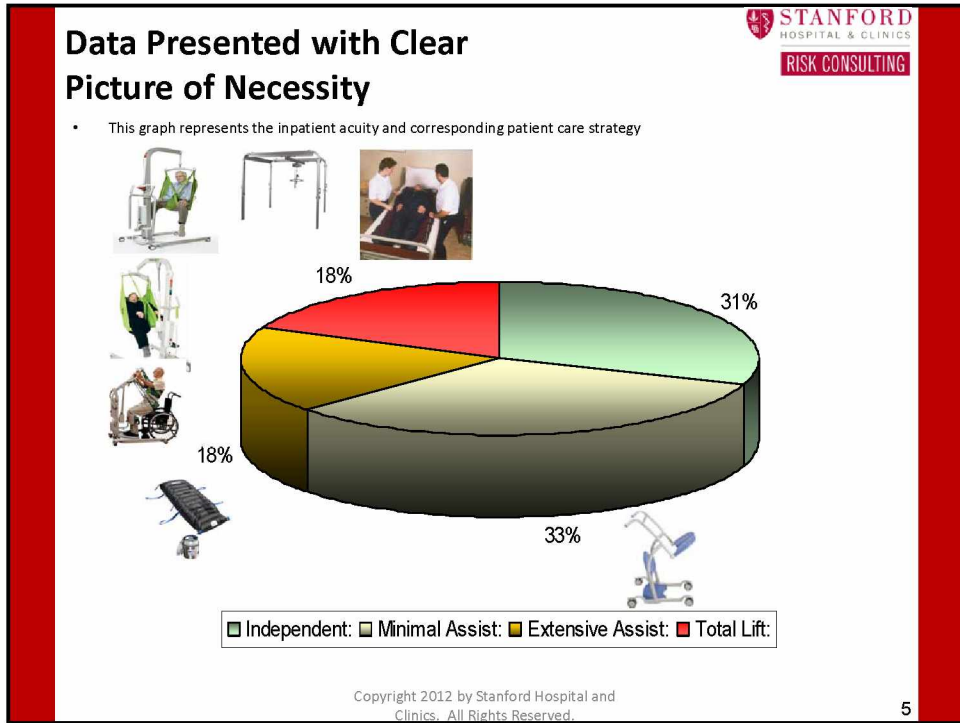
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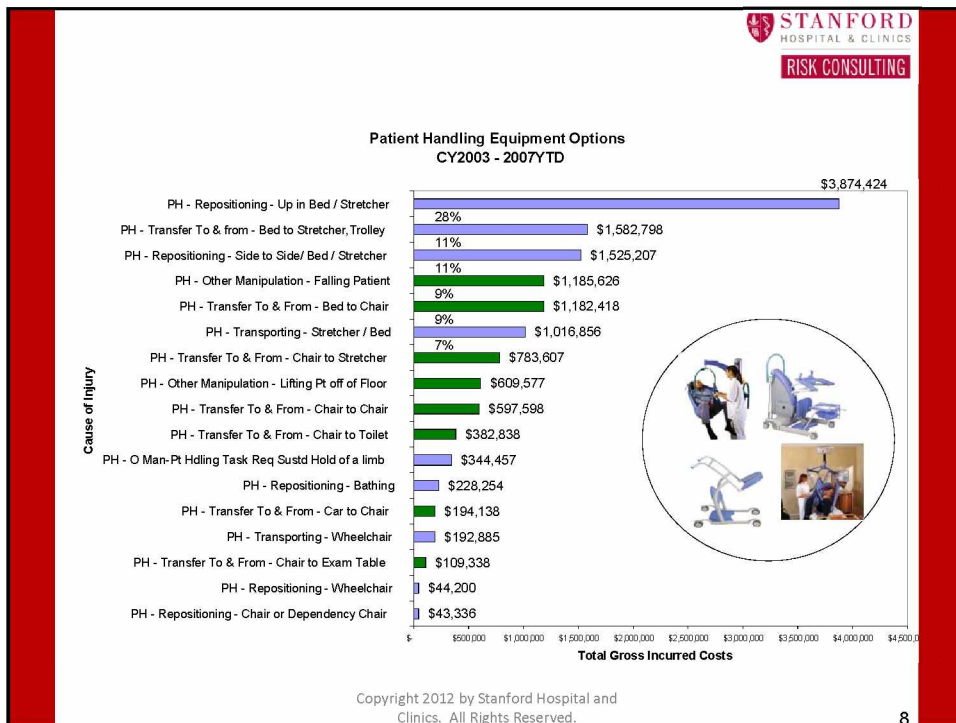
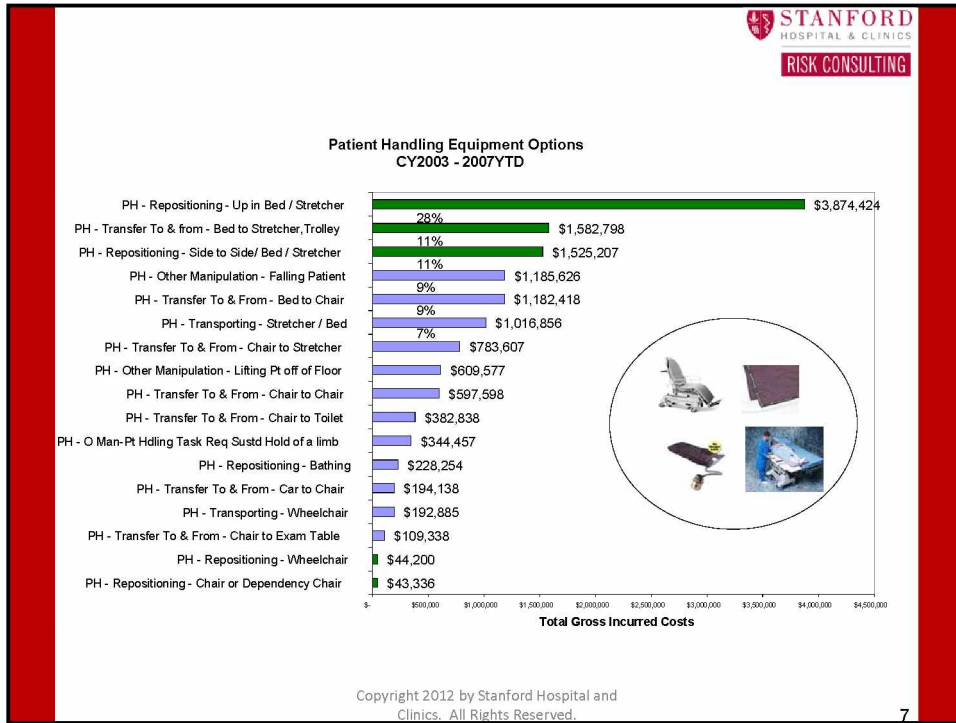
How to Make the Safe Patient Handling Financial Case Using Data that Matters

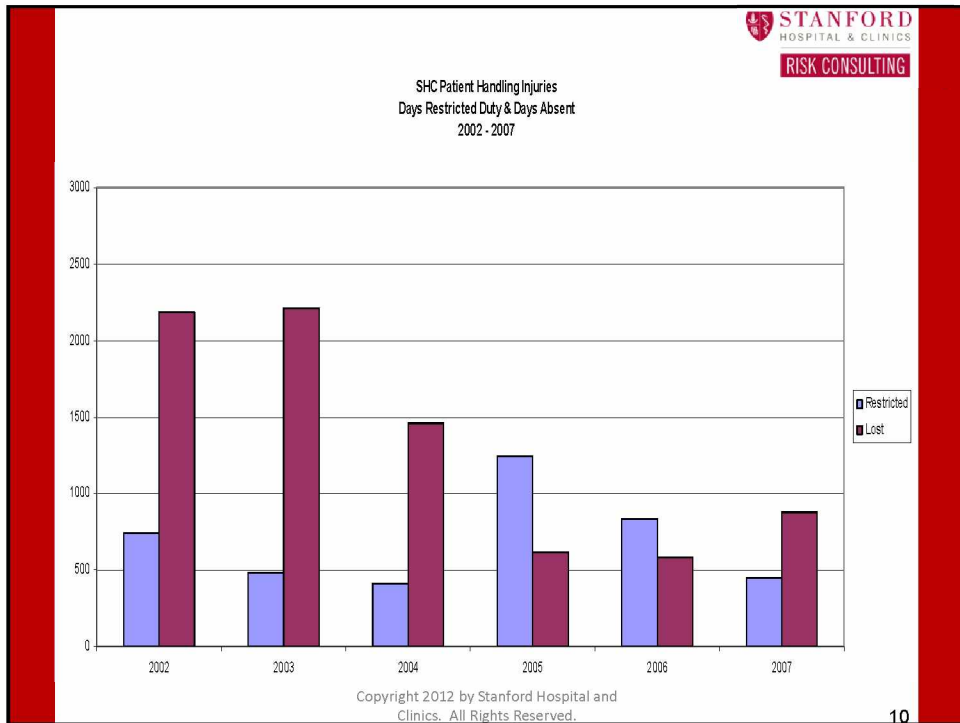
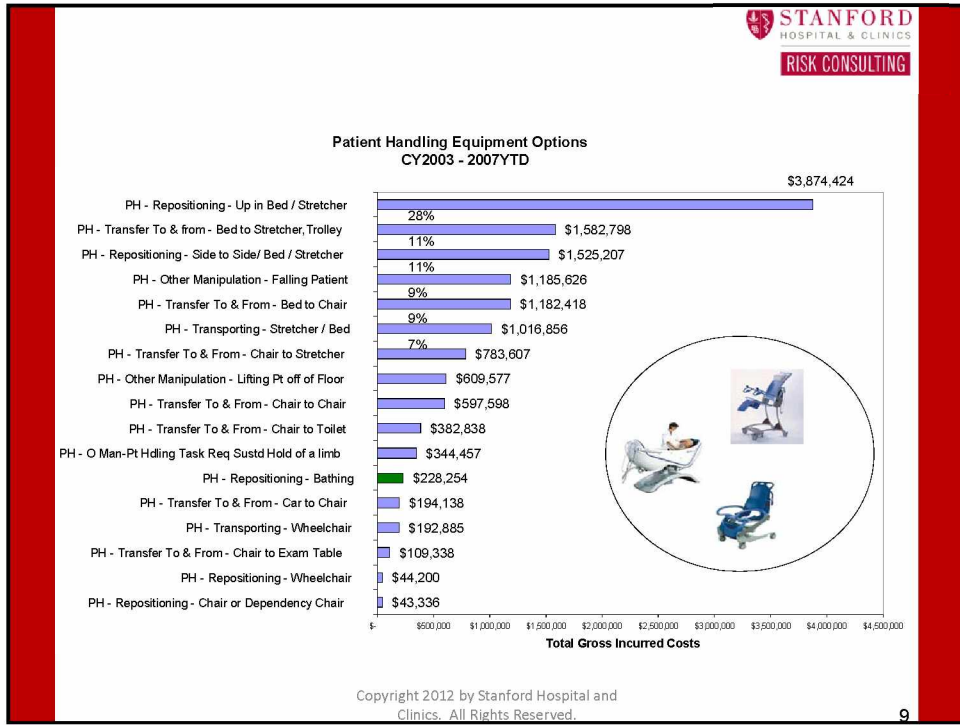
- Alternatives for Safe Patient Handling Programs
- Data Diagnostic Process
- Total Program Costs
- Simple Internal Rate of Return
- Advanced Financial Model

Alternatives When Considering Risk Intervention Options

- Risk Financing (Insure the Exposure) – Legal Requirement So Leverage the Investment
- Risk Assumption (Cost of Doing Business)
- Risk Avoidance (Contract out the Exposure)
- Loss Control (Aggressively Manage Claims)
- **Partial Loss Prevention (Implement Partial Intervention Strategies)**
- **Full Loss Prevention**









Data Drives Cost Acceptance

- Clinical training and consultation
 - Two years estimated at \$150K total
- Labor Training
 - \$700K (see next slide)
- Equipment Cost
 - \$800K
- Ongoing program expenses
 - Patient specific slings estimated at \$25,000 per year
 - Reoccurring staff and coach training estimated at \$6,000 to \$8,000 per year (2 coach days, 4 staff training days)

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STANFORD UNIVERSITY MEDICAL CENTER
Stanford Hospital & Clinics

Project Title Safe Patient Handling

Preparer's name Forte, Joann

Cost Center 83802 - Clinical Equipment

TOTAL \$ 825,675

SHC 100% \$ 825,675

LPOH \$ -

SSOM \$ -

OTHER \$ -

IRR = 27%

CATEGORY (Required) Necessary **CLASSIFICATION (Required)** Hospital **JUSTIFICATION (Required)** New Service

Market Analysis / Competitor

Extensive evaluation was done of the two main vendors. Equipment bids and RFPs were done. The vendor demonstrated the best value and price.

Conflict of Interest (Required. See Instructions)

None **USE YOUR TOOLS IN HOUSE**

Detailed Description of the Project

This is the equipment for the Safe Patient Handling Initiative, previously presented. The program involves new equipment and extensive education with a resulting significant drop in worker injury. Most organizations see at least a 80% return in year 1.

(SAVINGS)/COST ESTIMATES

	FY 2009	FY 2010	FY2011	FY2012	FY2013	TOTAL
REVENUES (Incremental)						
Projected Volume Increases						
Projected Charge						
Projected Gross Revenues	-	-	-	-	-	
Collection Rate Assumption						
Projected Net Revenues						
OPERATING EXPENSE (Expense)						
Salaries	(63,247)	(126,494)	(126,494)	(126,494)	(126,494)	(569,223)
Benefits (34% of Salaries)	(21,504)	(43,008)	(43,008)	(43,008)	(43,008)	(193,536)
Supplies						
Maintenance						
Other	512,950	(436,881)	(499,301)	(499,301)	(499,301)	(1,421,854)
Total Operating Cost/(Savings)	429,899	(606,383)	(668,803)	(668,803)	(668,803)	(2,184,613)
Total Capital Cost (expense)	825,675	-	-	-	-	825,675
Net Savings (Cost)	(1,253,774)	606,383	668,803	668,803	668,803	1,358,938
FTE (Reductions) Additions						

Note: Additional operating expenses must be approved through the operating budget process.

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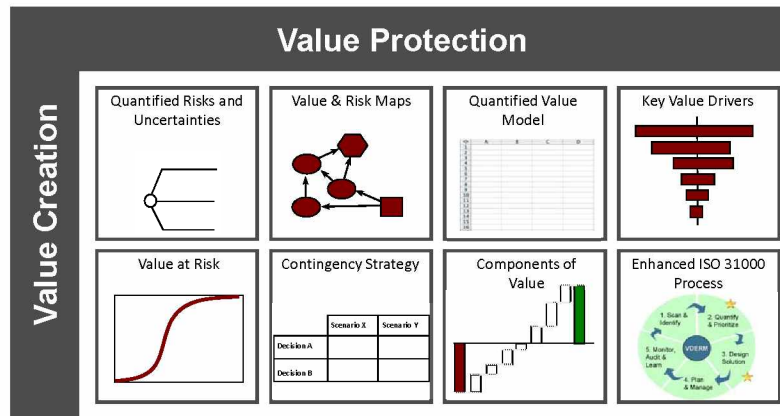
Signatures to be obtained by Capital Assets Department

Authorization

CEO/COO	Date	VP or Department Chair	Date
		Chair Finance Committee	Date

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Now a More Advanced Approach



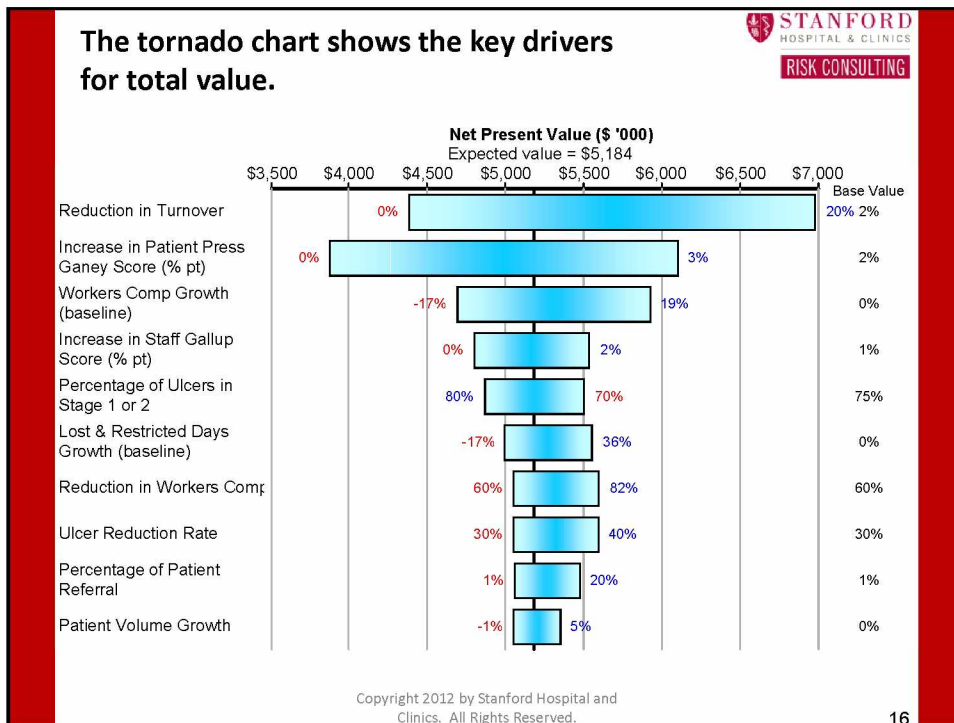
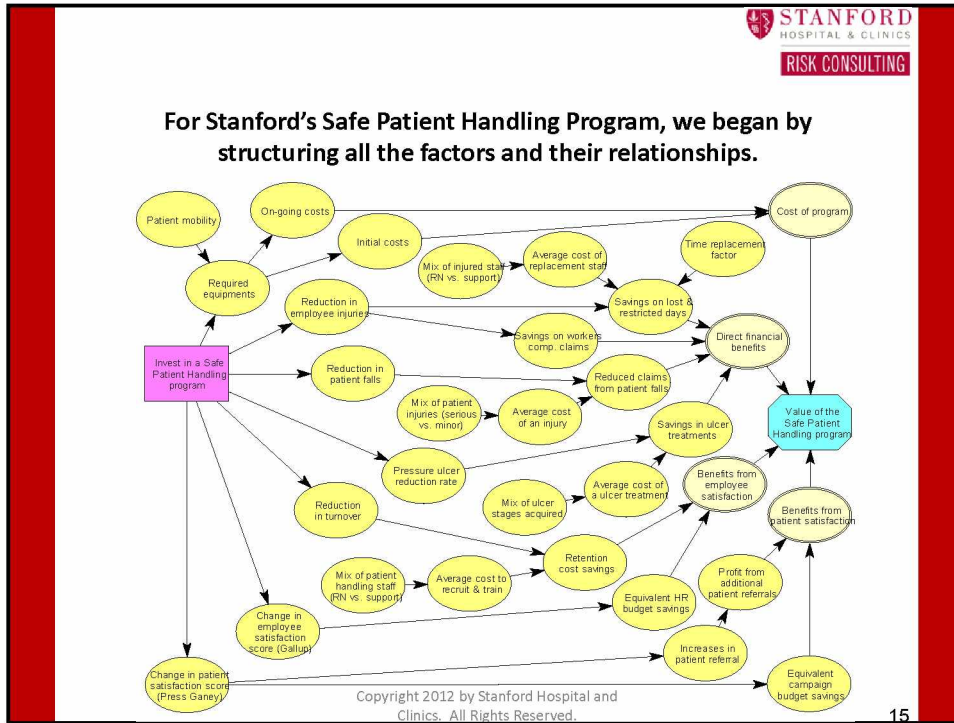
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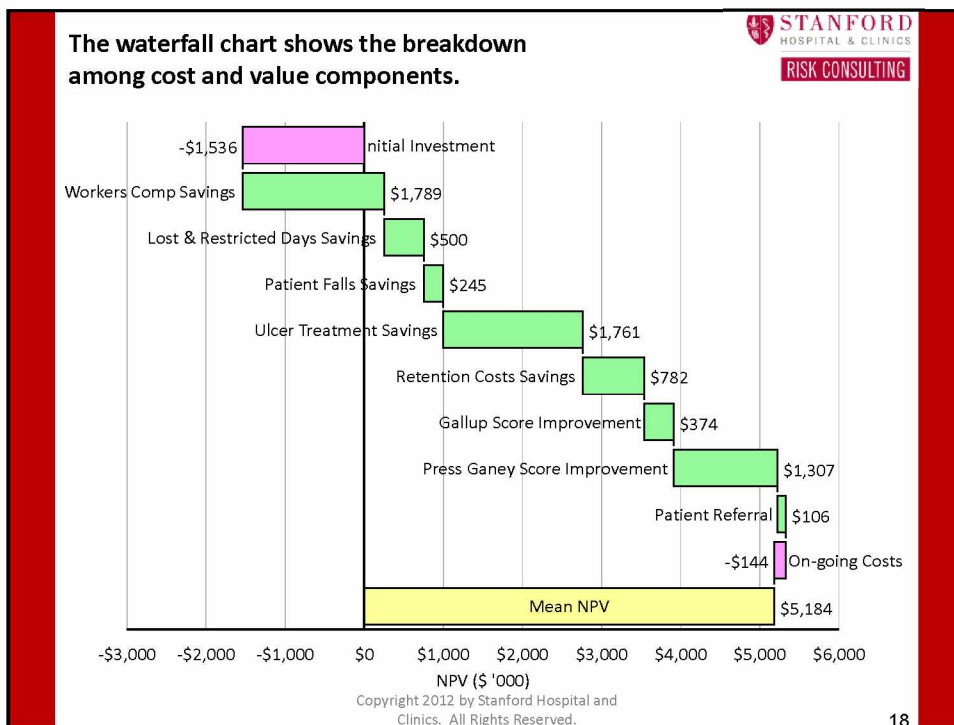
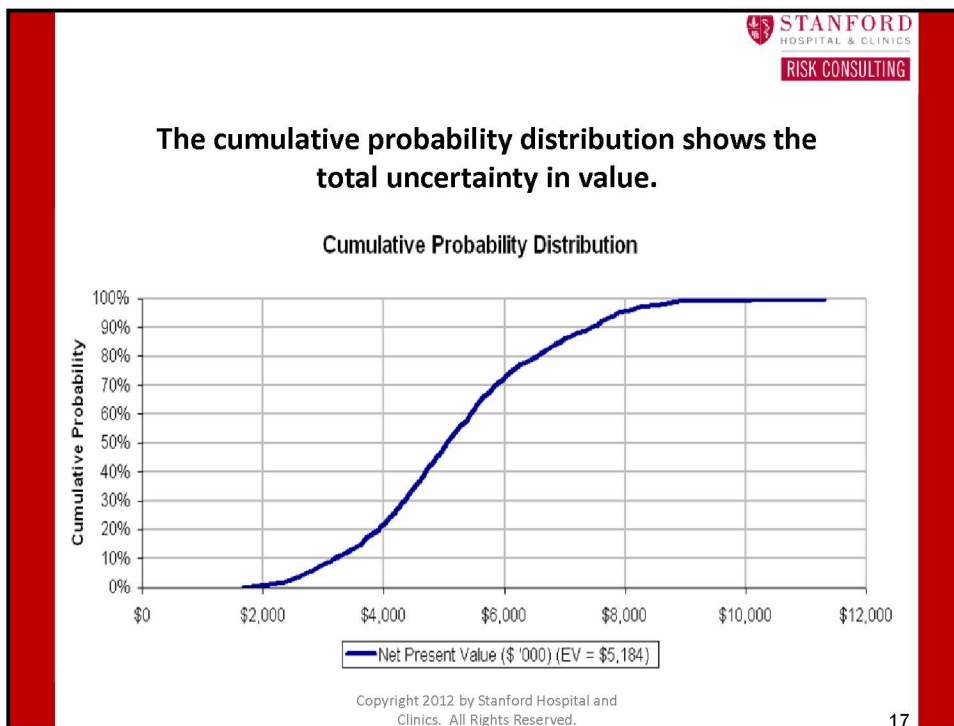
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Application to Develop the Business Case for Safe Patient Handling Programs

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The approach provides a more robust and comprehensive way of understanding and increasing value.

- It makes use of all available data, but also captures hard-to-quantify factors.
- It identifies the most important value drivers and risk factors.
- Done well, it provides a reliable guide to actual realized costs and benefits.
- It provides a defensible, transparent, “investment grade” basis for making difficult decisions under uncertainty and among competing priorities.
- It provides a means of creating new alternatives to increase value and reduce costs.

Stanford Hospital Renewal Project



Safe Patient Handling Options for New Construction

Patient Lift System - Estimate for Stanford's New Hospital

High Risk Area Coverage	Coverage of ICU beds Only
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Number of Beds Room Type
122 ICU Beds

Typical Patient Lift System Cost

\$6,500	Traverse Lift System
\$4,500	Budget for Installation of Lift System and supports
\$6,400	Budget for Structural Engineering and Supplemental Steel
<u>\$17,400</u>	

122 Rooms x \$17,400 =	\$2,122,800
Sling Budget =	\$500,000
Mobile Lifts =	\$116,000 Sit to Stands (29 @ \$4,000 ea.)
	<u>\$148,200 Total Lifts (26 @ \$5,700 ea.)</u>
Total =	<u>\$2,887,000</u>

Assume 2 mobile lifts for every 10 non-ICU beds, 3 sit to stands for ICU.

Patient Lift System - Estimate for Stanford's New Hospital

High Risk and Expanded Coverage	100% ICU Coverage and 50% of swing beds
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Number of Beds Room Type
122 ICU Beds
132 Acute Care Universal Beds (M/S or IICU)

Typical Patient Lift System Cost

\$6,500	Traverse Lift System
\$4,500	Budget for Installation of Lift System and supports
\$6,400	Budget for Structural Engineering and Supplemental Steel
<u>\$17,400</u>	

254 Rooms x \$17,400 =	\$4,419,600
Sling Budget =	\$500,000
Mobile Lifts =	\$84,000 Sit to Stands (21 @ \$4,000 ea.)
	<u>\$102,600 Total Lifts (18 @ \$5,700 ea.)</u>
Total =	<u>\$5,106,200</u>

*Assume 2 mobile lifts for every 10 non-ICU beds, 3 sit to stands for ICU,
and 2 for every 30 covered by overhead lifts.*



Patient Lift System - Estimate for Stanford's New Hospital

Optimal Risk Reduction	100% coverage of inpatient beds
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Number of Beds Room Type
 122 ICU Beds
 264 Acute Care Universal Beds (M/S or IICU)

Typical Patient Lift System Cost


\$6,500	Traverse Lift System
\$4,500	Budget for Installation of Lift System and supports
\$6,400	Budget for Structural Engineering and Supplemental Steel
<u>\$17,400</u>	

386 Rooms x \$17,400 =	\$6,716,400.00
Sling Budget =	\$500,000
Mobile Lifts =	\$48,000 Sit to Stands (12 @ \$4,000 ea.)
	<u>\$51,300 Total Lifts (9 @ \$5,700 ea.)</u>
	<u>\$7,315,700</u>

Assume 2 mobile lifts for every 10 non-ICU beds, 3 sit to stands for ICU, and 2 for every 30 covered by overhead lifts.

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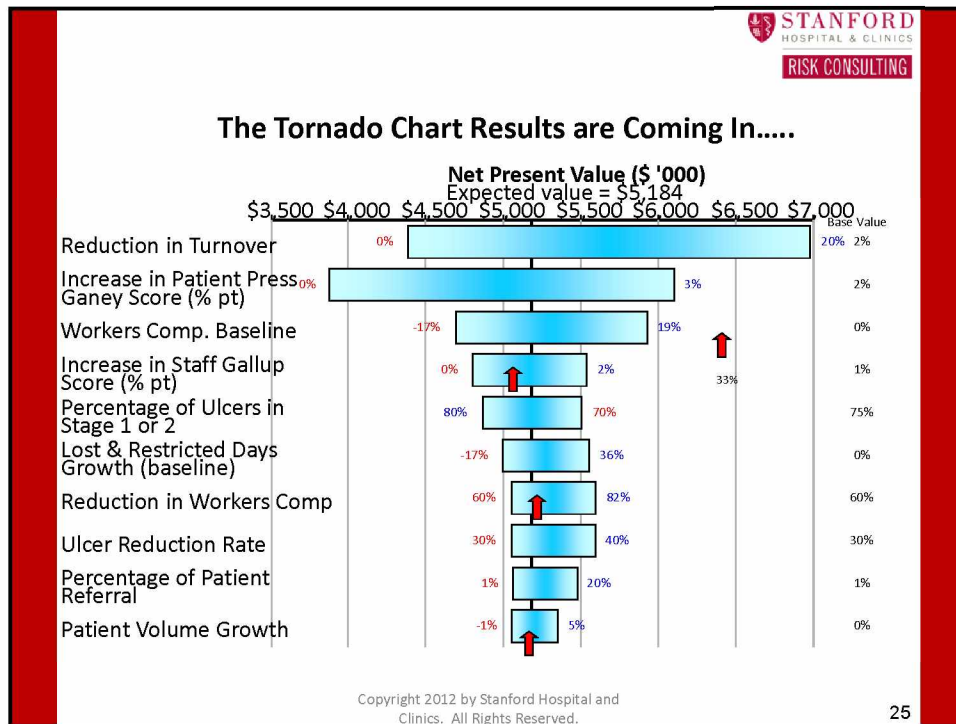


Alternatives When Considering Risk Intervention Options

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Core Competencies of Staff was a Second Wave Initiative

Required Skills

- Financial Acumen**-Demonstrated through budgeting, cost justification and/or vendor negotiation
- Team Leadership**-Demonstrated through assembling and leading a cross functional team
- Policy and Procedure** Deployment-Demonstrated through the development, modification and implementation of SPH P&P
- Training Deployment**-Demonstrated by development and delivery of training
- Clinical Knowledge & Experience**-Demonstrated through clinical job duties
- Risk Analysis & Control**-Demonstrated through formal analyses and linking control measures to risk results
- Program Promotion**-Demonstrated by promoting the benefits and/or results of the SPH program internally and externally
- Program Audit**-Demonstrated by a formal review and reporting of program performance
- Unit Specific Customization**-Demonstrated by adapting procedures to unit specific and patient specific needs.

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