



Quality Update

Seven Tactics for Hardwiring Quality, Cost Savings into Hospital Operations **By John Byrnes, M.D.**

Meeting the escalating demands of the national agenda in quality and patient safety while simultaneously reducing expenses is a challenge for many health care executives. The critical issue is how to do it all. How to mobilize an organization to action, how to implement effective programs, how to obtain executive and physician support, how to structure and staff programs and how to develop reliable measurement systems to prove that top quality and safe patient care is being delivered. For many, the keys to implementation are elusive.

Using the financial model of reporting as a framework, organizations can adopt a practical, common sense approach that hardwires quality improvement into the heart of hospital operations—an approach that will create high quality and lower costs. At Spectrum Health in fiscal year 2007, this approach resulted in more than \$10 million in increased revenue and more than \$15 million in opportunities for cost reduction.

The strength of the finance model lies in the ability to monitor progress within a structured framework of accountability and reporting. By adapting these principles to quality improvement, it becomes apparent that the structure used in finance can be applied to quality, that accountability for quality metrics can mirror the accountability used with the budget, and that measurement is the cornerstone of managing the quality process. As this is accomplished, organizations see their quality and safety programs accelerate and quality metrics improve rapidly. Following are some specific tactics.

Board Engagement is Crucial

Board engagement is crucial to driving the quality program. When board members understand their responsibility for ensuring the quality and safety of patient care, the quality agenda becomes a significant cornerstone of the organization's activities.

At Spectrum Health, the Board Quality and Safety Committee meets monthly. The agenda is focused on reports by project leaders and data review for major initiatives in the strategic plan. The committee members make rounds in the hospital quarterly and attend quality improvement team meetings. Every two years, they hold a strategic planning retreat for board education and review of quality and safety initiatives.

Strategic Plan

The key quality and safety initiatives must be clearly articulated in the organization's strategic plan. As one chief financial officer recently stated, "If it's not in the plan, it won't get the priority attention it deserves." Just as finance goals are in the strategic plan, the quality and safety goals must be included.

Incentive Compensation

To ensure adequate attention from hospital leaders, the quality goals must be embedded in the incentive compensation plan. This ensures that quality projects receive appropriate priority and resource allocation. The incentive compensation plan—or ICP—that reaches the director level is adequate, but an incentive

compensation plan that reaches all the way to the front-line or supervisor level is much more effective. Given human nature, when a goal is tied to financial reward, it is usually attained. A rule of thumb: Quality and safety should make up 25 percent of the incentive compensation goals.

Chief Quality Officer

All organizations have a chief financial officer, yet few organizations have a chief quality officer. No organization can operate without a CFO. The CFO is ultimately accountable for the financial performance of the organization. It's a full-time job.

Quality has become a national mandate and as such, it requires expertise and leadership at the top of the organization. In adequately sized organizations, it is also a full-time job.

The CQO provides the leadership and know-how to advance the quality and safety initiative. When organizations fail to make this investment, their quality program rarely makes substantial progress.

Organizations that have made this resource commitment are showing improvement in quality metrics and winning many quality awards.

Resources and IT Infrastructure

Most organizations have not invested adequate resources to improve quality across all service lines. As a starting point, compare the staffing and IT systems of the finance department with that of the quality and safety department. Are the full-time-equivalent counts the same for each department? Does the quality staff have access to adequate database and business intelligence tools? Can the quality department report on the outcomes and error rates for all departments and the majority of patients served?

If not, your quality department is under-resourced, both from a human resource and IT standpoint.

An adequate quality reporting system must be able to produce clinical dashboards for at least 80 percent of inpatient volume. For most organizations, this equals approximately 30 high-volume conditions. The dashboards should contain measures reflecting process, outcomes and cost metrics.

The data need to be reported at three levels: the hospital, the nursing unit and the individual physician. The surprising fact is that almost every hospital in the country could create these reports with three to six months of work. A cost accounting system is ideal for this purpose, or the finance and coding system can work equally as well.

Annual Quality Budget

All organizations have a yearly financial budget. It's often considered the holy grail of business operations. If we do the same for the clinical side of the house and create a quality budget, (outlining the major initiatives and the year-end goals in terms of measurable process and outcome indicators), we would have a valuable management tool for the quality program.

Financial reports are produced monthly and progress to plan is clearly articulated. Administrative leaders are

held accountable for meeting the financial plan and monthly variance reports are required of all departments not meeting the monthly milestones. The same discipline can be applied to the quality targets. It's this structure of reporting and accountability, borrowed from our finance colleagues, that is driving some of the most successful programs in the country.

As an example, at Spectrum Health, we have a yearly quality budget. All teams have year-end targets with monthly or quarterly milestones. Quality reports are updated monthly and reported throughout all levels of the organization (again mirroring the finance process). Performance against plan is an expectation of our administrative and medical directors, and variance reports are built into the process.

The Greatest Untapped Resource: Medical Directors

Many organizations have medical directors and most are paid for their time. However, many do not have a clear set of expectations or annual goals tied to their respective roles. To be effective, medical directors need job descriptions clearly articulating their leadership role in quality and patient safety. They need yearly targets for each quality measure they influence, and they need a yearly performance review. They also need to be guided by an expert; a mentor who can coach them through the tough day-to-day interactions with physician colleagues—the CQO.

With this structure and support in place, medical directors become one of the most effective drivers of quality improvement. The medical directors champion implementation of evidence-based medicine and standardization of medical practices. As an example, instead of five order sets for total joint replacement, one order set becomes the standard, variation in physician practice is removed and the nurses have one clinical pathway rather than five. All parties are more efficient, mistakes and errors are reduced and the most up-to-date medical practices are implemented. The cost of medical care is reduced through proper resource utilization, and when evidence-based practices are embedded, complication rates are decreased.

Medical directors can also multiply the time of the CQO. An organization with 20 medical directors, paid for a quarter of their time, effectively gives the organization the equivalent of five FTEs deployed against the quality agenda. Rather than one CQO, you now have six CQOs working hand in hand with your medical staff to drive the quality agenda.

Hardwiring quality and safety into the heart of hospital operations is hard work. These are just a few of the tactics that will help build an organized quality effort and achieve higher quality and safer patient care.—
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