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a guide to highly effective quality programs

Delivering value—high quality at low cost—is key to tomorrow’s success. Take these steps today to create an approach that works.

AT A GLANCE

To dramatically improve quality while decreasing costs, hospitals should:

- > Ensure all executives are vocal and visible supporters of quality improvement
- > Focus the board of directors on quality as a strategic priority
- > Strategically target quality resources to improve care for the majority of patients
- > Use the finance system as the foundation for automated quality reporting
- > Form a strong alliance between the CFO and chief quality officer, with each playing a leadership role in the quality program
- > Rely on a well-executed quality program to improve efficiency and decrease the cost of care

When we consider all of the changes under way in health care—whether it’s value-based purchasing, bundled payments, reimbursement for “episodes of care,” accountability for quality performance, or the “value equation”—it becomes clear that the “value equation,” combining high quality with low cost, will be the secret to future success.

For most healthcare organizations, the approach to cost reduction is “more with less,” with productivity enhancement, supply chain management, outsourcing, and various other strategies used to produce the same level of service, but with fewer resources. Although long-term success with this approach has been marginal, these strategies are likely to always be arrows in the quivers of healthcare CFOs.

However, the new frontier of cost management will be in seeking ways to achieve better outcomes—including reduced complication rates and readmissions—by improving quality and reducing variability in practice patterns.

This effort also will be geared toward creating a more efficient total package, like other industries in our economy. In this respect, the same value demands placed on most other sectors will be placed on health care. Whatever the specifics turn out to be, it is clear that quality *will* be the defining characteristic of the future from both a patient care and cost perspective.

To be successful in this environment, hospitals require a highly effective, well-organized, and results-oriented quality program. But developing such a program seems to have come more easily to some organizations than it has to others. Why are some organizations consistently in the top 10 percent for clinical outcomes and patient satisfaction? Why are some organizations seemingly expert at performing in the lowest quartile on costs

To view an example of a clinical dashboard that can be used to monitor a hospital’s efforts to improve quality, go to www.hfma.org/hfm.

and the top quartile in quality—the ideal value equation?

In our experience, an effective quality program displays four essential characteristics:

- > Engaged leadership
- > Well-targeted improvement efforts
- > Quality and finance measures that drive performance
- > Effective reporting using reliable data sources

To answer the questions we have posed, let's consider each of these characteristics.

Engaged Leadership

A focus on quality and everything it implies should become a daily reality for healthcare organizations. This reality cannot be created without the dedicated involvement of the board of directors and the corporate suite. Executive leadership is a critical ingredient in any successful quality program.

Board of directors. As the role of the board has become refined over the past several years, it's now commonly accepted that the board's fiduciary responsibility for quality and safety is equal to their responsibility for financial performance. This position is supported by many organizations, including the National Quality Forum, the Institute for Healthcare Improvement, and The Joint Commission.

In fact, the board can have a significant impact on quality. A study published by The Governance Institute found a link between higher quality performance and active board oversight with the existence of a board quality subcommittee.^a In this study, researchers traced a relationship between performance excellence on measures of hospital quality, based on Hospital Compare data (representing clinical processes of care) and AHRQ's Inpatient Quality Indicators (representing patient outcomes), and six specific board activities:

Every quarter, in place of their regular meeting, board members conduct hospital quality rounds. This activity is a visible reminder to unit directors, staff, and physicians of the board's keen interest in quality and safety performance.

- > Setting quality goals at the theoretical ideal (e.g., zero central line infections)
- > Requiring public reporting of quality performance to the public
- > Reviewing quality performance at least quarterly, using tools such as dashboards and run charts
- > Requiring that new clinical programs meet quality performance goals
- > Devoting significant time to quality issues at board meetings
- > Working with medical staff and management to set the agenda for the board's discussion of quality

At Spectrum Health System, our board has employed additional activities that have been helpful in driving the quality program.

To develop a board that is equally versed in both finance and quality topics, we have offered the board a heavy dose of education in healthcare quality and safety principles, including two-day retreats where the entire agenda focused on quality.

Board members have joined quality and safety teams, where they present the perspective of both board member and patient while gaining insight into the complexities of healthcare delivery. A side benefit of this approach is accelerated team performance.

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a. *Board Room Press*, The Governance Institute, October 2009, p. 11.

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CEO. Much has been written about the CEO's role in promoting quality, but a few points deserve repeating. Above all else, it's of paramount importance that the CEO fully and unequivocally endorse, support, and visibly lead the organization's quality program. To this end, the CEO must be an active and visible advocate of the importance of quality and safety. It sends a powerful message when a CEO makes consistent reference to quality as a cornerstone in all public appearances and internal meetings.

The CEO also must ensure that quality goals are embedded in the organization's strategic and operational plans, and that incentives (including incentive compensation programs and performance reviews) are aligned to support and promote the goals of the quality program.

Ultimately, it is the CEO's responsibility to ensure that quality is included in board and executive team meetings, in direct proportion to the time allotted to finance. Lack of support from the leader, no matter how subtle, sends a powerful message to the entire organization that quality is not a priority.

CFO. Some writers have suggested that the CFO should be "engaged" in quality efforts. However, we believe the CFO can play a much larger role by being visible and vocal not only as an advocate for quality, but also as a leader for improvement.

Beyond supporting quality as a strategic priority, the CFO should form a strong and visible working relationship with both the chief medical officer (CMO) and the chief quality officer (CQO). A strong partnership among these three leaders provides a strong voice for improvement.

Together, these leaders can drive improvements in quality and cost simultaneously, often through a single project or program instead of several separate programs that are focused variously on improving either quality or costs. The three leaders can reinforce the strategic importance of

the value proposition—that there is a direct link between high quality and lower costs. In our organization, the strength of this partnership has clearly accelerated our improvement program and simultaneously demonstrated over \$30 million in cost savings (based on findings of an internal study from 2004 to 2007, which identified savings resulting from reduced complications in 26 high-volume diagnosis-related groups).

When CFOs are strong proponents of quality and safety, their commitment also is translated into budget support for adequate quality staff, capital investment in quality-reporting systems, and access to decision support expertise and systems. Budget support is generated based on calculated and/or inherent ROI principles approved by the executive team.

CFOs also can support a strong medical leadership infrastructure for the quality effort.

Involvement of physician leaders is necessary, as they have tremendous influence to help change physician practice patterns to eliminate waste of resources due to variations in practice. Given that physician practice patterns and clinical decisions are responsible for 70 to 80 percent of resource utilization, effective medical leaders could return five to 10 times their cost through expense reductions and increased revenue by various means (including, for example, pay-for-performance programs, value-based purchasing, pay-for-outcome programs, market share gains resulting from marketing on the value equation, and clinical excellence).

The days when CFOs regarded improvement programs as overhead or a Medicare requirement are now past. The new understanding is that financial success—whether defined as revenue, margin, market share, or reputation—is explicitly tied to quality.

CFOs also are in a position to be instrumental in helping their CQO peers establish a board quality subcommittee that is both functional and highly effective. Taking the lessons learned from the board finance committee, the CFO can help the

CQO design an effective committee structure, membership, and agendas. The CFO should also be a key member of the quality subcommittee.

CQO. The role of a CQO is now widely accepted as critical to successful quality programs. It is identical to the role of the CFO, with the obvious exception that the CQO designs, leads, and is personally accountable for organizational performance in quality and patient safety. The CQO also must articulate an aptitude and appreciation of financial concepts such as cost reductions due to improved quality, ROI on quality department resources, and overall financial stewardship.

Ideally, a CQO has a clinical background. Most organizations select physician executives who have special expertise and training in quality and safety science. In the future, this executive will require insight and expertise in both hospital and medical group management—qualities that will be critical to establishing a seamless continuum of care between inpatient and outpatient settings.

Even organizations that have all of these champions in place and that are committed to cost-effective quality efforts must acknowledge the challenges that almost certainly lie ahead, given that most healthcare organizations have been developed over time with little coordination among quality, safety, and cost management. Changing this paradigm is possible only with the endorsement, sponsorship, and support of everyone in management. A good model starts with a healthy relationship between the CFO and CQO. Ideally, this relationship starts with an honest and sincere curiosity about the other discipline, which, in turn, generates healthy respect and a positive environment for developing the new quality-driven model.

Well-Targeted Improvement Efforts

Considering the scarce resources in most organizations, getting the biggest result from each investment of time, personnel, and dollars is critical.

For clinical improvement projects, the key lies in establishing selection criteria tied to the demographics of the patient population; projects should be selected based on conditions and procedures that are high volume, high cost, and high risk to patients (for example, congestive heart failure, a typical high-volume condition, and bypass surgery, a typical high-cost procedure). This is the same approach used by the Centers for Medicare & Medicaid Services (CMS) in selecting medical conditions for Hospital Compare and by The Joint Commission for selecting core measures. There also will be a strong correlation between a hospitals' or health systems' list and the medical conditions and procedures reported by HealthGrades.

In the typical hospital, the 10 highest-volume conditions/procedures represent 30 percent of inpatient volume. The top 20 represent approximately 50 percent of inpatient volume, and the top 30 represent over 70 percent of inpatient volume.

With this approach, it's easy to see that within a few years, projects will have improved quality for more than 70 percent of the organization's patient population. Stated another way, performance, both in terms of clinical outcomes and the cost of care, will have been improved for diagnoses and procedures representing over 70 percent of inpatient revenue.

Quality and Finance Measures that Drive Performance

Once projects have been selected, measuring performance becomes critical to driving improvement. What to measure and how to share the information with physicians and organizational leaders will be key decision points that differentiate successful programs from those that fail to achieve their goals.

Measures identified for each condition and procedure on an organization's priority list should generally fall into three categories:

- > Process measures
- > Outcomes measures
- > Costs of care

Process measures. These measures indicate the degree to which patients are receiving medications and/or treatments that have been shown to improve outcomes, based on the current evidence base in medicine, which also has established that the medications and treatments are appropriate for the great majority of patients who have the condition requiring an intervention. The higher these measures are, the greater the assurance that patients will experience the best outcomes.

Outcome measures. The measures typically include the most frequent complications, as well as mortality, length of stay, and readmission rates. They reflect the outcomes of care, and high rates in these categories represent higher cost. The targets for these measures therefore should be as low as possible.

Costs of care. This third category of measures includes the traditional cost buckets and two cost-saving analyses. Two ways of achieving cost savings have been identified: by eliminating complications that result in increased costs, and by reducing the costs for patients whose costs of care are higher than the average for all patients with the same condition.

All of these measures should be contained in a clinical dashboard, which is a common approach for displaying and reporting performance for clinical improvement projects. Dashboards typically represent 12 months of performance and can be reported for a hospital as well as for individual physicians. Each measure also can be trended over time to see the effect of improvement efforts. (For examples of a clinical dashboard and a statistical process control chart, in which data are trended over time to track improvements, go to www.hfma.org/hfm.)

Effective Reporting Using Reliable Data Sources

In the authors' opinions, the best source of data for reporting quality is the healthcare organization's finance or cost accounting system because all of the treatments shown on the dashboard trigger charges that are already captured by the

hospital's revenue system.^b The outcomes—complications and mortality rates—are captured by the coding system. Combining these two sources makes available most of the data required for clinical reporting. The remaining measures—such as timing of antibiotics administration and Joint Commission core measures—can be obtained from chart review or manual data collection.

Because most of the data come from administrative databases, reports can be produced and distributed automatically. Likewise, a dashboard can be produced for *any* medical condition or procedure, because every patient, every patient charge, and every code describing outcomes is captured in these two databases. In reality, all hospitals in the country have a ready and virtually unlimited source of financial and clinical quality data.

Ideally, dashboards should be produced and distributed monthly. They should be used to actively manage and improve clinical performance in much the same way that monthly financials are used to manage the financial performance of the organization.

Is all of this reporting necessary? Absolutely! Measurement of clinical quality is a central requirement in proposed reform legislation and in CMS efforts already under way. Core measures are just the tip of the iceberg. Demands for measurement will continue to expand. Value-based purchasing will require highly accurate reporting of clinical performance, and independent organizations such as HealthGrades are already reporting performance for more than 10 high-volume conditions. Many healthcare organizations may view meeting a reporting requirement as a daunting challenge, not realizing that they have this capability internally. To meet this challenge, they need only start reporting and improvement efforts now.

b. Byrnes, J., "Data Collection," *The Healthcare Quality Book: Vision, Strategy, and Tools*, Chapter 6, Editors: Ransom, E.R., Joshi, M.S., Nash, D.B., and Ransom, S.B., Chicago: Health Administration Press, 2008, pp. 109-130.

VARIATION IN USE OF BLOOD PRODUCTS FOR TOTAL JOINT REPLACEMENT

Lower Body Joint Replacement Disease Study
1/1/02 through 12/31/02

= Unfavorable Sev. Adj. Variance at 95 % Confidence Level

= Neither Favorable nor Unfavorable at 95 % Confidence Level

= Favorable Sev. Adj. Variance at 95 % Confidence Level

Note: Observed Values Displayed

Phys ID	Name	Spec	Avg. Sev	No. of Pat	Clinical Issues			Quality Issues			
					Blood Product Given?	Rev'n Knee Replcmt	Hip Replce Revision	Hemorr from Comp	Iatrogenic Complications	Phlebitis DVT	Readmit31
		ORT	1.82	103	82.5%	2.0%	5.8%	1.0%	5.8%	0.0%	5.8%
		ORT	1.79	66	80.3%	1.5%					0.0%
		ORT	1.58	12	58.3%	16.7%					8.3%
		ORT	1.54	56	57.1%	8.9%					8.9%
		ORT	1.90	49	57.1%	10.2%					4.1%
		ORT	1.81	16	56.3%	6.3%					0.0%
		ORT	1.43	70	48.6%	0.0%					0.0%
		ORT	2.03	160	47.5%	7.5%					6.3%
		ORT	1.85	20	45.0%	0.0%					0.0%
		ORT	1.76	88	42.0%	1.1%					3.4%
		ORT	1.82	11	36.4%	9.1%	0.0%	0.0%	0.0%	0.0%	0.0%
		ORT	2.70	10	30.0%	0.0%	0.0%	0.0%	30.0%	0.0%	10.0%
		ORT	1.83	332	27.7%	9.6%	14.8%	0.0%	3.9%	0.0%	3.3%
		Other	2.08	39	23.1%	7.7%	0.0%	0.0%	0.0%	0.0%	2.6%
		ORT	1.81	54	22.2%	3.0%	14.8%	1.9%	1.9%	0.0%	14.8%
		ORT	1.65	113	13.3%	8.0%	2.7%	0.0%	1.8%	0.0%	5.3%
		ORT	1.57	7	13.1%	5.1%	4.0%	0.0%	3.0%	0.0%	3.0%
		ORT	1.83	43	11.6%	0.0%	2.3%	0.0%	4.7%	0.0%	11.6%
		ORT	1.66	93	9.7%	11.8%	6.5%	0.0%	2.2%	0.0%	3.2%

VARIATION
 9.7% to 82.5%
 21 Orthopedic Surgeons

A Process that Works

In the end, these basic questions remain:

- > How do you drive clinical improvement while simultaneously decreasing costs?
- > How do you generate cost savings without alienating the physicians who are critical to making this happen?
- > Can you lead with cost cutting as your primary goal, or is there a better way to gain physician cooperation?

Finding the right answers to these questions is tantamount to finding the Holy Grail of health-care quality improvement. To that end, here are three suggestions.

First, never launch a team with the sole intention of cutting costs, particularly when a clinical process or physician decision making is involved and when physicians are the key to making it happen. Physicians are less likely to become engaged when the goal is cost cutting alone.

Second, cost saving goals can always be accomplished by improving quality first. Well-executed

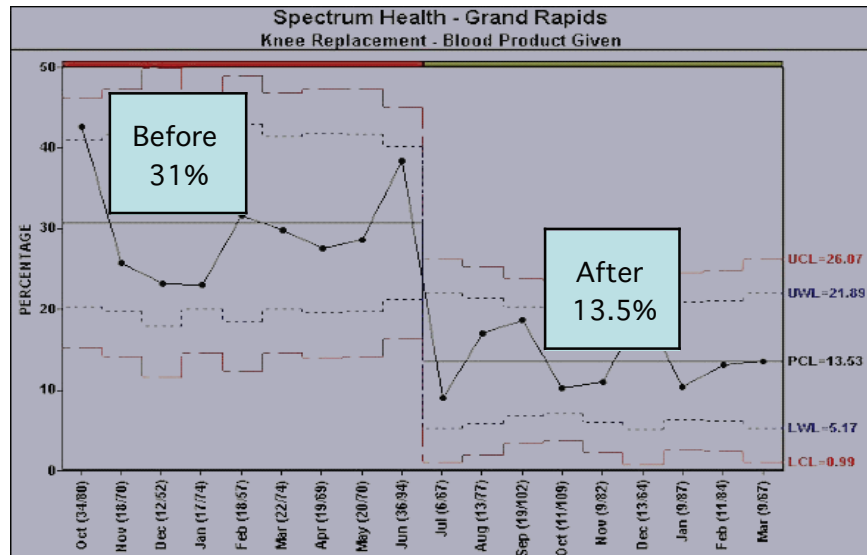
quality projects save money. Consider that a primary purpose of clinical improvement teams is to reduce complications. At the patient level, the cost impact for many routinely observed complications is substantial. For UTIs, the additional cost per patient is roughly \$6,300 to \$9,600, and for decubitus ulcers, it is \$17,500 to \$28,200.^c From these examples, it becomes obvious that if a quality improvement focused on reducing complication rates is successful, the results will be reduced cost of care.

Also in the arena of improving quality first, well-managed clinical improvement teams reduce variation in physician practice patterns. Often, the treatments that different physicians choose for the same, or a similar, problem will differ significantly. Some treatments will be less expensive, others more expensive. By moving physicians to a uniform standard of practice, using the most effective and cost-efficient treatments, costs will decrease.

For example, the use of blood products can vary widely between physicians during total joint

DATA TRENDED OVER TIME TO TRACK IMPROVEMENTS – STATISTICAL PROCESS CONTROL (SPC) CHART

Knee Replacement – Blood Transfusion



replacement. In our institution, we saw a variation from 9.7 to 82.5 percent. After improvement efforts, the average blood products use for all physicians decreased from 31 percent to 13.5 percent in total knee replacement, representing a savings of hundreds of thousands of dollars.

Third, if they are approached in the right way and given the chance to provide input, physicians will gladly participate in projects designed to improve outcomes for their patients—i.e., projects that improve quality, decrease complications, decrease mortality, and improve patients’ functional status. Goals such as these will motivate physicians to use the latest evidence-based treatments and embed these practices in standard order sets, thereby decreasing variation and the cost of care.

c. Fuller, R.L., McCullough, E.C., Bao, M.Z., and Averill, R.F., “Estimating the Costs of Potentially Preventable Hospital Acquired Complications,” *Health Care Financing Review*, Summer 2009, pp. 17-32.

Simply put, the goal of any healthcare organization should be to create effective quality program that raises both clinical outcomes and financial performance to levels rivaling the top organizations in the country. The strategies described here offer a well-tested means to achieve this goal. ●

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