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The revenue rationale for improving quality

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With value-based payments a fait accompli and market competition intensifying, providing poor-quality care is perhaps the most wasteful, expensive and counter-productive thing a hospital can do.

In early 2015, The Centers for Medicare & Medicaid Services (CMS) announced new, more aggressive targets to advance payment reform: by 2016, health care organizations must tie 85 percent of Medicare fee-for-service payments to quality or value. In addition, 30 percent of Medicare payments will be tied to quality or value through alternative payment models, such as accountable care organizations and bundled payment for care programs (50 percent by 2018).[1] Private payers and state Medicaid programs are expected to follow CMS's lead, if they aren't already.

Historically, the principal driver of patient safety and quality efforts has been executives' and clinicians' fundamental desire to "do the right thing" and prevent harm to their patients. Clearly, market forces are aligning to reward safety and quality. This isn't as disruptive a trend as it may seem.

Associating financial incentives with performance isn't a recent phenomenon: Witness Medicare's successful 1991-1996 demonstration project to test quality and cost outcomes of bundled payment for coronary artery bypass surgery. Similarly, the movement toward publicizing hospital quality has roots in ancient history: Recall for example The Joint Commission's 1997 ORYX core measures initiatives. Other programs were subsequently introduced, and followed, not because they materially affected organizational strategy or bottom line, but because they were seen as part of a regulatory framework that required compliance.

A shift is now well underway that converts quality to currency. What is new is that safety and quality are no longer window-dressing. Instead, they are at the root of how providers do business. The transition to value-based care is a market force to be leveraged by high-performing health systems. Delivering quality, safety and reliability is an opportunity to thrive under payment reform—on multiple levels.

The carrots and sticks of value-based care

CMS's far-reaching drive to reduce hospital costs and improve quality of care includes its Hospital Readmissions Reduction Program (HRRP) and Hospital-Acquired Condition (HAC) Reduction Program. Both impose escalating payment penalties when hospitals fail to meet performance targets.

For example, under the HRRP, the majority of U.S. hospitals face payment penalties for higher-than-expected 30-day readmissions for certain patient populations. Penalties begin at 1 percent of reimbursement being withheld and increase to 6 percent if outcomes don't improve measurably over time.

Under 2015's HAC program, more than 700 hospitals may face payment penalties. This could mean hundreds of millions in lost revenue for some hospitals, not to mention loss of patient confidence and diminished institutional credibility within the community.

There is a flip side to penalties for poor quality: hospitals may be able to leverage high-quality care to preserve their margins under bundled and capitated payment programs.[2] For example, the CMS Comprehensive Care for Joint Replacement (CJR) model launched launch in 67 markets in 2016. This program encompasses roughly 25 percent of all Medicare lower extremity joint replacements performed nationally. One payment will cover all providers, beginning with the hospital episode and continuing for 90 days post-op.

With providers at risk to share in the cost of the entire episode of care, transitioning patients from one care setting to another will have direct, bottom-line consequences. For example, medication errors cost the U.S. an estimated $3.5 billion annually and harm an estimated 1.5 million people;[3] approximately two-thirds of medication errors occur during care transitions, including admission, discharge or transfer.[4] CJR participants that can minimize errors will avoid absorbing the costs of errors, preserving their margin under a bundled payment.

Organizations that think strategically are making quality management a central component of their business model. Why? Because quality is at the intersection of transformational cost management, value-based purchasing, evidence-based medicine and consumerism.

Medication error statistics

3.5 billion medication errors annually

1.5 million people harmed by medication errors annually

2/3 of medication errors occur

It's not just what you do, but how you report it and who values it

The past decade has seen steady progress in some aspects of quality and safety within health systems—suggesting that a body of knowledge and proven processes already exist and are accessible through shared experience and literature. Most organizations do some things very well, but look for support in other areas to strengthen their overall quality "portfolio" quickly.

Using a Lean approach, exceptional data and a team of clinical and process improvement experts, the work begins with a current state assessment to identify the areas of need. This leads to prioritization and implementation of an action plan to improve performance—all on a rapid timeline, with ongoing support as needed. Bringing "science to safety" resonates with clinicians, who respond to credible metrics and clinical expertise. Their shared goal is to have the right person do the right thing at the right time, every time.

Every hospital operates in a unique market, with unique resources and demands. In our national consulting experience, however, the top three quality management capabilities that high-performing health systems should perfect are:

1. Identify and fix process-related defects that can result in patient harm and penalties
2. Optimize reporting resources to meet regulatory, market and internal needs with accurate data
3. Embed quality, safety and reliability as a C-suite business imperative

The costs of preventable adverse events

Annual waste[5]

$766 billion due to overutilization, redundancy, inefficiency, medical errors and unnecessary variation in clinical care

Medication errors[6]

Cost to United States: at least $3.5 billion

Estimated people harmed: 1.5 million

Medical liability[7]

A 2010 study by the Harvard School of Public Health estimated that the medical liability annual price tag includes:

- $45.6 billion in defensive medicine costs
- $5.7 billion in malpractice claims payments
- $4+ billion in administrative and other expenses

Preventable medical errors[8]

Approximately 200,000 Americans die from preventable medical errors, including facility-acquired conditions

Case study: aligning clinical resources and processes to improve care, reduce harm and avoid penalties

A large, Texas-based hospital system identified a key opportunity to improve performance in one the four HAC domains measured by CMS: prevention of central-line associated bloodstream infections (CLABSI). CLABSI and catheter-associated urinary tract infections (CAUTI) are performance measures subject to financial penalties for poor outcomes.

The hospital partnered with Vizient™ to reduce CLABSI, a complex but pivotal improvement opportunity with immediate and important benefits to patients and the organization.

"To tackle this issue, we needed an integrated approach and multiple strategies," notes the director of nursing. "Vizient provided the structure to identify the root cause and brought performance improvement and change management solutions."

Data analytics helped narrow potential approaches to specific opportunities that would positively impact CLABSI rates. Vizient experts evaluated intensive care units (ICUs), cardiovascular ICUs, and inpatient departments with high CLABSI rates. Our data revealed that each CLABSI occurrence cost the system more than $27,000 in care delivery and resulted in nearly 16 avoidable days. Most importantly, CLABSI increased the mortality risk by 25 percent.

This clear, actionable evidence galvanized the leadership and clinicians to support a multifaceted CLABSI reduction approach. Nursing staff, infection control and supply chain personnel all played a role. Sharing the initial evaluation data with physicians gained their buy-in for new safety protocols and helped them understand CLABSI-related issues that floor nurses face.

The results? Ninety days after implementation, the hospital experienced zero CLABSI and saved $2.9 million in avoided variable costs and more than 1,700 total avoided days. Related mortalities were also prevented. The benefits to patients are clear.

"Our engagement with Vizient gave us the data to manage CLABSI on a daily basis. We could see how efficient practices can evolve on the floor, create change and improve results," adds the director of nursing. "Just as importantly, it encouraged employee buy-in to the initiative by showing in real-time how measuring data links to achieving strategic outcomes—and it didn't take too long and wasn't too labor intensive."

Other initiatives saw similar, stunning results, including elimination of CAUTI and wrong-site surgeries. Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores jumped, excess readmissions plummeted and the organization achieved 100 percent reliability in value-based purchasing.

Strategic business impacts of quality infrastructure and reporting

Hospitals generate cost, quality and safety data every minute of every day with every patient they treat. This data becomes the face of the hospital's quality management infrastructure—the most accessible view into how the organization approaches and manages outcomes of care.

This data is used for internal purposes: to identify quality and safety initiatives, create baselines, monitor progress, provide feedback and continue the cycle of performance improvement and cost management. They can also influence management and clinician compensation.

Data also flows out the door into what seems like an increasingly unsynchronized web of public reporting: American Hospital Association, state hospital associations, National Healthcare Safety Network (NHSN) Leapfrog, CMS, Agency for Healthcare Research and Quality (AHRQ), The Joint Commission—the list goes is endless. Payers, regulatory bodies, community leaders, consumers and plaintiff's attorneys are among the many audiences who see and act on a health system's quality reporting.

Every item of data carries a cost—to document, code, crunch, cleanse, gather, review, report and archive. For that reason alone, it makes sense to avoid squandering precious resources. Rarely does one encounter a health system that needs to generate more data.

But hardly a day passes without a new opportunity to help providers (1) value the data they create and (2) understand the financial, competitive and quality impacts of acting on that data.

Success snapshot

- Zero CLABSIs in 90 days — $2.9 million saved
- Zero CAUTIs for 360 days and counting
- Zero wrong site surgeries
- Patient experience HCAHPS scores improved from 40th to 85th percentile
- 100 percent reliability achieved in value-based purchasing
- Excess readmissions reduced 40 percent

In the world of value-based purchasing, an organization's quality and safety data—and the management infrastructure it reflects—hold the potential for significant bottom-line impact. Poor quality and safety practices yield poor outcomes; these in turn are captured and reported in the data. Incomplete or inaccurate data can lead to misguided prioritization of quality initiatives, misrepresentation of actual outcomes, and severe patient care and business consequences. It's strategically vital to ensure

the highest-quality data in order to reflect accurately the organization's true performance of quality management.

We're often engaged to help health systems improve their safety and clinical quality infrastructure, including reporting capabilities. One hospital in the southwest reached out after receiving a low Leapfrog Hospital Safety Score. This score analyzes publicly available measures of care outcomes (CLABSI, falls, preventable surgical complications, etc.) and processes (infrastructure to prevent medication errors, implementation of evidence-based clinical protocols, etc.). The hospital was understandably alarmed by their Leapfrog score, certain of a disconnect between their actual outcomes and the data they used to report them.

A multidisciplinary workgroup convened to address specific issues in the measurement and reporting framework.

For example, patient charts with codes that could indicate possible patient safety or HAC indicators had been moving through to final coding and billing without thorough and consistent review of whether the coding was truly accurate.

To ensure correct reporting, the hospital initiated a "pre-final coding and billing" step. Following a more rigorous electronic search process, coding, quality and clinical staff now flag charts with suspect codes to determine whether the data indicates a "false positive" or accurate capture of a patient safety issue requiring further review and action. As a result of these and other initiatives, the hospital's Leapfrog score improved two grades by the next reporting period.

The Leapfrog issue identified a larger opportunity to create greater consistency in defining quality metrics and improve preparation for responding to reporting requirements for multiple surveys and accreditation requirements. The organization's visible quality dashboard now includes all major annual reporting initiatives, their requirements and timelines for submission. It also displays the status of all major clinical improvement initiatives. In addition to aligning resources for reporting, the dashboard provides an unprecedented level of transparency and accountability for hospital executive and clinical leadership.

It all starts at the top: safety, quality and reliability as organizing principles

According to a recent study published in the journal Health Affairs, "National policies to improve health care quality have largely focused on clinical provider outcomes and, more recently, payment reform. Yet the association between hospital leadership and quality, although crucial to driving quality improvement, has not been explored in depth." [9]

This supports the idea that attention factors ranging from the uppermost reaches of a health organization (from the board, the c-suite and front-line management) to quality measures can influence organizational performance.

Our boots-on-the-ground experience supports this. In any engagement to assess an organization's quality, safety and reliability infrastructure, we naturally evaluate the quality department's role, staffing, resources and operations. We analyze their workflow, current reporting initiatives, staffing skill mix and much more.

From a wider perspective, we take a deep dive into the medical staff's role in performance improvement and how integral their processes, incentives and governance are to quality management. Many proven best practices are already in place in health systems across the country that can readily be adapted to reach a higher level of performance.

Finally, we assess what is arguably the most important contextual element in an organization's patient safety, quality and reliability results—leadership. The governing board and executive leadership set priorities, remove barriers and ultimately allocate the resources. In doing so, they visibly value the transparency, teamwork, human talent and environmental factors that underpin a culture of quality and continuous process improvement.

Conclusion

Not one single reimbursement trend points away from quality as a driver of financial viability. Thus the key imperatives for leaders are to:

1. **Quantify** and understand the many risks mediocre or poor quality presents in value-based purchasing programs, consumerism and competitive markets
2. **Understand**, then buy or build, the best practices for quality management operations and infrastructure
3. **Elevate** quality to be an organizing principle of your business and clinical leadership

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Biographies

Eric Burch, vice president
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Mr. Burch has over 20 years of experience in all aspects of health care leadership and the delivery of health care services within the acute and ambulatory care arenas. His background and experience reflect a wide range of industry experience, having held executive officer leadership positions in nursing and operations.

Eric possesses a strong knowledge of national market trends and a keen understanding of health care challenges. He helps providers with performance improvement, process design and redesign, assessment of hospital operations, quality and clinical utilization, physician practice management, leadership and business development, labor optimization, change management, recruitment and retention strategies, and team-building and coaching. Prior to joining Vizient, he worked for Health Management Associates as a chief operating officer. His previous experience includes roles as chief operating officer for Hillcrest Medical Center and chief operating officer and chief nursing officer for Oklahoma State University Medical Center, both in Tulsa, Oklahoma. Additionally, Eric is a Fellow in the American College of Healthcare Executives and has served as adjunct faculty at the University of Oklahoma School of Nursing.

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Ms. Buczkowski has over 30 years of health care experience in consulting and serving in leadership roles in the delivery of health care services. Her background and experience provide strong knowledge and proven leadership skills for accreditation and regulatory compliance, clinical quality, case management, and medical staff affairs. Prior to joining Vizient Consulting she was a regional leader in a large multihospital system. In this role, she provided leadership for the clinical and operational aspects of clinical quality and informatics, accreditation, medical staff administration (including credentialing and peer review), case management, utilization review, social work and infection prevention. Core competencies include innovative health care delivery models, case management and care coordination, value-based care strategies, clinical quality processes and structures, physician-hospital alignment, accreditation and regulatory compliance, medical staff affairs and physician performance. She was an active member of the Michigan Health and Hospital Association's Quality and Accountability Committee and recently published two books on the topics of OPPE and FPPE and has had national speaking engagements as a result of the publications.

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