Yosef D. Dlugacz

VALUE-BASED HEALTH CARE

Linking Finance and Quality

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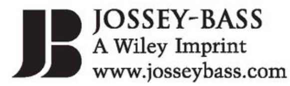

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Published by Jossey-Bass

A Wiley Imprint
989 Market Street, San Francisco, CA 94103-1741—www.josseybass.com

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Library of Congress Cataloging-in-Publication Data

Dlugacz, Yosef D., 1947-
p. cm.
Includes bibliographical references and index.
eISBN : 978-0-470-49812-5
1. Medical care—United States—Quality control. 2. Medical economics. I. Title.
RA399.A3D58 2010
362.1068’1—dc22
2009021529

PB Printing

PREFACE

As I travel around the country and internationally, speaking to health care professionals, policymakers, and administrative leaders about quality management, I have come to realize how many are unfamiliar with the new concepts of value and value based purchasing and the relationship between these concepts and quality care, organizational efficiency, and financial success. I am writing this book in order to explain these relationships, especially for those individuals who will be in a position to influence the future of the delivery of care in health care organizations.

In the past when I advocated for performance improvement processes, support came primarily from clinicians and the regulatory agencies. Today, as new processes for improvement are being designed, the C suite has become interested and involved. CEOs and CFOs are beginning to realize that concepts of waste and redundancy in care involve correlations between costs and expenses on the one hand and poor processes and outcomes on the other. Happily, I am beginning to be asked how quality management can help to transform organizations to meet the challenge of value and value based purchasing. Those who spend money on health care, whether individual patients or large organizations who purchase coverage for thousands of people, are insisting that they get value for their expenditures. Value means good outcomes. Good outcomes require quality management tools, techniques, and processes. Leaders realize that their organizations will fail if they do not provide their patients with value.

Attaching a financial benefit to compliance with quality indicators, as the Centers for Medicare and Medicaid Services and other national organizations are doing, will reinforce the importance of introducing quality oversight into the processes of care. Many administrators still regard compliance with quality indicators as an unnecessary expense and an annoying waste of time. As concepts of value evolve, these same administrators are learning how quality management can increase efficiency and reduce unnecessary expense. By improving care and minimizing errors, organizations receive positive media attention and increased market share. By learning to think about health care as a business, leaders are beginning to take quality management more seriously.

As the senior vice president and chief of clinical quality, education and research for the Krasnoff Quality Management Institute of the North Shore-LIJ Health System, I am in a position to design and implement processes that improve patient safety and reduce unnecessary expenses. Clients of the institute—hospitals and health care systems—ask us to help them develop a strong quality management infrastructure that will improve processes and reduce unnecessary expenses. They are impressed with improved processes that result in fewer excess days for length of stay, better turnaround time in the operating rooms, improved throughput from the emergency department through discharge, and more streamlined purchasing. That is, they see the advantage of planning, data collection, performance improvement, communication, and education about quality management. As organizational inefficiencies improve and the delivery of care results in improved outcomes, administrators and financial professionals realize the benefit to the organization. I hope this volume will illuminate the link between quality and finance for everyone invested in

improving health care delivery, patients and professionals alike.

Great Neck, New York Yosef D. Dlugacz *January 2009*

ACKNOWLEDGMENTS

This book is a product of my many years in health care and my association with professionals who have generously shared with me their devotion to quality patient care and their belief that sustained improvements are possible.

I want to thank, in particular, Michael Dowling, president and CEO of the North Shore LIJ Health System (NS LIJHS); Mark Solazzo, senior vice president and chief operating officer (NS LIJHS); Gene Tangney, senior vice president and chief administrative officer (NS LIJHS); and Mark Claster, Trustee (NS LIJHS) for their support of the Krasnoff Quality Management Institute and their belief in the value of quality management.

The Krasnoff Institute owes its success to the many professionals who work tirelessly to improve the quality of care in the organizations with which we work. To Carolyn Sweetapple, Cathy Besthoff, Anne Marie Fried, Charles Cal, Jackie Kostic, and Mary Chaber, nurses whose expertise in business management, quality processes, regulatory requirements, utilization, nursing excellence, and education have proved invaluable, many thanks. Marcella De Geronimo and her outstanding staff of data analysts, Roshan Hussain, Nimmy Mathew, Peter Deng, Liz Ciampa, Christina Cheung, Carol Cross, and Ann Eichorn, have provided me with sophisticated information and reports that have enabled me to convince reluctant physicians and administrators about the value of quality data. Thanks also to Robert Silverman, MD, for his commitment to quality research and to his work with the Institute. My son, Hillel Dlugacz, contributed his time and his artistic talent to the cover. Working together is a pleasure and makes me proud.

Special thanks to Debi Baker, for her administrative ability and her graphic design talent, and to Quiana Binns for her clerical support. Joyce Guerriere has made it her business to assist me administratively with diligence and personalized attention. I could not manage without her.

I wish to express my gratitude to the publishing staff at Jossey-Bass, especially Andy Pasternack, who have been supportive of my efforts and generous with their professional advice throughout the years. Working with them has been a pleasure.

To Alice Greenwood, my friend and colleague, who has become my personal trainer of the mind, encouraging me to stretch myself intellectually and who challenges me to be my most productive, coherent and articulate self, I want to express my gratitude and my love.

My wonderful family, Doris, Adam, Stacey, Kylie, Stefanie, and Hillel, has put up with my travels, my long hours, and my many working weekends with understanding, support, and love. Every day I feel how lucky I am to have been so blessed.

THE AUTHOR

Yosef D. Dlugacz, PhD, is the senior vice president and chief of clinical quality, education, and research of the Krasnoff Quality Management Institute of the North Shore LIJ Health System. The goal of the Institute is to bridge the gap between theoretical knowledge learned in the academic setting and the realities of applying quality management methods in today's health care environment. With decades of experience dealing with process variables and educating professionals and the community about the importance of integrating quality methods into the delivery of care to improve health outcomes, Dlugacz's research focuses on developing models that link quality, safety, good clinical outcomes, and financial success for increased value and improved efficiencies. Dlugacz collaborates with other professionals and organizations to be at the forefront of the national agenda in improving health care services.

Dlugacz's methodologies have been praised nationally and internationally. His academic appointments include Adjunct Associate Professor of Medicine of the New York Medical College; Adjunct Research Professor at New York University; Visiting Professor to Beijing University's MBA Program; Executive in Residence, Hofstra University Frank G. Zarb School of Business; and Adjunct Professor of Management at Baruch/Mount Sinai MBA Program in Health Care Administration, City University of New York. He has appeared in numerous national audio and video teleconferences promoting quality and safety.

Dlugacz has published widely in health care and quality management journals on a variety of clinical care and quality topics. Recently, the Healthcare Financial

Management Association published his article “High-Quality Care Reaps Financial Rewards” in their Strategic Financial Planning publication. His book, *The Quality Handbook for Health Care Organizations: A Manager’s Guide to Tools and Programs* (Jossey-Bass, 2004), has been praised as a valuable text for new quality professionals. His book, *Measuring Health Care: Using Quality Data for Operational, Practical, and Clinical Improvement* (Jossey Bass, 2006), helps to educate professionals about the relationship between quality care and financial success. He was invited to write the foreword for the Joint Commission Resources publication, *Getting the Board on Board: What Your Board Needs to Know About Quality and Patient Safety (2007)*.

For Kylie Madeleine Dlugacz, my first grandchild, who enriches my life every day

INTRODUCTION

Unless you have just recently landed on this planet, you are aware that health care in the United States is undergoing dramatic changes. And you probably also realize that health care organizations are failing—clinically, organizationally, and financially—which is precisely why things have to change.

Shockingly, patient care has been defined as “unsafe,” with infections, for example, running rampant through hospitals, causing serious harm to patients, and costing organizations a great deal of money and time to rally the resources necessary to address these hospital acquired infections. Errors—that is, avoidable mistakes, such as giving the wrong dosage of medicine or operating on the wrong part of a patient’s body—are now being commonly recognized, again resulting in great harm and expense. As health care organizations have expanded and grown and also have become monsters of their own making, their financial situation has grown correspondingly grim. Furthermore, the population is sicker than ever before, with chronic diseases such as diabetes and heart disease on the increase, requiring constant and expensive interventions. The patient population is also aging, which means that patients come into hospitals with multiple problems and conditions and in somewhat vulnerable physical health. Today’s health care environment must address all of these issues. Everyone—health care leaders, governmental agencies, and private insurers—is looking to make a change to repair the clinical, financial, and public relations damage.

Money is driving the change. The carrot of reimbursement and the stick of nonpayment will cause a cultural change

that will define value to the patient as not being hurt (that is, being safe) while he or she is in a hospital. Health care organizations still receive reimbursement on the basis of providing treatment. If a hospital patient needs a reoperation or acquires an infection or falls and needs treatment for the resulting injury, the hospital is paid for those services rendered. If a patient is allowed to remain immobile and develops a decubitus ulcer (also known as a pressure injury or bed sore) and that ulcer becomes infected and the patient is medicated for sepsis and requires ICU care, the hospital gets paid. In other words, no matter whether the care is good or bad, the hospital gets paid. Payment is based on volume, the diagnosis, and the procedures required (called the case mix) and also on the length of stay (LOS), the number of days the patient remains in the hospital.

In the past few years, however, the Centers for Medicare and Medicaid Services (CMS), the agency that reimburses hospitals for health care, and other governmental agencies have realized that in effect they were rewarding poor care and the complications of poor care. Now CMS has determined to change things, to reward value and to penalize poor care. For example, methods such as turning the patient to reduce the rate of decubitus ulcers and well-defined processes to help to eliminate these wounds do exist. Yet in today's health care environment, they are still a problem. However, now that CMS has attached a value to reducing this problem, organizations will take more steps to improve processes. Simply put, organizations that provide good care will survive; others will not.

The government has stepped in to encourage hospitals to adopt safer practices through offering financial incentives to hospitals that can document that they have met specific and defined quality measures, such as giving aspirin to heart attack victims or reducing the rate of decubitus ulcers.

In the near future, if this trend continues, all reimbursements will be based on performance measures. Medicare calls this pay for performance initiative *value-based purchasing.* The idea is to give doctors and hospitals incentives to improve and to give patients value for their health care dollar. The media have also joined the effort and are publishing “report cards” on hospital care so that consumers can be aware and can make intelligent choices for themselves, and the Medicare web site supplies potential health care consumers with comparative data showing how specific hospitals rank on important quality measures.

The government is representing the public in demanding value for health care services. Therefore, hospitals, if they are to survive, have to provide value as their product to their consumers (the patients). It is no longer enough to hire physicians with good credentials and to purchase expensive equipment and then call yourself a “good” hospital. Value, defined as the efficient and effective delivery of good services, must be woven into the entire fabric of the organization, into every process and procedure, department, and service. This book addresses the issue of value in health care: how it can be defined, measured, assessed, and incorporated into the organizational process of the delivery of safe patient care. It also talks about the role and responsibilities of the governing board and the organizational leaders, both clinical and administrative, in determining value for health care spending, and provides information about the relationship between quality and finance. Clearly, improvements in quality lead to improvements in cost management, but many leaders in the health care field, even if they have good intentions, have no idea how to operationalize these improvements. This book should help them realize their goals.

By using quality management methodologies, hospital and health care leaders can link safe care to financial

success. Obviously, if you do not make mistakes, you do not have to spend money to correct them. Under the new standards, if a patient requires a reoperation because the initial operation was not performed properly, no one gets paid. Moreover, the expensive resource of the operating room must be used for the reoperation, preventing a paying patient from using the service. If infections and their complications are reduced, the expensive resource of the ICU is avoided. If processes are in place to control unintended consequences, such as falls, then follow-up expenses are also controlled.

When patients are managed properly and care is delivered intelligently, with consistent attention to a method of monitoring care, then everyone benefits and the service delivered is valuable to the patient and productive to the organization. When care is efficient, LOS for patients is shorter than it is when patients acquire unnecessary complications from their hospital stay. When certain conditions can be managed on an outpatient basis, there is less expense for patient, hospital, and insurer. Good care leads to good finances. The concepts presented in this book will help the reader understand the relationship between method and outcome, how quality methods help to produce good outcomes, and how good outcomes lead to value. Quality methods connect operations and the budget and can predict patient outcomes.

Traditionally, there has been a separation between administrative duties and clinical practice, with the physicians in complete control of the delivery of care. Operations, quality management, and budget were considered independent entities, with no connecting corridors, so to speak. That approach is entirely unworkable in today's health care environment. If the CEO does not see that good quality leads to good outcomes that in turn lead to a good bottom line, the organization will fail. If

administrative leaders do not have a method for monitoring and improving services and also an approach that develops an effective communication process between administrative and clinical staff, the organization will suffer financially.

Rarely are finance and operations appropriately linked. For example, a member of the board or the CEO might ask why the budget goals have not been met. The financial officer might point to operations to answer the question, saying that LOS is too long or that staffing salaries are too high. However, the question that the board or CEO should ask is, what processes can be used to increase the quality of care so that expenses can be successfully predicted? More specifically, what algorithms for care are in practice? What discharge plans are efficient? Are patients accurately assessed to determine whether they need end of life care rather than ICU care? Is the level of competency among the staff appropriate?

Today, these questions must be asked. Today, registered nurses and physicians are enrolling in MBA programs. Today, the silo approach to education is a disservice to everyone involved in health care. Today, the entire scope of care must be considered as a whole. With time, these new educational programs will transform the hospital culture from a focus on caring (treatment) to a focus on curing (outcomes).

The idea of establishing a method to continuously monitor the delivery of care for specific patient populations and particular services is foreign to many leaders. Without such a method, and one that is accepted and internalized by everyone involved in the hospital, the financial picture will remain grim. Quality variables provide such a method, and connect operations, the budget, and patient outcomes. Experts in organizational processes underline the importance of a leadership commitment to making change in order for change to be made. This is as true for health

care organizations as it is for automobile manufacturers. Involvement has to move past the boardroom and past the budget to the bedside. Only then can the “product” of the industry increase in value.

For those professionals working in health care and for students who hope to make an impact on the way health care is delivered, the challenge is to apply theory to practice. When a defect in the manufacture of a car model is identified, the company can recall those cars for correction, at no expense to the consumer. And on rare occasions, patient readmissions can be perceived as recalls. For example, when a department of health (DOH) assesses that the spread of an infection is due to a physician in a private office or in a hospital not meeting protocols, the DOH will require the health provider to recall all patients associated with the procedure to make sure that the break in protocol did not result in harm to many patients. But health care professionals cannot recall all patients whose care was imperfect, substandard, or inappropriate to the hospital. We need to commit to processes and methods that identify and eliminate poor care if we are to enhance the safety of patients in our health care organizations.

This book is divided into two parts. Part One, Chapters One through Four, introduces basic principles of quality management in health care and describes how health care is changing because of the public reporting of quality measures. Part Two, Chapters Five to Nine, offers the business case, explaining how quality care improves the value of health care services for the patient and for the organization. Each chapter of the book offers examples of health care issues and outlines processes for improvements. These examples, although hypothetical, are based on actual events and incorporate real responses. Each chapter ends with a summary, a list of key terms, and a set of questions called “Things to Think About.”

In Chapter One I present the key drivers for changing health care practices in order to improve care and services: some drivers are external to the hospital, such as governmental agencies and private organizations, and some are internal, such as the governance, leadership, and quality management functions.

Chapter Two explains the relationship between quality data and patient safety and also the role of quality measurements in monitoring and improving health care. This chapter also outlines information on how to collect data and present the results of data analysis.

Chapter Three introduces the advantages of establishing a patient-centered environment of care. I discuss strategies to improve communication and the barriers to effective communication. The importance of patient education is also explained.

Chapter Four addresses the links among good processes and outcomes and reduced costs. Improving quality processes results in improved outcomes and reduced waste for the financial benefit of the organization. I also describe the roles of the administrative leaders, the clinicians, and quality management processes and data in improving outcomes.

In Chapter Five I discuss the value of promoting prevention to improve outcomes and reduce costs for health care organizations. Barriers to successful implementation of preventive strategies and possible ways to overcome the barriers are outlined. The roles of the government, the patient, the organization, measures, and methodologies are also discussed. I also describe problems that keep people from accepting prevention methods in the ambulatory setting and present examples of successful interventions.

In Chapter Six the high price paid by organizations and clinicians when a sentinel event occurs is reviewed. Developing processes that mitigate potential risks is not only important for patient safety but also cost effective. Once a sentinel event occurs, steps are required to correct whatever faulty processes are identified as contributing to the event.

In Chapter Seven I discuss the cost effectiveness of appropriate use of high risk environments such as ICUs, operating rooms, and emergency departments, focusing on the advantages of establishing objective criteria for patient admission to these units and understanding the complex barriers involved in optimal utilization. I also discuss the interaction among the issues of quality of care, organizational efficiency, and financial costs when treating patients at the end of life.

Chapter Eight discusses the role of effective communication in improving patient outcomes and the importance of trust among the different levels of staff. Issues involved in reporting or not reporting poor outcomes are explained. Several examples of performance improvement efforts are offered as illustrations of using quality data and open communication to help sustain changed practices. This chapter also explains assessing staff competency through objective measures.

Chapter Nine presents issues related to promoting safety in the environment. I explain how the environment interacts with clinical care and discuss the importance of integrating safety officers and engineers into the health care team. Disaster preparedness involves not only hospital services but connections to the community and regional agencies as well.

Chapter Ten, the conclusion, reviews the points made for employing quality management processes to monitor care

and define value for the patient and the organization.

PART 1

BASIC PRINCIPLES OF QUALITY MANAGEMENT