

Communicating the Financial Case for Clinical Improvement

Finance executives and clinicians tend to speak different languages. Yet as clinical performance increasingly becomes tied to the bottom line, the quality with which conversations take place between the two groups takes on ever greater importance for a hospital's competitive positioning. To best leverage the organization for success, finance executives and clinicians need to work together and build understanding. In the following roundtable, HFMA, with sponsorship from VHA Inc., asks five thought leaders to recommend ways that finance executives and clinical staff can break down the barriers between them.

What advice would you offer to finance staff when communicating with clinical performance improvement leaders?

Kenneth Smithson: Recognition is the first step toward resolution. Finance people should acknowledge right off the bat that they may not understand how some of the clinical issues affect their business.

On the flip side, the performance improvement teams often view the finance people as 'overseers' by virtue of the budgetary process. In addition, most clinicians have little understanding of the terminology or methods that are often used in finance. And they typically do not receive a lot of this information. Nursing staff are asked to manage staffing budgets, not financial budgets. There is a real gap between finance and clinicians that needs to be closed for them to work together effectively.

Maureen Bisognano: It's true that clinical people don't really understand finance processes well. At the Institute for Healthcare Improvement, we are trying to help clinicians develop the skills and knowledge to translate processes into financial terms.

The finance side can help clinicians develop this understanding in several ways. If finance is able to offer a short course on these issues at a nursing or medical staff meeting, it would go a long way. Also, if finance people could make waste more visible in the budgeting process, it would make it easier for the clinical side to understand the need for efficiencies, particularly when times get tough.

There is tremendous waste in the system, but healthcare professionals haven't been effective tackling it yet because it hasn't been universally defined.

They also haven't been positioned well to use necessary improvement methods. In finance, we tend to give middle managers budgets that have FTEs, overtime, and supplies. And when we ask them to cut the budget, they go straight to these line items. But cutting staff and resources or leaving positions vacant is not the only answer to a financial crisis.

John Byrnes: Focusing on obtaining the necessary buy-in to efforts also is important. Clinicians often feel that cost containment is the hospital's responsibility, and not theirs. In working with physicians in particular, it is important to keep that in mind. Cost won't be the primary motivator to that constituency.

What do you think is the general mindset regarding performance improvement, and are there ways this should change?

Kenneth Smithson: Often healthcare organizations sponsor performance improvement activities because they figure they have to, due to joint commission or federal or state requirements. They also tend to focus solely on cost savings, rather than the whole financial picture.

It may come as a surprise, but our research shows that cost savings associated with performance improvement efforts tend to be minimal. There are some complex reasons for this—reimbursement, payer mix, and other issues—

but the most important reason is that most of the resources in the hospital are fixed expenses. We approximate these to be between 85 percent and 90 percent of total costs. True variable costs are only 10 percent to 15 percent of the total expenses. So it is not very likely that performance improvement teams can have a real short-term impact on such a small sliver of the hospital's costs.

Other industries that have high fixed costs—such as manufacturing and transportation—are not focused solely on cost reduction. Rather, they concentrate on how they can maximize the current value of their resources, such as people and IT. The more units that they put through their plants, the higher their profit margins are.

You can apply the same logic to performance improvement in health care. You want to reduce medical errors and maximize capacity, so you need to look beyond cost reduction. Skimping on the resources you need to get a good outcome will likely increase medical errors, and efforts to minimize use of expensive equipment, pharmaceuticals, and other resources can have a negative impact on capacity.

Bill Ward: Health care for a long time has tried to minimize costs. What we need to do is maximize the effectiveness of our investments in staff and equipment. You are not going to reduce cost because it is basically fixed. But if you can improve quality, you can reduce length of stay and bring more patients through. It is not that different from other industries that are trying to maximize their capacity. When you backfill the capacity that you have opened up, you take in more revenue.

PARTICIPANTS

Maureen Bisognano is executive vice president and COO for the Cambridge, Mass.-based Institute for Healthcare Improvement, and coauthor of *10 MORE Powerful Ideas for Improving Patient Care*.

John Byrnes, MD, is senior vice president of system quality at Spectrum Health, Grand Rapids, Mich. The not-for-profit system serves western Michigan through seven hospitals and more than 140 service sites.

Joyce Zimowski, FHFMA, CPA, is senior vice president of Park Ridge Hospital, part of Unity Health System in Rochester, N.Y. Previously, she was vice president of financial performance improvement for the system.

Bill Ward is associate professor and director of the Master of Health Science Program in Health Finance and Management at Johns Hopkins Bloomberg School of Public Health.

Kenneth Smithson, MD, is vice president of research, VHA Inc., Irving, Texas. He has authored more than a dozen monographs focused on patient safety and clinical improvement programs.

Maureen Bisognano: When helping others to adopt effective views about improvement, we use a framework that we borrowed from Japanese quality guru, Noriaki Kano. He describes three key aims of quality initiatives: 1) eliminating quality problems that arise because consumer expectations are not met 2) reducing costs significantly while maintaining or improving quality 3) expanding the expectations of consumers by providing services that they perceive as unusually high in value. These three types of initiatives provide a way of understanding the relationship between quality and cost—as well as providing a basis for an integrated approach to improving care.

There's also the impact that quality improvement can have on market share. Can you talk about that?

John Byrnes: When an organization is meeting and exceeding national benchmarks, it can become a competitive issue. Here at Spectrum, we are trying to use clinical excellence as a way to increase market share. For example, we can currently report our performance on more than 50 clinical and surgical conditions that represent probably 60 percent to 70 percent of our volume. Our competitors can't.

On our web site, we post quality report cards on eight major conditions and procedures [available under “Quality Report Cards” at www.spectrum-health.org].

Joyce Zimowski: Unity recognizes that payers, government, and patients are increasingly interested in quality indicators. For the past two years, we have posted our performance against national benchmarks in about 15 different areas on part of our web site [available at www.unityhealth.org/quality_c2c.asp]. Quality is tracked in relation to child-birth, emergency care, heart care, the intensive care unit, and infection prevention. This section of the web site is second only to job listings in the number of hits it receives.

What effect do you think pay-for-performance initiatives will have on these functions?

Joyce Zimowski: In addition to working with CMS (the Centers for Medicare and Medicaid Services), Unity is involved in pay for performance with a local Blue Cross plan. Our agreement includes an increase in our inflation factor over a three-year period if we achieve certain indicators.

John Byrnes: Some of our quality programs have actually become revenue centers. With pay for performance this year, we had more than \$6 million in improved revenue coming to the organization—that has really helped to accelerate the alignment between finance and clinicians.

What are some of the unknowns related to pay for performance?

Kenneth Smithson: Under some of the CMS proposals for government programs, hospitals would need to revise coding to be able to show complications that occurred prior to admission and during admission. The expectation is that there would be reduced reimbursement around complications. If that happens, there will be a huge incentive for hospitals to focus on performance improvement initiatives.

But if you look at the current quality indicators, that is not always the case. For example, the myocardial infarction measures are designed so that most of the payoff occurs outside of the hospital. Giving patients aspirin, offering smoking cessation counseling, and prescribing medications, such as beta blockers, at the time of discharge are important strategies for improving long-term clinical outcomes. However, such actions have no impact on hospital mortality and morbidity. Elizabeth Bradley, MD, and her group at Yale New Haven Hospital recently reported that even when the admission measures are included, less than 6 percent of the variation in outcomes for heart attack patients can be explained by the cardiac indicators. At present, hospitals may expend a lot of resources in areas that will have no impact on their outcomes.

Bill Ward: In addition to establishing useful incentives, selecting which measures to reward can be challenging in itself. I like the notion of pay for performance as long as there is a way to accurately describe the performance. You don't want to compete on cost, you want to compete on value—the intersection of cost and quality.

What processes can organizations use to help finance and clinical teams work better with one another?

Bill Ward: Transparency of information is critical. In finance, we sometimes assume that because we can read the reports, everyone can. Yet a lot of clinical people don't understand the reports that they receive. Finance staff should take the time to walk through the reports so that clinicians understand revenue, expenses, and charges.

Joyce Zimowski: A lot of times, it's just about bringing the two groups to the same table. Our chief of surgery, a general surgeon, is a big champion of performance improvement and cost efficiency. When looking at various high-volume procedures by general surgeons, we found a big variation in practice patterns and utilization. For example, when closing after laparoscopic cholecystectomy, the data showed that our chief used hand sutures while others were using

staples and staple guns, which were more costly. The chief decided to present the blinded data at a division meeting. All the surgeons discussed why they used staples, and they decided that there was no good clinical reason. So they agreed that that they would go back to simple suturing.

John Byrnes: The best process to put in place is to get the finance people to join the quality improvement teams. When they do, their perspective becomes larger.

Also, at Spectrum, we use financial databases—most often the cost-accounting systems—to provide the data for clinical reporting. Once I have done that and the clinicians understand where the data are coming from, it broadens their perspective. Eventually, we want to get to the point where we have one database that can be used for quality reporting and financial reporting. We should have that in place in another three to six months.

Another thing that works here: As a physician representative, I often switch places at meetings with our vice president of hospital finance, Joseph Fifer. He will do the quality report, and I will do the finance report. Although we received a big chuckle the first time we did this, it worked because we had prepped each other so well. By doing this every so often, we show that quality and financial performance in an organization are everyone's responsibility, regardless of where they are coming from.

Maureen Bisognano: I think it is also useful to examine how successes are viewed. There is a managerial process that we see in every other industry but rarely in health care: They actually note this year's savings on their budgets for next year. In health care, the budgeting process tends to start by picking up last year's spending. When that happens, the savings from clinical improvements tend to get erased. Why should clinical teams work so hard if there are no changes coming from it? By reviewing successes, we encourage future improvement efforts.



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When it comes to investing in clinical performance improvement, where should organizations focus their efforts?

Kenneth Smithson: Performance improvement initiatives don't all have the same value, and some require more resources than others. One that has received much publicity recently is computerized physician order entry. Hospitals are looking at investing millions of dollars in IT, staff training, and new processes. But the payoff is really not well demonstrated.

We need to look at other areas, such as controlling hospital-acquired infections. This probably has a much greater bottom line to the hospital. If you can avoid infections and open up bed days, you can put more paying patients in the hospital.

Clearly, hospitals need a process to determine which performance improvement initiatives to invest in. At VHA, we have developed a spreadsheet tool to provide a standardized approach and nomenclature to this process. By plugging in some basic data, performance improvement teams can perform a cost-benefit analysis to determine the potential payoff and impact on cash flow, which should be of enormous interest to financial people. [This tool is available at www.vha.com. Click on "research" under the clinical quality improvement section.]

What is the best way for finance to understand some of the special challenges that affect clinical performance and motivate individual change?

Maureen Bisognano: When any administrator understands what is happening on the front line, they are compelled to action. More and more, we are seeing CFOs "adopt" a unit, such as intensive care. They make rounds with a nurse once a week and talk to staff about safety and other problems they see.

Such visits may be awkward for both sides at first. Finance people may not know what to say, and nurses may feel wary because they think they are being inspected. But relationships develop over time. A simple question that a finance manager can ask of nurses is, 'What are you worrying about today?' Also, to ease the process, finance should first select a unit where there is strong, natural leadership between the physician and nurse management. That is a good place for finance to get their sea legs.

Bill Ward: Executive walk-arounds can be very productive. At Hopkins Hospital, each of their vice presidents has adopted a nursing unit. It gives them a different perspective on their business.

If you are going to run an airline company, you don't need to be a pilot. But you do need to understand the business. The business of hospitals is not in finance. The business of hospitals is on the floor. And that is where finance needs to be.

Besides the people issues, what are some of the challenges organizations face when putting dollars behind clinical improvement and patient safety initiatives?

Joyce Zimowski: In most healthcare organizations, capital equipment and other business ventures require a certain ROI to be readily funded. But the impact of new ideas or equipment purchases is not easily obtainable. Also, hospitals are very complex organizations. Healthcare consultant E. C. Murphy, PhD, has concluded from extensive research that health care is eight times more complex than other service-oriented industries. Because of that complexity, making changes tends to be more difficult.

Bill Ward: The reality is this: You need to take a broad-brush view of clinical improvement. If you only look at what is happening on the floor, you may be missing what is happening further down the chain. For example, if you can empty a bed on the floor, you may be able to empty a bed off of the intensive care unit. With more beds open in the intensive care unit, you may not need to divert as much. Being on divert in the emergency department carries a pretty heavy financial penalty: The cost stays, but the revenue bypasses you. So, if you can improve throughput, you can improve your revenue. It is a way to expand capacity for free. In other words, by improving quality, you are able to leverage your fixed costs like a champ.

Kenneth Smithson: Hospitals want to improve the health of their communities. Their ability to carry out this mission depends on their clinical and economic success. Unfortunately, the current financial model may not reward them for patient safety and clinical excellence.

The greatest challenge is creating a vision in which better care can be translated into better business decisions. Ultimately, the business case and the clinical case must resonate with the mission. If organizations can accomplish that, there is no limit to the good they can do.



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