



# The Governance Institute's E-Briefings



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## Welcome to The Governance Institute's E-Briefings!

This newsletter is designed to inform you about new research and expert opinions in the area of hospital and health system governance, as well as to update you on services and events at The Governance Institute. Please note that you are receiving this newsletter because you are a Governance Institute member or expressed interest at one of our conferences.

### Managing the Margin through Quality

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Managing the margin through quality—specifically, more efficient clinical delivery—has become a critical component of the healthcare revenue cycle. However, we often overlook it in the midst of this churning and evolving healthcare environment. Typically, labor is tagged as the most expensive line item. The truth is, significant financial potential is hidden in clinical gaps. It appears as redundancy, re-work, readmissions, unclear instructions, hospital-acquired infections, falls, medical errors, scheduling conflicts, wrong-site procedures, and medically unnecessary delays.

Financial executives in hospitals across the country are taking notice—some in surprise—as they begin to focus on the relationship between clinical quality and profitability. These financial leaders are aware that the predominant number of hospital processes are clinical—processes that veil incremental, yet potentially significant contributions to the bottom line. Analyzing the return on capital requests for costly durable medical equipment and similar budget requests from service lines are familiar territory for most financial leaders. *This* cost analysis is quite different.

### Why Now?

With increased transparency and aggressive financial incentives, healthcare organizations are being held accountable to rigorous standards of “Always” and “Never.” As a result, *every* step in a clinical pathway is subject to scrutiny. Generally, controllable costs embedded in the multitude of steps in a clinical process have escaped thorough examination. Yet through this new lens, the gaps present themselves as glaring opportunities for cost savings and growing the bottom line.

For the most part, the determination of clinical necessity—including the costs and the risks—has been the purview of clinicians. *They should know, right?* Consequently, many financial executives avoid digging deeper into the details as they defer to clinical staff. But their lack of knowledge has implications.

For example, at a recent annual meeting sponsored by the HFMA, a large group of hospital CFOs, controllers, and financial leaders, were asked several basic questions:

- What is the average cost of a fall without complications?
- What is the average cost of a bed sore without complications?
- What is the average turnaround time between the “official” discharge and when the patient actually leaves the room so it could be prepped for the next patient?

Perhaps not surprisingly, no one raised a hand.

## Why Is This Important?

Although the *administrative* process improvements have helped our operational efficiency, it's the focus on the clinical processes that may harvest the most sustainable savings. In the eyes of finance leaders, incremental clinical "tasks" may seem relatively minor when compared to, for example, a radiology purchase. But the cumulative impact of multiple incidences on revenue is profound. The discovery and learning for healthcare leaders is that it is just these relatively *small* things—done frequently and done well—that add up to *big* cost savings.

## Cases in Point

Providence Hood River Memorial is a rural, critical access hospital. Upon studying their patient fall rate, they found that they were tracking 6.1 falls per 1,000 patient days. While this may not seem noteworthy, bear in mind that falls cost hospitals \$15,418 on average<sup>1</sup>—a significant expense for which the hospital will not be reimbursed. And this is a conservative estimate. When Providence *reduced* their fall rate to less than 1.0 per 1000 patient days, they put \$350,000 back into their operations within a year. And patients experienced better outcomes.

Nine years ago here at Baptist Health Care (BHC) in Pensacola, Florida, our average decubitus ratio was 9.0 percent per average daily census. Our efforts to curtail the incidence of decubiti (now a "Never" event), helped reduce that rate to 4.5 percent per average daily census in 2005. But 4.5 percent was still too high. Over the next year we continued a relentless focus on eliminating the incidence of decubiti altogether, and reduced the rate even further to 2.3 percent. For BHC, that adds up to \$756,000 annually. And although we have sustained that savings each year since, we think we can do even better.

## How Did We Do It?

At BHC, we discovered several hidden tasks related to quality that have had a direct impact on our bottom line. And some were unexpected.

For example, our largest hospital is community-based and provides a significant amount of uncompensated care. Much of it is delivered in the emergency room. It is there that we found two tasks related to quality that directly impacts our financial performance: waiting room rounding and discharge phone calls.

Many patients come to our emergency room and leave without being seen. Frequently they will return, and their illness or injury is more advanced or exacerbated. It is then more costly to treat, and more demanding on our staff. For underinsured or uninsured patients, the implication was clear. We realized that it was better for our patients—and more cost effective—if we kept people in the *first* time they came to us.

We've *reduced* our "left without being seen" rate from 4.5 percent to 2.4 percent (even as our emergency room volume has increased 12 percent) by establishing "touch points" in the emergency room waiting areas, such as frequent, purposeful rounding in the ED. This is a triple win. First, reduction in the left without being seen category contributes at least \$1.7 million dollars in gross revenue to the bottom line. Second, we're growing volume. And third, we continue our legacy and commitment to providing the community access to needed emergency services.

Another quality-related task that impacts our bottom line is that we call patients at home within 24–48 hours following discharge—for both ED and inpatient. In fact, we call 100 percent of inpatient discharges. During the call, we assess the patient's progress, their compliance with clinical instructions, and we monitor potential warning signs. In most cases the calls help trigger early intervention, reduce adverse effects, and prevent unnecessary readmission into the hospital. And again, in the case of uncompensated care, while the goal is clinical quality, the impact on the bottom line is direct. To put this into perspective, a

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<sup>1</sup> Advisory Board, "Nursing's cost savings discovery: The prevention imperative" (2009).

recent article in *The New England Journal of Medicine* cited that Medicare paid for \$17 billion in unplanned hospitalizations.<sup>2</sup>

### **Quality follows Culture**

BHC continues to adopt quality-driven tactics to reduce hospital-acquired infections, ventilator associated pneumonia, central line infections, and similar threats. More importantly, the BHC culture helps us discover new ways to cost-effectively serve our patients. Early on in the BHC journey, we made a tough and dramatic shift from being tolerant to being accountable. From some tasks being optional to non-negotiable. From “we vs. they” thinking to aligned teamwork. Our successes in elevating quality scores and improving clinical outcomes have been a direct result of our shift to rigorous accountability—starting with our leaders. One result is sustaining both the clinical and financial outcomes. VHA Southeast recently released their 2008 Hospital Quality Score Report, revealing Baptist Gulf Breeze ranks first and Baptist Pensacola ranks sixth among the 50 participating hospitals in this benchmark group.

We are currently halfway through our fiscal year, and we’re outperforming against budget by \$10 million dollars in net income. We went from projecting an operating margin of 1 percent to greater than 3 percent. Moody’s has taken notice in our improved performance and has given Baptist Health Care a two-level upgrade in our bond rating. We believe this is a strong reflection of our outcomes, especially in an environment where many hospitals are burdened with bond downgrades.

Our own journey has given us the unique ability to help others with a similar mission. For example, our Baptist Leadership Group has partnered with Grays Harbor Community Hospital, a high-performing hospital located in Aberdeen, Washington. Applying these best practices, Grays Harbor went from being a hospital that would occasionally lose \$1 million per month to regularly making \$1 million per month in operating net revenue. To put this into perspective, their operating income improved from 1.5 percent at the start of their journey to 8.3 percent today. At the same time, their clinical quality scores went from next to last in the state of Washington to the upper third. Grays Harbor reduced the number of patients who left without being seen in the ED in half from 4.5 percent to 2 percent or less. Additionally, they reduced their fall rate from 5.5 percent to 2 percent per patient days and length of stay has been reduced to 3.2 days.

In 2008, Grays Harbor received the HealthGrades Outstanding Patient Experience Award for achieving the top 15 percent in perceptual quality for patient satisfaction. And, their journey has been further validated as they are one of two finalists for HealthLeaders Media’s Top Leadership Teams in Healthcare for 2009 among mid-sized hospitals. According to John Mitchell, leader and president of Grays Harbor Community Hospital, “If you pay attention to culture and quality, any hospital can have a great story to tell.”

### **The Bottom Line?**

Research studies have documented the pervasiveness of preventable adverse events, and researchers continue to establish the link between effective communication and reduced litigation. At Baptist Healthcare, our focused efforts have helped us thrive in the midst of a litigious environment. Our claims severity has decreased 70 percent from \$74,000 per case to \$20,000 per case. Additionally, our confidence in our quality care and patient communications has enabled us to absorb additional risk with our liability insurers, which decreased our umbrella premium from over \$1 million to \$500,000.

We continue to evolve in our communications as a means to reduce preventable adverse events, improve quality outcomes and increase patients’ perceptions of care. In fact, we just introduced our Baptist Leadership Group’s newest communication tool, RELATE, into operations to ensure consistent, patient-centered communications. As an organization, we are monitoring the impact of this new protocol on both efficiency and service.

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<sup>2</sup> S. F. Jencks, M. V. Williams, and E. A. Coleman, “Rehospitalizations among Patients in the Medicare Fee-for-Service Program,” *The New England Journal of Medicine*, Vol. 360 (2009), pp. 1418–1428.

Clearly, clinical outcomes impact financial success. In our “no excuses” environment, making those discharge phone calls has not been at the convenience of staff, but rather the requirement of world-class patient care for better quality outcomes. As a result of more rigorous accountability, we have been able to track each of these tasks closely. The fact that these basic steps to improve quality and save lives will also save millions of dollars annually is worth a closer look.

*The Governance Institute thanks Al Stubblefield and Greg Nelson for contributing this article. Al Stubblefield is the author of The Baptist Health Care Journey to Excellence: Creating a Culture that WOWs! He has led Baptist Health Care to numerous accolades including the Malcolm Baldrige National Quality Award and six consecutive years on Fortune Magazine's "100 Best Places to Work in America."*

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