Saving Health Care

"Quality"

The Diamond in the Rough in Helping Us to Save Health Care!

1

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2014
2.2%

2015-2017
-44%

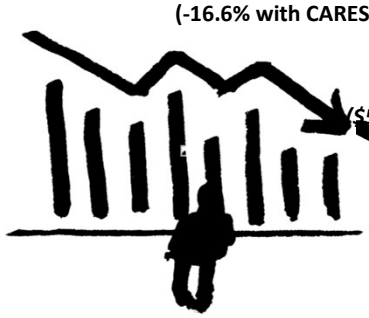
2020
-55%
(-16.6% with CARES)

2021
$94-$122 Billion
($53 Billion with CARES)

Revenues

Handouts

Expenses



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The Cost of Quality For Hospitals!

A Trillion Dollars a Year

- *$600 Billion in Administrative Costs*
- *$380 Billion in the Cost of Medical Errors*
- *$300 Billion in Lost Business Opportunities*

3

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How we lose so much money to the way we manage quality?

How we keep doing it?

How we have to act differently to stop it?

4

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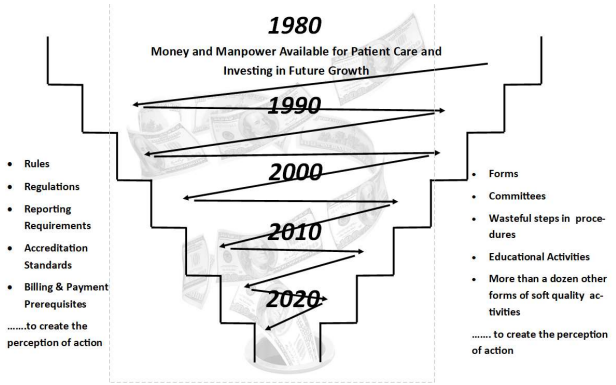
Healthcare's Tit-for-Tat Quality Model



Adapted from the work of James Reason

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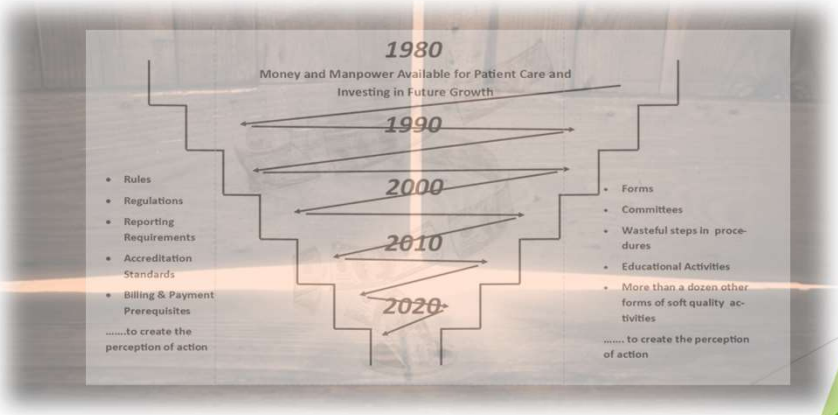
The Losing Game of Tit-for-Tat



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20 minutes
X 3 shifts
X 365 days in a year
21,900 minutes
X 25 patients
547,500 minutes
/ 60 min in an hr
9125 hours
/1800 hours per FTE
5.07 FTEs

7

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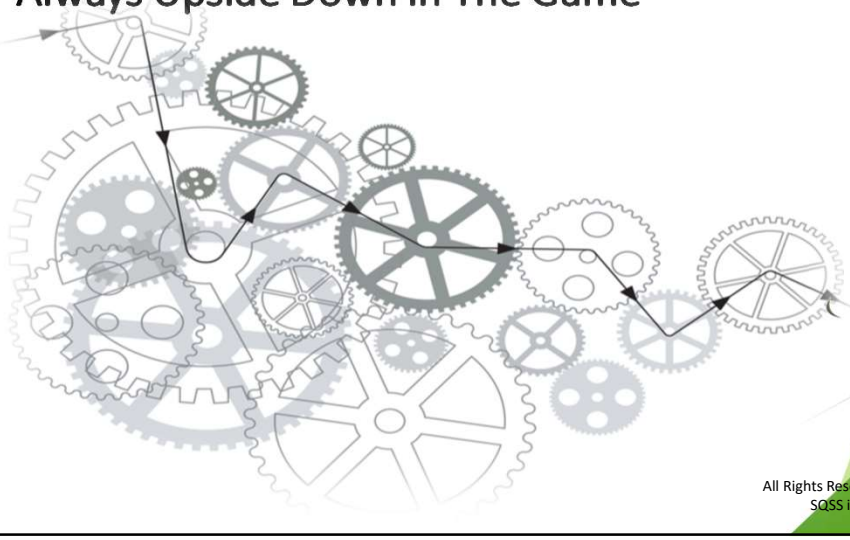
Always Upside Down in The Game



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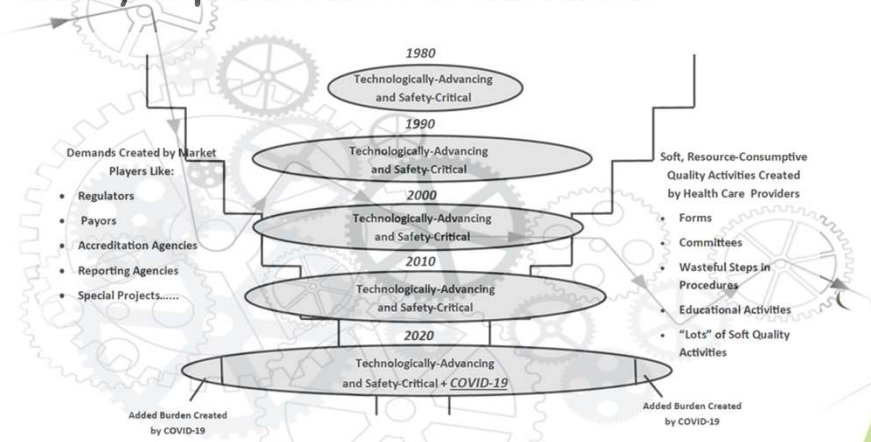
Always Upside Down in The Game



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Antibiotic Stewardship!

- Leaders establish antimicrobial stewardship as an organizational priority.
- The hospital educates staff and licensed independent practitioners involved in antimicrobial ordering, dispensing, administration, and monitoring about antimicrobial resistanc
of initial
- The hosp
program.
- The antib
improve
- The antib
departme
- The antib
leadershi
- The hosp
stewards

Antibiotic Stewardship!

- -Education: Educating practitioners, staff, and patients on the antimicrobial program, which may include information about resistance and optimal prescribing.
- The antibiotic stewardship program monitors the hospital's antibiotic use by analyzing data on days of th
use data to t
Antimicrobia
- The antibiot
improve ant
Exam
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- P
- U

Antibiotic Stewardship!

- The hospital's antimicrobial stewardship program includes the following core elements:
- Leadership commit
technology resource
  - Accountability:
  Experience with
- Drug expertise: App
antibiotic use.
- - Action: Implement
treatment need, afte
after 48 hours).
  - - Tracking: Monitorir
information on antib
  - - Reporting: Regular
which may include i
relevant staff.

Antibiotic Stewardship!

- The governing body appoints a physician and/or pharmacist who is qualified through education, training, or experience in infectious diseases and/or antibiotic stewardship as the leader(s) of the antibiotic stewardship program.
- The antibiotic stewardship program demonstrates coordination among all components of the hospital responsible for antibiotic use and resistance, including, but not limited to, the infection prevention and control program, the quality assessment and performance improvement program, the medical staff, nursing services, and pharmacy services.
- The antibiotic stewardship program implements one or both of the following strategies to optimize antibiotic prescribing: - Preauthorization for specific antibiotics that includes an internal review and approval process prior to use - Prospective review and feedback regarding antibiotic prescribing practices, including the treatment
- The antibiotic stewardship program evaluates adherence (including antibiotic selection and duration of therapy, where applicable) to at least one of the evidencebased guidelines the hospital implements. Note 1: The hospital may measure adherence at the group level (that is, departmental, unit, clinician subgroup) or at the individual prescriber level. Note 2: The hospital may obtain adherence data for a sample of patients from relevant clinical areas by analyzing electronic health records or by conducting chart reviews.

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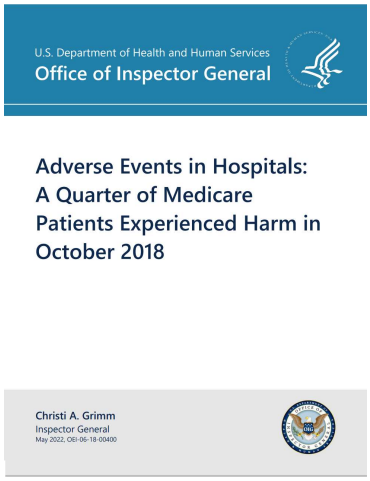

From 2008 to 2018, Medicare patients only saw a 2% decline in medical errors "with no statistically significant improvement in harm-producing errors detected".

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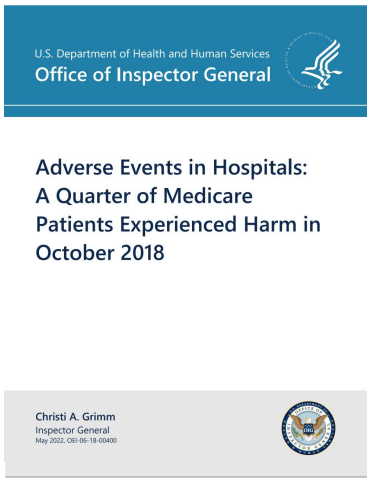

Only 5% were on the list addressed as part of CMS's Hospital-Acquired Condition Reduction Program (HACRP) and , only 2% on its Deficit Reduction Act Hospital Acquired Conditions list (DRA-HAC)!

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U.S. Department of Health and Human Services
Office of Inspector General

Adverse Events in Hospitals:
A Quarter of Medicare Patients Experienced Harm in October 2018

Christi A. Grimm
Inspector General
May 2022, OEI-06-18-00400

RECOMMENDATION:

1. Expand the lists
2. Expand the types of harm addressed as part of pilot projects and special programs
3. Identify and develop new strategies for the hospitals in reducing errors

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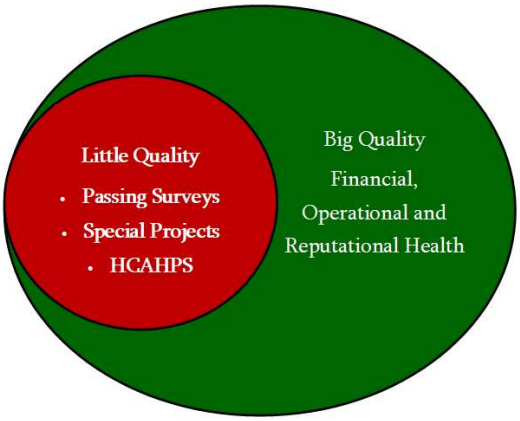

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3 non-value-adding steps
X 500 procedures
X 3 minutes per step
X 200 implementations a year
900,000 non-value-adding minutes
/60 minutes in hr
15,000 hours
/1800 actual work hrs/FTE
8.3 FTEs

5 non-value-adding steps
X 500 procedures
X 3 minutes per step
X 200 implementations a year
1,500,000 non-value-adding minutes
/60 minutes in hr
25,000 hours
/1800 actual work hrs/FTE
13.9 FTEs

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ID	Name	Department	Function
#PRO-20-69566	Cardiopulmonary Scope of Services	Hospital Nursing	Patient Safety
#PRO-20-60090	Cardiopulmonary Services	Hospital Nursing and Emergency Room, Surgery, and Urgent Care	Patient Safety
#PRO-20-94489	Care of Body After Death	Hospital Nursing and Emergency Room	Patient Satisfaction
#PRO-20-83177	Care of Patient with Vancomycin-Resistant Enterococci	Hospital Nursing	Infection Control
#PRO-20-30359	Case for Police Notification	Hospital Nursing and Emergency Room	Public Reporting
#PRO-21-67090	Cellular Phone Usage	EHR and HIPAA and Central Supply, DEPARTMENT MANAGERS, Drug Room, Emergency Room, Hospital Nursing, Housekeeping, Information Technology, Laboratory, Laundry, Maintenance, Physical Therapy, Radiology, Surgery, and Urgent Care	HIPAA Compliance
#PRO-21-48912	Certification Policy	EHR and HIPAA and Anesthesia, DEPARTMENT MANAGERS, Drug Room, Emergency Room, HIM/Medical Records, Hospital Nursing, Housekeeping, Human Resources, Information Technology, Laboratory, Laundry, Maintenance, Medical Staff, Physical Therapy, Providers, Radiology, Surgery, and Urgent Care	HIPAA Compliance
#PRO-21-37654	Chain of Custody Drug Screen Collections	Laboratory and Hospital Nursing	Patient Satisfaction
#PRO-21-30309	Changing of Oxygen Administration Equipment	Hospital Nursing and Emergency Room, Surgery, and Urgent Care	Patient Safety
#PRO-23-07980	Chaperone Procedure	Emergency Room and Hospital Nursing	Patient Safety

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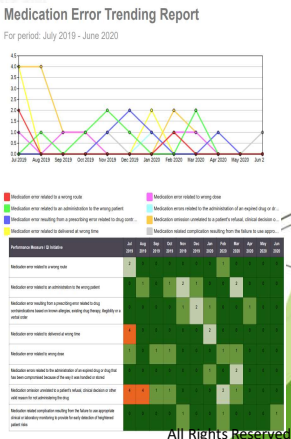

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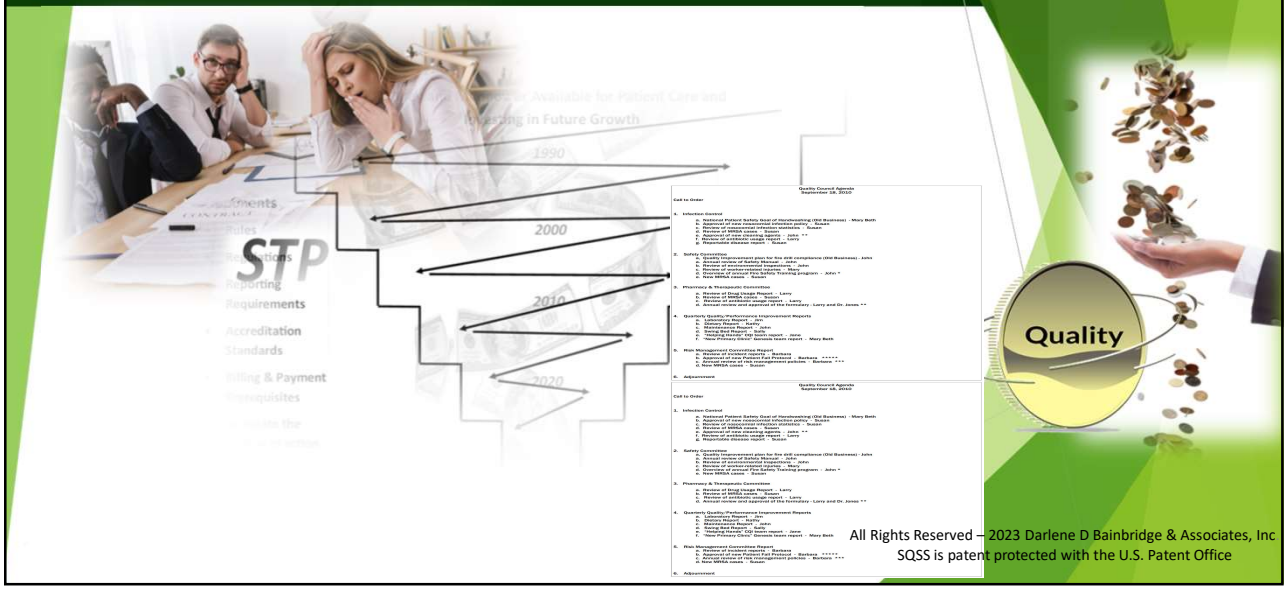

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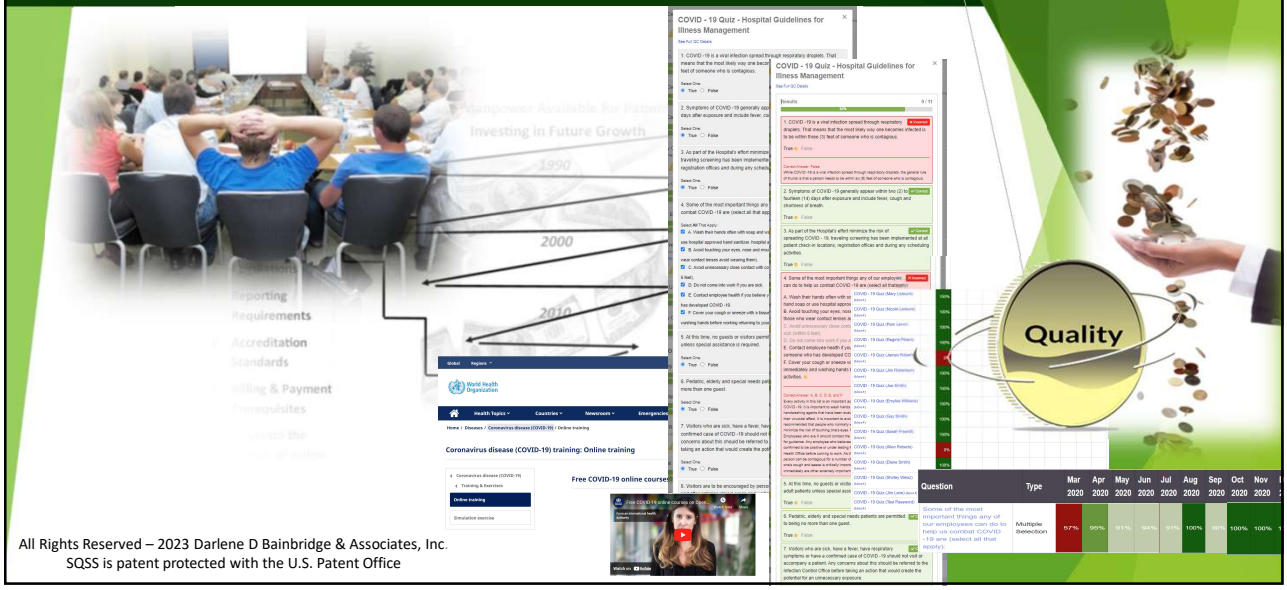

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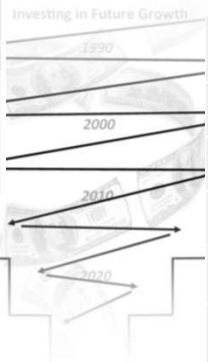

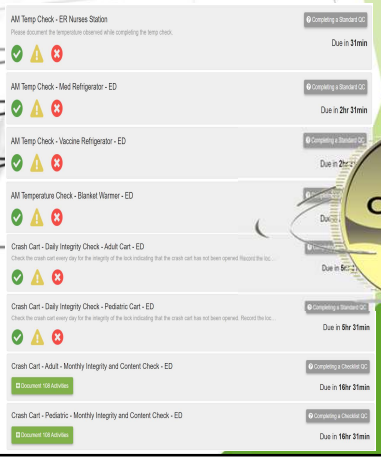

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1:10:100 Rule

1,000

10,000

100,000

1,000,000

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What Can An Incident Managed to the "100" Cost

1. Allocate one hour of time out of the bucket for future growth and into the buckets for fixing the past for the employee who has to spend as much as an hour of time manually completing and submitting the incident report.
2. Move another ten hours of time for the individual who has to initially investigate and manage the event. This is commonly the risk manager who has to receive it, log it, initially investigate it, orchestrate all future reviews and manage its closure.
3. Add on six hours of time into the bucket for fixing the past for the frontline manager that has to be involved in investigating it, talking to unhappy patients and their families and addressing what went wrong.
4. Add three hours of leadership costs for the discussions and involvement of every operational leader that is impacted by the investigation.
5. Add three hours of physician costs for every physician involved if the incident includes a physician-related error.
6. Add one hour of staff time if the incident has to be reported to a regulatory agency.
7. Triple the risk manager costs if the incident involves patient harm or an investigation by an outside agency.
8. Quadruple leadership and physician costs if the error results in long term or permanent harm.
9. If the event requires the creation of a formal corrective action plan for an outside agency that requires long term tracking, they can add in a cost factor of three hours for every quality professional involved and five for each operational and tactical leader for every month they have to manage the plan.
10. The leaders can then add ten to thirty hours of time for the marketing staff if the story associated with the event is negative and becomes public.
11. Triple all costs to this point if the event threatens Medicare certification or a payer relationship).
12. Add the costs for the time of every member of every committee involved in the review of the activity for every time it is reviewed, including prep time.
13. If the incident resulted in additional care because of a change in the patient's plan of care, add in those costs associated with having absorb the cost of that additional care because a DRG and "Never Events" obligation.
14. If the risk requires the notification of other patients because of an exposure and some form of mass testing or treatment, add in those costs.
15. If the incident is a potentially compensable event (an event that could result in a lawsuit), add in the possible costs associated with managing the claim and all related claims for a period of three to seven years (depending on venue) and its (their) potential direct losses.
16. Add in the costs associated with disciplinary or privilege-related actions that are part of the corrective --action plan for a professional staff member.

1:10:100 Rule

1,000

10,000

100,000

1,000,000

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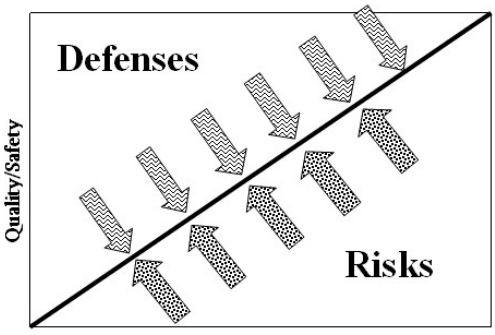

Adapted from the work of James Reason

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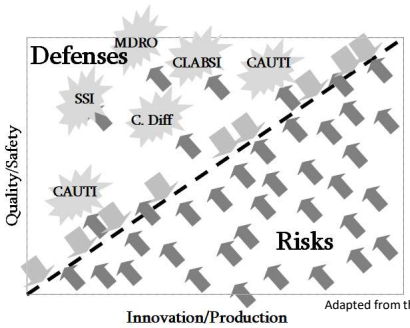
Cost of IC Program

2005 — $80,000
2013 — $140,000
2020 — $220,000



Adapted from the work of James Reason

Cost of Infections

2010 — $10,300
2017 — $14,000
2022 — $25,000—$67,000 +++

$28—$47 billion in hospital costs
$1.9 billion in multi-resistant (2021)

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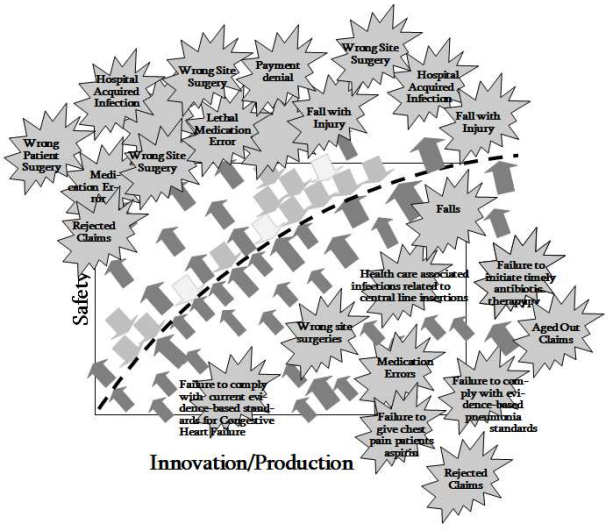

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Cost of Managing to the "100"!

- One infection - $31,000 to $67,000 +
- (CLBSI) - $48,000 to $69,000 +
- One fall - $6,700 to $14,668+
- One CAUTI - $13,793 to $22,568 +
- One ventilator associated infection - $47,238 to $72,587 +
- One surgical site infection - $28,000 to $58,000 +
- One C. diff infection - $17,260 to $35,000 +
- One VTE - $17,367 to $22,898 +
- One preventable pressure ulcer - $20,900 to $51,000+
- One medication error - $5,800 to $15,441 +

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Non-Clinical Costs Associate with "100"!

- Claim denials that are on the rise and estimated to be costing the average hospital more than 5% of their potential earnings.
- $40,000 to $51,700 comes straight off the bottom line every time a hospital loses a nurse.
- A $270,000 loss or more is created every time a turnover rate grows by 1%.
- Costs accumulate as it is estimated that 17% of new nurses quitting within 1 year of hire and 33% quitting within 2 years of hire.
- Then there is the $7 million (+) in loss every time there is a successful cybersecurity attack.
- EHR costs, initial software and infrastructure costs, annual maintenance, additional licenses, upgrade fees, and support costs - including staff FTEs dedicated to the application.

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The cost of poor quality – the difference between the realized cost and losses associated with how a service is delivered or an activity is carried out and what the much larger gain and smaller cost could be if the performance was laser focused on getting it right the first time in the most business smart, defect-free and customer-focused ways possible.

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Quality – how well a business or group does anything and everything it does in the most business smart, defect-free and customer-focused ways possible so to have the best chance of succeeding in an increasingly competitive, cost conscious and consumer-driven world.

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The Cost of Chasing New Money Without Managing the Quality Side of the Coin!

A multi-million dollar piece of diagnostic technology

Revenue
Net patient service revenue
- Minus revenues related to the six month delay
- Minus revenues lost due to scheduling problems
- Minus revenues associated with physician support issues
- Minus lost revenues because of poor stories on social media sites

Total Revenues

Expenses
Salaries and professional fees
- Staff Turnover

Employee benefits
Supplies
Purchased Services
Depreciation
Insurance
- Malpractice claim

Provision of uncollectable accounts
- Unable to bill procedures for first two months
- Wrong billing codes
- Lack of prior approval
- Untimely filing
- No follow-up for rejected claims

Rent and utilities
Repairs and maintenance
Interest
Other
- Five patient complaints and error investigations per month

Total Expenses

Operating Income

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Money

Quality

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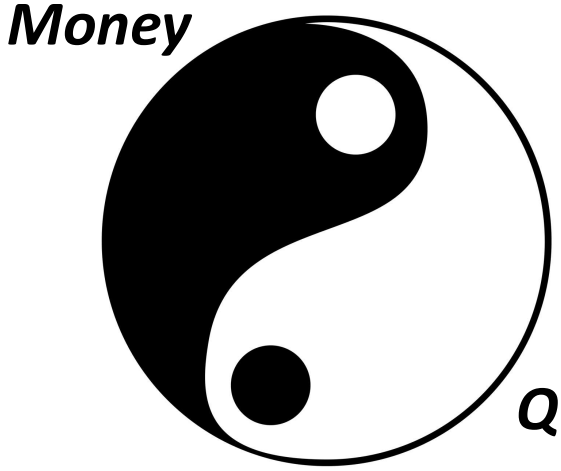

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What does it mean to be in the 95th percentile on a question where the herd is running tight and its collective performance is only 67%.

What do it mean if that question that has nothing to do with what decides whether a patient feels so well cared for and personally cared about that he or she will be back with family and friends in tow because of the great stories they have to tell?

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Is it one more activity in the game of Tit-for-Tat where we pretend that it means that we are winning

or

is it how we position ourselves to survive in an increasingly competitive world?

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