

✓ Saving Health Care

“Quality”

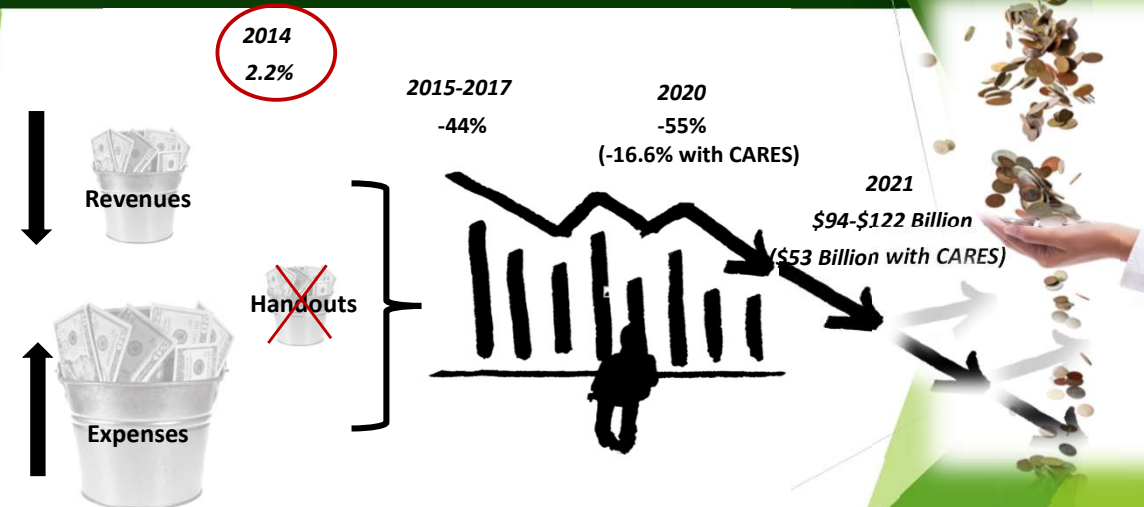
The Diamond in the Rough in Helping Us to Save Health Care!



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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

Expenses

Handouts

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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*

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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?

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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



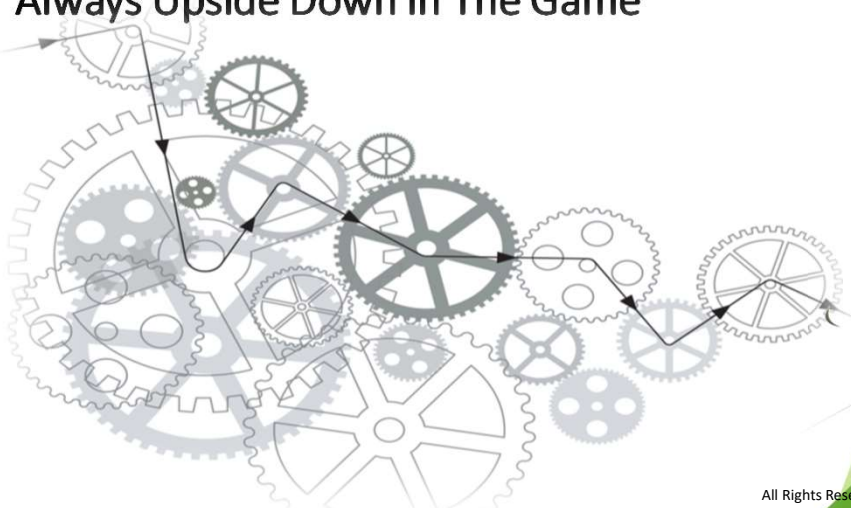


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Always Upside Down in The Game



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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 education, administration, and monitoring about antimicrobial resistance.
- The hospital may include information about resistance and optimal prescribing.
- The antibiotic stewardship program monitors the hospital's antibiotic use by analyzing data on days of therapy.
- The antibiotic stewardship program includes the following core elements:
 - Leadership commitment
 - Accountability: Experience with antibiotic use.
 - Action: Implement treatment need, after 48 hours).
 - Tracking: Monitor information on antibiotic use.
 - Reporting: Regular which may include 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 evidence-based 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. The hospital may obtain adherence data for a sample of patients from relevant clinical departments by analyzing electronic health records or by conducting chart reviews.


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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
No. 022-034-06-19-0003



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



**Adverse Events in Hospitals:
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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)!

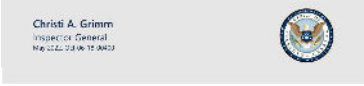
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**Adverse Events in Hospitals:
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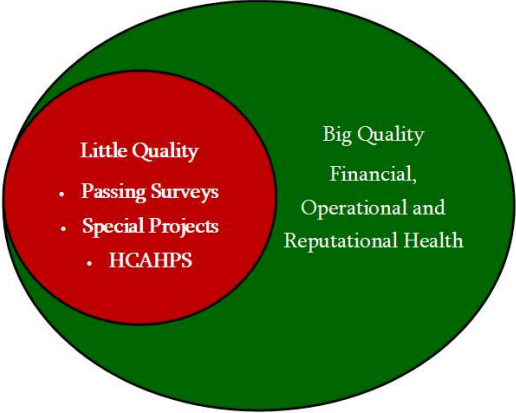
RECOMMENDATION:


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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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-20-84489	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-21-16912	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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Manpower Available for Patient Care and Investing in Future Growth

1990
2000
2010
2020

STP

- Accreditation Requirements
- Billing & Payment Requisites
- Compliance
- Data Analytics
- Financial Management
- Information Systems
- Legal & Regulatory
- Marketing & Sales
- Operations & Logistics
- Quality Improvement
- Risk Management
- Staffing & Human Resources
- Supply Chain Management
- Technology & IT
- Training & Education
- Compliance & Ethics
- Environmental Health & Safety
- Facility Management
- Patient Safety
- Regulatory & Accreditation
- Research & Innovation
- Strategic Planning
- Sustainability
- Vendor Management
- Workforce Management

Quality

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Quality

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1:10:100 Rule

1,000
10,000
100,000
1,000,000

Quality

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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 bucket for fixing the pot for the employee who has to spend as much as an hour of time manually completing and submitting the incident report.
2. Move together ten hours of time for the individual who has to manually 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's closure.
3. Add one 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 event.
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 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 of the story associated with the event is negative and becomes public.
11. Triple all costs to this point if the event threatens the brand, reputation or a major white table.
12. Add the costs for the time of every committee involved in the review of the activity for every time it is reviewed, including sleep 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 about 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

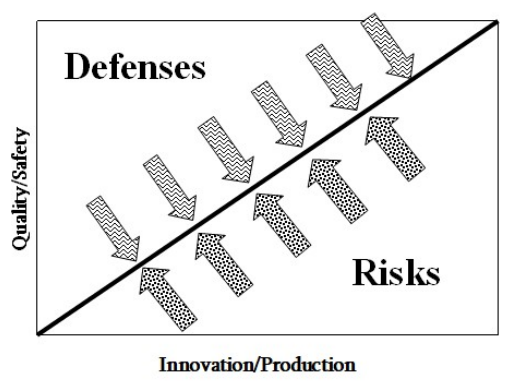
1,000,000




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Cost of IC Program

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

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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Safety

Innovation/Production


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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
<i>Missed revenues related to the six month delay</i>
<i>Missed revenues lost due to scheduling problems</i>
<i>Missed revenues associated with physician support issues</i>
<i>Missed lost revenues because of poor stories on social media sites</i>
Total Revenues
Expenses
Salaries and professional fees
Staff Turnover
Employee benefits
Supplies
Purchased Services
Depreciation
Insurance
<i>Malpractice claim</i>
Provision of uncollectable accounts
<i>Unable to bill procedures for first two months</i>
<i>Wrong billing codes</i>
<i>Lack of prior approval</i>
<i>Untimely filing</i>
<i>No follow-up for rejected claims</i>
Rent and utilities
Repairs and maintenance
Interest
Other
<i>Five patient complaints and error investigations per month</i>
Total Expenses
Operating Income

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Money

Quality

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Money



Quality




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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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