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Driving Out Clinical Variation to Drive Up Your Bottom Line

Hospitals have always worked to be efficient. Now more than ever, it is increasingly important to reduce costs to offset growing financial pressures. These pressures come from an array of drivers such as; ongoing challenges from lower Medicare and Medicaid reimbursement and the shift to consumers paying more out-of-pocket for healthcare. And while there are many ways for hospitals to tackle cost cutting, an area that tends to not be explored enough is the opportunity to improve clinical resource management.

Typically, the conversation to reduce cost begins by looking at workforce productivity and the supply chain. Many facilities have squeezed all they can from current labor and supply chain processes. They have pushed their staffing levels to top quartile or decile performance and have maximized supply chain contracts through their GPOs or locally negotiated agreements.

These areas are valid and essential to review; however, a hospital can miss millions of dollars in savings without also addressing clinical resource management. Care variation costs the industry billions each year. In a JAMA essay, former CMS administrator Don Berwick and RAND researcher Andrew Hackbarth found that failures of coordinated care costs $25 billion to $45 billion in 2011.

Additionally, Harvard Business Review found that clinical waste (where clinical operations improvement work is needed) accounts for 14 percent of health care spending in 2015.

Types of Waste in U.S. Health Care Spending

Category	Description	Percent of Health Care Spending
CLINICAL WASTE	Spending that could be reduced with better prevention or higher-quality initial care; replacing services with less-resource-intensive alternatives; or improving process by standardizing best practices	14%
ADMINISTRATIVE COMPLEXITY	Spending that could be eliminated with simpler, more-standardized processes for billing and collections, credentialing, compliance, and oversight	9%
EXCESSIVE PRICES	Overspending resulting from paying high prices charged by inefficient suppliers (including providers), which could be eliminated by tying prices to efficiency, outcomes, and a fair profit	5%
FRAUD AND ABUSE	Spending associated with illicit schemes to extract payments for illegitimate delivery of health care services	7%

Source: Harvard Business Review

The next evolution of cost reduction is in addressing how care is delivered. Reimbursement changes and patient volume shifts to more chronically ill inpatients and higher outpatient volume demand a fresh look at resources and how they are utilized across the continuum.

Clinical operations house many hidden expenditures. **Are these hidden expenditures increasing your costs?**

- Unnecessary inpatient stays
- Insufficient discharge or post-discharge communications
- Inadequate communication back to primary care providers
- Admissions through the ED that should be direct admissions
- Unnecessary or redundant testing
- Treatment inefficiencies (i.e. certain services being arbitrarily unavailable on certain days)
- Operating room supply utilization
- Ordering patterns
- Inappropriate level of care (i.e. unneeded ICU or IMCU time)

To improve clinical resource management, hospitals need to maximize the benefit of organizational expenditures through reduction of variation. Improving efficiencies in this way can be achieved through two distinct approaches: **1)** making sure patients are treated in the right setting of care, with the right clinical, workforce and supply chain resources; and **2)** prioritizing capital expenditures to achieve improved financial performance.

To understand variation in practice patterns, hospitals should look at how much extra care is being provided to patients that will not positively impact outcomes. This approach will improve quality outcomes and reduce costs along the way.

Utilizing data to inform reduced length of stay initiatives and decrease resource consumption within specific patient populations would lead to the greatest savings. Along each step of the continuum of care and using established benchmark data, look for pockets of elevated cost and identify strategies for improvement.

Hospitals and health systems around the U.S. need to develop strategies and plans to answer this key question, ***"How are we helping patients progress toward discharge?"***

One example of a healthcare system determined to answer this question, is in Southern California. As the only game in town, the hospitals' volumes were approaching capacity; therefore, resulting in throughput and LOS issues, case management roadblocks, patient placement inefficiencies and care variation challenges. The health system engaged Quorum Health Resources (QHR) to drive improvements and focus on evidence-based care.

The focus areas listed below helped the health system identify opportunities for improvement that reduced LOS at one campus by 0.74 excess days per case and 0.58 excess days per case at the other campus. The financial value of these improvements realized to date is over $13M.

- **Patient Management Accountability**
  - **Challenge:** From lack of accountability to inconsistent tracking of available beds in between units—patient placement needed improvements.
  - **Solution:** By implementing an effective structure and process to provide the right level of care, in the right place, at the right time, the care team maximizes skill sets and resources to meet patient needs.

- **Interdisciplinary Care Coordination**
  - **Challenge:** LOS needed to decrease and patient satisfaction needed to increase through improved care coordination between physicians, bedside nurses and case managers. Additionally, the health system lacked a consistent, structured interdisciplinary communication process.
  - **Solution:** QHR's team worked onsite with the health system to facilitate meetings with nurses, physicians, case management and ancillary to create a plan for the day and a plan for the stay for each patient. This facilitated improved communication throughout the continuum.

- **Case Management and Social Work**
  - **Challenge:** An inconsistent escalation process and limited reporting created bottlenecks in patient flow.
  - **Solution:** By retooling the case management processes and roles, the system can now provide patients and their families with a proactive discharge plan that effectively meets their needs for a safe discharge.

- **Care Variation**
  - **Challenge:** Service lines have associated high costs, high volume and high variability, with a minimal use of established order sets and pathways.
  - **Solution:** QHR is starting the work for this in October 2017, which will include one-on-one time with physicians to share data and influence physician practice patterns while focusing on evidence-based care.

The CNO expressed how excited he was to see positive results in such a short period of time. "This project is a top-priority for us and we are deeply committed to sustaining the success after the engagement ends. It is hard work, but the work is well-organized and well led by QHR's team. In just six months' time—we are already experiencing positive results. We are excited to see what the rest of the engagement will bring—particularly in regards to the reducing care variation portion, which we have not begun work on."
To have your "house in order" so to speak and create a clinical resource management blueprint, you can start by looking at the following:

- **Cost per Case Opportunity**
  - Assess your ability to reduce the overall cost per case, and improve the overall capacity through opportunities in length of stay, level of care, and resource utilization relative to peers.

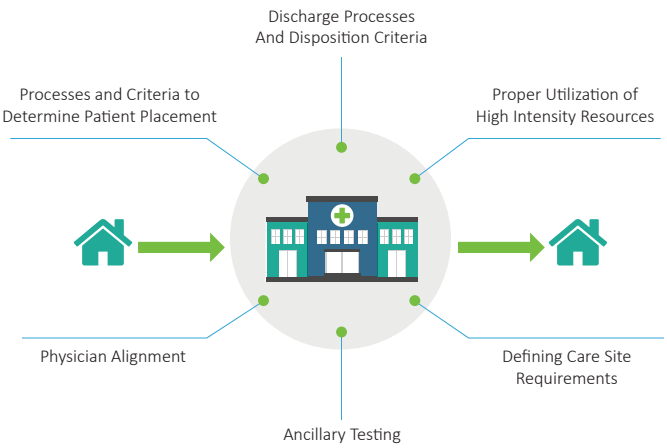
- **Service Line Approach**
  - Determine the patient-centered quality and cost opportunities in high opportunity primary service lines.

- **Care Variation**
  - Identify clinical variation opportunities and process gap analysis relative to many factors; including readmissions, complications, mortality, and level of care by DRG, service line, physician and other select populations.

- **Focus on Ability to Implement**
  - Outline the most leveraged opportunities to deploy teams to implement the clinical resource management blueprint recommendations.

A collaborative, multidisciplinary approach identifies inefficiencies along the care continuum that drive up total costs, resource utilization, length of stay and inappropriate level of care: clinical staff utilization and efficiency; supply costs and physician preference items; utilization of high intensity resources; physician alignment; ancillary testing; and level of care. This approach enables hospitals to address

Address Inefficiencies Along the Care Continuum



inefficiencies throughout the care continuum. QHR employs this approach after a thorough clinical analysis, which includes interviews with executives, physicians, management, nursing staff, case managers, social work staff, techs and other key departments. These interviews help us understand where your hospital is and how we can get you where you need to be. An assessment will also be conducted, which requires an integrated data set in the areas of quality, patient satisfaction, utilization and operational performance (among others). This data should then be compared to benchmarks to identify strengths, weaknesses, opportunities and threats. The assessment provides a road map for focused performance improvement.

To learn more about how improving clinical operations can reduce costs at your hospital, please contact Michele Mayes at **MMayes@QHR.com.**

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Harvard Business Review, How the U.S. Can Reduce Waste in Health Care Spending by $1 Trillion, Oct. 13, 2015, https://hbr.org/2015/10/how-the-u-s-can-reduce-waste-in-health-care-spending-by-1-trillion

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