Greenlight Issues for the CFO: Investing in Patient Safety

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The new actors, a new stage, new roles, and new threats in health care, it is time to define new roles for chief financial officers (CFOs) and financial executives more than a supporting player in the unfolding drama of our industry. A tsunami of cost containment has hit, and spending on performance improvement is key to survival. Survival of our current financial crisis will require great financial leaders.

Fairly or unfairly reflecting reality, many in the quality and patient safety leadership positions bemoan that the role of the CFO has been to say "No" to spending on performance improvement. Yet, changes in health care will mandate new coalitions and new partnerships between players who are often on opposing sides of budget debates.

The next generation of great hospital leaders may come from the ranks of our finance leaders, who can help translate core values into bottom line performance by educating themselves in the financial impact of performance improvement. There are a number of "greenlight" issues with great potential for performance improvement, which include performance envelopes, chasing zero infections, impact scenarios, legal myths, quality teams and financial know-how, changing revenue assumptions, readmission red-ink revenue, coding issues, evidence-based point estimates, delegated purchasing risk, vendor risk, cost of technology adoption, cost of leadership failure, and purchaser gain sharing.

The surfers (and survivors) of the "No Outcome No Income Tsunami" will align their teams on a common platform, develop talent, ignite passion, and put the strokes of hard work into action. The art of improving-at-improving will demand a new-found respect of all. Great CFOs could be at the center of the winning teams.

It is a defining moment for chief financial officers (CFOs) and financial executives. Health care is having more than just the yearly crisis du jour. Survival of our current financial crisis will require great financial leaders. Heretofore, finance teams and their financial leaders, have been supporting actors; however, they are being thrust into the spotlight center stage and are becoming the key decision makers and influencers of "greenlight" decisions for investment in patient safety and quality. Taken from the movie industry, this term refers to the action of final commitment of funds to a project that triggers mobilization of a team to action. In current conditions, their vote can either kill or "greenlight" a project. There are key greenlight issues that must be considered and that can be refined by safety reams to enhance the probability of success at obtaining investment and, more importantly, saving lives.

Finance executives will have to take on new skills and knowledge to survive the waves of change that are befalling their hospitals and organizations.[1–3]

The new actors are quality drivers at Centers for Medicare and Medicaid Services (CMS), purchasers, policy makers, and the press. Their impact is creating a new script and new roles for hospital executives.

The new stage is health care reform, the national recession, and transparency. The issues of access, cost reduction, and quality failures will play out at the local level….at your level.

The roles for CFOs will be to develop into educators, diplomats, implementers, negotiators, cheerleaders, and even inspirational leaders. They must become investment advisors in performance improvement.

In the words of Warren Buffett,

> *"If past history was all there was to the game, the richest people would be librarians."*[4]

The new risks lie in the acceleration of the financial-quality crisis. Hospitals have survived and even succeeded through cost cutting; however, changes in reimbursement pose changing risks. We may need to challenge our previous methods. Malcolm Gladwell, author of *Outliers*, shared, in his

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recent article, *Cocksure: Banks, Battles, and the Psychology of Overconfidence,* "As we get older and more experienced, we overrate the accuracy of our judgments." [5] His premise is that our national financial leaders have had minimal feedback on the risks of their decisions, compounded by self-fueling cycles of success. This has led to their being blindsided by the consequences of their errors in judgment. It is critical that they take this seriously and that safety leaders do their best to help finance leaders make the best informed greenlight decisions and vote appropriately regarding investments in patient safety. The consequences of today's financial decisions regarding patient safety may come to rest on the shoulders of the CFO tomorrow.

THE NO OUTCOME–NO INCOME TSUNAMI

Hospital investment revenue is down, self-pay revenue streams are at risk, and capital acquisition is challenging against a backdrop of global financial woes. However, just when it could not get any worse, a tsunami that has been quietly building offshore for years in a climate of stakeholder unrest now threatens all but the best prepared. Pay-for-performance and transparency demands have been hammering our health care leaders in ever more powerful waves. They have now coalesced into an enormous force that is bearing down on our hospitals.[6]

Medical misadventures have risen from the eighth to the third leading cause of death in America[7]

Our incremental approach to patient safety has had some impact. However, with the recognition by the Centers for Disease Control and Prevention that, in the United States, more than 99,000 deaths are caused by infections that we have given to our patients, preventable harm is even greater than we had believed. The issue has become superheated as medical harm has climbed to third on the "cause-of-death" meter.[8]

Factoids capture the attention of the press and consumers during health care reform and the cost gives sticker-shock to even those in the heart of the quality movement. David Goldhill, a consumer, framed our industry when he said, in his article, *How American Healthcare Killed My Father*, that the 100,000 infection deaths are more than double the number killed in car accidents, five times all homicides, and 20 times the troop deaths in Afghanistan and Iraq. Additionally, from his research he concluded,

"All profits from insurance companies and pharmaceutical companies would pay for 11 days of U.S. health care."[9]

Goldhill found that profits from all insurance companies would pay for 4 days of care for Americans. The ten largest pharmaceutical company profits would cover us for 7 days.[9]

We will need to have our finance experts weigh in on more than accounting and transactions. With the advent of hospital-acquired conditions[10] and a growing trend of no-pay for preventable adverse events, we find ourselves at the end of an era of blind health care purchasing.[11]

Many hospitals have survived by playing defense in the arena of quality. For some, every play of their game is to fall on the revenue ball. Fixated on the margin scoreboard, many have not worried about making quality touchdowns as long as the cash flowed and they contained cost.

In our article, *The No Outcome–No Income Tsunami is Here,* we describe how hospital leaders who pull their teams together can build a platform that will surf the waves of payment change; however, this will require that the CFO be at the center of the action—as a designer and leader…in a new role.[6]

Surfers will make things happen, swimmers will watch what happens, and the sinkers will wonder what happened.[6]

NEW ROLE FOR CFOS

As the house lights of our national health care theater come up, our CFOs will be thrust into the floodlights of transparency. Their governance boards are going to expect them to transform from managers to leaders, from managing budgets and accounting for numbers to leading people (beyond their direct reports) and advising on investments in performance.

The days of driving up revenue through volume and cutting silo costs are over. The recently articulated statement of an anonymous CFO, who says what many finance leaders tell us keeps them up at night, echoes words of the past.

"If I can't shut it down or lay it off, you don't save me a dime."

From research of patient safety and quality leaders in our 3100 hospital research test bed,[12] we find that finance and operations executives are often seen as the natural Darwinian opponents of quality improvement and patient safety leaders. Their role is seen as running the "No" department when it comes to spending money on performance improvement. Rightly or wrongly accused, it is the reality. The new changes in health care will create new coalitions and new partnerships between players who are often on opposing sides of budget debates.

Thomas Hamilton, the director of the Survey and Certification Group, Center for Medicaid & State Operations, CMS, the leader in charge of those who descend on your hospital after an adverse event or complaint, is a brilliant public servant who knows what is going on in our hospitals. He has said, "We know that hospitals are dancing in the spotlight. What we are worried about is what they are doing in the dark" [6] It is only a matter of time before the widening lights of transparency reveal the real impact of our cost cuts and failure to invest in our infrastructure.

Harvard professors, Rosabeth Moss Kanter, author of *SuperCorp*[13]; Bill George, former Medtronic CEO and author of *7 Lessons for Leading in Crisis*[14]; and David Gergen, author of *Eyewitness to Power: The Essence of Leadership*,[15] all emphasize leveraging the power of core values in their best-selling business books.

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It is our belief that the next generation of great leaders may come from the ranks of our CFOs and finance leaders who help translate core values into bottom-line performance.

GREENLIGHT ISSUES FOR INVESTING IN PATIENT SAFETY

Great CFOs who rise to the occasion of their new roles have terrific jobs cut out for them. They will educate themselves in performance improvement and then educate their colleagues in the issues of the financial impact of improvement. They will have to face up to the inadequacies of their own cost accounting systems and lack of understanding of cost. They must examine the myths, truths, facts, and fiction about the linkages between clinical, operational, and financial performance.

So what are some of the critical greenlight issues that CFOs, their teams, and safety leaders must address to help them with their decisions and approval of safety projects?

- **Performance Envelopes and Migration of Boundaries:** In our article, *May I Have the Envelope Please?* we describe the hospital-related, near-death incident that happened to the twins of actor, Dennis Quaid. In this article, we illustrated the concept of the performance envelope.[12] Simply put, human beings have a predictable performance zone. Furthermore, their behaviors migrate out of a safety envelope under pressure which, with repetition, becomes invisible to them. We start driving the speed limit; then, over time, we creep up to 10-over, then 15-over and so on. With what is called normalization of deviance—it becomes normal to function out of the legal zone and subsequently out of the safe zone. Many of our mid-level managers are nonclinical. When we call for continuous reductions in staffing, no one knows "where the edge is" until bad things happen. Hospital leaders rarely see the consequences of care after discharge. Herein lies the "gotcha" of episode of care payment—we will have to warrantee readmissions—a huge risk and cost. The Medicare Payment Advisory Commission reported that Medicare spends about $12 billion on potentially preventable readmissions. Episode of care payment system could potentially save these readmission costs.[28]
- **Chasing Zero—The Future:** Infections are no longer the cost of doing business. This is not about return on investment—it is about SIB…"Stay in Business." Soccer moms, senators, and the press all understand when someone gets an infection from your hospital. The fully loaded cost of your last crisis will look like rounding error if you develop a house-wide infection problem. Shorting investment in infection prevention is like not paying for oil changes in a fleet of vehicles. Such deferred maintenance is a time bomb.[29,30]
- **Impact Scenarios and Events:** Adverse events have predictable economic consequences. Knowledge about adverse events in medication management, information transfer, infections, and leadership failure is exploding. Have your safety leaders brief you about your probabilities. If they cannot use your numbers, invest in their education. Risk managers, spending almost all their time managing claims from the past, leave little time for real preventative risk management for current patients or future patients. This is shocking to leaders of other industries.
- **Legal Myths and Truths:** Our legal advisors are woefully behind in strategies for reducing malpractice costs. Disclosure and rapid remediation can save a typical hospital millions per year. Even the *Wall Street Journal* has recognized this issue profiling the University of Illinois and the work of Dr. Tim McDonald.[17]
- **Quality Teams Financial Know How:** The very survival of a hospital depends on converting improvement to bottom-line performance. Your quality, safety, and risk managers can become "chief revenue preservation officers."[4] Ground them in financial terms and tools—you will need to work together. Paradoxically, shrinking the topline through quality will grow the bottom line as purchasers hone in on overuse, misuse, and underuse of care processes.
- **Changing Revenue Assumptions:** Dramatic changes in revenue per unit of care are on the way. Run impact scenarios regarding future revenue but be careful of using historical performance. CMS is expanding the Hospital Acquired Conditions, with a name change to Healthcare Acquired Conditions, telegraphing expansion across patient trajectories. Keep an eye on CMS. Pay-for-performance revenue threats are real and growing.
- **Red Ink Revenue:** It is a big mistake to consider that all revenue is positive. Readmissions consume 60% of hospital resources, yet represent only 15% of patients.[7,18,19] As recently reported by Jencks et al.[20] who studied rehospitalizations in 11,855,702 Medicare beneficiaries, the cost to Medicare of unplanned rehospitalizations is $17.4 billion. This study reported that almost one-fifth (19.6%) of the discharged Medicare beneficiaries were rehospitalized within 30 days, and 34.0% were rehospitalized within 90 days; 67.1% of the patients who had been discharged with medical conditions and 51.5% of those who had been discharged after surgical procedures were rehospitalized or died within the first year after discharge. In the case of 50.2% of the patients who were rehospitalized within 30 days after a medical discharge, there was no bill for a visit to a physician's office between the time of discharge and rehospitalization.

  Many think they are gaining with up-codes and readmissions when they may be bumping high contribution margin cases out of the pipeline, burning out staff, and wasting capacity. When payers close the noose on these issues, it will be hard to break the addiction to bad profits. Yes, there are "bad profits". Rheicheld, author of *The Ultimate Question*[27] defined bad profit as that which is obtained at the expense of customer loyalty. No one noticed when we received revenue for our failures in the past...it was the cost of doing business. Many legislators and quality leaders are going to change that through mandated transparency. This elephant in the room will now have a name.
- **True Cost—Attributable, Avoidable, and Fully Loaded Value Chain:** In our TMIT Greenlight Program, a collaborative which has studied infections in more than 200 frontline hospitals, we found that hospitals do not understand cost structures for individual cases, nor do the academic papers provide enough detail about point reference assumptions. This makes it very difficult for a Corporate Suite team to make a return on investment analysis for a given intervention. We have teamed up with leading hospital systems and national infection-related organizations, composed of infection control specialists and physician specialty societies, to clear up these issues. Our preliminary findings reveal that you need to focus on "attributable cost" for a given infection type and scenario. Then, most importantly, you need to define "avoidable cost," always a smaller number. These should be CFO-validated before a pitch is made for investment. We believe that the numbers can be defined; however, assumptions cannot be directly taken from most academic papers. The ranges are too great and do not easily allow translation. A range of $6000 to $134,000 attributable cost per case gives you no help at all in the board room.[21,22] Safety leaders need to have a CFOs

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greenlight vote counted before presenting a projecf for consideration. This will require numbers that can be backed up and forecasts applied to one's own organization.

- **Confounding Coding Issues:** Coding complexity, payment maximization strategies, and the roll-up coding groups make it difficult to identify cost, revenue, and contribution margin. Carefully unwrap these elements for high volume, high impact scenarios. Our research reveals that many feel paralyzed because of lack of trust in their calculations.
- **Point Estimate Strengths and Weaknesses:** There is much more evidence regarding hospital performance than you may realize. Make sure point estimates from medical papers apply to you as previously noted. Carefully selected and validated, many are very valuable. CFOs and finance teams should press your quality teams on these givens. This will pay dividends.
- **Great Risk of Delegated Purchasing:** Demanding supply cost cuts from nonclinical staff can make us penny wise and pound foolish. For example, iodine surgical prep is cheaper than chlorhexidine, yet purchasing staff has no idea that the second solution can reduce surgical site infections (SSI) by 40%.[23,24] SSIs are a hot area for the federal agencies. Ask your quality teams about supplies when they seek a "greenlight."
- **Vendor Risk—"Trust Me" Versus "Trust But Verified":** Align your vendor incentives with yours (i.e., Pay for verified performance). For instance, computerized physician order entry vendors want to be in and out fast. TMIT operates the computerized physician order entry Evaluation Tool for Agency for Healthcare Research and Quality researchers. Through that, and the Leapfrog survey work, we find big surprises when we validate performance. Make sure to contract for performance.[25]
- **Technology Adoption Cost and Rates:** The soft cost and time to adopt new technologies is almost always underestimated. Make sure these factors are validated and not just "pasted" into proposals. We often find a one-to-one cost ratio of vendor costs to internal adoption and training costs.
- **Cost of Leadership Failure:** The Joint Commission has revealed that the fastest growing risk area is failure of leaders to assure that their staff is adhering to policies and procedures. This represents huge risk. Explore it. According to Peter Angood, MD, former chief patient safety officer of The Joint Commission; "Leadership is one of the more common root causes for sentinel events."[16,26]
- **Negotiating with Purchasers—Win Win Gain Sharing:** There is no reason why you cannot approach your payers with co-investment in programs that both save lives and money. Dr. Allan Korn, the widely respected CMO of the Blues, representing more than 100 million covered lives says: "We can't have value based purchasing until we have value based selling. We are involved with such strategies. They work." [oral communication, Aug. 27, 2009]

CONCLUSIONS

The surfers of the *No Outcome No Income Tsunami*[6] will leverage the power of the wave and blow by competitors who will be caught behind the curve. They will read the horizon, align their teams on a common platform, develop talent, ignite passion, and put the strokes of hard work into action. They will catch the wave and almost magically accelerate away from the ranks. The art of improving-at-improving will demand a newfound respect of all.

Those in finance pride themselves at risk reduction. Now the risk of not acting on safety issues exceeds the risk of inaction. The words of Theodore Roosevelt come to mind about the man in the arena. Now that the spotlight will be on our finance teams, we encourage them to experience the joy of success in the patient safety arena. Like it or not, they will be a very visible combatant in our nation's war against preventable harm. In Roosevelt's speech "Citizenship in a Republic," Sorbonne, Paris, 1910, he states of the man who steps into the arena "if he fails, at least he fails while daring greatly, so that his place shall never be with those cold and timid souls who knew neither victory nor defeat." The greater risk to finance teams is to be timid, not embrace safety as an opportunity to improve care while improving financial strength because inaction will be visible, embarrassing, and painful to them. As counter intuitive as it is to invest in safety now with poor economic conditions what has been the right thing to do in the past is not the right thing to do to get paid. Thoughtfully undertaken, giving the greenlight to some safety projects may be the lowest risk of all.

Great CFOs will be at the center of the winning teams. Godspeed on your journey ahead. There is a payoff for greatness, and it is your time.

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