Success Belongs to Those Who Can Manage Money and Quality as Two Sides of the Same Coin

From Common Sense To Health Cents

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When Mick Jagger and The Rolling Stones sang, "Time is on my side," they certainly weren't referring to the situation that hospitals in particular, and healthcare in general, now find themselves in going into 2022 as:

***IT IS HERE* for the American Healthcare Industry:**

That moment in time *that all entrenched players eventually face in what David Packard, co-founder of Hewlett-Packard, and Jim Collins, the author of so many savvy business books, described as Packard's Law—WHEN LEADERS HAVE TO CHOOSE BETWEEN MORE OF THE SAME ….. OR SURVIVAL.*

Operating for far too long with the same hubris of over-confidence and resulting decline that made the Great Recession of 2008 the American auto industry's equivalent to the COVID-19 pandemic and that almost destroyed it, too many of the country's hospitals are now at that point where the only way out of the financial hole that they have been digging for themselves for more than fifty years lives in getting control of the ever-growing trillion-dollar cost center where the industry keeps sacrificing money to its costs associated with poor quality - ***and start turning those dollars back into spendable cash*.**

The cost of poor quality – the *difference* between the realized cost in delivering a service based on how it is managed and what the bigger gain and smaller cost could be if the delivery process was laser focused on getting it right the first time in the most business-smart, defect-free and customer-focused ways possible. A cost center that is now estimated to be a *trillion-dollar black hole* that hospitals keep dumping money into because of a set of decades-old falsehoods that makes quality an incidental to how hospitals make money and create success. It is the double-edged sword that just keeps hacking away at operating margins because of the dual losses experienced in a safety-essential environment where failing to get it right the first time introduces a whole host of avoidable costs to the "100" in the 1:10:100 Rule while undermining the support and loyalty the industry enjoys from the American people.

They are the kind of avoidable costs that I witnessed day-after-day during my cancer care when safety practices like handwashing — and the lack thereof — caused the hospital to spend way too much money to the "100" on errors while setting itself up to get to spend even more of what would have once been discretionary dollars available for funding future growth on new rounds of rules, regulations and reporting requirements because of how ineffective its internal quality efforts were. Costs that were set to grow exponentially the moment a vice president of nursing came to me with a quality improvement plan that would have *all clinical staff* complete a skills competency to demonstrate proper handwashing. A plan that I rejected because of what it would cost while failing to have a value-adding impact on patient safety — as it would not address the real need that, in fact, was to break the poor handwashing habits that my caregivers mindlessly engaged in in a fast-paced and overwhelming environment — *something that is not fixed with a one-time encounter in a controlled setting where people have time to think about what they are doing*.

Asked if she understood how much money this one activity would cost, her answer is why so many of today's hospitals have such dangerously small operating margins - *as the cost "was not her concern since it did not come out of her budget"*. Asked if she understood that it does not matter what budget line these kind of costs fall to because all costs associated with poor quality falls straight to the bottom line to detract from the profitability that feeds mission continuation, raises for her staff, and purchasing new equipment, she just looked at me with a blank stare.

If, as she estimated, 2,000 of the hospital's 3,000 employees were in clinical positions and had to take one hour away from patient care time to complete a non-value-adding activity with as much as thirty minutes of reduced productivity on either side — and an average salary-related cost of about $85 — the hidden costs that the hospital would never account for in terms of lost patient care time because of the way health care has always buried its costs associated with poor quality in general operations was $260,000 to $340,000 — *a figure that moved closer to $400,000 adding in the costs for orchestrating it*. Then factoring in the costs of continued treatment of the infections that would not be prevented in a world of Never Events — using the $55,000 that my CLABSI added to the cost of my care as the benchmark — the combined calculated loss to the hospital was roughly $1,000,000 for just the first ten infections treated.

While this investment of time, money and manpower would have probably helped it score well on its next survey, the more important question is about its value in protecting patients from harm and our hospitals from financial demise — with the later being increasingly worrisome when she was asked how many soft-quality educational activities the hospital did in a year and she replied "several dozen with maybe half involving all 3,000 employees".

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"The greatest chance for success belongs to those who can manage money and quality as two sides of the same coin"

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To learn more about how to start recovering the abundance of low hanging money that is available for reallocation out of a hospital's hidden bucket that funds poor quality - watch for the upcoming two-part recording titled:

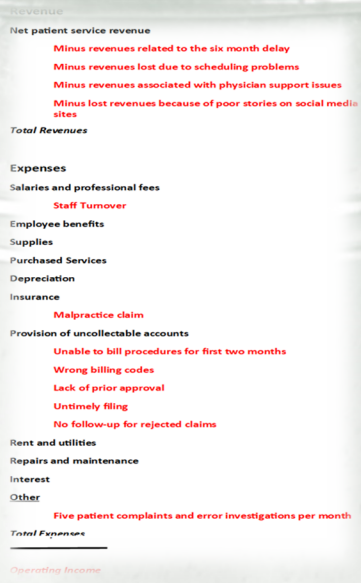
Getting Control of the Real Bucket of Money That Can Protect Health Care's Bottom Line!

A Victim of Packard's Law by Choice!

As the costs associated with health care's resource-consumptive, reactive and minimal compliance approaches to quality management continue to feed its biggest and riskiest cost center - its other greatest risk lives in the way today's hospitals keep trying to solve their financial challenges by chasing new revenues without practicing the kind of business-oriented quality that controls for the risks, perils and losses that reduce the potential of what their net returns will be. It is a fifty-year-old leadership choice that is now overwhelmingly dangerous to our hospitals as factors like inflation, new rounds of COVID-19 cases, a country in crisis and riskier forms of grasping for salvation evolve — complicated by the uncertainty of how much, if any, new bailout money might appear — play out in an environment where it is estimated that 2021 could end with at least one-third of the country's hospitals closing their books with negative margins after *the median operating margin for American hospitals reportedly dropped in 2020 by 55% - 55.6 percent without CARES money and a dangerous 16.6% with it. Numbers that only entrenched players still living in a world of denial would conveniently attribute to the pandemic and explain away as being inconsequential in a trend that saw a 44% drop from 2015 to 2017, a very weak median margin of 1.7% in 2018 and a fortunate increase to 2.4% in 2019 driven by small increase in revenues and patient volumes that COVID-19 wiped out in a heartbeat. A trend set to be made far worse in 2022 if hospitals do not get control of the twenty cents or more of every earnable dollar that they keep missing out on when they implement a new service or technology and the forty cents or more of every dollar that they do earn but wastefully spend on things like managing to the "100" because of the way they control for quality.*

It is numbers like these and decisions to just keep doing more of the same, and generally more of it, that keep feeding the slow and insidious decline of an entrenched hospital caught up in Packard's Law where — with enough time — the proverbial swan song that a business rarely sees coming plays as it makes that final grasp at salvation with a silver bullet that it cannot survive because it no longer has the money, manpower and goodwill to endure the cumulative negative effect created when that loss is added to the too many similar losses from its past.

It is like the story discussed in our *July 2020 newsletter* about a hospital CEO and CFO who convinced their board of trustees that the best answer to a shrinking bottom line was the purchase of a very expensive piece of diagnostic equipment in the absence of a quality management plan that controlled for all those variables that would undermine what they were able to achieve in the five critical business outcomes of patient loyalty, new patient acquisition, patient retention, market domination and long term profitability — causing them to join a growing club of executives who cannot survive their positions for more than three years or so because they tolerated way too much *quality-related red* in the way they managed that project and two more subsequent projects that were all *haunted by fifty-year-old attitudes born out of how health care reacted to the changes introduced by its technological revolution*. Always making it acceptable to ignore the importance of managing money and quality like they are two sides of the same coin so to maximize the money to be made and control for how that money gets to be spent.



So whether it is this hospital's three new pieces of very expensive technologies that all turn out to be the kind of sawtooth financial losses described in Packard's Law…..or the similar experience that another CEO had when his new dental clinic that should have been a winner became the loser described in the same previous newsletter…..or the hospital that still believes that its recovery after COVID-19 will live in adding more fixed costs associated with the blind investment in bricks and mortar without any real plan for how it will maximize the patients it draws to it during a time when its earnable dollar will be even smaller....or the groups of hospitals that will band together to create new healthcare systems with no real quality plan for how they are going to build stronger operating margins after they pay for all the new overhead costs they create with a new layer of leadership…..or the tertiary hospital that will keep buying even more smaller hospitals in what resembles an old-fashioned land grab on an assumption that it is also buying patient loyalty no matter how little effort it puts into protecting it…..or the hospital system that is going to make its fortune operating a hotel…..the next 18-24 months, just like they were for the auto industry in the aftermath of the Great Recession, *will be a critical time in determining which healthcare providers survive and who does not in the chaos of an environment where handouts for funding status quo will more than likely not be what they need to be, if they materialize at all.*