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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Stop Digging and Start Climbing:

Using Quality to Escape Healthcare's Hole of Futility

Nowhere does the 1:10:100 rule need to apply more stringently than in healthcare today where dollars needed for survival—and more crucially, for saving lives—are now at stake.

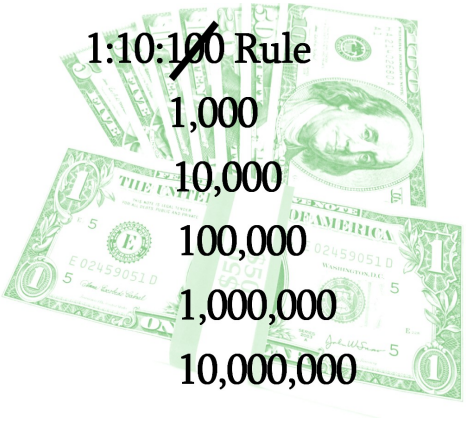
And this is the reason why we are starting 2021 with a series of newsletters about this very big form of savings!

This axiom, which tells us how the relative cost that is $1 or one manhour to do things right the first time turns into some factor of $10 or 10 manhours to correct an error midstream, and $100 or 100 manhours to fix an abject failure, is the quintessential formula for how healthcare can start to cure what ails it - and secure the patient satisfaction, quality outcomes, and bottom lines that it is now going to take to survive. Yet, too often, hospitals remain content to let situations drift to the 10 in the equation—or, worse yet, the grim 100 factor that most generally ends up being a loss of $10,000, $100,000, $1,000,000 or more.

So, even though managing to the "1" to get something right the first time is the least expensive, most practical and best return-on-the-dollar investment hospitals can make - *why isn't it happening more often?* Because for too long, the healthcare industry has fixated on trying to solve its problems by chasing some new form of revenue that never turns into the earnings it hopes for, by defining quality in terms of minimal compliance surveys instead of the five critical business outcomes of patient loyalty, new patient acquisition, patient retention, market domination and long-term profitability and by assuming that Uncle Sam will always have to be there with a bailout if things really get too bad.

So now not only have things gotten bad — thanks to COVID-19, they've gotten really bad *with the potential of getting a whole lot worse*, where even the survival of largest healthcare systems in the country is looking kind of iffy. And since the government can't print money forever—what is health care to do?

As COVID-19 turns 2021 into the year that will test the survival strategies of even the country's largest healthcare systems, one of the most important choices every leader and physician will make is *what they will do to get control of their piece of a trillion dollar cost center* — known as the ***costs associated with poor quality*** — that makes their operating margins too tiny to fund long-term survival in a technologically-advancing world. With hospitals going into the COVID pandemic having experienced as much as a 44% deterioration in their operating margins between 2015 and 2017 and then only gingerly stabilizing them with a median margin around 1.7% in 2018 — *during a time when some experts were suggesting a minimum margin of 2.5% or better for mere survival* — and then watching them begin a new steep descent in 2020, where are leaders and physicians going to find the savings they need to compensate for the loss of revenue growth potential that COVID-19 has taken away from them as they watch their bloated cost centers explode in a world where the kind of handouts the industry once counted on when times got tough are becoming the dreams of fools.



The situation is one where as hard as the industry has worked over the past fifty years to convince itself that the way it has chosen to manage quality is an incidental to how it creates opportunities for success, dealing with the hard cold truth of what that mantra is costing it is now positioned to decide who survives, who does not and just how ugly survival might look if the best answer the industry comes up with is more of the same. Whether it is the hospital system that continues to chase its pot of gold with its own insurance product without a strong enough quality model to maximize the number of premium dollars that make their way to the bottom line or the hospital CEO who still thinks he can fix a failing financial report with the purchase of a new very expensive piece of diagnostic equipment that, when all is said and done, cannot generate enough money to pay for itself because of all the poor quality costs it has to absorb or the leadership team who clings to the false belief that they are enjoying a competitive advantage when their hospital scores in the 97th percentile on a patient satisfaction survey where the herd is running tight with a group performance of only 61%, the critical question is how much longer can today's healthcare providers survive in the Panic Zone described by Robert Kriegel and David Brandt where their challenges so outnumber the resources they have available for managing them, *that no matter how hard they work they always take too many steps backwards for every step they take forward because they manage way too many things to the "100" in the 1:10:100 rule.*

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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 when one manages to the "1" - instead of the "100" - please click on the link below and download the white paper titled:

The Ruminations, Revelations and Reality of a Modern Day Hospital CEO

How Far Could a Hospital Climb?

Perhaps the most important business move that healthcare leaders can make today starts with acting on the realization of just how much money and manpower they could free up for investing in future growth if they diminished their ***costs associated with poor quality***. Whether it is the twenty cents of every potential dollar they could earn but leave on the table with the implementation of new service or innovation or the forty cents or more of every dollar they do earn but spend to the "10", or more importantly the "100", whatever the savings is — tens of thousands for smaller providers or millions, maybe billions, for the largest healthcare systems— it is now a figure big enough to be the difference between margins that barely stays black, if they do that well, and margins that start to grow again.

Perhaps the best example to start this series of 1:10:100 newsletters with is the one about how much money and manpower the average hospital throws at managing to the "100" by still waiting to act on risks only once errors make it all the way to a patient, or to the bottom line based on a faulty 1980s premise that leaders would have more money to spend on new technology if they addressed only those errors that could not be ignored than if they embraced the simple and small changes that could prevent errors from happening at all.

While there was a time that health care could operate and survive with that attitude — when hospitals were paid to fix what they did not get right — there are now all the costs that come with managing errors that can no longer be ignored and turn into incident reports — starting out with the one hour of time that reporting an error can take away from the direct care of patients. *And that's is just the beginning:*

*As leaders have to add ten hours or more of initial risk management time to the bucket for fixing the past for managing the investigation;

*Add another six hours or more for the frontline manager who has to be involved in investigating it, talking to much more discerning types of unhappy patients and families about what went wrong and why while addressing what was probably preventable in a far more costly way;

* Add three hours or more of leadership costs for the discussions and involvement of every operational leader that is impacted by the investigation;

*Plus the three hours or more of physician time taken away from patient care for every physician involved in the investigative process if the incident includes a physician-related error;

* Along with one hour of time if the incident is reportable to a regulatory agency;

*The quadrupling of the risk manager's time if the incident involves patient harm or an investigation by an outside agency, and tripling of leadership and physician costs; *still knowing that that is not the end.*

* If the event requires a formal corrective action plan for an outside agency that requires long term tracking — there is the added cost factor of three to ten hours for every quality professional involved and five or more for each operational and tactical leader for every month that the plan has to be managed;

*Then a leader can expect to add ten to thirty hours of time or more for the marketing staff if the story is tragic enough to makes it out into the public while tripling all costs up to this point if the event threatens Medicare certification or a payer relationship;

*And, then there are the costs for every member of every committee involved in the review and monitoring of the activity for every time it is reviewed in an bureaucratic quality model where the same issue can have to be discussed by as many as five different committees for months – and do not forget committee meeting prep time.

**And worse case scenario:* If the incident results in additional care, hospitals now need to add in all those costs that they will not be reimbursed for along with those that come with notifying other patients because of concerning exposures, such as endoscopic equipment not cleaned correctly, plus all the costs that come with litigation and other actions such as a disciplinary actions and hearings.

So, while it might seem easier from the isolation of the C-suite to not do what needs to be done to manage to the "1", it is the reality of just how little today's leaders can do to save their hospitals and protect their own tenures if they cannot free up what they spend to the "100" that is creating health care's purgatory — where every year leaders who still operate with a quality model that too easily allows for the introduction of new errors while the same old ones keep crossing the line over and over and over again can take two-thirds of the collective costs that one incident report can generate, multiple it by the number of incidents dealt with in the previous year and add ten-percent of that cost back in to create their next year's budget for managing errors — *all while they contemplate the fact that incident reports are only one of the many ways health care manages to the "100" and throws its money away!*