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

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

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Quality: the financial epicenter that will save health care …what a concept!

That paraphrase of the late, great Robin Williams' Grammy-Award winning album, *"Reality…What a Concept,"* is what this white paper is all about: the concept that quality — not one more new diagnostic machine, not another new service, not another layer of administrative positions, not an adjoining hotel, not layers of new steps added to already overwhelming practices, not more forms to fill out — is the real answer to the financial and operational challenges that face every hospital in the nation.

Quality — how well a hospital does anything and everything it does in the most business-wise ways possible — is the lynchpin for what drives how much money it ends up making and how that money gets to be spent: real, tangible, and impactful patient and operational quality—*that makes patients return to a hospital with family and friends in tow, makes surveys a whole lot less costly and resource-consumptive, aids in protecting and improving employee morale, decides the health of an operating margin, and transforms an underperforming hospital into a smooth, patient-centric facility that focuses on care, not cash, and yet delivers both.*

My four-decade career in hospital quality, risk management and leadership, starting out as a quality director in 1980 and evolving to the role of CEO responsible for saving a failing, cash-strapped hospital has taught me that the focus on quality — not the little quality that health care has practiced for five decades to pass surveys but the big quality that Juran described as impacting all levels of operations for the purpose of fostering stronger performance and long-term survivability — is synonymous with business success, no matter what the business. Rather than the kind of quality that is treated as an incidental to making money or like a game played with regulators, it is the kind of quality that works to manage the outcomes of everything a business does — *and how it does it* — with a focus on maximizing the size of the pot of discretionary money leaders end up with for reinvestment in future growth!

This white paper explores why my transition from the practice of little, regulatorily-driven quality to a hyper-focus on big business-oriented quality was so important to saving our hospital and *the role that SQSS, the enterprise quality management tool I have created in response to that experience,* can play in expediting the transition from one to the other for the alarming number of hospitals that are too quickly running out of the money, manpower, time and goodwill it is going to take to survive in the absence of the kind of breakthrough performance that smartly moves as many operational dollars as is possible back into the bucket for funding future growth — *during a time when the decades old practice of making the bottom line work by chasing new revenues is not the answer it was before COVID-19, or, perhaps it never was.*

INTRODUCTION

Like so many CEOs today, there I was....a new leader responsible for saving a financially-failing hospital. No good news, just bad...very bad:

> *Out of cash.*

> *All financial reserves spent down.*

> *Praying from payroll to payroll that enough money would somehow magically show up to take care of my staff.*

> *Begging vendors to not shut off the flow of important patient care supplies.*

> *A workforce terrified about losing their jobs.*

> *Community confidence so low that there was no way - on my best day - that my top-line revenues could meet my bottom line needs as patients were being siphoned off by a competing hospital fewer than 30 miles away.*

> *A board of trustees desperately asking every day where the magic bullet was going to come from for saving their hospital now that chasing new revenues without any consideration for the costs that it added was no longer the easy answer it once was seemed to be!*

It was the Titanic of hospitals - and the more I dug into the mess I inherited, the more depressing the reality I found. And on top of the overwhelming number of financial and operational crises I was scrambling to stay one step in front of....I had an accreditation survey for continued participation in the Medicare program looming six short months into the future — a survey that we had absolutely no way of passing if it had to happened any sooner – *and that could generate enough extra costs to take the hospital down.*

This began my journey of learning about how to use quality as the fulcrum for saving my hospital, rebuilding community confidence and support, creating workforce stability, and getting rid of all the wasteful costs and activities that my hospital had been absorbing in the name of quality for years — *and that in reality, had come to undermine it because of the way that soft quality displaces money and manpower away from the very activities important to the patient care at the heart of why hospitals exist.*

I could not look to the kind of quality management that the healthcare industry has practiced for the past fifty years and ignore the conspicuous consumption of patient care resources that it promotes while too frequently doing nothing more than creating the costly illusion of action — and can now cause the average hospital to too easily and frivolously throw away as much as fifty cents or more of every dwindling dollar it can earn — while still ending up a day late and a safety action short in protecting itself *and its patients from all the harm, costs and busywork that come with answers borne out of constant rounds of new rules, regulations, reporting requirements, accreditation activities, billing prerequisites, investigations and assorted quality projects that consume cold, hard cash without doing much of anything to slow the country's explosion of medical errors and costs.* What I needed was something different *that would manage money and quality* ***like they were two sides of the same coin*** so that I could make a much smaller dollar work without compromising the reason my hospital existed — to save lives and advance the health of our communities.

Darlene D. Bainbridge, CEO/President

Darlene D. Bainbridge & Associates, Inc.

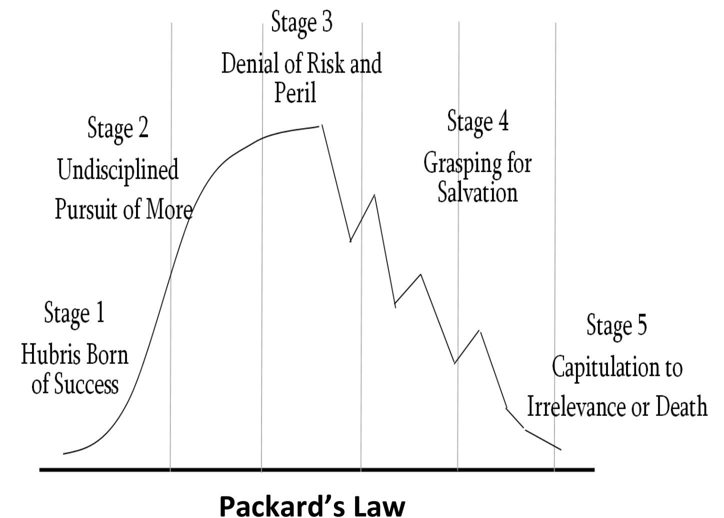
FIXING A HOLE

What I walked into is best paraphrased by a quote from Craig Lounsbrough: "*My hospital, like most hospitals today, was in a hole because its leadership had picked up a shovel fifty years ago when faced with the quality challenges created by the industry's scientific and technological revolutions — and had been digging ever since. Like any hospital now wanting to survive — it needed to trade in its shovels for ladders and start climbing with a very different and more business-oriented attitude about what quality really means*."

Just as where so many hospitals find themselves today, mine — *by the time I had arrived* — had dug a deep enough hole for itself because of how poorly it had managed money and quality as if they were two distant cousins; it had worked its way through the first four stages of something David Packard and Jim Collins described as Packard's Law. It was at that point where it no longer had the resources it took to grasp for salvation and keep its operating margin in a reasonable state of health using the same old practices and beliefs that had brought it to where it was. It was facing the very real possibility that it would end up capitulating to irrelevance — *if it survived at all* — because of how upside down its revenue generation/cost production ratio was.

It had exhausted its financial reserves. It had made so many poor money-making and money-saving choices at the expense of its relationship with its community that it had lost the loyalty of enough patients that it could not generate the basic top-line revenues it needed to cover its ever growing list of operational costs. Because it kept practicing a very costly type of quality management *designed to create the illusion of value through the conspicuous consumption of resources in the name of quality* — lost in the notion that its actions were enough because they satisfied a whole host of regulatorily-driven, process-oriented activities without having to ask the all-important question about outcomes — it was paying the slow and insidiously destructive price that has always hidden in the industry's long-standing and troubling arguments that have allowed hospitals to treat quality as a incidental to making money.

Consequently, its problem-solving model was one where it kept taking resources away from the frontlines of patient care where money and patient experiences are created to fund administrative activities that made it too easy to take too many steps backwards for every single step it tried to take forward. It had spent so long hanging on to an industry-wide belief that—because of what they do in the delivery of life saving care—hospitals are too important, too special and too woven into the day-to-day life of the American people to fail — ***it was positioned to do just that***.



Packard's Law

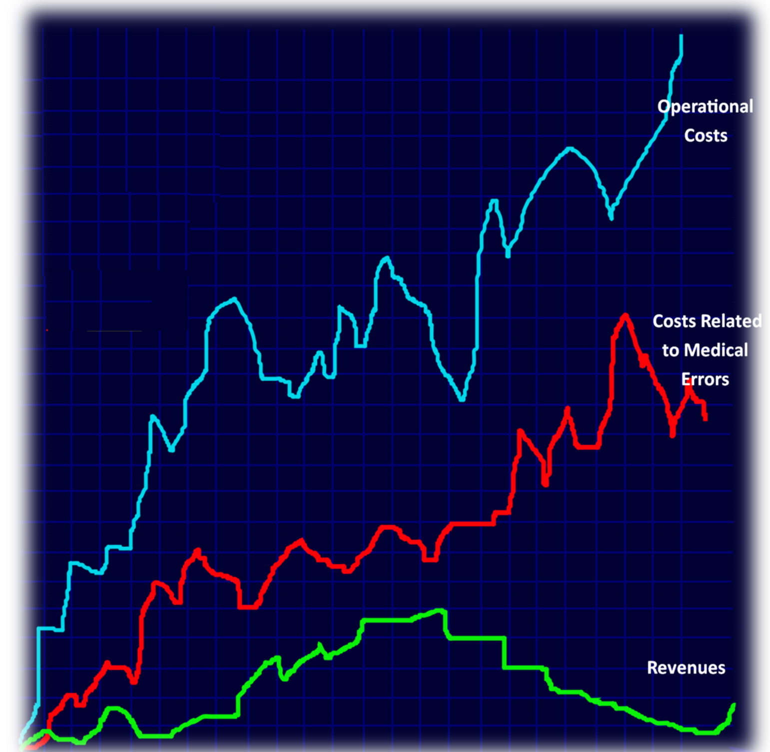
To understand Packard's Law, please read:

- ***HOW THE MIGHTY FALL — AND WHY SOME COMPANIES NEVER GIVE IN ….. by Jim Collins***
- ***GOOD TO GREAT …… by Jim Collins***

My hospital, like too many hospitals today, could no longer afford the kind of escalations in costs that came with the way it had managed quality — something it had never worried about prior to the late 1990s during a time when it was compensated very well for what it did, was paid to treat the errors its patients experienced, and could count on a once legendary type of loyalty from older generations of patients who were willing to accept errors as factors of fate, not of skill and competence. In addition to all the process-oriented soft quality costs it was accumulating, it could no longer afford to absorb all the costs that were starting to go straight to the bottom-line when it experienced a medical error that was determined to be preventable and categorized as a *Never Event.*

My hospital did not have the money to chase new opportunities that could turn into pie-in-the-sky ideas if they fell prey to a fifty-year-old argument that quality is an incidental to how one makes money. It would never survive if I could not fix what had become a serious imbalance between revenues and expenses by improving both without creating the boomerang effect that seems to be so prevalent in health care when leaders seek to solve their financial problems by chasing new money but too frequently losing more than they make because of how few controls they put in place for the operational and risk-related variables that exist to diminish what the final discretionary dollar can be.

If I were to save my hospital in an increasingly hypercomplex, tight-coupling and safety-critical environment being defined by the rapid-growth of very expensive technological and scientific advancements, I was going to have to adopt a more business-oriented strategy about how I managed both money and quality in ways that prioritized revenue-producing patient loyalty while avoiding the wasteful conspicuous consumption of resources that health care has engaged in over the past half-a-century as it has treated quality has a necessary evil to its regulatory relationships in a world where it has been too easy to view itself as the victim of a society that does not appreciate it for all the great things it can do.



WHAT WERE MY ALTERNATIVES?

Did I continue to practice a kind of tired quality that—by design—moves more and more of the industry's most highly skilled people off the front lines of patient care where the money and patient experiences are made to sit in offices counting hashmarks and playing with Excel spreadsheets with the goal of identifying errors in patient care after it is too frequently too late to prevent something from hurting a patient and creating costs that I would have to absorb?

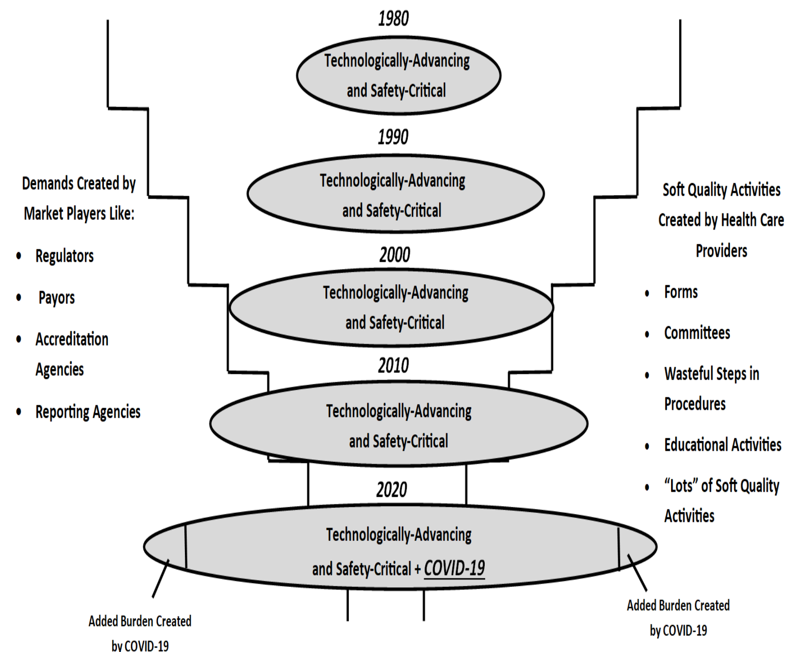
Did I keep defining quality in terms of a resource-consumptive and costly game of Tit-for-Tat where the definition of quality is minimal compliance with some resource-consumptive rule, regulation, accreditation standard, or reporting requirement that is generally satisfied by some resource-consumptive new form, committee, or process-oriented soft quality practice that with enough time justifies the creation of one more resource-consumptive rule, regulation, accreditation standard and reporting requirement?

Did I buy into the illusion that my hospital was achieving something value-adding by performing at the 97th percentile on some quality or patient satisfaction measure where the herd was running very tight with an average performance of 51%, or did I accept the fact that the kind of success-producing quality and patient satisfaction that I needed are about something much bigger — and extremely important to securing the *twenty cents or more of every dollar that could be earned* but is too frequently left on the table when a hospital introduces a new service or technology?

Did I keep digging the hole I found myself standing in with answers that told me to do more of the same on a hope and a prayer that divine intervention would cause it to produce something better, or did I actively do whatever it took to go after the patients the hospital had lost along with the *thirty cents or more of every dwindling dollar that the average hospital earns* but can now so easily lose to a host of wasteful operational practices created in the name of quality?

Did I continue to promise my workforce that things would get better with every new exhausting and overwhelming act of soft quality I might create to play Tit-for-Tat — when in my heart of hearts I knew that it was a lie — or did I look for something that would help them stay focused on, and naturally do better, at what they were hired to do?

Or, did I break free of the past in pursuit of being part of the 2.5 percent that Roger's wrote about in his theory on the diffusion of innovation to find that kind of quality that could take my hospital back to a black bottom line where it would be easier for it to survive as the industry continues to evolve and the healthcare dollar continues to shrink?



FACING MY FIRST BIG CHOICE!

It did not take long for me to face my first real test of conviction in how I would challenge status quo as our accreditation process that loomed just a few short months away crept closer and closer — one that was famous for the busywork it produced and a host of resource-consumptive activities that can leave a hospital able to ace a survey on Wednesday and have a patient needlessly die by Friday from some risk the survey process failed to identify. I could spend what few discretionary resources I had on all the soft quality activities that have historically come with healthcare's survey relationships or I could be as ready as possible to demonstrate our control of key activities important to *minimizing the potential for patient harm while also telling my managers that we would not be passively implementing any new forms, creating any new committees or engaging in any other type of soft quality activity that the surveyors might recommend unless they could show me how what they suggested would actually improve the care and safety of our patients in ways that would further our efforts to save the hospital.*

While I clearly understood the important role that quality would have to play in rebuilding the hospital's reputation so we could rebuild the revenue side of the general ledger by getting our patients, and then some, back, I also understood how many resource-consumptive activities that health care can engage in — *in the name of quality — in the bureaucratic quality model where industry stalled in the 1990s and that measures success in terms of process measures that may or may not have anything to do with making things better.*

What I had to avoid because I could not afford them if I were to achieve what I was hired to do were all the hidden — and insidiously lethal — kinds of *more* that health care has historically accepted in the way it has managed quality — and that date back to a time when my job as a hospital quality director was to generate a big enough abundance of soft quality activities that my hospital could *dazzle the surveyors with how much paper I could engulf the boardroom table with, how many **more** forms I could show them that we had created in the past year, how many **more** new procedures we had created, how many **more** steps we had added to all our existing procedures, how many **more** committees we had created, how many **more** employees we had disciplined and thrown under the bus in the name of quality, how many **more** educational programs we had conducted, how many **more** memos we had issued and how many **more** dollars and manhours we had dedicated to the conspicuous consumption of resources in the name of improving quality* — knowing that the one question that would never be asked was "what positive, value-adding difference it all made?"

NO MORE SOFT QUALITY AND BUSYWORK!

Within hours after the surveyors arrived, I got my first call from a manager to alert me that a surveyor had pulled a form out of his briefcase and was recommending that she implement it "because he liked it." It was when I questioned him about the value it would create in helping us to raise the bar on quality in a way that would save the hospital that his dismissive answer of how "it only required twenty minutes for the nurses to fill out and only needed to be done once a shift for every patient" set the stage for the challenge that their three-day visit was going to create for me. It was what played out in the next thirty minutes that defined what my leadership role had to be — when we did the math together and determined that maintaining this one form ***that would only take twenty minutes to fill out and only had to be done on every patient once a shift*** would require the dedicated fulltime commitment of the equivalent of 5.07 full-time nurses for every twenty-five patient we would care for each day over the coming year. It was the equivalent of taking twenty fulltime nurses away from value-adding direct care activities for every one-hundred patients a hospital would care for to engage in a soft quality activity that we both ended up agreeing would produce no added value in helping my staff to create a safer and more patient-focused environment.

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

After three very long days and five more conversations that always started with some soft quality recommendation like the one about how we should create another committee so my overwhelmed leadership team could take time away from saving the hospital to be caught up in "STP" where "the same ten people" spend *more and more* of their day sitting around the boardroom table discussing issues that they probably already discussed at that same table during as many as five other meetings, we passed our survey with two minor deficiencies that were truly meaningful opportunities to improve in ways that would feed our goal of saving the hospital — and we did it without all the additional busywork and new costly demands that health care's survey process is famous for.

Perhaps the most important thing to come out of it for me came when the physician surveyor knocked on my office door before the team left to thank me for a great survey and tell me how educational it was for all of them — *as they had never considered the cost of what they might recommend and the potentially negative consequences that could come with something done with the best of intentions*. He shared how satisfying it was for all of them to lose every debate we had because, as he and his team had just been discussing in my boardroom, it was okay to lose that argument to someone whose quality goals were bigger than their own.

With one palpable money and manpower saving win for our patients, caregivers and financial health under my belt that actually raised the bar on quality, I started looking for how many other big quality, cost-saving ideas that authors like Juran and Crosby had written about there were to help me achieve what I was hired to do — closely watching the mistakes of the CEOs around me when they would fail as they put a heavier emphasis on chasing revenues in the absence of an equally strong focus on getting so much right the first time that they were maximizing their return on investment.

A Common Loss I Could Not Afford

I had to avoid the kind of quality consequences that came with the decision made by one executive team to deal with a similar financial situation to mine — *and that shares a lot of similarities to decisions being made in response to COVID-19* — by looking to fix the bottom-line through a workforce reduction on the frontlines of patient care where the money is made and patient experiences are created without any consideration for how the work of those removed would still get done in ways that would not inflict more harm than already existed for the five critical business outcomes of patient loyalty, new patient acquisition, patient retention, market domination, and long-term profitability.

It was the absence of a leadership plan for how to protect all those things important to producing and hanging on to what little patient loyal and financial reserves the hospital had that made their leadership tenures very, very short and created the final straw that pushed the hospital deep enough into Stage 5 of Packard's Law that there was no way it would survive — *as it was the work of the people removed that managed the majority of the activities critical to keeping patients safe while making them feel so well cared for and personally cared about that they would keep coming back with family and friends in tow because of the great stories they told.*

All of that hospital's major indicators of business health, which were already in a dangerous place, started moving in the wrong direction even faster within weeks of the workforce reduction as the hospital experienced a drastic decline in patient volumes while its error rates went up and stories of patient harm and poor care grew. Patient satisfaction scores tanked. Accusations of poor quality and service dominated social media sites. Revenues shrank, costs associated with fixing the damage done consumed what little could have been invested in trying to grow the future and its cries of victimization went unheard. When asked how much better off the hospital was because of a plan that did not include the management of big quality — so they had a better chance of achieving their goals — the chief executives who had been in their positions less than two years did not have a lot to say as they updated their references and contemplated their next career moves.

Revenue

- **Decline in Patient Loyalty**
- **Decline in New Patient Acquisition**
- **Decline in Patient Retention**
- **Decline in Market Domination**

Total Revenues

Expenses

- ***Increase in Patient Complaints***
- ***Increase in Medical Errors Costs***
- ***Increase in Costs Associated with Inefficiencies and Not Getting Too Many Things Right the First Time***

Total Expenses

Smaller Operating Margin

Another Common Loss I Could Not Afford

Like where far too many hospitals find themselves today staring into the face of dangerously small operating margins, I could not afford the kind of story that two chief executives created for themselves when — the CEO and CFO — persuaded their board of trustees to chase what they projected to be the kind of big financial gains *that would miraculously fix their failing margin* with the purchase of a very expensive piece of innovative diagnostic technology that very few hospitals had. The financial projections they offered up made it hard for the board to imagine how the hospital could lose — *until a string of poorly managed quality-related costs started to pile up* because of a C-suite that still treated quality as something linked to regulatory compliance rather than to making sure that enough things were done right the first time in the most business smart ways possible that leadership could maximize its returns on the investment made.

The hospital's first major setback came when the equipment installation was delayed by six months because of physical plant issues that were not anticipated, and a failure to submit the correct paperwork to the required state agencies. Giving the hospital on the other side of town that six months to close the competitive gap, scheduling problems, physician support issues and an instantaneous reputation on social media sites for poor patient experiences caused the hospital to only achieve about half of the patient volumes it projected.

Procedures done during the first two months could not be billed because the hospital had not started the set up process with its payers early enough. One-fifth of all revenues that should have been collected were lost during the first five months of billing because wrong charge codes were used. One-eighth of the completed cases could not be billed because they lacked the required prior approval that payers demanded. An additional four percent of all claims for payment were rejected for untimely filing, while an additional five percent of collectable revenues went unrecovered as no one was following up on claim rejections for missing information.

With the accumulation of these and other problems, the year one earnings were just enough to keep up with the loan obligation for the equipment and other associated maintenance requirements — with each subsequent year thereafter not being even that good as the neighboring hospital got its equipment going with stories of better customer satisfaction.

Typical of why so many leadership tenures are dubiously small these days, and getting even smaller as COVID-19 continues, this hospital, just like mine, could not afford all the red — and avoidable — contributions to its financial reports that came with this CFO's dismissive reiteration that quality has nothing to do with making money. What he and I both needed was a kind of performance management that lives in tools like the balanced scorecard that Kaplan and Norton have written so much about and that now lives as a feature of SQSS with the goal of helping healthcare providers to better align the management of money and quality so to make the money work better.

Revenue

Net patient service revenue

- **Minus revenues related to the six month delay**
- **Minus revenues lost due to scheduling problems**
- **Minus revenues associated with physician support issues**
- **Minus lost revenues because of poor stories on social media sites**

Total Revenues

Expenses

Salaries and professional fees

Employee benefits

Supplies

Purchased Services

Depreciation

Insurance

- **Malpractice claim**

Provision of uncollectable accounts

- **Unable to bill procedures for first two months**
- **Wrong billing codes**
- **Lack of prior approval**
- **Untimely filing**
- **No follow-up for rejected claims**

Rent and utilities

Repairs and maintenance

Interest

Other

- **Five patient complaints and error investigations per month**

Total Expenses

Operating Income

So like where so many leaders find themselves today, I could not afford the kind of business decisions that promoted the sawtooth short-term gains that, more often than not, yield too many long term losses common to the stage in Packard's Law where leaders grasp for salvation by chasing new revenues but then lose too much by treating quality— big business-oriented quality — as an incidental to making money with:.

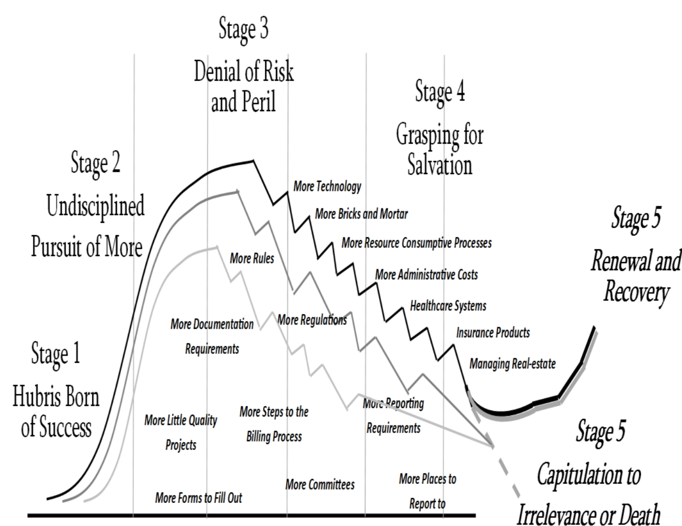
- the purchase of a new piece of equipment without knowing it can generate enough volume to yield a big enough net financial gain to protect the operating margin — and an actionable plan to manage its implementation with the kind of focus on quality that can make the desired outcome happen; and
- adding more fixed costs to the expense side of the general ledger with more bricks and mortar inside a dangerous old-school belief that if you build it they will come;

at the same time I could not take on the risk associated with the kind of quality-related financial losses that can come when:

- a group of hospitals band together to create a healthcare system on the assumption that the simple act of coming together will somehow be enough to make their bottom lines stronger in the absence of a quality plan for how they will create enough new revenues and cost savings to produce a future-saving profit for each and every member after paying for roughly one million dollars in new administrative overhead; and
- a tertiary hospital buys up a number of smaller hospitals in what has come to resemble an old-fashioned landgrab without any quality plan for how they will manage the fact that patient loyalty is not a guaranteed part of the purchase price; and
- a hospital system creates an insurance product that is not aligned with strong enough quality practices for protecting how many of its premium dollars make it all the way to the bottom line of its financial reports after paying for all the avoidable errors, inefficiencies, and delays in patient care outcomes that it will have to pay for.

Whether it is an activity borne out of being lost in a decades old belief that health care has somehow been winning a war against change by pouring resources into a bureaucratic quality model defined by a never-ending game of Tit-for-Tat with regulators, surveyors, and payers that keeps producing activities that make patient-focused quality harder and harder to achieve or clinging to the notion that there is some magic bullet out there that will — all by itself — reset a shrinking bottom line:

the same question that haunted me now haunts too many of the country's healthcare providers: how will today's healthcare providers make it if they do not operate with the kind of quality commitment to top-line and bottom-line gains that can lead to profit maximization in the absence of the money, manpower, time, and goodwill that it takes to preserve status quo.



So, as our hospital's patient volumes started to steadily grow and our bottom line began to continuously improve — as every day we focused on making patients feel so well cared for and personally cared about they would keep coming back, *bringing new patients with them* — while we also worked to do everything we did in far more business-smart ways so to have a positive double effect on the bottom line — what kept me awake a night shifted from the crisis management of making payroll and paying aged-out bills to how we would hang on to whatever we were able to achieve in ways that always left me with enough money, manpower and time to keep moving the hospital forward in a technologically-advancing environment that by its very nature was becoming so hypercomplex, tightly coupled and safety-critical that it could overwhelm even the most dedicated and caring healthcare provider.

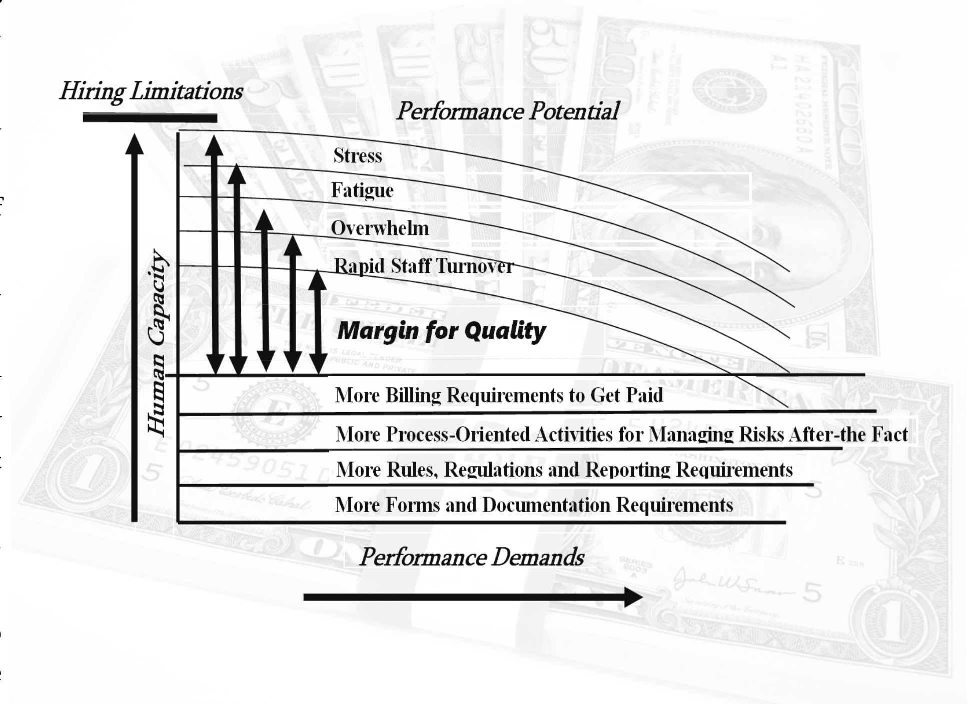
Protecting What We Had

Watching the struggles experienced by my people grow under the pressures created by the need to do more while also holding the line for all the activities that were important to what we had gained, I found myself constantly thinking about the potential benefits that could come with the kind of systematization that a growing number of authors were starting to write about but that health care had historically resisted because of attitudes from the past that have caused hospital leaders and physicians to confuse the risks that come with standardization in the field of medicine with the benefits that could come with finding smarter ways to work through stronger systematization — *the act of organizing something according to a system or rationale — so it was easier to manage the present while still having the time and capacity to keep growing the future.* What I needed was a type of systemization that would make it easier for my people and I to consistently manage to the "1" in the 1:10:100 Rule — and break free of all the very risk-laden and costly practices common to a bureaucratic quality culture that manages most everything to the "100" or some factor thereof.

For every dollar spent to the "1" to get something right the first time, the cost of making a mid-course correction is a factor of "10" while fixing an error after the fact comes with a cost calculated to the "100". For technologically-advancing and safety-critical environments — like health care — the significance of managing to the "1" lives in the fact that managing to the "100" is too frequently some factor of 1,000, 10,000, 100,000, 1,000,000 or more.

Needing to avoid the kind of very expensive experiences that most every hospital has had in the way that they adopted electronic health records as victims of a Tit-for-Tat strategy that ended up yielding tools that cost too much, deliver too little of the type of innovations that creates breakthrough performance, are too hard on the performance potential of an increasingly overwhelmed workforce, and are now costing a small fortune to try to fix, I — *and every CEO I have talked to since my own experiences* — needed a type of systematization that made it perpetually easier to:

- get a lot more things right the first time in sustainable ways so to minimize the kind of losses that are inherent to a much more costly and safety-critical environment largely reliant on expensive halfway technologies.
- always manage as much as is possible to the "1" in the 1:10:100 Rule.
- make it possible for one person to manage a whole lot more quality-related activities with minimal disruptions of the duties he or she was hired for as the demands created by a technologically-advancing environment grow exponentially in number.
- keep my skilled FTEs on the frontlines of patient care where revenues are generated and patient experiences are created.
- always made my hospital survey-ready without having to reallocate huge numbers of resources to doing so every three years.
- support my people in making improvements happen much more quickly in less resource-intensive and more results-oriented ways.
- substantially reduce the amount of time my managers would spend babysitting quality — with phrases like "did ya" and "don't forget" — at the expense of the time they could spend helping their staff build bigger and better patient experiences that would help to rebuild the hospital's future.
- maximize the financial and reputational outcomes of any new endeavor we might undertake.
- reduce the costly redundancy characteristic of a bureaucratic and siloed approach to quality management that adds stress to the performance potential of a workforce and compresses the very margin for quality that the activities are intended to help.

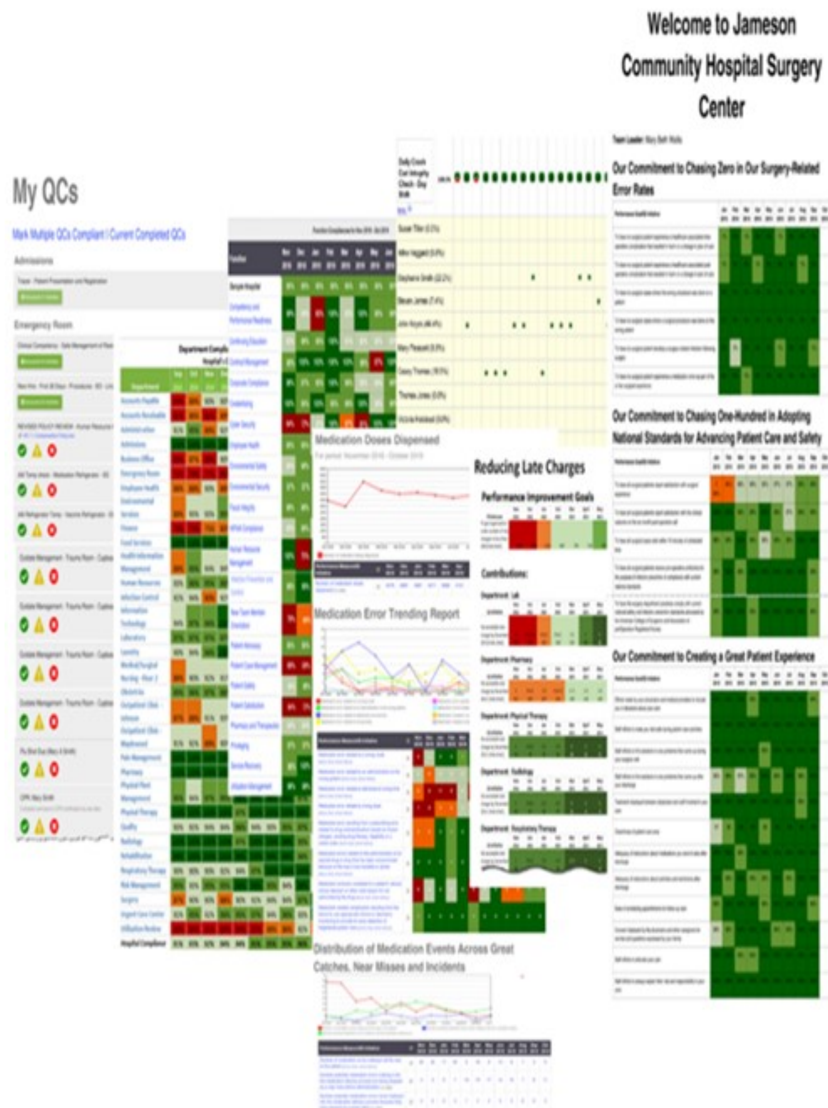


- create a more user-friendly and less stressful environment for my frontline workforce so it was easier for them to stay focused on their patients in ways that discourage the desire to seek out alternate career opportunities.
- have the kind of real time data, reports and opportunities for analysis that foster making the best possible decisions that minimize the risk of the kind of costly quality surprises can destroy strategic opportunities and consumer relationships.
- generate the kind of big quality data sets that it was going to take to compete as a new type of consumerism settles into the industry and is backed by corporate America's efforts to make it easier for its workforces to find alternatives to traditional healthcare approaches that deliver more for less.
- yield a net financial gain by getting rid of more costs than those it adds.

BUILDING WHAT I NEEDED

Recognizing that the only way to create the kind of control, efficiency, effectiveness and savings that I kept imagining — as the number of demands on my people kept growing — was through a type of cost-effective electronic systematization that multiplied the capacity of my workforce in a big way that it would reopen my margin for quality, my musings shifted from how to help my people work harder to how to help them work smarter. What I needed was a tool that could create a virtual memory for the thousands of things that it took to manage a complex and risk-laden environment to the "1", free people up from administrative activities, and keep me out in front of what could hurt my hospital while never getting tired, never calling in sick and never forgetting — no matter how much there was to do.

Validating my observations as I worked as the lead consultant to a national quality project with over one-hundred participating hospitals seeking to achieve the same success that my hospital had in turning its bottom-line around, I finalized my plan for how to build Strategic Quality Support System (commonly known as SQSS) while I laid in a hospital bed for two weeks recovering from a preventable central line sepsis that nearly took my life — watching my overwhelmed caregivers struggle every day in a sea of ever-growing regulations, evidence-based standards and survey-readiness requirements while still trying to find the time to meet my most basic needs — *and then living with my caregivers and all the patients around me through four more potentially life-altering medical errors that got stopped by me, not systems that supported my healthcare teams that wore their fatigue on their faces every day.*



Focused first on helping caregivers on the frontlines of patient care get a whole lot more right the first time in ways that reduced the stress I witnessed every day of my leadership tenure and cancer care — because of the hugely positive downstream effect it could have for patients, providers and a hospital as a whole, the most impactful piece of SQSS that my team and I may have created for an environment as hypercomplex and safety-critical as health care has become is the feature where leadership tells the System what has to happen, when it needs to happen, how often it needs to happen, who has to do it, who the back-up is if that person is suddenly unavailable and who is responsible for validating the integrity of the activity from time to time so SQSS can take over managing the range of very important safety and quality control activities that can now exceed *100,000* for the average one-hundred bed hospital, *a million for some of our largest healthcare systems* — and has become something that only a fool would try to manage manually on a hope and a prayer that everything would somehow get done.

Whether it is the simple way that SQSS reminds people when their licenses and certifications need to be renewed, prompts very busy people to take care of crash cart checks and important refrigerator temperatures, stays on top of the need for important contracts to be renewed, schedules competencies to validate skill levels from time to time, tracks the ever-growing list of credentials that medical providers must possess, supports integrating a new employee into the day-to-day life of safe patient care or expedites being in control of a new threat as big as COVID-19, the goal is sustainable control in ways that promotes stronger safety, freed up manhours and better bottom-lines.

Then taking advantage of a feature unique to SQSS that allows it to generate real-time reports using real-time data that update as fast as any new work is done in the System — for the first time in the duration of my forty year career — leaders can have instantaneous access to real-time information in value-adding formats so it is easier to make smarter data-driven decisions at that moment in time when the choice being made will have the greatest impact on what the future can be.

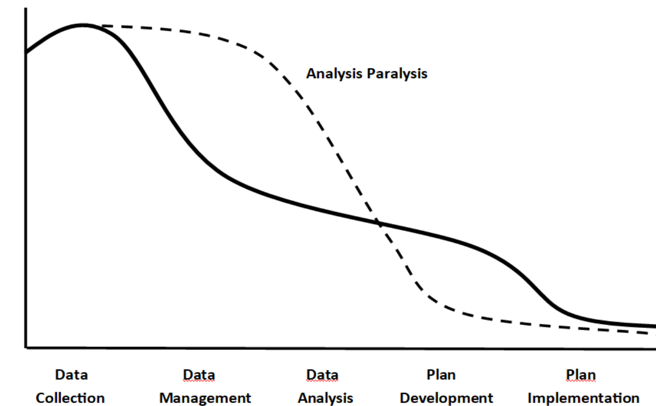
With an infinite capacity to manage big quality data — that reaches well beyond the little quality measures it takes to achieve regulatory compliance and pass surveys — one of the most important goals of SQSS is to help leaders avoid being a day late and important decision short in protecting one or more of the five critical business outcomes — making the report generation features in SQSS one of those paradigm shifts that health care has needed for a very long time.

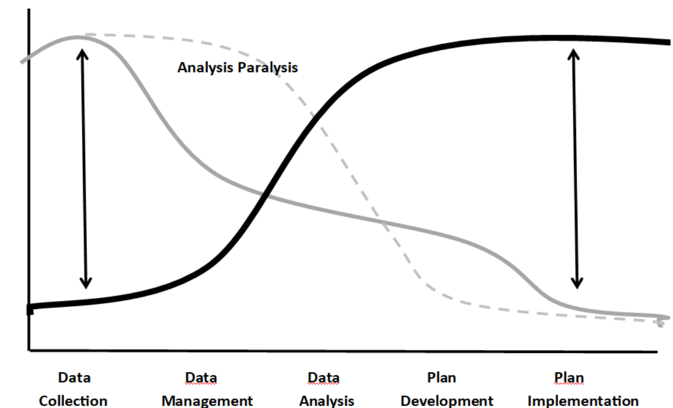
Whether it is the critical at-a-glance compliance reports that SQSS is designed to automatically generate with the goal of staying on top of numerous safety-related tasks that just need to get done to minimize the potential for patient harm or the customized reports that can be more tailored to the individualized business needs of a particular hospital, what makes the report features in SQSS so value-adding is how many skilled people — who now sit in offices counting hashmarks and playing with Excel spreadsheets to always be too late in preventing the kind of errors I experienced — *can be freed up to be back on the front-lines where their potential of making a difference is much, much greater.*

ESCAPING "ANALYSIS PARALYSIS"

A very important goal of the report feature in SQSS is to flip a fifty-year-old pattern of behavior that has gotten significantly worse since the turn of the century where hospitals and all kinds of providers spend so much time collecting and managing data — too frequently lost in the act of paralysis analysis — that they struggle to get to the critical business-oriented steps of plan development and plan implementation so they can make safety, quality and financial performance better. It is an especially important consideration for hospitals struggling to manage their bottom-lines these days as a new group of outsiders are lining up to take even more money away from the direct care of patients to perform the act of analysis for them — minus the context in which the data they crunch was created.

It is like the hospital that spent two years trying to improve its poor performance related to the quietness of its patient care units — investing a lot of money and time on activities recommended by outside parties who knew nothing about the context in which its numbers were being created but who ended up playing a very big role in the evolution of activities that demoralized the staff. Finally breaking free of an old-school practice that has relied on outsiders to drive the quality bus so it is easier for leaders to distance themselves from the sometimes painful act of change-management, the hospital finally took a deep dive into its own numbers to figure out that the primary issue that kept this satisfaction number so low lived in the way fire doors slammed closed all day and all night at the end of the patient care hallways as caregivers used that stairwell to more quickly access the patient care units in the performance of their jobs. A simple rerouting of staff travel patterns — in a way that did not negatively impact the delivery of care — changed its numbers for the good. What could have saved a lot of money, time and employee grief if it had been managed with the goal of avoiding the kind of sawtooth losses common to health care's externally-driven Tit-for-Tat approach to quality management became just one of the many ways this hospital threw away huge sums of discretionary dollars that would have been better spent on funding future growth.





DATA DRIVING DECISIONS …. AND QUALITY

As access to timely data and what leaders then do with it takes on a whole new level of importance in a decade where a new, more discerning type of consumer emerges — and is gaining the support of the awakened sleeping consumer giants that has always laid dormant in corporate America — SQSS is designed to serve the needs of a hospital leader for access to a much more robust pool of big data that with a few simple clicks can be sliced and diced in a host of different ways to make sure that a decision-making team is on top of what works for and against the top-line and bottom-line numbers that determines business success.

It is like the Departmental Compliance Report that automatically and instantaneously shows the collective health of the contributions that every hospital department or group is making to the performance of the organization as a whole. With one click, all those data points — that can number in the thousands — can instantly be redistributed across the twenty-two areas of risk that the industry is now having to manage. With a handful of different clicks, leaders can easily figure out where their strengths are, but more importantly what they need to target to protect their patients and organizations in ways that are timely enough to make a difference.

BIG QUALITY…THE BIGGER THE BETTER!

I — like every hospital CEO today — needed the capacity that now lives in SQSS to manage much bigger sets of quality management and risk prevention data points and activities so to minimize the potential of becoming a victim of the kind of lack of awareness that lives in little quality — *like the price one hospital CEO paid when he signed his hospital up to participate in one of the many "little quality" benchmarking projects that are now flooding the industry.*

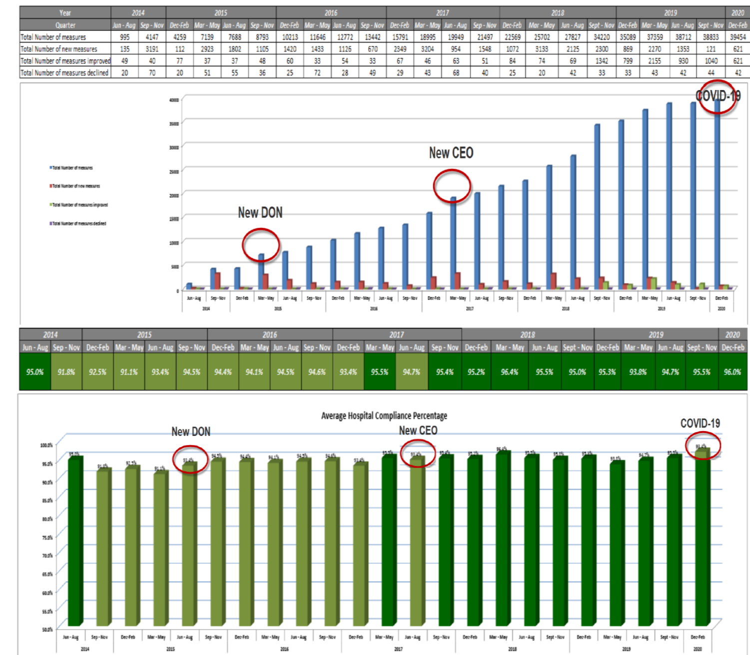
Focused on making sure that his hospital scored well on the handful of measures that the project prioritized — without having the same attention to detail for the much larger set of variables that created a whole bunch of risks for patient safety — his feelings of power and the gains he expected to experience were very short lived when — after putting up a billboard advertising his hospital as one of the safest in the country — it was discovered that staff in the operating room were not cleaning the equipment used for endoscopic procedures according to manufacturer recommendations, *and not compliant in a big enough way to create serious patient safety concerns*. Having to share the risk this practice, or lack thereof, created for patients in the local paper and on the local radio stations while having to encourage some patients to come in for infectious disease testing, everything he had hoped to gain became a very big negative net loss — especially when a new billboard appeared just a few blocks from his encouraging any patient having an endoscopic procedure in the last twelve months to visit the local law firm in town.

Whether it is the mistake of the emergency room that brags about how fast it gets patient in and out while ignoring how many stories it is accruing about wrong diagnoses and rude staff or the hospital that reads more into passing a basic accreditation survey that only looks at a tiny piece of what it now takes to keep a patient safe, the little quality that has been enough to get by in the past is becoming the new threat to survival that SQSS is designed to manage going forward.

What I needed — *and every hospital in this country now needs* — is depicted in this set of graphics and the story that its director of nursing tells about her experiences when she came into work one morning in 2015 with the title of Informatics Nurse and went home that same night with all the responsibilities that came with being the Director of Nursing. With a few simple clicks in SQSS, she moved all the nursing department responsibilities from the old DON to herself — so she did not have to take the time to figure them out. As SQSS worked every day with her entire workforce to make sure that all the basic activities of patient safety and quality management just happened like they were supposed to — knowing that the System would let her know if something did not happen like it was supposed to or was not compliant with a current standard — she dedicated a lot more of her time to learning her new role and figuring out how to help her hospital improve the patient experience and feed its top-line returns.

While the blue bars in these graphics reflect the number of quality, safety and operational activities that SQSS has grown to manage for this hospital in highly sustainable ways while cutting the number of people in quality positions by more than half because of its data management and report generation features, reducing the time managers dedicate to babysitting quality by more than half, and making it easier for one person to manage a lot more with far fewer distractions for patient care, the hospital has been able to continuously improve its overall compliance rate over the past six years to now be 95% or better every month even as the number of activities it manages in SQSS has grown to exceed 40,000 — and in spite of the sudden increase in chaos and necessary quality control activities created by COVID-19.

Whether it is all the big changes that came with bringing on a new CEO, more than doubling its patient volumes or the need to always be ready for the sudden increase in demands created by a crisis as impactful as COVID-19, SQSS is designed to be there every day helping the hospital to be in control of whatever it has already achieved and more easily control for any new challenges that may emerge so its leaders can stay focused on what has to happen to create a better tomorrow — *while always being ready to pass the next survey without having to slow its forward movement.*

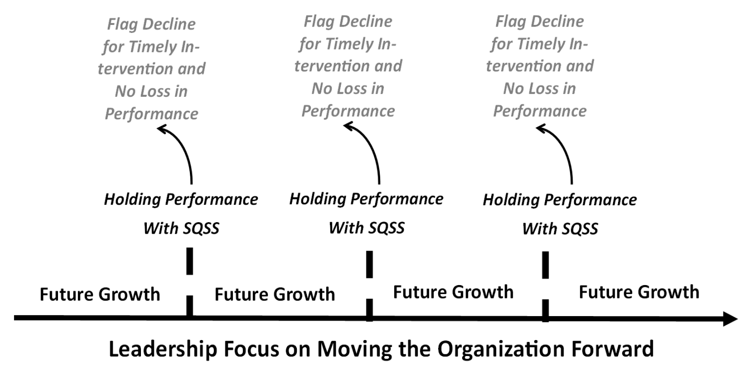


Year	2014		2015				2016			
Quarter	Jun - Aug	Sep - Nov	Dec-Feb	Mar - May	Jun - Aug	Sep - Nov	Dec-Feb	Mar - May	Jun - Aug	Sep - Nov
Total Number of measures	995	4147	4259	7139	7688	8793	10213	11646	12772	13442
Total Number of new measures	135	3191	112	2923	1802	1105	1420	1433	1126	670
Total Number of measures improved	49	40	77	37	37	48	60	33	54	33
Total Number of measures declined	20	70	20	51	55	36	25	72	28	49

Year	2017				2018				2019				2020
Quarter	Dec-Feb	Mar - May	Jun - Aug	Sep - Nov	Dec-Feb	Mar - May	Jun - Aug	Sept - Nov	Dec-Feb	Mar - May	Jun - Aug	Sept - Nov	Dec-Feb
Total Number of measures	15791	18995	19949	21497	22569	25702	27827	34220	35089	37359	38712	38833	39454
Total Number of new measures	2349	3204	954	1548	1072	3133	2125	2300	869	2270	1353	121	621
Total Number of measures improved	67	46	63	51	84	74	69	1342	799	2155	930	1040	621
Total Number of measures declined	29	43	68	40	25	20	42	33	33	43	42	44	42

2014		2015				2016				2017	
Jun - Aug	Sep - Nov	Dec-Feb	Mar - May	Jun - Aug	Sep - Nov	Dec-Feb	Mar - May	Jun - Aug	Sep - Nov	Dec-Feb	Mar - May
95.0%	91.8%	92.5%	91.1%	93.4%	94.5%	94.4%	94.1%	94.5%	94.6%	93.4%	95.5%

2017		2018				2019				2020
Jun - Aug	Sep - Nov	Dec-Feb	Mar - May	Jun - Aug	Sept - Nov	Dec-Feb	Mar - May	Jun - Aug	Sept - Nov	Dec-Feb
94.7%	95.4%	95.2%	96.4%	95.5%	95.0%	95.3%	93.8%	94.7%	95.5%	96.0%

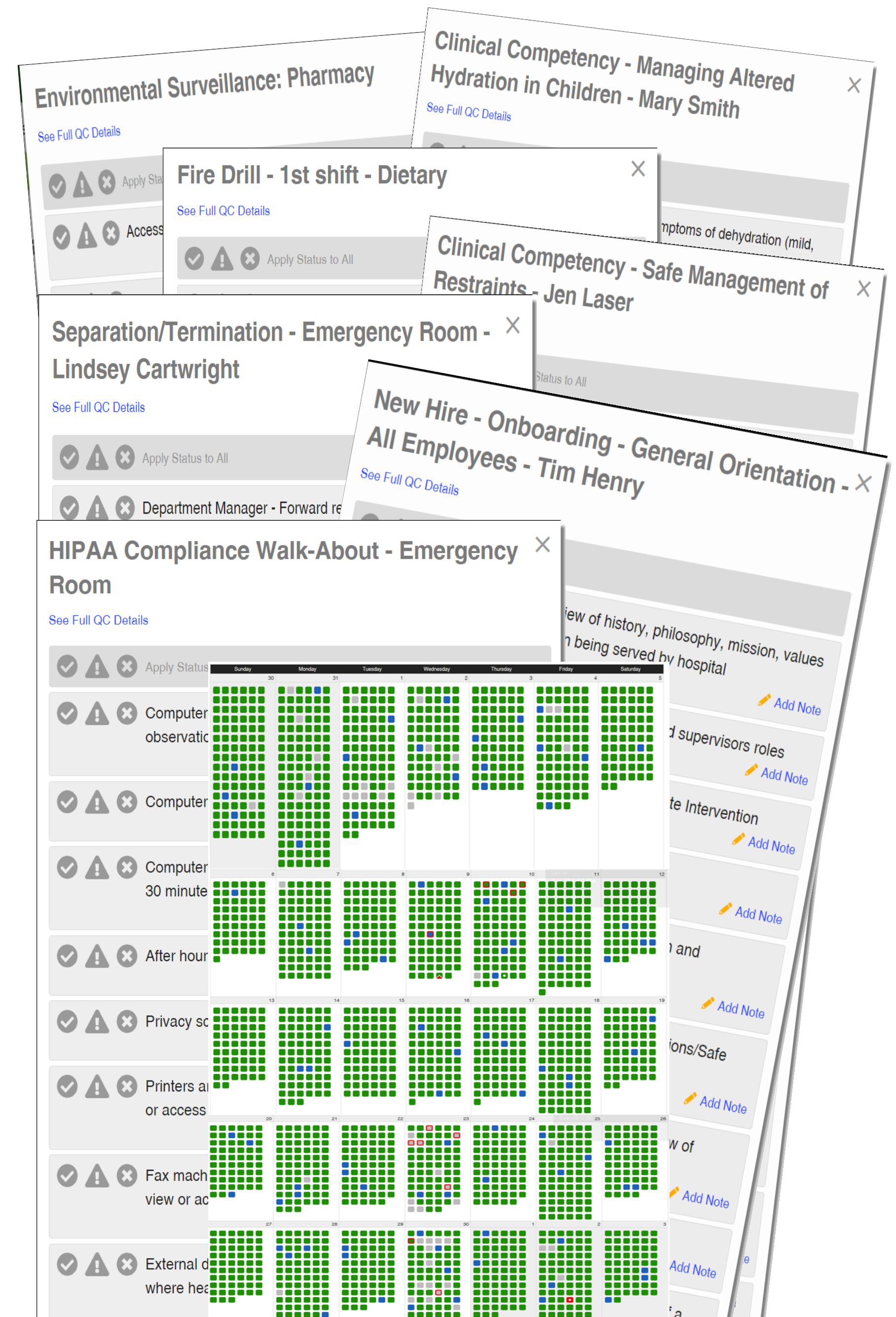


With a shift in focus from passing surveys no matter how hard it might be on the frontlines of patient care to one of supporting those on the front lines — managers and staff alike — but still being able to comply with regulations and pass survey as a basic to building a stronger future, there are a host of features in SQSS designed to keep quality management simple and small. It is like the one that makes it easier to keep people informed of all the rapid changes that occur in an environment as hypercomplex and dynamically evolving as health care. With a couple of simple clicks, managers can disseminate information to all the right people in a matter of minutes, determine who did and did not pay attention to it and push it back to the to-do lists of those who need a higher level of managerial encouragement. Those receiving messages can then have instantaneous access to all the information they have received — as SQSS maintains it for them in a personalized way in the System's library — if they need to refresh their memory at that moment in time when they need to get it right.

Then there is the feature that allows people to bump quality-related concerns or episodes of non-compliance to the to-do list of a responsible team member so to get rid of the need for dozens of post-its, yellow legal pads, and hours of personnel time dedicated to chasing answers. It is like the safety officer that bumps a concern about an obstructed emergency exit to the SQSS to-do list for the nurse manager of the unit with a few simple clicks during a fire drill. SQSS immediately notifies her, tracks to make sure that the issue gets addressed, notifies the safety officer of the corrective action plan she documents and alerts the quality department of a potential problem for patient and workforce safety if she does not address the concern in a designated period of time. While the safety officer moves on to the next important, future-oriented activity that needs his or her area of expertise as fast as the fire drill is over and he has sent all pertinent JDIs, SQSS takes over managing the follow-up that is important to fixing today in preparation for operating in a stronger tomorrow.

Recognizing that issues that haunt health care today are not about how much harder our people need to work but are about how hard they are having to work in the absence of systems and efficiencies that help them to work smarter, SQSS is designed to help organize the thousands of activities it now takes to be in control of a patient care environment and do it in a way that controls for the peaks and ebbs in demands that can be so hard on the patient/provider experience. Whether it is the risk of failure that now lives in an environment where onboarding just one new ICU nurse can involve over two hundred different activities during a time when staff turnover is at an all time high or the fact that the separation of just one employee can require fifty i's to be dotted and t's to be crossed, or the voluminous number of competencies it now takes to optimize safety and patient outcomes in a safety-sensitive environment that evolves as fast as health care does or all the environmental monitoring that is important to holding the line for safety, the expressed purpose of SQSS is to make it easier to organize, control, manage and sustain quality in ways that produces more gains and fewer losses.

It is like how a hospital can use the System to fix what too frequently happens to a new employee these days who ends up sitting in a classroom having oodles and oodles of information thrown at him or her while no one ever asks whether it is video three, four — or if the hospital is lucky, number five — that causes the employee to become overwhelmed and stop absorbing the information critical to patient safety. Working to reverse a trend that has picked up speed over the past two decades ago where the priority of these types of activities has shifted from a focus on growing our people to making sure that checkmarks got put in all the right boxes, it is the power of systematization that lives in SQSS that allows leaders to do better so their people can do better with less stress on everyone. Because of how SQSS never forgets, it makes it easier to start spreading things out over a more effective window of time to create a healthier balance of demands — ***for patient care and all those quality activities important to creating an optimal patient care environment.***



Designed to substantially reduce the number of realized stories of added risk and harm that leaders are finding harder and harder to explain away — like those that one CEO faced when it was discovered through survey that he had nurses working without active licenses, physicians dispensing narcotics with expired DEA certificates and more than a dozen pieces of safety-critical equipment lacking current biomedical inspections — SQSS is designed to bring the management of all twenty-two areas of risks, and any new ones that may emerge, together in ways that get rid of the isolationism that lives in the very costly and difficult to coordinate siloes that define quality management in health care's bureaucratic quality model.

To address all the added demands and costs I experienced when a manager would come into my office wanting to buy some new compliance-oriented software package that was almost identical to one I had just purchased while having to listen to my staff complain about having to work inside one more program that would take them away from their patients and the job duties I hired them for at the same time I was always left to operate more and more in the dark about what was really happening in my building unless I took more and more time out of my very busy day to look inside each and every silo, SQSS is designed to move the management of quality — big quality associated with all twenty-two areas of risk — into a safety net model that makes it easier to know what is going on while getting rid of the costs and inefficiencies that come with niche programs and the siloed approaches to quality management that they promote by encouraging people to create their own ways of doing things, their own power structures, their own repetition of something that as many as three other silos can already be doing, their own committees, and their own slew of burdens for the frontline staff — *all in the name of improving quality.*

- HR Management Software - $40 to $100 per 50 users per month
- Contract Management Softwa… per user per month
- Incident Reporting Software … user
- Credentialing Management … $25 per user per month
- Equipment Management … $150 per user per month
- Employee Health Softwa… ployee per month
- Work Order Managem… $125 per user per mo…
- Root Cause Analysis S… user per month
- Dashboard Creation … per user per month
- IT Help Desk Softw… month
- Basic Compliance … - $100 per user p…

Revenue

Net patient service revenue

Rental and other revenue

Net assets released from donor restriction

Federal and state grants

Total Revenues

Expenses

Salaries and professional fees

Employee benefits

Supplies

Purchased Services

Niche softwares

- **licensing or purchasing cost**
- **maintenance fees**
- **upgrade fees**
- **training staff to use program**
- **training staff on every update**
- **pulling information together for different programs to create reports**
- **time it takes for workforce to move in and out of one program to the next**
- **losses incurred because leaders do not have time to track performance inside each program**

Depreciation

Insurance

Provision of uncollectable accounts

Rent and utilities

Repairs and maintenance

Interest

Other

Total Expenses

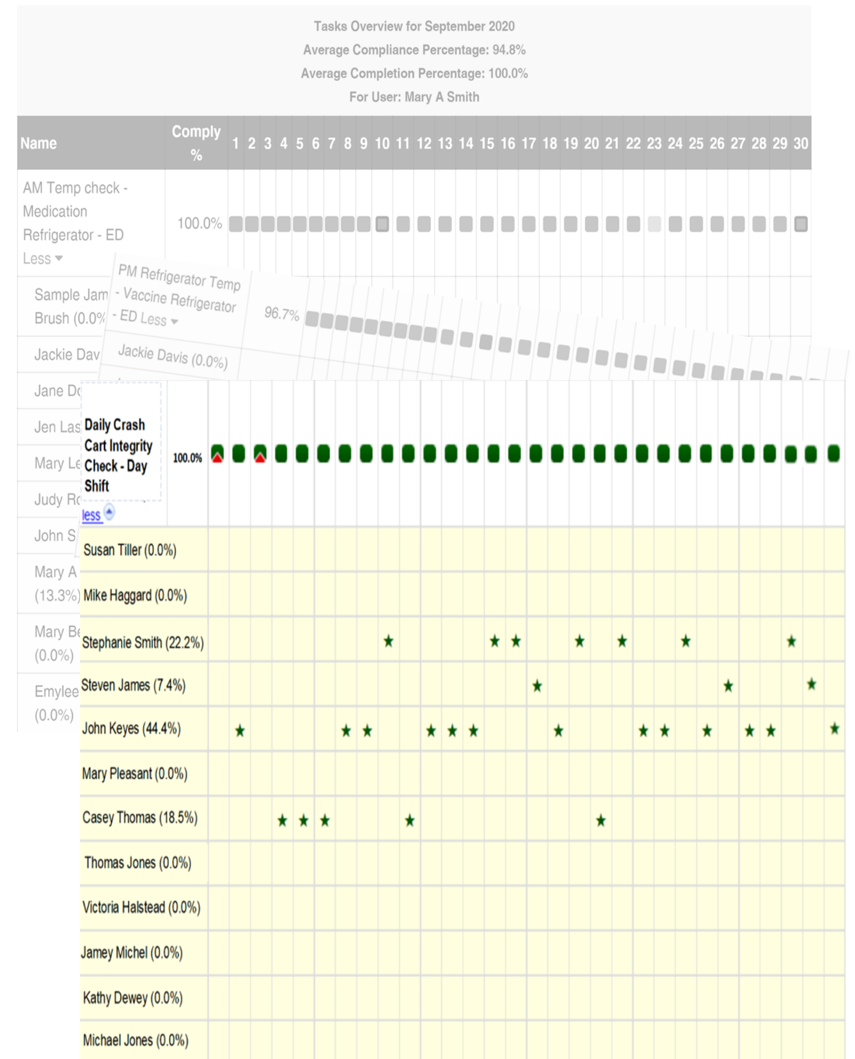
Operating Income

CREATING A HIGHER LEVEL OF ACCOUNTABILITY

While being able to get a whole lot more done right the first time in the most business smart ways possible is at the heart of how SQSS operates, there are also the multiple features that make it easier to raise the bar on accountability at the same time the System makes it easier for leaders to more effectively manage — like the feature that allows tasks to be assigned to teams of people and then lets leaders look at the individual performance inside those teams so to better protect the morale of those who are our better performers while more effectively addressing the performance of those who are not.

Making it easier to manage the growing number of activities that require small armies of people to make them happen — like the checking of crash carts — as they cannot be overlooked just because it is a holiday, someone calls in sick, it is finally vacation time and a crisis as impactful as COVID-19 hits the industry, it is the power of SQSS that makes sure that each of these activities just show up on the to-do list of every person in a big enough team every time they come due so to make it easier to ensure that they happen while shifting the role of the manager from chasing day-to-day assignments to the much simpler act of managing the make-up of the team as staffing complements shift from time-to-time.

It is a feature that addresses an age-old problem that my director of nursing struggled with every day — in an environment where 80-90% of all clinical safety activities across all the departments she was responsible for were team-based — when she would come into my office looking for my support in addressing the performance of a poorly performing employee only to be frustrated when my human resource director pointed out that she had no data to back up what she said — *because the performance she was talking about was hiding in that of a team*. Even though everyone knew she was right, her daily struggle to effectively manage her team-based world worked against what I needed to achieve and her ability to do her job because we did not have the feature that now lives inside SQSS to see and manage individual employee performance inside teams.



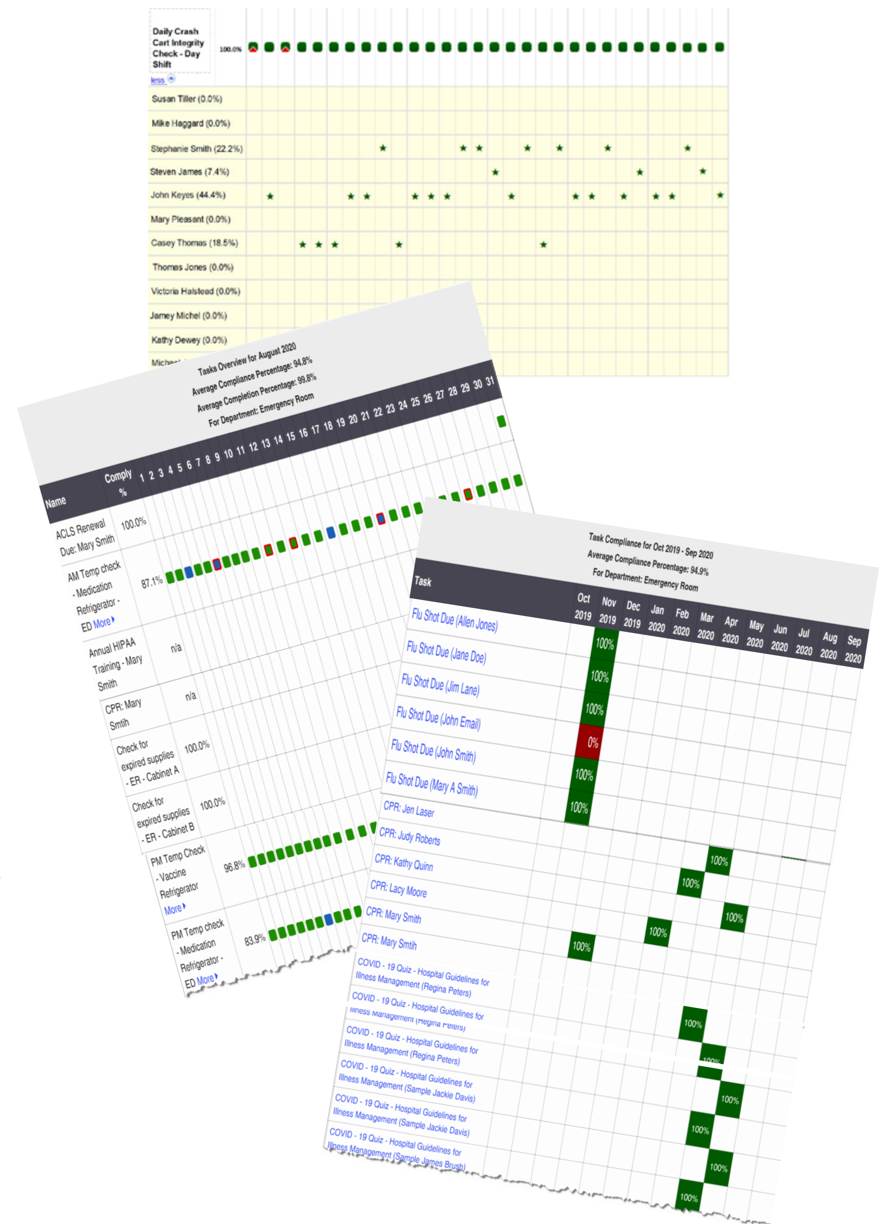
Because SQSS can know who the back-up is to any member of the health care team if all of a sudden he or she is absent and unable to fulfill assignments important to making sure quality-related responsibilities happen, it is the System's ability to automatically move all of a person's tasks to the right peoples' to-do lists with a few simple clicks so nothing is lost that keeps the risk of errors lower, and the chance of cleaning up a mess to some factor of "100" much smaller. It is like the hospital where the chief financial officer would suddenly no longer be coming back to work. When all his tasks were redistributed to all those people designated to be his back-ups, it was the first time the CEO was aware that the CFO was in the middle of the hospital's reapplication for participation in a major payer program that could have had devastating results if that awareness had come when the first round of claims for payment got rejected.

By simply marking people absent in SQSS, key safety, quality and operational activities can be instantly and automatically shifted to those who are designated as the back-up for the extent of the absence. When someone permanently leaves the hospital through a separation, one click can isolate all that employee's responsibilities so they can be easily redistributed to new responsible parties. It is these types of features that finally give leaders the kind of control they have needed to address a decades old problem where they find out what a past employee was taking care of only when those things have not happened for a long enough period of time that some new surprise requires something to be managed to some factor of "100".

REAL TIME DATA FOR REAL TIME ACTION

For the first time since I became a healthcare professional in the 1970s, SQSS gives our managers on the frontlines of patient care instant access to real-time data automatically converted into the kind of useable information that allows them to more effectively manage for today and tomorrow — not from behind. Because of the way the System will notify them as soon as something that should have happened did not, they have a greater opportunity of preventing an error and ensuring a great survey. Using the special at-a-glance report generation features that SQSS makes available to them, they can quickly identify concerning trends and patterns that tell them that a decline in performance is in play. They can more proactively act in the best interest of their patients, staff members and the organization as a whole.

Rather than spending their time sitting in their offices counting hash marks, playing with Excel spreadsheets, taking time away from managing their departments to manually preparing reports for some upcoming meeting, and chasing data that is always too old to make a real time difference by the time they catch up with it, they spend more time helping their people to grow while figuring out how to make patients feel so well cared for and personally cared about that they will come back with friends and family in tow *because of the great stories of caring, competence and leadership that SQSS helps them to create.*



ACCOMPLISHING MORE WHILE DOING LESS

Like how all the many features in SQSS use systematization to raise the bar on quality, the quiz feature is a great example of one that addresses a problem that has only gotten worse for managers over the years as they ***might have time to create a quiz and — maybe grade it —*** but will never find time to provide the feedback necessary for each person whose different knowledge deficient could lead to patient harm. In SQSS, managers can now quickly and easily build quizzes, disseminate them to the exact lists of people whom they apply to, have the System instantly grade them as fast as the employee clicks "submit quiz", and provide each employee with immediate feedback on how well he or she did along with providing the knowledge-building information important to any of the questions that each person did not answer right the first time.

The System then requires the employee to sign off that he or she has reviewed all the information about those questions he or she got wrong — *and if the topic is important enough to demonstrate greater understanding and growth, pop the quiz back to his or her to-do list to redo it.* So while managers might spend the same amount of upfront time getting a quiz ready to go, it is the way they can use SQSS to do all the heavy-lifting associated with dissemination and follow-up that transitions quizzes from being one more form of soft quality where our very important caregivers take valuable time away from their patients to participate in an activity *where they too frequently come out it no better off than they were when they went into it* to something that can actually help them to raise the bar on what they know and what they can do.

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Part of the big difference that SQSS is designed to make is demonstrated in how easy it is to manage multidisciplinary improvement projects that are so common to the industry today *and can too frequently resemble the chaos and dysfunction that comes with herding cats.* It is like the hospital that spent two years trying to reduce its number of late charges using old-school manual approaches while the number of them kept climbing during a time when the costs associated with each one was also climbing. After finally agreeing to give the PI feature in SQSS a try, the project was set up in one of the many accountability reports designed to raise the bar on quality. While each department that generated charges was doing their quality improvement work in SQSS to reduce late ones, the CFO was periodically glancing at the multi-disciplinary performance improvement report that <u>the System was automatically updating for him as fast as any department was doing any work on its contributions.</u> At least once a month, a quick glance told the CFO what progress looked like, who was making progress, who was not and where he needed to focus his time and attention. In less than a year, he and his hospital were able to achieve what had only gotten worse over the prior two years because as he said — <u>SQSS made the activity manageable in his very busy job because of how it did all the heavy-lifting for data management and workforce accountability while he stayed focused on what it would take to create success.</u>

Reducing Late Charges

Performance Improvement Goals

PI Outcome	Nov 2012	Dec 2012	Jan 2013	Feb 2013	Mar 2013	April 2013	May 2013	June 2013	July 2013	Aug 2013	Sept 2013	Oct 2013	Nov 2013	Dec 2013	Jan 2014	Feb 2014
To get organization-wide number of late charges to less than 200 (hide chart)	2055	1898	1313	847	779	573	475	357	278	169	197	186	209	151		

Contributions:

Department: Lab

QI Initiative	Nov 2012	Dec 2012	Jan 2013	Feb 2013	Mar 2013	April 2013	May 2013	June 2013	July 2013	Aug 2013	Sept 2013	Oct 2013	Nov 2013	Dec 2013	Jan 2014	Feb 2014
No avoidable late charge by December 2013 (hide chart)	C 629	PACe 598	PAC 201	PAC 143	CE 101	C 69	C 45	C 37	C 61	C 41	C 53	C 38	C 40	C 32		

Department: Pharmacy

QI Initiative	Nov 2012	Dec 2012	Jan 2013	Feb 2013	Mar 2013	April 2013	May 2013	June 2013	July 2013	Aug 2013	Sept 2013	Oct 2013	Nov 2013	Dec 2013	Jan 2014	Feb 2014
No avoidable late charge by December 2013 (hide chart)	C 411	PAC 349	CE 287	PACE 251	CE 195	CE 121	CE 142	C 101	C 39	C 32	C 41	C 22	C 35	C 28		

Department: Physical Therapy

QI Initiative	Nov 2012	Dec 2012	Jan 2013	Feb 2013	Mar 2013	April 2013	May 2013	June 2013	July 2013	Aug 2013	Sept 2013	Oct 2013	Nov 2013	Dec 2013	Jan 2014	Feb 2014
No avoidable late charge by December 2013 (hide chart)	C 93	PAC 78	CE 72	CE 56	C 49	C 32	C 22	C 7	C 0	C 2	C 6	C 4	C 0	C 1		

Department: Radiology

QI Initiative	Nov 2012	Dec 2012	Jan 2013	Feb 2013			May	June 2013	July 2013	Aug 2013	Sept 2013	Oct 2013	Nov 2013	Dec 2013	Jan 2014	Feb 2014
No avoidable late charge by December 2013 (hide chart)	C 82	PAC 87	CE 62	CE 47					C	C 0	C 3	C 0	C 0	C 1		

Department: Respiratory Therapy

QI Initiative	Nov 2012	Dec 2012	Jan 2013										Nov	Dec 2013	Jan 2014	Feb 2014
No avoidable late charge by December	C 68	PAC	CE													

Laboratory Contribution

History

Period	Stages	Number of Late Charges	Value Notes	Notes
November 2012	Check	629.0		
December 2012	Plan, Act	598.0		The highest percentages of late charges are related to RBCs and WBCs run along with inaccurate patient information collected at the time of registration. The issue is related to the way those charges are reported and the lack of key information needed for billing. The processes for reporting has been corrected. The registration manager is working on the information collection issues. There is a also a recognized trend with Hemoglogins and Hematocrits for which a fix in in the works. There are a few late charges that we will not be able to remedy because they are related to tests that are set out to reference labs. The turn-around time on those procedures will never allow us to get those charges in in less than 4 days.
January 2013	Plan, Act, Check	201.0		We only had three WBCs that were problems for this month. The fix we implemented last month for RBCs and WBCs appears to have worked. We have implemented the fix for Hemoglobins and Hematocrits. The next area that we will be working on are Chemistries. While that list is not as long, it is the next most common area of late charges when you take out RBCs, WBCs, Hemoglobins and Hematocrits.
February 2013	Plan, Act, Check	143.0		Making good progress. Continuing to work on chemistry.
March 2013	Check	101.0		Working on Urinalysis.
April 2013	Check	69.0		Most of what continues to be on the list of late charges are related to tests sent out to reference labs. Will continues to work to tighten up systems for those charges not related to tests sent out.
May 2013	Check	45.0		Only six of these tests have to do with cases that are not related to isolated occurrences and
June 2013	Check	37.0		Only two cases were not related to reference lab testing. We continue to look at these cases to determine opportunities to tighten up our systems.
July 2013	Act, Check	61.0		Number of late charges are up because of a new employee orienting during this month. Will work to strengthen the orientation process related to processing charges.
August 2013	Check	41.0		Numbers looking good. No cases not related to reference lab testing.

So whether it is the need to get control of charges or the need to be in control of the seventy-five or more activities that now create the hypercomplexity of the revenue cycle in a world where the phrase "no money, no mission" has taken on new meaning or maintaining the kind of physician performance profiles that are now starting to impact reimbursement in bigger and bigger ways, the business critical question that it is increasingly difficult to dance around is how leaders plan to do what SQSS was built to do without having it — <u>in the absence of the money, manpower, and time that it takes to do all these activities manually.</u>

Performance Profile—Dr. Kieffer

Performance Profile - Dr. James Kieffer

Statistical Data

HIPAA Compliance

Pharmacy & Therapeutics

Cyber Security

Professional Staff Privileging

Infection Prevention and Control

Professional Staff Credentialing

Employee Health

Environmental Safety

Patient Safety

Corporate Compliance

Patient Satisfaction

Utilization Review

Service Recovery

Revenue Cycle Management

Upstream RCM - Scheduling/Pre-registration

Performance Measure / QI Initiative	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015

Upstream RCM - Financial Counseling

Performance Measure / QI Initiative	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015
To have all approvals for financial assistance (100%) processed	C	P, A, C	C	C	C	C, E	C

Upstream RCM - Insurance Verification

Performance Measure / QI Initiative	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015
Insurance verification of all high dollar outpatient (100%) will occur							

Upstream RCM - Registration

Performance Measure / QI Initiative	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015
To have less than 5% of claim processing on hold because of registration	C	P, A	C	C	C, E	C	C

Upstream RCM - Patient Access

Performance Measure / QI Initiative	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015
The Master Patient Index duplication rate is less than 1% of total	C	C	P, A, C	C	C	C	C

Upstream RCM - General

Performance Measure / QI Initiative	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015
To have no (0%) lost patient care opportunities because of delay problems							

Midstream RCM - Charge Capture and Clinical Documentation

Performance Measure / QI Initiative	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015
All charges for admission encounters (100%) are entered within 7 days							

Midstream RCM - Case Management

Performance Measure / QI Initiative	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015
To have 95% of all impatient stays with a 1:1 ratio of the							

Midstream RCM - Charge Description Master (CDM) Maintenance

Performance Measure / QI Initiative	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015
To have less than 1% of claims with charge code errors	P, A, C	C, E	C	C	C	C	C

Downstream RCM - Billing and Claims Submission

Performance Measure / QI Initiative	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015
Late charges are less than 2% of total charges	C	P, A, C	C, E	C, E	C, E	C, E	C, E

Downstream RCM - Cashiering, Refunds and Adjustment Posting

Performance Measure / QI Initiative	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015
To have all copays collected at the time of service	C, E	C, E	C	C, E	C	C	C, E

Downstream RCM - Third Party and Guarantor Follow-up

Performance Measure / QI Initiative	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015
To have bad debt write-offs as a % of gross revenue not exceed 3%	P, A, C	C	C	C	C	C	C

Downstream RCM - Customer Service

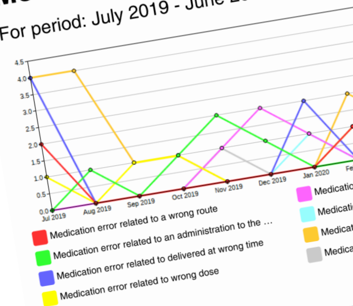
Performance Measure / QI Initiative	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015
Number of patient calls regarding billing concerns referred to							

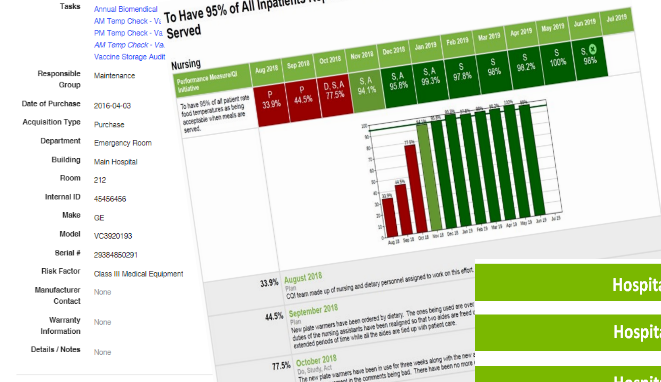
Downstream RCM - Collections and Outsourcing

Performance Measure / QI Initiative	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015
To have 3rd-party EBO fee of 15% or less as a percentage of collections	C	C	C	C	C	C	C

Whether it is taking rapid-cycle quality improvement to the next level so to produce value-adding results much faster in less resource-consumptive ways or finally being able to bring the strengths of enterprise quality and risk management together in ways that make it easier to identify risks and then act on them much more quickly than the industry's bureaucratic quality model has allowed for, SQSS is designed — and is constantly evolving — <u>to support an environment where quality is easier to manage and sustain in a way that allows leadership to dedicate more time and money to rebuilding the future of an industry drowning in opportunities but struggling to benefit from them.</u>

Whether it is making improvements happen faster or targeting the best answer much more quickly or instantaneously knowing what important safety-critical data looks like or determining at-a-glance when a piece of safety-sensitive equipment has exhausted its useful life or being able to more effectively manage quality across multiple locations, the goal of SQSS — in addition to making it easier to manage quality — *is for leaders and professionals to have timely access to the information they need for self-analysis and stronger decision making with the benefit of knowing the context in which the data is produced.*





Hospital A
Hospital B
Hospital C
Hospital D
Rehab Center
Clinic A
Clinic B
Clinic D
Clinic E
Clinic F
Clinic G
Assisted Living Center
Long Term Care Facility
Dialysis Center
Ambulatory Center Center

SUMMING IT UP!

So, as COVID-19 imposes a potentially future-altering tipping point on the health care industry, similar to how the Great Recession of 2008 almost destroyed the U.S. auto industry — too many of today's hospital leaders are in the same tough situation I faced with top-line numbers too small, bottom-line numbers too big and a bag of answers that work against fixing either, or more importantly, both. More and more of them are now face-to-face with the same hard, cold reality that caused me to finally give up the perceived and artificial safety of a bureaucratic quality culture and to start practicing the kind of quality that recognized that quality and money have to be managed as two sides of the same coin—if either is to be strong enough to protect the future.

I built SQSS to help leaders achieve the quality and efficiencies that I could only dream of. As it becomes easier and more prevalent for quality to be the weight that will pull too many of our hospitals over the edge and in the abyss of financial demise from which there is no return, *health care leaders have to start doing the real math about what helps them and what hurts them — absent the rose-colored glasses that have always allowed them to treat quality as a liability instead of the financial asset it can be.* It is akin to a conversation I had with a group of hospital leaders looking to save their financially failing hospitals — and how every question they asked came back around to some aspect of quality that was important to helping grow top-line revenue numbers, reduce bottom-line expense numbers and turn a red bottom line black by working in much more business-smart ways. It was a discussion that made it increasingly obvious that the *more* that will save today's hospitals is not *more* of the same — but *more* quality; *more real big quality — the kind that focuses more time and energy on our patients in far more business smart ways so that in the end every leader can have more to spend on future growth.*

SQSS is a new kind of quality management tool built to raise the bar on quality, reopen a hospital's margin for quality, free up money, aid in protecting and improving employee morale, and position a hospital to sell itself as the real preferred provider that can deliver on the kind of quality and confidence that patients have always wanted but are now willing to travel to find.

Welcome to Anywhere Community Hospital's Surgery Center

Team Leader: Jane Doe

Our Commitment to Chasing Zero in Surgery-Related Error Rates

Performance Measure / QI Initiative	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015
To have no patient experience a wrong site surgery	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
To have no surgical cases where a surgical procedure was done on the wrong patient	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
To have no surgical cases where the wrong procedure was done on a patient	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
To have no surgical patient develop a surgery-related infection following surgery	0.00%	2.00%	0.00%	0.00%	0.00%	1.00%	0.00%	0.00%	1.00%
To have no surgical patient experience a healthcare associated intra-operative complication that resulted in harm or a change in plan of care	1.00%	0.00%	1.00%	0.00%	0.00%	1.00%	0.00%	0.00%	0.00%
To have no surgical patient experience a healthcare associated post-operative complication that resulted in harm or a change in plan of care	1.00%	0.00%	0.00%	1.00%	0.00%	0.00%	0.00%	1.00%	0.00%
To have no surgical patient experience a medication error as part of his or her surgical experience	0.00%	0.00%	1.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

Our Commitment to Chasing One-Hundred in Adopting National Standards for Advancing Patient Care and Safety

Performance Measure / QI Initiative	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015
To have all surgical cases start within 10 minutes of scheduled time	98.00%	99.00%	100.00%	98.00%	96.00%	99.00%	98.00%	100.00%	100.00%
To have all surgical patients receive pre-operative antibiotics for the purpose of infection prevention in compliance with current national standards	99.00%	100.00%	98.00%	100.00%	100.00%	100.00%	100.00%	100.00%	99.00%
To have all surgical patients report satisfaction with the clinical outcome on the six month post-operative call	100.00%	100.00%	98.00%	98.00%	100.00%	98.00%	97.00%	98.00%	99.00%
To have all surgical patients report satisfaction with their surgical experience on week after it	C 94.00%	94.00%	96.00%	96.00%	95.00%	97.00%	97.00%	98.00%	99.00%
To have the surgery department practices comply with current national safety and infection prevention standards advocated by the American College of Surgeons and Association of periOperative Registered Nurses	99.00%	100.00%	100.00%	99.00%	100.00%	100.00%	100.00%	100.00%	98.00%
To have the surgical interventions for all patients keep pace with recommended evidence-based national recommendations as they evolve	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

Our Commitment to Creating a Great Patient Experience

Performance Measure / QI Initiative	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015
Adequacy of instructions about activities and restrictions after discharge	100.00%	98.00%	100.00%	99.00%	99.00%	100.00%	99.00%	100.00%	100.00%
Adequacy of instructions about medications you were to take after discharge	100.00%	100.00%	99.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Cleanliness of patient care area	97	98	100	100	99	100	100	100	100
Concern displayed by the physicians and other caregivers for worries and questions expressed by your family	96.00%	98.00%	100.00%	100.00%	100.00%	99.00%	99.00%	100.00%	100.00%
Ease of scheduling appointments for follow-up care	99.00%	100.00%	100.00%	100.00%	98.00%	100.00%	100.00%	100.00%	99.00%
Efforts made by your physicians and medical providers to include you in decisions about your care	100.00%	100.00%	100.00%	99.00%	100.00%	100.00%	100.00%	100.00%	99.00%
Staff efforts to alleviate your pain	100.00%	100.00%	99.00%	99.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Staff efforts to always explain their role and responsibility in your care	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Staff efforts to find solutions to any problems that came up after your discharge	95.00%	98.00%	97.00%	99.00%	100.00%	98.00%	100.00%	99.00%	100.00%
Staff efforts to find solutions to any problems that came up during your surgical visit	100.00%	100.00%	100.00%	100.00%	99.00%	100.00%	100.00%	100.00%	100.00%
Staff efforts to make you feel safe during patient care activities	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Teamwork displayed between physicians and staff involved in your care	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	99.00%	100.00%

It’s time to start:

⇒ **getting a lot more right the first time;**

⇒ **in far more sustainable and business-smart ways;** ***so……***

⇒ ***there are enough discretionary dollars for investing in future growth going forward;***

……… and making it all happen with:

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