HospitalMD®
EMERGENCY | HOSPITALIST | HYBRID

in•sight™
APRIL 2018

INSIGHTS AND INNOVATION FOR RURAL HOSPITALS AND PROVIDERS

Performance Improvement-101 PART 2

by Jim Burnette, President/CEO, HospitalMD

In case you missed it, the last issue of **in•sight™** titled **Performance Improvement 101 - Part 1**, introduced the concepts of quality, value, and performance; and the two attributes of performance (efficiency and effectiveness). You can read that issue (#15) online at: ***hospitalmd.com/resources/insight.***

IT USED TO BE THAT PEOPLE did not "shop" for healthcare. They simply went to their personal physician, who referred them to a specialist if necessary. Patient charts were on paper. Insurance was 80/20. Insurance paid the claim and life was simple. Healthcare wasn't concerned about quality and value from the patient's perspective.

That has all changed. Radical shifts have occurred where coverage varies by choice of provider, as well as coverage and payment plan limits. Customers are bearing a significantly larger share of the cost of services. Providers are rewarded or punished based on customer satisfactions surveys. And all providers are paid less year to year regardless of satisfaction score. This new structure economically limits customer choice so that purchasing decisions are actually made jointly by both the insurer as well as patient. In effect, the patient must use the provider the insurance says to use or pay significantly higher out of pocket costs. With this in mind, it is imperative that providers understand how to compete. Delivery process performance affects quality and value, and ultimately the solvency—and growth—of your hospital!

The healthcare industry has "kicked the can" down the road too long. Insurers have a significant head start. Government and commercial insurers have taken the initiative to aggressively reduce the price they pay for services. These reductions in price come with the implicit mandate that high quality and value are not compromised. If providers don't seize the opportunity now to re-design and improve business **and** clinical models, the outside market will **dictate** even more aggressively how service is delivered. I don't believe this view is "Chicken Little". Advances in information and medical technology make

CALL US AT:
1.877.881.8783

EMAIL US AT:
insight@HospitalMD.com

**400 Westpark Court,
Suite 230
Peachtree City, GA 30269**

HospitalMD.com

this prospect not too far-fetched. The doctor as he/she is known today may not be fully replaced, but may become a medical technician.

These dramatic changes spotlight the importance of understanding how process performance determines quality and value. Terms such as ***quality, value***, and ***performance*** are often used interchangeably although they have different meanings, thus causing confusion. Let's look at each.

QUALITY AND VALUE

Quality is a measure of how well the service meets a need.

Value is a sense of the fairness of the price paid relative to the quality expected or provided.

Quality and value are subjective perceptions viewed from the customer's outside perspective. The standards and measurements of quality and value are vague because customers have not directly purchased healthcare services from the perspective of quality; since services are generally paid for by third-party insurers, value is an even more difficult concept. Also, the view of payers is likely different from that of the recipient.

PERFORMANCE

There are two components of performance—***effectiveness*** and ***efficiency***.

Effectiveness is a measure of how well a service is provided by the delivery system, and/or how appealing the service is to the customer. For example:

1. How quickly one can access the service (i.e., door-to-doc)
2. How long it takes overall to deliver service from arrival to discharge (i.e., LOS)
3. Was I treated with respect and sensitivity?
4. Did I understand what was wrong and what was done?
5. Did the treatment work?

Efficiency is the measure of the cost incurred by the provider to produce each unit of service and directly impacts the financial viability of the hospital. An example is the average cost per ED patient visit. If efficiency results in a profit, viability improves. The hospital continues in business and can grow. If efficiency results in financial loss, viability declines, the hospital suffers and may eventually close.

CAUTION

Without understanding the relationship between effectiveness and efficiency, we can easily be inclined to make changes in delivery processes aimed specifically at improving effectiveness without regard to the impact on efficiency. This is dangerous. We can think we improved performance. In effect we did not. We improved effectiveness but decreased efficiency. Effectiveness and efficiency are interdependent. Both can change independently or in concert, for better or worse, or in ways that offset each other. Not every change will result in improvement. Successful improvements in effectiveness must consider the impact on efficiency and effectiveness and vise versa.

For example, adding a second provider only in the ED makes the service more costly and less efficient. However, adding a physician along with instituting a process (workflow) decision rule can also reduce the ALOS (effectiveness) and make the service more appealing (effective), and attract more patients which can improve revenue. In this case, an increase in revenue can more than offset the cost and improve efficiency. What about adding a nurse? This makes the service more costly and less efficient, and rarely improves effectiveness alone. The good news is that well designed changes using the tools of an effective Performance Improvement Methodology (PIM) can improve both effectiveness and efficiency concurrently, and significantly.

CLARITY INSTEAD OF CONFUSION

Although quality, value, and performance do not have the same meanings, these terms are often used interchangeably which can create confusion. However, there are distinct relationships between internal

provider performance and the customer's outside quality and value that have consequences. One such distinction is that a provider's impact on a customer's perception of quality and value is indirect and only occurs by improving the effectiveness of the service delivery process. In other words, process dictates the quality and value of the service.

Efficiency (performance) may improve only by as much as 10% by "working harder" and by using alternative less costly resources. At some point, reducing expense will cut into service quantity and/or quality resulting in revenue decline. Continuation of this trend creates an irreversible downward spiral. The most significant improvements occur through well-designed changes in the delivery system that are catalytic to revenue growth.

Visit our website for a graphical illustration of **The Business Excellence Model** of these relationships along with examples and contains other examples of other topics discussed in this article. Go to: **hospitalmd.com/resources/insight16/model.**

IMPACT

The conundrum is that as hospitals wrestle with process performance, the financial outlook for hospitals in general, and most rural hospitals, in particular, is bleak. Two trends are occurring that are irreversible. We are seeing the convergence of declining revenue per service (reimbursement) and increasing operating expenses per service. For most rural hospitals, this convergence has already created acute operating losses.

We are most aware of these economic market disruptors through the national media which makes the reality of them seem so far away. However, their impact is being felt every day in the local community hospital. The National Rural Health Association reports that 82 hospitals have closed since 2010 and predicts there are 700 vulnerable to closure within the next 10 years or less.

We recently conducted a survey of rural hospitals in Kentucky and Texas and found that hospitals in these states lost an average of $3.1 million and $9.4 million annually respectively. Many fragile hospitals are managing to hang on. But the only way to operationally survive is to continue to delay payments to vendors. Our vendors would probably not be pleased to hear this. We hear this dismal message weekly reminding us of the growing storm. Unlike the Titanic, we are aware today that there is an iceberg on our course.

ENCOURAGING NEWS

I have two words of encouragement: (1) more than 80% of rural hospital communities each have enough population and demand to ensure each hospital's viability, and (2) a fully integrated PIM is the specialty to diagnose and treat the diseased medicine and business of medicine.

I believe we can be successful starting together on a different path. Over the next several issues of **in•sight**™, I will share many of these tools and techniques from HospitalMD's proprietary PIM called CATALYST™.

Feel free to email me at **insight@hospitalmd.com** or at **877.811.8783** with questions or comments. I want to hear your experiences and your insights as well. See you next issue!

Jim Burnette is the Founder and CEO of **HospitalMD**. Jim has worked in healthcare for more than 20 years. His mission is to strengthen small community hospitals across the nation and help them thrive in today's rapidly changing healthcare climate. Jim is a graduate of Georgia Tech and resides in Peachtree City, a small community right outside Atlanta.

QUALITY.
VALUE.
PERFORMANCE.
SUCCESS.

UP.

EXECUTIVE INSIGHTS AT:

Facebook.com/HospitalMD

Linkedin/HospitalMD

in·sight™

HospitalMD®

EMERGENCY | HOSPITALIST | HYBRID

Performance improvement - 101 PART 2

CALL US AT: 1(877) 881.8783

OR EMAIL US AT: insight@hospitalMD.com

HospitalMD®

Delivering Excellence. Every Time.

400 Westpark Court, Suite 230
Peachtree City, GA 30269
Direct 770.631.8478

PRESORTED
STD RATE
US POSTAGE PAID
PEACHTREE CITY, GA
PERMIT NO 1