Peter E. Carlson & Associates

The High Road to Lower Cost

Pete Carlson
June 2003

For the past two decades, hospitals have been under a lot of pressure to cut costs in response to managed care and cutbacks in reimbursements. Now, they are coming under increasing pressure to improve the quality of patient care in response to increased competition and public demand. However, a lot of the problems that hospitals are having with improving quality are the direct result of the way they have gone about cutting costs.

Downsizing and reengineering, the prevailing strategies hospitals have used to cut costs, have mainly focused on cutting staff. Since labor costs make up 55-60 percent of the typical hospital's budget (RN's make up 25-30 percent), staff has been an inviting target for budget cutters. However, after repeated rounds of cutting staff, many hospitals are at bare-bones minimums, leaving them little room to continue cutting without seriously jeopardizing patient safety.

But much damage has already been done. Randomly plucking "nonessential" personnel out of a care delivery system that was already inefficient to begin with has destabilized hospital operations. Nurses now spend much of their time "nursing the system," rather than focusing on the needs of their patients. Detailed studies of how nurses spend their time, conducted by the Pittsburgh Regional Healthcare Initiative (PRHI) and others, have found that nurses spend only one-third to one-half of their time providing direct care to patients. The rest of their time is spent doing the clerical and ancillary work that used to be done by others whose jobs have been eliminated, and trying to hold the pieces together of an increasingly fragmented and chaotic system.

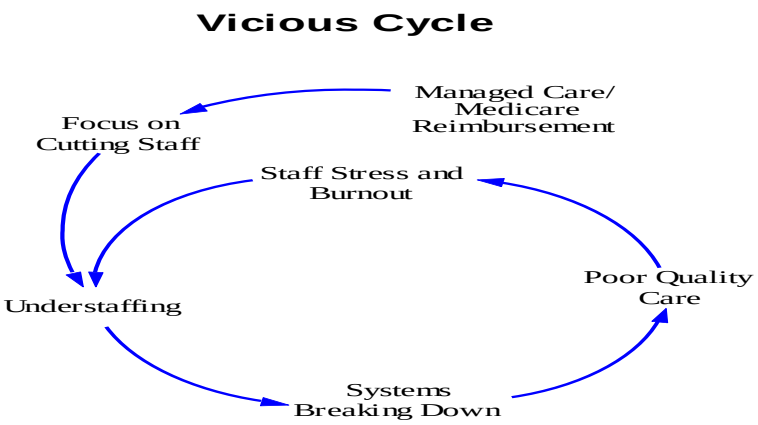
The breakdown of the care delivery system is also increasing the amount of complexity and turmoil that managers have to deal with every day. Nurse

managers, whose ranks have also been thinned by budget cuts, frequently report that they spend as much as half their time just trying to fill the holes in the daily schedule. The rest of their time is largely devoted to fighting fires, leaving little time to focus on improving the quality of patient care.

As a result, the nursing staff is being stretched to the breaking point. According to a survey conducted by Linda Aiken and her colleagues at the University of Pennsylvania School of Nursing, only a third of nurses report that there are enough staff left to provide high-quality care for a patient population that is getting older and sicker (Aiken et al, 2002a). Chronic understaffing is leading to job dissatisfaction and burnout rates that are several times the average in other industries. Nurses are leaving the profession faster than they can be replaced by a dwindling supply in the pipeline, putting additional strain on those who are left behind and destabilizing day-to-day operations in the hospital. One in 5 nurses report that they are planning to leave in the next year. Burnout and turnover among nurse managers are also increasing.

Quality of patient care is suffering as a result. Nurses typically intercept 86 percent of all medication errors made by physicians, pharmacists, and others before the patient is ever in danger (Leape et al, 1995). However, having fewer nurses with less time to spend with their patients is leading to more medication errors and to other adverse events. Research conducted by Jack Needleman and Peter Buerhaus (AHRQ, 2002) found that low levels of RN staffing were associated with higher rates of complications such as pneumonia, upper gastrointestinal bleeding, urinary tract infections, shock, sepsis, and cardiac arrest, including deaths from those complications. A report recently released by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO, 2002) found that inadequate staffing levels were implicated in 24 percent of "sentinel events" – unanticipated events that result in death, injury or permanent loss of function.

All of this is creating a vicious cycle where chronic understaffing is causing systems to break down, which is making it hard to provide quality care, which is causing nurses to burn out and discouraging other from choosing to enter the profession, which is making the problem of understaffing even more acute.



This vicious cycle is actually adding cost to the bottom line, which helps explain why the prevailing cost cutting strategies have failed to produce the expected savings. Hospitals need to find a better way to cut costs. If they continue down the path they're on, they'll eventually hit a dead end if they haven't already. It's time to back up take a different approach.

Getting Back to Basics

A growing number of hospitals are embracing the idea that the best way to cut costs is to focus on quality. This is a radical departure from the conventional wisdom held by most managers today. But, as more and more hospitals realize that they can't cut their way to prosperity, and they turn their attention from survival to growth, this is really the only direction they can go.

They have to attract doctors, because that's who brings 80 percent of patients to the typical hospital. And they have to satisfy patients and their families to get them to return and to recommend the hospital to others. Because all institutions have access to the same technology for the most part, and because it's only possible to dominate highly profitable niche markets temporarily until somebody else comes along, these aren't effective long-term strategies. Hospitals will ultimately need to compete on their ability to produce superior outcomes for patients.

This new competitive reality is driving hospitals toward a more patient-centered approach to care. That, in turn, requires getting back to the basics of consistently giving patients exactly what they need, when they need it, without any wasted time or effort, and with the best possible outcomes.

As hospitals have begun moving in this direction, the outline of a new care delivery system is beginning to emerge, defined by four basic organizing principles:

1. Focus on the needs of patients and their families, not the needs of the institution
2. Get it right the first time, based on the best available scientific evidence and timely access to all relevant patient information
3. Allow patients to move through the system without any delays
4. Ensure that patients are better off as a result of the care they receive, and are not harmed in the process

When hospitals focus on the basics, the result is fewer adverse events, lower mortality, shorter hospital stays, fewer ICU days, lower costs for drugs and ancillary services, and lower turnover. Research suggests that the average cost of a medication error is $4,000 per incident. Each postoperative infection adds 9-10 days to the length of stay, which results in $39,000 per patient in excess charges (Zahn, 2003). Meanwhile, it costs $42,000 to replace a medical-surgical nurse and $64,000 for a specialty nurse (The Advisory Board Company, 2000). It's clear that the savings from higher quality quickly add up and flow straight to the bottom line.

Getting back to basics has other benefits as well. It gets rid of a lot of the clutter that keeps staff from focusing on what really makes a difference to patients. By simplifying and streamlining these systems, which frees up nurses to spend more time at the bedside, hospitals can dramatically improve both the quality of patient care and nurses' satisfaction with their work, while also improving the bottom line. A recently released study of 71 hospitals by the Murphy Leadership Institute (2003) found that getting rid of 1.0 percent of wasteful work improves the operating margin by 0.25 percent, while also improving employee satisfaction by 1.0 percent

Simplifying and streamlining systems is different from reengineering. Instead of taking the people out of the system first, then rearranging the work, the focus is on taking unnecessary work out of the system, then rearranging the people. Also, instead of focusing within individual units or departments, the focus is on streamlining the flow of patients across departments and through the whole delivery system from intake to recovery, eliminating the handoffs that are the

cause of so many errors and so much waste. Similar efforts in other industries have yielded 30-50 percent reductions in cost with substantial improvements in quality.

This approach is also different from what goes on in most quality improvement efforts today. The conventional approach is to make a lot of little changes, based on the assumption that enough little changes will add up to a big breakthrough in performance. However, experience shows that a lot of little changes rarely produce a breakthrough, only a lot more complexity to manage. Making a breakthrough requires the sustained and focused application of resources and effort on key points of leverage, and that is impossible to pull off if people are trying to do too many things at once.

Experience suggests that the only way to find those points of leverage is to study the entire pathway that patients follow through the care delivery system to understand how different parts of the system interact with each other. That requires careful and close observation of how the system actually works, since things rarely work the way they are supposed to. The best approach is to pull together representatives from along the pathway to map the entire process as it actually works, using relevant data as a reality check. This group of "experts" can often spot where the system is breaking down and where a small amount of effort can make the biggest difference in overall performance.

Magnet Culture

Getting back to the basics of patient care also requires changing the culture. One of the lessons from other industries is that it's impossible to sustain improvements to a system unless the workforce is constructively engaged. A lot of the cost cutting that's gone on in hospitals has put nurses on the defensive and left them feeling disrespected. As a result, many have grown angry and cynical about the hospital's motives and have chosen to disengage. Attempts to maintain productivity through various "feel-good" programs have taken the edge off of nurses' anger in some cases, but these programs have done little to overcome the mistrust that has taken root.

A growing number of hospitals are taking a more radical approach. These "magnet hospitals" are consciously transforming their culture into one that focuses primarily on providing high-quality patient care and offering nurses professional respect, a high degree of control over their work, a supportive work

environment, and mutually respectful relationships with doctors. They maintain staffing levels adequate to deliver high-quality care, and give nurses a meaningful voice in how that care is delivered. As a result, magnet hospitals are having more success than other hospitals in recruiting and retaining nurses.

This approach, which has been employed by a number of hospitals for years, is now gaining increasing visibility as a result of the recognition process overseen by the American Nurses Credentialing Center. The hospitals that are taking this approach are getting good results. Research conducted by Linda Aiken (2002b) and Donna Havens (2001) has found that patient outcomes are better in magnet hospitals, including lower mortality rates, reduced number of patient and family complaints, and higher patient satisfaction.

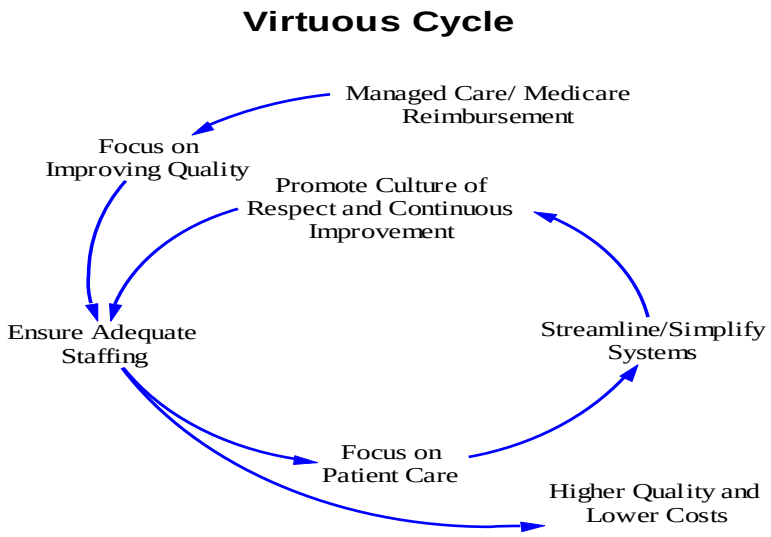
The research also shows that Magnet hospitals are able to operate at lower costs than the typical hospital, despite higher staffing levels (Aiken, 2002b). In other words, having more nurses can actually lead to higher quality and lower costs at the same time. One reason why is because people are more productive when they feel good about coming to work. Another reason is because with adequate staffing levels, there's more stability, so nurses and managers don't waste as much time fighting fires, and they can focus more on improving patient care.

As patient care improves, costs go down. That's because there are fewer costly errors and adverse events that require additional resources. The costs of poor quality are very real, but they don't appear directly in the budget. Instead, they show up as additional hours of work or FTE's, additional supplies, and in some cases, the cost of defending a lawsuit. Regardless, they go straight to the bottom line.

Virtuous Cycle

Taken together, the elements of this new approach to cutting costs create a virtuous cycle. A patient-centered approach doesn't require hospitals to choose between cutting costs or improving quality. It allows them to make progress on both at the same time. It focuses attention on the floor where services are delivered to patients, and on improving the systems that deliver that care. It eliminates a lot of the busywork that wastes so much of people's time, and lets them focus instead on improving the quality of care. And it eliminates the need for much of the complex and costly infrastructure that exists today to coordinate the current complex and fragmented delivery system.

The starting point is an adequate level of staffing to maintain stability. With less turmoil, nurses and others have an easier time focusing their attention on patient care, and they are able to find time to simplify and streamline the systems they work in. The magnet culture allows nurses to reconnect with the passion that brought them into their profession to begin with, and engages their energy and creativity in continuously improving the quality of care. This cycle leads to better patient outcomes, lower costs, and higher nurse satisfaction.



This high road to lower costs leads to a much simpler, streamlined delivery system that's easier to manage and capable of continuous improvement, and to a much more engaged workforce who's hearts and minds are focused on achieving superior outcomes for patients. Hospitals that can figure out how to put these pieces together will have doctors, patients, and nurses lined up at their doors, and a healthy margin.

References

Agency for Healthcare Research and Quality (AHRQ). (2002). "New Analysis Confirms Direct Link Between Nurse Staffing and Patient Complications and Deaths in Hospitals." Press Release, May 29, 2002., Rockville, MD.

Aiken, L., Clark, S., Sloan, D., Sochalski, J., and Silber, J. (2002a). "Hospital Nurse Staffing and Patient Mortality, Nurse Burnout, and Job Dissatisfaction," *Journal of the American Medical Association*, 288(16).

Aiken, L. (2002b). "Superior Outcomes for Magnet Hospitals: the Evidence Base," in Margaret L. McClure and Ada Sue Hinshaw (Eds.), *Magnet Hospitals Revisited*, American Nurses Publishing, 2002

Havens, D. (2001). "Comparing Nursing Infrastructure and Outcomes: ANCC Magnet and Nonmagnet CNE's Report," *Nursing Economics*, 19(6).

JCAHO. (2002). *Health Care at a Crossroads: Strategies for Addressing the Evolving Nursing Crisis*

L. Leape, D. Bates, D. Cullen, J. Cooper, H. Demonaco, T. Gallivan, R. Hallisey, J. Ives, N. Laird, G. Laffel, R. Nemeskal, L. Peterson, K. Porter, D. Servi, B. Shea, S. Small, B. Sweitzer, B. Thompson, and M. Vander Vleit (1995). "Systems Analysis of Adverse Drug Events," *Journal of the American Medical Association*, 274(1).

Murphy Leadership Institute (2003). "Eliminating Wasteful Work in Hospitals Improves Margin, Quality, and Culture," *Research Brief*.

The Advisory Board Company, Nursing Executive Center. (2000). *Reversing the Flight of Talent: Nursing Retention in an Era of Gathering Shortage*. Washington, DC.

Zahn, C., and Miller, M. (2003) "Excess Length of Stay, Charges, and Mortality Attributable to Medical Injuries During Hospitalization," *Journal of the American Medical Association*, 290(14).