I recently copresented a daylong workshop titled Quality BootCamp® for a group of physician leaders. At the end of the day, my fellow presenters and I asked for feedback. We wanted to know whether the information provided during the workshop would help improve care in the participants’ local hospitals.

Some of the responses we received were frightening—not only for their patients, but also for the financial viability of their organizations.

Of the majority of hospitals represented, most administrative teams were cutting resources in their quality departments. For example, one hospital was eliminating improvement specialists; another had decided not to invest in safety training; a third hospital was postponing front-line patient experience training; and a fourth had eliminated the American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP) registry, a resource for preventing surgical complications—all in an effort to reduce costs.

Now is not the time to cut these resources. Rather, there is a solid business case for increasing our investment in quality improvement.

Taking Performance Data Off the Chopping Block

The ACS NSQIP registry helps physicians identify and eliminate post-op complications. The ACS states that, on average, an NSQIP-supported improvement program has the opportunity to prevent 250 to 500 complications, save 12 to 36 lives, and reduce costs by millions of dollars each year in just one hospital. Previous studies have estimated that the average hospital complication adds approximately $10,000 to the cost of care. Eliminating 250 to 500 complications would save a hospital an estimated $2.5 million to $5 million dollars per year, while the cost to run the NSQIP registry (one FTE and the license fee) is less than $100,000 per year. This investment would also save 12 to 36 patient lives in the same year, according to the ACS. The business case for maintaining the ACS NSQIP registry is clear, and it’s a great example of how the finance and clinical sides of the house need to come together to understand each other’s work and the tools clinicians can bring to bear to provide value—improving quality and reducing patient suffering while decreasing costs.

Maintaining Quality Improvement Staff

The savings generated by many of our national improvement priorities can be substantial. Preventable complications add approximately 9.5 percent to our inpatient costs, or $88 billion per year to our national healthcare expense, according to a study published in 2009 (Fuller, Richard L., et al., “Estimating the Costs of Potentially Preventable Hospital-Acquired Complications,” Health Care Financing Review, Summer 2009). For example, for each catheter-related bloodstream infection that is avoided, savings average $18,000 to $22,000 per case, according to the study. For every decubitus ulcer avoided, $17,500 to $28,000 is saved. Postoperative infections with deep wound disruption cost

Investing in quality and safety programs and developing a group of internal experts that can take performance to the next level remains critical for hospitals—even as they seek to become more cost-efficient.
an additional $14,400, and venous thrombosis costs approximately $11,000 to $16,000, the study’s authors found. Eliminate just five instances of one of these complications, and you’ve paid for an improvement specialist. An average improvement specialist can run three to five improvement teams at a time. The ROI for their work is immense.

Protect Training that Improves the Patient Experience

Hospitals also would be ill-advised to postpone front-line training designed to improve patient-experience ratings. First, the patient’s experience can affect inpatient volume and market share, both positively and negatively. Second, satisfaction ratings are part of Medicare’s Hospital Value-Based Purchasing (VBP) Program.

My colleagues and I conducted a quick study for an 11-hospital system about a year ago. Based on the system’s HCAHPS scores and yearly improvement rates, the system was projected to lose more than $4 million in VBP revenue over the next five years if it did not make changes in its approach. One recommended intervention was an investment in training for the system’s front-line staff. The training can be provided on demand via recorded webinars, during unit-based meetings, during leader rounds, through one-on-one coaching with patient experience experts, and more. The cost is minimal, and the rewards, substantial: increased admission volumes, market share, and VBP revenue, to name a few.

Continue Safety Training

Medical errors are the third-leading cause of death in the United States, with 440,000 lives lost each year in our hospitals (James, J. “New, Evidence-Based Estimate of Patient Harms Associated with Hospital Care.” Journal of Patient Safety, September 2013). Effective safety programs, which require well-trained front-line staff, can reduce errors resulting in serious patient harm by more than 90 percent (Reform in Action: Improving Quality in Hospitals, Robert Wood Johnson Foundation, August 2012). Front-line training is typically only two hours in duration and is one of the highest-impact interventions in the program. Sure, there’s an opportunity cost to the training, but really, it’s only two hours per associate—and that’s a small price to pay to eliminate just one death from a medical error. A children’s hospital in Michigan that implemented front-line training achieved a 90 percent decrease in serious errors. It’s our moral obligation to make our institutions the safest they can be, and this is the first step in that journey.

The Business Case Is Clear

Although all of our institutions are under pressure to reduce costs, the business case for maintaining and even expanding our investment in quality and safety is well-proven. Rather than cutting quality and safety resources, now is the time to ensure we have adequate staff to eliminate errors and complications while improving efficiency and removing waste. Based on the average staffing levels in hospitals across the country, I would even argue that it is time to expand these resources. And why not? For every CEO I’ve worked for, I’ve guaranteed a threefold to tenfold ROI on the investments they make in quality and safety. Why? Because as I’ve shown above, 90 percent of well-targeted efforts have an incredible ROI. In 20 years, I’ve yet to miss this mark. We should be investing in these resources rather than cutting the very staff and interventions that will help get us to those Medicare breakeven rates.

But money aside, the lives that can be saved through investments in quality and safety are in the hundreds of thousands. It’s our ethical and moral obligation to invest in this work; it’s our core mission, our sacred duty. Our patients, families, and community expect nothing less. Maintaining or increasing investments in quality and safety is simply the right thing to do.

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