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FREE SUMMARY REPORT

JULY 2014

The New Quality Equation: Measuring Success and Eliminating Waste

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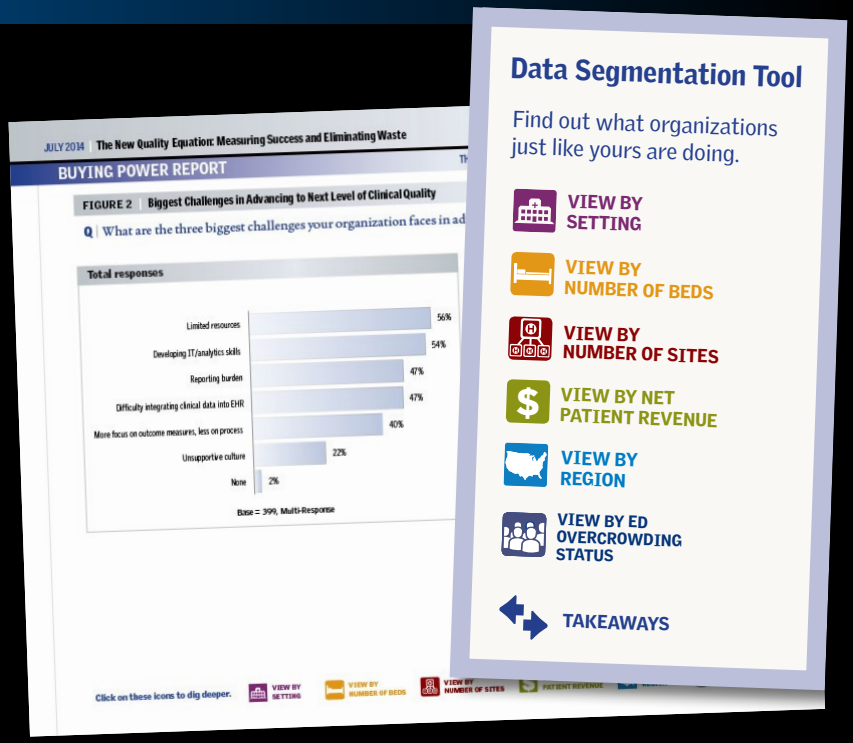
The New Quality Equation:

Measuring Success and Eliminating Waste

This report reveals how best to employ continuous improvement and other tools to standardize processes, improve patient care, and cut costs.

- Discover how Scripps Health enhanced its efforts to standardize clinical and operational functions across its hospitals and outpatient centers by adopting a horizontal leadership structure
- Find out how Virginia Hospital Center improved its HCAHPS physician scores from the 50th percentile to the upper 80th percentile in two years
- Uncover how the misalignment of the EHR with clinical workflow hinders improvements in clinical quality, care redesign, and collaborative care
- Learn how Methodist Health System facilitates the sharing of best practices through an annual peer-driven quality summit for employees



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About the Premium and Buying Power Editions

This is a summary of the Premium edition of the July 2014 HealthLeaders Media Intelligence Report. In the full report, you'll find a wealth of additional information. For each question, the Premium edition includes overall response information, as well as a breakdown of responses by various factors: setting (e.g., hospital, health system, physician organization), number of beds (hospitals), number of sites (health systems), net patient revenue, and region.

Available separately from HealthLeaders Media is the Buying Power edition, which includes additional data segmentation based on purchase involvement, dollar amount influenced, and types of products or services purchased.

In addition to this valuable survey data, you'll also get the tools you need to turn the data into decisions:

- A Foreword by Jeffrey DiLisi, MD, Vice President and Chief Medical Officer of Virginia Hospital Center in Arlington, Virginia, and Lead Advisor for this Intelligence Report
- Three Case Studies featuring initiatives by Methodist Health System–North Texas in Dallas; Scripps Health In San Diego; and Virginia Hospital Center in Arlington, Virginia
- A list of Recommendations drawing on the data, insights, and analysis from this report
- A Meeting Guide featuring questions to ask your team

Table of Contents

Methodology

The *2014 Clinical Quality Survey* was conducted by the HealthLeaders Media Intelligence Unit, powered by the HealthLeaders Media Council. It is part of a series of monthly Thought Leadership Studies. In April 2014, an online survey was sent to the HealthLeaders Media Council and select members of the HealthLeaders Media audience from hospitals, health systems, and physician organizations. A total of 405 completed surveys are included in the analysis. The bases for the individual questions range from 369 to 405 depending on whether respondents had the knowledge to provide an answer to a given question. The margin of error for a sample size of 405 is +/-4.9% at the 95% confidence interval.

Each figure presented in the report contains the following segmentation data: setting, number of beds (hospitals), number of sites (health systems), net patient revenue, region, purchase involvement, dollar amount influenced, and types of products/services purchased. Please note cell sizes with a base size of fewer than 25 responses should be used with caution due to data instability.

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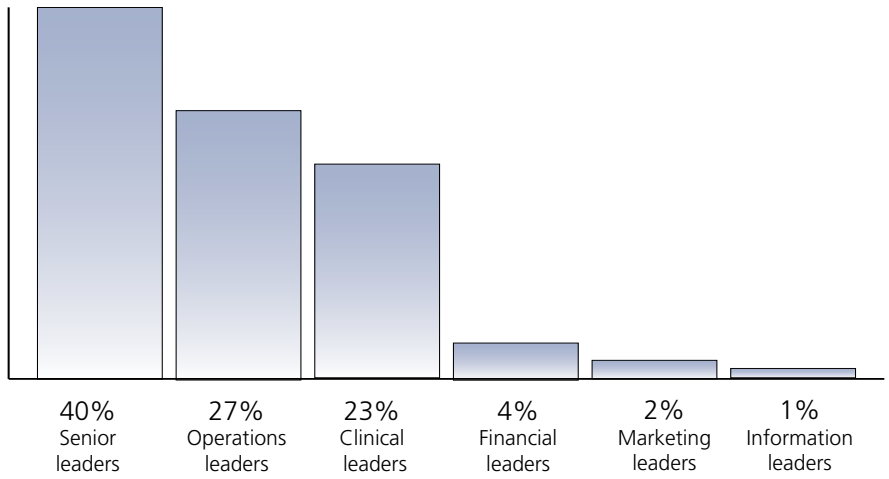
Respondent Profile

Respondents represent titles from across the various functions at hospitals, health systems, and physician organizations.

Title

Base = 405



Senior leaders | CEO, Administrator, Chief Operations Officer, Chief Medical Officer, Chief Financial Officer, Executive Dir., Partner, Board Member, Principal Owner, President, Chief of Staff, Chief Information Officer

Clinical leaders | Chief of Orthopedics, Chief of Radiology, Chief Nursing Officer, Dir. of Ambulatory Services, Dir. of Clinical Services, Dir. of Emergency Services, Dir. of Nursing, Dir. of Rehabilitation Services, Service Line Director, Dir. of Surgical/Perioperative Services, Medical Director, VP Clinical Informatics, VP Clinical Quality, VP Clinical Services, VP Medical Affairs (Physician Mgmt/MD)

Operations leaders | Chief Compliance Officer, Asst. Administrator, Dir. of Patient Safety, Dir. of Quality, Dir. of Safety, VP/Dir. Compliance, VP/Dir. Human Resources, VP/Dir. Operations/Administration, Other VP

Information leaders | Chief Medical Information Officer, Chief Technology Officer, VP/Dir. Technology/MIS/IT

Financial leaders | VP/Dir. Finance, HIM Director, Director of Case Management, Director of Revenue Cycle

Marketing leaders | VP/Dir. Marketing/Sales, VP/Dir. Media Relations

Type of organization

Base = 405

Hospital	42%
Health system	22%
Long-term care/SNF	12%
Physician org.	10%
Ancillary, allied provider	6%
Health plan/insurer	5%
Government, education/academic	2%

Number of sites

Base = 90 (Health systems)

1–5	17%
6–20	34%
21+	49%

Number of beds

Base = 170 (Hospitals)

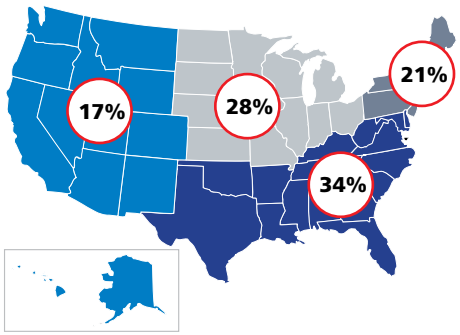
1–199	51%
200–499	33%
500+	16%

Number of physicians

Base = 40 (Physician orgs.)

1–9	30%
10–49	30%
50+	40%

Region



WEST: Washington, Oregon, California, Alaska, Hawaii, Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming

MIDWEST: North Dakota, South Dakota, Nebraska, Kansas, Missouri, Iowa, Minnesota, Illinois, Indiana, Michigan, Ohio, Wisconsin

SOUTH: Texas, Oklahoma, Arkansas, Louisiana, Mississippi, Alabama, Tennessee, Kentucky, Florida, Georgia, South Carolina, North Carolina, Virginia, West Virginia, D.C., Maryland, Delaware

NORTHEAST: Pennsylvania, New York, New Jersey, Connecticut, Vermont, Rhode Island, Massachusetts, New Hampshire, Maine

ANALYSIS

Clinical Quality: Reassessing Care Metrics and Leadership Models

MICHAEL ZEIS

Clinical quality is fundamental to healthcare, and while that won't change, the industry itself is, and that is having an impact. Payers, increasingly, are requiring better clinical results in return for better reimbursements. Providers, too, are developing initiatives and incentives around clinical quality processes and outcomes. Technology offers more ways to measure and communicate, but also can be a burden. And, of course, there is continuing pressure to control the cost of care, and that creates both challenges and opportunities for the clinical team. The HealthLeaders Media survey on clinical quality uncovers some areas where change is prompting some rethinking and recalibration.

- For instance, who is in charge? The quality department might be responsible for monitoring, reporting, and in many cases, for driving quality improvement initiatives. But the clinical team is responsible for delivering quality patient care. And report advisors tell us that we can't expect quality to improve unless responsibility for quality is shared organizationwide.

- In addition, as a response to healthcare reform, there is considerable attention paid to metrics and reporting. As a result, there is a unified focus on a particular set of quality metrics, and quality improvement

WHAT HEALTHCARE LEADERS ARE SAYING

"We are joining a larger healthcare system. One benefit is access to a large proven database and a wealth of experience implementing best practices."
—CEO of a medium hospital

"We are working with our state hospital association as well as local hospital association on care coordination efforts."
— Chief financial officer of a small hospital

"We are establishing a clinically integrated network with another independent hospital to reduce expenses and demonstrate the quality and cost-effective care we provide. We work with the next sites of care for a smooth transition and to make sure all patient needs are met and there is continuity of care."
—Chief information officer of a medium hospital

"We are involved in a CMS bundled payment demonstration project for COPD. We need information from our postacute care providers (quality and cost) and it will have to be a quid pro quo in which they provide information, but so do we."
—Chief medical officer of a medium hospital

"We currently partner with a group purchasing organization and utilize internal software to help us with quality tracking. We also participate in multiple databases where we can benchmark quality."
—Chief nursing officer of a small health system

"We are only focusing on mandatory tracking and exchange relationships."
— Chief nursing officer of a small hospital

Analysis (continued)

techniques are broadly practiced. But some say the additional reporting burden drains resources away from delivering care.

- And the EHR, which is becoming a vital infrastructure element in delivering healthcare today and is expected to be the foundation for many healthcare improvements in the future, is said not to be aligned with the clinical workflow by 49% of healthcare leaders. Such a mismatch between capabilities and needs may hinder improvements in clinical quality, specifically, and place limits on the success of many more broadly stated care-enhancement efforts such as care redesign and collaborative care.

Of course reform is prompting positive changes, too. The industry is paying attention to quality not only as a discipline in its own right, but also as a component in delivering value. There is broad recognition that individuals within and outside of the organization contribute to clinical quality. Their performance is monitored and, in many cases, a portion of their compensation is based on that performance. And even though 49% say that their EHR isn't well matched to clinical workflows, 49% also say that access to the patient's health record improves clinical quality. This means that the workflow challenges will be recognized and eventually addressed.

Clinical quality: A hands-on activity. Healthcare leaders acknowledge that both clinical team members and leadership drive quality performance, with 47% including clinical staff support among the top three contributors to success in clinical quality, 41% citing physician support, and at the top, 56% including leadership support. The non-staff-related items mentioned most as success factors are continuous improvement techniques (40%) and integration of clinical data close behind (37%).

> "It seems to me that the biggest contributor to achieving clinical quality is to have economic incentives aligned between the health system and its physicians."
>
> —James LaBelle, MD

James LaBelle, MD, chief medical officer and corporate senior vice president of Scripps Health, a private nonprofit integrated health system with four hospitals on five campuses and more than 20 outpatient centers and clinics in the San Diego area, recognizes the importance of alignment when the organization is striving to improve clinical quality. "It seems to me that the biggest contributor to achieving clinical quality is to have economic incentives aligned between the health system and its physicians," he says.

More than half (56%) include resource limitations on their list of the three biggest challenges they face in advancing to the next level of clinical quality. Advisor Sam Bagchi, MD, senior vice president, chief quality

Analysis (continued)

officer, and chief medical informatics officer for Methodist Health System, a nonprofit health system with four owned acute care hospitals and a total of 1,161 licensed beds in the Dallas-Fort Worth area, explains how a more inclusive perspective on quality can provide relief for what may be in many organizations an overworked quality department. "Our goal at Methodist is to make all 8,000 of our employees and medical staff experts in quality and safety. That's the only way we can really get to a zero-harm environment, an environment where everybody feels that it's part of their job, and that quality is the most important thing they're doing every day," he says. "The more organizations can make quality improvement and patient safety part of what their entire workforce is doing and less about what the quality department is doing, the less they will feel that lack of resources is a limiting factor."

LaBelle, an advisor to this Intelligence Report, relates quality to process, and wants those on the front lines to take responsibility. "The real issue is changing the dialogue so that quality is seen as an attribute of our clinical processes of care. We need to drive accountability for improving those clinical processes out to the front lines. At Scripps, the quality department is about facilitating a dialogue around process and developing outcomes."

Balancing efficiency and quality. One-quarter of respondents say that initiatives aimed at efficiency and reducing utilization put some patients at risk. We can't take much solace by observing that it's only a minority; 25% is a considerable segment of the industry. LaBelle wonders, "When our response to the environment is that we clamp down on labor costs or we deny care, we should ask, 'What are we doing wrong?' "

LaBelle says we should examine the model of care, considering a broader set of options. When some consider previous unsuccessful experiences with capitation or managed care reimbursement systems and their current responsibilities for delivering positive financial results, LaBelle says, "We have a lot of anxiety around changing the business model." Some comments from respondents who say efficiency efforts may place some patients at risk bear out what LaBelle says. For instance, one leader noted that "outliers" may come to harm as physicians order fewer tests. Others mentioned possible adverse effects as the clinical staff spends more time on documentation and reporting instead of patient care. LaBelle says understanding the relationship between waste and quality will help organizations strengthen their approach to the cost/quality trade-offs.

"The more organizations can make quality improvement and patient safety part of what their entire workforce is doing and less about what the quality department is doing, the less they will feel that lack of resources is a limiting factor."

—Sam Bagchi, MD

Analysis (continued)

"What's the real barrier to dealing with waste? To me [the response to this question] means we're not dealing with that."

Broader care team. Perhaps the HCAHPS measure getting the most attention now is CMS' all-cause hospitalwide readmissions, which is the outcome measure presenting the biggest challenge to 43% of respondents. The arithmetic is relatively easy to understand. According to report lead advisor Jeffrey DiLisi, MD, senior vice president and chief medical officer for Virginia Hospital Center, a 342-licensed-bed nonprofit teaching hospital in Arlington, Virginia, "When you look at Medicare spending per beneficiary, the biggest chunk of noninpatient costs are readmission. So if you reduce readmissions, you're going to reduce your average cost per episode of care. So the all-cause hospitalwide readmission measures is really critical for all of us to be thinking about."

DiLisi provides two reasons that readmissions are challenging. First, although some patients can be readily identified as candidates for readmission, others can't be. "The question isn't so much, 'Who's the highest risk for readmission?' The bigger risk is from people who you think are not at risk for readmission but are actually high-risk patients." Second, addressing readmissions is multifaceted. "There are so many factors that go into it. It's a challenge because there's not one silver bullet. You need to attack the problem from multiple angles."

In addition, providers of acute care must face the unknown when considering the 30-day readmission issue because of patient behavior and the care patients receive from others. Bagchi notes that 30-day mortality measures present a similar challenge, one that extends beyond the hospital. "All-cause readmissions and all-cause mortality, particularly the 30-day mortality, both relate to your community standard of care, not just your hospital standard of care. That is extremely challenging for most traditional healthcare systems."

> "We're going to all need to be more accountable and transparent about the continuum of care. They're going to need us, and we're going to need them."
>
> —Jeffrey DiLisi, MD

Continuing to focus on reporting. For many respondents, the reporting task itself seems to stand in the way of improving quality: nearly half (47%) include the burden of reporting among the top three challenges keeping them from advancing to the next level of clinical quality. It is clear that the industry is feeling the burden of reporting. But it is also clear that, reviled by some as the measures might be, tracking and reporting HCAHPS has been good for the industry and good for patients.

First, HCAHPS demands attention. Says LaBelle, "The fact that there is public reporting may not have changed a lot of behavior, but consider

Analysis (continued)

that we weren't measuring clinical processes until we began public reporting." In addition, HCAHPS provides a single set of performance benchmarks, used by nearly all in the industry. LaBelle explains, "That's allowed the boards of each of the health systems and hospitals to be accountable in some measure for quality without having to develop their own quality metrics."

More than half (58%) now exchange clinical quality performance metrics with outside care collaborators, and another 12% expect to do so within the next 12 months. At Methodist Health System, quality information is exchanged with a preferred provider network consisting of home health providers and skilled nursing facilities. Methodist holds quarterly forums with its preferred providers, and invites those who have not yet joined the network, as well. Bagchi says, "These are collaborations where not only do we share data, but our improvement efforts also are being synchronized around shared accountability metrics like readmissions."

Those who have begun such collaborations will be more prepared for the extension of the Medicare Spending per Beneficiary to cover three days before admission, during the hospital stay, and 30 days after discharge, which is expected to go into effect in October 2014. About Virginia Hospital Center's care partners, DiLisi says, "We're having more open conversations with them now that this is coming. We're going to all need to be more accountable and transparent about the continuum of care. They're going to need us, and we're going to need them. We've set up an HIE to begin that process."

Accountability: More will track costs. More than half of respondents (56%) say their organizations commit an adequate level of resources to clinical quality, and 19% say the level of resources is exceptional. Yet getting a firm handle on the level of resources can be difficult, especially in organizations that have been successful at engaging their whole staff in the effort. "This is really about cultural transformation," says LaBelle. "I could gather up all the FTEs and project management who work in quality ... but that still doesn't touch all the transformational efforts that are going on in the organization that those people support."

> "The real issue is changing the dialogue so that quality is seen as an attribute of our clinical processes of care. We need to drive accountability for improving those clinical processes out to the front lines."
>
> —James LaBelle, MD

However, the need to hold staff and care partners responsible for performance may bring some discipline to the cost-measurement function. Today, 39% track costs or ROI and 45% don't. Says DiLisi, "If systems are taking on risk and they're getting paid per person, there are going to be more ROI calculations on these things in the future."

Analysis (continued)

Investments: Is the EHR ready for prime time? Of course the EHR is a pivotal infrastructure element in healthcare, contributing to clinical quality in a variety of ways, according to respondents. The EHR supports better care collaboration (53%), provides ready access to patient information (49%), supports quality reporting (43%), provides care alarms such as medication warnings (40%), and aids clinical decision support (39%).

However, nearly half (49%) say that poor alignment with the clinical workflow prevents the EHR from contributing even more, which sounds like a severe limitation. "There's a whole science around usability," says Bagchi. "And much of that science and many of those usability tools have not made their way into clinical IT."

Without a clean alignment with the clinical workflow, there is dysfunction, as Bagchi explains. "If the workflow is not aligned with the EMR, then the clinical data you're getting is likely to be misleading or incomplete. That's because when tools are not aligned with clinical workflows, certain things don't make it into the EMR, or they get double-documented, or there's a paper trail—a piece of paper somewhere where the real story is, and it's getting scanned into the EMR. Those are the work-arounds that happen when you don't have workflow alignment with your EHR, and that means that your clinical analytics and your ability to use the data that you have is limited."

Although the EHR contributes a great deal now, many of the transformational steps to be made going forward will depend on EHR-based analytics, and a substantial portion of the industry seems to be using EHRs that need considerable fine-tuning before they can provide higher levels of support. DiLisi suggests that software publishers and healthcare customers share the responsibility for the mismatch. "You customize how you want to implement the EHR in your institution. That creates problems because an EHR company may not necessarily be an expert in what the clinical workflow is. And a hospital may not necessarily be an expert in how to set up an EHR."

> "If systems are taking on risk and they're getting paid per person, there are going to be more ROI calculations on these things in the future."
>
> —Jeffrey DiLisi, MD

With 50% of respondents expecting to invest in their electronic health record, 44% expecting to spend on IT-based clinical decision support, and 52% planning continuous improvement investments, it appears that investments will be more infrastructure-related than staff-related. But we have to remember that it is people who do the work, not tools. Although only 14% say they intend to increase spending on quality-related leadership, leadership is, indeed, the first component to get right.

Analysis (continued)

"How do we train our leaders and managers," asks DiLisi. "We have to invest in our leaders and managers, making sure they're trained to make the right hiring decisions, making sure that they're holding their people accountable, making sure that their employees are being really efficient. If you can get good managers and you can get good employees, process improvement and improving patient safety becomes a lot easier."

Eventually, transform healthcare. In examining clinical quality, we see two main vectors. First, there is the quality objective that is integral with the mission of healthcare: to get the right care to the right person at the right time. Closely linked is the goal of patient safety, which is to deliver care in a way that prevents harm. The second vector is related to measuring and reporting quality performance, which is required as part of healthcare reform, with its overall mission of transforming care to increase value. Neither vector works in isolation.

One would assume that efforts toward efficiency and driving cost out of the healthcare system would be undertaken in a way that does not put patients at risk. But 25% say that at least some patients are, after all, at risk due to efficiency efforts. Comments from these respondents indicate that both vectors are at play. First, care transformation requires modification of age-old care procedures and protocols. Such changes may place patients at risk, especially during early shake-out phases. The good news is that the paths to modify and optimize care protocols are well known by the healthcare industry. The second vector revealed in respondent comments relates to how the very process of quality reporting may place some patients at risk. Respondents indicate, for example, that reporting requirements place time pressure on caregivers, and therefore take time away from patient care.

> "There's a whole science around usability. And much of that science and many of those usability tools have not made their way into clinical IT."
>
> —Sam Bagchi, MD

This second vector—reporting—is a newer problem, and the causes are likely to vary depending on the organization. For some, reporting can threaten the delivery of quality care, which, ironically, the reporting is trying to foster. We observe 25% who say that efficiency efforts place some patients at risk, but we have 56% who say that limited resources keep them from advancing to the next level of clinical quality. And one-third (30%) say the reporting burden keeps their EHR from contributing more to clinical quality.

What we have is friction that is the result of the sweeping nature of healthcare reform. Healthcare leaders are addressing the issue by investing in infrastructure (EHRs and clinical decision support, for instance) and staff (through new hires, training programs, and developing capabilities such as continuous process improvement).

Analysis (continued)

Near-term investments are important, of course, but because care transformation is a long-term activity, attention needs to be paid to the consequences of care transformation on clinical quality long-term, as well. Advisors suggest that beefing up the quality department may not resolve perceived resource constraints. Instead, they recommend that quality become an attribute of the processes for delivery of care rather than an activity done by the quality department.

As mentioned earlier, LaBelle relates removing waste with increasing quality. "Under a different business model," he says, "one in which you're accountable for addressing the healthcare needs of a population, an investment in reducing errors and waste in the clinical environment translates into improved outcomes for the patient and lower costs."

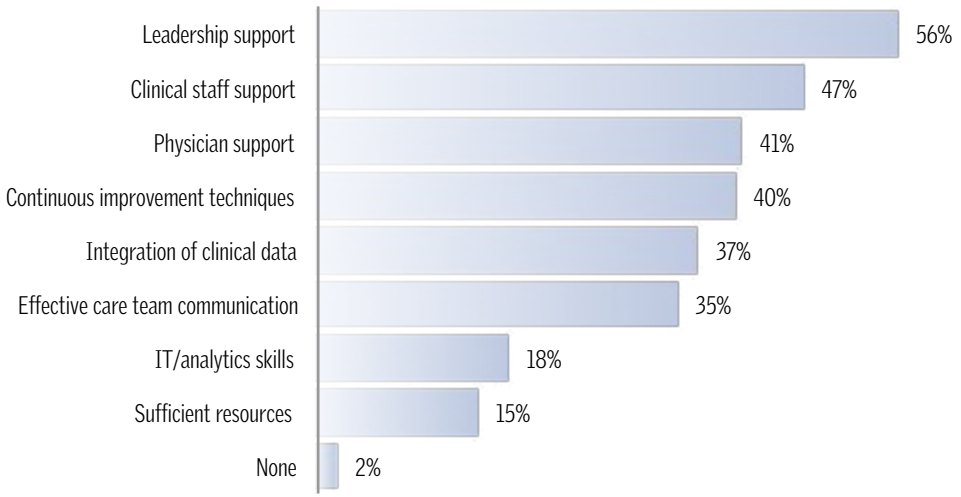
Striving toward such an objective increases staff and provider satisfaction, too, LaBelle says. "That aligns everyone around that activity, and instead of an investment in quality, leads us toward a value-based purchasing metric. Fundamentally, the business model around getting paid for a population of patients allows you to align the elimination of waste with improvement, which is how healthcare has to add value going forward."

Michael Zeis is senior research analyst for HealthLeaders Media. He may be contacted at mzeis@healthleadersmedia.com.

FIGURE 1 | Biggest Contributors to Achieving Clinical Quality

Q | What are the three biggest contributors to the success your organization has experienced to date in achieving clinical quality?

Total responses



Base = 404, Multi-Response

TAKEAWAYS

- Nearly two-thirds of hospitals (62%) include leadership support among the three biggest contributors to their success at clinical quality.
- Support for quality efforts by physicians themselves is included among the three biggest contributors to success at clinical quality by more health systems (57%) and physician organizations (60%) than hospitals (38%).
- Respondents from all settings most frequently include either leadership or physicians among their top three reasons for clinical quality success.

WHAT DOES IT MEAN?

Success in clinical quality efforts depends on support from leadership, physicians, and the clinical staff, factors that outscore logistical or operational items such as IT/analytics skills and clinical data integration as contributors to success. Even as the industry's financial foundation is shifting from a production-driven fee-for-service orientation, executives remain focused on improving clinical quality; as such, they are ensuring that physician leaders are involved in both clinical and administrative decision-making, establishing in-house programs to train physicians in business management and executive skills, establishing dyad management structures, and, when circumstances permit, recruiting physicians with business aptitude and experience.

FIGURE 1 *(continued)* | Biggest Contributors to Achieving Clinical Quality

Q | What are the three biggest contributors to the success your organization has experienced to date in achieving clinical quality?

Click on these icons to dig deeper

BUYING POWER Who controls the money? Click on the icons to learn how they think

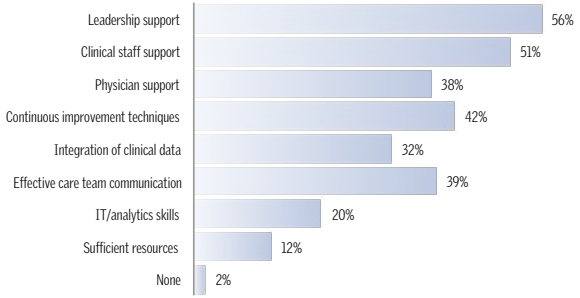
VIEW BY PRODUCTS/SERVICES
Indicates the type of goods or services the respondent is involved in purchasing

VIEW BY INVOLVEMENT
Indicates the role of the respondent in making purchasing decisions

VIEW BY DOLLARS INFLUENCED
Indicates the total dollar amount the respondent influences

PRODUCTS/SERVICES

Clinical products



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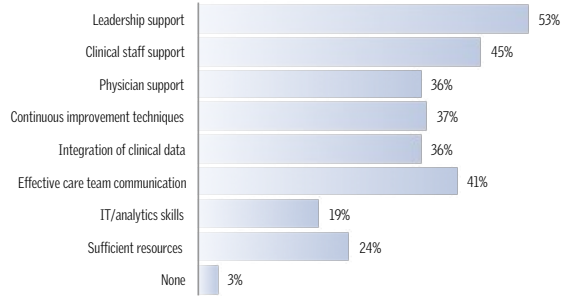
Financial services



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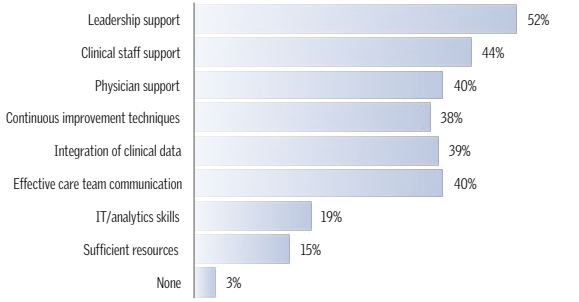
Executive search



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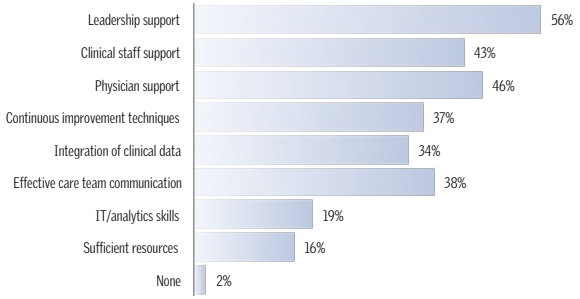
Consulting services



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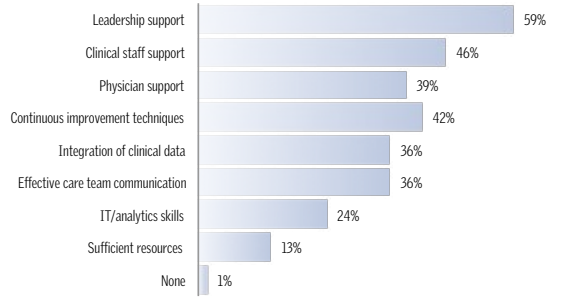
Outsourcing services



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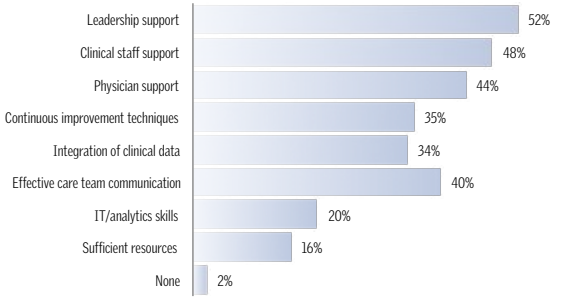
Legal services



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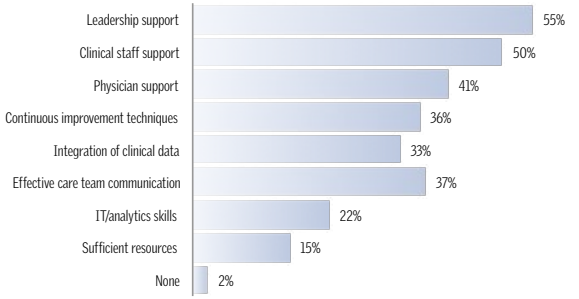
Information technology

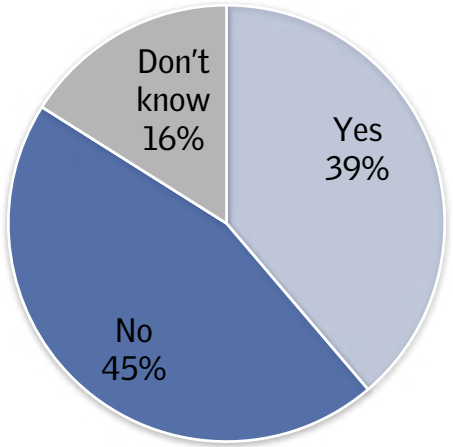


Base = 220, Multi-Response

FIGURE 11 | Tracking Financial Cost or ROI for Clinical Quality Initiatives

Q | Does your organization track the financial cost or return on investment for clinical quality initiatives?

Total responses



Base = 405

TAKEAWAYS

- Nearly half of health systems (46%) and 34% of hospitals track the financial cost or return on investment for clinical quality initiatives. Relatively few physician organizations (28%) do so.
- The prevalence of cost or ROI tracking is related to size. More than half of organizations with net patient revenue of $1 billion or more (52%) track cost or ROI, compared to 34% of organizations with net patient revenue less than $250 million, and 39% of those with net patient revenue between $250 million and $999.9 million.

WHAT DOES IT MEAN?

Figure 8 shows that 76% use clinical quality outcome measures as a basis for compensation incentives, and here we see that 39% are tracking financial cost or ROI on clinical quality initiatives. With the industry's focus on value, we expect that there will be more emphasis on the connection between improving patient outcomes and improving the organization's financial health. That emphasis, plus the appraisal of 56% that funding is merely adequate (Figure 10), may lead to more organizations closely tracking clinical quality initiative cost or ROI.

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