Next-Generation Healthcare Metrics

Measuring rate of change, patient flow and staffing show quality program’s effectiveness

by Chip Caldwell, Nancy Dodson and Kevin Sprecher

Executive-level strategic dimensions measured by most healthcare organizations—often called pillars—include clinical outcomes, patient experience, physician loyalty, market share and financial margin. Due to the introduction of the Accountable Care Act (ACA), population health has joined that list. Lately, the greatest strides being made in strategy-level healthcare metric development are in the dimensions of clinical outcomes and patient experiences.

For clinical outcomes, the 2015 National Impact Assessment of the Centers for Medicare and Medicaid Services (CMS) Quality Measures Report encompasses nearly 700 quality measures.¹ The affinity for these metrics support the National Quality Strategy created by the ACA and contains six strategies:

1. Affordable care.
2. Patient-centered care.
3. Patient safety.
5. Effective communication with patients and families.
6. Health and wellness.

Is it working?
A critical question is: Are CMS’s quality metrics making differences in patient care, and are healthcare providers making a difference in any of these six national quality aims? The CMS believes they are.

The key findings of the 2015 CMS Impact Report indicate that 95% of 119 performance rates showed improvement and, on the provider front, CMS measures related to heart and surgical care saved 10,000 lives and more than 7,000 infections were averted.²

Many researchers believe the evolving pay-for-performance (P4P) movement contains inadequate incentives or that incentives are ineffective in general,³ ⁴ coming in at about a 3% incentive opportunity, based on total reimbursement for federal payments,⁵ and 6% in some commercial payment programs.⁶

Others point to PFP and increasing visibility of quality performance from rating services such as Healthgrades, Angie’s List and Castlight as key drivers of improved results. Regardless of the rationale, a tour of any healthcare system’s strategy room points to the importance of how the organization’s clinical outcomes compare to competitors and national Medicare program participants.

The “next-gen” patient experience is enjoying a revolution for the same reasons behind the current emphasis on clinical outcomes—transparency and P4P. Next-generation patient experience metrics must consider patient flow and throughput, and this focus should go beyond popular attitude improvement approaches—such as acknowledge, introduce, duration, explanation and thank you (AIDET), and rounding—that have been fully optimized and have little juice left.

Patient flow is the next-generation battleground to drive patient experience scores higher. A statistical correlation of most healthcare organization’s patient experience drivers supports that more than half of the statistical drivers of patient experience are impacted by treatment and information delays. The output metrics of patient throughput processes (response to concerns and complaints, pain management response time and timely care updates). ⁷
CEO Jayne Pope and chief operating officer Mike Reno of Hill Country Memorial Hospital (HCM) in Fredericksburg, TX—one of the top-performing healthcare organizations and recipient of the 2014 Malcolm Baldrige National Quality Award—recognized that the focus of the last decade on attitudinal tools, such as the AIDET (five fundamentals for service), and rounding (keeping the C-suite involved in frontline processes and patient encounters), have largely been hardwired in top performers. They believe the next-generation patient experience falls on eliminating patient waits times and delays through more efficient throughputs.

HCM was rewarded for its improvement efforts, and it’s reflected in its patient experience scores from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) shown in Figure 1. The HCAHPS survey is a national survey that’s publically reported, consisting of patients’ perspectives on hospital care.  

**Hill Country patient experience scores / FIGURE 1**

*HCAHPS Percentile Trends*

[Graph showing HCAHPS percentile trends for different aspects of care such as nursing, physician, responsiveness, pain, medication, environment, discharge, and quality.]

HCAHPS = Hospital Consumer Assessment of Healthcare Providers and Systems
New skills

Impacting quality outcomes by improving throughput requires radically different skill sets than attitudinal improvements. Specifically, healthcare systems will need to master quality methods such as lean, that accelerate processes by eliminating nonvalue-added steps, waits and delays in both patient flow and information flow.

How did HCM get there? The answer isn’t simple, but it has a simple form. Senior leaders and directors became master change agents. Interestingly, while clinical outcome and patient experience metrics have matured, measuring an organization’s rate of change continues to lag, or worse, fails to be recognized by CEOs as an organization’s critical competitive advantage.

According to HCM CEO Jayne Pope, “HCM leverages one of its core competencies—execution—to develop and deploy its strategic plan, goals and associated action plans through a systematic strategy development and deployment process. This process results in deployment of action plans at all levels of the organization to enhance execution and accomplishment of its organizational strategy.”

To measure change effectiveness, a simple addition to Pope’s balanced scorecard tracked the number of changes per director per month. Research suggests that top quartile performers average two changes per director per month, and bottom quartile performers barely eek out 0.1 changes per director per month.⁹

Jim Dahling, CEO of Children’s Hospital of the King’s Daughters (CHKD) in Norfolk, VA, and COO John Harding are two leaders who understand the positive effects of change. Recognizing that managing change in the children’s healthcare sector was becoming increasingly complex, Dahling and Harding implemented a leader development and accountability program (LEAP) and change process known as the 100-day workout to enrich the skill sets of their directors. LEAP research—analyzed by Caldwell
Butler’s database of more than 80,000 changes made by directors in more than 80 organizations during the previous 10 years—suggested that top performers differentiate themselves in five critical elements:

1. High-impact focus—what Joseph M. Juran called “the vital few” strategies versus “the useful many,” a point that low performers don’t understand.

2. Speed-to-action plan.

3. Accountability and speed to implementation.


5. Connecting the dots to key performance indicators.

As Figure 2 illustrates, CHKD was amply rewarded for its efforts. Prior to their invigorated commitment to leader development, their senior leaders and directors scored at the U.S. midpoint. After just 100 days, however, not only did their competencies in change management increase dramatically, they surpassed national scores of top performers in two of the five categories.
Staffing

Another quality metric that suffers from a lack of attention in healthcare is the impact of staffing on both quality and efficiency. Traditional thinking places staffing in the domain of finance and does not include it in a quality metrics list.

This could not be further from reality. It was found that staffing explains as much as 40% of the variation in patient waits and delays. As observed by Rob Thames, CEO of Northern Arizona Health System, “Benchmarking is fine for finance folks examining staffing patterns over long periods of time to determine staffing budgets, but patients don’t experience our averages.”

This means current labor benchmarking has three major weaknesses. First, benchmarking attempts to provide an apples-to-oranges comparison of one health system’s staffing model by statistically normalizing for differences in the comparison group. While this sounds logical enough on the surface, managers often say, “If you’ve seen one hospital, you’ve seen one hospital,” meaning there are simply too many variables in a complex care system to adequately account for them all.

Second, benchmarking methods as well as productivity systems are silo-based approaches that analyze only one department silo at a time without a method to account for the complexity of handoffs in care. Care systems involve multiple handoffs, and many of them are independent of one another and are therefore highly unpredictable.

Third, benchmarking and productivity systems are resource-based comparisons, not process-based comparisons, making them flawed based on their definition. In-quality staffing, on the other hand, is a process-based staffing analysis approach. Through hour-by-hour sampling, directors can
determine the systemic impact of variations in processes, the influence of handoffs in care and the true
effects of patient acuity and demands on the underlying processes.

As shown in Figure 3, variations in both inputs (volume) and staffing swing wildly over a 24-hour
period and these wild swings negatively impact patients’ experiences, but they’re masked when finance
aggregates staffing data over long periods of time. This harms patient experience and efficiency.

While clinical outcome and patient experience metrics have enjoyed increased attention, the
most impactful elements of any quality program’s effectiveness—the rate of change and in-quality
staffing—continue to lag. In this new era of ACA and healthcare reform, CEOs and executives who
recognize that coaching senior leaders and directors to become master change agents is their most vital
competitive advantage.
References


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