Podcast Transcript

Making Sense of Dollars and Cents: Patient Safety

Episode 1 – The Business Case for Safety, Part 1

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Host

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Transcript

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FAITH ROBERTS, HOST: Hi, everyone. My name is Faith Roberts, and I'll be your host for this Elite Learning podcast series, Making Sense of Dollars and Cents: Finance, Budgeting, and Staffing Skills for Nurse Leaders.

We're going to focus this last podcast on making the business case for patient and workplace safety.

Finance is an absolutely huge topic. And it doesn't sound exciting to some people. And for others, they have followed each of these sessions through, and taken probably copious notes, because they're getting exactly what they need from our presenter, which is an understandable way to approach the different issues in finance that nurse leaders deal with on a daily basis.

In my own practice as a nurse leader, I understand that these topics may or may not be the first ones you think of. But the reality is, if we don't understand finance, then we won't be successful in managing our departments and units, and for some of us, our whole section of the hospital. If I am the OB leader and have mother/baby and labor and delivery and NICU all reporting to me, it is very important that I understand finance and how we can make that understanding of a difficult topic, how we can help it make sense for us.

We can realize that gaining this knowledge is not just nice to know at all. It is required for all of us to have a stronger understanding.

If you look back in the history of nursing, for a long time, nurse leaders were not even at the table for discussing budgets. They didn't even see the monthly reports that came out.

They may not have even seen the monthly reports, or worse, even been able to understand them if they had been shown to them. The end result for nurse leaders is that a lot of times, we weren't even at the table when the big decisions were being made. That is definitely in the past.

Today, we are expected to not just be part of the discussion, but many times to lead it. Whether you work within the constraints of a budget for a state entity or the detailed specifics of a donor grant, whether you have a large area that you lead or a small department, finance-related aspects of healthcare are a valuable component of every nurse leader's skill set. A solid knowledge base in finance will help a nurse leader obtain what an area needs, as well as be open to creating different staff mixes based on their understanding of how a budget works.

I think what it comes down to for everyone, especially those of you who have listened to these podcasts in order, it's thinking to yourself which camp did you fall in before you started listening? Were you in the "I don't do this, my one-up does it for me?" Were you in that group? Or were you in the group that said, "Oh my goodness, thank goodness I have a friend who likes to do this stuff because I don't. So, he or she just does it for me"?

Or for many of us, were you given the title but not the knowledge and the fact that you never had it covered in your orientation? And now you are responsible for a multi-million-dollar budget, and you don't even know how to find it on your facility's accounting website. Regardless of your circumstances or motivation, it's become clear that in order to be a well-rounded and effective leader, finance and budgeting are among the skills you've got to master.

Twenty years ago, I met our guest speaker, Pamela Hunt, at a national conference for nurse leaders. She had an audience that filled a room, and she was speaking about budget. Her knowledge of staffing, ROI, and how to build a case for a capital purchase – they were amazing. Since then, Pam and I have traveled to many conferences and have enjoyed to this day a close friendship.

An expert on finance and healthcare, Pamela Hunt is a frequent presenter at national organizations, state and local conferences. She's led many nurse leader workshops and retreats. She's authored articles and co-authored books about finance in the healthcare industry. And in 2020, Pamela Hunt was

named a fellow in the American Academy of Nursing. You can read a lot more about Pam and her accomplishments, experience, and background in the notes that accompany every single podcast.

So let's get started with "Making the Business Case for Patient and Workplace Safety."

Welcome, Pam. I am looking forward to talking with you in this session. And I would definitely want to hear your take on workforce safety, as the term patient safety is what we all hear constantly. And I'm very anxious to hear today your explanations of why workforce safety is just as important. Welcome.

PAMELA HUNT, GUEST: Well, thank you, Faith. And this is probably one of my most favorite sessions. And so, if you haven't listened to the other podcasts – don't get me wrong; those are my favorites, too.

But this is the culmination of all that we've learned together, and it puts all those pieces together. If we were together for a whole day, I call this putting the pieces together. So, thank you for allowing me to put the pieces together for this last and final session.

During our time together in this session, we're going to learn how to provide quality care and create cost avoidance – how providing quality care and creating cost avoidance can be demonstrated in a business case for patient and workforce safety. We're going to contrast the difference between tangible and intangible cost of errors and the impact of each. And you're going to be inspired to choose quality metrics, which may be impacted by a process change in your department and evaluate at least one metric for patient care improvement and cost avoidance in your department.

Faith, you mentioned workforce safety. Our workforce is very dear to us, and it always has been. Certainly is in today's environment. And providing a safe place for our employees, for the employees, for the workforce to practice, whatever their practice is, to do their role responsibilities is so important.

And when we think about things such as – I'll foreshadow here a little bit a topic later on in our presentation. But I had a hospital once that was trying to justify the development of a lift team. And they really needed it. They had all of those descriptors.

Our patients are getting heavier. Our nursing staff are maybe getting a little older and not able to handle the heavy patients anymore. We really need a lift team. It's important for us to ambulate these patients. They had all the descriptors.

What they hadn't thought to do is stop and think of how this was impacting their workforce safety. So we went back, and we included our partners in employee compensation, such as workman's comp and back injuries, our employee health. We looked at back injuries.

We looked at time away from work. We looked at employee workman's comp cases going up. And we looked at the insurance claims going up for those and was able to articulate financially the need for the lift team, and that we could have a cost avoidance that made sense.

So, when I think about patient safety and workforce safety, a lot of what we're going to be talking about in this session and in this podcast is about cost avoidance. And that's how we get our business case or our return on investment for these types of initiatives that we want to do.

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HUNT: I always say that the business case for patient safety isn't about cost versus quality, but it's cost *and* quality.

So, let's think about this, connecting cost to quality. What's the cost of a patient fall, the cost of a hospital-acquired pressure ulcer, the cost of a medication error, the cost of staff injury, the cost of caregiver turnover? How does caregiver turnover relate to quality? Well, everyone knows that if you're a caregiver, and number one, you feel like your own personal safety is at risk, you may leave the organization.

Or number two, you feel like you cannot provide quality care. You may leave the organization. And how about the cost of not meeting CNS or gold star standards? There's definitely cost tied and demonstrated to particularly the lack of quality.

Oftentimes, when I'm working with nursing leaders and they want to demonstrate a proposal for a change in a process, or perhaps it's additional staffing or perhaps it's equipment, they find it difficult because of how do I prove that this is going to decrease my cost? Well, if you don't have that information internally – so some organizations are blessed with knowing what their average cost is for a patient fall or for a hospital-acquired condition or for a drug event. Some hospitals do have that information.

But if you don't, and you want to make a business case for quality, the Agency for Healthcare, Research, and Quality, that website is www.ahrq.gov. That information is in your notes for this particular session – that website is. That website has the average cost of many harm events to our patients. And you could use that cost very easily when making this business case for patient safety and for workforce safety.

For example, on that website, the hospital-acquired infection costs an average of $21,700. What's included in that cost? It doesn't break it down on the website, but let's you and I just discuss that.

What's included in that cost is the treatment of the infection, the increased length of stay of the infection, perhaps additional not only medications - we think of the treatment being the medications. But possibly that's putting in a PICC line. Possibly that's putting in an IV if the patient didn't have an IV. There's lots of things that go into that. The average cost of a fall in today's hospitals is $17,500.

You may say to yourself, we have many falls in your institution. Hopefully, you don't have many falls. But we have falls in our institution that don't cost $17,000. No, but I'm speaking average. So, if one of five falls results in a fall fracture, and that patient goes to surgery, you can easily see how that average can be $17,000.

The cost of a drug event – so a wrong medication being given to the patient can result in 8- to 10-day longer length of stay per patient at a cost of $16,000 to $24,000 per patient. So, these are expensive errors. And you know what? We're talking about these in financial terms. But you and I know the cost of these errors to the patient, to the patient's family, and to our caregiver staff, who try every day to provide exceptional patient care to everyone that comes to us and trusts us to care for them.

When we think about breaking down the cost factors related to safety, think about how often the medical error occurs. Think about the prevention of the medical error. And think about the treatment of the medical error. And those are specific places to go when you're looking for this cost avoidance.

(SOUNDBITE OF MUSIC)

HUNT: I'm going to talk about tangible and intangible cost of errors. As nurses, we oftentimes go down the route of intangible. So, I'm going to go tangible first, and then we're going to talk about intangible secondly.

Both are important. Tangible cost of errors – repeated or unnecessary treatment and procedures. If you're looking to build a case for whatever it may be, whether it's a new piece of equipment, whether it's additional staffing, whether it's a process change, you might look to how many times is this procedure being repeated or unnecessary because that's a waste and creates a cost.

One that I think of in that area is, I worked with a hospital that tried to eliminate their phlebotomy and transfer that responsibility to the nursing staff. And they gave it time. Whenever you do a process change, you have to give it time. They gave it 6 months. And still, we're having so many lab errors that they put phlebotomy back in the place because the timeliness of the reports and the number of lab errors, the patient satisfaction from repeated draws, was more than what it would cost to have the phlebotomists that were really, really skilled in this area.

Another tangible cost is the increase in the length of stay. The cost of length of stay varies according to your unit. But working with a finance partner, you can get an estimate on the average cost of an additional day's length of stay in your department. And that would be a day that is outside of your geometric norm for your DRG, so you would not be getting reimbursed for that.

The cost of medication and treatments to correct the error. How about the cost of malpractice claims and litigation and the cost of additional malpractice premiums? Because your premiums increase due to the number of claims that you may be having if poor quality of care is being delivered on a routine basis. Here's some other tangible costs. How about operational inefficiencies? So, it causes the cost of time.

Marketing cost. If your organization has an error that reaches a patient, and it causes something that reaches the media, your marketing department spends thousands upon thousands of dollars to gain the confidence of the public back. This was very public. I won't say where, but it was very public. There was an incident some years ago where an infant was given the wrong dose of heparin, and the infant passed away. And the tragic, tragic event, you can imagine the loss obviously, to that family, the loss of that precious life, the impact that it had on that nursing staff, and the financial impact it had on the organization.

Employee support for EAP. So, if you're in an environment where caregivers are not able to provide the care that they want to provide, then oftentimes employees are seeking out employee assistance programs. And those EAPs are free to the employee, but they are not free to the organization. So that could create costs for your organization as well.

What if you're in a place where your quality is such that accreditation and compliance is challenged? All of us know how serious that could become for your organization. And let's face it. If your quality and risk management staff are spending all of their time investigating and doing root-cause analysis, they're not spending time looking toward the future and seeing how we can provide better quality care. So there's a risk there.

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HUNT: Now let's talk about the intangible cost that all of us know in our nursing heart and in our caregiver heart. Employee morale. No one wants to work somewhere where I cannot provide the level of care and the quality of care that I know is necessary for these patients. Decreased productivity. When systems are such that they don't allow for smooth transition, and they are created around waste and rework and retesting and additional medications to compensate for errors made, then we have decreased productivity.

I already talked about community trust as it relates to the marketing cost. But how does it feel to go to the grocery store and have someone stop you and want to talk about the event that happened in your hospital and that made the social media? We used to say made the front page of the paper, but now it's out there immediately on Facebook or any other type of social media. And the intangible cost of negatively impacting recruitment and retention for your department. Word gets out there, and high-functioning caregivers want to work where they know they can provide quality care and they can be proud to be a member of that team.

(SOUNDBITE OF MUSIC)

HUNT: So, in the notes that are available for this podcast, I give an example of a department that wanted to justify a change and increase in their hours per patient day. Boy, does that sound on target for most of us. And so how do I go about justifying using quality data? How do I go about making my case, telling the story, that I can actually save you money by spending money? That's what we're asking. That's the case that we're trying to prove.

So I'm going to give you a real-life story. And there's nothing like a real-life story. So the real-life story is that in early in 2018, a PCU3 was asked to decrease their hours-per-patient day by 10%.

There was a staffing consultant who came in, and there wasn't a lot of benchmarking done. There was just a blanket across the board: we needed to decrease staffing by 10%. In order to achieve that, the leader of that particular unit made a decision to reduce staffing on the night shift by one licensed caregiver per hall. So one licensed-caregiver-per-hall reduction got them down to their 10%

So, what happened at that juncture? Well, what I want to ask you next is, before I finish the story – so I think I have you hooked. Before I finish the story, I want to ask you, does your department do a good job with establishing metrics and measuring those metrics before you make a change? Does your department do a good job about establishing metrics and measuring those metrics before you make a change?

I hope the answer is yes. And if you don't, that is number one in any process change, in any product change; and in any change, that you want to know and think, what could this potentially impact if it does not work well? So, this department did that. And they decided to measure, OK, if I take away one person on her hallway on night shift, what could possibly go wrong? How could that possibly affect quality?

Well, they chose patient falls because it would be less people on that unit to watch patients to answer call lights. They chose medication errors because patients may not get their medications in a timely manner. And they chose patient satisfaction.

So those are the three. There's many. Those are the three metrics that this department decided to measure. They made the change.

And in this particular department, guess what happened? Well, 6 months prior to the change, they compared that time period with 6 months after the change. And for full transparency, and for leveling the playing field, they also adjusted these numbers per patient day –- so per number of patients.

And their falls went up. Their hospital-acquired pressure ulcers went up, and their patient satisfaction went down, and their medication errors went up as well. So, their quality metrics demonstrated that this had an impact.

The two that this leader decided to actually use as their demonstration, because they showed the greatest impact, was 6 months after the change, the quality metrics per adjusted patient day had changed to the fact that they had two additional pressure ulcers in that 6 months at $45,000 per pressure ulcer. That's the average financial burden of a pressure ulcer, hospital acquired. They had 10 additional patient falls at, remember, $17,500 per patient fall. So, in that 6 months, between the pressure ulcers and the patient falls, they had actually had $265,000 worth of cost, additional from the prior 6 months.

If we annualize that – and you know what we do when we annualize the 6 months. If we multiply that by two to annualize it, if they continue at that same rate of quality or lack of quality, that's going to mean a cost of $530,000.

(SOUNDBITE OF MUSIC)

HUNT: Faith, what do you think about that at this point, $530,000 for the lack of quality?

ROBERTS: I think that it is very surprising that dropping one nurse from night shift that it was that evident that quickly. And you know, something I'm wondering is, when you said for various reasons, they made the decision to take one night nurse off, and then you said they made the decision to look at falls, and they identified the indicators they would track, who made that decision? Was it that nurse leader with their person they report to or was it the staff? Who makes that decision what we're going to track?

HUNT: I can't speak specifically to who made that particular decision because I wasn't part of it. But I'm going to answer your question of who needs to be in that discussion instead.

ROBERTS: All right. All right.

HUNT: OK, so who needs to be in discussions like that is certainly the nurse leader, the nurse leader's director – or again, we don't have the nomenclature for that next level, so that nurse leader's next-level. But also, I would loop in and include a staff nurse, and maybe that's your professional practice council chair. Maybe that's a few of your professional practice council individuals. So understanding how they might rearrange their work, how that might impact their work at the bedside, would be very impactful. That group of individuals also should be the ones that develop the metrics – or determine the metrics is a better word – that determine the metrics that we're going to track because they better than anybody are going to know what this could potentially damage, if you will.

ROBERTS: I definitely agree with who should be in that makeup of the group who makes the decision. And I think when you look at all of these podcasts that you have led, Pam, it does bring to the forefront that if decisions are made in a small room with the door closed, the staff has no buy-in to this – where the immediate thought I had was that if the staff were part of the decision, I would think they would be being ultra-careful about falls. They knew how this was going to work.

And so it's just fascinating to me to think about who might have been in the room when those were picked, although I think they were great indicators to use. But I like your point of, this is who should be in the room because too often the person who's working nightshift is not part of the decision about night shift. So I think that speaks for itself.

HUNT: I absolutely agree with you there, Faith. I will say that in something like this, when it's come down from an outside agency, if you will, I don't know. You could get many people in that room, but

nobody would agree that it was the right thing to do. It was something that they were told they had to do. You know what I mean?

And so, I agree with you totally. In most decisions, you want to get a lot of people involved, so that they have ownership in the success. I will tell you in this case, the leader did not have ownership in this success because they did not believe it was the right thing to do. Does that make sense?

ROBERTS: It sure does. It absolutely does.

HUNT: Yeah. So now we know at this point, the leader knows that 6 months afterwards, which my heart aches when I talk about this real-life case scenario because I think, wow, 6 months went by that patients were put at risk. Six months went by that patients were put at risk. So the leader came to me and said, what do I do? How do I convince somebody that this is not working?

So, I said, well, first of all, we have the metrics to show that it's not working. But in order to go to leadership and say this is not working, and we need to put this back, we've got to demonstrate what the cost of putting it back would mean. We just can't say we're spending $530,000 annually. Well, yeah, that's true. But if you put back that staff, you're going to be spending money, too.

So, you marry the two. It's not cost plus quality. It's cost *and* quality.

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HUNT: So, we go to cost then, and we say, OK, what is the increase of additional staff going to cost us? Well, in this case scenario, because this unit knew exactly what they had decreased, what they had downsized – which that 10% equated to 0.338 hours-per-patient day – they knew exactly what they wanted to increase. So, what they did was took that proposed increase of 0.338 hours-per-patient day, multiplied it by their average daily census – so that was 20.57 patients – multiplied by 365 days a year and multiplied by the average hourly rate.

All this, again, is in your handouts for this session. And it's well-labeled so you know what each of these are. So, in this case scenario, the financial impact, if you needed to hire an additional FTE to cover this cost for this average daily census, this additional hours-per- patient day, it would cost the organization about $76,000 to put this amount of labor back on this unit.

Remember, we said – and that's an annual now. That $76,000 is annual. We estimated that if the quality continues at the current rate of post-6 months from the change, we're going to have a cost of quality of $530,000.

The additional FTE requirement to get us back up to where we were is going to be a $76,000 cost to the organization annually. $530,000 minus $76,000 is a potential cost avoidance of $453,000. This leader took this proposal to who she needed to take it to, and it was accepted.

But it's not going to stop there. Whenever you do something like this, I really encourage you to promise and provide that in 6 months, you're going to look at that same data, those same metrics, after you add those additional hours back into this unit. And you're going to see if your hypothesis was correct and the quality actually improves.

And that is in the demonstration in your notes, that yes, this leader went back, revisited those quality metrics. And thankfully, as predicted, the falls and the hospital-acquired pressure ulcers had both improved significantly since the additional hours were added back in. In fact, they were improved so

much, that this demonstration actually moved from unit to unit. And a lot of those hours were able to be moved back in because the quality was suffering so much.

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ROBERTS: These kinds of real-world examples are what set Pam apart in her efforts to help nurse leaders fully understand how to base patient care and safety decisions on metrics, along with the importance to every nurse leader of mastering financial skills.

Pam has provided a wealth of information and resources that supplement this episode, as well as previous episodes in this series. I encourage you to download the show notes that are available with each episode at our website, EliteLearning.com/Podcasts.

In our next episode, which will wrap this series for nurse leaders, Pam offers another practical example to help us clearly make a business case for patient safety needs. Please join us.

This is Faith Roberts for Elite Learning.

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