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Bending the Cost Curve With the Help of a Dedicated Cost Leader

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Like quality improvement, cost improvement needs a single senior leader who is responsible for driving cost improvement throughout the organization.

A recent HIMSS study showed that reducing cost was the top strategic priority for hospitals, academic medical centers, children's hospitals and ambulatory care providers. However, despite this focus, the overwhelming majority of hospitals do not have a senior leader solely dedicated to cost reduction — or even a single person in any department, dedicated to organization-wide cost reduction.

Juxtapose this to the infrastructure of quality improvement. Most hospitals have a vice president of quality and a chief medical officer who dedicate a majority of his or her time to driving quality initiatives. Most providers also have Quality Leaders who collaborate with operational and clinical leaders to drive change, analytics staff that produce quality metrics, and high-functioning quality committees that engage stakeholders and hold initiative owners accountable for achieving goals and for preventing harm events.

But if we look back to the mid-1990's, Quality Improvement looked much like Cost Improvement looks today. There were a few zealots who identified quality issues and tried to drive change. Some hospitals had quality committees too. But without access to data or staff to run the data and lead the projects, these efforts were largely ineffective. Moreover, there were few, if any, widely accepted quality metrics and certainly no goals.

There was little movement in Quality Improvement until the 1999 when the Institute of Medicine released their report "To Err is Human." This ground-breaking report exposed the death and harm caused by medical errors and low quality care. From there, the awakening began. The Leapfrog group, The Agency for Healthcare Research and Quality (AHRQ), and others began a national dialogue on quality.

With this dialogue came a new vocabulary, never before seen transparency, and well-defined metrics that quickly became industry standards. Today, of course, almost every hospital across the country has a robust quality improvement function because that is core to their mission.

Yet, despite being a top strategic priority, despite cost reduction needs that are eight or nine figures, despite large investments in EDWs, productivity tools, supply chain and consulting, cost improvement is still in its infancy. In addition to the lack of staff focused on cost improvement, there is a still a vast gap in knowledge and know-how about strategy and tactics required to drive out cost.

In fact, a recent survey showed that 88 percent of hospitals and health systems had cost reduction goals, but only 15 percent were successfully achieving targets. Over 80 percent were achieving some savings, but were not hitting their targets. Lack of accountability and difficulty in measuring savings were cited as the top drivers of this wide-spread under-performance.

This is not surprising given the three ways that most hospitals are approaching cost reduction currently:

Clinical/Operational Department Leaders leading cost improvements Projects that significantly reduce cost generally require deep analytics, diligent change management, and cross-functional participation. With many other priorities on their plate, department leaders simply cannot dedicate the time or attention to these initiatives and may not have the skill set necessary to do so.

Performance Improvement Leaders leading cost improvements Some hospitals have staffed cost projects with performance improvement leaders, which typically come from the Quality Improvement department. Two things generally happen which cause savings to fall short. First, the projects chosen will increase efficiency, but not generate measurable cost savings, unless additional actions are taken. One example of this is reducing length of stay. Unless worked hours are reduced or more patients are added, there is no financial impact, other than a reduction in reimbursement from per diem or fee for service payers. Second, projects are often done with a contained scope. While this is good from a project management perspective, critical upstream and downstream processes are often neglected and the impact is limited.

Value Analysis Committees spearheading improvements While the intent is there to drive accountability by engaging a cross functional group with senior leadership sponsorship, results are typically underwhelming because the people tasked with driving the initiatives have too many competing priorities.

I propose that until there are resources dedicated to cost improvement — people who think about driving out cost all day every day- providers will not realize the level of cost savings they need.

Imagine a new role — the Cost Leader.

The Cost Leader should align closely with finance, operational, and clinical leadership. The Cost Leader should understand what is needed to drive true margin on the income statement, what will and won't work operationally, and how to engage physicians. This role, or department for larger facilities, should have access to financial, clinical and operational data and be able to nimbly pull this data together to identify and quantify cost savings opportunities.

From there, the Cost Leader should work collaboratively with department leaders to validate savings opportunities operationally, and then facilitate implementation of improvements. Most importantly, the Cost Leader needs to be an innovator – someone who challenges conventional wisdom, proposes new approaches to old ways of doing things, and can work with operational and clinical leaders to transition these ideas into practice.

Like Quality Improvement, Cost Improvement needs a single senior leader who is responsible for driving cost improvement throughout the organization. His or her role is to garner support from other senior leaders for cost reduction efforts as well as to ensure efforts are coordinated and in-sync with other strategic initiatives in the organization.

Also like Quality Improvement, Cost Improvement is highly data intensive, labor intensive, and change intensive… yet quite necessary. Unfortunately, the nature of the work and the lack of tools, makes cost reduction costly.

Fortunately, there are applications which are starting to gain traction that will combine large data sets to make complex analyses approachable even to less analytically sophisticated organizations. And other applications on the horizon that run algorithms to find cost savings then continuously measure the savings realized for each initiative and promote accountability by highlighting variance to goals. These tools will be a game-changer for the cost crisis in health care, but they will be most effective in the hands of a dedicated, innovative, collaborative Cost Leader and Cost Improvement Department.