Winning at Quality and Safety: Do You Need a Chief Quality Officer?

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In the past several months, healthcare organizations have been inundated with results from a variety of quality-rating agencies. The Centers for Medicare & Medicaid Services (CMS) released star ratings for hospitals, announced reimbursement penalties for high readmission rates, and issued draft regulations for new mandatory cardiac bundles. And as if that were not enough, U.S. News & World Report updated its hospital ratings and the Leapfrog Group released its newest Hospital Safety Scores.

QUALITY AND SAFETY AGENDA EXPLODES

These developments highlight the fact that (a) the nation’s quality and safety agenda continues to expand; (b) more aspects of healthcare organizations’ performance are readily available in the public domain than ever before; and (c) more hospital revenue than ever before is tied directly to providers’ performance on clinical outcomes, patient safety, and the patient experience. In fact, 70% to 80% of inpatient performance metrics (mortality and complication rates) is reported to the public via Healthgrades (https://www.healthgrades.com), almost every hospital receives a patient safety rating in the form of a letter grade from the Leapfrog Group (http://www.leapfroggroup.org), and CMS recently converted hospital performance reporting to star scores on Hospital Compare for patients to easily assess hospital quality rankings (https://www.medicare.gov/hospitalcompare/search.html).

Indeed, CMS plans to update the star ratings quarterly. Of the 4,559 hospitals listed, 133 currently have received one star, 723 have two stars, 1,770 have three stars, 934 have four stars, and 102—only 2.2% of hospitals—have five stars (Medicare.gov, 2016).

The Move to Pay-for-Value

The link between quality and financial performance is by now undisputed. Furthermore, because the move from pay-for-volume to pay-for-value is well under way, an institution’s performance on clinical quality and patient safety now has multimillion-dollar consequences. Consider the following:

• The federal government’s readmission penalties on hospitals have hit a new high as Medicare withholds more than a half billion dollars in payments for fiscal year 2017. The government expects to penalize more than half of U.S. hospitals—a total of 2,597—in 2017 (Rau, 2016).
• Most commercial insurance pay-for-performance programs and rate increases are now tied to quality, safety, patient satisfaction, or all of these factors.
• Commercial payers have begun to exclude poor-quality, high-cost hospitals from their networks—some markets in Tennessee and Kentucky are host to such exclusive networks, for example.
• The Medicare Access and CHIP Reauthorization Act of 2015 and its related initiatives, such as CMS’s Merit-Based Incentive Payment System and Comprehensive Primary Care Plus, will link more and more of physician outpatient performance to reimbursement (Beaulieu, 2016).
• By 2018, 90% of Medicare reimbursement will be linked to quality or value, according to the U.S. Department of Health & Human Services (2015).

THE QUESTION
All healthcare organizations have dedicated executives for finance, human resources, and IT, but many have failed to place the same level of importance on quality and safety leadership by recruiting a full-time chief quality officer (CQO). In these organizations, quality and safety are considered a part-time job—one often assigned to the chief medical officer or chief nursing officer as just two of many important responsibilities. With millions of dollars at risk and patient well-being hanging in the balance, hasn’t the time come to install a full-time CQO—someone who lies awake at night worrying only about quality and safety?

Influence of Physician Leadership
Many of us have debated the need for a CQO, but once we make the decision to invest in one, we move to the next consideration: Does the position require a physician, a nurse, a pharmacist, a nonclinician? I have seen many models work, but the most common is to have a physician executive at the helm. The following points offer compelling reasons:

• Eighty percent of clinical quality and costs are affected by the decisions made and orders written by physicians (Edelstein, 2014). They must be involved in, and in many cases direct, clinical improvement initiatives. Physicians are best led by other physicians, not least for efficiency reasons.
• To improve quality and costs, physicians must practice evidence-based medicine, which means changing their practice patterns and standardizing care. This effort requires in-depth medical literature reviews, physician-to-physician conversations, consensus building, and often some very frank debates about current medical practice. These activities are time consuming and are best led by a respected physician leader.
• Quality programs must focus on preventing complications on a broad scale. They require adherence to current best practices—treatments shown in the literature to be the most effective. Physicians are more open to advice and recommendations from peers and colleagues—other physicians, especially those whom they respect and consider excellent clinicians—than from
nonphysicians. It is a characteristic of the culture of medicine, and for now, we need to work within its boundaries.

• High complication rates can quickly erase a hospital’s profit margin. As a recent article by Healy, Mullard, Campbell, and Dimick (2016) in *JAMA Surgery* reported, mean hospital costs were $19,626 higher for patients with complications than for those without complications ($36,060 compared to $16,434, or 119% higher), and mean third-party reimbursement was $18,497 higher for patients with complications than for those without complications ($35,870 compared to $17,373, or 106% higher). Consequently, following risk adjustment, the overall (hospital) profit margin decreased from 5.8% for patients without complications to 0.1% for patients with complications.

**WHAT DOES IT TAKE TO BE THE BEST?**

I’m often asked, “If a CQO role is a full-time job, what tasks and responsibilities do I assign to the CQO? What are her priorities—her deliverables—and what should I expect in 3 to 5 years?” Let’s approach these questions as a series of steps:

1. **Design a quality and safety program that adopts the same level of discipline and vigor as your financial management system.** Replicate every best practice that drives your financial success into your quality program. For example, embed quality and safety into the strategic plan; make it a key component of the incentive compensation plan; and hold every leader, manager, and employee accountable for accomplishing these goals.

2. **Establish quality and safety reporting with the same scope as your financial reporting system.** We have the ability to report our financial performance for every department in our organizations; we should be able to report on our quality and safety performance in every department as well. How else will you improve care for the majority of patients who come to your institution?

3. **Develop a safety program that eradicates preventable errors.** This is an entirely new area of science that everyone in healthcare must learn. Leading the required change and achieving success take strong leadership. You will need a charismatic cheerleader to bring about this cultural revolution.

4. **Improve clinical outcomes by eliminating preventable complications, readmissions, and mortality for your 20 to 30 most common diagnosis-related groups.** These measures should cover 70% to 80% of your patient population. Driving large-scale change, across all medical specialties, requires an organized group of physician leaders who can work one-on-one with their physician peers to generate the needed changes in medical practice. Who better to lead this group than a well-respected, full-time physician leader?

**CQO Model Organizations**

Several organizations across the United States have created a CQO role. Spectrum Health in Grand Rapids, Michigan, has a CQO. At Henry Ford Health System in
Detroit, Michigan, quality is the responsibility of the senior medical director, vice president–quality, and at OhioHealth, headquartered in Columbus, the system CQO has been in place for many years. But more healthcare organizations need to establish a CQO role if the U.S. healthcare system is to deliver the outcomes patients deserve. The time is now to make this small and reasonable investment in quality expertise and leadership. Even from a purely financial perspective, the return on investment of this position is solid.

CONCLUSION
Organizations receiving a one-, two-, or three-star rating with Hospital Compare (currently 2,626 hospitals); garnering a C, D, or F grade on the Leapfrog Group’s Hospital Safety Score platform (approximately 40% of U.S. hospitals); or being assessed any penalties on the basis of readmission rates (2,597 hospitals) need a game-changing course correction. The first step for many of these organizations is to hire a full-time physician executive—a competent, experienced physician CQO.

If the CEO does not have a CQO on his team, the quality agenda does not receive the same degree of disciplined execution as the finance agenda. To hand the quality role to an already overloaded senior leader or middle manager—the most common model seen in hospitals and health systems today—leaves the entire quality agenda impotent and the manager frustrated. Leading today’s quality agenda is a full-time job, and the organization’s investment in a senior quality leadership position will pay off handsomely—not only in quality and safety outcomes but also in the financial returns those outcomes generate.

Imagine the day you receive word that your organization has achieved the lowest complication rates in the nation, eliminated more than 90% of errors that harm patients, been rated as among the best in the country for patient experience, and driven mortality rates to a new, all-time low. When all of these positive indicators are in place, good financial performance is nearly guaranteed, and your staff’s, physicians’, and community’s pride in your organization soars. This result is possible in large part because your CQO will have built an organized and educated group of physician leaders who partnered with your institution, your nurses, and your community to deliver best-in-class care. Remember, physician leadership is key because 80% of cost and quality are influenced by the decisions we make and the orders we write (Edelstein, 2014).

If you had a choice between a hospital with a Hospital Safety Score of D or one with straight As, where would you send your family member?

REFERENCES

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