Today’s Session: 
Developing Financial Models

Kathy Luther, RN, MPM
Jill Duncan, RN, MS, MPH

These presenters have nothing to disclose

WebEx Quick Reference

- Welcome to today’s session!
- Please use Chat to “All Participants” for questions
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Please send your message to All Participants

If you’re joining with colleagues, please type the organization you represent & the number of people joining from your organization.

Example: Midwest Health Alliance – 3

Please type your name and the organization you represent in the chat box!

Example: Chris Jones, Midwest Health Alliance
IHI Expedition Team

Kathy Luther, RN, MPM  
Vice President, IHI

Jill Duncan, RN, MS, MPH  
Director, IHI

Kayla DeVincentis  
Project Coordinator

Today’s Guest Faculty

Lucy A. Savitz, PhD, MBA,  
Director of Research and Education  
Intermountain Health Care,  
Institute for Healthcare Delivery Research  
Salt Lake City, Utah
Agenda

- Welcome & homework review
- Evaluating Cost Impact: Financial Models
- Wrap up and next steps

**Primary Drivers**

**WILL**
- Align Enterprise

**Secondary Drivers**

- Establish True North Metrics (Big Dots)
- Align Waste Reduction Strategy Throughout Organization
- Align Systems for Efficiency
- Adopt Integrated Performance Measurement Systems

- Engage Staff in the What & Why of Value Delivery
- Establish Data & Feedback Loops
- Patient & Family Perspective of Waste
- Ensure a Safe Environment for Sharing Ideas
- Develop New Skills at All Levels

**Ideas**

- Identify Waste

- Eliminate Clinical Quality Problems
- Optimize Staffing
- Maximize Flow Efficiency
- Manage Supply Chain
- Reduce Mismatched Services—overuse, coordination
- Reduce Environmental Waste (Healthy Hospital Initiatives)

**Execution**

- Prioritize, Manage Portfolio of Projects to Remove Waste

- Evaluate Cost & Quality Impact
- Prioritize Projects and Manage Organizational Energy
- Create a Portfolio of Projects
- Solve Problems and Execute PDSA Cycles
- Measure and Monitor Results

Driver Diagram

IHI’s Cost + Quality Collaborative Work

AIM

Reduce operating expenses 1% per year while continually maintaining or improving quality.
Homework Review

• Test the Waste Identification Tool in at least 1 clinical or support service area
• Bring results back to a multi-disciplinary team
• Identify and define potential “waste streams”
• Define data collection process
• Collect and categorize “waste”
• Identify at least 3 projects for your portfolio; could include current projects or new opportunities

Ground Rules

We learn from one another – “All teach, all learn”

Why reinvent the wheel? - Steal shamelessly

This is a transparent learning environment

All ideas/feedback are welcome and encouraged!
The Association for Professionals in Infection Control and Epidemiology, or APIC, happens to have a cost calculator aligned precisely with where I was heading. While not perfect, it was a good starting point for me and gave me a first dollar amount for HAIs within our organization.

Paul Gruen, MHA | Project Manager
Corporate Quality & Safety
Virginia Mason Medical Center

Online cost calculator from APIC:
http://www.apic.org/Resources/Cost-calculators

Royal Commission Medical Center
Yanbu Industrial City - KSA

IHI Expedition:
Partnering Quality & Finance Teams to Improve Value
Assignment # 1

1. **Approach:** department-specific projects  
2. **Aim:** 1-3% reduction in the overall cost of patient days/year  
3. **Team members:**  
   a) Dr. Alber Paules (Quality Officer – Quality Improvement Dept.)  
   b) Mr. Ahmed Saleh Al-Amri (Receptionist – Patient Affairs Dept.)  
   c) Radhwan Khedher Al-Ameer (Payable Manager – Finance and Budget Dept.)  
   d) Mr. Hani Ibrahim Al-Ogaibi (Customer Services Officer – Patient Affairs Dept.)  
   e) Mr. Mohamed Azrae (Budget Specialist – Finance and Budget Dept.)  
   f) Ms. Hessah Faisal Al Refai (Auditor Salaries Specialist – Finance and Budget Dept.)  
   g) Ms. Yusra Naeem Qari Tilbay (Customer Services Officer – Patient Affairs Dept.)  
   h) Mrs. Salma Khaled Baabbad (Bank Guarantee Specialist - Finance and Budget Dept.)

Assignment # 2

- The Waste identification tool was customized and 2 new versions were developed in order to be utilized in the following 2 areas:
  a) In the patients affairs department: the customized waste identification tool (figure 1) was used to trace patients, for whom a discharge order has been given by the treating physician, in order to identify the reasons behind their delayed discharge to the following day instead of being discharged on the same day of the discharge order.  
  b) In the medical insurance department: the customized waste identification tool (figure 2) was used to identify the possible reasons behind the rejection of the hospital claims by the medical insurance companies.
### Figure 1

**Waste Identification Tool Worksheet: Delay of Patient's Discharge**

<table>
<thead>
<tr>
<th>Patient Identifier</th>
<th>WASTE Streams</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pharmacy-related delay</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lab test result delay</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Radiology test result delay</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Accounting consultation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Transfer delay</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No documentation received from discharged patient</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Legal or police issues</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-patient receiving the discharged patient</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Discharged patient facing transfer to another hospital</td>
<td></td>
</tr>
</tbody>
</table>

**TOTALS**

*Patient identified transfers need the direct approval of the Tertiary Director of Medical Affairs, whereas transfers approved during the weekdays or the verbal approval during the weekends and during nights.*

### Figure 2

**Waste Identification Tool Worksheet: Loss of Expected Reimbursements from the Insurance Companies**

<table>
<thead>
<tr>
<th>Patient Identifier</th>
<th>WASTE Streams</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No follow-up of the expected claim*</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physician noted the case but did not document</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physician made a decision to document, which resulted in claim rejection</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Insurance company was not informed of the physician’s opinion</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Patient did not meet UCMAT time to the insurance company</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specific UCMAT form</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Patient denied authorization</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Patient received services without pre-authorization</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Patient did not pay the deductible</td>
<td></td>
</tr>
</tbody>
</table>

**TOTALS**

*Whereas an insurance company reviews a medical claim from the hospital, the hospital’s finance and budget department should prepare a response within 60 days, thus excluding the rejection of the rejected claims.*
Assignment # 2  continued

Data Collection Process:
1. For the (Delay in the Patient Discharge) project:
   a) Two team members check the Hospital Information System everyday (during the working days) at 11 AM, the time after which most of the discharge orders for the admitted inpatients are already given by the treating physicians.
   b) The same two team members check the hospital information system on the next day to identify the patients for whom a discharge order was given the day before yet they are still admitted in the hospital. Once they identify the list of those patients, they go to the units/wards at which those patients are admitted to interview the nurse-in-charge in order to identify the reasons behind the delay and subsequently fill the relevant waste identification tool.

Assignment # 2  continued

Data Collection Process:
2. For the (Loss of Reimbursement) project:
   a) One team member reviews the records of rejected claims at the medical insurance department in order to identify the causes of those rejected claims.
   b) The relevant waste identification tool is subsequently filled.
DATA ANALYSIS PLAN:

The aggregated data from both worksheets shall be used to identify the most common or the most contributing (the vital few ones) waste streams in both the discharge and the reimbursement processes in order to tackle them and subsequently minimize the potential future wastes.

PORTFOLIO MANAGEMENT

- Aim of Portfolio:

<table>
<thead>
<tr>
<th>Project #</th>
<th>Project Name</th>
<th>Projected Savings</th>
<th>Savings to Date</th>
<th>Quality Metrics</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Reducing the financial loss resulting from the non-reimbursement from the insurance companies for the already-provided services.</td>
<td>SAR</td>
<td>SAR</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Reducing unnecessary extra patient days resulting from the prolonged stay of inpatients due to poor coordination of the processes associated with discharge.</td>
<td>SAR</td>
<td>SAR</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Reducing unnecessary admissions at the weekends for patients who are scheduled for surgery at the beginning of the new week.</td>
<td>SAR</td>
<td>SAR</td>
<td></td>
</tr>
</tbody>
</table>
Documentation of waste/inefficiency in health care and the ability to reallocate these resources holds promise.

Ovretveit, 2004
## Deciding on Approach to Estimate Waste

<table>
<thead>
<tr>
<th>Analysis Level</th>
<th>Approach</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td>Dartmouth Atlas,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Wennberg</td>
<td>Supply-induced demand</td>
</tr>
<tr>
<td>Episode</td>
<td>Six Sigma &amp; ATP</td>
<td></td>
</tr>
<tr>
<td></td>
<td>QI Projects</td>
<td>Selected opportunities</td>
</tr>
<tr>
<td>Patient Care</td>
<td>TPS/Lean</td>
<td>Inefficiency of front-line work</td>
</tr>
</tbody>
</table>

- Reducing waste in health care is key to affordable, high quality health care.
- About 1/3 of consumed resources represent potentially recoverable waste in hospitals

Considering Waste

- **Inefficiency waste** is the use of resources for no (or little) benefit, or a failure to use resources on clearly beneficial activities.
  - Technical – using more inputs than required
  - Economic – using mix of inputs other than cost minimizing mix
  - Allocative (care design waste) – producing with the wrong bundle of goods and services
- **Quality waste** is when a step in a clinical process fails, some proportion of those process failures lead to outcome failures

Realistic Expectations for Waste Reduction

<table>
<thead>
<tr>
<th>Expected Cost Decrease</th>
<th>Strategy</th>
<th>Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-5%</td>
<td>Cost containment</td>
<td>Short-Term</td>
</tr>
<tr>
<td></td>
<td>(economic efficiency)</td>
<td></td>
</tr>
<tr>
<td>5-10%</td>
<td>Consolidation</td>
<td>Mid- to Long-Term</td>
</tr>
<tr>
<td></td>
<td>(technical efficiency)</td>
<td></td>
</tr>
<tr>
<td>10-20%</td>
<td>Process redesign</td>
<td>Mid- to Long-Term</td>
</tr>
<tr>
<td></td>
<td>(allocative efficiency)</td>
<td></td>
</tr>
</tbody>
</table>
Dark green dollars:

- Those dollars that can be directly identified as savings, extracted, and redeployed in a system of care
  (aka, CFO validated savings)

Drivers to Get to Dark Green $
Considering both primary & secondary drivers in project selection

<table>
<thead>
<tr>
<th>Primary</th>
<th>Secondary (examples)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical quality</td>
<td>Coordination of care, ↓ readmissions</td>
</tr>
<tr>
<td>Staffing</td>
<td>↓ premium pay, ↓ turnover</td>
</tr>
<tr>
<td>Patient flow</td>
<td>↑ throughput, ↑ productivity</td>
</tr>
<tr>
<td>Supply chain</td>
<td>Inventory control</td>
</tr>
<tr>
<td>Mismatched services</td>
<td>Eliminate unnecessary procedures</td>
</tr>
</tbody>
</table>
Framework for Tracking the Cost of Waste

Savings from Enhanced Efficiency
Avoided Costs
Revenue Enhancement
Increased Productivity

Dark Green $

Change in Cost/Unit of Service

Thinking About Cost

- **Fixed Costs**—expenses that accrue irregardless of case volume (e.g., base staffing, physical plant costs, equipment)
- **Variable Costs**—marginal, per case expenses (e.g., drugs, supplies)
- **Fixed vs. Variable Costs**—*Just because I lower my infection rate and the patient goes home on time doesn’t mean I don’t have to pay for the bed* unless you are operating at capacity and you can place a higher paying patient in the bed OR you can otherwise eliminate the fixed cost of the staffed.
Example Cost Metrics

- Change in net operating income
- Change in cost per unit of service
- Return on investment
- Contribution to fixed cost
- Contribution to margin

Contribution to Margin

- An independent MD approaches a hospital system, suggesting that the hospital should shift “appropriate” surgery patients to her OP surgery center because she is “cheaper.”
- From a financial perspective, should the hospital do it?

| Hospital Cost | OP Center Cost | Savings |
Contribution to Margin, Fixed vs. Variable Costing

- Only if the hospital has additional patient volume that can fill the now empty OR suites or otherwise eliminate the fixed cost.

Alternative Approaches for Capturing Costs

- Cost accounting system
- Time-driven activity-based costing
- Map out a process and assign costs as best as possible
- Derive estimates from the literature
Look to the Published Literature

- Once you identify portfolio area(s) of focus, you need to identify improvement interventions.
- I posit that one form of waste is re-inventing the wheel without looking at what others have tried to determine what we know about:
  - What works?
  - What doesn’t work?

Palliative Care Cost Cutting Example

Savings Summary

- On average, patients receiving palliative care incurred $6,900 less in hospital costs
  - $4,098 per admission for those discharged alive
  - $7,563 per admission for those who died in the hospital
- Palliative care recipients spent less time in ICU, were less likely to die in ICU, & more likely to receive hospice referrals.

External Validation

- Looked at several studies conducted elsewhere.
- Benchmarking Information
Patient “Qualification” Principles

Use for developing financial models for:

• Clinical conditions
  — VAPs, CLABSI, Heart Failure, Chest pain
• Flow projects
  — EC – left without being seen
  — Inpatients delayed to OR, radiology, procedures

Methods

• Identify patient population
• Qualify (segment population) by specific criteria ex: admit source, age, co-morbid conditions
• Agree on identification criteria with finance using MSDRGs, APR-DRGs, exclusion criteria
• Evaluate potential patients for “inclusion” to assure large enough group to impact
Example: What is cost of HAI?

• Literature review (VAP, CLABSI, pressure ulcers)
  — “Good enough” to use?
    ➢ Use as approximation of cost for each HAI –
    ➢ Multiply each condition avoided by $$ for
      approximate savings

• Internal calculation
  ➢ Identify patients with specific condition
  ➢ Case match with like patients in age, diagnosis illness
    severity, co-morbid conditions, admit source, length
    of stay – who did not have HAI
  ➢ Calculate cost of patients with and without
  ➢ Use difference for cost within your organization

Project: Improving EC flow to reduce LWBS
What is cost of EC patients LWBS*?

• How many patients LWBS per month?
• What is payer mix?
• Estimate acuity levels? (Typically lowest)
• What is return on payer mix at lowest acuity
  levels per case
• Multiply by payer mix of LWBS
• Are some admitted? What is return on
  those patients?

  *Left Without Being Seen
Reducing LOS Cost Calculation

- Infection cases had 39.5 day LOS (n=32)
- Uninfected cases had 17.9 day LOS
- If we moved the infected group to the norm of 17.9 day LOS, then we would save 692 days.
- Assuming ALOS is 4.5 days, we could see 153 new cases; average reimbursement is $12k.
- Savings: $12k x 153 new cases = $1,836,000

Formula: Total Cost Savings = Marginal Cost per Case x ‘Avoided’ Cases

COST PER CASE
- Utilized Cost Accounting System to generate costing data for all accounts within the control and trial groups and calculated the difference.
  - Average Cost of Trial Group – Average Cost of Control Group = Marginal Cost per Case
- Identify control group and trial groups of patients by:
  - CAUTI – Quality Department Records
  - CLABSI – CPT 4/ICD 9 Codes
  - Contrast Induced Renal Failure – CPT 4 Codes
  - Palliative Care – HIM System (EPIC)
  - VAP – Charge Item/Quality Department Records

‘AVOIDED’ CASES
- FY 2010 as Avoided Cases (Base Period) and FY 2011 as Trial Period
- Quality Department Records
## Annual Savings Matrix

<table>
<thead>
<tr>
<th>Cost</th>
<th>Savings per 'Avoided' Case</th>
<th>Base Period</th>
<th>Trial Period</th>
<th>Unit Difference</th>
<th>Total Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catheter Associated UTI (CAUTI)</td>
<td>$1,316.08</td>
<td>21</td>
<td>10</td>
<td>11</td>
<td>$14,476.88</td>
</tr>
<tr>
<td>Central Line Assoc. Blood Stream Infection (CLABSI)</td>
<td>$21,898.16</td>
<td>17</td>
<td>5</td>
<td>12</td>
<td>$262,777.92</td>
</tr>
<tr>
<td>ICU – LOS Palliative Care*</td>
<td>$2,547.99</td>
<td>1330</td>
<td>1303</td>
<td>27</td>
<td>$68,795.73</td>
</tr>
<tr>
<td>Ventilator Associated Pneumonia (VAP)</td>
<td>$43,062.65</td>
<td>15</td>
<td>12</td>
<td>3</td>
<td>$129,187.95</td>
</tr>
<tr>
<td>Renal Failure – Contrast Induced</td>
<td>$11,359.64</td>
<td>18</td>
<td>9</td>
<td>9</td>
<td>$102,236.76</td>
</tr>
</tbody>
</table>

* Assumes 2% Success Rate

Grand Total Savings: $577,475.24

## Reimbursement Impact

<table>
<thead>
<tr>
<th>Cost Structure Improvement</th>
<th>Payment Mechanism</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Discounted FFS</td>
</tr>
<tr>
<td>Decrease cost per unit</td>
<td>↑</td>
</tr>
<tr>
<td>Decrease # units per case</td>
<td></td>
</tr>
<tr>
<td>Other units</td>
<td>↓</td>
</tr>
<tr>
<td>LOS (# nurs hrs)</td>
<td>↓</td>
</tr>
<tr>
<td>Decrease # of cases</td>
<td>↓</td>
</tr>
</tbody>
</table>
Examples of financial models

Example

Mental Health Integration in Primary Care Practice as Improvement Focus
Inefficiency Waste from Process Variation

Reducing variation in compliance with evidence-based guidelines.

- **Care Process Models (CPMs)** are narrative documents that aim at representing state-of-the-art medical knowledge.

- **Clinical Decision Support (CDS)** tools can include all ways in which health care knowledge is represented in health information systems.

EB-CPM: Mental Health Integration (MHI)

A standardized clinical and operational process that incorporates mental health as a complimentary indicator of wellness & healing.

“Listen—just take one of our brochures and see what we’re all about….In the meantime, you may wish to ask yourself, ‘Am I a happy cow?’”
Speed/Efficiency of a Process is Controlled By:

• Way work is organized (process centered)
• Efficiency of individuals carrying out their role (staff-person centered)
• Defects that require extra processing (rework)

MHI Treatment Cascade
“Care Treatment & Management Matching”

Case Identification

MHI Packets

ROUTINE CARE
Mild Complexity

COLLABORATIVE MHI TEAM
Moderate Complexity

Higher Order Mental Health Services
Severe Complexity
Recoverable Waste

Payer specific analysis
Average allowed charges in the 12-month period after dx increased by 19% ($725) in treatment vs. 30% ($1,392) for usual care clinics
If the cohort of usual care patients were treated in MHI clinics, they would have incurred $286,143 less in overall charges 1 year post dx
— $1,392 – 725 = $667
— $667 * 429 patients
Assumptions & Approach

- **Assumption:** Clinics are receptive to expanded role; overcapacity of higher order mental health services
- **Approach:** Quasi-experimental study (comparing patients treated in MHI clinic vs. those not treated in MHI clinic)
- For patients treated for depression, having Select Health insurance coverage, meeting clinical criteria who were treated over a consecutive 2-year period (1 yr pre dx), — compare reimbursement & utilization pre vs. post
- You could further this analysis by looking at multiple payers AND factoring in increased clinic productivity (less losses due to ED and IP) together with reduced of decreased turnover

Example

*Reducing Unnecessary Induction of Early Labor as Improvement Target*
Early Induction Improvement

- Reduce variation in process using a care process model
  - Elective inductions not meeting CPM for clinical appropriateness fell from 28% to <2%
  - Labor length fell by 31 days/year
- IH can now deliver an additional 1,500 babies/year without additional beds/nursing staff & average reimbursement per normal delivery is $3,640 (to generate a conservative estimate)
  - $3,640 \times 1,500 = $5,475,000

Assumptions & Approach

- **Assumption**: High birth rate
- **Approach**: Simple population estimate
- Compare increased number of births (productivity) and associated revenue (less additional costs, which are 0 in this case)
- *You could further this analysis by looking at multiple payers AND factoring in that some of these additional births (using historical percent) would be c-section and have high reimbursement*
Using Evidence Based Resources to Build a Robust Portfolio

Strategy for Goal Attainment

- Directional strategies—portfolio (e.g., throughput, flow)
- Operational strategies—implementation of specific changes/improvements
  — Standardized manager action plan (due date, assumptions, expected cost recovery)
Expectations for Cross-Department Collaboration:  
Targeting Specific Areas for Cost Reduction

<table>
<thead>
<tr>
<th>Department</th>
<th># Improvements</th>
<th>Ex. Change/Improvement</th>
<th>Attributable Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing</td>
<td>4</td>
<td>Pt. Education</td>
<td>X</td>
</tr>
<tr>
<td>HR Education</td>
<td>5</td>
<td>Staff Training</td>
<td>X</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>3</td>
<td>Med. Rec.</td>
<td>X</td>
</tr>
<tr>
<td>ED</td>
<td>7</td>
<td>Bed Mgmt</td>
<td>X</td>
</tr>
<tr>
<td>...</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>19</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

Adapted from Caldwell et al.

Taking Action

- Define your portfolios:
  - Identify targeted changes/improvements
  - Estimate expected cost recovery by budget/impact area together with relevant metrics
  - Prioritize opportunities
- Develop a cost tracking system that reflects cross-departmental contributions.
- Monitor progress.
Contextual Considerations

- Be sure to think about external and internal drivers in “making the business case”
- Look at both direct and indirect cost/revenue streams, including current vs. expected future reimbursement.
- Determine who will benefit from avoided inefficiency waste—patients, payers, providers, facility(ies)?
- Identify relevant, financial measure(s) that are linked to your improvement effort and incorporated into your project goal statement.

Strategies to Harvest Quality Savings

1. Target specific improvement projects
   • Project likely medical & cost improvements
   • Track to final budgets
   • Select projects with internal savings
2. Use in contract negotiations
   • Demonstrate that clinical improvement has produced a superior total cost compared to competitors, even with a lower FFS discount
3. Partner with purchasers → shared risk contracts
Selected References

- Clark, DD et al. “Cost Cutting in Health Systems without Compromising Quality Care”

Additional References

Questions?

Raise your hand

Use the Chat

Partnering Quality and Finance Teams to Improve Value
Expedition Worksheet

| Align senior support | Decide where you want to start
| What is your aim? [Operating expenses? Cost/case? Cost/discharge?]
| Engage frontline staff | Begin to identify projects that will get you to your aim
| Begin building a portfolio
| Consider projects you are already working on as potential for your portfolio
| If you have no idea where to start? Consider adapting and testing the Waste Identification Tool
| Build and leverage partnerships | Collaborate with your financial colleagues to review your suggested portfolio and identify what might get at dark green dollars.
| Develop financial models | Define how you will measure the potential and actual savings for each project
| Monitor quality to ensure improvement | Identify best practices, financial models, aims & charters for each area of work
| Develop a series of projects around the aims identified by your team (your portfolio)
| Develop a sequencing plan for the work
| Test improvement interventions as well as financial measurement strategies
| Implement systems to encourage rhythm and discipline around the work
| Track progress
| Learn & spread across a community | Spread learning and best practices
| Re-engage & re-commit on a regular schedule
Partnersing Quality and Finance Teams to Improve Value
Expedition Worksheet

Align senior support
1. Decide where you want to start
2. Begin to build a partnership with leaders from the finance team
3. Define your aim (% operating expenses? Cost/case? Cost/discharge?)

Engage frontline staff
1. Begin to identify projects that will get you to your aim
2. Begin building a portfolio
3. Consider projects you are already working on as potential for your portfolio
4. Don’t know where to start? Consider adapting and testing the Waste Identification Tool

Build and leverage partnerships
1. Collaborate with your financial colleagues to review your suggested portfolio and identify what might get at dark green dollars.

Develop financial models
1. Define how you will measure the potential and actual savings for each project

Monitor quality to assure improvement
1. Identify best practices, financial models, aims & charters for each area of work
2. Develop a series of projects around the ones identified by your team (your portfolio)
3. Develop a sequencing plan for the work
4. Test improvement interventions as well as financial measurement strategies
5. Implement systems to encourage rhythm and discipline around the work
6. Track progress

Spread & spread across a community
1. Spread learning and best practices
2. Re-engage & re-commit on a regular schedule

Homework for Next Call

For your selected approach, identify and discuss several key waste streams. For one (1) of the streams discuss how you’d build a financial model.

Send ‘Tweet-like’ message of 140 characters or less to Jill at jduncan@ihi.org by Monday, July 23rd
Expedition Listserv

We have set up a listserv for participants in this Expedition to share improvement strategies, and pose questions to one another and faculty.

To use the listserv, address an email to QualityFinanceExpedition@ls.ihi.org.

If you would like additional people to receive session notifications please send their email addresses to improvementmap@ihi.org.

Schedule of Calls

- Session 1 – Tuesday, June 12th 1:30 – 3:00 EDT
  – Align senior support & build and leverage partnerships
- Session 2 – Tuesday, June 26th 2:00 – 3:00 EDT
  – Engage frontline staff & prioritize portfolios
- Session 3 – Tuesday, July 10th 2:00 – 3:00 EDT
  – Develop financial models
- Session 4 – Tuesday, July 24th 2:00 – 3:00 EDT
  – Monitor quality to assure improvement
- Session 5 – Tuesday, August 7th 2:00 – 3:00 EDT
  – Learn & spread across a community
- Evaluate Cost & Quality Impact
- Prioritize Projects and Manage Organizational Energy
- Create a Portfolio of Projects
- Solve Problems and Execute PDSA Cycles
- Measure and Monitor Results

**PRIMARY DRIVERS**

**WILL**
Align Enterprise

**SECONDARY DRIVERS**

- Establish True North Metrics (Big Dots)
- Align Waste Reduction Strategy Throughout Organization
- Align Systems for Efficiency
- Adopt Integrated Performance Measurement Systems

- Engage Staff in the What & Why of Value Delivery
- Establish Data & Feedback Loops
- Patient & Family Perspective of Waste
- Ensure a Safe Environment for Sharing Ideas
- Develop New Skills at All Levels

**IDEAS**
Identify Waste

- Eliminate Clinical Quality Problems
- Optimize Staffing
- Maximize Flow Efficiency
- Manage Supply Chain
- Reduce Mismatched Services—overuse, coordination
- Reduce Environmental Waste (Healthy Hospital Initiatives)

**EXECUTION**
Prioritize, Manage Portfolio of Projects to Remove Waste

- Evaluate Cost & Quality Impact
- Prioritize Projects and Manage Organizational Energy
- Create a Portfolio of Projects
- Solve Problems and Execute PDSA Cycles
- Measure and Monitor Results

**Driver Diagram**
IHI's Cost + Quality Collaborative Work

**AIM**
Reduce operating expenses 1% per year while continually maintaining or improving quality.

**WILL**
Engage Staff, Physicians and Patients

**Thank You**