

## Voices

### *Thought Leadership*



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## We need new strategic relationships between quality and finance

**H**ealthcare's challenges with financial, workforce, quality and safety issues are not merely blips on the radar. They're at the core of every provider organization, meaning solutions for them cannot be easy or superficial. Instead, responses must promote systemic and sustainable change, including the formation of new strategic relationships between quality and finance teams to drive healthcare forward.

In old models of healthcare, quality and finance were each fairly straightforward: Quality meant compliance, and finance measured revenue and expenses. But thinking about quality as compliance is a reactive approach. And bending the curve on finances means seeking ways to squeeze more margin out of current activities,

just to keep our heads above water.

As CEOs of healthcare associations representing quality and finance—two of the most critical operations in any health system—we see a future where quality impacts finance more than ever, and vice versa. The efforts must be bi-directional, with leaders collaborating to change the status quo, not just continuing to launch a series of projects that don't produce sustainable results.

The path ahead must lead to reliable, higher-quality, safer and more affordable healthcare. For this reason, it is imperative that the finance team doesn't view quality as just another department or vertical pillar that competes for resources against other service lines. Quality should be seen as the catalyst through which all other initiatives can thrive and financial pressures can be relieved.

A May 2022 report from the Health and Human Services Department's Office of Inspector General stated that 1 in 4 hospitalized Medicare patients experienced some type of harm during October 2018, and nearly a quarter of those events resulted in additional costs to Medicare. Physician-reviewers determined that 43% of the harm events could have been prevented. Higher-quality care is clearly more cost-effective care.

We hear all the time that the goals of the C-suite seem disconnected from the goals of the quality team and frontline staff. Why? Because there's a sense that organizations need to either cut costs or deliver higher-quality care. This is a false choice. Both are possible when minds are opened to more collaborative and sustainable approaches to care delivery.

Another difficulty in funding quality initiatives is that as systems expand through mergers and acquisitions, quality infrastructures can become highly variable. We've heard of mergers between 18 hospitals that resulted in 18 quality committees, 18 staffing structures and more than 150 job descriptions for quality team members. This makes it difficult to understand the relative investment at each site, as well as for the system as a whole. Legacy benchmarking tools provide some insight, but much more depth is needed to understand the most critical needs.

For that reason, Anthony Warmuth, executive director of clinical transformation at Cleveland Clinic— with the support of the organization's finance leadership team—approached the National Association for

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Healthcare Quality about developing a robust benchmarking tool, which launched in 2021. As much as systems value the peer-to-peer benchmarking the tool offers, a clear understanding of the health system's investments across sites is its most beneficial feature. Cleveland Clinic is using the tool to visualize variability and intentionally allocate resources to quality.

Quality improvement initiatives also must encompass health-related social needs—factors that affect people's ability

to maintain their well-being. The Healthcare Financial Management Association shares insights learned from initiatives such as Maryland's Health Enterprise Zone project, which exemplifies how collaboration among providers, community service agencies and local government can improve quality of care by mitigating social factors in a population of very high healthcare users, resulting in lower costs. In its final year, the Maryland project's care coordination and other interventions yielded a significant return on investment, including a 47% reduction in hospital visits and a 37% reduction in per-patient hospital charges. But the program was funded by a time-limited grant, not third-party payers or community benefit dollars, so the services ended when the grant expired.

Simply put, quality and outcomes improvement produces a financial return on investment time and time again. Leaders must move beyond legacy views of quality as compliance, to a better model in which quality excellence is the pathway to both improved clinical outcomes and financial sustainability. ■