“There are a lot of skeptics out there who say: ‘What is the urgency now? The rising cost of health care has been a problem for a long time,’” says Christopher Moriates, M.D., director of the Caring Wisely program and the UCSF Center for Healthcare Value. “But we’re in a period now where there is rapid change. All eyes and the spotlight are on this problem.”

The UCSF Health Continuous Process Improvement team is keeping the spotlight on health care costs, like detectives on the case, identifying costs throughout UCSF Health and educating frontline health care providers and staff about how to manage the costs and reduce waste. The initial goal is to facilitate $2.6 million in savings for fiscal year 2016.

“It’s not about squeezing more productivity and efficiency from hard-working providers and staff; it’s about identifying the low-hanging fruit and getting rid of that,” explains Ralph Gonzales, M.D., chief innovation officer and head of the CPI team.

“Reducing costs at UCSF Health is really about increasing value to the patient and to the purchasers of our health care services.

“We’re looking for quadruple wins. Quadruple wins not only improve the quality of care and the quality of the patient experience, but they also reduce the costs all while making UCSF the best place for staff and providers to work.”

Our inpatient cost per case is in the 90th percentile among academic medical centers. Dr. Moriates admits, “Cost is a hard problem for us to grapple with. This idea of trying to address cost in medicine is not comfortable, but it is important.”

Cost Reduction Tool Kit

It is important to give faculty and staff the tools they need to more easily identify costs and areas to reduce waste. Kim Berry, recently hired as Financial Improvement Project Manager, is working closely with Decision Support Services to develop a tool kit especially for this purpose. It will define for managers and directors how to estimate, rank and prioritize program and unit contributions to operating cost per hospital case. The tool kit is scheduled for release in Q1 2016. This project is just one of many Berry is undertaking to help UCSF Health attain its FY 2016 IAP health care cost reduction goal.

Fiscal Year 2016 IAP Goal
Health Care Cost Reduction
12.5% of the incentive bonus will be tied to the operating cost per hospital case.
- Threshold: Budget — $26,438 per adjusted discharge
- Target: Budget less 0.5% - $26,326
- Outstanding: Budget less 1.0% - $26,193

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Through Caring Wisely projects we have reduced surgical supply costs per case and reduced the cost of blood. “We found we had some of the highest blood costs in the country, because we were some of the highest blood transfusers in the country,” says Dr. Ralph Gonzales, chief innovation officer. “By implementing practice guidelines for more judicious use of blood transfusions we were able to see a big drop in blood cost and blood utilization, without having any adverse effect on patient outcomes.”

There’s been a 20 percent reduction in blood utilization across the affected services, amounting to about $1.3 million in savings since 2013. And after giving individual snapshots to surgeons detailing their supply costs per case, we have seen an 8% reduction in median surgical supply costs per case for surgeons who received snapshots, versus a 6% increase in median surgical supply costs for surgeons who did not receive snapshots.

This amounts to about $550,000 in savings so far in 2015, according to Dr. Corinna Zygoourakis, UCSF neurosurgery resident and Center for Healthcare Value Fellow who serves as the project leader for the OR SCORE (OR Surgical Cost Reduction) project.

Congratulations to the new UBLTs!

Starting January 2016:

<table>
<thead>
<tr>
<th>ED-Parnassus</th>
<th>ED-MB</th>
<th>Clinical Decision Unit</th>
<th>8/11 ICU</th>
<th>10 ICC</th>
<th>MB ICU</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hematology-BMT Clinic</td>
<td>Screening &amp; Acute Care</td>
<td>Pain Management-MZ</td>
<td>OHNS-MZ</td>
<td>Head &amp; Neck Surgery &amp; Oncology MB</td>
<td>Intensive Care Nursery</td>
</tr>
</tbody>
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CPI Announcements

♦ Want to direct people to the CPI Hub, but can’t remember how to find us? We’re now on Carelinks. >> Communication banner.

♦ The FY16 Organizational Goals is posted on our CPI website (cpi.ucsf.edu), under Events

♦ Curious what UBLTs are working on? Find all A3-T Project Charters for each improvement cycle on the CPI website, under Our UBLTs
Reduced Blood and Surgical Supply Expense Transformations

and Center for Healthcare Value Fellow who serves as the project leader for the OR SCORE (OR Surgical Cost Reduction) project receive snapshots. This amounts to ~$550,000 in savings so far in 2015, according to Dr. Ralph Parnass, chief innovation officer. “By implementing practice guidelines for more judicious use of blood transfusions we were able to see a 20 percent reduction in blood utilization across the affected services, amounting to about $1.3 million in savings,” he says. The highest blood costs in the country, because we were some of the highest blood transfusers in the country,” says Dr. Ralph Parnass. Currently, many are siloed. There is no one comprehensive management committee focused on High Value Care that is aligned with organizational goals and with each other. To address this, we have also tried to shift the mindset from being an old-fashioned multidisciplinary group and have had terrific support from the Decision Support team. We have also tried to shift the mindset from being an old-fashioned UM committee to being a committee focused on High Value Care. Our specific goals for the committee are to:

- Reestablish an engaged, multidisciplinary committee to champion, lead and oversee programs to assure high value care at UCSF.
- Provide a mechanism for disseminating information about high value programs to UCSF faculty and staff.

**HH: What is the committee’s focus this year?**

**AG:** The first thing we’ve tried to do is to educate everyone on the committee as to why this work is important. Rather than assume that everyone understands hospital finance and the drivers of cost, we’ve spent a lot of time on our first two meetings providing education. Our patients (and payers) are looking for high value care, that is high quality health care at the lowest cost. We asked Dr. Green to share her vision for the committee.

HH: Why did you reorganize the Utilization Management Committee and how is it different from the old committee?

**AG:** When reducing cost per case became an incentive goal for UCSF staff and providers this year, and the need for length of stay reduction was explicitly called out on the organizational work plan, it gave us the opportunity to rethink the committee, hopefully gain greater buy-in for the work and to obtain the resources needed for greater success. We re-launched the committee with a much larger multidisciplinary group and have had terrific support from the Decision Support team. We have also tried to shift the mindset from being an old-fashioned UM committee to being a committee focused on High Value Care. Our specific goals for the committee are to:

- Reestablish an engaged, multidisciplinary committee to champion, lead and oversee programs to assure high value care at UCSF.
- Provide a mechanism for disseminating information about high value programs to UCSF faculty and staff.

**HH: Why is it important to focus on length of stay?**

**AG:** Quite simply, it is important to focus on length of stay because there are more patients in need of our beds than we have capacity. We see this daily in the chaos that occurs when patients are boarded in the ED or experience delays in moving from the PACU to the floor. We also know that with our current and projected growth rate, we won’t have beds for all of our patients if we don’t use our inpatient beds more efficiently. On many of our services, patients are staying in the hospital longer than their benchmarked length of stay so we know we have opportunity to improve.

HH: Is it better for a patient to be discharged before noon or to have a shorter length of stay?

**AG:** I am frequently asked about this and in particular many people think that perhaps the push to discharge patients before noon incentivizes us to keep patients overnight just to achieve that metric. First, the most important thing is to discharge patients when they are clinically ready to be discharged and a safe discharge plan is in place. We should never keep a patient overnight just to discharge before noon. That said we know that if we plan ahead, we can discharge a portion of our patients before noon and it is enormously helpful from a patient flow perspective when we do this. We have tracked data related to discharge before noon for several years now. During the months when we’ve done well, there has been no adverse impact on patient satisfaction, length of stay or readmissions.

**HH: What is the one takeaway you want readers to get from this story?**

**AG:** I would like everyone to feel as if they have a role in contributing to this work. The impact of many small efforts can be significant. Whether you think twice before ordering a test or opening something that is likely to just be thrown away, or change your rounding patterns to discharge one patient early in the day, or promote compliance with best practices to reduce c. diff, you will be making an impact.
CPI Partner Spotlight

CPI work is promoted daily by committed faculty and staff throughout the clinical enterprise who work collaboratively to achieve our goals. This month we focus on a few CPI partners whose work is making a difference in identifying and removing waste from patient care delivery.

“I don’t know how we can continue to be viable without efforts to change our behaviors and how we provide care,” says Director of Decision Support Services Claudia Hermann. “We do a lot of things that are not necessary. Any waste that we eliminate will help our patients.”

Hermann, a CPI partner, has been educating UBLTs about what comprises inpatient costs. From room and board to medication, from supplies to the use of blood, Hermann has been providing concrete statistical information about utilization patterns by practice and diagnosis. The information, such as blood use, had made a difference.

“Our physicians have been able to use that information to support findings that we’ve actually over transfused some of our patients,” says Hermann. “We make transparent the facts of how patients are being treated and through that transparency providers are able to see opportunities for changing ordering behavior.”

No shows and late cancellations are two key improvement areas for UCSF Health’s outpatient clinics that affect our ability to maximize utilization for fixed costs. They waste resources—our committed providers’ and staff time in the clinic and exam rooms. Reducing the no-show rate and late cancellations begins with having accurate data. Michael Wang, data specialist with the CPI Hub, creates special reports for the UBLTs that tracks patient activity on a monthly and weekly basis. This information allows staff to devise better ways to communicate with patients to ensure they keep appointments or cancel earlier so other patients can take their slots.

“We are working to set a target* for how many patients should be seen in the exam rooms on a daily basis. We don’t want to see the rooms go empty,” says Wang. “This work is critical. Ultimately we will help improve the patient experience and their life without increasing cost to our practices and to our patients.”

* The target is an average of six patients per exam room per day across ambulatory practices. Currently we see from three to five patients per exam room per day.

“Cutting cost and efficiency go hand in hand,” says David Rein, director of Business Operations and Analytics for the UCSF Faculty Practice. He contends, “It’s really not as much about cost as it is about efficiency; UCSF is continuing to grow and we need to become more efficient to meet the very high demand for our health care services.” To this end, Rein has been using the Decision Analytics Reporting Tool (DART) to help CPI staff access and understand the data related to physician services and expenses. Rein has shown CPI staff how to compare the data to national benchmarks. He has also solved some mysteries about outpatient expenses, clarifying what costs can and cannot be cut.

“Recently in one of the pediatric clinics they had huge charges in a bucket called ‘other’. They thought maybe it was an opportunity for savings and I showed them that the charges were actually for the clinic’s call center; so the fund was not discretionary.”

Right now Rein’s attention is squarely on actual costs. However, he says there may come a time when “opportunity costs” will be investigated. Opportunity costs are those cases where UCSF is providing services that are not being billed.

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