OUR TAKE

Standardize the process for care standardization

What it takes to reduce unwarranted care variation at scale

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The key to unlocking clinical cost savings

Care variation reduction (CVR) is one of the few opportunities in health care to capture multi-million dollar cost savings while maintaining care quality.

To unlock that potential, health care organizations cannot approach CVR on an initiative-by-initiative basis. Organizations must pursue CVR as a coordinated, system-level effort—and have a consistent, standardized process for care standardization that is condition- and site-agnostic.

Advisory Board

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The conventional wisdom

CVR is one of the few opportunities in health care to net multi-million dollar cost savings, while maintaining—or even improving—care quality. For this reason, CVR has become a mainstay on most executives' strategic agendas, and virtually all hospitals and health systems have deployed clinical teams to tackle unwarranted variation in some form or fashion. Additionally, in light of increased financial pressure and the quality microscope organizations are under amid Covid-19, many are looking to double down on their CVR efforts.

Most hospitals and health systems are at a point where they've made initial investments in care variation reduction, and are now attempting to scale CVR organization-wide. The most common approach is to expand the CVR ambition or goal and add to the number of initiatives in progress. However, when CVR efforts are pursued on an ad hoc or pilot basis, with clinical teams customizing their process for each new condition, organizations quickly find they cannot scale.

Despite concerted efforts, most organizations have not yet achieved sustained standardization at the front line nor significant CVR-driven cost savings to their bottom lines.

Source: Physician Executive Council interviews and analysis.

Definitions

Care variation

The overuse, underuse, or misuse of care services and interventions, based on the available clinical evidence

Care standard

An accepted, evidence-based clinical practice that is defined and approved by a health system

Care pathway

A series of care standards expected across a clinical episode for a given condition or procedure

Source: Physician Executive Council interviews and analysis.

Our take

The CVR cost savings potential is immense. We've worked with organizations that have achieved tens of millions of dollars in year-over-year savings by reducing internal care variation—but not by an initiative-by-initiative approach.

To unlock the cost savings potential of CVR, health systems must break out of pilot mode and find an efficient way to scale CVR efforts across diverse facilities, service lines, and clinical conditions. **That's why the most important protocol that a hospital or health system can standardize is the process for standardizing care itself.**

A standard protocol for care standardization is, by definition, applicable across facilities, service lines, and conditions—and is best governed at the system level. This approach enables organizations to prioritize their greatest cost saving opportunities system-wide, and effectively concentrate system resources on addressing that variation. This approach also ensures that all published care standards meet a consistently high level of rigor.

The net effect: Organizational competency in care standardization that can be scaled across the system. In fact, hospitals and health systems that focused on fewer clinical conditions while establishing a standard, system-level process for care standardization found that it gets easier to create and implement successive care standards over time.

Source: Physician Executive Council interviews and analysis.

Five imperatives to standardize the process for care standardization

01

Imperative 1

Pursue the path of least resistance for care standardization

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Do not delegate system-level oversight

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Pace CVR based on system capacity to implement—not define—new care standards

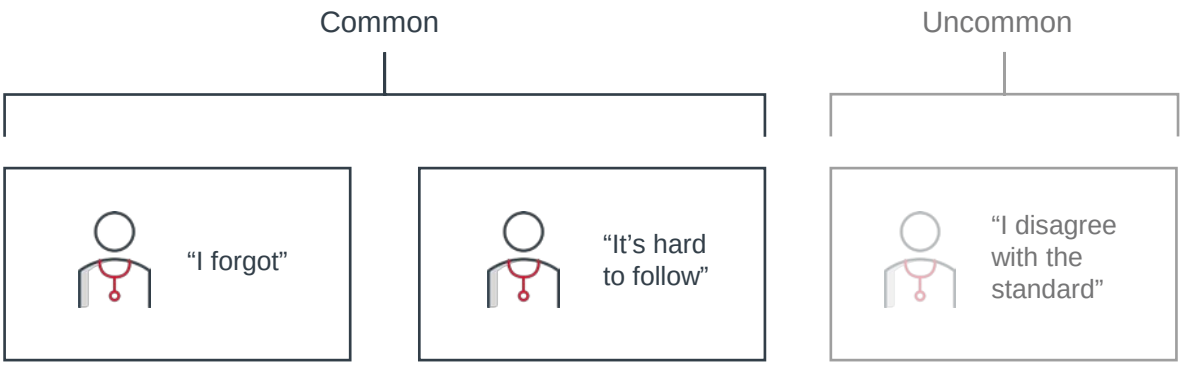
Source: Physician Executive Council interviews and analysis.

01 Pursue the path of least resistance for care standardization

Many organizations start their CVR effort by going after the most contentious conditions, where there is not a clear standard of care nor clinical consensus. At first blush, standardizing conditions for which there is a lot of debate can seem like a good tactic to drum up clinical interest.

However, the bigger—and better—opportunity is to pursue standards where clinical consensus exists, but clinician adherence is lacking. In these cases, most clinicians agree with the widely-accepted clinical guidelines and want to comply, but simply forget the standard or find that the standard too hard to follow. By starting with care standards clinicians already agree on—i.e. the path of least resistance—you can more easily win buy-in for CVR.

Reasons clinicians don't adhere to care standards



Starting with the path of least resistance can also mean standardizing care in an area where there are clear physician champions to help you get quick wins to build organizational momentum for CVR.

Source: Physician Executive Council interviews and analysis.

02 Do not delegate system-level oversight

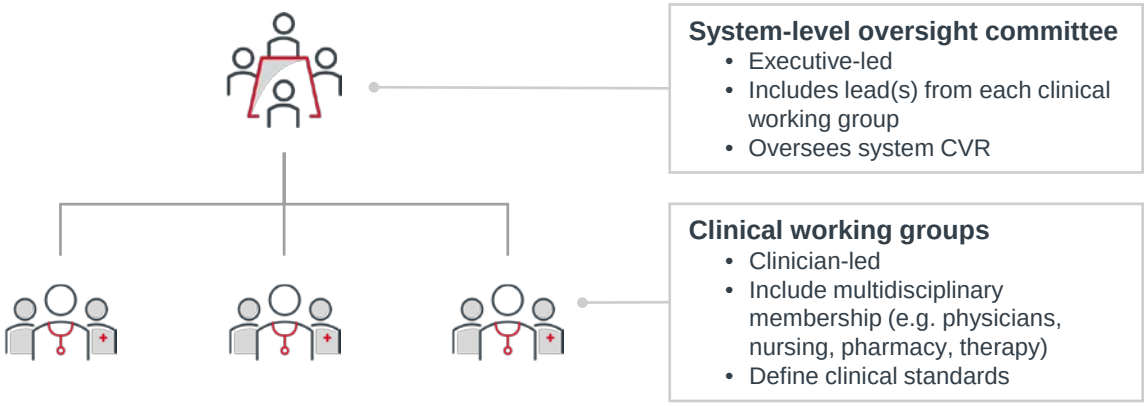
To reduce unwarranted care variation at scale, there are certain decisions that have to be held at the system-level—not in siloed pockets across the organization.

The most successful organizations stand up a dedicated system-level oversight committee for CVR that is responsible for ensuring a coordinated approach to CVR across the system, including:

- Setting system-level cost savings and quality goals attributable to CVR
- Prioritizing among CVR opportunities and selecting which to pursue
- Convening clinical working groups to develop care standards
- Allocating centralized resources to working groups
- Evaluating and approving care standards ahead of rollout

Source: Physician Executive Council interviews and analysis.

Effective CVR governance structure



Oversight committee membership

The system-level oversight committee should be executive-led and include both clinical and non-clinical executives in order to ensure alignment around CVR goals and resource allocation decisions.

Clinical executives include: the system-level Chief Physician Executive and the system-level Chief Nursing Executive (or senior-most CNO). Non-clinical executives include: CEO, CFO, and CIO or CMIO.

The key is that the system-wide oversight committee stays focused on governance, including setting strategy, prioritizing vision, monitoring key indicators of success, and guiding decision-making for CVR.

To learn more about effective CVR governance structures, access How to build a governance structure to support CVR at scale.

Source: Physician Executive Council interviews and analysis.

03 Make the ‘right care’ the easiest care for clinicians to deliver

Creating an implementation-ready care standard means ensuring that every step of the care standard is feasible for clinicians to follow. Often, CVR task forces consider their work done once they’ve reviewed internal and external evidence and come to clinical consensus. However, care standards that only include clinical requirements are incomplete, and lack the functional requirements, or “workflow enablers,” needed to implement the standard at the frontline. A comprehensive care standard includes the workflow enablers that clinicians will need to complete each step of the care standard successfully. Common workflow enablers include:

- **EHR supports** such as alerts, order sets, and fields to document the step
- **Equipment and supplies** that are both available in the relevant facilities or units, and readily accessible to clinicians at the point of care
- **Requisite information** to complete the step, such as job aids or checklists to perform the step effectively, or clinical information, such as required lab results
- **Care team members or other people** who are required to sign-off on the step, supervise the step, or actually perform it

For customizable templates and examples of care standards, access our Toolkit for building implementation-ready care standards.

Source: Physician Executive Council interviews and analysis.

04 Enlist non-clinicians to lead care standard design

Clinical expertise is necessary, but not sufficient, to scale CVR. While clinicians are well-versed in clinical evidence and have first-hand experience of workflow realities, they often do not have the non-clinical design skills required to operationalize a care standard. Once clinical consensus has been reached among clinicians, the bulk of the actual design work should be done by internal process experts that have the requisite skills to create implementation-ready care standards.

Five skillsets needed to design care standards

Project management
- Project plan management
- Logistics coordination
- Resource management

Process engineering
- Clinical workflow analysis
- Impact forecasting
- Implementation planning

Data analytics
- Data extraction
- Performance evaluation
- Dashboard management

Clinical informatics
- Electronic health record optimization
- Clinical decision support creation

Clinical education
- Education plan development
- Communication strategy guidance

The good news is that most hospitals and health systems already have this talent internally in project management offices, finance departments, and IT departments. Considering prioritizing internal expertise as you build or expand your design team.

Source: Physician Executive Council interviews and analysis.

05 Pace CVR based on system capacity to implement—not define—new standards

Hospitals and health systems that accomplish the first four imperatives often run into a new challenge: the number of care standards they create far outpaces what their clinicians can feasibly implement into daily practice at any one time.

From an operational perspective, the system-level oversight committees can help prevent this bottleneck by sequencing and scheduling care standard rollouts centrally—taking into account not just other CVR efforts, but all major change initiatives that impact clinicians. Organizing changes on a single, system-wide change calendar allows leaders to identify 'hot spots' where frontline clinicians are being asked to absorb too many changes at one time. In turn, leaders can shift rollout dates to accommodate clinician capacity, as well as re-prioritize which new care standards are in development across the system.

Excerpt of Texas Health Resources' change calendar

Initiative	Type	Audience	Jan-17	Feb-17	Mar-17
Antibiotic Stewardship	Refresher Training	Internal Medicine			Low
DVT Prophylaxis	New process change	All clinicians	High		
COPD Guidelines	New process change	All physicians	High		
Glycemic Control	New process change	All clinicians	High	Medium	
Heart Failure Diagnosis Guidelines	New process change	IM, Cardiology			High
CABG Guidelines	New process change	Cardiac Services			High
Physician Leadership Initiative	Training	Physician Leaders		Medium	

Impact of each initiative on clinicians rated low, medium or high, based on:

- Degree of change
- Training required
- Staff anxiety around the change

Source: Texas Health Resources, Dallas-Fort Worth, Texas; Physician Executive Council interviews and analysis.

But there is also a larger strategic question that leaders need to address when thinking about the pace of CVR efforts: how fast *can* your organization go after CVR at scale?

Whether you're starting CVR from scratch or transitioning from an initiative-by-initiative approach to a scaled approach, it's important to consider whether the timeline for reaching your system-level CVR cost savings and quality goals actually aligns with the resources your organization is willing to dedicate to the effort. Based on our conversations with progressive organizations, the types of organizational resources that determine how quickly organizations can scale CVR include:

- Clearly defined, system-level vision for CVR
- Executive-level engagement
- Frontline clinician engagement
- Dedicated clinical governance
- Functional order set capabilities
- Effective supply chain management

Whether your organization is in a position to sprint towards your CVR goal or needs to extends your CVR timeline to match the resource commitment, the key to successfully scaling CVR system-wide is ensuring the pace matches your organizational commitment to the effort.

To determine whether you have the level of organizational commitment to scale CVR, see Assess your organization's commitment to care variation reduction.

Source: Physician Executive Council interviews and analysis.

Parting thoughts

Organizations that initially work on just a few CVR opportunities—and focus on standardizing the process for care standardization itself—soon discover that it becomes easier to create and implement successive care standards.

There are three reasons for this impact.

1. Clinical and non-clinical experts involved in care standardization develop ‘muscle memory’ and the standard process gets easier over time.
2. Because a standardized process is condition-agnostic by definition, it allows systems to more easily export their process for CVR cross new service lines and facilities that have not previously been involved.
3. Clinicians at the frontlines of care delivery have the bandwidth to implement effectively sequenced care standards and become familiar with how to navigate standardized outputs, such as workflow maps and clinical decision supports.

Your organization likely already has the clinical expertise and resources needed to scale CVR effectively. A good first step to centralize the effort is to take stock of existing efforts, including what elements of individual initiatives are working well and should become standard system-wide—and what common challenges are present across initiatives that could be solved centrally.

For additional support scaling your organization’s CVR efforts, please access our additional resources on the next page, or contact AskAdvisory with questions.

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