Safety in a Recession?

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That hospitals are under financial stress in 2009 is not a secret to anyone who has been reading the newspapers, trade journals or your own organization's financial statements. Investment income (on which too many institutions had become dependent) has dropped off the map, and philanthropic giving is now following suit. Patient volumes have plummeted, as financially strapped patients postpone or forego elective procedures. The rating agencies have issued "negative" outlooks on hospitals, and credit downgrades far exceed upgrades. Many hospitals are tripping the triggers for "days cash on hand" on their bond covenants.

Hospital leaders' response has been exactly what one would expect. In many settings, capital spending has come to a halt. More than half of all U.S. hospitals have cut staffing expenses. More than one-fourth of hospitals have eliminated or reduced services. Most of these steps are painful, but some of them might also be unsafe.

Many hospitals have made substantial improvements in safety during the last 5 to 7 years--times that in retrospect will likely come to be viewed as the "good years," financially speaking. We are aware of dozens of hospitals where hospital-acquired infections have been reduced dramatically, medication safety has improved by an order of magnitude, and risk-adjusted mortality rates have dropped by 20 percent or more, during this time. These results are no accident. They have occurred because hospital leaders chose to pay a new level of attention to safety and to make additional investments in infrastructure and technology.

The resulting improvements are gratifying--and fragile. In many cases, these improvements have not been permanently "baked into" the hospital's operations and culture but continue to depend on special attention from leaders and managers, new levels of measurement and support from the quality staff, and other add-ons to care processes that leaders chose to make *during the good years.*

Will Safety Become a Casualty of the Recession?

The question is: Will these improvements in safety be sustained and strengthened during the lean years? Specifically, will the positive safety trajectory that many hospitals have established carry forward if managers and trustees now channel all their attention to finances? Will mortality rate improvements survive reductions in nurse staffing? Will nosocomial infection rates, venous thrombo-embolic events, and other indicators of harm continue to improve without special data analysis and project support from your quality resource group?

Forgive us for being skeptical, but we are worried. We have all been in far too many meetings of senior executives in the past few months in which major cuts in nurse staffing, quality infrastructure, and other resources were proposed or made without *anyone* raising the question of the potential impact of these cuts on patient safety.

In contrast, we are also aware that the leadership teams at a number of hospitals are openly discussing this problem and are facing up to their financial challenges while maintaining a steadfast commitment to safety. The hospitals in the VHA Central Atlantic Region have adopted a "Stuff, not Staff" policy of focusing their operational expense reductions on just about everything but bedside nurse staffing levels. Henry Ford Health System, Detroit, and Cincinnati Children's Medical Center have held difficult conversations at the board level during which the resolve of the board has been made crystal clear: Safety will not be a casualty of the recession in *this* care system.

Avoiding Backsliding

How can boards make sure that their hospitals don't backslide on safety during this recession? We have several suggestions:

- Talk about it, openly. Don't pretend this risk doesn't exist. It does. We know that for every additional patient per nurse in medical/surgical units, the mortality rate goes up by 7 percent. Everyone, including the board, should be ready to ask this question about any proposed staffing decrease: "Can we do this safely?" If the answer is a quick "yes," the board should then ask; "How do we know? Where is the data?"
- Put safety at the top of your agenda. If you open every board meeting with a brief review of current data on the safety of your hospital, you will signal that this is your first priority--even if the majority of the meeting is then devoted to doing what is necessary to maintain financial viability. And you'll also get an early warning if the data show that the organization's safety performance is starting to slip, so that you can intervene early with corrective actions.
- Publicize both your safety aims and your performance. The board of Beth Israel Deaconess Medical Center, Boston, has published its quality and safety aims--including "Eliminate preventable harm by Jan. 1, 2012,"—on its Web site. It also displays its performance against that aim quarterly, for all to see. With so many stakeholders watching both inside the hospital and in the community, do you think it's likely the organization will backslide, even during a recession?
- Ask for background information. If the management team brings you a financial plan that appears to simply be a reduction in inputs (staffing, supplies and so forth) to the hospital's processes, ask the following questions: "Can you please tell the board what improvements, such as reductions in wasted time or rework, have been made in the work processes of nurses, pharmacists and other professionals, that allows these staffing reductions without affecting safety?"
- Recognize that safe care is less expensive care and actually can *save* money. This is especially true under the new "Hospital Acquired Conditions" (HACs) Medicare payment model, where Medicare and commercial payers will not pay hospitals for care necessary to treat the consequences of such conditions. Boards should ask how much money their hospital will lose if their HAC rates persist or get worse, and more importantly, how much money they will save if they can reduce those rates and make care safer.

- Apply your steadfast commitment to patient safety in challenging economic times to your "pitch" for philanthropic giving. It can be a compelling and effective story.

Boards are responsible for finances. But they are also responsible for quality and safety of care. And during a recession, it's not enough for the board to protect your portfolio and your profits. You also need to protect your patients.

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