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Taking Control of Quality: Using Data to Improve Value

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Hospital board members are in the unenviable position of being responsible for the quality of clinical care delivered by their institution but without the means to exercise quality controls. Most board members are community businessmen and women who are graciously doing their civic duty by serving on the board, many of whom have minimal or no clinical backgrounds. In fact, most are struggling with their own businesses' and patients' cost increases just like everyone else, and with no end in sight. They know how to purchase products and services in virtually every other aspect of their business and personal lives but have no clue concerning value-based purchasing of healthcare services.

This article looks at how board members can take control by using big data, machine learning, and easily understood clinical and financial outcomes of care to help control the costs and quality of their hospital's patient outcomes.

Key Board Takeaways

Subsidiary/local boards should consider the following questions:

- How much cost variation is present in our hospital's three most common surgical procedures and medical diagnoses?
- Do our doctors have the information they need to determine which of the estimated 30 percent of resources are wasted in our Medicare and Medicaid procedures and medical diagnoses?
- Does our hospital have the information necessary to determine the risk-adjusted morbidity (complication) rates and resource consumption differences compared to the other system hospitals? How about other regional hospitals?
- Do our physicians use clinical pathways to improve over time and do we share these data with other hospitals in our system?
- In addition to the two mandated quality metrics, which are the National Hospital Quality Measures and hospital readmission rates, does our hospital measure our risk-adjusted mortality rates, morbidity rates, and reductions in resources and resource consumption rates?

Tracking Resource Utilization and Outcomes of Care

In order to improve medical quality and costs (value), it is necessary to measure the hospital's overall, and each physician's, outcomes of care. Virtually all resources are generated when physicians admit patients and order the necessary tests and treatments to diagnose and treat their patients' clinical conditions. Unless physicians have the information that quantifies the variations in which they utilize specific lab, pharmacy, and other resources, how can they be expected to reduce resource variations to create higher quality and lower costs? Board members can influence the decisions to ensure clinicians have the information they need to reduce resource variations and improve their clinical and financial outcomes. Moreover, conventional wisdom suggests that 30 percent of resources are wasted—but which ones?

Hospital executives don't order tests and doctors believe every test they order is clinically indicated or they wouldn't order them. Using their own data, why not show each doctor those resources he or she used in their most efficiently managed cases in order to replicate these superior resource utilizations for future patients. Equally important is the ability to demonstrate the additional resources consumed in the less efficiently managed cases so doctors can decide if they could eliminate them when treating future cases. At the same time, it is essential to demonstrate for all the doctors who treat similar, risk-adjusted medical and surgical patients, the resource

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consumptions they collectively used to treat their most efficient cases. These most efficiently ordered tests can be used to modify the hospital's clinical pathways, which virtually ensures the groups' future care will be continuously improved.

Using the Medical Value Index to Achieve Value-Based Care

The hospital's and physicians' clinical and financial outcomes can then be measured and incorporated in the Medical Value Index™ (MVI). This index is created using the six, time-tested major metrics of clinical quality and cost efficiencies. Its usage will be extremely important to the hospital and physicians as value-based healthcare becomes the means by which employers begin to measure and direct the care of their employees to the highest-quality, most cost-efficient providers. Every clinician who manages inpatients in these most expensive venues in our system should be rewarded on the basis of his/her individual outcomes. By objectively measuring and reducing variations in their use of resources (lab, pharmacy, etc.), competitive, value-based healthcare can become a reality. These reductions in variation of resource utilizations can be translated to cost saving for their hospital and improve the institution's MVI, whether the hospital is a subsidiary/local or major institution. Subsidiaries can work with their system-level quality committees to determine the best processes for reducing clinical and cost variations and use the MVI to monitor their outcomes' improvements. Moreover, the institutions can use the MVI to objectively compare themselves to other regional/national hospitals in order for patients and self-insured employers to purchase healthcare on the basis of value, not price.

The MVI's six major metrics of clinical quality and cost efficiencies are fundamentally different from the systems that are presently utilized to rank hospitals. Systems that rely primarily on patient satisfaction data and less specific measures such as readmission rates are basically perception-based systems (e.g., *U.S. News and World Report's* rankings, Medicare's Star system, and others). Systems whose data are derived primarily from insurance companies or billing data are categorized as financially based systems (e.g., Premier and Crimson). These systems differentiate hospitals primarily on the basis of price not quality or value. To date, these two types of systems have been all employers and patients have had as they attempted to purchase healthcare for value, as they do every other product and service. It is critical to note that in both the perception-based and financial-based systems, individual doctors' clinical performances have virtually no effect on their hospital's rankings. Only the MVI is differentiated by its hospital scores being generated directly by each physician's clinical and resource consumption outcomes.

Conclusion

Hospitals have the data. Physicians manage resource consumptions and clinical quality, and board members, if they choose to exercise their influence, will have not only the responsibility but also the control of their institution's medical quality, for the first time. This is the means by which board members can lead their hospitals into the future, which will feature value-based care as the salvation of healthcare delivery as we presently know it.

The Governance Institute thanks Bill Mohlenbrock, M.D., FACS, Founder and Chief Medical Officer, Verras Ltd., for contributing this article. He can be reached at bmohlenbrock@verras.com.