ROUNDTABLE

The Emerging Role of Transparency

The paradigm shift occurring in healthcare is elevating transparency from buzzword status to a strategic component of many hospitals' and health systems' efforts to achieve the Triple Aim. Companies that provide consumers with ways to evaluate the quality and safety of hospitals are also driving the call for more transparency. Pushing out data to internal and external audiences so that it will lead to more accountability for quality and patient outcomes takes considerable clinical, technological, and workforce resources. Providers who are tackling the challenge of transparency often cite the various scorecards and rating systems as a starting point for change. Collecting accurate data and mining it for meaning remains a significant hurdle; however, metrics are an important part of the transparency toolbox that aims to improve clinical quality, patient experience, and value.

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Roundtable Highlights

HEALTHLEADERS: *Does your organization use scorecards and ratings systems to inform its quality initiatives?*

KIM PARDINI-KIELY, RN, THE RISK AUTHORITY, STANFORD UNIVERSITY MEDICAL NETWORK: The role that these scorecards play is really a catalyst for figuring out where one needs to focus improvement efforts. The fact that they're public now really lends a lot of credibility to getting groups engaged and understanding the importance of focused improvement efforts to improve outcomes and eliminate harm. While the data are a reflection of hospital and physician performance, I don't believe that the data are easily understood yet by the public. What we are seeing is that patients are bringing them to their appointments and they are asking their physicians to try to explain, and that's a conversation worth having. I think there is still a need for greater public education about what all of it means and how best to determine where to receive healthcare.

FERDINAND VELASCO, MD, TEXAS HEALTH RESOURCES: I agree. These scorecards have an important role in the overall transparency discussion by facilitating a dialogue about two things. One is value. We're moving away from a model where patients pay for healthcare services to one where patients are paying for value, and so [these scorecards represent] a more comprehensive view of what it is that we as healthcare organizations provide. The other is improvement. There's definitely, I think, much more visibility into the areas that we have [targeted] for improvement at multiple levels, whether it's clinical quality, patient safety, efficiency, patient readmission rates, or patient experience. Those are the things I think that these scorecards highlight. It also touches on a need for health literacy, too, because you can't really just expose these things without informing or educating the public about what they represent. That's an important aspect of this, as well.

ROBERT LERMAN, MD, DIGNITY HEALTH: I think scorecards are a big part of the increased profile of consumerism in healthcare. The general public is being a lot more active in making choices about where they get their healthcare, and the scorecards are certainly a part of that. We support the idea that the public should have more information. It can be challenging to figure out how to help the public understand these because very small differences in actual clinical outcomes can be represented as fairly significant changes on these scorecards. We have had one mortality per year or one readmission per year be the difference between a letter grade or a star rating. When you think about how the public perceives that, is that accurately reflecting perhaps the differences in an organization's performance?

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Those are the type of issues that we struggle with. Conceptually, we're all for giving the public accurate information. I think the challenge for us is that there are so many of these scorecards out there. You can't participate in everything, and they're all somewhat different.

EVAN MARKS, HEALTHGRADES: Many hospitals struggle with which of the available approaches to focus on to inform quality initiatives. While each rating organization uses different approaches to evaluate benchmarked performance, it is the use of externally benchmarked data as the central

Robert Lerman, MD
Vice President & Medical Director
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player in quality improvement processes that is important. While there may be strengths or weaknesses among differing approaches, the issues and implications they raise with their various ratings need to be couched with hospital administrators and clinicians in probabilistic rather than deterministic ways. As an example, most of the outcomes Healthgrades is looking at utilize a risk-adjustment process to account for differences in outcomes associated with older or sicker patients. A good or bad score doesn't mean that a hospital is good or bad; it just means that they're *probably* doing better or worse than they would be expected to given the levels of risk observed in their patients. "Probably" being the important qualifier.

If the organization subscribes to and focuses on using one approach, that should be an adequate step in the process to help the organization work through a series of problems it's

trying to solve. Compare this to worrying about reconciling what many different tools are saying because they're all going to be slightly different. While the methods might be different, using a tool and recognizing its limitations is better than waiting for perfection while doing nothing.

HEALTHLEADERS: *What sort of transparency efforts are emerging at your organizations?*

LERMAN: Internal quality transparency has always been a high priority. We tend to focus, from a mandatory reporting standpoint, on some of the governmental reports like the hospital quality reporting. Every fiscal year we will send out a list of initiatives and focus areas that come out of our CMO's office, and those are looked at really across the continuum from the highest leadership levels down to the individual hospitals and medical staffs. Every single month we're looking at the internal quality data.

Evan Marks
Chief Strategy Officer
Healthgrades

The discussions around transparency that are happening on the leadership level are more and more frequent. I think increased transparency creates an opportunity as we build our clinically integrated networks with our physicians. One of the reasons that we are building our own very robust quality reporting system is to be able to be proactive, not only with discussions with consumers, but with health plans and employers, as well. We believe that if we can demonstrate that we are measuring our quality and paying attention to it, as well as have physicians who have agreed to dedicate themselves to quality improvement and cost reduction, that that will be perceived as value.

PARDINI-KIELY: The whole idea around transparency really has two audiences. External-facing, which is the public, but let's not forget the value of internal-facing, which is comparison among a group.

"The real challenge with transparency is getting the medical community through the denial stage toward the acceptance stage."

We sat down and used external data and then maximized internal data for one of our surgical specialties. Looking at Healthgrades, we found that we were not scoring where we wanted to be. We didn't have at least a three-star. So we started drilling into why. A couple of things came up for us. The first was accuracy in how you document in the record. We started with leveling that playing field, making sure that what we do is well documented in the record so it can get coded, and that makes a huge difference.

But that wasn't enough. You have to start looking at what [to] improve upon. For that, we used internal data and looked comparatively among the group of physicians who did really well, and we got them to start talking about what they do so the group could collectively learn.

We found that everybody did things differently, so we said, "Sounds like an opportunity to standardize." When you start talking about standardization, you think "cookbook," but the bottom line is that when you level-set all of the basic processes, you get better outcomes in the long run.

We launched a preoperative clinic that made a whole lot of sense in terms of optimizing our patients prior to surgery and our outcomes, and then on the back side we also standardized care postoperatively using hospitalists, something that many hospitals are now putting into place. That work then resulted in dramatic improvements in our outcomes for our patient population.

VELASCO: Texas Health Resources put out its own quality report to the public, and implicit in your question is, how does the release of the public report impact our conversations or our engagement with our internal stakeholders? It's very intentional, actually, that there is a linkage there. When we released the public report, it was interesting. About a third of the people accessing it were actually our own workforce. That was intentional. It was a desired effect.

It was also apparent in the conversations we were having with our medical staff that they were paying attention to these data and were very interested in the results, which was surprising because these are results that they should have been aware of. It did stimulate some interesting conversations. The physicians went through a similar process that [Elisabeth] Kübler-Ross [the author who developed the "five stages of grief" model] has described.

LERMAN: Denial?

VELASCO: "It is wrong. It doesn't look right." Then they go through various stages of eventually accepting it. Then they say, "OK, the data looks right, but it's not my fault. It's the hospital care."

PARDINI-KIELY: Another comment we often hear is "My patients are sicker or more complex." And while that may be true, there are many other high-acuity medical centers across the U.S.

VELASCO: There are different situations that explain that, but eventually

they do get there. What's interesting is that the data that they often question are data that they should have been paying attention to. It's the fact that we have now made this decision to make the data public that has finally caught their attention and made them interested in improving those results, whether it's addressing documentation issues, which are a contributing factor, or, in fact, real opportunities for improvement in the processes or outcomes or care that are reflected in the data. It's making an impact. It really is driving that accountability and ultimately stimulating the conversation about how do we improve, who is doing well, what are they doing right, who isn't, and what do we need to do about that?

MARKS: The famous five stages of grief have similar application for organizations dealing with the new levels of transparency. The real challenge with transparency is getting the medical community through the denial stage toward the acceptance stage. Whether they accept immediately is not really of tremendous concern, but they need to go through the various steps of that process. We're all in the infancy of this process, and it's getting organizations to that breakthrough ... to get them to realize that the perfect can be the enemy of the good. Well, it might not be perfect, as I mentioned before, but it's good enough for us to begin asking some hard questions about how we are doing and why.

That transformational process needs to occur, and what we see oftentimes is that there are individuals in organizations that don't want to go over that threshold. They resist with, "Those measures are inappropriate. They're never adjusted right. The data is wrong. It's not my patient. It's administrative data." There are a million excuses, but I think that once organizations go through that process and begin looking for the signal in all the information, it opens up the door to a process of continuous improvement.

HEALTHLEADERS: *How difficult is it to get physicians to agree to some standard care protocols?*

PARDINI-KIELY: It was a challenge because every patient is different, and yet many medical specialty societies have come to agreement on evidence-based practices, and those are easily adopted. We had to do some education in that process of, for example, a surgeon's understanding of the specificity required in documenting heart failure. And let's not forget that for teaching hospitals there is the added complexity of educating the house staff. When you have house staff that do the lion's share of documentation, and they're spending four weeks at Stanford and four weeks at the VA, and then they go over to the community hospital, trying to keep all of them informed is exceptionally challenging. Better use of electronic records, that can make that process easier and is something that we are doing. We've optimized our electronic medical record so that when you pull up heart failure, it's very clear what documentation is required.

> **"We've optimized our electronic medical record** so that when you pull up heart failure, it's very clear what documentation is required."

In addition, one of the things that we're now working on, which, to me, is phase two of transparency, is measuring and reporting on what really matters when we look at creating value for the patient. You can look good on a report card with the measures that we have, but are they really the right measures? Are we focused on improving outcomes, clinical quality, the patient experience, and the cost/benefit of treatments?

From the work that we did, we've launched into clinical effectiveness work, and it is really about demonstrating value. For example, we are now in the process of looking specifically at spine surgery and evaluating what matters to the patients in the long term and their quality of life after surgery. This is what gets the physicians really fired up because that's what they want to know. And setting up a coordinated system to assist clinicians with improving care and reducing harm is critically important.

Kim Pardini-Kiely, RN
Vice President
The Risk Authority, Stanford University Medical Network

LERMAN: We are starting down a similar type of road. We developed our first of our new breed of clinical councils in orthopedics that started in January of this year. We have representatives from all eight of our service areas. However, we have discovered a couple of things. One is that even among the 10 or 12 physicians in the room, it is not always easy to get consensus on some of the more controversial issues such as anticoagulation around total joint repairs.

But beyond that, we have a further challenge of, even if we were able to obtain a consensus, how do we drive that across over 30 hospitals and a variety of mostly independent physicians with different medical staffs and different types of physician alignment strategies? We know that the more broad-based engagement we can get, the more success that we'll have. But figuring out how to scale that across

multiple facilities and hospitals and community cultures, organizational cultures, is a complicated one.

Some things are easy. For example, we drew a very clear message from our orthopedic surgeons that they were having difficulty getting physical therapists after conventional hours to see their patients if they came out of the operating room at 4:00 or 5:00 or 6:00 in the evening. They felt that for total joints, it's very important to mobilize the patients even on postop day zero. So that was something that we can handle from a hospital organizational standpoint. In fact, we did. But when you talk about the more physician-centric behaviors or standardizing clinical care in controversial areas, it's not easy how to figure out how to create that level of standardization.

Ferdinand Velasco, MD
Chief Health Information Officer
Texas Health Resources

VELASCO: The challenge, whether it's transparency or some other initiative, is that many of the systems that do need to be reformed, whether it's documentation or coding, have a different intent in mind than quality measurement. So getting to that is difficult because of the intrinsic nature for which those systems were designed. For instance, coding was designed basically for billing. It's determining, "What will we get reimbursed for this encounter?" So for good or bad, unfortunately many of the coding practices are geared towards that.

Health information management professionals tend to look for things that will help optimize that reimbursement objective, and that could mean looking for things that may not have happened. A physician said that they're ruling out something. They're suspicious of something, but it was never actually explicitly ruled out. Then we get into the issue of identifying complications that may have only been suspected but never really confirmed.

Likewise with documentation, the history behind that, as all of us who are clinicians know, is that was intended to narrate the care process, to communicate among each other what's going on with the patient, what needs to happen. We didn't really have the idea that this would be used for quality measurement and reporting. We do now, and so that's a challenge. It's getting over the kind of limited idea of what these things are intended for and how they're being used for management.

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LERMAN: *Standardization* is kind of a scary word, but consistency can have a lot of benefits come out of it, even if you can't get all the way there. Transparency is a journey. For example, our orthopedic council has only met twice, but already within six months we have an agreement to participate in a total joint registry, which will give us a tremendous amount of additional data, moving toward transparency. These are pretty significant steps. So even if we haven't quite been able to figure out how we're going to get several hundred orthopedic physicians to practice in the same way, simply by increasing the level of physician engagement, we've been able to make a couple of very significant steps along that road. Rome wasn't built in a day.

MARKS: One of the roles of transparency is to foster accelerated development in both documentation and coding. It's critical because at the end of the day, whether you're using administrative data or EHR data, the information you get out of these systems is only as good as what people put in them. When you evaluate hospital process or outcomes information comparatively, a significant part of that evaluation depends on the quality of the risk capture. All of the metrics that Healthgrades uses for determining risk-adjusted complications and mortality are based on the patient risks captured and recorded by the hospital staff and clinicians. Some hospitals do a better job than others.

It's not an insignificant part of the process, and some may complain that coding and documentation are just an administrative task with little clinical value. Standardizing recordkeeping is a fundamental process required to fine-tune your data and the tools you need to improve your process. Imagine you had a thermometer that was plus or minus five degrees … you can't really trust that tool. Well, you've got to figure out how to reduce the controllable error to improve the accuracy of the tool, which is the way that we're looking at risk capture. A tool crafted from this process becomes something you can rely on and then trust going forward. That's that same process that needs to occur in organizations seeking informed continuous improvement.

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