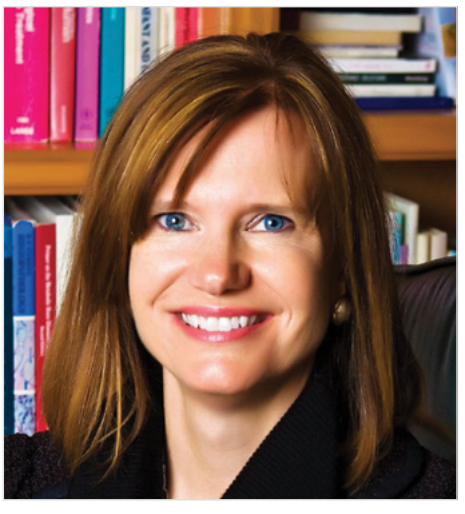
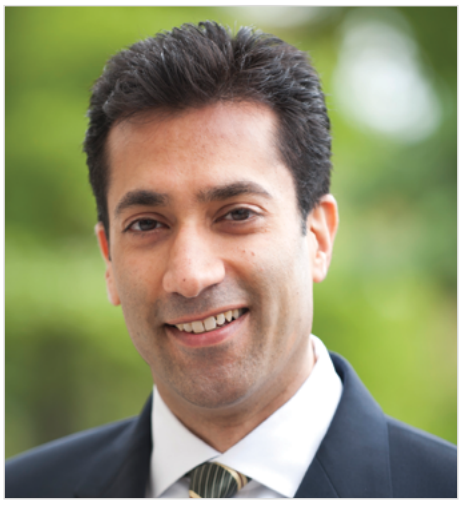
# The Quest for Better Health Care Quality, Safety, and Patient Outcomes



**DR. CATHERINE MACLEAN**
Chief Value Medical Officer
Hospital for Special Surgery
(212) 606-1197
mediarelations@hss.edu



**DR. ROHIT BHALLA**
Vice President and Chief Quality Officer
Stamford Health
(203) 276-5540
rbhalla@stamhealth.org

Safety, quality, and successful outcomes—these three elements define the very best hospital care. How to define and measure quality, however, is complicated. Hospitals need objective standards that can be implemented at all institutions, with the goal of consistent quality. For now, this country's quality of care is uneven and costs are high.

Fixing that issue is a task that preoccupies quality experts. Patients also are increasingly sensitive to the differences in quality care among hospitals, data that are published in report card format.

The federal government, through the Centers for Medicare and Medicaid Services (CMS), hopes to reward quality performance by changing how hospitals and doctors are paid. These new payment models potentially will realign how care is delivered, resulting in higher quality at lower cost.

But improving quality and the value of health care is difficult. It takes a culture change at hospitals. Doctors must track data on the quality of the care they deliver, and then transform how they practice medicine. It takes a team of experts to track data and guide physicians in that transformation. The end result, at the best hospitals, is better care delivered at lower cost.

Transforming the quality of care is a complex quest. To explore how hospitals are tackling the challenge, Crain's Custom spoke to two experts on measuring and improving health care quality.

**Dr. Catherine H. MacLean** is the chief value medical officer at Hospital for Special Surgery (HSS), where she leads the development and execution of strategies to measure, report, and improve health care value. MacLean is responsible for the strategic planning, implementation, and evaluation of population health, quality, and value programs. A nationally recognized expert, MacLean has been a principal investigator on numerous academic research projects, and has been a director, chair, or participant on national boards, committees, and panels related to health care quality and value. She is a graduate of the Washington University School of Medicine and has a Doctorate in Health Services from UCLA School of Public Health.

**Dr. Rohit Bhalla** is vice president and chief quality officer at Stamford Health, where he oversees quality, patient safety, and care management initiatives, as well as hospitalists and the pain and palliative medicine programs. Bhalla is a graduate of the Boston University School of Medicine BA/MD program and Columbia University's Mailman School of Public Health, and is board certified in internal medicine and in public health/general preventive medicine. An associate clinical professor of medicine at Columbia's Vagelos College of Physicians and Surgeons, Bhalla has published several papers on quality improvement and health policy.

**Crain's: U.S. health care is expensive, and outcome measures fall short compared to other countries. What steps can we take to improve value, given quality is closely related to costs?**

**MacLean:** At the societal level, we must think broadly about ways to improve health and target influential factors, including public health measures and social determinants such as education and poverty. It is no coincidence that other developed nations spend less money on health care and more on social services.

The highest value care prevents disease in the first place. But our health system has had fairly limited focus on prevention. Providers should re-examine how diseases might be prevented, and then determine the role clinicians, physician practices, or health systems can play in prevention. We also must double down on our efforts to measure and report health care quality, because we are unlikely to improve what is unknown or unmeasured.

**Bhalla:** Outcomes are driven not only by hospitals and physicians, but also by public health and social services. In the U.S., we spend less on social services. At the same time, health care organizations are being asked to take important next-generation steps to improve value.

**Crain's: How do hospitals prioritize quality measurement?**

**MacLean:** Quality measurement is critical in health care. But sometimes convenient metrics win out over metrics that truly matter. At HSS, we aim to put better quality measures into practice. We first identify clinical areas where knowledge of quality is both important and actionable. We look at

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clinical areas where there might be quality gaps, and that's where we prioritize. But we also keep in mind that on some quality measures, hospitals may receive a bonus or penalty for performance. Some measures are publicly reported and influence reputation. All these areas also are a priority. And of course, we think about what matters most to patients, including improvements in patient-reported outcome measures.

Once we know what we want to measure, we make sure resources are available to assess and report these metrics. We engage clinical and administrative staff to measure and report quality metrics, and to develop strategies to improve quality measures.

**Bhalla:** Hospitals are currently awash in quality measures. Take for example the Meaningful Measures initiative of CMS at the federal level. Among its goals is reducing the burden of measuring data that are redundant and of dubious value. It's important for hospitals to prioritize and focus on measures that are most meaningful.

And the best defense is sometimes a good offense. Hospitals are under the external measurement microscope, so it's important that when it comes to data, they promote internal transparency and easily accessible information on quality. That information is most useful if it's seen by front-line staff, managers and hospital leadership. Hospitals always should think of ways to ingrain quality into their daily operations. For example, scheduling daily unit-based huddles allows staff to identify quality and safety concerns in real time, and to hear feedback on current performance.

**Crain's: In a recent trend, some hospitals have hired a Chief Value Medical Officer to guide them on quality and cost. How can this new role help improve the patient experience, quality, and outcomes?**

**MacLean:** At HSS, we believe that when we focus on what matters to patients, that drives improvement in patient experience, quality and outcomes. That's why our hospital has made an investment in this physician leadership role. The Chief Value Medical Officer (CVMO) should be an expert in quality measures and measurement, value-based contracting, and population health. Their job is to develop a hospital's overarching strategy for quality, efficiency and population health. And they need to be sure that the hospital's various institutional programs are all aligned to meet this vision. The CVMO also should be the one who identifies which quality measures are important, and takes leadership of operational efficiency and population health programs. By definition, the implementation of quality and efficiency programs should drive improvements in these areas.

**Bhalla:** A number of new roles and titles are emerging. In part, they are driven by the evolution of hospitals into large health systems experimenting with innovative care models. With this evolution, quality has become a currency of transformation and a barometer of health care's innovation potential. Quality measures are what determine the success or failure of a whole range of new models: value-based arrangements, accountable care organizations, bundled payments, and population health initiatives. So a new role like a CVMO has the specialized expertise demanded by approaches that have many new, unique features.

**Crain's: How do patient-reported outcomes data lead to better care?**

**MacLean:** Simply put, patient-reported outcomes data inform care decisions. They provide great insight into the current health state of patients, which means clinicians have the data they need to make decisions about treatment. Outcomes data also provide valuable insight into whether the specific therapeutic course selected for a patient actually is working. If it isn't, the treatment can be adjusted. Patient-reported outcomes data also help patients and providers make better informed, shared decisions about treatments. Let's say a patient has relatively highly functional performance before surgery; that person is less likely to see big gains after a hip or knee replacement. This important outcome information should inform the decision about whether to have that surgical procedure.

There are numerous validated patient-reported outcome instruments that assess function and quality of life. But they are not routinely used in health care, and if we really want to improve health, we need to know where we stand.

**Bhalla:** Patient-reported outcomes data are important, but associated measures are in their infancy. Health care is a complex service with many determinants. It's unlikely that selecting a green smiley face or a red frowning face after a health care visit will reveal enlightening information about patient and family-centered care.

Appropriate time and thought should be given to developing and testing meaningful patient-reported outcomes. Some would say that patient-centered measures are simplistic. I would argue that they are more complex. These measures need to incorporate notions of health literacy, linguistic concerns, cultural factors, belief systems and socioeconomic factors. It's also important to recognize that medical or cognitive impairments may prevent patients from being able to report outcomes. Family-centered outcomes are an important alternative to consider.

**Crain's: We are moving towards pay-for-quality. At the federal level, initiatives include a payment system based on meeting performance standards. But some doctors are dissatisfied with these quality measurement approaches. Why?**

**MacLean:** Many of the standards in the federal measure sets need significant improvement. Some suffer from a lack of specificity. For example, there are subsets of patients who actually wouldn't benefit from—or may be harmed by—the process in that quality measure. There is also a lack of evidence that the prescribed process will make a difference in outcomes. And then some of the federal standards have limited clinical applicability, so that even if doctors have data about their performance on the measure, that information actually doesn't help them improve quality. Finally, physicians are frustrated because some federal measures just don't deal with the most important quality issues.

**Bhalla:** They have good reasons to be dissatisfied, as the measures are far from perfect. They often lack proper risk adjustment for medical factors; they don't properly take into account how functional a patient may be. And the measures exclude considerations of social determinants of health and whether a patient is motivated to become healthier. In addition, patients are seen by many providers, so it is difficult—if not impossible—to attribute quality of care to any single provider. Provider-specific numbers are often too small to draw conclusions about meaningful differences in performance. But even with all these limitations, great gains have been achieved through publicly reported quality information, and to a lesser degree, payment for quality.

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**Crain's: Do hospital quality "report cards" capture health care value?**

**MacLean:** Yes, to a limited extent. CMS is doing the best work in this area. But we need better metrics so that we can measure on an absolute rather than relative basis. Another challenge with current report cards is that they are not specific to certain procedures or treatments.

**Bhalla:** These report cards have substantial limitations. They rely upon data that is very limited and untimely. They typically select a subset of measures derived not from clinical records, but from claims and billing data. Another problem is that it is not uncommon for report cards to arrive at different conclusions about performance, based on the exact same measure, over the same time frame. That's because the various report card organizations use different analytic approaches, and can assign different weights to the same measure. It's not surprising that report cards frequently disagree in their overall conclusions.

**Crain's: Will health care value be improved by the shift to population health?**

**MacLean:** Absolutely. Population health promotes prevention, and that represents the very highest value care. It's also an area where payment models reward better health outcomes. Payment mechanisms directed at the population level provide funding for implementing care coordination. That means the health care team has an incentive to communicate, coordinate and synchronize the delivery of care. The results are high-quality patient experiences and improved health care outcomes.

**Bhalla:** The shift to population health should help greatly. Some health spending is avoidable, especially in the inpatient setting. Key interventions include counseling, screening, primary care, care management, telehealth, home care and self-management. To fully realize the value of these approaches, there must be an evolution in health care reimbursement. The idea of investing additional money in the health system may not be palatable, but we know that it can work. Population health drives value, but reimbursement must reward health interventions.