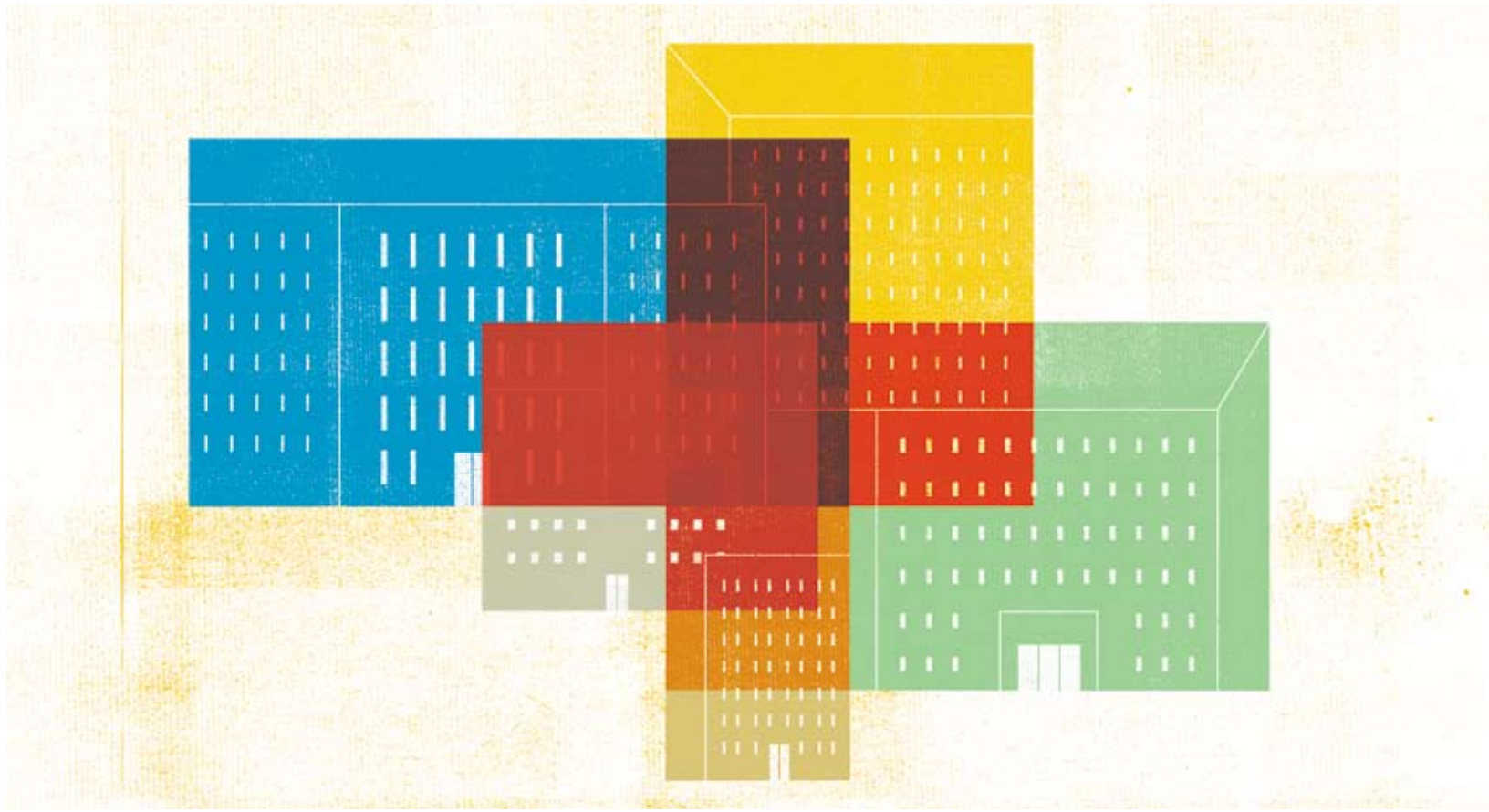


How hospitals can respond to increased quality transparency

By taking a holistic approach to quality improvement, hospitals can provide better care to patients, strengthen their financial performance, and enhance their competitive positions.

Tobias Möhlmann, MD; Florian Then, MD; and Reinhard Wichels, MD

For centuries, health professionals have held to the ethical principle *salus aegroti suprema lex*—the patient's well-being is of utmost priority. In theory, therefore, all patients should receive high-quality care. This does not always happen, though; the quality of care varies markedly in all countries.[1]

Uneven care quality is an important problem for hospitals—and not only because it violates their ethical responsibility to patients. Since data about hospital quality are now being publicly reported in many countries, patients, payors, and others are learning how well or poorly hospitals perform. The increased transparency is putting some hospitals at a competitive disadvantage and subjecting them to closer regulatory scrutiny. Furthermore, poor-quality care can hurt a hospital's financial performance—but improved care quality can often lower costs.

The trend toward greater transparency into hospital quality is unlikely to go away; if anything, it will become more pronounced in coming years. By taking a holistic approach to quality improvement, hospitals can provide better care to patients, enhance their competitive positions, and strengthen their financial performance. The approach we recommend requires hospitals to develop a clear vision for the changes they must implement, a highly trained quality-assurance organization that can implement those changes, and a proactive communication strategy to retain patient and payor loyalty.

In this article, we provide examples from Germany to illustrate how hospitals are responding to increased performance transparency, as well as the impact that poor quality can have. We then detail steps hospitals can take to respond to these challenges.

Why and how transparency has increased

Multiple factors have increased the focus on hospital quality. Rising costs have led governments, health insurers, and others to question whether the care they are paying for is as good as it could be. Increased consumer consciousness has encouraged patients to demand high-quality care. The introduction of diagnosis-related groups (DRGs) has made it easier to compare outcomes among similar groups of patients treated at different hospitals. And the Internet has made it possible to disseminate the results of those comparisons widely.

The result is that most countries are undertaking efforts to assess, compare, and improve hospital quality. Most of these efforts, however, are still in their early stages. We will use three examples from Germany to illustrate the range of approaches being tried.

Some initiatives aim to measure the performance of different hospitals. Germany, for example, has established a federal agency, the *Bundesgeschäftsstelle Qualitätssicherung* (BQS), to collect data about how well hospitals perform on a variety of quality indicators. Since 2006, German hospitals have been required to publish their results on 27 indicators selected for the strong scientific evidence of their validity. In the future, the number of required indicators will increase as more of them are scientifically validated.

The BQS data reveal that for virtually all quality indicators, performance is substandard at some hospitals.[2] For example, one-quarter of all German hospitals fail 10 percent or more of the time to provide antibiotic prophylaxis to women undergoing hysterectomy (Exhibit 1). Similar variations in care quality have been uncovered in other countries that monitor hospital

[1] For another look at how care quality varies within countries, see "Comparing payor performance to enhance health outcomes," p. 48.

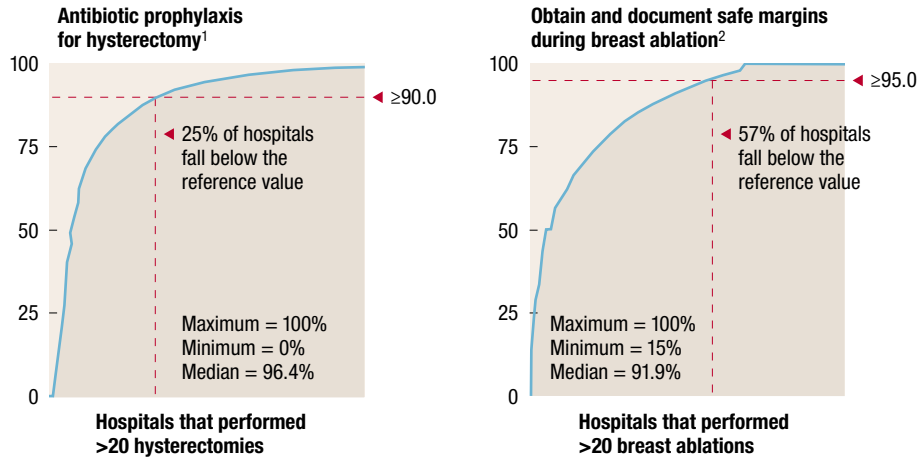
[2] This finding remained true even when the *Bundesgeschäftsstelle Qualitätssicherung* (BQS) excluded hospitals that had treated fewer than 20 patients with the relevant conditions—the hospitals least likely to have good outcomes.

Exhibit 1

How safe is your hospital?

Quality indicators show that hospital performance varies widely.

Quality indicators, reference values, %



[1] *Bundesgeschäftsstelle Qualitätssicherung* (BQS) result parameters 2006/15n1-GYN-OP/47637.
[2] BQS result parameters 2006/18n1-MAMMA-PCI/68100.

Source: Quality Reports According to §137 S GB V, 2006

performance; in many cases, the variations cannot be explained by patient characteristics or other logical factors. (For a look at why these variations have been allowed to persist, see the sidebar, "Why hospital quality varies widely," p. 65.)

Third parties are making the BQS data available online in ways that permit direct comparisons between hospitals. Because only a limited amount of information is being shared at present, the inferences that can be drawn are not always fair. Nevertheless, the availability of this type of information is beginning to affect how patients, payors, referring physicians, regulators, and government officials view hospitals, a trend we expect to strengthen over time.

Other initiatives are designed to improve quality of care directly. For example, a joint effort of several German hospitals and payors has established a way to use routinely collected inpatient data (such as mortality and rehospitalization rates) to enhance patient care.[3] The collaboration has enabled the participants to assess not only quality of care during inpatient stays but also its impact on patients' health for up to one year after discharge.

Still other initiatives encourage hospitals to meet quality standards. German hospitals, for example, can be awarded certificates from various organizations if they meet specific sets of quality requirements. However, it is not clear how well these certificates reflect actual care delivery, because the hospitals are allowed to decide for themselves how and when they want to be audited.

Similar quality-improvement initiatives are under way in many other countries. None of them is perfect: for example, none of them assesses all aspects of care quality, the information being collected is not always directly comparable, and some of the quality indicators being measured

[3] The *Qualitätssicherung der Stationären Versorgung mit Routinedaten* system is being jointly developed by the Helios hospital chain, the *Wissenschaftliches Institut der AOK* (Scientific Institute of the AOK), and the *Forschungs und Entwicklungsinstitut für das Sozial- und Gesundheitswesen Sachsen-Anhalt* (Research and Development Institute for Social and Health Affairs of Saxony-Anhalt).

have not yet been scientifically validated. Nevertheless, these initiatives are likely to gather steam in the next few years; it is highly probable that most countries will eventually mandate that all hospitals publicly report quality data to ensure transparency into their performance. The challenge for each country will be to reach consensus on which metrics it is most interested in monitoring to avoid the parallel evolution of different quality-evaluation systems. In some countries, multiple evaluation systems using different sets of data have already arisen, and they may be providing more confusion than reassurance for some patients and other stakeholders.

How poor-quality care hurts hospitals

Within 20 kilometers of Stuttgart, Germany, there are 17 hospitals that perform elective hip replacement surgery (Exhibit 2). At 7 of these hospitals, the rate of revision surgery after hip replacement is 2 percent or less. At 3 other hospitals, it is 9 percent or higher. The worst performer has a revision rate of almost 17 percent. What will happen to the poor performers once such differences become publicly reported?

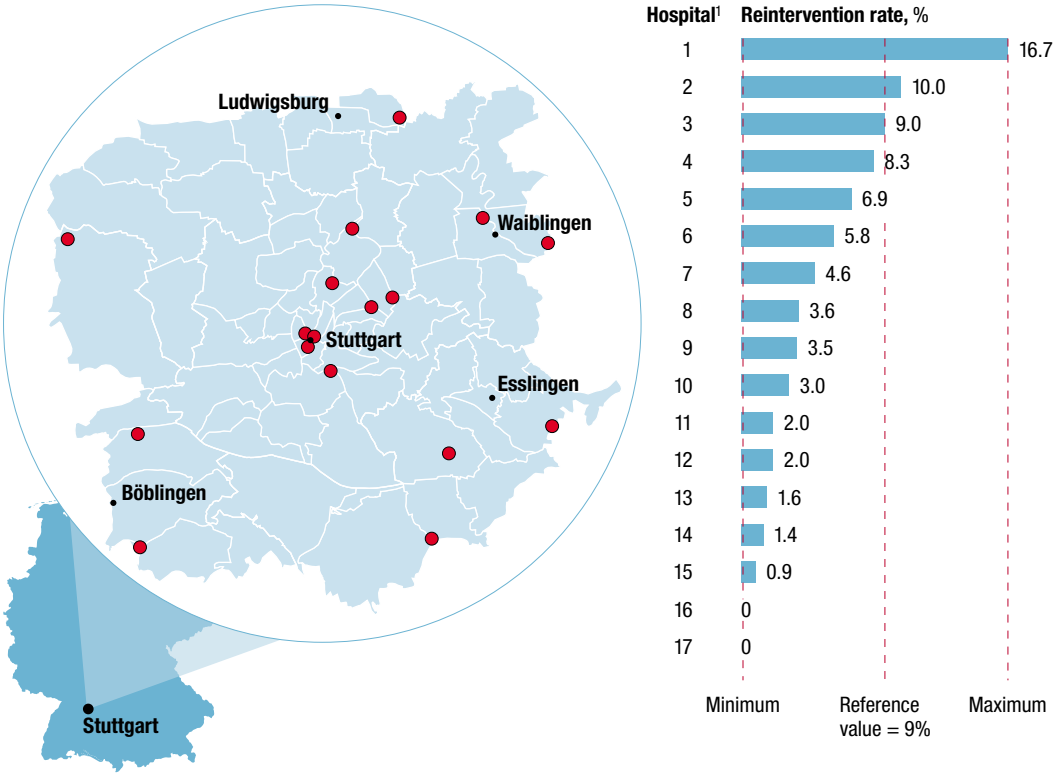
The answer is still uncertain, largely because many people are as yet unaware that quality information is being published, and few know how to interpret the reported data.

Exhibit 2

Variations in quality

Even within small regions, hospital quality is inconsistent.

Rate of reintervention for complications[1] following initial total hip replacement



[1]*Bundesgeschäftsstelle Qualitätssicherung* (BQS) result parameters: Code 45059/17n2-Hüft-TEP.

Source: Quality Reports According to §137 S GB V, 2006

Even small decreases in case volume could set up a vicious circle, because the success of many procedures is strongly linked to the number of cases treated

It is possible that the physicians and other health professionals at many poorly performing hospitals have already decided to enhance their skills and the care they deliver. In the absence of a turnaround program, however, many poorly performing hospitals could find themselves at a competitive disadvantage once the public's awareness about quality reporting rises. Patients may become reluctant to be treated at hospitals with low-quality scores, and physicians may become reluctant to refer patients to those institutions. Payors may opt to steer patients away from the poorest performers (knowing that complications drive up their long-term costs), and they could use the quality metrics as a bargaining chip in contract negotiations with hospitals. However, hospitals that score well could use the results to their advantage by demanding quality-dependent compensation models (for example, pay-for-performance bonuses).

The extent to which poor-performing hospitals could lose case volume or be forced to accept decreased reimbursements may depend on the number and quality of nearby competitors. However, even small decreases in case volume could set up a vicious circle, because the success of many procedures is strongly linked to the number of cases treated. As volume dwindles, it could be impossible for a hospital to maintain—never mind improve—its skill levels, and quality could decline further. A drop in case volume could also force some hospitals to stop offering certain treatments. Many countries are establishing minimum-volume requirements for some procedures;[4] a hospital could lose its authorization to perform those procedures if its case volume drops below the minimum threshold. Even a large hospital could face this risk if a smaller but more specialized provider is nearby.

Even in the absence of public reporting, however, poor-quality care can hurt hospitals financially. In many DRG systems, payments to hospitals are capped. As a result, each extra day a patient spends in the hospital and each complication that must be treated increase the hospital's costs and lower its profitability. Indeed, studies in Germany have found a correlation between poor hospital quality and an increased risk of insolvency.[5]

By improving care quality, however, hospitals can reduce length of stay (LOS), minimize complications, and thereby lower costs. For patients with community-acquired pneumonia, for example, simple quality improvements, such as early ambulation and a timely switch from intravenous to oral antibiotics, can have a strong effect on hospital economics. At one US hospital chain, a mere one-day improvement in time to antibiotic conversion decreased LOS by 0.8 days and per-patient costs by $456.[6] The net effect was to increase the chain's margin on pneumonia patients by more than 60 percent. Earlier antibiotic conversion was also associated with a decreased complication rate.

[4] Germany, for example, has established minimum-volume requirements for knee joint replacement; complex pancreatic or esophageal surgery; and kidney, liver, and stem-cell transplantation.

[5] "Hospital rating report 2008: Quality and economics," RWI Essen (rwi-essen.de).

[6] K. Grote et al., "The 'new economics' of clinical quality improvement: The case of community-acquired pneumonia," *Journal of Healthcare Management*, July-August 2007, Volume 52, Number 4, pp. 246–58.

How hospitals should respond to quality concerns

Hospitals that want to survive and thrive in an environment of increased performance transparency must strengthen their quality-improvement efforts. This does not mean that they should simply increase the number of metrics they monitor or the number of initiatives they undertake. Rather, they should develop an integrated program that clearly defines which areas to focus on, establishes metrics that help implement the necessary changes efficiently, and ensures that the hospital receives credit for the results achieved. Each of these three components is described below.

A clear vision for change

Any quality-improvement program should include a clear vision for the hospital's aspirations in five areas: clinical outcomes, patient safety, patient satisfaction, internal culture, and external reputation.

Clinical outcomes are the key indicators on which the improvement program should be based, because they are the heart of a hospital's operations—they gauge how well patients' health problems have been addressed. Because outcomes are disease-specific, each hospital should examine the portfolio of services it offers when selecting which clinical outcomes to focus on, but it should also bear in mind which outcomes it is required to report.

Among the factors that strongly influence clinical outcomes are the staff's qualifications, the processes a hospital uses to standardize care delivery, and the levers it has available to encourage compliance with standardization. If staff qualifications are a concern, the hospital can institute continuing-education programs. Care can be standardized through clinical pathways that specify the recommended tests and treatments for each diagnosis. Use of the pathways can be encouraged through staff training, as well as through wall posters, checklists, and other materials.

Patient safety is another important quality indicator because it gauges whether anyone was unnecessarily harmed while in the hospital. All treatments have risks, but no patient should be injured through preventable error. In Germany, as many as 17,000 hospitalized patients may die each year because of such errors.[7]

The United States has taken the lead in finding ways to increase patient safety. Hospitals there have developed sophisticated programs to minimize the risk of patient misidentification, medication errors, patient falls, and other common preventable problems. Some of these programs can be implemented at very low cost, but others require expensive IT and infrastructure investments. Most hospitals, given their limited resources, can implement only a certain number of patient-safety programs at a time. One of the ways in which a hospital

[7] *Aktionsbündnis Patientensicherheit, "Agenda patientensicherheit 2007."*

can determine which programs have the best cost-benefit ratios is by establishing a "critical incident reporting system" to identify both errors (mistakes that resulted in patient injury) and near-errors (mistakes that did not cause harm but could have). Experience from other industries that use this type of system suggests that best results are obtained when mistakes can be reported in a safe environment (where the emphasis is not on assigning blame but on taking advantage of the opportunity to learn and prevent similar mistakes in the future) and when problems are addressed immediately.

Patient satisfaction is becoming a more important metric as consumer consciousness rises. To ensure patient satisfaction, all staff members should remember the basics: for example, they should communicate clearly with patients, interact respectfully with them, and make sure that they (or their families) are involved in all treatment decisions. In addition, wait times should be minimized, and patient rooms should be kept as clean and attractive as possible.

Patient surveys are a good way to assess satisfaction—but if the only surveys used are those administered on site, results are likely to be biased. Typically, too few patients complete these surveys to make their results meaningful, and the emotional stress of hospitalization skews the information obtained. A better way to gauge patient satisfaction is through external surveys sent to patients after discharge. If possible, the surveys should be conducted and analyzed by independent third parties, which can then publish the results for multiple hospitals online so that site visitors can compare their performance.

A hospital's internal culture strongly influences its ability to improve care quality. For a quality-improvement program to succeed, the staff should, ideally, understand why changes are necessary and agree to those changes, be given the opportunity to develop their talents and skills, and be offered incentives to adopt the desired behaviors. Role models to guide them are also crucial. Senior physicians must therefore be willing to serve as clinician leaders who can establish best practices throughout the hospital. These clinician leaders should be willing to demonstrate their own commitment to delivering high-quality care, their readiness to admit when they have made mistakes, and their openness to accepting feedback from others.

Getting people to change is not easy, however—even when the people are health professionals who have dedicated their lives to patient care. As initial steps, hospitals can use staff surveys to gauge attitudes, conduct workshops during which the staff jointly develops solutions to identify quality deficits, and provide staff training on new procedures. These efforts can pay off enormously: a staff that is committed to delivering high-quality patient care will go beyond the changes the hospital mandates, proactively finding ways to further improve care quality.

External reputation should never be the primary metric a hospital considers when designing a quality-improvement program, but neither should it be overlooked. As it is developing its quality-improvement efforts, the hospital should take into account all the stakeholders in its value chain, including prospective patients, referring physicians, payors, and the staff at rehabilitation facilities and nursing homes. For example, referring physicians may develop a better opinion of a hospital's quality if they can call a hotline to quickly get information about their patients or if the hospital offers them continuing-education classes.

Why hospital quality varies widely

Several reasons help explain why variations in hospital quality have been allowed to persist. The first is that there is, as yet, no standard definition of what "quality of care" means.[1] Is it enough that a hospital engages in sufficient quality-assurance activities that it can earn certificates or be accredited? Is a more integrated approach required, one that considers multiple other dimensions, including clinical outcomes, the subjective experiences of patients and their relatives, staff satisfaction, and the opinions of referring and follow-up physicians?

Even with regard to patient care, it can sometimes be difficult to determine what constitutes high-quality care. Although consensus guidelines have been developed for most common diseases, the evidence base to support many of the guidelines' recommendations is often weak.

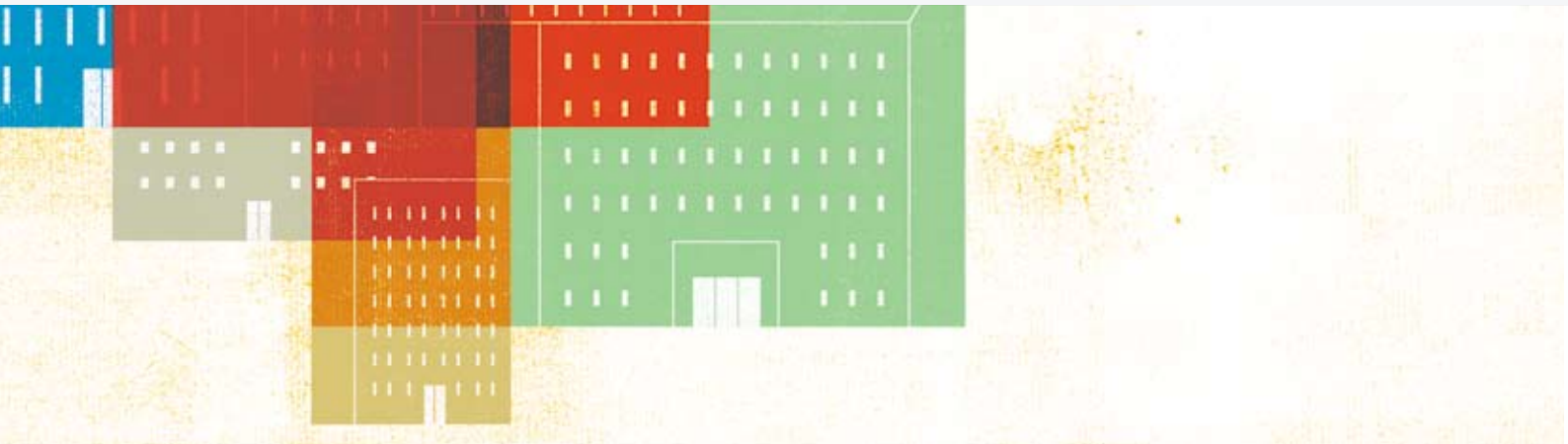
Complicating the absence of a standard definition of quality of care is the wide range of variables that hospital quality-assurance departments must already scrutinize. Simply to assess patient safety, for example, they must monitor the staff's hygiene practices; whether steps are taken to prevent medication errors, patient falls, and decubital ulcers; whether sharps and other devices are used and disposed of safely; whether patients are appropriately identified (and whether the staff checks the identification to avoid administering erroneous treatments); whether all documentation is in order; and many other things. The high number of variables makes it difficult for the staff to identify which actions would have the greatest impact in improving quality of care. (It also explains why consensus on the key metrics to include in a quality-evaluation system is so important.)

Cultural factors within hospitals may also encourage a lack of data transparency and permit variations in care to persist. For example, pride and esprit de corps often make it difficult for physicians to admit that they—or some of their colleagues—are not following best practices. Furthermore, many physicians and other health professionals believe that patient care is a highly complex enterprise that cannot be adequately assessed simply by monitoring a discrete set of actions. Some experts also argue that greater transparency could create a moral hazard; for example, surgeons concerned about having their mortality rates reported might refuse to operate on high-risk patients. (Evidence suggests that this may have happened in some US states.[2]) In the face of this opposition, many hospitals have been reluctant to assess or acknowledge their own shortcomings.

Finally, lack of management attention has enabled variations in care quality to persist. Most hospital executives view quality-assurance efforts primarily as a legal requirement. They accept the fact that they must underwrite the expense of maintaining systems for reporting errors, fielding patient complaints, and monitoring certain statistics, but they consider these activities to be ancillary to their main business. They fail to appreciate that if used strategically, quality-improvement efforts can strengthen their hospitals' financial as well as clinical performance.

[1] Organizations around the world are working on this problem. For example, the US Institute of Medicine has defined quality of care as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge." In the United Kingdom, the National Health Service's Next Step Review has also created a broad definition of quality of care. However, there is still little consensus on how these broad definitions translate into specific actions that all hospitals should be expected to take.

[2] N. A. Omoigui et al., "Outmigration for coronary bypass surgery in an era of public dissemination of clinical outcomes," *Circulation*, 1996, Volume 93, pp. 27–33; and J. H. Burack et al., "Public reporting of surgical mortality: A survey of New York State cardiothoracic surgeons," *Annals of Thoracic Surgery*, 1999, Volume 68, pp. 1195–1200.



The hospital should also reach out to the local community, which is a source not only of potential patients but also potential employees. The hospital's Web site and printed materials should clearly communicate its commitment to quality, and care quality should be stressed whenever potential employees are interviewed.

A highly trained quality-assurance organization

Given today's increased emphasis on transparency, hospitals need to gather and report the required data as efficiently and accurately as possible. Thus, they should invest in the resources required to do this job well. Many of the hospitals the BQS has flagged as substandard have claimed that documentation problems are the reason for their apparent poor performance. These hospitals would benefit from having highly trained quality-assurance organizations that are responsible for obtaining, disseminating, and analyzing the necessary information, and then seeing that appropriate corrective steps are taken when necessary.

A strong quality-assurance organization can do more than simply gather and report required data. For example, it can work with clinician leaders to determine which quality metrics should be tracked voluntarily. This decision must balance the academic desire for thoroughness against the pragmatic need to develop actionable insights. No one benefits if data collection becomes burdensome for the staff or if long reports are produced but never read.

The best results are achieved when a small number of voluntary metrics are selected. These metrics should, ideally, be easily obtainable through routine data collection and, if possible, they should reflect the efficiency as well as the quality of care. For example, the time until antibiotic conversion reflects both care quality and care efficiency, given that it shortens LOS. Better scheduling of operating rooms improves both patient satisfaction and equipment utilization, since fewer surgeries have to be postponed. These types of metrics make sense to the staff members, because they can immediately grasp the significance of improving them.

Once the required and voluntary metrics have been identified, the quality-assurance organization can work with the clinician leaders and other staff members to determine what steps are required to improve them. This approach requires that the hospital allocate sufficient resources to the quality-assurance organization so that it can develop, test, and implement improvement programs.

The organization should also be empowered to respond to error and near-error reports swiftly. It should offer support and appreciation to the staff members who reported the errors and provide feedback to those who made the errors so that they can learn from their mistakes. At least one hospital has gone so far as to publish a "mistake of the month" on its intranet so that its staff can discuss it and learn how to avoid it.

A proactive communication strategy

Although many hospitals would still prefer not to have their quality scores made public, they no longer have that choice in many countries: either they are forced to release their data by legal requirements, or third parties gather available data and publish the results. When the latter occurs, hospitals lose the opportunity to control the message and select the metrics they want to emphasize.

It is far preferable for hospitals to take a proactive approach and communicate their quality results themselves. The idea is not to misrepresent the hospital's performance—after all, there are plenty of ways in which inaccuracies can come to light, and over the long term, only a serious commitment to transparency about care quality will be successful. But there is no reason that a hospital should not highlight its areas of strength.

We believe that a hospital's best interests are served if it communicates its quality scores openly on its own Web site and in its other materials. We recommend that the quality-assurance organization work closely with the marketing department to craft the messages conveyed and to ensure that the hospital receives appropriate credit for its quality-improvement efforts. And by promising to report its scores annually, the hospital can underscore its commitment to its patients' well-being.

Patients and other stakeholders understand that mistakes will occasionally occur, even in the best hospitals. Thus, they do not demand flawless performance, but they do expect honesty, openness, and a heavy emphasis on care quality and mistake avoidance. A 1994 tragedy at the Dana-Farber Cancer Institute, in Boston, Massachusetts, provides a tremendous example of how hospitals can deal publicly with mistakes. A patient, Betsy Lehman, died from a medication error, and the case made headlines across the United States. But instead of trying to conceal the mistake, Dana-Farber publicly acknowledged its error and became the nucleus of a movement to increase the safety of oncology patients. As a result, the institution is widely regarded today as a champion of hospital quality and is in high demand among patients seeking effective and safe treatment for cancer.

Neither the increased emphasis on health care quality nor the desire to make quality scores publicly available is likely to disappear. In fact, the trend appears to be widening: in some countries, quality scores are now being published for rehabilitation centers, nursing homes, and even primary care physicians. Hospitals that choose to ignore the increased transparency may find their survival threatened. But those that respond by improving the care they deliver will fulfill their ethical obligation to patients—and they may well find that they have improved their financial performance in the process.

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