

**EXECUTIVE INSIGHTS**

**RESILIENCY + RECOVERY**



# **MEASURING QUALITY AND OPERATIONAL EFFICIENCIES ACROSS THE CONTINUUM OF CARE**

Creating a model of patient-centered, high-value care delivery

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# MEASURING QUALITY AND OPERATIONAL EFFICIENCIES ACROSS THE CONTINUUM OF CARE

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**Improving the quality and safety of patient care is critical for success in value-based care models.** Such models reward providers for doing what's best for their patients by driving innovation, improving outcomes, reducing costs and enhancing the patient experience. Most quality initiatives and patient safety efforts have focused on hospital inpatient care. Yet, more than 80% of the care delivered by integrated delivery systems, which include acute-care facilities, occurs in ambulatory-care facilities or other outpatient settings. As the main access points to health care services, quality and safety initiatives in these nonacute-care settings can achieve goals central to value-based care success, such as disease prevention, chronic-care management, reductions in avoidable emergency department visits and hospitalizations, lower costs and improved population health. But with that ever-widening continuum of care comes the potential of unnecessary clinical variations, differences in practice patterns, disparate health information technology systems, lack of care coordination, operational inefficiencies and incompatible quality metrics. This executive dialogue looks at how leading hospitals and health systems are redefining their care continuum and adopting innovative ways to collect and use performance data to build patient-centered and high-value care delivery models.

## 3 ways health leaders derive actionable quality and safety improvement insights for data-driven, value-based care



**Collect** both quantitative and qualitative medical and health data from patients at every encounter regardless of where the encounter takes place along an ever-widening continuum of care. That continuum includes ambulatory and outpatient settings as well as in patients' communities, homes, schools, churches and more.



**Standardize** how you collect and report patients' medical and health data and standardize the quantitative and qualitative data along the entire continuum of care. Standardization enables the identification of gaps in care in distinct subgroups of a hospital or health system's patient population.



**Know** what success looks like. Measuring quality and efficiency across a growing continuum of care won't be meaningful from a patient-centered, high-value care delivery perspective unless hospitals and health systems know what they want to accomplish with those data. Hospitals and health systems should define their key performance indicators at the start of any new initiative as well as the expected return on investment.

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**MODERATOR** (*Suzanna Hoppszallern, American Hospital Association*): **How are you measuring quality and operational efficiency across all your care settings? What barriers and gaps have you encountered?**

**ARLAN JOHNSON** (*Howard County Medical Center*): We gauge our quality by measuring how our patients feel about the care they received. We do that on an ad hoc basis through phone calls and surveys via various avenues like text messages. We also have a standing patient advocacy group that we call the patient family advisory council and whose membership changes annually. We ask a group of people to come in on a regular basis and provide feedback on the services they want, those that we offer and could offer moving forward. We need to do a great job because people today have more options on where to get their care. From that standpoint, we want to give them everything they need to keep them here.

**TONY FRANCIS** (*Edgar P. Benjamin Healthcare Center*): We measure our quality through a large matrix of data that we build through employee and patient satisfaction surveys. It gives us a way to compare the perceptions of different employee groups and different patient groups as well as the perceptions of employees vs. patients. The gaps in perception among employees, among patients and between employees and patients tell us where we need to improve.

**RUBY KIRBY** (*West Tennessee Healthcare Bolivar-Camden*): I work directly with two of our critical access hospitals, and we collect and report to the system our patient experience and clinical outcomes data. Then we work with a systemwide committee to improve our numbers. We develop and implement plans as soon as we identify an opportunity to improve. Being in a small community, we know what kind of job we're doing before we receive formal feedback from the top of our organization.

I share my phone number, and most people in our community have it. They call me directly to tell me what they think or they walk directly into our office to share their perspectives.

**KINNEIL COLTMAN** (*Atrium Health*): Like all of you, we have standard quality goals and metrics across our organization. But our biggest complexity regarding measuring quality comes from how we've grown as a system, which has primarily been through strategic combinations, where we've integrated with other health systems and operate through a joint operating company or similar arrangement. Each time we combine with another organization, that organization comes with its own information technology systems, its own data and its own methodologies around risk-adjusting data. The challenge is trying to harmonize everything. We need to synthesize and align all the data so that we're speaking the same language from a clinical quality standpoint. We have overarching quality metrics that apply to everyone, so that we're rowing in the same direction. Now we're working on health equity metrics that apply to the opportunities we have in specific regions and markets.

**MODERATOR**: **Thank you for those candid descriptions of how you're measuring quality and operational efficiency across your organizations. It sounds like an ever-changing mix of quantitative and qualitative initiatives. Sandeep, please give us an overview of what you've been seeing on this issue nationally. And what questions do you have for our provider panel?**

**SANDEEP WADHWA** (*3M Health Information Systems*): We're seeing many of the same themes that each of you described. But what I'm most interested in, and what I'm most curious about are two things. First, how are you structured to capture data on patients' social needs like health disparities and health equity? Do you have a systematic way of doing that? And second, how are

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you structured to capture data on the quality and safety of patient care in your outpatient settings? The structure on the inpatient side is well-established. But how are you looking at quality and safety on the outpatient side?

**FRANCIS:** What we saw, thanks to the pandemic, is how deep and wide the disparities really are. It's not just color. It's age, sexual orientation, gender identity. The LGBTQ+ community was left behind during COVID-19. We started mapping our patient population by ZIP code to better understand what was happening in individual communities and neighborhoods. In the Boston area, you might have 10 different ZIP codes in a 15-mile radius. Who was less likely to get vaccinated? Who was homebound? Who couldn't go to the grocery store? We started with vaccines by setting up mobile access, and we're moving beyond that now to other social needs.

**KIRBY:** In small communities, the hospital can't take on 100% of the ownership of these social issues. You must partner with community groups, social organizations and other providers. In the two counties where my hospitals are located, we created health councils comprising our hospitals, the schools, churches, local health departments, FQHCs (Federally Qualified Health Clinics) and payers. With COVID-19, we coordinated everything from testing to vaccines. The ministers educated their congregations. The schools provided buses for transportation to and from testing and vaccination sites. Other efforts grew out of that, such as identifying food deserts. We received a grant to help set up farmers markets in small, predominantly Black communities that had little access to fresh food. We conduct community needs assessments together through the councils, and we choose the metrics for those assessments that apply most to us. Then we share the results with each other to decide what we're going to work on next.

**JOHNSON:** We became involved in social determinants of health and measuring and addressing patients' social needs in an indirect sort of way. We created a patient navigator role that originally was charged with estimating the cost of oncology care for patients with cancer or for maternity care for pregnant women. That's when we started to find out what patients couldn't afford and why. They couldn't afford nutritious food or good housing. Their kids weren't going to school every day. So now, not only are we helping them find health insurance benefits that offer low- or no-cost prevention and wellness services, but we're helping them with other social needs. We're opening a day care center for our employees. We've hired two new social workers, and we attracted a psychologist to our building. Like all of you, behavioral health needs specifically are off the charts right now. Every time we meet with someone, we're collecting data on the social needs in our community.

**MODERATOR:** What you're all doing is trying to keep your distinct patient populations as healthy as possible to prevent an acute-care crisis. That's a net positive in value-based care models. Where does value-based care fit into this discussion? Eric, what are you seeing around the country?

**ERIC EVENSON** (3M Health Information Systems): We're seeing a lot more people, whether senior leaders are concerned about expenses, payers are concerned about reimbursement or citizens are concerned about higher taxes. They're saying, 'Prove it. What's the return on investment (ROI)?' If we build a basketball court, are we going to see body mass index rates drop? If we improve literacy, will we see an increase in healthier lifestyles? If we put in a community pool, will we see more seniors swimming and lowering their blood pressure? These are more than just feel-good projects or doing what's right for your community. We need to step back, go a little slower and build in quantitative metrics to these ideas. We need to

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know what works, what doesn't work and how well it works.

The same is true on the outpatient side. We're starting to see more metrics on things like transitions of care. Medical procedures formerly done in an inpatient setting are now done in ambulatory care settings. The metrics must go where the care goes. What are your thoughts on measuring your ROI on investing in social determinants or your performance on care provided outside the hospital? Both are critical success factors in value-based care models.

**COLTMAN:** I've spent a lot of time thinking about answers to those questions. I spend much of my time building programs that are more upstream from the acute-care setting. We put together an internal community health team that includes epidemiologists, health services researchers and data scientists. The team's job consists of two functions: to seek grant money to fund our programs and calculate the downstream financial, utilization and health impacts of our programs. In doing so, we are also growing the body of literature around how these upstream interventions can benefit patients, while also reducing the cost of care. We have a responsibility to bring the same evidence to our community-based interventions as we do to the bedside.

**FRANCIS:** It all goes back to data, which includes everything we're doing on the outpatient side, too. We need to stop doing what we think we should be doing and looking for the evidence later. We need to look at the data first to tell us what our patients and our communities need and what we should do about it. The ROI will follow.

**MODERATOR:** **What are other critical success factors that you feel are important when you're looking at population health outcomes and try-**

**ing to optimize health and costs?**

**KIRBY:** The elephant in the room that we haven't discussed is workforce. If we're moving services outside of the hospital, the workforce is going to be our biggest challenge in implementing any of these ideas. Who is going to do the work? Is it going to be artificial intelligence? And how do we get more kids interested in health professions?

**JOHNSON:** Another thing we're looking at, especially if you're a small or rural hospital, is partnering with a larger hospital or health system via telemedicine. We're exploring a telenursing partnership that would bring a higher level of nursing care to our stroke patients. That would allow them to recover here and with their families rather than traveling to another facility.

**COLTMAN:** We're focusing much more on primary care access and reducing the friction for patients to connect easily to their providers. We're developing mobile primary care models, and we're expanding school-based virtual care models — particularly for Title 1 schools. We also have enterprise goals around growing the percentage of Medicaid and uninsured who are connected with primary care providers, as we know that access to primary care can improve the health of our patients while also reducing the overall cost of care.

**MODERATOR:** **Thank you for sharing these great ideas and practical advice for your peers. San-deep, do you want to add any final comments?**

**WADHWA:** We've been talking about a lot of these things for years, but we never reached this level of intervention nor this level of conversation about community. We're actively listening to our communities. It's incredible to hear about the work that you're doing as you meet the needs of your community as your community defines them.

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