

Last year, NCQC interviewed staff at seven NC hospitals/health systems, asking questions about the use of data to improve healthcare quality. This report summarizes our findings.

*What are your top quality priorities for this year?*

- **Infections, safety, readmissions, and mortality are top priorities for NC hospitals.** These were mentioned most frequently by hospitals. Other areas which were mentioned by multiple hospitals include: population health, core measures, IT issues, value-based purchasing, PQRS, DVT and efficiency.
- **While population health and IT are priorities, NC hospitals vary in the specific projects they are undertaking.** For instance, one hospital identified a project on diabetes, another was working with their self-insured population, another was improving their prevention bundle, and yet another identified ACO quality metrics as a top priority. While all of these are population health efforts, it is clear that each hospital is pursuing population health in a very different way. Similarly, in the area of IT, hospitals identified the following priority projects: the patient identifier, medical record accuracy, and eQMs.

*What does the quality department of the future need to do to be successful over the next 3-5 years in a transformed healthcare environment?*

- **For the near term, hospitals need to understand and clean data in order to succeed under pay-for-performance programs.** For instance, one hospital discussed the importance of appropriately documenting comorbidities or present on admission indicators, thereby ensuring the hospital received full reimbursement for these programs.
- **Quality departments need to work outside of traditional silos.** This was a recurring theme across respondents. For instance, one respondent stressed the importance of taking a service line, instead of a setting-based, approach to care. For example, s/he proposed looking at holistic quality of cardiovascular care for a patient who passes through multiple settings. Another respondent identified the need to connect with community physicians. Others pointed to the importance of tracking costs, including readmissions or drug costs, which occur outside of their system.
- **Hospitals and health systems must move beyond scorecards. Instead, hospitals should use predictive analytics, specifically timely data which allows caregivers to change the course of care.**
- All hospitals are using scorecards to review their performance. Using this data, however, is similar to “driving a car using the rearview mirror,” because, by the time this data is available, the patient’s course of care has typically ended. In contrast, hospitals are looking for opportunities to use their data to intervene on patients while hospitalized or soon after discharge. For instance, hospitals are working to predict readmission risk or sepsis risk while a patient is still in the hospital.
- **Hospitals should stop reacting to CMS or payer priorities, and instead proactively identify quality priorities.** Some population health work has moved in this direction, for instance by identifying those patients who are admitting frequently and working on the specific issues identified by reviewing those cases.

*What are your top three go-to sources for data? What data do you use most in your work?*

- **Hospitals identified internal data sources**, such as EMR reports or their data warehouse as routine sources of information.
- **Hospitals also identified a number of external reports used routinely**, including UHC, Premier, Truven, The Advisory Board, NDNQI, DICON, HospitalCompare, QualityNet, insurance companies, NCHA/NCQC reports. Many hospitals found used these sources to pull benchmarking information which they use for internal scorecards.

*What main barriers do you face in using data for improvement?*

- **The data is not available.** For instance, some data is from sources external to the hospital/system (SNFs, readmissions to other hospitals, costs). Other times, the data is in multiple different EMRs and has to be pulled into one data warehouse to be used. As another example, the data element of interest may not be tracked discreetly as an EMR element (e.g., it might be part of a transition bundle and requires chart abstraction).
- **An overemphasis on documentation, not patient care.** As reporting becomes more automated, there is a focus on making sure that care is documented in the right fields to end up in the right quality reports. When data is not documented in the right places, reports may be incomplete or misleading to end users. This problem is partly due to vendor products which are not adequate to hospital needs. However, as staff focus on fixing documentation issues, attention is taken off of true quality improvement. This, in turn, can lower the morale of staff.
- **The data is too old.** Multiple respondents remarked on the large lag before quality data is available. While some data is available on a monthly basis, claims data or benchmarking data may lag behind by many months or years.
- **Lack of appropriate benchmarks.** When benchmarks are available, they may be too old. In another case, a hospital tried to systematically set a goal of top 25% performance across all measures, but found that the top 25% benchmark was not calculated by all vendors and thus was not always available. In a different case, a hospital found it challenging to identify the appropriate benchmark (e.g., given how this vendor defines an academic hospital, is this still an appropriate benchmark for our hospital?).
- **Data is too expensive.** While a vendor may be available to help obtain and analyze the data, the vendor charges can be higher than the value the hospital expects to extract from the data. Another hospital described the time-consuming process of trying to evaluate whether their return on investment with a particular vendor was positive. Finally, one hospital identified the cost associated with timely benchmark data as a particular challenge.

*Where do you wish you had more data, different data or better data? Where do you have too much data, confusing data, or bad data?*

- **Some answers focused on having data which is more focused on outcomes, not processes.** This includes better data on complications, mortality, readmissions, and predicting index admission. Looking farther ahead, one respondent wished there was better data on functional outcomes, e.g. can a person play basketball after their knee surgery?
- **Other answers focused on challenges around existing data/measures/programs**, such as better data on CMS readmission measures, data which was easier to understand on value-based purchasing, better definitions within the PSIs (e.g., defining accidental punctures), or doing a better job of cleaning data (e.g., patients with BMI of 150 should be cleaned from the data before analysis).

- **Physician attribution is challenging.** One respondent called out physician-level reporting as a particular challenge. In an inpatient setting, patients may be seen by multiple physicians. Moreover, physicians are quick to discount the data if errors are found.

*In general, what would make the data you get more usable?*

- **Several respondents said they wished the data made it easy for staff to explore data themselves,** e.g. a staff person with an idea or question could drill and explore—instead of having to submit a detailed data request. For example, one respondent mentioned that staff sometimes make very specific data requests of their analytic team. However, in some cases, when their analytic team has worked to better understand the staff member’s project, they are able to provide a better tool or report. As s/he put it, “Don’t give me what I ask for, give me what I want.” Another respondent mentioned that, as they currently operate, staff primarily use data in one specific way: they review their performance scorecards to identify where they fall below benchmark, and use this to decide on their next quality improvement project. In the future, s/he’d like staff to use data more proactively, i.e. when a staff person has an idea about where a problem lies, s/he could run a report and explore this idea in more depth.
- **Another hospital stressed the importance of assisting staff with interpreting data.** This hospital is working to develop a standardized reporting template, with data value, sources, dates, etc.

*Where do you see the same data reported differently, and wish all the players were more aligned?*

- **Readmission rates.** Many respondents pointed to the dizzying array of different readmission rates.
- **Public sites.** Many respondents noted that public sites are often not synchronized with each other, or rely on different, overlapping measure sets.
- **eQMs versus core measures.** These two measure sets are specified differently and not harmonized.
- **Sometimes the hospital itself creates the discrepancy.** For instance, a senior leader may find data on a CMS website or from another report, and use it in a presentation. Or, a business unit may have a spreadsheet developed by their own analyst, but this data hasn’t been integrated with other data in the warehouse.

*What kind of data are senior leaders most interested in? Nursing managers? Physicians? Quality departments? Are there discrepancies in what different groups want?*

- Respondents described several characteristics of the data needs of **senior leaders.** Senior leaders, as respondents characterized them, are interested in seeing that the organization has used the data to make changes. Additionally, they are interested in timely data, and they are interested in the measures which have been selected for the hospital/system scorecard. Senior leaders want to understand causes, not just correlations. Finally, since the data is complex (particularly on CMS pay-for-performance programs), respondents noted that opportunities exist to better educate senior leaders.
- One respondent noted that **physicians** sometimes want to delve too deeply, analyzing mortality/readmissions in every possible way. This can be a challenge when resources are limited.

- **Different groups want the data sliced for different subpopulations.** For instance, a physician wants to see his/her patient panel; a nursing manager wants to see information on his/her unit.

*How does NCQC support your organization the most, particularly around data/measurement?*

- Respondents noted a number of ways **NCQC supports their work**. First, NCQC can act as a convener, providing opportunities to network with other hospitals. In addition, NCQC convenes hospitals without a stick, providing a non-threatening forum. Respondents also noted that NCQC provides benchmark data, a valuable asset. Finally, one interviewee observed that NCQC's focus on the patients helps him/her think beyond the hospital perspective.

*Think big! What's your big idea for how data could be used to transform care and make it much, much better? In a perfect world, what would we be doing?*

- **Data would be so real-time and so predictive, it would routinely guide care.** For instance, hospitals could use hard stops that affect patient care in real time.
- **Data would be available across settings and systems, including care in the community and pharmacy data.** That is, data would be focused on providing the complete picture of the patient.
- **Hospitals would drive quality improvement internally, by exploring their own data and surfacing quality problems by asking good questions.** In the current state, quality priorities are very much driven by CMS or other payers. As hospitals become more sophisticated with their quality data, the hope is that the strategic priorities will be driven by what they learn about their specific patient panel and local circumstances. This would also allow hospitals to use their limited resources more effectively by identifying those areas where they have most opportunity to improve.
- **The hospital/system would know its organization and patients better than anyone else.** As one respondent put it, "No one outside our organization should be telling us things we don't know for ourselves; there should be no surprises."
- **Effective advocacy with CMS would reduce the complexity of tracking quality data.** There are too many measures, and vendors are not held to high enough standards to provide functionality around them. Documenting and collecting this data is "breaking the backs" of staff and taking the focus off patient care.
- **Quality and IT would work together seamlessly.** In the current state, quality too often works in a silo separate from IT, even though much of the work spans both disciplines. In the future, hospitals would have seamless translators explaining quality need to IT.
- **We need to use data to engage, empower, and educate the patients more.** Patients make decisions for many reasons, and don't always have the information they need to make good patients. Data should be more available for patients to use.