Health Care Providers Need Performance Data Audits to Market Trust

written by Theresa Hush | May 4, 2017

Health care systems once thought it was crude and undignified to use marketing to attract patients. No more. Now they use qualitative anecdotes to promote status at a time when data is king and consumers view comparative quality data on the Internet. Why not use quantitative evidence? Because their data doesn't promote their cause—and even they don't believe it.

That avoidance behavior is a huge mistake. Health care organizations need to take steps now to turn performance data into valid indicators of both quality and cost. Otherwise they will risk losing control over their stories as providers of excellence. Consumers will make decisions based on whatever is out there, accurate or not.

Health Care Marketing Practices Ignore Data and Evidence

Let's admit it: the public face of health care systems is unresponsive to consumers at a time when there is a growing distrust of institutions—including insurance companies, hospitals and

doctors. While consumers grapple with rising health care costs and the media reports on medical errors as the third leading cause of death, health care organizations still try to attract patients with "trust me" messaging:

> We're in the top 10 hospitals/physician groups of (some popular survey, like *U.S. News & World Report*).
> The best sports teams are treated by our doctors.
> We are rated the best by our patients (responding to our surveys).
> We have the latest technology and facilities.
> We have the most advanced doctors (talking to each other on commercials about saving patient lives).

Unfortunately, this "trust me" attitude turns a blind eye to health care consumerism trends, Value-Based Health Care and responsible stewardship of quality and cost.

Performance Data Is Often Sidelined in Health Care Organizations

There are many reasons why health care organizations distrust their health care performance data, and many of these reasons are valid. When the problematic data is then aggregated and used to compare physicians, additional issues compound the unreliability of comparative performance.

However, health care organizations also have played a role in promulgating invalid performance data. Their high investment in electronic medical records—and magical thinking—has often obscured investigation about how patient data is mapped to performance measures, as well as how that data is retrieved and sent to CMS and other external entities, not to mention that the mapping is often erroneous or missing data. They have frequently also been "soft" on the standard implementation of their EMRs, in the interests of providing clinicians with flexibility.

Providers have also often viewed performance measurement as a "compliance" activity for outside reporting, not as a baseline for identifying areas for improvement. Therefore, since the data has not (until recently) been publicized, health care organizations did not see it as relevant to a public perception of their performance.

But these reasons should now compel providers to take performance data seriously. When data becomes public—especially data that will weigh into public perception of patient safety and quality—the ability for providers to control their own story is limited.

The bottom line is this: data spit out of systems is not ready for prime time. To ensure that data can serve as a useful starting point for both measuring and improving performance, it must be evaluated and curated for that purpose.

Which Performance Data Really Matters?

Health care systems should arguably have a broad-based program for measuring both physician and hospital performance, regardless of what is reported to payers or other entities. Why? Because tracking all performance also helps to upgrade the data involved in performance measurement and to identify missing data. At a minimum, performance data needs to include the following:

> All standardized quality measures that are being tracked by CMS, Medicaid, health plan contracts, specialty organizations and various certification programs (e.g. NCQA and PCMH);
> Cost performance calculations included in CMS QRUR and SQRUR calculations, and health plans, as feasible, including costs associated with episodes of care;
> Outcome measures that include those in performance measures—which are "intermediate" measures of patient status—but also those not included, such as infection and complication rates, surgical re-dos, post-surgical DVTs;
> Patient safety measures;
> Patient functional status as reported by patients and/or to providers;
> Patient satisfaction, which should incorporate not only historical issues but also those of more current relevance to health care consumers.

This should be clear: in order for the data to be valuable, it must be grounded by a patient-centric performance database that will ensure that all data for given patient is correctly attributed. This will allow for correctly populating data in quality measures and validation of that data by providers.

A patient-centric, shared database also keeps the results honest. For example, by including data from multiple sources, under-coding by single providers will be less significant. The existence of a post-surgical DVT can be contributed within radiology data to a patient's records, and surgical infections can be identified in the hospital or primary care office. These can offset lack of data by a surgeon.

External Auditing Is Key to Usable Performance Data

There is a reason that organizations use accounting firms to validate financial statements and guarantee them to stakeholders. Trust. For the same reasons, quality and outcome results

should assure trust to stakeholders, including consumers, donors and clinicians who are participating in the enterprise. Raw data that is retrieved out of systems is not curated for achieving that level of trust.

Health systems may initially challenge the notion of audited performance data. Instead, they should welcome it. Only by ultimately improving their own performance data will they be able to gain the engagement of their physicians and other providers in performance improvement. It is easy to challenge false data, but once the data becomes trustworthy, it becomes the basis for collaboration and improvement.

Consumers who are making selective choices of providers will be more convinced by the organization's self-publication of audited performance data than by infomercials. It speaks volumes to patient care commitment if providers are willing to engage in comprehensive performance measurement, contract with experts for outside opinions and submit their data for review.

Who is the Best Data Auditor?

One question remains: who can perform such an external auditing function? The most obvious choice is a Clinical Data Registry (CDR) that is already aggregating and measuring provider data in a patient-centric database.

But not all registries undertake this task comprehensively, and many have performed the function of quality reporting as a data transmission exercise, without investigating or reporting underlying data problems, nor trying to remap EMR data to measures. While Medicare is pushing the concept of "Qualified" Clinical Data Registries to upgrade the standards of organizations curating performance data, we are in early days.

My role as a CEO of a CDR—with perhaps a unique perspective on the problems of data-generated performance scores—discourages me from saying a lot more, except that my goal is to push the envelope for better health care and not particular organizations. The organizations involved in data, performance measurement and improving outcomes are still evolving.

Consumers may not wait for that evolution, however, and neither will entrepreneurs. The story of providers may well be told by Apps that use existing data, good or not. Health care organizations should act quickly to examine their own data, choose methods of validating that data, and put a priority on curating and improving both data and clinical performance.

Founded as ICLOPS in 2002, Roji Health Intelligence guides health care systems, providers and

patients on the path to better health through Solutions that help providers improve their value and succeed in Risk. Roji Health Intelligence is a CMS Qualified Clinical Data Registry.

Image Credit: Ryan McGuire