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From the Editor

Providing Comparative Clinical Data for Continuous Quality Improvement: The UHC

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From the Editor

Providing Comparative Clinical Data for Continuous Quality Improvement: The UHC

Integrated delivery systems like the Jefferson Health System (JHS) are under increasing pressure to utilize resources in the most efficient way possible. Given policy changes in our nation's capitol, such as the Balanced Budget Act of 1997, and the increasing penetration of managed care, the plight of these large delivery systems, especially those with a medical school at their core, has been well documented.[1,2] Certainly, the JHS, through the efforts of many groups and individuals, is responding to these marketplace forces. One aspect of our collective response involves JHS' membership in the University HealthSystem Consortium (UHC) and the tools and techniques they make available to systems like ours. Let me review the components of the UHC with a particular emphasis on the comparative data available from them for clinical process improvement.

The UHC, headquartered in suburban Chicago, Illinois, is a member-driven alliance of the clinical enterprises of academic health centers and affiliated health care organizations. According to their most recently available material, the mission of the UHC is "to advance knowledge, foster collaboration, and promote change to help members compete in their respective health care markets."[3] The UHC describes itself as an "idea-generating and information-disseminating enterprise where its members pool resources, create economies of scale, improve clinical and operating efficiencies, and influence the direction and delivery of health care"[3]—certainly, a tall order by anyone's measure.

Thomas Jefferson University Hospital has been a key member of the UHC, and with the advent of the Jefferson Health System, all of its constituent organizations may have a good deal to learn from the UHC. From my own perspective, the Office of Health Policy and Clinical Outcomes began its involvement with the UHC in 1992 with the creation of the Clinical Evaluative Sciences Council—a group of like-minded physicians interested in clinical process improvement, benchmarking, and the use of comparative databases on a regional and national scale. Careful readers of this column over the years remember some of our early work (The University Hospital Consortium [Editorial], May 1993, Vol. 6, #2).

Among those early projects was the development of a clinical benchmarking tool where a small group of stalwart UHC members worked together to construct a unique comparative dataset on such topics as kidney transplantation, hip arthroplasty, and coronary artery bypass graft surgery. In many ways, our office and other initial UHC members cut our collective teeth with the kidney transplant benchmarking program, working for nearly three years to better understand how we could improve our performance for patients undergoing this complex procedure. We discovered important opportunities for improvement that have subsequently been realized for these very ill patients.

One key arm of the UHC is the Clinical Practice Advancement Center (CPAC) led by David Burnett, MD, Vice President of the UHC. CPAC works with UHC members and related organizations to help them effectively meet the demands of the evolving health care marketplace by providing participants with "practical, scientifically rigorous information that supports strategic decision making and change

management."[4] A particular strength of the CPAC is its ability to link empirical data with the opportunity for information exchange among peer, integrated delivery systems across the country.

In a word, CPAC provides a series of tools to help the JHS and other systems compete. One specific tool, beyond the benchmarking activities mentioned earlier, is the novel UHC clinical database (CDB)—a cornerstone of the Clinical Information Management Program of CPAC. Again, according to the UHC, the clinical database is the richest source of all payor comparative in-hospital data from academic medical centers available anywhere! "For each 1.3 million encounters per year, the CDB contains up to 16 diagnoses and 16 procedure codes, information on patient demographics, treating physician, payor charges, costs, and components of costs. Membership in the database has grown from the pilot group of 10 hospitals in 1989 to the current membership of more than 100 integrated delivery systems. Participation in the database is open to UHC members, their affiliates, and any member of the Council of Teaching Hospitals or COTH."[5] The CDB is also endorsed by the Association of American Medical Colleges, an important national organization headquartered in Washington, D.C.

How exactly does the CDB contribute to improving care at a complex regional organization like the Jefferson Health System? With the support of Thomas J. Lewis, President and Chief Executive Officer, Thomas Jefferson University Hospital, and Stanton Smullens, MD, Chief Medical Officer, Jefferson Health System, our office has been fortunate to be able to participate in the CDB. Readers may be surprised to learn that from any personal computer with an appropriate UHC-provided password, members can evaluate diagnosis-specific information on the Jefferson Health System as well as from many of our regional and national competitor institutions. The clinical database enables institutions to view diagnosis-specific physician performance information on-line and make important comparisons about their overall utilization of resources, lengths of stay, and complication rates. Some institutions can extract detailed information on pharmaceutical utilization patterns within these clinical populations. By receiving relevant, non-punitive information about performance, especially as it relates to peer organizations, an institution can give the clinician at all levels important insights about his or her own performance. Readers of this newsletter know how important these kinds of activities are in effecting changes in physician behavior and improving a system's competitive posture (Practice Profiling: Vision or Villain? [Editorial] January 1994, Vol. 7, #1).

I think readers would agree that in the past eight years, the JHS and the UHC have made a tremendous amount of progress as we have evolved from paper abstracting exercises in the kidney transplantation benchmarking project to databases available in real time on the Internet. As the technology matures, so has our office's ability to organize, disseminate, and utilize a tremendous amount of clinical and economic information.

These kinds of tools support the work of the Jefferson Health System Quality Council (the group charged with overseeing the quality improvement efforts across the system and creating the annual JHS Performance Report Card). The JHS-wide clinician leadership education programs, appropriately titled Toolbox I and Toolbox II, routinely incorporate information from the CDB of the UHC.

Undoubtedly, the UHC will continue to supply the JHS and other integrated delivery systems with increasingly sophisticated tools to deal with our increasingly complex

environment. As always, I am interested in your views. My e-mail address is David.Nash@mail.tju.edu.

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