

## **Knowledge management and case-mix – adding value to health services** *(draft version)*

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As in any other industry, modern day healthcare organizations are committed to excellence and feel the need to pursue means of measuring the extent of that commitment and the results achieved. Data has become a major asset for healthcare managers and one of the most challenging issues is the transformation of massive volumes of raw clinical and non-clinical data into contextually useful information for decision-making and delivery of care.

Knowledge management (KM) - a systematic process of production, organization, codification, acquisition and dissemination of information, appears to be an essential process for healthcare to face that challenge. KM ultimately aims at transforming tacit knowledge that arises from individual experience into explicit collective knowledge that is imbedded in the organization's processes.

Healthcare has traditionally been a rather disjointed industry in terms of information exchange among and within organizations. However, the minimum Basic Data Set (MBDS) associated with case-mix classification systems, particularly the DRG system generated a worldwide movement towards a clinical focus on standardized management information enabling meaningful comparisons of results between hospitals and between clinical services.

DRGs were introduced in Portugal in the early eighties of the 20<sup>th</sup> century as part of a national project for the development of an integrated information system for the management and financing of hospitals. The first DRG pricing list was published in 1990 and a new funding model was developed to progressively adjust hospital global budgets, for case-mix. The changeover to public contracting was initiated in the mid-nineties when Contracting Agencies were created at the regional level to negotiate performance targets with the hospitals of their geographical areas. DRG and associated case-mix concepts were maintained as key tools of the new process but only after 2000 were they effectively included in the terms of the hospitals' funding contracts.

DRG are definitely associated with the major financing reforms for the introduction of efficiency based incentives in Portuguese public hospitals. Nevertheless the maintenance of a non-competitive environment with little or even non-existing financial risks has determined a limited impact of the case-mix funding system on hospital management and on the performance of individual hospitals.

The progressive transformations of public hospitals into firms, along with the growing restrictive economic and financial environment in which they operate have accentuated the need for change. In short, healthcare managers are being given more authority and responsibility to scrutinize their performance and to discover ways to carry out activities better, faster and cheaper. From the payer's point of view, the resource allocation model is gradually giving place to a payment by results approach, whereas from the providers' perspective the response implies the elimination of inefficiencies and the search for a better use of the physical and human resources present at their units.

Case-mix and DRG are still at the heart of this new paradigm fueling a whole set of new initiatives for hospital performance evaluation and for knowledge dissemination, which includes for example, external ratings and internal clinical benchmarking.