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About the Measures in the Community Checkup

1. Q: What measures are included in the Community Checkup and who determined them?

A: The Community Checkup contains 21 measures of medical group care and 41 measures of hospital care. The medical group measures address important topics in health care including preventive care, such as screening for certain cancers; appropriate use of commonly overused services, such as prescriptions for antibiotics; generic drug prescribing; and care for certain chronic conditions—asthma, depression, diabetes, and heart disease. The hospital measures

include care for heart failure, heart attack, and pneumonia; surgical care, the occurrence of “never events” (errors that should never happen); and patients’ experience of care. All of the medical group measures are based on extensive work by Clinical Improvement Teams convened by the Alliance. These teams are comprised of local physicians and other community and medical leaders. Reports from these teams are available to the public. Each team recommended measures, most of which are based on generally accepted national guidelines for quality care endorsed by the National Quality Forum, the Institute of Medicine and/or HEDIS. The hospital measures are combined from several public sources including the Washington State Department of Health, the Leapfrog Group, and the US Department of Health and Human Services Hospital Compare Program. These measures were selected based on the guidance of a committee of regional experts. Future updates of the Community Checkup will include additional measures.

Before publishing the first version of the Community Checkup in January 2008, the Alliance circulated the proposed list of medical group measures throughout the community and received feedback from physicians, consumers, employers, health plans and others. Staff and committees reviewed the input, made a few adjustments, and the Alliance Board approved the final set of measures.

2. Q: What is the benchmark or desired rate for each measure?

A: The report shows how the medical group results compare to those for the top 10 percent of medical groups in the nation for which measurements are available. But the primary purpose of this version of the Community Checkup is to establish a baseline for our region. This Checkup gives everyone in the community a snapshot idea of how we are doing across the community and where opportunities for quality improvement exist. Note that it is not reasonable to expect 100% compliance with any measure, because there are valid reasons why care for certain patients may differ from the generally recommended standards. Also, doctors cannot guarantee that patients will follow their recommendations.

3. Q: Why does the Community Checkup emphasize primary care and not specialists?

A: The focus areas of the Community Checkup—mainly addressing care for people with diabetes, heart disease and other chronic conditions—reflect the categories of care that make up a significant portion of health care services provided in the community. Primary care clinicians typically provide the care that is known to be effective to keep people with chronic conditions as healthy as possible; however, data collected and reflected in the Community Checkup does include care provided by both primary care providers and by specialists. Also, often it is more difficult to set measures for specialty care because there is less consensus about what care is effective.

4. Q: Why does the Community Checkup publish hospital measures that are already available elsewhere?

A: There are two distinct benefits to including the hospital performance measures in the Community Checkup. First, the report assembles in one place hospital data from several different sources--the Washington State Department of Health, the Leapfrog Group, and Health and Human Services’ Hospital Compare. Second, including hospital performance data along with medical group performance data gives you a one-stop option for finding health care performance information.

About the Medical Group Data in the Community Checkup

5. Q: What data is included in the Community Checkup medical group measures?

A: The Community Checkup is based on data that reflect care provided to approximately 1.6 million people in the region. The following organizations provided data:

- The Boeing Company (*Regence*)
- Carpenters' Trust
- City of Seattle (*Aetna*)
- Community Health Plan of Washington
- First Choice Health (*self-funded owners*)
- Group Health Cooperative
- King County (*Aetna*)
- Molina Healthcare of Washington
- Premera Blue Cross
- Recreational Equipment Inc (*Aetna*)
- Regence Blue Shield
- Retail Clerks (*Zenith Administrators*)
- Snohomish County (*Regence*)
- Washington Mutual (*United/MedStat*)
- Washington State Health Care Authority Uniform Medical Plan (*FIServ*)

The Community Checkup uses insurance claims data to measure aspects of care. The data are “de-identified”, meaning that they do not include any information that identifies individual patients, such as name and address. Combined, the data reflect about 70% of the insured, non-Medicare population in King, Kitsap, Pierce, Snohomish and Thurston counties.

6. Q. Did participating clinics have an opportunity to review the data before it appeared in the Community Checkup?

A: Yes. Before the Community Checkup was released, the Alliance shared the draft results privately with participating clinics and asked for feedback. At that time, each clinic system could see how their results compared to other clinic systems (the results were blinded). They also received all results for individual clinicians within their clinic system (but no others).

7. Q: Why is the Community Checkup based on claims data?

A: For accurate measurement and comparison across the community, large data sets are essential. Claims data are the only type of high volume data that we are aware of that is readily available in electronic format for the vast majority of health care providers. Over time, the Alliance intends to expand the Community Checkup to reflect data from other sources, such as electronic medical records, labs, and patient experience surveys. Currently, much of that information is inaccessible because it is trapped in paper, rather than electronic, files.

8. Q: How can quality of care be measured using claims data?

A: Claims data reflect information clinics submit to health insurance plans as a part of the billing process. While not all medical care shows up in billing data, the data do include quite a bit of information about diagnoses and services provided. Using claims data, for example, one can measure whether services such as cholesterol tests or cancer screenings happened with individual patients. In the current version of the Community Checkup, all of the measures look at specific elements of care provided. None of the measures consider the cost or payment for that care. (In fact, none of the information submitted to the Alliance for use in creating this report included data on cost, charges or payment.) In the future, the Community Checkup will include efficiency or resource use measures, after the Alliance Board determines the best way to do that.

9. Q: Are there limitations when using claims data for performance reporting?

A: Yes. While claims is the only high volume data source that we are aware of which is readily available in electronic format for all health care providers, the claims data do not show every aspect of care. There is no billing, procedure or diagnosis code for certain health services or

problems, so some information does not appear in claims. For example, it is impossible to measure the percentage of patients with diabetes who have a foot exam. (Only measures that can be calculated using claims are in the report.) Everyone would prefer the report to show very recent data; however, there will always be lag time when using claims due to the steps involved in billing and payment, and time to aggregate data and produce results. Claims may include errors due to variation in how care is coded and billed. It also may be missing information needed to identify whether a patient should be included in a measure denominator. For example, if a claim does not show that a 45 year old woman had a hysterectomy and cervix removal, she would inadvertently be counted as someone who should have been screened for cervical cancer. Because the total amount of data analyzed for this report is so large – reflecting care for about 1.6 million people – the impact of these individual errors in the data is likely small.

10. Q: Why isn't the report based on data from electronic medical records?

A: In the future, we would like to produce the Community Checkup using the more comprehensive information available from medical records and charts; however, too many clinics, hospitals and other facilities still use paper records (making it virtually impossible to collect a high volume of that data across the region). Increasingly, clinics and hospitals are using software to efficiently track care provided to all of their patients, and to remind patients and providers when it is time for certain services. Not only can this help doctors provide effective care to patients more consistently, it can allow comparisons across the entire patient population to help identify targets and track progress for quality improvement. Several clinic systems in the area already use electronic medical records, including the Evergreen Medical Group, Group Health, Lakeshore Clinic, MultiCare, Northwest Physicians Network, The Everett Clinic, Valley Medical Center, and Virginia Mason.

11. Q: Are the results in the Community Checkup absolutely accurate?

A: Accurately measuring health care performance, with all the complexities in the health care system, is challenging. Several issues must be kept in mind before drawing specific conclusions based on the results for any clinic or clinic system included in the Community Checkup. For example, some measures cannot be *fully* assessed with available data. The best example is the colon cancer screening measure: the evidence-based guideline suggests that patients over age 50 should have a screening test at least once in the ten years after age 50; however, the data used for this first report spans less than four years. Over time, as more data are added, future Community Checkups will show results based on a longer measurement period. Another consideration involves patients who receive recommended care that they might pay for out-of-pocket (no insurance involved) or that is paid for by an organization that did not contribute data for this report. In these cases, that information is not in the data used for the report, so the clinics would not get credit for providing the recommended care to those patients. Or, if patients do not have insurance coverage for recommended care, they may be less likely to seek that care or follow the doctor's advice. Indeed, even with insurance coverage, not all patients do what is best for their health; doctors have only so much ability to influence patient choice. All of these factors and more influence the results and should be considered when interpreting the results.

12. Q: How old are the claims data used in this report?

A: The data used for the report reflect care provided from January 2004 through September 2007. Over time, the report will be updated with more current data.

13. Q: Is the sample size big enough so that results are statistically valid?

A: Yes. To ensure the results are valid, the public report includes only results for clinics or physicians with at least 160 patients with the condition being measured. Clinic leaders get private reports with all of the results associated with their own clinic, regardless of minimum sample size.

14. Q: When will the Alliance Community Checkup be based on chart data instead of claims data?

A: There is great interest in expanding the data sources beyond claims data, but the timing hasn't been determined yet. Most chart or medical record data is largely inaccessible because it is kept on paper, rather than an electronic format. Even when data are available in electronic medical records, the process for collecting, incorporating, and managing these data to enhance claims data based performance measurement is in its infancy. The Alliance is exploring options to be able to tackle this challenge in the future.

15. Q: Without information identifying individual patients, how do you know that results in the Community Checkup are based on care provided to actual patients at each clinic?

A: The Alliance worked with medical groups that volunteered to help verify that the results were based on data about their patients. Two large health plans agreed to provide individual patient names back to each of the medical groups. Overall, participating medical groups reported that they were satisfied that patients appearing on the list were theirs. One medical group that performed an especially detailed review was able to achieve greater than 98% agreement using a combination of automated and manual matching. This confirmed that the technical algorithms used by the Alliance were appropriately attributing patients to the right clinics and clinic systems.

16. Q: How is risk adjustment handled for clinics that treat patients who are sicker?

A: At this point, the Community Checkup measures “processes of care” that do not require adjustment in the results to account for differences in patient populations. For example, every patient who has diabetes should receive an HbA1c test at least once per year. This is true whether the patient is relatively healthy or has several chronic conditions. In the future, when the Community Checkup includes “outcome measures,” the Alliance is committed to applying an appropriate risk adjustment. It is also worth noting that the current database does not include Medicare members, who are older and consequently have higher health risks than the under 65 population that this report covers.

About How the Report Will be Used

17. Q: How can clinics use the data in the Community Checkup?

A: All clinics and medical practices for whom results are included in the report receive all of the data for their individual physicians or clinicians for use in internal discussion and quality improvement work. In addition, clinic systems can see how they compare at the clinic-level to their professional peers. Using the comparative results in the report, any clinic can select one or more measures for which they would like to improve.

A tool for quality improvement that can be used within a practice setting is software called a “registry” —either paper-based or electronic. Health care providers can use registries to track their patients with certain health conditions (including sending reminders when patients are due

for certain services) and support more consistency in providing effective care to specific groups of patients, such as those with diabetes or other chronic conditions.

18. Q: What if patients don't comply with physicians' recommended treatment?

A: Certain patients are less likely to follow through with recommended care. The Community Checkup is intended to inform everyone about aspects of care that are vitally important to getting and staying as healthy as possible, especially for patients with chronic conditions. In addition to producing the report, the Alliance is also working with health plans and employers to align incentives to reduce barriers for patients, such as ensuring that needed services are covered in health benefit packages. Information is also being provided to patients so they can do their part to improve personal health and comply with their doctors' advice.

19. Q: How can clinics improve their results if they aren't given the names of specific patients who are missing certain elements of effective care?

A: The Community Checkup results identify where improved care processes may be needed within a clinic location or a clinic system overall. For example, what methods are in place to support the consistent provision of annual HbA1c tests for all patients with diabetes? One suggestion is for clinics to use patient registries, an essential software tool for tracking the care of patients with chronic disease within a practice.

20. Q: Is the Community Checkup mainly to benefit health plans and other purchasers?

A: No. Clinics received the most comprehensive set of Community Checkup data for their use in internal quality improvement efforts. Health plans and purchasers will receive the public version of this report, which only includes results at the clinic location and medical group levels. For the first two reports produced by the Alliance (this is the second), no one is allowed to use the reports for business purposes, including establishing networks, negotiating contracts or marketing.

About How the Report Fits with Other Health Care Improvement Efforts

21. Q: Where can I find examples of other comparison reports on health care quality?

A: California Office of the Patient Advocate www.opa.ca.gov
Greater Detroit Area Health Council www.gdahc.org
Health & Human Services Hospital Compare www.hospitalcompare.hhs.gov
Health Partners Quality Measurement www.healthpartners.com/portal/143.html
Joint Commission Quality Check www.qualitycheck.org
Leapfrog Group www.leapfroggroup.org/cp
Massachusetts Health Quality Partners www.mhqp.org
Minnesota Community Measurement www.mnhealthcare.org
National Committee for Quality Assurance www.ncqa.org
NY Health Accountability Foundation www.nyshaf.org/index/hmo_report_card
OR Assn of Hospitals & Health Systems Price Point www.orpricepoint.org
Premera Quality Scorecard www.premera.com (link in lower right corner)
Washington State Hospital Association www.wsha.org/page.cfm?ID=transparency
Wisconsin Collaborative for Health Care Quality www.wchq.org

22. Q: Why add another report? Will the other reports in the region go away?

A: The Community Checkup is the most comprehensive public report ever produced in this region, based on data compiled from 15 suppliers and reflecting care provided to about 1.6 million people in the region. With one report that is comprehensive and trusted (developed in the community by physicians, hospitals, employers, unions, consumers and health plans working together), over time there will be less value in creating competing reports.