

Aggregating Data for Public Reporting: The Experience of Community Alliances

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Constructing community reports that compare the performance of physicians and medical groups is a key component of the Aligning Forces for Quality (AF4Q) strategy to improve health care. In most communities this means moving from reports produced by individual health plans for distribution only to their members to a report that combines data from many different sources, including health plans, and is available to all community residents. Data aggregation—the combining of data from multiple different sources for the purpose of constructing performance measures—is a critical step in creating community reports. In this issue brief, we describe the manner in which AF4Q alliances are addressing three challenges to their data aggregation efforts: developing partnerships needed to carry out data aggregation activities, overcoming technical issues, and securing financing.

Background

Community reports have several advantages when compared to reports produced by health plans for their members. Because they are based on combined data from multiple sources, the measures in community reports are more reliable, and less subject to random variation, than the measures in health plan reports, which typically are based on far less data. Also, consumers and physicians may regard community reports as more trustworthy than reports produced by health plans, and therefore community reports may have a greater influence on decision-making with respect to choice of provider and allocation of resources for quality improvement. And, to the extent that community reports replace health plan reports, they

Aligning Forces for Quality

The Robert Wood Johnson Foundation (RWJF) is investing in efforts to improve health systems in 14 regions across the nation.

Called Aligning Forces for Quality (AF4Q), the initiative brings an unprecedented commitment of resources, expertise and training to turn proven health care reforms into real results at the community level.

The AF4Q initiative focuses on care provided in doctors' offices, clinics and hospitals and the support provided in the community. It also emphasizes reducing racial and ethnic disparities in care and strengthening nursing's role in improving quality. It advances three interrelated reforms that experts believe are essential to improving health care quality:

- **Performance measurement and public reporting**
- **Consumer engagement**
- **Quality improvement**

For more information about AF4Q, please visit

<http://www.rwjf.org/quality/quality/af4q/about.jsp>

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Background (continued)

can help rationalize the sometimes conflicting assessments of physician performance produced by different health plans. At the time that they were selected to participate in AF4Q, two communities already had produced public reports involving data aggregation (Minnesota Community Measurement (MNCM) and the Maine Health Management Coalition (MHMC)). For instance, Minnesota Community Measurement has produced an annual medical group quality report since 2004, directed primarily at the treatment of chronic illness. In January, 2008, the Puget Sound Health Alliance (PSHA) published its first Community Check Up, building on work undertaken prior to being chosen as an AF4Q community. Two additional AF4Q organizations, The Greater Detroit Area Health Council and Better Health Greater Cleveland, now have also completed inaugural physician quality reports. The remainder of the AF4Q communities are currently in various stages of developing community reports.

Developing Partnerships

Claims data submitted to health plans by physicians have been the building blocks for community reports. Securing and maintaining the support of health plans can be difficult as the health plans compete against one another for business, often based on their ability to measure the quality of health care services delivered by their contracted providers. With the longest history of medical group quality reporting, MNCM was initially conceived by local health plans. MNCM continues to rely on the donated time of health plan staff to prepare data and financial support. To maintain the trust and support of its member health plans, MNCM delayed releasing its report when concerns arose regarding some of the data submitted by a health plan. Puget Sound also began its work towards medical group quality reporting by securing commitments on the part of health plans in the region to provide claims data for the report and financing to

Developing Partnerships (continued)

data. For Puget Sound and many other sites this process involved lengthy negotiations with health plan legal counsel concerned about sharing confidential patient health information as well as plan CEOs seeking to maintain a competitive advantage in the marketplace.

After securing data-sharing agreements with health plans, alliances then must decide how the data will be aggregated and performance measures calculated. Typically, this involves a contractual relationship with another entity. MNMCM works with a Minnesota analytics company, Data Intelligence, to aggregate data from participating health plans. Representatives for those plans meet regularly to determine a standard data submission format. PSHA engaged in a rigorous RFP process before selecting Milliman, an international consulting firm with expertise in developing quality reporting tools, as its partner for data aggregation and the calculation of measures. PSHA leadership considers Milliman's interactions with medical groups as crucial to the success of its reporting efforts. In producing the quality measures, Milliman interacts often with participating medical groups to validate data. Additionally, medical groups look to the aggregator for assurances that quality scores are being correctly calculated.

The P2 Collaborative of Western New York (P2) took a different approach to data aggregation.

P2 and its counterpart in the eastern part of the state jointly received a grant from the state to support the creation of a community quality report. Consequently, the two organizations together issued an RFP for a data aggregator and selected VIPS, Inc. a Maryland based health data management firm. The statewide approach to data aggregation is considered extremely important to Alliance leadership given the political climate in the state. After facing legal action from the New York State Attorney General, a number of health plans in the region have been compelled by the Attorney General, or voluntarily agreed, to suspend their public reporting efforts. Some of these plans also have discontinued support for community wide reporting efforts. The state reporting grant has insured that the three major health plans in Western NY continue to support P2's reporting efforts. P2 also elected to maintain staff to interact with health plans and providers in the community. It desired to retain control over developing and maintaining the positive relationships with plans and providers necessary to produce quality reporting. P2 plans to maintain project management (and some data analysis) and liaisons to health plan as well as providers. VIPS will aggregate the data supplied by the health plans and work with P2 to calculate quality measures.

Addressing Technical Issues

The credibility of physician quality reports depends on the quality (and amount) of patient data as well as the accuracy of measurement calculations. Each supplier may collect, calculate, and format data differently, and the data aggregator must minimize or eliminate those differences in calculating final physician ratings. In Puget Sound, for example, commercial health plans and administrators for self-insured employers provided the data for the report. MNCM reports include data from private and public managed care programs, in the state. The joint P2/New York Quality Alliance (NYQA) will involve integrating commercial health plan claims data and Medicare claims data. P2 is also negotiating with local Medicaid managed care plans to include that data in the planned quality report. Medicare and Medicaid fee for service data submissions may differ significantly from commercial health plan data in both format and content. Health plans also often contract out data services to consulting or analytics companies adding an additional level of complexity to the process. Data aggregators in all cases work with data suppliers, and any parties participating in the data, to insure that data supplied is thorough and correct.

The amount of data provided by health plans, and the ability of the aggregator to combine that data with other sources, can impact the types of measures an organization may use in quality reporting and the level of reporting. In some AF4Q communities, health plans have

agreed to provide summary data only. Those plans will produce clinic or group scores adequate for producing reports of overall clinic or group quality, but summary level data will not provide information necessary to calculate quality scores at the individual physician level. Additionally, some plans and or larger physician groups are able to provide laboratory results. Without that data an organization may only report process measures, for example whether a physician ordered a blood sugar test, but not outcomes measures like whether the patient's blood sugar test results indicate that the diabetes is being well managed.

In addition, linking patient specific data to the proper physician, especially across data sources, is often difficult. For example, a diabetic patient may be assigned to a particular primary care physician under a managed care plan, but may actually see a specialist for diabetes care or eye care. Puget Sound's aggregator has worked with physicians to review this physician attribution. **"There is a level of work that the clinics do to help us increase the credibility of the data... to make sure that the provider lists are as clean as we would like them to be. That was one of the toughest things in the first report...14 different data suppliers and trying to make sure that you have the right provider identified. It just takes a lot of re-work."** (Puget Sound -Margaret Stanley p 8 2/12/08) By interacting directly with Milliman, medical groups in Seattle may have greater confidence that their data is being correctly handled.

Financing

Data aggregation activities can be costly. A substantial amount of the cost is borne by health plans through in-kind contributions of staff time to prepare data for submission. Staff contributions can be significant. Representatives from plans participating in the MNCM report, for example, meet twice monthly to discuss issues and procedures relating to data aggregation. Funds are also needed to pay for the expenses incurred by the contracted data aggregator. The NYS DOH grant awarded to P2 provided funding for data aggregation services through the completion of the first public report in 2009. The Alliance has begun negotiations with health plans to secure ongoing funding for data aggregation services to be initiated when the grant expires. Puget Sound's quality reporting is funded primarily through contributions of its members, though King County provided the initial funding for the effort. Likewise, MNCM reporting staff and efforts are funded by the organization's members as well as grants. All three organizations also have received grants from the Robert Wood Johnson Foundation to support public reporting as well as consumer engagement and quality improvement work. The Alliances believe that they must continue to make a strong business case to the health plans and other organizations involved in funding reporting efforts.

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Summary

The aggregation of health plan claims data has been an essential step to the production of community reports. It requires that partnerships be developed and maintained with health plans and outside vendors, that technical issues (especially in assigning patients to specific physicians for the calculation of measures) be addressed on an ongoing basis, and that funding be secured and maintained over time. While reliance on claims data from multiple sources is likely to continue in the near future, some alliances have initiated, or are considering, efforts to

Summary (continued)

bypass health plan claims data by collecting information directly from medical groups. This expands the number and type of measures available for public reports, but imposes costs on physicians, especially when electronic records are not part of physician practices. Even where electronic records are available, construction of some measures may depend on information most likely to be found as part of a physician note.

This report was prepared by the Aligning Forces for Quality Evaluation Team at Penn State University's Center for Health Care and Policy Research which is studying the AF4Q initiative to gain insights about community-based reform that can guide health care practice and policy. The AF4Q Evaluation Team presents periodic issue briefs on key findings and policy lessons gleaned from its ongoing mixed-method evaluation of the AF4Q program.

For more information about the AF4Q Evaluation Team -

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