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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 first Community Checkup contains 21 measures addressing diabetes, heart disease, low back pain, depression, the use of generic pharmaceuticals, and preventive services. All of the measures are based on extensive work done 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. As the Community Checkup is updated over time, other measures will be added.

From October 2006 through January 2007, the Alliance circulated the proposed list of measures throughout the community and received feedback from hundreds of physicians, in addition to consumers, employers, health plans and others. Staff and committees reviewed the input, made a few adjustments, and in April 2007, the Alliance Board approved this first set of measures. For a list of the measures, see [www.pugetsoundhealthalliance.org/documents/AmbulatoryMeasures-ClinicalDescription012407.pdf](http://www.pugetsoundhealthalliance.org/documents/AmbulatoryMeasures-ClinicalDescription012407.pdf).

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

**A:** No benchmarks or specific goals have been established for this first Community Checkup. It is not reasonable to expect 100% compliance with any measure, as there are valid reasons why care for certain patients may need to differ from what is being measured. 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.

**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 includes care provided by primary care providers and by specialists.

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**About the Data in the Community Checkup**

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**4. Q: What data is included in the Community Checkup?**

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

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

The Community Checkup uses insurance claims data to measure aspects of care. The data being provided is “de-identified”, meaning that it does not include any information that identifies individual patients, such as name and address. Combined, the data reflect about 65% of the insured, non-Medicare population in King, Kitsap, Pierce, Snohomish and Thurston counties.

**5. 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 (blinded). They also received all results for individual clinicians within their clinic system (but no others).

**6. 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 which 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 possibly patient experience surveys. Currently, much of that information is inaccessible because it is trapped in paper, rather than electronic, files.

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

**A:** Claims data reflect information submitted by providers to payers as a part of the billing process. While not all medical care shows up in billing data, it does include quite a bit of information about diagnoses and services provided. Using claims data, for example, one can measure ‘care processes’ such as “What percentage of patients with diabetes were given an HbA1c test at least once during the measurement year?” In the first Community Checkup, all of the measures address specific elements of care provided. None of the measures consider the cost or payment for that care. (In fact, no data on cost, charges or payment was included in the information submitted to the Alliance for use in creating the report.) In the future, the Community Checkup will include efficiency or resource use measures, after the Alliance Board determines the best way to do that.

**8. 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, using claims data is not perfect. 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 in a clinic’s denominator 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.

**9. 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 aggregated medical records and charts; however, too many clinics, hospitals and other facilities still use paper records (making aggregation of a high volume of that data across the region virtually impossible). Increasingly, clinics and hospitals are using software to efficiently track care provided to all of their patients, including reminders for patients and providers when it is time for certain services. Not only can this help doctors improve the consistency with which they provide effective care to patients, the data can be analyzed across the entire patient population for use in quality improvement programs. 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.

**10. Q: Are the results in the first 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 only spans three years. Overtime, as more data is 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 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 and 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.

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

**A:** The data used for the first report reflect care provided between January 2004 through December 2006. Over time, the report will be updated with more current data.

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

**A:** All of the results are shown as a "range" with a mid-point, calculated using a 95% confidence interval. The minimum sample size for the Community Checkup is 250 patients for clinics with six or more clinicians (if this minimum threshold is not met, results are not shown in the report). Based on feedback from physician leaders who asked to receive all data, each clinic has received all of the results associated with their own clinic, regardless of minimum sample size.

**13. 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.

**14. Q: How will physicians be able to validate that the data being used to rate their clinic is based on patients who are actually their patients?**

**A:** The Alliance understands that physicians want to be able to verify which patients whose care is reflected in the results in the Community Checkup. Alliance staff continue to work with clinic systems, health plans and other data suppliers to explore options for patient verification; however, as long as the data collected by the Alliance does not include any "patient identifiers" this will continue to be a challenge. As an interim step, three of the volunteer clinic systems worked with one of the large data suppliers to verify that the patients whose data is in the first report were indeed the patients of that clinic system in a pilot patient verification program.

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

**A:** The first Community Checkup measures “processes of care” which 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 “outcome measures” are added to the Community Checkup, the Alliance is committed to applying an appropriate risk adjustment.

**About How the Report Will be Used**

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**16. Q: How is the data in the Community Checkup actionable for clinics?**

**A:** All clinics and medical practices for whom results are included in the first report received 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.

In addition, all clinics and practice locations can use the list of measures to focus on care processes to improve, even if the clinic’s results aren’t yet shown in the report. A tool for quality improvement that can be used within a practice setting is software called a “registry” —either paper-based or electronic. Registries can be used by health care providers to track their patients with certain health conditions (including sending reminders when patients are due for certain services) while supporting more consistency in providing effective care to specific groups of patients, such as those with diabetes or other chronic conditions.

**17. Q: What if patients don’t comply with physician’s 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 keeping people as healthy as possible, especially 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 to do their part to improve personal health and comply with their doctor’s advice.

**18. 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 can be used to 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.

**19. 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 the first report, which only includes results at the clinic location and clinic-system levels. For the first two reports produced by the Alliance, no one is allowed to use the reports for business purposes, including establishing networks, negotiating contracts or marketing.

**20. Q: How will the Community Checkup be used by patients?**

**A:** The Alliance is using this Community Checkup to encourage patients to be more aware of the variation of care that exists in the region, then to discuss with their physicians the elements of care that are applicable to their own care. The first Community Checkup shows only clinic-level results, so patients will not see comparative results for individual physicians.

**About How the Report Fits with Other Health Care Improvement Efforts**

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**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](http://www.opa.ca.gov)  
Greater Detroit Area Health Council [www.gdahc.org](http://www.gdahc.org)  
Health & Human Services Hospital Compare [www.hospitalcompare.hhs.gov](http://www.hospitalcompare.hhs.gov)  
Health Partners Quality Measurement [www.healthpartners.com/portal/143.html](http://www.healthpartners.com/portal/143.html)  
Health Scope (CA Health Care Quality Ratings) [www.healthscope.org](http://www.healthscope.org)  
JCAHO Quality Check [www.qualitycheck.org](http://www.qualitycheck.org)  
Leapfrog Group [www.leapfroggroup.org/cp](http://www.leapfroggroup.org/cp)  
Massachusetts Health Quality Partners [www.mhqp.org](http://www.mhqp.org)  
Minnesota Community Measurement [www.mnhealthcare.org](http://www.mnhealthcare.org)  
National Committee for Quality Assurance [www.ncqa.org](http://www.ncqa.org)  
NY Health Accountability Foundation [www.nyshaf.org/index/hmo\\_report\\_card](http://www.nyshaf.org/index/hmo_report_card)  
OR Assn of Hospitals & Health Systems Price Point [www.orpricepoint.org](http://www.orpricepoint.org)  
Premera Quality Scorecard [www.premera.com](http://www.premera.com) (link in lower right corner)  
Washington State Hospital Association [www.wsha.org/page.cfm?ID=transparency](http://www.wsha.org/page.cfm?ID=transparency)  
Wisconsin Collaborative for Health Care Quality [www.wchq.org](http://www.wchq.org)

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

**A:** The Community Checkup is the most comprehensive public report ever produced in this region, based on data compiled from 14 suppliers and reflecting care provided to about 1.6 million people in the region. By creating 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.