

Health Care Accountability

Data Collecting and Reporting



Indiana Hospital & Health Association

Introduction

Purchasers of health care, both private and public, and policymakers are demanding information concerning the cost and quality of health care. The accountability of health care providers in terms of the quality and cost of the services provided is escalating. The Indiana Hospital Association has taken a proactive role in collecting data that enables participating members to develop a comprehensive database that can be used to demonstrate the value of their services.

IHA believes that all parties involved in health care transactions have a responsibility to understand quality, utilization, cost, and outcomes of health care services. Toward that end, IHA has led the development of joint data initiatives with the Indiana State Medical Association and the Indiana State Department of Health. Joint data initiatives are designed to improve the quality and quantity of data available for clinical decision-making and for public education.

Collection of vast amounts of data with minimal significance can, however, be counterproductive to the goal of increasing both member and public understanding. IHA is working with multiple parties to ensure that efforts on data collection and reporting remain useful and appropriate. As data systems that generate information about the value of health care services emerge, including the Association's databases, the external reporting of that information is inevitable and numerous issues surrounding that reporting need to be examined.

While many releases of aggregated hospital information have been conducted around the state, employer coalitions are now demanding provider-specific data from local hospitals. Policymakers, purchasers, and the media are requesting specific, detailed information from the Indiana State Department of Health. Entrepreneurs are repackaging public databases, such as CMS' Medicare billing and cost report files, for resale to the public. The CMS Hospital Compare data can be readily downloaded from the Internet for further manipulation. Rapid advances in information technology permit electronic public access to data. This environment raises many issues, such as adequate protections for patient confidentiality.

The overall purpose of this policy is to provide local health organizations and other entities with a set of guiding principles and suggestions about the release of information to policymakers, purchasers of health care, and others.

Types of Information and Appropriate Uses

IHA is committed to helping its members acquire and disseminate information that demonstrates “value” in health care. Value can generally be defined as a balance between the outcomes of care, the resources consumed to provide that care, and the patients’ perception of care. One objective of this policy, and any information release, is to enhance understanding of the relationships among clinical outcomes, utilization behaviors, and health care expenditures. There are essentially four types of information needed to demonstrate value:

Financial -- Comparative patient-level information on charges (prices) by diagnosis or procedure, and adjusted for acuity, is the minimal financial dataset. Stakeholders also need information on standard financial indicators (e.g., payment shortfalls, payer mix, productivity, efficiency, solvency, etc.) to put the pricing structure in context.

Utilization -- Information is needed on how health care is utilized, and by whom. Use rates by diagnosis and procedure can be calculated, and variations by age, sex, geographic region, or provider can be determined.

Quality – Databases should track and compare clinical indicators of medical quality. Usefulness of data may be increased when coupled with longitudinal studies of patient functional status following medical intervention.

Patient Perception – Patients’ perceptions of the health care experience should also be measured as an indicator of value.

When taken together, such databases can be invaluable for:

- Examining the potential impact of delivery system or financing changes upon access to and utilization of care.
- Monitoring, improving, and reporting clinical performance.
- Managing resource consumption.
- Studying the incidence of disease and identifying the opportunities for public education and preventive interventions.
- Planning and developing new, cost-effective alignments among stakeholders.
- Choosing a provider.
- Meeting purchasers’ or regulators’ varying information requests.

IHA is committed to having the strongest voluntary databases in the U.S. addressing cost, utilization, and quality.

Desirable Features of a Health Care Database

IHA, in developing its databases, has benefited from the professional and scientific insight of the clinicians and managers working in our member institutions. We believe the guidelines they established for IHA can serve others well as they assess additional databases for external accountability. Databases should be tested for the following features:

Accuracy. The data are factual. Edit checks are made to detect errors, and identified errors are corrected.

Uniformity. Data elements are clearly defined and specific enough to insure comparability. Whenever possible, the information is generated with nationally accepted, standardized definitions and formulas.

Timeliness. The data are collected and reported in a time frame sufficient to assure their usefulness. The data are trended over time, to help identify patterns.

Validity. Data are abstracted from the most appropriate source.

Severity adjustment. The data are adjusted to reflect the severity of illness or acuity of the patient. The severity adjustment system is developed by physicians and other health professionals. It is clinically relevant to the patient population in question. It is endorsed by others. The methodology is open to review.

Significance. There are sufficient data to guarantee statistical significance and reliability.

Utility. The data are useful. They raise appropriate questions. They clarify, illuminate, and/or educate. They increase knowledge.

Patient confidentiality. The database developer provides absolute protection of patients' identities. Safeguards are in place to assure that no user may abridge the right of individual privacy.

Acceptability. Other stakeholders participated in defining the data elements. Stakeholders endorse it and use it.

Comparative information. Comparative information is available from other regional and/or national databases.

Public Disclosure of Provider Data

Purchasers and the public are searching for credible descriptive information on costs and quality of hospitals, physicians, and other providers. Providers and other interested parties are seeking provider-specific data for the purposes of controlling costs and improving the quality of health care. It is imperative that hospitals and physicians take a leadership role in releasing such information.

The public interest is considerably served when society has information on cost, quality, and access to health care that is accurate, timely, and useful. Emphasis should be on demonstrating value, performance improvement, and on improving individual and community health status. Education should be a primary purpose of data release.

The Association recommends the following principles be applied to any release or disclosure of provider-specific information.

- **Participation Should Be Voluntary**
The pressures of the marketplace, rather than the law, should lead providers and other data generators to share information. Each provider should make the decision to release his or her data based upon the perceived public or economic good it will serve. As active participants in a release, all interested parties can assure that data are useful and understandable.
- **Stakeholders Should Define the Scope of Release**
Providers should collaborate with other stakeholders in defining what should be measured, how it should be reported, and what clinical issues are relevant. All parties have a responsibility to assure the accuracy and validity of the databases used, as well as the interpretation and use of the data.
- **Data Must Be Put in Perspective**
No two patients or their medical conditions are identical, nor are the resources which must be expended to provide care or service. Therefore, whenever possible, data should be adjusted for patient acuity, and providers should be compared with those peers whose patient mix and operational characteristics are most similar. Providers should have an adequate opportunity to review and comment on data to be released about them, and the public should have access to their perspectives on the data. Purchasers must recognize that even adjusted data do not account for all unique variations in patient populations.
- **Data Releases Should Promote Dialogue**
The most useful data releases are those that take place at the local level, where care is provided. It should be part of an ongoing educational activity between providers and their key constituencies -- patients, purchasers, and partners in improving community health. Releases by third parties (regulators, accrediting

bodies, researchers, etc.) usually lack sufficient local context and are subject to misinterpretation. Participants should publicize their own information in comparison to relevant norms and standards and refrain from direct comparisons with individual hospitals for marketing and promotion purposes.

- **Limitations Should Be Delineated**

The releaser of information has a duty to make clear the limits of one's ability to draw conclusions about quality of care beyond the conditions and circumstances reported for analysis. Inferences about one aspect of care cannot always be successfully drawn from data about another facet of the process.

- **The Data Repository Should Make No Claims or Judgments**

To maintain credibility as a public resource, data repositories should present information with comparisons to relevant norms and standards. Unlike commercial rating and reporting services, the releasing data repository should not rank hospitals or otherwise make judgments about organizational performance.

The Roles of the Association

The members of IHA are firmly committed to improving the quantity and quality of information available for clinical management, purchasing, and policy purposes. Full participation by all hospitals is encouraged to ensure complete information is available to members and other interested parties. Toward that end, the Association has set forth the following requirements for its own data initiatives:

Information and Knowledge Management

Databases must be accurate, timely, valid, complete, significant, useful, severity-adjusted and must advance knowledge.

Information should be useful for members to improve community health, manage health resources, and improve clinical quality. Usefulness of data is enhanced by benchmarking. Benchmarking refers to both review of best practices and performance for similar activities. Benchmarks are one form of comparative data.

Comparative data also includes review of similar organizations. Review of comparative data allows for an organization to determine their relative performance and prioritize improvement opportunities. By providing transparency of results, members may compare their performance and benchmark across the state in order to achieve improved patient outcomes.

Mechanisms should be in place to assist members in the release of their information to constituencies. The decisions on when and what to release at the local level are made by members. Staff is to provide and analyze the data and, upon request, help explain the databases to local publics.

Reports must advance the members' interests in public policy formation. The Association may, from time to time, use aggregate and institution-specific data to illustrate the potential impact of public policy changes upon the Indiana marketplace.

Plans and strategies must continually be developed for linking health care data across the continuum of care.

Safeguards

Policies and practices must be in place to assure confidentiality of patients' records and uphold their right of privacy. The Association believes that public records laws should explicitly prohibit access to information that may in any manner disclose the identity of an individual patient.

Policies must protect membership from antitrust implications of data sharing. Current anti-trust standards caution against release of provider-specific financial comparative data that are less than 90 days old, with a six-month minimum lag time preferred.

Procedures for using databases for quality assessment and peer review analysis must ensure the peer review evaluations remain confidential.

Partnerships

Initiatives to involve other stakeholders in the voluntary release of health care data must continue to be advanced. IHA has already developed joint data projects with the Indiana State Medical Association and the Indiana State Department of Health. This work should contribute to the development of a statewide health data center, integrating information from various contributing databases.

A concerted effort must be made to educate information recipients, in tandem with other interested parties, on the fair use and possible abuse of health data. Association staff is available to all members releasing data to help explain how the data may be used for better decision-making.

Bibliography

American Medical Association, "Physician Profiling and the Release of Physician-Specific Health Care Data: A Summary of American Medical Association Policy," 1994.

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