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Five Guidelines for Provider Data Management

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This article is the second in a series about provider data quality. Click here *to read the first article titled, "Why Provider Data Quality Matters."* The majority of healthcare provider data today is fraught with inaccurate or duplicate information, causing a multitude of issues for claims organizations, notably workflow inefficiencies and suboptimal outcomes. An accurate provider database can help to improve efficiencies, but managing provider information is more difficult than it may seem on the surface. The healthcare industry spends $2.1 billion each year trying to maintain accurate and current provider databases, according to CAHQ. In order to maintain a pristine provider database, claims organizations need to not only improve the data they currently have but also create a scalable and sustainable approach to managing provider data in the future. Here are five guidelines every provider data program should consider, whether a claims organization is implementing the project on its own or partnering with a vendor.

1. Create a Single Source of Truth for Provider Data

In approaching the provider data management program, a claims organization or the vendor it chooses to outsource the program to should institute and maintain a single source of truth for that data. This single source should maintain the provider data's underlying historical integrity and be able to show the data as it was at any moment in time. In a way, the source provider data with all of its deficiencies is itself a part of this single source of truth. From a myriad of perspectives, chief among them being compliance, this is an important acceptance criteria for the program.

2. Augment Source Provider Data

A provider management program should both identify and supplement missing, incorrect or inaccurate data elements, including demographic, facility and organizational information (first and last name, provider specialty, Taxpayer Identification Number (TIN) and more) using the established single source of truth.

3. Identify and Solve for Duplicate Provider Records

One of the most important features of a provider data management program is that it addresses the duplicate provider records found in the database. Duplicate records could appear in a couple of ways—either multiple records with exact matches in the majority of data elements except one or two, or records that have subtle differences across the span of data elements but that actually represent the same provider. In order to have an accurate and "clean" provider database, it's important to resolve both types of duplicate data issues.

4. Take a Sustainable and Scalable Approach

It is important to underscore that "cleaning up" a provider database is much more than a one-time project—claims organizations should be managing their provider data on an ongoing basis. By staying on top of data quality issues, companies can use that data to help improve decision making and claim outcomes on a daily basis.

5. Integrate Transformed Provider Data into the Claims Workflow

The ultimate goal of any provider data management program should be to propel the claims workflow with the data-driven insights and analytics supported by enhanced provider information. For example, companies could embed provider analytics into their workflow to help appropriately triage claims with complex provider behavior, like upcoding, to the right adjuster. By including provider data and analytics into the claims workflow, claims teams can equip their adjusters with the appropriate context and information at the right time to help them make informed decisions. As claims organizations embark on the path of provider data management, it's important that they follow the five guidelines above in order to improve workflows and see improved outcomes. In the next article in the series, we will explain what types of workflow and organizational improvements companies can make once they've put a data management solution into place.

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