Utah Health Data Committee

Biennial Report

2008

Utah Code Title 26 Chapter 33a
Utah Health Data Authority Act
Enacted 1990

**Office of Health Care Statistics
Center for Health Data
Utah Department of Health**

Salt Lake City, Utah
Released: January 2009

For more information, contact:

Utah Department of Health
Center for Health Data
Office of Health Care Statistics
PO Box 144004
Salt Lake City, UT 84114-4004
Phone: (801) 538-7048
Fax: (801) 538-9916
Email: healthcarestat@utah.gov
Web address: http://health.utah.gov/hda

This report is available online at:

http://health.utah.gov/hda/Reports/biennial2008.pdf

Utah Health Data Committee

Biennial Report

2008

Utah Code Title 26 Chapter 33a
Utah Health Data Authority Act
Enacted 1990

Office of Health Care Statistics
Center for Health Data
Utah Department of Health
288 N 1460 W
Salt Lake City, Utah 84116-4004
Voice: (801) 538-7048
Fax: (801) 538-9916
http://health.utah.gov/hda

Clark Hinckley, Chair
Large Business
Zions Bancorporation

Robert P. Huefner, Vice-Chair

Kim Bateman
Physicians
DirectMD and
HealthInsight

Terry Haven
Consumer Advocacy
Utah Children

MISSION STATEMENT

The mission of the Utah Health Data Committee is to support health improvement initiatives through the collection, analysis, and public release of health care information.

Through public-private collaboration, the Committee will participate in the development and implementation of a statewide health data reporting system capable of providing accurate and independently validated information in a timely way.

The committee will implement policies to transform data into objective baseline, trend, and performance measurement information which will be made available to all legitimate users without compromising patient privacy and confidentiality.

Adopted 1994, Amended 2002

David Call
Third Party Payer
Deseret Mutual Benefit
Administrators

Kevin Martin
Nursing
Shriners Hospital

Leslie Francis
Public Health
University of Utah

Jim Wall
Business
Deseret News

Douglas Hasbrouck
HMO
Regence BlueCross/
BlueShield

Greg Poulsen
Hospital
Intermountain HealthCare

Gary Nordoff
Public Interest
Urban Chase Property
Management

Pending
senate
confirma-
tion

Consumer Advocacy

Stephen Kroes
Small Business

> *"The Health Data Committee has been a conscientious and respected steward of health care data affecting the lives of Utahans for over twenty years."*
>
> Clark Hinckley, HDC Chair 2002-2008
>
> *"HDC work over the past two years has received noteworthy acknowledgment from payers, providers, legislators and the general public. I believe this recognizes the meticulous care taken by our staff when preparing health care data for dissemination statewide and at a national level. "*
>
> Bob Huefner, HDC Vice-Chair 2002-2008

Promote ▪ Prevent ▪ Protect Utah
Department of Health

Judy Ann Buffmire
Consumer Advocacy
Former Utah Legislator

Marilyn Tang
Business
Certified Handling

Gail McGuill
Nursing
Utah Valley Regional

Executive Director's Office, Utah Department of Health

David N. Sundwall, M.D.	Executive Director
Richard Melton, Dr.PH	Deputy Director
Allen Korhonen	Deputy Director
Barry Nangle, Ph.D.	Director, Center for Health Data

Office of Health Care Statistics Staff

As of December, 2008:

Keely Cofrin Allen	Director
Mark Gaskill	APD Project Manager
Jamie Martell	Support Services Coordinator
Mike Martin	Research Consultant II
Carol Masheter	Epidemiologist II
John Morgan	IT Programmer Analyst III (DTS)
Lori Savoie	Web Developer I
Sam Vanous	HMO Program Manager

Former Staff Who Contributed During the Reporting Period:

Wu Xu	Director, Office of Public Health Informatics

Introduction

Part I. Program Profile and Performance Report

Part II. Utah Health Data Plan Update

Part III. Appendices

The Utah Health Data Committee (HDC) is proud to submit this biennial report to the Governor and the Utah State Legislature to highlight its accomplishments in 2007-2008 and planning for the next two years. It has been a two-year period of transition and growth for the Office of Health Care Statistics (OHCS). In June of 2008, Wu Xu moved from OHCS to the newly-formed Office of Public Health Informatics after providing visionary leadership for six and a half years. Keely Cofrin Allen assumed the position of OHCS director after 3 years with OHCS. Three additional staff members have joined the team: Sam Vanous in the position of HMO Health Program Manager, Mark Gaskill as the new All Payer Database project manager, and Jamie Martell as the new Support Services Coordinator.

This year marked a significant achievement in the history of the OHCS. The 2008 legislature appropriated $615,000 of on-going funding to launch a new project that will significantly improve the depth and breadth of health care system reporting in Utah. Starting in 2009, Utah will be the first in the nation to analyze episodes of care derived from statewide health insurance claims. The All Payer Database (APD) will collect claims data from all of the major payers in the state and will allow reporting on approximately 85-90% of all covered lives in Utah. For the first time, it will be possible to report on the actual cost of an entire course of care: cost to the health plan as well as out-of-pocket costs to the consumer.

Work on this new project was accompanied by expansion and improvement of existing projects within OHCS. The 2005 State Legislature unanimously passed SB132 requiring the HDC to publish annual reports that compare hospitals in the areas of charges, quality, and patient safety. In addition to producing five updated consumer-friendly reports on topics such as maternity, cardiac, orthopedic, and pneumonia, two new facility comparison reports were released during the reporting period: gallbladder removal and stroke. The gallbladder removal report marked the first time that outpatient facility encounters were included in the SB132 reports. The stroke report reflects the growing emphasis on stroke prevention and treatment by the Utah Department of Health.

The past two years also marked a time of partnership building for the Health Data Committee. The US Department of Health and Human Services created 14 new Chartered Value Exchanges in 2008. These multi-stakeholder organizations were recognized for having taken clear action in their communities to convene industry stakeholders to advance value-driven healthcare. Utah formed the Partnership for Value-Driven Healthcare (UPV) which includes several staff from the Utah Department of Health. The Health Data Committee is developing a comprehensive agreement with the UPV that will allow data sharing and cooperative work on transparency projects. A second important partnership is with the Health Reform Task Force. This legislative body was created by HB133 (2008) and oversees a variety of subcommittees working on aspects of health care reform in Utah. The OHCS director serves as one of several executive lead that reports to the Governor's Health Policy advisor.

The next two years will bring new challenges and new opportunities. Stakeholders from the federal level all the way through the state and local level are identifying health care as a critical issue for the nation. The Utah Health Data Committee is poised to provide needed information on health care facilities, providers, health plans, and systems. By combining existing programs with the new all payer database, Utah will remain a leader in health care analysis and reporting.

The Health Data Committee's (HDC) Responsibilities and Operation:

The Health Data Authority Act (§26-33a) was enacted in 1990 and established the HDC. The committee directs a statewide effort to collect, analyze, and distribute health care data to facilitate the promotion and accessibility of quality and cost-effective health care and to facilitate interaction among those with concern for health care issues.

HDC oversees the Office of Health Care Statistics (OHCS) to implement ten administrative rules and manage reported health data from 51 hospitals, 62 ambulatory surgical centers, 41 emergency departments, 5 commercial HMOs and 6 Medicaid or Children's Health Insurance Program-contracted health plans. HDC/OHCS has produced many publications, data products, web systems to meet the needs of health care providers, purchasers, payers, public programs, policy-makers, consumers, patients and families in Utah since 1992.

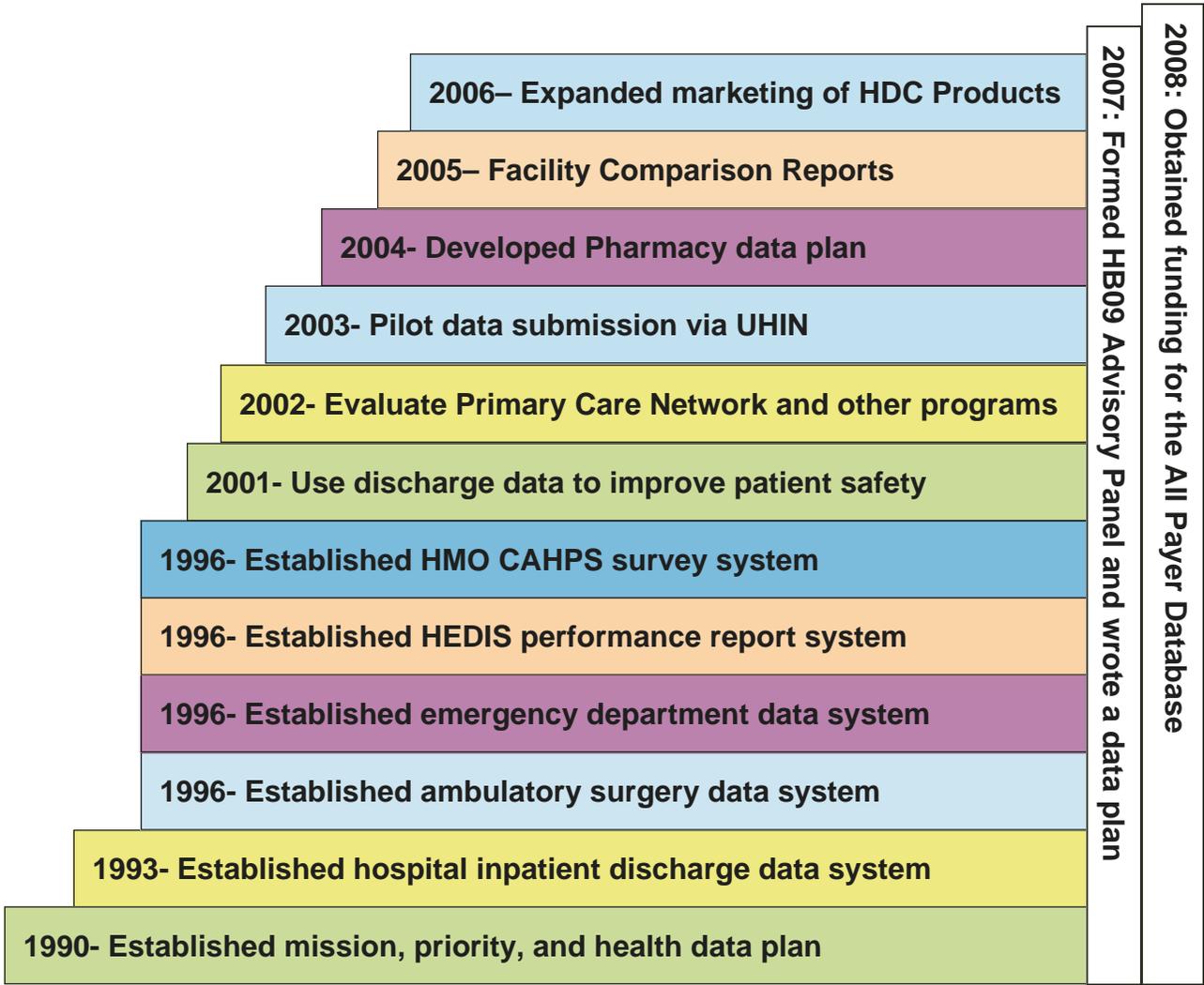### Highlights of HDC New Major Achievements From 2006 to 2008

♦ Completed the mandate set by HB09 (2007) to develop a health data plan for the development of an all payer database. Approved health data plan in July 2008. Began work on the APD in summer 2008 with major purchases and planning completed by the end of the year.

♦ Released Challenges in Utah's Health Care report in June 2007.

♦ Successfully completed a disenrollment survey for the Children's Health Insurance Program (CHIP).

♦ Completed a strategic evaluation of Health Data Committee consumer reporting using targeted focus groups from around the state.

♦ Released five new facility comparison reports and developed two new topics: gall bladder removal (using outpatient data) and stroke.

♦ Released two HMO comparison reports on five commercial HMOs, four Medicaid health plans and two CHIP HMOs. Conducted consumer satisfaction survey on the Primary Care Network plan (PCN).

♦ Improved marketing of HDC products to include promotion on two major Utah websites, six press releases and one news advisory.

♦ Continued to expand the reach of the consumer website MyHealthcare in Utah. The site received 73,072 visits between 2006 and 2008; with a 17% increase in visits during this period.

HDC Priority Projects For 2009 and 2010

1. Launch of All Payer Database analysis and reporting

2. Report on Potentially Preventable Readmissions (PPRs) in Utah hospitals

3. Report on consumer satisfaction with Preferred Provider Organizations (PPOs)

4. Update submission specifications for facility datasets

5. Develop and launch a secure upload for facility data submission

1990 to 2006:
The Health Data Committee built twelve milestones for Utah's statewide health care information network.

2007 to 2008:
The Committee expands its reporting to include an All Payer Database for Statewide transparency efforts
(See Part II: Health Data Plan Update)

2006– Expanded marketing of HDC Products

2005– Facility Comparison Reports

2004- Developed Pharmacy data plan

2003- Pilot data submission via UHIN

2002- Evaluate Primary Care Network and other programs

2001- Use discharge data to improve patient safety

1996- Established HMO CAHPS survey system

1996- Established HEDIS performance report system

1996- Established emergency department data system

1996- Established ambulatory surgery data system

1993- Established hospital inpatient discharge data system

1990- Established mission, priority, and health data plan

2007: Formed HB09 Advisory Panel and wrote a data plan

2008: Obtained funding for the All Payer Database

1990

2008

Part I.

Program Profile & Performance Report

INSIDE THIS SECTION - PART I

All Payer Database Project

The Cost and Quality Data Project (House Bill 9), passed by the Utah Legislature in 2007, directed the Utah Health Data Committee (HDC) to create an advisory panel to study issues related to the development of an All Payer Database (APD) that would assist in the analysis of a variety of health care data in Utah. Over a nine-month period (August 07-May 08), a diverse panel of stakeholders developed a draft health data plan for this project. The plan, as outlined by House Bill 9, addressed the necessity of an All Payer Database, how it would be compiled, and how and by whom it would be used. On July 8, 2008, the HDC unani-mously approved the plan at its quarterly meeting

> *The All Payer Database will play an important role by providing consumers, business owners, and policymakers with the tools to make wise decisions.*"
>
> Rep. David Clark (R-Santa Clara), co-chair of the Health Reform Task Force

In order to finance the project, the 2008 Legislature appropriated $615,000 of on-going monies via House Bill 133, Health Care Reform. This bill passed with overwhelming support from both parties and now has become a major focus of health care reform in Utah. The Utah Depart-ment of Health Office of Health Care Statistics (OHCS) is currently responsible for building and managing the APD.

Health care insurance claims data will be submitted to the OHCS from insurance companies (payers) operating in Utah and then entered into the APD. These data will represent claims for medical, pharmacy, and laboratory services. Specifics surrounding how said data will be submitted and by whom will be outlined in an administrative rule to be issued by the Utah Department of Health. The administrative rule will be issued for public review in early 2009.

> "*Understanding the true cost of health care is critical for reform to move forward. Without it, it will be difficult to hold all stake holders, including consumers, accountable for better health outcomes and greater participation in health care decision making.*"
>
> Rep. David Litvack (D-Salt Lake), member of the Health Care Reform Task Force

The Utah APD will represent a rich and deep source of health care data. Other states have APDs however, **Utah is poised to become the first in the country to analyze episodes of care (EOC) derived from statewide health insurance claims.** An EOC is defined as a complete course of care from the initial diagnosis through treatment and follow-up. For example, in the context of maternity, the EOC would begin with the first prenatal visit and include all other visits, pharmacy claims, lab tests, special procedures, delivery and postpartum care of the mother.

By examining an EOC from start to finish, the real costs of health care can be compared, rather than the costs of its individual components, such as delivery alone. EOC analysis will help evaluate questions such as how limitations in access to health care may impact costs. For example, health professionals have long stressed the importance of prenatal care for healthy outcomes for mother and baby. An analysis based on EOC will allow the HDC to compare, among other things, the costs of caring for newborns whose mothers had limited or no prenatal care with those for newborns whose mothers had the recommended number of prenatal visits. EOC analysis is by no means limited to maternity care. For example, with respect to people with diabetes the cost savings associated with appropriate preventive care could be described in detail. Statewide EOC analysis across payers will yield a broad spectrum of data vital to public health, economic, and policy decision making.

All Payer Database Project

The APD will provide access to, and analysis of, Utah health care data capable of answering questions such as: What happened? When and where did it happen? How much did it cost? Who paid for what (including patient out of pocket costs)? What costs were not covered? Furthermore, the APD will assist the HDC compare health care cost efficiencies statewide. The APD will employ analytic software that provides sophisticated risk adjustment. That is, the costs associated with treating a specific condition in a sicker population will not be compared to treating the same condition in a less medically compromised population, thereby reducing or eliminating disparity in cost analysis and allowing more accurate comparisons.

An initial dataset containing payer data for 2007, 2008, and first quarter 2009 will be submitted to the OHCS in early to mid 2009. The OHCS anticipates this combined dataset will contain between 100-150 million records (claims). The APD will receive continuous claim submissions from payers following the initial data submission. The OHCS anticipates that the APD will receive between 50 and 65 million new claims annually. These claims will be submitted to the OHCS through the secure Utah Health Information Network (UHIN) using industry standard and uniform transaction formats. Many Utah payers currently process their claims transactions through UHIN. The OHCS has incorporated industry standard transaction formats and the UHIN network into the APD architecture to help reduce burden and minimize impact on payers required to submit data.

The OHCS has contracted with 3M Health Information Systems and Care Advantage, Inc. to provide analytic and dynamic querying tools to further strengthen Utah's APD. The OHCS will analyze the claims data using 3M Clinical Risk Grouping (CRG) software, allowing for classification and consideration of clinically meaningful risk adjustment and analysis. CRGs can be used to retrospectively analyze and predict future healthcare utilization trends and costs. These data are critical for health care reform efforts, promoting health care transparency, epidemiological analysis, and the study of financial and clinical efficiency in healthcare delivery. The 3M CRG grouping package will be supported by the Care Advantage RPNavigator which provides powerful dynamic querying capabilities. This tool will allow the OHCS to efficiently create custom queries along a broad spectrum of variables such as demographics, co-morbidities, individual EOCs, diagnosis or procedure codes, and cost breakdowns.

"*As a member of both the Health Data Committee and the Health System Reform Task Force, I have a front row seat to the way Utah is rising to the challenge of reforming its health care system. The term most commonly heard in the Task Force is 'consumerism'. There is a strong consensus that empowering consumers and allowing them to take more ownership of their health care will go a long way towards improving the system. A big part of consumerism is accurate and relevant data. That's where the All Payer Database becomes a vital part of health system reform. If we are going to give ownership of health care to consumers, we need to ensure they have accurate and relevant data upon which to base their decisions. I applaud the efforts to bring this information to the public and look forward to having accurate and relevant data at my fingertips that is as understandable as any article in an issue of Consumer Reports*."

Rep. Brad Daw (R-Orem), Member Health Data Committee and the Health System Reform Task Force

Management of Facility Encounter Databases

OHCS manages three statewide health care datasets: Hospital Inpatient Discharge Database, Emergency Department Encounter Database, and the Ambulatory Surgery Database. In total, these datasets contain over 11.5 million records from 1996 through 2006. These databases contain consolidated information on complete billing, medical diagnosis and procedure codes, personal characteristics describing a patient, the services received, and the charges billed for each inpatient stay, each emergency department encounter and each outpatient visit for a selected subset of ambulatory surgical procedures.

Hospital Inpatient Discharge Database: Administrative Rule R428-10 became effective December 1991, and mandated that all Utah licensed hospitals, both general acute care and specialty, report information on inpatient discharges. Since 1992, the Office of Health Care Statistics has collected a wealth of information from the 60 Utah hospitals which have submitted data. To date, some of these hospitals have closed or been renamed. In 2006, 48 hospitals submitted inpatient discharge data. These hospitals include 39 acute care facilities, three psychiatric facilities, five specialty hospitals, and the Veterans Administration Medical Center.

Ambulatory Surgery Database: Administrative Rule R428-11, which became effective in March of 1998, mandated that all Utah licensed hospital and freestanding ambulatory surgical facilities shall report information on selected ambulatory surgical procedures. However, voluntary reporting started on January 1, 1996. The Office of Health Care Statistics collected information from 64 Utah ambulatory surgery facilities in 2006. Of these 64 facilities, 43 were acute care hospitals while the remaining 21 were freestanding ambulatory surgical centers.

Emergency Department Encounter Database: Administrative Rule R426-1-7(I) mandates all licensed Utah hospitals to report information on emergency department patient encounters starting in 1996. Fourty eligible hospitals submitted data in every calendar quarter in 2006.

The OHCS makes its databases accessible to stakeholders through a variety of means: printed reports, consumer brochures, online query systems, and public-use datasets. In order to reach a broad audience, relieve staff of the burden of responding to data requests, and maximize utility of its data products, OHCS has taken advantage of Internet technology and was among the first state data agencies in the nation to implement a web-based data dissemination system. Reports using OHCS data are currently available online through the following systems:

- My Health Care in Utah (http://health.utah.gov/myhealthcare)
- Indicator-Based Information System for Public Health (IBIS-PH) (http://ibis.health.utah.gov/home/welcome.html)
- Health Information Internet Query (HI-IQ) System (http://health.utah.gov/hda/hi_iq/hi_iq.html)
- Utah Pricepoint System (http://utpricepoint.org)
- Agency for Healthcare Research and Quality HCUPnet (hcupnet.ahrq.gov)

The health care encounter data are made available to researchers through public datasets and research oriented datasets. In addition, OHCS is a partner in the National Healthcare Cost and Utilization Project (HCUP), a family of healthcare databases and related software tools and products developed through a Federal-State-industry partnership and sponsored by the Agency for Healthcare Research and Quality. The HCUP databases include the largest collection of longitudinal acute care hospital data in the United States, with all-payer, encounter-level information beginning in 1988.

Encounter Databases: Application

Monitor Facility Charges

Average Inpatient charges have steadily increased since 1996, however, its proportion to all facility charges has decreased from 82% in 1996 to 70% in 2006.

Average Total charges for ambulatory surgical procedures have experienced more than four-fold increase ($214M in 1996, $1,021M in 2006) during the reporting period, partially due to improved reporting.

Average Charges for emergency department (ED) visits among facilities have increased five-fold ($126M in 1996, $665M in 2006), which raise concerns about the reasons for increased ED visits.

Aggregate proportions of ambulatory (11% to 18%) and ED (7% to 12%) charges have increased since 1996.

Table 1. Average Total Facility Charges (in Millions of Dollars) by Type of Health Care Services Utah, 1996-2006
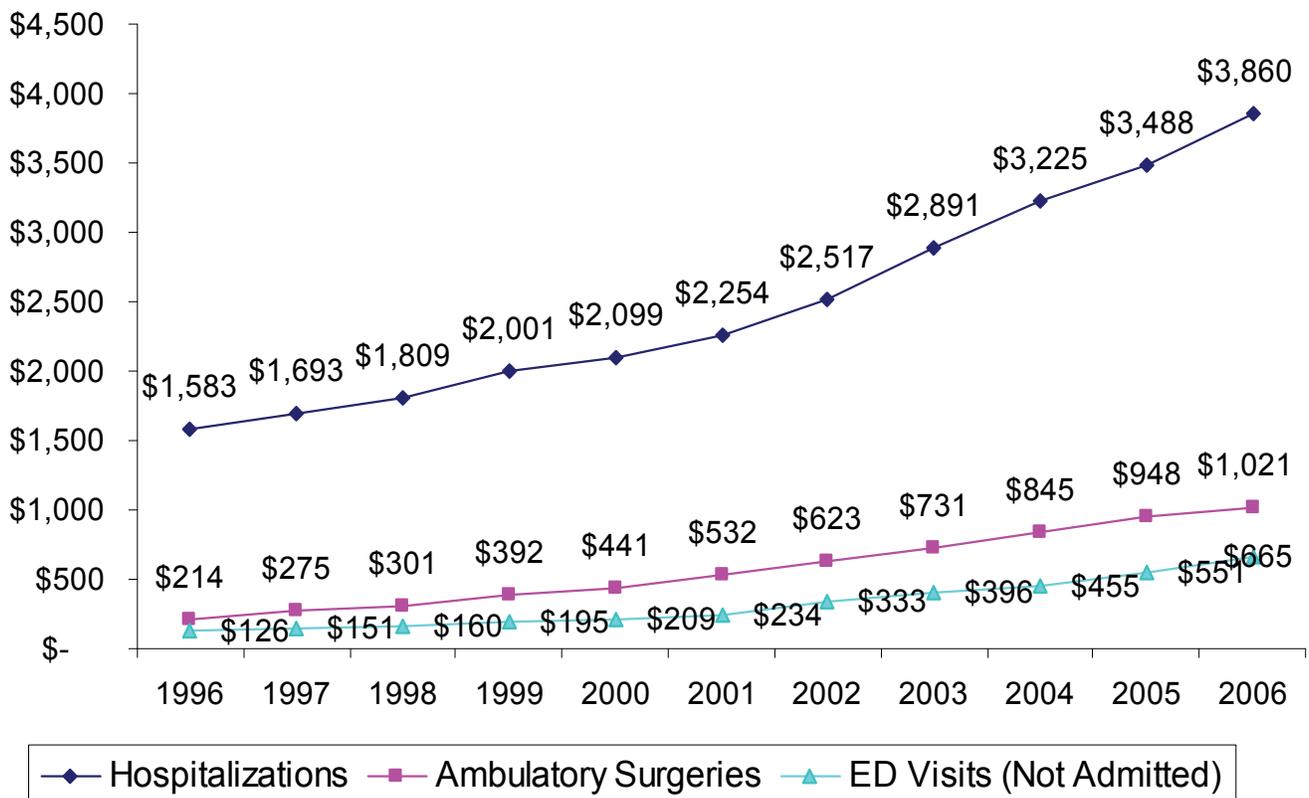
Measuring Health Plan Performance

The Utah Health Data Committee (HDC) continues to monitor the performance of commercial HMOs, Medicaid health plans, and CHIP HMOs. These findings are reported annually at the end of the year. In accordance with Administrative Rules 428-12 and 428-13, Utah's managed care organizations (MCOs) collect and report HEDIS to the Office of Health Care Statistics each year. The purpose of this monitoring is to provide important data to Utah's consumers, businesses, and other purchasers of health care about the state of health care quality in the state. The performance measurement system is comprised of two projects: the Health Plan Employer Data and Information Set (HEDIS) and the Consumer Assessment of Health Plans Survey (CAHPS).

The HEDIS dataset contains 68 quality of care measures across six domains. HEDIS measures health plans' performance quality on measures such as childhood immunizations, cancer screenings, and prenatal care. The data are collected from queries of the administrative datasets and by medical chart review.

The CAHPS survey monitors the quality of health care using mail and phone questionnaires administered to HMO enrollees by a licensed vendor. The survey measures satisfaction with different aspects of plan performance such as customer service, getting needed care, getting care quickly, helpfulness of doctor's office staff, overall ratings of the plan, health care quality, and personal doctor. CAHPS is administered to adults in odd-numbered years, and to caregivers of children in even-numbered years.

Results for 2007-2008

The 2007 report had some key findings. Commercial HMOs were meeting national averages for children's immunizations; adolescent immunizations, however, were well below national averages. Commercial HMOs were also below national averages on access to primary care providers for both children and adults. Medicaid HMOs were below national averages on adolescent and child well-care visits, but were above national averages for the ratings for physicians, specialists, health care, and health plans. CHIP HMOs were meeting national averages for children's immunizations; however, were well below national averages on adolescent immunizations. CHIP HMOs were above national averages for nearly all consumer satisfaction measures.

Key findings in the following year were similar to 2007, although the 2008 report contained survey information regarding children. Commercial HMOs were above national averages for ratings of health plan, personal doctor, health care, and specialist most often seen. Commercial HMOs are also meeting national averages for children's immunizations. Medicaid HMOs are above national averages for access to primary care for children and access to preventive/ambulatory services for adults. Medicaid HMOs are also above national averages for the ratings of health plan, personal doctor, health care, and specialist seen most often. CHIP is meeting national averages for children's immunizations, and nearly all consumer satisfaction measures.

> "This report will help health plans Identify areas for improvement that will ultimately benefit the entire health care system. We're pleased to note that many important measures, like childhood immunizations, have increased significantly since we began monitoring health plan performance in 1996."
>
> Dr. David N. Sundwall, UDOH Executive Director.

Measuring Health Plan Performance

In 2006, two new custom questions were developed in cooperation with the health plans and added to the CAHPS survey. These two questions are now included on each CAHPS survey. The first question asked respondents who rated the health plan a 0-7 on a 10-point scale to indicate their reasons for doing so. These reasons included: claims process, co-pay costs, deductible costs, premium costs, customer service, health care providers, and benefits offered by the plan. The second question asked respondents to indicate the reasons that they called customer service. These issues were: questions about covered benefits, to find a provider, help understanding a bill, information about claim payments, eligibility for services, and help in changing plans. Typically, it has been found that commercial enrollees score plans lower than an 8 due to cost issues.

The 2007 and 2008 results echo trends found in the past. Results indicate that General Child and Adult Enrollees list cost as a major factor in the low ratings of commercial health plans. Following table shows the percentage of caregivers for commercial child enrollees (among those who rated their plan a 0 through 7) who marked each of the response options in 2008.

Analysis of the Medicaid plans showed that covered benefits and providers were their most important reasons for low health plan ratings (response options regarding deductibles and premiums were not included on the Medicaid survey).

The second question asked respondents to indicate why they called customer service in the past six months (Medicaid) or twelve months (commercial). The majority of both Medicaid and commercial enrollees called with questions about covered benefits or to get pre-authorization. The largest differences between the products can be seen in commercial enrollees being more likely to call about getting an appointment and Medicaid enrollees being more likely to call to change managed care plans.
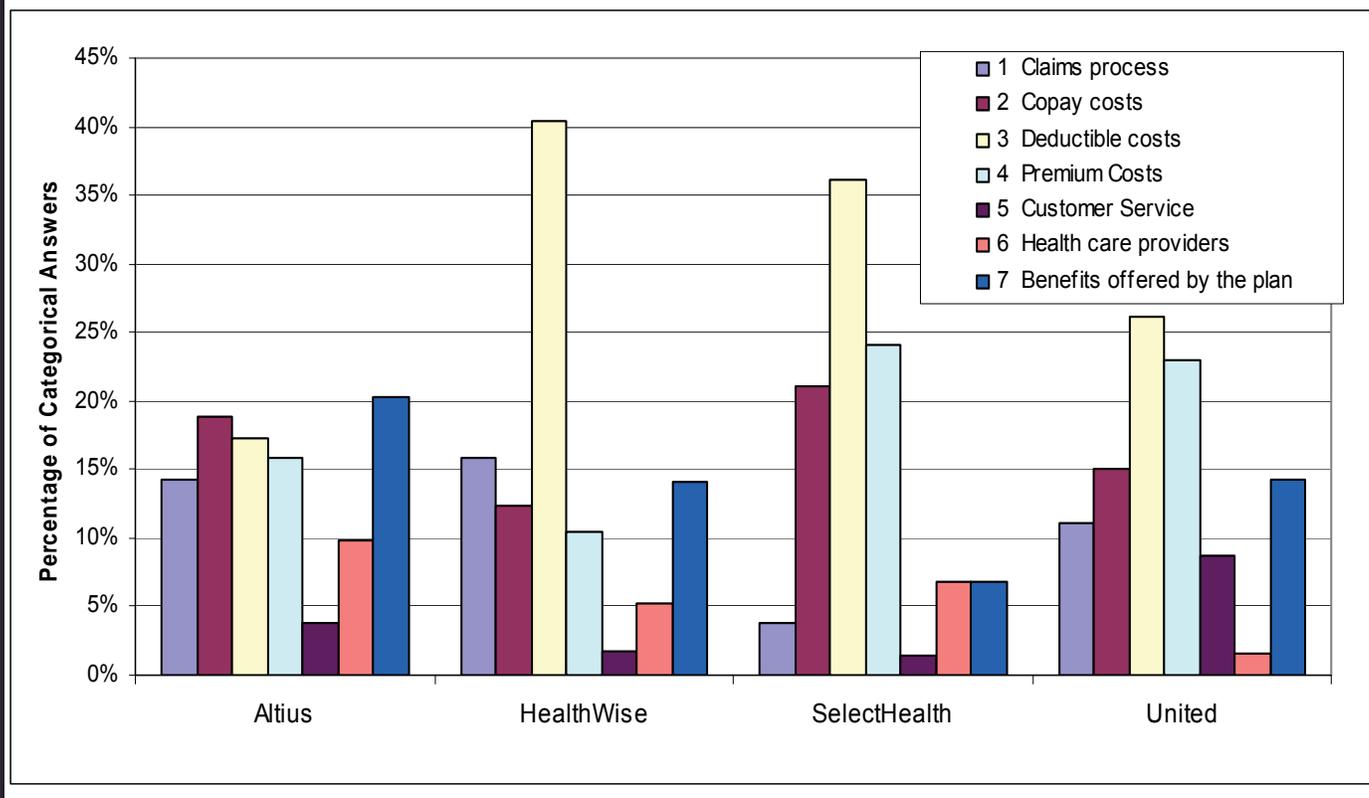
The Children's Health Insurance Program (CHIP) was developed to provide medical and dental care for uninsured, low-income children that are not eligible for Medicaid. The purpose of the current report was to describe findings from a survey project that assessed those who disenrolled from CHIP after at least six months of continuous enrollment. It is important to note that these individuals still qualified for CHIP.

CHIP was interested in a variety of questions related to their enrollees, so the Office of Health Care Statistics (OHCS) and CHIP staff collaborated to develop a 35-question survey instrument to be administered to disenrollees. The instrument contained questions in the following categories: reasons for disenrollment, health care utilization and current health status.

Survey Methodology

OHCS was provided a list of CHIP members who were continuously enrolled in CHIP from January to June 2007 but were not enrolled in October or November 2007. The first wave of surveys was mailed in early November 2007. This was followed by a reminder postcard, a second survey, a second reminder, and finally a third survey. The last wave of mailings took place in early December, 2007. Upon completion of the survey, participants were sent phone cards for their participation. 406 surveys were returned from respondents for a 46% response rate.

Results

The most important question on the survey was to determine where the CHIP enrollees have gone, since they are still eligible for CHIP. The results shown in the following figure indicate that many of the CHIP enrollees' caregivers believe they earn too much money to be eligible for CHIP. The second highest category of responses indicates that CHIP enrollees are finding insurance elsewhere.

CHIP Disenrollment Survey

The source for insurance after leaving CHIP varied by family, but the two main sources of insurance were from employers of caregivers (61.0%) and Medicaid (25.7%). The remaining caregivers found health insurance through other sources, such as other family members paying for it through private insurance.

There were many other questions on the survey related to the costs and customer service of CHIP. The respondents to the survey were also asked to rate CHIP on a scale of 0 to 10. 81.2% of the respondents rated CHIP with an 8, 9, or 10. Written comments in the survey indicate that families are very appreciative of CHIP. Those that scored CHIP with a score below an 8, indicated that this was due to customer service issues, such as getting complaints/concerns resolved, and enrolling their child in CHIP.

While caregivers scored CHIP favorably as a program, the respondents also scored their child's health favorably as well. The majority of respondents indicated that their child's health needs were being met by CHIP. Only 2% of respondents indicated that their child's health needs were not being met by CHIP.

There were very few issues related to the cost of CHIP, most enrollees were content in the fact that they had health insurance for their child. Nearly all of the respondents to the survey indicated they would re-enroll their child with CHIP if given the option.

Table 1. Reasons for not re-enrolling in the CHIP program
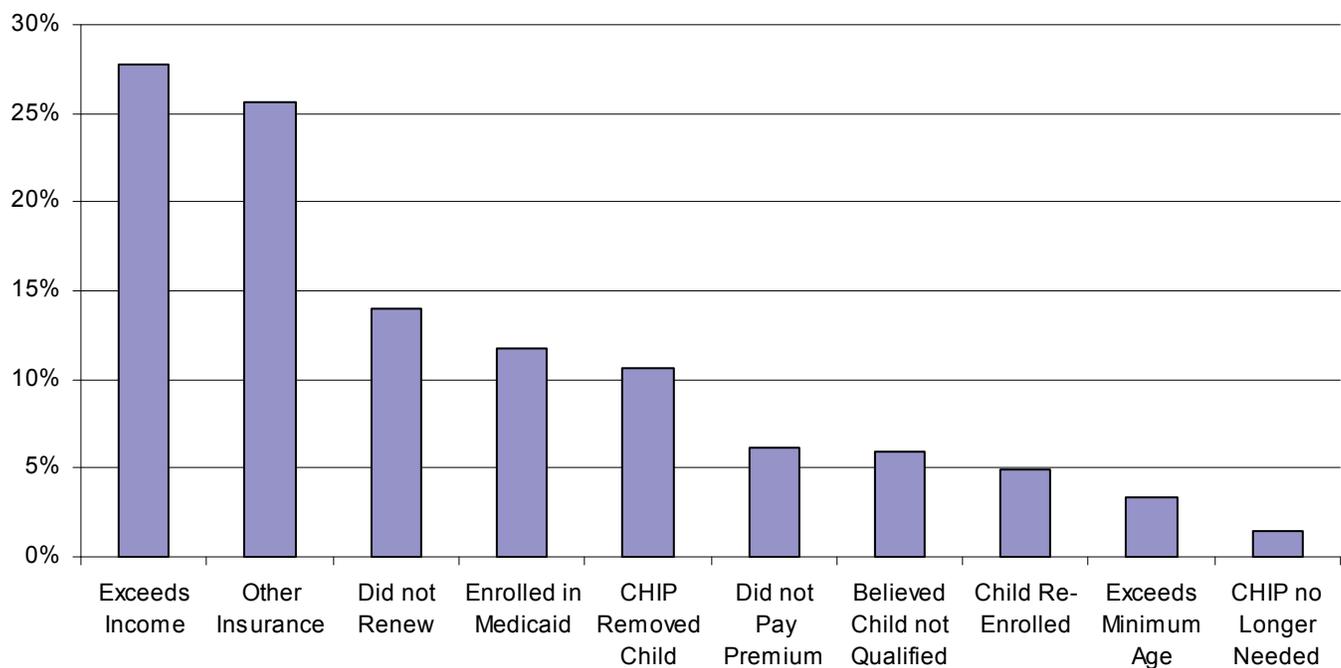
Hospital Readmission

Some hospital readmissions are part of an accepted process of care. However, preventable hospital readmissions can be an indication of less than optimal care both during and after the hospital stay. Preventable readmissions add to the cost of care and can be traumatic to patients. Valid determinations of preventable hospital readmissions could be a valuable indicator of both the process and outcome of some kinds of health care.

Up until now, the determination of useful hospital readmission rates has been hindered by the lack of:

- A way to associate more than one hospital stay with a given patient
- Agreed-upon definitions of preventable hospital readmissions
- Nationally recognized standards for preventable hospital readmissions

Recently, solutions to some of these problems have become available:

- OHCS staff received a 13-month hospital discharge dataset from the Office of Public Health Infomatics (OPHI) that permits the tracking of specific patients' hospital stays

- 3M, a company that provides widely used software to manage health care data, has developed software to determine clinically relevant, potentially preventable readmissions (PPRs)

- Other states, such as Massachusetts, Pennsylvania, Texas and Virginia, are developing hospital readmission reports for private use within hospitals and for public reporting.

National hospital readmission rates based on the 3M PPR software are not currently available. However, comparison of Utah and other state readmission rates based on the 3M PPR software is an initial step toward better understanding of hospital readmissions in Utah.

OHCS staff has begun preliminary analyses for potentially preventable hospital readmission rates among Utah inpatients. To date, OHCS staff has determined hospital readmission rates in Utah using the 2005 dataset from the Office of Public Health Informatics and the 3M PPR software.

Findings for Utah and Florida hospital readmissions are comparable (see Table 1). The Utah potentially preventable readmission rate within a 15 day readmission period is 5.2% of at-risk adult patients, compared to 6.9% for Florida. When the readmission period is extended to 30 days after the previous discharge date, the Utah potentially preventable readmission rate for 2005 is 7.5%.

Hospital Readmission: Application

Currently, we are unsure why Florida's 15-day potentially preventable readmission rate is higher than Utah's. Possible reasons include Utah's relatively young population, Utah as a "magnet" state for hospital care, and Utah as an outdoor holiday destination for out-of-state vacationers. Compared to Utah, Florida may include a higher portion of older people with chronic and acute conditions that result in more readmissions. Out-of-state patients who receive hospital care in Utah may be readmitted to hospitals outside Utah. Currently, we have no way to capture these out-of-state readmissions, possibly resulting in an "artificial" lowering of Utah's readmission rate. We advise further study of reasons for differences in readmission rates across states.

Different readmission periods serve different purposes. Shorter readmission periods are more meaningful to hospitals because admissions during these shorter periods are more likely to be related to care during the previous hospitalization and aftercare planning with the patient. Longer readmission periods can be useful to payers, consumers and policymakers for making better estimates of cost of care and access to appropriate care in outpatient settings. We advise further study and dialogue with various stakeholders about readmission period.

Table 1. Potentially Preventable Hospital Readmissions in Utah (15- and 30-day) and Florida (15-day)

	Utah	Utah	Florida
Time Period Start	1/1/2005	1/1/2005	4/1/2006
Time Period End	12/31/2005	12/31/2005	3/31/2007
Readmission Period (Days)	30	15	15
Patients*	153,918	153,918	
Admissions**	195,668	195,668	2,200,000
At Risk Admissions***	114,307	117,485	877,228
% At Risk	58.4%	60.0%	39.9%
Readmitted Patients+	8,567	6,137	60,707
% Readmitted Patients+	7.5%	5.2%	6.9%

Patients* can have one or more hospital readmissions.

Admissions** are the hospital stays during this time period.

At Risk Admissions*** exclude maternity, newborn and pediatric admissions as well as those for which readmission is an accepted program of care, such as for advanced cancer and burns.

Readmitted patients+ counts patients with one or more readmissions only once.

For % Readmitted patients+, Readmitted Patients is the numerator and At Risk Admissions is the denominator.
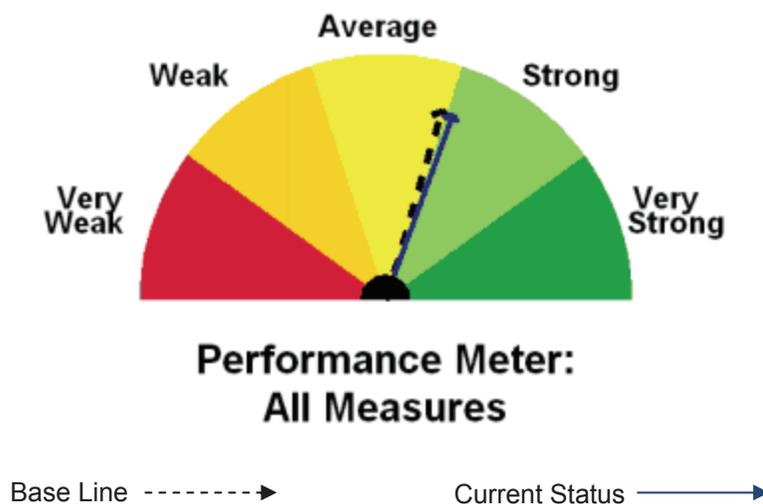
Health of Healthcare in Utah Report

The Challenges in Utah's Healthcare report was released in June 2007. This report, previewed in the 2006 Health Data Committee Biennial Report, presented an overview of the state of healthcare in Utah. The report release coincided with the Agency for Healthcare Research and Quality's 2006 State Snapshots. The report contained 16 summary indicators organized into three main categories: quality and patient safety, access and cost.

Utah's health overall was rated as "strong" in the report, one of only eight states in the nation and the only state in the Mountain West to receive that designation. Table 1 shows a summary of Utah's performance showing that the state is moving it the right direction overall. While Utah is one of the healthiest states in the nation, there are still opportunities for improvement in several areas.

Measures of prevention care in Utah (e.g., cancer screening immunizations) continue to lag behind national benchmarks. In 2005, Utah's uninsured rate surpassed that of the nation for the first time. Coupled with this figure is a concomitant increase in the number of uninsured patients being admitted through the emergency department. Clearly Utah's status as one as a healthy state could be jeopardized if those who have insurance do no get appropriate preventive care and the ranks of those without health insurance continue to rise.

Healthcare costs are another area where Utah is trending worse than national benchmarks. Utah's annual percentage growth in health care expenditures was higher than the national average (9.7% vs. 8.6%) for the period of 1980 to 2004. While some areas of growth, such as home health, are appropriate, other cost increases are cause for concern. The total facility charges for inpatient care, outpatient surgery, and ED visits have doubled since 1997. Personal expenditures on medication also increased significantly during this period.

**Performance Meter:
All Measures**

Base Line - - - - - - - ➤   Current Status ──────➤

Application: Challenges in Utah's Healthcare

Utahans enjoy high quality of care in most settings. The National Quality Report ranks Utah's chronic care, hospital care and home health care as above average compared to other states in the nation. One major strength in our state is the emphasis on public reporting. Making reports on quality and patient safety freely available to the public draws attention to these important issues. As a consequence, performance in these areas improves over time. The Utah Health Data Committee publishes annual reports on the quality of care in Health Maintenance Organizations (HMOs), as well as facility comparison reports in several areas.

The rates of ED visits and hospitalizations for ambulatory-care sensitive conditions have been stable, indicating that Utah's providers are doing a good job of caring for patients in the appropriate care setting. Overall utilization rates in these settings also remained stable. Finally, between 2003 and 2005 Utah saw an improvement in the use of generic drugs, which helps to hold down rising healthcare costs.

Table 1. Summary of healthcare indicators from Challenges in Utah's Healthcare 2006 Report

➡ Trend is moving in the right direction

Trend	Area	Highlights
➡	Quality / Patient Safety	⇒ Overall health care quality ranked as "Strong" ⇒ Established baseline measures for hospital patient safety
➡	Access	⇒ Decline in uninsured ED visits for primary care sensitive conditions (PCSC) but increased % of visits for the general population, 2001 to 2005 ⇒ Stable hospitalization rates for ambulatory care sensitive conditions over past decade
➡	Cost	⇒ Decline in proportion of personal health care expenditures for hospitals and nursing homes and increased proportion of expenditures for home health care, 1980 to 2004 ⇒ Slower increase in median charge for hospitalizations over 2004 but similar to the national trend ⇒ Stable utilization rates of hospitals, emergency departments and outpatient surgery centers, 1999 to 2005

Strategic Evaluation of HDC Products

Introduction

The Health Data Committee (HDC) and its staff from the Office of Health Care Statistics (OHCS) constantly strive to become more efficient to serve the people of Utah.

In the 2006 HDC Biennial Report, the committee mandated that $10,000 of its state general funds be used each year to:

♦ commission 'objective and independent' evaluation studies that assess the impact of HDC products and performance of the OHCS;

♦ adjust and direct the OHCS priorities, resource allocations, work plan, or strategies based on findings of the annual evaluation.

Source: *Utah Health Data Plan Update, 2007-2008, Project Four, pg. 3.7*
http://www.health.utah.gov/hda/Reports/Biennial2006.pdf

Timeline of Events

April 2007: HDC members identified "MyHealthcare in Utah" as the first choice for impact assessment. Voting was unanimous at the HDC quarterly meeting on April 17, 2007.

Note: MyHealthCare was created by the HDC in response to Senate Bill 132 (2005) so that consumers can access health facility comparison reports and related healthcare information. As evidence of its ever-growing popularity, there have been approximately 70,000 visits to MyHealthCare over the past three years.

January 2008: HDC/OHCS chose *HealthInsight* as the vendor for this project. In sum, the vendor agreed to the following in its contractual arrangements with the HDC:

♦ conduct and lead 3-4 focus groups with Utah consumers to assess the impact of MyHealthCare; convene the groups in both urban and rural locations around Utah;
♦ provide office space for the urban meetings; charge $9,950 for administration of the various focus groups; present a final report to the committee by October 2008.

February—April 2008: OHCS and *HealthInsight* worked jointly on preliminary tasks such as clarifying project goals, selecting potential participants, etc.

June—July 2008: Vendor conducted three focus groups, one each in three separate locations: *HealthInsight* (SLC-urban), University of Utah (SLC-urban), and Richfield (rural). Due to a lack of sufficient participants, individual interviews were held with residents of Ephraim, UT (rural).

October 2008: *HealthInsight* presented key findings and overall recommendations at the HDC quarterly meeting on October 14, 2008. Report was well-received by HDC members and considered an essential planning and quality improvement resource for future reporting/web development. A summary is given on the following page.

Strategic Evaluation: MyHealthCare in Utah

Key Findings

♦ Participants reacted favorably to being able to look up physician information regarding licensure and location.

♦ Many people were interested in the main navigation links (i.e., Verify a License, File a Complaint).

♦ Most people said they choose hospitals based upon physician recommendations and/or insurance requirements.

> **Can you use the healthcare facts you find on the Internet?**
>
> **Please share your opinions with us**
>
> **April 30, 2008**
>
> **6:00 p.m.—7:30 p.m.**

♦ Several participants noted that the doctor is more important to quality than the hospital.

♦ Some people felt the reports might be more interesting if they appeared at a time when relevant to the viewer.

♦ The technical data was a challenge according to many participants.

♦ While the majority of respondents admitted to using the Internet for healthcare information, 95.6% had neither heard about nor seen MyHealthCare in Utah.

Recommendations

♦ Simplify the language to achieve consumer friendly verbiage (5th grade reading level has been suggested for Medicaid documents).

♦ Use "everyday" language to describe what the indicators can tell the consumer.

♦ Put only a few indicators in any single report and make them meaningful to consumers.

♦ Use meaningful comparisons. For example, length of stay (LOS) is meaningful to care providers as an indicator of performance but may be interpreted differently by consumers.

♦ Make the data interactive; provide a spreadsheet with sort capabilities.

♦ Create tables by hospital so that consumers can review all the information available for any single hospital in one place.

♦ Show links to information about prevention or screening for the diagnoses included. Consumers want to know what they can "do about" it.

Improved Marketing of HDC Consumer Products

Introduction

In September 2008, the Agency for Healthcare Research and Quality (AHRQ) asked state sponsors of health care quality reports to outline their respective efforts in consumer engagement. OHCS provided a detailed a response to three central questions and was then invited to present its findings at a national conference in December 2008. Utah was one of only two states chosen for the presentation.

Summary

What have you done to let people know about your reports?

♦ Alerted the Media: distributed a news release with each report and set of reports

♦ Targeted Distribution: streamlined dissemination to critical users of the reports

♦ Creative Marketing: created advertising spots on prominent web sites in Utah

Do you have any sense of what was (or is) effective?

♦ Brochures for the comparison reports are considered effective; especially if the person is interested in the report topic (i.e. mom's-to-be).

♦ News releases are effective due to 1) post-release increase in web visits and 2) positive response from health care facilities.

♦ Web advertising is considered effective due to spike in report visits.

♦ Focus groups deemed effective because 1) they promote awareness among caregivers and 2) the consumer is not only heard but represented in the report themselves.

♦ Certain reports are effective because of their public health awareness (e.g. pneumonia).

What challenges have you faced, and how did you overcome them?

♦ *Challenge: cost effectiveness.* In response, our reports are now presented solely on the Web. Printing and mailing costs have been drastically reduced by disseminating consumer brochures instead of lengthy reports.

♦ *Challenge: reader-friendly reports.* In response, we conduct focus groups with consumers and send out easy-to-read brochures.

♦ *Challenge: reach the rural population.* In response, our distribution of consumer brochures has been extended to all parts of the state. Also, the reports can be viewed on the Web and thereby accessed by a larger audience.

Consumer Engagement in HDC Products

Summary

As reported in the 2007-2008 HDC Biennial Report, the HDC believes that increased marketing of its publications inevitably leads to an enhancement of data usage for improving health care in Utah.

Committee members decided to annually reserve $10,000 (3%) of the OHCS state budget for direct promotion of HDC products through the MyHealthCare in Utah website.

HDC members hold their marketing efforts accountable by each providing "60-second feedback" at every quarterly meeting. Other notable achievements over the past two years include:

♦   Six news releases, one news advisory announcing both health facility and health plan comparison reports

♦   Over 11,000 consumer-friendly brochures distributed statewide

♦   Web advertising established with KSL.com and FOX13.com (surge in user visits)

♦   Front page news story in the Salt Lake Tribune; editorial in Deseret News (see below)

♦   National recognition: "You're probably THE leader in single-diagnosis-specific hospital comparison reports - often the kind of report that consumers find easier to navigate than pull-down menus and diagnosis codes. " *Editor—consumerhealthratings.com*
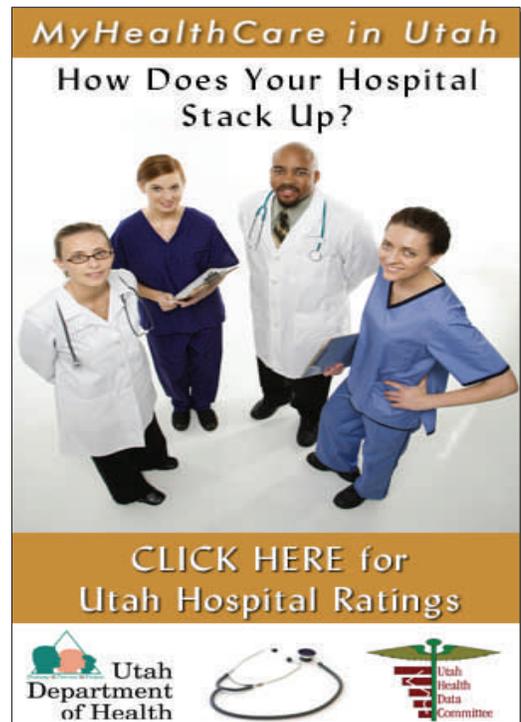
…………………………………...**Sample new story**…………………………………….

Data a boon to patients

Deseret Morning News editorial

Published: December 7, 2007

It's common sense that patients and health-care providers can make better decisions about treatments, surgeries and, yes, even giving birth, if they have access to accurate information about costs and quality of care.

For people who have no health-care coverage, information about cost is vital. It may literally mean the difference between undergoing a needed procedure or surgery or not, which could impact their quality of life, if not their longevity.

Thanks to the Utah Department of Health and the Utah Health Data Committee, Utahns have ready access to information about hip and knee surgeries, maternity and newborn delivery, pneumonia hospitalizations and heart surgeries and conditions — all at the click of a computer mouse. The reports are available at health.utah.gov/myhealthcare.

Part II.

Utah Health Data Plan Update

INSIDE THIS SECTION - PART II

Utah Health Data Plan Update 2007-2008

Legislative Requirements:

> "The committee shall develop and adopt by rule, following pubic hearing and comments, *a health data plan* that … identifies the key health care issues, questions, and problems amenable to resolution or improvement through better data, more extensive or careful analysis, or improved dissemination of health data."
>
> *Utah Code (26-33a-104(2))*

Utah Health Data Plans and Adoption Dates:

- The Health Data Plan, December 6, 1991
- Utah Health Care Performance Measurement Plan, July 1996
- Utah Pharmacy Data Plan, April 6, 2004
- Utah Cost and Quality Reporting Project Data Plan, July 8, 2008

Health Data Plan Updates:

The committee is required to *"report biennially to the governor and the legislature on how the committee is meeting its responsibilities."* (26-33a-104(2)(d)) This provides an opportunity for the committee to prioritize its efforts in the coming two years and set a strategic plan for the Office of Health Care Statistics to implement. Since the 2002 biennial report, the HDC began to include a section entitled "Health Data Plan Update" in the biennial report. Public input on the biennial updates of the health data plans were solicited. The committee adopted the biennial updates after all public comments are reviewed and considered.

- Health Data Plan Update 2003-2004, submitted with the HDC 2002 Biennial Report.
- Health Data Plan Update 2005-2006, submitted with the HDC 2004 Biennial Report.
- Health Data Plan Update 2007-2008, submitted with the HDC 2006 Biennial Report.
- Health Data Plan Update 2009-2010, included in Part II of this report.

Utah Health Data Plan Update 2009-2010

Planning for the Health Data Plan Update 2009-2010

The Health Data Committee held a biennial retreat on July 8th 2008. Health reform and the all payer database were central themes of the discussion. John T. Nielson, Special Advisor to the Governor for Health System Reform gave the keynote address. Mr. Nielson emphasized the need for health data to inform the discussion on how to change the health care system. He described the mission of the Health Reform task force and described the relationship between the HDC and health reform.

The meeting also included a presentation from another community partner: the Utah Partnership for Value-Driven Healthcare. Christie North, Executive Director of the UPV, gave a presentation entitled "CVE and HDC: Partners in Transparency". Ms. North described the Health and Human Service's Chartered Value Exchange mission and the role of the local CVE's in transforming healthcare. Once again, the important role of the HDC's data in helping make the system more transparent

Staff made presentations on upcoming projects and took questions from the HDC members. Based on these discussions, the committee made five recommendations for enhancing and improving HDC's work in 2009-2010. The Office of Health Care Statistics followed the committee's recommendations and guidelines, consulted with partners and developed the following new or expanded projects:

1. Launch of All Payer Database analysis and reporting

2. Report on Potentially Preventable Readmissions (PPRs) in Utah Hospitals

3. Develop a performance report on preferred provider organizations (PPOs)

4. Update and expand the submission specifications for facility data reporting

5. Develop a secure upload for facility data submissions

> *"Our health reform efforts contemplate moving toward a more consumer oriented system. In order to do so the consumer must have sufficient information available to make informed choices and that will certainly entail cost and quality information. The information gathered by the Health Data Committee is vital to the success of this process."*
>
> *John T. Neilson*
> Special Advisor to the Governor for Health System Reform

1. All Payer Database

Project Description:

The Utah All Payer Database (APD) will be the first of its kind in the nation. The APD will provide data on episodes of care for approximately 90% of insured Utahans. This will build on existing reporting resources within the UDOH and creating new partnerships with vendors and the Utah Health Information Network (UHIN), The Utah Legislature has supported this project as part of the larger healthcare reform initiative and appropriated $615,000 of on-going funding. When the project is fully implemented, the HDC will produce reports that will provide state-wide healthcare cost and quality information for a Utah that has not previously been available to the public.

> "This bill amends the Health Data Authority Act to authorize the Health Data Committee, as funding is available, to collect data on the costs of episodes of health care, and, as funding is available, authorizes the Department of Health to develop a plan to measure and compare costs of episodes of care."
>
> House Bill 9, 2007

Benefit to the Public:

Healthcare reform groups at the state and national level are calling for increased transparency in our healthcare system. The all payer database will be able to bring a information important to achieving greater transparency to Utah stakeholders. A transparent healthcare system would mean that consumer and purchasers, payers and policy makers would all be able to compare quality and actual costs across providers, facilities or health plans. Transparency in healthcare has a number of benefits. For example, patients would be able to shop for the best value before they seek care for a given condition. Purchasers would be able to determine which plan offers the highest quality of care at the best price for their employees, and policy makers would be able to examine regional variations in cost and quality across the state. In addition to promoting transparency and supporting health care reform efforts, the data emerging from Utah's all payer database will provide relevant and helpful data to a variety of epidemiological analysis and the study of clinical efficiency in healthcare delivery. These represent tremendous public health benefits to all Utah residents.

Tasks and Time Line:

The All Payer Database has already reached a number of milestones (see pages 1.2 and 1.3 of this report). The database will be implemented over the course of the next six months and is expected to be fully operational by the end of 2009. Key points in the 2009 time line are:

- ♦ January: set up and test secure servers and software; receive pilot data
- ♦ February: finalize data submission specifications and file administrative rule
- ♦ April - July: receive initial twenty-eight month data submission
- ♦ September: begin receiving data feed from plan via UHIN
- ♦ October: release first APD reports to the public

All Payer Database, continued

Key Partners:

♦ Utah Health Plans:

- Aetna
- Altius Health Plans
- CIGNA Healthcare
- Deseret Mutual Benefit Association
- Educator's Mutual
- Healthy U

- Molina Healthcare
- Public Employee Health Program
- Regence Blue Cross/Blue Shield
- SelectHealth
- United Healthcare
- Utah Medicaid

♦ Utah Health Information Network (UHIN)
♦ Specter Enterprises
♦ 3M Information Systems
♦ CareAdvantage, Inc.
♦ Informatica
♦ Health Reform Task Force
♦ Utah Health Insurance Association (UHIA)

Required Resources and Funding Sources:

> "This bill appropriates as an ongoing appropriation, $615,000, from the General Fund for fiscal year 2008-09 to the Department of Health to be used to fund health care cost and quality data collection, analysis, and distribution."
>
> House Bill 133, 2008

This project was funded by a block grant requested by the Utah Department of Health. The legislature appropriated $615,000 in on-going funding for this project as part of House Bill 133: Health Care Reform. An additional $185,000 will come from matching funds provided by Health Care Financing (Medicaid).

Measurable Outcomes:

The HDC has formed an advisory committee, the Utah Transparency Advisory Panel, to help plan a variety of reports on analyses of the APD. These reports will be made available on the MyHealthcare website. OHCS regularly tracks visits to the main page of the site as well as to specific reports.

2. Hospital Readmissions (PPR)

Project Description:

In July of 2008, the HDC directed the OHCS to begin a new project focused on facility comparisons. This new work will report on potentially preventable hospital readmissions (PPRs) for the first time in Utah. (see page 1.10 of this report for statewide analysis of PPRs)

Benefit to the Public:

Public reporting of PPRs will benefit the public at large as well as hospitals and providers. If patients are given the ability to compare facilities, they can use this information as one of the factors they use to determine which facility they choose for their health needs. The information on PPRs can be presented along with educational material that will help consumers understand what they can do to prevent being readmitted to a hospital after an inpatient stay .

Hospitals and providers will also benefit from this information. Hospital-specific analyses will be given back to the data suppliers after analysis. This will allow hospitals to identify specific readmissions that could be targeted for quality improvement efforts.

Tasks and Time Line:

Early 2009: meeting with hospitals and stakeholders to kick off the project
Spring 2009: linkage of inpatient records, pilot data project conducted by 3M
Fall 2009: initial analysis of 2007 inpatient data
Late 2009: publication of first PPR report

Key Partners:

♦ Utah hospitals and Health Systems
♦ Utah Hospital Association
♦ Florida Agency for Healthcare Research & Quality
♦ 3M Information Systems

Required Resources and Funding Sources:

No new funding will be required for this project. 3M is providing the PPR software at no cost to state agencies. OHCS already collects the necessary inpatient data for the analysis. Staff time for analysis and report writing will be a part of the overall operations of OHCS.

Measurable Outcomes:

A public report will be made available on our website. Interest in the report can be gauged by hits and downloads. HDC will also solicit input from the hospitals, providers and consumers on the utility of the report.

3. PPO Quality Reporting

Project Description:

In 2008, the Health Data Committee (HDC) authorized the collection of PPO data for the State of Utah. This is beneficial in a number of ways. The current HMO Performance Report covers about 40% of insured Utahans. This includes enrollees in Commercial and Medicaid HMOs, as well as CHIP plans. This leaves a large portion of Utahans without quality and consumer satisfaction information regarding their health plans. Individuals will now be able to compare health plans and make informed decisions regarding their families' health care. With this knowledge, families can choose health plans that fit their needs.

Benefit to the Public:

The public, with adequate information, can make informed decisions regarding their health-care choices. This publicly available information that will enable them to choose the right health plan for themselves and their families.

Tasks and Time Line:

Beginning January 1, 2009 the reporting process for PPOs will commence. The HDC recommended that CAHPS data be collected. The CAHPS survey monitors the quality of health care using mail and phone questionnaires administered to PPO enrollees by a licensed vendor. The survey measures satisfaction with different aspects of plan performance such as customer service, getting needed care, getting care quickly, helpfulness of doctor's office staff, overall plan ratings, health care quality, and personal doctor. The surveys and data collection are typically completed by July of each year.

The report will be broken into two separate releases. One report will consist of CAHPS data for both the HMOs and PPOs, while the second report will consist of HEDIS data for the HMOs only. The reports will still come out yearly, but will be released at different times of the year, possibly September and November.

Key Partner:

The key partner in administering the CAHPS surveys is DataStat, an NCQA-accredited CAHPS vendor.

Required Resources and Funding Sources:

The survey, depending upon the year, is estimated to cost $10,000 per health plan. The state is billed for the administration of the surveys; the state then bills the various health plans the full amount for the surveys.

Measurable Outcomes:

PPOs will be rated by its own members on a variety of outcomes: physician, specialist, health-care, health plan, getting care quickly, getting needed care, communication and customer service.

4. Updated Facility Data Submission Specifications

Project Description:

Update and expand the submission specifications for facility data reporting (including Inpatient, Ambulatory Surgery and Emergency Department) to current industry standards including UB-04, X12 837 and HIPPA. None of these data collection systems based on the UB-92 claims have been significantly updated since they were started back in the mid 1990s. The additions to the UB-04 include the National Provider Identifier (NPI), Present on Admission, Do Not Resuscitate, additional diagnosis codes and E-codes among others. Other improvements include more standardized reporting of procedure codes, payers and charges. All facilities should be supplying revised data submissions by the 2010 data cycle.

Benefit to the Public:

The Office of Health Care Statistics has invested substantial resources to make these statewide facility encounter databases easily and widely accessible for analysis. Incomplete reported data or non-standardized data elements reduce accuracy and comparability of this data. Improvements in data quality and timely health care information can significantly improve market monitoring and disease surveillance for health care providers, public health professionals, and epidemiologists. These databases also serve as one of the core components of the IBIS Web-based Query module which can be accessed by any consumer, provider or health care worker. Also de-identified data is used by Federal AHRQ HCUP project, hospital systems, and university researchers.

Project Tasks and Time Line:

Early 2009: Put together drafts of complete modifications of each of the Submittal Manuals compared with current UB-04, X12-837, HCFA 1500 standards -- also revisit affected Utah State Rules.

Mid 2009: Reconvene the HDC-Systems Technical Advisory Committee to review and advise on specifications -- follow up internally and with the HDC.

2009-2010: Publish and disseminate revised submittal documents -- then follow up and train individual facilities or IT vendors about changes and resolve technical issues.

Key Participating Organizations:

♦ All reporting hospitals and FASCs in Utah and their IT vendors
♦ The HDC System Technical Advisory Committee
♦ UHA, Utah Hospitals and Health Systems Association
♦ UASCA, Utah Ambulatory Surgery Center Association
♦ Utah Health Information Network (UHIN)

Required Resources and Funding Sources:

Use existing resources including sharing knowledge, programming and technology improvements from the All Payer Database Project.

Measurable Outcomes:

Enhanced reporting capabilities in the quality indicators software and provider level reporting. We will be able to directly track the number of facilities/systems that have changed submittal formats. Decreased facility error rates during validation and improved data reporting.

5. Develop Secure Upload for Data Submissions

Project Description:

The Office of Health Care Statistics/ Utah Health Data Committee (OHCS/HDC) is in the initial stages of developing a secure data submittal portal entitled Health Data Online Reporting System (H-DORS) for Utah data providers to electronically submit Inpatient Discharge, Ambulatory Surgery, and Emergency Department data files as mandated by R428-10, R428-11 and R426-1-7(I) to the Office of Health Care Statistics. It is the intent of OHCS to have all Utah hospitals and facilities utilizing this tool for data submissions by 2010.

The H-DORS secure portal will establish a statewide standard for data submissions for all Utah hospitals and facilities and will streamline communication between OHCS and individual hospital personnel and/or systems in the area of submissions, data validation and deadlines pursuant to the data submission schedule, Administrative Rule R428-10-5.

Benefit to the Public:

By standardizing how Utah hospitals and facilities submit required data to OHCS it will assist with staff productivity by eliminating resources that are currently devoted to receiving, logging and notifying submitter of receipt of incoming data files that are submitted via U.S. mail. The new system will also decrease the staff time spent on verifying the submitted data and will improve timeliness of data release. With these advances, staff will have the ability to devote their time to other priority projects as outlined within this report.

Key Participants:

- All licensed facilities required to report data to OHCS
- Office of Health Care Statistics/Utah Health Data Committee

Tasks and Time Line:

2009 Recruitment and Beta Testing: During the beta phase OHCS plans to recruit eight to ten users to act as a beta group. OHCS will ask for volunteers from urban, rural and ambulatory facilities.

2009-2010: Statewide Implementation: The Utah health data online reporting system (H-DORS) will be rolled out to all hospitals in Utah. Targeted users include hospital administrators and other authorized staff as determined by individual facility/hospital administration. Adequate user support materials will be provided through user training and online help menus within the application itself. OHCS will provide on-going training and user support as needed.

2010: Modification and Upgrade: The OHCS will solicit user input concerning tool performance, user support and desired new features. OHCS will ensure adequate user support and upgrade the tool if resources become available or as time permits within existing resources.

Required Resources and Funding Sources:

Use existing resources.

Measurable Outcomes:

- Each Utah hospital or facility uses the tool at least once per quarter for data submission.
- Elimination of data submissions via U.S. mail.
- Users are satisfied with system performance and support, as measured by direct feedback from users within the beta group as well as system wide.

Part III.

Appendices

INSIDE THIS SECTION

HDC Legislative Statute and Responsibilities

Legislative Authority: <u>Utah Health Data Authority Act (26-33a).</u>

Administrative Rules:

Responsible for rule enforcement, data management and reporting:

1) R428-10. Health Data Authority Hospital Inpatient Reporting Rule. *Revised: 02/27/2004*

2) R428-11. Health Data Authority Ambulatory Surgical Reporting Rule. *Revised: 02/27/2004*

3) R428-12. Health Data Authority Survey of Enrollees in Health Maintenance Organizations and Preferred Provider Organizations *revised 1/6/2009*

4) R428-13. Health Data Authority Audit and Reporting of HMO Performance Measures.

Responsible for data management and reporting:

1) R380-210. Health Care Facility Patient Safety Program.

2) R426-1-7(I). Emergency Medical Services Encounter Data.

Responsible for strategically planning health data collection and use:

1) R428-1 and R428-20. Health Data Collection and Request for Health Data Information.

2) R428-2. Health Data Authority Standards for Health Data.

3) R428-5, R428-10, -11, -12, -13. Data Validation and Reporting Procedures.

Membership, Appointment, and Operation

- 13 members appointed by the governor and confirmed by the Senate, representing: large business (1), business (1), small business (1), physician (1), nursing (1), HMOs (1), third party payers (1), hospitals (1), public interest (1), consumers (2), public health (2)

- "No more than seven members of the Committee may be members of the same political party." (26-33a-103(2))

- Members elect a Chair and Vice Chair annually and meet quarterly. The HDC chairs have been business representatives in the past 14 years.

- The Director for Office of Health Care Statistics is the Committee's Executive Secretary who "shall be appointed by the [UDOH] Executive Director, with the approval of the Committee, and shall serve under the administrative direction of the Executive Director." (26-33a-105(1)).

Chronology of Major Milestones: 1990-2004

The Health Data Committee's work since 1990 can be divided into several stages, listed below:

1990-1993:
The committee established a vision, mission, and priorities. A public process was established for planning. Technical capacity of hospitals and the state were assessed.

1993-1996:
The inpatient hospital discharge data collection and reporting system was implemented, including all-payer hospital encounters from all licensed hospitals in Utah and the Veterans Administration Salt Lake Medical Center.

1996-1998:
In 1996, S.B. 171 inserted "report card" intent language into the Utah Health Data Authority Act. During the HMO report card implementation, the committee also oversaw expansion of the inpatient hospital discharge data reporting system to include ambulatory surgery and emergency department encounters. The Office of Health Data Analysis was retained by Medicaid to implement its managed care reporting system (HEDIS reporting and CAHPS satisfaction surveys).

1998-2000:
A 1998 legislative audit confirmed the value of the data collected by the HDC, both to the public and to the industry. The legislature reduced the general fund portion of the HDC budget with the intent that it would be made up by increased revenue from data users. The Office of Health Data Analysis was changed to the Office of Health Care Statistics (OHCS) in the Center for Health Data.

2001-2004:
The HDC established a coalition with HMOs, Medicaid, CHIP, and Division of Community and Family Health Services to jointly conduct the HMO enrollees satisfaction surveys, resulting in improvement in the quality of survey data and reduction in financial burden for all parties. The HDC began to publish standard facility-level reports on ambulatory surgery data and policy oriented report on emergency department encounter data. The OHCS assumed responsibility to manage patient safety databases for implementing the administrative rule, R380-210 Health Care Facility Patient Safety Program. Hospital discharge data became a supplementary method to retrospectively detect adverse events among inpatients. The Utah Pharmacy Data Advisory Committee developed the Utah Pharmacy Data Plan. Several health plans voluntarily participated in the implementation. The OHCS began to conduct policy analysis and program outcome evaluation of the Primary Care Network (PCN), a Medicaid waiver program.

Chronology of Major Milestones: 2005-2008

2005-2006:

The 2005 Utah Legislature passed the Senate Bill 132 Health Care Consumer's Report, requiring the Health Data Committee to publish annual reports that compare hospitals based on charges, quality and patient safety for consumers. The committee commissioned a SB132 Task Force to oversee the implementation. The OHCS developed a one-stop shopping web portal, MyHealthCare in Utah, for consumers. Four new types of consumer reports were published. The Committee established formal partnership with the Utah Hospital Association and *HealthInsight*, a quality improvement organization for Utah, to promote transparency of health care. The first report on pharmacy data, *Selected Prescription Drug Usage in Utah, 2003*, won an award from the National Association of Health Data Organizations. The HDC developed a secured Web patient safety tool for hospitals to use for internal quality improvement.

2007-2008:

This was a period of partnership building for the HDC as it significantly expanded its mission and its budget. The 2007 legislature passed House Bill 9 which called on the HDC to create a task force and write a plan for the creation of an all payer database in Utah. A block grant to fund the APD was passed by the 2008 Utah Legislature. This ongoing funding doubled the size of the OHCS budget and at the same time expanded the number of data providers and will allow reporting of episodes of care for the entire state in late 2009. The APD will also be used to support health reform efforts spearheaded by the Health Reform Task Force. The HDC also continued to expand into new areas of facility reporting. In August of 2007, OHCS published a facility comparison report on gall bladder removal, marking the first time that ambulatory surgery center data was used in this type of report. In June of 2007, OHCS published the first "Challenges in Utah's Health Care" report in partnership with the Agency for Healthcare Research and Quality (AHRQ). The HDC also built a strong relationship with the Utah Partnership for Value-Driven Healthcare during this period. The UPV was chartered by the Department of Health and Human Services to bring together stakeholders in healthcare with the mission of improving transparency and value.

> *"The Utah Partnership for Value-driven Health Care was created to bring about greater transparency of the Utah healthcare system. That could not happen without an excellent working relationship with the Health Data Committee and the access to the extensive data repository the HDC oversees"*
>
> Christie North
> Executive Director, Utah Partnership for Value-Driven Healthcare

OHCS Expenses and Revenues: SFY2000 - SFY2008

Office of Health Care Statistics Revenues by Source: SFY1998-SFY2008

State Fiscal Year	Total	General Funds	Data Product Sales	Contracts	Contract Sources
2000	$681,519	$286,000	$79,076	$316,443	Medicaid
2001	$754,329	$289,500	$72,838	$391,991	Medicaid, Emergency Medicine Services (EMS)
2002	$715,285	$285,459	$73,744	$356,082	Medicaid, CHIP, Health Plans, AHRQ, Division of Community and Family Health Services
2003	$734,554	$283,600	$104,068	$346,886	Medicaid, Health Plans, AHRQ, Division of Community and Family Health Services
2004	$1,000,237	$281,900	$93,595	$624,742	Medicaid, Health Plans, AHRQ, Division of Community and Family Health Services, Bioterrorism Grant
2005	$890,216	$287,500	$92,010	$510,706	Medicaid, Health Plans, AHRQ, Division of Community and Family Health Services
2006	$695,677	$297,700	$105,401	$292,576	Medicaid, Federal AHRQ/National Association of Health Data Organizations, Division of Community and Family Health Services
2007	$734,406	$314,088	$104,041	$316,277	Medicaid, Emergency Medical Services (EMS), Health Plans
2008	$747,543	$276,254	$109,774	$361,515	Medicaid, Emergency Medical Services, Bureau of Access, Health Plans, Huntsman Cancer Institute

Visit our sites:

Health Data Committee

http://health.utah.gov/hda

MyHealthCare in Utah
(consumer based*)

http://health.utah.gov/myhealthcare

MyHealthCare in Utah provides easy access to the hospital comparison reports and other helpful health care information for consumers and assists in the fulfillment of Senate Bill 132,