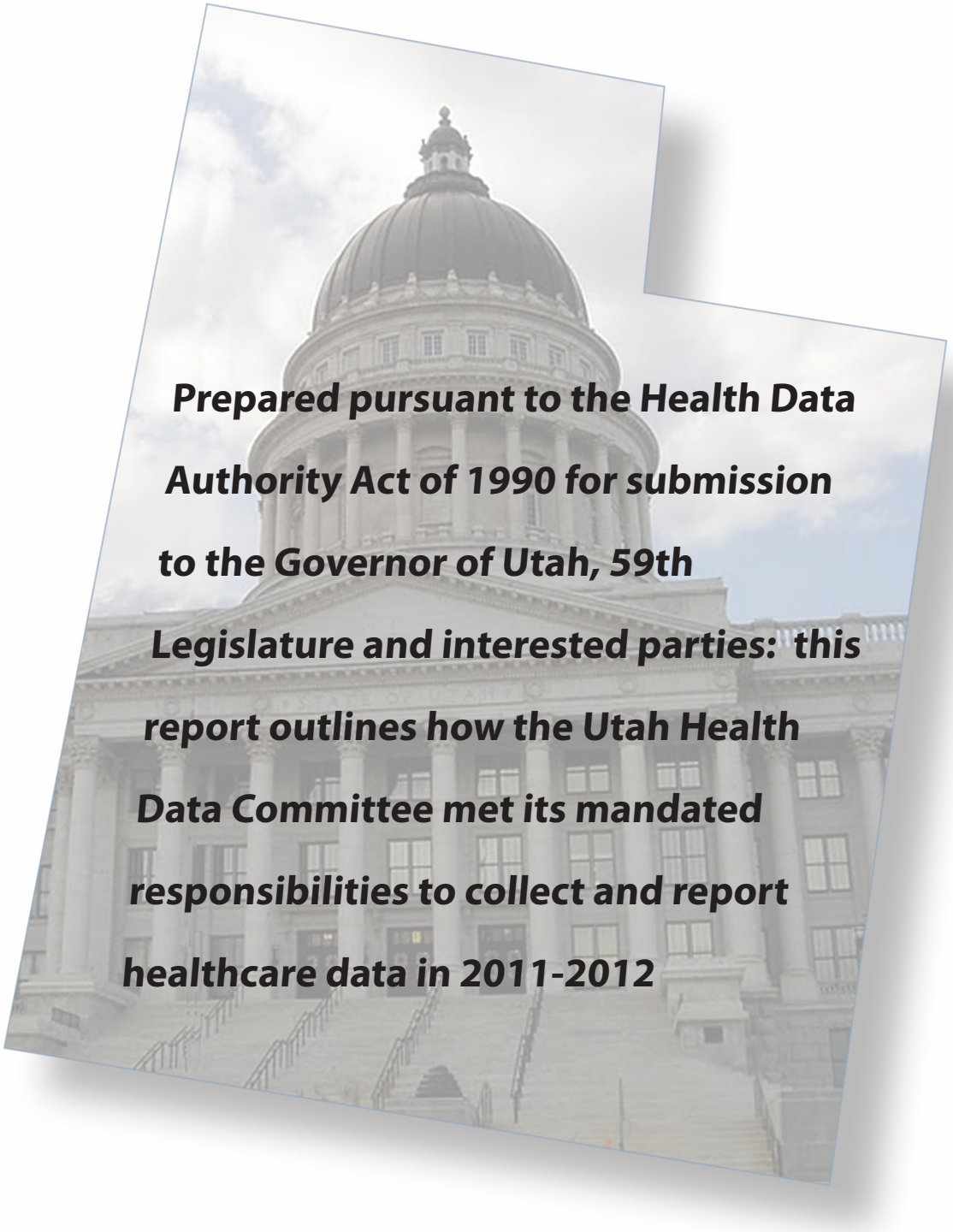
UTAH HEALTH DATA COMMITTEE

Office of Health Care Statistics, Center for Health Data

2012 BIENNIAL REPORT



Prepared pursuant to the Health Data Authority Act of 1990 for submission to the Governor of Utah, 59th Legislature and interested parties: this report outlines how the Utah Health Data Committee met its mandated responsibilities to collect and report healthcare data in 2011-2012

UTAH DEPARTMENT OF HEALTH

Utah Health Data Committee

This report is available online at:

http://health.utah.gov/hda/Reports/biennial2012.pdf

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Letter from Health Data Commitee (HDC) Chair

On behalf of the HDC and its staff members, we are pleased and honored to submit this report to the Governor of Utah, Gary R. Herbert, and also to the Utah Legislature as required by Utah Code 26-33a-104. The purpose of this publication is to 1) outline how the committee met its responsibilities over the past two years and 2) update its Health Data Plan to reflect priority work through 2014.

For 22 years the committee and staff have had the privilege of supporting the Governor's Office, the Legislature, and the citizens of Utah in efforts to improve health outcomes in Utah. Our focus is to improve quality, increase access, and reduce cost of healthcare. After several years of successfully establishing relationships with the care providers in Utah and creating standardized reporting methods, we have established one of the most respected and comprehensive healthcare data reporting systems in the nation. This data is currently being used to support healthcare research and to make informed health policy decisions. We are increasing our focus on providing actionable data that can be used by consumers, providers, healthcare administrators, and legislators to improve healthcare in Utah. The scope of the HDC is expanding from data collection and dissemination to active participation in defining opportunities for the improvement of healthcare. Utah enjoys one of the best healthcare systems in the nation as well as an enviable economy and quality of life. Improving the healthcare system will be critical to our success in maintaining Utah as desirable place to live and work in the future.

In order to satisfy the healthcare data needs of the state, we will increase the scope of our data as well as our collaboration with groups that influence healthcare. We are excited to expand the community reach of our data by tracking potentially avoidable hospitalizations with a readmission to Utah hospitals report. Our data systems will significantly grow with the inclusion of Accountable Care Organizations. Our technical relationship with the National Association for Health Data Organizations (NAHDO) will help to refine the APCD's direction and further capitalize on its potential. As we collaborate with a greater variety of organizations, we will remain focused on developing and implementing new data initiatives that impact healthcare reform at local and state levels.

In conclusion, the HDC has provided strategic and policy oversight of Utah's healthcare data systems for over twenty years. As we move further into the 21st century and a more challenging healthcare landscape, we look forward to being part of healthcare reform that ultimately improves the lives of people living in Utah.

We appreciate your interest in our efforts and are happy to provide you with this 2012 Utah Health Data Committee Biennial Report.

Respectfully,

Scott Baxter, Chair
Health Data Committee

Executive Summary

The Utah Health Data Committee (HDC) was created in 1990 by the Health Data Authority Act (§26-33a). Along with its staff in the Office of Health Care Statistics (OHCS), the HDC has provided critical leadership in managing a wide variety of complex data systems in Utah since 1992. The missions of the HDC and OHCS, in compliance with eight administrative rules, have largely been implemented through three core programs: health discharge databases, health plan measurement, and the All Payer Claims Database (APCD). These programs are often supplemented by ad hoc projects requiring OHCS skill and expertise, though always remain under a solid umbrella of professional values and unwavering commitment to data integrity. Over the past few years, committee and staff have strengthened their common purpose by increasing outreach, collaboration, and distinction.

Highlights of Significant HDC Achievements, 2011-2012

- Expanded the hospital comparison project by launching an online tool, MONAHRQ, which significantly broadens our outreach of administrative data for data users;
- Received national honors for Utah's All Payer Claims Database (APCD): 2011 Laureate for Innovation – International Data Group and 2011 Research Leadership Award – Ventana Research;
- Established a "dashboard" of measures for online presentation to accurately and publically monitor the performance of selected HDC data;
- Reorganized the Health Data Committee as directed by HB 128 (2011) – added one additional representative for each of the following areas: physician, payer and public interest;
- Published standard reports on inpatient and ambulatory surgery datasets and offered data for public sales to researchers and other stakeholders;
- Conducted a strategic planning retreat involving all HDC members focused on committee priorities, purpose, and future objectives;
- Released two separate reports measuring the quality of Utah's health plans including commercial HMOS, PPOs, Medicaid, and CHIP;
- Coordinated a survey project involving 2,750 persons who applied, renewed, or closed their cases with Utah Medicaid or CHIP over the past year (2011-12);
- Provided data support to the UDOH Ombudsman's Office - created by Governor Herbert in response to the 2012 State of Utah information breach.

2012-2013 Health Data Committee Priority Projects

"These projects firmly support the committee's central role of providing high-level leadership for workable and meaningful health data systems in the state of Utah."

--Lauren O. Florence, MD, HDC Vice Chair

Part I

HDC Performance: Core Projects

Hospital Inpatient Discharge Database (R428-10)

Under Administrative Rule R428-10, the Hospital Inpatient Discharge Database mandates that all Utah licensed hospitals, both general acute care and specialty, report information on inpatient discharges. Since 1992, the Office of Health Care Statistics (OHCS) has collected a wealth of information from 60 Utah hospitals including several which have subsequently been closed. In 2011 the hospital discharge database contained data on all hospitalizations from 54 Utah hospitals, which included 41 general acute care hospitals, three psychiatric hospitals, nine specialty hospitals, and the Veterans Administration Medical Center. With 20 years of data now available (1992-2011), it is possible to assess trends in health care utilization, quality, and access to hospital care.

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. 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 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 sponsored by the Agency for Healthcare Research and Quality (AHRQ). 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.

"Our hospitals use administrative data to help monitor their capacity for providing efficient health care and to help promote state-of-the-art patient services."

--Rod L. Betit, President/CEO, Utah Hospital Association

Hospital Inpatient Total Admissions and Charges

Inpatient Total Charges (figure 1) have steadily increased from 1999 through 2010. This amounts to over a 270 percent increase during that decade. The total number of hospital admissions (figure 2), on the other hand, displays a slowly increasing pattern modeled after natural population growth. Starting in 2008 this admission rate has dropped substantially. This drop can be partly attributed to a reduced birth rate that has occurred during this period. For more information please visit http://health.utah.gov/hda/report/inpatient.php

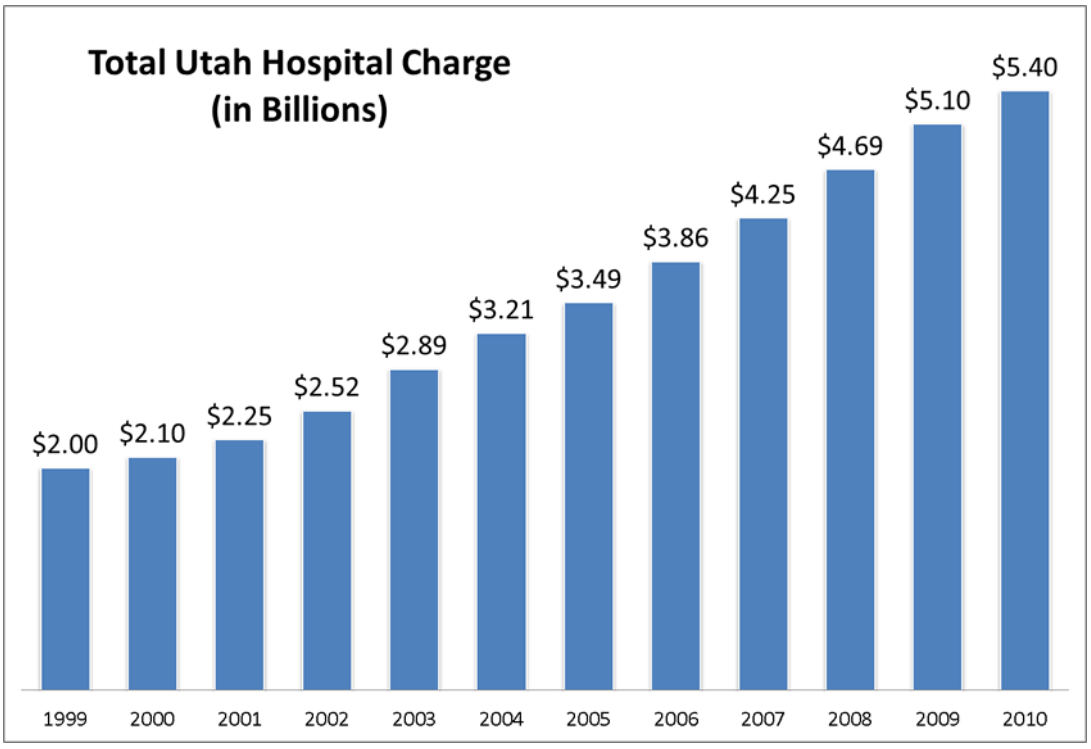


Figure 1. Total Hospital Charge (in Billions) by Year, Utah
Source: Utah Hospital Inpatient Discharge Database. Utah Department of Health, Office of Health Care Statistics.

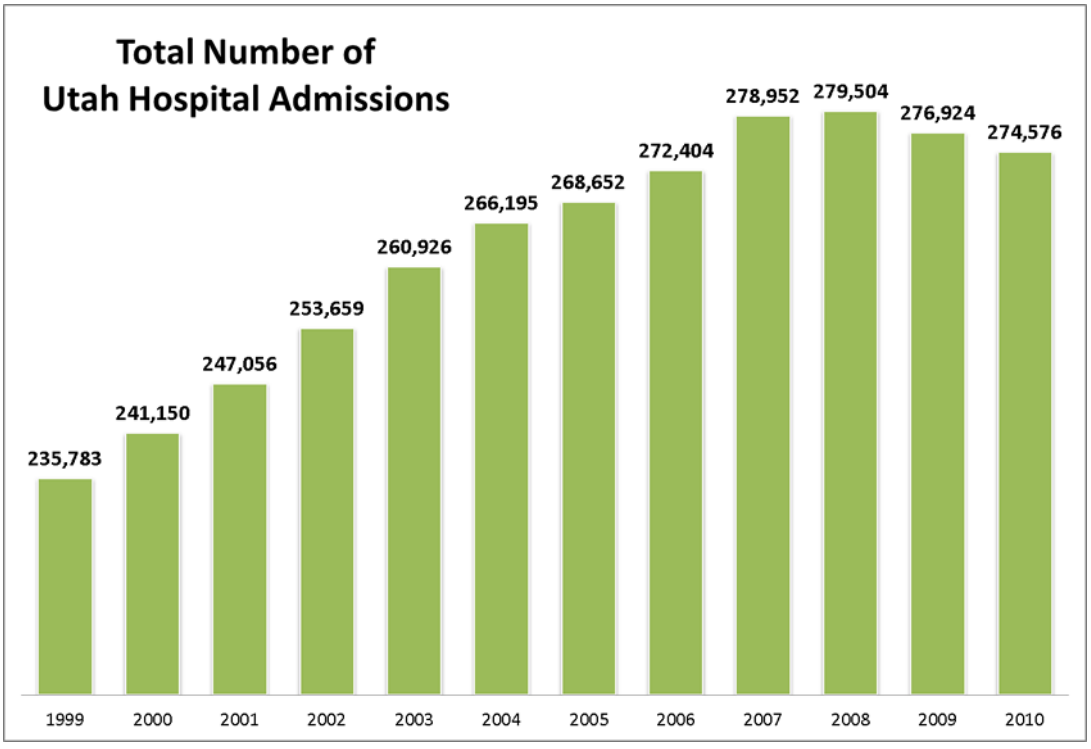


Figure 2. Total Number of Hospital Admissions by Year, Utah

Source: Utah Hospital Inpatient Discharge Database. Utah Department of Health, Office of Health Care Statistics.

Hospital Reporting Procedures: MONAHRQ System

MONAHRQ, standing for "My Own Network, Powered by AHRQ", is a comprehensive web development tool provided by the Agency for Healthcare Research and Quality (AHRQ), utilized by the Office of Healthcare Statistics (OHCS) in producing a more effective and efficient hospital comparison report. MONAHRQ acts as an online data querying system, capable of summarizing important key indicators of care at the provider-level (ex. Hospital). These data are presented in a clear and understandable format, which allows public consumers the ability to quickly learn about the healthcare available to them.

The following information that can be obtained from MONAHRQ includes but is not limited to:

- Performance ratings of a hospital
- Frequency of discharges for a given condition or procedure
- Length of hospital stay and associated costs for a given condition or procedure

The information available in the MONAHRQ system is based on admission rates and pre-calculated AHRQ Quality Indicator (QI) measures derived from local hospital discharge data. The AHRQ QIs are a series of standardized measures that highlight potential health care safety and quality concerns. Furthermore, measure results from the Centers for Medicare & Medicaid Services (CMS) Hospital Compare are also utilized in MONAHRQ. The CMS Hospital Compare measures are comprised of patient satisfaction results, provided by the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey, and other important aspects of healthcare quality that includes but is not limited to:

- Timeliness and best practices of care
- Hospital readmissions, complications, and death rates
- Use of medical imaging tests

MONAHRQ is designed to produce a web-based tool that is capable of appealing to all audiences. Its simplistic design makes the website easy for public consumers, policy makers, and other key stakeholders to navigate while hospital ratings and accompanying graphs are being reviewed.

This report also appeals to research investigators, health economists, and other highly-trained individuals by providing alternative data views comprised of detailed statistics such as: numerator/denominator counts, observed, expected, and risk-adjusted rates, and their accompanying confidence intervals.

Individuals in need of care that access MONAHRQ are now able to answer important healthcare-related questions. For example, an expectant mother can utilize MONAHRQ in choosing a hospital that excels in uncomplicated newborn deliveries. An individual suffering from heart conditions can use MONAHRQ in choosing a hospital that frequently performs routine heart procedures, with a track record of having minimal complications and excellent health outcomes. Furthermore, an elderly individual in need of a hip replacement can utilize MONAHRQ in identifying the costs associated with the procedure at competing hospitals. These examples highlight a few of the potential health questions and concerns that MONAHRQ is capable of addressing, ultimately allowing individuals to become consumers of care by providing the information necessary in making important health care decisions.

Over the last two years the following MONAHRQ related activity has occurred:

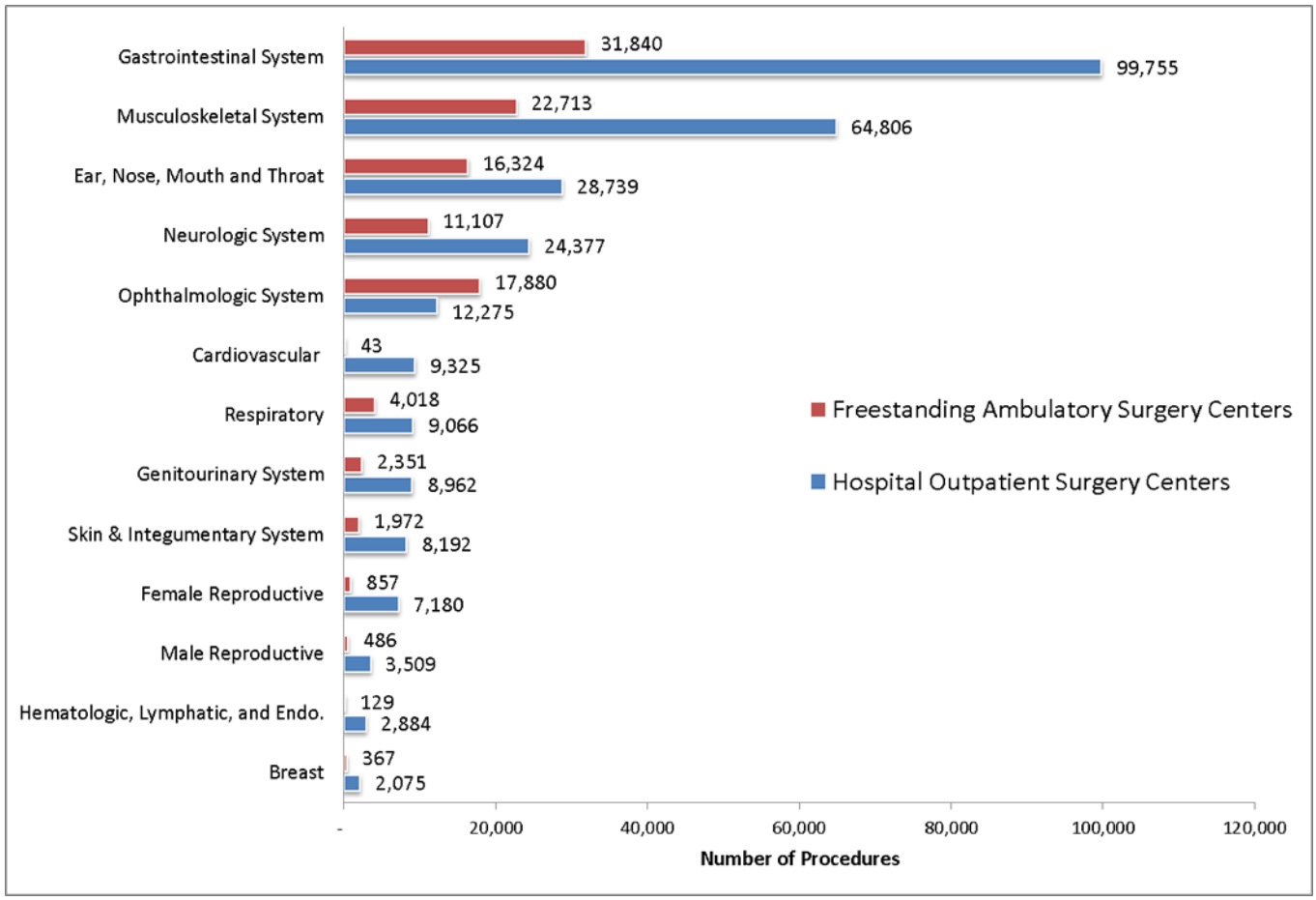
- OHCS developed the basic data infrastructure needed to create a MONAHRQ hospital comparison report
- OHCS launched the MONAHRQ (version 2.0.2) 2008-2010 Utah Hospital Comparison Report on December 13, 2011, accompanied by press release
- AHRQ released MONAHRQ (version 3.0) June 2012, which provides the ability to report provider-level composite measures and imaging, outpatient, and surgical patient safety CMS measures
- OHCS actively participated as a beta testing site for MONAHRQ (version 4.0), where important feedback was ascertained on the utility and usability of software enhancements
- AHRQ released MONAHRQ (version 4.0) August 2012, which provides the ability to report on two additional CMS measures - Central Line Associated Blood Stream Infections and Statin Prescribed at Discharge
- OHCS launched the MONAHRQ (version 4.0) 2009-2011 Utah Hospital Comparison Report in Winter 2011 December 18, 2012, accompanied by press release

Ambulatory Surgery Database (R428-11)

Under Administrative Rule R428-11, which became effective in March 1998, the Ambulatory Surgery Database mandates that all Utah licensed hospitals and freestanding ambulatory surgical facilities shall report information on selected ambulatory (outpatient) surgeries, starting January 1, 1996. This database contains the consolidated information on complete billing, medical codes, and personal characteristics describing a patient, the services received, and charges billed for each visit for a selected subset of ambulatory surgical procedures. 70 Utah ambulatory surgical facilities submitted data in 2010, this includes 45 acute care hospital based surgery centers and 25 freestanding ambulatory surgery centers.

Approximately 34% of reported ambulatory procedures were performed on the digestive system of patients, followed by the musculoskeletal system (22%).

Total Number of Ambulatory Surgical Procedures Performed by 3M Enhanced Ambulatory Procedure Group (EAPG) Category, 2009



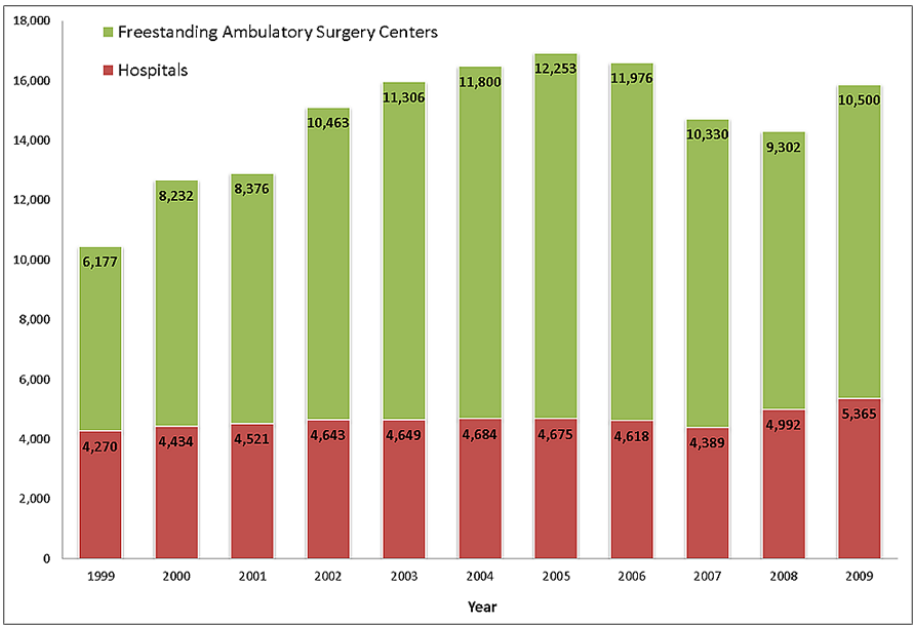
Source: Utah Ambulatory Surgery Database. Utah Department of Health, Office of Health Care Statistics.

"Accurate reporting and accessibility of ambulatory surgery data helps ASCs monitor and continually improve the patient care services we provide to our communities."

-- Robyn Archer, R.N. CEO/Administrator, Salt Lake Surgical Center; President, Utah Ambulatory Surgery Center Association

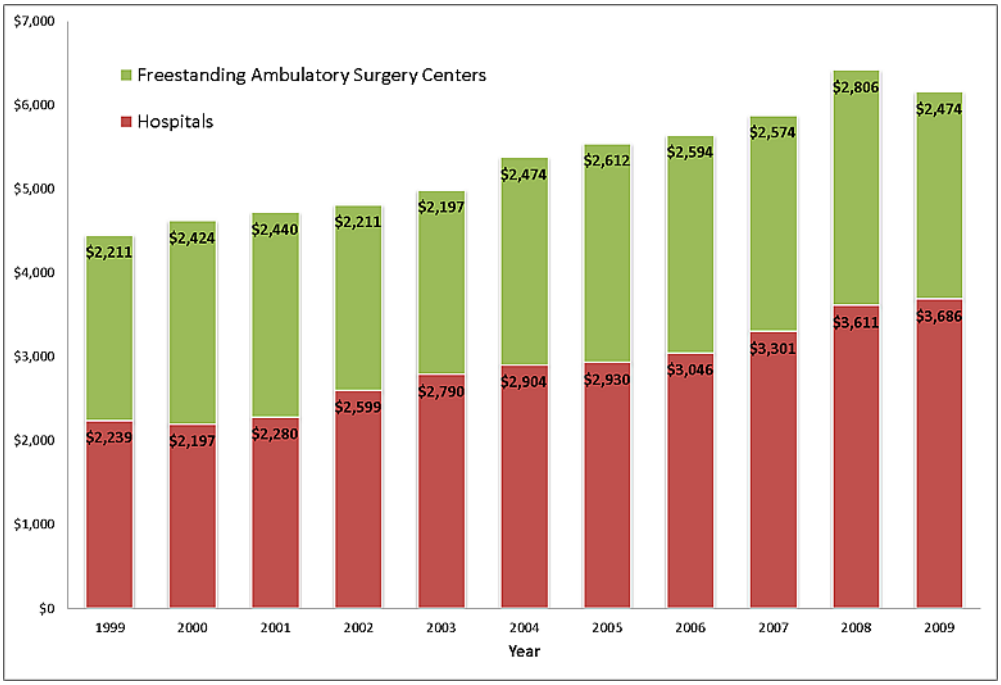
The figures below display the differences over time in patient volumes and average charges for cataract surgeries between hospitals and freestanding ambulatory surgery centers. The overall number of procedures per year remained relatively constant over the second half of the last decade, with the market proportion performed in the freestanding centers ranging from 59% in 1999 to a high of 72% in 2005, and dropping to 66% by 2009. Although the average charge for the hospital based surgeries increased substantially by 39% over the period, the corresponding increase at the freestanding centers was only 11%. For more information please visit http://www.health.utah.gov/hda/report/outpatient.php

Total Number of Cataract Procedures Performed by Facility Type , 1999-2009 (APG 214, EAPG 233 in 2009)



Source: Utah Ambulatory Surgery Database. Utah Department of Health, Office of Health Care Statistics.

Average Charge for Cataract Procedures by Facility Type ,1999-2009 (APG 214, EAPG 233 in 2009)



Source: Utah Ambulatory Surgery Database. Utah Department of Health, Office of Health Care Statistics.

Emergency Department Encounter Database (R426-7-4)

Administrative Rule R426-1-7(I) mandates all licensed Utah hospitals to report information on emergency department patient encounters starting in 1996. Forty three eligible hospitals submitted data in 2010. Lone Peak Emergency Center, a new satellite emergency department affiliated with St. Mark's Hospital, opened on May 25th, 2010. The Office of Health Care Statistics (OHCS) manages this database through a collaborative agreement with the Bureau of Emergency Medical Services and Preparedness (BEMSP).

"The Crash Outcomes Data Evaluation System (CODES) uses ED data in numerous projects, such as demonstrating importance of safety restraints and graduated driver licensing. CODES would be less effective without this vital resource."

-- Larry Cook, PhD, MStat, Assistant Professor

Emergency Department (ED) Encounters and Charges

During 2010, there were 731,545 encounters with Utah hospital EDs for a rate of 26.5 encounters per 100 persons in the state. The number of Utah hospital ED encounters has remained relatively flat in recent years, as shown in Figure 1, although a trend analysis projects slight upward growth.

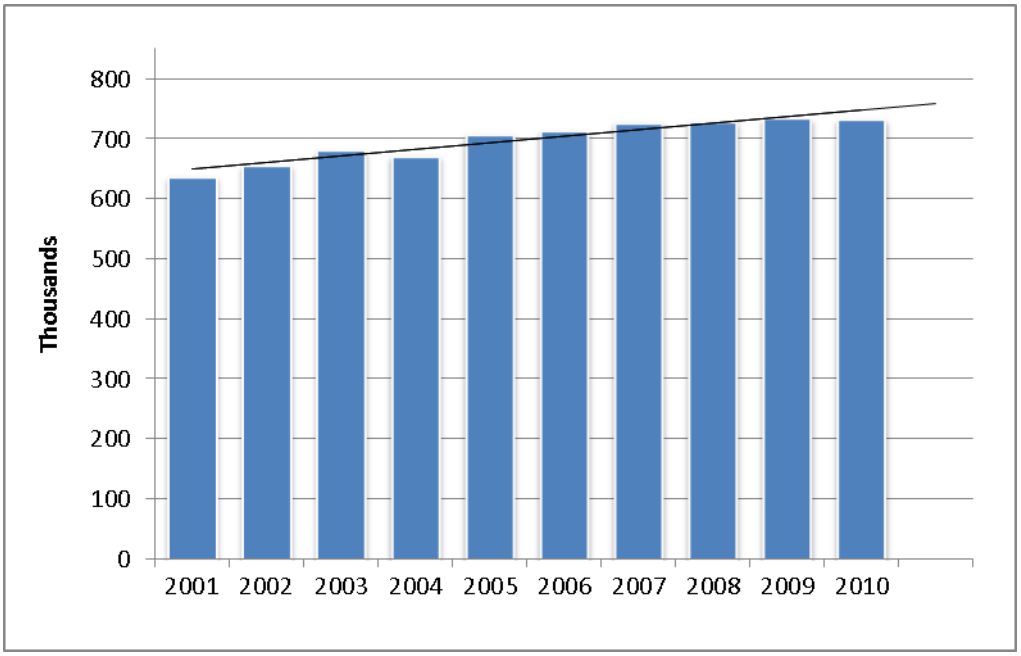


Figure 1. ED Encounters in Utah: 2001—2010
Source: Utah Emergency Department Encounter Database. Utah Department of Health, Office of Health Care Statistics.

Figure 2 shows the slight downward trend of the encounter rate (encounters/(population/100)) since 2001. This trend is noteworthy when considered in the context of population growth and in relation to charges incurred.

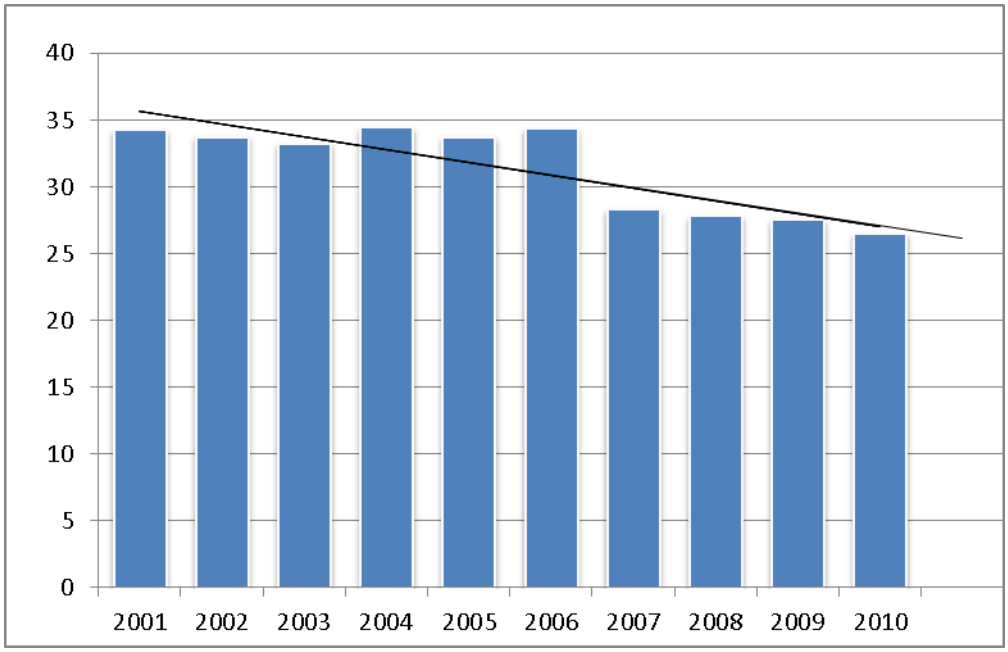


Figure 2. Encounter Rates per 100 persons in Utah: 2001—2010
Source: Utah Emergency Department Encounter Database. Utah Department of Health, Office of Health Care Statistics.

In 2010, the overall total charges for the 731,545 encounters were $3,179,594,128. Figure 3 represents the total charges for ED encounters from 2001 through 2010. The median charge for all 2010 encounters was $1,347. While encounters have increased by approximately 15% over the past 10 years, charges have seen a nearly three-fold increase. For more information please visit http://health.utah.gov/ems/data/er/

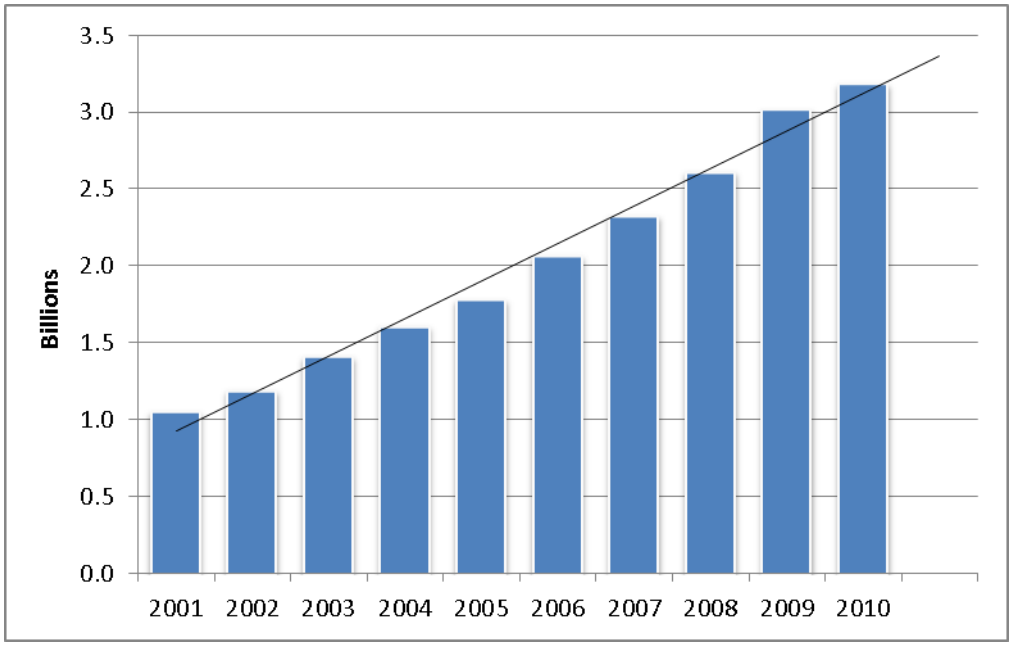


Figure 3. ED Charges in Utah: 2001-2010
Source: Utah Emergency Department Encounter Database. Utah Department of Health, Office of Health Care Statistics.

Consumer Assessment of Health Plans (CAHPS)

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys are a collection of questionnaires used to collect information on how people feel about the healthcare they received in the previous year. These surveys were developed by the Agency for Healthcare Research and Quality (AHRQ) and other health care research partners over the last 10 years. The Office of Health Care Statistics (OHCS) uses the CAHPS Health Plan Survey to find out how consumers rated aspects of their health plan. Administrative Rule R428-12 mandates that all Utah Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) provide survey data to the OHCS annually. The commercial, Medicaid and CHIP plans that participate in the survey cover 70% of Utahns with health insurance.

"CAHPS reporting helps us monitor the performance of our managed care plans and improve quality of patient care for Medicaid and CHIP enrollees."

-- Emma Chacon, Bureau Director
Utah Department of Health
Bureau of Managed Health *Care*

The CAHPS surveys are administered to adults in odd-numbered years and to caregivers of children in even-numbered years. The exception to this are the CHIP plans, who conduct a child survey every year since they do not cover adults. The survey measures satisfaction with aspects of plan performance, consisting of overall ratings and questions that create composite scores (two to four questions make up each composite). In 2011 and 2012 the survey project was conducted by DataStat, an NCQA-certified vendor. Some commercial plans contracted with their own vendors to conduct the survey and then sent the results to the OHCS.

2011 Key Findings for Adult Enrollees

Ratings *(state average for the percentage of members who gave their plan a score of 8, 9, or 10 on a 10-point scale)*				**Composites** *(state average for the percentage of members who gave their plan a score of "usually" or "always" on these performance measures. Response options were "usually", "always", "sometimes", and "never")*				
	Health Plan	Health Care	Specialist	Doctor	Getting Needed Care	Getting Care Quickly	Doctor Communication	Customer Service
HMOs	−	−	−	−	−	−	−	−
Medicaid Health Plans	−	+	+	+	+	+	+	−
CHIP (children)	+	+	+	+	+	+	+	+
PPOs	−	+	−	−	−	−	+	+
− = below national average				**+ = above national average**				

The full report can be found at http://health.utah.gov/myhealthcare/reports/cahps/2011/index.php

A total of 15 plans participated in the 2011 CAHPS project: 3 Medicaid HMOs, 1 CHIP, 3 commercial HMOs and 8 commercial PPOs. Utah's CHIP program has consistently performed above national benchmarks, 2011 marks the third year in a row that CHIP has scored above the national average on every rating and composite. Utah Medicaid plans are also performing well but are behind national benchmarks on ratings of the health plan and customer service.

Utah HMOs scored consistently under all national benchmarks, which is cause for concern. PPOs scored somewhat better than national benchmarks, but still received low marks on characteristics such as the rating of health plan, health care, and customer service. The next adult survey will be in 2013 and many plans have performance improvement programs in place to address these scores.

2012 Key Findings for Child Enrollees

Ratings *(state average for the percentage of members who gave their child's health plan a score of 8, 9, or 10)*				**Composites** *(state average for the percentage of members who gave their child's health plan a score of "usually" or "always" on these performance measures)*				
	Health Plan	Health Care	Specialist	Doctor	Getting Needed Care	Getting Care Quickly	Doctor Communication	Customer Service
HMOs	−	+	+	+	+	+	+	+
Medicaid Health Plans	+	+	−	+	+	+	+	−
CHIP	−	+	+	+	+	+	+	−
PPOs	−	+	−	+	+	+	+	+
− = below national average				**+ = above national average**				

The full report can be found at http://health.utah.gov/myhealthcare/reports/cahps/2012/index.php

Only the CHIP surveys can be compared from year to year since they always survey caregivers about their child's health plan. CHIP did not perform as well in 2012 as in 2011, with rating of health plan and customer service falling below national averages.

Both HMOs and PPOs scored better in the child survey than they did in the adult survey conducted in 2011. HMOs scored above national averages on every measure but rating of health plan when the survey responders were parents. PPOs followed a similar pattern, scoring above national benchmarks on every measure but two: rating of health plan and customer service.

Medicaid health plans scored below national benchmarks on customer service in the child survey, as they did in the adult survey. The Medicaid program conducted additional surveys in 2012 and gathered additional information about the aspects of customer service that were problematic for enrollees. More work will be needed to address these areas.

cahps® Surveys and Tools To Advance Patient-Centered Care

Healthcare Effectiveness Data and Information Set (HEDIS)

The Utah Health Data Committee (HDC) continues to monitor the performance of commercial HMOs (health maintenance organizations), CHIP HMOs, and Medicaid health plans. These findings are described in an annual report in accordance with Administrative Rule 428-13. This provides consumers, brokers and businesses that purchase insurance with information about the quality of care provided by health plans in the state. HEDIS measures are reported to the National Committee for Quality Assurance (NCQA) by accredited health plans so the results for Utah plans can be compared to health plans nationally.

The Healthcare Effectiveness Data and Information Set (HEDIS) is a national standardized set of performance measures used to monitor the quality of care provided by health plans.
HEDIS comprises 71 measures across eight domains that measure how well consistently preventive care services are provided and how often unnecessary care is avoided.

Domains

- **Effectiveness of Care**
  Example: *child immunizations*
- **Access/Availability of Care**
  Example: *access to primary care providers*
- **Satisfaction With the Experience of Care**
  Example: *CAHPS survey questions*
- **Use of Services**
  Example: *Well-child visits*
- **Cost of Care**
  Example: *Relative resource use for diabetes*
- **Health Plan Descriptive Information**
  Example: *Board certifications*
- **Health Plan Stability**
  Example: *Total health plan membership*

"HEDIS reporting allows us to measure and improve the quality of care and service provided to our members and ultimately the clinical outcomes and service experiences for our members."

--David L. Larsen RN, MHA, Director of Quality Improvement, SelectHealth

It should be noted that this report only contains data from HMOs; PPO data is not collected for HEDIS at this time.

HEDIS 2011 and 2012 Key Findings

Below is a sample of 2011 and 2012 HEDIS key findings for selected measures.						
	2011			2012		
	Commercial HMOs	Medicaid Health Plans	CHIP	Commercial HMOs	Medicaid Health Plans	CHIP
Child Immunizations	+	+	+	+	+	+
Well-Care visits for Adolescents	−	+	−	−	−	−
Appropriate use of medication for Asthma (Ages 5 to 11)	−	+	+	+	+	+
Diabetics who received blood sugar screening	−	+	Not Measured	−	+	Not Measured
Cervical cancer screenings	−	+	Not Measured	−	−	Not Measured
− = below national average			+ = above national average			

The full 2011 report can be found at http://health.utah.gov/myhealthcare/reports/hedis/.

The full 2012 report will be released January of 2013.

The above table shows a sample of results from the HEDIS submissions in 2011 and 2012. Utah health plans are doing well on childhood immunizations, scoring above the national average in both years. Appropriate use of asthma medications is also a strong measure. However, health plans scored below national averages for adolescent well-care visits. Blood sugar screenings for diabetics and cervical cancer screenings are a mixture (these measures are not collected for CHIP since they are adult-only measures). The Medicaid health plans are performing on both measures. The Commercial HMOs are consistently under the national average. By collecting and reporting these measures, the OHCS brings attention to important health issues for plans, providers, and consumers.

In 2011, about 35% of Utahns who had health insurance were covered by one of the health plans in the Consumer Satisfaction report. In 2012 about 30% of Utahns who had health insurance were covered by this report.

Future Directions for HEDIS

PPOs will be collecting and reporting HEDIS data for the first time in 2013. The first HMO & PPO state-wide report will be released in the Fall of 2013.

All Payer Claims Database (APCD) R428-15

Utah's All Payer Claims Database (APCD) has been collecting data since September 2009 and participating health plans have been submitting enrollment, pharmacy, and medical file data going back to 2007. In June 2012 the database also started receiving fee-for-service claims from Medicaid. As of this biennial report, there are now 21 payers submitting data on the current schedule. The schedule entails submitting data within 30 days of receiving a claim. In 2011 and 2012, the APCD received more than 46 million medical and pharmacy claims. These claims account for $11.1 billion in medical charges of which $4.43 billion was paid. In addition to the medical claims, the APCD received $3.22 billion in paid pharmacy claims from 2011-2012.

The database contains enrollment, pharmacy and medical claims data for 2007-2012 from the following health plans:

- SelectHealth
- Regence
- Public Employees Health Program (PEHP)
- Altius
- Deseret Mutual Benefit Association (DMBA)
- United Healthcare
- Great West
- Cigna East
- Meritan Health
- University of Utah
- Educator's Mutual Insurance Association (EMIA)
- Cigna Behavioral
- Aetna
- Humana
- Assurant
- Optum
- Tall Tree

The APCD is capable of reporting on quality measures, cost and efficiency, and utilization rates. It is also a goal of the Office of Health Care Statistics (OHCS) to empower researchers outside the Utah Department of Health (UDOH) with reporting capabilities. Publications include *Making Cents of Utah's Healthy Population*, May 2011, and *A Snapshot of Clinical Performance by Small Area*, July 2012. OHCS continues working to provide access to the APCD for these various projects:

- HealthInsight and their IC^3 Beacon Community grant
- Utah Health Information Network (UHIN) for cHIE identity validation
- Relative value (RVU) study for the Department of Insurance
    - First study was completed in spring 2011, and OHCS is working on a follow-up report for spring 2013.
- Providing access to a research database for researchers at the University of Utah, as well as actuaries for Utah's Health Insurance Exchange

"Utah's All Payer Claims Database is the best data source to understand health care utilization, costs and quality of care both cross-sectionally and longitudinally. It is an important source of information for measuring the impact of health care reform."

-- Jaewhan Kim, PhD, Asst. Professor, University of Utah,
Family and Preventative Medicine

The APCD is a powerful tool for understanding healthcare cost, utilization, and quality in the state of Utah. According to the National Association for Health Data Organizations (NAHDO), Utah's APCD is one of ten operating APCDs in the nation. There are six more states in the implementation process. Furthermore, NAHDO tells us there are only five states producing public reports from data in an APCD. Utah is one of those states, and one of only two states with plans to report clinics' quality performance using APCD data.

House Bill 128 (HB128) was passed in 2011 and mandates the creation of the Utah Clinic Performance report. This report will use nationally accredited quality measures to provide compliance rates for primary care clinics in the state of Utah. In July 2012, OHCS produced A Snapshot of Clinical Performance by Utah Small Area. This report is a preliminary investigation into how comparable small areas are performing on the same quality measures that will be reported for primary care clinics in 2013.

OHCS successfully created a research warehouse in 2011. This data warehouse contains processed and deidentified data for use by researchers such a Jaewhan Kim, an Assistant Professor in the Division of Public Health at the University of Utah. Dr. Kim is using the APCD's research warehouse in conjunction with Medicare data to conduct research on the impact of primary care redesign on overall healthcare utilization and costs to patients.

All Payer Claims Database Collaborative Efforts:

Beacon Community Grant

In May 2010, HealthInsight was awarded one of seventeen Beacon Community grants by Health and Human Services. The goal of the Beacon Community programs is to achieve better health and better care at lower cost. Utah's Beacon Community is known as IC3 for "Improving Care through Connectivity and Collaboration". This project is designed to support the expansion of health information technology and promote Meaningful Use of electronic health records (EHR) in the Salt Lake MSA. IC^3 seeks to increase the Meaningful Use of electronic health records by clinicians to improve the quality of care for diabetics and patients with other chronic conditions.

The goals specific to IC^3 Beacon Project are stated as follows:

1. Improve the management and coordination of care for people with Diabetes Mellitus (DM) through care process redesign and information exchange.

2. Reduce avoidable hospital admissions, readmissions, and ED visits for patients with DM.

3. Improve consistency between patient wishes and care provided during last 6 months of life.

4. Improve communicable disease reporting capacity among hospitals.

IC^3 is working closely with nearly 70 medical practices including 360 providers that touch the lives of 23,712 patients in Utah. IC^3 focuses on helping practices and providers improve workflow processes through the use of EHRs and quality clinical documentation in order to improve health outcomes. Quarterly community-wide primary care learning sessions are focused on diabetes management and HIT. Other activities include performance feedback to providers by clinic, clinical guideline best practice use/dissemination, patient reminder/follow-up systems, care managers and care transition training for clinic staff, patient engagement tools, and quality improvement coaching. As part of the patient reminder and follow-up systems, IC^3 is also developing and testing patient engagement tools to utilize technology outside the clinics to help patients manage their chronic disease. IC^3 also trains emergency medical personnel and providers how to access Physician Order for Life-Saving Treatment (POLST) documentation which is available via an electronic repository.

Utah's Clinical Health Information Exchange (cHIE) is pivotal to IC^3 participants for exchanging data electronically to support Beacon and other initiatives. These data are being used to evaluate the progress of clinics with varying levels of preparedness in meeting Beacon's quality improvement challenges. IC^3 selected 12 practices based on their leadership, motivation to implement Beacon interventions, and early indications of rapid adoption of quality improvement processes. These practices are participating in a robust cohort program to achieve Meaningful Use, connect to the cHIE, and meet all five of the focus measure goals for their patients with Diabetes: 10% improvement in LDL, A1c and BP control; 20% improvement in A1c, LDL, microalbumin screening. All robust cohort clinics appear likely to meet their goals by the end of the program.

All Payer Claims Database Usage:

Relative Value Study Methodology for 2010

In cooperation with the Utah State Department of Insurance, the All Payer Claims Database (APCD) is being utilized to provide the data for calculations to derive the Fee Schedule Dollar Amount (FSDA) for each Current Procedural Terminology (CPT) or Code on Dental Procedures and Nomenclature (CDT).

Medical claims data from the APCD were selected from the most commonly performed procedures for each professional specialty; Medicine, Surgery, Pathology, Anesthesia, Radiology, Dentistry, and Evaluations and Management. Claims were selected to provide statistically valid samples of practitioners operating in Salt Lake County, Utah for the 2012 calendar year.

The medical claims were sorted by CPT and CDT codes into the seven categories listed above. Each billed charge was divided by its corresponding CMS Relative Value Unit (RVU). This resulted in a list of conversion factors (Billed Charge / CMS Relative Value Unit = Conversion Factor). Then the Conversion Factors were ranked from lowest to highest within each of the seven Specialty Groups. This was used to determine the Conversion Factor at the 75th percentile for each group.

The next step involved calculating the FDSA for each individual CPT and CDT code by multiplying the applicable Medical Specialty Group Conversion Factor by the CMS Relative Value Unit for each particular CPT and CDT code (Medical Specialty Group Conversion Factor x CMS Relative Value Unit = Fee Schedule Dollar Amount). The RVU value for each CPT code with its modifiers was selected from proprietary RVO data purchased from Ingenix. The RVU value for each CDT code with its modifiers was selected from proprietary RVO data purchased from Relative Values Study, Inc.

The range of codes used for each group of codes differed. Codes for these groups included Surgery (CPT 10021 through CPT 69990), Radiology (CPT 70010 through CPT 79999), Pathology (CPT 80047 through CPT 89356 and CPT 89398), Medicine (CPT 90281 through CPT 99199 and CPT 9950 through CPT 99607), Evaluation (CPT 99201 through CPT 99499), Dental (CDT D0120 through CDT D9999), and Anesthesia (CPT 00100 through CPT 01999). The number of claims for a specified code with modifier also varied.

The criteria for inclusion of cases, exclusion of claims with invalid values, calculation of most intermediate variables, such as adjusted amount billed, and final variables, such as FSDA, were the same.

The use of the APCD has provided the Department of Insurance with a high level of transparency as to the method/calculations utilized for the RVU Study over prior vendors and their methods.

In response to the 2012 MONAHRQ release...

"Good consistent information is at the heart of quality and value improvement, Providing accurate, clear and easy to understand data helps consumers to make wise choices, and providers to make improvements."

-- Greg Poulsen, Intermountain Healthcare,
VP, Chief Strategy Officer

Part II

Special Projects

Improve Facility Reporting Compliance

Project Overview

- The Office of Health Care Statistics (OHCS) is continually trying to improve reporting compliance for facility reporting. Back in 2009, data was collected from 53 hospitals and 21 freestanding ambulatory surgery centers (FASCs). The hospitals include 41 emergency departments at acute care and critical access hospitals. Also included with the inpatient data are three psychiatric hospitals, eight specialty hospitals and the Veterans Administration Medical Center.
- The current reporting by the FASCs is dramatically incomplete and caution should be used when trying to perform market level comparisons with this data. In 2009, 12 out of 33 possible FASCs were identified that did not report data. Over the last three years, efforts have been made to improve this reporting.

Methods

- As a first step towards understanding the problem, a work group consisting of staff was put together. They developed a detailed survey that was sent out to contacts at each of the identified FASCs to try to determine how to make data submissions for Ambulatory Surgery Centers more efficient.
- OHCS requested assistance from the Utah Ambulatory Surgery Center Association to assist the department in reaching out to their association contacts on their behalf.
- A letter was sent out to all non-compliant facilities explaining the reporting requirements, along with a technical submittal manual.
- For those facilities that responded to the initial letter, there is a lengthy process to bring each facility on board. The process may consist of multiple contacts over several months with various individuals from facility managers, medical records clerks, vendors or IT staff to explain initial requirements, working through technical issues, and finally, performing detailed tests before they start submitting data.
- Facilities that had not responded to the initial letter have been contacted several times individually by staff during 2010 and 2011 with varying degrees of success.

Outcome

In 2010 several new facilities started reporting that previously had never submitted data to the Office of Health Care Statistics. Shriner's Hospital for Children, a charity hospital that was previously exempt from reporting, voluntarily started submitting data beginning in October 2010. Lone Peak Emergency Center, a new satellite emergency department affiliated with St. Mark's Hospital, opened in May 2010 and started reporting data soon thereafter. Five freestanding ambulatory surgery centers have also become compliant from 2010 to the present. These facilities include Alpine Surgical Center, American Fork Surgery Center, Granite Peaks Endoscopy Center, Mountain West Endoscopy Center and St. George Endoscopy Center.

Update Submission Specifications for Facility Health Encounter Databases

Project Overview

- 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 2013 data cycle.
- Expansion of hospital inpatient reporting to current uniform billing standards. This will coordinate our reportable data elements to match improvements the hospitals are currently making to their systems to meet the federal HIPAA version 5010 transaction standard and the upcoming transition to ICD-10 in the billing industry.

Outcome & Timeline

- On May 31, 2012, significant changes to the Inpatient reporting rule (R428-10) were enacted, adding the new fields listed above to the set of reportable data elements.
- In January 2013, OHCS published and disseminated a revised Inpatient submittal manual to the individual hospitals or IT vendors for them to update their systems beginning in spring of 2013.
- In Spring/Summer 2013, OHCS will follow up and train data contacts about changes in reporting and resolve technical issues.
- In Fall 2013, OHCS will evaluate the Ambulatory Surgery and Emergency Department reporting rules and submittal specifications for needed updates starting in 2014.

Impact

- 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.
- Enhanced reporting capabilities in the quality indicators software and provider level reporting. OHCS 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.

Coordinate UDOH Medicaid Survey Project, 2012

Project Overview

- In May 2012, the UDOH Division of Medicaid & Health Financing, Bureau of Eligibility Policy, asked the Office of Health Care Statistics to conduct a survey project analyzing experiences of the program's application, renewal, and closure processes.
- OHCS mailed surveys and reminder postcards to 7,500 eligible people over a five week period and entered results from completed surveys into a database. OHCS analyzed the data and produced a full report of detailed findings on September 30, 2012.
- All costs—including materials and labor used for the project—were paid by the Robert Wood Johnson Foundation, Maximizing Enrollment Grant.

Method

- OHCS hired a temporary worker to send out the mailings; contracted with Utah Correctional Industries to input data from completed surveys; and provided OHCS staff to coordinate the project, track returns, analyze data, and create a final report.
- From May-June 2012, OHCS mailed out surveys to a sample of Medicaid (3,000), CHIP (3,000), and Denied/Closed (1,500) cases, with at least one child under age 19.

Outcome

- As of June 29, 2012, the mailing and data entry portions of the project were completed.
- The OHCS delivered a report of detailed findings to the Bureau of Eligibility Policy on September 30, 2012.

Impact

- Survey feedback will be used by UDOH's Bureau of Eligibility Policy (BEP) to identify improvements in the application and renewal processes.
- Primary goal is to improve services of BEP so that they better meet the needs of Utah families.
- OHCS' role as internal process evaluator will directly impact the delivery of quality healthcare to Utahns.

Part III

Priority Projects: 2013 - 2014

Priority Project I:
Readmissions to Utah Hospitals Reporting

Project Description

The majority of hospitalizations are often necessary and appropriate; however, a substantial fraction of these hospitalizations can often be classified as potentially avoidable. Avoidable hospitalizations are characterized by patients that are returning to the hospital soon after their previous stay. These readmissions are normally defined by examining re-hospitalizations that have occurred within 30-days of the original stay. Literature suggests that readmission rates are influenced by patient diagnoses, treatment protocols, severity of illnesses, and discharge planning procedures of the hospital.

It is the general consensus that hospital readmissions be prevented, due to their costliness and negative impact on patient health. Hospitals have reduced readmission rates by improving core transition discharge processes, with a focus on coordination of future care and patient self-management. Knowing a hospital's readmission rate for select conditions may be an important factor in determining the functionality of their discharge process. In addition, this information may also be helpful to the public as they seek out the best available health care for their needs. Thus, the Office of Health Care Statistics (OHCS) plans to release a Utah hospital readmissions report, which will address these factors while also further improving the transparency of care.

Benefit to the Public

This readmission report will provide consumers of care the ability to closely examine a hospital's efficiency and quality of care. In addition, this report will also act as a benchmark for health care providers and administrators to examine when seeking to improve their discharge process and thoroughness.

Tasks and Time Line

- Winter 2013: Link inpatient hospitalizations (2008-2010) to individual patient identifiers, in preparation to running analyses.
- Spring 2013: Analyze hospitals readmissions by running 3M Potentially Preventable Readmissions (PPR) grouping software on patient-linked (2008-2010) inpatient hospitalizations.
- Summer 2013: Develop and release a Utah hospital readmissions report for years 2008-2010, accompanied by press release.

Measurable Outcomes

- Utah hospital readmission rates will be compared and validated against the readmission rates available from the Centers for Medicare and Medicaid Services (CMS) Hospital Compare.
    - CMS Hospital Compare only examines readmissions for a few select conditions.
- Feedback from readers of the report be gathered and reviewed.
- Number of visits to the online report's website will be tracked and analyzed.

Priority Project II:
Improve Facility Reporting (Long Term Trend Reporting)

Project Description

The Health Data Committee and the Office of Health Care Statistics has a long history of collecting and managing facility claims data from the Hospital and Ambulatory Surgery communities. With 20 years available in the Inpatient database (1992-2011) and 16 years available in both an Emergency Department Encounter database and an Ambulatory Surgery database much more can be done to assess historical trending patterns in healthcare for Utahns. Although efforts have been done to expand the use of this data outside of the Health department through widespread usage of Internet technology and partnerships with the research community, in many ways the wealth of information contained in this data has not been fully realized. We are proposing to develop procedures and modules to accompany current annual standard reporting that would expand current analyses to include additional long-term trend topics. Potentially a series of these topics may be published on the public facing OHCS website to educate consumers and the hospital community. The effect of the recent recession on hospitalization trends, newborn birth rates, insured status, optional surgery rates along with patterns of emergency department utilization are examples of trends worth exploring.

Benefit to the Public

Reporting on these trending patterns would empower consumers with greater knowledge when utilizing the healthcare community. It also will present them an opportunity to see trends in quality, cost of care and access to services. Interesting topics could potentially aid researchers in producing reports which may affect payment reform and innovation in healthcare delivery.

Tasks and Time Line

- Summer 2013: Consult with OHCS staff to identify and plan for potential topics.
- Fall 2013: Develop programs to streamline creation of trending graphs and charts.
- Late 2013: Publish selected topics with standard reports or on the OHCS website.
- 2014: Review and expand existing topics reported.

Measurable Outcomes

Success of this project will be determined by improvements in the current standard annual reports and broader usage of the OHCS website.

Priority Project III:
Improve Public Awareness of the MONAHRQ Reporting System

Project Description

As mandated by Senate Bill 132, the Health Care Consumer Bill in 2005, the Utah Health Data Committee is responsible for providing to the public a Utah hospital comparison report. MONAHRQ, standing for "My Own Network, Powered by AHRQ", is a comprehensive web development tool provided by the Agency for Healthcare Research and Quality (AHRQ) that is utilized by the committee's staff in producing this report. A web metric tool, utilized in recording the frequency of website traffic, has reportedly shown that the previous MONAHRQ hospital comparison report (2008-2010) had been visited 3,692 times within the last year. The Office of Health Care Statistics (OHCS) staff are pleased that the hospital comparison report is being utilized, but seek to increase website traffic to the newly released MONAHRQ hospital comparison report (2009-2011). Thus, OHCS staff will launch a public awareness campaign of the MONAHRQ hospital comparison report in order to increase the number of users utilizing the valuable information found in the report. This campaign will be directed at key interest groups within the Utah Department of Health and among research investigators, faculty, staff, and students at the University of Utah.

Benefit to the Public

Utilization of the MONAHRQ reporting system allows OHCS staff the ability to create a web-based hospital comparison report that is user friendly for all audiences. Consumers of care are able to learn about the health care available to them, thus impacting their ability to effectively choose the best provider (ex. Hospital) for their needs. Policy makers, health economists, and research investigators can review the hospital comparison report in order to better understand the health care-related needs of Utahns. Thus, the information accessible in the report can act as a resource in formulating important health policies.

Tasks and Time Line

- Winter/Spring 2013: Conduct MONAHRQ-related workshops for Utah Department of Health key interest groups:
  - IBIS Analysts work group
  - Health Promotion and data evaluation work group
  - Healthcare-Associated Infection (HAI) work group
- Summer 2013: Conduct a MONAHRQ awareness presentation at the Public Health Grand Rounds sponsored by the Department of Family & Preventative Medicine at the University of Utah.
- Fall 2013: Perform a 12-month comprehensive evaluation of website traffic trends associated with the 2009-2011 MONAHRQ hospital comparison report.

Measurable Outcomes

The OHCS staff will appropriately track the number of visits to the MONAHRQ hospital comparison report website. These figures will be recorded and examined monthly. A trend examination will be performed after 12 months of visits have been recorded. This analysis will seek to characterize the potential impact of the public awareness events on website traffic.

Priority Project IV:
Implementation of HEDIS & CAHPS Data Collection for Accountable Care Organizations ACO's in Utah

Project Description

An Accountable Care Organization (ACO) is a healthcare organization designed to provide care for a group of patients in return for a contracted fee. The ACO is responsible for all aspects of patient care, with a special focus on primary and preventive care. Since the ACO is paid by a third party payer on a contractual basis, and not a fee-for service basis, its focus is on providing high quality care at the lowest cost.

The payment structure of ACOs rewards providers for providing the best care for the least cost, rather than rewarding high utilization, which is the case in the current healthcare system. By increasing care coordination and quality, ACOs can help reduce unnecessary medical care and improve health outcomes. This leads to a decrease in utilization of acute care services and an overall reduction in healthcare costs.

Benefit to the Public

The transition to ACO-based care marks an important milestone in the movement toward more affordable healthcare for all. The formation of ACOs is supported by the Patient Protection and Affordable Care Act ("ObamaCare"). An important part of the Medicaid ACO model is a "medical home". Each Medicaid client would have a personal physician or group of providers who would deliver primary care and also coordinate any other care that the client receives through the ACO network. Public reporting of quality measures for these ACOs will allow potential enrollees to make an informed decision when choosing a Medicaid plan.

Tasks and Time Line

- **January 2013:** Medicaid ACOs begin enrollment
- **January 2014:** ACOs collect HEDIS data on patient care from 2013
- **July 2014:** Medicaid ACOs report 2013 data to OHCS
- **October 2014:** Report on Medicaid ACO quality measures released

Measurable Outcomes

Impact of the report will be measured by tracking the number of hits and downloads the on-line report receives.

Priority Project V:
External Quality Review Project

Project Description

Managed Care Organizations (MCOs) and Pre-Paid Inpatient Health Plans (PIHPs) that contract with Medicaid must conduct performance improvement projects in compliance with Federal Regulation 42 CFR §438.240(b)(1). Performance Improvement projects are an important part of an MCO's service to Medicaid enrollees. By ensuring that quality is emphasized, plans provide continually improving care to those who need covered services. In 2013, the Office of Health Care Statistics (OHCS) will expand its existing contract with Medicaid to assume responsibility for the integrity, validity and completeness of these projects and will ensure that the projects are effective in raising the quality of care.

- Performance Improvement Projects (PIPs) involve:
- Measuring performance using objective quality indicators
- Implementing system interventions to achieve improvement in quality
- Evaluating the effectiveness of the interventions, and
- Planning and initiating activities to increase or sustain improvement

Oversight of the performance improvement projects is also mandated by CMS and is called an External Quality Review (EQR). States have the option of doing this review themselves, or contracting with an External Quality Review Organization (EQRO). An EQRO can be a licensed vendor or some other entity that has the necessary qualifications. Federal matching funds are provided to Medicaid to support the EQR activities. Medicaid will contract with the Office of Health Care Statistics (OHCS) to conduct EQR activities that will begin the first of the year. Activities involve working with 14 MCOs that contract with Medicaid: 9 pre-paid mental health plans, 1 physical health plan, 2 CHIP managed care entities, and 1 specialty program. The OHCS will oversee all aspects of each plan's Performance Improvement Project (PIP) and also provide technical assistance to plans as needed.

Benefit to the Public

Quality improvement project ensure that Medicaid plans are delivering the highest-quality of care to their enrollees. Oversight of these projects certifies that the projects are conducted with integrity and that the results are valid.

Tasks and Timeline

- January 2013: OHCS begins oversight of Medicaid performance improvement projects
- February – October 2013: Plan audits and technical assistance
- November 2013: Final report to Medicaid

Priority Project VI:
All Payer Claims Database Vendor Improvements

Project Description

In August of 2012, the APCD lost an important software element when the now defunct CareAdvantage Inc. went out of business. This has temporarily limited the ability of OHCS to analyze episodes of care and produce reports on quality measures such as those mandated by House Bill 128 (HB128). However, the APCD continues to receive and process data, which will be used to produce reports upon selecting new software in 2013.

The Department of Health has contracted with the National Association of Health Data Organizations (NAHDO) to develop a request for Proposal for software purchase/development to restore our APCD analytic capability and to fill the gaps in data needed to fulfill the requirements for these data in Utah public health and health care. This software vendor selection process will take into account the needs of those currently collaborating with OHCS, and the healthcare community as a whole.

Benefit to the Public

Completion of the vendor process will restore the APCD to its full analytic capability. This will allow OHCS staff to respond to requests from stakeholders in the healthcare community, as well as the media, with great expedience. The new vendor will also enable OHCS to analyze nationally accredited quality measures.

Tasks and Time Line

- December 2012: Request for Proposals for aggregation and analytic vendor(s) to produce quality and cost reports
- January 2013: Conduct review of RFP responses for vendor selection
- Early 2013: Consult with selected vendor on methodology for attributing patients to physicians and conducting comparative analysis of quality

Measurable Outcomes

Success of this project will be measured by whether or not OHCS completes an RFP process for a new software vendor within the timeframe provided.

Priority Project VII:
All Payer Claims Database Reporting Improvements

Project Description

The Health Data Committee has accepted a challenge from Utah Department of Health (UDOH) Executive Director to take an active role in 2013 in ensuring that the development and analysis of the All Payer Claims Database (APCD) aligns with the strategic goals of the Department of Health in making Utahns the healthiest people and in keeping health in health reform. The initial analysis of the APCD focused on aggregate analysis of episodes of care at the state and small geographic area levels of analysis. Publications include Making Cents of Utah's Healthy Population, May 2011, and A Snapshot of Clinical Performance by Small Area, July 2012. Despite special emphasis from the Executive Branch of State Government and Utah Legislature on the need for more specific comparative reports at the clinic level, the data elements in the APCD are currently inadequate to support this more granular analysis. The Office of Health Care Statistics (OHCS) will leverage the capabilities of the selected vendor to ensure completion of clinical performance reporting. OHCS will also provide researchers outside UDOH with access to reliable data for creation of independent reports.

Benefit to the Public

Reporting empowers consumers with greater knowledge when choosing providers, and presents an opportunity for improvement in quality and cost of care. The development of a robust environment for researchers to produce reports outside the scope of UDOH is important to both payment reform and innovation in healthcare delivery.

Tasks and Time Line

- Early 2013: Present healthcare reporting issues to appropriate stakeholders and seek consensus on APCD reporting requirements
- Early 2013: Consult with selected vendor and UDOH staff to design a standard output and other CRG related products from the APCD
- Early 2013: Consult with selected vendor
- Mid 2013: Submit clinic performance data to clinics for review
- Mid 2013: Publish clinic performance report
- Mid 2013: Research database available for expanded researchers' reporting
- 2014: Repeat clinic performance reporting with expanded quality measures

Measurable Outcomes

Success of this project will be determined by publishing the clinic performance report on schedule. Reporting success is also determined by the ability of researchers to gain access to APCD data for independent reporting.

Priority Project VIII:
All Payer Claims Database Quality Analysis Improvements

Project Description

Utah's All Payer Claims Database (APCD) is mandated to produce quality reports on primary care clinics. It is important we be able to accurately identify and link providers' claims across practice locations, as well as accurately attribute patients to providers, in order to report clinics' performance based on nationally accredited quality measures. The Office of Health Care Statistics (OHCS) purchased Informatica Identity Resolution (IIR) for the sake of linking patients' claims and assigning a patient a unique identifier. IIR is capable of discerning a patient that moves, changes names, or switches insurance plans. OHCS will utilize the power of IIR software to identify individual providers in the claims. These providers can then be assigned patients and aggregated into clinics. Clinics will then receive their data and be able to provide feedback on the quality of attribution before publishing.

Benefit to the Public

Governor Herbert has stated that one of the main priorities for Utah is "self-determination", or the continuance of Utahns solving Utah's problems. As part of an objective toward self-determination, the governor states we need to "increase the efficiency of healthcare markets by providing accurate information on cost and quality to insurers, providers, and consumers through multiple channels, including the 'All Payer Database'." Clinic performance reports will provide consumers information for comparing primary care clinics throughout the state. Reporting also gives providers an opportunity to participate in understanding and improving data quality in order to build a community wide acceptance of reporting methods. The reports will also show areas where clinics can improve their quality of care.

Tasks and Time Line

- Spring 2013: Finalize patient attribution to providers and aggregate providers into clinics.
- Mid 2013: Publish Clinic Performance Report with clinic-level quality measures.
- Winter 2013: Receive feedback from healthcare community about data quality and utilize information to improve identification and attribution process.
- 2014: Repeat process for 2013 with new quality measures added.

Measurable Outcomes

Success of this project will be measured by publishing accurate reports in each of the next two years. These reports will be made publically available on the OHCS website.

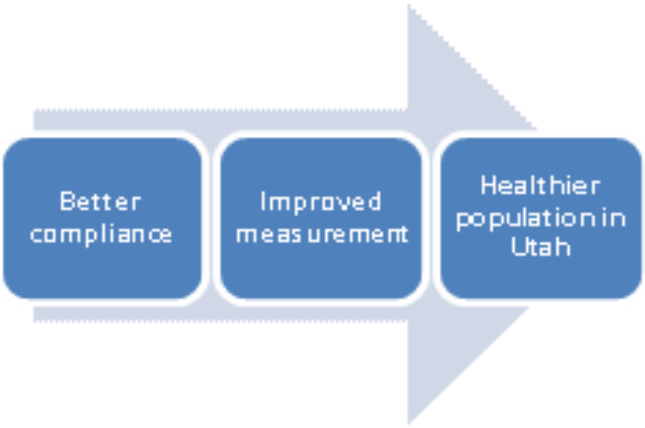
Priority Project VIII:
Improve Reporting Compliance for OHCS Data Systems

Project Description

As noted earlier in this report, the Health Data Committee's (HDC) staff in the Office of Health Care Statistics (OHCS) collects health care data for three primary areas: 1) Discharge databases, including inpatient, ambulatory and emergency department; 2) Health plan measurement, including CAHPS and HEDIS; and 3) Utah's All Payer Claim Database. In the past, compliance activities—such as ensuring full reporting from data suppliers—have rested solely with the OHCS program managers and/or Office Director. Many effective strategies have been implemented over the years to help ensure adherence to various administrative rules relating to the collection, analysis, and reporting of HDC data. In late 2012, the Office decided to have one person monitoring compliance with OHCS data systems, working closely with program managers when applicable.

Impact

The importance of comprehensive and timely compliance with OHCS data systems cannot be underestimated. A full and accurate picture of the healthcare system in Utah is only accomplished by having complete data as well. In a nutshell, what gets measured gets improved. Compliance oversight and assistance from the OHCS pays dividends to our bottom line of supporting meaningful health improvement initiatives, managing statewide health data reporting systems, and implementing policies which transform data into actionable, performance information.



Timeline

Fundamentally, OHCS compliance management should create a process that its staff can follow to bring non-compliant facilities and plans into compliance resulting in an improvement in data quality. Overall, enhanced compliance monitoring should ensure that working criteria for extensions/exemptions are being consistently used and made publicly available to stakeholders.

January-December 2013: Recruit and implement a process improvement team (PIT) or teams comprised of OHCS staff and other interested, appropriate stakeholders; review the R428 administrative rules and make clearer, where possible, expectations of new and existing data suppliers; work with UDOH Legal to ensure penalties are consistent with our rules.

Ongoing: Report PIT suggestions to the Health Data Committee as needed.

Measurable Outcomes

To be established by the Process Improvement Team(s).

Part IV

Appendices

HDC Members

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

Scott Baxter, Chair
Large Business Representative

Lauren Florence, Vice Chair
Physician Representative

Bill Crim
Consumer Advocacy
Representative

Sharon Donnelly
Public Interest
Representative

Lynette Hansen
Third Party Payer
Representative

David Vaughn Holbrook
Third Party Payer
Representative

Laura Polacheck
Consumer Advocate
Representative

David E. Purinton
Small Business
Representative

Pat Richards
HMO Representative

James Gregory Tabery
Public Health
Representative

Keith Tintle
Hospital Representative

James VanDerslice
Public Health Representative

Christopher R. Wood
Physician Representative

Office of Health Care Statistics Staff

Photo credit: Michelle Christensen, Starz & Fx Photography

Front row left to right:

Keely Cofrin Allen, HMO Health Program Manager

Jamie Martell, Support Services Coordinator

Barry Nangle, Director

Lori Savoie, Senior Business Analyst

Zachary Burningham, Senior Research Analyst

Back row left to right:

Mike Martin, Research Consultant

David Arcilesi, All Payer Claims Database Administrator

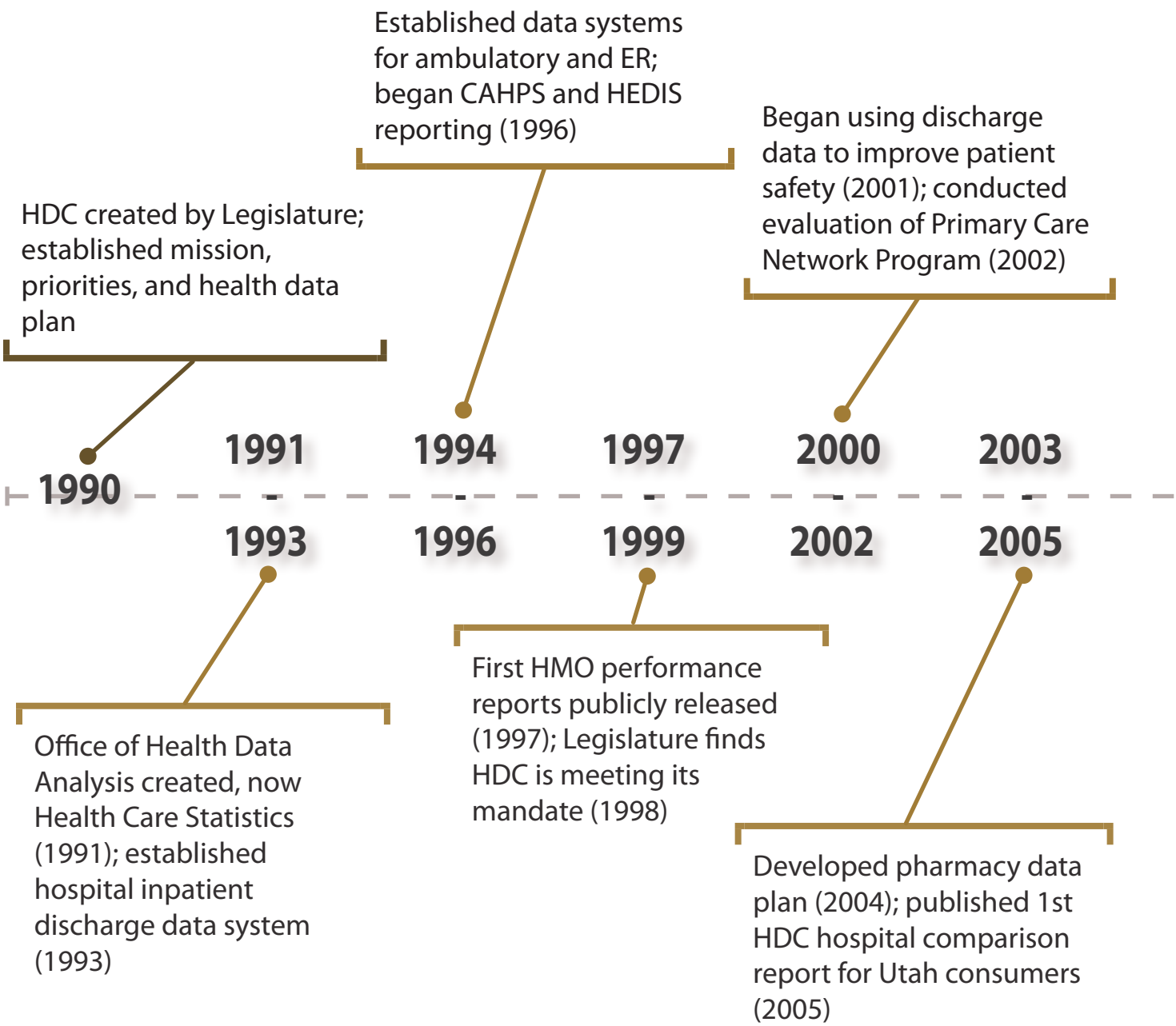
John Morgan, Hospital Discharge Database Manager

Charles Hawley, Beacon Project Manager

Health Data Committee (HDC)

Highlights

1990 - 2013



And a Glimpse Ahead...

2006 - 2008

Formed HB9 Advisory Panel to guide work on All Payer Claims Database (APCD); obtained funding for the APCD to support statewide transparency efforts

2009

Publicly reported CAHPS for Preferred Provider Organizations (PPOs); APCD began receiving data from suppliers

2010

Released first public reports from APCD generating state and national interest; published readmission rates in Utah hospitals for selected conditions

2011

Established MONAHRQ reporting system; received multiple national honors for APCD work; HDC reorganized due to new legislation

2012 - 2013

Become the External Quality Review Organization for Utah Medicaid; continue to expand the APCD

UTAH DEPARTMENT OF HEALTH

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