



Data Consortium:
*Leveraging Kansas health data to advance
health reform via data-driven policy*

Standards Developed in Silos Can be Confusing



Process/Performance Improvement (PI) Lifecycle

- Identification of area for improvement & issues (Health Policy)
- Benchmarking:
 - Peers
 - Self (historical)
- Survey of existing body of knowledge for best practices
- Planning:
 - Stakeholder identification & Team formation
 - Aim statement
 - Selection of interventions and timeline
 - Selection of PI metrics
- Implementation
- Data Monitoring:
 - Pre-(baseline) vs. post-implementation
 - Frequent and regular to track impact and fine-tune interventions

Outline

- Data Consortium Charter Amendments
- Data Consortium Workgroups
 - Organization: Leads & Membership
 - Objectives
 - Meeting format and schedule
- Indicators & Measures for Workgroups
 - Starting menu of draft measures
 - Criteria for selection
 - Feasibility: 3-Tier Categorization

Outline (continued)

- Reporting: Proposed Dashboard Design
- Hospital Discharge Data Collection Plans
- KHIIS Reporting Update
- Data Analytic Interface Update
- Discussion / Q & A

Data Consortium Charter Amendments

Two Major Revisions to Charter

- Four workgroups instead of three:
 - Access
 - Affordability and Sustainability
 - Quality & Efficiency
 - Health & Wellness
- Two health insurance carriers appointed by Insurance Commissioner :
 - Coventry
 - Blue Cross Blue Shield of Kansas
- Amendments approved by KHPA Board on January 22, 2008

Updated Data Consortium Membership

- Executive Director of the Health Policy Authority or designee (Chair)
- Department of Health and Environment
- Department of Social and Rehabilitation Services
- Kansas Insurance Department
- University of Kansas Medical Center
- University of Kansas Medical Center-Wichita
- Kansas Health Institute
- Kansas Foundation for Medical Care
- Kansas Medical Society
- Kansas Hospital Association
- Kansas Association of Osteopathic Medicine
- Kansas Mental Health Association
- Kansas Association for the Medically Underserved
- Kansas Nurses Association
- AARP
- Kansas Public Health Association
- Kansas Health Care Association (KHCA)
- Kansas Association of Homes and Services for the Aging (KAHSA)
- Two self-insured employers appointed by Kansas Chamber of Commerce and Industry:
 - >> Hills Pet Nutrition
 - >> Lawrence Paper Co.
- Two insurance carriers:
 - >> Coventry
 - >> Blue Cross Blue Shield of Kansas

Consortium Workgroups



Vision Principles & Health Indicators

- Adopted by the Board in 2006
- Provides governance and operational direction to the Board
- Provides guiding framework to analyze health reform options
- Provides “yardstick” to measure over time improved health in Kansas



Access to Care

Kansans should have access to patient centered health care and public health services which ensure the right care, at the right time, and at the right place.

■ Indicators:

- (1) Health insurance status;
- (2) Health professions workforce;
- (3) Safety net stability;
- (4) Medicaid eligibility;
- (5) Health disparities

Quality and Efficiency

The delivery of care in Kansas should emphasize positive outcomes, safety and efficiency and be based on best practices and evidence-based medicine.

■ Indicators

- (1) Use of Health Information Technology/Health Information Exchange;
- (2) Patient Safety;
- (3) Evidence based care;
- (4) Quality of care;
- (5) Transparency (of cost and quality of health information).

Affordable & Sustainable Health Care

The financing of health care and health promotion in Kansas should be equitable, seamless, and sustainable for consumers, providers, purchasers, and government.

■ Indicators

- (1) Health insurance premiums;
- (2) Cost sharing by consumers;
- (3) Uncompensated care;
- (4) Medicaid and SCHIP enrollment;
- (5) Health and health care spending.

Health and Wellness

Kansans should pursue healthy lifestyles with a focus on wellness as well as a focus on the informed use of health services over their life course.

■ Indicators

- (1) Physical fitness;
- (2) Nutrition;
- (3) Age appropriate screening;
- (4) Tobacco control;
- (5) Injury control.

Lead (Coordinating) Organizations for Workgroups

- Access to Care – **KHPA**
- Affordable, Sustainable Health care – **KHI**
- Quality and Efficiency – **KFMC**
- Health & Wellness - **KDHE**

Workgroup Membership & Format

- Voluntary membership open to members of the consortium
- Membership in multiple workgroups possible
- Workgroups could invite other non-member organizations as needed
- Workgroup meetings open to the public to allow broad participation

Workgroup Objectives

Data Consortium Charge

To serve as a multi-stakeholder public advisory group to the KHPA Board with the following specific responsibilities:

- Make recommendations regarding the scope of the Authority's responsibilities for managing health data;
- Recommend reporting standards and requirements for non-programmatic data owned or managed by the Authority;
- Craft data use policy recommendations governing access to health information by external users;
- Recommend empirical studies and evaluations supporting the goals and objectives of the Authority;
- Provide input on health and health care data initiatives in other organizations and agencies;
- Develop recommendations for public reporting standards for consumers, health care providers and other health care organizations.

Workgroup Objectives

- Select measures and indicators for reporting in the 4 domains of:
 - » Affordable, sustainable health care
 - » Access to care
 - » Quality and efficiency
 - » Health and Wellness
- Choose and prioritize measures for public reporting if necessary
- Identify essential elements to include in report design
- Identify existing and needed data to produce these reports (Explore creating/improving collection mechanisms if necessary)
- Coordinate with any current initiatives in other agencies and organizations
- Create strategy for capacity-building and staffing for routine reporting

Time Line / Milestones

- Goal is to have a list of indicators and measures identified and populated by each workgroup by October 2008
- Data Consortium Parent Committee will meet every 2 months in:
 - April 2008
 - June 2008
 - August 2008
 - October 2008
- Each workgroup to meet at least once in between each of the Data Consortium meetings, and brief the larger group
- First round of workgroup meetings tentatively scheduled for:
 - » February 27, 2008 - Access to Care
 - » March 12, 2008 - Quality & Efficiency
 - » March 26, 2008 - Affordability & Sustainability
 - » April 9, 2008 - Health & Wellness
 - *Exact workgroup schedule at discretion of workgroup leaders.*
- KHPA Board to discuss Data Consortium recommendations in November 2008
- December 2008 Report preparation
- January 2009 – Report baseline and trend data on indicators

Menu of Draft Measures

- A tentative menu of draft measures is provided in your handouts as a starting point for workgroups
- Workgroups can add or subtract to this list as necessary
- Consider availability of data and apply selection criteria
 - Reliability
 - Validity
 - Frequency of measurement
 - Comparability
- Categorize into 3 tiers

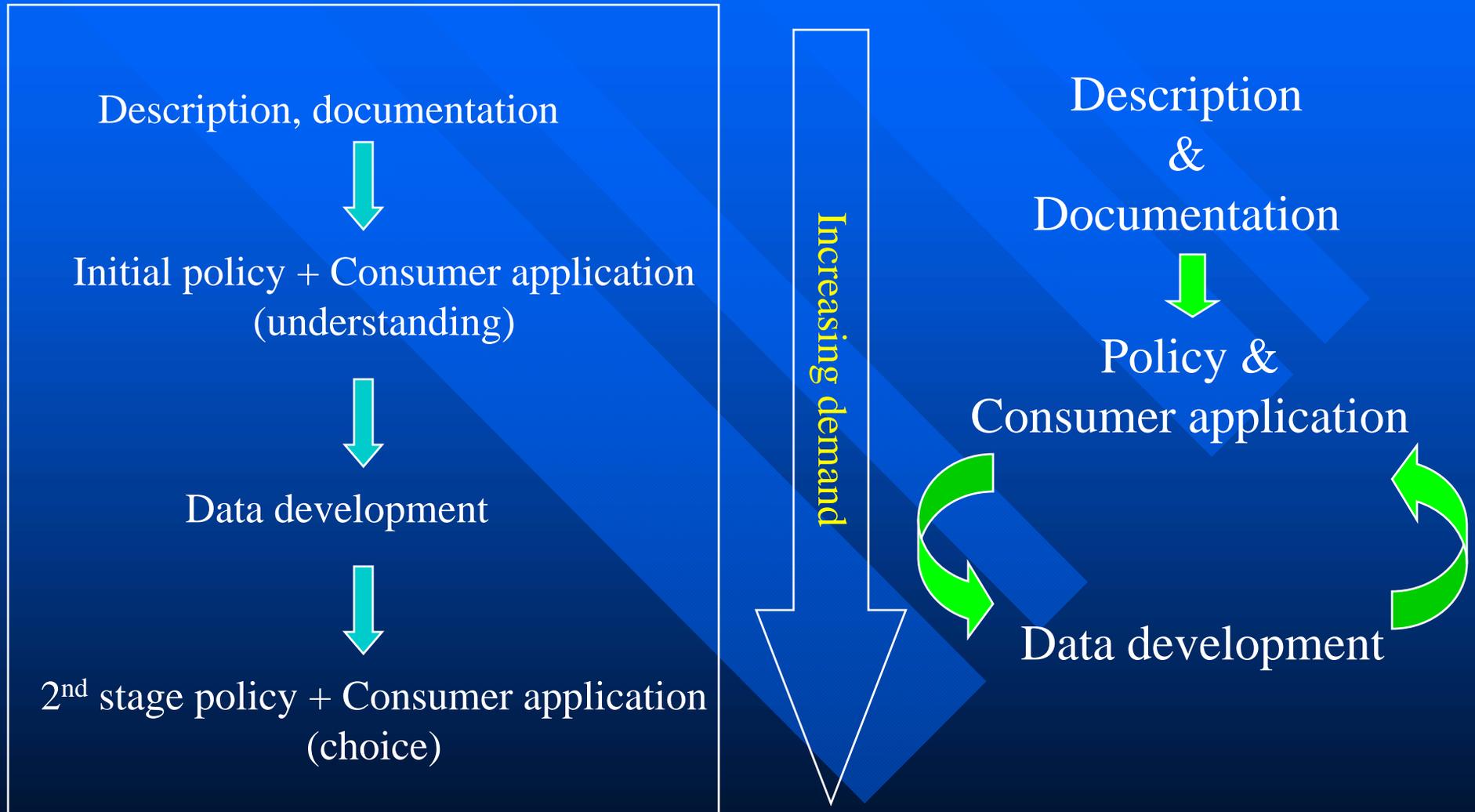
Measure Prioritization: *3 Tier Classification*

- **Tier 1:** The measure is computed routinely (Data exists and has been checked for integrity)
- **Tier 2:** Data is collected routinely as part of a database, but not checked for integrity
- **Tier 3:** Data required for the measure is not currently collected

Validation

- **Measure Validation:** Validity and reliability of the measure. Does it accurately measure what is intended?
 - Validated measure resources: NQF, NCQA, AHRQ
 - Validation of created measures through approved protocols
- **Data Validation:** level of consistency and accuracy of the data submitted by hospitals, MCOs, physicians
 - Administrative data (claims/encounters/other databases)
 - Abstracted data (adherence to measure specifications for data collection)

Reporting Strategy



Envisioned Dashboard Design

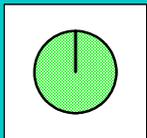
Desired Features of Dashboard

- Historical Self-Comparison – Chronological Trends
- Peer Comparison – Benchmarking with other states or nation; Comparison between counties
- Absolute Targets and Minimum Acceptable Thresholds
- Superimposed statistical indicators to allow tests of change (e.g. policy impact) or proactive alerts/triggers

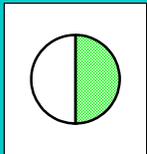
Example of statistical indicators

PERFORMANCE INDICATORS - LEGEND

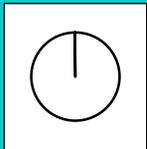
(Based on the 3 most recent data points and their position relative to the previous point)



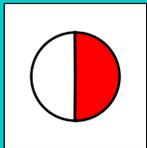
Goal reached or statistically significant improvement (control limit exceeded in "desirable" direction)



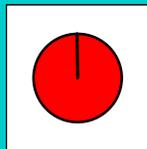
Improving trend - i.e. 3 consecutive points all showing improvement over the previous point; or sustained above-average performance - i.e. 3 consecutive points all on "desirable" side of average. While potentially promising, there is no statistical significance yet.



Process steady around average and within control - no statistically significant movement in either direction

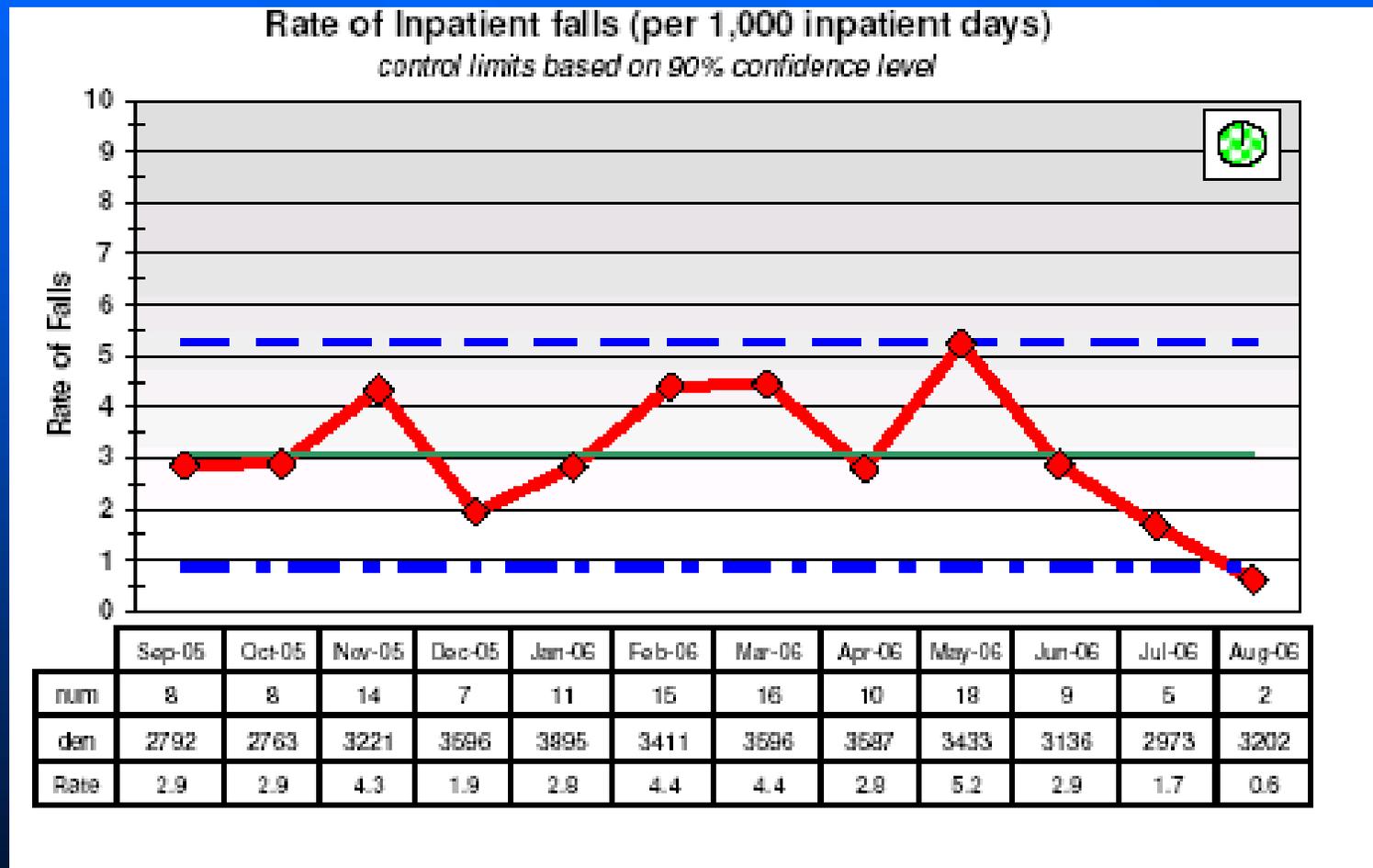


Worsening trend - i.e. 3 consecutive points all showing worsening from previous point; or sustained below-average performance - i.e. 3 consecutive points all on "undesirable" side of average. While potentially indicating slipping performance, there is no statistical significance yet.

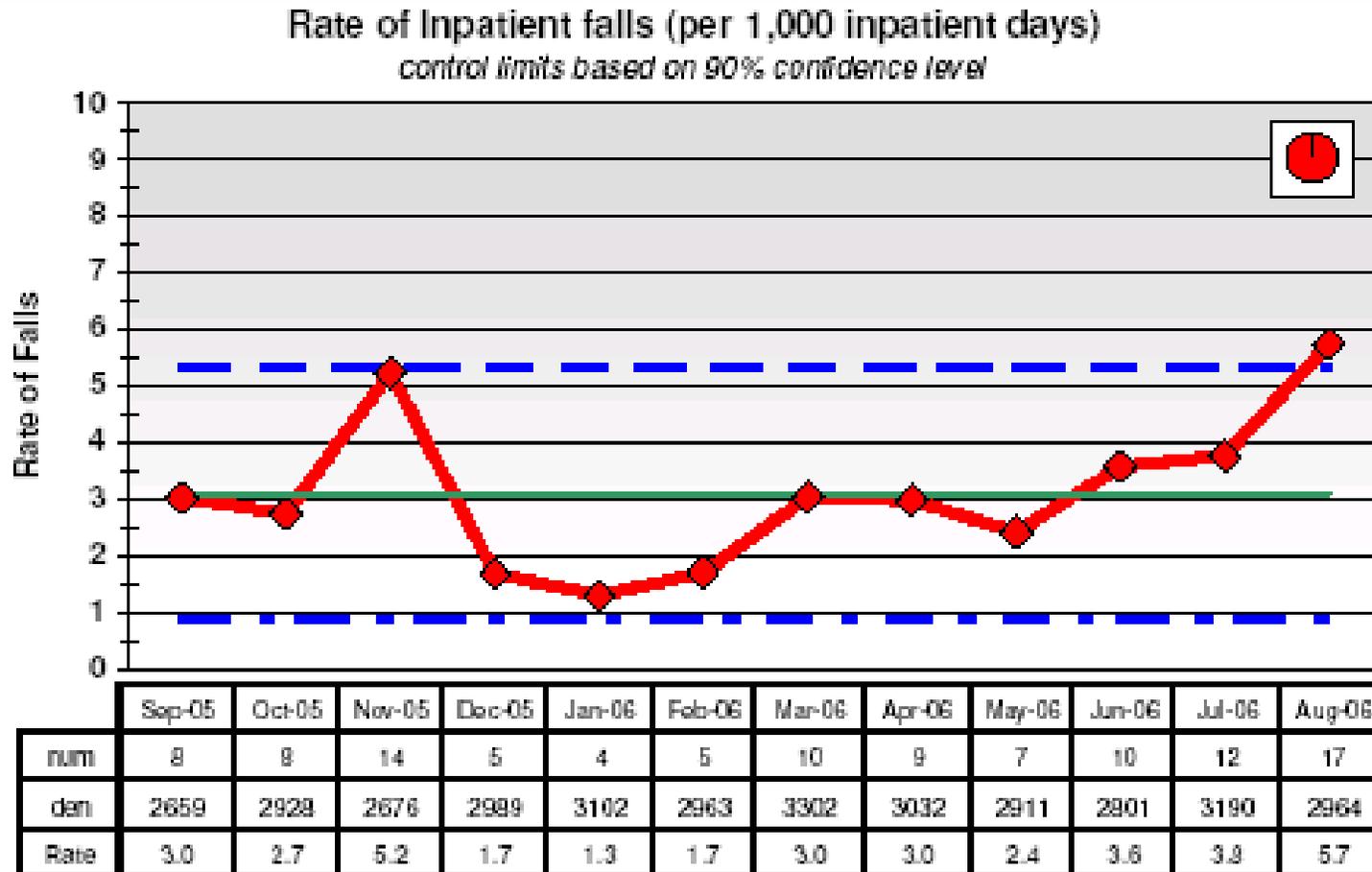


Statistically significant decline in performance (control limit exceeded in "undesirable" direction)
Merits intervention or study to identify possible causes

Example 1: Dashboard with Superimposed Statistical Indicators

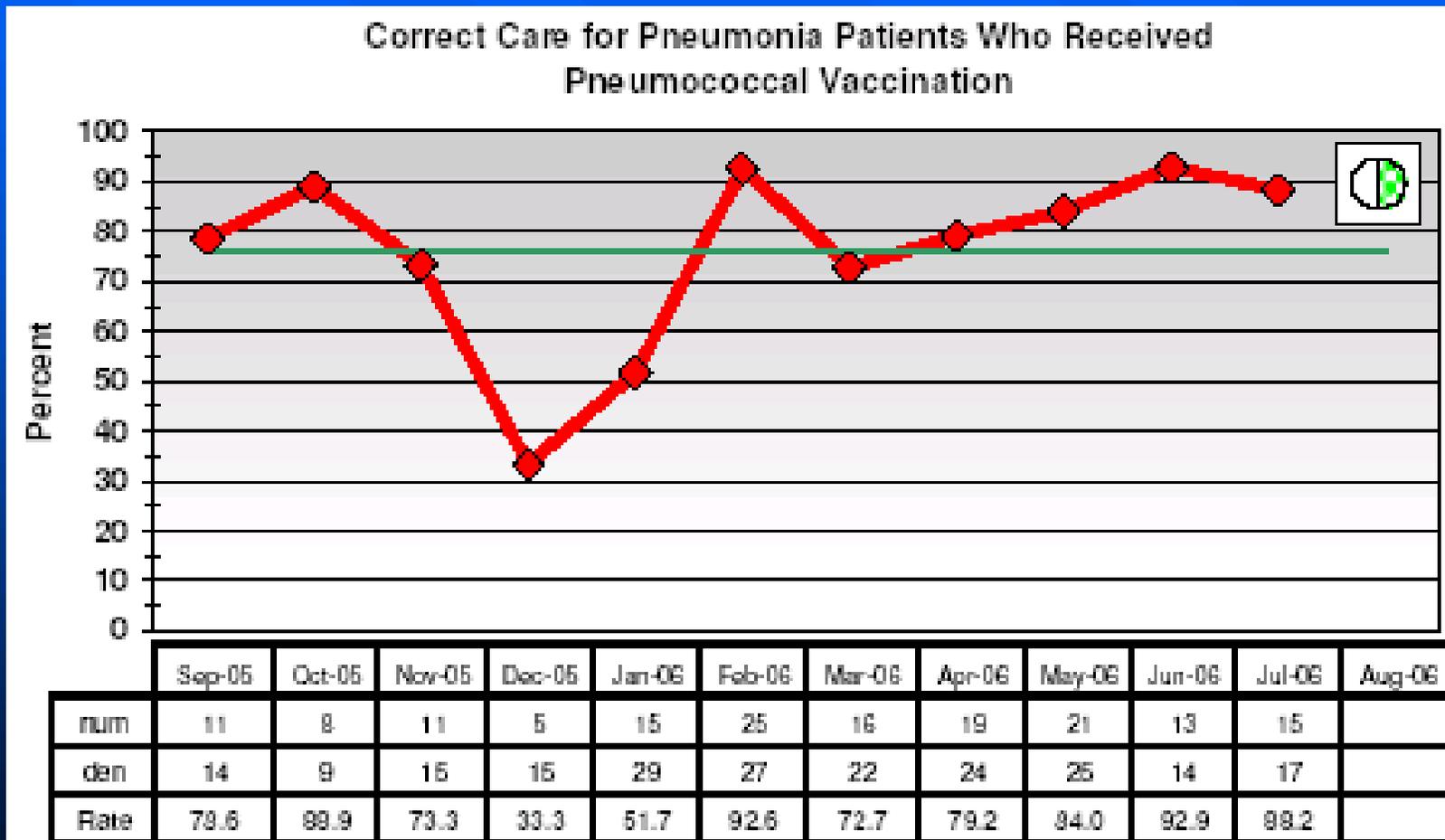


Example 2: Dashboard with Superimposed Statistical Indicators



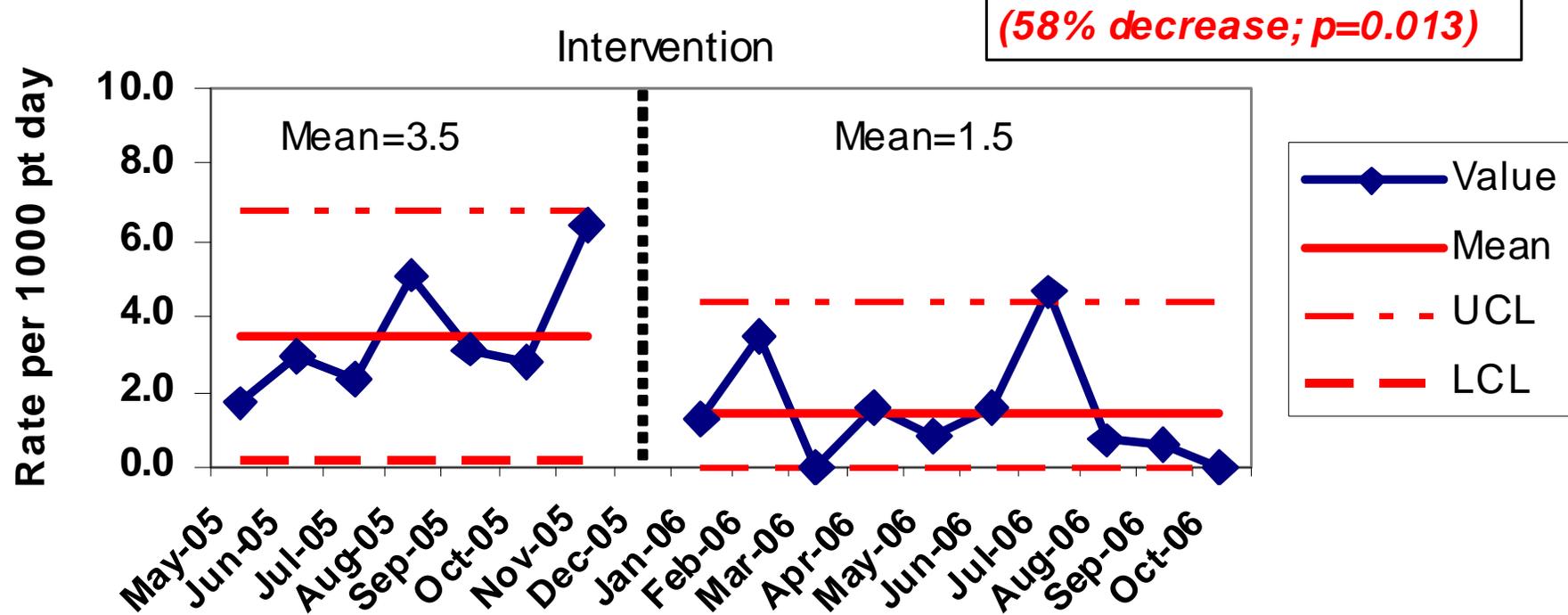
Example 3: Dashboard with Superimposed Statistical Indicators

(Absolute target of 100% instead of intrinsic control limits)

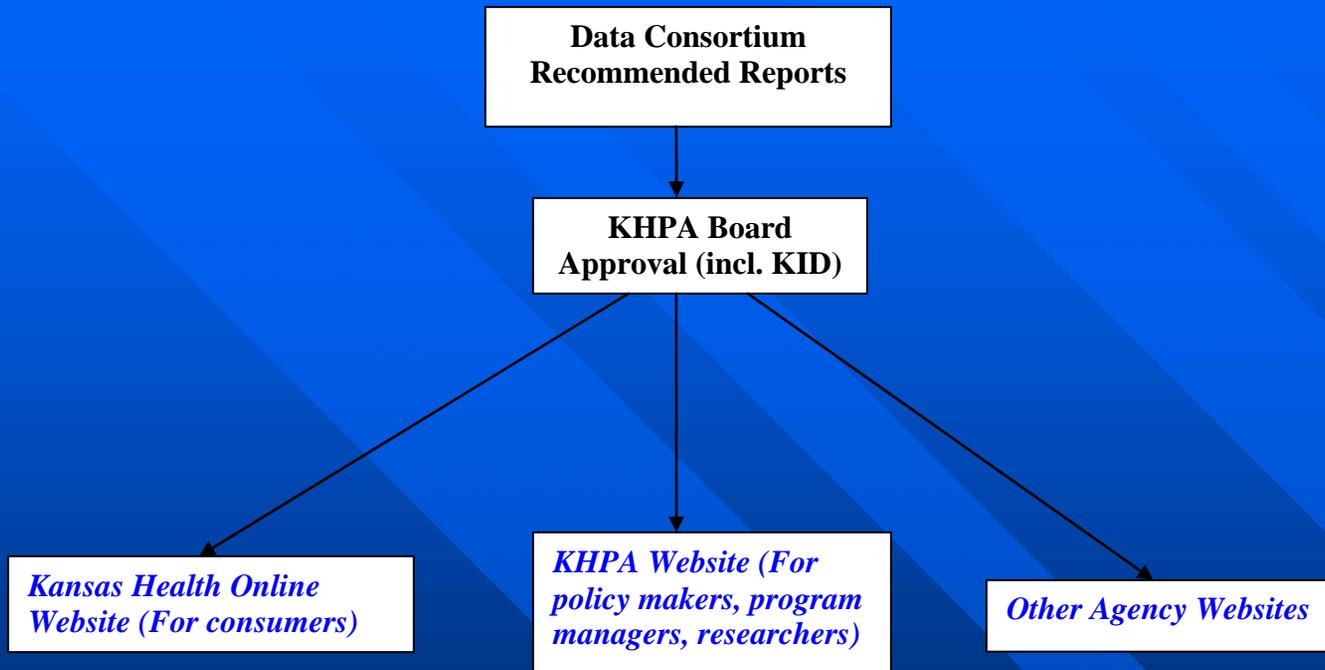


Example 4: Dashboard Allowing Tests of Change (E.g. Policy Impact)

Positive blood cultures excl. cath tips obtained >3 days LOS
Control Chart



Reporting Channels



Plans for Collection of Hospital Discharge Data

General/Community Hospital Data

- KHPA will enter into data use / business associate agreement with KHA to receive KHA hospital discharge data and Kansas-specific HCUP data
- National Inpatient Dataset (NIS) will be purchased from HCUP along with a few comparable states (Iowa, Colorado) for benchmarking purposes

Specialty Hospital Data

- Plans to to notify KSHA and send request letters directly to specialty hospitals to submit discharge data in a format comparable to the KHA database so as to allow combined analyses

KHIIS Reporting Plans Update

KHPA – KID Discussions

- Meeting between KHPA Executive team and KID
- Agreed upon an approval process for KHIIS reporting
- Planning a meeting with Insurance carriers in Feb/Mar 2008

KHHS Reporting

- KID retains responsibility for public reporting
- Data Consortium identifies measurement needs and makes recommendations both to KHPA and KID

Data Analytic Interface Update

Current Realities

- Data-driven health policy
- Huge stock of health care and provider data:
 - Medicaid/SCHIP
 - State Employee Health Benefits/Workers' Compensation (SEHBP)
 - Kansas Health Insurance Information System (KHIIS)
 - Licensure
 - Hospital Inpatient Claims

Current Needs

- Need the ability to respond to questions from diverse stakeholders
- Access to data by staff with different levels of need and skill
- Modern analytical tools

→ *DATA ANALYTIC INTERFACE (DAI)*

DAI – Desired Functionality

- Allow benchmarking of Kansas Medicaid/non-Medicaid/external normative data
- Rapid response to wide range of questions from diverse stake-holders
- Value-added tools:
 - » Episode groupers
 - » Record linkage to create master patient/provider index
 - » Built-in calculation of widely-accepted measures for acute/long-term health care quality
- Allow monitoring of policy impact by tracking input, process, and outcome measures factored by population, age, gender, location, etc.
- Support data-sharing (with suitable privacy controls) with other state agencies and external researchers

DAI – Update

- January 2008 - Vendor proposals reviewed (technical & cost) to shortlist top vendors
- February 2008– Vendor presentations and first round of negotiations
- February 2008 – Revised cost proposals from all 3 vendors received
- March/April (2008) – Site visits to clients of potential vendors (reference checks)
- April (2008) – Contract awarded
- Expected one year for implementation



<http://www.khpa.ks.gov/>