

Data Consortium Meeting Summary 04-07-10

The Kansas Health Policy Authority (KHPA) hosted the second 2010 (thirteenth overall) meeting of the Data Consortium on Wednesday, April 7th at the SRS Learning Center in Topeka. 21 persons attended, representing 13 agencies, organizations and businesses.

Kansas Health Indicators Document

Dr. Hareesh Mavoori reported the most recent update to the Kansas Health Indicators – annotations to help interpretation of the chart representing “Pregnant Women Who Receive Prenatal Care in the First Trimester of Pregnancy.” As Data Consortium members and stakeholders continue to use and provide feedback on the Kansas Health Indicators, such online documentation will be continuously updated.

Usage of the site rose in March to near peak levels, following a 3-month decline. KHPA continues to monitor the indicators receiving the most hits to assess interest levels and prioritize indicators for enhancement. An analysis of 10 months of cumulative “top 20” lists was presented in a format that depicts sustained levels of interest and recency of interest. Infant mortality, provider to population ratios, congestive heart failure, heart disease, teenage pregnancy, overweight/obesity, uninsured rates, and some preventive care measures (ambulatory care sensitive conditions, prenatal care) ranked among those most often visited.

AHRQ National Emergency Department Sample (NEDS)

Dr. Mavoori presented an overview of the NEDS database which produces national estimates about emergency department (ED) visits across the country. It combines data for treat-and-release ED visits and those that result in hospital admission; includes over 100 variables describing the hospital, patient, visit, diagnoses, discharge status and charges/payment source; and excludes data which could identify individuals, hospitals, or states. It is a resource which public health professionals, administrators, policymakers, researchers and clinicians may find useful for conducting high-level studies relating to quality, utilization and access issues.

This requires additional statistical software (SAS, SPSS) for analysis, at least 10 GB of memory, completion of a Data Use Agreement, and \$500 for 1 year of data. More information is available at <http://www.hcup-us.ahrq.gov/db/nation/neds/nedsdbdocumentation.jsp>

Kansas Healthcare Collaborative

Kendra Tinsley announced plans for the 2010 Quality Summit, scheduled October 22nd at the Wichita Hyatt. The 2nd annual meeting sponsored by the organization, which focuses on improving the quality of healthcare and patient safety, will feature 3 keynote speakers and 8 breakout sessions. Speakers will be:

- J. Michael Henderson, MD, a surgeon who is the Chief Quality Officer for the Cleveland Clinic;
- Jay Kaplan, MD, an emergency physician who is Medical Director of the Studer Group and Director of Service and Operational Excellence for CEP America Emergency Physician Partners;
- Brian Wong, MD, a Family Physician who is a founding partner of Healthcare Performance Solutions and current CEO of The Bedside Project.

In the past year, KHC has worked to become established as an independent organization, now with its own Board of Directors. The launch of a website is expected in May; more information about the organization and the upcoming summit will be available there.

Data Analytic Interface (DAI) Update

Major activity since the last meeting:

- KHIS data assessment and integration discussions are underway
- Significant progress in resolution of discovered issues as use of the system and number of trained users continues to increase
- Preparation of developmental DAI draft reports for public sharing (at this meeting)

Anticipated in the near future:

- May 2010 – upgrade of Medicaid data to 5 years of history

Health Professions Workforce Workgroup Update

Data Consortium members were briefed and asked for feedback on the workgroup's recommendations developed over the course of 3 meetings designed to conduct a comprehensive state-level needs assessment, data gap analysis, and collaborative brainstorming involving users, regulators, suppliers, and other stakeholders with an interest in workforce data. The third meeting, held March 30th, was attended by 19 representatives of 10 groups (state agencies, licensing boards and health organizations). The focus was on brainstorming solutions and crafting recommendations for collecting data needed to support statewide workforce planning while minimizing the cost/burden to providers and associations. Based on work completed at and pursuant to the first 2 meetings, 4 strategies for data collection were considered by the group, along with a proposed minimum dataset and the following recommendations made: (For more complete minutes and handout materials from the meeting, go to http://www.khpa.ks.gov/data_consortium/Health_Professions_Workforce_Data.html)

Workgroup Recommendations -

o Data Collection Model:

1) The strategy which was favored by the members present was:

Each Licensure Board independently collects core elements (after data specifications have been standardized across the various Boards) and submits an extract to a third party vendor or State agency. That entity collects augmented data centrally from providers and merges it with the extracts from Boards and other datasets (Medicaid, CAQH, NPI, Dept of Labor, etc.) for State reporting.

2) Another proposed strategy will remain an option for consideration in the long-term, but was not favored at this time. In that scenario:

All core and augmented data is to be collected by a single agency or third party vendor (state-level "clearing house" model). Data needed by the Boards is made available to them; analysis and State reporting is conducted centrally.

3) It is the intent of the workgroup to create a seamless process for collecting data needed for licensure, by the Boards, and that which is essential for policy-making and workforce analysis, collected by another entity while minimizing burden on providers and duplication of effort in the data collection process.

o Proposed Minimum Dataset

A table was presented which lists the data elements essential for policy-making and workforce planning, as identified by the various workgroup members and other stakeholders both during, and in-between workgroup meetings. (See [Proposed Minimum Dataset](#).) Those items which are considered "Core Data" (preferably collected by the Boards) are noted with an X. Many are already on the Board application/renewal forms. For those items that are not currently being collected by all 8 Boards, the X is shaded (indicating a gap which will need to be addressed).

The Licensure Boards have been asked to further review the proposed minimum dataset and send comments to KHPA to help create a harmonized, multidisciplinary standard for core workforce data elements by December 2010. Dr. Allison will pursue working with the Boards individually to discuss the process of filling the gaps and standardizing the questions to be asked of providers for augmented data to help with health policy analyses.

Suggestions by Data Consortium Members -

- Inclusion of a look-up function for the providers to be able to see what is “in the system” for them (would especially streamline renewals)
- Seamless transition between core and augmented questions on forms
- Pre-population of data fields, when possible (to streamline process/reduce burden on providers)
- Ability to save partially completed form and return at another time

Data Analytic Interface Reports

Developmental Drafts of 3 reports derived from the DAI were presented for review by the Consortium. All 3 included data from Medicaid and the State Employee Health Plan (SEHP) to demonstrate usefulness of having the ability to compare costs.

- [Provider Services by Type](#) – 2009
- [Durable Medical Equipment \(DME\) by Procedure Codes](#) - 2009
- [Pharmacy by Therapeutic Class](#) – 2008 and 2009

Some explanations/discussion:

- The Provider Services Report shows broad comparisons by provider type (aggregated across all places of service) of allowed amounts per service between Medicaid and SEHP. The primary intent of this report is to show the percent of Medicaid and SEHP data that is comparable using a price index methodology matched by provider type. For the FY 2009 data used in this report, 97% of all Medicaid data and 75% of SEHP data would be captured in such a price index.
 - Medicaid data includes Fee-for-Service only, not Managed Care
 - In the Provider Services report, service units in some broad categories vary widely, warranting comparisons at the finest level of detail possible (e.g., an “Emergency Medicine” unit may be a visit, a test, a unit of medication, etc.)
 - The ability to aggregate services into “Episodes of Care” is a feature built into the DAI, which will assist with making more valid comparisons
- The DME report illustrates using the DAI for comparative price indexing. For those services paid by both Medicaid and SEHP, costs are normalized (or weighted) by applying Medicaid service counts to the unit prices for SEHP and comparing those amounts to the actual Medicaid costs. Price differential is then determined by dividing Medicaid Totals by SEHP weighted totals and subtracting 1 from that result.
 - Categories with fewer than 50 service counts in SEHP, they were rolled up into a single “SEHP svc count<50” category. This was a guarded approach adopted for this first report to prevent identification of any specific price for any one provider, service, or health plan within SEHP. This was not an issue for Medicaid data, as payments are made on a public fee schedule; no “trade secrets” need to be protected. In the future, the Data Consortium will help with establishing data use policy and guidelines for topics such as balancing transparency with trade secret protections for the purposes of public reporting.
 - While the overall difference is small for FY 2009, this report could be a useful tool to flag specific prices which vary greatly between programs.
 - Differences in population could account for some of the differences.

- Pharmacy report – This illustrates both multi-program as well as multi-year price indexing using Medicaid and SEHP pharmacy data for FY 2008 and FY 2009.
 - “Metric quantity dispensed” (a consistent unit that tracks drugs dispenses at the pill or ml level rather than at the more granular prescription count) was chosen as the weighting factor.
 - The report shows aggregation at Therapeutic class level while the price index computations use more detailed NDC level data.
 - Drug Rebates – SEHP prices reflect after-rebate cost; Medicaid does not (Medicaid does benefit from rebates, but they are added back to the program later and not attributed to individual claims)

Suggestions for DAI reports to be presented in the future:

- Price indexing of medical services (similar to the DME report seen today) for Medicaid and SEHP. (Attempt to make “apples-to-apples” comparisons by drilling down to procedure codes, billing codes, and/or MSDRGs; take advantage of DAI software features which allow for episode grouping and accounts for levels of acuity.)
 - Compare by professions - Family Practice, Internal Medicine, Pediatrics, etc.
 - Compare by hospital services
 - Focus on services with the greatest differences between Medicaid and SEHP (examples on today’s report- Renal Dialysis Therapy, Medical Technician, Medical Doctor)
 - Rather than comparing by “service” use more definite units (by day, visit, ml-for drugs)

Members are encouraged to suggest other reports that they would like to see come out of the DAI. These can be sent to Laverta.Greve@khp.ks.gov

Future Meetings:

- * Next scheduled Data Consortium meeting – July 15, 2010 1:00-4:00 pm
- * Reports to be discussed will be distributed a week prior to the meeting for member preview.