

Data Consortium Meeting Summary 8-20-08

The Kansas Health Policy Authority (KHPA) hosted the fifth meeting of the Data Consortium on Wednesday, August 20th at the Landon State Office Building in Topeka. Thirty-three persons were in attendance, including representatives of 15 member agencies/organizations and other interested parties.

Following introductions, Dr. Barb Langner, KHPA's Director of Policy, presented an overview of Health Information Technology and Exchange initiatives in Kansas and an update of the recently appointed E-Health Advisory Council. Resulting from work of the Health Care Cost Containment Commission (H4C) established by Gov. Sebelius in 2004, the HIE Roadmap was issued in January 2006. Recommendations included the creation of a public-private coordinating entity to provide consumer/stakeholder education, address privacy and security barriers to health information exchange, manage existing resources and seek additional funding for the initiatives. About the same time, Kansas became one of 34 states involved in the Health Information Security and Privacy Collaboration (HISPC I), a federal HHS project. The Health Information Exchange Commission and HISPC II followed in 2007. KHPA initiatives which have come out of these are: Community Health Record (pilot project in Sedgwick County, involving Medicaid recipients); Health-e Mid-America (consumer centered e-health product available to State employees in the Kansas City area); and the E-Health Advisory Council, appointed in recent months by the Governor's office and KHPA, to guide the development and administration of the statewide health information technology and exchange. It will begin meeting Sept. 10th.

The four workgroups presented their preliminary list of around 20 recommended reporting measures for each of the domains – Access to Care, Affordability/Sustainability, Quality/Efficiency, and Health/Wellness. Questions and suggestions about specific recommendations will be taken back to the workgroups for reconsideration before making the final presentation to the Data Consortium in October. General points of discussion follow.

- The workgroups' focus was on "tier 1 data" at this point – direct measures which are reliable and publicly reported, therefore available for reporting in 2009. Other measures may be added in subsequent years as reliable sources are found/developed. Caution will be needed when using "constructed measures."
- Data related to the health professions workforce is not complete. KDHE has statutory authority to collect data on physician and dental supply, but not in other areas; even for those reporting groups, it is voluntary, not mandatory. Dr. Allison indicated that it is the purview of the Data Consortium to identify data gaps such as this and to push for stronger policies/statutes related to data collection. This will become a greater focus of this group in the coming years, once initial reports have been established.
- Some reports will need to include 1-2 sentence explanations to assure that they are not misleading. Such limiting statements may be necessary if reporting is voluntary, data only includes a portion of the population, or other factors make a brief title inadequate to describe the report. This body will need to look at reports before they are published and determine an appropriate "level of caveating." It is critical that they be easy to understand and not be misleading.
- "Underinsurance" is an area that may not currently be measured, but would be important to capture and report. KHI has a report that might be helpful for this purpose.

- Whether to measure administrative costs of health care was debated. While it may not be an indicator of the health of the State, it may be helpful information for policy-makers. Other issues: are administrative costs included in the measures recommended; if so, is it possible to break that out?
- It was noted that there is a lack of indicators of positive health; most focus on poor health or deficiencies in health care.
- The measure of mental health that was chosen relates only to nursing home residents. A question was raised as to whether a better indicator might be found. The challenge is to find one that fits the criteria of tier 1.
- Subjective (self-reported) data has some biases, but BRFSS survey data has nationwide comparability.
- The measures will need to be carefully evaluated to eliminate duplication and the possibility of reporting conflicting data on a measure from different sources.

In addition to the above suggestions applicable across the board, the following workgroup-specific recommendations were also made by the Data Consortium for consideration by workgroup members:

- Access to Care:
 - Pursue inclusion of underinsurance rate (KHI report)
 - Consider capturing geographic access restrictions (proximity to providers, transportation availability, etc.)
 - Several of the measures under “Health Insurance Status” can be grouped as one measure, broken down by categories/types of coverage
- Affordability and Sustainability:
 - Minimize potential for misinterpretation on measures such as CS15 and CS16 – Average deductibles/out of pocket expenses and the percent of family income they represents by clearly documenting limitations, and leveraging the footnotes used by other states reporting similar measures (carefully consider whether CS16 is tier 1 or tier 2)
 - Tap National Health Expenditure Accounts (NHEA) for break down of costs by administrative versus claims
 - SE2 and SE3 (and possibly others) – it would be meaningful to compare Kansas to other states in the region, or of similar size
- Quality and Efficiency:
 - Add measures that reflect quality of mental health of broader populations than nursing home residents alone. Rick Shults offered to share a survey on self-reported anxiety/depression (nationally reported) with Larry to help with this.
 - Measures relating to women receiving prenatal care in the 1st trimester and childhood immunizations overlap with Health and Wellness selections
- Health and Wellness:
 - Consider adding measures such as: Years of productive life lost, workers compensation data on injuries, hospital days, sick days (e.g. school days or work days missed), positive health measures (e.g. mental health)
 - Report Kansas ranking for measures such as suicide death rate (#25)
 - Hospital Discharge Rate due to fall-related injuries (#26) may be more appropriate as a Quality and Efficiency measure

- Selections related to addictions and suicide (1, 4, 5, and 25) may serve as measures of mental health

Stratification issues:

- If there are established guidelines, such as census breakouts, which would make it easier to compare to other states, default to that. For issues only related to Kansas, other strata may be more appropriate and helpful for policy-making. The suggestion was also made to look at the stratification used by all of the data sources for the recommended measures to find the most common groupings.
- If data elements are to be compared to other states, the group needs to decide which states would be most reasonable to include.

Further feedback was requested from the group on the stratification suggestions.

Dr. Mavoori reported that the contract has been awarded to Thomson Reuters for the Data Analytic Interface with a target implementation date in one year. Also, KHPA has hired a reporting specialist who will be researching the data sources suggested by this group and begin working on the report designs.

Workgroups will consider suggestions made today and submit their final recommendations to Hareesh Mavoori or LaVerta Greve so that a list of all of the measures can be presented to the Data Consortium at the next meeting, which will be October 2, 2008 from 9:00 am – 12:00 pm.