

**Access to Care Workgroup
Meeting Notes
8-5-08, Held at KHPA offices**

Present: Hareesh Mavoori, Nikki Harrison, Tom Johnson, Sally Perkins, Robert Stiles, Mary Tritsch, Lynne Valdivia. By Phone: Sonja Armbruster, John Bottenberg and Ruth Wetta-Hall.
Others invited: Mary Gambino, Cathy Harding, Melissa Hungerford, Chad Moore, Allison Peterson, Jerry Pope.

Purpose of this meeting: To review measures recommended by workgroup members and the changes made to the grid since the last meeting.

Summary of Work: Hareesh explained the above-mentioned changes, which mostly involved renaming and rearranging categories, moving measures to different categories, adding points of clarification, and eliminating duplication. The group then reviewed the entire list of measures, individually. Suggested changes follow:

Access Outcomes –

- Add CAHPS as a data source for J13, J19 and K6 (**Lynne will send information to Hareesh**)
- Add the Trauma Registry as a source for K13 (**Robert**)
- Check on other sources for long-term care services – K15 (**Mary**)

Health Insurance Status –

- Eliminate J4 (duplicate of J3)
- All of the measures except L6 and L7 seem to be subsets of the measure that could be called “Type of Health Insurance”
- Add “Persons with Long Term Care Insurance” (possible source – KID)
- L6 and L7 could be moved to the “Demographics” category

Demographics –

- Add “Percent employed part-time” - Bureau of Labor Statistics is possible source (**Sonja**)

Health Professions Workforce –

- Find definition of K11 – (**Hareesh**). If it relates to length of response time for EMS, that might go to the “Quality” workgroup.
- Break down X2 by type of physician. See if Physician FTE data is available (would be a more accurate representation of availability than a raw count of physicians).
- X4 – be clear about what is shown in report – “staffed beds” vs. “licensed beds”
- Add a measure to indicate % Medicare/Medicaid patients in a physician’s practice
- Add a measure to indicate whether physicians accept new Medicare/Medicaid patients (**Robert – KDHE’s underserved population reports**)
- Add “Patient/Provider ratio” (**KDHE’s “Health Professional Shortage Analysis – Robert**)
- Add a measure of waiting time to get an appointment (especially Medicare)...tier 2?

Safety Net Stability –

- K10 - Sonja indicated that there is a wide variation in reporting between cities, counties, etc.

Medical Home –

- J15 – CAHPS is an additional source (**Lynne**)
- J18 – Health Connect KS and MCO data are additional sources (**Lynne**)
- J10 – Break this down by the 3 facility types

Standardized Stratification –**Age Groups:** (after the meeting, Robert confirmed the MEPS groupings for children)

<1	45-64
1-4	65-74
5-17	75-84
18-25 (to capture young adult student population)	85 +
26-44	Missing

Race/Ethnicity:

White	Hispanic, Black	Multiple
Black	Native American	Other
Hispanic, White	Asian/Pacific Islander	Unspecified

Income Categories: (No change recommended)

- <100% FPL
- <200% FPL
- <300% FPL
- >300% FPL

Population Categories (of interest for reporting; not necessarily mutually exclusive)

- Aged
- Disabled
- General Assistance
- Primary Language not English
- Foster Care Children

Health Service Categories:

- Hospital Care
- Physician & Clinical Services (including Behavioral/Mental Health, Specialty)
- Other Professional Services (practitioners other than physicians and dentists, including behavioral, mental, specialty)
- Prescription drugs and Non-Durable Medical Products
- Durable Medical Equipment
- Dental Services
- Home Health Care
- Long-term Care (Skilled nursing facility, nursing home care)
- Hospice Care
- Other Personal Health Care

Geographic Divisions:

- U.S. Congressional Districts
- State Senate Districts
- State Representative Districts (could be difficult, as there are several per county in urban areas)
- Urban (5 counties) vs. Non-urban (100 remaining counties)
- National vs. State vs. surrounding states

Next Meeting:

Only needed if there are questions/issues to resolve after these recommendations are presented at the Data Consortium meeting on Aug. 20th.

**Access to Care Workgroup
Meeting Notes
7-1-08, Held at KHPA offices**

Present: Andy Allison, Hareesh Mavoori, Sally Perkins, Robert Stiles, Mary Tritsch (by phone), Tony Wellever.

Others invited: Claudia Blackburn, Mary Gambino, Barbara Gibson, Tom Johnson, Allison Peterson, Jerry Pope, Lynne Valdivia, Ruth Wetta-Hall.

Purpose of this meeting: To select measures and indicators for reporting in the domain of Access to Care.

To facilitate discussion, KHPA staff pre-populated the grid with data source information for those measures which were recommended by the workgroup members, and grouped them into tentative indicators and tiers.

Summary of Work: The group reviewed 99 measures. Of these, 44 were screened out, mostly because they were duplicative or because they were more appropriate for consideration by another workgroup, and will be referred accordingly. Each of the remaining measures were discussed and evaluated on a variety of criterion; more were eliminated. The resulting list includes 20 tier 1 measures, 16 in tier 2, and 3 that are either tier 3 or undetermined at this time. Five items were identified as important demographic data, rather than specific measures of Access to Care.

The selected measures were grouped into these indicators: *Health Insurance Status, Access to Primary Care, Health Professions Workforce, Medicaid Eligibility, Safety Net Stability, Medical Home, and Cross-Cutting*. It was decided that health disparities would be handled by sub-grouping of certain measures (by age, ethnicity, income, etc.) rather than as a category of its own.

Information to explore with KHI:

Is it possible to capture the population of those eligible for Medicaid, but not participating?

Is there data available that measures unmet need?

What sources are there related to “usual source of care” issues?

Other research/discussion needed:

Is NHIS data available by state?

Explore BRFSS and KHA as sources of certain measures (noted on grid).

Do we intend to report only gaps in care, or indicators which show that Kansas is doing well?

Follow-up: Grid will be updated and re-distributed for review before meeting again.

Next Meeting of the Access to Care Workgroup: Wed. Aug. 5, 2-4pm; KHPA Offices – Landon State Office Building (900 SW Jackson St, Topeka), Conf. Rm. 9E

**Access to Care Workgroup
Meeting Notes
5-14-08, Held at KHPA offices**

Present: Andy Allison, Tom Johnson, Hareesh Mavoori, Sally Perkins, Jerry Pope, Mary Tritsch, Ruth Wetta-Hall (by phone)

Others invited: Claudia Blackburn, Mary Gambino, Barbara Gibson, Allison Peterson, Lynne Valdivia, Tony Wellever

Purpose of this meeting: To review the list of measures recommended by workgroup members, add any new data sets or measures not already considered, and begin to populate the Measure Selection Grid.

Discussion points:

The measures being selected by this and the other three workgroups will be used to report to legislature and the public (on the website) to reflect the “health of the state.” It will hopefully help identify areas where policy-makers can have an impact by making changes and/or focusing resources. The reports will be intended to facilitate, educate and drive policy.

The initial steps of reviewing the list of measures brought about many questions regarding the data sources. For example, the first measure (persons under age 65 with health insurance) was considered important, but CPS was suggested as a better source for insurance data than NHIS, which was listed on the grid. Also, there was a recommendation to eliminate all HEDIS and CAHPS measures, since Kansas data is not collected – or at least move those measures to tier 2 or 3. A third point of debate was whether NHIS data, if only collected every 10 years, should be excluded from our consideration or, since it was collected as recently as 2006, it is worthy of inclusion.

The group requested KHPA staff to supply more information about each source – how often data is collected, the reliability, validity, and availability of the reports – before proceeding with the exercise. This will help to identify the “tier” designation. They also asked that the measures be organized according to the categories of indicators originally proposed by KHPA: 1) health insurance status; 2) health professions workforce; 3) safety net stability; 4) Medicaid eligibility; and 5) health disparities. Finally, if there are multiple sources for a measure (as with insurance data, explained above) and one source is better than another, the group asked that KHPA make that distinction.

Ruth Wetta-Hall offered to share a decision-making methodology that she has used which may be helpful to the group in the winnowing process.

Assignments:

Outlined in the last two paragraphs, above.

Next Meeting:

July 1st, 1:30-3:30 pm. at KHPA offices.

**Access to Care Workgroup
Meeting Notes
4-16-08, Held at KHPA offices**

Present: Barbara Gibson, Hareesh Mavoori, Sally Perkins, Jerry Pope, Lynne Valdivia, Tony Wellever, Claudia Blackburn (by phone)

Others invited: Andy Allison, Mary Gambino, Tom Johnson, Allison Peterson, Mary Tritsch, Ruth Wetta-Hall

General points raised:

- Following a discussion of the definition of “tier 1 data” that occurred in the Quality and Efficiency workgroup, it has been modified so as to not require such a strict standard of validation, which would exclude many data sources. Tier 1 is now defined as including data that has a high degree of integrity and is publicly reported and is accepted by industry standards.
- A wealth of data is available; members summarized a variety of sources, ranging from surveys reported only in nationwide totals to statistics reported by individual hospitals on costs of specific services. Some is readily available in a format for public presentation (For example, on the KHA website <http://www.kha-net.org> and the Kaiser Foundation website <http://www.kff.org/MFS/>); some is freely available, but will require some analysis for our use; other information must be purchased.
- Self-reported health status is a good indicator of overall health.
- As an indicator, “hospital costs” is more valid than “revenues” and is publicly available.
- Sets of data measures discussed included:
 - MEPS (Medical Expenditure panel Survey)
 - CAHPS (Consumer Assessment of Health Plans)
 - NNHS (National Nursing Home Survey)
 - NHHCS (National Home and Hospice Care Survey)
 - AHRQ (Agency for Healthcare Research and Quality)
 - HCUP SID (Healthcare Cost and Utilization Project State Inpatient Databases)
 - KHA/AHA (Kansas Hospital Association / American Hospital Association)
 - NHDS (National Hospital Discharge Survey)
 - NCQA (National Committee for Quality Assurance)
 - Commonwealth Fund Healthcare Quality Survey
 - Medicare Cost Reports (from Centers for Medicare and Medicaid Services)
 - BRFSS (Behavioral Risk Factor Surveillance System)
 - CPSS (Client/Patient Sample Survey)
 - Numerous reports compiled by KDHE (E.g. Safety Net Monitoring, Top DRGs & procedures, Patient Migration, etc.)

Next Steps (Assignments in bold)

- **All workgroup members** – Please review all of the attachments presented at the meeting (and sent electronically following the meeting) and any other sources you may know of to identify which measures should be included in the list of recommended measures.
- Send them (suggested number of measures: ~ 20) to Hareesh and/or LaVerta **by Wednesday (4/23)**, so that a master list can be compiled in preparation for the Data Consortium meeting on April 30.

Next Meeting

May 14, 2008 at KHPA Conf Rm. 9E, Landon Building, 900 SW Jackson St., Topeka.

**Access to Care Workgroup
Meeting Notes
3-19-08, Held at KHPA offices**

Present: Andy Allison, Mary Gambino, Barbara Gibson, Tom Johnson, Hareesh Mavoori, Sally Perkins, Lynne Valdivia, Tony Wellever

Others invited: Claudia Blackburn, Allison Peterson, Jerry Pope, Robert Stiles, Mary Tritsch, Ruth Wetta-Hall

Workgroup's Mission:

To establish a data-rich reporting infrastructure that supports informed decision making to continuously enhance access to health care services in Kansas.

Workgroup's Goal: To have recommendations ready for presentation to the Data Consortium by October 2008. The recommendations will include: A list of 20-50 measures for public reporting. These measures will be preferably grouped into indicators and identified as tier 1, 2, or 3. The target audience and data sources for each of these measures will also be identified.

- First year – concentrate on “tier 1 data” (currently collected and already validated)
- Tier 2 and 3 data can be identified, then discussed further, later on

General points raised:

- To make a case for policy changes, we need to be able to measure and document the current situation and identify areas of deficits/shortages that need to be addressed.
- KHPA and KDHE have data collection authority. It may be possible to expand the collection of some data which is currently done only on a voluntary basis.
- To have a complete picture, hospital data needs to include both community and specialty hospitals.
- Reporting numbers/rates alone isn't always enough; analysis and interpretation is necessary before information is to be published.
- Looking at disparities in utilization of services (with respect to income, geographical factors, language barriers, etc) is a key to assessing access of care. This demographic stratification needs to be tracked by all 4 workgroups in their respective domains.
- If data is not available for the total population (the ideal), it still may be valid to report on the subpopulation(s) for which data is available and annotate what group is included (e.g. Medicaid only).
- In addition to routine reporting (e.g. Annual reporting of data aggregated at state or county level), it would be beneficial to drill down into selected areas of interest within each workgroup for an in-depth survey/analysis periodically as required.

Some suggested measures/indicators discussed:

- Prevention Quality Indicators – using indicators developed by AHRQ
- Access to specialists
- Birth Records - Where are babies born vs. where do the mothers live; where is pre-natal care available? (31 counties don't deliver babies) – Adequacy of Prenatal Care Index
- Medicare discharge data
- Barrier Free Utilization Rate – adjusts the population for certain demographic factors; used to determine adequate FTE of medical personnel needed for a particular area

Next Steps (Assignments in bold)

All workgroup members – Please review the following resources/links:

- Draft Vision Principle 1 with starter list of suggested measures
- List of validated Access to Care measures from the AHRQ National Health Disparities Report
- Principles for development of a national performance measurement data strategy (Page 10 of the 2008 white paper by the Joint Commission)
- <http://www.accessproject.org/medicaid.html> - The Access Project with reports on the experiences of several states in using data to improve access to health care (Florida, Illinois, District of Columbia, Massachusetts, New York, Oregon, Pennsylvania, Texas)
- Healthy People 2010 (Access to Quality Health Services):
<http://www.healthypeople.gov/Document/HTML/Volume1/01Access.htm>
- Kaiser website: <http://www.kff.org/uninsured/access.cfm>
- Any other sources you may know of (Kindly share links to these sources or overview articles with the rest of the workgroup so that other members may review them as well)

Based on this review, identify which measures should be included in the list of recommended measures. Send them to Hareesh and/or LaVerta to compile. The focus of the next meeting will be to populate the grid (following the example in attachment D).

Thanks to the following workgroup members who offered to look into certain data sets, especially to determine what data elements are available at the state or county level, time period of availability, and frequency of collection:

Lynne – MEPS, CAHPS, National Nursing Home Survey (NNHS), National Home and Hospice Care Survey (NHHCS)

Sally – AHRQ, HCUP SID, NHDS, American Hospital Association (AHA)

Tony – Commonwealth, Medicare cost report data (ER visits, etc.)

Barbara – BRFSS (she will also send out the link); Adequacy of pre-natal care index; Dartmouth Study (Cost and outcomes by county); Claims by physician and zip code (matched to Medicaid data) currently used by KDHE to identify shortage areas by county

Tom - NCQA

Hareesh – CPSS, Medicare Cost report data (Contact KHI)

Next Meeting

April 16, 9:00 –11:00 am, @ KHPA Offices (Conference Room 9F), 900 SW Jackson St, Topeka.