Utah Health Data Committee Biennial Report 2002

Utah Code Title 26 Chapter 33a
Utah Health Data Authority Act
Enacted 1990

Office of Health Care Statistics
Center for Health Data
Utah Department of Health

Salt Lake City, Utah
November 2002

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This report is available online: http://health.utah.gov/hda/Reports/Biennial2002.pdf

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Executive Summary

Background

The Utah Health Data Authority Act (26-33a) enacted in 1990, established the Utah Health Data Committee (HDC) and defined its purpose. The 1996 Legislature expanded data collection activities through H.B. 305 in 1995 and inserted "report card" intent language into the Act in 1996 with S.B. 171.

New Legislation or Regulation

The new administrative rule R380-210 Health Care Facility Patient Safety Program went into effect in 2001. The rule requires hospitals and ambulatory surgery centers to establish patient safety programs and report adverse drug events through established electronic reporting systems, for example the hospital discharge data system. OHCS assumed the management of patient safety data systems.

Initiated by health plans, HDC/OHCS made substantive rule changes to R428-12 Survey of Enrollees in Health Maintenance Organizations (CAHPS) and R428-13 Audit and Reporting of HMO Performance Measures (HEDIS). These changes further standardized the HMO data collection methods that will improve data's comparability across health plans.

New Coalition and Partnership

HDC fulfills its mission through partnerships with other public health programs, health plans, providers, data agencies from other states, national organizations, and federal agencies. The HDC established a coalition of HMO performance reporting with health plans, Medicaid, CHIP, and Division of Community and Family Health Services to jointly conduct the HMO enrollees satisfaction surveys, resulting in substantial improvement in the quality of survey data and reduction in financial burden for all parties.

Building upon partnerships with researchers and practitioners, OHCS received two grants from the Agency for Healthcare Research and Quality for improving patient safety and building infrastructure for health services research. In 2001-2002, HDC has strengthened its collaborations with health plans, Utah Hospital Association, *HealthInsight*, IHC Research Institute for Healthcare Delivery, VA Salt Lake Healthcare System, University of Utah Department of Medical Informatics, Brigham Young University Department of Public Administration, and the National Association for Health Data Organizations.

Major Publications/Data Products' Impact

The Committee published a hospital discharge data-based report on *Adverse Events Related to Medical Care in Utah, 1995-99* in July 2001. The Associated Press released the news nationwide.

It was the first time for OHCS to be able to release the HMO performance reports in the same year of the data collected. Enrollee satisfaction survey data sets were made available for public use.

Approximately 22 individuals supported HDC to complete its *Review of Utah Medicaid Nursing Home Bed Moratorium, 1989-2001*. This report was the second most frequently downloaded document on the UDOH web site following its release (575 downloads in September 2002).

OHCS developed its first standard report on ambulatory surgery data using 3M Ambulatory Patient Grouper (APG) software. Utah is one of the first states in the nation that report statewide utilization of outpatient surgeries.

OHCS also produced more trend and comparative analyses on HMO performance measures, including CAHPS and HEDIS. Utah Medicaid and CHIP

Executive Summary

Programs used these timely analyses to improve quality of their services and negotiate contracts.

Data Purchasers and Web Site Users

More organizations have purchased the HDC public use datasets of hospital inpatient discharges, ambulatory surgery data, and emergency department encounter data in 2001-2002. The average annual revenue from data sales in SFY2001-SFY2002 was about $73,000 that was about $16,000 higher than the annual revenues for the previous reporting period SFY1998-SFY2000.

Members of the private sector, especially hospitals, health care systems and consulting firms, are the major purchasers of the HDC datasets (29 out of 31 purchasers). The revenue from data sales was about 26% of the state general funds.

The HDC's reports and on-line publications are free to the general public, consumers, policy makers, students, and researchers. In October 2002, the average number of hits per day on the HDC web site was 1,877 and the number of unique users was 3,396.

Major Projects and Funding Sources:

OHCS has implemented the following projects:

- Health care utilization databases, including statewide inpatient discharges, ambulatory surgeries, and emergency department encounters (Ongoing project funded by the State)
- Data reporting and dissemination (Ongoing project funded by the State)
- Health plan performance measurement (Ongoing project funded by Medicaid, other public health programs, and health plans)
- Patient safety initiative (New project funded
- Building health services research infrastructure and capacity (New project funded by a federal grant)
- Primary Care Network Enrollee Health Outcome Evaluation (New project funded by Division of Health Care Finance)

Health Data Plan Updates: 2003-2004

The Health Data Authority Act requires that the Health Data Committee shall adopt a health data plan to govern its activities. The changing dynamics of the health care industry call for a periodic review. For the calendar years 2003-2004, the Committee is proposing to update its strategic plan in the following areas:

- Improve patient safety using administrative data
- Improve reporting HMOs' performance
- Improve timeliness of data release
- Monitor prescription drug utilization
- Evaluate Primary Care Network
- Develop electronic data interchange

Major Challenges Faced

The Committee has successfully overcome obstacles in the past and will face challenges in implementing the above tasks. In addition, the HDC and OHCS need support in the following areas:

- Provide useful information to health care purchasers and consumers.
- Strengthen and expand collaborations with health care providers, consumer and business organizations, pubic health programs and policy makers.
- Assess the main drivers of recent cost increase in health care and amend the Utah Health Data Plan accordingly.

Organization of This Report

Table of Contents

Table of Contents	Page
Executive Summary	i
About this Report	iv
Utah Health Data Committee	v
Part I. Current Projects	
Health Care Encounter Databases	1
Reporting and Dissemination	7
Health Plan Performance Measurement	9
Improving Patient Safety Using Administrative Data	13
Primary Care Network Evaluation	15
Reviewed Nursing Home Bed Moratorium	17
Part II. Utah Health Data Plan Update	
Improve Patient Safety Using Administrative Data	21
Improve Monitoring of Managed Care Performance	24
Improve Timeliness of Data Release	25
Monitor Medicaid Prescription Drug Utilization	27
Evaluate Health Outcome for the PCN Enrollees	29
Electronic Data Reporting-Preparedness for Bioterrorism	31
Part III. Appendices	
1. HDC Legislative Statue and Responsibilities	35
2. Chronology of Major Milestones: 1990-2002	36
3. HDC/OHCS Bibliography: 1990-2002	37
4. OHCS Expenses and Revenues: SFY1998-SFY2002	41
5. Testimonies by Clark B. Hinckley and Robert P. Huefner	42

About This Report

- This report reviews the major activities and accomplishments of the Utah Health Data Committee (HDC) and its staff, the Office of Health Care Statistics (OHCS). The report is submitted pursuant to statutory requirement for submission of a biennial report to the Utah legislature. This report covers the period from November, 2000 to October, 2002.

- The *Executive Summary* provides a background and brief history of the HDC and OHCS, an overview of activities and accomplishments during the reporting period, and a brief description of current challenges and plans for the next two years.

- Part I. Current Project describes the major projects that the HDC and OHCS are conducting, with particular focus on those initiated during the reporting period. The section also features efforts to utilize OHCS data and technical resources for monitoring cost of care, measuring quality, evaluating access to care, and identifying disparities in health and health care.

- Part II. Utah Health Data Plan Update describes the directions that the Committee is headed in areas of data development and use.

- The *Appendices* provide information on statutes relevant to the HDC and administrative rules that govern the data development activities of OHCS (*Appendix 1*), a chronology of major milestones (*Appendix 2*), bibliography of publications (*Appendix 3*) spanning the entire existence of the Committee, budget and revenue (*Appendix 4*), and the Committee's Chair (Clark B. Hinckley) and Vice Chair's (Robert P. Huefner) testimonies at the Health and Human Services Appropriate Committee's Public Hearing on January 10, 2002.

Utah Health Data Committee

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

Members as of November, 2002

Clark Hinckley, Chair
Large Business
Zions Bancorporation

Robert P. Huefner, Vice-Chair
Public Health
University of Utah

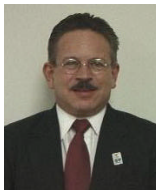
Kim Bateman
Physicians
Manti Medical Clinic/
HealthInsight

Andrew Bowler
Small Business
HR Advantages, Inc.

Leslie Frances
Public Health
University of Utah

Terry Haven
Consumer Advocacy
Utah Children

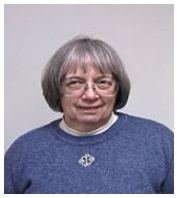
Annette Herman
HMO
United Healthcare of Utah



Scott Ideson
Third Party Payer
Regency BC/BS of Utah

Wen H. Kuo
Public Interest
University of Utah

Gail McGuill
Nursing
Utah Valley Regional
Medical Center



Sandra L. Peck
Consumer Advocacy
League of Women's Voters

Greg Poulsen
Hospital
Intermountain Health Care

Marilyn Tang
Business
Certified Handling Systems

Utah Health Data Committee

"I have been a member since 1994 of the Health Data Committee, …I have seen the office develop an ever improving organization, building relationships with health care providers that allow them to gather, analyze, and disseminate information about hospitals, outpatient surgery, emergency rooms and HMOs. That information is then analyzed and returned to the community …enabling them to make wiser decisions about health care."

- Sandra L. Peck, Consumer Advocacy

Members whose term ended during the reporting period

Penny Brooke
Nursing (1990-2001)
University of Utah

Orrin T. Colby, Jr.
Business (1990-2001)
Wasatch Crest Insurance

Lori Reichard
Consumer Advocacy (1998-2001)
Lefavor Envelope

Michael J. Stapley
Third Party Payer (1990-2001)
Deseret Mutual

Executive Director's Office, Utah Department of Health

Rod Betit	Executive Director
Richard Melton	Deputy Director
Scott D. Williams	Deputy Director
Robert Rolfs	State Epidemiologist, Former Director, Center for Health Data
Barry Nangle	Director, Center for Health Data

Office of Health Care Statistics Staff

As of November, 2002:

Wu Xu	Director
Heidi Bergvall	IT Programmer Analyst I
Paul Hougland	Epidemiologist II
Chung-won Lee	Epidemiologist II
Mike Martin	Research Analyst III
Carol Masheter	Information Analyst II
John Morgan	Information Analyst Supervisor
Millie Paita	Secretary (part time)
Steven Pickard	Research Consultant II
Janet Scarlet	Executive Secretary

Former Staff Who Contributed:

Gulzar Shah	IT Programmer Analyst II
Greg Stoddard	IT Programmer Analyst I
Keith McMillan	IT Programmer Analyst I
William Stinner	Research Consultant II
Ryley Fogg	IT Programmer Analyst I

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Part I. Current Projects

Current Projects

Health Care Encounter Databases

Hospital Inpatient Discharge Database

Administrative Rule R428-10 became effective in December 1991, and mandates that all Utah licensed hospitals, both general acute care and specialty, shall report information on inpatient discharges, beginning on January 1, 1992. The Utah Hospital Discharge Database contains the consolidated information on complete billing, medical codes, and personal characteristics describing a patient, the services received, and charges billed for each inpatient hospital stay. Fifty Utah hospitals submitted data in 2002, including four psychiatric facilities, four specialty hospitals, and the Veterans Administration Medical Center. Shriners Hospital, a charity hospital, and the State Hospital are exempt from reporting requirements.

Ambulatory Surgery Database

Administrative Rule R428-11, which became effective in March of 1998, mandated that all Utah licensed hospital and freestanding ambulatory surgical facilities shall report information on selected ambulatory surgical procedures. Voluntary reporting started on January 1, 1996. The database contains the consolidated information on complete billing, medical codes, and personal characteristics describing a patient, the services received, and the charges billed for each visit for selected ambulatory procedures. The Office of Health Care Statistics has collected information from 61 Utah ambulatory facilities submitted in 2002. Of these 61 facilities, 41 are acute care hospitals while the remaining 50 are freestanding ambulatory surgical centers.

Emergency Department Encounter Database

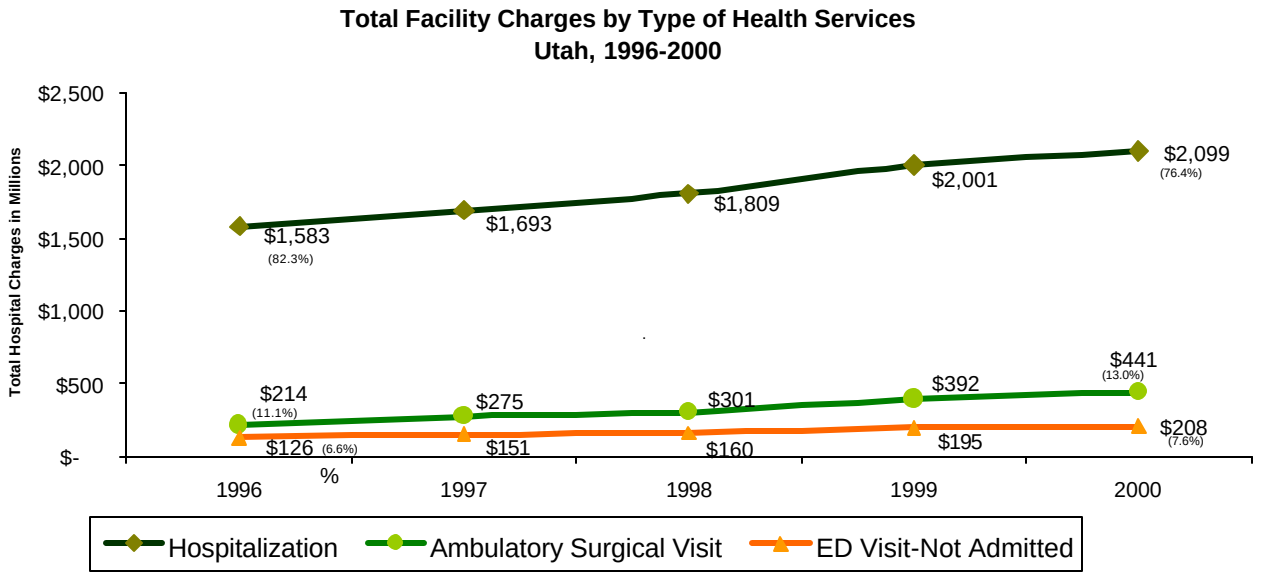
Administrative Rule R426-1-7(I) mandates all licensed Utah hospitals to report information on emergency department patient encounters. The database contains the consolidated information on complete billing, medical codes, personal characteristics describing a patient, services received, and charges billed for each patient emergency department encounter. All forty one eligible hospitals submitted data in 2001.

> *"These data …. have enabled Utah to be on the frontier of the diagnosis of community health problems. We can measure the frequency of conditions that indicate less than optimal medical care, that indicate environmental problems, that reflect social-economic disparities, and that reflect poor lifestyles."*
>
> *- Robert P. Huefner, HDC Public Health Representative*

Current Projects

Health Care Encounter Databases: Application

Monitor Facility Charges



Sources: Utah Hospital Inpatient Discharge Database, Ambulatory Surgery Database, and Emergency Department Encounter Database.
Utah Department of Health Office of Health Care Statistics.

A 1998 Legislative Audit concluded that [Health Data Analysis'] data were being used to promote cost effective, quality healthcare in the state and noted specific examples from users of how data make a difference. Health care organizations, health plans and hospitals, market research companies, health services researchers, federal and state programs continue to be the major users and purchasers of the data products.

Revenues from sales of data products have increased significantly, along with the expansion of office activities and addition of data products (see Executive Summary and Appendix 4). The Office continues to strive to meet the Legislative mandate of self-sustenance from data products, an objective that is proving difficult to attain.

> *"It is the intent of the Legislature that the Office of Health Data Analysis becomes self sustaining through the sale of its data, published reports, products or services to all business, insurance, research or commercial entities to the greatest extent possible."*
>
> *- Legislative Auditor, 1998*

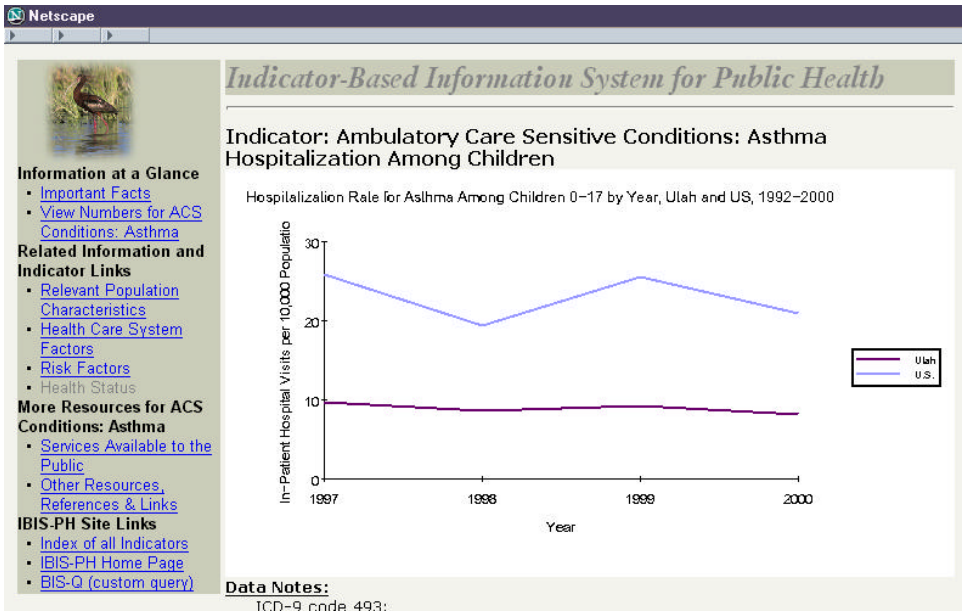
Current Projects

Hospital Inpatient Discharge Data: Application

Monitor Ambulatory Care Sensitive Conditions: Asthma Hospitalization

Conditions, for which hospitalization could have been prevented through timely and appropriate outpatient care, are called *ambulatory care sensitive conditions* or *preventable hospitalizations*. Asthma is a good example of an ambulatory care sensitive (ACS) condition. Treatment for asthma has improved substantially over the past decade and patients who receive appropriate outpatient care should rarely worsen to the point that hospitalization is needed. Not all such hospitalizations can be prevented by improving access to and quality of care, but observing a high asthma hospitalization rate in a community should prompt an examination of the factors contributing to the high rate. The analysis of hospital discharges for ACS conditions will help assess the relative effectiveness of health care delivery systems in each small area as well as in Utah, and will guide policy makers in targeting and planning the appropriate interventions.

- Utah has a higher rate of children's asthma hospitalization than the national average. The Utah Department of Health includes this indicator in the annual Public Health Outcome Measures Report and the Indicator-Based Information System for Public Health (IBIS-PH) (see the web page below).
- The HDC Quality Advisory Committee decided to produce more detailed analyses of ambulatory care sensitive conditions as a periodical publication.
- The Utah Asthma and Diabetes Control Programs, local health districts, community health centers, Medicaid, CHIP, and the Maternal and Child Health and Environmental Health programs have been major users of this information.



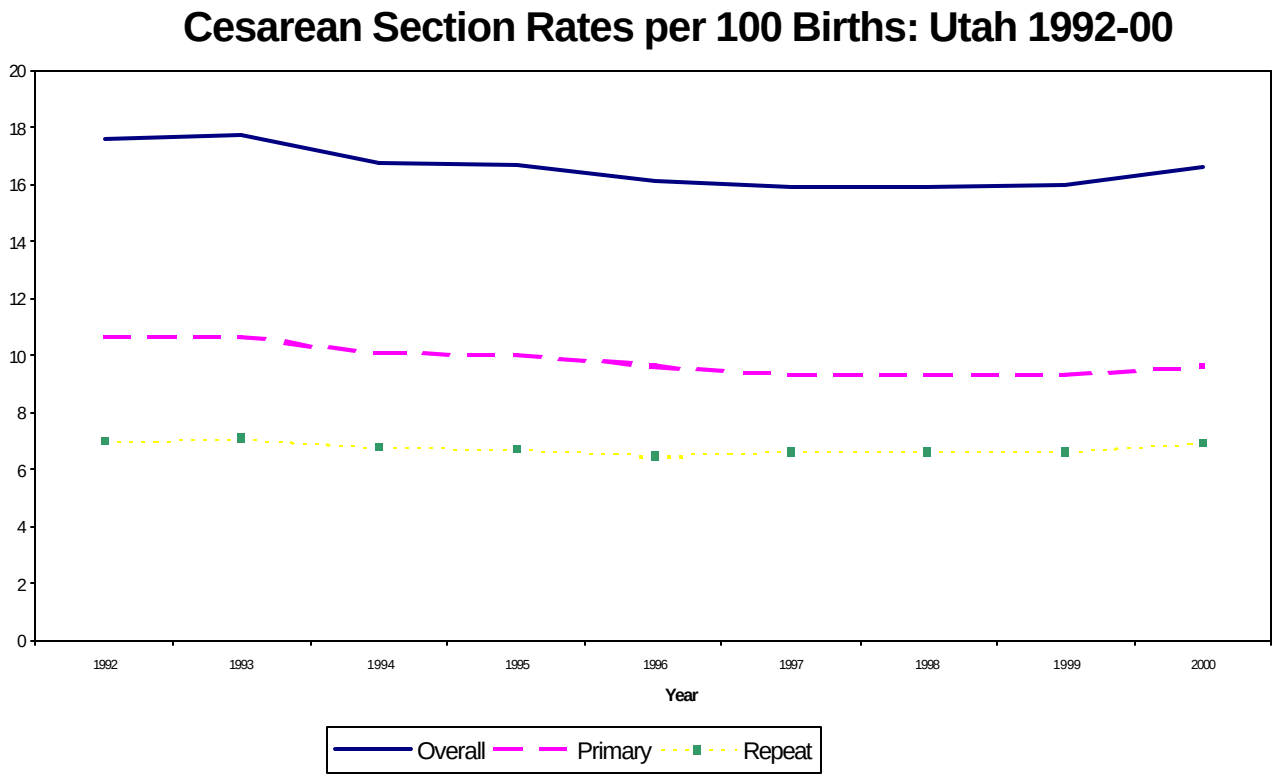
For more information, please go to http://health.utah.gov/ibis-ph.

Hospital Inpatient Discharge Data: Application

Monitor Quality Improvement - Example of the Trend of Cesarean Sections

Cesarean sections (c-sections) are the most frequently performed major surgical procedure in Utah and the U.S. Concerns about adverse health and economic effects of unnecessary c-sections prompted the HDC's effort to report hospital c-section rates since 1996. Utah's c-section rate has consistently been lower than the national rate. However, despite the relatively low rate, the variance in c-section rates among hospitals, payers, and patient factors indicates that there is room for improvement.

- Hospitals used the HDC reports to compare their own c-section rate to their peer's and the state's rates to identify improvement areas.
- A new collaborative investigation of the reasons for increased c-section rates since 1999 has been undertaken by the HDC, the Utah Bureau of Maternal and Child Health, and the University of Utah, Department of Obstetrics and Gynecology.



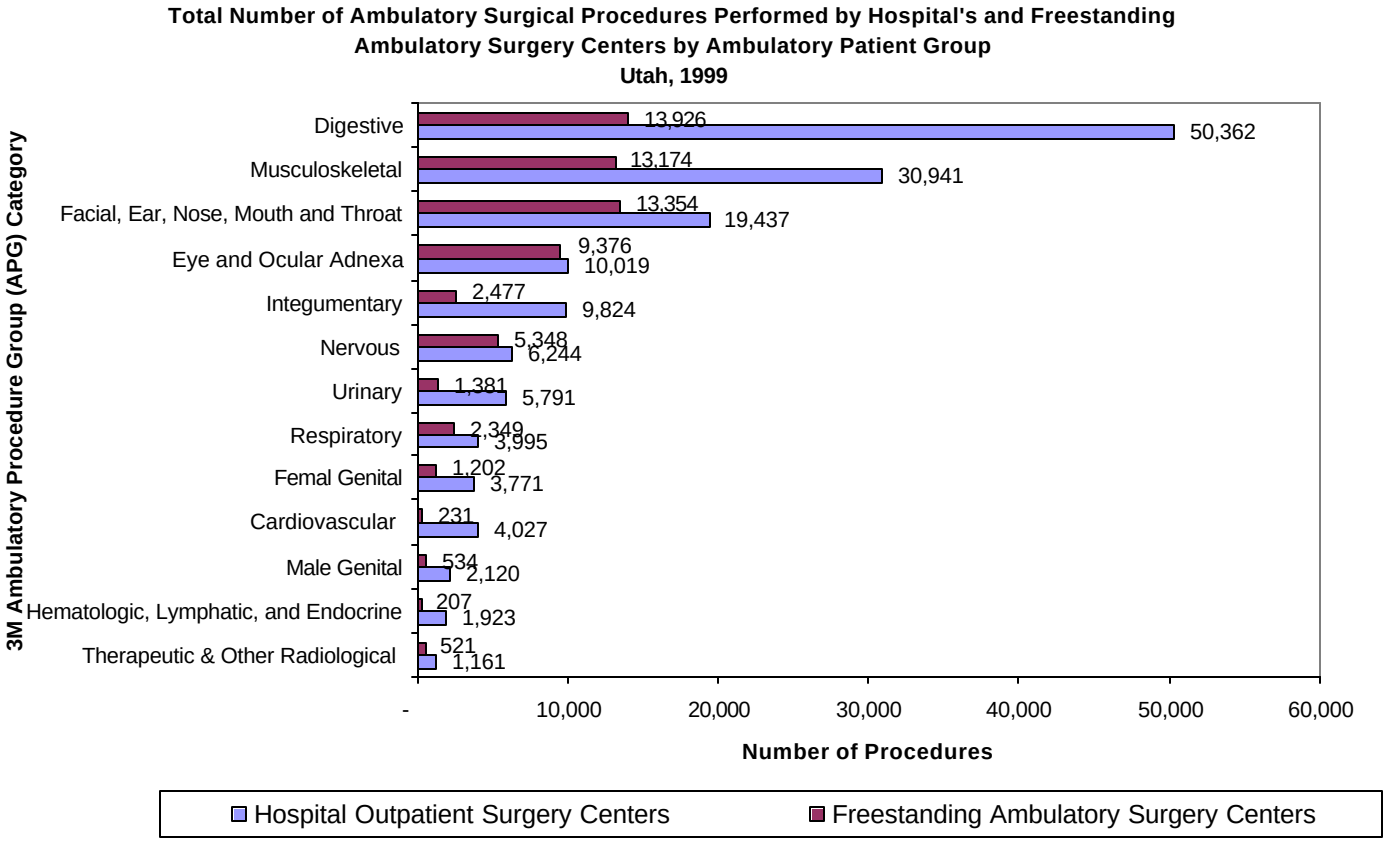
For more information please go to http://health.utah.govhda/Reports/csection.pdf

Current Projects

Ambulatory Surgery Data: Application

New Standard Report: Utah Hospital and Freestanding Ambulatory Surgery Centers (FASC) Profile

- There were 190,012 patient visits and 260,624 ambulatory procedures reported in 1999 in Utah. The statewide total charge for all reported ambulatory surgery visits was about $392 million in 1999.
- Approximately 30% of reported ambulatory procedures was performed on the digestive system of patients, followed by musculoskeletal system (21%).
- Hospital-based and freestanding surgery centers performed a similar volume of procedures on nervous and eye and ocular adnexa systems in 1999.
- This new standard report, for the first time, provided statewide comparative information on outpatient surgeries to consumers, payers, and health care providers.



For more information please go to http://health.utah.gov/hda/Reports/ambsurg_99.pdf.

Current Projects

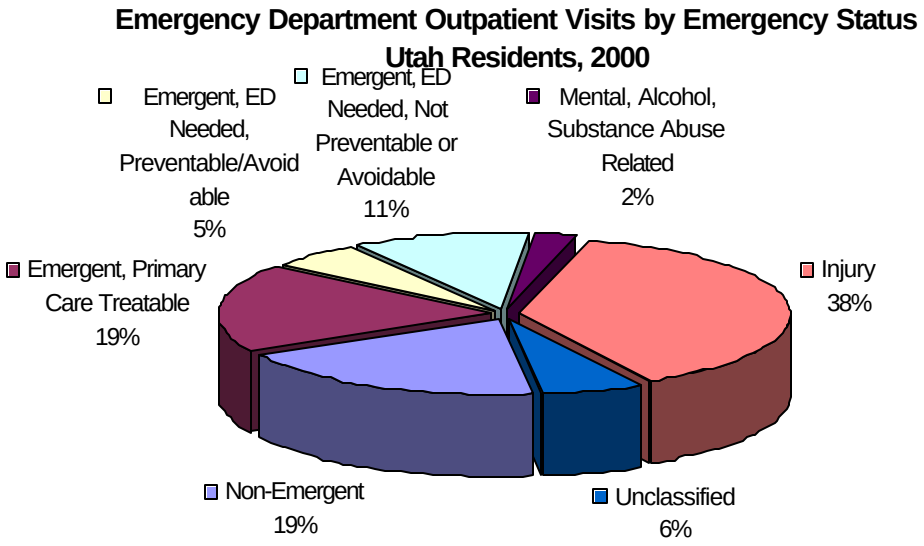
Emergency Department Encounter Data: Application

New Analysis: Non Optimal Use of Emergency Departments

Using a classification algorithm developed at New York University, OHCS assigned ED visits for the year 2000 into one of five categories: (1) non-emergent, (2) emergent but primary care treatable, (3) emergent-ED needed but preventable/avoidable, (4) emergent-ED needed-not preventable/avoidable, and (5) other. The last category included injuries and conditions related to mental health, alcohol, and substance abuse, and residual diagnoses codes. The first three of these categories comprised non-optimal ED use.

The analyses showed that:

- Four out of every ten ED visits in 2000 were for conditions deemed to represent non-optimal ED use.
- Percent of non-optimal use varied by primary payer of the patient; the highest being Industrial, CHIP and Medicaid and the lowest being Medicare, charity and managed care.
- Urban health districts show a relatively lower proportion of ED visits for non-emergent conditions than that of rural districts.
- The higher non-optimal ED use in a small area/community, the higher hospitalization rates for ambulatory sensitive conditions. This suggests a relationship between non-optimal use and primary care access.
- Percent of births with prenatal care in the first trimester provides some evidence of a relationship between non-optimal ED use and use of preventive care.



Current Projects

Reporting and Dissemination

The Utah Office of Health Care Statistics makes its databases accessible to stakeholders through a variety of means: printed reports, consumer brochures, online query systems, and public-use datasets.

Statistical Reports

OHCS releases printed reports containing summary statistics from its health care encounter databases and health plan performance measures. The target audience for the reports varies according to the subject matter and objectives of the report.

Appendix 3 provides a list of published reports and studies released by the HDC/HCS, or unpublished studies completed by staff, and published studies conducted by other agencies using OHCS data.

HDC Analytic Priorities:

- Tracking cost of care
- Monitoring health care trends
- Measuring quality of care
- Assessing access
- Identifying disparities
- Assessing community needs
- Projecting health care needs
- Measuring performance

Web-Based Data Dissemination Systems

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:

Health Information Internet Query (HI-IQ) System *(http://hlunix.hl.state.ut.us/hda/hi_iq.html)*
Internet-Based Indicator System (IBIS) *(http://health.utah.gov/ibisq/entrybody.htm)*
Emergency Department Internet Query System (EDIQS) *(www.nahdo.org/ediq/idform/indi_form.html)*

Data Release for Research and Public Use

The health care encounter data collected by OHCS are made available to researchers through public datasets 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 developed through a Federal-State-industry partnership and sponsored by the Agency for Healthcare Research and Quality. The HCUP databases include the largest collection of longitudinal hospital care data in the United States, with all-payer, encounter-level information beginning in 1988.

Current Projects

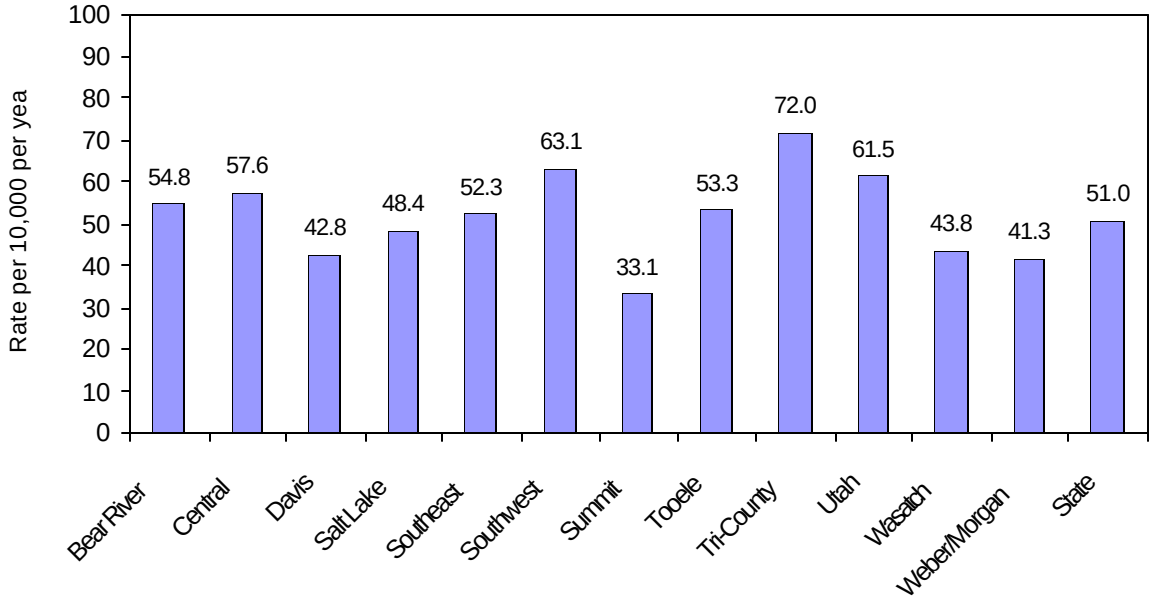
Reporting and Dissemination: Example

Cardiovascular Disease in Utah: Selected Findings

Many public health programs, such as the Utah Division of Community and Family Health Services, use the Health Data Committee's data to assess disease prevalence and program interventions' impact. The Utah Cardiovascular Health Program reported the following findings using hospital discharge data:

- Rural health districts had higher hospitalization rates for coronary heart disease than urban health districts, except for the Summit and Utah County districts.

Rate of Hospitalization for Coronary Heart Disease by Local Health District, Utah: 1998 - 2000



Source for Figure: Utah Hospital Discharge Database; Utah population estimates from the Utah Governor's Office of Planning and Budget UPED model, published in January 2000. From the report produced by the Cardiovascular Health Program, Cardiovascular Disease in Utah, Salt Lake City, UT: Utah Department of Health. (2002).

For more information, please go to http://www.hearthighway.org

Health Plan Performance Measurement: CAHPS

Consumer Assessment of Health Plans Survey (CAHPS)

The Utah Health Data Committee has implemented the Utah Health Plan Performance Measurement Reporting System in 1996. Its purpose is to provide meaningful data to help Utah's consumers, business, and other purchasers of health care, and health care providers make informed decisions about health care. The performance measurement system is comprised of managed care enrollee satisfaction survey data and Health plan Employer Data and Information Set (HEDIS) reporting. Each year, Utah Department of Health conducts the satisfaction surveys of Utah's commercial and Medicaid-contracted managed care organizations and report findings to the public. The managed care enrollee satisfaction surveys measure satisfaction with different services, such as MCO's customer service, getting needed care, getting care quickly, helpfulness of doctor's office staff, and overall ratings of the MCO, health care quality, and personal doctor.

Why is it important?

As of January 2001, about 70% of all Utahns received their health care coverage through a managed care organization (MCO). It is important to monitor and report the satisfaction level of current MCO members because such information will help Utah's consumers and employers make informed choices when choosing a health plan. The Utah Health Plan Performance Measurement Reporting System is the only public source in Utah that allows for comparison between Utah MCOs' performance . In addition, health plan satisfaction surveys conducted by the UDOH has put emphasis on the satisfaction level of persons with special health care needs. Satisfaction survey data help Utah's MCOs identify service areas that need improvement for their enrollees and stimulate competition among organizations, which leads the improvement in the overall performance of Utah's MCOs.

Accomplishments in 2001-2002

In 2001, Utah Department of Health has established a coalition with Utah's MCOs to merge two surveys that have been previously conducted separately by the department and MCOs into one. The coalition has substantially improved the quality of survey data and reduced the financial burden of survey administration for both MCOs and UDOH.

In 2002, the satisfaction survey expanded its scope to include children with chronic conditions for both commercial and Medicaid MCOs. The consensus of the health care industry is that children with chronic conditions are the heaviest users of health care service and they are the most vulnerable to poor quality of health care. The 2002 survey results provide information on how Utah's children with chronic conditions rate their health care and health plan as well as where Utah's MCOs stand compared to their counterparts in the nation.

"The data [collected by OHCS] help both employers and individuals make informed health insurance purchases, by providing important information about the quality of care in managed care plans, hospitals and surgery centers."

Clark Hinckley
HDC Large Business Representative

Current Projects

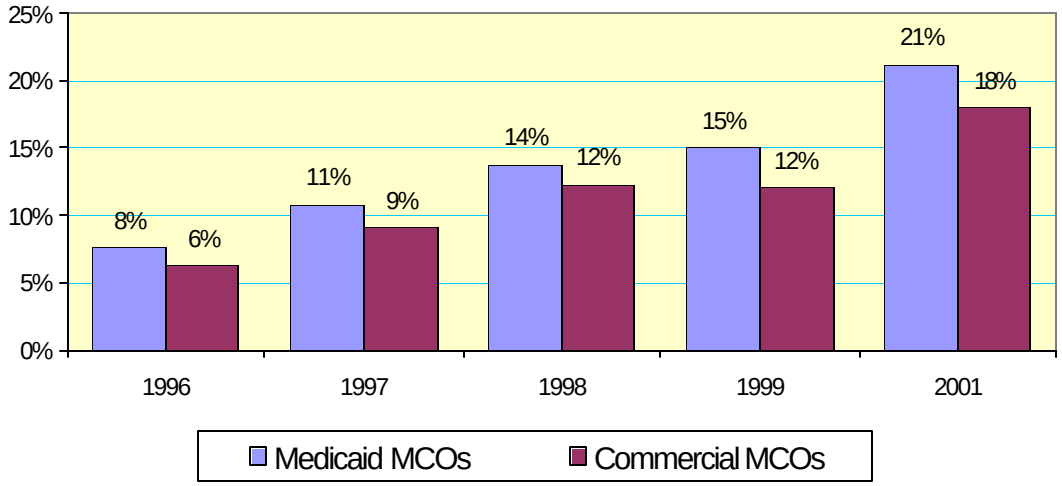
CAHPS: Application

Measuring Problems in Receiving Necessary Care

Health plans and the Utah Medicaid Program have been using the CAHPS survey results to identify problem areas to improve their services since 1996. The figure below shows the percentage of Medicaid and commercial health plan enrollees that reported having problems in receiving care that their doctor believed necessary.

Survey findings show an increase in proportion of both Medicaid and commercial health plan enrollees reporting problems in receiving care from 1996 through 2001.

Percentage of Utah's Medicaid and commercial health plan enrollees with problems in receiving health care their doctor believed was necessary



Selected Publications in 2001-2002

1. 2001 Utah HMO Performance Report: How to Compare HMOs, Part I - Consumer Satisfaction Survey Results
2. 2001 Utah HMO Performance Report: How to Compare HMOs, Part II - HEDIS
3. Medicaid HMO Enrollees with Special Health Care Needs: Results of the 1999 survey of adults and children enrolled in five Medicaid HMOs
4. 1999 Utah Commercial HMO Performance Report: How to Compare HMOs

For more information and to see the full reports, please go to http://health.utah.gov/hda/consumer%20publications/HmoPerformance2001.pdf.

Health Plan Performance Measurement: HEDIS

Health Plan Employer Data and Information Set (HEDIS)

The Utah Health Data Committee implemented the Utah Health Plan Performance Measurement Reporting System in 1996. This System's purpose is to provide comparable data to help Utah's consumers, business, other purchasers of health care, health care providers, and health plans to make informed decisions about performance of health plans. The performance measurement system is comprised of managed care enrollee satisfaction survey data and Health plan Employer Data and Information Set (HEDIS) reporting. In accordance with Administrative Rule 148-13, Utah's managed care organizations (MCOs) collect and report HEDIS to the Office of Health Care Statistics annually. HEDIS measures health plans' performance quality through their administrative database and medical charts of their enrollees. Performance measures in HEDIS include clinical quality of care, utilization of services, access to care, general plan management, cost of care, and membership.

Why is it important?

It is important for managed care organizations to have a system that can capture standardized performance measures across different health plans because there are no commonly acceptable alternatives to monitor and evaluate the quality of each MCO's performance. Like health plan enrollee satisfaction survey results, information provided by HEDIS helps Utah's consumers and employers make informed choices when choosing a health plan. In addition, the Health Plan Performance Measurement Reporting System helps Utah's MCOs identify service areas that need improvement for their enrollees, and it stimulates competition among organizations, which leads the improvement in the overall performance of Utah's MCOs

Accomplishments in 2001-2002

In 2002, for the first time since the start of the Utah Health Plan Performance Measurement Reporting System, the "Utah HMO Performance Report" was released to the public during the same year as the data were reported. Utah's MCOs especially welcomed this accomplishment, because they rely on the report to gather regional benchmark figures on HEDIS and health plan enrollee satisfaction surveys.

In 2001 and 2002, Utah's MCOs have reported more complete HEDIS data than in previous years. The number of 'Not Reported' measures has decreased, thus making public reports using HEDIS more comprehensive.

Currently, the Office of Health Care Statistics is working with Utah Diabetes Control Program in the Utah Department of Health to introduce Diabetes HEDIS Partnership Project to all MCOs in Utah and assure uniform data collection and cost sharing.

Current Projects

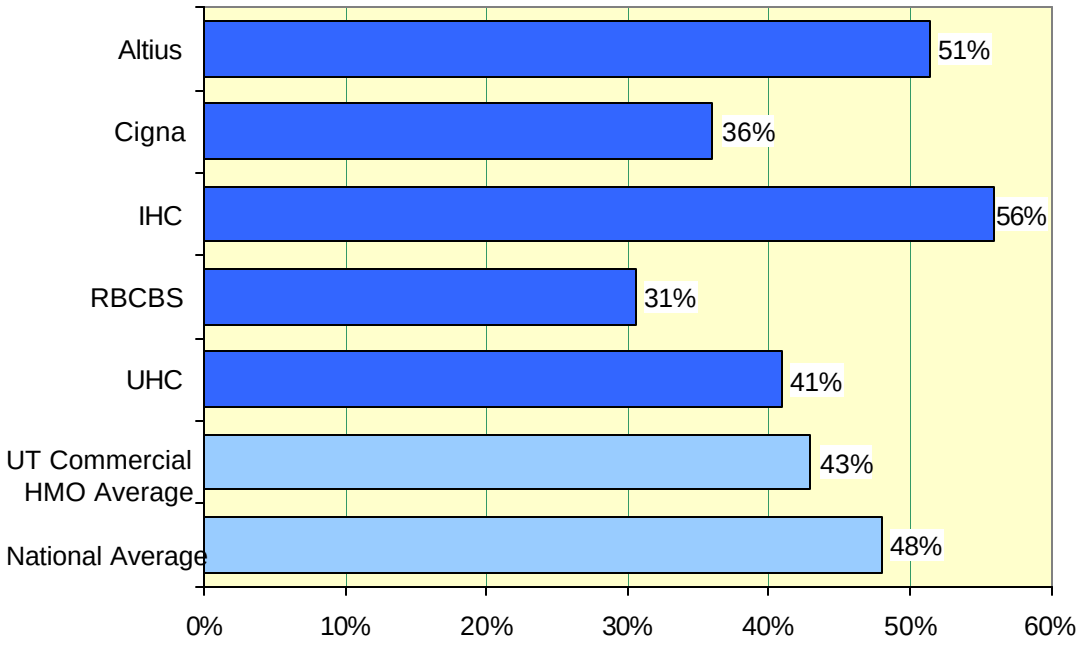
HEDIS: Application

Comparing Quality of Diabetic Care Among Health Plans

Blindness from diabetes can be reduced with early detection through eye exams. The graph below shows the percentage of Utah's commercial health plan enrollees living with diabetes who received an eye exam during 2000.

- Utah's commercial MCOs' overall performance in providing preventive care for persons with diabetes is lower than their national counterparts.
- Variations among MCOs may be due to different data reporting practices and thus may be reduced after the Diabetes HEDIS Partnership Project is fully implemented.

Percentage of Utah's commercial health plan enrollees with diabetes that received eye exam during 2000 by Health Plan



Data Source: HEDIS 2001

Selected Publications in 2001-2002

1. 2001 Utah HMO Performance Report: How to Compare HMOs, Part II - HEDIS
2. Utah Health Status Update (March 2002): Utah HMO Performance - HEDIS, 2001
3. 1999 Utah Commercial HMO Performance Report: How to Compare HMOs

For more information and to see the full reports, please go to http://health.utah.gov/had.

Current Projects

Improving Patient Safety Using Administrative Data

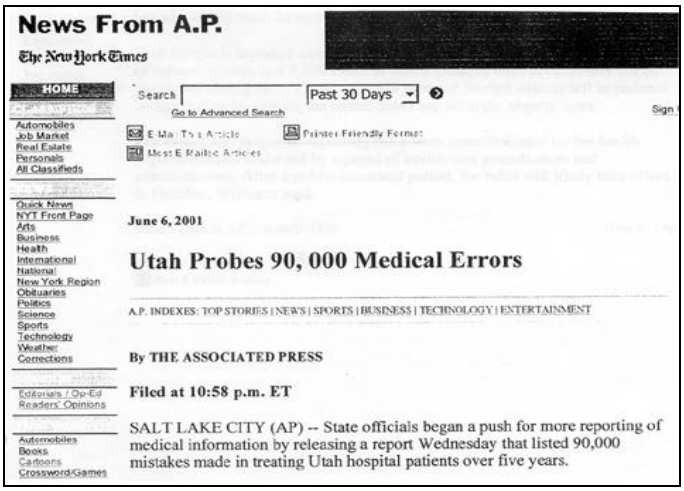
The Utah Health Data Committee is committed to the goal of increasing patient safety in health care facilities. Since early 2001, the Office of Health Care Statistics (OHCS) has began to use the International Classification of Disease Version 9 Clinical Modification (ICD-9-CM) to analyze hospital detected adverse events. In September 2001, the Office of Health Care Statistics received a three-year federal grant to demonstrate how to improve patient safety using administrative data. Through a number of collaborative initiatives with Utah Hospital and Health System Association, *HealthInsight*, University of Utah Department of Medical Informatics, and LDS Hospital, OHCS has reported and is providing patient safety information from the hospital discharge database to hospitals. Hospitals can use the information to better understand the nature and occurrence of adverse events in hospitals and to facilitate hospitals' interventions aimed at reducing the incidence of adverse events.

Why is it important?

Studies cited in the Institute of Medicine report, *To Err Is Human*, estimate that between 44,000 and 98,000 Americans die each year as the result of medical errors, with national health care costs from preventable adverse events totaling between nine and fifteen billion dollars. Medical injuries are an increasingly critical public health problem that imposes enormous burdens such as loss of life, disability, and economic consequences. Proper reporting, and data collection and analysis are critical first steps to effective prevention.

Accomplishments: in 2001-2002

Utah is one of the leading states in the nation to improve quality of health care, especially in the area of patient safety. The Committee published a hospital discharge data-based report on *Adverse Events Related to Medical Care in Utah, 1995-99* in June 2001. The Associated Press released the news nationwide. The Missouri Department of Health and Senior Services adopted the Utah's ICD classification and analytical approach and partnered with UDOH to apply for the federal grant. The patient safety grant project organized a national expert panel to refine the previous ICD classification and categorized 1,003 ICD codes into 66 adverse event classes for analysis. OHCS has supported *HealthInsight* to conduct educational interventions among acute care hospitals and consulted the UHA adverse drug event user group on developing standards and tools to detect adverse drug events when delivering the care. OHCS started a quarterly newsletter, *Utah Patient Safety Update.*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June 6, 2001

Utah Probes 90, 000 Medical Errors

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By THE ASSOCIATED PRESS

Filed at 10:58 p.m. ET

SALT LAKE CITY (AP) -- State officials began a push for more reporting of medical information by releasing a report Wednesday that listed 90,000 mistakes made in treating Utah hospital patients over five years.

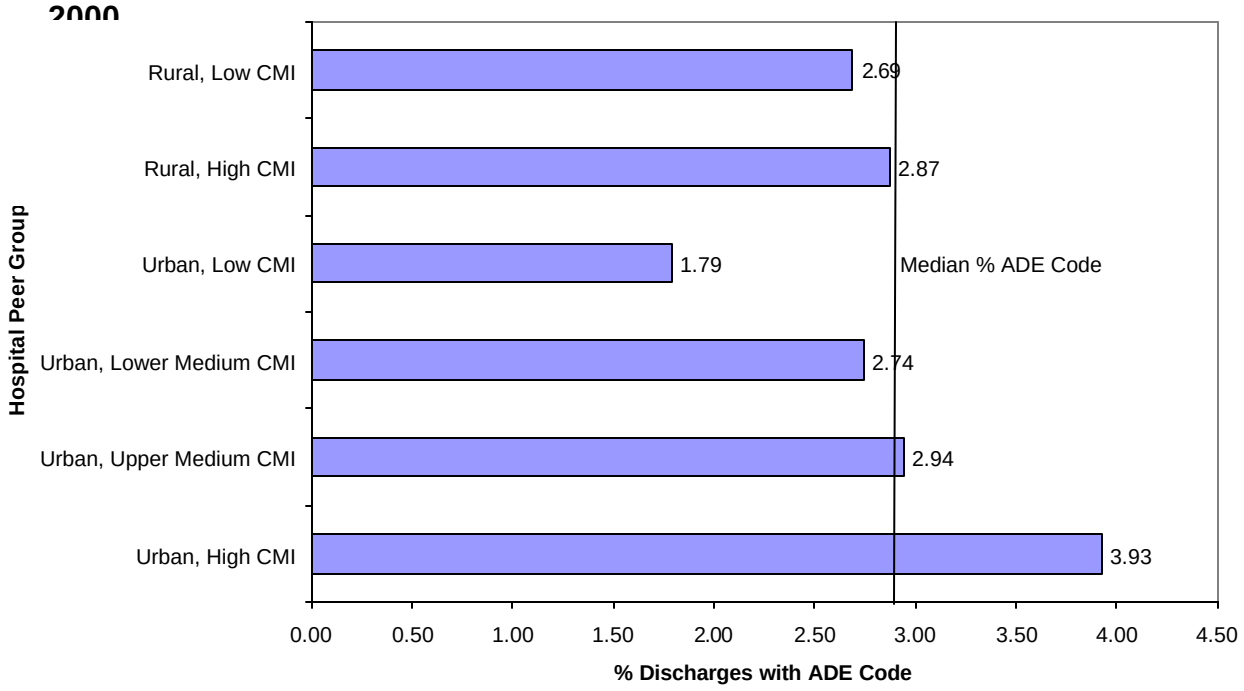
Current Projects

Patient Safety: Application

Tracking Adverse Drug Events (ADEs) Related to Hospital Care

Patient safety literature reports a positive correlation between adverse drug events and length of stay in hospital, hospital total charges, and patient severity of illness. The Health Data Committee uses hospital patient case-mix indices to group hospitals and provides a reference for hospital patient safety personnel to assess each hospital's ADE rate in relation to its peer group (hospitals which have the same level of complexity in their patient population).

Percent Discharges with at Least One Adverse Drug Event ICD-9 Code by Hospital Case Mix Index (CMI) Group: Utah, 39 Acute Care Hospitals, 2000



* Veterans' Administration and Primary Children's Hospitals excluded.

"The beauty of this [Utah Patient Safety Update] is to illustrate that we are trying to take administrative data that you [hospitals] have built in, and turn that into pertinent information, at no extra effort from the hospitals."

- Kim Bateman, MD, HDC Physician Representative

"[Our] success will be indicated initially by seeing an increased number of events detected and reported across the state."

- Scott D. Williams, MD, Deputy Director , Utah Department of Health

For more information go to http://health.utah.gov/psi/

Current Projects

Primary Care Network Enrollees' Health Outcome Evaluation

Utah Department of Health established the Primary Care Network (PCN) program, a new health insurance initiative to reduce the number of uninsured adults, on July 1, 2002. The distinctive feature of the PCN Program is that it emphasizes primary and preventive care by offering limited coverage, in hopes of reducing the needs of acute care/hospitalizations and emergency room visits. The Office of Health Care Statistics (OHCS) is in charge of evaluating the health outcomes of the PCN enrollees. The outcome evaluation will answer the following question on the PCN impact: Does the availability of primary and preventive care improve the enrollees' health status and enhance their success in achieving employment offering full coverage?

OHCS has developed a PCN enrollees' self health assessment survey tool. The purpose of the survey, initially, is to gather baseline health information of all first year Primary Care Network (PCN) enrollees. The health assessment surveys measure various aspects of overall PCN health status, such as access to services, usage of specialists, limitation due to physical/emotional health problems, and general psychological well-being.

Why is it important?

As of October 2002, over 5,500 Utahns have enrolled in the Primary Care Network of Utah. It is important to monitor and report the health status of PCN members because such information will help PCN management and policy makers not only understand critical aspects of the service population but also identify potential pitfalls and improvements to adjust the management and policies. Evaluation outcomes will enable program leaders to employ informed judgments when measuring overall success of the PCN and its objectives.

Accomplishments in 2001-2002

Since the inception of PCN in July 2002, Utah Department of Health (UDOH) has received surveys from over 5,000 PCN enrollees originating from all parts of the State. UDOH has been able to establish and coordinate strong communication links with all Wasatch Front managed care offices and rural Local Health Departments responsible for distributing the health assessment surveys. Preliminary results have been presented to UDOH management and the Health Data Committee for review and comment.

In an effort to track the former Utah Medical Assistance Program (UMAP) population, surveys were directly mailed to those who were June 2002-eligible UMAP and are currently PCN clients. UDOH achieved a response rate of over 82% without phone follow-up. Currently these surveys, along with those for the general PCN population described above, are being analyzed and readied for presentation to appropriate parties.

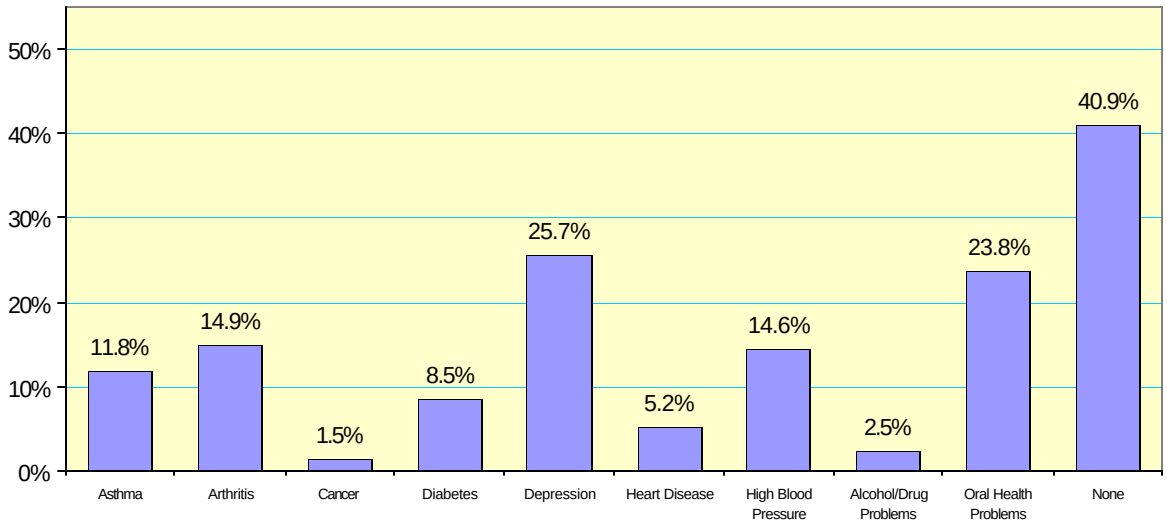
Current Projects

Primary Care Network Evaluation: Applications

Preliminary Findings from the PCN Enrollee's Health Assessment:

The graph below shows approximately one of four PCN enrollees is either affected by depression or oral health problems. Equal percentage (15%) of enrollees had high blood pressure or asthma.

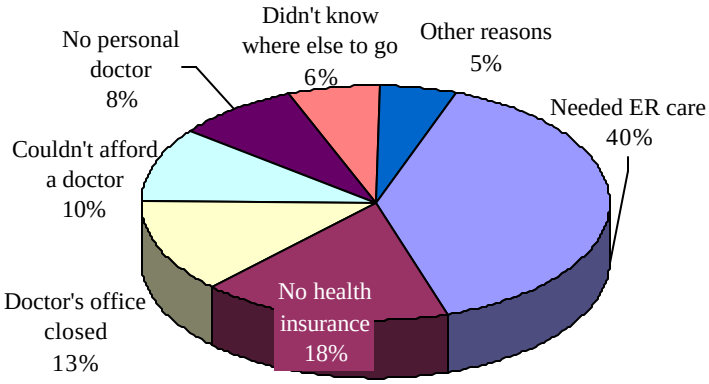
Percentage of Primary Care Network Enrollees* Who Reported Having Certain Medical Conditions At Time of Enrollment: Utah, 2002



*Preliminary analysis based on the first group of 2,516 PCN enrollees.

Reasons for Visiting EDs

Responses to the assessment question on the reasons for going for emergency department (ED) care among those PCN enrollees who visited ED revealed that only about 40% thought they needed ED care.



Completed Project

Reviewed Nursing Home Bed Moratorium: 1989-2001

During the first six months of 2001, approximately 9,500 Utahns, or 4.32 percent of persons age 65 and over, were in long-term care (LTC) facilities. In response to growing changes and concerns in the LTC industry, the Utah Health Data Committee, in partnership with the Divisions of Health System Improvement and Health Care Finance, and the Health Facility Committee, evaluated whether the Utah Administrative Rule R455-07A - Moratorium on New Medicaid-certified Nursing Home Bed Construction, was fulfilling its intended purpose in today's environment.

Based on analyses of relevant data, the HDC concluded that slow and incremental changes with tailored policies for different communities and patient populations will lead to a healthy transition and benefit long term care consumer and providers in Utah.

Specifically, the Committee recommends that the Utah Department of Health periodically publish the following LTC indicators:

- Capacity Indicator: Number of Beds
- Performance Indicator: Occupancy Rate
- Quality Indicator: Number of Deficiencies
- Projected Needs Indicator: Ideal Number of Nursing Home Beds at 90% or Higher Occupancy Rate

HDC Members' Comments:

"Access to quality health care in nursing homes and the affordability of these services are the aims of the Health Data Committee. The moratorium and subsequent analysis of the nursing home industry in Utah are aimed at maintaining the balance between access and costs. As a member of the Health Data Committee, I am encouraged that the steps taken since 1989 have and will continue to benefit the residents of Utah."

- Scott Ideson, Third Party Payer Representative

"Because of the complexity of the nursing home market and the constant changes in that market, it is vitally important to monitor the results of public and private policies and to be willing to reconsider adjustments in these."

- Robert Huefner, Public Health Representative

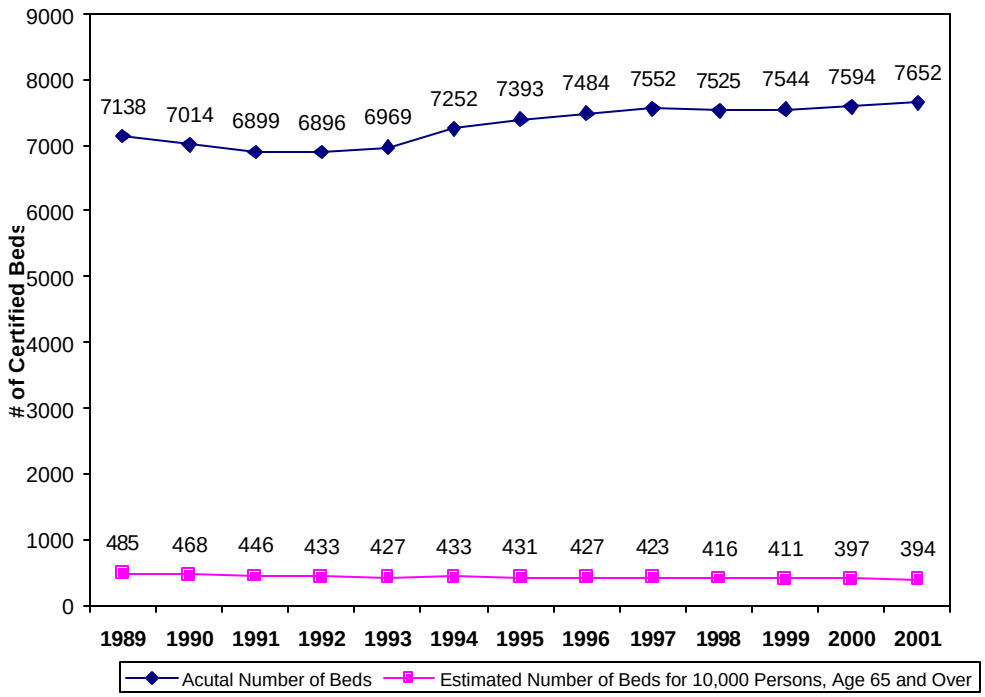
"We want to be sure there are enough nursing home facilities of good quality in Utah. It's a major concern for seniors and their families."

- Sandra Peck, Consumer Advocacy Representative

Completed Project

Reviewed Nursing Home Moratorium: Applications

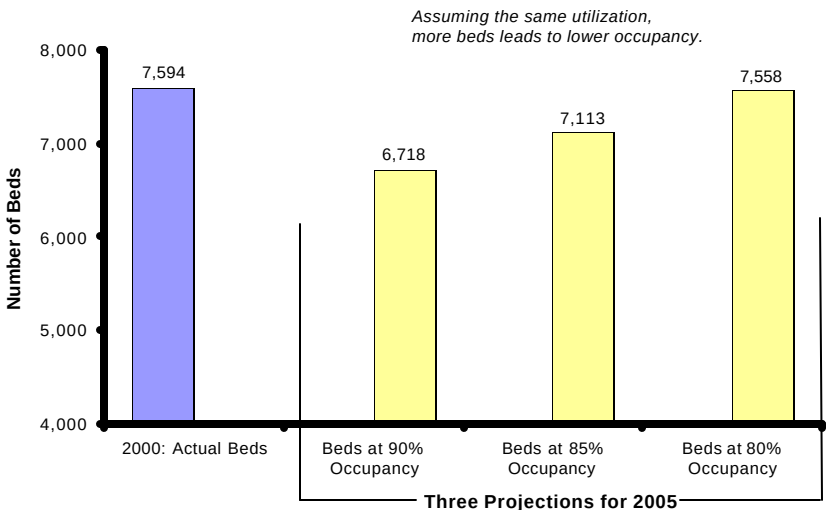
Medicaid/Medicare Certified Nursing Home Beds and Nursing Home Utilization Rate Utah, 1989-2001



The graph on the left shows there was a net growth of 514 nursing care facility beds between 1989 and 2001. In spite of the slow growth in nursing home beds, Utah's population over age 65 grew from 147,068 to 190,222, a 29.3% increase, during the period of 1989-2000. However, the nursing home utilization rates declined from 485 beds per 10,000 persons, age 65 and over in 1989 to 394 in 2001.

Projected need of nursing home beds, Utah 2005

The current number of nursing home beds should be adequate to meet the needs of nursing home patients in 2005. This projection was based on three assumptions: (1) the utilization pattern remains the same as that in 2000; (2) the projected statewide occupancy rate is 80% or higher; and (3) the growth rate of the population age 65 and over is 8% or lower between 2000 and 2005.



For more information go to http://health.utah.gov/hda/Reports/NHM02.pdf.

Part II. Utah Health Data Plan Update

Utah Health Data Plan Update 2003-2004

GUIDELINES FOR OPERATION:

The Utah Health Data Committee and its staff, the Office of Health Care Statistics, collect, analyze, and disseminate health data under the legislative authority of Utah Health Data Authority Act (Title 26-33a), ten Utah Administrative Rules and the HDC approved two Health Data Plans:

A. Administrative Rules:

- Hospital inpatient data: R428-10
- Outpatient surgery data: R428-11
- Customer assessment of health plans/HMOs data: R428-12
- HMOs and Medicaid, CHIP's health plans performance data: R428-13
- Population-based Patient Safety Data: R380-210
- Emergency Department Encounter Data: R426-1-7(I)
- Health data collection and reporting plan: R428-1 and R428-20
- Health data standards: R428-2
- Data validation and reporting procedures: R428-5

B. Utah Health Data Plan

- The Health Data Plan, adoption date: December 6, 1991
- Utah Health Care Performance Measurement Plan, adoption date: July 1996

PROCEDURE AND PROCESS TO DEVELOP NEW DATA COLLECTIONS:

"The committee shall develop and adopt by rule, following pubic hearing and comments, a health data plan" (26-33a-104(2)) when a new type of data collection is proposed. The Office of Health Care Statistics shall consult with data suppliers, subject experts, and the public to develop the plan.

BIENNIAL HEALTH DATA PLAN UPDATE:

The committee is required to *"report biennially to the governor and the legislature on how the committee is meeting its responsibilities."* (26-33a-104(2)(d)) This provides an opportunity for the committee to prioritize its efforts in the coming two years and set a strategic plan for the Office of Health Care Statistics to implement. The Office of Health Care Statistics will solicit public input on the biennial health data plan updates at advisory committee meeting(s) and public hearing(s). The committee will adopt the Health Data Plan Updates after all public comments are reviewed and considered.

The Health Data Plan Update 2003-2004 includes following initiatives:

1. Improve Patient Safety Using Administrative Data
2. Improve Monitoring of Managed Care Performance
3. Improve Timeliness of Data Releases
4. Monitor Medicaid Prescription Drug Utilization
5. Evaluate Health Outcome for the PCN Enrollees
6. Electronic Data Reporting—Preparedness for Bioterriorism

Improve Patient Safety Using Administrative Data

Initiative Description:

This initiative attempts to reduce the administrative data-detected adverse events in hospitals and ambulatory surgical centers by examining existing hospital discharge data reporting systems, producing quarterly reports on adverse events for hospitals, and conducting educational interventions (seminars, user groups, and on-site consultations) in Utah. This project will help hospitals and surgical centers to establish patient safety/adverse drug events programs and processes and enhance these facilities' capability in preventing medical errors. This initiative has been designated as a national demonstration project supported by the Federal Agency of Healthcare Research and Quality (AHRQ Grant HS11885).

Benefit to Public Health:

Medical care-related adverse events have become one of the leading underlying causes of deaths and injuries. Utah hospitals have taken significant steps toward increasing patient safety and reducing medical adverse events. Utah Department of Health has implemented two new administrative rules on patient safety since October 1, 2001. The Rule R380-200 requires hospitals to report serious patient injuries and to allow an independent, external review of these events. The Rule R380-210 requires hospitals and ambulatory surgical centers to implement processes to effectively identify and report to UDOH the incidence of all adverse drug events (ADEs). To reduce facilities' reporting burden, UDOH encourages the facilities to report the ADEs through the existing hospital discharge reporting system. This project will develop standard methods to analyze patient safety information in administrative data bases to facilitate the patient safety improvements in Utah.

Time Line to Implement:

Year 1 (September 2001 – August 2002): Design and implement
Year 2 (September 2002 – August 2003): Conduct educational interventions at hospitals
Year 3 (September 2003 – August 2004): Continue interventions and evaluation

Key Action Steps in Next 6 Months:

- Report the baseline information on pre-intervention medical chart review and facility survey at 41 acute care hospitals
- Work with *HealthInsight* and UHA to implement the educational and informational interventions among hospitals

Key Action Parties:

- Utah Department of Health: Executive Director's Office, Office of Health Care Statistics, Division of Health System Improvement
- *HealthInsight*: Office of Patient Safety and Scientific Affairs
- UHA, Utah Hospitals and Health Systems Association
- Intermountain Health Care Institute for Health Care Delivery Research and LDS Hospital
- Veterans Administration Salt Lake City Health Care System
- University of Utah Department of Medical Informatics
- Utah Medical Association

Improve Patient Safety Using Administrative Data

Key Action Parties (cont.):

- The Utah-Missouri Patient Safety Consortium for AHRQ Grant HS11885. In Missouri,
  - Missouri Department of Health and Senior Services
  - University of Missouri— Columbia, School of Medicine
  - Missouri Patient Care Review Foundation

Funding/Staff Required:

This initiative has been funded by an AHRQ grant. UDOH is the lead grantee in collaboration with *HealthInsight*, University of Utah, and Missouri Department of Health and Senior Services.

Fiscal Year	UDOH/OHCS Budget	UDOH/OHCS FTE	Budget Passed Through to Partners	Total Grant Budget
09/01-08/02	$289,239	2.5	$1,211,694	$1,500,933
09/02-08/03	$253,081	2.5	$993,476	$1,246,557
09/03-08/04	$275,565	2.5	$1,131,068	$1,406,633
Total	$817,885	2.5	$3,336,238	$4,154,123

Measurable Outcomes:

1) Reported hospital adverse event rates are expected to increase from 2002 to 2004. The project will set up a baseline in 2002 then monitor the change. Currently, adverse events are under reported due to lack of standard definitions and interventions. The increased rates will indicate the increased hospital efforts on tracking adverse events. We expect the rate may begin to decline by 2005.
   For example: During 1995-1999, there were 4,248 misadventures of surgical and medical care, including 128 hospitalizations during which a foreign object was left in the patient's body. We expect that the amount of care misadventures first will increase, then decrease during the project period.

2) Established hospital patient safety and adverse drug event reduction programs and processes measured by the pre-intervention and post-intervention surveys.

Current Status:

The initiative started in September 2001 and is being implemented as scheduled.

Improve Monitoring of Managed Care Performance

Initiative Description:

This initiative attempts to improve the standardization and cost-sharing of data collection and reporting system of the Managed Care Organizations' (MCOs') performance measures by expanding the project partnership to more public health programs within the Utah Department of Health. A public-private partnership was developed in 2001-2002 to share the costs of data collection on the Consumer Assessment of Health Plans surveys (CAHPS). This initiative attempts to expand the goals of the partnership to jointly decide the standardized method in reporting the Health plan Employer Data and Information Set (HEDIS). This initiative will further strengthen the collaboration by achieving the following goals:

1. Introduce the Utah Diabetes Control Program's HEDIS project to all health plans to assure uniform data collection on diabetic care performance measures in HEDIS
2. Pilot an alternative method to measure and monitor the performance of the Preferred Provider Network (PPN) for the Medicaid beneficiaries
3. Improve the comparability of managed care organization's performance measures and expand the dissemination of consumer reports.

Benefit to Public Health:

Managed Care Organizations' performance monitoring system has been in place since 1996. There has been concern with regard to inconsistencies in data collection and reporting systems across managed care organizations. Improving the quality of managed care data will help the public better understand the current status of Utah's health care providers. Also, expanding the scope of report dissemination will help more health care purchasers make more informed decisions in the future.

Time Line to Implement:

Year 1 (July 2002 - June 2003): Assist public health programs within UDOH to build partnerships with managed care organizations. Assist public health programs within UDOH to better utilize existing data on managed care organizations' performance measures

Year 2 (July 2003 - June 2004): Pilot the new performance monitoring system for PPN. Expand the scope of managed care organizations' performance data reporting and dissemination

Key Action Steps in Next 6 Months:

- Facilitate communication between public health programs and managed care organizations to assist partnership building

Improve Monitoring of Managed Care

Key Action Parties:

- Utah Department of Health:
  - Health Data Committee/Office of Health Care Statistics
  - Division of Health Care Financing
  - Children's Health Insurance Program
  - Division of Community and Family Health Services
  - Utah Diabetes Control Program

- Participating Managed Care Organizations:
  - Altius Health Plans
  - Cigna Health Care of Utah
  - IHC Health Plans
  - Molina Healthcare
  - PEHP
  - Regence BlueCross BlueShield of Utah
  - United Healthcare of Utah
  - University of Utah Hospitals and Clinics

Funding/Staff Required:

HCS will use the existing budget to carry out this initiative.

Measurable Outcomes:

- At least one more health plan participates in the Utah Diabetes Control Program' HEDIS project.
- Satisfaction with care by all Medicaid beneficiaries (MCO enrollees plus others) are monitored.
- The comparability of HEDIS performance measures among participating plans is improved.

Current Status:

The initiative started in May 2002 and is being implemented as scheduled.

Health Data Plan Update 2003-2004

Improve Timeliness of Data Release

Initiative Description:

The Office of Health Care Statistics plans to improve timeliness of releasing the public use data sets during 2003-2004. With the available funding from the federal patient safety grant, OHCS plans to pilot quarterly patient safety data release to hospitals to support health care providers' patient safety improvements.

The Office will consult with the HDC Technical System Advisory Committee to standardize several data elements in hospital discharge, ambulatory surgery, and emergency department encounter databases. The table below lists the data elements under consideration:

Data Element Need Improvement	Database Involved		
	Inpatient	Ambulatory Surgery	Emergency Department
Facility Charges		X	X
Physician Identifier	X	X	X
Physician Specialty	X	X	X
Payer Classification	X	X	X
ICD-9 Code		X	
CPT-4 Code		X	
Race	X		X
Ethnicity	X		X

"X" indicates a data element in a database is under consideration.

Benefit to Public Health:

The HDC data users, especially Utah hospital users, have requested the Office of Health Care Statistics to make more timely release of the statewide hospital discharge data. Non-standardized data elements or incomplete reported data reduce accuracy and comparability of the public use data sets. To improve the timeliness and standardization of the three major databases in the office will significantly increase the value of the data for data users.

Time Line to Implement:

Year 1 (2003): Implement the quarterly patient safety data release and planning standardization of selected data elements.

Year 2 (2004): Implement HDC-approved standardization of selected data elements.

Improve Timeliness of Data Release

Key Action Steps in Next 6 Months:

- Implement the quarterly patient safety data release
- Planning standardization of selected data elements

Key Action Parties:

- The HDC Technical System Advisory Committee
- The Emergency Medical Service Data Subcommittee
- UHA, Utah Hospitals and Health Systems Association
- Utah freestanding ambulatory surgery centers' (FASC) group
- Utah Health Information Network (UHIN)
- IT vendors for hospitals and FASCs
- Center for Health Data, UDOH

Funding/Staff Required:

The Office of Health Care Statistics will use existing funds for this initiative.

Measurable Outcomes:

Timeliness:

- The Office will release the first 6 months of 2002's patient safety information to hospitals in March 2003, then all 2002's quarterly data in July 2003.

Standardization:

- Facility Charges - Improved comparability
- ICD-9 Code - Improved comparability
- CPT-4 Code - Improved comparability
- Physician Identifier - Expanded analysis
- Physician Specialty - Expanded analysis
- Payer Classification - Expanded analysis
- Race - Expanded analysis
- Ethnicity - Expanded analysis

Current Status:

The Office has started the planning process.

Monitor Medicaid Prescription Drug Utilization

Initiative Description:

The Office of Health Care Statistics is one of five state partners in the Intermountain Consortium for Building Research Infrastructure (ICBRIC), formed in October 2001 with a grant from the Agency for Healthcare Research and Quality to the National Association of Health Data Organizations. Through a number of priority-setting workshops, the ICBRIC partners decided to conduct policy-oriented research on prescription drug utilization by Medicaid beneficiaries. OHCS will analyze and report the Utah data according to the ICBRIC research proposal. The specific aims of the project are as follows:

1. To describe the concentration of annual Medicaid beneficiary prescription drug expenditures by the type of beneficiary, including demographics, geography, therapeutic classes, and aid categories in Utah, Nevada, and California.
2. To identify the "high cost" beneficiaries, describe their characteristics, and describe the persistence of Medicaid beneficiary prescription drug expenditures over time by the type of beneficiary, including demographics, geography, therapeutic classes, and aid categories in three states.
3. To describe variation in prescription drug expenditures among geographic areas, and to describe the characteristics of those areas in terms of socioeconomic, provider and insurance characteristics.
4. To describe specific state cost and utilization control policies and the potential impact of variation in these polices across states on prescription drug expenditures.

Benefit to Public Health:

In recent years, federal and state officials have devoted considerable attention to the rising cost of prescription drugs in managed care organizations and the Medicaid program. Expenditures have grown at double-digit rates over the past decade, despite policies intended to reduce the per-unit cost and to ensure appropriate levels of utilization. Expenditures are expected to continue to grow at similar rates in the near future. The results of this study will help Medicaid and commercial HMO policymakers develop effective policies to ensure that the growth in overall expenditures on prescription drugs provides maximum value to beneficiaries. The study will identify the drug categories and types of beneficiaries that drive increasing expenditure by comparing the impact of different state level policies on utilization and cost.

Time Line to Implement: January 2003 – December 2004

Year 1 (2003): Complete the research design, access to required data files, analyze the data.
Year 2 (2004): Complete the report

Monitor Medicaid Prescription Drug Utilization

Key Action Steps in Next 6 Months:

- Complete the research design
- Access to required data files

Key Action Parties:

- Utah Office of Health Care Statistics
- Utah Division of Health Care Finance
- The Intermountain BRIC Consortium, coordinated and staffed by:
  - The National Association of Health Data Organization (NAHDO)
  - The state ICBRIC partners are state health data organizations/agency in
    - Idaho
    - Montana
    - Nevada
    - Utah
    - Wyoming
  - Stanford University's Center for Health Policy Studies, research consultants
- Interested health plans and health insurance companies in Utah

Funding/Staff Required:

HCS will use the BRIC second year budget ($19,000) for this activity to cover the analytical staff's time and cost related to access the Medicaid beneficiary and prescription drug data files.

Measurable Outcomes:

- Complete analysis and reporting as scheduled
- The report is useful for Medicaid policy makers

Current Status:

The research proposal has been developed by the researcher at Stanford University.

Evaluate Health Outcome for the PCN Enrollees

Initiative Description:

Utah Department of Health established the Primary Care Network (PCN) program, a new health insurance initiative, on July 1, 2002. Its key innovation is a limited State benefit plan with the emphasis of primary and preventive care. This plan does not include hospitalization and specialty care under Medicaid, but the State coordinates voluntarily donated care provided by specialty care providers and hospitals. PCN is the first program in which the federal government has allowed a state to reduce some benefits to current Medicaid eligibles in order to expand the coverage to working individuals who have no employer-provided health care plan. The Utah Office of Health Care Statistics will study whether this new health care plan will affect enrollees' health outcomes.

The Utah Office of Children's Insurance and Access Initiative is responsible for implementing the PCN program. The Division of Health Care Finance Evaluation and Research Unit evaluates the implementation process. The Office of Health Care Statistics is in charge of evaluating the health outcomes of the PCN enrollees.

The outcome evaluation will answer the following question on the PCN impact:

- Does the availability of primary and preventive care improve the enrollees' health status and reduce non-optimal use of emergency departments and hospitals?

Benefit to Public Health:

The current PCN enrollment plan aims to expand the primary care coverage to 25,000 uninsured low income adults (29% of the estimated eligible population). The outcome evaluation will assess whether the program benefits its enrollees and health care systems in Utah. The evaluation results will be shared with federal and state Medicaid policy makers to help other states develop new Medicaid waiver programs to improve health insurance coverage for low income population.

Time Line to Implement:

Year 1 (June 1, 2002 - June 30, 2003): Design the evaluation methods and protocol, conduct the baseline assessment, and provide feedback to the PCN program and providers.
Year 2 (July 1, 2003 - June 30, 2004): Conduct the first follow-up assessment and provide feedback to the PCN program and providers.
Year 3 (July 1, 2004 - June 30, 2005): Conduct the second follow-up assessment and report the final results of the evaluations.

Key Action Steps in Next 6 Months:

1. Conduct the baseline health assessments among the PCN enrollees
2. Support other PCN evaluation activities

Evaluate Health Outcome for the PCN Enrollees

Key Action Parties:

- Utah Department of Health: Office of Health Care Statistics, Center for Health Data
- Brigham Young University: Department of Public Administration
- The Salt Lake Valley Health Access Project
- UHA, Utah Hospitals and Health Systems Association
- Funding organizations

Funding/Staff Required:

The Office of Health Care Statistics will conduct enrollee health assessments, analyze and report evaluation data, and manage overall outcome evaluation. The Office will also support independent evaluators from outside of the Utah Department of Health to evaluate other aspects of the PCN program's outcomes. Currently, HCS evaluation efforts has been supported by the HCS-Medicaid contract and some of state general funds.

Fiscal Year	Estimated Contract Amount	FTE
06/02-06/03	$100,000	1
07/03-06/04	$100,000	1
07/04-08/05	$100,000	1
Total	$300,000	1

Measurable Outcomes:

1. Produce quarterly analytical reports on the PCN self health assessment results for the PCN program and providers
2. Produce annual evaluation reports for state health policy makers

Current Status:

1. Conduct the baseline PCN enrollees' self health assessment
2. Support the project design for evaluating hospital uncompensated care

Electronic Data Reporting-Preparedness for Bioterrorism

Initiative Description:

As a part of the CDC UDOH grant to develop surveillance and epidemiological capacity for Public Health Preparedness and Response for Bioterrorism, the Office of Health Care Statistics has received funding to achieve the following goals:

1) Establish capacity to receive electronic reporting of health care encounters at emergency departments and hospital discharge data transactions for 15 hospitals through the EDI switches
2) Establish capacity to use more widely ED and hospital discharge data for surveillance purposes by incorporating those data into the National Epidemiological Disease Surveillance System (NEDSS) Integrated Data Repository.

Benefit to Public Health:

The Office of Health Care Statistics has statewide hospital and ED discharge databases and has invested substantial resources to make those data easily and widely accessible for analysis. However, these data currently are not collected in a sufficiently timely manner for use in detecting or obtaining additional information about a bioterrorism event, serious outbreak or other emergency. Improving the timeliness of providing such information from these data sources would be of substantial value for preparedness and aid other surveillance uses as well.

Time Line to Implement:

1. By July 2003, implement electronic reporting of emergency department and hospital discharge data transactions through EDI switches
2. By August 2003, incorporate the ED and hospital discharge data into the NEDSS integrated data repository

Key Action Steps in Next 6 Months:

1. Recruit participating hospitals
2. Develop a technical implementation plan

Key Action Parties:

- Center for Health Data: Office of Health Care Statistics, the USIIS Program
- Division of Health Care Finance
- Utah Health Information Network (UHIN)
- Participating hospitals
- The Health Data Committee Technical Advisory Committee

Electronic Data Reporting-Preparedness for Bioterrorism

Funding/Staff Required:

Fiscal Year	UDOH/OHCS Budget	UDOH/OHCS FTE	Contractual Service	Total Grant Budget
One year project	$20,000	.5	$70,000	$90,000

Measurable Outcomes:

1. Timely submission of hospital and ED discharge data
2. Timely release of the hospital and ED public use data sets

Current Status:

Develop a technical implementation plan

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Part III. Appendices

APPENDIX 1

HDC LEGISLATIVE STATUE AND RESPONSIBILITIES

Legislative Authority: Utah Health Data Authority Act (26-33a).

Administrative Rules:

Responsible for rule enforcement, data management and reporting:

1) R428-10. Health Data Authority Hospital Inpatient Reporting Rule.
2) R428-11. Health Data Authority Ambulatory Surgical Reporting Rule.
3) R428-12. Health Data Authority Survey of Enrollees in Health Maintenance Organizations.
4) R428-13. Health Data Authority Audit and Reporting of HMO Performance Measures.

Responsible for data management and reporting:

1) R380-210. Health Care Facility Patient Safety Program.
2) R426-1-7(I). Emergency Medical Services Encounter Data.

Responsible for strategically planning health data collection and use:

1) R428-1 and R428-20. Health Data Collection and Request for Health Data Information.
2) R428-2. Health Data Authority Standards for Health Data.
3) R428-5, R428-10, -11, -12, -13. Data Validation and Reporting Procedures.

Membership, Appointment, and Operation

- 13 members appointed by the governor and confirmed by the Senate, representing: large business (1), business (1), small business (1), physician (1), nursing (1), HMOs (1), third party payers (1), hospitals (1), public interest (1), consumers (2), public health (2).
- "No more than seven members of the Committee may be members of the same political party." (26-33a-103(2))
- Members elect a Chair and Vice Chair annually and meet quarterly. The HDC chairs have been business representatives in the past 11 years.
- The Director for Office of Health Care Statistics (former Health Data Analysis) is the Committee's Executive Secretary who "shall be appointed by the [UDOH] Executive Director, with the approval of the Committee, and shall serve under the administrative direction of the Executive Director." (26-33a-105(1)).

APPENDIX 2

CHRONOLOGY OF MAJOR MILESTONES: 1990-2002

The Health Data Committee's work since 1990 can be divided into several stages, listed below:

1990-1993:

The committee established a vision, mission, and priorities. A public process was established for planning, and technical capacity of hospitals was assessed.

1993-1996:

The inpatient hospital discharge data reporting system was implemented, including all-payer hospital encounters from all licensed hospitals in Utah and the Veterans Administration Medical Center. Technical difficulties were solved and appropriate analytic methodologies were implemented in partnership with hospitals and other interested parties.

1996-1998:

In 1996, S.B. 171 inserted "report card" intent language into the Utah Health Data Authority Act. The committee went through its first community-wide planning process since 1990 and created comparative managed care reports for consumers. During the HMO report card implementation, the committee also oversaw expansion of the inpatient hospital discharge data reporting system to include ambulatory surgery and emergency department encounters. The Office of Health Data Analysis was retained by Medicaid to implement its managed care reporting system (HEDIS reporting and satisfaction surveys).

1998-2000:

A 1998 legislative audit confirmed the value of the data collected by the HDC, both to the public and to the industry. The legislature reduced the general fund portion of the HDC budget by $200,000 with the intent that it would be made up by increased revenue from data users. An increase of that magnitude was not achieved. The Office of Health Care Statistics (OHCS) was able to support some Committee work through partnerships with parts of the Department of Health whose mission overlapped that of the Committee. However the reduction in staff resources impaired the ability of the Committee to undertake new initiatives in response to changes in the health care industry, to maintain timely releases of data, and most importantly to improve the dissemination of targeted information to consumers.

2001-2002:

The HDC established a coalition with HMOs, Medicaid, CHIP, and Division of Community and Family Health Services to jointly conduct the HMO enrollees satisfaction surveys, resulting in substantial improvement in the quality of survey data and reduction in financial burden for all parties. The OHCS obtained federal funding for a three year grant to OHCS to improve patient safety using existing hospital discharge data reporting systems. OHCS assumed management of patient safety databases for implementing the new administrative rule, R380-210 Health Care Facility Patient Safety Program. OHCS published the first standard report on ambulatory surgery data using 3M APG grouper. OHCS is implementing an enrollee health outcome evaluation on the Primary Care Network program.

APPENDIX 3

HDC/OHCS BIBLIOGRAPHY: 1990-2002

1. **Reports, monographs, or brochures published by the Office of Health Data Analysis/Office of Health Care Statistics since the establishment of the Health Data Committee**

HDC/HCS Web Site: http://health.utah.gov/hda

Quarterly Publications

Utah Patient Safety Updates Vol. 1, No. 1 (August 2002)

Annual Publications

Utah Hospital Utilization and Charges Profile, Hospital Detail (ST-1) (1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000)

Public Use Data File Users Manual-Inpatient (1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001)

Utah Hospital and Freestanding Ambulatory Surgery Center Utilization and Charge Profile for Outpatient Surgery, Facility Detail (AMBST-1) (1999)

Public Use Data File Users Manual-Ambulatory Surgery (1996, 1997, 1998, 1999, 2000)

Utah Emergency Department Encounter Data, Emergency Department Annual Report (EDAR-1:96, EDAR-2:96) (1998), (EDAR-98) (2001)

Public Use Data File Users Manual-Emergency Department (1999, 2000, 2001)

Utah Hospital Inpatient Admission Through Emergency Department Utilization and Charges Profile: Statewide Summary, 1997 (EDAR-2:97) (2000)

2001 Utah HMO Performance Report: How to Compare HMOs, Part I - Consumer

Satisfaction Survey Results (2001)

2001 Utah HMO Performance Report: How to Compare HMOs, Part II – HEDIS (2001)

Medicaid HMO Enrollees with Special Health Care Needs: Results of the 1999 survey of adults and children enrolled in five Medicaid HMOs (1999)

1999 Utah Commercial HMO Performance Report: How to Compare HMOs (1999)

Utah Medicaid HMOs: A Report Card for Consumers (1999)

APPENDIX 3

HDC/OHCS BIBLIOGRAPHY: 1990-2002

Compare Your Utah Medicaid HMO Choices: An HMO Health Care Report Card – 1998

Consumer Survey Results and 1997 HMO Performance Measures (2000)

Utah Medicaid HMO Satisfaction Survey: "How to Select an HMO Plan" (1996)

Special Reports

Review of Utah Medicaid Nursing Home Bed Moratorium, 1989-2001 (2002)

Adverse Events Related to Medical Care, Utah: 1995-1999 (2001)

Hospitalizations for Conditions Related to Lifestyle or Behavior/Standard Report (ST-2), 1992-1995 (1995)

Top 50 DRGs: Clinical, Charge, and Demographic Profiles (ST-3): 1996 (1998)

Inpatient Hospitalization of Utahns for Most Common Procedures and Diagnoses in 1996-1998 (2001)

1998 Selected Quality Indicators of Hospital Inpatient Care in Utah (HCUP-3) (2000)

Child and Adolescent Hospitalizations for Most Frequent and Expensive Conditions in Utah: 1999 (1999)

Small Area Analysis of Hospitalizations for Ambulatory Care Sensitive Conditions in Utah: 1992- 1996 (1999)

Cesarean Section Deliveries in Utah Hospitals, 1992-1997 (1999)

Patient Severity, Total Charges, and Length of Stay: Special Report Series (SP-1) (1992)

Medicaid Prepaid Mental Health Waiver Renewal Report (1999)

Hospital Financial Data Reports (based on Medicare Cost Reports purchased from HCIA, Inc.), 1988-1995

Online Data Query Systems for Public Use

Utah Hospital Discharge Database Health Information Internet Query System Users Manual

Utah Health Information Internet Query (HI-IQ) System (1995-present)

Coding for External Cause of Injury (E-Code)

APPENDIX 3

HDC/OHCS BIBLIOGRAPHY: 1990-2002

Utah Hospital Utilization and Charges Profile, Hospital Detail (ST-1) (1993-2000)

Maternal and Child Health (MatCHIIM), developed by the Utah Division of Community and Family Health Services (1998-2001)

Indicator-Based Information System for Public Health – Query (IBIS-Q), developed by the Utah Office of Public Health Assessment since 2000

Federal HCUPnet – State Statistics http://hcup.ahrq.gov/HCUPNet.asp

Emergency Department Internet Query System (EDIQS), developed by the National Association of Health Data Organizations (NAHDO)

Utah Hospital Discharge Query System—Descriptive Statistics

Utah Hospital Discharge Query System-Hospitalization Rate

Utah External Injury Data System

Utah Hospital Inpatient Discharge Data Sets (1992-2001)

Utah Ambulatory Surgery Discharge Data Sets (1996-2000)

Utah Emergency Department Discharge Data Sets (1996-2000)

Consumer Brochures

Utah Health Systems Update 1: Review of Nursing Home Moratorium, 1989- 2001 (2002)

Utah Health Status Update: Utah HMO Member Satisfaction, 2001 (2001)

Utah Health Status Update: Utah HMO Performance-HEDIS, 2001 (2002)

Be An Informed Parent – 1992 Average Maternity and Newborn Hospital Charges, Office of Health Data Analysis (1994)

Utah Hospital Consumer Guide: 1995, 1996, 1998 Average Inpatient Hospital Charges, Utah's Most Common Conditions Requiring Hospital Admission (1997, 1999)

APPENDIX 3

HDC/OHCS BIBLIOGRAPHY: 1990-2002

2. Research articles or monographs that were not published by the Office of Health Care Statistics/the Health Data Committee but used the HDC's data in the publications

Cardiovascular Health Program. 2002. Cardiovascular Disease in Utah. Salt Lake City, UT: Utah Department of Health.

Horrocks, Julie C. and Mary E. Thompson. 2002. "Modeling Event Times with Multiple Outcomes Using the Utah Hospital Inpatient Discharge Data." Submitted to a peer-reviewed statistical journal.

Mason, Marlys J., Bebra L. Scammon, and Robert P. Huefner. 2002. "Does Health Status Matter? Examining the Experiences of the Chronically Ill in Medicaid Managed Care." *Public Policy & Marketing* 21(1): 53-65.

Office of Public Health Assessment. 2001. Injuries in Utah. Salt Lake City, UT: Utah Department of Health.

Office of the Executive Director. 2000. Utah Public Health Outcome Measures Report. Salt Lake City, UT: Utah Department of Health.

Clark, S., W. Xu, F. Porter, and D. Love. 1998. "Institutional Influences on the Primary Cesarean Section Rate in Utah, 1992 to1995." *American Journal of Obstetrics and Gynecology* 179(4): 841-5.

Paita, Luis. 1998. *Satisfaction with Health Maintenance Organizations: Exploring Axes of Differentiation Among Medicaid Beneficiaries in Utah.* (Utah State University Dissertation 1998).

Paita, Luis, Denise Love, Kevin Lertwachara, and Irina Grabovsky. 1998. "Evaluating the Reliability and Validity of Selected HEDIS Measures." Submitted *to Journal of the Society of Actuaries*.

Beaudoin, D., W. Xu and R. Rolfs. 1997. "Take a Close Look at Women's Health in Utah." *Utah's Health: An Annual Review* IV (1996): 6-13.

Paita, Luis. 1997. "Utah's HMO Enrollees' Satisfaction Survey: Planning and Implementation." *Utah's Health Journal*, 1997.

Rolfs, Robert and Wu Xu. 1996. "Uses of Hospital Discharge Data for Population-based Health Assessment." in *Utah's Health: An Annual Review* III.

Xu, Wu, Lois Haggard, and Robert Rolfs (eds.). 1996. Women's Health in Utah (Report). Salt Lake City, UT: Utah Department of Health.

Note: The Office of Health Care Statistics does not know all publications that use the Health Data Committee's data but independently produced by the data purchasers.

APPENDIX 4

OHCS Expenses and Revenues: SFY1998 - SFY2002

Office of Health Care Statistics' Expenses and Revenues: SFY1998—SFY2002

State Fiscal Year	General Funds	Data Product Sales	Contracts	Contract Sources
1998*	$500,000	$34,880	$226,178	Health Care Finance (Medicaid)
1999	$509,000	$58,835	$161,906	Medicaid
2000	$286,000	$79,076	$316,443	Medicaid
2001	$289,500	$72,838	$391,991	Medicaid, Emergency Medicine Services
2002	$285,459	$73,744	$356,082	Medicaid, CHIP, 6 Health Plans, Federal AHRQ, Division of Community and Family Health Services

* State Fiscal Year—07/01/1997 - 06/30/1998

APPENDIX 5

Testimony by Clark T. Hinckley

Testimony of Clark B. Hinckley

Vice Chair of Health Data Committee, Large Business Representative
The Health and Human Services Appropriate Committee's Pubic Hearings
January 10, 2002

My name is Clark Hinckley. I am a resident of Salt Lake City and Senior Vice President of Zions Bancorporation. I represent large businesses on the Utah Health Data Committee where I serve as the vice-chair. The chair of our committee, Andrew Bowler, is out of the state on business today.

As a senior officer of one of the state's largest companies, and as a resident and citizen, I have particular interest in the work of the Office of Health Care Statistics. Our company and its employees pay nearly $29 million per year in health insurance premiums – about 40% of this is incurred in Utah.

The data collected by the Office of Health Care Statistics, such as Hospital Discharge Data, HMO data, and patient safety data, help both employers and individuals make informed health insurance purchases, by providing important information about the quality of care in managed care plans, hospitals and surgical centers. The collection and distribution of these databases provides an important discipline on both the quality and cost of health care in the state.

OHCS data also provides both quantitative and qualitative information which enables employers and employees to make intelligent selections regarding healthcare plans. The office's annual report card on HMOs not only is a valuable tool for consumers and employers, its very existence improves the performance of the state's HMOs.

Since the Office of HCS began gathering data on hospital discharges in 1992, the average hospital stay in the state of Utah has declined by 22% -- from 5.3 days to just over 4 days in 2000. The total charge for all hospitalizations per year, however, has increased by 75% – from $1.2 billion to $2.1 billion for the same period. The result is that total annual hospitalization charges increased by nearly one billion dollars! Without the data collected and distributed by the Office of HCS, there would be no meaningful way to monitor and manage these escalating costs.

In their 1998 report, the Legislative Auditors noted that "The State Industrial Commission has used OHCS's hospital discharge data to observe and improve practice patterns for injured workers." They also concluded that "The actuary industry would suffer a tremendous setback if HDA [now the Office of HCS] was not doing what they were doing."

Reliable data and information is the foundation for controlling costs. Without the basic data collection performed by HCS, our ability to manage healthcare costs in this state would flounder.

On a very personal level, the potential major impact of eliminating these systems can be highlighted by considering the impact of medical errors. For example, based on data provided largely by Utah, the Institute of Medicine estimates as many approximately 44,000 people die in hospitals each year as the result of medical errors. This would make medical errors the eighth leading cause of death in this country. In Utah alone, 2,297 patients died in hospital from 1995-99 with at least one adverse event or complication. The Advisory Commission on Consumer Protection and Quality in the Health Care Industry (1998) reported that forty-two percent of respondents in a survey had been affected by a medical error, either personally or through a friend or relative. Thirty-two percent of the respondents indicated that the error had a permanent negative effect on the patient's health. HDC and OHCS have been a pioneer in patient safety initiatives and reporting medical injuries in the nation. Without an independent third party to gather and report this data, this serious medical problem could grow significantly. I believe that the work done by the OHCS saves lives and prevents sufferings in Utah.

A member of the HDC commented yesterday that to eliminate the $300,000 general fund support of the OHCS would be akin to buying a luxury automobile but trying to save money by eliminating the speedometer. We spend billions of dollars on healthcare each year in this state. I hope we are willing to spend $300,000 to monitor how we are doing.

Thank you.

APPENDIX 5

Testimony by Robert P. Huefner

Testimony of Robert P. Huefner

Member of Health Data Committee, Public Health Representative
The Health and Human Services Appropriate Committee's Pubic Hearings
January 10, 2002

My name is Bob Huefner. I represent Public Health on the Utah Health Data Committee. I direct the University of Utah's Matheson Center for Healthcare Studies.

Health care is crucial to our quality of life AND is one of biggest, and probably the fastest growing financial burdens for government, business and individuals. It is complicated, and we are learning by experience. Good decisions will make Utahns healthier and the state economically competitive, poor decisions will not. We need reliable and current data to make good decision.

OHCS data measures the managed care that enrolls 69% of Utah's population. These systems of care change yearly and contain both serious risks of compromised quality as well as real possibilities for improved quality and efficiency. Stopping the measures eliminates an essential tool for assessing and guiding these changes. OHCS surveys satisfaction of managed care enrollees, of Pre-paid Mental Health clients, of Medicaid beneficiaries,and of CHIP enrollees, to produce report cards comparing HMOs with each other and with national experience. It also collects and analyzes health plan employer (HEDIS) data, to assure independent and comparable data for use in accrediting and evaluating health care plans -- to protect the health of consumers and the credibility of plans.

Here is one example of the value of independent and public data. Five percent of the population accounts for more than half of the health care costs. Thus plans have a strong incentive to satisfy the healthy 95% and treat poorly the sicker 5%. A plan that reports 95% may be avoiding the care most needed. OHCS data distinguishes the satisfaction of those who are relatively healthy and those who have serious medical problems, to provide real comparisons and for improving plans. These data support the continuous quality improvement that has brought the exceptional success of the Utah Medicaid program. Utah shifted its enrollees to the more cost effective managed care plans and did so in ways that Medicaid recipients, even though required to use managed care and having more health problems, report even higher satisfaction than do the commercial enrollees who are in managed care by choice.

Other OHCS data reports hospitalizations, emergency room treatments, and outpatient surgery. These data, combined with Utah's Health Status Survey and Vital Statistics have enabled Utah to be on the frontier of the diagnosis of community health problems. We can measure the frequency of conditions that indicate less than optimal medical care, that indicate environmental problems, that reflect social-economic disparities, and that reflect poor lifestyles. The geographic detail of these data allows us to identify problems of rural and urban regions, helping public health agencies, schools, and other community groups make Utahns among the healthiest in the nation and keeping costs low enough to nearly compensate for the state's unique frequency of maternity billings.

OHCS health data, now accessible by internet, provide data for health policy decisions, as is now being done reconsider the state's nursing home moratorium, and for research, as has been done to study automobile accidents. Trusted and current information is a sound, I say necessary, investment for an economic sector that shapes our personal health, consumes more than six billion dollars a year, and is undergoing rapid and complicated change.

Thank you.