



# Mental Health and Disability Services Redesign

## Service System Data & Statistical Information Integration Meeting Minutes

Wednesday, September 26, 2012

10:00 am – 3:00 pm

Location: Polk County River Place

**Workgroup members present:** Jody Holmes, Joe Sample, Sue Duhn, Andrea Jansen (Gina Fontanini), Jill Eaton, Lonnie Maguire, Karen Dowell, Karen Walters-Crammond, Dennis Petersen, Ashley Moore (substituting for Sam Watson), Kathy Stone, John Grush, Robin Harlow, Rick Shults, Sue Novak

**DHS Staff Present:** Lauren Erickson, Randy Clemenson, Norm Edgington, Lee Hill

**Public Attendees:** John Pollack, LSA; Jess Benson, LSA; Doug Wilson, evizzit; Marissa Eganson, Easter Seals

**Review of minutes:** The minutes from the August 29<sup>th</sup> meeting were accepted with no changes

### **Update from the Outcomes and Performance Measures Committee:**

The committee is working within a quality improvement framework for the dashboard indicators, this will allow us to identify issues and improve them. The committee has arrived at 6 domains and is examining outcome information they believe is best gathered from individuals (from some type of consumer survey) and also from providers (gathered through claims data). They discussed the idea of consumer sampling, and tailoring questions for different populations, and the discussion ended with what that means in terms of resources.

- Are they looking at any specific instruments?
  - The measures are coming from tools, but the difficulty with these kinds of tools is the cost associated with implementing them. They will have to look at these tools and determine if they fit our needs or if we create something on our own.
- Are they charged w/ performance based contracting?
  - Most of the information is covered by the legislation except for 3 items: timely reporting, administrative costs, and data collection. They didn't feel these fell within their charge, but they will be sure to cover all the other required information in their recommendations and then go beyond that.

### **Review of Preliminary Draft**

We can use this report as a way to describe the steps that we went through to drive our recommendations. We talked about using business functions as drivers and not primary data elements, what the business functions are that we identified for the data warehouse. We can carry the process through with one example. People need an actual plan for what we recommend, not just a theoretical process.

Workgroup members asked for clarification on how systems interact with one another. The general perception is that each provider will have their own system and filter up. But 2<sup>nd</sup> bullet point talks about interoperability within systems and makes it seem like every system will interact with one another. How we will work on information being accessed by the other external systems needs to be fleshed out.

Members also wanted clarification for what “link and exchange means”. Members thought it would be useful to describe usage at all levels, and how we can build the warehouse so it’s useful at every level. There should be an additional statement about how it interacts with other developing state incentives. The committee needs to be clear on all those moving parts and how they can shape it, like where this system fits in with the Health Information Exchange. The workgroup also asked for clarification that a client identifier will not preclude using others.

### **Discussion of the Iowa Health Information Network**

The Ehealth council is building Iowa Health Information Network (IHIN), with the purpose of building up clinical information. It makes connections between systems; this can be done 2 ways: sharing between entities directly or accessed through a patient data warehouse. IHIN not focused on MH, but is not designed in a way that leaves out MH. Medicaid is trying to watch and figure out a way to get entire care team involved to get all information in one place.

The data sources for this system come from electronic health records (EHRs) from participating providers. Your physician can send information off to a specialty and then these visits will sync up. The query portion comes in when you see a new provider and they don’t have any patient history (like in the Emergency Department), they will be able to look up a client. The Iowa Department of Public Health is in charge of the network, and oversight is provided by an executive council made up of Wellmark, University of Iowa, Mercy, and legislatively established board. Direct secure messaging started in August. The first participants in the master patient index will come up in Jan/Feb. The state is very interested in this, things are all up in the air with the ACA, Medicaid expansion etc., but there is interest in getting this big health picture for each client. Workgroup members noted that HCBS services also need to feed into this system. Some entities would also be able to feed into this system so we can provide access for consumers at any point.

### **Discussion over client identifiers**

One of the principles the workgroup agreed on was not to make people use same operational/transactional system. However, as we’re linking/exchanging information, we need a way to match information from different entities to one client. This process should result in as close of a match as possible. So, what information do we need to

collect to make this possible? Current IA Code (Ch 225C.6A) gives guidelines: is this sufficient or not? If not, what do we recommend that it look like?

Discussion:

In theory, all the key demographic pieces information can change: names, gender, birthday can change with adoption or it can be unknown. The goal is to collect consumer info that allows the best match possible to uniquely identify people. The current method does not do that. What kind of information do we need to collect so we can find out a patient's history and ensure that this patient is unique? Once you start populating the warehouse with new information, how do you combine the records to avoid duplication?

The goal is to get away from an ID that has any embedded intelligence and have a numeric "surrogate" key that everything relates back to. So client information can change over time, but it all ties back to another ID that doesn't change. However, systems all have different search requirements...so if you mess something up you won't get an exact match. What the workgroup will want to recommend is if you don't get an exact match (if you have the clearance) the system will give you options (within a certain level of confidence) based on relevance, and you can select the client from the list. This would then give you access to the information, so you can then update information as you go to improve matches. We need a list of things that have to be inputted, but need to keep in mind that client might not know all the required info.

List of data options: SSN, state ID, full name, DOB, phone number, email.

Best options (should be required): full name, DOB

Workgroup members discussed efforts involving the IHIN system. Members noted that the MHDS data warehouse is still needed as a stand-alone operation, because information in IHIN is decentralized, and is not stored in a central location, but there might be an opportunity for both of these systems to coordinate together. The IHIN has a master patient index, and has an algorithm to sort out different client IDs and see if they are a match. Their key client ID fields are: family name, given name, DOB, gender-start here for matching. Their optional fields are: SSN, Medicaid ID number, Driver's License number, Postal code, phone number, email, place of birth, mother's maiden name, death date, and multiple birth order (if relevant). The way this usually works: put in certain types of information and it comes back that anything above a certain threshold is a match. If it's below that threshold it will start to look at the optional fields. Privacy issues come into play when you look at the purpose/context of doing the search. When you have a near match it would have to go to someone with the authority to review.

Workgroup members discussed different levels of usage. If you are talking about outcome measures, you need to know that this information is unduplicated. There needs to be a provision to merge records as information is collected so these issues become fewer and fewer. There are essentially two different purposes: to retrieve individual client data, and then aggregate data for reporting.

So, we asking 2 different questions:

- If you're looking for specific information on a client, are people going to be able to go in and query their past? Yes, to extent available.

- Can we draw out this information out on an aggregate of people? For example, the number of people in inpatient services in Northeast Iowa.

Workgroup members came to a consensus on making given name and DOB required data entry fields and having the other fields be optional. Providers can still collect this information for their own records, and there will have to be an option for a null value for providers who don't. Members decided there should be a field to collect the state ID number, but it will not be necessary to add a data field for other private insurance IDs.

**Public Comment:** None.

### **Discussion over IA Code Ch. 228**

In the MH world, state law is much more restrictive than HIPAA. Experiences with IA Code Ch. 228 are very clear that you have to have written authority to release MH information, and several workgroup members expressed having problems sharing information. It is ok to share deidentified information, but if a provider is accessing it for clinical reasons, that is a problem. With CSN, you can see if someone is previously in the system and get basic information, but if you're getting treatment with one provider, you need express permission to share information if you get treatment with another provider.

There is an exemption in SF 2318 for the HIE. This exemption is for a private health network that is exchanging information for treatment and payment operations, but it will depend on who defines this term. Legislative intent was to provide for an information exchange, it supersedes other state laws, but not federal laws (for example, HIPAA also deals with billing). Policing the "treatment" purpose will be challenging; you might be being treated for something else. Workgroup members agreed that since this is an opt-out process, it would be necessary to inform individuals about this in their privacy forms.

What's missing from this type of system: services that are not billed by person, i.e. crisis services, consultation, education, MH services provided in jail, sheriff costs for transportation, etc. These are typically services that are funded by the MH Block Grant and are reported by an aggregate cost tied to a "dummy client." It is part of the overall financial picture, but can't be boiled down to a particular client. The main purpose of this system might not be financial reporting. Workgroup members acknowledged the need to recognize this in the report: when we go to this type of reporting system, there will be some loss of information (in regards to aggregate data).

Members noted that the system needs to be able to submit new records, change records, and delete records if necessary. There needs to be a tolerance for a reasonable level of change, and people will need to understand that it might take a while for information to be truly complete...so you end up with a lag time on the data. This ties into the 3<sup>rd</sup> process measure: timely payment of claims. You can't look at the service date vs. paid date to measure this; you have to look at received date vs. paid date. Workgroup members came to a consensus on data reporting frequency and agreed that the data be reported at least monthly, in order to cut down on lag time.

## **Discussion about the Outcomes and Performance Measures Committee**

Most likely, providers will submit encounter/outcome type data, clinical records, outcomes results etc. The payers would submit more claim based data-what providers bill us for and what we pay. We need a system where whoever knows the client best enters outcome data and it flows through the system so providers know how they're doing with outcomes. This will build up across providers, across regions to a state dashboard. How do we advise outcomes about how to implement this?

The workgroup also discussed the information providers will want about their clients that aren't related to claims i.e. employment. We can get supported employment because it's a Medicaid claim, but don't get information on setting, wages, etc. Service providers will be in the best position to report that. This type of information is important, so we want to track it as well.

The workgroup discussed the difference between an outcome assessment and a tool to determine service eligibility. The system will need a set of tools to determine service eligibility, but will need a separate tool to measure outcomes. An outcomes tool is a multiple point in time thing. You readminister the tool multiple times to see changes over time. The workgroup recommended that the data warehouse should store both eligibility information and outcomes information.

### **Wrap-Up Conversation:**

Workgroup members summarized the day's discussion and commented on other foundational principles needed to build this model. Members mentioned:

- Identifying where we're going to get this information or who is the best source of information. This will help us know who will be responsible for certain elements.
- Who's the owner of this system?
- Who's responsible for technical support, defining definition, ongoing adjustments.
- Who's going to administer the warehouse?
- What about compliance?
- When do we figure out how much this is going to cost? When do we figure out funding, how much it's going to cost to maintain etc.?

Members said that this is where you bring in experts to identify where the most cost efficient source of the data...this will help us figure out costs. It can also help us determine how much information to collect from different consumers; we need to focus on "who" we collect information from. We need to establish rules about which consumers you send in and don't send in. We're gathering accountability information for publically funded services so it wouldn't necessarily include private insurance. Do we also want Medicare information?

- Yes.-Health Homes will have/want information on dual eligibles. The Health Home model has to target everybody so that consumer profile will feed into the overall system network. We need a more robust entry point so consumer can move between service providers.

We need to be explicit when we say what the client core data is. Do we need to start a list about what we want to do with the data, like federal reporting, legislative reporting,

allocation of resources, knowing where we spend our money etc.? We need to know what's going to be on the dashboard so we know what to collect.

Thinking about consumer info: is there a way to get the information from consumers at a point of service? If anything is going to be consumer driven, there needs to be some web portal or else you're going to have to do a lot of data entry.

Next time: Will continue to flesh out preliminary draft of report with today's feedback. Also hoping to bring back more definitive outcome and performance measures.

**Public Comment:** None.

**For more information:**

Handouts and meeting information for each workgroup will be made available at: <http://www.dhs.state.ia.us/Partners/MHDSRedesign.html>

Website information will be updated regularly and meeting agendas, minutes and handouts for the redesign workgroups will be posted there.