



Mental Health and Disability Services Redesign

Service System Data & Statistical Information Integration Meeting Minutes

Tuesday, August 7, 2012

10:00 am – 3:00 pm

Polk County River Place, Room 1

2309 Euclid Avenue, Des Moines, IA

Members Present: Rick Shults, Robin Harlow, Kathy Stone, Karen Walters-Crammond, Karen Dowell, Sue Duhn, Jill Eaton, Gina Fontanini, Kevin Gabbert, John Grush, Jody Holmes, Cindy Kaestner, Dennis Petersen, Jane Erickson (substituting for Joe Sample), Ashley Moore (substituting for Sam Watson)

DHS Staff: Connie Fanselow, Lauren Erickson, Randy Clemenson.

Other Attendees: Jess Benson, Legislative Services Agency (LSA); John Pollak, LSA; Lee Hill, DHS; Laura Roeder-Grubb, Iowa Department of Human Rights.

Minutes: The minutes of the March 30, 2012 meeting were accepted as presented.

Opening remarks by Rick Shults:

Workgroup Charge:

The workgroup's charge has been slightly amended from the original as a result of the discussion at the first meeting. The mission remains the same. Bullet points have been added or revised and the tasks have been modified, including:

- Identifying "points of pain"
- Balancing the need for standardization with flexibility with how to accomplish the outcome
- Considering HIPAA (Health Insurance Portability and Accountability Act) requirements when determining data collected and outcome and performance measures

Rick asked for any thoughts or comments on the revisions:

- Should we add keeping consumer focus in mind?
- How does the information collection benefit the client or consumer?
- Keep the client at the center of what we do so that as they move from one agency or program to another, information moves with them.
- The system should have the ability to exchange information for the benefit and ease of consumer.

Rick provided an overview of the timeline that the Workgroup will have to complete their final recommendations to the legislature, due on December 14, 2012. Rick then provided the workgroup with an update of the legislative changes that have happened since the first meeting on March 30, 2012. A summary document is located on the MHDS Redesign website: in addition to copies of the enrolled bills http://www.dhs.state.ia.us/Partners/Partners_Providers/MentalHealthRedesign/2012Legislative.html/.

Rick provided a brief update on the workgroups that are continuing from last year, in addition to the workgroups that have started this year. He made special mention that it will be important for the Data and Outcomes and Performance Measures Committee to coordinate their work. Rick also informed workgroup members that a continuum of care group will be developed to look at existing services and identify gaps and challenges, including the role of residential care facilities, sub-acute services, crisis services, and how it all fits together for people to live successfully in the community; this group will be in addition to those called for in the legislation.

Outcomes Workgroup:

- In their first meeting the group identified domains that should have performance measures
- Anticipate that they will discuss the kinds of measures they want to recommend at the next meeting
- Outcomes should be about the people we serve; direct measures of quality of life
- Need to hear directly from individuals and their family and friends about the positive impact of the services they receive
- Looking at performance measures in terms of what the system needs to do in the delivery of services; what are the expectations?
- The group is very interested in focusing their efforts on the outcome side
- They are concerned with getting their work done so that this workgroup can follow-up with how it fits into the data system
- County representation is being added to the outcomes group

Data Systems Presentations:

Today's agenda is primarily sharing information and talking about what various data systems collect, who collects and stores the data, how they operate, what is available in them, and generally learning about what already exists. Handouts over the presentations are available on the MHDS Redesign website:

http://www.dhs.state.ia.us/Partners/Partners_Providers/MentalHealthRedesign/Service%20System%20Data%20and%20Statistical%20Information.html

DHS Mental Health and Developmental Disability Services Data Warehouse, presented by Rick Shults:

- MHDS system is a secondary data collection system that takes information collected elsewhere and extracts it for certain uses
- It includes demographic, service and payment data
- Data is submitted once a year from counties
- Counties collect the data, aggregate, and summarize it and report to DHS

- It is placed in a data warehouse where it can be accessed to generate reports
- Data is collected from persons who are funded by the county services system:
 - Persons with mental illness
 - Persons with intellectual disabilities
 - Person with other disabilities
 - Up to this point data has included both Medicaid and non-Medicaid eligible individuals
- Data is used for a variety of purposes:
 - Reporting to the federal government, particularly for mental health purposes connected to the Data Infrastructure Grant
 - Demographics
 - Service information; especially regarding inpatient care
 - High level information on community based services
 - It is a significant source of information for federal reporting, but not the only source
 - Providing an overall picture of the entire system:
 - How much is spent; budget planning
 - Strategic planning
 - Responding to legislative questions
 - Aggregate data
 - Total spent
 - Total number of persons served
 - Persons served by service; by funding stream
- DHS and ISAC have access to the Data Warehouse
- We have the technology to make it more widely available
- Data has been used primarily for reporting; more data analysis could be done regarding admission rates, readmission rates, prevalence, etc.
- Data available is from December 1 of the previous fiscal year
- It is a once a year snapshot and is quickly outdated

**Iowa Department of Public Health, Division of Behavioral Health
Substance Abuse Central Data Repository (CDR), presented by Kevin Gabbert:**

- The Central Data Repository is a data warehouse
- It has been operating since July 1, 2011 and some data goes back farther
- Data comes from two primary sources:
 - Data entered by providers into the I-SMART system
 - The I-SMART system is a customized version of a web-based data management platform; it can also be used as a clinical record keeping system
 - Data can also be uploaded from provider electronic health records
- Two types of data are collected: Federal data and State data
- Federal Data collected includes:
 - Treatment Episode Data Set (TEDS)
 - TEDS provides information for National Outcomes Measures (NOMS) collected from clients at admission and discharge

- Data elements include: demographics, drug of choice, frequency of use, and level of care through various outcomes
- State Data collected includes:
 - Client profiles (demographics)
 - Admissions (crisis intervention, placement screening, admission)
 - Services (including source of payer)
 - Discharge (including 4 client satisfaction questions)
 - Follow-up (completed 6 months after discharge)
- Data is collected from all licensed substance abuse evaluation and treatment programs in Iowa that receive IDPH funding or Medicaid, or provide OWI (operating while intoxicated) evaluations
- Data is used for:
 - IDPH planning
 - Performance management and quality improvement for the Iowa Plan
 - Trend analysis
 - Reporting for legislators, providers, stakeholders, grant applications
 - Federal reporting
- Results are used to monitor the utilization, performance, and outcomes of SA treatment services provided in Iowa, and project trends and future needs
- Populations covered include all clients who received substance use disorder services; especially services funded by IDPH and Medicaid – about 50,000 each year
- Considerations for this group:
 - 24 of the CDR reporters have integrated the data entry into I-SMARK or EHR processes so they only collect and report one time
 - Majority of providers collect client data on paper or EHR and then also enter it into I-SMART
 - The ideal for consumers and providers is an integrated data collection strategy
 - Data is gathered and reported in one step
 - Allows funders to access and report on aggregate data in real time

Discussion:

- I-SMART was provided to providers as an opportunity for data collection by IDPH
- Providers sometimes want to take it to the next step for their own use
- Providers may purchase their own electronic health records systems
- Currently CDR reporting is done every day, in real time
- Data is cut off on a certain date each year for annual reporting
- There are now over 120 licensed providers in Iowa
- Linking I-SMART with standard EHR systems has not been an issue

Remarks by Randy Clemenson:

- IMERS (Iowa Medicaid Electronic Records System) has about 10 years of data on Medicaid members
- It shows all services that were provided to that person

- There are two views: one full view for Medicaid, and one redacted view for providers that does not show higher sensitivity services

Remarks by Cindy Kaestner:

- Abbe Center recently purchased EHR system from Anasazi and they will make modifications to it for a fee
- The electronic clinical record is very different depending on what you want to look at in that record
- Providers will have to get away from the kind of narrative clinical records they are used to if we want to collect data points
- That would not fit current accreditation standards, however, because it is not written in a narrative form even though all the information needed to treat that client is there in data form
- It is not just front end data points; it also drills down to the clinical information and we it is gathered
- The change is not an issue with the Joint Commission or other national accreditation bodies
- We would need to look at changes to Chapter 24 of the Iowa Code
- Move to using concurrent data– data that is entered when the client is there

Community Services Network (CSN), presented by Robin Harlow:

- The CSN is operated under the Electronic Transaction Clearinghouse (ETC) 28e agreement with all 99 counties as members
- 95 counties participate directly and use CSN as a management tool
- Polk, Scott, Johnson, and Linn Counties operate separate systems
- The focus for COMIS (County Mental Health Management Information System) was just to capture data
 - The system was developed as the result of the state’s desire to gather data in 1996
 - Over the years 85 counties have kept it the same; others have made modifications
 - Some have recognized a need for a more analytic system
- There have been a lot of integrity issues with the data
- One goal was to improve the data collection and reduce the amount of manual entry
- Medicaid data is sent electronically to the system
- Handout shows the client in the center, surround by “bubbles” reflecting the modules that are in the system today:

○ Demographic information	○ Case management
○ Funding requests	○ Security
○ Providers	○ Data Exchanges
○ Services and rates	○ Data Warehouse
○ Claims	○ Users
○ Budget	
- Need to move from a data collection tool to a management tool

- The system allows us to scale up, for example: the counties in the CSS Region were moved all together under one data base
- Can collect provider information, look at services, rates, and claims history for clients, including where and by whom services were performed
- Helps control coding of GL
- The case management module is new; it allows us to look at client in terms of all the services they receive
- Provides a higher level of security over COMIS
- Uses the State's A & A system as an initial login system
- Mimics the level of security that banks use
- Data exchanges is one of the goals for this year
- Data warehouse provides the State with data
- Network gives counties a compliance level for their data so that it can be fixed before it is sent; they cannot send it until it meets a certain compliance level
- Helps ensure the data is as correct as possible
- How do we get current data so that we can make decisions based on what is happening now?

- CSN now has:
 - 453 active users
 - 1034 services
 - 6615 provider records
 - 70,085 active client records
- 594,024 claims were paid in fiscal year 2012
- CSN brought together counties using CoMIS
- The system is still maturing
- EHR is a challenge, but the technology is available
- We want to develop it to be a better tool to help manage client services
- How can CPCs be freed up from administrative duties and have more time to work with clients?
- There is a public portal that would potentially allow people to access the system to put in applications, etc.
- A lot of counties do not have IT (information technology) people; this system gives them a web-based program that they are not responsible for maintaining
- Counties that join together to form regions can easily have their data linked
- That allows for administration to be done regionally and still have the services delivered locally

Remarks by Randy Clemenson:

- Provides a unique identifier (ID)
- The less data that must be entered, the less opportunity for data entry error
- The more existing data can be linked and made available, the less work for everyone
- It is important to know what you want to analyze
- Some data can be good for analyzing expenditures, but not for analyzing utilization

- Need to look at more than just collecting data; analytics is different than data collection
- Need to think about what you will want to analyze now so that you include those mandatory elements into the system
- You cannot analyze data until you have collected it

County Interfacing, presented by Karen Crammond-Walters:

- Three counties jointly own MIS (Management Information System): Johnson and Polk
- System was designed to help manage the CPC, case management, and service coordination functions of the counties
- Polk has used it since September 2002
- Each county owns its own data and database
- Scott County has a license to use the web interface and has developed its own module to manage its General Assistance Program
- Technical aspects:
 - Polk County runs the application in a virtualized cloud environment
 - The county was able to move offices without any interruption in the data system
 - Johnson and Scott Counties run the application on local servers
 - All three counties have various Access databases that link to the SQL tables for data analysis
 - In process of using Business Intelligence to streamline the reporting of outcome measures data
 - Have role base security at the field level that is controlled by system administrators in each county
- Data collected:
 - Client demographics
 - Information to determine eligibility for funding
 - Minimum data requirements
 - Level of functioning and diagnoses
 - Service authorizations
 - Claims received and payment information
 - Information to track and report on outcome measures
 - Provider information, services provided, and rates
 - Case management module to record contact and time documentation, provide forms and other documents; allows for full electronic client record
- Uses of the system include:
 - Determining and recording eligibility
 - Organizing services into benefit plans based on level of functioning
 - Requesting, approving, and storing service authorizations; generating notices of decision
 - Uploading electronic claims from providers
 - Interfacing with ETC to accept and transmit electronic claims and remittance advices

- Adjudicating claims and transmitting payment information to the county auditor
 - Generating case management bills
 - Generating state warehouse data and state reports
 - County budget tracking
 - Outcome measurement reporting
 - Analyzing individuals served, services provided, etc.
- Polk County MIS:
 - 911 active users in 112 agencies
 - 641 different services in the table
 - 2380 provider records
 - 384,649 claims paid in FY 2012
- System is similar to CSN but more robust in terms of the information that can be pulled
 - Want to minimize the amount of data entry needed
 - One of the challenges for the Outcomes and Performance Measures group is that there are certain data questions that always rise to the top and we should plan for having that info readily accessible

Public Comment:

Questions asked:

- Are you looking at creating another data warehouse?
- If so, how will you maintain it?
- Where would it be housed?
- Do you know what elements you are going to take from what systems?
- If we all want to report the same things to the same people how is this going to come together to have public access to some information and more detailed access for DHS or others who need it?
- What elements would you collect for outcomes to drive decision making?

Response by Rick Shults:

- Some of those things are not yet part of our charge, such as unfettered public access to raw data
- We need to identify key elements that will be used for public reporting
- We are learning is that there is a lot of data gathered for a lot of systems and we are going to have to figure out how to have a single system

Response by Kathy Stone:

- It is hard to envision a single system
- We do not have all the players at the table
- The fall back is thinking about how do we decrease, or assure we are not increasing, the burden on reporters in submitting data and yet have everyone be able to pull out that data they need

Other Comments:

- We want to be able to access data from all sources to see the whole person and give them the best services and care
- We need a more accurate picture to benefit everyone

Outcomes, presented by Karen Crammond-Walters:

- Polk County measures outcomes to enforce system core values:
 - Self-sufficiency is the cornerstone to full citizenship in the community
 - Collaboration and accountability are essential for achieving quality outcomes
 - All informed choices come with opportunity and responsibility
 - Continuous innovation allows for system improvement, flexibility, and responsiveness
- Polk County uses outcome measures for two general purposes:
 - Evaluation of case management, service coordination, and Integrated Services Program
 - Scorecards to compare different providers – to give individuals the information that might help them decide which provider is best to fit their needs
- Outcome measures include the degree to which participants experience:

○ Safe, affordable housing	○ Participant satisfaction
○ Homelessness	○ Family/concerned others satisfaction
○ Jail days	○ Quality of life
○ Employment	○ Child education involvement (for children)
○ Education	○ Transition activities (for children)
○ Empowerment	○ Appropriate disenrollment (for children)
○ Somatic Care	
○ Community involvement	
○ Negative disenrollment	
○ Psychiatric hospitalizations	
○ ER visits	
- Employment includes information on number of hours and wage
- Somatic care is included because people with disabilities have a lower lifespan in general than people without disabilities
- Negative disenrollment is tracked because we don't want providers kicking people out just because they get hard to serve
- Appropriate disenrollment for kids is tracked because we don't want them stuck in the system forever
- Data for outcome measures are collected through various manners:
 - Recording of events; events have a beginning and ending date, such as achieving safe, affordable housing
 - Recording of contacts; a contact is a date that something happened
 - Interviews of a random 10% sample of program participants and their family members are conducted by the University of Iowa
 - File reviews are conducted

- It is an evolving process:
 - Started in 1998 using excel spreadsheets to track data for case management and the Integrated Services Program
 - Evaluation targets determine if a program exceeds expectations, meets expectations, needs improvement, or does not meet minimum expectations
 - Separate evaluation targets were set for each agency and disability group
 - In 2000, Polk Co. started used the University of Iowa Law, Health Policy and Disability Center
 - By 2004, standard evaluation targets were set for all agencies and disability groups
 - In 2007, service coordination was added and a supported employment scorecard was started
 - In 2011, work began on the development of a community living scorecard

- Lessons learned:
 - Systems change is ongoing and takes time and effort
 - Definitions have to be clearly written
 - Any changes to definitions must be done prior to the measurement year
 - It takes a while to understand and fully implement new definitions if complex
 - Need to review data throughout the year
 - Newly hired staff tends not to fight outcomes; they accept it as the way business is done
 - Training needs to reinforce values and best practices as well as outcomes
 - Train people on how to achieve core values and outcomes fall into place
 - Focusing on employment, education and community inclusion has an effect on other areas, for example: fewer jail days, hospital days, and ER visits and an improved quality of life
 - When everyone serving and supporting an individual comes from a common, holistic approach, outcomes are better; a recovery focus

- Biggest complaint is the time it takes to put the information in the system
- Used to have to report the status of person on outcome measures every month; now just have to report changes in status
- It is time consuming, but results are well worth it
- Use outcomes for evaluation of programs and for scorecards
- Started by looking at what Baltimore Mental Health Services was doing; they have a program where they blend Medicaid and state dollars into a case rate for people coming out of psychiatric services
- Meetings with service coordination providers help identify if there is a need to modify definitions and also to talk about adjusting any targets
- Fewer modifications are needed over time
- Sometimes there are outside factors that impact targets; for example, in 2008 when no one could find a job, employment targets were adjusted

Remarks by Rick Shults:

- Domains would be one level higher than outcomes shown here, for example: access, quality of life, etc.
- More specific measures would be included under each

State Facilities, presented by Rick Shults:

- These data are a reflection of what we do as a provider
- Treatment data is collected from patients and residents of the state mental health institutes (MHIs), state resource centers (SRIs), and juvenile facilities
- The data go into an electronic medical record
- It is an electronic record keeping system that collects information for people served; it is not a nationally certified EHR
- Data is collected on:
 - Persons with mental illness (served at the four MHIs)
 - Persons with a substance use disorder (served at Mt. Pleasant)
 - Persons in the gero-psychiatric program (at Clarinda)
 - Persons in the civil commitment unit for sexual offenders (at Cherokee)
 - Persons with intellectual disabilities (served at Woodward and Glenwood SRCs)
- There are a series of integrated modules
- Data is used for:
 - Patient and resident treatment
 - To measure certain types of outcomes or processes such as:
 - Demographic data
 - Admission and readmission (utilization) rates
 - Average length of stay
 - Seclusion and restraint rates (internal scorecard)
 - Other measures DHS has selected
- Data kept in a separate data warehouse; could be integrated
- It represents one form of a small electronic records system that is readily available
- Many other providers in Iowa also have systems

Provider Data Collection, presented by Cindy Kaestner:

- Cindy worked with Susan Seehase to compile handout
- The handout shows a sample of provider information collected by the Abbe Center and EPI (Exceptional Persons Incorporate); top half of the page is EPI and the bottom half is Abbe Center
- Some things are distinct and different for each organization
- A lot of what we collect is collected for others, not for internal use
- Over the last 10 years collecting more data for others, not for clinical purposes
- Quite a lot of it is manually collected
- Abbe has a certified EHR and are collecting data that can be moved on, but a lot of programs still collect much of their data in chart (narrative) form
- They are required to use CHI (Consumer Health Inventory) and CHI-C for DHS contracts

- ACT is all manual data collection
- The Integrated Health Home Project through Magellan has an ARNP (Advanced Registered Nurse Practitioner) onsite full time to collect physical health information for clients; that is the direction things are going and it will change everyone's systems
- Now there are many different systems and a very different level of collecting information
- It is important to think about what we are putting the clients through in terms of collecting information from them; if it takes two hours client time and four hours of staff time up front just to get people in the door, it may discourage people from coming back for the services they need
- Would like us to look at gathering information it as more service specific; we need different data for people who are just coming in for a few visits than for those who will have lifetime involvement in care
- Providers should be able to access a minimum data set from other providers
- Need to balance confidentiality and privacy and have important information available to those who need it
- At some point, clients should have some access to own records
- Most providers do not have IT departments and clinical people are trying to manage data
- There are some very good things about EHR

Remarks by Rick Shults:

- CMHCs (community mental health centers) will have to have EHR systems according to the requirements of the ACA (Affordable Care Act) and ultimately they will have to be integrated with the Health Benefits Exchange (HBE)

Iowa Medicaid Data Systems, presented by Jody Holmes:

- A privacy and security workgroup has been addressing mental health records and other privacy concerns
- The pathway to get there is through a certified EHR system
- Medicaid touches on almost 20% of Iowa's population

IABC – Iowa Automated Benefits Calculator:

- Starts with eligibility
- Automated eligibility system through IM (Income Maintenance) workers
- Captures demographic and financial information
- The system will be replaced on October 1, 2013 (not 2014, as handout shows)
- The new name will be ELIAS
- IME is looking at systems that are very service oriented with components available for reuse and that are better able to interact with other systems

ISIS – Individualized Services Information System:

- Contains workflow and case management for long term care and home and community based services
- It is also targeted for replacement

MMIS – Medicaid Managed Information System:

- Manages provider enrollment, managed care, processes claims and makes payments to providers
- Claim information generally includes diagnosis and procedure information; helps to gauge accuracy
- Keeps claims information in the system for about 3 years
- Current MMIS system will be replaced February 1, 2015 by MIDAS

- IME also has a pharmacy point of sale system that pays all pharmacy claims and a provider portal where providers can access information
- They anticipate having a new provider portal; providers will be able to submit claims through the portal and get review in real time
- Want members to have access to their personal health records
- Should also be able to use data analytical tools to help identify where to give people information and be a resource to help them manage their own health care better
- Information to assist people in selecting their health home
- Will have a client portal so people can get online and complete own application without the help of an IM worker
- A/R County billings – tracks services charge back to the counties
- Data warehouse – has 10 years of claims history and encounter data from Magellan (Iowa Plan) and Meridian (Managed Care)
- Disease management – using data mining from claims for program eligibility
- Program integrity:
 - Tools for service utilization and review; fraud and abuse research
 - Predictive modeling and population/member health risk scoring
 - Actionable indicators that can be followed up on and that help people maintain their health
- Can take data and see trends that we can study, learn from, take action on
- Onbase system – imaging and workflow system that provides for document imaging and workflow for reviews
- IME has to produce many reports that go to the federal government ; there is a lot of accountability with taxpayer dollars
- Seeing an increased demand for quality metrics; established clinical measures
- Not just looking at process and payment; looking at quality outcomes

Discussion:

Remarks by Rick Shults:

- Have become familiar with what Missouri has done with their health homes (Dr. Joe Parks study)
- They are having case managers pay attention to people's physical health, improved client health and resulted in a savings of money in areas that they did not anticipate, such as non-mental health pharmaceuticals
- People with disabilities are dying 25 years sooner than they should; we need to make use of the tools we can find to prevent that

Remarks by Jody Holmes:

- The Iowa e-Health Advisory Council is the governing body over the development of an electronic health information system in Iowa and includes stakeholders from across the State
- You can't treat a whole person if you are only seeing half of what's going on with them
- There was legislation last year about an all payer data base expanding on what the Iowa Hospital Association does now

Remarks by Randy Clemenson:

- Referenced a book called "Super Crunchers"
- It is primarily DHS that has access to Data Warehouse information, and they sometimes give data extractions on request
- A few non-DHS users such as DIA can use it based on their business relationship with DHS
- All DHS data is in one warehouse for:
 - Eligibility
 - Child welfare
 - Child abuse
 - Medicaid
- System has a portal – a web application that providers can come in and use
- Can be used for re-enrollment, submitting incident reports, and signing a person up for presumptive enrollment
- In 2015 with new system, DHS hopes to expand so they can submit claims online and have real time claim adjudication
- Will also have a new portal for members where they can log-in to see personal health records, claims that have been paid on their behalf, etc.
- The eligibility system will have a portal for people to apply or check on eligibility status
- That will open it up to more people for more applications

Magellan Health Services, presented by Dennis Petersen:

- Magellan's MIS systems are the foundation of their data processing capabilities
- All clinical and financial systems exist on one platform so all data can be integrated:
 - Integrated Product (IP)
 - Claims Adjudication and Payment System (CAPS)
 - Is linked to IP which allows federal eligibility information for appropriate authorizations
 - Integrated Provider Database (IPD)
 - Where all provider information is stored
 - Information feeds to IP and CAPS
 - Enrollment System
 - Resides on CAPS and supports all Magellan customers
 - Data Warehouse
 - Real time data is fed to data warehouse

- Clinical information is collected on all clients
- Have the ability to image documents and attach them to the client record
- Pharmacy claims are integrated and can be used in managing client's care
- Magellan owns the source code to all core systems
- Use an in-house team of IT professionals nationwide
- Can draw on their expertise for development, upgrades, and maintenance

What other data is collected?

- Outcomes data
 - CHI and CHI-C are offered to providers and adapted for DHS
 - Collects information for NOMS (National Outcomes Measurement System)
- Central Data Repository
 - Magellan receives a data feed from the Iowa Department of Public Health containing data from the CDR with substance abuse treatment (SA) data from licensed SA providers
 - Magellan has the ability to do matching with about 99.5% accuracy between IDPH and Medicaid clients

What is the data used for?

- Reporting - Generate hundreds of standard reports
- Decision Making - Used to make operational and clinical decisions
- Provider Profiling – Used to generate a provider profile, showing two years of quarterly data
- Ad-hoc Reports - General ad hoc reports when requested by DHS, IDPH, or internal management, with an average turn-around time of less than 2 days
- Magellan has about 500,000 annual enrollees on the Iowa Plan, (Iowa Medicaid eligible individuals)
- They touch on about 16% of those in any given month who are accessing services

General Observations (and review of what we heard today):

- Some data systems are primary and some are secondary systems that get data from primary sources
- Timing is important; current technology allows for real time data
- Much data can be obtained from EHR, although some modifications may be needed and modifications are costly
- The long term view needs to include analytics
- EHR need to be accepted for accreditation or other state standards
- Keep FAQ (frequently asked questions) in mind
- Data is not any good unless it is maintained and data elements must be consistently added on a long term basis
- If you want to use it you have to mandate it
- Unique identifiers vary by system
- Having one system is unlikely; maybe more of a central clearinghouse for reconciliation of data

- Interfacing can make it look like a single system
- Not everyone has to be the same; information technology needs to support business
- How you want to run your business should determine how you step up and run your IT system; it should support the way you want to get things done
- Need to be able to enter data as part of doing business, not a separate task or function
- Move from narratives to data points and keep it useful both for data collection and clinical information
- Concern about collecting too much information and putting clients off
- Keep data meaningful and use it
- Streamline and make manageable and useful
- There are benefits to collaboration because of limited IT resources
- Use data to get a better picture of whole individual/client
- Move to having information in one place
- All various entities who have responsibilities for services for a person need to gain useful access to the same information to improve the services they offer and best support the individual
- Need to clarify how HIPAA and Chp. 228 impact data sharing and availability

Public Comment:

No additional public comment offered.

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.