

Safety Net Data Work Group Meeting Summary Monday, February 23, 2009

Participants

Doreen Chamberlin, Iowa Department of Public Health
Beth Jones, Iowa Department of Public Health
Dr. Rahul Parsa, Drake University, Chair
Sandy Pickup, Iowa City Free Medical Clinic
Dr. Dana Shaffer, Des Moines University
Rochelle Spinarski, Safety Net Evaluator

Members Not Able to Attend

Libby Coyte, Redfield Rural Health Clinic
Dr. Tom Evans, Iowa Healthcare Collaborative
Dr. Tom Kline, Iowa Medicaid Enterprise
Deb Prins, Primghar Rural Health Clinic
Laura Sands, Health Access Partnership

Staff

Ted Boesen, Iowa/Nebraska Primary Care Association
Roger Chaufournier, CSI Solutions
Kristin Didonato, CSI Solutions
Sarah Dixon Gale, Iowa/Nebraska Primary Care Association
Dr. Bery Engebretsen, Iowa/Nebraska Primary Care Association

Welcome, Introductions, Review of the Agenda

Ted welcomed the group and asked for introductions. He noted that the Safety Net Data Work Group was formed based on consensus reached at the Safety Net Strategic Planning session held in fall 2008. Ted thanked Dr. Rahul Parsa for agreeing to chair the work group and also noted that Roger Chaufournier, a consultant from CSI Solutions, who also facilitated the strategic planning session agreed to help the work group to establish a charter and plan.

Review Draft Charter of the Work Group

Roger referred the group to a draft charter, which includes the following items:

- Recommend measures to assess the impact of the safety providers and the population they serve.
- Serve as a clearinghouse and aggregator of data from the safety net members of the Collaborative. This would involve developing a reporting and data collection strategy.
- Oversee the analysis of data and proposing strategies that might include improvement opportunities and model programs or for use in formulation of policy recommendations by the broader Collaborative.
- Develop products that include the key messages derived from the data and analyses.

The group agreed this was an appropriate charter considering the goals and needs of the Safety Net.

Definition of the Safety Net Population

Roger asked the group to define the safety net population. Roger referred to a PowerPoint presentation where a draft definition of the population included the following criteria: 200% of federal poverty and below and under/uninsured. He asked the group for their reaction and ideas, which included:

- Ted – this needs to be flexible to include free clinics and rural health clinics as they do not necessarily collect the income level of those they are serving. We use the 200% and below definition for the prescription program currently funded by the Safety Net.
- Sarah – the 200% definition is also used by the 10 grantees funded by the Safety Net that are working on specialty care and medical home projects.
- Dr. Parsa – we need to meet some standards in data collection as we are required to collect this data. Should we use the definition that was given to us?
- Rochelle – is there specific language in the legislation?
- Roger – are there other modifiers that would provide guidance?
- Dr. Parsa – is the concern that we will include more people than we should?
- Dr. Engebretsen – this is complicated because some of the groups like the rural health clinics focus more on being uninsured and underinsured than on income level.
- Dr. Shaffer – the underserved issue is much more common in the rural health clinics.
- Bery – for the rural health clinics we would pick up more people because the rural health clinic is often the only provider in the community.
- Rochelle – what is the purpose of collecting the data? It might be helpful to talk about what we want to collect and then define who the safety net is.
- Doreen – it may also be helpful to look at other definitions of the safety net (AHRQ, etc.). Iowa would probably have its own definition of safety net based on the vulnerable populations specific to the state.

Roger proposed using the working definition to guide the group and then come back to the definition discussion. The group agreed.

Benchmarks from Other Environments – What Is Possible On a Statewide Basis?

Roger introduced some examples of statewide data collection efforts from across the country. Many states are trying to align measures and determine common sets of measures. We know many providers have to report different data to many different agencies and this is often the impetus for undertaking statewide data reform initiatives. The examples discussed follow:

- HRSA and FQHCs as one example – UDS is one of the largest data sets that exists across providers throughout the country. Data has been used to motivate policymakers and collect best practices that can be spread.
- South Carolina example – data warehouse that links all databases in the state. They can drill down to various topics such as law enforcement and health care indicators. Ted – do they also get claims data? Yes – they get it from Medicaid, their self-insured fund for state employees, etc. They look for outliers to see if there is a best practice or potential fraud. Care South, the FQHCs, were able to maintain funding for wraparound services because of the data they collected and reported.
- Bridges to Excellence program – came from large employers, which includes a P4P program as well as NCQA criteria for medical home. There is a shared savings model where some funds come back to providers. It is national, but biased toward urban centers. Iowa Health System and Mercy may be participating in this.

- North Carolina model – this is primarily a Medicaid model. Providers receive a per member per month reimbursement and the network also receives a per member per month reimbursement. They track data around key indicators and undertake a review of claims data and regular chart reviews. Many states are looking to model this program and the reimbursement model, which directs funds to primary care. They conduct a monthly reporting of the data sets. In the system, they have 13 networks that all have a panel of patients. They must apply to become a network and then contract with safety net providers to take care of the safety net population. The network reports the data to Medicaid on a monthly basis. The networks may also support HIT at various levels.
- Wisconsin example – this was physician-driven. The physician community established a voluntary reporting system. A public website with full transparency was created and it is not tied to reimbursement. Fewer of the safety net providers are doing this. They use this to benchmark and look at best practices. They share among providers what others are doing to improve care. Dr. Parsa – this is what I have in mind. I like the web-based aspect of the reporting.
- Dartmouth model – this is a national database of primary care resources built around Medicare patients. They have broken down patterns of care in local communities. They look at where patients go for their primary care. They use mapping and various data sets for planning purposes.
- West Virginia – created a common set of measures and got all of the payors to agree to these to decrease the reporting burden for providers. Payors agreed to pull claims data into a third party, which is now beginning to report back to the payors on performance indicators. They are now launching a program to address outliers in those common data sets.
- Wellmark – nationally they have launched some aggressive data strategies. They are a potential partner in Iowa. Ted – has anyone put a payor class to the uninsured and then reported that data for comparison? Medicaid and UDS are probably the closest there is. The Dartmouth data set might provide a potential lens as well. Ted – you could ask all of the providers to create this class so there could be comparisons with the Medicaid and insured populations. Doreen – would this be similar to how hospitals do their charity/uncompensated care? Yes. Doreen – I wonder if they could provide some guidance.
- Rochelle – back to Dartmouth slide. Is this only Medicare patients? Roger – the original drawing is from the Medicare patient data set. This is how they determined the discrete service areas. To my knowledge, they have not yet added the Medicaid population. Ted – I think it is more about the creation of these primary care service areas. They originally used 1999 Medicare data and 2000 census data.

Roger concluded that clinical data is not enough to influence policy; you must include financial data to have the true picture, which makes this more difficult. You could look at the economic impact of safety net providers to the economy/medical costs, create common “cheat sheets” for stakeholder briefings, lead the adoption of a common set of measures across the payor community, or develop a methodology to quantify the gap that needs to be addressed.

Data to Collect/Data Currently Available/Local Efforts

Roger asked the group to think about what is going on locally and what they might be interested in collecting or already have available. Comments included the following:

- Dr. Parsa – what kind of resources do we have in place to undertake a project? What are we going to do with the data? That will determine what we try to collect.
- Roger – most of these efforts had resources, with the exception of the Wisconsin model, which was voluntary. They probably have received resources now that they are collecting and reporting data.
- Doreen – I wonder about a pilot project to test something out in a subset of the overall group.

- Ted – the formation of this group came out of the strategic planning session for the Safety Net. We want to expand our view about the possibilities around data. There is going to be and needs to be a larger vision for this group. We wanted to facilitate some larger thinking around this. If there is a vision that people can agree upon, we might be able to secure some resources from outside entities. The notion of a pilot community has value as the HIT Advisory Council is also thinking along those lines.
- Doreen – I always refer back to Healthy Iowans 2010 when I think about a vision. This could provide a good direction for what data we might want to collect.
- Ted – the access and cost categories need to be married together.
- Rochelle – how does the Safety Net legislation fit into this?
- Ted – I think including what we are collecting now has a place in this discussion, but we are looking at something bigger.
- Roger – there are other emerging issues that will surface and can be married to what you are currently collecting.
- Ted – there are capacity issues in getting the data we want from the safety net providers. We have learned from our experiences and know that free clinics and rural health clinics probably cannot provide as robust a data set as the CHCs and family planning agencies can.
- Dr. Parsa – you collect data to influence policy and you collect it for research purposes. The more the merrier mentality can become a burden especially with the complicated nature of health care. We have to ask the right thing, in the right amount, and ask the right people. And then infrastructure comes into play.
- Roger – it would be helpful to know what is already being collected.
- Dr. Parsa – what are we not collecting that we want? This is another place to start.
- Sandy – we are a larger free clinic so we have funding from multiple streams that support our ability to collect and report data, but many free clinics do not have this ability. The question is what else we could do to assist them.
- Ted – we are not collecting any clinical data. That is a gap.
- Rochelle – rural health clinics are often part of hospital systems that might have data available.
- Doreen – you can buy the data from the Iowa Hospital Association and some of the RHCs have to report UDS data if they are using a National Health Service Corps member.
- Ted – we can explore the Iowa Hospital Association data for the RHCs and find out how many do report UDS information.
- Dr. Parsa – can we look at all that we have available to us and then identify the gaps. Who has what kind of data and what format is it in? We may need to standardize the data.
- Roger – you should communicate to the members that the data work group has been launched and ask the members to send what they are currently reporting. This could be mapped and then gaps could be identified.
- Dr. Parsa – I love the Wisconsin model that is web-based. The Safety Net could be the collector and reporter of the data.
- Ted – who was the champion for their effort?
- Roger – they had several progressive groups in the quality movement. One community, for example, worked to reduce c-section rates to 6%. Nationally the rate is 25%. Their quality was already good so it was not so risky to report and make it transparent.
- Dr. Parsa – maybe you can identify some volunteers like Sandy to help think about how we should ask the members for what they currently collect.
- Rochelle – it seems to me a lot of organizations are focusing on the quality data collection piece. I am curious about the organization and patterns of care and how that is taking place in Iowa. I do not

see that happening and this is a huge issue for the safety net and the continuum of services and efficiency of care. This is a visionary issue that would have a huge impact on the safety net.

- Ted – this is what I am looking for. The patterns of care would be a reason to be part of the larger conversation.
- Roger – the ability to link clinical data with the models of care could help clarify this issue with policymakers. This could allow you to present a pilot project about medical homes, etc.
- Ted – the resources can be garnered if we have a larger vision that builds and recognizes both the potential and pitfalls.
- Dr. Engebretsen – what if a prescription becomes more than a prescription? It could include some data collection elements. Diabetes, hypertension, depression, and pre-natal vitamins for pregnant women are being tossed around as potential pharmaceuticals that could be provided through the state’s PBM settlement. We could ask the providers for a little bit of data and then issue the data collection requirement around some funds that will allow providers to provide free pharmaceuticals to safety net patients.
- Ted – to explain the pharmacy benefit manager (PBM) settlement further, there is \$483,000 that the Attorney General’s office has from a national PBM settlement. What is being proposed is providing generic chronic disease medications to safety net patients.
- Dr. Engebretsen – could we learn anything from a limited endeavor that could inform a larger effort?
- Ted – Rochelle, further define patterns of care for me.
- Rochelle – I think of it as how patients are flowing through health care services, where they are going to get care, and what do the patterns look like. The one group of providers that may not have resources around the clinical piece is the free clinics.
- Ted – is the activity at the larger clinics representative of the other free clinics?
- Sandy – we have more of a chronic care model than most of the free clinics. You could get some useful information, but it would have to be set up in such a way that you know what you are getting.

Action Planning and Next Steps

Roger noted there are certain activities mandated by the legislature, certain needs around a common platform, and there are emerging needs from around the country. What if the group crafted a vision of trying to explore four key areas, including:

- Review the Healthy Iowa 2010 statements and document the gaps in the safety net environment – make case for additional resources and better coordination.
- Conduct an impact analysis – the impact the safety net is having on the health care environment and economy (role, contribution, and value of safety net – multiple dimensions)
- Create an opportunity for collaboration within the safety net community – based on analysis of data and information there may be an opportunity to craft some type of community-wide program where you could seek external funding (disease collaborative, medical home, patterns of care, quality of care, standardization of the data platform, etc.)
- Develop a web-based reporting system that could lead to a statewide database that would allow the tracking of data over the long term.

Roger also commented that if the group sets a vision of trying to achieve some of these items you can then step back and develop a work plan around these larger goals. Comments included:

- Dr. Parsa – this is excellent and what I was looking for. I would add the following questions to the mix: what data is available; what data do we need; how do we collect it; what clinical data are we

interested in; what about the role of pilot sites; and, identification of what data we are missing. Is our ultimate goal to influence policy and improve health outcomes?

- Ted – we want to have a system that keeps up with the private system and ensures quality care for safety net patients.
- Sandy – I hope we can figure out how to do it better than the private system and influence policy nationwide.
- Ted – how does data help influence policy? This is another question to consider.
- Dr. Engebretsen – that has been demonstrated in CareSouth, where the safety net is providing better care to the Medicaid population than the private system.
- Ted – if you can get Medicaid and Wellmark together you have some pretty powerful claims data. I think one of the next steps is to think about what we want from Medicaid and Wellmark as well as what we want from policymakers. What type of data would we collect to address the patterns of care concept, which I found to be a great vision?
- Roger – how fast could you find out what data is available from the safety net members?
- Ted – we could probably request information from the more active clinics in each of the groups and that would probably give us a good sense of what is available. I think we could do this in 30 days or so. Sarah will query a sample of representatives from each group and compile a report.
- Dr. Parsa – I would like Rochelle to further flush out the patterns of care issue. We need to know what we mean by this and what information we need to address this issue.
- Rochelle – I can work on this with Ted. I think the sample is a good idea as long as we hit the systems and the independents.
- Dr. Parsa – I can ask my contacts at IFMC what they are doing around data. I will set up a meeting with IFMC and Ted.
- Dr. Engebretsen – I think a meeting with the IHA would be good too because I know they have ambulatory data.
- Ted – we can contact Heather at the IHA as a next step as well.
- Sandy – it would be easier for the free clinics if you could have resources available that could provide assistance in collecting and reporting data.
- Ted – we should ask about their capacity to collect various data sets as that could be good to know.
- Rochelle – how are free clinics being integrated into other quality improvement discussions? I would be curious about any models collecting data within free clinics.
- Ted – we could ask Wendy about this and approach other free clinic associations.

Action Items

- **Search for other definitions of the safety (AHRQ, etc.) – IA/NEPCA staff**
- **Further define the issue of patterns of care – Rochelle to follow up with Ted**
- **Review Healthy Iowans 2010 for guidance – IA/NEPCA staff**
- **Set up meeting with the Iowa Hospital Association – IA/NEPCA staff**
- **Set up meeting with key staff at Iowa Foundation for Medical Care – Dr. Parsa and Ted**
- **Follow up with Dr. Kline at Iowa Medicaid Enterprise – Ted**
- **Follow up with select rural health clinics and free clinics regarding what they are collecting, what could be collected, and what support/resources they need around data collection and reporting – IA/NEPCA staff**

The group agreed to meet on **Monday, April 6 from 9 a.m. to 11 a.m.** Sarah also agreed to send out the data collection instruments the free clinics and rural health clinics use to report data to the Safety Net, the last data report (with response rates, etc.) compiled by Safety Net staff, and a meeting summary.