

ACCESS TO HEALTH CARE ISSUES: OPPORTUNITIES AND BARRIERS FORUM

Conducted January 15, 2009

Sponsored by:

Fairfax County Office of Public Private Partnerships and the Department of Family Services

Report Date: February 4, 2009

SECTION I: INTRODUCTION

On January 15, 2009, the Office of Public Private Partnerships (OPPP) and the Department of Family Services (DFS) convened a forum on the issue of access to health care for at risk children and families in Fairfax County, Virginia. The purpose of the Forum was to explore best practices from research and “on the ground” practices in making health care accessible to low income populations. The Department and the Office engaged participants in a process of peer to peer dialogue and learning designed to:

- Inform current practice; and
- Inform the development of request for proposal (RFP) specifications to be issued by DFS.

Over fifty (50) individuals were invited to attend the Forum. There were twenty-seven (27) attendees representing Fairfax County and from the Northern Virginia region. Participants included individuals from government agencies (e.g. health departments), providers (e.g. doctors, hospitals and community agencies and clinics), and foundations. A presentation by Tim Henderson from the Center for Health Policy Research and Ethics, George Mason University provided forum participants with recent trends in health coverage for the state and county.

The agenda for the Forum can be found in *Appendix A* of this report.

SECTION II: BACKGROUND

Fairfax County is committed to providing health care services to low income children and families. While there are many programs that cover low income populations, including SCHIP, FAMIS¹, and Medicaid, children still fall through this safety net for many reasons, including insufficient outreach on the part of the programs designed to serve them or because they are found to be ineligible for the services or because the process to become enrolled is too complex, overwhelming, and/or intimidating for families.

In Fairfax County there were 137,723 individuals under 65 without health insurance coverage, or 15.2 percent of the population as of 2005.² From November 2007 to November 2008

¹ FAMIS (Family Access to Medical Insurance Security) is Virginia's program that helps families provide health insurance to their children.

² U.S Census Bureau and the Centers for Disease Control and Prevention as presented by Tim Henderson, Center for Health Policy Research and Ethics, George Mason University.

applications to FAMIS jumped up 24% statewide and up 16% in Fairfax County³. Nearly one in nine children in the United States has no health coverage.

A variety of programs exist to provide health care services, including:

- **Medicaid** provides health insurance to more than 700,000 people in Virginia. While most recipients are children, the program also covers very low-income parents, pregnant women, the elderly, blind and disabled, and certain women needing cancer treatment. In addition to comprehensive health insurance, Medicaid provides very costly long term care services in nursing homes and through a range of community-based care to eligible elderly and disabled.
- **Family Access to Medical Insurance Security (FAMIS)** – This is Virginia's State Children's Health Insurance Program (SCHIP) that offers health insurance to uninsured children who are not poor enough to qualify for Medicaid, but their families cannot afford private health insurance. The current gross income limit for FAMIS is 200% of the federal poverty line (FPL) (e.g., \$3442 per month for a family of four). "FAMIS Select" allows families with FAMIS eligible children to choose a monthly subsidy to purchase private health insurance instead of receiving regular FAMIS coverage. "FAMIS Moms" offers coverage to pregnant women with income under 185% FPL.
- **Medicare** is the national health insurance program for most individuals over age and certain people with disabilities. There are special benefits available for low-income Medicare beneficiaries, such as the "Low Income Subsidy" under the Part D prescription drug program and "Medicaid Savings Programs" that help with out-of-pocket Medicare expenses.
- **State-Local Hospitalization (SLH)** provides coverage for some hospital inpatient and outpatient services for very low income people without health insurance.
- **Indigent Care Programs** – There are other programs and services available to Virginia's uninsured. These include health department clinics, free clinics and federally qualified health centers, prescription assistance programs, and hospital indigent care programs.

Yet a significant proportion of children eligible for these programs remain uninsured. States have found that expanding eligibility and marketing new programs are not enough to increase enrollment of eligible uninsured children in public health programs. According to survey data, one key reason for under-enrollment is that families find enrollment and renewal procedures too complex.⁴

³ IBID, Source: The Washington Post, January 14, 2009

⁴ *Enrolling Eligible Children and Keeping Them Enrolled*, The Future of Children, Volume 13, Number 1

The Forum was designed to begin a conversation around five key issues we believe are critical to improving and expanding access to health care for low income children and families. The issue areas the Forum addressed were:

- **Outreach:** In general, the process and practice of reaching individuals and communities that could benefit from programs and services.
- **Assessment and Enrollment:** In general terms, assessment of health care status, requirements to become eligible for any program, and the process of enrolling into the program based on needs and requirements.
- **Service Utilization:** In general, defined as how much health care people use, the types of health care they use, and the timing of that care.
- **Case Management:** In general, related to managing access to care, effective coordination of care processes, quality outcomes, and, in the end, human and financial resources. Case management should be conducted at both a customer level and a systems level to achieve these ends.
- **Data Collection:** In general, the process and practices that are used to collect required information from customers to be used for accountability, reporting, tracking, trend analysis, and program improvements.

Forum participants broke into groups to discuss the issue areas identified above. Each dialogue group examined current challenges related to the issue; quality practices that may be used to address the challenge; and key programmatic elements to embed in a quality program design.

SECTION III: SUMMARY OF RECOMMENDATIONS

Three *fundamental premises* emerged from the dialogue and recommendations at the Forum:

- We believe that a grounded, in-depth understanding of the reasons some families miss out on health care coverage is critical to developing effective strategies for change and effective service delivery;
- We believe that local organizations can have a significant impact on barriers to health care if we work together to strategically choose the problems to address; and
- State and federal policy makers may need to be engaged to bring about changes in the way that health care is delivered.

The following *seven trends* emerged as consistent themes across each of the five issue areas:

- ❖ Develop a no wrong door, single point of contact approach to improve accessibility to all services and programs;
- ❖ Make it easy for customers by establishing methods for common data collection across programs and between service providers;
- ❖ Make it easy by establishing common eligibility practices and ease eligibility and renewal practices through streamlining processes and paperwork;

- ❖ Make it easy by establishing common definitions to enhance communication among providers and with customers;
- ❖ Develop an integrated delivery system to improve the quality of care; improve linkages; and expand capacity in all realms of care, including provision of specialty care;
- ❖ Be customer focused and provide quality customer service; and
- ❖ Rebrand and create a new message that these programs are not ‘just for poor people’ and are not about ‘being on welfare’.

BIG IDEAS

Each group was asked to identify two or three big ideas based on their table discussions. These big ideas support the seven trends identified above.

Outreach

- Strengthen the link between data and outreach. Gathering data can be cumbersome and difficult with current tools available to us.
- Use program goals, outcomes and measure data to evaluate the effectiveness of each outreach activity and build on those that are most successful.

Assessment and Enrollment

- The money follows the patient. This will eliminate or significantly reduce program confusion and multiplicity of “program determinations”.
 - Eliminates confusion
 - Demographic information could be extracted for this purpose; this would require IT systems modifications by Department of Medical Assistance Services (DMAS) and data-exchange between state and local providers.
- Eliminate the back and forth between fee for service and managed care for Medicaid recipients
 - This would allow for continuity of care with same provider
 - Eliminate additional workload for caseworkers
 - Ensure medical care is provided
 - Ensure prescriptions are covered

Service Utilization

- Create a NOVA Integrated Safety Net Network of Health Care Centers (all of which offer primary/specialty/dental/mental services) that is based on a single eligibility system and offers geographical ease of access while being supported by an integrated funding stream (that avoids having to apply to multiple small grant funders in favor of a regional collaborative approach). Such a Safety Net would ensure both that health care providers have the funds necessary to operate and that the health care recipient is adequately covered. The Net would also allow workers to be covered in the jurisdiction that is most logistically convenient for them.

Case Management

- Develop a case management model that combines social work and medical case management for optimal use of and access to healthcare.
- Develop transparent medical record and use of technology to teach health access and literacy and ensure case management for the sickest.
- Empower patients, children, and families to make choices and work with the case manager as a partner.
- Have the county hire case managers who would work with small practices. Case management could be diagnosis triggered, or when coordination of care is needed, or doctor triggered.

Data Collection

If implemented, these three concepts would begin to address the major problems related to data collection:

- Establish common definitions of enrollment and encounter information in order to build a single common electronic record. To do this, state and local health administration contracts should include funds for and require common data collection and sharing.
- Garner agreement on health outcomes data and implement these standards; and (again, contracts should require or encourage this element).
- Determine how to determine the need for more services: what kind, where and for whom. Conduct quality health access surveys and draw on current demographic utilization data.

SECTION IV: ISSUE AREAS: PROGRAM ELEMENT RECOMMENDATIONS

There were a wide variety of challenges identified within each issue area. These are fully described in ***Appendix B*** as part of the facilitators' notes for each issue area. However, a few challenges rang out across more than one of the issue areas. These common challenges included:

- Lack of specialty care,
- Need for access to both primary and specialty services,
- Lack of health literacy and cultural competency within the programs,
- Lack of capacity – case management and physicians,
- Fragmented delivery system, and
- Fragmented data collection.

Outlined below are the recommended key elements for any program design specific to each issue area. These elements grew from the discussions at each table. Forum participants were not limited to one issue area, instead at certain times in the discussion process participants could switch tables and add their ideas to the ongoing dialogue. Facilitators were at each table to capture these ideas.

Outreach

- Use program goals, outcomes and measurement data to evaluate the effectiveness of each outreach activity and build on those that are most successful.
- Create a multidisciplinary approach with people at the table knowledgeable in marketing, data collecting and analysis, and outreach staff.
- Engage the community in designing and conducting outreach efforts, through community advisory group or possibly focus groups. Get community involved.
- Work with charitable organizations and faith communities.
- Go where the people are who need the assistance, e.g., nail salons, grocery stores, schools, etc.
- Develop partnerships for resources.
- Use culturally appropriate staff to mirror the community
- Create new messages in an effort to take the “shame” and embarrassment or stigma out of receiving assistance.
- Ensure repetitive visits to community groups to keep them aware of the programs available

Assessment and Enrollment

- Create a multi-jurisdictional/”no wrong door” approach for Medicaid eligibility
 - Easy, consistent, transparent eligibility process across jurisdictions
 - Medicaid is a federal/state program so there should be no difference in what locality you apply
- Streamline the paperwork for Medicaid applications/eligibility purposes
 - There are several different applications for Medicaid depending on the type/funding stream

Service Utilization

- Create a Northern Virginia Safety Net
- Provide a community liaison to ensure cultural and linguistic familiarity
- Ensure that services are geographically and logistically accessible
- Simplify eligibility requirements within the programs
- Develop a no wrong door policy (always point to the right door).
- Provide case management designed to do more than fill out the required paperwork. Ensure that individuals get to the right door the first time. ID potential barriers beforehand and share information.
- Provide flexible hours of operation

Case Management

- Develop consistent education and training of case managers and common definition of core tasks.

- Case managers should be culturally competent, provide health education, help with patient compliance, and provide continuity from start to finish for patients.
- Case managers need access to a supervising doctor, (MB medical backup).
- Case managers can help new patients complete paperwork needed for enrollment, this expanded role would increase the number of enrollees (follow-up phone calls/meetings after forms given out).
- Peer programs, health literacy, community programs.
- Case managers need to work as a team with data and outreach.
- Simplify access and make it easy for people to get care.
- Case managers should be culturally literate, can't be effective unless get through cultural barriers

Data Collection

- *Disseminate and utilize quality indicators of quality medicine.* HEDIS is an example, but it is not the only standard of care that can be use. Free clinics in the area may refer to care definitions offered by Virginia Association of Free Clinics. At the Arlington Clinic, they have applied standards comparable to HEDIS. Benchmarks set for pap smears and mammograms and achieved very good results; 100% utilization of Pap smear and mammograms among the low-income population that utilizes the clinic.
 - Utilize associations like the Virginia Free Clinics to share and compare data
- *Strengthen the communication and sharing of information between providers of data and outreach professionals within an organization.*
 - Establish systems for sharing information.
 - Set mid-course markers that should be required to be reviewed by outreach professionals to make mid-course corrections for planning purposes.
 - Encourage the data team to provide more “real-time” information as opposed to the lag time traditionally involved in health care data collection.
 - Track and measure health care delivered (well and sick care) not just enrollment.
 - Get agreement on what data were using and at what time points to make decisions.
- *When doing surveys on health care access, ensure that you are considering language and literacy levels.*
- *Data collection efforts should be centralized and standardized.* “Data lives everywhere, make an effort to consolidate and collect it for a common system.”
 - Define the common elements, define the definitions and methodology
 - Centralize data collection at the local and federal levels
 - Standardize reporting requirements without being overly burdensome
 - State could require managed care organizations to provide data on # of enrolled, # of providers, # of encounters.
 - Simplify billing procedures
 - Reduce claim turnaround time

- *Develop a standardized electronic record.* This would incorporate and address many of the concerns listed in barriers, it could be automated to make collection more efficient and accurate and allow for quicker analysis and report times.
- *Consider offering incentives and/or penalties to improve data collection.*
 - May be expensive
 - Apply private sector approaches
 - May improve claims turnaround
- *Increase funding for data collection and provide assistance for IT-These investments will make organizations more cost-effective in the long run.*
- *Use state university partnerships to design and implement a consistent data collection system and conduct analyses.*

SECTION V: SUMMARY

The information and recommendations contained in this report will be used by the Fairfax County Department of Family Services to craft a request for proposal. The request for proposal (RFP) will be designed to solicit strategies to address the many challenges identified at the Forum to accessing health care and that incorporates many of the quality practices and key program elements described.

The Office of Public Private Partnerships is seeking venues through which to continue this dialogue and to work collaboratively with the stakeholders in the Northern Virginia region to address the systemic issues that inhibit access to quality health care for all the region's residents.

Appendix A: Forum Agenda

FORUM on Access to Health Care Issues: Opportunities and Barriers

January 15, 2009 - 1 p.m. to 4:30 p.m

Government Center – Rooms 9 and 10

Conveners: DFS and OPP

Facilitator: Lori Strumpf

Meeting Purpose: Engage individuals in the region in a dialogue about access to health care for those in need. Use the information from the dialogue to inform promising and best practices to facilitating access to health care. Use the dialogue to inform current practice, the development of RFP specifications, and to improve possible responses to the RFP.

Meeting Outcome: Report on the ideas and issues identified.

Audience: Anyone in the region that is interested in the issue in general and may be interested in responding to an RFP on providing access to medical care to low income populations.

1:00pm to 1:10pm

WELCOME

1:10pm to 1:20pm

INTRODUCTIONS

1:20pm to 1:30pm

**Overview of Meeting Purpose
Overview of Issue Areas**

1:30pm to 2:00pm

Framing of the Issues: What the Data Tells Us
Tim Henderson, Acting Deputy Director
Center for Health Policy Research and Ethics
George Mason University

Q and A

2:00pm to 2:15pm

BREAK

2:15pm to 3:30pm

**INTRODUCTION of EXERCISE for each table
Table Top Dialogue:**

Each table will be asked to answer the following questions:

- In your mind, what are the challenges to health care access in the following areas:
 - Assessment
 - Enrollment

- Outreach to children, families, and adults
- Case Management
- Data collection
- Utilization of services
- (we will add anything else that comes up in the large group discussion)
- What are quality practices that have been developed locally or are known to you through research that help/might help to address these challenges?
- What are key program elements that should be incorporated into any program design to ensure access to quality health care for children?

3:30pm to 4:15pm 3 BIG Ideas Discussion

Each Group reports out 3 Big Ideas/issues for any one of the questions that they choose

4:15pm to 4:30pm

NEXT STEPS

ADJOURN

Appendix B: Facilitator Notes on Challenges and Quality Practices.

OUTREACH

Challenges:

- Cultural and Linguistic Diversity...not enough outreach staff to serve the diverse populations in the county
- Former middle income households – We have done much outreach in previous years but are aware that there may be a new population that may be unaware of potential services available such as people recently terminated from their job.
- Outreach is never done. Must continually revisit previous outreach community partners/groups to re-educate. Partners have staff turnover and new staff assisting families may not be familiar with the services available or how to access.
- Reaching all of our sister agencies to make them aware of current Health Care Access. Recently learned that 80% of patients being served at Woodburn Mental Health did not know about the services of the Community Health Care Network Program
- Fear of immigrants to receive services from government agency. Also need to be aware of the words we use...example: A requirement of the program is a person must be a resident of Fairfax county. When immigrants here the word “residency” they relate this to their understanding of “legal residency” for immigration purposes.
- Lack of attendance – much time and effort to coordinate and market the event, send staff to cover the event and then you may have a very poor attendance.
- Technology – we need to be more forward thinking and not simply rely on what has worked in the past. May get better outcomes.

Quality Practices developed or known to address challenges:

- Interpretation and translation services available but staff with the languages is much more effective.
- Test the strategy – evaluate what worked and make changes for your next outreach event
- Must use different approaches such as radio, flyers, partners and internet
- Effective marketing....we need to think of this as money making events. Many of us in this field are not comfortable with this aspect of marketing.
- Data and Outcomes. Need to evaluate and analyze outreach efforts for what is effective
- Strengthen link between data and outreach. Gathering data can be cumbersome and difficult with current tools available to us.

- No wrong door. There needs to be access to services or an easy link to network for clients living in another locality but requesting and in need of health care services. There should be a streamline approach to assist with this.
- Streamline eligibility for programs to reduce duplication of documentation from client and staff hours in the evaluation of the documentation.

Key elements for any program design:

- Program goals, outcomes and measure data. Must use all of these to evaluate the effectiveness of each outreach activity and build on those that are most successful.
- Multidisciplinary approach with people at the table knowledgeable in marketing, data collecting and analysis, and outreach staff
- Community advisory – work within the community...possibly focus groups. Get community involved.
- Work with charitable organizations
- Go where the people are needing the assistance....nail salons, grocery stores, schools etc.
- Develop partnerships for resources
- Culturally appropriate staff to mirror the community
- Effort to take the “shame” and embarrassment or stigma out of receiving assistance.
- Repetitive visits to community groups to keep them aware of the programs available

Other Issues:

- Do we have enough physicians to meet the need? Is anyone recruiting more providers, dentists?
- Provider side: allow Nurse Practitioners to see patients
- Need resource materials of doctors in the area seeing new clients at a reasonable cost...for those that are not eligible for health care programs

Assessment and Enrollment

Issues:

- Enrollment paperwork for Medicaid is confusing
- Eligibility policy for Medicaid is confusing
- “Child < 1 year” policy for Medicaid – once child turns 1 years old Medicaid eligibility ends; new application must be filed to determine new eligibility
 - is extremely confusing for recipients, caseworkers and other professionals
 - parents don’t understand that they must have to complete a new Medicaid application
 - additional workload issue for caseworkers

- Access to dental care for children
 - not enough dental providers in area
- DMAS public website is not user friendly
 - It is difficult to find/search for Medicaid providers
- New recipients are in fee for service for the first two months of coverage and then moved to managed care
 - Recipients whose cases have closed and then reopened also are enrolled in fee for service and then moved to managed care after two months

Elements:

- Multi-jurisdictional/”no wrong door” approach for Medicaid eligibility
 - Easy, consistent, transparent eligibility process across jurisdictions
 - Medicaid is a federal/state program so there should be no difference in what locality you apply
- Streamline the paperwork for Medicaid applications/eligibility purposes
 - There are several different applications for Medicaid depending on the type/funding stream

Ideas:

- Provide a list of Medicaid children turning 1 years old to the managed care organizations; this would allow them to follow-up with the family and ensure new application is submitted in a timely manner so there would be no break in Medicaid eligibility
- When child turns 1 years of age, do not close Medicaid and don’t require new application be submitted; new application could be done at the time of the next yearly renewal for the entire family
- Jurisdictions should share their best practices
 - Web portal to access the resources available in each locality
- Revamp DMAS public website so that it would be easier for the public to search/find Medicaid providers
 - For instance, instead of listing a dentist who treats children as a “pediatric dentist”, list under “dentists” and then those who treat children
- DMAS should create a good, easy to understand video for new Medicaid recipients to use in order to inform them about the managed care process

SERVICE UTILIZATION

I. Utilization of Services:

- A) Need to provide access to both primary and specialty services
- B) First time exposure to Health care services (folks sometimes not familiar with institutional structures or procedures and therefore don’t know what to ask for or where to go). It is hard to navigate (especially for folks who come from countries where health access is a different process).
- C) Communication among providers inefficient. There is frequently a duplication of services (paper work redundancy, intake repetition)
No access to prior medical records.

Lack of hand-offs to successive providers, b/c clients can't really explain their conditions or how they were treated or what took place at other providers' offices. Extra time spent equal to 25% of administrative costs.

- D) Oral and Mental health care not available.
- E) Doctors don't want to see patients (who do not have diagnostic test results). But, there are not enough Doctors available to review results either. Not enough primary or specialty care providers.
- F) Transportation, Literacy, cross-jurisdictional issues (lack of open door).
- G) Undocumented Immigrants (fear of use, fear of provision)
- H) Emergency/ICU rooms used as default primary care outlets for the uninsured, leading to collection agencies hounding recipient.
- I) Cultural biases/profiling leading to incorrect presumptions as to how to treat certain socio-demographic groups.

II. Best Practices.

- A) Streamlined Eligibility (Homogenized Requirements)
- B) Electronic Access to Health Records (E.H.R.)
- C) "Project Access"
- D) QSC's link together partners (as satellites to one another).
- E) Integrated Services Program
- F) "Health Disparity Collaborative".
- G) "Medical Homes"
- H) PACE
- I) Faith-Based Community Health Workers (eg. Liaisons "Promotores").
- J) Pay for Performance measuring system
- K) Integrated Safety Net (eg. Portland).
- L) School based health services.
- M) Create communities where access to healthy foods available (to avoid fast food that leads to obesity/diabetes). More emphasis on preventative health care.
- N) Safety Issues (Police)
- O) Urban Planning that leads to the creation of green/open/play spaces.

III. Program Elements

- A) Northern Virginia Safety Net
- B) Community Liaison (cultural and linguistic familiarity)
- C) Geographically/Logistically Accessible
- D) Eligibility Simplification
- E) No Wrong Door Policy (always point to the right door).
- F) Case Management (get them to the right door the first time). ID potential barriers beforehand.
- G) Flexible hours of operation

CASE MANAGEMENT

Question #1 Challenges:

- not enough primary care physicians/providers
- reimbursement
- case mgrs help primary care practices be more efficient
- Medicaid recipients unreliable so case mgmt helps
- (should incentivize private providers to see Medicaid patients)
- Dentists would see more patients for free IF there were case mgrs
- Now we line up specialists willing to see patients for free but they drop out because of no-shows

Question #3 Elements:

- Need consistency in the education and tasks of case mgrs
- Case mgrs should be culturally competent, provide health education, help with patient compliance, and provide continuity from start to finish for patients
- Need case mgrs to have access to a supervising doctor. Need that in the program design (MB medical backup).
- Could use case mgrs to help new patients complete paperwork needed for enrollment, this expanded role would increase the number of enrollees (follow-up phone calls/meetings after forms given out)

Rotation 2

Question #1 Challenges & Issues

- Some case mgrs are not well-educated and are ignorant of local resources. They try to make assignments that are not local, e.g. specialist in Alexandria for someone living in Warrenton.
- How to define case mgmt – case mgmt vs care mgmt – what does it do?
- Who funds it?
- We find that some case mgrs are managing authorizations, not managing a patient holistically.
- Patients need to be managed holistically, look at all issues. Can't treat the medical condition if the patient has no housing or food.
- Problem that case mgrs are not at the table when resources are being allocated, eg. SLH and its use
- Need a combination of social work and mental health social worker
- Overwhelming problems and needs

Question #2 Best Practices

- Peer programs, health literacy, community programs
- How do we simplify access? Go to more of a community model.
- Need case mgmt working as a team with data and outreach
- Need to make it easy for people to get care, right now we punish them

- Case mgrs need cultural literacy, can't be effective unless get through cultural barriers

Challenges

- How to manage social workers and connecting case mgmt to funding more directly
- Case mgmt collection of complexities but not at table when discussing resources
- Need individual navigators at this point
- Need transparent medical record so plan is clearer, have to have all involved able to see it
- Silos – territorial
- HIPAA was an overreaction, makes life difficult now
- Need transparent medical records accessible to key people – now there is duplication, errors
- Make sure case mgr has knowledge of community resources
- Need medical home for each patient
- Teach people through pictures (photo journalism), or audio, e.g. video of KEFA micro-investment program
- Health literacy needs to be taught by case mgrs, e.g. simplify labels on meds

Rotation 3 Issues

- Expand case mgmt definition
- Need a team for each patient – nurse, social worker, someone who understands Medicaid policy
- Should be best practice all around not to have to ask for EPSDT, EPSDT not effective and takes time – should be automatic chart review to make sure being done
- Many admin processes are nonsensical, Baby First, EPSDT
- Now HAAT team screens for all medical needs/resources
- Which case mgmt are we talking about?
 - Depends on where you are in the health system/safety net
 - Depends on the program
- Problem with Medicaid HMOs who provide case mgmt – just say pay yes/no – act solely as gatekeepers, not really as case mgrs
- Care is more expensive than needs to be because primary care physician has to refer
- Hope for the day the system is working properly and case mgmt not needed. Right now need case mgmt because the system is broken and patients are uneducated about the system/health issues.
- Case mgmt mode vs diagnostic mode
- Need efficiency of case mgmt

DATA COLLECTION

Major Challenges to Health Care Access

Lack of established, uniform definitions: There is no uniformity among definitions or terms that are used in data collection. This lack of uniformity makes it impossible to compare enrollment, utilization or other trends accurately among providers or programs. The participants expressed multiple examples of the problem:

- Example 1: What is an encounter? An “encounter” is defined differently among providers (e.g., Is it a brief interaction by phone or in-person, a scheduled appointment or office visit. If it is an office visit, what type of office visit—acute, extended, etc.). Such variation makes comparison difficult.
- Example 2: Who are the uninsured? Very few organizations collect data accurately on the uninsured. The uninsured are not a uniform group in terms of need, status or length of time uninsured. (The U.S. Census Bureau distinguishes between the uninsured and the underinsured; also measures how long an individual has been uninsured).
- Example 3: What is a new client? Organizations define “new clients” by different time points; some define a new client when a new fiscal year begins, but in effect the client could be a regular user of service.
- Example 4: Misleading provider definitions: DMAS reports that 30% of its providers accept Medicaid patients. However, a provider can make this claim even if he accepts only one patient—a barrier to access.

Reporting Issues: Participants expressed a myriad of issues related to reporting data.

- No requirements to disclose data-There are no requirements to report data hence many do not disclose activity regarding utilization or other forms of data. Again, comparisons are difficult and information is not readily available.
- Data viewed as proprietary- Some organizations (e.g., Virginia Managed Care Organization) are not required and may not voluntarily report their data on enrollment, providers or utilization – they report to the State but not to localities.
- Selective reporting- There are few requirements controlling how an organization reports data. When providers do report, data is often presented in a biased way, leaving out factors that may not reflect positively on the organization’s performance. Techniques such as rounding up percentages present data in a more favorable light.
- Undercounting-There is no way to accurately obtain data on those served who are undocumented; their health care need and utilization may not be fully tracked.
- Overcounting-Persons may be enrolled in more than one public program simultaneously; there is a need to improve the filtering or tracking of individuals enrolled in programs to obtain accurate enrollment.

Language and/or literacy barriers-The populations served often have limited proficiency in English. Providers who develop surveys or collect data do not have information properly translated. Patients may not understand questions therefore data collection may be incomplete or

inaccurate. In addition, the literacy level of many instruments or data collection tools is too high, again limiting its applicability for the population it intends to better understand.

Failure to both define and provide standards of “quality care”-There are definitions of quality care available to providers such as those provided by the American Academy of Pediatrics, Health Care Effectiveness Data and Information Set (HEDIS). However, not all programs or providers utilize these standards; therefore, quality of care may be uneven.

Lack of understanding the need among the client base and implication for planning expanded services-Again, treating the uninsured as a “monolith” is not appropriate. There is a distinction between those at 185% of the federal poverty level and those at 200% in terms of health care, transportation needs and other access issues. On a related point, there are those at the higher end of the income scale who are temporarily uninsured (e.g., two working professionals whose normal income may exceed Fairfax County median suddenly find themselves unemployed and uninsured and use clinic). These populations differ widely in their health care needs and access issues. In general, the lack of uniform data collection makes it difficult to plan for expansion of services.

There is a lack of contact between the “data” teams and outreach teams-There is a disconnect between those that provide data and those who use data to inform practice regarding outreach.

Data collection is fragmented and incomplete for mental and dental health-Providers are not able to systematically collect data on other health needs like mental and/or dental health yet both affect patients’ overall health status.

Quality Practices and Program Elements aimed at Improving Health Care Access

Disseminate and utilize quality indicators of quality medicine. HEDIS is an example, but it is not the only standard of care that can be use. Free clinics in the area may refer to care definitions offered by Virginia Association of Free Clinics. At the Arlington Clinic, they have applied standards comparable to HEDIS. Benchmarks set for pap smears and mammograms and achieved very good results; 100% utilization of Pap smear and mammograms among the low-income population that utilizes the clinic.

- Utilize associations like the Virginia Free Clinics to share and compare data

Strengthen the communication and sharing of information between providers of data and outreach professionals within an organization.

- Establish systems for sharing information.
- Set mid-course markers that should be required to be reviewed by outreach professionals to make mid-course corrections for planning purposes.

- Encourage the data team to provide more “real-time” information as opposed to the lag time traditionally involved in health care data collection.
- Get agreement on what data were using and at what time points to make decisions

When doing surveys on health care access, ensure that you are considering language and literacy levels.

Data collection efforts should be centralized and standardized. “Data lives everywhere, make an effort to consolidate and collect it for a common system.”

- Define the common elements, define the definitions and methodology
- Centralize data collection at the local and federal levels
- Standardize reporting requirements without being overly burdensome
- State could require managed care organizations to provide data on # of enrolled, # of providers, # of encounters.
- Simplify billing procedures
- Reduce claim turnaround time

Develop a standardized electronic record.-This would incorporate and address many of the concerns listed in barriers, it could be automated to make collection more efficient and accurate and allow for quicker analysis and report times.

Consider offering incentives to improve data collection.

- May be expensive
- Apply private sector approaches
- May improve claims turnaround

Increase funding for data collection and provide assistance for IT-These investments will make organizations more cost-effective in the long run.

Use state university partnerships to design and implement a consistent data collection system and conduct analyses.