



*Thought  
Leader  
Perspectives*

# Musings From a Frustrated Human Services Integrator

By Jerry W. Friedman

ONCE HEARD HUMAN SERVICES integration described as an “unnatural act committed by no consenting adults.” While the structural and political barriers to interoperability within a categorical structure can appear daunting, there is emerging interest among policymakers to embrace client-centric strategies to better serve multiple-problem clients and families. But before we can achieve integration nirvana, we must address some practical barriers that are often minimized or overlooked by program planners. Simply put, our theory must comport to our operational reality.

I am soon to embark on my 40th year as a human services worker, much of that time spent as a crusader for service coordination. During that time, I have witnessed great change, including substantial program growth, the creation of umbrella management structures, automation, and the adoption of modern business practices. However, service integration efforts have met largely with unfulfilled expectations — and not for lack of trying. In response to the need for a holistic approach, to reduce costly duplicative procedures, confusing intake processes, poor interagency communication and administrative redundancy, human service administrators have implemented several positive approaches, including:

- **CO-LOCATION:** Housing multiple service providers at the same facility.
- **ADOPTION OF UNIFORM PROCEDURES:** Including forms, budget and planning cycles, and data elements.
- **TEAM CASE PLANNING:** Convening all ser-

vice providers involved in a case for joint staffing.

- **LEAD CASE MANAGEMENT:** A single case manager is assigned from a categorical agency to assume lead responsibility.

While these efforts have brought some improvements, especially in terms of interagency communications, the results have not fully addressed the inherent structural challenges related to an entrenched categorical framework. Most attempts to build a totally integrated system, where all intake and case management services are consolidated under a central organization, have met with only modest results, little public support, staff resistance and questionable transfer potential.

Recent events, however, including the advent of welfare reform, privatization and new technologies (artificial intelligence, remote computing and virtualization, for example), have revitalized interest in the field for greater interoperability and have generated a higher level of innovation and experimentation than at any time previously during my career. I find this to be truly heartening. However, as a cautionary note, I am reminded of the adage that those who fail to learn from history are doomed to repeat it.

In the Eighties I was involved in one of the most aggressive service integration experiments in the country, at the Northampton County (PA) Department of Human Services. All the organizational elements for a successful initiative were in place, including a solid project design, a supportive governance structure with sufficient authority, effective comprehensive planning, consolidated

accounting and client outcome-evaluation system field-tested in four pilot sites, and the use of a common taxonomy. With the exception of today's more favorable public sentiment for interoperability and advances in technology, the same component criteria and infrastructure considered essential now was in place then.

Unfortunately, the project was not considered a success due to a number of factors, including a changing political climate, loss of key personnel, employee resistance, poor public relations and, in some instances, less than stellar project execution. In hindsight, the project was probably over-

sold, which created unrealistic expectations. A review of subsequent efforts throughout the country indicates a consistent pattern of similar challenges that should inform future planning.

Developing an integrated human service system is a noble effort fraught with huge challenges, complexities, risks and probable internal and external resistance. While it is relatively easy to obtain conceptual consensus of the need for interoperability, all the forces of a mature categorical network, including our current governance structure, seem to be working in the opposite direction. In theory and as a modeling exercise, it is easy to

## Don't Forget the 'Human Factor'

**R**EMEMBER THAT THE MOST IMPORTANT ASSET of any human services operation is its workforce, and a successful outcome is directly related to its willingness to embrace change and commit to the effort. Failure to effectively strategize around this "human factor" and address the prevailing agency culture could place the project at great risk. To that end, I've compiled a list of practical considerations that should not be overlooked or minimized by project leadership in the design of an integrated system.

- **DIRECTION SETTING:** Does staff agree on a common definition of who the clients and stakeholders are, their needs, and what success looks like?
- **VALUES AND VISION:** Can staff articulate a clear vision and mission for the organization in integrating services? Can they rationalize the effort?
- **CUSTOMER SERVICE:** Is it generally easy to do business with the agency? Does the agency embrace change or resist it?
- **RISK TAKING:** Is leadership comprised of creative thinkers willing to partner to resolve problems?
- **PERFORMANCE MEASURES:** Can staff produce management reports on customer outcomes across program lines? Is the organization data driven?
- **STAMINA AND STABILITY:** Is leadership willing and able to devise a long-term strategy and stick with it for three to five years. Is it contingent on a charismatic leader and is change survivable? Does the political climate inspire confidence in long-term sustainability?
- **ENVIRONMENTAL SCANNING:** Can "hot buttons" be identified for each affected agency?
- **INFORMATION SYSTEMS:** Do IT staff and end users agree on the effectiveness of systems necessary to support the effort? Is the IT team on board with integrating computer systems to cre-

oversimplify this type of transformation because it is absolutely the right thing to do to better serve people in need. Leadership and commitment are intangible but essential elements.

Despite the challenges, however, the climate for interoperability is probably greater now than at any time during my career. The above considerations, at a minimum, need to be thoroughly vetted and addressed and a charter must be developed to capture the effort's philosophical underpinnings. One thing is clear – there is no quick fix, only hard work ahead. Correspondingly, service integration is not a device to fix a dysfunctional system, but rath-

er a process to enhance service delivery and accountability in a functional system. Personally, I long for the day when service integration becomes a "natural act among consenting adults."

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ate a supportive infrastructure or is it possessive and protective of the categorical applications it previously developed?

- **BUDGET AND FINANCE:** Does the effort reflect an investment strategy? Does it account for the potential for increased service demand with greater access? Will the system be able to routinely produce an unduplicated client count and calculate the total costs per client and family? Is there a uniform account code structure and an approved cost allocation process?
- **TRAINING:** Has leadership accounted for greater cross-discipline training needs? Has it established a rewards system for competence in this area?
- **OVERSIGHT:** Will evaluators and auditors approach their reviews from a conceptual framework of integration, or judge the composite pieces of the system through specific program lenses?
- **ADVOCACY:** Can program advocates see the big picture or will they resist in order to protect their pieces of the pie?
- **COMMUNICATIONS AND MARKETING:** Is a strategy in place to effectively respond to problems identified in an integrated environment that might not surface in a categorical system?
- **WORKFORCE:** Will staff at all levels embrace a sense of stewardship and deviate from a paradigm that generally rewards specialization? How will resistance be addressed? Are labor unions on board?
- **PROJECT MANAGEMENT:** Does the effort embrace professional project management standards with visible leadership support, end user involvement in the design, measurable mileposts, quality measures and a conversion strategy?
- **PERSONNEL MANAGEMENT:** Does the compensation and classification system account for the skills and knowledge required in an integrated system, or is there a differential that favors specialization? Is recruiting designed to seek out potential staff inspired by the opportunity to work in an integrated environment?

# In Race to ‘Meaningful’ Health IT Use, National Privacy Policy Necessary

HITECH’s privacy protections are a start, but consumers require a more cohesive approach to the transparency technology brings.

By *Jone M. Bosworth, JD*

**A**MERICANS HAVE ALWAYS HELD DEAR — as a matter of principle — the right to privacy. As we race toward the national goal of electronic health records (EHRs) for all patients, and health and human service organizations implement strategies to promote greater sharing of consumers’ personal information, no singular issue generates discussion to the extent that privacy does. The tension between consumer mistrust and government priorities is palpable: “I’m worried about how my personal data will be stored and used” and “We have to close the information cracks.” Cracks are most poignantly illuminated in systemic failures ranging from high-profile child abuse deaths to school shootings to sex offenders’ repeat crimes to terrorist attacks.

The government’s desire to better protect us is just one slice of the information-sharing pie. The use of health IT as a mechanism for driving safety, quality, accountability and better human outcomes, called the “vast social project of change management” by National Coordinator for Health IT David Blumenthal, MD, raises urgent questions around privacy rights in this technology era that allows for any and all information to be shared in real time. Nationwide surveys, recent health consumer focus groups and at least one lawsuit<sup>1</sup> to date challenging the IT sections of the 2009 American Recovery and Reinvestment Act (ARRA) as a violation of privacy protections in federal and state laws confirm that managing con-

fidentiality and security remains the “lighting rod” unaddressed gap. Given the federal priority — ambitious timeline, billions of dollars invested — for the “meaningful use” of health IT, can we afford to leave national privacy policy murky?

## Legal Aspects

U.S. privacy laws are intended to protect our dignity and prevent prospective misuse, inaccuracies, embarrassment, stigma or damage to reputation that may come from disclosure of personal information. Long-standing privacy rights have also promoted trust in “privileged” relationships between attorneys and clients, parents and schools, mental health practitioners and clients, doctors and patients. Ostensibly, privacy laws and associated regulations serve as the set of minimum standards prohibiting access to, and use of, our personal information without our consent, balancing individual rights with exceptions considered to be in the public interest.

Public policy exceptions include the authority of judges to determine when compulsion of disclosure may be necessary; in emergency and public health situations; investigations; audits; or to support more effective administration of federal programs created to reach vulnerable persons in achieving safety and economic security. In fact, the federal government actually requires the sharing of confidential information between designated agencies for purposes of administering other

federal programs. For instance, the Social Security Act details permissible information sharing without consent, such as child support enforcement to secure payments for children for whom states make foster care maintenance payments and the sharing of eligibility data between social services and schools to promote children’s access to free/reduced school lunch programs.

Well before the tsunami of health care reform, HHS professionals from field to federal officials, have struggled to achieve clarity around the complex web of privacy and confidentiality laws, seeking replicable strategies to enable cross-silo information sharing. From nonaligned federal privacy laws — HIPPA, FERPA, CAPTA, Social Security Act, and additional protections granted under alcohol/drug treatment and HIV provisions, to the numerous state-specific statutes that afford greater individual privacy rights — HHS leaders have had to devote extensive time and resources prior to taking calculated risks. Decision making opens HHS up to potential civil/monetary penalties, and now, with the Health Information Technology for Economic and Clinical Health (HITECH) Act, risk is increased.

Although policy analysts have called privacy laws “the convenient excuse” for giving up on time-intensive collaborative service delivery efforts that now may be facilitated by technology, there is broad consensus that the analysis of federal laws, regulations and statutes unique to each state is arduous. Infusing legal and regulatory analysis into implementable strategies that si-

multaneously respect consumers’ dignity and promote mission-critical information sharing has resulted in some common approaches for managing confidentiality: uniform, multiparty consent forms; umbrella organization structures; standardized judicial orders; legislation that mandates coordinated services planning; state-level inter-agency agreements or memoranda of understanding; cross-entity data-share agreements; and even “opt in/opt out”-type policies.

**‘As a nation, we remain deeply uncomfortable merely flowing with the torrential tide of technology capabilities and national health IT priorities without also tackling privacy rights issues.’**

## Health IT and EHRs: Consumer Concerns

Consumers, once made aware of the federal government’s health IT plans, express fervent concern about how the privacy of personal health information and the security management employed to protect their confidentiality

will be addressed. In surveys conducted to ascertain Americans’ opinions about health IT, while respondents generally articulated that they thought the use of EHRs would improve the quality of health care and reduce costs, and also might offer advantages such as direct access to records so they could correct mistakes, examine test results and e-mail doctors, nothing evoked stronger reaction than the subject of privacy rights. A 2007 Harris Poll found respondents divided roughly in half when it came to whether the potential benefits of EHRs outweighed privacy concerns. That poll illuminated that 50 percent of respondents felt they’d already lost control of how their personal health information was being used.

In conjunction with the ARRA acceleration toward health IT, the federal Agency for Healthcare



Research and Quality (AHRQ) recently commissioned 20 focus groups around the nation to gauge consumer perspectives.<sup>2</sup> Focus groups representing every geographic region, urban and rural, validated that privacy and security of medical data stimulates the most concern: "Participants consistently had strong feelings about the effect of computers upon the privacy of information," the report said. "With only a few exceptions, this concern is a matter of principle — a feeling that one's medical data is no one else's business."

At the threshold level, participants said individual consent for their data to even be stored electronically is the best approach. And, queries around consumer involvement in privacy policy-setting unearthed that "participants do not have a clear idea about how these policies on getting consent could be set in place, or on how consumers could influence these policies."<sup>3</sup> The juxtaposition is alarming — consumers overwhelmingly want to influence privacy protection policies but have no idea how to go about it. Not surprisingly, researchers concluded that more public education about health IT is needed.

Meanwhile, the Office of the National Coordinator for Health Information Technology attempted a collaborative approach in development of its October 2009 "Consumer Preferences Requirements Document," acknowledging upfront, "The need to protect the privacy of health information and promote security is paramount" and is a "highly sensitive and complex topic" that could require a "national discussion."

Aligned with AHRQ research findings, the ONC notes, "Without appropriate protections, consumers may be less willing to participate in information exchange and the benefits of an electronically enabled health care delivery system may not be fully realized," implying that public

education is critical if health IT investments are to pay off.

The ONC laudably raises but understandably punts on key privacy policy issues, chief of which is whether a national policy or uniform standard to address consumer rights is possible: "These out-of-scope issues may best be handled by laws in particular jurisdictions, policies the entities sending or receiving this information and, in some cases, by the Department of Health and Human Services." The ONC postulates what HHS professionals have lamented and dreamed of — national privacy and confidentiality clarity.

### What the Watchdogs Say

Despite the 17 new privacy protections under ARRA's HITECH Act, privacy rights advocates remark that significant gaps remain: "The new protections do not constitute the comprehensive framework ... that helps break the privacy logjam that has impeded progress on health IT."<sup>4</sup> More specifically, as one health IT network consultant commented recently, "There are only two options. Either you adopt a uniform privacy policy for everyone ... which is not feasible in this country, or each person gets his or her own privacy policy."<sup>5</sup>

The nation's leading health privacy watchdog group, Patient Privacy Rights, provided written testimony to the Health IT Policy Committee, emphasizing that only authentic individual consumer controls and informed choices will meet the national consensus. PPR Chair Deborah Peel, MD, warned that "any industry or government call for a new, one-size-fits-all national privacy policy"<sup>6</sup> would be contrary to Americans' expectations," cautioning that "blanket consents, coerced consents or all-or-nothing policies" that lessen the meaningfulness and intent of privacy laws would be unacceptable to both consumers and physicians.

### 'North Star' Not Enough

The Meaningful Use Workgroup, charged with recommending a defining framework to meet the "north star" vision for a transformed health care delivery system that specifically stresses the use of IT, included as one of five objectives "maintaining privacy and security of systems and data."<sup>7</sup> This vision — in which "all patients are fully engaged in their health care, and providers have real-time access to all medical information and tools to help ensure the quality and safety of the care provided while also affording improved access and elimination of health care disparities" — is inspirational and obviously desirable.

However, in light of the overwhelming consensus that privacy rights remain the most vital unaddressed gap, clear indications that extensive public education is needed and serious doubts as to whether a cogent national policy is possible, is trust in the "north star" for meaningful use sufficient? As a collection of refreshingly commonsensical academicians remind us: "In real life, with any information disclosure there is always some privacy loss."<sup>8</sup> With the overlay of contemporary enabling technologies, what privacy and confidentiality should Americans reasonably expect?

As a nation, we remain deeply uncomfortable merely flowing with the torrential tide of technology capabilities and national health IT priorities without also tackling privacy rights issues. Unless we are willing to accept that the tool (technology) is the master, for the sake of consumers, and health and human service professionals who strive to be increasingly effective and accountable, it is time to launch an outcome-focused dialogue that results in the establishment of a nationally coherent privacy policy that authentically reflects the American principle — the right to privacy.

As we race at breakneck speed toward meaningful health IT use, we must simultaneously address privacy rights in a nationally cohesive way.

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# Stimulating Human Services Interoperability in Health IT

Ultimately, ARRA aims to improve health care quality and accessibility through interoperable technology.

By Rick Friedman

THE STIMULUS BILL enacted last February — the American Recovery and Reinvestment Act of 2009 (ARRA) — touches nearly every aspect of the U.S. economy. Health care and human services are no exception.

ARRA specifically sets aside an unprecedented \$19 billion to drive the use of interoperable technologies by Medicaid and Medicare providers to improve the health and health care of all Americans. Eligible Medicaid providers can receive up to \$63,750 over a six-year period as an incentive to adopt and use certified health information technology (HIT) and electronic medical records to improve patient health and health care. Medicare providers are eligible for sums up to \$44,000 for this same purpose. In addition, qualifying hospitals can receive considerably more, assuming they meet the conditions specified in the accompanying regulation currently under development by the Centers for Medicare and Medicaid Services (CMS).

The *quid pro quo* for these incentive funds is that the providers must use certified HIT technologies in a “meaningful” way to enhance the quality of care and improve health care outcomes. The

specific conditions that constitute “meaningful use” are under discussion and are due to be published by CMS in the form of a draft regulation by year-end 2009 and in final form by spring 2010.

Regardless of how participants eventually work out all the details, it is clear there is significant interest and financial support to move toward an interoperable HIT world. More significantly, the use of HIT and electronic health records is viewed only as a means to an end, not the end in itself. The ultimate goal of the ARRA legislation is to use these interoperable technologies to enhance the quality of care, provide greater opportunities for access, reduce fraud and waste, and improve health care outcomes overall.

## Electronic Data Sharing to Improve Outcomes

While the vendor community has been a strong advocate to “digitize” paper records, Congress has a much broader set of objectives than simply having providers convert patients’ medical records from paper to electronic. Doing so may be a necessary first step in some cases. The key to improving outcomes, however, lies in the electronic sharing of data among those who have a need

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to know in a manner consistent with clients’ privacy and confidentiality rights. This is where the real payoff ultimately lies. The literature is filled with studies showing that duplication of tests, inappropriate dispensing of drugs and failure of multiple providers of care to know about previous health care decisions have all lead to higher costs, lower quality and patient dissatisfaction.

To this end, ARRA established the Office of the National Coordinator for HIT (ONC) to orchestrate the myriad activities associated not only with the adoption of e-health technology but, more importantly, interoperability in the context of meaningful use.

Beyond the previously mentioned incentive funds for Medicaid and Medicare providers, an additional \$2 billion in ARRA has been set aside for ONC grants and loans to spur health information exchange (HIE). Of particular interest to states is ONC’s State Health Information Exchange Cooperative Agreement Program. These grants support states in their efforts to establish HIE capacity among health care providers and hospitals across their jurisdictions beyond Medicaid and Medicare.

Such efforts at the state level will establish and implement appropriate governance, policies and network services within the broader national framework to rapidly build capacity for connectivity among health care providers. The purpose of this program is to continuously improve and expand HIE services to all health care providers and boost the quality and efficiency of health care overall. (See <http://www.healthit.hhs.gov> for details.)

## Put the ‘Human’ Into Health Care

What does any of this have to do with “human services”? Who are these care providers and what opportunities exist for them to participate in the

building of these “on-ramps” to an interoperable world?

Most of us think of health care as different from human services. Even the federal agency in Washington, D.C., that is home to both the ONC and the CMS is called the “U.S. Department of Health and Human Services” (emphasis mine). The way we characterize these services makes it seem as if “health” and “human services” exist in two parallel universes, separate and distinct from one another.

Such an approach may have made sense in an environment driven by an emphasis on which insurer pays the bill. But it makes no sense in our increasingly interdependent, technology-connected world. Distinguishing health from human services means nothing to a sick child enrolled in a foster care program, a WIC mother whose child suffers from an intestinal problem, or an elderly Medicaid client in need of social services.

Foster children as a group, for example, are more at-risk medically than nonfoster children because many in the foster care system have been removed from their homes as a result of abuse or neglect. In addition to increased medical needs, behavioral health problems exhibit early in foster children and often persist through adolescence. Because of these differences, the average total monthly Medicaid health care cost (physical, behavioral, mental) for Texas’ foster children, for instance, is five times higher than for the state’s nonfoster children in Medicaid. Prescription drugs used to treat behavioral health conditions in foster children tend to be more expensive and prescribed for long-term use, contributing further to the increased cost of treating this population — the cost of behavioral care for Texas’ foster children is almost 40 times higher than for the state’s nonfoster children in Medicaid.

Consequently, such children require services not only administered directly by the state Medicaid program but also by state and county public health agencies, mental health and substance abuse agencies, public school programs, the U.S. Department of Agriculture's Women, Infant and Children (WIC) program and the USDA's Supplemental Nutritional Assistance Program (SNAP, or "Food Stamps"), among others.

While reliance on separate sources of program funding has contributed to our failure to view human service clients holistically, the current emphasis on interoperability, enterprise architecture, shared resources, reduced duplication of efforts and costs and, now, the high-tech provisions of ARRA are creating opportunities to work across boundaries in ways many of us had only dreamed of.

Imagine if a health care provider working with a Medicaid foster child in Texas had electronic access not only to its own longitudinal medical records but to those of other health care providers that participate in Medicaid, work for a local school system, receive compensation through a federal, state or foundation's grant mechanism, the Indian Health Service or anywhere else the child has received care, both in state and out. Now we can begin to appreciate the value of interoperability and data-sharing across silos. And why stop with "health care" professionals? Think how much stronger caseworkers' decisions would be if they were not limited to just one small slice of their clients' health records.

#### How Does ARRA Address This Issue?

Both ONC and CMS require every state and territory that wants funding through the State Health Information Exchange Cooperative Agreement Program and the Medicaid provisions in Section

4201 of ARRA (incentive funding to providers) to develop an HIT plan describing its current, "as-is" world (how health care works now), its vision of the "to-be" world (how it pictures health care by 2016), and a "roadmap" that includes measurable "milestones" of progress to achieve that vision. The states and territories must include a broad array of caregivers in their client-centric plans, extending beyond the traditional boundaries and requirements, which tend to focus on who pays for what.

Is there a role for social and human service agencies in this process? Absolutely! As a first step, contact your state Medicaid agency to discuss plans to include human services in its state Medicaid HIT plan. While most offices should be aware of CMS' intent for them to take a broader, client-centric view of Medicaid clients, you may need to contact your CMS regional office to ensure your agency or program has a seat at the table. A plan that fails to recognize the need for a comprehensive, long-term view of how social and human service programs will share data across organizational boundaries with Medicaid and other "health" programs is shortsighted and doesn't adequately address the goals of Medicaid provisions in ARRA.

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## What Business Are We In?

Making the case for a national health and human services business architecture

By Rick Howard

**H**EALTH AND HUMAN SERVICE AGENCIES throughout the country have arrived at a critical decision point — continue doing business as usual or fundamentally transform the way social services are delivered in America. The choice is a stark one, but it seems that in the present economic crisis business as usual simply isn't an option.

The traditional approach of providing government services within program-centric "silos" appears particularly outmoded when efficient and effective delivery of human services to citizens can be realized through the use of modern information and communication technologies.

A wide range of social programs spans the enterprise of health and human services and reflects the breadth of need in a modern society. Each program is designed to address the specific social needs of target populations. Not surprisingly, state human service agencies have come to operate as a collection of discrete programs rather than a set of interrelated services. Moreover, these specific programs are supported by stand-alone, "stovepipe" data systems that contain many of the same functions and business processes.

The symptoms associated with a fragmented information technology infrastructure are familiar: poorly coordinated service delivery, redundant

data, nonstandard and duplicative work processes, increased operating costs, unreliable performance and unpredictable outcomes. Innovation is stifled, and it's difficult to determine how to pay

for what works when information is nonexistent or not readily available.

But it doesn't have to be this way. In the past decade new technologies have emerged, standards have matured and robust architectural frameworks have been developed to the degree that we now have the opportunity to create human service systems that are flexible, accountable and person-centric. Such practices — adopted with great success by the private sector —

reduce overall costs and improve quality with interoperable information systems and shared business processes. Ultimately, better outcomes result and citizen satisfaction increases when service delivery is coordinated and systems of care are connected.

#### Business Blueprint

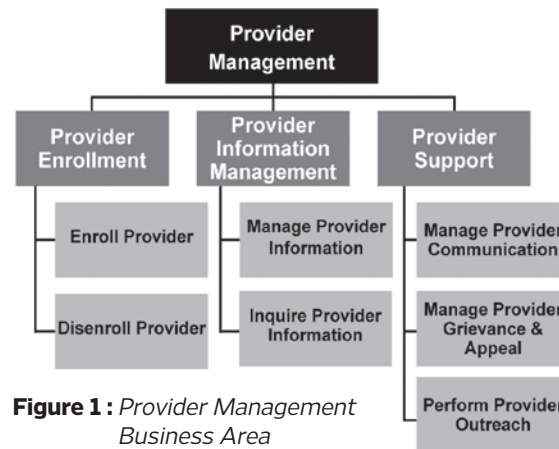
Many states are now working independently to increase interoperability among social programs by identifying common services and processes that can be shared among various business units within and across health and human service agencies. To that end, social program experts and their

The adoption of a national health and human services business architecture will support real transformation in the delivery of social services.

information technology counterparts are developing a “business blueprint” or business architecture for their state agencies. A business architecture is foundational to any modern enterprise. It describes the mission-critical functions and processes of an organization, independent of programs or individual lines of business.

For example, many human services and public health programs issue contracts to individuals and institutions that provide direct care and other services on behalf of the state. The steps needed to establish a provider’s identity and determine that it is authorized to render the services for which it will be paid are remarkably similar from program to program — whether it’s long-term care, behavioral health or foster care. When reduced to a functional level, the “provider management” business area is comprised of processes that can be standardized and shared by many programs; the example in **Figure 1** reflects the value of a business architecture as described in the Medicaid IT Architecture (MITA) framework developed at the Centers for Medicare and Medicaid Services (CMS).

But the value of a business architecture isn’t limited to services within one state agency or even among multiple agencies. In fact, most jurisdictions — federal, state and county — use business processes that can be standardized and shared at all levels of government. Health and human service organizations throughout the nation are, for the most part, in the same line of work. In terms of workflow processes and information needs, the variability from program to program, from state to state, isn’t as great as is widely believed. The differences that do exist often take the form of business rules. These business rules reflect policies that are unique to each state and are stored in a rules engine software application



that applies them to appropriate state-specific programs. In this way, business operations can be standardized and shared throughout the health and human services enterprise while preserving the distinct requirements associated with each program they support.

A national business architecture recognizes that health and human service agencies around the country are essentially in the same business and rely on services or processes that can be readily shared among programs or states. Many benefits are associated with a national model for health and human services (see **sidebar**, next page).

One of the most compelling benefits of a national health and human services business architecture is its role in promoting federal funding reform for state IT systems. The chaotic landscape of state health and human services data systems is the result of the program-centric, categorical nature of funding practices that perpetuate information silos rather than improve interoperability and promote shared services among programs.

Another key benefit of a fully developed architecture for health and human services is its recognition of the two distinct but complementary

business models that distinguish public health from human services. And while public health and human services have different missions, they share common business functions (see **Figure 2**, next page). The MITA framework clearly demonstrates that the Medicaid program bridges public health and human services by establishing functional business requirements that can be shared by both. Medicaid delivers person-centered health care while generating transactional, administrative and clinical information that is used to formulate or evaluate public health policy.

Public health represents a range of programs that are population-based and can be characterized loosely as the “community well-being business.” With an emphasis on prevention and education activities, public health might declare, “We don’t know who you are but you benefit from ser-

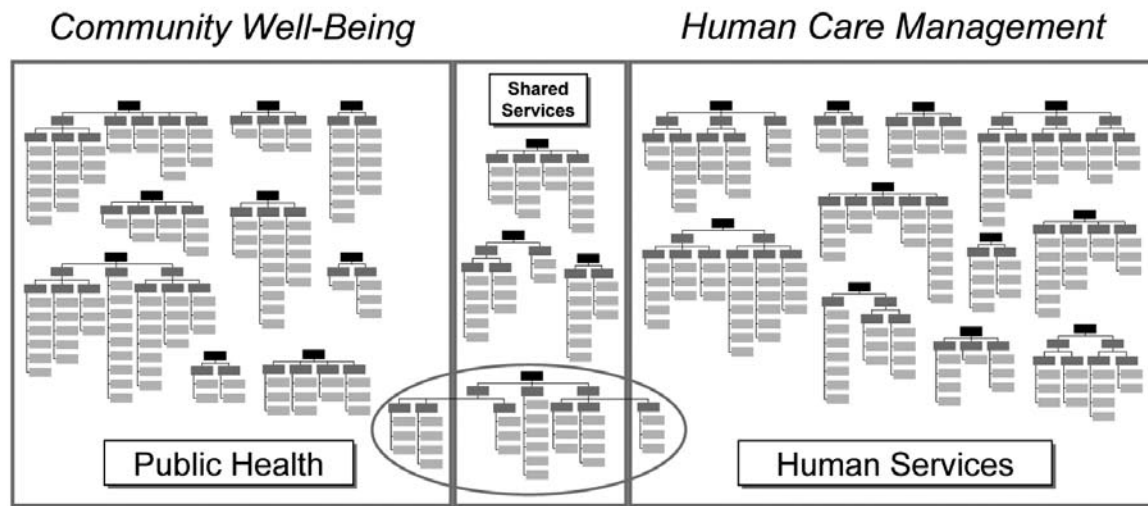
vices like clean drinking water, restaurant inspection, and disease surveillance and reporting.” Human services, on the other hand, are in the “human care management business.” This business model centers on case management services in which intervention and assistance are the means to improve the quality of life for individuals or families. A high-level arc of events describing human services might be: “A person presents with one or more needs, those needs are assessed and resources are applied over time to reduce the level of need or — in the best circumstances — eliminate it altogether.”

So while public health and human services are distinctly different business models, the need to understand the dynamic relationship between them is critical to fulfill their respective missions. For example, it stands to reason if community

## Why We Need a National Health and Human Services Business Architecture

- Increases the effectiveness of social programs by supporting the coordinated delivery of human services to citizens through the use of modern information and communication technologies.
- Accelerates the creation of person-centric, flexible and accountable human service delivery systems.
- Promotes reform of current federal cost allocation methodologies and regulatory practices to incent state investments in interoperable information systems and shared business processes instead of stand-alone, program-specific “stovepipe” data systems.
- Enhances government interoperability as health and human service agencies nationwide adhere to a common architecture and business language that describes the services they provide.
- Connects systems of care and improves service coordination across state agencies, multiple jurisdictions and among states.
- Aligns and harmonizes the public health (the community well-being business) and public assistance/case management (the human care management business) business models.





**Figure 2 :** Two Business Models for Health and Human Services

well-being is bolstered by an effective public health teen pregnancy program at the county level, fewer pregnant teens will require the services of the human care management business. Timely information exchange between public health and human services will increase as we develop an IT infrastructure according to a business architecture that describes both. Most importantly, the clinical data acquired from a regional health information exchange will greatly enhance both public health programs and case management services.

For these reasons and more, the adoption of a national health and human services business architecture will support real transformation in the delivery of social services. By taking this foundational step, the seamless, coordinated and citizen-centric delivery of social services that has been envisioned among policymakers and program administrators for more than a decade will finally be realized.

For more information see the following box:

**"Fixing What's Broken: A Rational Model for Funding State IT"**

<http://www.aphsa.org/Home/Doc/TechnologySpeaks-HowardPPAug09.pdf>

**"Federal Regulatory Reform Needed to Support State IT Modernization Efforts"**

<http://www.nascio.org/advocacy/dcFlyIn/NASCIO-CallforActionRegulatoryReform2009.pdf>

**"A New Model for Human Care Management: Defining the Business of Health and Human Services"**

<http://www.aphsa.org/Home/Doc/NewModelforHumanCareManagement.pdf>

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## Taking Cues From Public Safety: Building an SOA Mobile Records Management System

Service-oriented architecture provides the agility to allow data sharing and accommodate ever-changing rules and processes.

By Marty Elisco

**T**HIRTY YEARS AGO, PUBLIC SAFETY found itself in the same position in which human services finds itself today – completely paper-based in its day-to-day operations. Over the past three decades, electronic records management systems, designed for public safety, have matured to the point at which they can be used by a state or local agency to digitize its records, minimizing operational costs and maximizing officer safety.

Public safety officers are mobile and need reliable access to critical records in the field. Therefore, the unique aspect of public safety records management is that the best systems are designed from the ground up with mobility in mind, to provide officers with access to real-time critical data from desktop computers in the office or mobile devices in the field in any environment, urban or rural.

With respect to data access, it has become evident that the needs of human service caseworkers are similar to the needs of public safety officers, both in the field and in the office. Access to real-time critical data at the point of contact between caseworker and client can help to improve outcomes just as it can help an officer prevent or reduce crime.

Based on these congruent needs, opportunities abound for human service agencies to "borrow" from the advancements of public safety agencies and adopt mobile records management

systems to digitize their records and provide access to caseworkers in the field.

### SOA Foundation for Flexibility

On the front end, from a desktop PC or mobile device, a public safety records management system meets the needs of both officer and caseworker. This congruency can hold true on the back end as well; state-of-the-art public safety records management systems have been designed using the same IT architecture fundamentals that experts recommend for human services systems – most notable, a service-oriented architecture (SOA).

Public safety has adopted SOA for many of the same reasons human services is adopting it. Both need to share data among other agencies, yet can't afford to be cemented to any specific communication method or interface. Likewise, both must be able to update their own systems due to inevitable legal, organizational and business process changes without requiring other connected but unaffected agencies to update their own systems to avoid loss of data continuity, which is possible due to the agility provided by SOA.

In the context of continual change, both need to optimize services using various technologies to maximize client and constituent value. If the homicide division changes its IT system, why should the narcotics division be required to follow suit? If child welfare changes its IT system, why would behavioral health be required to do the same?



### SOA in Action

The fundamentals of SOA can be used all the way from the federal systems down through state systems and finally down to the caseworker holding his or her mobile computing device, accessing records on the fly.

For example, SOA services can be used for mobile-device-to-server communication. A client device communicates with its own internal services, and this client service in turn communicates with the server's services, and the server's services in turn transmit requests to the data warehouse. All data is XML-based and shredded into appropriate tables. The records management server that contains the organization's SQL data warehouse does not accept direct data requests.



A public safety officer is never guaranteed to have a wireless network connection from his or her mobile computing device to the data warehouse — he or she might be in a basement, a rural area or an urban canyon, yet still needs access to data. Therefore, the services on the mobile device are designed to provide data access whether the device is online or offline, storing data on the mobile device only when offline, and using metadata to reconcile differences between client and server data as the client comes back online and synchronization begins. Caseworkers operate in similar environments and could benefit from this same functionality.

Even within the mobile device itself, services are used to take advantage of the peripheral functionality built into the mobile device — photo capture, barcode scanning, GPS, biometrics, voice recording, document capture, printing and more — and incorporate it into the electronic case file. The technology can be used to gather evidence such as the physical condition of a child or facility or simply provide proof that a case visitation occurred. Because the data is captured via services, a client application remains agnostic to the type of mobile device on which it is installed.

From an administrative perspective, the mobile records management system helps facilitate and monitor compliancy and enable data-driven management decisions to be made. For example, a service is used to log every user interaction, significant or insignificant, with data on the system, to enable complete forensic analysis, event reconstruction and compliancy checks pertaining to a case, client or provider, all of which holds up in court if needed. Services also allow for sharing of this data outside of the records management system.

Services also present a graphical interface for users to create customized forms and agency-

specific workflows. In the same way every human services agency is different, every public safety agency is different, and the ability to customize forms and processes is critical.

Agencies can graphically configure forms, user- and role-based security, workflows, organizational structures, thresholds, conditional parameters, reports, dashboards and compliancy checks, all without requiring specialists to code, program or redesign the architecture. SOA effectively enables an agency to quickly become self-sufficient in managing its own system, eliminating the need to procure additional vendor support services. But more importantly, an agency can convert paper forms and processes to electronic forms and processes at its own pace or as policy changes require.

### Easy Does It

Key to the acceptance of any technology by caseworkers is ease of use. Key to this ease

of use is another SOA service that provides a “folder view” window that amalgamates data about a specific client or provider from various systems into a single screen. This “folder view” effectively mimics a client's case file. Technically speaking, the folder shows all the information associated with a specific master index number, and that number can identify a client, caseworker or provider. By mimicking the ergonomics of a case folder, the learning curve associated with moving from paper to electronic data shrinks.

The concept of service-oriented architecture is not limited to electronics. For example, a third-

party provider may not have yet modernized its systems and still requires paper forms. Remaining true to SOA means that even though data may be entered electronically into the system, the system should still print paper forms if needed to support third-party legacy systems.

Just as services are reused between back-end servers, service-oriented architecture client services can be reused in various mobile devices or, more importantly, in the next generation of mobile devices and infrastructure (4G LTE and WiMax networks and devices, for example) that comes to market, achieving increasing economies of scale throughout the technology lifecycle.

### Moving Forward

The successes and best practices of public safety and other government sectors that have modernized their communications systems may provide a path for human service agencies to achieve similar gains in

agency efficiency and client outcomes. Equipping caseworkers with the tools to deliver real-time data about clients during visits, and being able to provide this access in a cost-effective, ergonomic and reliable manner, remains key to achieving these gains.

**Marty Elisco** ([martin.elisco@motorola.com](mailto:martin.elisco@motorola.com)) is the health and human services business lead at Motorola. He is an accredited Six Sigma Green Belt and has degrees in biomedical and electrical engineering from Duke University. He also attends the Kellogg School of Management at Northwestern University.

**‘Even within the mobile device itself, services are used to take advantage of the peripheral functionality built into the mobile device – photo capture, barcode scanning, GPS, biometrics, voice recording, document capture, printing and more.’**

# How Health IT is Improving the 'Medical Home'

The medical home is an essential mechanism for uniting the many segments of a child's care, including primary and specialty medical care, behavioral health, oral health and school programs. Health IT is proving to be a key factor in the creation and function of the medical home, serving to connect physicians, patients and community programs, and creating smooth transitions and, ultimately, improvements in the care of our nation's children.

By Cheryl Austein Casnoff

**T**HE "MEDICAL HOME" CONCEPT, introduced in 1967 by the American Academy of Pediatrics (AAP), was defined as the center of a child's medical records. At that time, the care of children with special health care needs was the primary focus of the medical home. Over time, however, the definition has evolved to reflect changing health care needs and perspectives.<sup>1</sup>

Today, the medical home concept, expanded on its original foundation to serve as a home base for any child's medical and nonmedical care. It is a cultivated partnership among the patient, family and primary provider in cooperation with specialists and community.

In 2007, the AAP joined with the American Academy of Family Physicians (AAFP), the American College of Physicians (ACP) and the American Osteopathic Association (AOA) to form the Joint Principles of the Patient Centered Medical Home. This collaboration developed the following seven principles on which the medical home is based:

1. The personal physician is the first contact and offers continuous and comprehensive care
2. The medical practice is physician directed

3. A "whole person" orientation is used in regard to the patient
4. All care is coordinated and/or integrated
5. Quality and safety are at the center of the concept
6. Access to care is enhanced
7. The medical practice adheres to specific payment guidelines.<sup>2</sup>

As the definition of the medical home has changed to reflect the evolving nature of health care, so have the tools used to create it. The field of health IT is now providing key ways for the medical home to be more connected and more efficient and to ensure patient centeredness.

## Health IT Smooths Transitions

Throughout childhood, children may transition between multiple primary providers and specialists. These shifts may affect all children at some point, but children with special health care needs or those in unique circumstances, such as foster children, experience such transitions more often.

The need for care by multiple providers may also increase as a child transitions into and through adolescence. In adolescence, children de-

velop a greater need for a combination of primary and preventative care. A medical home comprised of a team of various medical professionals, along with additional specialists, such as behavioral health providers and gynecologists, can provide appropriate services to accommodate adolescents' changing needs.<sup>3</sup>

While providers within the medical home can support these adjustments in care, the application of health IT can provide further aid to make for smoother transitions. Health IT can promote communication between primary providers and specialists in the medical home through technologies such as electronic health records (EHRs) and telehealth.<sup>4</sup> Information can also be shared through personal health records (PHRs) between providers and patients and families in order to assist transitions in care.

## Making the Right 'Connections'

Health IT also facilitates coordination, increases efficacy and improves quality of care. The medical home establishes the primary care provider as the first point of care and team leader responsible for the patient's overall well-being. By implement-



ing health IT functionality for scheduling, evaluations and communications, providers can significantly improve access to quality care. And while the medical home can be implemented without health IT, the variety of health IT options available today offers tremendous advantages in keeping the medical home "connected."

EHRs, PHRs, patient portals and telehealth applications, for example, already show great promise for use in the medical home. Functionalities of these tools, such as secure messaging, test-results accessibility and scheduling capabilities, have fostered the vision of the medical home model that provides accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally effective care.<sup>5</sup>

## Increasing Cost-Effectiveness

Health IT has the potential to improve cost-effectiveness, as well. The associated cost of health IT may be a factor that impedes its adoption within medical practices. These costs are not limited to the direct financial aspects of implementing and maintaining health IT systems within a practice. There are also costs associated with the human factors involved in implementing health IT, such as building consensus and changing workflow. Particular challenges may exist for pediatric practices due to special considerations in the use of health IT for the care of children and adolescents, such as growth tracking, pediatric-specific terminology and increased family involvement.

Even with the associated costs of health IT, over time it ultimately has the potential to improve cost-effectiveness in medical practices and to support the medical home. Health IT can reduce duplicate work efforts, improve workflow, reduce errors and allow for a more well-informed care community overall. These efficiency and

safety improvements can enable financial benefits as well.

As stated in the Congressional Budget Office's paper "Evidence on the Costs and Benefits of Health Information Technology," wider adoption of health IT has the potential to generate both internal savings — those captured by the provider or hospital that has implemented health IT — and external savings — money that the patient, another provider or insurance companies can capture.<sup>6</sup>

### Linking Health and Human Services

Health IT can build bridges to allow for cross-sector collaboration. A key component of the medical home model is the creation of links across sectors of child health and well-being, including medical care, behavioral health, schools, child care and other family programs. There is a variety of initiatives emerging to connect health and human service programs providing services to children. Critical to the success of these initiatives is the use of integrated systems to support data sharing and allow for coordinated care that focuses on children and their families and follows the children wherever they are served.



Health IT can connect all information integral to each child's health and well-being while creating an efficient, child-centered environment in which the child can grow and develop. An integrated system also allows for the tracking of the child over time, and the ability to provide essential reports and information on the effectiveness and quality of care to a range of providers, the child and his or her family.

**Cheryl Austein Casnoff** (*Casnoff-Cheryl@norc.org*) has a distinguished career in government, working on health policy and public health topics, including work on Capitol Hill and in several agencies of the Department of Health and Human Services (DHHS). Her experience includes service as Director of the Division of Public Health Policy in the Office of the Assistant Secretary for Planning and Evaluation, the Director of the State Children's Health Insurance Program (SCHIP) at the Centers for Medicare and Medicaid Services (CMS) and most recently as Associate Administrator for Health Information Technology at the Health Resources and Services Administration (HRSA). She was recently appointed a Senior Fellow at the National Opinion Research Center (NORC), working in both Health Care Research and Public Health Research.

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3. Fox H, McManus M, Limb S, Schlitt J. Structuring health care reform to work for adolescents. Issue Brief No. 2. November 2008.
4. Kim G, Lehmann C. The Council on Clinical Information Technology. Pediatric aspects of inpatient health information technology systems. *Pediatrics*. 2008; 122: e1287-e1296.
5. D'Alessandro D, Dosa N. Empowering children and families with information technology. *Archives of Pediatrics and Adolescent Medicine*. 2001; 155:1131-1136
6. Congressional Budget Office. Evidence on the costs and benefits of health information technology. May 2008.

### THOUGHT LEADER PERSPECTIVES

## Expediting Health IT

How states can improve health care delivery under ARRA *now*

*Patricia Richards*

**T**HE AMERICAN RECOVERY and Reinvestment Act (ARRA) of 2009 offers states an impetus to quickly lay the groundwork for a clear strategic path to health care transformation while addressing health care disparities. Working in tandem with all stakeholders, "fueling while in flight" and taking advantage of already invested assets, states can assist Medicaid providers with health information technology (HIT) implementation, expedite their own HIT initiatives and comply with national standards as they improve effectiveness and performance in their health care delivery programs.

### Trends and Dynamics

ARRA and its component, the Health Information Technology for Economic and Clinical Health (HITECH) Act, authorizes some \$36 billion solely for incentive payments to Medicare and Medicaid providers associated with the adoption and use of health information technology. Under Title IV of the Act, with regard to Medicaid, states have access to an additional \$1.1 billion of 90 percent federally matched funds to support their administrative costs for managing the incentive payments.

Through the Office of the National Coordinator, states also have the opportunity to extend the use of electronic health information through automated exchanges between providers; they can access \$300 million in grant programs for which they or their designated entities qualify, and can earn bonus funding to enroll and retain Medicaid recipients. Other funding allocations of up to \$1.5 billion are available to Federally Quali-

fied Health Clinics (FQHC) for infrastructure improvements, including electronic health record (EHR) networks. Further, the bill establishes Regional Extension Centers (REC) that are allocated \$2 billion to assist providers in achieving "meaningful use" of EHRs.

Together, these investments provide the most substantial new funding ever for the purpose of laying the foundation for health care reform, encouraging the propagation of electronic health records and promoting interoperability in the health care industry.

According to the *recovery.gov* Web site, "Most of the Recovery Act funding will go to States, Territories, and Tribes, who will in turn distribute funds through grants, contracts, subsidies, loan programs, etc." over 18 months. States that will benefit most are those that can readily apply these funds to fuel strategic initiatives and jump-start planning efforts. HP believes it is critical for states to immediately establish strong, focused strategic direction and plans to orchestrate the processes governing the provider incentives. This should be aligned with the state's goals of higher quality, efficiency and accountability.

Enabling providers with higher-qualifying patient loads (including acute care, children's and critical access hospitals, pediatricians, and individual physicians and nurses in FQHCs, health clinics and state facilities) to participate as early as possible builds the groundswell. It also rewards those who install and optimize appropriate technologies to electronically capture and exchange health care data. In subsequent stages, by com-



binning the ARRA incentives and the administrative and Health Information Exchange (HIE) implementation funding with other initiatives — such as Medicaid Management Information Systems (MMIS), Medicaid Infrastructure Technology Architecture (MITA) deployment and existing HIE projects — states can facilitate the anticipated architecture of collaboration, health care transformation and performance management.

**State Administration of ARRA HITECH Initiatives**

Below we address the states’ immediate imperatives to maximize the opportunity for program and performance improvement. As outlined in **Table 1**, states have a significant undertaking to quickly and accurately distribute these funds to participating clinical professionals — the largest component in the HITECH portion of the bill. States are mandated to convene public-private partnerships and meet federally stated deadlines. They also must put in place the screening/eligibility and payment procedures to ensure the funds are disbursed equitably. The schedule expectations are aggressive.

A structured State Incentive Program (SIP) that addresses the intent of the ARRA funds while realizing the proposed outcomes is an imperative. Recognizing that the state must establish a program that disburses the allocated funds, ties to existing initiatives and supports its HIE efforts, ARRA includes the following provisions:

- State administration of Medicaid provider incentives
- Competitive state HIT planning and implementation grants
- Loan program, as applicable
- Qualification for future funding

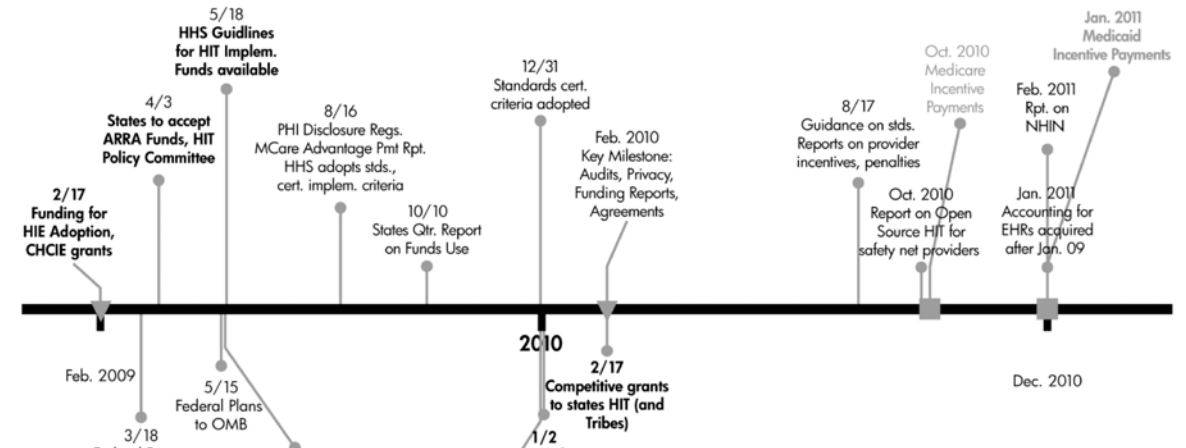
**What States Should Do Now**

States are already eligible to apply for funds. The Information in **Figure 1** (next page) outlines a timetable of events and the states’ suggested milestones for consideration. Important near-term activities to be accomplished include:

- Creating the strategies and plans that will guide administration, organization and structure
- Applying and qualifying for available funding at both the legislative and federal levels

February 2009	ARRA authorization for HITECH funds
April 2009	Begin to apply for funds
May–Dec 2009	Establish governance organizations (stakeholders, criteria, rules)
Fall 2009	Formally receive fund notices, awards Establish strategic plans, support structures Determine methods to establish Medicaid patient threshold Begin collaboration with Regional Centers
October 2009	Report quarterly on the use of funds
December 2009	Begin applying for HIT implementation grants Adopt meaningful use and certified EHR standards
January 2010	Kick off State Incentive Program (SIP) Prepare grant application for state loans to adopt EHRs
February 2010	Apply for competitive state grants on sliding scale for HIT (including Indian Health Services)
Spring 2010	Begin state-wide phased outreach program Conduct technology upgrades, provider screens Establish funding administration processes, allowable cost criteria Achieve CMS approval
October 2010	Medicare Incentive Payment available—no “double dipping”
January 2011	Medicaid Incentive Payment available
2011–2021	Assist qualified Medicaid providers to make meaningful use of EHRs, achieve incentives Measure and make progress against established quality metrics

**Table 1:** ARRA HITECH Initiatives



**Figure 1:** ARRA Timeline — Key Milestones

- Conducting an inventory of existing leverageable assets and engaging with suppliers and other resources

**Following are the key components of the recommended SIP:**

**Policy development and governance:** States need to adopt and apply federal rules to meet higher expectations of program performance, and convene a representative governance board to ensure adherence to federal and state rules. These stakeholders will adopt methods for determining the baselines used to measure progress and resolve issues — for example, net average allowable costs, certified EHR and patient loads.

**Provider outreach and enrollment:** As an inherent part of the incentive administration, states will likely be responsible for ongoing communication to eligible professionals to meet federal certification requirements. Critical components of a

communication plan are eligibility disclosure, duplicate eligibility considerations (Medicaid versus Medicare), timing of and windows for payment, costs and return on investment. Existing enrollment systems and processes can be modified for this purpose. States can more easily adapt to accommodate the new requirements by reusing the existing framework and modifying the in-place provider eligibility processes.

**Provider certification and enrollment:** States must be prepared to carefully select, certify and enroll or re-enroll program participants throughout the next seven years. Understanding the enrollment guidelines, the “window” of opportunity and the penalties (where applicable), and automating the processes to reduce disruption to eligible professionals, are important components of the program and the state’s responsibility. Systems must be in place to document all activity, including screenings, file changes, waivers, eligibil-

ity approvals, patient load variances and the like. Those who do not implement a “certified system” face severe penalties against Medicare reimbursements (analysts estimate \$3.2 million for a typical 500-bed hospital).

**Beneficiary outreach and enrollment:** Public campaigns to drive awareness and build program enrollment among the targeted patient population will follow the implementation of the “certified EHR” and provider training. Outreach can be designed to facilitate re-application, perhaps highlighting those who meet certain criteria, such as eligibility set to expire within 30 days. Existing Medicaid site offices, community centers, health fairs and other venues may be used.

**Technical resources and support:** States must offer the right level of technical resources to ensure that qualified providers enroll in the program, meet requirements and receive the incentive payments for which they are eligible. Providers will likely look to the state first, as it will take some time for the RECs to be established. From a technology perspective, this indicates the need for support resources to assist providers with the following:

- > Help desk services and an assistance team to help providers and their staffs
- > Best practices for application selection, certified technologies or options of meeting meaningful-use criteria while limiting capital outlay
- > State and federal sources of assistance
- > Loan program details, where appropriate
- > Technology assistance to address issues of usability, ease of integration, and support availability

**Payment administration:** Providers may receive incentives until 2021. The states’ oversight will in-

clude fiscal arrangements for qualification, disbursement, audit and accountability in managing provider payments. Existing MMIS systems may be modified using FFP funding to allow for these payments, and to ensure that maximum limits are not exceeded. Payments will be made on a quarterly or annual basis; either approach can be accommodated in current MMIS payment systems.

**Audits and verification:** The states can validate their programs’ by drawing on the existing fiscal agent staffs and using surveys, re-enrollment, and desk and field audits. The states can anticipate either random or risk profiling to confirm use according to the established criteria.

**Analysis and reporting:** ARRA funding is foundational to achieving informatics goals and required milestones for reporting program achievements aligned to the planning, policy and governance established early on. The data aggregation from EHR and MMIS systems can be used to provide periodic reports that highlight key success metrics, build lessons learned and measure public policy, social and economic impacts. Examples include number of participants, characteristics, impact on cost and quality, and enterprisewide comparisons between participating and nonparticipating physicians.

**Regional Extension Center collaboration:** States may also be called upon to assist the RECs, which may not have all the resources necessary for their extension role. States may need to collaborate by using existing infrastructure, staffing, supplier alliances and other capabilities in areas such as outreach and enrollment, training, ongoing technology support and vendor selection.

#### **Time Is of the Essence**

States now have an enormous opportunity to drive significant momentum toward better, more

targeted quality in health care coordination and delivery. The strategic imperatives are clear: Lay the groundwork in policy and infrastructure, help providers qualify for incentives, and extend health information exchange initiatives and patient enrollment — ameliorate care disparities. States will have to move in advance of key federal decisions to convene governance structures, prepare training and outreach efforts, and set up payment processes, as well as collaborate with the RECs.

A coordinated State Incentive Administrative program — appropriately planned and executed to expedite EHR installations, certification and payment for Medicaid providers — can extend the states’ investments in pre-invested people, process and technology resources. States can quickly

leverage these assets and resources to accelerate progress, setting up policy and governance oversight, eligibility, reporting, loan and contracts management, disclosure and outcomes tracking, and technology remediation. Taking action on priority items immediately, while fine-tuning the roadmap in flight, will help states meet the aggressive schedule, comply with policy and standards expectations, and improving quality and efficiency of their health care programs.

**Patricia Richards, MM, eMBA, is a director for U.S. eHealth Strategies in the HP Enterprise Services Global Healthcare Industry group. She is responsible for crafting eHealth services and solutions aimed at reducing the cost of care while improving quality and access.**

#### **For More Information**

- <http://www.recovery.gov/>
- <http://www.cms.hhs.gov/Recovery/>
- **H.R.1 (2009)—American Recovery and Reinvestment Act of 2009**, [http://www.rules.house.gov/111/LegText/111\\_hr1\\_text.pdf](http://www.rules.house.gov/111/LegText/111_hr1_text.pdf)
- **Congressional Budget Office (2009). Review of the Conference Agreement for H.R.1, the American Recovery and Reinvestment Act of 2009**, <http://www.cbo.gov/ftpdocs/99xx/doc9989/hr1conference.pdf>
- **Library of Congress (2009). Text of Legislation**, <http://thomas.loc.gov/cgi-bin/bdquery/z?d111:H.R.1>
- **HIT Policy Committee Meeting Minutes, June 16, 2009**
- **Department of Health and Human Services, Office of the Secretary (2009) HITECH Act Guidance**
- **Department of Health and Human Services, Office of the National Coordinator on Health Information Technology, Health Information Technology Expansion Program (May 29, 1009), Federal Register, Vol. 74. No. 101**
- **CMS Office of Public Affairs (June 16, 2009), Medicare and Medicaid Health Information Technology: Title IV of the American Recovery and Reinvestment Act**
- **HIT Policy Committee (June 15, 2009). Meaningful Use Matrix**
- **Health Outcomes Policy Priorities**, [http://healthit.hhs.gov/portal/server.pt/gatewayPTARGS\\_0\\_11113\\_872719\\_0\\_0\\_18/Meaningful%20Use%20Matrix.pdf](http://healthit.hhs.gov/portal/server.pt/gatewayPTARGS_0_11113_872719_0_0_18/Meaningful%20Use%20Matrix.pdf)

# Social Services Get Smart

Intelligent processing means faster, more efficient systems.

By Martin Duggan

**S**Ocial service systems have developed over many years with a strong transactional focus: A consumer makes a claim for benefits, the organization checks the claim for accuracy, conducts assessments, collects evidence, applies benefit rules to determine eligibility and entitlement and, if the claim is valid, makes a payment. At regular intervals, the agency tests for ongoing eligibility (see **Figure 1**).

This basic process applies across nearly all benefit types — disability, unemployment, welfare... in fact, any program involving money paid to a client or third party, such as an elderly person's housing allowance or a grant to a remedial education program. It is tried and tested and used in just about every social system today.

## Client Disservice

Benjamin Franklin is quoted as saying: "There is no kind of dishonesty into which otherwise good people more easily and frequently fall than that of defrauding the government." Indeed, it shouldn't be surprising that, over time, government agencies have had to put various checks and balances in place at each stage of the eligibility process in an attempt to prevent system fraud. And with time, the sophistication of the fraud mechanisms and the comprehensiveness of the corresponding defenses have increased to the point at which, in most social service systems, every person applying for a benefit is assumed to be doing so with criminal intent.

The same, basic information is collected, checked

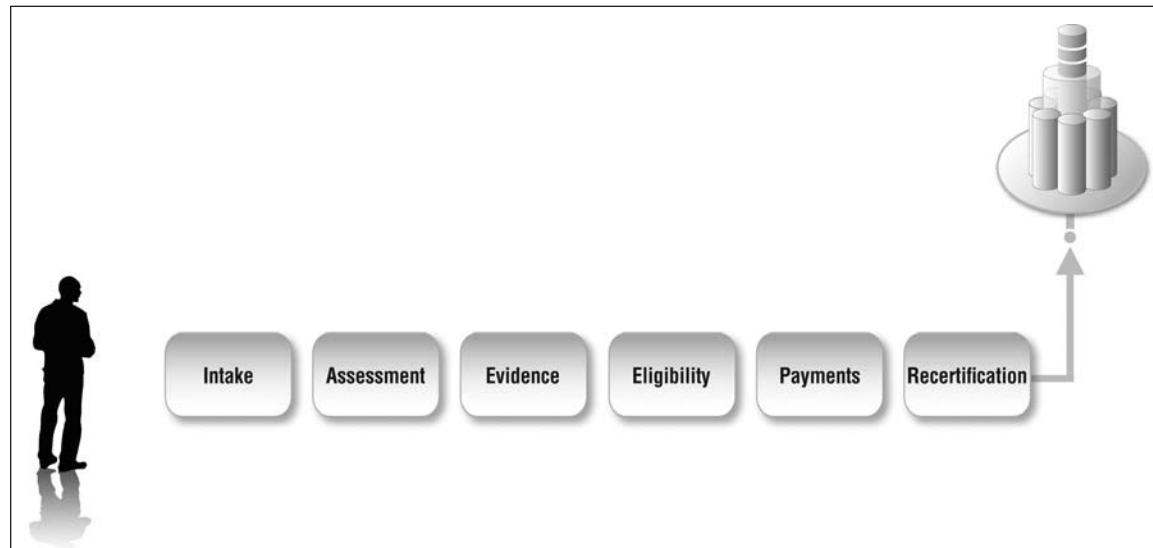


Figure 1: Basic Claims Process

and rechecked so often that what was once a simple process in the United States and most other countries has become burdensome, complicated and costly. In some cases, in fact, the complexity of the controls creates a disincentive to applying for those entitled to benefits. The problem: All clients are treated as high-risk — all are assumed to be trying to game the system.

Several countries, though, have recognized that treating all clients as potential criminals is not the best approach. These countries, which include the United States, Canada and Australia, apply intelligence to their social service claims processing, taking each individual's circumstances into account. Every claim is analyzed against existing data, using external input — data from other agen-

cies — where legal and appropriate. By comparing a claim with previously collected information, the agency may determine eligibility or payment level based on a lower "risk rating" (see **Figure 2**) and therefore a lower threshold of evidence and lower costs overall.

The US Social Security Administration uses intelligent processing to screen Disability claims, for example. Original claims are fast-tracked if they appear likely to succeed based on initial assessment. SSA also applies intelligence to its Disability recertification program, called Continuing Disability Reviews (CDRs). Instead of insisting that all claimants undergo Full Medical Reviews (FMRs), those likely to remain eligible for Disability payments are sent a mailer for a less extensive

**Several countries have recognized that treating all clients as potential criminals is not the best approach to the claims process.**

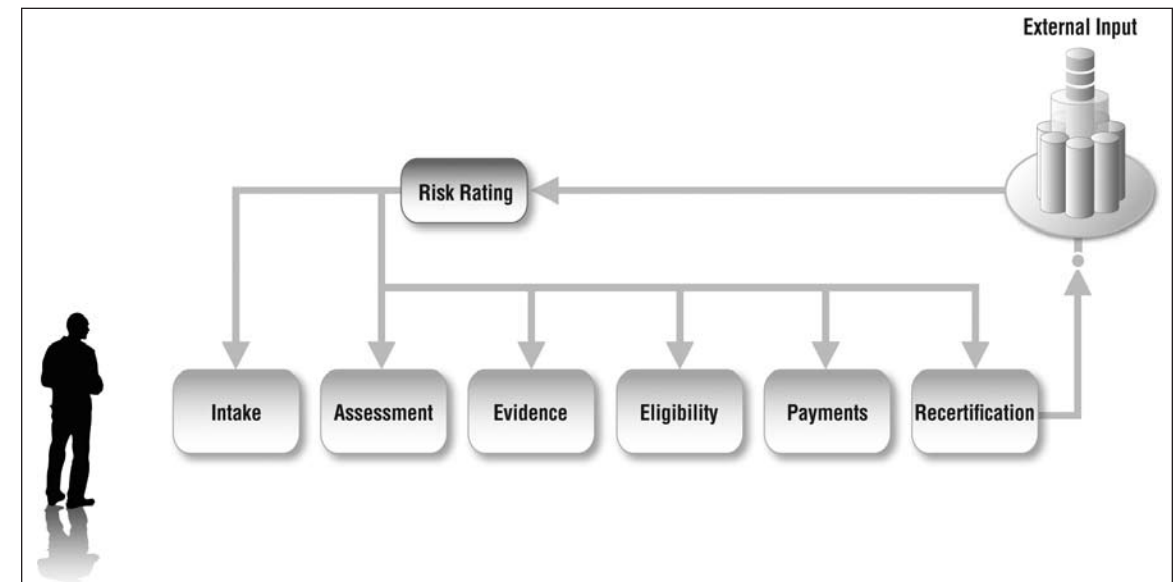


Figure 2: Intelligent Claims Process



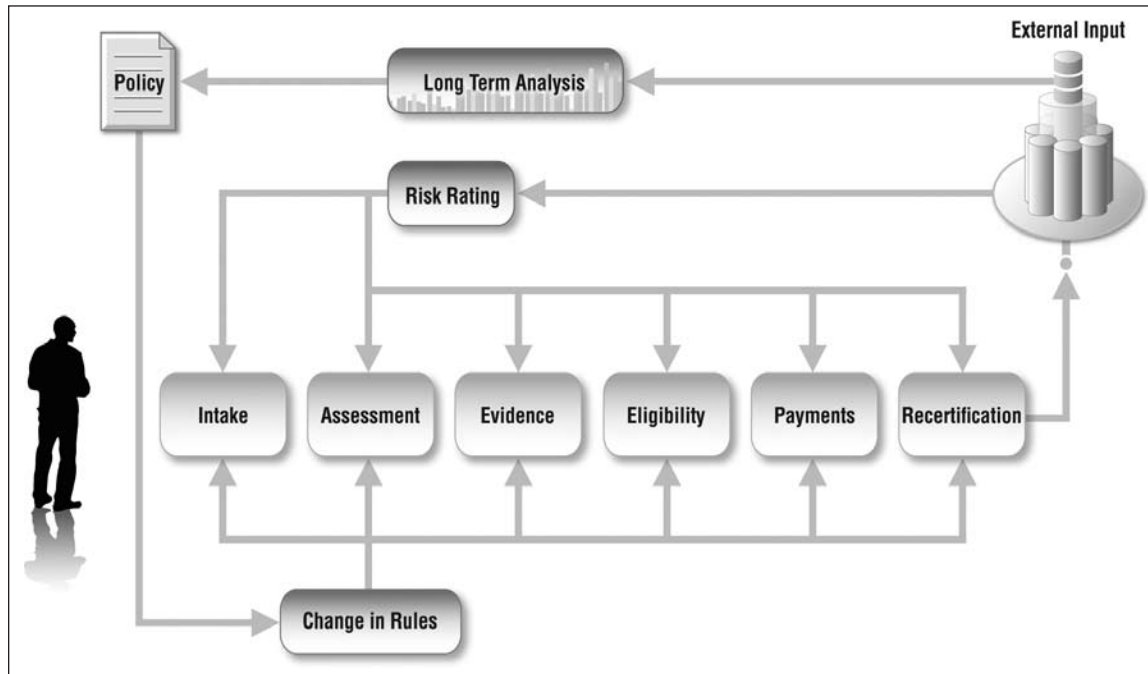
assessment. This process saves SSA hundreds of millions of dollars a year.

Intelligence can be applied at all levels of a claims process (see **Figure 3**). Initially it looks to relax the controls for low-risk claimants, saving client time and frustration and saving organizational overhead. Long-term, it can be applied to the policy itself. In the case of a terminally ill client claiming Disability benefits, for instance, rules are applied to fast-track both the initial application and ongoing claims.

“In practical terms,” said SSA Commissioner Michael Astrue, “this means that in 2009, 100,000 to 125,000 disabled Americans—those with the most severe disabilities — will be approved for benefits in about 10 days instead of waiting the 3 to 4 months it typically takes for an initial decision.”

IBM believes that static legacy social service systems must be made dynamic by adoption of intelligent processing principles and practices. Focusing resources on the riskiest parts of the eligibility process and applying previously collected information where appropriate to relax the controls on low-risk claimants, who form the majority, will result in faster, more efficient decisions that benefit both the organization and its clients.

**Martin Duggan** cofounded the IBM Global Social Segment and leads its research and development activities. He has published numerous books and papers on innovation topics relevant to social services and social security organizations and has recently worked on social transformation programs in the United States, Canada and Australia.



**Figure 3:** Smarter Processing

THOUGHT LEADER PERSPECTIVES

# Continuity of Care: Inherently Geographic

Location plays a crucial but often overlooked role in health and human service outcomes.

By Bill Davenhall

**C**ONTINUITY OF CARE is a long sought-after ideal among health and human service professionals. The concept has many friends, including patient-centric care, continuum of care, service integration, client tracking and whole-patient perspective.

In a monumental step toward making the electronic health record a reality, the passage of the recent Health Information Technology for Economic and Clinical Health (HITECH) Act has created a surprise opportunity to refocus our efforts on why our nation, or for that matter any nation, would want to invest in continuity of care. The electronic health record without continuity of care is nothing more than interesting information.

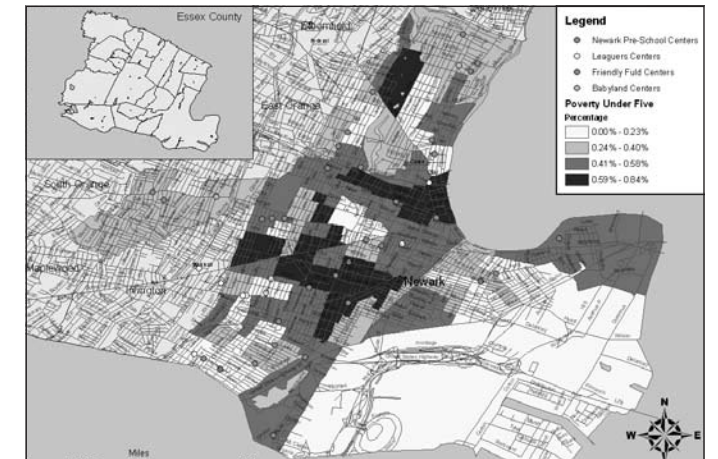
Recently, National Coordinator for Health IT David Blumenthal, MD, restated a notion he believes absolutely necessary for the electronic health record to work: “Information should follow the patient, and artificial obstacles — technical, business-related, bureaucratic — should not get in the way.

“As a doctor,” he continued, “I have many times wanted access to data that I knew were buried in the computers or paper records of another health system across town. Neither my care nor my patients were well served in those instances. That is what we must get beyond. That is the goal we will pursue,

and it will inform all our policy choices now and going forward. This means that information exchange must cross institutional and business boundaries. Because that is what patients need.”

Former Wyoming Governor Jim Geringer, now ESRI’s director of public policy, has a saying that seems appropriate here: “Everything happens somewhere.” To that I would add that continuity of care should happen everywhere.

So what does geography have to do with continuity of care? Think location instead of geography. Location is nothing more than a different way to express a geographic feature — like “place.” When we tell our friends to “come over to my place,” we are using geography. The person who



**Children in Poverty:** Under age 5 population density in Newark, NJ

knows where our house is relies on geographic information (directions) to get there. When we send patients or clients on a referral, we typically refer to geographic information to get them there. This information may be in verbal, written or electronic form, but it's all based on geography. When we are comparing the efficacy of a health or human service, we typically compare geographies such as states, counties, zip codes, census tracts and so on. In the delivery of any service, geography is an intrinsic and essential attribute that complements the associated clinical, social and administrative information.

Continuity of care requires a diligent approach to information management. Data must be interoperable, meaning it will flow seamlessly, and it must be semantically interoperable, so it means the same thing both technically and literally, at every point along the continuum. You cannot have continuity of care if any of your information, regardless of origin, is not connected. That would simply defeat the value of trying to make care continuous.

### Putting Care in Context

The idea of geography carries with it something else — context. Where one lives, works or is being cared for has as a backdrop the cultural, social, economic and physical “environment” in which care will be delivered. Geographic information, such as the patient’s or client’s “place history,” must be a piece of the larger puzzle. Measuring

outcomes that are solely dependent on clinical and social interventions without reference to the underlying context — geography, or the client’s “place history” — will not allow accurate comparative evaluative research to support public policy.

To illustrate this point, consider the placement of children in foster or adoptive homes. A great deal of deliberation will go into the selection of surrogate parents based on a wide range of factors directly relevant to the household. The success of that placement will also depend on the geography in which the child is being placed — including such things as the quality of the neighborhood, distance to schools and social services, and access to fresh fruits and vegetables, while also considering proximity to disrupters, such as sexual predators, liquor stores and so on. Some of these factors may even weigh more heavily in the outcomes than the cohesiveness of the family unit into which children will be placed.

This is not new information for case managers; in fact, the case management systems already in place typically seek this more comprehensive environmental scan. The problem with the information tools most organizations still use is that they don’t scale well in light of rising caseloads, diminishing ranks of caseworkers, and shrinking budgets for information resources to deliver on the promise of continuity of care.

In the early Eighties, I participated in a unique demonstration project sponsored by the US Department of Health and Human Services. The aim

**‘Measuring outcomes that are solely dependent on clinical and social interventions without reference to the underlying context — geography, or the client’s “place history” — will not allow accurate comparative evaluative research to support public policy.’**

was to build an information system that would “guarantee” delivery of social services through a seven-county metropolitan southern city. It lasted about 10 years and led to some useful ideas for how continuity of care could be managed and evaluated. It was not easy in those days without low-cost computing and modern portable data-collection systems — but nonetheless, it drove home some important points:

- There are many valid reasons for service duplication in any community — it’s not intentional, but it’s a reality.
- There can be many sponsors of what appear to be duplicative services. Clients and patients do not always make the determination of what is “official” and what is not.
- There is no substitute for a comprehensive inventory of accurately, geographically located services offered within a community. This means you must use a common vocabulary to define the services so you’re actually comparing apples with apples.
- Client tracking is complex and fraught with a lack of organizational resources that al-

low “fact checking.” Is this the same client or a different client with a similar name? Has this client been to other service sites, is he or she receiving services, and if so, which ones, where? Is there any way we can determine where the client is across the vast community network of service providers? Can we get service providers to sign digital receipts that a client received the services for which they were referred there? Having a way to prove the whereabouts of a client or patient is essential if continuity of care is to be delivered.

- Many barriers were artificially imposed on delivering that continuity, including governmental policies; program rules imposed by funding sources such as federal entitlement programs, privacy and confidentiality laws; and agency-imposed business rules.

### Making Patients the Priority

Suffice to say, these problems became insurmountable because the client was not at the center of the information “train wreck.” As sad as it is to report, the project discovered that the “system” was unable to assure that clients actually received and benefited from the care for which the various agencies and funders had hoped. While we have vastly improved our information capacities across all health and human services, we still face major challenges in delivering on the promise of continuous care.

As David Blumenthal so succinctly put it, the patient is at the center of all this, and without the patient’s interest in our plans, information system enhancements are meaningless. Many innovations will be required to make this work, but in the meantime, we must be sure to include relevant information in our decision points that accurately



portray all aspects of a client's situation — physical, social, environmental — as we make investments in the continuity of care. Information systems that get caseworkers closer to understanding their clients' time-sensitive reality — where clients have been, who has done what for them, and where they need to go next — are within our grasp and our budgets. Now we must commit to enabling continuity of care in its fullest sense.

Until the client is at the center of our work and at the apex of agencies that fund efforts to improve the health and well-being of those we serve, we cannot get to continuity of care easily, and we certainly cannot expect to make a big difference

in the lives of those we serve. Working toward delivering on the promise of continuity of care should be our highest priority.

**Bill Davenhall** ([bdavenhall@esri.com](mailto:bdavenhall@esri.com)) is an internationally recognized expert in the application and use of geographic information systems. His experience in health and human services spans nearly four decades and includes executive leadership of hospitals, health and social service research organizations, and private technology companies. He holds a Master's degree and was the recipient of a National Institutes of Mental Health traineeship in conjunction with his work at the University of Kentucky Medical Center.

## THOUGHT LEADER PERSPECTIVES

# Effective Interoperability Planning Requires Targeted Business Process Review

By Abhijit Verekar with Simeon Ivanov, Leslaw Janus and David Chege

**W**ITH HEALTH AND HUMAN SERVICE organizations facing intense resource constraints even as they try to improve life-critical service delivery to their communities' neediest citizens, it is paramount for health and human service administrators to develop innovative ways to harness the power of people, processes and technology to implement true InterOptimability™. One of the crucial steps along this journey — toward achievement of a holistic, interoperable vision — is HHS organizations' development of an understanding of their internal business processes. Only through a detailed study of these processes can we identify potential impediments to achievement of their interoperable vision.

In this article, we illustrate the comprehensive

approach used to discover, document and analyze the "as-is" state of the Montgomery County Department of Health and Human Services (DHHS), MD, and the Montgomery County Human Services Administration (HSA), PA. RNR Consulting and Stewards of Change documented and analyzed select "as-is" business processes at these organizations as an early step toward identifying InterOptimability opportunities through information portability.

Our project team applied proven industry best practices to analyze a combined total of 27 business processes from programs including Child Intake, Child Placement, Drug and Alcohol, Medical Assistance Eligibility, Integrated Case Management, Mental Health and Rental Assistance. The

project team captured workflow, data flow and information exchange (paper-based and electronic) from internal (programs, offices and departments) and external (federal, state and local administrators, vendors and service providers) stakeholders related to key businesses processes. This approach ensured a comprehensive discovery and analysis of key process gaps and redundancies, including areas of data duplication, identifying avenues to improve processes as well as opportunities to eliminate data silos.

### Maintaining Client Focus

Additionally, by highlighting bottlenecks and areas of overlap, our analysis revealed that a significant amount of staff time is spent on administrative tasks rather than on client interaction. For instance, during the eligibility determination process for human services programs, caseworkers must access several systems and paper records to obtain client information. This takes the caseworker's focus off core social work to administrative and clerical tasks. Similar fragmentation in other processes also revealed areas where significant cost savings, efficiencies and synergies could be realized through the elimination of information silos and increased information sharing.

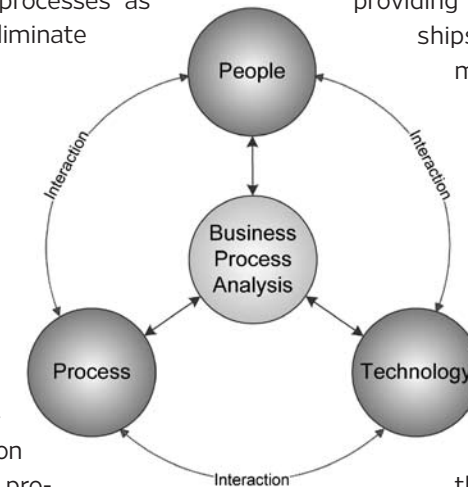
Such outcomes from our "as-is" business process analyses in both counties served as inputs for InterOptimability assessment deliverables including organizational readiness, IT architecture and confidentiality evaluations.

In addition to understanding the intricacies of

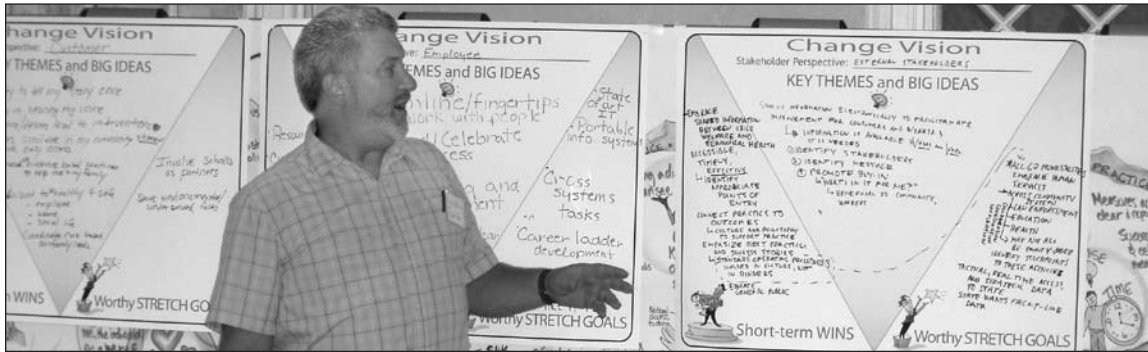
the "as-is" business processes, it is critical to comprehend the social fabric of the organization within which these processes are executed. This provides insight into the inner workings of the organization and the interaction — or potential interaction — of its programs. Our approach to understanding the organization's "as-is" state includes a graphical representation of the interplay among stakeholders and their social networks, providing insight into types of relationships, such as formal versus informal, frequent versus infrequent and strong versus weak; it also provides a layer of detail that complements "as-is" business process analysis deliverables with a big-picture view.

As part of the InterOptimability process, health and human service administrations can articulate the desired "to-be" future state of their organizations through visioning sessions and development of organizational vision landscapes. An in-depth understanding of the status quo through the development of process maps, stakeholder maps and social network maps serves as an essential starting point to bridging the gaps between the organizations' existing and future states.

Through continued business process assessments of health and human service programs at the DHHS, MD, and the HSA, PA, the project team continues to develop unique approaches to understanding the "as-is" state of such organizations and identifying impediments to change. Information is gleaned from firsthand interviews and observation of subject-matter experts — casework-







**The InterOptimability™ Process in Progress:** Working toward a holistic, interoperable vision

ers, supervisors, managers — to capture and graphically illustrate the overall environment and the manner in which work is performed.

Followup validation analysis of the documented process maps with process stakeholders and project partners allows for well-founded discussions about each organization’s strategic goals and action steps. This bottom-up approach produces essential grass-roots information to help steer the organization toward its vision and strategic goals.

Thus, “as-is” business process analysis continues to serve as a window into the interaction among the organization’s people, processes and technologies. At the overall project level, output from the “as-is” business process analysis deliverables (swimlane process maps, stakeholder maps, social network maps and narratives, for example) is useful as input toward further targeted InterOptimability assessments.

**Identifying and Eliminating Obstacles**

What’s more, health and human service organizations operate under a plethora of federal, state and local legislations in unique cultural environments. But conducting business process assessments in such distinct organizations brings to

light that, despite such widely varied regulations and settings, HHS programs and their underlying business processes inherently suffer from common impediments to change and to the achievement of InterOptimability. Business process analysis enables identification and understanding of those common roadblocks and reveals opportunities for enhanced efficiencies and technology usage, paving the road for better service delivery to needy consumers.

As we continue our journey to bring entrepreneurial best practices to public sector health and human service organizations, “as-is” business process analysis continually proves to be one of the most critical and rewarding steps toward an interoperable continuum of care. (See SOC’s “*InterOptimability™ Handbook*” for a guide through each step of the InterOptimability process.)

**Abhijit Verekar** ([averekar@rnrconsulting.com](mailto:averekar@rnrconsulting.com)) is a senior manager at RNR Consulting, a Cleveland-based management consulting firm focusing on city and county government. Verekar leads the company’s health and human services projects. He and his team have worked closely with SOC on InterOptimability initiatives in Montgomery County, MD, and Montgomery County, PA.

# Disconnected Data Means Disconnected Youth

Fragmented programs and policies are failing our children and youth.

By Thaddeus Ferber

**T**HE AMERICAN DREAM, IN WHICH our children grow up to do better than their parents, is fading for millions.

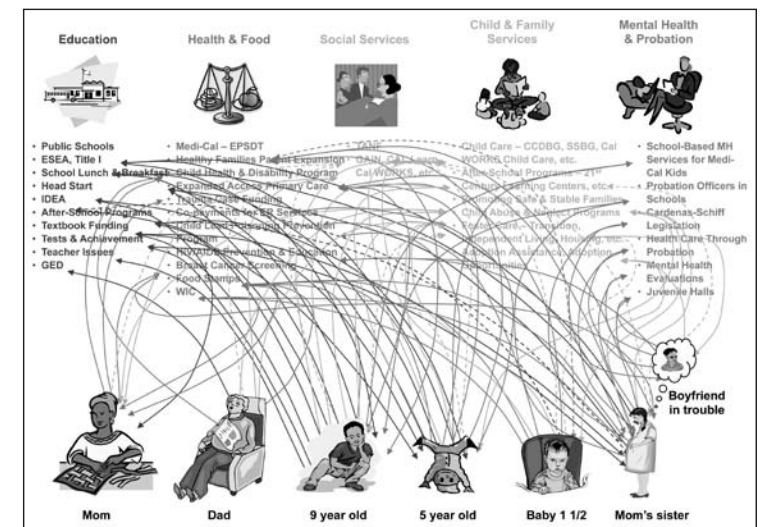
Much of this failure stems not only from an absence of vital funding and resources, but also from a severely fractured federal framework. In 2003, the White House Taskforce for Disadvantaged Youth identified 339 isolated, unaligned federal programs to serve young people run by 12 separate departments, and concluded “the complexity of the problems faced by disadvantaged youth is matched only by the complexity of the traditional federal response to those problems. Both are confusing, complicated and costly.”

This fragmentation is replicated on the state and local levels. **Figure 1** (courtesy of George Washington University and the Los Angeles County Children’s Planning Council) depicts the actual fragmented array of programs administered by Los Angeles County, CA. A similar picture could be drawn for other counties, cities and states nationwide.

As a result — despite the best of intentions and the most capable educators, health care and social service providers — the federal, state and local government is providing fragmented supports when we need comprehensive solutions. One child finds educational servic-

es but not the mentoring needed to make sense of his lessons. Another receives life-saving medical care but misses out on the supplemental assistance she needs to prevent further complications. Other children find foster care but not health care, shelter without education, counseling yet no adult supervision. These cases are tragically repeated, in every corner of the country, millions of times over.

Fragmented data systems result in wasted resources; we are letting young people fall through the cracks. If we don’t provide our policy makers the information they need to see how fragmented programs and policies could fit together, and if we don’t provide our direct service providers the in-



**Figure 1:** Child and Youth Services in Los Angeles

formation they need to see a complete picture of their clients' needs and available supports, we will continue to fail our young people.

Fragmented data systems waste government resources – that alone should be a compelling enough reason to act. But the greatest waste of all is the young lives shattered by missed warning signs, missed connections and lost opportunities to intercede. This is why it is deplorable that child and youth data is every bit as fragmented as our child and youth policies and programs.

Here is a small sampling of fragmented federal efforts under way to create data systems with child and youth information:

- **Head Start** allocates \$100 million to State Advisory Councils on Early Childhood Education and Care, which must “develop recommendations for a unified data collection system for public early childhood programs and services”
- **McKinney-Vento Homeless Assistance Act** (\$70 million) requires local education agencies to “collect and disseminate data and information regarding the number and location of homeless children and youth, the education and related services such



children and youths receive, and the extent to which the needs of homeless children and youth are being met”

- **The National Youth in Transition Database (NYTD)** will collect case-level information on youth in care, including the services paid for or provided by the state agencies that administer the Chafee Foster Care Independence Program (CFCIP), as well as the outcome information on youth who are in or have aged out of foster care
- **The Workforce Data Quality Initiative** (\$15 million) will “provide competitive grants to support the development of longitudinal data systems that integrate education and workforce data”
- And the list goes on ... and on ... and on.

In the American Recovery and Reinvestment Act (ARRA) alone multiple funding streams were created for disparate efforts to develop data systems that contain information about children and youth. For example, the Department of Education is providing \$245 million for “statewide, longitudinal data systems to improve student achievement,” while the Centers for Medicare & Medicaid Services was appropriated \$140 million a year for fiscal years 2009 through 2015 (and \$65 million for FY 2016) to accelerate the adoption of certified electronic health records (EHRs) by health professionals through the development of systems and incentives.

These programs are being implemented largely in isolation from each other, even though in many cases they are designed to collect information about the same children. Instead of pooling resources to develop one effective, interconnected, interagency set of data systems, many states and localities are developing parallel data systems —

one for each federal, state, local and foundation-funded grant.

These parallel data systems make for redundant technological expenditures and often overlapping sets of information, and are built in ways that inhibit the flow and transfer of data among them. As a result, despite new resources devoted

to data systems, most state and local policy makers and practitioners still do not have the information they need to be effective.

### **Working Toward the Solution: States' Efforts**

Several states are working to align disparate data systems. While still the exception, not the rule, a

## **The Governor's Children's Cabinet Network's Vision for Child and Youth Data Systems**

### **Integrate data across systems**

A comprehensive data system would allow education, child welfare, early childhood, juvenile justice, workforce development, health and other systems to better track and understand how well youth are doing across systems.

### **Integrate data across levels and boundaries**

Data sharing conversations are occurring at many different levels — national, state and local. Even within states there are different geographic boundaries, such as municipalities, school districts, counties and service regions, that must be aligned.

### **Integrate data across age groups**

As President Obama called for in his February 2009 Address to Joint Session of Congress, we need a system to support young people “from the day they are born to the day they begin a career.”

### **Integrate data across common outcome areas**

We must pay attention to the full range of ways young people grow and develop, including academic, vocational, social/emotional, physical and civic/cultural development.

### **Integrate multiple types of information**

A complete data system would include information on:

#### **CHILDREN AND YOUTH OUTCOMES**

- Child and youth demographics (e.g., census data)
- Child and youth well-being (indicators of well-being)
- Child and youth enrollment and participation data

#### **AVAILABLE SUPPORTS**

- Quality or performance-level data
- Program availability and participation rates
- Provider workforce capacity data
- Resource and investment data



few members of the Governor's Children's Cabinet Network have begun efforts to align disparate child and youth data systems. For example:

- **The Commissioner of Education in Maine** created a single student identifier and plans to use it within the Maine Governor's Children's Cabinet across the other state agencies. The Maine Legislative Committee on Education and Cultural Affairs also passed LD 1356, an act to Improve the ability of the Department of Education to conduct longitudinal data studies. The purpose is to compile, maintain and disseminate information about educational history, placement, employment and other measures of success of participants in state educational programs through the use of social security numbers. This is the first step in supporting the development of an interagency data "hub."<sup>1</sup>
- **Florida's Children and Youth Cabinet** is developing a data-sharing system among its eight participating state agencies. The system builds off their Office of State Courts advanced electronic system; the pilot will encompass eight data pieces from various agency sources including: Agency for Workforce Innovation, Department of Children and Families, Department of Juvenile Justice, Department of Health and Agency for Healthcare Administration.
- **The New Mexico Children's Cabinet** creates an annual child report card (indicators of child well-being) and children's budget (size and allocation of state funding) using a common set of results, indicators and service categories across more than 12 state agencies.

We can learn from these efforts and others like them, as we seek out examples of best practices for what an interconnected set of data systems could look like, and the real savings that can be realized, both in dollars and in young people's lives. But these fledgling efforts will require additional resources and attention to succeed.

#### Federal Efforts

With the Obama Administration, the time is ripe to work across departmental lines for children and youth. Departments are actively working together in new and innovative ways. The Department of Education and the Department of Labor, for example, have been collaborating on the development of their data systems. With this administration's focus on working together for children and youth, and their focus on data, there are real opportunities for aligning data systems that contain child and youth information to create efficiencies across sectors not only to reduce cost, but also to work across settings — from schools to hospitals to afterschool programs and beyond — to seamlessly connect young people to the services they need.

If the White House were to call together the secretaries of all relevant departments and request that they align their efforts to create children and youth-related data systems, these initial efforts by individual federal departments to connect with each other would gain the traction they need to excel. There are numerous ways departments could work together to promote the alignment of data systems; for example:

- A federal interagency program could incentivize states and localities to connect their disparate child and youth data systems.
- All federal RFPs related to data systems could include language providing a priority

to states and localities that use a portion of the funding to connect disparate data systems.

- The federal government could clarify and address legal restrictions that might inhibit states and localities from linking some of their data systems.
- The federal government could help advance an overarching vision for an ideal, interconnected child and youth data system (see "The Governor's Children's Cabinet Network's Vision for Child and Youth Data Systems" on **page 53** as a useful starting point for the development of a federal vision).

#### Bottom Line

Work to coordinate child and youth policies and programs is already under way. The proposed



Federal Child and Youth Coordination Act (based on the original Federal Youth Coordination Act, PL 109-365) calls for the development of a National Child and Youth Strategy. The Governor's Children's Cabinet Network is aligning statewide investments in children and youth. And the National Ready by 21 Partnership (consisting of the Forum for Youth Investment, United Way of America, National Conference of State Legislatures, American Association of School Administrators and other organizations) is developing tools for state and community leaders to align disparate efforts.

These efforts require a solid foundation built on interagency data that can be secured only with the leadership and vision of the current administration. Without interagency data we can never have true interagency accountability, and without that, efforts to collaborate will ultimately be futile. This is why we must act now to align disparate data systems containing critical information about children and youth.

By aligning these systems, we can help states and localities reduce fragmentation of policies and programs, make efficient use of scarce resources, prevent children in need of supports from falling through the cracks, and transform young lives.

**Thaddeus Ferber** ([thaddeus@forumfyi.org](mailto:thaddeus@forumfyi.org)) is vice president of policy for the Forum for Youth Investment.

#### REFERENCE

1. The Governor's Children's Cabinet Network, managed by the Forum for Youth Investment, consists of the directors, chairs and members of State Children's Cabinets. Children's Cabinets are high-level interagency coordinating bodies consisting of the heads of state agencies who administer child and youth programs. Children's Cabinets meet on a regular basis to coordinate services, develop a common set of outcomes, and collaboratively develop and implement plans to foster the well-being of young people.