

California Health Policy and Data Advisory Commission

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Minutes
California Health Policy and Data Advisory Commission
August 15, 2005

Kathleen Maestas, California Rural Health Policy Council, called the meeting to order at 10:05 a.m., at the Holiday Inn Hotel, Sacramento, California.

Commissioners**Present:**

Vito Genna, Chairperson
M. Bishop Bastien
William Brien, MD
Marjorie Fine, MD
Janet Greenfield, RN
Howard L. Harris, PhD
Sol Lizerbram, DO
Hugo Morris
Corinne Sanchez, Esq.
Kenneth M. Tiratira, MPA
William S. Weil, MD

Absent:

Jerry Royer, MD, MBA

Staff Present:

CHPDAC: Kathleen Maestas, Rural Health Policy Council; and Rebecca Markowich, Executive Assistant

OSHPD: David Carlisle, MD, PhD, Director, OSHPD; Bob David, Chief Deputy Director, OSHPD; Teresa Smanio, Assistant Director, Legislative Public Affairs; Angela Smith, Executive Director, Health Professions Education Foundation; John Kriege, Acting Deputy Director, Healthcare Information Division and Healthcare Quality and Analysis Division; Jonathan Teague, Health Information Resource Center; and Candace Diamond, Acting Deputy Director, Healthcare Workforce and Community Development Division;

Others in Attendance: Sarah Minden-Weil, MSW, County of Los Angeles, Department of Mental Health; Dorel Harms, Vice President, California Hospital Association

A replacement to fill the position of Executive Director has not been appointed.

Oath of Office: Governor Schwarzenegger recently reappointed Vito Genna (a former Commissioner who was replaced by Paula Hertel approximately four years



ago) to the Commission, and was also appointed Chair of the Commission. Ms. Hertel's term expired, and Mr. Genna now replaces Paula Hertel on the Commission. Dr. David Carlisle, Director of OSHPD, administered the oath of office.

Chair's Report: Mr. Genna thanked Governor Schwarzenegger and Dr. Carlisle for the opportunity and privilege of again serving on the Commission. He also thanked former Chair, Dr. William Weil, for his offer of support and allegiance.

Terms of some Commissioners have expired. The Governor's staff has assured that appointments will be made more quickly. Commissioners wanting to be reappointed should have submitted applications to the Governor's Office.

It is the duty of Commissioners to work on one of the committees that serve the Commission. All Commissioners are invited to attend committee meetings.

The Technical Advisory Committee looks at risk adjusted outcome studies of care in California hospitals, including maternal outcomes, acute myocardial infarctions, hip fractures and pneumonia.

The Appeals Committee hears appeals of fines levied against providers for not submitting data reports in a timely manner. On April 28, an appeal was heard involving a long-term care facility. The Appeals Committee makes a recommendation to the Director of OSHPD, who makes the final decision. There has not been an appeal for a couple of years and Commissioner Morris asked that the record be reviewed as to providing a summary of action, the amount of fine that was levied, and resolution of the appeal.

The Committee to advance Patient Safety, Privacy and Care is currently chaired by Clark Kerr, who is a former Commission Chair. This committee developed guidelines that promote the use of electronic medical records, with efficient access to a patient's complete medical record.

The Health Data and Public Information Committee reviews the data collection and public information activities related to data

Mr. Genna, representing long-term care, gave an update on what has been happening in that field.

Legislation was recently passed to enable nursing facilities to levy a quality assurance fee, a provider tax, on private pay patients in nursing homes to infuse more money into the Medi-Cal system. This money increases the amount of money the State pays for Medi-Cal patients to help increase staffing and other things in nursing facilities. New York and several New England states have been doing this for years.

Medicare has to approve the actual rate structure, which will probably be accomplished in September. OSHPD collects cost reports from facilities annually, from which the rate structure is derived.

There are many organizations looking for changes in the healthcare system in California. Work is being done on QI issues such as trying to reduce the number of restraints and pressure sores.

The Medicare D drug benefit bill goes into effect on January 1, requiring payment of a new premium. There is much confusion surrounding this and talk of a three to four month slide-in for those in LTC facilities. The emphasis for Medicare D is to have more managed care groups take over the health plans.

Approval of Minutes:

The minutes from the meeting of April 11, 2005 were approved. Research the law to determine the title of the Commission's Executive Secretary/Director position.

OSHPD Director's Report:

Dr. Carlisle thanked former Commissioner Paula Hertel, representing long-term care, for her contributions to the Commission,

OSHPD has filled several staff positions since the last meeting. Teresa Smanio was appointed Assistant Director for Legislation and Public Affairs. She brings experience from the Senate Health Committee.

Bob David was appointed as Chief Deputy Director. Mr. David comes from the Hospital Council of Northern California. Previous to that, he was an Assistant Secretary to the previously named Health and Welfare Agency.

An examination and search process is underway to fill two Deputy Director Positions for the Healthcare Information Division and the Healthcare Workforce and Community Development Division. The Director of Legal Affairs position is also vacant, with the retirement of John Roskopf. OSHPD will be offering an examination for managers at the SSMI category.

Several important articles have appeared in publications recently. A Health Affairs article covered the contribution of malpractice in defensive medicine to the difference in healthcare expenditures per capita between the United States and other nations.

Two articles on quality of care were interesting in that OSHPD is actively engaged in producing quality of care reports. The techniques used, often called proxy process of care measures, are being promoted by the Center for Medicare and Medicaid services to capture the complexity of inpatient care. Dr. Patrick Romano, consultant on OSHPD's outcome reports, comments on the relevance of measures that are being used and about increased compliance with the measures.

An upcoming mandatory CABG (coronary artery bypass graft) outcome study will report first on hospital outcomes for CABG surgeries and then report surgeon-specific outcomes from that procedure. A second pneumonia report will be released shortly. Work is progressing on the next AMI report. Staff is developing reports on hip fractures and maternal outcomes.

Question was asked if there is a measure to the degree to which the uninsured are not covered or not given medical care because they have no insurance. Publications generally say that the uninsured receive fewer preventive services and there are differences in their ability to access services. Dr. Carlisle said there was an article in Health Affairs last year that talked about which factors might be contributing to the difference in per capita healthcare expenditure. Information technology may be a significant part of costs of providing healthcare in America. Many countries that have lower healthcare costs do not have data available such as that in California. Many nations use the California discharge data set to understand the relationship between providers and the utilization.

Commissioner Morris requested that a copy of the presentation made by Dr. Carlisle at UCLA last week be made available.

Update on Health Professions Education Foundation: Angela Smith, Executive Director

The Health Professions Education Foundation is a nonprofit, public benefit corporation established to provide health professionals to under-served areas of California, governed by an 11-member board, appointed by the Governor and members of the Legislature. Some of the terms have expired and staff is working with the Governor's Office to make appointments.

The purpose of the Foundation is to increase the number of health providers practicing in under-served areas and to increase the number of under-represented and economically disadvantaged students participating in these health professions.

SB 476, authored by Senator Watson in 1987, created the Foundation. Legislation in 1988 assessed nurses a surcharge of \$5 on their license renewal fee to support nursing scholarships for associate and baccalaureate degree nursing students. That fund is currently collecting \$1.2 million to provide for nurses in California.

AB 2516 (Thompson) in 2000 allowed State-operated health facilities to be eligible as practice locations for recipients of the Foundation's programs.

AB 1241 (Parra) created legislation that would increase the amount of funding available for associate degree nursing students

AB 938 created the licensed mental health provider education program, including LCSWs, marriage/family therapists, and psychologists. These providers are being assessed a \$10 surcharge on their license renewal fee.

SB 358 (Figueroa) in 2003 created the vocational nurse educational program, designed to address the shortage of vocational nurses practicing in long-term care facilities and hospitals. At that time, LTC facilities were short about 3,500 vocational nurses and were projecting there would be a shortage of 28,000 LVNs over the next ten years.

The Foundation is also funded through grants and contributions received from foundations and corporations. From this funding, nine programs focus largely on nurses at the associate, baccalaureate and master's degree level, as well as dentists, physician assistants, nurse practitioners, nurse midwives, and other allied health providers. The exception to the classification is physicians. At one time, there was a medical scholarship program in the range of about \$10,000 annually. The average medical student's debt was about \$125,000 after residency. Only three awards were given. The focus was redirected to support nurses and other allied health providers.

The California Medical Board administers a physician loan repayment program, which may be transferred to the Foundation. The Office is watching AB 920 (Aghazarian) closely for the outcome. The Healthcare Workforce Division at OSHPD directly supports physicians.

A Youth for Adolescent Pregnancy Program annually honors eight youths throughout California, who are working in their communities to reduce rates of teen pregnancy, and who have an interest in pursuing a health career. The Foundation supports that program and gives those individuals \$25,000 which can be used over a five-year period.

Recipients of scholarships and loan repayments must demonstrate financial need, as well as maintain good grades, and be a permanent resident or U.S. citizen. Their transcripts are reviewed and they must have letters of recommendation from their employer, dean or instructor, familiar with their educational goals. Health-related work experience, community involvement, and career goals are reviewed. A determination is made as to their experience in under-served areas and the likelihood of working in an under-served area once academic studies are completed. Under SB 308 (Escutia), awardees are required to practice in an under-served area of California for a minimum of two years. About 70 percent actually practice in health facilities that are designated shortage areas. At the beginning of the program, the awardees from under-represented backgrounds did not have to practice in an under-served area. Awardees have practiced in 51 of the 58 counties in California.

Awardees of the Allied Healthcare Scholarship program only have to practice in an under-served area for one year because the award amounts are much smaller, \$2,500, while RN students and other mid-level providers are awarded \$8,000.

Information from the Healthcare Workforce Division, as well as the patient population of a facility (50 percent Medi-Cal or more), is used to determine medically under-served areas.

There have been over 1,700 awards; 860 individuals have completed their contract terms successfully; staff is currently monitoring over 550 awardees. There is about a 16 percent breach of contract rate, and staff is working on reducing those defaults. A new database is being implemented to help with tracking and monitoring the students. Recipients who default are required to repay funds at a ten percent interest rate over a seven-year period.

Since 1990, the Foundation's awards have totaled over \$11.5 million. The majority of those awards, \$8.1 million, went to nurses, funded by a surcharge on RN license renewal fees. The Foundation has a budget of about \$3.4 million to support scholarships, staff and overhead costs for managing the programs. Even though the Foundation receives no monies from the General Fund, the State's budgetary process must be followed. The

majority of the funding is through special funds, either through licensure fees, grants, or other fund raising efforts.

Chairman Genna said the biggest issue today is that there are not enough RN teachers for the programs. The community colleges are turning applicants away. He asked if the Foundation could look at some incentive to give larger scholarship if students would go into the teaching side. Ms. Smith replied that the Governor's trailer bill allocated \$3 million for a State Nursing Assumption Loan program for educators, and those funds will be used to provide loan repayment to the nursing students at the MSN and doctoral level who will agree to practice in a nursing education program for at least five years. The Foundation will do the marketing and outreach for that new program, which is just being developed.

Dorel Harms of the California Hospital Association said the biggest deterrent is the salary. A new graduate coming out of a nursing school in the San Francisco area can make \$70,000 a year. A PhD educator in a nursing program with approximately 15 years experience would be lucky to make \$65,000. Only about half of the nurses that are needed in California are being educated. Over the last four years, California has attracted 43,000 nurses, but lost 42,000. Many nurses are foreign born, coming in on a temporary basis and stay four to six months; there is a cultural issue.

Janet Greenfield said the ratio of students to teachers is about five or six to one, especially in the clinical setting. It's very expensive to train, and universities have a tough time finding the money to make it work. In the classroom, the ratio is ten to one.

Hospitals have been contributing about \$53 million yearly to nursing education. Many hospitals are now creating healthcare educational programs.

Legislation restricts the Foundation to funding individuals and not organizations.

Healthcare Information Division and Healthcare Quality and Analysis Division Update: John Kriege, Acting Deputy Director

- Emergency Department and Ambulatory Surgery Data Reporting: In 1980, legislation passed that required California's hospitals to report 12 data elements. In 1998 legislation required OSHPD to reduce the timelines for collecting and making the data available to the public, which began the core phase of the MIRCal project. That phase was completed when hospitals began using the MIRCal system to report 2002 inpatient discharge data over the Internet.

That legislation also expanded the patient level data reporting programs to include the collection of emergency department and ambulatory surgery encounters. Emergency department and ambulatory surgery data reporting is a new addition to the MIRCal project; it's an expanded phase. This year began collection of emergency department data from hospitals and ambulatory surgery data from both hospitals and licensed surgical clinics. About 100 hospitals and about 60 surgical clinics voluntarily submitted fourth quarter 2004 data to OSHPD. Mandatory reporting began with the first quarter of 2005 data.

In the first quarter of 2005, 340 hospitals reported over two million emergency department encounters. Surgical clinics (439) and hospitals (370) reported almost 700,000 ambulatory surgery encounters. Licensing information from the Department of Health Services is not always up to date, so it is difficult to determine which facilities actually should be reporting this data. One hospital that had added emergency services to its license had not actually opened its emergency room. Another hospital was not able to report due to computer problems, and one hospital went into bankruptcy during the first quarter of reporting and data was not available. For 2004, approximately a dozen surgical clinics closed, about 30 new ones opened, and some clinics were not ready to report, mostly due to computer issues and training of staff. For hospitals reporting ambulatory surgery data, licensing information in combination with the annual utilization reports helped determine the reporting.

This new reporting totals about 2.8 million records. With the inpatient discharge data, OSHPD will be receiving about 15 million total records each year through the MIRCal system.

Since this is a new reporting program and many facilities are new to reporting to OSHPD, there was limited editing of the new data by OSHPD. Some facilities had trouble submitting the data and OSHPD granted some modifications, which allowed some exceptions to the data while not passing all of the edits. E.g., Kaiser was not able to report some of the fields of disposition of patient and expected source of payment. The Kaiser hospitals are in various stages of implementing a new medical record keeping system. Some other hospitals had similar reporting issues, which are expected to be resolved soon.

There were some issues related to receiving data from surgical clinics having no history of reporting to OSHPD. About one third of the surgery records reported race and ethnicity as either unknown or blank. Hospitals reported about five to six percent of the records blank or unknown for race and ethnicity. Emergency department records from hospitals reported about ten percent blank or unknown for race and ethnicity. In surgery centers, patients have refused to tell their race or ethnicity. OSHPD has included information on the website explaining the importance and reason for collection of this data. OSHPD will continue to work with clinics to improve reporting. The surgery centers are working hard to explain that the State is gathering the information because of a new law.

OSHPD is adding more edits to the data to improve the feedback to the facilities having difficulties in reporting. Staff will offer assistance to facilities reporting unknown for race and ethnicity.

A newsletter called quick notes is being distributed on a regular basis to facilities and is also on the website, addressing how to accurately report some of the different elements and the meaning of the different disposition values. There is a survey on the website allowing feedback about use of the MIRCal system.

While staff is looking at the first quarter and developing new edits, the due date for the collection of the second quarter of 2005 data is nearing. Facilities are allowed extensions up to 14 days to submit the data to OSHPD. This is the first time period for collection of ambulatory data and inpatient data at the same time, which is a good test for how well the MIRCAl system can handle the workloads.

Staff will be developing reports to be available on the website, showing aggregate findings from the data. Patient level data sets will also be available to researchers who want to look at access, cost, quality of care issues. At this point, it is hard to anticipate all the future uses for the data.

Many of the surgeries were moving outside the hospital setting, and inpatient discharge data was not giving a complete picture of healthcare in California. Collection of ambulatory and surgery center data is the next step in looking at data across the continuum of care. This data is used to inform the planning, design and delivery of healthcare services to the public and is an information source widely used by university researchers doing academic medical healthcare service research and economists. Because of the quality of the system and the data in California, it is looked to for seeing trends and developing new programs.

OSHPD has tried to keep the cost of collection of data down by using standard data elements collected and reported to other entities. OSHPD basically redirects, electronically, the data streams to OSHPD for the collection of this data.

Patients are identified by collection of Social Security numbers, generally to look at readmissions. The Social Security number is not released; an encrypted version of the SSN is used for identification. Researchers often request data linkages for emergency ambulatory information.

- Charge Master Reporting: On July 1, 2004, hospitals were mandated to make available their hospital charge masters, their price lists, for viewing onsite at the facility. On July 1, 2005, hospitals began to submit the charge masters to OSHPD, as well as a list of charges for 25 common procedures or services. In 2006, hospitals will also submit an estimate of the percentage increase in the hospitals' gross revenue due to price increases. OSHPD has collected, electronically, about 97 percent of the first group of charge masters. There is no standard format.
- Consolidated Financial Reporting System Project: Staff is working on moving the hospital and long-term care financial reporting from the mainframe technology to more up-to-date, easier to support technology, and improving the availability dissemination of that data. This reporting program uses COBOL programming language, and is becoming difficult to support, as there are very few COBOL programmers now. This is a problem across the country.

A feasibility study to upgrade has been submitted to the Department of Finance. Upon approval, staff will work with the Department of General Services for consulting services to design and develop the new system. Facilities could probably begin reporting using the new system in late 2008. The data reporting is funded by special funds, but authority from the Department of Finance approval is needed before any monies can be spent.

- Coronary Artery Bypass Graft (CABG) Reporting: OSHPD has been collecting CABG data voluntarily since 1996 in partnership with Pacific Business Group on Health. Three voluntary reports have been issued since 2001 containing information from about 70 or 80 hospitals. Mandatory reporting is now required for all 120 hospitals performing CABG surgeries in California. The first mandatory CABG report, using 2003 data, will be released in the fall. The next report will show outcome rates for hospitals, as well as information about surgeon performance. Question was asked if there would be a TAC meeting to discuss the report before it is released. Dr. Carlisle thought this to be a good idea
- Reports in Development: A second report on intensive care (ICU) outcomes, using 2002 and 2003 data, will soon be released. A second report on community-acquired pneumonia will be released in late 2005 or early 2006. Reports on heart attacks and hip fractures will be reported on sometime next year. Validation work on maternal outcomes has not been completed yet, but is in the queue.

One of the major criticisms of using administrative data for outcome reports has been timeliness. Because of MIRCal, the reporting periods have been accelerated and data made available more quickly. Previously, discharge data was 12 to 18 months old. Now, the data are no older than six months to a year. Based on the accelerated data availability, because of electronic reporting, there should be major improvements in turnaround time for outcome reports.

- Current Legislation Being Followed:

SB 739 (Speier) Reporting of hospital-acquired infections: As recently amended, this bill would require all California hospitals to report to OSHPD their rates for certain acquired infections. This bill would establish an advisory panel to define and expand reporting requirements. Other requirements for hospitals related to infection control programs would be monitored by Department of Health Services.

CHA is looking at another part of the bill relating to the 2008 date when all caps go away for any of the data collection.

AB 1627 (Frommer) Modification of charge master reporting: Currently hospitals are submitting a list of 25 common procedures or services, along with their charge master. This bill would substitute a list of 25 common outpatient procedures and charges to be reported, determined by OSHPD. It would also require OSHPD to determine the 25

most common inpatient DRGs and charges by hospital, and to develop an online query system for making this data available. One provision of the bill has already been implemented. A new data product is on the website, which can be downloaded, to look at the 25 most common DRGs by hospital.

Healthcare Workforce and Community Development Division Update – Candace Diamond, Acting Deputy Director

For about 30 years, the Song-Brown program has been supporting and helping family practice residency programs, with the theory that if there are more primary care residencies, this will attract more primary care physicians, particularly to serve in underserved areas and populations. The goal is to increase the number of primary care physicians and improve the quality of training, and improve access to care. Until last year, the General Fund supported this program. Last year, some of the Data Fund money was redirected to completely fund the program, which was controversial. For the 2005-06 fiscal year, the program will be funded 50 percent by the Data Fund and 50 percent by the General Fund.

In California, there are eight million persons in areas that meet the criteria for health professional shortage areas. A measurements for physicians is that there is less than one physician for every 3,500 persons. There are other measurements for other professions that this program deals with. OSHPD has the responsibility to make the designations, through a cooperative program with the Federal Government.

Many of the teaching hospitals treat patients. All of the UC hospitals participate in the Song-Brown program, as well as county facilities.

This year, there is \$3.9 million available to institutions. This money does not go to individuals for tuition, etc., but goes to institutions.

Applicants for the programs are determined by the Healthcare Workforce Policy Commission, which is a mandated Commission whose members are appointed by the Governor, the Assembly, and the Senate. A meeting is scheduled for September to review applications for the family practice physicians.

There are 30 family practice residency programs currently, with four physician assistant programs and seven family nurse practitioner programs. Song-Brown supports the training of about 16 percent of the residents coming out of family practice. About 12 percent of California physicians practice in medically under-served areas. Forty-five percent of the trainees in Song-Brown choose to serve in communities defined as under-served, often the same communities where they were trained.

OSHPD developed a press release to say that Song-Brown would be expanding with a nurse-training program, of about 2.75 million dollars, which developed into a press release from the Governor's Office announcing the expansion of the Song-Brown program. This generated much interest by the media and legislators. The funding will be dedicated to the actual nursing training programs. The nursing schools will be a new set of partners for this Division. The Health Profession Education Foundation will assist with the outreach activities.

Recent legislation increased the 10-person Commission to 15, three of whom will be practicing nurses and two will be students in RN programs.

Nursing education includes some new innovations for schools to expand their capacity and efficiency, as well as working with nurses from other counties who need to pass the licensing examination.

Hugo Morris made a **motion** to go on record as supporting the idea of allocating funds with some emphasis on the need for educators to be hired for nursing education. Dr. Harris suggested gathering information to determine the shortage of educators in community colleges or at a four-year level if, in fact, that is a critical factor. The motion was amended to include this.

Discussion: There are two paths for the Song-Brown grant awards. One is a capitated amount, particularly for the family practice physician training. The residency program can indicate that a certain amount of slots can be added, and the cost per each slot for several years. The physician assistant and nurse practitioner programs justify the good of healthcare workforce issues and shortages. Funding is requested rather than an individual slot at a time.

The outreach will include talking to stakeholders, Board of Registered Nurses, nursing schools, and other programs to increase nurses in California. There are monies available from other State departments, all aimed at increasing the number of nurses and resources needed. Criteria will need to be set, and the Song-Brown Commission will need to consider physician assistant and nurse practitioner applications within the next ten months. Grants will need to be given by early summer in order for students to begin the fall academic season.

Because there are monies from other areas, many nursing schools have been writing grants and applications and have been gathering local statistics and needs, and may be able to respond to OSHPD more quickly. The money will be spent over a number of years because the training program would cover several years. The RFP language could be tailored to reflect CHPDAC's concerns.

The motion was seconded and carried.

Healthcare Information Resource Center: Jonathan Teague, Manager

Staff has been working on a report on preventable hospitalizations in California, using administrative data. The report is based on prevention quality indicators developed by the Federal Agency for Healthcare Research and Quality. Statewide data is good for benchmarking, but most of the real improvement in healthcare and public health activities really happens at the local level. The report focuses on the local level of ambulatory care sensitive conditions. The 15 conditions are those that probably would not be seen if patients involved were receiving good primary care. They are indirect indicators that perhaps the primary care system is not working as well as it should.

The county data will be on a blind website with access provided to local health departments. OSHPD is working with a group called the California Council of Local Health Officials to review the county data and give their feedback. The report will be a descriptive statistical analysis to determine trends and hypotheses to investigate. It is hoped that others will look at the numerical trends and delve more deeply into the data.

“Perspectives in Healthcare Report for 2003” is being reviewed internally and is expected to be released soon.

Patient discharge data for the year 2004 are now available in public masked data sets and confidential data sets. Data sets for emergency department and ambulatory surgery centers are being worked on. The patient discharge data covers demographic and clinical data, diagnosis procedures, E codes, patient zip codes, admission source disposition, do-not-resuscitate code and conditions present on admission. This inpatient data will be important when linked with emergency department and ambulatory surgery center data.

Linkage of the inpatient data set with birth and death records results in a very powerful data set, allowing for examination on mortality and morbidity resulting from medical care, as well as birth outcomes.

The inpatient data uses ICD-9 clinical management coding for procedures, while ED and ambulatory surgery centers use a different coding system. The databases are different because staff is trying to integrate national data standards, which came along well after inpatient data collection began. A big project is an all-encounter emergency department file. The ED data covers any patient encounter not leading to an inpatient admission. A person admitted to the hospital will not have a record in the ED file. The two files need to be linked in order to obtain the full population of those encounters through the emergency department.

The key to linkage is having shared identifiers across the file. The Social Security number is used, as well as other individually identifiable information. The SS number is not given out; a nonreversible encryption algorithm is used to construct a record linkage number. Not all persons have SS numbers so many records cannot be linked in this manner. Secondary variables can be used such as age, date of birth, and gender to get a match. Longitudinal linkages can be done to determine how individuals will fare as they go through the care system, such as readmissions, the effect of the treatment, and whether the treatment caused a subsequent readmission.

The State's Information Practices Act restricts those parties who can request the confidential data set and restricts the use of the data.

Many persons who do not have a primary care physician use the emergency department for care, even though the emergency room could be prevented. Once the emergency room data become available, a definition of a preventable emergency room visit can be made. This would facilitate putting primary care professions in a community or focus clinics to save money and have more efficient care.

Next Meeting: The next meeting will be held in Sacramento. The previously scheduled meeting date of October 19 was changed to October 17. Staff will poll Commissioners to determine their ability to attend.

Adjournment: The meeting adjourned at 2:30 p.m.