

# Iowa Collaborative Safety Net Provider Network

## Data Work Group

Tuesday, September 22, 2009

1:00 p.m.

### Participants

Bobbi Buckner Bentz, Iowa Department of Public Health  
Libby Coyte (via phone), Redfield Medical Center  
Dr. Tom Kline (via phone), Iowa Medicaid Enterprise  
Sandy Pickup (via phone), Iowa City Free Medical Clinic  
Dr. Dana Shaffer (via phone), Des Moines University  
Rochelle Spinarski (via phone), Rural Health Solutions

### Staff

Ted Boesen, IA/NEPCA  
Kate Burgener, IA/NEPCA  
Sarah Dixon Gale, IA/NEPCA

### Welcome, Introductions, Review of the Agenda

Sarah welcomed the group and participants provided introductions. She reviewed what would be covered during the meeting and the attachments from the email. She also asked if there were any questions about the notes provided from the last meeting.

### Discussion of Data Recommendations

Sarah explained that it would be helpful to establish definitions to help our partners collect and report data. Following are data items that were discussed with the decision of the team and key points made.

#### *Patients vs. Encounters*

The team agreed that both patient numbers and encounters should be reported. Rochelle noted that we are more likely to get better data for each because it emphasizes the differences in the two data points. These definitions need to be very clear. Sandy noted that some may report each service a patient receives at one visit as different encounters (i.e. in one visit receive x-ray, throat culture, blood draw – counted by some as three encounters and by others one).

#### *Race and Ethnicity*

The team agreed that four races would be reported:

- White/Caucasian
- Black/African American
- Asian/Pacific Islander/Native Hawaiian
- Native American/Native Alaskan

The team agreed that ethnicity would be:

- Hispanic/Latino
- Not Hispanic/Latino

Race and ethnicity will be reported separately and an unknown response category will be included for each.

#### *Age*

The team agreed to approach our partners to report date of birth and IA/NEPCA staff will aggregate. This yields more useable data. We will have to put in the instructions if we want dates reported as month/day/year or day/month/year. An unknown category will also be provided.

#### *Gender vs. Sex*

The team agreed to report sex and provide a definition. An unknown category will be provided.

#### *Insurance Status*

The team agreed to have six categories of insurance status:

- Uninsured/Private Pay/Self Pay
- Private/Commercial Insurance
- Medicaid
- Medicare
- Dual Eligible
- Other Public Insurance (SCHIP, VA, CHAMPS, etc.)

Our definitions for these categories need to be comprehensive as different partner groups have many more categories than these which they will have to distill into these six categories. An unknown category will also be provided.

#### *Income*

The group agreed to remove this from the list. This decision was informed by comments that included:

- There is difficulty in obtaining accurate data as most is self report
- Some felt that most patients served at the clinics would be at or below 300% FPL
- There is difficulty in some of our partners obtaining this information at all

#### *Unknown v Unreported*

The team agreed to report only “unknown.”

#### *ICD9*

After great discussion, the team agreed to begin to ask all partners for this information. While there may be some variability given coding preferences at one location versus another, we can still find major

themes of care from this data. It is important to know, both internally and for advocacy purposes, what type of visits are most common at our centers and clinics – acute, chronic, or preventive.

#### *Provider Hours/Enabling Services/Referrals*

The team agreed that this information is important to collect. It is an important workforce issue and helps to define the safety net. It was recommended that we set definitions and decide how we want to use this information. Similarly, it was suggested that we also try to obtain information on the number of providers obtaining indemnification through the Volunteer Health Care Provider Program.

#### **Review of Data Findings from 2007 and 2008**

Sarah reviewed the report on data finding comparisons from 2007 to 2008. This information might be useful in eliciting partners to report data because they will be able to see the importance, trends, and how we can use the data for advocacy purposes. The team commented that different entities might find various pieces of the data more useful but as a whole, it is an important type of document to share in the future. It also engages the people who are reporting this data to make it more valuable.

Ted suggested that staff develop this document for review by the Leadership Group before distributing back out to our partners.

#### **Discussion of Survey Development**

Sarah reviewed the proposed survey questions. Changes and additions were made including the following:

- 1) Following is a list of demographic and clinical data that you will be reporting. Please indicate if you are able to report in the categories listed below and whether or not you would like additional training or clarification. (list each demographic and clinical item individually with a yes we can report/ no we cannot report and a check box for need additional clarification or training/do not need additional clarification or training)
  - Number of patients
  - Number of encounters
  - Race
    - White
    - Black
    - Asian/Native Hawaiian/Pacific Islander
    - American Indian/Alaska Native
    - Unknown
  - Ethnicity
    - Hispanic/Latino
    - Unknown
  - Birth date of all patients
    - Unknown
  - Sex
    - Male
    - Female
    - Unknown

- Insurance Status
    - Uninsured/Private Pay/Self Pay
    - Private/Commercial Insurance
    - Medicaid
    - Medicare
    - Dual Eligible
    - Other Public Insurance
    - Unknown
  - Top 5 ICD9 Codes Provided in Calendar Year
  - FTE Types/Provider Hours
  - Enabling Services/Referrals Made
- 2) If you have not submitted data in the past, please explain why in the space provided below so we can better understand some of the challenges clinics face with collecting and reporting data?
  - 3) What, if anything, do you do with the data you collect?
  - 4) Would you find it helpful if we provided a report to you that compared your organization to the safety net as a whole?
  - 5) Would you find it helpful if we provided a report that compared your organization against the rest of the providers in your group (i.e. your free clinic compared to all free clinics reporting data in the state of Iowa)?
  - 6) Would you find it helpful if we provided a report that compared your organization across each year data is available?
  - 7) What data are we not currently asking you to provide that you would like to see? (i.e. Travel time to clinic? What happens when a person does not show up for his/her appointment? What specialty referrals are most difficult to make? Additional clinical items?, etc.)
  - 8) In the space provided below, please describe how you collect your data (i.e. registry, EMR, chart pulls, etc). This could be collected using a matrix as multiple mechanisms might be used to collect various data points.

### **Action Planning and Next Steps**

Sarah reminded the group that the Leadership and Advisory Groups meet October 29. Because we were able to reach consensus on most items, we will draft definitions, refine data categories, edit the document on data comparisons, draft additional survey questions, and provide it back to this group to make edits if necessary. We can report on the work we have completed on October 29 and then use the Data Work Group for other purposes going forward. Thanks to everyone for their time and dedication to this effort.