Data Workgroup Meeting Summary  
Tuesday, May 4, 9-10:30am

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<td>Project Overview</td>
<td>The meeting opened with introductions and a brief project status update. A PowerPoint presentation with preliminary data results was presented, followed by possible next steps and future HEAL funding opportunities.</td>
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| Discussion     | *Data Analysis:*  
  The group noted that in the ICD 9 Diagnoses presentation charts, Product Line listings for non-emergent and primary care treatable categories/diagnoses are too vague (e.g., “Signs and Symptoms” category), and should not be used. ICD 9 listings are a bit too specific, and some of the larger diseases such as diabetes, CHF, COPD, etc., are broken into sub categories, which is most likely why they don’t show up in the top Product Line categories.  
  FLHSA staff noted that they did not use Product Line codes in their analysis – they used ICD 9 codes and tried to roll related issues into groups. They also ran PQI data to determine chronic conditions. FLHSA used a socioeconomic |           |
algorithm, as well, and found that satisfaction increased when socioeconomic status went down – people felt that their needs were served better in the ED.

It was noted that it would be good to show % frequency in the ICD 9 charts so the rate of ED occurrences could be examined. It was also noted that it would be interesting to see how the most common ED admission conditions compared to the most common ED treat and release conditions.

One workgroup member commented that the self pay group can be misleading. It is a low yield group – only a small percent actually pay. People in this group often have no other choice for care except to go to the ED, where they can be seen and treated quickly.

Rank ordered slides (e.g., primary care diagnoses ranked by demographic group), were clear and informative - this is a good way to present the data.

There is little distinction between non-emergent and primary care related visits to the ED. The most common diagnosis for primary care related visits was URI; the most common non-emergent visits were dental related. Women, lower income populations, and minorities utilized ED services most often.

Among the areas with high non-emergent ED visits, Schenectady had a disproportionately high percent of self pay visits. The group speculated that this could be due to patients in this area having other health care options nearby (e.g., Schenectady Free Clinic, etc.), a DSS problem (not being aggressive enough with Medicaid enrollment), a larger immigrant population, cultural perceptions, etc.

Northeast Health is starting a program next month where a physician will triage people to appropriate care. This will help drop door-to-doc wait times.

Consumer education is important – focus should be on people who use the ED for convenience. Consumer education efforts are underway in several areas (UAlbany, CDPHP, etc.). Potential future models could be similar to Ellis, but with a dental clinic. The University of Chicago was mentioned as having a good screening model.

Courtney will speak with dentists and obstetricians for the gap analysis.

HCDI staff will identify geographically based urgent care alternatives in Albany, Schenectady, and Troy.

HCDI staff will examine area consumer education efforts and the U of C screening model.