

Data Reporting: Building Effective Partnerships with Your Contractor

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TRANSCRIPTS

Operator: Welcome to the dataCHATT technical assistance web conference sponsored by HRSA HIV/AIDS Bureau. The topic for this afternoon session is “Data Reporting: Building Effective Partnerships with your Contractors”. Please note that this session is being recorded. During the presentation, the phone lines will be muted. After the presentation, we will open the lines for questions. At this time, I will hand the call over to Mira Levinson. Please go ahead.

Mira Levinson: Thank you. Hello, everyone, I want to welcome you all to today’s web conference. I’m Mira Levinson, Project Director for the Ryan White Data TA and Training Cooperative Agreement and I’ll be the moderator for today’s web conference. The topic of today’s call is Data Reporting: Building Effective Partnerships with your Contractors. The goal of this web conference is to discuss systems and strategies to support your ability to receive timely, complete, and accurate data from your contracted service providers. Our grantee presenters will focus on how to implement systems that work for both grantee and contractor, and on specific strategies such as timelines, contractual approaches, provision of feedback, and training.

Today we will hear from two grantees. First, from a Part A grantee who has been successful in getting high quality data from contracted service providers and second from a Part B grantee with a twenty-seven member network of providers who will talk about her strategies for working with contractors to balance multiple reporting requirements.

If you haven’t already, please download the materials for today’s call. Links to these materials were posted on the original registration page and are also available on the dataCHATT website which is: www.datachatt.jsi.com. The document accompanying today’s call is titled “Making the CADR Work for You”. As you can see, some of the terminology is outdated, but I assure you that the content is as valuable now as when the document was produced in 2003.

You’ll hear today’s presenters talk about the importance of getting buy-in from your contracted service providers in order to ensure that the data they submit is timely, complete, and accurate. A key part of this process is to make sure that they value and use the data they’re required to collect. Today’s accompanying document “Making the CADR Work for You” provides a series of helpful examples and exercises to help programs use data for purposes beyond reporting data to HAB.

Our first presenter, Jeananne Cappetta, joins us from the Nassau-Suffolk Part A program where she serves as Senior Contract Administrator and Data Manager. Jeananne has been in this dual role for seven and a half years, and has also recently taken over the quality management component.

After the close of both presentations, we will have a question and answer period. If you have questions at any point in time during or after the presentations, you may type them into the “chat” box on the right hand side of your screen and they will be addressed during the Q&A. After both presentations are finished, you may also dial the operator, to ask your question by phone. If appropriate, feel free to let us know if you’d like your question to be directed to a specific presenter.

Before we begin, I’d like to review a few additional technical details. All participants are currently in listen-only mode, so you don’t have to mute your individual phone lines. If you have any technical difficulties during today’s web conference, please dial “14” to reach the telephone operator or type your problem into the “chat” box on the right side of your screen.

Okay, now I’ll turn it over to our first presenter, Jeananne Cappetta. Jeananne, please go ahead.

Jeananne Cappetta: Thank you, Mira. I just wanted to give you all a little overview. We are a Part A grantee, meaning that we directly receive Ryan White funds, but we do not provide direct services to clients. For client services, we contract with thirteen different service providers for a total of twenty-two individual program contracts, nineteen of which are for core medical services and four are for support services.

Today I’m going to go over how we use data for contract monitoring and meeting the requirements of the Ryan White funding as well as helping to fulfill and identify the needs of the HIV/AIDS community. I will also go over some of our processes for helping all stakeholders be successful at data collecting.

In 2001, when the CADR report was first released, we recognized that we had to expand the variables that we were currently collecting to complete necessary HRSA reports such as the mid- and annual progress narratives and the SAR report. For those of you who may not know, the SAR report was the annual data report that was prior to the CADR which of course was before the RDR report. By using this new report as the backbone to establish data variables for the region, we developed data reports to encompass and meet the needs of us as the grantee of record, HRSA, the reason for establishing priorities, services providers, and for the clients.

The first client asked us why is data collection important for contract management? Collecting data is important because not only does it allow us to have the information that we need to complete mandated reports, it helps us to monitor individual service-provider contracts, program performance, progress of priorities, gaps in services, and barriers to care. Once the data is compiled from all of the providers, utilization data reports are generated by priority and are shared with the planning council, priority settings, and resource allocation groups as well as other Ryan White parts throughout the region.

How to implement a system to work for you and your service providers. We needed to identify a system that worked for both us, the grantee, and for our service provider. By using the concept of why data is important to meet all of the outcomes that a grantee is responsible for, we use this as a basis to create what we needed and required from providers. For example, we had to have a buy-in process where we were able to engage contractors in the process of data collection and not only what we needed and were required to collect, but what would help them at the program

as well. We wanted a system that would affect data needs of our region, create a method to collect the type of data that we needed. We needed to establish training, technical assistance, guidance documents, and reference materials. We developed and provided customized reports for the providers, programs, and the region.

Establish adequate deadlines and timelines suitable for both the grantee and the service provider. Part of engaging the providers is helping to understand how we can require—how the data we require can help them with their Ryan White program. For example, providers can use data to monitor access to clients' medical care, assist them to facilitate continuous quality improvement activities, identify barriers to service, identify trends, supervise their own quality management program in addition to working with our quality management program at the region and develop intake forms that will include all Ryan White elements as well as specific provider variables.

Create a method to collect the type of data that you need. The system we use is that providers are mandated to collect data elements and variables as identified by us, the grantee, HRSA, and even the providers themselves. Specific contract language allows us to standardize reports and collection systems across all of the funded Part A service providers. The contract also allows us to enforce deadlines and consequences for not reporting; should a provider consistently be late with reporting, development of corrective action plans begin. The ability to meet deadlines and follow procedures is part of the overall administrative functions of the program. Therefore, this process is shared with external review committees when reviewing the annual request for proposal. Providers are aware that they are monitored administratively and this helps to build a stronger relationship between the grantee and the provider.

The process that we used originally was providers submitted aggregated data reports on both a monthly and quarterly time frame. Over time this has been expanded, slowly introducing more client-level information. The monthly and quarterly reports are critical to us because we generally do not go back to a provider throughout the funding year unless there has been a significant new mandate to collect or complete a report. What is gathered in this format is all of the data variables needed for us, the grantee, to complete reports. Once received, data is downloaded into a master database which then filters by the type of report required and by the priority track it's linked to. Later, I will show a slide that outlines the different types of data files that we have to meet all of our data needs.

Each provider is given specific reports developed for the programs they are funded for. Once completed, this data is kept by program, provider, and by priority. Quarterly data mimic the RDR data that we collect. This data is collected on a provider or agency level, similar to the RDR. While monthly data is program-specific and links to a priority, quarterly data is unduplicated based on the provider. In this district we collect narrative reports that are required on a quarterly basis that contains no data but any challenges or accomplishments that a provider has faced throughout the quarter in regard to their funded programs. In some instances, we have found challenges to be very similar across programs and we are able to assist the providers to overcome some barriers and develop new program guidelines. This process has helped the region in moving forward client level reporting and identifying and customizing reports that we need to continue to connect contracting programs' data and priority settings for the region.

Support your service providers to collect and submit data that meets your requirements. Process the training providers so that all key staff are involved in learning what and why we were formalizing data collection. Technical assistance was given either through conference calls or onsite any given time. E-mail blasts that include any upcoming changes or reminders are sent out on a regular basis. Regional program data manuals were created as a reference for all programs and staff. The manuals are our bible of data reporting and include all HRSA definitions for each data element, the reasons for specific information, timelines, and examples. These manuals are handed down from staff to staff and are sent out with changes when needed and annually for any new staff. As time progresses and client level variables are included, the manual will be expanded as well as training for data staff, alternative staff, and program directors.

In addition to what I've been explaining we also involve the consumer advocacy committee so that they are aware what types of information will be required at provider sites of the clients and why. We do not want the clients to feel that there is a secret agenda by the provider. We want them to understand that this information is key for us to have what we need to continue to be funded for services in this region. By having client buy-in, it helps the providers to feel comfortable collecting their data. When it's understood that new elements have been added not because the provider wants the information, but because it's actually the funding source mandating them, it makes for easier communication between providers and clients.

Now that we have the data, what's next? Once we collect the data, we need to verify its completeness and accuracy. We do this on a monthly basis as well as a quarterly basis. For example, on the grantee level, every program is tracked in a master database that I have mentioned and any outlying data is given back to the provider for correction. So, if a report comes in and they reported that they had seven unduplicated clients in a month, we expect that the report matches all data variables to equal the seven unduplicated clients. Monitoring of this data allows us to monitor a program more closely. For example, if a program after a quarter is above or below ten percent of their projections for units of service as outlined in their approved work plan, then we need to follow up as to why. If they are exceeding ten percent, then they must submit an explanation so we can monitor new trends in spending of dollars. If they are underperforming of ten percent or greater, a corrective action plan is instituted to monitor the program's success for the remainder of the funding year as well as if reallocation of funds is necessary.

The process of verifying data extends beyond part A. We also require that if your service provider receives dollars from other Ryan White parts, that on a quarterly basis, either onsite meetings or conference calls are held with those responsible for the other parts where data reporting takes place. This helps us to see where the provider falls with data validity and makes the compilation of the RDR easier.

This process has helped our region as a whole and has established a confident RDR reporting system. As a result, the timeliness that we have set up for RDR submission is respected by the other parts of Ryan White who work with us to complete the reports and it helps them as well. They know that their own reports that involve part A will be clean and easy to complete as well as early so that they can focus on their remaining reports.

This slide as I mentioned earlier is just an example to see how we set up our data flow, originating from the provider data report. There are two time frames that we have set the data to cover: the funding year and the calendar year as required by RDR. Once we collect our data on a monthly and quarterly basis, I mentioned that we do not go back to the providers and this just gives us a little overview on what we can do with that data.

Internal timelines need a mandated report, for example the RDR. This slide is a specific example of how mandated data is worked into everyday delivery of services and data collection. We set the providers' RDR data due-date at least four weeks before March 15; actually we have extended that, I think we're going to make it six weeks. Why? This is to allow for any kinds of questions, errors, or corrections that are needed with the data. We send out a save-the-date reminder mid-year. Generally this is sent out around September and is being sent in e-mail blasts starting in November so that staff can plan accordingly to meet their deadlines.

We have set up quarterly conference calls and meetings with all parts to ensure data are on target. We run a mock RDR report mid-year to work out any potential problems for the final RDR. We communicate with all the other parts program so that when you write the RDR is completed or develop a timeline with the parts so that we make sure that all of our work is coordinated together. By completing this report early shows us how to prepare for closeout for the funding year and setup for the beginning of the next funding year. Because we are Part A-funded, our new funding period begins on March 1 which is just two weeks before the RDR deadline. Since we submit our reports in February, the focus on data collection and new reports for the next year begins several weeks ahead, allowing more time for accurate data reporting.

In this last slide is a more visual way in which we have reestablished deadlines for the RDR reporting. We share this with all the other parts so they know what the timeframes are that we are looking at and have over the last year have been very cooperative and very excited to get this wrapped up in our region. So in conclusion, I basically wanted to explain why we had developed the system that we had developed, how it works for a reason and the system has taken time to build and it's constantly expanding and enhancing to meet all of our data requirements. Each region does vary and we had to develop something that will meet our needs while keeping at a minimum simplicity of data collection for those who are multi-part-funded. We have been successful and continue to hope as we expand to the new requirements in 2009 to continue to adhere to this level of quality. Thank you.

Mira: Thank you, Jeananne. We'll be able to take some questions for Jeananne at the end of today's call, but now our second presenter, Rashidah Abdul-Khabeer, is the deputy director of the Circle of Care. The only Part D grantee in Philadelphia, Circle of Care is committed to providing quality comprehensive care to HIV affected women, children, adolescents and their families, and to the prevention of HIV disease in these populations. Rashidah, you may begin.

Rashidah Abdul-Khabeer: Thank you, Mira. Good afternoon. As Mira has indicated, Circle of Care is the Title IV or, Part D grantee in the City of Philadelphia. We began as a pediatric demonstration project under Ryan White. We are also both a funder of services and a direct provider of services, serving women, now men, and children. We have a twenty-seven member network that consists of the continuum of care for all of the service providers. We have a population-specific HIV prevention program that is internally managed that includes peri-natal HIV prevention, as well as our neighborhood options for women (Project NOW), and most recently has added "Straight Up" which is an HIV prevention program

for men. We began our contracting process with all of our subcontractors submitting a work plan and budget each year. Our clinical provider contracts were very specific that included the data management parameters which was always client level data. It was presented in a coded fashion. Each client received a specific code that was developed with our evaluation department. We used an Access database originally. We moved to CAREWare as soon as it was available, and we maintained in special fields the client-level information that dealt with services. Each client—clinical provider – also submitted service data and when we crafted the new contracts we put in a new outline for the fee-for-service payment allocation.

In developing a new system of improving data collection, we had two primary motivations. The first one was that we wanted to, in 2003, we wanted to free up dollars to add additional primary care sites that were specific for women who did not have a positive children and also to improve the accuracy of the data. In our new system, the intent was to use the data to actually drive the activities that were going on in the clinical sites. Each clinical provider negotiated the number of clients in population category. There were those that were HIV positive, those of unknown of indeterminate status, and those who were affected, largely family members. We crafted a set amount of dollars for each category and the clinical providers then projected the number of individuals in each category that they felt that they would serve at the beginning of the contract period. Advances in the earnings was based on the projection and then provided to them monthly. This was a major challenge, I would say to our clinical providers in that they had not had to have this intense scrutiny of the data, but we were being asked as providers for more and more information. What we do each year is we review the process quarterly. The data is reconciled with each provider and at the end of a period, for the first quarter, for example, the provider is either on target with their projections or they have over earned (that is they've served more clients than they originally projected and therefore will receive additional funding), or they have under-earned, (that is if they haven't served the initial projection of clients and therefore their grant would actually be reduced). The reconciliation for either under- or over-earning is done at the end of the contract period, and the projections are then redone for the coming year. Under-earned dollars represent dollars that could be utilized to fund additional HIV services.

In 2005, the results of the two year demonstration project were that all providers either met or exceeded their projections. Those who exceeded their projections were awarded additional funding based on the category or rate so if they had additional HIV-positive clients that they saw, the funding fees for that particular category would have increased their grant. We were able as a result of that to analyze the composition of our families to really look at whether we had adequate retention rates for maintaining clients in care because the data was very clean. One of the things that the data analysis prompted us to really look at was what in fact a family was, what constituted a family? We had had a definition that we had been using for approximately sixteen years and it had originated as a mother with an infected child. Over time, however, looking at the data, we've been able to say it's actually individuals that are living in the household with at least one HIV-positive client served in our system as an index. We were able to look at personnel changes, we could look at shifts in the way the epidemic is moving by looking at our perinatal data, and we were able to really reexamine the basic tenets of the Circle of Care in providing services to our clients.

When we developed the rate, we used several factors. We included the cost of a visit to the specialty clinics by meeting with our state medical assistance representative and crafting from their data what an average visit would be and, using the requirements to be the party of last resort, we crafted the rates for each of the categories. There are two categories for reimbursement: those that are HIV-exposed that dealt with our newborns and those that are positive individuals. The rate is paid for the first visit to the clinic in that particular fiscal grant period.

With the quarterly reconciliation we really work hard to make sure that the data that we have in our system and the information that the clinics believe they put in the system match. Our Director of Evaluation prepares a data report from each client and entered for each of the clinical sites. The report

addresses any questions or concerns about any of the information that's there, if they're missing data that's identified, it's sent to the agency. They can then go through their database and concur with whether or not they have the right number of clients, the right client mix, and if we have pregnant men in the wrong system, we certainly, again, have an opportunity to clean that up. Any discrepancy between the data and the information in this system, we were able to correct or negotiate and then for the following year we do revenue projections based on that information.

We have seen significant improvement in the quality of our data. First we have significant timeliness. People are very conscientious about getting their data entered as quickly as possible. The quality has significantly improved and certainly the accuracy was markedly increased over the time period of the two years that we worked to implement this system. All of our clinical sites and now all of our support service sites use CAREWare. We do have very specific custom fields that we've incorporated into the process that allow our client-level data to reflect the specific services that are being rendered and the frequency of those services, so it gives us additional information and a richness to the information on our clients system. Reconciliations actually do verify the accuracy of the data so that both we as the funder and the clinic as the providers are equally satisfied with the information that's in the database.

Those providers who under-earn their projections because they would have received funding monthly based on their projections, if they have an excess payment because they've under-spent then we deduct that from the following year's revenue base. New projections are evaluated against the achievement for the previous year and in doing that we make sure that the new projections, that no projection exceeds 10% of the previous year and in that way we're able to control and maintain cost. We have additional reports that can come through our system because we do have the client-level data already present in the system. We're able to do narrative and report back to the funders and they provide us with narrative reports related to the specifics of their work plan. That gives us, again, an opportunity to look at the depth of our system, the clients that are being served; they present us with information related to barriers and challenges to care. We've been able to determine, for example by looking at the utilization at the client level, mental health services and looking again at the narrative report from the providers we can see that we had a significant gap in mental health services and we were able to develop additional funding through grant writing to support those services. So having this combination of data and narrative reports has been very beneficial. As I said, it does reflect the wide range of services that are available for our clients.

One of the things I want to say finally is that this process really did occur over a two year period. The first year of the implementation, we held the system harmless. That is we only used the base award as information and demonstrated that if we were going to pay on that particular methodology that first year the providers would be able to recognize whether they would have over-earned or under-earned and that's really what sparked them to see that putting the data in accurately, verifying that information with us quarterly was of a financial benefit to them. For a provider who was not able to meet those projections, they were able to then go back and assess their system and in that first year, we did have a provider who was not able to meet their projections and they had to go back and assess the status of their clinic, their return rate, and ultimately they lowered their projections for the following year until they were able to implement the changes that they needed to insure retention in care and other issues that they felt reduced their attendance.

While CAREWare is the data system that we use for our project, our providers are offered an opportunity to send us that data in three ways. One they can submit that data to us electronically as a download directly to our server; two, they can send it to us on disk and we can download it on our internal systems; and three, we have some providers who are still using paper and we have to input the information through our data folks here at the Circle. It does allow for some flexibility in that as we bring each of our providers up to speed. This year we are implementing this same process for our support service providers, particularly for case management so we're going to see, again, how well we can improve the data for services being received in our support services. Thank you.

Mira: Thank you very much Rashidah. Before we move on to the question and answer session, I'm going to take a minute to tell everyone about a few important resources. First, archived versions of our previous web conferences on "HIPAA and Data Sharing" are available on the recently updated dataCHATT website (that's dataCHATT.jsi.com, and again that's in the lower right hand corner of the slide) and a "Frequently Asked Questions" document for those sessions is coming soon. Also, as soon as it's available, we'll post an archived version of today's presentation.

Second, the next web conference in the series will focus on "Ensuring the Privacy, Confidentiality, and Security of your Client's Data." This web conference will be held on Wednesday, November 19th at 2 PM eastern time. Registration information will be posted on the target website a few weeks beforehand and you can also link to that information from the dataCHATT site. Now let's begin the question and answer session. As a reminder, there are two ways to ask questions. You may type your question into the chat box on the right hand side of the screen or you can ask your question by phone. The operator will now give instructions for dialing into the telephone queue and while we're waiting we'll take some questions from the "chat" box. Operator?

Operator: Ladies and gentlemen, to register question by the phone line, we ask that you press the one followed by the four. Your line will then be accessed from the conference to obtain information. If your question has been answered and you'd like to withdraw your registration, please press the one followed by the three. And if you are using a speakerphone, please lift your handset before entering your request.

Mira: Thank you, operator. As I mentioned earlier, when asking your questions, please let us know if you'd like your question to be addressed to a specific presenter. While we're waiting, we received a number of questions during the registration process and we're going to go to those first.

A couple of questions came in about CAREWare and associated training. While those are not questions that dataCHATT can answer we have forwarded those questions to HAB and we'll make sure that John Milberg gets a heads-up about those questions.

Our next question came in from Michael Bryson in Phoenix, Arizona and he asks, despite months of prep work, I believe the impact of the complexity of client-level data reporting has not yet hit my contractors. Whether you have eight clients or eight hundred, the reporting requirements are the same. How do I convey that any Ryan White funding requires full reporting? Rashidah, do you want to try to respond to that one?

Rashidah: Yes, because we had very similar kinds of challenges. One of the things that we did was look at how we wanted to implement change and the first was written communication. People needed to see it significantly in advance before the actual implementation. We followed that up with meetings and PowerPoint presentations to really walk them through what they system that we were going to be using looked like, how specific the data really was, and it gave them an opportunity to really think about what was going to be required on their part to implement the data input. We followed that up with arranged site visits to see that there was the technology available that we could meet the individuals that would be putting the information in and get a sense of the system that was already in place for gathering the data.

The last was of course to do technical assistance. To provide support on "is this the right button?, Did it print out the way it was supposed to?, I don't know how to export." All of those kinds of things we worked on with technical assistance. We made sure with some of our clients that we needed to improve their capacity to do the data collection so we're looking at matters of technology. That is one of the reasons why we allowed, in the beginning, some of our clients to still do paper submissions because they did not have the computer capacity or they didn't have a technical personnel to be able to do the data input.

Mira: Jeananne, do you want to add anything? Or shall we go on to the next question.

Jeananne: I'll just be real brief. Basically what we've been doing is introducing the whole concept of client-level reporting for a long time and we started introducing the variables slowly to our providers so they understood and we had gotten some buy-in. Unfortunately—I guess fortunately for us, we were able to put it as part of our contract with them. There's a mandate that they have to if they would like to continue receiving Ryan White funds is to convert over to the new process. I have to say for people who are against it they have to understand what we need to do. And they are onboard with trying to get there and the technical assistance that we've made available to them has been enormous. I think they feel more comfortable that they're not alone out there and that everybody has to do it. We frequently had priority meetings just with the data staff to see that they're all in the same boat and that's been helpful so far.

Mira: Thanks. So another question slightly along these lines came from Theresa Ramos in Chicago and she asks can we do the submissions on behalf of our provider? According to HAB that possibility is actually discussed in the instruction manual for the new dataset and we wanted to make sure that all of you know how to find out more about the requirements for the new Ryan White Services Report so in order to do that, go to the client-level data section of the HAB website and look under "Manage your Ryan White Grant" and you'll see a link to client-level data. I'll give you the direct link to that specific section now: that's HAB.HRSA.gov/manage/cld.htm. And we're going to put that into the chat box in a moment as well. This information is also expected to be up on the target website by Monday of next week.

Our next question was: "Can you supply examples of standardized releases of information that clients sign for use throughout your region?" First, I'll give a general response and then I'll find out if Jeananne or Rashidah has anything to add.

For this question, if you haven't already, first you may want to go to the dataCHATT website and look under web conferences for archived versions of our web conferences on "HIPAA and Data Sharing" and you'll also find a very helpful HRSA document there and you'll find a link to it and that document that we discussed in detail on those web conferences is a document called "Protecting Health Information Privacy and Complying with Federal Regulations, A Resource Guide for HIV Services Providers and the Health Resources and Services Administration HIV/AIDS Bureau Staff." Jeananne or Rashidah, do you have anything to add for this one?

Rashidah: I don't.

Jeananne: I do.

Mira: Okay. Go ahead.

Jeananne: Actually because of the contract language that we use with our providers to provide data, we require that our providers have memoranda's of understanding or agreements of business associate agreements between each of the providers and I believe what Mira had mentioned earlier about going to the HIPAA site, I believe it's section 164.512 discusses federal oversight, where you can share the uses of data for recording to monitor your agencies and providers and we've used that with our clients and with our consumer advocacy groups so that they understand to what extent information regarding their services are shared with the grantee and any other provider.

Mira: Thanks, Jeananne. And for those of you who find reading the legislation a little bit overwhelming, you may find that this particular document that you'll see on the dataCHATT site under web conferences

is a much easier way to get exposed to the information and get some answers to these kinds of questions. People have found it very useful so far.

We have another question that says: “In one part of our state, a contractor subs medical care to an HIV doctor. He’s a one man practice and the only local specialist. Confirm the requirements for what he must report and if he refers out to a vision specialist or OB/GYN, who reports their findings? Since he’s a sub, won’t our contractor be obligated to collect and report all this information from our medical providers?”

JSI conferred with HAB on this one and requirements are the same for all medical providers. As for referrals, HAB would expect you to provide the same quality of care for a referral as for care to all clients that you provide.

All right, we have another question from Greg Haggler in Tallahassee, Florida and he asks, “For some providers it’s not mandatory that they use our data collection system to enter and submit data; however, we’d like for everyone to use this system. Is there a good tactic to use to get all providers on board?” Jeananne, do you want to try this one?

Jeananne: Sure, Mira. Like I mentioned earlier, I think it’s key to figure out what data system that they are using and find out what the common elements are because we have found out that some of our providers may use Lab tracker or an internal agency data collection system and what we did was went out and found variables they shared. We’re using CAREWare as well as a region-specific system and we went out and we looked at the data collection system that we knew that they could already gather and we incorporated that in with additional data that we needed. We brought them all in and explained what and why we needed the information, and actually made them a part of the process so they felt that they owned it more and we were a little bit more successful in having them turn around their way of thinking and join us.

Mira: Rashidah do you have anything to add?

Rashidah: All I can say really is that we moved the entire city of Philadelphia’s HIV system into reporting in CAREWare and it’s taken about six years, pretty much what Jeananne described, but the information and the compatibility became such a technological nightmare that we just progressively moved people in and it’s a contractual requirement.

Mira: So we have a couple of questions that have come in through the “chat” box, but before I do that I want to check in with the operators, to see if anyone has dialed in through the phones?

Operator: There are no questions at this time.

Mira: Okay. One of the questions that came in through the “chat” box is directed at Jeananne and asks what software do you use to collect your program data?

Jeananne: We actually use two. We use CAREWare and, prior to CAREWare coming on board, we created our own local system. What we did was we took our system and as I mentioned earlier, we developed our own customized reports so that in CAREWare we continue to collect this data. We’re under different reporting requirements here in our region and in order to maintain that integrity of data we are running multiple systems right now, but they work together and the actual provider sites don’t duplicate data, it just comes into us in two ways and CAREWare we’re going to be 100% on once we’re all on the new client data collection system.

Mira: Okay. And Rashidah, I know you also answered that a little bit at the end of your presentation, around what you ask your providers to use, does that pretty much cover it?

Rashidah: Covers the same. Yes.

Mira: Okay, great. So let's see, we have one more question, which came in from Sharon Black. "Is everyone supposed to submit data that we contract with or is it just specific providers?" For that question, I want to redirect you back to the instructions on the client level data website that we gave the link to. If you look up in the "chat" box, just scroll up there. It's under HAB.HRSA.gov/manage/cld.htm and we recommend that you go and look at those instructions there.

So does anyone else have any other questions? Feel free to put them into the "chat" box if you there's anything you feel we haven't answered yet and operator if you could give instructions to dial into the queue one last time.

Operator: Once again, ladies and gentlemen, to register a question it is the one followed by the four on your telephone. Your line will then briefly be accessed from the conference to obtain information.

Mira: Has anyone dialed in?

Operator: There are no questions at this time.

Mira: Okay. Then we are going to bring this call—oh, look, there's one that looks like it's coming in. Bonnie Harness asks, "how do you decide who to count when only part of a physician's salary is funded at a providers? Should everyone that doctor sees be counted even though some are not Ryan White clients?"

For that one I would say, again, stay with your eyes peeled on the TARGET website. We may be able to provide you with a little bit of information on the dataCHATT website if you look under Data TA needs there. We did a poster at the Ryan White All-Grantee Meeting (posted on dataCHATT.jsi.com] where you can learn a little bit more about reporting scope, but I think there's a lot more to come from HRSA, so I think that's all we can say for now.

I'm going to go ahead and bring this call to a close. First, I want to thank our wonderful presenters, Jeananne Capetta and Rashidah Abdul-Khabeer for joining us today and I would also like to thank all of you for listening and participating in today's call. If anybody has any comments on today's call and you want to let us know what you thought about how things went, feel free to e-mail us at any time. Our e-mail address is datachatt@jsi.com. And don't forget to check dataCHATT, the TARGET Center site, and HAB e-mails for information about upcoming events as well as archived materials from past web conferences. Thanks again for joining us. Good bye.

Operator: Ladies and gentlemen, that does conclude the conference call for today. We thank you for your participation and ask that you please disconnect your lines.

[End of Recording]