Iowa
Collaborative
Safety
Net
Provider
Network

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Data Work Group Meeting Summary

Wednesday, August 5, 2009
10:00 a.m.

Participants
Bobbi Buckner Bentz, Iowa Department of Public Health
Libby Coyte, Redfield Medical Clinic
Bery Engebretsen, Primary Health Care, Inc.
Beth Jones, Iowa Department of Public Health (via phone)
Sandy Pickup, Iowa City Free Medical Clinic (via phone)
Dr. Dana Shaffer, Des Moines University
Rochelle Spinarski, Network Evaluator (via phone)

Staff
Ted Boesen, Iowa/Nebraska Primary Care Association
Kate Burgener, Iowa/Nebraska Primary Care Association
Sarah Dixon Gale, Iowa/Nebraska Primary Care Association

Welcome, Introductions, Review of the Agenda
Sarah and Ted opened the meeting and reviewed the agenda.

Data as Defined by the Safety Net Legislation
Sarah provided a brief history of the data collection efforts through the Safety Net and highlighted some of the limitations of the data being collected. Discussion points included the following:

- Libby – One group we do not collect data from is the critical access hospitals, but they are pretty resource rich.
- Bery – Hospitals in general through their emergency rooms are probably considered part of the safety net as well, but that would be a whole new world in terms of data collection.
- Ted – I think the Safety Net could position itself to be the “go to” source for information about the safety net.
- Libby – The IowaCare program should definitely be included as part of the safety net, but I am not sure how to go about getting data about this program.
- Bobbi – There are 70 sites already designated as National Health Service Corps sites and this could be another place for data. They are supposed to be safety net providers to receive the loan repayments. The participation varies, but they have to be in designated Health Professional Shortage Areas and a lot of them are in behavioral health centers. I have information about the sites and the contact people at the site. Community Mental Health Centers would be a good group to include if we expand to behavioral health.
- Rochelle – Perhaps it would be easier to define the safety net by the population being served rather than the provider type.

- Dana – You have to be looking at the mission of the organization if you go this route.
- Rochelle – Uninsured and below 200% of the Federal Poverty Level has been the working definition so looking at providers with high percentages of these individuals could be a way to look at it.
- Ted – We are looking at this to have information, but also to position the Safety Net in the policy arena. We also have to make provider awards so we need to make some decisions about data and we know we have inconsistent data from the groups that currently participate.
- Libby – There is a small amount of money available through the provider awards, but the clinics need to be able to generate this information.
- Sarah shared two different approaches that could be taken related to collecting data from the various providers. Instead of collecting data from every entity that receives an award, data could be collected using a sample and could be secured via chart reviews. The data requests for each entity could also be pared down and aligned with specific definitions provided for each specific piece of data to ensure consistency.
- Sandy – A lot of the Free Clinics count on the provider awards and collecting and reporting the data is difficult for many of them.
- Ted – Could we get a measure that validates the universe, such as encounters per year or patients per year? I do not think it has to be a change to the provider awards going out, but maybe is should not be tied to data.
- Sandy – Could there be a system with definitions that makes it clear for those reporting? It might involve some training too.
- Rochelle – It would be helpful for all of these groups to decide together what they care about. Have you reported the information back to those who send data?
- Sandy – The problem with the Free Clinic world is the disparity in size of the clinics and that some people really do not care about the data.
- The group discussed the data being collected through the Volunteer Health Care Provider Program that involves the Free Clinics. This same data is provided to the Safety Net with a couple of additional questions as well.
- Libby – Many Rural Health Clinics (RHCs) are looking for new software systems and you could provide an Excel spreadsheet to the smaller clinics. For the most part, the clinics that did not respond are part of smaller clinics around critical access hospitals that should have some capacity.
- Ted – If we get a universal measure and then build a sample from there and survey them about the other measures, would that accomplish our goals?

Expanding/Revising Approach to Collecting Data

The group then began to devise a plan for data collection for calendar year 2009. Discussion points included the following:

- Libby – How many specialty referrals are you having trouble making? This is a question we should be asking the clinics.

- Bery – I like the notion of asking the clinics to report what they can and then pulling a sample to seek additional information. You may be peeling yourselves down to Free Clinics and RHCs that cannot provide some of the basic information we are seeking.
- Dana – A basic question is what population is being served by these entities. You do not want to lose the valuable information about who these patients are. I think it is important to know the basic demographic questions.
- Ted – What if you are committed to sampling a reliable population to get this information instead?
- Libby – Have we ever asked why they have not participated or failed to submit data? Survey Monkey could be a good tool to ask these questions.
- Rochelle – We should review the data collection tools and plan on providing some training. If we could standardize that tool and figure out what the barriers are for each group, the training could be customized. It may be simple for them to recalculate what they are sending in. We need to tell them this is what we need and get it consistently. We also need to help people get to a point where they can send it. I believe most clinics are savvier than we think.
- Sandy – I think this is possible and it is important to be able to share this information. A training would not hurt.
- Rochelle – The idea of sampling to get some richer information would compliment it in a really great way.
- Ted – Maybe we need to stick with what we are asking for and then think about how to motivate them to do it. We could send the data we have collected thus far out with an appeal and share the inadequacies of it. We will work on getting more data from those capable of providing it.
- Libby – The provider award is probably a big motivator for many of the clinics.
- Bery – There are interesting things in the report. For example, 10% of the RHC patients are uninsured so approximately 60,000 visits were uncompensated visits. The reasons for services provided are really interesting about the RHCs. It means your care is getting more complicated and you are not getting compensated for a pretty large percentage of the patients.
- Libby – I think looking at this information has been important for our clinic. We have invested more resources into diabetic education because of it. I do think we need to clarify the patients versus encounters and ask for this information.
- Bobbi – If you provide the data to those sending it in, it might help everyone to see the benefit of the information. You could also make a link to the Iowa Medication Voucher Program because most of the medications are for chronic diseases, which links to what the common visits in RHCs were last year.
- Dana – I would also make sure each clinic gets their data back as compared to the aggregate.
- Rochelle – Looking at the 2007 versus the 2008 report is also interesting. You could summarize the key findings from each report and I think this would help inform our conversation for the data work group.
- Ted – This could also help with policymaking discussions.
- Bery – We were not asked to send in the frequency of diagnoses and I want to run this for Primary Health Care because we have never done that.

- Libby – The data could position the clinics for the Electronic Health Record funding opportunities as well.
- Rochelle – The number of volunteer hours at the Free Clinics from the 2007 and 2008 report has doubled, but the number of patients served went down. You could have discussions with the groups about these findings.
- Sandy – We have to find out about the reliability of data too. It would be nice if everyone had the same tool to use so the training is more meaningful.
- Ted – We will come to the next meeting with some observations about the data we have already collected. We could have a proposal for what we want to ask ready for this group to review. We can go ahead and get the provider awards out and then follow up with the groups about data. To think some of the information could change how clinics do business is a big deal. The diabetes education piece was a good example from Libby.
- Bery – You should also send out the data to the groups too and I would provide a summary of some of the key findings.
- Libby – I would get rid of the CPT request for the RHCs as it does not provide meaningful information.
- Ted – The specialty referral pieces and other community utility-related questions could be asked too.
- Bobbi – I would be interested to know how far people travel to receive care.
- Sandy – I would like to know what happens to people who do not show up for their appointment.
- Bery – We could also convene each group to talk about the priorities for each group, each groups' "wish list."
- Sarah – We could also ask why they cannot report for the questions in which they cannot provide data.
- Libby – We could ask about RHC use of the Vaccinations for Children program. This would tell us a lot about the pediatric population.
- Dana – What about looking at how they are using the funds they receive from the Safety Net.
- Sarah – this information is collected, but it is only collected on the front end.
- Libby – You could ask how they really ended up using it versus how they proposed to use it.
- Bobbi – You could also have that as the first or last question as part of the data report.
- Ted asked Rochelle about Institutional Review Board research constraints.
- Rochelle – If you did your own work, you would get better data, have more hoops, and get more resistance. If you figure out what you want to learn first, then we can come up with the best approach to get the information. A chart review would be significantly better because you control the sample and the information you get as part of it.

Action Planning and Next Steps

The group recommended the next meeting be scheduled in mid-September to ensure an update can be provided to the Safety Net Leadership and Advisory Groups during their October meetings.