



# Module 11: Analysis and Use of Data Transcript

## **Slide 1: Analysis and Use of Data**

Welcome to the Bureau of Primary Health Care's 2011 Uniform Data System Training. This is the eleventh in a series of training modules which describe the reporting requirements and step-by-step instructions for completing your 2011 UDS report. In this module we will discuss analysis and use of UDS data.

## **Slide 2: Importance of the UDS**

The UDS is a valuable tool for several reasons. The Bureau of Primary Health Care has collected program data on the 330 program since 1977. A core set of data elements have been collected from the beginning, allowing the BPHC to document the effectiveness of the 330 funded programs to funders over time. The data set continues to expand and evolve over time in order to support program monitoring and improvement. The UDS data is reported to OMB and Congress, and is used by HRSA and BPHC grantees for program improvement.

The UDS is directly linked to the 330 application process, and grantees are required to include selected clinical and financial measures in their Service Area Competition and Budget Period Renewal Applications. BPHC will monitor progress on achieving goals set out in the SAC/BPR with data reported on the UDS. Because of this, it is particularly important that UDS data is reported accurately to support effective program monitoring and improvement. Although there are no established normative or standardized benchmarks, grantees will be expected to demonstrate improvement over time or to maintain a high level of performance.

Remember, the tables of the UDS are interrelated. For analysis to be useful and valid, tables must be completed according to the instructions and according to the same scope. If different people are completing the tables separately, make sure that you work as a team and coordinate efforts.

## **Slide 3: T3A, 4B, and 4: Analysis and Use of Data**

The Patient Profile is an overview of the patients served by your health center. The Patient Profile can be used to describe patients in terms of their age, gender, ethnicity, race, income, insurance, and special population status. The data obtained from the patient profile tables is very important and can be used and analyzed in a variety of ways.

The zip code data is used to create GIS maps of all of the patient service areas to look for gaps and overlaps. This helps the Bureau to make decisions about whether or not there is unmet capacity and in turn, whether or not expansion can be justified. The maps allow us to see where there is adequate coverage and where there is not, which aids in decision making.

The number of patients is used as the denominator for various calculations including cost per patient, charges per patient, and average capitation per member month among other measures. Be sure that the total number of patients is reported accurately as it has the

potential to throw off various calculations. For example, if you have a duplicated count of patients, it may seem as if you have poor continuity of care with very few visits per patient.

#### **Slide 4: Table 5: Analysis and Use of Data**

There are several things that can be looked at using data from Table 5.

Staffing ratios can be calculated to see the ratio of various levels of support to provider FTEs. Panel size, or patients per provider, can also be calculated. Similarly, there is a relationship between the number of visits and number of patients, and a simple calculation can be performed to find out the average number of visits per patient. This helps to give us an idea about the continuity of care being offered by the health center. If the visits per patient were very low, we might wonder about whether or not the health center is providing comprehensive care, or we might wonder whether or not the health center is entering in patients and visits that should not be counted, such as those who are seen only at a health fair, screening, or vaccination clinic.

As with the patient profile tables, data from Table 5 is used as the denominator for various performance measures, for example, cost per visit, medical cost per visit, and dental cost per visit. With Table 5 data, we can look more specifically at service categories, rather than at the patient population as a whole.

#### **Slide 5: T6A: Analysis and Use of Data**

By reviewing and analyzing the number of patients and corresponding visits reported on Table 6A, useful information can be gleaned. For instance, we can calculate the average number of visits per patient per year for selected chronic conditions such as hypertension or diabetes. Also, we can look at the frequency of acute care services such as well child immunizations. Another very important analysis that can be performed is comparing Table 3A which reports patients by age and gender to Table 6A in order to calculate the approximate penetration rate for routine preventive services. For example, we could look at the number of patients who have received a pap test during the year and compare that number to the number of women reported on Table 3A who would fall into the age category for which we would expect or hope that a pap test would be performed.

#### **Slide 6: Table 6B: Analysis and Use of Data**

The data from Table 6B can be used to calculate the compliance rate for the clinical measures. By looking at the number of patients immunized divided by the EHR total or sample, we can calculate the compliance rate which could theoretically be applied to your Universe. The same is true for all other clinical performance measures captured on Table 6B.

For example, by looking at the prenatal patient information provided on Table 6B, we can calculate the percentage of women who entered into prenatal care during their first trimester.

This is a number that is very important and has been included as one of the key measures on the health center trend report.

We look at the information being reported on Table 6B over time and hope to see improvement being achieved. Health center data can be compared with prior year data at the individual health center level as well as with national averages for BPHC-funded programs, and with Healthy People goals. In reviewing data, health centers can assess performance and identify areas of excellence, as well as opportunities for improvement.

### **Slide 7: Analysis: Use of Table 7 Data**

Similar to Table 6B, the data reported on the various clinical measures on Table 7 can be used to calculate compliance rates and can be used for comparison with prior year data, national averages, and Healthy People goals. Again, the Bureau is not expecting 100% compliance, but hopes to see improvement over time.

The prenatal care data can be looked at and analyzed to calculate measures including the percent of normal weight births and also to look at disparities in health outcomes by race and ethnicity. Please be careful not to draw conclusions about health disparities at the individual grantee level as the numbers reported are too small to provide reliable assumptions. Disparities are looked at by the Bureau by aggregating data at the National level.

### **Slide 8: T8A - Data Analysis**

As you might imagine, the financial information can be used in a variety of ways. For instance, we can compare data reported on Table 8A in order to calculate the total cost per total patient, or we could look just at medical costs and medical patients reported on Table 5 if we want to know more specifically about the average medical cost per medical patient. The same is true for the other service categories; this is why it's so important to make sure that Table 5 is tied to Table 8A and reported consistently! Similarly, we can calculate the average charge per visit by looking at Table 5 visits that are reported. Also, we can look at the overall distribution of costs to different cost centers to calculate measures such as percent of overhead costs. This list is not exhaustive, but gives a few good examples of how the data from Table 8A can be used and why it's so important.

### **Slide 9: T9D - Data Analysis**

The data reported on Table 9D can be used alone to calculate the payor mix or in conjunction with other tables to calculate measures such as charges per visit or a charge to cost ratio. We can also look at the sliding fee discounts as a percent of self-pay charges or the ratio of bad debt to self-pay charges. As with the cost data, the data relating to charges and collections, including sliding fee and bad debt write off information is very important.

### **Slide 10: T9D and T9E - Data Analysis**

Together, Tables 9D and 9E help us to see where the income that the health centers receive is comes from. By looking at these two tables together, we can evaluate the diversification of funding. We can look at the data on these tables to see the total revenues per grantee or to calculate measures such as total revenues per provider FTE. Also, as stated previously, we can compare cash collections with costs. This gives a good indication of the cash flow of the health center. Analysis of Tables 9D and 9E can also provide an overview of the diversification of funding sources at the health center.

### **Slide 11: Thank you for attending and for working to provide clean and accurate data to BPHC!**

Thank you for viewing this module. If you are interested in learning more about the UDS Reporting Requirements and step-by-step instructions for completing the UDS tables, please be sure to visit the other modules available online. Remember to download training materials, available by clicking on the Resources button in the upper right hand corner of your screen.