

## **Data for Decision Making Transcript**

### **Slide 1 - Welcome**

Welcome to the Bureau of Primary Health Care's Data for Decision Making training module. Upon completion of this training, you will be able to use the data from the 2009 UDS reports for program review.

### **Slide 2 – 2009 UDS Feedback Package**

Four reports, currently available in the EHB and part of the feedback package, will be useful for your program review. These reports are intended to provide each BPHC grantee with an analysis of their own organizations UDS data, as well as comparable statistics for a series of relevant comparison groups, against which the grantee's statistics can be examined. Grantees can access the 2009 UDS Feedback package through the EHB. To access the 2009 UDS Feedback package, log into the EHB. Click "View Portfolio" under "Grants Portfolio". In the "Grants List", click "Open Grant Handbook" for the grant that you want to view. Click on the "Performance Reports" link under "Submissions" in the side menu. You will need to click on the "Search" button in the upper right corner of the list to view the accepted reports. The page that opens gives you the ability to search for UDS reports that you have submitted. Enter your search parameters for the report that you would like to view. Make sure you choose "submitted" as your schedule status. When your report comes up, click the "View Report" link in the lower left corner. Under "Action", click the "View" link to open printable versions of the reports. The reports can also be downloaded by clicking "Download as a ZIP File". As a grantee, you have access to the Summary Report, the National and State Rollup Reports, the Health Center Trend Report, and the Health Center Performance Comparison Report. Each of these reports and how to use them will be explained in greater detail in the following slides.

### **Slide 3 – Health Center Trend Report**

The Health Center Trend Report is comprised of 16 performance measures that are of particular importance to the BPHC and is used to monitor program improvements over time. The report compares the health center's performance for these 16 measures with state and national averages over a 3-year period. The measures describe health center performance in three categories: Access, Quality of Care/Health Outcomes, and Financial Cost/Viability and provide an overall picture of the health center's performance in each of these areas. This report is available at the Grantee, State and National level. The information presented in the Health Center Trend Report must be reported in SAC and BPR grant applications.

### **Slide 4 – Performance Comparison Report**

The Performance Comparison Report, created in 2010, includes three pages, which together, present a limited number of performance measures. The Performance Comparison Report is designed to compare the performance of your specific program

against the performance of programs in similar peer groupings. By comparing your program against these comparison groups, your service delivery model is described in more nuanced terms.

Each program can compare key measures against the averages of the nation and its state. Grantees can also compare against fellow peers: urban or rural grantees, based on number of service delivery sites, size of program, special populations served, and various percentile groupings (25<sup>th</sup>, 50<sup>th</sup>, and 75<sup>th</sup>). We will give more information on how to interpret averages and percentiles later in the module.

The peer groups are more sensitive than they have been in the past. Program size measures total patients served: less than 5,000, 5,000-10,000, 10,000-20,000, 20,000-50,000, and greater than 50,000. Grantees can also compare against programs with similar numbers of service sites, including administrative location. The comparison groups for service sites are: 1 site, 2-5, 6-10, 11-15, 16-20, and 21+ sites. The comparisons done at the special populations level looks at the percentage of population served who are homeless and who are migrant of the total patients served. Comparisons are divided into less than and greater than 25% of total patients served based on this criteria.

The BPHC chose these performance measures and particular emphasis is put on the following categories: patients, visits, staffing, clinical information, clinical performance, costs, and revenues.

### **Slide 5 – Summary Report**

The Summary Report functions as a quick 'dashboard' of key data that is intended to describe each grantee in a statistical manner. The Summary Report allows you to compare your performance with the performance of the state as well as the nation to identify programmatic strengths and weaknesses. The measures are broken out into two main categories: 1) Demographic and Clinical Data (Patients, Visits, Staffing and Clinical Information) and 2) Fiscal Information (Costs and Revenues).

It is important to pay close attention to what it is that you are comparing. Many of the measures, such as total FTEs, patients, and visits, are shown as gross numbers. Comparing yourself against gross averages will not be beneficial in identifying areas of strength or areas for improvement, but the percentages reported are useful for this purpose.

### **Slide 6 – 2009 National Rollup Report**

The 2009 National Rollup Report is a compilation of all 330 program data in the format of the UDS Tables. The National Rollup Report includes copies of all of the UDS Tables. Each cell indicates the national total for that measure and may provide additional information and calculations. Summary health center program grantee data are provided for patient demographics, socioeconomic characteristics, staffing, patient diagnoses and

services rendered, quality of care, health outcomes and disparities, financial costs, and revenues. This report provides the values and measures for universal and grant specific data at the National and State level and are available online at the BPHC public website.

### **Slide 7 – Interpreting the Reports**

The next series of slides will help you interpret Health Center Trend Report, Performance Comparison Report, Summary Report, and Rollup Reports so that you can get the most out of this feedback package. Although these are the only standard reports available to you, there are many other calculations that you may like to perform to better understand your program performance in key areas. You can use the data presented in the different reports and your own UDS report to calculate variables that might not be provided directly in the reports.

### **Slide 8 - Calculating Averages**

The average, also known as the Mean, is the summarized statistic for all grantees in the comparison group. The average for each comparison group is calculated by summing the raw numbers for all grantees in the group and then performing the calculation. For example, the national average for % Having First Prenatal Visit in the First Trimester is calculated by summing all prenatal patients seen in the first trimester by the sum of all prenatal patients. Averages describe the group as a whole, but are sensitive to "outliers" in terms of any grantee's relative 'size' and degree of variation from the center (ie. one grantee with many prenatal patients and very few entering in the first trimester can reduce the average for this statistic significantly). Averages for the following comparison groups are presented:

- State: All grantees in the same state as the reported grantee. This group is suppressed if there are fewer than 3 grantees in the group, to protect grantee confidentiality.
- National: All grantees in the nation.
- Urban/Rural: All grantees in the same Urban/Rural classification as the report grantee. Each grantee is classified as Rural or Urban by the BPHC.
- Size: All grantees in the same size classification as the report grantee based on total patients and classified by <5000, 5000-9999, 10,000-19,999, 20,000-49,999, or 50,000 or more.
- Sites: All grantees with the same number of active sites, including administrative locations as of the last date of that calendar year, classified as 1, 2-5, 6-10, 11-15, 16-20, or 20+
- Special Population Migrant: Grouped with grantees who, of the total patients, serve 25% or more migrant populations or grouped with grantees who serve less than 25% migrants.
- Special Population Homeless: Grouped with grantees who, of the total patients, serve 25% or more homeless populations or grouped with grantees who serve less than 25% homeless.

### **Slide 9 – Calculating Percentiles**

Percentiles are derived by calculating the statistic being reported for each grantee separately, and then ranking those values in numerical order (grantees for whom the statistic is not valid are not counted). Each percentile represents the calculated value for the individual grantee whose value is greater than or equal to, that percent of all grantees. Essentially, the grantee percentile tells you where your program stands in relation to the position of its peers. To explain percentiles a little more easily, take this example. If we placed you and a group of your coworkers in a line from shortest to tallest, where would you fall in that line? Your place in that line defines your height percentile for that group. Unlike averages, percentiles are not sensitive to outlier values in the group and may, therefore, be more representative of a 'typical' grantee when the values are not normally distributed. Percentiles are reported for the national group only, as they require significant numbers of values for validity.

### **Slide 10 – Percentiles**

It is important to note that percentiles are calculated only for those grantees that have the variable being measured. For example, if we consider 1<sup>st</sup> Trimester in Prenatal Care, we can only evaluate health centers performance against other centers which have reported prenatal care activity.

The standard reports provide percentile calculations at the median, 25<sup>th</sup>, 75<sup>th</sup>, and grantee percentile. The 50<sup>th</sup> percentile, or median, is the value at which the grantees are divided in half, with one half of grantees falling above that value, and half falling below. The 25<sup>th</sup> percentile is the value at which 25% of grantees had a lower number for the statistic, and 75% had a higher value. The 75<sup>th</sup> percentile indicates that 75% of grantees have a lower value, while 25% have a higher number for the statistic.

The grantee percentile reports the ranking of the grantee being reported amongst all grantees in the nation, on a 100 point scale. Unlike the National Percentiles, which report the value of the statistic at certain rankings (the 25th, 50th, and 75th percentile), the Grantee Percentile reports the percentage of grantees that have a value less than or equal to the value calculated for the grantee being reported.

### **Slide 11 – Percentiles Example**

Using the example from the previous slide, the grantee with the highest percentage of prenatal women having first prenatal visit in the first trimester in the nation (over 80% of the grantee's prenatal patients) will be at the 75th percentile for that statistic. The grantee with the lowest percentage of visits in the first trimester (60% seek prenatal care in the first trimester) will be at the 25th percentile, and the grantee with a percentage of prenatal visits in the first trimester higher than half of the grantees (almost 71%) will be at the 50th percentile (median). If the statistic is not valid for the report grantee, the grantee percentile will be blank on the report and the grantee will not be included in the percentile ranking.

### **Slide 12 – Grantee Percentile and Trend**

It is important to remember that a percentile does not have meaning on its own. A high or low percentile could be good or bad, depending on the measure. For example, being in a percentile lower than 50<sup>th</sup> for cost would indicate that your program has lower costs than half of the reporting grantees. Conversely, being at the 90<sup>th</sup> percentile for trimester of entry is very good, as this indicates that fewer than 10% of grantees report more women entering into a prenatal care program in their first trimester than you. Remember, 90<sup>th</sup> percentile *does not* mean that 90% of women enter prenatal care in their first trimester – it is merely a comparison between applicable programs.

You can also evaluate trend statistics for the parameters shown on the Health Center Trend Report. The trend will show the gross change and the percent change in that statistic between 1-year and 2-years. The gross change shows the numerical difference from the previous year to the current year. The percent change is calculated as the gross change over the raw statistic for the earlier year. These trends can show you whether you are heading in the right direction, or not.

### **Slide 13 – Formula Guide**

Formula Guides for these reports are available for download in the EHB.

### **Slide 14 – Formula Guide**

The Formula Guide provides the formulas for all of the measures in the order they appear in the report. The formulas provided in the formula guide “replicate” the report for which it is providing the formulas. The formulas may seem daunting, but they are really quite intuitive and show you how to manually calculate measures using the logic of the formula guide.

### **Slide 15 – Formula Guide**

Where reports show both the raw number and a percent, the formula must necessarily do the same. The red line in the chart on this slide highlights the separation of the formula for the raw number and the formula for the percentage calculation. In guides where there are references to ‘sum at each grantee level’ or ‘sum at national or state level’, for your purposes of understanding the calculations, this language can be ignored. It merely describes what programmatically happens to calculate the information for Rollup Reports at a national or state level. The remainder of the formula gives you the calculation that you can use.

### **Slide 16 – Formulas Calculated**

The formulas refer to the cells in the UDS by naming each cell with its table number, line number, and column letter. So, T6B\_L7\_CA translates to Table 6B Line 7 Column A – number of prenatal women seen in the first trimester by the grantee. The math symbols

used in the formulas are basic arithmetic functions: addition, subtraction, multiplication, and division. Remember to perform the functions in parentheses first!

As an example, if we were talking about the percentage of women having their first prenatal visits in the first trimester, you would divide the information found in Table 6B Line 7 Column A plus Table 6B Line 7 Column B, all over Table 6B Line 6 Column A.

### **Slide 17 – Rollups and Tables for Calculating Performance**

The formulas are simply mathematical calculations which allow you to manually calculate results of measures that may be of importance to the health center. These may highlight how well you are performing in other areas. Refer to the 2007 reference guide for examples of formulas you may want to perform that may not be provided in the standard reports anymore. By following the, “code” used to write the formulas, you can create any comparison that you would like to see. You are not limited to the formulas provided in the formula guide. By creating your own comparisons to generate the information that you want to know, you can make the most of your UDS Report.

### **Slide 18 – Using UDS as a Diagnostic Tool**

The following slides will provide tips that will allow you to identify programmatic strengths and focus your efforts on areas of your program with room for improvement.

### **Slide 19 – Identifying Strengths and Areas for Improvement**

In order to identify your areas of strength and areas that can be improved, look at your percentile in order to gauge how you compare to other programs. If you compare unfavorably to other programs, you might target that area for improvement. It may highlight areas where you compare favorably to other health center.

It is very important to also consider the percent change over the last two years. This can show you how your efforts have paid off. Remember, improvement over time and positive momentum is expected in both budget period renewals and SACs.

### **Slide 20 – Identifying Strengths and Areas for Improvement – Step 2**

In addition to your percentile, you will also want to look at the averages for your programs and compare them against group averages to see if there are large differences. Though you should be sure to look at the national picture to get an idea of areas in which you should improve, you should remember that an average is the compilation of the low and the high.

You should also remember to compare your program with an appropriate peer group. In addition to the national group, peer groups can be based on state, size, number of sites, urban/rural, and percentage of special populations served.

### **Slide 21 – Identifying Strengths and Areas for Improvement – Step 3**

As you know, it is essential to be aware of the interrelatedness of the UDS tables when you are reporting the data, and thus it follows that the interpretation of the data must also take into consideration the interrelatedness of the measures.

For example, when considering whether or not a program is covering its costs, one must look at collections and charges, and the billable visits. If a program is not charging enough to meet 100% of its costs, it will not be possible to completely cover costs, even with 100% charge collection.

### **Slide 22 – Focusing Your Efforts**

The UDS collects and reports a great amount of data. There is far too much information for you to evaluate completely. It would be of greater benefit to you to take a “snapshot approach” and focus on a few high-impact measures.

Four standard areas to investigate include your patient profile, quality of care, efficiency, and financial security. Consider how well the health center is meeting the Bureau’s expectations. The following slides will provide an overview of how to quickly assess those areas.

### **Slide 23 – Patient Profile**

The patient profile evaluates who is being served by your program. Your mission as a 330 funded program is to serve individuals with barriers to care, specifically the uninsured, low income populations, minority groups, and individuals best served in a language other than English. Of course, you also need to evaluate your total number of patients.

In addition to assessing gross numbers of patients, you also need to evaluate the growth of your services. The Bureau is looking for health centers to incorporate the medical home model into their programs and having comprehensive care programs for patients to access all their health care needs with the health center is working toward this model. Evaluating the change in the target populations served by your health center will identify if you are meeting the 330 mission to serve those with barriers to care.

### **Slide 24 – Quality of Care**

Assessing routine and preventive care services, serving those with chronic diseases, and prenatal care activities are the three commonly looked at measurements of performance relating to quality of care delivered by the 330 program grantees. Demonstrating quality of care improvements and initiatives at your center are important to BPHC and understanding how the BPHC looks at your performance in these areas is essential.

Examples of indicators of routine and preventive care include the percent of women who received a pap test and the percentage of children who have been appropriately immunized. Controlled diabetes, controlled hypertension, and the average number of visits per patient are indicators for chronic disease care. Prenatal care is assessed by early entry into prenatal care and the number of children born with normal birth weight. For these indicators, improvements over time will result in better health outcomes.

### **Slide 25 – Efficiency**

Evaluating efficiency requires assessing the cost effectiveness of the services delivery model. Efficiency can be assessed by looking at the cost per visit as well as the cost per patient. Evaluating the costs for medical, dental, and any other services that may be provided will help you to understand the costs in relationship to the services offered. The percentage of administrative costs at a national level has been 25% for a number of years and assessing if the level that your health center is at is reasonable and if above that or below that what might explain those differences.

The health centers capacity can be assessed by looking at providers. Panel size, which is the average number of patients served by one provider is an assessment of the medical home model. The number of visits a provider typically can take in a year may help to evaluate levels of excess capacity.

Remember, when you evaluate your efficiency, take two looks. Take one look that is a general overview and one look with an eye on reality – what it is really like to be a provider at your health center. For example, the productivity of midlevel practitioner often looks quite low. However, midlevel work is often attributed to physicians if the midlevel works under the supervision of a physician. Thus, it is not that the midlevel is underproductive; their productivity may be captured through the visits reported under the provider that is supervising.

### **Slide 26 – Financial Security**

It is also important to understand the financial viability of your program, and how the 330 funds allocated to you are being utilized.

The diversification of funding streams is important. Are you heavily reliant on particular funding sources? Look at how much of your income comes from the BPHC and the percentage of income that comes from patient services. You will also need to look at your fee structure in order to ensure that the amount you charge could potentially cover your costs. Review collection rates. Surplus or deficit as a percent of total costs, which can be calculated by evaluating costs versus revenues may point out important financial solvency.

You should also evaluate your change in net assets as a percentage of expense, your working capital to expense ratio, and your debt to equity ratio, though that information does not come from the UDS.

**Slide 27 – Thank You**

Thank you for attending this online training. For more information on UDS reporting requirements and step by step instructions for completing your UDS report, view our other modules, available online. Help is also available through the UDS Helpline and Help Email.