

Online UDS Trainings

Module 9 – Data Analysis and Use

Slide 1 - Welcome

Welcome to Data Analysis and Use Module of the Bureau of Primary Health Care's 2009 Uniform Data System training. This is one module in a series of 9 which describe the reporting requirements and step-by-step instructions for completing your 2009 UDS Report.

Slide 2 - The UDS: What is it?

The UDS is a standardized reporting system that is used by the BPHC to monitor the performance of 330 funded programs including Community Health Centers, Migrant or Farmworker Health Centers, Health Care for the Homeless Centers and Public Housing Primary Care Centers. The set of data has expanded over the years, but some core data remains the same. The trends that have been shown in this core set of data have allowed the Bureau to make strong statements about the success of the Health Center program.

The data set is uniform, meaning that all health centers completing the report are required to follow the same set of reporting guidelines and use the same definitions. The reporting instructions, training program, and review process help to ensure that this happens.

Slide 3 - Importance of the UDS

The UDS report is important for several reasons. The Bureau of Primary Health Care has collected program data on the 330 program since 1977. The data set continues to expand and evolve to support program monitoring and improvement. UDS data is reported to OMB and Congress and is used by HRSA and BPHC grantees for program improvement.

With the UDS being directly linked to the application process, 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 in the UDS. As a result, it is particularly important that UDS data is reported accurately to support effective program monitoring and improvement. Grant applications should set realistic goals. 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 4 - Patient Profile Data

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

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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 to aid in this decision making.

The profile information including income status, insurance coverage, and special population data helps the Bureau to see whether or not the target populations that are intended to be reached by the 330 program are actually being reached.

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.

Slide 5 - Table 5 Data

There are several things that are looked at using table 5 data.

Staffing ratios can be calculated to see the ratio of various levels of support to provider FTEs. Also, provider productivity by provider type can easily be calculated by looking at the number of providers and the corresponding encounters. Similarly, there is a relationship between number of encounters and number of patients, and a simple calculation can be performed to find out the average number of encounters 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 encounters 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. With table 5 data, we can look more specifically at service categories rather than at the patient population as a whole.

Slide 6 - Table 6A Data

By reviewing and analyzing the number of patients and corresponding visits reported on table 6A, there is useful information that can be gleaned. For instance, we can calculate the average number of visits per year for selected chronic conditions such as hypertension or diabetes. Also, we can look at the frequency of acute 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 7 - Table 6B 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

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calculate the compliance rate which could theoretically be applied to your Universe. The same is true for the pap test measure as well.

By looking at the prenatal patient information provided on table 6B, we can calculate the % of women who enter 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 6B over time and hope to see improvement being achieved.

Slide 8 - 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. Again, the Bureau is not expecting 100% compliance, but hopes to see improvement in each year's data.

The prenatal data can be looked at and analyzed to calculate measures including the % 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 or state level.

Slide 9 - Table 8A Data

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 encounter by looking at table 5 visits that are reported. Also, we can look at the overall distribution of costs to different cost center to calculate measures such as % 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 10 - Table 9D Data

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 encounter 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.

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Slide 11 - Tables 9D and 9E Data

Together, tables 9D and 9E help us to see where the income that the health centers are receiving is coming from. By looking at these 2 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.

Slide 12 -Thank You

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.

Slide 13 – Module 9 Quiz/Survey

Now that you've viewed module 9, let's see how much you've learned! Please take a few moments to complete a short quiz. To access the quiz, click on the link on this slide. Your participation will help to show how well you understand the content of this module, and will help us to improve our training program for next year.