Region VIII Health Center
Uniform Data System (UDS)
Data Collection and Reporting: Challenges, Best Practices, and Recommendations

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Introduction:

For more than 40 years, health centers have delivered comprehensive, high-quality primary health care to patients regardless of their ability to pay. During that time, health centers have become the essential primary care provider for America’s most vulnerable populations. Rooted in a commitment to community based patient centered care, health centers continue to focus on comprehensive services that meet the varying needs of their patient population. Health centers provide comprehensive care that must address the major health care needs of the target population and ensure the availability and accessibility of essential primary and preventive health services. Health centers also include a variety of supportive and enabling services that promote access and quality of care such as: translation/interpretation, case management, community outreach, nutrition, and transportation. Health centers provide care in non-traditional sites and settings including schools, homeless shelters, and migrant camps to maximize access and meet community needs. More than 20 million people (mostly poor and underinsured) get primary care at the federally funded centers.
Data collection, analysis, and reporting are central elements of the Health Center Program’s requirements for all grantees. Since 1996, HRSA’s Uniform Data System (UDS) has been used to annually collect and track data on patient demographics, services provided, staffing, clinical indicators, utilization rates, costs, and revenues. HRSA also utilizes these data to assist individual health centers and the Program as a whole to drive performance and quality improvement.

According to Patrick Monahan, Executive Director, Wyoming Primary Care Association, Wyoming health centers have experienced limitations in the collection of UDS data due to their IT infrastructure, staff education, and at times staff turnover. (Monahan, 2012) The University of Montana Masters of Public Health (MPH) practicum project was done by Janell Porter, RN, MPH candidate in collaboration with Patrick Monahan and the Wyoming Primary Care Association. The purpose of the project was to:

- Identify areas of discrepancies and inaccuracies in UDS data collection and reporting.
- Identify model reporting practices and successful strategies being implemented by region VIII health centers for UDS data collection and reporting.
- Establish recommendations and best practices for UDS data collection and reporting and report those recommendations to CHAMPS, the region VIII primary care associations, and health centers.
Methods:

University of Montana Institutional Review Board (IRB) reviewed the proposal and determined the project exempt from review. However, maintaining confidentiality and protecting the anonymity of health centers and health center staff remained important throughout the project.

The interview tool was developed based on areas of the UDS that had been identified as possible areas of inaccuracies and those that had been deemed worthy of further exploration. The first half of the interview focused on general information about UDS reporting and the second half of the interview was focused on the individual UDS tables.

Prior to conducting interviews with health centers, a pilot test interview was conducted and the interview tool was modified based on feedback and observations from the pilot test.

Structured phone interviewing was used for qualitative data collection. Each informant was asked the same set of prepared questions, with the same wording, in the same order. Notes were taken during phone interviews and were typed immediately following the interview. After all interviews had been conducted, interview transcripts were thoroughly reviewed to identify common themes around interview topics.

Results Related to UDS reporting in General:

The student conducted 30 minute phone interviews with a total of 10 health centers. Project participants included 4 health centers in Wyoming, 1 health center in Montana, 3 health centers in Colorado, 1 health center in North Dakota and 1 health center in South Dakota.

In order to develop a profile of staff at health center sites that are responsible for UDS reporting, respondents were asked to provide the job title and areas of the report each
individual is responsible for. Respondents were also asked to indicate whether any of the staff identified were new to UDS reporting. Health centers in region VIII vary greatly in the profile of staff responsible for UDS reporting. Some centers have an individual who is responsible for the entire report while others have a team of people in which each individual is responsible for a specific aspect of the report. While the majority of respondents indicated that they have been involved in UDS reporting for some time, one respondent reported being new to UDS reporting.

Respondents were also asked whether their health center is using an electronic health record (EHR) for UDS reporting. All but one of the health centers that participated in the project reported having an electronic health record system (EHR) in place that they are using for UDS reporting. While there were no differences in UDS reporting between the center that does not have an EHR in place and those centers that do, one of the predominant themes that came out of the interviews was that health centers experience challenges related to a lack of interface between data generated from the EHR and the UDS.

There are many available training/technical assistance tools to assist health centers with collecting and reporting data for the UDS. The student was interested in whether or not health centers are actually utilizing these tools for their reporting processes. Respondents were asked to indicate which of the technical assistance tools they have utilized and which of the tools they find to be the most helpful. Four of the respondents indicated that the most helpful training/technical assistance tool is the annual statewide UDS training because they have the opportunity to ask questions directly to a live person. However, one respondent did state “the annual statewide UDS training is not helpful at all” This respondent went on to say “we feel like we are pretty much on our own.” When asked what they feel would make the data collection
and reporting process easier this health center indicated that having one on one technical assistance, “a hands-on person in place to help us understand what we need to report and where the information needs to go (in the UDS).”

**Submitting UDS Data:**

Grantees submit UDS data using the electronic handbook (EHB). The EHB allows multiple users to work on a single UDS report in a collaborative manner. It also lets users complete tables as they are able, allowing them to be saved intermittently before completion. The EHB provides users with a summary of which tables to submit and also guidance through various resources available through the site. When a grantee completes a table, if there are errors, the system displays an edit for the table. Each edit has an ID #, name, description, and status. Edits marked with a red icon represent errors that must be corrected. Links are provided to tables where there are errors. Clicking on the link allows the person to go to the table and correct the data. Edits marked with a yellow icon represent questionable data. These may be corrected or explained as appropriate in the comments field. After fixing edits, the system requires you to run the audit report. Once all the tables and forms have been validated the report can be submitted.

Respondents were given a series of statements regarding the EHB. They were asked to indicate their level of agreement with each statement using a Likert scale in which a rating of 5 indicated strong agreement; a rating of 4 indicated agreement; a rating of 3 indicated no opinion or that the respondent neither agreed or disagreed with the statement; a rating of 2 indicated disagreement; and a rating of 1 indicated strong disagreement with the statement. One of the respondents does not do data entry for UDS so did not respond to this question.
Regarding EHB ease of use, 6 respondents indicated that they agreed with the statement and 3 respondents indicated that they disagreed. Five of the respondents indicated that entering data into the EHB can be done in a minimal amount of time while 2 disagreed; 1 strongly disagreed; and 1 had no opinion about the statement. Four of the respondents agreed that the data editing features and feedback that is built into the EHB is helpful and easy to understand. The other 5 respondents each offered varying responses including unsure, neutral, disagree, and strongly disagree. All 9 respondents agreed/strongly agreed that the ability to enter data into the EHB in part and then return to complete the report later is helpful.

**UDS Review:**

Health centers are expected to submit their initial UDS report by February 15th each year. Between February 15 and March 31 reports are reviewed. The report must be finalized by March 31. The review process enables the reviewer to highlight significant changes from the prior year when comparing the site to itself and also significant outliers where the CHC is substantially different than other CHCs. The reviewer has access to a number of reports that facilitate review including: 1) prior year UDS submissions 2) a summary report that compares the current year submission with the prior year, with other CHCs in the same state, and CHCs nationally; and 3) an audit report that flags missing information or indicators of potential concern that do not appear to align with the center’s patient mix or that are significantly different than expected. Respondents were asked whether or not they feel the UDS review process is helpful. Eight of the respondents indicated that they do feel the review process is helpful; 1 respondent is new to UDS reporting this year so was unable to comment and 1 respondent indicated that the review process is not helpful because the review report is sent to
management and the staff that are responsible for data collection and reporting do not see the report.

When asked whether or not the UDS accurately reflects the services and programs and the population being served by the health center, the majority of respondents indicated that while the UDS does reflect the population being served, the UDS does not give an accurate picture of the services being provided. One health center respondent stated, “There is not enough information about controversial things such as pain management, counseling regarding the use of medications, infectious diseases, mental health, substance abuse, injury management, other respiratory diseases, adult immunizations, and special populations. We are a state surveillance site and we don’t get credit for this on the UDS.” Another site respondent reported that “there are several educational and prevention programs (such as family planning services and mammography education) that we do that are not included in the report so our services are not accurately reflected.”

**Use of Data:**

Respondents were asked to provide examples of how they use the data. Many of the health centers indicated that they use the data when applying for grants. Many of the centers are also using the data for clinical quality improvement. One center reports that they look at the demographic numbers a lot. This respondent stated, “We use the data for funding and to determine whether or not we are meeting the needs of our population by asking should we be doing things differently?” However, some centers reported that they have not used the data very much.”
Results Related to Individual UDS Tables:

In looking at results related to individual UDS tables, the phone interview revealed that the majority of respondents do not experience any challenges to reporting data in the service area (patients by zip code) table.

Challenges with the patient profile tables (3A, 3B, and 4) are with the patients by language category and correctly identifying patients by race and ethnicity as two separate categories.

Challenges related to the staffing and utilization tables (5 and 5A) are the result of difficulties with counting face to face visits and accounting for full time staff that are contracted and not on site.

Challenges related to the clinical measures tables (6A, 6B, and 7) include issues related to accurately coding diagnoses (especially persistent asthma); difficulties related to getting documentation for services that have been performed by other providers such as childhood immunizations or pap smears; and a lack of clarity of expectations regarding measurement criteria (such as for weight counseling and tobacco cessation intervention).

For the financial tables (8A, 9D, and 9E) the greatest challenges reported are reflecting the cost of services covered by vouchers to accurately account for billing and payments. There are also challenges being experienced by some centers related to sliding fee vs. self-pay write off.
Discussion:

Accurately Reporting using an Electronic Health Record System:

Health information technology (HIT) and specifically the adoption of electronic health records is increasingly viewed as one of the most promising tools for improving the overall quality, safety, and efficiency of the health care delivery system. The Health Information Technology for Economic and Clinical Health (HITECH) Act, a component of the American Recovery and Reinvestment Act (ARRA) of 2009, represents the Nation’s first substantial commitment of Federal resources to support the widespread adoption of EHRs. The ARRA specifically provided $1.5 billion in grants to address significant and pressing capital improvement needs in health centers, including the acquisition of HIT systems for health centers and health center controlled networks.

Despite the advantages of electronic medical record systems and the fact that project respondents do have electronic health record systems in place that they are using for UDS reporting, there is a significant problem with gaps in data that are being generated by the EHR. BPHC is aware of potential issues related to UDS data that is being generated from an EHR system and cautions that just because the EHR is generating the information does not mean that the query was developed correctly and it does not mean that the data is where you think it is in your systems. BPHC advises health centers to look over data after it has been generated from the system and to evaluate whether or not it makes sense and can be considered reasonable data. Besides additional data checks, health centers in the study report that they have overcome these issues by customizing reports so that the EHR will generate the
appropriate data and manipulating data so that it meets UDS requirements. Many of the health centers that participated in the project reported that they are using the Next Gen EHR system. Considering this, an additional strategy might be the development of a Learning Collaborative between health centers who have the same EHR system to share strategies for success with using that system.

**Taking Advantage of Training and Technical Assistance Tools:**

There are a number of training/technical assistance tools that are available to health centers to assist them with UDS reporting including: regional trainings, webinars, online training modules, the UDS manual, fact sheets, and the HRSA website which has other technical assistance materials available. In addition, health centers can utilize the helpline; the UDS review process, primary care associations, the HRSA call center and the BPHC help desk. Each of these tools has a specific purpose. The BPHC UDS Support Center is to be utilized when there are issues regarding the content of the UDS report or about the use of UDS data. Defining patients or visits, questions about clinical measures, questions on how to complete various tables, or how to make use of finalized UDS data are instances in which the BPHC UDS support center might be helpful. The BPHC helpline provides technical assistance throughout the UDS reporting period. The helpline can be used by grantees when completing the UDS report in the EHB. The HRSA Call Center is available for EHB account access and structure. The HRSA call center can be used to get an EHB account, for password assistance, and setting up roles and privileges associated with your EHB account. The UDS mapper provides geographic information related to U.S. federally funded health centers. The UDS mapper tool is an online tool that uses zip code data reported on the UDS to map health center service areas and to relate patients to
community population and resources. Maps and data can also be generated from the UDS mapper for grant applications and other reports.

Despite the fact that all of these resources exist, one of the dominant themes that came out of the phone interviews with health centers was that there is inconsistent processes in place for training staff that is new to UDS reporting. In order to produce accurate and comprehensive UDS reports, health center staff needs to be able to take full advantage of available training and technical assistance tools. The most helpful training/assistance tools for new staff are: the UDS manual, the statewide UDS training, introduction to clinical measures training, and introduction to random sampling/randomizer.org. These resources provide detailed instructions for reporting; specific information regarding measurement criteria, codes, exclusions, and specifications. UDS training should be incorporated into new employee orientation programs. An additional strategy could be to implement a mentoring program in which new staff is paired with staff that are experienced with UDS data collection and reporting.

**UDS Review:**

Despite the fact that the majority of respondents find the UDS review process to be helpful, Jonathan Stewart, the region VIII UDS reviewer, indicates that health centers don’t necessarily take full advantage of the review process. He says, “Some seem to really appreciate the process. Some just want to get it off their plate which is understandable because they are very busy and stretched. A few sites, not too many, consistently submit their reports so late that it is difficult to engage on improving the quality of the report.” Jonathan has the following advice/recommendations for health center staff completing the UDS report. “Ask questions
early-our UDS helpline is available year round. Don’t submit a partially completed report or a report with known problems that can be fixed. Partially completed reports just generate a bunch of spurious audit findings that create double work for the health center and the reviewer.”

**Use of Data:**

The interview revealed that many health centers are using their UDS data. Unfortunately, there are centers that are not using the data very much. Data can be used for priority setting, strategic development, comprehensive planning, performance evaluation, service delivery modeling and strategy, resource allocation, statements of need, funding applications, quality management, leveraging resources, advocacy, identifying collaborative partners and allies, mapping the locus of power and identification of power brokers, and improving community responsiveness to health care needs across the community. Data is important for identifying areas of improvements and gaps in services, but data also helps to demonstrate program successes and value. Comprehensive data collection and analysis are the foundations of data supported decisions. Data supported decision making is a continuous process of assessing, prioritizing, planning, implementing, evaluating, and reporting. This process is central to the health of an organization, the patient base, and the community. HRSA advises, in addition to looking at your data to see how accurate it might be, look at your data to determine where the opportunities are for program improvement.

In considering challenges to UDS data collection and reporting that are specific to the individual UDS tables, the greatest challenges are with the patient profile tables (3A, 3B, and 4) and the clinical tables (6B and 7). Let us consider each of these areas more closely.
Accurately Reporting the Patient Profile Tables:

In table 3B grantees are required to report race and ethnicity for all patients. Race is self-reported by patients. Ethnicity is also self-reported but is only reportable for Hispanic/Latino. Respondents report that patients don’t understand the Hispanic/Latino race vs. ethnicity as they do not self-identify as two separate things. Respondents also indicated that many patients refuse to report race/ethnicity. Respondents feel that patients by language are a difficult category to report. One respondent indicated that patients will identify themselves as English speaking but then need a translator for interactions with the provider. When there is a bilingual provider and patients are speaking Spanish it is tough to know if the patient really does not speak English or is just speaking their native language because they know the provider is able to. Data reported for language may be estimated. But this is the only field in the UDS that an estimation is allowed. For race/ethnicity data, a standardized process may help with challenges that are being experienced in this area of the UDS. The following steps could be incorporated into the current data collection processes related to race/ethnicity. Information should be asked of patients or their caregivers and should never be gathered by observation alone. Information should be collected upon admission or patient registration to ensure that appropriate fields are completed when the patient begins treatment. Questions that assess patient race/ethnicity could include questions about UDS race and ethnicity categories; a question about ethnicity with locally relevant response categories selected from a national standard set; a question to determine English language proficiency; and a question about language preference needed for effective communication. Data should be stored in a standard
format for easy linking to clinical data. Patient concerns should be addressed when the information is being obtained and staff should receive ongoing training and evaluation.

On table 4, patients by income may be self-reported as part of the registration/intake process or confirmed by information used to calculate the sliding fee scale. For source of insurance grantees should report the patient’s primary health insurance covering medical care. Primary insurance is defined as the insurance plan/program that the grantee would normally bill first for services rendered. BPHC requires that grantees obtain medical insurance information from all patients in order to maximize third party payments. In some states CHIP is paid for by Blue Cross Blue Shield. Children with CHIP are incorrectly entered into the system as having private insurance. On the UDS, primary patient medical insurance is divided by type (uninsured, Medicaid, the State Children’s Health Insurance Program, CHIP-Medicaid, Medicare, state or local government programs, other public and private insurance). As per the UDS manual, in those states where CHIP is contracted through a private third party payor, participants are to be classified as “other public-CHIP” NOT as private, even if the third party is in fact a traditional third party payor such as Blue Cross.

**Accurately Reporting Clinical Tables:**

The next area of the UDS that seems to be troublesome for reporters is the clinical tables. HRSA and the BPHC have very specific instructions and processes for health centers to follow when reporting on the clinical measures. For 12 of the 14 clinical measures, health centers have the option to report on either the “universe” (all patients who meet the reporting criteria) or a scientifically drawn random sample of 70 patients selected from all the patients
who fit the criteria. For prenatal care and birth weight measures, grantees must report on the universe. They must also report on the universe if the universe is 70 or less. If an EHR is present it may be used in lieu of a review of a sample of charts if the EHR includes every single patient who meets the criteria; the EHR excludes every single patient who meets exclusion criteria; and has been in place long enough to find the data required for prior year’s activities. While some centers are reporting on the universe for all measures, some centers are reporting on a random sample of all measures and still other centers are reporting on the universe for some measures and a random sample for other measures. Challenges with reporting on clinical measures arise from inaccurate coding of diagnoses and whether or not patients that meet the measurement criteria are being appropriately identified as part of the universe.

For the childhood immunization measure, the goal is to have fully immunized children. The recommended childhood vaccines protect against 16 diseases including: diphtheria, haemophilus influenza type B (Hib), Hepatitis A, Hepatitis B, Human Papillomavirus (HPV), influenza (flu), measles, meningococcal disease, mumps, pertussis (whooping cough), pneumococcal disease, polio, rotavirus, rubella, tetanus (lockjaw), and varicella (chickenpox). (CDC vaccines for children program) Full immunization means receiving all of the vaccines; evidence that the child had already had the disease and therefore didn’t need to be immunized; or that the child has a contraindication to the vaccine (such as an allergy to eggs). HRSA/BPHC has very specific instructions for documenting compliance for this measure. Appropriate documentation of compliance includes: 1) a chart note with the date and name of the vaccine; or 2) a certificate of immunization prepared by an authorized health care provider or agency including the dates and types of immunizations administered. Immunization records may also
be obtained from the state immunization registry as long as it shows comparable information. For documented history of illness or a seropositive test result, the health center should find a note indicating the date of the event. A note that the patient is “up to date” does not count as sufficient evidence of immunization, nor does verbal assurance from a parent or other person that a vaccine has been given. Good faith efforts to get a child immunized which fail, remain non-compliant including: parental failure to bring in the patient; parents who refuse for religious reasons; parents who refuse because of beliefs about vaccines. To be counted as compliant, a child must be documented as being compliant for each and every vaccine.

Childhood immunization compliance is a difficult area to collect data for a variety of reasons. Some health centers do not offer immunizations at their sites so immunization services are referred to other providers. Many centers do not have systems in place for obtaining documentation for immunizations that were done by other providers. One of the other challenges reported by health centers regarding childhood immunizations is use of the state immunization registry for obtaining childhood immunization records.

Each of the states in the region has a system for tracking childhood immunizations. The Wyoming Immunization Registry (WYIR) is a secure, confidential, Internet-based immunization database containing the vaccination records of Wyoming residents. WYIR is administered and maintained by the Immunization Section within the Wyoming Department of Health. WYIR is available free of charge to authorized users, 24 hours a day, seven days a week. WYIR provides an electronic method of recording a patient’s vaccination history; assists the provider in managing vaccine inventory; and generates reminder/recall notifications to alert patients when their immunizations are due or needed.
Web-based immunization registry database (WIZRD) is an internet-based application that is used to access records in the Montana State Health Department’s immunization registry. The registry houses the immunization records for children in Montana. All immunization providers within the state can create and share electronic immunization records for their clients. Currently, the majority of private providers report to the registry by paper through an agreement with their local County Health Department. Access for registry query or immunization reporting is limited to duly authorized providers who are enrolled with the registry.

The Colorado Immunization Information System (CIIS) is a confidential, population-based, computerized system that collects and disseminates consolidated immunization information for Coloradans of all ages. CIIS is operated by the Colorado Immunization Section at the Colorado Department of Public Health and Environment and enables any immunization provider in Colorado to electronically track immunizations a person has received.

The North Dakota Immunization Information System (NDIIS) is a confidential, population-based, computerized information system that attempts to collect vaccination data about all North Dakotans. The NDIIS is an important tool to increase and sustain high vaccination coverage by consolidating vaccination records of children from multiple providers, generating reminder and recall vaccination notices for each child and providing official vaccination forms and vaccination coverage assessments. Children are linked into the NDIIS at birth through a linkage with electronic birth records. An NDIIS vaccination record also can be initiated by a healthcare provider at the time of the child’s first immunization.
South Dakota does not have an electronic immunization registry. So, in order to request a South Dakota Immunization Record a person can: 1) check with the doctor, community health or public health alliance office where the immunization was given or 2) contact the South Dakota Department of Health Immunization Program by phone or email. The department maintains microfilm files of immunization records required for school entry from the 1976-1977 school years through the present. In order for the department to locate the correct record you must provide: a name; date of birth; year the individual entered kindergarten or transferred into a school system; the school name; and city. There is no charge to copy the record which can be either mailed or faxed.

The Utah Statewide Immunization Information System (USIIS) is a statewide information immunization system that contains immunization histories for Utah residents of all ages. But, only authorized health care users have access to USIIS.

While HRSA does recognize the state immunization registry as an appropriate resource for obtaining childhood immunization records, there are several factors that make use of the state registry difficult. For instance, not all providers use the registry to report childhood immunization status so it is difficult for health centers to get those records. Second, not all health centers have access to the state immunization registry so they have to rely on the Public Health department or other providers as a source for immunization records. Third, the state immunization registry system is not a standardized system so for children who have moved from another state, health centers are not able to access those records.

The challenges experienced by health centers with regard to reporting on pap tests are very similar to those for childhood immunizations. The goal is to have pap tests for all women.
The requirement is not that the center provides a pap test to all these women but that as the host in their medical home, the health center is ensuring that they have received that service. In many cases pap tests are a service that is referred out so health centers struggle with getting documentation that the pap has been done. Many centers are relying on patient report for this information. Unfortunately, it is not sufficient to have a note that says that the patient was referred for a pap test or that the patient reported receiving the pap. If a patient goes to another provider for a pap test, the health center needs some sort of official response noting the date, the provider, and the results of the test. Patients who refused to receive a pap test or who you schedule a test for but who fail to come in for the test are considered as having not met the quality standard. Documentation in the medical record must include a note indicating the date the test was performed and the result of the finding. A chart note which documents the name, date, and results from a test performed by another provider which is based on communications between the clinic and the provider is also acceptable. Health centers should not count as compliant, charts which note a referral to a third party but which do not include a copy of the lab report or a report of some form from the clinician/clinic that provided the test. Health centers should not count as compliant unsubstantiated statements from patients which cannot be backed up with third party documentation. HRSA and the BPHC are mindful of the fact that because of the difficulty in obtaining records from third parties, it is likely that a number of women will not be able to be counted as compliant, even though the grantee has referred the patient for services. Some centers have overcome issues related to data collection for pap tests by implementing preventive screening programs that tracks where and when pap smears were done and lets the provider know by generating an order in the EHR if a pap test is
needed. Other centers have implemented systems for reconciling and getting records back from other providers.

The purpose of the child weight assessment and counseling measure is to ensure that all children have a BMI percentile assessed and that they are counseled on healthy eating and active living. For this measure, ALL children should receive counseling, not just those who may have a high or low BMI percentile. It is not sufficient to just document weight and height in the chart or to say that a well-child visit was performed. Health centers need to have some documentation in the chart to confirm that both the BMI percentile was calculated and counseling is provided. While health centers are sufficiently documenting the assessment of a BMI, the biggest challenge faced by health centers when reporting this measure is the fact that there are no clear criteria for coding the counseling piece. Because this is an all or nothing category, health centers are only partially meeting the standard (assessment of BMI). Health centers also reported that while they have an easy time meeting the standard for this measure for children up to age 5 or 6, they are struggling to meet the standard on children over age 6. After age 5 or 6 there are no more shots due for the kids so the parents stop bringing them. For older children, health centers are using sports physicals or the annual well child visit as an opportunity to assess BMI and provide counseling.

The goal of the adult weight assessment and follow-up is to make sure that all adults are assessed for their BMI but in contrast to the child weight assessment and counseling measure, counseling and intervention is only done for those adults who have a high or low BMI. Again, to be considered compliant for this measure, appropriate documentation must be in the chart. For the adult weight assessment and follow-up measure, challenges are similar to that of weight
assessment and counseling for children and adolescents with regard to the counseling piece. Additional challenges for this measure are related to issues with obtaining a weight on some adult patients. Some patients decline a weight check; some centers report that they do not have a scale to weigh heavier patients and that they are unable to get a weight on handicapped people.

The goal of the tobacco assessment measure is that all adults who are medical patients of the health center be assessed for their tobacco use. The next measure is tobacco cessation intervention. Unlike the tobacco use assessment, this measure is focused on tobacco users only. Intervention includes either cessation counseling or a pharmacological intervention. This is similar to weight assessment data; all or nothing. Health centers are assessing tobacco use but are not charting the intervention. Health centers express frustration with the tobacco measure stating that rather than an all or nothing category, there needs to be a way to account for those cases where a discussion was done or the patient was not interested in intervention and not just that the intervention was done or not done.

The goal for the asthma measure is that asthma patients with a diagnosis of persistent asthma receive therapy. One of the biggest challenges for this measure is the fact that there is no diagnostic code for persistent asthma. The BPHC recognizes this. (Stickgold, 2012) However, the BPHC expects health centers to set up a process to handle these issues. (Stickgold, 2012) Interview respondents revealed that they have implemented strategies to successfully identify those patients with intermittent asthma. Some of those strategies include teaching staff early on how to code accurately for persistent asthma; meeting weekly to go over UDS to clearly identify patients and define with the CPT code the diagnosis; doing chart audits to make sure
patients are being correctly identified; and working with the pulmonologist to get the diagnosis coded correctly.

The three new measures for the 2012 UDS (coronary artery disease and lipid lowering therapy; ischemic vascular disease and aspirin or other anti-thrombotic therapy; and the colorectal cancer screening) were not assessed as part of the project. Because of the timing of interviews, some respondents had completed their 2012 UDS prior to being interviewed while other sites had not. It was felt that in order to draw comparisons and accurately identify inadequacies in reporting, data collection methods needed to be consistent.

In general strategies for success with reporting on clinical measures include: medical staff involvement to determine baselines and what information is needed to accurately collect data; understanding the principle of randomizing and documenting carefully the process being used to randomize; drawing enough additional patients to allow for some exclusions; developing logs or registries to track patients by diagnosis or service; and the development of collaborative relationships with agencies/organizations in the community who are also providing services to health center patients in order to have greater success in accessing those records.

Conclusion:

Despite the challenges to UDS data collection and reporting, the Health Center Program is a proven solution for a nation searching for better returns in health care delivery. Health centers offer high quality care and effectively manage patient’s health care needs while reducing the use of costly emergency departments and hospitals. As health centers continue to expand into underserved areas, evidence shows they will serve ever larger numbers of patients
with complex health problems and at higher risk for poor health outcomes than the general public. Although health centers provide services not typically found in other care settings, their costs are still lower. Health centers also generate significant return on investment. Their proficient provision of preventive and primary care services reduces unnecessary, avoidable, and wasteful use of health resources. Health centers save $1,263 per person per year and $24 billion annually. As they expand to reach new, underserved communities, health centers will save an additional $122 billion in total health care costs between 2010 and 2015. This includes $55 billion for Medicaid over the five year period. Health centers also meet or exceed national practice standards for chronic condition treatment. The IOM and the U.S. Government Accountability Office have recognized health centers as models for screening, diagnosing, and managing chronic conditions such as diabetes, cardiovascular disease, asthma, depression, cancer, and HIV. Health centers significantly reduce the expected lifetime incidence of diabetes complications and their chronic care management activities have significantly improved clinical processes of care in just one or two years and clinical outcomes in two to four years. Health centers by nature exemplify the basic tenets of a patient centered medical home. They serve as a place and a relationship in which patients can receive preventive and primary care, make sense of their conditions, integrate their care, and be coached on changing their behaviors to improve their overall health.
Resource list:

- UDS manual

- Community Health Association of Mountain Plains States (CHAMPS)  
  http://champsonline.org

- HRSA Primary Care: The Health Center Program  
  http://bphc.hrsa.gov

- State immunization registries:

  Wyoming Immunization Registry (WYIR)  
  Immunization Section  
  Community and Public Health  
  Public Health Division  
  Wyoming Department of Health  
  6101 Yellowstone Road, Suite, 420  
  Cheyenne, Wyoming 82002  
  www.immunizewyoming.com  
  Phone: 1-800-599-9754  
  Fax: 307-777-7996  
  Email: wyir@wyo.gov

  Utah Statewide Immunization Information System (USIIS)  
  Utah Department of Health Immunization Program  
  288 North 1460 West  
  Salt Lake City, Utah 84116  
  Phone: 801-538-9450  
  Fax: 801-538-9440  
  Email: immunize@utah.gov
South Dakota Immunization Information System (SDIIS)
South Dakota Department of Health
600 East Capitol Ave
Pierre, South Dakota 57501-2536
Phone: 1-800-592-1861
Email to request an immunization record: Ronnie.Sluiter@state.sd.us

North Dakota Immunization Information System (NDIIS)
North Dakota Department of Health Immunizations
600 East Boulevard Avenue
Bismarck, North Dakota 58505-0200
http://www.ndhealth.gov
Phone: 701-328-3386 or 1-800-472-2180

Colorado Immunization Information System (CIIS)
Colorado Department of Public Health and Environment
Division of Disease Control and Environmental Epidemiology
DCEED-IMM-A3
4300 Cherry Creek Drive South
Denver, Colorado 80246
http://www.colorado.gov
Phone: 303-692-2437 or 1-888-611-9918#1
Fax: 303-758-3640
Email: cdphe.ciis@state.co.us

Web-based Immunization Registry Database (WIZRD)
Montana Department of Health and Human Services
https://immtraxmt.gov
Phone: 406-444-5580
<table>
<thead>
<tr>
<th>Training/technical assistance tool</th>
<th>Purpose</th>
<th>How to Contact</th>
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| BPHC UDS Support Center | To be utilized when there are issues regarding the content of the UDS report or about how to make use of UDS data. | Phone: 866-837-4357 or 866-UDS-HELP  
Email: udshelp330@bphcdata.net  
Website: [http://bphcdata.net/html/bphctraining.html](http://bphcdata.net/html/bphctraining.html) |
| BPHC helpline | Provides technical assistance throughout the UDS reporting period. The helpline can be used by grantees when completing the UDS report in the EHB. | Phone: 877-974-2742  
Email: BPHCHelpline@hrsa.gov  
Website: [http://bphc.hrsa.gov/healthcenterdatastatistics/index.html](http://bphc.hrsa.gov/healthcenterdatastatistics/index.html) |
| HRSA Call Center | Is available for EHB account access and structure. The HRSA call center can be used to get an EHB account, for password assistance, and setting up roles and privileges associated with your EHB account. | Phone: 877-464-4772  
Email: callcenter@hrsa.gov  
Website: None |
| UDS mapper | Provides geographic information related to U.S. federally funded health centers. The UDS mapper tool is an online tool that uses zip code data reported on the UDS to map health center service areas and to relate patients to community population and resources. Maps and data can also be generated from the UDS mapper for grant applications and other reports. | Phone: None  
Email: None  
Website: [http://www.udsmapper.org](http://www.udsmapper.org) |
**Strategies for Success:**

**Wyoming Strategies for success:**

Top leadership/board involvement and medical staff involvement (for clinical measures)

Know the changes to the report each year.

For new health centers, attend as much training as possible

Have a good data collection system as well as technical assistance and support

The February 15\textsuperscript{th} deadline is difficult to meet. Be mindful of this.

**Strategies for success from health centers outside of Wyoming:**

Educate yourself as much as possible

Be sure you understand the principle of randomizing and document carefully the process you are using to randomize

Figure out where you are pulling data from and educate the staff that develop reports to make sure data is coming from the right place-make sure that everyone is on the same page

Don’t forget that the UDS is all year long, not just in January

Periodic review with chart audits, fiscal audits, and previous years reports to identify areas that we are lacking and then make changes to documentation to more accurately capture data.

**HRSA Strategies for success:**

Work as a team-tables are interrelated

Adhere to definitions and instructions-read the manual, and apply defined criteria, codes, exclusions, and specifications.

Check your data before submitting-review data and relationship of clinical information to patients served, activity, and race ethnicity across tables; address edits in EHB by correcting or providing explanations that demonstrate your understanding (identifying that the data are directly from the PMS or EHR is not a sufficient response

Report timely, accurate data

Work with your reviewer
**Student Recommended Strategies for Success:**

For staff that is new to UDS reporting, incorporate UDS training into new employee orientation.

Ensure that staff that is new to UDS training has access to the following training/technical assistance tools: read, review and thorough understanding of the UDS manual; introduction to clinical measures; introduction to random sampling/randomizer.org; and the statewide UDS training.

Consider implementing a mentoring program in which someone who is experienced with UDS reporting is paired with staff that is new to UDS reporting.

For data that is being generated from an EHR, look over the data and ask yourself, “does it make sense?”; conduct periodic data review; customize reports so that the data being generated more closely matches that being requested for the UDS; consider the establishment of a learning collaborative between centers that have the same EHR system so that those who have experience with the system can assist others who are new to using the system.

Understand your data

Identify gaps in data and opportunities for improvement

Use data to celebrate program success and value

Make your center accountable for its data by sharing the data with the board of directors, health center administration, staff, and the community.
References:


