Welcome

We All Do IT: UDS and Reporting Software

Tuesday, May 3, 2016

We will begin promptly at (3pm EST)

Event Host
Juli Hishida
National Health Care for the Homeless Council

Tech support: Caroline
Phone support: Lori

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Presenters

Susan Friedrich, MBA, PMP
Managing Director, JSI
Bow, NH

Chuck Amos, MBA
Director of Performance Improvement/ Interim Director of Health Informatics, HCH
Baltimore, MD

Chris Espersen, MSPH
Independent Contractor, Past President of MWCN
Franklin Park, IL
The Role of Technology in UDS Reports
The HITEQ Center collaborates with HRSA Partners to support health centers in full optimization of their EHR/HIT systems for continuous, data driven quality improvement.
HITEQ Advisory Committee

Includes PCA, HCCN, Health Center, REC & NCA representatives

• Baltimore Health Care for the Homeless, Chuck Amos
• Colorado Community Health Network, Erin Lantz
• Colorado Regional Health Information Organization (CORHIO), Morgan Honea
• Family Health Clinic of Carroll County, Jim Layman
• Massachusetts League of Community Health Centers, Ellen Hafer
• Mississippi Primary Health Care Association, Joseph Grice
• National Association of Community Health Centers, Inc., Shane Hickey
• New Mexico Primary Care Association, David Roddy
• Primary Health Care Inc., Chris Espersen
• Purdue Healthcare Advisors, Randy Hountz
• Qualis Health. Foster C. “Bud” Beall, Jr.
• Ravenswood Family Health Center, Nai-Yun (Ariel) Hu
HITEQ Team

- JSI, AHP, Westat
- Access to a national audience
- Experience managing TA/T centers to connect health centers to timely expertise
- Experience establishing clearinghouses and assembling lessons learned
- No affiliation with EHR vendor or IT service
- Supporting expertise in UDS data reporting, practice transformation, EHR implementation and quality improvement
Needs Assessment

UDS Data Analysis
- Assemble data set to integrate UDS data with other data sources
- Analyze data to understand state of HIT across health centers

Stakeholder Input
- Document current and past activities
- Raise awareness of the HITEQ Center as resource
- Solicit input re. role for HITEQ Center
- Identify best practices for dissemination
Increasing EHR Reporting

Reporting Method by Year

% of Total Number of Records

- 2011: 78% EHR, 22% Sample
- 2012: 64% EHR, 36% Sample
- 2013: 53% EHR, 47% Sample
- 2014: 44% EHR, 56% Sample

Reporting Method Key:
- Blue: EHR
- Red: Sample
Improving Results Overall

Avg. Performance by Method and Year

<table>
<thead>
<tr>
<th>Year</th>
<th>EHR</th>
<th>Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>29.7%</td>
<td>40.3%</td>
</tr>
<tr>
<td>2012</td>
<td>37.0%</td>
<td>50.1%</td>
</tr>
<tr>
<td>2013</td>
<td>43.0%</td>
<td>58.0%</td>
</tr>
<tr>
<td>2014</td>
<td>47.8%</td>
<td>61.0%</td>
</tr>
</tbody>
</table>

Reporting Method Key
- EHR
- Sample
Different Distribution by Method

Compliance Distrib. by Reporting Method (2014)

Reporting Method Key
- EHR
- Sample

<table>
<thead>
<tr>
<th>% of Total Count of Number of Records</th>
<th>&lt; 10%</th>
<th>10 to 20..</th>
<th>20 to 30..</th>
<th>30 to 40..</th>
<th>40 to 50..</th>
<th>50 to 60..</th>
<th>60 to 70..</th>
<th>70 to 80..</th>
<th>80 to 90..</th>
<th>90 to 10..</th>
</tr>
</thead>
<tbody>
<tr>
<td>EHR</td>
<td>3.8%</td>
<td>1.3%</td>
<td>2.9%</td>
<td>3%</td>
<td>4.2%</td>
<td>19.4%</td>
<td>19.4%</td>
<td>14.0%</td>
<td>15.2%</td>
<td>19.1%</td>
</tr>
<tr>
<td>Sample</td>
<td>9.3%</td>
<td>13.1%</td>
<td>8.9%</td>
<td>15.2%</td>
<td>13.1%</td>
<td>5.2%</td>
<td>19.1%</td>
<td>20.3%</td>
<td>12.5%</td>
<td>10.2%</td>
</tr>
</tbody>
</table>
Impeded Average Overall Performance
Key Findings – Stakeholders

• Provide the “glue to bring silos together”
• Identify and disseminate best practices from across stakeholder groups to a national audience
• Operate as an independent, objective broker to link grantees to available resources
• Assemble and facilitate access to relevant, timely and high quality resources
HITEQ Services

• Searchable and adaptable web-based Health IT Clearinghouse

• Workshops and webinars on Health IT and Data Driven QI topics

• Technical assistance and responsive teams of experts to work with small groups of health centers experiencing specific challenges or needs
• Data Driven Quality Improvement
• QI/HIT Workforce Development
• Health Information Exchange
• EHR Selection and Implementation
• Privacy and Security
• Emerging Technologies
• Electronic Patient Engagement
• *Updated UDS EHR form and instructions to provide accurate reporting*
Health Care for the Homeless, Baltimore

EHR: GE Centricity Practice Solution

PHM: Azara DRVS
Goals

1. Understand the stories that data tells us
Goals

1. Understand the stories that data tells us
2. Describe the differences between EHR and population health management (PHM) systems
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1. Understand the stories that data tells us
2. Describe the differences between EHR and population health management (PHM) systems
3. Explain how Baltimore used these systems to improve UDS scores and client care
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4. Be able to identify the best systems
Goals

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We need our data to tell us a story.
Maybe a story about how our diabetics are doing …

HbA1c ≤ 9 - Monthly

- April: 66%
- May: 64%
- June: 70%
- July: 71%
- August: 67%
- September: 72%
- October: 69%
- November: 69%
- December: 74%
- January: 72%
- February: 68%
- March: 68%
... and who our diabetics are ...

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Last Visit</th>
<th>Next Visit</th>
<th>Last A1c Date</th>
<th>Last A1c Value</th>
<th>Last LDL Date</th>
<th>Last LDL Value</th>
<th>Last Foot Exam</th>
<th>Last Eye Exam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smith, Jane</td>
<td>44</td>
<td>3/18/16</td>
<td>6/20/16</td>
<td>7.2</td>
<td>10/1/15</td>
<td>94</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jones, Joe</td>
<td>68</td>
<td>12/26/14</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient, Test</td>
<td>49</td>
<td>4/21/16</td>
<td>5/20/16</td>
<td>6.7</td>
<td>4/21/16</td>
<td>133</td>
<td>4/21/16</td>
<td>4/21/16</td>
<td></td>
</tr>
</tbody>
</table>
It’s important to include sad stories ...

Depression Screening Rate - Monthly
... so we can change the endings.
But sometimes we face a different situation ...
... like lots of data, but no story ...
... or barely any data at all ...
... or even worse!
Solution

• Use a strong EHR system to capture and store data
• Use a strong PHM system to convert that data into clinical quality information ... and into compelling and informative stories
Goals

1. Understand the stories that data tells us
2. Describe the differences between EHR and population health management (PHM) systems
3. Explain how Baltimore used these systems to improve UDS scores and client care
4. Be able to identify the best systems
A strong EHR allows us to:

- ensure our information systems reflect clinical workflows, not the other way around
- document the care we provide
- capture data appropriate to our population
- capture discrete data for UDS and other quality measures
- help demonstrate the quality of our care
EHR vs. PHM

A strong PHM allows us to:

• identify workflow problems
• better understand our population
• monitor our progress toward UDS and other quality measure goals
• work proactively, not reactively
• help demonstrate the quality of our care
Combining EHR & PHM

Cervical Cancer Screening by Housing Status

- Housed: Screened 51.2%, Not Screened 48.8%
- Doubling up: Screened 40.5%, Not Screened 59.5%
- Transitional: Screened 42.3%, Not Screened 57.7%
- Shelter: Screened 14.6%, Not Screened 85.4%
- Street: Screened 23.4%, Not Screened 76.6%
- Other/Unknown: Screened 18.8%, Not Screened 81.2%
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2013

- Baltimore researching better use of data
- Missed opportunities to test A1c in diabetics
- Manual proof-of-concept
- A story started to emerge...
2013

A1c Tests Ordered for Diabetics

- Pre-Intervention: 57.14%
- PDSA 1: 72.57%
2014

- Investigated our cervical cancer screening data
- Identified data integrity issues
- EHR workflows did not reflect clinic workflows
- Another story started to emerge ...
Ways to Order a Pap Smear

April 2014: 30
April 2015: 8
2014

- Time to invest in a PHM system
- Considered several options
- Consulted with several health centers
- Implemented Azara DRVS in late 2014
2014

Our UDS quality scores were worse!!!
2015

• Monthly review of UDS quality data
• Focused quality improvement interventions
• First UDS quality report based entirely on our “universe”
2015

• Our UDS scores got better!
• Improvement on 80% of UDS quality measures
2016

- Monthly provider-level UDS quality reports
- Addition of dental EHR
- Creation of Health Informatics team
- Addition of Chief Quality Officer
Goals

1. Understand the stories that data tells us
2. Describe the differences between EHR and population health management (PHM) systems
3. Explain how Baltimore used these systems to improve UDS scores and client care
4. Be able to identify the best systems
EHR & PHM systems

• There is no perfect EHR or Population Health Management system

• Every system has its strengths and weaknesses

• The best system is the one that fits your health center
EHR & PHM systems

A few of the things to consider when choosing a system:

• Data ownership
• Data access
• EHR form customization
• Leadership buy-in
• Staffing
• Budget
• Staff readiness
• Data readiness
Goals

1. Understand the stories that data tells us
2. Describe the differences between EHR and population health management (PHM) systems
3. Explain how Baltimore used these systems to improve UDS scores and client care
4. Be able to identify the best systems
Smart investments in quality pay for themselves
Organization

34,000 patients

6 sites

Level 3 PCMH + JC
Our UDS Philosophy

“Oh no, its UDS time...”

“Oh boy, let’s see those numbers!

Tip: Have management AND frontline staff brainstorm why UDS is important to help improve your UDS data collection and reporting. Explain how their job affect UDS and the organization.
Benefits of Good UDS Data

Grants....needs assessments...advocacy....oh my!

Tip: Use your UDS data as much as possible: in your HRSA required Needs Assessment, advocacy efforts to legislature and community, and of course, for grants!
In the beginning...

Tip: It’s ok to still be here! Write down your step-by-step process so everyone reviews charts in a standardized way. Better data = better care to patients!

“Oh no, its UDS time...”
Tip: Be watchful for local opportunities that align with your UDS data...pay for performance, local resources to leverage, and of course, the HRSA quality awards!
## UDS Report

### Table 3A: Patients By Age and Gender - Universal

<table>
<thead>
<tr>
<th>S.No</th>
<th>Age Groups</th>
<th>Male Patients (a)</th>
<th>Female Patients (b)</th>
</tr>
</thead>
<tbody>
<tr>
<td>34</td>
<td>Ages 65-69</td>
<td>420</td>
<td>558</td>
</tr>
<tr>
<td>35</td>
<td>Ages 70-74</td>
<td>280</td>
<td>366</td>
</tr>
<tr>
<td>36</td>
<td>Ages 75-79</td>
<td>176</td>
<td>386</td>
</tr>
<tr>
<td>37</td>
<td>Ages 80-84</td>
<td>121</td>
<td>191</td>
</tr>
<tr>
<td>38</td>
<td>Age 85 and over</td>
<td>82</td>
<td>212</td>
</tr>
<tr>
<td>39</td>
<td>Total Patients (Sum lines 34-38)</td>
<td>1,079</td>
<td>1,613</td>
</tr>
<tr>
<td></td>
<td>Total Patients (Sum lines 1-38)</td>
<td>14,357</td>
<td>16,825</td>
</tr>
</tbody>
</table>

### Table 3A: Patients By Age and Gender - Health Care For The Homeless

<table>
<thead>
<tr>
<th>S.No</th>
<th>Age Groups</th>
<th>Male Patients (a)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Under Age 1</td>
<td>24</td>
</tr>
</tbody>
</table>

A1c <9

![Graph showing A1c levels for different providers](Image)
UDS Report Resources

PCAs/HCCNs!

Vendors at conferences!

UDS reviewers!
## Mind the Gap

<table>
<thead>
<tr>
<th>Site</th>
<th># PVP</th>
<th>F2F</th>
<th>Phone</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>NCM A</td>
<td>26</td>
<td>195</td>
<td>48</td>
<td>269</td>
</tr>
<tr>
<td>NCM B</td>
<td>637</td>
<td>1542</td>
<td>377</td>
<td>2556</td>
</tr>
<tr>
<td>NCM C</td>
<td>252</td>
<td>471</td>
<td>374</td>
<td>1097</td>
</tr>
<tr>
<td>NCM D</td>
<td>57</td>
<td>163</td>
<td>57</td>
<td>277</td>
</tr>
<tr>
<td>NCM E</td>
<td>408</td>
<td>789</td>
<td>18</td>
<td>1215</td>
</tr>
<tr>
<td>NCM F</td>
<td>496</td>
<td>1550</td>
<td>236</td>
<td>2282</td>
</tr>
</tbody>
</table>

Tip: Even the best EMRs are only as good as the data and codes you enter. If you don’t bill for a certain service, make sure you have another documented process to track UDS measures.
Tip: Communicate with front line staff the reason drop down boxes are generally the best is because many systems can be programmed to search for critical values.

### MAMMOGRAM
- Birads 1
- Birads 2
- Birads 3
- Birads 4
- WNL
- Moved to Texas
- Refusing
- Patient declines 1/2011
- Completed 12/8/11
- Completed Dr Paulson
- n/a
- unknown
**Start with the data!**

### MAMMOGRAM
- Birads 1
- Birads 2
- Birads 3
- Birads 4
- WNL
- Moved to Texas
- Refusing
- Patient declines 1/2011
- Completed 12/8/11
- Completed Dr Paulson
- n/a
- unknown

### LANGUAGE
- Husband
- SpAbbyT
- Erica
- Ever
- C2Spanish
- VaoLao
- Bermese
- Bermuise
- Burmice
- Burmesel
- Burmease

**Tip:** Communicate with front line staff the reason drop down boxes are generally the best is because many systems can be programmed to search for critical values.
OBS Terms

For almost any clinical indicator you will be tracking, you will most likely need the clinical value to be populating your flowsheets.

IMPORTANT: for any measure you are tracking, you will want to ensure fidelity of the clinical values.

Tip: Always invite questions AND criticism about your data. An open dialog = more conducive environment to quality improvement, and therefore, quality care!
Start with the data..end with better outcomes!

**Tip:** Develop and document your plan for ensuring a consistent data auditing. Visit [hiteqcenter.org](http://hiteqcenter.org) for more details!
Start with the data..end with better outcomes!

Tip: Develop and document your plan for ensuring a consistent data auditing. Visit hiteqcenter.org for more details!
Improving Care for Consumers
Tip: Don’t overload your huddles! Only include your QI priorities and items that your clinical staff have agreed to.
Tip: Reviewing your day before it starts is good and will make your day easier. Reviewing how the day went is great and will make your future brighter!
Using data to involve the team
Outreach to Patients

DINOSAURS NEVER WENT TO THE VET
LOOK WHAT HAPPENED
Reports of patients overdue for items (TIPS)

- One call for all items!
Reports of patients overdue for items (TIPS)

- One call for all items!
- Filter patients who have upcoming appointments
Reports of patients overdue for items (TIPS)

- One call for all items!
- Filter patients who have upcoming appointments
- Effective calls
Reports of patients overdue for items (TIPS)

- One call for all items!
- Filter patients who have upcoming appointments
- Effective calls
- Track intervention!
Reports of patients overdue for items (TIPS)

- One call for all items!
- Filter patients who have upcoming appointments
- Effective calls
- Track intervention!
- Communicate with others
Table 4: Outreach and Enrollment
## SDH: Own Health Risk Assessment

<table>
<thead>
<tr>
<th>Access Barriers</th>
<th>Mental Health Barriers</th>
<th>Social Barriers</th>
<th>Other SDH</th>
</tr>
</thead>
<tbody>
<tr>
<td>78% - Affordability of Care</td>
<td>5% Substance Abuse</td>
<td>23% - Lack adequate housing</td>
<td>39% - LEP</td>
</tr>
<tr>
<td>67% - Regular medical</td>
<td>12% Mental Health</td>
<td>24% - No reliable transportation</td>
<td>11% - Cultural</td>
</tr>
<tr>
<td>appointments</td>
<td>Issues</td>
<td></td>
<td>barriers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>18% - Incarcerated</td>
<td>20% - Other</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>barriers</td>
</tr>
</tbody>
</table>

**Tip:** Before going full steam into some social determinant of health project, investigate what insurers in your area are requiring and how to integrate data systems and processes instead of having staff duplicate efforts.
Table 6A

Substance Abuse- billed vs documented

<table>
<thead>
<tr>
<th>ICD-9 billed</th>
<th>External Problem</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Diabetes- billed vs documented

<table>
<thead>
<tr>
<th>ICD-9 billed</th>
<th>Problem</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Domestic Violence – billed vs documented

<table>
<thead>
<tr>
<th>ICD-9 billed</th>
<th>External Problem</th>
<th>Other Profile Item</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Tip: Look at your Dx codes on UDS and see if it makes sense for your population. Look for opportunities to improve coding—this will help with value based payments down the road!
Who has the best data, wins!

Beyond UDS to HEDIS/P4P

“I felt like someone cared”
Resources

- Free Training & Technical Assistance on all HCH administrative issues
  - [https://www.nhchc.org/get-assistance/](https://www.nhchc.org/get-assistance/)

- Sign-up for **alerts** on upcoming HCH webinars and training events
  - [https://www.nhchc.org/about/membership/individual-members/individual-membership-application/](https://www.nhchc.org/about/membership/individual-members/individual-membership-application/)
Questions & Answers

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Managing Director, JSI
Bow, NH

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