

# Using UDS Reporting as an Internal Quality Improvement Tool

David M. Carr, MPH

Primary Care Informatics Manager, CVN/HCCN

# Purpose & Format

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- Purpose: To discuss lessons learned from the past two years of UDS clinical data and how to proactively impact 2018's clinical measures.
- Consists of four topics and several polling questions regarding the information.

# Peer Learning Connection

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- Using the “disseminate best practices” mandate to review UDS data and highlight mechanisms that can improve outcomes both for patients and federal stakeholders

# Question Time!



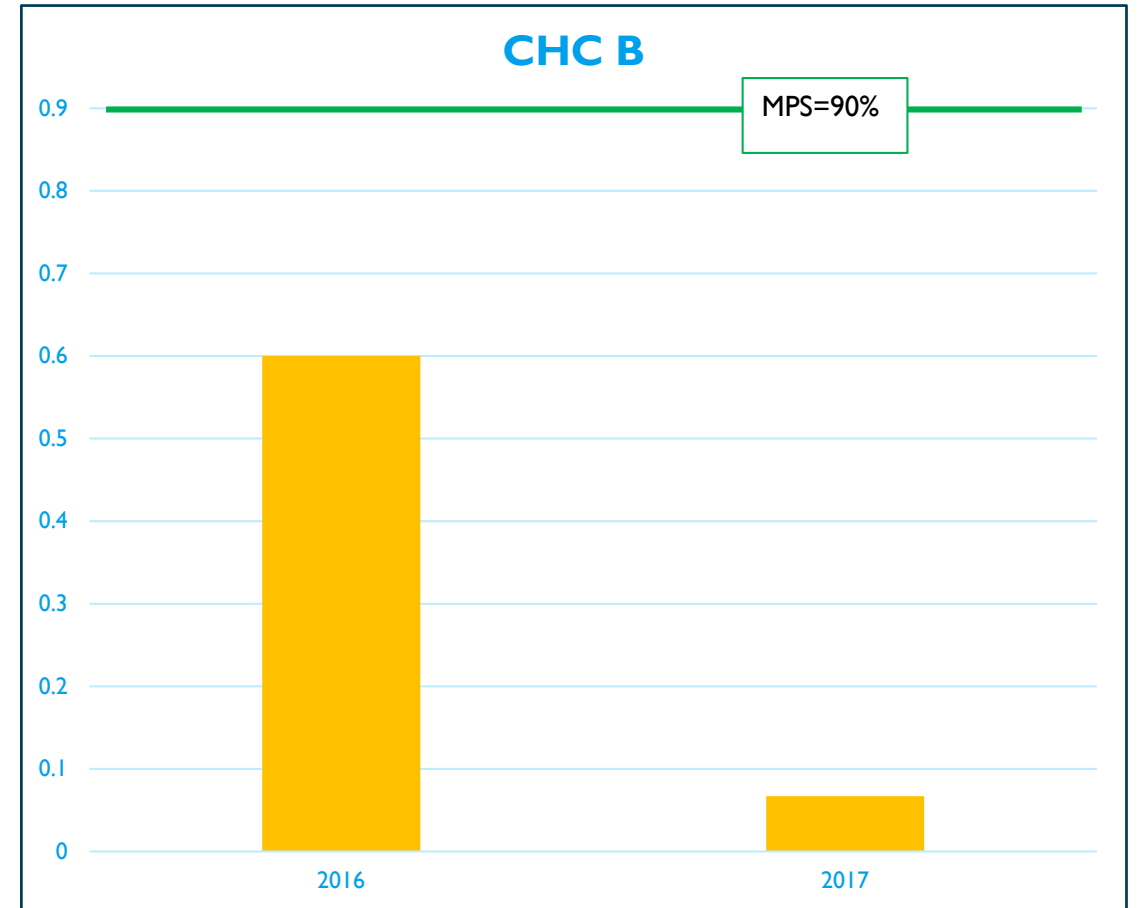
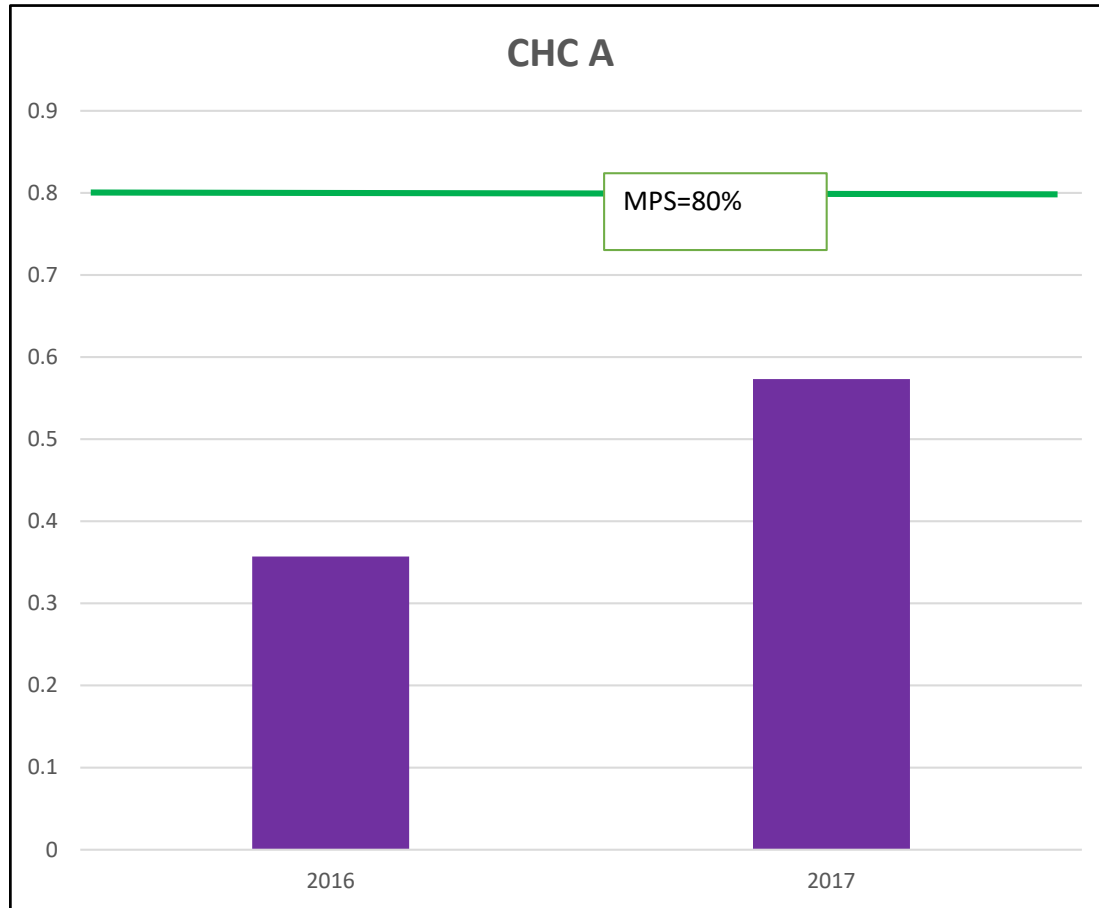
# Answer:

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Changing methodology from chart auditing to full population review will **impact** the percentages reported.

- Sampling error among others can impact results, thereby if possible using population health software and biostats methods will minimize those issues as much as possible.

# Examples of Chart Auditing vs. Total Population



# Question Time...Double Jeopardy!!

# Answers

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- What gets measured, gets **done**
  - QI reporting's premise
- Trick Question- everyone gets a point 😊
  - The goal is to be able to mitigate or explain variations in your reporting. The more often (within reason) the closer to every day practices
  - Davida's goal- biannually by Dec. 2018; quarterly by Sept. 2019.



# UDS Measure Surveillance

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- Not just for the sake of reviewing. Allows for advanced notice of potential problems
- Think small, i.e. determine the “path of least resistance” for your own QI clinical data

Think Small: Surprisingly Simple Ways to Reach Big Goals- Service&Gallagher, 2017.

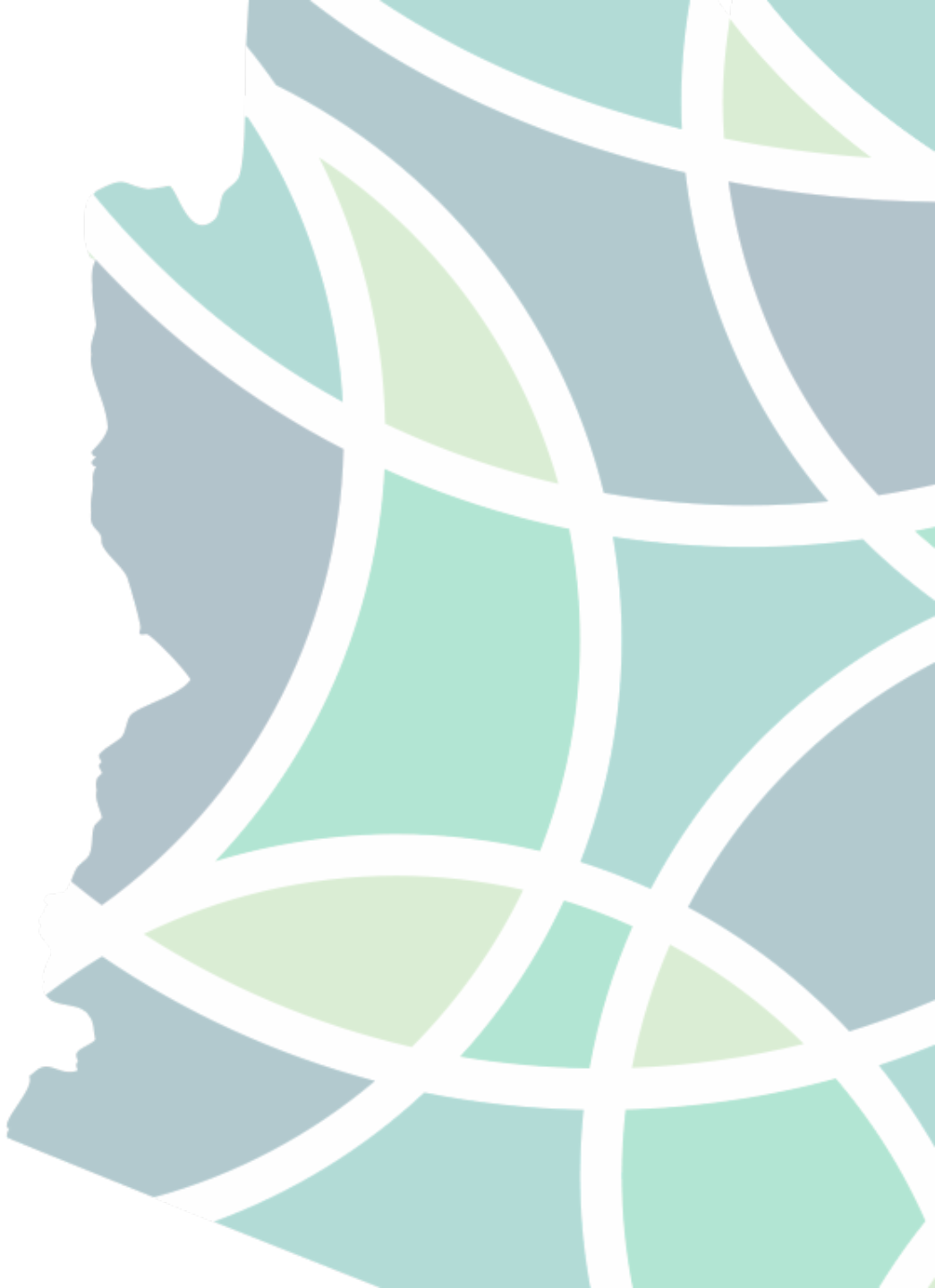
- *“GALLAGHER: We had a very simple intervention, which was to write to those doctors who were prescribing the highest amounts of antibiotics and just let them know that they were in that top cohort, and things that they could do to avoid over-prescription. It was primarily about feedback, about where they sat compared to their peers, but also a set of specific actions that they then could take.*
- *DUBNER: And how effective was it?*
- *GALLAGHER: It was very effective. Over the six-month period of the trial, GPs [general practitioners] who received that specific letter prescribed an estimated 73,000 fewer antibiotic items than those who didn't receive the letter.”(Freakonomics Radio, 3/17)*

# Community Health Center Application

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- Review 2017 UDS report
  - Anything in particular stand out? Personnel remember having challenges with? HRSA asked about(again)?
- Check into at least a few perennial problem measures
  - Diabetes labs not being logged automatically? Childhood Immunizations missing? Colonoscopy STILL being ordered more than FIT testing?
- Determine if there's opportunities for improvement or replication
  - Increase in Childhood Immunization rates at one clinic could be replicated to others; cervical cancer screening mapped incorrectly in 2017, etc.

# Question Time!!!



# Answer

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- Deciding to monitor the data is the first step.
- The remaining three options HCCN is available to assist your process of working through.

# Technical Briefings and Updates

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- Though proliferate, helps to keep you “in the loop” if/when policymakers update guidelines, change methodology, etc.
- Example: Diabetes Quality Improvement Initiative & Site Visit Notification

## David's Update Roster:

CMS- eHEALTH, Post Acute Care Quality Reporting, Hospital Quality Reporting, QPP

HRSA- FORHP, Primary Health Care

HCCN

AACHC

Azara

CDC- MMWR

# Training & Policies

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- Varies by a number of factors among HCCN community health centers
- Regardless of process, goal is identical: ensuring consistent, “clean” data input into the appropriate place in HER.
- Training is easier when policies match & up to date
- Keep-It-Simple 😊

## Last Question\*:

Did your organization train personnel by discipline or some other grouping method? Was it successful?



# Questions??

Thank you!

David M. Carr, MPH  
Primary Care Informatics Manager  
[davidac@healthyarizona.org](mailto:davidac@healthyarizona.org)

