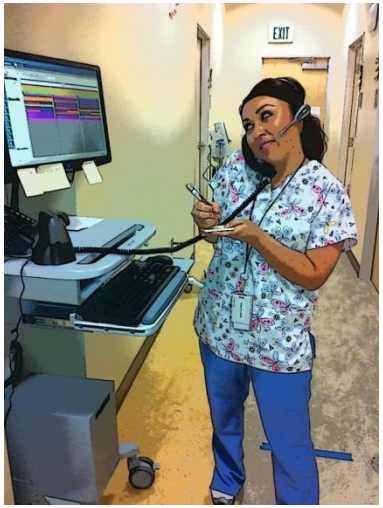
Mastering UDS: Implementing New Measures and Improving Your Outcomes



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Learning Objectives

- Discuss the UDS clinical measures for 2015.
- Explain changes in the UDS clinical measures from 2014 to 2015.
- Identify best practices for meeting HRSA goals for UDS clinical measures.
- Apply at least one new technique for improving UDS clinical measure outcomes.

Agenda

- Introduction
- Part 1 – Table 6B
- Part 2 – Table 6B
- Part 3 – Table 7
- Part 4 – Pediatric and OB Measures
- Conclusion

- Petaluma Health Center
  - Opened 1996, FQHC since 2000
  - 23,000 patients → 100,000 annual visits
  - Main Practice Site
    - Dental Services
    - Medical Services – 3 Family Medicine Teams, 1 Women's Health Team
    - Mental Health Services
    - Wellness Services
  - Mary Isaac Center - Homeless Clinic

- Providers
  - 27 Family Medicine
  - 5 Women's Health
  - 7 Mental Health
  - 5 Dental Health

Uniform Data System (UDS)

- Began in 1977
- Way for BPHC to measure effectiveness of health centers
- Standard set of data:
  - patient demographics (Tables 3 & 4)
  - services provided (Tables 5 & 6A)
  - staffing (Table 5 & 5A)
  - **clinical indicators (Tables 6 & 7)**
  - utilization rates (Table 8)
  - costs, and revenues (Table 9)
- Trend toward standard measures – NQF (National Quality Forum)
- Data is now public

Table 6B: Quality of Care Indicators

- Prenatal care
- Childhood immunization
- Cervical cancer screening
- Adolescent weight screening and follow up
- Adult weight screening and follow up
- Tobacco screening and cessation intervention
- Asthma therapy
- Cholesterol treatment in patients with CAD
- Aspirin therapy in patients with ischemic vascular disease
- Colorectal cancer screening
- HIV linkage to care
- Depression screening and follow up

2013 Health Center Profile

PETALUMA HEALTH CENTER, INC.
PETALUMA, CALIFORNIA

Total Patients Served: 21,519

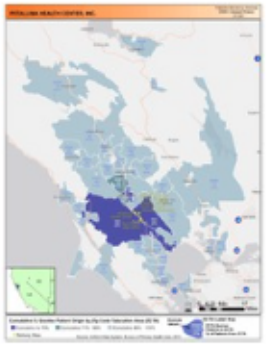
EHR PCMH

Download:

Find a Health Center

View all California Program Grantees

View National and State Program Grantee Data



Click to enlarge

View By:

National Data
- Program Grantees
- Look-Alikes

State Data
- Program Grantees

Health Center Profiles
- Program Grantees
- Look-Alikes

Reporting and Technical Assistance

Access Data Tools

- Data Warehouse
- Data Snapshot
- Data Comparisons

View also:

Special Populations:
- Homeless
- Migrant Health
- Public Housing

Age and Race/Ethnicity

Patient Characteristics

Services

Clinical Data

	2011	2012	2013	2011 - 2013 Trend %Change
Patients				
Medical Conditions (% of patients with medical conditions)				
Hypertension [3]	16.1%	17.9%	16.1%	0.0%
Diabetes [4]	7.5%	7.6%	8.0%	7.1%

Resources and Trainings

- Online:
  - http://bphc.hrsa.gov/datareporting/index.html
- PCA in-person training in the fall
- Your EHR vendor

Annual Process

- February: Submit report
- March – April: Training
  - BPHC read PALs, webinars
  - EHR vendor
- May – June: Implement new measures
  - EHR customization
  - Clinical team education/training
- July – December:
  - Clinical data run monthly
  - Data QA process – ongoing
- January: Create final report

Health Center UDS Team

- CFO
- CMIO
- Data analyst
- Director of finance
- Director of practice operations

Proposed changes for 2015

- Table 4 – The number of dually eligible Medicare and Medicaid patients
- Table 6B – The number of children age 6-9 years at “elevated” risk for cavities who received a dental sealant
- Table 7 – Diabetes A1c results between 8-9% no longer need to be reported

UDS Clinical Measures in a Health Care for the Homeless Setting

Bernie Delgado, RN
Elizabeth Scott, APRN

WYA "Wherever You Are"
Health Care for the Homeless
Community Health Center, Inc.
Middletown, CT

Community Health Center, Inc.

Founded in 1972

Primary Care Hubs - 13

School-Based Health Centers

- 21 Comprehensive Medical and Behavioral Health
- 28 Behavioral Health
- 189 Mobile Dental

Organizational Staff - 605

Patient who consider CHC their healthcare home: 130, 000

Health care visits: More than 429,000

Patient-Centered Medical Home (NCQA Level 3 recognition)

CHC Locations in Connecticut

WYA "Wherever You Are"

Primary, behavioral health, and substance abuse care

- Mobile dental 1-2 times a year

6 sites

- 2 domestic violence shelters
- 3 general homeless shelters
  - 1 with half of residents on parole, DOC
- 1 food pantry

2 new sites opened this year!

- Staff from nearby clinics

WYA "Wherever You Are" 2014 Data

	Patients	Encounters
Medical	999	2639
BH	89	294
Dental	244	256
Total	1172	3188

WYA Patient Overview

2014	Patients	Percentage
Female	546	45.8 %
Male	645	54.1 %

2014	Patients	Percentage
Has SSN	842	71.8 %
No SSN	330	28.3 %

Part 1 – Table 6B

- Cervical cancer screening
- Colon cancer screening
- Adult weight screening and follow up
- Tobacco use screening and intervention

Table 6B: Cervical Cancer Screening

- Women age 24 – 64 who have had a PAP test within the measurement year or the two years prior.
  - IF they are > 30 yoa and have had an HPV test, then a PAP in the measurement year or the FOUR prior years

Table 6B: Cervical Cancer Screening

- Challenges
  - You must have evidence of the test being done – lab report
- PHC process for improving cervical cancer screening rates:
  - Ask all new patients and obtain records ASAP
  - “Sneak-a-pap” – take advantage of ANY visit and complete the screening
  - Pap party – Evening clinic for homeless women
    - Age cohort of 6-8 women
    - Tea and chat about preventive care with providers and RN
    - Split up for exams

Table 6B: Colorectal Cancer Screening

- Patients between 50 – 74 who have been screened for colon cancer
  - Colonoscopy
  - Sigmoidoscopy
  - FOBT/FIT test
- Challenges
  - Lack of resources for colonoscopy/sigmoidoscopy
  - FIT tests can be complex – especially for homeless patients (where will they complete it?)
  - The need for the test to be returned to the health center or lab

Table 6B: Colorectal Cancer Screening

- PHC strategies for improving colorectal cancer screening rates
  - Use alerts/huddles to remind care teams to order a test
  - Use respite space to allow for FIT completion and colonoscopy prep
  - Use a FIT test first strategy
  - Create easy instructions in English and Spanish
  - Consider a video to watch with provider/staff

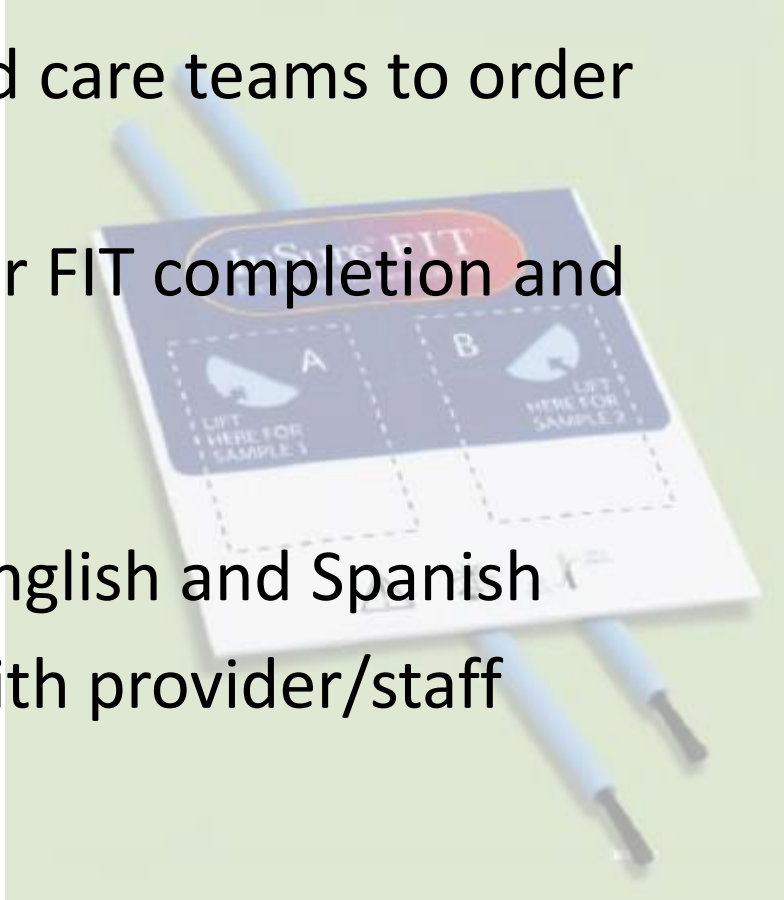
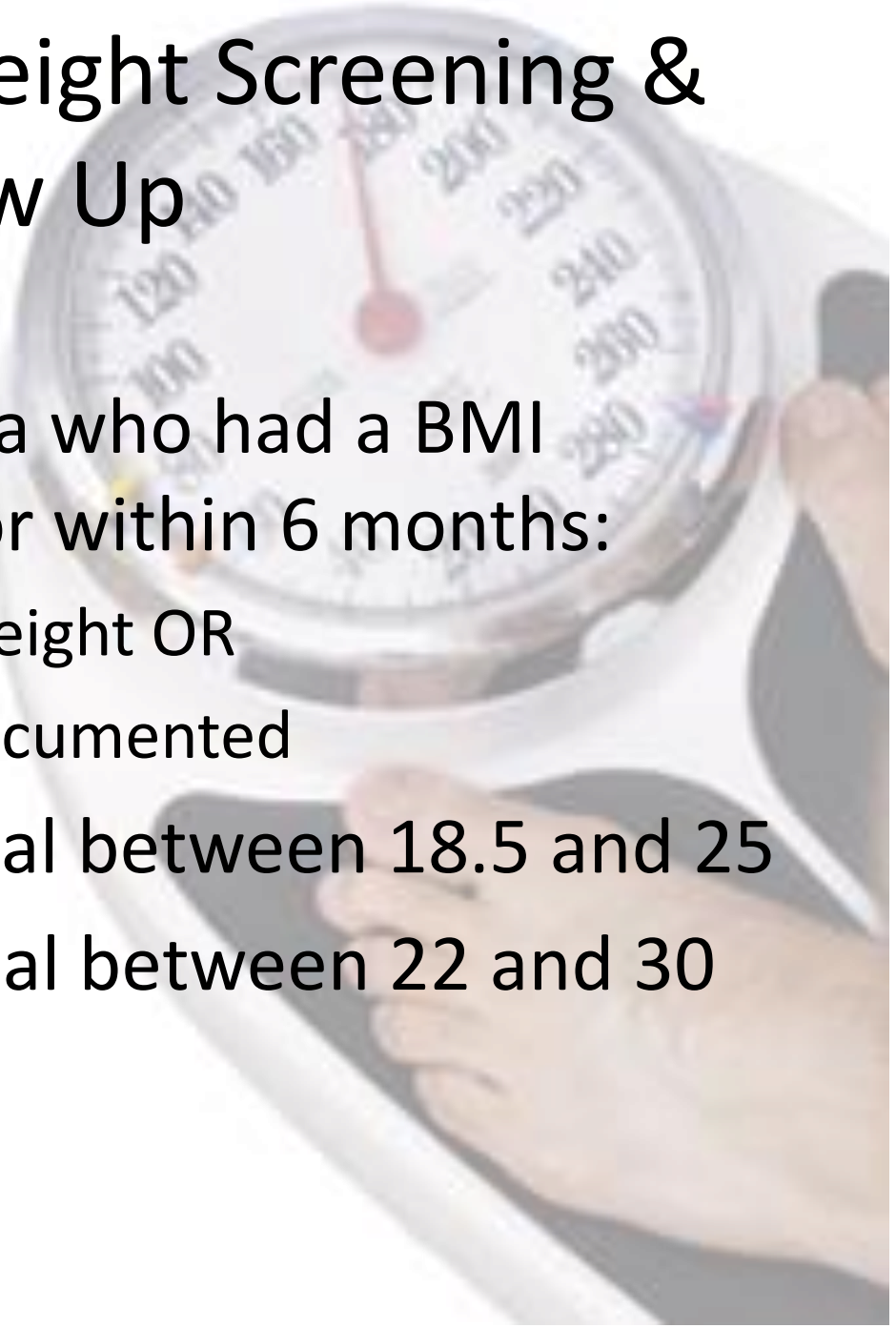


Table 6B: Adult Weight Screening & Follow Up



- For all patients > 18 yoa who had a BMI measured at last visit or within 6 months:
  - Either have a normal weight OR
  - had a follow up plan documented
- < 65 yoa – BMI is normal between 18.5 and 25
- > 65 yoa – BMI Is normal between 22 and 30

Table 6B: Adult Weight Screening & Follow Up

PHC strategies for improving weight screening and follow up

- Follow the process measure of “follow up” plan for abnormal weight
- Provide support in the EHR – well templates that include the correct structured data collection
  - This coupled with increasing rates of well visits will improve this measure
- Using alerting systems within the EHR

Table 6B: Tobacco Screening & Cessation Intervention

- Combined measure
- Denominator includes all adults who were screened for tobacco use
- Numerator now includes BOTH patients who do not use tobacco AND patients who do (or have within the last 2 years) and have had a cessation intervention.

Table 6B: Tobacco Screening & Cessation Intervention

- Cessation Intervention:
  - Medication
  - Counseling
- Challenges:
  - EHR data collection

Table 6B: Tobacco Screening & Cessation Intervention

- PHC strategies for improving tobacco screening and cessation intervention
  - Ask at every visit
  - Put the ICD code on the patient's problem list
  - Use alerts in the EHR to remind providers and MAs to intervene
  - Provide EHR templates and order-sets to streamline the ability to order cessation medications or referral to smoking cessation classes
  - Non-provider staff can also provide the intervention

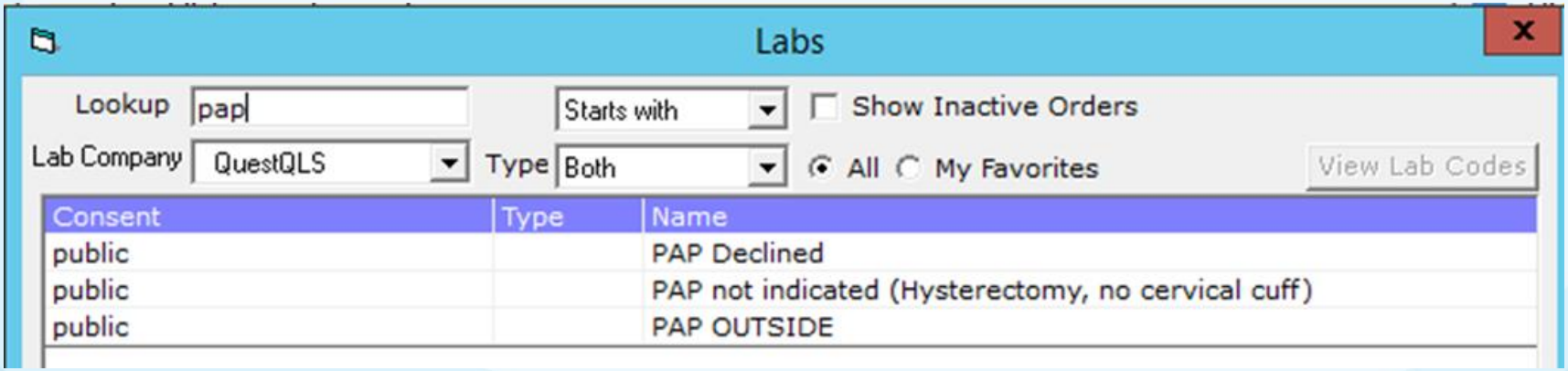
Cervical Cancer

2014	WYA	Agency
Percentage	58.29%	51.51%
Numerator	102	10485
Denominator	175	20355

Cervical Cancer

Strategy:

- CDSS reminder
- Action reminder for established patients
- 'Pap outside' lab and release of information
- Pap declined



Cervical Cancer

- Challenges:
  - New guidelines, EMR reminders often incorrect
  - Difficult to get records from outside providers
  - Patient confusion over what a pap is
  - Patients declining paps
- Ideas:
  - Setting actions to follow up on records
  - Fitting paps into other visits
  - More frequent data review

Colon Cancer

2014	WYA	Agency
Percentage	21.05 %	40.44 %
Numerator	24	5665
Denominator	114	14007

Colon Cancer

Strategy:

- FOBT for uninsured patients
- CDSS reminder
- Limited Early Detection Screening funding for uninsured patients
- 'Colonoscopy Outside' lab and release of records

Challenges:

- Patient awareness, patient discomfort
- Unstable housing
- FOBT cards: logistical problems
- Outside records

Ideas:

- Troubleshoot FOBT
- Patient education
- Coordination with grant programs

Adult Weight Screening and Follow Up

2014	WYA	Agency
Percentage	59.17 %	40.70 %
Numerator	258	17449
Denominator	436	42873

Adult Weight Screening and Follow Up

Strategy:

- Dashboard
- BMI at every visit
- On problem list
- Education structured field

Challenges:

- Priorities
- Click fatigue!
- Actually helping patients lose weight

Ideas:

- Dashboard
- Referrals to nutrition
- CBT Weight loss group

Adult Weight Screening and Follow Up

Scott, Elizabeth

Data as of 4/27/2015

Appointment Range

Display only patients with an upcoming appointment within the selected range.

Data Legend

In Compliance	3/15/2015 A date indicates that a Due Date is upcoming or has past.
Out of Compliance	
Not in Denominator	

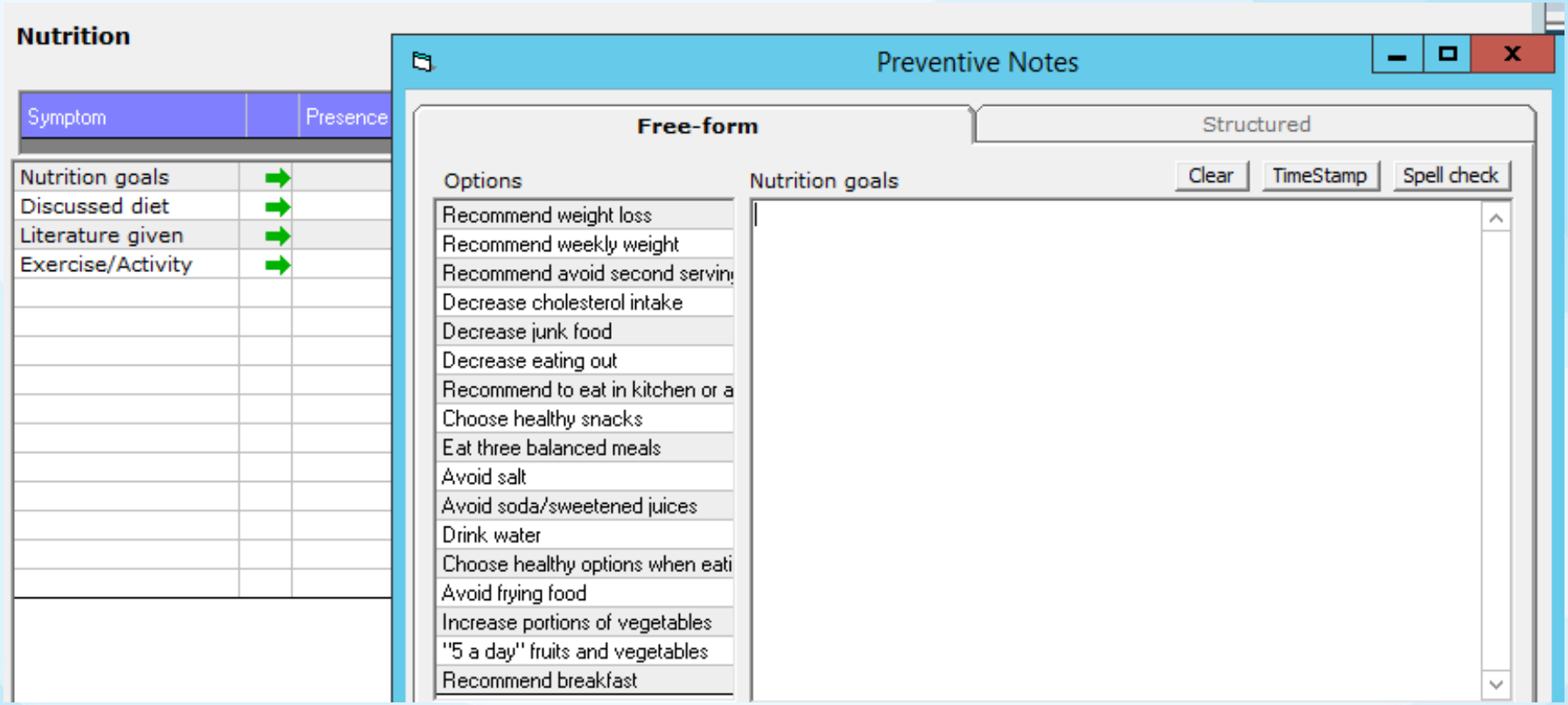
PCP Name	Adult Weight Screen and Edu	Smoker Inter-vention	Breast Cancer Screen	Cervical Cancer Screen	Colon Cancer Screen	Child Immun	DM A1c Control	Asthma Control Med	CAD Lipid Med	IVD Aspirin	HTN Control	TE
Scott APRN, Elizabeth FP												

Next Medical Appointment:
4/27/2015 1:20:00 PM

Last Dental Visit:
12/29/2006

ALERTS	Last Date	Due Date	Value	Notes
Needs Flu Vaccine 2014-2015				
Colonoscopy Screening	Never Done	Never Done		Ordered in last 30 days. Declined in last 30 days.
Blood Pressure	4/20/2015		136 / 87	
Body Mass Index	4/20/2015		30.97	

Adult Weight Screening and Follow Up



Tobacco Use Screening and Intervention

2014	WYA	Agency
Percentage	91.81%	88.49%
Numerator	370	36536
Denominator	403	41288

Tobacco Use Screening and Intervention

Strategy:

- Part of vital signs
- CDSS Reminder
- Structured field in EMR
- Rewards to Quit Program

Challenges:

- Click fatigue
- Priorities
- Actually helping patients to quit

Tobacco Use Screening and Intervention

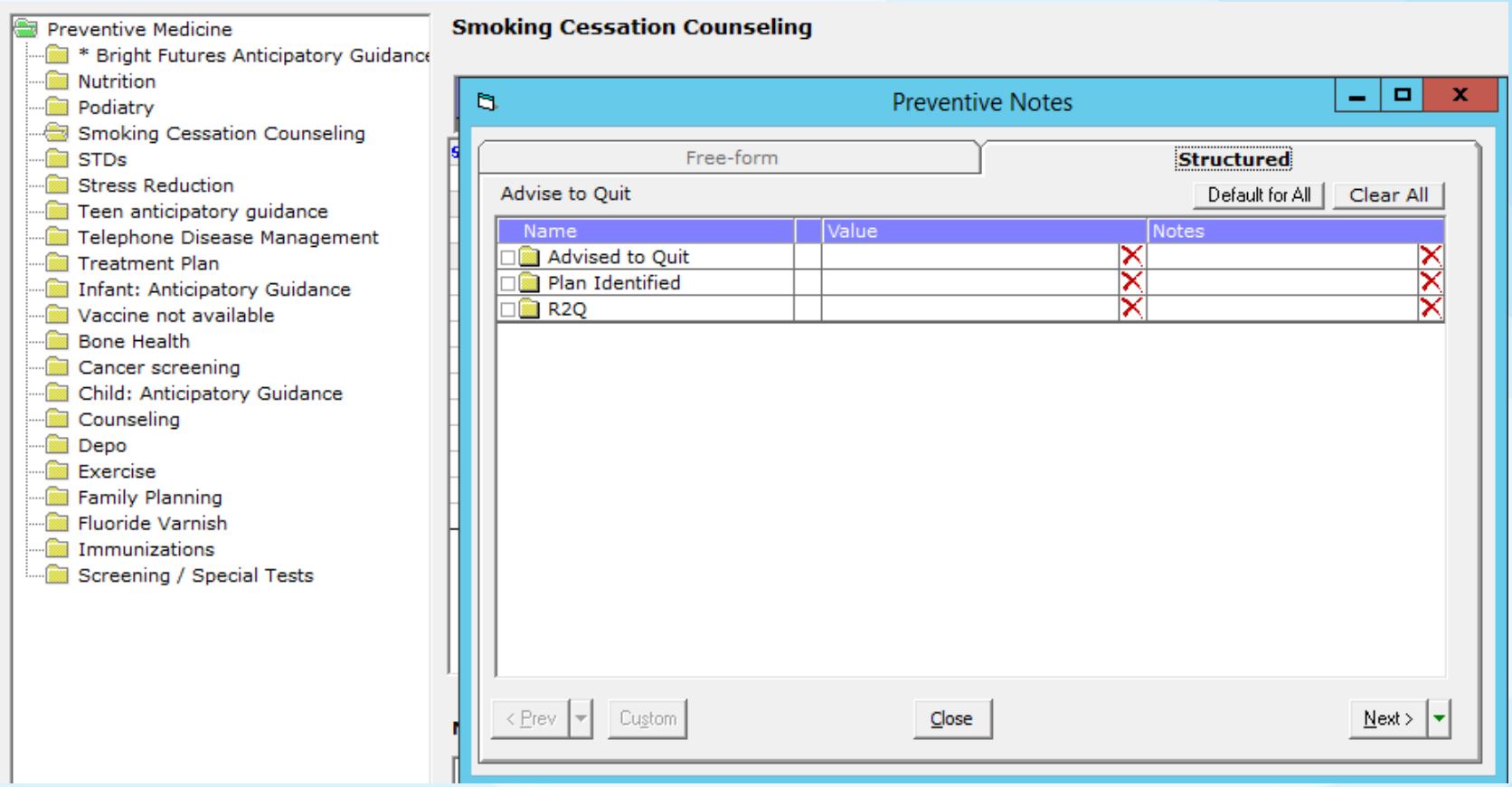


Table Time

- Discuss your own best practices for each of the covered measures
- Brainstorm new and novel ideas
- Take notes on your workshop handout
- Report out to the group

Part 2 – Table 6B

- CAD and lipid lowering therapy
- IVD and antithrombic therapy
- Depression screening and follow up
- HIV Linkage to Care

Table 6B: Cholesterol Treatment in Patients with CAD

- Patients diagnosed with CAD who are prescribed a lipid lowering therapy OR had a last measurement of LDL < 130.
- Challenges:
  - Diagnosing CAD
  - Provider/patient resistance to statin use
  - Capturing LDL measurement – requires lab testing

Table 6B: Cholesterol Treatment in Patients with CAD

- PHC strategies for improving cholesterol treatment in patients with CAD
  - Improve data entry of hospital records/consult notes
  - Use alerts/templates to remind providers to order labs or medication
  - Follow up of outstanding labs process
  - Provider CME to improve buy-in for statin use
  - Consider obtaining an in-house lipid test

Table 6B: Aspirin Therapy in Patients with Ischemic Vascular Disease

- Patients with the diagnosis of IVD who are on any antithrombic medication
- Challenges:
  - Diagnosis of IVD
  - Capture of ASA on the medication list
- PHC strategies for improvement
  - Use of Huddle / EHR - alerts, order sets
  - Improve documentation of hospital care in outpt record
  - Last resort – calling patients and asking if they are taking ASA

Table 6B: Depression Screening & Follow Up

- For patients > 12 yoa screening for depression and if positive has a documented follow up plan.
- Challenges:
  - Choosing a screening test and applying it regularly
  - Documenting a follow up plan
  - Screening adolescents

Table 6B: Depression Screening & Follow Up

- Strategies for improvement of depression screening and follow-up
  - Screen with a short screen every visit (PHQ-2)
  - Follow up plan documentation needs to be built in EHR

Table 6B: HIV Linkage to Care

- Patients who have been diagnosed with HIV (measure on table 4) who receive follow up care within 90 days of the visit.
- Challenges:
  - Much more difficult to follow if not providing the HIV care
  - Need to have good data on diagnosis date

Coronary Artery Disease and Lipid Lowering Therapy

2014	WYA	Agency
Percentage	0 %	81.49 %
Numerator	0	559
Denominator	1	686

Ischemic Vascular Disease and Antithrombic Therapy

2014	WYA	Agency
Percentage	100 %	86.82 %
Numerator	3	810
Denominator	3	933

Table Time

- Discuss your own best practices for each of the covered measures
- Brainstorm new and novel ideas
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Part 3 – Table 7

- Hypertension control
- Diabetes Control

Table 7: Health Outcomes & Disparities

- All reported by race and ethnicity
  - Birth weight
  - Blood pressure control
  - Diabetes control
- Create a health disparities dashboard to follow on a regular basis

Table 7: Blood Pressure Control

- Patients 18-85 yoa with a diagnosis of HTN in the first 6 months of the measurement year or prior
  - who had 2 medical visits
  - the last blood pressure was < 140/90
- Challenges:
  - Measurement and documentation of blood pressures
  - Difficult to have patients follow up – particularly uninsured/homeless

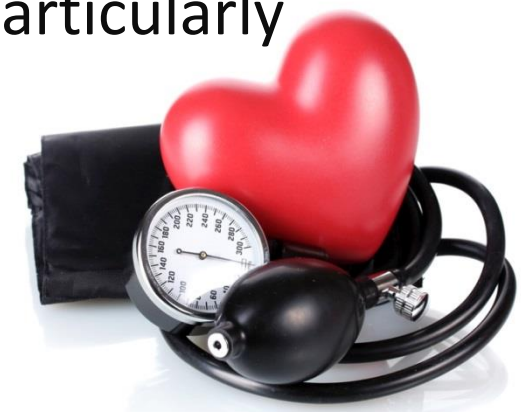

Table 7: Blood Pressure Control

- Strategies for improvement of blood pressure control
  - Training on measurement and documentation of BP
  - Use of templates, order-sets, alerts to prompt repeat checking and treatment
  - Use of treatment algorithms for nurses and providers
  - Free MA blood pressure check visits

Table 7: Diabetes Control

- Patients 18 – 75 yoa with the diagnosis of diabetes who have had 2 or more visits in the measurement year, whose last A1c was <9% at the time of last reading.
  - IF no A1c was completed it is counted as >9%
  - *NEW* no longer reporting <8-9%
    - >9%
    - <8%

Table 7: Diabetes Control

- Challenges:
  - Measurement and documentation of blood pressures
  - Difficult to have patients follow up – particularly uninsured/homeless
- Strategies for improvement of diabetes control
  - Case management
  - Group visits
  - Consider use of new technology
  - Texting, telemedicine

Hypertension

2014	WYA	Agency
Percentage	66.67%	64.29%
Numerator	48	7607
Denominator	72	11832

Hypertension

Strategy:

- Vitals every time
- Dashboard
- Panel Management
- Recall
- RN visits

Challenges:

- Age/co-morbidity appropriate
- Diet, medication, priorities, follow up

Ideas:

- Brainstorm

Hypertension Dashboard

	Last Visit Targets						Last LDL		Last HDL		Last A1C				
Gender	Systolic BP	Diasttolic BP	BP Above Target	Smoking	DM Status	DM BP Above Target	Date	Value	Date	Value	Date	Value	Last Panel Mgmt Date	Last Encounter W/PCP	Last BMI
Male	128	82	N		250.00	Y	7/23/2014	127	7/23/2014	29	8/6/2014	6.8	08/13/2014	9/9/2014 1:40:00 PM	35.1400
Female	126	69	N		N/A	N/A							12/10/2013	10/28/2013 10:20:00 AM	31.3000
Female	118	73	N		N/A	N/A	5/11/2010	82	5/11/2010	40				9/24/2014 9:20:00 AM	37.0000
Male	129	80	N		250.00	Y	1/6/2014	52	1/6/2014	44	5/5/2014	7.9	08/13/2014	5/12/2014 2:40:00 PM	44.0700
Male	132	86	N		N/A	N/A	12/23/2014	144	12/23/2014	36				1/7/2015 4:00:00 PM	32.2700
Male	149	81	Y		N/A	N/A	3/11/2014	84	3/11/2014	81			12/10/2013	2/17/2015 12:24:00 PM	23.5000
Female	132	86	N		N/A	N/A	6/7/2011	113	6/7/2011	67			02/10/2014	12/17/2013 10:40:00 AM	31.3600
Female	156	78	Y		N/A	N/A	8/8/2014	120	8/8/2014	50				9/29/2014 11:00:00 AM	31.8500
Female	142	98	Y		250.00	Y	3/4/2013	115	3/4/2013	33	1/12/2015	11	10/13/2014	4/13/2015 4:40:00 PM	43.9600
Female	117	85	N		N/A	N/A	1/23/2014	117	1/23/2014	57				4/21/2015 2:40:00 PM	28.6900
Male	139	83	N		N/A	N/A	5/19/2014	88	5/19/2014	90				4/27/2015 1:20:00 PM	31.1300
Male	144	94	Y		N/A	N/A	1/19/2015	90	1/19/2015	55				3/30/2015 1:20:00 PM	32.6800
Male	151	99	Y		N/A	N/A								1/12/2015 11:40:00 AM	22.5600
Female	124	72	N		250.02	N	6/2/2014	63	6/2/2014	42	9/29/2014	14.4	08/13/2014	2/23/2015 3:40:00 PM	35.6300
Male	130	78	N		250.00	Y	10/7/2014	132	10/7/2014	39	10/7/2014	6.6	01/17/2015	1/28/2015 11:00:00 AM	33.1700
Female	111	73	N		250.00	N	12/5/2011	93	12/5/2011	109	12/5/2011	5.4	08/13/2014	12/30/2013 1:20:00 PM	26.8300
Male	130	73	N		250.02	Y	12/4/2013	86	12/4/2013	30	2/17/2015	8	01/17/2015	4/28/2015 2:40:00 PM	33.4300

Diabetes

2014	WYA	Agency
Percentage	61.40%	78.31%
Numerator	35	4292
Denominator	57	5481

Diabetes A1C

Strategy:

- CDSS reminder
- Dashboard
- Panel Management
- Recalls
- RN Insulin Titration
- CDE/Nutrition

Diabetes A1C

Challenges:

- A1C measurement:
  - DOC – unable to leave shelter
  - Contacting patients, follow up visits, lab draws
- A1C control: Many!

Ideas:

- Diabetes Group Visits
- In house A1C testing at busiest shelter site
- RN Care Coordination

Diabetes Dashboard

Community Health Center, Inc.

Diabetes Analysis

Patient Detail -- Scott APRN, Elizabeth FP

	Last Visit Targets				Averages				
Last Panel Mgmnt Date	Systolic BP	Diastolic BP	A1C	A1C in Last Year	Avg Systolic	Avg Diastolic	Avg A1C	Last Retinal Screening	Last Foot Exam
1/17/2015	110	70	11	Y	105	66	11.5	3/25/2015	4/15/2014
1/17/2015	111	69	7.2	Y	107	67	7.2		2/25/2015
1/17/2015	111	61	5.8	Y	108	63	5.95	7/9/2014	12/2/2014
1/17/2015	112	68	10.6	Y	108	64	10.6	12/2/2013	3/18/2015
1/17/2015	105	64	8.3	Y	109	69	8.65	3/24/2014	11/12/2014
8/13/2014	121	68	6.3	Y	110	68	6.45	6/5/2014	6/3/2014
9/22/2014	106	76	5.9	Y	111	74	5.9	3/24/2014	2/4/2015
	113	67		N	112	61			
3/31/2015	114	71	12.9	Y	113	71	12.9	11/24/2013	3/6/2014
1/17/2015	130	81	12.6	Y	114	71	11.65	6/11/2014	2/10/2015
1/17/2015	102	66	6.6	Y	115	69	7.17	12/3/2014	10/1/2014
10/13/2014	134	83	7.2	Y	115	74	8.05	5/8/2014	6/18/2014
7/1/2014	136	85	6.5	Y	116	77	6.55	2/24/2015	2/16/2015
8/13/2014	131	88		N	117	82		6/19/2013	3/27/2014
8/13/2014	138	90	6.5	Y	118	78	6.5		
8/13/2014	118	80	7.5	Y	118	79	7.5	1/17/2015	1/12/2015
	119	71		N	119	71			3/14/2011
10/24/2014	106	77	13.6	Y	119	79	13.6	2/4/2015	
8/13/2014	142	76	5.3	Y	120	69	5.3		5/7/2014
1/17/2015	128	74	9	Y	120	72	9.8	7/10/2014	1/21/2015
8/13/2014	109	68	9.8	Y	120	75	9.8	4/6/2015	2/23/2015

Table Time

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Part 4 – Pediatric & OB (6b &7)

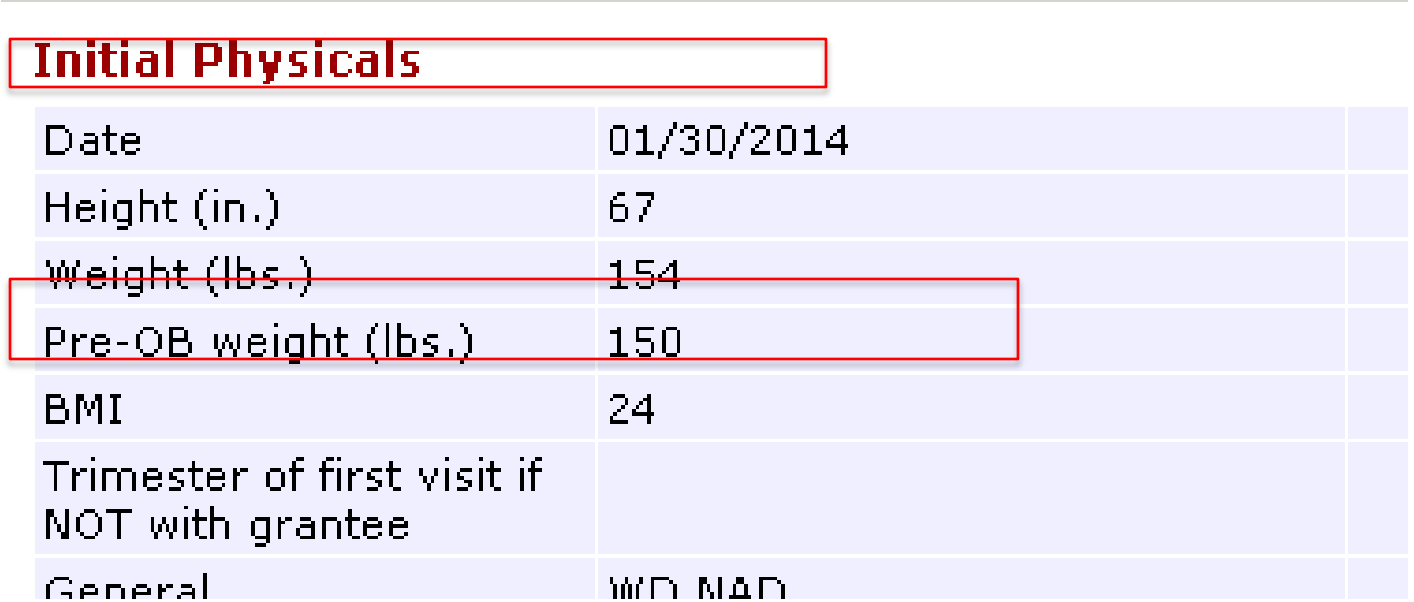
- Entry into Prenatal Care
- Childhood Immunizations
- Weight Assessment and Counseling for Children
- Appropriate pharmacotherapy for Asthma
- Birth Weights
- Sealants for children 6-9 who are at risk for caries

Table 6B: Prenatal Care

- Timely entry into care
- First visit with a prenatal care provider is reported
- The data is reported for both at the health center and those who had the first visit outside of the health center

Table 6B: Prenatal Care

- Challenge:
  - Collecting data on women who establish care with an outside entity
  - Staff training



Initial Physicals

Date	01/30/2014	
Height (in.)	67	
Weight (lbs.)	154	
Pre-OB weight (lbs.)	150	
BMI	24	
Trimester of first visit if NOT with grantee		
General	WD WN	

Table 6B: Childhood Immunization

- Children fully immunized before the third birthday
  - 4 Tdaps
  - 4 Pneumococcal
  - 3 IPV
  - 3 Hep B
  - 3 Hib
  - 1 MMR
  - 1 VZV

Table 6B: Childhood Immunization

- Challenges:
  - Use of CAIR/COCASA
  - Lack of bidirectional interfaces between registry and health center EHR
  - Some organizations are not using the registry or have only just begun
  - Keeping the denominator in CAIR correct
    - Needs to be checked against the EHR as frequently as resources allow
    - Patients need to have been seen at least once in the measurement year
    - Cannot provide provider specific or site specific data if not entered into CAIR

Table 6B: Childhood Immunization

- Strategies for improving childhood immunization rates
  - All immunizations are double entered at the time of the visit.
  - CAIR is the “One Truth” for immunization information.
  - Check CAIR at all pediatric visits (acute and WCC) to capture all opportunities to immunize
  - CAIR cleanup quarterly to make sure all assigned patients are active patients

Table 6B: Child/Adolescent Weight Screening & Follow Up

- 3-17 year olds who have had documentation of BMI percentile and counseling for nutrition AND physical activity.
- Challenge: Collecting structured data vs coding

Table 6B: Child/Adolescent Weight Screening & Follow Up

- PHC strategies for improving weight screening and follow up
  - Provide support in the EHR – WCC templates that include the correct structured data collection
    - This coupled with increasing rates of WCC will improve this measure
  - Using alerting systems within the EHR

Table 6B: Asthma Therapy

- Patients 5 – 40 yoa with a diagnosis of persistent asthma who were prescribed inhaled corticosteroids
- Challenges
  - ICD coding does not have a unique code for persistent asthma
  - Capturing the classification of asthma within the EHR

Table 6B: Asthma Therapy

- PHC strategies for improving asthma therapy
  - Focus on asthma classification
  - Use alerting and huddling to prompt providers to complete the classification
  - Use actionable alerts, templates, smart-forms, and order sets to prompt easy ordering of asthma control medications
  - Provide an asthma education class and include the classification and creation of an action plan within the class

Table 7: Low Birth Weight

- Percent of births that are of normal birth weight by race/ethnicity
- Challenges
  - Capturing birth weights of babies
    - Using standard in grams
    - Getting data on patients who delivered with other providers
  - Race/ethnicity data quality

Table 7: Sealants for Children Who are at Risk for Caries

NEW!

- The number of children ages 6-9 who are at elevated risk for cavities who have received a dental sealant on a permanent first molar tooth
- Challenges
  - Data collection
  - Access to dental services

Table Time

- Discuss your own best practices for each of the covered measures
- Brainstorm new and novel ideas
- Take notes on your workshop handout
- Report out to the group

- Plan for the UDS rather than scrambling in December.
- Consider Data in and Data out in planning. Work with EHR vendors where necessary.
- Have a monthly (or quarterly) process for looking at clinical data.
- Have a regular data QA process.
- Begin running the report early in January if possible.
- Use previous year data, comparative data from other health centers, and your own community data to assess your data accuracy.

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