Using UDS Data to Improve Quality and Efficiency

<table>
<thead>
<tr>
<th>Reference Group Change</th>
<th>Grantee Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>State 'CA' %</td>
<td>National %</td>
</tr>
<tr>
<td>17%</td>
<td>7.22%</td>
</tr>
<tr>
<td>16%</td>
<td>6.63%</td>
</tr>
<tr>
<td>34%</td>
<td>10.18%</td>
</tr>
<tr>
<td>35%</td>
<td>3.69%</td>
</tr>
<tr>
<td>19%</td>
<td>-3.78%</td>
</tr>
<tr>
<td>13%</td>
<td>18.27%</td>
</tr>
<tr>
<td>13%</td>
<td>8.44%</td>
</tr>
<tr>
<td>34%</td>
<td>11.41%</td>
</tr>
<tr>
<td>10%</td>
<td>10.16%</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>- 2003 Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003 - 2002 Trend</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3-Year Trends in Key UDS Variables</th>
</tr>
</thead>
<tbody>
<tr>
<td>UDS</td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>40,979</td>
</tr>
<tr>
<td>36,631</td>
</tr>
<tr>
<td>5,185</td>
</tr>
<tr>
<td>647</td>
</tr>
<tr>
<td>0</td>
</tr>
<tr>
<td>2,246</td>
</tr>
<tr>
<td>7,304</td>
</tr>
<tr>
<td>1,158</td>
</tr>
<tr>
<td>9,668</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Current Year Ratio Performance Measures</th>
<th>Quarters</th>
<th>CA</th>
<th>Nat</th>
</tr>
</thead>
<tbody>
<tr>
<td>PW1</td>
<td>Ratio of Uncompensated Care to BPHC Receipts</td>
<td>6%</td>
<td>15%</td>
</tr>
<tr>
<td>PW2</td>
<td>Medical Team Productivity</td>
<td>4,823</td>
<td>4,750</td>
</tr>
<tr>
<td>PW3</td>
<td>Medical Cost Per Encouneter (eables lab and med)?</td>
<td>$137</td>
<td>$137</td>
</tr>
<tr>
<td>PW4</td>
<td>Self Pay Collection Rate</td>
<td>23%</td>
<td>19%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3-Year Trend Performance Measures</th>
<th>Raw Data</th>
<th>2004</th>
<th>2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>PW5</td>
<td>Medical Users Growth</td>
<td>16,551</td>
<td>26,500</td>
</tr>
<tr>
<td>PW6</td>
<td>Total Encounters Growth (add bureau nursing visits)</td>
<td>132,457</td>
<td>133,418</td>
</tr>
<tr>
<td>PW7</td>
<td>Medical Users Growth</td>
<td>14,715</td>
<td>10,700</td>
</tr>
<tr>
<td>PW8</td>
<td>Unmet Needs Growth</td>
<td>14,412</td>
<td>13,689</td>
</tr>
</tbody>
</table>

**CLIN**

- Service Users to Target
- Pap smear users / female

**USERS**

- Total Users: 29,250
- Total Encounters: Medical, Dental, Mental Health, Substance Abuse, Other Professional, Enabling
- Medical Encounters per 100,000
- Dental Encounters per 100,000
- Mental Health Services
- Substance Abuse Services
- Other Professional Services
- Enabling Services
- Migrant/Seasonal Farmworker Users: 1,903
- Homeless Users: 11
- Total Prenatal Users: 2,402
- Target populations:
  - % Pediatric (15 years old): 37%
  - % Geriatric (age 65 and over): 4%
  - % Women's health (age 15-44): 35%

**HRSA**

- Health Resources & Services Administration

**BPHC**

- Bureau of Primary Health Care
UDS
UNIFORM DATA SYSTEM

HRSA
Health Center Program

Calendar Year
2015
Objectives

This training program will address:

- The UDS – where it came from and what it was.
- How it has changed to its current iteration
- Four UDS management reports: when, and how they are created
- How BPHC is seeing the UDS today – where it is used and how.
- Measures that are currently being officially tracked
- Reports that are available for official measures and others
- Selecting comparison groups for different purposes.
- The concept of “benchmarks” and how the UDS can be used to develop appropriate benchmarks for a center.
- Using reports to identify problems at a health center.
- Using reports to identify areas of excellence at a health center.
Where did this come from?

- BPHC has always collected data on programs:
  - The
How has the UDS changed?

- There has been tremendous growth to the UDS over time
How is the UDS used?

- The law says . . .
Must we stop there?

- The law says . . .
What data are available?

**Four key reports to know and use**

- *Your* UDS report
- The UDS Summary Report
- Trend Report – yours, state and national
- Rollup reports – national and state
- UDS Health Center Performance Comparison Report
The Basic Tools
It is always critical to have the basic raw data available when looking at your profile. Any analysis it will always be important to look back at the original numbers! The UDS is prepared in your Electronic HandBook (EHB) and is always available to you and anyone who can view your reports – Includes your reviewer, your Project Officer and others. Make sure you are using the final version.
Look at the list of errors which were identified during the review with AHP editor
  - Some were just clean errors or typos or whatever
  - But many (if not most) result in you saying something akin to “but the number is correct!!”

Errors are usually identified by comparing your number with:
  - Your own prior year’s (PY) data
  - PY state and national data
  - Some external standard (HP-2020, literature etc.)
  - Reasonableness
1-3. The UDS Report

Any “error” which is really a different number is a number that is worthy of review. Some examples:

– Proportion of male patients is higher than . . .
– % of uninsured patients have increased . . .
– Dental support staff ratio has decreased by . . .
– Number of visits per diabetic patient appears . . .
– 3 year olds in IZ universe is greater than expected
– Average cost per mental health staff is . . .
– Medicaid collection rate is . . .
2-1 The UDS Summary Report

- Seven pages of data organized around
  - Patients
  - Visits
  - Staffing (marginally useful)
  - Staff Tenure (marginally useful)
  - Quality of Care (also in roll-ups)
  - Costs
  - Revenue and Adjustments (no calculations provided)

- Includes “un-official” calculated variables
Patients:
- Proportion of patients who are medical patients
- Proportion who are dental / mental health / etc.
- Patients by age: children, adults, older adults
- Proportion uninsured
- Prevalence (sorta) of
  - Hypertension
  - Diabetes
  - Asthma
  - HIV
Patients (LA / National):
- Medical patients LA = 78.3%, National = 85.2%
- dental = 20.7 / 20.8%
- mental health = 11.0 / 5.5%
- Substance abuse = 0.2 / 0.4%
- Children 26.6 / 31.3%
- Adults 67.2 / 61.1%
- Older adults 6.2 / 7.3%
- Proportion uninsured  37.2 / 27.9
Patients – Prevalence (sorta) (LA / National):
- Hypertension 27.0 / 23.2%
- Diabetes 12.0 / 12.7%
- Asthma 4.6 / 5.8%
- HIV 1.1 / 0.7%

Need to estimate proportion who are medical patients and project to age groups
2-5 The UDS Summary Report

- Visits
  - Medical visits per medical patient (excluding nursing)
  - Dental Visits per dental patient
  - Mental health . . .
  - Substance abuse . . .
  - Vision . . .
  - Enabling . . .
Visits per patient of that type (LA / National):

- Medical (excluding nursing) 2.76 / 3.12
- Dental 2.16 / 2.50
- Mental health 3.5 / 5.0
- Substance abuse ... 16.45 / 9.75
- Vision ... 1.24 / 1.38
- Enabling ... 3.06 / 2.43
2-7 The UDS Summary Report

- Staff Tenure (LA / National):
  - All primary care 3.01 / 5.53
  - FP 3.36 / 5.04
  - Internists 2.94 / 5.57
  - Dentists 2.97 / 4.22
  - CEO 7.35 / 10.29
  - CFO 5.52 / 6.05
Costs per patient and per visit for:

- Total
- Medical
- Dental
- Mental Health
- Substance Abuse
- Vision
- Enabling
Costs per patient (LA / National):
- Total (**official measure**) $679 / 762
- Medical $468 / 516
- Dental $454 / 438
- Mental Health $504 / 744
- Substance Abuse $1128 / 1102
- Vision $192 / 185
- Enabling $476 / 618
Costs per visit (LA / National):

- Total $189 / $193
- Medical (**official measure**) $169 / $165
- Dental $210 / $175
- Mental Health $143 / $150
- Substance Abuse $68 / $113
- Vision $155 / $134
- Enabling $155 / $255
Provides data in five categories:

- Quality of Care / Health Outcome Indicators
  - Perinatal Health
  - Preventive Health Screenings and Services
  - Chronic Disease Management

- Costs
  - Costs per patient
  - Cost per visit
3-2 The UDS Health Center Comparison Report

- After showing health center numbers it shows
- HP2020 goals and averages for additional comparison groups
  - State
  - National
  - Urban / Rural
  - Size by patient number (< 10K, 10-20K, 20-)
  - Number of sites (1-5, 6-10, 11-
  - MSFWs (<25%, 25%+)
  - Homeless (<25%, 25%+)
- No – no table which shows comparisons within a group. Sorry.
(Measures of Central Tendency)

- **Average (Mean):**
  - Numerator = total of all numbers in the cell (e.g., all family practice visits for all centers)
  - Denominator – total of all numbers in the cell (e.g., total FTEs for all family practitioners in the nation)
  - Averages are provided for each comparison group
Also provides
- “adjusted quartiles” for clinical measures
- and percentile values for costs

Adjusted quartiles are controversial for some
- bphc.hrsa.gov/datereporting/reporting/ranking.html
- bphc.hrsa.gov/datereporting/reporting/rankingfaq.html

Percentile values
- provide a way to measure your quartile placement
- and provide some idea of the standard deviation / spread
- shows 25th, 50th and 75th percentile – not your’s
Calculations

(Central Tendency – 2)

- Median is the 50\textsuperscript{th} percentile
- Difference between Mean and Median
  - \textit{If} the curve is “normal”, both numbers will be the same.
  - If the curve is “skewed” the median may be substantially higher or lower than the mean.
    - Most likely to happen if range goes from zero to relatively large numbers:
      - Large agencies have an inordinate impact on the mean
      - Small agencies have an inordinate impact on the median
Centrally Tendency – 3

Calculations

(Central Tendency – 3)

Percentiles:

- No longer calculated for individual grantees
- **Median**: value which divides those target grantees in half – half have more, half have less.
- **25th Percentile**: 25% of grantees had a lower value, 75% had a higher value
- **75th Percentile**: 75% of grantees had a lower value, 25% had a higher value
Produced at the health center, state and national levels.

Includes three different groups of data:
- Access (Tables 4 and 5)
- Quality of Care
  - Perinatal (Tables 6b and 7)
  - Preventive Health Screening and Services (Table 6)
  - Chronic Disease Management (Tables 6b and 7)
- Financial Cost / Viability (Table 8A/T4, T8A/T5, T9e/5)

(This table once included 8 groups and a total of 118 measures – now has 3 and 27)
4-2. The UDS Health Center Trend Report

- Table covers trends (three years) for:
  - Access variables being used to demonstrate performance in terms of seeing proposed patients

- Likely to be used by OSV teams when on site

- Ties to data that are required to be reported in grant applications

- May be pre-populated in grant applications
Roll-up Reports for the Rest
5-1. Roll-ups

- Are UDS reports which add together the data for a (usually large) number of grantees and display it as if they were one reporting entity.
  - The 2014 Louisiana report includes 30 grantees
  - The 2014 National report includes 1278 grantees

- Reports are also available for special population groups – but they are strange
  - Includes all XYZ only groups plus the grant reports for those which are XYZ and 330
  - Means it can only cover some of the tables
    - Demographics, clinical, and Table 5 without FTEs
5-2. Roll-ups

- Are available at the BPHC web site:
  - National data are available at
    - And select “view full national report 2014”
  - OR for state data
    - And then select a state and in the state section
    - Select immediately below the map:
      - State Program Grantee Data
      - Louisiana Program Grantee State Data
5-3 Roll-ups

- Rollups give you raw data which permit you to calculate many variables that are not in the comparison reports.
- They are also provided in a format which includes analytical information that is not present on the regular forms.
  - E.g., adds column a and b to get totals by age.
5-4 Roll-ups
How Measures are Calculated
Benchmarking
The dictionary says:

Main Entry: bench-mark
Pronunciation: 'bench-"märk
Function: noun
1 usually bench mark : a mark on a permanent object indicating elevation and serving as a reference in topographic surveys and tidal observations
2 a : a point of reference from which measurements may be made b : something that serves as a standard by which others may be measured or judged c : a standardized

With the UDS, we are using “benchmarking” in the second sense to refer to a standard that any individual clinic can use to evaluate itself.
Where do we use benchmarks

- To see how we are doing compared to others like us
- To find areas which may be problematic and fruitful places for intervention
- To establish reasonable goals for improvement
- To establish targets where we want to excel
The BCRR had “BCHS Indicators for Funding” which eventually became the “Performance Measures” in the final 1991 version.
Also referred to as the “Federal Funding Criteria,” they were definitely tied to funding.

- Onsite encounters per physician:
  - Between 4200 and 6000 per year
- % of ambulatory costs attributable to admin:
  - No more than 16% except grantees with total costs < $125,000 the standard is no more than 26%
- Charges as a percent of reimbursable costs
  - At least 90%
- Average cost per medical encounter
  - Between $16 and $24 excluding lab, x-ray and pharmacy
The 1991 BCRR manual retained all of the Performance measures except

- Maximum allowable average cost per encounter was raised from $26 to $43
  - A commitment was made that the cost per encounter would be "adjusted periodically using the physician services component of the consumer price index"
- The 4200 – 6000 screen for physician visits was change to *include* in-patient visits
In April, 1993 BPHC announced:
- each health center “will establish its own medical encounter goals.”
- “Beginning in FY-1994, the encounter screen of 4200 encounters . . . will be eliminated.”

A new basis for productivity benchmarks was needed
Many turned to Medical Group Management Association (MGMA) for published data but:

- It was expensive:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>MGMA member</td>
<td>$270.00</td>
</tr>
<tr>
<td>Joint MGMA-ACMPE member</td>
<td>$270.00</td>
</tr>
<tr>
<td>MGMA affiliate</td>
<td>$320.00</td>
</tr>
<tr>
<td>Nonmember</td>
<td>$480.00</td>
</tr>
</tbody>
</table>

- And didn’t reflect CHC users or services
Most critical step is to select the appropriate comparison group. Criteria can include:

- Others who are like me
- What I want to look like
- Satisfying minimal expectations
- Defining “excellence”
- (Some combination of these)
First rule: Always start with the largest (national) group that includes you!

Additional comparisons may be valuable to your center when there are significant difference in:

- Your patients
- Your services
- Your providers
- Your state or region
- Your size
Ideally, the biggest difference – the idea that 330 funded health centers have a different type of patient or a different level of acuity is eliminated by looking at just 330 agencies.

In theory, do not need to worry about:
- Our patients are sicker
- We provide a broader range of enabling services
- Our patients are more likely to be on Medicaid
Other issues, which may in fact be quite important, may or may not be possible to control for in the published UDS data:

- Age: seeing far more pediatric or geriatric patients
- Area: Northeast, West, Midwest, South
- Services: family planning, obstetrics, pharmacy, radiology, etc.
- Type of providers: GPs, FPs, NPs, etc.
- Provider’s experience
Selecting a Benchmark

- Age:
  - Unfortunately this is 10 years old
  - Infants: 6.6 visits per year
  - Geriatrics: 6.6 visits per year
  - 13 – 21 year olds: 1.2 /year

- Issues where it could make a difference:
  - Visits per year?
  - Productivity by provider type?
  - Cost per encounter?
  - Users by third party payor?

Comparison Group – 5

Benchmarking

Annual rate of visits to office-based physicians and corresponding standard errors (SE) by detailed age groups

- Under 1 year (662.8 per 100 persons, SE=75.6)
- 1–12 years (217.2 per 100 persons, SE=17.0)
- 13–21 years (117.7 per 100 persons, SE=12.0)
- 22–49 years (256.0 per 100 persons, SE=11.6)
- 50–64 years (398.5 per 100 persons, SE=18.3)
- 65 years and over (663.7 per 100 persons, SE=33.3)
Comparison Group – 6

- **Area:**
  - (Also fairly old)
  - Utilization in different parts of the country is different!
  - If you have 10,000 patients – what does it say?

- **Issues where it could make a difference:**
  - Number of providers?
  - Cost per patient?
  - Cost per encounter?
  - Users by third party payor?

<table>
<thead>
<tr>
<th>Geographic Area</th>
<th>Visits/year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northeast</td>
<td>3.54</td>
</tr>
<tr>
<td>Midwest</td>
<td>2.83</td>
</tr>
<tr>
<td>South</td>
<td>3.32</td>
</tr>
<tr>
<td>West</td>
<td>2.99</td>
</tr>
<tr>
<td>National</td>
<td>3.17</td>
</tr>
</tbody>
</table>
The UDS as a Diagnostic Tool
The same review of comparisons and trends can identify areas
– Needing improvement or
– Demonstrating excellence

Sometimes these are indications of where current quality *improvement* efforts are succeeding

Sometimes they represent on-going quality

These areas all too often go without “official” recognition on the part of administrators
Using multiple indicators

Looking at a set of indicators can help you to

- Confirm a finding
- Explain a finding
- Confirm or reject an explanation
- Mitigate an observation
- Reject a conclusion
Diagnosing

To understand better – example 1

- What is causing decrease in cost/user?

<table>
<thead>
<tr>
<th></th>
<th>2004</th>
<th>2003</th>
<th>2002</th>
</tr>
</thead>
<tbody>
<tr>
<td>U5.20 Costs per user</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>U5.21 Medical Cost per Medical User ³</td>
<td>$271</td>
<td>$292</td>
<td>$299</td>
</tr>
</tbody>
</table>

- Visits per user?

<table>
<thead>
<tr>
<th></th>
<th>2004</th>
<th>2003</th>
<th>2002</th>
</tr>
</thead>
<tbody>
<tr>
<td>U4.10 Medical Encounters per Medical User ³</td>
<td>2.38</td>
<td>2.46</td>
<td>3.43</td>
</tr>
</tbody>
</table>

- Cost per encounter?

<table>
<thead>
<tr>
<th></th>
<th>2004</th>
<th>2003</th>
<th>2002</th>
</tr>
</thead>
<tbody>
<tr>
<td>U5.31 Medical cost per medical encounter ³</td>
<td>$114</td>
<td>$137</td>
<td>$102</td>
</tr>
</tbody>
</table>
To mitigate – example 2

- General practitioner productivity is low

<table>
<thead>
<tr>
<th>UNIVERSAL</th>
<th>Grantee</th>
<th>state</th>
<th>Grantee Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>U3.22 General Practice Productivity</td>
<td>2,314</td>
<td>2,622</td>
<td>16%</td>
</tr>
</tbody>
</table>

- But she was off on paid paternity leave from 9/03 to 3/04 and normally sees more:

<table>
<thead>
<tr>
<th></th>
<th>2004</th>
<th>2003</th>
<th>2002</th>
</tr>
</thead>
<tbody>
<tr>
<td>U3.22 General Practice Productivity</td>
<td>2,314</td>
<td>2,549</td>
<td>3,773</td>
</tr>
</tbody>
</table>

- You sometimes need to go beyond the data
Watch numbers as well as rates!

- Pediatrician is going great guns:

<table>
<thead>
<tr>
<th>PERSONNEL BY MAJOR SERVICE CATEGORY</th>
<th>FTEs (a)</th>
<th>Encounters (b)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Family Practitioners</td>
<td>4.00</td>
<td>15,431</td>
</tr>
<tr>
<td>5. Pediatricians</td>
<td>0.20</td>
<td>952</td>
</tr>
</tbody>
</table>

- But the number is of little importance to the center as a whole!
More Management Tools from the UDS
Most health centers serve populations with similar health care deficits but tremendous differences can be seen in:

- Age distributions

<table>
<thead>
<tr>
<th>National Percentiles</th>
<th>25th</th>
<th>Median</th>
<th>75th</th>
</tr>
</thead>
<tbody>
<tr>
<td>U1.12 % Geriatric (age 65 and over)</td>
<td>4%</td>
<td>6%</td>
<td>11%</td>
</tr>
</tbody>
</table>

- Income

| U1.41 % < 100% Poverty * | 57% | 71% | 83% |

- Insurance status

| U1.43 % Uninsured | 26% | 39% | 55% |

- Etc.
Productivity, staff support, and utilization of services vary greatly and have great community impact:

- **Staff support** – back and front office

<table>
<thead>
<tr>
<th>UNIVERSAL</th>
<th>Grantee</th>
<th>state</th>
<th>Averages</th>
<th>National</th>
<th>Rural</th>
<th>Large</th>
<th>National Percentiles</th>
</tr>
</thead>
<tbody>
<tr>
<td>U3.10 Support Ratios</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>25th</td>
</tr>
<tr>
<td>U3.11 Direct medical support</td>
<td>2.89</td>
<td>1.61</td>
<td>1.64</td>
<td>1.59</td>
<td>1.69</td>
<td>1.17</td>
<td>1.54</td>
</tr>
<tr>
<td>U3.12 Direct dental support ratio</td>
<td>1.42</td>
<td>1.38</td>
<td>1.41</td>
<td>1.43</td>
<td>0.90</td>
<td>1.20</td>
<td>1.69</td>
</tr>
<tr>
<td>U3.13 &quot;Patient support&quot; ratio</td>
<td>1.02</td>
<td>1.40</td>
<td>1.21</td>
<td>1.26</td>
<td>1.24</td>
<td>0.71</td>
<td>1.09</td>
</tr>
</tbody>
</table>

- **Provider productivity**

| U3.26 Overall Physician Productivity (excl. spec. phys.) | 3,674 | 3,999 | 3,904 | 4,033 | 3,976 | 3,146 | 3,751 | 4,350 |
| U3.27 NP/PA/CNM Productivity | 1,901 | 2,875 | 2,820 | 3,021 | 2,930 | 2,256 | 2,785 | 3,311 |

- **Panel size**

| U3.29 Medical Users per Provider FTE | 1,241 | 1,202 | 1,118 | 1,144 | 1,145 | 895  | 1,097 | 1,325 |

- **Utilization**

| U4.10 Medical Encounters per Medical User | 2.38 | 3.00 | 3.15 | 3.18 | 3.17 | 2.59 | 3.10 | 3.55 |
| U4.20 Dental Encounters per Dental User | 1.99 | 2.38 | 2.41 | 2.38 | 1.81 | 2.25 | 2.68 |
| U4.30 Mental Health Encounters Per MH User | 11.08 | 5.10 | 4.88 | 5.16 | 2.45 | 3.76 | 6.27 |
| U4.40 Substance Abuse Encounters Per SA User | 0.00 | 9.92 | 4.87 | 10.70 | 2.45 | 4.12 | 10.19 |
| U4.50 Enabling Encounters per Enab. User | 1.37 | 2.38 | 2.93 | 2.84 | 2.93 | 1.69 | 2.50 | 4.04 |
Cost per visit or cost per user are often cited but data can be broken down much further:

- Costs by parts of the medical visit

<table>
<thead>
<tr>
<th>Grantee</th>
<th>Universal</th>
<th>Averages</th>
<th>National</th>
<th>Rural</th>
<th>Large</th>
<th>25th</th>
<th>Median</th>
<th>75th</th>
</tr>
</thead>
<tbody>
<tr>
<td>U5.30 Costs per encounter</td>
<td>$114</td>
<td>$90</td>
<td>$109</td>
<td>$101</td>
<td>$107</td>
<td>$92</td>
<td>$108</td>
<td>$131</td>
</tr>
<tr>
<td>U5.31 Medical cost per medical encounter³</td>
<td>$110</td>
<td>$128</td>
<td>$129</td>
<td>$125</td>
<td>$106</td>
<td>$131</td>
<td>$172</td>
<td></td>
</tr>
<tr>
<td>U5.32 Dental Cost per dental encounter</td>
<td>$2</td>
<td>$8</td>
<td>$13</td>
<td>$13</td>
<td>$1</td>
<td>$5</td>
<td>$16</td>
<td></td>
</tr>
<tr>
<td>U5.33 Pharmacy Cost per medical encounter³</td>
<td>$21</td>
<td>$17</td>
<td>$9</td>
<td>$9</td>
<td>$2</td>
<td>$7</td>
<td>$13</td>
<td></td>
</tr>
<tr>
<td>U5.34 Lab &amp; X-ray Cost per medical encounter³</td>
<td>$0</td>
<td>$3</td>
<td>$7</td>
<td>$8</td>
<td>$0</td>
<td>$3</td>
<td>$8</td>
<td></td>
</tr>
</tbody>
</table>

- Overhead: Facility and administration

| Administration % of Total Cost | 34% | 26% | 25% | 24% | 24% | 21% | 27% | 31% |
| Facility % of Total Cost       | 3%  | 6%  | 7%  | 7%  | 7%  | 5%  | 7%  | 9%  |
Charge and collection data may tell you about fee schedules, collection effectiveness, discounts to low income patients, and more.

- Charge to cost ratio

- Discounts provided to low income patients

- Free care compared to grant funding
Receiving funds from a variety of sources makes an agency less dependent on each income source.

- Income by source

- Changes should also be considered