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**Moderator: Jillian Maccini
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Operator: Ladies and gentlemen, thank you for standing by. Welcome to the UDS Adjusted Quartile Rankings Training Webinar. During the presentation all participants will be in a listen-only mode. Afterwards we will conduct a question and answer session.

At that time if you have a question please press the 1 followed by the 4 on your telephone. If you need to reach an operator at any time please press the star followed by the zero. As a reminder this conference is being recorded, Tuesday, October 16, 2012. I would now like to turn the conference over to Dr. Ngo-Metzger. Please go ahead.

Quyen Ngo-Metzger: Thank you. Good afternoon and good morning to those on the West Coast. My name is Dr. Quyen Ngo-Metzger. I am Chief of the Data Branch here in the Office of Quality and Data in the Bureau of Primary Healthcare at HRSA.

This afternoon we're going to talk about the adjusted quartile rankings for the new 2011 UDS clinical performance measures. Just to give you an outline of where - why we're doing this, I'd like to just kind of talk about the Bureau of Primary Healthcare quality strategy.

Our triple aim is to have better care, have improved healthy people, healthy communities, and affordable care. In order to do this our strategy is to give you, our grantees the best data information available so that you can form partnerships and collaborations for quality improvement.

We've always focused on access to care. We want to move towards comprehensive services provided at the health centers with integrated services with behavioral and oral health, and also integrating into the larger health system.

Our priorities and goals, as you all know very well, that we want all of our health centers to implement quality improvement, quality assessment systems. And we want all of the call centers to fully implement their QAQI plans. We're also promoting adoption and meaningful use of electronic health records. We want all of our health centers to implement electronic health records across all the sites and all the providers.

Another big push from the Bureau is the Patient Center Medical Home and we want all of our health centers to receive Patient Center Medical Home recognition. Additionally we are all pushing towards clinical outcomes because ultimately it's about the patients. We want all of our health centers to meet or exceed the Healthy People 2020 goals on at some, at least one and preferably in some of our uniform data system clinical measures.

And we know that in order to do this there has to be work force development and team based care. So why have grantee-adjusted quartiles? What we attempted to do this year was to rank clinical performance of our grantees compared to other grantees while accounting for specific differences for the following grantee characteristics.

We know that you're all slightly different from one another especially in the - as far as your patient population, so the percent of patients that are uninsured, percent of minority patients, percent of patients who are part of the special population, and then some of you are further along than others in the adoption of the electronic health record. And all of these characteristics and factors actually may affect your clinical performance.

So we ranked everyone from a quartile, one being the highest quartile, 25% of all of the reporting grantees, to quartile four, or the lowest 25%. Now why is it necessary to provide adjusted rankings? As I said previously, we know that there are differences in the types of patients served and the use of electronic health record.

And where you are in the continuum of adoption of the electronic health record may affect the way you're able to access your data, report your data and do quality improvement activities based on this data. So the adjusted rankings provide grantees with additional information to compare for performance to other grantees on a level playing field, so that in some sense we adjust or control for these characteristics.

How are the rankings determined? We use multi-variant models to predict clinical performance based on a grantee's characteristics, and the difference between the predicted and the actual reported clinical performance is then used to determine the ranking. So it's actually the difference between predicted and actual.

The grantee should expect to see a high ranking if it's performing as what is predicted for such a health center with similar characteristics. I'm going to go into more details about this. At this time I'd like to introduce Dr. Leiyu Shi

who is a professor at the John Hopkins University School of Public Health and Director of the Primary Care Policy Center. Dr. Leiyu Shi and his team helped us with this adjusted ranking and he's going to go into more details about how we did this.

Leiyu Shi: Thank you Quyen for the introduction and also for the overview. My task is going to provide some details in the methods of this adjustment. First of all I want to talk about the data set. The data we used for this particular analysis is the 2011 UDS, Uniform Data System that grantees provided to the Bureau of Primary Healthcare.

So the unit of analysis will be at the grantee level. The total sample size for this analysis is 1128 grantees. Specifically, we used multi-variant regression techniques to estimate the association of selected grantee characteristics with the clinical performance measures. The dependent variables are the 13 clinical performance measures collected through UDS 2011.

Let me give me you some examples. For example, childhood immunization, which refers to the percent of children age two who are fully immunized, diabetes control which refers to the percent of patients who have diabetes and who have most recent hemoglobin A1c level which is under 9%. And the other examples include hypertension control, Pap test, low birth weight.

So those are 5 among the 13 clinical performance measures that we used in the analysis. Now I'd like to talk about the independent variables. Those are the variables that we include in the adjustment. First I want to talk about the rationale for the selection of those independent variables. Before me are some of the important considerations we made in the selections of those measures.

First of all those measures should reflect key vulnerable populations served by health centers, such as percent minority population, percent uninsured patients, percent homeless patients, percent agricultural worker patients. And then the second consideration is that those measures were also deemed significant in differentiating a health center's performance on the clinical performance measures based upon prior research and analysis using previous year's data such as 2010 UDS.

And then a third consideration is that we also want to capture the method used in reporting, because some grantees used EHR, electronic health records in reporting their cases and others just did sample chart review. Our studies have shown the choice of method is also related to the clinical measure performance.

And the final consideration is that there should be very few or no missing values in the controlled measures, because if there are too many missing values then you will lose many grantees in the analysis. So based upon those considerations, the following characteristics were selected as independent variables, percent minority patients, percent uninsured patients, percent homeless patients, percent agricultural worker patients, and then EHR status.]

EHR status is defined as when grantees provide greater than 70 cases of observation, they are considered using EHR. When grantees provide 70 or less cases they are considered as not using EHR, rather using the sample chart review method.

Now not all grantees are used in the analysis because some grantees did not report all clinical measures. So for grantees with missing clinical performance measures, they were excluded from that particular clinical measure analysis so they will not get the quartile ranking for that measure.

The other criteria, exclusion criteria, has to do with sample size. We used a sample size of 30 to limit the grantees. In other words, grantees who report less than 30 patients, whether in the universe or in the sample chart revealed were excluded because we felt that with under 30 sample size we would not have enough observations to provide reliable estimates.

Now I'm going to go through the detailed steps used in providing this quartile analysis. In step one, we used the multi-variant model to compute parameter estimates. Those are the regression coefficients we obtained from the multi-level linear regression model. The dependent and independent variables were described earlier.

Step number two, we then compute the predicted rate based on the estimates from the multi-variants' linear regression model. Here only significant betas are used in the calculations since the non-significant betas are no different from zeros.

Step number three, we then calculate the difference between the actual and predicted rates. Step number four, the final step, we compute the quartile ranking based on the difference between the actual and predicted rates.

Now let me comment on this methodology.

The implication of this method is that grantees whose actual rate that is higher than the predicted rate will see higher ranking. Conversely, grantees whose actual rate is lower than the predicted rate might see lower rankings. This is because this analysis adjusted for characteristics that make grantees different.

Of course when actual rate is close to or similar to the predicted rate there is no change in the ranking. This actually happened in most situations. Now I

would like to share some of the results that illustrate this process, and the results will demonstrate how the regression analysis is used to compute the predicted performance rates. I'm going to cite two examples that show changes in the rankings based upon applying this analysis.

The first example will show that a higher ranking for a grantee whose actual performance rate significantly exceeds its predicted performance rate. The second example will show a lower ranking for a grantee whose predicted performance rate significantly exceeds its actual performance rate.

Again as I said earlier, when the actual performance rate is close to or similar to the predicted performance rate there is no change in the ranking and we are not going to show that. So we will use one measure, childhood immunization, to illustrate the adjusted analysis process.

Table 1 here shows the linear regression results of the childhood immunization clinical performance measure. As you can see the beta of the intercept and the coefficient entered into the model. We will then apply those beta in the prediction formula seen in the middle. As you can see measures that are not significant are set to zero.

You might ask, why do you include it in the analysis anyway, but those measures, even though they are not significant in this model, they are significant in other measures so we want to apply a consistent method with all the 13 clinical measures, therefore we use all those in the adjusted model.

So the first example shows grantee's actual clinical performance is higher than its predicted performance. The measure is childhood immunization. Now the actual performance rate, that is the rate without any adjusted analysis, was 55.56%. In other words, 55.56% of children received adequate immunization

for that grantee, that grant, that particular grantee in the second quartile without the adjustment.

Then we applied the adjustment technique which incorporates information on their percent minority patients, their percent uninsured patients, their percent homeless patients, and their percent agricultural workers which are listed there, as well as their EHR use status. For this grantee it is a yes. In other words, they used EHR to report those numbers.

So their predicted performance rate based upon the formula is actually 31.97%. In other words, this is the predicted rate for grantees with similar characteristics like this one. As you can see, this predicted rate is actually lower than the actual rate. In other words, this grantee did actually better than grantees with similar characteristics. Then you would expect their ranking to jump, so this is actually the case.

So then we take the difference between the grantee's actual and predicted performance rate and then rank that, and then that the differential is now ranked in the first quartile after the adjustment. My second example is going to show the other way in the change in the ranking.

So for this particular grantee the actual clinical performance is lower than its predicted performance. Still we use the same measure, childhood immunization. The actual performance rate was 45.71% of children with adequate immunization for this grantee. Without adjustments this grantee would be ranked in the second quartile.

Now after adjusting their characteristics similarly, percent minority, percent uninsured, percent homeless, percent agricultural workers and EHR use status, the predicted performance rate based upon those characteristics is 50.22%

which is actually higher than the actual performance rate by about five percentage points.

And that actually resulted in lowering the ranking for this grantee. Now they are placed in the third quartile after the adjustment. Hopefully those two examples will illustrate this process as I described earlier. Now I want to switch back to Quyen who will discuss the implication of this particular technique.

Quyen Ngo-Metzger: Thank you Dr. Shi for the very clear, detailed explanation. So how will the Bureau use and interpret grantee adjusted quartiles and how should grantees use these adjusted quartiles? The adjusted quartile rankings are for your information. They are for informational purposes and they don't really change or replace the actual reported clinical performance. They're just another piece of data.

Grantees should continue to focus on the performance improvement based on your actual reported clinical performance. And the Bureau will use the reported clinical performance to assess this performance over time. Additionally grantees should also use the Uniform Data System Health Center Trend Report to set attainable goals for future years based on past years' performance.

And these methods of ranking are still being evaluated by the Bureau, and additional refinements will likely occur before they improve the adjusted rankings. More information can be found at the following sites. The adjusted quartile data can be found in the Electronic Handbook in the Health Center Performance Comparison Report, and then also on line in individual health center data reports at bphc.hrsa.gov/uds/view.

And the adjusted quartile ranking description, a kind of a summary of what we talked about today and also frequently asked questions can also be found at bphc.hrsa.gov/healthcentersdatastatistics/reporting/index. If you have any comments or questions they can be directed to allqdcomments@hrsa.gov. Thank you so much for participating in this Webinar today and we'd like to open it up to questions.

Operator: Certainly. Ladies and gentlemen, if you'd like to register for a question please press the 1 followed by the 4 on your telephone. You will hear a three-tone prompt to acknowledge your request. If your question has been answered and you would like to withdraw your registration, please press the 1 followed by the 3.

Once again ladies and gentlemen, to register a question it is the 1 followed by the 4 on your telephone. One moment please for the first question. And our first question comes from the line of (Liz Hunt). Please proceed with your question.

(Liz Hunt): So a grantee whose actual and predicted performance are the same would just, if they were, if their predicted was 2, in the second percentile and their actual was in the second percentile, then it would just be the second percentile. Correct?

Leiyu Shi: Yes, yes. That is correct. If the predicted and the actual are very similar or close to each other, they are actually ranked in the same quartile. So actually we look at all the results. This actually happens with most cases anyway so there are very few, there are relatively few grantees that changed in the ranking based upon the adjustment.

(Liz Hunt): I'm sorry. Can you repeat that again? There are few grantees who changed their rankings?

Leiyu Shi: There are relatively a few. There are not that many, you know, grantees that changed significantly their quartile ranking between predicted and the actual, because the predicted and actual sometimes are very close together. And also this is not percentage ranking. This is quartile ranking so you have to be very significantly different from the actual to see a significant ranking change.

(Liz Hunt): Thank you.

Operator: Our next question comes from the line of (Beth Newell). Please proceed with your question.

(Beth Newell): Hi, can you talk a little bit why age wasn't chosen as a measure? Just because, you know, it seems like it's unfair to clinics with large senior populations.

Leiyu Shi: So I want to maybe comment on that first and then Quyen can add on to it. We actually initially looked at 2010 data. We tried to enter the measures, tried to see whether they were significantly related to clinical performance measures. So as I said, the measures we selected were found to be significantly related to the clinical performance measures. For that particular analysis, age was not deemed, was not found to be significantly associated with the clinical performance measures.

Quyen Ngo-Metzger: And then I'd - this is Quyen Ngo-Metzger. I'd just like to add that for each, we look at each clinical measure separately. So for childhood immunizations, you know, we look at that age group to two years. For, you know, Pap smear it's those specific women in those age groups.

So in some sense, you know, it doesn't really make sense. I mean it's a clinical quality measure. All the people within the age group should reach that mark. It doesn't matter what age you are within that particular clinical measures. So that's why we didn't consider age. So let's say, you know, in Pap smear between the ages of 13 and 64 it doesn't matter where you are.

(Beth Rule): Yes but something like diabetes under control in a large senior population would be a lot different than, you know, a younger 40 population.

Quyên Ngo-Metzger: Well, that may or may not be true. I mean I think with diabetes control it's actually more related to how long you've had diabetes, so the longer in your duration of diabetes you are less likely to have control just because the disease progresses over the years.

And we actually don't have that information because you can, you know, even if we were able to adjust for age, somebody who is 70 but only has had diabetes for two years may have much better control than somebody who is 50 and has had diabetes for 10 years.

And because we don't have that kind of granular data we were not really able to do that. So I think even within these measures, you know, we don't have age specific range, you know, age specific data for us to do that kind of detailed modeling.

Leiyu Shi: I just want to maybe add another comment. As I said earlier in the inclusion of criteria for consideration, we want to make sure that we pick as few measures, you know, as possible that are consistent across the clinical performance measures.

Therefore, for example, in terms of diabetes, the elderly might make a difference but maybe age is not that, you know, related to other measures which are more age specific. So this is one of the considerations. Again, as we become more experienced with this approach, you know, the future analysis might be different, so.

Quyen Ngo-Metzger: I think, and this, just to add one more thing, also to streamline it, we also didn't want to have different adjusting variables for each of the clinical measures. And so as what, just to reiterate what Dr. Shi said, these are characteristics that are across all of our grantees, and in some ways are similar across all the clinical measures, so that we didn't, you know, have to have a very complicated adjusters for each of the clinical measures. Thank you for your question.

Operator: Our next question comes from the line of (Susan Johnson). Please proceed with your question.

(Susan Johnson): Hi, I just have a clarification question on the independent variable. If we used our EHR to generate reports for some of the indicators but we didn't have the reports for others, like immunizations, we had to do a chart review, did you use that independently with each measure? Do you understand my question?

Quyen Ngo-Metzger: Yes.

(Susan Johnson): So...

Quyen Ngo-Metzger: Yes, we did. So for each of your measure, whether if it's, if you did not use EHR, then for that particular measure it came in as no, you did not use EHR. And then for a different measure if you used the - we took that into consideration measure by measure.

Leiyu Shi: Yes, if you look at this particular model, I'm showing Table 1, EHR is one of the control measures, so it is coded as dichotomous, EHR versus non-EHR. So if you don't use EHR, you know, you are also included in that consideration.

(Susan Johnson): Okay, thank you.

Leiyu Shi: Sure, welcome.

Operator: And there are presently no further questions at this time. As a reminder, ladies and gentlemen to register for a question it is the 1 followed by the 4 on your telephone. And our next question comes from the line of (Carrie Midsaw). Please proceed.

(Carrie Midsaw): Hi, how are you today?

Quyên Ngo-Metzger: Great, thank you.

(Carrie Midsaw): I was just curious, and I work at a federally qualified health center look-alike, and we were required to submit UDS data for the first time in 2011, and couldn't find any data or quartile rankings for our look-alike or any other look-alike on the national data reported with the clinical performance measures. Were look-alikes excluded from the study?

Quyên Ngo-Metzger: Yes, because this was your first year, in a sense, of reporting. We realize that it does take a couple of years to kind of get to know the UDS and know how to report. So we actually made a decision not to include the look-alikes since it was your first year. We expect that in the future we will be doing that. But you're correct, we did not do it for the look-alikes because it's the first year of data reporting.

(Carrie Midsaw): Okay, thank you very much.

Quyen Ngo-Metzger: Sure.

Operator: Our next question comes from the line of (Jill Franken). Please proceed.

(Jill Franken): Yes, I am wondering about next steps with this particular data set that we have, and the opportunity for us to be able to query this and look at those with top quartile rankings in areas where maybe we are not achieving as high of a ranking as we think we should be or would like to be. And so how will we be able to easily query this, to be able to contact and network with other health centers as we look for opportunities to improve?

Quyen Ngo-Metzger: That's a great question and thank you for asking it. We did not plant you to ask the question. Actually what we are hoping for is by posting this data it does in fact provide that opportunity for you to see where you are particularly, and then find others, health centers who may be similar.

And we've provided some of that comparison data over time through our trend and comparison reports in the UDS, but you never knew who it was and how they compared to you. So now you have some sense of how your neighbors or people in other areas are doing, and you can reach out and make some contacts.

So while you could surely do that at a, you know, individual health center by individual health center basis, the other opportunity, we have a pretty robust training and technical assistance support through our primary care association, some of our national cooperative agreement that have done that, some of our

health center controlled networks that are focusing on data, data quality and quality improvement.

So I encourage you to reach out to your primary care association who, as part of their cooperative agreement and work plan with the Bureau, is really thinking about how to support health centers with advancing their clinical quality outcomes. And, you know, that may be a good forum.

They also have access to this data, and I'm sure they're looking at where, you know, all of the health centers in their particular state or region fare, and what are the opportunities, who has really made some significant improvements and what lessons can be learned and shared across. So I think those are some good places to start with.

So you have some opportunities individually to begin, and then I think also most effective would be to try to look at some things, you know, regionally or at a state level.

(Jill Franken): Thank you.

Operator: Our next question comes from the line of (Frank Killian). Please proceed.

(Frank Killian): Hi. You know, I'm looking at our results on the UDS page, and the question I got, it's got, obviously our actual adjusted quartile ranking. Do you have - where can I see what the predicted was?

Quyen Ngo-Metzger: So we actually, you know, it actually gets very complicated to include all of that, the predicted minus the actual and then rank. What we really want you to focus on is your actual, both your actual numbers and benchmark it to yourself as far as the trend. That's why we encourage you to use the trend

reports, and then this predicted minus, you know, this difference between predicted and actual where then the difference was ranked.

And so we felt that it was actually too much to show that data, because in some sense it's actually most valuable for you to use the actual raw numbers of the percentages over the years, and then use the rankings and the quartiles mainly to see how, where you are quartile-wise with, comparable to other grantees who are like you. Does that answer your question?

(Frank Killian): Yes. Yes, all right, thank you.

Operator: Our next question comes from the line of (Liz Young). Please proceed.

(Liz Young): Yes, hi. My question is similar to the very first question that was posed, was why API's all English proficiency was not considered as a characteristic.

Quyen Ngo-Metzger: So I think that what we have is - from the UDS is we have basically percent primary language, you know, and not in English. We feel that at this time that data point isn't really fine, isn't granular enough to be included. And I think that we did, at some point did include that in the original, in our original research, and found that it wasn't a good predictor.

Leiyu Shi: I just want to add two points. In the initial analysis with 2010 data we actually did include a measure. It was not significant. And then the second point is, there were a number of grantees that did not report that. In other words, you know, as we said, we want as few missing values as possible. So that was not chosen for those two reasons.

(Liz Young): Great, thank you.

Operator: Our next question comes from the line of (Krishna Roy). Please proceed.

(Krishna Roy): Thank you. We are an FQHC, and we have submitted our UDS in the regular format from 2008. My question is, we do use, since 2008, EHR, however up to Table 6 of UDS we are able to report on our entire, our universe, whereas from Table 7 onwards, we are able to, in some of the table, we are only able to use a 70% sample.

For example, a prenatal immunization and birth weight, that is low birth weight and so forth, we are able to use our universe. Now, this change from universe to sample in reporting our quality measures, how is that reflected, or is that reflected in our ranking?

Quyen Ngo-Metzger: So that's a great question and I'll start with generally responding to that, and then hand it over to Leiyu to talk about the details of how the adjustment was done. But generally speaking, there is the notion that a full universe, so if you have your entire patient population and all their information in your electronic health record, then trying to calculate the clinical measures using that entire universe will provide you a better representation of the quality of care and outcomes within your health center patient population.

Where - as we know we had had significant EHR adoption and implementation across the board, but it's been incremental. And so for a number of our measures you have to have a look back period. So where you haven't been able to have your full universe, and therefore you've been kind of having to use the chart audit methodology, we - you had that opportunity to highlight that when you submitted the UDS.

And so we really are strongly encouraging and looking forward to getting data from your full universe out of your EHR, but in the interim where you have

that data where it's missing or you've only implemented more recently, we do still allow for chart audit. And then maybe Leiyu you can talk, just remind again how we, how you adjust...

Leiyu Shi: Yes, the analysis did not take into account changes in the reporting method. In other words if you used EHR one year and then changed to a sample chart review or vice versa, that does not play a role in the analysis. Because the analysis is cross sectional, it's - you know, for example we just used 2011 data for the analysis. We did not really look at 2010's influence on 2011.

So for this particular analysis, if you did use EHR, we will capture your use of EHR. If you used sample chart review, we will code you as using non-EHR in the analysis.

(Krishna Roy): In other words then, you only took into account those tables in 7 onwards, of quality measures where we used 7B chart reviews, is that right? You did not take into...

Leiyu Shi: We used both 6B and the Table 7 for the analysis, so the - so your question is - could you repeat your question? Because I thought your question has to do with changing reporting method, was that captured in the analysis.

(Krishna Roy): Right.

Leiyu Shi: Was I not?

(Krishna Roy): Right. Table 7 onwards, where we do, we measure quality and we report from Table 7 onwards. In some of the tables, for example, prenatal immunization, birth weight, et cetera, we reported on our universe, whereas for diabetes, hypertension, Pap, et cetera, we could, we only did 70% random sample.

Leiyu Shi: Right. Now I understand your point.

((Crosstalk))

(Krishna Roy): Yes.

Leiyu Shi: Yes. Actually the analysis is measure by measure. For the 13 measures we performed analysis individually and independently. So for some measures if you use EHR, you are coded as using EHR. For other measures, if you use sample chart review you will be coded as using sample chart review. So for the same grantee they could use two different methods for different measures. Does that answer your question?

(Krishna Roy): And yet the - your methodology for ranking remains the same, irrespective whether it was a mixture of the two methods or it was only EHR method, it remains the same?

Leiyu Shi: Exactly. We did not take into account whether they used EHR for all measures or for select measures. That does not bias against a center, a grantee in our analysis.

(Krishna Roy): Okay, thank you. That means there was no weightage, separate weightage provided for the use of EHR only, or use of a mixed sample and EHR.

Quyen Ngo-Metzger: I think that what we're trying to say is because each - depending on each of the clinical measure, you know, say for Pap smear because it requires a three-year look back, if you use sample, then for that Pap smear and that ranking, we counted that you used sample. For a different measure such as

diabetes or hypertension if you ended up using EHR, then for that particular ranking we counted you as using EHR.

So we did take it into account but it's within the individual clinical measures and your ranking within that measure.

(Krishna Roy): Thank you.

Operator: Our next question comes from the line of (Theodore Ross). Please proceed.

(Theodore Ross): Yes, hi. How are you doing? Hello?

Quyen Ngo-Metzger: Good, thank you. Go ahead.

(Theodore Ross): Yes, my question is that, on your independent variable, on the example, Example 1 and 2 - and I'm not for sure if those are actual examples or they're just more or less, they are just to show how the quartile ranking changed. But my question is, I noticed that the percentage of minority and also the percentage of uninsured seemed to have a higher predictive performance rate.

And I didn't know if that's just because the assumption is that those patients are more compliant, or how did you derive that?

Leiyu Shi: I think it is measure specific. For certain measures they might not have that particular outcome. I assume you are referring to Table 1, right?

(Theodore Ross): Right. Right, if you look at Table 2 you have a 97% minority and you have a 38% uninsured, but your predicted performance rate is actually higher and, in Example 2 than it is in Example 1, which has a lower percentage of minority

and uninsured. And even with the childhood immunization I am somewhat confused as to why that is the case.

Leiyu Shi: So I think you are referring to the, this particular example...

(Theodore Ross): Right.

Leiyu Shi: ...where you have grantees having percent, you know, 97% minority, 38% uninsured and why their rates are suddenly become, actually predicted rates actually worse than the actual rate, right?

(Theodore Ross): Right. Why the predicted performance rate is actually expected to be higher than the previous example, which has less uninsured and less minority.

Leiyu Shi: Yes. That has to do with particular model, the regression model. If you look at this particular regression model, percent of minority is positively related to childhood immunization for this measure. For other measures, there might be very different. Okay, for this particular measure it is positively related. And then percent of uninsured is negatively or inversely related to the childhood immunization.

(Theodore Ross): Okay.

Leiyu Shi: So because of their actual rates, actual numbers on those two measures, that could become a factor in that predictive rate.

(Theodore Ross): Okay. Okay, thank you.

Operator: Our next question comes from the line of (Fred Fletcher). Please proceed with your question.

(Fred Fletcher): Yes. I was wondering if you considered and rejected potential independent variables that were related to characteristics of the health center. For example, is it an urban health center or rural? Or is it a large or small, or does it have a lot of clinical support staff compared to primary providers or not? Or does it have a lot of visits per provider, or a small number of visits per provider? Did you consider any characteristics of the health center for independent variables?

Leiyu Shi: Again, in the initial analysis, we used 2010 data. We included size of the center, rural, urban of the center, and other measures such as number of providers, primary care team, primary care population ratios, financial indicators, net revenue, a bunch of other measures.

Those were not found to be consistently significantly correlated with the clinical performance. Therefore, you know, eventually we decided not to use those.

(Fred Fletcher): Well you did consider those, so I'm glad to hear that you did. Thank you.

Leiyu Shi: Yes, we did use that. You know, it doesn't mean it won't be significant in the future, but for that particular year it was not.

Quyen Ngo-Metzger: Yes, I think that we, this research that Dr. Shi's mentioning is actually on our Web site. It was published in Health Services Research and that was kind of like the background research that we used. So if you're really interested, you can go to that paper, and it's actually on the BPHC Web site, and that was, you know, that will show you the fact that we actually used, considered all of these characteristics in the previous models, and then we basically simplified it from that work.

(Fred Fletcher): Okay, well thank you very much.

Quyen Ngo-Metzger: Thank you.

Operator: And our next question is a follow up question from the line of (Beth Newell).

(Beth Newell): I was wondering if you could talk a little bit about the rationale for having adjusted quartile rankings versus I guess having a, the information presented as, you know, what is the goal of, you know, the number of women Pap test - because, you know, just by the nature of quartile ranking, you know, the - 50% are going to be ranking as a 2 or 3 based on, you know, their percentage.

And I was just curious - that it doesn't necessarily say anything with what actually is the quality of the measure, if the majority of health centers are above or below. Thanks.

Quyen Ngo-Metzger: Sure. So that's a great question. And as, you know, since we started rolling these clinical measures out in 2008 the primary purpose was always to support clinical quality improvement at each health center organization.

And so as we continue to collect and, you know, get more sophisticated with this we're just trying to find different ways to slice and dice and present the data to help people, you know, the UDS reports that each grantee gets for your internal quality improvement, information that we get at state and regional levels.

And then now we've kind of crossed in our journey to putting this data out publicly. And so we felt that the adjusted quartile ranking provides some context to the public who may not be familiar with all of the nuances of the

health centers and their populations and all of that, to understand how different grantees perform and adjust for some of these.

So to your point about then, why we didn't necessarily put - so that was the purpose of that. And we want to talk about how well we're performing relative to our goals, so for all of the measures that have a equivalent counterpart with Healthy People 2020, we've set as our national programmatic goal our benchmarks that we'd like to achieve is by 2020 make sure that we're meeting and exceeding the goals that have been set out for the entire nation.

So that is the benchmark by which we're all driving to. Now, we've always been very careful, and we still very much hold to the fact that each grantee, though, you know, if you're currently performing at 65% on a Healthy People goal that happens to be 90%, it's not necessarily feasible to have an expectation that you would make that leap in one year.

So we've encouraged each grantee to look at your own performance, your performance over time, further contextualize that with other health centers that look like you, getting to the question of urban, rural, small, large, you know, single site, multi site, and compare to your state, and figure out what are the appropriate goals that you can set up for yourself every year.

And to support that we've asked that you speak to that in your service area competition applications and then your budget period renewal. Speak to your project period goals and then how you're making in terms of your annual targets that you're shooting toward.

And so adding all of that on this public Web site, I think, we've muddied it, but we have said, you know, in our quality strategy slides and other things that more or less, all of the metrics that have a counterpart in Healthy People 2020,

that really is our goal. And where there's not a goal in Healthy People 2020, whatever appropriate national benchmark or standard is what we would be shooting for, similarly.

Operator: And there are presently no further questions at this time. Presenters please go ahead and conclude your presentation.

Quyen Ngo-Metzger: Well this concludes our presentation for today. Thank you very much for participating. Thank you to all of you who asked questions, and we welcome your feedback and questions at our comments line. Thank you very much.

Operator: Ladies and gentlemen, that does conclude your conference call for today. We thank you for your participation and ask that you please disconnect your lines.

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