C.Y. 2014 UDS Reporting Enhancements
For Reports Due on February 15, 2015

Bureau of Primary Health Care

April 9, 2014

Agenda

- 2014 Changes Background and Overview
- Table-by-Table Changes
- Available Assistance and References

Overview of Today's Presentation

- Today's presentation will review the changes in *CY 2014 data collection* that are required to permit accurate UDS data analysis and submission on *February 15, 2015.*
- The changes which will be discussed are:
  - First time reporting of public housing patients
  - Reporting of newly diagnosed HIV patients
  - Addition or changes to five clinical quality measures
  - Changes to EHR Capabilities and Quality Recognition questions

3

BACKGROUND AND OVERVIEW OF THE 2014 CHANGES

The UDS Change Process

- The 2014 UDS changes were:
  - Published initially as PAL 2013-07 on May 10, 2013 and revised as PAL 2014-01 on December 13, 2013
  - Announced in Federal Register
  - Comments and recommendations solicited from health centers, PCAs, PCOs, and the general public
  - Reviewed based on comments received and a modified package approved by OMB
  - Introduced in the 2013-2014 UDS Trainings

Objectives for Today's Presentation

- Today's presentation is designed to assist health centers understand:
  - The new and revised clinical measures
  - The new demographic data added
  - How to complete and submit data on these changes to Tables 4, 6A, 6B, 7, and the EHR Capabilities Form

Health Center Program Look-Alikes

- Look-alike reporting will continue to move toward mirroring the Section 330 grantee report. Added to their report will be:
  - Table 6A – diagnoses and services
  - Table 9D – all cells which had been blocked, specifically lines 2a-2b, 5a-5b, 8a-8b and 11a-11b (managed care details) and columns c1, c2, c3, and c4 (retroactive payments)

Importance of EHR

- Universal adoption of Electronic Health Records (EHR) with interoperability capabilities has the potential to:
  - reduce health care costs
  - enhance the capability of clinicians to serve their patients
  - improve the quality of care provided to patients and, ultimately
  - improve patient health
- Health centers are encouraged to continue to expand HIT capacity including using the EHR for reporting the UDS clinical measures
  - Health centers may use their EHR for some or all of the measures depending on their readiness

EHR in Health Centers

- In 2012, 60% of health centers used an EHR or some other electronic data system for reporting of one or more clinical measures
  - Virtually all used their data systems to identify the universe of patients
  - Nearly two thirds were able to pull the information on meeting the criteria for at least one of the measures
- 79% of health centers indicate that they have an EHR installed and in use at all sites and for all providers
- 44% of health centers are PCMHs.

TABLE 4:
PATIENT CHARACTERISTICS

Table 4: Public Housing Patients

- For the first time, "residents of public housing" will be reported on Table 4, Line 26
  - While the Public Housing Primary Care program (Section 330(i)) has been a part of the 330 program for many years, the number of patients have not been tracked in the same way as homeless or agricultural worker patients have been in the UDS
  - Defined as residents in publicly supported multiple unit "projects" – either high-rise or low-rise
  - Explicitly excludes scattered site Section 8 housing
- Most can be identified from a set of known addresses
  - Or may be a characteristic added to registration form

CHARACTERISTIC	NUMBER OF PATIENTS (a)
26. PUBLIC HOUSING PATIENTS (ALL GRANTEES REPORT THIS LINE)	

TABLE 6A:
DIAGNOSES AND SERVICES

Table 6A: Newly Diagnosed HIV Patients

- The number of patients receiving a diagnosis of HIV for the first time in their lives during the measurement year
  - *Not just first time at your center – first time <u>ever</u>*
- Note that there are no ICD-9 /ICD-10 codes for this
  - Multiple methods can be used to track

	Diagnostic Category	Applicable ICD-9-CM Code	Number of Visits by Diagnosis regardless of primacy (A)	Number of Patients with Diagnosis regardless of primacy (B)
Selected Infectious and Parasitic Diseases				
1-2.	Symptomatic HIV , Asymptomatic HIV	042 , 079.53, V08		
1-2(a)	**Initial HIV Diagnosis: Persons diagnosed for the first time ever in their lifetime (see manual)**			

TABLES 6B AND 7: CLINICAL MEASURES

Tables 6B and 7: Prenatal Services

- *All* health centers will now report on prenatal and perinatal services whether they are provided directly at the health center, by formal referral to another provider, or by a combination of the two. This will include:
  - Age and trimester of entry into care on Table 6B
  - Deliveries and infant birth weights on Table 7
- Health centers which diagnose a woman's pregnancy but do not directly provide prenatal care must refer for this care. If they do, they must:
  - Track the referral to establish and record the date of her first comprehensive obstetrical visit.
  - Track her delivery and record the weight of the infant(s) at birth.

Table 6B: Tobacco Use Screening and Intervention

UNIFORM DATA SYSTEM
FOR HEALTH CENTERS

- Tobacco use screening and cessation intervention, formerly two separate measures (lines 14 and 15), are now combined into one measure (line 14a)
  - Count as compliant (1) patients who were screened for tobacco use who were not tobacco users AS WELL AS (2) those identified as tobacco users who received cessation intervention.

Tobacco Use Screening and Cessation Intervention		Total Patients Aged 18 and Over (a)	Number Charts Sampled or EHR Total (b)	Patients Screened and Intervened With As Appropriate (c)
14a	MEASURE: Patients age 18 and older (1) screened for tobacco use AND (2) received cessation intervention or medication if identified as a tobacco user in the measurement year or prior year			

16

Table 6B: New Measure - HIV Linkage to Care

- Patients first ever diagnosed with HIV (reported on Table 6A, line 1-2a) who receive follow-up care within 90 days of the diagnosis
  - If follow-up care is provided by referral by a Ryan White clinic or another provider, follow-up must be completed within 90 days of diagnosis, not within 90 days of referral.

	New HIV Cases With Timely Follow-up	Patients First Diagnosed with HV (a)	Charts Sampled or EHR Total (b)	Patients First Diagnosed and Seen Within 90 Days of Diagnosis (c)
20	MEASURE: Patients whose first ever HIV diagnosis was made by health center staff between October 1 and September 30 and who were seen for follow-up within 90 days of that first ever diagnosis			

Table 6B: New Measure - Clinical Depression Screening

- Clinical depression screening of (medical) patients age 12 and older during the reporting period using a standardized instrument _and_ if screened positive, had a follow-up plan documented

	Patients Screened for Depression and Followed Up As Appropriate	Total Patients Aged 12 and Older (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Screened and Documented As Appropriate (c)
21	MEASURE: Patients aged 12 and over who were (1) screened for depression with a standardized tool and (2) had a follow-up plan documented if screened positive			

Table 6B: New Measure - Clinical Depression Screening

Standardized Depression Screening Tool – A normalized and validated depression screening tool developed for the patient population in which it is being utilized

Examples of depression screening tools include but are not limited to:
- Adolescent Screening Tools (12-17 years)

Patient Health Questionnaire for Adolescents (PHQ-A), Beck Depression Inventory-Primary Care Version (BDI-PC), Mood Feeling Questionnaire, Center for Epidemiologic Studies Depression Scale (CES-D) and PRIME MD-PHQ2
- Adult Screening Tools (18 years and older)

Patient Health Questionnaire (PHQ9), Beck Depression Inventory (BDI or BDI-II), Center for Epidemiologic Studies Depression Scale (CES-D), Depression Scale (DEPS), Duke Anxiety-Depression Scale (DADS), Geriatric Depression Scale (SDS), Cornell Scale Screening and PRIME MD-PHQ2

Table 6B: Coronary Artery Disease (CAD) and Lipid Lowering Therapy

- Measures percentage of patients aged 18 years and older with a diagnosis of CAD whose lipid levels were determined to be high who were prescribed a lipid-lowering therapy.

- BPHC had proposed a modification to this measure in PAL 2013-07. The proposed change was canceled in PAL 2014-01 due to recently updated clinical guidelines.

- BPHC may revisit the modification of the measure once a consensus has been established by the scientific and medical communities.

Table 7: Diabetes Control

- Diabetes control measure will continue to be all patients whose last HbA1c in the measurement year is equal to or less than 9%

  - Instead of four categories, reporting will divide compliant patients into those with HbA1c levels less than 8%, between 8% and 9% and those with HbA1c over 9%.

  - Health centers will no longer be required to report on HbA1c less than 7%.

Section C: Diabetes by Race and Hispanic/Latino Ethnicity

Column (3c), patients with Hba1c<7 has been deleted in the table below.

Line #	Race and Ethnicity	Total Patients with Diabetes	Charts Sampled or EHR Total	Patients with Hba1c <8%	Patients with 8%<= Hba1c <=9%	Patients with Hba1c >9% Or No Test During Year
		(3a)	(3b)	(3d)	(3e)	(3f)

EHR CAPABILITIES AND QUALITY RECOGNITION FORM

EHR Capabilities and Quality Recognition Form

- BPHC will continue to collect information on the implementation of electronic health records (EHRs)
  - Revised questions are found in PAL 2014-01, Attachment 2: http://bphc.hrsa.gov/policiesregulations/policies/pal201401.pdf
- HRSA will continue to collect information on patient-centered medical home recognition/certification and accreditation.

AVAILABLE ASSISTANCE AND REFERENCES

Available Assistance

- Telephone and email support line for UDS reporting questions and use of UDS data: 866-UDS-HELP or udshelp330@bphcdata.net
- Technical Assistance materials:
    - http://www.bphcdata.net
    - http://bphc.hrsa.gov/healthcenterdatastatistics/index.html
- PALs:
    - CY 2013: http://bphc.hrsa.gov/policiesregulations/policies/pal201302.html
    - CY 2014: http://bphc.hrsa.gov/policiesregulations/policies/pal201307.html
- EHB Support
    - HRSA Call Center for EHB account access and roles: 877-464-4772
    - BPHC Help Desk for EHB system issues: 301-443-7356

References

- National Quality Forum:
  - http://www.qualityforum.org/Measures_Reports_Tools.aspx
- Meaningful Use:
  - http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Recommended_Core_Set.html
- SAMHSA-HRSA Center for Integrated Health Solutions (possible depression screening tools):
  - http://www.integration.samhsa.gov/clinical-practice/screening-tools#depression
- President's National HIV/AIDS Strategy (NHAS):
  - http://www.whitehouse.gov/administration/eop/onap/nhas/
- Healthy People 2020:
  - http://healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=8

Questions?

Thank you for attending this webinar and for all of your hard work to provide comprehensive and accurate data to BPHC!