

UNIFORM DATA SYSTEM

Calendar Year 2014



INTRODUCTION TO UDS CLINICAL MEASURES

Bureau of Primary Health Care
October 20, 2014, 2-4 PM (EST)

Agenda

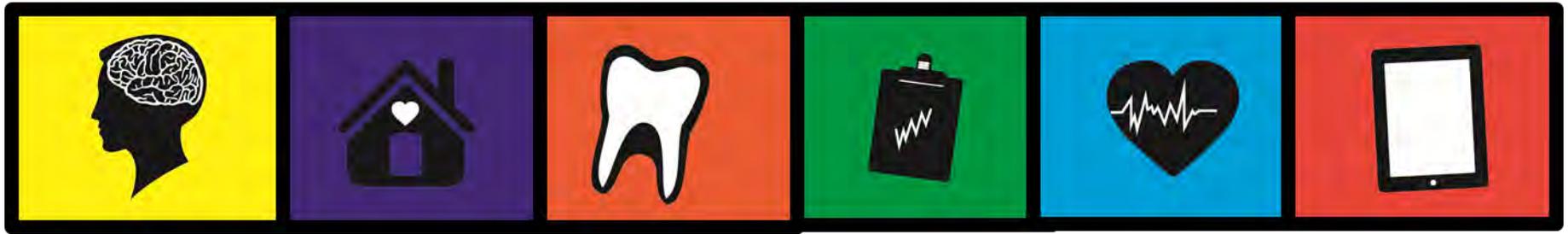


- Review of Uniform Data System (UDS) Clinical Measures
- Changes to 2014 UDS
- Meeting the Measurement Standard
- Assessing Data Accuracy
- Reporting Methods
- Reminders and Strategies for Successful Reporting
- References and Available Assistance

Purpose of this Webinar



- Understanding clinical measures and identifying ways to check data reliability
 - Some quick methods for checking data accuracy
- Identify benchmarks for assessing clinical quality
 - BPHC's 3-year health center trends (*where available*) and program averages
 - National benchmarks, including Healthy People 2020
- Brief overview of clinical measures
 - Available UDS instructor-led training



CLINICAL MEASURES ASSESSMENT AND DATA ACCURACY

12 Tables Provide a Snapshot of Patients and Quality



What is reported	Table(s)
Patients served & their socio-demographic characteristics	ZIP code, 3A, 3B, 4
Types and quantities of services you provide	5 and 6A
Staffing mix and tenure	5 and 5A
The care you deliver; quality of care measures	6A, 6B, 7
Costs of providing services	8A
Revenue sources	9D and 9E

Clinical Quality Tables



- Three of the tables focus on clinical care:
 - Table 6A: Selected Diagnoses and Services Rendered
 - Table 6B: Quality of Care Measures
 - Table 7: Health Outcomes and Disparities
- UDS clinical measures will continue to be revised to align with national measures, such as the National Quality Strategy, Meaningful Use, and Healthy People.

Summary of Clinical Reporting Changes for 2014 UDS



- **Table 6A:**
 - Will be reported by look-alikes for the first time
 - Line 1-2a “Newly diagnosed HIV” added
- **Table 6B:**
 - Tobacco use: assessment and cessation intervention measures have been combined into one measure “Tobacco Use Screening and Cessation Intervention”
 - New measure: HIV linkage to care
 - New measure: Clinical depression screening and follow-up
 - Prenatal care services: Reported for all women including referrals
- **Table 7:**
 - Diabetes: Reporting categories of “HbA1c less than 7%” and “7 - 8%” have been combined into “HbA1c less than 8%”
 - Perinatal outcomes: Reported for all women including referrals

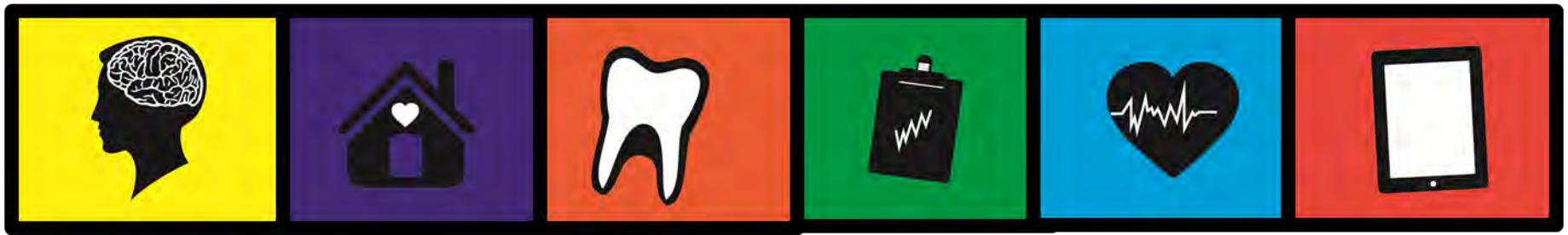


TABLE 6A

Selected Diagnoses and Services Rendered

Table 6A: Selected Diagnoses and Services



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		
1-2a. Newly diagnosed HIV	042, 079.53, V08		
3. Tuberculosis	010.xx – 018.xx		
4. Syphilis and other sexually transmitted infections	090.xx – 099.xx		
4a. Hepatitis B	070.20, 070.22, 070.30, 070.32		
4b. Hepatitis C	070.41, 070.44, 070.51, 070.54, 070.70, 070.71		
Selected Diseases of the Respiratory System			
5. Asthma	493.xx		
6. Chronic bronchitis and emphysema	490.xx – 492.xx		
Selected Other Medical Conditions			
7. Abnormal breast findings, female	174.xx; 198.81; 233.0x; 238.3 793.8x		
8. Abnormal cervical findings	180.xx; 198.82; 233.1x; 795.0x		
9. Diabetes mellitus	250.xx; 648.0x; 775.1x		
10. Heart disease (selected)	391.xx – 392.0x 410.xx – 429.xx		
11. Hypertension	401.xx – 405.xx;		
12. Contact dermatitis and other eczema	692.xx		
13. Dehydration	276.5x		
14. Exposure to heat or cold	991.xx – 992.xx		
14a. Overweight and obesity	ICD-9 : 278.0 – 278.02 or V85.xx excluding V85.0, V85.1, V85.51 V85.52		
Selected Childhood Conditions			
15. Otitis media and Eustachian tube disorders	381.xx – 382.xx		
16. Selected perinatal medical conditions	770.xx; 771.xx; 773.xx; 774.xx – 779.xx (excluding 779.3x)		
17. Lack of expected normal physiological development (such as delayed milestone; failure to gain weight; failure to thrive); Does not include Sexual or Mental Development; Nutritional deficiencies	250.xx – 269.xx; 779.3x; 783.3x – 783.4x;		

- Purpose of table:
 - Reports visits and patients for selected diagnoses and services
 - Permits estimation of prevalence rates for specific diagnoses and services
 - Indicates continuity of care (average visits per patient by diagnosis)

Data Requirements for Selected Diagnoses: Column A, lines 1-20d



- Reports on the number of visits which reported the selected **diagnosis**
 - Each row has a name (e.g., diabetes), but is *defined by one or more* ICD-9 codes as listed on the table and in the reporting manual
 - Some codes are intentionally excluded, such as the code for gestational diabetes
 - Each visit with the identified diagnosis is counted
 - If patients have more than one reportable diagnoses during a visit, each is counted
 - E.g., hypertension and diabetes and obesity

Data Requirements for Selected Services: Column A, lines 21-34



- Reports on the number of visits which reported one or more of the selected **services**
 - Each row has a name (e.g., childhood immunizations), but is *defined by one or more* CPT (or ICD-9) codes or – in the case of dental services – ADA codes
 - Some codes are intentionally excluded, such as the codes for some surgically related procedures
 - Each visit with the service provided is counted
 - If patients have more than one reportable service during a visit, each is counted
 - E.g., Pap test and contraceptive services
 - But not multiple services in the same category at one visit
 - E.g., a DPT and an MMR at the same visit

Data Requirements for Patient Count: Column B



- Reports on the number of unique patients who had a specific diagnosis or received one or more of the selected services
 - Each row has a name *defined by one or more* CPT, ICD-9 or ADA codes
 - Some codes are intentionally excluded, such as the codes for some surgically related procedures
 - Each patient who has had one or more visits with the designated codes is reported once and only once in column B
 - E.g., a patient seen five times for diabetes is counted once and only once as a patient in column B

Assessing Accuracy of Table 6A Data on Diagnoses and Selected Services



- Data Accuracy Checks:
 - Check patient counts in Column B by estimating prevalence rates for chronic conditions (e.g., hypertension, diabetes) with what you report for your community in your needs assessment
 - Column B number divided by medical patients on Table 5
 - Check Columns A and B by calculating average number of service visits per patient (e.g., visits per year for diabetics, well child visits per child)

Table 6A Changes for 2014 UDS



- Look-alikes will complete this table for the first time this year.
- Added Line 1-2a: Newly Diagnosed with HIV
 - Persons first diagnosed with HIV during the reporting year
 - Count only individuals who had never been formally diagnosed with HIV prior to a visit with your provider
 - Do not count persons who had been previously diagnosed but who were being seen for the first time at *your* health center
 - ICD-9 codes do not identify *initial* diagnosis of HIV - this will need to be identified from your EHR or an alternative system

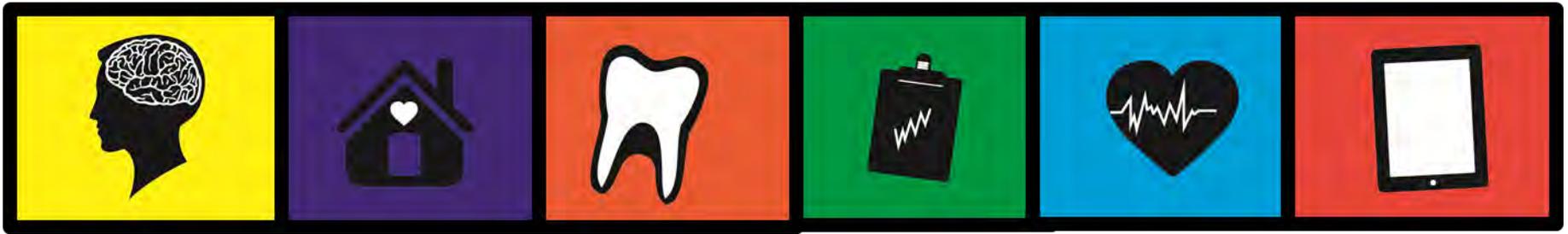


TABLE 6B

Quality of Care: Measures

Table 6B: Measures of Preventive and Chronic Care



- Purpose of Table
 - Evaluate the extent to which medical patients are receiving appropriate preventive and chronic care. This serves as a proxy for improving health status
 - *If patients receive timely preventive care, then we can expect improved health status*
- Access to prenatal care (first prenatal visit in 1st trimester)
- Childhood immunizations
- Cervical cancer screening
- Child and adolescent weight screening & counseling
- Adult weight screening & follow-up
- Tobacco use screening and cessation intervention
- Asthma pharmacologic therapy
- Coronary artery disease and lipid-lowering therapy
- Ischemic vascular disease and aspirin
- Colorectal cancer screening
- HIV Linkage to care
- Depression screening and follow-up



Timely Entry into Prenatal Care

- **Goal:** Timely entry into care
- **Evaluate:** Percent of pregnant patients – including patients referred out – who enter prenatal care in first trimester
 - Entry into prenatal care begins with a complete prenatal physical exam with a physician or NP/PA/CNM
 - Does not include a pregnancy test, nurse assessment, etc.)
 - Prenatal patients include all patients with ANY prenatal care *regardless* of whether some or all of the prenatal care or the delivery is provided by a health center provider
 - Prenatal patients who transfer *in* are reported in column (b)

SECTION B – TRIMESTER OF ENTRY INTO PRENATAL CARE			
TRIMESTER OF FIRST KNOWN VISIT FOR WOMEN RECEIVING PRENATAL CARE DURING REPORTING YEAR		Women Having First Visit with Health Center (a)	Women Having First Visit with Another Provider (b)
7	First Trimester		
8	Second Trimester		
9	Third Trimester		

Measuring Timely Entry into Prenatal Care Data



- **Measurement Standard:** Early (first trimester) entry into prenatal care
 - Include patients who began care with another provider
 - Include women whose only service with you in 2014 was their delivery
 - Include women who were referred to care, transferred, or were “risky out”, as well as women who were delivered by another health center’s provider

Prenatal Care Measure



- All Health Centers will report on all pregnant *medical* patients who were provided any of the following required services:
 - ***NEW (2014 UDS Change)***: Referral for prenatal care with no prenatal care provided by the health center
 - some prenatal care and then transferred because of risk status
 - some prenatal care and then referred out for late prenatal care and delivery
 - some or all prenatal care and then referred for delivery
 - full perinatal services including delivery by the health center

Prenatal Care 2014 UDS Reporting Changes



- Report ALL health center patients who receive prenatal care services at the health center OR are referred elsewhere for prenatal care

Assessing Accuracy of Early Entry into Prenatal Care Data



- Data Accuracy Checks:
 - Universe:
 - Prenatal medical patients by age must equal prenatal patients by trimester of entry
 - Measurement Standard:
 - Large number of late entry into prenatal care with another provider or no entry into care with another provider suggests error
 - National Comparisons:
 - 2013 health centers average: 71.6% of women enter care in first trimester
 - Healthy People 2020 goal: to have 77.6% of females receiving prenatal care in 1st trimester

Childhood Immunizations



- **Goal:** Fully immunized children
- **Evaluate:** Percent of children receiving medical care during the measurement year who were fully immunized* before their *third* birthday.

*11 diseases vaccinated against: 4 DTP/DTaP, 3 IPV, 1 MMR, 3 Hib, 3 Hepatitis B, 1 VZV (Varicella), 4 Pneumococcal conjugate

No exclusions

SECTION C – CHILDHOOD IMMUNIZATION			
CHILDHOOD IMMUNIZATION	TOTAL NUMBER OF PATIENTS WITH 3 RD BIRTHDAY DURING MEASUREMENT YEAR (a)	NUMBER CHARTS SAMPLED OR EHR TOTAL (b)	NUMBER OF PATIENTS IMMUNIZED (c)
10 MEASURE: Children who have received age appropriate vaccines prior to their 3 rd birthday during measurement year (on or prior to 31 December)			

Measuring Childhood Immunization Data



- **Measurement Standard:** Number of children who, before their *3rd* birthday, for each and every disease, are (1) fully immunized, or (2) had evidence of the disease or (3) have a contraindication for vaccine
 - Medical records must indicate the name of the provider and the date for each vaccine
 - Parental refusal or failure to bring in patient means non-compliance
 - Vaccines are clinically required by age 18 months
 - Requires 3 years of immunization history

Assessing Accuracy of Childhood Immunization Data



- Data Accuracy Checks:
 - Universe:
 - Turned 2 years and 364 days in 2014 - Not all patients 3 or younger
 - At least one medical visit in measurement year - Includes any medical visit, not just well-child visits
 - Excludes dental-only or vaccine-only patients
 - Measurement Standard:
 - Will not equal the number of patients identified as having received ‘Selected Immunizations’ on table 6A (line 24) because table 6A includes other age groups and the table 6B measure includes vaccinations given elsewhere
 - National Comparisons:
 - 2013 health centers’ average 76.4%
 - Healthy People 2020 goal: 80% for complete series

Cervical Cancer Screening



- **Goal:** Provide cervical cancer screening for adult women aged 24 through 64
- **Evaluate:** Percent of all women aged 24-64 who had at least one medical visit in a health center clinic during 2014 and were first seen before age 65

Excludes patients with hysterectomy

PAP TESTS		TOTAL NUMBER OF FEMALE PATIENTS 24-64 YEARS OF AGE (a)	NUMBER CHARTS SAMPLED OR EHR TOTAL (b)	NUMBER OF PATIENTS TESTED (c)
11	Measure: Female patients aged 24-64 who received one or more Pap tests to screen for cervical cancer			

Measuring Cervical Cancer Screening Data



- **Measurement Standard:** Women who received one or more documented Pap tests (regardless of where performed):
 - During the measurement year or prior two years OR,
 - During the measurement year or the prior four years prior for women who were 30 or older at the time of the test who chose and received a Pap test accompanied with an HPV test
- A copy of the test result (your lab or another lab) or notation by your provider or clinic staff in the patient's chart that includes the provider, test date, and result
 - Not sufficient:
 - A note that “patient was referred” or “patient reported receiving pap test”
 - Patient refused or failed to return for test
 - Look back into 3-5 years of medical records (based on age and tests)

Assessing Accuracy of Cervical Cancer Data



- Data Accuracy Check:
 - Universe:
 - Number of women aged 24-64 years
 - Unlikely to exceed total women aged 24-64 reported on Table 3A
 - Will be lower than Table 3A count if there are non-medical patients (those who receive only dental, mental health, etc.) at the clinic
 - At least one medical visit in measurement year
 - Includes all medical visits, not just OB/GYN visits
 - Measurement Standard:
 - Will not be equal to ‘Pap test’ reported on table 6A (line 23) because patients may receive Pap tests elsewhere
 - National Comparisons:
 - 2013 health center average 57.8%
 - Healthy People 2020 goal: 93.0%

Child and Adolescent Weight Screening and Counseling



- **Goal:** Children and adolescents have their weight assessed and receive related counseling
- **Evaluate:** Percent of children and adolescents aged 3 until 17 receiving medical care who had documentation of Body Mass Index (BMI) *percentile* **AND** counseling for nutrition (not just diet) **AND** physical activity (not just exercise) during the measurement year.

CHILD AND ADOLESCENT WEIGHT ASSESSMENT AND COUNSELING		TOTAL PATIENTS AGED 3 – 17 ON DECEMBER 31 (a)	NUMBER CHARTS SAMPLED OR EHR TOTAL (b)	NUMBER OF PATIENTS WITH COUNSELING AND BMI DOCUMENTED (c)
12	MEASURE: Children and adolescents aged 3 until 17 during measurement year (on or prior to 31 December) with a BMI percentile, and counseling on nutrition and physical activity documented for the current year			

Measuring Adolescent Weight Screening and Counseling Data



- **Measurement Standard:** Patients who had a recorded BMI percentile and documented counseling on both nutrition and activity.
 - Just recording that a well child visit does not meet the requirement
 - All three criteria must be documented: BMI percentile, counseling on nutrition, and counseling on physical activity
 - Review medical records for the entire measurement year – services may be provided at multiple visits

Assessing Accuracy of Adolescent Weight Screening and Counseling Data



- Data Accuracy Checks:
 - Universe:
 - Children 3-17 on Table 3A
 - Number will be less when some children are seen just for dental or other non-medical services
 - At least one medical visit in measurement year
 - Includes all medical visits, not just well child visits
 - National Comparisons:
 - 2013 health center average 51.8%

Adult Weight Screening and Follow-up



- **Goal:** Weight assessed and follow-up provided if needed
- **Evaluate:** Percent of medical patients aged 18 and older who had their BMI recorded at their last visit or within 6 months of that visit and had a follow-up plan documented if BMI is outside parameters.

Excluding pregnant women and terminally ill patients

ADULT WEIGHT SCREENING AND FOLLOW-UP		TOTAL PATIENTS AGED 18 AND OLDER (a)	NUMBER CHARTS SAMPLED OR EHR TOTAL (b)	NUMBER OF PATIENTS WITH BMI CHARTED AND FOLLOW-UP PLAN DOCUMENTED AS APPROPRIATE (c)
13	MEASURE: Patients aged 18 and older with (1) BMI charted <i>and</i> (2) follow-up plan documented <i>if</i> patients are overweight or underweight			

Measuring Adult Weight Screening and Follow-Up Data



- **Measurement Standard:**
 - Measure BMI
 - BMI must be recorded at last visit or within 6 months of last visit
 - Just recording height and weight is not adequate – BMI must be visible in chart or on template
 - Measurement standard is also met if adults within normal BMI range have BMI recorded in medical record
 - Document a follow-up plan if:
 - under age 65: BMI was ≥ 25 OR < 18.5 or
 - age 65 and older: BMI was ≥ 30 OR < 22

Assessing Accuracy of Adult Weight Screening and Follow-Up Data



- Data Accuracy Checks:
 - Universe:
 - Adults on Table 3A adjusted for non-medical patients seen
 - National comparisons:
 - 2013 average 53.3%

Tobacco Use Screening and Cessation Intervention



- **Goal:** Adults assessed for tobacco use and, if identified as tobacco user, received cessation counseling and/or pharmacotherapy
- **Evaluate:** Percent of medical patients aged 18 and older
 - with 2 or more medical visits (ever, although at least one must be in the measurement year)
 - who were queried by any provider at least once within 24 months of their last visit (during measurement year) about any and all forms of tobacco use
 - **AND** received tobacco cessation counseling intervention and/or pharmacotherapy if identified as a tobacco user

No exclusions

SECTION G – TOBACCO USE SCREENING AND CESSATION				
TOBACCO USE SCREENING AND CESSATION		TOTAL PATIENTS AGED 18 AND OLDER (a)	NUMBER CHARTS SAMPLED OR EHR TOTAL (b)	NUMBER OF PATIENTS ASSESSED FOR TOBACCO USE AND INTERVENTION PROVIDED AS APPROPRIATE (c)
14a	MEASURE: Patients aged 18 and older (1) screened for tobacco use and (2) received cessation counseling intervention or medication if identified as a tobacco user one or more times in the measurement year or prior year			

2014 Change: Tobacco Use Screening and Cessation Measure



- **2014 Change:** The Tobacco Use Screening and Cessation Intervention measures reported in 2013 have been combined into one measure.
- Measure checks:
 - were patients age 18 and older assessed for tobacco use? **AND**
 - if they were found to be users, were they provided intervention?
- Will no longer have separate questions to assess screening and treatment separately

Tobacco Use Screening & Cessation Intervention Data



- **Measurement Standard:** Documentation must evidence:
 1. **Medical** patients queried about tobacco use by any staff
 - Query for tobacco use - not just smoking
 - Include query by any staff – medical, dental, vision, etc.
 - Query was in the measurement year or within 24 months of last visit which means three years of data are needed
 2. **AND** if found to be a tobacco user:
 - Received tobacco use cessation services *or*
 - Received an order for a smoking cessation medication (prescription or OTC) *or*
 - Found to be on a smoking cessation agent

Assessing Accuracy of Tobacco Use Screening Data



- Data Accuracy Checks:
 - Universe:
 - Number is compared to adults age 18 and older on Table 3A adjusted for non-medical patients seen
 - National comparisons:
 - Historical data:
 - 2013 Tobacco Use Assessment 91.5%
 - 2013 Tobacco Cessation Intervention 63.7%
 - *2013 UDS data are not comparable to current year due to measure revision*

Asthma Treatment



- **Goal:** Asthma patients should be on appropriate pharmacologic therapy
- **Evaluate:** Percent of patients aged 5 through 40 with two or more visits (at least one medical), who had a diagnosis of persistent asthma, who received or were prescribed corticoid steroids or approved alternative pharmacologic therapy.

Excludes patients with allergic reaction to asthma medications and those with intermittent asthma

ASTHMA TREATMENT PLAN		TOTAL PATIENTS AGED 5 - 40 WITH PERSISTENT ASTHMA (a)	NUMBER CHARTS SAMPLED OR EHR TOTAL (b)	NUMBER OF PATIENTS WITH ACCEPTABLE PLAN (c)
16	Measure: Patients aged 5 through 40 diagnosed with <i>persistent</i> asthma who have an acceptable pharmacological treatment plan			

Measuring Asthma Treatment Data



- **Measurement Standard:** Documented treatment for persistent asthma patients as evidenced by:
 - Inhaled corticosteroids being prescribed or given *or*
 - an approved alternative medication being prescribed or given *or*
 - Evidence that patient was on one of these medications
- Look back into patient records for history of persistent asthma, ideally over at least three years

Assessing Accuracy of Asthma Treatment Data



- Data Accuracy Checks:
 - Universe:
 - Estimated Prevalence: 2013 BPHC average indicates 5%
 - Patients on Table 3A adjusted for non-medical patients
 - Will not be equal to the number of patients identified as having 'Asthma' on table 6A (line 5) because of differences in age, severity, and visit criteria
 - National Comparisons:
 - 2013 health center average 77.7%

Cholesterol Treatment (Lipid Therapy for CAD patients)



- **Goal:** CAD patients on lipid lowering therapy
- **Evaluate:** Percent of CAD patients (including patients who had an MI or cardiac surgery) aged 18 years and older with two or more medical visits (at least one during the measurement year) who were prescribed a lipid-lowering therapy.

excluding individuals whose last LDL lab test was <130 mg/dL or with an allergy to or a history of adverse outcomes from or intolerance to LDL lowering medications

LIPID THERAPY		TOTAL PATIENTS AGED 18 AND OLDER WITH CAD DIAGNOSIS (a)	NUMBER CHARTS SAMPLED OR EHR TOTAL (b)	NUMBER OF PATIENTS PRESCRIBED A LIPID LOWERING THERAPY (c)
17	MEASURE: Patients aged 18 and older with a diagnosis of CAD who were prescribed a lipid lowering therapy			

Measuring Cholesterol Treatment



- **Measurement Standard:** CAD patients in the universe who received a prescription for, were provided with, or were taking lipid lowering medications.
 - Look back into 2 years of patient records to identify all CAD patients.
 - Need not have been seen with a CAD diagnosis in the current measurement year

Assessing Accuracy of Cholesterol Treatment Data



- Data Accuracy Checks:
 - Universe:
 - Estimated Prevalence: 2013 BPHC average indicates 2% of estimated adult medical patients had a diagnosis of CAD
 - Adults on Table 3A adjusted for non-medical patients
 - National Comparisons:
 - 2013 health center average 75.1%

Heart Attack/Stroke Treatment (Aspirin Therapy for IVD Patients)



- **Goal:** IVD patients on aspirin therapy
- **Evaluate:** Percent of IVD patients (AND patients who had been discharged after AMI or CABG or PTCA in the prior year) aged 18 years and older with at least one medical visit who had documentation of use of aspirin or another antithrombotic.

No exclusions

ASPIRIN OR OTHER ANTITHROMBOTIC THERAPY		TOTAL PATIENTS 18 AND OLDER WITH IVD DIAGNOSIS OR AMI, CABG, OR PTCA PROCEDURE (a)	CHARTS SAMPLED OR EHR TOTAL (b)	NUMBER OF PATIENTS WITH ASPIRIN OR OTHER ANTITHROMBOTIC THERAPY (c)
18	MEASURE: Patients aged 18 and older with a diagnosis of IVD or AMI, CABG, or PTCA procedure with aspirin or another antithrombotic therapy			

Measuring Heart Attack/Stroke Treatment Data



- **Measurement Standard:** Documentation of aspirin or another anti-thrombotic medication being prescribed, dispensed or used by patients with IVD.
 - Look back into 2 years of patient records to find universe of IVD patients

Assessing Accuracy of Heart Attack/Stroke Treatment Data



- Data Accuracy Checks:
 - Universe:
 - Estimated Prevalence: 2013 BPHC average indicates 3% of estimated adult medical patients had a diagnosis of IVD
 - Adults on Table 3A adjusted for non-medical patients
 - Percent of total adults diagnosed with IVD
 - National Comparisons:
 - 2013 health center average 74.8%



Colorectal Cancer Screening

- **Goal:** Patients screened for colorectal cancer
- **Evaluate:** Percent of patients aged 50 through 74* with at least one medical visit who had appropriate screening for colorectal cancer.

Excluding patients who have had colorectal cancer or a colectomy

COLORECTAL CANCER SCREENING		TOTAL PATIENTS 51 THROUGH 74 YEARS OF AGE (a)	CHARTS SAMPLED OR EHR TOTAL (b)	NUMBER OF PATIENTS WITH APPROPRIATE SCREENING FOR COLORECTAL CANCER (c)
19	MEASURE: Patients age 51 through 74 years of age during measurement year (on or prior to 31 December) with appropriate screening for colorectal cancer			

* Note: Age 51-74 is used since detail calls for persons to be screened within a year of turning 50.

Measuring Colorectal Cancer Screening



- **Measurement Standard:** Patients who had documentation of appropriate colorectal cancer screening.
 - Include patients who received:
 - Colonoscopy conducted during reporting year or previous 9 years **OR**
 - Flexible sigmoidoscopy conducted during reporting year or previous 4 years **OR**
 - Fecal occult blood test (FOBT), including the fecal immunochemical (FIT) test, during the reporting year
 - Look back into 10 years of patient records for screening

Assessing Accuracy of Colorectal Cancer Screening Data



- Data Accuracy Checks:
 - Universe:
 - Adults on Table 3A adjusted for non-medical patients
 - At least one medical visit in measurement year
 - National Comparisons:
 - 2013 health center average 32.6%
 - Healthy People 2020 goal: 70.5% screened for colorectal cancer

New HIV Cases with Timely Follow-Up



- **Goal:** Initiate HIV medical care for patients newly diagnosed with HIV within 90 days of diagnosis
- **Evaluate:** Percent of medical patients diagnosed with HIV for the first time ever with HIV between 10/1/13 and 9/30/14.

No exclusions

NEW HIV CASES WITH TIMELY FOLLOW-UP		TOTAL PATIENTS FIRST DIAGNOSED WITH HIV (a)	CHARTS SAMPLED OR EHR TOTAL (b)	NUMBER OF PATIENTS SEEN WITHIN 90 DAYS OF FIRST DIAGNOSIS OF HIV (c)
20	MEASURE: Patients whose first ever HIV diagnosis was made by health center staff between October 1 of the prior year and September 30 of the measurement year and who were seen for follow-up within 90 days of that first ever diagnosis			

Measuring New HIV Cases with Timely Follow-Up



- **Measurement Standard:** Patients who had a medical visit for HIV care within 90 days of their first-ever HIV diagnosis
 - Medical visit with a health center provider who initiates treatment for HIV
 - Visit with (not referral to) a referral resource who initiates treatment for HIV
- Visit must be conducted and referral loop closed

Assessing New HIV Cases with Timely Follow-Up Data



- Universe
 - Exclude persons who have only a reactive, initial test without confirmation by a positive, supplemental test
 - Include patients referred after a reactive, initial test elsewhere where you run supplemental test
- Data Accuracy Checks:
 - Universe: should be less than the number of patients with HIV
 - National Comparisons:
 - Historical data not available – new measure for 2014

Patients Screened for Depression and Follow-Up



- **Goal:** All patients age 12 and older are screened for depression using a standardized tool, and if positive, have a follow-up plan documented
- **Evaluate:** Number of patients age 12 and older who have at least one medical visit during the year who had a screening for depression

Excluding persons participating in ongoing treatment for depression

PATIENTS SCREENED FOR DEPRESSION AND FOLLOW-UP		TOTAL PATIENTS AGED 12 AND OLDER (a)	CHARTS SAMPLED OR EHR TOTAL (b)	NUMBER OF PATIENTS SCREENED FOR DEPRESSION AND FOLLOW-UP PLAN DOCUMENTED AS APPROPRIATE (c)
21	MEASURE: Patients aged 12 and older who were (1) screened for depression with a standardized tool and (2) follow-up plan documented if patients were considered depressed			

Measuring Patients Screened for Depression and Follow-Up



- **Measurement Standard:**
 - Documented screening for depression using a standardized tool *AND*
 - If screening is positive, a follow-up plan is documented

Assessing Patients Screened for Depression and Follow-Up



- Data Accuracy Checks:
 - Universe:
 - Patients age 12 and older adjusted for non-medical patients
 - One medical visit during the reporting year
 - National Comparisons:
 - Historical data are not available – new measure for 2014

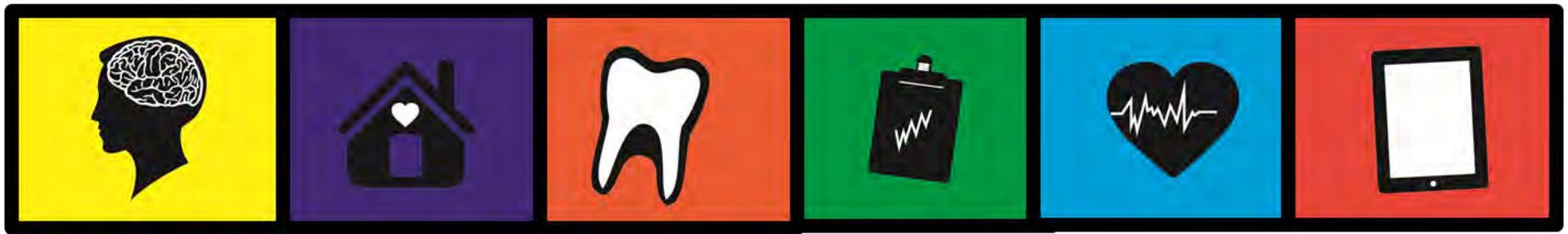


TABLE 7

Health Outcomes and Disparities: Intermediate Outcome Measures

Table 7: Health Outcomes and Disparities

- Intermediate Outcome Measures



- Purpose of Table
 - Evaluate the extent to which medical patients are receiving clinical intervention using proxy “intermediate outcome” quality of care measures
 - If this measurable intermediate outcome is met then later negative health outcomes will be less likely.
 - Intermediate Outcome Measures Evaluated:
 - Birth outcomes (normal birth weight)
 - Blood pressure control (hypertensive patients with blood pressure < 140/90)
 - Diabetes control (diabetic patients with HbA1c \leq 9%)



Birth Weight

- **Goal:** Newborns with normal birth weight
- **Evaluate:** Percent of children born that are normal birth weight.

Exclusions: None

Prenatal Care Patients Who Delivered During the Year (1a)	Live Births: <1500 grams (1b)	Live Births: 1500-2499 grams (1c)	Live Births: ≥ 2500 grams (1d)
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Measuring Birth Weight Data



- **Measurement Standard:** Number of babies born with a birth weight of 2,500 grams or greater.
 - Report birth outcomes for all prenatal patients who were known to have delivered during the year, even if some or all of the prenatal care (including the delivery) was done by another provider.
 - Include the weight for each baby born of a multiple birth
 - Include births of women whose only prenatal service in 2014 was their delivery
 - Births are reported by race and ethnicity

Assessing Accuracy of Birth Weight Data



- Data Accuracy Checks:
 - Universe:
 - Reporting by race and ethnicity
 - Comparison to patients of race reported on Table 3B
 - Comparison of prenatal patients (Table 6B) to women delivering (Table 7)
 - Not all women deliver in same reporting year or carry to term
 - Comparison of births to women delivering (both Table 7)
 - Multiple birth = 1 delivery, multiple children. Stillbirth = 1 delivery, 0 children
 - National Comparisons:
 - 2013 health center average: 5.9% LBW, 1.4% VLBW, 7.3% combined
 - Healthy People 2020 goal: 6.4% LBW, 1.4% VLBW, 7.8% combined



Blood Pressure Control

- **Goal:** Controlled hypertension
- **Evaluate:** Percent of patients
 - aged 18 to 85
 - diagnosed with hypertension prior to June 30
 - who had two or more medical visits
 whose blood pressure (BP) was less than 140/90 at the time of the last reading in the measurement year.

Excluding pregnant women and patients with End Stage Renal Disease

Total Hypertensive Patients (2a)	Charts Sampled or EHR Total (2b)	Patients with HTN Controlled (2c)

Measuring Blood Pressure Control



- **Measurement Standard:** Hypertensive patients with blood pressure (BP) less than 140/90.
 - If there was no documented BP during reporting year record fails the measurement standard
 - Include results for all hypertensive patients even if their hypertension was not treated during the measurement year
 - Look back into 3 years of patient records to identify hypertensive patients

Assessing Accuracy of Blood Pressure Control Data



- Data Accuracy Checks:

- Universe:

- Adults (adjusted for non-medical patients) on Tables 3A (age) and 3B (race and ethnicity)
- Compare prevalence to patients reported as having ‘Hypertension’ on Table 6A (line 11) – (note age and inclusion criteria are different)
- Estimated Prevalence: 2013 BPHC average indicates 24% of adult health center medical patients have hypertension; other national prevalence indicates 32% of adults age 20 and older are hypertensive.
- Disease tracking systems can be used to identify universe only if they include 100% of the hypertensives being served by the health center

- National Comparisons:

- 2013 BPHC average 63.6%
- Healthy People 2020 goal: 61% of HTN patients to have controlled BP



Diabetes Control

- **Goal:** Controlled diabetes
- **Evaluate:** Percent of patients
 - with a diagnosis of Type I or Type II diabetes
 - aged 18 to 75
 - with two or more medical visits
 - whose hemoglobin A1c (HbA1c) was less than or equal to 9% at the time of the last reading in the measurement year.

Excluding those with only a diagnosis of gestational diabetes or steroid-induced diabetes)

Total Patients with Diabetes (3a)	Charts Sampled or EHR Total (3b)	Patients with HbA1c <8% (3d1)	Patients with 8% ≤ HbA1c ≤ 9% (3e)	Patients with HbA1c >9% or No Test during Year (3f)
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Measuring Diabetes Control

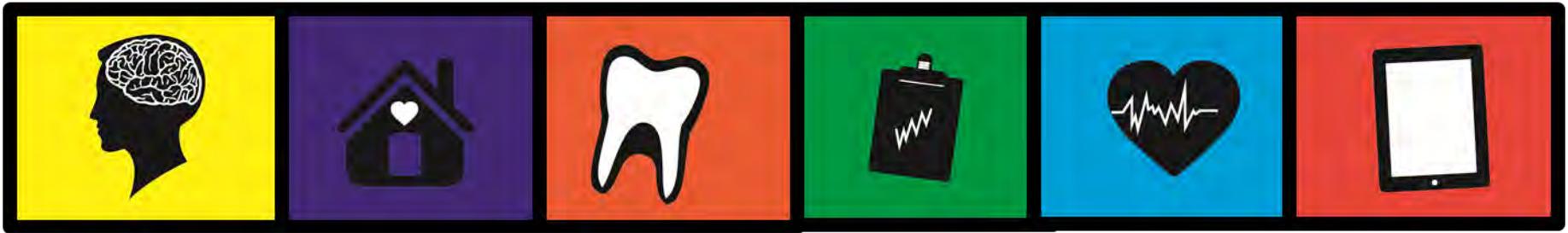


- **Measurement Standard:** Diabetic adult patients whose most recent hemoglobin A1c level during the measurement year is $\leq 9\%$.
 - Charts of diabetics with no documented HbA1c during reporting year fail the measurement standard
 - Include results for diabetic patients even if diabetes was not treated during the measurement year
 - Look back a minimum of 3 years of patient records to identify all diabetic patients
- **2014 Change:** Note that the reporting categories have been reduced such that all patients whose HbA1c levels are $\leq 8\%$ are reported in column 3d1

Assessing Accuracy of Diabetes Control Data



- Data Accuracy Checks:
 - Universe:
 - Adults (adjusted for non-medical patients) on Tables 3A (age) and 3B (race and ethnicity)
 - Compare prevalence to patients reported as having ‘Diabetes Mellitus’ on Table 6A (line 9) – (note age and inclusion criteria are different)
 - Estimated Prevalence: 2013 BPHC average indicates 13% of adult health center patients have diabetes; other national prevalence indicates 12% of adults are diabetic.
 - Disease tracking systems can be used to identify universe only if they include 100% of the diabetics being served by the health center
 - National Comparisons:
 - 2013 health center average 70%
 - Healthy People 2020 goal: 84% of with HbA1c \leq 9%



MEASURES SELECTION AND REPORTING METHODS

Options for Reporting: Table 6B



- **Column A:** Universe – All patients who meet the reporting criteria.
- **Column B** may report on
 - The universe – all patients who meet criteria *OR*
 - A sample – 70 randomly selected patients
 - Except for prenatal care where Universe must be reported
 - May select method for each measure independently
- **Column C:** Measurement Standard is the number of patients *included in column B* whose clinical record indicates that the measured criteria was met.

CHILDHOOD IMMUNIZATION		TOTAL NUMBER OF PATIENTS WITH 3 RD BIRTHDAY DURING MEASUREMENT YEAR (a)	NUMBER CHARTS SAMPLED OR EHR TOTAL (b)	NUMBER OF PATIENTS IMMUNIZED (c)
10	MEASURE: Children who have received age appropriate vaccines who had their 3 rd birthday during measurement year (on or prior to 31 December)	Universe	Sample or Universe	Records meeting the measurement standard

Options for Reporting: Racial and Ethnic Disparities Format (Table 7)



- **Columns 1a, 2a, and 3a:** Universe requires totals of:
 - 1a: women who delivered
 - 2a: hypertensive patients
 - 3a: diabetic patients
- Universe must be used for reporting on delivery and birth data (columns 1a-1d).
- **Columns 2b and 3b:** For diabetes and hypertension report on:
 - The universe of patients meeting criteria (number in columns 2a and 3a) **OR**
 - 70 randomly selected patients
 - May use different method for each
 - Random sample is across total, not 70 for each race or ethnicity
- Data must be reported by race & ethnicity for all table sections: Births, Hypertension, Diabetes

Line #	Race and Ethnicity
Hispanic/Latino	
1a	Asian
1b1	Native Hawaiian
1b2	Other Pacific Islander
1c	Black/African American
1d	American Indian/Alaska Native
1e	White
1f	More than One Race
1g	Unreported/Refused to Report Race
	<i>Subtotal Hispanic/Latino</i>
Non-Hispanic/Latino	
2a	Asian
2b1	Native Hawaiian
2b2	Other Pacific Islander
2c	Black/African American
2d	American Indian/Alaska Native
2e	White
2f	More than One Race
2g	Unreported/Refused to Report Race
	<i>Subtotal Non-Hispanic/Latino</i>
Unreported/Refused to Report Ethnicity	
h	Unreported/Refused to Report Race and Ethnicity
i	Total

Sample Size



- Reasons to choose a sample of 70
 - Automated systems cannot generate the number meeting measurement standard (e.g., exclusions cannot be removed)
 - Not all sites have been on the system for the entire measurement period
 - Not all patients are included in the EHR
- Sample can:
 - Produce accurate data with a reasonable confidence limit
 - Work where automated systems do not contain required data
 - Comply with OMB mandate of 70 for sample size

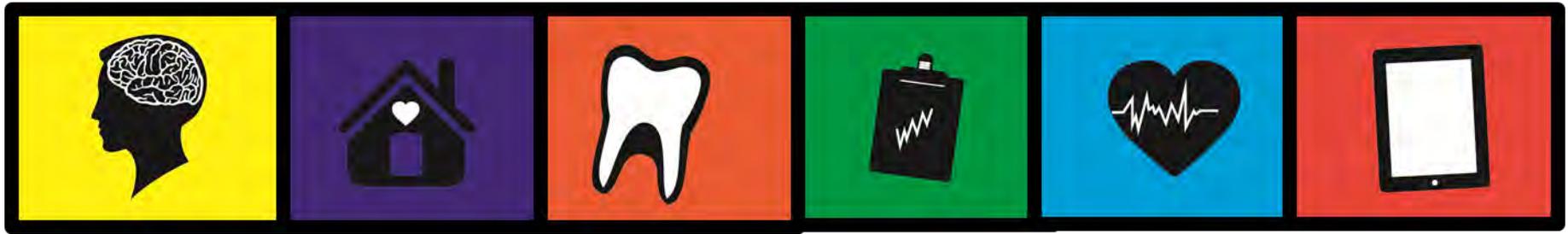
Upcoming Webinar Assistance



UDS Sampling Methods, including Randomizer.org

When: November 6, 2014 from 1:30-3 PM (EST)

Objectives: Review purpose of random sample and correct methods for generating random sample and chart substitutions



STRATEGIES AND AVAILABLE ASSISTANCE

Critical Dates in the UDS Process



- DATA ENTRY: Report through EHB (“Electronic Handbook”) beginning January 1, 2015
<https://grants.hrsa.gov/webexternal/login.asp>
 - EHB training available through HELP in application and online training module.
 - EHB incorporates hundreds of edits to alert you to possible problems that require follow-up.
- REPORT DUE DATE: February 15, 2015
- REPORT FINALIZED BY: March 31, 2015
- REPORT FEEDBACK: Trend and Comparison reports available in the summer
 - Final data can be used as part of QI initiatives

Strategies for Successful Reporting



- Work as a team
 - Tables are interrelated
- Adhere to definitions and instructions
 - Read manual, fact sheets, and other resources and apply definitions
- Check your data before submitting
 - Refer to last years reviewer’s letter emailed to UDS Preparer
 - Check data trends, relationships across tables, and compare benchmarks
 - Address edits in EHB by correcting or providing explanations that demonstrate your understanding
 - Data “says so” is not sufficient
 - Report timely, accurate data
- Work with your reviewer

Available Assistance



- Regional trainings: <http://www.bphcdata.net/html/bphctraining.html>
- On-line training modules, manual, fact sheets, webinars, and other TA materials available:
 - <http://bphc.hrsa.gov/healthcenterdatastatistics/reporting/index.html>
 - <http://www.bphcdata.net>
- All TA resources and information about general UDS requirements, including PALs are located at <http://bphc.hrsa.gov/healthcenterdatastatistics/reporting/index.html>
 - PAL 2014-01: <http://bphc.hrsa.gov/policiesregulations/policies/pal201401.html>
 - PAL 2014-02: <http://bphc.hrsa.gov/policiesregulations/policies/pal201402.html>
- Telephone and email support line for UDS reporting questions and use of UDS data: 866-UDS-HELP or udshelp330@bphcdata.net
- Technical support to review submission
- Primary Care Associations/Primary Care Offices
- 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



- Healthy People 2020:
 - <http://healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=8>
- US Preventive Services Task Force:
 - <http://www.uspreventiveservicestaskforce.org/uspstf/uspsoebes.htm>
 - <http://www.uspreventiveservicestaskforce.org/uspstf/uspshivi.htm>
- State Tobacco statistics:
 - http://www.cdc.gov/tobacco/data_statistics/state_data/state_highlights/2010/map/index.htm
- State Diabetes statistics:
 - <http://www.ncsl.org/issues-research/health/diabetes-state-rates.aspx>
 - CDC National Center for Health Statistics State Facts:
http://www.cdc.gov/nchs/fastats/map_page.htm
- SAMHSA-HRSA Center for Integrated Health Solutions (possible depression screening tools):
 - <http://www.integration.samhsa.gov/clinical-practice/screening-tools#depression>

Questions?



UNIFORM DATA SYSTEM

Calendar Year 2014



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

Ongoing questions can be addressed to

UDSHelp330@BPHCDATA.NET

866-UDS-HELP.