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

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

- 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)

<table>
<thead>
<tr>
<th>Trimester of First Known Visit for Women Receiving Prenatal Care During Reporting Year</th>
<th>Women Having First Visit with Health Center (a)</th>
<th>Women Having First Visit with Another Provider (b)</th>
</tr>
</thead>
<tbody>
<tr>
<td>7  First Trimester</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8  Second Trimester</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9  Third Trimester</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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 “risked 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

<table>
<thead>
<tr>
<th>Childhood Immunization</th>
<th>Total Number of Patients with 3rd Birthday During Measurement Year (a)</th>
<th>Number Charts Sampled or EHR Total (b)</th>
<th>Number of Patients Immunized (c)</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>MEASURE: Children who have received age appropriate vaccines prior to their 3rd birthday during measurement year (on or prior to 31 December)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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*

<table>
<thead>
<tr>
<th>Pap Tests</th>
<th>Total number of female patients 24-64 years of age (a)</th>
<th>Number charts sampled or EHR total (b)</th>
<th>Number of patients tested (c)</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>Measure: Female patients aged 24-64 who received one or more Pap tests to screen for cervical cancer</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>Number of Patients with Counseling and BMI Documented (c)</th>
<th>Total Patients Aged 3-17 on December 31 (a)</th>
<th>Number of Charts Sampled or EHR Total (b)</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>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</td>
<td></td>
</tr>
</tbody>
</table>

UNIFORM DATA SYSTEM
Calendar Year 2014
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*

<table>
<thead>
<tr>
<th>Adult Weight Screening and Follow-up</th>
<th>Total Patients Aged 18 and Older (a)</th>
<th>Number Charts Sampled or EHR Total (b)</th>
<th>Number of Patients with BMI Charted and Follow-up Plan Documented as Appropriate (c)</th>
</tr>
</thead>
<tbody>
<tr>
<td>13</td>
<td>MEASURE: Patients aged 18 and older with (1) BMI charted <strong>and</strong> (2) follow-up plan documented <strong>if</strong> patients are overweight or underweight</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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*
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
Defining Compliance and Assessing Accuracy of Tobacco Assessment Data

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*

<table>
<thead>
<tr>
<th>Asthma Treatment Plan</th>
<th>Total Patients aged 5 - 40 with persistent asthma (a)</th>
<th>Number Charts Sampled or EHR total (b)</th>
<th>Number of Patients with Acceptable Plan (c)</th>
</tr>
</thead>
<tbody>
<tr>
<td>16</td>
<td>Measure: Patients aged 5 through 40 diagnosed with <em>persistent</em> asthma who have an acceptable pharmacological treatment plan</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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*

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

<table>
<thead>
<tr>
<th>Aspirin or Other Antithrombotic Therapy</th>
<th>Total Patients 18 and Older With IVD Diagnosis OR AMI, CABG, or PTCA Procedure (a)</th>
<th>Charts Sampled OR EHR TOTAL (b)</th>
<th>Number of Patients With Aspirin or Other Antithrombotic Therapy (c)</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 MEASURE: Patients aged 18 and older with a diagnosis of IVD or AMI, CABG, or PTCA procedure with aspirin or another antithrombotic therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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*

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

* 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

<table>
<thead>
<tr>
<th>NEW HIV CASES WITH TIMELY FOLLOW-UP</th>
<th>TOTAL PATIENTS FIRST DIAGNOSED WITH HIV (a)</th>
<th>CHARTS SAMPLED OR EHR TOTAL (b)</th>
<th>NUMBER OF PATIENTS SEEN WITHIN 90 DAYS OF FIRST DIAGNOSIS OF HIV (c)</th>
</tr>
</thead>
<tbody>
<tr>
<td>20</td>
<td>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</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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.*

<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
</tr>
</thead>
</table>
| 21      | 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 ≤ 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) |
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*

<table>
<thead>
<tr>
<th>Total Hypertensive Patients (2a)</th>
<th>Charts Sampled or EHR Total (2b)</th>
<th>Patients with HTN Controlled (2c)</th>
</tr>
</thead>
</table>
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*

<table>
<thead>
<tr>
<th>Total Patients with Diabetes (3a)</th>
<th>Charts Sampled or EHR Total (3b)</th>
<th>Patients with HbA1c &lt;8% (3d1)</th>
<th>Patients with 8% ≤ HbA1c ≤9% (3e)</th>
<th>Patients with HbA1c &gt;9% or No Test during Year (3f)</th>
</tr>
</thead>
</table>
Measuring Diabetes Control

• **Measurement Standard:** Diabetic adult patients whose most recent hemoglobin A1c level during the measurement year is ≤ 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 ≤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 <= 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.

<table>
<thead>
<tr>
<th>CHILDHOOD IMMUNIZATION</th>
<th>TOTAL NUMBER OF PATIENTS WITH 3RD BIRTHDAY DURING MEASUREMENT YEAR (a)</th>
<th>NUMBER CHARTS SAMPLED OR EHR TOTAL (b)</th>
<th>NUMBER OF PATIENTS IMMUNIZED (c)</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>MEASURE: Children who have received age appropriate vaccines who had their 3rd birthday during measurement year (on or prior to 31 December)</td>
<td>Universe</td>
<td>Sample or Universe</td>
</tr>
</tbody>
</table>
### 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**

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

  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 year’s 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://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
- 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:

• US Preventive Services Task Force:
  – [http://www.uspreventiveservicestaskforce.org/uspstf/uspshivi.htm](http://www.uspreventiveservicestaskforce.org/uspstf/uspshivi.htm)

• State Tobacco statistics:

• State Diabetes statistics:

• SAMHSA-HRSA Center for Integrated Health Solutions (possible depression screening tools):
Questions?
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.